



Review of Drugs - evidence relating to drug use, supply and effects, including current trends and future risks

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The content in this evidence pack was commissioned by Dame Carol Black as part of the Review of Drugs, to provide detailed data on the illicit drug market, its associated harms and the interventions currently in place to tackle and respond to these harms. Public Health England analysts were commissioned to provide the content for chapters 1, 6, 8, 9, Home Office analysts were commissioned to provide the content for chapters 2, 3, 4, 5 and 7, while the other chapters were jointly produced.

i. Summary of the market analysis

The following grids provide a summary of an analysis of the drugs market in England covering five widely used substances: heroin, crack cocaine, cocaine powder, cannabis and synthetic drugs (such as MDMA and amphetamines)

For each one it follows the path from production to the end user, identifying the main distribution routes, the costs and harms as well as international comparisons and emerging risks

Heroin

<p>Production/trafficking into the UK</p> 	<p>How produced</p> <p>Opium poppy is cultivated, processed into base form, adulterated with cutting agents, and then pressed into blocks and packaged for export.</p>	<p>Where produced</p> <p>Limited to specific regions. Most heroin destined for the UK market is thought to originate from Afghanistan.</p>	<p>Trends in production</p> <p>A 44% increase in Afghan heroin production since 2015, which is predicted to continue. This has led to increases in purity. However, these increases do not appear to have impacted on heroin use thus far.</p>	<p>Main supply routes into UK</p> <p>Three main routes:</p> <ul style="list-style-type: none"> i) via the Middle East and the Balkans; ii) via northern Asia into Russia and northern Europe; iii) via Africa and into southern Europe. <p>The Balkan route is thought to be the most frequently used.</p>	<p>Enforcement at the border</p> <p>488kg of heroin seized in 2018/19, a 217% increase from 2017/18.</p>	<p>Potential to disrupt supply chains</p> <p>The heroin ‘drought’ in 2009/10 seemed to lead to a significant fall in purity, a reduction in deaths and better treatment outcomes. However, enforcement activity to restrict supply does not appear to have had similar impacts.</p>
<p>Distribution within the UK</p> 	<p>Import/wholesale supply</p> <p>Estimated 118 import OCGs in England and Wales.</p> <p>Estimated 845 supply (wholesale and retail) OCGs in England and Wales.</p>	<p>Import/wholesale supply</p> <p>UK-based OCGs with Pakistani links and Turkish familial OCGs are heavily involved in heroin importation and supply, while British OCGs are dominant in the North West of England.</p>	<p>Retail supply</p> <p>In large cities, heroin is supplied by local OCGs or USGs, usually alongside crack. In other areas county lines groups have increasingly taken control of heroin and crack supply. Street dealers consist of user-dealers and junior OCG or USG members.</p>	<p>Links to exploitation</p> <p>County lines groups in particular are associated with widespread exploitation of young people as drug runners, and of vulnerable drug users through cuckooing. Local OCGs and USGs selling heroin/crack have also been identified to use these practices.</p>	<p>Links to violence</p> <p>Heroin and crack markets are the most closely linked to violence, likely due to the large financial rewards on offer, the high levels of deprivation associated with heroin/crack affected areas, and the use of young people.</p>	<p>Trends in enforcement</p> <p>The number of heroin seizures by police forces has fallen considerably in recent years despite usage remaining high. This indicates that heroin suppliers may be effectively avoiding detection by law enforcement. This trend began to change in 2018/19, with an increase in heroin seizures.</p>
<p>Prevalence and profile of users</p> 	<p>Estimated number of users</p> <p>261,000 users in England.</p>	<p>Trends in prevalence</p> <p>The overall number of illicit opiate users has remained relatively stable over the last 10 years. However, new incidence has fallen, particularly among under 30s.</p>	<p>Patterns of use (frequency/purchase routes)</p> <p>The majority of users will use most days to avoid withdrawal. Mainly purchased from street level dealers.</p>	<p>Trends in patterns of use</p> <p>More users are now also using crack cocaine and or NPS, often injecting both drugs. This has been linked to increases in HIV infections.</p>	<p>Profile of users - geography/demographics</p> <p>An ageing heroin cohort, with many starting use in 1980s and 1990s. Highest rates of use in North West and North East, though the profile of users is different.</p> <p>Prevalence strongly correlates with deprivation.</p> <p>Heroin users often have multiple and complex needs such as mental health, unemployment, family estrangement, homelessness and offending histories.</p>	

Harms and economic costs 	Main harms/risks to individual users <ul style="list-style-type: none"> Substantially increased risk of morbidity and premature mortality High CVD and respiratory risk BBVs/wound infections Family breakdown 90% of Hepatitis C infections among PWID 	Main societal harms and economic costs <p>Over four-fifths of the estimated cost of drug use is associated with opiate and crack users (OCUs). Crime and CJS costs make up half of the overall costs. 95% of the crime costs are estimated to be related to crack and heroin use.</p>	Main societal harms and economic costs <p>Drug-related deaths and homicides make up the next largest cost with OCUs making up nearly 80% of the cost associated with drug poisonings.</p>	Trends in harms and costs <p>Heroin deaths have more than doubled since 2012 and are now at their highest level ever Bacterial wound infections have increased significantly over recent years</p>	Trends in harms and costs <p>With the proportion of the prevalent population in treatment reducing against stable prevalence, costs and harms will likely be increasing.</p> <p>The numbers of people sleeping rough have increased by 165% since 2010 and drug-related deaths amongst this group have risen sharply.</p>
Responses/ interventions 	Primary responses/ interventions <p>Drug treatment – combination of pharmacological and psychosocial interventions in community, prison and residential settings. Needle exchange – to prevent spread of BBVs and other harms.</p>	Proportion of users in treatment <p>Currently 53% though this has fallen over recent years (from a peak of 65%) as prevalence has remained stable and numbers in treatment have fallen. Treatment number decreases have reflected similar falls seen in expenditure.</p>	Trends in treatment access/outcomes <p>The number of opiate users in treatment has fallen by a fifth over the last seven years with the proportion completing treatment falling by a third over this time.</p>	Potential for treatment to disrupt markets <p>High – having heroin users in treatment means they are far less likely to access drugs via dealers and it helps prevent the induction of peers into starting use.</p>	Considerations/issues <p>Treatment funding inadequate to meet needs of ageing heroin cohort, new users and emerging threats.</p> <p>Lack of accountability at national and local level which needs to be increased.</p> <p>Links need to be strengthened between the CJS and treatment via improving pathways, particularly from prison to community.</p>
International comparison/emerging threats 	International comparisons <p>The global area of opium cultivated is more than 60% larger than it was a decade ago. The increases in cultivation do not appear to have led to increases in usage.</p> <p>The UK has significantly more high-risk opioid users than any other EU country, with 8.4 users per 1000. Some countries are experiencing opioid epidemics, largely driven by synthetic opioids such as fentanyl and its analogues.</p>		Possible policy initiatives/considerations <p>Most heroin users have one or more additional complex needs. Need to increase local partnership and cross-government working. Recovery is not just about treatment but also requires the integration of other services, including housing and employment support. A more effective, wraparound response is required that responds jointly to the housing and health needs of the rough sleeping cohort.</p>		Emerging threats/risks <p>Increased use of crack cocaine among existing users will increase mortality and morbidity risk. New crack users could transition to heroin use.</p> <p>About 0.5m people have been taking prescription opiates for three years or more. Some will have dependence and withdrawal needs to be properly managed by GPs or local specialist services to avoid a US-style crisis.</p> <p>Synthetic opioids such as fentanyl that are many times stronger increase the risk of overdose and other harms significantly. Risk that fentanyl or other synthetic opioids which can be more easily imported start to contaminate or replace heroin.</p>

Crack cocaine

<p>Production/trafficking into the UK</p> 	<p>How produced</p> <p>Coca plant is cultivated, processed into a base form, adulterated with cutting agents, and then pressed into blocks and packaged for export. Powder cocaine is then ‘cooked’ into crack. Primarily this is done in the UK.</p>	<p>Where produced</p> <p>Cocaine production is limited to specific regions – Colombia, Peru and Bolivia.</p>	<p>Trends in production</p> <p>Colombian cocaine production has increased by over 250% since 2013. This has led to a surge in purity across Europe, and appears to have contributed to increased use of crack and powder cocaine in England and Wales.</p>	<p>Main supply routes into UK</p> <p>Cocaine is trafficked into Southern Europe using maritime transport, either via Africa or via Central America/the Caribbean. From Southern Europe it is trafficked through the Netherlands and Belgium into the UK. It is often trafficked together with heroin and other drugs from Central Europe.</p>	<p>Enforcement at the border</p> <p>Typically low amounts of crack cocaine are seized at the border as it is rarely cooked from cocaine powder before it enters the UK. Powdered cocaine is seized at the border in much higher quantities.</p>	
<p>Distribution within the UK</p> 	<p>Level of OCG involvement</p> <p>Estimated 606 supply (wholesale and retail) OCGs in England and Wales.</p>	<p>Import/wholesale supply</p> <p>Crack cocaine is produced close to the retail level, so the import/wholesale stages generally follow that of powder cocaine.</p>	<p>Retail supply</p> <p>In large cities, crack is supplied by local OCGs or USGs, usually alongside heroin. In other areas county lines groups have increasingly taken control of heroin and crack supply. Street dealers consist of user-dealers, junior OCG members or USG members.</p>	<p>Links to exploitation</p> <p>County lines groups in particular are associated with widespread exploitation of young people as drug runners, and of vulnerable drug users through cuckooing. Local OCGs and USGs selling heroin/crack have also been identified to use these practices.</p>	<p>Links to violence</p> <p>The evidence suggests that drug markets involving crack are among the most violent. OCGs supplying both heroin and crack are thought to be more violent than those only supplying heroin.</p>	<p>Trends in enforcement</p> <p>The number of police force seizures of crack cocaine has increased over the last few years, likely reflecting the increase in use and availability, and the enforcement focus on county lines.</p>
<p>Prevalence and profile of users</p> 	<p>Estimated number of users</p> <p>181,000 users in England.</p>	<p>Trends in prevalence</p> <p>Significant increases in both older heroin users additionally using crack, as well as new users of all ages not using alongside heroin.</p>	<p>Patterns of use (frequency/purchase routes)</p> <p>Crack tends to be used in binges of a few days at a time, often alongside alcohol and other drugs. It is highly addictive but the highs are relatively short-lived.</p>	<p>Trends in patterns of use</p> <p>Some of the stigma associated with crack in the past has gone and younger users now see it as more acceptable. With the changes in price and purity of cocaine, some cocaine users are moving from smoking it (freebasing) to the use of cheaper more ready-to-use crack.</p>	<p>Profile of users - geography/demographics</p> <p>While London still has one of the highest rates of crack use, it has fallen over the last 10 years. Whereas other regions such as the East of England, South East and the North East have seen significant increases since 2012. Crack increases tend to be outside established urban areas – possibly corresponding with the growth in county lines.</p>	

<p>Harms and economic costs</p> 	<p>Main harms/risks to individual users</p> <ul style="list-style-type: none"> Heart failure, abnormal heart rhythms (arrhythmias) and sudden death; abnormally high blood pressure (pulmonary hypertension); depression; aggression and possible violence; psychotic reaction similar to acute paranoid schizophrenia and psychosis; injecting increases the risk of HIV and hepatitis C; may be a risk factor for use of heroin. 		<p>Main societal harms and economic costs</p> <p>Over four-fifths of the estimated cost of drug use is associated with opiate and crack users. Crime and CJS costs make up half of the overall costs. 95% of the crime costs are estimated to be related to crack and heroin use.</p>	<p>Trends in harms and costs</p> <p>Cocaine and crack cocaine deaths have increased nearly six-fold since 2011 and were cited in one in seven deaths in 2018. As most of the individual and societal harms and costs are associated with opiate and crack users then any increases in prevalence will increase these.</p>		
<p>Responses/ interventions</p> 	<p>Primary responses/ interventions</p> <p>Psychosocial interventions in community, prison and residential settings.</p>	<p>Proportion of users in treatment</p> <p>Only 39% of crack users are currently in treatment.</p>	<p>Trends in treatment access/outcomes</p> <p>Crack cocaine presentations to treatment (both with and without opiates) have increased by 32% since 2013/14 with the successful completion rates of crack users (both with and with out opiates) falling over this time.</p>	<p>Potential for treatment to disrupt markets</p> <p>High – like with heroin it can reduce demand for street dealing and help avoid induction of new users. Long-term recovery rates of users of crack without opiates are relatively good.</p>	<p>Considerations/issues</p> <p>Lower rates of crack users in treatment than users of opiates and these are mainly users of crack and heroin.</p> <p>Relatively few ‘new’ crack users currently in treatment.</p>	
<p>International comparison/ emerging threats</p> 	<p>International trends</p> <p>EU - new EMCDDA data suggests that the use of crack cocaine may be spreading. Increases in the number of crack cocaine clients entering treatment since 2014 have been reported in Belgium, Ireland, France, Italy, Portugal, as well as in the United Kingdom.</p> <p>US – increased crack use has been strongly linked to spikes in serious violence.</p>		<p>International comparisons</p> <p>Crack use is higher in the UK than elsewhere in Europe, where crack is only prevalent in a small number of larger cities and the UK reports the most demand in the EU for crack-cocaine treatment (65%).</p>	<p>Possible policy initiatives/considerations</p> <p>Treatment funding inadequate to attract and treat ‘new’ crack users. Links need to be strengthened between the CJS and treatment.</p>	<p>Emerging threats/risks</p> <p>Cocaine use has increased significantly over the last few years. Risk that crack users also start using heroin.</p> <p>Historically crack users have been known to use heroin to help manage the come downs. With aggressive marketing of both drugs by county line groups, risk that heroin use could increase.</p>	

Cocaine powder

<p>Production/trafficking into the UK</p> 	<p>How produced</p> <p>Coca plant is cultivated, processed into a base form, adulterated with cutting agents, and then pressed into blocks and packaged for export.</p>	<p>Where produced</p> <p>Limited to specific regions – Colombia, Peru and Bolivia.</p>	<p>Trends in production</p> <p>Colombian cocaine production has increased by over 250% since 2013. This has led to a surge in purity across Europe, and appears to have contributed to increased use of crack and powder cocaine in England and Wales.</p>	<p>Main supply routes into UK</p> <p>Cocaine is trafficked into Southern Europe using maritime transport, either via Africa or via Central America /the Caribbean. From Southern Europe it is trafficked through the Netherlands and Belgium into the UK. It is often trafficked together with heroin and other drugs from Central Europe.</p>	<p>Enforcement at the border</p> <p>The number of seizures have fallen while quantities seized have been increasing.</p> <p>There was a record 8.9 tonnes of cocaine seized in 2018/19.</p>	<p>Impacts of shocks to the supply chain</p> <p>The increasing quantity of cocaine seized does not appear to have affected purity, usage or harms. The increase in cocaine seized is likely to reflect greater availability and levels of importation rather than a step change in enforcement activity.</p>
<p>Distribution within the UK</p> 	<p>Level of OCG involvement</p> <p>Very high</p> <p>Estimated 219 import OCGs</p> <p>Estimated 1,054 supply (wholesale and retail) OCGs.</p>	<p>Import/wholesale supply</p> <p>Albanian OCGs dominate the UK cocaine market, with a supply network from source country to towns and cities across the UK, acting as the main wholesaler to powder cocaine retail operations, including those converting it to crack. Some British OCGs also operate at the wholesale level.</p>	<p>Retail supply</p> <p>Many users obtain these drugs for free through social supply, rather than buying from a dealer. Compared to crack, powder cocaine dealers tend to be older, white, and are less likely to be dependent users. It is often sold in the night-time economy alongside other recreational drugs such as ecstasy and amphetamine.</p>	<p>Links to exploitation</p> <p>Less evidence of links to exploitation in the powder cocaine supply chain compared with heroin and crack. However, powder cocaine may provide revenue to Albanian and other OCGs involved in other exploitative activities such as human trafficking.</p>	<p>Links to violence</p> <p>Powder cocaine markets in the UK are thought be more violent than cannabis and MDMA but less violent than heroin and crack.</p> <p>There is significant violence associated with cocaine trafficking around European ports.</p>	<p>Trends in enforcement</p> <p>Police force seizures of powder cocaine have gradually fallen in recent years, despite an increase in use and availability. This may indicate a decreased enforcement focus on powder cocaine relative to other drugs.</p>
<p>Prevalence and profile of users</p> 	<p>Estimated number of users</p> <p>976,000 people in England and Wales used powder cocaine in the last year.</p>	<p>Trends in prevalence</p> <p>Increased use over the last five to six years, mainly driven by those under 30. Though most demographics have seen similar levels of increased use.</p>	<p>Frequency of use</p> <p>0.1% daily 5% weekly 22% a few times a month 73% less than monthly</p>	<p>Trends in patterns of use</p> <p>As well as an increase in recreational use of powder cocaine, data on treatment presentations and deaths suggests an increasing issue with problematic use of powder cocaine.</p>	<p>Profile of users - geography/demographics</p> <p>Around 37% of powder cocaine users have a household income of £40,000 or more. Usage is more common among regular club and pub goers and often associated with alcohol use.</p> <p>The South West has seen the largest increase in cocaine prevalence since 2013/14 with London the largest decrease</p>	<p>Trends/changes in profile</p> <p>The overall prevalence of cocaine use in the last year has increased by around a quarter since 2013/14 with the largest increases in the under 30s, in rural areas and in those with higher incomes</p> <p>Problematic use also appears to have increased particularly in the over 30s</p>

<p>Harms and economic costs</p> 	<p>Main harms to individual users</p> <ul style="list-style-type: none"> • Heart failure, abnormal heart rhythms (arrhythmias) and sudden death; • abnormally high blood pressure (pulmonary hypertension); • depression; • aggression and possible violence; • psychotic reaction similar to acute paranoid schizophrenia and psychosis; • paranoid ideation; • chronic rhinitis; • loss of sense of smell/nosebleeds; • risk factor for use of crack. 		<p>Trends in harms and costs</p> <p>Cocaine and crack cocaine deaths have increased nearly six-fold since 2011 and were cited in one in seven drug deaths in 2018. There have also been significant increases in hospital admissions related to cocaine use.</p>		
<p>Responses/ interventions</p> 	<p>Primary responses/ interventions</p> <p>Psychosocial interventions in community, prison and residential settings.</p>	<p>Proportion of users in treatment</p> <p>There were 31,500 cocaine users in treatment in 2018/19 (3% of users). A large proportion of those in treatment for cocaine also have problems with other drugs and alcohol.</p>	<p>Trends in treatment access/outcomes</p> <p>The number of cocaine users presenting to treatment has increased by 30% since 2013/14. The recovery rate of cocaine users in treatment has fallen slightly since 2013/14 and is now just under 40%.</p>	<p>Potential for treatment to disrupt markets</p> <p>Medium to low – the majority of cocaine users will not require structured treatment. Potentially other lower threshold interventions could be developed to support cocaine users.</p>	
<p>International comparison/emerging threats</p> 	<p>International trends</p> <p>Estimated global illicit manufacture of cocaine reached an all-time high in 2017. Cocaine availability is now at an all-time high in the EU – purity is the highest for a decade whilst the price has remained relatively stable.</p> <p>The fragmentation of the cocaine trade in Europe has resulted in increased competition and violence among OCGs.</p>		<p>International comparisons</p> <p>The UK has the highest prevalence of cocaine use amongst young people (15 – 34 years) in the EU (4.7%) - this is more than double the EU average (2.1%). Whilst the average purity of powder cocaine in the UK is similar to EU levels, it is comparatively cheaper than in most of the EU.</p>	<p>Possible policy initiatives/ considerations</p> <p>Increases in prevalence are likely to lead to increases in problematic use.</p> <p>Drug treatment is currently not sufficiently resourced to provide outreach and treatment to this potential new cohort.</p>	<p>Emerging threats/risks</p> <p>Risk of people transitioning from cocaine use to crack use.</p> <p>Currently limited understanding of the extent to which county lines is driving increases in prevalence. But anecdotal evidence that both crack and cocaine powder being dealt at universities.</p> <p>Risk that if more county lines operations start supplying, cocaine use will increase further.</p>

Synthetics (MDMA, amphetamines and NPS)

<p>Production/trafficking into the UK</p> 	<p>How produced Drugs are synthesised through a series of chemical reactions involving precursor chemicals.</p> <p>The drug is then separated into the base form, purified or crystallised into salt form, then adulterated packaged into powder or tablets ready for export.</p>	<p>Where produced Can be manufactured anywhere in theory. In practice, MDMA and amphetamines are produced mainly in Belgium and the Netherlands, although some amphetamine production takes place in the UK.</p> <p>Synthetic cannabinoids and other NPS are manufactured primarily in China, and to a lesser extent India.</p>	<p>Trends in production Increases in the number and quantity of ecstasy and MDMA seized across Europe are an indication that production of both substances may be increasing. The strength of ecstasy is also increasing with dose levels in many tablets now very high.</p> <p>The number of seizures of NPS in Europe has fallen since 2015, indicating that source production may have reduced.</p>	<p>Main supply routes into UK Production and trafficking routes of synthetics are likely to move in response to changes in costs and risks. MDMA and amphetamines will often be trafficked alongside other drugs such as heroin and cocaine from the Netherlands and Belgium, via maritime and other freight. Synthetic cannabinoids and other NPS are trafficked to Europe via air and sea.</p>	<p>Enforcement at the border Both the number and quantity of MDMA and amphetamine seizures have increased considerably in recent years. The rise in seizures appears to have outstripped the trends in usage, suggesting an increase in detections by Border Force. A total of 256 seizures of NPS were made at the border in 2018/19 (16 of which were synthetic cannabinoids).</p>	<p>Impacts of shocks to the supply chain The number of new NPS identified in the EU has fallen considerably since 2015, particularly for synthetic cannabinoids, indicating a slowdown in the generation of new substances. This may be a result of new legislation in China to restrict NPS production, and new controls in Europe around the supply of NPS.</p>
<p>Distribution within the UK</p> 	<p>Level of OCG involvement Estimated 31 ecstasy import OCGs in England and Wales.</p> <p>Estimated 85 ecstasy supply (wholesale and retail) OCGs in England and Wales.</p>	<p>Import/wholesale supply There are high levels of overlap between OCGs supplying ecstasy and those supplying powder cocaine and cannabis. The dark web is also an important source of supply for synthetics, particularly for NPS outside of synthetic cannabinoids.</p>	<p>Retail supply Retail supply of ecstasy and amphetamines is often based around the night-time economy and involves high levels of social supply. Synthetic cannabinoids used to be sold legally in 'head shops', but after legislation changes they now tend to be sold by street dealers.</p>	<p>Links to exploitation Little evidence is available on the extent of exploitation associated with the supply of synthetics.</p>	<p>Links to violence The MDMA market is thought to be less violent than that of the other mainstream drug markets.</p> <p>However, synthetic cannabinoids are closely linked to violence specifically within prisons.</p>	<p>Trends in enforcement The number of MDMA seizures has declined slightly in recent years, despite increased usage among young people. The introduction of the Psychoactive Substances Act 2016 has led to a fall in NPS use, although the impacts on problematic synthetic cannabinoid use are less clear.</p>
<p>Prevalence and profile of users</p> 	<p>Estimated number of users In the last year 524,000 people in England & Wales used MDMA; 188,000 people used amphetamines; and 152,000 people used NPS.</p>	<p>Trends in prevalence MDMA use has shown small increases in the last few years but it has been up and down over the last decade. Use of amphetamines has decreased in recent years. NPS use among the general population has significantly fallen since the 2016 Act, but robust data on the use of synthetic cannabinoids is not available.</p>	<p>Frequency of use Of those who used MDMA in the last year, 93% used it less than once a month.</p> <p>Of those who used NPS in the last year, 77% used it less than once a month.</p>	<p>Profile of users - geography/demographics Most users of ecstasy and amphetamines are under 30, with men twice as likely to use the drug than women generally but use by gender in the under 25s is at similar rates. Most NPS use is also in the under 30s with prevalence being particularly high in rough sleeping populations. The North East and Midlands have the lowest rates of MDMA use, nearly a third of those seen in the South West and North West.</p> <p>For amphetamines the highest rates are seen in the North East, Yorkshire and Humber, and the South West. Often these drugs are used together and alongside alcohol.</p>	<p>Trends/changes in profile There has been little change in the profile of the users of MDMA and amphetamines, but while NPS use has fallen substantially, prevalence remains very high among rough sleepers and prisoners.</p>	

<p>Harms and economic costs</p> 	<p>Main harms/risks to individual users</p> <p>Increased heart rate and blood pressure; tremors, seizures and fits; increase in body temperature (hyperthermia); toxic delirium with amnesia; psychotic reaction similar to acute paranoid schizophrenia; anxiety and paranoia; suicidal thoughts.</p> <p>High level of NPS use among rough sleeping population leaves them vulnerable and more susceptible to physical and mental health harms</p>		<p>Trends in harms and costs</p> <p>Increases in NPS use in prison in recent years has led to increases in violence, bullying and negative health incidents.</p>
<p>Responses/ interventions</p> 	<p>Primary responses/ interventions</p> <p>Psychosocial interventions in community, prison and residential settings.</p> <p>Psychoactive Substances Act 2016.</p>	<p>Proportion of users in treatment</p> <p>Most users of these drugs will not require treatment.</p> <p>Currently there are 9,000 problematic users of amphetamines in treatment, 1,500 MDMA users and just over 2,000 presenting with problems with NPS.</p> <p>A large proportion of those in treatment for these drugs also have problems with other drugs and alcohol.</p>	<p>Trends in treatment access/outcomes</p> <p>The number of people presenting to treatment with amphetamines has halved since 2013/14. MDMA presentations have fallen by a third during this time. NPS presentations have also fallen by a third since a peak in 2015/16. However, there has been a recent increase in NPS presentations among the homeless population and those using opiates.</p> <p>Successful completion rates for these substances have fallen slightly since 2013/14.</p>
<p>International comparison/emerging threats</p> 	<p>International trends</p> <p>Synthetic drug production in Europe, although difficult to monitor, appears to be growing, diversifying and becoming more innovative. There are now also growing indications of Europe's importance in the global market for synthetic drugs.</p> <p>The global NPS market has however shown some signs of slowing down with less new substances being reported in recent years.</p>	<p>International comparisons</p> <p>Prevalence of MDMA use in young adults (15-34) in the UK is twice the EU average and the third highest within the EU.</p> <p>Amphetamine use is on par with the EU average at 1%.</p>	<p>Possible policy initiatives/considerations</p> <p>Treatment funding is not sufficient to be able to provide capacity or outreach services to ensure problematic users of these substances can get the support they need.</p> <p>Treatment services are not necessarily currently equipped with the expertise and resources required to meet the needs of some of the users of these substances.</p>

Cannabis

<p>Production/trafficking into the UK</p> 	<p>How produced</p> <p>Crop is grown indoors or outdoors.</p> <p>Herbal: Dried leaves and buds removed and packaged into bags or blocks to be sold. Resin: Resin gum is removed by hand or sieving then pressed into blocks and packaged for export.</p>	<p>Where produced</p> <p>Can be grown anywhere. Resin is mostly imported from Morocco and Afghanistan. A large proportion of the herbal cannabis consumed in the UK is domestically produced, although some is imported from Albania and the Netherlands among other countries.</p>	<p>Trends in production</p> <p>There appears to have been a long-term switch towards domestic production, and a significant increase in potency and a particularly higher THC as opposed to CBD content.</p> <p>However, there is limited data on total cannabis cultivation in the UK or globally.</p>	<p>Main supply routes into UK</p> <p>Moroccan cannabis resin is trafficked via Spain, with the Netherlands acting as an important distribution centre. Imported herbal cannabis is trafficked via various different routes depending on the source country, and the Netherlands is again an important distribution centre.</p>	<p>Enforcement at the border</p> <p>The quantity of cannabis seized has fluctuated considerably over time, while the number of seizures has increased in recent years.</p> <p>Herbal cannabis now accounts for the large majority of cannabis seized at the border.</p>	<p>Potential to disrupt supply chains further</p> <p>The supply chain for cannabis is relatively resilient given the large presence of domestic cultivation. The use of indoor cultivation means that yields are largely unaffected by changes in weather.</p>
<p>Distribution within the UK</p> 	<p>Level of OCG involvement</p> <p>Estimated 111 import OCGs in England and Wales.</p> <p>Estimated 836 supply (wholesale and retail) OCGs in England and Wales.</p> <p>Estimated 364 cultivation OCGs in England and Wales.</p>	<p>Import/wholesale supply</p> <p>Cannabis production is generally controlled by British OCGs, although South East Asian, Dutch and Albanian OCGs also have a presence.</p>	<p>Retail supply</p> <p>Cannabis is obtained through a combination of dealers, social supply, and individuals growing cannabis for their own consumption.</p>	<p>Links to exploitation</p> <p>Young people with heavy cannabis use may potentially be pulled into county lines supply in order to pay for their drug use.</p> <p>South East Asian OCGs are known to exploit individuals to work on cannabis farms.</p>	<p>Links to violence</p> <p>The available data indicates that cannabis markets are less closely linked to violence than the markets for heroin/crack and powder cocaine.</p>	<p>Trends in enforcement</p> <p>Police seizures of cannabis are significantly lower than in 2009/10, despite usage remaining at a similar level. This fall matches the trend in stop and search figures, and indicates a reduction in proactive enforcement activity relating to cannabis.</p>
<p>Prevalence and profile of users</p> 	<p>Estimated number of users</p> <p>2,572,000 people in England and Wales used cannabis in the last year</p>	<p>Trends in prevalence</p> <p>Cannabis use remained flat between 2009/10 and 2015/16, but has since shown signs of a small increase, particularly among those aged between 25-29 years.</p>	<p>Frequency of use</p> <p>10% using daily 16% weekly 16% a few times a month 58% less than monthly</p> <p>Cannabis is more likely to be used frequently than other recreational drugs.</p>	<p>Trends in patterns of use</p> <p>Increased media attention on medicinal use of cannabis and sale of CBD products in shops.</p>	<p>Profile of users - geography/demographics</p> <p>The majority of cannabis users are under 30 with use widespread across the general population and most demographics.</p> <p>Rates of use are higher in the South with the South West and East of England seeing the largest increases in use over the last five years.</p>	<p>Trends/changes in profile</p> <p>There has been little change in the profile of cannabis users.</p>

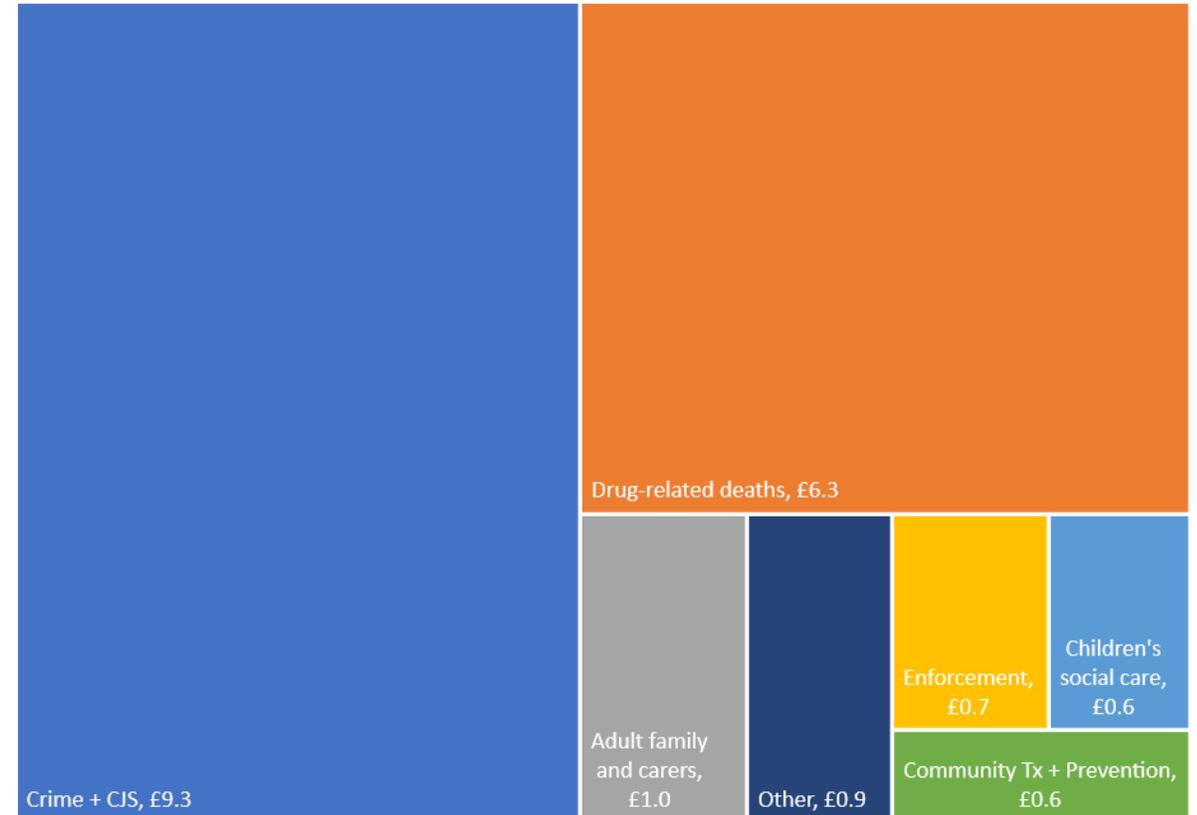
<p>Harms and economic costs</p> 	<p>Main harms/risks to individual users</p> <p>Cannabis is associated with increased risk of psychotic symptoms and disorders. There are also risks associated with smoking of the substance often alongside tobacco.</p> <ul style="list-style-type: none"> • Risks of chronic bronchitis/lung damage; • subtle impairment in higher cognitive functions of memory, learning processes, attention and organisation; • insomnia; • depression; • aggression; • anxiety. 		<p>Main societal harms and economic costs</p> <p>Most of the societal costs associated with cannabis use are from enforcement and mental ill health support and treatment.</p>		
<p>Responses/ interventions</p> 	<p>Primary responses/ interventions</p> <p>Psychosocial interventions in community, prison and residential settings. DHSC and PHE have committed to doing more work on: assessing if treatment meets need; brief interventions and raising awareness of harms.</p>	<p>Proportion of users in treatment</p> <p>2% in 2018/19, with nearly half of those also in treatment for heroin use.</p> <p>Many of those in treatment for cannabis are also receiving interventions for other substances including alcohol.</p>	<p>Trends in treatment access/ outcomes</p> <p>Cannabis is the most cited problematic substance of users of non-opiates, though the number of presentations have fallen since 2013/14.</p>	<p>Potential for treatment to disrupt markets</p> <p>Limited as the vast majority of cannabis users will not require drug treatment.</p>	
<p>International comparison/emerging threats</p> 	<p>International trends</p> <p>Across the globe a growing number of countries are passing legislation to legalise recreational cannabis, including Canada, Uruguay and some States in the US.</p> <p>This has led to an expansion in the types of cannabis products available including edibles and vaporized, and increased availability in high potency THC products (75%+).</p>		<p>International comparisons</p> <p>Cannabis continues to be the most widely used drug worldwide.</p> <p>Prevalence of cannabis use in the UK is lower than many European countries and use in young people is lower than the EU average with prevalence at 12.3% (EU average us 14.4%). This is significantly lower than France which has the highest prevalence at 21.8%.</p>		

1. Drug-related individual and societal harms

There are substantial social and economic costs related to illicit drug use

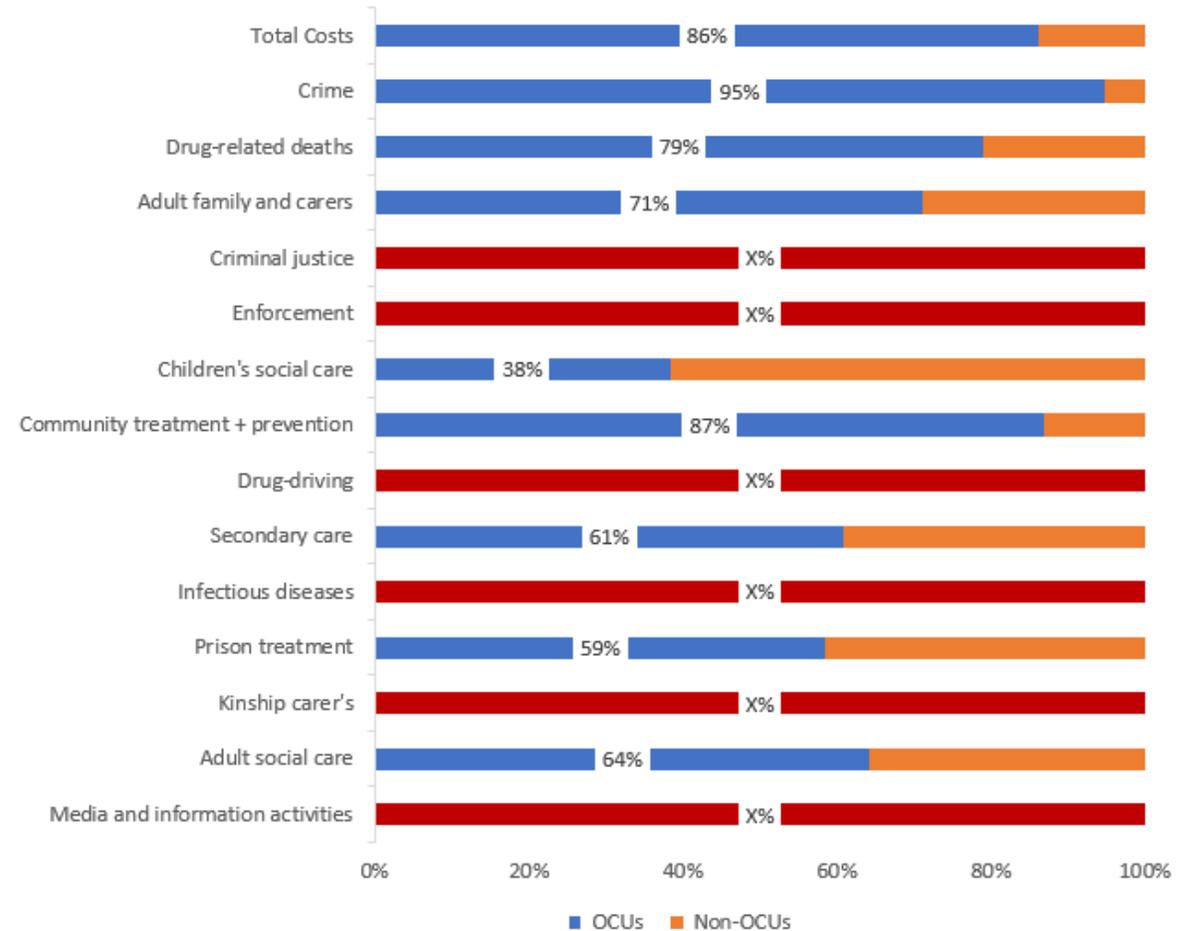
- The total cost of harms related to illicit drug use in England was £19.3 billion for 2017-18
- Drug-related crime was the main driver of total costs, with recorded offences committed in England by drug users amounting to ~ £9.3 billion in 2017-18
- Within this overall crime cost, criminal justice services (CJS) cost £733 million
- Drug-related enforcement costs amounted to £680 million
- The harms associated with drug-related deaths and homicides made up the next largest cost at £6.3 billion
- Drug treatment and prevention only made up a small fraction of the total cost at £553 million

Components of drug-related costs, £bns



The majority of the costs (86%) come from users of illicit opiates and crack cocaine

- It is estimated that there are about 300,000 users of illicit opiates and/or crack cocaine (OCUs). The number of OCUs increased significantly between 2014-15 and 2016-17
- This compares to about 3 million users of other substances (who reported taking any non OCU drug) in 2017-18
- The estimated economic cost per user is over 50 times greater for OCUs compared to those that use other drugs
- Fewer OCUs that need treatment are now receiving it compared to five years ago – as a result, the harms and costs associated with this cohort are likely to have increased over this time
- OCUs generate 95% of the costs of drug-related crime, though users of other substances who need treatment also have relatively high conviction rates
- Drug-related deaths are at their highest level ever. The increase in deaths has been driven by opiate users, with three-quarters of people dying under 50
- The impact on family members and carers is most significant for people supporting users of opiates and crack, with 71% of the costs incurred by this group



*X% = split by type of drug user not available

	Direct cost	Indirect cost	Intangible cost	Total cost
Cost per OCU	£27,000	£11,000	£20,000	£58,000
Cost per non-OCU	£400	£200	£300	£1,000

Direct, indirect and intangible costs estimated to result from drug misuse

46% of total costs are estimated to be a 'direct' cost to the economy

Cost component	Direct cost (£s)	Indirect Cost (£s)	Intangible costs (£s)	Total cost (£s)
Crime	5,470,000,000	1,810,000,000	1,265,000,000	8,545,000,000
Drug-related deaths	294,000,000	818,000,000	5,156,000,000	6,268,000,000
<i>Adult family and carers*</i>	<i>36,000,000</i>	<i>1,000,000,000</i>	<i>n/a</i>	<i>1,037,000,000</i>
Criminal justice	733,000,000	n/a	n/a	733,000,000
Enforcement	680,000,000	n/a	n/a	680,000,000
<i>Children's social care*</i>	<i>616,000,000</i>	<i>n/a</i>	<i>n/a</i>	<i>616,000,000</i>
Community treatment and prevention	553,000,000	n/a	n/a	553,000,000
<i>Drug driving*</i>	<i>38,000,000</i>	<i>81,000,000</i>	<i>256,000,000</i>	<i>374,000,000</i>
Secondary care	193,000,000	n/a	n/a	193,000,000
Infectious diseases	162,000,000	n/a	n/a	162,000,000
<i>Prison treatment*</i>	<i>76,000,000</i>	<i>n/a</i>	<i>n/a</i>	<i>76,000,000</i>
<i>Kinship carers*</i>	<i>n/a</i>	<i>73,000,000</i>	<i>n/a</i>	<i>73,000,000</i>
<i>Adult social care*</i>	<i>14,000,000</i>	<i>n/a</i>	<i>n/a</i>	<i>14,000,000</i>
Media and information activities	500,000	n/a	n/a	500,000
TOTAL	8,865,500,000	3,782,000,000	6,677,000,000	19,324,500,000

*21% of total costs have not been estimated before

Direct costs - reflect the diversion of resources towards the management of drug use, for example police services and health care

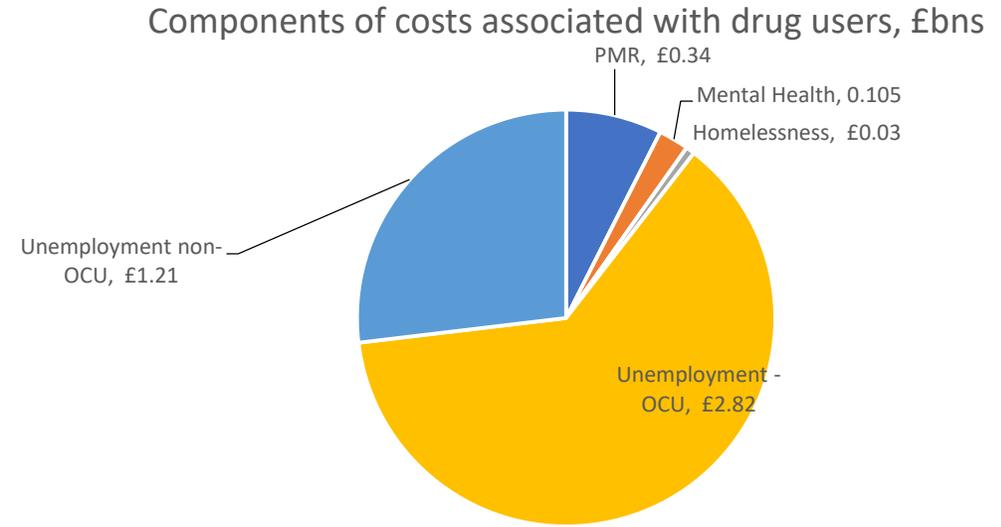
Indirect costs - represent the resources unavailable for productive use because of drug use, for example absenteeism, or in the case of crime, the cost to avert future victimisation through defence and insurance policies

Intangible costs - are a non-monetary valuation of an individual's willingness-to-pay to avoid pain, grief and suffering or loss in length and quality of life and can be expressed as quality-adjusted life years (QALYs) or as statistical life years (SLYs)

There are also substantial social and economic costs associated with people with drug problems

These are the costs that do not directly result from drug use (there is no direct causal link) but we assume there is an association, for example, in many cases someone with an untreated drug problem may struggle to hold down a job.

- The total cost associated with people with drug problems in England was £4.5 billion for 2017-18
- The costs of unemployment associated with drug users were the main driver of total costs, with costs amounting to £4 billion in 2017-18
- Almost three-quarters (70%) of the costs of unemployment were associated with opioid and/or crack cocaine users
- The costs of people with co-existing mental health disorders and substance misuse were estimated at £105 million in 2017-18
- The majority of the costs associated with drug use are indirect costs related to lost outputs from the labour market

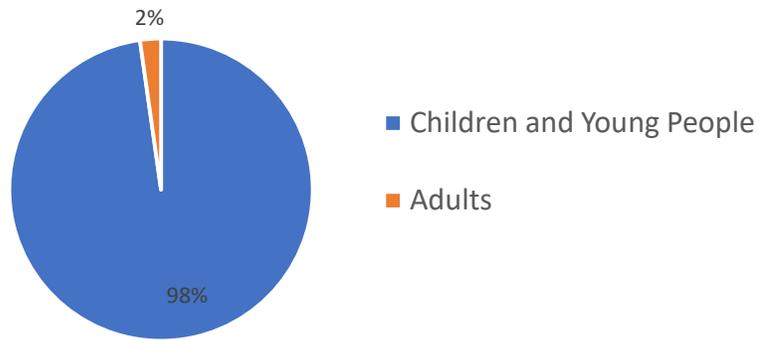


Due to limitations in available data, the costs we present should be considered as an illustrative estimate and represent a step towards estimating the total cost associated with each cost component

Cost component	Direct cost (£s)	Indirect Cost (£s)	Intangible costs (£s)	Total cost (£s)
Unemployment	n/a	4,032,000,000	n/a	4,032,000,000
Long term prescribing of medicines liable to dependency	335,000,000	n/a	n/a	335,000,000
Mental Health	105,000,000	n/a	n/a	105,000,000
Homelessness	31,000,000	n/a	n/a	31,000,000
TOTAL	471,000,000	4,032,000,000	n/a	4,503,000,000

The impact of drug use on social care

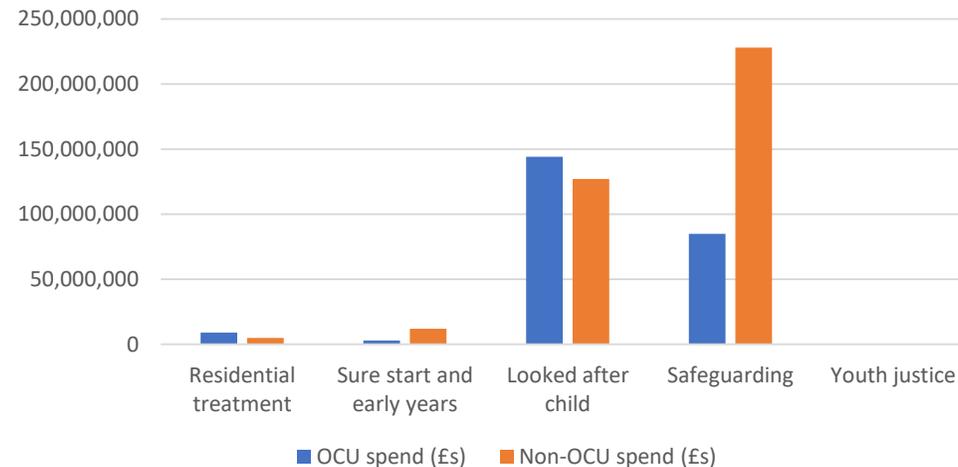
Estimated drug related social care spend by type of care, 2017-18



- The harms associated with drug-related social care are estimated at £630 million.
- These costs are driven by the social care support provided to children and young people who are affected by drug use/users.
- The table below shows the fraction of relevant types of social care that are estimated to be associated with drug use/users.

Type of social care service	Total spend (£s)	Fraction estimated to be drug-related	Total drug-related spend (£s)
Sure Start and Early years	481,000,000	3%	15,000,000
Looked after children (LAC)	4,285,000,000	6%	270,000,000
Youth justice	201,000,000	8%	16,000,000
Safeguarding	2,127,000,000	15%	312,000,000
Adult substance misuse support - residential treatment	22,000,000	65%	14,000,000

Spend on social care by type of dependency, 2017-18



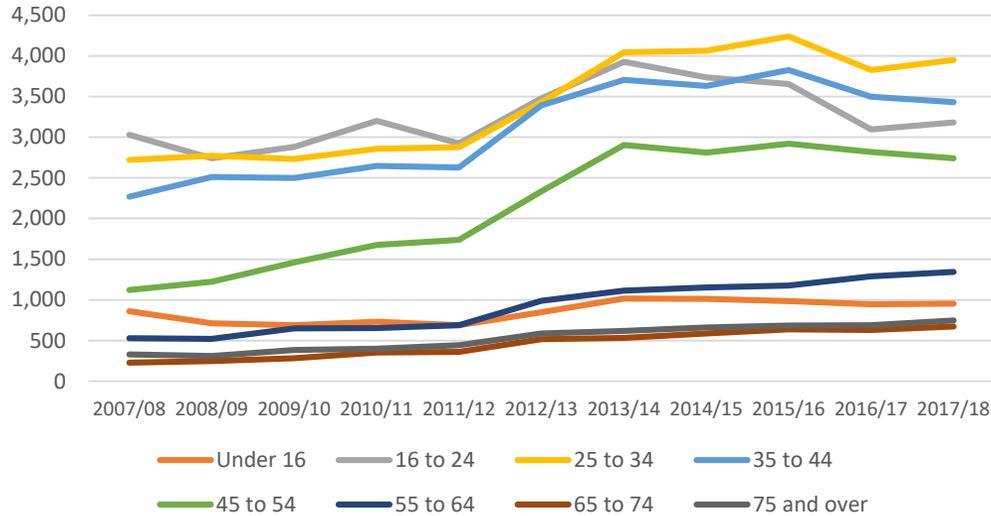
- Almost two-thirds of total spend on social care was related to non-opiate and/or crack cocaine use/users.
- However, it is estimated total spend is greater on opioid and/or crack cocaine use/users in residential treatment for adults.

Research shows that treatment for dependent drug users can reduce the cost of drug related social care by 31%.

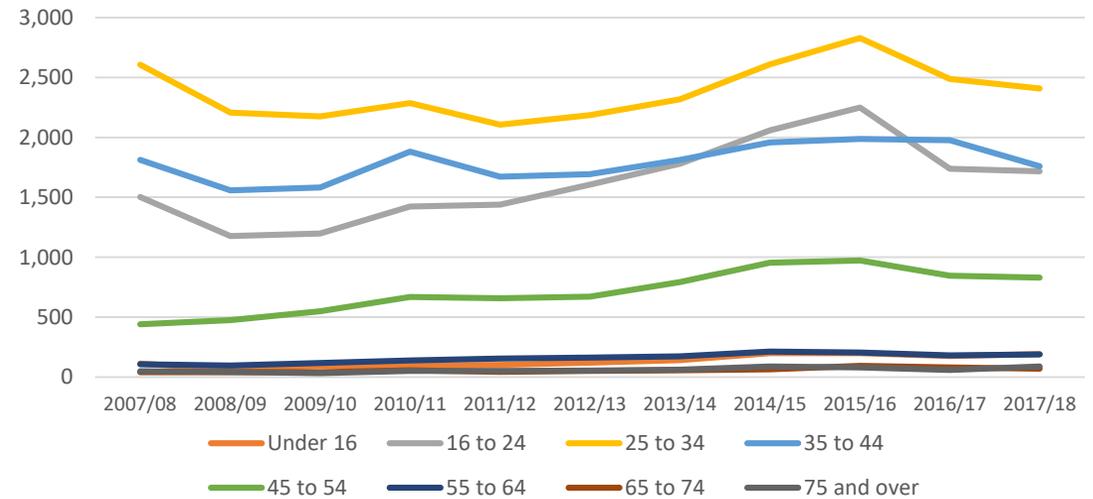
Source: i) [Local Authority revenue statistics](#), Ministry of Housing, Communities and Local Government 2018; ii) [Children in need and child protection statistics](#), Department for Education 2018; iii) [Youth Justice Statistics](#), Youth Justice Board / Ministry of Justice 2019 iv) [why invest drugs and alcohol](#), Public Health England

Direct impact of drug use on secondary care

Admissions in England with a primary diagnosis of poisoning by drug misuse, by age group



Admissions with a primary diagnosis of drug-related mental and behavioural disorders, by age group



- Overdoses and poisonings were the main driver of hospital admissions wholly attributable to drugs.
- There has been an increase in admissions for drug poisonings in most age groups.
- Opiates make up most of the hospital admissions.
- The harms associated with wholly drug-related hospital admissions are estimated at £37 million. This cost includes admissions for mental and behavioural disorders, overdoses and poisonings, and drug-related neonatal disorders.

- The increase in admissions for drug-related mental and behavioural disorders has been driven by those under 35.
- Multiple drug use makes up nearly half the presentations followed by opioids and cannabinoids.
- In 2017-18, over 80% of mental and behavioural disorder admissions were via A&E and 99% of poisoning admissions were via A&E also.

