

Review of drugs part two: prevention, treatment and recovery: annexes

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Annex A: trends in prevalence of drug use and the associated harms

Summary

The following evidence section presents an overview of the trends in the prevalence of drug use and the associated harms, as well as the treatment response. It also includes information on how these harms are very much associated with deprivation and often concentrated in the poorest areas of the country.

In summary, all the main indicators have worsened in the last 5 to 10 years, with:

- the use of opiates and crack increasing significantly
- the use of other drugs by adults and children also increasing significantly
- drug misuse deaths now at a record high
- fewer people that need treatment receiving it and poorer treatment outcomes for those that do receive it
- a clear divide between north and south having emerged in terms of problematic use and harms

The high cost of illicit drug use

It is estimated that the costs associated with illicit drug use are over £19 billion per year. Drug-related crime is the main driver of these costs, making up nearly half. The harms from drug-related deaths and homicides make up the next largest cost. Expenditure on drug treatment and prevention is only a small proportion of the total costs. The estimated costs per year associated with drug use are:

- £9.3 billion for crime and the criminal justice system
- £6.3 billion for drug related deaths
- £1 billion for adult family and carers of drug users
- £0.7 billion for enforcement
- £0.6 billion for children's social care

- £0.6 billion for drug treatment and prevention
- £0.9 billion for other costs (including social care, drug-driving, drug-related secondary care, prison treatment)

Most of these costs (86%) are incurred by the 300,000 users of illicit opiates and crack cocaine [estimated by PHE](#). The average annual cost of someone using these drugs is estimated to be approximately £58,000. This compares to an average annual cost of less than £1,000 each for the 3 million users of other drugs.

Drug-related deaths are currently at the highest level since records began. [ONS reports](#) that these have increased by nearly 80% since 2012. Figure A1 below shows the upward trend in drug poisoning deaths between 1993 and 2019. Drug misuse deaths in England in 2019 were the highest ever. This increase is largely due to a sharp rise in heroin deaths, which have doubled over this time.

Most areas of the country have seen increases in drug deaths. Figure A2 below shows the death rate per million people for all English regions. The North East has seen a particularly large rise. The rate of deaths per million population in this region is now by far the highest in the country and is almost 3 times that of London and other areas of the south.

Most drug deaths occur in people aged 40 to 50 and data is expected to show that drug poisonings and other drug-related deaths killed more people under 50 during 2020 than COVID-19.

Figure A1: number of drug misuse poisonings in England between 1993 and 2019

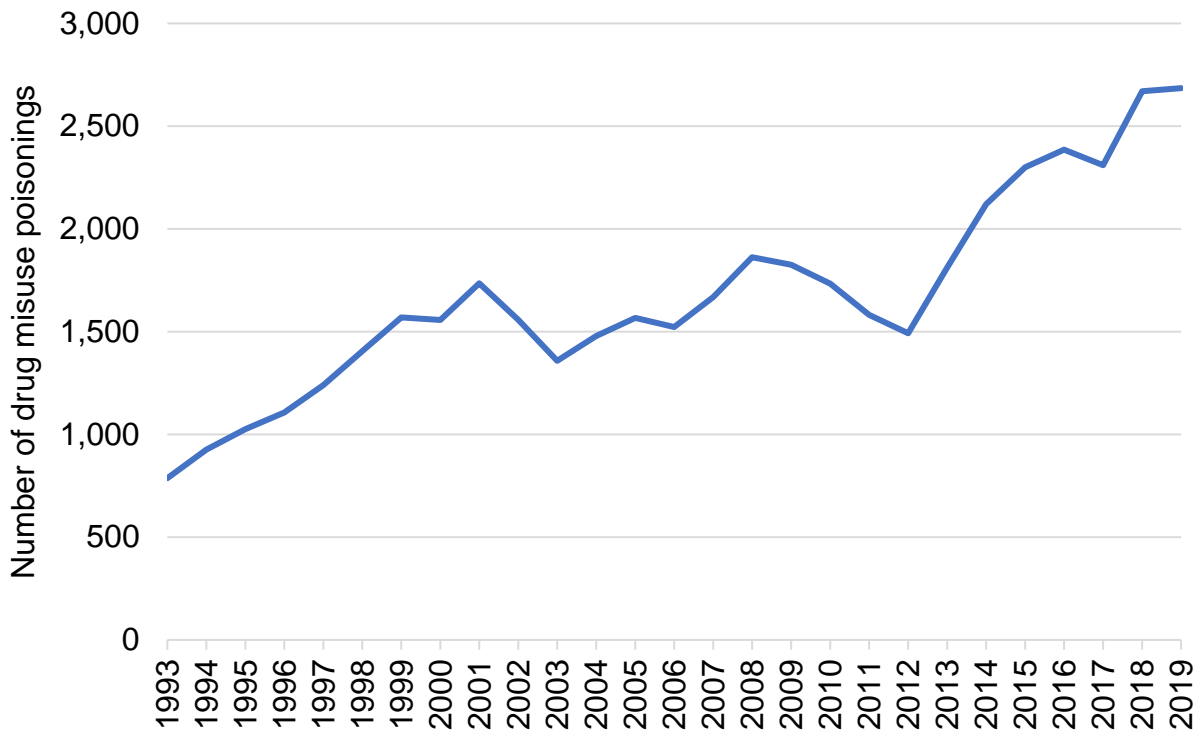
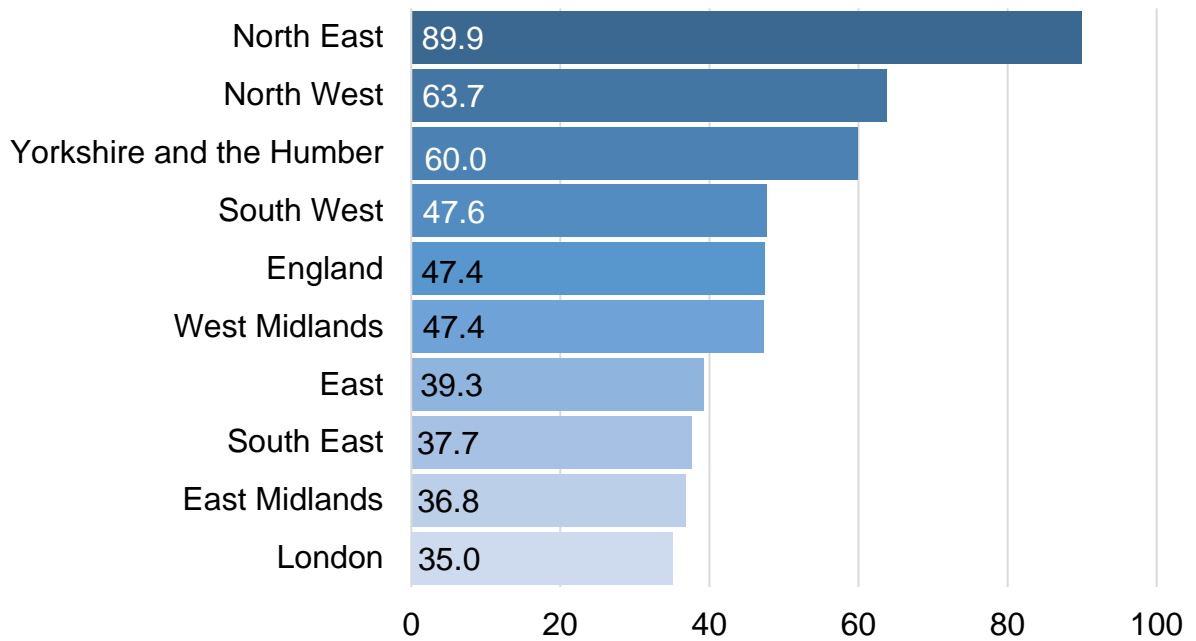


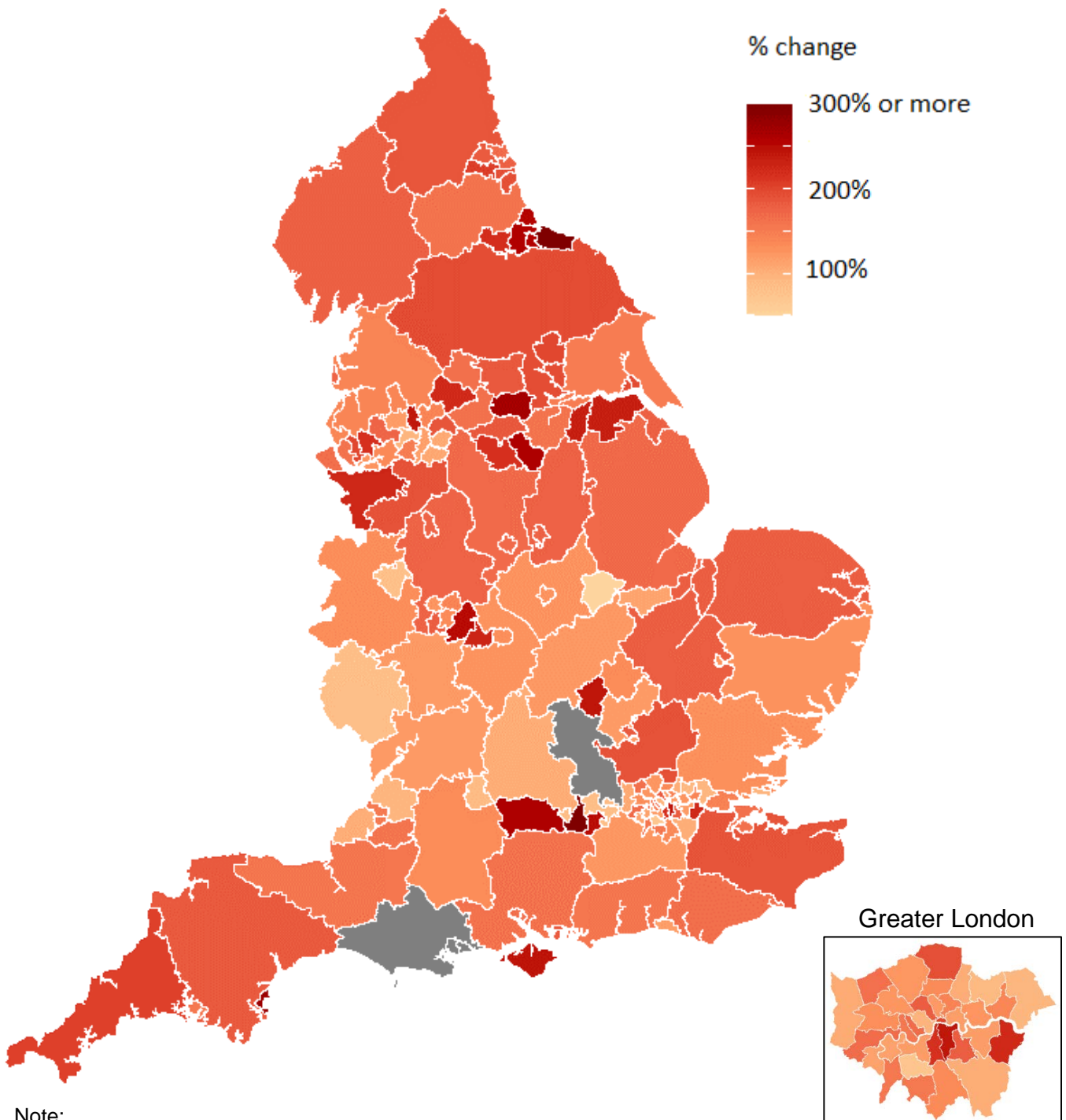
Figure A2: drug misuse deaths rate per million people in English regions in 2019



Note: 2019 drug misuse poisonings against 2019 mid-year population estimates

The map in figure A3 below shows the change in number of drug misuse poisonings by local authority between 2010 to 2012 and 2017 to 2019. The darker-red areas indicate large increases over this time period. Most of the local authorities showing an increase in drug poisonings are in the north of the country and the South West.

