Imperial College School of Medicine

The Centre for Research on Drugs and Health Behaviour

responding to drug and alcohol use in jersey:

key findings report

April 2001

Introduction

People in Jersey use illegal drugs. A much larger number use alcohol. However, whilst there are no shortage of personal appraisals of the situation, there are comparatively fewer evidence-based descriptions on which to base meaningful action.

To inform the recent policy initiatives *Responding to Substance Misuse* and *The Crime and Community Safety Strategy*, a seven month research study was conducted during 2000. This had two main aims:

1. to describe the extent and nature of drug and alcohol use in Jersey
2. to develop indicators which could be used to monitor the progress of the strategies

The findings of this assessment were submitted in a detailed report to the States of Jersey in January 2001. This shorter document has been written to publicly disseminate the study's key findings.

Why drugs?

Jersey has an active illegal drug market. However, until this assessment, little research had been conducted on the scale of substance use taking place, or on the challenges this poses. This has made it difficult to target resources towards public health, prevention and law enforcement efforts.

Jersey also faces serious drug-related challenges: there has been a particularly marked increase in heroin use since 1992, and this appears to have been accompanied by an increasing preference for users to *inject* rather than smoke the drug. These twin factors pose considerable public health challenges in the form of infectious diseases such as HIV and hepatitis C that require immediate and sustained action.

Why alcohol?

Alcohol use in Jersey has both a visibly important social and commercial role, but also poses significant public health and community safety challenges. The positive aspects of alcohol use in Jersey have already been well documented: in many parishes, the public house continues to provide a focus for community activity, whilst annually around £111 million is spent on alcohol by local residents and tourists, providing employment opportunities, and annual government revenue streams[1]. However, comparatively little knowledge exists about alcohol use, or conversely its *misuse*.

What next?

This report represents the first step towards a comprehensive evidence base. Already, initiatives to reduce the health and social harms of substance use have been put into place, and it is hoped that this public document will allow interested parties and stakeholders to participate and contribute to this ultimate aim.

---

[1] "Jersey Household Expenditure", Personal communication with Policy and Resources, 2000

executive summary

People in Jersey use illegal drugs. A much larger number use alcohol. This report describes the results of a seven-month assessment conducted by The Centre for Research on Drugs and Health Behaviour, Imperial College in 2000, to describe the use and misuse of these substances.

key findings: drugs

1. *A comprehensive array of illegal drugs and 'diverted' pharmaceuticals are available in Jersey.*

2. This study estimates that *there are approximately 780 problematic opiate users in Jersey, of which 530 may be injecting drug users.*

3. These *problem drug users are typically male, employed, and aged between 27 and 29.* Their drug of choice is heroin, which they will probably inject.

4. *Injecting drug users in Jersey are already known to have HIV and Hepatitis C.* Almost one in five of the Island's recorded 62 HIV cases, and one in two of all recorded HCV cases, has been an injecting drug user.

5. *The majority of injecting drug users surveyed report sharing used syringes or other injecting equipment during the last month.* Ninety-one percent of those injecting drug users surveyed in the study reported sharing syringes or other injecting equipment during the last month.

6. *There is a shortage of clean injecting equipment in Jersey.* The current annual provision to drug injectors of around 40,000 clean syringes provides just one in four of the Island's estimated injectors with a single syringe each day.

7. *Without action, there is the risk that HIV and Hepatitis C could quickly spread among Jersey's injecting drug users.* These infections could also be sexually transmitted to non-injectors.

8. *Jersey's law enforcement agencies make contact with large numbers of individuals with drug problems.* However, at the point of arrest, opportunities to encourage offenders to contact with welfare agencies are under-exploited.

key recommendations: drugs

(a) *The distribution of clean injecting equipment in Jersey – including syringes and other paraphernalia – urgently needs to be expanded.*

(b) *The number of injecting drug users with HIV and Hepatitis C needs to be estimated to assess the presently unknown spread of such conditions.*

(c) *'Arrest referral schemes' should be introduced. These aim to quickly put offenders with drug-related problems who have been arrested by law enforcement agencies in contact with treatment services.*

key findings: alcohol

1. *Alcohol use is a part of daily-life in Jersey.* There are 653 establishments licensed to sell alcohol in the Island, with half being located in St Helier. However, patterns of alcohol use and misuse are likely to have changed significantly since current alcohol legislation was formulated in the 1970s.

