

United-Kingdom

United Kingdom Country Drug Report 2019



This report presents the top-level overview of the drug phenomenon in the United Kingdom, covering drug supply, use and public health problems as well as drug policy and responses. The statistical data reported relate to 2017 (or most recent year) and are provided to the EMCDDA by the national focal point, unless stated otherwise.

THE DRUG PROBLEM IN THE UNITED KINGDOM AT A GLANCE

Drug use

in young adults (16-34 years) in the last year

Cannabis

12.3 %

Gender	Percentage
Female	8.9 %
Male	15.6 %

Other drugs

MDMA	3.3 %
Amphetamines	1 %
Cocaine	4.7 %

High-risk opioid users

341 576

(336 153 - 354 421)

All treatment entrants

by primary drug

149 420

Opioid substitution treatment clients

149 420

Overdose deaths

3251

New HIV diagnoses attributed to injecting

11

Source: ECDC

Drug law offences

106 862

Top 5 drugs seized

ranked according to quantities measured in kilograms

- Herbal cannabis
- Cannabis resin
- Cocaine
- Amphetamine
- Heroin

Population

(15-64 years)

42 200 259

Source: Eurostat Extracted on: 18/03/2019

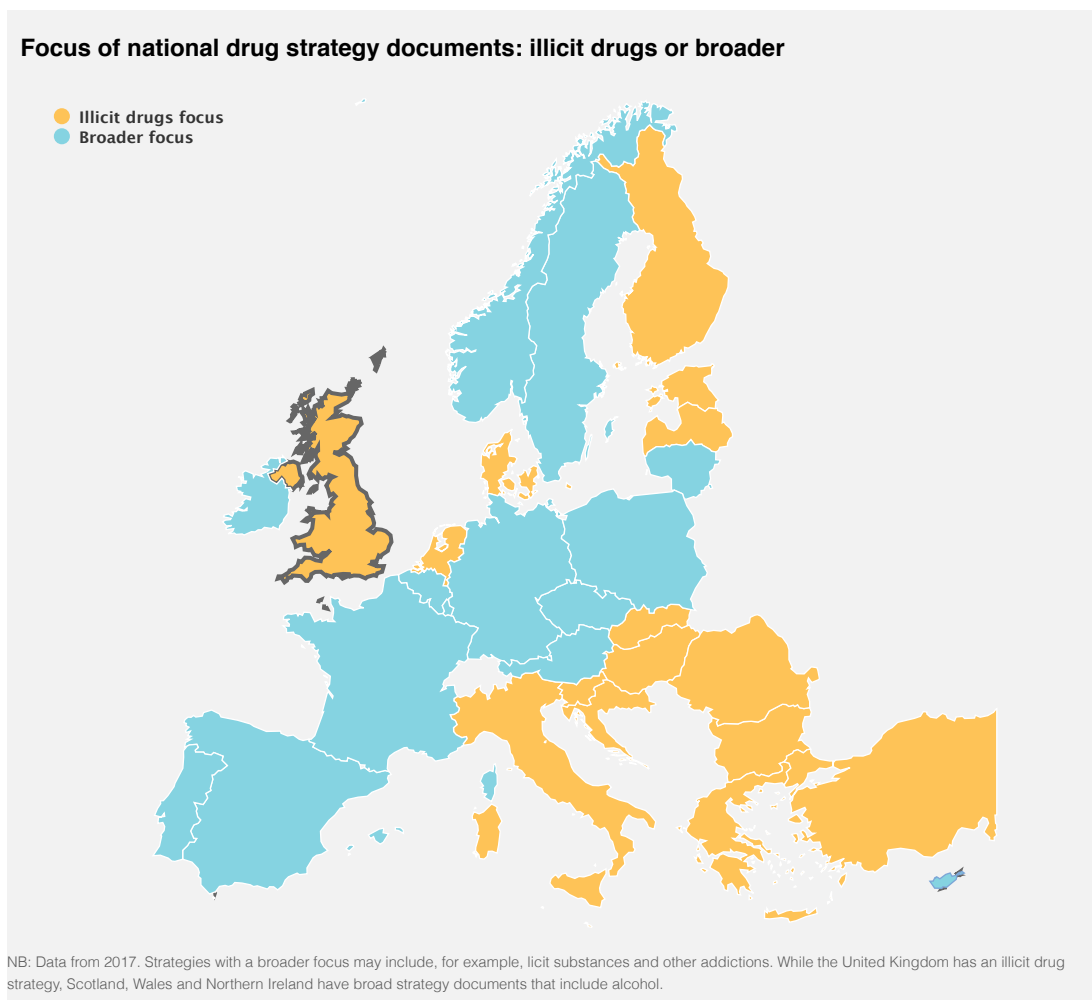
NB: Data presented here are either national estimates (prevalence of use, opioid drug users) or numbers reported through the EMCDDA indicators (treatment clients, syringes, deaths and HIV diagnoses, drug law offences and seizures). Detailed information on methodology and caveats and comments on the limitations in the information set available can be found in the EMCDDA Statistical Bulletin. In the case of the 'Drug use' 'Clients in OST' sections, data are for England and Wales only.

National drug strategy and coordination

National drug strategy

The UK 2017 Drug Strategy addresses illicit drug problems with two overarching aims: to reduce illicit and other harmful drug use and to increase the rates of people recovering from dependency. These aims are supported by four key themes: (i) reducing demand; (ii) restricting supply; (iii) building recovery; and (iv) global action. Within the strategy, policies concerning health, education, housing and social care apply to England, those concerning policing and the criminal justice system cover both England and Wales, while the tasks of the Department for Work and Pensions relate to England, Scotland and Wales. A number of powers are devolved to Northern Ireland, Scotland and Wales, and each of these countries has its own strategy and action plans. Both the current Welsh strategy, Working Together to Reduce Harm: The Substance Misuse Strategy for Wales 2008-18, and Scotland's strategy, The Road to Recovery: A New Approach to Tackling Scotland's Drug Problem, were adopted in 2008. In 2018, Scotland launched a new drug and alcohol strategy. Northern Ireland's policy, New Strategic Direction for Alcohol and Drugs Phase 2: 2011-16, was launched in 2011, and had a final review in 2018. The strategies in Scotland, Northern Ireland and Wales address both illicit drugs and alcohol.

All European countries evaluate their drug policies and strategies through ongoing indicator monitoring and specific research projects. In 2017, the Home Office published an evaluation of the actions in the Drug Strategy 2010, a multi-criterion assessment looking at the effectiveness of the responses, their costs and value for money; the evaluation focused on England. In 2018, the Welsh Assembly published an evaluation of the Substance Misuse Strategy for Wales 2008-18 as part of the process of developing a new strategy.



National coordination mechanisms

In the United Kingdom, the Home Office has lead responsibility for the coordination of the delivery of the 2017 Drug Strategy on behalf of the government and is supported by the Drug Strategy Board, chaired by the Home Secretary. Scotland's 'Rights, respect and recovery' strategy is implemented locally by 30 alcohol and drug partnerships and a range of partners at a national level. In Wales, the Substance Misuse National Partnership Board coordinates and monitors the implementation of the

Welsh substance misuse strategy by the government and other stakeholders and is assisted by seven area planning boards. Northern Ireland's substance misuse strategy is coordinated by the New Strategic Direction Steering Group and the Department of Health.

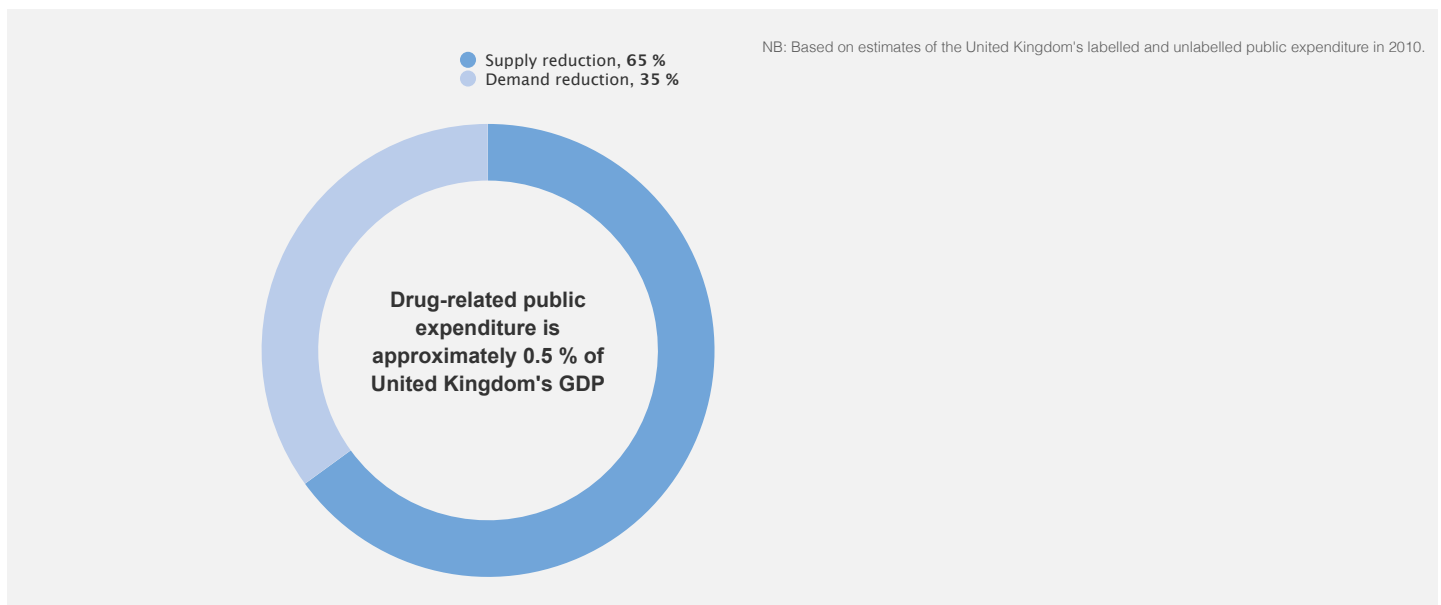
Public expenditure

Understanding the costs of drug-related actions is an important aspect of drug policy. Some of the funds allocated by governments for expenditure on tasks related to drugs are identified as such in the budget ('labelled'). Often, however, most drug-related expenditure is not identified ('unlabelled') and must be estimated using modelling approaches.

No budgets are allocated under the UK drug strategies. Budget allocations are provided annually to those in charge of providing services. The last comprehensive estimates of both labelled and unlabelled expenditure were provided for 2010. In 2010, drug-related public expenditure amounted to 0.5 % of gross domestic product (GDP), with 35 % of this spending allocated to demand reduction, 65 % to supply reduction and close to 0.1 % to transversal initiatives. Currently, estimates are routinely published only for drug-related health expenditure.

The UK Government has funded three studies on the economic and social costs of drugs, in 2002, 2006 and 2013. Since then, only partial estimates of drug-related public expenditure have been released, which do not allow an assessment of drug-related public expenditure trends.

Public expenditure related to illicit drugs in the United Kingdom



Drug laws and drug law offences

National drug laws

The Misuse of Drugs Act 1971, with amendments, is the main law regulating drug control in the United Kingdom. It divides controlled substances into three classes (A, B and C), which provide a basis for attributing penalties for offences. Maximum penalties vary according to whether the conviction is made at a magistrates' court for a summary offence or made on indictment following a trial at a Crown Court, with mitigating and aggravating factors determining which type of court is the most appropriate for a given case. Detailed guidance for sentencing in each case is published by the Sentencing Council. A distinction is made between possession of controlled drugs and possession with intent to supply; the latter effectively refers to drug trafficking offences.

