STILL AMBITIOUS FOR RECOVERY

How to address illegal drug addiction and strengthen law enforcement's role

December 2024



CSJ The Centre for Social Justice

Contents

About the CSJ

Established in 2004, the Centre for Social Justice is an independent think-tank that studies the root causes of Britain's social problems and addresses them by recommending practical, workable policy interventions. The CSJ's vision is to give people in the UK who are experiencing the worst multiple disadvantages and injustice every possible opportunity to reach their full potential.

The majority of the CSJ's work is organised around five "pathways to poverty", first identified in our ground-breaking 2007 report Breakthrough Britain. These are: educational failure; family breakdown; economic dependency and worklessness; addiction to drugs and alcohol; and severe personal debt.

Since its inception, the CSJ has changed the landscape of our political discourse by putting social justice at the heart of British politics. This has led to a transformation in Government thinking and policy. For instance, in March 2013, the CSJ report *It Happens Here* shone a light on the horrific reality of human trafficking and modern slavery in the UK. As a direct result of this report, the Government passed the Modern Slavery Act 2015, one of the first pieces of legislation in the world to address slavery and trafficking in the 21st century. Our research is informed by experts including prominent academics, practitioners, and policymakers. We also draw upon our CSJ Alliance, a unique group of charities, social enterprises, and other grassroots organisations that have a proven track-record of reversing social breakdown across the UK.

The social challenges facing Britain remain serious. In 2024 and beyond, we will continue to advance the cause of social justice so that more people can continue to fulfil their potential.

Foreword

Addiction is a crisis that affects every corner of our society. It destroys lives, devastates families, and creates ripple effects that are felt in our communities, workplaces, and public services. As someone who grew up with a father struggling with alcoholism, I know all too well the pain and chaos that addiction brings. For years, I believed my experience was just the life I had – a fridge full of wine and lager but no food, weekends spent caring for a parent instead of being a child, and ultimately, the loss of someone I loved dearly.

That personal experience shaped my determination to do everything I could to ensure no child grows up feeling as isolated and unsupported as I did. Addiction is not a moral failing; it is a public health crisis that demands a compassionate and systematic response.

This report sheds light on the scale of the illegal drug addiction crisis we face today, not only in terms of the lives lost to overdoses and drug poisonings, but also the lives blighted by stigma and a lack of support. It echoes the findings of Dame Carol Black's independent review of drugs, which so starkly warned that the Government must invest in tackling the problem or keep paying for the consequences.

The evidence presented here makes it clear: we need action, and we need it now. We need properly funded addiction recovery services, better mental health support, and a stronger focus on prevention. These aren't just policy recommendations; they are lifelines for people at their most vulnerable.

To those in my party who say the answer is for law enforcement to wash their hands of the problem by removing legal frameworks altogether, I say that is not the solution. The answer lies in harnessing the power of diversion, where law enforcement, health services, and community organisations work together to channel individuals into treatment and recovery rather than punishment.

What's more, this report doesn't just focus on those suffering from addiction directly. It also recognises the untold suffering of their families, who too often are forgotten in the conversation. They are not just witnesses to addiction; they are survivors of it. Millions are suffering in silence, and it is our duty to ensure they are no longer invisible.

Addiction can affect anyone – regardless of background, status, or circumstance. It is everywhere, though often hidden. Addressing it is not just about saving lives; it is about restoring dignity, hope, and opportunity. That is why I have long advocated for better addiction services, and why I am proud to contribute to this report.

I hope the findings and recommendations within it will galvanise leaders across government, healthcare, law enforcement, and the voluntary sector to act. Recovery is possible, and no one should face addiction alone.

Rt. Hon Jonathan Ashworth
CEO, Labour Together

Acknowledgements

We extend our gratitude to the individuals and organisations whose insights and guidance shaped the conclusions and recommendations of this report. The opinions or recommendations expressed herein are our own and may not fully reflect the views of every party mentioned.

Several organisations and experts have generously shared their time, expertise, and knowledge. Some have challenged our perspectives, while many have influenced and refined them. All have contributed with the shared goal of improving the lives of the most vulnerable members of our society.

Firstly, we would like to thank those charities, organisations and professionals that participated in our focus groups. Those organisations are: Alpha House; Hetty's; Recovery Connections; Double Impact; Forge Project; The Moses Project; The Carpenters Arms; Spider Project; High Level Trust; Reflections House; and BAC O'Connor.

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Finally, we would like to extend a particular thank you to the sponsor of this report, the Nick Maughan Foundation, without whom this work would not have been possible.

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Disclaimer: Please note that the views, findings and recommendations presented in this report are those of the CSJ alone, and not necessarily those of any organisation or individual who has fed into or enabled our research. Any errors remain our own.

In Memory of Noreen Oliver MBE

We dedicate this report to the memory of Noreen Oliver MBE, our founding board member and CSJ Lifetime Achievement Award winner. Her passing is an immense loss to all of us, but her legacy remains an enduring source of inspiration.

Noreen was an extraordinary woman who used her own life experiences to change and save countless others. As the driving force behind the BAC O'Connor Centres, she provided a sanctuary of healing and recovery for those struggling with addiction. Under her visionary leadership, the O'Connor Gateway Charity became a beacon of hope, offering critical support to vulnerable individuals and fostering resilience and renewal. Thousands of lives have been transformed because of her compassion and tireless efforts.

Her deep commitment to social justice was evident throughout her time on the board of the Centre for Social Justice. Noreen's strategic insights and relentless advocacy helped amplify the voices of those too often forgotten, driving forward policies aimed at true systemic change. She never wavered in her belief that individuals could rise above addiction and reach their full potential. Her unwavering stance against the failed culture of maintenance treatment and her call for expanded access to rehabilitation, both locally and nationally, continues to inspire us.

Noreen's legacy is powerful. Ten years on from the CSJ report *Ambitious for Recovery*, for which Noreen was the Chairman of our working group, we are pleased to publish this piece in her memory. At the CSJ, we remain committed to carrying forward her work—seeing people not as problems to be solved but as potential to be developed.

We will miss her deeply and honour her by continuing her mission.

Executive Summary

There is a hidden crisis of illegal drug addiction in this country, and it is silently worsening. A blight on individuals, families, and communities alike, it claims thousands of lives and undermines the futures of countless others. Last year, 5,448 people lost their lives to drug poisonings, 84 per cent higher than a decade ago and the highest peak since records began.[1] The death toll from drugs is three times higher than fatal car incidents[2] and 22 times higher than deaths from knife crime.[3]

Despite the staggering number of drug-related deaths, drug use remains largely hidden. 3.1 million working age adults (9.5 per cent) reported using a drug in the past 12 months, which as a self-reported figure collected by the ONS is likely to be an underestimate. In this report, the CSJ reveals that since 2012/13, there have been an estimated 13,809 babies born in England with neonatal withdrawal symptoms from maternal use of drugs[4] and more than one in 10 men now show signs of drug dependency.[5]

Illegal drugs are becoming more potent and perilous, catalysing the rising number of drug related deaths.[6] In May 2022, xylazine, an animal tranquiliser rampant in the US, claimed its first fatality in the UK, signalling a troubling shift in the drug market. The UK is feeling the impact of synthetic drugs, with deaths from novel opiates surging 17 times higher than in 2021.[7] Alarming data further reveals nearly a quarter of those who injected drugs in 2022 experienced a non-fatal overdose - a 16 per cent increase from 2013.[8]

Lessons from Abroad: Liberalisation does not tackle addiction

Countries around the world, grappling with similar challenges, have raced to implement policy solutions aimed at alleviating suffering, saving lives, and breaking the cycle of addiction. Yet, many of these efforts have had unintended and even severe consequences.

A year on since British Columbia, Canada, decriminalised the personal possession of small amounts of drugs, drug deaths have reached their highest point with more than 2,500 lives lost in that province alone in 2023, up 5 per cent from the previous year.[9] In addition, the Deputy Chief Constable of the Vancouver Police Department has spoken publicly about how the legal changes have significantly constrained law enforcement capabilities, compromising public safety.[10] She stated that officers find themselves unable to

1 Office for National Statistics, *Deaths related to drug poisoning in England and Wales: 2023 registrations*, October 2024.
2 Department for Transport, *Reported road casualties Great Britain, provisional results: 2023*, July 2024.
3 Office for National Statistics, *Homicide in England and Wales: year ending March 2023*, February 2024
4 Centre for Social Justice, Analysis of NHS Digital Freedom of Information Request, June 2024.
5 NHS England, *Adult Psychiatric Morbidity Survey*, September 2016.
6 Financial Times, *Lethal 'tranq' has ' penetrated' illicit drug market in the UK*, April 2024.
7 Office for National Statistics, *Deaths related to drug poisoning by selected substances, England and Wales*, October 2024, Table 3.
8 UKHSA, *Unlinked anonymous monitoring survey of HIV and viral hepatitis among people who inject drugs*, January 2024.
9 BC Gov News, *More than 2,500 lives lost to toxic drugs in 2023*, January 2024.
10 The Telegraph, *How decriminalisation made Vancouver the fentanyl capital of the world*, July 2024

act when witnessing drug use in public spaces.[11] Alongside this up to 50 per cent of the available spaces at certain withdrawal management facilities were left vacant, despite substantial waiting lists.[12]

Legalising cannabis has not been the answer hoped for in these places. In cities such as New York and Vancouver, legalisation has not eliminated the illicit market which was a key goal of the proposal. Cheaper and more potent products continue to thrive on the illegal market. In Canada, the illegal market still accounts for up to 52 per cent of cannabis sales more than five years after cannabis was legalised.[13] The promised economic benefits have largely failed to materialise. Analysts suggest the 10 largest publicly traded US cannabis companies lost more than $2 billion in 2022.[14]

On this side of the Atlantic, Portugal was initially praised for reducing drug related deaths through their decriminalisation process. What is often ignored is that these legal changes were implemented alongside a huge investment in recovery. The number of people in treatment rose by nearly two thirds in the early stages of the policy change.[15] Unfortunately, as funding has fallen for those treatment programmes, the rate of overdose deaths in Portugal has also reversed.[16] With a long view of the impact of Portugal's approach now possible, the most robust evidence indicates minimal impact on health outcomes.[17] In fact, the architect of the policy, João Castel-Branco Goulão, publicly stated that, "*Decriminalisation is not a silver bullet. If you decriminalize and do nothing else, things will get worse. The most important part was making treatment available to everybody who needed it for free. This was our first goal.*"

Closer to Home: Safer Drug Consumption Facilities

Scotland is soon to open the first Safer Drug Consumption Facilities (SDCF), a supervised healthcare setting where people can inject drugs, obtained elsewhere, in the presence of trained healthcare professionals. The opening of the SDCF marks a radical shift in the legal framework on drug policy in the UK and raises all sorts of legal knots that could arise in its implementation. The Lord Advocate of Scotland has stated that those caught in possession of Class A drugs in Scotland could be let off with a police warning, if they offer the defense of travelling to the SDCF. This defense could be abused.

A comprehensive approach is essential to ensure the SDCF functions not merely as a harm reduction site, but as a bridge to meaningful recovery and social stability. When evaluating the SDCF, it is essential that they offer pathways to employment, housing, and community reintegration as well as helping individuals to build sustainable and healthy lives beyond the cycle of addiction.

It is the most disadvantaged who will lose out if drug taking becomes more normalised. Drug dependence is already three times more prevalent among those on out of work benefits.[18]

11 Rebecca Paulsen, *British Columbia police officer perceptions of mandatory drug treatment within the context of decriminalization*, 2024.
12 The Globe and Mail, *Detox beds in B.C. routinely sit empty because of staff shortages*, June 2024.
13 Rishi Malkani, *Clearing the smoke: insights into Canada's illicit cannabis market*, 2023.
14 Politico, Broken promises: *How marijuana legalization failed communities hit hardest by the drug war*, December 2023.
15 Hannah Laqueur, *Uses and Abuses of Drug Decriminalization in Portugal*, Law & Social Inquiry 40, no. 3 (Summer 2015): 746–81.
16 The Lancet, *Drug decriminalisation: grounding policy in evidence*, 2023.
17 Antonio Laplana, *Beyond the War on Drugs: Evidence from Portugal's Drug Decriminalization Reform and the Retornados Migration*, August 2023.
18 NHS England, *Adult Psychiatric Morbidity Survey*, September 2016.

Drug-related mental health and behavioural disorders are almost eight times more common in the most deprived areas[19] and drug misuse hospital admissions are five times more likely in these regions.[20]

It is in light of all this that the core message of this report is a simple one:

> *The government should resist moves to liberalise laws on drug possession at a central, devolved, and localised level, and instead invest in treatment and recovery.*

Fund the Treatment Sector

The push for liberalisation stems from the failures of the current system. However, instead of tampering with the legal framework - tried and tested elsewhere with mixed results - resources should be put behind what we already know works: funding the treatment sector. It is crucial that the Government reinvests in addiction services and rehabilitation as current funding is 60 per cent lower than it was in 2012. According to CSJ analysis of Care Quality Commission data, while the North West hosts 30 facilities specialising in residential substance misuse, the North East, where the drug misuse death rate is the highest in the country, has just 3.[21] These treatment deserts mean access to essential rehabilitation services is largely determined by where someone lives.

Despite the publication of Dame Carol Black's independent review of drugs and the Government's 10-year drug strategy in 2021, the numbers continue to head in the wrong direction. The strategy's goals are not on track to be met. Among the key targets to be achieved by the end of 2024/25, this whole-of-government mission was expected to:

- Prevent nearly 1,000 drug-related deaths, reversing a decade-long upward trend.
  - In contrast, drug-related deaths have continued to rise each year since the strategy's launch, signalling an ongoing public health crisis.[22]
- Expand treatment capacity by at least 54,500 new high-quality treatment places – a 20 per cent increase, including:
  - 21,000 new places specifically for opiate and crack users, ensuring 53 per cent of users are in treatment.
    - However, current statistics show that treatment capacity remains insufficient, with many individuals unable to access these promised placements, especially in high-demand areas.
  - At least 7,500 additional treatment places for those rough sleeping or at immediate risk, marking a 33 per cent increase.
    - Despite this goal, over one in twelve people entering treatment are at risk of homelessness, highlighting a gap between treatment provision and support for housing stability.[23]

19 NHS England, *Statistics on Public Health*, August 2024.

20 NHS England, *Statistics on Public Health*, August 2024.

21 Centre for Social Justice, *Analysis of CQC FOI response*, October 2024.

22 Office for National Statistics, *Deaths related to drug poisoning in England and Wales: 2023 registrations*, October 2024.

23 Office for Health Improvements and Disparities, *Adult substance misuse treatment statistics 2022 to 2023: report*, Updated 21 December 2023

- Ensure that every offender with an addiction is provided with a treatment place.
  - Yet, many offenders with substance dependencies continue to be incarcerated without adequate access to treatment services, and diversionary cautions are inconsistently applied, leaving gaps in the intended treatment-focused approach.
- Contribute to the prevention of three-quarters of a million crimes, including 140,000 neighbourhood crimes, through increased access to drug treatment.
  - While the strategy aims to reduce crime through treatment access, the rising rates of addiction and homelessness have contributed to persistent levels of drug-related crimes, impacting communities across the UK.

This contrast between the Government's projected promises and the current state of drug treatment and support highlights a clear need for more effective interventions and consistent implementation to achieve the intended outcomes.

Therefore, this report makes recommendations including:

1. Re-commit to long-term, ring-fenced funding for drug treatment services. This should include a three to five year funding plan to allow for better service planning and expansion of treatment options for those in community settings and should be reflected in the next Spending Review.
2. Introducing and expanding adequate support for families, women, and ethnic minority groups.
3. Recognising the growing need for supporting those with cannabis induced psychosis, NHS Trusts should examine the needs of the catchment area they serve, request a business plan which includes initial funding, and include patients and carers in the development of further clinics.
4. Expand a national system to track non-fatal overdoses to enhance situational awareness, guide resource allocation, and inform public health interventions aimed at reducing drug-related harm.
5. Expand wastewater testing nationally as an early warning system to understand the changing drug market and the prevalence of drug misuse.
6. Explore large-scale data linkage of death registrations with NHS and other administrative data sources to contribute to a better understanding of the patterns of drug misuse, causal relationships, and the individual pathways of those who die of drug-related causes.
7. A "deep dive" on fatal overdoses and non-fatal overdoses to understand factors that contributed to overdoses in the past, and to inform the development of strategies to prevent them in the future.
8. When evaluating the impact of the SDCFs, the Scottish Government should ensure it measures metrics including overall drug dependency, recovery rates, crime rates in the surrounding area and potential inconsistencies in the legal framework.

Support People to Move from Maintenance and to Recovery

Many individuals struggling with addiction find themselves trapped in a cycle of methadone dependency, hindering their path to full recovery. While methadone prescription is an appropriate option in specific circumstances as part of opioid substitution treatment, for too many, it is a destination rather than a passing through point. The latest ONS statistics reveal a 74 per cent increase in deaths involving methadone from pre-pandemic level and a 244 per cent increase from when data collection started in 1993.[24] While some with lived experience of addiction spoke positively about the stability being on methadone provided, many told the CSJ that the prolonged effects of methadone can lead to dependency on the treatment itself. Therefore, this report makes recommendations including:

1. Individuals receiving opioid substitution therapy also be provided with integrated psychological support to ensure that mental health issues are addressed concurrently.
2. Ensure channels are developed for patients who wish to transition from methadone to alternative treatments like buprenorphine.

Harness the Positive Power of Law Enforcement

Those who push for liberalised drug policy rightly identify the important role of the law and its enforcers. In England, people find themselves addicted to heroin and crack cocaine contribute to nearly half of all burglaries, robberies, and other acquisitive crimes.[25] However, CSJ polling found nearly three quarters (74 per cent) of police think that the current drug possession policies and strategies in the communities they serve are ineffective. Yet, 77 per cent say drug related crime and disorder are a significant part of the overall workload and resource allocation of their team.

In the UK, cannabis continues to be the predominant substance (87 per cent) for which young people seek treatment.[26] However, two thirds (66 per cent) of police officers think cannabis is, to all intents and purposes, fully or partially decriminalised in practice, showing ambiguity and inconsistency in how cannabis laws are interpreted and enforced on the ground. CSJ polling found that almost a quarter (24 per cent) of young people would consider taking cannabis if it were legalised, paving the way for a potential maximum of 355,000 more people needing treatment for cannabis dependency.

The role of law enforcement should be to leverage interactions with drug users to support individuals in their recovery and deter potential users from embarking on the path to addiction.

Police have the opportunity to act as frontline responders, connecting individuals to the treatment they need, such as through the Out-of-Court Disposal (OOCD) framework currently under review. If utilised properly, OOCDs could channel individuals from the criminal justice system into treatment, addressing both addiction and associated criminal behaviour. In addition, police should be equipped with naloxone and prioritise treatment referrals following overdoses. Therefore, this report makes recommendations including:

24 ONS, *Deaths related to drug poisoning in England and Wales: 2022 registrations, December 2023*.

25 Home Office, Department of Health and Social Care, Ministry of Justice, Department for Work and Pensions, Department for Education and Department for Levelling Up, Housing and Communities, From Harm to Hope: A 10 year drug plan to cut crime and save lives, December 2021.

26 Office for Health Improvement & Disparities, *Young people's substance misuse treatment statistics 2022 to 2023*, January 2024

1. Equip every police force with drug testing technology to better identify and respond to drug-related offenses.
2. Expand the distribution of naloxone to first responders and the police, with an emphasis on high-risk areas, to reduce the incidence of fatal overdoses.
3. Establish a unified framework for diversion schemes that accounts for existing regional programmes and integrates the proposed two-tier Out-of-Court Disposal framework.
4. Publish the promised evaluation of Project ADDER in order to inform decision making about the project's future funding, due to end in March 2025.

Recovery from addiction is possible. This Government must ensure that a strategy that integrates public health, law enforcement, and community support is front and centre of a renewed approach. Only then can we hope to make meaningful progress in the fight against drug addiction in the UK.

While these figures are silhouettes, each one represents a person with a family, friends, and potential who lost their life to drug poisoning in 2023.

Introduction

Dame Carol Black's independent review of drugs brought to light the deeply ingrained and persistent nature of drug misuse throughout the country.[27] The report underscored the prevalence of violence and exploitation within the drug supply chain, the high demand for drugs across the population, and the inadequacy of the treatment system in addressing the needs of individuals dealing with drug-related issues. In response to these findings, the Government unveiled its 10-year drug strategy, *From Harm to Hope*.[28] This initiative focused on three key strategic priorities: dismantling drug supply chains, establishing a world-class treatment and recovery system, and catalysing a generational shift in the demand for drugs. Since publication, some of Dame Carol Black's recommendations have yet to be implemented. The number of people who die from drug misuse is 20 times higher than deaths from knife crime[29] and three times higher than fatal car incidents.[30] With 5,448 drug related deaths last year,[31] the current system is failing far too many people.