2. *Consumption levels in Jersey are high.* In 1998, Jersey had an estimated per capita consumption level of 12.9 litres of pure alcohol, higher than most European counter-parts, and 1½ -2 times higher than the UK.

3. *This level of consumption is around 25 units per week.* Such use has been associated with long-term physical health consequences in women and men.

4. *Alcohol misuse can lead to other health harms.* The Jersey Ambulance Service report that two-thirds of their work between 10.00pm and 7:00am involves people who have been drinking alcohol.

5. *Alcohol misuse can lead to social harms.* In 1999, nearly one in two States Police attendances at domestic violence incidents involved alcohol or drugs.

6. *However, behaviour change is possible.* There have been annual decreases in drink driving offences from 1996 onwards, with 1999 witnessing the second lowest levels since 1977. This has been accompanied by decreases in serious and fatal injuries.

7. *There also appears to be a good degree of self-regulation amongst Jersey's public house and night-club industry.* However, the control and monitoring of other retail outlets such as off-licenses needs to be addressed.

8. *Although public order offences are at relatively low levels, under-age and public drinking appear to remain key law enforcement issues.* However, only limited powers are available to the States and Honorary Police when dealing with under-age drinkers, whilst Alcohol Exclusion Orders are not being fully utilised by the courts system.

key recommendations: alcohol

(a) *Alcohol legislation in Jersey needs to be officially reviewed and reformed.*

(b) *Partnership work with the alcohol retail trade needs to be built upon and expanded – currently, there is only limited communication between health and commercial bodies.*

(c) *Research on the health impact of alcohol misuse in Jersey needs to be urgently improved – currently, there is no estimate of alcohol's role in illness and deaths.*

key findings: strengthening the evidence base

1. *There are at least 20 agencies in Jersey which regularly collect data on problematic drug and alcohol users.*

2. *However, the majority of information collected by these agencies cannot be used to answer questions central to effective policy-making and planning.*

3. *Furthermore, patterns of substance use and misuse can change rapidly.* Future research needs to be conducted to measure this change. This should be conducted at 2-3 year intervals, using this study as a base-line.

4. *Without action,* it will be difficult to establish the present extent of substance use, related harms, illness and death, or the impact and cost-effectiveness of initiatives to reduce these.

key recommendations: strengthening the evidence base

(a) *Immediate measures need to be taken to improve a number of individual agency reporting systems.*

(b) *Longer-term activity should be focused on the co-ordination and combination of multiple data sources.*

(c) *Further research is central to the development of Jersey's Responding to Substance Misuse Strategy: both to measure change over time, and to understand issues such as factors influencing HIV transmission in more detail.*

(d) *Building local capacity within Jersey to undertake these tasks should be a key future activity.*

1. What drugs are being used?

A comprehensive array of illegal drugs and diverted pharmaceuticals is available in Jersey.

Heroin

Heroin has been available on Jersey since at least 1992 and has become the primary drug of choice among the Island's population of *problematic drug users* (those users either experiencing or causing social, psychological, physical or legal problems related to their self-administration of drug):

- in 1999, nearly three out of every ten referrals made to the Jersey Alcohol and Drug Service were opiate-related, compared to the four in every 100 referrals made in 1988 (see opposite: Figure 1.1)
- in 2000, 96% of the 110 problematic drug users interviewed in community settings as part of the Jersey Community Survey reported using heroin during the last month

The future

Data from the Jersey Community Survey indicates that heroin use may be becoming increasingly popular, and that individuals are now also choosing to inject, rather than smoke, the drug:

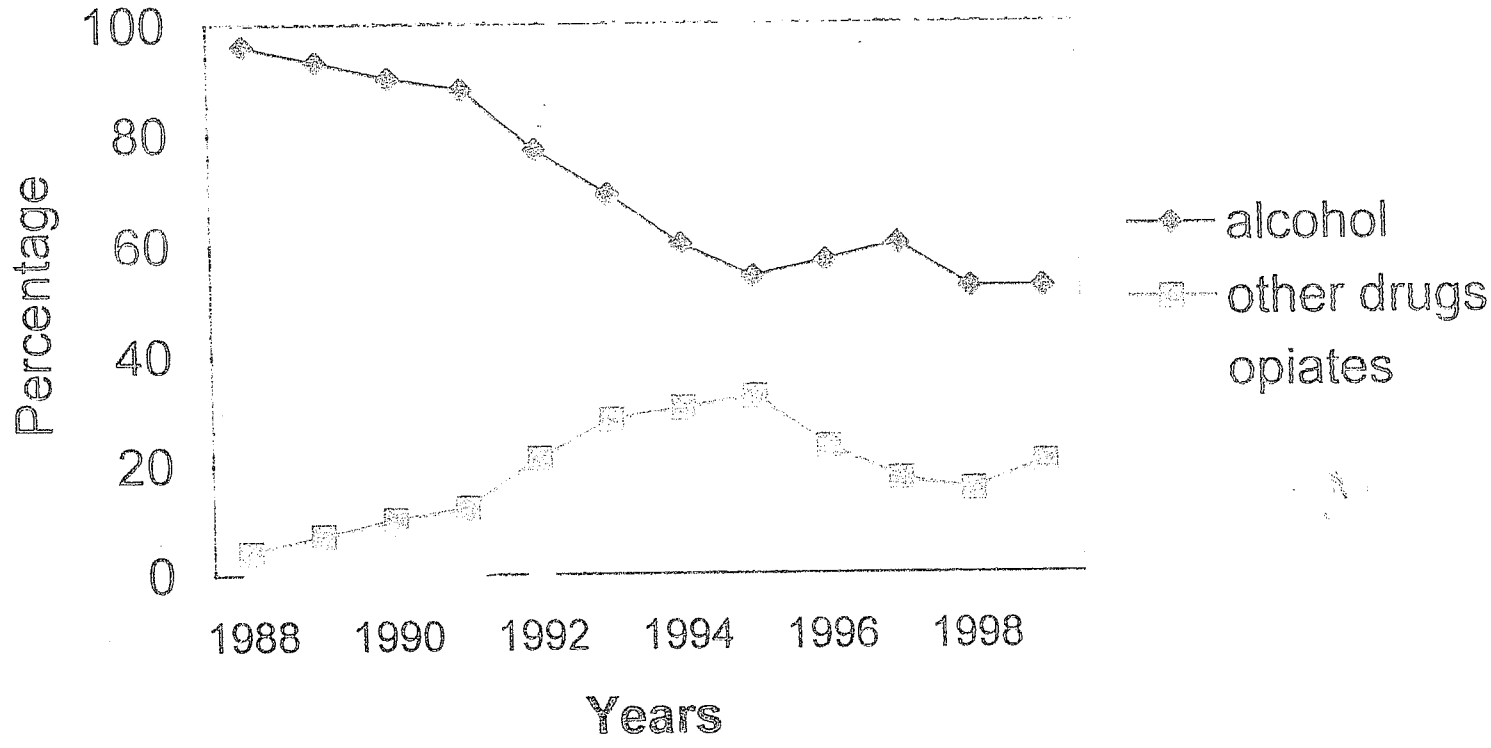
- in the community sample half of the heroin users started using heroin in 1996 or later (53%, 55/104)
- nearly two thirds of all injectors started injecting from 1997 onwards (61%, 46/75)
- half of the injectors only started injecting regularly (on a weekly basis) either in 1999 or 2000 (49%, 35/72)

Heroin use is a chronic condition. If the trends described above continue then the prevalence of heroin users in Jersey may increase further, and also the potential for the transmission of infectious diseases such as HIV, HBV and HCV.

