European Monitoring Centre for Drugs and Drug Addiction

United-Kingdom

United Kingdom Drug Report 2018

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 2016 (or most recent year) and are provided to the EMCDDA by the national focal point, unless stated otherwise.

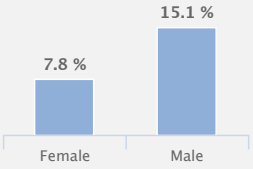
THE DRUG PROBLEM IN THE UNITED KINGDOM AT A GLANCE

Drug use

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

Cannabis

11.5 %



Other drugs

MDMA	**2.6 %**
Amphetamines	**0.7 %**
Cocaine	**4 %**

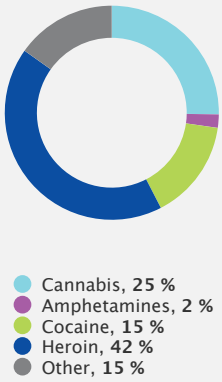
High-risk opioid users

330 445

(324 048 - 342 569)

Treatment entrants

by primary drug



Opioid substitution treatment clients

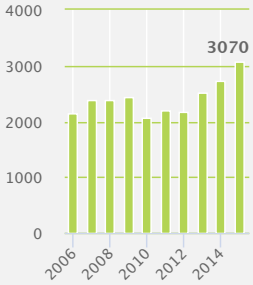
138 422

Syringes distributed

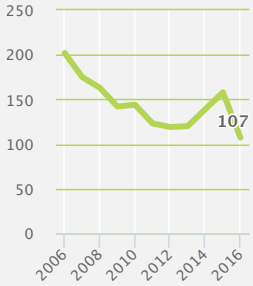
through specialised programmes

No Data

Overdose deaths



HIV diagnoses attributed to injecting



Source: ECDC

Drug law offences

115 377

Top 5 drugs seized

ranked according to quantities measured in kilograms

1. Herbal cannabis
2. Cannabis resin
3. Cocaine
4. Amphetamines
5. Heroin

Population

(15-64 years)

42 069 267

Source: EUROSTAT Extracted on: 18/03/2018

"NB: Data presented here are either national estimates (prevalence of use, opioid drug users) or reported numbers through the EMCDDA indicators (treatment clients, syringes, deaths and HIV diagnosis, drug law o?ences 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. For the Drug use and OST sections data are for England and Wales only."

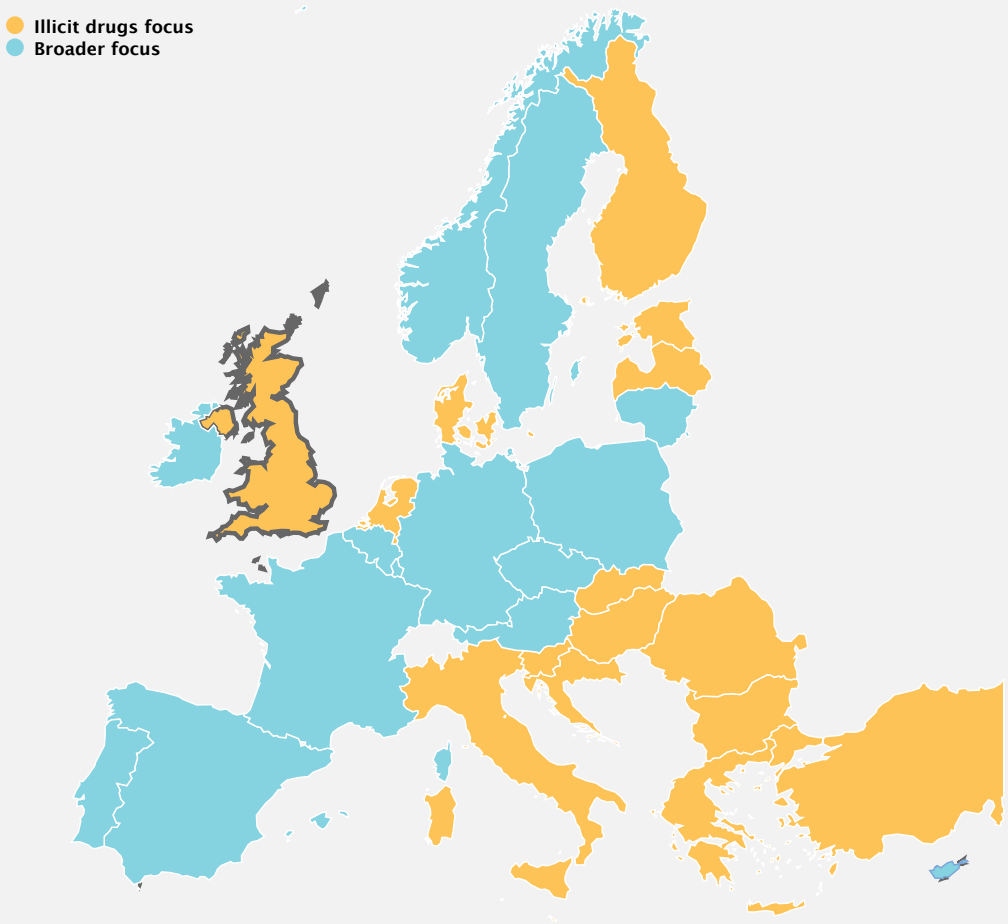
National drug strategy and coordination

National drug strategy

Launched in July 2017, the United Kingdom's 2017 Drug Strategy addresses illicit drug problems and has 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 that structure the approach being taken: (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 for 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. Northern Ireland's policy, New Strategic Direction for Alcohol and Drugs Phase 2: 2011-16, was launched in 2011. The strategies in 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.

Focus of national drug strategy documents: illicit drugs or broader



NB: Year of data 2016. Strategies with broader focus may include, for example, licit drugs and other addictions. While the United Kingdom has an illicit drug strategy, both Wales and Northern Ireland have broad strategy documents which include alcohol.

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 Road to Recovery strategy is implemented locally by 30 Alcohol and Drug Partnerships and the Partnership for Action on Drugs in Scotland. 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

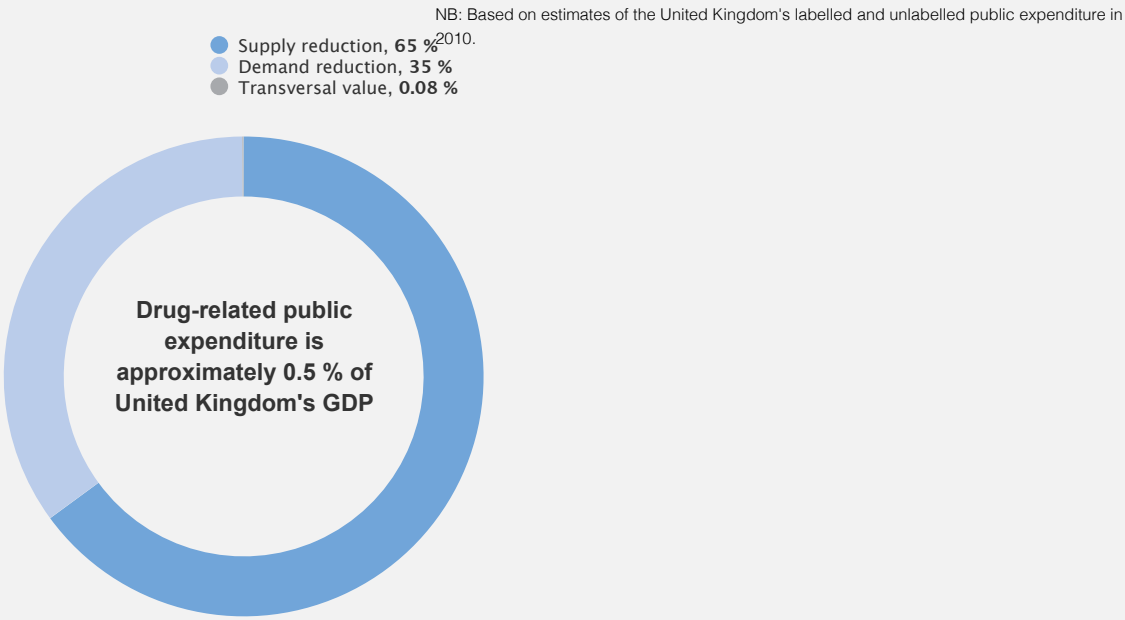
Understanding the costs of drug-related actions is an important aspect of drug policy. Some of the funds allocated by governments for expenditure on tasks related to drugs are identified as such in the budget ('labelled'). Often, however, most drug-related expenditure is not identified ('unlabelled') 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 represented 0.5 % of gross domestic product, with almost 65 % of this spending allocated to demand reduction, 35 % 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.

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 not only according to the class of substance but also 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 surrounding the offence determining which type of court is the most appropriate for a given case. 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 six months' imprisonment and/or a fine; on indictment, penalties may reach seven years' imprisonment. Possession of Class B drugs, such as cannabis and amphetamines, incurs a penalty of up to three months' imprisonment and/or a fine at magistrate level; on indictment, the penalty is up to five years' imprisonment and/or an unlimited fine. Possession of most Class C drugs, such as benzodiazepines, attracts a penalty of up to three months' imprisonment and/or a fine at magistrate level, or up to two 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.

Under the Misuse of Drugs Act 1971, a distinction is made between the possession of controlled drugs and possession with intent to supply to another; the latter, effectively, refers to drug trafficking offences. 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. The penalties applied depend on the classification of the drug and on the penal procedure (magistrate level or Crown Court level). 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 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 seven years was introduced for a third conviction for trafficking in Class A drugs. In addition, 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.

