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alcohol and drug alliance

An evidence base for the London crack cocaine strategy

A consultation document prepared for the Greater London Alcohol and Drug Alliance

April 2004

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Foreword

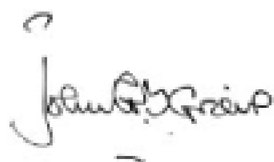
The Greater London Alcohol and Drug Alliance (GLADA) is a network of organisations and agencies concerned with addressing the harm caused by drugs and alcohol in the capital. This unique partnership brings together members from the voluntary and statutory sectors to identify strategic priorities to address the complex set of drug and alcohol issues facing the capital.

GLADA members have identified the development of a consistent and effective approach to crack cocaine across London as a priority for action.

Crack cocaine has been present in the capital since the 1980's and its effects touch many aspects of London life. The drug contributes to Londoners fear of crime, to street crime and violence, to mental and physical health problems and to family breakdown. The knowledge around crack cocaine is scanty. The drug and related issues are shrouded in myths and stereotypes. These can be damaging to those affected by the drug and those trying to work with the impact of the drug.

To effectively inform policy, planning and co-ordination of effort it is essential that we improve our knowledge and understanding of crack cocaine use and supply in London. This report represents the first stage of the development of the London Crack Cocaine Strategy. It presents the first comprehensive overview of crack cocaine in the capital and attempts to quantify the nature and scale of the problem.

The report provides the basis for informed discussion and widespread consultation. GLADA will now be seeking the views of key community stakeholders as it seeks to develop inclusive and sustainable solutions to the problems associated with crack cocaine in London



John Grieve
Independent Chair
Greater London Alcohol and Drug Alliance

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Greater London Alcohol & Drug Alliance

April 2004

Greater London Alcohol & Drug Alliance

GLADA is a strategic network of organisations and agencies concerned with reducing the harm associated with alcohol and drugs in the capital and was established by the Mayor of London in 2002 as part of his alcohol and drug policy. GLADA addresses strategic pan-London issues through partnership working. GLADA provides added value by addressing priorities that are not fully dealt with through local structures or a single agency.

All GLADA members have a London-wide remit and aim to seek the views of and represent their network or constituencies and provide a link back to these groups. The current members of GLADA include: ADFAM, Association of London Government, Black Londoners Forum, Federation of Black and Asian Drug and Alcohol Workers, Government Office for London, Greater London Association of Directors of Social Services, Greater London Authority, HM Prison Service London Area, Imperial College, London Alliance of Service Users, London Directors of Public Health, London Drug and Alcohol Network, National Drug Users Development Agency, London Drug Policy Forum, London Probation Area, Metropolitan Police Service, National Treatment Agency (London Region), London Regional Public Health Group.

One of GLADA's priorities is to base all strategic directions and priorities on a robust evidence base and to continually review the nature and impact of alcohol and drug use in London. GLADA continues to publish an annual shared work programme as part of the Mayor's policy on alcohol and drugs. Previous studies produced include: London – the Highs and the Lows (2003) which assessed the extent of drug use in London and the impact of problematic drug use on Londoners, and the London Agenda for Action on Alcohol (2004) which described the nature and scale of alcohol use in the capital and the priorities for reducing the harm caused by its use.

In its first year of existence GLADA recognised the need for a crack cocaine strategy for London to promote a co-ordinated and consistent approach across the capital, and this report represents the completion of the first phase of this work.

1. Summary

1.1 For over a decade crack cocaine has been a growing problem in Britain. London faces a greater problem than the other parts of Britain from crack cocaine use. The Greater London Alcohol and Drugs Alliance (GLADA) is developing a crack cocaine strategy for London. As a first step it has commissioned a report to establish the available evidence on patterns and trends in crack cocaine use, and in responses to crack cocaine use, in London[1]. The key findings of the report are summarised here.

Crack cocaine – the national context

1.2 Britain has sizeable crack cocaine and cocaine markets and associated problems. As in other European countries, increasing amounts of cocaine are seized each year, and the number of users is rising. The cocaine market accounts for a significant proportion of the overall illicit drug market in Britain. Crack cocaine is a central part of the repertoire of many dependent poly-drug users, and problematic drug use (in terms of social and criminal problems and/or need for treatment) is dominated by opiate and crack cocaine use. Use is at its most frequent in deprived areas and within certain groups, such as sex workers. Many crack cocaine users are heavily involved in offending to support their drug use, and those that come to police attention spend around £500 a week on illicit drugs. Many have dropped out of treatment, or have not been able to access treatment services.

1.3 Cocaine and crack cocaine markets take many forms. They are sensitive to policing, but adapt rapidly to new enforcement threats. It is possible to disperse open drug markets, but much harder actually to reduce levels of supply. The fall in prices across the country indicates that cocaine and crack cocaine are more readily available now than hitherto. The available evidence suggests that retail crack cocaine markets are best tackled using a mix of enforcement tactics, situational prevention and treatment.

1.4 Traditional treatment services have been shown to be neither attractive to or nor able to meet the needs of those using crack cocaine. Numerous studies have highlighted the additional problems faced by problematic crack cocaine, cocaine and poly-drug users.

1.5 **The National Strategic Framework**

In 1998 the Government published a ten-year drug strategy, 'Tackling Drugs to Build a Better Britain', and updated this in 2002. Overall, the updated strategy proposes an increased focus on Class A drugs; it was supplemented by the National Crack Plan (NCP) recognising the rise in crack cocaine use and related problems. The NCP identified 37 High Crack Areas (HCAs) of which almost half (16) are in London[2]. The HCA Drug Action Teams (DATs) were required to assess local problems and to design strategies to address them.

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[1] The report was prepared by staff from the National Treatment Agency, Government Office for London (Crime and Drugs Division), Metropolitan Police Service, Prison Service, Probation Service, Imperial College, Kings College London, and the Greater London Authority

[2] The 16 HCAs are: Brent, Camden, Croydon, Hackney, Hammersmith and Fulham, Haringey, Islington, Kensington and Chelsea, Lambeth, Lewisham, Newham, Southwark, Tower Hamlets, Waltham Forest, Wandsworth and Westminster.

Crack cocaine use in London

1.6 Illicit drug use is largely a hidden activity. Police statistics and those of treatment agencies reveal no more than part of the picture: only a proportion of users come to the attention either of the police or of treatment agencies, and there are probably systematic biases in the sorts of people who do so. These statistics can say as much about organisational responses to crack cocaine as they can about crack cocaine users.

1.7 However using the 'capture-recapture' technique of analysis it is possible to combine statistics from several sources to yield estimates of the number of problem drug users. Such an analysis was mounted using five data sources in 12 London Boroughs[3]; this found that there were about 20,000 crack cocaine users in these boroughs, over half of whom are also opiate users. Extrapolating to London as a whole, the results indicate that there were some 45,000 crack cocaine users in 2001. These estimates are subject to a wide margin of error and further work needs to be done to corroborate them, especially to obtain estimates by ethnic group, and to examine in more detail the overlap with opiate use. However they provide us with the best current estimate of the size of the London crack cocaine-using population. Although no trend data are available, it is very likely that a decade ago the crack cocaine-using population in London was in the low thousands; and that a substantial part of the growth of crack cocaine use has been generated by its adoption by opiate users and the growth in opiate use.
On the basis of information from Metropolitan Police Service (MPS) test-purchases, the price of crack cocaine halved in the early 1990s and has since fallen more slowly (King, forthcoming)[4]. As elsewhere in the country, crack cocaine users known to the police spend around £500 a week on drugs, though much lower levels of expenditure have been found for samples not in contact with the police.

1.8 Crack cocaine is smoked and injected. Users may develop a range of acute and chronic health problems such as lung damage, cardiovascular problems and mental illnesses. Those injecting crack cocaine may do so more frequently than users of other drugs and some are involved in selling sex. These users are at risk of HIV/AIDS, Hepatitis, wound infections and sexually transmitted infections.

Those who come to police attention and drug seizures

1.9 In 2002/03 the MPS recorded 2,138 offences involving crack cocaine – 7 per cent of all drug offences, and 39 per cent of all Class A offences. Of these 933 were for possession and 1,194 for supply[5]. The number of crack cocaine offences since 1998 has increased by 103 per cent.

1.10 The number of crack cocaine seizures in London has risen between 1997 and 2001 by 18 per cent. Of crack cocaine offences known to the police in England and Wales, more than half are in London. Rates of increase in seizures are steeper outside of London, however, suggesting a process of diffusion of use from inner London to outer London, and from London to the rest of Britain.

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[3] These estimates are derived from a capture-recapture study, funded by the Home Office, conducted in 2001 (Hope et al., forthcoming; Hickman et al., 2003, in press). Capture-recapture analyses the overlap between multiple data sources (specialist drug treatment, syringe exchange, arrest referral, community survey, A&E) to estimate the number unobserved by the data sets, and therefore the prevalence.
[4] The report did not state that analysis had accounted for inflation.
[5] Eleven cases were not identified at either supply or possession.

1.11 Given that there may be around 45,000 crack cocaine users in London, clearly only a small minority of crack cocaine users come to police attention for crack cocaine offences. However a very much larger proportion comes to police attention for other offences. In selected Criminal Justice Intervention Programme (CJIP) areas[6], arrestees committing any of 10 'trigger offences' – typically theft offences known to be committed by dependent drug users[7] - are now routinely tested for opiates and cocaine. In London CJIP areas just under half of all tests proved positive for crack cocaine or powder cocaine. The tests cannot distinguish between the two forms of the drug, but interview data show that the majority of powder or crack cocaine users will have used crack cocaine. Half of those testing positive for cocaine also tested positive for opiates.

1.12 The CJIP data suggest that a large number of those passing through the Criminal Justice System (CJS) who are arrested for a range of acquisitive and drug offences are also using cocaine and/or crack cocaine problematically.

Demographics of crack cocaine users known to the police

1.13 Nine out of ten of those arrested for drug offences in London are male and their average age was mid-twenties. Around half are white European and under a third African Caribbean. However, two thirds (67 per cent) of those accused of supplying crack cocaine in 2002/03 were African Caribbean.

1.14 Police arrests for crack cocaine supply are concentrated in inner city boroughs with hotspots in the West End, Brixton and North Kensington. Cocaine supply exhibited a similar a pattern with its main hotspot in Westminster. In total, five boroughs (Brent, Haringey, Camden, Lambeth and Kensington & Chelsea) accounted for over half of the crack cocaine supply offences in 2002/03.

1.15 There are clear patterns of association between social deprivation and Class A drug offending, with highest *levels* in poorer inner London boroughs. However the *rate of increase* in recorded crack cocaine offending is now higher in outer London boroughs.

Treatment

1.16 Those who seek treatment for crack cocaine problems often present with a complex set of needs, with problems that are directly related to their use, those associated with mode of use (such as blood-borne viral infection) and problems associated with accommodation, finance, employment and childcare.

1.17 The National Treatment Agency (NTA) evidence based guidance recommends that support services for crack cocaine users:

- Deliver psycho-social interventions through counselling, group therapy, and structured day or residential care
- Provide intensive programmes for users with multiple needs
- Market themselves in a different way and pro-actively engage clients
- Offer treatment quickly and avoid pharmaceutical interventions

[6] CJIP areas are boroughs with high levels of acquisitive crime, with central government funding to set up Criminal Justice Intervention Programmes targeting drug related offending.

[7] The trigger offences are: theft; robbery; burglary; taking motor vehicle without authority; obtaining property by deception; going equipped for stealing, etc.; production or supply of Class A drug; possession of Class A drug; and possession with intent to supply a Class A drug.

- Through case management and commissioning, establish care pathways including through the criminal justice system and including aftercare

1.18 NTA stresses the role that primary care and mental health services have in supporting crack cocaine users. Users are likely to need help with accommodation problems, and they also need access to harm minimisation services e.g. interventions to reduce blood borne virus infections, and services must be able to address their housing needs for treatment to be more effective.

1.19 In November 2003 Government Office for London and the London Region NTA conducted a survey of 116 London services providing services for crack cocaine or cocaine users. Two-thirds of these services had an 'acceptable' competence in responding to crack cocaine and a quarter provided specialist services. The survey found:

- Service provision is very unevenly distributed across London, with most services located in three high crack area boroughs
- The majority of service provision is during normal working hours
- The most common low threshold interventions were 'motivational interviewing' and/or brief intervention, and assessment
- Two thirds of services provide support for families and/or carers and housing advice
- More than a quarter of low threshold providers said they were 'stretched' by their workloads
- About three quarters of structured services offered care planning and structured counselling, with about half prescribing and the same proportion providing for drug users with mental health problems
- One third of structured care services stated the majority of their workload (67 – 100 per cent) involved crack cocaine or cocaine.

1.20 The audit also showed that only twelve London DATs had a partnership protocol for enforcement activities against premises where crack cocaine use or supply gives rise to serious public nuisance. Most DATs (22 out of 29 responding) indicated that arranging for secure housing for people in or completing treatment.

Treatment workloads

1.21 The National Drug Treatment Monitoring System (NDTMS) was set up in 2001/02. In that year it recorded 21,305 demands for treatment, of which nine out of ten were new demands. 36 per cent of these involved crack cocaine, but in only 11 per cent of cases was crack cocaine reported as the main drug involved. Broadly comparable data were collected by the Regional Drug Misuse Database until 2000/01. From the mid 1990s, 'treatment episodes' for crack cocaine use doubled (and those for powder cocaine use more than doubled). By 2000/01 crack cocaine accounted for 14 per cent of all annual notifications in London compared with 3 per cent in the South East and 2 per cent in the Eastern regions.

1.22 It is clear on the one hand that demand for treatment for crack cocaine problems is growing. On the other hand, treatment services 'capture' a much smaller proportion of crack cocaine users in their workloads than the MPS does in theirs. Against a London estimate of 45,000 crack cocaine users, the workload statistics show that under 2,500 people sought treatment for crack cocaine in 2001/02 and under 8,000 of those seeking treatment of any sort used crack cocaine. A recent study of a

cohort of 100 crack cocaine users in London found that most users regarded treatment as poorly tailored to their needs and somewhat unresponsive.

1.23 Of those seeking treatment, people in inner London were more likely to report crack cocaine use than those in outer London, and were more likely to report combined use of crack cocaine and heroin. Those seeking treatment for any form of drug problems were mainly in their 20s and 30s. Three quarters were white, 10 per cent Black, 8 per cent Asian and 4 per cent from other ethnic backgrounds. Two thirds (62 per cent) of Black people seeking treatment used crack cocaine, compared with a third of white people. Black people were much less likely to report heroin use.

Linking treatment and criminal justice
1.24 This analysis suggests that the police are in contact with a much larger proportion of crack cocaine users than treatment services are. There have been several initiatives to increase the chances that problem drug users have access to treatment as they pass through the criminal justice process. The Metropolitan Police Service has invested heavily in arrest referral schemes, for example, and the London Probation Service has a substantial programme of Drug Treatment and Testing Orders.

Criminal Justice intervention Programme
1.25 The most recent Government initiative has involved setting up Criminal Justice Intervention Teams (CJITs) in areas with high levels of acquisitive crime. There are already teams in twelve priority London boroughs, and from April 2004, teams will be established in a further five boroughs. The teams are responsible for co-ordinating quick access to treatment for problematic drug users, particularly those who previously have not previously accessed services.

Arrest referral
1.26 The London Arrest Referral Monitoring Database shows that from April 2000 to February 2003, 55 per cent of those assessed reported using crack cocaine and 11 per cent cocaine. Mirroring treatment data, White arrestees were likely to be dual heroin/crack cocaine users, whilst Black arrestees were more likely to use only crack cocaine.

Innovative Community Programmes
1.27 An evaluation of good or promising practice in addressing crack cocaine problems though community leadership and environmental and situational prevention was commissioned by the Greater London Authority. The fieldwork for this evaluation took place over a four-week period in December 2003 and January 2004. 11 London Drug Action Teams (DATs) responded to call for example projects. Respondents were keen to highlight treatment, but less aware of environmental and situational prevention initiatives, though the evaluation notes the importance of this work. Some DATs reported improved partnership working as a result of the introduction of local 'crack house' protocols.

1.28 The evaluation looked in detail at nine initiatives in eight boroughs. These were :

Prothero House Micro Community Safety Strategy in Brent
West End Drug partnership in Camden and Westminster
Peer Education Project in Ealing
Hackney Crackdown Project
Haringey Peace Alliance

Brixton Area Forum in Lambeth
Southwark Building Safer Communities Drug House Protocol
Ocean New Deal for Communities in Tower Hamlets
Drug Advisory Service Haringey

1.29 A number of challenges were identified, including the difficulty in recruiting appropriately skilled staff, though there is an opportunity to use recruitment as a way of empowering and engaging with communities. Common key themes in addressing crack cocaine through community leadership and prevention are:

- A neighbourhood focus, usually smaller than the area covered by the DAT
- Effective links with regeneration partnerships and early investment in community development
- Strategically planned, long-term funding
- A combination of approaches including community development, treatment, spatial management, enforcement, tackling crime and anti-social behaviour, and work with young people.

Conclusions

1.30 The evidence-base about crack cocaine in London is sparse but growing. The following can be said with some confidence:

- Best estimates suggest that there are around 45,000 crack cocaine users in London
- Injecting crack cocaine is associated with a higher risk of Hepatitis C and HIV infection
- Expenditure on crack cocaine use is high, and many users are criminally involved
- The MPS is in contact with a significant proportion of crack cocaine users – but mainly in relation to offences committed to finance drug use
- Treatment services are currently in contact with a growing but smaller proportion of crack cocaine users
- Crack cocaine users remain a challenging population to attract to treatment, and to retain in treatment
- Treatment services are often stretched by the demands and needs of this client group

1.31 London has led the country in developing criminal justice initiatives intended to draw criminally involved problem users into treatment. However, a priority must be to also ensure that effective treatment is identified and made available. Therefore it is essential that treatment services are reconfigured to meet the multiple needs of crack cocaine using offenders.

Enforcement

1.32 The MPS drugs strategy aims to tackle drug markets by enforcing legislation and through adopting a problem solving approach. The main focus is on the most harmful drugs (e.g. heroin and crack cocaine) and related crime (e.g. acquisitive offending, gun crime and violence). Different strategies are aimed at various tiers of the market structure e.g. retail, wholesale and importation. Some of the key performance measures include increasing the number of prosecutions, crack house closures, drug seizures and dismantling of organised criminal groups. A range of educational and diversionary work complements these actions.

Community
1.33 As with the problem solving approach to enforcement, community initiatives that include a co-ordinated set of responses are most likely to succeed. Responding to crack cocaine presents an opportunity to strengthen local partnerships, but these partnerships need to better engage with the communities they serve. This is especially true for London's Black communities, where there is a low uptake of treatment and a high level of involvement in the Criminal Justice System, and a different pattern of crack cocaine use.

1.34 There are issues to be addressed about low take-up of treatment for some groups, such as those from Black Minority Ethnic (BME) communities. The different characteristics of those being arrested for crack cocaine and cocaine offences and those accessing treatment services indicate a high level of unmet need. Furthermore the potential pool of crack cocaine and cocaine users was found to be roughly double the total number of those accessing services for any drug 2001/02.

1.35 This report shows that London has a sizeable and growing crack cocaine market. Whilst it is concentrated in the deprived inner city boroughs, the market seems to be broadening to poorer outer boroughs and areas outside of London. Furthermore, those who traditionally used opiates have adopted crack cocaine. The report found that crack cocaine was being used by a number of groups, for example BME users, youths and females, all of whom have traditionally been under-represented amongst drug service clientele. Many of these have multiple needs. The report presents evidence of a clear need to redesign and reconfigure drug treatment and associated services, so that they attract these 'hard to reach' groups. To succeed in this aim, services will have to offer more holistic and seamless care pathways covering the full range of users' needs.

Improving the knowledge base
1.36 It is essential to improve the knowledge base about crack cocaine problems in London. Estimates of prevalence need to be corroborated and refined to include ethnic group and overall scale of problematic opiate use and crack cocaine use. Once it has bedded in, the treatment database needs to be analysed more fully. There are important gaps in our knowledge about the risks associated with blood-borne viruses. Further the impact of crack cocaine use on overdose and drug related deaths needs to be examined.

Next steps in developing the strategy
1.37 GLADA will co-ordinate a eight-week consultation process from 29th April 2004 to develop proposals for a crack cocaine strategy for London. Stakeholders, including the general public, are invited to contribute to this process. The final strategy will be published in Autumn 2004 and will cover the period 2005 – 2008. The progress of the priorities developed will be monitored and improved sources of information will be used as part of a regular process of review. Priority areas for the strategy could include:

Initiatives to:
Share and disseminate best practice including in relation to pregnancy, childbirth and childcare
Develop early warning systems
Ensure that the response to crack cocaine is part of mainstream provision

Development of the treatment response to:
Promote treatment and support services and widen access to them

Improve cultural competence and ability to meet the needs of people who use crack cocaine
Develop the drug treatment workforce
Ensure improved joint working with mental health and other relevant services

Development of aftercare provision to:
Ensure better co-ordination
Improve access to housing, employment, training and education
Promote self-help

Development of criminal justice system initiatives to:
Improve linkage with treatment services
Improve information sharing
Ensure that the needs of people who use crack cocaine are met in new and existing community sentences
Develop initiatives which target prolific offenders

Development of the enforcement response to:
Improve partnership working
Promote community engagement
Promote the problem solving approach
Ensure that Police performance measures reflect evidence of what is effective

Work with communities to:
Improve engagement with local partnerships
Provide education and promote the sharing of knowledge
Support faith and other groups which support users
Work preventatively with young people
Further develop environmental and situational prevention initiatives

Ensure diversity issues are addressed, especially too:
Ensure that the needs of Black and Minority Ethnic communities, of workers in the sex industry, of women, of young people who may use crack cocaine and of older poly drug users are met
Reduce the vulnerability of new minority groups or those with emerging problems

Further investigation into:
The needs of women and young people
The links between crack cocaine and domestic violence
The links between crack cocaine and gun crime

To run a communications campaign on crack cocaine in London which targets:
Professionals
Users
Communities, including families and carers

1.38 GLADA would like to hear from stakeholders about priorities for regional action and examples of effective ways of addressing crack cocaine in the capital. For more information regarding the consultation process please contact Laura.Juett@london.gov.uk or write to the address at the front of this report.

2 Introduction

2.1 For over a decade crack cocaine has challenged people working in the criminal justice system, in drug treatment services and in health agencies. Across the country there has been a great deal of positive and innovative work to address the problems posed by crack cocaine, both at central government level and locally.

2.2 London faces more serious crack cocaine problems than the rest of the country. This report offers the first attempt to chart the extent of the crack cocaine market, enforcement activity and treatment provision in London. It aims to take stock of the region's crack cocaine problems and to establish a robust evidence-base on which to ground a crack cocaine strategy for London.

2.3 It presents information about the scale of illicit drug markets, patterns and trends in use, demographic profiles of users, treatment demand and capacity, and the direct and indirect costs associated with crack cocaine use. The information is intended to help develop a strategy with realistic objectives and targets.

Thumbnail sketch of London

2.4 London is a modern, diverse, multi-cultural and dynamic city with a population of just over seven million people. London is one of the most densely populated cities in Europe. The city has good national and international transport links with two major airports (Heathrow and Gatwick) and, more recently, direct rail routes to Europe. The city comprises 33 boroughs with coterminous Crime and Disorder Reduction Partnership's (CDRPs) and Drug Action Teams (DATs). The city is policed by the Metropolitan Police Service (MPS) and the City of London Police[8].

2.5 London has a young population and a rich and vibrant economy. Just under two-thirds (64 per cent) of the population are below 30 years of age, and incomes are above the UK average. However, despite its wealth London also has areas with entrenched deprivation: around a fifth of wards fall into this category, and some are amongst the most deprived in England. The most deprived boroughs are Tower Hamlets, Hackney, and Newham. London's unemployment rate is above the national average. The highest levels of unemployment are concentrated in the inner boroughs, with Tower Hamlets and Hackney having rates around double the regional average.

2.6 The 2001 Census showed that just over a third (37 per cent) of Londoners are from minority ethnic groups, of which Asians form the largest proportion (16 per cent of all Londoners). These groups are concentrated within the inner city boroughs. In addition, in recent years these boroughs have also become home to large numbers of asylum seekers.

2.7 According to the British Crime Survey, around a third of Londoners between the ages of 16 and 30 used illicit drugs in 2001/02, compared with a quarter elsewhere in England and Wales. A much smaller proportion uses Class A drugs, and only a proportion of these will be problematic or dependent users. To help with the problem of substance abuse there are around 150 treatment services[9].

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[8] The MPS has a total of just under 29,000 officers, equating to four officers per 10,0000 population across the 32 CDRPs or boroughs which it covers.

[9] www.drugscope.org.uk

Characteristics of crack cocaine

2.8 Cocaine powder (cocaine hydrochloride) cannot be smoked – or at least doing so is an inefficient way of delivering cocaine to the brain because much of the active ingredient is burnt. However, cocaine powder can be prepared into a smokeable form, by dissolving it in water, adding an alkali such as sodium bicarbonate and then boiling off the water. The residue – crack cocaine – is smokeable.

2.9 Smoking crack cocaine is a highly efficient way of getting cocaine to the brain. Smoking crack cocaine is a much more intense experience than snorting powder cocaine. The 'high' occurs much more rapidly, and the impact wears off much more quickly, than when cocaine powder is 'snorted'. It is this speed of delivery that is thought to put crack cocaine smokers at greater risk of psychological dependency than cocaine powder.