Other illegal drugs

Cannabis remains the most popular illegal drug. The majority of States Police arrests for drug possession involve cannabis, with around seven in ten drug arrests in 1998 involving cannabis. Cocaine and crack use is reported as comparatively rare (based on treatment, arrests and seizures data). Whilst ecstasy use takes place, this does not figure strongly in either treatment or arrest data, although large consignments have been intercepted by law enforcement agencies. There is little reported use of amphetamine type stimulants or synthetic hallucinogens such as LSD.

Figure 1.1
Percentage of referrals made to Jersey Alcohol and Drug Service by drug type, 1988–1999



Source: Alcohol and Drug Service (2000)
Notes: A referral is recorded as taking place the very *first time* a client attends the service, and when a client *returns to the service* after being out-of-contact (either having been previously discharged from treatment, or after not attending for three months or more). Referrals can be made by the client, their carers, a doctor, or any other third-party.

Legal drugs

Only limited information is available on the non-medical use of prescription drugs in Jersey[2].

Data from the Accident and Emergency Department in St Helier provide a rough guide to the ratio of presentations made relating to 'prescription' and 'street' drugs: with 90% of these presentations involving drugs such as benzodiazepines, anti-depressants, and non-opiate analgesics. These data indicate that presentations for these particular drugs fell dramatically between 1997-1999, possibly reflecting wider efforts to curb irresponsible prescribing practices.

Drug use and young people

Young people are specifically identified as a key population group in the *Responding to Substance Misuse* strategy, and the Jersey Schools Survey provides a solid data-set on a range of health-related behaviours, including the use of illegal drugs, from approximately 1500 children in school years 8 and 10 (ages 12-13, and 14-15).

Key findings from the 2000 survey[3] include:

- the majority of pupils in both Year 8 and 10 report never having used any of the drugs asked about
- however, for almost every one of the drugs these pupils were questioned about, a higher proportion of young people in Jersey reported their use when compared to school-children in Scotland and England (the exceptions being amphetamine and natural hallucinogen use among Year 8 females).
- cannabis and ecstasy were the most widely used drugs
- however, between one and three per cent of the sample also reported the use of heroin. This was the first year of the survey that any pupil from Year 8 had reported using heroin, and reported lifetime use of heroin rose amongst all pupil categories compared to surveys conducted in 1996 and 1998

2. Problem drug users

Whilst the majority who use drugs will normally do so safely, and without harming themselves or others, some individuals will become '*problem drug users*': either experiencing or causing social, psychological, physical or legal problems related to their self-administration of drugs.

Who are they?

Drawing on a review of existing data-sources (Box 2.1), the average problem drug user in Jersey is male, probably aged between 27 and 29, and employed. His drug of choice is heroin, which he may well inject, and if so, he will probably share his equipment and paraphernalia with others. Possibly spending around £230 a week on heroin, the average user will also take other opiate drugs, such as dihydrocodeine, as well as non-opiate drugs such as ecstasy.

---

[2] What data are available are subject to significant problems in their collection and coding, or cannot be easily analysed in their current form to identify drug-related problems.

[3] A Picture of Health. Jersey 2000. Jersey Health Promotion Unit.

Box 2.1
Overview of main data-sources on drug use in Jersey

	Community survey	A+D service	Addicts Index	Police convictions	A+E
Individuals	opiate and stimulant users	opiate referrals	opiate and stimulants	opiate offences	opiate presentations
Contact	interviews	referrals	reports	convictions	presentations
Year(s)	2000	97 - 00	95 - 00	97 - 00	97 - 00
Numbers	110	276	296	71	38

How many are there?

Problem drug users comprise a relatively 'hidden' population. Whilst a small number of problematic users will be in contact with helping or law enforcement agencies, the larger number will often remain unknown. This can make resource allocation, service planning and the targeting of appropriate interventions difficult.

To identify the number of problem drug users in Jersey, a method known as 'capture-recapture' was employed (see Appendix 1)[4]. This estimate suggests that:

1. there may be around 780 problematic opiate users currently in the Island
2. over half of these users – 420 individuals – did not make contact with either conventional drug treatment, public health surveillance or law enforcement agencies between 1997 and 2000 (54%, 420/780)
3. if data from the Jersey Community Survey of 110 problem opiate users – where 68% reported injecting opiates – are applied to the above estimate, then there could be around approximately 530 opiate injectors in Jersey (68%, 530/780)

3. Associated health problems

There is a high risk of infectious disease transmission among Jersey's injecting drug users, and an accompanying risk of sexual transmission to non-injectors. There are potentially at least three reasons for this: existing pools of infectious disease in the Island; high levels of injecting risk; and significant geographical mobility among injectors.