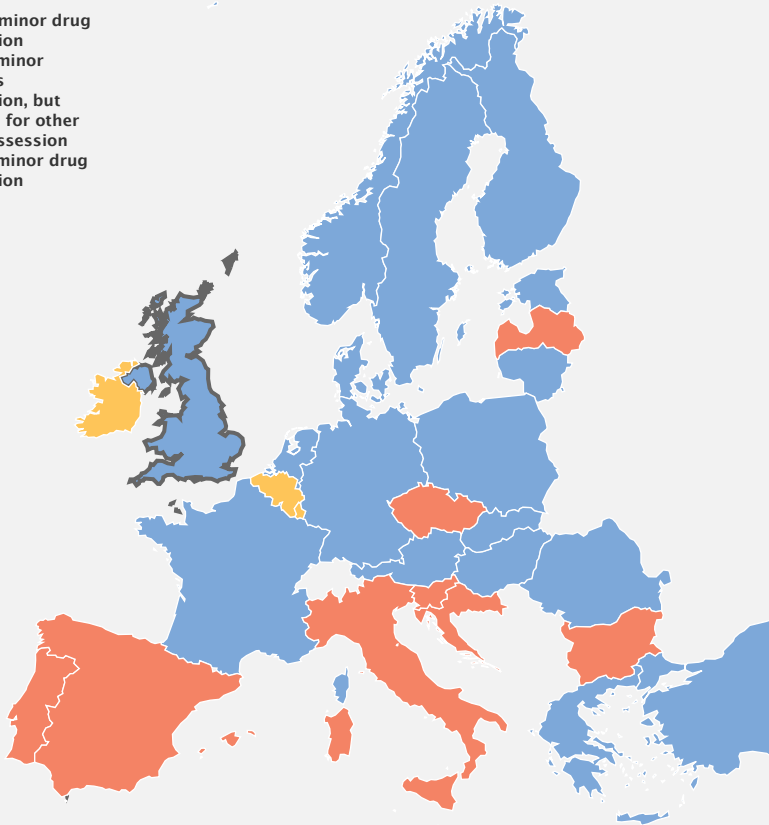
Drug use per se is not an offence under the Misuse of Drugs Act 1971; it is the possession of the drug that constitutes an offence. Summary convictions for the unlawful possession of Class A drugs, such as heroin or cocaine, involve penalties of up to 6 months' imprisonment and/or a fine; on indictment, penalties may reach 7 years' imprisonment. Possession of Class B drugs, such as cannabis and amphetamines, incurs a penalty of up to 3 months' imprisonment and/or a fine at a magistrates' court; on indictment, the penalty is up to 5 years' imprisonment and/or an unlimited fine. Possession of most Class C drugs, such as benzodiazepines, attracts a penalty of up to 3 months' imprisonment and/or a fine by a magistrate, or up to 2 years' imprisonment and/or an unlimited fine on indictment. There are also a number of alternative responses, such as cannabis warnings and cautions from the police, who have some powers of discretion.

The Drug Trafficking Act 1994 defines drug trafficking as transporting or storing, importing or exporting, manufacturing or supplying drugs covered by the Misuse of Drugs Act 1971. For trafficking in Class A drugs, the maximum penalty on indictment is 'life' imprisonment (which is 25 years in the United Kingdom), while trafficking in Class B or Class C drugs can incur a penalty of up to 14 years in prison. Under Section 110 of the Powers of Criminal Courts (Sentencing) Act 2000, a minimum sentence of 7 years was introduced for a third conviction for trafficking in Class A drugs.

Temporary class drug orders were introduced through the Police Reform and Social Responsibility Act 2011 to allow a faster legislative response to new psychoactive substances (NPS) supply offences. In 2016, the Psychoactive Substances Act criminalised the production, supply or possession with intent to supply of any psychoactive substance (with some exemptions) if it is known that it is to be used for its psychoactive effects. Supply offences are aggravated by proximity to a school, using a minor as a courier or being carried out in a custodial institution. Simple possession of NPS does not constitute an offence unless it takes place within a custodial institution. Maximum penalties are 7 years' imprisonment on indictment or 1 year's imprisonment on summary conviction.

Legal penalties: the possibility of incarceration for possession of drugs for personal use (minor offence)

- For any minor drug possession
- Not for minor cannabis possession, but possible for other drug possession
- Not for minor drug possession



NB: Data from 2017.

Drug law offences

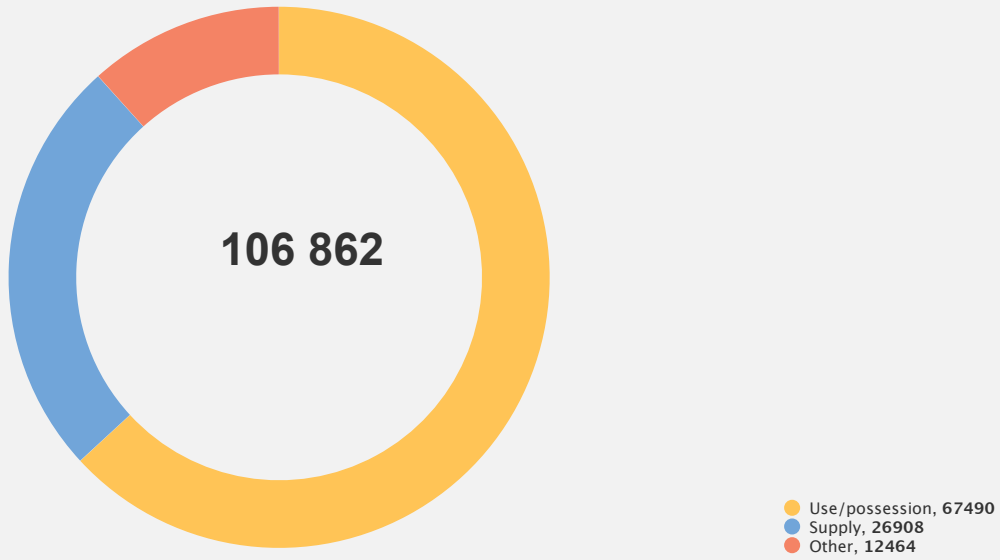
Drug law offence (DLO) data are the foundation for monitoring drug-related crime and are also a measure of law enforcement activity and drug market dynamics; they may be used to inform policies on the implementation of drug laws and to improve strategies.

The number of arrests for drug law offences has decreased in recent years. In 2015/16, approximately 107 000 court convictions and police cautions for drug offences were reported in England, Wales, Scotland and Northern Ireland. Of the offences in which the drug involved was recorded (in England, Wales and Scotland), 55 % were cannabis related, 23 % were cocaine related (excluding crack cocaine) and 12 % were heroin related.

Reported drug law offences in the United Kingdom

NB: Data from 2016.

Drug law offences



Prevalence and trends

Overall prevalence of drug use reported in general population surveys in England and Wales is similar to a decade ago, with almost 1 out of 10 adults aged 16-59 years reporting illicit drug use in the last year. In Scotland, there was a decline in last year illicit drug use between 2008/09 and 2014/15.

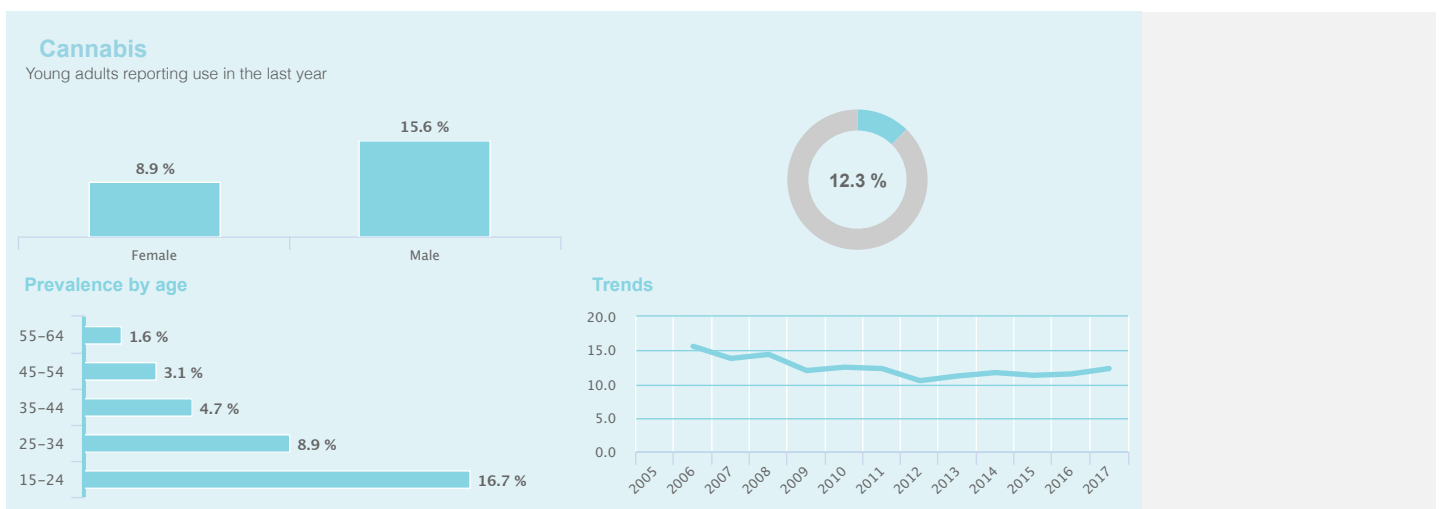
In the early 2000s, prevalence of last year cannabis use reported by the Crime Survey for England and Wales was among the highest reported by European countries; however, this is now at a level that is fairly typical to that seen elsewhere in Europe. Following a decrease in prevalence between 2003/04 and 2009/10, the trend in cannabis use in the general population has since been relatively stable. The prevalence rate in 2017/18 was the highest reported since 2008/09; however, the increase from 2016/17 was not statistically significant.

Prevalence of new psychoactive substances (NPS) use in general population surveys is generally low in comparison with the main traditional drugs. Mephedrone was the only stimulant NPS to show signs of becoming established alongside traditional substances among recreational drug users in these surveys. However, prevalence of use of this drug has fallen since the 2010/11 Crime Survey for England and Wales, when questions were first asked about its use.

There was a steady decline in lifetime prevalence of drug use among school children (11- to 15-year-olds) in England between 2004 and 2014; however, an increase was reported in 2016. Drug use prevalence among young people in Scotland has declined since 2004 but remained stable between 2013 and 2015. Cannabis is the most commonly used drug among school children, and there has been a long-term downward trend in reported use with a more recent levelling off that is similar to the trend for the general population. A similar trend is also seen for other illicit drug use, as well as for alcohol and tobacco use.

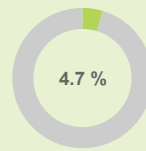
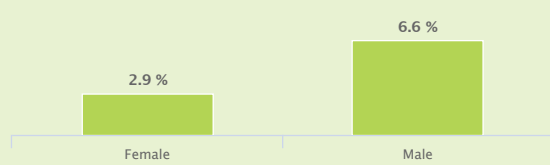
London and Bristol participate in the Europe-wide annual wastewater campaigns undertaken by the Sewage Analysis Core Group Europe (SCORE). This study provides data on drug use at a municipal level, based on the levels of illicit drugs and their metabolites found in sources of wastewater. For 2018, only data for Bristol were available. The results pointed to a possible increase in cocaine use in Bristol since the initiation of the study (2014). Furthermore, higher levels of cocaine metabolites were detected at the weekends.