2.10 The toxicity of cocaine – whether snorted or smoked – is lower than that of heroin. Whilst there are high risks of overdosing from heroin, the short-term risks associated with crack cocaine are lower. By contrast the risks associated with chronic use are higher than those for heroin. Heavy crack cocaine users are likely to face serious pulmonary complications, ailments associated with malnourishment and psychiatric problems.

2.11 There are certainly upward trends in crack cocaine use, as reflected by both drug agency workloads and by the views of well-informed professionals. This may in part reflect the overall growth in cocaine use, as indicated by the British Crime Survey, but it may also be a function of the particular qualities of crack cocaine.

2.12 Before crack cocaine was common in London, heroin was the principal illicit drug of dependence. In the early and mid-1990s it was thought that those who smoked crack cocaine tended not to use heroin, and *vice versa*. Since then, there has been a striking convergence. Problem drug users interviewed in London-based studies over the last five years are more likely to report using both heroin and crack cocaine than either one or the other by themselves. Those who are primary crack cocaine users report that heroin helps them manage the come-down from a crack cocaine 'high', whilst those whose heroin use predates that of crack cocaine say that they simply broadened their pattern of use. As a result, poly-drug use centring on heroin and crack cocaine is now the dominant pattern of problem drug use amongst those who come to the attention of the criminal justice system. An evaluation of an arrest referral scheme for sex workers in Kings Cross, London, found that 53 out of 55 interviewees had used crack cocaine in the month prior to interview. Forty-seven were daily users, 32 were daily dual heroin and crack cocaine users.

Crack cocaine in context

2.13 This sub-section presents background information placing London's crack cocaine problem into a global and European the context and provides an overview of key and relevant findings from national studies. It concludes with a summary of the current national and local drugs policies and strategies aimed at addressing drug misuse and related harm.

International and European overview

2.14 Information from the United Nations (Global illicit drug trends, 2003) showed that the world's illicit cocaine production derives very largely from three countries:

Columbia, Peru and Bolivia. The UN report also demonstrated that in recent years cocaine seizures in the US have declined and prevalence rates have stabilised. In contrast, European seizures have increased with its proportion of the global share of seizures doubling (to 17 per cent) and sharp upward trends in user prevalence since 2001. The report suggested these trends reflected shifts in cocaine trafficking from the US to Western Europe.

2.15 Spain and the Netherlands are considered the continental entry and trans-shipment points for trafficked cocaine, accounting for the majority (70 per cent) of all European seizures in 2001. In 2000, the UK had the third highest number of cocaine seizures in Europe (14 per cent) and the second highest prevalence rates (between 1994 and 2001/02) next only to Spain.

The size of the UK drug market

2.16 The total overall value of the UK's illicit drugs market in 1998 was broadly estimated at £6.6 billion (Bramley-Harker, 2000)[10]. A significant proportion of this market was accounted for by cocaine derivatives (around £2 billion). However, while HM Customs and Excise seize mostly cocaine powder, Bramley-Harker and colleagues suggested the cocaine market was dominated by crack cocaine[11]. This suggests that the majority of crack cocaine was manufactured in the UK.

2.17 The 2002/03 British Crime Survey (BCS) estimated that 12 per cent of all 16-59 year olds had used an illicit drug and three per cent had used a Class A drug in the preceding year. These figures suggested a drug using population of around 4 million people using any illicit substance and roughly a million using Class A drugs annually. The BCS suggests that over 600,000 people use cocaine and around 60,000 use crack cocaine over a twelve month period. It should be stressed that these are rough estimates: the BCS is thought to provide reasonable estimates of non-problematic cannabis use, but its estimates of Class A use, and especially problematic Class A use, are less reliable[12].

2.18 Current best estimates offered by the Home Office suggest a problematic drug using population somewhere in the region of 250,000 individuals. The total numbers of regular crack cocaine and cocaine users have been estimated to be between 100,000 and 150,000 (Bramley-Harker, 2000). The same study calculated that around a third of crack cocaine and a quarter of cocaine users had been imprisoned in the previous year with about 15 per cent imprisoned at any given time.

Provisional estimates of the prevalence of problematic crack cocaine use in London

2.19 Provisional estimates of the prevalence of problem drug use including crack cocaine are derived from a capture-recapture study[13], funded by the Home Office,

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[10] However this figure should be considered with caution as the data produced wide confidence intervals.

[11] In terms of *numbers of users*, rather than *volume of drugs used*, cocaine powder almost certainly predominates, however.

[12] The BCS is a household survey and does not canvass the views of those living in care-homes, prisons and hostels and arguably under-estimates problematic drug users with transient lifestyles.

[13] Capture-recapture requires two or ideally three or more data sources which in some way identify individual problem drug users (e.g. initials, date of birth and sex) and can identify the number of matches between the data sources (i.e. the number of people that occur in more than one data source). The data sources are referred to as the observed or raw data, and the proportion matched represents the overlap or sampling intensity (i.e. the proportion of the total population of problem drug users observed in the data

conducted in 12 London boroughs[14] in 2001 (Hope et al., forthcoming; Hickman et al, 2003; Hickman et al., in press).

2.20 Capture-recapture studies analyse the overlap between multiple data sources to estimate the number unobserved by the data sets, and thereby estimate prevalence. In the 12 London boroughs the prevalence of problematic crack cocaine users was estimated to be about 1.5 per cent of the population aged15-44. Of these users, about 60 per cent also were opiate users. Applying these data to the London population as a whole suggests that there maybe 45,000 crack cocaine users between the ages of 15 and 44.

2.21 The estimate of the prevalence of crack cocaine use in London is one of the first examples of capture-recapture applied to crack cocaine/cocaine in the United Kingdom. However, these figures are **provisional** and must be treated cautiously. Nevertheless, the estimates provide an important step forward in measuring the spread of problematic crack cocaine use. It is important that further work is commissioned to corroborate these estimates, and crucially also to provide estimates by ethnic group.

Trends in drug use

2.22 Research has shown crack cocaine and cocaine is more common amongst those involved in sex work (May et al, 1999), among minority ethnic groups (Aust and Smith, 2003) and 'heavy-end', poly-drug users (Edmunds, 1996). While the BCS has shown overall drug use as relatively static, particular groups have demonstrated upward trends especially those using stimulants e.g. females, young people and minority ethnic groups. In his longitudinal study of drug using careers, Parker (1998) indicated that users of particular drug types (e.g. stimulants) tend to extend their range of drugs to others with similar effects i.e. ecstasy to cocaine use. This suggests ways how cocaine in general, and crack cocaine in particular, may have grown in popularity. Furthermore, anecdotal and ethnographic information has highlighted the growing number of older, problematic opiate users now using crack cocaine and opiates in combination.

Drug expenditure and related crime

2.23 Numerous studies have demonstrated the high cost of problematic drug use (Hough, 1995; Edmunds, 1996 and 1998); others have shown how dependent crack cocaine use (alone or in combination with other drugs) accounts for even greater drug expenditure (Harocopos et al., 2003)[15]. The majority of those with severe drug dependency are unemployed, either as a consequence of drug use or reflecting their lifestyle: many cannot fund their drug use through legitimate means and rely on crime to do so. Nevertheless, there is a complex relationship between drug use and crime. Criminal careers often precede drug using careers, and may sometimes actually be causally implicated in drug use[16]. Dependent drug use may sometimes trigger crime careers, but more often it would seem to amplify offending amongst people who have already become involved in crime (cf Hough, 1995, Hough and Mitchell, 2003). Whatever the case, a high proportion of shoplifters, burglars and other thieves have

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sets). Statistical techniques can be utilised to estimate the number of drug users who appear in none of the data sources, which combined with the observed number generates the prevalence estimate.

[14] The 12 London boroughs comprise approximately two fifths of Greater London, 60% of inner-London (Inner-London: Camden, Hammersmith and Fulham, Islington, Kensington and Chelsea, Lambeth, Lewisham, Southwark, Westminster. Outer-London: Brent, Ealing, Harrow, Hounslow

[15] This study found that the poly-drug users sampled had a large median average weekly drug expenditure of £800 in the month prior to treatment.

[16] For example, acquisitive crime provides the means to acquire a drug habit.

been shown to be drug dependent, and a high proportion of problem drug users report involvement in acquisitive crime, drug selling or other illicit activities that support their drug use (eg Edmunds 1998 and 1999; Turnbull, 2000 and Sondhi, 2002). It is also clear that some crack cocaine users tend to binge heavily; they may also use crack cocaine in combination with opiates. They are heavy drug users, and thus heavy spenders; and they are thus more likely to be criminally involved, and in more depth, than other problem users.

2.24 Evaluations of criminal justice drug intervention programmes and research studies have highlighted the high numbers of dependent drug users passing through the criminal justice system. New English and Welsh Arrestee Drug Abuse Monitoring (NEW-ADAM) data showed that in 1998 14 per cent of arrestees interviewed reported using crack cocaine and nine per cent for cocaine, equating to around 97,000 and 60,000 arrests annually in the UK (with significant proportions serving time in prison). However, participation in NEW-ADAM was voluntary, and this may have skewed results. New powers have been introduced to drug-test arrestees charged with one or more of ten acquisitive 'trigger' offences. The evaluation of the pilots has shown much higher proportions having used cocaine derivatives.

Importation and wholesale distribution

2.25 Traditionally, the structure of drug distribution systems has been regarded as pyramidal, with large-scale importers and traffickers operating at the apex, filtering down to street dealers who operate on the lowest tier. Research has suggested a more complex picture. There can be several styles of operation:

- Freelancers – small non-hierarchical entrepreneurial groups
- Family businesses – cohesive groups with clear structures and authority derived from family ties
- Communal businesses – flexible groups bound by a common tie such as ethnicity
- Corporations – large, formal hierarchies with well-defined divisions of labour.

2.26 Whilst media stereotypes suggest that domestic trafficking organisations follow the 'corporation' model, research suggests that in both US and the UK distribution systems can often take the form of a cottage industry. For example Nicholas Dorn and colleagues (1992) found that in the pre-crack cocaine era in the late 1980s at least, domestic supply systems (as opposed to importers) were not "organised as neat, top-down hierarchies controlled by a 'Mr Big'... No cartels; no mafia; no drug barons." This is not quite the same as saying that British supply systems are disorganised. Rather, Dorn and his colleagues painted a picture of a fragmented and fluid system populated by a range of opportunistic entrepreneurs from a variety of backgrounds - licit businesses with an illicit sideline; career criminals who turn from other 'project' crime such as bank robbery or major fraud to trafficking; people who may to some extent believe in their product; users buying for each other, and so on. This characterisation should not be overstated, however. In more recent research on importation into Britain, Dorn and other colleagues (1998) paint a rather different picture, one more in keeping with media images of 'organised crime'.

2.27 Very little research has been done specifically on how importation and middle-level markets may affect London. However several generalisations can safely be made:

- Most cocaine originates in producer countries in South America (Columbia, Peru and Bolivia in particular)
- It is imported to the UK as cocaine powder
- Some is imported by air, often through Jamaica and other Caribbean islands, though these routes have become riskier for participants
- Larger scale importation is via the European mainland, for example through Galicia in Northern Spain.

The organisation of importation and wholesale distribution of cocaine powder is thought to be much more heterogeneous than heroin distribution. Whilst some importation will follow the 'organised crime' model (hierarchical structure, clear division of labour etc) there are also significant numbers of much smaller entrepreneurial groups also at work along the lines proposed by Dorn and colleagues.

Types of distribution

2.28 As with any other type of commodity, crack cocaine is traded within a market through which buyer and seller have to locate one another in order to conduct a transaction. Research has described various forms of retail market system.

2.29 In the early and mid-1990s London heroin markets were predominantly place-based *open markets*. That is, they are open to any buyer, with no need for introduction to the seller, or other similar barriers to access. As crack cocaine became more common throughout the 1990s, these open markets began to sell crack cocaine. The main advantage of an illicit open street market – the ease of locating buyers and sellers– is also its major drawback for participants: it renders them vulnerable to policing. In response to the risks of enforcement, open markets tend to be transformed into *closed markets*[17]. These are markets in which sellers will only do business with buyers whom they know, or for whom another trusted person will vouch. The degree to which markets are closed – the barriers to access put in the way of new buyers – will depend largely on the level of threat posed by the police. Intensive policing can quickly transform open markets into closed ones. It is clear that crack cocaine markets both in North America and the UK have evolved from open systems to closed ones in response to enforcement.

Technology and market transformation

2.30 If retail drug markets have always been responsive to policing, their capacity to adapt has been greatly extended by the emergence of mobile phones. The pace of change has been so rapid that ethnographic work conducted before the mid-1990s is only a very partial guide to the way in which retail drug markets now function. Until the mid-1990s, street sellers tended to operate in specific, well-defined, places. This was to allow buyers to locate them with ease. Increasingly contact is now made by the buyer ringing the seller's mobile and making an appointment to meet at an agreed (or pre-specified) place. A variant on this is for delivery systems, where drugs are delivered to the buyer's home or other specified locations. Mobile phones thus minimise the risks associated with illicit transactions by making police surveillance largely impractical. Looking ahead, it is possible that the role of the internet in illicit drug distribution will develop, though at present only cannabis seeds, cannabis chocolate and more recently pharmaceutical drugs are known to be sold over the internet.

[17] However, open markets can re-emerge over time.

Crack /dealing house markets

2.31 Crack /dealing houses are, at least in part, another development that can be understood as a response to enforcement against open markets. They can be defined as: premises use in connection with the production, supply or use of Class A drugs and associated with the occurrence of disorder or serious nuisance (Anti-social behaviour Act, 2003). Whilst it may be obvious to both police and other residents that a crack /dealing house is in operation, it is often difficult getting sufficient evidence to secure convictions and close down the site. Although new civil powers have been introduced, it still remains true that relatively low level door security will buy participants enough time to dispose of drugs for sale. However security has not been the only factor leading to the establishment of crack houses. Many crack cocaine users prefer to smoke in crack houses. There are a number of reasons for this:

- Some people like to smoke crack cocaine in a social setting;
- Most crack houses are open 24 hours and crack cocaine is almost always available at times when 'mobile phone' dealers may not be;
- There is the opportunity to smoke the crack cocaine bought by fellow users who are acquaintances or friends once money has run out;
- Similarly it is possible to exchange sex for crack cocaine; and
- At some crack houses it is possible to exchange stolen goods directly for crack cocaine.

2.32 London crack houses take a variety of forms, and research has identified three predominant types:

- The fortified retail outlet
- The take-over (where the flat of a vulnerable tenant is used as a selling base)
- Places in which the sale of drugs and sex are heavily associated.

It is unclear what share of the crack cocaine market is held by open markets, closed markets/networks and crack houses.

Policing markets and crack houses- adaptations and perverse effects

2.33 Illicit drug markets are resistant – to varying degrees - to policing. Many of the buyers are intensely motivated to buy, and sellers are equally motivated by profit. Research has identified various adaptations to, and perverse effects of, policing strategies.

2.34 The most frequent response to policing is *displacement* – over place, time or mode of operation. As discussed, open markets tend to be transformed into closed ones by policing operations, or else are relocated to other sites. Where the police are successful in arresting sellers, this often results in *substitution,* where often someone who previously worked at a lower level in the process replaces the seller. In other words, policing can create promotion opportunities.

2.35 American researchers have argued that vigorous enforcement may achieve the intended effects of increasing scarcity and thus raising prices. If so, however, the raised prices may be followed by unwanted consequences, such as a greater volume of drug-related crime and/or an increase in the number of market participants, attracted by the increased profits. In the London context, crack cocaine prices were relatively stable in the 1990s and have fallen since then. This suggests that policing has not imposed high

enough costs on distributors to make them push prices up. Support for this comes from the evaluation of the MPS 'Operation Crackdown'. Considerable resources were deployed against open crack cocaine markets and crack houses in two co-ordinated operations in late 2000 and early 2001. Over 300 operations were run, resulting in 1,621 arrests and over 800 judicial disposals. Police costs were in the region of £800,000. Interviews with key informants – police officers, drug workers and drug users– clearly suggested that the operation had achieved no discernible impact on the crack cocaine distribution system in London (Webster, 2001).

2.36 These are disappointing results, but they do not necessarily imply that nothing can be done by way of enforcement. On the one hand, there are likely to be clear social benefits in transforming open drug markets into closed ones, in reducing disorder associated with markets and in displacing crack houses. On the other, one needs to ask what would be the result of relaxing levels of enforcement against crack cocaine markets.

2.37 Maintaining pressure on buyers and sellers may make markets unpredictable for participants, and thus both depress demand and contain supply. It should also be noted that *some* crackdowns in other places and other countries have had more success. In particular, where concerted action is taken against markets in relatively small and isolated towns, supply can be significantly disrupted. However studies have suggested that in large cities, the linkage between levels of supply and prices is a rather loose one, and that enforcement tends to leave prices unchanged.

2.38 The consensus from evaluations and research into markets in the US and elsewhere is that successful action is likely to derive from a 'problem solving' approach, and solutions are likely to include not only enforcement but measures such as:

- Situational design and management
- Action against landlords whose premises are being used for dealing
- Provision of treatment services to reduce demand amongst dependent buyers.

The policing of crack houses poses particular problems, associated with the fact that the tenant involved is often not the principal operator, and is often a vulnerable individual subjected to a degree of coercion. Close partnership work has been the aim of the increasing number of protocols for handling crack houses that London boroughs have developed.

Treatment provision for crack cocaine and cocaine

2.39 Traditional substance misuse services and the interventions provided have largely been designed for and catered to opiate users. Historically, those accessing such services have been largely white, male and in their late twenties and early thirties. A range of studies have indicated that the strategies used to assist crack cocaine and cocaine users have been derived from opiate and alcohol based models of care and that treatment services have not adapted to the needs of the large pool of potential service users (Haracopos, 2003 and Gossop, 2002). Numerous studies have found that limited knowledge of treatment efficacy, poor staff experience, and inadequate service provision have acted as barriers to those requiring specialist treatment for their crack cocaine or cocaine problems. Studies have shown that problematic drug users have multiple health and social needs; impose large costs on health services; that crack cocaine users engage in more high risk behaviours compared to opiate users and thus have a greater range of needs that require assistance when presenting to treatment

services compared to opiate users (Netten and Curtis, 2000; Gossop, 1998 and Grella, 1995). These needs have been shown to be difficult to address in community based settings and more effective in residential treatment and self-help arenas (Gossop, 2000; Harocopos et al., 2003).

2.40 The Audit Commission (2002) considered the needs of crack cocaine users were not being met. Both the City Roads follow up study (Harocopos et al, 2003) and Gossop (2000) recommended a similar approach whereby client needs should be identified early via high quality assessments and then matched to the most appropriate treatments. Although the City Roads follow-up study and National Treatment Outcome Rehabilitation Study (NTORS) showed crack cocaine users to have decreased their drug use significantly while initially in treatment, though many relapsed as other areas of need had not been addressed appropriately.

2.41 Furthermore, NTORS showed some opiate users not using crack cocaine prior to treatment switched to using crack cocaine on completion of, or during, their treatment. However, treatment showed a significant cost-benefit whereby the authors suggest for each £1 spent on treatment saved £3 to the Criminal Justice System. However, this statement is about drug treatment *per se* and needs to be qualified for crack cocaine treatment. To remedy the multiple difficulties faced by crack cocaine users the Audit Commission called for a holistic approach to problematic crack cocaine treatment whereby treatment services and associated agencies such as mental health, housing, health, social services, probation, police and prisons were required to work in partnership and develop seamless care pathways.

2.42 Several studies (e.g. Bennett et al, 2001 and Sondhi et al, 2002) have found that services tend to be tailored best to the needs of White male opiate users in their twenties and thirties. Women, people from minority ethnic groups, those using stimulants and young and older users may refuse to engage with drug treatment services, including arrest referral schemes. If they do engage with referral schemes they often fail to access appropriate treatment or disengaged soon thereafter. In addition, crack cocaine users accessing employment and training schemes are less likely to attend compared to traditional service users while those using a combination of opiates and cocaine have been found to be harder to engage and retain in treatment (McSweeney, 2003 and Rowan-Szal, 2000).

The National Strategic Framework for Action on Crack

2.43 The Government published a ten-year drug strategy, 'Tackling Drugs to Build a Better Britain' in 1998. The Updated National Drug Strategy was published in 2002. This proposed a sharper focus on Class A drugs and was supplemented with the National Crack Plan (NCP)[18]. The NCP acknowledges the rise in crack cocaine use and the problems it creates for users, their families and communities.

2.44 The NCP stresses the importance of agencies working together to combat the problem. It advocates a balanced package of enforcement measures, treatment, community engagement, education and harm reduction. The Government has acted to:

- Ensure that local structures and resources are in place to tackle cocaine trafficking;
- Encourage police to disrupt local crack cocaine drug markets;
- Give police and local authorities new powers to close crack houses with 48 hours;

[18] See Tackling Crack – A National Plan (2002).

- Set up the Asset Recovery Agency to seize the financial assets of those who distribute and sell Class A drugs;
- Raise awareness of the problems and promote treatment, though media and communication campaigns;
- Introduce new 'criminal justice interventions' providing greater access to treatment and support services for crack cocaine users who are involved in crime.

Improving Treatment

2.45 The National Treatment Agency (NTA) has supported these initiatives by developing guidance on commissioning and providing treatment services for crack cocaine users. It has argued the case for more treatment, on the basis of the research evidence, and has co-ordinated development and delivery of a comprehensive training package for those who work with crack cocaine users.

High Crack Areas (HCAs)

2.46 The NCP identified 37 priority areas in the country where crack cocaine was considered as problematic. Sixteen are in London: Brent, Camden, Croydon, Hackney, Hammersmith and Fulham, Haringey, Islington, Kensington and Chelsea, Lambeth, Lewisham, Newham, Southwark, Tower Hamlets, Waltham Forest, Wandsworth and Westminster[19].

DAT areas were nominated as High Crack Areas if they met at least three of the following tests:

- Contains a Basic Command Unit (BCU) which is in the top 35 for acquisitive crime
- In a police force area which is in the top 10 for gun crime
- In a petty sessional area which is in the top 35 for soliciting offences
- Contains a BCU which is in the top 35 for crack cocaine related offences
- Is in a Health Authority Regional Office Area in the top 35 for crack cocaine users presenting for treatment.

2.47 HCA DATs were tasked with carrying out extensive needs analysis to take stock of crack cocaine problems in their communities and developing strategies for addressing the problems. Government Office drug teams and the Drug Strategy Directorate have supported this work and closely monitored progress, and have established a Crack Delivery Forum. This group shares best practice, and benefits from the advice of a multi-agency forum, the Crack Advisory Group, with representatives from Association of Chief Police Officers (ACPO), treatment agencies, BME community leaders, the Black Police Association and specialist advisers from within the Home Office[20].

How this report was produced

2.48 This report was produced for GLADA by a partnership of academic and strategic organisations working in the drugs and crime fields. They include: The National Treatment Agency, Government Office for London (Crime and Drugs Division), Metropolitan Police Service, Home Office, Greater London Authority, London Health Observatory, London Probation Service, Institute for Criminal Policy Research (King's

[19] The other (HCAs) include: Birmingham, Bradford, Brighton and Hove, Bristol, Coventry, Derby, Leeds, Liverpool, Manchester, Middlesbrough, Nottingham, Oxford, Reading, Rochdale, Salford, Sandwell, Sheffield, Slough, Stockport, Stoke on Trent and Trafford.

[20] For more information visit www.drugs.gov.uk or www.nta.nhs.uk.

College London) and the Centre for Research on Drugs and Health Behaviour (Imperial College). The study was conducted over a six-month period from September 2003. Each of the policy stakeholders provided a range of relevant information, including:

- MPS drug seizure, supply and possession offence statistics
- Guidance information on 'best practice' treatment modalities derived from service providers strategic bodies
- A treatment service audit of those services working with cocaine and crack cocaine users
- RDMD and NDTMS statistics
- Data from a range of CJ drug intervention programmes (such as arrest referral, drug testing on charge and Drug Treatment and Testing Orders).
- As the report draws on a number of different data sources, differing terminology and categories may have been used when they could not be reconciled.

Report outline

2.49 The report comprises seven sections. Chapter 3 examines national and regional crack cocaine and cocaine offences and trends; Chapter 4 explores the geography of drug supply and possession across London; Chapter 5 outlines current treatment practice to address problematic crack cocaine/cocaine use and service capacity in the capital; Chapter 6 examines trends in drug treatment demand in London; Chapter 7 provides an overview of Criminal Justice drug initiatives and examines the scale of crack cocaine use by those participating in the schemes. Chapter 8 offers some conclusions that may help to framework developing the strategy.

3 Drug offences and crime statistics

3.1 This section presents information on drug offences. It examines drug trends over time, describes the nature and characteristics of seizures in London and draws some comparisons with the rest of the UK. It offers a brief demographic description of those accused of supplying and possessing crack cocaine, examines differences with other drug users and assesses the linkages between crack cocaine use and offending behaviour. The section concludes with a brief assessment of the information presented.

The prevalence of crime and drug misuse in London

3.2 The BCS shows the region to have the highest rates of crime and drug misuse. Comparing offences recorded by the police, London had higher rates than the rest of England and Wales for all crime types except criminal damage and burglary. Table 3.1 shows that the total crime rate for London for the year 2002/03 was 152 per 1,000 population whereas the national figure was 113. The drug offence rate for London was also higher than the national figure: 5 offences per 1,000 population compared to 3 per 1,000.