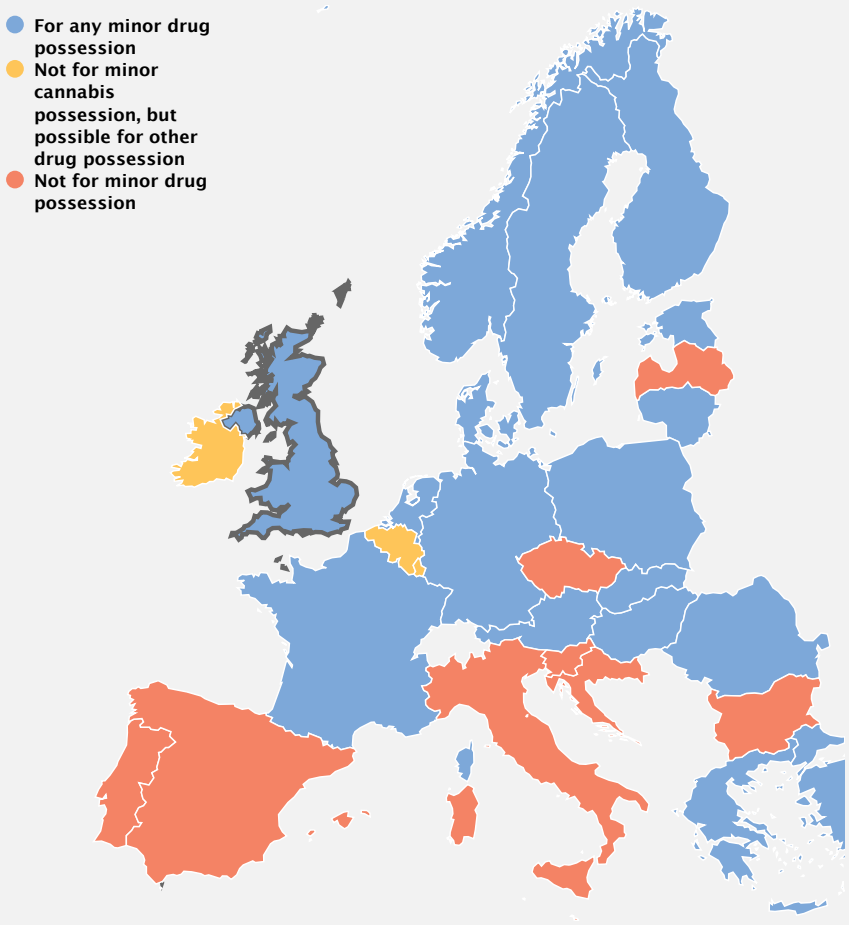
In 2016, the Psychoactive Substances Act criminalised the production, supply or possession with intent to supply of any psychoactive substance (with some exemptions) if it is known that it is to be used for its psychoactive effects. Supply offences are aggravated by proximity to a school, using a minor 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 seven years' imprisonment on indictment or one year's imprisonment on summary conviction.

Drug law offences

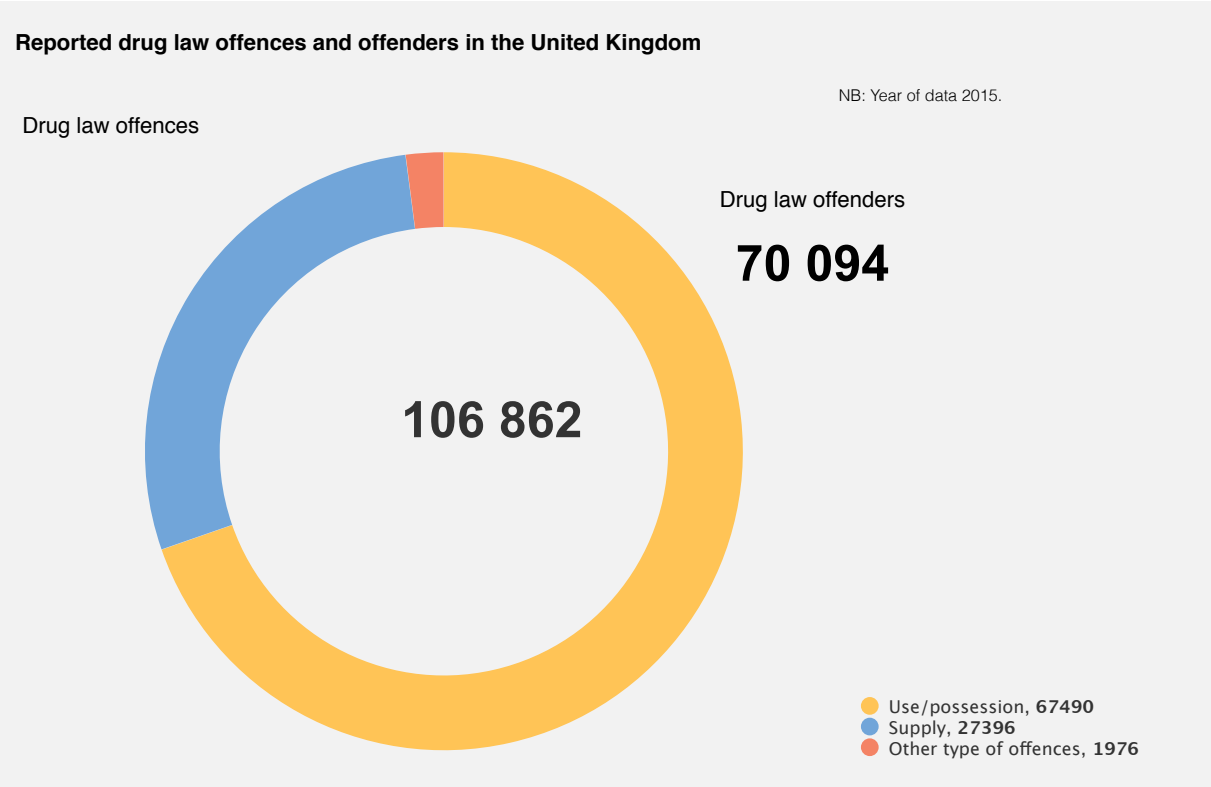
Drug law offence (DLO) data are the foundation for monitoring drug-related crime and are also a measure of law enforcement activity and drug market dynamics; they may be used to inform policies on the implementation of drug laws and to improve strategies.

After increasing between 2006/07 and 2010/11, the number of arrests for drug law offences has decreased in recent years. In 2015/16, approximately 115 377 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), 57 % were cannabis related, 20 % were cocaine related (excluding crack cocaine) and 11 % were heroin related.

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



NB: Year of data 2016



Drug use

Prevalence and trends

Overall drug use in the United Kingdom has declined from the level seen 10 years ago, remaining stable in the past three years. Because of its relatively high prevalence, cannabis has been a substantial driver of this overall trend. Cannabis remains the most commonly used illicit drug, while powder cocaine is the most prevalent stimulant in the United Kingdom and the second most prevalent drug overall. MDMA/ecstasy is the next most commonly reported stimulant. In general, MDMA users are younger than cocaine and amphetamines users.

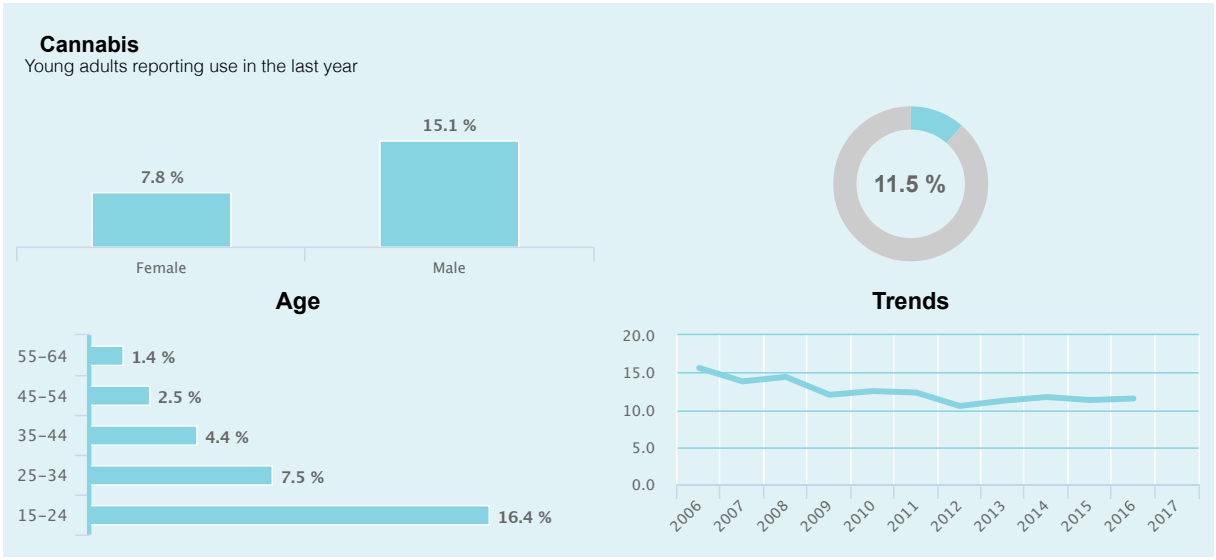
According to the Crime Survey for England and Wales, among 16- to 34-year-old young adults, cannabis use declined between 2006 and 2013, but has since levelled off. Cocaine use decreased between 2008 and 2010 and has been relatively stable since. Having previously declined, the level of reported MDMA use has returned to a level broadly similar to that seen around 10 years ago.

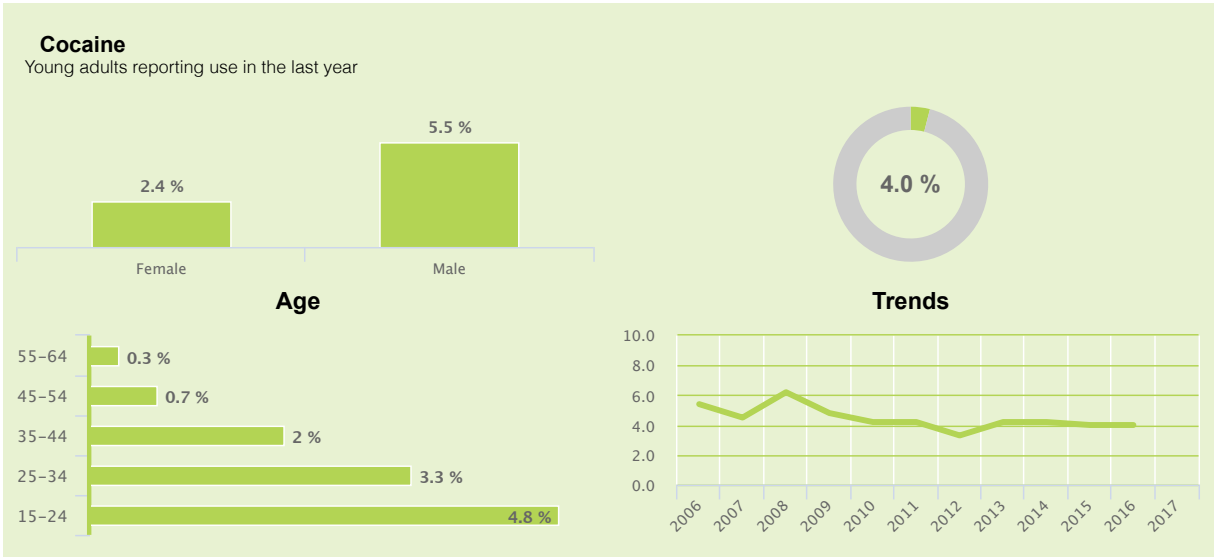
Prevalence of new psychoactive substances (NPS) in general population surveys is low in comparison with the main traditional drugs. Mephedrone is the only stimulant NPS to have become established alongside traditional substances among recreational drug users within the general population. However, the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

