

United Kingdom Drug Situation 2016



UK Focal Point On Drugs



Public Health
England



The Scottish
Government



Department of
Health
An Roinn Sláinte
Máinnystríe O Póistíe



Llywodraeth Cymru
Welsh Government



Home Office

United Kingdom Drug Situation: Focal Point Annual Report 2016

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The United Kingdom Focal Point on Drugs

The United Kingdom (UK) Focal Point on Drugs is based at Public Health England (PHE). It is the national partner of the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) and provides comprehensive information to the centre on the drug situation in England, Scotland, Wales and Northern Ireland.

The Focal Point works closely with the Home Office, other government departments and the devolved administrations. In addition to this annual report, it collates an extensive range of data in the form of standard tables (STs) and responses to structured questionnaires, which are submitted regularly to the EMCDDA. It also contributes to other elements of the EMCDDA's work such as the development and implementation of its five key epidemiological indicators, the Exchange on Drug Demand Reduction Action and the implementation of the Council Decision on New Psychoactive Substances (NPS).

Further information about the UK Focal Point, including previous annual reports can be found on the Focal Point website at <http://www.nta.nhs.uk/focalpoint.aspx>

The EMCDDA's website is www.emcdda.europa.eu

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Acknowledgments

In addition to those already mentioned thanks are extended to:

- staff at the **Home Office** who contributed to this report including Jenna Marsh, Jodie Hargreaves and Laura Udeh;
- staff who contributed from the **Scottish Government** including Fiona Fraser and Frances Warren;
- staff who contributed from **Information Services Division, Scotland** including Joanna Targosz;
- staff who contributed from the **Welsh Government**;
- staff who contributed from **Public Health Wales** including Elizabeth Walsh;
- staff who contributed from **Department of Health, Northern Ireland**, including Deirdre Corrigan;
- staff at **Police Service of Northern Ireland**;
- Andrew Jones, Stefan Jahr and Donal Cairns at the **National Drug Evidence Centre**;
- staff at the **National Crime Agency** including Tony Siggers, Richard Prosser and Vikki Reynolds;
- staff at the **Ministry of Justice** including Maria Angulo, Sarah Morton, Sarah Smith and Graham Mackenzie;
- John McCracken and Stewart Killala at the **Department of Health**;
- Pete Burkinshaw, Steve Taylor, Robert Wolstenholme, Kirsty Blenkins, Michael O’Kane, Virginia Musto, Nino Maddalena and Helen Clark at **Public Health England**.

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Technical Notes

Accompanying Tables

The accompanying tables referenced in the text are published alongside the report on the Focal Point webpage: <http://www.nta.nhs.uk/focalpoint.aspx>. A list of accompanying tables and their data sources is included in Part B of this document.

Cut-off for updates

The 31st December 2016 was used as the cut-off date for developments or publications to be included in this report. Where the terms ‘latest’ or ‘most recent’ are used in relation to statistics, they should be interpreted as meaning the most recent data available as at the end of the calendar year. New statistics, reports, or other relevant developments between the end of the calendar year and the publication of the report have not been factored in.

Executive summary

- Overall drug prevalence in the general population is lower now than ten years ago, with cannabis being the main driver of that reduction. However, there has been little change in recent years.
- The order of drugs most commonly reported by respondents has not changed much over this time, with cannabis most prevalent (6.5%) followed by powder cocaine (2.2%) and ecstasy/MDMA (1.5%), according to the most recent *Crime Survey for England and Wales*.
- Seizures data suggests that herbal cannabis has come to dominate the market. While resin was involved in around two-thirds of cannabis seizures in 2000, it was involved in only five per cent in 2015/16.
- On 26 May 2016, the *Psychoactive Substances Act 2016* came into force in the UK, prohibiting the production, supply, import/export and possession on prison grounds of psychoactive substances, other than those exempted by the legislation. This act was brought in to tackle the trade in new psychoactive substances (NPS) which has steadily grown in recent years. Over 350 premises in the UK trading in NPS have either closed or stopped selling substances covered by the legislation.
- In addition, synthetic cannabinoid receptor agonists (SCRAs), a class of NPS whose use among the prison population and vulnerable people has caused concern, became controlled under the *Misuse of Drugs Act 1971* as Class B substances in December 2016.
- Temporary class drug orders on methylphenidate-related compounds (including ethylphenidate) and methiopropamine have been remade for another 12 months.
- Using the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) definition, which refers to deaths caused directly by the consumption of at least one illicit drug, the total number of drug-related deaths (DRDs) in the UK during 2014 was 2,655; a five per cent increase from 2013 and the highest number reported to date.
- Due to substantial delays being typical between occurrence and registration of DRDs in England and Wales, UK-wide DRD figures are not yet available covering deaths occurring beyond 2014. However, published statistics for DRDs occurring in Scotland during 2015 showed a 15% increase on 2014.
- Deaths registered in 2015 in England and Wales were notably higher than deaths registered in 2014. It is therefore likely that DRD figures for 2015 will set a new record.
- Across the UK there were 2,304 deaths reported which featured an opioid (87% of UK cases). As in previous years, the substance with the largest number of associated deaths was heroin. In contrast to the UK as a whole, tramadol was the most commonly mentioned opioid drug in Northern Ireland.
- The proportion of deaths involving cocaine has risen; however, many of these deaths are believed to be heroin users who also use crack cocaine.
- The number of MDMA-associated deaths in England and Wales rose to 57 cases, returning to levels seen prior to the decrease in availability of MDMA in the late 2000s.
- Over the last decade the average age of death has increased from 37.6 years in 2004 to 41.6 in 2014, with males being younger than females (40.3 years and 44.6 years

respectively). The largest proportion of deaths in the UK in 2014 was in the 40–44 years age group.

- There were 124,234 treatment presentations in the UK in 2015. This total includes for the first time, data from individuals presenting to treatment services in prisons in England.
- Fifty per cent of all treatment presentations in the UK were for primary opioid use, with 26% of all service users presenting for treatment of cannabis use. However, among those who had never previously been in treatment, just under half (48%) of clients had a primary substance of cannabis, compared to 21% who presented for treatment of heroin. The proportions of users presenting for treatment of these substances appear to have stabilised over the past two years.
- The primary drugs cited by those presenting to specialist substance misuse treatment services varied notably between each of the four countries of the UK. While almost half of treatment entrants cited heroin in England, Scotland and Wales, less than 10% did in Northern Ireland.
- Benzodiazepines were cited as a primary problem substance in far greater proportion of cases in Scotland and Northern Ireland than in England or Wales, whereas Wales had a far higher proportion of clients citing amphetamines/methamphetamines than in any of the other countries.
- Treatment data from prisons showed that 27,836 individuals presented to treatment services in English prisons in 2015, with 564 presenting in prison in Northern Ireland; approximately one-quarter of the treatment clients from each country. Heroin was the most common primary substance among clients in England, whereas cannabis was the most common substance in Northern Ireland.
- The use of NPS, and SCRA in particular, remains a growing concern in prisons in the UK. Surveys carried out in England, Wales and Scotland found that around 10% of prisoners reported use of SCRA while in prison, behind cannabis with a prevalence at around 15%.
- The Prisons and Probation Ombudsman has found 64 deaths that occurred in prisons in England and Wales between June 2013 and April 2016 that were associated with NPS. NPS use has also been associated with self-harm incidents, intimidation and violence.
- National Take-Home Naloxone programmes continue to supply naloxone to those exiting prison in Scotland and Wales: there were 932 kits issued by NHS staff in prisons in Scotland, and 146 in Wales, in 2015/16.
- Prevalence of HIV among people who inject drugs (PWID) participating in the Unlinked Anonymous Monitoring (UAM) survey in England, Wales and Northern Ireland in 2015 was one per cent (a similar level to recent years). HIV prevalence among ‘recent initiates’ to injecting substantially increased in 2015 to 2.6%, the highest level seen in the last ten years. However, this likely represents an increase in prevalence among men who have sex with men rather than among the wider population who inject drugs.
- There were 50 new diagnoses of HIV among PWID reported from Scotland, compared with 17 in 2014. This increase was due to an outbreak of HIV in PWID in Glasgow.
- Around 90% of the hepatitis C infections diagnosed in the UK are acquired through injecting drug use. The prevalence of hepatitis C among PWID has remained fairly stable over the last ten years, and was 50% in the UAM survey of PWID in 2015.

- Hepatitis B prevalence rates have also remained stable for 2015 at 13%. This is half the level seen ten years ago, with the decrease likely to be due to the increased uptake of the hepatitis B vaccination among the PWID population.
- The level of direct sharing of needles and syringes reported by participants in the UAM Survey of PWID has declined over the last decade from 28% in 2005 to 16% in 2015. However, levels of concern have increased around the harms associated with people who inject NPS such as mephedrone. One-third of participants in the UAM survey of PWID who were currently injecting mephedrone reported they had shared needles or syringes previously used by someone else.
- *An Independent review into the impact on employment outcomes of drug or alcohol addiction, and obesity* was published in December 2016 and made a number of recommendations to promote employment of those with addictions, including that those making a claim should be required to attend a structured discussion with a healthcare professional on the impact of their health condition on their ability to work.
- The Association for Young People's Health, in conjunction with Public Health England, published *A public health approach to promoting young people's resilience*, to aid policy makers and commissioners. Similarly, Mentor-ADEPIS published a briefing paper aimed at teachers and practitioners on how building resilience can prevent substance abuse.
- The numbers of recorded incidents of possession and supply offences across the UK, and arrests for drug offences in England and Wales, have fallen in 2015/16, continuing the trends seen over the past five years. In 2015/16, 31,342 supply/trafficking offences and 157,271 possession offences were recorded in the UK.
- Heroin purity has continued to rise since the low level seen in the early 2010s, and in 2015 was 44%, more than twice the purity seen in 2011 and 2012 when it reached its nadir. Similarly, cocaine purity, which was at its lowest in 2010, has risen since that time, and in 2015 was also 44%.
- Street level price data from law enforcement agencies suggests that most recorded drug prices have remained stable in recent years.
- The number of cannabis seizures in all forms in England and Wales in 2015/16 decreased, continuing the downwards trend seen in recent years. Cocaine, ecstasy and heroin seizure numbers all remained stable, while the number of crack seizures increased in 2015/16.

1 Overview of illicit drug use in the UK

1.1 Introduction

The UK population was estimated to be 65.1 million according to the 2015 mid-year estimate (Office for National Statistics, 2016d). Eighty-four per cent (54.8 million) live in England, eight per cent (5.4 million) in Scotland, five per cent (3.1 million) in Wales and three per cent (1.9 million) in Northern Ireland. General population surveys (GPS) indicate that cannabis is the most commonly used illicit drug in the UK, and it has been in each year that relevant surveys have been conducted. Treatment demand for cannabis has risen for as far back as there is reliable data, despite prevalence having fallen. Cocaine (in powder form) is the next most commonly used drug, followed by ecstasy.

Although its use in the general population is relatively uncommon (Home Office, 2016a), heroin is associated with causing substantial health and social harm to users as well as the most harm to society (for example in the form of drug-related crime). As such, heroin is of particular importance to policy makers in the UK. Around 80% of people in treatment for issues with drugs cite heroin as a problematic substance (see [section 4.3.3](#)). Crack cocaine is commonly cited as an adjunctive drug by heroin clients in treatment, but its use among the general population is rare in comparison to that of powder cocaine. Poly-use of benzodiazepines and heroin is also common in the UK, particularly in Scotland.

Prevalence of new psychoactive substances (NPS) in GPS is low in comparison to the main traditional drugs (Home Office, 2016a). However, concerns have emerged in recent years regarding use of NPS among prisoners and problem drug users (see [section 5.5.1](#)).

Overall drug use in the UK is lower than it was 10 years ago, principally reflecting a decrease in cannabis use, which, due to its relatively high prevalence, is the main driver of the overall trend.

1.2 Cannabis

1.2.1 Prevalence of cannabis

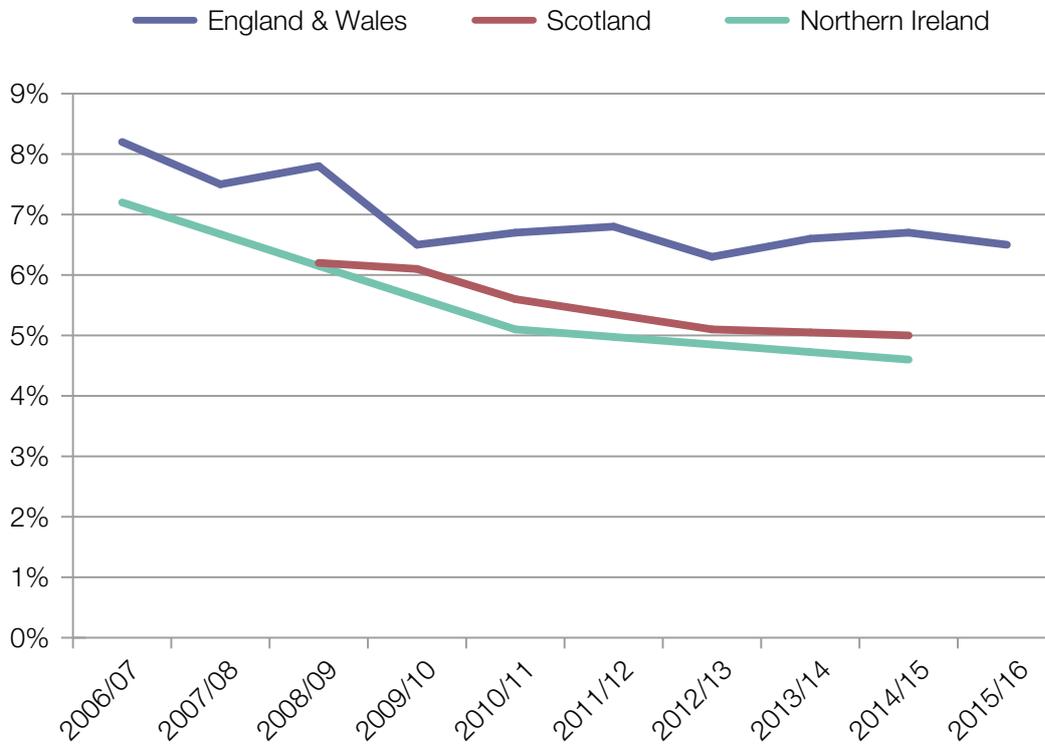
The most recent *Crime Survey for England and Wales* (CSEW) reported that the last year cannabis prevalence rate in 2015/16 was 6.5%, in comparison to 2.2% of respondents using cocaine, the second most commonly reported illicit drug (Home Office, 2016a). Use of cannabis in the general population had been on a long-term downward trend since 2003/04, but the trend since 2009/10 has been relatively flat (see Figure 1.1). Prior to this reduction in prevalence, last year cannabis use reported by the CSEW had been fairly high in comparison with that reported by other European countries; however, this is now at a level that is fairly typical to that seen elsewhere (European Monitoring Centre for Drugs and Drug Addiction, 2015).

Use of cannabis is most common among younger respondents and the long-term downward trend is also more apparent among this group, with last year prevalence for 16–24 year-olds decreasing from a high of 28% in 1998 to 16% in 2015/16. However, this declining trend also appears to be levelling out (Home Office, 2016a).

Similar proportions of last year cannabis use have also been reported in Scotland and Northern Ireland. The *Scottish Crime and Justice Survey* (SCJS) covering 2014/15 showed last year use as five per cent (Scottish Government, 2016c), and the most recent *Drug use in Ireland and Northern Ireland – Drug Prevalence Survey* covering 2014/15 reported last year use at 4.6%

(National Advisory Committee on Drugs and Alcohol (NACDA) & Department of Health Northern Ireland, 2016), although these surveys are not fully comparable.

Figure 1.1: Percentage of adult respondents to prevalence surveys across the United Kingdom reporting last year use of cannabis, by country, 2006/07 to 2015/16

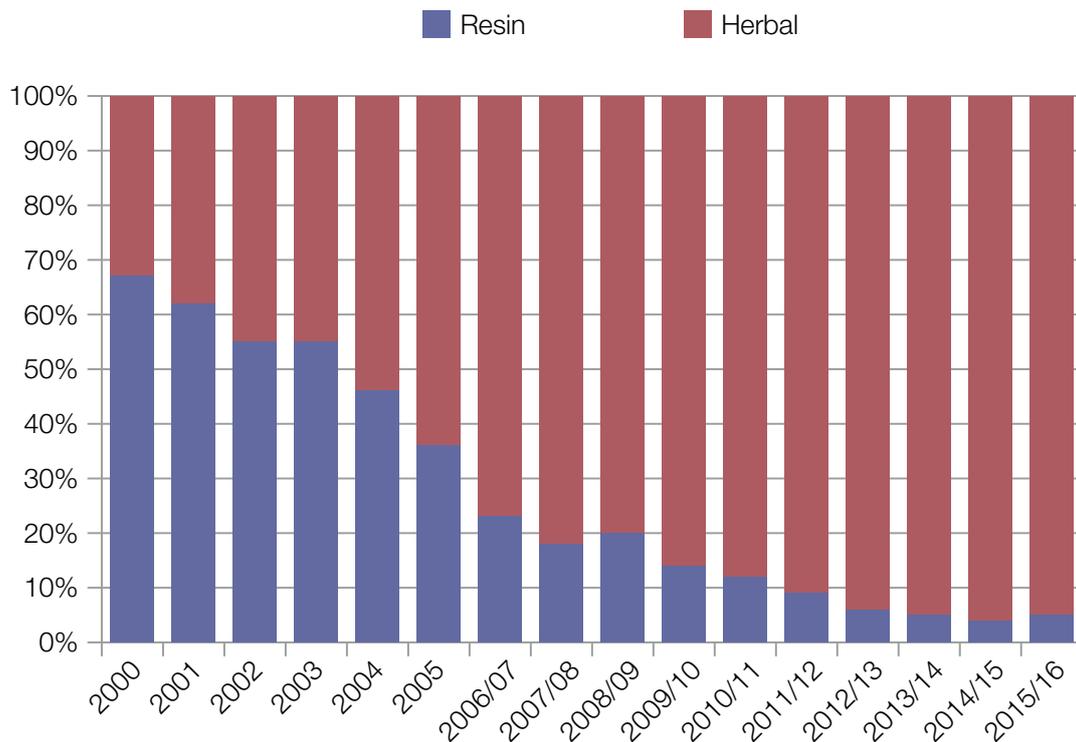


Source: (Home Office, 2016a; National Advisory Committee on Drugs and Alcohol (NACDA) & Department of Health Northern Ireland, 2016; Scottish Government, 2016c)

Rates of use of cannabis in the last month are also fairly similar across the UK: 3.2% in England and Wales; 2.8% in Scotland; and 2.2% in Northern Ireland. The proportion of last year cannabis users in England and Wales that reported having done so more than once a month has fallen in recent years, from 52% in 2009/10 to 37% in the last CSEW (Home Office, 2016a). However, this remains a very high proportion of last year users compared to other drugs.

GPS do not currently report on the use of herbal versus cannabis resin. The 2009/10 CSEW previously showed that 71% of last year cannabis users used herbal cannabis, with 38% using resin (Home Office, 2010a). Seizures data provides insight into the relative prevalence of these forms of cannabis over time. In 2000, over 60% of cannabis seizures made by police forces in England and Wales involved resin (Home Office, 2010b). The proportion of seizures involving herbal cannabis has since greatly increased and in 2015/16 accounted for 95% of cannabis seizures (excluding cannabis plant seizures (see Figure 1.2) (Home Office, 2016g).

Figure 1.2: Percentage cannabis seizures made by police forces in England and Wales by type of cannabis (excluding plants), 2000 to 2015/16



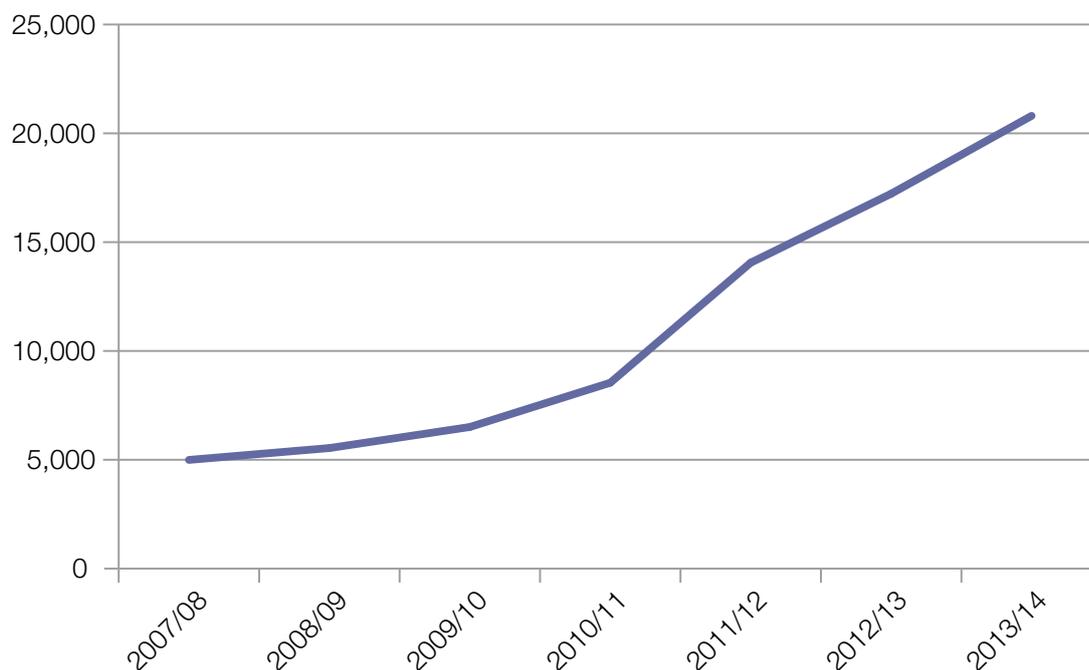
Source: (Home Office, 2010b, 2016g)

1.2.2 Commentary on cannabis trends

All GPS in the UK show a reduction in prevalence of cannabis use since around 2003/04; however, treatment presentations for cannabis (cited as the primary problematic substance) have risen in recent years (see [section 4.4.4](#)). There is no universally agreed explanation for the divergence of these trends, although one possibility is that while fewer people are using cannabis, those who are using it are experiencing greater harm and, as such, are more likely to seek treatment.

Hospital inpatient discharges data produced for the UK Focal Point provides a further indication that the number of people experiencing harms associated with cannabis may be greater in recent years. Figure 1.3 shows data produced for the Focal Point on hospital inpatient discharges for mental and behavioural disorders where cannabinoids was given as one of the diagnoses. Due to the way that hospital data is recorded it is not possible to distinguish between cannabis and synthetic cannabinoid receptor agonists (SCRAs), so some of the rise during this period may be accounted for by NPS.

Figure 1.3: Hospital inpatient discharges across the United Kingdom for mental and behavioural disorders with cannabinoids as one of the diagnoses, 2007/08 to 2013/14



Source: Personal communication – Public Health England, NHS Wales Informatics Service, NHS National Services Scotland, Department of Health Northern Ireland

The increased dominance of high potency herbal cannabis within the UK market and/or the increasing strength and tetrahydrocannabinol to cannabidiol ratio of cannabis are reasons that increased harm from cannabis use might be expected. Freeman and Winstock, publishing on findings from the Global Drug Survey (GDS), found that high-potency skunk was far more commonly associated with negative effects such as memory loss and paranoia, despite being the most popular type of cannabis with respondents (Freeman & Winstock, 2015). Di Forti et al found far greater risk of first episode psychosis among those using skunk-like cannabis versus hash users (Di Forti et al., 2015).

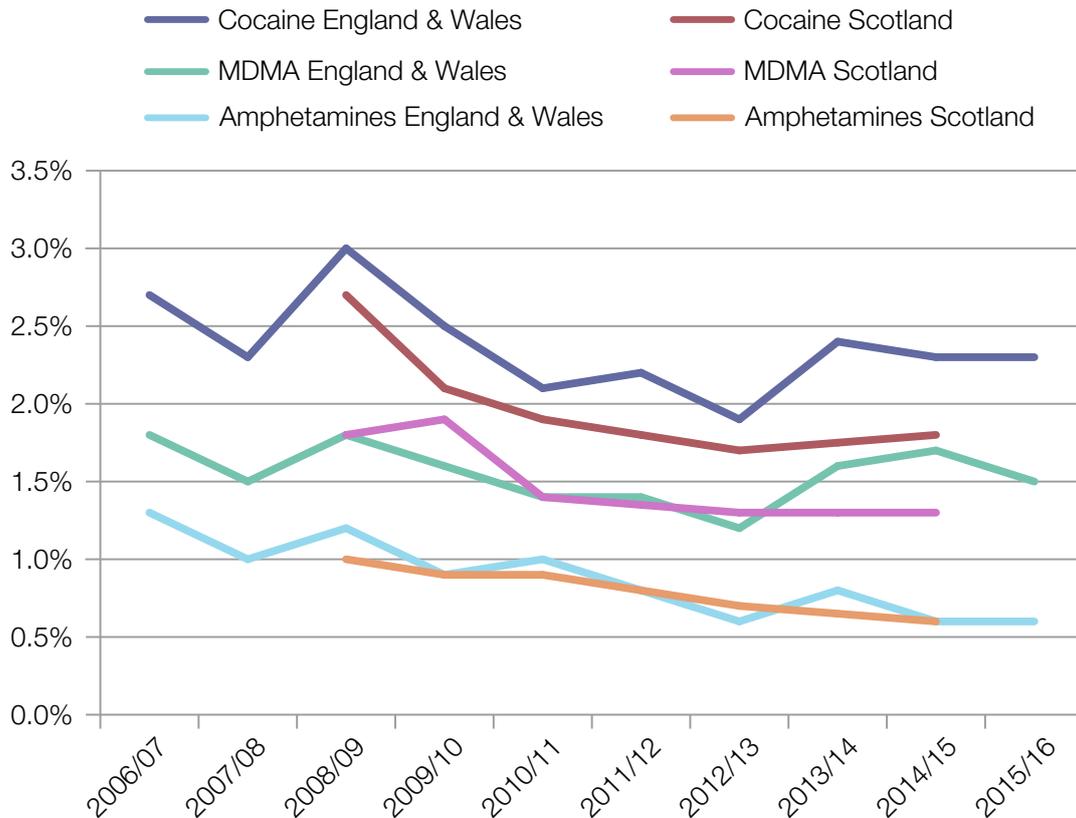
It should be noted that cannabis potency data is not reported for the UK; however, most cannabis consumed in the UK is imported via Europe (see [section 9.2.2](#)) where potency is reported to have risen (European Monitoring Centre for Drugs and Drug Addiction, 2016a).

1.3 Stimulants

There has been a small, long-term downward trend in the overall use of any stimulant drug¹ among 16-59 year-olds reported in the CSEW since the beginning of the time series, from 4.4% in 1996 to around 3.5% in recent years. The dip to 3.0% reported in 2012/13 appears not to be reflective of the longer term trend (Home Office, 2016a). Last year prevalence of cocaine, amphetamine and ecstasy from both the CSEW and the SCJS are shown in Figure 1.4. Of the individual drugs included in the CSEW stimulant category, only amphetamine and amyl nitrite were statistically significantly reduced from 2005/06.

1 'Any stimulant drug' comprises powder cocaine, crack cocaine, ecstasy, amphetamines and amyl nitrite plus methamphetamine since 2008/09 and mephedrone since 2010/11

Figure 1.4: Percentage of respondents to prevalence surveys in England & Wales and Scotland reporting last year use of selected drugs, 2006/07 to 2015/16



Source: (Home Office, 2016a; Scottish Government, 2016c)

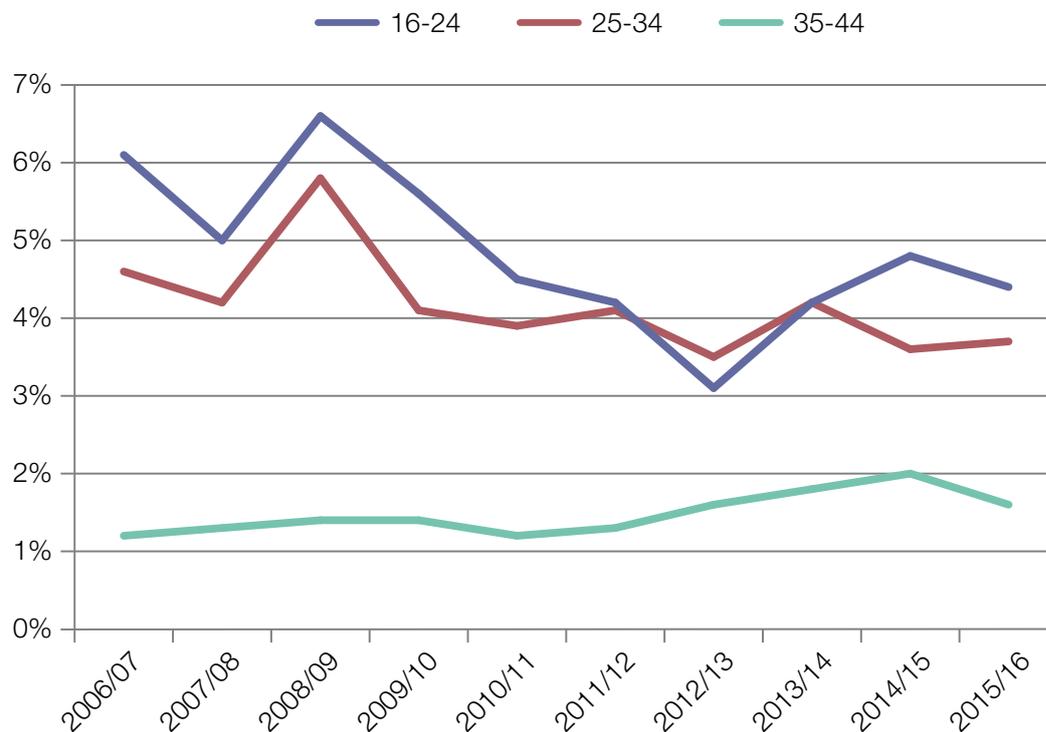
1.3.1 Cocaine

Powder cocaine is the most prevalent stimulant in the UK and the second most prevalent drug overall, with last year use reported at 2.2% in the latest CSEW (Home Office, 2016a). Although varying methodologies and sampling techniques place limitations on the comparability between surveys, this is high compared to prevalence reported for most other European countries (European Monitoring Centre for Drugs and Drug Addiction, 2016a). Analysis of wastewater in a selection of European cities suggests London consumes a relatively large amount of cocaine.² Last year use in both Scotland and Northern Ireland was 1.8% in the most recent surveys available (National Advisory Committee on Drugs and Alcohol (NACDA) & Department of Health Northern Ireland, 2016; Scottish Government, 2016c).

Since 2008/09, an overall fall in the prevalence of cocaine use has been reported in the CSEW (Home Office, 2016a). This appears to have been driven by lower levels of use in younger age groups, suggesting there were fewer initiates among this generation; however, prevalence among those under 35 appear to have stabilised in the past two years. Use among the 35-44 age group has increased over the past decade (see Figure 1.5). This may indicate that a greater proportion of people from this generation are continuing to use cocaine as they transition into middle age than was the case among those born a few years earlier.

2 See: <http://www.emcdda.europa.eu/topics/pods/waste-water-analysis#panel2>

Figure 1.5: Prevalence of last year cocaine use among under 45s in England and Wales by age group, 2006/07 to 2015/16



Source: Personal communication – Home Office

The proportion of powder cocaine users stating that they are frequent users of this drug (ie using powder cocaine more than once a month) dropped from 27% in 2008/09 to 13% in 2009/10, and has remained at around this level since. Eleven per cent of cocaine users stated they were frequent users in 2015/16 (Home Office, 2016a).

Cocaine (powder) is also the most seized stimulant in the UK, both in terms of number and quantity of seizures (see [section 9.5.1](#)). Having been 51% in 2003, the purity of powder cocaine seized in small quantities (ie the category that includes seizures from users) fell to 20% in 2009. However, it has risen since then and was 44% in 2015 (see [section 9.3.4](#)).

Use of crack cocaine is far less common among the general population than use of powder cocaine. Although crack cocaine use is relatively rare, it is associated with very problematic use and drug-related crime, predominantly among those also using opioids. Due to the often chaotic nature of users' lives, it is likely that household surveys underestimate crack use. The last indirect point estimate of problematic crack use in England for 2011/12 put the rate at 4.76 per 1,000 population aged 15-64 years (Hay, Rael dos Santos, & Worsley, 2014).

Having dropped considerably from 2009 to 2011, drug-related deaths with cocaine mentioned on the death certificate (but not necessarily implicated) rose steeply year on year to a record high in 2015. However, this trend broadly reflects the trend in heroin-related deaths and may to an extent be an artefact of the high prevalence of crack cocaine among heroin users (see [section 6.4.2](#)).

1.3.2 Ecstasy (MDMA)

Ecstasy (MDMA) is the second most commonly reported stimulant from UK household surveys: last year use was reported as 1.5% in the 2015/16 CSEW, 0.8% in 2014/15 in Northern Ireland

and 1.3% in the 2014/15 SCJS (Home Office, 2016a; National Advisory Committee on Drugs and Alcohol (NACDA) & Department of Health Northern Ireland, 2016; Scottish Government, 2016c). Prevalence rates among survey respondents in England and Wales have remained generally stable over the past decade, with a small drop in usage seen in 2012/13.

Findings from the CSEW suggest a relatively small proportion of people who use ecstasy do so more than once a month (seven per cent compared with 11% of cocaine last year users) (Home Office, 2016a). As noted with cocaine, there was a large fall in the number of ecstasy users reporting frequent use between 2008/09 and 2009/10, from 14% to 5.5%, and this proportion has remained low since. The age profile for ecstasy is younger than cocaine and amphetamines. While the likelihood of having used any of the most common stimulants in the last year increases substantially with number of visits to nightclubs or to pubs/bars, this is particularly the case with ecstasy (Home Office, 2016a).

MDMA is sold in pill and powder/crystal form. Data for England and Wales shows there was a very sharp fall in the number of ecstasy pills seized from 2007/08 to 2008/09 and the level has not yet returned to that seen before the drop (see [section 9.5.1](#)). Data is not available on the quantity on MDMA seized in powder/crystal form.

Potency has risen in recent years with batches of super strength tablets causing some concern (European Monitoring Centre for Drugs and Drug Addiction, 2016b). After having dropped sharply to a low in 2009, deaths in England involving MDMA have risen in recent years to levels similar to those seen before the drop (Office for National Statistics, 2016c). However, aside from MDMA itself, there have been several deaths since 2011 resulting from overdoses of the far more toxic substances para-methoxyamphetamine (PMA) and para-methoxymethamphetamine (PMMA) which are likely to have been sold to users as ecstasy.

1.3.3 Amphetamine

Last year prevalence of amphetamine use in England and Wales has more than halved since the 2005/06 CSEW. However, despite this long-term downward trend, amphetamine remains one of the most commonly reported stimulants in surveys (0.6% in the 2015/16 CSEW; 0.6% in the 2014/15 SCJS; and 0.5% in the 2014/15 Northern Irish prevalence survey) (Home Office, 2016a; National Advisory Committee on Drugs and Alcohol (NACDA) & Department of Health Northern Ireland, 2016; Scottish Government, 2016c). Although amphetamine prevalence is lower than that of ecstasy, the overall number of amphetamine seizures in the UK is roughly twice that of ecstasy (see [section 9.5.1](#)). This may indicate that amphetamine users are more likely to come into contact with police, higher levels of consumption of amphetamine and/or that amphetamine users (like crack and heroin users) are less well represented in household surveys than users of other drugs.

1.3.4 Methamphetamine

Prevalence of methamphetamine use is low in the UK. Its use is mostly associated with men who have sex with men (MSM) involved in chemsex, and in these instances it is often used alongside mephedrone and GHB/GBL. Injecting and other risky behaviours are high among this group, making this an area for concern (see sections [7.3.1](#) and [7.6.3](#)). Methamphetamine purity is high compared to that of the more commonly used stimulants (around 74% at street level compared with 44% for powder cocaine (personal communication – National Crime Agency)).

1.3.5 Mephedrone

Mephedrone is the only stimulant NPS to have become established alongside traditional substances among recreational drug users within the general population. However, prevalence has fallen since being controlled in 2010. Having been 1.3% (akin to ecstasy) in the 2010/11 CSEW (the first year for which mephedrone prevalence was collected on the CSEW), last year use of mephedrone stood at 0.3% in England and Wales in 2015/16 (Home Office, 2016a).

Last year prevalence of mephedrone in Scotland was reported at 0.3% in 2014/15 (Scottish Government, 2016c). Last year prevalence of mephedrone in Northern Ireland was double the level seen in the rest of the UK, at 0.6% in 2014/15 (National Advisory Committee on Drugs and Alcohol (NACDA) & Department of Health Northern Ireland, 2016). Like ecstasy, the age distribution of mephedrone users is younger than that of either cocaine or amphetamine.

Use of mephedrone is of concern among specific groups such as injecting problematic drug users (particularly in Wales) and MSM due to its association with chemsex.

Data from the European Drug Emergencies Network (Euro-DEN), set up to collect data on patients presenting to emergency departments (EDs) with toxicity caused by drugs of misuse, showed that between October 2013 and September 2014 mephedrone was involved in 176 presentations to three EDs in the UK (two in London; one in York). This accounted for 11% of the total of 1,580 presentations to these centres (Dines et al., 2015). Of the 13 other EDs included in the study, only Dublin and Gdansk showed similarly high rates of presentations for mephedrone.

1.4 Heroin/‘high risk drug use’ and other opioids

1.4.1 Heroin and ‘high risk drug users’

Heroin

Heroin is the most commonly used illicit opioid in the UK. While drugs such as cannabis, cocaine and ecstasy are used by a larger proportion of the population, heroin is associated with causing the most health and social harm to users as well as harms to society in the form of drug-related crime. As such, heroin is of key importance to policy-makers in the UK.

Heroin users make up the majority of the population receiving structured drug treatment (see [section 4.4.3](#)). Of the 59,763 individuals presenting for treatment in 2015 citing an opioid as their primary problem substance, 85% cited heroin. Of the entire presenting population ($n=124,234$), heroin was cited as a secondary drug in just two per cent of cases, indicating that heroin is almost always seen as the most problematic substance for those who use it.

The number of people using heroin rose considerably during the 1980s and 1990s, and many of those still using the drug started using around this time with fewer starting since. As such, the cohort of heroin users is ageing. Since 2003/04 the percentage of primary heroin users entering treatment who were over the age of 40 years has more than trebled, increasing from 10% to 35% in 2015 (see [section 4.4.3](#)).

Supply indicators suggest there was a lull in heroin availability from late 2010 through to 2012, with falls also seen in drug-related deaths and treatment presentations during this period. Heroin-related deaths have now surpassed levels seen before the heroin shortage and are at an all-time high (see [section 6.4.1](#)). The ageing cohort of heroin users is thought to be a factor behind the long-term upward trend in deaths. The median age of those dying from a drug-related death has also risen.

High risk drug use estimates

Due to the association between illicit opioid use and both individual and societal harms, estimating the size of the problem opioid using population is a key element of the evidence base used to formulate policy and inform service provision. However, due to their often chaotic lives, problem opioid users are heavily underrepresented in household surveys (Home Office, 2016a). As such, England, Scotland and Wales all commission regular indirect estimates of their problem drug using populations and they each include problem opioid users within their definitions. While none of the studies include estimates of the number of users of specific opioids, based on the methods used, the target populations are made up principally of current heroin users as well as former users who are successfully managing their problem through opioid substitution treatment (OST).

Estimates of problem drug use (PDU) in the UK are derived using two indirect measurement techniques: the capture-recapture method; and the multiple-indicator method. In England, estimates are produced for opioid and/or crack cocaine users (together and separately) and injecting among users of those drugs. In Scotland, PDU refers to the problematic use of opioids and/or the illicit use of benzodiazepines and drug injecting. Wales have commissioned a new suite of estimates over 11 years with an expanded scope; the last published estimates look at injecting drug use or long duration/regular use of opioids, cocaine and/or amphetamines. The last estimates in Northern Ireland covered 2004 and estimated high risk opioid and/or problem cocaine powder use.

In England, the latest estimates are for 2011/12 (Hay et al., 2014); in Scotland, 2012/13 (Information Services Division, 2014a); and in Wales, for 2014/15 (Public Health Wales, 2015). The estimates of the numbers of high risk drug users in each country are shown in Table 1.1.

Table 1.1: The estimated number of high risk drug users in Great Britain: number and rate per 1,000 population aged 15 to 64, by country

Country	Year	Estimate	95% Confidence Interval		Rate	95% Confidence Interval	
England	2011/12	293,879	291,029	302,146	8.40	8.32	8.63
Scotland	2012/13	61,500	59,900	63,300	17.4	16.9	17.9
Wales	2014/15	58,186	53,104	63,507	–	–	–

Source: (Hay et al., 2014; Information Services Division, 2014a; Public Health Wales, 2015)

1.4.2 Diversion of opioid substitution treatment medications

Medications prescribed in OST are sometimes diverted from the treatment system and, as such, methadone and buprenorphine also form part of the range of drugs used illicitly by the problem opioid using population. Supervised consumption, the need for which is determined in accordance with clinical guidelines (Department of Health England and the devolved administrations, 2007), was introduced in the late 1990s and is an effective way of reducing diversion (Strang, 2010). Given both the source of supply and the population at risk of abusing them, diverted OST medications may be considered an adjunctive issue to the heroin problem.

Drug-related deaths figures from England, Scotland and Wales suggest there may have been an increase in use of diverted methadone during the ‘heroin drought’. This is in contrast to the drop in numbers accessing the treatment system over this period being prescribed this substance legitimately (Home Office, 2015a).

1.4.3 Misuse of prescribed opioids

The misuse of opioids prescribed for pain-relief (for example tramadol and codeine) among the general population is a concern, particularly given the increasing practice of prescribing such medicines; however, the UK does not have a problem similar in scale to that of the USA.³ While 7.4% of respondents to the CSEW in 2015/16 reported non-prescribed use of prescription only pain-killers, only 0.2% had done so for the feeling it gave (as opposed to having done so for medical reasons) (Home Office, 2016a). Although the number of tramadol-related deaths has risen substantially in recent years, the inclusion of such cases in official drug misuse death statistics is due to the definition used for these statistics which counts any death involving a substance controlled under the *Misuse of Drugs Act 1971* (see [section 6.4](#)).

1.5 New psychoactive substances and other drugs

1.5.1 Prevalence of new psychoactive substances

Data from the 2015/16 CSEW shows that 2.7% of 16-59 year-olds in England and Wales reported ever taking an NPS, with 0.7% of 16-59 year-olds reporting having used an NPS in the past year (Home Office, 2016a). Those who reported use of an NPS in the last year had most commonly used a herbal smoking mixture (52%); one-fifth had used a powder, crystals or tablets (22%); three per cent had used a liquid; and 22% had used another type of substance.

Prevalence of NPS use among the general population in Scotland and Northern Ireland is slightly lower than that seen in England and Wales. In 2014/15, 2.2% of adults aged 15-64 in Northern Ireland reported ever using an NPS (excluding mephedrone), and 0.3% reported last year use, compared to 2.8% and 0.8%, respectively, in England and Wales in the same year (Home Office, 2015a; National Advisory Committee on Drugs and Alcohol (NACDA) & Department of Health Northern Ireland, 2016). The SCJS in 2014/15 found that 1.6% of adults aged 16 and over had ever used an NPS or 'legal high', and 0.4% had used one of these substances in the last year (Scottish Government, 2016c).

1.5.2 Synthetic cannabinoids

Prevalence of synthetic cannabinoids

When the CSEW asked about last year use of 'Spice' and other SCRAs in 2011/12, prevalence was low at 0.1% (Home Office, 2012). Although 'Spice' has been removed from the CSEW, respondents who report having used an NPS (0.7% of adults) are also asked what type of product they used on the last occasion. Over half (52%) of last year NPS users in 2015/16 reported that the NPS they had last used was a herbal smoking mixture (Home Office, 2016a).

As with heroin use (see [section 1.4.1](#)), SCRA prevalence may be underestimated by household surveys such as the CSEW, as use of these substances is believed to be particularly high among homeless and vulnerable people, as well as those in prison (see [section 5.4.2](#)). In Scotland, a recent survey attempted to establish the level of use of NPS among a number of vulnerable or potentially at risk groups, including people who inject drugs, mental health service users, vulnerable young people, homeless people and MSM (Scottish Government, 2016e). SCRAs were the most commonly used type of NPS in the survey population alongside benzodiazepine-type NPS (both used by 41% of users who had used NPS in the past six months). SCRA

3 See: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/456464/ACMD_DISM_Interim_Advice_-_Aug_15.pdf

use was particularly high among those NPS users in contact with mental health services, and homeless people, vulnerable young people, and people who inject drugs.

SCRAs are rarely cited as problematic by those seeking help from specialist drug treatment services compared to traditional recreational drugs. Data from the English National Drug Treatment Monitoring System showed that 1,277 clients in treatment during 2015/16 cited either primary or adjunctive problematic use of SCRAs, whereas 59,918 cited cannabis (Public Health England, 2016a).

Problems associated with synthetic cannabinoids

Despite the apparent low prevalence of use and low treatment presentations, SCRAs have caused concern in the UK with regard to hospital presentations. The UK National Poisons Information Service (NPIS) provides advice to healthcare professionals on the clinical management of potentially poisoned patients via telephone enquiries from the healthcare workers, or via the online database TOXBASE. In 2014/15 SCRAs were the most enquired-about class of drugs of misuse to the NPIS, with 454 phone calls made to the service in this year, compared to the next most commonly enquired about substance, cocaine, with 164 calls (National Poisons Information Service, 2015). This represented a huge increase since 2011/12, when SCRAs were the 25th most common subject of telephone enquiries to the NPIS regarding drugs of misuse (National Poisons Information Service, 2012).

The TOXBASE entry for SCRAs was the sixth most commonly accessed drug of misuse TOXBASE entry in 2015/16 with 4,770 accesses, an increase of 88% from 2,544 accesses in 2014/15 (National Poisons Information Service, 2016). This suggests that presentations to healthcare services by patients experiencing SCRA-induced toxicity are not uncommon.

SCRAs have become an established drug within prisons in the UK. Recent reports have shown that 10% of prisoners surveyed in England and Wales, and nine per cent of prisoners in Scotland, had taken SCRAs while in prison (Her Majesty's Inspectorate of Prisons, 2015; Scottish Prison Service, 2015a) (see [section 5.4.2](#)). There have been many reports of issues stemming from heavy use of SCRAs in prisons, including health effects, debt, violence, bullying, self-harm, suicide and death (see [section 5.5.1](#)).

1.5.3 Synthetic cathinones

Mephedrone is the most established and prevalent synthetic cathinone in the UK, and is the only one specifically asked about on any of the GPS. Last year prevalence of mephedrone use in the latest CSEW (2015/16) was 0.3%, which is the same level reported in the latest SCJS (2014/15) (see [section 1.3.5](#)).

In Northern Ireland, 2.6% of clients presenting to treatment reported primary synthetic cathinone use in 2015; in England, this proportion was 1.4%. The proportion of synthetic cathinone clients presenting to treatment in Northern Ireland in 2015 was more than double that of crack, amphetamines, methamphetamines and MDMA combined (see accompanying table Treatment 1).

1.5.4 Nitrous oxide

In recent years, use of nitrous oxide has increased in the UK, in particular among young people. In the 2013/14 CSEW, 2.3% of 16-59 year-olds and 7.6% of 16-24 year-olds reported using nitrous oxide in the past year (Home Office, 2014). Nitrous oxide use appears to be less common in Scotland, with 0.5% of adults aged 16 and over reporting use of this gas in the last year

(Scottish Government, 2016c). Among the UK respondents to the 2016 GDS, 34% reported that they had used nitrous oxide in the past year, with 48% of UK clubbers reporting last year use (up from 34% in 2014) (Global Drug Survey, 2016). This made nitrous oxide, according to the GDS, the fourth most common drug used by clubbers in the UK (excluding alcohol, tobacco and caffeine).

1.5.5 GHB/GBL

Prevalence of GHB/GBL use was first asked about in the CSEW in 2009/10, and was removed from the CSEW in 2012/13 (Home Office, 2013). Prevalence has been low among all respondents to the CSEW, with the overall last year use recorded as between 0.0% and 0.1% in the 2009/10, 2010/11 and 2011/12 surveys (when GHB/GBL was included in the CSEW) (Home Office, 2010a, 2012). However, use of GHB/GBL is believed to be higher among MSM, who use this substance during chemsex (Abdulrahim, Whiteley, Moncrieff, & Bowden-Jones, 2016).

Data from Euro-DEN suggests that London has greater use of GHB/GBL than other European cities included in the study (Dines et al., 2015). Of the 711 GHB/GBL presentations to the 16 participating EDs across Europe between October 2013 and September 2014, more than half (380; 53%) were to St Thomas' Hospital or King's College Hospital in London. GHB/GBL was the most common drug seen on presentation to St Thomas' Hospital, and was involved in almost one-third of all drug-related presentations to this ED (293/956; 31%). By comparison, GHB/GBL was not seen in any of the 202 presentations to York Hospital.

Deaths involving GHB/GBL in England and Wales increased in the late 2000s, going from four deaths in 2005 to 20 deaths in 2008. However, the number of deaths has fluctuated around 20 in the years since. There were 26 deaths where GHB was recorded on the death certificate in 2015 (Office for National Statistics, 2016c).

1.5.6 Image and performance enhancing drugs

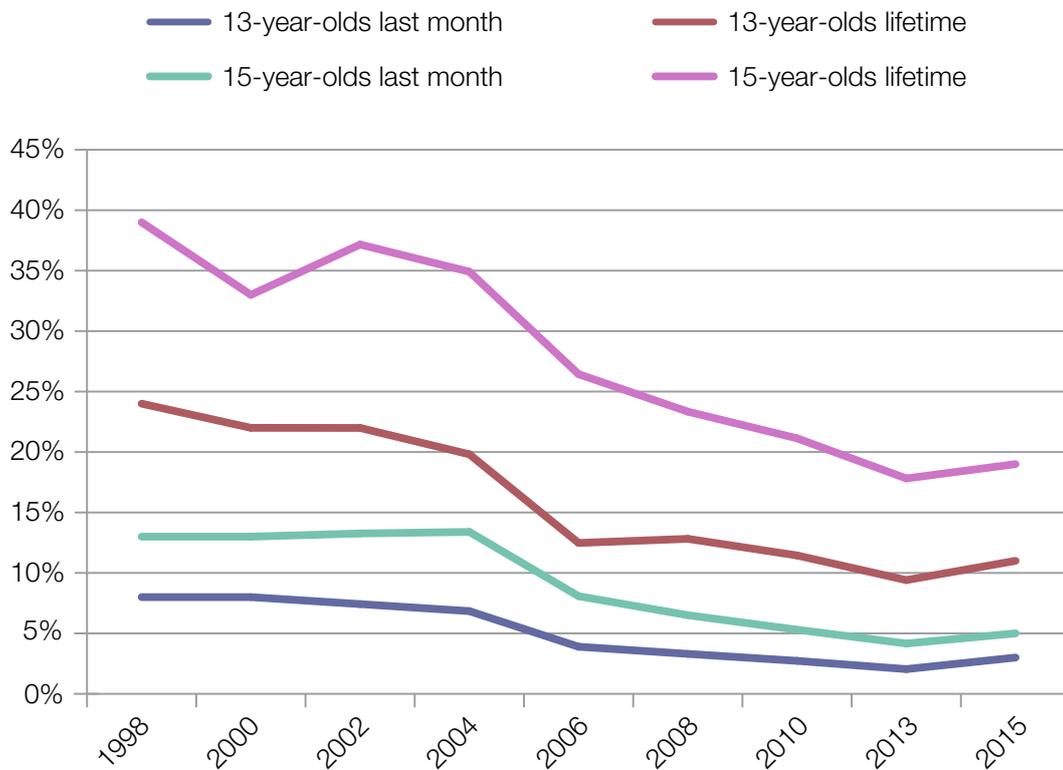
Limited information exists regarding the prevalence of image and performance enhancing drugs (IPEDs). The latest CSEW estimated that in 2015/16 lifetime prevalence among 16-59 year-olds was 0.8%, a slight decrease from 2014/15, with last year prevalence at 0.2%, the same as 2014/15 (Home Office, 2016a). IPED use was less prevalent in the 16-24 age group, with lifetime and last year prevalence at 0.7% and 0.1%, respectively, among these respondents.

1.6 Drug use in the school population

1.6.1 Scottish Schools Adolescent Lifestyle and Substance Use Survey

The *Scottish Schools Adolescent Lifestyle and Substance Use Survey* (SALSUS) was last carried out in 2015 and results were published in October 2016 (Scottish Government, 2016d). Following long-term decreases in lifetime and last month use of drugs by both 13-year-olds and 15-year-olds, there were small increases in use reported in the 2015 SALSUS (see Figure 1.6). Eleven per cent of 15-year-olds and three per cent of 13-year-olds stated they had used drugs in the month prior to the survey, with 19% of 15-year-olds and five per cent of 13-year-olds reporting lifetime use. Cannabis was the most commonly reported drug, used by 17% of 15-year-olds ever and 10% in the past month. Ecstasy and NPS had ever been used by five per cent of 15-year-old respondents (three per cent and two per cent, respectively, in the past month); cocaine had been used by four per cent of 15-year-olds in their lifetime (two per cent in the past month).