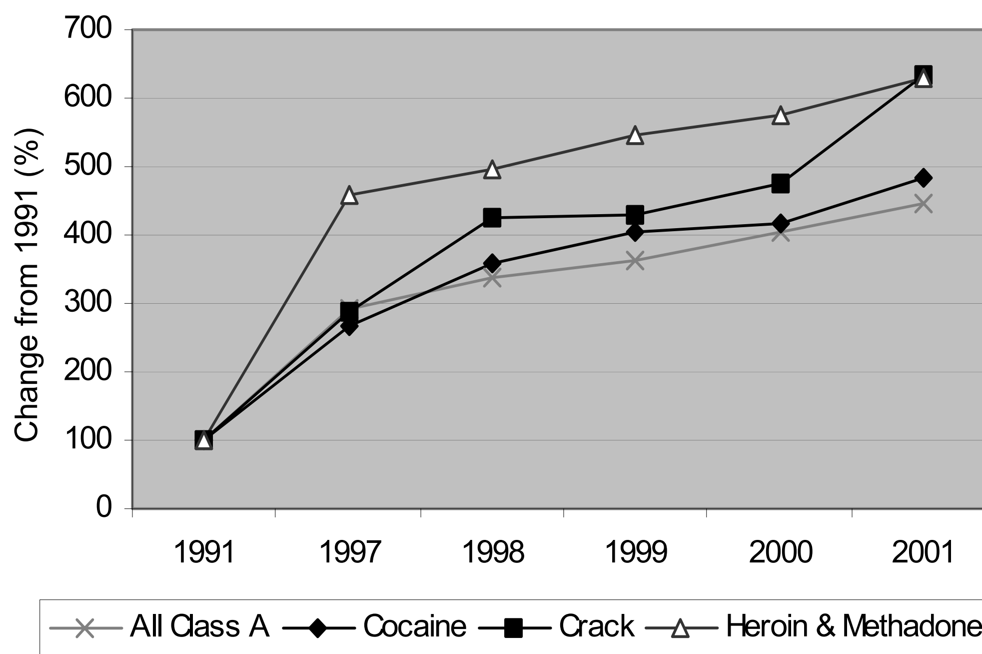
Table 3.1 London recorded offence rates compared to England and Wales 2002/03.

Offence	London Region	England and Wales
Violence against the person	25	16
Sexual Offences	1	1
Robbery	6	2
Total violent crime	32	19
All burglary	16	17
Vehicle crime[21]	24	19
Theft and handling of stolen goods	65	45
Fraud and forgery	12	6
Criminal damage	20	21
Drug offences	5	3
Other offences	2	1
Total recorded offences	**152**	**113**

[21] Includes theft of a motor vehicle, theft from a motor vehicle and aggravated vehicle taking.

Drug seizure data

Figure 3.1 Indexed trends of annual Class A seizures for England & Wales 1991 to 2001 (1991 = 100%)



3.3 This sub-section presents statistics collated by the police and HM Customs and Excise on drug seizures. Figure 3.1 shows ten year trends for England and Wales from 1991. It demonstrates a steep upward trend in Class A drug seizures for England and Wales in the ten years from 1991.

3.4 Between 1991 and 1997 there were a total of 715,312 drug seizures across the UK of which Class A drugs comprised 15 per cent. Overall, seizures of Class A drugs increased by 347 per cent (from 8,500 in 1991 to just under 38,000 in 2001). However, cocaine powder, heroin and methadone, and crack cocaine seizures all showed increases in excess of that for all Class A drugs (with rises of 383 per cent, 527 per cent and 533 per cent respectively)[22].

3.5 Examination of specific drug types seized across the ten-year period showed some proportional changes. In 1991 heroin and methadone accounted for 36 per cent of all Class A seizures followed by cocaine (17 per cent) and crack cocaine (7 per cent). By 2001 all had increased as a proportion of Class A seizures with heroin and methadone accounting for over half (51 per cent), cocaine just under a fifth (18 per cent) and crack cocaine (10 per cent).

3.6 Although the three drug types appeared to indicate similar trends over the period crack cocaine seizures increased markedly (33 per cent) between 2000 and 2001 (from 2,765 to 3,688) compared to a 16 per cent rise for cocaine (from 6,005 to 6,984) and nine per cent for heroin and methadone (from 17,628 to 19,236)[23]. However, some caution should be taken when assessing these data as increases could reflect several

[22] Between 1991 and 2001 all Class A seizures increased from 8,504 to 37,915, cocaine powder (from 1,446 to 6,984), heroin and methadone (from 3,067 to 19,240) and crack (from 583 to 3,688).
[23] During 2001, of the 2,625 crack seizures in England and Wales 1,607 (61%) were made in London.

factors in addition to increased prevalence: changes in policing and customs priorities and practices could account for some of the trend.

3.7 Focussing in on the four years from 1998 to 2001, there was a total of around half a million drug seizures in England and Wales, of which Class A drugs accounted for roughly a quarter (24 per cent)[24]. Of these heroin accounted for almost half (49 per cent), cocaine 18 per cent and crack cocaine 9 per cent[25]. Over the four years Class A seizures showed consecutive annual increases with an overall rise of 32 per cent (from 28,801 to 37,915). Crack cocaine showed the largest increase amongst Class A drugs – a 48 per cent rise from 2,488 to 3,688 seizures. Next came cocaine, rising 34 per cent, from 5,209 to 6,984, followed by heroin – 19 per cent, from 15,152 to 18,168. In terms of the weight of Class A drugs seized over the four year period, cocaine accounted for the greatest quantity (12.7 tonnes) followed by heroin (11 tonnes) and then crack cocaine (123.1 Kg)[26].

3.8 Customs and Excise data showed the *numbe*r of both crack cocaine and cocaine seizures had increased markedly from 1999[27]. However, the *quantity* of cocaine seized decreased annually since 1998 while crack cocaine had risen (from 2.1Kg to 21.9Kg) reflecting the overall upward trend in crack cocaine seizures.

3.9 It has generally been thought that crack cocaine is made from cocaine powder following importation and then distributed locally – often doubling profits for those involved. Interpretation of the data – decreasing quantities of cocaine and increasing quantities and seizures of crack cocaine – appears to suggest a minor though possibly significant shift in the nature of importation and the location where crack cocaine is manufactured (either at source and/or en-route to the UK). Such a shift may also indicate a maturing and more established business that is seeking to maximise financial returns.

Drug seizures in London

3.10 Between 1998 and 2001 there were just over 113,160 drug seizures made in London, representing 26 per cent of the total for England and Wales[28]. Just over a quarter (26 per cent) of these involved Class A drugs. Just over a third of Class A seizures (10,328) involved heroin. This was followed by cocaine (32 per cent or 9,317) and crack cocaine (22 per cent or 6,436). Over the four year period the overall number of seizures fell by 33 per cent (from 36,018 to 24,447) and Class A seizures also decreased by 13 per cent (from 7,946 to 6,929). While cocaine and heroin showed this downward trend (falling by 15 per cent and 13 per cent respectively) crack cocaine seizures increased by over a fifth (22 per cent).

3.11 Table 3.2 presents the number of seizures in London as a proportion of those in England and Wales. Heroin seizures in London account for a fairly small proportion of the total (16 per cent), whilst London crack cocaine seizures account for the majority (57 per cent) and London cocaine seizures account for 40 per cent.

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[24] Between 1998 and 2001 there were a total of 537,340 drug seizures in England and Wales, of which Class A drugs accounted for 132,143 offences.
[25] The remaining 24% of Class A seizures comprised LSD, Ecstasy and Methadone.
[26] Weights of seizures remained relatively stable over the 4 years for cocaine and crack but the weight of heroin peaked during 1999 and 2000 (on average 437 Kg per annum).
[27] Crack seizures increased from six to 43 and cocaine from 869 to1,514 between 1999 and 2001.
[28] Between 1998 and 2001 there were a total of 144,332 drug seizures in London

Table 3.2 Class A drug seizures and percentages for London and England and Wales (1998 – 2001).

	All Class A drugs	Heroin	Cocaine	Crack cocaine
London	30,303	10,550	9,739	6,569
England & Wales	132,143	65,296	24,056	11,448
London as a proportion of England and Wales (%)	**23%**	**16%**	**40%**	**57%**

3.12 Although both London and the rest of England and Wales showed steady upward seizure trends from the late 1990s, London recorded greater numbers. However, over the period the gap between London and the rest of the country narrowed for both cocaine and crack cocaine (see Figures 3.2 and 3.3). Since the late 1990s London seizures have actually declined. This is as likely to reflect policing practice as consumption trends, though the two figures do suggest that both crack cocaine and cocaine have become more prevalent outside of London. The London market(s) may have matured - a hypothesis supported by the stability or decline of street prices in the last five years (see King, forthcoming).

Fig 3.2 Annual number of cocaine seizures for London & the rest of England & Wales

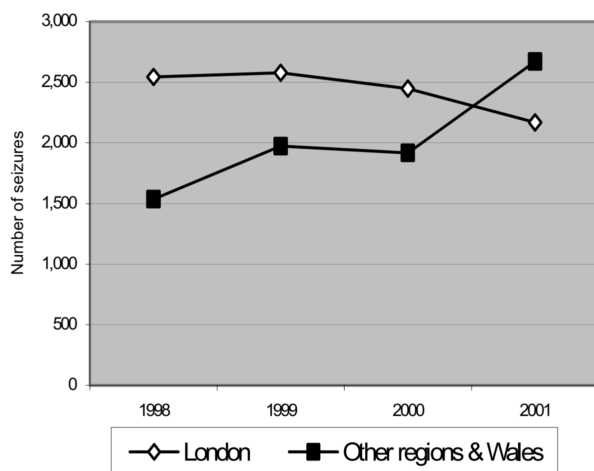


Fig 3.3 Annual number of crack seizures for London & the rest of England & Wales

Recorded drug offences 1998/99 to 2002/03

3.13 This section examines drug offences recorded by the MPS covering five financial years from 1998/99 to 2002/03[29]. It provides an overview of all recorded drug offending with a particular focus on offences of crack cocaine supply and possession.

3.14 Between 1998/99 and 2002/03 the MPS recorded a total of 5,465,222 crimes, of which drug offences accounted for 3 per cent (141,540). Of these, possession offences comprised the largest proportion (84 per cent), followed by supply (14 per cent) and other drugs offences. Just over 60 per cent of recorded offending was

[29] The MPS covers 32 of the 33 London boroughs. The analysis presented excludes data for the City of London Police.

acquisitive crime. Violent crime made up 14 per cent, sexual offences under 1 per cent and criminal damage 13 per cent[30].

3.15 Figure 3.4 shows that over the five years examined, *all* recorded drug offences showed a small increase of about four per cent (from 32,152 in 1998/99 to 33,321 in 2002/03). However, these figures masked a minor overall increase of two per cent for possession offences (from 27,719 to 28,142) while supply offences increased by 27 per cent (from 3,803 to 4,841).

Figure 3.4: Indexed trends for all recorded drug offences, possession and supply between 1998/99 and 2002/03 (n = 141,540).

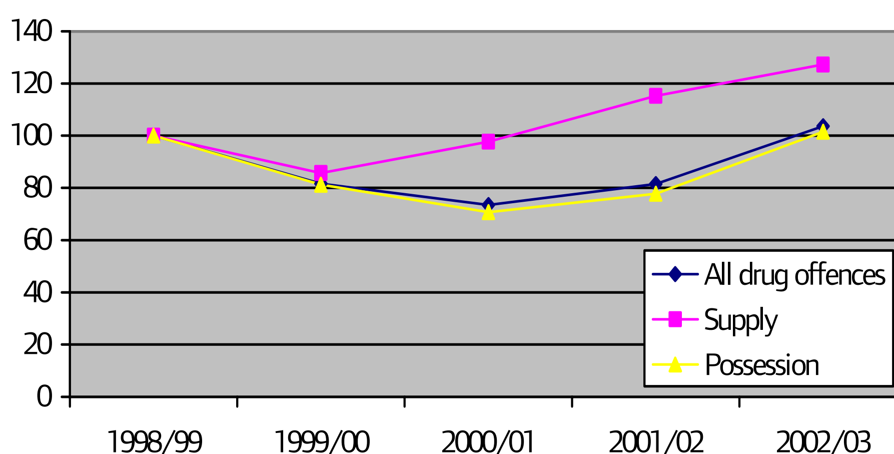
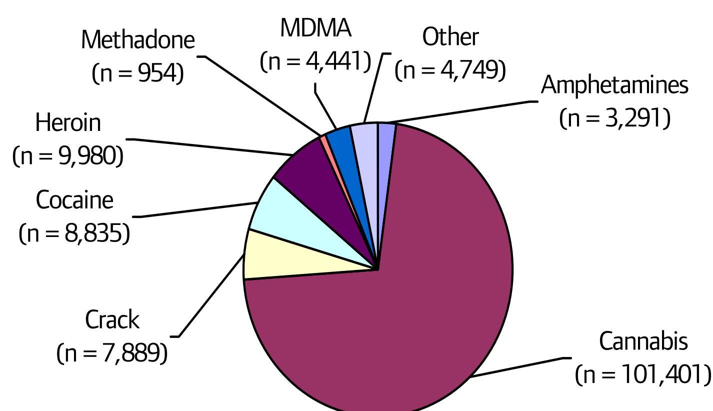


Figure 3.5 Total number of MPS drug offences by drug type (1998/99 to 2002/03)



3.16 Figure 3.5 shows that over the five-year period, cannabis accounted for the vast majority (72 per cent) with just over 100,000 recorded offences. The remainder included heroin (7 per cent), crack cocaine and cocaine (6 per cent each), ecstasy and other[31] drugs (3 per cent each), amphetamines (2 per cent), and methadone (1 per cent). Examining possession and supply offences by drug type over the period showed some distinct differences. Cannabis accounted for the largest proportion of supply and

[30] The remaining recorded crime was made up of other offending.
[31] The 'other' category includes anabolic steroids and unspecified substances (Class A, B and C).

possession offences (with 38 and 78 per cent respectively). Heroin accounted for 15 per cent of supply and 6 per cent of possession cases, crack cocaine (20 and 3 per cent), cocaine (12 and 5 per cent) and amphetamine (two per cent respectively).

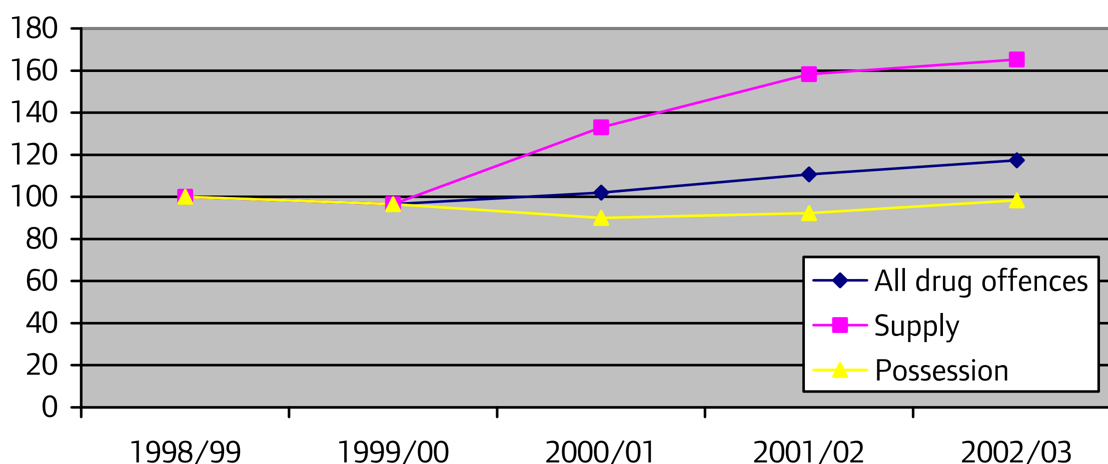
Class A offences

3.17 Between 1998/99 and 2002/03 there were a total of 33,000 recorded Class A drugs offences, accounting for just under a quarter (23 per cent) of all drug offences. Of these, just under two-thirds (65 per cent) were for possession and just over a third (35 per cent) were for drug supply. Just over four-fifths (81 per cent) of all Class A offences were accounted for by three drug types: heroin 30 per cent, cocaine 27 per cent and crack cocaine 24 per cent. The remainder comprised: MDMA (13 per cent) and illicit methadone and 'other Class A drugs' (3 per cent respectively).

3.18 Figure 3.6 shows trends. Over the five years, Class A drug offences in aggregate showed a rise of 17 per cent (from 6,278 to 7,366). Possession offences actually decreased slightly by two per cent (from 4,505 to 4,433), and supply offences increased significantly by 65 per cent (from 1,759 to 2,907). These divergent trends obviously reflect changes in police priorities rather than a change in patterns of sales or use.

3.19 Examination of Class A offences for *supply* offences showed that crack cocaine comprised the largest proportion with 35 per cent (4,035). Heroin accounted for a quarter (26 per cent) and cocaine a fifth (21 per cent). The remainder consisted of ecstasy, other drugs and methadone (with 14, 2 and 1 per cent respectively).

Figure 3.6 Indexed trends for all Class A recorded drug offences, possession and supply between 1998/99 and 2002/03 (n = 141,540).



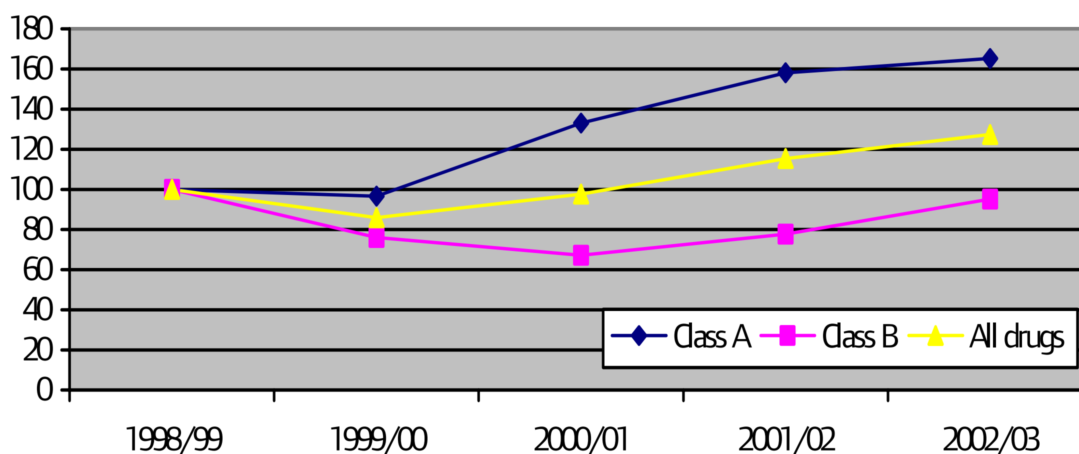
3.20 Of the 21,501 *possession* offences involving Class A drugs, heroin accounted for the largest proportion with almost 10,000 (32 per cent). This was followed by cocaine (30 per cent), crack cocaine (18 per cent), MDMA (13 per cent) and methadone and other drugs (with 4 per cent respectively). For all but one drug type, possession offences comprised the majority of overall offences. The exception were those involving crack cocaine, of which supply offences accounted for just over half (51 per cent)[32].

[32] The only other drug category to have supply offences above the average was MDMA with 37 per cent (1,659 out of 4,441). For all other Class A drugs possession offences were greater than the overall average (heroin 70%, cocaine 72%, methadone 86% and other drugs 79%).

Supply offences

3.21 Between 1998/99 and 2002/03 there were a total of just over 20,000 recorded drug supply offences of which Class A drugs accounted for over half (57 per cent).

Figure 3.7 Indexed trends for supply offences by all, Class A and Class B drugs for 1998/99 to 2002/03 (n = 20,007)

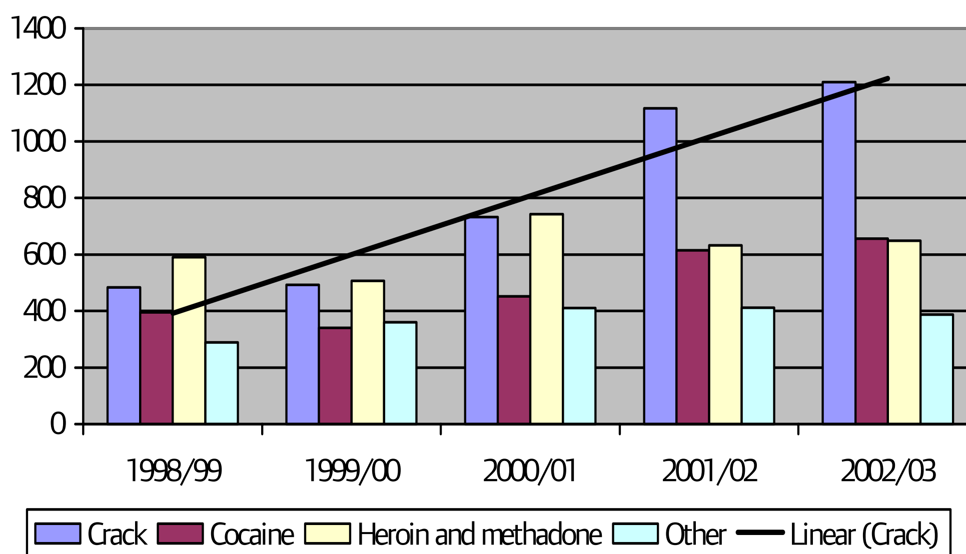


3.22 Figure 3.7 shows that over the five years drug supply offences increased by just over 27 per cent (from 3,803 to 4,841). However, while Class B offences decreased by five per cent (from 1,940 to 1,847) Class A offences rose by 65 per cent (from 1,759 to 2,907). From 1999/00 to 2002/03 both Class A and all drugs supply offences rose year-on-year (with the former rising at the steepest rate). Within the same period, Class B offences continued to decline until 2000/01 from which they increased until 2002/03 whereupon they reached parity with 1998/99 levels.

3.23 Over the five years crack cocaine accounted for the largest proportion of Class A drug supply offences with 35 per cent (4,035). This was followed by heroin (26 per cent), cocaine (21 per cent), MDMA (14 per cent) other drugs (2 per cent) and methadone (1 per cent)[33]. Only crack cocaine supply offences showed both consecutive annual and overall increases. Figure 3.8 shows the number of supply offences per year.

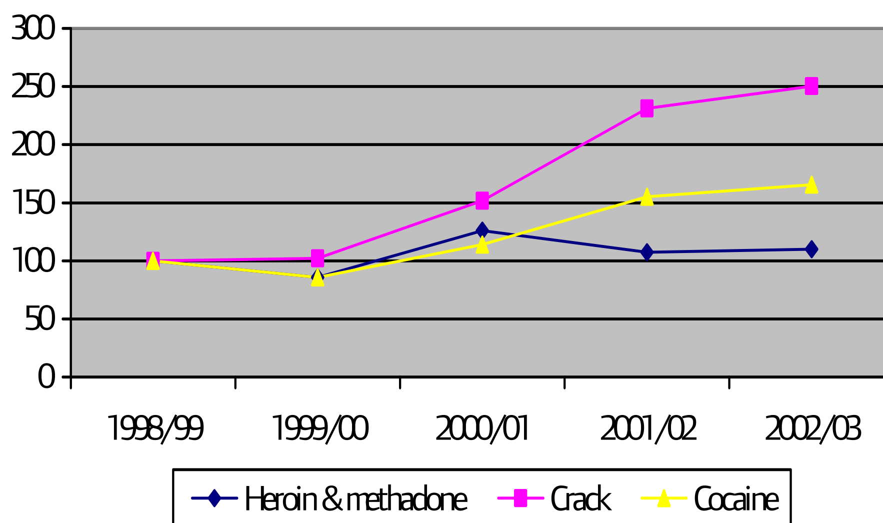
[33] Percentage totals were rounded up and therefore equate to more than 100 per cent.

Figure 3.8 Total Class A supply offences by drug type for 1998/99 to 2002/03 (n = 11,475).



3.24 Figure 3.9 presents the same data as indexed trends, with levels at 1998/99 indexed at 100. Both cocaine and crack cocaine showed sizeable overall increases (66 and 151 per cent respectively) from 396 and 483 offences in 1998/99 to 656 and 1210 in 2002/03. Heroin and methadone offences showed a slight upward trend increasing by 10 per cent (from 590 to 649).

Figure 3.9 Indexed trends for crack cocaine, cocaine and heroin and methadone supply offences (1998/99 to 2002/03).