[4] All estimates have limitations. These are also outlined in Appendix 1.

Infectious disease: overview

1. almost one in five of the Island's 62 recorded HIV cases has been an injector. However, whilst 12 known cases have been recorded among injectors, the actual prevalence of HIV in the community is not known (Table 3.1).
2. at the end of 1999, almost one in two HCV cases were occurring among injectors, with this group comprising 61 out of the 126 cases recorded since testing began in 1992[5].
3. whilst only partial data on HBV are available, amongst those responding to the Jersey Community Survey, 12% of the whole sample, and 17% of injectors, reported having had HBV at some time, whilst 27% of the sample and 31% of the injectors had been vaccinated against HBV. Compared to the UK, this represents low infection rates and high vaccination levels.

High levels of risk behaviour

Data from the Jersey Community Survey indicates that sixty-eight per cent of the sample had *injected* illegal drugs at some time (75/110), whilst 91% had shared some sort of injecting paraphernalia in the last month (Table 3.2). Those 67 injectors completing an Injecting Risk Questionnaire - which records the sharing of needles, syringes and other paraphernalia - reported the highest level of syringe sharing that we have encountered: sharing more often, with more people, and with higher risk on every specific risk practice, than either their English counterparts, or peers using the Jersey Alcohol and Drug Service needle-exchange.

High geographical mobility

A high geographical mobility was reported by injectors participating in the Jersey Community Survey. In the last twelve months, 41% had injected outside of Jersey in 13 different countries (31/75), including known but low HIV prevalence UK cities, as well as countries with high rates of HIV infection among injectors (such as Portugal, Thailand, France and Holland). Clearly, potential exists for HIV to both enter the Island's drug using networks, and to quickly spread amongst its injectors.

Other health problems

Almost one in six injectors participating in the CS reported an opiate overdose during the last year (17%, 19/109). On six (out of 36) occasions, Narcan was administered. Most overdoses involved the *combined* use of heroin, benzodiazepines, and alcohol. Data from the Viscount's (coroner's) office indicates that since 1997, there have been at least four heroin-related deaths a year, with the majority of these again involving the use of other opiates, benzodiazepines, or alcohol.

[5] Additionally, of the 33 cases where an 'unknown' origin was returned, it has been suggested that these could also be injecting-related.

Table 3.1
Cumulative prevalence of HIV, end of 1999

	Disease State				
	Unknown	Asymptomatic	Symptomatic	Deaths	Total
Homo/bisexual	3	7	11	6	27
IDU	6	1	2	3	12
Heterosexual	0	9	6	0	15
Other	1	1	2	4	8
Total	10	18	21	13	62

Source: States of Jersey Pathology Laboratory (2000)

Table 3.2
Sharing of injecting paraphernalia in the last month

	Jersey injectors*	English injectors***
Basic sharing question: 'During the last 4 weeks how often have you shared injecting equipment?'		
Frequently	27%	14%
Sometimes	30%	17%
Hardly ever	16%	21%
Never	27%	48%
Sharing of any paraphernalia – in answer to more detailed questions **	91%	78%
Median number of people with whom shared	4	2

Source: Community Survey (2000), Alcohol and Drug Service (2000), Hunter et al (2000)[6]
Notes: * n=67, based on 69 who had injected in last month, 2 nk. ** n = 66 for subsequent Qs.
*** n = 1214, community recruited injectors, 7 cities UK. Hunter et al 2000.

[6] Measuring Injecting Risk Behaviour in the second decade of Harm Reduction: a survey of injecting drug users in England. Hunter, G., Stimson, G.V., Judd, A., Jones, S., Hickman, M. Addiction (2000) 95(9), 1351-1361.