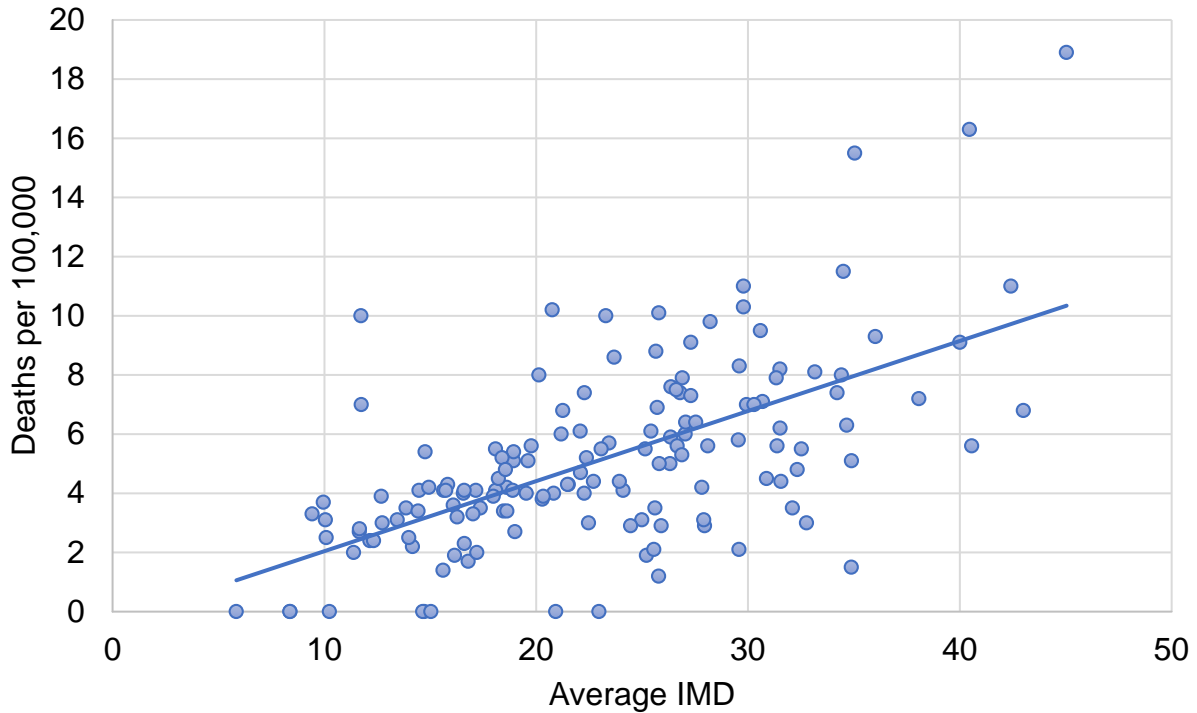
Figure A3: map showing the change in number of drug misuse poisoning deaths between 2010 to 2012 and 2017 to 2019 (% change)



Note:
The areas were capped at 300%.
Grey areas show low numbers or missing data

Figure A4 shows the correlation between the rate of drug deaths per 100,000 people and the deprivation score for the local authority. The trend line shows that the rate of deaths tends to increase with increased levels of deprivation.

Figure A4: drug misuse deaths per 100,000 population according to index of multiple deprivation (IMD) between 2017 and 2019



Prevalence of drug use

Prevalence of opiate and crack use

Figure A5 shows the estimated prevalence of opiate and crack use (OCU), between 2004 to 2005 and 2016 to 2017. OCU prevalence fell between 2005 and 2012. This is in part as a result of the rapid expansion of the drug treatment system. Since 2013 there has been a significant increase in the number of opiate and crack users. This is likely to be a result of the increase in crack cocaine use and the number of new younger users of this drug.

Figure A6 shows the rates of opiate and crack use per 100,000 people in 9 regions across England. London has seen a sharp decline in the estimated number of OCUs since 2005, whereas prevalence in the North East has risen steadily during this time. The North East now has the highest rates of use in the country. Generally, OCU prevalence tends to correlate closely with deprivation.

Figure A5: prevalence of illicit opiate and crack use

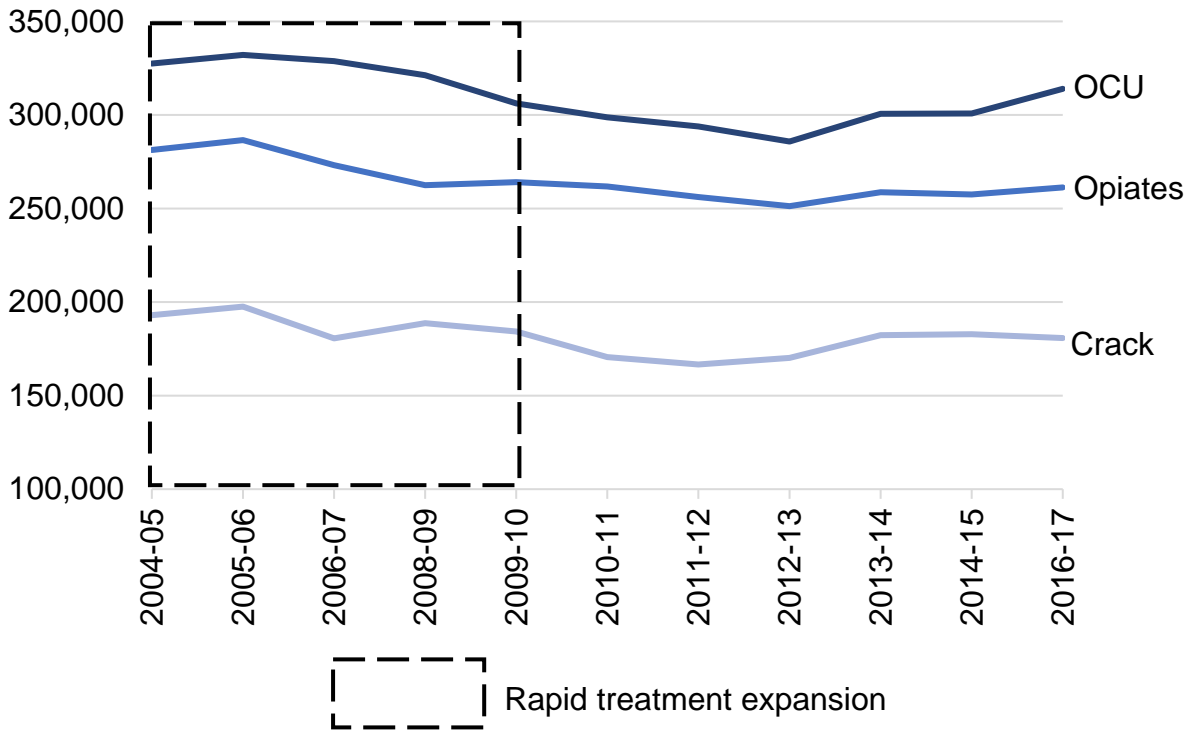
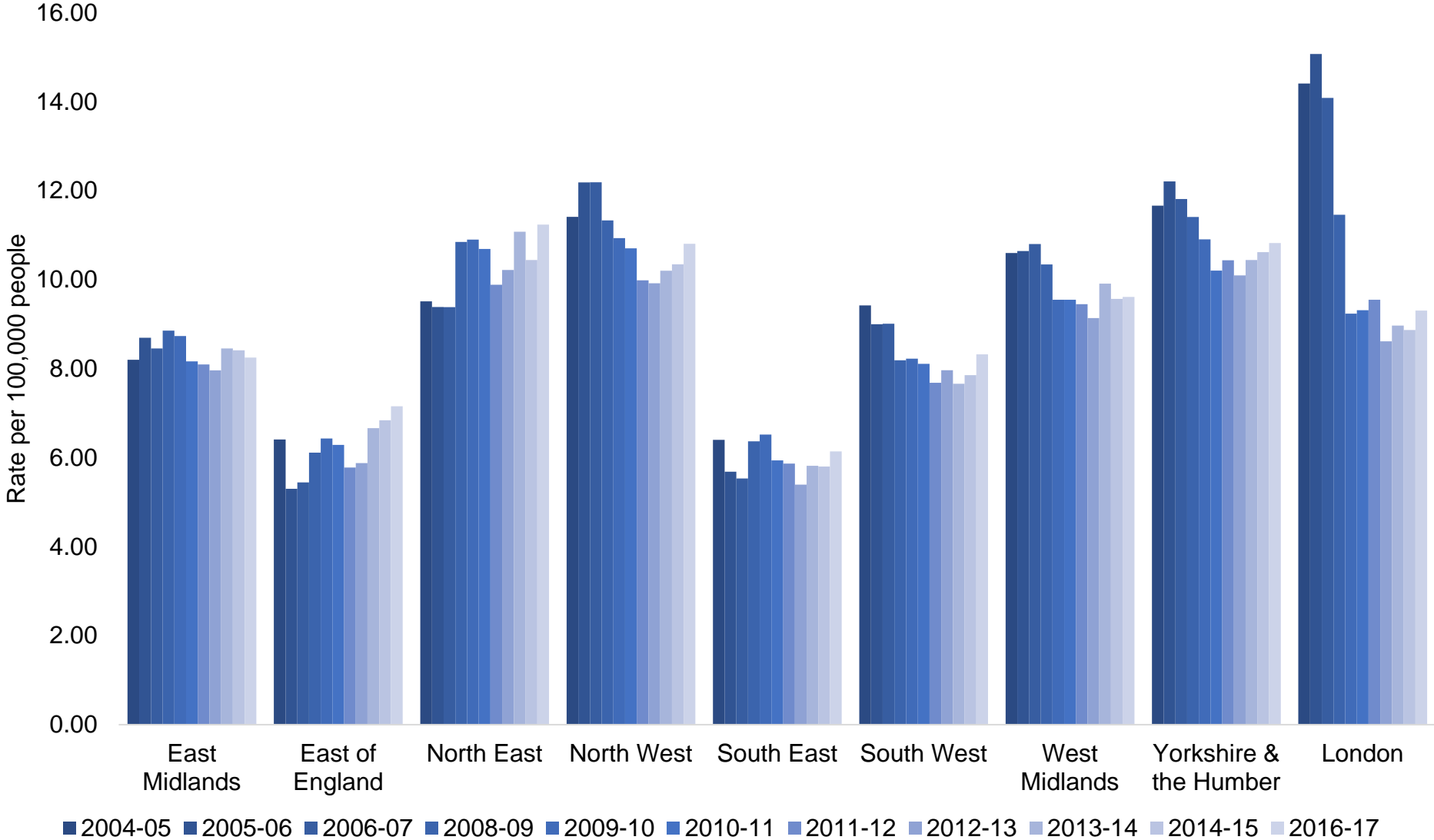