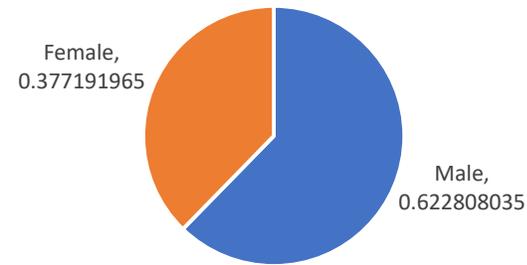
Type of hospital admission	Total no. of drug-related admissions	Total no. of drug-related admissions, emergency
Mental and behavioural disorders	7,721	6,484
Overdoses and poisonings	17,221	17,150
Drug-related neonatal disorders	735	61

Source: [i\)hospital admissions for drug misuse NHS digital](#)

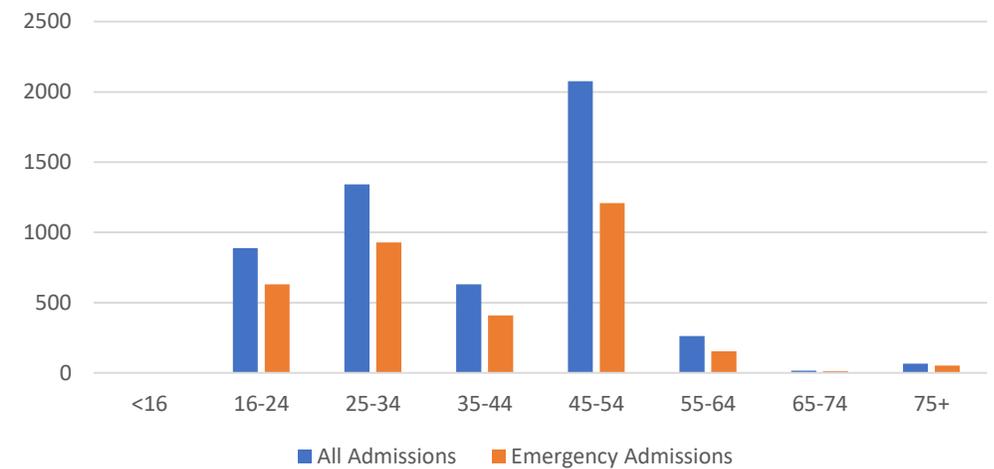
Drug use will also be the reason for other types of hospital admissions

- The use of drugs will also be a factor in other admission types apart from non-fatal poisonings and behavioural disorders
- These are referred to as partially attributable admissions
- The largest other admission type that is drug-related is for suicide or self harm, where it is estimated that there were about 60,000 admissions in 2017-18, nearly all via A&E.
- Nearly two-thirds of these admissions were for men.
- Admissions for schizophrenia and assault/homicide are the next largest groups accounting for 13,000 admissions and nearly 10,000 A&E attendances.

Proportion of suicide/intentional self-harm hospital admissions, 2017/18



Age of admission for schizophrenia, 2017/18



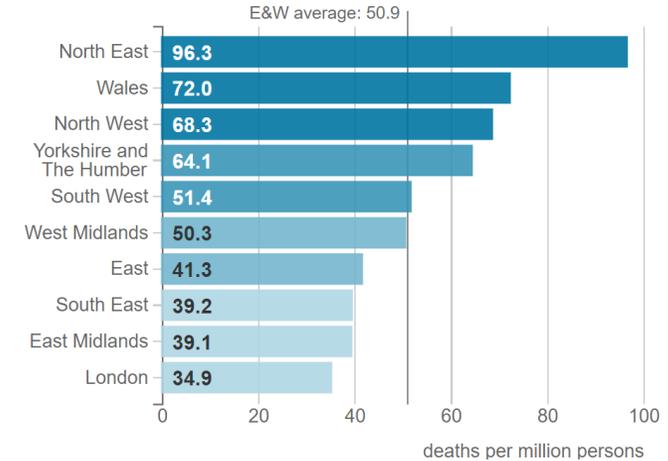
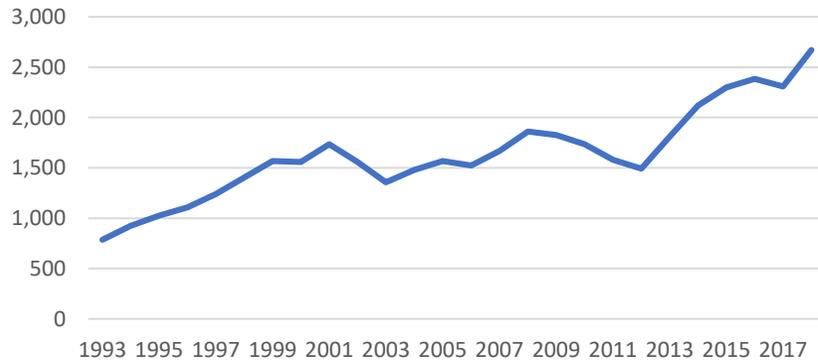
- A notable driver of partially attributable admissions was schizophrenia
- In 2017-18, approximately 39% of admissions occurred in the 45-54 year old age group.
- The total cost of all harms associated with partially drug-related hospital admissions are estimated at £156m.

Type of hospital admission	Total no. of admissions	Total no. of admissions, emergency	Fraction estimated to be drug-related	Estimated drug-related admissions	Estimated drug-related admissions, emergency
Suicide/intentional self-harm	189,607	187,089	31.90%	60,538	59,727
Schizophrenia	119,101	78,370	4.40%	5,284	3,396
Assault/homicide	35,637	27,484	22.10%	7,876	6,074
Antepartum haemorrhage	87,530	23,692	1.10%	1,000	279
Low birth weight	125,787	6,021	1.40%	1,761	84

Research shows treatment for drug users can reduce the cost of drug related hospital attendances by 31%.

Deaths from drug misuse poisonings have increased substantially over the last seven years with those in the most deprived areas disproportionately affected

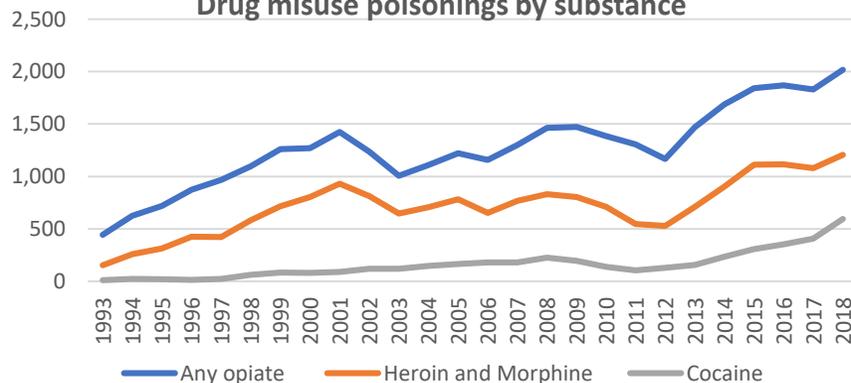
England drug misuse poisonings



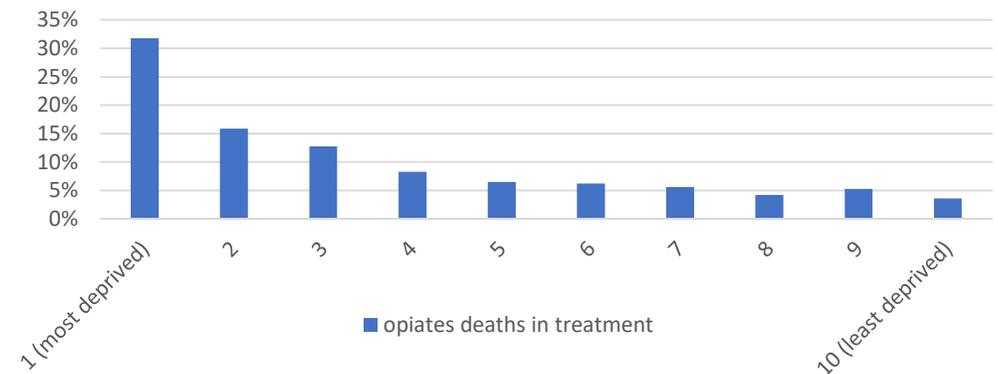
- Drug misuse poisoning deaths have increased by nearly 80% since 2012.
- In the main this has been driven by increases in heroin deaths which have doubled, though other substances such as cocaine have seen notable recent increases.
- Homeless deaths increased by 22% in 2018 in the main driven by a 55% increase in drug poisonings among this population.

- The rate of deaths in the North East is nearly three times that of London with the North generally having much higher rates than the rest of the country.
- The rate of deaths of heroin users in treatment is over six times higher in the most deprived areas compared to the least.
- The harms associated with drug misuse poisonings are estimated at over £5 billion

Drug misuse poisonings by substance



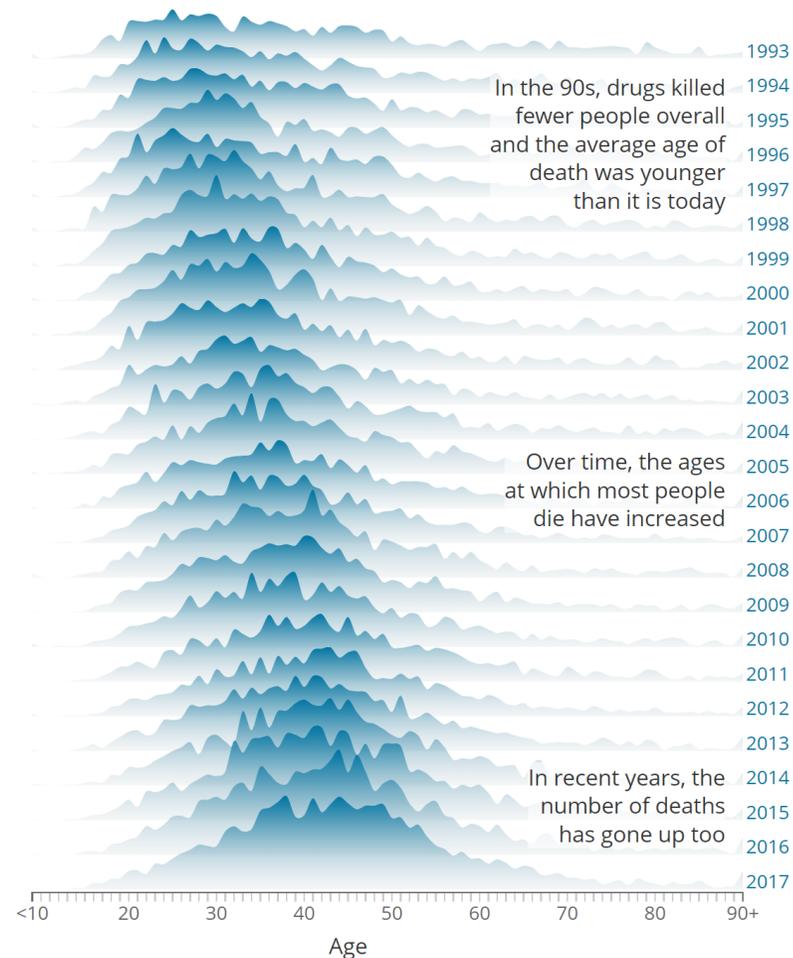
In treatment deaths by deprivation



Source: i) [Drug-related deaths statistics](#), Office for National Statistics 2019; ii) unpublished NDTMS data

Poisonings from drug misuse have primarily affected a generation, who are now in their 40s and 50s

Number of drug poisonings by single year of age, England and Wales, deaths registered between 1993 and 2017



- A generation of people born in the 1960s and 1970s, are dying from drug poisoning (and suicides) in greater numbers year on year.
- The age at which most people died by taking their own lives or drug poisoning was concentrated around this generation, who were in their 20s in the late 1980s to early 1990s.
- Since that time, deaths from these two causes have continued to affect the same generation, who are currently in their 40s and 50s to a higher degree than any other.
- Similar patterns have been observed in Canada and the US.
- The difference in the rate of deaths between the most deprived quintile and the least is most pronounced in these age groups with the rates being 10 times higher for people aged in their mid 40s.

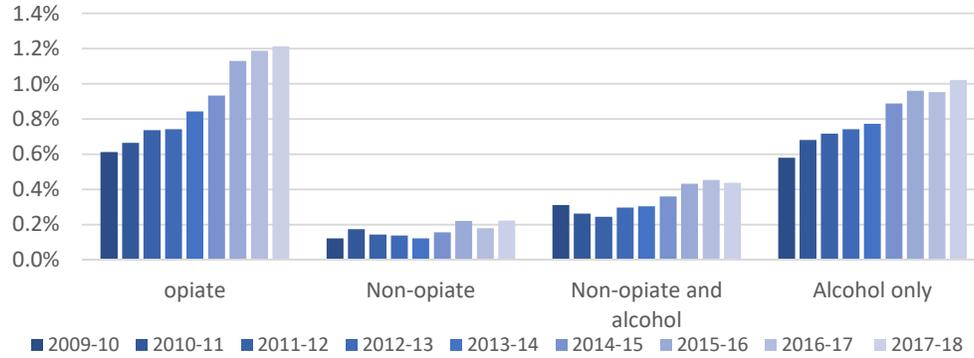
Drug poisonings by IMD quintile and single year of age, England, registered between 2013 and 2017



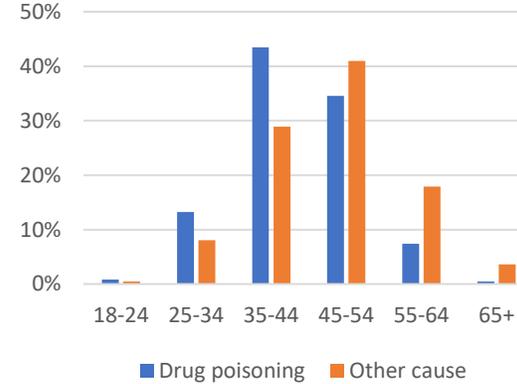
Source: i) [Drug-related deaths statistics](#), Office for National Statistics 2019;

However drug misuse poisonings are likely to be a smaller subset of the overall number of annual deaths related to drug use

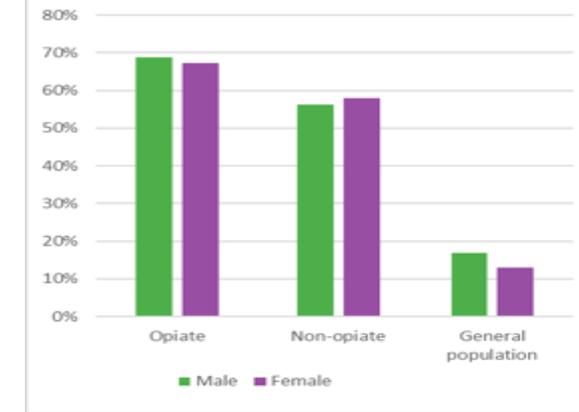
Proportion of deaths out of all in treatment



Age of opiate deaths by cause



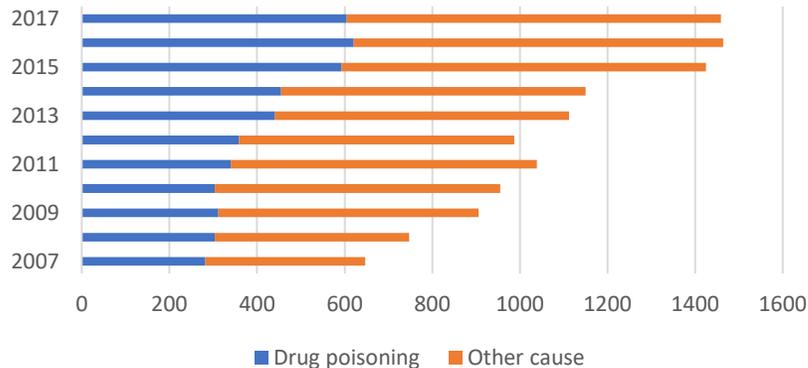
Smoking rates at treatment start



- While research has demonstrated treatment is very protective against premature mortality, deaths during treatment have doubled since 2009-10.
- In 2017 about 60% of deaths of opiate users in treatment were from causes other than a drug misuse poisoning (chart below)

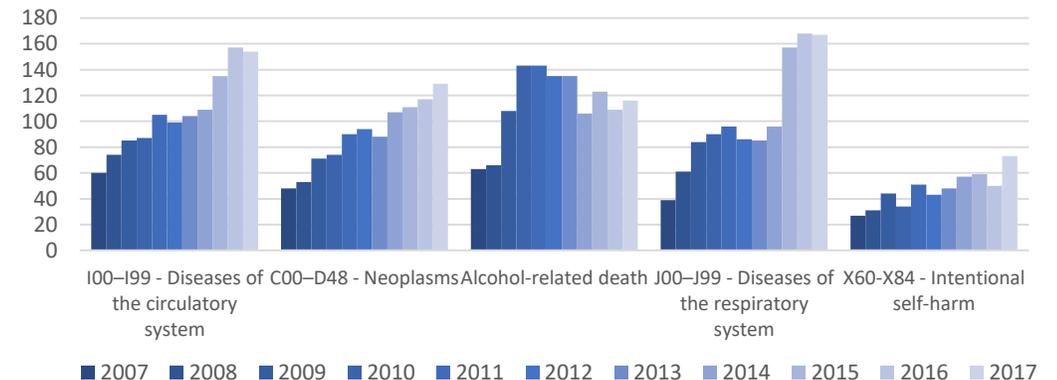
- Opiate users dying of other causes are generally a little older than those dying of drug poisonings, but not substantially so and 95% are under 65.
- Risky behaviours such as smoking and injecting will likely increase mortality risks
- Nearly all disease condition types for those dying of other causes have seen increases apart from alcohol-related deaths, which have fallen since 2013.

Cause of death of opiate patients dying in contact with treatment



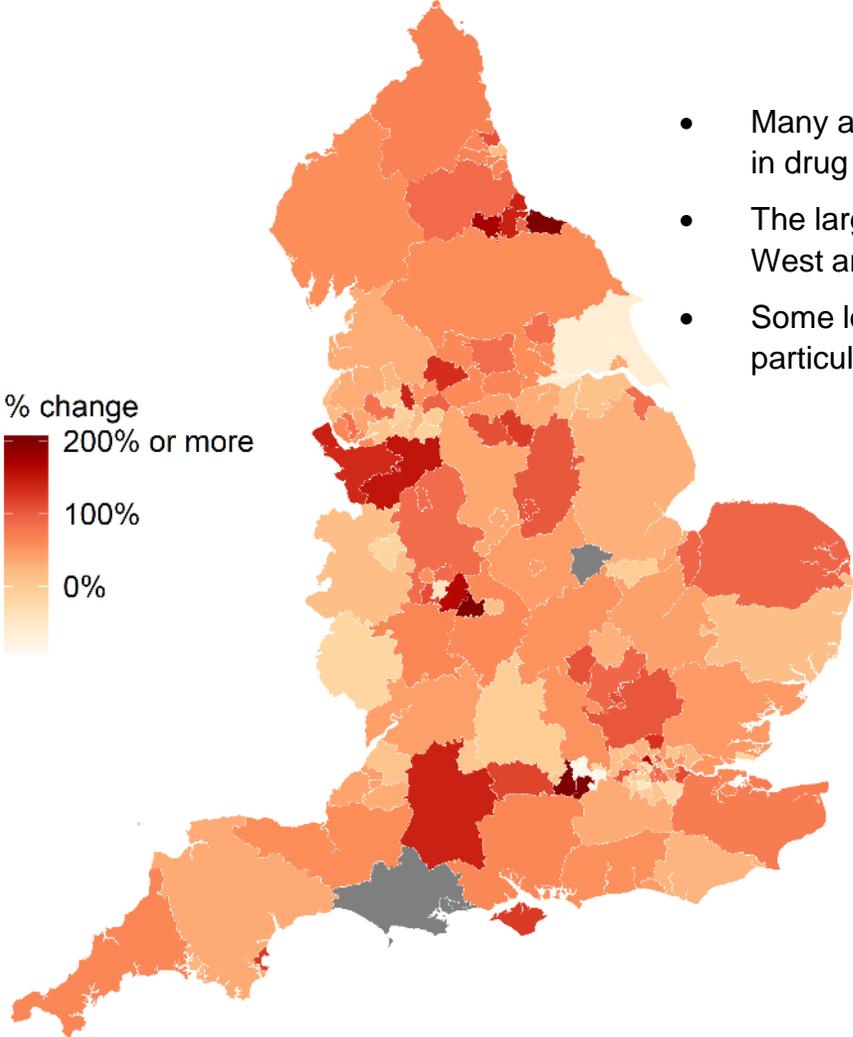
It is estimated that there could have been closer to 5,000 drug-related deaths in 2018 making up a sizable proportion of all deaths in the under 50s

Reasons for death of opiate patients in contact with treatment



Local changes in drug misuse deaths and deaths in treatment

Change in number of drug misuse poisoning deaths from 2010-12 to 2016-18 -% change (areas capped at 200%)



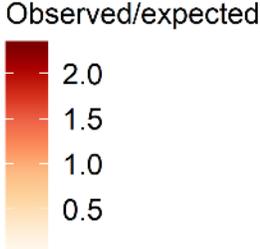
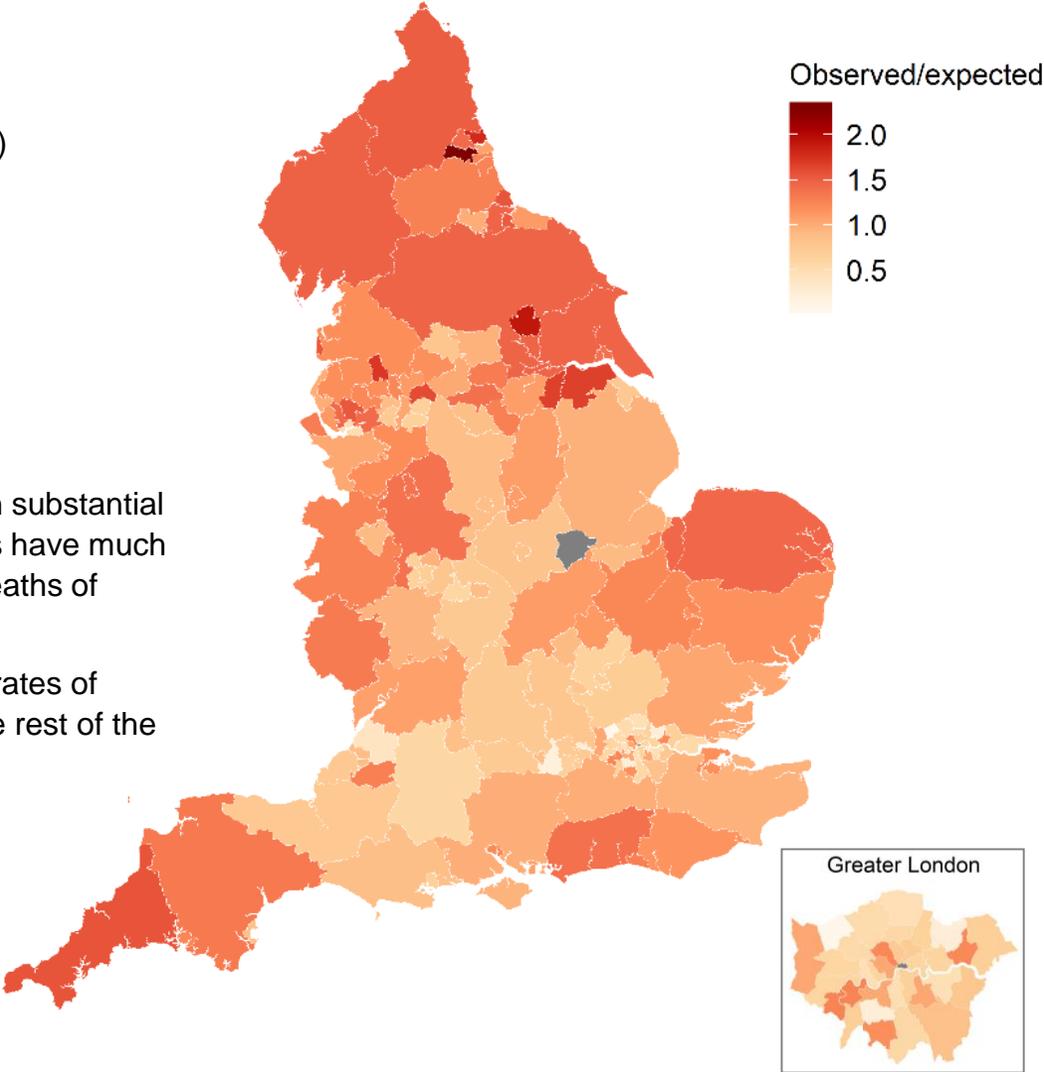
- Many areas have seen a doubling (or even greater) in drug misuse deaths since 2010-12
- The largest increases have been seen in the North West and areas of the North East
- Some local authorities have seen decreases, particularly London

- A lot of the areas that have seen substantial increases in drug misuse deaths have much higher than expected rates of deaths of people dying during treatment
- Again, London has much lower rates of deaths during treatment than the rest of the country



Grey areas indicate low numbers or missing data

Deaths in treatment – observed / expected 2018-19



Grey areas indicate low numbers or missing data

Source: i) [Drug-related deaths statistics](#), Office for National Statistics 2019; ii) unpublished NDTMS data

Drug-related deaths summary

- Drug-related deaths have increased substantially over the last six years. There will also have been significant increases in premature mortality of drug users that are not reported as drug poisonings.
- Drug poisonings have increased disproportionately among homeless populations. Targeted interventions, policies and funding are needed to help prevent these deaths.
- Many heroin users are in ill health after many years of drug use. Treatment and local health services will need to ensure palliative care is provided appropriately to all those that need it.
- Drug users entering treatment have smoking rates over four times the general population.
- There is significant local authority variation in the rates of death of people dying while in treatment.
- Cocaine and crack cocaine deaths have increased over five fold since 2012 and increased crack use among long-term heroin users is likely to be raising the mortality risk for this cohort
- Drug dependence and death rates are far more prevalent in deprived areas and the North of the country.
- It is likely that drug-related deaths account for a sizable proportion of all deaths in those aged 20-50 and may well be contributing to the slow down in life expectancy in England (and the UK as Scotland is seeing large increases in drug deaths).
- Harms of most new psychoactive substances (NPS) are unknown but synthetic cannabinoid receptor agonists (SCRAs) are especially problematic, with growing reports of serious harm from some.

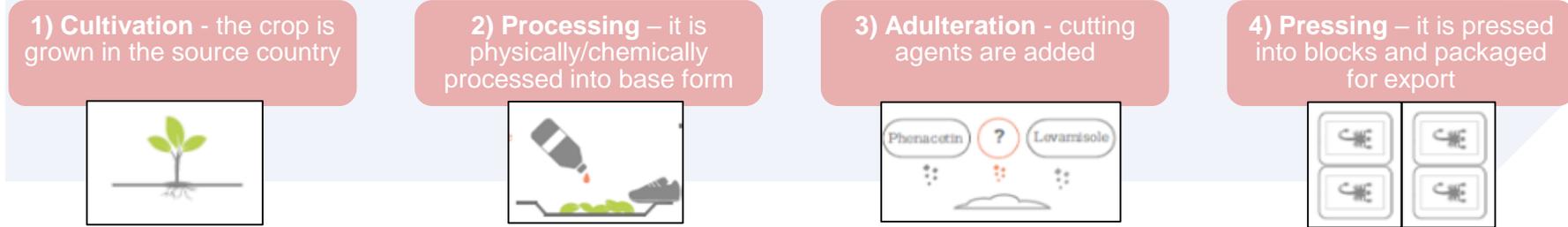
Key findings from Public Health England (PHE) investigation into the increase in drug poisonings and the Office for National Statistics (ONS) deep dive using coroners' records

- An ageing cohort of long-term heroin users, many of whom who will likely be in ill health.
- Increases in heroin purity following the drought.
- Increases in alcohol and polydrug use.
- The most commonly observed demographics and living circumstances (not necessarily in combination) were:
 - white
 - single or divorced
 - unemployed
 - male
 - living alone
- In at least two-thirds of cases, there was a mention of a mental health condition; only 14% had a record of being in contact with mental health treatment services when they died and 42% had no record of any such contact. Over a quarter had previously attempted suicide (increasing to half of those who died by suicide).
- A significant minority were reported as having suffered a chronic pain condition (29%) and many had been in receipt of a long-term prescription for pain.
- In three-quarters of cases, the individual was found having already died, and this was even more common where the person had been using alone and/or overdosed at their own home.

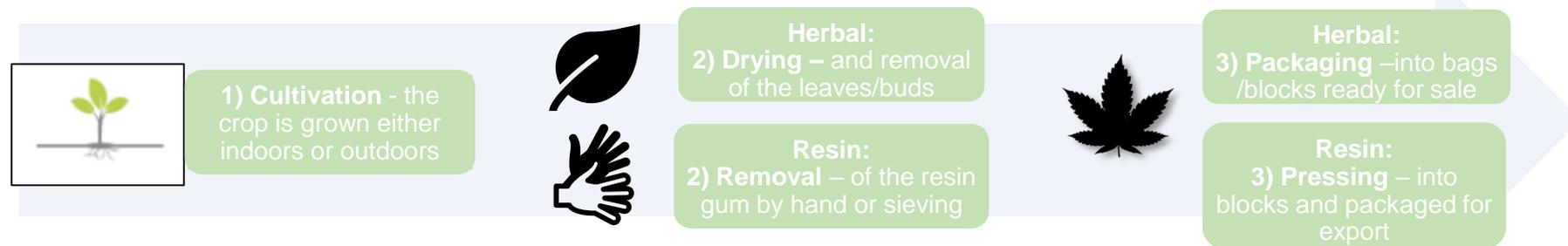
2. Drug production and trafficking to the UK

An overview of the drugs production process

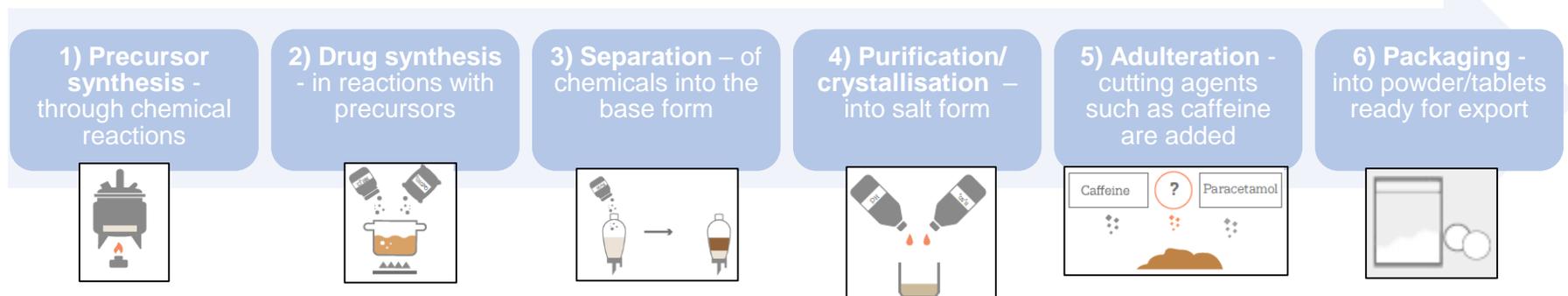
Heroin and cocaine



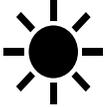
Cannabis



Synthetic drugs (ecstasy, amphetamines, fentanyl)



Comparing production by drug type

	Heroin and cocaine	Cannabis	Synthetics	Implications
Geographical scope of production	Limited to specific regions 	Can be grown anywhere 	Can be made anywhere 	<ul style="list-style-type: none"> Less data available on trafficking routes and total production of cannabis and synthetics. Production and trafficking routes of cannabis and synthetics may be more likely to move in response to changes in costs and risks.
Production environment	Outdoors 	Either indoors or outdoors 	Indoors 	<ul style="list-style-type: none"> Heroin and cocaine production are dependent on environmental factors such as the weather. Synthetics production is dependent on input chemicals and level of expertise.
Complexity of production	Semi-complex 	Simple 	Complex 	<ul style="list-style-type: none"> Low barriers to entry for cannabis production due to simplicity of cultivation process. Information on synthetics production is available on the internet, lowering barriers to entry.
Value per kilogram	Relatively high 	Low 	Very high for fentanyl 	<ul style="list-style-type: none"> Cheap drugs such as cannabis are less cost effective to transport in bulk. Valuable synthetics are less easily detected as they can be trafficked in small postal packages.
Size of processing facilities	Cocaine – large Heroin – small 	Range of small to large 	Large 	<ul style="list-style-type: none"> Larger processing facilities are easier to detect and dismantle. However, larger facilities benefit from greater efficiencies through economies of scale.

The economics of heroin and cocaine production

- There is significant scope for profit at every stage of the heroin and cocaine supply chains apart from production.
- The minimal value associated with source production means that eradication programmes often have little impact on the final street price of drugs.
- The profit margins at each stage of the supply chain reflect conventional business costs such as equipment and labour, but also the risks of detection by law enforcement.
- This means that the level of mark-up from source production to final product far outweighs that of licit products, with a 29,000% mark-up for heroin and a 5,000% mark-up for cocaine.
- Organised crime groups (OCGs) who are able to set up supply chains direct from the source country to the end market (such as Albanians with powder cocaine) are able to significantly cut costs and provide a consistent supply to retailers.

Distribution of profit across the heroin supply chain (per kg)



Distribution of profit across the cocaine supply chain (per kg)



Heroin production supply chain



Cocaine production supply chain



Transfer of goods/money (blue arrow)
Coercion/control (orange arrow)

Cocaine production

- Production is overseen by OCGs which exert **market power** using violence and intimidation to coerce growers into selling at a certain price and volume.
- This means that policies to increase costs for growers or promote alternative incomes are **likely to be ineffective**.
- This coercion means the supply chain is vertically integrated, so shocks spread **through the system quickly**.

Heroin production

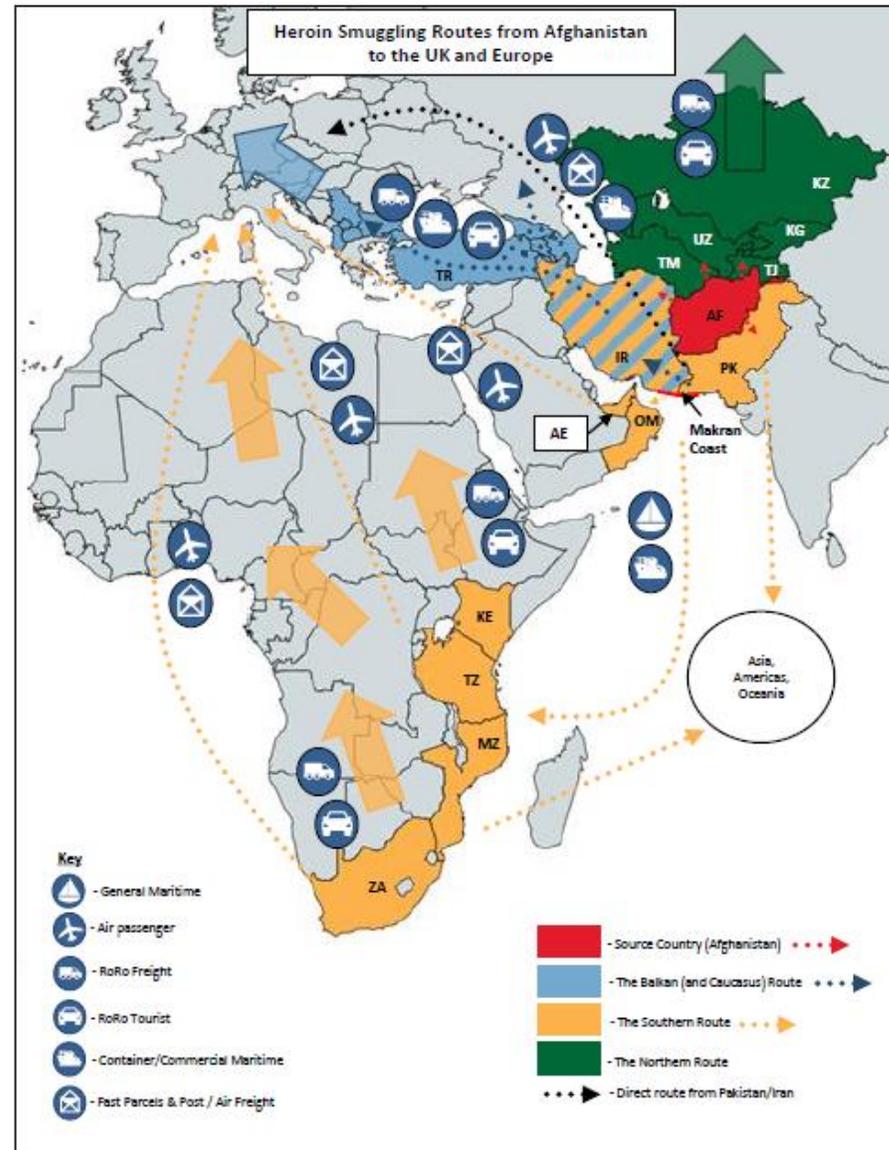
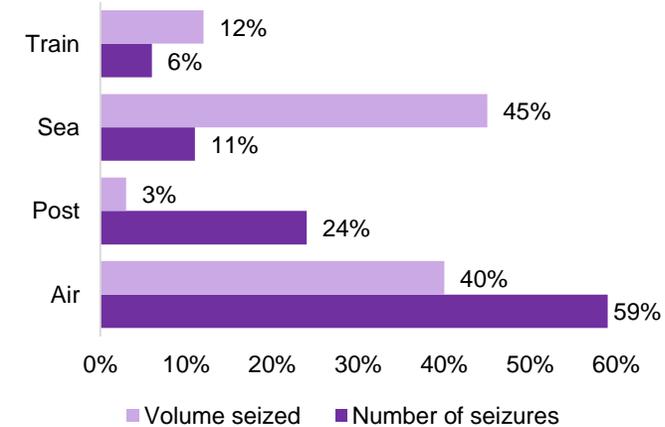
- Production is overseen by a large number of small tribal OCGs. They have less market power, as they tend to permit locals to grow poppy in their area **rather than coercing them** to do so.
- This means that policies focussing on **alternative incomes** for growers may be more effective for opium than for coca.
- Also, there is a **gap in the market** for an OCG to take end-to-end control of production, like for cocaine. This risk should be monitored during the Afghan peace process.
- The **disjointed, dispersed nature** of the supply chain means that coordination is likely to be a problem, and production shocks will take some time to spread through the supply chain.

Source: Unpublished Criminal Markets Analysis, Home Office SOCR, 2019

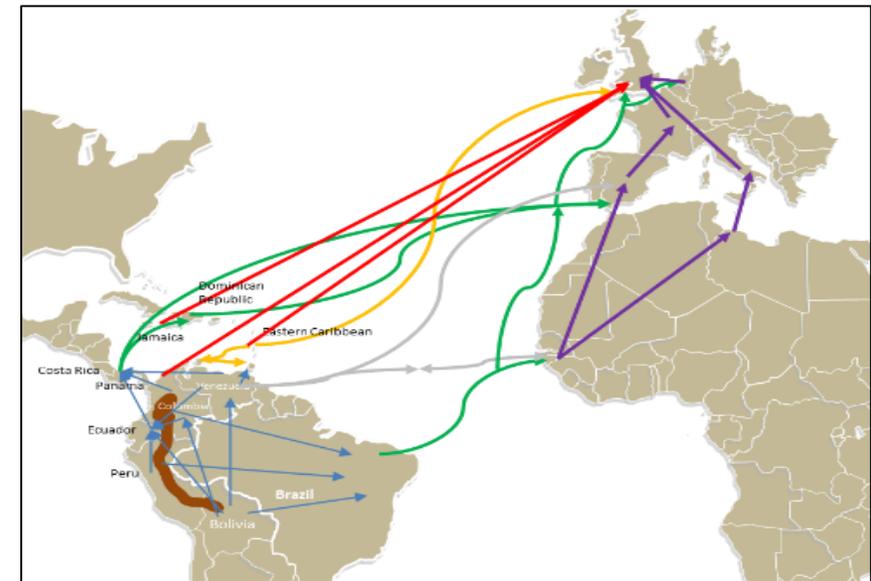
Heroin and cocaine trafficking routes

- There are three main heroin trafficking routes into the UK:
 - Balkan Route – via the Middle East and the Balkans
 - Northern Route – via Northern Asia into Russia and Northern Europe
 - Southern Route – via South and West Africa into Southern Europe
- The Balkan route is thought to be most frequently used. As shown below, a range of transport methods are employed.

Border Force heroin seizures by transport method (2015/16 to 2018/19)



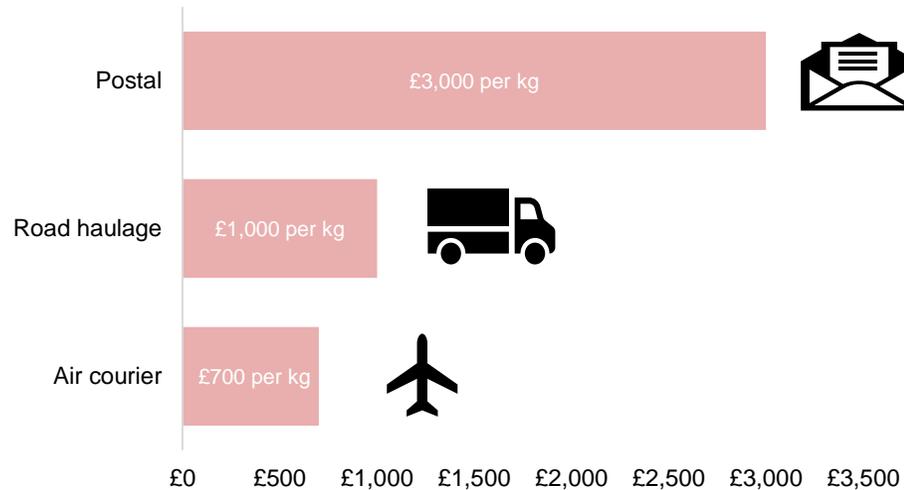
- Cocaine is trafficked into Southern Europe mainly using maritime transport, via Central America and the Caribbean, or via Western/Southern Africa.
- A significant amount of cocaine is trafficked via sea into Dutch and Belgian ports where the cocaine is stockpiled. It is then broken down to be transported into the UK in freight and tourist vehicles travelling through the South East (Dover, Channel Tunnel) or the East coast (e.g. Harwich port). Cocaine is also trafficked direct to the UK from South America via air.
- Colombian and Italian groups dominate wholesale cocaine supply into Europe in co-operation with other groups such as British, Dutch and Spanish OCGs. Western Balkan OCGs have significant control in the supply of cocaine to the UK.



Sources: i) Unpublished Criminal Markets Analysis, Home Office SOCRA, 2019 ii) Unpublished Heroin and Cocaine Threat Placemats, Border Force Intelligence Analysis 2019

Costs of heroin and cocaine trafficking

Heroin trafficking costs

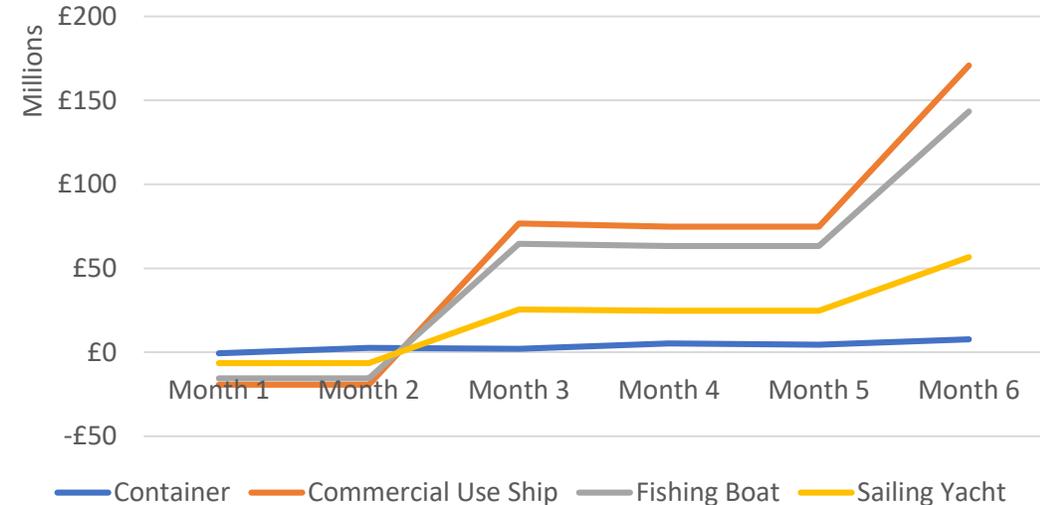


Cocaine maritime trafficking costs



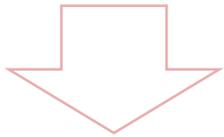
- The trafficking costs for heroin and cocaine are relatively similar, excluding postal methods. Once heroin and cocaine, and other drugs such as cannabis and ecstasy, reach Europe they are likely to be trafficked using the same methods, incurring similar costs.
- The chart opposite shows that within six months most maritime trafficking methods will yield over £50 million of profit.
- The profit from one successful shipment is sufficient to offset the losses of multiple shipments. This means seizures of cocaine are unlikely to materially affect established cocaine OCGs, and are only likely to affect OCGs in their infancy, before they have built up sufficient profits.

Estimated monthly profit from different cocaine trafficking methods

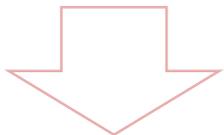


Trends in cocaine and heroin production

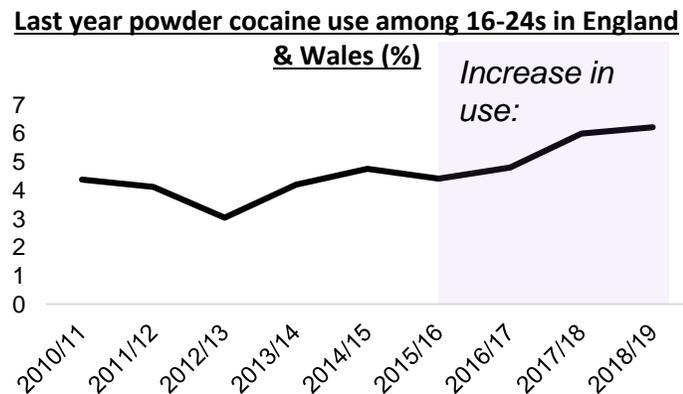
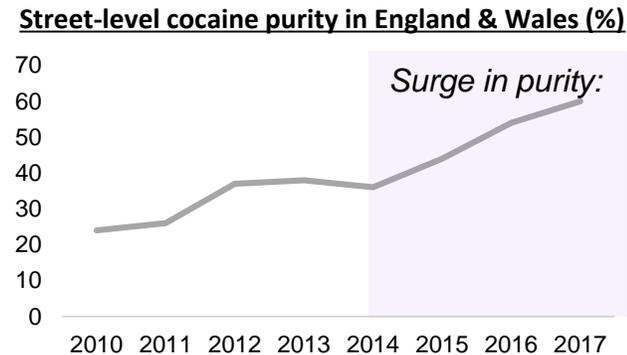
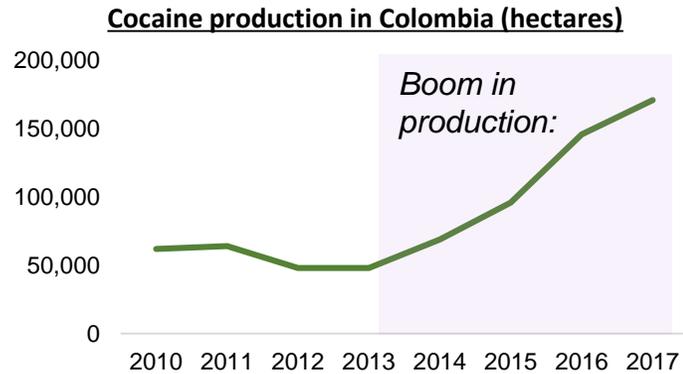
Cocaine production in Colombia has boomed in recent years



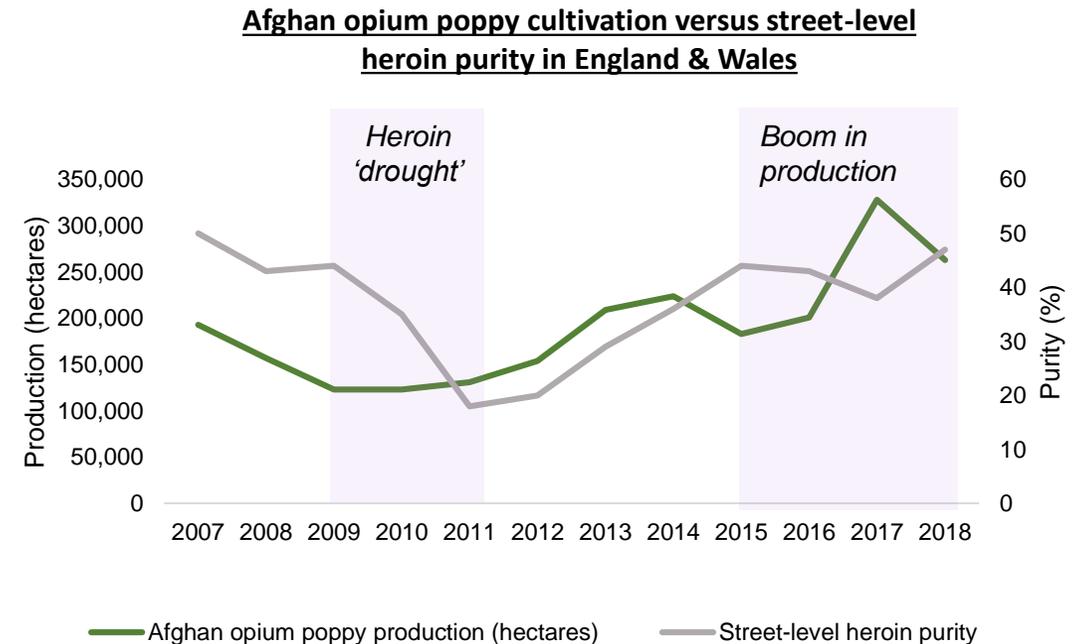
Which appears to have led to increased purity in England & Wales (and across Europe)



And this appears to have contributed to the increase in cocaine use in England & Wales (and across Europe)

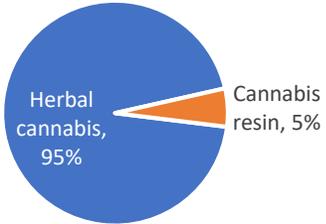


- As with cocaine, heroin production appears to be **closely associated with street-level purity**. Greater cocaine production also appears to be leading to increased consumption, with dealers aggressively selling the additional supply.
- Heroin purity is affected around a year after changes in production, which likely reflects the **disjointed nature of the heroin supply chain** (see slide 29).
- Opium production in Afghanistan reached record levels in 2017 and 2018, so going forward there is a **risk that this will affect heroin purity and use**.
- The Joint Narcotics Analysis Centre expects opium production to **continue to increase in the future**, due to uneven government eradication efforts, few financial alternatives for growers and Taliban inducements to grow poppy.



Cannabis production and trafficking

Cannabis seizures in England and Wales (2014/15 to 2018/19)



Herbal cannabis

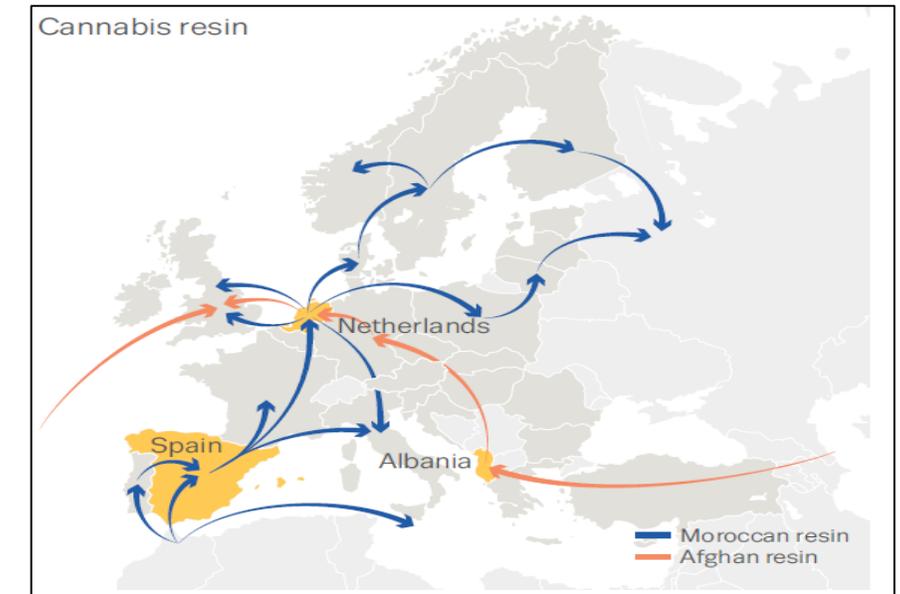
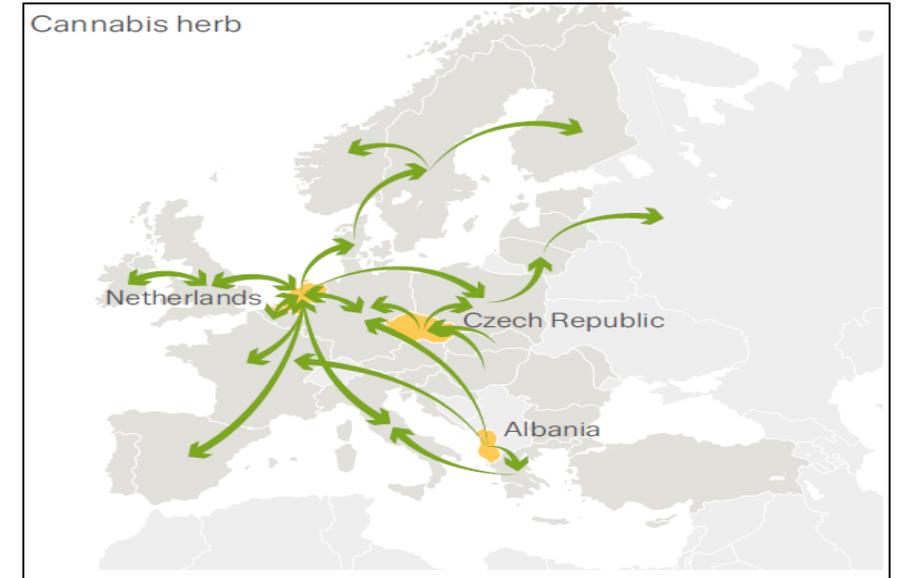
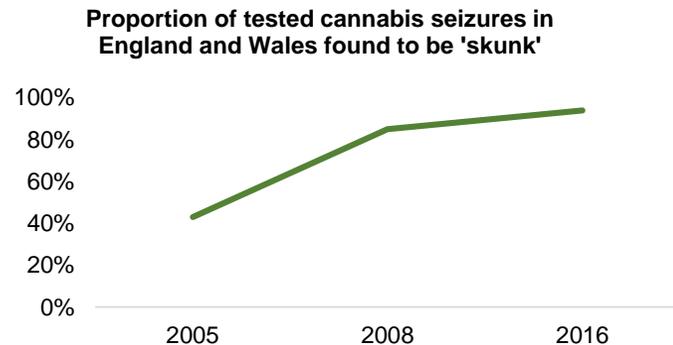
- Herbal cannabis is likely to be more prevalent than resin, given the larger quantity of herbal cannabis seized.
- It is thought that most UK herbal cannabis is domestically produced, but significant seizures at the border indicate that large quantities are also imported.
- Imported herbal cannabis comes from Albania and the Netherlands, as well as further afield such as Africa and the Caribbean.

