ASSESSING PREVALENCE

How much of it is there and what is it like? 'Simple' questions about drug misuse/problems with no simple answers. Joy Mott maps out the options for finding answers and discusses the pros and cons.

Joy Mott

ONE IMPORTANT WAY of assessing the effects of government efforts to reduce the extent of drug misuse,[1] would be the regular monitoring of the number of drug misusers in the population, and of the types of controlled drugs being misused. Such information would also be valuable for the planning of local treatment and rehabilitation services. The DHSS recently attempted to assess the prevalence of drug misuse in all the local health authority areas in England and Wales.[2] However, since no precise advice was given on how drug misusers were to be defined or the time period to be studied, the assessment proved difficult.

The main source of information in the United Kingdom about the number of misusers of cocaine, heroin or methadone (and of 11 other drugs controlled in class A of the Misuse of Drugs Act) is provided by the Home Office Addicts Index. Under the Misuse of Drugs Act 1971, all medical practitioners have a statutory duty to notify the Chief Medical Officer of the Home Office of patients they attend whom they consider, or have reasonable grounds to suspect, have "as a result of repeated administration . . . become so dependent upon the drug that he has an overwhelming desire for the administration of it to be continued."

The number of addicts receiving treatment on 1 January and the numbers of new and former addicts notified during the year are published by the Home Office in the annual *Statistics of the misuse of drugs in the United Kingdom*. The *Supplementary tables* contain details of the number of addicts notified from each police force area. These national and local statistics, of necessity, are a year out of date before they are published.

The notification statistics do not, and cannot, provide precise estimates of the number of drug misusers during any year. Only those regarded as dependent on one or other of 14 specified drugs are required to be notified. It is unlikely that all dependent or regular or occasional misusers of these drugs will be notified as addicts during any particular year. Some will not come, or choose to bring themselves, to the attention of the medical services, perhaps because they are unwilling to be notified as addicts,[3] and some will not be notified by the doctor they attend.[4]

TO OVERCOME these difficulties an 'indicator' method has been developed to estimate the number of drug misusers who come to the notice of the medical and social agencies in local areas. Typically, research workers have used the Addicts Index to count all the addicts notified from the area during a specified time period and have asked all the local medical and social agencies, and the police, to inform them of all the drug misusers known to them during the same period. Coroners Court records may be searched to identify persons who have died as a consequence of drug misuse, and notifications of persons suffering from hepatitis may also be obtained. Drug misusers may also be asked to estimate how many other drug misusers they know.

In effect the method allows for the counting of what the Advisory Council on the Misuse of Drugs called "problem drug takers",[5] and defined as "people who experience social, psychological, physical or legal problems related to intoxication and/or dependence as a consequence of their use of drugs or other chemical substances (excluding alcohol and tobacco)".

The 'indicator' method is the most feasible, quickest and least costly way of monitoring 'problem drug use'.

There are two major problems in attempting to make, and to compare, estimates of the number of drug misusers in local areas using the 'indicator' method:
— ensuring that a drug misuser is defined in the same way in each area; and
— ensuring that unique individuals are counted.

The drug misusers may be defined as "regular opioid users", that is, people who have used heroin and similar drugs on at least six days a week for at least a month during a specified period and when the drugs have not been prescribed for the treatment of a physical disease.[6] Or they may be defined as "people who are proven or reasonably suspected as ingesting psychoactive drugs when there were no justificatory medical reasons, and the way in which the drugs were used had led to medical, social and/or legal problems as evidenced by involvement with specific 'indicator agencies' and when the primary drugs used were opioids, barbiturates, psychedelics, cannabis, inhalants or stimulants".[7] Individuals known to the various agencies may differ considerably in terms of their reasons for making contact, the nature and extent of their drug misuse, and of the types of problem they present.

Ensuring unique individuals are counted presents difficulties since it is possible, even likely, that some drug misusers will be in contact with several agencies. To preserve a confidential relationship with their clients or patients the agencies may be unwilling to identify them other than by their initials, sex and date of birth. These details should be sufficient to reduce the risk of double counting.

Several 'indicator' studies have been conducted using more or less sophisticated statistical methods of analysis to estimate the number of variously defined drug misusers in local areas during certain periods[8] and several more are in progress. A manual describing the method has been prepared.[9] Since these studies have been conducted at different times in different places and with different definitions of a drug misuser, findings are not strictly comparable. What seems clear, though, is that the prevalence of "problem drug taking" is likely to vary greatly in different parts of the country at the same time and in the same part at different times.