Estimates of last-year drug use among young adults (16-34) in England and Wales

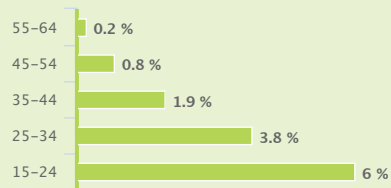


Cocaine

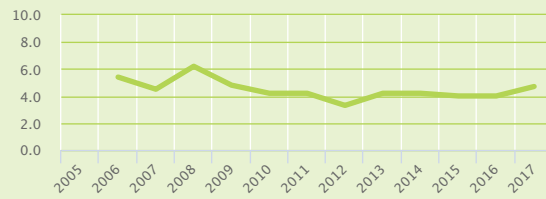
Young adults reporting use in the last year



Prevalence by age

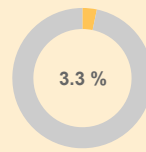
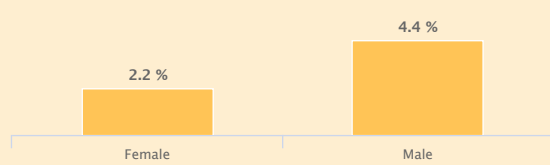


Trends

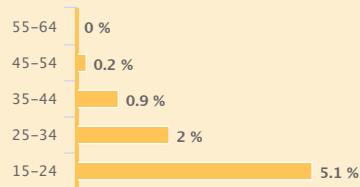


MDMA

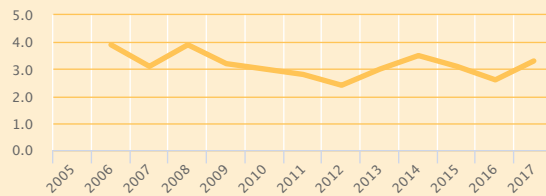
Young adults reporting use in the last year



Prevalence by age

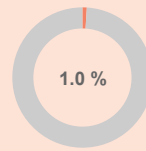
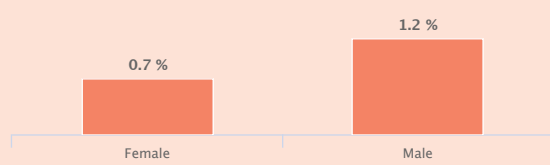


Trends

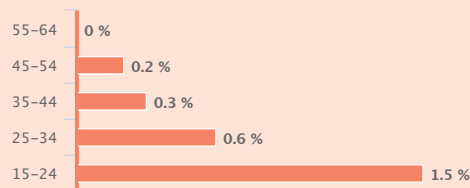


Amphetamines

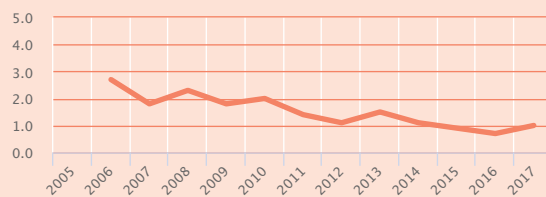
Young adults reporting use in the last year



Prevalence by age



Trends



NB: Estimated last-year prevalence of drug use in 2017. Data under the label 15-24 years corresponds to 16-24 years.

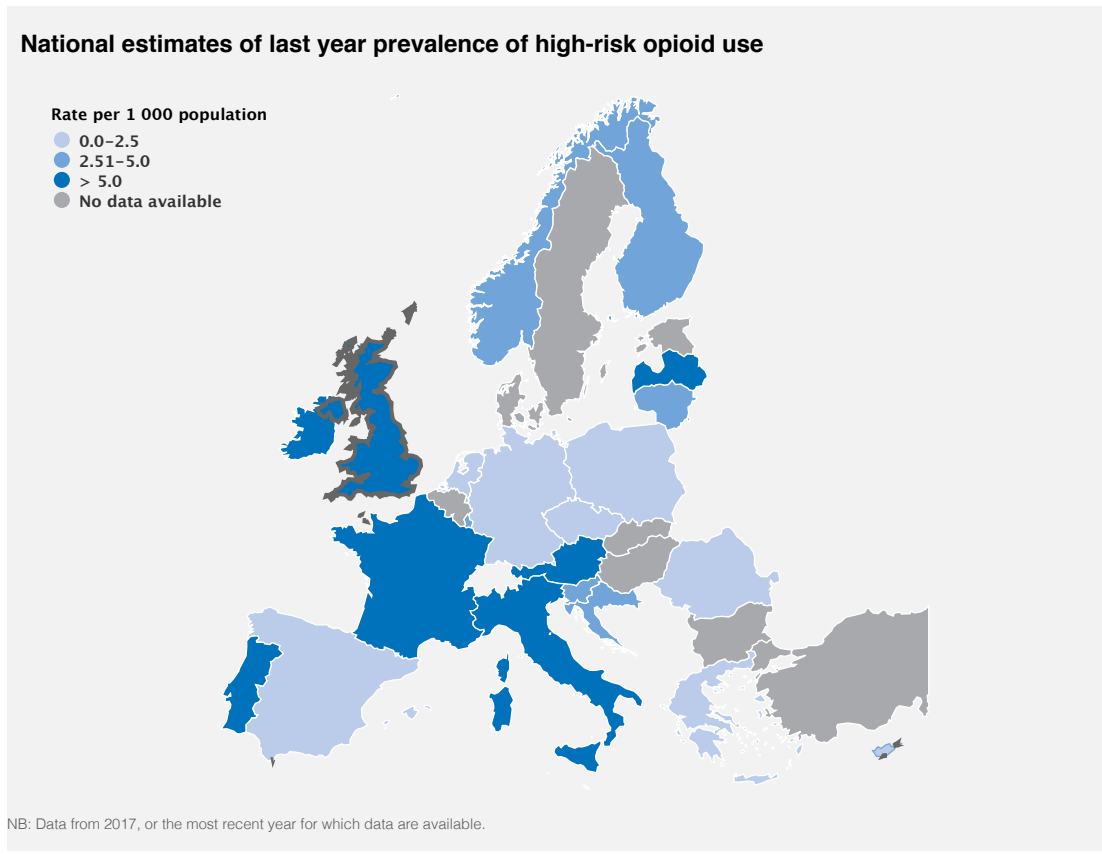
High-risk drug use and trends

Studies reporting estimates of high-risk drug use can help to identify the extent of the more entrenched drug use problems, while data on first-time entrants to specialised drug treatment centres, when considered alongside other indicators, can inform an understanding of the nature of and trends in high-risk drug use.

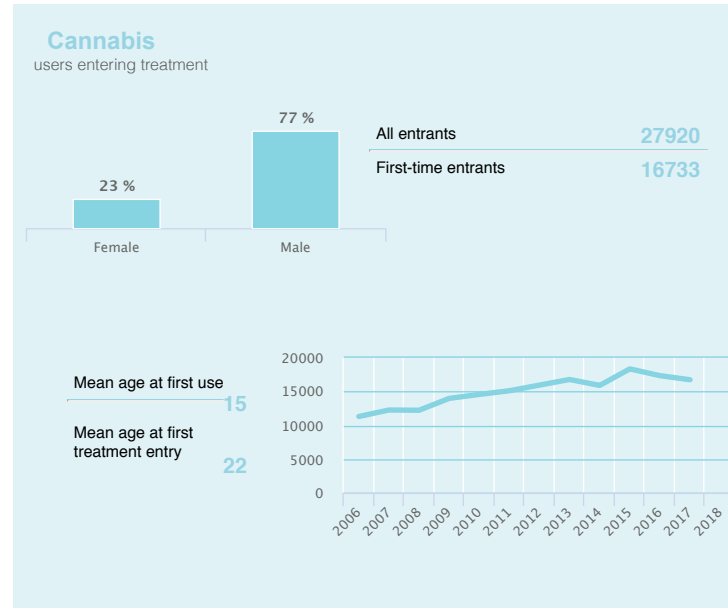
Opioids, particularly heroin, remain associated with the greatest health and social harms caused by illicit drugs in the United Kingdom. While there has been a decline in the prevalence of injecting among opioid users, around one third of people who seek treatment for heroin use in England report use by injection. There are concerns about changes in the patterns of drug injection in the United Kingdom, in particular the increased injection of crack cocaine and amphetamine-type stimulants, and the emergence in recent years of the injection of NPS. Data from the 2017 Unlinked Anonymous Monitoring survey of people who inject drugs indicate that the injection of crack has increased in recent years in England and Wales, with 51 % of those

who had injected during the preceding 4 weeks reporting the injection of crack cocaine.

Data on the characteristics of those entering treatment in the United Kingdom indicate that heroin is the most commonly reported primary substance among those seeking treatment for drug use problems; however, there has been a long-term reduction in first-time clients seeking treatment for heroin use. Among first-time treatment clients, cannabis is the most commonly reported substance, followed by cocaine. An increase in the number and proportion of first-time treatment entrants for cocaine (both powder and crack) has been reported since 2014. Presentations to community treatment services for primary use of NPS have decreased markedly in England, and problematic NPS use is now found primarily among the adult prison population and street homeless people. Studies among vulnerable populations, such as homeless people, suggest that the use of synthetic cannabinoid receptor agonists is high among this group.

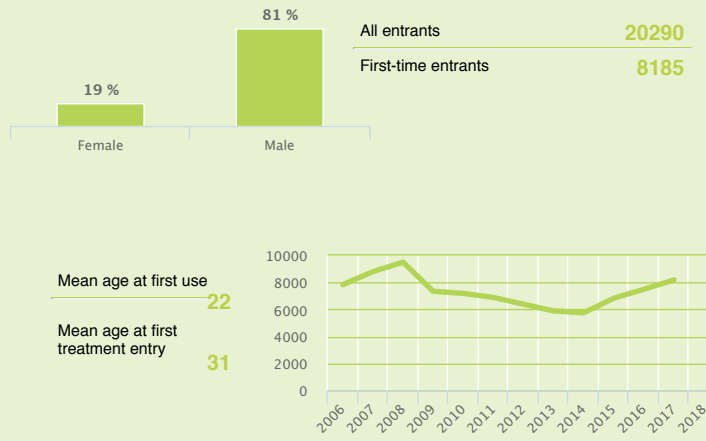


Characteristics and trends of drug users entering specialised drug treatment in the United Kingdom



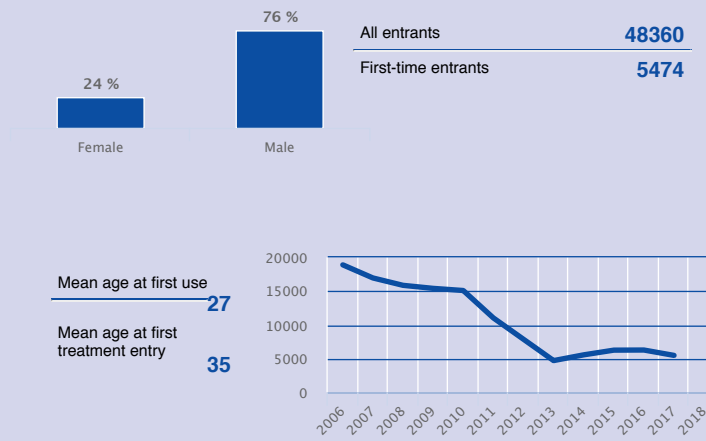
Cocaine

users entering treatment



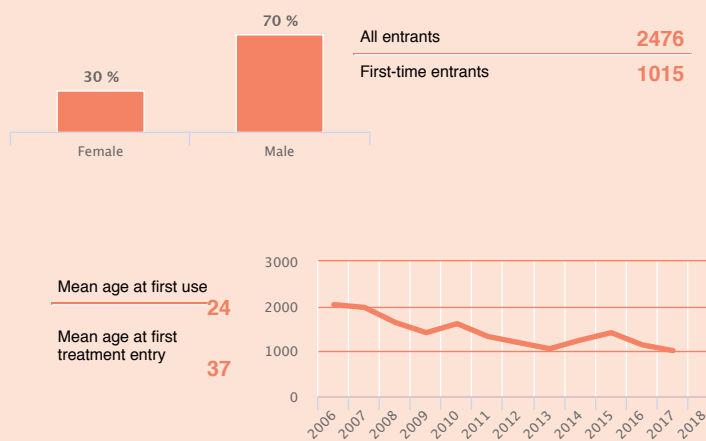
Heroin

users entering treatment



Amphetamines

users entering treatment



NB: Data from 2017. Data are for first-time entrants, except for the data on gender, which are for all treatment entrants. From 2015 onwards, data include clients entering treatment in prison settings; therefore, data are not directly comparable with those for previous years.