Cannabis resin

- Cannabis resin is mainly imported.
- Resin is mainly imported from Morocco and Afghanistan. Moroccan cannabis is trafficked via Spain.
- Netherlands is an important distribution centre for cannabis resin, especially from Morocco, trafficked via Spain.

Cannabis potency

- The market has shifted towards much more potent 'skunk' products, which matches the wider European trend.
- Prices have remained stable, indicating that cannabis products now provide better 'value for money' for customers.

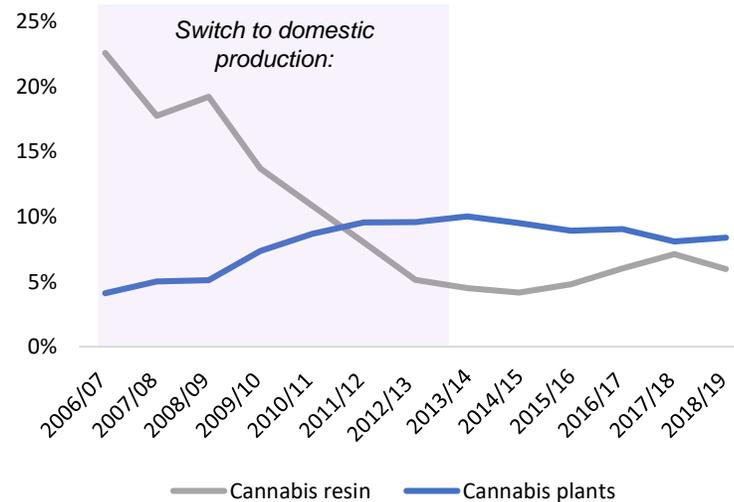


Domestic cannabis production

The scale of domestic cannabis production

- Between 2006/07 and 2011/12, cannabis seizures became more likely to involve plants and less likely to involve resin, which may indicate greater domestic production.
- This matches a wider European trend of greater within-country cannabis cultivation.
- However, this trend looks like it may now be starting to reverse in the UK.

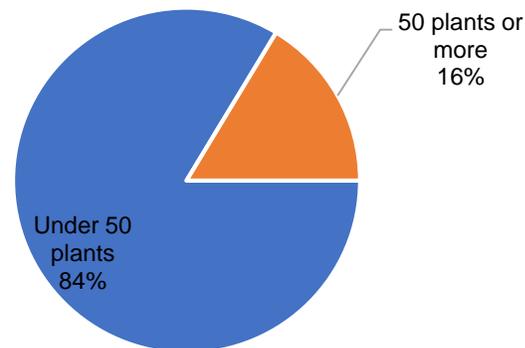
Proportion of police seizures of cannabis involving plants vs resin



Cannabis production by individuals

- There is a large number of small-scale seizures of cannabis plants in the UK, suggesting that there are many individuals or small groups growing cannabis.
- Some of these individuals/small groups are likely to be growing cannabis for their own consumption, while others may also be selling cannabis on a small scale.

Size of cannabis plant seizures by police forces in England & Wales, 2018/19



Cannabis cultivation by OCGs

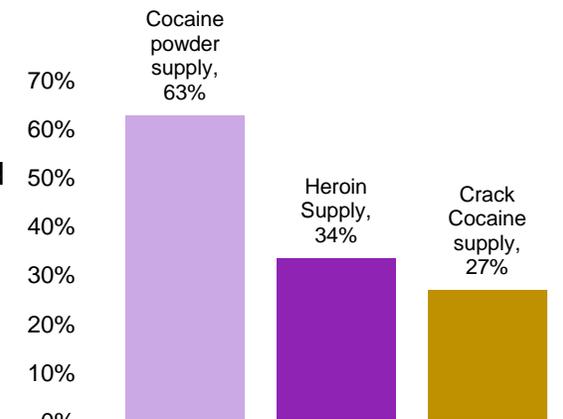
- There are also considerable levels of cannabis production by OCGs, with 364 OCGs known to be involved in cannabis cultivation in the UK in 2018. This represents 21% of all OCGs involved in drug supply.
- A number of foreign nationality OCGs from Vietnam and Albania are known to be involved in cannabis cultivation in the UK, although white British OCGs dominate in terms of the numbers of groups.

- Vietnamese and Albanian OCGs have been known to commit human trafficking and modern slavery offences whilst coercing individuals to work on cannabis farms.

- There are large overlaps between cannabis cultivation and the supply of other drug types, particularly powder cocaine.

- Albanian OCGs are thought to use cannabis farms to provide a stable income which can be reinvested in the more lucrative but riskier cocaine trade. This increases their resilience to outside shocks such as those from law enforcement.

Proportion of OCGs involved in cannabis cultivation who are also involved in other types of drug supply, Q2 2018



Synthetics production and trafficking

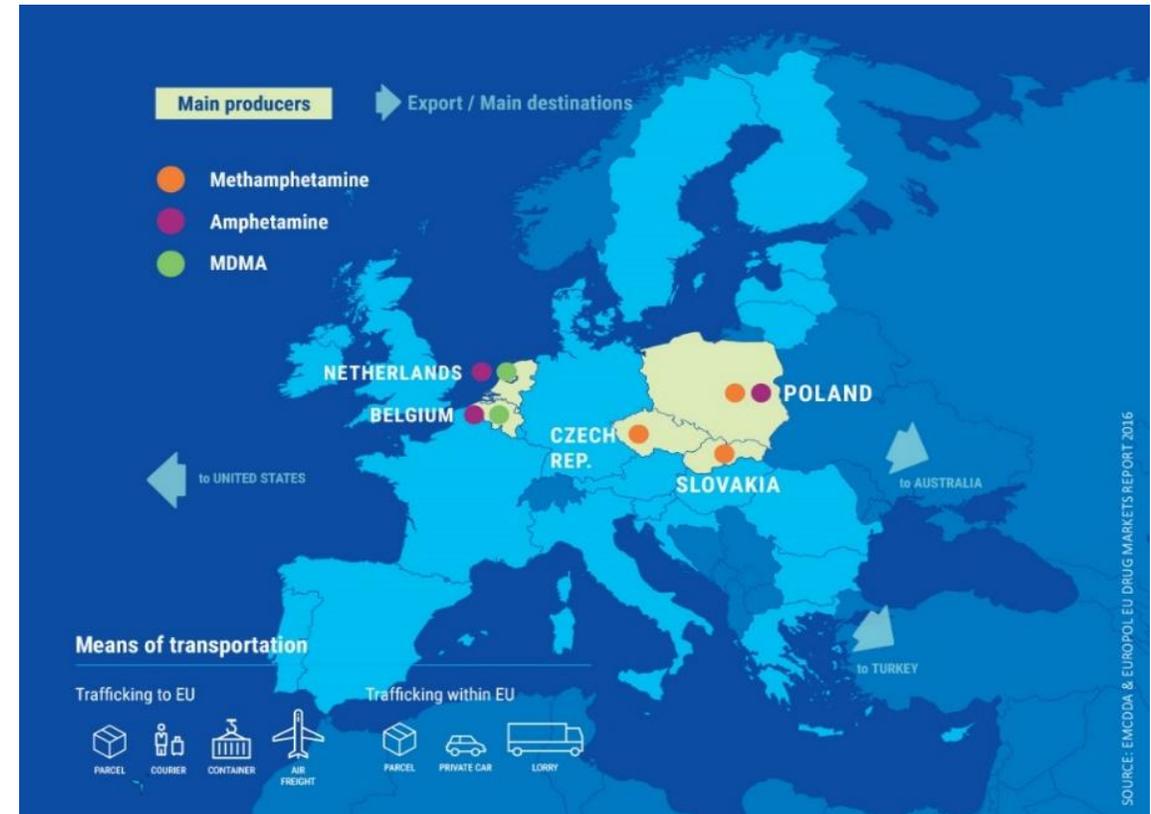
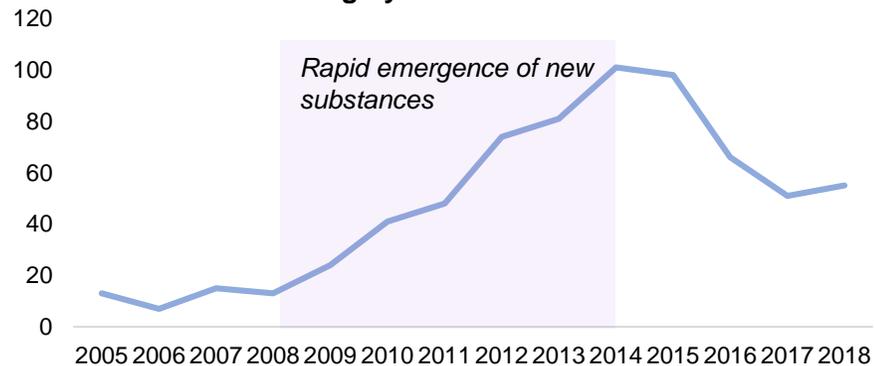
'Traditional' synthetics (MDMA and amphetamines)

- MDMA (known as ecstasy) and amphetamines are produced in the Netherlands and Belgium, although amphetamines are also produced in the UK.
- OCGs trafficking synthetic drugs are often involved in the supply of other substances, with Dutch and Belgian OCGs heavily involved.

'New synthetics'

- In the last decade a diverse range of new substances have been created to evade drug legislation.
- They are generally manufactured in bulk in China or India and shipped to the UK by air, sea or post.
- The market is now maturing, with the number of newly created substances slowing down. The main substances to establish a foothold in the UK are synthetic cannabinoids, often used among rough sleepers and prisoners.

New psychoactive substances notified to the EU Early Warning System for the first time



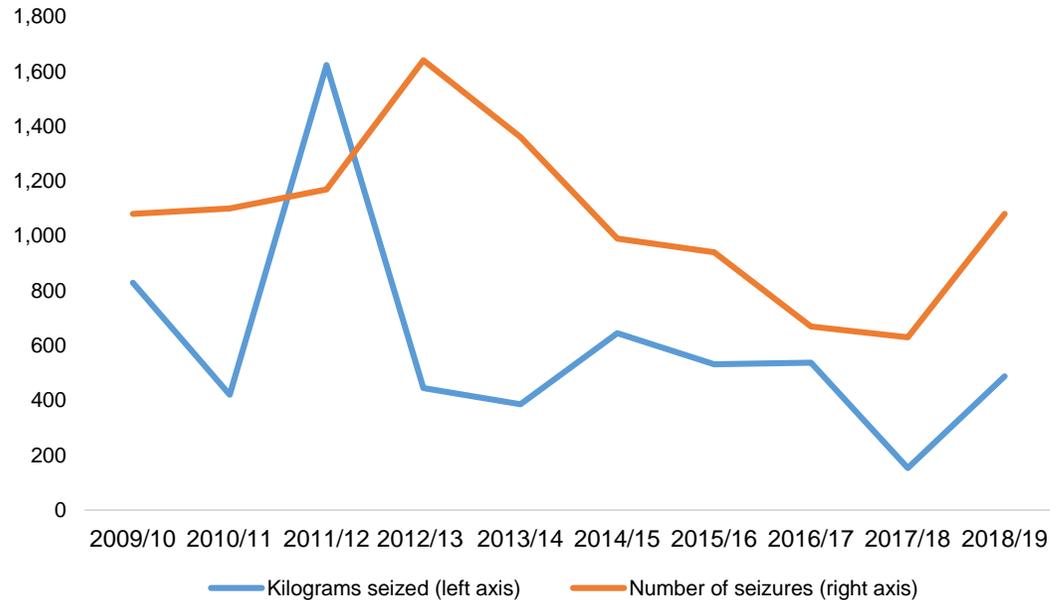
- Despite the slowdown in newly created substances there remains a very real threat of potent fentanyl or other synthetic opioids becoming more mainstream in the UK, bringing a risk of increased drug deaths and other harms, as witnessed in North America in recent years.
- Due to their high potency, synthetic opioids can be posted in relatively small parcels that are high value and difficult to detect.
- Border Force intercepted 68kg of Fentanyl in 2018/19.

Sources: i) [EU Drug Markets report](#), EMCDDA & Europol 2019 ii) Unpublished Home Office Drugs Review, NCA, 2019 iii) [European Drug Report 2019](#), EMCDDA 2019

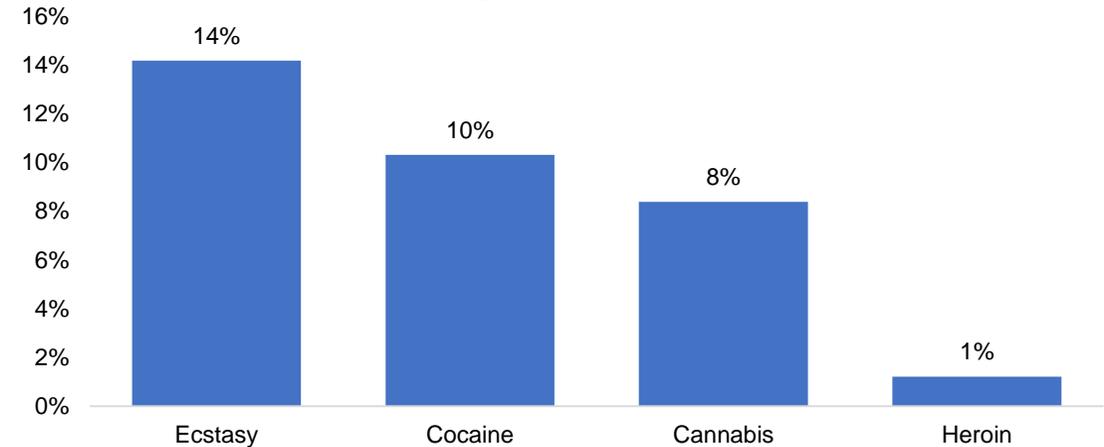
Border Force seizures

- Only a small proportion of the total drug supply entering the UK is seized by Border Force. OCGs will allow for a certain amount of losses through seizures when projecting their profits from trafficking.
- The largest proportions are seized for ecstasy (14%, ~800,000 doses per year seized) and cocaine (10%, ~4.5 tonnes per year seized).
- The lower proportion of cannabis seized is at least partially explained by the significant amount of domestic production.

Number and quantity of heroin seizures by Border Force



Estimated proportion of annual drug supply which is seized by Border Force

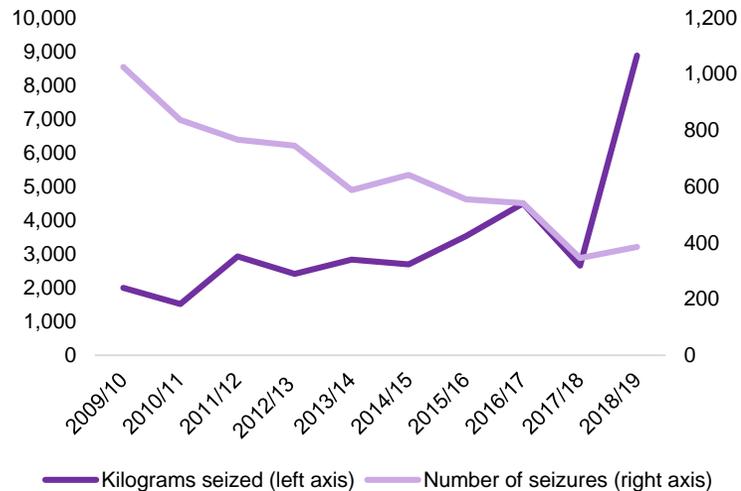


The chart above compares the average annual quantity of drugs seized by Border Force between 2014/15-2018/19 with the estimated quantity of drugs consumed in 2016/17.

- The proportion of heroin supply seized is particularly low. The reason for this is not known with certainty, but it may be due to greater diversification of heroin routes or more limited law enforcement intelligence on heroin trafficking.
- The number and quantity of heroin seizures has generally fallen in the last few years, indicating that heroin traffickers are increasingly able to avoid detection.
- However, this trend has reversed in 2018/19, with a sharp increase in the number of seizures and quantity seized.

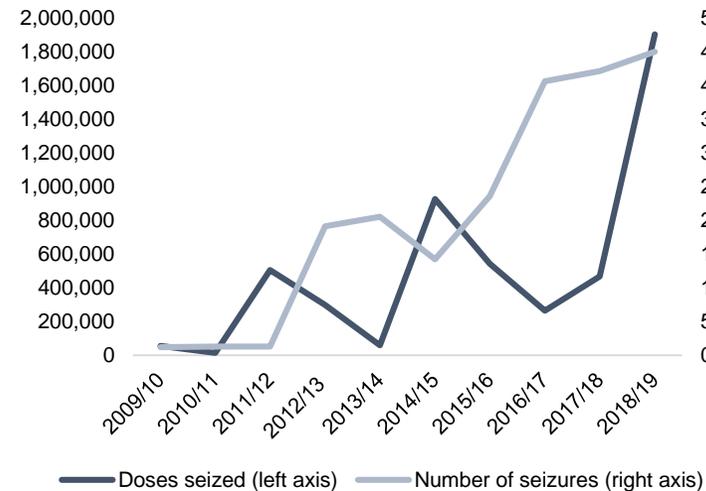
Border Force seizures (2)

Number and quantity of cocaine seizures by Border Force



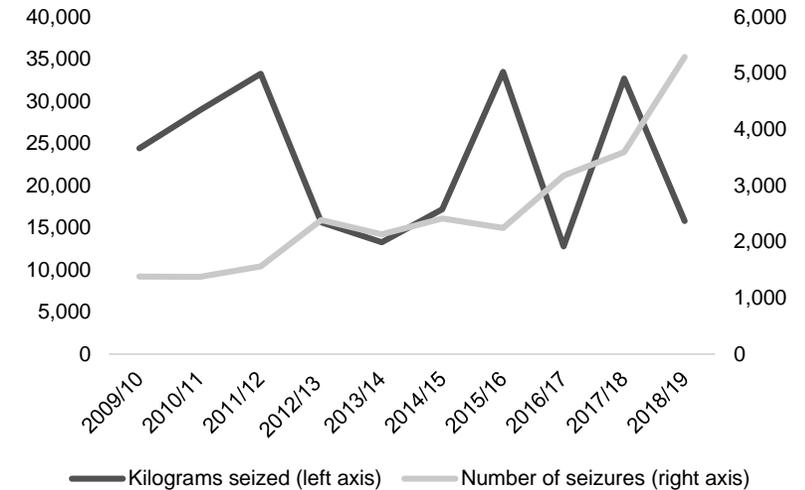
- The quantity of cocaine seized has followed a general upward trend in recent years, while the number of seizures has generally fallen. This includes a record quantity seized in 2018/19.
- Given that the purity and usage of both powder and crack cocaine have also increased in recent years, the increase in seizures is likely to reflect greater availability of cocaine.

Number and quantity of ecstasy seizures by Border Force



- Both the number and quantity of ecstasy seizures have increased considerably in recent years, with a large increase in the quantity seized in 2018/19.
- The rise in seizures appears to have outstripped the rise in ecstasy usage, suggesting an increase in detections by Border Force.

Number and quantity of cannabis seizures by Border Force



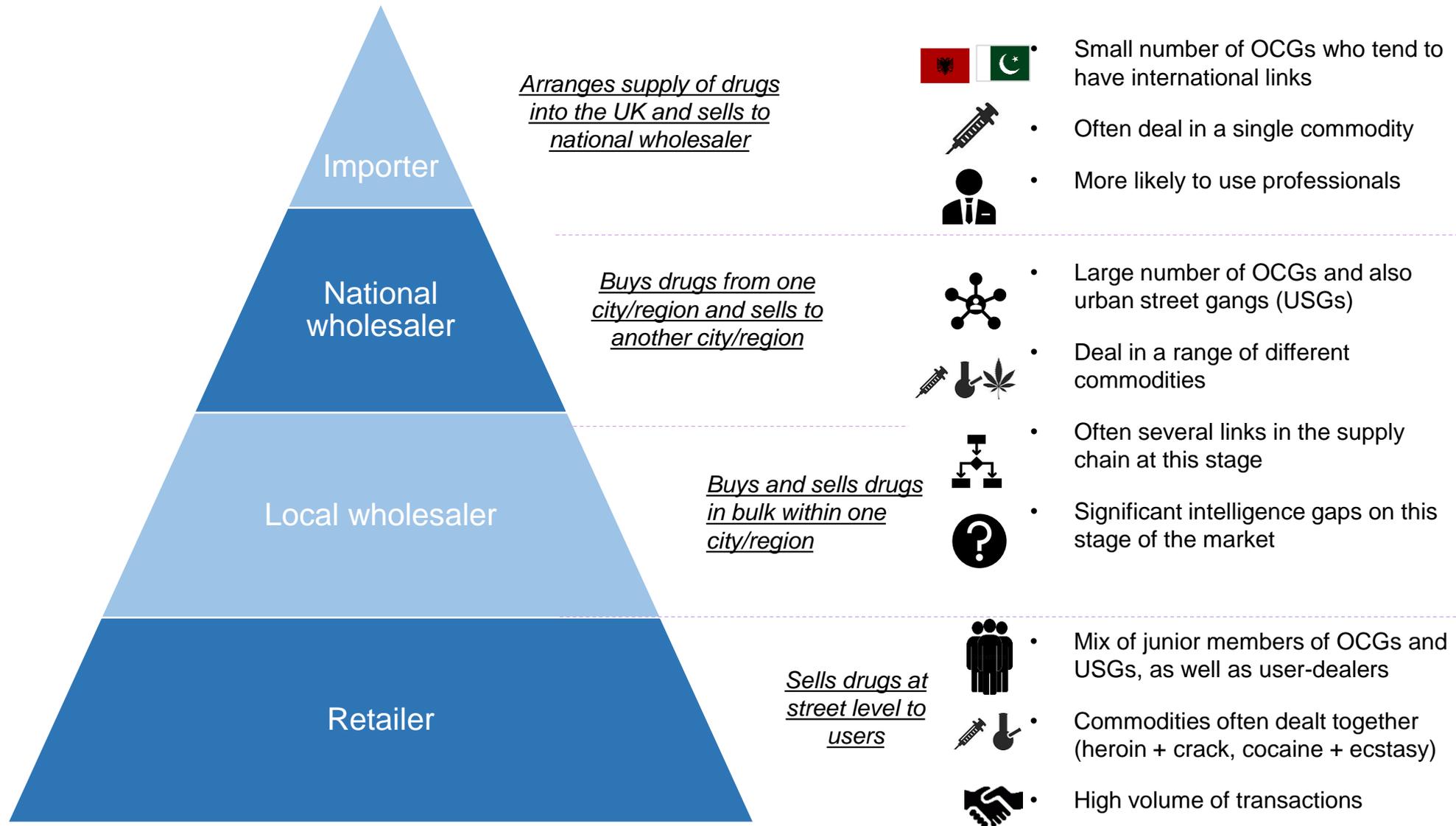
- The quantity of cannabis seized has fluctuated significantly in recent years while the number of seizures has increased.
- This may indicate that shipment sizes have fallen, which could be linked to increasing cannabis potency.
- The proportion of cannabis seizures involving the herbal variety has increased from around 50% to 80%.

Drug production and trafficking to the UK summary

- Most of the heroin imported into the UK is thought to originate from Afghanistan, often trafficked via the Balkans. The most common methods of importation are either by air or sea.
- Nearly all the cocaine imported into the UK is thought to originate from Colombia, and is often trafficked into Europe by sea before being transported onwards into the UK via freight or tourist vehicles.
- There appears to be a growing trend of more cannabis being domestically produced in the UK. Cannabis which is cultivated by Organised Crime Groups is often linked to exploitation and modern slavery offences.
- Traditional synthetics such as ecstasy and amphetamines tend to be produced in Belgium or the Netherlands, whereas newer psychoactive substances and synthetic opioids are often produced in China and India.
- The new synthetic opioids such as fentanyl are many times more potent than heroin and can be sent in smaller parcels in the post, making them difficult to detect. The increased potency poses a significant mortality and morbidity risk to users, many who will end up taking it by mistake.
- There has been a substantial boom in cocaine production since 2013, resulting in a surge in purity levels in England and Wales. The increased supply of cocaine is likely to have contributed to greater use of both cocaine powder and crack in recent years.
- Similar increases in heroin production have been seen in recent years, which appears to have led to an increase in purity, but does not appear to have affected consumption. Increased purity could be playing a part in increased heroin overdoses.
- A record quantity of cocaine was seized by Border Force in 2018-19, which is likely to reflect the greater supply and availability of cocaine. It is likely that Border Force is only capturing a relatively small proportion of the total volume of drugs entering the UK.

3. Domestic drug distribution

Overview of domestic drug distribution



Organised Crime Groups involved in drug distribution

	Powder cocaine 	Crack 	Heroin 	Cannabis 	Ecstasy 
Import OCGs	 219	n/a	 118	 111	 31
Supply OCGs (wholesale & retail)	 1,054	 606	 845	 836	 85
Number of users (in the last year)	 976,000	 181,000	 261,000	 2,572,000	 524,000
Estimated consumer expenditure	 £1.9 bn	 £1.3 bn	 £3.8 bn	 £2.4 bn	 £0.03 bn

A total of 1,745 OCGs are involved in drug supply or importation. One OCG can be involved in multiple drug types.

Characteristics of OCGs involved in drugs distribution

High level of organisation

(Defined as OCGs who are more likely to: use professional expertise, have high cash flow, own legitimate businesses)

Cannabis import



Cocaine import



Cannabis cultivation

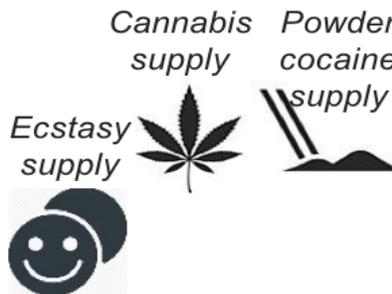


Heroin import



OCGs involved in the importation or production of drugs tend to be more organised and less violent

OCGs involved in wholesale and retail supply are less organised but more violent, particularly those supplying crack cocaine.



Heroin supply



Crack supply



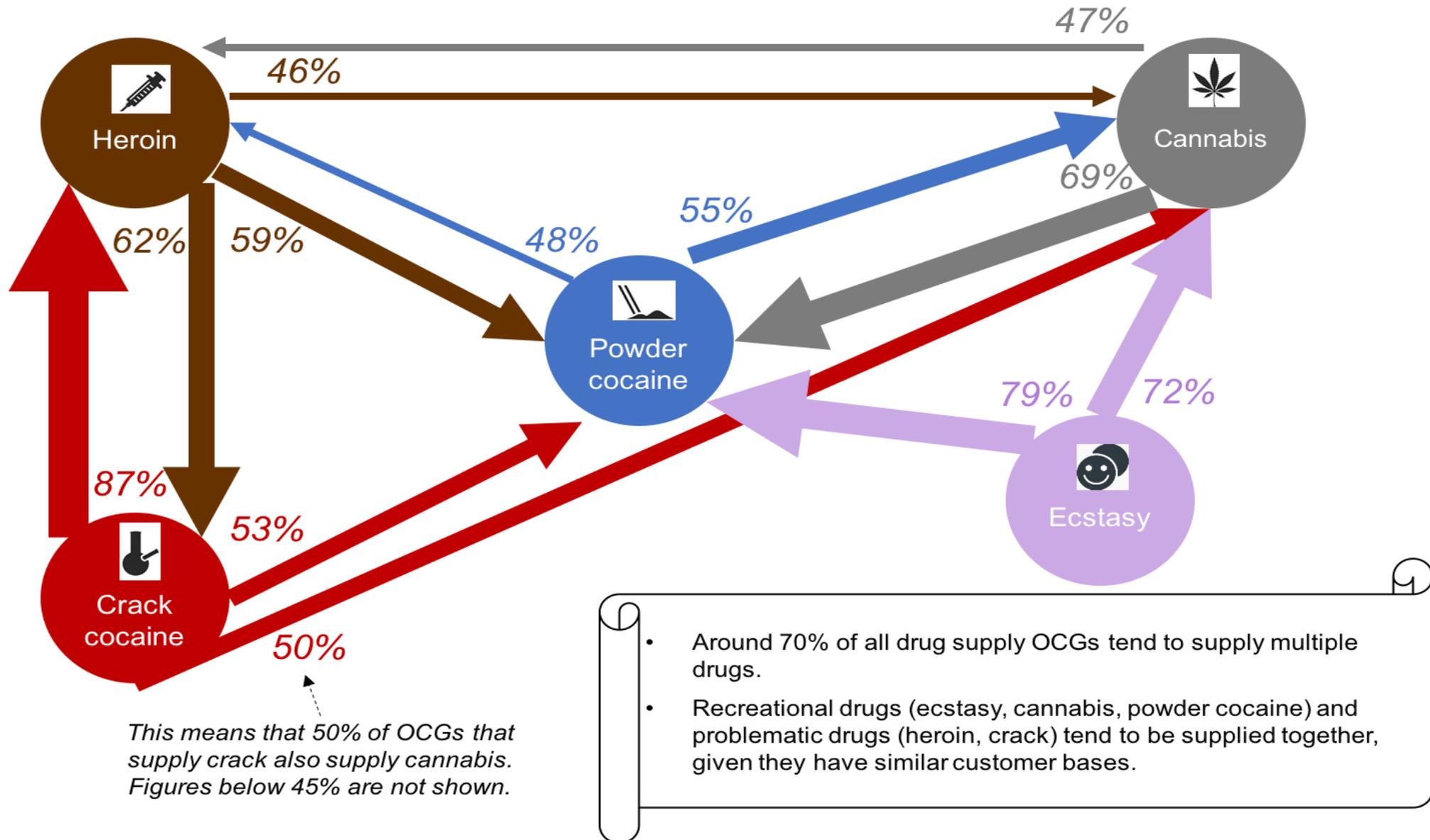
Low level of organisation

Low level of violence

High level of violence

(Defined as OCGs who are more likely to: have violent capability, to use firearms, to commit violence against the person)

Multi-commodity drug supply

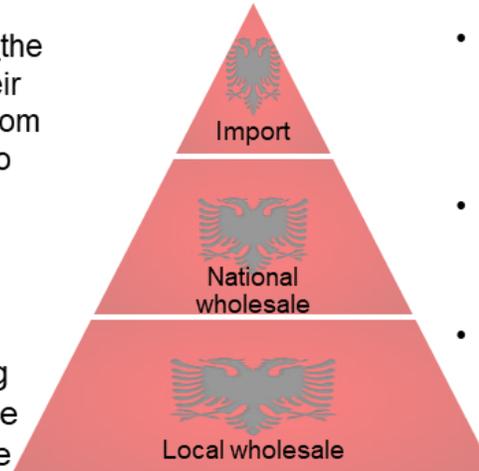


Cocaine and heroin distribution

Import & wholesale level

Cocaine

- **Albanian OCGs dominate** the UK cocaine market, with their supply network stretching from source country all the way to UK towns and cities.
- They act as the **main wholesaler** to powder cocaine retail operations, including those converting it to crack. Although, some British OCGs also operate at the wholesale level.



Heroin

- **Pakistani** groups are known to import heroin directly by air or post, and London-based **Turkish** familial crime groups are dominant heroin importers and wholesale distributors.
- **British OCGs** remain dominant in bulk heroin importation and wholesale supply in the North West of England.
- **Albanian OCGs** have the ability to supply wholesale heroin, although their links to the heroin trade are not as well-developed as those for cocaine.



Retail level



Powder cocaine

- Powder cocaine is supplied by different dealers to crack, as they have different cohorts of users.
- Powder cocaine dealers tend to be older, are more likely to be white, and are less likely to be dependent users.
- Powder cocaine is often sold in the night-time economy, alongside other recreational drugs such as ecstasy and amphetamines. Many users obtain these drugs for free through social supply, rather than buying from a dealer.



Heroin and crack cocaine

- Heroin and crack are generally dealt together, as they are often used simultaneously. Powder cocaine is converted into crack close to the street level, using basic equipment.
- At the street level, heroin and crack dealers consist of user-dealers or the young, junior members of OCGs or USGs.
- In large cities heroin & crack are generally sold by locally-based OCGs/USGs, in smaller cities/towns heroin and crack are increasingly sold by county lines groups.

County lines distribution



A group from an urban hub (i.e. London, Liverpool, Birmingham or Manchester) establishes a network with a county location (e.g. a rural or coastal town).



Customers in the county location make drug orders via a branded mobile phone line, often controlled from the urban hub.



The group uses and exploits young people (often aged 15-17) to regularly travel from the urban hub to the county location to sell drugs and move cash.

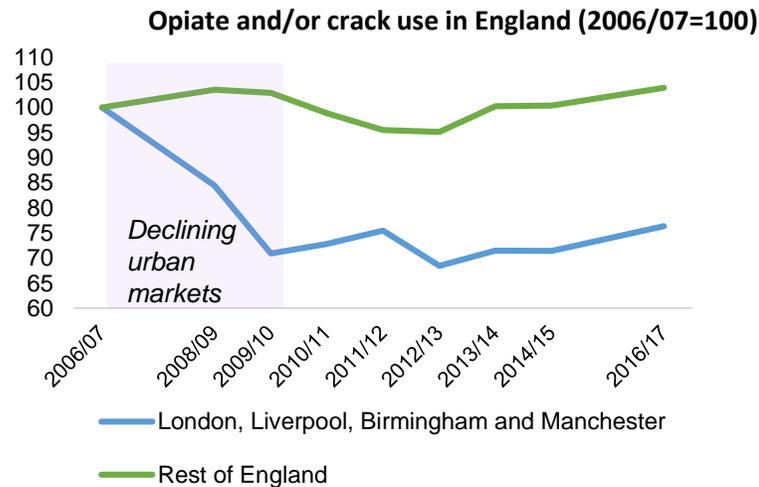


The group also often exploits vulnerable people (e.g. dependent drug users) in the county location to sell drugs or to operate from their home ('cuckooing').

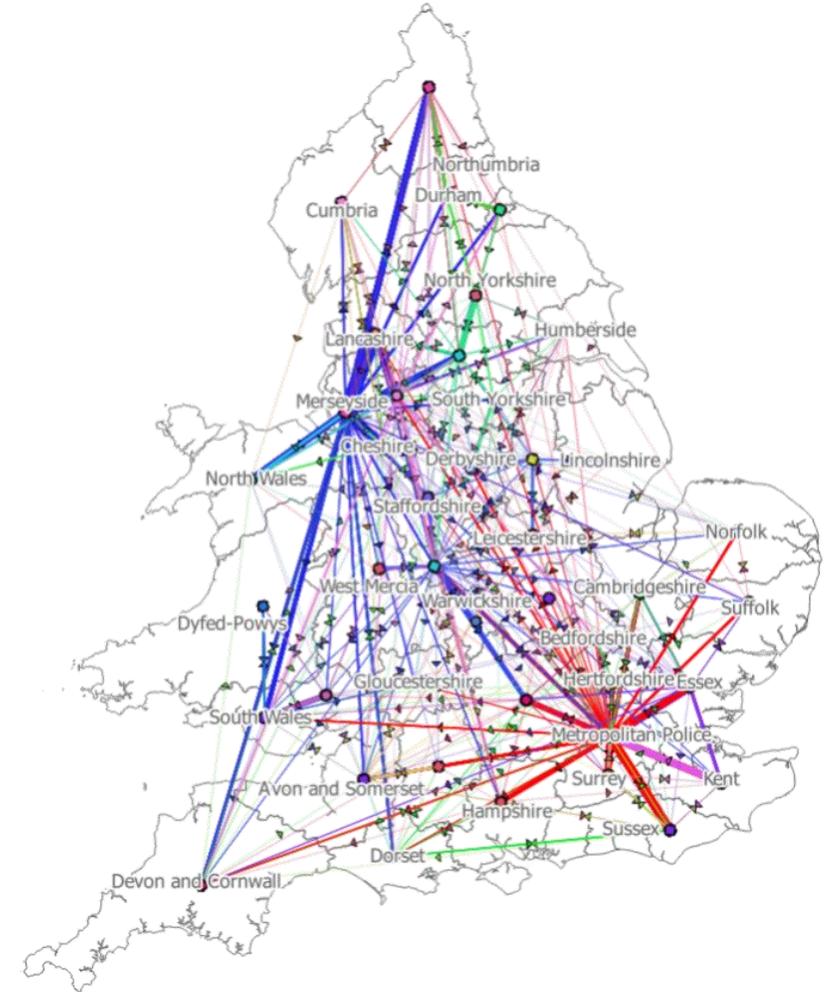


The group is inclined to use intimidation, violence and weapons in the county location including knives, corrosives and firearms.

- The expansion of county lines is likely to have been driven in part by declining heroin/crack markets in the urban hubs and also recognition of untapped markets in less established areas - see chart.
- It may also have been driven by an increase in the number of vulnerable young people (e.g. children in care, excluded from school) available for use and exploitation in county lines.



'County lines' drug supply routes used to supply heroin or crack cocaine (Q4 2017)



This map shows all recorded supply routes for heroin or crack cocaine between police force areas. The routes are coloured according to the area that they originate from and the thickness of the line indicates the frequency with which that supply route is used.

Sources: i) Unpublished Drug Supply Routes, SOCR Home Office 2019 ii) [Estimates of opiate and crack use](#), Public Health England 2019, iii) [County Lines Drug Supply, Vulnerability and Harm](#), NCA 2018

Distribution of recreational drugs

Whilst heroin and crack are generally supplied by street dealers, recreational drugs (e.g. powder cocaine, cannabis and ecstasy) are supplied in a number of other ways:



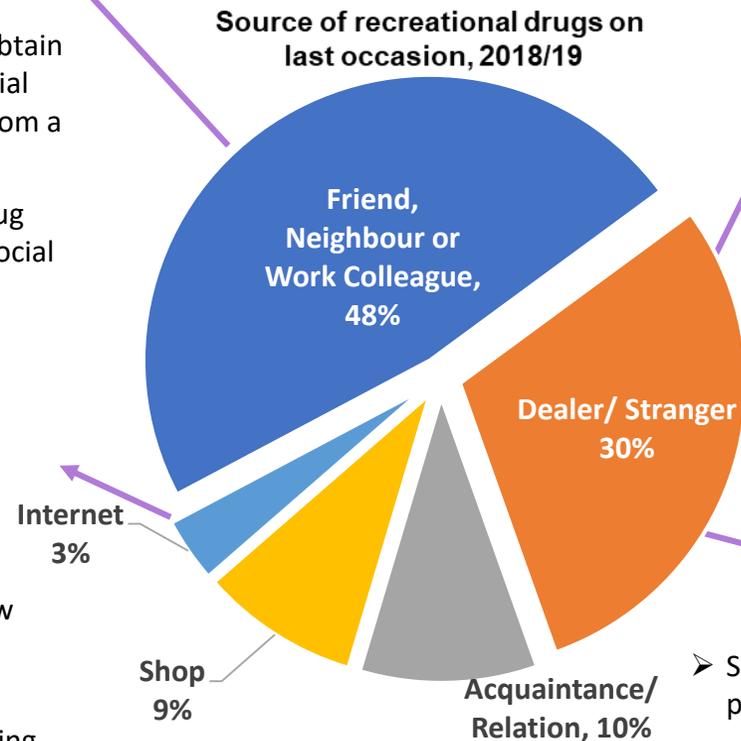
Social supply

- Many recreational drug users obtain drugs for free through their social networks, rather than buying from a dealer.
- **Roughly half** of recreational drug users obtained drugs through social supply on the last occasion.



The dark web

- The dark web is a small but growing part of the recreational drug market, particularly for new psychoactive substances.
- The proportion of recreational drug users who reported obtaining drugs from the dark web **increased from 12% to 29%** between 2014 and 2019 in the UK.



Social media



- There is increasing anecdotal evidence that young people are sourcing recreational drugs via social media.
- Recent research found that **1 in 4 young people** had seen illicit drugs advertised for sale on social media.
- Cannabis was the drug most commonly seen advertised on social media, followed by cocaine, ecstasy and Xanax.

County lines?

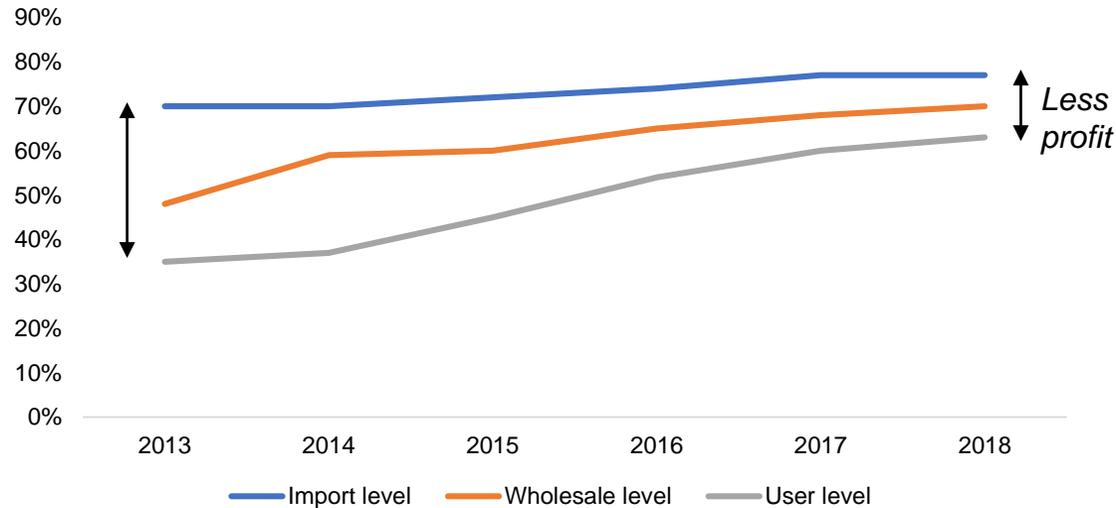


- Some county lines drug runners sell cannabis or powder cocaine as a 'side-line'.
- Data on powder cocaine use in particular appears to show a county lines pattern, with **increased use in rural areas** – see later slides on recreational drug use.

Trends in drug purities

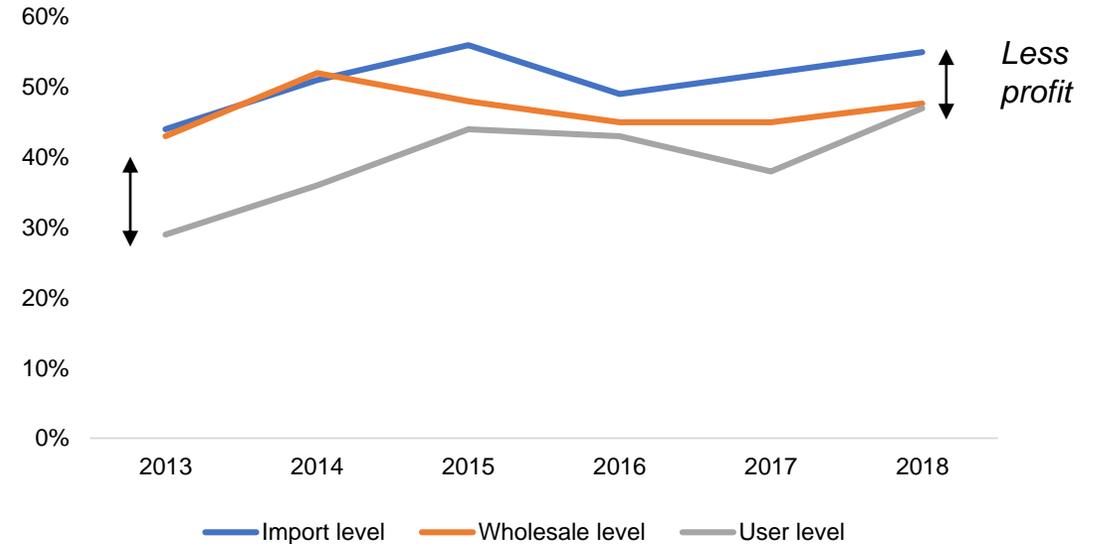
Data on drug purity provides an indication of the ease of supply into the UK, the levels of profit made at different levels of the market, and the level of competition in the market:

Powder cocaine purities in England & Wales



- The surge in cocaine production has produced a highly competitive UK market, with increased purities evidencing that supply is outstripping demand.
- With street prices for powder and crack cocaine remaining constant, this has eroded profits per gram of cocaine sold at the retail stage. However increase in usage balances this out to a certain extent
- Powder cocaine has a two-tier user market – a standard, cheaper product and a purer, more expensive product. The sharp increase in user purity indicates a potential shift in the market to the upper tier product.

Heroin purities in England & Wales

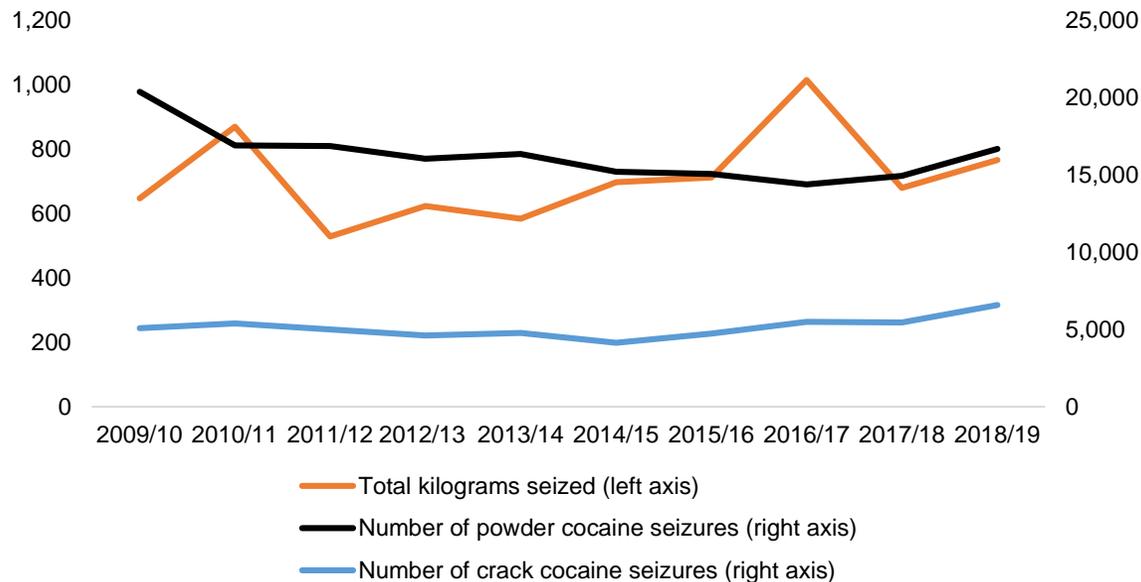


- User-level heroin purity has also increased in recent years, reflecting a recovery from the 2009/10 heroin drought and the recent increase in source production.
- Import purity has also increased in parallel, but wholesale purity has lagged behind. This means that wholesalers may be seeking to maintain their profit margins while the margins of retailers and importers are squeezed.

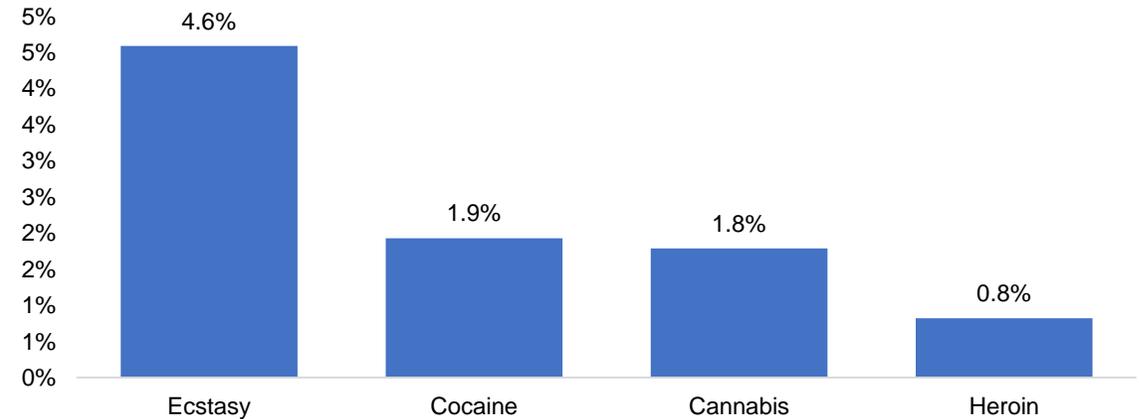
Drug seizures by police forces

- Only a small proportion of the total drug supply is seized by police forces. The quantity seized by police is much smaller than for Border Force, as drug consignments are broken down into smaller packages after they pass through the border.
- OCGs will account for a certain amount of losses through police seizures when projecting their profits from drug distribution.
- As with Border Force seizures, the largest proportion seized is for ecstasy and the lowest proportion is for heroin.

Number and quantity of cocaine seizures by police forces in England and Wales



Estimated proportion of annual drug supply which is seized by police forces in England & Wales

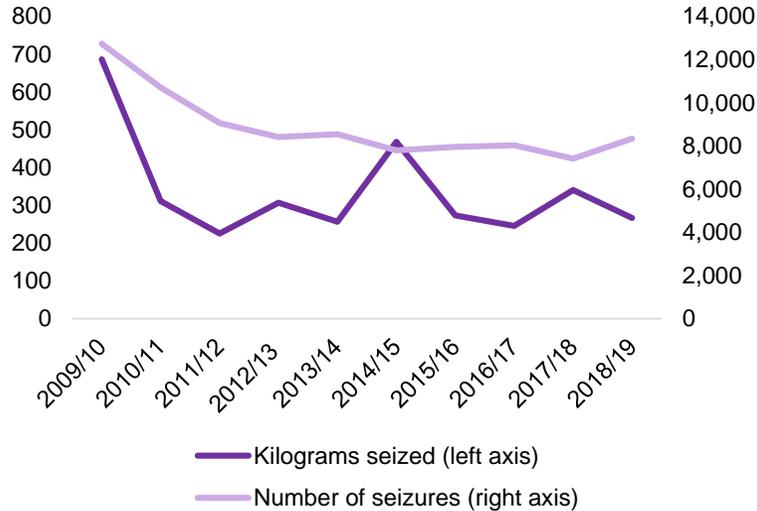


The chart above compares the average annual quantity of drugs seized by police forces between 2014/15-2018/19 with the estimated quantity of drugs consumed in 2016/17.

- As with Border Force, the quantity of cocaine seized by police forces has shown an upward trend in recent years, reflecting increased availability and use.
- The number of powder cocaine seizures has remained relatively flat over the last four years while the number of crack seizures has increased by almost 40%, despite significant increases in use across both substances over this period.
- This difference in enforcement activity may reflect the increased focus on disrupting county lines groups in recent years.

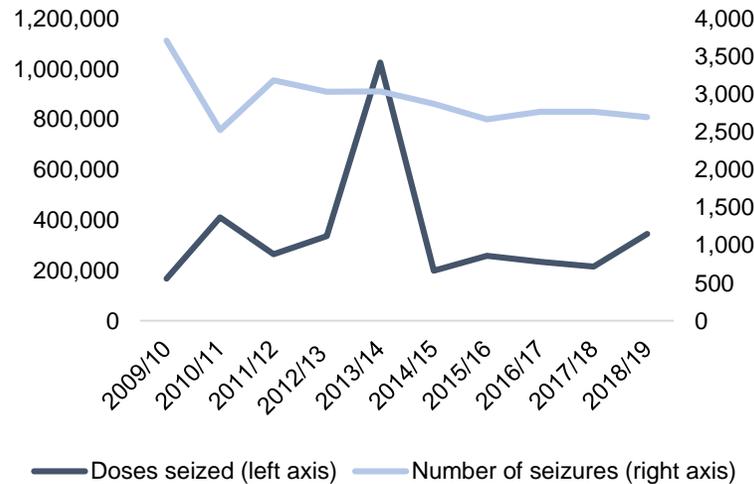
Drug seizures by police forces

Number and quantity of heroin seizures by police forces in England & Wales



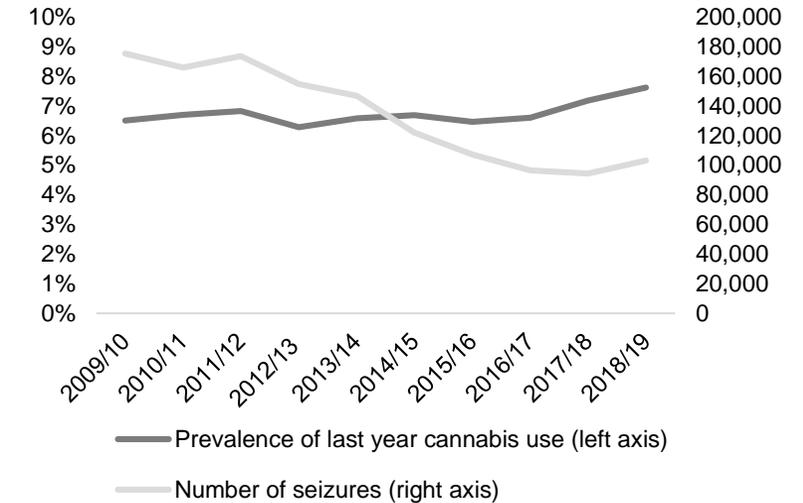
- As with Border Force, the number of heroin seizures has fallen considerably in recent years despite usage remaining high.
- This indicates that heroin suppliers may be more effectively avoiding detection by law enforcement.
- As with Border Force, there has been an increase in seizures in 2018/19, bucking the previous trend.