Figure 1.6: Percentage of 13-year-olds and 15-year-olds reporting last month and lifetime use of drugs in the Scottish Schools Adolescent Lifestyle and Substance Use Survey, 1998 to 2015

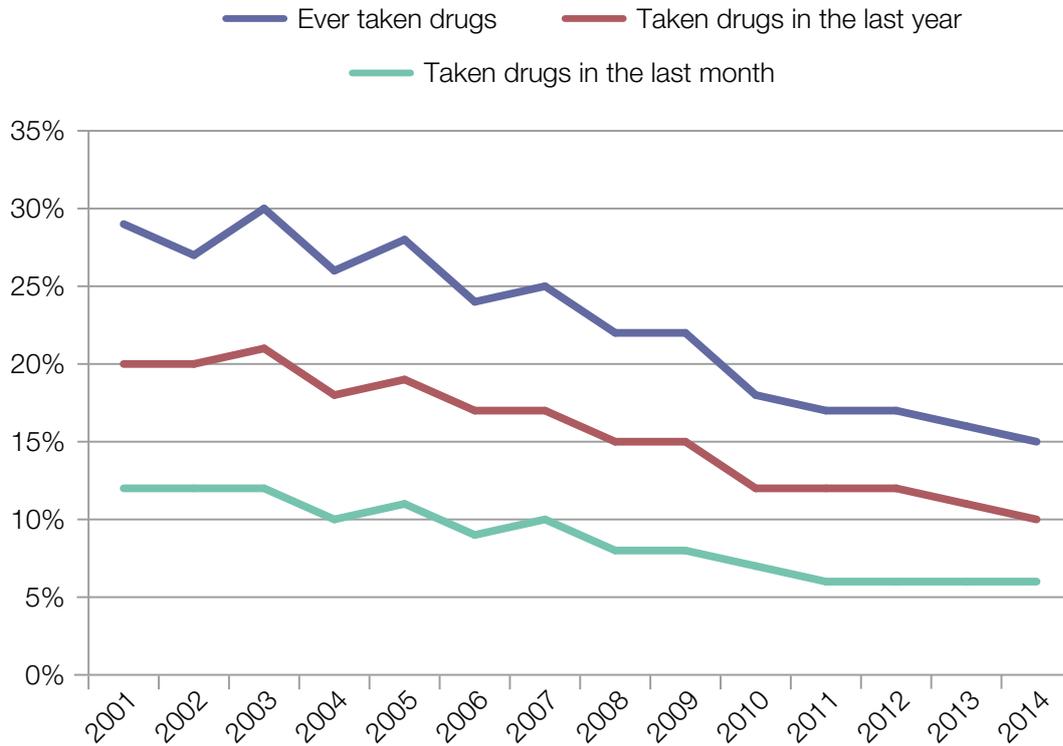


Source: (Information Services Division, 2014b; Scottish Government, 2016d)

1.6.2 Smoking, drinking and drug use amongst young people in England

Data from the *Smoking, drinking and drug use among young people in England* survey (SDD) showed that the prevalence of drug use among 11 to 15 year-olds in England is continuing to decline, although at a slower rate than in the period between 2001 and 2010 (see Figure 1.7) (Health and Social Care Information Centre, 2015).

Figure 1.7: Percentage of pupils aged 11 to 15 years who have taken drugs ever, in the last year and in the last month, 2001-2014



Source: (Health and Social Care Information Centre, 2015)

In 2014, 15% of pupils aged 11 to 15 years old had ever taken drugs, 10% had used drugs in the last year (recently), and 6.1% had used drugs in the last month. Cannabis was the most prevalent drug, with 6.7% of pupils using it in the last year. Volatile substances⁴ were the second most common, with 2.9% of pupils having used them recently.

The proportion of pupils (aged 11-15) reporting use of stimulants in the last year has come down from 6.9% in 2007 to 2.1% in 2014. The decline in prevalence rates over this period was most prominent for poppers which had been the most commonly reported stimulant in the SDD in 2007, with 4.9% reporting use in the last 12 months compared with 1.8% for cocaine (the next most prevalent stimulant) (Health and Social Care Information Centre, 2015). Only 0.7% reported using poppers in the last 12 months in the 2014 SDD compared with 0.9% reporting cocaine.

4 Glue, gas, aerosols or solvents.

2 Drug policy

2.1 Introduction

The UK government is responsible for setting the overall strategic approach to reducing drug harms and for its delivery in the devolved administrations in matters where it has reserved power. As such, policies concerning health, education, housing and social care are confined to England; those for policing and the criminal justice system cover England and Wales; and the work of the Department for Work and Pensions (DWP) applies to England, Scotland and Wales.

The *Drug Strategy 2010, Reducing demand, restricting supply, building recovery: supporting people to live a drug-free life* (Her Majesty's Government, 2010) emphasises supporting those who are drug dependent to achieve recovery and includes dependence to prescription and over the counter medicines as well as tackling new psychoactive substances (NPS). In addition to the drug strategy produced by the UK government, each of the devolved administrations has produced their own drug strategy, which reflects their ideology and the devolution of responsibilities to the national government.

The Scottish government and Welsh government's national drug strategies were published in 2008 (Scottish Government, 2008d; Welsh Assembly Government, 2008a), the latter combining drugs, alcohol, and addiction to prescription drugs and over the counter medicines. Each strategy aims to make further progress on reducing harm and helping individuals recover from their drug problems. The Scottish and Welsh strategy documents are also accompanied by an action or implementation plan, providing a detailed set of objectives, actions and responsibilities, expected outcomes, and a corresponding timescale for delivery (Scottish Government, 2008d; Welsh Assembly Government, 2008b).

Northern Ireland's strategy for reducing the harm related to alcohol and drug misuse, the *New Strategic Direction for Alcohol and Drugs* (NSD), was launched in 2006 (Department of Health Northern Ireland, 2006). The strategy contained actions and outcomes, at both regional and local level, to achieve its overarching aims. A review of the strategy was conducted in 2010, and, after consultation, a revised strategy, the *New Strategic Direction for Alcohol and Drugs Phase 2, 2011-2016*, was launched in January 2012 (Department of Health Northern Ireland, 2011).

The drug strategies in Wales and Northern Ireland are underpinned by performance management frameworks, including Public Service Agreements and associated sets of performance indicators, against which progress is measured.

2.2 Current national drug strategies and action plans

A summary of the UK and devolved administrations' drug strategies is given below. While none of these strategies have yet been formally evaluated, outlines of the most recent reviews have been included.

2.2.1 United Kingdom

The UK *Drug Strategy 2010, Reducing demand, restricting supply, building recovery: supporting people to live a drug free life* (Her Majesty's Government, 2010) was published in December 2010. This strategy places greater emphasis than preceding strategies on supporting those

who are drug dependent to achieve recovery and on the provision of the integrated support necessary to enable this, such as housing and employment.

The 2010 drug strategy widened its focus to include dependence on all drugs, including prescription and over the counter drugs, as well as tackling the emergence of NPS. It highlighted a shift in responsibility away from central government to locally led treatment plans. New legal powers aimed at restricting the supply of drugs were also introduced, including Temporary Class Drug Orders for NPS (see [section 8.2](#)) and new powers to seize cutting agents and precursor chemicals.

The Home Office currently leads on the implementation of the strategy within England, and with regard to reserved matters elsewhere.

Drug strategy annual review

In February 2015, the Home Office published the *Drug Strategy Annual Review: A balanced approach* (Home Office, 2015b), highlighting both key achievements and future priorities for all three strands of the drug strategy (reducing demand, restricting supply and building recovery).

Key achievements included:

- the continued expansion of the Troubled Families programme (see [section 3.5.2](#))
- the 2015 launch of the ‘Rise Above’ online resource (see [section 3.4.1](#))
- implementation of new legislation including the *Serious Crime Act* (Her Majesty’s Government, 2015c) and the introduction of a drug-driving offence
- the addition of a new condition to the Public Health Grant to encourage local authorities (LAs) to invest in the provision of high quality drug and alcohol treatment services
- the provision of £5 million to the Health Premium Incentive Scheme for 2015/16, to be distributed to LAs who can show a two per cent improvement in the number of successful completions for treatment

The review also included progress made towards meeting other potential needs of those in treatment for substance misuse, such as statutory guidance on social housing and improvement of training packages at Jobcentre Plus.

Recommendations/priorities cited for the next year included:

- the promotion of evidence-based practice in schools, the continuation of funding for the Alcohol and Drug Education and Prevention Information Service (ADEPIS) and addressing wider aspects associated with potential substance misuse such as reducing the number of youths who are not in education, employment or training
- increased collaboration between police, festival organisers, night time economy stakeholders and LAs, the implementation of the National Institute for Health and Care Excellence (NICE) NSP guidance and the continued roll-out of Liaison and Diversion (L&D)⁵ schemes (see [section 8.5.1](#))

5 L&D schemes are designed to identify, assess, screen and refer offenders who have mental health, learning disability, substance misuse or other vulnerabilities to an appropriate treatment or support service. See: <https://www.england.nhs.uk/commissioning/health-just/liaison-and-diversion/ld-about/>

Future work will also include:

- a crackdown on UK-based websites in violation of the *Misuse of Drugs Act 1971* (Her Majesty's Government, 1971); and increased access to centralised data on drug testing on arrest to enable the identification of local trends.

2.2.2 Scotland

The Scottish government's national long-term drug strategy, *The Road to Recovery: A new approach to tackling Scotland's drug problem*, was published in 2008 (Scottish Government, 2008d). Central to the strategy is the concept of recovery and supporting people to live a drug-free life as active and engaged members of society. It has received cross-party support from the Scottish Parliament. The strategy includes multiple objectives across five principal action areas: promoting recovery; delivering the recovery model; prevention; enforcement; and children affected by substance misusing families.

The key priorities of the strategy are:

- better prevention of drug problems, with improved life chances for children and young people, especially those at particular risk of developing a drug problem, allowing them to realise their full potential in all areas of life
- to see more people recover from problem drug use so that they can live longer, healthier lives, realising their potential and making a positive contribution to society and the economy
- having communities that are safer and stronger places to live and work because crime, disorder and danger related to drug use have been reduced
- ensuring that children affected by parental drug problems are safer and more able to achieve their potential
- improving the effectiveness of delivery at a national and local level

To help achieve these priorities, the Scottish government has developed an alcohol and drugs quality improvement framework to ensure quality in the provision of care, treatment and recovery services, as well as quality in the data that will show the outcomes people are achieving (Scottish Government, 2014) (see [section 4.2.2](#)).

In Scotland, the 2015/16 *Updated Guidance for Alcohol and Drug Partnerships (ADPs) on Planning and Reporting Arrangements* (Scottish Government, 2015b) identifies nationally agreed core outcomes and indicators that all ADPs are expected to deliver against. The Scottish government has developed a Recovery Outcomes Web tool, which will form part of the new national Drug & Alcohol Information System (DAISy), which aims to support the tracking of progress towards recovery for individuals in drug (and alcohol) services.

2.2.3 Wales

The Welsh government also published its long term substance misuse strategy, *Working together to reduce harm 2008-2018*, in 2008 (Welsh Assembly Government, 2008a). The strategy combines drugs, alcohol, and addiction to prescription drugs and over the counter medications. It has a clear focus on reducing the harms associated with substance misuse, citing its four aims as:

- reducing the harm to individuals (particularly young people), their families and wider communities from the misuse of drugs and alcohol, while not stigmatising substance misuse
- improving the availability and quality of education, prevention and treatment services and related support, with a greater priority given than under the previous strategy to those related to alcohol
- making better use of resources – supporting evidence based decision making, improving treatment outcomes, developing the skills base of partners and service providers by giving a greater focus to workforce development and joining up agencies and services more effectively
- embedding the core Welsh Assembly government values of sustainability, equality and diversity, support for the Welsh language, and developing user-focused services and a rights base for children and young people in both the development and delivery of the strategy

Since the launch of the strategy several accompanying shorter term delivery plans have also been published, most recently the *Substance misuse delivery plan 2016-2018* (Welsh Government, 2016). These delivery plans set out performance measures for each of the strategy's key action areas: preventing harm; supporting substance misusers to improve their health and aid and maintain recovery; supporting and protecting families; and tackling availability and protecting individuals and communities via enforcement activity. Progress of the delivery plan is monitored through an internal cross-government Substance Misuse Programme Board and an external Substance Misuse National Partnership Board which meets three times a year. The current plan highlights the importance of the substance misuse agenda in relation to the *Well-Being of Future Generations (Wales) Act 2015* (National Assembly for Wales, 2015). There is also a greater emphasis on prevention and early intervention.

2.2.4 Northern Ireland

Northern Ireland's strategy, the *New Strategic Direction for Alcohol and Drugs* (Department of Health Northern Ireland, 2006), was launched in 2006 with a focus on reducing the harms related to alcohol and drug misuse. The NSD emphasised five supporting pillars for the strategy: prevention and early intervention; treatment and support; law and criminal justice; harm reduction and monitoring; and evaluation and research. It identified two themes: children, young people and families; and adults, carers and the general public, to be addressed across the five pillars as well as the three cross-sectional threads of workforce development, stakeholder involvement and vulnerable groups to run throughout the strategy.

The strategy was reviewed and revised before being relaunched in 2011 as the *New Strategic Direction for Alcohol and Drugs Phase 2, 2011-2016* (Department of Health Northern Ireland, 2011).

A number of key priorities were identified including:

- developing a regional commissioning framework for treatment
- targeting those at risk and vulnerable
- alcohol and drug-related crime including anti-social behaviour and tackling underage drinking
- reduced availability of illicit drugs
- addressing community issues

- promoting good practice in respect of alcohol and drug-related education and prevention
- developing harm reduction approaches
- workforce development

In July 2016 the fourth annual report of progress towards outcomes contained within the drug strategy was published, showing that the majority of the 141 outcomes are on track for achievement within the timescale expected (Department of Health Northern Ireland, 2016a).⁶

It is anticipated that a final review and evaluation of *NSD Phase 2* will be conducted in 2017 with consideration being given to developing a new strategy after this. The ongoing development and implementation of the drug strategy is overseen by the NSD Steering Group.

2.3 Drug policy co-ordination

2.3.1 England

Figure 2.1 shows a summary graphic of drug treatment commissioning bodies in England.

Inter-Ministerial Group on Drugs

The Inter-Ministerial Group on Drugs, chaired by the Home Office, includes ministerial representation from across several key government departments and oversees the delivery of the UK drug strategy.

Home Office

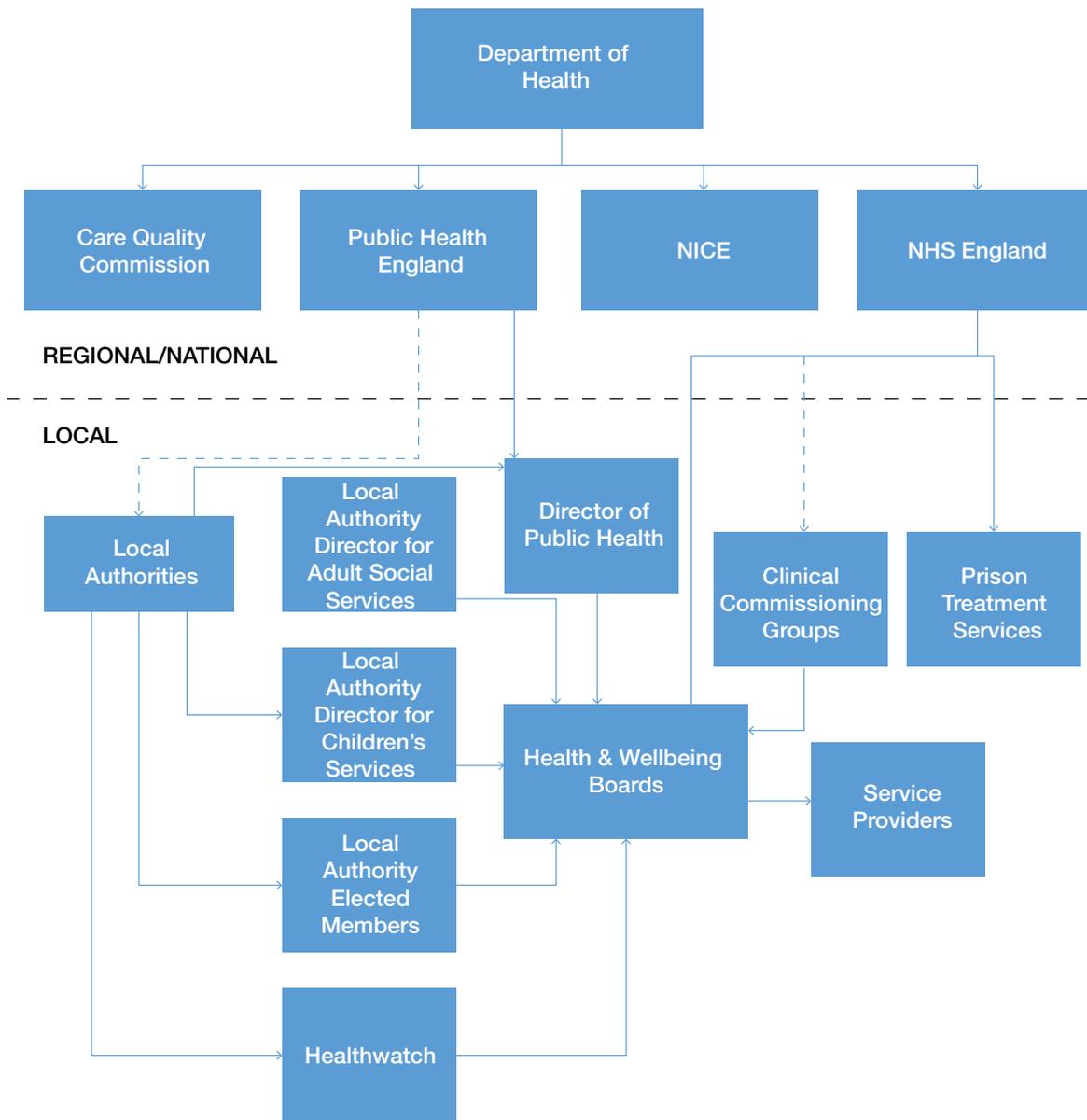
The Home Office has lead responsibility for the co-ordination of the delivery of the UK drug strategy on behalf of the government, and publishes annual reviews detailing the progress made towards the strategy's objectives. The Home Office is supported by various departments and organisations including the DWP, Department of Health (DH), the Department for Communities and Local Government, the Department for Education (DfE), the National Crime Agency (NCA) and the Ministry of Justice (MoJ).

Advisory Council on the Misuse of Drugs

The Advisory Council on the Misuse of Drugs (ACMD) is an independent expert body responsible for, among other things, making recommendations on the control of dangerous or otherwise harmful drugs, including classifications and scheduling under the *Misuse of Drugs Act 1971*, and carrying out in-depth inquiries which focus on emerging threats and challenges that are causing concern.

6 These include outcomes relating to both drugs and alcohol

Figure 2.1: Commissioning structure for drug treatment in England



National Crime Agency

The NCA is a non-ministerial government department, accountable to the Home Secretary. They work with the police, Border Force and international collaborators to lead the UK law enforcement's fight to cut serious and organised crime, including restricting the supply of drugs into the UK.

Local authorities

LAs are accountable for meeting the needs of their local drug using population under the *Health and Social Care Act 2012* (Her Majesty's Government, 2012b). This includes tendering and commissioning the drug and alcohol treatment services they feel will provide the most suitable support for the needs of their constituents. The director of public health (DPH) is appointed jointly by Public Health England (PHE) and the LA, and as officer champion for health within each upper tier and unitary authority has the responsibility of delivering public health outcomes in their local area.

Health and wellbeing boards

Health and wellbeing boards (HWB) were established under the *Health and Social Care Act 2012* (Her Majesty's Government, 2012b) and assumed responsibility for providing the overall strategic direction for improving wellbeing in their area. There are a number of statutory members each HWB must contain, including: at least one local elected representative; a Healthwatch representative; a representative of each local clinical commissioning group (CCG); the LA director for adult social services; the LA director for children's services; and the LA DPH.

Each HWB is required to produce a Joint Strategic Needs Assessment which outlines the current and future health and social care needs of their area, and a plan to meet these needs in the Joint Health and Wellbeing Strategy.

Healthwatch

Local Healthwatch organisations are commissioned directly by LAs and together with the nationally-focused Healthwatch England form the Healthwatch network. Their role is to represent the users of health and care services at the HWB, providing feedback to service providers and commissioners on how and why people use local services and their experience when doing so.

Department of Health

The DH is responsible for developing the statute and policy underpinning the health and care system. It leads on the 'Building Recovery' strand and jointly manages the 'Reducing Demand' strand of the 2010 strategy with the Home Office. It is supported by key agencies such as NHS England, the Care Quality Commission (CQC) and PHE.

NHS England

NHS England is involved in the provision of pharmacological treatments including opioid substitution therapy; the implementation of L&D programmes; and is responsible for commissioning health services within prisons, including drug and alcohol treatment services. NHS England also oversees CCGs, which are clinically led groups that commission local healthcare services within their geographical boundaries. CCGs do not commission drug and alcohol treatment services directly, although it is mandatory that a representative from the local CCG sits on each HWB.

Public Health England

PHE is an executive agency of the DH. PHE supports LAs to commission and deliver alcohol and drug services by providing evidence-based guidance and advice, and by collating and analysing alcohol and drug treatment performance data via the National Drug Treatment Monitoring System.

Care Quality Commission

The CQC is an independent body charged with monitoring, inspecting and regulating health and social care services in England. Services must be registered with the CQC who then ensures that they are meeting core standards of care (see [section 4.2.2](#)).

National Institute for Health and Care Excellence

NICE is an executive non-departmental public body of the DH. Their role is to develop guidance, standards and information to improve health and social care. NICE directions are used by the NHS, LAs and anyone else involved in the delivering of care. NICE products are based on the best available evidence and are developed by multi-disciplinary teams of healthcare professionals and consumers or guideline development groups with particular expertise or experience in the topic.

Ministry of Justice

The MoJ is charged with protecting the public, reducing offending and overseeing courts, prisons, probation services and the secure youth estate. They are therefore involved in the hearing of criminal cases concerning drug-related offences and the rehabilitation of offenders.

National Offender Management Service

The National Offender Management Service (NOMS) is an executive agency sponsored by the MoJ. Through Her Majesty's Prison Service and the National Probation Service, NOMS is accountable for ensuring that both prison and community sentences in England and Wales are carried out.

The National Partnership Agreement for the Co-Commissioning and Delivery of Healthcare in Prisons in England (NHS England, Public Health England, & National Offender Management Service, 2015), is a tripartite agreement between NHS England, NOMS and PHE, which sets out respective roles for the co-commissioning and delivery of services in England (see [section 5.3.2](#)).

Department for Work and Pensions

Given the emphasis placed in the drug strategy on integrated working, the DWP plays an important role in ensuring that those accessing treatment are receiving the full range of benefits which they are entitled to and supporting those recovering from addiction back into work. Universal Credit⁷ is currently being rolled out across the UK, and is a new single payment for people who are looking for work or on a low income, which brings together a range of working-age benefits into a single payment, replacing the employment benefits, income support benefit, tax credits and housing benefit.

7 As part of Universal Credit, the Department for Work and Pensions introduced 'tailored conditionality' where work search and work availability requirements can be suspended for a period of up to six months in any 12 month period for claimants actively participating in structured recovery-orientated treatment. This is to give claimants the time and space to engage in treatment, and begin their recovery journey. After the end of the period of 'tailored conditionality', on-going treatment commitments are still taken into account when an individual is looking for employment. This is recognised as a critical step in enabling people with dependencies to become ready for sustainable employment.

Department for Communities and Local Government

The DCLG supports local governments to help ensure that their areas are working efficiently and effectively. They publish annual reports based on fiscal data provided by LAs on their revenue expenditure and financing, including that spent under the Public Health Grant.

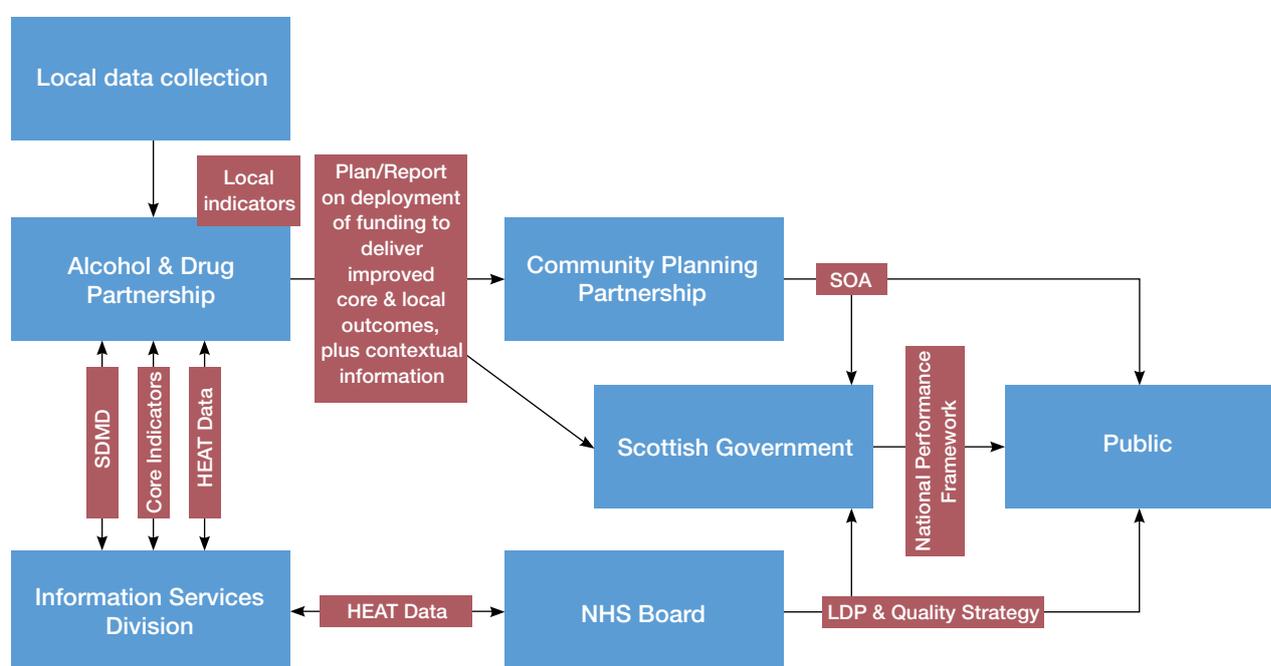
Department for Education

The DfE is responsible for education and children's services in England. In 2013 drug education became a statutory part of the science curriculum for schools in England.

2.3.2 Scotland

See Figure 2.2 for an accompanying summary structure graphic.

Figure 2.2: Overview of planning and reporting arrangements for Alcohol and Drug Partnerships in Scotland



Scottish government

The Scottish government has devolved powers for policies concerning health, education, housing, social care, policing and the criminal justice system. It provides annual funding, in the region of £70 million, across drugs and alcohol to the ADPs, via NHS Boards, to enable them to implement their local delivery plans (LDPs). LDPs are guided by ministerial priorities and ADP core outcomes, informed by a robust assessment of local need and developed and delivered in line with the recognised evidence base.

In April 2016 responsibility for drugs policy in Scotland transferred from the Justice portfolio to the Health portfolio. At the same time, the Drugs Policy Unit also took on responsibility for alcohol interests for ADPs, and has since been renamed the Substance Misuse Unit.

Convention of Scottish Local Authorities

The Convention of Scottish Local Authorities represents local governments in Scotland and was involved, along with NHS Scotland and the Scottish government, in producing the updated guidance for ADPs.

Alcohol and Drug Partnerships

There are 30 ADPs in Scotland and each is responsible for designing and implementing a comprehensive evidence-based local alcohol and drug strategy, as well as for the commissioning of treatment services most suitable for their local resident population. The partnerships include representatives from local NHS Boards, LAs and other key partners such as Police Scotland, the Scottish Prison Service, Housing and Social Services.

Community Planning Partnerships

The Community Planning Partnerships hold the ADPs to account and are involved in the generation of Single Outcome Agreements.

NHS boards

NHS boards develop annual LDPs which contain designated Health improvement, Efficiency and Access Treatment (HEAT) targets, including those relating to drugs and alcohol, and strategies for how they will be achieved. For 2015/16 the HEAT targets for drugs and alcohol (around reducing waiting times to treatment and delivery of Alcohol Brief Interventions) have evolved to become LDP Standard to support sustained performance.

Information Services Division

The Information Services Division (ISD) is part of NHS Scotland and provides health data, information and advice services, enabling NHS Scotland to make informed decisions regarding health and care facilities. The Scottish government has commissioned ISD to lead on the development of the new national combined drugs and alcohol data system, DAISy, which will eventually replace the current Scottish Drug Misuse Database.

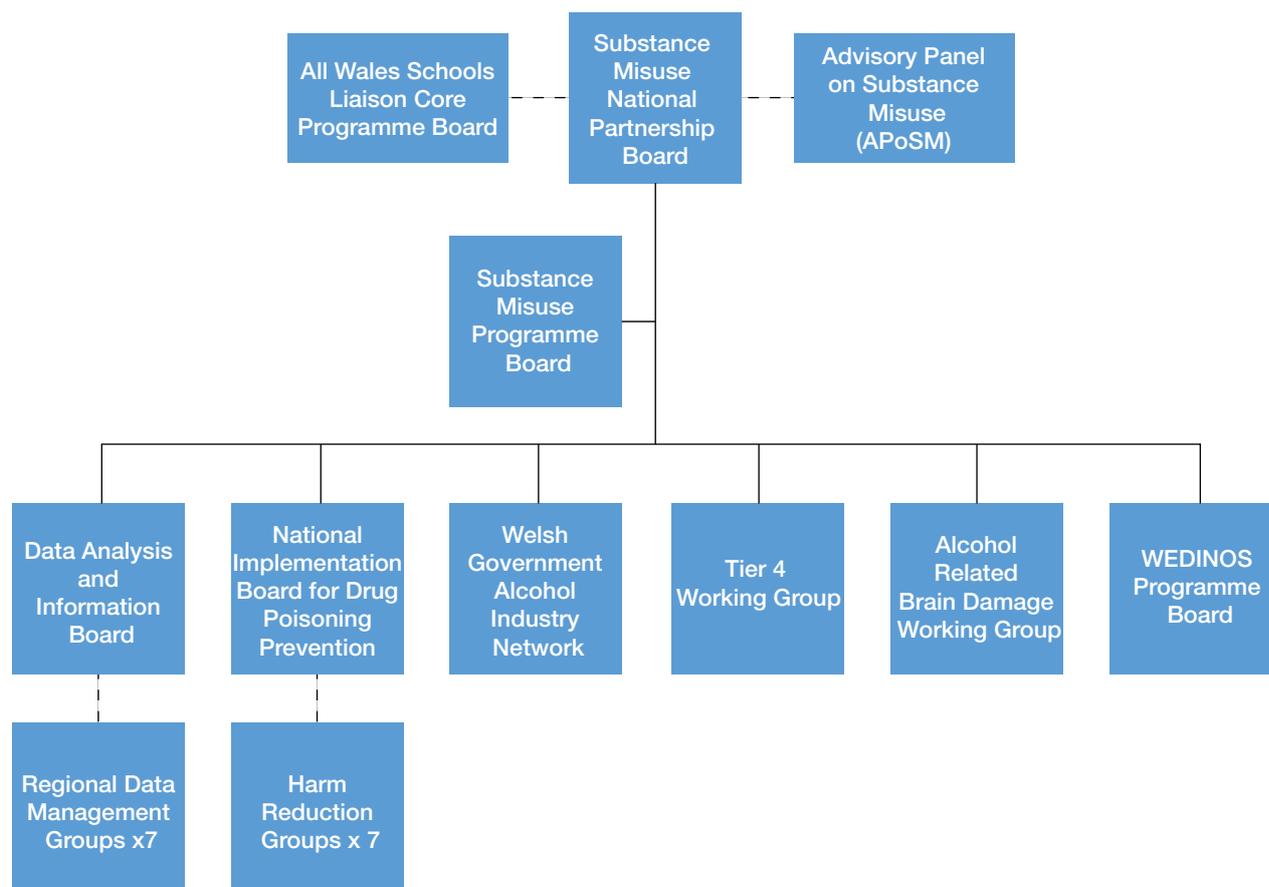
Partnership for Action on Drugs in Scotland

The Partnership for Action on Drugs in Scotland, which replaces the work of the former Drug Strategy Delivery Commission, advises, leads, and collaborates with partners, directly delivering on areas of work including: harm reduction and drug deaths; quality of standards; education and prevention; communities and stigma; and research.

2.3.3 Wales

See Figure 2.3 for an accompanying summary structure graphic.

Figure 2.3: Commissioning and reporting structure of substance misuse services in Wales



Welsh government

The Welsh government has devolved powers for policies concerning health, education, housing and social care.

Substance Misuse National Partnership Board

The role of the Substance Misuse National Partnership Board is to guide and monitor progress and to facilitate co-ordination between the Welsh government, statutory agencies and the third and independent sectors.

Community Safety Partnerships

Established in each of the 22 LA areas with the aim to reduce substance misuse and crime, Community Safety Partnerships contain representatives from local stakeholders including the police, LAs, the NHS, fire and rescue services and voluntary organisations. They are responsible for the commissioning and delivery of substance misuse services in their area.

Area Planning Boards

Seven Area Planning Boards (APBs) support the planning, commissioning and performance management of substance misuse services at a regional level. The boards include representatives from local health boards, LAs, police, prison, probation, housing, social services, service providers and service users.

Local health boards

Local health boards commission healthcare services in public sector prisons, including drug treatment services.

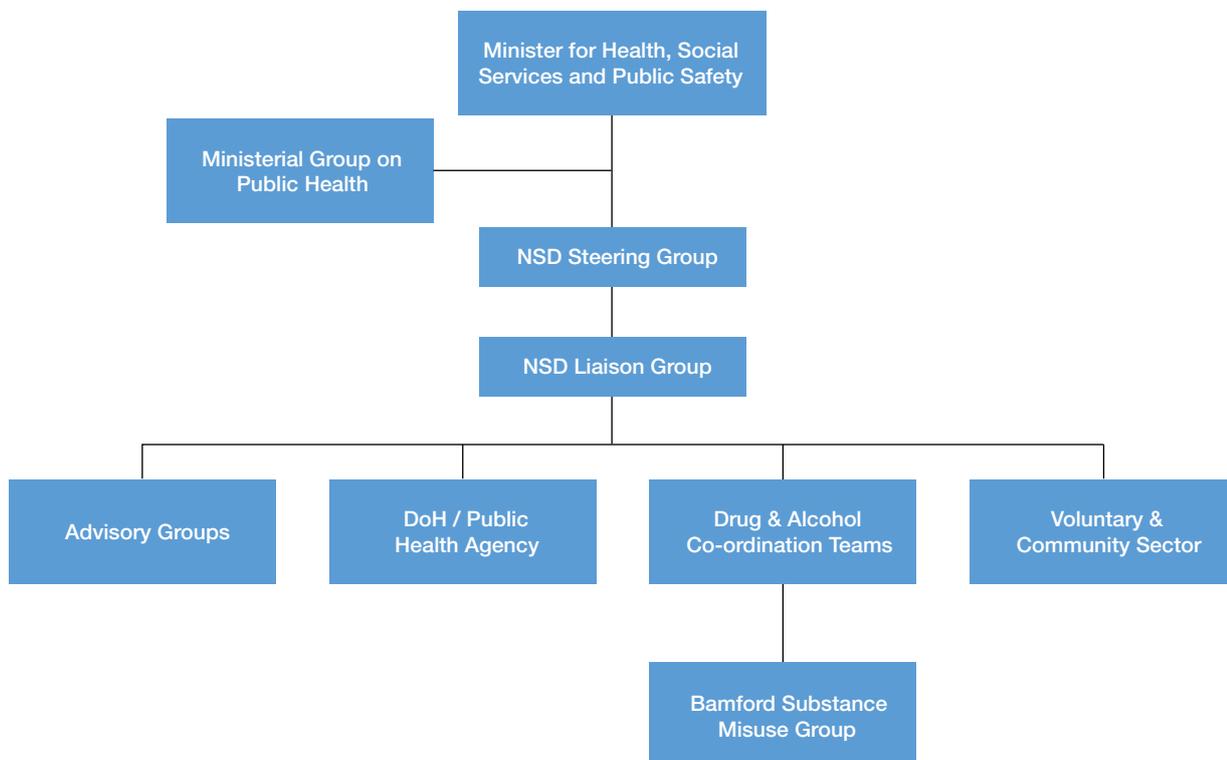
Advisory Panel on Substance Misuse

The Advisory Panel on Substance Misuse is a Welsh government-sponsored body established under general executive powers of the Welsh Ministers. The panel is an independent expert advisory body whose remit is to advise the Minister on measures to prevent or reduce substance misuse and the associated health and social harms.

2.3.4 Northern Ireland

See Figure 2.4 for an accompanying summary structure graphic.

Figure 2.4: Commissioning and reporting structure of substance misuse services in Northern Ireland



Department of Health

The Northern Ireland Department of Health (DoH) was responsible for the development and launch of the Northern Ireland drug strategies in 2006 and 2011, and will be responsible for the evaluation of the strategy.

Public Health Agency

The Public Health Agency (PHA) provides expert advice and commissions a range of alcohol and drug services under the *NSD Phase 2*. They also support the work of the Drug and Alcohol Co-ordination Teams (DACTs).

New Strategic Direction Steering Group

Established in 2006, the NSD Steering Group is chaired by the Chief Medical Officer. Its primary role is to oversee the ongoing policy development, delivery of the strategy and the achievement of outcomes. The steering group includes all key government departments, including the Department of Justice and the Department for Communities, and ensures a cross-sectoral approach to developing policy and implementing the strategy. The group monitors progress towards NSD targets and outcomes.

Drug and Alcohol Co-ordination Teams

DACTs generate local action plans and priorities to implement the drug strategy and guide the expenditure of PHA funding, including the commissioning of drug treatment services. They work closely with other local groups and partnerships, including Policing and Community Safety Partnerships.

2.4 Funding for drug treatment

2.4.1 England

LAs in England received a ring-fenced Public Health Grant of £3.4 billion for public health services in the 2016/17 financial year.⁸ Funding for drug and alcohol treatment is not ring-fenced within the Public Health Grant and expenditure on services is determined by an assessment of the local population's needs by local HWBs. LAs are required to report their annual forecasted and actual expenditure on each public health intervention making up the grant. The categories for reporting this data include: adult drugs, adult alcohol and young people's drug and alcohol spend. The public health grant for 2017/18 has been announced as £3.3 billion. From 2016/17 to 2020/21, £16 billion will be invested to support LAs' public health responsibilities which include prevention reduction and treatment for drugs, alcohol and tobacco.⁹

2.4.2 Scotland

The Scottish government has invested over £630 million to tackle problem alcohol and drug use since 2008, with £574 million of this funding being provided via NHS health boards to ADPs for investment in local prevention, treatment and recovery support services.

2.4.3 Wales

The Welsh government invests almost £50 million annually to deliver the commitments within its substance misuse strategy and its associated delivery plan (Welsh Government, 2016). As well as the £17.1 million ring-fenced funding within the health board budget for substance misuse services, the Substance Misuse Action Fund budget for 2014/15 stands at £32 million. Over £22 million of this funding goes directly to the seven APBs in Wales supporting a number of projects ranging from education and prevention to treatment services.

8 See: <https://www.gov.uk/government/publications/public-health-grants-to-local-authorities-2016-to-2017>

9 See: <http://www.parliament.uk/business/publications/written-questions-answers-statements/written-statement/Lords/2016-12-15/HLWS360>

2.4.4 Northern Ireland

Expenditure on alcohol and drugs services has remained broadly consistent in Northern Ireland: around £8 million per year is allocated to the implementation of NSD Phase 2, and a further £8 million is allocated to statutory addiction services through the mental health budget.

2.5 New developments

2.5.1 Psychoactive Substances Act 2016

The *Psychoactive Substances Act 2016* (Her Majesty's Government, 2016f) came into force on 26 May 2016. It is now an offence to produce, supply, possess with intent to supply, import or export substances which cause a psychoactive effect in those who consume them. There are a number of exempt substances, including nicotine, alcohol, caffeine, drugs already controlled under the *Misuse of Drugs Act 1971* and medicines as defined by the *Human Medicines Regulations 2012* (see [section 8.3.1](#)).

2.5.2 Public Health England inquiry into drug-related deaths

In September 2016 PHE published the report of an expert working group convened as part of an inquiry to investigate the causes of the recent rises in drug-related deaths (DRDs) in England, and what could be done to prevent future premature deaths (Public Health England, 2016i). The report includes some key principles, recommendations for action by national and local stakeholders who can directly impact on DRDs, and stresses the need for continued research and investigation to better understand DRDs and their prevention. PHE will provide additional drug-related deaths data to LAs to benchmark their performance and encourage improvement through the Public Health Outcomes Framework (see [section 4.2.1](#)).

2.5.3 Dame Carol Black review

In December 2016 *An independent review into the impact on employment outcomes of drug or alcohol addiction, and obesity* was published (Black, 2016). Chaired by Dame Carol Black, the review made a number of recommendations: that the measure of a client's recovery includes work and meaningful activity alongside successful treatment completion; that the government trials Individual Placement and Support approaches for those receiving treatment; that Jobcentre Plus trials the use of peer mentors; and that the government develops guidance on best practice in recruiting alcohol- and drug-dependent people. Significantly, the review did not advocate the mandatory attendance at treatment services for people with substance misuse problems; rather it recommended that those making a claim should be required to attend a structured discussion with a healthcare professional on the impact of their health condition on their ability to work.

2.5.4 Modern Crime Prevention Strategy

In March 2016, the *Modern Crime Prevention Strategy* was published (Home Office, 2016b), which aims to tackle six key drivers of crime, namely: opportunity; character; the effectiveness of the criminal justice system; profit; drugs; and alcohol. The strategy asserts that reducing drug-related crime should focus on three areas: treatment of users; preventing people from starting to use drugs in the first place; and enforcement of drug laws. A new drug strategy is due to be launched in 2017 which will build on these themes.

3 Prevention

3.1 Introduction

The UK government's *Drug Strategy 2010 – Reducing demand, restricting supply, building recovery* (Her Majesty's Government, 2010) has been refreshed to mix universal actions aimed at all young people with targeted actions for those most at risk of using drugs or who have already started using drugs. It tackles the risk factors that make people vulnerable to substance misuse, which includes investing in a range of evidence-based programmes that have a positive impact on young people and adults, giving them the confidence, resilience and risk management skills to resist drug use.

Prevention initiatives are also covered in each of the drug strategies of the devolved administrations. In Wales this is through *Rights of Children and Young Persons (Wales) Measure 2011* (Welsh Government, 2011). The Welsh government in the *Working Together to Reduce Harm Substance Misuse Strategy Annual Report – 2015* (Welsh Government, 2015b) also emphasises the importance of delivering prevention messages within the workplace, and that the early identification of young people at risk of engaging in risky behaviours can be an important aspect of prevention.

The Getting It Right For Every Child programme¹⁰ provides the methodology for delivering the Scottish government's three social policy frameworks (the Early Years Framework; Achieving our Potential; and Equally Well (Scottish Government, 2008a, 2008b, 2008c)), which aim to develop the prevention and early intervention agenda. More recently updated practice guidance, *Getting Our Priorities Right* (Scottish Government, 2013), was developed for agencies and practitioners working with children, young people and families affected by substance use in Scotland.

In Northern Ireland, *Our Children and Young People – Our Pledge: A 10 year strategy for children and young people in Northern Ireland, 2006-2016* (Office of the First Minister and Deputy First Minister for Northern Ireland, 2006) sets a framework for addressing the needs of young people. Improved education and early interventions for young people and families (especially those most at risk) and improved public information about drugs are priority areas.

3.2 The evolution of prevention approaches

Evaluations of drug prevention programmes have shown that the impact of drug education alone is unlikely to prevent young people from using drugs, and that 'scare' approaches are likely to be ineffective, if not counterproductive. Therefore, in recent years the focus of prevention policy has shifted away from interventions aimed specifically at drugs, to strengthening general resilience factors with the aim of reducing the desire to explore risky behaviours including drug use (Faggiano, Minozzi, Versino, & Buscemi, 2014; James, 2011; UK Drug Policy Commission, 2012). A stronger emphasis has also been put on the importance of parent/carers and family influence on children's substance misuse and associated behaviours, and how early life interventions, which should include prenatal family support, can reduce risk factors and strengthen the associated protective factors. Such interventions can include parenting skills education, support to families from pregnancy, for example the Family Nurse Partnership (see [section 3.5.2](#)), and parent and family skills training such as the Strengthening Families Programme (UK Focal Point, 2014).

10 See: <http://www.scotland.gov.uk/Topics/People/Young-People/gettingitright/publications/practice-guide>

Modern education and prevention programmes take into account the concept that young people's behaviour is affected by the perceived behaviour of their peers, in particular their tendency to overestimate the prevalence of risky behaviours among their peers. Therefore, providing them with information about the real prevalence of such risky behaviours might reduce their participation in such actions (such as the 'social norm' approach (Chowdry, Kelly, & Rasul, 2013)). Some of these programmes tend to focus on relationships between individual behaviours and a range of social and environmental influences they are subject to, and the inter-relationship between individual behaviours as 'lifestyles'. Such programmes put an emphasis on the need to communicate effectively with young people through a range of networks (such as web-based activity) and through the media, as well as through traditional school health education. These approaches have increasingly used social marketing methodologies, which advocate an integrated 'whole person' approach, to disseminate their message and to support behaviour change in young people.

3.3 Environmental prevention

Environmental prevention strategies aim to alter the immediate cultural, social, physical and economical environments in which people make their choices about drug use.

Across the UK there are a number of policies and strategy documents concerned with illicit and licit substances (such as tobacco and alcohol) (see Table 3.1).

Table 3.1: United Kingdom strategy documents for alcohol, tobacco and illicit drugs

Country	Substance(s) covered	Reference
UK	Illicit drugs	<i>The Drug Strategy 2010, 'Reducing demand, restricting supply, building recovery: supporting people to live a drug-free life'</i> (Her Majesty's Government, 2010)
	Alcohol	<i>The Government's Alcohol Strategy</i> (Her Majesty's Government, 2012a)
England	Tobacco	<i>Healthy Lives, Healthy People: A Tobacco Control Plan for England</i> (Her Majesty's Government, 2011a)
Wales	Illicit drugs and alcohol	<i>Working Together to Reduce Harm: The Substance Misuse Strategy for Wales 2008-2018</i> (Welsh Assembly Government, 2008a)
	Tobacco	<i>Tobacco Control Action Plan for Wales</i> (Welsh Government, 2012)
Scotland	Illicit drugs	<i>Road to Recovery: A New Approach to Tackling Scotland's Drug Problem</i> (Scottish Government, 2008d)
	Alcohol	<i>Changing Scotland's Relationship with Alcohol: A Framework for Action</i> (Scottish Government, 2009a)
		<i>Changing Scotland's Relationship with Alcohol: A Framework for Action – Progress Report</i> (Scottish Government, 2012)
Tobacco	<i>Scotland's Future is Drug Free: A Smoking Prevention Action Plan</i> (Scottish Government, 2008e)	
Northern Ireland	Illicit drugs and alcohol	<i>New Strategic Direction for Alcohol and Drugs Phase 2 2011-2016</i> (Department of Health Northern Ireland, 2011)
	Tobacco	<i>Ten-Year Tobacco Control Study of Northern Ireland</i> (Department of Health Northern Ireland, 2012)

3.3.1 Legislation

Drug driving legislation

England and Wales

In March 2015 levels for the maximum blood concentration allowed for a selection of legal and illegal drugs for drivers were introduced in England and Wales under the *Drug Driving (Specified Limits) (England and Wales) Regulations 2014* (Her Majesty's Government, 2014a). Limits are specified for eight illicit drugs such as cannabis, heroin and cocaine,¹¹ and eight medicines which may be abused (the limits for these compounds are higher to reflect their medical use).¹²

Following the implementation of drug driving limits in 2015, the Department for Transport launched an anti-drug driving campaign called "Think" which includes a TV campaign aiming to deter people from using drugs and driving under the influence.

Northern Ireland

Under the new *Road Traffic (Amendment) Act* (Northern Ireland) (Her Majesty's Government, 2016g), the legal alcohol limit for drivers has been lowered from 80mg in 100ml of blood to 50mg. The limit for learner and professional drivers is lower at 20mg. The recent drug driving laws introduced in England and Wales do not extend to Northern Ireland; however, individuals may still be arrested if they are unfit to drive.

Psychoactive Substances Act 2016

The *Psychoactive Substances Act 2016* (Her Majesty's Government, 2016f) places a blanket ban on psychoactive substances (with some exemptions) in the UK, prohibiting the production, distribution, sale and supply of substances capable of producing a psychoactive effect within the country. Exempted substances are: those substances already controlled under the *Misuse of Drugs Act 1971*; medicinal products listed under the *Human Medicines Regulations 2012*; alcohol; tobacco and nicotine products; caffeine; and food and drink. The main aim of the *Psychoactive Substances Act 2016* is to halt the sale and supply of psychoactive substances through retail premises (such as headshops) and online retailers based in the UK (see [section 8.3.1](#)).

Smoking legislation

Scotland

The *Smoking Prohibition (Children in Vehicles) Bill* (Scottish Parliament, 2016) received Royal Assent on 21 January 2016. It is now an offence for an adult to smoke in a private motor vehicle when there is a child in the vehicle and the vehicle is in a public place.

Northern Ireland

The *Tobacco Retailers Act (Northern Ireland) 2014* (Her Majesty's Government, 2014d) strengthened existing age of sale legislation by requiring all tobacco retailers in Northern Ireland to register centrally from April 2016. The act also introduces banning orders for retailers; fixed penalties for a number of tobacco-control offences; and a new offence of proxy purchasing (buying tobacco on behalf of a minor).

11 Illegal drugs and limits in the new legislation: benzoylecgonine (cocaine), 50µg/L; cocaine, 10µg/L; delta-9-tetrahydrocannabinol (cannabis), 2µg/L; ketamine, 20µg/L; LSD, 1µg/L; methylamphetamine, 10µg/L; MDMA, 10µg/L and 6-monoacetylmorphine (heroin), 5µg/L.

12 Medicines and limits in the new legislation: clonazepam, 50µg/L; diazepam, 550µg/L; flunitrazepam, 300µg/L; lorazepam, 100µg/L; methadone, 500µg/L; morphine, 80µg/L; oxazepam, 300µg/L and temazepam, 1,000µg/L.

The *Health (Miscellaneous Provisions) Act (Northern Ireland) 2016* (Her Majesty's Government, 2016b) was passed in May 2016. It places a ban on smoking in cars where children are present, and it makes provision in relation to age of sale restrictions for e-cigarettes. The Department of Health expects to consult on the regulations in the autumn and for the regulations to be in force in the first half of 2017.

Alcohol minimum unit pricing

Minimum unit pricing (MUP) for alcohol sales is yet to be implemented anywhere in the UK, although there are moves towards doing so in Scotland, Northern Ireland and Wales (UK Focal Point, 2016).

Scotland

The *Alcohol (Minimum Pricing) (Scotland) Bill* was passed and received Royal Assent in 2012 (Scottish Parliament, 2012). The Scotch Whisky Association (SWA) (in conjunction with the European Spirits Organisation and the Comité Européen Des Entreprises Vins) sought a judicial review of the act, which was held in January 2013 and found comprehensively in favour of the policy. The SWA et al appealed that decision, and following a hearing in February 2014 the case was referred to the Court of Justice of the European Union (CJEU) to clarify points of EU law. In September 2015, the Advocate General of the European Court of Justice stated that in their opinion, Scotland's alcohol MUP legislation does not contravene European law.¹³ In December 2015, the CJEU ruled that the plans to impose a blanket minimum price per unit would breach EU free-trade laws unless the policy was found to be more effective than just using general taxation. It ruled that the judgement on its effectiveness was to be made by national courts.

In October 2016, the Scottish Court of Session ruled that MUP of alcohol is lawful. The SWA has since successfully applied to appeal in the UK Supreme Court.

NHS Scotland reported in May 2016 that more than half (51%) of alcohol sold in supermarkets and off-licences was sold at less than 50p per unit,¹⁴ the MUP threshold previously suggested by NHS Scotland.

3.3.2 Tobacco control

Standardised packaging of tobacco

In May 2016, the High Court dismissed a legal challenge brought forward by tobacco companies against the standardisation of tobacco packaging, and the *Standardised Packaging of Tobacco Products Regulations 2015* (Her Majesty's Government, 2015d) came into effect the following day as planned. Tobacco companies have been given one year to comply with new regulations which include a ban on packs of ten cigarettes and a ruling that all tobacco packaging must be uniformly olive green and display large health warnings. This includes both packets of cigarettes and hand rolling tobacco.