Drug-related infectious diseases

There is a long-term declining trend in new human immunodeficiency virus (HIV) cases linked to injecting drug use in the United Kingdom, and the rate of injecting-related HIV remains low. In 2017, there were 115 new HIV diagnoses associated with injecting drug use in the United Kingdom, 32 of which were registered in Scotland. This is a reduction from the 51 new diagnoses in Scotland in 2015, when an outbreak of HIV was detected among people who inject drugs (PWID) in Glasgow, but the same number as in 2016.

Data from the Unlinked Anonymous Monitoring (UAM) Survey in England, Wales and Northern Ireland indicate that the estimated prevalence of HIV among PWID has been in decline.

It is estimated that the majority of hepatitis C virus (HCV) infection cases in the United Kingdom are acquired through injecting drug use. The prevalence of HCV infection among PWID remains relatively high and has changed little in recent years; in 2017, half of all PWID in England, Wales and Northern Ireland were estimated to be positive for HCV antibodies. Half of those positive for HCV antibodies were also positive for ribonucleic acid (RNA) virus, indicating a current infection. There are geographical variations in HCV prevalence across the United Kingdom, with the prevalence of HCV (and other blood-borne viruses) being lower in Northern Ireland than in the rest of the United Kingdom. The prevalence of HCV antibodies among recent initiates to injecting drug use has remained fairly stable over the past decade.

Prevalence of HIV and HCV antibodies among people who inject drugs in the United Kingdom (%)

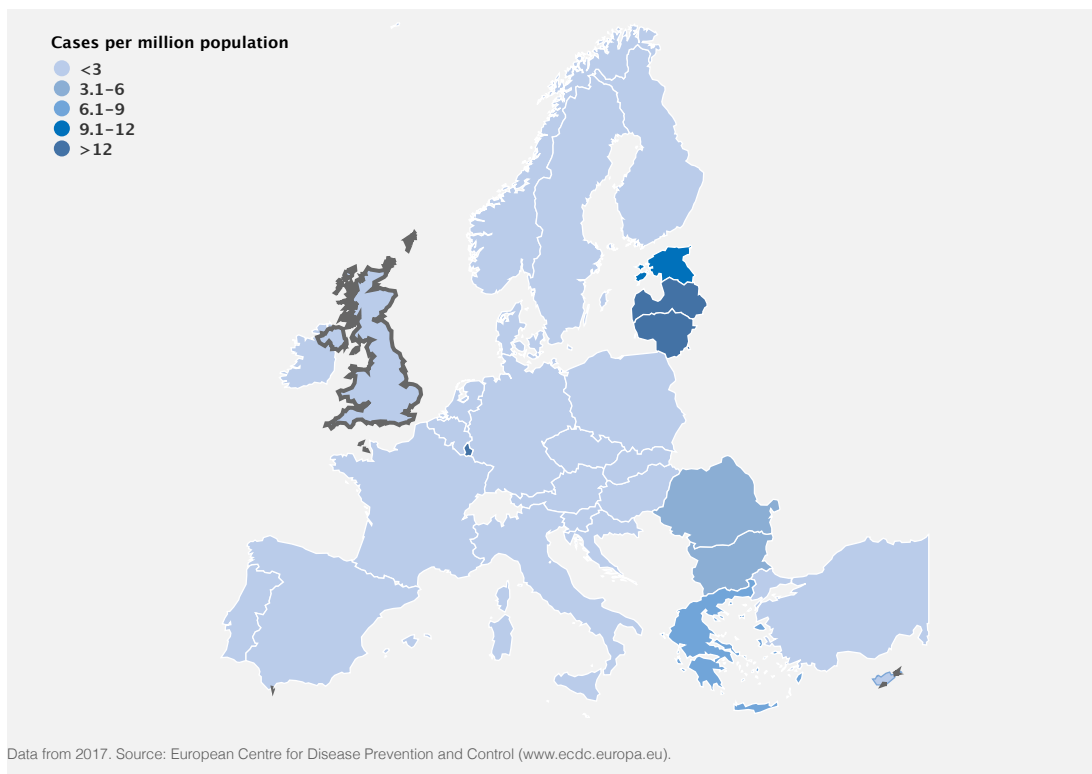
Region	HCV	HIV
National	:	:
Sub-national	22.5 - 52.2	0.0 - 0.89

Data from 2017.

The prevalence of hepatitis B virus infection among PWID in England, Wales and Northern Ireland has remained relatively stable in recent years, but in general it is lower than the level seen 10 years ago.

With regard to other drug-related infectious diseases, sporadic cases of anthrax, tetanus and wound botulism have been reported among PWID. In 2016, more than one third of PWID participating in the UAM survey reported that they had experienced an abscess, sore or open wound during the preceding year, indicating symptoms of injecting-site infection.

Newly diagnosed HIV cases attributed to injecting drug use



Drug-related emergencies

The Information Services Division reported that there were over 8 500 general acute admissions with a diagnosis of drug use in Scotland in 2016/17, of which the vast majority (around 8 000) were the result of an emergency admission. More than half of all emergency admissions were attributed to opioids. More than half of the patients admitted to hospital because of a drug-related emergency had not experienced a similar emergency episode in the past 10 years.

Emergency rooms from two hospitals in London and one in York participate in the European Drug Emergencies Network (Euro-DEN Plus) project, which was established in 2013 to monitor acute drug toxicity in sentinel centres across Europe.

Drug-induced deaths and mortality

Drug-induced deaths are deaths that can be attributed directly to the use of illicit drugs (i.e. poisonings and overdoses).

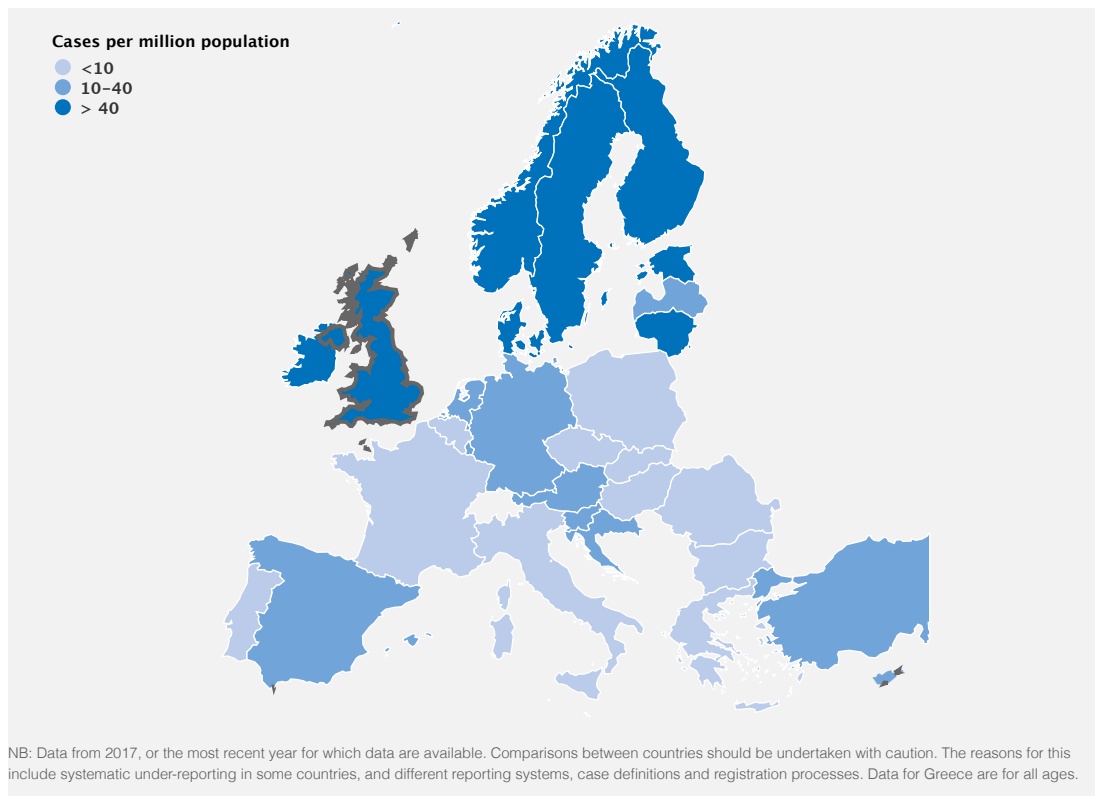
In 2016, the United Kingdom reported a record number of drug-related deaths, continuing the increasing trend since 2012. Males accounted for two thirds of drug-related deaths in 2016, and the mean age at time of death was 42 years. The average age of those dying has risen every year since 2006. Because of delays in the registration of deaths, the total number of drug-induced deaths in 2017 in the United Kingdom is not yet known, but data published on the number of deaths registered in Scotland in 2017 suggest that a further increase in the UK total can be expected.

Opioids (primarily heroin, but also methadone) were involved in the majority of deaths (almost 9 in 10). Other drugs commonly associated with deaths from illicit substance use include benzodiazepines, cocaine (frequently in combination with heroin) and amphetamines. The most recent data from the Office for National Statistics in 2017 show that fentanyl was present on the death certificate of 75 drug-induced deaths registered in England and Wales, and fentanyl analogues were present in 31 cases; both are record figures. The presence of multiple psychoactive substances in drug-induced deaths is becoming more common in the United Kingdom.

The number of deaths linked to new psychoactive substance (NPS) use remains relatively low but has increased since 2010. In 2017, 61 NPS-related deaths were registered in England and Wales (half the number registered in 2016). The number of deaths associated with synthetic cannabinoids continued to increase, while deaths related to synthetic cathinones decreased. In Scotland, in 2017, NPS were implicated in 337 deaths, a four-fold increase compared with 2015. Benzodiazepine-type NPS (mostly etizolam) were involved in almost all NPS-related deaths in Scotland (these are also counted as benzodiazepines deaths).

