European Monitoring Centre for Drugs and Drug Addiction

UK Focal Point On Drugs

United Kingdom

Country Drug Report 2017

THE DRUG PROBLEM IN THE UNITED KINGDOM AT A GLANCE

Drug use

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

Cannabis

11.3 %

7.2 % 15.5 %

Other drugs

Cocaine	4 %
MDMA	3.1 %
Amphetamines	0.9 %

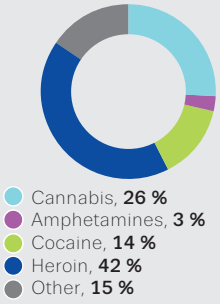
High-risk opioid users

330 445

(324 048 - 342 569)

Treatment entrants

by primary drug



Opioid substitution treatment clients

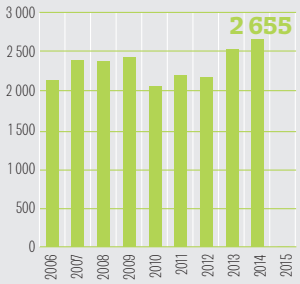
142 085

Syringes distributed

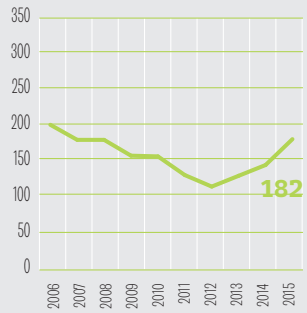
through specialised programmes

No data

Overdose deaths



HIV diagnoses attributed to injecting



Source: ECDC

Drug law offences

128 260

Top 5 drugs seized

ranked according to quantities measured in kilograms

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

Population

(15-64 years)

41 898 460

Source: EUROSTAT
Extracted on: 26/03/2017

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 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.

About this report

This report presents the top-level overview of the drug situation 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 2015 (or most recent year) and are provided to the EMCDDA by the national focal point, unless stated otherwise.

An interactive version of this publication, containing links to online content, is available in PDF, EPUB and HTML format: www.emcdda.europa.eu/countries

National drug strategy and coordination

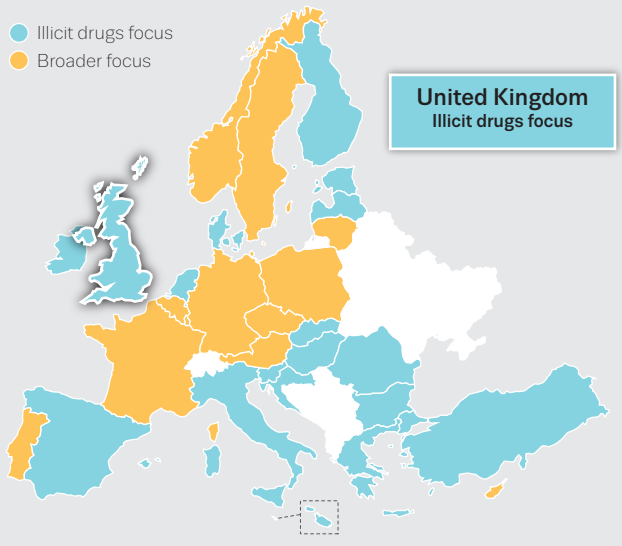
National drug strategy

Launched in 2010, the United Kingdom's (UK) Drug Strategy 2010: Reducing Demand, Restricting Supply, Building Recovery addresses illicit drugs and has two overarching aims: (i) to reduce illicit and other harmful drug use; and (ii) to increase the number of people recovering from their dependence (Figure 1). These aims are addressed though three thematic areas: (i) reducing demand; (ii) restricting supply; and (iii) building recovery in communities. The UK Government is responsible for the strategy and its delivery in the devolved administrations only in matters where it has reserved power. Within the strategy, policies concerning health, education, housing and social care are confined to England, while those for policing and the criminal justice system cover both England 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. Strategies in Northern Ireland and Wales address both illicit drugs and alcohol.

FIGURE 1

Focus of national drug strategy documents: illicit drugs or broader



NB: Year of data 2015. 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.

All European countries evaluate their drug policies and strategies through ongoing indicator monitoring and specific research projects. Both the UK's and all the devolved administrations' drug strategies are subject to annual implementation progress reviews. None of the current strategies has been formally evaluated, but a framework for evaluating the UK's strategy focused on costs and benefits was published in 2013.

The UK drug strategy's overarching aims are (i) to reduce illicit and other harmful drug use; and (ii) to increase the number of people recovering from their dependence

National coordination mechanisms

In the UK, the Home Office has lead responsibility for the coordination of the delivery of the UK drug strategy on behalf of the government and chairs the Inter-Ministerial Group on Drugs. 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 to expenditure on tasks related to drugs are identified as such in the budget ('labelled'). Often, however, the majority of drug-related expenditure is not identified ('unlabelled') and must be estimated using modelling approaches.

No budgets are allocated under the UK's drug strategies. Budget allocations are provided annually to the entities in charge of providing services.

Comprehensive estimates of both labelled and unlabelled expenditure were provided for 2005 and 2010, but these are not comparable. They used different methods and estimated different elements of expenditure.

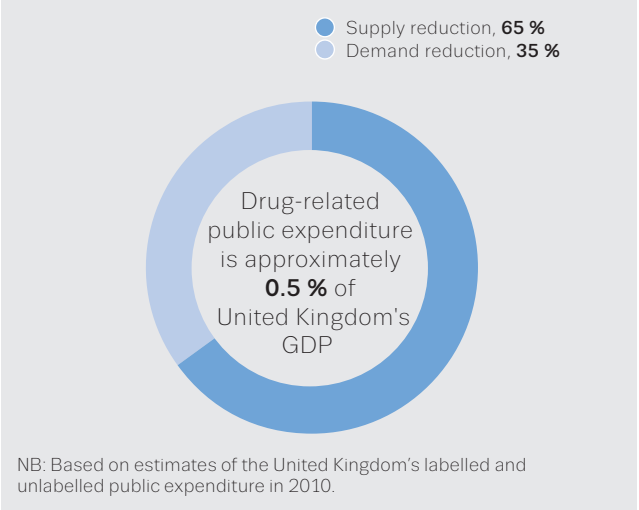
The authorities funded three studies on economic and social costs, in 2002, 2006 and 2013. Between 2005 and 2010, labelled expenditure was estimated every year through administrative records, but levels of unlabelled expenditure were rarely available.

In 2010, total drug-related expenditure, including expenditure on some indirect consequences of drug use, was around EUR 8.4 billion and represented 0.5 % of gross domestic product (GDP), with 64.9 % financing public order and safety, 22.5 % for social protection and 11.7 % for health. This distribution was identical for both total and unlabelled expenditure. From a total of EUR 1.1 billion for labelled expenditure, 64.5 % was allocated to health, 28.4 % to public order and safety, 6.0 % to general public services, 1.0 % to social protection and 0.1 % to education (Figure 2).

Trend analysis shows that, between 2005 and 2010, labelled expenditures remained broadly stable in terms of percentage of GDP (varying between 0.07 % and 0.08 % of GDP). In the years up to 2010, some labelled expenditures have declined, mainly as a result of the mainstreaming of certain grants and a reduction in expenditure on counter-narcotics work in Afghanistan. Budgets for items that require large expenditures, such as drug treatment, have seen funding levels maintained in cash terms.

FIGURE 2

Public expenditure related to illicit drugs in the United Kingdom



NB: Based on estimates of the United Kingdom's labelled and unlabelled public expenditure in 2010.

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 UK. 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.

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 penalties 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 barbiturates, 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 considerable powers of discretion (Figure 3).

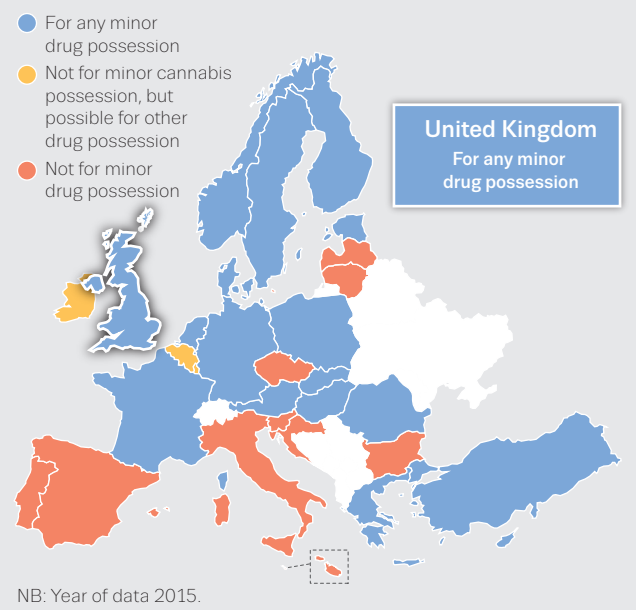
Under the Misuse of Drugs Act 1971, a distinction is made between the possession of controlled drugs and possession with intent to supply to another; the latter is, effectively, refers to drug trafficking offences. The Drug Trafficking Act 1994 defines drug trafficking as transporting or storing, importing 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, while trafficking of Class B and C drugs can incur a penalty of up to 14 years in prison. Under Section 110 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 knowing that it is to be used for its psychoactive effects.