Figure A6: rates of opiate and crack use per 100,000 people



Prevalence of other drug use

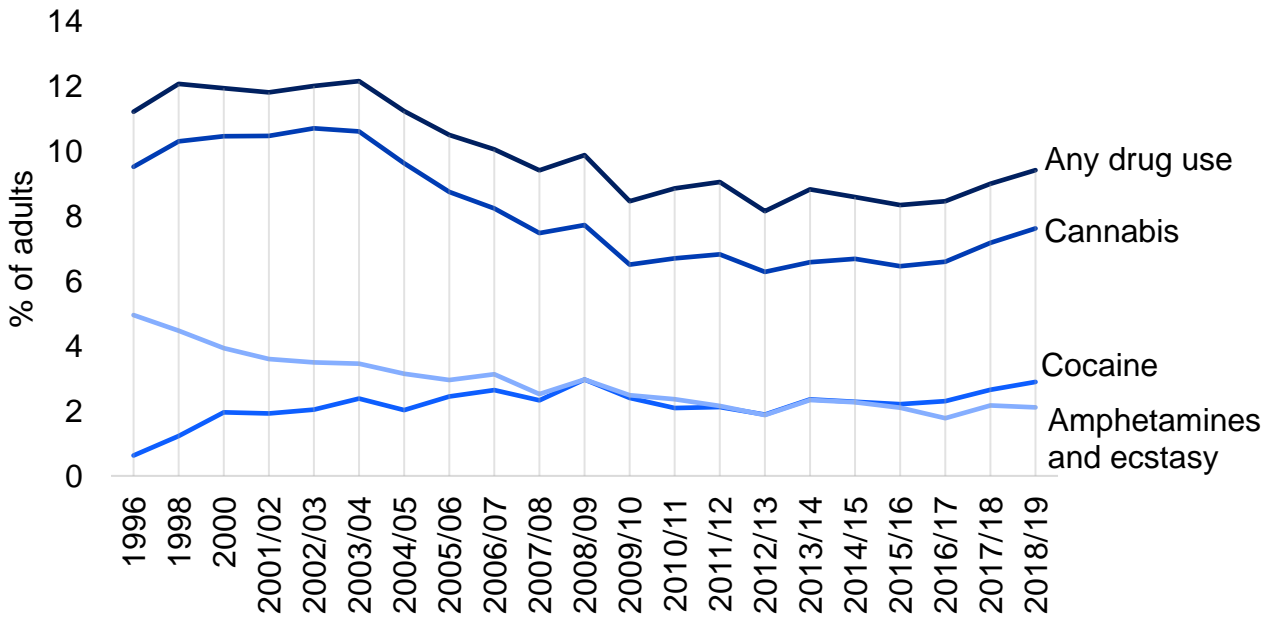
The use of other drugs ebbs and flows over time depending on many factors including:

- availability
- purity
- price
- the cultural backdrop
- the economy

Other drug use has increased across most substances over the last 5 years reported. However, recreational use is lower than it was 20 years ago, and powder cocaine use is currently at similar levels as 10 years ago. Most people that use these drugs do so infrequently and recreationally. However, a small but significant minority will develop problems and will then need treatment and other support.

Figure A7 shows the percentage of adults reporting use of specific drugs between the years 1996 and 2018 to 2019. The trend lines show a decline in cannabis use to around 2013, then a slight rise. It also shows a slight decrease across the years for amphetamines and ecstasy and slight rise for cocaine.

Figure A7: percentage of adults reporting use of specific drugs in the last year between 1996 and 2018 to 2019



Unlike with opiate and crack, people who use drugs recreationally are not concentrated in the most deprived areas of the country. They are equally as likely to live in the least deprived communities and in households with higher incomes. The rates of use of recreational drugs are higher in the south of country, particularly in London and in the South East and South West. Recreational drug use tends to be concentrated in people under 30 and is often associated with pubs and clubs, so, it is common for these substances to be taken alongside alcohol.

The percentage of 16 to 59 year olds reporting any drug use in the last year between 2016 to 2017 and 2018 to 2019 were:

- 10.8% in the South West
- 10.2% in the South East
- 9.7% in London
- 9% in the North West
- 8.4% in the East of England
- 8.2% in the East Midlands
- 8% in Yorkshire and The Humber

- 7.2% in the West Midlands
- 7.1% in the North East

Prevalence of drug use among children and young people

Drug use among school aged children has also increased over the last few years. Table A1 shows the proportions of children who reported using drugs in the last year, comparing 2014 and 2018. There is an overall 41% rise in any drug use, and there are rises in the use of most individual drugs.

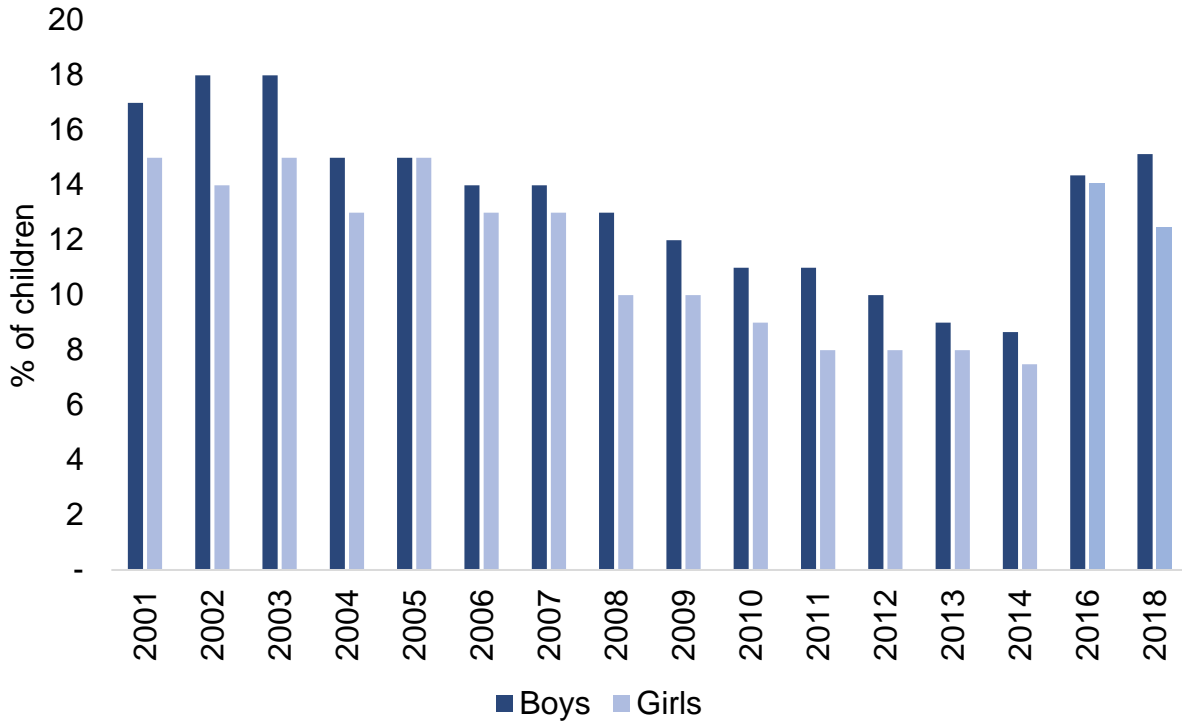
However, drug use among children remains below the peak of 20 years ago. Increases have been seen for both boys and girls and also for most substance types, with notable increases in the use of cocaine, ecstasy and ketamine.

Figure A8 shows the percentage of children (aged 11 to 16) who reported using drugs in the last year (excluding volatile substance), by sex, between the years 2001 and 2018. There is a downward trend from 2001 to 2014 for both sexes, then increases in 2016 and 2018.

Table A1: proportion of children who reported using drugs in the last year in 2014 and 2018

	2014 (%)	2018 (%)	% change
Any drug use	10.3	14.5	+41%
Cannabis	6.7	8.1	+20%
Glues or solvents	2.9	4.2	+45%
Cocaine	0.9	1.4	+66%
Ecstasy	0.8	1.3	+62%
Ketamine	0.4	1.0	+156%
LSD	0.5	0.8	+62%
Magic mushrooms	0.8	0.7	-19%
Amphetamines	0.7	0.7	-3%
Tranquilisers	0.4	0.6	+67%
Poppers	0.7	0.6	-13%
Mephedrone	0.5	0.2	-67%
Other drugs	0.3	0.8	+122%

Figure A8: percentage of children (children aged 11 to 16) who reported using drugs in the last year (excluding volatile substance), by sex



Treatment funding and workforce

Treatment funding

Against the backdrop of increasing drug use among adults and young people, as well as the significant rise in drug deaths and other harms, the funding of, and expenditure on, drug treatment has fallen substantially since 2014.

The expenditure on adult drug and alcohol prevention and treatment has decreased by nearly a fifth (17%) in nominal terms during this time, with the expenditure on treatment for young people falling by 28%. Overall, the public health grant funding has fallen by 19% since 2014. The reduction in local authority expenditure has resulted in a substantial reduction in the numbers in treatment for both adults and young people.

Figure A9 shows this decrease in the overall nominal expenditure adult treatment from the public health grant (PHG), alongside the numbers of people in treatment, which has also decreased or remained at a similar level. Figure A10 shows similar decreases in expenditure in young people's treatment and falls in the numbers of young people in treatment. The main difference being that spending on young people's treatment increased slightly in 2019 to 2020.