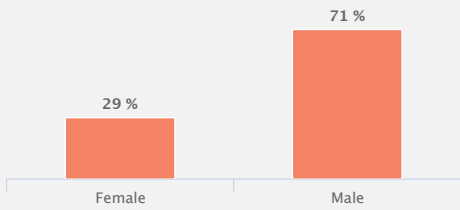
The drug-induced mortality rate among adults in the United Kingdom (aged 15-64 years) was 74 deaths per million in 2016.

Drug-induced mortality rates among adults (15-64 years)

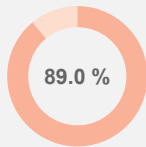


Characteristics of and trends in drug-induced deaths in the United Kingdom

Gender distribution

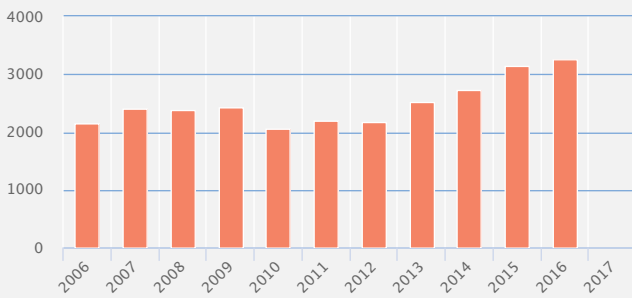


Toxicology

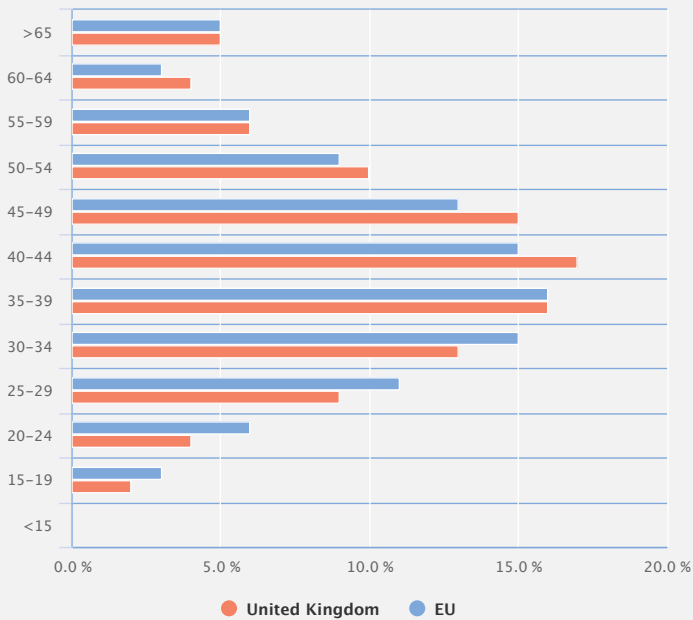


Deaths with opioids present among deaths with known toxicology

Trends in the number of drug-induced deaths



Age distribution of deaths in 2016



NB: Year of data 2016

Prevention

Establishing a life-long approach to drug prevention covering early years, family support, drug education and targeted specialist support is one of the main aims of the UK drug strategy. The role of prevention initiatives is also stressed in each of the drug strategies of the devolved administrations. All the UK drug strategies favour a broad approach to prevention that does not target drugs specifically but instead aims to strengthen general resilience factors that are associated with reducing the desire to explore risky behaviours such as drug use.

Prevention interventions

Prevention interventions encompass a wide range of complementary approaches. Environmental and universal strategies target entire populations, selective prevention targets vulnerable groups that may be at greater risk of developing substance use problems and indicated prevention focuses on at-risk individuals.

Environmental prevention approaches include policies relating to the sale of alcohol and tobacco products. These include minimum unit pricing of alcohol (introduced in Scotland in 2018) as well as standardised packaging of tobacco. All prisons in England, Wales and Scotland are currently smoke free. Prisoners who smoke were offered vaping kits a month before the smoking ban came into effect.

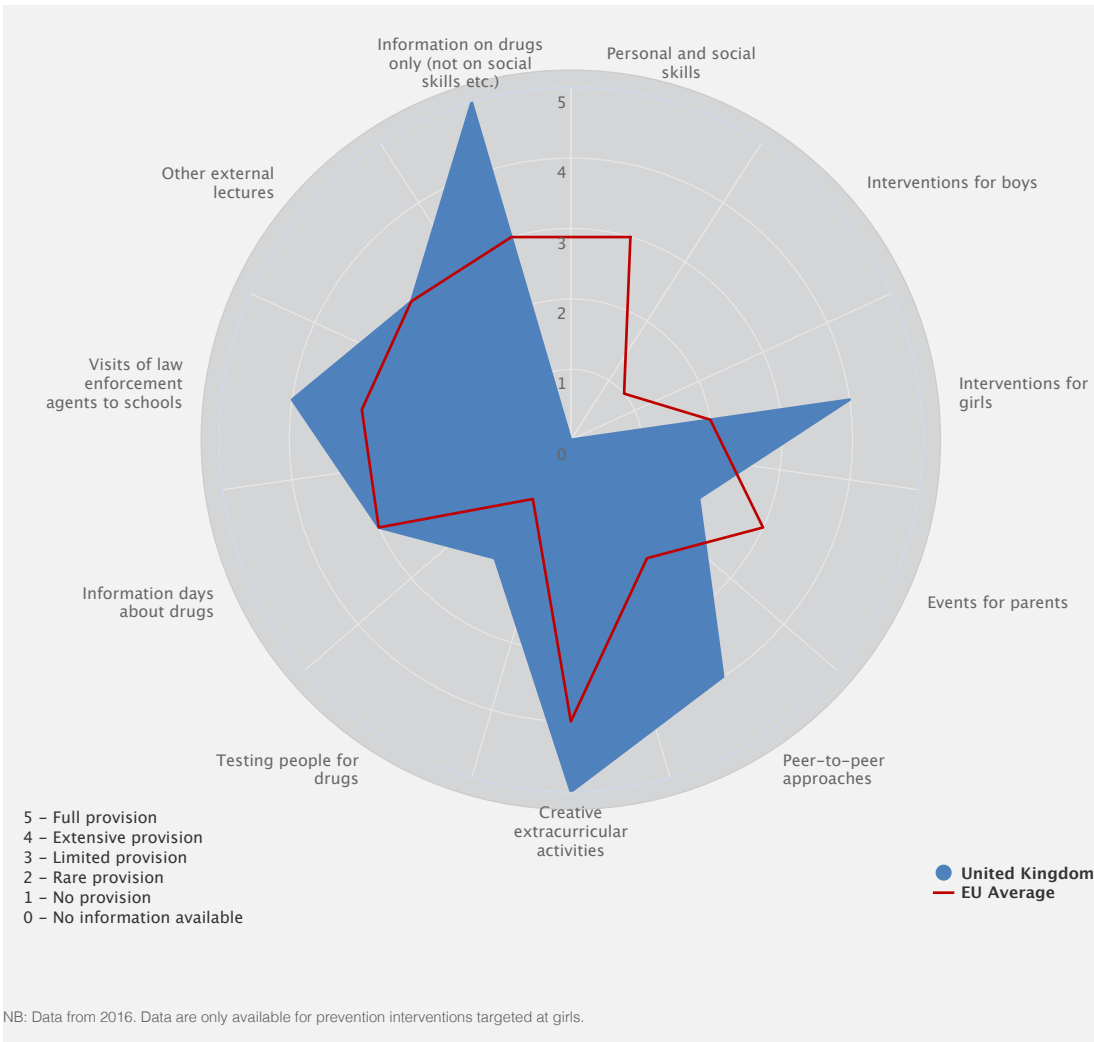
Drug education is part of the national curriculum throughout most of the United Kingdom, and most schools have a drug education policy and guidelines on dealing with drug incidents. Several well-researched universal prevention programmes, such as the Good Behaviour Game and Unplugged, have been piloted in the United Kingdom. A 2018 evaluation report did not find any evidence that the Good Behaviour Game improved students' concentration, reduced disruptive behaviour or promoted pro-social behaviour; however, implementation varied, so the results should be interpreted with caution.

A study conducted in 2016 with over 1 600 young people on their views and needs regarding new psychoactive substances (NPS) suggested that beyond familiar activities, which should continue, service providers need to (i) use social media, the internet and phone tools to reach young people; (ii) work to reduce the stigma that young people feel subject to on account of their NPS use; (iii) develop NPS harm reduction messages that are incorporated into wider health and wellbeing support; and (iv) consider how to reach young people as they are reaching a decision to stop their NPS use and provide support in dealing with any withdrawal symptoms.

The UK Government has prioritised the early identification of at-risk children and families and the provision of suitable interventions through the Troubled Families Programme, which aims to provide a focused approach to the needs of the family as a whole and a tailored support service. A preliminary impact evaluation suggested that the programme is having a positive impact. Integrated Family Support Services, which are available across most of Wales, provide support for families with parental substance misuse issues.

There are several online sources of information about drugs. Communication programmes, such as Talk to Frank in England, Know the Score in Scotland and DAN 24/7 in Wales, provide information and advice to young people and their families. Additionally, programmes such as Rise Above and Talk to Frank offer interactive and live chat services.

Provision of interventions in schools in the United Kingdom (expert ratings)



Harm reduction

The overarching aims of the UK 2017 Drug Strategy are to reduce use of illicit and other harmful drugs and to increase rates of recovery. Health responses in the United Kingdom include those aimed at the prevention of drug-induced deaths, infectious diseases, comorbidity and other health consequences. The strategy recognises the positive role of drug treatment and of needle and syringe programmes (NSPs) in helping to reduce harms caused by drug dependency. Scotland, Wales and Northern Ireland have their own national drug strategies, each including a number of harm reduction-related objectives.

Local authorities have the flexibility to plan their approaches, within the wider national strategy, and the resulting structure and organisation of harm reduction services in the United Kingdom is complex. Harm reduction services in England are funded by local authorities and delivered by specialist treatment services or, sometimes, through related services such as sexual health clinics and blood-borne virus vaccination services.

Harm reduction interventions

Harm reduction interventions in the United Kingdom cover activities such as information on safer injecting and safer sex; provision of injecting equipment; promotion of safe disposal of used equipment; infection counselling; support and testing; vaccinations against hepatitis B virus (HBV); referral to drug treatment; treatment for human immunodeficiency virus (HIV) and hepatitis C virus (HCV) infections; and the provision of take-home naloxone and the training of drug users and their family members on its use.

Sterile needles and syringes, as well as other injecting equipment, are provided by a wide range of facilities, principally pharmacies and specialist treatment agencies, as well as a small number of mobile providers, usually attached to a local treatment service. In Wales, a vending machine is available in a community-based centre for the homeless, and the first vending machine for the disposal of used material and the dispensing of new equipment was introduced in January 2018 in England.

NSPs are available across all regions of the United Kingdom; however, data are available only for Scotland, Wales and Northern Ireland. The latest available estimates of the number of syringes distributed are 4.4 million for Scotland in 2016/17; almost 2.6 million for Wales in 2017/18; and about 310 000 for Northern Ireland in 2016/17.

Addressing the large number of drug-related deaths is a priority objective in UK drug policy. Initiatives that aim to prevent such deaths include the distribution of the overdose reversal drug naloxone to those at risk of overdose and to their families and carers. Nationwide naloxone programmes are implemented in Scotland, Wales and Northern Ireland. In England, the distribution of naloxone is common, despite barriers to equivalent naloxone programmes. Take-home naloxone programmes also operate in non-clinical settings, such as hostels. Data from Scotland and Wales show that over 12 000 naloxone kits were given out in the past 12 months and that more than 56 000 kits have been circulated since the start of the programmes.