4. Available services

Whilst the basic components of drugs service provision – including methadone reduction programmes, needle-exchange, and referral links between health and criminal justice agencies – were already in place in Jersey by the mid 1990s, the availability and accessibility of these services was limited.

Driven by changes in the Alcohol and Drug Service, and the realisation that the increasing number of opiate drug users was not a temporary phenomenon, a concerted effort was made from 1997 onwards to both improve access to services, and to extend the range of interventions provided.

Interventions

This inter-play has resulted in a network of at least nine specialist drug agencies, and a larger number of generic agencies whose client base also includes drug users. Key interventions include: methadone; needle-exchange; and Narcan.

Methadone

A seventy slot oral methadone reduction programme is in operation. Whilst methadone has been available from the Alcohol and Drug Service in conjunction with consultant psychiatrists from the Mental Health Unit since 1993, what is new are efforts to increase the availability and accessibility of these programmes. Whilst confirmatory client figures are not available, key informant interviewees often reported that previous methadone provision had limited take-up, and that instead many opiate users chose to obtain prescriptions for dihydrocodeine from General Practitioners (often in large quantities). Although non-prescribed methadone use was reported by eleven per cent of the Jersey Community Survey (1% in the last month), it is thought that these figures are likely to be related to off-Island use, or methadone brought in from the UK.

Needle-exchange

Around 40,000 clean syringes are thought to be distributed to drug injectors in Jersey each year. However, this is enough to provide just one in four of the Island's injectors with a single syringe each day, and potentially high levels of sharing among injectors indicate that such needle-exchange schemes need to be urgently expanded. Whilst plans are in place to expand syringe distribution through the provision of a free-needle exchange scheme in Lloyds Pharmacy outlets, it is arguable that there is also a need to encourage the Accident and Emergency department to increase their provision of needles (an activity which is currently neither encouraged or promoted), and to also expand *retail* needle and syringe sales among other community pharmacists on the Island. The distribution of syringes through other primary care settings might also be considered (such as GPs – with whom injectors report high levels of contact).

Narcan

Since its introduction in 1999, it is reported that the lives of at least six drug users have been saved by 'Narcan' (an injectable antagonist used to 'reverse' the effects of opiate drug overdoses). The Ambulance Service has included Narcan as part of their standard vehicle kit since October 1999, and the Alcohol and Drug Service provide Narcan distribution to around 40-50 users a year (on an easily obtainable prescription basis). This is now supported by a training course for clients on preventing and avoiding overdose.

Links with the criminal justice sector

Whilst Jersey has retained a strict sentencing policy, it is now acknowledged that drug use – usually in combination with other social problems – can significantly contribute to an individual's offending behaviour. Consequently, a number of programmes have been developed which aim to challenge and change offender's patterns of drug use.

Drug awareness programmes

Prior to 1992, custodial sentences were common for many offences under the Misuse of Drugs (Jersey) Law 1978, including possession offences involving small amounts of cannabis (which could result in short prison sentences). An alternative sentencing option – the *Drug Awareness Programme* - was launched in the autumn of 1992, partly diverting the flow of drug offenders away from imprisonment and into a programme of individual assessment and education administered by the Alcohol and Drug Service. (Since this time, the Probation Service has also begun to offer a separate drugs education course to offenders receiving a probation order.)

Greater discretion for Centeniers

Whilst the Drug Awareness Programmes provided courts with an alternative sentencing option, it did not stop the flow of drug offenders reaching the court system in the first place. The reason for this lay with the policing of drug offences in Jersey. At the time, Centeniers were not able to use discretion when dealing with small possession offences, with these immediately becoming a matter for the courts, regardless of class, amount or mitigating circumstances. In 1998, new guidelines allowed Centeniers to caution first-time drug offenders in possession of personal amounts of cannabis or amphetamines, often on the condition that they attend the Drug Awareness Programme at the Alcohol and Drug Service. Some members of the Centeniers Association felt that these sentencing options could be increased further to also include first-time drug offences involving ecstasy and heroin.