The purpose of this report is to assess the nature of and response to addiction in the community, with a particular focus on the role of law enforcement and the underlying legal frameworks.

This report exclusively focuses on illicit substance addiction, omitting discussions on behavioural or alcohol addiction, to maintain a targeted examination of a specific subset of substance abuse issues. By narrowing the scope to illicit substances, the aim is to provide a more thorough analysis of the unique challenges, patterns, and policy considerations associated with this type of addiction.

Furthermore, this report will exclusively examine the challenges associated with addiction prior to recovery. Solely focusing on addiction in the community, drugs in prisons will not be analysed in this report.

27 Department for Health and Social Care and Home Office, *Independent review of drugs by Dame Carol Vlack; government response*, July 2021.

28 Home Office, Department of Health and Social Care, Ministry of Justice, Department for Work and Pensions, Department for Education and Department for Levelling Up, Housing and Communities, From Harm to Hope: A 10 year drug plan to cut crime and save lives, December 2021.

29 ONS, *Homicide in England and Wales: year ending March 2023*, February 2024

30 Department for Transport, *Reported road casualties Great Britain, provisional results: 2023*, July 2024.

31 Office for National Statistics, *Deaths related to drug poisoning in England and Wales: 2023 registrations*, October 2024.

Project Methodology

Qualitative Evidence

- Thematic analysis of 14 original focus groups across England involving those with lived experience of addiction.
- Five case studies derived from interviews with individuals who have lived experience of addiction.
- Meetings with sector experts.

Quantitative Evidence

- Original polling conducted by Opinium for The Centre for Social Justice of 250 police officers in the UK, between 14th October and 19th October 2024. Opinium is a member of the British Polling Council, Market Research Society, and ESOMAR.
- Original polling conducted by Opinium for The Centre for Social Justice of 2,116 adults in the UK, weighted to be nationally and politically representative, between November 13th – 15th 2024.
- Freedom of Information Requests to the Care Quality Commission on the locations and availability of drug and alcohol treatment programmes.
- Freedom of Information Requests to NHS England on neonatal abstinence syndrome diagnoses.

International Comparisons

- Engagement with front line organisations, and those with lived experience.
- Quantitatively assess and compare addiction prevalence and trends, the effectiveness of support services, and relevant policy frameworks across multiple countries.

This report's recommendations and findings are guided by focus groups with individuals with lived experience and over 40 on the record interviews and discussions with professionals in the sector. For more information on the methodology please see the appendix.

Part 1:

Understanding Addiction and Its Impacts

The following section provides a comprehensive analysis of key aspects of drug use in the UK. It begins with a case study, then an overview of national drug use trends, followed by an examination of drug consumption among young people. The section addresses the serious consequences of drug-related harms and associated deaths, explores the wider impacts of addiction and dependence on individuals and communities, and highlights the current challenges facing the drug treatment sector. This chapter will lay the foundation for understanding the complex issues surrounding drug use and the need for effective interventions.

Sarah's Story

This case study shines a light on the experiences of Sarah (name has been changed to protect identity), a woman who found herself trapped in a cycle of addiction, mental health struggles, and exploitation on the streets. Sarah's story illustrates the immense challenges faced by those caught in the grips of homelessness, substance abuse, and domestic violence - a tragic intersection that too many vulnerable individuals are forced to navigate. The Forge Project, one of the CSJ's Alliance charities, was a lifeline for Sarah, providing her with the vital support and resources she desperately needed.

For years, I was caught up in a cycle of addiction and mental health struggles. I've been in and out of mental health institutions since I was 14. I had been diagnosed with borderline personality disorder and bipolar disorder but never got dual diagnosis, even though I tried.

The streets were a dangerous place, and there was a lot of bullying and violence. I slept on a mattress up an alleyway behind where we used to sell. I didn't actually become proper [sic] addicted and into it until I started working on the streets. I realised I could get crack and heroin every day by selling your body, then you become addicted because then you end up needing every day and not focusing on anything else. One day, a man followed me and tried to strangle me in a graveyard. It was a terrifying experience, and I was lucky to escape with my life. I reported the incident to the police, but I still didn't feel safe anywhere, not even walking down the high street in broad daylight.

I didn't trust services, so I never went to any drug services. I went through a lot of temporary accommodation. It's hard when your life is so chaotic, and the landlord doesn't get it. I was always getting kicked out for silly things like smoking. It's not easy to follow the rules when your lifestyle is so chaotic, you're just not thinking rationally. People on substances can also struggle with mental health and having so much going on at once makes it impossible to try to follow housing rules. The people that own the B&Bs or the temporary accommodation need to understand the complexity and the needs of different people.

The only good experience I had was with this one man, he's lovely. And he's not stupid. He knew what I was doing. He knew I was smoking, but he turned a blind eye, and he even helped me clean my room. And he still kept me in there. He didn't kick me out. He understood and he didn't judge me. I'm not suggesting that every service ignore people and let them do anything but if you take the time to work with them, they should work with you.

The turning point for me was when another girl I worked with on the street and the guy she was with started assaulting me and throwing bricks at my face. They beat me so badly that I ended up in the hospital with a broken eye socket. The hospital staff there treated me horribly, they looked at me like I wasn't a real person. I knew I couldn't go back to that situation. That's when the Forge Project team stepped in and fought to get me temporary housing in a B&B, even though the local authority didn't want to pay for it.

After staying in the B&B for a while, I was able to secure a flat in Hull, which was a complete change. Being removed from the people and places that fuelled my addiction was a game-changer. I got a dog for companionship, and I started volunteering. I finally felt safe and supported.

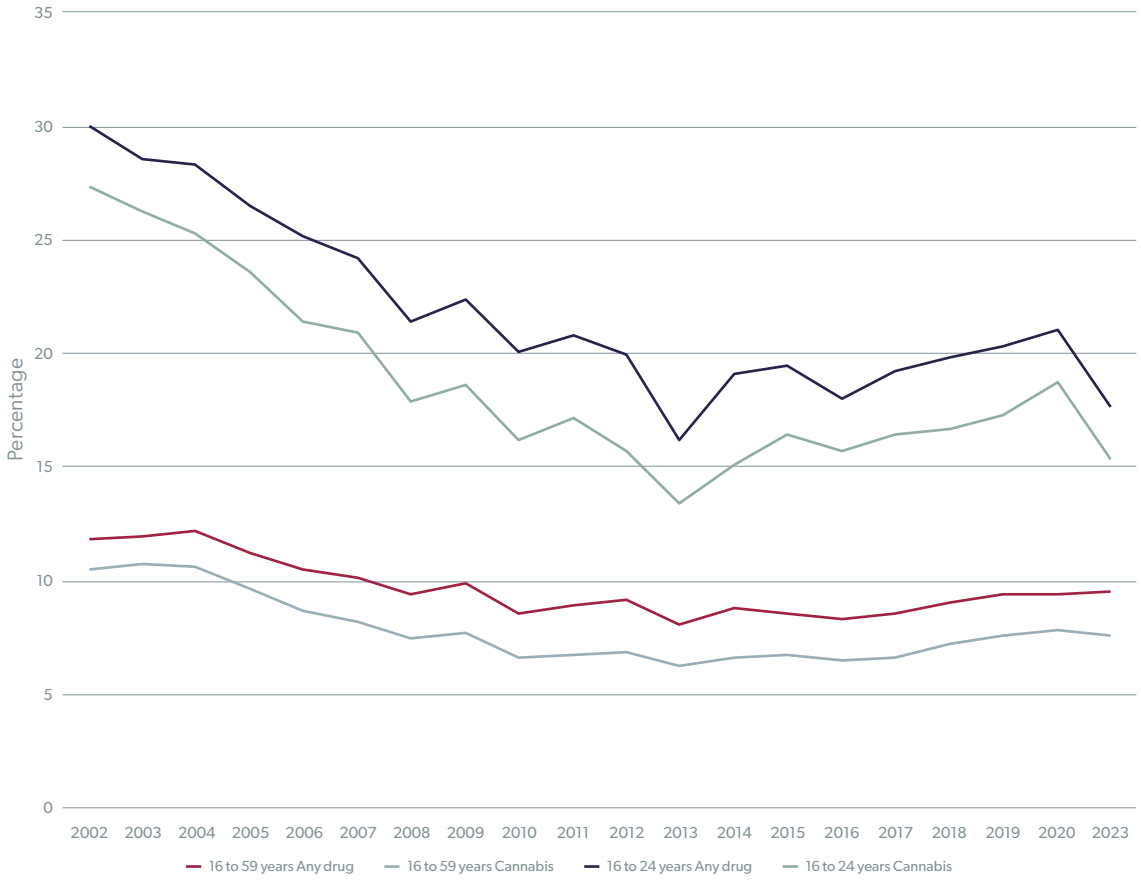
Looking back, I can see how the Forge Project's support and understanding made all the difference. They never gave up on me, even when I was at my lowest. Now, I'm proud to share my story and show that recovery is possible, no matter how dark things may seem. I'm grateful for the Forge Project and the chance they gave me to rebuild my life.

Drug Use

While statistically many people who take illegal drugs will never become addicted, for the small number of consumers who do, it can have catastrophic consequences.

According to the Office for National Statistics (ONS), 3.1 million people (9.5 per cent) aged 16 – 59 reported using a drug in the past 12 months.[32] Drug use is higher than it was ten years ago for any drug (8.1 per cent), cannabis (6.3 per cent), and Class A drugs (2.5 per cent), as shown in Figure 1.[33]

Figure 1: Proportion of people reporting use of any drug and cannabis in England and Wales.



Source: ONS, Drug misuse in England and Wales: year ending March 2023, December 2023.

In terms of specific drug types, most showed no changes in usage compared to the year ending March 2020, except for hallucinogens (including magic mushrooms), ecstasy, and nitrous oxide. Hallucinogen use increased from 0.7 per cent to 1 per cent, while ecstasy use decreased from 1.4 per cent to 1.1 per cent, and nitrous oxide use decreased from 2.4 per cent to 1.3 per cent.[34]

32 Office for National Statistics, *Drug misuse in England and Wales: year ending March 2023*, December 2023.

33 Ibid.

34 Ibid.

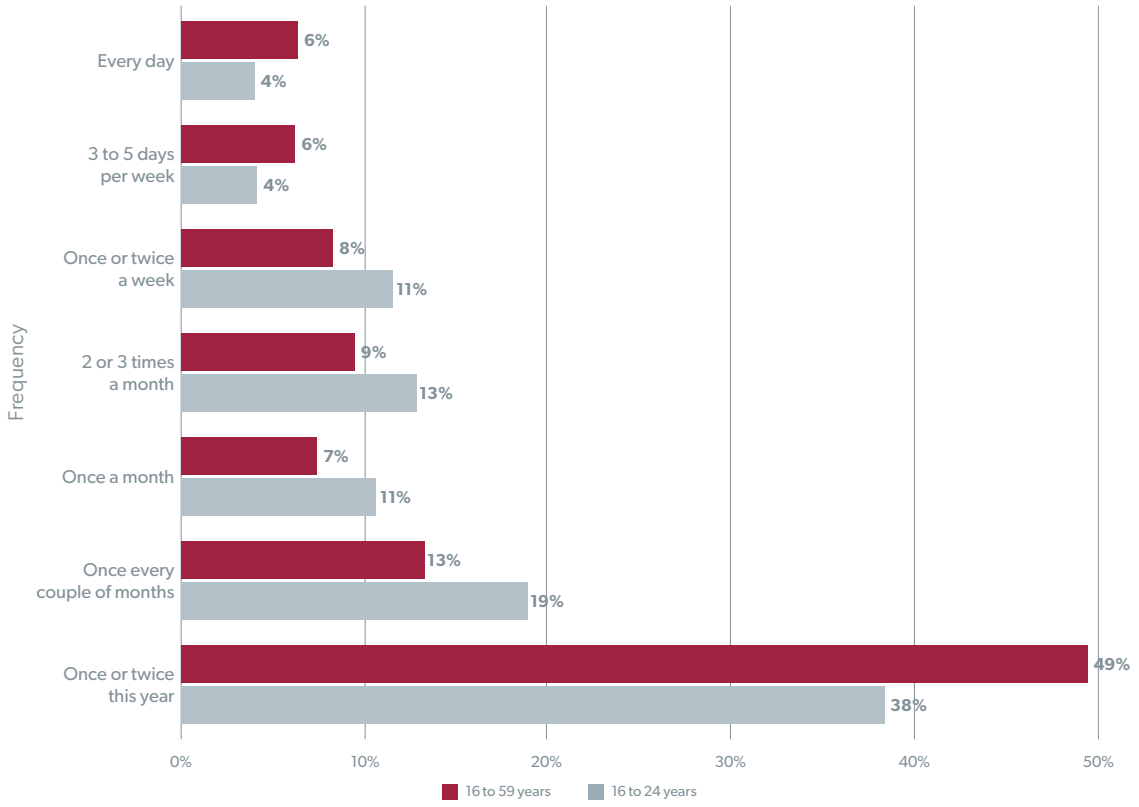
The ONS does not gather data on drug addiction or physical dependence. However, the latest statistics reveal frequency of drug use. Overall, approximately 2.3 per cent (around 777,000 individuals) of people were frequent drug users, similar to the year ending March 2020 (2.1 per cent).[35]

It should be noted that this is likely an underestimate. Due to survey bias, participants may offer less truthful responses or inaccurate answers, particularly when reporting on illicit behaviour such as drug use. Although the findings of the ONS crime survey almost certainly reflect survey bias, it is important that we address the findings to understand a baseline for drug prevalence in England and Wales.

Prevalence was higher among people aged 16 to 24 years than those aged 25 to 59.

Approximately one million individuals (17.6 per cent) reported any drug use.[36] This represents a decrease compared to the year ending March 2020 (21.0 per cent), primarily due to declines in cannabis use in this age group (from 18.7 per cent to 15.4 per cent).

Figure 2: Frequency of use in people who had taken any drug in the last year, England and Wales, year ending March 2023.



Source: ONS, Drug misuse in England and Wales: year ending March 2023, December 2023.

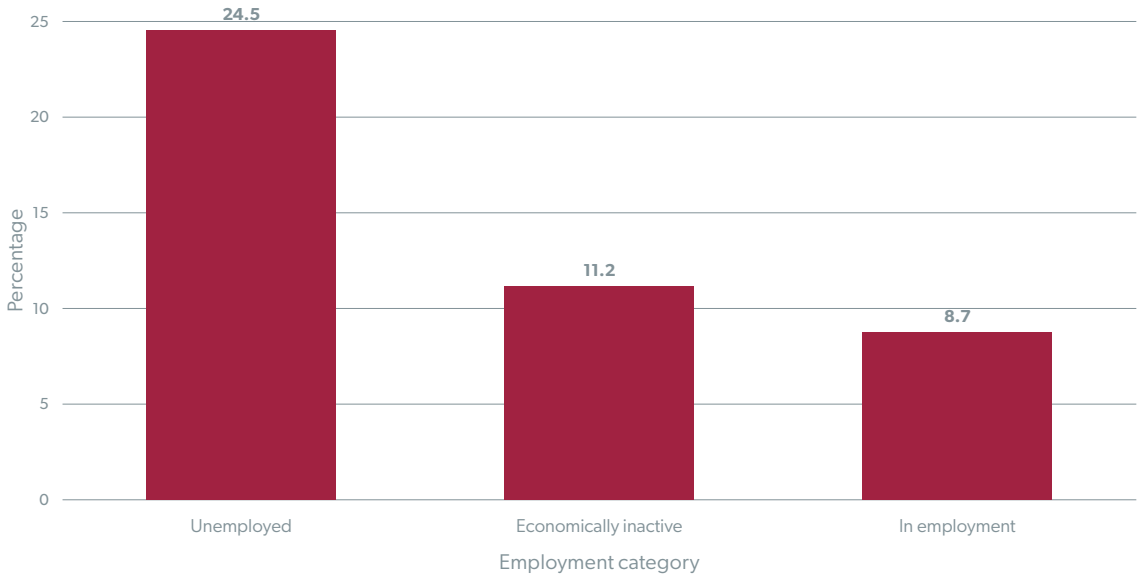
Frequent drug use is associated with employment status. As seen in Figure 3, unemployed individuals are nearly three times more likely to report using illicit drugs than those in employment.[37]

35 Ibid.

36 Ibid.

37 *ONS, Drug misuse in England and Wales: year ending March 2023, Table 3.01, December 2023.*

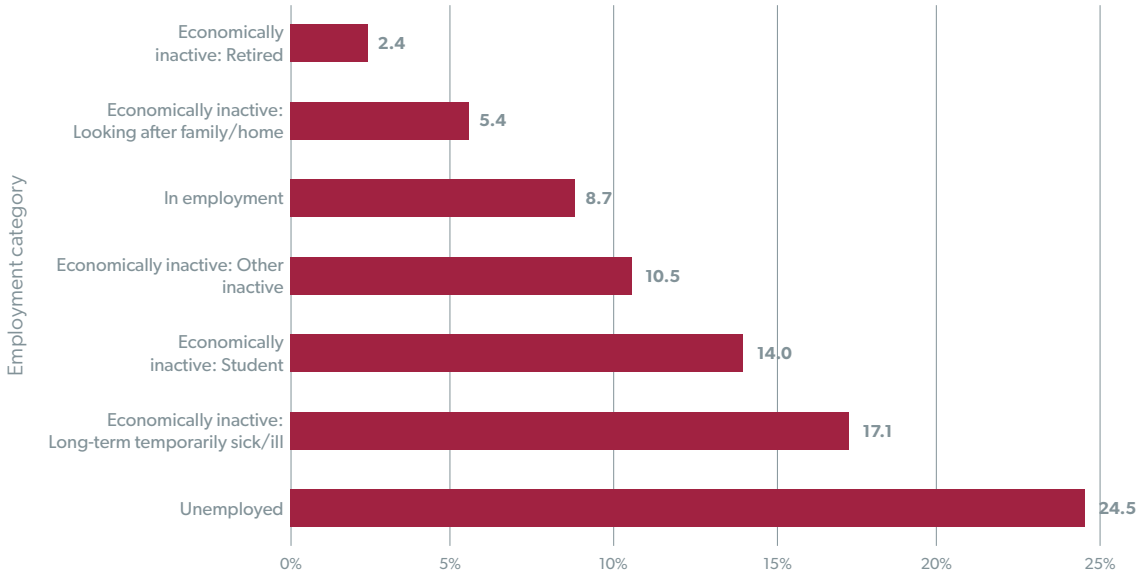
Figure 3: Proportion of 16 – 59-year-olds reporting use of illicit drugs in the last year by employment status.



Source: ONS, Drug misuse in England and Wales: year ending March 2023, Table 3.01, December 2023. 'Any drug comprises powder cocaine, crack cocaine, ecstasy, LSD, magic mushrooms, heroin, methadone, amphetamines, methamphetamine, cannabis, ketamine, mephedrone, tranquillisers, anabolic steroids, GHB and any other pills/powders/drugs.

Figure 4 details the different categories of economic inactivity and associated drug use. People who are economically inactive due to long term sickness are the second highest drug using category, with a rate of 17.1 per cent of individuals using a drug in the past year.