Figure A9: amount spent on drug and alcohol treatment and number of people in treatment between 2014 to 2015 and 2019 to 2020 for adults

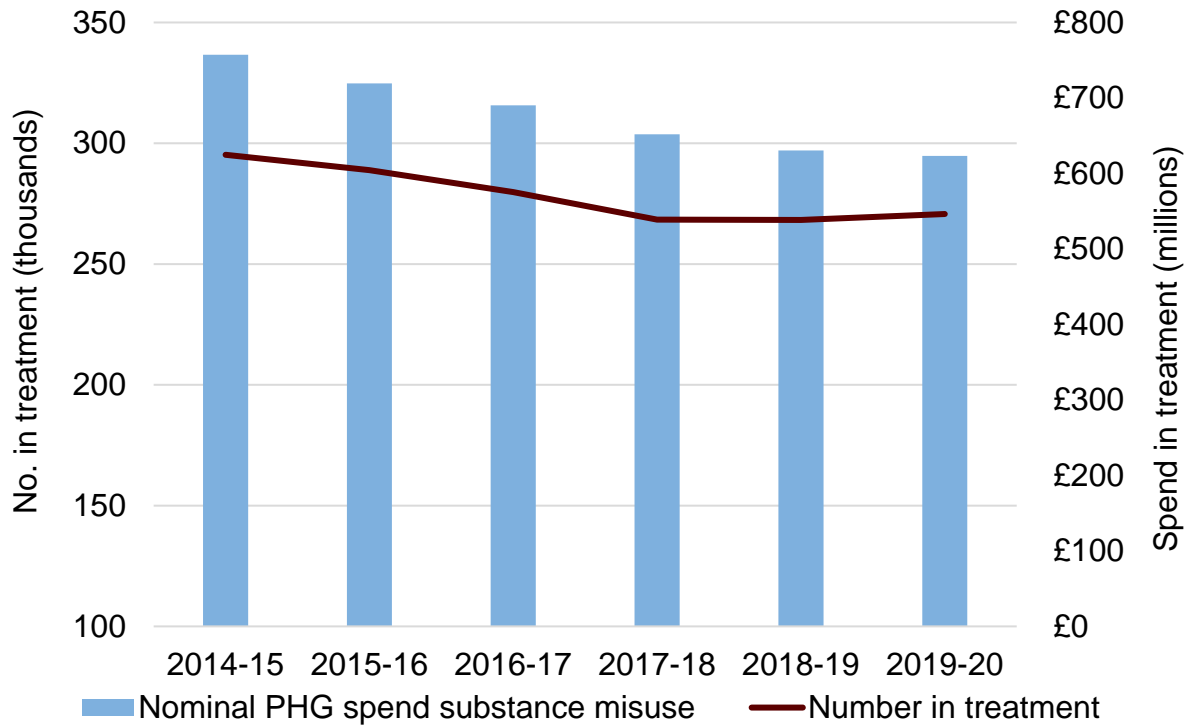
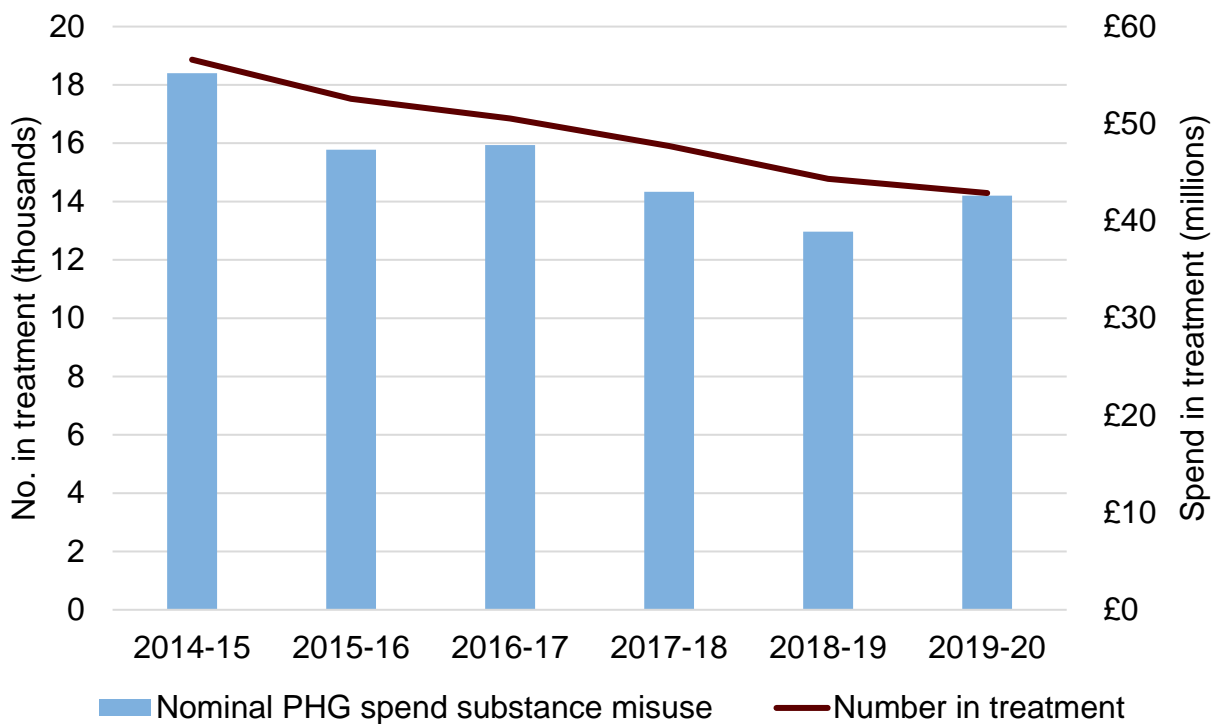


Figure A10: amount spent on drug and alcohol treatment and number of people in treatment between 2014 to 2015 and 2019 to 2020 for young people



Effect of funding reductions on the workforce

To understand the impact of this funding reduction on the workforce, a survey of treatment providers was commissioned as part of this review and carried out over summer 2020.

Table A2 below shows the results from this survey. Three hundred treatment providers responded, and these returns were then extrapolated to give a national picture. The table includes the number of people employed by each profession and also the ratio of each staff type per 1000 people in treatment.

The survey also asked about average caseload numbers and figure A11 shows the response to this question. The average caseload of a drug and alcohol keyworker was approximately 50 at any given time and over 10% of providers had average caseloads of 80 patients or more. Caseloads of this size have both safety risks and mean that practitioners will not be able to provide the intensive support needed by some of those in treatment.

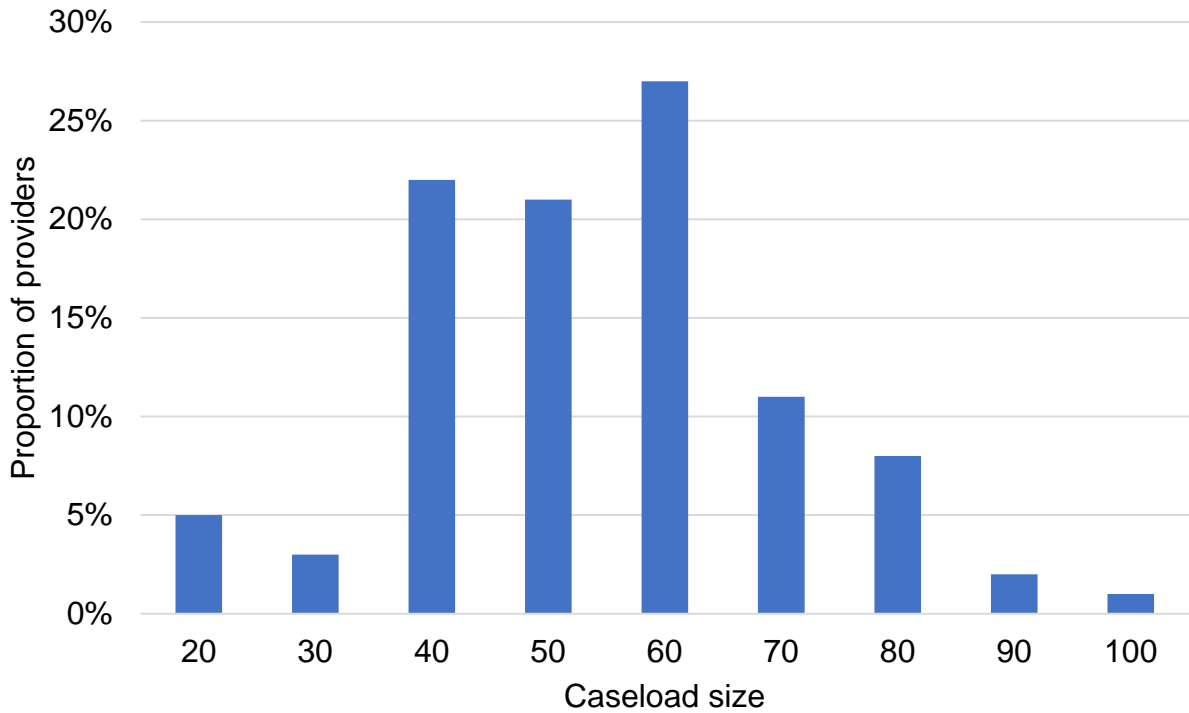
Average caseload sizes range from 20 to 100, but the majority range between 40 and 60. In over a quarter of services (27%), the keyworkers' average caseload is 60, 22% have 40 and 21% have 50.

The lack of psychiatrists and psychologists with cognitive behavioural and psychotherapeutic skills limits the amount of support that can be given to people. This results in very high levels of unmet psychological need among people in treatment.

Table A2: staff employed by profession (extrapolated) in treatment services

	Current ratio per 1000 people in treatment	Current numbers employed (extrapolated)
Social workers	0.38	96
Pharmacists (including non-medical prescribers)	0.31	79
Nurses	6.49	1665
Psychiatrists	0.43	110
Doctors	0.90	231
Consultant psychologists	0.20	51
Practitioner psychologists - assistant	0.12	32
Practitioner psychologists	0.64	164
Drug and alcohol workers	Not known	6935
Total		9363

Figure A11: average caseload size per keyworker



Treatment outcomes and unmet need

The increases in drug use prevalence and the fall in numbers in treatment have resulted in fewer people who need treatment for heroin or other opiates receiving it now than 10 years ago. Alongside this, successful completion rates have fallen significantly, particularly for opiate users, with the proportion completing treatment each year now nearly half what it was 8 years ago.

Figure A12 shows the proportion of people using opiates who were in treatment between 2005 to 2006 and 2019 to 2020. The proportion climbs steadily from 49% in 2005 to 2006, reaching a high in 2008 to 2009 of 65%. The proportion goes down slightly to 64% in 2009 to 2010 but goes back up to 65% in 2010 to 2011. Since then, the proportion falls each year until it reaches 54% in 2019 to 2020.

