

Review of Drugs

Executive Summary

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Foreword

My independent review of drugs, commissioned in February 2019 by Sajid Javid (then Home Secretary), was to be in two phases, an up-to-date analysis of the problems and then recommended policy solutions.

This publication summarises the work from phase one, which included many months of rigorous and ground-breaking analysis to understand the complex and overlapping markets for illegal drugs. I took a market approach because the supply of drugs is driven by profit, and violence is often the result of competition for market share. Only by understanding the market and the drivers behind it can Government hope to disrupt it. For example, the growth in the county lines appears to be largely caused by market saturation in the big cities. It has exploited vulnerable people, especially the young. Some 27,000 young people now identify as gang members, many drawn into drug dealing, often with deadly consequences as the supply and distribution of drugs have become increasingly violent.



There is a very tragic human story behind this market analysis. Drug deaths in 2018 were the highest on record. Since 2012 heroin-related deaths have more than doubled, while deaths involving cocaine have increased five-fold. We have the highest number of rough sleepers dying on our streets from drug poisoning since records began. Long-term drug users are cycling in and out of our prisons, at great expense but very rarely achieving recovery or finding meaningful work. Many of their children are taken into care. Problem drug use is highly correlated with poverty, and these problems blight our most deprived communities.

I have seen first-hand, in prisons, schools, youth clubs and charities, the effects of increasing supply, greater drug purity and easier availability, combined with the loss of many protective factors – a perfect storm, to abate only if the Government takes action.

Treatment services have been curtailed by local government funding cuts. The total cost to society of illegal drugs is around £20 billion per year, but only £600 million is spent on treatment and prevention. So the amount of un-met need is growing, some treatment services are disappearing, and the treatment workforce is declining in number and quality. Ultimately, we need to transform our approach to treatment, investing in it but also innovating so that treatment services are able to respond to today's drugs market and future developments.

Previous Governments have de-prioritised these problems - from drugs entering the country right through to helping drug users access appropriate treatment and achieve recovery. I hope that the first phase of this review, with its thorough analysis of the market and assessment of areas for further policy investigation, will provide a firm platform for decisive action by the new Government.

Acknowledgements

I wish to acknowledge the contribution and sheer hard work of the team with whom I worked, in particular Lucy Lowton, Dan Broadfield, Jon Knight and Donna Ward. Many Government officials, organisations and individuals gave us of their time and expertise, and my challenge group held up a very necessary mirror to the work.

My especially grateful thanks go to those men and women, living on our streets in our prisons or in shelters, who shared their stories, dreams and hopes. I very much hope that, moving forward from this review, we shall not fail them.



Summary of key findings

1. The illicit drugs market is big business, worth an estimated £9.4 billion a year. Around 3 million people took drugs in England and Wales last year, with around 300,000 in England taking the most harmful drugs (opiates and/or crack cocaine).
2. Drug deaths have reached an all-time high and the market has become much more violent. Taking the health harms, costs of crime and wider impacts on society together, we estimate the total costs of drugs to society are over £19 billion, which is more than twice the value of the market itself.
3. The drugs market consists of a number of distinct but overlapping product markets. Most drugs consumed in the UK are produced abroad. The supply of drugs has been shaped mostly by international forces, the activities of Organised Crime Groups and advances in technology.
4. The demand for opiates and crack/cocaine, and deaths from misuse of these substances, is closely associated with poverty and deprivation. There is an ageing population of heroin users with severe health needs, some of whom are using crack cocaine too, but there is also a new population of younger crack cocaine users that do not use heroin.
5. The heroin and crack cocaine retail market has been overtaken by the county lines model, which is driving increased violence in the drugs market and the exploitation of young people and vulnerable drug users.
6. The demand for powder cocaine is closely linked to that for other recreational drugs, such as ecstasy and amphetamines. Increased use of powder cocaine has been driven by those under 30. The demand for these drugs is strongly linked to the night-time economy and alcohol.
7. The use of new psychoactive substances among the general population has fallen but has increased in vulnerable populations such as those sleeping rough and those in prison.
8. Government interventions to restrict supply have had limited success. The key institutions involved are Border Force, the National Crime Agency (NCA) and police forces. All have faced budgetary constraints in the past decade and competing priorities. Even if these organisations were sufficiently resourced it is not clear that they would be able to bring about a sustained reduction in drug supply, given the resilience and flexibility of illicit drug markets.
9. There has been a renewed focus in recent years by the NCA and police forces on drugs in response to the serious violence caused by the county lines model.

10. More than a third of people in prison are there due to crimes relating to drug use (mostly acquisitive crime). These prisoners tend to serve very short sentences, have limited time in prison treatment and poor hand-offs back into the community. They are very likely to re-offend.
11. Drugs within prisons are widely available, with around 15% of prisoners testing positive to random drug tests. The problems are greatest in male local and category C prisons. New psychoactive substances have become increasingly problematic in prisons. Drug use in prisons is closely linked to the amount of purposeful activity available to prisoners.
12. Treatment in the community is the responsibility of Local Authorities. Spending on treatment has reduced significantly because Local Government budgets have been squeezed and central Government funding and oversight has fallen away. There is significant local variation, with some Local Authorities having reduced treatment expenditure by 40%.
13. Local Authorities commission treatment from NHS Trusts and third sector providers. A prolonged shortage of funding has resulted in a loss of skills, expertise and capacity from this sector. Treatment providers often have to prioritise the severe needs of the long-term heroin using population, meaning that services for other drug users have had less investment.
14. Even if more funding became available for treatment (which is vital), there would be a lot of work to do to build up capacity and expertise in this market. In addition to dedicated funding, the re-introduction of incentives and levers, and locally held joint responsibility and accountability, would go a long way to regenerate and vitalise the system.
15. Recovery is about more than just treatment. Other factors are equally important, particularly housing and employment. Central Government has funded some excellent pilots to address the complex housing and employment needs of long-term drug users but these are time-limited and small-scale.
16. Young people and children have been pulled into drugs supply on an alarming scale, especially at the most violent end of the market. There are strong associations between young people being drawn into county lines and increases in child poverty, the numbers of children in care and school exclusions. Social media has played a facilitating role.
17. There is a considerable increase in children using drugs, after a long period of a downward trend. Those seeking treatment have a number of complex needs, including mental health needs, that can only be met through a combination of specialist treatment and wider social and health care.