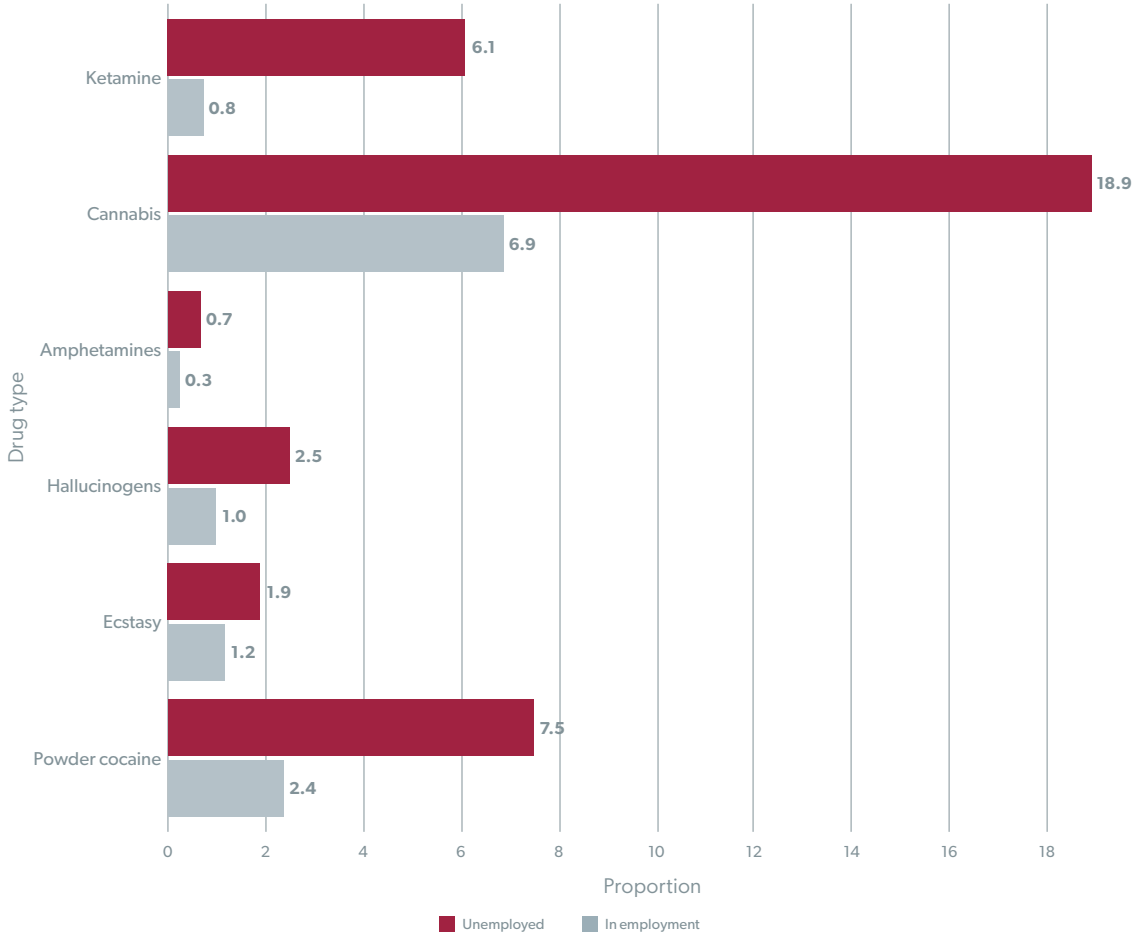
Figure 4: Proportion of 16 – 59-year-olds reporting use of illicit drugs in the past year by employment status. Economic inactivity categories separated.



Source: ONS, Drug misuse in England and Wales: year ending March 2023, Table 3.01, December 2023. 'Any drug comprises powder cocaine, crack cocaine, ecstasy, LSD, magic mushrooms, heroin, methadone, amphetamines, methamphetamine, cannabis, ketamine, mephedrone, tranquillisers, anabolic steroids, GHB and any other pills/powders/drugs.

The unemployed respondents to the Crime Survey show signs of the highest rates of Class A drug use, which are linked to more severe health and legal consequences. Figure 5 below highlights the social and economic dimensions of drug use, suggesting that employment status is a critical factor in understanding and addressing drug-related issues.

Figure 5: Proportion of 16 – 59-year-olds reporting use of illicit drugs in the last year by employment status.

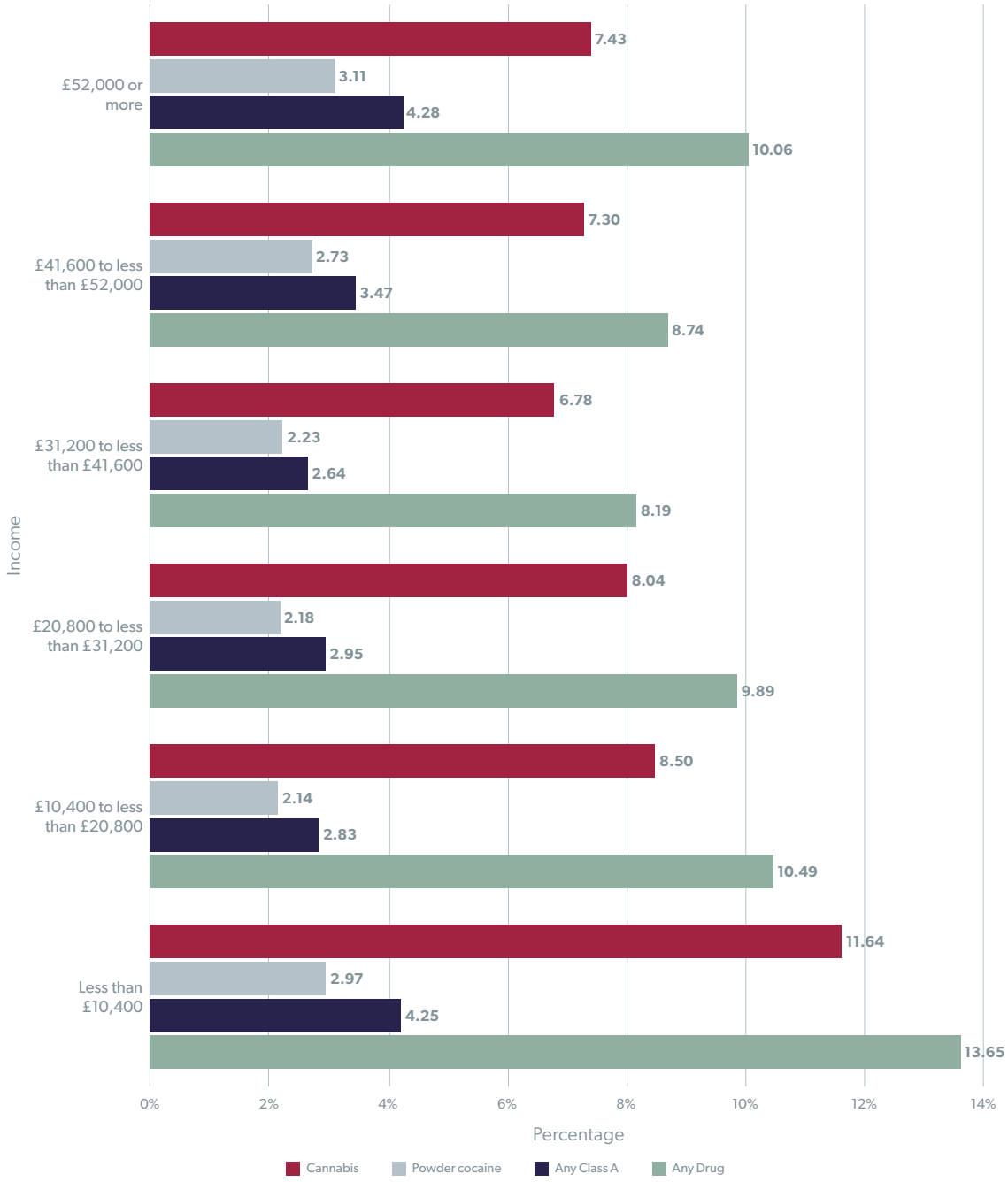


Source: ONS, Drug misuse in England and Wales: year ending March 2023, Table 3.01, December 2023.

The latest ONS Crime Survey statistics reveal those with household incomes of less than £10,400 per year were more likely to use any drug in the last year (13.6 per cent), and in particular cannabis (11.6 per cent), than those with higher incomes. [38]

38 Office for National Statistics, *Drug misuse in England and Wales: year ending March 2023*, December 2023.

Figure 6: Proportion of people aged 16 –59 years who reported using a drug in the last year by total household income, England and Wales, year ending March 2023.



Source: ONS, Drug misuse in England and Wales: year ending March 2023, December 2023.

Ultimately, drug use disproportionately affects those on low incomes and the economically inactive, with limited opportunities and support exacerbating the issue. As addiction continues to take hold in these communities, addressing the root causes of poverty and unemployment is crucial to reducing drug dependency and its devastating impact.

Drug use among young people

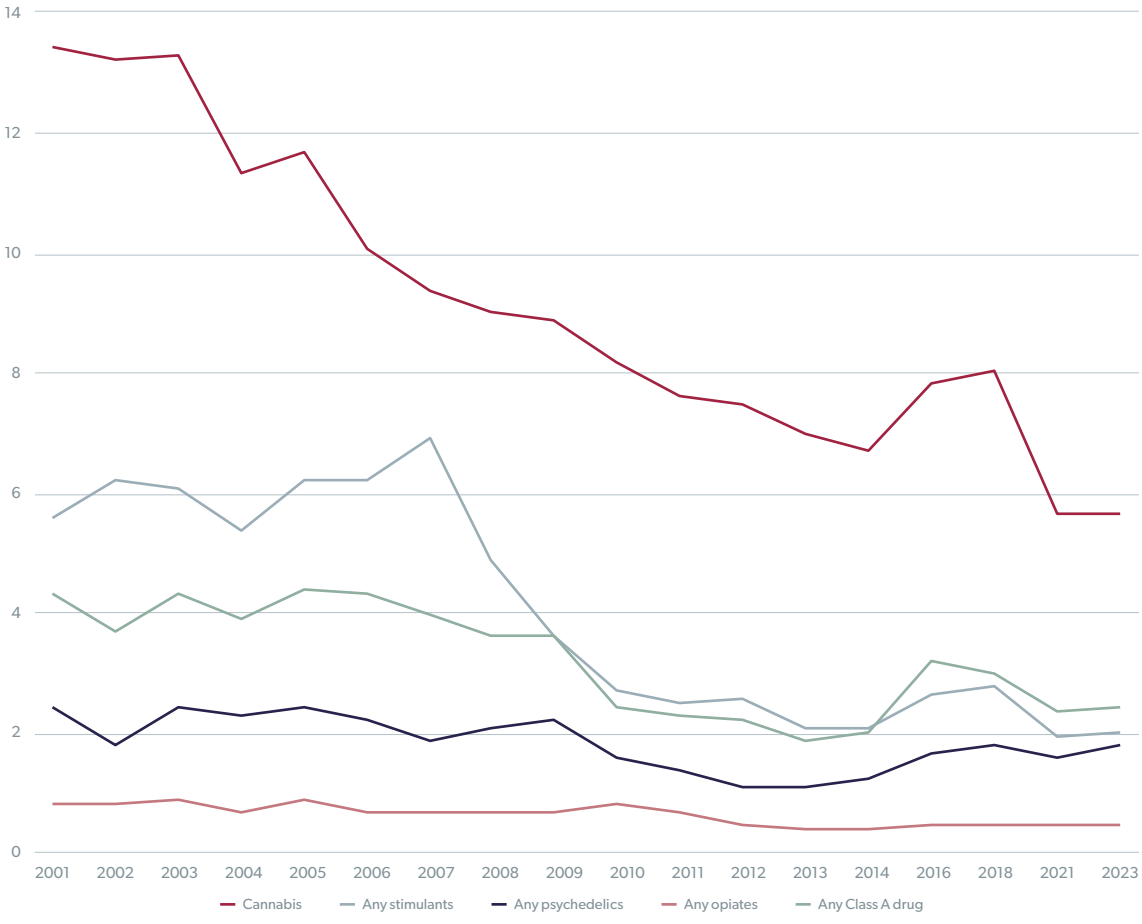
Drug use is highest amongst young people.

NHS England published figures on smoking, drinking, and drug use among secondary school pupils in years 7 to 11.[39] Survey participants are mostly aged 11 – 15 years old.

Results suggest 13 per cent of pupils have taken drugs in their lifetimes. 9 per cent had taken drugs in the last year, and 5 per cent in the last month.[40] The likelihood of having ever taken drugs increases with age, from 6 per cent of 11-year-olds to 23 per cent of 15-year-olds.

Figure 7 shows only the most common responses for each drug type young people reported using. Cannabis is the most common drug consumed (6 per cent).[41] The proportion of young people who had taken a class A substance has remained between 2 and 3 per cent since 2010.[42]

Figure 7: Drug types taken by young people from 2001 – 2023.

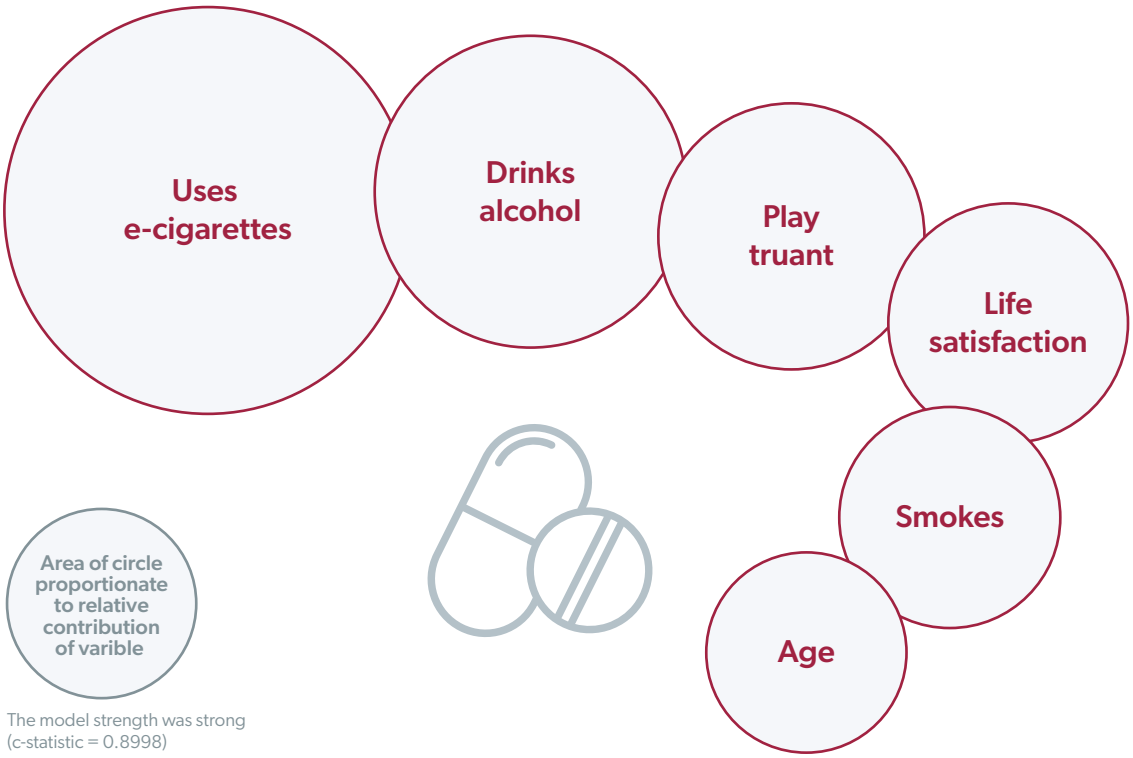


Source: NHS England, Smoking, Drinking and Drug Use among Young People in England, 2023, October 2022.

39 NHS England, *Smoking, Drinking and Drug Use among Young People in England, 2021*, October 2024.
40 Ibid.
41 Ibid.
42 Ibid.

A logistic regression model exploring characteristics associated with having taken any drugs in the last month identified several significant associations. Smoking e-cigarettes had the strongest association, followed by drinking alcohol, and then playing truant. In line with the CSJ's work on so-called ghost children,[43] absence from school acts as a risk factor for anti-social behaviour and drug consumption.

Figure 8: Characteristics associated with having taken any drugs in the last month.



Source: NHS England, Smoking, Drinking and Drug Use among Young People in England, 2023, October 2022.

Similarly to the Crime Survey, these results are subject to survey bias. Due to the taboo nature of illicit drug use, respondents are likely underreporting or omitting information.

In July 2024, the Universities UK Drugs Taskforce published research addressing concerns about student drug use and its impact on learning, mental health, and future job prospects. Their survey of nearly 4,000 participants found that 18 per cent had used drugs, with 12 per cent having done so in the past year, lower than the national statistics' rate.[44] Notably, 44 per cent of these students expressed a desire to reduce their drug use due to its negative effects on health and academics.

The taskforce highlighted the need for universities to take action by preventing drug use and supply, offering support to affected students and working with local authorities.[45] Their findings indicate a lack of confidence among higher education providers in tackling student drug use and emphasise the importance of evidence-based support and sharing of good practices.

43 Centre for Social Justice, *Lost but not forgotten*, January 2022.

44 Universities UK, *Enabling student health and success Tackling supply and demand for drugs and improving harm reduction*, July 2024.

45 Ibid.

Drug use during childhood and adolescence is a well-established risk factor for developing a substance use disorder in adulthood.[46] The persistent levels of drug use in the UK, particularly among young people, highlights a critical challenge that remains unresolved despite the Government's 10-year strategy aimed at reducing generational demands for drugs. With Labour now in power, it remains to be seen whether they will prioritise this issue with the urgency it demands.

As the country faces the ongoing consequences of drug misuse, the Government must decide whether to uphold and intensify efforts to curb this trend or to risk allowing it to continue unchecked. Their approach will be a crucial indicator of their commitment to tackling one of the nation's most pressing public health concerns.

Illegal Drug Related Harms

The Changing Drug Market

The illegal drug trade in the United Kingdom has long cast a dark shadow over public health, safety, and social stability. Fuelling crime, exacerbating economic inequality, and devastating individuals and communities, it has severe consequences. The constantly evolving nature of the drug trade only worsens these issues, as new and more dangerous substances have emerged and challenged existing systems of prevention, treatment, and law enforcement.

The total cost of harms related to illegal drug use in England is estimated at £20 billion per year.[47] Approximately £9.3 billion of this is from drug related crime.[48] Harms associated with drug-related deaths and homicides are the next largest cost at £6.3 billion. The Treasury dedicates only a small fraction of expenditure to drug treatment and prevention.[49]

Opiate and/or crack cocaine users generate 95 per cent of the costs of drug-related crime.[50] Most of the societal costs associated with cannabis use are from enforcement and mental ill health support and treatment.

Historically, the UK's drug epidemic was marked by the prevalence of substances such as heroin, cocaine, and ecstasy. Current trends indicate a troubling shift towards more potent and perilous drugs. Last year, opium cultivation in Afghanistan decreased by 95 per cent, falling from 6,200 tons in 2022 to 333 tons in 2023.[51] Consequently, experts suggest lower quality heroine is cut with synthetic opioids, such as nitazines.[52] Indeed, earlier this year, a BBC report found nitazenes, potent synthetic opioids, are openly advertised on social media platforms such as X (formerly Twitter) and Soundcloud.[53]

The effects of this market shift are exemplified in data on drug related deaths. In the United States, overdose deaths have surged, catalysed by the proliferation of synthetic opioids, namely fentanyl.

46 UNOCD, *World Drugs Report,* 2023.

47 Home Office, Department of Health and Social Care, Ministry of Justice, Department for Work and Pensions, Department for Education and Department for Levelling Up, Housing and Communities, *From Harm to Hope: A 10 year drug plan to cut crime and save lives,* December 2021.

48 Ibid.

49 Dame Carol Black, *Review of Drugs - evidence relating to drug use, supply and effects, including current trends and future risks,* February 2020.

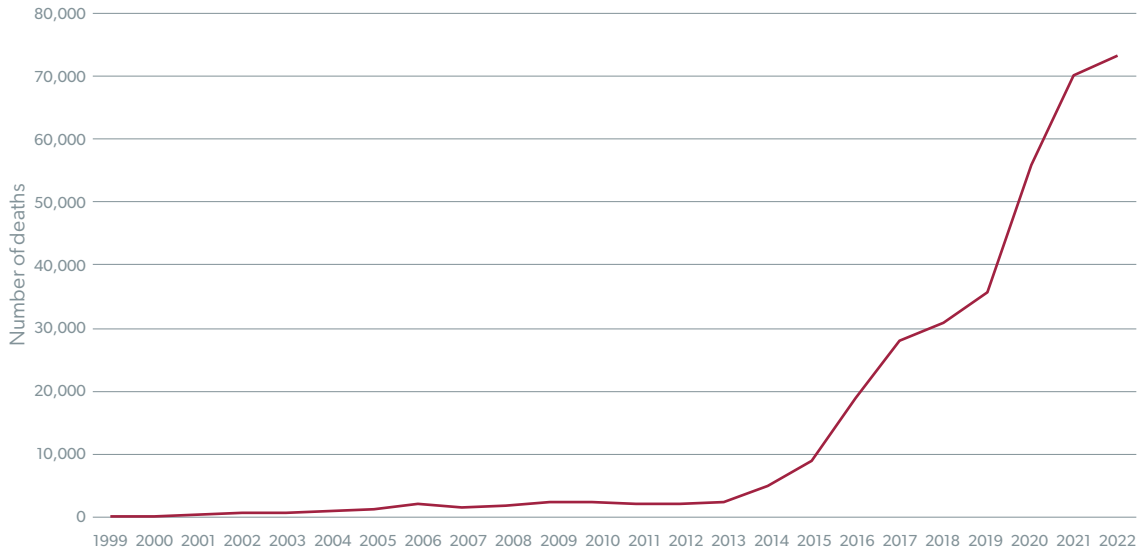
50 Ibid.