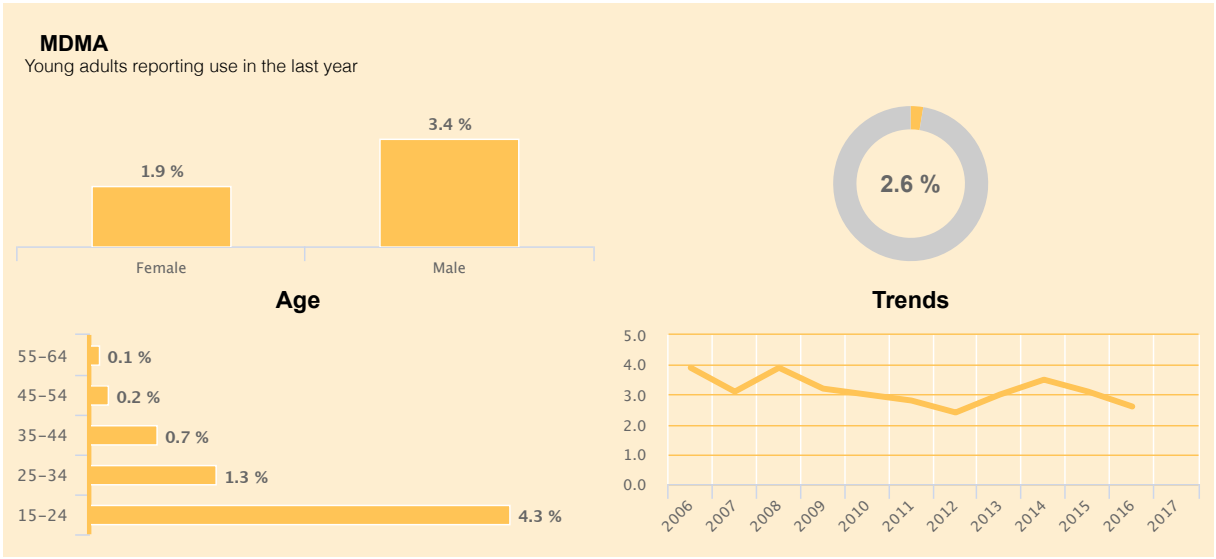
Cannabis is the most prevalent drug reported by school surveys and has shown a long-term downward trend with a more recent levelling off that is similar to the trend for the general population. The patterns in school surveys are not unique to cannabis, and are seen in other illicit drug use, as well as in alcohol and tobacco use.

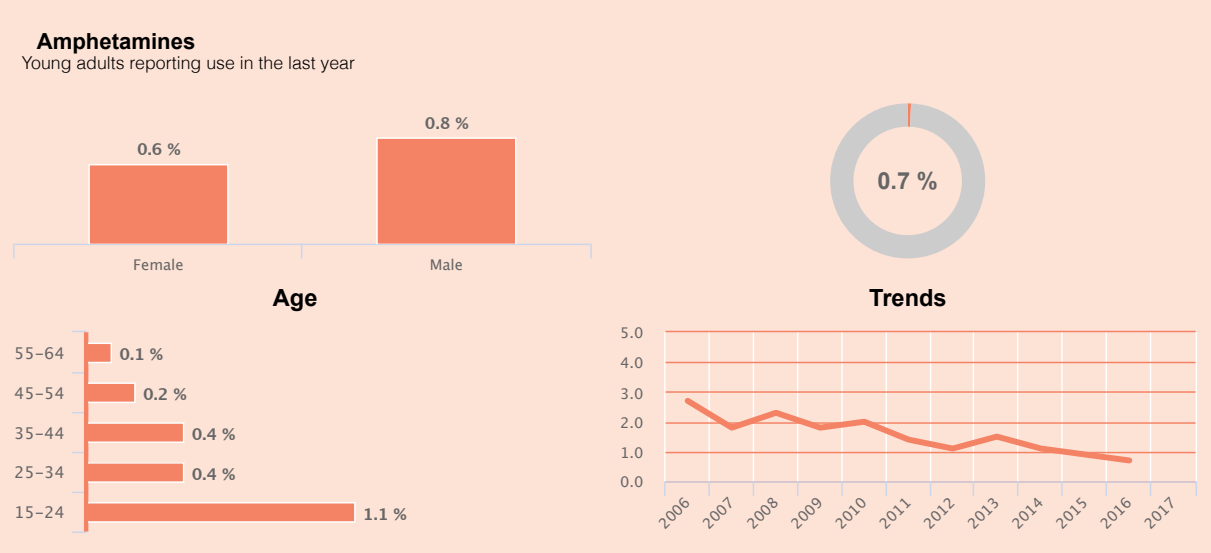
London and Bristol participate in the Europe-wide annual wastewater campaigns undertaken by the Sewage Analysis Core Group Europe (SCORE). This study provides data on drug use at a municipal level, based on the levels of illicit drugs and their metabolites found in sources of wastewater. For 2017, only 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 weekends.

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









NB: Estimated last-year prevalence of drug use in 2016.

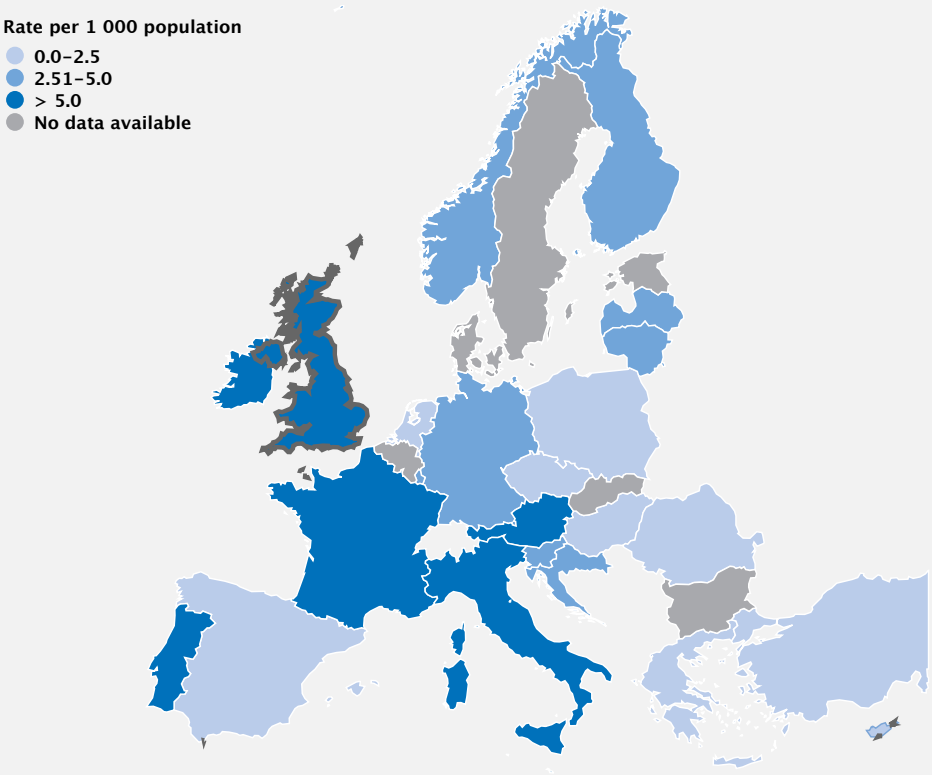
High-risk drug use and trends

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 it appears that there has been a decline in the rate of injecting among opioid users, around one quarter of people who seek treatment for heroin use report its 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 and amphetamines, and the emergence in recent years of the injection of NPS. Studies among vulnerable populations such as homeless people also indicate that the use of synthetic cannabinoid receptor agonists is high among this group.

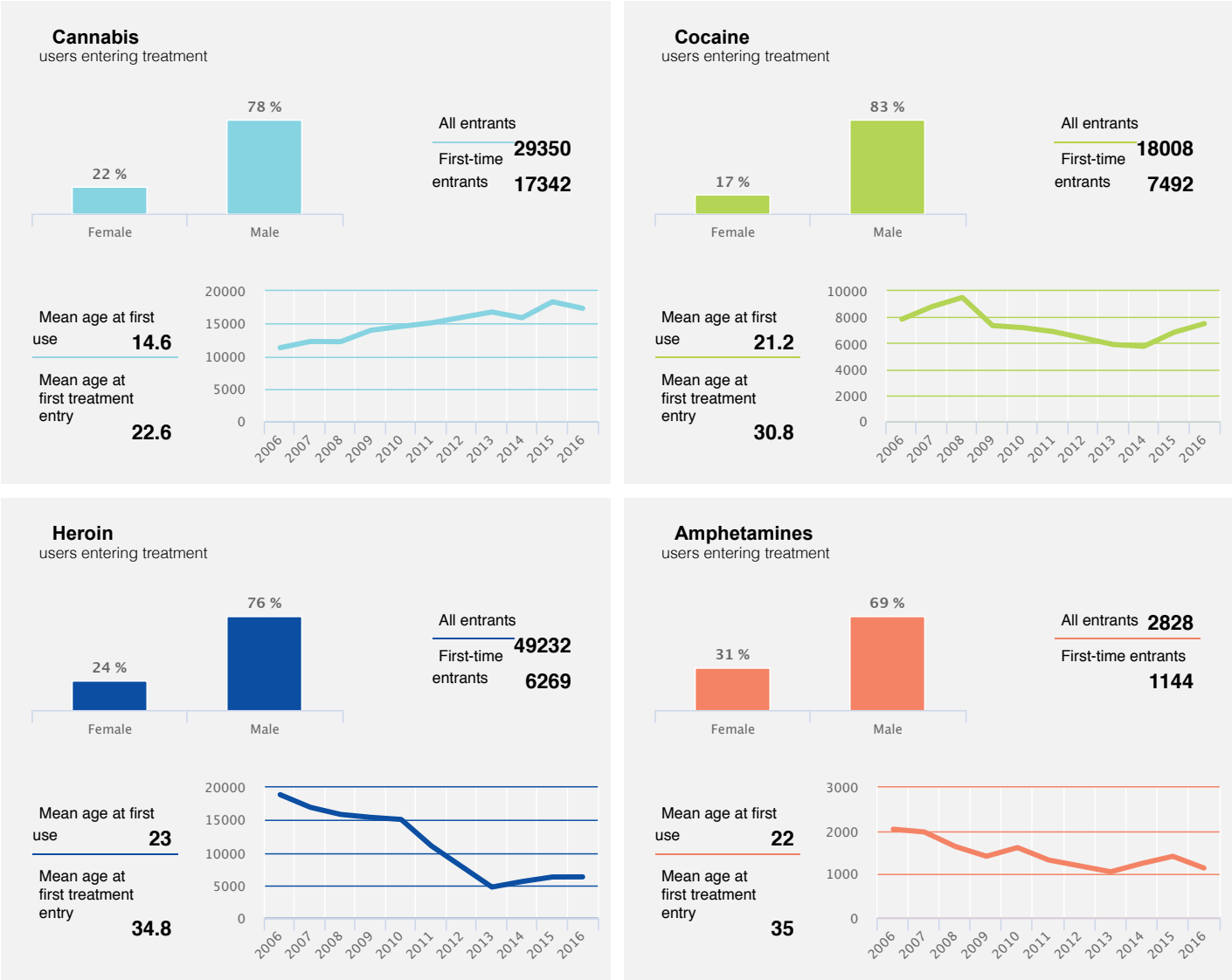
Data on the characteristics of those entering treatment in the United Kingdom also indicate that heroin is the most commonly reported primary substance among those seeking treatment for drug use problems; however, there has been a long-term reduction in first-time clients seeking treatment for heroin use. Among first-time treatment clients, cannabis is the most commonly reported substance, followed by cocaine.