Figure A12: the proportion of people using opiates who were in treatment between 2005 to 2006 and 2019 to 2020

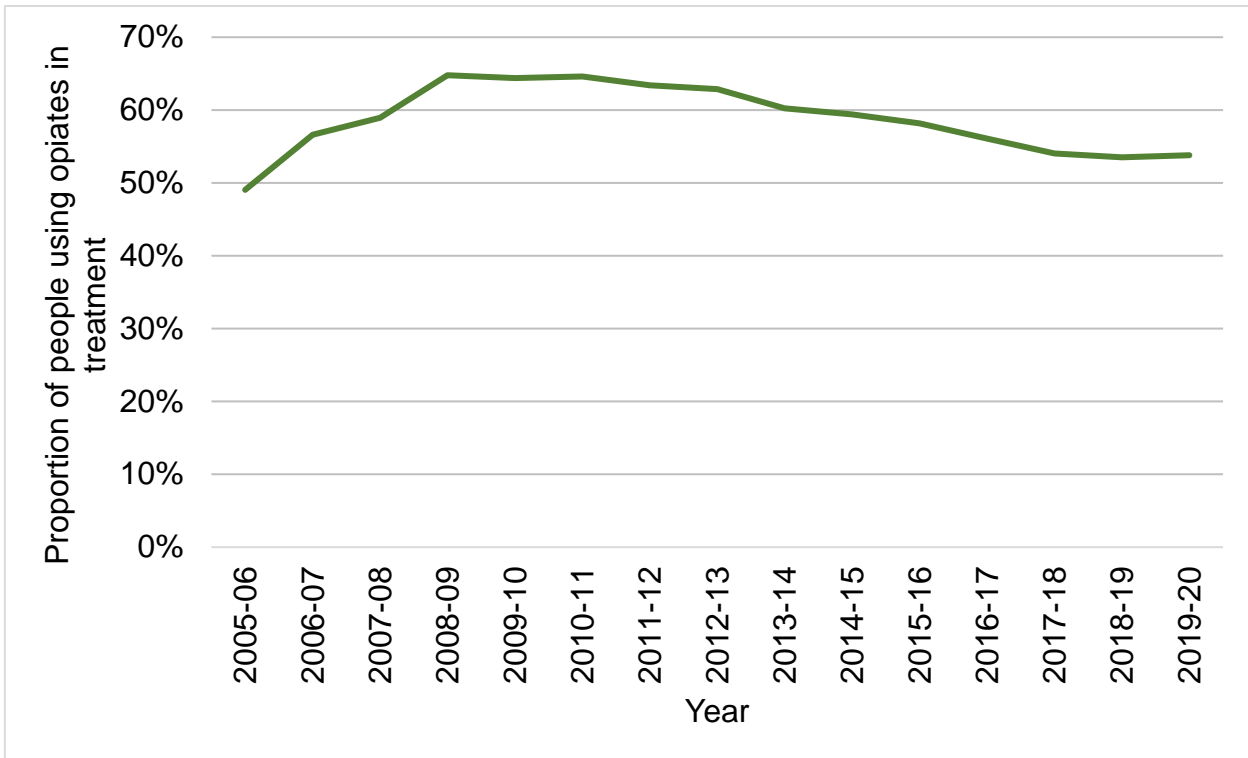
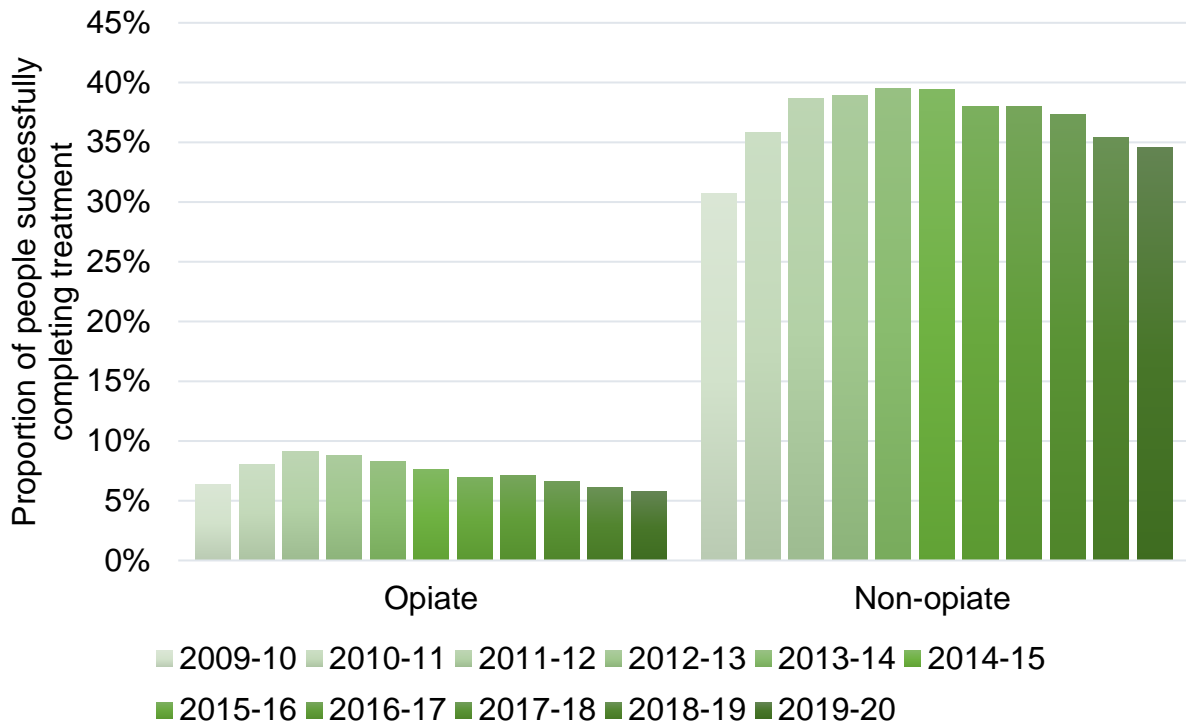


Figure A13 shows the proportion of people using opiates and non-opiate drugs who completed treatment successfully between 2009 to 2010 and 2019 to 2020. The proportion of opiate users completing treatment is much less than that for non-opiate users.

The proportion of opiate users successfully completing treatment peaked at 9% in 2011 to 2012 and has been declining since (it was 6% in 2019 to 2020). The proportion of non-opiate users successfully completing treatment peaked at 40% in 2013 to 2014 and has been declining since (it was 35% in 2019 to 2020).

Figure A13: the proportion of people using opiates and non-opiates who completed treatment successfully between 2009 to 2010 and 2019 to 2020



Deaths in treatment have also sadly increased over the last 7 years with both the number and the rates of opiate deaths now over twice what they were in 2012 to 2013. Although they are much lower, the number and rate of deaths for users of other substance have also increased significantly during this time.

Figure A14 shows the number people who use opiates and the numbers of people who use non-opiates who died while they were in treatment between 2009 to 2010 and 2019 to 2020. The number of opiate users who died increased from 1040 in 2009 to 2010, to a peak of 2010 in 2019 to 2020. The numbers of non-opiate users who died while they were in treatment has also been increasing, but at a much lower level. They have had a general rise from 53 in 2009 to 2010 to 179 in 2019 to 2020.

Figure A15 is a similar chart, showing the proportion of people who use opiates and the proportion of people who use non-opiates who died while they were in treatment between 2009 to 2010 and 2019 to 2020. This is a proportion of all people in treatment. The proportion of opiate users who died increased from 0.6% in 2009 to 2010, to a peak of 1.43% in 2019 to 2020. The proportions of non-opiate users who died while they were in treatment has also been increasing, but at a much lower level. They rose from 0.2% in 2009 to 2010 to 0.37% in 2018 to 2019, before falling slightly to 0.32% in 2019 to 2020.

Figure A14: number of deaths of people who use opiates and people who use non-opiates during treatment between 2009 to 2010 and 2019 to 2020

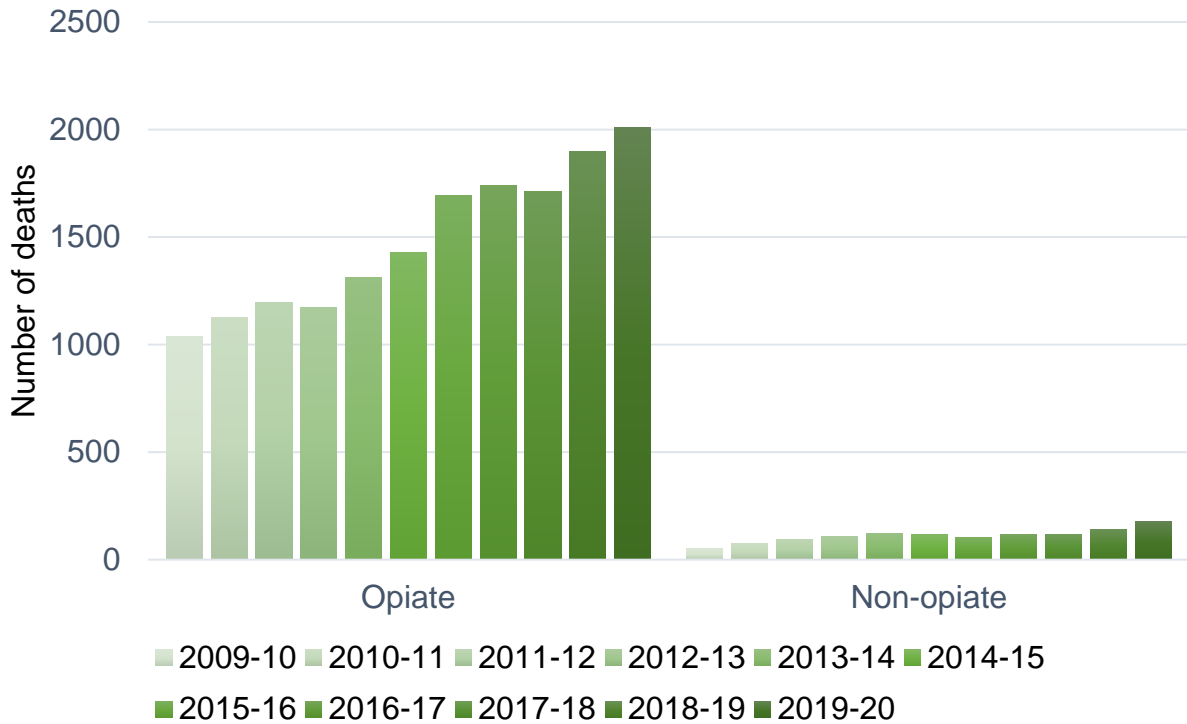
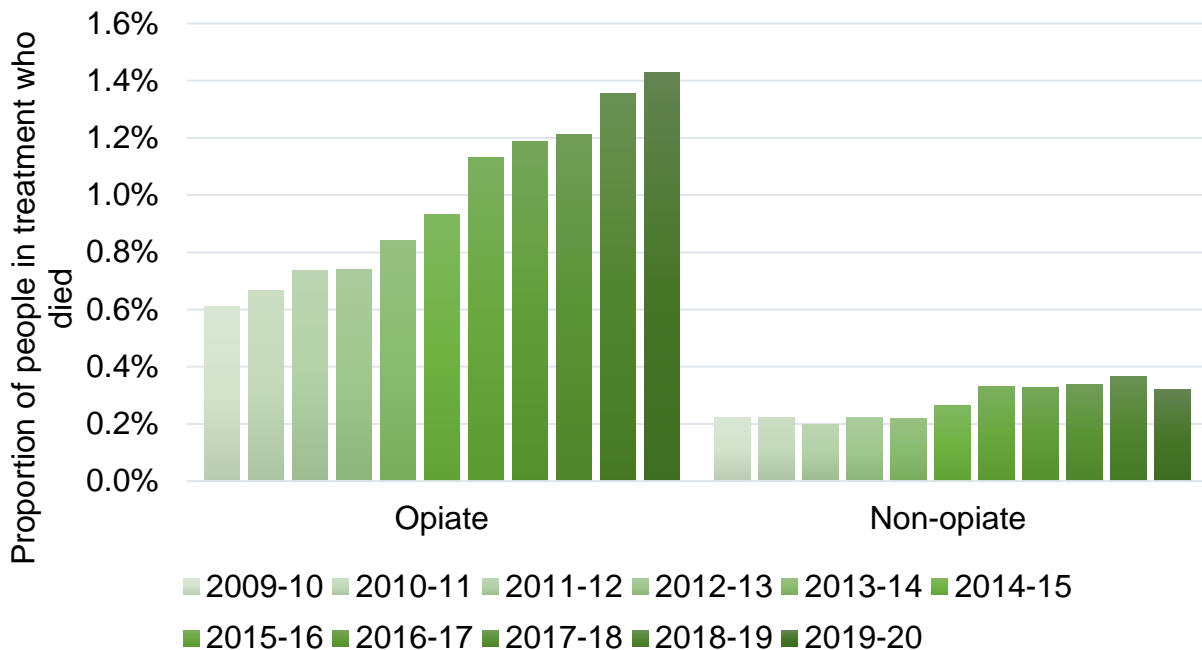


Figure A15: the proportion of people in treatment using opiates and using non-opiates who died between 2009 to 2010 and 2019 to 2020



Poorer treatment outcomes are often associated with deprivation. Figure A16 shows how lower rates of successful completion of treatment by opiate users correlate with higher levels of deprivation. There is a gradual decline in the proportion of people successfully completing treatment as the index of multiple deprivation rises.