Number and quantity of ecstasy seizures by police forces in England & Wales



- The number of ecstasy seizures has declined slightly in recent years despite increases in usage among young people.
- There was a sharp increase in the quantity of ecstasy seized in 2018/19, which may be linked to the increasing quantity of powder cocaine seized, given these drugs are often distributed by the same OCGs.

Number of police cannabis seizures vs prevalence of cannabis use

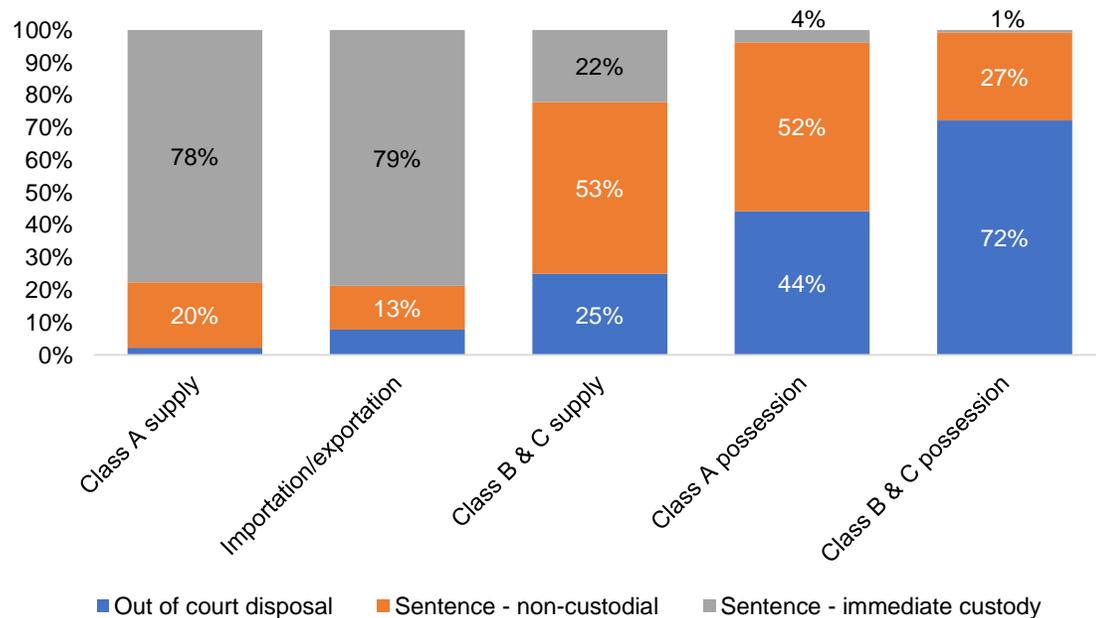


- Trends in cannabis seizures are often driven by changes in proactive policing such as stop and search activity, rather than changes in prevalence.
- The number of cannabis seizures has fallen sharply since 2010/11 in line with decreased stop and search activity, before increasing in 2018/19 when the trends in stop and searches also reversed.

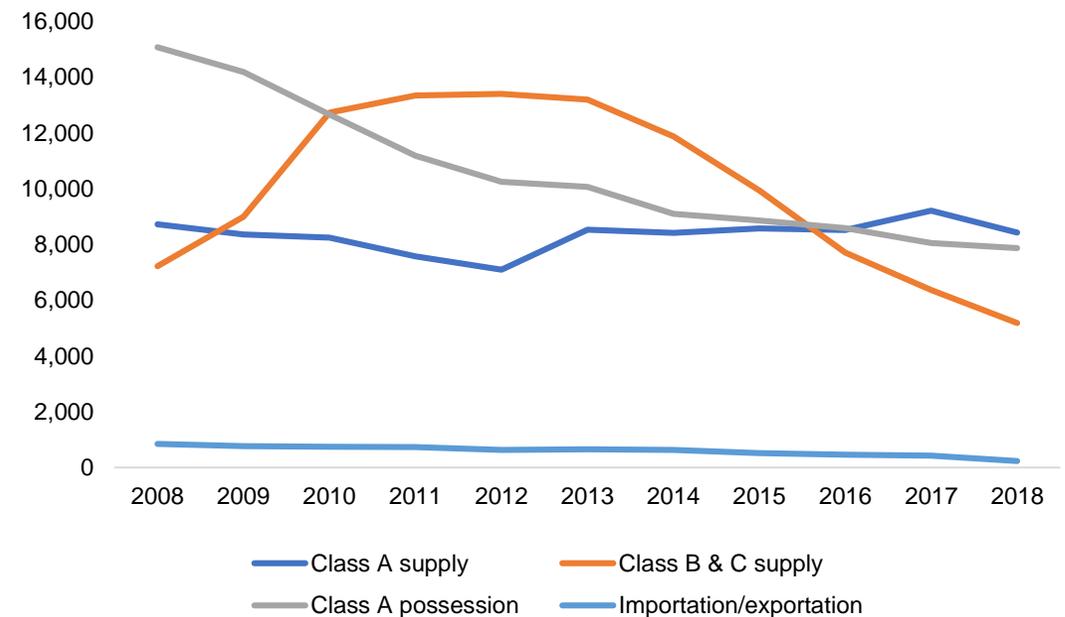
Drug offence sentencing

- Outcomes for drug offenders vary considerably depending on the offence and the class of drug.
- Only 1% of defendants receive an immediate custodial sentence for Class B/C possession offences and 4% for class A possession, compared with 22% for class B/C supply offences and 78% for Class A.
- Similar rates of immediate custody are seen for those people convicted of importation/exportation.
- Seventy two per cent of defendants received an out of court disposal for Class B/C possession offences, compared with 2% for Class A supply offences.
- There has been a dramatic drop in prosecutions for most drug offences in the last 10 years, falling by more than 40% for Class A possession offences, Class B/C possession offences and Class B/C supply offences. Class A supply offences have remained relatively flat, although there was a slight increase in 2017.
- This reflects the fall in drug seizures by police forces in previous years, with trends in drug offences and seizures often following a similar pattern.

Court and out of court outcomes for drug offences, 2018



Number of defendants prosecuted for drug offences



Sources: i) [Criminal Justice Statistics quarterly - Outcomes by Offence data tool](#), Ministry of Justice 2019 ii) [Crime Outcomes in England and Wales](#), Home Office 2019

Evidence on the impacts of enforcement activity

- Overall, the evidence base on the impact of enforcement activity is poor. Despite considerable expenditure on enforcement activity, the impacts of these interventions are rarely evaluated.
- Changes to legislation to make certain drugs illegal (e.g. the Psychoactive Substances Act 2016, the control of mephedrone) appear to have reduced usage of these substances, although they may have caused displacement to other drugs.
- The available evidence is complex, but suggests that enforcement 'crackdowns' have little impact on the overall drug supply. Some enforcement can have short-term benefits in reducing harm, but these are often short-lived given the resilience and flexibility of OCGs.
- Enforcement can often have the unintended consequence of increasing violence, for example by creating a gap in the market for dealers to compete over, or increasing distrust in the drugs market.
- Academics suggest that enforcement activities should recognise that not all dealers are equally destructive, and should instead target those with the most harmful selling practices.
- The evidence suggests that enforcement can have a beneficial role in diverting drug users into treatment. There is some evidence that previous schemes such as the Drug Interventions Programme are associated with reduced offending, by diverting drug users into treatment.

Domestic drug distribution summary

- Import and wholesale supply of powder cocaine is thought to be largely dominated by Albanian OCGs, acting as the main wholesaler to powder cocaine retail operations, including those converting it to crack.
- Pakistani and Turkish OCGs are thought to be heavily involved in the import and wholesale levels of the heroin market, with British OCGs also dominant in the North West of England.
- Over two thirds of drugs OCGs supply multiple substances. Drugs with similar customer bases tend to be sold together by OCGs, such as heroin and crack or powder cocaine and cannabis.
- Drug selling groups from urban hubs have increasingly established networks in smaller markets through the county lines model, using violence and exploiting children and vulnerable young people.
- At the retail level, heroin and crack are generally supplied by street dealers, such as junior OCG/USG members or user-dealers. Recreational drugs such as cannabis and powder cocaine are distributed through a range of different methods, for example from friends, via social media or in the night-time economy.
- The total number of drug seizures by police forces has fallen considerably in recent years, mainly driven by falls in cannabis seizures. This has reversed in 2018/19 with an increase in seizures, likely driven by greater stop and search activity.
- Overall, the evidence base on the impact of enforcement activity is poor. The available evidence is complex, but suggests that enforcement 'crackdowns' have little sustained impact on the overall drug supply.
- Enforcement can often have the unintended consequence of increasing violence, for example by creating a gap in the market for dealers to compete over, or increasing distrust in the drugs market. The evidence suggests that enforcement can have a beneficial role in diverting drug users into treatment, which can increase rates of recovery and reduce re-offending.

4. Drug-related violence

Types of drug-related violence

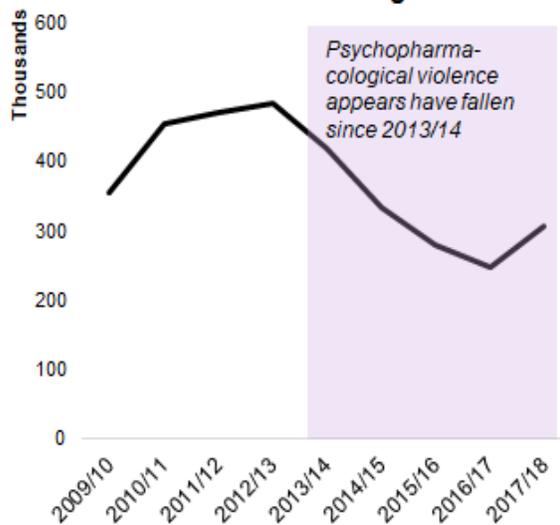
The academic literature categorises drug-related violence into three main types:



1) Psychopharmacological violence

Committed by drug users whilst under the psychoactive influence of drugs. Stimulants such as crack may be more likely to cause violence.

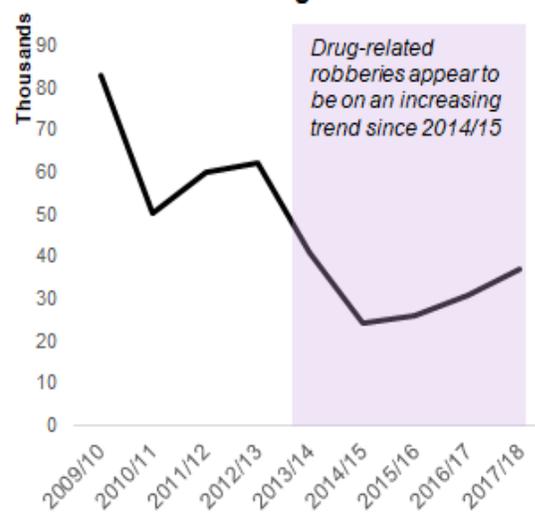
Number of violent incidents where the offender was thought to be under the influence of drugs



2) Economic-compulsive violence

Committed by drug users in order to fund their drug habit, for example during the course of robberies or burglaries. However, survey data only captures robberies committed whilst under the influence of drugs.

Number of robberies where the offender was thought to be under the influence of drugs



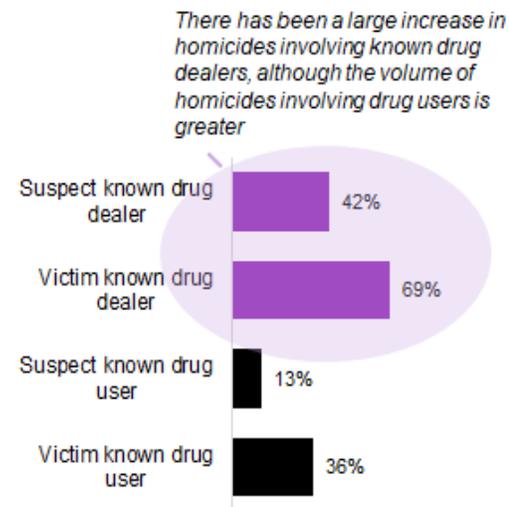
These changes are not statistically significant



3) Systemic violence

Committed by drug dealers to protect reputation, profits and territory, as they do not have legal means to settle disputes. Systemic violence is usually responsible for sudden increases in serious violence.

Change in drug-related homicides between 2013-15 and 2016-18



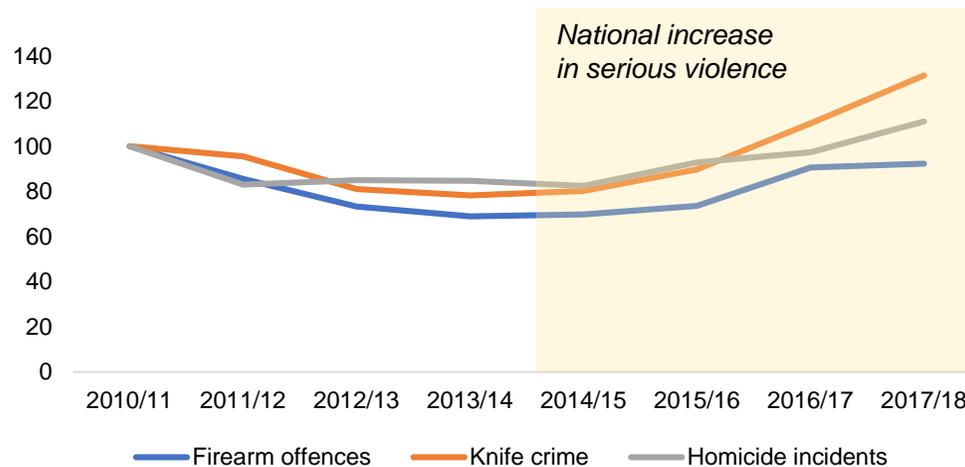
Since around 2014, there have been three related changes in the drugs market which are likely to have driven the increase in drug-related violence:

1. The increased prevalence of crack cocaine use
2. The expansion of county lines activity
3. The increasing involvement of young people and urban street gangs

The increase in vulnerable groups in the last few years (such as rough sleepers, children in care/excluded from school) may also be contributing to the above factors - either through their consumption of drugs or their involvement in drug supply.

Drugs appear to be a major driver in the recent increases in serious violence

Serious violence trends in England & Wales

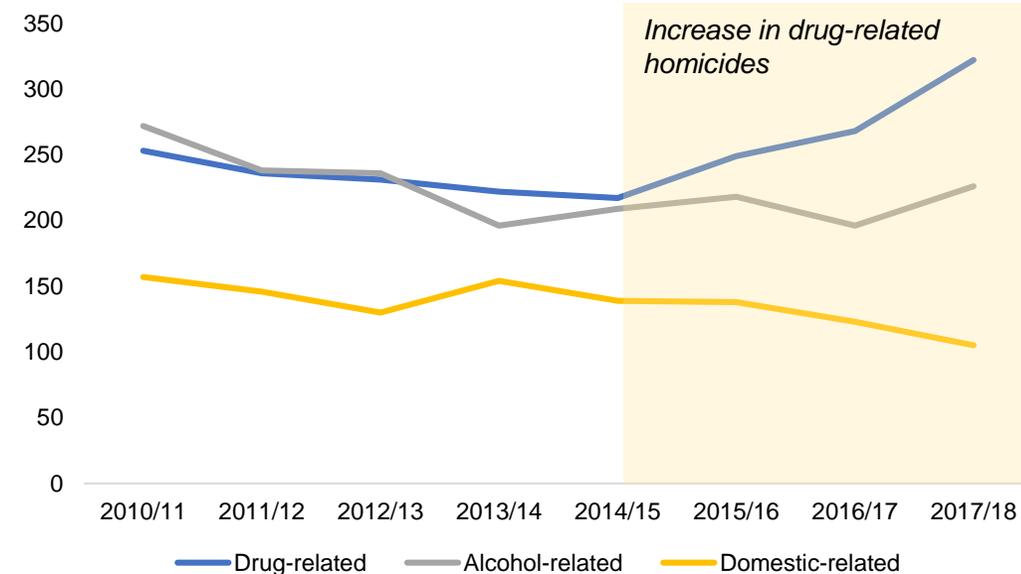


- Since around 2014, serious violence has increased across nearly all areas of England and Wales.
- Homicide data indicates that there are specific types of cases which are driving this increase:

Change in homicides between 2013/14 and 2017/18

All homicides	+39%
Victim was male and under 35 years old	+58%
Sharp instrument used (male victims only)	+63%
Victim and suspect were strangers (male victims only)	+71%
Occurred in a public place (male victims only)	+72%

Homicides in England & Wales by type of homicide

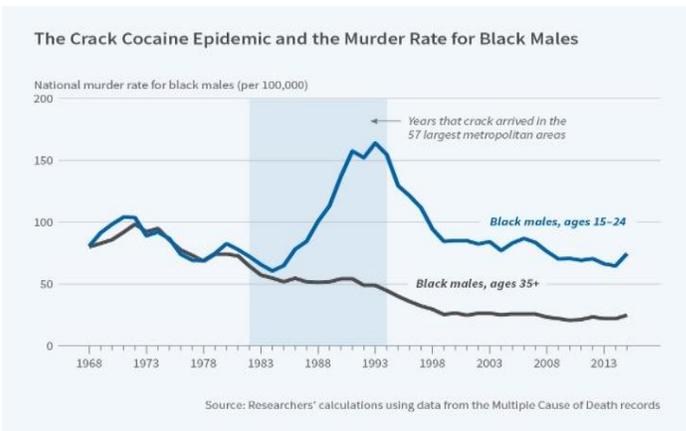


Note: Some homicides will include cases which are a combination of drug, alcohol and/or domestic-related

- Around 50% of the increase in homicides between 2013/14 and 2017/18 is due to cases involving drug dealers or drug users or a drug-related motive.
- Meanwhile, domestic homicides and homicides those which are alcohol-related (including those involving drugs) have not risen to the same extent. Drugs therefore appear to be an important factor behind rising serious violence.
- However, as identified in the 2018 Serious Violence Strategy, it is likely that there are also non-drug factors driving the increase in serious violence.

Increased prevalence of crack cocaine use

- A number of data sources indicate that crack cocaine use started increasing in England from around 2013. This is around the same time that serious violence, including drug-related homicides, also began to increase.
- In the US, a significant increase in crack use in the 1980s/1990s is widely believed to have caused large increases in serious violence – see chart below.
- This raises the question of whether the current increase in crack cocaine use may similarly be responsible for an uptick in serious violence.



Factors behind the US crack epidemic:

- 1) **Drug markets involving crack tend to be inherently more violent, due to the effect of the drug**
 - The fleeting high of crack means that users make multiple purchases per day, increasing the number of interactions with dealers and the scope for violence.
 - Crack is often prevalent in the most deprived communities, where violence is more likely to occur.
 - The stimulant effect of crack has been known to cause aggression among users of the drug.

2) Crack formed a new market of users and dealers

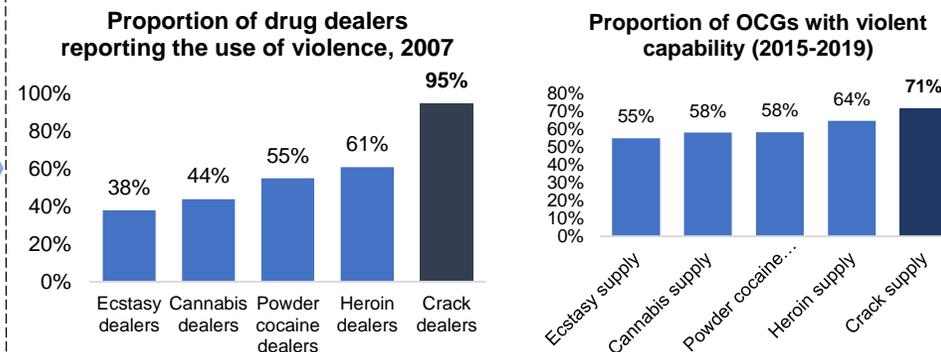
New relationships between users and dealers meant there were low levels of trust in the market, and the need to establish a share in the new market made violence more likely to occur.

3) There was a surge of much younger dealers

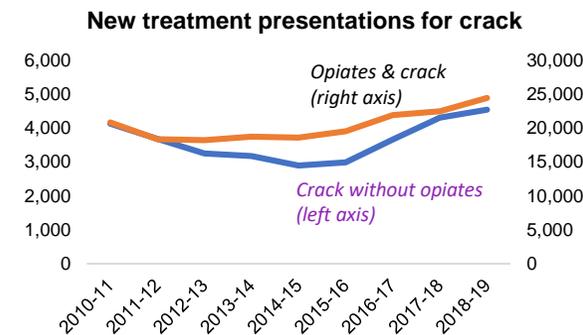
The emergence of a new market meant that new dealers were needed quickly – this led to a sudden increase of much younger drug dealers to fill the gap. Younger dealers are thought to be more likely to act impulsively and use violence.

Are these factors present in England?

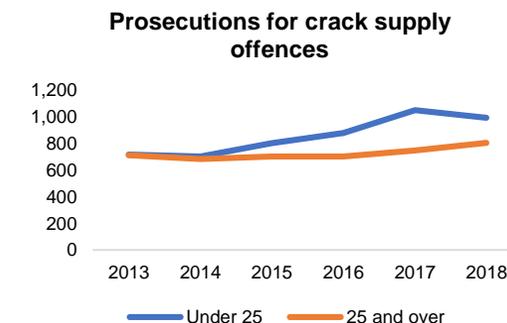
1) Yes – intelligence from police forces and drug dealers indicates that drug markets involving crack is inherently more violent:



2) Partially – crack use has increased among entrenched heroin users, but there is also a new cohort of people using crack without opiates. And county lines has brought an influx of new dealers into existing markets.



3) Yes – since serious violence began increasing there has been a sharp rise in the number of younger drug dealers, particularly in the crack market.

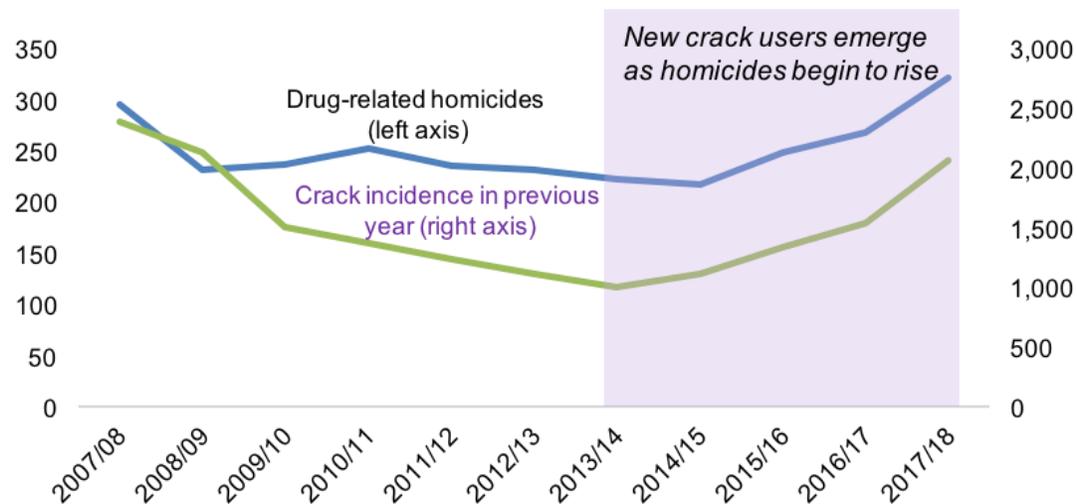


Sources: i) Unpublished estimates of crack incidence, Public Health England 2019 ii) [Homicide in England and Wales](#), ONS 2019 iii) [Guns and Violence: The Enduring Impact of Crack Cocaine Markets on Young Black Males](#), Evans et al 2018 iv) Unpublished Organised Crime Group Mapping data 2015-2019, NCA

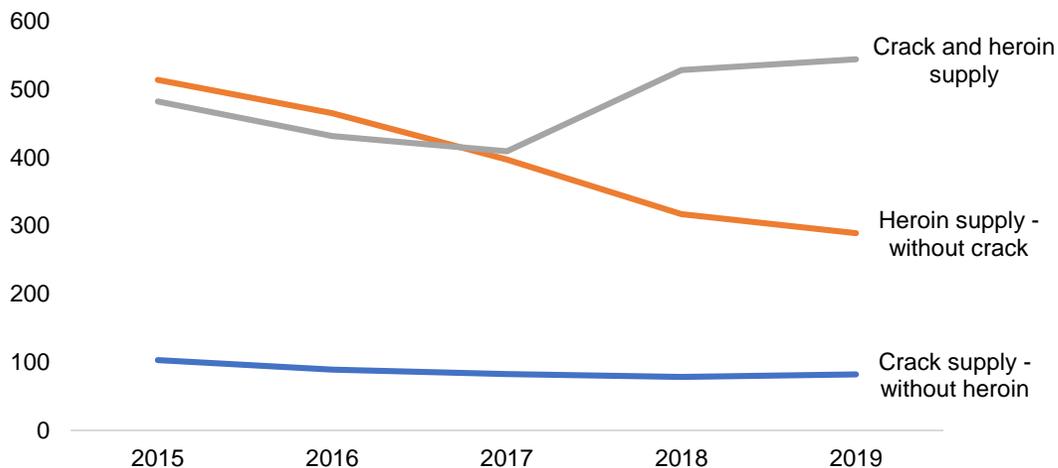
Increased crack cocaine supply and violence

- The chart on the right shows that as new crack users began to emerge, drug-related homicides began to rise a year later.
- As well as increase use of crack, data from police forces on OCGs indicates that there has been an increase in OCGs supplying crack. The proportion of drugs groups who supply crack has increased from 25% in 2015 to 36% in 2019.
- This has mainly involved OCGs supplying heroin also beginning to supply crack – see chart below. This is also reflected in data on drug users, with increasing use of both heroin and crack together.
- Drug markets which involve crack cocaine tend to be more violent than drug markets not involving crack – see chart on the bottom right. The increased prevalence of OCGs supplying crack is therefore likely to have contributed to the overall increase in drug-related violence.

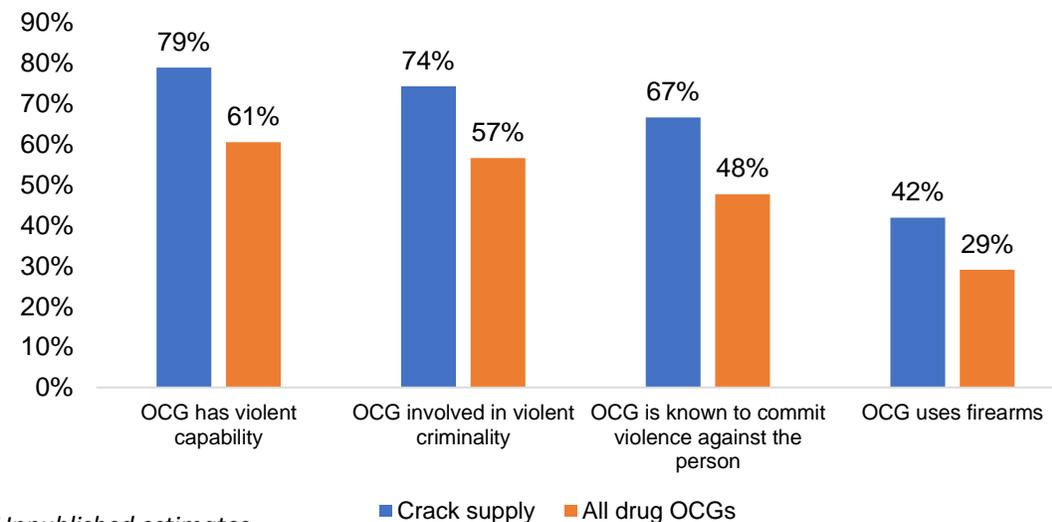
Crack incidence (1 year lag) versus drug-related homicides, 2007/08-2017/18



Number of drug OCGs supplying crack and/or heroin



Violence of crack OCGs versus all drug OCGs (2019)



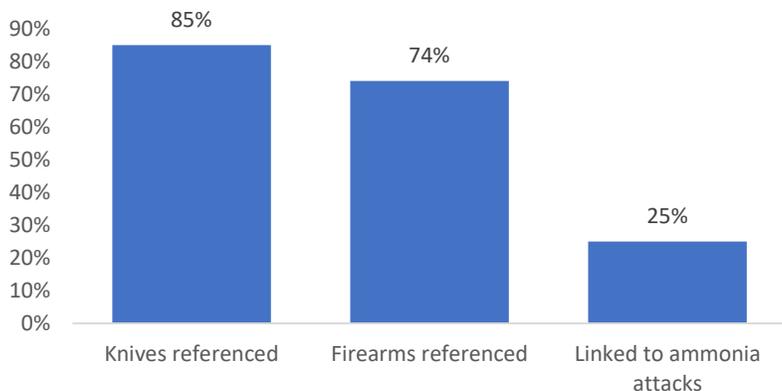
Sources: i) Unpublished Organised Crime Group Mapping data 2015-2019, NCA, ii) Unpublished estimates of crack incidence, Public Health England 2019, iii) [Homicide in England and Wales](#), ONS 2019

County lines and young people involved in drug supply

County lines and serious violence

- Evidence from recent government research and academic studies finds that county lines groups are more violent than local groups who previously controlled drug markets in county towns. The NCA also regularly document the violence associated with county lines groups in their annual reporting.
- County lines groups may commit violence in order to establish their reputation in the new market in response to competition from local drug dealers. They may also use violence during the exploitation of young drug runners or vulnerable drug users.
- As county lines is not a specific crime type or drug type, systematic data on these groups and their use of violence is limited, although the regular collection of information through the National County Lines Coordination Centre should improve the intelligence picture.

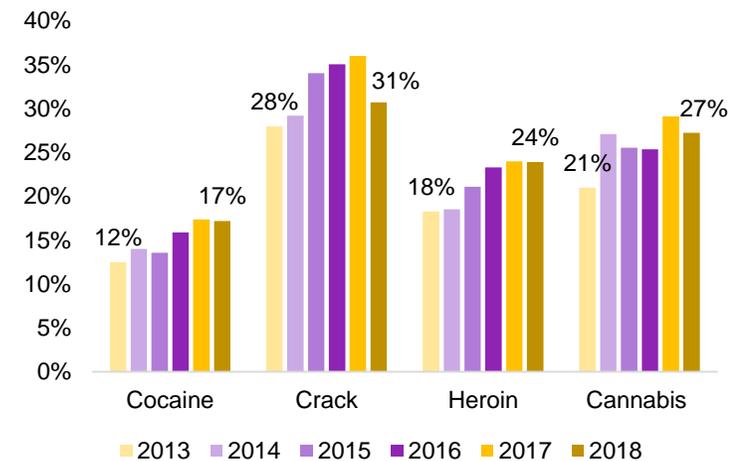
Proportion of police forces reporting use of weapons by county lines groups (2017)



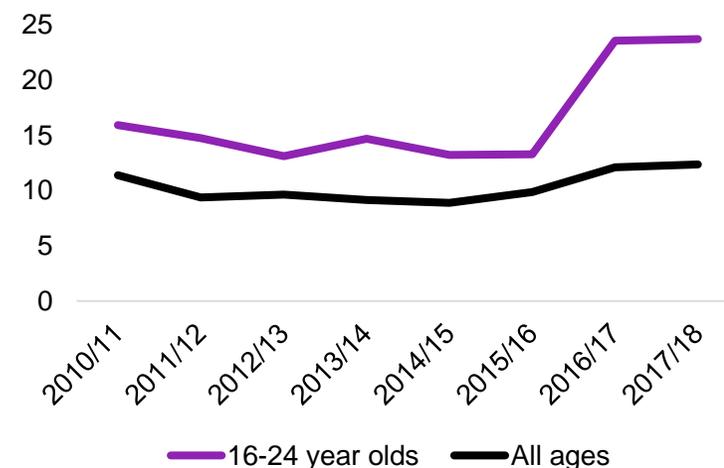
Young people and violence

- Increasing numbers of young people are committing drug supply offences. Some of this increase is likely to reflect the growth of county lines, with drug offences by young people growing at a much faster rate outside of London.
- However, some of this likely to be outside of county lines, given the increase in young people being sentenced for drugs such as powder cocaine and cannabis – see chart.
- Some of the increase may also reflect the increasing involvement of Urban Street Gangs (USGs) in organised drug supply, evidenced by academic studies such as Whittaker et al (2018). Compared with OCGs, USGs are more likely to involve young people, less likely to be organised and may be more likely to use violence.
- Reuter (2009) argues that young people involved in drug supply lack foresight and are more likely to use violence to settle disputes. Whittaker et al (2018) found in particular that the younger gang members involved in drugs between the ages of 12-17 were increasingly becoming active in serious violence such as stabbings and weapon carrying.

Proportions of individuals sentenced for drug supply who were aged under 21



Homicide victim rate per million of the population

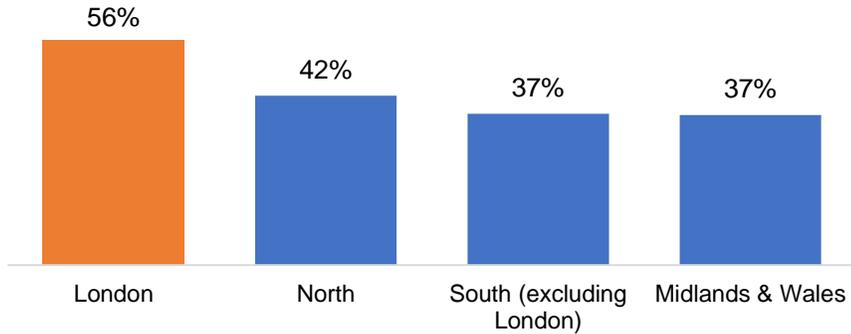


Sources: i) Unpublished Youth Pathways into Commodities-Based SOC in Merseyside ii) [Ending Gang and Youth Violence](#), Home Office 2016 iii) [Systemic violence in drug markets](#), Reuter 2009 iv) [From Postcodes to Profit](#), Whittaker 2018 v) [Proceedings and outcomes by HO offence code](#), Ministry of Justice 2019 iv) [County Lines Violence, Exploitation and Drug Supply](#), NCA 2017

Drug related violence by region

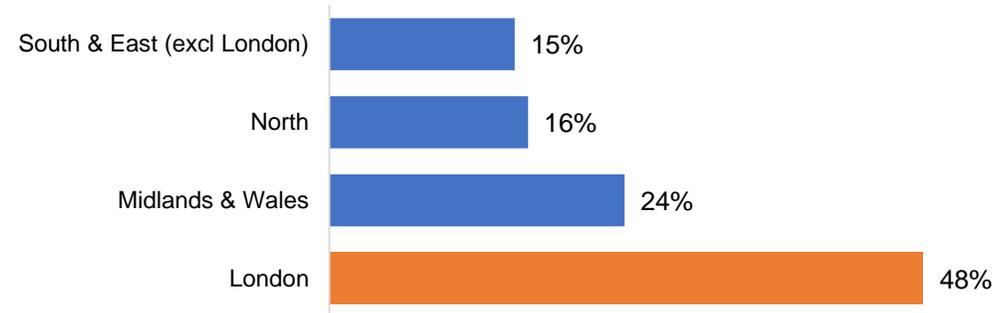
Homicides occurring in London are more likely to be drug-related than in the rest of England and Wales:

Proportion of homicides which are drug-related (2012/13-2017/18)



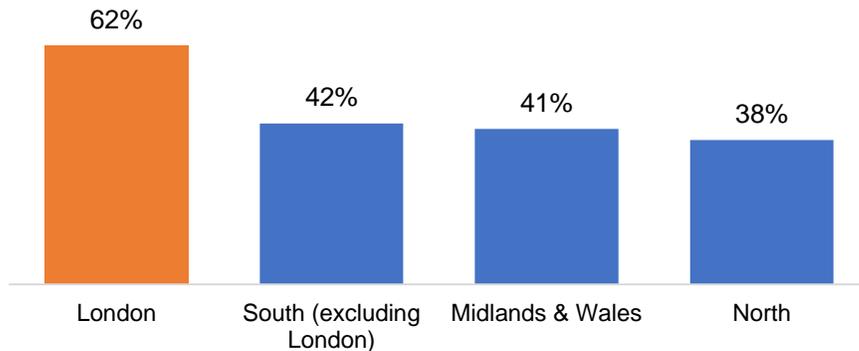
Drug-related homicides have increased at a faster rate in London than in the rest of England and Wales:

Change in drug-related homicides (three years to 2014/15 vs three years to 2017/18)



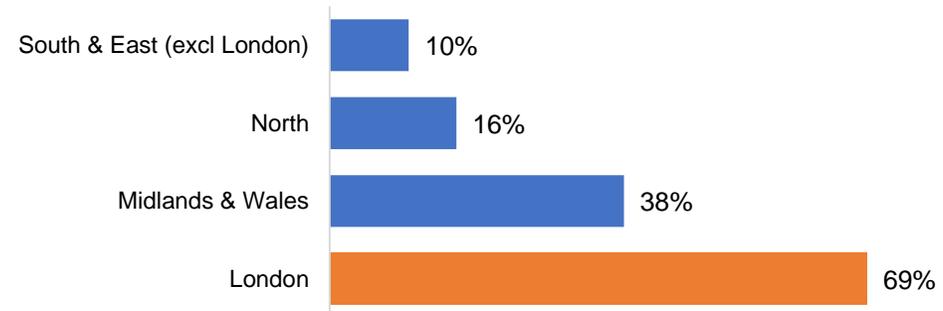
Drug-related homicides in London are more likely to be stabbings:

Proportion of drug-related homicides which are stabbings (2012/13-2017/18)



Drug-related stabbing homicides have increased at a faster rate in London than in the rest of England and Wales:

Change in drug-related stabbing homicides (three years to 2014/15 vs three years to 2017/18)



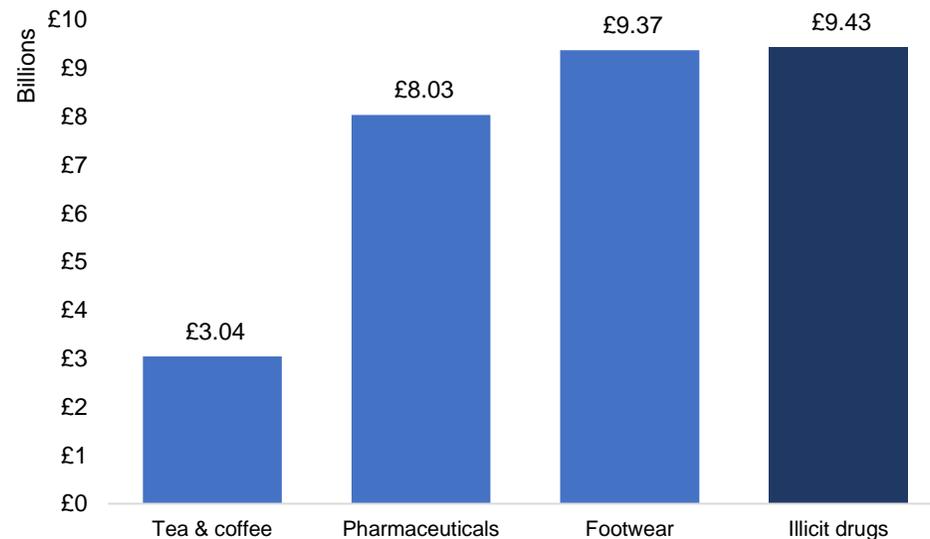
Note – 'Drug-related' is defined as a homicide where either the victim or the suspect was a known drug user or dealer, or where the known motive for the homicide was to steal drugs or drugs money. 'Stabbings' refers to homicides where the apparent method of killing was 'sharp instrument'.

5. Illicit drug market revenue

The size of the illicit drugs market

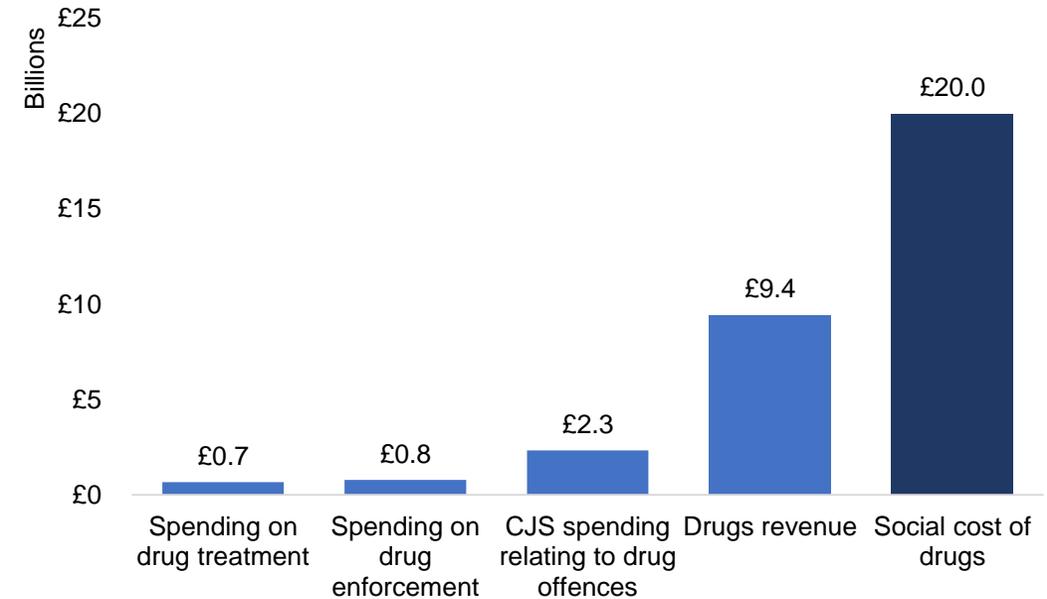
- In 2016/17, consumers in England and Wales spent approximately £9.4 billion on illicit drugs.
- This was more than the total expenditure in consumer sectors such as tea and coffee, pharmaceuticals and footwear.
- The revenue of the drugs industry is greater than the UK revenue of Aldi (£8.7 billion in 2016/17), Boots (£6.9 billion in 2016/17) and EasyJet (£5.0 billion in 2016/17).

Consumer expenditure on illicit drugs and other products, 2016/17



To note that illicit drugs relates to expenditure in England & Wales only, other products relates to total expenditure across the UK. Figures may look similar due to rounding.

Illicit drugs revenue and drug-related costs/expenditure

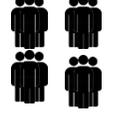
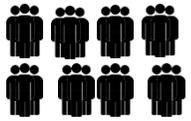


- Government expenditure to address drug-related issues is dwarfed by total revenue from the drugs market.
- The total costs to society from drug use (which includes government spending) is considerably greater than the revenue generated by the sector.
- It has been estimated that the total EU drug market was worth around £26 billion in 2017.
- This indicates that England and Wales is equivalent to around 36% of the total EU drug market, although the studies use different methodologies and data sources.

Spending habits by drug type

- Cannabis and powder cocaine have a large number of users who purchase a small amount of drugs on average as their use is infrequent, whilst the opposite is true for heroin and crack, where dependent users will consume these drugs most days in order to avoid withdrawal.
- Each individual heroin/crack user represents a significant source of revenue. The annual spend of someone using both heroin and crack (~£19,000) is around 80% of the median wage in the UK (~£23,000 in 2016).

[To note that all of the data in the chart below relates to 2016/17 in England and Wales, so it may not be consistent with more recent data presented in other slides]

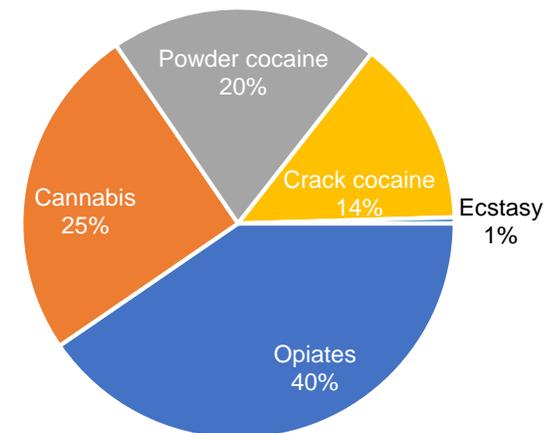
	Average amount consumed per day of use	Cost per day of use	Average days of use per year	Average annual spend per user	Number of users	Total spend
Powder cocaine	 0.9 gram	 £71	 30 days	 £2,152	 883,000	 £1.9 bn
Ecstasy	 1.2 pills	 £12	 7 days	 £90	 483,000	 £0.04 bn
Cannabis	 1.2 grams	 £12	 76 days	 £914	 2,592,000	 £2.4 bn
Crack	 0.4 grams	 £40	 157 days	 £6,263	 210,000	 £1.3 bn
Opiates	 0.5 grams	 £50	 251 days	 £12,538	 303,000	 £3.8 bn

Sources: i) Unpublished Drug Revenue Estimates, Home Office 2019 ii) [Drug Misuse Statistics](#), Home Office 2019 iii) [Estimates of opiate and crack use](#), Public Health England 2019

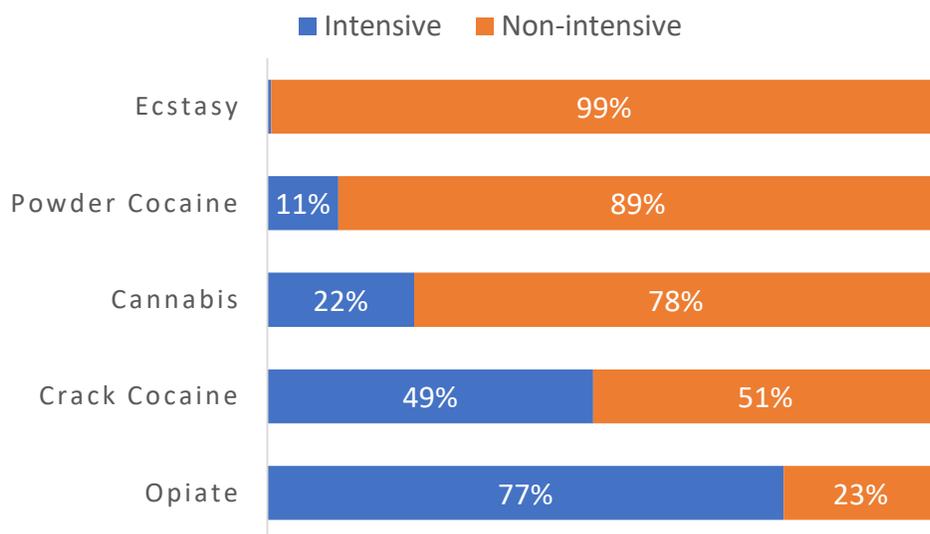
Revenue by frequency of use

- Opiates have the largest share of the drug market, but cannabis, powder cocaine and crack also drive significant revenue.
- Drug market revenue is almost entirely derived from those with intensive drug habits (i.e. defined as those who use three or more times per week) – they account for 91% of total expenditure.
- For example, 89% of all powder cocaine users use less than three times per week, but this group only account for 13% of total powder cocaine revenue.
- Nearly all the revenue from opiates (97%) comes from those using more than three times a week.
- Thus, attempting to reduce drug use among occasional users is unlikely to have a material impact on drug market revenues.

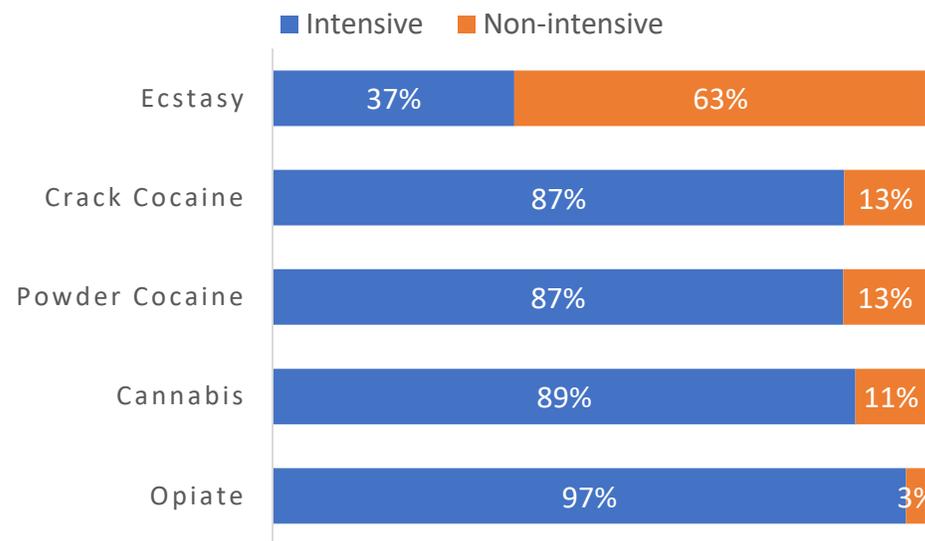
Breakdown of revenue by drug type



Breakdown of users by intensive versus non-intensive use



Breakdown of revenue by intensive versus non-intensive use



Drug-related violence and revenue summary

Drug-related violence

- There are three types of violence linked with illicit drugs: violence committed whilst under the influence of drugs, violence committed to fund drug use and systemic violence related to drug supply.
- Since around 2014 serious violence has increased nationally, and drugs have been identified as a major factor behind this increase. Around half of the increase in homicides between 2013/14 and 2017/18 is due to cases involving drug dealers or drug users or a drug-related motive.
- The increase in drug-related violence is likely to be driven by the following three interrelated factors:
 - increased prevalence of crack cocaine use
 - expansion of county lines activity
 - greater involvement of young people and urban gangs in drug supply.

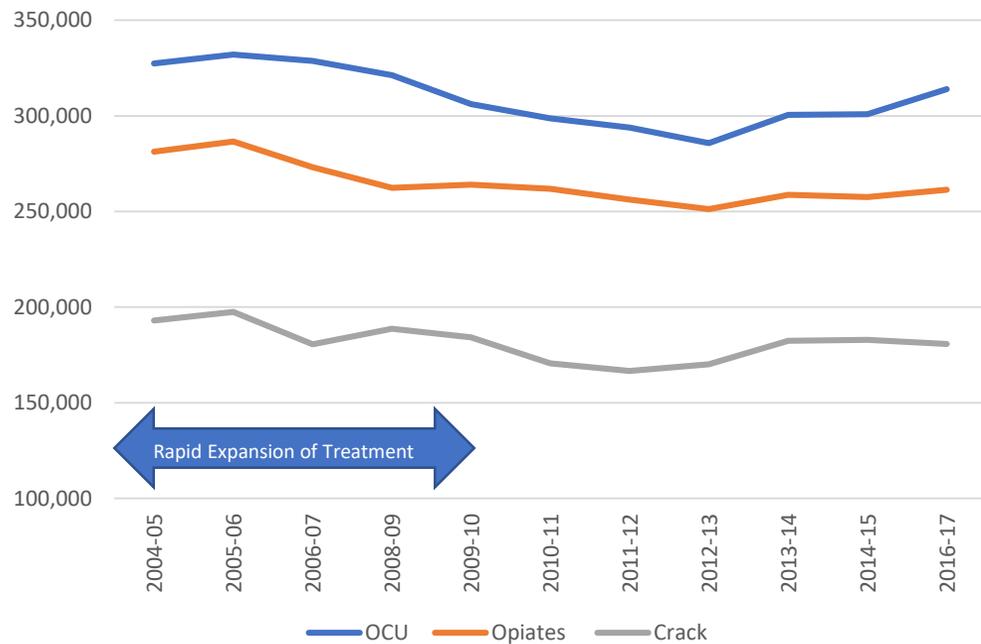
Revenue

- It is estimated that consumers in England and Wales spent £9.4 billion on drugs in 2016/17. The largest market is opiates (£3.8 billion), followed by cannabis (£2.4 billion) and powder cocaine (£1.9 billion).
- Heroin users also have the highest average annual spend (£12,500) followed by users of crack cocaine (£6,300). Average annual spend is lower for drugs such as powder cocaine (£2,200) and cannabis (£1,000), as there are a large number of occasional users.
- Those who use drugs three or more times per week account for 91% of total expenditure on drugs. Thus, attempting to reduce drug use among occasional users is unlikely to have a material impact on drug market revenues.