The number of notified addicts from the area have been included in all the local estimates. Hartnoll *et al* very tentatively suggested, on the basis of their work in two London boroughs between 1979 and 1982, that perhaps there were five regular users of heroin and similar drugs in the population for each user notified to the Home Office as an addict.[10] Ditton and Speirits working in Glasgow and using different indicators, including the guesses of doctors, the police and a few drug users, suggested there were 10 unknown heroin users for each one notified in 1981.[11] Pattison *et al* had difficulty in locating an area in 1981 in North East England where there were enough "problem drug users" to merit the effort of attempting to count them.[12] Thus, the use of some notional 'multiplier' of the number of newly notified addicts to arrive at a national estimate of the number of opioid misusers is likely to produce an over-estimate in some places and an under-estimate in others.

SURVEYS of self-reported drug misuse among samples of the general population have been used to estimate the general prevalence of drug misuse. Samples have included members of private households, young people attending youth clubs, school children, school leavers and university students. Information has been collected by interviews, or by postal or supervised self-completion questionnaires.

Since respondents are being asked whether they have indulged in an illegal activity, great efforts have to be made to convince them of their anonymity and of the confidentiality of their replies. Even so they may refuse to take part in the survey, or exaggerate or conceal their drug use.

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They may be more willing to admit to having used some controlled drugs than others. Some may not even know if the substances they have used *were* controlled drugs and what drugs they were.

Household surveys present particular difficulties. Some drug misusers, perhaps the heaviest users or those with the most problems, may not be living in private households. If they are, they may be the most difficult to contact and the least willing to provide information about their drug use in sufficient detail during a single interview session with a stranger. Some respondents, particularly those aged under 16, may be interviewed in the presence of their parents or another member of the household, and this is likely to affect the reliability of their answers. All these difficulties would preclude the option of simply adding questions on drug misuse to any of the existing household surveys which are regularly conducted in this country.

Estimates of the prevalence in the population of any activity or behaviour derived from a sample of that population will be subject to error and the errors are likely to be large when relatively rare or infrequent behaviours are being studied. In the United States, where regular household surveys of self-reported drug use have been conducted since 1972, very small proportions of the samples have admitted to heroin use because it is a rare occurrence and because addicts are unlikely to be found in private households.[13] For all these reasons a national household survey of self-reported drug use, no matter how well designed and conducted, cannot be expected to produce precise estimates of the number of people who have misused any type of controlled drug during a particular period of time.

No national household survey of the self-reported use of all types of controlled drugs has been conducted in this country. Some estimates of the prevalence of the misuse of amphetamines, cannabis, cocaine, heroin and LSD were made from a national survey of public attitudes to drugtaking conducted in 1969.[14]

During the late 1960s and early 1970s there were a number of local surveys of self-reported drug use among samples of school children and university students. Despite the differences in the designs of the survey questionnaires, there was no doubt that the majority of those who admitted to having ever misused a drug admitted to having used cannabis. There were marked differences in the proportions of students from different parts of the country, and between students studying different subjects in the same part, who admitted to having ever used a drug. The 1982 British Crime Survey found some differences in the proportions admitting to having ever used cannabis among the household samples interviewed in England and Wales and in Scotland, and between people living in rural and urban areas.[15]

ALL THREE METHODS of estimating the prevalence of drug misuse in the UK have limitations and disadvantages.

► Notifications of addicts to the Home Office should provide the most reliable estimate of the number of people dependent on certain controlled drugs and who come to the attention of a medical agency, but it seems that not all medical practitioners notify all such patients they see. Some drug misusers may be reluctant to approach a medical agency because they have misconceptions about the consequences of notification as an addict.

► Surveys of self-reported drug use among representative household national or local samples require the cooperation of those selected for interview but the heaviest drug users, or drug users with the most problems, may be the most difficult to contact and the least willing to describe their drug use. To estimate changes in the prevalence of self-reported drug use, surveys would need to be carried out regularly and would need to be specially commissioned. They would take some time to conduct and would be costly, since large samples would need to be interviewed.