Treatment orders

Greater Centenier discretion further reduced the flow of drug offenders into the larger court and criminal justice system. However, there was still little provision for those individuals whose drug-related problems were perceived as contributing to their offending. In 1999, an alliance between the Courts, Alcohol and Drug Service, and the Probation Service resulted in the introduction of non-custodial sentences with a treatment or supervisory component. Otherwise known as *BOTOs* (binding-over treatment orders) and *POTOs* (probation orders with treatment options), these options are reported as being increasingly used by the court system since their introduction. Importantly, a new position – the Court Liaison Officer – was created early in 2000 to co-ordinate activity between these agencies.

Prison based work

Prison provides an important setting in Jersey for the prevention of drug-related harm. It is currently estimated by key informants in the prison service that 60-70% of all inmates entering La Moye already have a drug-related problem (primarily with heroin), whilst the Jersey Community Survey indicated that imprisonment is not uncommon amongst problematic drug users, with almost one in five respondents reporting a sentence in La Moye during the previous 12 months (23/110).

Table 4.1
Treatment Orders, 1999 – 2000*

	1999	2000
Reports requested	45	63
Psychological reports recommending treatment intervention	14	24
Treatment recommendations supported by Magistrate's court	11	19
Percentage of treatment recommendations supported by Magistrate's Court	78%	79%
Total number of individuals on treatment orders	13	23
Percentage of individuals on treatment orders that have not been breached	70%	66%

Source: Court Liaison Officer (2000). *Data cover period January – April 2000.

Box 4.2
Drug-related services provided at La Moye Prison

- the opiate antagonist naltrexone can be made available to prisoners up to five days before their release
- HIV, HCV and HBV tests 'on-demand'
- a drug awareness course for prisoners – including young offenders - providing basic health and legal information on substance use
- individual and group addiction counselling
- pre-release and after-care work – currently, 65-80% of prisoners involved in these sessions keep appointments with the Alcohol and Drug Service on their release.
- treatment services are provided 'in-house' by prison medical staff, with and through work between the Prison Service and external agencies such as the Alcohol and Drug Service, the Probation Service, and ACET.

5. Offences and offenders

Seizures

Whilst drugs do penetrate the Island's borders, there are stringent measures in place to prevent illegal drugs coming into Jersey. Currently three agencies in Jersey make seizures of controlled drugs: Customs and Excise (responsible for all seizures made at Jersey's airport, two seaports, postal service and coastline); States Police (majority of inland operations); and the Honorary Police (minor involvement). In the case of all three agencies, officers may make seizures in the course of duty, or through specialist units (C+E have an anti-smuggling team, whilst the States Police have a dedicated Drugs Squad).

What drugs are seized in Jersey?

Cannabis is the most commonly seized drug, and comprises almost four out of every five seizures made by C+E. Mainly entering Jersey from France, Spain and the Netherlands, cannabis is also the only drug regularly seized in kilogram consignments. After cannabis, amphetamine seizures are the second most commonly seized drug, with seizures of ecstasy also regularly occurring. Consignments of heroin (mainly from the UK) are also intercepted by law enforcement agencies. Seizures of cocaine and LSD are relatively rare.

Are seizures large?

On weight alone, the size of seizures being made in Jersey is not large. The average weight of all cannabis and cocaine seizures has risen for both the States Police and C+E, whilst consignments of amphetamine powder have fallen. Looking at just C+E data, the average weight of C+E heroin seizures has risen during the last five years, as have seizures of ecstasy, cocaine and amphetamine tablets.

Are more seizures being made?

Calculating similar averages to those above, it is clear that more seizures were made by C+E for all drug types apart from amphetamine powder and LSD.

What does this say about seizure policy?

It is difficult to evaluate the effectiveness of current seizure policy using such estimations. There are four main reasons for this. Firstly, data on seizures, purity and price, are not available for the period prior to the introduction of recent strategy initiatives. Secondly, seizures of heroin made outside of Jersey's territorial waters by C+E - whose operational policy is now to seize drugs at the most appropriate point - are not included. Thirdly, and most importantly, drug seizures are *not* the only measure of the 'disruption' of organised dealing teams. Arguably, the seizure of assets, successful abortion of attempted drug importations, arrest and conviction of key individuals, and dissemination of information to other law enforcement agencies, are equally as important.