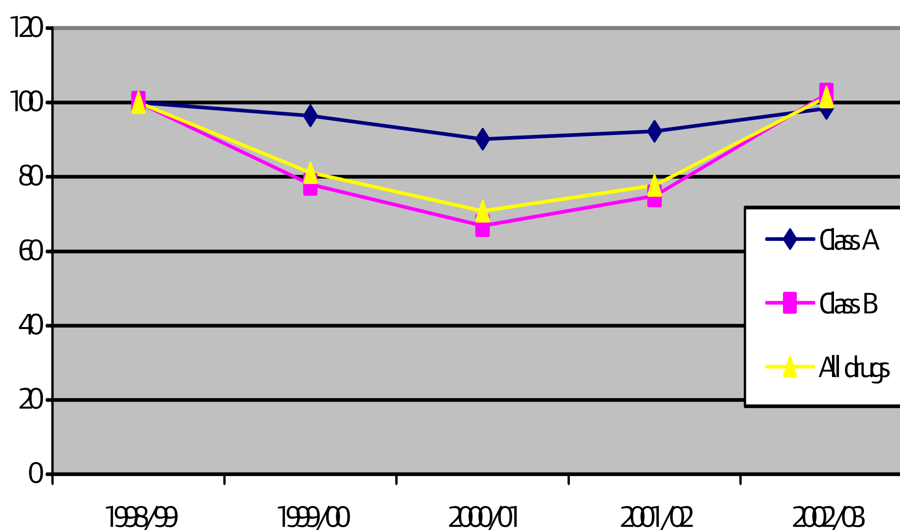
Possession offences

3.25 Between 1998/99 and 2002/03 there were a total of just under 120,000 recorded drugs possession offences in London. Class B drugs accounted for the vast majority (81 per cent) of these offences[34] and Class A drugs accounted for just under a

[34] Offences involving cannabis accounted for 97 per cent of all Class B possession offences.

fifth (21,501). Figure 3.10 shows that over the period all possession offences increased by just under two per cent (from 27,719 in 1998/99 to 28,142 in 2002/03). During the same period Class B drug offences rose by 521 (2 per cent) from 22,945 in 1998/99 while Class A possession offences decreased by a similar proportion (2 per cent or 72) to 4,433 in 2002/03. Over the five years there was an overall decline in all drug category possession offences from 1998/99 that 'bottomed' in 2000/01 before rising to almost 1998/99 levels in 2002/03. While Class B possession offences (due to their voluminous levels) reflected overall offences, Class A offences showed a less marked though similar trend.

Figure 3.10 Indexed trends for possession offences by all Class A and Class B drugs for 1998/99 to 2002/03 (n = 119,518).



3.26 There were 21,501 offences of possession of Class A drugs over the five years (Figure 3.11); Heroin accounted for the largest proportion at 32 per cent (6,966). This was followed by cocaine (30 per cent), crack cocaine (18 per cent), MDMA (13 per cent) and methadone and other drugs (4 per cent respectively)[35]. Over the period, only crack cocaine possession showed consecutive annual percentage rises (averaging 15 per cent per annum) with an overall increase of 69 per cent (from 568 to 958 offences between 1998/99 and 2002/03)[36].
Figure 3.12 shows indexed trends for these offences.

[35] Percentage totals were rounded up and therefore equate to more than 100 per cent.
[36] Annual percentage increases in crack possession were as follows: 26 per cent for 1998/99 to 1999/00 (from 568 to 715 offences); five per cent for 1999/00 to 2000/01 (up 34 offences); eleven per cent between 2000/01 and 2001/02 (from 749 to 829 offences) and 16 per cent between 2001/02 and 2002/03 (from 829 to 958 offences).

Figure 3.11 Total Class A possession offences by drug type for 1998/99 to 2002/03 (n = 21,501).

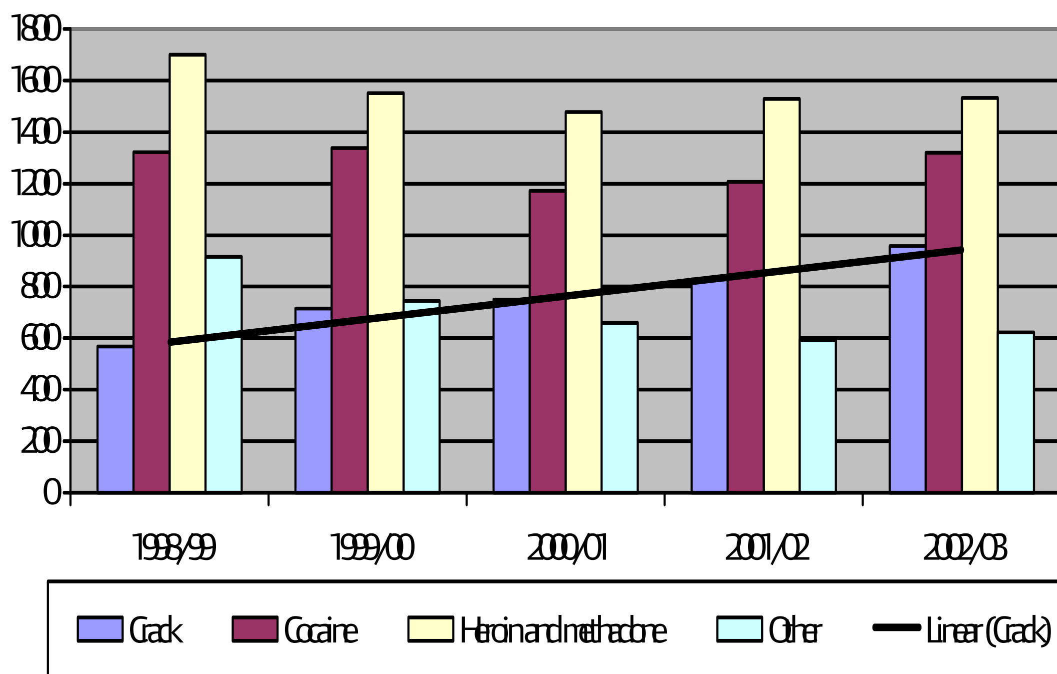
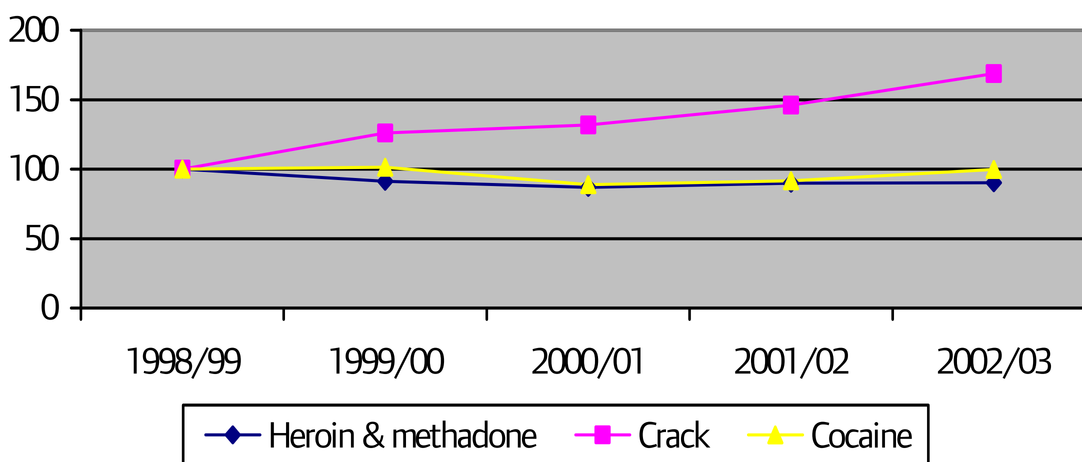


Figure 3.12 Indexed trends for crack cocaine, cocaine and heroin and methadone possession offences (1998/99 to 2002/03).



Drug costs and purity

3.27 Information about drug costs and purity levels is taken from a Home Office study examining 538 case records covering 896 test-purchases made by the MPS between 1992 and 2003 (see King, forthcoming)[37]. Presumably the costs reflect prices that are charged by dealers to unknown first-time buyers purchasing small deals, and could thus be higher than those charged to well-established buyers. Data collected included: weight of drug purchase; price per gram; purity; date of purchase and drug

[37] The test-purchases were all conducted between January 1992 and February 2003 and focussed on Kings Cross, Brixton and Greenwich.

type. Analysis was only conducted on 'unmixed' drugs. Crack cocaine accounted for 57 per cent of all purchases; heroin just over a third, and cocaine 7 per cent[38].

3.28 The average unit cost of both crack cocaine and heroin fell across the period covered, while the unit quantity (weight) rose. The "notional" (cash value of the deal) price remained unchanged[39]. The average purity levels of drugs seized were also examined. This showed crack cocaine with an average purity of 72 per cent, cocaine 52 per cent and heroin 44 per cent[40]. The study found no evidence of consistent trends in cocaine and heroin purity from 1992, but purity levels of crack cocaine were found to have fallen from 88 per cent in the mid 1990s to 72 per cent in 2002.

3.29 Even if notional prices remained stable, the actual unit price per gram of all three drugs actually decreased significantly between 1992 and 2003. The price per gram of crack cocaine almost halved (from £200 in the early 1990s to £110 in 1994) while heroin prices decreased by 73 per cent between the early 1990s and 1997. However, prices have remained relatively stable over the last five years, with the average costs of crack cocaine, heroin and cocaine powder equating to £99, £89 and £83 per gram respectively.

Demographic profiles of accused drug offenders

3.30 The MPS offence data includes demographic details of all offenders accused and proceeded against[41]. Between 1998/99 and 2002/03, there were just under 700,000 people accused of a criminal offence in London with just under 109,000 (17 per cent) accused of all drug offences[42]. The vast majority (92 per cent) of these were male, with an average age of 25. The age breakdown was as follows:

Table 3.3 Age breakdown of those accused of drug offences (1998/99 – 2002/03)

Age range	Proportion of drug offences
10-14	1%
15-19	29%
20-25	32%
26-30	15%
31 plus	23%

3.31 Just over half (53 per cent) were White European and just under a third (29 per cent) were African-Caribbean. Other ethnic groups accounted for the remainder and included: Indian/Pakistani (10 per cent), Dark Europeans (6 per cent) and Chinese/Japanese and Arabian-Egyptian (1 per cent each respectively)[43].

[38] There were no records of cocaine purchases for 1992, between 1994 and 1996 and 2003 that accounts for the relatively low level.
[39] No correlation was found for all three drugs between purity levels and price.
[40] It should be noted that the theoretical maximum purity of cocaine hydrochloride is 89% (see King, forthcoming).
[41] Some caution should be taken when examining recorded crimes (and demographic profiles) as it is often difficult disentangling crime trends from policing practice and priorities.
[42] In total, 657,000 individuals were accused of a criminal offence in London over the five years.
[43] Ethnicity classifications were derived from those used by the MPS.

3.32 Drug offenders were older, on average, than those accused of other offences. Between 1998/99 and 2002/03 the median average ages of all those accused of *all* offences and possession remained relatively consistent (at 22) while those accused of drug supply decreased on average by two years (from 27 to 25 years)[44].

Class A supply offences

3.33 Those accused of Class A supply offences were overwhelming male (nine out of ten, over the five year period). The average age of accused men fell by two years (from 27 to 25 years) between 1998/99 and 2002/03 while for females it was unchanged[45]. Half of those accused were white, a third (32 per cent) were African/Caribbean, Indian/Pakistani (10 per cent), Dark European (6 per cent) and other ethnic groups accounted for the remainder.

3.34 Looking specifically at *crack cocaine* supply, 67 per cent of accused were African/Caribbeans and 24 per cent white Europeans[46]. African/Caribbeans accounted for the largest proportions of both males and females accused (67 and 68 per cent).

Those accused of drug possession

3.35 The vast majority of those accused of possession of illicit drugs were found with cannabis in their possession. They were largely white, male and young. Those accused of possession of Class A drugs were again predominantly male, and largely white, but typically in their mid twenties. Males again accounted for the vast majority (90 per cent) of those accused of Class A possession offences over the five years. The average age of accused males remained stable over the five years at 25 years while their female counterparts were on average two years older. Looking specifically at those in possession of crack cocaine, these had an average age of 26 for men and 27 for women. Women accused of being in possession of crack cocaine were mostly white (44 per cent were white European and 39 per cent African/Caribbean).

Ethnic disproportionality

3.36 The above findings point to some disproportionality between different ethnic groups amongst accused. According to the 2001 census, people from white communities accounted for 71 per cent of the London population. If used as a benchmark, this proportion suggests that white people were under-represented amongst those accused of crack cocaine offences: they constituted 38 per cent of those accused of possession and nine per cent for supply. Asian people were also under-represented, accounting for 14 per of the overall London population, but eight per cent and three per cent, respectively, of those accused of possession and supply. In contrast, people from Black communities comprised 12 per cent of the population. However they accounted for 39 per cent of those accused of crack cocaine possession and 67 per cent of those accused of crack cocaine supply. Similar but less marked disproportionality was found in relation to supply of powder cocaine – though not for possession of cocaine.

3.37 These findings need to be interpreted with some care. In the first place, those involved in Class A drug possession and supply are typically in their twenties, and it would be of interest to compare proportions accused with proportions of each ethnic group in the young adult population. There is also an argument for taking into account

[44] This evidence (combined with the upward trend in male suppliers) suggests an increase in young male suppliers across London in recent years.

[45] Between 1999/00 and 2000/01 both males and females recorded their lowest median average ages (23 and 22 years respectively) thereafter generally increasing over the period.

[46] The remaining ethnic groups comprised Asian (6%), Dark European (2%) and other.

other demographic variables such as social class, which is correlated both with ethnicity and with patterns of drug use. It is also worth remembering that the 2001 Census may have significant shortcomings in its counts of inner-city populations, and in particular of minority ethnic groups. Leaving these measurement issues aside, there are also questions about the possibility of selective policing.

3.38 Perhaps the safest conclusion to draw from these findings is that there is little persuasive evidence to be found in police statistics of grossly disproportional involvement in either crack cocaine or cocaine use – as reflected by possession offences – amongst different ethnic groups. However there are clear pointers to disproportional involvement of black groups in the supply of both crack cocaine and cocaine, at least in that proportion of the supply process that comes to police attention. Clearly this is a sensitive topic that deserves more detailed examination.

3.39 Summary – Drug offences and crime statistics

- Between 1998 and 2001 Class A seizures decreased by 15 per cent (from 8,174 to 6,931). Cocaine and heroin both fell (by 15 and 13 per cent respectively) whereas crack cocaine seizures increased by almost a fifth (18 per cent)
- Thirty two per cent of London's Class A seizures involved cocaine, 22 per cent involved crack cocaine and just over a third involved heroin.
- Heroin seizures in London accounted for a fairly small proportion of those for England & Wales (16 per cent), whilst London crack cocaine seizures accounted for the majority (57 per cent) and London cocaine seizures accounted for 40 per cent
- London and the rest of England and Wales showed steady upward seizure trends from the late 1990s though London recorded greater numbers. Over the period the gap between London and the rest of the country narrowed for both cocaine and crack cocaine
- Over four-fifths (81 per cent) of all Class A offences in London were accounted for by three drug types: heroin 30 per cent, cocaine 27 per cent and crack cocaine 24 per cent
- Crack cocaine constituted the largest proportion (35 per cent or 4,035) of Class A *supply* offences in London, Heroin 26 per cent and cocaine 21 per cent. For Class A *possession* offences, heroin accounted for the largest minority with almost 10,000 (32 per cent) followed by cocaine (30 per cent), crack cocaine (18 per cent)
- Over the period, crack cocaine possession showed consecutive annual percentage rises (averaging 15 per cent per annum) with an overall increase of 69 per cent (from 568 to 958 offences between 1998/99 and 2002/03)
- For crack cocaine supply, 67 per cent of suspects were African/Caribbeans and 24 per cent white Europeans. African/Caribbeans accounted for the largest proportions of both males and females accused (67 and 68 per cent)
- The average age of males accused of Class A possession remained stable at 25 years females were on average two years older. Crack cocaine users had an average age of 26 for men and 27 for women.
- People from Black communities comprised 12 per cent of the population but accounted for 39 per cent of those accused of crack cocaine possession and 67 per cent of those accused of crack cocaine supply. Similar but less marked disproportionality was found in relation to supply of powder cocaine.

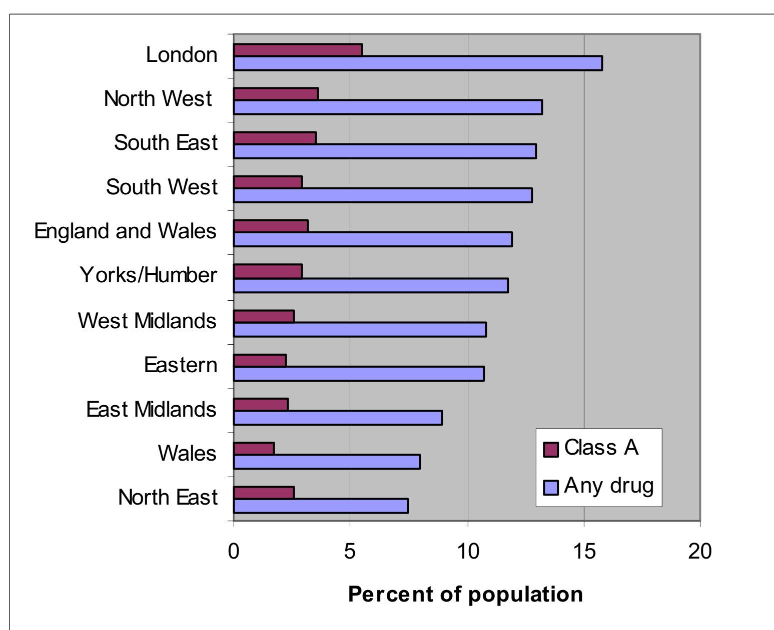
4 The geography of drug supply and possession

4.1 This section presents geographical variations in crack cocaine and cocaine offending. As in the previous chapter, this is largely reliant on police statistics, that can reflect policing activity as much as patterns of drug use. Before examining police statistics, however, some BCS findings have been presented, comparing drug use in London with the other eight regions in England.

Regional variations in drug use

4.2 Table 4.1[47] shows that Londoners in 2001/02 had higher levels of drug use in the previous year than any other region (16 per cent, as against 12 per cent in the rest of the country). Londoners were twice as likely as others to have used Class A drugs in the last year (6 and 3 per cent respectively). Cocaine use was over twice the national average. Although the BCS suggests that overall trends in drug use have remained stable since 1996, the trend is upwards for all Class A drugs and for cocaine and crack cocaine in particular, both in London and elsewhere.

Figure 4.1 BCS drug prevalence (any and Class A) by Government Office Region (2001/02).



4.3 Analysis of the demographic make-up of London suggests that this is part of the reason for its higher levels of Class A drug use. The BCS suggests that four types of area are especially prone to drug use: affluent urban areas, inner city areas, areas with high densities of council housing and low income areas. London is largely comprised of such areas.[48]

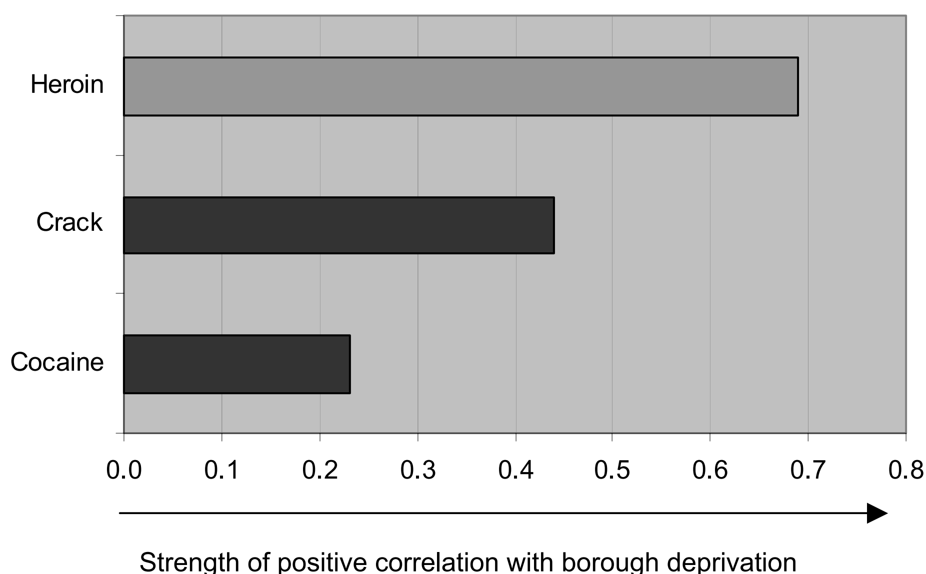
[47] Drawn from Aust and Condon, 2003. At the end of BCS interviews people aged between 16 and 59 complete a series of questions about their own drug use.

[48] The composition of the London region is markedly different from the national average (and other regions). A third of London is consists of 'affluent urban' and almost a quarter (24%) is comprised of council estates and low income areas (compared to national averages of 9% and 20% respectively)[48]. The remainder of London is made up of: new home-owning (17%), mature home-owning (14%), affluent suburbs and rural (10%) and affluent families (3%). The high levels of Class A use in affluent urban areas appears to reflect greater use of cocaine and ecstasy.

The geography of drug offending in London
4.4 Figure 4.2 uses police statistics to show the strength of correlations between different Class A drug offending and deprivation[49]. Heroin shows the strongest association with deprivation. Crack cocaine showed a significant but relatively weak relationship with borough deprivation. Cocaine and deprivation are only weakly associated.

The regional distribution of drug offending
4.5 The geographic analyses presented here rely on MPS recorded offence statistics for drug supply and possession from 1998/99 to 2002/03. The maps present information both on hotspots and on levels of use across London.

Figure 4.2 Correlation between borough deprivation levels and different Class A drug offending (2000/01-2002/03)

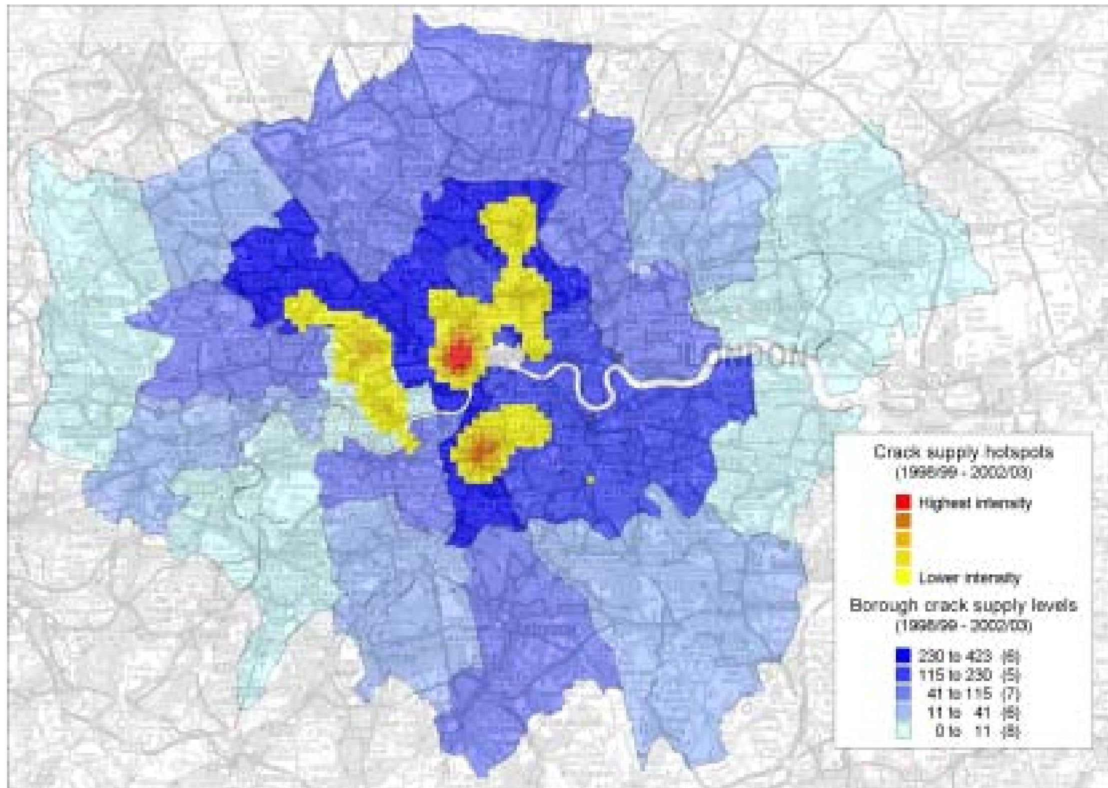


[49] Indices of Deprivation 2000 average ward scores were tested for correlation with three financial years of MPS offence data. The results were significant to the 0.05 level.

Crack cocaine supply

4.6 Over the five-year period, crack cocaine supply offences were concentrated largely within inner city boroughs, and there were hotspots in the West End, around Kings Cross, in Brixton and in North Kensington.

