British Journal of Psychiatry (1987), **151**, 240–243

Referrals to a Scottish Drug Dependence Unit
A Descriptive Study

M. M. O'ROURKE AND J. A. TAYLOR

The social and demographic characteristics, drug history and current levels of drug taking, drug-related illnesses, and criminal records of a one year cohort of attenders at the Southern General Hospital are described. The findings are compared with those of previous studies at the same clinic; made when methadone was prescribed for a limited period in reducing dosage and when this policy was being replaced by one of the use opiate-free drugs to cover withdrawal.

The misuse of drugs, and in particular of opiates, has increased substantially in the past 5 years. The number of addicts notified to the Home Office in Britain in 1983 (5850) was 42% up on the figure for 1982, and although the 1984 and 1985 figures are not yet available, social indicators of abuse (i.e. the seizure of drugs, the number of drug offences and attendance at clinics) suggest that the figures are likely to show an increase of at least that figure (Home Office, 1985). Ditton (unpublished) predicts a prevalence of 30 500 heroin addicts for Scotland by 1987.

Illegal drugs constitute a multinational industry worth many millions of pounds. The value of drugs seized in 1984 by HM Customs and Excise exceeded the 1983 figure by over 60%. These drugs, mainly cannabis, heroin, amphetamines, and cocaine, were worth £102 million at street prices. Estimates of successful detection rates vary between 5% and 10%; this suggests that illegally imported drugs worth £1000–2000 million found their way into Britain in 1984. It is worth noting that vast quantities of barbiturates and other drugs originate inside the country, and these in turn add to profits made on the illicit market (Institute for the Study of Drug Dependence, 1985).

Since 1980 Glasgow, in common with other European cities, has faced an increase in the availability of heroin on the illegal market. The attention it has received from the mass media has resulted in fear, confusion, and misinformation, emphasising the need for empirical research.

The Scottish Office has responded to the problems by funding several projects in Glasgow, Edinburgh and elsewhere in Scotland. The data in this paper are from referrals to one of these new projects – the Drug Stopping Programme (DSP) at the Southern General Hospital in Glasgow. The DSP available to drug takers is a modification of that described by Drummond *et al* (1986). Replacement opiates are not prescribed; withdrawal is aided by brief reducing prescriptions of chlordiazepoxide and temazepam. In-patient care is offered only to those whose physical or mental condition is sufficiently serious to warrant it. Access to the programme is open; appointments are available by telephone, and the waiting period between contact and appointment is rarely more than one day. First contact assessments are carried out by clinic staff on a rota basis. The process of assessment continues throughout the participant's contact with the programme, using a problem-oriented form of record. Data reported in this paper are taken from first contact interviews.

Method and results

Referrals

During the period of study (Oct. 1984 to Oct. 1985) 279 people were either referred to the programme or booked themselves in. Of these, 216 kept their appointments. The default rate of 22% compares favourably with that for new out-patient appointments in the Department of Psychiatry as a whole. Complete data were obtained from 172 of those attending; reasons for failure to complete the initial interview included time pressure, lack of co-operation, inappropriate referral, and intoxication. Forty percent of the 172 were self-referred; 27% were referred by general practitioners, 20% by social work agencies, 10% by casualty departments, 2% by employers, and 1% by the courts.

Drug preference

There appears to be a trend towards increasing variability in drug-taking behaviour. Although almost all of those interviewed expressed a preference for one drug or drug type over all others, it is clear that their drug-taking was by no means restricted solely to that. They were likely to have at least experimented with the full range of illicitly available

mood altering drugs. In particular, the use of cannabis was universally reported by our sample.

Using the main 'problem' drug or drug of choice as the basis for classification, 84% (N = 145) took opiates, (the vast majority heroin); 6% took amphetamine sulphate; cannabis and LSD were causing problems with 3% each; and cocaine, barbiturates, benzodiazepines, and poly-drug abuse accounted for 1% each.

The more detailed description and comparisons below are restricted to the 145 opiate drug takers. The mean age was 22.6 (s.d. = 6.3 years); the modal age was 20, and 51% of the patients were under 21. Seventy-two percent were male.

Drug-taking variables

The mean age at which opiate drugs were first taken was 18.9 years (s.d. = 3.4 years), with a modal age of 17. Seventy percent of the sample had their first experience of opiates between the ages of 13 and 20. Twenty-one percent were taking opiates daily within one week of first exposure; 34% (figures are cumulative) within one month; 50% within three months; 68% within six months; and 93% within the first year. The mean duration of drug-taking prior to contacting the programme was 3.8 years (mode = 2 years). Only 8% of the sample sought help during the first six months, and 19% within the first year, of their addiction.

Estimation of the quantity of heroin consumed is complicated by variations in purity and in the way it is sold. Forensic evidence indicates that the purity of street heroin in the West of Scotland can vary between 8% and 20%. The price has remained reasonably constant over the past 3–4 years at £80/g. It may, however, be sold in 'score deals' of £25, £10 or £5 bags, all of indeterminate quantity; someone who buys eight £10 bags may well end up with less than the person who buys one gram. Differences in the form in which heroin is produced are likely to reflect the availablity of ready cash and access to different levels of the distribution network.