National estimates of last year prevalence of high-risk opioid use



NB: Year of data 2016, or latest available year

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



"NB: Year of data 2016. Data is for first-time entrants, except for gender which is for all treatment entrants. 2015 and 2016 data include clients entering treatment in prison settings in England and, therefore, data is not directly comparable with previous years"

Drug harms

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 2015, an outbreak of HIV occurred among people who inject drugs (PWID) in Glasgow, with 50 new HIV cases reported in Scotland, which was more than double the average number of new HIV cases detected annually in the period 2006-2014. In 2016, Scotland registered a total of 36 new HIV cases.

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

It is estimated that the majority of all hepatitis C virus (HCV) infection cases in the United Kingdom are a result of injecting drug use. The prevalence of HCV infection among PWID remains relatively high and has changed little in recent years; in 2016, almost half of all PWID were estimated to be HCV positive. 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	22.4-54.3	0.0-1.38

Year of data: 2016
HIV range is 0.0 (NI) to 1.38 (Wales). HCV range is 22.4 (NI) to 54.3 (England)

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 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, all indicating symptoms of injecting-site infection, during the preceding year.

Drug-related emergencies

In 2013/14, 41 628 people were discharged from hospital inpatient treatment after poisoning by drugs in the United Kingdom, which was an increase on 2012/13. The Information Services Division reported that there were 8 546 general acute stays with a diagnosis of drug use in Scotland in 2016/17, of which the vast majority (8 006) were as a result of an emergency admission. More than half of all emergency admissions were attributed to opioids. Of all patients who stayed in hospital because of a drug-related emergency, more than half 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

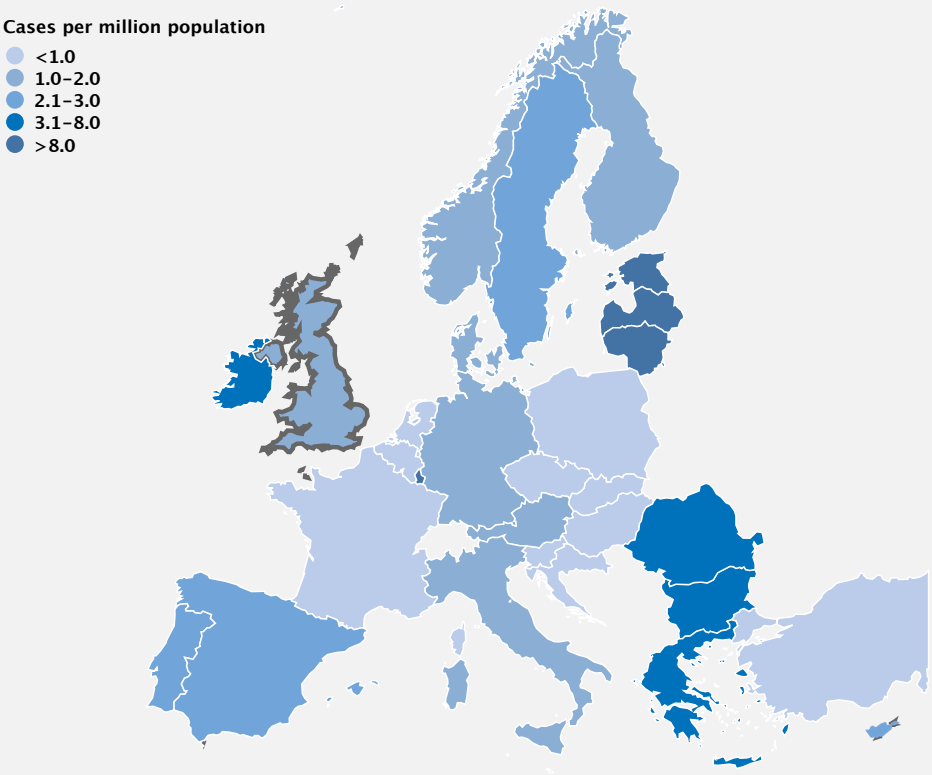
In 2015, the United Kingdom reported a record number of drug-related deaths, indicating an increasing trend since 2012. Because of delays in the registration of deaths, the number of deaths in 2016 is not yet known, but statistics published on the number of deaths registered in 2016 in particular in Scotland suggest that a further increase in the UK total is expected. Opioids (primarily heroin, but also methadone) were involved in the majority of deaths (almost 9 in 10), and other drugs commonly associated with deaths from illicit substance use include benzodiazepines, cocaine (frequently in combination with heroin) and amphetamines. The presence of multiple psychoactive substances in drug-related deaths is becoming more common in the United Kingdom. Males made up almost three quarters of drug-related deaths cases in 2015, and the mean age at time of death was 42 years. The average age of those dying has risen every year since 2006.

The number of deaths linked to new psychoactive substance (NPS) use remains relatively low but has increased since 2010. In 2016, 123 NPS-related deaths were registered in England and Wales, an increase on the number registered in 2015. The number of deaths associated with synthetic cannabinoids increased, while the number related to synthetic cathinones decreased. The number of NPS-related deaths registered in Scotland in 2016 was more than double the number registered in England and Wales; this figure increased from 74 in 2015 to 286 in 2016. The vast majority of NPS-related deaths in Scotland involved benzodiazepine-type NPS.

Several mortality cohort studies have been conducted in the United Kingdom in recent years, focusing mainly on opioid users and on drug-induced deaths among prisoners.

The drug-induced mortality rate among adults in the United Kingdom (aged 15-64 years) was 69.9 deaths per million in 2015, almost three times the most recent European average of 21.8 deaths per million.

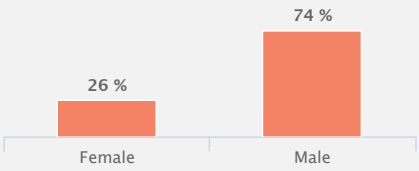
Newly diagnosed HIV cases attributed to injecting drug use



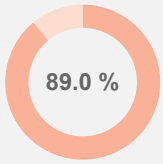
NB: Year of data 2016, or latest available year. Source: ECDC.