Supply offences are aggravated by proximity to 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 on summary conviction.

FIGURE 3

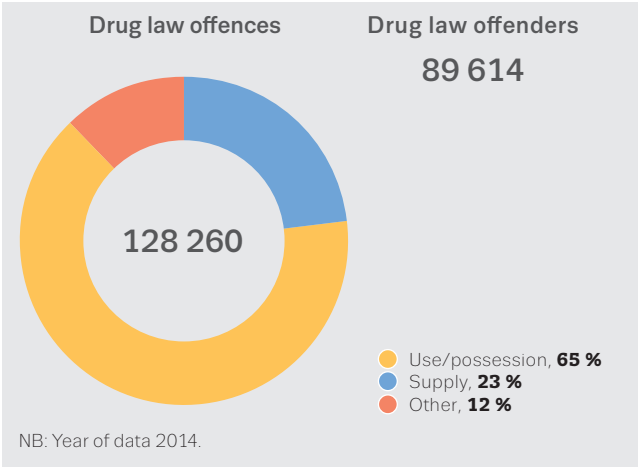
Legal penalties: the possibility of incarceration for possession of drugs for personal use (minor offence)



NB: Year of data 2015.

FIGURE 4

Reported drug law offences and offenders in the United Kingdom



NB: Year of data 2014.

Drug law offences

Drug law offences (DLO) data are a measure of law enforcement activity and drug market dynamics and may be used to inform policies. After increasing between 2006/07 and 2010/11, the number of arrests for drug law offences has decreased in recent years, although they remain higher than the levels before 2006/07. In 2014, approximately 128 260 convictions or cautions for drug offences were reported in England, Wales, Scotland and Northern Ireland (Figure 4). Of the offences in which the drug involved was recorded (in England, Wales and Scotland), 50.8 % were cannabis related, 14.5 % were cocaine related (excluding crack cocaine) and 8.9 % were heroin related.

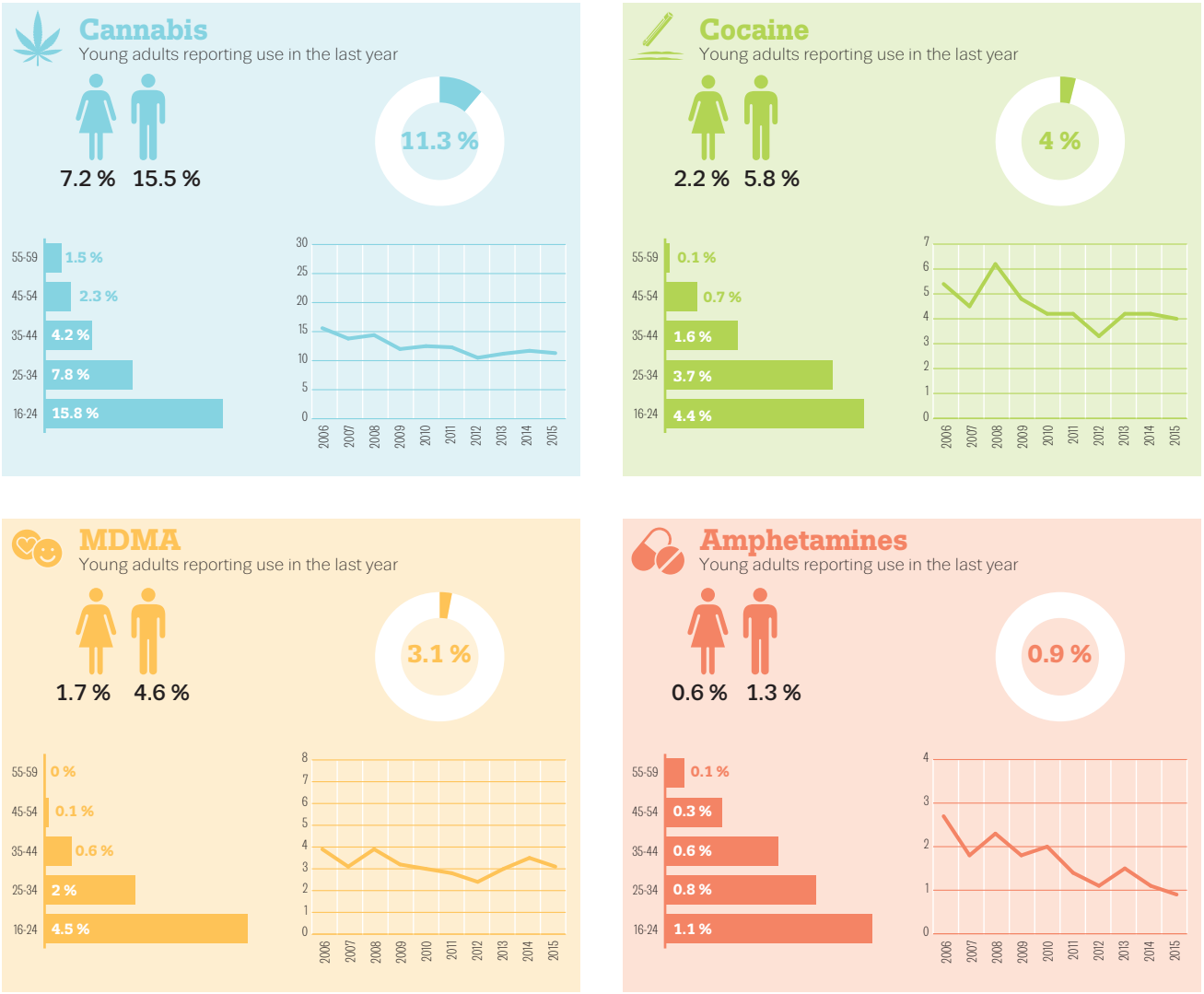
Drug use

Prevalence and trends

Overall, drug use in the UK has declined over the last 10 years; however, because of its relatively high prevalence, cannabis has remained a substantial driver of this overall drug trend. Cannabis remains the most commonly used illicit drug, while powder cocaine is the most prevalent stimulant in the UK and the second most prevalent drug overall, with a peak reported in 2007/08. MDMA/ecstasy is the next most commonly reported stimulant. In general, MDMA users are younger than cocaine and amphetamines users (Figure 5).

FIGURE 5

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 2015.

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 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 was the most prevalent drug reported by the school surveys and shows a downward trend (and possible levelling off) that is similar to the trend for the general population. The pattern in school surveys is not unique to cannabis and is 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 community level, based on the levels of different illicit drugs and their metabolites in sources of wastewater. The level of cocaine metabolites was higher in wastewater samples from London than in samples from Bristol. This is consistent with data from other countries with multiple locations, which indicate higher levels in larger cities. Nevertheless, the results pointed to increases in cocaine use in London and Bristol since the initiation of the study (2011 and 2014, respectively); however, the increasing trend seems to have levelled off for London. Furthermore, higher levels of cocaine metabolites were detected at weekends.

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 the first-time entrants to specialised drug treatment centres, when considered alongside other indicators, can inform understanding of the nature and trends in high-risk drug use (Figure 7).

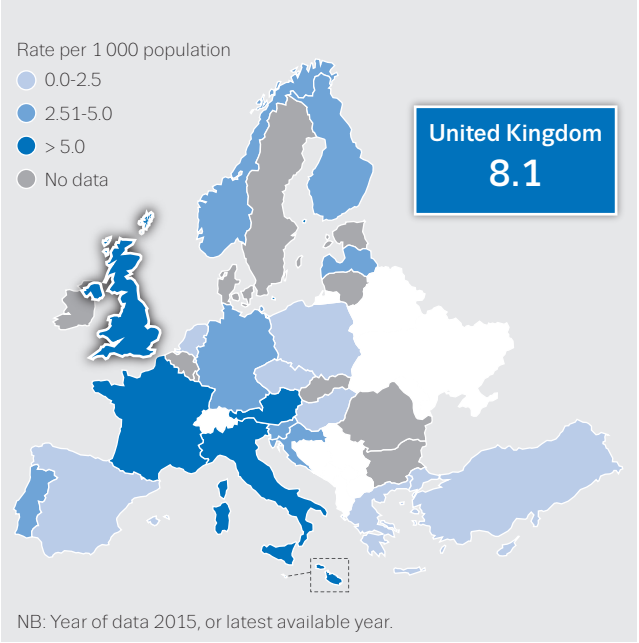
Opioids, particularly heroin, remain associated with the highest health and social harm caused by illicit drugs in the UK (Figure 6). There are current concerns about changes in the patterns of drug injection in the UK, in particular the increased injection of amphetamines and the emergence of injection of NPS. While it appears that there had been a decline in the injection of opioids and crack cocaine in England, opioids remain the most commonly injected drug.