E-cigarettes

Since May 2016 all e-cigarettes and e-liquids sold in the UK must either meet the provisions of the Tobacco Products Directive (TPD) (2014/40/EU)¹⁵ or be licensed as a medicine or medicinal

13 See: <http://curia.europa.eu/juris/document/document.jsf?text=&docid=166846&pageIndex=0&doclang=en&mode=req&dir=&occ=first&part=1&cid=203295>

14 See: <http://www.healthscotland.com/uploads/documents/27345-00.%20Alcohol%20consumption%20and%20price%20in%20Scotland%202015%20-%20May2016.pdf>

15 See: http://ec.europa.eu/health/sites/health/files/tobacco/docs/dir_201440_en.pdf

device by the Medicines and Healthcare products Regulatory Agency. In areas outside of the harmonised rules set out in the TPD the countries of the UK may, within the scope of their devolved powers, make their own policy on e-cigarettes.

Smoke free prisons

England and Wales

Since January 2016, all prisons in Wales are smoke free. This has been trialled in four early adopter sites in England, extended to seven further establishments by January 2017, with a view to the entire prison estate being smoke free in future. E-cigarettes and nicotine replacement therapies are now available to purchase by prisoners and access to stop smoking support is increasing throughout the estate. For further information, (see [section 5.8.3](#)).

Scotland

The current position in Scotland is that prisoners are only permitted to smoke in their own cells and during outdoor recreation. Staff, visitors and contractors are not permitted to smoke anywhere on Scottish Prison Service (SPS) property. The Cabinet Secretary for Justice in Scotland has accepted recommendations that all Scottish prisons should be smoke free within a timescale of up to five years. SPS will be working closely with NHS health boards and the Scottish government, as well as other partner agencies, to develop comprehensive plans in preparation for the change. A decision has still to be made on whether e-cigarettes should be introduced to prisons in Scotland as part of moves towards smoke free prisons. A working group is in place to consider the options available.

3.4 Universal prevention

Universal prevention targets the entire population, regardless of individual levels of risk, with programmes, initiatives and messages aimed at preventing or delaying the onset of illicit drug use.

3.4.1 England

Universal drug education is included in the national curriculum in England, where it is a statutory part of the science curriculum for schools. Pupils are required to be taught “*the effects of ‘recreational’ drugs (including substance misuse) on behaviour, health and life processes.*” Drug education can be expanded through the non-statutory Personal Social and Health Education (PSHE) programme; however, there is no standardised approach for doing so. Guidelines do state that teaching should draw on good practice (Department for Education, 2014). Evidence suggests that well-delivered PSHE can have a positive effect on young people, and that interventions that help build confidence and resilience can prevent drug use (Home Office, 2016b). In 2015, four House of Commons committees requested that PSHE be made mandatory in schools; however this proposal was rejected and is still under review.

Alcohol and drug prevention briefing papers

As part of a series of briefing papers for teachers and practitioners, Mentor-ADEPIS (Alcohol and Drug Education and Prevention Service) published a document in 2016 that looks at how building resilience and preventing children and young people’s mental ill health can prevent substance abuse. It aims to provide teachers, educators and the wider school workforce with practical guidelines on how to prevent children and young people from developing mental health problems as a result of alcohol and drug misuse (Mentor-ADEPIS, 2016).

In 2016 the Association for Young People's Health in conjunction with Public Health England (PHE) published a resource, *A public health approach to promoting young people's resilience*, on building resilience in young people (Association for Young People's Health, 2016). This document is aimed at policy makers, commissioners and service planners and providers, and builds on previous work such as the PHE framework for young people's health, and resources such as Rise Above which is focused on resilience and helping young people to make positive health decisions.

Sources of support and information about drugs

There are several universal prevention communication programmes in England. For example, 'Talk to FRANK',¹⁶ a campaign from PHE, provides information about drugs to young people (under 16) and their families. Advice can be accessed through a number of channels including a 24-hour helpline operated by trained advisors, the FRANK website, SMS, email and a live online chat service. There have been increases in the number of website visits and emails to FRANK in recent years (2.2 million in 2009/10 to 4.2 million in 2014/15).

Rise Above is another prevention communication programme, which was launched by PHE in November 2014. It is an interactive resource where young people can find material aimed at encouraging them to build resilience, encourage empowerment and talk about important issues in their life, including drugs, alcohol, smoking, body confidence, relationships and exam stress. Rather than providing information only, a range of situational tools and skills-based resources are available on the website. Since Rise Above was launched, there have been almost 350,000 unique visits to the website, 1.09 million views of BuzzFeed posts, 4.9 million video views of Rise Above content across vloggers and the Rise Above channel on YouTube and 52,429 unique visits to the MTV Rise Above Wall.

PHE has also developed its role in supporting local areas: sharing evidence to support commissioning and the delivery of effective public health prevention activities; and launching toolkits to support local areas' responses on specific issues around new psychoactive substances (NPS) and other drug groups.

3.4.2 Scotland

In Scotland, education has developed to encapsulate broader life learning for children and young people through the Curriculum for Excellence,¹⁷ where traditional education is integrated with wider life learning for three to 18-year-olds. In the Curriculum for Excellence, learning in health and wellbeing is designed to promote confidence, independent thinking and positive attitudes. This learning helps enable children and young people to become resilient to risk taking behaviours and understand the wider impacts of staying safe and making positive choices.

In December 2016, the Scottish government produced a literature review examining drug education and prevention (Scottish Government, 2016f). The report argued that drug prevention is better provided through holistic strategies that promote healthy development and wellbeing, with targeted drug-specific interventions provided for those at most risk of harm or already misusing drugs.

16 See: <http://www.talktofrank.com/>

17 See: [https://education.gov.scot/scottish-education-system/policy-for-scottish-education/policy-drivers/cfe-\(building-from-the-statement-appendix-incl-btc1-5\)/What%20is%20Curriculum%20for%20Excellence](https://education.gov.scot/scottish-education-system/policy-for-scottish-education/policy-drivers/cfe-(building-from-the-statement-appendix-incl-btc1-5)/What%20is%20Curriculum%20for%20Excellence)

Know the Score

'Know the Score'¹⁸ provides factual information and advice to young people, their families and professionals. It is supported by the Scottish government and provides an online 24-hour information service and a telephone helpline on drugs information and advice from 8am to 11pm, seven days a week.

Choices for Life

The Scottish government funds the 'Choices for Life' schools-based substance misuse education programme, delivered in partnership with Young Scot and Police Scotland. This programme provides education on drugs, alcohol and tobacco through an information website for young people and their parents, teachers and carers. It also provides a series of community events to engage young people directly and provide credible information to help them make the right health choices. The Choices for Life website hosts a series of interactive short films to educate teenagers on a wide range of topics including the dangers of NPS, peer pressure, alcohol, smoking, cannabis, substance misuse and drug driving.

In 2015/16, Choices for Life aligned itself with an existing successful event, Rock Challenge. This performing arts initiative delivers positive healthy lifestyle messages to young people. It raises awareness of social issues affecting young people including smoking, drugs, alcohol and anti-social behaviour, and encourages them to make informed lifestyle choices. Police Scotland allocated a support officer to the participating schools and made funding available to help with their projects.

In light of the findings of the literature review '*What works*' in drugs education and prevention (Scottish Government, 2016f), the Scottish government is currently reviewing the education and prevention activities that it supports directly, to ensure that these are in line with the evidence base on what works. It is proposed that in the 2017/18 financial year, a review of the Choices for Life programme will be undertaken.

3.4.3 Wales

In Wales, in line with the goal laid out by *Working Together to Reduce Harm: The Substance Misuse Strategy for Wales 2008-18* (Welsh Assembly Government, 2008a), the All Wales School Liaison Core Programme has been developed to deliver drugs education in primary and secondary schools.¹⁹ The *Steroids and Image Enhancing Drugs Educational Toolkit for Young People (11-16 years)* has been developed and issued for all schools and youth groups across Wales (Public Health Wales, 2014b).²⁰

Welsh Network of Healthy School Schemes

The Welsh Network of Healthy School Schemes (WNHSS)²¹ is an initiative to ensure schools adopt a holistic approach to health with a focus on substance use (both licit and illicit). Each local authority employs healthy schools practitioners to support schools in the areas. Once schools have been involved in the scheme for nine years, they can apply for a National Quality Award (NQA). This award assesses the school on its approach to the seven key topic areas of food and fitness, mental and emotional health and wellbeing, personal development and

18 See: <http://knowthescore.info/>

19 The All Wales School Liaison Core Programme is jointly funded by the Welsh Government and the four Welsh police forces and targets pupils aged between five and 16. See: <https://www.schoolbeat.org/en/parents/know-the-programme/national-events/what-is-the-all-wales-school-liaison-core-programme/>

20 See: <http://www.wales.nhs.uk/sitesplus/documents/888/SIEDS%20Toolkit%20English.pdf>

21 See: <http://www.wales.nhs.uk/sitesplus/888/page/82249>

relationships, substance use and misuse, environment, safety and hygiene. In August 2015, 87 schools across Wales had achieved the NQA, an increase from 65 in August 2014. A further 266 are working towards being assessed.

Healthy and sustainable further education and higher education settings

The Healthy Colleges and Healthy Universities framework²² was launched in Wales in 2015 as an extension of the WNHSS into Higher Education and Further Education settings. One of the six health topics detailed in the framework is substance use and misuse. The framework sets out criteria for various aspects of college and university life, covering: governance, leadership and management; facilities, environment and service provision; community and communication; and academic, personal, social and professional development. It aims to create a healthy and sustainable further education environment for both staff and students and provides guidance on how this may be achieved.

DAN 24/7

Dan 24/7²³ is a bilingual (Welsh and English) 24-hour information and telephone helpline service, which frequently runs targeted campaigns. Traffic to the website increased by 29% from 2013/14 to 2014/15. It has been updated to reflect current issues such as NPS and a recent campaign to raise awareness of hepatitis C in Wales. The service has also increased its presence on social media platforms in the past year. It is hosted by the Betsi Cadwaladr University Health Board with funding provided by the Welsh government. The helpline is aimed at assisting individuals, their families, carers, and support workers within the drug and alcohol field to access appropriate local and regional services.

3.4.4 Northern Ireland

The school curriculum places a specific focus on the development of relevant ‘life skills’ among pupils. In particular, through Personal Development and Mutual Understanding²⁴ in primary schools, pupils are provided with opportunities to develop strategies and skills for keeping themselves healthy and safe. Post-primary school pupils, through Learning for Life and Work,²⁵ are provided with opportunities to investigate the effects on the body of licit and illicit substances and the risks and consequences of their misuse.

During the 2014/15 financial year the Council for Curriculum, Examinations and Assessment (CCEA) updated the CCEA/Department of Education guidance on drugs and alcohol. The new guidance was published on the CCEA website in August 2015.²⁶ In Northern Ireland, the Public Health Agency²⁷ develops public information campaigns for various target groups and settings. In addition, Northern Ireland buys into the telephone helpline element of the FRANK campaign.

A new community support and local awareness raising service, called ‘Connections’, was put in place in July 2015 to raise awareness of the harm alcohol and drug misuse can cause, work with local communities to address their priorities, and raise awareness of local services.

22 See: <http://www.wales.nhs.uk/sitesplus/888/document/270938>

23 See: <http://www.dan247.org.uk>

24 See: http://ccea.org.uk/curriculum/key_stage_1_2/areas_learning/personal_development_mutual_understanding

25 See: http://www.nicurriculum.org.uk/docs/learning_for_life_and_work/training/LLW-Guidance.pdf

26 See: http://ccea.org.uk/curriculum/drugs_guidance

27 See: <http://www.publichealth.hscni.net/>

Thingyapp

In Northern Ireland, the Police Service of Northern Ireland, Big Lottery Fund, Youth Justice Agency and Family Support Northern Ireland have funded an app, designed by young people, called Thingyapp. Thingyapp offers young people health advice, including advice on drugs and alcohol, and signposts individuals to agencies where they can receive further help and information.

3.4.5 UK-wide

Good Behaviour Game

The Good Behaviour Game is a classroom-based approach that has been trialled in a number of countries around the world. A trial is ongoing in UK primary schools funded by the Education Endowment Fund and led by Mentor. The programme is an approach to classroom management and aims to develop life skills in young people to build resilience and confidence in dealing with challenges. Evaluations in other countries have shown long term benefits including a reduction of risk-taking behaviour, including substance abuse, later in life. An evaluation report will be published in August 2017.

Unplugged

Unplugged is an intervention aimed at 12-14 year-olds and is delivered through a series of 12 one-hour modules in schools. The programme has been trialled in a number of European countries and has been shown to be effective in preventing and reducing alcohol misuse and smoking. It aims to give young people the skills they need to resist influences from peers and information regarding the negative health consequences of drug use.

3.5 Selective prevention in at-risk groups and settings

Selective prevention initiatives target subsets of the total population that are deemed to be at greater risk of substance misuse or risky behaviour, such as truants or young offenders.

3.5.1 Young people

Substance misuse services for young people

Specialist substance misuse treatment for young people is recognised as a form of prevention in the UK, as it aims to stop drug and alcohol use escalating, to reduce harm to young people or others and to prevent them becoming drug or alcohol-dependent adults. The Young People's Statistics from the National Drug Treatment Monitoring System (NDTMS) showed that in 2014/15 18,349 young people (under 18 years) accessed specialist substance misuse services (see [section 4.5.1](#)). The majority presented with cannabis (73%) or alcohol (17%) as their primary problem substance, followed by amphetamine (three per cent), NPS (two per cent) and ecstasy (one per cent) (Public Health England, 2015i).

The Drug Treatment Database in Northern Ireland shows that in 2015/16 149 clients aged under 18 were in treatment for drug misuse – just under seven per cent of all those in treatment.

Young people with multiple vulnerabilities

Young people presenting to specialist substance misuse services frequently have multiple vulnerability factors such as being a looked after child, being involved in child sex exploitation, having a history of self-harm or offending behaviour. The Young People's Statistics from NDTMS

identify 17 of these vulnerability factors.²⁸ Of the 13,127 new presentations in 2014/15, 83% had two or more of these vulnerability factors (Public Health England, 2015i).

RisKit

The RisKit programme has been developed by the University of Kent and Kent County Council following a review of existing research and consultations with young people. The school-based programme screens those aged 14-16 and offers interventions to those who are deemed at risk. The interventions include drug and alcohol awareness sessions, motivational interviewing and life skills training sessions. Following an evaluation (Stevens et al., 2014), it was found that the programme is positively viewed by both pupils and those delivering the programme. Information on how to implement the programme has been made freely available on a Creative Commons licence.

3.5.2 At-risk families

Troubled Families Programme

The first phase of the Troubled Families Programme was launched by the UK government in 2012 and aimed to turn around the lives of 120,000 'troubled families' across England by May 2015 (Department for Communities and Local Government, 2012). Delivery of the Troubled Families programme was unprecedented for an initiative of its kind in the UK in terms of the scale and pace required. Families taken on to the programme had multiple problems: children not in school; children committing crime; anti-social behaviour; parents not working; and other high cost problems, such as drug abuse and domestic violence.

In 2013 the government announced an expansion of the programme (phase two) to reach up to an additional 400,000 families from 2015/16. Funding totalling £720 million has been made available to meet these commitments by 2020 (Bate, 2016). The new programme retains the focus on families with multiple high cost problems and continues to include families affected by poor school attendance, youth crime, anti-social behaviour and unemployment.

In 2016 an independent evaluation of phase one was published (Department for Communities and Local Government, 2016). Local authorities reported monitoring data which recorded problems being experienced by families, including assessments of drug and alcohol dependency in adults and young people. Where completed information was available at entry and exit to the programme, the monitoring data indicated a reduction in these issues for around one-third of families at exit from the programme.

The evaluation also included a family survey which contained self-reported drug and alcohol misuse questions. It compared responses from families starting the intervention with those nine months from the start of the intervention. There were no significant differences identified between the responses of these two groups in relation to their self-reported drug and alcohol use. However, a majority of the families at nine months after the intervention were identified subsequently as still receiving the intervention at the time of interview, so limited conclusions can be drawn from these findings.

Emerging findings from the expanded programme evaluation are expected in 2017.

28 The 17 vulnerability factors are: began using primary substance aged under 15; has been involved in antisocial behaviour; reports self-harming behaviour; is a looked after child; is subject to a child protection plan; is a child in need; reports using opioids and/or crack; has ever injected; is not in education, employment or training; reports unsettled accommodation status or has no fixed abode; reports using two or more substances in combination (poly substance use); is pregnant or a parent; is a high risk alcohol user; is affected by others' substance misuse in their close family and/or members of the household; has been affected by domestic abuse; reports a mental health problem; and reports sexual exploitation.

Family Drug and Alcohol Courts

Family drug and alcohol courts (FDACs) are specialised courts designed to work with parents who abuse substances and are involved with the child welfare system. They aim to improve children's outcomes by addressing their parents' difficulties, and parents and children are able to remain together safely during the court proceedings. The courts are able to make quick alternative placement decisions for the child if parents are unable to successfully address their substance misuse problems. A dedicated judge will usually preside over all hearings in a given case, and families are supported by a multi-disciplinary specialist support team which reports back to the judge on their progress.

A two-stage independent evaluation of pilots in 2008-2012 provided evidence that FDACs were more successful than ordinary care proceedings in helping parents overcome substance misuse in order to be reunited with their children (Harwin, Alrouh, Ryan, & Tunnard, 2014). It also found that FDACs enable parents to access and stay in treatment. These findings have been confirmed by the recently published report on the five year outcomes of FDACs. The study showed that a significantly higher proportion of mothers from FDACs than in the comparison group had ceased to misuse drugs, which led to a higher rate of family reunification (Harwin et al., 2016).

There are currently FDACs in England, in London, Gloucestershire, Milton Keynes & Buckinghamshire, East Sussex, Coventry, the South West Peninsula, Southampton, West Yorkshire and Kent & Medway.²⁹ Further FDACs are expected to open, with plans to open four more per year over the next five year period.

The Family Nurse Partnership

Since 2007, the Family Nurse Partnership³⁰ has provided support to young mothers in the UK from pregnancy to the baby reaching two years old, with structured home visits by trained nurses. A randomised controlled trial looking at its effectiveness was conducted in the UK and its findings were published in October 2015. Results showed the programme had no effect on pre-natal tobacco use, birth weight, emergency department attendance and subsequent pregnancy by 24 months, which were the study's four main short term outcomes. There were small positive impacts on some of the secondary outcomes of the study, such as maternally reported child cognitive development, language development, levels of social support and partner-relationship quality (Robling et al., 2015).

3.5.3 Other at-risk groups

Vulnerable women

Following research carried out by the Stella Young Women's initiative, the Against Violence and Abuse project produced guidelines in 2013 for engaging young women who experience domestic and sexual violence, substance misuse and mental ill-health (Against Violence and Abuse, 2013). The guidelines promote a holistic model of support.

Published in March 2016, the *Ending Violence against Women and Girls Strategy 2016-2020* (Her Majesty's Government, 2016a) sets out plans to tackle harm and exploitation associated with prostitution, including substance misuse.

29 See: <http://fdac.org.uk/locations/existing-sites/>

30 The Family Nurse Partnership provides support to young families (mothers aged 19 years or younger); see: <http://fnp.nhs.uk/>

Chemsex

PHE have published a briefing for commissioners and providers of services who work with people who engage in chemsex (Public Health England, 2015g). This includes targeted interventions, and also encourages collaboration between sexual health services and community groups. The 2015/16 PHE action plan to promote the health and wellbeing of gay, bisexual and other men who have sex with men aims to increase intelligence on the prevalence of chemsex, provide support to services and reduce the availability of drugs associated with chemsex (Public Health England, 2014).

The Mental Health Taskforce

The independent Mental Health Taskforce published the *Five Year Forward View* in March 2016 and set out the NHS commitments towards improving mental health care (Mental Health Taskforce, 2016). One of the key recommendations focused on the need for better integration between physical and mental health care services; for example ensuring those with severe mental illness, who are twice as likely to smoke, are signposted to smoking cessation services. It also highlighted the importance of early intervention for children and young people.

The taskforce noted the change in commissioning of alcohol and substance misuse services from the NHS to local authorities. This led to the closure of specialist NHS inpatient addiction units. As a result, referral pathways have become more complex and this may have affected the provision of holistic care for those people with mental health and co-morbid substance misuse problems.

Every line counts

The National Crime Agency launched a campaign, #EveryLineCounts, in December 2015 to highlight the harm caused by the production and distribution of cocaine. Alongside their work on targeting organised crime groups, this campaign aims to target recreational users to highlight the social justice issues related to cocaine use. The campaign uses various social media outlets to share graphic images related to cocaine production and a video documenting the harm that is caused from production to when the product arrives on the street in the UK.

4 Treatment

4.1 Introduction

UK drug strategies identify treatment as being effective in tackling problem drug use and seek to improve its quality and effectiveness. Co-ordination and integration across a range of service providers is seen as key in helping problem drug users integrate into society, and all recent UK drug strategies focus on this area. Substance misuse services are commissioned by local authorities (LAs) in England; by local NHS health boards in Scotland; by community safety partnerships in Wales; and by drug and alcohol co-ordination teams in Northern Ireland. Each of these commissioning bodies receives advice and input from a number of other organisations, including Public Health England (PHE), the Public Health Agency in Northern Ireland, voluntary organisations and the police.

In terms of quality assurance, the *Drug Misuse and Dependence: UK Guidelines on Clinical Management* (Department of Health England and the devolved administrations, 2007) provide guidance for clinicians delivering drug treatment in the UK. The Care Quality Commission (CQC) is responsible for monitoring, inspecting and regulating health and social care services in England, including the majority of substance misuse services.

Community-based specialist drug treatment centres are the most common providers of substance misuse services in the UK. Treatment interventions in any given area are expected to include: advice and information, care planning, psychosocial interventions, community prescribing, inpatient drug treatment and residential rehabilitation.

Treatment Demand Indicator (TDI) data on numbers presenting to treatment are from four separate systems: the National Drug Treatment Monitoring System (NDTMS) in England; the Scottish Drug Misuse Database (SDMD); the Welsh National Database for Substance Misuse; and the Northern Ireland Drug Misuse Database. Data from the four systems is combined into UK totals for reporting to the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). Continuous national data are available from 2003/04.

In 2015 there were approximately 250,000 individuals recorded as being in drug treatment in England and Wales, with around 140,000 in continuous treatment at the start of the year, and 110,000 presenting to treatment during the year. More than 80% of clients in continuous treatment in England and Wales ($n=112,000$) cited opioids as their primary substance, and 100,000 clients were receiving opioid substitution treatment (OST). Fifteen thousand clients presented to treatment in Scotland and Northern Ireland in 2015. Of those presenting to treatment in the UK in 2015 approximately half reported primary use of opioids, and one-quarter reported cannabis as their primary substance. In England, around 15,000 people aged under 18 years old were in contact with drug misuse services in 2014/15, with almost 90% of these clients citing cannabis as their primary substance.

Since 2008/09 there has been a steady decline in the number of new treatment presentations across the UK, from a peak of almost 140,000 clients to just over 100,000 in 2015. Between 2003/04 and 2015, the percentage of new presentations citing cannabis more than doubled, while the proportion citing heroin and other opioids decreased from over 70% to just over half of all presentations. The number of opioid users in prescribing treatment in England increased steadily between 2005 and 2010; however, the heroin drought that began in late 2010 saw the number of clients receiving OST decrease in 2011, and level off since then. The opioid treatment seeking population is ageing, with over one-third of those presenting for treatment in 2015 aged 40 and over.

4.2 Policy, strategy and quality assurance

4.2.1 Strategy and policy

United Kingdom

The UK *Drug Strategy 2010, Reducing demand, restricting supply, building recovery: supporting people to live a drug free life* (Her Majesty's Government, 2010) emphasises supporting those who are drug dependent to achieve recovery, and the provision of the integrated support necessary to enable this (see [section 2.2.1](#)).

The 'building recovery' strand of the strategy includes a number of objectives relating to treatment. These include:

- ensure that all those on a substitute prescription engage in recovery activities
- support services to draw on a client's 'recovery capital'
- commission drug treatment and recovery services which are locally led, transparent about performance and delivered in line with best practice
- launch PHE, whose role is to support LAs on commissioning services most suitable for their area and population
- encourage local areas to jointly commission services to deliver 'end-to-end' support
- enable people to successfully reintegrate into their communities following treatment by tackling housing needs and helping them find sustained employment
- launch six Payment by Results pilots to investigate affordability and value for money in drugs recovery for adults.

England

The *Public Health Outcomes Framework (PHOF)*³¹ (Department of Health, 2012) set out the government's strategic direction in meeting two high level objectives: to increase health life expectancy; and to reduce differences in life expectancy and health life expectancy between communities.

The framework includes an indicator and sub-indicators which are explicitly related to drugs: reporting successful completions of treatment for opioid and non-opioid users who do not return within six months. In response to the rising trend in drug-related deaths in recent years, a further sub-indicator reporting the number of deaths from drug misuse was added to the PHOF in April 2016 (Department of Health, 2016).

Scotland

The concept of recovery and supporting people to live a drug-free life as active and engaged members of society is central to the Scottish government's drug strategy, *The Road to Recovery: A new approach to tackling Scotland's drug problem* (Scottish Government, 2008d) (see [section 2.2.2](#)).

The key treatment-related priorities of the strategy are: to see more people recover from problem drug use so that they can live longer, healthier lives, realising their potential and making a positive contribution to society and the economy; and to improve the effectiveness of delivery at a national and local level.

31 See: <http://www.phoutcomes.info/>

The Scottish government has developed a Recovery Outcomes Web tool³² for use by local services to record and monitor people affected by problem drug and alcohol use. This is an independently validated, peer-reviewed tool which has been developed through consultation with Alcohol and Drug Partnerships (ADPs), drug and alcohol frontline staff, managers, service users and research groups.

The key aim of the tool is to measure changes in a person's life as a result of an intervention received when they access specialist support from drug and/or alcohol services in Scotland. This tool will help to provide a better understanding of an individual's recovery journey, related needs and motivation for change. Secondary benefits of the outcomes measurement tool are to inform workforce development, service improvement and future service provision for managers, ADPs, funding bodies and the Scottish government.

Wales

The Welsh Assembly government's substance misuse strategy, *Working together to reduce harms 2008-2018* (Welsh Assembly Government, 2008a), predominantly focuses on reducing the harms associated with substance misuse (see [section 2.2.3](#)). Their treatment-related objectives include: improving the availability of treatment services and related support; making better use of resources (for example, utilising evidence-based decision making, improving treatment outcomes, developing the skills of those working in the treatment sector and promoting joined up working across agencies); and developing user-focused services.

The strategy has been accompanied by shorter term implementation plans which outline performance measures for each of the key action areas, including supporting substance misusers to improve their health and aid and maintain recovery. Establishing recovery-oriented systems of care, peer-led recovery community support, and implementing best practice across Wales continue to be prioritised.

The most recent three year delivery plan was launched in September 2016 (Welsh Government, 2016), and captures the final three years of the strategy. The plan was developed in close collaboration with a wide range of stakeholders, including service users, and is clear about the contribution the substance misuse agenda can make to achieve the goals set out in the *Well-being of Future Generations (Wales) Act 2015* (National Assembly for Wales, 2015). The plan covers both mental and physical wellbeing.

Northern Ireland

The current Northern Irish strategy, *New Strategic Direction for Alcohol and Drugs (NSD) Phase 2, 2011-2016* (Department of Health Northern Ireland, 2011), has a number of treatment-related priorities including: developing a regional commissioning framework for treatment; targeting those at risk and vulnerable; and workforce development.

4.2.2 Quality standards

England

Care Quality Commission

The CQC is an independent body charged with monitoring, inspecting and regulating health and social care services, including substance misuse treatment services based in hospitals, communities and residential rehabilitation. Five key questions are asked of all services during inspection to ascertain whether they are: safe; effective; caring; responsive to people's needs; and well-led.

32 See: <http://www.ssk.s.org.uk/media/134321/ro%20web%20tool%20-%20pdf.pdf>

At present, the CQC generally only provides ratings for substance misuse services delivered by an NHS trust. Such services are not always included in trust ratings: their inclusion is based on specific criteria, such as whether the service represents a large proportion of a provider's activity or expenditure. These services are rated on a four point scale (outstanding, good, requires improvement and inadequate) for each of the five key questions. Ratings will be shared with service users and their families and carers, the public, treatment providers, commissioners and other stakeholders.

Local quality governance

While the CQC is responsible for regulating the majority of substance misuse services, a significant minority of locally commissioned services do not fall within the scope of their remit, for example community-based services where care is not provided by a listed professional. To assist LA commissioners, in July 2015, PHE provided guidance describing what quality governance is, its importance, and setting out the responsibilities of provider organisations, commissioners and national and regional bodies to ensure that quality and safety are not jeopardised (Public Health England, 2015f).

Scotland

Local delivery plans

The Local Delivery Plan (LDP) standard (formerly Health, Efficiency, Access and Treatment standard) for drug and alcohol treatment waiting times expects that 90% of people receive access to appropriate drug and/or alcohol treatment within three weeks of referral to support their recovery (Information Services Division, 2015). Getting people into treatment quickly for drug-related problems is a priority for the Scottish government, as evidence suggests this is likely to result in improved client outcomes.

Data is published on a quarterly basis at national, health board and ADP level. The most recent statistics, published in December 2016, indicate that in July – September 2016, 93.9% of the 11,438 people who started their first drug or alcohol treatment waited three weeks or less (LDP standard) (Information Services Division, 2016d). This ambitious standard therefore continues to be exceeded at national level.

Quality principles

The Scottish government has developed an alcohol and drugs quality improvement framework to ensure quality in the provision of care, treatment and recovery services, as well as quality in the data that will show the outcomes people are achieving (Scottish Government, 2014). There are eight overarching principles, each with a set of supporting statements and all underpinned by a recovery philosophy. The broad ethos of the principles being:

- an emphasis on high-quality, evidence-informed interventions
- workers who are appropriately trained and supervised
- comprehensive strengths-based assessments
- person-centred recovery plans that are agreed and regularly reviewed
- the opportunity for family members to be involved in recovery (if this is helpful to the individual).

4.2.3 Guidelines for treatment

UK guidelines on clinical management

In September 2007 the *Drug Misuse and Dependence: UK Guidelines on Clinical Management* (Department of Health England and the devolved administrations, 2007) were published, to be used as a guide by all clinicians working in drug misuse treatment, particularly those providing pharmacological interventions.

The guidelines include the following key principles underlying appropriate care of drug misusers:

- drug misusers have the same entitlement as other patients to the services provided by the NHS
- the General Medical Council's statement that: *"The investigations or treatment you provide or arrange must be based on the assessment you and the patient make of their needs and priorities, and on your clinical judgement about the likely effectiveness of the treatment options. You must not refuse or delay treatment because you believe that a patient's actions have contributed to their condition. You must treat your patients with respect whatever their life choices and beliefs"*
- it is the responsibility of GPs to provide general medical services for drug misusers. Health authorities, Primary Care Trusts in England, local health boards in Wales and health boards in Northern Ireland and Scotland all have a duty to provide treatment for drug misusers, to meet local population needs. This should include interventions to reduce drug-related harm such as hepatitis B vaccinations and needle exchange provision, together with evidence-based drug treatment
- every doctor must provide medical care to a standard which could reasonably be expected of a clinician in their position. An increasing number of clinicians are trained and supported to provide drug treatment under the terms of a contract negotiated with their local commissioners
- the focus for the clinician treating a drug misuser is on patients themselves. However, the impact of their drug misuse on other individuals and on communities should be taken into consideration.

Following a consultation carried out by PHE (on behalf of the departments of health in England, Scotland, Wales and Northern Ireland) in 2014, an independent expert working group conducted a review of the evidence on drug treatment since the 2007 guidelines were published. The guidelines are being updated in accordance with the group's findings, and are expected to be published in 2017.

National Institute for Health and Care Excellence

The National Institute for Health and Care Excellence (NICE) has produced a range of guidelines, technical appraisals and pathways relating to best practice and standards of care in the treatment of substance misuse. Interventional procedures apply to all countries of the UK. Clinical guidelines and technology appraisals apply to those using the NHS in England and Wales only and are usually disseminated after local review in Northern Ireland. Public health guidance applies to those using the NHS in England only and is often disseminated after local review in other UK countries. New guidelines for drug misuse prevention are currently in development, and are expected to be published in February 2017.

The key NICE guidelines relating to substance misuse treatment are:

- CG51 (2007) Drug misuse in over 16s: psychosocial interventions (National Institute for Health and Care Excellence, 2007b)
- CG52 (2007) Drug misuse in over 16s: opioid detoxification (National Institute for Health and Care Excellence, 2007a)
- CG120 (2011) Co-existing severe mental illness (psychosis) and substance misuse: assessment and management in healthcare settings (National Institute for Health and Care Excellence, 2011)
- NG58 (2016) Co-existing severe mental illness and substance misuse: community health and social care services (National Institute for Health and Care Excellence, 2016)
- PH4 (2007): Substance misuse interventions for vulnerable under 25s (National Institute for Health and Care Excellence, 2007d)
- PH52 (2014): Needle and syringe programmes (National Institute for Health and Care Excellence, 2014b)
- PH49 (2014) Behaviour change: individual approaches (National Institute for Health and Care Excellence, 2014a)
- QS23 (2012) Drug use disorders in adults (National Institute for Health and Care Excellence, 2012)
- TA114 (2007) Methadone and buprenorphine for the management of opioid dependence (National Institute for Health and Care Excellence, 2007c).

Project NEPTUNE

The Novel Psychoactive Treatment UK Network (NEPTUNE), an independent charity funded by the Health Foundation, conducted a systematic review of the evidence on club drugs,³³ focusing particularly on their acute and long-term harms and convened a group of UK experts to provide clinical consensus on their treatment. This evidence was used to develop *Guidance on the clinical management of acute and chronic harms of club drugs and novel psychoactive substances* (Abdulrahim & Bowden-Jones, 2015), published in March 2015. The guidance is now being translated into a number of free-to-access e-learning modules for clinicians and other practitioners, which will be available online in 2017.

4.3 Organisation and provision of drug treatment

4.3.1 Outpatient drug treatment system

Main providers

In the UK, community-based specialist drug treatment centres are the most common providers of substance misuse services. Specialist services account for 92% of community-based treatment units reporting to the NDTMS in England ($n=786$). GPs prescribing OST medications in a shared care arrangement report to NDTMS through the specialist service providing the shared care component. Some GPs prescribing in isolation do not report to NDTMS; therefore there is some under-reporting from these services.

33 The term 'club drugs' is used here to refer to a group of psychoactive substances typically used in dance venues, house parties, music festivals and sometimes in a sexual context.

Specialist drug treatment centres are predominantly public services, commissioned and funded by local government. The contracts to deliver drug treatment services commissioned by LAs are often held by registered charities. Some organisations specialise solely in substance misuse, while others deliver contracts for mental health services and services for people with learning disabilities. Specialist drug treatment services are also provided by the NHS by Mental Health Trusts.

Client utilisation

Almost all clients treated in the UK receive treatment in a community setting, including some who receive treatment in the community before or after attending a residential unit. The majority of all clients in the UK (both outpatient and inpatient) cite heroin as a problematic drug (see [section 4.4.3](#)). Comparisons with Problem Drug Use estimates suggest that in England around half of the problem opioid and/or crack using population access community treatment services.³⁴ However, the most recent problem drug use estimates cover 2011/12, therefore this figure should be considered an approximation.

4.3.2 Inpatient drug treatment system

Main providers

Inpatient and residential facilities account for 11% ($n=128$) of all substance misuse treatment units reporting data to the NDTMS in England.

Inpatient units are for those alcohol or drug users whose needs require supervision in a controlled medical environment. These units provide assessment, stabilisation and/or assisted withdrawal, with 24-hour cover from a multidisciplinary clinical team who have had specialist training in managing addictive behaviours. In addition, the clinical lead is a consultant in addiction psychiatry or another substance misuse medical specialist. The multi-disciplinary team may include psychologists, nurses, occupational therapists, pharmacists and social workers. Inpatient units are often based within hospitals, but can be attached to residential rehabilitation services or standalone. Inpatient detoxification interventions may also be delivered on a general ward within a hospital.

Residential rehabilitation services are primarily run by voluntary and private sector organisations. They offer structured programmes that may include psychosocial interventions, individual and group therapy, education and training, and social and domestic skills. There is a wide range of different types of residential rehabilitation available, and services differ widely in terms of their philosophy, intensity, inclusion criteria, programme content and duration.

Another non-hospital based residential setting in the UK is a recovery house. This is a residential living environment, in which integrated peer support and/or integrated recovery support interventions are provided for residents who were previously, or are currently, engaged in treatment to overcome their drug and alcohol dependence. The residences are also referred to as dry-houses, third-stage accommodation or quasi-residential.

Client utilisation

The proportion of the overall treatment population who receive treatment in inpatient/residential settings is low compared to those who receive it on an outpatient basis. In England in 2015/16, 5.2% of the total treatment population were reported as having been treated in an inpatient unit;

³⁴ Based on the most recent estimates for prevalence of opioid use and/or crack cocaine use: 293,879 from 2011/12 (Hay et al., 2014).

2.6% were treated in a residential service;³⁵ and 0.2% were treated in a recovery house (with some clients having been treated in more than one setting).

The average cost of inpatient treatment is £160.42 daily compared with £100.86 for residential rehabilitation.³⁶ Given the average time spent in residential rehabilitation is 11 weeks, this equates to an average of over £7,750 for every treatment episode commissioned by LAs. As such, clients accessing rehabilitation will usually be required to meet certain admission criteria, including: being abstinent from drugs and alcohol following detoxification; a commitment to becoming substance free; a desire to leave treatment; and having been assessed as capable of achieving abstinence and being prepared to do so. Clients are usually also required to complete a period of community treatment prior to rehabilitation and may return to community services for further support after exiting inpatient facilities.

The NICE guideline CG51 (National Institute for Health and Care Excellence, 2007b) recommends that residential rehabilitation be used for the “most complex” clients. As such, those accessing residential rehabilitation will usually have:

- not benefited from previous community-based psychosocial treatment
- longer and more entrenched drug and alcohol misusing careers
- a range of problem substances
- more significant housing problems
- co-morbid physical and/or mental health problems.

In addition, residential rehabilitation services treat a higher proportion of clients who are using both heroin and crack, injecting drugs, polydrug users, and offenders.

In 2015/16, in England 5,217 clients accessed support through residential rehabilitation, as reported by the NDTMS (Public Health England, 2015a).

4.3.3 Prisons

There are 138 prisons across the UK (120 in England and Wales, 15 in Scotland and three in Northern Ireland), and the majority offer some form of treatment for substance misuse. Prison drug treatment reporting is not yet fully integrated with community datasets, and until 2014 only Northern Irish prison treatment data was included in TDI figures. However, from 2015 data from prisons in England will also be included. The provision of treatment in prisons is covered in [section 5](#).

4.4 Data from the Treatment Demand Indicators

4.4.1 Changes to the treatment demand indicator and reporting

The TDI records the number of clients presenting to a treatment centre in a particular year, but does not provide information on clients who remain in treatment without starting a new treatment episode. Data is presented for the UK as a whole unless otherwise stated.³⁷ Due to

35 These figures do not include private clients as they are not reported to the NDTMS.

36 Based on the New Economy Unit Cost Database, see: http://neweconomymanchester.com/stories/832-unit_cost_database

37 Percentages quoted are valid percentages.

changes in the TDI protocol, data from 2013 are not directly comparable to previous national reports. Further information is available in accompanying tables Treatment 1, 2 and 3.

In 2015, 124,234 clients presented to treatment in the UK. This figure includes data from NHS Greater Glasgow and Clyde and NHS Tayside health boards, which was not included last year, and (for the first time) data from clients receiving treatment in prison in England.

For the reporting year 2015, the EMCDDA began to collect data not only on those presenting to treatment in the given year, but also on clients that were in treatment at the beginning of the year (treatment prevalence). The data collected on these individuals is not as comprehensive as that for TDI cases; however, information available includes age, primary substance, duration in treatment and OST status. Treatment prevalence data is available for England and Wales only. As with TDI, English prisons data is included in these figures.

4.4.2 Treatment centres

A total of 1,086 treatment centres reported TDI data through national treatment monitoring systems in the UK during 2015. Of these, 71% provided outpatient services ($n=775$), 10% provided inpatient services ($n=110$), 12% were treatment services in prison ($n=131$) and 4.5% were GP services ($n=49$).

Table 4.1 shows that 72% of all clients presenting to drug treatment in the UK during 2015 were treated in outpatient centres. Opioid users make up a larger proportion of clients within inpatient and GP services than within outpatient services.

Table 4.1: Primary drug by centre type in the United Kingdom, 2015

	Outpatients		Inpatients		Prison*		GP†		Other		Total	
	n	%	n	%	n	%	n	%	n	%	n	%
Amphetamines	2,301	2.9	29	2.3	609	2.1	10	1.0	0	0	3,122	2.6
Benzodiazepines	1,294	1.6	20	1.6	712	2.5	157	15.3	45	7.5	3,205	2.7
Cannabis	22,841	28.4	55	4.5	6,047	21.3	65	6.3	351	58.4	31,129	25.9
Cocaine powder	8,208	10.2	127	10.3	2,951	10.4	24	2.3	72	12.0	11,858	9.9
Crack cocaine	2,556	3.2	116	9.4	2,073	7.3	12	1.2	0	0	4,815	4.0
Opioids	38,861	48.4	835	67.6	14,516	51.2	663	64.6	45	7.5	59,763	49.7
Other	4,241	5.3	53	4.3	1,457	5.1	95	9.3	88	14.6	6,402	5.3
Sub-total	80,302	100	1,235	100	28,365	100	1,026	100	601	100	120,294	100
Not known	144		3		35		5		0		3,940	
Total	80,446	72.0	1,238	1.1	28,400	25.4	1,031	0.9	601	0.5	124,234	100

*Data are for England and Northern Ireland only

†Data are for England only

Source: TDI

4.4.3 Characteristics of treated clients

The following data outlines the characteristics of clients seeking treatment in the UK and is based on data from TDI and TDI Prevalence tables. Similarly to previous years, 78% of clients presenting to treatment were male, and 33% had never received treatment previously.

Source of referral

As in previous years, the most common source of referral among clients starting a new episode of treatment in 2015 was self-referral (46%), with the criminal justice system (CJS) the next most

common referral source (20%). Despite the association between opioid use and crime, the proportion of opioid clients referred to treatment through the CJS was actually slightly lower than the proportion of primary cannabis and cocaine users (19%, 22% and 23% respectively). Previously treated clients were more likely to self-refer than those who were new to treatment (50% and 38%, respectively) (TDI).

Primary drug

Primary drugs reported through the treatment demand indicator

In 2015 half of all treatment presentations in the UK were for primary opioid use (50%; a small decrease from 52% in 2014), with just over one-quarter (26%) for primary cannabis use (see accompanying table Treatment 1). However, the pattern is markedly different between those reporting that they have been previously treated and those who have not, with cannabis being the most frequently reported primary drug among first ever presentations (46% compared to 16% of those reporting previous treatment). The proportion of previously treated clients reporting primary opioid use was approximately three times that of those new to treatment (64% and 22%, respectively). This is indicative of heroin clients being more likely to drop out of treatment and to subsequently re-present, or to relapse after completing a treatment episode and to seek treatment again as a result.

While new treatment entrants were around twice as likely to report a primary substance of powder cocaine as previously treated clients (14% and 7.6% respectively), they were less likely to report a primary substance of crack cocaine (2.8% and 4.6% respectively), indicating that crack users are also more likely to have multiple episodes. First time treatment entrants were more likely to report the primary use of stimulants other than cocaine (7.0%), and benzodiazepines (3.5%), compared to those who had been previously treated (3.8% and 2.2% respectively).

Comparisons of clients accessing treatment across the United Kingdom

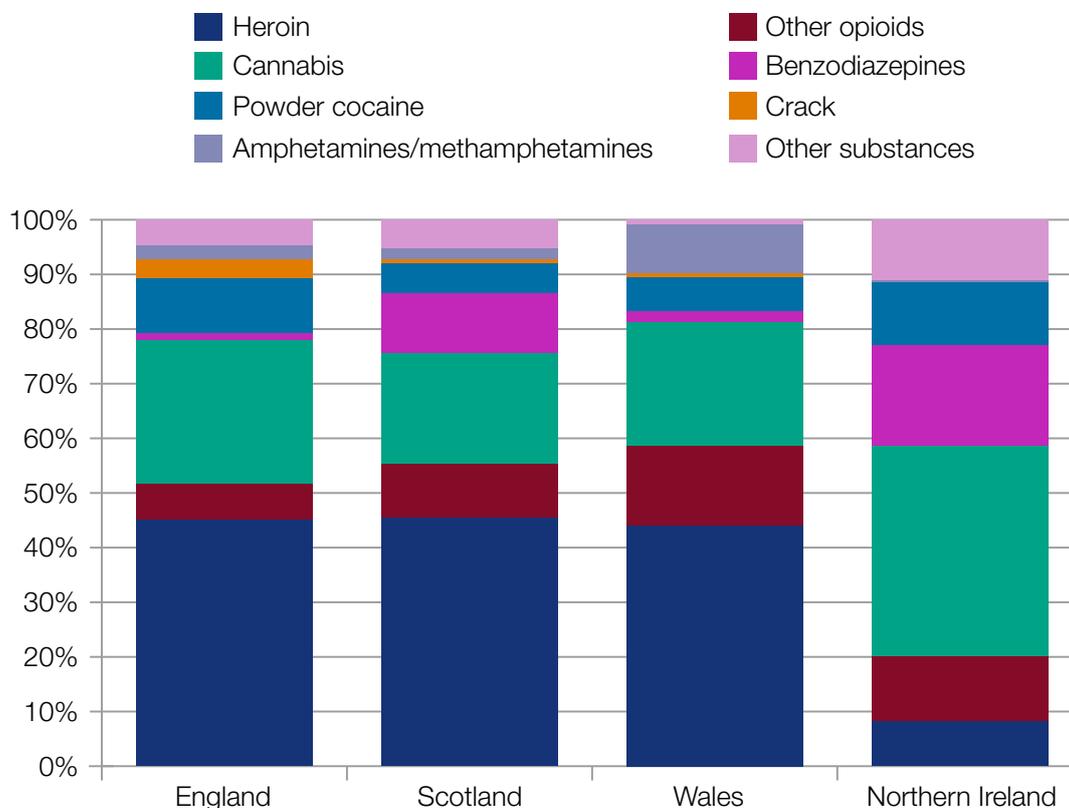
Due to its greater population size, data from the treatment system in England has a substantial influence on primary drugs reported for the UK; however, there are a number of differences between the countries of the UK in the primary drugs cited by clients, shown in Figure 4.1. While primary opioid use was reported by around half of all treatment entrants in England, Wales and Scotland (49%, 55% and 55%, respectively), only 20% of clients starting treatment in Northern Ireland in 2015 reported primary use of these drugs. England had almost twice the proportion of treatment entrants citing primary use of powder cocaine in comparison to Wales and Scotland (10%, 6.1% and 5.4%, respectively), and more than five times the proportion of treatment entrants citing primary crack use (4.6%, 0.8% and 0.7%, respectively).

Northern Ireland reported a relatively large proportion of its treatment entrants as seeking help for drugs that are commonly prescribed as medicines. 'Other opioids' represented 10% of treatment entrants (compared to 3.3% in the UK overall), and 18% of clients reported primary benzodiazepine use in this country, compared to 1.6% in England and 2.0% in Wales. These values are high even when taking into account the differences caused by the smaller proportion of opioid treatment seekers in Northern Ireland. Scotland also reported a high proportion of primary benzodiazepine users, with 11% of treatment entrants citing these substances.

There were also differences between the countries of the UK with respect to stimulants other than cocaine reported upon treatment entry. Wales reported the greatest proportion of these clients in 2015, with 8.9% of all treatment entrants reporting primary use of amphetamines (compared to 2.2% in England, 2.0% in Scotland and 0.3% in Northern Ireland). Synthetic cathinones were reported by 1.4% of clients in England and 2.6% of clients in Northern Ireland; primary synthetic cathinone use was reported by more clients in Northern Ireland than primary

use of amphetamines, methamphetamine and MDMA combined. Scotland and Wales did not provide information on synthetic cathinone use.

Figure 4.1: Proportion of clients presenting to treatment in the United Kingdom in 2015, by country and primary drug



Source: TDI

Primary drug breakdown for continuous treatment clients (England and Wales)

The length of time that clients spend in drug treatment differs greatly depending on the nature of the drug for which they are seeking help; in particular, opioid clients are typically in treatment for much longer than non-opioid clients. As such, the distribution of primary drug for just those clients who commence treatment in a year (ie TDI cases) does not take into account those (mostly opioid) clients in continuous treatment from the previous year. Of the 137,409 clients in continuous treatment in England and Wales in 2015, 82% were in treatment due to primary opioid use, with 72% of all clients citing heroin. This is a much greater proportion than for those commencing treatment in 2015 (see above). At nine per cent, cannabis was the only other primary drug cited by more than five per cent of those in continuous treatment. Methadone use was cited by 4.6% of clients, and powder cocaine was cited by 3.2% (TDI Prevalence).

Secondary substances

Alcohol was the most common secondary substance reported by those entering treatment in 2015, with 22% of all clients ($n=25,789$) reporting a secondary alcohol problem. Secondary alcohol use was most common among those reporting primary powder cocaine (40%), MDMA (30%), crack cocaine (29%) and cannabis (29%) (TDI).

Crack cocaine was the next most common secondary substance, reported by 23,540 clients (20%). The vast majority ($n=22,207$; 94%) of these clients were primary opioid users. The number of primary heroin clients entering treatment in the UK reporting secondary use of crack cocaine has been increasing since 2003/04, and in 2015 accounted for 45% of all primary

heroin presentations (a rise from 38% in 2013 and 41% in 2014). In England, crack use was reported by 43% of primary opioid users, whereas in Scotland and Northern Ireland, only 3.3% and 1.6% of primary opioid users reported secondary crack cocaine (TDI).³⁸

The number of clients presenting to treatment in the UK in 2015 reporting a secondary benzodiazepine problem ($n=9,384$) was over three times the number of presentations reporting a primary benzodiazepine problem ($n=3,079$). Heroin users accounted for more than two-thirds (67%) of these secondary benzodiazepine users. As with primary use, secondary benzodiazepine use was high in Northern Ireland and Scotland, with 40% and 30%, respectively, of primary opioid users in these countries reporting secondary use, whereas 11% of opioid users in England reported secondary benzodiazepine use (TDI).

Age

Age of treatment presentations

The mean age of all treatment presentations in 2015 was 32.4 years. However, those who had never previously received treatment tended to be younger (28.2 years). Of all clients accessing treatment, males tended to be slightly older than females (32.6 years and 31.8 years respectively), but the ages across genders were more similar in new treatment entrants (28.1 years in males and 28.2 years in females) (TDI).

Of all clients accessing treatment in 2015, those accessing treatment for heroin, methadone, crack cocaine and benzodiazepines tended to be older (36.6 years, 37.3 years, 35.9 years and 36.6 years, respectively) than those accessing treatment for cannabis, MDMA and volatile substances (24.3 years, 22.1 years and 25.0 years, respectively). Among users of stimulants other than cocaine, those who presented for treatment of amphetamine or methamphetamine use were almost ten years older than those who required treatment for use of synthetic cathinones (35.0 years, 35.8 years and 26.1 years, respectively). These patterns of age differences were seen irrespective of gender or treatment history, except for volatile inhalant users, where those new to treatment were approximately ten years younger than those who have received treatment previously (21.0 years and 30.4 years, respectively).

Since 2003/04 the percentage of primary heroin users entering treatment who were over the age of 40 years has more than trebled, increasing from 10% to 35% in 2015; this is reflective of the static population of an ageing cohort.

Age of those in continuous treatment (England and Wales)

Age breakdowns of those in continuous treatment are available for clients in England and Wales (see accompanying table Treatment 2). Nearly two-thirds (64%) of the 137,409 clients in continuous treatment in 2015 were aged 35 and over. However, as clients in treatment for opioid use make up more than three-quarters (82%) of all those in continuous treatment, they heavily influence age breakdowns. Excluding primary opioid clients, the majority of service users in continuous treatment were aged under 35 years (68%), with 38% aged under 25.

Of the 98,811 clients in treatment for heroin use in 2015, the greatest proportion (44%) were in the 35-44 years age bracket, with 71% aged 35 and over. Crack cocaine also showed a similar age split, with 65% of these clients aged 35 and over, whereas cocaine powder users were more likely to be younger, with 67% of clients aged under 35. Benzodiazepine and amphetamine clients were mostly aged 35 and over (61% and 59%, respectively).

38 Data from Wales has not been included, as data on secondary substance use was not known for 87% ($n=6,385$) of the 7,345 Welsh treatment clients.

Three-fifths (60%) of those in continuous treatment for cannabis use were aged under 25, and 83% were under 35. More than four-fifths of clients in treatment for primary use of MDMA, hallucinogens and synthetic cathinones were aged under 35 (80%, 82% and 86%, respectively).

Age at first use among treatment entrants (England and Northern Ireland)

Data on the age at first use of the primary drug cited is only available for England and Northern Ireland (TDI). The ages at first use of cannabis, volatile substances and MDMA were lower than for other drugs (14.7 years, 15.9 years and 17.1 years, respectively). This was similar regardless of gender and history of previous treatment.