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

Gender distribution

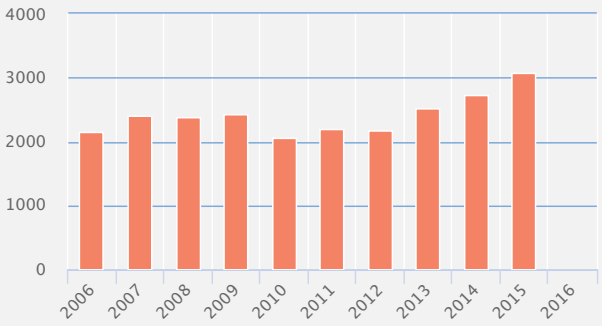


Toxicology

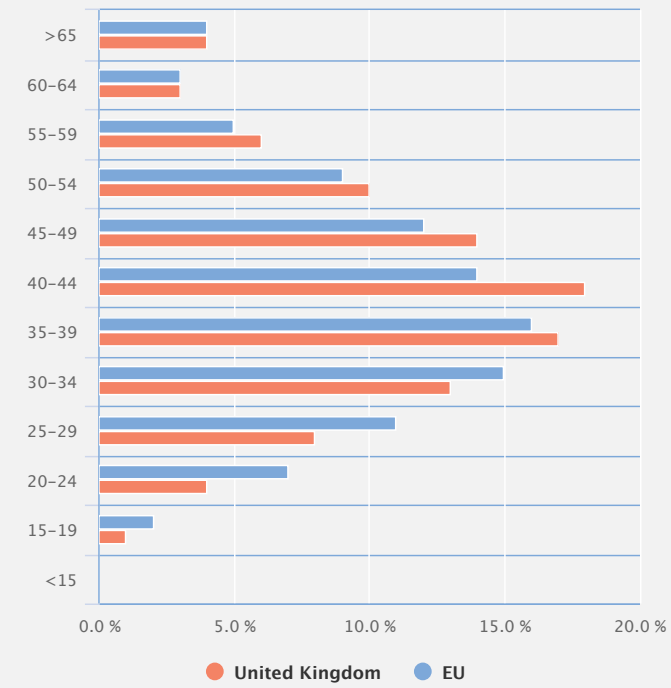


Deaths with opioids present among deaths with known toxicology

Trends in the number of drug-induced deaths

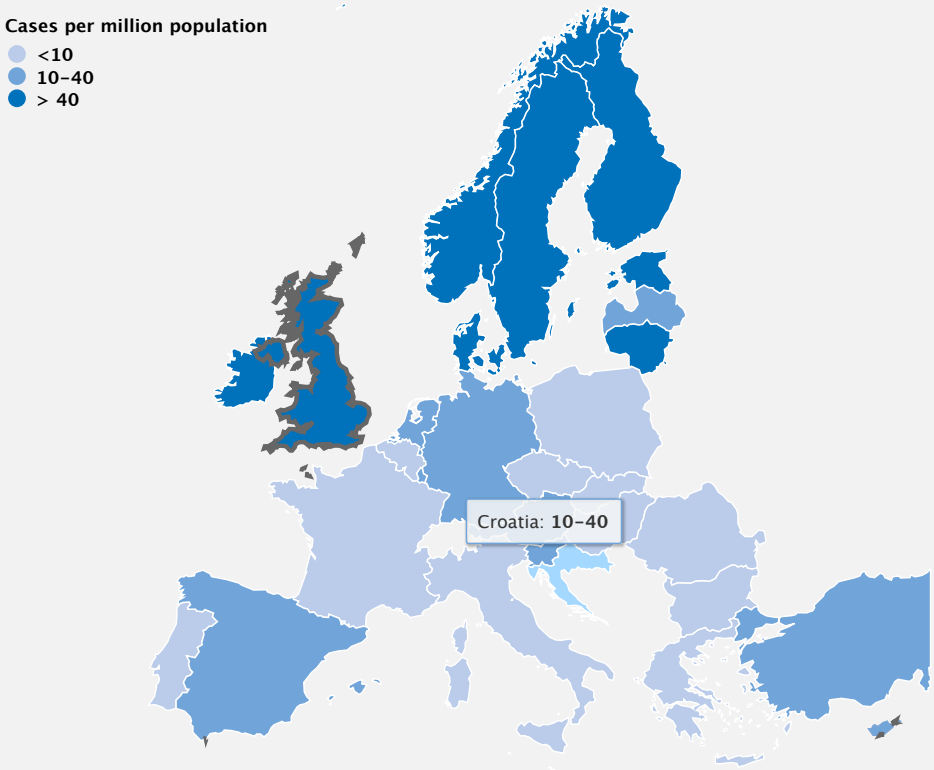


Age distribution of deaths in 2015



NB: Year of data 2015

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



"NB: Year of data 2016, or latest available year. Comparison between countries should be undertaken with caution. Reasons include systematic under-reporting in some countries, different reporting systems and case definition and registration processes."

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 (which will be introduced in Scotland this year) as well as standardised packaging of tobacco. All prisons in Wales and more than half of those in England are currently smoke-free, with plans for the remainder of the prisons in the English estate and for all Scottish prisons to become smoke-free in the near future. Drug driving legislation was introduced in England and Wales in 2015, and will be introduced in Scotland in 2019.

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. In England, universal drug prevention is a statutory part of the science curriculum for schools and can be expanded through non-statutory personal, social and health education. In Scotland, prevention is part of broader life learning for children and young people through the Curriculum for Excellence, which is integrated with traditional education for 3- to 18-year-olds. In Wales, drug prevention initiatives are included as part of the All Wales School Liaison Core Programme, which targets pupils aged 5-16 years, and in Northern Ireland, the school curriculum has a specific focus on the development of relevant life skills, with the aim of keeping children safe and healthy.

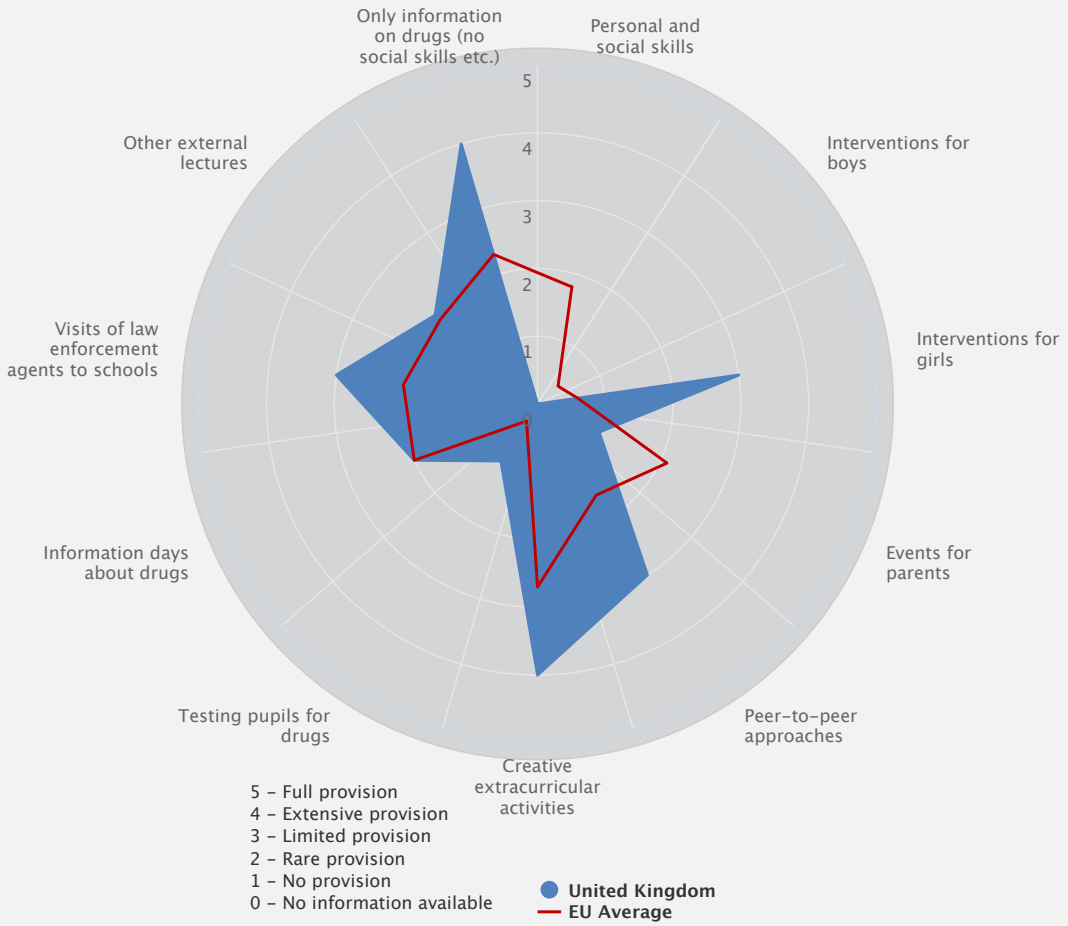
Several well-researched universal prevention programmes, such as the Good Behaviour Game and Unplugged, have been piloted in the United Kingdom. Rise Above, an online resource for young people, was launched in 2014 by Public Health England and aims to build young people's skills by encouraging them to engage with a range of situational resources. The Healthy Child Programme is the UK Government's early intervention and prevention programme and targets children from birth to 19 years.

There are also a number of prevention initiatives under way that address young people with multiple vulnerabilities, young mothers and troubled families.

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. Interventions within the programme include: parenting skills; drugs education for children; family support to help them stay together; addressing other problems; support for kinship carers; and, in some cases, intensive interventions. Integrated Family Support Services, which are available across most of Wales, provide support for families with parental substance misuse issues.

There are several sources of information about drugs available online. 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)



NB: Year of data 2016. Data is only available for prevention interventions targeted at girls

Harm reduction

The overarching aims of the UK 2017 Drug Strategy are to reduce illicit and other harmful drug use 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 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 the hepatitis B virus (HBV); referral to drug treatment; treatment for human immunodeficiency virus (HIV) and hepatitis C virus infections; and the provision of take-home naloxone, and 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, and are also provided through detached street outreach workers and mobile van units. In Wales, a vending machine is available in a community-based centre for the homeless.

Services 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 4.7 million for Scotland in 2015/16; almost 3.1 million for Wales in 2016/17; and almost 310 000 for Northern Ireland in 2015/16.

National naloxone programmes are implemented in Scotland, Wales and Northern Ireland; these include distribution of naloxone in non-clinical settings, such as hostels, and facilitating the distribution of naloxone kits to those at risk of overdose, and to their families and carers. Data from Scotland and Wales document that over 10 000 naloxone kits were given out in 2016, and that more than 40 000 kits have been put into circulation among the target group since the start of the programmes in these countries. Naloxone is also commonly distributed by local authorities in England.

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.

Availablity 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	No	No
Bulgaria	Yes	No	No	No
Croatia	Yes	No	No	No
Cyprus	Yes	No	No	No
Czech Republic	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 is seen as key in 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 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.

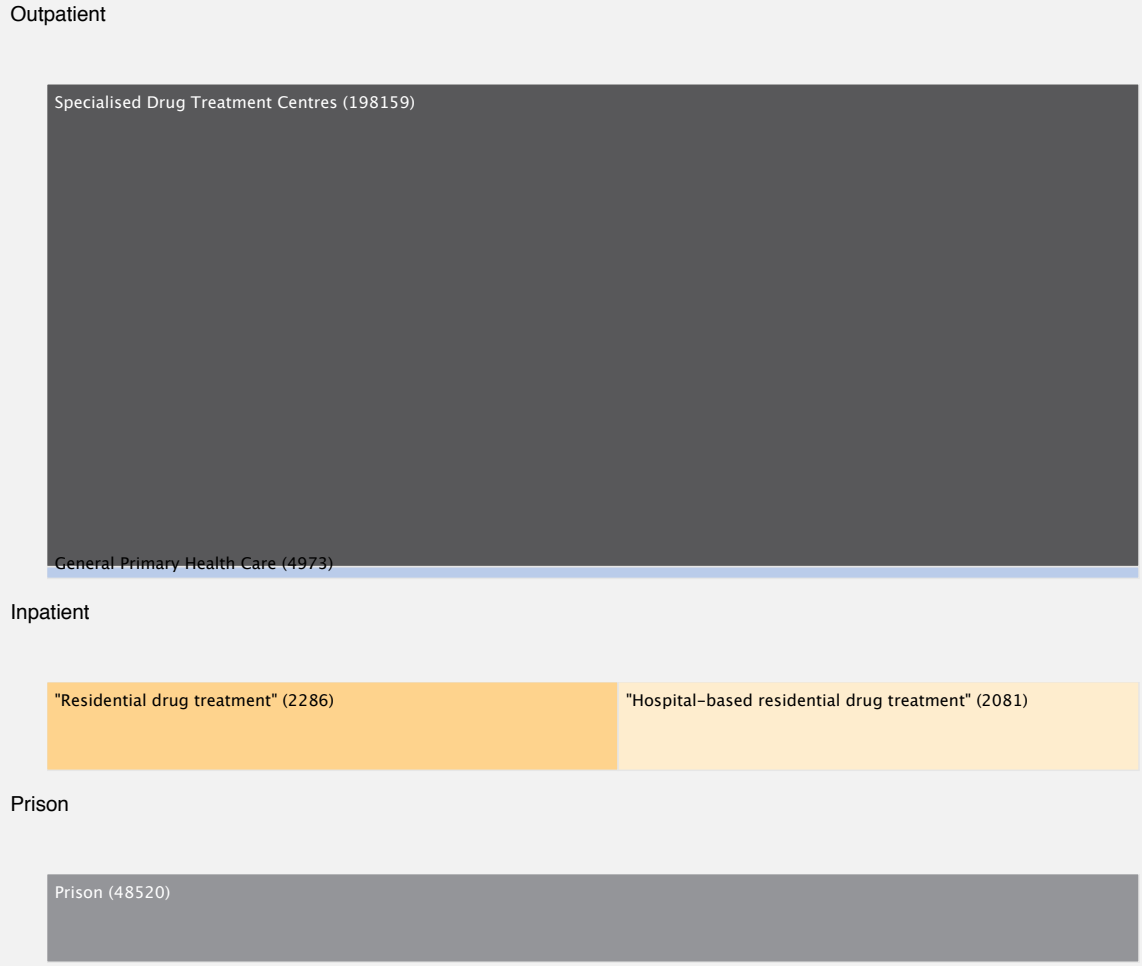
Opioid substitution treatment (OST) remains the most common treatment in the United Kingdom for opioid users, and is mainly offered through specialist outpatient drug services, commonly in shared care arrangements with general practitioners. The enabling legislation for OST is the Misuse of Drugs Regulations 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 245 000 clients received drug treatment in England and Wales in 2016. Approximately half of them presented for treatment in the United Kingdom during 2016, one third of whom had never been treated previously. Just under half of all clients presenting for treatment in this year were primary opioid users. Cannabis is the most frequently reported primary drug among first treatment presentations, and has increased in importance in recent years.