Opioids, particularly heroin, remain associated with the highest health and social harm caused by illicit drugs in the UK

Data on the characteristics of those entering treatment in the UK also indicate that opioids (mainly heroin) are the most commonly reported primary substances among those seeking treatment for drug use problems, followed by cannabis. Among first-time treatment clients, cannabis is the most commonly reported substance, followed by cocaine. The long-term trend indicates a steady increase in the age of opioid users seeking treatment. Recent trends in heroin treatment demand indicate that the decreasing trend reported in previous years seems to have been halted (Figure 7).

FIGURE 6

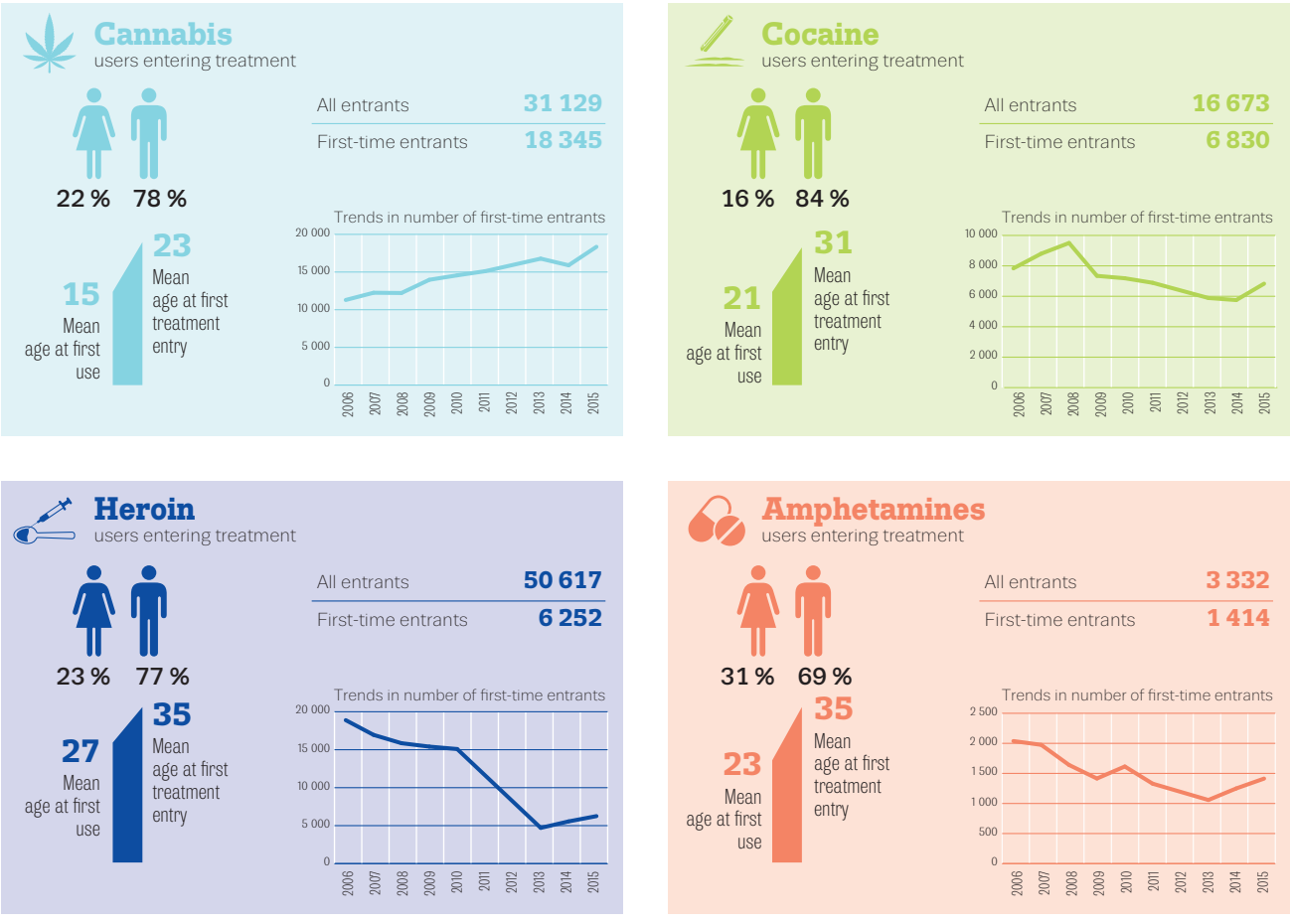
National estimates of last year prevalence of high-risk opioid use



NB: Year of data 2015, or latest available year.

FIGURE 7

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



NB: Year of data 2015. Data is for first-time entrants, except for gender which is for all treatment entrants.
2015 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

Data on the prevalence of blood-borne infectious diseases among people who inject drugs (PWID) are available from the Unlinked Anonymous Monitoring (UAM) survey of current and former PWID attending drug services in England, Wales and Northern Ireland. There are also regular sero-behavioural surveys of PWID attending needle and syringe programmes in Scotland. Other sources of information on blood-borne infections are laboratory reports, which are collected separately for England, Wales, Scotland and Northern Ireland.

The latest notification data show that, in 2015, there were 182 new cases of human immunodeficiency virus (HIV) infection thought to be a result of injecting drug use (Figure 8); this is an increase from 146 new cases in 2014.

The overall prevalence of HIV amongst PWID in 2015 was similar to that seen in recent years and remains higher than in the late 1990s (Figure 9).

It is estimated that around 90 % of all cases of hepatitis C virus (HCV) infection 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 2015, 6 out of 10 PWID were HCV positive. There are marked geographical variations in HCV prevalence across the United Kingdom, and prevalence is lower in Northern Ireland than in the rest of the UK. The prevalence of antibodies to HCV among recent initiates to injecting drug use has also been fairly stable.

The prevalence of hepatitis B virus (HBV) infection among PWID in England, Wales and Northern Ireland has remained relatively stable in recent years and varies by country, but 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 2015, there was an outbreak of botulism among PWID in Scotland, which was part of the largest cluster of botulism seen among PWID in Europe.

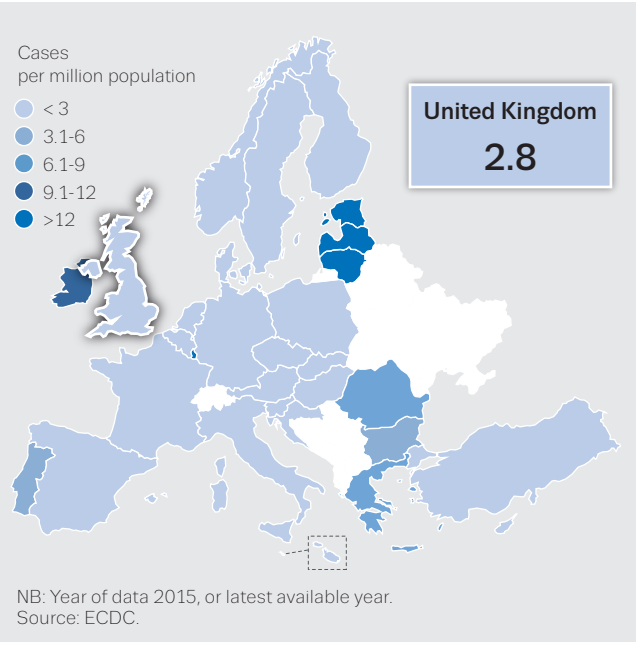
Drug-related emergencies

Data on drug-related emergencies in the UK are available from hospital inpatient data.

In 2013/14, hospital inpatient data showed that 41 628 inpatient discharges recorded poisoning by drugs in the UK, which was an increase from 2012/13.The majority were due to 'other opioids including morphine and codeine', and this number has increased every year since 2008.