Figure A16: proportion of people in treatment for opiate use successfully completing treatment, by index of multiple deprivation (IMD)

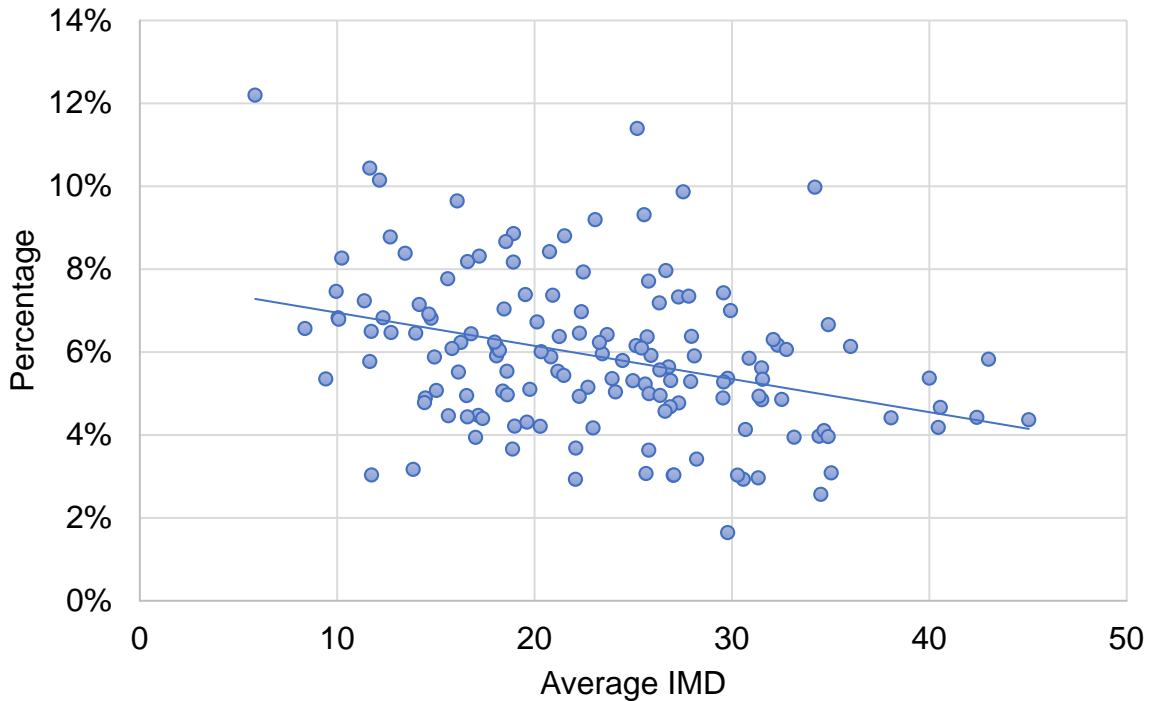
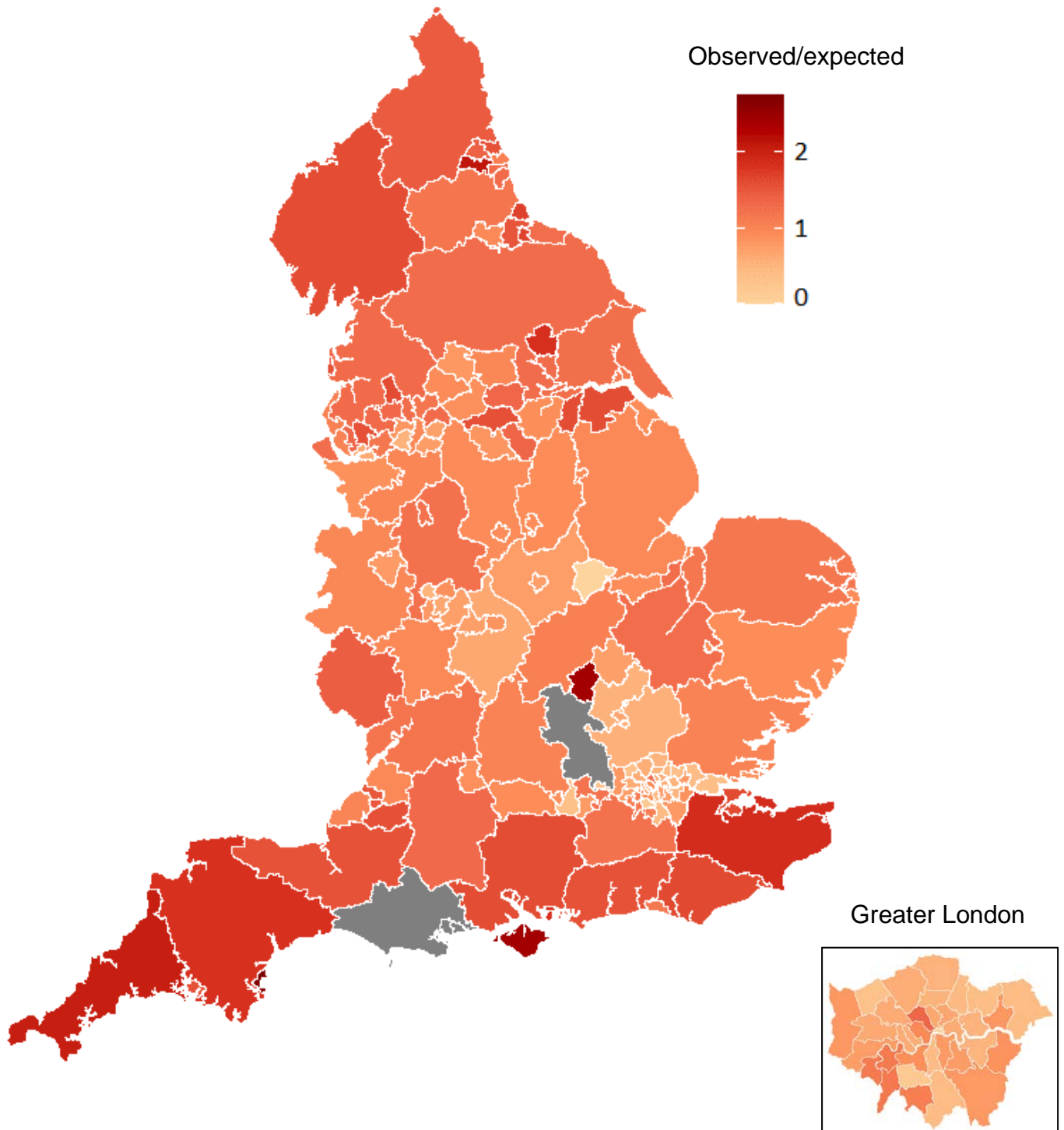


Figure A17 presents the ratio of observed to expected numbers of deaths in treatment. The expected number of deaths adjusts for the substances used and age to estimate the number of deaths you would predict in each local authority based on the profile of people in treatment. The areas that are over 1 (darker red) have more deaths than would be expected and the lighter areas fewer deaths.

It can be seen clearly that most of London has fewer deaths than expected whereas many areas in the north as well as the South West have more deaths than would be expected based on the profile of the treatment population. Overall, just under half of all deaths of people who die while they are in treatment occur in communities in the most deprived quintile of the country.

Figure A17: map showing the ratio of observed to expected numbers of deaths in treatment for each local authority in 2018 to 2019



Note: grey areas indicate low numbers or missing data.

Annex B: methodology

The review drew together evidence from a range of sources, which are described below.

Call for evidence

The call for evidence was made on the government consultation portal and responses were invited from any individual or organisation who wished to respond. It ran for a month from 2 July 2020 until 6 August 2020. The call for evidence asked for responses to 27 questions covering four broad categories, which were:

- prevention and harm reduction
- young people
- treatment and recovery
- cross-cutting issues

The review received 156 responses to the call for evidence. These came from individual members of the public, and from organisations working in the sector or with an interest in drug misuse and treatment from all regions of England. All the responses were read and summarised to draw out the key themes raised, along with any wider evidence cited or examples of best practice. The main themes and areas of consensus or debate for each question were compiled, before summarising into a final report which focussed on the responses which fell within the scope of the review.

Expert reference group

Dame Carol Black invited a group of experts from across the drug misuse sector to inform and guide the review. Members of the expert reference group were selected and invited based on their ability to fulfil some or all the following criteria:

1. Expertise in areas relevant to the review.
2. Seniority or relevant roles in organisations with strategic or national roles relevant to the review.
3. Representatives of government departments involved in implementing the review's recommendations.
4. Experts by experience

Three meetings were held, in which the group provided the review team with advice on which stakeholders to engage, helped the review team to access relevant information and reviewed and commented on findings and draft recommendations. Ultimately, however, the views expressed in this report are those of Dame Carol Black. The full list of expert reference group members was:

- Karen Biggs, Chief Executive, Phoenix Futures
- David Buck, Senior Fellow, King's Fund
- Samantha Cole, lived experience ambassador
- Phil Copple, Director General, HM Prison and Probation Service
- Adrian Crossley, Head of Addiction at the Centre for Social Justice
- Dr Ed Day, UK government's Drug Recovery Champion and Birmingham University
- Sunny Dhadley, lived experience ambassador
- Danny Hames, Chair, NHS Addictions Provider Alliance
- Jason Harwin, Deputy Chief Constable, Lincolnshire Police
- Rachael Hope, Drug Strategy Coordinator, Newcastle City Council
- Ben Hughes, Head of Wellbeing and Public Health, Essex County Council
- Professor Keith Humphreys, Stanford University
- Professor Tim Kendall, NHS England, National Clinical Director for Mental Health
- Dr Euan Lawson, Lancaster University; Acting Editor, British Journal of General Practice
- Jo Lenaghan, Director of Strategy, Health Education England
- John-Paul Marks, Director General for Universal Credit, Department for Work and Pensions
- Noreen Oliver MBE, Founder and manager of BAC O'Connor
- Justin Russell, HM Chief Inspector of Probation
- Professor Sir John Strang, King's College London