Why we have done this review

1. The illegal drugs market has long existed but has never caused greater harm to society than now. An estimated 3 million people took drugs in England and Wales last year, with around 300,000 using the most harmful drugs (opiates and/or crack cocaine).
2. Drug deaths in 2018 were the highest on record (2,917). The increases have been primarily driven by deaths involving heroin, which have more than doubled since 2012, alongside a five-fold increase in deaths involving cocaine or crack cocaine. We have seen the highest number of rough sleepers dying on our streets from drug poisoning since records began. Many of these deaths also involve alcohol. The high incidence of drug deaths is likely to be contributing to the slowdown in life expectancy in the UK after decades of growth.
3. Huge geographical and socioeconomic inequalities lie beneath these trends, with entrenched drug use and premature deaths occurring disproportionately in deprived areas and in the north of the country.
4. Drugs appear to be a major driver of the national increases in serious violence over recent years. An unprecedented number of very young people have been drawn into the drugs trade. The Children's Commissioner estimates that 27,000 children in England and Wales identify as gang members, and 2,000 teenagers from London alone have been identified as having a link to county lines activity.
5. Taking the health and criminal justice costs together (alongside associated costs to families and society), the total cost of the illicit drugs trade is now estimated to be over £19 billion a year, which is more than double the estimated value of the illicit drugs market itself, a similar scale of magnitude to the costs associated with alcohol.
6. To understand how we got here, we need to analyse the market and assess how it has been shaped by international and domestic forces. There are, of course, several markets at play, many of which interact. We also need to understand where and how Government has intervened and to what effect.

Part One - the illicit drugs market

Heroin and crack cocaine

7. Most (86%) of the drug-related costs to individuals and society are concentrated in the markets for heroin and crack cocaine. These two markets are quite distinct in terms of production and importation but start to overlap significantly in the retail stage of the market, with a growing overlap in the customer base.
8. The heroin market is long established, with a relatively stable number of long-term users (approximately 260,000). It is by far the largest drug market with an estimated £4 billion/year of revenue, and the crack market represents an additional £1 billion of revenue. The heroin market expanded rapidly in the 1980s and 90s but the numbers of new users has declined substantially over time. Much of the 'core' heroin population are entrenched users with increasingly severe and costly health problems, many of them cycling in and out of treatment services. The ageing of the heroin population and their length of drug use is a big factor in the record number of drug-related deaths.
9. Increasingly, long-term heroin users are also using crack cocaine due to rising production and purity of cocaine and much more aggressive marketing of both substances together. There is also a growing market segment of younger crack users that do not use heroin. The estimated number of crack users is approximately 180,000, with a large proportion of this population also using heroin.
10. Heroin and crack use are strongly linked to deprivation and this drives the geographical distribution of entrenched drug use and premature deaths, described above.

Supply and distribution of heroin and crack cocaine

11. Because source production for both products is limited to certain geographical areas, local factors such as political developments and changes in weather conditions can have big impacts on price and volumes produced.
12. Worldwide production of cocaine boomed from 2013, while heroin production boomed three years later. The rise in cocaine production has led to increased competition amongst UK suppliers, increases in street-level purity and increased use of cocaine and crack cocaine.
13. The powder cocaine market in the UK is dominated by Albanian Organised Crime Groups, with their supply network stretching all the way from the source country to individual towns and cities. Powder cocaine is converted to crack

much further down the supply chain – near street-level distribution, using basic equipment.

14. Heroin tends to be imported into the UK by Pakistani and Turkish Organised Crime Groups. Turkish and British Organised Crime Groups dominate the wholesale supply across the country, with some involvement by Albanian groups.
15. At street level, heroin and crack tend to be dealt together. In large cities, this is by locally-based Organised Crime Groups or Urban Street Gangs. In other areas, many heroin and crack markets have been overtaken by county lines groups. There is also a risk that fentanyl, which has been found in the UK contaminating heroin supply, could become a mainstream drug given its low manufacturing cost, high potency and ease of distribution through the post.