FIGURE 8

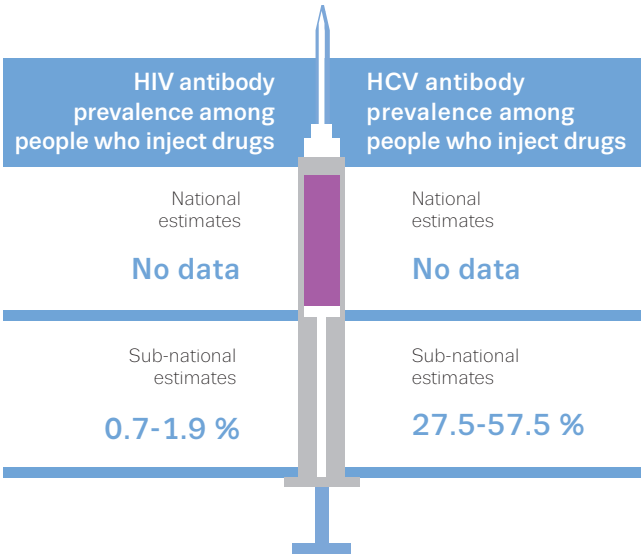
Newly diagnosed HIV cases attributed to injecting drug use



NB: Year of data 2015, or latest available year.
Source: ECDC.

FIGURE 9

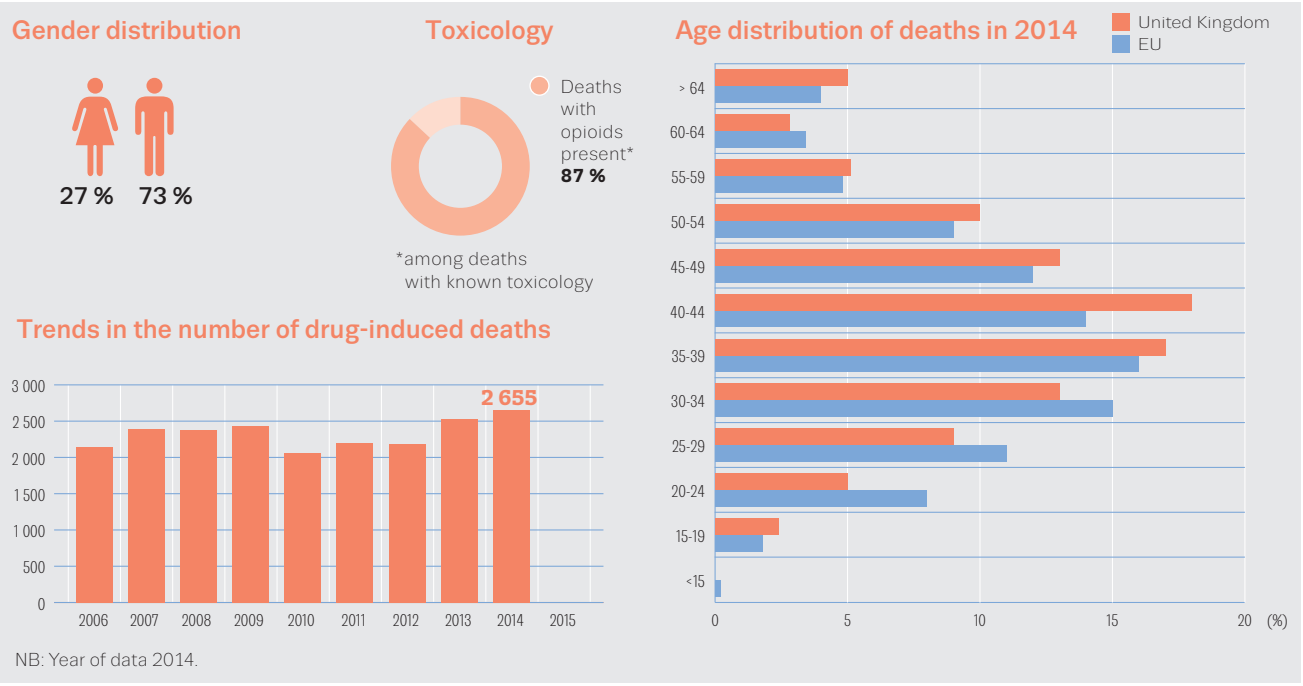
Prevalence of HIV and HCV antibodies among people who inject drugs in the United Kingdom



NB: Year of data 2015.
HIV range is 0.0 (Wales) to 1.9 (Scotland). Range 0.65 to 1.00 is for NI and EW. HCV range is 22.3 (Wales) to 57.5 (Scotland). Range 27.5 (NI) and 51.8 (EW).

FIGURE 10

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



NB: Year of data 2014.

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

Drug-induced deaths and mortality

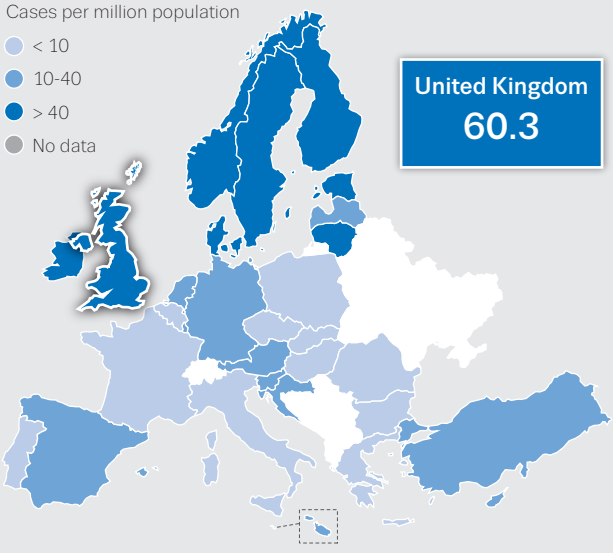
Drug-induced deaths are deaths directly attributable to the use of illicit drugs (i.e. poisonings and overdoses).

Drug-induced death is the fifth most common cause of preventable death among 15- to 49-year-olds in the United Kingdom. In 2014, the United Kingdom reported a record number of drug-induced deaths. Because of delays in the registration of deaths, the number of deaths in 2015 is not yet known, but statistics published so far on the number of deaths registered in 2015 suggest that a further increase is likely. Heroin is involved in the majority of deaths, and other drugs commonly associated with deaths from illicit substance use include benzodiazepines, cocaine and amphetamines. The number of deaths linked to NPS use is relatively low, but has increased greatly since 2010. In England, there were 107 NPS-related deaths in 2015, compared with 82 in 2014. In 2014, almost three quarters of victims were male and the mean age at time of death was 41.6 years (Figure 10).

The drug-induced mortality rate among adults in the United Kingdom (aged 15-64 years) was 60.3 deaths per million in 2014, almost three times the most recent European average of 20.3 deaths per million (Figure 11).

FIGURE 11

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



NB: Year of data 2015, or latest available year.

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. 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 approaches, which are complementary. Environmental and universal strategies target entire populations, selective prevention targets vulnerable groups that may be at greater risk of developing drug use problems and indicated prevention focuses on at-risk individuals.

Drug prevention is part of the national curriculum throughout most of the United Kingdom, with a focus on building resilience in young people, 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 the non-statutory personal, social and health education (PSHE) programme. To improve the implementation of this programme, the Alcohol and Drug Education and Prevention Information Service (ADEPIS) has introduced quality standards for schools that cover the delivery of effective alcohol and drug education in the classroom. 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. A diversionary and educational initiative delivered by Police Scotland, Choices for Life, aims to give young people credible information on drugs and also allows teachers and other educators to exchange prevention practices. For example, specific activities addressing NPS were introduced in 2014. In Wales, drug prevention initiatives are included as part of the All Wales School Liaison Core Programme, which targets pupils aged 5-16, and, in Northern Ireland, the school curriculum puts 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 programmes, have been piloted in the UK (Figure 12).

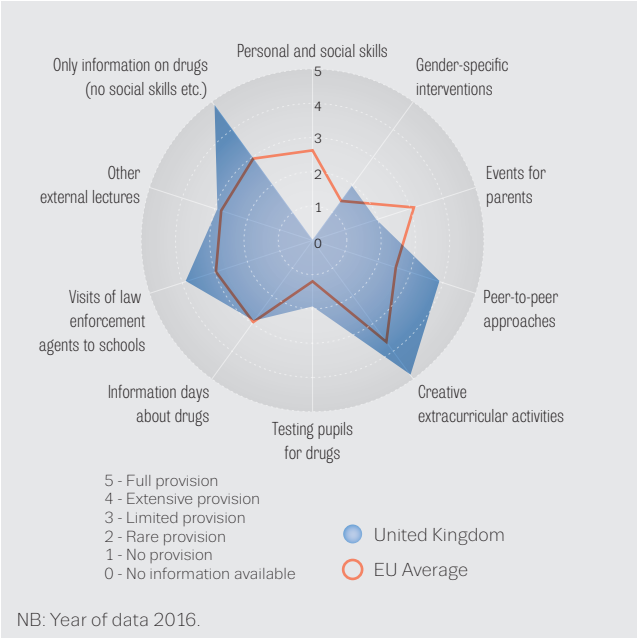
Rise Above, which is an online resource for young people, was launched in 2014 by Public Health England (PHE). Targeting 11- to 16-year-olds, Rise Above aims to build young people's skills by encouraging them to engage with a range of situational resources, rather than simply providing them with information. The Healthy Child Programme is the UK Government's early intervention and prevention programme and targets children from birth to 19 years. A new series of guides has been published to assist local authorities in commissioning and delivering services that provide an integrated approach to public health for children.