The United Kingdom has a targeted HBV vaccination programme that focuses on the most at-risk population groups, including people who inject drugs (PWID). The most recent surveys show that around three quarters of PWID report uptake of the HBV vaccination.

Availability of selected harm reduction responses in Europe

Country	Needle and syringe programmes	Take-home naloxone programmes	Drug consumption rooms	Heroin-assisted treatment
Austria	Yes	No	No	No
Belgium	Yes	No	Yes	No
Bulgaria	Yes	No	No	No
Croatia	Yes	No	No	No
Cyprus	Yes	No	No	No
Czechia	Yes	No	No	No
Denmark	Yes	Yes	Yes	Yes
Estonia	Yes	Yes	No	No
Finland	Yes	No	No	No
France	Yes	Yes	Yes	No
Germany	Yes	Yes	Yes	Yes
Greece	Yes	No	No	No
Hungary	Yes	No	No	No
Ireland	Yes	Yes	No	No
Italy	Yes	Yes	No	No
Latvia	Yes	No	No	No
Lithuania	Yes	Yes	No	No
Luxembourg	Yes	No	Yes	Yes
Malta	Yes	No	No	No
Netherlands	Yes	No	Yes	Yes
Norway	Yes	Yes	Yes	No
Poland	Yes	No	No	No
Portugal	Yes	No	No	No
Romania	Yes	No	No	No
Slovakia	Yes	No	No	No
Slovenia	Yes	No	No	No
Spain	Yes	Yes	Yes	No
Sweden	Yes	No	No	No
Turkey	No	No	No	No
United Kingdom	Yes	Yes	No	Yes

Treatment

The treatment system

Drug strategies from across the United Kingdom identify treatment as being effective in tackling problem drug use and seek to improve its quality and effectiveness. Coordination and integration across a range of service providers are seen as key to helping problem drug users integrate into society.

Substance misuse services are commissioned by local authorities in England, by local health boards in Scotland, by community safety partnerships in Wales and by drug and alcohol coordination teams in Northern Ireland. Each of these commissioning bodies receives advice and input from a number of other organisations, including Public Health England, the Public Health Agency in Northern Ireland, voluntary organisations and the police. Contracts to deliver drug treatment services are often held by third-sector organisations (i.e. registered charities).

Drug treatment in the United Kingdom encompasses a range of available treatments and services, including community-based prescribing, community one-to-one and group-based psychosocial interventions to support recovery, inpatient treatment, day programmes and quasi- and full-time residential drug treatment and rehabilitation support. In addition, drug users should be offered aftercare and relapse prevention programmes, hepatitis B virus (HBV) vaccination, testing for HBV, hepatitis C virus and human immunodeficiency virus (HIV), and access to hepatitis and HIV treatment.

Community-based specialised drug treatment centres are the most common providers of substance misuse services in the United Kingdom. Almost all clients receive treatment in an outpatient setting, including some who receive treatment in the community before or after attending a residential unit. Drug treatment is also provided in prisons.

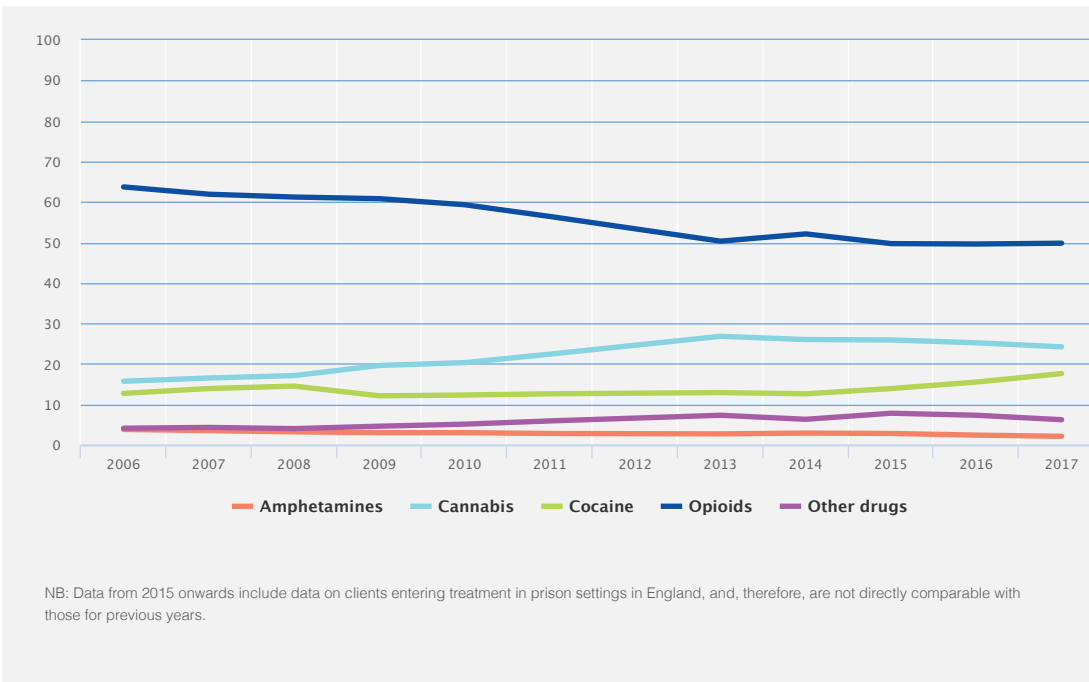
Opioid substitution treatment (OST) remains the most common treatment in the United Kingdom for opioid users and is mainly offered through specialist outpatient drug services, commonly in shared care arrangements with general practitioners. The enabling legislation for OST is the Misuse of Drugs Regulations 2001, and treatment can be initiated and provided by general practitioners, specialised doctors and treatment centres. Oral methadone is the most commonly prescribed drug for OST, although buprenorphine has also been available since 1999. Prescribed injectable methadone and diamorphine are also available in England but are rarely provided.

Treatment provision

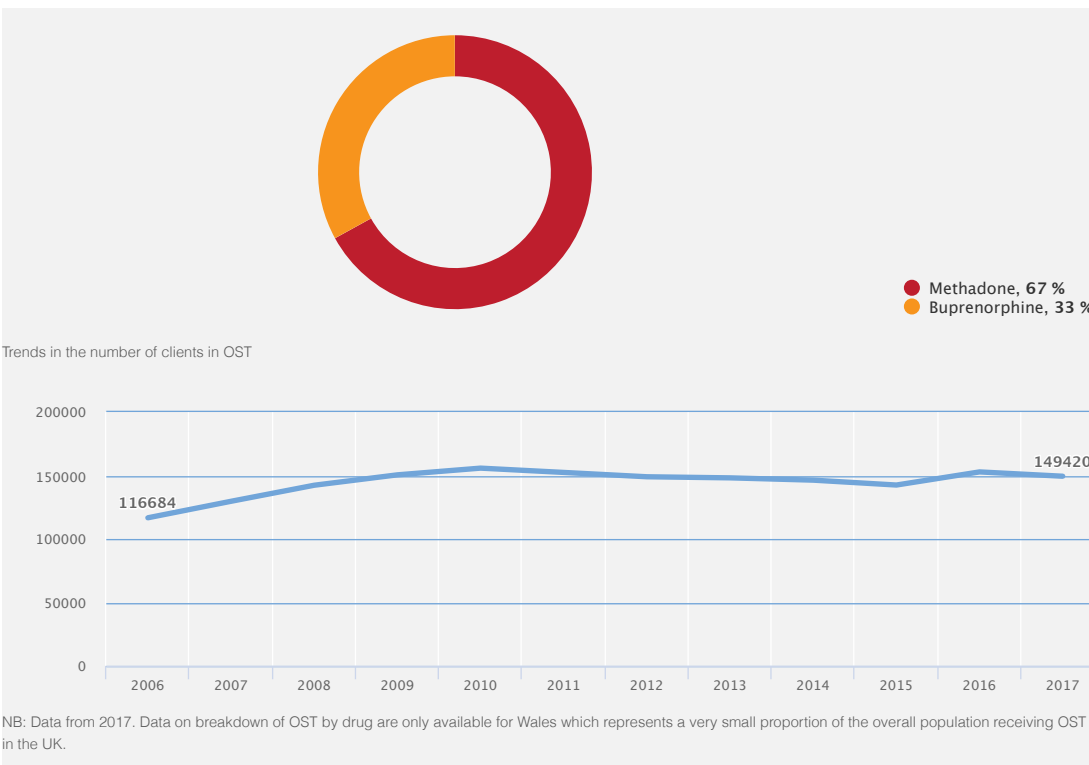
Around 238 000 clients received drug treatment in England and Wales in 2017. Approximately half of them entered treatment during 2017, one third of whom had never been treated previously. Under half of all clients entering treatment in 2017 were primary opioid users, mainly heroin users. Cannabis was the most frequently reported primary drug among first-time treatment entrants; the increasing trend for the proportion of clients that were primary cannabis users stopped in 2015. A notable increase in the number and proportion of primary cocaine clients, including first-time treatment entrants, has been reported since 2014. Cocaine clients may use powder and, to a lesser extent, crack cocaine. More than half of heroin treatment entrants also use crack cocaine; this pattern of use has been increasing since 2003/04.

The number of opioid users prescribed OST decreased following the 2010 peak, although it remains above 2006 levels. In 2017, around 150 000 clients received OST in England and Wales.

Trends in percentage of clients entering specialised drug treatment, by primary drug, in the United Kingdom



Opioid substitution treatment in England and Wales: proportion of clients in OST by medication and trends of the total number of clients



Drug use and responses in prison

Prison services in the United Kingdom are managed by three separate administrations: England and Wales, Scotland and Northern Ireland. The drug strategy of each of the three administrations aims to reduce the supply of and demand for illicit substances while also focusing on the treatment and recovery of prisoners with substance use problems.

Survey data suggest that the majority of prisoners have used illicit drugs prior to imprisonment, and about one quarter have used drugs during their current term of imprisonment. The levels of drug use in prisons are lower than in the community, with a shift away from stimulants and towards sedative drugs. Cannabis is the most prevalent drug used both outside and inside prison; the use of other illicit substances, such as heroin and benzodiazepines, is also commonly reported in prison.

In recent years, the use of synthetic cannabinoids in prisons has emerged as an issue. Drug testing data available for some prisons indicate that around one in eight prisoners use synthetic cannabinoids. Moreover, a number of deaths have been associated with their use. Responses to new psychoactive substances include a number of measures to prevent smuggling of these substances into prisons as well as the introduction of toolkits and other guidelines for prison and healthcare staff.

Across the United Kingdom, responsibility for healthcare provision in prisons lies with the health services. A number of organisations are responsible for substance misuse treatment policy, commissioning, delivery and provision in prison, including health authorities and prison and probation services.

Prisoners have access to a range of treatment services for substance use problems, including clinical services such as detoxification and opioid substitution treatment, structured psychosocial interventions, case management and structured counselling. Blood-borne viruses (BBVs) remain a cause for concern; to improve the detection, surveillance and management of these infections, a programme of opt-out BBV testing has been ongoing in prisons in England since 2014.

In 2017, new developments in demand and supply reduction took place in English prisons, including the introduction of a new national partnership agreement for prison healthcare, the creation of a drugs taskforce and the launch of a pilot project for a 'drug recovery prison', which aims to create a whole-prison approach to tackling the supply of drugs into prison. In 2018, all prisons in England, Wales and Scotland became smoke-free environments.