Given these considerations, the amount consumed is best presented in terms of cost rather than weight. At the time of interview 4% of the sample reported spending an average of £5/day or less on heroin; 25% spent £10/day; 25% spent £20/day; 29% spent £40/day; 3% spent £60/day; 10% spent £80/day; and 2% spent between £100–160/day.

Patients were also asked what was the maximum amount they had taken on any one day. Forty-four percent had taken £20–40 worth; 24% had taken £40–80 worth; 15% had taken £80 worth; and 17% had taken £80–160 worth.

The most common method of administration was injection, 73% of the sample using this route by the time of interview. Fourteen percent inhaled and 1% only smoked. Twelve percent took their drugs orally; these were predominantly cases where pharmaceutical products such as codeine linctus, dipipanone, or buprenorphine were the favoured opiates. Drug-related illnesses, predominantly hepatitis B or abscesses at injection sites, had been experienced by 37% of the sample. Four cases had suffered fungal infection of the eye. There were no reports of drug-induced psychosis or other acute reactions; 8% showed evidence of previous psychiatric disorder.

Almost half the sample, 46%, reported one period of abstinence from opiates; 38% reported two or more, and 16% had never been abstinent. There was little evidence that those who had previously attempted to give up drug-taking through their own efforts had been successful; most such attempts had lasted no more than two or three days. However, the mean duration of periods of abstinence for the sample as a whole was 93 days, because drug-taking had been prevented by imprisonment.

Social and demographic variables

Given the average age of the sample, it is not surprising that 74% were single. Sixteen percent were married or co-habiting, and 10% were divorced or separated. The overwhelming majority (93%) left school at the age of 16 without any form of qualification. Indeed, 32% claim to have effectively left school, through truancy, by the age of 15. Six percent had obtained 'O' levels, and one individual had achieved university entrance but failed to complete the course. Eighty-two percent were unemployed, and had been so for a mean duration of 2 years; 16% were working, and 2% were still at school or employed on youth training schemes.

Eighty-nine percent of the sample lived in local authority housing, 10% in privately rented accommodation, and 1% were of no fixed abode. Sixty percent lived with their parents.

There is little evidence of a social support network available to the sample. Only 29% said that they had friends who were not opiate drug-takers; the remainder stated that all their circle of acquaintance had drug-taking habits similar to their own.

There is a clear association between drug-taking and criminal behaviour: 84% of the sample reported financing their drug-taking through crime, predominantly shop-lifting and other forms of theft. There were no reports of crime involving violence against a person. Charges were pending against 65%, and 66% had previous convictions, not all related to drug-taking.

Comparison with other samples

In comparing this sample with those from the same unit in 1983 (Fraser & Leighton, 1984) and 1984 (Drummond *et al*, 1986), a number of interesting points come to light (Table I). The best comparison can be made with Fraser & Leighton's sample, since both their study and ours looked at characteristics of attenders (Drummond *et al* mainly investigated the replacement of the prescribing service by the opiate-free day programme currently in operation). The sample of Fraser & Leighton were prescribed methadone for a limited period, in reducing dosage. Fraser & Leighton studied all patients attending the unit at the time, and the dates of first contact thus spread over a number of years; they analysed the data for those whose first contact occurred after 1981 separately, however, and found no significant differences.

Both the mean age at first contact and the age range have decreased since Fraser & Leighton's study (Table I)

TABLE I
Comparisons between three cohorts of referrals to a drug dependency unit

	Fraser & Leighton (1984) (n=80)	*Drummond et al (1986) (n=63)*	*Present study (n=145)*
Attributes			
Self-referred	—	39%	40%
Age at First Contact: years			
Mean	25.1	21.8	22.6
s.d.	5.46	—	6.3
Range	19–55	—	15–35
Married	48%	—	16%
Single	45%	75%	74%
Divorced	7%	—	10%
Unemployed	70%	83%	82%
Employed	25%	17%	16%
In full time education or on a Youth Training Scheme	5%	0%	2%
Criminal convictions	69%	42%	66%
Current illegal activities	30%	27%	84%
Psychiatric history	27%	—	8%
Drug-taking variables			
Age at first use of drugs: years			
Mean	21.0	18.98	18.9
s.d.	4.25	—	3.4
Range	15–55	—	13–35
Mean duration of drug use before contact: years	3.89[1]	2.04[1]	3.8[2]
User friends	75%	—	71%
Never abstinent	44%	—	16%
Abstinent only once	35%	—	46%
Abstinent more than once	21%	—	38%
Hepatitis B	32%	38%	37%

1. Period before contact with any drug agency
2. Period before contact with the clinic where study was carried out

(although the drop is not statistically significant). The initial conclusion might be that drug-taking is becoming popular among younger individuals, due to the greater availability. However, this view may be simplistic. Drummond *et al* (1986) argue that the changes in service provision marked by the introduction of the DSP has made the unit more attractive and available to the younger drug-taker. This trend appears to have continued.