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. Another important element of selective and indicated prevention activities in the UK is the focus on vulnerable young people, such as young offenders, looked-after children, young homeless people, ethnic and sexual minorities, young people in deprived neighbourhoods and young people from families with parents that have substance use problems, through special programmes at a community level. Integrated Family Support Services, which are available across most of Wales, provide support for families with parental substance misuse issues.

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.

FIGURE 12

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



NB: Year of data 2016.

Harm reduction

Reducing the drug-induced deaths, infectious diseases, comorbidity and other health consequences are key policy issues within the United Kingdom's drug strategies.

The structure and organisation of harm reduction services in the United Kingdom is complex. Funding for such initiatives can be through local authorities and specialist treatment services or, sometimes, through related services, such as sexual health clinics and blood-borne virus vaccination services.

Harm reduction interventions

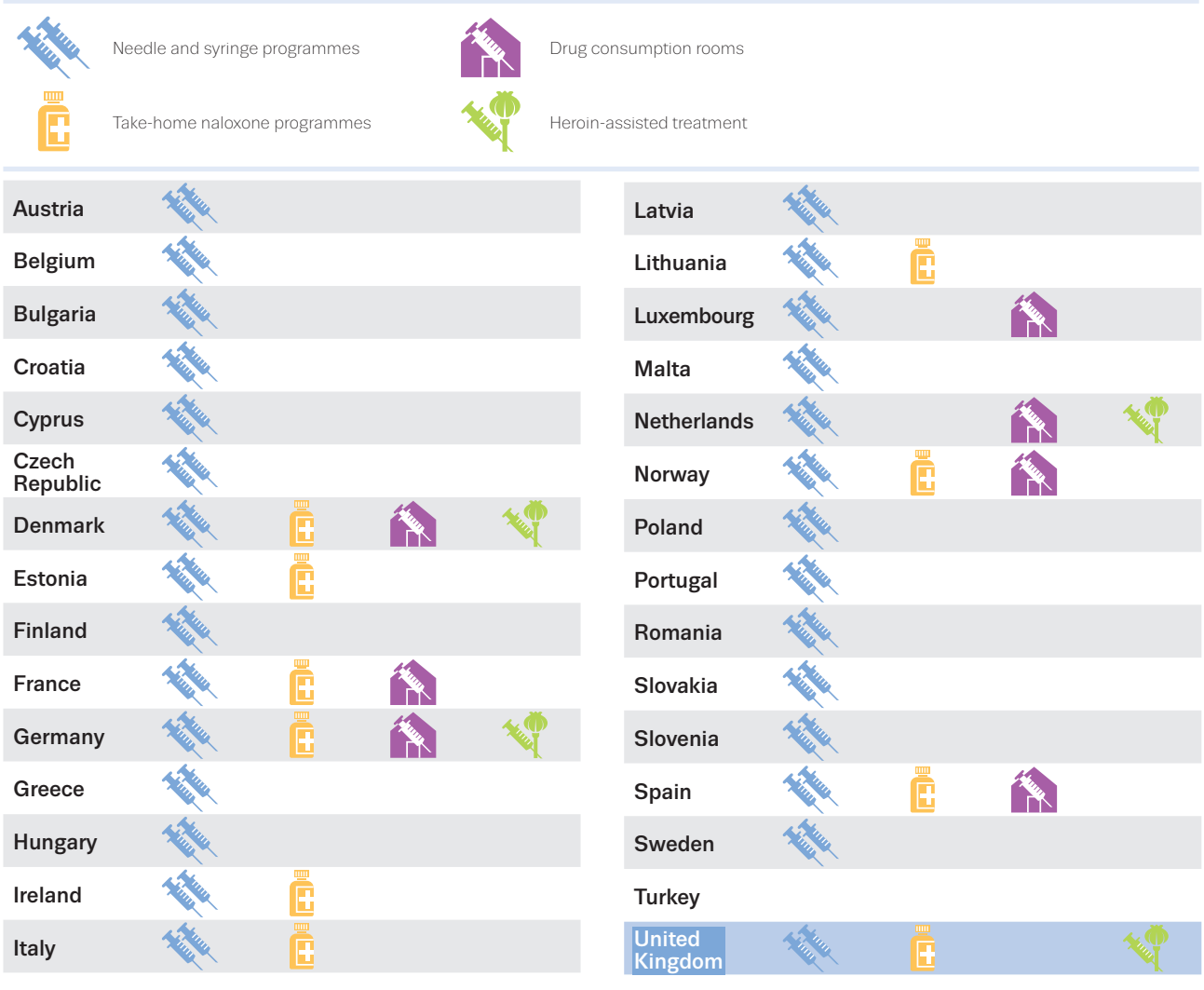
Harm reduction intervention in the UK cover activities such as information campaigns on the risks associated with drug use; information on safer injecting and safer sex; provision of free needles, syringes and other equipment; promotion of safe disposal of used equipment; infection counselling; support and testing; vaccinations against HBV; referral to drug treatment; treatment for HIV and HCV infection; and the provision of take-home naloxone and training of drug users and their family members on its use (Figure 13).

In April 2014, updated public health guidance on needle and syringe programmes was issued by the National Institute for Health and Care Excellence (NICE).

Sterile 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.

FIGURE 13

Availability of selected harm reduction responses



NB: Year of data 2016.

Services are available across all regions of the United Kingdom. The latest available estimates of the number of syringes distributed are almost 3.4 million for Wales in 2015/16, 4.4 million for Scotland in 2015/16 and almost 290 000 for Northern Ireland in 2014/15; data on syringes distributed in England are not available. The vast majority of the PWID in the UAM survey indicated that they had used needle and syringe programmes in 2015.

National naloxone programmes are implemented in Scotland, Wales and Northern Ireland; these allow the use of naloxone in non-clinical settings, such as hostels, and facilitate the distribution of naloxone kits to those at risk of overdose and to their families and carers.

The United Kingdom has a targeted hepatitis B vaccination programme that is focused on the most at-risk population groups, including PWID. The most recent surveys show that around three quarters of PWID report uptake of hepatitis B vaccination.

National naloxone programmes are implemented in Scotland, Wales and Northern Ireland

Treatment

The treatment system

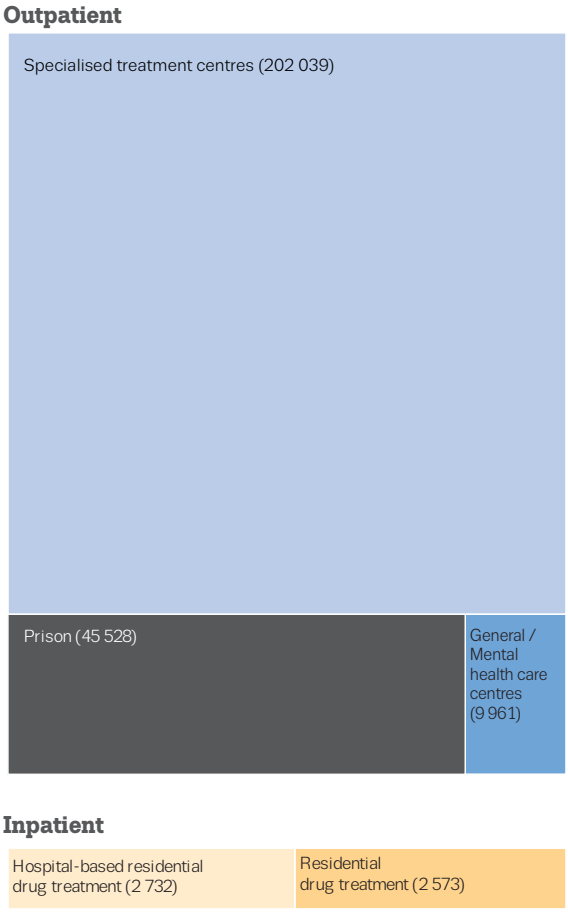
The UK drug strategies identify treatment as being effective in tackling problem drug use and seek to improve its quality and effectiveness. Coordination and integration across a range of service providers is seen as key in helping problem drug users integrate into society.