51 UNODC, *Afghanistan opium survey 2023 Cultivation and production after the ban: effects and implications*, November 2023.

52 Financial Times, *Lethal 'tranq' has ' penetrated' illicit drug market in the UK,* April 2024.

53 William McLennan, Colin Campbell and Abby Newbery, *Deadly nitazene drug adverts on X and SoundCloud, BBC finds - BBC News*, BBC News, April 2024.

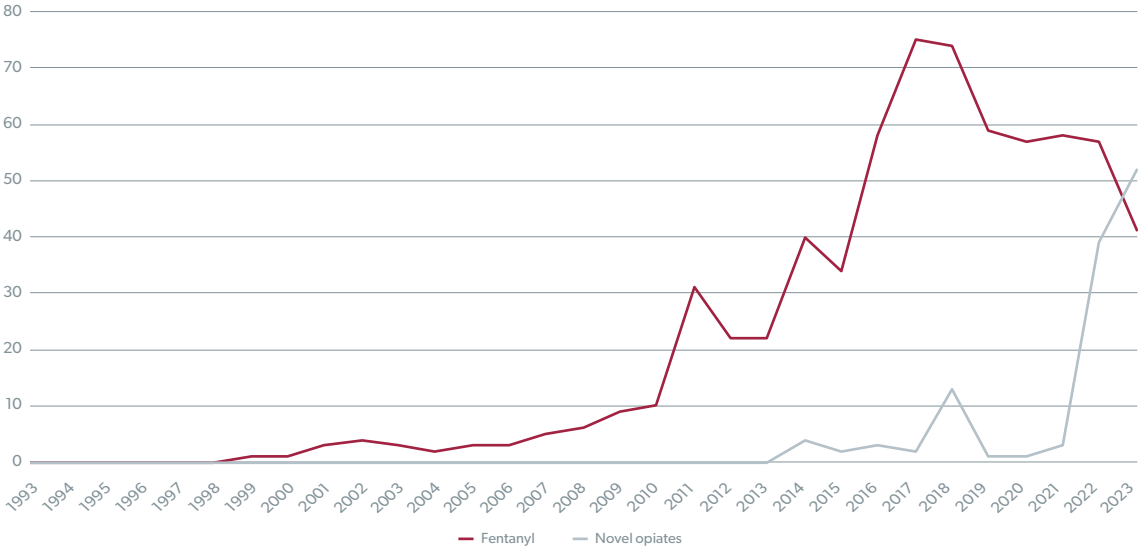
Figure 9: Synthetic opioid deaths other than methadone in the United States.



Source: NIDA, Drug Overdose Deaths: Facts and Figures. National Institute on Drug Abuse, Overdose Data Tables, August 2024.

The UK is not immune to this trend. This past year, novel opiate deaths were 17 times higher than in 2021 and fentanyl, up to 100 times more potent than morphine,[54] was featured on 41 death certificates.[55] By 19 September 2024, the Office for Health Improvement and Disparities and the National Crime Agency confirmed through lab tests that 179 deaths involving nitazenes occurred between 1 June 2023 and 31 May 2024.[56]

Figure 10: Number of drug related deaths in England and Wales where fentanyl and novel synthetic opioids were included on death certificates.



Source: ONS, Deaths related to drug poisoning by selected substances, England and Wales, October 2024, Table 3.

54 NIDA, *Fentanyl*, December, 2021.

55 Office for National Statistics, *Deaths related to drug poisoning by selected substances, England and Wales*, October 2024, Table 3.

56 Office for Health Improvement and Disparities, *Deaths linked to potent synthetic opioids*, October 2024.

New substances are constantly entering the UK drug market, and the potential rise of substances like fentanyl cannot be dismissed.

A Walk Through Kensington

As part of this research project, the CSJ visited Kensington, a neighbourhood in Philadelphia, the United States of America. This is an area deeply impacted by the opioid crisis, particularly by heroin and fentanyl addiction. Drug-related issues have significantly impacted the area, with the effects of the evolving drug market clearly visible across the community. The following account describes the CSJ's experience in Kensington.

Known as the biggest open-air drug market in the United States, the streets of Kensington, Philadelphia are lined with individuals whose lives are deeply affected by addiction. The effects of the tranquilizer xylazine, commonly referred to as "tranq," are stark. On a sweltering 35-degree day, hundreds of people are sprawled across street corners, their bodies marked with wounds that stubbornly refuse to heal.

At first mistaking the pungent smell of the air for rotting garbage, our guide informed us that it was people's unhealed wounds festering and decaying in the scorching sun.

A few blocks down is a playground known as "Needle Park" where children play in a fenced-off area to shield them from the sight of overdoses and discarded syringes. I saw people injecting needles into the necks of their friends. Our guide told me that sometimes when people have overdosed, a bystander will remove the needle from the person's arm and inject the remaining drugs into themselves. "It's an opportunity for a free high" he told the CSJ.

The local Mayor has called for more police presence, but the diversion schemes that once helped people avoid criminal charges in favour of treatment no longer appear to be in place. I watched new police recruits cycle around the streets, chatting to each other, seemingly desensitised to the chaos around them.

Many times during the day dealers shout out "sample!" and users flock to them, lured by the promise of free drugs. The scene is frequently captured by YouTubers, filming it to attract clicks and advertising dollars on the internet. Viewers across the United States see the films and are drawn to the place by the promise of free drugs, only to find themselves trapped in a cycle of addiction and unable to leave. Facebook groups like "Lost in Kensington" have thousands of members desperately searching for their loved ones last seen heading for Kensington.

Those who could leave did, and those who remained were carving out a life for themselves in an area most people had chosen to forget.

Kensington, Philadelphia, is a stark reminder of the devastating impact of drug addiction. The changing drug market poses a threat to the UK as well as abroad. Xylazine, a non-opioid sedative commonly used in veterinary medicine, exacerbates the effects of opioids, complicating treatment, and recovery efforts. Known as 'tranq' when mixed with heroin or fentanyl, this drug is already causing significant harm in the US by dangerously affecting breathing and heart rate.[57] In May 2022, xylazine claimed its first victim in the UK, a 43-year-old man from Solihull. As of summer 2023, toxicology reports have detected xylazine in sixteen individuals in the UK, with eleven fatalities recorded.[58]

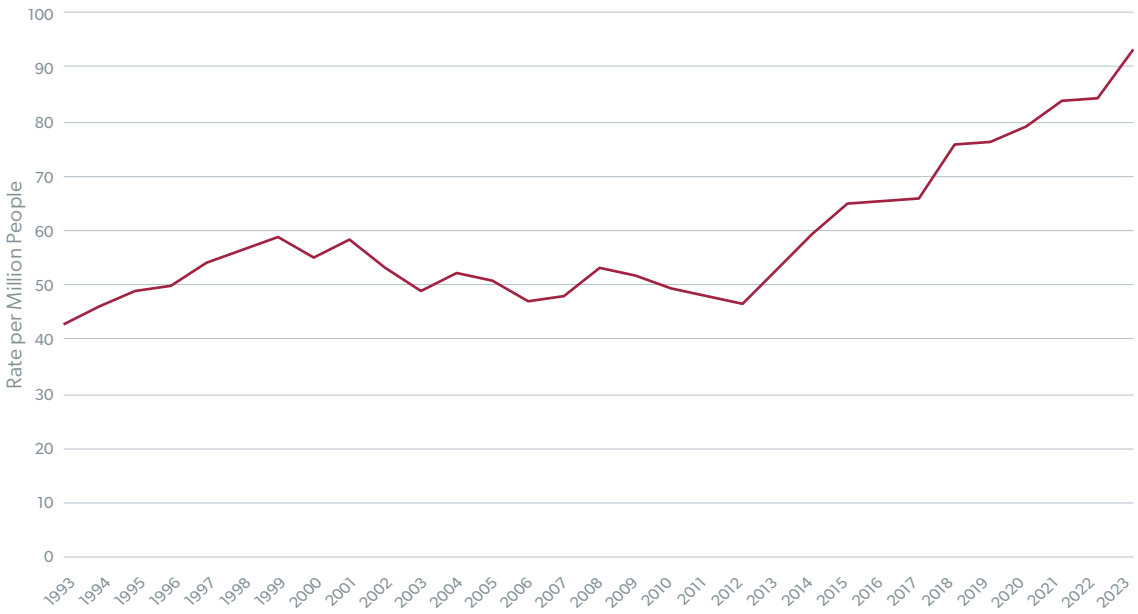
Kensington exemplifies exactly what the toxic drug supply can do. The Government cannot afford to maintain the status-quo if they have any hope of mitigating this looming crisis.

Deaths Related to Drug Poisoning

The most severe consequence of drug use is the potential for fatal overdose, which tragically represents the ultimate cost of substance abuse.

Deaths related to drug poisoning have reached their highest on record. The latest ONS figures recorded 5,448 deaths in 2023 related to drug poisoning in England and Wales, equivalent to a rate of 93 deaths per million people.[59] This is 84 per cent higher than a decade ago.[60] The age-standardised mortality rate (a weighted average of the age-specific mortality rates per 100,000 persons) related to drug poisoning has risen every year since 2012.

Figure 11: Age-standardised mortality rates for deaths related to drug poisoning, England and Wales, registered between 1993 and 2023.



Source: ONS, Deaths related to drug poisoning in England and Wales: 2023 registrations, October 2024.

57 Friedman J, Montero F, Bourgois P, Wahbi R, Dye D, Goodman-Meza D, et al. Xylazine spreads across the US: a growing component of the increasingly synthetic and polysubstance overdose crisis. *Drug Alcohol Depend*. 2022; 233:109380.

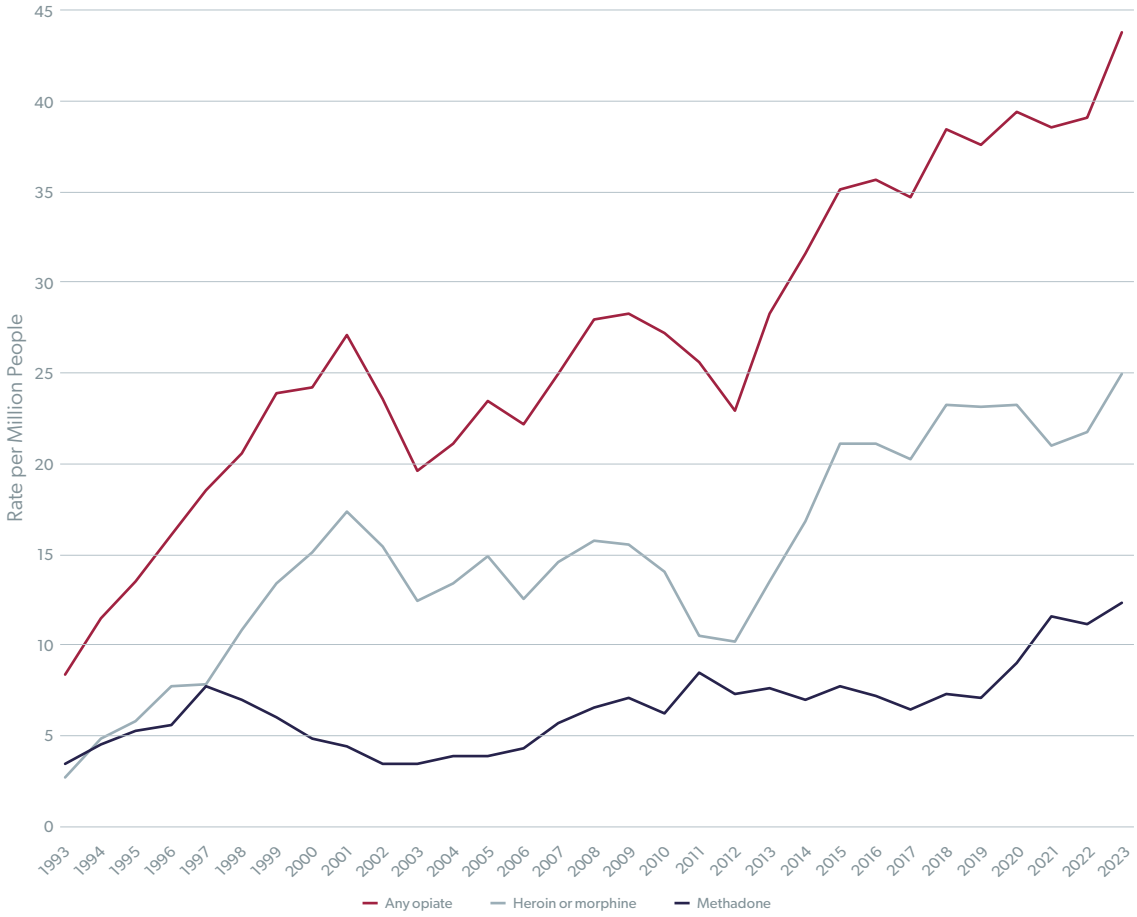
58 Copeland, Caroline S., et al. *Broad evidence of xylazine in the UK illicit drug market beyond heroin supplies: Triangulating from toxicology, drug-testing and law enforcement,* Addiction, 2024.

59 Office for National Statistics, *Deaths related to drug poisoning in England and Wales: 2023 registrations,* October 2024.

60 Office for National Statistics, *Deaths related to drug poisoning in England and Wales: 2013,* September 2014.

In 2023, 2,551 drug poisoning deaths involved opiates, marking a 12.8 per cent increase from 2022 registrations.[61] Opiates contributed to nearly half (46.8 per cent) of all drug-poisoning fatalities, rising to 60.7 per cent when deaths lacking drug type information on the death certificate are excluded. Among opiates, heroin and morphine—often indistinguishable in toxicology tests—remained the most cited substances, accounting for 1,453 drug-poisoning deaths in 2023 (equating to 25 deaths per million individuals).[62]

Figure 12: Age-standardised mortality rates for deaths by all opiates, heroin or morphine, and methadone, England and Wales, registered between 1993 and 2023.



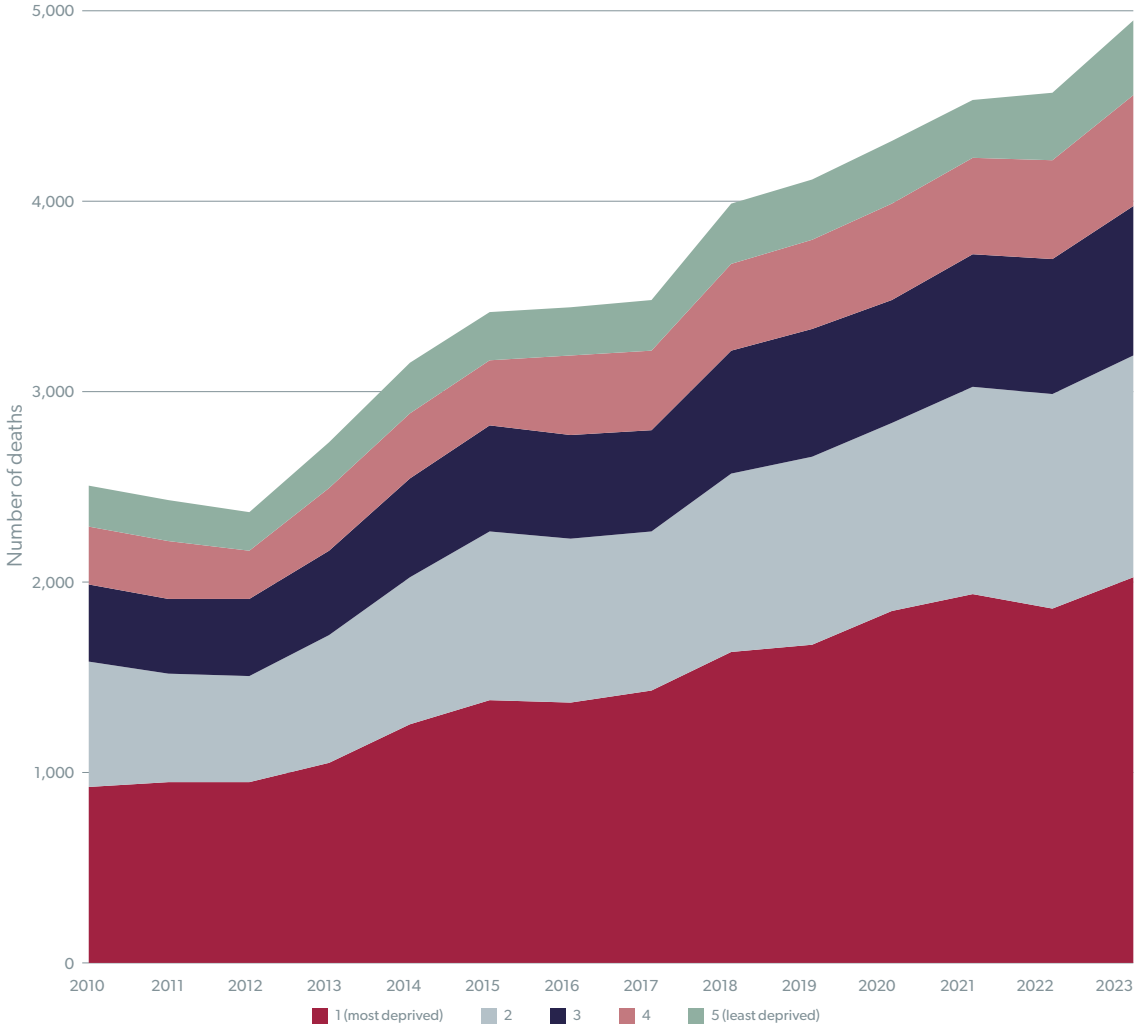
Source: ONS, Deaths related to drug poisoning in England and Wales: 2023 registrations, October 2024.

In 2023, a total of 1,118 deaths linked to cocaine were recorded, marking a 30.5 per cent rise from the previous year's 857 deaths.[63] This is almost a tenfold increase from the 112 deaths reported in 2011. Men made up the majority of these fatalities, accounting for 79.2 per cent, with 886 male deaths compared to 232 female deaths. Over the past decade, cocaine has remained the second most commonly used drug in England and Wales, following cannabis.[64]

61 Office for National Statistics, *Deaths related to drug poisoning in England and Wales: 2023 registrations,* October 2024.
62 Ibid.
63 Ibid.
64 Ibid.

The most disadvantaged people are disproportionately affected by drug poisonings, as shown in Figure 13. The rate has increased every year since 2012, after remaining relatively stable over the preceding two decades. Powerful, potent opioids infiltrating the drug supply, an aging drug user population, and a struggling treatment sector are all potential reasons behind this shift.[65]

Figure 13: Number of deaths and age-standardised mortality rates for deaths related to drug poisoning, by IMD quintile, England, deaths registered between 2010 – 2023.



Source: ONS, Deaths related to drug poisoning, England and Wales, Number of deaths and age-standardised mortality rates for deaths related to drug poisoning, by sex and IMD quintile, England, deaths registered between 2010 and 2023, Table 8, October 2024.

Those facing socioeconomic hardships are more vulnerable to the risks associated with drug poisonings. These individuals often lack the resources and support systems needed to address addiction effectively, leading to higher rates of overdose and death. Addressing these underlying social determinants is crucial in reducing the impact of drug poisonings and improving overall public health outcomes.

65 Jessica Murray, *Drug poisoning deaths in England and Wales at highest level in 30 years*, December 2023.

Deaths Classified as Drug Misuse

Deaths classified as drug misuse must meet either one or both of the following conditions:[66]

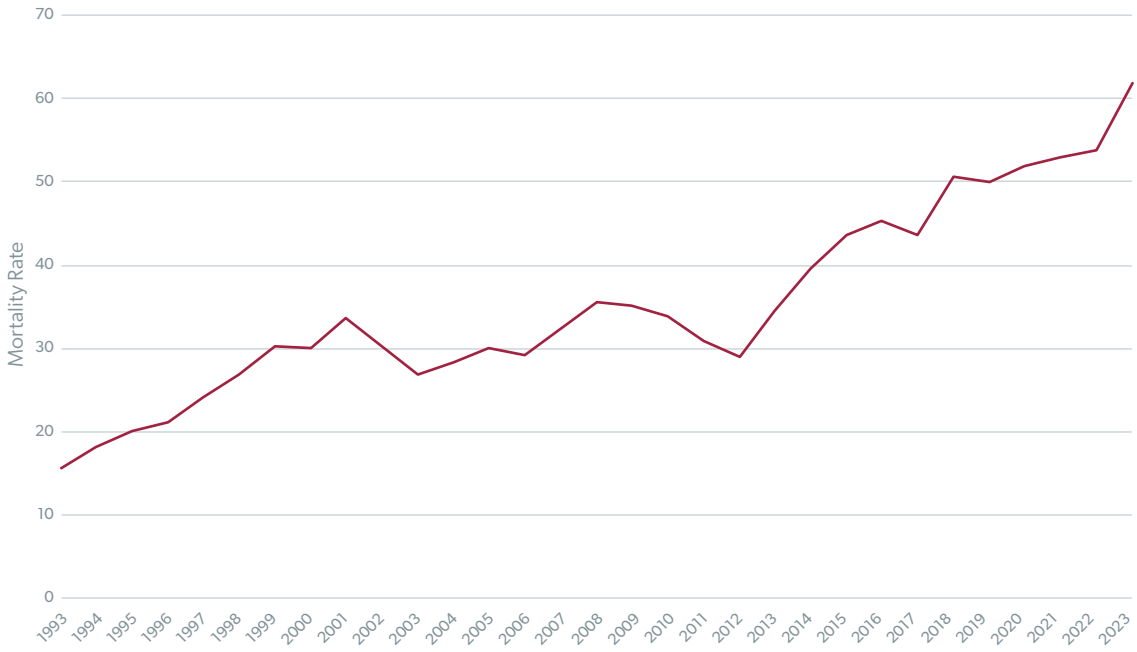
- The underlying cause is drug abuse or drug dependence; and
- any of the substances involved are controlled under the Misuse of Drugs Act 1971.