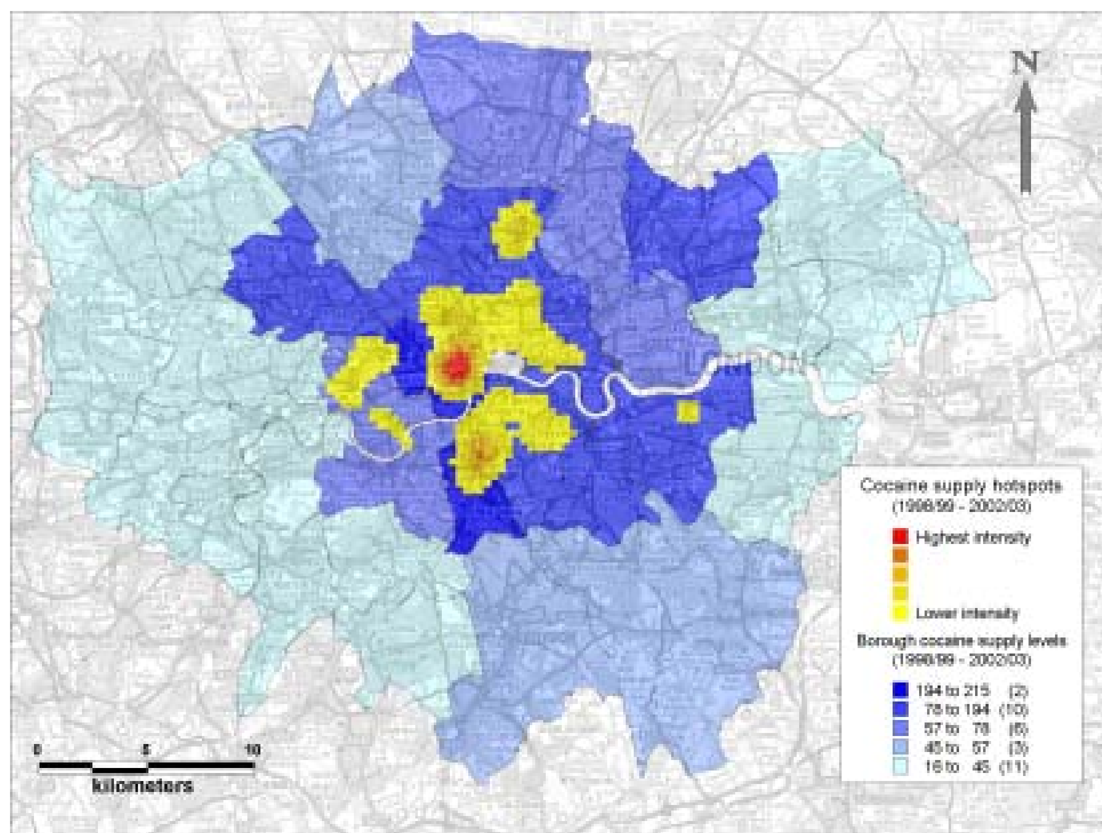
Figure 4.3 Recorded crack cocaine supply: borough levels and regional hotspots (1998/99 – 2002/03)



Cocaine supply

4.7 Cocaine supply was also concentrated in central London, with the main hotspot in Westminster (Figure 4.4). Over the five year period, central boroughs recorded the highest levels (ranging from 78 to 194 offences). Boroughs in the north and south recorded intermediate levels and areas with the lowest levels were found across the western half of the region and peripheral boroughs in the east (recording between 16 to 45 offences).

Figure 4.4 Recorded cocaine supply: borough levels and regional hotspots (1998/99 –2002/03)



Heroin supply

4.8 The spatial distribution of heroin supply was significantly different to both crack cocaine and cocaine powder, generally being more dispersed. We identified three principal hotspots: the largest was around the borders of Camden and Islington. One was in Tower Hamlets and one in north-east Greenwich. Generally, the outer boroughs recorded the higher figures with Enfield, Barnet, Ealing Hounslow, Richmond and Croydon having the highest number of offences (between 310 and 392).

Borough 'family' comparisons

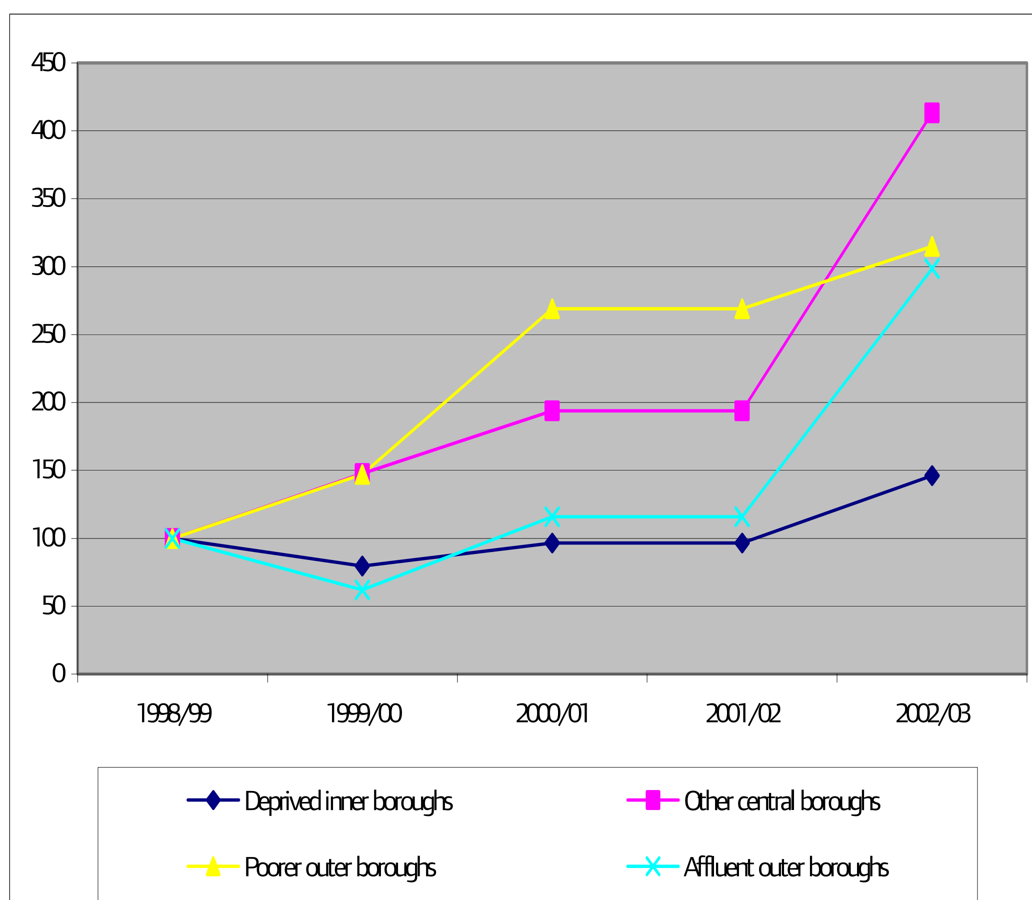
4.9 The London boroughs can be grouped into four 'families' or demographic types: deprived inner boroughs; other central boroughs; affluent outer boroughs and poorer outer boroughs[50]. The following analyses examine trends in drugs supply between 1998/99 and 2002/3 for each of the 'families'.

[50] Deprived inner boroughs comprised: Hackney; Islington; Lambeth; Newham; Southwark and Tower Hamlets. "Other" central boroughs: Camden; Hammersmith and Fulham; Kensington and Chelsea; Wandsworth and Westminster. Poorer outer boroughs: Brent; Ealing; Greenwich; Haringey; Lewisham;

Crack cocaine supply

4.10 All four 'families' recorded large increases for crack cocaine supply from 1998/99 to 2002/03. Central boroughs demonstrated an increase of over 300 per cent (from 82 offences to 339), the poorer and affluent outer boroughs just over 200 per cent and the deprived inner boroughs increased by just under 50 per cent.

Figure 4.5 Borough 'family' indexed trends: crack cocaine supply offences (1998/99 -2002/03)

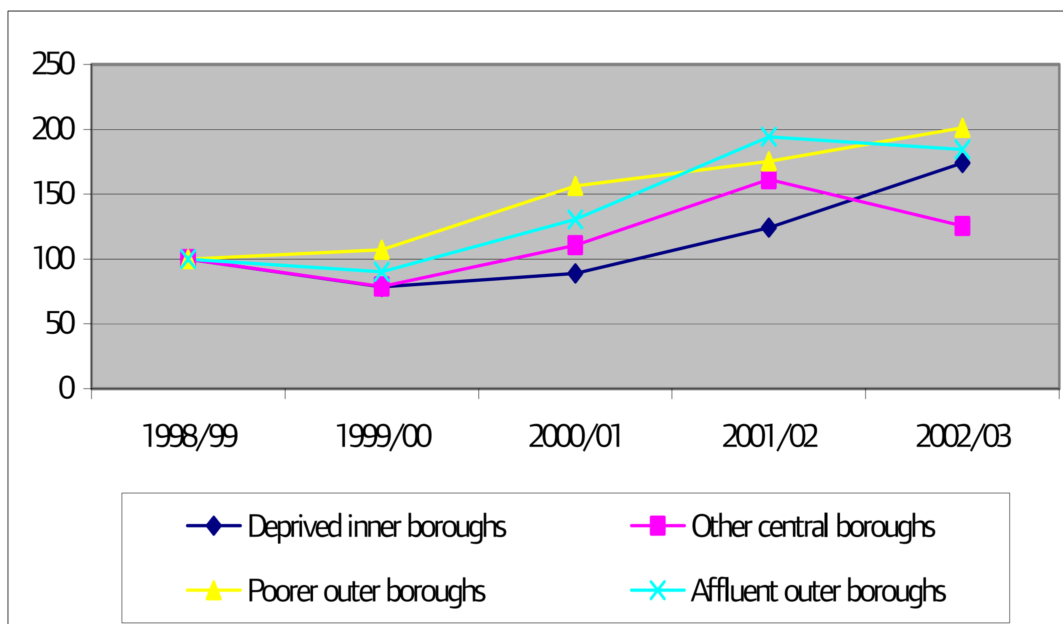


Waltham Forest and Barking and Dagenham. Affluent outer boroughs: Bexley; Barnet; Bromley; Croydon; Enfield; Hillingdon; Havering; Harrow; Hounslow; Kingston; Merton; Redbridge; Richmond and Sutton.

Cocaine supply

4.11 All four 'families' demonstrated increases for cocaine supply offences on 1998/9 levels, but to different extents (Figure 4.6). Offences for the poorer outer boroughs showed over a 100 per cent increase on 1998 levels. Deprived inner and affluent outer boroughs had rises of about 75 per cent and other central boroughs the smallest increases (25 per cent) on 1998/99 levels.

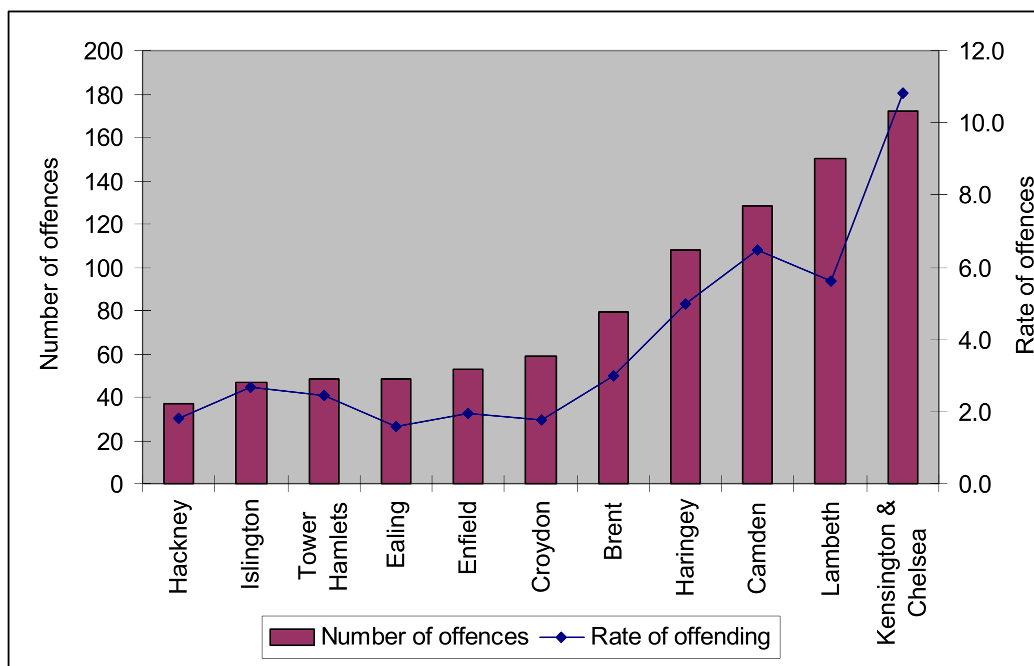
Figure 4.6 Borough family indexed trends: cocaine supply offences (1998/99 – 2002/03)



Boroughs with high recorded levels of supply in 2002/03

4.12 Eleven of London's 32 boroughs accounted for 77 per cent (of the 1,208) crack cocaine supply offences during the year recording levels above the regional average of 38 offences per year. Two boroughs were affluent outer boroughs (Croydon and Enfield) although these boroughs had comparatively low rates of offending (at 2 per 10,000 population). Five boroughs (Brent, Haringey, Camden, Lambeth and Kensington and Chelsea) accounted for just over half the offences. Kensington and Chelsea recorded both the greatest number of offences (172) and also the highest rate (11 per 10,000 population). Lambeth and Camden both had high levels of offending (95 and 79) but Camden had a higher rate of offending (6.5 compared to 5.6 per 10,000 population)

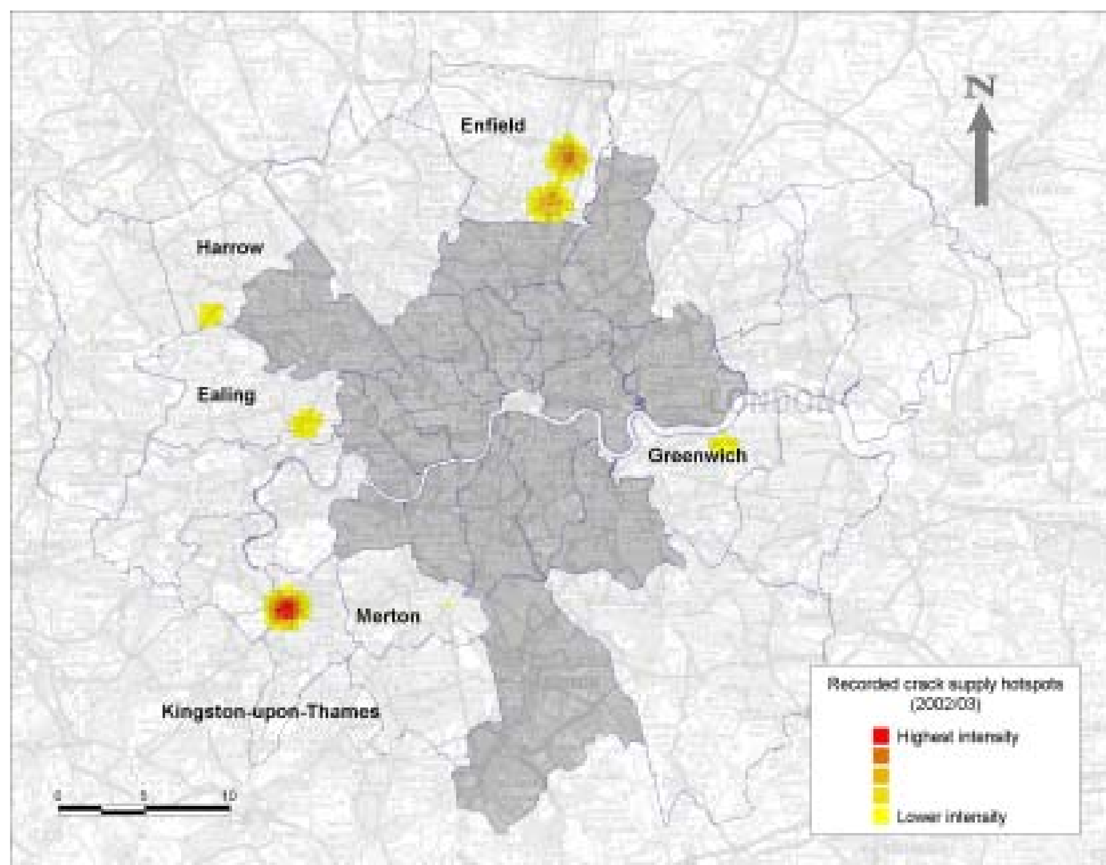
Fig 4.7 Recorded crack cocaine supply: boroughs above the regional average (2002/03)



Crack cocaine supply outside 'High Crack Areas'

4.13 There are 16 of London boroughs that have been designated high crack areas (Figure 4.8 shows these boroughs highlighted in grey). Figure 4.8 illustrates where crack cocaine supply offences were most concentrated once offending in these high crack areas has been excluded. We found concentrations in Kingston (Surbiton) and Enfield (Edmonton) and to a lesser extent Greenwich, Ealing and Harrow. Whereas most of these boroughs had lower than average levels of offending (36 offences) Enfield and Ealing were higher (53 and 48 respectively). Enfield also had a slightly higher than average rate of offending (1.9 compared to 1.8 offences per 10,000 population).

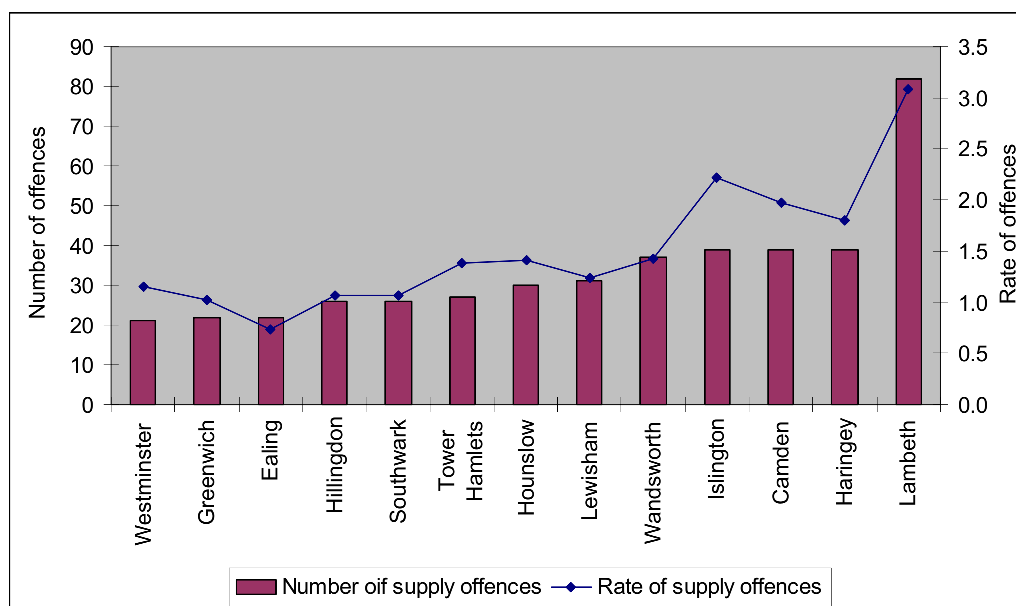
Figure 4.8 Crack cocaine supply hotspots outside boroughs designated 'High Crack cocaine Areas' (1998/99 – 2002/03



Cocaine supply

4.14 Thirteen boroughs accounted for just over two-thirds (67 per cent) of the 655 cocaine supply offences during 2002/03 (see Figure 4.9). All these boroughs recorded cocaine supply levels above the regional average (20 offences). Two of these areas were affluent outer boroughs (Hounslow and Hillingdon). Lambeth recorded twice the level of cocaine supply of other high level boroughs (82 offences with the next highest being 39). Lambeth also had the highest rate of cocaine supply (3 per 10,000 population) three time that of the regional average rate for the year at (1 per 10,000 population).

Fig 4.9 Recorded cocaine supply: boroughs above the regional average (2002/03)



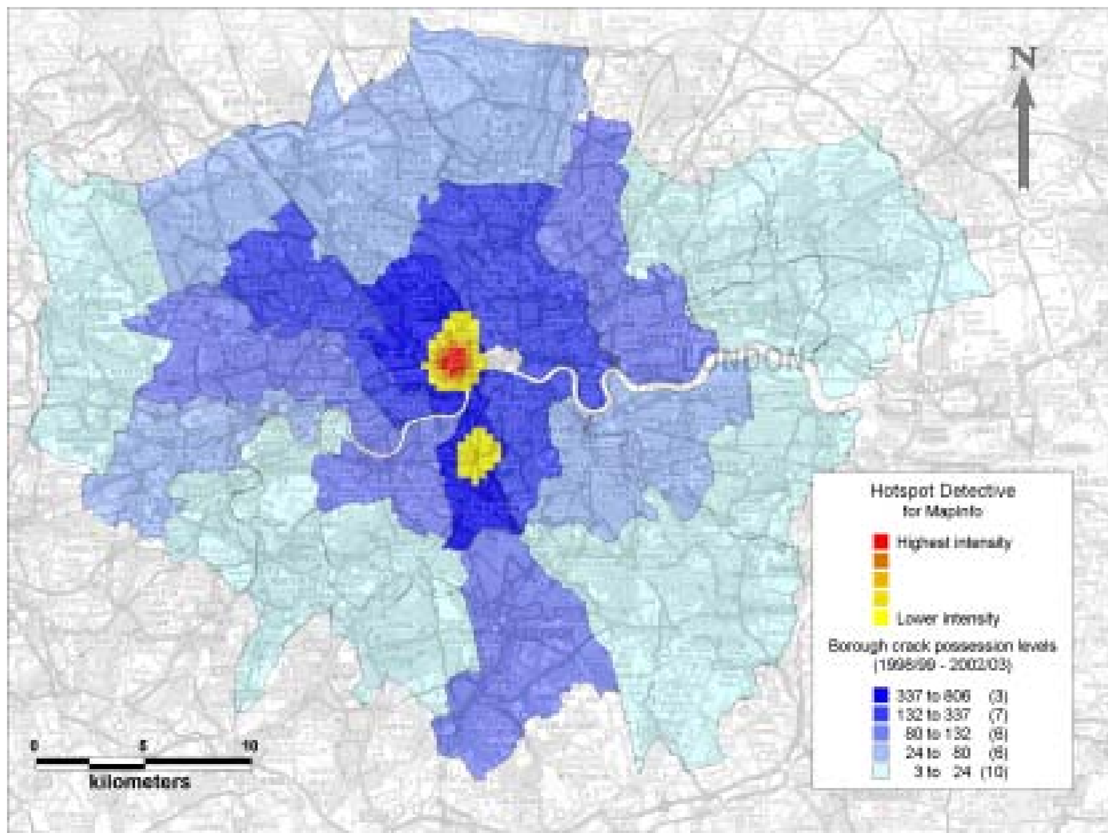
Heroin supply

4.15 Twelve boroughs (Islington, Croydon, Lambeth, Westminster, Haringey, Southwark Camden, Kensington and Chelsea, Brent, Tower Hamlets, Hammersmith and Fulham and Richmond) recorded heroin supply levels above the regional average (19 offences). Collectively these boroughs accounted for 72 per cent of the 622 offences recorded in the year. Islington Lambeth and Croydon all recorded high levels (98, 66 and 55 respectively) and together accounted for a third (33 per cent) of all the regions heroin supply offences. Islington recorded the highest rate (5 offences per 10,000 population) with the remainder recording rates not much greater than the regional average of 1 offence per 10,000 population.

Crack cocaine possession

4.16 Figure 4.10 demonstrates how recorded crack cocaine possession offences were focused in the West End (Westminster) and Brixton (Lambeth). Possession offences were more common across the central boroughs (Lambeth, Westminster and Camden) with the neighbouring areas recording high to intermediate levels of offending (80 to 337 offences).

Figure 4.10 Recorded crack cocaine possession: borough levels and regional hotspots (1998/99 – 2002/03)



Possession of cocaine

4.17 The regional hotspots for the possession of cocaine were similarly located to those for crack cocaine except there were small hotspots in Kingston (Surbiton) and Havering (Romford).

4.18 Summary – the geography of drug supply and possession

- Crack cocaine supply offences were concentrated within the inner city boroughs. There were hotspots in the West End, around Kings Cross, in Brixton and in North Kensington. Cocaine powder supply was also concentrated in central London, with the main hotspot in Westminster
- All borough 'families' recorded large increases for crack cocaine supply from 1998/99. Central boroughs demonstrated an increase of over 300 per cent (from 82 offences to 339), both the poorer and affluent outer boroughs just over 200 per cent and the deprived inner boroughs increased by just under 50 per cent
- During 2002/03, five boroughs of 32 (Brent, Haringey, Camden, Lambeth and Kensington and Chelsea) accounted for just over half of London's crack cocaine supply offences. Kensington and Chelsea recorded both the greatest number of offences (172) and also the highest rate (11 per 10,000 population)
- Thirteen boroughs accounted for just over two-thirds (67 per cent) of cocaine supply offences during. Two of these areas were affluent outer boroughs (Hounslow and Hillingdon). Lambeth recorded twice the level of cocaine supply of other high level boroughs (82 offences with the next highest being 39)
- Crack cocaine possession offences were focused in the West End (Westminster) and Brixton (Lambeth). Possession offences were more common across the central boroughs (Lambeth, Westminster and Camden) with the neighbouring areas recording high to intermediate levels of offending (80 to 337 offences)
- The regional hotspots for the possession of cocaine were similarly located to those for crack cocaine except there were small hotspots in Kingston (Surbiton) and Havering (Romford)

5 Responding to the problem

5.1 The first half of this chapter summarises the knowledge base about effective treatment practice for helping crack cocaine users. It draws on guidance prepared by the NTA and other strategic bodies working in the substance misuse field, and aims to summarise the principles that inform best practice. For example the NTA Models of Care (MOC) currently structures the work conducted with crack cocaine users and other drug users.

5.2 The second half presents information about current service provision for crack cocaine and cocaine users across London. It draws on an audit of crack cocaine and cocaine treatment service provision in London. The audit was commissioned to assess and describe the resources applied to crack cocaine and cocaine treatment.

Treatment practice and interventions for crack cocaine users

5.3 In June 2002, the NTA published a series of papers on best practice in providing and commissioning treatment services for crack cocaine users[51]. These summarised the key components required for effective practice as follows:[52]

- The most effective interventions appear to be 'psycho-social' delivered via individual counselling and group therapy, provided in structured day care or residential setting.
- Users with multiple needs require intensive treatment regimes;
- Services need to employ strategies to engage crack cocaine users that differ significantly from those for opiate users, both at the point of first contact and while in treatment[53].
- Agencies should minimise delays between service contact and treatment take-up and offer specialist treatment alongside a range of practical and social interventions;
- Waiting times for treatment should be short and comply with NTA targets (see Table 5.1);
- No recognised pharmacotherapy for cocaine dependence exists and thus far, pharmaceutical interventions are not currently recommended, unless crack cocaine is used in combination with other drugs of dependence or the users has mental health problems.
- Commissioning should establish specific care-pathways for problematic users with strong therapeutic relationships, with emphasis placed on case management, through-care and aftercare.