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 PHE, 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 UK encompasses a range of available treatments and services, including community- and primary care-based prescribing, community one-to-one and group-based psychosocial interventions to support recovery,

FIGURE 14

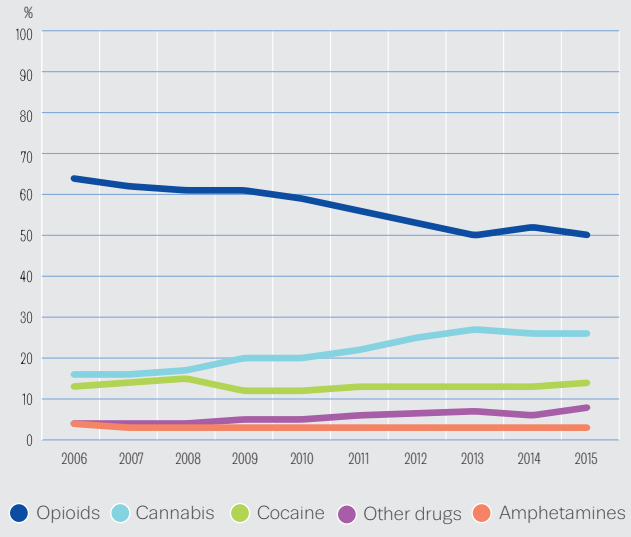
Drug treatment in England and Wales: settings and number treated



NB: Year of data 2015.

FIGURE 15

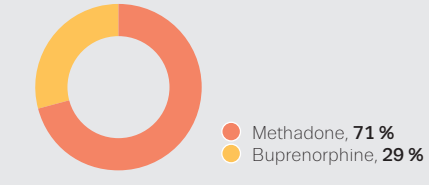
Trends in percentage of clients entering specialised drug treatment, by primary drug, in the United Kingdom



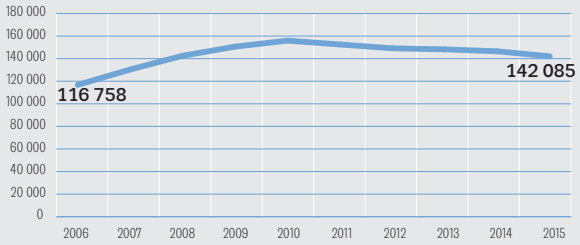
NB: Year of data 2015. 2015 data include clients entering treatment in prison settings and, therefore, data is not directly comparable with previous years.

FIGURE 16

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



Trends in the number of clients in OST



NB: Year of data 2015. Share of clients by type of medication are for England. Data for Wales available (36% buprenorphine; 64% methadone).

inpatient treatment, day programmes and quasi- and full-time residential drug treatment and rehabilitation support. Local areas across the United Kingdom are expected to provide a wide range of services, including information and advice, screening, care planning, psychosocial interventions, community prescribing, inpatient drug treatment and residential rehabilitation. In addition, drug users should be offered aftercare and relapse prevention programmes, HBV vaccination, testing for HBV, HCV and 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 treated in the United Kingdom receive treatment in an outpatient setting, including some who receive treatment in the community before or after attending a residential unit (Figure 14).

Opioid substitution treatment (OST) remains the most common treatment in the United Kingdom for opiate users, and is mainly offered through specialist outpatient drug services, commonly in shared care arrangements with general practitioners (Figure 16). 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. Furthermore, prescribed injectable methadone and diamorphine are also available in England, but are rarely provided.

Treatment provision

About one third of the 124 234 clients who presented for treatment in the United Kingdom during 2015 had never been treated previously. Just under half of all clients were primary opioid users, although this figure rises to 64 % among those who had been treated previously (Figure 15). Cannabis is the most frequently reported primary drug among first treatment presentations, and has increased in importance in recent years (Figure 7). The United Kingdom is the European country reporting the highest number of clients starting treatment for opioids; in addition, the numbers of clients reported entering treatment for primary use of crack cocaine and synthetic cathinones are higher than in other European countries.

The number of opioid users prescribed treatment has decreased slightly since the 2010 peak, although it remains above 2006 levels. In 2015, about 142 085 patients were receiving OST in England and Wales (Figure 16). The number of new clients entering treatment for heroin use decreased for several years, but now seems to have stabilised (Figure 7). These trends should be carefully monitored in the coming years.

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. Drug strategies from each of the three administrations aim to reduce the supply of and demand for illicit substances, while also focusing on the treatment and recovery of prisoners with substance misuse 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. The use of NPS, in particular synthetic cannabinoids, has recently become common in some English prisons, and survey data suggest these substances are now more prevalent in prisons than heroin. Use of NPS, in particular synthetic cannabinoids, has been associated with recent increases in violence, self-harm incidents, presentation to emergency departments and deaths in prison, as well as mental health issues, medical emergencies, debt, bullying and intimidation. The Psychoactive Substances Act 2016 made it an offence to be in possession of a substance capable of producing a psychoactive effect (with exceptions) in a custodial institution.

Across the United Kingdom, responsibility for healthcare provision in prisons lies with the health services. Prisoners have access to a range of treatment services for substance use problems, including clinical services such as detoxification and OST, 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 England in 2014. Take-home naloxone is widely available in Scotland for prisoners who are at risk of opioid overdose on release and is becoming increasingly available in England and Wales. 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.

Use of NPS, in particular synthetic cannabinoids, has been associated with increases in violence, self-harm incidents and deaths in prison, as well as mental health issues, medical emergencies, debt, bullying and intimidation

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. Various organisations are involved in the promotion of best practice and the quality assurance of services, including the devolved administrations, NICE, PHE, the Department of Health 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.

The 2007 clinical guidelines, Drug Misuse and Dependence: UK Guidelines on Clinical Management, provide guidance for clinicians delivering drug treatment in the United Kingdom. Clinical guidelines and technology appraisals apply only to those using the National Health Service (NHS) in England and Wales and are usually disseminated following local review in Northern Ireland.

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. 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 (NCAC) scheme, which is a professional certification for drug and alcohol counsellors who want to provide counselling or psychotherapy to individuals, couples and families.

Front-line workers in the field of substance use are offered training and qualifications in the Drug and Alcohol National Occupational Standards as part of their development. Higher education institutions in the United Kingdom offer a wide range of academic courses, particularly at postgraduate level, focusing on drug and alcohol addiction, psychology, mental health and social work, and on the impact of addictions on individuals and society. There is an addiction specialisation in medicine, as well as opportunities for life-long continuing education for healthcare professionals.

The National Institute for Health and Care Excellence has produced a range of guidelines, technical appraisals and pathways relating to best practice and standards of care in the treatment of substance misuse

Drug-related research

The United Kingdom conducts a large quantity of drug-related research, which originates mainly from university departments. Research is disseminated through articles published in academic peer-reviewed journals and reports, on websites, in official guidelines based on evidence-based practice, and quality standards and reported in oral presentations. The UK Government funds some of the drug-related research in the United Kingdom directly. Funding for drug-related research comes from a range of departments with a stake in drugs, including the Department of Health, 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 include cost-effectiveness studies; evaluations of how substance use services are funded to determine if the current method is effective; and the design and evaluation of interventions, especially those related to treatment and prevention. Scotland recently published its own separate National Research Framework for Problem Drug Use and Recovery, framing a number of high-level priorities for research.

A wide range of basic biological, neurobiological and behavioural research results have been published; the results of research on cannabis and cocaine are the most prevalent, although research into NPS is becoming more common. Most published research is centred on the negative effects of licit and illicit substances; however, some research has also focused on the potential usefulness of these substances. Drug use prevalence studies are widespread, including studies examining drug consumption trends. Research into associations of use and consequences of use has also been carried out. Studies looking at the prevalence of NPS use and the motivations behind substance use on a population level are becoming more widespread.

Research into demand reduction is focused on various topics, including novel treatment methods of treating substance use dependence; providing treatment to specific populations; and identifying common risks within certain populations. In order to measure the efficacy of harm reduction interventions, randomised controlled trials are often employed. Evaluations of prevention programmes have mainly used a cohort study methodology to understand the specific needs of the at-risk population. Systematic reviews measuring the efficacy of interventions aimed at reducing harm have also been published.

Research into supply and supply reduction has been limited in the UK.