6. Prevalence and incidence of problematic drug use

There has been a significant increase in the estimated number of opiate and/or crack cocaine users

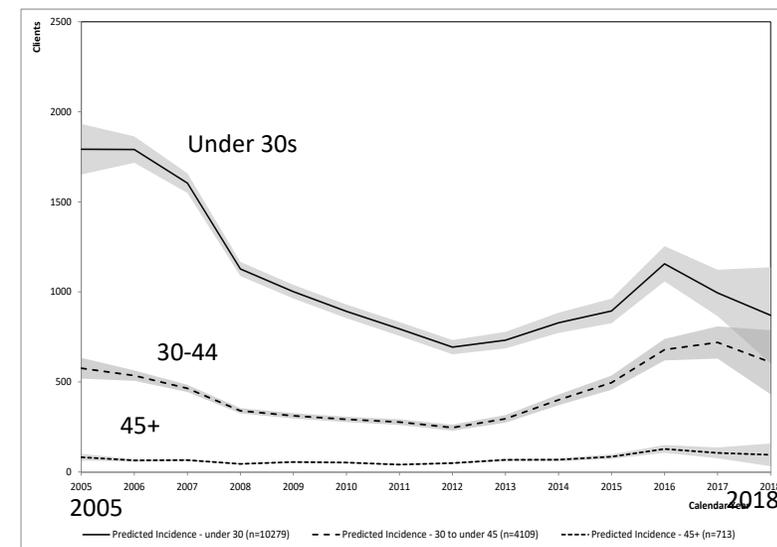
Prevalence of illicit opiate and crack cocaine use



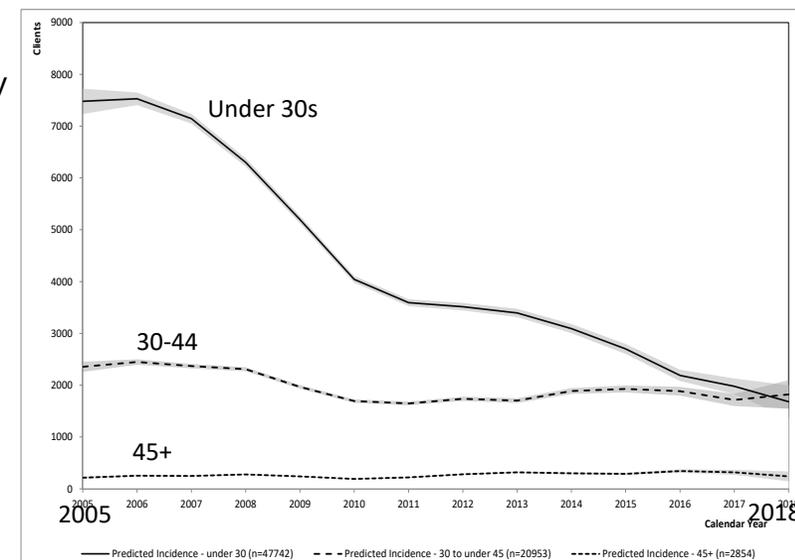
- The rapid expansion of treatment during the 2000's helped reduce OCU prevalence and incidence.
- Crack cocaine prevalence has increased since 2011-12.
- The prevalence of illicit opiate use has remained relatively stable during this time though is showing a recent slight upward trend.
- The overall use of opiates and/or crack cocaine increased significantly between 2014-15 and 2016-17 as a likely result of increased crack use.

- Using NDTMS data it is possible to model new incidence of crack and heroin use
- The estimate number of new users of crack fell substantially between 2005 and 2012.
- However incidence has increased since then.
- Notably in the under 30s.

Modelled incidence of crack cocaine use

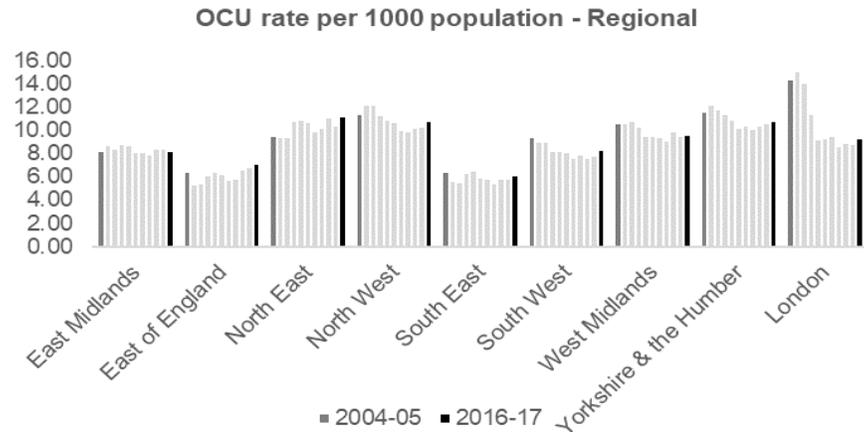


Modelled incidence of heroin use



- Contrastingly, new incidences of heroin use have fallen continuously since 2005.
- This is driven by a substantial reduction of under 30s using the drug.
- Though this fall has slowed over recent years.

The highest rates of illicit opiate and/or crack use are in the north of the country



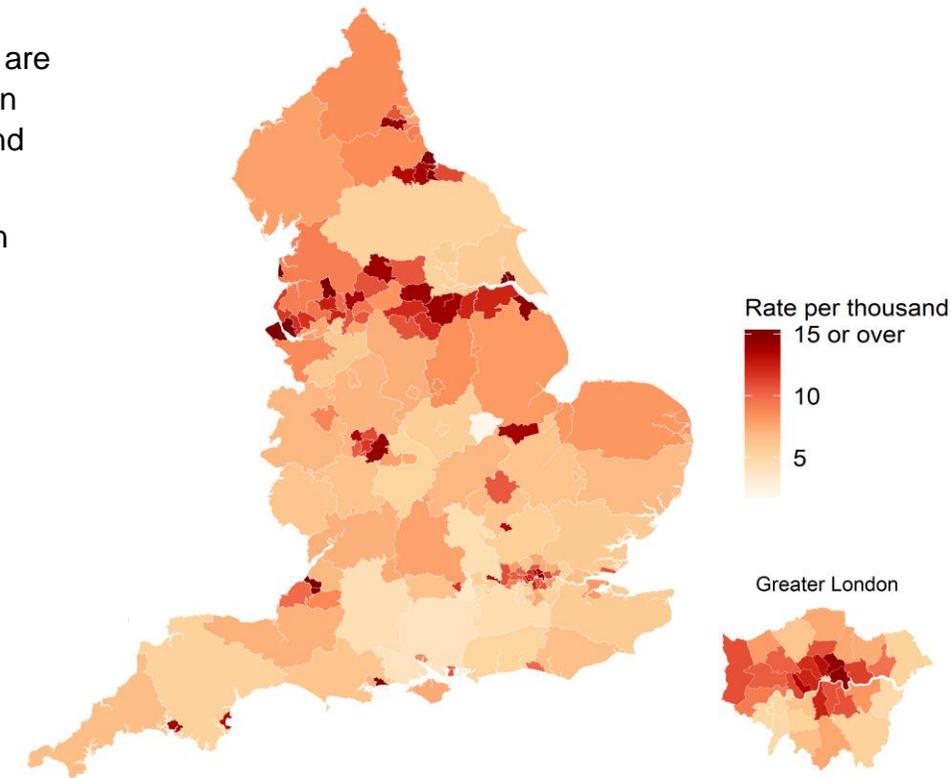
- Middlesbrough and Blackpool have the highest rates of OCU per population, 2.5 times the national average (8.7 per 1000).
- Nearly all the areas with the lowest rates are in the South East or London.

Highest and lowest rates of opiate and/or crack cocaine use			
Local Authority	OCU rate per 1000 population	Local Authority	OCU rate per 1000 population
Middlesbrough	25.51	Warwickshire	5.26
Blackpool	23.45	Richmond upon Thames	4.91
Hartlepool	20.63	Kingston upon Thames	4.89
Blackburn with Darwen	18.84	Bexley	4.88
Kingston upon Hull, City of	18.15	Bracknell Forest	4.58
Liverpool	17.06	Surrey	4.56
Bristol, City of	15.66	Buckinghamshire	4.46
Wirral	15.63	Wiltshire	4.41
Bournemouth	15.05	Hampshire	4.07
Stoke-on-Trent	14.67	Wokingham	3.63

- The North West and North East now have the highest rates of illicit opiate and/or crack cocaine use, with the North East seeing a sustained increase in use over the last 15 years.
- Most other regions have seen falls in their rates during this time or they are at the same level as they were in 2004-05.
- London saw substantial falls in their rates at the end of the last decade, with the rate levelling off since then.

- The highest rates of OCU are clustered primarily in urban areas of the North East and North West.
- With pockets also in urban areas across the country

OCU prevalence rate per 1000 population

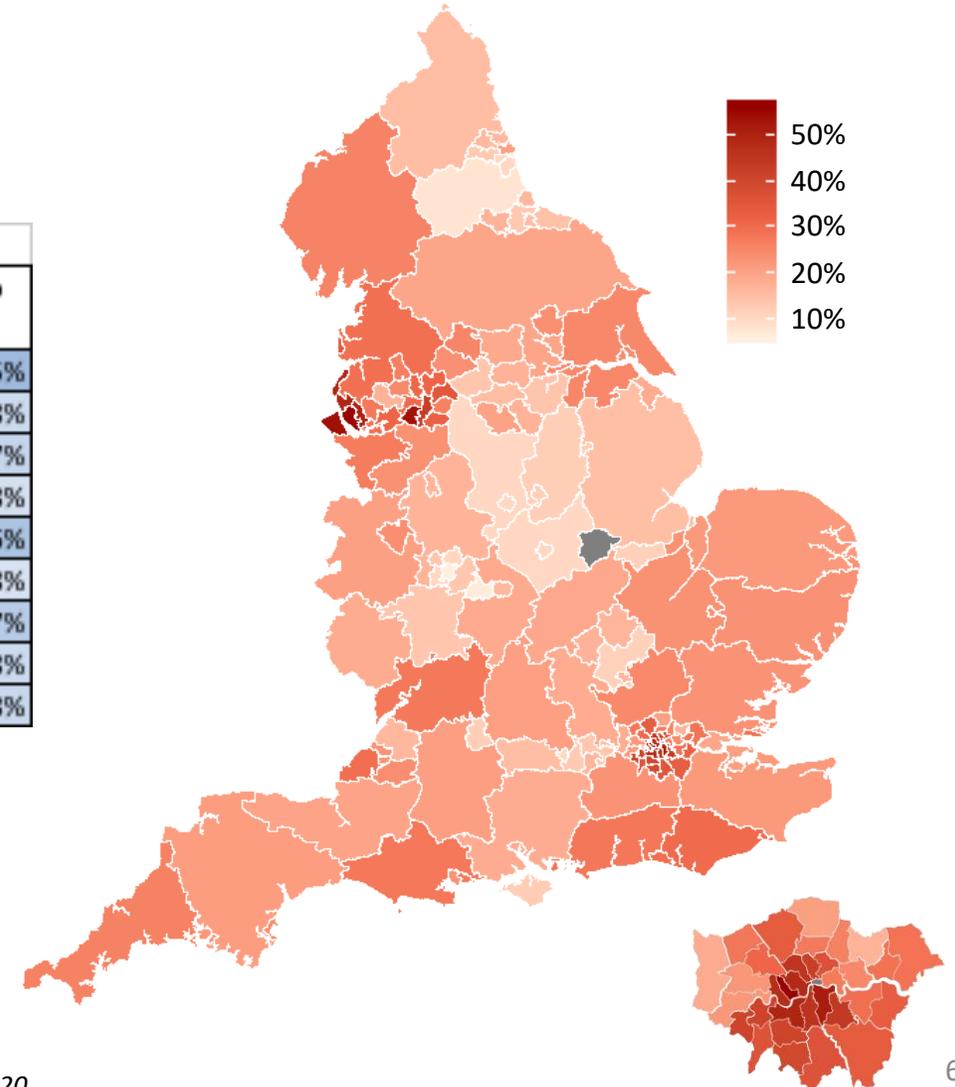


The heroin epidemics of the 1980s and 1990s hit the North West and London first

- While the North East and North West have very similar rates of opiate and/or crack use, many more users in the North West currently in treatment started their use pre-1990 (table below).
- The North East has the highest percentage of heroin users having started their use post-1990.
- London has a similar pattern of 'year of first use' as the North West with nearly a third of heroin users in treatment having started pre-1990.

Year of first heroin use by region								
	1980 and before	1981 to 1985	1986 to 1990	1991 to 1995	1996 to 2000	2001 to 2005	2006 to 2010	2011 to 2015
North West	2%	14%	18%	22%	17%	10%	6%	5%
London	6%	12%	13%	17%	18%	11%	9%	8%
South West	3%	7%	13%	23%	22%	13%	10%	7%
East of England	3%	6%	11%	19%	23%	15%	11%	8%
Yorkshire	2%	5%	13%	28%	25%	11%	7%	6%
South East	5%	6%	11%	19%	22%	15%	12%	8%
West Midlands	10%	4%	8%	21%	31%	15%	9%	7%
East Midlands	5%	4%	9%	22%	29%	14%	10%	8%
North East	4%	3%	9%	24%	28%	15%	9%	8%

Opiate clients by year of first use
% of clients pre-1990

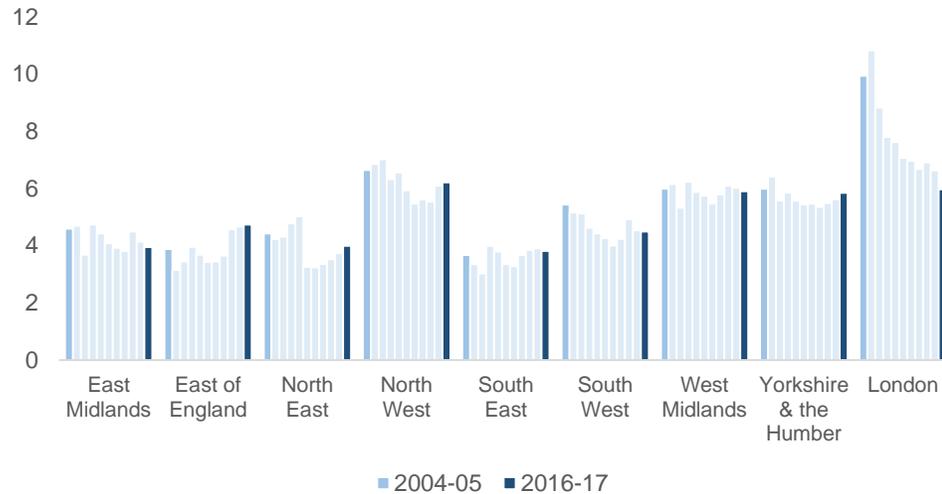


- The 20 Local Authorities with the highest rates of long term heroin use are all in the North West and London.
- However outcomes, mortality and morbidity is vastly different for heroin users between the two regions with the North West having much poorer rates of recovery and much higher rates of deaths.

The increases in crack cocaine use have occurred outside of the more established urban areas

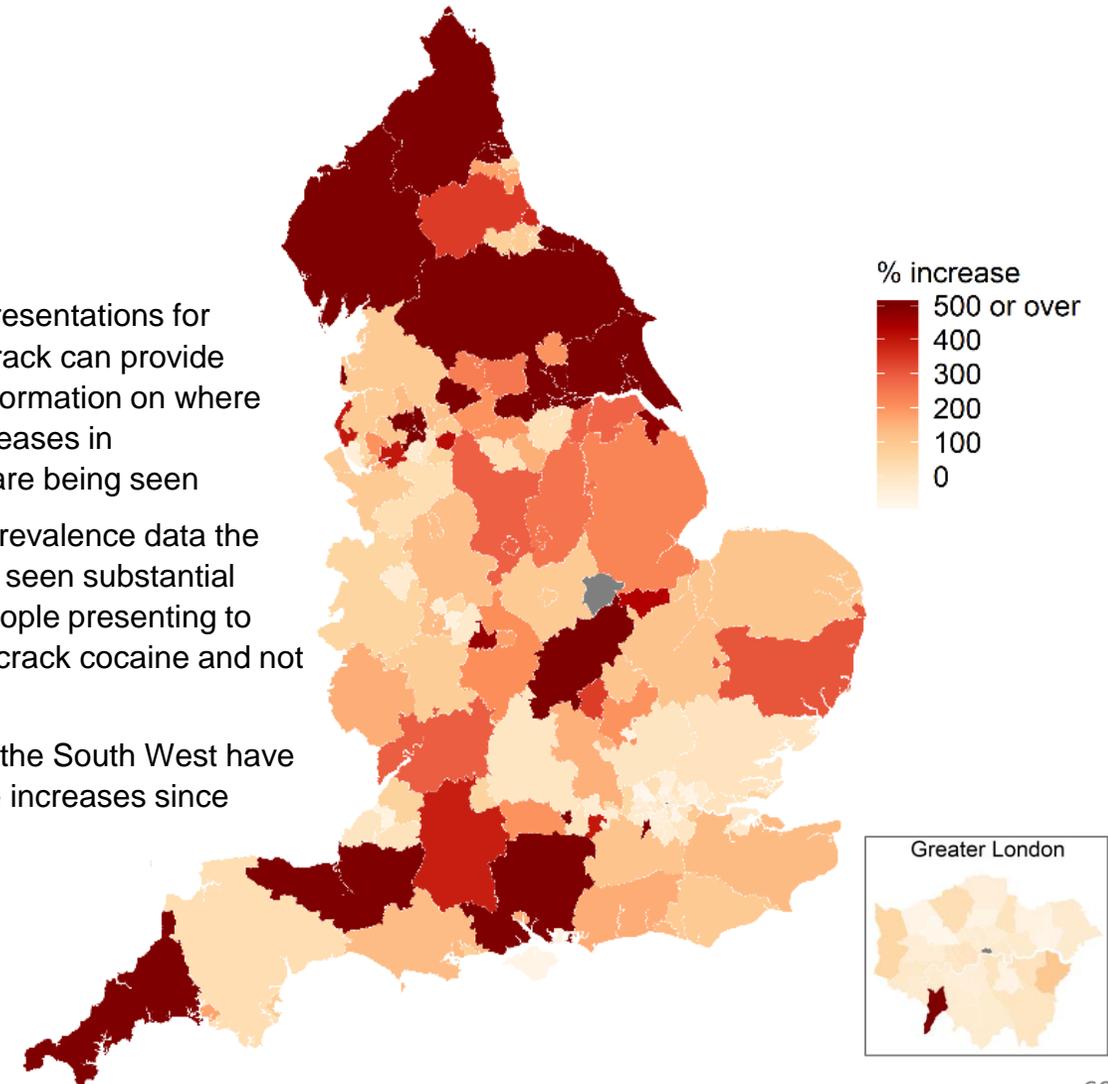
Increase in crack only clients from 2012-13 to 2018-19

Estimated rate of crack cocaine use per 1000 population - Regional



- While London still has one of the highest rates of crack use, it has fallen substantially over the last 10 years.
- Whereas other regions such as the East of England, the South East and the North East have seen significant increases since 2012.
- The increases in crack use in these areas are likely, in part to be due to changes in patterns of distribution/quality.
- Particularly county lines and the increases in availability and purity

- Data on new presentations for treatment for crack can provide more recent information on where the largest increases in use/incidence are being seen
- Similar to the prevalence data the North East has seen substantial increases in people presenting to treatment with crack cocaine and not opiates
- Some areas in the South West have also seen large increases since 2012-13



Prevalence summary

- The increases in opiate and crack users (OCUs) is likely to be driven by people using crack without opiates.
- The highest rates of OCU are seen in the north of the country and in the most deprived areas, this is also where the poorest treatment outcomes and highest harms are seen.
- The rates in the North vary in terms of when each of the regions was hit by the heroin epidemics of the 1980s and 90s. The North West has a much higher percentage of people starting heroin use in the 1980s and before, similar to London.
- The increases in crack use have been geographically widespread but particularly concentrated in the North East and also in less established urban areas.
- New crack drug markets are opening up in these areas driven by changes in distribution patterns and county lines.
- New crack use has been seen across all age groups, with more use of crack alongside opiates in older long-time heroin users increasing their risk of mortality.
- Anecdotal evidence suggests that previous negative associations with crack are not seen in freebasing cocaine, with a risk that cocaine smoking then leads to cheaper and easier crack use.
- As most of the individual and societal harms and costs are associated with OCUs then any increases in prevalence will likely increase the level of drug-related harms and costs.
- Further research is needed into why some, particularly younger and new, crack cocaine users do not access currently available treatment.

Key findings from PHE and HO investigation into increases in crack cocaine prevalence – carried out in 2018

Factors influencing the rise in crack use

The investigation has identified several factors which may have influenced the rise in crack use, including increased availability and affordability of crack and aggressive marketing of the drug by dealers.

These factors are likely to be linked to the surge in global production of cocaine since 2013, as organised crime groups have potentially taken advantage of excess supply to push crack cocaine onto a captive market of entrenched heroin users and groups of new users.

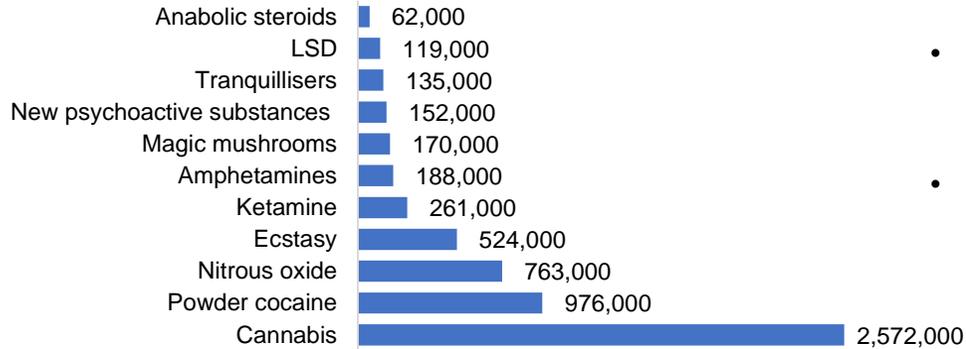
Other factors linked to the increase in crack cocaine use, which were not directly linked to the increased supply, were changes in the stigma about crack and a lack of police focus on targeting drug dealing. It was not clear from this enquiry whether county lines drug dealing operations had driven the increase in crack use, given that use had also increased in areas where county lines were not prevalent.

However, the findings support existing evidence and there was a widespread view among police officers, treatment workers and service users that county lines groups were much more likely than local groups to engage in serious violence and to exploit vulnerable young people and drug users.

7. Recreational drug use

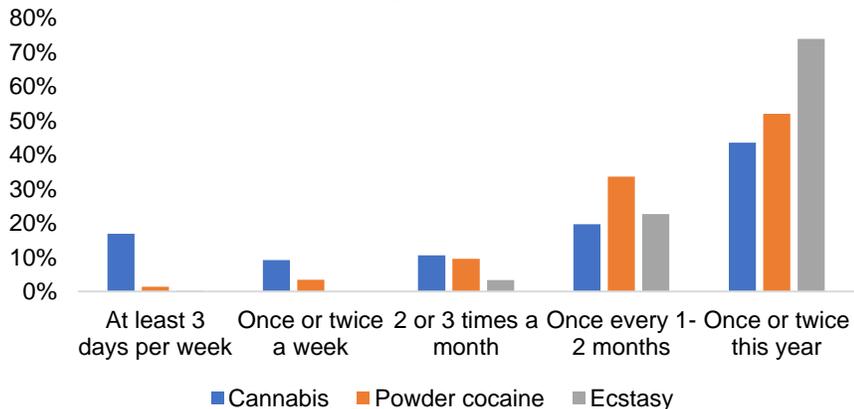
Use of recreational drugs in those aged 16 and over

Number of people aged 16-59 in England and Wales who used selected drugs in the last year, 2018/19



- The large majority of people who use drugs each year are occasional users.
- This is particularly the case for drugs associated with the night-time economy such as powder cocaine and ecstasy, where over half of users had only used the drug once or twice in the year.
- Frequent use of cannabis is more prevalent, with 17% of users reporting that they had used the drug at least 3 days per week.

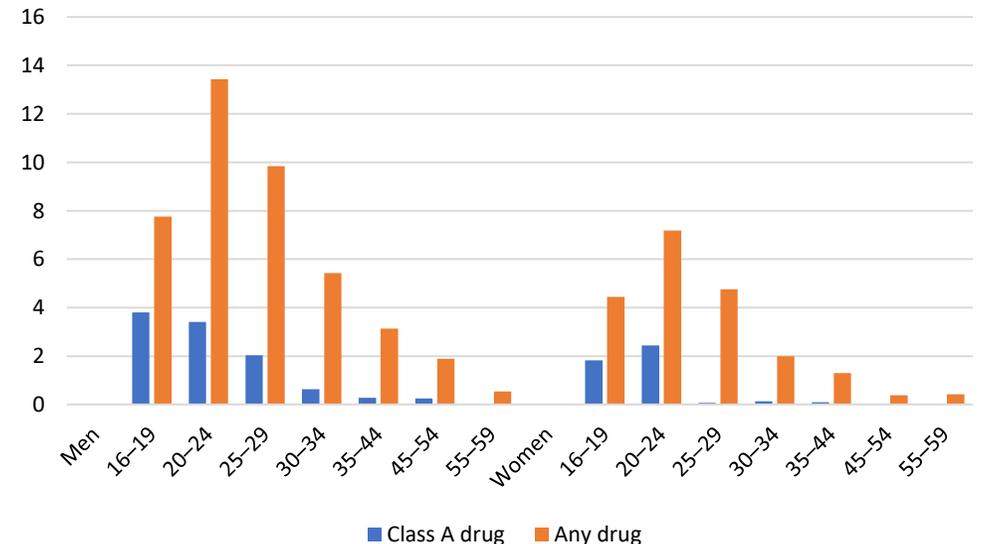
Frequency of use among people aged 16-59 in England and Wales who used selected drugs in the last year, 2018/19



- Around 9% of the population (3.2 million people) used any drug in the last year, although 34% (11.6 million people) have used a drug at some point in their lifetime.
- A large number of recreational drugs are available, but cannabis is by far the most widely used among those aged 16 and over in England and Wales, with an estimated 2.6 million people doing so in 2018/19.
- The large majority of people who use recreational drugs will not go on to develop issues with problematic use, and will often stop using them by their 30s.

- Drug use is far more prevalent in those aged under 30, peaking in the 20-24 age group for class A and all drugs.
- The rate of drug use among men is about twice that of women in nearly all age groups.

Percentage of people reporting drug use in the last year by age and gender



Rates of drug use among 16-59 year olds

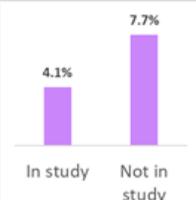
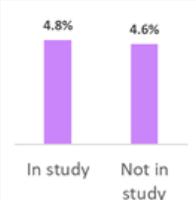
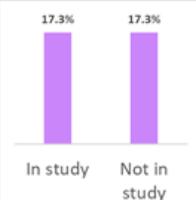
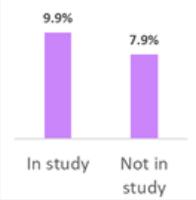
This table presents the rates of drug use among different groups. For example, the table shows that 4% of men reported cocaine use in the last year, with 7.7% of those aged 20-24 and 5.2% of those that said they had low life satisfaction saying they used the drug.

	Total population (aged 16-59)	Age	Sex	Ethnicity	Income (£)	Life satisfaction																																												
Powder cocaine	 2.9%	<table border="1"> <tr><td>16-19</td><td>4.1%</td></tr> <tr><td>20-24</td><td>7.7%</td></tr> <tr><td>25-29</td><td>6.2%</td></tr> <tr><td>30-34</td><td>2.9%</td></tr> <tr><td>35-39</td><td>2.6%</td></tr> <tr><td>40-49</td><td>1.1%</td></tr> <tr><td>50-59</td><td>0.4%</td></tr> </table>	16-19	4.1%	20-24	7.7%	25-29	6.2%	30-34	2.9%	35-39	2.6%	40-49	1.1%	50-59	0.4%	4.0% 1.7%	<table border="1"> <tr><td>White</td><td>3.3%</td></tr> <tr><td>Mixed</td><td>6.2%</td></tr> <tr><td>Asian or Asian British</td><td>0.3%</td></tr> <tr><td>Black or Black British</td><td>0.6%</td></tr> <tr><td>Chinese or Other</td><td>0.6%</td></tr> </table>	White	3.3%	Mixed	6.2%	Asian or Asian British	0.3%	Black or Black British	0.6%	Chinese or Other	0.6%	<table border="1"> <tr><td>Under 10,000</td><td>2.0%</td></tr> <tr><td>10,000- 19,999</td><td>2.0%</td></tr> <tr><td>20,000-29,999</td><td>2.1%</td></tr> <tr><td>30,000-39,999</td><td>1.6%</td></tr> <tr><td>40,000- 49,999</td><td>2.8%</td></tr> <tr><td>50,000 or more</td><td>3.4%</td></tr> </table>	Under 10,000	2.0%	10,000- 19,999	2.0%	20,000-29,999	2.1%	30,000-39,999	1.6%	40,000- 49,999	2.8%	50,000 or more	3.4%	<table border="1"> <tr><td>Low</td><td>5.2%</td></tr> <tr><td>Medium</td><td>3.9%</td></tr> <tr><td>High</td><td>3.0%</td></tr> <tr><td>Very High</td><td>2.2%</td></tr> </table>	Low	5.2%	Medium	3.9%	High	3.0%	Very High	2.2%
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Rates of drug use among 16-24 year olds

This table presents the rates of drug use among 16-24 year olds specifically for demographics which are correlated with age (for example educational status, as young people are more likely to be students). For example, this table shows that 8.1% of 16-24 year old males used powder cocaine in the last year.

	Total population (aged 16-24)	Sex	Students vs. non-students	Alcohol Consumption Per week	Visits to pubs Per month	Visits to clubs Per month	Highest Qualification																														
Powder cocaine	 6.2%	 8.1%  4.2%		<table border="1"> <tr><td>Less than once</td><td>0.9%</td></tr> <tr><td>Less than a day</td><td>4.3%</td></tr> <tr><td>1-2 days</td><td>9.1%</td></tr> <tr><td>3 or more days</td><td>22.7%</td></tr> </table>	Less than once	0.9%	Less than a day	4.3%	1-2 days	9.1%	3 or more days	22.7%	<table border="1"> <tr><td>None</td><td>1.2%</td></tr> <tr><td>1-3 times</td><td>4.5%</td></tr> <tr><td>4-8 times</td><td>9.8%</td></tr> <tr><td>9+ times</td><td>28.6%</td></tr> </table>	None	1.2%	1-3 times	4.5%	4-8 times	9.8%	9+ times	28.6%	<table border="1"> <tr><td>None</td><td>3.0%</td></tr> <tr><td>1-3 times</td><td>12.9%</td></tr> <tr><td>4+ times</td><td>19.7%</td></tr> </table>	None	3.0%	1-3 times	12.9%	4+ times	19.7%	 <table border="1"> <tr><td>None</td><td>3.5%</td></tr> <tr><td>GCSE</td><td>4.3%</td></tr> <tr><td>Apprenticeship or A/AS level</td><td>8.7%</td></tr> <tr><td>Degree or diploma</td><td>6.1%</td></tr> </table>	None	3.5%	GCSE	4.3%	Apprenticeship or A/AS level	8.7%	Degree or diploma	6.1%
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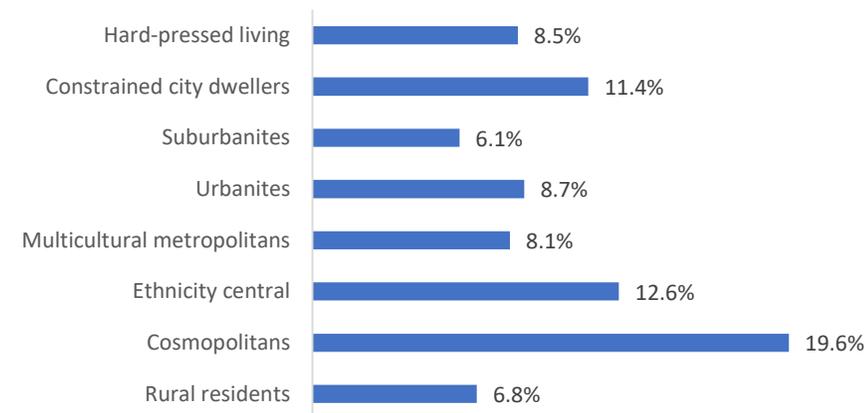
Rates of drug use by geography

This table presents the rates of drug use among different groups. For example, the table shows that 6.9% of 16-24 year olds living in a rural area used powder cocaine in the last year.

	Rural/Urban 16-24	Rural/Urban 25-59	Deprivation (Employment)
Powder cocaine	6.9%	1.7%	Most Deprived 20% 2.4%
	6.1%	2.2%	Middle 60% 3.1%
			Least Deprived 20% 3.0%
Ecstasy	3.7%	0.5%	Most Deprived 20% 1.2%
	4.9%	0.9%	Middle 60% 1.6%
			Least Deprived 20% 1.8%
Cannabis	18.0%	3.6%	Most Deprived 20% 8.7%
	17.2%	5.8%	Middle 60% 7.5%
			Least Deprived 20% 6.9%
Nitrous Oxide	8.6%	0.7%	Most Deprived 20% 1.4%
	8.7%	0.8%	Middle 60% 2.3%
			Least Deprived 20% 3.0%

- Recreational drug use was most prevalent in cosmopolitan areas and least prevalent among suburbanites and rural residents.

Any drug use in the last year among people aged 16-59 by residential area (2016/17-2018/19)



Any drug use in the last year among people aged 16-59 by region (2016/17-2018/19)



- The South West and South East had the highest rates of recreational drug use, while it was lowest in the North East and the West Midlands.

Profile and demographics of users of different drugs – number of users

This table presents a breakdown of the total number of people who used a certain drug in the last year. For example, the first cell in the table shows that 11% of all people who used powder cocaine in the last year were aged between 16 to 19. These figures are approximations as they involve combining CSEW data with other survey data with different samples and methodologies. A number of users will also use two or more of these drugs either together or throughout the course of the year. This is covered in more detail in the slide on multiple drug use.

	Age	Sex	Ethnicity	Profession	Income (£)																																				
Powder cocaine	<table border="1"> <tr><td>16-19</td><td>11%</td></tr> <tr><td>20-24</td><td>29%</td></tr> <tr><td>25-29</td><td>25%</td></tr> <tr><td>30-34</td><td>12%</td></tr> <tr><td>35-39</td><td>10%</td></tr> <tr><td>40-49</td><td>8%</td></tr> <tr><td>50-59</td><td>4%</td></tr> </table>	16-19	11%	20-24	29%	25-29	25%	30-34	12%	35-39	10%	40-49	8%	50-59	4%	<p>70% 30%</p>	<table border="1"> <tr><td>White</td><td>94%</td></tr> <tr><td>Mixed Asian or Asian</td><td>5%</td></tr> <tr><td>British Black or Black</td><td>1%</td></tr> <tr><td>British Chinese or Other</td><td>1%</td></tr> <tr><td>Other</td><td>0%</td></tr> </table>	White	94%	Mixed Asian or Asian	5%	British Black or Black	1%	British Chinese or Other	1%	Other	0%	<p>Unemployed 3% Manual work 35% Intermediate occupations 21% Higher managerial & professional occupations 42%</p>	<table border="1"> <tr><td>Under 10,000</td><td>3.2%</td></tr> <tr><td>10,000- 19,999</td><td>19.9%</td></tr> <tr><td>20,000-29,999</td><td>24.9%</td></tr> <tr><td>30,000-39,999</td><td>14.7%</td></tr> <tr><td>40,000- 49,999</td><td>13.5%</td></tr> <tr><td>50,000 or more</td><td>23.8%</td></tr> </table>	Under 10,000	3.2%	10,000- 19,999	19.9%	20,000-29,999	24.9%	30,000-39,999	14.7%	40,000- 49,999	13.5%	50,000 or more	23.8%
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Summary of the demographics of recreational drug users

Age

Under 30s account for 61% of all last-year users of recreational drugs
Ecstasy and nitrous oxide use is particularly prevalent among younger users, while use of powder cocaine and cannabis are more likely to persist in the over 30s

Gender

Men account for 67% of all last-year drug users
Across all the main drug types, men are twice as likely as women to use drugs

Ethnicity

For all of the main drug types, recreational drug use is much higher among those who self-define as “Mixed” ethnicity, which may be partially linked to higher levels of deprivation among this group

Household income

Cannabis use is more prevalent among those with an annual household income of less than £10,000, while powder cocaine use is most prevalent among those on annual household incomes above £50,000

Geography

Overall drug use is highest in the South West and South East of England, and is the lowest in the North East and the West Midlands

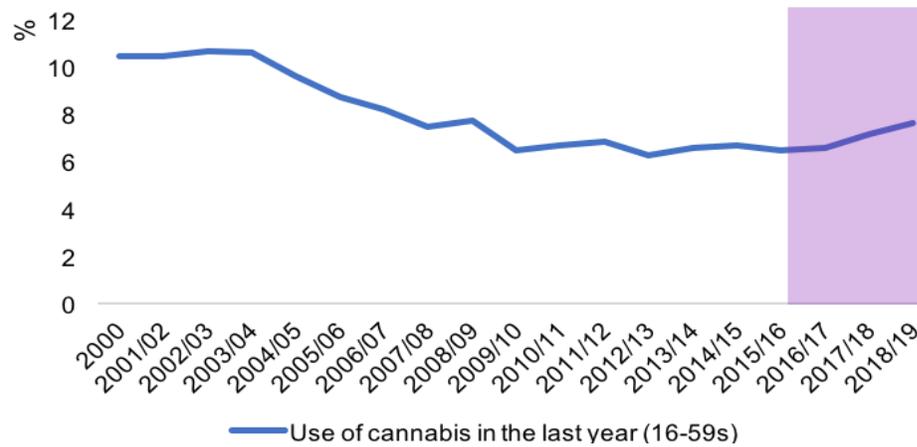
Other factors

Use of ecstasy and nitrous oxide is higher among students than non-students of the same age
Drug use is considerably higher among those who regularly consume alcohol and visit pubs/clubs, even after controlling for age

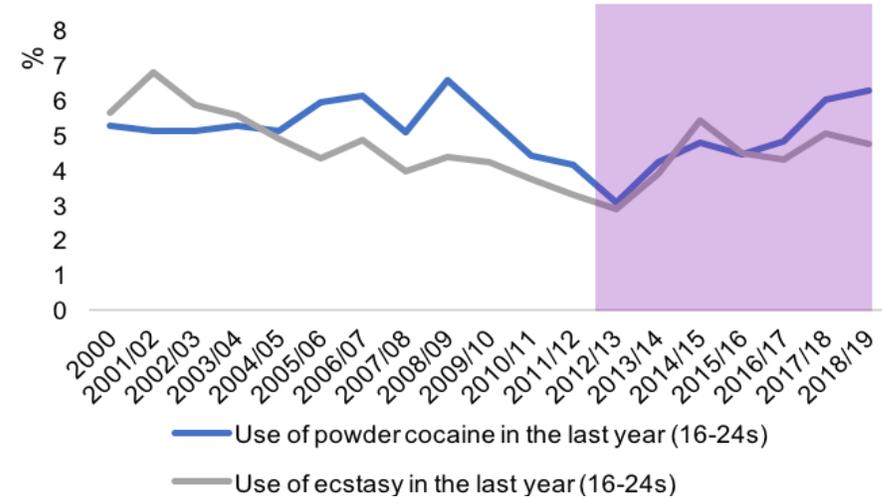
Trends in recreational drug use

- While drug use is generally lower than or at similar levels as 20 years ago, there have been notable increases in use over the last six years for a number of substances.
- The increase in use has been particularly apparent among the under 30s and also those of school age.

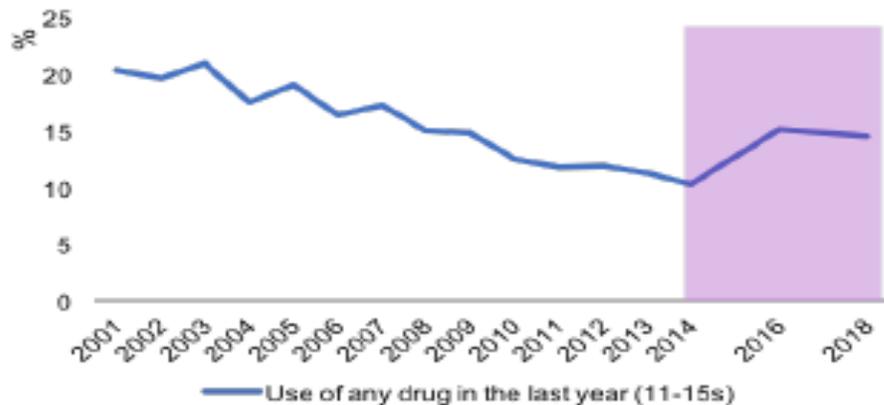
1) Increased use of cannabis



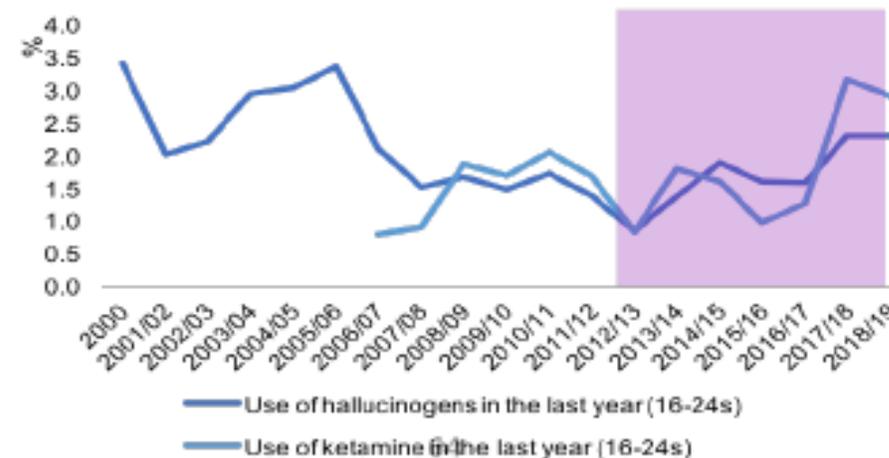
2) Increased use of powder cocaine & ecstasy among 16-24s



3) Increased use of drugs among children



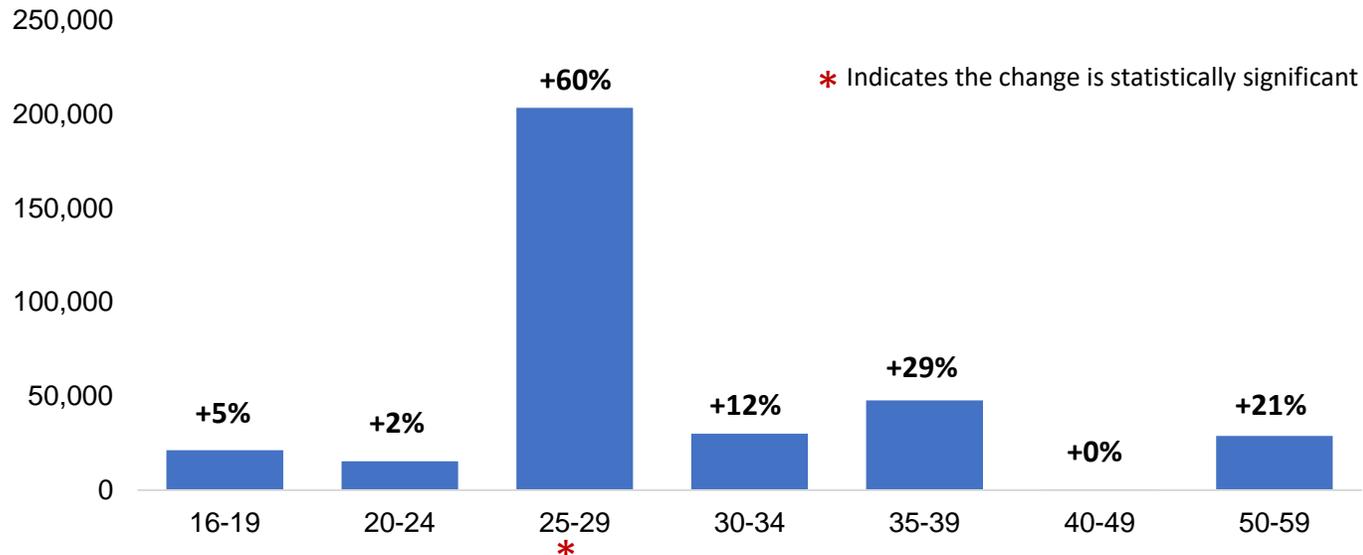
4) Increased use of hallucinogens & ketamine among 16-24s



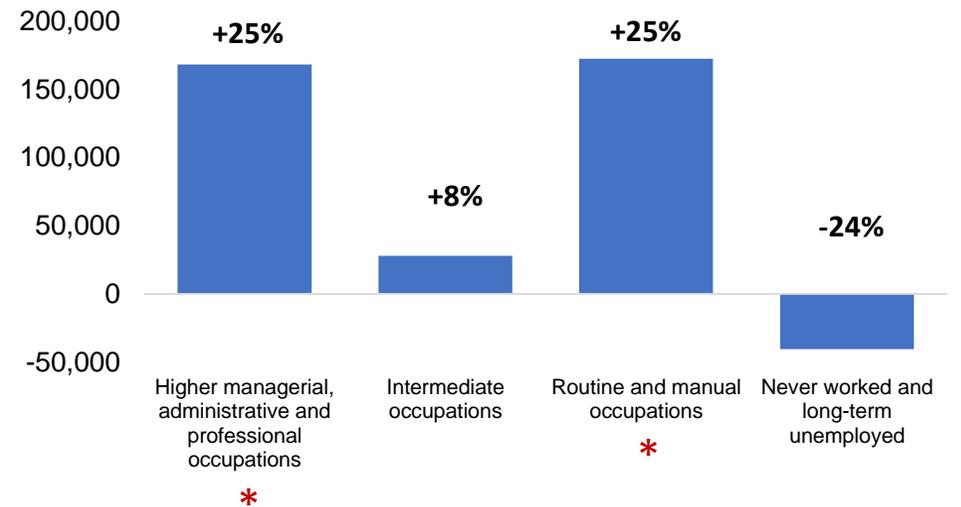
Trends in cannabis use

- Between 2016/17 and 2018/19, the number of cannabis users has risen by around 350,000 (a 16% increase).
- This increase was largely driven by those aged 25-29, who accounted for around 60% of the total increase in users.
- There were increases in use among other age groups, but the increase among 25-29 year olds was particularly marked and was statistically significant.
- The increase in use was also driven by males, with a rise of 221,000 men who used cannabis in the last year, compared with an increase of 131,000 women. However both were statistically significant increases.

Change in the number of cannabis users between 2016/17 and 2018/19 by age

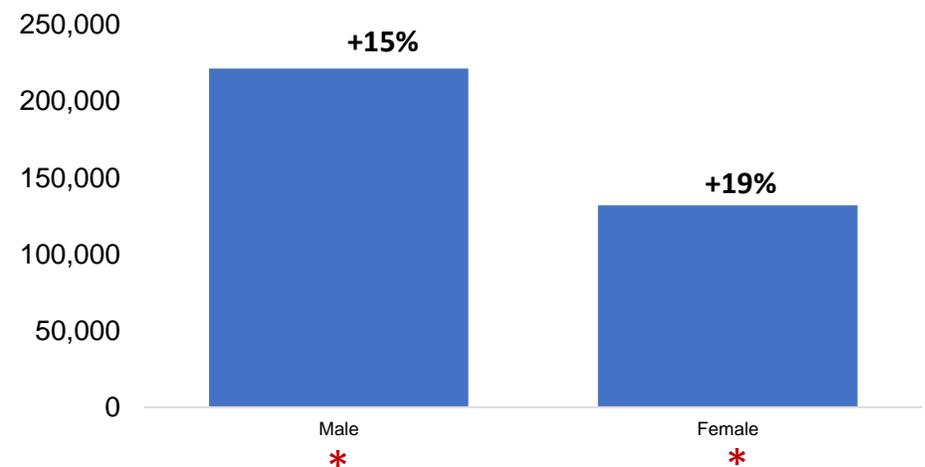


Change in the number of cannabis users between 2016/17 and 2018/19 by profession



* Indicates the change is statistically significant

Change in the number of cannabis users between 2016/17 and 2018/19 by gender



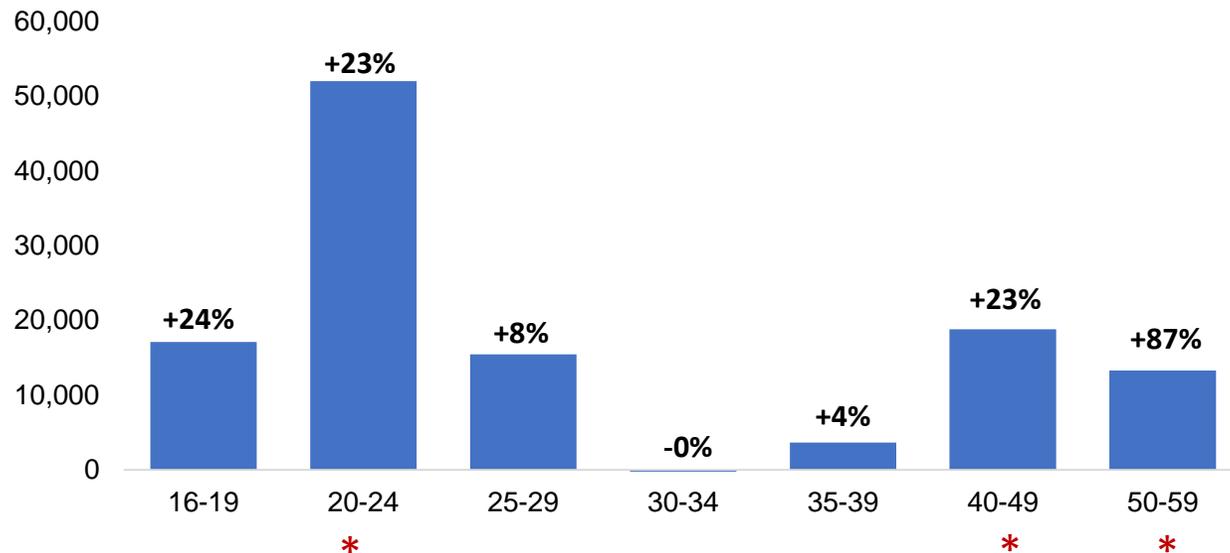
* Indicates the change is statistically significant

Source: i) [Drug Misuse Statistics, Home Office 2019](#). ii) [England and Wales 2011 Census](#). iii) [Estimates of the population, ONS 2019](#). iv) Unpublished data from [Drug Misuse Statistics, Home Office 2019](#)

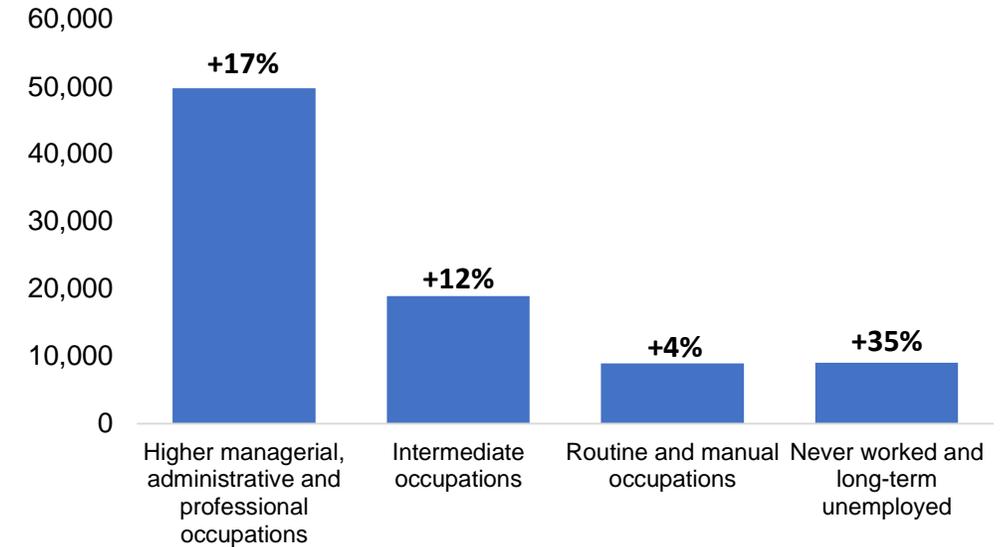
Trends in powder cocaine use

- Between 2013/14 and 2018/19, the number of powder cocaine users has risen by around 200,000 (a 24% increase).
- Men under the age of 30 are the largest group of powder cocaine users, so they have made the largest contribution to this increase in use.
- However, use has also increased across most other demographics, such as those in their 50 or those aged 16-19 and there was a statistically significant increase in the number of women reporting use of the drug.
- Those in higher managerial, administrative and professional occupations are also driving much of this increase, as they make up a large proportion of powder cocaine users.