Take-home naloxone is widely available in Scotland and Wales for prisoners who are at risk of opioid overdose upon release. There is a focus on continuity of care in the transition between community and prison and vice versa. Drug recovery wings/units have also been piloted in England, Wales and Northern Ireland.

Quality assurance

The current drug strategies in the United Kingdom place an emphasis on evidence-based interventions, achieving outcomes and continuing development of best practice. The UK 2017 Drug Strategy emphasises the government's commitment to grounding its approach in the latest available evidence, the use of which is central to reducing demand, building recovery and global action.

Various organisations are involved in the promotion of best practice and the quality assurance of services, including the devolved administrations, the National Institute for Health and Care Excellence (NICE), Public Health England, the Department of Health and Social Care and the Care Quality Commission (CQC). NICE has produced a range of guidelines, technical appraisals and pathways relating to best practice and standards of care in the treatment of substance misuse, aimed at supporting local areas in the delivery of high-standard and evidence-based prevention and treatment services. It has also updated public health guidance on needle and syringe programmes.

In England, the CQC is the independent regulator of health and social care. Its purpose is to monitor, inspect and regulate the services delivered by health and social care providers, including those providing substance misuse treatment. Organisations similar to the CQC exist in Wales (Care Inspectorate Wales and Healthcare Inspectorate Wales), Scotland (Care Inspectorate and Healthcare Improvement Scotland) and Northern Ireland (the Regulation and Quality Improvement Authority). From July 2018, CQC inspections of substance misuse services will include a rating (Care Quality Commission, 2014). Previously only some services were rated.

The Federation of Drug and Alcohol Professionals (FDAP) is the professional body responsible for individual accreditation in the field of substance misuse and dependency for the United Kingdom. FDAP has a National Counsellor Accreditation Certificate scheme, which offers professional certification valid for 3 years for drug and alcohol counsellors who want to provide counselling or psychotherapy to individuals, couples or families.

Front-line workers in the field of substance use may undertake training and achieve qualifications under the Drug and Alcohol National Occupational Standards as part of their development. Higher education institutions in the United Kingdom also offer academic courses that may be completed by those in the field. Substance misuse teaching in medical training covers the clinical, psychological and social effects of substance misuse.

Drug-related research

The UK 2017 Drug Strategy states that the government is committed to grounding its approach in the latest available evidence, the use of which is central to achieving the strategy's aims, namely: (i) reducing demand, by using the evidence base to build resilience and confidence in young people to prevent drug use; (ii) building recovery, by improving treatment quality and outcomes for different user groups; and (iii) global action, by taking a leading role in driving international action, sharing best practice and promoting an evidence-based approach to preventing drug harms. In addition, a report from the Advisory Council on the Misuse of Drugs, published in 2016, recommends that the government fund independent research to inform and fill gaps in the evidence base on both the causes and the prevention of opioid-related deaths.

The UK Government funds drug-related research indirectly, which comes from a range of departments, including the Department of Health and Social Care, the Department of Education, the Home Office and the Ministry of Justice. Non-governmental organisations that have an interest in drugs also fund drug-related research. Furthermore, the government has attempted to translate the results of research into practice. The evidence base results of the drug policy evaluation of July 2017 have contributed to the elaboration of the 2017 Drug Strategy.

The United Kingdom conducts a large quantity of drug-related research, which originates mainly from university departments. Research is disseminated through academic peer-reviewed journal articles, reports, presentations at conferences and lectures, and national evidence-based guidelines and quality standards. Areas that are of current topical interest largely focus on the user; however, research on toxicology, the effectiveness of interventions and treatments, the effectiveness of drug-related policies and strategies, and the social impact of substance use is also regularly published. In recent years, there has been a noticeable increase in the number of papers published on new psychoactive substances.

Drug markets

The identified drug supply chains to the United Kingdom, on the whole, follow well-established trafficking routes. Heroin originates from Afghanistan and is most commonly brought in via either Pakistan or Iran, or more recently through Ukraine.

The Netherlands and Belgium are the main transit hubs within Europe for cocaine en route to the United Kingdom. Furthermore, the Netherlands and Belgium are the most significant sources of established synthetic stimulant drugs, such as MDMA/ecstasy, amphetamine and methamphetamine, while most non-retail quantities of new psychoactive substances bought online originate from China.

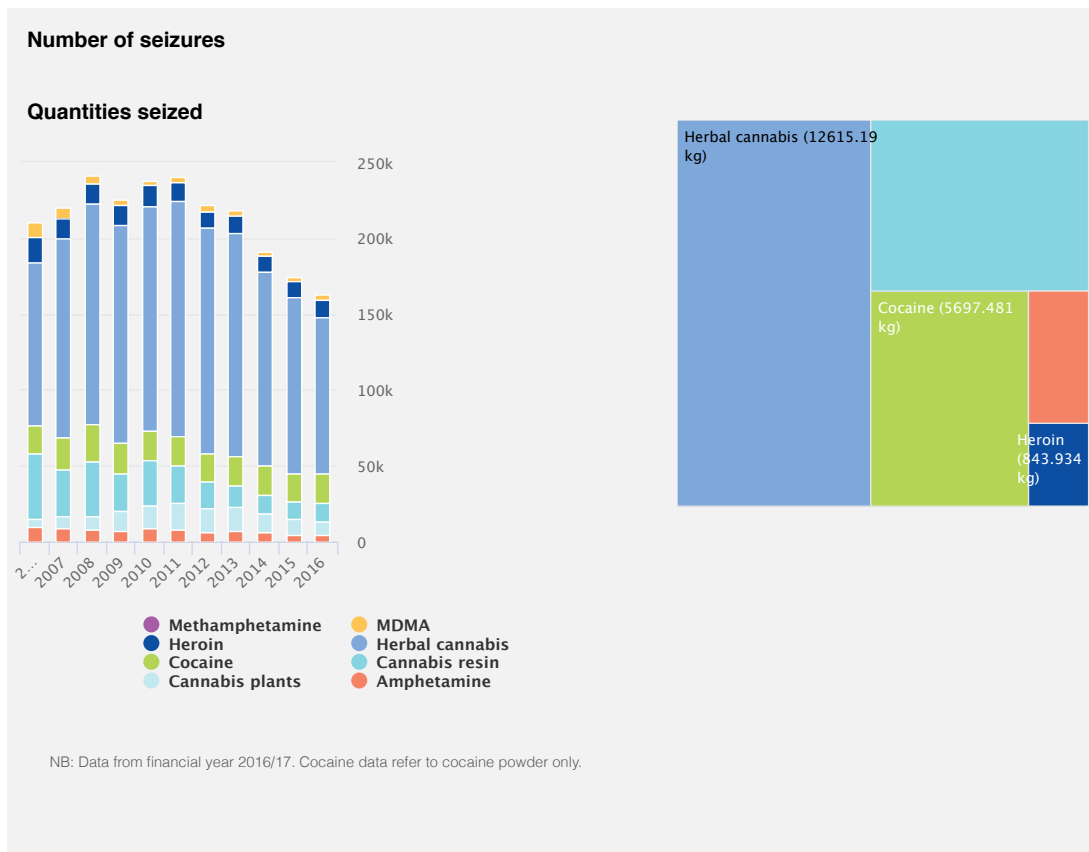
South and West Africa and the Caribbean are the main sources of imported herbal cannabis, while cannabis resin originates mainly from Morocco and, to a lesser extent, Afghanistan. Branded strains of high-potency cannabis are imported from the Netherlands. Cannabis is also cultivated in significant quantities across the United Kingdom, with production being controlled, for the most part, by British organised crime groups. Crack cocaine is converted locally from imported cocaine powder. Amphetamine may also be produced in the United Kingdom, with active laboratories believed to be most commonly located in the north-west of England. Within the United Kingdom, supply chains take many forms, with a varying number of levels between the importer and the user.

Cannabis is the most frequently seized drug in the United Kingdom, followed by cocaine. The long-term trend indicates a marked decrease in the number of cannabis resin seizures in the last decade, while increases in the number of herbal cannabis seizures were reported during 2011/12, with a steady drop thereafter.

The United Kingdom reports seizures of both cocaine powder and crack cocaine, with powder being seized more frequently. There was a marked shortage of heroin in the period 2009-10, but the market gradually recovered and has remained stable since around 2012/13. Nevertheless, the United Kingdom reports some of the highest heroin and cocaine seizures in Europe, both in terms of numbers and quantities seized. The number of MDMA seizures has remained relatively stable since 2010/11, while the quantities seized have increased.

Data on the retail price and purity of the main illicit substances seized are shown in the 'Key statistics' section.

Drug seizures in the United Kingdom: trends in number of seizures (left) and quantities seized (right)



Key statistics

Most recent estimates and data reported

	Year	Country data	EU range	
			Min.	Max.
Cannabis				
Lifetime prevalence of use — schools (% , Source: ESPAD)	n.a.	n.a.	6.51	36.79
Last year prevalence of use — young adults (%)	2017	12.3	1.8	21.8
Last year prevalence of drug use — all adults (%)	2017	7.2	0.9	11
All treatment entrants (%)	2017	24.2	1.03	62.98
First-time treatment entrants (%)	2017	45.3	2.3	74.36
Quantity of herbal cannabis seized (kg)	2016	12 615.2	11.98	94 378.74
Number of herbal cannabis seizures	2016	103 695	57	151 968
Quantity of cannabis resin seized (kg)	2016	6 281.5	0.16	334 919
Number of cannabis resin seizures	2016	12 093	8	157 346
Potency — herbal (% THC) (minimum and maximum values registered)	n.a.	n.a.	0	65.6
Potency — resin (% THC) (minimum and maximum values registered)	n.a.	n.a.	0	55
Price per gram — herbal (EUR) (minimum and maximum values registered)	n.a.	n.a.	0.58	64.52
Price per gram — resin (EUR) (minimum and maximum values registered)	n.a.	n.a.	0.15	35
Cocaine				
Lifetime prevalence of use — schools (% , Source: ESPAD)	n.a.	n.a.	0.85	4.85
Last year prevalence of use — young adults (%)	2017	4.7	0.1	4.7
Last year prevalence of drug use — all adults (%)	2017	2.7	0.1	2.7
All treatment entrants (%)	2017	17.6	0.14	39.2
First-time treatment entrants (%)	2017	22.1	0	41.81
Quantity of cocaine seized (kg)	2016	5 697.5	0.32	44 751.85
Number of cocaine seizures	2016	18 912	9	42 206
Purity (%) (minimum and maximum values registered)	2017	1 - 95	0	100
Price per gram (EUR) (minimum and maximum values registered)	2017	44 - 110	2.11	350
Amphetamines				
Lifetime prevalence of use — schools (% , Source: ESPAD)	n.a.	n.a.	0.84	6.46
Last year prevalence of use — young adults (%)	2017	1	0	3.9
Last year prevalence of drug use — all adults (%)	2017	0.5	0	1.8
All treatment entrants (%)	2017	2.1	0	49.61
First-time treatment entrants (%)	2017	2.7	0	52.83
Quantity of amphetamine seized (kg)	2016	1 356.2	0	1 669.42
Number of amphetamine seizures	2016	4 030	1	5 391
Purity — amphetamine (%) (minimum and maximum values registered)	2017	1 - 65	0.07	100
Price per gram — amphetamine (EUR) (minimum and maximum values registered)	n.a.	n.a.	3	156.25
MDMA				
Lifetime prevalence of use — schools (% , Source: ESPAD)	n.a.	n.a.	0.54	5.17
Last year prevalence of use — young adults (%)	2017	3.3	0.2	7.1
Last year prevalence of drug use — all adults (%)	2017	1.7	0.1	3.3
All treatment entrants (%)	2017	0.5	0	2.31
First-time treatment entrants (%)	2017	1.1	0	2.85
Quantity of MDMA seized (tablets)	2016	513 259	159	8 606 765
Number of MDMA seizures	2016	3 483	13	6 663
Purity (MDMA mg per tablet) (minimum and maximum values registered)	n.a.	n.a.	0	410
Purity (MDMA % per tablet) (minimum and maximum values registered)	n.a.	n.a.	2.14	87
Price per tablet (EUR) (minimum and maximum values registered)	n.a.	n.a.	1	40
Opioids				
High-risk opioid use (rate/1 000)	2014-15	8.42	0.48	8.42
All treatment entrants (%)	2017	49.8	3.99	93.45
First-time treatment entrants (%)	2017	21.8	1.8	87.36
Quantity of heroin seized (kg)	2016	843.9	0.01	17 385.18
Number of heroin seizures	2016	11 075	2	12 932
Purity — heroin (%) (minimum and maximum values registered)	2017	1 - 91	0	91
Price per gram — heroin (EUR) (minimum and maximum values registered)	2017	44 - 66	5	200
Drug-related infectious diseases/injecting/death				
Newly diagnosed HIV cases related to injecting drug use (cases/million population, Source: ECDC)	2017	1.7	0	47.8
HIV prevalence among PWID* (%)	2017	n.a.	0	31.1
HCV prevalence among PWID* (%)	2017	n.a.	14.7	81.5
Injecting drug use (cases rate/1 000 population)	2004-11	3	0.08	10.02
Drug-induced deaths — all adults (cases/million population)	2016	73.6	2.44	129.79
Health and social responses				
Syringes distributed through specialised programmes	n.a.	n.a.	245	11 907 416