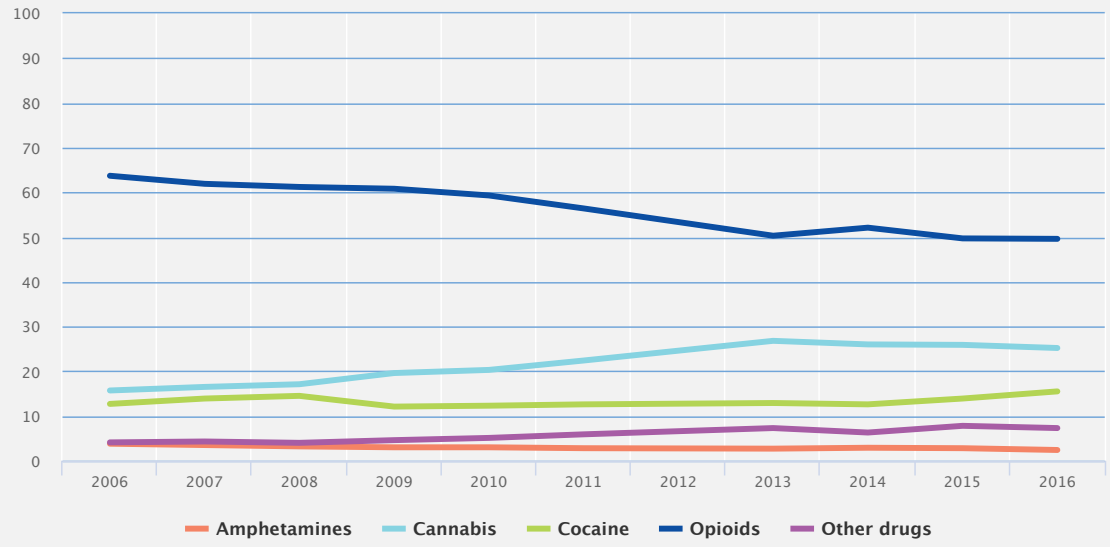
The number of opioid users prescribed OST has decreased slightly since the 2010 peak, although it remains above 2006 levels. In 2016, 138 422 patients received OST in England and Wales. The number of new clients entering treatment for heroin use decreased for several years but now seems to have stabilised.

Drug treatment in England and Wales: settings and number treated



NB: Year of data 2016

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

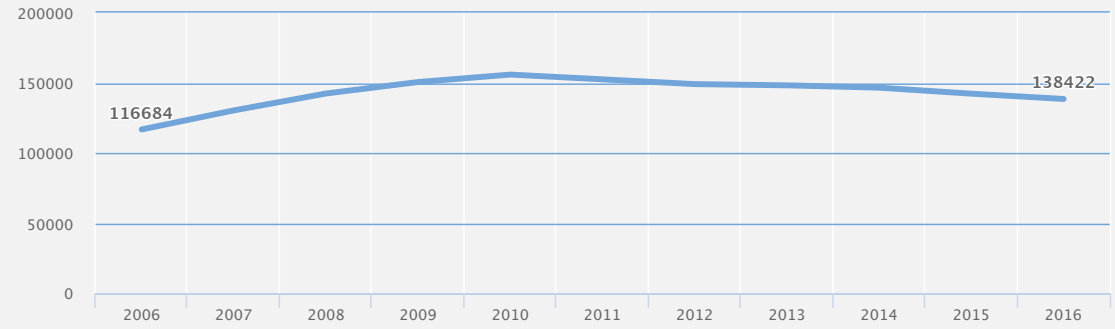


"NB: Year of data 2016. Data for 2015 and 2016 includes clients entering treatment in prison settings in England , therefore data is not directly comparable with previous years"

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

Methadone, **67.6 %**
Buprenorphine, **32.4 %**

Trends in the number of clients in OST



NB: Year of data 2016. Data on breakdown of OST by drug is only available for Wales

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. Cannabis is the most prevalent drug used both outside and inside prison; other illicit substances, such as heroin and benzodiazepines, are also commonly reported to be used in prison.

In recent years, the use of synthetic cannabinoids in prisons has emerged. 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. Possession of a psychoactive substance in custodial institutions is an offence.

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 new programme of opt-out BBV testing was introduced in prisons in England in 2014.

Take-home naloxone is widely available in Scotland and Wales for prisoners who are at risk of opioid overdose on 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 to develop best practice. The UK 2017 Drug Strategy emphasises the government's commitment to grounding its approach in the latest available evidence, and use of this is central to the reducing demand, building recovery and global action strands of the strategy.

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. The CQC makes judgements on the quality of care provided, carrying out in-depth investigations, reporting on the quality of care services and publishing information including performance ratings. Organisations similar to the CQC exist in Wales (the Care and Social Services Inspectorate Wales), Scotland (the Care Inspectorate) and Northern Ireland (the Regulation and Quality Improvement Authority).

The Federation of Drug and Alcohol Professionals (FDAP) is the professional body responsible for individual accreditation in the field of substance misuse and addiction for the United Kingdom. FDAP has a National Counsellor Accreditation Certificate scheme, which offers professional certification valid for three 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, and use of this is central to three of the four approaches used to achieve the strategy's aims, namely: reducing demand — using the evidence base to help to build resilience and confidence in young people to prevent drug use; building recovery — improving treatment quality and outcomes for different user groups; and global action — taking a leading role in driving international action, sharing best practice and promoting an evidence-based approach to preventing drug harms.

The UK Government published *An evaluation of the Government's Drug Strategy 2010* in July 2017, the results of which contributed to the evidence base for the 2017 Drug Strategy. Additionally, a report from the Advisory Council on the Misuse of Drugs, published in December 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 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 in lectures, national evidence-based guidelines and quality standards. The UK Government funds some drug-related research indirectly, which comes from a range of departments with a stake in drugs, 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 some drug-related research.

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. Subjects covered in research produced in the United Kingdom include addiction; risk factors; trends in drug use; harm reduction; prevention measures; the misuse of prescribed substances; the wider impact of substance misuse (e.g. domestic violence); the effectiveness of treatment interventions; cohort studies; and the attitudes and views of professionals who work alongside the drug-using population. In recent years, there has been a noticeable increase in the number of papers published on new psychoactive substances, including on their effects, clinical toxicology, methods for their detection and the populations using these substances; the ageing cohort of drug users, including the harms experienced by this group and the policy responses to this issue; and the use of particular substances by men who have sex with men during chemsex.

There are a large number of United Kingdom-based scientific journals publishing drug-related research. Departments of the UK Government as well as the devolved administrations also publish reports on the research they carry out. Work is also published independently by academic institutions.

Drug markets

Most of the identified drug supply chains to the United Kingdom 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.

Cocaine is produced in Colombia, Bolivia and Peru, with the Netherlands and Belgium being the main transit hubs within Europe for cocaine en route to the United Kingdom. The Netherlands and Belgium are the most significant sources of established synthetic stimulants, such as MDMA/ecstasy and amphetamines, while most new psychoactive substances bought online originate from China.