Change in the number of powder cocaine users between 2013/14-2015/16 and 2016/17-2018/19 by age

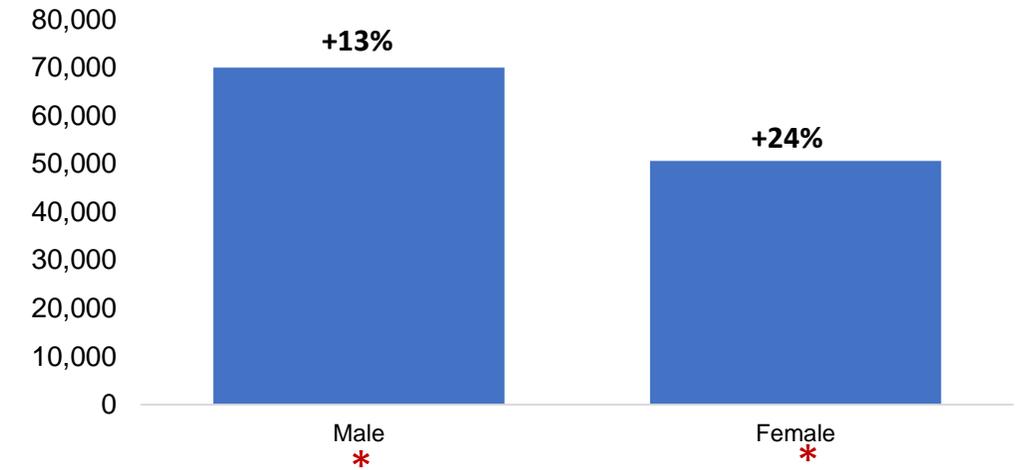


Change in the number of powder cocaine users between 2013/14-2015/16 and 2016/17-2018/19 by occupation



* Indicates the change is statistically significant

Change in the number of powder cocaine users between 2013/14-2015/16 and 2016/17-2018/19 by gender

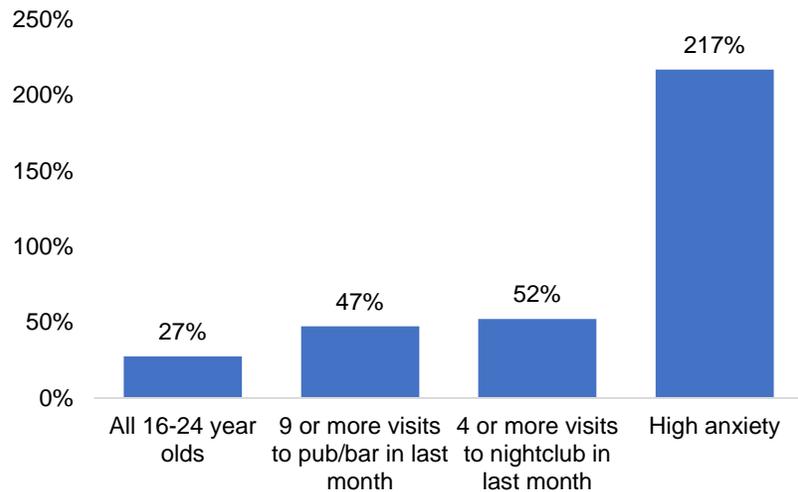


* Indicates the change is statistically significant

Potential drivers behind the increase in powder cocaine use

- Although the night-time economy has always been closely associated with powder cocaine use, this association appears to have grown stronger in recent years. Powder cocaine use has increased considerably more among those who regularly visit pubs and clubs.
- Anxiety among young people may also be a factor, with large increases in the use of powder cocaine (and of other recreational drugs) among young people who report high levels of anxiety:

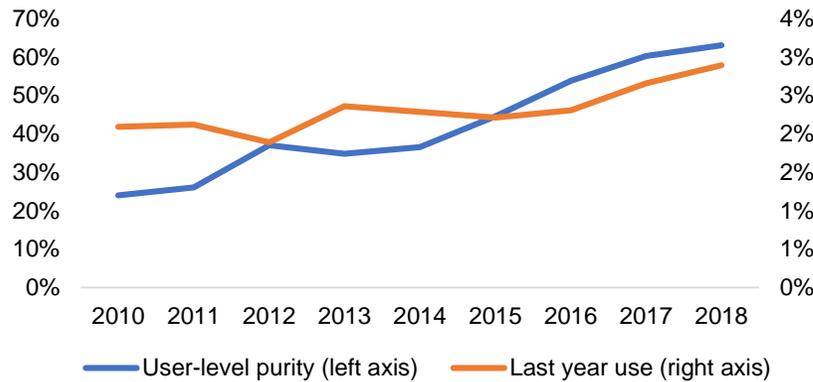
Change in the rate of powder cocaine use among 16-24 year olds (2013/14-2015/16 vs 2016/17-2018/19)



- Academics have identified the normalisation of drugs in the media as a potential factor behind increased drug use more generally, such as coverage of international cannabis legalisation and county lines.

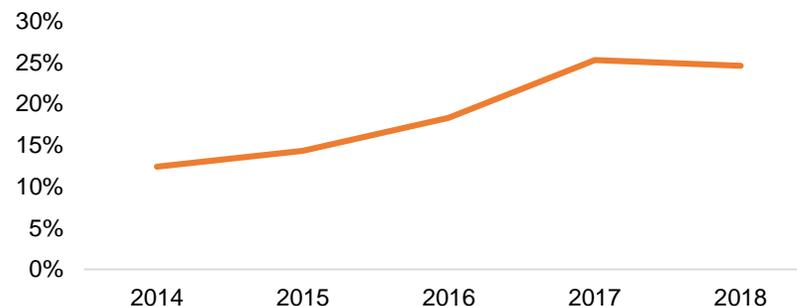
- It is likely that the increased availability and affordability of powder cocaine is a key driver of increased use, with usage increasing in line with purity:

Use of powder cocaine in the last year and user-level purity of powder cocaine



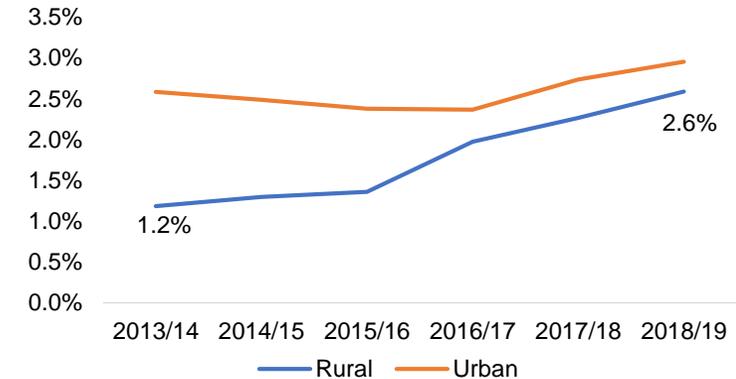
- The dark-web and social media may also be a factor, given the increase in young people obtaining drugs this way:

Proportion of UK drug users who had obtained drugs from the dark web (average age of respondents in 2018 = 25)



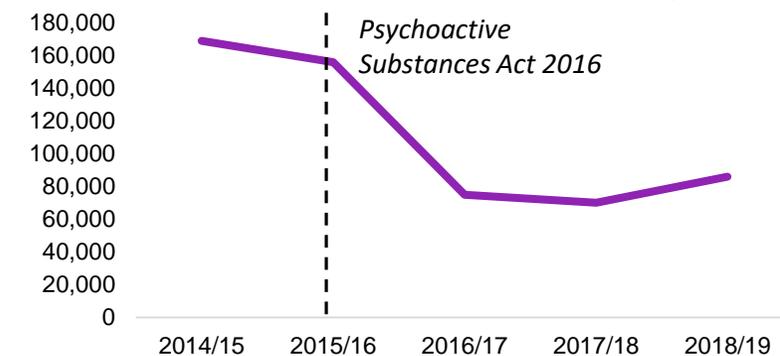
County lines may be factor, as usage is particularly increasing in rural areas. Intelligence suggests that some individuals in county lines groups may supply drugs such as powder cocaine as a side-line:

Powder cocaine use in the last year



- Another factor may be displacement from new psychoactive substances (NPS), with NPS use among 16-24 year olds falling considerably when the Psychoactive Substances Act was introduced:

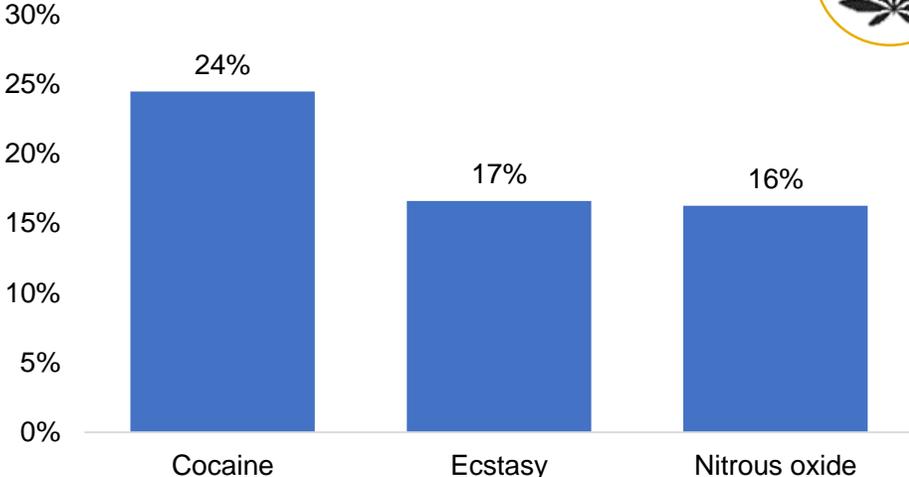
Number of 16-24s who used NPS in the last year



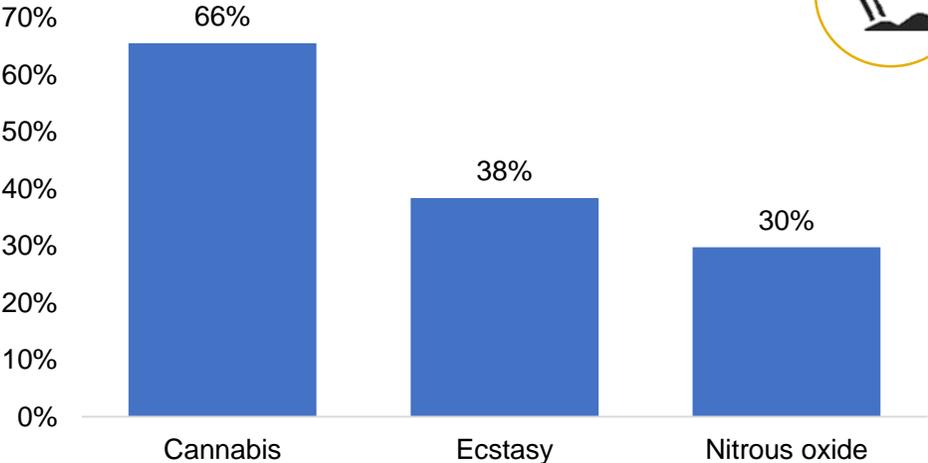
Use of multiple recreational drugs

- There is significant overlap between the use of recreational drugs. 36% of those who took a drug last year took more than one drug (although not necessarily at the same time).
- Ecstasy users reported the highest levels of polydrug use, with just over four in five saying that they had also used cannabis in the year and 7 in 10 also powder cocaine.
- The lowest overlaps are for cannabis, with a quarter reporting use of cocaine as well and less than 1 in 5 also using ecstasy. This is to be expected given that the estimated number of cannabis users far outweighs that of other drugs.
- 0.8% of the population used cocaine, ecstasy and cannabis all within the past year.
- The trends in polydrug use over the last five years have remained broadly flat.

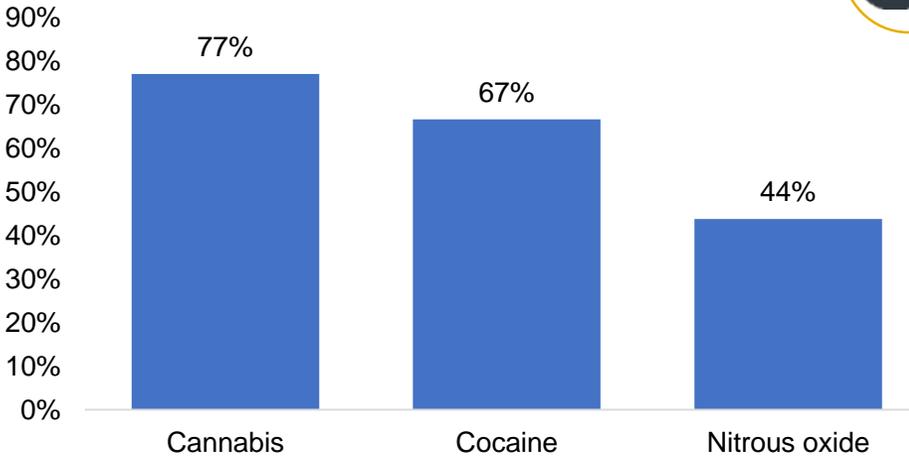
Proportion of last-year cannabis users who also used other drugs in the last year, 2018/19



Proportion of last-year powder cocaine users who also used other drugs in the last year, 2018/19



Proportion of last-year ecstasy users who also used other drugs in the last year, 2018/19



Source: Unpublished data from [Drug Misuse Statistics](#), Home Office 2019

8. Drug treatment and the factors associated with ensuring recovery from dependence

Funding, expansion and oversight of drug treatment – a brief history

National Treatment Agency (NTA) created with remit to oversee treatment in England and target to double number of drug users in treatment.

A ring-fenced pooled treatment budget (PTB) created – central funding allocated on need. Additional funding contribution from LAs, police and NHS. Funding increases from £50 million to nearly £500 million during 2000s.

Number in treatment target achieved highest rates of opiate users in treatment in western world. Focus shifts to recovery. PTB includes outcome component.

NTA subsumed into PHE and responsibility for drug and alcohol treatment moves from NHS to LAs. Ring-Fenced Public Health Grant (substance misuse about 25%).

Ring-fence on Public Health Grant proposed to be removed. Business Rates Retention proposed to supplement PHG funding.

2000

Close association identified between drug use (particularly heroin) and crime. Very few users in treatment.

2005

Drugs Intervention Programme led by HO. Specific funding and targeted interventions to ensure close links with CJS and treatment.

National Drug Treatment Monitoring System set up to monitor local set targets and performance manage sector.

2010

Effectiveness and cost effectiveness toolkits produced. Local areas supported to improve outcomes and reduce harms.

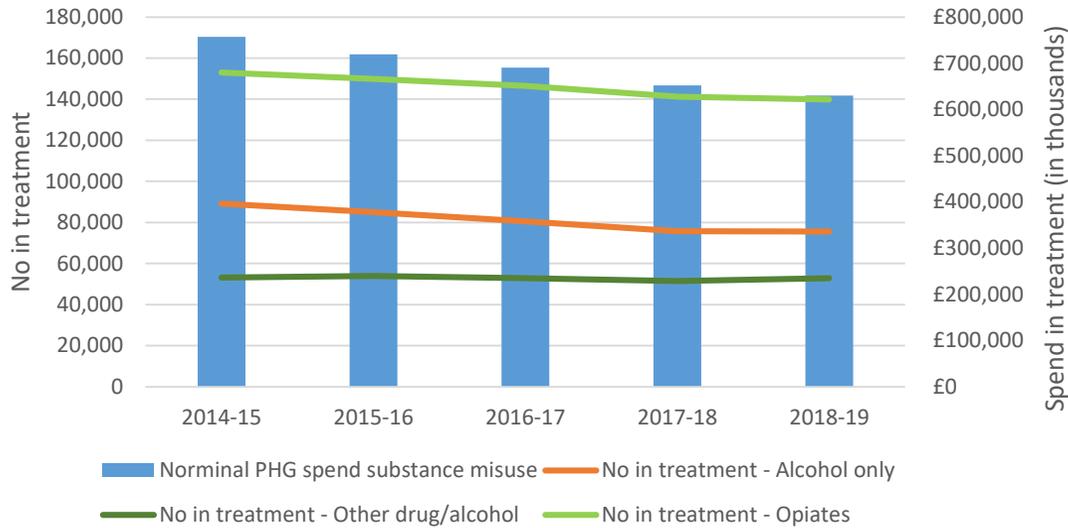
2015

Funding for treatment reduces significantly. Less accountability and limited oversight of drug treatment effectiveness and outcomes.

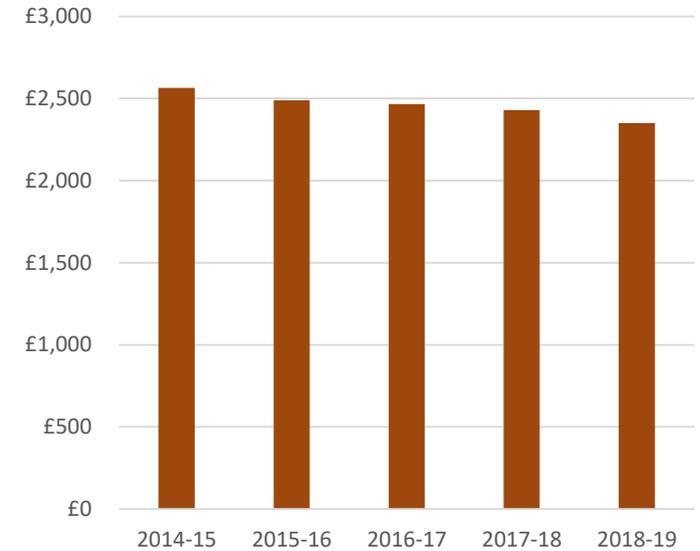
2020

Drug Treatment – funding, cost effectiveness and unmet need

Drug and Alcohol spend and numbers in treatment



Spend per person in treatment

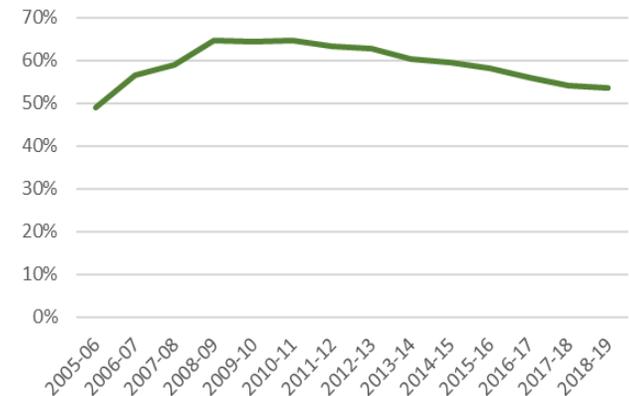


- The overall numbers in treatment have fallen at a similar rate as funding with the largest decreases seen in opiate users (and those in treatment for alcohol only)
- As both funding and numbers in treatment have fallen the cost per person has remained relatively stable over time

- Overall funding for treatment has fallen by 17% (it is not possible to disaggregate accurately between alcohol and drug treatment spend due to lack of robustness in reported expenditure data)
- Many local authorities will have reduced drug and alcohol expenditure by far larger amounts, with residential services being particularly hard hit
- Some areas are already 'rationing' treatment by setting higher thresholds for being able to access structured care
- With drug users who would have received treatment previously being diverted into less intensive and potentially less evidence based interventions
- Likely many areas are now offering the bare minimum service with large increases in worker caseloads an inevitability

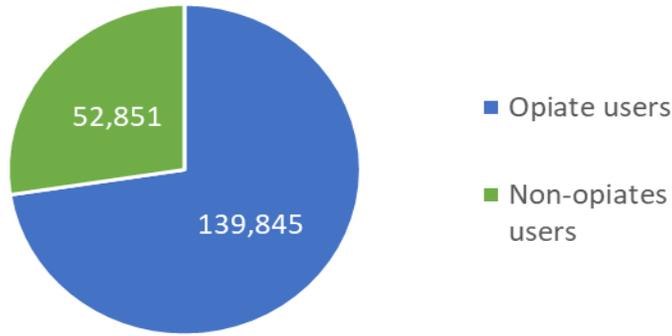
- With the prevalence of opiate and crack use increasing and number of opiate users in treatment falling, the levels of unmet need (those that need treatment not getting it) has increased

Proportion of opiate prevalent population in treatment



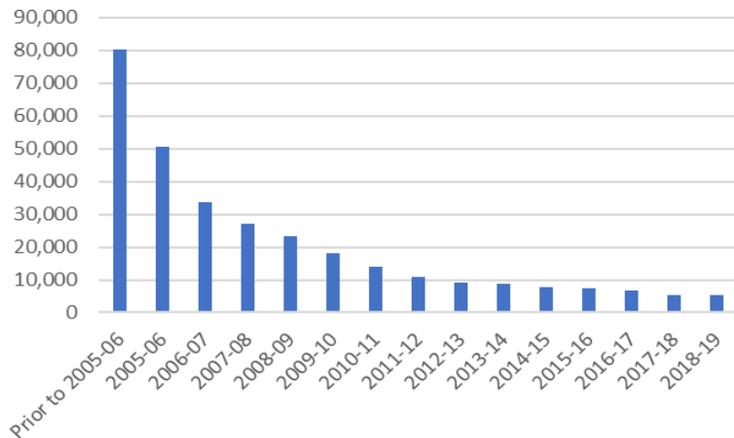
Profile of opiate users in treatment in 2018-19

Substance split of people in drug treatment

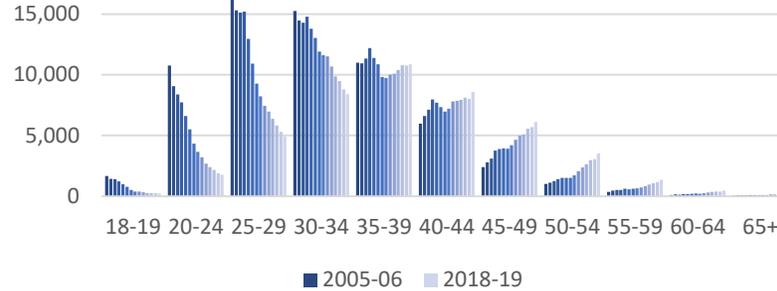


- Nearly three quarters of individuals in treatment are opiate users (primarily heroin)
- Most opiate users have been known to treatment services for some time, with a diminishing number of presenting for the first time ever (chart below)

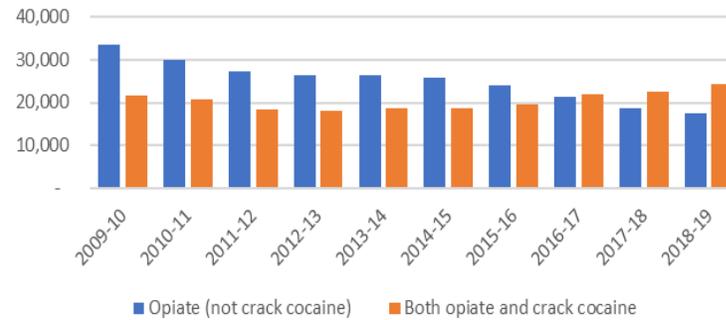
Opiates users first year of presentation to treatment



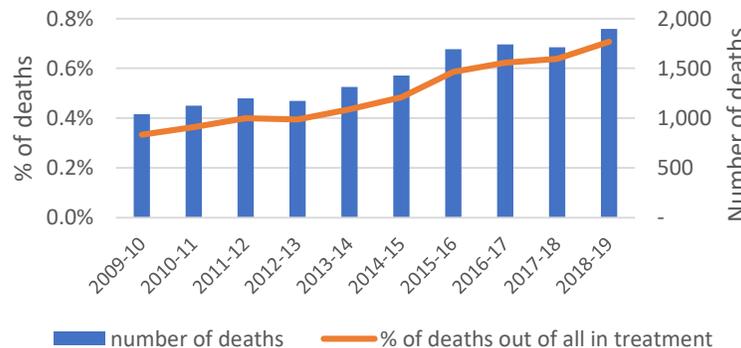
Opiate presentations to treatment by age



Presentations of opiates and crack cocaine



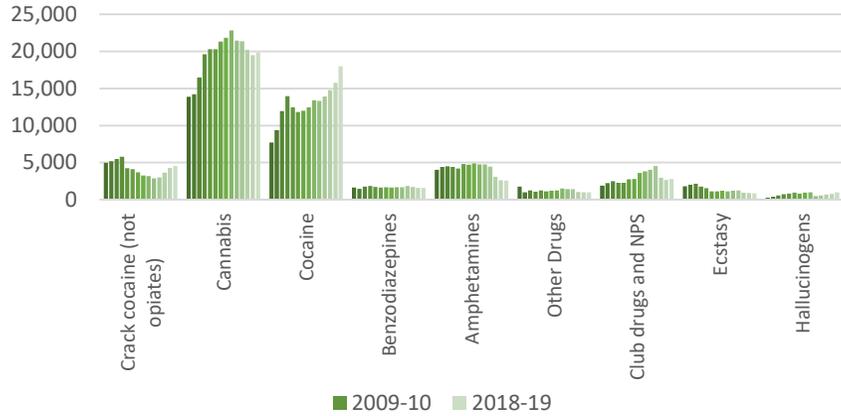
Deaths during treatment



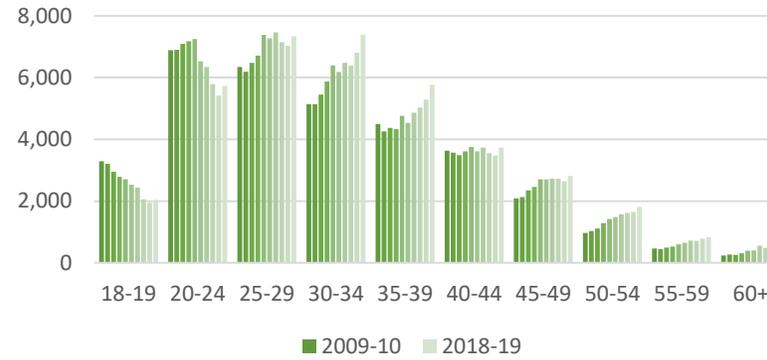
- Overall the number of opiate presentations fell sharply between 2005-06 and 2010-11 with the fall more gradual since then
- The fall in presentations was most substantial in the younger age groups reflecting the trends in incidence and prevalence
- Presentations in people aged over 35 have increased year on year since 2013-14
- Over recent years the proportion of opiate users presenting with crack problems has increased and is now higher than presentations without crack
- This will be predominantly long term heroin users that have now started using crack posing serious mortality and morbidity risks and reducing success rates
- The increased crack cocaine use in this group will reflect changes in supply and distribution patterns
- The number and rate of deaths during treatment have increased substantially since 2012-13
- With over 1% of opiate users now dying each year
- Nearly three quarters of these deaths occur in people under 50

Profile of non-opiate users in treatment in 2018-19

Presenting substance cited by non-opiate users



Presentations of non-opiate users by age

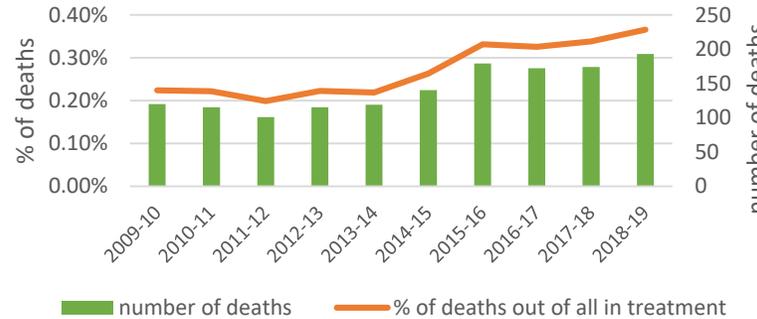


- Cannabis is the most cited problematic substance of users of non-opiate drugs, though the number of presentations has fallen since 2013-14
- There have been recent increases in crack and powder cocaine presentations
- The number of new non-opiate users (below) has remained stable reflecting relatively stable prevalence and a regular churn of people accessing treatment for the first time then achieving recovery.

Non-opiate clients presenting for the first time ever

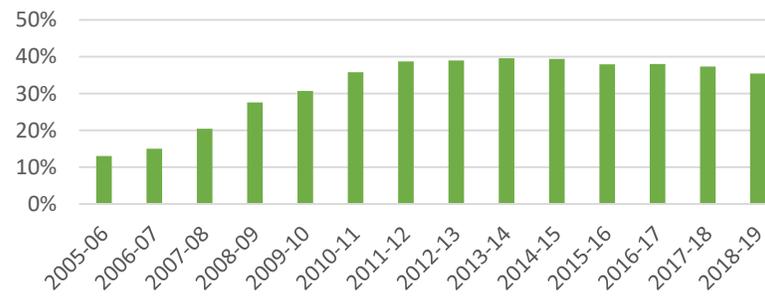


Deaths during treatment - non-opiates



- Overall the number of non-opiate presentations have remained relatively stable since 2009-10
- With the falls seen since 09-10 in the number of under 25s presenting being offset by large increases in the 25-40 age groups

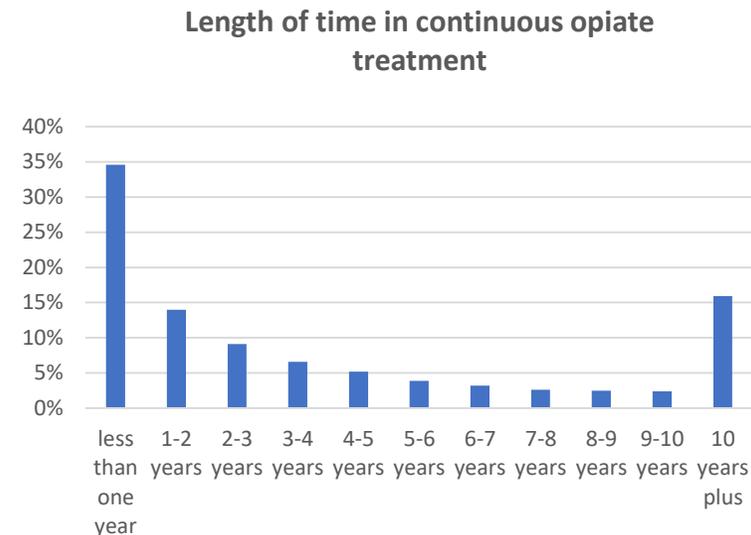
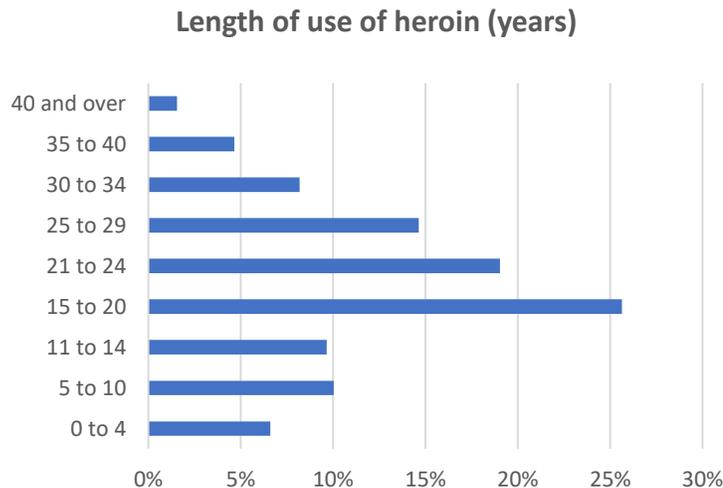
Successful completion of treatment - non-opiates



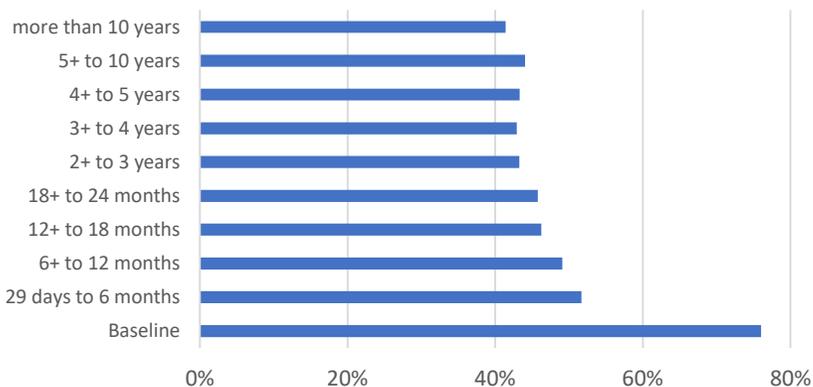
- While the rates and numbers of deaths are lower than seen in opiates, non-opiate deaths have increased at the same rate and over a similar time period
- Increasing 91% since 2011-12
- The rate of non-opiate users completing treatment successfully increased year on year until 2012-13
- After which the rate has remained more level and has seen a small fall in the last four years

Opiate users in treatment 2017-18 – factors impacting on recovery rates

- Half of heroin users in treatment have been using the drug for 21 years or more, with 1 in 7 using for over 30 years.
- The proportion using for longer periods is increasing year on year as fewer recently initiated users of heroin commence treatment.
- Thirty per cent of opiate users have been in treatment for over five years continuously with nearly 1 in 6 in treatment for over 10 years.
- People using heroin and those in treatment continuously for longer periods are significantly less likely to complete treatment successfully.
- While illicit heroin use falls substantially during treatment, there are around 1 in 4 people still using irrespective of length of time in treatment (chart below).



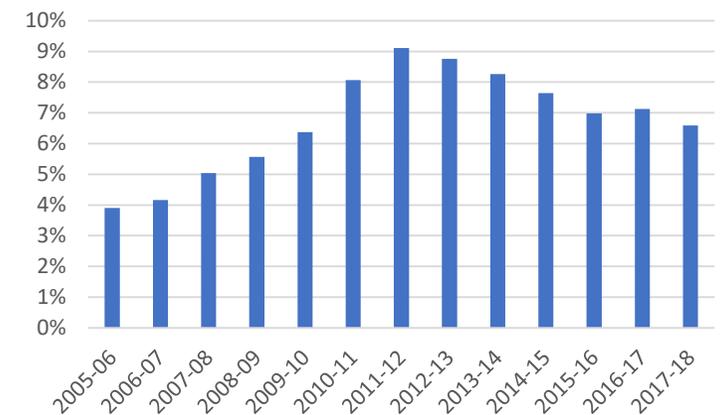
Proportion of opiate users reporting use of illicit opiates by length of time in treatment



There was a concerted system wide effort to improve treatment outcomes and recovery rates from 2008/09.

- Local areas were provided with toolkits, evidence, guidelines and offers of central clinical and other support with a focus on the poorest performing areas.
- Funding linked with both activity and outcomes also helped to drive improvements.
- The fall in recovery rates will be in part due to the most entrenched opiate users left in treatment and also reduced focus, prioritisation and accountability in the system.

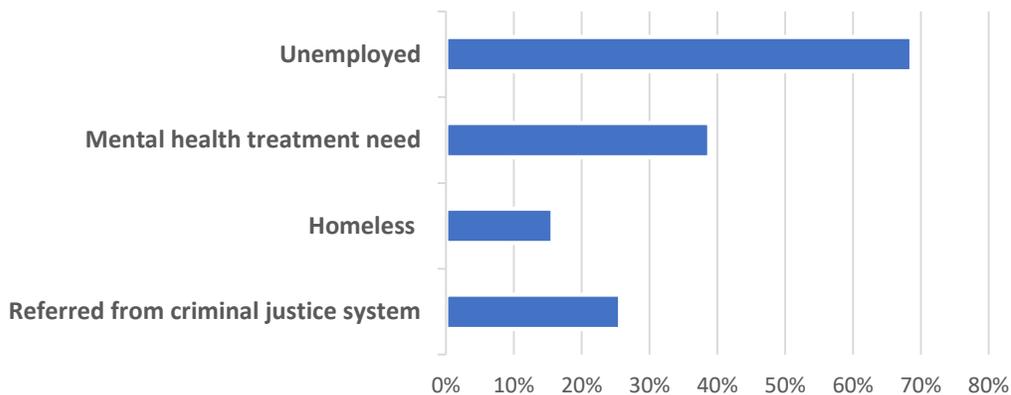
Successful completion of treatment - opiate users



Source: Unpublished NDTMS Analysis, PHE, 2020

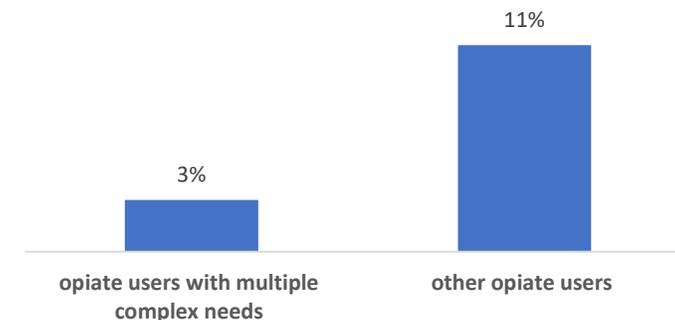
The majority of opiate clients have two or more 'complex' needs in addition to their substance use, reducing their chances of completing treatment successfully

Complex need factors at start of treatment - opiate clients



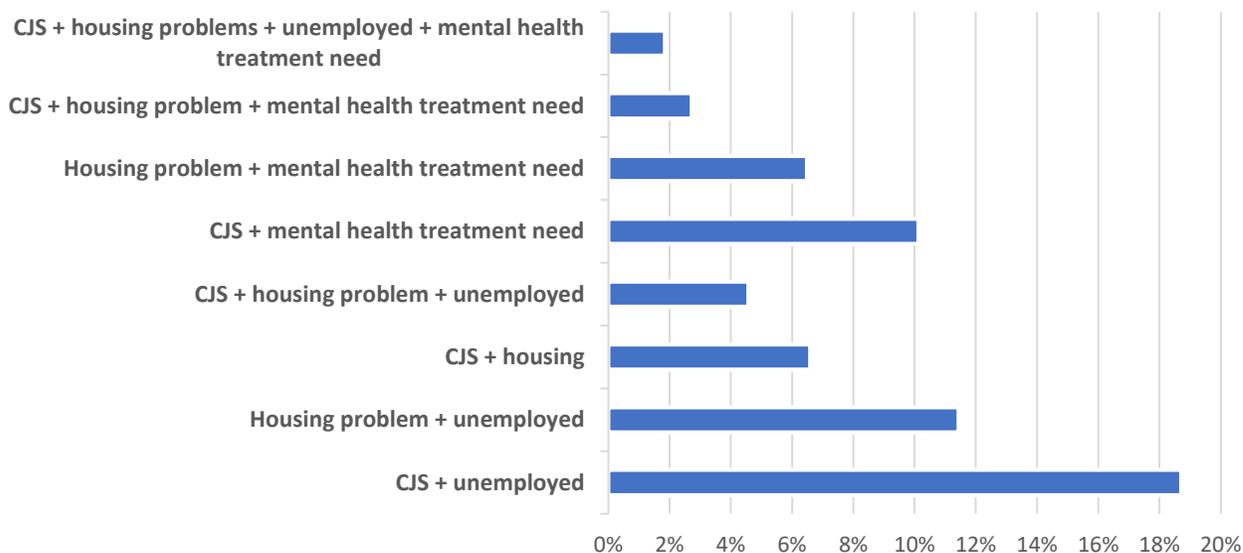
- Nearly 70% of opiate users are unemployed at the start of treatment;
- with 40% having a mental health need;
- and a quarter having been referred from the CJS.

Proportion completing treatment free of dependency



- Opiate users without two or more complex needs are nearly four times as likely to complete treatment successfully each year.
- Addressing the other needs of drug users in treatment is crucial in achieving and sustaining recovery.

Multiple complex needs at start of treatment - opiate clients



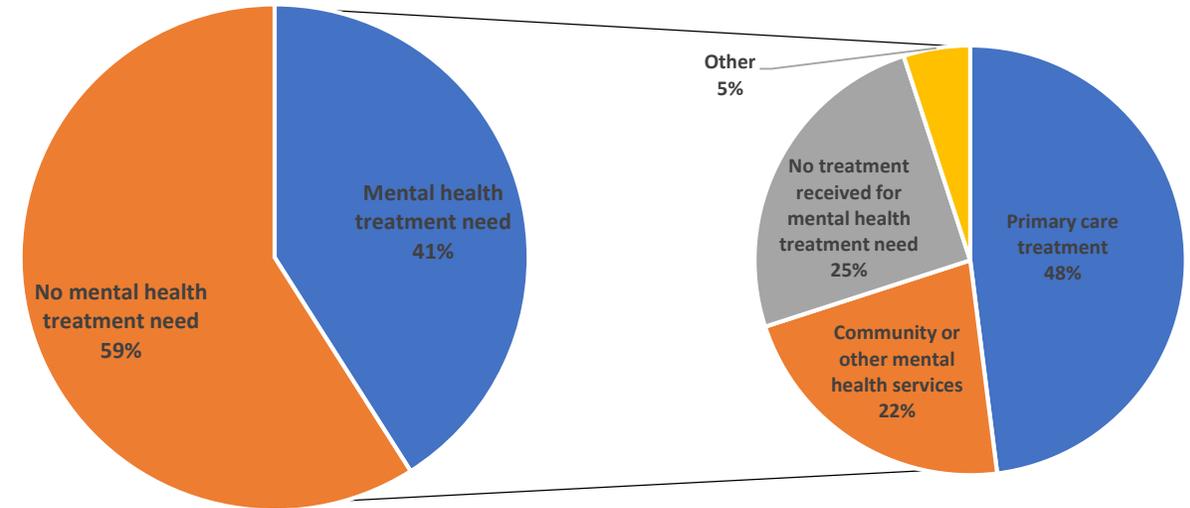
- Over 60% of opiate clients have two or more complex needs alongside their drug use;
- With nearly 1 in 5 being unemployed and referred from the CJS;
- One in 10 having a mental health need and being referred from the CJS;
- And 1 in 50 having all four complex needs.

Substance misuse and mental health

People with co-occurring mental health and drug/alcohol use conditions (or 'co-occurring conditions') including dependence, often have multiple needs with poor physical health alongside social issues such as debt, unemployment or housing problems. They are also more likely to be admitted to hospital, to self-harm and to die by suicide.

Level of need

- Information on whether a person starting drug treatment has a mental health need was introduced into the annual community and secure setting drug treatment statistics in 2017/18.
- Of those starting community drug treatment where a mental health status was recorded, 41% reported a mental health treatment need. 32% of those in drug treatment in secure settings reported a mental health treatment need.
- Almost 1 in 2 (47%) people in community drug treatment for non-opiates and alcohol reported a mental health treatment need. Opiate clients were the most likely to have a mental health treatment need in secure settings (36%).
- These figures are likely to under-estimate the levels of mental health treatment need in community and secure settings as this was first year of data and the new data item is still bedding in with services.
- Research shows, for example, that:
 - mental health problems are experienced by 70% of people in community drug treatment;
 - 44% of community mental health patients have reported problem drug use or harmful alcohol use in the previous year;
 - 34% of mental health inpatients were misusing substances.



Unmet need

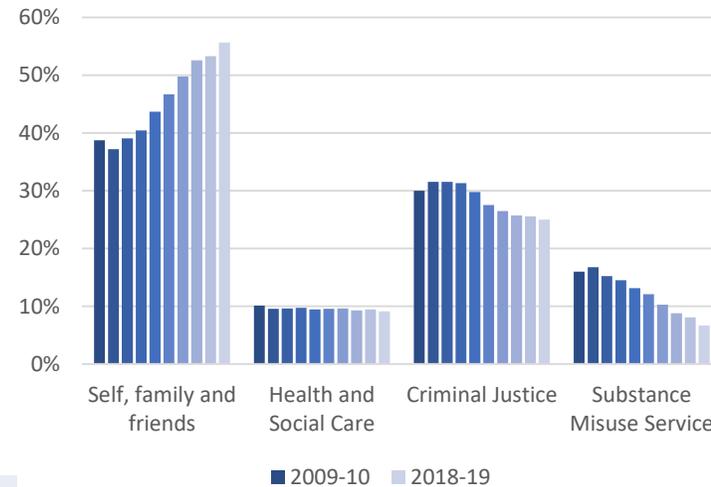
- Despite the shared responsibility that the NHS and LA commissioners have to provide treatment, care and support, there is a persistent and widespread issue of people with co-occurring conditions often being excluded from services. It is not uncommon for mental health services to exclude people because of co-occurring alcohol/drug use, a particular problem for those diagnosed with serious mental illness, who may also be excluded from alcohol and drug services due to the severity of their mental illness.
- Three quarters (75%) of people entering community drug treatment reporting a mental health treatment need said that they were currently receiving treatment for their mental health with most of this treatment in primary care.
 - Just under half (48%) of those in community drug treatment with a mental health treatment need received treatment from their GP in primary care and a further 22% were engaged with community or other mental health services. It is likely that the level of mental health treatment being offered within primary care is not sufficient to meet client's mental health needs.
- Drug treatment service users and professionals continue to identify improving treatment provision and pathways for people with co-occurring conditions as a key priority.

Community treatment, Crime and the Criminal Justice System

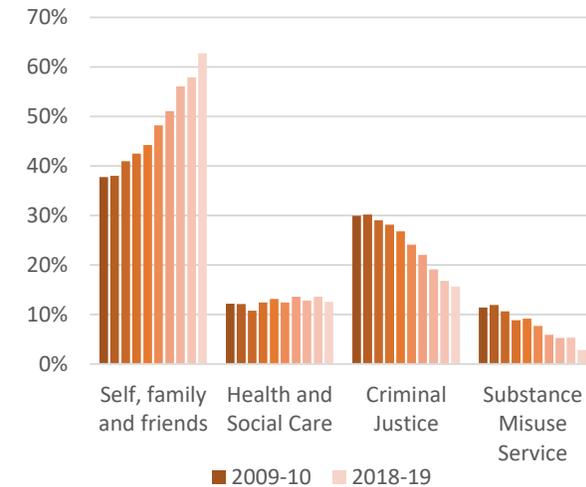
- Nearly half of acquisitive crimes (excluding fraud) are estimated to be associated with drug use
- Research using linkage between treatment and CJS data systems has demonstrated that treatment can reduce drugs users offending (for all crime types) by 23%
- Opiate users that complete treatment successfully reduce their offending by nearly 40%
- Similar reductions are also seen for the time that opiate users maintain contact with treatment
- The table below presents the fraction of relevant crime types that are estimated to be associated with drug use / users

Crime Type	Total no.of crimes	% estimated to be drug related	Total drug-related crimes
Homicide	691		322
Violence with injury	1,263,805		-
Violence without injury	836,051		-
Rape	174,641		-
Other sexual offences	1,499,289		-
Robbery	294,916	27.6%	81,397
Domestic burglary	1,074,488	56.9%	611,384
Theft of vehicle	86,593	16.2%	14,028
Theft from vehicle	703,815	30.9%	217,479
Theft from person	575,763	19.2%	110,547
Criminal damage	531,815		-
Fraud	3,456,864	30.5%	1,054,344
Commercial robbery	7,524	36.0%	2,709
Commercial burglary	122,440	43.3%	53,017
Shoplifting	5,826,606	65.6%	3,822,254
Other theft	350,344	14.5%	50,800
Total			6.018,278

Referral source for treatment - opiate users (%)



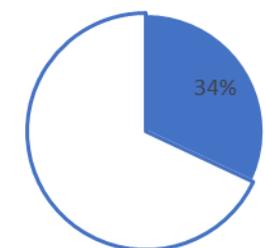
Referral source for treatment - crack users w/o opiates (%)



- Previously there were strong links between the CJS and treatment through the Drugs Intervention Programme with many referrals coming from teams based in custody suites
- Referrals from the criminal justice system have fallen substantially particularly for crack users, with the largest falls seen since 2013-14
- Conversely there have been large increases in self, family and friends referrals since 2009-10 for both crack and opiates

Prison leavers who receive community treatment

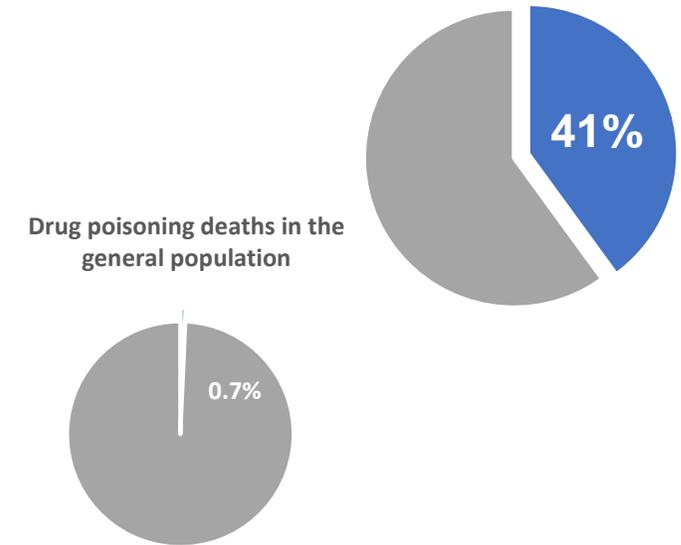
- Only a small proportion of people leaving prison identified as needing further treatment in the community receive it



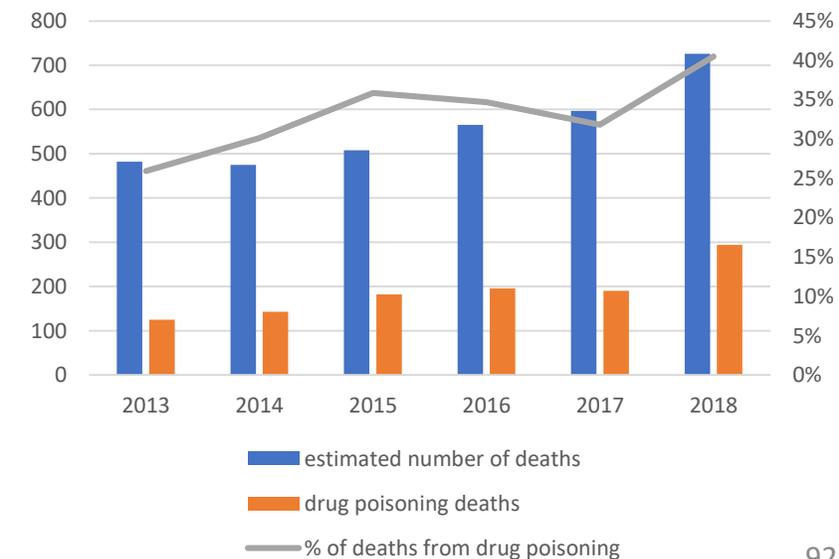
Homelessness, rough sleeping and drug use

- According to the rough sleeping count statistics from 2018, rough sleeping has increased by 165% since 2010.
- Data from the Greater London Authority CHAIN database shows that the proportion of people sleeping rough with a recorded drug support need in London rose from 31% in 2015/16 to 41% in 2018/19.
- Data from the Greater London Authority CHAIN database shows that over 60% of people rough sleeping are in need of drug or alcohol treatment with 40% having drug related use issues.
- Thirty six per cent were reported as having co-occurring mental health and substance use needs.
- Evidence suggests substance use can be a cause as well as consequence of a person becoming homeless.
- Homelessness and substance use are mutually reinforcing problems, often co-occurring with and exacerbated by mental ill health and physical health needs.
- Research has shown that people who are homeless are likely to have experienced some form of trauma, often in childhood.
- Those who rough sleep are more likely to have respiratory conditions and other comorbidities which may increase the risk of mortality compared to the general population.
- Deaths among the homeless population due to drug poisoning increased by 55% in 2018, with drug poisonings now contributing to two-fifths of all deaths.
- Recent research demonstrates a high proportion of deaths in the homeless population are from treatable diseases.
- Co-morbidity (two or more diseases or disorders occurring in the same person) among the longer-term homeless population is common.
- The mean age at death for those rough sleeping was 45 years for males and 43 years for females in 2018; in the general population of England and Wales, the mean age at death was 76 years for men and 81 years for women.

Rough sleepers with a drug treatment need



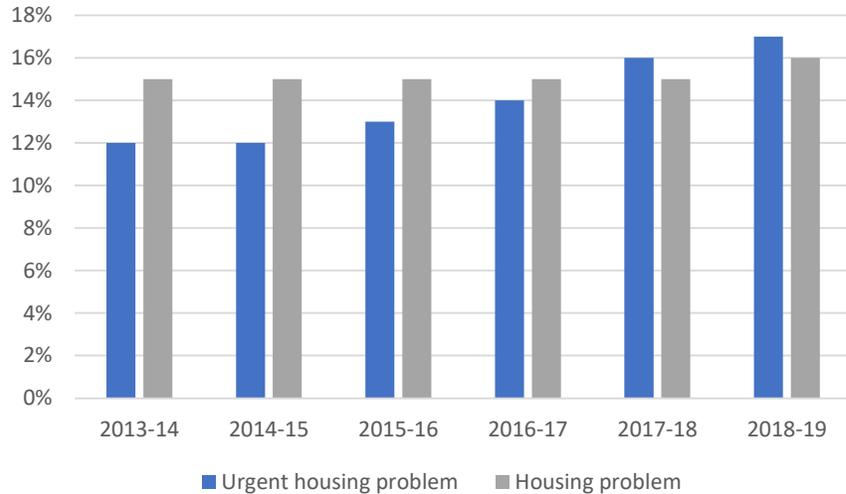
Deaths among the homeless population



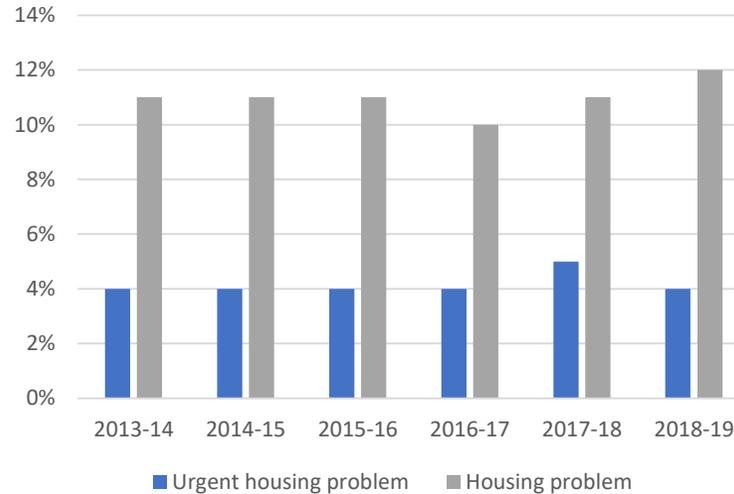
Source: [Deaths among rough sleepers](#) – Office of National Statistics

Homelessness and Drug Use – treatment and support

Proportion of new presentations for opiate treatment with an housing or urgent housing problem from 2013-2019



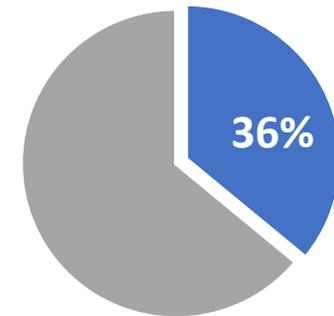
Proportion of new presentations for non-opiate treatment with an housing or urgent housing problem from 2013-2019



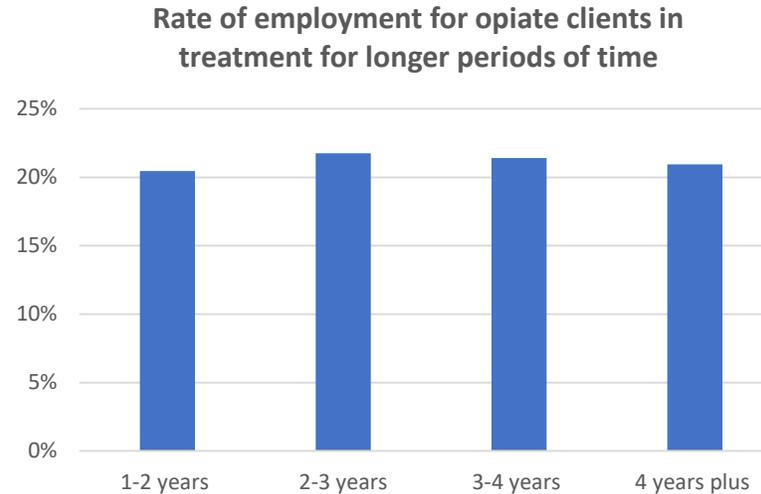
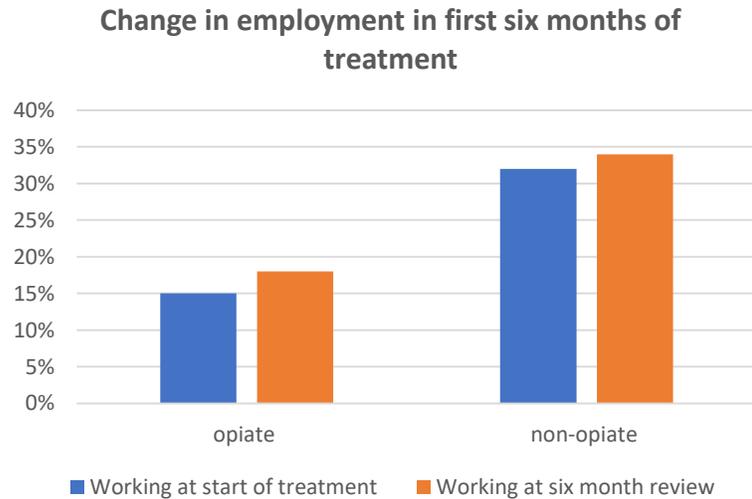
- 30% of opiate users starting treatment are NFA or have a housing problem
- With the proportion NFA increasing from 12% to 16% since 2013-14
- Nearly two thirds of people in treatment for NPS and opiates are rough sleeping or have significant housing issues
- Users of other drugs have lower rates of housing issues though one in twenty still report an urgent housing problem / being NFA

- Evidence from third sector case studies show funding cuts have affected drug and alcohol services resulting in what are seen as ‘nice to haves’ being cut.
- These include outreach services, flexible working hours and drop in sessions– elements of the service which are critical for those rough sleeping and who may have chaotic lifestyles. These means services are no longer able to effectively support this cohort
- Hostel providers have reported a lack of dual diagnosis services for homeless people where mental health support is needed in order to tackle dependence on drugs and alcohol
- There is some evidence that accommodation-base services for homeless people that have strict rules, i.e. operate an inflexible, ‘zero tolerance’ policy around drug and alcohol use, require engagement with treatment and set strict requirements around behaviour only achieve mixed results and can be ineffective in particular for single homeless people with very high and complex needs

Service users encountered difficulties in accessing drug services



Employment and drug use



- The majority of people start treatment unemployed, with the rate of employment of opiate users, half that of users of other drugs.
- For both substance groups there is little change in employment after six months.
- For opiate users in treatment for longer periods of time the rate of employment remains steady at about 20%.