County lines

16. County lines is a relatively recent distribution model whereby a group supplying drugs from an urban hub establishes a network with a county location, for example rural or coastal towns (which have fewer law enforcement resources than metropolitan areas). Customers in the county location make drug orders via a branded mobile phone line, often controlled from the urban hub.
17. The county lines model of distribution appears to have evolved as a result of market saturation and declining heroin and crack use in big cities. London, Birmingham, Manchester and Liverpool supply the largest number of lines. The areas receiving the largest number of lines are coastal and market towns, such as those in the South East and East of England.
18. The county lines model now stretches all over the country and has largely displaced local dealers, although there is evidence that this model co-exists alongside local dealers in parts of the country.
19. A distinct feature of the county lines model is the use and exploitation of young people (often aged 15-17 and mostly male). Children displaying vulnerabilities, such as poverty, family breakdown, becoming known to social workers, looked-after status and exclusion from school are targeted but so, too, are children from seemingly stable families with no previous contact with police or children's services. Children and young people are predominantly recruited as 'runners' to transport drugs and money, and are at most risk of facing the criminal justice system. Not all young people are groomed or coerced – some see it as their best opportunity to earn money and status.
20. Adult victims of exploitation by county lines are predominantly people with drug addiction and mental health issues. They will often be 'cuckooed',

whereby their residences are taken over as a base for preparing and dealing drugs.

21. Victims of exploitation are recruited face-to-face but also online. It is a highly adaptable business model, constantly evolving to avoid detection. For example, young people are being increasingly recruited for exploitation from local areas, as opposed to being transported in from urban hubs, and short-lets on properties are increasingly being used in favour of 'cuckooing'.
22. County lines remain profitable, with potential profits estimated to be over £800k per year from an individual line. It is a very violent business model, both for victims and between groups. The rise in the county lines business model seems to be a major factor in increased drug-related violence in the UK, alongside the related factors of the growth in the crack cocaine market and the increasing role of young people in drug supply. Potential future saturation of county lines markets raises the threat of violence still further.

Powder cocaine

23. As with crack cocaine, the boom in global production in cocaine has resulted in increased levels of purity and increased availability of powder cocaine. The powder cocaine market is worth just under £2 billion in value, with an estimated 976,000 users each year (nearly four times the number of heroin users but with much less frequent average usage).
24. The number of powder cocaine users has increased sharply over the past five years. Use has increased across a wide range of demographic groups, but much of the increase in the number of users has been driven by white males aged under 30. Geographically, relative increases in use have been greatest in the South West of England and the East Midlands, with London seeing the largest decrease.
25. The importation and wholesaling of powder cocaine is largely dominated by Albanian Organised Crime Groups, as outlined above. When it comes to retail supply the powder cocaine market diverges from that of heroin and crack, with dealers tending to be older, white and often delivering to venues within the night-time economy. Many powder cocaine users will have accessed the drug through a friend, rather than directly from a dealer.
26. At the retail level, the powder cocaine market is associated with less violence than the markets for heroin and crack, although the supply chain internationally is extremely violent. There is evidence that individuals from county lines are also starting to deal powder cocaine, albeit as a side-line, with anecdotal reports of county lines groups setting up in universities.

27. The increase in powder cocaine use is a growing health concern, with cocaine-related deaths at an all-time high and making up 1 in 7 of all deaths from drug poisoning (although some are likely to be crack cocaine deaths – it is not possible for coroners to differentiate). Currently, only around 3% of powder cocaine users access treatment.
28. Although most powder cocaine users are occasional users, there is a risk that the increase in prevalence amongst young people will lead to more problematic use in future. Powder cocaine use is a risk factor in crack cocaine use. The involvement of county lines groups increases the risk of both powder and crack cocaine markets growing further.

Cannabis

29. The cannabis market is the single biggest product market in terms of the number of consumers – with over 2.5 million users in the last year and an estimated revenue of around £2 billion. However, with a huge number of users and intermediaries, it is not the most profitable.
30. Cannabis use is widespread across the population, but the majority of users are aged under 30. Cannabis is more likely to be used frequently than other recreational drugs – of those who used cannabis in the last year 10% used it daily and a further 16% weekly. Higher levels of use are associated with lower incomes and more deprived areas.
31. Cannabis use remained fairly flat between 2009/10 and 2016/17 but has since shown signs of an increase, especially amongst those in their 20s.
32. After heroin and crack cocaine, cannabis is the most common drug that results in people seeking treatment (around 25,000 people in 2017/18). Cannabis poses a large number of health risks, including psychological and respiratory disorders, particularly given recent increases in potency.
33. The cannabis market is very hard to monitor – there are low barriers to entry and it can be grown and produced almost anywhere. There is no robust data on production but it is thought that for herbal cannabis, domestic cultivation exceeds importation. Resin cannabis tends to be imported.
34. There is a considerable amount of small-scale private production but also a large number of Organised Crime Groups involved in the growth, importation and distribution of cannabis in the UK. Vietnamese groups are known to be involved in human trafficking, where Vietnamese nationals are forced to work on cannabis farms in the UK. There is evidence that young people with heavy cannabis use have been pulled into county lines operations to pay off debts.

Synthetic drugs (ecstasy, amphetamines and New Psychoactive Substances)

35. There is no reliable estimate of the value of the overall synthetics drugs market, although the ecstasy market is estimated at around £40 million a year in revenue. There are estimates of the numbers of users in England and Wales – 524,000 users of ecstasy, 188,000 users of amphetamines and 152,000 users of New Psychoactive Substances (NPS) (in the last year), with many people using two or more of these substances concurrently.
36. Most users of ecstasy and amphetamines are under 30. There has been little change in the prevalence of use and profile of users over time. NPS use among the general population declined in response to the Psychoactive Substances Act 2016 but remains high in rough sleeping and prison populations, particularly for potent synthetic cannabinoids.
37. Synthetic cannabinoids have become a growing problem in prisons, with growing levels of violence, disorder and health issues. They have also contributed to the increased health problems and deaths of rough sleepers.
38. Synthetic drugs, in principle, can be produced anywhere. In practice, ecstasy and amphetamines are produced largely in Belgium and the Netherlands, although amphetamines are also produced in the UK. Synthetic cannabinoids and other NPS are primarily manufactured in China and, to a lesser extent, India.
39. Organised Crime Groups are involved in the importation of synthetic drugs into the country. The dark web has also become an important source of retail supply, especially for NPS outside of synthetic cannabinoids. The retail supply of ecstasy and amphetamines is often based around the night-time economy and is linked to the sale of powder cocaine. Synthetic cannabinoids were sold legally prior to the Psychoactive Substances Act 2016 but are now sold by street dealers alongside other substances such as heroin and crack.
40. As identified above, there is a serious risk that potent fentanyl will become an established market in the UK, following the US.