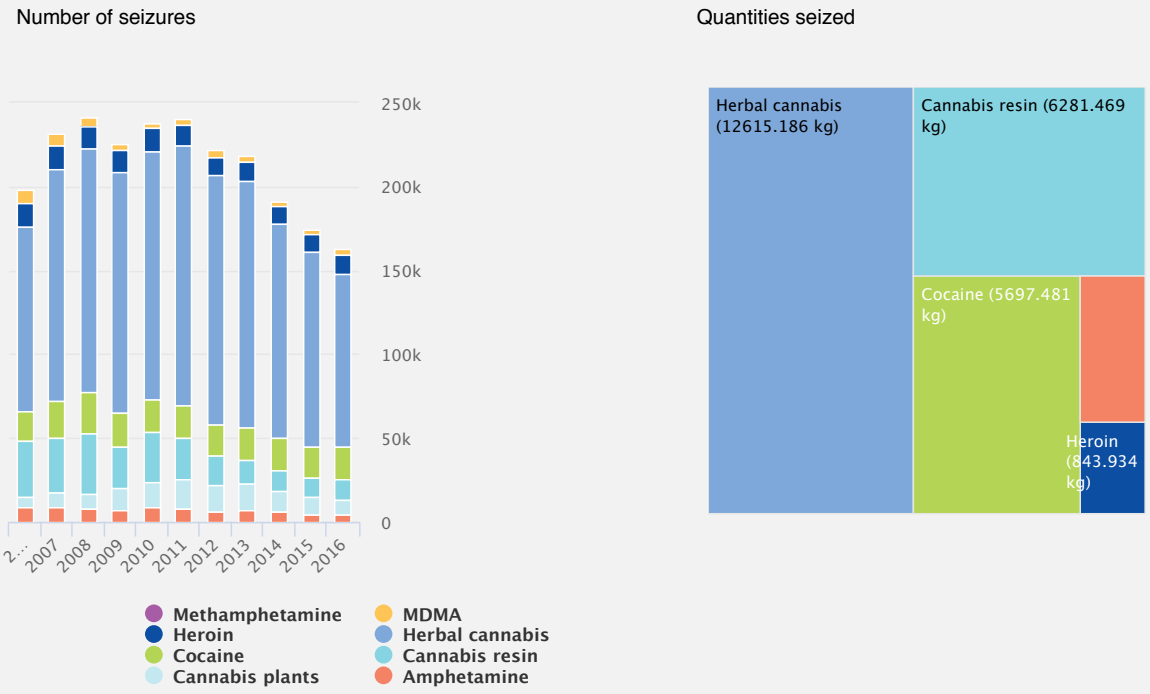
South and West Africa and the Caribbean are the main sources of herbal cannabis, while resin originates mainly from Morocco and Afghanistan. Branded strains of high potency flowering head cannabis are imported from the Netherlands. Cannabis is also cultivated in significant quantities across the United Kingdom, with production being controlled for the most part by British organised crime groups. Crack cocaine is converted domestically from imported cocaine powder. Amphetamine is also produced in the United Kingdom, with laboratories believed to be most commonly located in the north-west of England. Within the United Kingdom, supply chains take many forms, with varying numbers of transactions 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 seizures of herbal cannabis were reported to 2011/2012, with a steady drop thereafter.

The United Kingdom reports seizures of both cocaine powder and crack cocaine, with powder being seized more frequently. The number of heroin seizures has decreased since 2007/08, but have remained stable since around 2012/13. Nevertheless, the United Kingdom reports some of the highest numbers of heroin and cocaine seizures and quantities seized of both substances in Europe. 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 table.

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



NB: Year of data 2016. For cocaine data refers to cocaine powder only

Key statistics

Most recent estimates and data reported

	Year	Country data	EU range Min.	EU range Max.
Cannabis				
Lifetime prevalence of use - schools (% , Source: ESPAD)	n.a.	n.a.	6.5	36.8
Last year prevalence of use - young adults (%)	2016	11.5	0.4	21.5
Last year prevalence of drug use - all adults (%)	2016	6.6	0.3	11.1
All treatment entrants (%)	2016	25.2	1.0	69.6
First-time treatment entrants (%)	2016	45.2	2.3	77.9
Quantity of herbal cannabis seized (kg)	2016	31131.1	12	110855
Number of herbal cannabis seizures	2015	115716	62	158810
Quantity of cannabis resin seized (kg)	2016	7807.3	0	324379
Number of cannabis resin seizures	2015	11359	8	169538
Potency - herbal (% THC) (minimum and maximum values registered)	2016	n.a.	0	59.90
Potency - resin (% THC) (minimum and maximum values registered)	2016	n.a.	0	70
Price per gram - herbal (sinsemilia) (EUR) (min. and max. values registered)	2016	3.5 - 6.1	0.60	111.10
Price per gram - resin (EUR) (minimum and maximum values registered)	2016	3.5 - 6.1	0.20	38.00
Cocaine				
Lifetime prevalence of use - schools (% , Source: ESPAD)	n.a.	n.a.	0.9	4.9
Last year prevalence of use - young adults (%)	2016	4	0.2	4.0
Last year prevalence of drug use - all adults (%)	2016	2.3	0.1	2.3
All treatment entrants (%)	2016	15.5	0.0	36.6
First-time treatment entrants (%)	2016	19.5	0.0	35.5
Quantity of cocaine seized (kg)	2016	4316.5	1	30295
Number of cocaine seizures	2015	18594	19	41531
Purity (%) (minimum and maximum values registered)	2016	1 - 96	0	99
Price per gram (EUR) (minimum and maximum values registered)	2016	48.8 - 146.4	3.00	303.00
Amphetamines				
Lifetime prevalence of use - schools (% , Source: ESPAD)	n.a.	n.a.	0.8	6.5
Last year prevalence of use - young adults (%)	2016	0.7	0.0	3.6
Last year prevalence of drug use - all adults (%)	2016	0.5	0.0	1.7
All treatment entrants (%)	2016	2.4	0.2	69.7
First-time treatment entrants (%)	2016	3.0	0.3	75.1
Quantity of amphetamine seized (kg)	2016	561.20	0	3380
Number of amphetamine seizures	2015	4631	3	10388
Purity - amphetamine (%) (minimum and maximum values registered)	2016	1 - 66	0	100
Price per gram - amphetamine (EUR) (minimum and maximum values registered)	2016	n.a.	2.50	76.00
MDMA				
Lifetime prevalence of use - schools (% , Source: ESPAD)	n.a.	n.a.	0.5	5.2
Last year prevalence of use - young adults (%)	2016	2.6	0.1	7.4
Last year prevalence of drug use - all adults (%)	2016	1.3	0.1	3.6
All treatment entrants (%)	2016	0.5	0.0	1.8
First-time treatment entrants (%)	2016	1.1	0.0	1.8
Quantity of MDMA seized (tablets)	2016	825516	0	3783737
Number of MDMA seizures	2015	3178	16	5259
Purity (MDMA mg per tablet) (minimum and maximum values registered)	2016	n.a.	1.90	462
Purity (MDMA % per tablet) (minimum and maximum values registered)	2016	n.a.	0	88.30
Price per tablet (EUR) (minimum and maximum values registered)	2016	6.1 - 12.2	1	26.00
Opioids				
High-risk opioid use (rate/1 000)	2011	8	0.3	8.1
All treatment entrants (%)	2016	49.6	4.8	93.4
First-time treatment entrants (%)	2016	22.4	1.6	87.4
Quantity of heroin seized (kg)	2016	882.1	0	5585

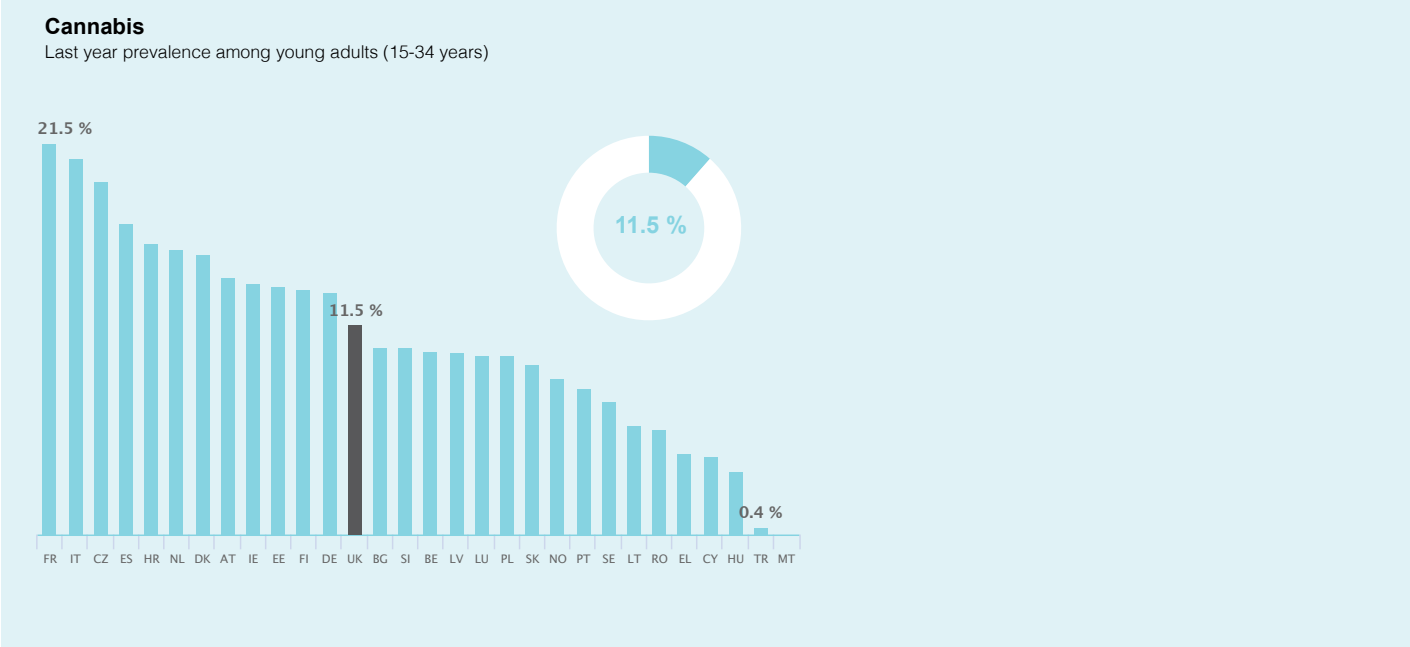
Number of heroin seizures	2015	10620	2	10620
Purity - heroin (%) (minimum and maximum values registered)	2016	1 - 92	0	92
Price per gram - heroin (EUR) (minimum and maximum values registered)	2016	48.8 - 73.2	4.00	296.00
Drug-related infectious diseases/injecting/death				
Newly diagnosed HIV cases related to Injecting drug use -- aged 15-64 (cases/million population, Source: ECDC)	2016	1.6	0	33.00
HIV prevalence among PWID* (%)	n.a.	n.a.	0	31.50
HCV prevalence among PWID* (%)	n.a.	n.a.	14.60	82.20
Injecting drug use -- aged 15-64 (cases rate/1 000 population)	2011	3	0.1	9.2
Drug-induced deaths -- aged 15-64 (cases/million population)	2015	69.93	1.40	132.30
Health and social responses				
Syringes distributed through specialised programmes	n.a.	n.a.	22	6469441
Clients in substitution treatment	2016	138422	229	169750
Treatment demand				
All entrants	2016	119973	265	119973
First-time entrants	2016	39059	47	39059
All clients in treatment	2016	237405	1286	243000
Drug law offences				
Number of reports of offences	2015	115377	775	405348
Offences for use/possession	2015	73180	354	392900

* PWID — People who inject drugs.