Areas that are of current topical interest include cost-effectiveness studies; evaluations of how substance use services are funded; and the design and evaluation of prevention interventions

Drug markets

Most of the identified drug supply chains to the United Kingdom follow well-established trafficking routes. Heroin originates from Afghanistan and is brought in through either Pakistan or Iran.

Cocaine is produced in Colombia, Bolivia and Peru, with the Netherlands and Spain being the main transit hubs within Europe for cocaine en route to the United Kingdom. The Netherlands is the most significant source for established synthetic drugs, such as MDMA and amphetamines, while most NPS bought online originate from China.

Domestic production of high-potency cannabis does occur, although most cannabis comes from abroad; Africa and the Caribbean are the main sources of herbal cannabis, while resin originates mainly from Morocco and Afghanistan. Branded 'skunk' is imported from the Netherlands. Within the United Kingdom, supply chains take many forms, with varying numbers of transactions between the importer and the user.

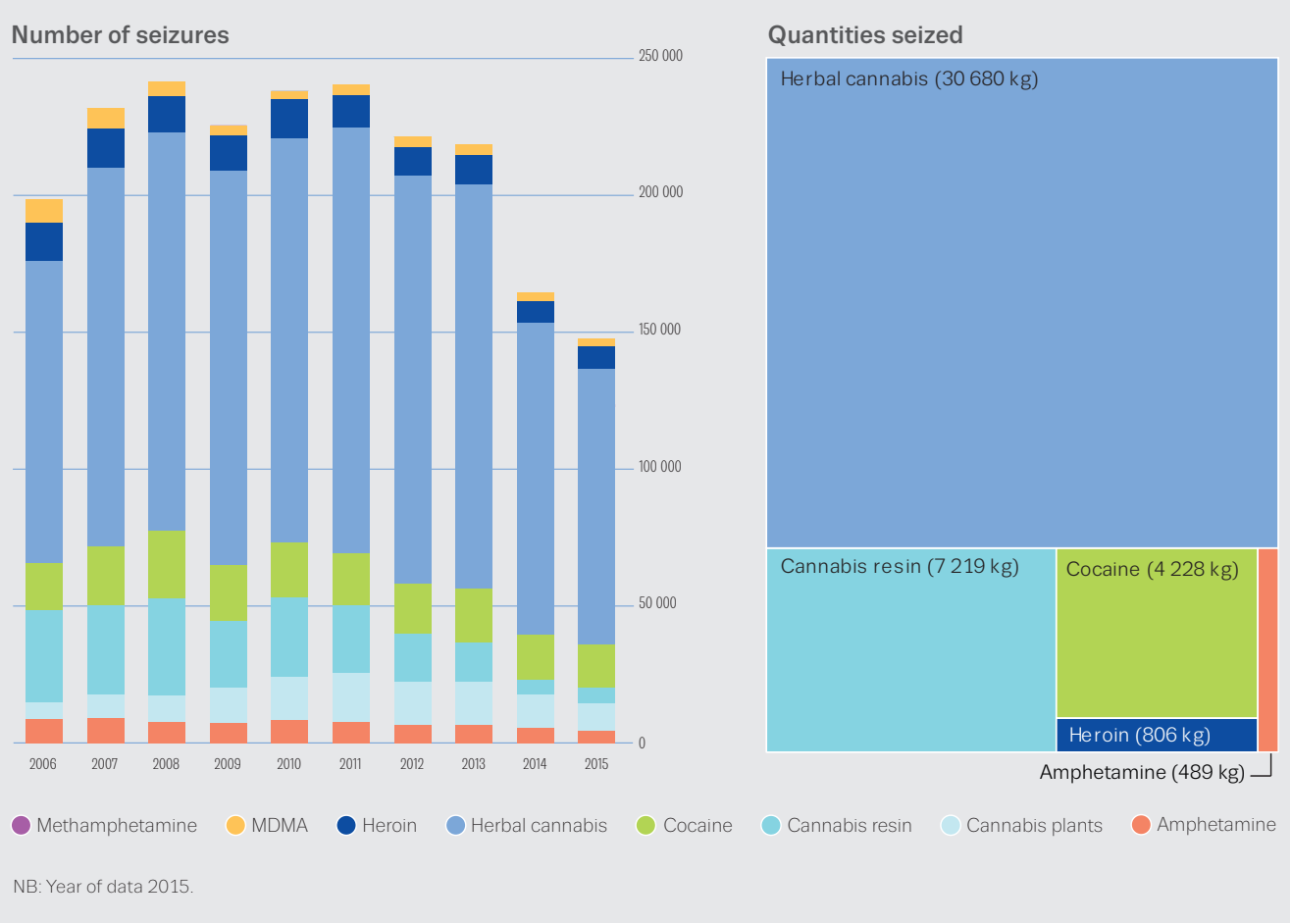
Cannabis is the most frequently seized drug in the United Kingdom, followed by cocaine. As UK drug seizure data have not been available on a consistent basis for the last six years, data from England and Wales are used to comment on trends. The long-term trend indicates an increase in seizures of herbal cannabis until 2011/2012 and 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, with the largest decrease between 2009/10 and 2010/11. Nevertheless, the United Kingdom reports some of the highest numbers of heroin and cocaine seizures and quantities seized of both substances in Europe (Figure 17).

Retail price and purity of the main illicit substances seized are shown in Figure 18.

FIGURE 17

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



NB: Year of data 2015.

FIGURE 18

Price and potency/purity ranges of illicit drugs reported in the United Kingdom

NB: Price and potency/purity ranges: EU and national mean values: minimum and maximum.
Year of data 2015. Herbal cannabis = sinsemilla.

KEY DRUG STATISTICS FOR THE UNITED KINGDOM

Most recent estimates and data reported

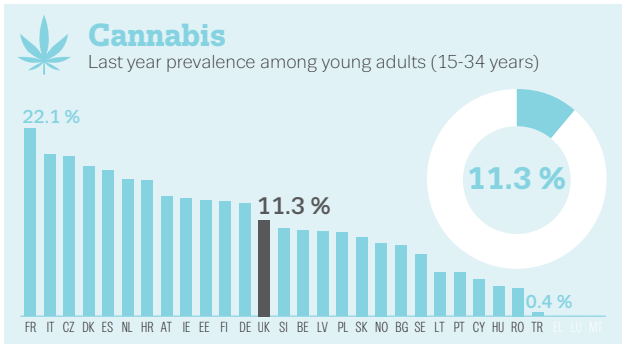
	Year	Country data	EU range Minimum	EU range Maximum
Cannabis				
Lifetime prevalence of use — schools (% , Source: ESPAD)	No data	No data	6.5	36.8
Last year prevalence of use — young adults (%)	2015	11.3	0.4	22.1
Last year prevalence of drug use — all adults (%)	2015	6.5	0.3	11.1
All treatment entrants (%)	2015	26	3	71
First-time treatment entrants (%)	2015	46	8	79
Quantity of herbal cannabis seized (kg)	2015	30 680.4	4	45 816
Number of herbal cannabis seizures	2015	100 811	106	156 984
Quantity of cannabis resin seized (kg)	2015	7 219.3	1	380 361
Number of cannabis resin seizures	2015	5 959	14	164 760
Potency — herbal (% THC) (minimum and maximum values registered)	No data	No data	0	46
Potency — resin (% THC) (minimum and maximum values registered)	No data	No data	0	87.4
Price per gram — herbal (sinsemilla) (EUR) (min. and max. values registered)	2015	13.8-27.6	0.6	31.1
Price per gram — resin (EUR) (minimum and maximum values registered)	2015	4-5.9	0.9	46.6
Cocaine				
Lifetime prevalence of use — schools (% , Source: ESPAD)	No data	No data	0.9	4.9
Last year prevalence of use — young adults (%)	2015	4	0.2	4
Last year prevalence of drug use — all adults (%)	2015	2.3	0.1	2.3
All treatment entrants (%)	2015	14	0	37
First-time treatment entrants (%)	2015	17	0	40
Quantity of cocaine seized (kg)	2015	4 227.8	2	21 621
Number of cocaine seizures	2015	15 588	16	38 273
Purity (%) (minimum and maximum values registered)	2015	1-96	0	100
Price per gram (EUR) (minimum and maximum values registered)	2015	41.4-165.6	10	248.5
Amphetamines				
Lifetime prevalence of use — schools (% , Source: ESPAD)	No data	No data	0.8	6.5
Last year prevalence of use — young adults (%)	2015	0.9	0.1	3.1
Last year prevalence of drug use — all adults (%)	2015	0.6	0	1.6
All treatment entrants (%)	2015	3	0	70
First-time treatment entrants (%)	2015	4	0	75
Quantity of amphetamine seized (kg)	2015	489	0	3 796
Number of amphetamine seizures	2015	4 496	1	10 388
Purity — amphetamine (%) (minimum and maximum values registered)	2015	1-67	0	100
Price per gram — amphetamine (EUR) (minimum and maximum values registered)	2015	13.8-13.8	1	139.8