Part Two - Government intervention

Law Enforcement

1. The starting point for Government intervention in the drugs market is the Misuse of Drugs Act 1971, which divides 'controlled drugs' into three classes – A, B and C – with class A drugs being considered the most harmful, and sets out a range of criminal offences in relation to them. This was followed by the Psychoactive Substances Act 2016, which introduced a blanket ban on the production, supply, possession with intent to supply and import and export of psychoactive substances.
2. There are three key enforcement agencies that deal with different stages of the supply chain and with associated violence and exploitation. Each has an important role to play, although changes in the supply of drugs over time have been driven largely by international forces. For example, the purity and price of heroin and cocaine have been determined far more by political and climatic conditions in production countries than by the actions of domestic agencies.
3. The evidence suggests that enforcement activity can sometimes have unintended consequences, such as increasing levels of drug-related violence and the negative effects of involving individuals in the criminal justice system.

Border Force

4. Border Force is a Home Office command that deals with all threats (from individuals and goods) at the border. Its activities are prioritised in accordance with the Border Force Control Strategy, which is refreshed on a six-monthly basis and places threats within five categories (A-E).
5. There are a number of potential smuggling routes for class A drugs to reach the UK and a range of transport methods used. For example, heroin tends to reach this country from Afghanistan through three different main routes and can be transported by sea, air, post or train. This makes seizure by border control very difficult. The number and quantity of heroin seizures has generally fallen in the last few years, suggesting traffickers are becoming better at avoiding detection, although this trend has reversed in 2018/19.
6. Cocaine is most commonly transported from South America to the UK by sea and the quantity seized by Border Force has increased considerably in recent years, although this is likely to reflect an increase in global supply rather than a step change in enforcement activity. These seizures are unlikely to dent the profitability of established Organised Crime Groups but could de-stabilise or deter newer entrants to the market.

Post and fast parcels

7. There has been a significant increase in the use of post and parcel services to traffic drugs across the EU, often linked to web-enabled transactions. Prescribed medicines such as synthetic opioids and drugs available in pill form like ecstasy are often delivered via post and fast parcel. The overall volume of legitimate parcel traffic has increased significantly over recent years, making it increasingly difficult for law enforcement agencies to detect and intercept all but a fraction of suspicious packages. The sheer volume of regular parcels makes the risk profiling approaches used for container searches more difficult.
8. Border Force is intercepting a small but significant proportion of illegal drugs entering the country but there is an inherent problem in penetrating supply further, given the sheer number of routes into the country, modes of transport and volume of traffic. Border Force faces competing priorities (that are subject to change as political priorities shift) and has limited resources. There are some welcome developments, such as the investment in new detection capabilities. However, the evidence suggests that efforts to restrict the supply of drugs rarely have lasting impacts on their availability or usage, given the resilience of drug markets to enforcement activity.

The National Crime Agency

9. The National Crime Agency (NCA) is an operationally independent agency, founded in 2013 to fight against organised crime, human, weapon and drug trafficking, cyber-crime and economic crime across regional and international borders. It is the leading source of intelligence on Organised Crime Groups at or near the top of the supply chain and focuses on both the operations and the profits of Organised Crime Groups.
10. Organised Crime Groups will typically launder the proceeds of crime through a variety of means, including cross-border movement of physical cash. Denying these profit-focused groups their money and assets is likely to be much more effective than prison as a means of shrinking the market. This requires specialist financial investigative resource in both the NCA and within police forces. Investing more in this area should be a key focus for Government, given the key role profits play in driving supply.
11. The NCA has a key role in tackling county lines. In September 2018, a new multi-agency team of experts from the National Crime Agency, police officers and regional organised crime units were brought together to form the National County Lines Co-ordination Centre.
12. The NCA has absorbed a range of responsibilities from the various organisations it subsumed or replaced. It has a considerably smaller budget

than that of those previous organisations combined. This means it must ration activities across competing priorities, which change over time in light of political preferences. In recent years, for example, it has focused heavily on child sexual exploitation and victims of modern slavery. Compared to the size of the problems it faces it has a relatively small budget (£424 million/year) and only around 1,250 investigators.