Individual Placement and Support

- While being employed is a key factor in helping people achieve and sustain recovery, historic and current employment support has proven relatively unsuccessful in helping those with drug and alcohol dependency to find work.
- Individual Placement and Support (IPS) has been demonstrated to be highly effective in obtaining employment for people with mental ill health.
- But the evidence is less conclusive for those with substance use issues. Public Health England and the Work and Health Unit are carrying out a randomised control trial (IPS-AD) in seven Local Authorities to understand the effectiveness and cost effectiveness of IPS for people in drug and alcohol treatment.
- Provisional self-reported results are very positive.

Provisional early findings from IPS-AD

- Self-reported outcomes suggest that IPS is an effective intervention for this cohort, including for people with very long periods out of work
- Many of the heroin users finding work have not been employed for many years (and some never)
- Many are working while still in treatment and receiving substitute medication.
- Employment outcomes will be corroborated via national database linkage

IPS-AD from a client's perspective – a case study

Background

Steven is currently 44 years of age and engaging on the IPS-AD trial. He was enrolled onto the trial in August 2018 after being referred by his Keyworker. Although he had some previous work experience within agency warehousing, he had not worked since 2004.

Throughout his life, Steven has had issues with substances and has been accessing treatment services for many years; during this time he has utilised community and residential rehabilitation. He has suffered from severe anxiety due to previous life situations as well as ongoing mental health issues. Due to this Steven has been attending counselling. He has a fractured relationship with his family, caused by his lifestyle and the history of drug use combined with severe social anxiety which culminated in a suicide attempt in 2017.

Steven's story

"My life was upside down, I was just existing and isolating myself from society. IPS has brought me out of myself without me realising it.

IPS mentioned about being in work in a short period of time, however I had mental health issues pop up. I withdrew from my antidepressant medication, mirtazapine and my IPS worker has supported me all the way through, and I feel he went the extra mile to support me when I needed it. Getting back into work is the best medication I could have been prescribed. My experience of the jobcentre and the experience with the IPS was totally different, with IPS giving me more motivation to get back to work, without pushing me over the edge. Without IPS this might not have happened and the positive impact on my mental health is enormous. I am looking forward to my job, working hard and my future."

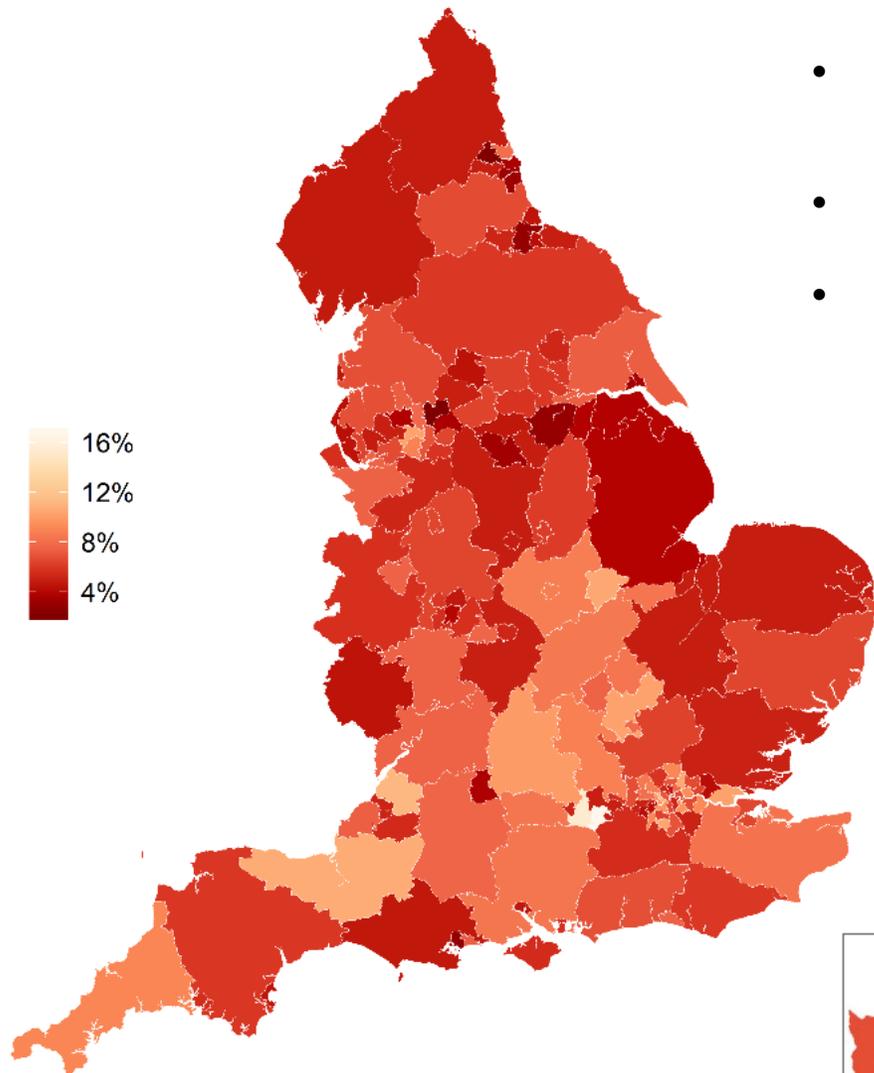
Recovery Staff

"Having worked with Steven for a period of time, I have seen a significant change in overall wellbeing since he commenced his placement through IPS. Through the work I and they have done with him, it was identified that purpose and structure are two things lacking in his life. This had a knock-on effect in regards to mental health, but through the work placement they have gained that structure and meaning, allowing them to gain self-confidence, dignity, and self-respect.

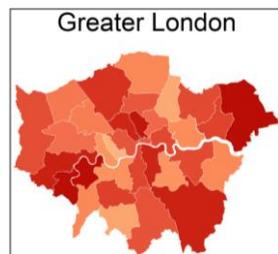
In terms of his recovery, Steven reports feeling a lot more positive and connected, which has helped build the foundation for him to re-integrate back into the community."

Variation in performance indicators – successful completion of treatment 2018-19

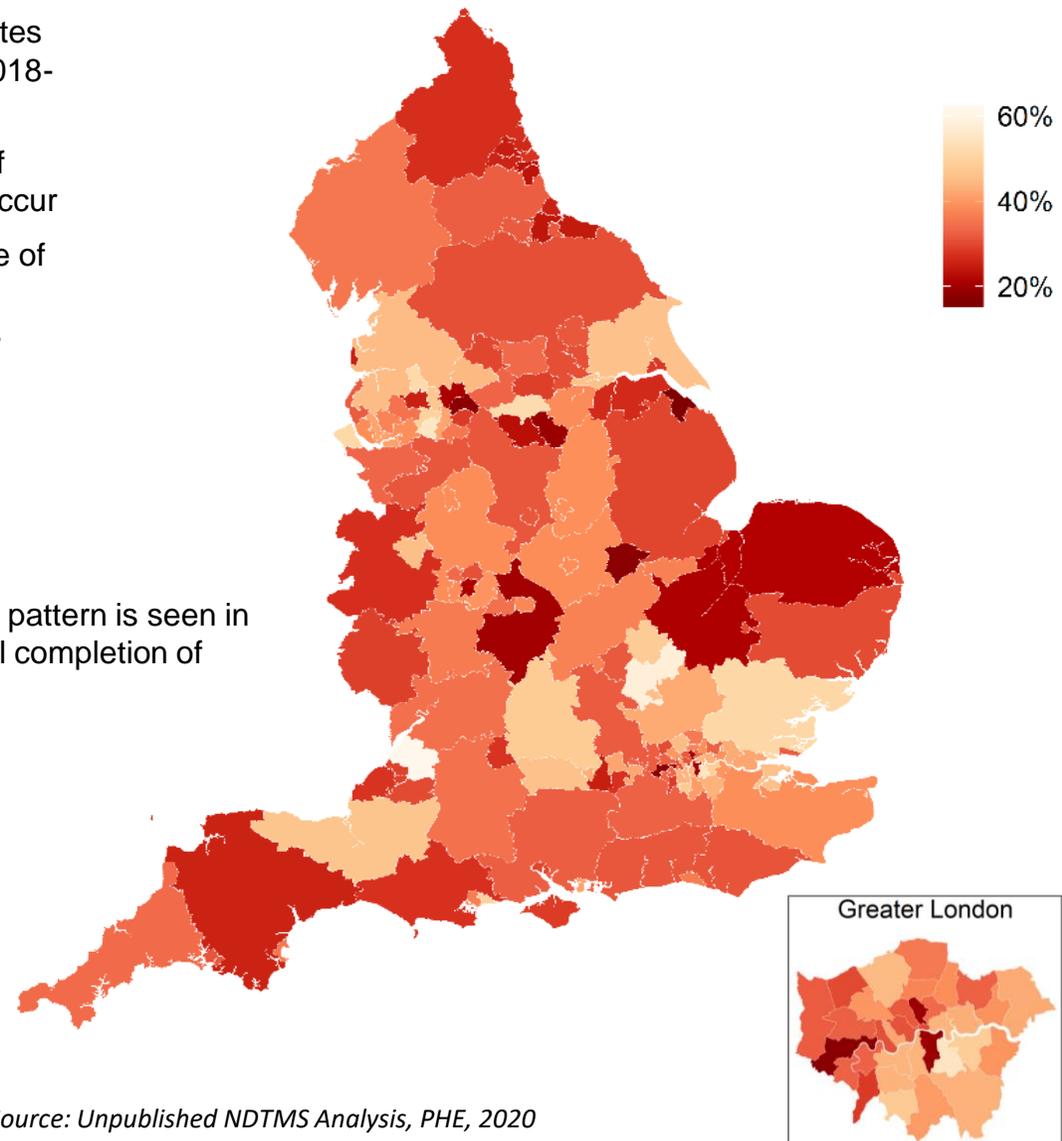
Opiate clients: Completion rates



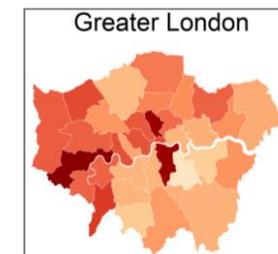
- Nearly all the areas with the lowest rates of opiate successful completions in 2018-19 are in the north of the country.
- This is also where the highest rates of prevalence and drug related deaths occur
- Conversely those with the highest rate of opiate successful completions are primarily in London or the South East.



Non-opiate clients: Completion rates



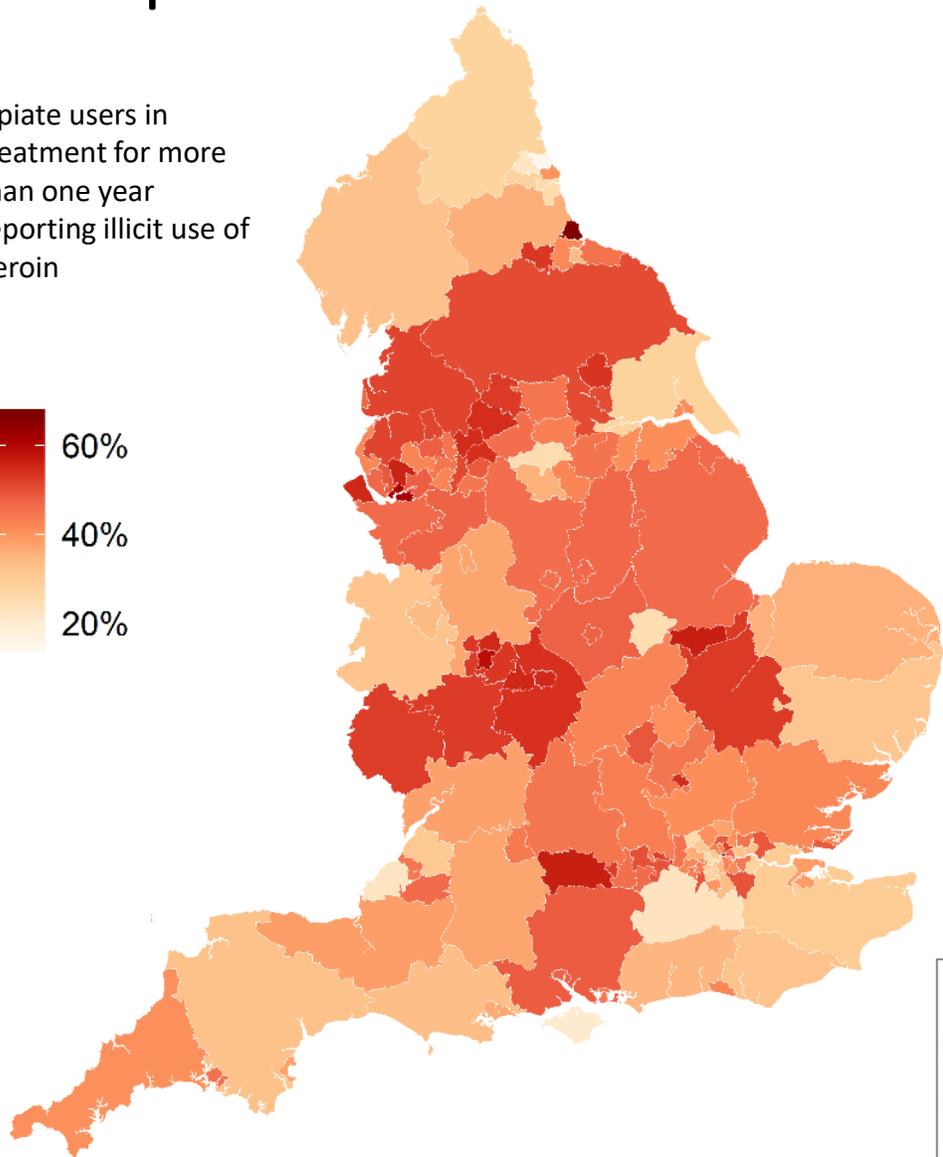
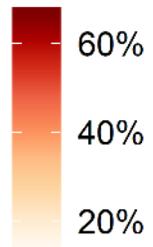
- A similar geographical pattern is seen in the rates of successful completion of users of other drugs



Source: Unpublished NDTMS Analysis, PHE, 2020

Local variation in performance indicators – length of time in treatment and use of illicit opiates

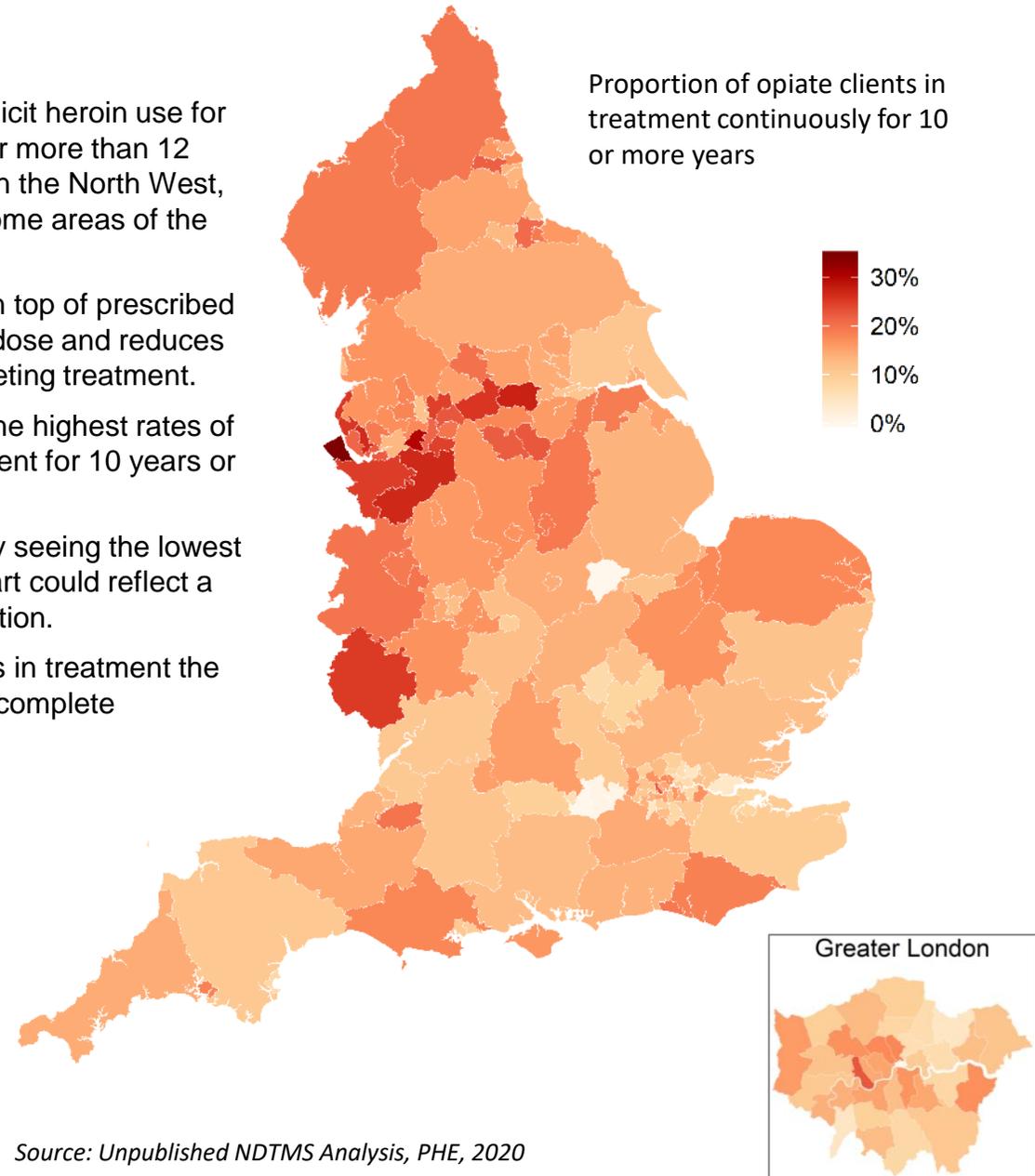
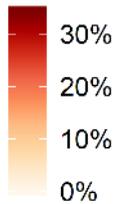
Opiate users in treatment for more than one year reporting illicit use of heroin



- The highest rates of illicit heroin use for people in treatment for more than 12 years is seen mainly in the North West, West Midlands and some areas of the East of England.
- Use of illicit opiates on top of prescribed medication risks overdose and reduces the chances of completing treatment.
- The North West has the highest rates of opiate users in treatment for 10 years or more continuously.
- With London generally seeing the lowest rates though this in part could reflect a more transient population.
- The longer a person is in treatment the less likely they are to complete successfully.



Proportion of opiate clients in treatment continuously for 10 or more years



Source: Unpublished NDTMS Analysis, PHE, 2020

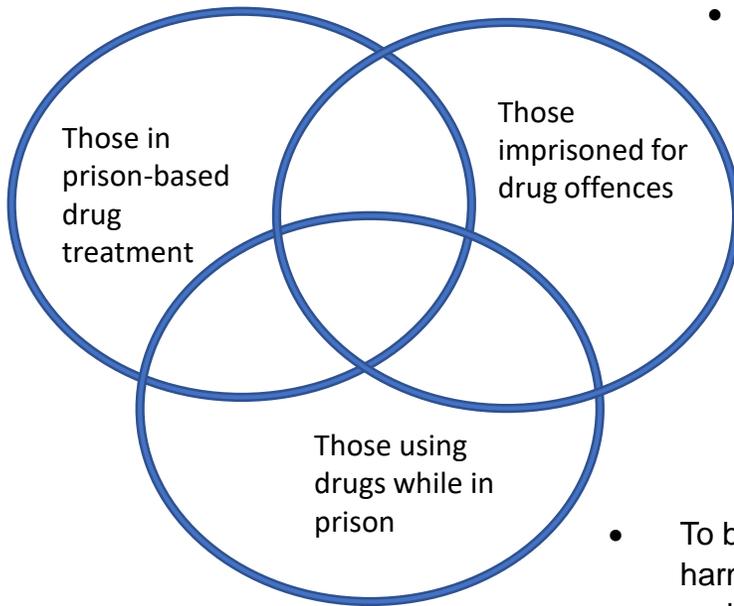
Treatment and recovery summary

- Expenditure on drug treatment has fallen since 2013/14 along with similar falls in the numbers in drug treatment during this time, against a backdrop of increases in the prevalence of problematic drug use.
- The unit cost per person has remained relatively stable over this time so cost effectiveness has not improved.
- Some areas are starting to 'ration' treatment, setting higher thresholds for those who can access it and/or just offering a minimum service due to workers having such large caseloads.
- The number of residential rehabilitation services have reduced significantly, removing a core treatment component for those that need it to support their recovery.
- Recovery is much wider than just substance use treatment with many drug users having multiple complex needs in terms of health (both physical and mental), employment, homelessness and offending.
- Referrals from the criminal justice system have fallen significantly over the last six years and only about a third of people requiring drug treatment following prison treatment go on to receive it.
- Many key indicators (deaths, unmet need, recovery rates) are going in the wrong direction and there is significant variation in both local spend in relation to need and the achievement of recovery and other outcomes.
- There is significant local variation, but outcomes tend to be worse in the north of the country and particularly in the North East, often these areas have higher rates of opiate and crack use and higher rates of drug related mortality.
- Levels of rough sleeping are rising, prevalence in the population is increasing: need is not being met and the problem is worsening with the levels of mortality at the highest since records began.
- The Individual Placement and Support trial is showing very promising early success in finding employment for people in drug and alcohol treatment.

9. Drug use and prisons

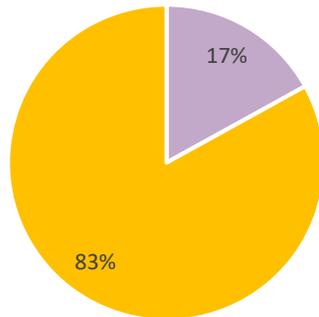
Drug use and prisons - prevalence

- There are three overlapping cohorts of drug users and drug-related offenders currently in the prison treatment system.



- Those receiving treatment while in prison will often be convicted for non-drug specific offences.
- Some of those imprisoned for drug offences will not be getting treatment as they are not drug users.
- Many of those who take drugs in prison will not have been sentenced for drug offences, nor will their drug use require treatment.
- To be able to accurately estimate costs, harms and prevalence it is important to understand the profile size of each of these cohorts and how they relate to each other.

Random drug test results

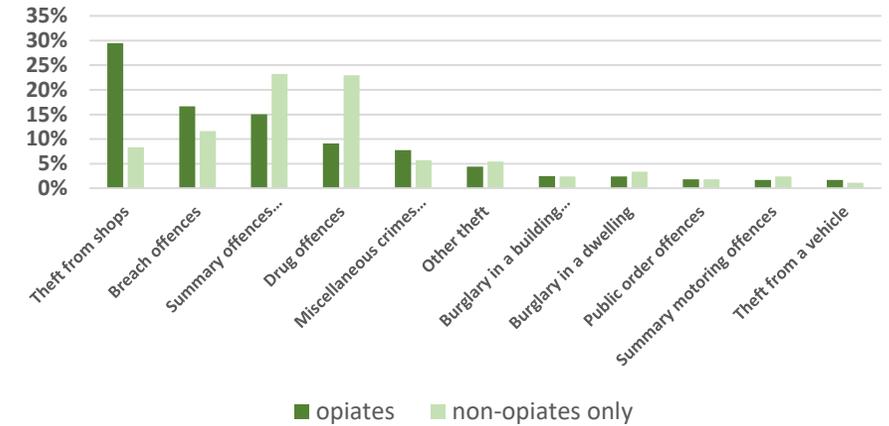


■ % of prisoners who test positive for drugs
■ % with negative test

No. of drug finds in prison 2018-19 **18,435**

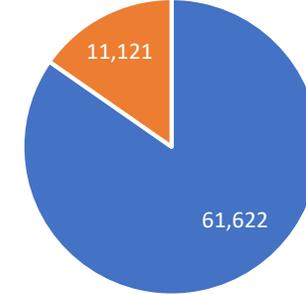
Sources: [The impact of community-based drug and alcohol treatment on re-offending, PHE & MoJ, 2017 ii\) ii\) Annual Prison Population 2019: Ministry of Justice](#)

Most common offences for those starting drug treatment



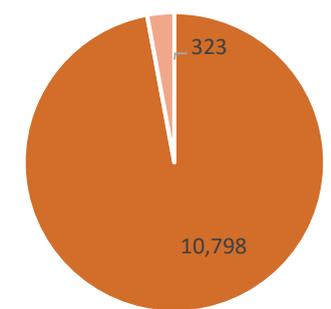
Number of individuals in prison-based treatment for drugs - March 2019 **20,815**

Prison population - drug offences (snapshot)



■ Number of individuals in prison other recorded offences
■ Number of individuals in prison for drug offences

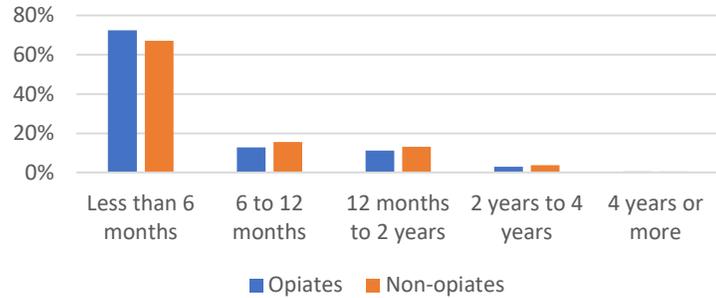
Type of drug offences



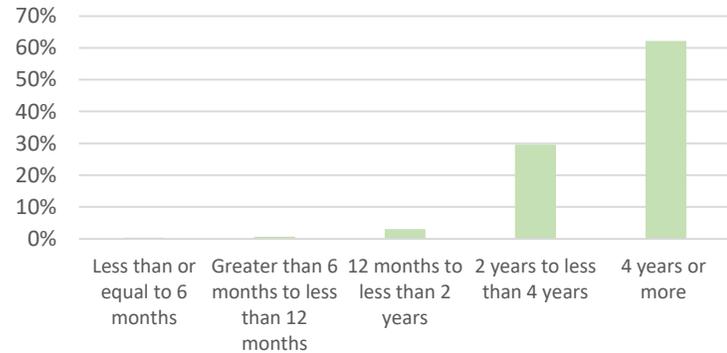
■ Trafficking in controlled drugs

Prison treatment and drug-related convictions

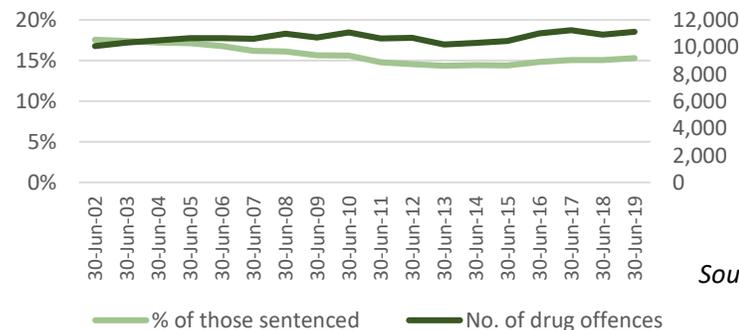
Length of time in treatment



Length of sentence for drug offences



No of drug offences and % of total prison population



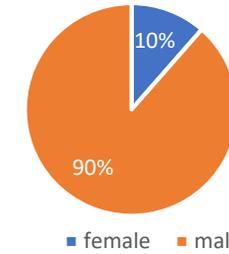
- Nearly three-quarters of adults receiving drug treatment in prison do so for less than six months.
- This will likely be reflective of the short duration of their sentences, particularly opiate clients.
- Less than 5% receive treatment for two years or more.

- Conversely over 90% of those in prison for drug offences are on sentences of two years or more.
- And fewer than 1% on sentences less than six months.
- As the majority of drug offences are for trafficking rather than possession these longer sentences would reflect this.

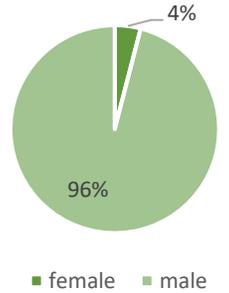
- The number of people sentenced for drug offences has remained relatively stable since 2002.
- With the proportion of drug offences out of all sentences falling slightly as the overall prison population has grown during this time.

Sources: i) [Substance misuse treatment in secure settings](#): PHE ii) [Annual Prison Population 2019](#): Ministry of Justice

Gender split of people in prison-based drug treatment

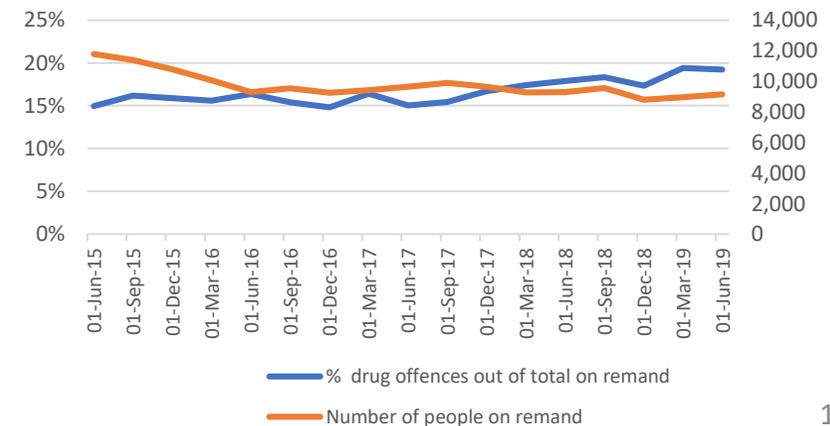


Gender split of people sentenced for drug offences



- There are proportionally nearly three times more women in drug treatment in prison than those sentenced for drug offences.
- The number of people on remand for drug offences has fluctuated between 1500-1750 over the last three years.
- With the proportion out of all on remand having increased slightly during this time as the overall numbers on remand have fallen.

Remand and drug offences



Prevalence of prisoners due to drug use and drug-related offending and costs

To try and estimate the total prevalence of people in custody on a given day due to their drug use or for drug specific offences the following assumptions have been made:

- Those with drug offence sentences greater than two years will be in prison for trafficking and will be separate from the treatment cohort;
- All those sentenced for possession will be in the treatment cohort;
- All those on remand will also be in the treatment cohort.

	2018-19
Number in prison drug treatment on a given day minus those on remand those sentenced for possession and those on drug sentences less than two years	18,356
Number sentenced for drug offences on a given day - trafficking only	10,787
Number on remand for drug offences on a given day	1,670
Total in prison either in drug treatment or in prison for drug offences	30,813
Total number on remand	9,150
Total number sentenced on a given day	72,743
Total in custody on a given day	81,893
Proportion of total in custody drug related on a given day	38%

Using the assumptions above, it is estimated that over a third of people in prison on a given day are there for drug-specific offences or offending related to their drug use.

Annual cost of prison stays for those in treatment for drug offences or offences related to their drug use

- Cost of those in treatment = £694 million
- Cost of those for drug specific offences = £471 million
- Total cost = £1.2 billion

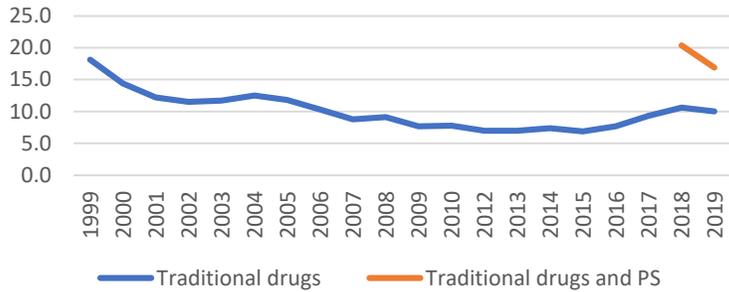
Annual cost of drug treatment in prison

- Cost of pharma = £23 million
- Cost of psych = £83 million
- Cost of Naloxone = £70,000
- Total cost = £106 million

Total annual cost = £1.3 billion

Drug use in prisons – finds and drug tests

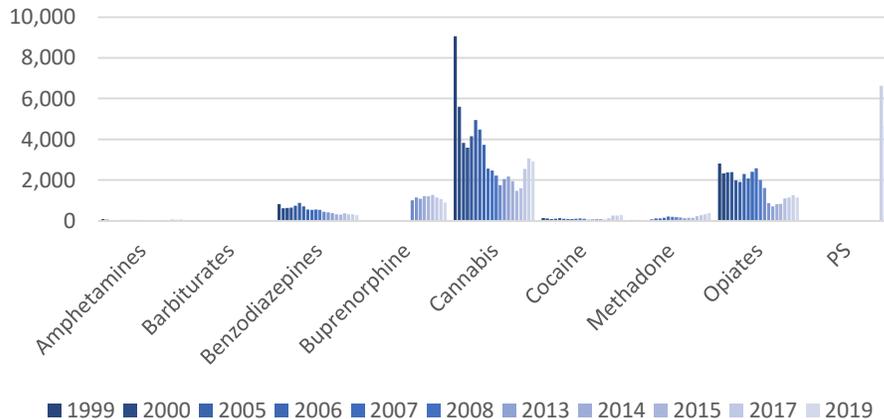
Percentage of prisoners testing positive for drugs



- The proportion of prisoners testing positive for drugs fell from 1999 to 2015.
- Since then, they have increased to 10% for traditional drugs.
- And closer to 20% overall with tests for psychoactive substances (PS) having been introduced in 2018.
- If the tests were indicative of general incidence then about 12,500 prisoners could be using drugs on a given day.

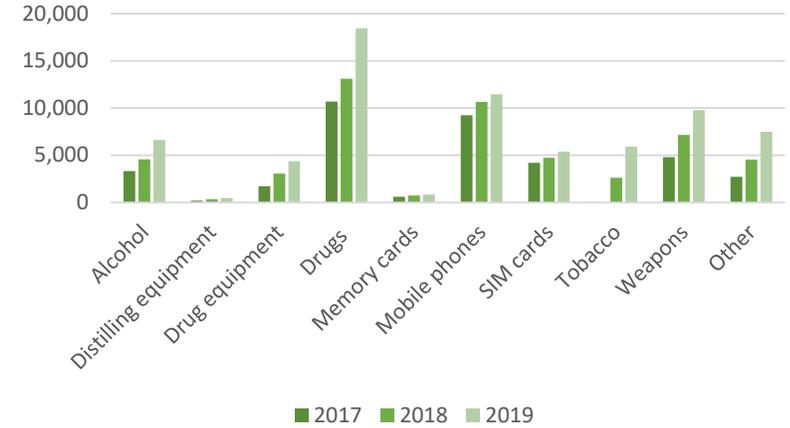
- Cannabis and opioids were by far the most prevalent substance that prisoners were testing positive for.
- Though positive test for both substances fell substantially (especially cannabis) to 2015, since then there have been increases.
- Now that it is being tested for PS provide the most positive results.

Number of positive tests by substance



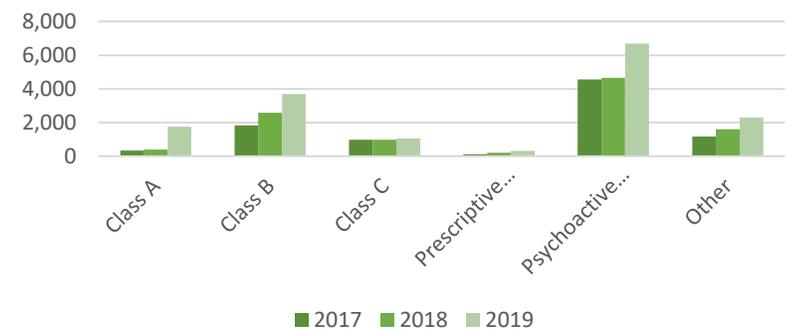
- PS now make up the largest % of illicit drug finds.
- Class A finds have seen the biggest proportional increase by fivefold over the last three years.

Number of illicit items found



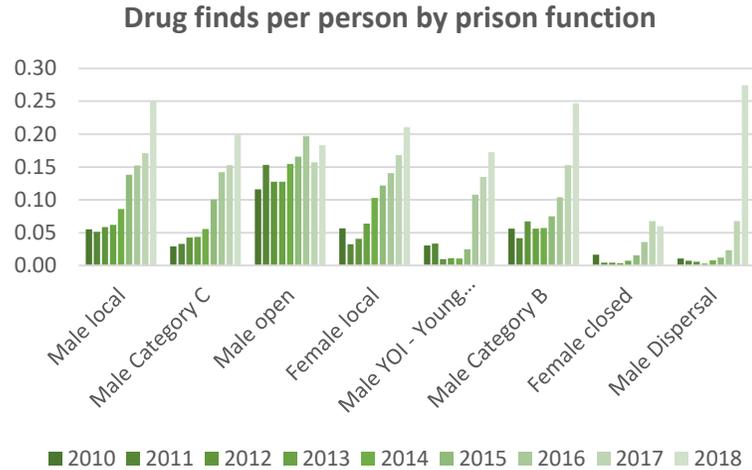
- Drugs are the most illicit found substance and the number of finds have increased by 72% over the last three years
- Though overall illicit finds have increased by more than this amount so it is hard to determine if this reflects a rise in use or better detection rates after significant recent investment.

Number of finds by drug class



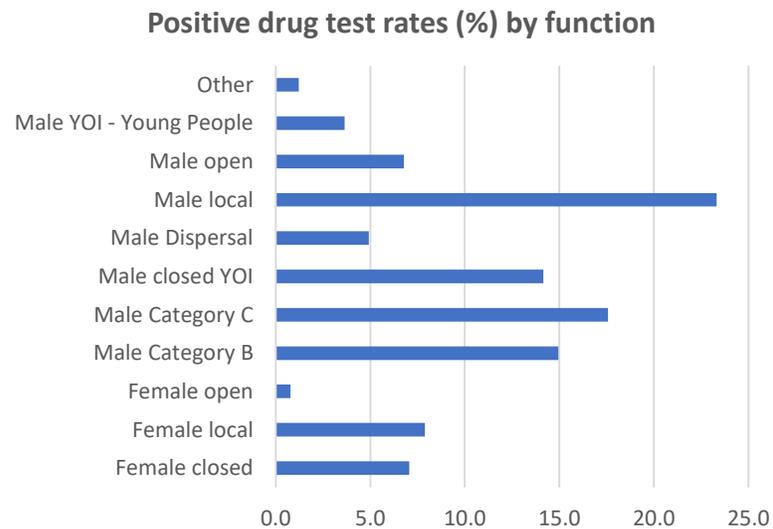
Drug use in prisons – finds and drug test by prison

Positive Test Rates and purposeful activity 2018-19



- Drug finds in all prison settings have increased over time with most now seeing the same rates of finds per prisoner.
- There have been particularly large increases in some settings over the last few years reflecting the general increase in illicit seizures.
- Finds in male open prisons have been the most stable over time

Prison	% testing positive	purposeful activity score
Littlehey	2.9	2
North Sea Camp	2.1	3
Bure	1.8	4
Rye Hill	1.8	4
East Sutton Park	1.6	4
Usk	1.6	3
Stafford	1.5	3
Werrington	1.5	3
Wakefield	1.2	3



- While the level of finds per person are relatively similar in most prison settings there is substantial variation in the positive drug test rates
- The highest rates are seen in male prisons generally and are particularly high in male local prisons.
- What also tends to be the case is that where there are low rates of drug tests and finds then the scores on the HMP Inspectorate 'purposeful activity' indicator are good.
- And conversely they are poor in the areas with high drug use.

- There is substantial variation in the rates of positive drugs tests by prison
- With 10 prisons having 30% or more prisoners testing positive for drugs in 2018-19

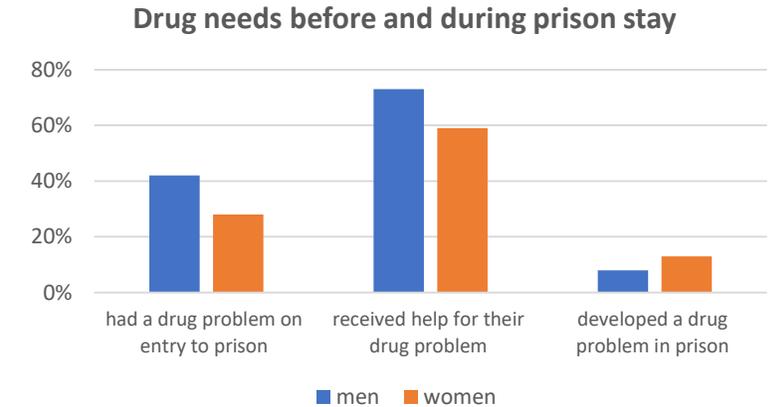
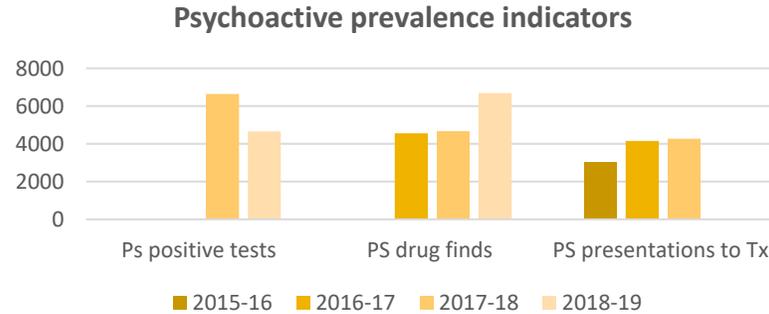
Positive Test Rates and purposeful activity 2018-19

Prison	% testing positive	purposeful activity score
Peterborough Male	40.3	3
Chelmsford	38.3	1
Rochester	37.8	2
Bedford	32.8	1
Hindley	32.5	1
Channings Wood	31.7	2
The Mount	30.9	1
Thameside	30.2	2
Liverpool	30.1	1
Lancaster Farms	29.6	2

Sources i) [HMPPS Annual Digest 2018 to 2019](#), MoJ, ii) [HMIP - purposeful activity](#) - HMIP

Drug use in prisons – ‘Spice’ and initiation of drug use in prison

Percentage of prisoners testing positive for PS 2018-19	9%
Estimated no. of PS users on a given day	6,240
Percentage of all drug finds that are PS	36%
Number of PS drug finds 2018-19	6,699
Number of drug users presenting to prison treatment for PS in 2017-18	4,271
% of presentations to treatment that are PS	13%



- The use of and problems associated with psychoactive substances (PS) in prison would appear to be increasing over the last few years.
- Nearly 1 in 10 people test positive for PS, a third of all drug finds are PS-related, and 1 in 8 people presenting to drug treatment in prison having a problem with PS.

“Spice” use among offenders supervised in Approved Premises and Community Rehabilitation Companies: a small qualitative study in 2017

Problem drug users, with long histories of drug addiction were more likely to use synthetic cannabinoid receptor agonists (SCRAs) like spice. People who did not use SCRAs tended to be people who did not use drugs in general or those who wanted to ‘keep their head down’ and get their sentence done.

SCRAs were used as an alternative to cannabis, which could be detected more readily.

Two-thirds of the prison SCRA users ceased to use the drugs on release and many had not come across SCRAs in the community.

Upon release, many prison SCRA users returned to a different drug of choice – usually cannabis – or were stabilised on methadone.

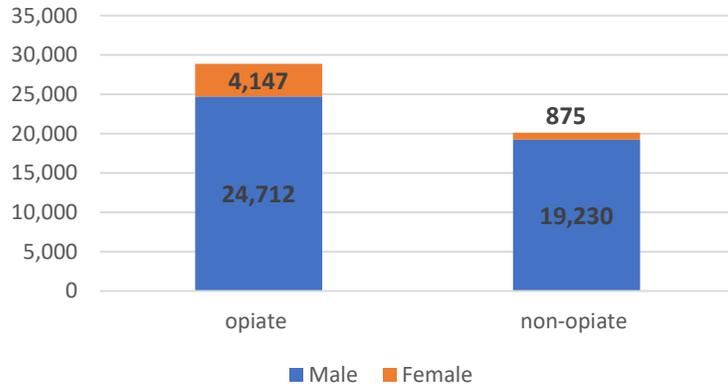
There was a view that SCRAs were just a ‘prison drug’ used as a means of coping with prison life and was too unpleasant to be used after release.

Some post-custodial, problematic SCRA use was reported among ex-prisoners in the community. There was a view that there is a link between those who continued to use SCRAs after release and those who were vulnerable, homeless and/or needed to escape reality – *“he found it helped him cope in custody. Turned back out and struggled to settle back in the community. So he struggled to resettle, he...it helped him cope outside”*

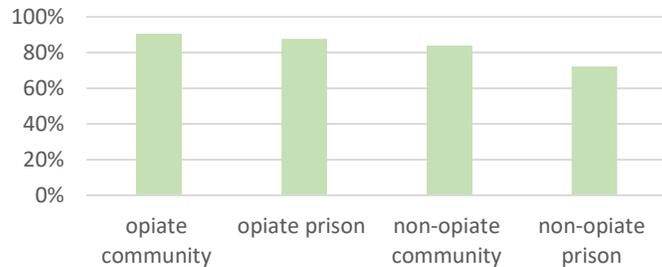
- A 2017-18 prison drug survey found that 42% of men and 28% of women entering prison had a drug problem
- And that 8% of women and 13% of men developed a problem with drugs while in prison
- What was defined as a problem is unclear; it could be a dependency, bullying or debt-related to either their own or others’ substance misuse.
- There was also no way of ascertaining what proportion of these initiated drug use in prison for the first time in their lives or who had previous drug issues.
- Of those that had a drug problem on prison entry 75% of men and just under 60% of women received help for it

Prison drug treatment for adults – profile

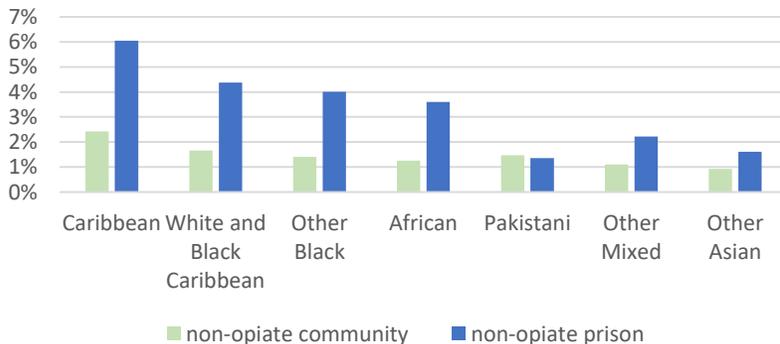
Substance group and gender – 2017-18



White British and other - prison vs. community



Non-White ethnic groups - community vs. prison

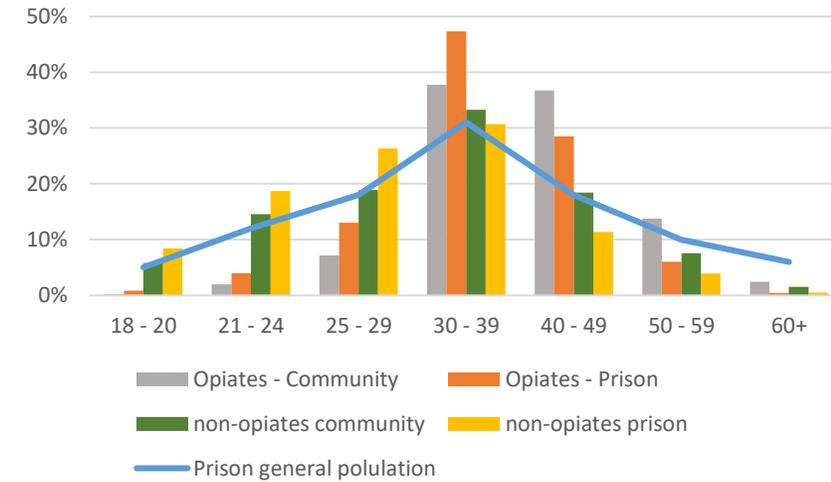


- There were nearly 50,000 people in contact with prison-based drug treatment in 2017-18.
- A fall of about 9% over the last three years.
- Just under 60% were receiving treatment for opiates, which is a lower proportion than community treatment (73%).
- Proportionally there are far less women in prison treatment than in the community with 1 in 10 overall and 1 in 20 for non-opiates.
- This will in part reflect that only 5% of the total prison population are female.

- The ethnic breakdown for opiate users in treatment is very similar in prison as it is in the community.
- However there is more difference in users of other substances with 84% White in the community compared to 75% in prison.
- The largest differences are seen in Caribbean, Other Black and African ethnic groups. Again this will in part reflect the make-up of the general prison population.

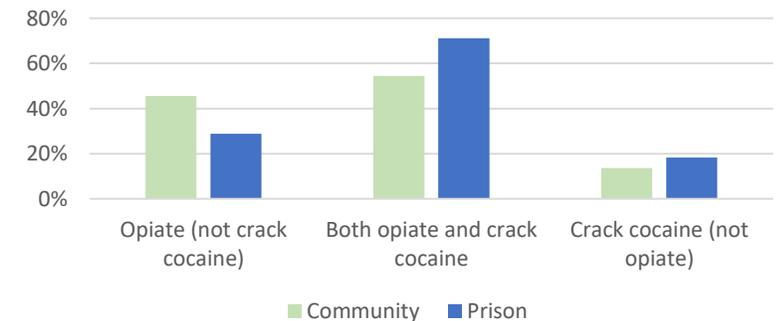
- More opiate users presenting to prison treatment are also using crack cocaine, possibly reflecting the higher harms related to this polydrug use.
- There is also a slightly higher % of people presenting with crack use (not with opiates) in prison.

Age profile - prison vs. community



- People receiving treatment in prison tend to be younger than those treated in the community.
- With the non-opiate prison population being similar in age distribution as the general prison population.
- And the opiate prison population being significantly older.