Injecting status

The majority (62%) of clients presenting to treatment reported that they had never injected drugs, with 16% reporting current injecting. Previously treated clients were three times more likely to report currently injecting than new treatment clients (see Table 4.2). Primary opioid users accounted for 90% of current injectors, with amphetamine users accounting for 2.4%. Heroin users were most likely to inject, with over one-third (37%) of treatment entrants citing injecting as their primary route of administration. Although accounting for small numbers, a high proportion of methamphetamine users (69/207; 33%) were recorded as current injectors. Clients in Northern Ireland were much less likely to have ever injected, or be currently injecting, than those in the rest of the UK: 12% of Northern Irish clients had ever injected, with 3.6% currently injecting (see accompanying table Treatment 1).

Table 4.2: Injecting status among all clients entering treatment in the United Kingdom, 2015

Injecting status	New treatment clients		Previously treated clients		All clients	
	n	%	n	%	n	%
Ever injected, but not currently	2,711	7.9	21,938	28.2	24,733	22.0
Currently injecting (in last month)	2,215	6.5	16,241	20.9	18,515	16.5
Never injected	29,347	85.6	39,714	51.0	69,254	61.6
<i>Sub Total</i>	<i>34,273</i>	<i>100</i>	<i>77,893</i>	<i>100</i>	<i>112,502</i>	<i>100</i>
Not known/missing/don't want to answer	6,117		5,017		11,732	
Total	40,390	32.8	82,910	67.2	124,234	100

Source: TDI.

4.4.4 Treatment demand indicator trends

As mentioned above, TDI data for 2015 includes data collected in prisons in England for the first time; previously only Northern Ireland had provided data for clients in treatment in prison. For the sake of continuity, the English prison data has been removed for the trends section of this annual report.

Due to the introduction of a new methodology for calculating TDI, differences between 2013 data and previous years should be interpreted with caution. Both the increase in proportion of cannabis presentations and the decrease in opioid presentations from 2011/12 to 2013 will have been exaggerated by the introduction of the new TDI protocol and should not be treated as one time series.

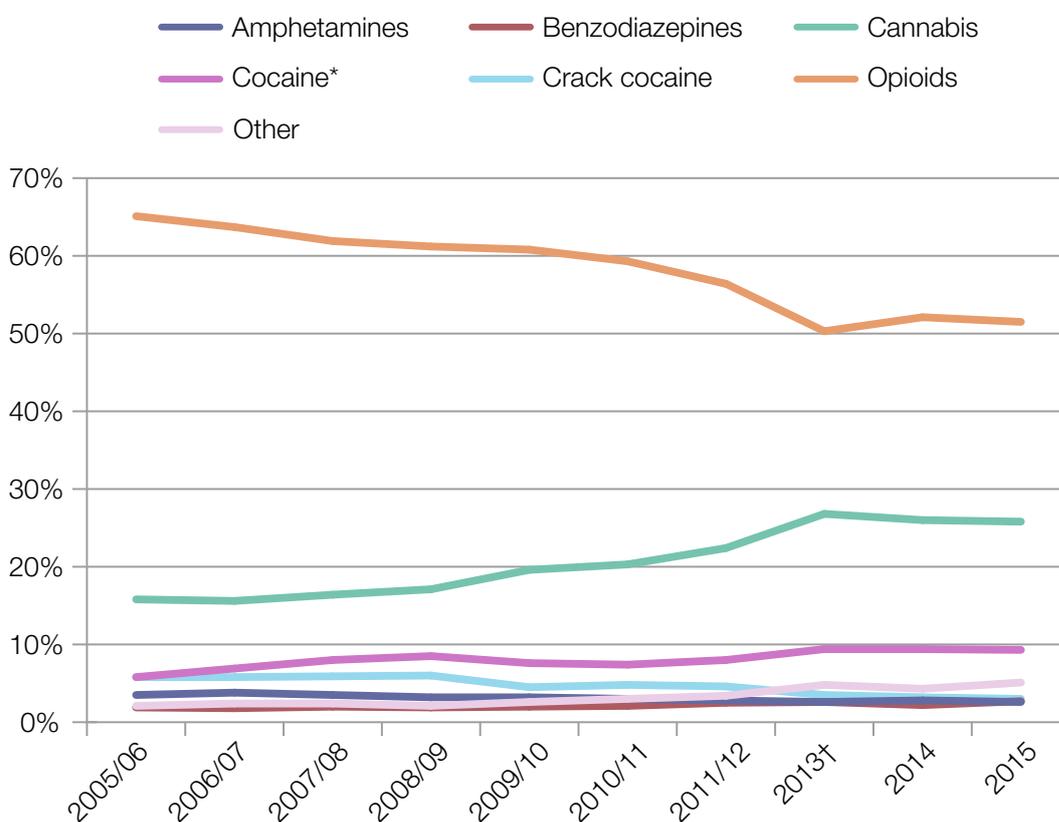
All treatment entrants

From 2003/04, the percentage of primary cannabis presentations steadily increased from 11% of all presentations through to 22% in 2011/12 (the last year of the previous protocol) (see Figure 4.2). After the change in TDI protocol in 2011/12, the proportion of treatment entrants with primary cannabis use increased to 27%; however, this has fallen to 26% in 2015.

There has been a decrease in the percentage of all clients accessing treatment for primary opioids, from a peak of 71% in 2003/04 to 56% in 2011/12 (see Figure 4.2). This proportion has remained at just over half of all treatment entrants in 2015 (51%).

Presentations for primary crack cocaine have halved from a peak of 6.0% in 2008/09 to 3.0% of the treatment cohort in 2015. The proportion of treatment entrants who are being treated for primary use of benzodiazepines has steadily increased since 2005/06, and in 2015 was 2.7% of the treatment entrants (up from 1.9% in 2005/06).

Figure 4.2: Percentage of all drug treatment presentations by primary drug in the United Kingdom, 2005/06 to 2015



*Includes cocaine powder and cocaine unspecified

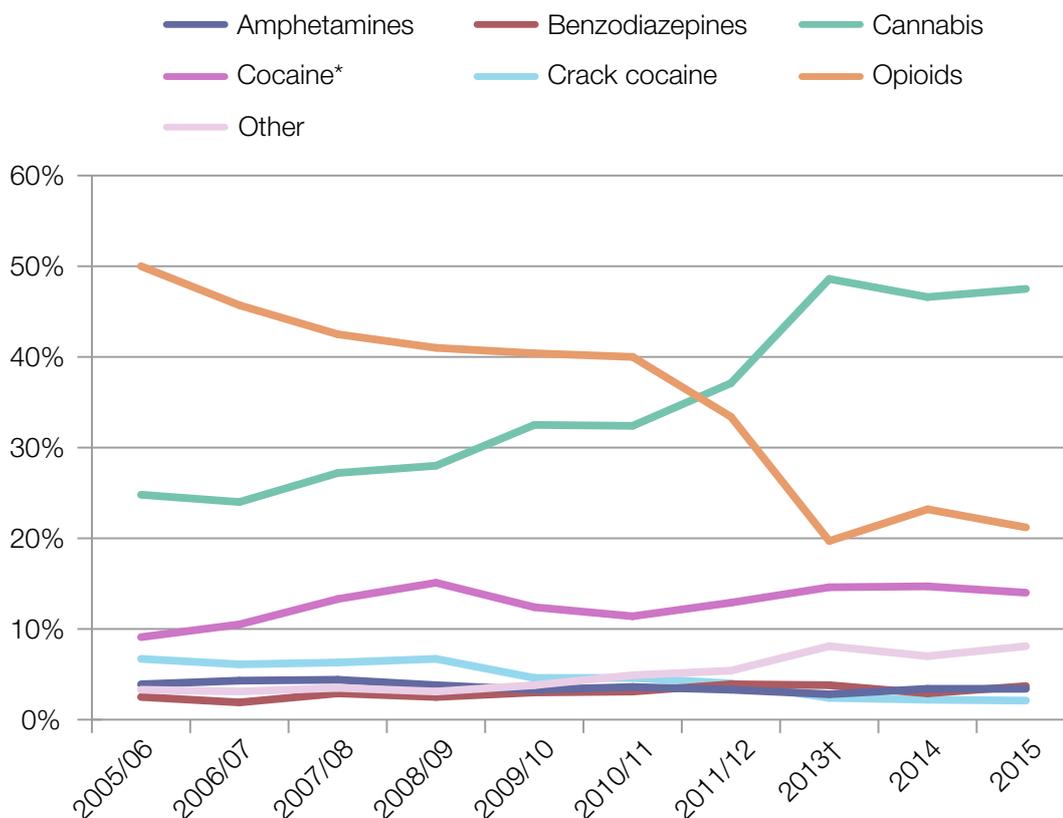
†Figures are not directly comparable to previous years due to changes in TDI protocol

Source: TDI

New treatment entrants

After recent rises in the percentage of first ever treatment presentations for cannabis, this proportion appears to have stabilised at just under 50% of the new to treatment population (48% in 2015). The overall percentage of primary opioid clients has decreased from a peak of 58% in 2003/04 to 21% in 2015/16 (see Figure 4.3). The long-term fall in the proportion of opioid cases among first presentations towards the beginning of the series will be partly an artefact of the methodology used prior to 2013. Additionally, the drop from 2010/11 to 2011/12 in opioid presentations may reflect reduced demand for treatment as a result of reduced supply of heroin at that time.

Figure 4.3: Percentage of first drug treatment presentations by primary drug in the United Kingdom, 2005/06 to 2015



*Includes cocaine powder and cocaine unspecified

†Figures are not directly comparable to previous years due to changes in TDI protocol

Source: TDI

4.5 Published statistics from national treatment reporting systems

Aside from TDI data, which is generated from national treatment reporting systems for the UK Focal Point/EMCDDA, statistics on clients in treatment are published by England, Wales and Scotland. In Northern Ireland, a census of those in treatment on a certain day is carried out every two years, with the most recent carried out in 2014.

4.5.1 Data from the National Drug Treatment Monitoring System in England

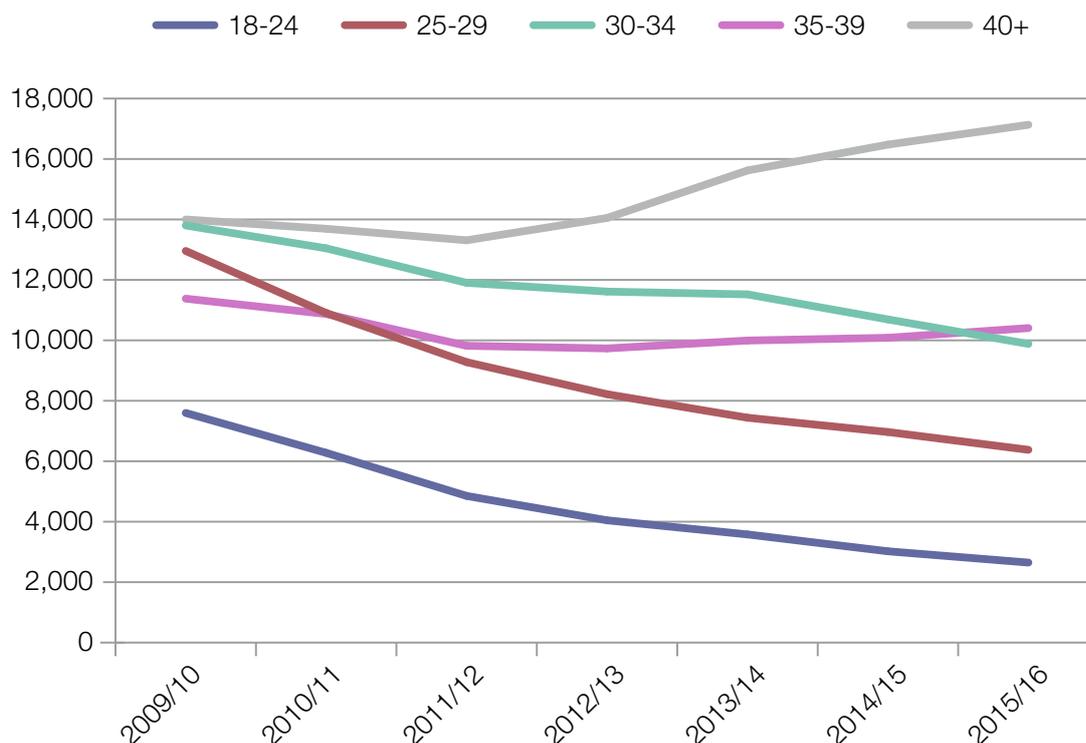
Adults in treatment

Due to a change in the methodology used by the NDTMS in England, it is not possible to compare previously reported figures of adult clients in treatment with those from 2014/15. Drug and alcohol treatment clients are now reported together, meaning that those who had drug use treatment needs who might previously have been seen by alcohol services (and so not included in drug treatment statistics) are now reported. Therefore, the total number will appear to have increased. NDTMS has, however, reanalysed previous data using the new methodology, allowing for some comparisons. Historical figures will not match those previously reported.

In 2015/16 there were 203,808 individuals over the age of 18 in drug treatment in England; a slight decrease from the previous year ($n=206,117$) and a continuation of the decreasing trend in numbers in treatment that started in 2009/10 (Public Health England, 2016a).

This reduction is principally driven by decreases in the numbers of new treatment journeys for opioids and/or crack cocaine. Between 2005/06 and 2015/16, decreases in treatment presentations for opioids and/or crack have occurred in all age groups except those aged 40 and over (see Figure 4.4). However, in recent years, the number in the 35-39 years age group has levelled out. These decreases mirror reductions in estimates of the prevalence of problem drug use (PDU) and suggest an ageing cohort of opioid and/or crack cocaine users.

Figure 4.4: Number of adult new treatment presentations for opioids and/or crack cocaine by age group in England, 2009/10 to 2015/16



Source: (Public Health England, 2016a)

Young people in treatment in England

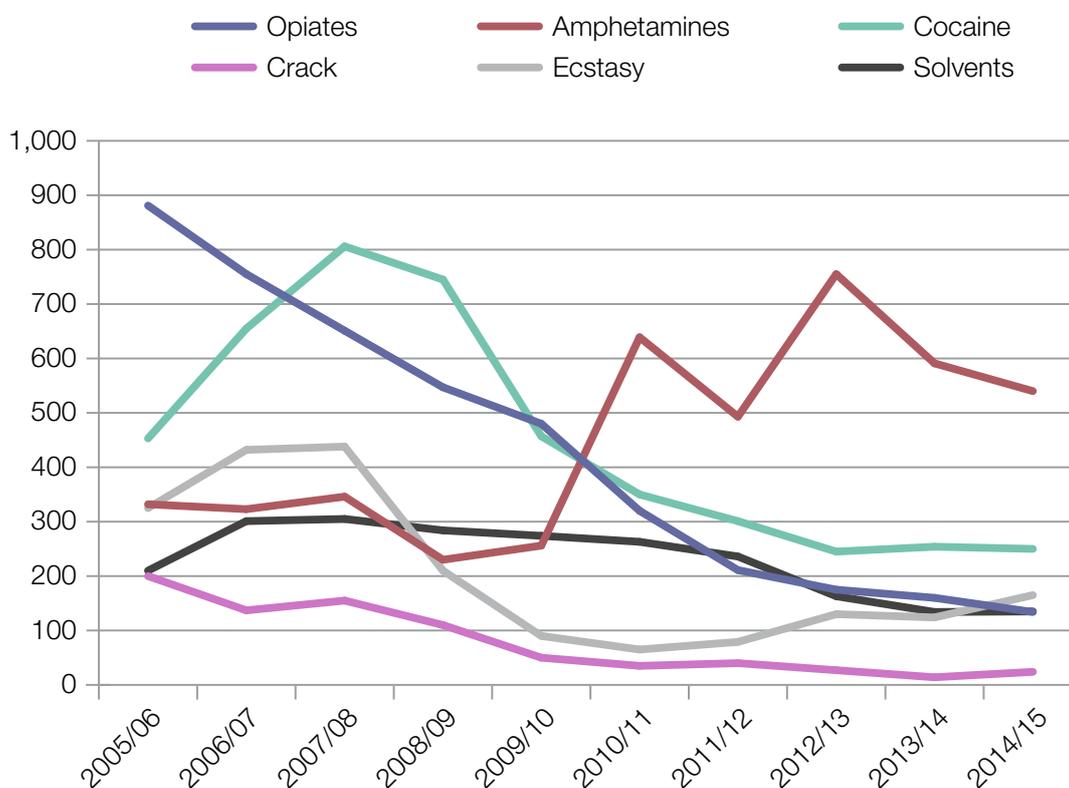
The number of young people (aged nine to seventeen) attending specialist drug misuse services during 2014/15 was 15,216, down from 15,350 in 2013/14 (a 0.9% decrease) (Public Health England, 2015i). This decrease is in line with decreases in self-reported drug use among young people (Health and Social Care Information Centre, 2015). Young people waited an average of two days to start treatment and 98% waited less than three weeks from the point of referral to the first appointment (Public Health England, 2015i).

Cannabis remains the most cited primary drug for which young people present to treatment in England. Although there has been a decline in self-reported use of cannabis, the number of young people entering treatment for primary cannabis use has been increasing steadily. In 2007/08 there were just over 9,000 young treatment entrants citing cannabis as a primary substance and in 2014/15 this had increased to 13,454 (88% of all young drug treatment entrants). However, the number of cannabis entrants seems to have stabilised between 13,000 and 14,000 within the last three years (Public Health England, 2015i).

In 2014/15, the number of young people citing heroin as their primary substance fell to a historic low of 97, continuing the decreasing trend since 2005/06 and mirroring adult treatment data. Following five years of decreasing presentations for powder cocaine (806 in 2007/08 to 245 in

2012/13), the figure has remained stable for the past two years, and was 250 in 2014/15 (see Figure 4.5). The number of presentations for amphetamine use has decreased over the past two years, nonetheless the number in 2014/15 was nearly double that seen in 2005/06.

Figure 4.5: Number of young people in treatment for the primary problematic use of selected drugs in England, 2005/06 to 2014/15



Source: (Public Health England, 2015i)

4.5.2 Data from the Scottish Drug Misuse Database

In 2014/15, 12,402 individuals in Scotland had an initial assessment for specialist drug treatment (Information Services Division, 2016f). As has been found previously, and observed in data from England, since 2006/07 an increasing proportion of individuals from older age groups have been assessed for specialist drug treatment each year. In 2006/07, under one-third (30%) of the assessed individuals were aged 35 and over, which has increased to just under half (48%) of clients in 2014/15.

While heroin was still the most common drug for which individuals sought treatment in 2014/15, the proportion of clients reporting this drug as their main substance has decreased over time, from 64% ($n=6,357$) in 2006/07 to 46% ($n=3,955$) in 2014/15; this proportion varied between health boards, from 35% to 64%. Cannabis was the second most common primary drug, with 20% of individuals reporting use of this substance, followed by diazepam (10%). Use of these two substances has increased over time, up from 14% and six per cent, respectively, in 2006/07. The proportion of individuals reporting 'other opiates' (ie those other than heroin, methadone and dihydrocodeine) has also increased, from 0.6% in 2006/07 to 5.2% in 2014/15.

In line with the trend reported over recent years, fewer young people are reporting heroin use upon initial assessment. In 2006/07, 58% of those under the age of 25 reported using heroin at their initial assessment; this fell to 23% in 2014/15. The percentage of individuals currently

injecting fell between 2006/07 and 2012/13, from 28% to 21%; this proportion appears to have stabilised, and was 20% in 2014/15, with a range between health boards of 11% and 31%.

4.5.3 Data from the Welsh National Database for Substance Misuse

In 2015/16, the number of new referrals to treatment citing drugs (including those with a primary substance of alcohol)³⁹ in Wales was 9,561, a decrease from 10,392 in 2014/15 (NHS Wales Informatics Service & Welsh Government, 2016).⁴⁰ The distribution of males/females has remained broadly consistent across the years; 72% of all clients referred were male and 28% female in 2015/16. Following an increase in 2012/13, the number of clients citing an opioid as their main problematic substance on referral has decreased every year since then, and in 2015/16 was 4,309, down from 4,871 in 2014/15. Heroin remains the most cited drug at treatment referral, accounting for 42% of all referrals for which drugs were specified as the main problematic substance, a slight decrease from 44% in 2014/15. Cannabis ($n=1,943$; 24%) was the second most common primary drug cited at referral. Amphetamines remained the third most common substance ($n=677$; eight per cent) in 2015/16, ahead of cocaine ($n=536$; six per cent).

4.5.4 Data from the Northern Ireland Drug Misuse Database

In Northern Ireland in 2015/16, a total of 2,229 clients presented to services for problem drug misuse, a similar number to 2014/15 ($n=2,262$), but 21% lower than the number that presented in 2012/13 ($n=2,824$) (Department of Health Northern Ireland, 2016b). However, the number of clients presenting to treatment has increased from 1,409 in 2003/04. Unlike treatment presentations in England, Wales and Scotland, heroin was the fourth most common main drug, with eight per cent of individuals citing it upon presentation. Cannabis, benzodiazepines and cocaine were more common than heroin, with 40%, 17% and 11% of clients citing these substances as their main drugs. Tramadol was reported as the main drug by 4.8% of clients, and 2.3% reported primary use of NPS.

4.5.5 Treatment outcomes

The Treatment Outcomes Profile (TOP) is a clinical tool that enables clinicians and drug workers to keep track of the progress individuals make through their treatment journey.⁴¹ It measures drug use and gives an early indication about a client's progress in overcoming problems with work, education or housing through a set of 20 questions. TOP was introduced in England in 2007 and has been used in Wales since 2009. In Scotland, from 2008 an enhanced, web-based SDMD follow-up reporting system was introduced to collect information on individuals throughout their treatment, not just at initial assessment. TOP data from England and Wales is not comparable due to differences in reporting methodologies.

39 Where there is a known substance type.

40 Figures will not match referenced figures as they exclude alcohol (used without other drugs) as a primary substance type.

41 A TOP assessment is completed at treatment entry and then should be completed every three months and on treatment exit. See: <http://www.nta.nhs.uk/healthcare-TOP.aspx>

Treatment outcomes profile data in England

Table 4.3 shows the mean number of days' use of a drug reported at treatment start and review, and the percentage of clients reporting abstinence of that drug at the six month treatment review in England in 2015/16 (Public Health England, 2016a). As with other NDTMS data, the reporting methodology changed in 2014/15, and so those using non-opioid drugs are divided into those also using alcohol and those not also using alcohol. In 2015/16 the mean days' use⁴² of a drug at treatment start was highest for opioids (all opioid clients) and cannabis (without alcohol) (22 days). This was followed by amphetamines (without alcohol) and crack cocaine (in those also using opioids) (both 14 days) and then cocaine powder (without alcohol; 10 days). For cannabis, powder cocaine and amphetamine users, those who also used alcohol all had a lower mean days' use at treatment start, a lower mean days' use at six month review, and were more likely to be abstinent at six month review.

Table 4.3: Self-reported drug use by Treatment Outcome Profiles at treatment start and six month review, and the percentage of abstinent clients at six month review in England, 2015/16

	Mean days' use of drug at treatment start	Mean days' use of drug at six month review	Percentage of clients abstinent at six month review
Opioids (all opioid clients)	21.6	8.3	39%
Crack (in those also using opioids)	13.7	6.7	43%
Powder cocaine (without alcohol)	9.9	2.5	65%
Powder cocaine (with alcohol)	8.9	2.2	67%
Amphetamines (without alcohol)	14.2	5.6	60%
Amphetamines (with alcohol)	11.6	4.5	67%
Cannabis (without alcohol)	22.0	11.3	38%
Cannabis (with alcohol)	19.0	9.0	50%

Source: (Public Health England, 2016a)

Users of both opioids and crack cocaine reduced their days of illicit opioid use by less than opioid only users (mean days' use of drug at six month treatment review was ten days compared to seven days out of the last 28 days) (Public Health England, 2016a).

Treatment outcomes profile data in Wales

Based on TOP data in Wales, for those with a main problematic substance of heroin the average number of days of heroin use fell from 22.4 at the start TOP to 8.5 at the exit TOP (a 62% reduction), with 56% having not used heroin at all in the 28 days prior to the exit TOP (NHS Wales Informatics Service & Welsh Government, 2016). Reductions were greater in clients citing use of powder cocaine, where the average number of days of powder cocaine use fell from 9.4 to 2.6 (a 72% reduction). Reductions were also seen in clients who used cannabis from 22.7 days to 14.0 (a 38% reduction), with 28% not having used cannabis at all in the 28 days prior to the exit TOP. Finally, the change in frequency in the use of amphetamines between start and exit TOPs fell from 17.6 to 8.8 days (a 50% reduction), with 47% having not used amphetamines at all in the 28 days prior to the exit TOP.

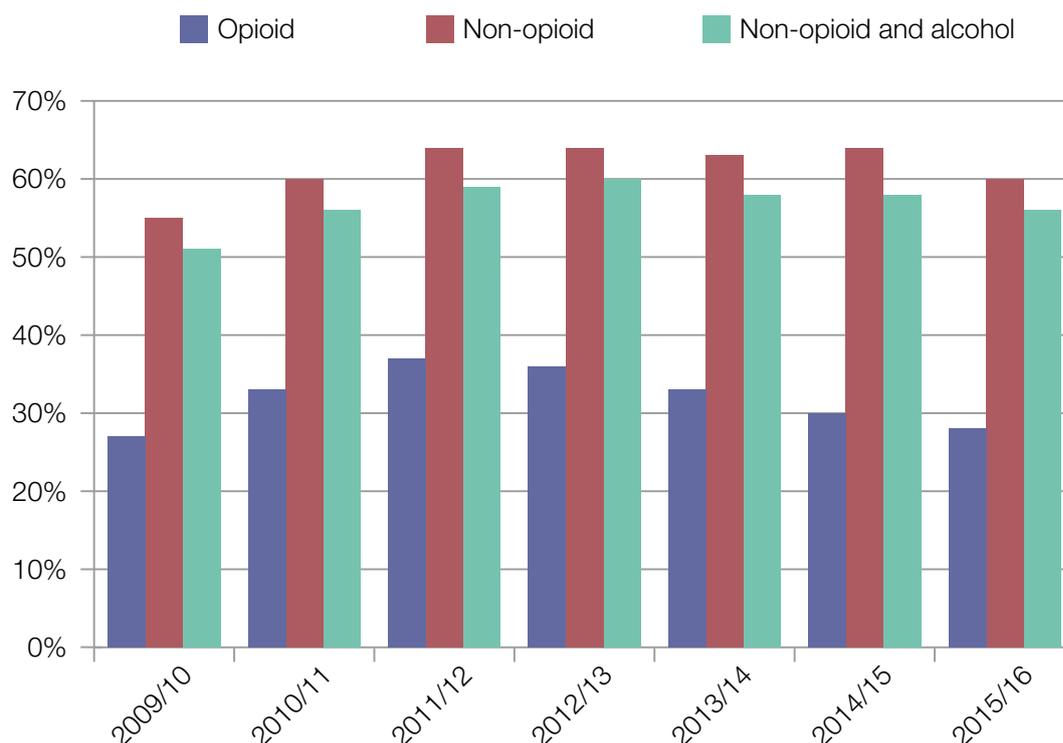
42 Self-reported use in the 28 days prior to starting treatment.

4.5.6 Clients leaving treatment successfully in England

Adult clients

The number of opioid clients leaving treatment successfully in England was 10,463 in 2015/16. This represented 28% of those exiting treatment. Slightly fewer clients who cited non-opioid drugs with or without alcohol left treatment successfully ($n=9,955$ and $n=10,545$, respectively); however, these successful completions represented 56% and 60% of the total treatment exits for these two groups of clients, respectively (see Figure 4.6).

Figure 4.6: Proportion of clients leaving treatment free from dependency in England, 2009/10 to 2015/16



Source: (Public Health England, 2016a)

Young people

In 2014/15 12,074 individuals under the age of 18 exited treatment, 80% of whom did so in a planned way and no longer required specialist treatment (Public Health England, 2015i).

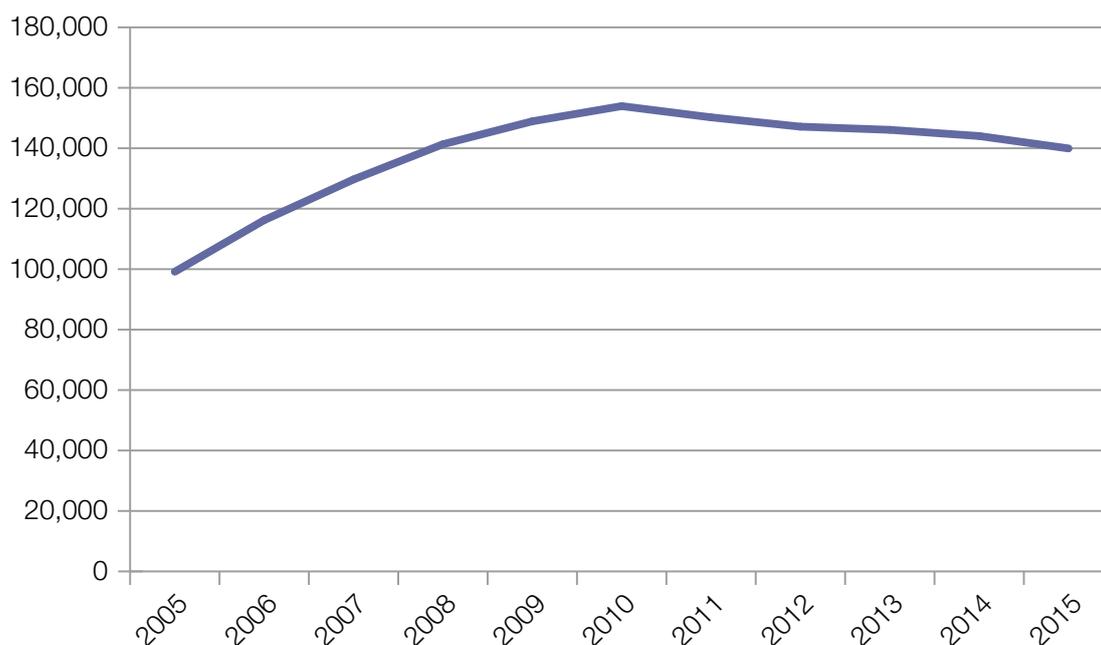
4.6 Opioid substitution treatment

In the UK OST can be prescribed and managed by any GP, although the vast majority is received through structured treatment services where clients are encouraged to also engage in other forms of treatment such as psychosocial intervention, counselling and/or groups. Both methadone and buprenorphine are recommended in NICE guideline TA114 as treatment options for people who are opioid dependent (National Institute for Health and Care Excellence, 2007c). Methadone currently remains the most commonly prescribed drug for OST overall in the UK; however, in Northern Ireland methadone and buprenorphine are prescribed at similar levels.

4.6.1 England

Data from the NDTMS shows that the number of opioid users in prescribing treatment increased from 99,149 in 2005 to a peak of 153,939 in 2010. It has decreased slightly from this point, and in 2015 treatment was prescribed to 139,937 clients in England, a fall from the 144,038 recorded in 2014 (see Figure 4.7).

Figure 4.7: Trends in numbers of clients in England receiving opioid substitution treatment, 2005 to 2015



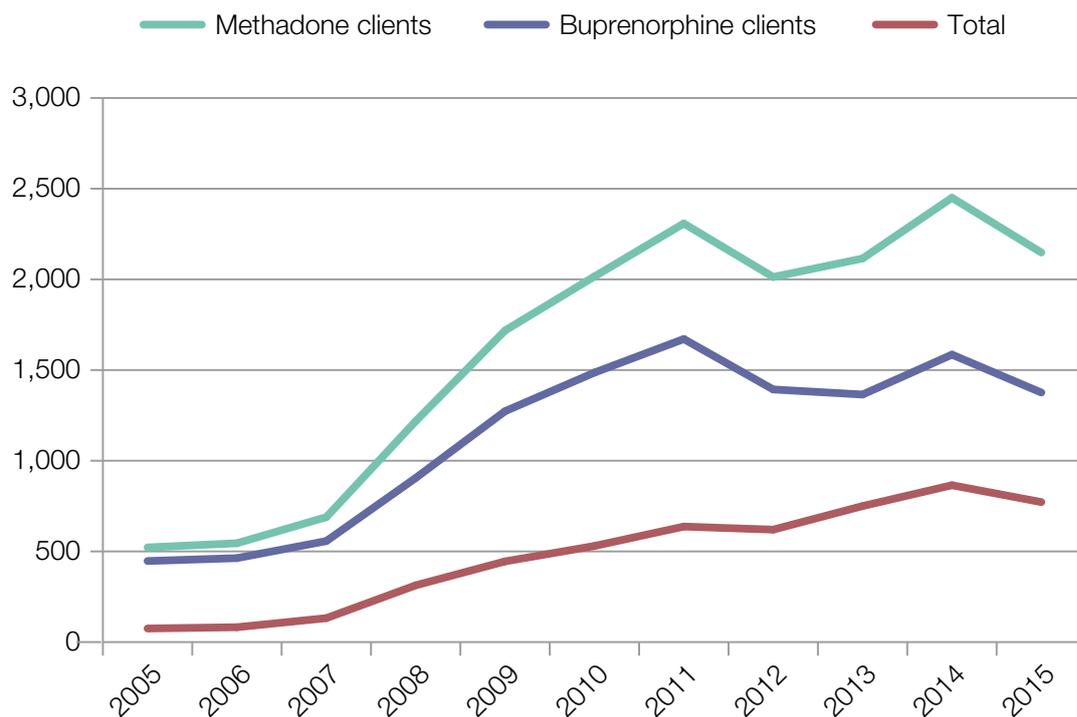
See: Accompanying Table Treatment 3

4.6.2 Wales

In Wales there was a steep increase in the total number of OST clients between 2005 and 2011, from 522 to 2,308.⁴³ Following a fall in 2012 to 2,013, the number increased again to 2,450 in 2014; however, the number decreased in 2015 to 2,148 (see Figure 4.8). This pattern was largely driven by the number of clients being prescribed methadone. The number of clients receiving buprenorphine steadily increased from 75 in 2005 to 865 in 2014; however, the number decreased slightly in 2015 to 772 (see accompanying table Treatment 3).

⁴³ Due to changes in the Welsh dataset these figures will not match those reported in previous years.

Figure 4.8: Trends in numbers of clients in Wales receiving opioid substitution treatment, 2005 to 2015



See: Accompanying Table Treatment 3

4.6.3 Scotland

In Scotland in 2015/16, methadone 1mg/ml solution was prescribed at least once to 25,569 individuals, based on prescriptions with a valid Community Health Index (CHI) number. Due to less than optimal CHI capture rates, this number should be treated as a minimum. In 2015/16, 112,480 (or 26%) of prescriptions did not have a valid CHI number, and it is not possible to determine how many additional individuals prescribed methadone would have been identified had this data been complete. The number of individuals prescribed methadone appears to have reduced from 26,197 in 2011/12, but this change should be treated with caution given the above caveats (Information Services Division, 2016b).

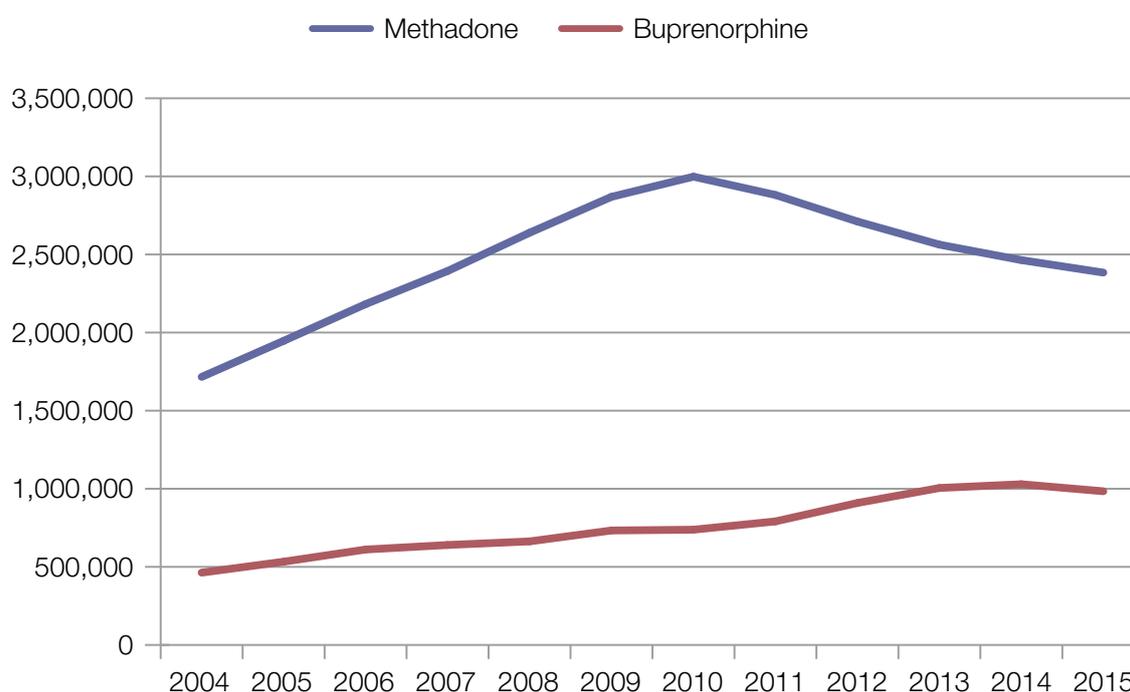
4.6.4 Northern Ireland

A total of 865 patients received substitute prescribing treatment across Northern Ireland in 2014/15, a five per cent increase on the previous year. Just under half (46%) of OST clients were prescribed methadone, while a further 46% were prescribed buprenorphine (personal communication – Department of Health Northern Ireland).

4.6.5 Prescription cost analysis

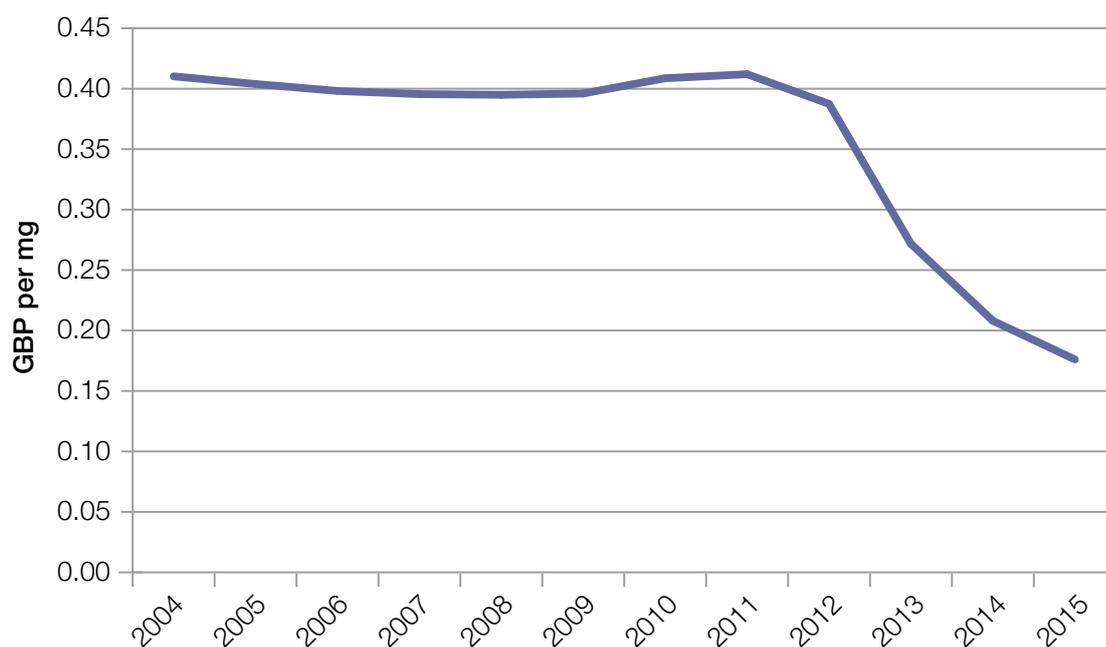
The Health and Social Care Information Centre publishes annual data on the number of prescriptions, quantity prescribed and cost of all medications (in their individual formulations) that have been dispensed by pharmacies in England (Health and Social Care Information Centre, 2016). The UK Focal Point have used this published data to calculate totals for methadone and buprenorphine prescribed for substance misuse going back to 2004. The number of methadone prescriptions rose by 75% between 2004 and 2010 as more people accessed OST, and retention improved. Buprenorphine prescriptions also rose over this time period, but the proportion of OST prescribing accounted for by buprenorphine fell from 21% to 20% as the increase in methadone prescribing was larger.

Figure 4.9: Number of prescriptions for methadone and buprenorphine dispensed in England, 2004 to 2015



Source: (Health and Social Care Information Centre, 2016)

After 2010 the total number of people receiving OST fell, and there was a corresponding fall in the number of methadone prescriptions dispensed. Despite this overall fall in OST prevalence, buprenorphine prescriptions continued to rise until 2014, lifting the proportion of OST prescriptions accounted for by buprenorphine to 30%. Buprenorphine prescriptions dropped for the first time in 2015, although the corresponding drop seen for methadone was similar, so the balance of OST medications prescribed in the English treatment system remained stable at 71% methadone to 29% buprenorphine in 2015. One possible contributing factor to the increase in the proportion of OST prescriptions accounted for by buprenorphine is the reduction in cost (see Figure 4.10).

Figure 4.10: Price per mg of buprenorphine prescribed in England, 2004 to 2015

Source: (Health and Social Care Information Centre, 2016)

4.7 New developments

4.7.1 New psychoactive substances in prison

In January 2016, PHE published a toolkit in response to increasing use of NPS in prisons. The toolkit is designed for prison custodial, healthcare and substance misuse staff and provides information on the effects of various NPS and how to manage the problems they cause in prison. The toolkit was supported by a national training programme undertaken between September 2015 and June 2016 (Public Health England, 2015d).

4.7.2 Chemsex

New guidance has been published by PHE to support those who commission and deliver services for MSM involved in chemsex. The briefing includes information on prevalence and guidance for local teams in recognising and engaging with clients (Public Health England, 2015g).

4.7.3 Project NEPTUNE

Building on its previous work project NEPTUNE is currently developing a series of clinical tools and an e-learning⁴⁴ package for clinicians who come into contact with people who use club drugs and NPS.

44 See: <http://neptune-clinical-guidance.co.uk/e-learning/>

4.7.4 Treatment funding in Scotland

In April 2016 responsibility for drugs policy in Scotland transferred from the Justice portfolio to the Health portfolio. At the same time, the Drugs Policy Unit also took on responsibility for alcohol interests for ADPs, and has since been renamed the Substance Misuse Unit. An alcohol team remains in Scottish government with responsibility for all other aspects of alcohol policy, including Minimum Unit Pricing and Alcohol Brief Interventions.

4.7.5 Social impact bonds

In July 2016 the UK government launched the Life Chances Fund, representing £80 million of funding directed towards a range of entrenched, complex social issues. The fund is structured around six key themes, one of which is drug and alcohol dependency, and £30 million of funding is allocated specifically for this area. The Life Chances Fund aims to encourage the use of social impact bonds, whereby treatment providers are given start-up funding by social investors to deliver a service. Upon successful achievement of the predetermined outcomes, the Life Chances money will be used to pay the social investor. Providers were asked to submit an expression of interest in this scheme by 30 September 2016, with the final application decisions to be made in July 2017.⁴⁵

4.7.6 Recovery Partnership quality standards frameworks

The Recovery Partnership, formed in 2011 and funded by the Department of Health, published a set of quality standards frameworks for community drug and alcohol treatment services in October 2016. There are separate frameworks for community substance misuse services and residential rehabilitation (Recovery Partnership, 2016a, 2016b).

45 See: <https://www.gov.uk/government/publications/life-chances-fund>

5 Drug users in prison

5.1 Introduction

The link between substance misuse and crime is strong and represents a major challenge to the efforts to turn prisoners away from further criminal activity. Offenders do not necessarily want to stop taking drugs just because they have been imprisoned and so the demand for drugs in prisons is strong. For many prisoners they form a ‘lifestyle’ as well as a physical and psychological dependency. As such, there is an unwelcome but deeply held desire for drugs in prisons: to maintain dependency; as recreation; to continue the ‘lifestyle’; or to make money out of their supply. Drugs can have a number of different impacts in prisons. In addition to making rehabilitation more difficult, they can present significant health risks as well as cause unpredictable and violent behaviour. They can also put pressure on families and staff to supply them and form the basis of a trade which involves debt, intimidation and violence.

The Department of Health (DH) funds clinical and non-clinical substance use treatment in all prisons and the community in England. As part of the new health and care changes set out in the *Health and Social Care Act 2012* (Her Majesty’s Government, 2012b), NHS England became responsible for commissioning health services in prisons and other secure accommodation in England. In Wales, health services are under the control of the Welsh government, with commissioning carried out by local health boards. The National Offender Management Service (NOMS) Wales retains responsibility for non-clinical substance misuse services for sentenced offenders. In Scotland, the NHS is responsible for the provision of health care services in prisons, with a range of health and substance misuse services now being provided within Scottish prisons by the respective local health boards. In Northern Ireland the South Eastern Health and Social Care Trust (SEHSCT) provides prison healthcare services.

One of the key elements of *Transforming Rehabilitation: A strategy for reform* (Ministry of Justice, 2013) was to provide offenders with the support they need ‘through the gate’, offering continuous support, including treatment for substance misuse, from custody into the community.

Those in prison have access to a range of treatment services for substance misuse including clinical services such as detoxification and opioid substitution treatment (OST), structured psychosocial interventions, case management and structured counselling. Testing for HIV and hepatitis, and the vaccination against hepatitis B, are also available. In Scotland, Take Home Naloxone (THN) is widely available for prisoners at risk of opioid overdose on release, and is becoming increasingly available in England, Wales and Northern Ireland.

5.2 Prison service overview

5.2.1 England and Wales

Custodial estate

There are 120 prisons currently in use in England and Wales. The majority (106) are run by Her Majesty’s Prison Service, while the remaining 14 are contracted out to private companies. Twelve establishments out of the 120 are predominantly for female prisoners, five are young offender institutions (YOIs), and two are immigration removal centres (National Offender Management Service, Her Majesty’s Prison Service, & National Probation Service, 2017).

When sentenced, adult male prisoners are assigned to a security category and allocated to the appropriate prison. Categorisation is based on the level of risk a prisoner might pose to the public or national security should they escape and the likelihood of their making attempts to do so.

Community

Under rehabilitation reforms which commenced operation in early 2015, Community Rehabilitation Companies (CRCs) are required to ensure that all sentence requirements or licence conditions/supervision requirements are delivered for the offenders they manage, which may include specific licence conditions such as drug testing. CRCs oversee the sentence of the court for each offender allocated to them to manage, and in doing so seek to rehabilitate offenders and reduce reoffending. CRCs are paid a fixed fee to ensure the sentence requirements and licence conditions are delivered, with further payment by results payments available for CRCs achieving reductions in offending. An essential aspect of these reforms is the creation of a nationwide 'through the gate' resettlement service, meaning most offenders are given continuous support by one provider from custody into the community (see [section 5.3.2](#)).

Young offenders

Offenders under the age of 18 can be held in a secure children's home (SCH), a secure training centre (STC) or a YOI. STCs accommodate males and females aged 12-17, while SCHs accommodate those aged 10-17 who are assessed as being particularly vulnerable. YOIs accommodate only 15-17 year-old male juveniles. There are five YOIs in England and Wales, which are distinct from young adult YOIs which cater for 18-21 year-olds and form part of the adult estate. Between April 2014 and March 2015 most young people under the age of 18 held in custody were in YOIs (69%), with 21% in STCs and the remaining 10% in SCHs (Ministry of Justice & Youth Justice Board, 2016).

Inmate profile England and Wales

On 30 September 2016, the prison population was 85,639, with 81,796 male and 3,843 female inmates (Ministry of Justice, 2016c). On the same date, the YOI population aged under 18 years was 652 (all male). The number of young people in custody is now almost one-quarter of the number in custody in 2008: in June 2008 the under 18 population in custody was 2,527 (Ministry of Justice, 2016c).

5.2.2 Scotland

The Scottish Prison Service (SPS) is an executive agency of the Scottish government established in 1993, and delivers custodial and rehabilitation services to those offenders sent to it by the courts.

There are currently 15 prisons within the Scottish prison system. Thirteen are publicly managed, and two prisons (HMPs Addiewell and Kilmarnock) are operated by private sector companies under contract to the SPS. There are ten male prisons, one female prison (HMP Cornton Vale), and four prisons that hold prisoners of both gender. Ten prisons hold adults, one prison is designated for young offenders (HMYOI Polmont), and four prisons house both adult and young offenders. Scotland has one open prison, HMP Castle Huntly, and HMP Addiewell is designated as a learning prison.

The available design capacity for prisons in Scotland is for 8,158 prisoners (personal communication – Scottish Prison Service). The average daily adult prisoner population during 2015/16 was 6,785 male and 385 female prisoners. In 2015/16, the average YOI population (aged under 21) was 505 inmates (486 males, 19 females). In total, the average daily prisoner population in Scotland in 2015/16 was 7,675 (Scottish Prison Service, 2016a).

5.2.3 Northern Ireland

In Northern Ireland there are three publicly run prison establishments: HMP Maghaberry, a modern high security prison holding adult male prisoners; HMP Magilligan, a medium-to-low security institution also holding adult male offenders; and HMP and Young Offenders' Centre Hydebank Wood College and Women's Prison, which holds male young offenders and female prisoners of all ages.

In December 2016 the prison population of Northern Ireland consisted of 1,415 inmates: 44 adult females, 1,277 adult males and 94 young offenders (four female and 90 male) (Northern Ireland Prison Service, 2017).

5.3 Strategy and co-ordination

5.3.1 Prison drug strategies

England and Wales

The *Drug Strategy 2010, Reducing Demand, Restricting Supply, Building Recovery: supporting people to live a drug free life* (Her Majesty's Government, 2010) notes that prison may not always be the best place for drug users to overcome their dependence and offending. Reference is made to the importance of encouraging offenders to seek treatment at every stage of contact with the criminal justice system (CJS) (see [section 8.5.1](#)). The strategy also covers reducing drug supply in prisons through increased security measures.

In the same year, *The Patel Report* (Department of Health, 2010) was published. Emphasising its role in reducing drug-related crime and in improving the health and rehabilitation of offenders, the report reviewed the provision of drug prison treatment in England at the time and made a number of recommendations for the future. These included recommendations to: develop a unified drug strategy for people in prisons, moving between prisons and on release; develop a national health and criminal justice outcomes model to help improve health outcomes; create an updated national drug treatment and interventions strategy that covers both community and prisons; and ensure that said drug treatment and interventions strategy is linked to other relevant initiatives and strategies as they develop.

In May 2013, the Ministry of Justice (MoJ) published a new strategy, *Transforming Rehabilitation: A strategy for reform* (Ministry of Justice, 2013), with the aim of reforming the CJS and reducing reoffending rates for prisoners. One of the proposed actions was to provide offenders with the support they need 'through the gate', offering continuous support, including treatment for substance misuse, from custody into the community. The strategy also called for new legislation which would make engagement with rehabilitation mandatory over a 12 month period for all prisoners released from short custodial sentences of up to two years. Upon release, offenders would be subject first to a standard licence period and then to an additional supervision period for the purpose of rehabilitation. Following release from prison, offenders would be supervised by either CRCs (who supervise low to medium risk offenders) or through the National Probation Service (which supervises the highest risk offenders).

Another change to the prison estate made under *Transforming Rehabilitation* was the designation of a number of prisons as 'resettlement prisons', in 2015. These establishments hold category C prisoners⁴⁶ who will engage with resettlement providers in the last three months of their sentence. Offenders released from these prisons are expected to leave with a package of support in place, delivered by their CRC, enabling better linkage with local settlement services and improved family contact.

In February 2015 two new licence conditions and supervision requirements (the drug appointment condition and the drug testing condition) became available to manage offenders in the community following their release, as part of the *Offender Rehabilitation Act 2014* (Her Majesty's Government, 2014c). These conditions make it mandatory for offenders whose use of illicit drugs (specific Class A or B drugs in the case of the drug testing condition) caused or contributed to them committing the offence for which they were convicted, or may cause or contribute to them committing an offence in the future, to attend treatment services or drug testing.

The MoJ has recently published a white paper, *Prison Safety and Reform* (Ministry of Justice, 2016d), outlining measures that the government intend to take in order to improve both the outcomes of prisoners released back into the community, and the conditions they experience while in prison. The government set out its intentions to introduce legislation to simplify the framework for testing for psychoactive substances, strengthen search capabilities within prisons, and reassess the approach taken to tackling the supply and demand for drugs in prison. Measures to be assessed include the substance misuse treatment pathway for prisoners; the relationship between substance misuse and issues such as mental health; drug treatment services to and from the community; and research to assess the methods currently used to tackle the supply of drugs. The government also set out its plan to employ a further 2,500 prison officers by the end of 2018.

Scotland

The Scottish drug strategy, *Road to Recovery: A new approach to tackling Scotland's drug problems* (Scottish Government, 2008d), focuses on recovery but also looks at prevention, treatment and rehabilitation, education, enforcement and protection of children. The role of prison-based drug treatment programmes is highlighted in the strategy as a means of assisting recovery.