Police

13. There are 44 police forces in England and Wales. They are operationally independent bodies, held to account by an elected Police and Crime Commissioner who sets out their strategic priorities in a Police and Crime Plan for the area. Police forces primarily tackle street-level drug dealing, whereas the NCA leads on the Organised Crime Groups further up the supply chain.
14. Over the past decade, tackling drugs has fallen down the priority list for nearly all police forces. This has partly been in response to funding cuts (of around 20% from 2010) and the emergence of other priorities, such as tackling domestic abuse and mental health incidents.
15. The police were traditionally key partners in the local authority-based Drug Action Teams that brought together social care, health, housing and education to develop collaborative local strategies to address substance misuse. They were also the lead partners in the Drug Interventions Programme, which received significant central funding and oversight from the Home Office to identify and divert drug users away from the criminal justice system and into treatment. The demise of Drug Action Teams and the Drug Interventions Programme over recent years has contributed to the fragmentation of partnership working in relation to drugs at a local level and this has particularly impacted on police engagement.
16. Efforts to find and convict drug dealers is largely discretionary for police forces, whereas responding to crimes reported by victims is not, so the former activity has been squeezed. Alongside the reduction in stop and search activities, the number of prosecutions for drug offences has fallen dramatically over time (a 40% fall between 2011 and 2019), largely driven by a fall in cannabis prosecutions. The number of drug seizures by police forces has fallen over the past decade for all of the main drug types.
17. The dramatic increase in violence associated with the growth of the county lines model has led to an increased focus by police forces most affected but this is mostly to tackle the violence and to seize weapons, rather than drugs. An increasing number of young people are being arrested and convicted for drug supply offences. In 2018, around 1 in 3 people sentenced for supplying

crack cocaine and 1 in 4 sentenced for supplying heroin were aged under 21. It is a similar picture for the supply of cannabis.

Prisons

18. In principle, the prison system presents a huge opportunity for positive government intervention on both the demand and supply sides of the drugs market. We estimate that just over a third of the prison population (of approximately 82,000 people on a given day) are there for a drugs-related crime. Of these, 40% have been convicted of a specific drugs offence (such as trafficking), whilst 60% are serving sentences for crimes related to drug addiction, such as theft.

Prisoners detained for crimes related to drug use

19. On a given day approximately 20,000 people, or nearly 1 in 4 prisoners, are detained because of offending related to their drug use, as opposed to being involved in supply. Over the course of the year the number is 50,000. These prisoners are generally cycling in and out of prison, serving short sentences, largely for theft. The crimes (mostly acquisitive) relating to drug use are therefore generating a huge pressure on the prison system.

20. The availability and speed of treatment within prisons appears to be good. Statistics on treatment in prison show almost all prisoners seeking treatment are triaged within three weeks and treated within a further three weeks.

21. However, those in prison treatment tend not to be there long. When offenders serve short custodial sentences of up to six months, the median time in prison is just six weeks, meaning these prisoners spend little sustained time in treatment. Around 40% of opiate users and a third of non-opiate users are in prison treatment for less than two months, with many only receiving treatment for two weeks or less.

22. However, prison treatment is operating in a challenging environment, with a high turnover of prisoners who have limited contact with family and friends and little purposeful activity. It is therefore not surprising that the review heard that prison drug treatment is generally limited to stabilising prisoners and not aiming to achieve longer-term recovery.

23. There are significant problems with the transition of prisoners to community treatment on release. Only a third of people referred for community treatment after release go on to receive it within three weeks. For non-opiate users, the figure is only 1 in 10 (and these are much more likely to be younger prison leavers). There is considerable variation geographically, with the north of the country doing considerably better than London, for example, and the worst Local Authorities doing six times worse than the best.

24. Accessing treatment is, of course, only one of the transition problems on leaving prison. There are also well-known problems of accessing housing, the benefits system and employment, which if not addressed are likely to increase the chances of people returning to drug use post release.
25. These transition problems are very likely contributing to the evidence that community orders and suspended sentences are better than short sentences at reducing re-offending, particularly amongst those with a previous history of offending, including problem drug users. However, community sentences and drug rehabilitation requirements have reduced dramatically over the last five years, despite an increase in problematic drug use.
26. The decline in referral pathways between the criminal justice system and community treatment have coincided with the Home Office's decision to cancel central funding with the Drugs Intervention Programme in 2013, as well as disinvestment in drug treatment services (discussed later).

Drug use within prisons

27. Random drug test data suggests that 12,500 prisoners (15% of the prison population) are using drugs within prisons on any given day. This problem is concentrated mostly in male local and category C prisons but there is significant variation between establishments, linked to the quality of the prison generally. In particular, a lack of purposeful activity and the sense of boredom and hopelessness that this engenders is a significant factor in driving the demand for drugs and the data shows that prisons with better purposeful activity scores have lower rates of positive drug tests and drug finds.
28. Most prisoners taking drugs entered prison already using or having a problem with drugs but 2017/18 prison survey data found that 8% of women and 13% of men surveyed had developed a problem with drugs while in prison. Cannabis and opioids were previously the most common drugs found in prisons but these have been overtaken by psychoactive substances, particularly synthetic cannabinoids (referred to as 'Spice').
29. Most prisoners tend not to continue to use psychoactive substances after leaving prison, so we do not believe prisons are creating a market for these substances on the outside (although this needs to be monitored as the use of Spice has increased amongst the homeless population, for example). However, drug use in prison is causing unrest and violence in prisons, disrupting the chances of recovery for those with pre-existing problems and creating opportunities for violent Organised Crime Groups to make significant profits.
30. The 2019 HMPPS/MoJ Prison Drugs Strategy addresses many of the issues raised here. For the first time, there will be comprehensive guidance for

governors on how to deal with drugs issues and an innovative, holistic approach to drug use prevention is being trialled at HMP Holme House. The strategy's success will depend on prisons having the funding, support and staff they need. Replicating the Holme House approach widely would be resource-intensive and require significant structural and cultural change in other establishments.