5.4 In recognition of the need to develop more effective services for those who misuse stimulants, particularly crack cocaine and cocaine, the NTA has established a work programme specifically to address this issue. This work has taken on even greater urgency with the growing concern about increased crack cocaine/cocaine use, links with crime and the commitment from central government to address this problem. The programme focuses on three key areas:

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[51] See NTA Guidance on Crack Treatment services at www.nta.nhs.uk.

[52] Although, the competencies were based on then current knowledge of 'best practice' and was accepted that there is a continuous need to develop and improve.

[53] To engage crack users in treatment, services should provide rapid intake, proactive reminders, and practical help with attendance.

- Developing a comprehensive training package based on new occupational standards
- Piloting a range of new materials and tools to enable drug workers to work more effectively with crack cocaine users
- Evaluating existing specialist services with a view to identifying and disseminating good practice

Current treatment practice

5.5 Anecdotal accounts from practitioners and treatment service records both suggest that the number of problematic crack cocaine and cocaine users accessing services is increasing. As with other service users, crack cocaine users often report poly-drug use; crack cocaine combined with opiates is common. Thus services need to cater for the specific needs of primary crack cocaine and cocaine users and also provide for the needs of a growing number of dual and poly-drug users using crack cocaine and/or cocaine and other drugs.

Models of Care and the NTA

5.6 NTA's 'Models of Care' requires DATs and treatment providers to provide treatment care pathways for crack cocaine users that pay particular attention to designing conduits between the CJS (Criminal Justice System) and treatment services. Re-designing treatment services to meet the needs of crack cocaine users has, to date, focused on tiers 2 and 3 to improve their responsiveness in engaging crack cocaine users and retaining them in treatment for longer. This work required drug services to review and improve assessment and triage procedures that have been shown to inhibit treatment access.

Table 5.1 NTA treatment targets

Treatment modality	Average baseline waiting time (weeks*) 1999/00	Maximum acceptable lengths of wait (weeks*)		Dec 03
		2002/03	2003/04	
Inpatient detoxification	6.1 weeks	4 weeks	2 weeks	3.7
Community prescribing – specialist	10.2 weeks	6 weeks	3 weeks	3.7
Community prescribing – GPs	5 weeks	4 weeks	2 weeks	1.2
Structured counselling	4 weeks	4 weeks	2 weeks	2.6
Structured day-care programme	3.3 weeks	4 weeks	3 weeks	2.9
Residential rehabilitation	5.4 weeks	4 weeks	3 weeks	3.2

Note: 1 week = 5 working days

Primary Care

5.7 Like many other problem drug users, those using crack cocaine are susceptible to numerous generic and specific health problems (e.g. general poor health, lung damage, cardiovascular problems and mental health issues) typically falling in the domain of the primary care services (e.g. GP practices). To remedy these concerns GPs should develop mechanisms so that:

- Patients displaying symptoms of problematic crack cocaine use are recognised and receive an appropriate assessment and referral to specialist services;
- The primary health care needs of their crack cocaine using patients are managed appropriately;
- Primary care practices liaise and work with specialist treatment providers including mental health services;
- Shared care schemes and protocols are revised to include crack cocaine users alongside those using opiates;
- GPs and other primary care staff receive training enabling them to work with and effectively manage the care of crack cocaine users.

Mental health services

5.8 Crack cocaine use can lead to a number of mental health problems and exacerbate existing psychological conditions. Drug use and mental health issues have often fallen through the service 'safety net' whereby the diagnosis is fraught with problems and unable to identify drug induced psychosis or underlying psychological problems, and thus the most appropriate treatment. It is these issues that may directly affect crack cocaine users (those with mental health problems may not be managed effectively by either mental health services for their drug use or drug agencies for their mental health problems). To address these issues specialist drug treatment, dual diagnosis and general psychiatric services should develop and agree local protocols and care pathways for managing crack cocaine users with psychological problems e.g. by improving arrangements between Community Mental Health Teams, GPs and Community Drug Teams (CDTs).

Harm minimisation

5.9 Drug services should endeavour to target and educate crack cocaine users in harm minimisation strategies and practices. For example, needle exchanges could develop services for those using crack cocaine intravenously by extending the range of injecting equipment distributed and increasing awareness the problems associated with injecting practices. Crack cocaine users tend to inject more frequently than opiate users, often leading to tissue and vein damage. Action is also necessary to combat crack cocaine related deaths[54].

Blood Borne Viruses.

5.10 As with other chronic and long-term drug users those using crack cocaine have been shown to have increased risks of blood borne viruses (BBV) such as HIV and hepatitis from sharing syringes and other drug using paraphernalia or via unprotected sex and/or sex work. Thus, services designed to treat and prevent BBVs could target crack cocaine users by adjusting opening hours, providing hepatitis immunisation, and working more closely with specialist and primary care services.

5.11 Crack cocaine injecting is growing. Recent studies have suggested that the incidence of HIV and HCV may have increased, and that the historic trends in low HIV prevalence and comparatively stable HCV prevalence are being reversed. Injecting crack cocaine is associated with higher risk of infection with HIV and HCV, partly because of an increase in injecting frequency, and may have contributed to the increase in

[54] An ONS study has demonstrated the increasing levels of cocaine related deaths from 66 in 1998 to 139 in 2003

transmission of HIV and HCV. A review is needed to assess the scale of harm reduction initiatives in London and to see whether coverage is adequate to prevent transmission of blood borne viruses, given extra risks generated through crack cocaine injection.

Housing

5.12 An essential part of any treatment strategy is user access to appropriate accommodation. There are two main routes by which problematic drug users can gain social housing. Firstly, if they are considered vulnerable, they may qualify for priority housing under the Housing Act (2002) or alternatively they may be able to access supported housing. Currently, there are 780 specialist supported housing units in London (the majority of which is defined as 'floating support'). Demand for social housing in London exceeds supply and local interpretations of what constitutes priority need and intentional homelessness have also been shown as a major barrier for users needing housing.

5.13 However, recently there has been a number of initiatives to improve and extend access to housing for problem users, such as the 'Supporting People' programme, set up in April 2003. This programme introduced a strategic approach to commissioning and delivery of supported housing services. Strategies are currently being developed and expected to incorporate a focus on drug related issues. The programme incorporates a review process aimed to improve effectiveness and efficiency and DATs should have a key role in this process ensuring the appropriateness and quality of services provided. Although the provision of specialist services is low there are several generic homeless projects and specialist schemes for offenders and people with mental health problems (accounting for about 30 per cent of supporting people's provision in the capital). DATs should ensure that the schemes are competent to work with drug users and develop appropriate care pathways into treatment[55].

5.14 The level of demand for housing in London has meant that homelessness issues cannot solely be addressed within the social housing sector. London boroughs are finding creative ways both to prevent homelessness and to make appropriate use of the private sector. Floating support schemes have been particularly effective in helping people, including those with drug problems, to maintain their accommodation. DATs can usefully work with housing colleagues to assist problem drug users both to access and maintain accommodation.

5.15 Research has also highlighted the need for better links between treatment services and supported housing agencies, including improved access to places within a supported housing environment. Staff in drug agencies were asked to estimate the difficulty of gaining access to secure housing for drug users in or completing treatment, or those leaving prison. Most indicated that access to this type of accommodation was difficult, with a small minority indicating that accessibility to secure housing was acceptable or easy.

London Crack Communications Campaign

5.16 The Government Office Drugs Team (GOLDT) with the Central Office for Information (COI) and the Drugs Strategy Directorate Communication Team are currently developing a crack cocaine communications campaign for London. The

[55] Some DATs have provided training to Tier 1 professionals, which has improved access to treatment and linkages with housing suppliers.

campaign will focus on a number of different audiences including professionals, communities and users.

Crack cocaine service provision in London

5.17 This section presents the findings from an audit of London treatment services working with crack cocaine and cocaine users conducted in November 2003. The purpose of the audit was to assess the levels of treatment provision and resources available to problematic users from 31 the 33 CDRP/DAT areas[56]. The key objectives of the exercise were to:

- Assess the number, location and operation of services catering to problematic crack cocaine users in London
- Describe the interventions provided and at which treatment tier
- Measure the extent of crack cocaine related treatment demand and treatment capacity
- Assess which services were crack cocaine competent e.g. having specific and established policies or protocols for addressing problems associated with crack cocaine/cocaine users, and
- Measure the levels of shared care

Services

5.18 The audit generated information on services provided to residents from the 31 DAT areas. The audit provides details of 116 different services from these areas to which young people and adults with problematic crack cocaine and/or cocaine use can be referred. The audit found that service provision is not evenly distributed across London, with just under a quarter of DAT areas (7) having a single provider while others offer substantially more. In addition, a quarter of London's provision is located in just three boroughs.

5.19 The majority of services (105) provide support during regular working hours (between 9am and 6pm) with only some offering services in the evenings (39), at night (4) or on the weekends (10). There were initially 12 CJIP areas in London, rising from April 2004 to 17. This is an intensive programme that will offer a point of contact within these boroughs 24 hours a day seven days a week (see Chapter 7).

Tier 2 interventions – Open Access Drug Treatment Services

5.20 The most common forms of tier 2 intervention offered by services dealing with crack cocaine/cocaine users in London included motivational interviewing and/or brief interventions (91 per cent) followed by assessment appropriate to crack cocaine/cocaine use (83 per cent). Two-thirds (66 per cent) provided housing advice and support for families and/or carers. More than half were able to offer advice on benefits (60 per cent), education, training and employment (59 per cent), complementary therapies (54 per cent), and outreach contact and onward referral (52 per cent). Fewer services provided needle exchange provision (46 per cent), low threshold prescribing (36 per cent) and floating support (27 per cent). Just under two-thirds (63 per cent) of the services in London provided six or more tier 2 interventions with low threshold services accessible in all London boroughs surveyed. Most services (57) described their workloads as 'manageable' while just over one in ten (12) felt that they were operating 'under capacity'. By contrast, 27 described their current workload as 'stretched'.

[56] The boroughs of Kingston and Hounslow did not submit data for the audit.

Tier 3 interventions – Community-based Drug Treatment Services

5.21 The audit indicated that crack cocaine/cocaine users in all DAT areas surveyed had access to tier 3 structured treatment services. Roughly three-quarters of services offered care planning and co-ordination, and structured counselling (74 per cent and 75 per cent respectively). About half provided structured complementary therapy (55 per cent) community stabilisation and/or maintenance (49 per cent), and services for dual diagnosis (48 per cent). Nearly half (49 per cent) of services in London provided four or more tier 3 structured services.

5.22 The audit also estimated the proportion of clients accessing London services using crack cocaine (either as primary users or in combination with other drugs). One-third of responding services stated that the majority (67 per cent to 100 per cent) of their workload involved crack cocaine/cocaine users. An additional 40 per cent thought they occupied between a third and two thirds of their caseloads. Three-fifths of services had established policies or protocols relating to the provision of support for crack cocaine/cocaine users. Two-thirds of services surveyed described their competence for dealing with crack cocaine/cocaine users as 'acceptable' and just over a quarter as 'specialist'.

General practices and shared care schemes

5.23 Given the growing demand for treatment places - particularly those provided by specialist services - studies since the early 1980s have sought to encourage and enhance the role of general practitioners in the treatment of drug users. This has included the publication of guidelines to support and promote the role of GPs and encourage local Primary Care Trusts (PCTs) in assisting the development of shared care arrangements (ACMD, 1982; Department of Health, 1984; 1995). Despite this, there is wide variation in the extent of GP involvement and arrangements for shared care. This reflects the availability of local treatment provision and the willingness and ability of GPs to engage in these arrangements. There is only a limited amount of research highlighting the contribution GPs and shared care schemes can play in the care of problem drug users, with most studies contacting only a small number of crack cocaine/cocaine users (Ryrie et al., 1999).

5.24 In July 2003, the Royal College of General Practitioners hosted a 'pooled experience day' that aimed to initiate the process of developing guidance for primary care to work more effectively with people who use crack cocaine/cocaine. A quarter (431) of the practices reported involvement in a shared care scheme. Most (70 per cent) estimated that less than a third of their workload involved crack cocaine/cocaine users with. Three-quarters of the DATs indicated that there was no formal policy or protocols relating to crack cocaine/cocaine use and a similar proportion (72 per cent) described their competence for dealing with crack cocaine/cocaine users as 'low'.

Aftercare services

5.25 Twelve of the 31 areas provided information about aftercare support. They reported a total of 1,316 places annually available across their boroughs. Most estimated that at least one-third of all clients accessing aftercare services were crack cocaine/cocaine users (evenly distributed between primary and poly users). Most of these aftercare services also had specific policies or protocols for working with crack cocaine/cocaine users and were described as having either 'acceptable' or 'specialist' competence in dealing with them.

Drug Treatment and Testing Orders (DTTO)
5.26 In 2002/03, 715 DTTO's were made in London. Only six London DATs indicated that they had a policy for dealing with crack cocaine/cocaine users sentenced to a DTTO. A larger number stated that DTTO programmes in their area had an 'acceptable' level of competence when it came to dealing with this particular group of users (16). The National Crack Plan has highlighted the need to ensure that DTTOs are as accessible to crack cocaine/cocaine users as they are for opiate users. To assist with this the National Probation Directorate and NTA have recently commissioned research to examine the growing evidence base about DTTOs and assess their effectiveness and ability to engage with crack cocaine/cocaine users (Home Office, 2003).

Tier 4 - Inpatient treatment
5.27 In 2002/03, 14 of the London DATs collectively had access to 496 inpatient treatment places. Estimates varied widely concerning those using crack cocaine/cocaine and accessing inpatient treatment. Twelve DATs stated that fewer than one-third of inpatient admissions (during 2002/03) were crack cocaine/cocaine users and these were thought to be evenly divided between primary and poly users. A similar number (10) did not have protocols and procedures in place for dealing with the specific needs of this group. Despite this, responding DAT Co-ordinators indicated that the degree of competence within inpatient services in their area to address crack cocaine/cocaine issues was either 'acceptable' (13) or 'specialist' (4).

Tier 4 - Residential rehabilitation
5.28 The audit showed that in 2002/03 120 residential rehabilitation episodes were commissioned across 12 of the London boroughs. As with inpatient admissions, about half the areas responding estimated that fewer than one-third of clients accessing residential services were crack cocaine/cocaine users. Again, the proportion of crack cocaine/cocaine users accessing residential rehabilitation was thought to be evenly split between primary and poly users. One in three DATs (11) indicated that they have policies in place for dealing with the specific needs of crack cocaine/cocaine users attending rehab. A similar number (14) stated that residential services had an 'acceptable' level of competence when it came to dealing with the needs of this user group.

Crisis intervention
5.29 City Roads is a crisis intervention centre in London offering 24-hour support to drug users in crisis, usually for periods of around 21 days. During 2002-03, 20 of the DATs across London commissioned a total of 333 treatment episodes from City Roads. Like the crack cocaine/cocaine using clients accessing other tier 4 services discussed above, those referred to City Roads from within the London area appear to be mainly primary crack cocaine users with slightly fewer areas referring clients using crack cocaine in combination with other drugs. Most areas described the competence of City Roads to deal with the needs of crack cocaine/cocaine users as 'specialist'.

Enforcement protocols
5.30 Twelve of the DAT areas responding to the audit had a current protocol for enforcement action against premises where crack cocaine/cocaine use gives rise to serious public nuisance, despite research suggesting that there should be procedures in place that aim to close identified premises within two to four weeks following notification (Webster et al., 2001). Just under half (5) had introduced their enforcement protocols during 2003. During the same period the Home Office published comprehensive guidance to help local agencies tackle crack cocaine markets more

effectively. This provided case studies and strategies for disrupting crack houses including action to prevent crack houses developing and proposals for taking action against crack houses using current legislation (Burgess, 2003).

Joint working

5.31 Mental health problems are more commonly reported among crack cocaine/cocaine users than physical problems. Perhaps unsurprisingly then ninety per cent (28) of DATs indicated that they had established joint working arrangements between local drug services and Community Mental Health Teams. By contrast, half (16) had developed links with Forensic Psychiatric Services.

Waiting times

5.32 Additional data supplied by the 33 DATs reveal that waiting times for the six modalities of service by which they are measured have fallen from the 1999/00 baseline to meet the 2002/03 targets.

5.33 Summary – Responding to the problem

Based on responses from 31 DAT areas providing details of 116 different services:

- Service provision is not evenly distributed across London
- Most services (91 per cent) offer support during regular working hours (i.e. between 9am and 6pm). A third offer support during evenings, and ten per cent weekends.
- The most common forms of tier 2 interventions include motivational interviewing and/or brief intervention (91 per cent) followed by an assessment appropriate to crack cocaine/cocaine use (83 per cent).
- A third of responding services considered that they were working with a high proportion of crack cocaine/cocaine users
- Almost two thirds of services have established policies or protocols relating to the provision of support for crack cocaine/cocaine users
- One in four GP practices identified were involved in a shared care scheme aftercare services were crack cocaine/cocaine users
- In 2002/03, 715 treatment places were commissioned via the DTTO programme
- Less than one-third of DATs in London have a policy for dealing with crack cocaine/cocaine users sentenced to a DTTO
- Half the areas estimate that less than one in three clients accessing inpatient and residential services were users of crack cocaine/cocaine
- Less than one in three DATs have a current protocol for enforcement action against premises where crack cocaine/cocaine use or supply gives rise to serious public nuisance.
- Most areas indicated that access to secure housing for drug users was difficult, with fewer indicating that accessibility was acceptable or easy.
- Most DATs have established joint working arrangements between local drug services and Community Mental Health Teams.
- Waiting times for the six modalities of service for which they are measured have fallen from the 1999/00 baseline to meet the 2002/03 targets.

6 The nature of treatment demand

6.1 This section presents information on the nature of treatment demand in London over the last few years. It draws on data from the Regional Drug Misuse Database (RDMD) and the National Drugs Treatment Monitoring System (NDTMS). These enable us to describe the extent of treatment demand across London by drug type, trends in demand and the characteristics of those presenting to treatment services[57].

The data sources

6.2 A public health surveillance system for monitoring trends in problematic drug use and treatment demand has been in operation since 1990. The system, originally known as the Regional Drugs Misuse Database (RDMD), was reviewed and revised in April 2001 as the National Drugs Treatment Monitoring System (NDTMS). It gathers data on drug users attending a range of specialist and generic drug agencies[58]. Information is kept on users' socio-demographic characteristics, drug use and on treatment details. The system preserves users' anonymity, but analysis of unique identifiers (initials, date of birth and gender) allows estimates to be made of the number of new users seeking treatment, and the overall number of users in treatment[59].

Trends and patterns of demand

6.3 The Regional Drug Misuse Database can provide trends for the six financial years from 1995/96 to 2000/01[60]. Figure 6.1 shows the main drug use of those accessing treatment services over the period[61].

[57] Accurate information concerning the demand for treatment was somewhat limited as a new database (NDTMS) designed to replace the RDMD had experienced a number of implementation difficulties and therefore data were not forthcoming.

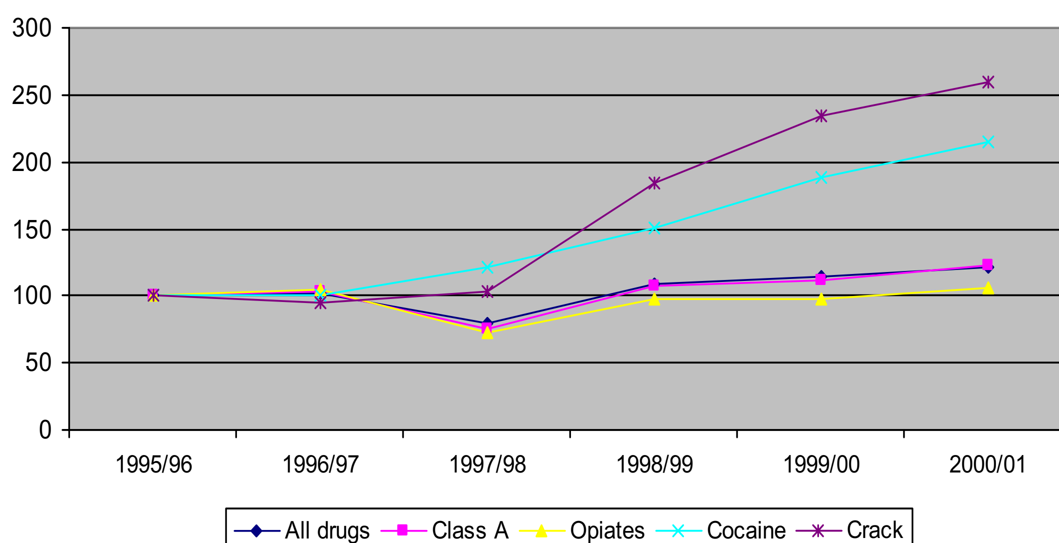
[58] However, the RDMD collected data on those presenting to services for the first time whereas data from the NDTMS gathered information on new and existing clients in 2001/02.

[59] The data relate users accessing treatment services in London and does not include London residents accessing treatment elsewhere, although this number is expected to be small. Figures also include information on non-London residents accessing treatment agencies within London.

[60] The two datasets are not directly comparable owing to changes in reporting methodology.

[61] Main drug use is defined as the drug which causes the client the most problems at the time of contact with the treatment service.

Figure 6.1 Indexed trends of London RDMD reports (1995/96 to 2000/01).



6.4 In total, there were almost 68,000 treatment demands in London during the period. Class A drugs accounted for the vast majority (83 per cent) of all notifications to the database[62]. Just over two-thirds (67 per cent) of the reports were for opiate problems of which heroin accounted for just over half the overall total[63]. Crack cocaine accounted for 11 per cent and cocaine 4 per cent.

6.5 Over the period, there was an increase in the number of notifications for *all* drugs by 22 per cent (from 10,855 to 13,270) with Class A reports rising by 23 per cent (from 9,041 to 11,108)[64]. However, while opiates showed a modest increase (6 per cent) over the same period (from 8,830 to 8,329) both cocaine and crack cocaine increased substantially (115 per cent and 159 per cent respectively) – albeit from low baselines[65]. However, by 2000/01 crack cocaine had become the second most commonly reported main drug used by those seeking treatment (14 per cent of all annual notifications in London) compared to neighbouring regions (South East 3 per cent and Eastern regions 2 per cent)[66].

6.6 The NDTMS can provide a snapshot of those in treatment workloads in 2001/02. London services recorded just over 21,000 treatment demands[67]. The vast majority derived from those groups traditionally associated with drug service provision: they were mostly male (76 per cent), White (66 per cent), opiate users (70 per cent).

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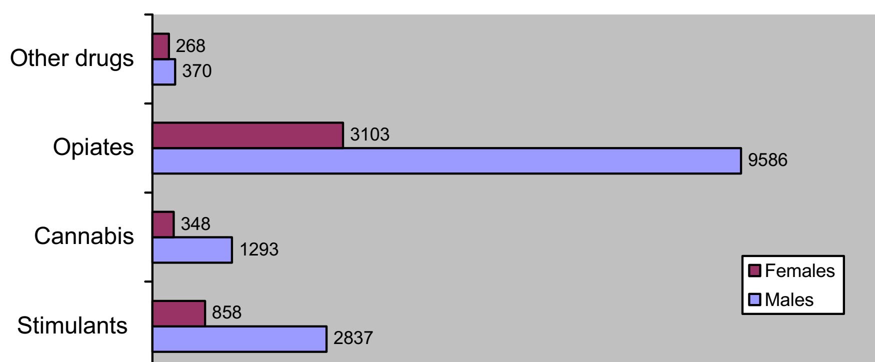
[62] Between 1995/96 and 2000/01 there were a total of 56,162 Class A notifications.
[63] Methadone and other opiates accounted for 14% and 2% respectively of all notifications over the six year period.
[64] Similar trends between all and Class A drugs largely reflected their inclusion of largely the same drug types.
[65] Between 1995/96 and 2000/01 cocaine and crack notifications increased from 342 and 741 to 735 and 1,917.
[66] The South East region comprised: Berkshire, Buckinghamshire, Kent, Surrey, Sussex, Isle of Wight, North and mid Hampshire, Northamptonshire, Oxfordshire, Portsmouth and SE Hampshire, Southampton and SW Hampshire and the Eastern region included: Bedfordshire, Cambridgeshire, Hertfordshire, Norfolk, Essex and Suffolk. The RDMD data used for comparative purposes was derived from the 1999/00 financial year.
[67] There were in total 21,305 demands for treatment in 2001/02 recorded by the NDTMS.

6.7 Figure 6.2 provides a breakdown of main drugs used. To avoid double-counting, repeat treatment episodes are excluded. ('New contacts' constituted 88 per cent or almost 19,000 of all NDTMS episodes for the year.) Three-quarters of all new contacts were male. Just over two-thirds (68 per cent) reported opiates as their main drug, almost all of which (84 per cent) related to heroin. There was little difference in the proportion of males (9,586) and females (3,103) disclosing opiate use.

Figure 6.2 Total number of male and female new contacts by main drug use reported to the NDTMS in 2001/02 (n = 18,663).