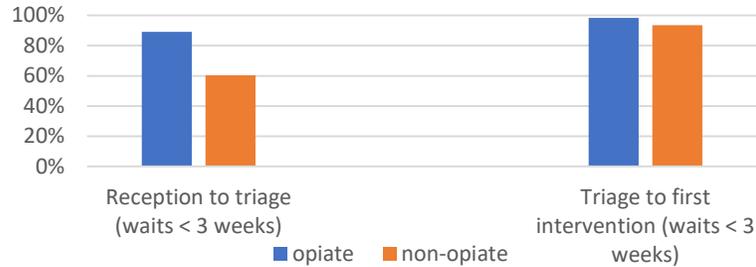
Opiate and/or crack - community vs. treatment



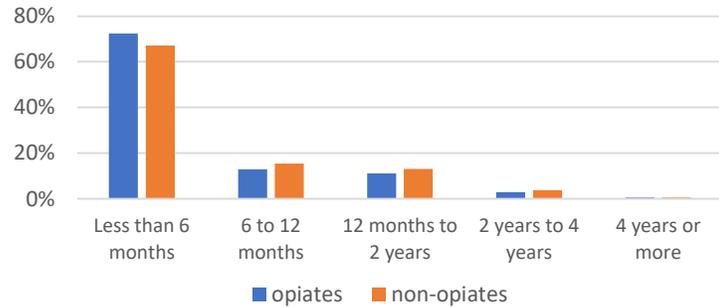
Source: [Substance misuse treatment in secure settings: 2017 to 2018, PHE, 2019](#)

Prison drug treatment adults – waits, time in treatment and community treatment

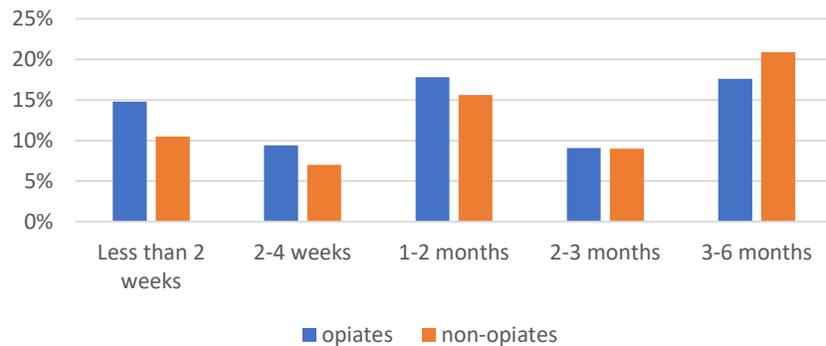
Time to starting prison-based drug treatment



Length of time in treatment

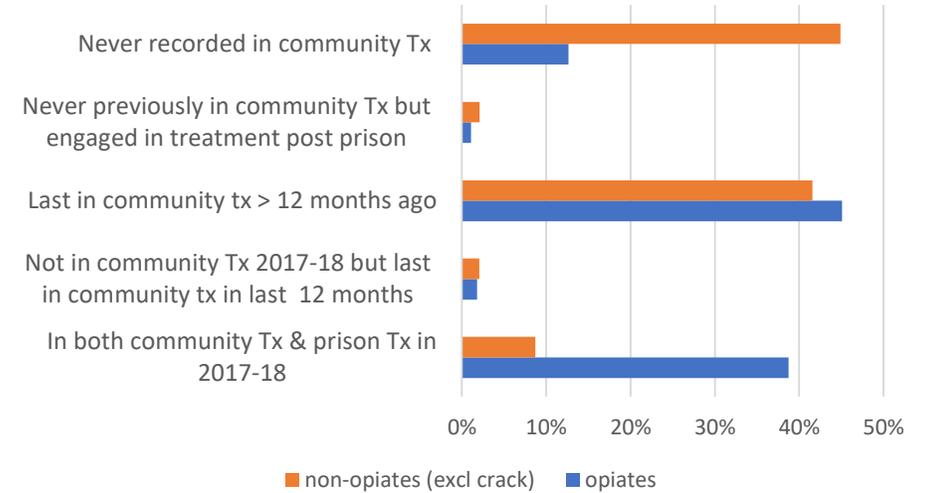


Breakdown of treatment spells < six months



- Prison-based drug treatment is readily available for those that need it.
- With the vast majority of opiate users being triaged within three weeks (median 0 days) and nearly all then starting treatment within 3 weeks.
- This reflects that many require immediate substitute medication on arrival in the secure estate.
- Nearly three quarters of prison treatment spells lasted less than six months.
- In the main this is in line with the short duration of prison sentences those with drug problems tend to receive.
- There was little difference by substance group.
- 40% of opiate users are in prison treatment less than two months.
- And a third of non-opiate users are in for the same duration.
- With 1 in 6 opiate users and 1 in 10 users of other drugs in prison treatment for less than two weeks.

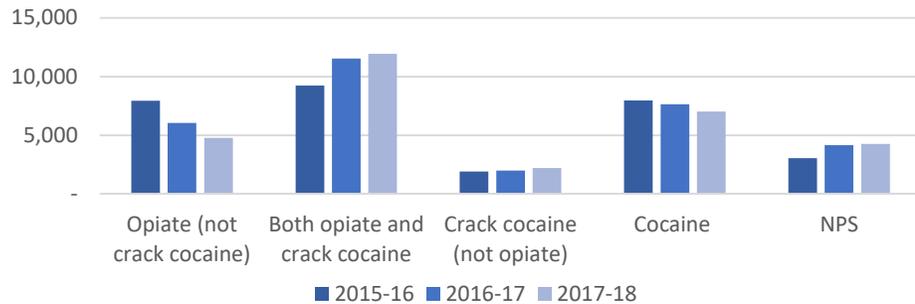
Prison and community treatment



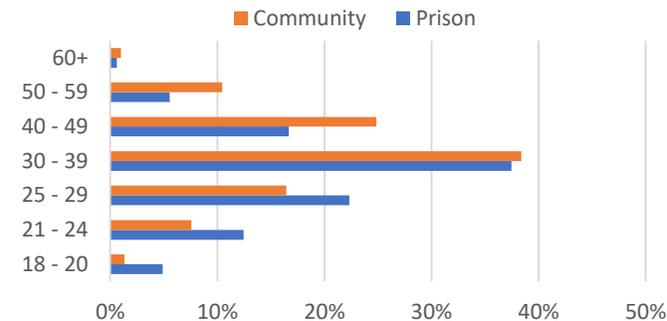
- Nearly 40% of opiate users in prison treatment in 2017-18 were also in contact with community treatment.
- Whereas less than 1 in 10 users of other drugs were also in contact with community treatment in the year.
- Similar proportions for both substance groups had been treated in the community over 12 months ago.
- Just over 10% of opiate users had never been in contact with community treatment.
- This compares to nearly half of non-opiate users who have never had community treatment.
- Overall almost nine out of ten people receiving treatment for non-opiates had either not been treated in the community in the last 12 months or never treated.

Prison drug treatment for adults – crack

Trend in prison presenting substances



Age of crack only - prison vs. community

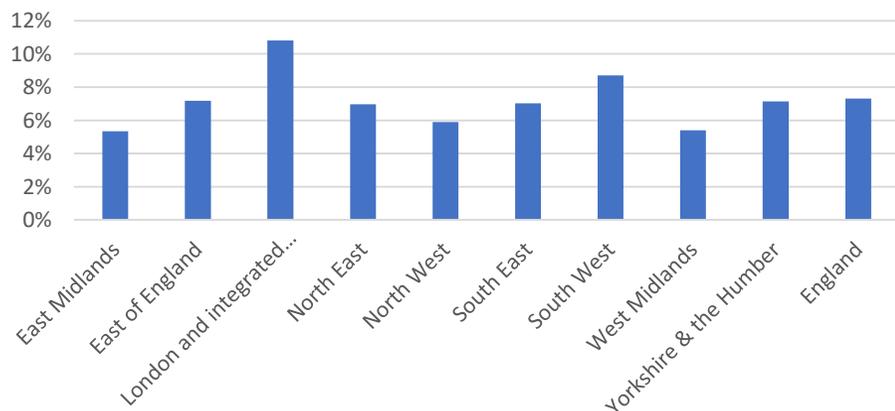


- Crack users in prison are in the main younger than the crack users in community treatment.

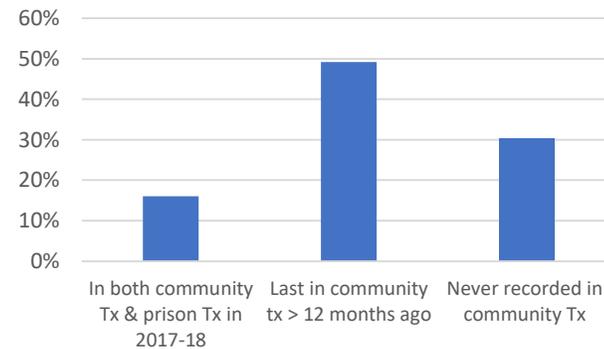
- Despite overall numbers presenting to prison-based drug treatment falling by 9% over the last two years, crack without opiate presentations have increased by 17%.
- Crack and opiate presentations have also increased during this time by 29%. This mirrors the trends seen in presentations to community treatment.
- Unlike in the community there has been a fall in cocaine presentations (and an increase in NPS presentations).
- London has the highest rate of crack only users in prison despite crack prevalence falling substantially in the region over the last few years.

- Half of crack only users were in contact with community treatment 12 months or more prior to prison entry, with 15% in contact with both community and prison treatment in 2017-18.
- A third had never been in contact with community treatment.
- Younger crack users tend to be less likely to have been in treatment either during 2017-18 or 12 month or more previously.

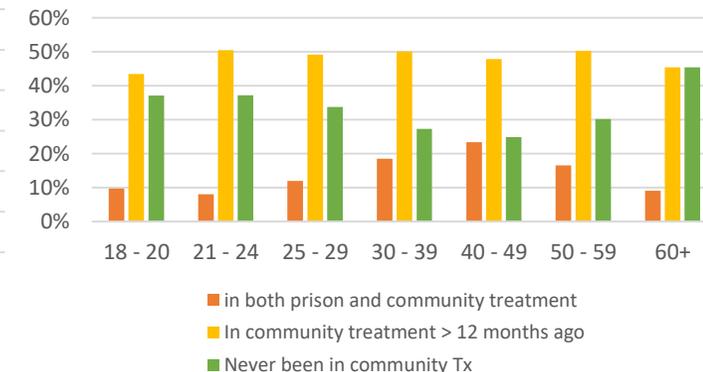
% of all in prison treatment crack w/o opiates



Crack only - links prison and community treatment



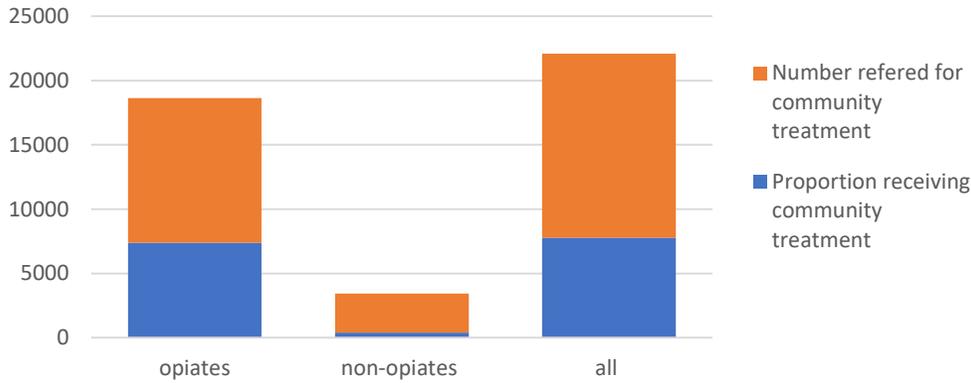
Links to community treatment by age



Source: [Substance misuse treatment in secure settings: 2017 to 2018, PHE, 2019 and unpublished NDTMS data](#)

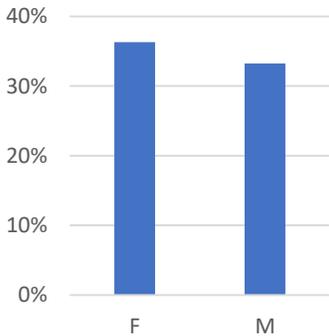
Prison drug treatment for adults – continuity of care 2018-19

Continuity of care by substance

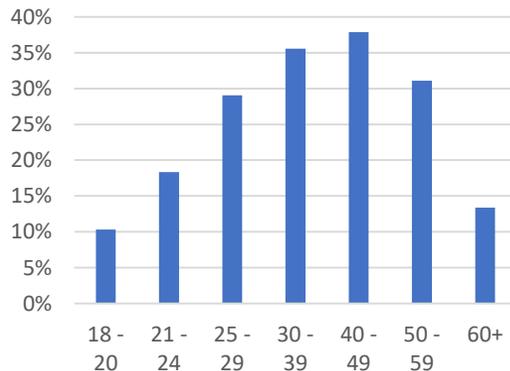


- Just over a third of people referred for further community treatment post-release go onto receive it within three weeks.
- This pick-up rate has remained relatively stable over time.
- Most referrals to community treatment are for opiate users, with just under 40% turning up after leaving prison.
- For users of other drugs just over 1 in 10 of those that are referred get further treatment.

Continuity of care by gender

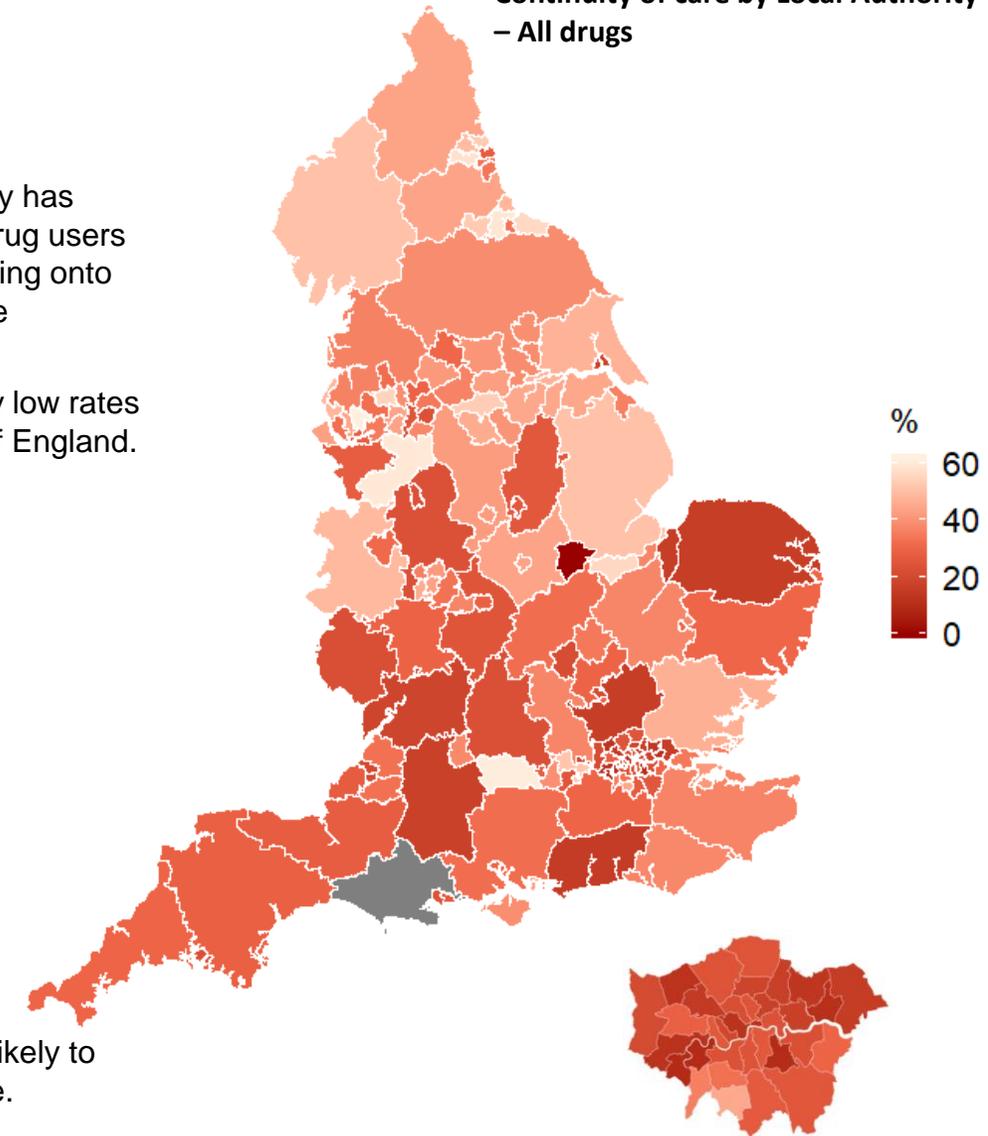


Continuity of care by age



- There is little difference in the rates of treatment after prison by gender.
- However younger people are far less likely to continue treatment post-prison release.
- This is likely a reflection that non-opiate users are younger than their opiate using counterparts.

Continuity of care by Local Authority – All drugs



- The north of the country has higher proportions of drug users referred from prison going onto receive treatment in the community.
- London has particularly low rates compared to the rest of England.

Sources: [Substance misuse treatment in secure settings: 2017 to 2018](#); [Public Health Outcomes Framework](#), both PHE, 2019

Sentencing lengths of drug users

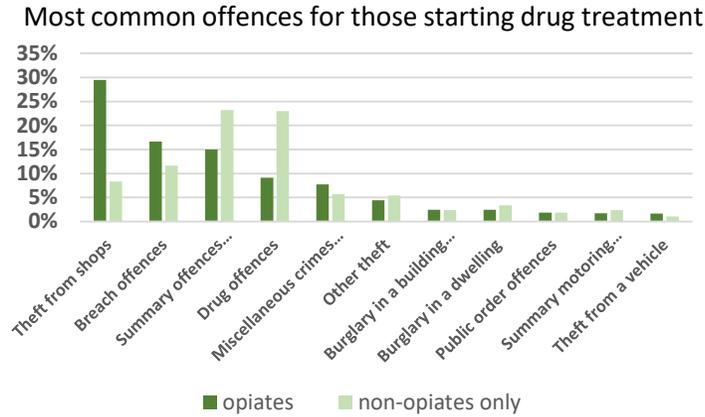
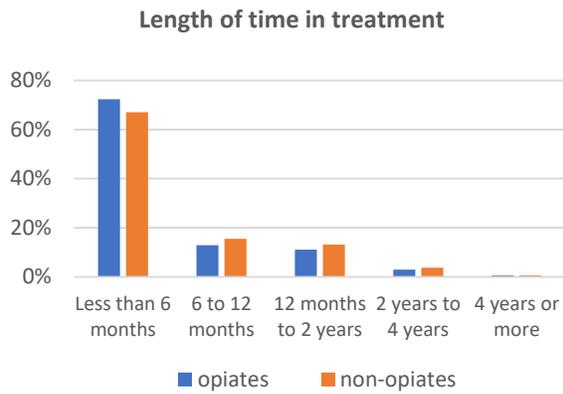


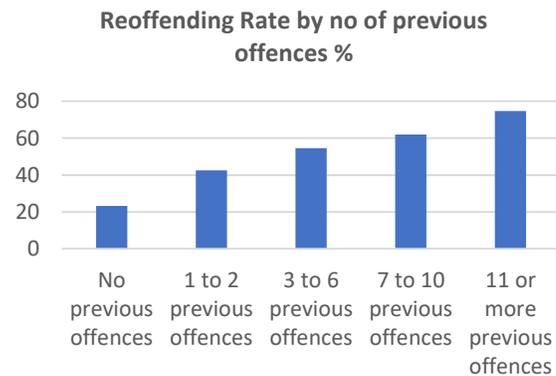
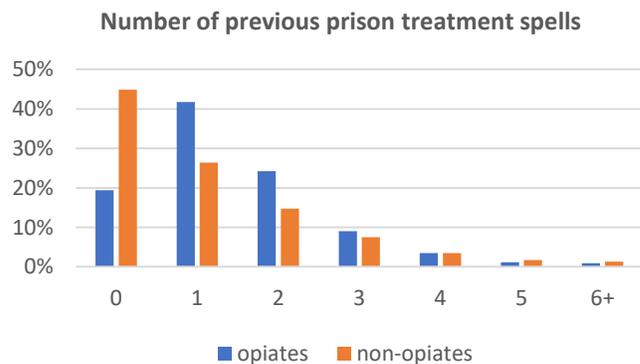
Table 6: Odds ratios of reoffending¹ with breakdown by the number of previous offences

Previous offences	STC vs. CO		STC vs. COM		STC vs. SSO		SSO vs. COM	
	Odds ratio	Sig ²	Odds ratio	Sig ²	Odds ratio	Sig ²	Odds ratio	Sig ²
0	0.90	-	0.84	-	1.06	-	0.73	-
1-2	1.00	0.41	0.95	0.35	1.19	0.41	0.84	0.04
3-5	1.00	0.39	0.94	0.33	1.18	0.39	0.80	0.17
6-10	1.06	0.14	0.98	0.19	1.30	0.10	0.78	0.34
11-15	1.14	0.04	1.10	0.02	1.25	0.18	0.82	0.09
16-25	1.34	0.00	1.26	0.00	1.50	0.00	0.88	0.00
26-50	1.35	0.00	1.28	0.00	1.45	0.01	0.85	0.02
>50	1.36	0.00	1.34	0.00	1.40	0.02	0.91	0.00

Notes:

1. Treatment sentence relative to control sentence.
2. Compared to odds ratio for no previous offences.
3. The regression model is as implied by Table 5.

- Nearly 75% of people in drug treatment in prison are in for less than six months, with many in for less than a month.
- The length of treatment will in the main reflect the length of their sentences which will usually be for offences like shoplifting or breach/summary offences.
- This limited exposure will not allow enough time for treatment to be effective, with the majority that need it not continuing treatment in the community post-release.
- Four out of five opiate users - and just over half of other drug users - have one or more prison treatment spells before their latest one (in the preceding four years).



- Many studies like the one above from the Ministry of Justice (2018) demonstrate that community orders (COM), court orders (CO) and suspended sentences are better than short sentences (STC) at reducing reoffending.
- This is particularly true for those with previous offending histories (such as those in prison drug treatment)
- However Community Sentences have decreased by 25% between 2009 -2016 and drug treatment requirements have also decreased by 40% over the same time period.
- The most expensive community order (at most £5,000) is half the cost of imprisoning someone for six months (around £11,000).

Drug use and prisons summary

Prevalence

There are three overlapping cohorts of drug users and drug-related offenders in the prison estate:

- Those in prison drug treatment;
 - Those in custody for drug specific offences;
 - Those using drugs in prison.
- The vast majority of those receiving prison drug treatment (and also those with offending associated with their drug use not in treatment) have been convicted for non-drug specific offences, but offences in many cases are associated with their drug use.
 - It is estimated that over a third of adults in custody on a given day are there due to drug offences or offending related to their drug use.
 - Short sentences mean that prison treatment is not long enough to be effective and patterns of drug use and offending are likely to continue post-release with poor continuity of care into community treatment for those that need it.
 - Positive drug test rates fell between 1999 and 2015 but have increased since then for traditional drugs and also because of the introduction of tests for psychoactive substances.
 - The number of illicit drug finds has increased substantially over the last three years, but the increases have been in line with the overall rise in illicit seizures from prisoners. Therefore it is difficult to tell whether the increase is due to increased drug use or better detection equipment and processes.
 - Rates of drug finds per person by prison function are relatively similar, though rates of positive tests vary substantially.
 - By prison, both rates of drug finds and positive drug tests show significant variation. Those prisons with the highest rates of drug use have the worst 'purposeful activity' HMP Inspectorate scores.
 - Psychoactive substance use has increased over the last few years, mainly driven by the use of 'spice'. While this increase is causing substantial problems for users and staff, there is no evidence so far that this type of drug use continues on release.

Drug use and prisons summary (2)

Drug treatment in prison and sentence lengths

- Prison treatment is readily available for those that need it, waiting times are very low particularly for opiate users needing substitute prescribing.
- Most people receiving treatment in prison do so for very short durations reflecting the short sentences those with drug problems tend to receive.
- Nine out of 10 opiate users in prison treatment in 2017-18 had also received treatment in the community in that year, while 9 out of 10 users of other drugs had either never been treated in the community or had been more than 12 months ago.
- There has been an increase in crack cocaine presentations to prison treatment, with users tending to be younger and nearly a third having never had contact with community treatment.
- Only a third of those needing treatment in the community post-release, go onto receive it. For non-opiate users the rate falls to 1 in 10.
- There is substantial variation in continuity of care performance with the best performing Local Authorities and prisons having pick-up rates in the community post-release six times higher than the worst performing areas.
- Like community drug treatment, there is little oversight or accountability of Local Authorities and NHS England for the very poor continuity of care performance in some areas.
- Short sentences do not allow enough time for prison treatment to be effective and they are even less so due to lack of continuity of care for most prisoners on release. Community sentences have been demonstrated to be more effective in reducing reoffending, especially for more prolific offenders.

10. Children and young people

Children and young people – supply, distribution and violence

Proportion of individuals sentenced for the supply of drugs who were 20 or under

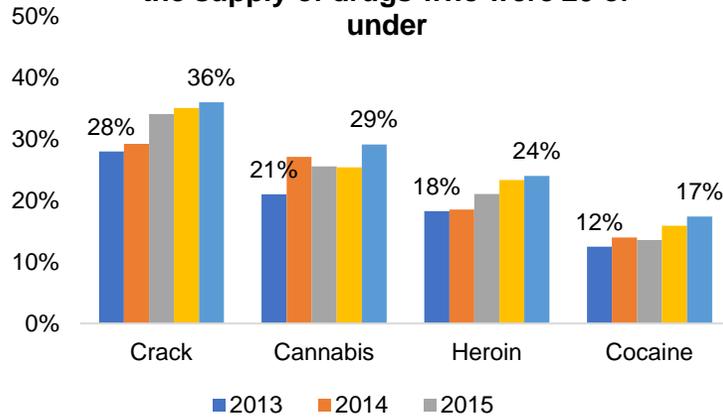
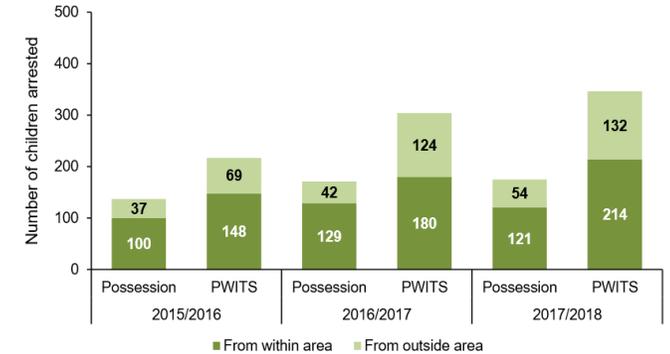
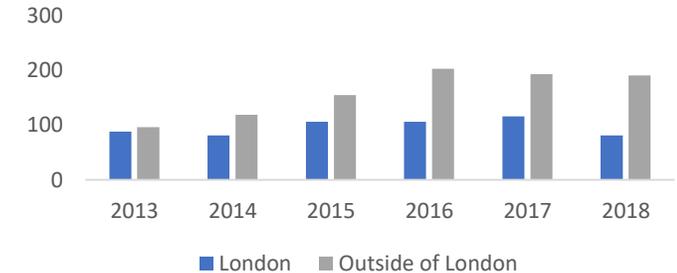


Figure 3: Total number of children arrested with intent to supply or for possession of a Class A by gender who were living within or outside police force area (n = 11)



- Data from 11 police forces showed that the number of children arrested for drug possession and possession with intent to supply offences had increased
- This was both among children living within the police force area and for those living outside.
- The number of 10-17 year olds sentenced for possession with intent supply class A drugs has increased considerably for those outside of London.
- Whittaker et al (2018) found in particular that the younger gang members involved in drugs between the ages of 12-17 were increasingly becoming active in serious violence such as stabbings and weapon carrying.

Number of 10-17 year olds sentenced for PWIS Class A drugs



Funding is predicted to have decreased by 96% in Gateshead, where funding will have fallen from £6,958,000 in 2010/11 to a predicted £277,000 in 2019/20.

Disinvestment in youth services

- A YMCA analysis of 84 local authorities across England that while the average spend on youth services per Local Authority in 2010 was £7.79 million, planned average spend for 2019/20 is just £2.45m – a 69% decline.
- A third (29%) of local authorities have planned cuts that would see their spending on youth services decline by 80% since 2010/11, while the vast majority of local authorities (83%) have planned to cut their funding in half over the nine-year period.

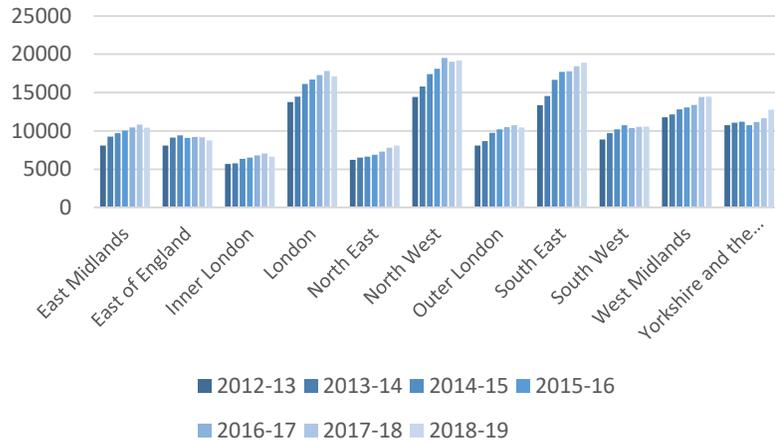
- Children and young people are increasingly becoming involved in the supply of drugs, with the proportion of those sentenced aged under 20 increasing for most substances.
- The young boys involved in gangs are more likely to be visibly violent as they carry out the 'dirty work' of elders.
- As use of drugs among children is increasing, this increases their exposure to drugs and the risks of becoming involved in supply.
- Andell and Pitts (2017) researched gangs in Ipswich and found that younger members were less business-minded and motivated by profit, but instead focused more on their image and reputation.

'One of the things that young people talk about the most is the amount of violence there is.'

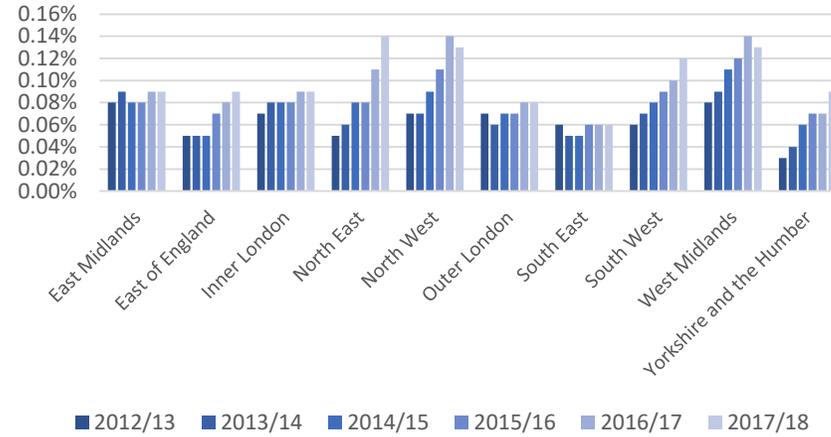
The Children's Society Practitioner 2019

Children and young people – social care and school exclusions

Number of children on a child protection plan

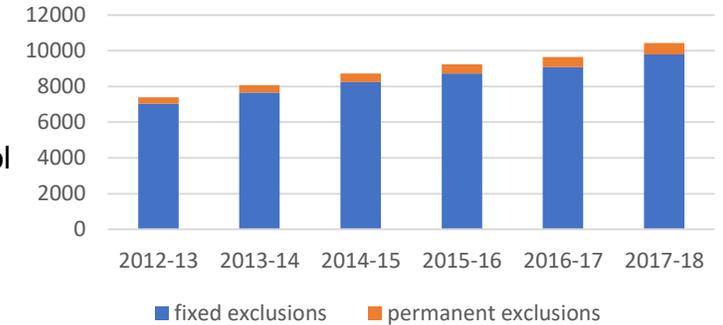


Rate of permanent exclusions



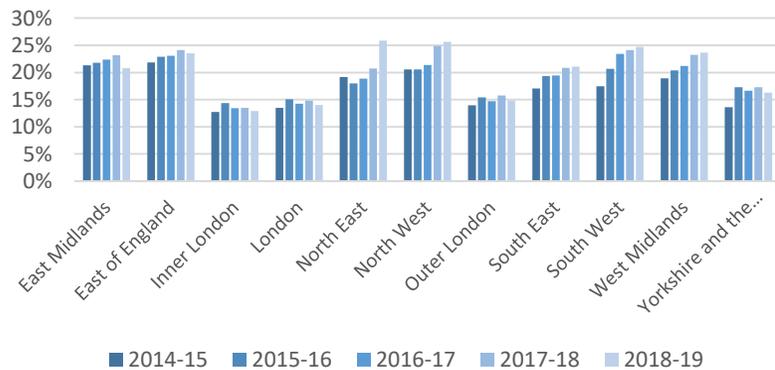
- The number of children permanently excluded in England has increased by 71% since 2012/13.
- The number of fixed exclusions have increased by 45% over the same period.
- The North East and Yorkshire and the Humber have seen the largest increases.
- London and the East Midlands have seen the smallest with a decrease in the South East.
- Around 8% of exclusions are due to drugs or alcohol, this proportion has remained stable.

No. of exclusions due to drugs or alcohol



- Overall the number of children on a child protection plan has increased by 26% since 2012/13.
- All regions saw an increase over this period, ranging from 19% in Yorkshire and Humber to 42% in the South East

Proportion of 'children in need' assessments where drug misuse is a factor



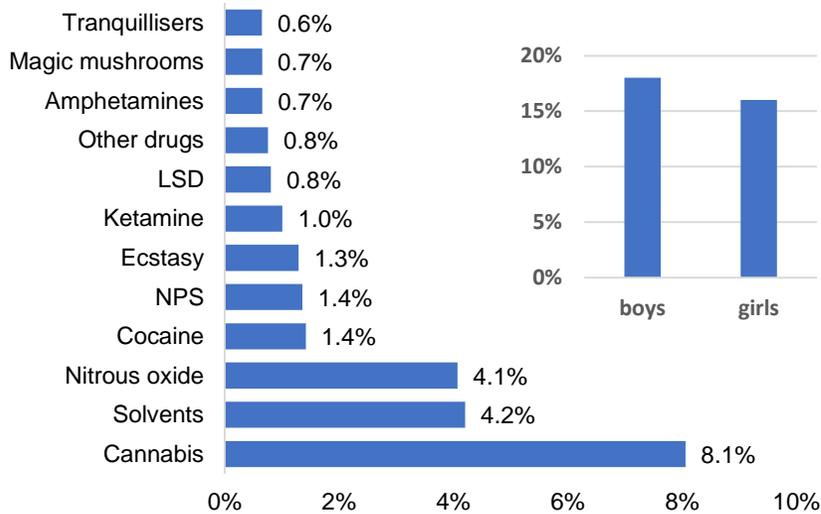
- The number of children excluded due to drugs or alcohol (8%) has increased by just over 40% since 2012/13.
- Nationally the proportion of children in need where drug misuse has been identified as a factor has increased by almost a fifth from 18% to 21%.
- The South West and Yorkshire and the Humber have seen the largest increases.
- London, where the rates are lowest, has seen no change since 2014/15.
- While the rates are far lower than for drugs the proportion of assessments where gang involvement was identified has doubled over the last four years.
- All areas of the country have reported increases with the highest rates in London.

Proportion of assessments where gang involvement is a factor



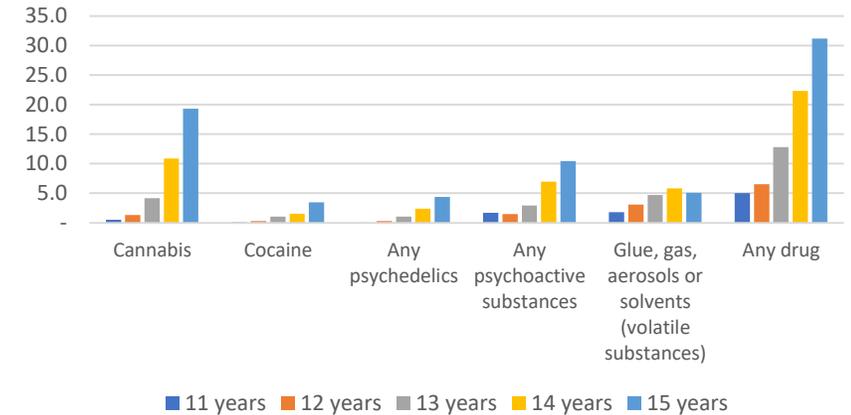
Recreational drug use among school children

Drug use in the last year among 11-15 year olds by drug type and sex



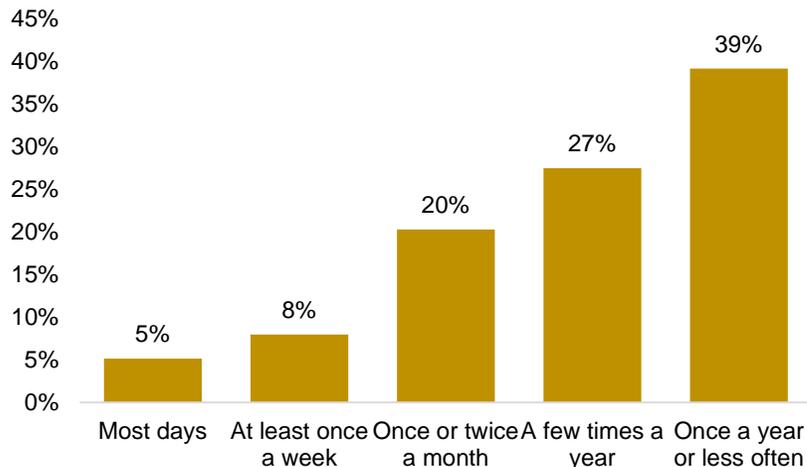
- As with adults, cannabis is the most popular drug among school aged children.
- Nitrous oxide use is much higher among children than adults, and use of solvents is also relatively high among children.
- Unlike adults there is little difference in levels of use between boys and girls.

Drug use in the last year among 11-15 year olds by age and drug type

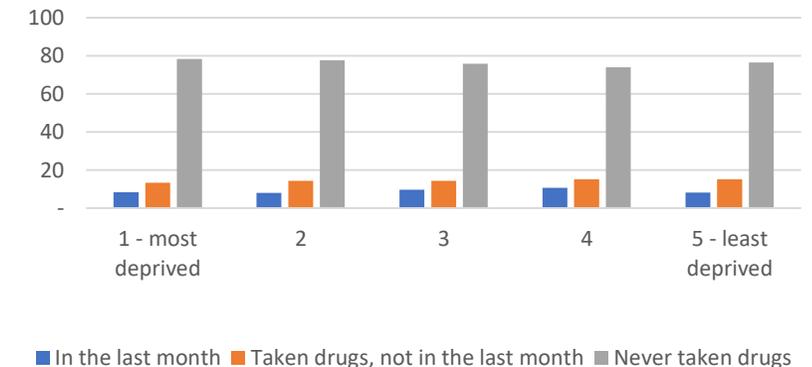


- The rate of drug use increases with age, with children aged 15 nearly five times as likely to have used drugs in the last year than those aged 12.
- The rate is ten times higher for cocaine and 15 times for cannabis use.
- For those reporting the use of volatile substances the rates by age are much more similar.

Frequency of drug use among 11-15 year olds

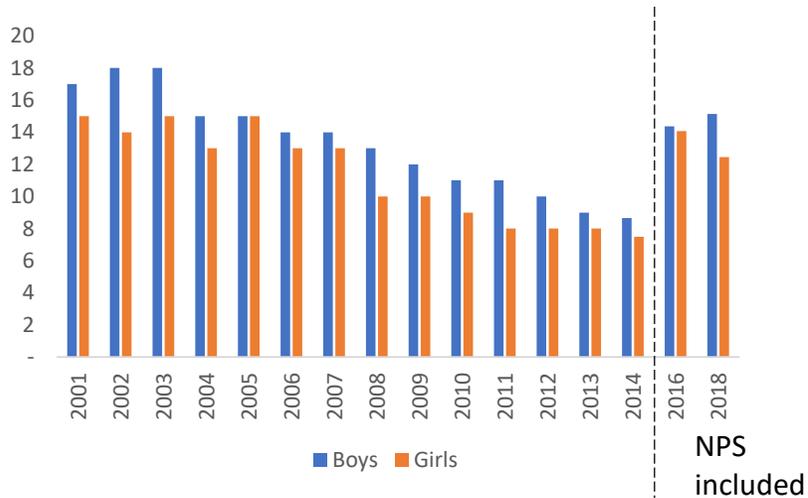


- For those children that report last year drug use, over two-thirds had used them a few times a year or less.
- One in 20 reported using drugs on most days.
- There is little difference in rates of school age drug use and deprivation.



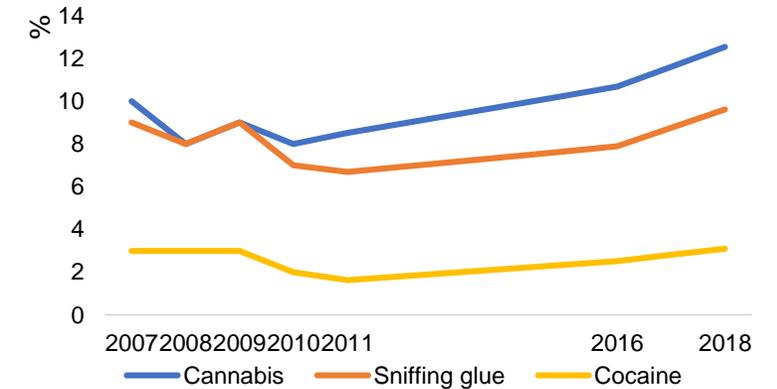
Trends in school-age drug use

Percentage of children who used drugs in the last year by sex (excluding volatile substances)

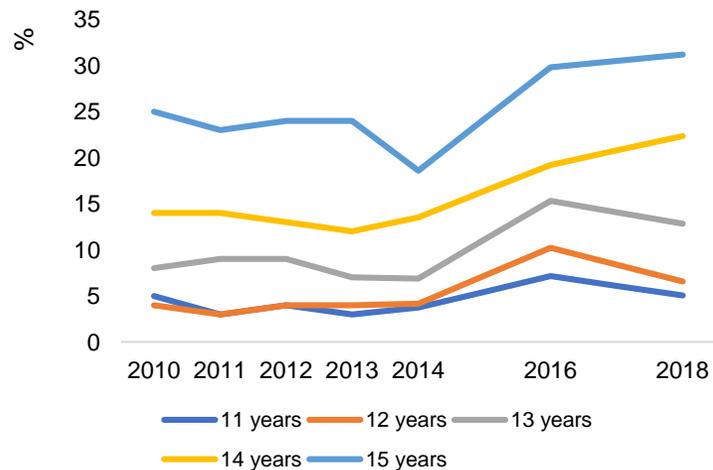


- There have been substantial increases in the proportion of school-aged children reporting the use of drugs in the last year since 2014.
- Though the level of use remains just below what was seen 20 years ago.
- The level of increase has been very similar for both boys and girls and across most ages.
- Nearly all drug types have seen an increase in use, with notable rises in the use of cocaine, ketamine and tranquilisers.

Proportion of children who believe it is acceptable to try drugs "to see what it's like"



Percentage of children who used drugs in the last year by age

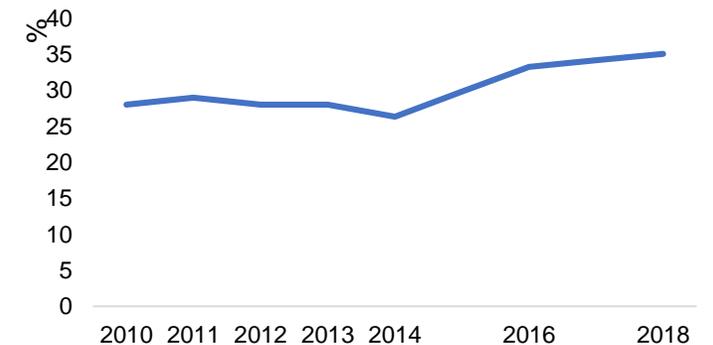


Proportion of children who used drugs in the last year

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

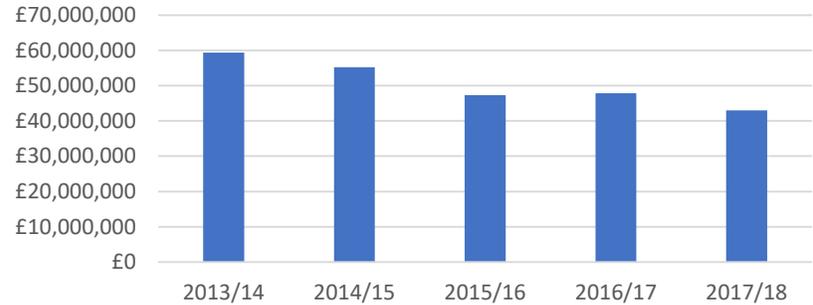
- It is unclear what is behind the recent increases in school-age drug use.
- However, there have been increases in children reporting that it was acceptable to use drugs and also more being offered drugs.

Proportion of children who have ever been offered drugs



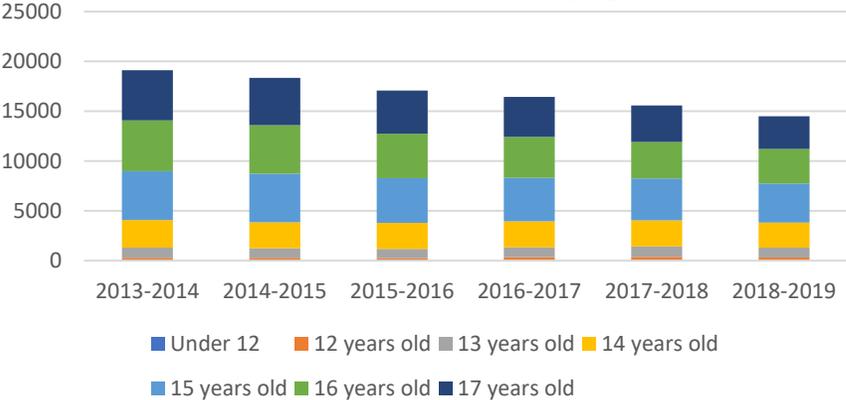
Children and young people - specialist treatment interventions

Expenditure on YP drug and alcohol treatment and prevention

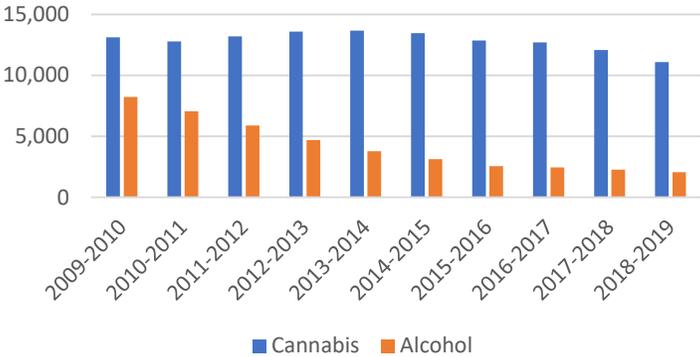


- The expenditure on young persons drug and alcohol interventions has fallen by 28% since 2013/14.
- It is estimated that about half of the spend is on treatment with the rest on prevention activities.
- The number receiving specialist YP treatment has fallen by a quarter since 2013/14 with some LAs reporting substantial reductions in activity.
- The majority of YP in treatment are aged 14 and over.

Number in YP treatment by age

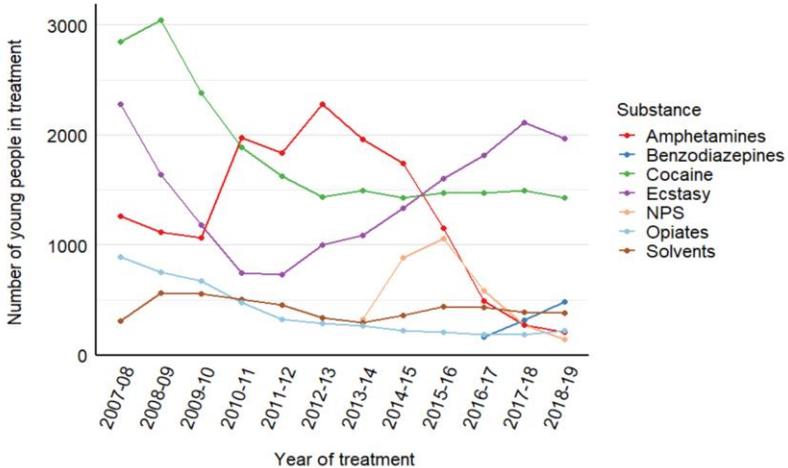


YP treatment cannabis and alcohol

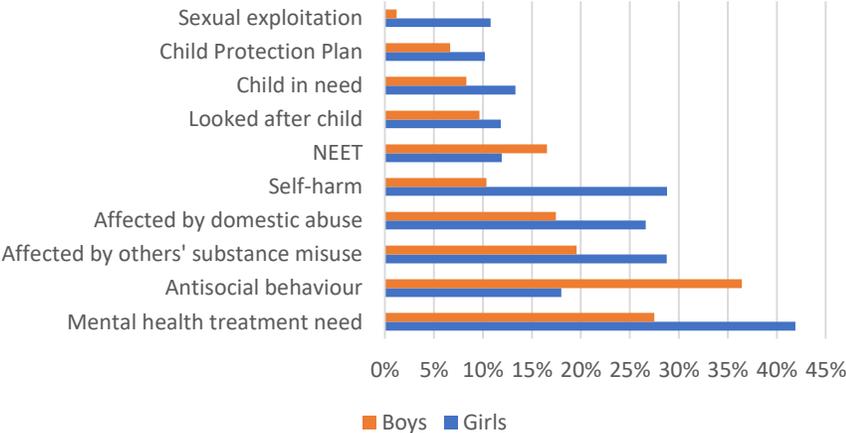


- The majority of young people receive intervention for cannabis or alcohol though the latter has declined substantially since 2009/10.
- The number of young people reporting a problem with benzodiazepines has trebled since 2016 to 2017, rising from 161 to 483 this year, likely as a result of increased use of alprazolam/Xanax.
- Most other substances have seen falls over the last five years apart from ecstasy which has increased, and cocaine which has remained relatively stable.
- The majority of YP present with other vulnerabilities alongside their drug use.
- The most common for girls is having a mental health treatment need though generally they have a higher rate of additional vulnerabilities, with 11% reporting sexual exploitation compared to 1% of boys.
- The most common additional vulnerability for boys was antisocial behaviour followed by a mental health treatment need.
- Over a third of young people in treatment have four vulnerabilities or more.

Other presenting substances



Vulnerabilities reported by YP in treatment



Children and young people summary

- Children and young people have become increasingly more involved in the supply of drugs, with the proportion aged under 20 sentenced for drug supply increasing significantly for most substances.
- Young people involved in drug supply tend to be more violent, often visibly so to carry out the 'dirty work' of their elders or in an attempt to prove themselves to other members of the gang or organisation.
- There has been an increase in stabbings and weapon carrying among young people involved in the supply of drugs.
- Drug use among school aged children (11-15) has increased by over 40% since 2014. Use has increased for both boys and girls and in most ages and demographics.
- Nearly all drug types have seen an increase in use, with notable rises in the use of cocaine, ketamine and tranquilisers.
- The number of children on a child protection plan has increased substantially since 2012/13 with most regions of the country seeing similar increases. The proportion of assessments where drug use or gangs is identified as factor has also risen during this time.
- There has also been a large increase in the number of permanent school exclusions, particularly in the North East and Yorkshire and the Humber.
- Funding for youth services has fallen by two-thirds with some Local Authorities reporting much larger reductions than this.
- Funding for specialist treatment for young people has fallen substantially since 2013/14 (28%), with similar large falls in the number of young people accessing these services (25%).
- Young people presenting to specialist services often have multiple vulnerabilities alongside their drug use and these services are important in addressing these, and/or ensuring that the proper support is provided from other external organisations.
- The most common additional vulnerability is a mental health treatment need, with 1 in 10 girls reporting that they had experienced sexual exploitation.

11. Research recommendations

Research recommendations

Drug supply

- **Quantifying the impact of drug markets on serious violence** – A local-level analysis of drugs and serious violence would help to quantify how much violence is driven by different changes in the drugs market.
- **National roll-out of wastewater analysis** – This would help to robustly quantify the size of the drug market and to track changes in the market over time.
- **Better evidence on the middle market** – This would help to identify how drugs are trafficked from the border to the street, and which groups are involved. It could involve research with law enforcement and other stakeholders, and interviews with drug offenders.
- **The impacts of drug enforcement** – This would help to identify the impacts of different types of drug enforcement and could involve quantitative analysis of local drug use, case studies of specific areas, using wastewater analysis or phone records to track local markets.
- **Quantifying the number of drug-motivated crimes** – This would help to identify the proportion of all violence and acquisitive crime which is drug-related. It could involve machine learning, access to the Police National Database, matching datasets such as Police National Computer and treatment data.

Research recommendations

Drug use and harms

- **Research into crack users not in treatment** – Little is known about the cohort of crack users who are not in treatment, particularly those who do not use heroin adjunctively. Research such as respondent-drive sampling would help to find out the demographics of these individuals and their pathway to crack use.
- **Research into the increase in powder cocaine use** – The analysis of recreational drug use has identified an increase in powder cocaine use in specific cohorts. Primary research could be conducted with these individuals, or through other organisations such as universities, in order to find out the reasons for this increase.
- **Research into the increase in drug use among school children** – Primary research with parents, teachers and children may help to uncover the drivers behind the increase in drug use among school children and if we would expect to see longer-term harms as a result of this increased use.
- **Research into synthetic opioids** – Synthetic opioids pose a significant risk of increased mortality and morbidity, but it is unclear what the prevalence of use currently is, which cohorts are most at risk and how the risks can be potentially mitigated.
- **Research into deaths among drug users outside of treatment** – a large proportion of drug-related deaths occur in users outside of treatment and research would look into why this cohort do not seem to access treatment, with a specific focus on rough sleeping populations where the rate of drug-related deaths is particularly high.

12. Abbreviations

A&E	Accident and Emergency	OCG	Organised Crime Group
BBVs	Blood borne viruses	OCU	Opiate and Crack User
CBD	Cannabidiol	ONS	Office for National Statistics
CJS	Criminal Justice System	PHE	Public Health England
CO	Court Orders	PHG	Public Health Grant
COM	Community Orders	PS	Psychoactive Substance
CSEW	Crime Survey of England and Wales	PTB	Pooled Treatment Budget
CVD	Cardiovascular disease	PWID	Person Who Injects Drugs
HO	Home Office	PWIS/PWITS	Possession with intent to supply
IPS	Individual Placement Support	RCT	Randomised Controlled Trial
LA	Local Authority	SCRA	Synthetic Cannabinoid Receptor Agonist
LAC	'Looked After' Children	SSO	Suspended Sentence
MDMA	3,4-Methylenedioxyamphetamine	STC	Short Sentence
MoJ	Ministry of Justice	THC	Tetrahydrocannabinol
NCA	National Crime Agency	Tx	Treatment
NFA	No Fixed Abode	USG	Urban Street Gang
NPS	New Psychoactive Substance	WHU	Work and Health Unit, Department for Work and Pensions
NTA	National Treatment Agency		