In the same year that the drug strategy was published, the Scottish government commissioned a task force to investigate health inequalities and published a new strategy, *Equally Well* (Scottish Government, 2008c). One of the key recommendations was for offenders who want to tackle their drug problems to be able to get access to addiction and health services within six weeks of release from prison. Improving the health and wellbeing of offenders was also cited as a means to reduce inequalities associated with violence and alcohol and drug problems. In 2010 a review of the strategy was conducted and it was agreed to continue offering Throughcare Addiction Services, which offer wraparound support to offenders with addiction issues being released from prison (Scottish Government, 2010).

The *Strategy framework for the management of substance misuse in custody* (Scottish Prison Service, 2010) reflects the aims and objectives of the Scottish government's national drug strategy. Over the past decade prison policy on managing prisoners with problematic substance misuse has moved from a punitive response to a therapeutic approach, offering a comprehensive integrated treatment service to support recovery and community integration

46 Category C prisoners are those who cannot be trusted in open conditions, but who do not have the resources and will to make a determined escape attempt.

and to reduce reoffending. The strategy focuses on robust security systems to divert, disrupt, detect and deter the supply of illicit substances and to support the provision of treatment services to encourage prisoners to reject the illicit drug culture.

In 2011 the responsibility and accountability for the provision of health services in prison, including substance misuse and mental health services, transferred to NHS health boards. The health boards provide a range of health and substance misuse services broadly comparable to that available in the community, with the emphasis placed on recovery-focused treatment options, including naloxone provision and improved throughcare services. An independent expert review of OST in Scotland published in 2013 acknowledged the role that prison healthcare has to play in delivering OST to assist recovery (Drug Strategy Delivery Commission, 2013).

Northern Ireland

The Northern Ireland Prison Service (NIPS) addresses substance misuse based around a three strand approach: to restrict supply; to reduce demand; and to assist recovery.

In March 2012 NIPS and SEHSCT, who assumed responsibility for providing healthcare (including addiction services) in prisons in 2008, jointly published a *Strategic Framework for the Reduction and Management of Substance Misuse in Custody*. The framework reinforced the two organisations' commitment to working in partnership to address misuse.

The purpose of the framework is to provide strategic direction and guidance in the management of prisoners with substance problems. NIPS and SEHSCT will take all reasonable measures to reduce the availability of illicit substances to prisoners, and provide recovery-aiding services broadly equivalent to those available in the community, while recognising that prisoners require different routes to recovery.

The strategic aims are to reduce the availability and supply of illicit substances; reduce the levels of substance misuse through recovery-based treatment programmes; ensure treatment programmes are integrated with a wide range of related prison-based services; and develop substance misuse services to reflect the diverse needs of the prisoner population.

NIPS also established a team to work in partnership with SEHSCT to address the recommendations from the *Safety of Prisoners held by the Northern Ireland Prison Service* report (Criminal Justice Inspection Northern Ireland, 2014). This includes an examination of the strategy to manage substance misuse in prisons. Both NIPS and SEHSCT are currently in the process of revising the substance misuse policy and strategy.

5.3.2 Co-ordination of drug-related prison health responses

England and Wales

In England, DH is responsible for determining the policy on substance misuse treatment and suitable approaches, including the balance between clinical treatment and psychosocial interventions. Substance misuse treatment services in custody are commissioned and funded by NHS England.

NOMS and NHS England have a co-commissioning responsibility to enable and support the efficient delivery of provision. The *National Partnership Agreement for the Co-Commissioning and Delivery of Healthcare in Prisons in England* (NHS England et al., 2015), a tripartite agreement between NHS England, NOMS and Public Health England (PHE), sets out respective roles, shared principles and development priorities as well as objectives to work together and address any issues arising from changes to the delivery environment. The agreement is overseen by the Prison Healthcare Board (England).

In October 2014, the 35 former Probation Trusts were dissolved and their responsibilities were transferred to either the newly established National Probation Service within NOMS or CRCs. The National Probation Service is responsible for providing supervision to the highest risk offenders in the community while 21 CRCs supervise lower to medium risk offenders.

In Wales, health and delivery of its services within public sector prisons are the responsibility of the Welsh government, with responsibility for service provision devolved to local health boards. NOMS retains responsibility for its non-clinical substance misuse services for sentenced offenders.

Resettlement

Key to successful drug treatment outcomes is continuity of treatment following release. The MoJ has been working closely with partners in health to help extend the focus of substance misuse treatment and recovery services in prison to plan and operate through the gate into the community. 'Through the gate' resettlement services have been introduced and new legislation means that all sentenced prisoners will be supervised for a minimum of 12 months post-release, and extends powers to drug test prisoners on licence as well as introducing a new drug appointment licence condition. In addition, a comprehensive 'end-to-end' approach to tackling addiction from custody to the community is being developed and tested in a number of resettlement prisons. DH funding has enabled NOMS, NHS England and PHE to test new pathway arrangements, develop products which can be used across the country, and capture learning by working closely with 10 resettlement prisons as early adopters in the north-west. The emphasis has been on joining up services in prison and on release.

Scotland

In Scotland, responsibility for the provision of healthcare services in prisons transferred from the SPS to the NHS in November 2011. There are 14 NHS boards in Scotland responsible for the delivery of healthcare services to those within their geographical area. The 15 prisons in Scotland are located within nine of these boards, each of which has responsibility for providing substance misuse services to prisoners within these areas. NHS boards provide a range of health and substance misuse services through primary and secondary care practitioners to those in prison.

Northern Ireland

The provision of substance misuse services within Northern Ireland's prisons has undergone significant change in recent years. The transfer of responsibility for prison healthcare services to the SEHSCT, and recommendations from a number of independent reviews, surveys and inspections, have influenced and reflected on a period of continued transition and change.

The provision of substance misuse services has seen progress regarding the implementation of a joint Prison Service and Trust substance misuse policy. Each of the prisons within Northern Ireland provides a range of treatment interventions through primary care, secondary care and specialist addiction services.

5.4 Drug use and problem drug use in prison

5.4.1 Drug use prior to imprisonment

Data regarding prevalence of drug use prior to imprisonment in England and Wales comes from self-reporting by prisoners as part of prison surveys (Her Majesty's Inspectorate of Prisons, 2016).

More comprehensive information became available in 2015, with the publication of an in-depth report into substance use in prisons, which asked respondents about their substance use in the two months prior to imprisonment (Her Majesty's Inspectorate of Prisons, 2015). In Scotland, as well as the biennial prisoner survey which asks about problem drug use before prison (Scottish Prison Service, 2015a), further information is available from addiction prevalence testing. This study, carried out during one month of the year (November 2015 for the 2015/16 results), tests offenders for a number of substances on reception to prison. Addiction prevalence test (APT) data and survey results from England and Wales suggest that the majority of prisoners used drugs in the period prior to coming to prison (see Table 5.1). A large proportion (around 30-40%) of prisoners report having a problem with drugs prior to imprisonment, with female prisoners apparently more likely to have a problem than male prisoners (Her Majesty's Inspectorate of Prisons, 2016; Scottish Prison Service, 2016b). The proportion reporting problematic use of drugs prior to imprisonment appears to be similar for young (those aged under 21) and adult prisoners (Her Majesty's Inspectorate of Prisons, 2016; Scottish Prison Service, 2016c).

Table 5.1: Self-reported drug use prior to imprisonment or positive drug tests on reception to prison in England & Wales and Scotland, 2015

	Illicit drug/medication use two months prior to prison	Problem drug use on arrival at prison	
England & Wales	52%	28% (41% female; 27% male)	
	Illicit drug/medication use on arrival at prison*	Problem drug use prior to prison	Receiving treatment for drug use prior to prison
Scotland	73%	38%	21% (30% female; 20% male)

*APTs positive for any illegal drugs or medications in 2015/16

See: <http://www.scotpho.org.uk/downloads/drugs/SPS-Addiction-Prevalence-Testing-Stats-Final-2015-2016.pdf>

Source: (Her Majesty's Inspectorate of Prisons, 2015; Scottish Prison Service, 2015a)

5.4.2 Drug use inside prison: drug testing and survey data

Prevalence of drug use inside prison is self-reported in surveys, and in-prison testing data is published for prisons in England, Wales and Scotland. Table 5.2 shows data from the in-depth survey into drug use in prisons in England and Wales (Her Majesty's Inspectorate of Prisons, 2015), the Scottish *Prisoner Survey* (Scottish Prison Service, 2015a), and APT. Levels of drug use in prisons are lower than in the community, with a marked decrease in the use of cocaine. Cannabis is the most prevalent drug both outside and inside prison, with around 40-50% of prisoners reporting use prior to imprisonment, and 10-15% reporting use inside prison. Heroin use appears to halve, from around 20% to less than 10% in prison. Recent surveys have reported that synthetic cannabinoid receptor agonists (SCRAs) are now more prevalent than heroin, with around 10% of inmates reporting use of these substances. However, other surveys suggested that prevalence of SCRA use may be even higher. One study on SCRA use in prisons, which collected data between October 2015 and March 2016, reported that 33% of respondents had used 'Spice' in the last month, with prevalence in nine different institutions ranging from 15% to 71% (User Voice, 2016). Due to their recent emergence, and the large number of SCRA compounds that may be found in synthetic cannabis products, SCRAs have only recently been included in routine in-prison drug testing programmes in England and Wales.

Table 5.2: Proportion of prisoners self-reporting or testing positive for use of selected drugs prior to and during imprisonment, in England & Wales and Scotland, 2015

	England & Wales ^a		Scottish Prisoner Survey ^b		APT (Scotland) ^c	
Used drugs in prison	18% (drugs) 26% (inc. medications)		43% (ever in prison) 24% (last month)		–	
	Used prior to prison	Used in prison	Used prior to prison	Used in prison	Use on arrival	Use on release
Cannabis	38%	13%	–	15%	52%	8%
Heroin	15%	7%	–	8%	25% (opioids)	8% (opioids)
Buprenorphine	–	9%	–	9%	7%	12%
Benzodiazepines	–	4%	–	9%	35%	6%
Cocaine	29%	4%	–	3%	15%	0%
‘Legal highs’	5% ^d	5% ^d	27%	11%	–	–
SCRAs	6%	10%	16%	9%	–	–

^a Used in the two months prior to imprisonment; or ever used in respondent's current prison

^b Ever used 'legal highs' or SCRAs prior to imprisonment; or used in the last month in prison

^c Positive tests on arrival at prison; or on release from prison

^d Does not include SCRAs

See: <http://www.scotpho.org.uk/downloads/drugs/SPS-Addiction-Prevalence-Testing-Stats-Final-2015-2016.pdf>

Source: (Her Majesty's Inspectorate of Prisons, 2015; Scottish Prison Service, 2015a)

As well as reporting drug use via surveys, prisoners in England and Wales can be subject to mandatory drug testing (MDT). There are five ways in which drug testing can be undertaken: random testing; reasonable suspicion; risk assessment (where prisoners are being considered for a privilege or position of trust); frequent test programme (prisoners selected because of their previous history of drug misuse); or testing on reception to prison. During 2015/16 the proportion of prisoners undergoing random mandatory drug testing (RMDT) that tested positive was 7.7%, a 12% increase on the rate for the previous year of 6.9%, and the highest rate seen since 2009/10, when the RMDT rate was 7.8% (National Offender Management Service, 2010, 2016).

5.4.3 Drug use inside prison: other indicators

England and Wales

Seizures of drugs inside prisons

In response to a question in the House of Commons, the Prisons Minister reported the number of prisoners in England and Wales that had been found in possession of drugs during a cell search, strip search or other searches (see Table 5.3). The number of prisoners found in possession has increased in recent years, from 1,556 in 2013 to 2,255 in the 10 months to the end of October 2015.

Table 5.3: Incidents where drugs were found in prisoners' possession, England and Wales, 2010 to 31 October 2015

	2010	2011	2012	2013	2014	2015*
No. of incidents	1,248	1,217	1,565	1,556	2,289	2,255

*Data to October 2015

Source: <http://www.theyworkforyou.com/wrans/?id=2015-11-25.17639.h&s=Alcohol+and+Drugs#g17639.r0>

Research conducted within a category B local prison⁴⁷ in England suggests that the type of drugs seized between 2005 and 2015 has altered dramatically (Ralphs, Williams, Askew, & Norton, 2016). In the first three months of 2015, 973g of SCRA were seized, compared to 15g of cannabis and three grams of heroin. The mass of SCRA seized in just this quarter of 2015 outweighed the total recovered in the same prison in the whole of 2014 (969g). Comparison to data from 2005 demonstrated the marked decreases in the amounts of cannabis and heroin seized: in one month in 2005, seizures of cannabis totalled two kilograms, with 60g of heroin also recorded.

Scotland

Scottish Prison Service report

The SPS 2015/16 annual report shows that 1,031 male and 102 female prisoners were disciplined for “administering, or allowing to be administered, a controlled drug to oneself”. This was an increase from 2013/14 when the figures were 901 and 102 respectively; the overall rate per 1,000 prisoners has increased every year since 2012/13 (see Table 5.4) (Scottish Prison Service, 2016a).

Table 5.4: Incidents where an inmate was disciplined for administering, or allowing to be administered, a controlled drug to oneself, in Scottish prisons, 2012/13 to 2015/16

	2012/13		2013/14		2014/15		2015/16	
	n	No. per 1,000 prisoners						
Male	509	67.4	790	106.5	901	123.3	1,031	141.8
Female	125	273.5	79	183.3	102	240.0	102	252.5
Total	634	79.1	869	110.7	1,003	129.7	1,133	147.6

Sources: (Scottish Prison Service, 2013, 2014, 2015b, 2016a)

5.5 Drug-related problems in prisons

5.5.1 Problems associated with new psychoactive substance use

Violence and intimidation

Anecdotal evidence suggests that the growing level of SCRA use in prisons is linked to a number of negative outcomes, including an increase in disturbed and disruptive behaviour by prisoners, increasing levels of debt, and heightened levels of intimidation and violence towards both staff and prisoners (National Offender Management Service, 2015). Until May 2016, a large number of SCRA were not controlled in the UK; therefore due to their relatively low price in

⁴⁷ Category B prisons house prisoners placed in the second highest of four security categories, ie for whom the very highest conditions of security are not necessary, but for whom escape must be made very difficult. Local prisons serve the courts and receive remand and post-conviction prisoners before their allocation to other establishments.

the community and the lack of comprehensive testing capable of detecting the use of these substances, SCRA's have been smuggled into prisons to be sold at a high profit, reportedly for up to 30 times their price outside of prison (Ralphs et al., 2016; User Voice, 2016).

In their report *Changing Patterns of Substance Misuse in Prisons and Service Responses*, Her Majesty's Inspectorate of Prisons described how debts accrued by prisoners could accumulate quickly, and be passed on to other prisoners (for example if a prisoner in debt left the prison, their debt can be passed on to friends or former cell mates) (Her Majesty's Inspectorate of Prisons, 2015). Prisoners who were prescribed medication may sell this to pay off their debts, or to be able to buy other drugs; and others became involved in the selling or transporting of drugs within prison to pay off their debts. Debt accrued as a result of SCRA use has been associated with violence and intimidation. Prisoners in debt may be used as 'spice pigs', whereby they are forced by dealers to test new SCRA products to ascertain what quantities are safe and the effects caused by the product (Her Majesty's Inspectorate of Prisons, 2015; User Voice, 2016).

Over the past two years, there has been a marked increase in the rate of assault incidents reported in prisons in England and Wales. The MoJ reported that in the 12 months to June 2016, compared to 2015 there was a 32% increase in the number of prisoner on prisoner assault incidents (rate per 1,000 prisoners: 208/1,000 vs 158/1,000), and a 43% increase in assaults on staff (rate per 1,000 prisoners: 70/1,000 versus 49/1,000). Over the same time period, serious prisoner on prisoner assaults increased from 1,926 to 2,462 (28% increase), and the number of serious assaults on staff rose from 579 to 697 (a 20% increase). The total number of serious assaults in prisons in England and Wales has more than doubled since 2013 (Ministry of Justice, 2016e). However, this increase has coincided with a reduction in prison staff, with the number of public sector prison officers⁴⁸ falling from 24,831 in March 2010 to 21,505 in March 2013, and to 18,003 in September 2016 (Ministry of Justice, 2016b). It is therefore possible that changes to staffing numbers may also have had an impact on violence levels within prisons.

Prisons in Scotland have also seen an increase in the number of assaults since 2012/13, although not to the same extent as those in England and Wales. In 2015/16 there were 83 serious assaults (both on prisoners and on staff), compared to 75 in 2012/13. There were also 2,173 minor assaults/assaults resulting in no injury on prisoners and staff in 2015/16, compared to 1,921 in 2012/13 (Scottish Prison Service, 2013, 2016a).

Self-harm and death

As well as an increase in assaults, there has also been a recent increase in the number of self-harm incidents reported in prisons in England and Wales. The MoJ reported that in the 12 months to June 2016, compared to the same time period in 2014/15, there had been a 26% increase in the number of self-harm incidents (rate per 1,000 prisoners: 426/1,000 versus 338/1,000). The number of deaths in prisons reported in the year ending September 2016 was 324, compared to 267 in the same period in 2015, an increase of 21%. The rate of deaths per 1,000 prisoners (now 3.8/1,000) has been rising since 2012.

In 2015, the Prisons and Probation Ombudsman (PPO) reported on 19 deaths which occurred between April 2012 and September 2014 where the deceased was known to be, or highly suspected of, using NPS prior to death (Prisons and Probation Ombudsman, 2015). In November 2016 the PPO reported in a speech that there had been 64 deaths that had occurred in custody that were related to the use of NPS between June 2013 and April 2016 (Prisons and Probation Ombudsman, 2016). The PPO outlined five risk factors that played important roles in these deaths:

- mental health risks – the majority (44) of the 64 deaths were self-inflicted, with psychotic episodes believed to be responsible for some, and extreme and unpredictable behaviour also found

48 Operational staff at bands 3 to 5, including prison officers, supervising officers and custodial managers.

- physical health risks – NPS may exacerbate the effects of underlying medical problems, and nine deaths were due to natural causes in prisoners who used NPS
- drug toxicity – six deaths were attributed to the toxicological effects of NPS or NPS in combination with other drugs
- debt and bullying – prisoners in debt to dealers may be at increased risk of self-harm or suicide due to the bullying and violence they experience
- behavioural problems – prisoners displaying aggressive or violent behaviour caused by their NPS use may not be identified to be using these substances, therefore opportunities for substance misuse and healthcare teams to intervene may be missed.

The PPO also outlined five areas of learning for prison staff to help to decrease the adverse effects that NPS are having among prisoners: reducing the supply of NPS; increasing staff awareness of NPS-related problems; addressing bullying and debt problems robustly; treatment services addressing NPS use and offering appropriate monitoring and treatment; and reducing demand for NPS among prisoners.

5.5.2 Drug-related health problems

Blood-borne viruses

England

One of the developmental priorities of the *National Partnership Agreement for the Co-Commissioning and Delivery of Healthcare in Prisons in England* between NHS England, PHE and NOMS was to improve the detection, surveillance and management of infectious diseases in prisons (NHS England et al., 2015). In April 2014 a new opt-out testing programme for blood-borne viruses (BBVs) was introduced in 11 prisons across England. In the first six months there was a doubling of BBV testing from 11% to 22% of new receptions being screened in the eight prisons that provided data (Public Health England, 2015b). The proportion of those testing positive remained stable, with 0.3% testing positive for HIV, 0.2% positive for hepatitis B virus (HBV) nine per cent testing positive for hepatitis C virus (HCV). Opt-out testing was initiated in a further 10 Phase 2 pathfinder prisons in April 2015. In September 2015 the third wave of eight prisons began implementing opt-out BBV testing, including HMP Pentonville, the first prison in London to participate in the programme. As of April 2016, NHS England estimated that 63% of prisons in England and Wales were offering opt-out testing. Preliminary data from the health and justice indicators of performance (HJIPs) (see [section 5.7.1](#)) for the Phase 2 prisons indicates that 16,425 HBV tests, 18,967 HCV tests and 40,705 HIV tests were carried out in England in 2015/16 (Public Health England, 2016b). It is hoped that opt-out BBV testing will be fully implemented across all prisons in England by 2017.

Wales

BBV testing programmes and access to treatment are available in each prison in Wales. In 2015, 13% of prison receptions to Welsh prisons were tested for BBV (personal communication – Public Health Wales). This was a small decrease from 14% of prison receptions undergoing testing in 2014.

Scotland

In 2009 the SPS commissioned a study into the prevalence and incidence of hepatitis C among a sample of 5,076 prisoners (Scottish Prison Service, 2012). Eight per cent (404/5,076) of respondents reported having ever injected drugs in prison, and 2.5% (127/5,076) reported

having injected during their current period of imprisonment. Of these 127 prisoners, 74 (58%) reported injecting with needles and syringes previously used by someone else. The HCV antibody prevalence among all prisoners who participated in the study was 19%; however, among injecting drug users (IDU) the prevalence rate was 53%. HCV antibody prevalence was higher in female IDU (65% versus 52% in male IDU) and older IDU (68% in those aged 40 years and over versus 14% in those aged under 20). Additionally, female IDU in prison had a significantly higher HCV positive rate than those in the community (65% versus 54%, respectively).

The Scottish government are working with NHS boards and the SPS to introduce opt-out testing for HBV, HCV and HIV for all new prisoners in Scotland during their induction period (Scottish Government, 2015a). As of November 2016, opt-out testing for these three viruses was available for new prisoners at eight prisons (out of the 15 in Scotland), with an additional three prisons conducting opt-out testing for HCV and HIV.⁴⁹

5.6 Drug-related health responses

5.6.1 England and Wales

Drug treatment in prisons is based on an assessment of local need and designed to meet the requirements of low, moderate and severe drug misusers within the prison population, including the many that spend a comparatively short time in prison. Local commissioners have the discretion to commission services that accord with national clinical guidelines and that they judge are best oriented towards recovery (and consequential reductions in re-offending). However, in general, available interventions are:

- clinical services including clinical responses to immediate needs, such as detoxification or maintenance prescribing of methadone or buprenorphine
- a range of accredited and non-accredited rehabilitative programmes, structured psychosocial interventions and other evidence-based approaches in prisons that are designed to address prisoners' substance use, offending behaviour and contribute to their wellbeing. Offenders are often encouraged to learn and practise life skills that will help them on their recovery journey.
- case management/continuity, structured talking therapies – including motivational therapy, coping/social skills training, behavioural self-control training, mutual aid (ie self-help) such as Narcotics Anonymous, life skills and family work

Drug treatment services in prison are commissioned on the basis of equivalence with community based treatment and underpinned by evidence-based clinical guidance.

Treatment figures

From 2015, treatment demand indicator (TDI) data for England contains treatment presentation figures from prisons as well as from the community (see [section 4.3.3](#)). TDI records data from those presenting to treatment services during that year; those already in treatment at the beginning of the year are not included in this indicator. In 2015, 27,836 clients presented to treatment units in prison; this represented more than one-quarter (27%) of all clients presenting to treatment in England. The proportion presenting for opioid use was slightly higher in prison than in the community (52% in prison; 49% in the community), with greater proportions of clients presenting for primary misuse of methadone (2.7% in prison versus 1.6% in the community)

49 See: <http://www.parliament.scot/parliamentarybusiness/28877.aspx?SearchType=Advance&ReferenceNumbers=S5W-04546&ResultsPerPage=10>

and buprenorphine (4.3% in prison versus 1.4% in the community). The proportion of primary heroin clients was similar in prison (43%) to in the community (42%). Cannabis was the second most common reason for presentation in prison, with 21% of clients reporting primary use of this drug (compared to 28% in the community). Primary use of cocaine was more commonly reported in prison, with more than double the proportion of those entering treatment reporting primary use of crack cocaine in prison than in the community (7.5% and 3.5%, respectively). As may be expected, presentation for stimulant use (other than cocaine) was lower in prison (3.9%, compared to 5.0% in the community), whereas primary use of benzodiazepines was higher (2.1% in prison, compared to 1.5% in the community) (see accompanying table Treatment 1).

Naloxone

The availability of naloxone to prisoners in England has so far been limited. There are proposals to pilot its use as part of the end-to-end approach to tackling addiction from custody into the community, currently being tested in the north-west area (personal communication – Public Health England). Naloxone distribution remains sporadic across England and its distribution is not required under treatment guidelines.

Sondhi et al (2016) conducted a study across ten prisons to analyse the perceptions of staff and prisoners regarding THN, and to assess the barriers preventing the training of prisoners and the effective and timely distribution of kits (Sondhi, Ryan & Day, 2016). They found confusion among staff and prisoners regarding the conflicting message that THN gave; concern regarding potential side effects and the consequences of being found in possession of THN; difficulties with identifying and encouraging these prisoners to take part in training; and logistical issues surrounding the training of prisoners and the distribution of kits at discharge. The study identified a need to reduce the loss of potential trainees through the complexity of the prison system, and that the beliefs and perceptions of prisoners needed to be given a more nuanced consideration, in order to ensure the effective distribution of THN in prison.

In comparison to England, THN is more widely available in Wales, and information is recorded regarding the number of prisoners being issued with this antidote on release (Public Health Wales, 2016b). Data from the Harm Reduction Database in Wales indicates that 17% of male unique individuals issued with THN between 1 April 2015 and 31 March 2016 were issued upon release from prison.⁵⁰ This is a reduction in the proportion of individuals from 2014/15; however, the number of individuals increased from 128 in 2014/15 to 146 in 2015/16. As with data from previous years, when compared to national Area Planning Board provision, prisons are the second highest distributors of THN within Wales.

5.6.2 Scotland

In Scotland a national health improvement framework, *Better Health, Better Lives*, which was developed in collaboration with key partners and launched in 2012, supports the delivery of action to improve health and wellbeing in prisons (Brutus et al., 2012). The framework provides recommendations consistent with a ‘whole prison’ approach to health improvement and was built around health promotion pillars including tobacco, alcohol and illicit drugs. A national multi-agency Prison Health and Wellbeing Group provides strategic support and direction to health improvement, and local multi-agency forums are implementing the framework across prisons in Scotland.

The Health Improvement Framework for Offenders in the Community is now being delivered by the National Health Improvement Agency, NHS Health Scotland, as part of their work supporting community justice.

⁵⁰ There are currently no female-only prisons in Wales, therefore comparisons are made for male individuals only.

Throughcare Addiction Service

The Throughcare Addiction Service (TAS) forms part of the voluntary aftercare service. TAS is delivered by local authority criminal justice social work who will work with the offender in the six week period prior to release from custody through the six week period post-release, offering an intensive motivational service to help the offender address their addiction and link them to appropriate services. Data shows that 633 individuals received assistance from the TAS on release from prison in 2014/15, just over half the number seen in 2013/14, and a decrease to 24% from 50% of all voluntary assistance cases (Scottish Government, 2016a).

Naloxone

The independent National Naloxone Advisory Group (NNAG) for Scotland was the body that engaged with the Scottish government to manage central funding of naloxone kits, allowing for continued service provision. The work of the NNAG ceased on 31 March 2016, when responsibility for kit reimbursement passed to NHS boards; however, the Harms Reduction sub-group of the Scottish government will monitor naloxone provision. The SPS and NHS health boards work in partnership to enable prisoners to undertake naloxone training while in custody and receive a naloxone kit on release.

There were 932 THN kits issued by NHS staff in prisons in Scotland in 2015/16 to persons at risk of opioid overdose upon release, which represented a six per cent increase on the number issued in 2014/15 ($n=878$) (Information Services Division, 2016e). Since 2011/12 there have been 4,343 THN kits issued in prisons in Scotland in total.

There has been a steady decline in the percentage of all opioid-related deaths occurring within four weeks of prison release, from the 2006-2010 baseline indicator of 9.8% to 3.1% in 2014. This percentage increased in 2015 to 4.7%; this was the same proportion that was seen in 2013, and is still significantly lower than the baseline indicator value, although the authors noted the figures should be treated with caution given the low numbers involved ($n=23$ in 2015) (Information Services Division, 2016e). Performance against the baseline indicator will continue to be monitored to ensure that the percentage in the post-naloxone period is estimated with sufficient precision.

The SPS has recently conducted a pilot in HMP Inverness which tested the effectiveness of a programme in naloxone administration to operational prison staff, which trained them to administer intra-muscular naloxone to prisoners in emergency 'first on the scene' situations. The SPS is now reviewing the options available to develop future training for front line staff responding to opioid overdoses (Scottish Prison Service, 2016a).

5.6.3 Northern Ireland

Treatment figures

In 2015, 564 individuals presented to drug treatment in prisons in Northern Ireland, a similar number of patients to 2014 ($n=546$). This represented one-quarter (25%) of all patients presenting to treatment in Northern Ireland in 2015. As in 2014, the most common primary drug on presentation was cannabis, which was reported by 26% of patients ($n=148$); however, this represented a decrease from 2014 (30%). Opioids were the most commonly used class of drugs, with 34% of prisoners reporting primary use of these substances. 'Other opioids' were the most common opioid reported (16% of all prisoners), followed by heroin (14%). Primary benzodiazepine use was reported by 23% of prisoners, an increase from 15% in 2014; and 13% of prisoners presented with primary use of cocaine (all powder). The percentage of treatment presentations for primary cannabis use was less than those presenting to treatment in the

community (43%), although there were more than double the proportion of primary heroin and opioid users seeking treatment in prison than in the community (community figures of 6.4% for heroin and 16% for opioids). Primary cocaine users accounted for a greater proportion of presentations in prison than in the community (13% versus 11%); however, stimulants other than cocaine were much more commonly reported in community treatment centres than prison (8.2% and 3.2% respectively) (TDI, 2016).

Opioid substitution treatment

SEHSCT is responsible for the provision of addiction services to NIPS, which comprise a clinical addiction team (for clinical treatments) and Alcohol and Drugs: Empowering People Through Therapy (AD:EPT) for all psychosocial interventions. The clinical team provides OST within the prison setting, adhering to the *Northern Ireland Opioid Substitution Services Interface Protocol between Prisons and Health and Social Care Trust Community Addiction Services (April 2015)*.

Psycho-social support / counselling / harm reduction

AD:EPT is a comprehensive drug and alcohol service delivered by Start360, a voluntary sector provider, across the three sites of the NIPS in partnership with SEHSCT. AD:EPT provides a range of services to people in custody who have problems associated with the misuse of substances. Interventions provided by AD:EPT include addiction severity index comprehensive assessment; one-to-one counselling; relapse prevention sessions; naloxone training; and pre-release work.

Naloxone

The *New Strategic Direction for Alcohol and Drugs Phase 2 2011-16* (NSD Phase 2) (Department of Health Northern Ireland, 2011) requires the Public Health Agency (PHA) to pilot a scheme for THN and for this to be reviewed. The pilot is being undertaken by a partnership between the PHA and the Health and Social Care Trusts, and community addiction teams and NIPS began to give out THN kits in July 2012. THN training in prisons is jointly provided by AD:EPT and the SEHSCT clinical addiction team. Initially it was offered to those on substitution programmes, but has since been expanded to anyone at risk.

The PHA service review highlighted some of the on-going challenges to the uptake of THN, which include consideration of how to increase the training and take-up for those leaving prison, and reducing the time between departure and receiving their naloxone (Shorter & Bingham, 2016). To date the statistical data collected regarding the distribution of naloxone is limited. However, it is estimated that approximately 150 THN kits have been distributed to patients being discharged from prison health care.

5.7 Quality assurance of drug-related prison health responses

5.7.1 England

Public Health Outcomes Framework indicators

There are a number of indicators on the Public Health Outcomes Framework (see [section 4.2.1](#)) related to people in contact with the CJS. Until April 2016, the proportion of people assessed for substance dependence issues when entering prison who then require structured treatment and who had not previously received community treatment was one of these. This measure was designed to give local authorities an indication of the scale of treatment need unmet in the community; in 2012/13 the average proportion across England was 47% (Public Health England, 2015e).

Following a consultation in 2015, this indicator was amended in May 2016 to report the proportion of adults with substance misuse treatment needs who successfully engaged in community-based structured treatment following release from prison (Department of Health, 2016). Prisoners with substance misuse treatment needs are at increased risk immediately following their release from prison; this indicator will therefore directly measure their engagement with treatment services during this important period.

Health and Justice Indicators of Performance

A set of HJIPs were developed by NHS England, PHE and NOMS to replace the previously used prison health performance and quality indicators (NHS England, 2014). These indicators are largely quantitative and include specific measures for drugs and alcohol. NHS England area teams will work with their commissioned providers to collect the HJIPs.

Quality assurance of mental health services

In May 2015 the Royal College of Psychiatrists' Centre for Quality Improvement established a Quality Network for Prison Mental Health Services, with the aim of promoting quality improvement in the field of prison mental health. This field is becoming increasingly important with regard to substance misuse with the increase in prevalence of SCRA in prison, and the mental health issues that have been associated with their use (see [section 5.5.1](#)). The network published its first edition of standards for services in June 2015, which were updated in September 2016 (Royal College of Psychiatrists Centre for Quality Improvement, 2016b). Standards include requiring written policies in place for liaison and joint working with substance misuse services and primary care in cases of co-morbidity, and a joint working policy on the control and management of substance misuse and illegal substances. Eighteen prisons participated in the first year of the network, carrying out self- and peer-review of services in these establishments, the results of which were published in the annual report in September 2016 (Royal College of Psychiatrists Centre for Quality Improvement, 2016a). Forty-two services have been recruited to participate in the second year of the network.

5.7.2 Wales

Across the public sector prison estate in Wales, standards of treatment provision will be matched against those set out above. In addition, the practice standards issued by the Royal College of Psychiatrists in relation to Mental Health services for prisoners will also be adopted.

5.7.3 Scotland

In February 2016 NHS Scotland and the SPS published joint guidance for quality service delivery of drugs, alcohol and tobacco health services in Scottish prisons (NHS Scotland & Scottish Prison Service, 2016). The report discussed current best practice in substance use interventions, and made a number of recommendations covering: data capture and reporting; use of national standards (for example adhering to relevant local delivery plan standards) and the development of service quality indicators; provision of purposeful activity; capacity of treatment services; and the use of service user views in planning and delivery.

5.8 New developments

5.8.1 Reform prisons

In May 2016, in its *Prisons and Courts Reform Bill*,⁵¹ the government announced plans to convert six institutions in England and Wales to ‘reform’ prisons, in addition to the newly built reform prison HMP Berwyn (due to open in 2017). The institutions to be converted are HMPS Coldingley, Highdown, Holme House, Kirklevington, Ranby and Wandsworth. The governors of these institutions will be given full autonomy over their resource budget, with the ability to opt out of national contracts and services. Responsibility for commissioning health care services in the new prisons is to be shared between NHS England and the prison’s governor, with the aim for this co-commissioning model to be subsequently rolled out nationwide.

5.8.2 New psychoactive substances

As discussed above, the presence of SCRA within prisons is now an established and significant problem (see [section 5.5.1](#)). In surveys carried out in England, Wales, and Scotland, SCRA (or ‘Spice’/‘Black Mamba’) were the second most commonly reported illicit ‘drug’ used in prison, following closely behind cannabis (Her Majesty’s Inspectorate of Prisons, 2015; Scottish Prison Service, 2015a) (see [section 5.4.2](#)). Of the 23-25 prison-based treatment services that responded to the *State of the Sector* survey (Recovery Partnership, 2016c), 96% reported an increase or significant increase in the number of prisoners with treatment needs relating to SCRA since September 2014. Sixty-two per cent and 58% of respondents also reported that there had been an increase or significant increase in the number of prisoners requiring support related to the use of new stimulants or new hallucinogens, respectively, since September 2014.

The *Psychoactive Substances Act 2016* came into force in the UK in May 2016, making it an offence to be in possession of a psychoactive substance in a custodial institution (Her Majesty’s Government, 2016f). See [section 8.3.1](#) for further details.

England and Wales

In November 2016 the PPO reported that there had been 64 deaths in prisons between June 2013 and April 2016 associated with the use of NPS (Prisons and Probation Ombudsman, 2016); this came after a report in July 2015, where the PPO reported on 19 deaths under similar circumstances (Prisons and Probation Ombudsman, 2015) (see [section 5.5.1](#)).

NOMS has developed an innovative new drug testing programme, the first in the world to routinely test for NPS through MDT. This was implemented across the prison estate in September 2016.

In May 2016 the Justice Secretary announced that an extra £10 million was going to be made available to prison governors to help tackle increasing levels of violence and suicides within English and Welsh prison establishments; funding was made available for additional drug testing, including for NPS, as well as extra prison staff, training, and equipment.⁵²

Scotland

The SPS is currently developing a national strategy and action plan to respond to prisoners under the influence of NPS. This includes developing a protocol on the management of prisoners under the influence of NPS who are demonstrating challenging behaviour including ‘excited

51 See: <http://researchbriefings.files.parliament.uk/documents/CBP-7601/CBP-7601.pdf>

52 See: <https://www.parliament.uk/documents/commons-committees/Justice/correspondence/letter-190516-michael-gove-response-prison-safety-report.pdf>

delirium', and the roll out of a national NPS staff training programme. The SPS is also working collaboratively with NHS health boards to support the development of a clinical response in line with the Project NEPTUNE guidance (see [section 4.2.3](#)).

5.8.3 Legislation

Smoking ban

The *Health Act 2006* (Her Majesty's Government, 2006) brought in a total smoking ban in enclosed public places in England on 1 July 2007 (similar bans had already been implemented in Scotland, Wales and Northern Ireland). Prisons were exempt from this ban and prisoners remained able to smoke inside their cells. This has led to a number of legal challenges, resulting in the Welsh Assembly committing to a full smoke-free policy being implemented from January 2016 in all prisons in Wales. In England, four early adopter sites (HMPs Exeter, Channing Wood, Dartmoor and Erlestoke) were chosen to become smoke-free as the first step of a phased approach to achieving an entirely smoke-free prison estate. Seven additional prisons in England have since become smoke-free. As of January 2017, all of these prisons are operating as entirely smoke-free, in both buildings and grounds. E-cigarettes and nicotine replacement therapies (NRT) are available to buy in prisons, and NRT can be obtained as part of a stop smoking service intervention through prison health services. In addition to this, access to stop smoking support is being increased throughout the estate and every prison now has voluntary smoke-free accommodation.

5.8.4 Guidelines

In response to the growing concerns over use of NPS in prisons, PHE developed a new toolkit designed to support prison custodial, healthcare and substance misuse staff. This provides information on the various categories of NPS, their prevalence within prisons, the effects seen after acute and chronic use of these substances, and advice on the management of prisoners who have taken them (Public Health England, 2015d). The toolkit was published in December 2015, and was supported by a training programme delivered by PHE and NOMS staff within 35 prisons, with over 500 prison staff attending these events (Public Health England, 2016f).

Guidance on the clinical management of substance misuse in prisons is currently being reviewed and updated to reflect changing patterns of drug use and to keep pace with the learning from recent reviews of unclassified deaths in custody and emerging best practice, and is linked to the redrafting of the NICE guidance on managing substances misuse. This work will pick up issues around OST, including the use of methadone and buprenorphine, and the use of THN.

6 Drug-related deaths

6.1 Introduction

Data on drug-related deaths (DRDs) submitted to the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) by the UK is based on three different definitions. The EMCDDA definition (Selection B) refers to deaths caused directly by the consumption of at least one illicit drug.⁵³ The UK Drug Misuse Definition (DMD),⁵⁴ originally adopted to measure the impact of the former UK drug strategy (Home Office, 2002), is where the underlying cause is drug abuse, drug dependence, or poisonings where any of the substances scheduled under the *Misuse of Drugs Act 1971* (Her Majesty's Government, 1971) are involved. The definition used by the Office for National Statistics (ONS) is much wider and includes legal drugs.⁵⁵

The UK DMD has been adopted by the general mortality registers (GMRs) across the UK and is a subset of the ONS definition. Information on deaths is also available from a Special Mortality Register.⁵⁶

In 2014, 2,655 deaths which met the EMCDDA definition of drug misuse were recorded across the three GMRs. This is a record high and data available for other definitions covering 2015 shows further increases. Heroin was involved in the majority of DRDs in the UK (46%), and 86% involved heroin and/or other opioids. Other drugs commonly associated with drug misuse deaths included benzodiazepines (14%), cocaine (13%) and amphetamine (seven per cent). About three-quarters of DRDs were among men. The average age of those who died in 2014 was 41.6 years. Women who died were on average about four years older than their male counterparts.

6.2 Changes to methodology

In England and Wales, there are significant delays in the registration of DRDs: for each year since 2007 the median delay was between five and six months. However, Scotland is subject to different legislation around the registration of deaths, and experiences only minimal delays. This is problematic for reporting figures based on registration year at UK level, as it combines up-to-date data from Scotland with generally delayed data from England and Wales. Consequently, UK figures under the EMCDDA definition are, from 2015 reporting year onwards, counting deaths from England and Wales according to year of occurrence. As such, 2014 is the latest available reporting year by this definition, as this is the most recent year where it can be assumed the large majority of relevant deaths in England and Wales have now been registered (it is probable a substantial proportion occurring in 2015 were not registered by the end of that year). As there will be DRDs falling under the EMCDDA definition occurring in 2014 in England and Wales which were not registered by the end of 2015, the figure for 2014 is provisional and will be revised upwards slightly in the next report to reflect this. For the ONS and drug misuse definitions, the figures continue to represent registrations in the most recent year (2015).

53 These deaths are known as 'overdoses', 'poisonings' or 'drug-induced deaths'. See: <http://www.emcdda.europa.eu/themes/key-indicators/drd>

54 Formerly known as the Drug Strategy Definition.

55 See: <https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsrelatedtodrugpoisoninginenglandandwales/2015registrations#things-you-need-to-know>

56 The National Programme on Substance Misuse Deaths (NPSAD) publishes data from inquests into DRDs reported by coroners in England, Wales, Northern Ireland, Guernsey, Jersey and the Isle of Man; Procurators Fiscal in Scotland and the Scottish Crime and Drug Enforcement Agency.

A further methodological change from the 2015 reporting year is that causes of death recorded as the International Statistical Classification of Diseases and Related Health Problems 10th Revision (ICD-10) codes X44, X64 and Y14 alongside relevant T-codes have been incorporated into UK figures using the EMCDDA definition. Due to historical coding practice in England and Wales, this has substantially increased the number of deaths counted under this definition. Because of a lack of specific drug information for some deaths in England and Wales, it is likely that some deaths relating to illicit use continue to fall outside the EMCDDA definition. Also, due to changes in reporting, a small number of deaths registered in England and Wales where the person was not resident in either country are no longer included. For each definition, the time series back to 2004 has been updated to take into account these changes (see accompanying table DRD2).

6.3 Overdose deaths

Using the EMCDDA definition, the total number of DRDs in the UK during 2014 was 2,655, at least a five per cent increase from 2013 ($n=2,529$) (see accompanying table DRD2), and the highest number reported to date. Using the slightly different definition of drug misuse, and reporting based on year of registration, there were 3,285 DRDs registered in the UK in 2015 (up from 2,936 in 2014). Using the much wider ONS definition, there were 4,609 DRDs registered in the UK in 2015 (up from 4,174 in 2014).

6.3.1 Overdose deaths recorded in each General Mortality Register

In 2014, a total of 1,864 DRDs were reported under the EMCDDA definition for England – this is 70% of the UK total. In Scotland, 574 deaths (22%) were reported, with 140 (six per cent) in Wales and 77 (three per cent) in Northern Ireland. England saw a two per cent increase in the number of DRDs compared to 2013, while Scotland experienced an increase of 11%, Wales an increase of 15%, and Northern Ireland a rise of 18%. Figures for England and Wales will still be somewhat incomplete for 2014 so they may ultimately make up a greater proportion of the total.

6.3.2 Age and gender

Of the deaths occurring in 2014 meeting the EMCDDA definition, almost three-quarters (73%, $n=1,948$) were males and one-quarter ($n=707$) were females (see accompanying table DRD1). This proportion is similar across the UK, ranging from 68% males in Northern Ireland to 75% males in Scotland. The number of deaths among males in the UK has increased by four per cent between 2013 and 2014, and among females by seven per cent.

In 2014, the average age of those dying was 41.6 years. Males tended to be about four years younger than females (40.3 years and 44.6 years respectively). The average age at death has increased from 37.6 years in 2004. The average age was lower in Scotland (40 years) than for the UK as a whole, particularly for women (40 years).

Overall, the largest proportion of deaths occurring in the UK in 2014 occurred in the 40 to 44 years age group (467; 18% of deaths). Compared to 2008, the number of DRDs decreased for all age groups below the age of 35 and increased for all age groups above this point. An increase was seen in all age groups in 2014 compared to 2013, with the exception of the 25-29 years cohort.

6.3.3 Intentionality

Three-quarters of deaths reported in the UK using the EMCDDA definition for 2014 (78%, 2,078 deaths) were accidental self-poisonings (see accompanying table DRD1). There were 219 deaths reported as intentional self-poisonings and 216 deaths as poisonings of undetermined intent (eight per cent each). The remaining five per cent of deaths were reported as mental and behavioural disorders due to psychoactive substance use ('F' codes). A higher proportion of deaths were reported as 'undetermined intent' in Scotland than in England and Wales (11% versus five per cent each). Northern Ireland had a significantly higher proportion of deaths reported as 'undetermined intent' (60%), as well as a higher proportion of deaths reported using the 'F' codes than the UK as a whole (14%), with only 23% reported as accidental poisonings.

6.4 Toxicology of overdose deaths

6.4.1 Headline figures

Across the UK under the EMCDDA definition, there were 2,304 deaths counted which featured an opioid in 2014. This was 87% of the UK total (see accompanying table DRD1). Eleven per cent involved non-opioid drugs without an opioid ($n=291$), while two per cent of the total did not have any drug specified ($n=60$). The large majority of cases with no drug specified ($n=51$) were in England. The proportion of cases with opioid use has remained broadly similar since 2004, while the proportion with non-opioid drugs without an opioid has risen from six per cent (see accompanying table DRD2). The proportion with no drug specified has fallen from six per cent.

The proportion of deaths featuring an opioid reported through each GMR in 2014 was highest in Scotland (93%), followed by Wales (87%) and England (86%). Northern Ireland experienced the lowest proportion (69%); a fall from 91% in 2013, although numbers are lower than the rest of the UK (total $n=77$ in 2014), therefore this should be interpreted with caution. The fall in Northern Ireland was attributable to an increase in deaths not involving opioids rather than a substantial fall in opioid deaths.

6.4.2 Detail of substances mentioned/implicated General Mortality Registers

Each of the three GMRs in the UK are subject to annual reporting and provide a greater level of detail on substances mentioned or implicated in death than is currently available at UK level.

England and Wales

The most recent figures for England and Wales cover 2015 registrations reported using the DMD and the broader ONS definition (Office for National Statistics, 2016c). There were 1,201 registrations of deaths where heroin/morphine was mentioned, which represented a 26% increase on registrations in 2014 and a 57% increase from 2013. The number of heroin/morphine deaths has more than doubled since 2012 ($n=579$). Although deaths registered in 2011 and 2012 were notably lower than the preceding years, the rate of heroin/morphine deaths per million population in 2015 was the highest on record. Heroin/morphine deaths accounted for 48% of the 2,479 deaths under the DMD, and heroin was the only drug mentioned in 24% of drug misuse deaths (603 deaths). Methadone was mentioned in 434 cases (18%), which was an increase from the 394 cases seen in 2014, but was a slight decrease in the proportion of deaths from 19%. Methadone was the only drug mentioned in 141 deaths (six per cent of the total).

Tramadol, which became a controlled drug in the UK in June 2014 (Her Majesty's Government, 2014b), accounted for 208 deaths (eight per cent); a decrease from the number ($n=240$) and proportion (11%) seen in 2014. This was the first decrease in tramadol deaths since the first registered death in 1996, and tramadol prescriptions have also fallen following a long-term rising trend. However, while early indications suggest that the control of tramadol may have led to a reduction in tramadol poisonings, registration delays in England and Wales mean that complete poisoning data after June 2014 remains limited and this relationship will continue to be monitored. In total, 1,989 deaths featured at least one opioid, disregarding those included as part of an analgesic compound. Just under one-third of deaths registered in 2015 where at least one opioid was mentioned also had a mention of alcohol (557 deaths, 28%), a proportion which has fallen over the last three years from 37% in 2012.

Benzodiazepines were mentioned in 366 deaths registered in 2015 in England and Wales, 15% of the total under the DMD. This represented a slight decrease from the 372 deaths registered in 2014, but was still a greater number than the 2013 figure ($n=342$). However, as seen in previous years, only a small number ($n=17$) of these cases did not also mention another drug. There was also a decrease in the number of drug misuse deaths mentioning antidepressants in combination with other substances, from 517 in 2014 to 447 (18% of all drug misuse deaths) in 2015. Conversely there were large increases in the numbers of deaths involving pregabalin and gabapentin, from 38 and 26 in 2014 to 90 and 49 in 2015, respectively.

Cocaine was mentioned in 320 deaths (13%), an increase of 30% on 2014 ($n=247$; the previous record number), and 89% on 2013 ($n=169$). It is believed that the increase in heroin deaths where cocaine was also present accounts for a large part of this increase in cocaine-related deaths. Eighty-eight cocaine deaths occurred without another substance present.

The number of mentions of amphetamines rose slightly to 157 (six per cent of deaths); this was a stabilisation in numbers after increasing from 56 deaths in 2010 to 151 in 2014. The largest proportion of deaths relating to amphetamines involved amphetamine itself ($n=90$). MDMA was mentioned in 57 cases (two per cent), an increase from 50 deaths in 2014. This was the second highest number on record, and an increase from eight deaths in 2010; however, this number is around the same level seen between 2001 and 2008, before a decrease in the availability of MDMA in the late 2000s. Mentions of new psychoactive substances (NPS) continued to rise, increasing to 114 (five per cent of deaths), a 39% rise from 2014. The majority of NPS deaths, and the increase seen in 2014, were accounted for by mentions of cathinones, principally mephedrone (44 out of 49 cathinone deaths, up from 22 of 27 in 2014) and GHB/GBL (26 deaths).

When broken down by substance, there were distinct differences in the age profile among deaths registered in England and Wales in 2015. The majority of deaths where NPS, cocaine or amphetamine were mentioned occurred in people under 40 years of age, while the reverse was true for deaths where opioids or benzodiazepines were mentioned. Furthermore, over one-third of deaths involving amphetamines or NPS occurred in people aged under 30 years.

Scotland

Statistics for DRDs in Scotland registered in 2015 were published in August 2016 (National Records of Scotland, 2016). For this report, DRDs are identified by National Records of Scotland (NRS) requesting further information on all deaths involving drugs or persons known, or suspected, to be drug-dependent, or where the information on the death certificate is vague or suggests that there might be a background of drug abuse. This corresponds closely to the UK DMD.

There were 706 such deaths registered in Scotland in 2015, an increase of 15% from 2014 ($n=613$). More than two-thirds (484 deaths; 69%) of the deaths were males. The largest proportions of deaths fell into the 35–44 years age category ($n=249$; 35%); however, as seen in the UK data, the proportion of deaths in the older age categories continued to increase. More than one-quarter of all deaths ($n=183$; 26%) were in the 45–54 years age category in 2015, compared to 5.5% of deaths in 2000. Almost three-quarters ($n=513$; 73%) of individuals were aged over 35, and more than one-third ($n=264$; 37%) were aged over 45 (increases from 67% and 32%, respectively, in 2013).

In 2015, there were 606 deaths in Scotland where an opioid was implicated, an increase of 13% from 2014 (535 opioid deaths). These 606 cases represented 86% of all DRDs, similar to the proportion seen in 2014. In 197 of these cases, only opioids (and possibly alcohol) were implicated in the death, a decrease from 209 deaths in 2014. Within the opioid category, heroin/morphine was the most commonly implicated drug, with 345 deaths (49% of all deaths), followed by methadone with 251 deaths (36%). There was a 40% increase in the number of cases where heroin/morphine was implicated in 2014. The implication figure for this substance has increased further for 2015, by 12%. Benzodiazepines were implicated in 191 deaths in 2015 (27%), which represented an increase of 58% on the 2014 figure, back to the level seen in 2011 and 2012 (185 and 196 deaths, respectively). As elsewhere in the UK, deaths where benzodiazepines were the only drug implicated (and then possibly with alcohol) were rare ($n=6$). The number of cases where cocaine was implicated more than doubled, from 45 in 2014 to 93 (13% of all deaths), among which there were 14 deaths where cocaine was the only drug. Ecstasy and amphetamines, reported distinctly, were each implicated in two per cent of deaths. All 15 ecstasy deaths were male. Alcohol was implicated in 107 DRDs (15%), a similar number to 2014 but representing a fall in the proportion of all deaths.

NPS were implicated in 74 cases, a 19% increase from 62 deaths in 2014. Benzodiazepine-type NPS were the most commonly implicated class of substances, contributing to 57 (77%) of the NPS deaths, and etizolam was the most commonly implicated of these NPS, contributing to 43 cases. Heroin, methadone or both were implicated alongside the benzodiazepine-type NPS in 50 cases (88% of benzodiazepine-type NPS deaths). In the remaining 17 cases involving non-benzodiazepine NPS, ethylphenidate (five deaths) and methiopropamine (four deaths) were the most commonly implicated substances. There were three cases where NPS were implicated without any other substance (two methiopropamine deaths and one where methylenedioxypropylvalerone (MDPV) was implicated).