Treatment in the community

31. Government has long recognised that effective drug treatment makes a significant contribution to limiting drug supply by reducing demand. However, political views have shifted over time on where accountability should lie and on what constitutes good treatment.

Accountability

32. Treatment services are provided and commissioned locally. Services expanded rapidly in the 1980s in response to the growth in heroin and cocaine use. Greater central oversight followed, with the Labour Government introducing the National Treatment Agency for Substance Misuse (NTA) in 2001. The NTA was jointly accountable to HO and DH Ministers and was given responsibility for overseeing spending of a pooled treatment budget, introduced to supplement local spending.
33. The pooled treatment budget, originally £50m a year at its inception, reached £467 million by 2012/13. This was on top of an estimated £200 million spent by local health and criminal justice budgets and councils. The number of adults in treatment more than doubled over that time, with England having one of the highest rates of heroin users in treatment in the world and average waiting days fell from 12 weeks to 5 days.
34. The 2012 Health and Social Care Act moved treatment funding into the public health grant, making Local Authorities fully responsible for the commissioning of drug treatment (and prevention). Since then, funding for treatment has fallen considerably (by 14% between 2014/15 and 2017/18 according to official figures), with considerable local variation (some Local Authorities cutting budgets by 40%) and accountability has weakened. The current intention is for the public health grant to transfer into full business rates retention from April 2021, meaning there will be no ring-fenced funding for public health services and Local Authorities will face difficult choices about treatment and other public health services alongside all of their other pressures.
35. Previous treatment commissioning arrangements included a high degree of accountability between local partners, including health, Local Authorities, and criminal justice partners, each holding others to account. Since Local

Authorities have been solely responsible for commissioning drug and alcohol treatment, this cross-cutting local accountability has fallen away.

Treatment provision

36. Funding reductions are exacerbating gaps in treatment provision. As funding pressures have increased, some services have disappeared altogether (such as out-reach services targeting newer users), whilst others have been rationed (such as in-patient detoxification for people with complex and multiple problems, heroin assisted treatment and residential rehabilitation).
37. Local Authorities commission services from NHS Trusts and third-sector providers. Because treatment is commissioned separately from other healthcare and is outside of the NHS, it is much harder to control the quality of care and clinical safety. Providers compete for commissions on price and, increasingly, a small number of third sector providers have dominated the market, offering basic services with no incentives to enhance quality.
38. The drugs treatment market operates in a very similar way to that of adult social care. Like in the adult social care market, drug treatment providers have been squeezed, staff are paid relatively badly and there has been high turnover in the sector and a depletion of skills, with the number of medics, psychologists, nurses and social workers in the field falling significantly. The unregulated role of drug and alcohol or recovery worker, which is inconsistently and poorly defined, makes up the vast majority of the workforce. The number of training places for addiction psychiatrists has plummeted from around 60 to around 5, meaning there is no capacity to train the next generation of specialists.
39. All of this means that, even if more funding became available (which is vital), there would be a lot of work to do to build up capacity and expertise in the market. Most current treatment capacity is absorbed by the long-term cohort of opiate users, many of whom have been in treatment for a long time (1 in 6 have been in treatment for over a decade). Some of these are also now using crack cocaine, creating new health problems. Providers often have to prioritise meeting the urgent health needs of this population, meaning the capacity to develop expertise and services to meet the needs of other cohorts is limited.

Geographical variation

40. Most of the national indicators of performance for treatment (completion rates, deaths in treatment, estimates of un-met need) are going in the wrong direction. There are huge geographical variations. For example, nearly all the Local Authority areas with the lowest rates of opiate completions are in the north of the country, with the highest rates primarily in London or the South East. Some of this variation reflects the differences in the drug-using

population and deprivation. But there are also big variations in the degree to which Local Authorities have prioritised spend in this area and commissioned effective services.

Local Integration – housing and employment

41. Recovery is much wider than treatment alone. Improving individuals' employment opportunities and housing status is essential in improving recovery outcomes, although not within the immediate remit of drug and alcohol treatment providers. The 2017 Drug Strategy stressed the importance of integration at local and government level to achieve this, but progress has been slow, and a scarcity of some wider support services and opportunities has compromised the outcomes achieved by drug treatment.
42. Homelessness and rough sleeping are the most visible examples of services not meeting needs. 20% of people in drug and alcohol treatment have a severe housing problem. The recent spike in the deaths of people experiencing rough sleeping has been mostly attributable to drug poisoning. Since the publication of the Rough Sleeping Strategy in 2018, there has been an increased focus on how to address the needs of people who experience rough sleeping. The government's ambition is to end rough sleeping by the end of the parliamentary term, which will require significant effort. A greater focus on homelessness prevention is needed to prevent people from having to experience rough sleeping in the first place.
43. The Housing First model offers a potential contribution. Housing First is an internationally-proven approach to supporting people experiencing rough sleeping, many of whom have multiple and complex needs (including mental ill-health and substance dependency), into long-term accommodation. It has been widely adopted across the US, Canada and parts of Europe. The Ministry of Housing Communities and Local Government is funding and evaluating pilots in Greater Manchester, Liverpool City Region and the West Midlands Combined Authority, with findings due next year.
44. On employment, it is well known that standard offers of employment support do not successfully engage people with drug dependency, who often have a range of other complex issues alongside their dependence. People in treatment or with a history of drug dependence often face stigma and negative perceptions from employers. Despite the positive impact employment can have on treatment and recovery, it can be incredibly hard for someone to get a foot on the ladder of the employment market, particularly when disclosure to the employer might be required to accommodate their treatment programme.
45. Early findings from the randomised controlled trial of Individual Placement and Support (IPS) funded by DWP and taken forwards by PHE are promising. Nearly a quarter of all IPS participants have self-reported finding work since

the trial began. This is over three times the rate in the control group. Half of the jobs have been sustained for 13 weeks or more. Many of the heroin users finding work have not been employed for many years (and some never).