Notably, information on the specific drugs involved in a death is not always available, leading to underestimates in figures on drug misuse. The proportion of drug-related deaths without information on the specific substances involved has increased over time, which warrants caution in interpreting these statistics.[67]

Of the 5,448 registered drug-poisoning deaths in 2023, 3,618 were identified as drug misuse, representing 66.4 per cent of drug poisonings.[68] Excluding deaths where no information was available on involved drugs (1,240 deaths), 86.1 per cent of drug-poisoning deaths were attributed to drug misuse.

The rate of drug misuse deaths in 2023 was 61.8 deaths per million people. The rate among males was 90.4 deaths per million (2,586 registered deaths), while among females it was 34.4 deaths per million (1,032 deaths).[69]

Figure 14: Age-standardised mortality rates per million people for drug misuse between 1993 - 2023.



Source: ONS, Deaths related to drug poisoning in England and Wales: 2023 registrations, Age-standardised mortality rates per million people, standardised to the 2013 European Standard Population. 2. Cause of death was defined using the International Classification of Diseases, Ninth Revision (ICD-9) for the years 1993 to 2000 and Tenth Revision (ICD-10) from 2001 onwards. More details can be found in our [Deaths related to drug poisoning in England and Wales Quality and Methodology Information], October 2024.

66 Ibid.

67 Paul Breen, *Comparability of drug-related death statistics across the United Kingdom*, August 2023.

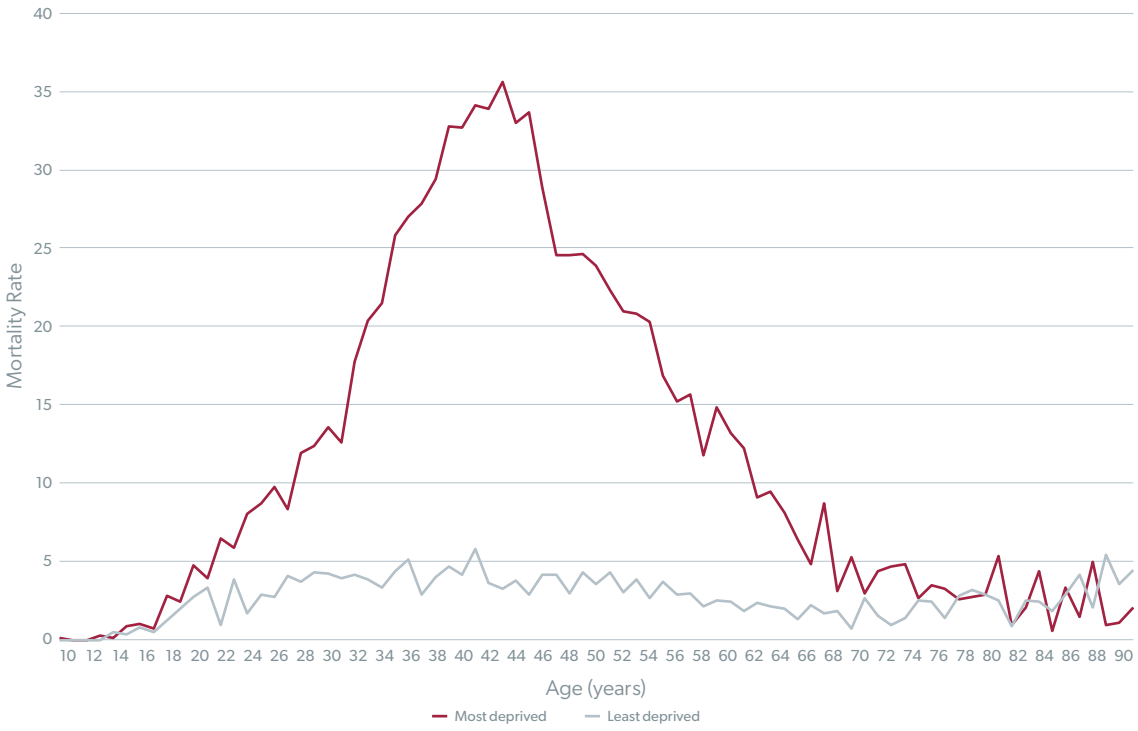
68 Office for National Statistics, *Deaths related to drug poisoning in England and Wales: 2023 registrations*, October 2024.

69 Ibid.

The highest rate of drug misuse deaths was found in those aged 40 to 49 years (147.3 deaths per million people). Those born between the late 1960s and early 1980s have consistently had the highest rates of drug misuse deaths for the past 25 years.[70] Contributing factors include long term drug use, economic deprivation, and declining health as they age, particularly in deprived communities.[71]

Drug deaths are relatively low in the least deprived areas, while the most deprived areas experience significantly higher numbers, particularly among middle-aged individuals.[72]

Figure 15: Drug poisonings in England by IMD quintile and single year of age, England, registered between 2013 - 2017.



Source: Office for National Statistics. Figures are based on the National Statistics definition of drug-related deaths with the cause of death being defined by the International Classification of Diseases, Tenth revision (ICD-10). Index of Multiple Deprivation (IMD) 2015 is the official measure of relative deprivation for small areas in England, which is the official measure of relative deprivation; quintile 1 is the most deprived and 5 is the least deprived. Figures are for deaths registered, rather than for deaths occurring in each calendar year. Figures for England excludes deaths of non-residents.

70 Office for National Statistics, *Middle-aged generation most likely to die by suicide and drug poisoning*, August 2019.

71 Ibid.

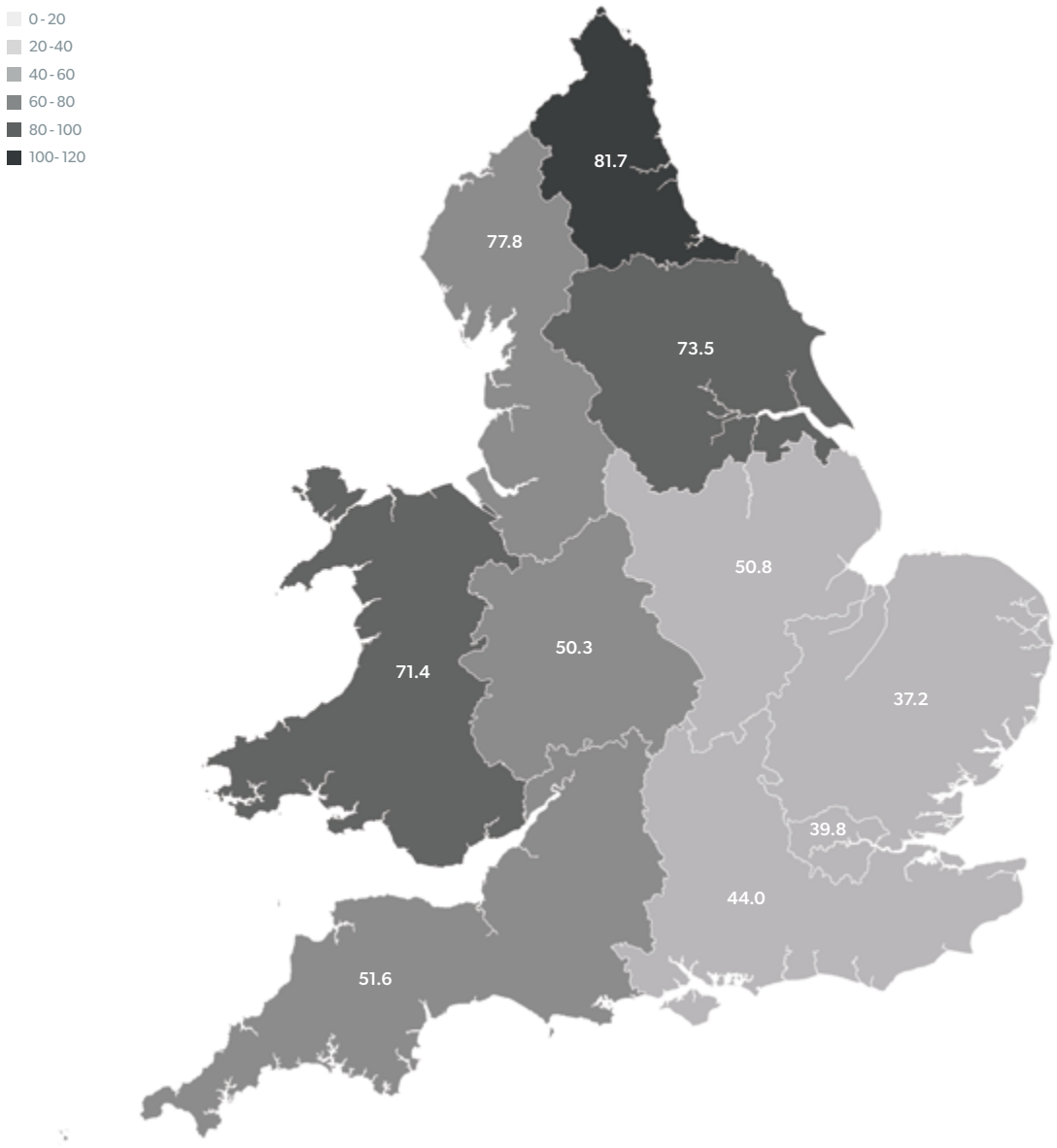
72 Office for National Statistics, *Middle-aged generation most likely to die by suicide and drug poisoning*, August 2019.

Regional Disparities

The highest rate of drug-poisoning deaths is in the North East (174.3 deaths per million; 441 registered deaths), while the lowest rate was in London (58.1 deaths per million; 500 deaths).[73] The North East has had the highest rate of drug-poisoning deaths for the past 11 years.

Similarly, the North East has the highest mortality rate for drug misuse deaths (108.5 per million).[74] London remains the lowest drug misuse mortality rate.

Figure 16: Regional variations of drug misuse mortality rates in England and Wales.



Source: ONS, Deaths related to drug poisoning in England and Wales: 2023 registrations, Table 7, October 2024.

73 Office for National Statistics, *Deaths related to drug poisoning in England and Wales: 2023 registrations*, October 2024.

74 Office for National Statistics, *Deaths related to drug poisoning in England and Wales: 2023 registrations*, Table 7, October 2024.

Addiction and Dependence

One of the greatest risks of drug use is addiction, which can have profound and lasting effects on a person's life.

The NHS defines addiction as 'not having control over doing, taking or using something to the point where it could be harmful to you'.[75] There is ongoing debate surrounding the classification of addiction as an independent mental disorder. However, consensus exists among authoritative bodies such as the World Health Organization (referencing the ICD-11), the Association of American Psychiatry (DSM-V), and the Royal College of Psychiatry, all of which recognise addiction as a distinct mental and behavioural disorder.

The concept of a loss of control in addiction holds significance as it underscores commonalities across various addictive behaviours. This makes discussions about the specific various substance less pertinent in certain contexts. Whether dealing with someone who uses cocaine or heroin, the shared experience of a fundamental loss of control unifies these individuals.

Drug Dependence

Drug dependence is separate from addiction. It is a physical dependency on a substance, involving tolerance and withdrawal. Addiction is characterised by a persistent and intense urge to use a drug or engage in a behaviour.[76]

The most up-to-date information on illicit substance dependence is gathered by the Adult Psychiatric Morbidity Survey (APMS), published in September 2016.[77]

APMS findings suggest 35.4 per cent of men and 22.6 per cent of women had used an illicit drug at least once in their lifetime. Among both men and women, those aged between 25 - 34 were the most likely to have ever used illicit drugs (52.9 per cent and 35.0 per cent respectively), decreasing to 3.3 per cent of men and 2.8 per cent of women aged 75 or over.[78]

Individuals who reported using specific drugs were questioned about indications of dependency on those substances. The markers inquired about included: consistent daily usage for a period of two weeks or more; experiencing a sense of need or dependency; inability to refrain from use; heightened tolerance; and withdrawal symptoms.

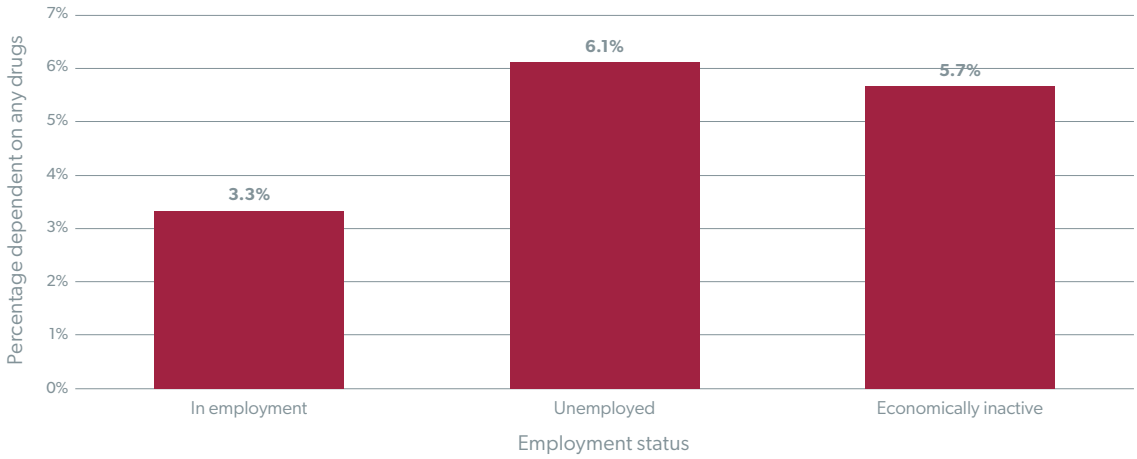
Overall, 3.1 per cent of adults display signs of drug dependency.[79] This includes 2.3 per cent who exhibit signs of dependency solely on cannabis and 0.8 per cent with dependency on other drugs (with or without concurrent cannabis dependency). Following increases during the 1990s, the overall rate has remained constant since 2000.

Dependency rates vary by age and gender. Specifically, 4.3 per cent of all men exhibit signs of dependence on illicit drugs (in comparison to 1.9 per cent of women), including 11.8 per cent of men aged 16 - 24 and 6.6 per cent of men aged 25 to 34.[80]

75 NHS England, *Addiction: what is it?*, July 2024.
76 National Institute on Drug Abuse, *Drug Misuse and Addiction*, Jul. 2011.
77 NHS England, *Adult Psychiatric Morbidity Survey*, September 2016.
78 Ibid.
79 Ibid.
80 Ibid.

Drug dependency varies by employment status. Among men, indications of drug dependency were most prevalent among economically inactive (9.6 per cent) respondents.[81] Conversely, among women, the highest prevalence was observed among the unemployed (4.4 per cent). The lowest prevalence was recorded among both men and women who were employed (4.5 per cent of employed men, 2.1 per cent of employed women). This trend contrasts with hazardous alcohol consumption, where rates are highest among individuals who are employed.

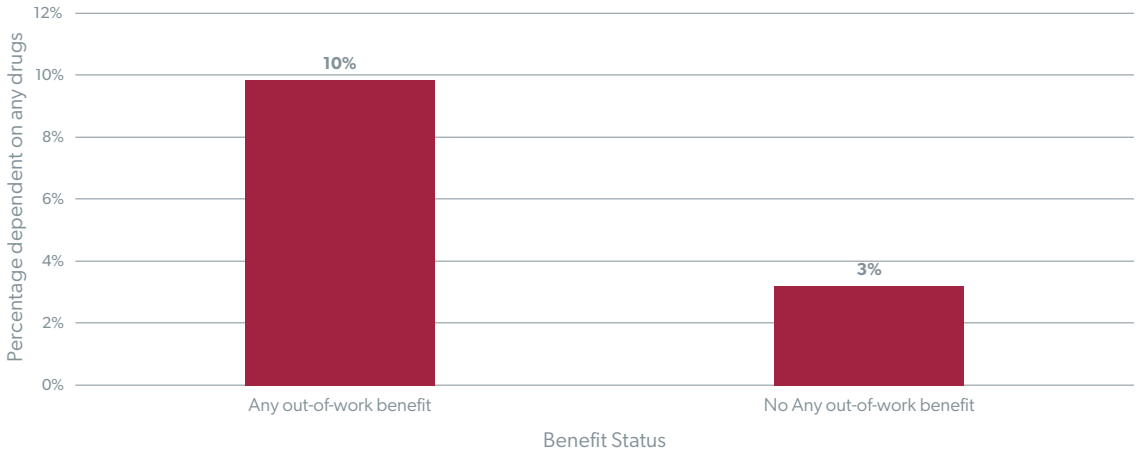
Figure 17: Drug dependence and employment status.



Source: Adult Psychiatric Morbidity Survey: Chapter 11, Drug Use and Dependence, September 2016. Dependence questions were asked about cannabis, amphetamines, cocaine, crack, ecstasy, heroin and methadone (asked about together), tranquilisers and volatile substances. They were not asked about LSD, magic mushrooms, amyl nitrite, ketamine, mephedrone, and anabolic steroids, as these types of drugs are less associated with the development of dependency. The 'economically inactive' group includes students, and those looking after home, long term sick or disabled, or retired.

Individuals receiving benefits are more likely to display signs of dependency.[82]

Figure 18: Drug dependence and out of work benefits.

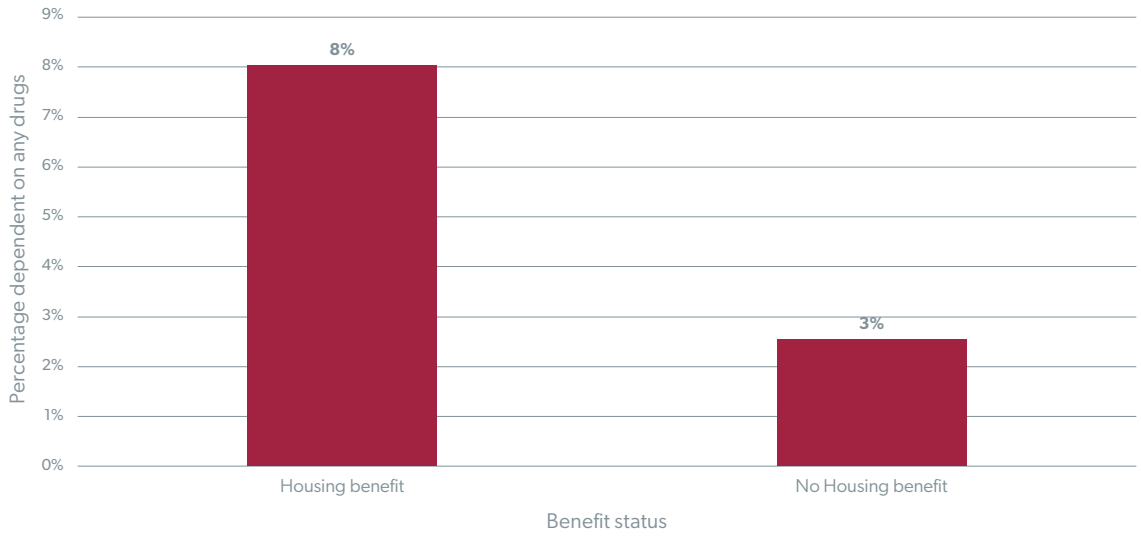


Source: Adult Psychiatric Morbidity Survey: Chapter 11, Drug Use and Dependence, September 2016. Dependence questions were asked about cannabis, amphetamines, cocaine, crack, ecstasy, heroin and methadone (asked about together), tranquilisers and volatile substances. They were not asked about LSD, magic mushrooms, amyl nitrite, ketamine, mephedrone, and anabolic steroids, as these types of drugs are less associated with the development of dependency. Employment and Support Allowance (ESA) is a benefit for people of working-age who are unable to work due to illness or disability. Includes benefits aimed at people who are out-of-work, including Jobseekers' Allowance and ESA.