Northern Ireland

Tables for DRDs registered in 2015 in Northern Ireland were published in September 2016 (Northern Ireland Statistics and Research Agency, 2016). These are reported according to the DMD and ONS definitions. In 2015, there were 144 DRDs registered in Northern Ireland, with 114 deaths reportedly due to drug misuse. As seen in the rest of the UK, opioids were the most commonly mentioned substance group, being mentioned in 88 deaths registered in 2015 (61% of DRDs) and 543 DRDs registered between 2005 and 2015 (53%). However, in contrast to the UK as a whole, tramadol was the most commonly mentioned opioid drug, mentioned in 28 deaths registered in 2015 (19% of all DRDs), followed by heroin, mentioned in 27 deaths (19%). There was a sharp increase in the number of deaths involving fentanyl, from one death in 2014 to 15 deaths in 2015 (10% of all DRDs). As seen in previous years, the number of deaths involving a benzodiazepine was high, with 63 deaths (44%) mentioning one of these substances on the death certificate. The number of deaths involving NPS (16; of which seven involved mephedrone) was more than the total involving cocaine and all amphetamines combined (15 deaths).

6.5 Provision of naloxone

In the UK, naloxone is used in hospitals and carried routinely on ambulances to treat patients suffering from severe respiratory depression following an opioid overdose. There are national naloxone programmes in Scotland, Wales and Northern Ireland which facilitate the distribution of naloxone in non-clinical settings such as hostels. These programmes also facilitate the distribution of naloxone kits to those at risk of overdose, including individuals at the point of release from prison, or to their families and carers. In October 2015 legislative changes came into force in the UK to increase the availability of naloxone. These changes made naloxone exempt from prescription-only medicine requirements when it is supplied by a drug service commissioned by a local authority or the NHS.

6.5.1 Wales

Data from the Welsh Harm Reduction Database (HRD) showed that in Wales, 1,397 take-home naloxone (THN) kits were distributed to new THN clients in 2015/16, with a further 1,789 re-supply kits being issued (Public Health Wales, 2016b). This represented a 14% increase in the total number of kits supplied in 2014/15 (2,785). Since 2009, 10,552 kits have been distributed within the country. THN was reported to have been used in 433 drug poisoning events in Wales in 2015/16; most commonly ($n=368$; 85%) to a third party. Death was reported in less than one per cent of cases where naloxone was administered.

6.5.2 Scotland

In October 2016, Information Services Division Scotland reported that 8,146 THN kits were issued in Scotland in 2015/16. This was an increase of 10% on the previous year. In the community, 7,214 kits were issued in the same time period, an 11% increase compared to the previous year (Information Services Division, 2016e). Throughout the five year cycle of the programme (April 2011 to March 2016), a total of 29,309 THN kits (including kits issued in the community and from prison) were issued in Scotland.

For Scotland as a whole, supply of kits more than doubled, from 52 kits per 1,000 problem drug users in 2011/12 to 132 per 1,000 in 2015/16. The percentage of kits distributed as a repeat supply increased each year from 12% in 2011/12 to 38% in 2015/16. In addition, 748 repeat kit supplies were made in 2015/16 because the previous kit was reported as having been used to treat an opioid overdose.

In Scotland, Take Home Naloxone (THN) is widely available for prisoners at risk of opioid overdose on release and is becoming increasingly available in England, Wales and Northern Ireland (see [section 5.6](#)).

6.6 Trends in drug-related deaths

6.6.1 Short-term trends

Using the revised figures under the EMCDDA definition, the figure of 2,655 DRDs in 2014 is the highest to date for the UK, exceeding the previous peak of 2,529 in 2013. Due to the registration delays in England and Wales, the 2014 figure will be revised slightly upwards when the UK reports to the EMCDDA in 2017. Following a previous peak in 2009, there was a sharp fall in DRDs in 2010 (to 2,058, a decrease of 15% from 2009), with a small rise in 2011, a stable figure

in 2012, and an increase of 12% in 2013. Table 6.1 shows the number of deaths recorded under the EMCDDA definition in England and Wales over the last decade.

Table 6.1: Mentions of selected drugs on death certificates in England and Wales, 2005 to 2014

	Date of death year									
	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Total	1,739	1,684	1,911	1,788	1,865	1,537	1,597	1,586	1,948	2,004
Opioids	1,467	1,384	1,581	1,503	1,636	1,360	1,427	1,368	1,687	1,719
Heroin	782	777	894	798	909	609	559	608	819	967
Methadone	231	290	349	399	375	401	490	392	386	343
Tramadol	29	20	28	37	37	84	163	178	248	199
Cocaine	186	181	231	214	156	108	120	138	183	260
Amphetamines	96	92	102	94	48	57	78	114	137	134
Ecstasy	46	48	50	39	4	9	25	40	41	47
Benzodiazepines	125	128	164	184	245	216	248	244	296	286
Opioids %	84%	82%	83%	84%	88%	88%	89%	86%	87%	86%
Heroin %	45%	46%	47%	45%	49%	40%	35%	38%	42%	48%
Methadone %	13%	17%	18%	22%	20%	26%	31%	25%	20%	17%
Tramadol %	2%	1%	1%	2%	2%	5%	10%	11%	13%	10%
Cocaine %	11%	11%	12%	12%	8%	7%	8%	9%	9%	13%
Amphetamines %	6%	5%	5%	5%	3%	4%	5%	7%	7%	7%
Ecstasy %	3%	3%	3%	2%	0%	1%	2%	3%	2%	2%
Benzodiazepines %	7%	8%	9%	10%	13%	14%	16%	15%	15%	14%

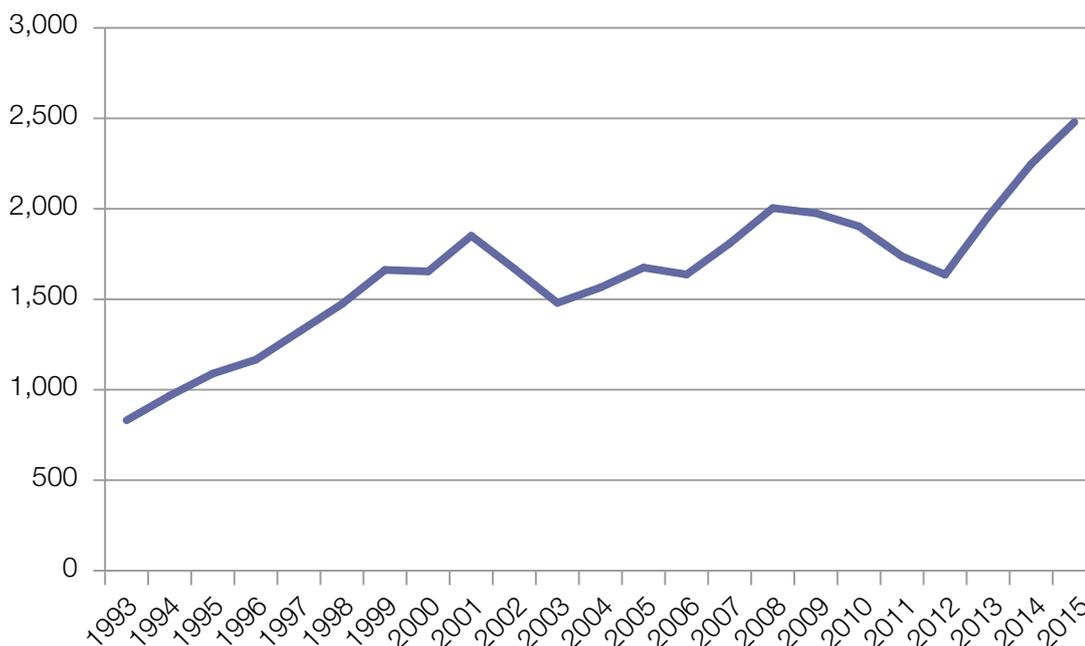
Source: Internal analysis from ONS GMR

It should be noted that figures for 2015 based on year of registration indicate that the large increase in DRDs in the UK for 2014, which followed a much larger increase in 2013, is very likely to have been followed by a further significant increase in 2015. This is evident in the figures submitted for the UK for 2015 registrations using the DMD, which show a 12% increase in registrations from 2014, and a 44% total increase from 2012. Figures published by the ONS for England and Wales for 2015 registrations (Office for National Statistics, 2016c) show a 10% increase using the DMD from 2013 and a 52% increase from 2012. In Scotland, where the registration delays are minimal and therefore registration year essentially equates to year of death, there was a reported 15% rise in 2015, to 706 deaths (National Records of Scotland, 2016). There was also an increase of 23% in deaths registered in Northern Ireland using DMD in 2015, to 111 deaths. It is therefore safe to conclude, with all the available information, that the increases reported for the UK for 2013 and 2014 probably represents the start of an increasing trend.

6.6.2 Long-term trends

The GMR for England and Wales has reported the number of deaths registered going back to 1993. Registrations increased steadily throughout the 1990s, reaching a peak of 1,851 in 2001 before falling to 1,480 in 2003. Numbers rose to around 2,000 deaths registered each year in 2008 and 2009, before falling to 1,636 in 2012 and rising again to the current peak of 2,479 in 2015 (Figure 6.1). The increases reported between 2012 and 2015 represent the sharpest gradient of increase over the full time period.

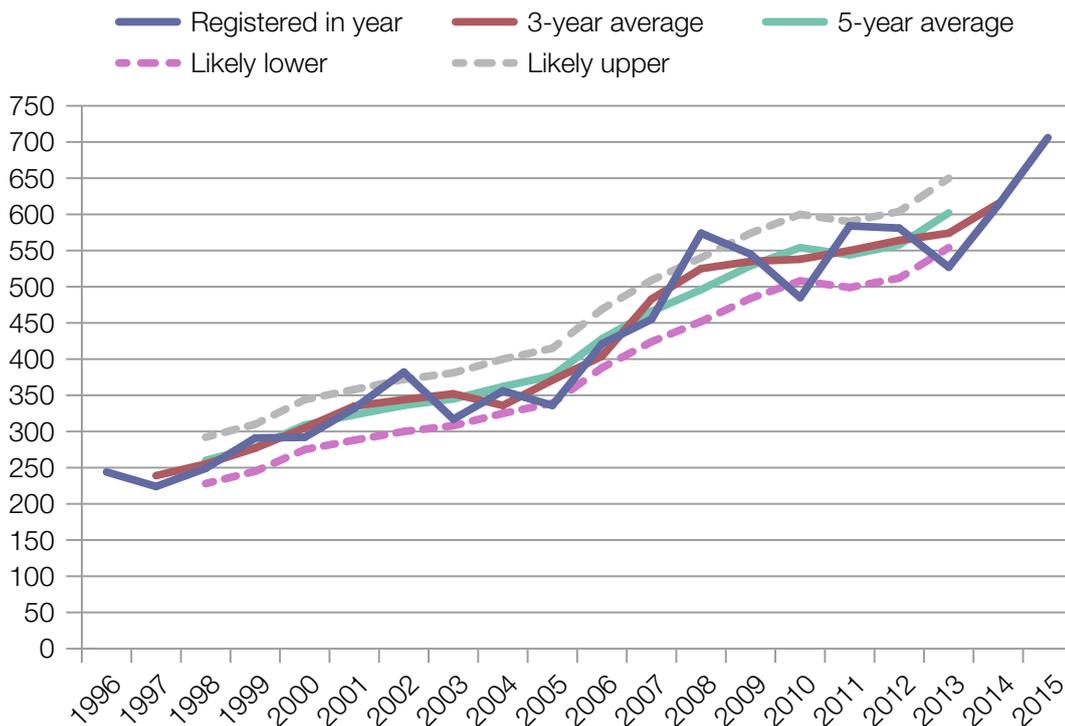
Figure 6.1: Number of deaths registered under drug misuse definition, England and Wales, 1993 to 2015



Source: (Office for National Statistics, 2016c)

The GMR in Scotland has reported figures going back to deaths registered in 1996. There has been a general increasing trend in DRDs since reporting began (National Records of Scotland, 2016). Figure 6.2 shows the annual figures, along with three- and five-year moving averages, to provide a better indication of the overall long-term trend. The broken grey lines show the likely range of random statistical variation around the five-year moving average.

Figure 6.2: Drug-related deaths registered in Scotland, three- and five-year moving averages, and likely range of values around five-year moving average, 1996 to 2015

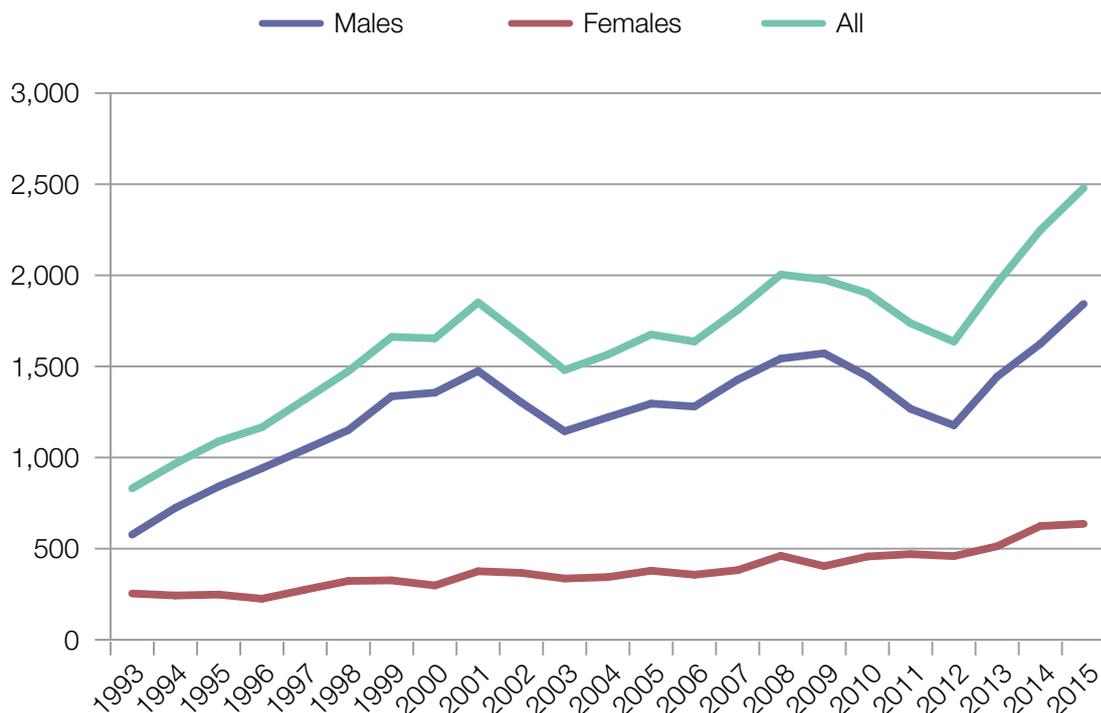


Source: (National Records of Scotland, 2016)

Gender

Males account for around three-quarters of DRDs in the UK. The number of deaths by gender in England and Wales is shown in Figure 6.3. While the number of female deaths has risen steadily since 1993, the number of male deaths has fluctuated to a greater degree over time. The peaks and troughs seen in the overall number of deaths appear to be as a result of these fluctuations.

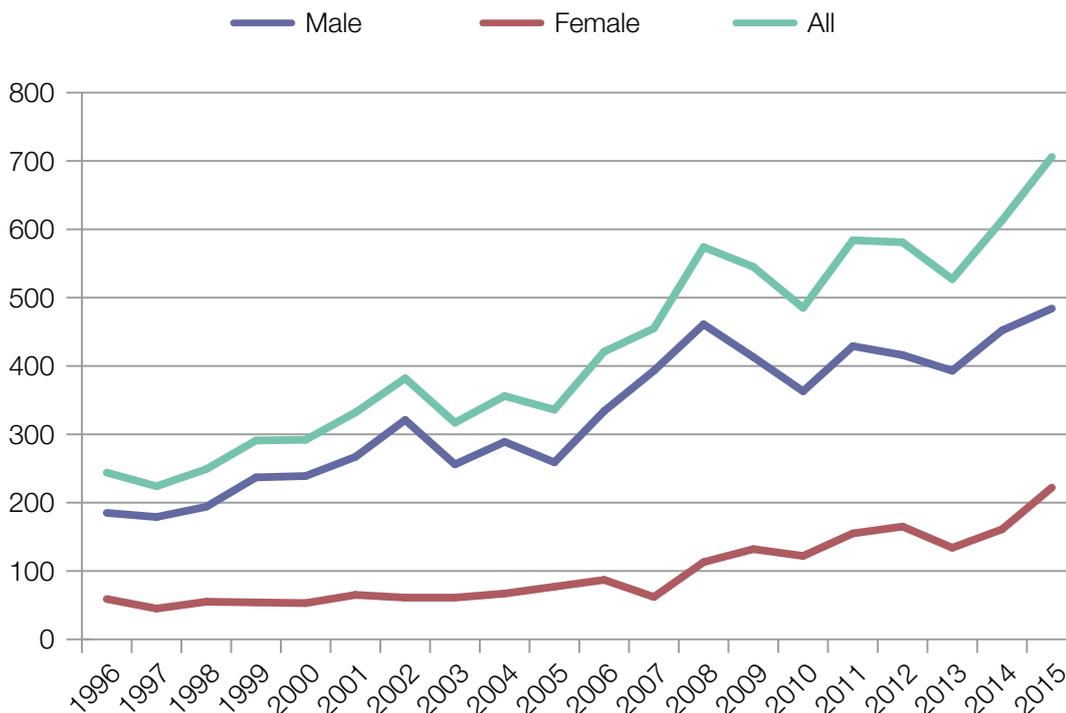
Figure 6.3: Number of deaths in England and Wales registered under the drug misuse definition, by gender, 1993 to 2015



Source: (Office for National Statistics, 2016c)

The pattern seen in Scotland (see Figure 6.4) is similar to that seen in England and Wales, with the number of female deaths tending to rise more steadily than the number of male deaths, and the overall shape of the curve being more influenced by male than female death figures. It is worth noting that the number of female deaths in Scotland has increased by almost the same amount as the number of male deaths between 2013 and 2015 (females: 134 to 222; males: 393 to 484), meaning that the number of female deaths has increased by 66% over the past two years, compared to an increase in male deaths of 23%.

Figure 6.4: Number of drug-related deaths in Scotland, by gender, 1996 to 2015



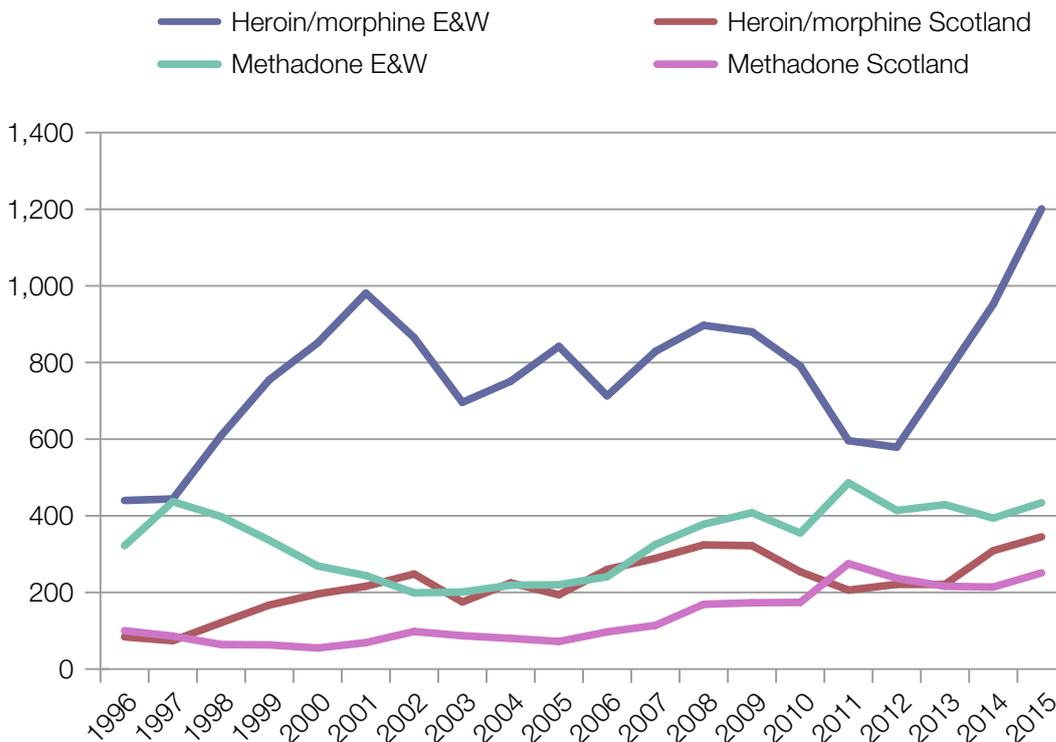
Source: (National Records of Scotland, 2016)

Toxicology

Data on the toxicology of deaths presented below are again presented by GMR. There are differences in the figures presented, in that the England and Wales data from the ONS is provided from all drug poisoning deaths, where a substance is mentioned on the death certificate, whereas the Scottish data from 2008 represents specifically where a drug was implicated in, or potentially contributed to, the cause of death.

Heroin is currently the most commonly mentioned drug at death in England & Wales and Scotland; however, in 1996, 1997, 2011 and 2012 methadone was more commonly mentioned than heroin in Scotland (see Figure 6.5).

Figure 6.5: Number of deaths mentioning heroin/morphine and methadone in England & Wales and Scotland, 1996 to 2015

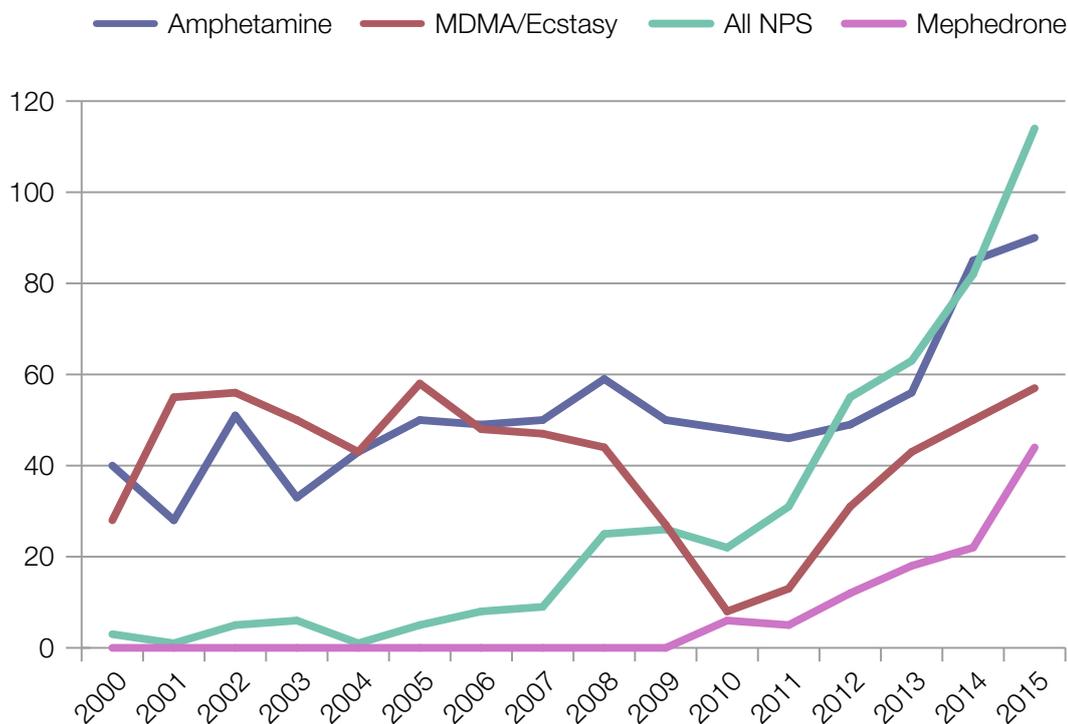


Source: (National Records of Scotland, 2016; Office for National Statistics, 2016c)

Over the last 16 years the number of cases where benzodiazepines were mentioned on the death certificate has increased in England and Wales, but decreased from a peak in 2002 in Scotland. In 2002, benzodiazepines were mentioned in more deaths in Scotland than in England and Wales combined. Following a fall in the number of benzodiazepine-related deaths to a nadir in 2006, the number of cases has been increasing in recent years. Tramadol, pregabalin and gabapentin are also increasingly being mentioned on death certificates in the UK.

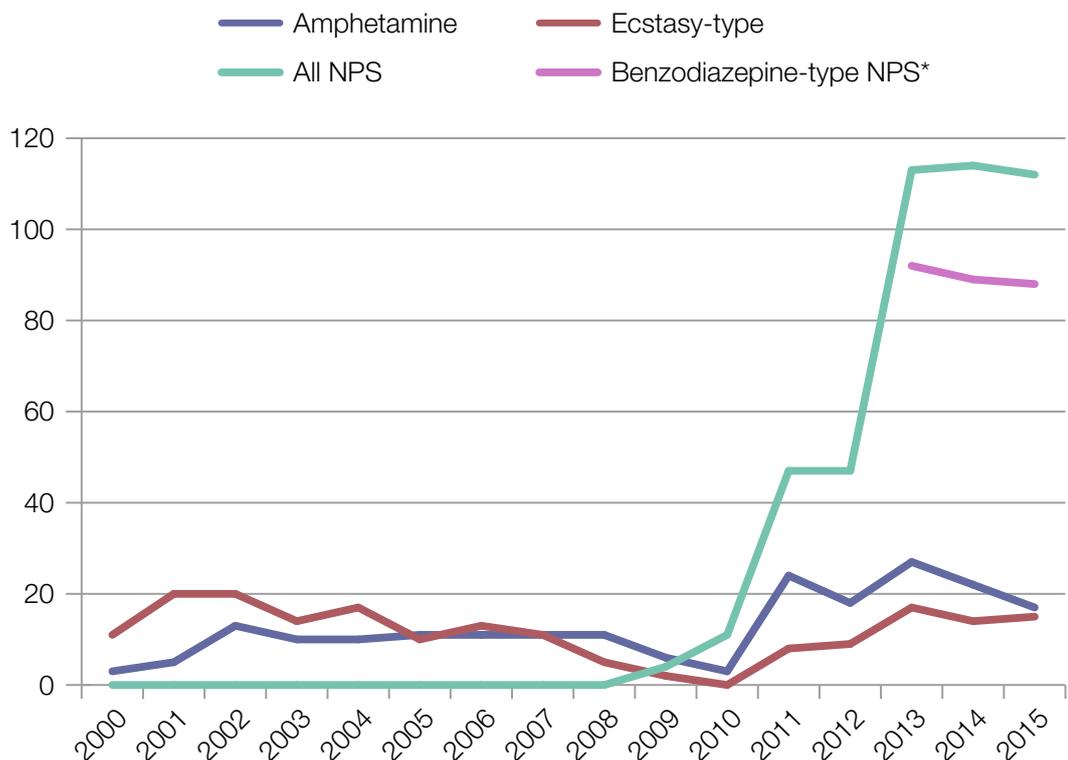
Ecstasy-type and MDMA deaths decreased in both registers to a low in 2010, and have since returned to a similar number (see Figures 6.6 and 6.7). Deaths involving NPS have increased greatly since 2010 in both England & Wales and Scotland. There were similar numbers of deaths in both registers in 2015; however, the nature of drugs involved differs, as mephedrone is responsible for the largest proportion of NPS deaths in England and Wales, whereas benzodiazepine-type substances are implicated in the majority of NPS deaths in Scotland. Deaths related to amphetamine have more than doubled in both registers since 2000.

Figure 6.6: Number of deaths involving amphetamine, MDMA and ecstasy-type drugs, new psychoactive substances and mephedrone in England and Wales, 2000 to 2015



Source: (Office for National Statistics, 2016c)

Figure 6.7: Number of deaths involving amphetamine, ecstasy-type substances and NPS in Scotland, 2000 to 2015



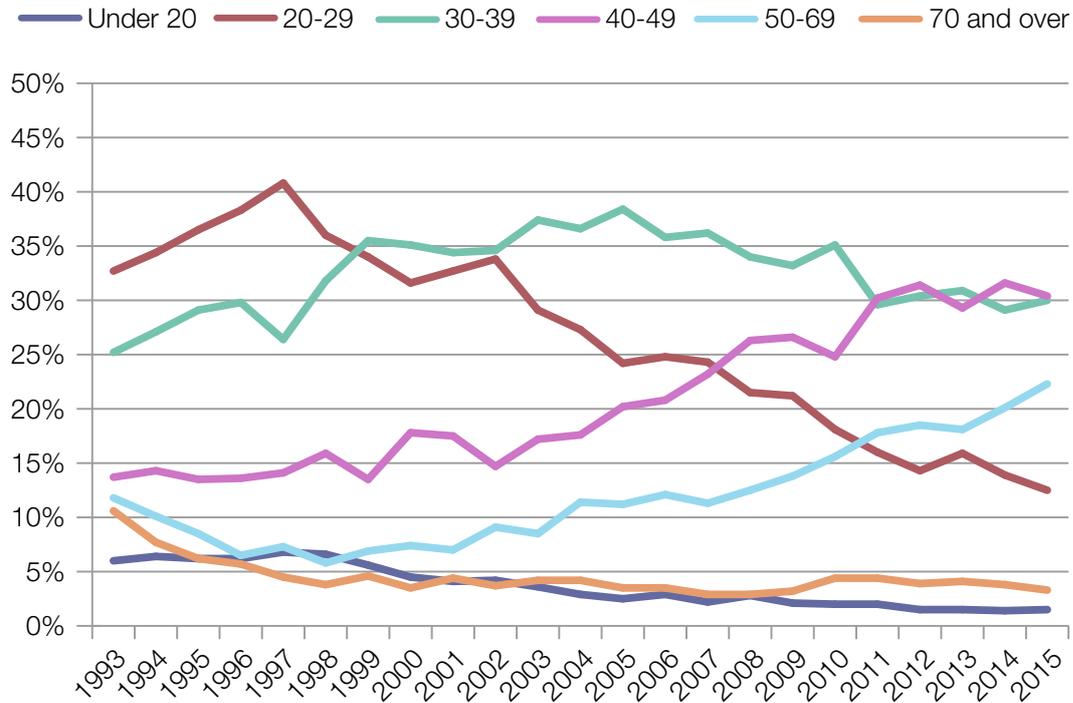
*Data only available from 2013

Source: (National Records of Scotland, 2016)

Age

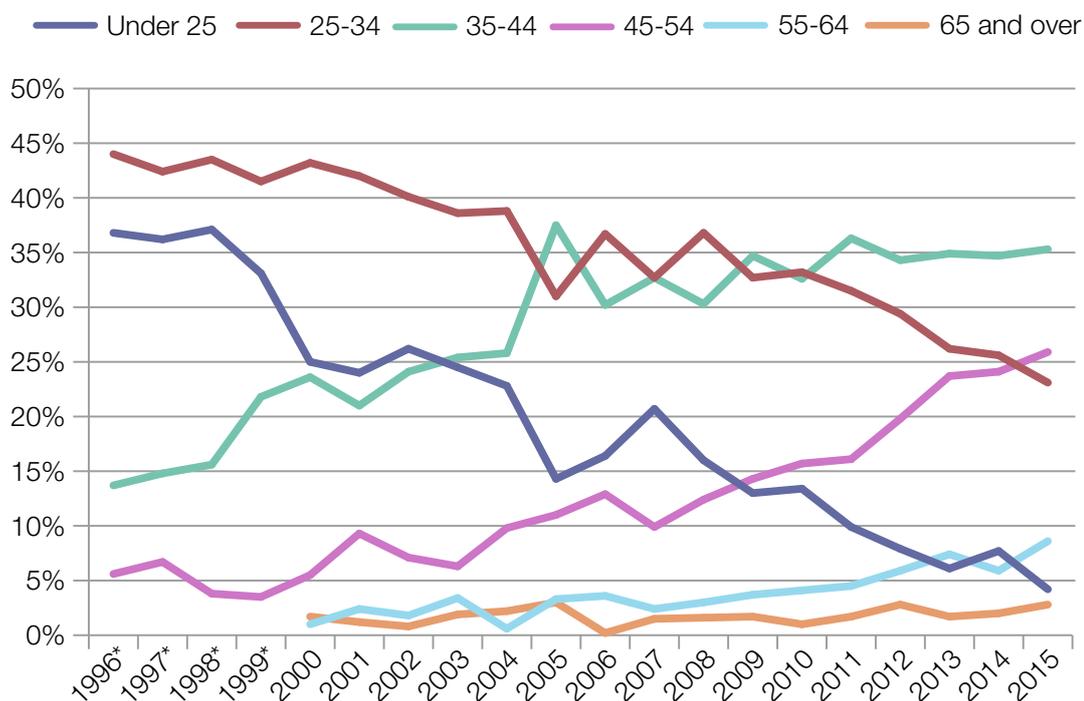
England & Wales and Scotland have seen long-term increases in the proportions of drug deaths occurring in older age groups, and decreases in the proportions occurring in younger age groups (see Figures 6.8 and 6.9).

Figure 6.8: Proportion of all drug-misuse deaths in England and Wales by age-group, 1993 to 2015



Source: (Office for National Statistics, 2016c)

Figure 6.9: Proportion of all drug-related deaths in Scotland by age-group, 1996 to 2015



* Between 1996 and 1999 the NRS did not have separate age brackets for 55-64 and 64 and over, therefore data for these age groups are available from 2000 onwards

Source: (National Records of Scotland, 2016)

6.7 Complementary sources of data

6.7.1 National Drug-Related Deaths Database (Scotland)

The sixth report from the National Drug-Related Deaths Database (NDRDD) in Scotland was published in March 2016, examining the personal circumstances of those who died a DRD in Scotland in 2014 (Information Services Division, 2016c). The DRDs in the NDRDD report were a sub-set of the 613 DRDs published by NRS in August 2015 (National Records of Scotland, 2015).

In 2014, there were 575 cases identified as eligible for inclusion in the main NDRDD cohort (an increase of 28% from the 448 eligible cases in 2013). As with previous years, around three-quarters (76%) were male. The proportion of deaths where the individual was aged 35 and over has increased over time, from half of deaths (50%) in 2009 to two-thirds (66%) of deaths in 2013; however, this proportion has remained at 66% in 2014. Similarly, while the mean age increased from 34.4 to 39.1 years in 2013, the mean age at death has remained at 39.1 years in 2014.

Around the same proportion of individuals (85%) were known to be using drugs prior to death in 2014 as in 2013, and two-thirds (66%) had a known history of intravenous drug use. Approximately three out of ten individuals (29%) were prescribed an opioid substitution treatment (OST) drug when they died (a decrease from 31% in 2013, but an increase from 21% in 2009). One-third of the cohort (34%) had been prescribed an OST drug at some point since 2009, a decrease since 2013 when over half (51%) had been prescribed an OST drug since 2009. However, the authors reported that the figure for 2014 may be an underestimate and did not publish inter-year comparisons for this figure. There had been a decrease in recent antidepressant prescribing in 2014, with 30% ($n=172$) of individuals prescribed an antidepressant in the 30 days before

death, compared to 37% in 2013. In three-quarters of these cases ($n=136$; 79%) this medication was present at post-mortem. Mirtazapine was the most commonly prescribed antidepressant, prescribed to 87 individuals (51% of those prescribed an antidepressant). There had also been a decrease in diazepam prescribing in 2014, falling to 13% of cases ($n=75$) from 21% in 2013. Three-fifths (60%) had experienced a psychiatric condition in the six months before death, a similar proportion to 2013.

Over half (53%) of those included in the cohort had been in contact with drug treatment services before they died, the same proportion as in 2013. Seventy per cent ($n=404$) had been in contact with at least one service (drug treatment, hospital, police or prison) which had the potential to address their problem drug use, or deliver harm reduction interventions, in the six months prior to death.

In 69% of cases, more than one drug was implicated in the death. Diazepam was the drug most frequently found to be present (70% of cases, a small increase since 2013, although down from 77% in 2009), but implicated in less than one-third of these cases (20% of all cases). Opioids were the most commonly implicated class of drugs: together, heroin/morphine, methadone and buprenorphine were implicated in 76% of deaths. Heroin/morphine was present in 58% of cases and implicated in 52%; both of these proportions were the highest recorded since 2010. Methadone continued to be present and implicated in a decreasing number of cases; in 2014 it was present in 40% of deaths and implicated in 36% (compared to 47% and 42%, respectively, in 2013).

6.8 New developments in drug-related deaths

6.8.1 Public Health England reports

Public Health England analysis

In July 2015 PHE produced an analysis of trends in DRDs in England using the DMD, based on extracts of data received from ONS (Public Health England, 2015h). This followed the reported rise in deaths registered in England using the DMD by ONS for 2013 (Office for National Statistics, 2014) and a national summit on DRDs in England held in January 2015. This report was updated in April 2016, using the ONS data released in September 2015, and covered deaths between 1999 and 2013, with provisional data for 2014 (Public Health England, 2016g).

For the 2015 analysis, PHE reported figures based on year of death, highlighting that registration delays meant that later years were incomplete. This analysis found that a large number of drug misuse deaths registered in 2013 had occurred in the same year (892 deaths), but that there had also been an increase in deaths registered after more than one year. In the 2016 analysis, the authors reported that there had been a large increase in the registrations of drug misuse deaths in 2014 (as there had been in 2013); however, the large majority of these deaths were classified as those that had been registered within six months. In total, there were 1,042 drug misuse deaths occurring in 2014 that were registered in that year, the largest number recorded to date.

In the latest report, PHE also showed that among deaths where heroin was mentioned on the death certificate, there was a clear long-term trend towards other substances (including alcohol) also being mentioned, and away from heroin being the only drug mentioned. A data linkage exercise between drug poisoning data and drug treatment data was included in the first report, and repeated in the 2016 update, which showed that around three-fifths (57%) of opioid misuse deaths in 2012 had received no treatment since at least 2006 (and possibly never). The proportion receiving treatment in the year prior to death had remained reasonably consistent,

at around one-third, over the full period studied (2008–2012). When considered in the context of prevalence estimates and treatment numbers, both analyses suggested that treatment had a significant protective effect for opioid users, corresponding to the findings of a previous report (White et al., 2015). However, they also suggested that there has been little change in the extent of the protective effect in recent years.

Public Health England inquiry into drug-related deaths

Following the two consecutive increases in the number of DRDs in England in 2014 and 2015, PHE and the Local Government Association convened a national inquiry to investigate the causes of these increases, and discuss how to prevent future premature deaths (Public Health England, 2016i). The inquiry consisted of meetings of a national expert group to lead the investigation and review data; analysis of existing and commissioned data; and five local events held around England to direct the inquiry and gather intelligence on local practice to prevent DRDs. There were a number of recommendations for drug treatment service commissioners and providers, PHE, NHS England, Clinical Commissioning Groups and the Ministry of Justice, which included: ensuring treatment is easy and desirable to access, optimising interventions and retaining those in treatment for as long as they benefit; promoting risk management, adequate OST dosing and stop smoking services; intervening following non-fatal overdoses; supporting THN provision and naltrexone use; strengthening governance and competence in treatment services; sharing learning and improving shared information; and continue to research and investigate DRDs and their prevention.

6.8.2 Office for National Statistics report on deaths involving ‘legal highs’

In April 2016 the ONS released an analysis of deaths caused by ‘legal highs’ in England and Wales that occurred between January 2004 and December 2013 (Office for National Statistics, 2016b). ‘Legal highs’ were defined as psychoactive substances which were not controlled at the time of death, but which may have been subsequently controlled. Between 2004 and 2013 there were 76 deaths in England and Wales where a ‘legal high’ was involved; by comparison, there were 7,748 deaths involving heroin and 1,752 deaths involving cocaine over the same time period. Between 2004 and 2013 around five in six ($n=66$; 87%) of all ‘legal high’ deaths were males, compared to 69% males for all drug misuse deaths over the same time period (Office for National Statistics, 2015). The median age at the time of death was 28 years for deaths involving ‘legal highs’, ten years younger than all drug misuse deaths (38 years). ‘Legal high’ deaths were more likely than drug misuse deaths to have more than one substance (including alcohol) mentioned on the death certificate: 57% of deaths involved another substance, compared to 35% of all drug misuse deaths. This may be due to the fact that NPS preparations often contain multiple chemicals in one package/tablet. The report also focused on mephedrone, analysing the number of deaths occurring before and after this substance was controlled in the UK. While use of mephedrone has decreased since the ban in April 2010, the number of deaths involving this substance rose from seven in 2010 to 22 in 2012, and has since risen to 44 deaths in 2015. However, the report argues that if mephedrone had not been banned, the number of deaths in 2011 onwards may have been higher.

6.8.3 Role of benzodiazepines in drug-related deaths in Scotland

Benzodiazepines have now become one of the most common drugs found at the time of death in DRDs in Scotland (see [section 6.4.2](#)). In February 2016 NHS Scotland published a report looking into the role of these substances in DRDs and drug-associated mortality, the increasing availability of unregulated benzodiazepines, the use of large doses of benzodiazepine-type

drugs, and the risks of short- and long-term mental health and cognitive problems associated with routine and excessive benzodiazepine use (Johnson, Barnsdale, & McAuley, 2016).

6.8.4 Cohort mortality study

Gao et al. (2016) conducted a cohort study looking at gender, age-group and quantity of methadone prescribed as risk factors for DRDs, and for methadone-specific DRDs, in Scotland's methadone-prescription clients (Gao et al., 2016). The study found that between July 2009 and June 2013, methadone-specific DRDs were higher in those aged 35 and over (4.2 deaths per 1,000; 95% CI, 3.6 – 4.7) than for younger clients (1.9 deaths per 1,000; 95% CI, 1.5 – 2.2). For methadone-specific DRDs, age related hazard ratios were steeper than for all DRDs; for example, those aged 45 and over experienced a hazard ratio of 2.9 (95% CI, 2.1 – 3.9) compared to 1.9 for all ages (95% CI, 1.5 – 2.4). The study also found that the highest quintile for quantity of prescribed methadone at cohort-entry (prescriptions of over 1960mg, representing for example 14 days at 140mg or 28 days at 70mg) was associated with an increased hazard ratio (1.8; 95% CI, 1.3 – 2.5).

6.8.5 Deaths in prison

In July 2015 the Prisons and Probation Ombudsman (PPO) reported on 19 deaths which occurred in prison between April 2012 and September 2014, where the prisoner was known, or strongly suspected to have been using NPS-type drugs before their death (Prisons and Probation Ombudsman, 2015). In November 2016 the PPO updated these figures, reporting that between June 2013 and April 2016 there had been 64 deaths in prisons associated with the use of NPS (Prisons and Probation Ombudsman, 2016) (see [section 5.5.1](#)).

6.8.6 Drug consumption rooms in Scotland

In April 2016 the Scottish Drugs Forum (SDF) published a report by Kirsten Horsburgh, Scotland's National Naloxone Programme Co-ordinator, who is based at the SDF, on reducing DRDs. The report detailed survey results on stakeholders' opinions on drug consumption rooms in Scotland, and a Winston Churchill Fellowship mission to Australia to assess Sydney's medically supervised injection centre. The three recommendations of the report were: that there is a clear need for supervised injection facilities wherever there are large numbers of people injecting in public, therefore legislative changes should be made to allow the Scottish government to provide funding for a pilot site; that THN should be available free-of-charge, and promoted widely, to those most likely to witness an overdose; and that low threshold services should be widely available across the country.

In response to the increased number of HIV diagnoses among PWID in Glasgow in 2015 (see [section 7.3.1](#)), NHS Greater Glasgow and Clyde published a report in June 2016 which examined the health needs of people who inject in public places in the city, and also recommended the introduction of a safe injecting facility in Glasgow city centre (NHS Greater Glasgow and Clyde, 2016). In October 2016, Glasgow City Joint Integration Board approved the development of a full business case for such a facility.

7 Drug-related infectious diseases and other drug-related harms

7.1 Introduction

The UK government and devolved administrations have a number of policy and guidance documents outlining best practice for responses to the health correlates and consequences of drug use (often referred to as harm reduction). Principles of harm reduction aim to reduce the risky behaviour of those active drug users who are either unwilling or unable to abstain. Each of the UK and devolved administration drug strategies include harm reduction objectives.

People who use drugs are at risk of both fatal and non-fatal overdose; experiencing periods of elevated overdose risk in the immediate period after leaving inpatient treatment and prison; and experiencing greater risk of contracting blood-borne viruses (BBVs) through injecting drug use. Reducing the harm associated from substance use has been a key priority of the 2010 drug strategy, and harm reduction programmes aimed at injecting drug users have traditionally focused on reducing rates of infection and transmission, increasing the diagnosis of current infections, and improving the provision and treatment and support to infected individuals. This is often achieved through specialist programmes and initiatives, such as the take home naloxone programme, needle and syringe provision and vaccinations against some BBVs.

Injecting drug use is the most significant risk factor for hepatitis C, with about half of injecting drug users in England, Wales and Northern Ireland testing positive for this infection in 2015. Prevalence of hepatitis C among injecting drug users has been fairly stable over the last ten years. Hepatitis B prevalence among injectors dropped from 28% to 20% between the 2007 and 2008 surveys and has dropped further since then to 13% in 2015. HIV prevalence in this cohort is one per cent, similar to that seen in recent years (Public Health England, 2016d).

HIV prevalence among 'recent initiates' to injecting substantially increased in 2015 to its highest level seen in the last ten years. However, this likely represents an increase in prevalence among men who have sex with men (MSM) rather than among the wider population who inject drugs.

7.2 National drug strategies on people who inject drugs

The UK *Drug Strategy 2010, Reducing Demand, Restricting Supply, Building Recovery: Supporting people to live a drug free life* (Her Majesty's Government, 2010) includes a key best practice delivery outcome that all drug services are commissioned to prevent drug-related deaths and prevent the spread of BBVs. Public Health England (PHE) routinely publishes guidance on best practice and reports annual surveillance on a range of key indicators associated with BBVs in the UK.

In Wales, *Working Together to Reduce Harm: The Substance misuse strategy for Wales 2008-2018* (Welsh Assembly Government, 2008a) sets out a national agenda for tackling and reducing the harms associated with substance misuse. Additional guidance is provided in *Diagnostic Testing for hepatitis C, hepatitis B and HIV* (Public Health Wales, 2014a); *Blood Borne Viral Hepatitis Action Plan for Wales 2010-2015* (Welsh Assembly Government, 2010); and *Together for Health – Liver Disease Delivery Plan* (Welsh Government, 2015a).

The Scottish government launched the *HIV Action Plan in Scotland, December 2009 to March 2014* (Scottish Government, 2009b) followed by the five year *Sexual Health and Blood Borne*

Virus Framework 2011–2015 (Scottish Government, 2011). Quality standards applicable to all HIV services (Healthcare Improvement Scotland, 2011) and quality indicators applicable to all hepatitis C services (Healthcare Improvement Scotland, 2012) have also been published.

In Northern Ireland, responses to health correlates and consequences of drug misuse are broadly covered by the overarching strategy for alcohol and drugs misuse, the *New Strategic Direction for Alcohol and Drugs Phase 2, 2011–2016* (Department of Health Northern Ireland, 2011). One of the overall aims of this strategy is to reduce drug-related harm and ensure continued support to further develop appropriate harm reduction approaches and strategies.

7.3 Blood borne viral infections amongst people who inject psychoactive drugs

7.3.1 HIV

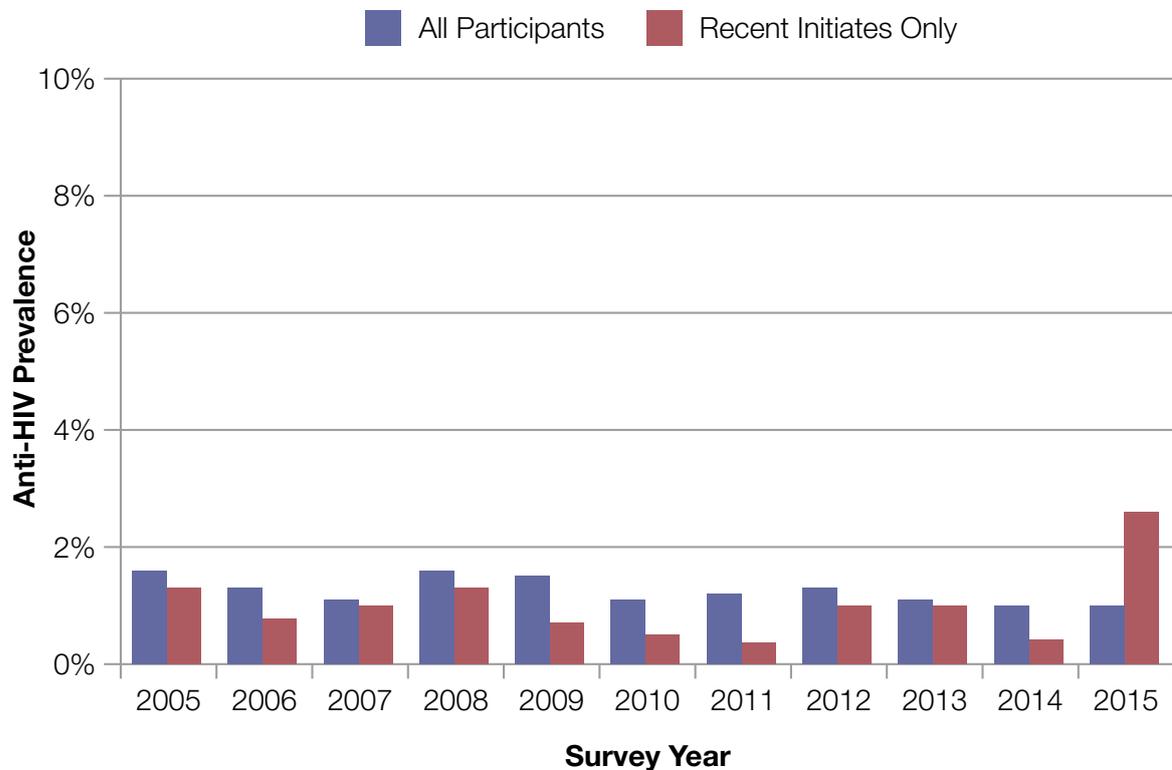
Prevalence

The overall prevalence of HIV seen among people who inject drugs (PWID) in 2015 was similar to that seen in recent years. The prevalence of HIV among the current and former PWID taking part in the Unlinked Anonymous Monitoring (UAM) Survey across England, Wales and Northern Ireland in 2015 was 1.0% (95% CI, 0.6%-1.3%) (Public Health England, 2016c). Between 2005 and 2014, prevalence varied between 1.1% and 1.6% (see Figure 7.1). In 2015 the HIV prevalence was 0.77% (95% CI, 0.01%-1.8%) in Wales, 0.65% (95% CI, 0.01%-1.9%) in Northern Ireland, and 1.0% (95% CI, 0.60%-1.4%) in England (see accompanying table DRID).

HIV prevalence among those who first injected during the preceding three years is an indicator of recent HIV transmission. The prevalence among these recent initiates participating in the UAM Survey of PWID was 2.6% (95% CI, 0.55%-4.7%) in 2015 (Public Health England, 2016c). This is a relatively large increase since 2014, when the prevalence among this population was 0.41%, and is the highest level seen in the past ten years (see Figure 7.1). In 2015, those with HIV in this group were men who reported having sex with men during the preceding year. The elevated prevalence of HIV in this group during 2015 therefore most probably reflects the increase in injecting drug use that has recently been seen among some groups of MSM, many of whom are HIV positive. This probably does not reflect an increase in the level of HIV transmission among PWID overall, where injecting drug use was the underlying route of transmission.

In Scotland, among those attending needle and syringe programmes (NSP) during 2015/16, 1.9% were found to be HIV positive (Public Health England, Health Protection Scotland, Public Health Wales, & Public Health Agency Northern Ireland, 2016).

Figure 7.1: The prevalence of antibodies to HIV among all participants and recent initiates* in the Unlinked Anonymous Monitoring Survey of people who inject drugs: England, Wales and Northern Ireland, 2005 to 2015



*A recent initiate is someone who first injected during the preceding three years
Source: (Public Health England, 2016c)

New cases

There were 182 new HIV diagnoses associated with injecting drug use reported in the UK during 2015, compared with 131 new diagnoses in 2014. Fifty of these diagnoses were reported from Scotland, compared with 17 in 2014. This increase is due to an outbreak of HIV in PWID in Glasgow (Public Health England et al., 2016). There were also 21 reported HIV diagnoses that were associated with MSM, for which injecting drug use was also reported as a risk (Public Health England et al., 2016).

Glasgow typically records around 10 new diagnoses of HIV associated with injecting drug use each year; 42 new diagnoses with this risk were reported for 2015, the majority with subtype-C virus. Data indicate that this increase in diagnoses is related to transmission among a small but appreciable population of highly chaotic, vulnerable and often homeless people who inject psychoactive drugs, mainly heroin. This outbreak is being managed through increasing awareness of the risks of HIV, making HIV testing more accessible and proactively supporting the early treatment of those newly diagnosed to reduce the risk of onward transmission.