Children and young people

46. The most alarming development in the recent evolution of the UK drugs market has been the widespread involvement of children and young people in drug supply. The most visible example of this is the county lines model, discussed above, where vulnerable young people have been actively drawn into street-level supply. Frontline practitioners suggest that some young people may initially be attracted to drug dealing, tempted by the promise of money, status and a certain lifestyle, but underestimate the risks attached and are subsequently exploited and can become both perpetrators and victims of violence.
47. They report a complex picture that mixes elements of conscious choice with grooming and exploitation against a backdrop of poverty, widening inequality and a lack of alternative opportunities for these young people. This overlap between victim, offender and conscious choice presents challenges in the current response, where there can be a binary approach in categorising individuals either as victims or perpetrators.
48. Guidance exists for Youth Offender Teams and frontline practitioners on how to use the National Referral Mechanism if they believe a young person is a victim of a Modern Slavery trafficking offence, but many young people involved in criminality will not meet the threshold for referral and support.
49. A conviction can have a lasting negative impact on a young person (and their wider life chances), risking them being caught up in a cycle of crime and violence. Those who receive a custodial sentence are also at risk of further exploitation by county lines gangs when in prison/youth offender institutes.
50. There is a big overlap with these young people also being drawn into drug use – among children in contact with children’s services, those who are assessed as gang-affiliated and in need are eight times more likely to use drugs than other children. The Children’s Commissioner estimates that around 27,000 young people in England and Wales identify as gang members, and 2,000 teenagers from London alone have been identified as having a link to county lines activity.
51. Children and young people are widely involved in the most violent segments of the drugs market, such as the retail supply of heroin and crack cocaine. This is likely to be driving the increase in violence and homicides involving young people, with the homicide rate among victims aged 16 to 24 almost doubling between 2015/16 and 2017/18.

52. The trends in young people becoming involved in drug supply, drug consumption and in serious violence have occurred against a backdrop of increasing numbers of children in care and children in need, falling local government budgets, cuts to young people's services and increasing child poverty. Another key factor appears to be the rapid increase in permanent exclusions from school over the past five years. There is clear evidence that those young people, disproportionately young black men, drawn into county lines and related activity are much more likely than other young people to have been affected by adverse experiences such as neglect, substance misuse problems in the family, domestic violence, poor mental health, and exclusion from school.
53. All of these economic and social factors have coincided with the near-universal availability of social media. Social media is used in the recruitment and tracking of young people within gangs, whilst the use of smartphones is used extensively in the marketing and selling of recreational drugs.
54. More widely, drug use among children (aged 11 to 15) has increased by over 40% since 2014, following a long-term downward trend. This appears to be occurring across a wide range of substances and across most demographics. However, there has been a sustained and significant decrease in the number of young people receiving specialist interventions for their drug use. Those who are accessing treatment interventions have complex needs, including poor mental health, self-harm, offending and experience of sexual exploitation.
55. The needs of young people who have drug use problems can only be met through a combination of specialist treatment and wider health and social care, which addresses all the challenges they face including their family circumstances. The significant reduction in resources across the children and young peoples' sector combined with the reduction in specialist treatment provision means that there is unlikely to be sufficient capacity to respond to the needs of children and young people, particularly if the increases in drug misuse and complex needs continue.

Appendices

Appendix A – Challenge Group

Dame Carol Black invited a group of experts from across the drug misuse sector to act as a challenge group to the review. The aim of the group was for members to provide advice, insight and constructive challenge to the review as it proceeded. Ultimately the views expressed in this report are those of Carol Black.

Challenge Group members:

- Ed Boyd, former member of the Centre for Social Justice
- Hardyal Dhindsa, Association of Police and Crime Commissioners' substance misuse lead
- Emma Disley, Associate Research Director, RAND Europe
- Jason Harwin, National Policing Lead for Drugs, Deputy Chief Constable, Lincolnshire Police
- Keith Humphreys, Director for Mental Health Policy, Department of Psychiatry and Behavioural Sciences, Stanford University
- Mark Johnson, founder, User Voice
- Junior Smart/Evan Jones, St Giles Trust (London)
- Dr Mike Kelleher, Consultant Psychiatrist, South London and Maudsley NHS Trust
- Paul Lennon, Community User Representative, Aurora Project
- Boris Pomroy, formerly Chief Executive, Mentor UK
- Mandy Saligari, private sector addiction treatment specialist
- Toby Seddon, Professor of Criminology, Manchester University
- Mike Shiner, London School of Economics, Associate Professor (Department of Social Policy)
- Dominic Williamson, Executive Director of Strategy and Policy, St Mungo's

Annex B – Visits, meetings and roundtables

As part of fact finding for the review, Dame Carol Black undertook the following visits, meetings and roundtable discussions.