Table 5.1
Weight of seizures made by Customs and Excise, 1995 – 1999

Weight of seizures made by Customs								
		1995	1996	1997	1998	1999	Total	% total seizures made by C&E and Police
Cannabis	Kilos	15	7	18	62	36	138	40
Heroin	grams	58	804	20	311	337	1530	44
Cocaine	grams	-	1	1	202	2	206	31
Amphetamine	grams	36	58	33	64	14	205	28
	tablets	-	-	2	997		999	97
LSD	tablets	2	2	2	1	-	7	3
Ecstasy	tablets	3877	473	1043	6	16448	21847	60
Methadone	Mls	-	-	915	120	-	1035	-

Table 5.2
Weight of seizures made by States Police, 1995 – 1999

Weight of seizures made by Police								
		1995	1996	1997	1998	1999	Total	% total seizures made by C&E and Police
Cannabis (resin)	kilos	42	14	35	96	24	211	60
Heroin	grams	411	873	657	1	1	1943	56
Cocaine (incl. crack)	grams	20	13	27	32	370	462	69
Amphetamine	grams	102	299	83	24	30	538	72
	tabs	-	18	13	-	-	31	3
LSD	tabs	118	136	1	-	2	257	97
Ecstasy	tabs	6657	2929	1706	2278	978	14548	40

Source: Customs and Excise (2000); States of Jersey Police (2000)
Notes: Calculations of the % total seized are based on the total weight of seizures made by Customs and Excise and the States Police for each drug type.

Arrests

Each year, the States Police and Customs and Excise make over 300 arrests for drug offences, and deal with an unknown number of problematic users who have committed non-drugs offences. However, whilst law enforcement agencies in Jersey will often encounter offenders with drug problems who are not in contact with health or welfare agencies, opportunities to encourage these individuals to seek treatment or help remain under-developed.

The main factor underpinning this 'revolving door' is the absence of an *arrest-referral* scheme in Jersey. The aim of arrest referral schemes is to quickly put *any* offender with a drug-related problem in contact with advice or treatment services. These work through providing individuals in custody with low-cost information cards or leaflets detailing local drug services (either handed over to all detainees, or in more targeted schemes to those suspected of being problem drug-users).

Convictions

Around 200 convictions are made each year for drug offences resulting from States Police activity, and approximately 60 from Customs and Excise operations.

However, such aggregate data mask the range of *options* available to the court system when sentencing those individuals either convicted of a drug offence (non-trafficking), or more generally, those offenders with drug-related problems. These include: *drug awareness programmes*; *treatment orders*; and *probation orders*.

6. Recommendations

Three major recommendations are made:

1. **Needle-exchange services need to be urgently expanded:**

   (a) HIV and other infectious diseases are already reported among Jersey's injecting population

   (b) 91% of injecting drug users report sharing syringes and paraphernalia during the last month

   (c) current syringe distribution programmes have limited coverage, and are only able to provide one in four of the Island's estimated injectors with a single syringe each day

   (d) unless preventative measures are taken this could lead to the transmission of HIV and other infectious diseases firstly among injecting drug users, and then via sexual transmission to the wider population

2. **The extent of HIV and HCV infection among injecting drug users needs to be established:**

   (a) almost one in five of the Island's 62 recorded HIV cases has been an injecting drug user

   (b) at the end of 1999, almost one in two HCV cases were occurring among injectors

   (c) however, these are only reported cases - the actual prevalence of HIV among injectors in the community is not known

   (d) an HIV and HCV prevalence study needs to be undertaken – this will help describe the scale of the problem, the rate at which disease transmission is occurring, and the population groups most at-risk

3. **An arrest-referral scheme should be established to counter the 'revolving door' of drug-related offending:**

   (a) each year, law enforcement agencies make over 300 arrests for drug offences, and deal with an unknown number of problematic users

   (b) opportunities to encourage these offenders to make contact with treatment and welfare agencies remain under-developed at the arrest stage

   (c) arrest-referral schemes may offer a low-cost and effective method of achieving this goal