7.3.2 Hepatitis C

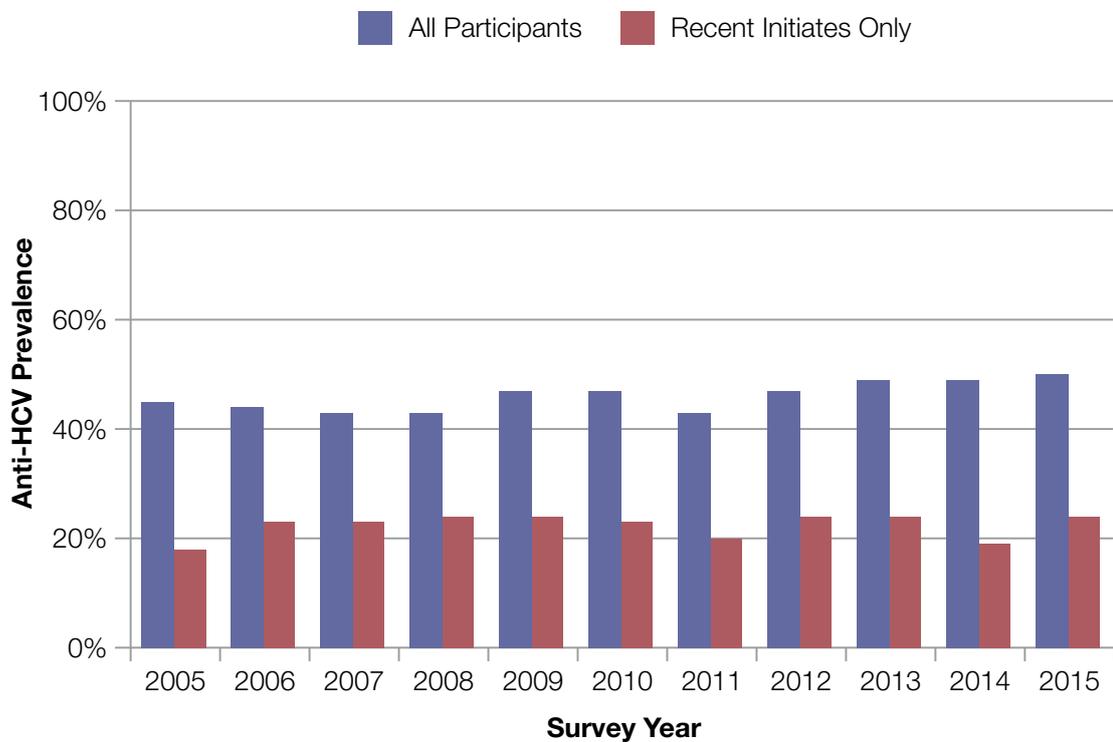
PWID are the group with the highest prevalence of hepatitis C in the UK. Around 90% of the hepatitis C infections diagnosed in the UK will have been acquired through injecting drug use. During 2015, 14,134 hepatitis C infections were diagnosed in England, Scotland and Northern Ireland (Public Health England et al., 2016). There has been a marked increase in the annual number of new diagnoses throughout the UK over the last decade, reflecting the increased availability and easier access to voluntary confidential testing.

The overall prevalence of antibodies to hepatitis C (anti-HCV) among the current and former PWID participating in the UAM Survey of PWID was 50% (95% CI, 49%-52%) in 2015 (Public Health England, 2016c). This proportion has remained relatively stable over the last decade (see Figure 7.2). Anti-HCV prevalence in Northern Ireland was 27% (95% CI, 20%-35%), which is lower than in England (52%, 95% CI, 50%-54%) and Wales (53%, 95% CI, 47%-59%). While the hepatitis C prevalence among the participants in the UAM Survey in England and Northern Ireland has remained relatively stable over time, in Wales there has been an increase from 19% recorded in the period 2003–05 (Public Health England, 2015c) (see accompanying table DRID). In England there were marked regional variations from 26% (95% CI, 19%-33%) in the West Midlands to 68% (95% CI, 63%-72%) in the North West (Public Health England, 2016c).

In Scotland, the estimated anti-HCV prevalence was 58% among current and former PWID surveyed at services providing injection equipment across mainland Scotland in 2015/16. This compares to 54%, 56%, 53% and 58% who tested positive in 2008/09, 2010, 2011/12, and 2013/14 respectively (Public Health England et al., 2016).

The level of hepatitis C transmission among PWID in the UK appears to have changed little in recent years. Anti-HCV prevalence among recent initiates has also been fairly stable. Among those in this group participating in the UAM survey of PWID, prevalence was 24% (95% CI, 18%-30%) in 2015 (Public Health England, 2016c). Over the last decade the prevalence in this group has ranged between 18% and 24% (see accompanying table DRID). In 2015, incidence of hepatitis C infection among PWID in the UK was estimated to be eight infections per 100 person years of exposure (Public Health England, 2016e). In Scotland, the incidence of hepatitis C infections among PWID was estimated to be 11.5 infections per 100 person years of exposure during 2015/16 (Public Health England et al., 2016).

Figure 7.2: The prevalence of anti-HCV among all participants and recent initiates* in the Unlinked Anonymous Monitoring Survey of people who inject drugs: England, Wales and Northern Ireland, 2005 to 2015



*A recent initiate is someone who first injected during the preceding three years

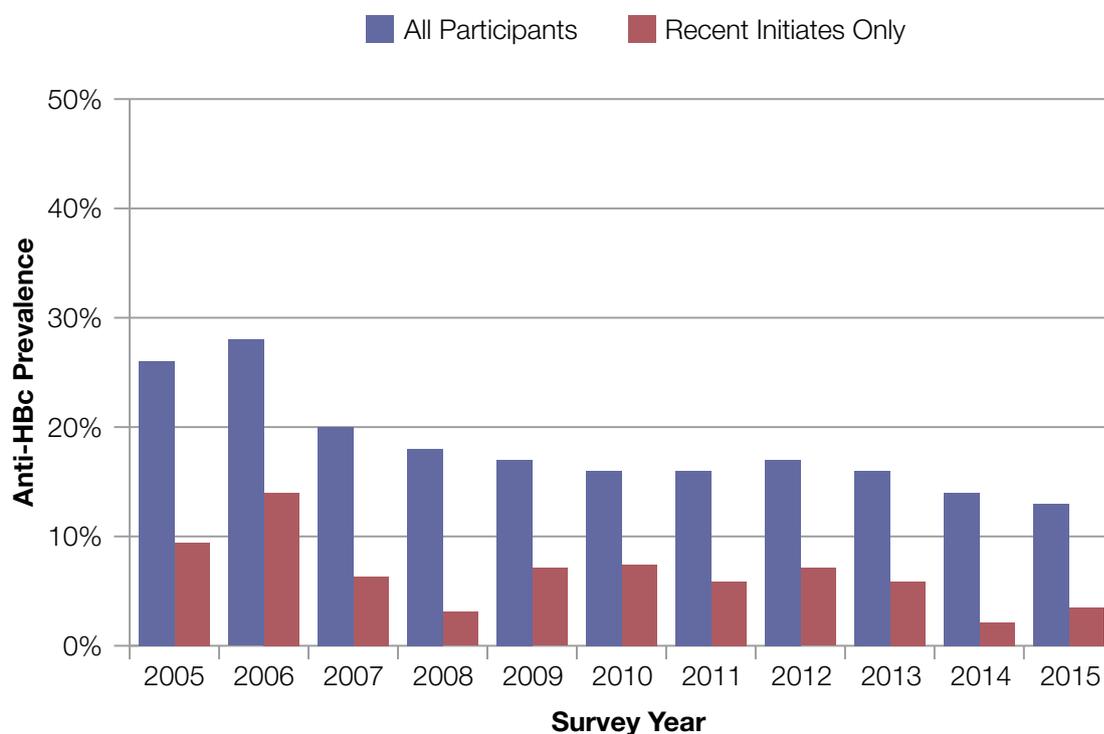
Source: (Public Health England, 2016c)

7.3.3 Hepatitis B

In 2015, 13% (95% CI, 12%-14%) of the current and former PWID who took part in the UAM Survey of PWID had antibodies to hepatitis B core antigen (anti-HBc, a marker of previous or current hepatitis B infection) (Public Health England, 2016c). This prevalence has remained relatively stable in recent years, but it is lower than the level seen ten years ago when prevalence was 26% (see Figure 7.3). The prevalence of anti-HBc varied by country: Northern Ireland, 6.5% (95% CI, 2.6%-11%; prevalence was 13% in 2005); Wales, 11% (95% CI, 7.0%-14%; prevalence was 9.3% in 2005); and England, 14% (95% CI, 12%-15%; down from 28% in 2005) (Public Health England, 2016c) (see accompanying table DRID).

The available data on reports of acute hepatitis B infections indicate that there are currently few of these among PWID, with most UK acquired cases associated with sexual activity. This is likely reflecting the impact of the marked increased in the uptake of the hepatitis B vaccine among PWID (Public Health England et al., 2016).

Figure 7.3: The prevalence of anti-HBc among all participants and recent initiates* in the Unlinked Anonymous Monitoring Survey of people who inject drugs: England, Wales and Northern Ireland, 2005 to 2015



*A recent initiate is someone who first injected during the preceding three years.
Source: (Public Health England, 2016c)

7.4 Blood borne viral infections amongst people who inject image and performance enhancing drugs

During the 2014/15 sampling period 354 individuals took part in the UAM sub-survey of those who inject image and performance enhancing drugs (IPEDs) from across England and Wales, where participants provided a dried blood spot specimen that was tested anonymously for HIV, hepatitis C and hepatitis B. Of these participants, 0.56% (95% CI, 0.01%-1.3%) had HIV (compared with 1.0% in PWID using psychoactive drugs); 2.5% (95% CI, 0.9%-4.2%) anti-HBc (compared with 13% in those PWID using psychoactive drugs); and 5.1% (95% CI, 2.8%-7.4%) had anti-HCV (compared with 52% in those PWID using psychoactive drugs) (Public Health England, 2016c, 2016d).

In Scotland, among those surveyed attending NSP who had only injected IPEDs during the past six months, 11% had antibodies to hepatitis C in 2015/16 (Public Health England et al., 2016).

The prevalence of BBV infections amongst IPED injectors in Northern Ireland is currently not known. A pilot survey of IPED injectors has recently been conducted in Northern Ireland; however, biological samples were not collected (UK Focal Point, 2016).

7.5 Other drug-related infectious diseases

7.5.1 Tuberculosis

In total there were 5,758 cases of tuberculosis (TB) reported in England in 2015 (Public Health England, 2016h). Among the cases with known information on the four 'social risk factors' monitored among TB cases in England: 4.3% (221/5,189) had either a history of, or currently had, a problem with drug use; 3.9% (205/5,191) of alcohol misuse; 4.4% (229/5,171) of homelessness; and 3.9% (198/5,033) of imprisonment. Twelve per cent (579/4,910) of TB cases in 2015 had at least one of these social risk factors, compared with 9.8% (538/5,708) of cases in 2014. A higher proportion of the UK-born TB cases had at least one social risk factor when compared to non UK-born cases (22% versus eight per cent).

7.5.2 Other injection-related bacterial infections

Severe illnesses among people who inject drugs due to hygiene-related bacterial infections, including those caused by *Staphylococcus aureus* and Group A streptococci, continue to occur. Data from the mandatory enhanced surveillance of meticillin-sensitive *S. aureus* (MSSA) and meticillin-resistant *S. aureus* (MRSA) bacteraemias indicate that in 2015, of those with risk factor information, 11% of the MSSA bacteraemias were associated with injecting drug use, as were 9.6% of the MRSA bacteraemias. Severe Group A streptococcal (GAS) infections have also been reported among people who inject drugs. During 2014/15 there was a large outbreak of soft tissue infections among people who injected psychoactive drugs in the Lothian Health Board area of Scotland, with many of the cases requiring prolonged hospital admissions and extensive surgical interventions. Though a number of different organisms were detected, GAS infections, and in particular one less commonly seen type of *S. pyogenes*, were often detected in the cases. Many of the cases had used one of the recently emerged psychoactive drugs, ethylphenidate.⁵⁷

In 2015, one-third (33%; 95% CI, 30%-35%) of individuals participating in the UAM Survey of PWID reported that they had experienced an abscess, sore or open wound, all indicating symptoms of injecting-site infection, during the preceding year (Public Health England, 2016c). This was similar to the level seen in recent years. There was an increase in symptoms of injection site infections among those aged under 25, from 24% in 2014 to 39% in 2015. However, the levels of injection site infections remained stable in those aged 25 and above. More women (38%) reported symptoms than men (31%). Among those attending NSP in Scotland during 2015/16, 20% reported that they had experienced an abscess, sore or open wound, during the last year (Public Health England et al., 2016).

Among the participants in the 2014/15 UAM sub-survey of people who inject IPEDs, 14% (95% CI, 11%-18%) reported that they had ever experienced symptoms of injecting-site infection, with the proportion being highest among the 25-34 age group (17%) (Public Health England, 2016d). This is a slight decrease from the 2012/13 report when 16% reported ever experiencing symptoms, and the proportion among the 25-34 age group was 22%.

57 See: <http://www.hps.scot.nhs.uk/ewr/article.aspx?id=63352>

7.6 Behavioural data: infection risks

The extent and patterns of infections over time reflect changing patterns of risk. Risk will be impacted by the extent of service provision, particularly the provision and uptake of harm reduction and health protection interventions such as NSP, opioid substitution treatment, vaccination and diagnostic testing services. The provision of these services is widespread in the UK, and provision and uptake have both improved over the last decade (see [section 7.7](#)).

7.6.1 Sharing of injecting equipment

People who inject psychoactive drugs

The level of direct sharing of needles and syringes reported by participants in the UAM Survey of PWID has declined from 28% (95% CI, 26%-30%) in 2005 to 16% (95% CI, 14%-18%) in 2015 (Public Health England, 2016c) (Figure 7.4). Throughout the 2005 to 2015 period, direct sharing levels were higher among women than men: in 2015, 23% (95% CI, 18%-27%) of women reported direct sharing compared with 14% (95% CI, 12%-16%) of men. Direct sharing was found to vary across England (17%), Wales (13%) and Northern Ireland (17%). In England regional variations were reported, ranging from 4.0% (95% CI, 0.01%-8.4%) in the West Midlands to 22% in both the south of England (95% CI, 17%-26%) and in the south-west of England (95% CI, 15%-29%).

Sharing of any of the injecting equipment asked about in the UAM Survey of PWID (ie needles, syringes, mixing containers, or filters; direct and indirect sharing) was reported by 38% (95% CI, 36%-41%) of those participating in the survey in 2015; this was the same as in the previous year (Public Health England, 2016c). Sharing of any of this equipment was reported by 38% of the participants in England (regional range: 25% to 51%), by 42% in Wales, and by 31% in Northern Ireland.

In Scotland, data from the Scottish Drug Misuse Database for 2014/15 indicates sharing of needles/syringes among those injecting drugs in the past month has decreased over time, with six per cent of this population reporting sharing of needles/syringes (Information Services Division, 2016f). This is the lowest percentage recorded since reporting began in 2006/07, when 12% of the current injecting population reported currently sharing needles. There was little variation between NHS health boards, ranging from two per cent to nine per cent. However, the percentage of injectors reporting having shared needles/syringes in the past, but not in the previous month was higher at 33% across Scotland (ranging from 23% to 42% between NHS health boards). This percentage has remained stable since 2006/07.

Among people reporting injecting in the past month, eight per cent reported sharing injecting paraphernalia in the past month, continuing the downward trend since 2006/07, and less than half the percentage seen in 2006/07 (20%). Again, there was similar variation between NHS health boards (ranging from five per cent to 12%). Forty-one per cent of current injectors reported sharing injecting paraphernalia in the past, ranging from 31% to 55% across the NHS health boards.

Figure 7.4: The percentage of current injectors* in the Unlinked Anonymous Monitoring Survey of people who inject drugs reporting needle and syringe sharing: England, Wales and Northern Ireland, 2005 to 2015



*Those reporting injecting in the four weeks preceding survey participation
Source: (Public Health England, 2016c)

People who inject image and performance enhancing drugs

Among the participants in the 2014/15 UAM sub-survey of people who inject IPEDs, 13% (95% CI, 9.5%-17%) reported ever sharing any injecting equipment (Public Health England, 2016d).⁵⁸ This was the same level as that reported in 2012/13.

People who inject new psychoactive substances

In England, Wales and Northern Ireland, 8.2% of those surveyed as part of the UAM Survey of PWID in 2015 reported that they had injected mephedrone during the preceding year. One-third (32%) of those currently injecting mephedrone reported sharing needles or syringes previously used by someone else. Only 18% of those who had not injected mephedrone reported sharing this equipment (Public Health England et al., 2016).

7.6.2 Condom use and sexual behaviour in people who inject drugs

In 2015, two-thirds (66%, 95% CI, 65%-68%) of the PWID participating in the UAM Survey of PWID reported having anal or vaginal sex during the preceding year. This level has been steadily dropping since 2010, when 75% of respondents reported having anal or vaginal sex during the preceding year (Public Health England, 2016c). Of those who had sex in the last year, 40% (95% CI, 38%-43%) reported having had two or more sexual partners during that time. Of these individuals, only 22% (95% CI, 18%-25%) reported always using condoms for anal and vaginal sex. The proportion of women reporting always using a condom increased from 21% in 2014 to 27% (95% CI, 20%-34%) in 2015. However, the proportion of males reporting always using a

58 Needle, syringe or vial.

condom has remained stable. This suggests increased efforts are required to improve the use of condoms in PWID.

Among the participants in the 2014/15 UAM sub-survey of people who inject IPEDs, 92% (95% CI, 89%-95%) reported having anal or vaginal sex during the preceding year, suggesting this cohort are more sexually active than participants in the main UAM Survey of PWID (Public Health England, 2016d). Within those who had sex in the previous year, 51% (95% CI, 46%-57%) reported having had two or more sexual partners during that time, and of this 51%, 17% (95% CI, 11%-24%) reported always using a condom; a smaller proportion than in the main UAM Survey of PWID.

7.6.3 Men who have sex with men

There are on-going concerns about the injection of methamphetamine and mephedrone among some sub-groups of MSM, many of whom are HIV positive. These drugs are typically being used by these men during sex in a practice known as chemsex, where injecting equipment is often shared and condoms are not necessarily used. Although the scale of this behaviour remains unclear, specialist lesbian, gay, bisexual and transgender (LGBT) drug services are continuing to see an increase in the number of MSM who report injecting these drugs. The use and injection of these drugs has also been reported to be a factor in the increased transmission of a number sexually transmitted infections (Bourne, Reid, Hickson, Torres Rueda, & Weatherburn, 2014; Kirby & Thornber-Dunwell, 2013).

Guidance documentation produced by Project NEPTUNE (Novel Psychoactive Treatment UK Network) has been developed for healthcare professionals who work alongside the LGBT population and MSM. It reports patterns of club drug use among LGBT populations, examines the factors that may impact on the use of substances, and discusses drug-related and other harms. It also looks at the use of drugs in a sexual context and at the risks associated with chemsex. The document addresses treatment responses to club drug use for MSM and is intended to guide improved service and treatment planning (Abdulrahim et al., 2016).

7.7 Prevention and control of drug-related infectious diseases: harm reduction services

7.7.1 Universal harm reduction

In the UK there are several government-funded websites that provide information on drug and alcohol use including harm reduction advice, such as FRANK, DAN 24/7 and Choices for Life (see [section 3.4](#)). Additionally, all treatment providers offer harm reduction advice as part of their range of interventions and some also make this available online (eg SMART).⁵⁹

Project NEPTUNE has been developed with the aim of improving clinical practice in the management of harms resulting from the use of NPS. One of the areas addressed by the project is harm reduction. The measures outlined comprise interventions aimed at preventing morbidity and mortality among individuals presenting to clinical settings, including measures to reduce the harms of new psychoactive substances for individuals and communities.

59 See: <http://www.smartcjs.org.uk/>

7.7.2 Needle and syringe programmes

NSP are provided throughout the UK in a variety of settings, principally through pharmacies and specialist drug treatment services. There are also a small number of mobile syringe exchanges, usually attached to a local treatment provider, and in Wales there is a single vending machine which can be used to obtain syringes. NSP aim to reduce harm by offering advice on safer injecting practice, helping PWID to access treatment and signpost them to other relevant health services such as BBV testing, mental health services and welfare and advocacy services. They may additionally provide foil to drug users to encourage them to switch to non-injecting methods. NSP are commissioned locally and are monitored by local authorities to ensure they comply with clinical guidelines. Services are also available in environments to meet the needs of people who use IPEDs – for example outreach services in gyms.

Harm reduction initiatives providing NSP also exist in areas outside of specialist drug services; for example sexual health clinics may offer advice aimed at drug users. In addition, a number of specialist services exist for the needs of those who are engaging in chemsex.

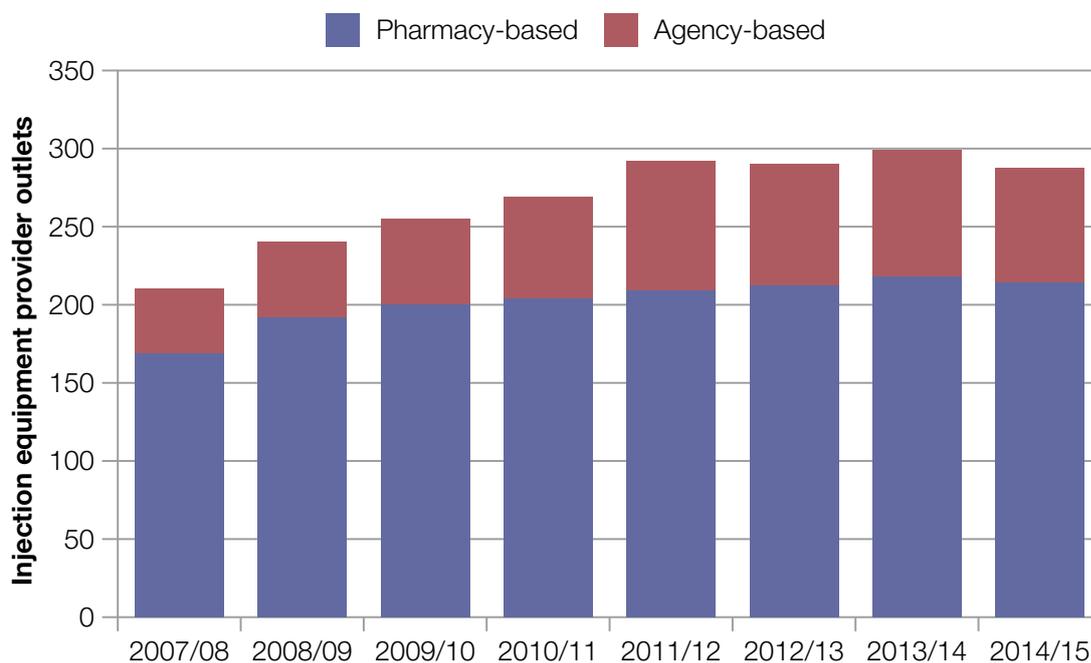
The vast majority (90%) of the participants in the UAM Survey of PWID from across England, Wales and Northern Ireland reported that they had used a NSP in 2015 (Public Health England, 2016c).

Scotland

In Scotland, there were 288 injection equipment provider outlets reported to be operating in 2014/15, of which 214 (74%) were pharmacy based (Information Services Division, 2016a). While this was an increase from 188 outlets in 2004/05, it represented a slight decrease from 2013/14 (299 outlets) (see Figure 7.5).

In 2014/15, 4.4 million needles/syringes were reported to have been distributed to PWID in Scotland, based on data collected from 95% (275/288) of the injection equipment provider outlets. This is similar to the number of needles/syringes (in the range 4.4 to 4.7 million per year) reported to have been distributed in recent years (2007/08 to 2012/13). The number of injecting paraphernalia items distributed to PWID has increased in recent years, with notable rises in the provision of filters and spoons/cookers between 2008/09 and 2009/10 and more recently in the provision of sterile water between 2012/13 and 2013/14. In 2014/15, the items distributed included: 3,211,000 filters; 3,176,000 spoons/cookers; 1,300,000 vials of sterile water; and 4,200,000 wipes/swabs.

Figure 7.5: Injection equipment provider outlets operating in Scotland between 2007/08 and 2014/2015



Source: (Information Services Division, 2016a)

Wales

The provision of NSP and other harm reduction services in Wales is monitored using the HRD. In 2015/16 the HRD was active in 46 statutory and voluntary sector NSP sites across Wales. In addition, the 215 community pharmacies providing NSP services were linked to the HRD in April 2014 (Public Health Wales, 2016a). Data from the HRD indicates that a total of 24,926 unique individuals accessed NSP services (including community pharmacy) from April 2015 to March 2016. Of these: 41% reported primary use of IPEDs; 40% opioids; 9.4% stimulants (including powder cocaine, crack cocaine, amphetamine, ecstasy); and 1.6% NPS.

In 2015/16 a total of 3,398,314 syringes were distributed in Wales. Fifty-eight per cent ($n=1,980,667$) of syringes were distributed through pharmacy-based NSP, while specialist agencies distributed 42% ($n=1,417,647$) (see accompanying table NSP).

Northern Ireland

In Northern Ireland, NSP were available at 15 sites (14 pharmacies and one community action team service) in 11 areas in 2014/15, as well as from two needle exchange outreach services (Public Health Agency, 2016). The number of packs dispensed by pharmacies has increased year-on-year since 2007/08, reaching 34,258 in 2014/15, a 21% increase on 2013/14 ($n=28,284$). In 2014/15 this totalled 288,615 needles distributed during 26,713 client contacts, predominantly (99%) through pharmacy-based NSP and the remainder via specialist agencies. Of the 20,939 contacts where the individual disclosed what they would use the needles for, 50% were for opioids, 46% were for steroids, 3.4% were for tanning products and 0.2% were using amphetamines (values will not add up to 100% due to some clients using multiple drug types).

7.7.3 Hepatitis B vaccination

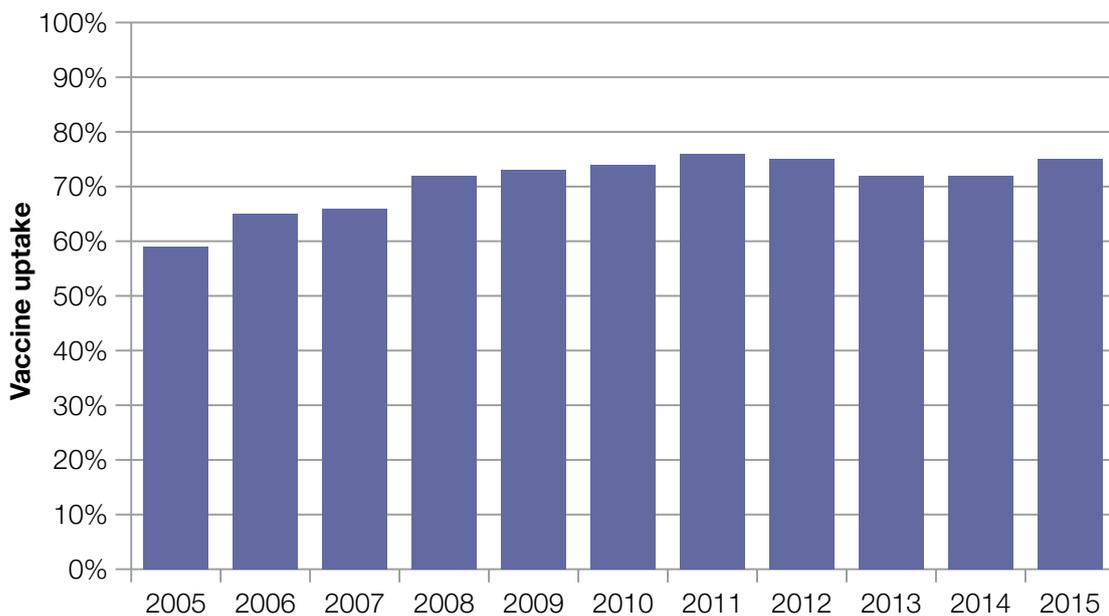
Hepatitis B is a vaccine-preventable infection that can cause long-term liver disease and liver cancer. The UK has a targeted vaccination programme focused on the population groups most at risk, including PWID.

The proportion of the PWID participating in the UAM Survey of PWID who reported having taken up an offer of the hepatitis B vaccination has increased markedly over time, rising from 56% (95% CI, 54%-58%) in 2004 to 76% (95% CI, 75%-78%) in 2011. Uptake dropped slightly in the following years but had returned to 75% (95% CI 74%-77%) in 2015 (Figure 7.6) (Public Health England, 2016c). Uptake of hepatitis B vaccination was comparable in England (75%) and Wales (74%). Northern Ireland reported uptake of 84%.

Among the participants in the 2014/15 sub-survey of people who inject IPEDs, the level for uptake of the hepatitis B vaccination was lower, with 38% (95% CI 33%-43%) of those injecting IPEDs reporting this (Public Health England, 2016d).

In Scotland, among those attending NSP during 2014/15, 77% reported uptake of the hepatitis B vaccine (Public Health England et al., 2016).

Figure 7.6: Uptake of hepatitis B vaccination among participants in the Unlinked Anonymous Monitoring Survey of People Who Inject Drugs: England, Wales and Northern Ireland, 2005–2015



Source: (Public Health England, 2016c)

7.8 New developments

7.8.1 Drug testing at events

Welsh Emerging Drugs & Identification of Novel Substances Project

The Welsh Emerging Drugs & Identification of Novel Substances Project (WEDINOS)⁶⁰ is a harm reduction service that collects and tests unknown/unidentified substances. Individuals can mail

60 See: <http://www.wedinos.org/>

samples for testing and the results are posted online. The website publishes information on the substance the individual intended to purchase as well as the actual contents of the sample.

WEDINOS conducted an analysis of 56 ecstasy pills that were recovered from the site of a music festival in summer 2016, testing the samples for purity and strength. The average dose of MDMA in these tablets was 129mg, with a dose range of 8mg to 275mg. Of the 20 different 'brands' recovered, 14 included tablets containing more than 140mg MDMA.

The Loop

The Loop⁶¹ is a not-for-profit Community Interest Company that provides harm reduction services, welfare and drug testing. In 2016, they offered a drug testing service at two English music festivals whereby attendees could take samples to be tested and find out what they contained. Approximately 200 people had substances tested at one of the events and received health and safety advice on drugs. They have previously tested drugs retrieved from amnesty bins in nightclubs and music festivals. The Loop has launched a social media campaign encouraging users to use less MDMA powder and wait for effects rather than re-dosing immediately – #CrushDabWait.

7.8.2 Remove All Prescription and Illicit Drugs

An initiative known as RAPID (Remove All Prescription and Illicit Drugs) has been set up in Northern Ireland. Fourteen bins have been placed across Northern Ireland and offer individuals a safe way to dispose both prescription and illicit drugs. Over 65,000 tablets have been disposed of so far, over 90% of which were prescription drugs.⁶²

7.8.3 Foil legislation evaluation

Monitoring the legal provision of foil to heroin users (Home Office, 2016c) explored how the legislation to allow the lawful supply of foil to heroin users by drug treatment services has operated in practice. Findings indicated that the supply of foil increased following the commencement of the legislation, and that needle exchange professionals considered foil provision as beneficial to treatment and recovery outcomes.

61 See: <http://wearetheloop.co.uk/>

62 See: <http://www.publichealth.hscni.net/news/new-initiative-tackle-drugs-our-streets>

8 Legal framework

8.1 Introduction

The *Misuse of Drugs Act 1971* (Her Majesty's Government, 1971) controls the possession, supply and production of psychoactive substances that are considered dangerous or otherwise harmful when misused, and sets maximum criminal penalties for each offence. Drug use is not a crime in the UK, but possession, production, supply and trafficking (including importation and exportation) are.

Penalties range from a warning, fine, or community sentence through to a custodial sentence, depending on the severity of the offence. Both recorded crime and arrests for overall drug law offences have been falling for several years.

The emergence of a large number of new psychoactive substances (NPS) has resulted in various different legislative approaches to tackle this issue. Initially, a small number of substances were classified under the *Misuse of Drugs Act 1971*. Temporary class drug orders (TCDOs) were then introduced through the *Police Reform and Social Responsibility Act 2011* (Her Majesty's Government, 2011b) to give a faster legislative response. The *Psychoactive Substances Act 2016* (Her Majesty's Government, 2016f) was introduced with the intention of preventing the trade of these substances; unlike the two previous approaches, this is a blanket ban rather than being substance-specific.

With the recognition of drug use (particularly heroin and crack) as a major driver of acquisitive crime, initiatives have been introduced at all stages of the criminal justice system (CJS) aimed at engaging drug users in treatment. These include drug rehabilitation requirements (DRRs) as a sentencing option for offenders on probation, as well as the more recent Liaison and Diversion (L&D) scheme introduced in 2010.

8.2 Current legal framework

The *Misuse of Drugs Act 1971* (Her Majesty's Government, 1971) is the principal legislation in the UK for the control and supply of psychoactive substances that are considered dangerous or otherwise harmful when misused.⁶³ The act divides such substances into three classes (A, B and C) and sets maximum criminal penalties for illegal production, possession and supply in relation to each class (see [section 8.4.1](#)).

Most drugs controlled under the act are also placed in one of the five schedules of the *Misuse of Drugs Regulations 2001* (Her Majesty's Government, 2001b), based on an assessment of their medicinal or therapeutic usefulness, the need for legitimate access and their potential harms when misused.⁶⁴ The schedules determine the circumstances in which controlled substances

63 **Possession:** In the UK it is unlawful to possess any quantity of a controlled drug, unless the individual is in possession of an authorisation in the form of a licence (for example a prescription), or the person can prove that they were unaware that the substance was a controlled drug.

Supply and possession with the intent of supply: Supply defined as the simple act of passing a controlled drug from one person to another. According to the law, it is irrelevant if the act is done for profit or not. The financial gain has influences only on the sentence given.

Production: In the UK it is illegal to produce any controlled drug, unless the individual is in possession of an authorisation in the form of a licence. Production is defined as 'manufacturing, cultivating or production by any other method'.

64 See: <https://www.gov.uk/government/policies/reducing-drugs-misuse-and-dependence/supporting-pages/classifying-and-controlling-drugs>

can be lawfully manufactured, possessed and distributed. Those drugs deemed to have no therapeutic value are placed on Schedule 1, meaning that they cannot be prescribed. Research can be conducted on these substances but this requires a licence to be obtained from the Home Office. Schedule 5 contains drugs that can be legally supplied and possessed without prescription.

Under the *Misuse of Drugs Act 1971*, police have special powers to stop, detain and search people on ‘reasonable suspicion’ that they are in possession of a controlled drug. Police may also enter and search premises with a warrant if there are reasonable grounds to suspect an offence against the act has been committed. A prison sentence is the most common outcome when found guilty at court of import/export and supply offences, but a fine, community sentence or conditional discharge are the most common disposals for possession offences (Ministry of Justice, 2016a). The range of possible penalties is covered in [section 8.4.1](#).

The *Psychoactive Substances Act 2016* (Her Majesty’s Government, 2016f) was introduced as a response to the increased use of NPS in the UK. This act is covered in greater detail in [section 8.3.1](#).

Prior to the implementation of the *Psychoactive Substances Act 2016*, the principle legislative response designed to tackle NPS was the creation of TCDOs, as part of the *Police Reform and Social Responsibility Act 2011* (Her Majesty’s Government, 2011b). This act added provisions for 12-month TCDOs to be made on specified compounds, putting these substances in a ‘temporary class’ under the *Misuse of Drugs Act 1971*. Therefore all the offences under the *Misuse of Drugs Act 1971*, with the exception of the possession offence, apply to these substances for the duration of the TCDO. This measure enables law enforcement activity against those trafficking or supplying temporary class drugs. Following the passing of the *Psychoactive Substances Act 2016*, the option of using TCDOs still remains available to the government.

The *Drugs Act 2005* amended the *Police and Criminal Evidence Act 1984*, introducing mandatory drug testing of detainees following arrest in certain circumstances (Her Majesty’s Government, 1984, 2005). The act also introduced a new offence of failing to attend a required assessment with a drug worker for those testing positive. These amendments provided a legally enforceable lever through which to identify drug using offenders on arrest and to engage them with treatment.

8.3 Recent changes in legal framework

8.3.1 Recent changes to drug misuse legislation

Psychoactive Substances Act 2016

The *Psychoactive Substances Act 2016*, which came into force on 26 May 2016, prohibits the supply, production and trafficking of psychoactive substances within the UK (Her Majesty’s Government, 2016f). The act was brought in as a response to NPS and the speed at which new substances emerge, and covers all substances capable of producing a psychoactive effect with the following exemptions: drugs already controlled under the *Misuse of Drugs Act 1971*; medicinal products listed under the *Human Medicines Regulations 2012*; alcohol; nicotine and tobacco products; caffeine; and food and drink. The term ‘psychoactive substance’ refers to any substance which, by stimulating or depressing the central nervous system, affects the user’s mental functioning or emotional state upon consumption. In March 2016 the Advisory Council on the Misuse of Drugs (ACMD) provided advice, accepted by the government, which stated that alkyl nitrites (commonly referred to as ‘poppers’) did not fall within the scope of the act, as their specific mode of action was deemed to not have a direct psychoactive effect.

Unlike under the *Misuse of Drugs Act 1971*, the substances controlled by the *Psychoactive Substances Act 2016* are not classified. The maximum penalties for each offence are the same for every substance covered by the legislation; penalties under the act are covered in [section 8.4.1](#).

To provide proportionate disposal options for substances that have not had their harms assessed, individuals believed to be involved in the sale of psychoactive substances can be given a prohibition or premises notice by a senior police officer or local authority. These notices require individuals to cease their involvement in the specified prohibited activity. Failure to comply with these notices can result in prohibition or premises orders being placed on the individuals involved by the court; non-compliance with these orders can lead to a criminal prosecution. Importantly, prohibition and premises orders are made by the court based on the balance of probabilities, rather than beyond reasonable doubt, therefore requiring a lesser burden of proof to be able to close premises trading in psychoactive substances. This is not a linear process, and in cases where they deem it appropriate enforcement agencies are able to proceed straight to prosecution. In December 2016 the Home Office reported that since the *Psychoactive Substances Act 2016* came into force in May, 31 headshops had closed down and 332 shops across the UK had stopped selling psychoactive substances covered by the act.⁶⁵

While simple possession is not an offence under this legislation, possession of a psychoactive substance within a custodial institution is prohibited, and applies to prison staff and visitors as well as inmates. Police have special powers to stop, detain and search individuals on 'reasonable' suspicion that they have committed, or are likely to commit, an offence under the *Psychoactive Substances Act 2016*. They also have powers to seize and detain psychoactive substances found in the course of the search. Furthermore, the act gives law enforcement agencies powers to close down UK-based websites trading in these substances. It is worth noting that an individual purchasing a psychoactive substance from a non-UK-based website may commit the offence of importation, and could be subject to the penalties discussed in [section 8.4.1](#).

A change to the Misuse of Drugs Act 1971: control of 'third generation' synthetic cannabinoid receptor agonists

'First' and 'second' generation synthetic cannabinoid receptor agonists (SCRAs) were controlled as Class B substances under the *Misuse of Drugs Act 1971* in the UK in 2009 and 2013, following reports to the government from the ACMD in 2009 and 2012 (Her Majesty's Government, 2009a, 2013a). In November 2014 the ACMD recommended a revised generic definition of SCRAs, to include the 'third generation' substances now available, which was revised over the course of 2015 and 2016 to include newly emerged SCRAs and exclude prescription medications with similar structures. In December 2016 third generation SCRAs became controlled as Class B substances under the *Misuse of Drugs Act 1971* (Her Majesty's Government, 2016c). Therefore, while supply of these substances was already illegal under the *Psychoactive Substances Act 2016*, this change in legislation made possession an offence too.

A change to the Misuse of Drugs Act 1971: control of dienedione

In response to a request from UK Anti-Doping, the ACMD reviewed the physical and social harms of estra-4,9-diene-3,17-dione (dienedione), which was at the time included on the World Anti-Doping Agency's prohibited list, but not controlled under the *Misuse of Drugs Act 1971*. In January 2016, the ACMD concluded that the harms associated with dienedione would be commensurate with those of other anabolic steroids. It was therefore recommended that

65 See: <https://www.gov.uk/government/news/psychoactive-substances-ban-6-months-on-almost-500-arrests-and-first-convictions>

dienedione be controlled as a Class C substance under the *Misuse of Drugs Act 1971*, and placed on Schedule 4 Part 2 of the *Misuse of Drugs Regulations 2001* (Advisory Council on the Misuse of Drugs, 2016c). The government accepted this advice, and controlled dienedione as recommended in December 2016 (Her Majesty's Government, 2016c).

Ketamine – rescheduling and patient group directions

In November 2015 ketamine was rescheduled from Part 1 of Schedule 4 to Schedule 2 of the *Misuse of Drugs Regulations 2001* (Her Majesty's Government, 2015a). This followed the ACMD's recommendations and the results of a public consultation regarding possible effects of the changes to legislation which reclassified ketamine from Class C to Class B in 2014 (Her Majesty's Government, 2014b). The amendments to the *Misuse of Drugs Regulations 2001* were made to ensure that ketamine could continue to be administered by nurses and other healthcare professionals under Patient Group Directions.

Temporary class drug orders on methiopropamine and ethylphenidate

Methiopropamine was controlled by the government under a TCDO in November 2015 (Her Majesty's Government, 2015b). Methiopropamine had reportedly been used in place of ethylphenidate and other methylphenidate-related compounds following the introduction of a TCDO controlling these substances in April 2015. In November 2016 the government remade the TCDO on methiopropamine for a further 12 months, as the ACMD had reported that they were not able, at this stage, to recommend full control of this substance (Advisory Council on the Misuse of Drugs, 2016g; Her Majesty's Government, 2016d). Similarly, in June 2016 the government remade the TCDO on methylphenidate-related substances for a further 12 months, as the ACMD were not able to provide full advice for control of these compounds before the TCDO expired (Advisory Council on the Misuse of Drugs, 2016b; Her Majesty's Government, 2016e).

8.3.2 Advisory Council on the Misuse of Drugs

Advice on the control of gabapentin and pregabalin

Recent concern over the misuse of the prescription medications gabapentin and pregabalin lead to the ACMD assessing the medical and social harms caused by these drugs. In January 2016, the ACMD advised the government that due to their potential for misuse, and the fact that the harms associated with their misuse were commensurate with that of other controlled substances, gabapentin and pregabalin should be controlled under the *Misuse of Drugs Act 1971* as Class C substances, and placed on Schedule 3 of the *Misuse of Drugs Regulations 2001* (Advisory Council on the Misuse of Drugs, 2016e). While the Home Office accepted this advice in principle, they informed the ACMD that they will carry out a public consultation to assess the impact of these changes, in particular the changes to the *Misuse of Drugs Regulations 2001* (Home Office, 2016e).

Advice on the control of U-47,700 and 'designer benzodiazepines'

As discussed in [section 6.4](#), benzodiazepines have recently been associated with an increasing number of drug-related deaths, particularly in Scotland and Northern Ireland. While many misused benzodiazepines are listed in Class C of the *Misuse of Drugs Act 1971*, a number of substances that have been linked to these deaths, such as etizolam and diclazepam, are not. In December 2016, the ACMD reported to the government on the evidence of use and harm caused by these 'designer benzodiazepines', and advised that they should be controlled under

a TCDO (Advisory Council on the Misuse of Drugs, 2016a).⁶⁶ At the same time, they reported on U-47,700, a synthetic opioid which has been associated with one death in the UK in 2016, and related to at least 46 confirmed deaths in the USA. Due to the risks posed by this opioid, the ACMD also recommended that it be controlled under a TCDO. The government, stating concerns about the well-established harms of these substances, requested further advice on the permanent control of U-47,700 and designer benzodiazepines under the *Misuse of Drugs Act 1971* (Home Office, 2016f); therefore the ACMD responded by recommending placing U-47,700 under Class A, and the benzodiazepines under Class C, of the *Misuse of Drugs Act 1971* (Advisory Council on the Misuse of Drugs, 2016f).

8.3.3 Recent debate surrounding drug legislation

Political discussion on changes to drug legislation

In September 2016 the All-Party Parliamentary Group for Drug Policy Reform published the report of an inquiry undertaken to investigate the use of medicinal cannabis in the UK (All-Party Parliamentary Group for Drug Policy Reform, 2016). The inquiry had included a review of the evidence of the effectiveness of medicinal cannabis, heard evidence from individuals about their use of medicinal cannabis, and set up online surveys of healthcare professionals and cannabis users about the role of cannabis-based medicines. The report recommended that the government accept that cannabis has a role as a medicinal product, and therefore be moved from Schedule 1 to Schedule 4 of the *Misuse of Drugs Regulations 2001*; that the government assesses the various models of allowing access to medicinal cannabis used worldwide; and that the government decriminalises home growing of small amounts of cannabis for medicinal use.

In July 2016, results of a poll of Members of Parliament indicated that the majority (58%) of those questioned supported the legalisation of cannabis for individuals using it for medical reasons.⁶⁷

At their national conference in October 2016, members of the Scottish National Party voted in favour of a motion calling for the decriminalisation of cannabis for medical use. In their response, the Home Office stated that the UK government has no plans to legalise cannabis or devolve drug control. Additionally, in March 2016, the Liberal Democrat Party proposed a framework for how a fully regulated cannabis market could function in the UK (Liberal Democrats, 2016).

Royal Society for Public Health report into drug decriminalisation

In June 2016, the Royal Society for Public Health, supported by the Faculty of Public Health, published a report which suggested that approaches to reducing the harm linked to substance misuse could include the decriminalisation of all illegal drugs, and treating drug possession and use as a health issue rather than a crime (Royal Society for Public Health, 2016). An editorial in *The Times* newspaper supported this report, and suggested that decriminalisation should be seen as the first step to legalisation and regulation.⁶⁸

66 Benzodiazepines included by the ACMD in this report were: etizolam, diclazepam, flubromazepam, pyrazolam, deschloroetizolam, flubromazolam, nitrazolam, nifoxipam, clonazolam, 4'-chlorodiazepam, bromazolam, meclonazepam, adinazolam, metizolam, 3-hydroxyphenazepam and fonazepam.

67 See: <http://www.telegraph.co.uk/news/2016/07/10/most-mps-back-legalisation-of-medical-marijuana-poll-finds/>

68 See: <http://www.thetimes.co.uk/edition/comment/breaking-good-svkvggj2k>

8.4 Drug law offences

8.4.1 Types of offences and range of penalties

Penalties under the Misuse of Drugs Act 1971

There are a number of activities related to controlled drugs that are considered offences under the *Misuse of Drugs Act 1971* (Her Majesty's Government, 1971). These are: possession; supply; possession with intent to supply; production; importation and exportation; and offences related to permitting the production, supply or use of a controlled drug on premises. The severity of the penalty applied is dependent on the class of the drug involved and the individual circumstances of the case. For each type of offence, the court considers the size of the operation/quantity of drugs involved, the individual's role in the crime and any aggravating or mitigating factors in order to impose an appropriate penalty in accordance with the definitive guidelines (Sentencing Council, 2009, 2012).

Table 8.1 summarises the maximum penalties according to the offence, the classification of the drug involved, and the mode of prosecution (offences tried on indictment are those tried in a Crown Court; summary offences are those tried in a magistrates' court).

First and second simple possession offences for cannabis and khat (for personal use) are dealt with using out-of-court disposals in England and Wales. In the case of first offences with no aggravating factors, this takes the form of a spoken 'cannabis warning' or 'khat warning'. Second offences generally incur a penalty notice for disorder of £80 under the *Criminal Justice and Police Act 2001* and the schedule to the *Penalties for Disorderly Behaviour (Amount of Penalty) Order 2002* (Her Majesty's Government, 2001a, 2009b).

Table 8.1: Maximum penalties for drug possession, supply, intent to supply and production in the UK under the Misuse of Drugs Act 1971, by drug classification

Class	Drugs included	Mode of prosecution	Possession	Supply, intent to supply, and production
A	Crack cocaine, cocaine, heroin, LSD, MDMA, methadone, methamphetamine, psilocybin-containing mushrooms	Indictment	Up to seven years in prison, an unlimited fine, or both	Up to life in prison, an unlimited fine, or both
		Summary	Up to six months in prison, a £5,000 fine, or both	Up to six months in prison, a £5,000 fine, or both
B	Amphetamines, barbiturates, cannabis, codeine, ketamine, methylphenidate, synthetic cannabinoids, synthetic cathinones	Indictment	Up to five years in prison, an unlimited fine, or both	Up to 14 years in prison, an unlimited fine, or both
		Summary	Up to three months in prison, a £2,500 fine, or both	Up to six months in prison, a £5,000 fine, or both
C	Anabolic steroids, benzodiazepines (eg diazepam), gamma-hydroxybutyrate (GHB), gamma-butyrolactone (GBL), khat, piperazines (eg benzylpiperazine)	Indictment	Up to two years in prison, an unlimited fine, or both*	Up to 14 years in prison, an unlimited fine, or both
		Summary	Up to three months in prison, a £1,000 fine, or both*	Up to three months in prison, a £2,500 fine, or both
TCDO	Currently: Methylphenidate-based substances (including ethylphenidate) and methiopropamine, and their simple derivatives	Indictment	None, but police can take away a suspected temporary class drug	Up to 14 years in prison, an unlimited fine, or both
		Summary	None, but police can take away a suspected temporary class drug	Up to six months in prison, a £5,000 fine, or both

*With the exception of anabolic steroids, where possession for personal use is not an offence
Source: <https://www.gov.uk/penalties-drug-possession-dealing>

Penalties under the Psychoactive Substances Act 2016

Possession within a custodial institution, supply, possession with intent to supply, production and import/export of a psychoactive substance are all prohibited under the *Psychoactive Substances Act 2016*; simple possession is not an offence (Her Majesty's Government, 2016f). There is no classification of substances under the act; therefore penalties are the same for each substance. The penalties for each type of offence are shown in Table 8.2.

Table 8.2: Penalties under the Psychoactive Substances Act 2016

Offence	Summary Conviction	Conviction on Indictment
Possession in a custodial institution	Up to 12 months* imprisonment, a fine, or both	Up to two years imprisonment, a fine, or both
Possession with intent to supply	Up to 12 months* imprisonment, a fine, or both	Up to seven years imprisonment, a fine, or both
Supply/offer to supply	Up to 12 months* imprisonment, a fine, or both	Up to seven years imprisonment, a fine, or both
Production	Up to 12 months* imprisonment, a fine, or both	Up to seven years imprisonment, a fine, or both
Importation/exportation	Up to 12 months* imprisonment, a fine, or both	Up to seven years imprisonment, a fine, or both
Failure to comply with a Prohibition or Premises order	Up to 12 months* imprisonment, a fine, or both	Up to two years imprisonment, a fine, or both

*In Northern Ireland, summary convictions can result in up to six months imprisonment rather than 12 months
Source: (Her Majesty's Government, 2016f)

8.4.2 Drug law offences

Data on drug law offences is available from various points in the CJS:

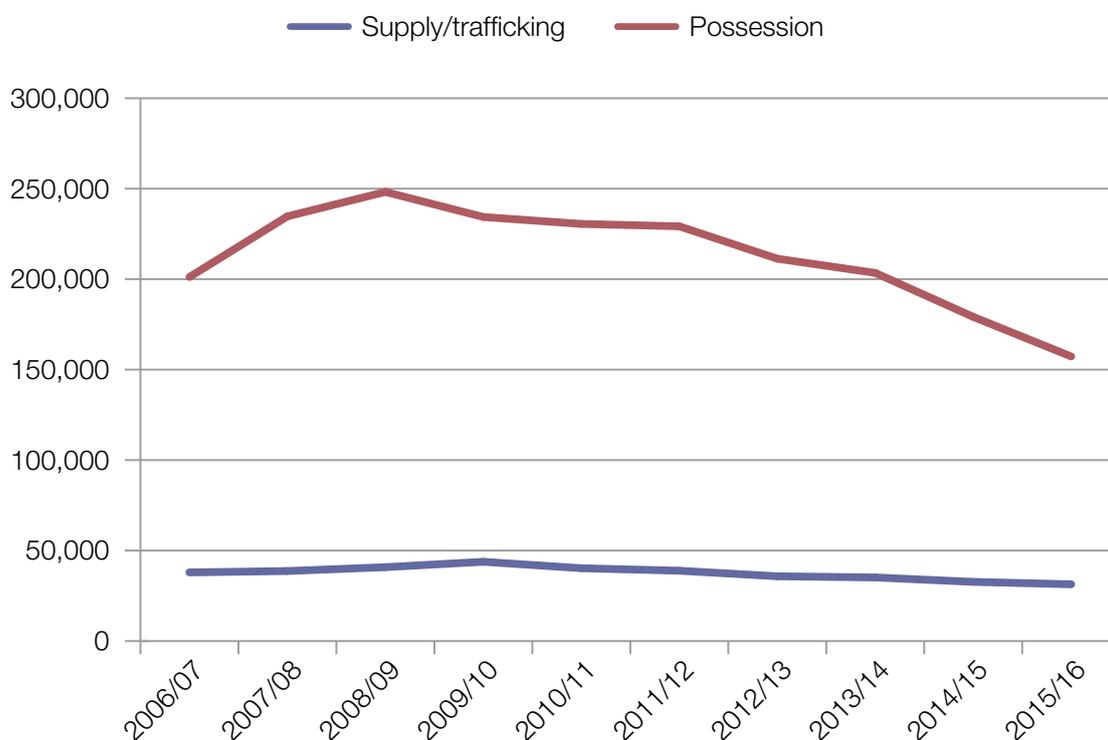
- recorded crime data counts the number of drug offences brought to the attention of police and represents the widest measure of drug offences available in the UK. However, at present the individual drug involved is not recorded (except for cannabis possession offences in England and Wales)
- arrests data records the number of persons who are arrested for a drug offence and represents a smaller proportion of drug offences, since some penalties such as formal warnings for cannabis do not constitute an arrest. This data is not available by drug or offence type
- cautions and convictions data records the number of offences where an individual is found guilty at court or cautioned for a drug offence

Data from each level of the CJS cannot be compared for a number of reasons, including: time lag between offence and conviction; the basis on which the data is provided (offender or offence); counting rules; and year of data (calendar or financial year). It should be noted that changes in police activities and priorities will impact on the recording of drug offences and, as such, trends may not be entirely reflective of underlying levels of drug offending.