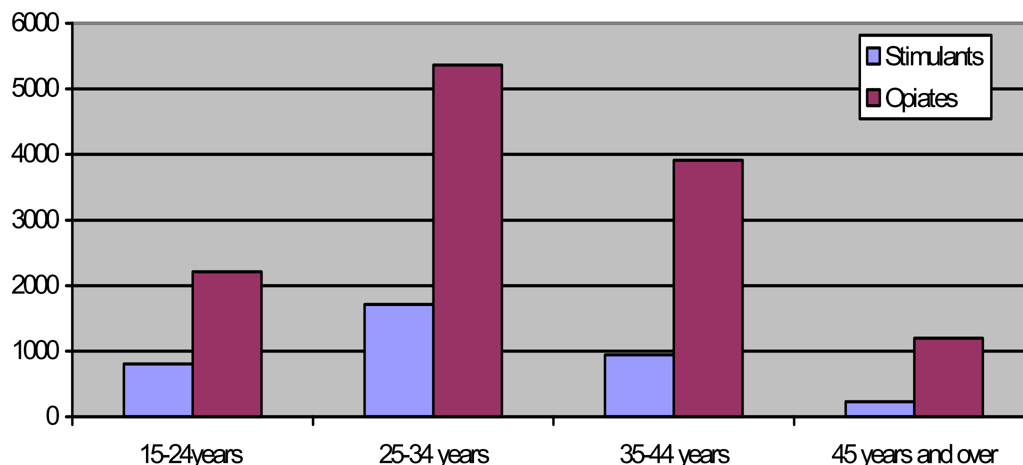
6.8 Stimulants were the next most commonly used drug type, accounting for a fifth (20 per cent or 3,695). Within stimulants the main drug was crack cocaine, accounting for almost two-thirds (58 per cent). Cocaine accounted for just under a third (1,164), and amphetamine and ecstasy accounted for the balance.

6.9 Cannabis accounted for a significant minority of episodes, at 9 per cent. Other drugs accounted for three per cent. It can be seen that Class A drug use was reported by the vast majority (87 per cent) of first contacts and somewhat reflects both the nature of problematic use and service provision to meet the needs of this group.

Age and drug use

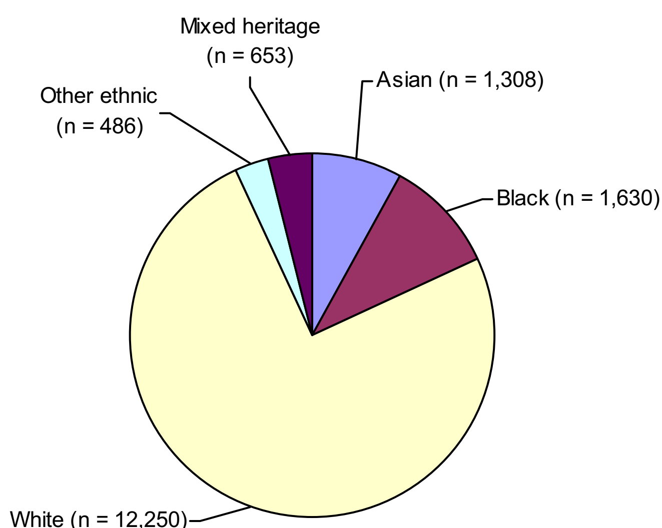
6.10 Just over two-thirds (69 per cent) of all new contacts reported to the NDTMS were aged between 25 and 44 years. The largest age group were those aged from 25 to 34 years (41 per cent). These were followed by those aged 35 to 44 years who accounted for just over a quarter (28 per cent). A fifth (21 per cent) were between 15 to 24 years, just under 10 per cent were 45 and over. Figure 6.3 presents this information graphically, showing opiates and stimulants separately.

Figure 6.3 Total number of reports to the NDTMS by age group and drug type (opiates and stimulants) for 2001/02 (n = 16,384)[68].



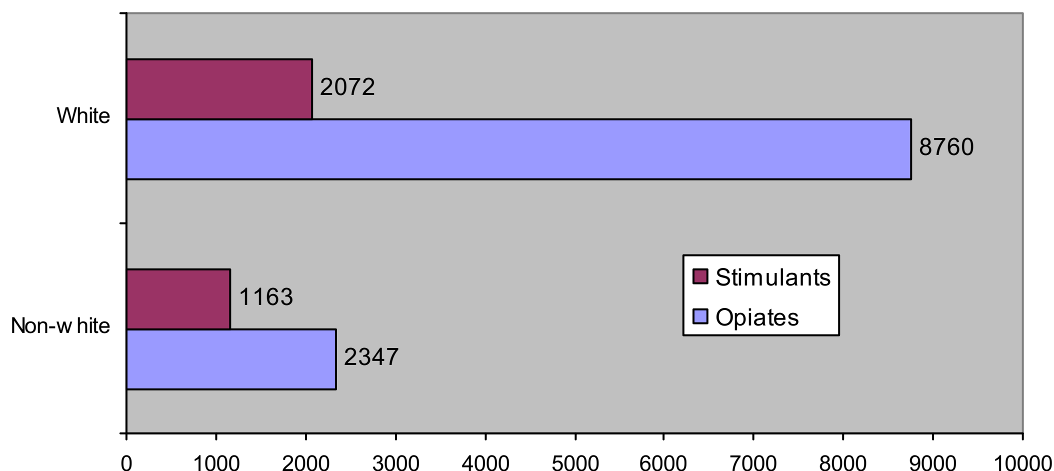
6.11 The ethnicity of just over 16,000 (87 per cent) new contacts was collected in 2001/02 (see Figure 6.4). Of these the vast majority were White (75 per cent) followed by Black users (10 per cent), Asians (8 per cent), those of mixed heritage (4 per cent) and other ethnic groups.

Figure 6.4 Total number of new contacts by ethnic group reported to the NDTMS in 2001/02 (n = 16,327).



[68] Fourteen years and under – stimulants 3 and opiates 5

Figure 6.5 Main drug use (opiates and stimulants) and ethnicity reported to the NDTMS in 2001/02 (n = 16,327).



6.12 Figure 6.5 shows differences between ethnic groups in terms of main drug used. Four out of five white 'first contacts' (79 per cent) were opiate users. Of those from minority ethnic groups, Asians reported the greatest opiate use accounting for almost half (46 per cent) of all non-white use. This was followed by Black users (24 per cent) and those with mixed heritage and other ethnic groups (15 per cent each). However, amongst opiate users, ethnic minorities were proportionately more likely to report heroin use than their white counterparts (92 per cent and 82 per cent respectively).

6.13 Reported levels of stimulant use were lower. In total, 3,235 individuals reported using stimulants as their main drug, of which whites accounted for just under two-thirds (2,072). Of those from minority ethnic groups, Black people reported the greatest stimulant use accounting for just over two-thirds (806) of all non-white use. Crack cocaine accounted for almost three-fifths (1,866) of all reports of stimulant use. Of these half (923) were White and a third (690) Black. The vast majority (84 per cent) of cocaine use was reported by White users.

6.14 Presenting numbers and percentages of 'main drug' can be slightly misleading as the majority of users reported are poly-drug users. Hence data presented below combines main and subsidiary drug (of which there can be up to four) into the following drug profiles:

Heroin + Crack cocaine: those who used both heroin and crack cocaine and any other drug
Heroin – crack cocaine: those who used heroin but not crack cocaine, and any other drug
Crack cocaine – heroin: those who used crack cocaine, but not heroin, and any other drug
Any other drug: those drug users who used neither crack cocaine nor heroin[69]

[69] For example any other drugs include: cocaine, methadone, other opiates, ecstasy, amphetamines, benzodiazepines and cannabis.

6.15 Provisional analysis showed that 24 per cent used heroin and crack cocaine and 17 per cent used crack cocaine only (without heroin, plus any drug). Whether drug services fully record secondary drugs used – and, indeed, whether users report the full range of their drug use to drug workers – is of course, questionable.

6.16 This analysis showed that almost two-thirds (61 per cent) of those from Black communities notified to the NDTMS in 2001/02 reported using crack cocaine and any other drug. Two-fifths (39 per cent) reported solely using crack cocaine and the same proportion heroin. Just under a quarter (22 per cent) of Black users stated they used heroin and crack cocaine. In contrast, two thirds (66 per cent) of Whites reported using heroin and any other drug, just over a quarter (26 per cent) used heroin and crack cocaine in combination. Furthermore, only a third (33 per cent) reported using crack cocaine, and seven per cent crack cocaine only.

6.17 We examined area of residence (divided by inner and outer London) and drug use for the year. This showed that those living in inner London areas were more likely to have reported combined use of heroin and crack cocaine than those living in outer London (19 per cent and 11 per cent respectively). Furthermore, those from inner London were more likely to report using crack cocaine (42 per cent) and heroin (55 per cent) compared of those from outer London (27 per cent and 51 per cent respectively). In contrast, those from outer London were more likely to have reported heroin (without crack cocaine) and other drug use, and using drugs other than crack cocaine or heroin compared to their inner London counterparts.

6.18 Summary - Treatment data

- Between 1995/96 to 2000/01 in total there were almost 68,000 treatment demands in London. Class A drugs accounted for the vast majority (83 per cent). Just over two-thirds (67 per cent) were for opiates, crack cocaine accounted for 11 per cent and cocaine four per cent
- Over the same period, Class A reports increased by 23 per cent. Opiates showed a modest increase (6 per cent) both cocaine and crack cocaine increased substantially (115 per cent and 159 per cent respectively) – albeit from low baselines
- By 2000/01 crack cocaine had become the second most commonly reported primary drug used by those seeking treatment (14 per cent of all annual notifications in London) compared to marginal increases experienced by neighbouring regions (South East 3 per cent and Eastern regions 2 per cent)
- London services recorded just over 21,000 treatment demands. The vast majority derived from those groups traditionally associated with drug service provision: they were mostly male (76 per cent), White (66 per cent), opiate users (70 per cent) and aged between 25 and 34 years (41 per cent)
- Three-quarters of all new contacts in 2001/02 were male. Stimulants accounted for a fifth of new contacts (20 per cent or 3,695). Within stimulants the main drug was crack cocaine, accounting for almost two-thirds (58 per cent) and cocaine accounted for just under a third (1,164)
- Demographic analysis showed stimulant users as more likely to be younger and from BME communities than their opiate counterparts.

7 Criminal justice interventions

7.1 This section presents information on current drug interventions in the Criminal Justice System (CJS) designed to reduce problematic drug use and related offending. Data derives from the New English and Welsh Arrestee Drug Abuse Monitoring (NEW-ADAM) research programme; arrest referral initiative, drug testing at charge in police custody under the Criminal Justice Interventions Programme (CJIP), and Drug Treatment & Testing Orders (DTTOs). The section assesses the extent and nature of the relationship between drug use (specifically focusing on crack cocaine) by criminal justice populations in London, and the potential implications.

Background

7.2 Research has demonstrated that offenders who misuse drugs commit significantly more offences than those who do not (see Hough, 1996, Hough and Mitchell, 2003; Edmunds, 1998, 1999). Problematic drug use is linked with acquisitive offending in particular, for example shoplifting, burglary, vehicle crime and theft. Reducing drug-related crime is a key objective for the Government (Updated Drug Strategy, 2002) and interventions have been established explicitly to reduce rates of drug use and related offending. The research evidence that underpins this strategy strongly associates problematic use of crack cocaine and heroin with offending, particularly as part of poly-drug use (Edmunds et al, 1996; Bennett et al, 2001; Stewart et al, 2000, Turnbull et al, 2001).

7.3 Evaluations of criminal justice interventions for drug users have suggested that heroin, crack cocaine and cocaine users are responsible for a significant proportion of all acquisitive crime. Initiatives to engage criminally involved problem users in treatment have tended to do well in reaching those who traditionally avoid contact with treatment services; they can provide interventions at an earlier stage in an individual's drug-using career, and reduce levels of offending and improve social functioning and health (Bennett et al 2001 and Edmunds et al, ibid). However, to date, these services have not been sufficiently coordinated, leading to inconsistent care, inefficient working practices and failure to effectively engage and retain offenders in treatment. A key area of development is the inadequate provision of aftercare services following release from prison.

7.4 The Updated Drug Strategy highlighted the need for better co-ordination of initiatives at different stages of the criminal process, from arrest through to the period following release from prison. The National Treatment Agency (NTA) and Government Office for London Drugs Team (GOLDT) are working to ensure that drug-misusing offenders have timely access to appropriate and co-ordinated treatment.

Criminal Justice Interventions Programme (CJIP)

7.5 In April 2003, the CJIP was launched in 25 Drug Action Team (DAT) areas of the UK, targeted at those areas with high levels of acquisitive crime. The programme is designed to reduce drug related crime by building upon current interventions and establishing new interventions to maximise opportunities for drug using offenders to access and remain in treatment.

7.6 In London 12 DAT areas (Lambeth, Southwark, Haringey, Hackney, Newham, Ealing, Westminster, Camden, Tower Hamlets, Islington, Waltham Forest and Wandsworth) have developed dedicated, community based teams taking referrals from the police, courts, probation and prisons. Key interventions include:

- Drug testing on charge at Police stations
- Co-ordination and provision of services at police stations and courts
- Triage assessment and referral to specialist treatment
- Harm reduction advice and information
- Access to rapid and low threshold treatment
- A single point of contact for service users and professionals
- Co-ordination and case management
- Specific interventions for crack cocaine users
- Facilitation of access to after services such as housing, employment, education and training
- Integrated working to support community sentences

7.7 From April 2004 the CJIP areas will be expanded to include: Brent, Croydon, Hammersmith and Fulham, Kensington and Chelsea and Lewisham. However, from April 2004 all DATS will receive funds to set up robust criminal justice system care pathways and improve aftercare provision.

Service Developments

7.8 To date, the numbers and needs of problematic crack cocaine and cocaine users within the CJS has not received specific attention. Previous findings from CJS evaluations have shown that those traditionally underrepresented in treatment services (e.g. women[70] and BME groups[71]) also suffer a number of obstacles affecting their engagement and service take-up with helping agencies via the CJS. CJIP areas have addressed some of these concerns, for example through the provision of childcare and assertive outreach schemes. Three London boroughs (Southwark, Camden and Newham) have been selected to run pilot young person's arrest referral programmes operational by April 2004 and compulsory drug testing of young people is planned in 2004.

New English and Welsh Arrestee Drug Abuse Monitoring (NEW-ADAM)

7.9 National baseline information concerning the prevalence of drug use and offending of arrestees has been collated by the New English and Welsh Arrestee Drug Abuse Monitoring (NEW-ADAM) research programme The programme covers 16 locations (including Hammersmith and Bethnal Green) across England and Wales[72]. The data presented is derived from around 1,500 interviews and voluntary urine tests conducted with arrestees from eight custody suites which participated in the first phase (1999–2000)[73]. Of those interviewed and tested the vast majority were male (87 per cent), White (82 per cent), with ages ranging from 17 to 59 years (half were aged between 17 and 24 years).

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[70] see Becker and Duffy (2002)

[71] see Sangster et al (2002)

[72] The other NEW-ADAM research sites were: Sunderland; Norwich; Newport; Southampton; Wolverhampton and Bournemouth and each data collection cycle lasts two years. Eight sites are visited in Year 1, followed by the remaining eight sites in Year 2.The first eight sites are revisited in Year 3, and so on

[73] The urine analysis tested for six drugs: opiates, cocaine, cannabis, benzodiazepines, amphetamines and methadone.

Urine analysis

7.10 Urine analysis is a good indicator of very recent drug use (i.e. in the last few days). Analysis showed that 65 per cent of arrestees tested positive for one or more illegal drugs and 30 per cent tested positive for multiple drug use (two or more substances). Examination of specific drug types showed just under half (48 per cent) had used cannabis and a quarter (24 per cent) had used opiates. The remainder included: cocaine (15 per cent); benzodiazepines (13 per cent); amphetamine (9 per cent) and methadone (5 per cent). Females were more likely than males to test positive for opiates (33 per cent vs 23 per cent) and cocaine (18 per cent vs 14 per cent)[74]. Older drug users (25 to 29 years) were more likely to positively test for all drugs except cannabis compared to younger arrestees. White users were more likely to test positive for amphetamines and benzodiazepines while those from BME communities recorded higher levels of positive tests for cocaine.

Self-reported drug use

7.11 As Table 7.1 shows, self-reported drug use by arrestees also indicated high rates of use[75]. 78 per cent of those interviewed reported using an illicit drug in the preceding year, with 70 per cent in the last month and 60 per cent in the last few days. Just over half (53 per cent) reported using Class A drugs in the last year (40 per cent in the previous month and 27 per cent in the last 3 days). High prevalence of use were also found for specific drugs.

Table 7.1 Arrestees' self-reported drug use over time (percentages in the last year, month and three days).

Drug type	**Last year**	**Last month**	Last 3 days
Cannabis	70	61	**48**
Heroin	28	22	**19**
Methadone	17	9	**5**
Cocaine	28	14	**4**
Crack cocaine	26	15	**10**
Amphetamines	31	17	**8**
Ecstasy	26	13	**4**
Alcohol	90	82	**64**
Any illicit drug	78	70	**60**
Class A drugs	53	40	**27**
Heroin, cocaine and crack cocaine	**43**	**31**	**23**

7.12 Just over a quarter of those interviewed reported having used heroin, cocaine and crack cocaine in the last 12 months (28, 28 and 26 per cent respectively). Just over a fifth (22 per cent) said they had used heroin in the previous month followed by crack cocaine (15 per cent) and cocaine (14 per cent). Of these three drugs heroin was the most frequently used with almost a fifth (19 per cent) reporting its use in the last week followed by crack cocaine (10 per cent) and cocaine (4 per cent). However, 43 per cent reported using all three of these drugs in the last year, just under a third (31 per cent) in the last month and almost a quarter (23 per cent) in the three days preceding interview.

[74] Females were also more likely to use amphetamines and benzodiazepines.
[75] The research suggested that there was generally good concordance between urine analysis and self-reported drug use - although, under-reporting was most evident with those using cocaine and heroin.

7.13 Average weekly drug expenditure also reflected the respondents' nature of drug use. Arrestees using any illicit drugs reported spending on average £169 per week whereas reported spending by those using heroin, cocaine and crack cocaine was on average 72 per cent higher at £290. Arrestees regularity and levels of offending were also associated with their nature of drug use. Just over half (53 per cent) of all respondents reported acquisitive offending in the year prior to interview compared to just under two-thirds (62 per cent) of those reporting any illicit drug use and three-quarters (75 per cent) of those using heroin, cocaine and crack cocaine. The number of acquisitive offences interviewees reported they had committed in the previous 12 months also reflected their drug use. Those using any illicit drug reported an average of 340 acquisitive offences whereas, Class A users reported almost a fifth (18 per cent) more and heroin, cocaine and crack cocaine users 27 per cent higher (432 offences per annum) and almost ten times that of non-drug users interviewed[76].

7.14 Just over two-fifths (44 per cent) of interviewees reported having illegal incomes in the past year. The most common methods were via property crimes (59 per cent) and selling drugs (32 per cent). Drug using arrestees reported higher levels of illegal income when compared to the sample as a whole with the former reporting an average illegal income of £7,000 per annum compared to the latter at £1000 less. Heroin, cocaine and crack cocaine users however, had illegal incomes averaging £15,000 per year (double that of other drug users) which equated with their annual drug spends. Although, this group only accounted for around a quarter of those interviewed they were responsible for about three-fifths of all illegal income reported. Interviewees were also asked if their was a connection between their drug use and offending. Forty per cent of those using any illicit drug (in the last year) stated there was a connection compared to almost double (78 per cent) for those using heroin, cocaine and crack cocaine.

Arrest referral

7.15 Information on the extent and nature of drug use and offending at arrest is also available through the national arrest referral initiative. This initiative aims to identify problematic drug users at arrest and encourage them to address their drug problem via referral to appropriate, specialist treatment services. The scheme is voluntary, without any coercive pressure on arrestees to take part. It is offered to arrestees by police custody staff as part of the booking-in process. Drug workers (based either on-site or on-call to the station) contact the arrestees who express an interest in the service while some workers also proactively 'search' for potential clients by trawling the cells, directly introducing the scheme to detainees. On agreeing to participate arrestees are assessed and if appropriate are then referred.

7.16 Information concerning those screened and assessed via the initiative is collated through the National Arrest Referral Monitoring System, which collects national epidemiological data on drug use, treatment history, income, offending behaviour and assessment outcome.

[76] Non drug users reported an average of 46 acquisitive offences per year.

Demographic profile of London arrest referral assessments

7.17 In 2001, arrest referral workers in London assessed just under 7,000 arrestees (equating to roughly 5 per cent of all those arrested in 2001)[77]. Just over half (55 per cent) of arrestees assessed from Inner London boroughs were White, just over a quarter (28 per cent) were from Black communities and 9 per cent were Asian. Those passing through the schemes from outer London boroughs were mostly (80 per cent) White, with the remainder evenly distributed from Black and Asian communities (8 and 8 per cent respectively).

7.18 Marked differences emerged between ethnic groups in type of drug use. Taking poly-drug users first, just over two-thirds (67 per cent) of those reporting heroin and crack cocaine in combination in the month prior to arrest were White, 16 per cent were Black and 10 per cent were Asian. The breakdown of those using heroin but not crack cocaine was similar: 64 per cent were White, 20 per cent Asian and 11 per cent Black. However, looking at the group who reported using crack cocaine by itself, almost half (49 per cent) were Black, 40 per cent were White and 3 per cent Asian. In other words Black users were heavily over-represented amongst those reporting use of crack cocaine but not heroin.

7.19 Table 7.2 compares the prevalence of drug use reported by arrestees who were assessed/screened by drug workers in the month prior to their arrest in London and the rest of England and Wales (Oerton et al, 2003). The table suggests distinct regional differences in crack cocaine and cocaine use, but much smaller variation in the prevalence of other drugs. The levels of recent crack cocaine and cocaine use by arrestees in London were almost double the rate of the rest of England of Wales. Over half (55 per cent) of those screened in London reported using crack cocaine in the month prior to arrest compared to just under a third (30 per cent) elsewhere. Similarly, cocaine was reported by 11 per cent of London arrestees compared to only 6 per cent of their regional counterparts. Furthermore, the prevalence of injecting (commonly used as an indicator of problematic use) was significantly higher in London compared to the rest of England and Wales (48 and 45 per cent respectively).

Table 7.2 Comparison of drug-using profiles between London and England & Wales as reported by Arrest referral workers

Drug use	London *	England and Wales **
Heroin	58%	58%
Methadone	7%	9%
Cocaine	**11%**	6%
Crack cocaine	**55%**	30%
Amphetamines	3%	6%
Ecstasy	5%	6%
Benzodiazepines	13%	13%
Cannabis	40%	32%
Injected (last 30 days)	**48%**	45%

[77] In total just over 6,600 individuals were assessed by AR schemes in London. This figure does not include information concerning those who were only contacted while in custody, refused or were inappropriate for AR assessment

7.20 Average weekly expenditures were found to vary according to drug use and between London and the rest of England and Wales (see table 7.3). London arrestees using only heroin reported spending an average of £276 per week which was 11 per cent higher than those from other regions. London arrestees reported spending on average 14 per cent more on their crack cocaine use than the rest of England and Wales (£543 and £478 per week respectively). However, the differential was even greater when arrestees reported using both heroin and crack cocaine with London arrestees reporting drug expenditure on average 30 per cent higher than their regional counterparts (£680 and £524 per week respectively).

Table 7.3 Comparison average weekly drug expenditure between London and England & Wales.

Average weekly expenditure on drugs (£)	London *	England and Wales **
All drug users	£444	N/a
Heroin/crack cocaine	**£680**	£524
Heroin only	**£276**	£248
Crack cocaine only	**£543**	£478

7.21 There were also differences in ethnicity and gender amongst crack cocaine users and non-crack cocaine users. Multivariate analysis suggested that females defined as 'Black' were significantly associated with crack cocaine use in the last month (Oerton et al, 2003).

7.22 The relationship between crack cocaine use and offending can be illustrated amongst those arrestees who have been assessed by an arrest referral worker. Oerton (2003) demonstrated that arrestees using only crack cocaine (in the last 30 days) were significantly more likely to report being arrested for the following offences: selling drugs; fraud; burglary; handling stolen goods; street robbery; soliciting and vehicle crime. In comparison, heroin only users are more likely to report shoplifting.

Comparison of Arrest Referral Data and Treatment data

7.23 Provisional analysis suggests differences in ethnic composition between the population of users self-referring into treatment and the population identified as users by arrest referral schemes. A higher proportion of crack cocaine-users in the arrest referral population were from the BME groups (49 per cent) than in the self-referred treatment population (31 per cent). Roughly three-quarters of those presenting to specialist drug agencies (recorded by 2001/02 NDTMS) were White while ten per cent were Black. In contrast, of those assessed via London Arrest Referral Monitoring three-fifths were White and a quarter were Black. However, there are a number of factors which may explain the variance in drug use and ethnicity between treatment and criminal justice populations. Explanations may indicate inequity of access to treatment and/or inequity of arrest by ethnic group.

Drug testing at charge

7.24 Another major initiative to reduce the levels of drug-related crime is drug testing adult offenders in police custody for Class A drugs[78]. The initiative targets arrestees who have been charged for one or more of ten 'trigger' offences. These are largely

[78] Offenders are tested for both opiates and cocaine. There is no current specific test for crack and therefore all data presented represents crack and powder cocaine combined.

acquisitive crimes, and are considered to have a strong association with problematic drug use. Table 7.4 compares positive drug test results of arrestees who have been charged for 'trigger' offences between sites in London and the rest of England.

Table 7.4 Comparison of drug-testing on charge results in London compared with rest of England (April 2003 to January 2004).