- Paul Townsley, Chair, Collective Voice; CEO, Humankind
- Mike Trace, CEO, Forward Trust
- Robin Tuddenham, Chief Executive, Calderdale Council
- Raj Ubhi, National Head of Operations (Young People's Services), Change Grow Live
- Dr Roya Vaziri, Medical Director, Humankind
- Mark Vickers, CEO, Olive Academies
- Donna Ward, Policy Director for Children, Families and Disadvantage, Department for Work and Pensions
- Dominic Williamson, Executive Director of Strategy and Policy, St Mungo's
- Dr Alice Wiseman, Director of Public Health, Gateshead Council
- Councillor Sue Woolley, Bourne North and Morton

List of meetings

Due to COVID-19 restrictions, all meetings were held online. Some were one-to-one, and others were group meetings. Broadly, the review team engaged with organisations working in the sector. This included:

- NHS and third sector organisations
- professional bodies
- mutual aid groups
- individuals with lived experience of substance misuse
- academics who specialised in drug treatment and recovery
- representatives from government departments

The meetings involved the following people:

- Mike Barton, former Chief Constable of Durham Police
- Karen Biggs, Chief Executive of Phoenix Futures

- David Burrows, former MP for Enfield Southgate
- Dame Louise Casey, government advisor on homelessness and Chair of the rough sleeping taskforce
- Adrian Crossley, Head of Addiction at the Centre for Social Justice
- Dr Ed Day, Drug Recovery Champion
- Sunny Dhadley, expert by experience
- Paul Farmer, CEO of Mind
- Dr Michael J Kelleher, Consultant Addictions Psychiatrist and Clinical Lead for Lambeth Addictions and Clinical Advisor to Public Health England on drug and alcohol treatment
- Noreen Oliver MBE, Founder and manager of BAC O'Connor
- Sarah Martin-Denham, Senior Lecturer at the University of Sunderland
- Dr Luke Mitcheson, Consultant Clinical Psychologist, South London and Maudsley NHS Foundation Trust, and Clinical Advisor to Public Health England on drug and alcohol treatment
- Trevor Pearce, Chair of UK Anti-Doping
- Fiona Spargo-Mabbs, Director and Founder of the Daniel Spargo-Mabbs Foundation
- Professor Sir John Strang, Head of the National Addiction Centre at King's College London

The meetings also included representatives from:

- British Psychological Society
- Centre for Social Justice
- Change Grow Live
- Commission on Race and Ethnic Disparities
- Department for Digital, Culture, Media and Sport
- Department for Education

- Health Education England
- The Health Foundation
- Her Majesty's Prison and Probation Service
- Ministry of Housing, Communities and Local Government
- Nelson Trust
- NHS Addictions Provider Alliance
- NHS England
- Public Health England
- Royal College of Emergency Medicine
- Royal College of Nursing
- Royal College of General Practitioners
- Royal College of Physicians
- Welsh Government (Substance misuse team)

Themed roundtable discussions

In July and August 2020, a series of 11 online roundtable discussions were held, based on the following themes:

Commissioning, outcomes, mechanisms and levers

This roundtable included representatives from Public Health Dorset, London Borough of Tower Hamlets, Calderdale Council, DWP, Recovery Group UK, Greater Manchester Combined Authority, Burton Addiction Centre, Forward Trust, Barnet and Harrow Public Health, Centre for Social Justice, SLAM, Brighton and Hove Children, Young People and PH Schools, Newcastle University and The King's Fund.

Criminal justice system

This roundtable included representatives from Public Health England, Hampshire Police, Avon and Somerset Police, Derbyshire PCC, Thames Valley Police, Lincolnshire Police,

West Midlands PCC, HMPPS Probation, HMPPS Prisons, Greater Manchester, Merseyside and Cheshire Prison Group, Delphi Health, User Voice, RECONNECT NHS England, NHS England, Stanford University and the Cabinet Office.

Employment

This roundtable included representatives from Blackpool Council, Royal Mail, Barclays, Blackpool Council, IPS Grow, Foundation for Change, Jobcentre Plus, University of York, DWP, Employment Related Services Association, and Humankind.

Health and mental health

This roundtable included representatives from NHS England and NHS Improvement, Hepatitis C Trust, Greater London Authority, King's College London, Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust, Staffordshire Council, Thameside and Westminster Drugs Project.

Housing

This roundtable included representatives from Voices of Stoke, Greater London Authority, Ministry of Housing, Communities and Local Government and Liverpool City Council.

Recovery networks

This roundtable included representatives from Recovery Group UK, Birmingham University, Hep CU Later, Narcotics Anonymous, Stanford University, Smart Recovery, Lancashire County Council, Aurora Peer mentoring, Cocaine Anonymous, King's College London, The Bridge, Changing Lives, Scottish Recovery Forum, Pushing Change and Faces of Recovery.

Research developments

This roundtable included representatives from South London and Maudsley NHS Foundation Trust, Haringey Council, Single Homeless Project, Homeless Link.

Treatment

This roundtable included representatives from King's College London, Change Grow Live, Humankind, Collective Voice, Greater Manchester Mental Health NHS Foundation Trust, Phoenix Futures, Turning Point, Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust, Bristol Drugs Project, Sefton Council, Recovery Group UK, South

London and Maudsley NHS Foundation Trust, NHS SMPA (now APA), Birmingham University and the British Psychological Society.

Vulnerable children and parental drug use

This roundtable included representatives from DWP, OASIS Project, Early Break, Staffordshire County Council, Olive Academies, Prime Minister's Policy Unit, Adfam, Deputy Chief Medical Officer, What Works for Children's Social Care, Core Education, Manchester Metropolitan University, Essex County Council, Change Grow Live, the Department of Health and Social Care, Adolescent Substance Misuse.

Workforce

This roundtable included representatives from Recovery Connections, Health Education England, We Are With You, Turning Point, Manchester Metropolitan University, Surrey and Borders Partnership NHS Foundation Trust, South London and Maudsley NHS Foundation Trust, Humankind and the Royal College of Physicians.

Young people treatment and targeted prevention

This roundtable included representatives from Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust, We Are With You, Home Office, Early Break, DWP, Office for Civil Society, Devon Y-Smart, Daniel Spargo-Mabbs Foundation, Youth Justice Board, Kent County Council and Change Grow Live.

Attendees were invited to join the roundtables based on expertise and experience (professional or personal) in the theme under discussion.

Lived experience

Throughout the review, Dame Carol met with a number of groups of people with lived experience. These included meetings hosted by organisations such as:

- Expert Link
- Fulfilling Lives programme, National Experts Citizens Group (NECG), facilitated by Revolving Doors
- Leaders Unlocked
- The Nelson Trust
- One Recovery Bucks

- Recovery Connectors
- Recovery Group UK
- WDP

Leaders Unlocked, generously funded by the Health Foundation, also ran 2 youth panels.

The King's Fund rapid evidence assessment

The Department of Health and Social Care (DHSC) commissioned The King's Fund to conduct a rapid evidence synthesis of the likely strengths and weaknesses of different models of commissioning and accountability for drug treatment services in England, to inform the review.

In the rapid evidence synthesis, 5 research questions were explored:

1. What are the strengths and limitations of different approaches to commissioning drug treatment services in England?
2. What are the strengths and limitations of different approaches to accountability for drug treatment commissioning?
3. What can be learned from other services with comparable commissioning and accountability arrangements – such as sexual health services in England - about the overall design of commissioning and accountability arrangements for drug services?
4. What does current practice tell us about wider conditions needed at a system level to ensure the effectiveness of commissioning and accountability mechanisms generally and what does this imply for drugs?
5. How would different approaches to commissioning and accountability align with the broader policy direction of integrated care systems in England and what are the broad implications of this for drugs?

The King's Fund team conducted several targeted literature searches using bibliographic databases (The King's Fund database, Medline and Psycinfo) and the internet. Relevant organisational websites and the references of key documents were also checked for further relevant material.

The team examined evidence submitted to the Department of Health and Social Care as part of the call for evidence on the review and drew on insights from experts at The King's Fund, plus a small number of conversations with commissioners and representatives from

national bodies. As part of the evidence assessment they identified case studies and models, and developed further insights through discussion.

The rapid evidence assessment is published on the [King's Fund and University of York PREPARE website](#).

Workforce survey

A survey of drug and alcohol treatment providers and commissioners was carried out to gain an understanding of the capacity and competencies of the workforce. There were 240 responses from treatment providers, including organisations with a network of providers, and single providers. This information has been used to model the gaps in the workforce, particularly in relation to health professionals, and to better understand the size of the caseloads carried by individual workers.

Official statistics, research reports, and academic literature

Wherever possible, the review ensured that the recommendations are evidence-based and are supported by the available academic literature, relevant statistical data and research findings.

Annex C: costs and benefits of the review recommendations to improve the coverage and quality of treatment, prevention and recovery

Summary

The following presents an overview of the costs and benefits of a proposed 5-year plan to respond to the recommendations in this review. The plan outlined will:

- improve the quality and capacity of the treatment system for both adults and young people
- increase the workforce numbers as well as training and skills, and bring in more qualified health professionals, particularly from mental health backgrounds
- increase the uptake and provision of residential and inpatient detoxification treatment
- ensure that there are well-resourced recovery communities in every area
- increase the provision of harm reduction interventions such as naloxone and needle and syringe exchange programmes
- increase the provision of employment support, housing support, and support for offenders
- create an innovation fund to help tackle recreational use

Additional investment

Table C1 below presents the total additional investment that would be required to implement and deliver the treatment and workforce expansion, as well as the other interventions and support listed above. This additional investment would be needed above the current baseline annual expenditure of £680 million by local authorities on drug and alcohol treatment, prevention and recovery from the public health grant. These estimates are based on a range of factors including staff numbers, stipends and support costs.

Year one would see additional costs of about £120 million rising to £550 million by the last year of the proposed plan. For every £1 invested in the first year, it is estimated there

would be a return on investment of over £2. By the last year this increases to over £5 as more recovery benefits are accrued each year.

Table C1: additional treatment, prevention and recovery costs and benefits across the 5 years of the plan

	Year 1	Year 2	Year 3	Year 4	Year 5
Total costs	£119 million	£231 million	£396 million	£484 million	£552 million
Total benefits	£261 million	£692 million	£1.315 billion	£1.875 billion	£2.381 billion
Net present value	£146 million	£476 million	£958 million	£1.453 billion	£1.917 billion
Benefit cost ratio	2.3	3.2	3.7	4.4	5.1

Additional treatment capacity and workforce

Table C2 below presents the additional numbers we would expect to see enter treatment over the 5 years as well as the increase in the number of inpatient and residential beds that would be used. The initial focus would be on opiate and crack users as well as referrals from the criminal justice system for users of other drugs and alcohol. As the professionalism of the workforce improves, we would then see more referrals for users of non-opiates because effective psychosocial treatments would be more readily available.