81 Ibid.

82 Ibid.

Figure 19: Drug dependence and housing benefits.



Source: Adult Psychiatric Morbidity Survey: Chapter 11, Drug Use and Dependence, September 2016. Dependence questions were asked about cannabis, amphetamines, cocaine, crack, ecstasy, heroin and methadone (asked about together), tranquilisers and volatile substances. They were not asked about LSD, magic mushrooms, amyl nitrite, ketamine, mephedrone, and anabolic steroids, as these types of drugs are less associated with the development of dependency. Housing benefit is paid to certain low income households to help with rent payments.

Individuals who are dependent on drugs are often trapped in a cycle of addiction that significantly impairs their ability to work and increases their reliance on social benefits. Results from the APMS show that people on benefits are disproportionately more likely to be dependent on drugs. This suggests that substance abuse contributes to a lack of employment and a higher dependency on government assistance.

However, recovery from addiction can have a profound impact on an individual's economic prospects. For instance, a report from the LSE Centre for Economic Performance suggests "a recovered addict has an increased probability of working of 20.8 per cent and would earn £17,743 a year and receive £9,056 less in benefits. [83] This shift not only improves their quality of life, but also results in tangible economic benefits.

The Treatment Sector

The treatment sector is a vital aspect of addressing drug addiction and substance use disorders, encompassing a broad spectrum of services designed to support individuals in their recovery journey. For young people in particular, it is crucial to assess how well current treatment programmes address their unique needs and challenges.

The cost saving implications for the Government are significant. The net cost to the Government for treating one person with an addiction in the first two years is -£1,341 with a saving of £10,308.[84]

By focusing on the treatment sector's ability to cater to this vulnerable group, we can better understand how to tailor interventions and support systems to improve outcomes for those battling addiction.

83 David Frayman, Christian Krekel, Richard Layard, Sara MacLennan and Isaac Parkes, *Value for Money,* p. 17, September 2024.

84 David Frayman, Christian Krekel, Richard Layard, Sara MacLennan and Isaac Parkes, *Value for Money,* September 2024.

The treatment landscape

Proximity often acts as a barrier to treatment access. The CSJ heard reports of "treatment deserts", areas where individuals are told there is no available abstinence-based treatment programmes. In response to these claims, the CSJ submitted two freedom of information requests (FOIs) inquiring on the locations and availability of drug and alcohol treatment programmes. The first, to the Department for Health and Social Care (DHSC), was unsuccessful as the department responded stating "DHSC does not hold the information you have requested."[85] A surprising finding, given the department's role in overseeing and regulating treatment statistics as well as funding.

The second FOI, to the Care Quality Commission (CQC), revealed information on registered services within their Care Directory Ratings. The CQC confirmed that it holds relevant information on rehabilitation facilities operating within England, particularly those providing residential accommodation in conjunction with substance misuse treatment.

This type of service, known as "Accommodation for people who require treatment for substance misuse" (ATSM), falls under a regulated activity that includes both accommodation and treatment interventions such as managed withdrawal, detoxification, and structured psychosocial programmes. ATSM is distinct from hospital-based detoxification services, which are regulated differently.

It should be noted that this data does not include rehabilitative services that are not registered with the CQC. Though this information provides a preliminary scoping of the treatment landscape, it does not include unregistered support services for those struggling with substance misuse.

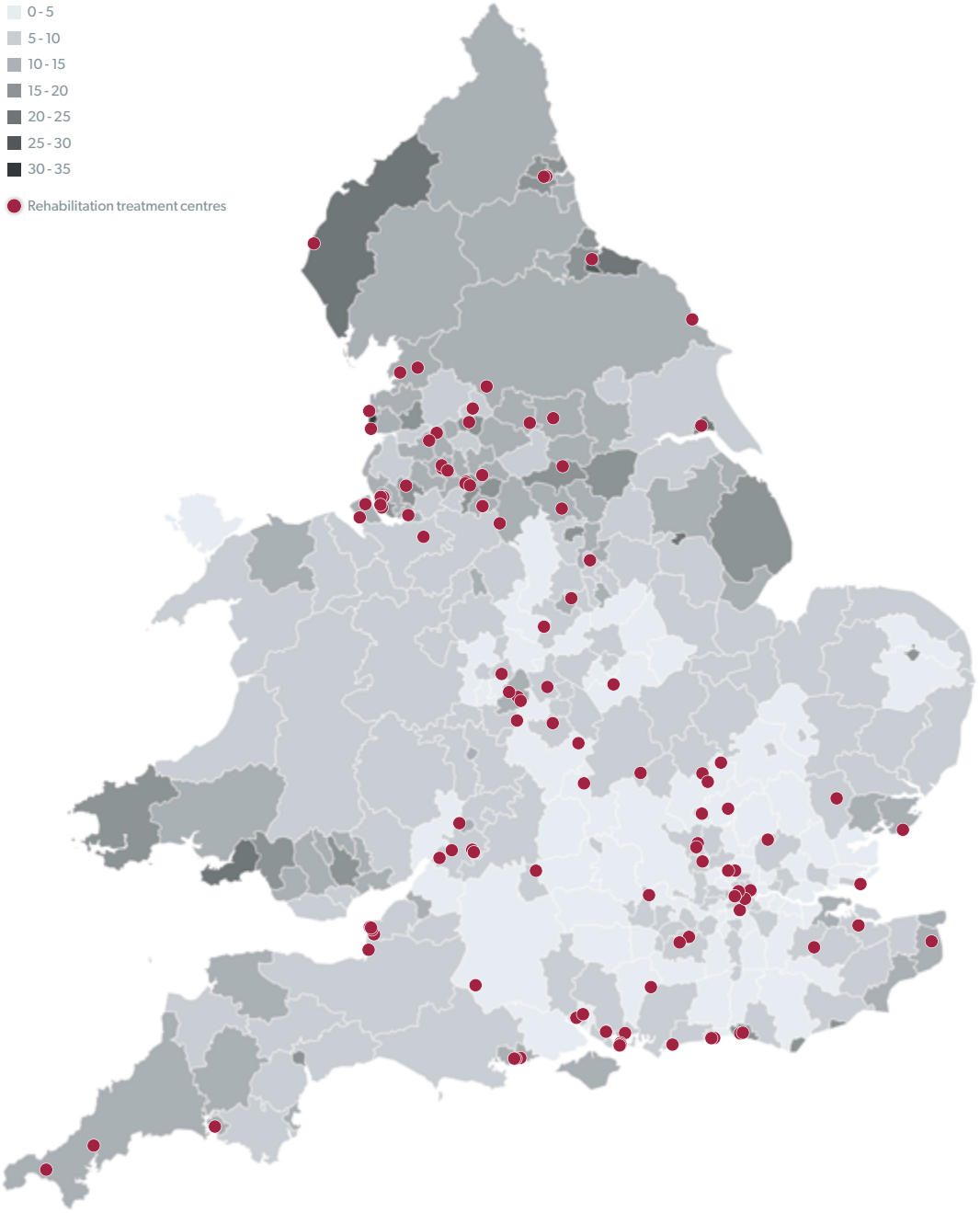
Based on the CQC's information, in October 2024, there are 121 Independent Healthcare Organisations whose primary inspection category is residential substance misuse. The distribution of these organisations across different regions are as follows:

Region	Number of Services
East Midlands	5
East of England	12
London	11
North East	3
North West	30
South East	24
South West	20
West Midlands	9
Yorkshire and The Humber	7

Figure 20 illustrates the locations of CQC registered Independent Healthcare Organisations whose primary inspection category is residential substance misuse. This map offers a clearer perspective on the regional disparities highlighted earlier and serves as a visual tool to better understand the uneven access to addiction treatment services across England.

85 Centre for Social Justice, *Freedom of Information Request to the DHSC*, August 2024.

Figure 20: Locations of CQC registered services whose primary regulatory activity is accommodation for people who require treatment for substance misuse and drug related deaths rates by local authority.



Source: CSJ analysis of FOI to the Care Quality Commission.

The CQC's data highlights a concerning postcode lottery in the availability of in-patient rehabilitation centres for drug and alcohol addiction across England. While the North West and South West have the highest concentration of facilities, the North East, despite having the highest drug misuse death rate for the past decade,[86] has only two centres.

When considering the Government's ambition to deliver a world-class treatment and recovery system,[87] this data reveals a significant shortfall in achieving that goal. It is particularly concerning that, despite the growing need for comprehensive addiction treatment, almost 20 per cent of services do not have a rating. This suggests that not only is there an uneven geographical distribution of services, but the overall quality of care in many regions may also be falling short of the standards necessary to effectively combat the addiction epidemic. Addressing this imbalance must be a priority if the Government's treatment and recovery ambitions are to be realised.

Location Latest Overall Rating	Number of Services
Good	84
Inadequate	1
Outstanding	6
Requires improvement	6
(blank)	24

Similarly, non-residential substance misuse services are unevenly spread. Observing the CQC's information on registered originations whose primary inspection category is the provision of a community substance misuse service, London, the area with the lowest drug misuse mortality rate,[88] has the highest concentration of services.

Community Substance Misuse Services by Region:

Row Labels	Number of Services
East Midlands	7
East of England	9
London	30
North East	14
North West	24
South East	23
South West	11
West Midlands	11
Yorkshire and The Humber	15

The North East, once again, falls behind. Despite its disproportionately high rate of overdose deaths, there are less services in this region compared to London, the North West, the South East, and Yorkshire and Humber. As seen in Figure 21, the community substance misuse services are unevenly spread.

86 Office for National Statistics, *Deaths related to drug poisoning in England and Wales: 2023 registrations,* Table 7, October 2024.

87 Home Office, Department of Health and Social Care, Ministry of Justice, Department for Work and Pensions, Department for Education and Department for Levelling Up, Housing and Communities, *From Harm to Hope: A 10 year drug plan to cut crime and save lives,* December 2021.

88 Office for National Statistics, *Deaths related to drug poisoning in England and Wales: 2023 registrations,* Table 7, October 2024.

Figure 21: Locations of community substance misuse treatment services (non-residential) in England.

Source: CSJ analysis of FOI to the Care Quality Commission.

Approximately 28 per cent of community substance misuse services do not have a rating from the CQC. Much like the ratings from the residential services, this data leaves room for improvement.

Row Labels	Number of Services
Good	83
Outstanding	14
Requires improvement	6
(blank)	41

This geographic bias means that access to essential rehabilitation services is largely determined by where someone lives, potentially leaving those in underserved regions without the help they desperately need. In areas with fewer treatment centres, individuals struggling with addiction may face longer wait times, limited bed availability, and a lack of specialised care. This unequal distribution of services intensifies the ongoing addiction issues, disproportionately affecting regions with already high rates of substance misuse and related deaths.

In further analysis, it may be beneficial to explore the capacity and specific services offered by these organisations to better understand their role in addressing addiction treatment needs in their respective regions. However, the CQC does not hold information on current availability within each service, nor does the DHSC.

Funding Treatment

Local authorities (both upper-tier and unitary) commission drug and alcohol treatment and recovery services as part of their public health responsibilities.

In December 2021, the Government unveiled a 10-year drug strategy, committing £780 million to "rebuild the drug treatment system." For 2024-2025, the DHSC plans to increase this support with a further £266.7 million.[89] In February of this year, the DHSC pledged £154.3 million in additional grants aimed at enhancing these services, aligning with the goals set out in the Government's drug strategy and the recommendations from Dame Carol Black's independent review.[90]

The Government's drug strategy promised that every local authority in England would receive increased funding to address drug and alcohol misuse over the next three years, prioritising areas with the most urgent needs. However, in practice, only £101.2 million was allocated in additional grants for treatment and recovery services for the year 2022-2023.[91] This amount increased to £144.6 million in 2023-2024 and to £257 million for 2024-2025.[92]

Despite these increases, the funding falls short of repairing the damage caused by a decade of underfunding and cannot compensate for the lives lost due to this neglect.

Before the introduction of the Health and Social Care Act 2012, funding for drug treatment services had steadily increased year after year.[93] The National Treatment Agency for Substance Misuse (NTA) had protected this funding, managing a budget of £467 million annually until it was reallocated and no longer ring-fenced specifically for opioid treatment services.[94]

89 Office for Health Improvement and Disparities, *Additional drug and alcohol treatment funding allocations: 2023 - 2024 and 2024 - 2025*, February 2023.
90 Office for Health Improvement and Disparities, *Additional drug and alcohol treatment funding allocations: 2023 - 2024 and 2024 - 2025*, February 2023.
91 Office for Health Improvement and Disparities, *Additional drug and alcohol treatment funding allocations: 2022 to 2023*, April 2022
92 Office for Health Improvement and Disparities, *Additional drug and alcohol treatment funding allocations: 2023 - 2024 and 2024 - 2025*, February 2023.
93 The King's Fund, *Improving drug treatment services in England Models for commissioning and accountability*, July 2021.
94 Ibid.

Although the 2021 Drug Strategy claims to allocate record funding to address drug misuse, the Government's £780 million commitment averages just £260 million per year if spread over the first three years rather than the full ten. Adjusted for inflation, the £467 million allocated in 2012 would equate to £656.4 million in October 2024.[95] This is a 60 per cent drop in funding. Without adjusting for inflation, this remains a 44.3 per cent drop.

This calculation also assumes that the current Government will meet its spending targets by the end of the third year, which may be optimistic given that only £257 million is currently earmarked for 2024-2025 by the previous Government.

A critical issue lies not just in the funding of rehabilitative interventions but also the quality of the therapeutic support provided by such services as well as the adequacy of the case management. Research on Birmingham's Drug Intervention Programme findings show that while clients were typically seen for an average of 44.3 minutes per session, only 10 minutes were dedicated to evidence-based interventions.[96] Session length and content varied widely, influenced by both client characteristics and staff factors. Independent Review of Drugs recognised this as a national problem.[97] This raises a fundamental question about why so few people receive evidence-based care, despite its necessity.

There is a lack of long term sustainable and equitable funding through clear pathways into treatment for the whole system. A harmony of equitable funding models that reflect across the diverse needs is required, which includes residential rehabilitation, community treatment services and lived experience recovery organisations. Following a decade of underfunding and the impact of the pandemic, experienced staffing is a key challenge which requires investment and long term funding to achieve.

Inpatient detoxification

Detoxification is a therapeutic process aimed at eliminating toxins from the body of individuals acutely affected by or dependent on substances, ensuring safe management through the withdrawal phase.[98]

Dame Carol Black's review found that inpatient detoxification, known as detox, was rationed and had nearly disappeared in some parts of England, resulting in significant unmet needs.[99] A clear consequence of this insufficient availability is that people are forced to wait for treatment.

Waiting for inpatient detoxification is emotionally and socially taxing. The waiting period is associated with feelings of powerlessness,[100] uncertainty,[101] discomfort, and stress.[102] However, people do benefit from attending support groups between referral and enrolment in a detoxification programme.[103]

Some improvements have been made. Between 2005/06 and 2022/23, the proportion of individuals waiting less than three weeks for their first treatment intervention improved significantly, with 98-99 per cent achieving this wait time across all substance groups by 2022/23.[104] This trend, influenced by factors such as additional funding from the 10-year drug strategy and remote interventions during the pandemic, is coupled with an

95 Bank of England Inflation Calculator.

96 David Best et al., *What treatment means in practice: An analysis of the delivery of evidence-based interventions in criminal justice drug treatment services in Birmingham, England*, January 2009.

97 Dame Carol Black, *Independent Review of Drugs Part 2: Prevention, treatment, and recovery,* August 2021.

98 American Psychological Association, *APA dictionary of psychology American Psychological Association,* 2023.

99 Dame Carol Black, *Review of drugs: phase one,* February 2020.

100 Bourdieu, Pierre. *Pascalian meditations*. Stanford University Press, 2000.

101 Biner, Zerrin Özlem, and Özge Biner. "Introduction: On the politics of waiting." *Social Anthropology/Anthropologie sociale* 29.3 (2021): 787-799.

102 Joanne Neale, et al. "Waiting for inpatient detoxification: A qualitative analysis of patient experiences." *International Journal of Drug Policy* 123 (2024): 104291.

103 Neale, Joanne, et al., *Waiting for inpatient detoxification: A qualitative analysis of patient experiences.*, *International Journal of Drug Policy* 123 (2024): 104291.

104 Office for Health Improvement and Disparities, *Alcohol and drug misuse treatment for adults statistics,* December 2023.

average waiting time of 1.9 days for a first intervention in 2022/23.[105] This is a welcomed change. Bolstering the spending into the treatment sector has mitigated some of the concerns raised in Dame Carol Black's review.

However, there is still room for improvement as drug related deaths continue to rise. Due to the challenges this cohort faces, a three-week period is a long time to wait to receive recovery support. The Government must maintain its support for drug and alcohol treatment facilities to keep waitlist times to a minimum across the nation.

Adults in treatment

The Office for Health Improvements and Disparities (OHID) published annual data on adult (over 18 years of age) substance misuse treatment[106] by collecting data from 600 sites that provide structured substance misuse interventions, covering every local authority in England. Treatment centres returning data include:

- community-based drug and alcohol services
- specialist outpatient services
- GP surgeries
- residential rehabilitation centres
- inpatient units

Alcohol and drug treatment services in England are funded and overseen by local authorities through the public health grant. These authorities are tasked with assessing the local demand for treatment and then commissioning a variety of services and interventions to address that demand.[107]

The conditions attached to the public health grant for 2023/24 stipulate that local authorities must prioritise improving the uptake of and outcomes from their drug and alcohol misuse treatment services.[108]

Between April 2022 and March 2023, there were 290,635 adults receiving support from drug and alcohol services, showing a 0.5 per cent increase compared to the previous year (289,215).[109] The number of adults entering treatment in 2022/23 was 137,749, which is higher than the figures from the previous two years (130,490 and 133,704).[110] The numbers of people entering treatment remained relatively stable from 2016/17 up to 2021/22.

Nearly half (48 per cent) of all adults in treatment were seeking help for opiate-related issues, although this number slightly decreased from the previous year (from 140,558 to 138,604).[111]

The next largest group of adults in treatment were those seeking help for alcohol-related problems, making up 30 per cent of all adults in treatment. While this number increased by 2 per cent from the previous year (from 84,697 to 86,257), it is lower than the peak observed in 2013/14 (91,651).[112]

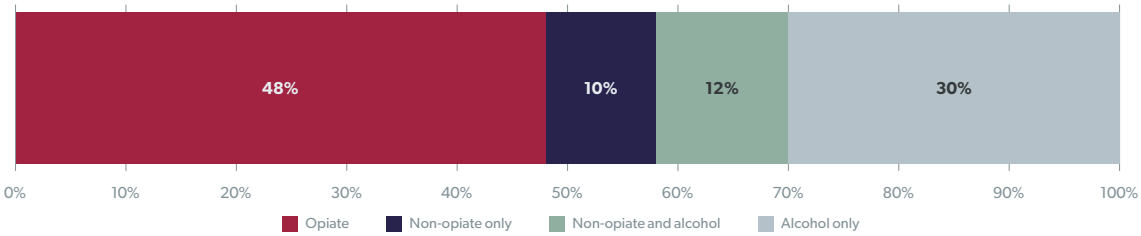
From 2021/22 to 2022/23, there were increases observed in the other two substance groups, with a 1 per cent increase in the non-opiate group and a 4 per cent increase in the non-opiate and alcohol group.

105 Ibid.
106 Office for Health Improvement and Disparities, *Adult substance misuse treatment statistics 2022 to 2023*, December 2023.
107 Ibid.
108 Department for Health and Social Care, *Public health grants to local authorities: 2023 to 2024*, August 2022.
109 Office for Health Improvement and Disparities, *Adult substance misuse treatment statistics 2022 to 2023*, December 2023.
110 Ibid.
111 Ibid.
112 Ibid.

This follows a rise in the previous year of 7 per cent for the non-opiate group and 11 per cent for the non-opiate and alcohol group.

After experiencing declines in the previous two years, there was an overall increase in the number of adults entering treatment for crack cocaine in 2022/23. This includes individuals using crack with opiates (from 18,832 to 20,158) and those using crack without opiates (from 4,711 to 5,444).[113]

Figure 22: Breakdown of adults entering treatment by substance group.