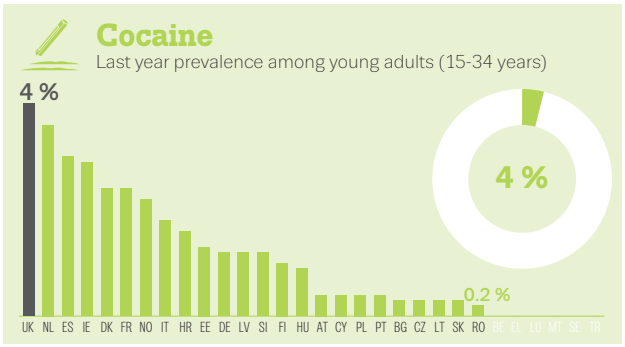
	Year	Country data	EU range Minimum	EU range Maximum
MDMA				
Lifetime prevalence of use — schools (% , Source: ESPAD)	No data	No data	0.5	5.2
Last year prevalence of use — young adults (%)	2015	3.1	0.1	6.6
Last year prevalence of drug use — all adults (%)	2015	1.5	0.1	3.4
All treatment entrants (%)	2015	0	0	2
First-time treatment entrants (%)	2015	1	0	2
Quantity of MDMA seized (tablets)	2015	812 127	54	5 673 901
Number of MDMA seizures	2015	3 030	3	5 012
Purity (mg of MDMA base per unit) (minimum and maximum values registered)	No data	No data	0	293
Price per tablet (EUR) (minimum and maximum values registered)	2015	2.8-13.8	0.5	60
Opioids				
High-risk opioid use (rate/1 000)	2010-11	8.1	0.3	8.1
All treatment entrants (%)	2015	50	4	93
First-time treatment entrants (%)	2015	22	2	87
Quantity of heroin seized (kg)	2015	806	0	8 294
Number of heroin seizures	2015	8 083	2	12 271
Purity — heroin (%) (minimum and maximum values registered)	2015	1-96	0	96
Price per gram — heroin (EUR) (minimum and maximum values registered)	2015	55.2-82.8	3.1	214
Drug-related infectious diseases/injecting/deaths				
Newly diagnosed HIV cases related to injecting drug use (cases/million population, Source: ECDC)	2015	2.8	0	44
HIV prevalence among PWID* (%)	No data	No data	0	30.9
HCV prevalence among PWID* (%)	No data	No data	15.7	83.5
Injecting drug use (cases rate/1 000 population)	2004-11	3.0	0.2	9.2
Drug-induced deaths — all adults (cases/million population)	2014	60.3	1.6	102.7
Health and social responses				
Syringes distributed through specialised programmes	No data	No data	164	12 314 781
Clients in substitution treatment	2015	142 085	252	168 840
Treatment demand				
All clients	2015	124 234	282	124 234
First-time clients	2015	40 390	24	40 390
Drug law offences				
Number of reports of offences	2014	128 260	472	411 157
Offences for use/possession	2014	82 762	359	390 843

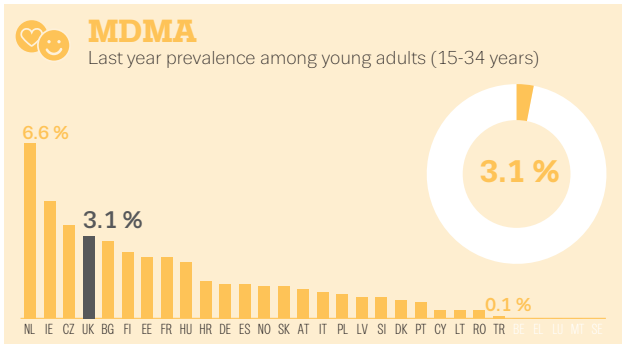
* PWID — People who inject drugs.

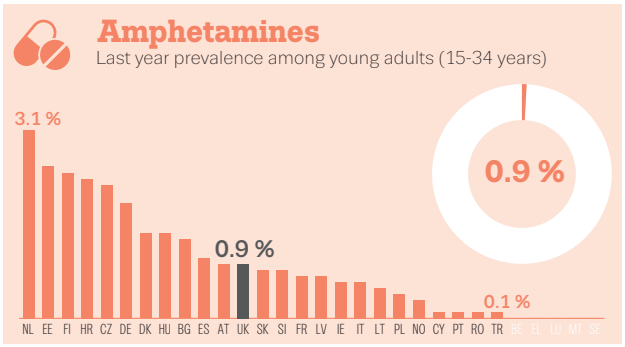
NB: Prevalence of drug use and the number of clients in substitution treatment refers to England and Wales.

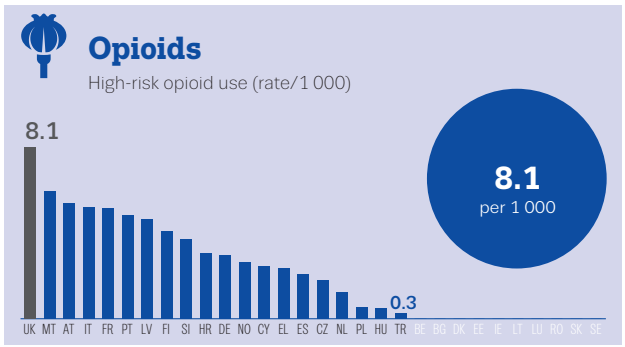
EU Dashboard

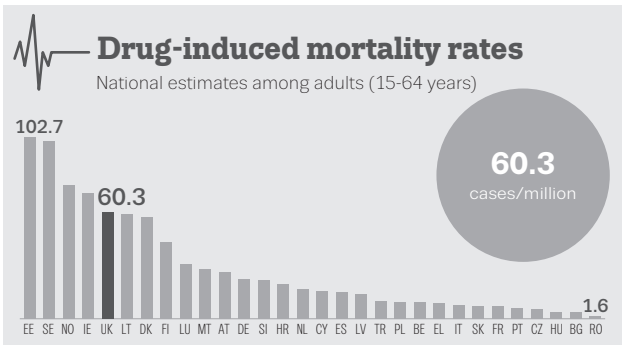


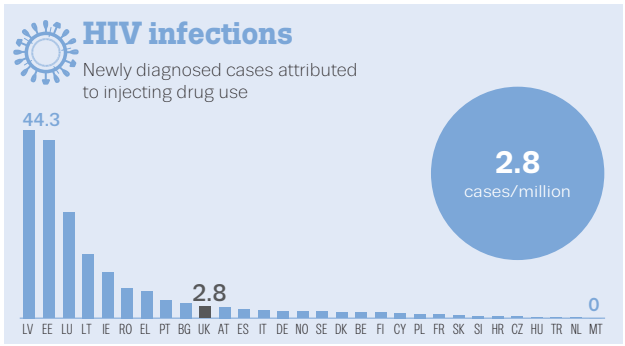


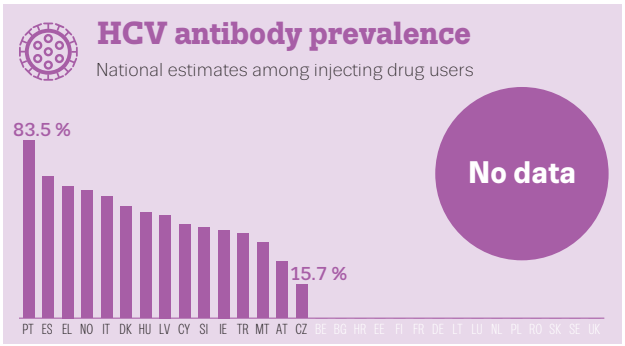












NB: Caution is required in interpreting data when countries are compared using any single measure, as, for example, differences may be due to reporting practices. Detailed information on methodology, qualifications on analysis and comments on the limitations of the information available can be found in the EMCDDA Statistical Bulletin. Countries with no data available are marked in white.

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About the EMCDDA

The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) is the central source and confirmed authority on drug-related issues in Europe. For over 20 years, it has been collecting, analysing and disseminating scientifically sound information on drugs and drug addiction and their consequences, providing its audiences with an evidence-based picture of the drug phenomenon at European level.

The EMCDDA's publications are a prime source of information for a wide range of audiences including: policymakers and their advisors; professionals and researchers working in the drugs field; and, more broadly, the media and general public. Based in Lisbon, the EMCDDA is one of the decentralised agencies of the European Union.

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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