Meetings:

- Dr Owen Boden-Jones, chair of the Advisory Council on the Misuse of Drugs
- Dr Ed Day, Drug Recovery Champion
- Cressida Dick, Commissioner, Metropolitan Police Service
- Naomi Eisenstadt, former director of the Sure Start Unit
- Steve Field, former chief inspector of General Practitioners
- Sir John Gieve, former Permanent Secretary at the Home Office
- Sean Harford, National Director of Education, OFSTED
- Lord Hogan Howe, former Commissioner, Metropolitan Police Service
- David Jamieson, West Midlands Police and Crime Commissioner
- Michael Maisey, motivational speaker and former drug user
- Craig Mackinlay, MP for South Thanet
- Karyn McClusky, Community Justice Scotland
- Ben Page, chief executive, Ipsos Mori
- Mark Sedwill, Cabinet Secretary
- Prof. Chris Witty, Chief Medical Officer
- Sarah Wollaston, former chair of the Health and Social Care Committee
- Rt Hon Priti Patel MP
- Rt Hon Sajid Javid MP
- Victoria Atkins MP
- Kit Malthouse MP
- Heather Wheeler MP
- Will Quince MP

And representatives from:

- Behavioural Insights Team
- Cabinet Office (Serious Violence Team)
- Centre for Social Justice
- Department for Education
- Department of Health and Social Care
- Department for Work and Pensions
- Her Majesty's Prison and Probation Service (HMPPS)
- Home Office
- Ministry of Housing, Communities and Local Government
- Ministry of Justice
- National Crime Agency (NCA)
- NHS England
- Northern Ireland Executive (Health development policy)

- Public Health England
- Scottish Government (Substance Misuse Unit)
- Welsh Government (Substance Misuse team)

Presentations:

- Drug Strategy Board meeting
- ACMD Full Council meeting
- Serious Violence National Strategy Implementation Group meeting

Roundtables:

- Law Enforcement roundtable – with representatives from the NPCC, Metropolitan police, Bedfordshire, Lancashire and Thames Valley police, British Transport Police, Regional & Organised Crime Units, National Country Lines Coordination Centre, the NCA and Border Force
- The neuroscience of substance misuse (Cambridge University) – with Dr Karen Ersche, Prof Barbara J Sahakian, Prof Trevor Robbins, Prof Richard Holton
- Clinicians and commissioners’ roundtable – with representatives from Public Health England, Staffordshire County Council, Harrow Council, Public Health Dorset, Southwark Council, South London and Maudsley NHS Trust, Midlands Partnership NHS Trust, Substance Misuse Management in General Practice (organised by Public Health England)
- Councils’ roundtable on prevention and education – with representatives from Wakefield, Southend, Sunderland, Newcastle, Birmingham, Nottingham, Leeds and Plymouth
- Third sector roundtable on treatment provision (organised by Collective Voice) – with representatives from NHS Buckinghamshire, Turning Point, Cranstoun, Changing Lives, Essex Council, Druglink, Change Grow Live, Humankind, Phoenix Futures, Making Every Adult Matter (MEAM), South London and Maudsley NHS and Adfam

Visits:

- National Crime Agency (for a demonstration of the dark web)
- Border Force, Felixstowe port
- Everton in the Community and Merseyside police (Serious and Organised Crime Prevent initiative)
- Margate Taskforce and police
- Hartsdown Academy, Margate
- YourStory (charity providing mentoring and support for disadvantaged young people in South London)
- Key4Life, Hammersmith (rehabilitation charity) – to hear from ex-gang members (organised by the Centre for Social Justice)
- HMP Holme House Drug Recovery Prison

- HMP Wandsworth
- HMP Bronzefield
- On The Out, Manchester prison rehabilitation charity
- MASH - Manchester Action for Street Health (charity offering advice and support to women in sex work)
- Coffee4Craig (Manchester homelessness charity)
- Spitalfields Crypt Trust (substance misuse charity providing services including residential recovery)
- Bedford Homelessness Partnership
- Club Drug Clinic, Central and North West London NHS Foundation Trust
- Lambeth Addiction Treatment Consortium

Call for evidence:

An online call for evidence opened on the Gov.uk website on 10 May 2019 and closed on 7 June 2019. It received 63 completed responses, including from members of the public, academics, individuals working in the sector and from the following organisations:

- APPGs for Drug Policy Reform and for Drugs, Alcohol and Justice (joint response)
- Brent Council Public Health
- British Medical Association
- British Psychological Society
- Build on Belief
- CAIS Ltd
- Cambridgeshire County Council (with input from Cambridgeshire police)
- Caniad (North Wales)
- Collective Voice
- Cymorth Cymru
- Devon County Council
- Faculty of Public Health
- Greater Manchester Mental Health NHS Foundation Trust
- Health Poverty Action
- Hertfordshire County Council
- in2change (Wrexham)
- Law Enforcement Action Partnership UK (LEAP UK)
- Mentor Foundation UK
- National Police Chiefs' Council
- Newcastle University
- NHS Substance Misuse Provider Alliance
- North Wales Area Planning Board
- Office of Police and Crime Commissioner Devon, Cornwall and the Isles of Scilly
- Office of Police and Crime Commissioner Durham
- Office of Police and Crime Commissioner Dyfed-Powys
- Office of Police and Crime Commissioner for North Wales
- Release
- Re-Solv

- Royal College of Psychiatrists
- South East Regional Organised Crime Unit
- Society for an Addiction Free Existence (SAFE) and Addiction Recovery Training Services (ARTS)
- South London and Maudsley NHS Trust
- South Tyneside Adult Recovery Service
- St Mungo's
- Transform Drug Policy Foundation
- Violence and Vulnerability Unit
- Volteface
- WDP
- West Yorkshire Police