Drug-use profiles	London	Rest of England [79]*
Cocaine only	26%	14%
Both (cocaine and opiate)	23%	20%
Opiates only	9%	17%
Negative	39%	48%
Not applicable	3%	1%

7.25 In total, three-fifths (61 per cent) of those arrested for trigger offences in London tested positive for opiates or cocaine compared to just over half (52 per cent) for the rest of England. Nearly half (49 per cent) of there had used cocaine in the last three days compared to just over a third (34 per cent) from other regions. London trigger offences arrestees also showed higher rates of dual drug use (using both opiates and cocaine) with just under a quarter (23 per cent) compared to a fifth (20 per cent) of those from other sites. However, heroin use by itself appeared more common outside of London. Test outcomes for different types of trigger offence are shown in Table 7.5.

Table 7.5: Comparison of drug-testing at charge by offence type in London (in bold) and the rest of England (in italics) between April 2003 and January 2004.

Offence	Pos. cocaine/opiate tests		Pos. test for cocaine only		Pos. test for opiates only		Negative test result	
Theft	**29%**	*23%*	**24%**	*14%*	**10%**	*18%*	**34%**	*43%*
Burglary	**21%**	*14%*	**3%**	*12%*	**10%**	*16%*	**40%**	*56%*
Robbery	**12%**	*13%*	**28%**	*12%*	**5%**	*10%*	**52%**	*62%*
Drug offences[80]	**17%**	*19%*	**27%**	*17%*	**7%**	*15%*	**45%**	*47%*

7.26 London arrestees who tested positive for both opiates and cocaine were more likely to have been charged for theft (29 per cent) and burglary (21 per cent) than their counterparts in the rest of England (23 and 14 per cent respectively) while there was almost parity for robbery and drugs offences between the areas. There were wider differentials for those in London testing positive for cocaine only and charged with theft, robbery and drug offences (24, 28 and 27 per cent respectively) although the opposite was found for those charged for burglary (3 per cent). Conversely, proportionately fewer of those charged in London tested positive for opiates or tested negatively in all offence categories compared to their counterparts in other areas in England.

7.27 Drug testing data suggests that London has one of the highest rates of crack cocaine use amongst criminal justice populations. The highest rate of those who have

[79] Rest of England comprises the other sites that form part of the original 25 Criminal Justice Intervention Programme sites.'

[80] Excludes data where an incomplete test has been recorded; * Drug offences include possession of Class A/B drugs (with and without intent) and producing/supplying drugs.

been charged for a trigger offence and subsequently tested positive for cocaine (including those who test for cocaine and opiates) was Camden with 62 per cent. In a further five boroughs, more than half of tests proved positive for cocaine (Lambeth 55 per cent, Hackney and Islington 54 per cent each, Wandsworth 53 per cent and Waltham Forest 50 per cent)[81]. The highest levels of opiate and cocaine use were in Camden (33 per cent), Tower Hamlets (28 per cent) and Wandsworth (27 per cent). The highest levels of cocaine use by itself were found in Hackney (35 per cent), Islington (32 per cent) and Lambeth (31 per cent). The boroughs indicating the highest levels of negative tests were Haringey (55 per cent) and, somewhat surprisingly, Westminster (46 per cent).

Table 7.6 Drug-testing at charge by London DAT/CJIP areas (April 2003 to January 2004)[82].

DAT	Pos. cocaine/opiate tests	Positive test for cocaine only	Positive test for opiates only	Negative test result
Camden	33%	29%	8%	26%
Ealing	25%	18%	13%	44%
Hackney	19%	35%	9%	36%
Haringey	15%	23%	7%	55%
Islington	22%	32%	7%	37%
Lambeth	24%	31%	10%	33%
Newham	23%	17%	13%	45%
Southwark	22%	25%	9%	39%
Tower Hamlets	28%	19%	16%	38%
Waltham Forest	23%	27%	4%	43%
Wandsworth	27%	26%	4%	38%
Westminster	20%	22%	5%	46%

The London Probation Service

7.28 The London Probation Service supervised a wide range of offenders with drug problems under a range of different orders, but Drug Treatment and Testing Orders (DTTOs) are designed specifically for persistent or serious offenders with significant drug problems. DTTOs are a high intensity community sentence. During the order offenders are expected to attend a treatment programme for about 20 hours per week[83]. The programmes consist of a range of sequenced components to match offender progress. These include; clinical treatment (substitute prescribing and health needs), structured drug day care programmes, alternative therapies, offending behaviour programmes and other interventions designed to provide social re-integration skills.

7.29 Where needed, accommodation support is also provided. Some offenders may be assessed as needing to undergo their treatment programme in a residential setting, either from the outset of their sentence, or when ready to do so during their order, and provision is made to facilitate this. Offenders are tested for drugs at least twice a week

[81] Amongst the nine pilot sites for 'drug-testing on charge' initiative, the London site (Hackney) reported the highest prevalence of positive tests for cocaine (including crack) a fifth higher than any other region (Matrix MHA and Nacro, 2002).

[82] Excludes data where an incomplete test has been recorded.

[83] Hours of attendance can reduce in the latter stages of the order if the offender is making good progress.

for the first thirteen weeks, reducing to a minimum of once per week dependent upon progress.

7.30 DTTO legislation requires courts to maintain oversight of these orders through review hearings. The Probation Service is required to advise the courts about the progress of the order and drug tests results. The probation service has set a target of 1,964 DTTOs for London in 2004/05 equating to a 50 per cent increase on the previous year[84].

7.31 Internal research conducted in early 2003 reviewed 521 DTTO client files from across London[85]. In total, two-fifths (42 per cent) of those on DTTOs were poly-drug users. Just under a third (29 per cent) used crack cocaine and just over a quarter (26 per cent) heroin. However, there was wide variation in crack cocaine use across the probation areas. Over half (7) the 12 probation area teams had higher proportions of crack cocaine users than the regional average. These included: the North and Wandsworth teams (with 48 and 47 per cent respectively), North West (38 per cent), West central (36 per cent) South team (34 per cent) and East (32 per cent)[86]

Profile of DTTO offenders

7.32 This sub-section compares and contrasts offenders on DTTOs who only use crack cocaine with those who reported using other drugs.

- The majority of crack cocaine users were male (88 per cent) and from BME communities (56 per cent);
- Although both crack cocaine and other drug users were sentenced to DTTOs averaging 17 months, just over two-thirds (68 per cent) of crack cocaine users were on orders longer than a year compared to just over half (56 per cent) of those using other drugs;
- The largest proportion (27 per cent) of BME crack cocaine using offenders were of British/Caribbean origin followed by Africans (18 per cent) and Asians (11 per cent);
- On average crack cocaine users tend to be slightly younger than offenders using other types of drugs (at 31 and 32 years respectively) with almost half (47 per cent) of crack cocaine users on the current DTTO caseload are under the age of 30 years;
- Information derived from 243 (47 per cent) offenders on DTTOs showed that that crack cocaine users were more likely to be homeless or in temporary housing compared to other drug users (26 per cent and 19 per cent respectively).

7.33 Compared to other drug users subject to DTTOs those who used crack cocaine were more likely to have been convicted of burglary (45 per cent compared to 40 per cent), handling stolen goods and fraud (8 per cent compared to 4 per cent), robbery (4 per cent compared to 2 per cent) and motoring offences (3 per cent compared to 2 per cent). Those who reported using other drugs were less likely to be convicted of theft, shoplifting, assault and drugs offences.

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[84] See Turnbull et.al. (2000) and Hough et. al. (2003) for a complete process and outcome evaluation.

[85] The analysis provides a profile of current offenders on 28th February 2003.

[86] The area teams' are comprised of the following boroughs: North (Barnet, Enfield & Haringey); North West (Brent and Harrow); West central (Hammersmith and Fulham and Kensington and Chelsea); South (Bromley and Croydon); East (Hackney, Tower Hamlets and Newham); South West (Merton, Sutton, Kingston & Richmond); South East (Greenwich and Bexley); South Central (Lewisham, Southwark and Lambeth); North East (Redbridge, Waltham Forrest, Havering and Barking and Dagenham); North Central (Camden and Islington); West London (Ealing, Hounslow and Hillingdon) and Wandsworth.

7.34 At present there are a variety of different treatment models used to deliver DTTOs across London. The majority (59 per cent) of crack cocaine using offenders were referred to structured day programmes (which typically offer quick access to treatment) and a quarter (27 per cent) received residential treatment. However, crack cocaine using offenders appear to have a higher attrition rates than others. Recently, the London Probation Area (LPA) has sought to encourage commissioners to develop arrangements with crack cocaine specific services to better serve the needs of problematic users. Examples include block purchase of treatment places and reducing waiting times for treatment[87]. In addition to DTTOs, contracts have been developed with the voluntary (drug and alcohol) sector to provide satellite workers for probation offices with lower intensity DTTOs coming on-line in the near future.

[87] During the first half of the financial year 2003-2004 95% of offenders placed on DTTOs entered treatment within two working days.

7.35 Summary - Criminal Justice Interventions

- The levels of recent crack cocaine and cocaine use by arrestees in London were almost double the rate of the rest of England of Wales. While over half (55 per cent) of those screened in London reported using crack cocaine in the month prior to arrest compared to just under a third (30 per cent) by their counterparts from other regions.
- Arrest referral data showed that over half (55 per cent) of arrestees assessed from Inner London boroughs were White, just over a quarter (28 per cent) were from Black communities 9 per cent were from Asians communities. Those seen through the schemes from outer London boroughs were mostly (80 per cent) White. However, half (49 per cent) of sole crack cocaine use was reported by Black users.
- The prevalence of injecting (an indicator of problematic use) was higher in London compared to the rest of England and Wales (48 and 45 per cent). London arrestees reported spending on average 14 per cent more on their crack cocaine use than the rest of England and Wales (£543 and £478 per week). However, the difference was even greater with arrestees using both heroin and crack cocaine (£680 versus £524).
- Comparison between arrest referral and treatment data showed that higher proportions of crack cocaine-users arrested were Black compared to those in treatment.
- Drug testing at charge indicated that half of London arrestees tested had used cocaine in the last three days compared to a third (34 per cent) from other regions. London arrestees showed higher rates of dual drug use with a quarter (23 per cent) compared to a fifth (20 per cent) of those from other sites.
- The highest rates of trigger offence and positive tests for cocaine was Camden (62 per cent) with a further five boroughs (Lambeth 55 per cent, Hackney and Islington 54 per cent each, Wandsworth 53 per cent and Waltham Forest 50 per cent) having positive cocaine tests for half or more of all tests conducted. The highest levels of cocaine use (only) were found in Hackney (35 per cent), Islington (32 per cent) and Lambeth (31 per cent).
- 521 DTTO client files from across London indicated that just under a third (29 per cent) used crack cocaine and just over a quarter (26 per cent) heroin while the largest group were poly drug users. The majority (88 per cent) of crack cocaine users were male and from BME communities (56 per cent).
- Information derived from 243 (47 per cent) offenders on DTTOs showed that that crack cocaine users were more likely to be homeless or in temporary housing compared to other drug users (26 and 19 per cent respectively).

8 Conclusions

8.1 This report has assembled information about crack cocaine and cocaine in London. For over a decade politicians, criminal justice agencies, drug treatment providers, health services and communities have been challenged by the problems associated with crack cocaine and cocaine. Although much of the work has been positive and innovative both at national and local levels, there has been very limited work at a regional level. Such work could serve as an essential bridge between ground level initiatives and national policy.

8.2 The report has assessed the extent and scale of the capital's crack cocaine/cocaine market and the enforcement activity and treatment provision designed to tackle it. Best estimates suggest that there are around 45,000 crack cocaine users in London, and that numbers are rising. The evidence is clear that London has more serious crack cocaine and cocaine problems than the rest of the country. It should be stressed that the analysis in this report is a first attempt to address complex, hidden problems; as with any innovative work, some of the conclusions may need revisiting and revising.

8.3 It can be seen how damaging crack cocaine can be. The characteristics of the drug can result in compulsive binging. It poses significant health risks. Injecting crack cocaine – which appears to be increasing – is associated with a higher risk of HCV and HIV infection. The financial costs can be overwhelming. Many crack cocaine users commit acquisitive crimes, sell drugs or sell sex to fund their use. The causal links between crack cocaine use and other forms of crime are complex; in many cases it may amplify levels of pre-existing involvement in crime, rather than push previously law-abiding people to a criminal career. Whatever the case, crack cocaine users can be amongst the most prolific offenders.

Crack cocaine and cocaine trends

8.4 The trend information from statistics on drug seizures, offence statistics and treatment data strongly suggests that London had a sizeable and growing crack cocaine/cocaine market.

8.5 The examination of the geography of crack cocaine/cocaine supply and possession confirms that the problems are greatest in those boroughs designated as high crack cocaine areas. However, there is evidence suggesting that several boroughs outside of this area should be closely monitored, such as Ealing, Enfield and Kingston-Upon-Thames. Like heroin, crack cocaine use is prevalent in areas of deprivation – although police statistics on offences of supply show somewhat different patterns for the two drugs.

8.6 Crack cocaine supply offences are concentrated within the inner city boroughs with hotspots in Westminster, Camden and Lambeth; crack cocaine possession offences were focused in the West End and Brixton in Lambeth. Cocaine possession is much more dispersed, with hotspots both in Kingston-Upon-Thames and Romford. Whilst crack cocaine problems are greatest, and most long-standing, in deprived inner London boroughs, there is evidence of diffusion to outer boroughs, especially the less affluent ones.

8.7 Predicting future trends is difficult. Fifteen years ago, American drug experts warned that London faced an imminent threat of a crack cocaine epidemic akin to that

in New York and other US cities. The prediction proved wrong at least as far as timing is concerned. However, London's crack cocaine problems are still rising, whilst those in New York abated some years ago. The safest assumption on which to base policy is that problems associated with crack cocaine will continue to spread across the capital, and to grow in intensity.

Responding to crack cocaine

8.8 There are three forms of response to crack cocaine problems. The first is to reduce supply and demand by deploying the criminal law against those who sell or use the drug. The second is to provide treatment for those who are dependent on crack cocaine. The third is to invest in primary prevention – providing individuals and communities with the resources needed to ensure that crack cocaine use does not become established. London's crack cocaine strategy needs to strike the best balance between these forms of response.

Enforcement

8.8 The MPS is in contact with a significant proportion of crack cocaine users – but mainly in relation to offences committed to finance drug use. Numbers arrested for either supply or possession offences remain quite low. The MPS drugs strategy aims to tackle drug markets by enforcing legislation and through adopting a problem solving approach. The main focus is on the most harmful drugs (e.g. heroin and crack cocaine) and related crime (e.g. acquisitive offending, gun crime and violence). Different strategies are aimed at various tiers of the market structure e.g. retail, wholesale and importation. Some of the key performance measures include increasing the number of prosecutions, crack house closures, drug seizures and dismantling of organised criminal groups. A range of educational and diversionary work complements these actions.

Treatment

8.9 Treatment services are currently in contact with a growing but small proportion of crack cocaine users. Crack cocaine represents a particular challenge to treatment agencies. The range of proven interventions is limited, with greater expertise evident in responding to opiate users. Treatment services are often stretched by the demands of crack cocaine users in some areas.

8.10 There are issues to be addressed about low take-up of treatment for some groups, such as those from BME communities. The different characteristics of those being arrested for crack cocaine and cocaine offences and those accessing treatment services indicate a high level of unmet need. Furthermore the potential pool of crack cocaine and cocaine users was found to be roughly double the total number of those accessing services for any drug 2001/02.

8.11 London has led the country in developing criminal justice initiatives intended to draw criminally involved problem users into treatment. However, the most pressing priority must be to ensure that effective treatment is identified and made available.

8.12 The Audit Commission advocated that the best way forward was for those agencies both in contact and working with crack cocaine/cocaine users to work in partnership and offer a holistic approach which simultaneously addresses their drug use and other related problems e.g. mental health, housing, criminal justice, physical health and child care.

Community initiatives: primary prevention

8.13 The ideal response to crack cocaine, of course, is to ensure that it never takes hold in communities in the first place. In practice, ensuring that individuals and communities have the right resources to achieve this is a real challenge. As with the problem solving approach to enforcement, community initiatives that include a co-ordinated set of responses are most likely to succeed. Responding to crack cocaine presents an opportunity to strengthen local partnerships and improve engagement with local communities. This is especially true for London's Black communities, where there is a low uptake of treatment and a high level of involvement in the Criminal Justice System, and different patterns of crack cocaine use.

Improving the knowledge base

8.14 It is essential to improve the knowledge base about crack cocaine problems in London. Estimates of prevalence need to be corroborated and refined to include ethnic group and overall scale of problematic opiate use and crack cocaine use. Once it has been established, the treatment database needs to be analysed more fully. There are important gaps in our knowledge about the risks associated with blood-borne viruses. Further the impact of crack cocaine use on overdose and drug related deaths needs to be examined.

Glossary of key terms and definitions

Arrest referral - An intervention offering drug users at the point of arrest an opportunity to engage with drug treatment and related services

BME communities – Black and Minority Ethnic communities

BBV – Blood borne virus

CJIP – Criminal Justice Intervention Programme

'Crack house' – A premises used in connection with the production, supply or use of Class A drugs and associated with the occurrence of disorder or serious nuisance

DAT – Drug Action Team

DTTO– Drug Treatment Testing Order based on a probation order to attend treatment services for a specified duration

DUO – Drug Using Offenders

MPS Ethnicity categories – White European, Indian/Pakistani, African/Caribbean, Dark European, Arabian/Egyptian, and Chinese/Japanese

London borough 'families' – Groups of demographically comparable boroughs

MPS – Metropolitan Police Service

High Crack Areas (HCA) – The National Crack Plan identified 37 priority areas in England and Wales where crack cocaine was considered as problematic**.**

HIV – Human Immunodeficiency Virus

HCV - Hepatitis C Virus

Hotspot – An area with a high concentration of recorded offending

NCP – National Crack Plan

NDTMS – National Drug Treatment Monitoring System

NEW ADAM – New English & Welsh Arrestee Drug Abuse Monitoring

NTA – National Treatment Agency

Primary drug – Drug users may be involved in different types of substance abuse, their primary drug is that which they use most frequently and is identified as most problematic

Poly drug use – When an individual is using two types of drug or more

RDMD – Regional Drug Misuse Database

Test purchase – A police intelligence and enforcement strategy whereby drugs are purchased from sellers then analysed to confirm their composition. The drug supplier is subsequently arrested

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Appendix

Community-led innovation in addressing the problems caused by crack cocaine in London

This appendix summarises the results of a review conducted by Doyle Training & Consultancy Ltd. This examined 'promising practice' in addressing crack cocaine problems through community leadership in London. This work was commissioned by the Greater London Authority for GLADA.

The aim of the evaluation was to describe and evaluate current resources and identify examples of good practice in addressing crack cocaine problems through community leadership and prevention, and assess whether they are deployed efficiently, effectively and appropriately. Its objectives were to undertake a short evaluation of current 'promising practice' across London:

In addressing crack cocaine problems through community leadership, including engagement of local community groups
In local environmental and situational prevention, including the removal of drug paraphernalia and the prevention of drug consumption, and
To produce a short report detailing examples of 'promising practice' for inclusion in the final report of the London Crack cocaine Strategy.

The fieldwork for this evaluation took place over a four-week period in December 2003 and January 2004. The evaluation had two distinct phases. This included: gathering information and identifying potential case studies, and gathering and presenting detailed information of projects and initiatives. Of the 33 London DATs contacted, responses were received from the following areas: Brent, Camden, Ealing, Hackney, Hammersmith & Fulham, Haringey, Kensington & Chelsea, Lambeth, Lewisham, Southwark and Westminster. The nine projects and initiatives examined as case studies included:

Prothero House Micro Community Safety Strategy (Brent)
West End Drugs Partnership (Camden)
Peer Education Project (Ealing)
Hackney Crack cocainedown Project (Hackney)
Haringey Peace Alliance (Haringey)
Drug Advisory Service Haringey (DASH) (Haringey)
Brixton Area Forum (Lambeth)
Southwark Borough Building Safer Communities Protocol (Southwark)
Ocean New Deal for Communities (Tower Hamlets)

Results
A number of respondents were keen to highlight treatment services but were generally less aware of environmental and situational prevention initiatives. This may well reflect the position of respondents at the strategic and planning levels, as opposed to 'grass roots' involvement. Having said this, innovative examples of low-threshold treatment projects were cited, including thoughts on the transferability of a crack cocaine hostel project in Paris, and it was widely acknowledged that treatment options need to be a part of an integrated response.

There were few examples of work driven by concerns over crack cocaine specifically but rather by a wider set of concerns. For instance, much of the work undertaken in Brent did not solely focus on crack cocaine but on wider areas such as gun crime. This had been identified as an issue for the borough following an extensive community consultation process facilitated by the local community safety unit in partnership with local community representatives and groups.

In practice this evaluation found that environmental and situational prevention were key core elements of wider strategic and operational mechanisms. It appears that the better examples of community involvement include situational prevention as a part of their remit and also attempt to address community, practitioner and service manager involvement within local strategies.

Many DAT respondents were keen to highlight their local crack house protocol. Whilst most reported improved partnership working, there appeared to be variable degrees of confidence in their implementation, with some observating that there is still a lack of cross-authority collaboration and communication. Some respondents felt strongly that there should be a London wide police and community strategy, and this should focus on continual disruption of street crack cocaine markets. Whilst this may result in lower arrest rates it would make a marked difference to the problems experienced by the community due to crack cocaine use and dealing. Good inter-borough police protocols would be vital.

Key conclusions
All nine case studies exhibited some elements of promising practice, albeit at different stages of development. The research team identified several common themes which appear to be key in addressing crack cocaine problems through community leadership and prevention: neighbourhood focus, partnership working, workforce recruitment and retention, robust monitoring systems, secure funding, and a combination of approaches.

Neighbourhood focus
Common interest comes together more effectively around locally defined 'neighbourhoods', which may not always fit easily with local authority (and DAT) boundaries. The most developed examples demonstrated a high level of community engagement in both strategic and project management and operational delivery. Among the most promising of programmes were those supported through the New Deal for Communities initiative.

Partnership working
DATs need to forge effective collaborative arrangements with regeneration partnerships. It is important that these partnerships invest at an early stage in community development to build community understanding and awareness of drug issues. Furthermore, getting the drug elements of programmes from ideas to implementation may require funding a specialist drug post working within the partnership.

Community workers and/or neighbourhood wardens make a real difference. They can help local people access services (users and non-users), build community confidence that 'something' will be done about any given problem, act as information gatherers and information disseminators, and help build a picture of local needs.
This type of investment can produce real paybacks and increase community ownership of communal spaces.

Workforce recruitment and retention
In the context of a national shortage of skilled, qualified staff, it will be important that adequate recruitment time is allowed for all new projects and that contracts are of a decent length (i.e. longer than one year) in order to encourage workers to apply. New posts could also be offered to less qualified individuals and include substantial in-house training. This has the additional advantage of increasing the numbers of workers in the field. This needs to be supported by adequate long-term funding.

The best approaches seek to use recruitment and retention as another way of empowering and engaging with local communities. For example, a number of the projects examined for this study were making increasing use of ex-users, who are being trained as outreach workers. Using ex-users as workers in the community has all sorts of added value - they have credibility, it increases the number of workers in the field, provides positive role models for current users, and increases the number of ex-users in gainful employment.

Monitoring systems
Those projects and initiatives which were best able to demonstrate effectiveness had clearly defined strategic and operational aims that facilitated the consistent and organised collection of data.
Sample aims are suggested by the Home Office, covering a range of indicators and requiring both quantitative and qualitative methodologies, but these are not yet widely followed:

An increase of presentation for treatment and people staying in it.
Local reduction in drug related crime.
Changes in attitudes to drugs in at risk groups.
Less environmental damage from drug use.
Improved resident participation in anti-drugs initiatives.
Reduced fear of crime.

A simple focus on outputs, such as those suggested by the Home Office, is readily achievable through agency data collection systems, but this needs to be established as a priority early on in project development, and factored into commissioning.
Generally, a greater focus is needed on both outcomes and process indicators, for which many of the case studies are well placed by engagement with CDRPs and DATs. Effective links with such bodies should seek to access the views and perceptions of residents, key professionals, users and dealers.

Funding
The research team observed that strategically planned, long-term funding is key to the most effective interventions. The most robust examples had a range of long-term objectives supported through mainstream and dedicated funding, whilst even a relatively short break in funding can serve to de-stabilise development work and undermine the confidence of both the community and professionals.

Combination of approaches
Assessment of projects, partnerships and community-led initiatives as part of this review would support Home Office guidance suggesting that the most effective action plans or consultation processes include most, or all of the following components:

- Community development
- Drug treatment
- Work with young people
- Action to tackle drug related crime and anti-social behaviour
- Action to tackle the management of the space/environment
- Action to tackle supply through enforcement.

In practice, the most effective community leadership and prevention work draws upon a wide range of inter-disciplinary skills and experiences to meet local community agendas for crack cocaine-related social issues. These skills are identified by the Home Office as including community liaison, intelligence handling, crime environment analysis, housing management, outreach and youth work. However, the examples reviewed in this study also relied upon the identification and empowerment of 'local champions', able to translate agency priorities into tangible local actions, that the community feel a part of, as opposed to, 'acted on'.

The importance of a coherent and proactive communications and marketing strategy was also raised, with media and public relations skills observed to be key in both combating media bias and 'advertising' the range of initiatives available to the community to combat crack cocaine.