Source: Office for Health Improvement and Disparities, Adult substance misuse treatment statistics 2022 to 2023, December 2023. Breakdown of the substances reported by people in treatment in 2022 to 2023, split into the 4 substance groups. Up to 3 substances can be recorded at the start of treatment, so one person could be counted for several substances in their substance group (for example, somebody who uses cocaine, cannabis and alcohol, would appear in the non-opiate and alcohol group for these 3 substances).

Within substance groups, the number of adults starting treatment in 2022/23 with powder cocaine problems increased by 10 per cent (from 21,298 to 23,529), surpassing the previous peak number observed in 2019/20.[114]

Similarly, new entrants to treatment with cannabis problems increased by 2 per cent (from 28,263 in 2021/22 to 28,845 this year).[115] However, new entrants with benzodiazepine problems decreased by 6 per cent (from 3,848 in 2021/22 to 3,620 this year), after showing consistent increases from 2018/19 until 2021/22.

Although the numbers are relatively low, there was an increase in adults entering treatment in 2022/23 with ketamine problems (from 1,551 in 2021/22 to 2,211 this year), part of a trend of rising numbers seeking treatment over the last nine years, with the total now over five times higher than it was in 2014/15.[116]

Opiates were the most cited drug, with slightly more individuals reporting the use of opiates alongside crack compared to opiates alone. Out of all individuals receiving treatment, 50 per cent reported issues with opiates, crack, or both.[117]

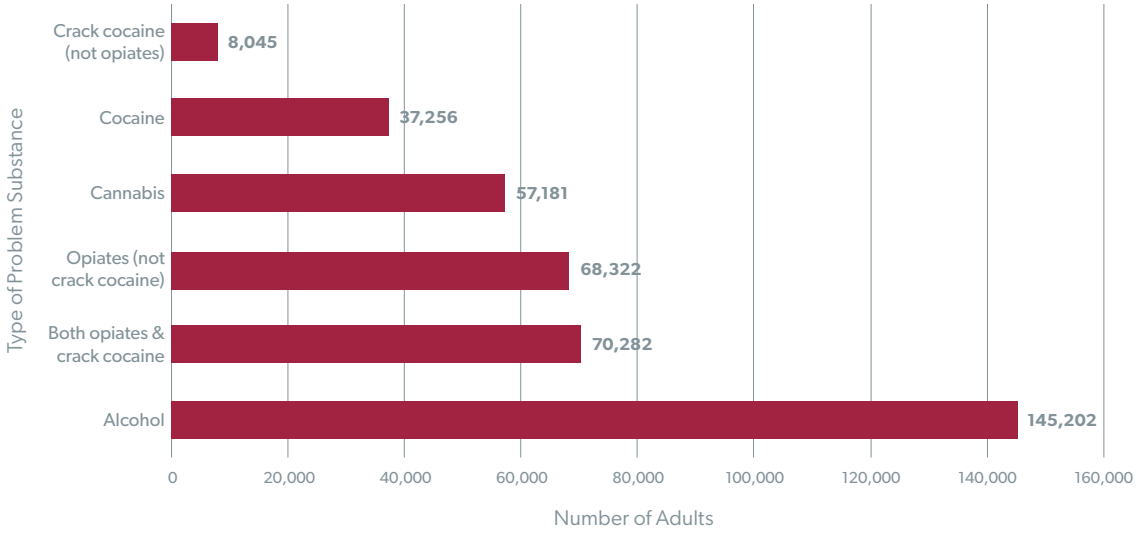
Additionally, half of the individuals entering treatment reported problems with alcohol, with the majority falling into the alcohol-only category.

One-fifth of individuals entering treatment (20 per cent) reported cannabis use, with this being most prevalent in the opiate substance group.[118]

113 Ibid.
114 Ibid.
115 Ibid.
116 Ibid.
117 Ibid.
118 Ibid.

Cocaine (excluding crack) was reported by 13 per cent of individuals, with the largest proportion falling into the non-opiate and alcohol substance group.

Figure 23: Breakdown of people in treatment by substance type.



Source: Office for Health Improvement and Disparities, Adult substance misuse treatment statistics 2022 to 2023, December 2023. Breakdown of the substances reported by people in treatment in 2022 to 2023, split into the 4 substance groups. Up to 3 substances can be recorded at the start of treatment, so one person could be counted for several substances in their substance group (for example, somebody who uses cocaine, cannabis and alcohol, would appear in the non-opiate and alcohol group for these 3 substances).

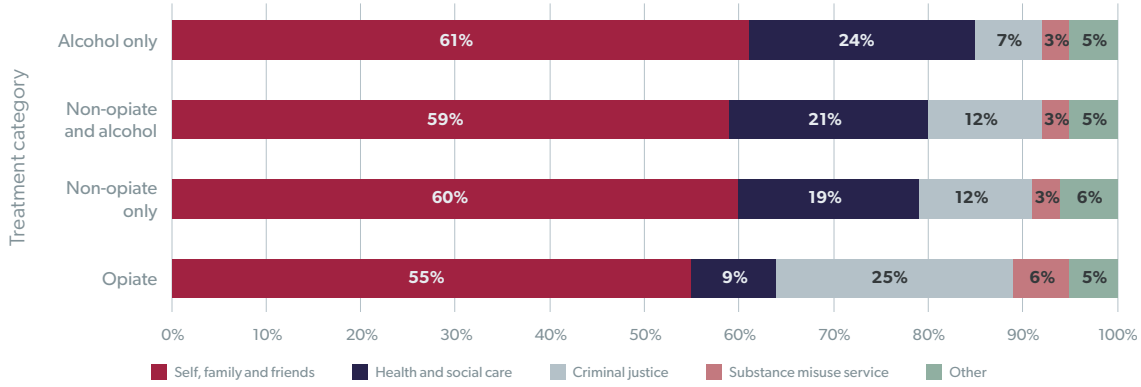
Of the individuals initiating treatment in 2022/23, 59 per cent either self-referred (possibly following advice from a healthcare professional) or were referred by family and friends.[119] This was the most common referral source across all four substance groups.

Referrals from health and social care constituted the second most common referral source, comprising 19 per cent of all referrals. This category includes referrals from GPs, which accounted for 6 per cent of all referrals but were more prevalent in the alcohol-only group at 8 per cent.[120] Hospitals accounted for 5 per cent of all referrals, while social services accounted for only 3 per cent.[121] Referrals from healthcare varied among the different substance groups, with only 9 per cent of opiate referrals originating from healthcare compared to 24 per cent of referrals for alcohol-only issues.

Collectively, referrals from the criminal justice system account for 13 per cent.[122] However, there was a significant disparity between substance groups, with 25 per cent of opiate referrals coming from the criminal justice system compared to just 7 per cent for individuals with only alcohol problems. Prisons accounted for 5 per cent of all referrals.[123]

119 Ibid.
120 Ibid.
121 Ibid.
122 Ibid.
123 Ibid.

Figure 24: Substance group referral sources.



Source: Office for Health Improvement and Disparities, Adult substance misuse treatment statistics 2022 to 2023, December 2023.

The data on drug treatment referrals for 2022/23 reveals that self-referrals and support from family and friends are the most common pathways into treatment, reflecting the importance of personal initiative and social networks in addressing substance misuse. While healthcare and social care professionals are the second most common referral source, with GPs contributing a relatively small proportion (6 per cent). Overall, their involvement is higher in alcohol-only cases (24 per cent). This highlights a potential gap in healthcare engagement with more complex substance use issues, particularly for opiates. Referrals from the criminal justice system, especially for opiate users (25 per cent), point to the close link between addiction and legal issues, with prisons playing a notable role in treatment referrals. The low contribution from social services (3 per cent) and GPs suggests that these systems could be better integrated into early intervention efforts. Overall, the data underscores the need for improved healthcare and social service involvement in substance misuse treatment to reduce the reliance on criminal justice pathways, especially for high-risk substance users.

Young People in Treatment

OHID publishes annual data on young people (aged under 18) in treatment for substance misuse.

Young people entering treatment can record up to 3 substances that they have a problem with. Numbers in this section are based on all substances recorded during their treatment.

Between April 2022 and March 2023, there were 12,418 young individuals (under the age of 18) receiving support from alcohol and drug services, marking a 10 per cent increase from the previous year (11,326).[124] However, this represents a 13 per cent reduction in the number of young people in treatment since 2019/20 (14,291).

Cannabis continues to be the predominant substance (87 per cent) for which young people seek treatment.[125]

Among those in treatment, approximately 44 per cent reported problems with alcohol, while 7 per cent and 9 per cent had issues related to ecstasy and powder cocaine, respectively.

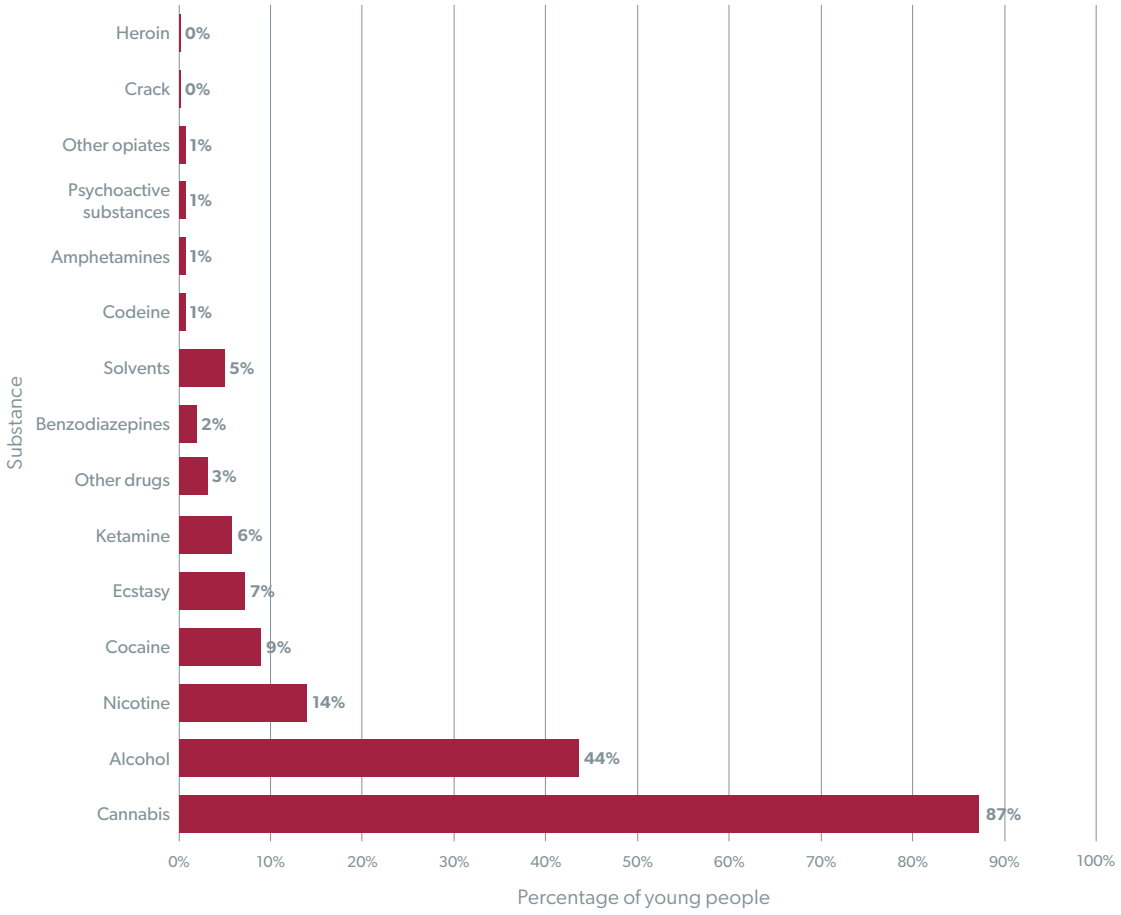
124 Office for Health Improvement & Disparities, *Young people's substance misuse treatment statistics 2022 to 2023*, January 2024.
125 Ibid.

The proportion of young people seeking help for codeine has decreased over the past two years, dropping from 1.2 per cent in 2020 to 2021 to 0.8 per cent this year.[126]

Similarly, reports of problems with benzodiazepines continues to decline, with only 2 per cent citing issues with this drug compared to 3.7 per cent in 2020/21.

Notably, there has been a substantial increase in the number of young people seeking treatment for solvent misuse, rising from 329 individuals in 2021 to 2022 to 629 individuals in 2022 to 2023 – a 91 per cent increase. Additionally, there has been a rise in the number of individuals reporting problems with ketamine, increasing from 512 (4.5 per cent) in 2021 to 2022 to 719 (5.8 per cent) this year.[127]

Figure 25: Young people in treatment for addiction.

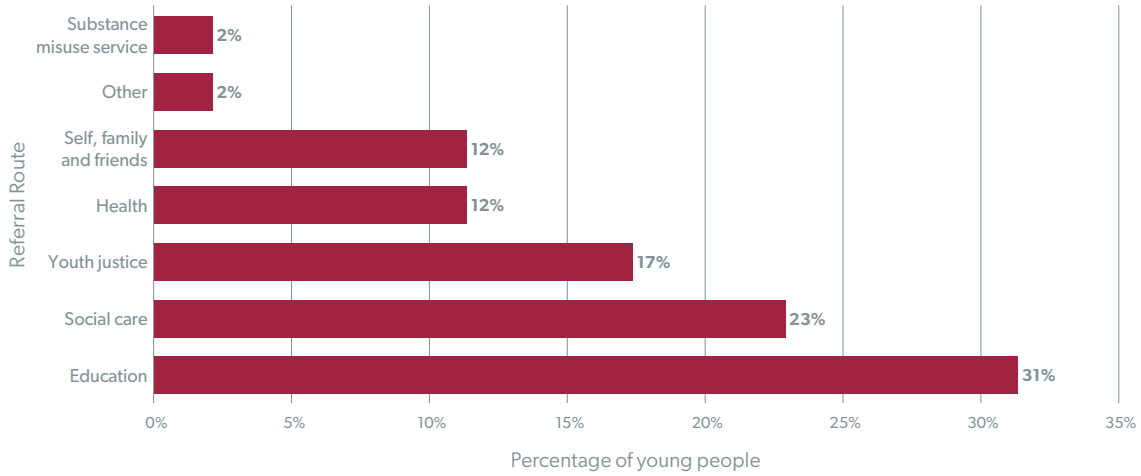


Source: National statistics Young people's substance misuse treatment statistics 2022 to 2023, 25 January 2024.

Most young people are referred to treatment by an education provider (31 per cent). There was a significant drop in education providers' referrals during the pandemic, though this year reflects almost pre-pandemic levels.[128] Social care (23 per cent) and youth justice (17 per cent) are the next most common referral sources.

126 Ibid.
127 Ibid.
128 Ibid.

Figure 26: Referral source for young people in treatment.



Source: National statistics Young people's substance misuse treatment statistics 2022 to 2023, 25 January 2024. 'Other' referral routes include non-substance misuse outreach services, helplines, housing services and domestic abuse services.

Young individuals who seek assistance from specialist substance misuse services often present a variety of vulnerabilities in addition to substance misuse. These vulnerabilities are highlighted based on data from young people who entered drug and alcohol treatment services during 2022 to 2023.

The most prevalent vulnerability reported was the early onset of substance use, with 79 per cent of young individuals reporting substance use before the age of 15.[129] Girls reported this vulnerability more frequently than boys, with rates of 81 per cent and 78 per cent, respectively. Polydrug use was reported by 56 per cent of young people, with girls again reporting this more than boys (64 per cent and 51 per cent, respectively).

Proportionally, girls tend to report a higher number of vulnerabilities compared to boys, particularly in relation to self-harming behaviours (51 per cent compared to 17 per cent) and experiences of sexual exploitation (11 per cent compared to 1.5 per cent).[130] Conversely, boys reported higher rates of antisocial behaviour (37 per cent compared to 17 per cent), criminal exploitation (12 per cent compared to 5 per cent), and involvement in gangs (9 per cent compared to 2 per cent).

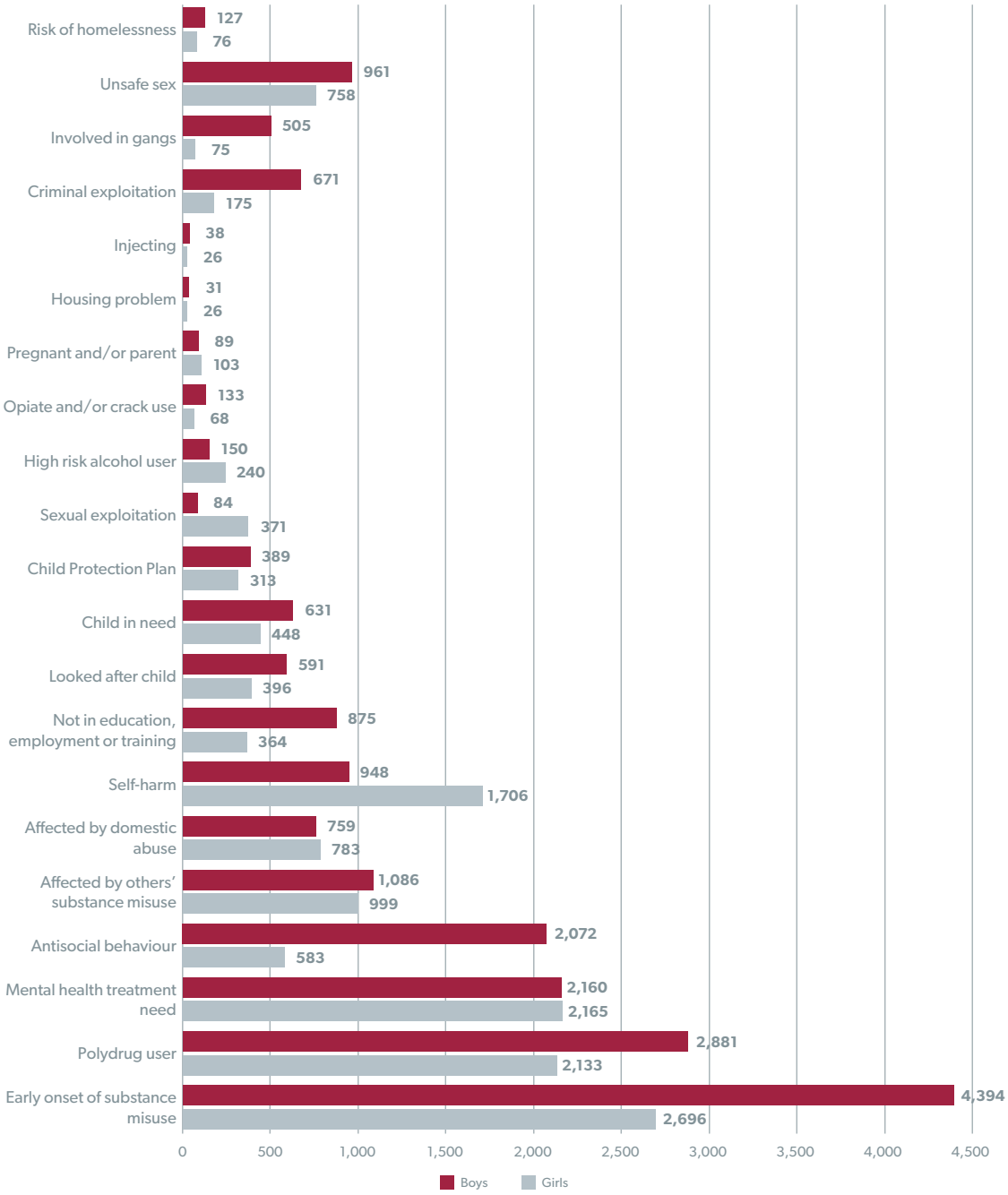
Other vulnerabilities reported by young individuals include:[131]

- Being affected by others' substance use (23 per cent);
- Engaging in unsafe sex (19 per cent);
- Being affected by domestic abuse (17 per cent);
- Engaging in high-risk alcohol use (4 per cent);
- Being at risk of homelessness (2 per cent);
- Using opiates or crack cocaine (2 per cent);
- Being pregnant or a parent (2 per cent);
- Experiencing housing problems (1 per cent); and
- Engaging in injecting drug use (less than 1 per cent).

129 Office for Health Improvement & Disparities, *25 January 2024.National statistics Young people's substance misuse treatment statistics 2022 to 2023, 25 January 2024.*
130 Ibid.
131 Ibid.

Prior research suggests children in care have a four-fold increased probability of drug and alcohol use compared to their peers.[132] Findings from OHID's data on young people in treatment similarly suggests involvement with social services as a looked after child (11 per cent), a child in need (12 per cent), or having a child protection plan (8 per cent) are particular vulnerabilities amongst young people enrolled in treatment last year.[133]

Figure 27: Vulnerabilities among young people initiating treatment.