► The 'indicator' method of counting the number of drug users in contact with all the relevant local social, medical and law enforcement agencies requires the cooperation of the agencies. Agencies may be more or less willing to cooperate, depending on their perception of the extent of drug use in the area. There may be limits on the number of individuals some agencies are able to reach. Once it becomes known that the agencies are providing some details of their clientele to research workers, drug users may become reluctant to approach them. Great care has to be taken to provide the agencies with precise definitions and, having due regard to confidentiality, to ensure that unique individuals are counted.

The 'indicator' method cannot be used to estimate the total number of people in an area who have ever misused drugs or who are currently misusing them, but it does offer the most feasible, quickest and least costly way of regularly monitoring the number of "problem drug takers" in an area. A repeated series of simultaneously conducted 'indicator' studies in several selected areas, including some areas which do not appear to have many "problem drug takers" at the time, could provide the means of describing the development of drug misuse in a local community and of assessing the effects of policy initiatives to reduce the number of drug misusers. □

THE MAIN SOURCES OF INFORMATION

Method/source	Comments
Official statistics:	
— notifications of addiction from doctors	Limited to people dependent on 14 specified drugs. Only a proportion of these people attend doctors and not all of these are notified.
'Indicator' method:	
— notifications of addiction	Most feasible, quickest and least costly way of monitoring *problem* drug use.
— hepatitis notifications	Cannot be used to estimate total number of misusers.
— medical agencies	Definitions of problem drug use vary.
— social agencies	Risk of 'double counting'.
— police	Requires agencies' cooperation.
— Coroners Courts	Problems of maintaining confidentiality.
— known drug misusers	
Surveys of, eg:	
— private households	Respondents may be unwilling to admit drug use or not know what they used.
— young people at youth clubs	Heaviest, most problematic users most likely to be missed by household surveys.
— school children	Requires specially commissioned surveys of large samples.
— school leavers	Expensive.
— students	
by means of:	
— interviews	
— questionnaires.	

1. Home Office. *Tackling drug misuse: a summary of the government's strategy*. 2nd edition. London: Home Office, 1986.
2. Department of Health and Social Security. *Drug misuse prevalence and service provision: a report on surveys and plans in English National Health Service regions*. DHSS, 1985.
3. Bennett T. and Wright R. Opioid users' attitudes towards and use of NHS clinics, general practitioners and private doctors. *British Journal of Addiction*: 1986, *81*, p757-763.
4. Strang J. and Shah A. Notification of addicts and the medical practitioner — an evaluation of the system. *British Journal of Psychiatry*: 1985, *147*, p195-197.
5. Advisory Council on the Misuse of Drugs. *Treatment and rehabilitation*. London: HMSO, 1982.
6. Hartnoll R., Lewis R., Mitcheson M., *et al*. Estimating the prevalence of opioid dependence. *Lancet*: 1985, *1*(8422), p203-205.
7. Parker H., Bakx K. and Newcombe R. *Drug misuse in Wirral. A study of 1800 problem drug users known to official agencies*. University of Liverpool, 1986.
8. De Alarcon R. and Rathod N.H. Prevalence and early detection of heroin abuse. *British Medical Journal*: 1968, *2*, p549-553.
   Ditton J. and Speirits K. The rapid increase of heroin addiction in Glasgow in 1981. University of Glasgow, 1981.
   Hartnoll *et al*, *op cit*.
   Haws S. Drug problems in Greater Glasgow. Glasgow: SCODA, 1985.
   Parker *et al*, *op cit*.
   Pattison C.J., Barnes E.A. and Thorley A. *South Tyneside drug prevalence and indicators study*. Newcastle: Centre for Alcohol and Drugs Studies, 1982.
9. Hartnoll R. *et al*, *Drug problems: assessing local needs*. London: Drug Indicators Project, 1985.
10. Hartnoll *et al*, *Lancet*, *op cit*.
11. Ditton *et al*, *op cit*.
12. Pattison *et al*, *op cit*.
13. National Institute on Drug Abuse. *Community Epidemiology Work Group Proceedings*. Rockville, Maryland: NIDA, 1983.
14. Home Office. *Public attitudes to drug taking. A short report based on work carried out through the OPCS for the Home Office*. Unpublished, 1973.
15. Mott J. Self-reported cannabis use in Great Britain in 1981. *British Journal of Addiction*: 1985, *80*(1), p37-43.