Clients in substitution treatment	2017	149 420	209	178 665
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Treatment demand

All entrants	2017	118 342	179	118 342
First-time entrants	2017	37 577	48	37 577
All clients in treatment	2017	237 841	1 294	254 000

Drug law offences

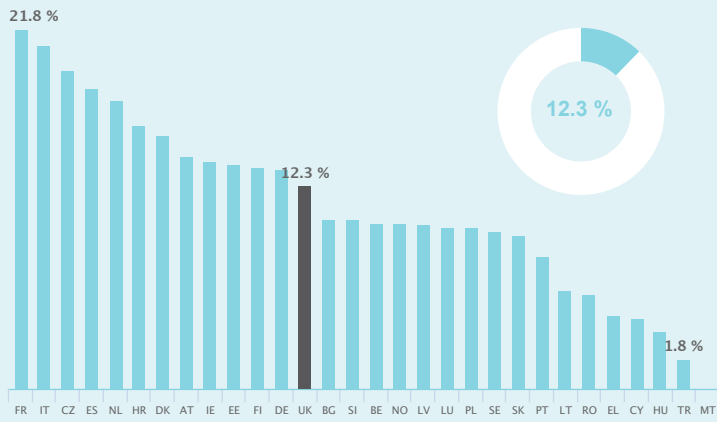
Number of reports of offences	2016	106 862	739	389 229
Offences for use/possession	2016	67 490	130	376 282

Prevalence of drug use data, 'Clients in opioid substitution treatment' and 'All clients in treatment' refer to England and Wales only. Under 'Cocaine', price/purity data are for street/retail level and for powder cocaine only. Under 'Amphetamines', purity data are for street/retail only. Under 'Opioids', price/purity data are for street/retail level.

EU Dashboard

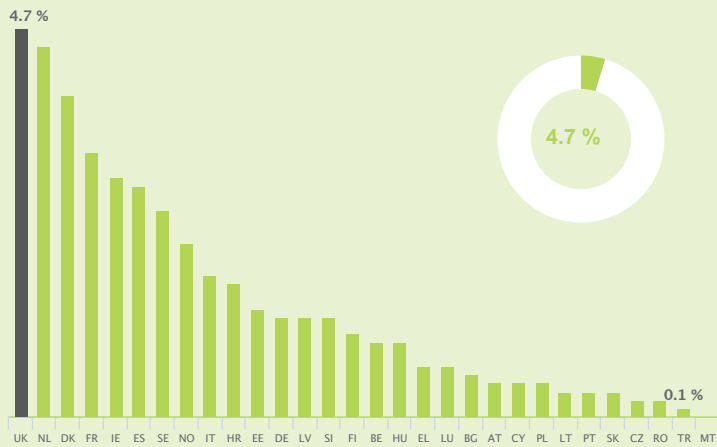
Cannabis

Last year prevalence among young adults (15-34 years)



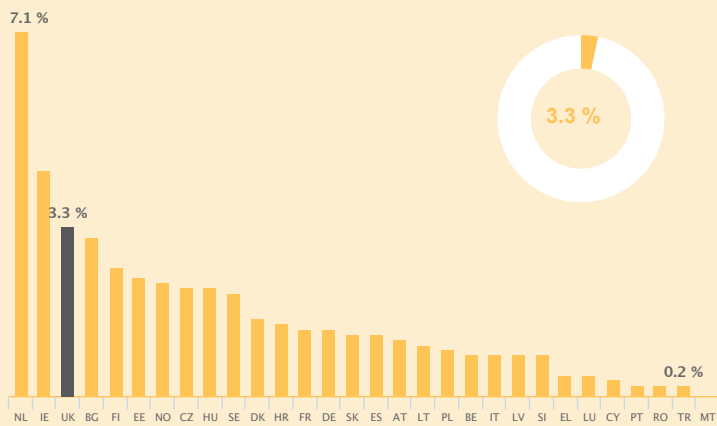
Cocaine

Last year prevalence among young adults (15-34 years)



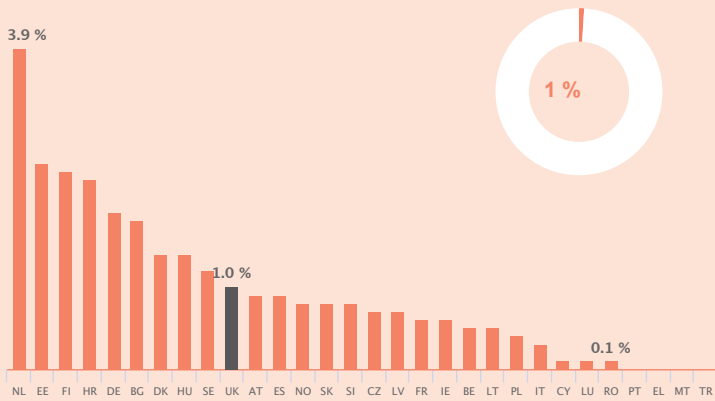
MDMA

Last year prevalence among young adults (15-34 years)



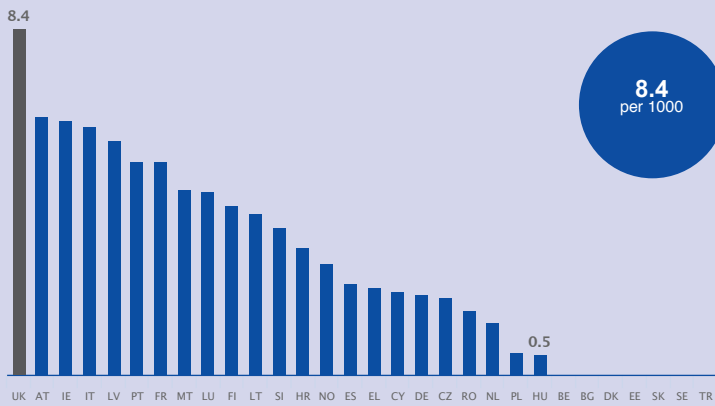
Amphetamines

Last year prevalence among young adults (15-34 years)



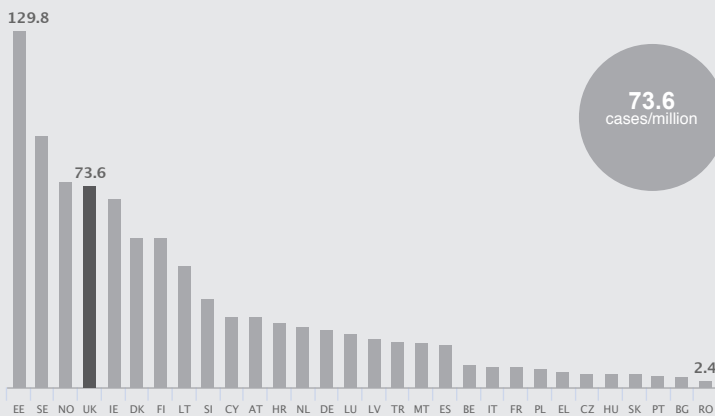
Opioids

High-risk opioid use (rate/1 000)



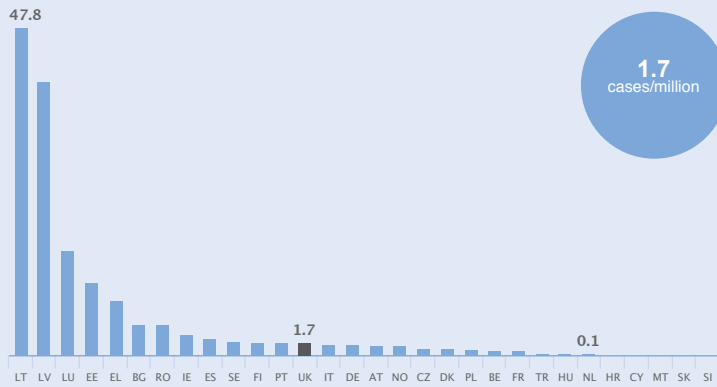
Drug-induced mortality rates

National estimates among adults (15-64 years)



HIV infections

Newly diagnosed cases attributed to injecting drug use



NB: Caution is required in interpreting data when countries are compared using any single measure, as, for example, differences may be due to reporting practices. Detailed information on methodology, qualifications on analysis and comments on the limitations of the information available can be found in the EMCDDA Statistical Bulletin. Last year prevalence estimated among young adults aged 16-34 years in Denmark, Norway and the United Kingdom; 17-34 in Sweden; and 18-34 in France, Germany, Greece and Hungary. Drug-induced mortality rate for Greece are for all ages.

About our partner in the United Kingdom

The UK Focal Point on Drugs (the national focal point) is based in Public Health England. It works closely with the Home Office, other government departments and the devolved administrations (Northern Ireland, Scotland and Wales) in providing information to the EMCDDA.

[Click here to learn more about our partner in the United Kingdom.](#)

UK national focal point



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Head of national focal point: Ms [Catherine Crawford](#)

Methodological note: Analysis of trends is based only on those countries providing sufficient data to describe changes over the period specified. The reader should also be aware that monitoring patterns and trends in a hidden and stigmatised behaviour like drug use is both practically and methodologically challenging. For this reason, multiple sources of data are used for the purposes of analysis in this report. Caution is therefore required in interpretation, in particular when countries are compared on any single measure. Detailed information on methodology and caveats and comments on the limitations in the information set available can be found in the [EMCDDA Statistical Bulletin](#).