The marital status of both samples also differ. There are more single people in the present sample; this may be because the age group as a whole is younger, or it may have resulted from more chaotic living associated with illegal drug-taking. The number of unemployed persons in the sample is roughly similar, as is reported psychiatric history.

The proportions of patients in the two studies having had criminal convictions was similar. However, in contrast, a greater proportion of the present sample (84%, compared with 30% of Fraser & Leighton's sample) admitted to being engaged in illegal activity to finance their drug taking. A possible explanation for this difference may be that the individuals in the earlier sample found it difficult to admit to criminal activity, as medication was dependent on some measure of conformity.

The mean age for first use of drugs was similar across all three samples. There was an interesting difference in the percentage of patients who were never abstinent: this figure was 44% in Fraser & Leighton's sample, but only 16% in the present sample. Forty-six percent of the present sample were abstinent more than once, while in Fraser & Leighton's sample the figure was only 17%. This improvement may be attributable to health education advertisements encouraging people to attempt to stop using hard drugs. It may also be related to the expense of the habit; when people are paying for the drugs themselves, as in our sample, they are more likely to need to control how much they use.

Discussion

This paper describes the clientele of one of Glasgow's drug clinics; it may or may not be typical of others. The generalisations that can be made from this sample are limited by the fact that only a minority (5–10%) of drug-takers attend a drug dependence clinic (Ditton, 1981). The comparison of this sample with that of Fraser & Leighton (1984) shows these opiate takers to be remarkably similar demographically, although younger. It is possible that younger drug takers are coming to the clinic because staff at the unit are now full time specialist addiction counsellors, with an open appointment system.

The majority of the sample lived with their parents or with a partner. Most have no qualifications, and are unemployed. The level of crime reported is high, and even this may be an underestimate. Roughly one-third of patients gave a past history of hepatitis, which is comparable with figures found in other studies (Stimson & Ogbourne, 1970; Woodside, 1973; Fraser & Leighton, 1984; Drummond *et al*, 1986).

Although we have studied referrals to the DSP, rather than causal factors of drug addiction, some comments regarding the latter are worth making. Speculations about causes of heroin addiction include unemployment, peer pressure, and availability of drugs. In the present sample, 82% were unemployed at the time of first contact. Unfortunately, we do not have data regarding their employment status at or before the time of first use of drugs and unemployment is high in this sample's area anyway. Closer investigation is needed before any relationship can be determined.

Seventy-one percent of the sample reported that all of their friends used heroin. Again, this figure relates to the time of first contact and not to their situation at or before the time of first use. However, 84% reported that they first used drugs in the peer context (either at parties, in pubs or in the company of friends). Again, the peer pressure or social learning theory requires further empirical examination.

Finally, most patients reported that heroin was easily available to them. Perhaps this availability made it more likely that individuals would try the drug in the first place.

These and other factors associated with causation (such as personality factors or rebellion against authority) merit further detailed and long-term investigation.

Acknowledgements

The authors thank Dr P. J. Mullin, Mr S. M. Hammond, Miss S. Gilmartin, Mrs A. Denovan and Ms S. Kerr.

References

DITTON, J. (1981 *The Rapid Increase of Heroin Addiction in Glasgow during 1981. Background Paper Two*. Glasgow: Department of Sociology, University of Glasgow.

DRUMMOND, C. A., TAYLOR, J. A. & MULLIN, P. J. (1986) Replacement of a prescribing service by an opiate-free day programme in a Glasgow drug clinic. *British Journal of Addictions*, **81**, 559–565.

FRASER, A. A. & LEIGHTON, K. M. (1984) Characteristics of attenders at a Scottish drug dependence clinic. *British Journal of Psychiatry*, **144**, 307–310.

HOME OFFICE (1985) *Tackling Drug Misuse: A Summary of the Government's Strategy*. London: HMSO.

INSTITUTE FOR THE STUDY OF DRUG DEPENDENCE (1985) *Drugs – What Every Parent Should Know*. London: Institute for the Study of Drug Dependence.

STIMSON, G. & OGBOURNE, A. (1970) Survey of addicts prescribed heroin at London clinics. *The Lancet, i*, 1163–1166.

WOODSIDE, M. (1973) The first one hundred referrals to a Scottish drug addiction treatment centre. *British Journal of Addiction*, **68**, 231–241.

*M. M. O'Rourke, BA, MA, MAppSci, *Clinical Psychologist, Division of Psychological Medicine, Southern General Hospital (now Senior Clinical Psychologist, Graylingwell Hospital)* and J. A. Taylor, MA, PhD, ABPS, *Chief Clinical Psychologist, Division of Psychiatry, Southern General Hospital, Glasgow*

*Correspondence: *Department of Clinical Psychology, Graylingwell Hospital, Chichester, West Sussex PO19 4PQ*