Recorded crime: drug offences

There has been a downward trend in recorded drug offences in the UK in recent years; however, trends differ between the administrations (see Figure 8.1 and accompanying table DLO). Northern Ireland has seen a fairly steady increase in both supply/trafficking and possession offences recorded over the last decade, with around twice the number of each category reported in 2015/16 as were in 2006/07 (Police Service of Northern Ireland, 2016). Supply/trafficking offences in Scotland have fallen over the same time period, whereas possession offences have remained relatively stable (Scottish Government, 2016b). In England and Wales, the numbers of both offence types peaked between 2008 and 2010, and have since decreased. The number of possession offences in England and Wales in particular has seen a dramatic decrease, from 213,651 in 2008/09 to 122,155 in 2015/16 (Office for National Statistics, 2016a).

Figure 8.1: Trends in recorded possession and supply/trafficking offences in the United Kingdom, 2006/07 to 2015/16

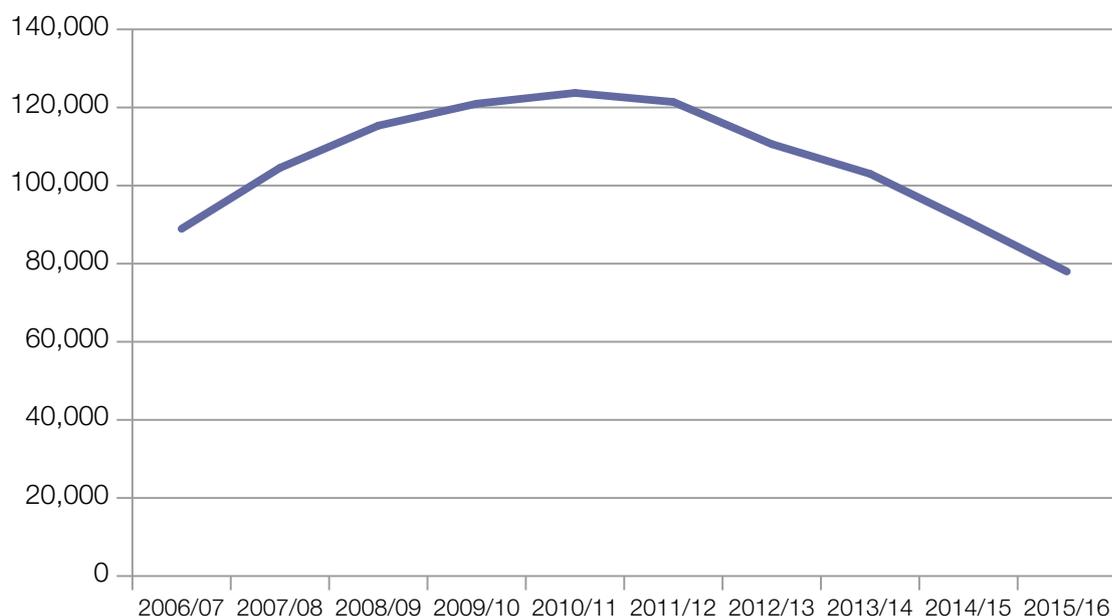


Source: (Office for National Statistics, 2016a; Police Service of Northern Ireland, 2016; Scottish Government, 2016b)

Arrests for drug offences

Having risen between 2006/07 and 2010/11, arrests for drug offences in England and Wales have dropped in recent years, and as with recorded crime figures, are now below the level seen in 2006/07 (see Figure 8.2).

Figure 8.2: Trends in arrests for drug offences in England and Wales, 2006/07 to 2015/16



Source: (Home Office, 2015c, 2016d)

Out of court disposals and sentencing of drug offenders

In 2015, there were 116,869 proven drug law offences⁶⁹ in England and Wales, representing a 19% decrease from the previous year, which itself was a decrease of 17% from 2013. The majority of drug offences were dealt with outside of a court setting (60%). Of these, over half (55%) were in the form of a cannabis warning, one-third (33%) cautions, and 12% were penalty notices for disorder (Ministry of Justice, 2016a).

Of the 46,242 individuals sentenced at court for drug offences in England and Wales during 2015, 19% were given immediate custody (Ministry of Justice, 2016a) (see Table 8.3). The most common sentence was a fine, meted out in 36% of cases. The vast majority (86%) of those convicted of import/export offences, and the greatest proportion of those convicted of trafficking offences (including supply offences), received immediate custody. Over half (53%) of individuals convicted of a possession offence were subjected to a fine as punishment.

Table 8.3: Number and percentage of offenders receiving each disposal at court for drug offence type in England and Wales, 2015

	Immediate custody		Suspended sentence		Community sentence		Fine		Other		Total sentenced	
	n	%	n	%	n	%	n	%	n	%	n	%
Import/export	421	86.4	45	9.2	9	1.8	9	1.8	3	0.6	487	100
Trafficking*	7,106	44.7	4,871	30.6	2,526	15.9	842	5.3	565	3.6	15,910	100
Possession	1,037	3.5	611	2.1	3,998	13.7	15,501	52.9	8,129	27.8	29,276	100
Other	54	9.5	152	26.7	186	32.7	93	16.3	84	14.8	569	100
Total	8,618	18.6	5,679	12.3	6,719	14.5	16,445	35.6	8,781	19.0	46,242	100

*Includes production, supply and possession with intent to supply

Source: (Ministry of Justice, 2016a)

69 Defendants who have been proven to have committed an offence (includes convictions, cautions, cannabis warnings and penalty notices for disorder).

8.4.3 Recent changes to drug law offences

Recorded police warnings in Scotland

In January 2016 Police Scotland, in conjunction with the Crown Office and Procurator Fiscal Service, implemented the new recorded police warning (RPW) scheme in Scotland. This scheme allows police officers dealing with low-level offenders aged over 16 (for example those caught in possession of a small amount of cannabis) to administer an RPW as an on-the-spot disposal at their discretion. An RPW can be used for offences which, if they were instead formally reported to the Procurator Fiscal, would most likely result in no action being taken due to the minor nature of the offence, or a non-court disposal being administered by the Procurator Fiscal. However, if the RPW is refused or appealed, a formal report may be sent to the Procurator Fiscal. RPWs are recorded on the Criminal History System for two years, but are not a finding of guilt.

Local policing priorities

Policing priorities for forces in England and Wales are set by locally elected Police and Crime Commissioners who have control over their policing budgets. Citing budgetary constraints and prioritisation of more serious offences, Durham, Derbyshire, Dorset and Surrey police forces announced in 2015 that they will no longer actively target people for possessing or growing cannabis for personal use.

More recently, it has been reported⁷⁰ that Durham and Avon & Somerset police forces have been piloting schemes whereby individuals caught in possession of drugs are diverted into educational programmes. Individuals in Avon & Somerset can choose to attend a drugs education programme, while those in Durham sign a four-month contract stipulating the individual must not break the law, and must attend a series of drug awareness, restorative justice and community work programmes. If the programmes are completed successfully, the individual's drug possession offence is dropped.

8.5 Drug interventions in the criminal justice system

Rehabilitative and treatment opportunities are made available to those who need them at all stages of the CJS (police station, court, community sentence or custody) either on a voluntary basis or as part of a court-mandated sentence or post-release licence.

8.5.1 England and Wales

Drug rehabilitation requirement

A DRR is available to courts as a sentencing option, under Section 209 of the *Criminal Justice Act 2003* (Her Majesty's Government, 2003). DRRs can be made as part of a community order or a suspended sentence order, and the treatment element is provided from local drug services. These provisions present local providers with flexibility to tailor requirements to individual needs, changing patterns of substance misuse and moving towards a recovery-focused approach to treatment.

The supervision on licence of low-to-medium risk offenders is now managed by community rehabilitation companies as part of the changes brought in by *Transforming Rehabilitation* (Ministry of Justice, 2013), with high risk offenders being supervised by the new the National Probation Service (see [section 5.3.1](#)). In Wales, the director of the National Offender Management

70 See: http://www.vice.com/en_uk/read/drug-decriminalisation-in-uk-narcomania-heroin-crack

Service Wales is responsible for the planning and commissioning of drug treatment services for offenders on DRRs.

Criminal Justice Integrated Teams and test on arrest

The primary method of engaging drug misusing offenders with treatment services in England and Wales is through the interventions that formerly made up the Drug Interventions Programme (DIP). Criminal Justice Integrated Teams (CJITs) carry out drug assessments on arrestees and provide case management, low threshold interventions and referrals to structured treatment where appropriate. Mandatory test on arrest was implemented in 2006 for specified ‘trigger offences’ (ie those most associated with drug use: shoplifting, robbery, theft) in areas designated as being ‘DIP intensive’. Although DIP ceased to be a national programme from April 2013, the decision as to whether to continue funding such interventions is taken locally and these interventions are still widely in operation. The majority of local authorities continue to report CJIT activity to Public Health England, and around 28 police forces still run a drug intervention initiative based on drug testing on arrest. This suggests that the provision of such services has largely survived the transition to a locally led commissioning structure (personal communication – Home Office).

Liaison and Diversion

The L&D programme was created in 2010 in response to findings of the Bradley Report (Department of Health, 2009). L&D schemes are designed to identify, assess, screen and refer offenders who have mental health, learning disability, substance misuse or other vulnerabilities to an appropriate treatment or support service. Ten trial schemes were implemented from April 2014 with a further 15 schemes instigated from April 2015, taking coverage up to 50% of England. It is anticipated that full coverage will occur in 2020/21.

8.5.2 Scotland

In Scotland, there are a number of interventions at different levels of the CJS, including diversion from prosecution to drug treatment/education, community payback orders with a drug treatment requirement, drug treatment and testing orders (DTTOs) for particularly high tariff offenders who are entrenched in their drug use, as well as services for prisoners post-release, including Throughcare Addiction Services (see [section 5.6.2](#)). DTTOs provide offenders with access to treatment services with which they are required to comply, combined with regular progress reviews from the court. A less intensive version (DTTO II) has been developed for lower tariff offenders, who are less entrenched in their drug use and offending. The scheme is operating in Edinburgh and the Lothians, and currently accounts for about a quarter of the DTTOs in these areas. The Scottish government will support wider availability of DTTO IIs across Scotland in 2017 by working with the pilot site to produce guidance on how to develop and deliver a DTTO II service.

9 Drug markets

9.1 Introduction

Most of the identified drug supply chains to the UK follow well-established trafficking routes. Heroin originates in Afghanistan and is transited through either Pakistan or Iran. Cocaine is produced in Colombia, Peru and Bolivia, with Spain and the Netherlands being the main transit hubs within Europe for cocaine en route to the UK. The Netherlands is the most significant source of traditional synthetic stimulant drugs such as ecstasy and amphetamine, while the majority of new psychoactive substances (NPS) bought online originate in China. There is domestic production of high potency cannabis within the UK; however, most cannabis comes from abroad. South and West Africa and the Caribbean are the main sources of herbal cannabis, while resin mainly comes from Morocco and Afghanistan. Branded 'skunk' is primarily imported from the Netherlands.

The restricting supply strand of the UK *Drug Strategy 2010, Reducing demand, restricting supply, building recovery: supporting people to live a drug free life* (Her Majesty's Government, 2010) aims to make the UK an unattractive destination for drug traffickers. The *Serious and Organised Crime Strategy* (Her Majesty's Government, 2013b) focuses, with regard to drugs, on: restricting the supply to the UK; engaging international partners to help disrupt Organised Crime Groups (OCGs) smuggling illicit drugs through the UK's borders; and ensuring the retrieval of the proceeds and assets from the crimes these groups commit. The publication of the strategy coincided with the launch of the new National Crime Agency (NCA).

Drug seizure samples are tested for strength by the NCA. This analysis shows that the purity of small quantity heroin seizures (ie seizures primarily from users) fell from over 40% to below 20% between 2009 and 2011; purity has risen since then and is now at the same level as it was before the drop (44%). Purity of small quantity cocaine seizures has also been rising since a low in 2009. The number of seizures of cannabis in England and Wales increased by more than a quarter between 2006/07 and 2011/12; however, this number has fallen over the past five years to a level below that seen in 2006/07. This trend is mostly due to the change in number of herbal cannabis seizures.

9.2 Supply to and within the country

The commentary provided below is based on correspondence with the NCA.

9.2.1 Domestic production

Cannabis

Cannabis cultivation within domestic and commercial premises is widespread across the UK, although most production sites are domestic dwellings. These dwellings are often converted with rooms fitted for different stages of production: seedling/cutting propagation; developing plants; those in final/harvest stages; and post-harvest drying. Equipment such as grow lights and systems to produce an environment where cannabis can be harvested in 10 to 12 week cycles are used. Initial start-up costs can run into thousands of Great British Pounds (GBP), but cyclical commercial scale production remains highly profitable. Production is predominantly controlled by British OCGs; involvement of Southeast Asian OCGs, utilising the labour of illegal immigrants and victims of modern day slavery, is significant but in decline.

Cultivation of the types of cannabis commonly referred to as ‘skunk’ continues to be widespread. While some of this is branded ‘skunk’ (types developed in the Netherlands, designed to give the user a range of experiences and tastes), the majority of that produced in the UK is non-branded. Branded varieties fetch a premium price and appeal to the connoisseur and experimental user.

Amphetamine Sulphate

Production of amphetamine sulphate from precursors is rarely encountered in the UK; however, the conversion of amphetamine base to sulphate is becoming established. Liquid amphetamine oil and wet base for conversion are commonly imported from the Netherlands and Belgium. This process requires much less expertise, chemicals and equipment than is required for production from precursors, but offers control of quality. Production of amphetamine sulphate is most common in the north-east of England through direct links to supply sources in the Netherlands and Belgium.

9.2.2 Drug trafficking routes for imported drugs

Cocaine

Cocaine is almost exclusively produced in Colombia, Peru and Bolivia. Primary exit points in South America include Colombia, Venezuela, Ecuador, Peru, Brazil and Guyana. Drugs are commonly concealed within sea freight, air freight, yachts and air passengers.

Cocaine transported to the UK in sea freight uses commercial freight shipping routes via major European ports in Spain, Belgium and the Netherlands, before onward transportation to the UK in smaller consignments. Primary entry into the UK is via commercial road transport, with the most common access points being ports on the north-east, east, south-east and south coasts of England.

Yachts are commonly used to transport cocaine across the Atlantic, often sailing from a Caribbean island to the Iberian Peninsula. Cape Verde is an important trans-Atlantic staging post, as are other West African countries along the Atlantic coastline. From there, cocaine is distributed onwards to destinations across Europe, arriving in the UK by vehicle (most commonly commercial), but with general aviation (smaller aircraft/micro-craft) being increasingly used.

Air couriers commonly traffic cocaine direct from South America and the Caribbean in addition to transiting via West Africa, European hubs and (recently) the Middle East. South Africa is also a key transit location, with traffickers utilising the cover of air- and sea-facilitated trade routes and legitimate consignments.

Heroin

Heroin destined for the UK principally originates in Afghanistan, transiting through either Pakistan or Iran (depending upon the onward direction of travel). Some UK-bound heroin may also arrive into the EU via Ukraine, having travelled north from Afghanistan through central Asia. Heroin that comes to the UK via Pakistan is sent directly by air freight and air passengers as well as via eastern and southern Africa, having travelled south from the Makran coast through the Indian Ocean.

Heroin destined for the UK by land typically enters Turkey via Iran or Iraq, known as the ‘Balkan route’. Heroin is most commonly conveyed by land in goods vehicles along the Balkan route. The majority travel to Holland where the drugs are stored in warehouses before onward transportation to the UK in smaller quantities. The UK is most commonly accessed using ‘roll-on/roll-off’ haulage, commercial and private vehicles via south-east and north-east coast ports, with heroin concealed within vehicle structures, cavities and consignment loads.

Amphetamine and MDMA/ecstasy

The Netherlands is the primary source for traditional synthetic stimulant drugs imported into the UK, with points of entry at ports in north-east, east and south-east England being most common, either direct from the Netherlands or via France.

Cannabis

The Netherlands is the primary source for skunk cannabis imported to the UK. The main points of entry are the north-east, east and south-east ports of England, either direct from the Netherlands or via France.

The most common sources of herbal cannabis are South Africa, West Africa and the Caribbean. Importation to the UK is frequently direct via air couriers, maritime freight vessels and containers.

Morocco and Afghanistan are the major sources for UK-bound cannabis resin. Moroccan resin generally routes overland via Spain and France, although much enters the UK directly in maritime freight. The Netherlands is a hub for cannabis resin destined for the UK, with south-east ports being the primary UK access points. Afghan resin tends to follow traditional heroin routes into the UK.

New psychoactive substances

NPS are commonly ordered via the internet and then shipped to the UK from sources in China and India. Prior to the introduction of the *Psychoactive Substances Act 2016* (Her Majesty's Government, 2016) much of this trade was conducted on the 'clearnet'. Transit points such as Spain are believed to hold larger consignments which are broken down to supply individual online orders, which are most commonly despatched via the fast parcel system to the UK.

9.2.3 Drug trafficking within the country

The UK drug market is exploited by a very diverse demographic of drug dealers/distributors of a wide range of nationalities. Nationals from more than 30 countries are believed to influence the drugs threat at organised crime level within the UK. British OCGs exert the largest influence by nationality in each of the main drug markets with Albanian, Turkish, Pakistani, Jamaican, Somali, Lithuanian, Irish (Rep), Nigerian and Vietnamese gangs also involved. It is also recognised that foreign nationals play a significant role in the provision of transport and logistics for drug trafficking towards and into the UK.

Drugs are concealed in many ways during domestic distribution. Vehicle concealments (as those encountered at ports) are increasingly prevalent. An established supply trend has developed involving urban gangs distributing user quantities of heroin and crack cocaine into country and coastal towns and cities from central hubs. Gangs acquire drugs from OCGs, send 'runners' out to establish markets in wider locations and then exploit young and vulnerable people to facilitate onward supply and safe houses. This activity is facilitated via a 'line' – a trusted mobile phone number which is accessed by customers having been introduced by a runner. The line facilitates a 24-hour demand and supply market, with the mobile phone commonly being isolated in an urban location, with runners able to respond to requests upon demand. London is the most prolific (but by no means the only) urban hub.

NPS are often ordered over the internet by the end user in quantities of less than one kilogram (kg). Transportation is via traditional postal and parcel delivery services.

9.2.4 Diversion of controlled medicines

There has been increasing concern about the diversion and illicit supply of medications in recent years. In 2016, the Advisory Council on the Misuse of Drugs (ACMD) reported on the extent of this in the UK. The investigation found that the most common diverted medicines were opioids and benzodiazepines, and the amount of diverted pregabalin and gabapentin is increasing. It is likely that the rising number of online pharmacies with unethical prescribing practices may be behind this increase, as well as diversion of wholesale supplies (Advisory Council on the Misuse of Drugs, 2016d).

As part of the ACMD's investigation, it was reported that the UK Medicines and Healthcare products Regulatory Agency (MHRA) and the Irish Health Products Regulatory Authority had uncovered illegal diversion of prescription-only medicines from the regulated supply chain to the criminal market, including significant diversion from one UK wholesaler. As part of the MHRA's ongoing investigation, two pharmacists have been arrested following the purchase of at least 200,000 packets of benzodiazepines and other medications, of which only a small proportion had been dispensed.⁷¹ A number of other arrests and seizures have been made.

9.3 Prices and purity

9.3.1 Market influences

The value of the GBP against the US Dollar and Euro remains an important factor in drug market trends, as cocaine and heroin are traded in these currencies en route to the UK and within distribution hubs accessed by OCGs supplying the UK. When the value of the GBP drops, no market adjustment is made by suppliers to UK-based customers, hence less spending potential following exchange and greater wholesale outlay leads to reduced profit margins. This has previously generated UK domestic wholesale price increases.

Despite significant cocaine seizures bound for the UK between 2014 and 2016, the wholesale (kg) price has declined by about 15% during the same period. Part of the decline can be explained as a recovery from some unnecessary high prices that had to settle down as they were generating adulteration down to unacceptable purity levels towards the retail market. It is also accepted, however, that the high volumes of cocaine being smuggled towards and into the UK are compensating for the losses and allowing a competitive market to prevail. This is reflected in lower wholesale prices, less need to bulk and higher purity user deals at the same retail prices as before this period.

9.3.2 Street-level price data from law enforcement sources

Street/retail deals tend to be in one gram units for cocaine, amphetamine, MDMA, NPS, ketamine and high quality skunk cannabis, with other cannabis types typically being sold for 1/8th ounce (3.5 grams). Heroin and crack cocaine are commonly sold as 'bags' and 'rocks' respectively, in 0.1 gram and 0.2 gram deals.

Street-level price data from law enforcement sources suggest that the price of most drugs remained stable in 2015 (see Table 9.2). After rising in 2014, the prices of cannabis resin and sinsemilla fell back to around the levels seen in 2013. The price per tablet of ecstasy/MDMA remained at £5 in 2015.

⁷¹ See: <https://www.gov.uk/government/news/regulator-investigating-the-diversion-of-prescription-only-medicines>

Table 9.1: Common street-level prices of certain illicit drugs in the United Kingdom, 2007–2015

	Price per gram except where otherwise stated								
	2007	2008	2009	2010	2011	2012	2013	2014	2015
Amphetamine	£9.00	£10.00	£10.00	£10.00	£10.00	£10.00	£10.00	£10.00	£10.00
Cannabis herb*	£3.95	£2.85	£2.85	£2.82	£5.00	£5.00	£3.00	£2.86	£2.86
Cannabis resin*	£2.82	£2.85	£2.85	£2.82	£5.00	£5.00	£3.00	£5.20	£2.86
Cannabis (sinsemilla)†	£6.21	£5.63	£7.15	£7.15	£10.00	£10.00	£8.50	£15.20	£10.00
Cocaine powder	£46.00	£40.00	£40.00	£40.00	£40.00	£40.00	£40.00	£40.00	£40.00
Crack cocaine	£65.00	£65.00	£60.00	£50.00	£50.00	£60.00	£60.00	£60.00	£60.00
Ecstasy/MDMA (per tablet)	£3.00	£3.00	£2.50	£2.50	£5.00	£3.00	£3.00	£5.00	£5.00
Heroin	£48.00	£45.00	£45.00	£45.00	£40.00	£40.00	£50.00	£50.00	£50.00
LSD (per dose)	£3.50	£3.00	£3.00	£3.00	–	–	£3.00	£3.00	£3.00
Mephedrone	–	–	–	£10.00	£20.00	£20.00	£15.00	–	–
Ketamine	–	–	–	£25.00	£25.00	£20.00	£20.00	£20.00	£20.00

*Price per gram converted from the 1/8oz street deal equivalent, except for in 2011 – 2013, where prices were reported on a gram basis

†Price per gram converted from the 1/8oz street deal equivalent between 2007 and 2010; from 2011 prices are reported on a gram basis

Source: National Crime Agency

9.3.3 Purity of drugs and composition of drugs/tablets in the domestic market

From forensic insight, the majority of adulteration tends to take place before the drug reaches the ‘street dealer’. Their means of profit making will more often be division and reduction in deal size for the very small amounts. For example, if a street dealer buys quarter of an ounce of heroin (3.5 grams) and sells in 0.08 gram, rather than 0.1 gram deals, this will provide 44 deals at £10, instead of 35 deals; an additional return of £90 in return for a small outlay.

Purity of powdered drugs may be affected by the size and nature of the supply chain, of which many forms are present in the UK. Short supply chains, consisting, for example, of importer to retail supplier to user, facilitate the sale of high and bulked quality products, as control remains entirely with those importing and dealing. An example of a longer supply chain might include an importer, national distributor, regional distributor, local supplier and street dealer before reaching the consumer. In this scenario there is likely to be bulking with cutting agents at each stage to maximise profits. This can result in a lack of insight of purity, as each onward transaction adds distance from the importation. In such a scenario, purity can very often only be guessed or generally assessed by use.

Data on the purity of drugs/tablets is provided by the NCA using samples from a number of forensic agencies. The data is collected from tests conducted on police seizures within the domestic market including seizures of packages weighing up to 25 grams from users and from one or two stages above street level. As such, the mean purities reported for substances may be higher than if data were based on street-level seizures alone. Purity data is shown in Table 9.2.

Table 9.2: Mean percentage purity/potency of small quantity drug seizures in England and Wales, 2007 to 2015

	2007	2008	2009	2010	2011	2012	2013	2014	2015
Amphetamine (%)	11	8	8	8	10	5	7	12	10
Cocaine powder (%)	33	29	20	24	26	37	38	36	44
Crack cocaine (%)	52	43	27	31	26	30	36	37	48
Ecstasy (mg/tablet)	52	33	44	49	71	102	†	90	†
Heroin (%)	40	43	44	35	18	20	29	36	44

†No data available

Source: National Crime Agency

Amphetamine

Amphetamine purity has appeared to stabilise following a decrease in purity seen in 2012 and 2013. Almost all amphetamines seized are cut with caffeine, while other common diluting agents include lactose and glucose.

Cocaine

Cocaine entering the UK tends to be sold at premium prices as a high quality commodity, or is adulterated. The average purity of powder cocaine has now more than doubled since a nadir of 20% in 2009, and was 44% in 2015. Levamisole is commonly detected in wholesale cocaine seizures (added at the point of production) while benzocaine is used to bulk out the product within the UK and remains the most significant adulterant used for cocaine. Other adulterants detected by forensic agencies include caffeine and phenacetin. Current indications within the UK marketplace demonstrate common approximate adulteration rates for cocaine between importation and street level distribution of one / two parts adulterant to one part commodity (1:1 or 2:1). Purity of crack cocaine has followed a similar pattern to that of cocaine in powder form over the past ten years.

Heroin

Currently, heroin being imported into the UK is at a consistently high purity. Less adulteration is being seen, resulting in higher purity heroin available at street-level which may, however, vary unpredictably between batches. While the price of user deals remains stable, the purity of a £10 bag (0.1 gram) can range from five to fifty per cent.

After a large decrease in the purity of street-level heroin in 2010 and 2011, which was largely sustained in 2012, the purity of this drug has risen back to levels seen in the late 2000s, and in 2015 was 44%.

9.3.4 Wholesale drug market prices

The kg remains the most common wholesale trading weight for all solid and powder drugs, with the exception of crack cocaine which is packaged following domestic conversion. As such, an ounce (28 grams) has become the most frequently encountered trading unit, with each ounce capable of making 280 x 0.1 gram 'rocks'.

Tablet and paper tab drugs, such as ecstasy and LSD, are most commonly traded in 1,000, 5,000 and 10,000 unit batches at wholesale.

Common wholesale prices include for certain illicit drugs in the UK are shown in Table 9.3.

Table 9.3: Common wholesale prices of certain illicit drugs in the United Kingdom, 2015

	Lower price (GBP)	Upper price (GBP)
Cocaine (kg)	28,000	38,000
Heroin (kg)	19,000	25,000
MDMA crystal (kg)	4,000	6,000
Amphetamine (kg)	1,000	4,000
Cannabis resin (kg)	800	1,000
Cannabis herb (kg)	900	1,800
Cannabis skunk (kg)	4,000	8,000
Ecstasy tablets (1,000 tablets)	1,500	5,000

Source: Personal communication – National Crime Agency

9.4 Drug supply reduction activities

9.4.1 Areas of activity of supply reduction

In the last year, progress towards restricting supply has included several pieces of new legislation: the *Serious Crime Act 2015* (Her Majesty's Government, 2015c) was introduced for counter-terrorist work and has four components: prosecuting and disrupting people engaged in serious and organised crime (Pursue); preventing people from engaging in this activity (Prevent); increasing protection against serious and organised crime (Protect); and reducing the impact of this criminality where it takes place (Prepare). On illicit drugs, the strategy particularly focuses on restricting the supply to the UK, engaging international partners to help disrupt OCGs smuggling illicit drugs through UK borders and ensuring the retrieval of the proceeds and assets from the crimes these groups commit.

There has been widespread national activity to support the implementation of the *Psychoactive Substances Act 2016* (see [section 8.3.1](#)). Following awareness raising campaigns by local police forces, hundreds of retailers across the United Kingdom have either closed down or are no longer selling psychoactive substances. As of August 2016, police forces had made nearly 200 arrests. Action by the NCA has resulted in the removal of psychoactive substances being sold by UK-based websites.

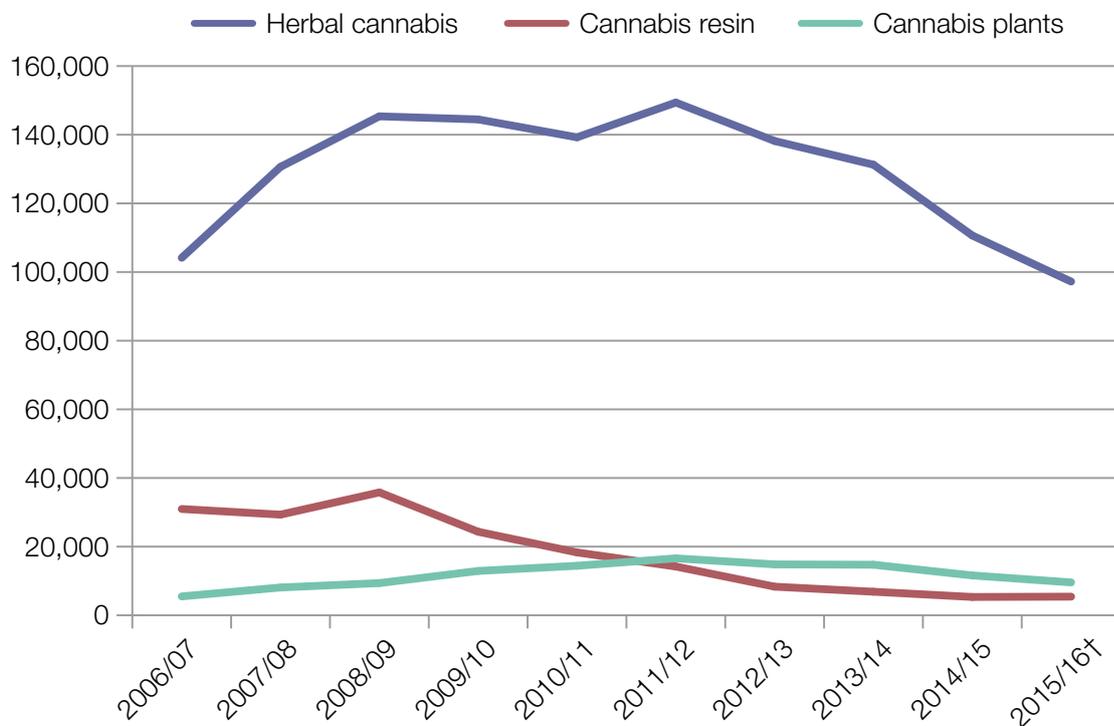
9.5 Drug seizures

9.5.1 Trends in drug seizures in England and Wales

As UK drug seizure data has not been available on a consistent basis in the past six years, data from England and Wales have been used to comment on trends. Cannabis has remained the most commonly seized drug throughout the period, and therefore is the main influence on the trend in total number of drug seizures (Home Office, 2016g). The number of seizures of herbal cannabis increased between 2006/07 and 2008/09, and remained stable for three years, but has decreased since then (see Figure 9.1). The quantity of herbal cannabis seized does not reflect this trend, as the vast majority of seizures are carried out by police forces, but Border Force are responsible for seizing the greatest quantity of herbal cannabis, which may include single high quantity seizures (see Figures 9.2, 9.3) (Home Office, 2016g). Over the past ten years

there has been a substantial decrease in the number and quantity of cannabis resin seizures, most likely reflecting a decreased use of this type of cannabis in England and Wales.

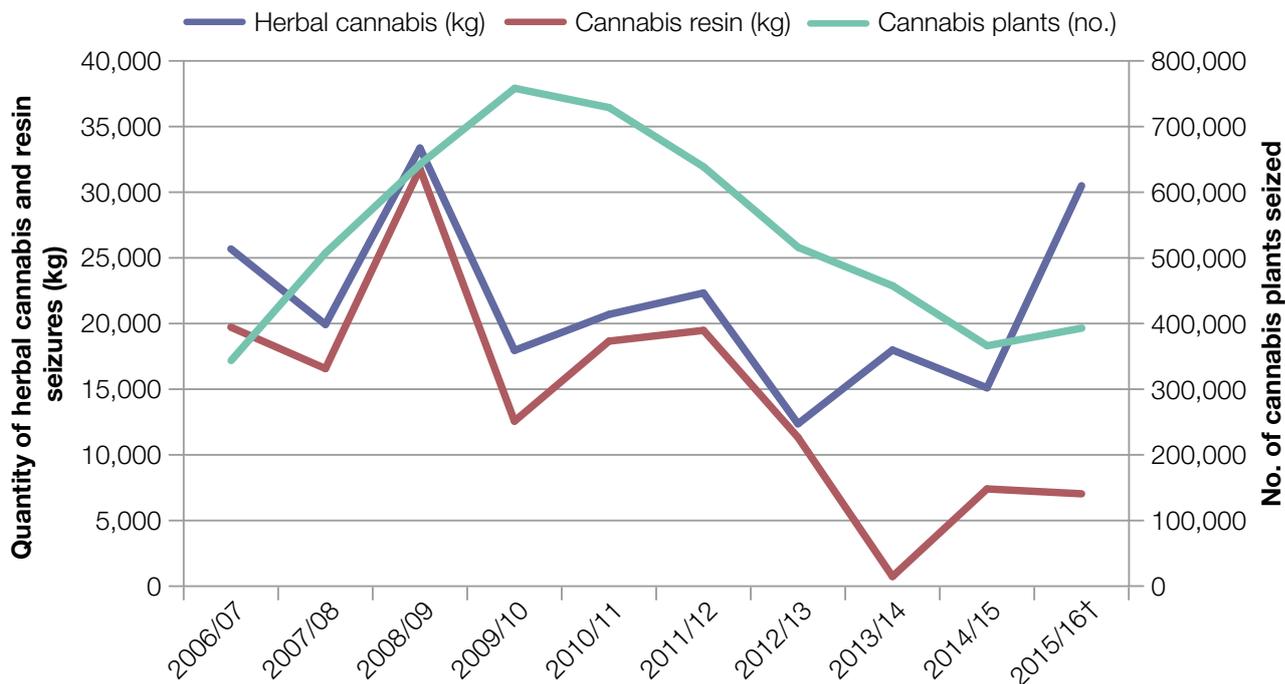
Figure 9.1: Number of cannabis seizures made by police forces and Border Force in England and Wales, 2006/07 to 2015/16



†Bedfordshire, Dorset, Essex and Leicestershire police forces were unable to supply reliable estimates, therefore imputation methods, based on police recorded crime have been used to estimate data for these forces
 Source: (Home Office, 2016g)

While accounting for a much smaller proportion of the total, the number of cannabis plant seizures trend shows a similar pattern to that of herbal cannabis (see Figure 9.1). There was a large increase in the number of seizures between 2006/07 and 2011/12, which has been followed by a downwards trend for four years. The quantity of cannabis plants seized steadily rose more than eightfold from 2004 (data not shown) to 2009/10. However, since then fewer plants have been seized each year, and the total quantity seized has fallen by 48% from the peak of 758,943 in 2009/10 to 393,702 in 2015/16 (see Figure 9.2).

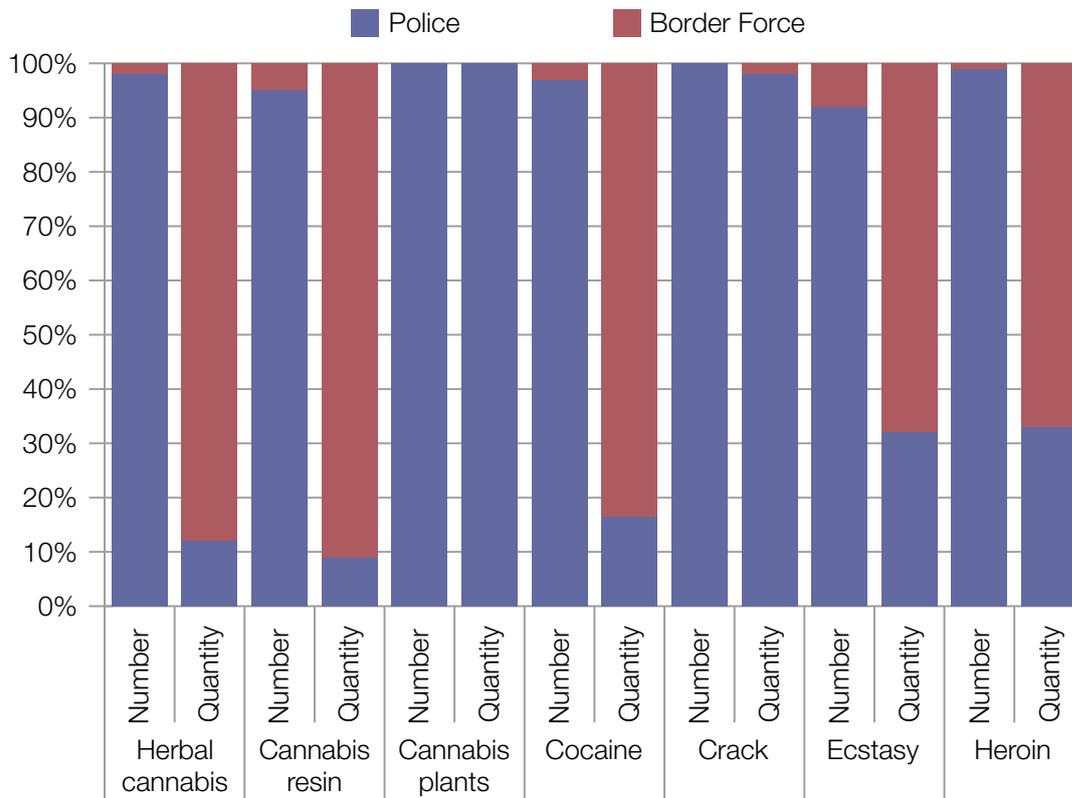
Figure 9.2: Quantity of seizures, in kilograms, of selected drugs by police forces and Border Force in England and Wales, 2006/07 to 2015/16



†Bedfordshire, Dorset, Essex and Leicestershire police forces were unable to supply reliable estimates, therefore imputation methods, based on police recorded crime have been used to estimate data for these forces

Source: (Home Office, 2016g)

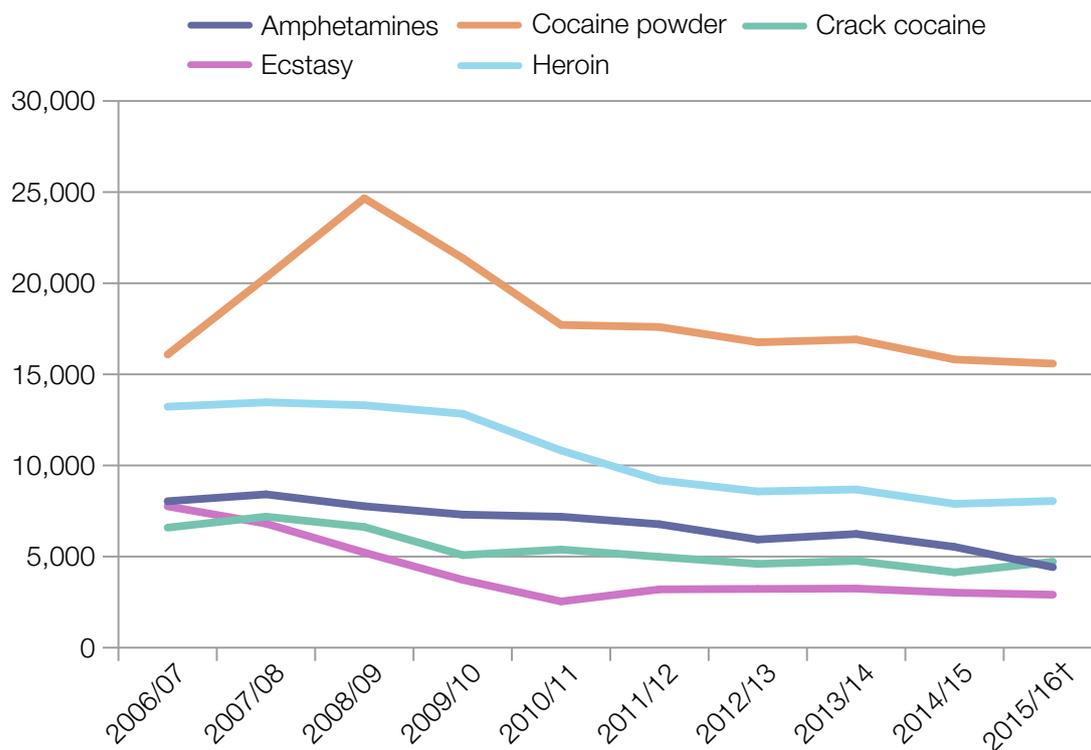
Figure 9.3: Proportion of the number and quantity of seizures made by police forces* and Border Force in England and Wales, 2015/16



* Bedfordshire, Dorset, Essex and Leicestershire police forces were unable to supply reliable estimates, therefore imputation methods, based on police recorded crime have been used to estimate data for these forces
 Source: (Home Office, 2016g)

The number of seizures of heroin decreased between 2008/09 and 2012/13 (see Figure 9.4). The number of seizures has since stabilised, and in 2015/16 was 8,050 (down from a peak of 13,463 in 2007/08). Similar to the cannabis data, the quantity of heroin seized over the last decade has varied greatly, again primarily influenced by the quantity of seizures made by Border Force (see Figures 9.3 and 9.5).

Figure 9.4: Number of seizures of selected drugs by police forces and Border Force in England and Wales, 2006/07 to 2015/16



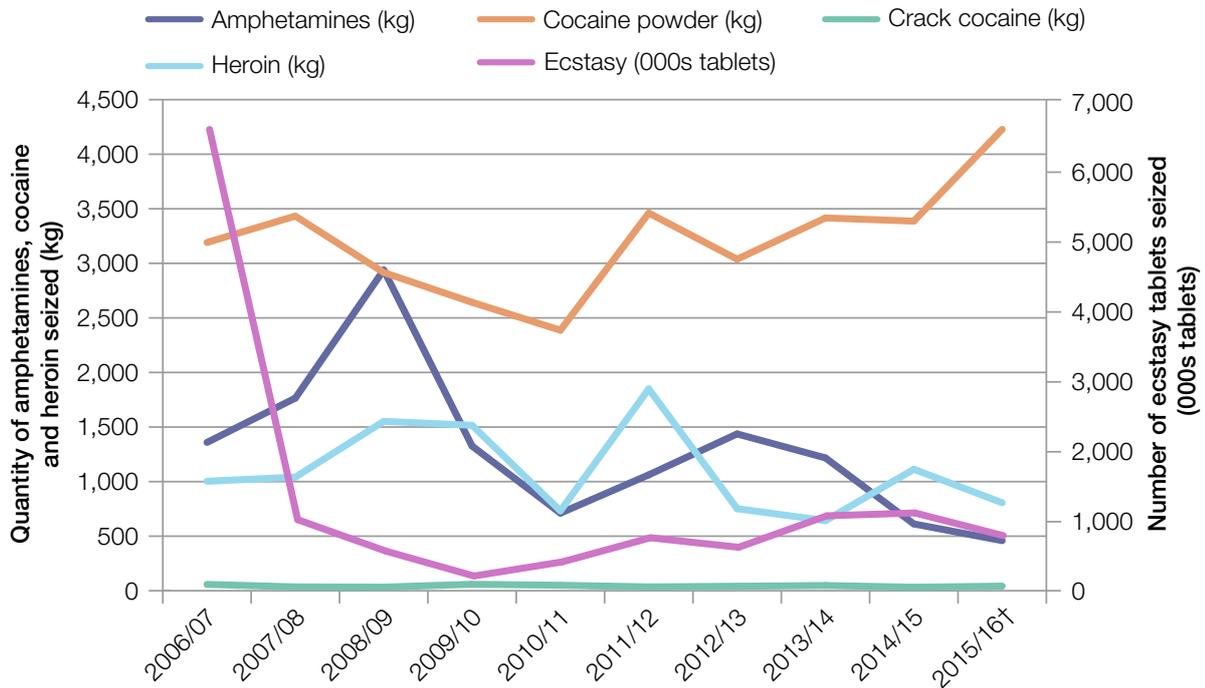
†Bedfordshire, Dorset, Essex and Leicestershire police forces were unable to supply reliable estimates, therefore imputation methods, based on police recorded crime have been used to estimate data for these forces

Source: (Home Office, 2016g)

The number of cocaine powder seizures decreased from a peak of 24,659 in 2008/09 to 15,815 in 2014/15; this number decreased slightly again in 2015/16, to 15,588 (see Figure 9.4). The quantity of cocaine powder seized this year was 4,228kg, the highest amount seen in the past ten years (see Figure 9.5). Crack seizure numbers have remained stable for the past five years, and this figure was 4,718 in 2015/16 (see Figure 9.4). While the greatest quantity of cocaine powder is seized by Border Force, virtually all crack cocaine seizures (number and quantity) are made by the police force, reflecting the importation of cocaine powder from abroad, and the domestic production of crack cocaine within the UK (see Figure 9.3).

Seizures of ecstasy tablets (both number and quantity) declined between 2006/07 and 2010/11. The number of seizures has remained stable since this time ($n=2,906$ in 2015/16); the quantity seized has increased since 2010/11, although not to the level seen in 2006/07 (see Figures 9.4 and 9.5).

Figure 9.5: Quantity of selected drugs seized by police forces and Border Force in England and Wales, 2006/07 to 2015/16



†Bedfordshire, Dorset, Essex and Leicestershire police forces were unable to supply reliable estimates, therefore imputation methods, based on police recorded crime have been used to estimate data for these forces.
Source: (Home Office, 2016g)

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13 List of abbreviations used in the text

£	Pound sterling (UK)
Mg	Microgram
ACMD	Advisory Council on the Misuse of Drugs
AD:EPT	Alcohol and Drugs: Empowering People through Therapy
ADEPIS	Alcohol and Drug Education and Prevention Information Service
ADP	Alcohol and Drug Partnership
Anti-HBc	Antibodies to Hepatitis B Virus
Anti-HCV	Anti-Hepatitis C Virus
APB	Area Planning Board
APoSM	Advisory Panel on Substance Misuse
APT	Addiction Prevalence Test
BBV	Blood-Borne Virus
CCEA	Council for Curriculum, Examinations and Assessment
CCG	Clinical Commissioning Group
CHI	Community Health Index
CI	Confidence Interval
CJEU	Court of Justice of the European Union
CJIT	Criminal Justice Integrated Team
CJS	Criminal Justice System
CPO	Community Payback Order
CQC	Care Quality Commission
CRC	Community Rehabilitation Company
CSEW	Crime Survey for England and Wales
DACT	Drug and Alcohol Co-ordination Team
DAISy	Drug and Alcohol Information System
DH	Department of Health
DIP	Drug Interventions Programme
DMD	Drug Misuse Definition
DoH	Department of Health (Northern Ireland)
DPH	Director of Public Health
DRD	Drug-Related Death
DTTO	Drug Treatment and Testing Order
DWP	Department for Work and Pensions
ED	Emergency Department
EMCDDA	European Monitoring Centre for Drugs and Drug Addiction
EU	European Union
Euro-DEN	European Drug Emergencies Network
FDAC	Family Drug and Alcohol Court
G	Gram

GAS	Group A Streptococcal
GBL	Gamma-butyrolactone
GBP	Great British Pounds
GDS	Global Drug Survey
GHB	Gamma-hydroxybutyrate
GMR	General Mortality Register
GP	General Practitioner
GPS	General Population Surveys
HBV	Hepatitis B Virus
HCV	Hepatitis C Virus
HEAT	Health Improvement, Efficiency, Access and Treatment
HIV	Human Immunodeficiency Virus
HJIP	Health and Justice Indicators of Performance
HMP	Her Majesty's Prison
HMYOI	Her Majesty's Young Offender Institution
HRD	Harm Reduction Database
HRDU	High Risk Drug Use
HWB	Health and Wellbeing Board
ICD-10	International Statistical Classification of Diseases and Related Health Problems – Tenth Edition
IDU	Injecting Drug Users
IPED	Image and Performance Enhancing Drug
ISD	Information Services Division
Kg	Kilogram
L&D	Liaison and Diversion
LA	Local Authority
LDP	Local Delivery Plan
LGBT	Lesbian Gay Bisexual and Transgender
LSD	Lysergic Acid Diethylamide
MDMA	3,4-Methylenedioxymethamphetamine
MDT	Mandatory Drug Testing
MDPV	Methylenedioxypropylone
Mg	Milligram
MHRA	Medicines and Healthcare products Regulatory Agency
ml	Millilitre
MoJ	Ministry of Justice
MRSA	Meticillin-resistant <i>Staphylococcus aureus</i>
MSM	Men who have Sex with Men
MSSA	Meticillin-sensitive <i>Staphylococcus aureus</i>
MUP	Minimum Unit Price/Pricing
NACDA	National Advisory Committee on Drugs and Alcohol
NCA	National Crime Agency

NDEC	National Drug Evidence Centre
NDRDD	National Drug-Related Deaths Database
NDTMS	National Drug Treatment Monitoring System
NEET	Not in Education, Employment or Training
NEPTUNE	Novel Psychoactive Treatment UK Network
NHS	National Health Service
NICE	National Institute for Health and Care Excellence
NIPS	Northern Ireland Prison Service
NNAG	National Naloxone Advisory Group
NOMS	National Offender Management Service
NPIS	National Poisons Information Service
NPS	New Psychoactive Substances
NPSAD	National Programme on Substance Misuse Deaths
NQA	National Quality Award
NRS	National Records of Scotland
NRT	Nicotine Replacement Therapy
NSD	New Strategic Direction
NSP	Needle and Syringe Programmes
OCG	Organised Crime Group
ONS	Office for National Statistics
OST	Opioid Substitution Therapy/Treatment
PDU	Problem Drug Use
PHA	Public Health Agency for Northern Ireland
PHE	Public Health England
PHOF	Public Health Outcomes Framework
PMA	Para-methoxyamphetamine
PMMA	Para-methoxymethamphetamine
POM	Prescription Only Medication
PPO	Prisons and Probation Ombudsman
PSHE	Personal, Social and Health Education
PWID	People Who Inject Drugs
RAPID	Remove All Prescription and Illicit Drugs
RMDT	Random Mandatory Drug Testing
RPW	Recorded Police Warning
SALSUS	Scottish Schools Adolescent Lifestyle and Substance Use Survey
SCH	Secure Children's Home
SCJS	Scottish Crime and Justice Survey
SCRA	Synthetic Cannabinoid Receptor Agonist
SDD	Smoking Drinking and Drug Use Among Young People in England Survey
SDMD	Scottish Drug Misuse Database
SEHSCT	South Eastern Health and Social Care Trust
SMR	Special Mortality Register

SPS	Scottish Prison Service
STC	Secure Training Centre
SWA	Scotch Whisky Association
TAS	Throughcare Addiction Service
TB	Tuberculosis
TCDO	Temporary Class Drug Order
TDI	Treatment Demand Indicator
THN	Take Home Naloxone
TOP	Treatment Outcomes Profile
TPD	Tobacco Products Directive
UAM	Unlinked Anonymous Monitoring
UK	United Kingdom
USA	United States of America
WEDINOS	Welsh Emerging Drug and Identification of Novel Substances
YOI	Young Offender Institution

14 List of accompanying tables

Number	Title	Source
Prevalence 1	Basic results and methodology of population surveys on drug use	England and Wales – <i>Crime Survey for England and Wales</i> (CSEW);
DRD1	Acute/direct related deaths	General Mortality Registers (GMRs) for England and Wales, Scotland and Northern Ireland
DRD2	Evolution of acute/direct related deaths	GMRs for England and Wales, Scotland and Northern Ireland
DRID	Prevalence of hepatitis B/C and HIV infection among injecting drug users	PHE and Health Protection Scotland (HPS)
NSP	Syringe availability	Injecting Equipment Provision (IEP) in Scotland Survey, NHS ISD Scotland; Northern Ireland Needle and Syringe Exchange Scheme; Harm Reduction Database (HRD), Public Health Wales
DLO	Arrests/reports for drug law offences	Ministry of Justice; Scottish Government; Northern Ireland Office; Northern Ireland Police Service (NIPS)
Treatment 1	Treatment Demand Indicator data	National Drug Treatment Monitoring System (NDTMS) in England; Scottish Drug Misuse Database (SDMD); Welsh National Database for Substance Misuse (WNDSM); Northern Ireland Drug Misuse Database (NIDMD)
Treatment 2	Treatment Prevalence	NDTMS in England; WNDSM
Treatment 3	Access to treatment	NDTMS in England; WNDSM

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2905931 March 2017

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