Prevalence of drug use data, price/purity data, Clients in substitution treatment refer to England and Wales only. Price/purity data are for stree/retail level and for cocaine are for cocaine powder only. Injecting drug use (cases rate / 1 000 population) corresponds to 2004-2011. Data for price of Amphetamine available: 28g; 85.4€ - 244€

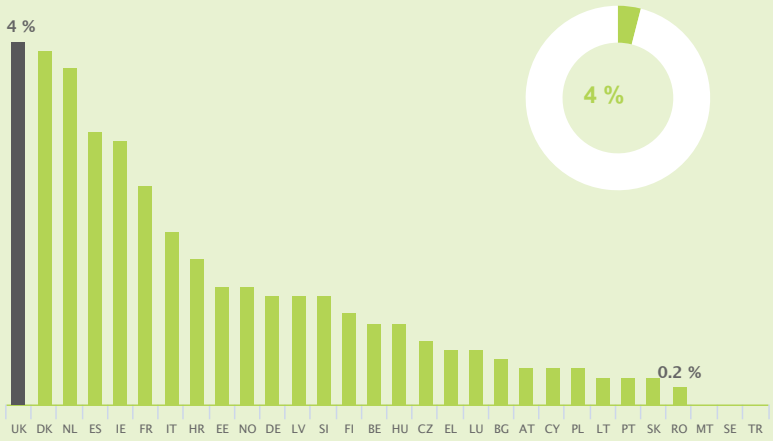
EU Dashboard

EU Dashboard



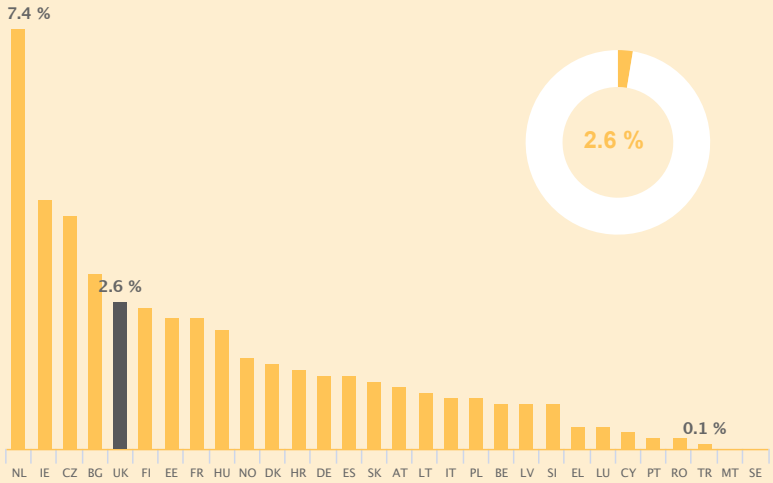
Cocaine

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



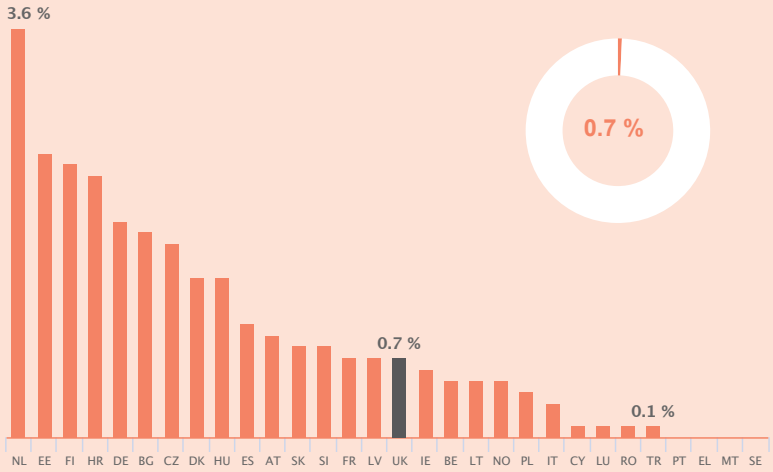
MDMA

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



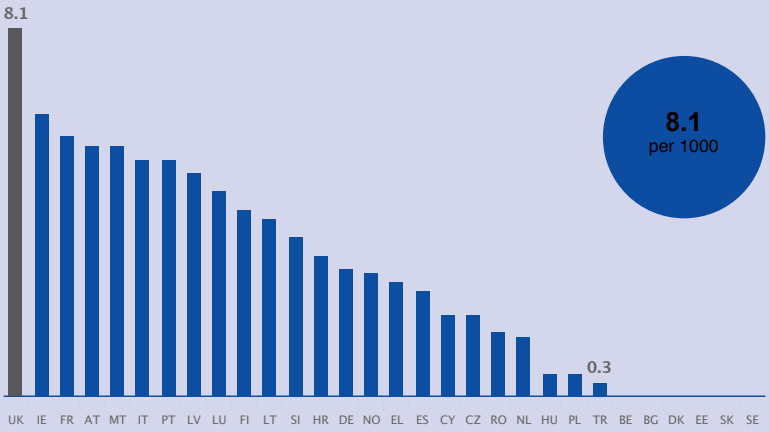
Amphetamines

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



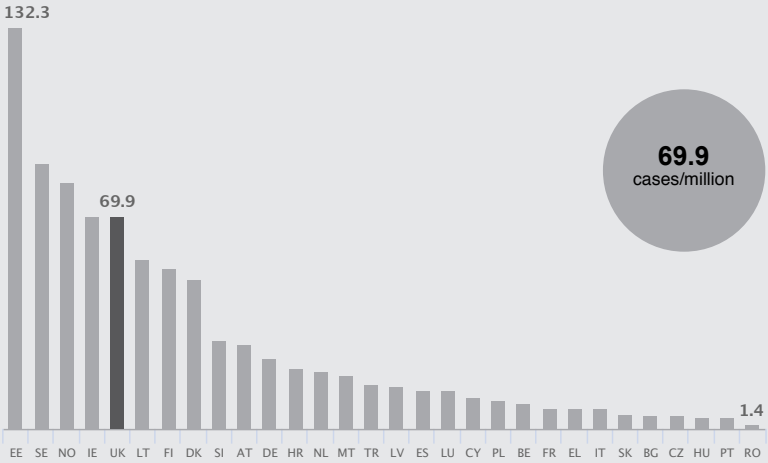
Opioids

High-risk opioid use (rate/1 000)



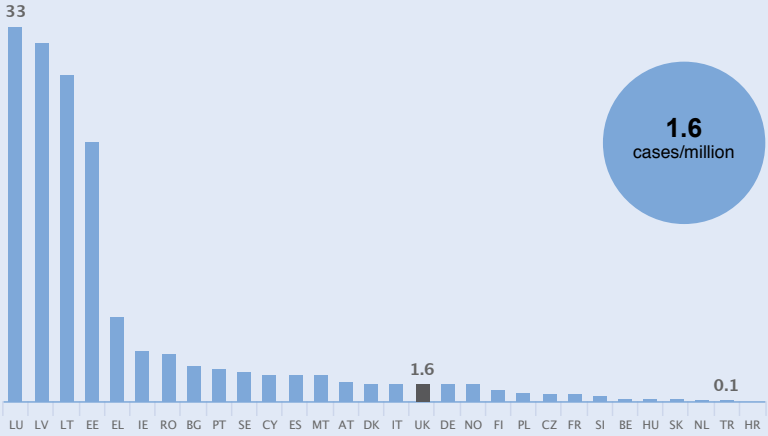
Drug-induced mortality rates

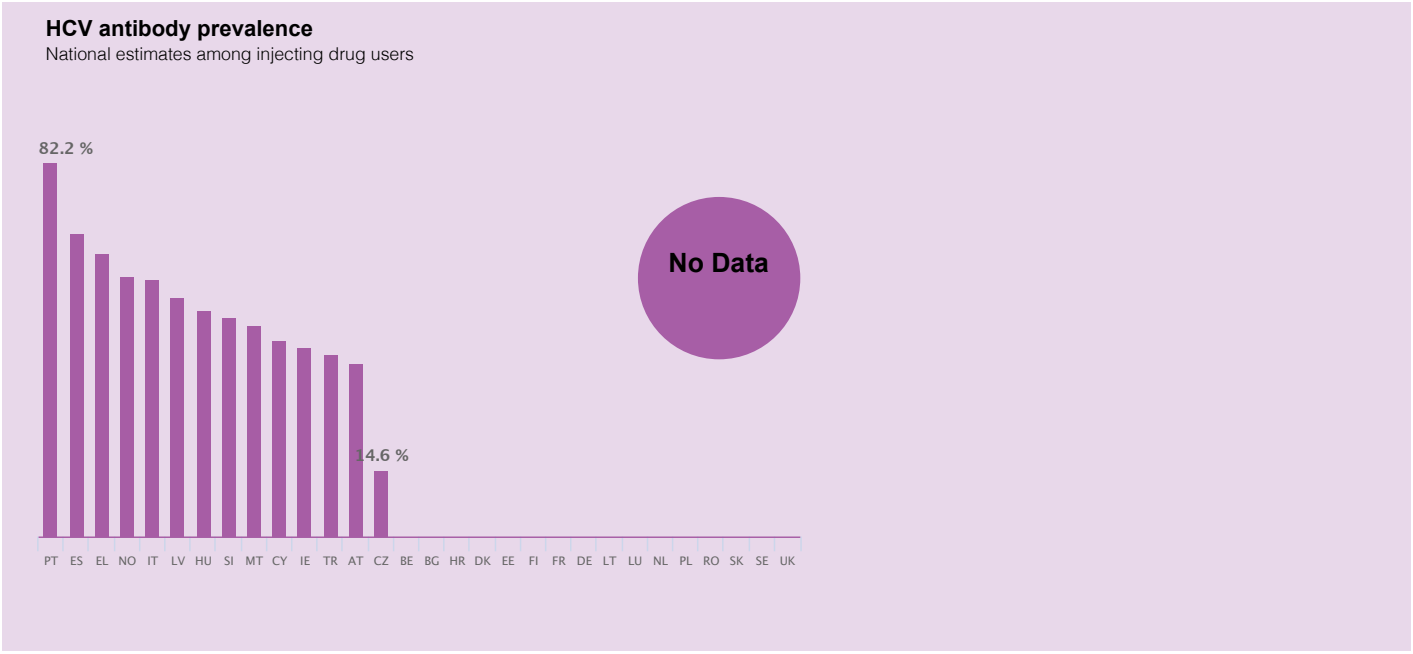
National estimates among adults (15-64 years)



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, di?erences may be due to reporting practices. Detailed information on methodology, qualifcations on analysis and comments on the limitations of the information available can be found in the EMCDDA Statistical Bulletin. Countries with no data available are marked in white. The age range for last year prevalence among young adults is 16 -34."

UK Focal Point On Drugs

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.

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