Table C2: extra numbers of people expected to enter treatment across the 5 years of the plan

	Year 1	Year 2	Year 3	Year 4	Year 5
Opiate users	3,200	11,000	24,000	29,000	37,000
Crack users	660	1,700	3,300	5,000	6,600
Non-opiate users	1,500	7,300	14,000	19,000	19,000
Alcohol	4,000	9,900	25,000	32,000	32,000

	Year 1	Year 2	Year 3	Year 4	Year 5
Young people	1,600	4,000	8,000	8,000	8,000
Inpatient	1,000	2,800	5,900	7,300	7,900
Residential rehab	610	1,900	4,200	5,200	5,700

The workforce survey referenced in Annex A (commissioned as part of this review) provided information on the current level of provision. It identified that the treatment workforce had been significantly depleted both in terms of overall numbers and specifically when it came to particular profession types.

Table C3 below presents the workforce required across England as part of a 5-year transformation strategy to ensure that caseloads are at manageable and safe levels and that the professionalism of the workforce is increased substantially. This will allow services to achieve better recovery rates and other outcomes for heroin and crack users. It will also provide appropriate interventions to users of other drugs to achieve better recovery rates and outcomes. Recovery rates for non-opiate users are usually higher.

Table C3: workforce required across the 5 years of the plan

	Year 1	Year 2	Year 3	Year 4	Year 5
Social workers	11	28	52	65	78
Pharmacists	3	9	18	23	27
Nurses	100	200	300	375	450
Psychiatrists	20	40	60	75	90
Doctors	33	83	133	167	200
Lead clinical psychologists	20	45	70	88	105
Practitioner psychologists	50	100	200	250	300
Practitioner psychologists – assistants or graduates	80	180	280	350	420
Drug and alcohol workers (generic and criminal justice system)	600	900	1200	1500	1500
Commissioners or coordinators	150	150	150	150	150

Additional outcomes to be achieved with this investment

Drug treatment already provides a wide range of benefits. The proposed 5-year expansion of the treatment system and workforce will build on these benefits, providing more treatment to those that need it as well as better outcomes for both existing and new service users.

These outcomes will include:

- reduced health harms and mortality
- fewer children in care
- reduced offending and reoffending
- more people achieving long term recovery

The biggest impact of these improvements will be seen among individuals, families and communities in the poorest areas of the country.

Preventing drug deaths

Drug-related deaths are at the highest levels since records began with the majority in those aged under 50. The rate of deaths is 4 times higher in the most deprived areas compared to the least.

We estimate that using this investment to increase the number of opiate users in treatment as well as to increase the provision of harm reduction interventions will have a significant impact on preventing overdose deaths.

If the 5-year plan is implemented from the financial year 2022 to 2023, it is estimated that this would reverse the current upward trend of drug misuse poisoning deaths within 2 years and start to show significant reductions in the following 3 years. Table C4 shows the estimated number of opioid overdose deaths that would be prevented.

Table C4: numbers of opiate overdose deaths prevented across the 5 years of the plan

	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Number of opiate overdose deaths prevented	133	339	641	842	1,128	3,084

Increasing long term recovery

With the increased numbers in treatment, expansion of the workforce and improvements to the quality of the workforce, it is estimated that over the 5 years nearly 100,000 adults and young people will achieve recovery and sustain it in the long-term. Table C5 shows the estimated additional people in recovery throughout this time.

Table C5: numbers of extra people in recovery across the 5 years of the plan

	Year 1	Year 2	Year 3	Year 4	Year 5
Cumulative additional people in recovery	4,000	13,000	32,000	57,000	95,000

Reducing crime

Crime benefits are realised immediately for most people entering treatment and are maintained for all the time that they remain in treatment. Crime benefits also accrue for people who leave treatment successfully and sustain recovery.

Table C6 below presents the estimated number of crimes prevented over 5 years for those in treatment and those in recovery during this time. Crimes such as possession or low-level dealing have been excluded.¹ A large proportion of the estimates below would be acquisitive crimes such as shop theft or stealing from vehicles.

¹ Possession offences have been excluded as they are high in volume but almost consist entirely of low level buying and selling of drugs and possession offences. These crimes would still be prevented but as they are technically victimless and the majority would go unreported, there would be no real savings realised.

Table C6: estimated number of crimes prevented across the 5 years of the plan

	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Estimate of crimes prevented (excluding minor possession offences)	100,000	340,000	630,000	800,000	940,000	2,810,000

Wraparound support costs and benefits

Individual Placement and Support

Employment and meaningful activity are one of the key tenets in enabling people to achieve and sustain recovery. Traditional employment interventions have not proven to be that successful with people with drug problems or dependence. Individual Placement and Support (IPS) is an approach that has been demonstrated to be effective with people with mental health issues, but the evidence was weaker for the drug treatment sector.

To improve the evidence for this sector, a randomised control trial of IPS for drug and alcohol users (IPS-AD) was commissioned in 2018. The trial will conclude this year (2021) with early self-reported results looking promising. So, it is proposed that IPS is expanded to all areas of the country over a 3-year period.

Table C7 shows the costs of this expansion and the estimated benefits of doing so.

Table C7: estimated costs and benefits of expanding IPS across the 5 years of the plan

	Year 1	Year 2	Year 3	Year 4	Year 5
Number of local authorities (cumulative)	37	94	150	150	150
Total cost (inflated discount)	£6.2 million	£11.4 million	£16.5 million	£15.9 million	£15.1 million

	Year 1	Year 2	Year 3	Year 4	Year 5
Total benefits (inflated discount)	£7.6 million	£19.5 million	£29.2 million	£28.8 million	£28.4 million
Net present value	£1.4 million	£8.1 million	£12.7 million	£12.9 million	£13.4 million
Cost benefit ration	1.23	1.72	1.77	1.81	1.89

Housing support

We estimate that an additional investment of £150m over a 5-year period is needed to provide housing support services to individuals in treatment with a housing problem alongside the expansion of IPS.

This estimate is based on a model of embedding specialist housing support workers within substance misuse treatment to provide 'floating support' services. In this analysis, these services are rolled out to all local authorities alongside IPS over a 5-year period and the capacity of treatment services is expanded according to the 5-year plan described above. The average costs of providing these services are based on assumptions of an average caseload for a housing support worker.

The estimated number of individuals requiring housing support each year is based on the current number of adults and young people (under 18) in entering treatment with a housing problem and the number of adults with an urgent housing problem that have been in treatment for opiate use for over a year, as measured by the National Drug Treatment Monitoring System (NDTMS) for 2019 to 2020. Fifteen per cent of people entering treatment for the first time are assumed to drop out.

People in treatment who have a housing problem are assumed to have low support needs and those with an urgent housing problem (no fixed abode) are assumed to have high support needs. The analysis also assumes that only 50% of these individuals require housing support and that only 80% of these will take up the services.

Table C8: estimated number of individuals receiving housing support services across the 5 years of the plan

Housing need	Year 1	Year 2	Year 3	Year 4	Year 5
Clients with low-support needs	2,275	4,738	6,688	6,688	6,688
Clients with high-support needs	2,498	4,447	6,026	5,660	5,660

Table C9: estimated total housing support costs across the 5 years of the plan (£ million)

Cost	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Clients with low-support needs	3.4	7.1	10.0	10.0	10.0	40.6
Clients with high-support needs	9.4	18.5	25.9	25.7	25.5	105.1
Programme costs	0.6	0.7	0.7	0.7	0.7	3.4
Evaluation	0.3	0.3	0.0	0.0	0.0	0.6
Total	13.7	26.7	36.7	36.5	36.2	149.7

These cost estimates are based on high-level assumptions about the current need for housing support services among individuals in substance misuse treatment. So as a result, the additional funding that would be needed to provide housing support may differ.

Further work is needed to improve evidence on the gap between housing need and the available housing and housing support for people with alcohol and drug dependency.

Annex D: areas to be covered by the national Commissioning Quality Standard

Based on the findings of the review, the following areas should be covered by the National Commissioning Quality Standard.

1. Thorough data and evidence-based local needs assessments.
2. Multi-agency place-based strategic and commissioning plans are agreed by local health, criminal justice and local authority partners (including housing and employment).
3. Experts by experience are engaged in planning, commissioning and service delivery processes
4. The drug and alcohol treatment workforce is multidisciplinary.
5. Harm reduction services and outreach are a well-resourced part of the system, including needle and syringe programmes and naloxone provision.
6. Non-opiate users are targeted through dedicated capacity based on local need, including younger crack only users, cannabis and powder cocaine users.
7. Specialist young people's services deliver evidence-based treatment interventions, brief and early intervention, and targeted early identification.
8. There is family involvement in treatment and family support needs are met.
9. Every area has a professionalised and psychology led programme of psychosocial interventions.
10. Broader recovery, including housing and employment support, is a core part of the integrated system of care.
11. Aftercare support is sustained and meaningful.
12. Mechanisms and incentives are introduced to ensure that the NHS (particularly mental health trusts) works with drug and alcohol users with multiple and complex needs.
13. Drug and alcohol services provide access to healthcare, such as smoking cessation, lung health and hepatology clinics.

14. Healthcare services target drug and alcohol users with long-term chronic health conditions, including through outreach work in drug and alcohol services.
15. Drug and alcohol services for children and young people work with wider health and social care services to meet complex needs.
16. There are effective pathways into treatment from the criminal justice system including prisons; police custody suites and courts.
17. Each local area encourages the development of (and supports) a recovery community and grass roots organisations which target local populations, including BAME communities, according to local need.
18. Service contracts include capacity to train specialists, support research and implement new interventions.

Annex E: reference documents

The following reports, reviews, guidance and data were important reference documents for this review.

Advisory Council on the Misuse of Drugs. 2021. [Drug-related harms in homeless populations](#).

Dame Carol Black. 2020. [Review of drugs: phase one report](#).

Dame Carol Black. 2020. [Review of drugs: evidence relating to drug use, supply and effects, including current trends and future risks](#)

Department of Health. 2017. [Drug misuse and dependence: UK guidelines on clinical management](#).

Home Office. 2021. [UK government Drug Recovery Champion annual report](#).

Home Office, Prime Minister's Office, 10 Downing Street, Department of Health and Social Care. 2021. [Press release: £148 million to cut drugs crime](#).

Ministry of Housing, Communities, and Local Government. 2020. [Extra help for rough sleepers with drug and alcohol dependency](#).

Ministry of Housing, Communities, and Local Government. 2020. [Rough sleeping questionnaire: initial findings](#).

Ministry of Justice. 2020. [A Smarter Approach to Sentencing](#).

National Health Service. 2019. [NHS Mental Health Implementation Plan 2019/20 – 2023/24](#).

National Health Service. 2019. [The community mental health framework for adults and older adults](#).

National Health Service. 2021. [NHS mental health dashboard](#).

Public Health England. 2018. [Alcohol and drug prevention, treatment and recovery: why invest?](#)

Public Health England. 2020. [Substance misuse treatment for young people: statistics 2019 to 2020](#).

Public Health England. 2020. [Substance misuse treatment for adults: statistics 2019 to 2020](#).

The Health Foundation. 2020. [Press release: Today's public health grant announcement provides some certainty, but more investment is needed over the longer-term](#) (Health Foundation response to the public health grant allocations).