Source: National statistics Young people's substance misuse treatment statistics 2022 to 2023, 25 January 2024.

132 Meltzer H. *The mental health of young people looked after by local authorities in England*. London: H.M.S.O.; 2003.

133 Office for Health Improvement & Disparities, *National statistics Young people's substance misuse treatment statistics 2022 to 2023, 25 January 2024.*

Specialist substance misuse support for young people is distinct from adult treatment. Young individuals typically use different substances, with cannabis and alcohol being more prevalent among them, as opposed to heroin, which is more commonly used by adults. Moreover, for some young people, substance misuse may not be their primary issue, particularly in cases involving neglect, abuse, or other child safeguarding concerns.

It is imperative that support services for young people provide a safe environment, tailoring to their needs, and are age appropriate. Staff should establish therapeutic relationships of trust with parents and carers when necessary and ensure smooth transitions to adult care when the time is right.

Efforts are underway to enhance the quality of treatment for young people. This includes the development of quality standards for alcohol and drug services, aimed at assisting local partnerships in more effectively commissioning age-appropriate services.[134] As part of the Government's drug strategy, £780 million has been allocated to improve treatment and recovery services, with a target of enabling 5,000 more young people to access alcohol and drug treatment by 2024 to 2025.[135]

Cannabis Clinic for Psychosis

As previously discussed, cannabis is the most commonly used drug in the UK,[136] with an estimated 2.3 per cent of people aged 16 or over displaying signs of cannabis dependency.[137] Roughly 10 per cent of recreational users and 11 per cent of medical users become dependent on cannabis.[138]

There were 28,845 new adult substance misuse treatment cases for cannabis-related issues last year.[139] As previously noted, cannabis is the predominant substance for which young people seek treatment, accounting for 87 per cent of cases.[140] With rising cannabis consumption and dependency, there is a growing need for specialised interventions to address the unique challenges faced by those affected.

High-potency cannabis not only elevates the risk of developing psychosis but also worsens clinical outcomes for those who continue its use after the onset of this condition.[141] In South London, 24 per cent of new psychosis cases are associated with the use of high potency cannabis.[142] This issue is particularly acute in Lambeth, where incidents of psychosis (71.9 cases per 100,000 persons a year) far surpass the English national average (41.5 cases per 100,000 persons a year).[143] In response to this need, the UK's first Cannabis Clinic for Patients with Psychosis (CCP) was established in 2019 address this treatment gap.

The CCP is a tertiary service operating within the South London and Maudsley NHS Foundation Trust.[144] It is a small, community-based service that operates with three dual diagnosis practitioners, a lead Consultant with expertise in psychosis and cannabis use, and the active support of people with lived experience of psychosis associated to cannabis. The CCP has also developed an online digital portal

134 Office for Health Improvement and Disparities, *Commissioning quality standard: alcohol and drug services*, August 2022.

135 Ibid.

136 Office for National Statistics, *Deaths related to drug poisoning in England and Wales: 2023 registrations*, October 2024.

137 NHS England, *Adult Psychiatric Morbidity Survey*, September 2016.

138 Schlag AK, Hindocha C, Zafar R, Nutt DJ, Curran HV. Cannabis based medicines and cannabis dependence: A critical review of issues and evidence. Journal of Psychopharmacology. 2021;35(7):773-785. doi:10.1177/0269881120986393

139 Office for Health Improvement and Disparities, *Adult substance misuse treatment statistics 2022 to 2023*, December 2023.

140 Office for Health Improvement & Disparities, *Young people's substance misuse treatment statistics 2022 to 2023*, January 2024.

141 Matra Di Forti et al., *High-potency cannabis and the risk of psychosis*. British Journal of Psychiatry, December 2009.

142 Di Forti, Marta et al., *Proportion of patients in south London with first-episode psychosis attributable to use of high potency cannabis: a case-control study,* The Lancet Psychiatry, Volume 2, Issue 3, 233 – 238.

143 Paolo Fusar-Poli et al., *Outreach and support in South-London (OASIS) 2001-2020: Twenty years of early detection, prognosis and preventive care for young people at risk of psychosis*. October 2020.

144 Maudsley Charity, *Cannabis Clinic for Patients with Psychosis*, August 2024.

where patients can access information, intervention tools and watch video testimonies of others who share the same experience.

The CSJ submitted a freedom of information request to the CCP Maudsley NHS Foundation Trust inquiring about patient care and capacity. Results were received in August 2024.

The information returned showed that the CCP can manage up to 20 patients actively receiving treatment at any given time.[145] As of July 2024, the clinic had 20 patients receiving one-to-one weekly sessions, over 40 individuals attending a weekly online peer group, and 50 patients accessing its online portal.[146] The clinic collaborates closely with two individuals who have lived experience with psychosis and cannabis use disorder, who actively participate in the peer group and contribute to the creation of online resources. In September the CCP launched a carers monthly group and now runs a monthly in person breakfast club for the patients under its care.

The clinic faces a significant demand for its services with 14 patients on the waiting list as of July 2024.[147] The average waiting time for treatment is two months, though this was previously one month when additional staff were available. The longest waiting time recorded is 15 weeks.

In addition to direct patient care, the clinic functions as an educational hub, welcoming clinical placement students and running a monthly group for carers. Patients on the waiting list are not left without support; they can attend the weekly online peer group, which is accessible to all referred patients, including those on wards and in the community.[148] Outcome data for this clinic is expected to be released early 2025.

The CCP represents a crucial advancement in addressing the complex needs of individuals affected by cannabis-related psychosis. However, the persistent high rates of cannabis use, and lengthy waitlist times highlight the urgent need for expanded treatment opportunities to better support those struggling with cannabis use disorders. Increased resources and more comprehensive services are essential to effectively manage and mitigate the growing impact of these conditions.

RECOMMENDATION

The Government should recognise the growing need to support those with cannabis induced psychosis. Considering the successful outcome data of the Cannabis Clinic for Psychosis, NHS Trusts should examine the needs of the catchment area they serve, request a business plan which includes initial funding, and include patients and carers in the development of further clinics.

RECOMMENDATION

The Government must re-commit to long-term, ring-fenced funding for rehabilitation and recovery services in the next multi-year spending review. This should include a three-year funding plan to allow for better service planning, staff recruitment, training and expansion of treatment options for those in a community setting.

145 Centre for Social Justice, *Cannabis Clinic for Psychosis Freedom of Information Request*, August 2024.
146 Ibid.
147 Ibid.
148 Ibid.

Conclusion

The prominent levels of drug-related deaths, particularly in deprived areas, highlight the urgent need for more effective and targeted interventions. The substantial proportion of individuals seeking treatment for cannabis issues—especially among young people—further indicates the scale of the problem and the necessity for specialised support systems.

The reliance on self-referrals and the varied role of healthcare and criminal justice system referrals reveals both strengths and gaps in current treatment pathways. As drug dependency and related health issues continue to evolve, it becomes increasingly critical for policy makers to enhance and diversify treatment options. This includes investing in public awareness, integrating social services, and developing tailored interventions for different substance groups. Addressing these challenges with a comprehensive and adaptive strategy will be crucial in improving treatment outcomes and reducing the overall burden of drug misuse.

Part 2:

Liberalisation and Lessons from Abroad

The Dame Carol Black Review emphasised the need for a cultural shift to reduce demand for drugs, yet progress on this front appears slow. Meanwhile, drug-related deaths continue to rise, and long waiting lists for recovery services highlight the inadequacy of current support systems. In the face of this problem, some countries have adopted a stance that reduces the legal and criminal penalties for drug use in an attempt to mitigate some of its harms.

This section will examine the effectiveness of these strategies in aiding recovery and at addressing the root causes of addiction. While addiction is not just a criminal issue but a social ill that reflects broader failures in addressing the root causes of substance abuse, the following case studies from at home and abroad indicate that removing any element of criminality can sometimes hinder the common aim of seeing lives free from addiction.

The following chapter will explore opportunities for legislative reform and initiatives from the UK and abroad.

Liberalisation

The legal frameworks governing substance use are pivotal in shaping the effectiveness of public health and criminal justice responses to the addiction crisis. This section outlines the distinctions between legalisation and decriminalisation, exploring their implications for addressing addiction and their impact on broader societal outcomes. While these frameworks offer potential pathways for reform, it is essential to recognise that they alone will not resolve the complex and multifaceted issue of addiction.

Legalisation

The legalisation of drugs removes all criminal penalties for possessions and personal use. Typically, regulations are established to manage where and how the legal drug is produced and distributed and consumed. Criminal and civil penalties only apply if production, distribution, and consumption occur outside of set regulations.

Alcohol, for instance, is a legal drug. In the UK, businesses must be licensed to sell alcohol, and sales are restricted to a minimum age.[149] Selling alcohol to a minor under the age of 18 remains an illegal offence.

149 GOV.UK, *Alcohol and young people*, n.d.

Much of the discourse surrounding legalisation focuses on cannabis. The most common arguments in favour of legalising adult cannabis consumption are: that its adverse health effects are modest compared to other licit and illicit drugs; that criminalising cannabis use harms users and the communities;[150] and that legalisation enables cannabis to be better regulated and taxed.[151]

A growing number of countries are passing legislation to legalise recreational cannabis, including Canada, Uruguay and some states in the US.

Medicinal Cannabis

Before delving into the topic of legalising cannabis for recreational purposes, it is important to address cannabis-based products for medicinal use. The CSJ recognises the therapeutic potential of cannabis-based medicinal products for certain medical conditions, as highlighted by the Chief Medical Officer's review and supported by the Advisory Council on the Misuse of Drugs (ACMD).[152] In light of the evidence, the CSJ does not oppose the rescheduling of cannabis from Schedule 1 to Schedule 2, provided its use is strictly regulated and properly prescribed.[153]

The Government's decision in 2018 to allow cannabis-based products for medicinal use, following high-profile cases, reflects the growing public support for cannabis in treating serious conditions. The review process initiated by the Home Secretary, which included the expert advice of the Chief Medical Officer and the ACMD, confirmed that cannabis-based products offer significant therapeutic value in specific circumstances. As such, the re-scheduling of these products is a responsible step towards ensuring that patients who could benefit have access to them under medical supervision.

However, it is crucial that cannabis for medicinal use remains tightly regulated to safeguard public health. Prescriptions must be given by qualified healthcare professionals, and products should be dispensed in a controlled manner, such as in the form of oils or pills, which can be easily distinguished from recreational cannabis. This will assist law enforcement in preventing misuse, while ensuring that those in need receive safe and effective treatment.

We also urge caution in the expansion of medicinal cannabis use. While public opinion strongly supports the legalisation of cannabis for medical reasons, it is essential that decisions remain rooted in clinical evidence and public health concerns. The process for evaluating the safety and efficacy of cannabis-based treatments must continue to adhere to the established protocols set by the DHSC and the Medicines and Healthcare products Regulatory Agency. Careful monitoring and ongoing research are vital to understanding the long-term impact of these treatments and ensuring patient safety.

150 Hall WD, Stjepanovic D, Caulkins J, et al Public health implications of legalising the production and sale of cannabis for medicinal and recreational use. *Lancet.* 2019;394:1580–1590.

151 Rolles S, Murkin G, *How to regulate cannabis: a practical guide, September 2014.*

152 Professor Dame Sally Davies, *Cannabis Scheduling Review Part 1: The therapeutic and medicinal benefits of Cannabis based products – a review of recent evidence*, June 2018 pp2, para 1.4

153 Centre for Social Justice, *Cannabis,* December 2018.

Legalising Cannabis - Health Considerations

There are risks associated with smoking cannabis often alongside tobacco:[154]

- risks of chronic bronchitis/lung damage;
- subtle impairment in higher cognitive functions of memory, learning processes, attention and organisation;
- insomnia;
- depression;
- aggression; and
- anxiety.[155]

Other research suggests individuals who use cannabis had a higher risk for cardiovascular problems regardless of whether they used tobacco products or had other underlying cardiovascular risk factors.[156] Consuming cannabis can also compound issues with fertility.[157] Furthermore, cannabis and cannabinoids as significant contributors to community-wide genotoxicity, linking them to congenital anomalies and various cancers.[158]

Consumption of cannabis is associated with an increased risk of psychotic symptoms and disorders.[159] A study analysing the health records of six million individuals over five decades in Denmark has found that young men with cannabis use disorder are at an increased risk of developing schizophrenia. The findings suggest that up to 30 per cent of schizophrenia cases among men aged 21-30 could have been prevented by avoiding cannabis use disorder.[160] The association between marijuana and schizophrenia is stronger in people who start using marijuana at an earlier age and use marijuana more frequently.[161]

In 2013, 23.6 million psychotic disorder cases were reported worldwide of which one in two people with schizophrenia did not receive treatment. In accordance with The National Institute for Health and Care Excellence guidelines, for the first episode of psychosis, individuals should be offered antipsychotic medication and psychological therapies such as cognitive behavioural therapy and family intervention.[162]

Cannabis use has steadily increased across various age groups in North America, particularly among at-risk populations like individuals with depression[163] and pregnant women.[164] This rise is accompanied by

154 Mack A, Joy J. Marijuana as Medicine? The Science Beyond the Controversy. Washington (DC): National Academies Press (US); 2000. 3, HOW HARMFUL IS MARIJUANA? Available from: www.ncbi.nlm.nih.gov/books/NBK224396/

155 Myran, Daniel T. et al., *Development of an anxiety disorder following an emergency department visit due to cannabis use: a population-based cohort study,* eClinicalMedicine, Volume 69, 102455, March 2024.

156 Jeffers, Abra M., et al. "Association of Cannabis Use with Cardiovascular outcomes among US adults." *Journal of the American Heart Association* 13.5 (2024): e030178.

157 Ilnitsky S, Van Uum S. Marijuana and fertility. CMAJ. 2019 Jun 10;191(23):E638. doi: 10.1503/cmaj.181577. PMID: 31182459; PMCID: PMC6565391.

158 Reece AS, Hulse GK. Cannabis and Pregnancy Don't Mix. Mo Med. 2020 Nov-Dec;117(6):530-531. PMID: 33311778; PMCID: PMC7721409. See also: Reece, A.S., Hulse, G.K. Epidemiological overview of multidimensional chromosomal and genome toxicity of cannabis exposure in congenital anomalies and cancer development. *Sci Rep 11*, 13892 (2021). doi.org/10.1038/s41598-021-93411-5

159 Di Forti, M., Quattrone, D., Freeman, T.P., Tripoli, G., Gayer-Anderson, C., Quigley, H., Rodriguez, V., Jongsma, H.E., Ferraro, L., La Cascia, C. and La Barbera, D., 2019. The contribution of cannabis use to variation in the incidence of psychotic disorder across Europe (EU-GEI): a multicentre case-control study. *The Lancet Psychiatry*, *6*(5), pp.427-436.

160 Hjorthøj C, Compton W, Starzer M, et al. Association between cannabis use disorder and schizophrenia stronger in young males than in females. *Psychological Medicine*. 2023;53(15):7322-7328. doi:10.1017/S0033291723000880

161 *Volkow ND, Swanson JM, Evins AE, et al. Effects of cannabis use on human behavior, including cognition, motivation, and psychosis: a review. JAMA Psychiatry. 2016;73(3):292-297. doi: 10.1001/jamapsychiatry.2015.3278.*

162 National Institute for Health Care Excellence, *Psychosis and schizophrenia in adults: prevention and management*, February 2014.

163 Pacek LR, Weinberger AH, Zhu J, Goodwin RD. Rapid increase in the prevalence of cannabis use among people with depression in the United States, 2005-17: the role of differentially changing risk perceptions. *Addiction*. 2020;115: 935-943.

164 Corsi DJ, Hsu H, Weiss D, Fell DB, Walker M. Trends and correlates of cannabis use in pregnancy: A population-based study in Ontario, Canada from 2012 to 2017. *Can J Public Health*. 2019;110:76-84.

higher rates of cannabis use disorder,[165] cannabis-impaired driving,[166] and adolescent-related cognitive and mental health issues.[167] As these negative outcomes grow, particularly in regions where cannabis has been legalised, understanding the impact of legalisation on these trends is essential for informing global cannabis policy developments.

The UK's treatment sector is already under immense strain, struggling to meet the needs of those battling existing substance dependencies. CSJ polling reveals that 30 per cent of the population has tried cannabis recreationally,[168] and if the drug were legalised, nearly a quarter of young people aged 18–35 indicate they would be inclined to try it.[169] Based on existing research that 10 per cent of users develop a dependency,[170] this could mean up to 355,594 young people in this age group are at risk of cannabis dependency.[171] However, this projection is contingent on several assumptions, including patterns of use and regulatory frameworks, which could influence the actual rates of dependency. This significant increase in potential cannabis use poses a serious challenge, especially given the well-documented risks of dependency and the already limited capacity of addiction services.

To legalise cannabis without first addressing the critical shortfalls in the treatment sector would be profoundly negligent, leaving vulnerable individuals without adequate support and placing additional burdens on an overstretched system.

Legalising Cannabis - Economic Considerations

The argument for legalising recreational cannabis is often bolstered by the promise of significant tax revenue. Despite 21 states in the US taxing recreational marijuana, the wide variety of tax designs, including ad valorem and potency-based taxes, can limit the revenue potential. States collected nearly $3 billion in marijuana revenue in 2022, with potential nationwide legalisation possibly generating $8.5 billion annually.[172] However, tax rates must be low enough to compete with illicit markets. Additionally, the ideal tax design—potency-based taxation—remains costly, making hybrid weight-based taxes more feasible in the short term.

While legalisation of cannabis in certain states of the US has led to some reduction in the number of people going to prison, especially from black or minority ethnic backgrounds, the promised economic benefits for marginalised communities have not materialised. Politico analysis of financial findings suggest that the 10 largest publicly traded US cannabis companies lost more than $2 billion in 2022.[173]

The offer of home delivery, cheaper prices, and stronger potency make the illegal market all the more appealing to cannabis users. In the US, unlicensed cannabis can cost as much as 50 per cent less than what is sold by a licensed business.[174] More than five years after Canada legalised cannabis, the illicit market is estimated to account for between 25 per cent – 52 per cent of all cannabis sales in the

165 Azofeifa A, Mattson ME, Schauer G, McAfee T, Grant A, Lyerla R. National estimates of marijuana use and related indicators - National Survey on Drug Use and Health, United States, 2002-2014. *MMWR Surveill Summ*. 2016;65:1-28.

166 Myran DT, Gaudreault A, Pugliese M, Manuel DG, Tanuseputro P. Cannabis-Involved Traffic Injury Emergency Department Visits After Cannabis Legalization and Commercialization. JAMA Netw Open. 2023;6(9):e2331551. doi:10.1001/jamanetworkopen.2023.31551

167 Pacek LR, Weinberger AH, Zhu J, Goodwin RD. Rapid increase in the prevalence of cannabis use among people with depression in the United States, 2005-17: the role of differentially changing risk perceptions. *Addiction*. 2020;115: 935-943.

168 Centre for social Justice, *Opinium Commissioned Poll, "Have you ever used cannabis recreationally? Please exclude any prescribed or medically recommended use through legal channels"*, November, 2024.

169 Centre for social Justice, *Opinium Commissioned Poll, "If cannabis were made legal for recreational use, would you consider trying it?"*, November, 2024.

170 Schlag AK, Hindocha C, Zafar R, Nutt DJ, Curran HV. Cannabis based medicines and cannabis dependence: A critical review of issues and evidence. Journal of Psychopharmacology. 2021;35(7):773-785. doi:10.1177/0269881120986393

171 Calculation based on ONS Estimates of the population for the UK, England, Wales, Scotland, and Northern Ireland and cannabis dependency rate of 10 per cent.

172 Tax Federation, *Cannabis Taxation: Lessons Learned from U.S. States and a Blueprint for Nationwide Cannabis Tax Policy*, December 2023.

173 Politico, Broken promises: *How marijuana legalization failed communities hit hardest by the drug war,* December 2023.

174 Goldstein, Robin, and Daniel Sumner. *Can Legal Weed Win?: The Blunt Realities of Cannabis Economics*. 1st ed., University of California Press, 2022. *JSTOR*, doi.org/10.2307/j.ctv2ks6tx4. Accessed 29 Aug. 2024.

country. Factors contributing to the thriving illegal market include product variety, pricing differentials, accessibility, and marketing strategies.[175]

Legalising cannabis involves complex policy decisions, not a simple "yes or no" choice. Different models of legalisation can lead to very different health outcomes.[176] For legalisation to reduce harm in the UK, strict regulations and careful allocation of revenue would be essential. However, political changes and business influence could weaken these protections. Once legalised, reversing the decision is unlikely, so long-term impacts must be considered.

The effects of legalisation would disproportionately impact disadvantaged groups, requiring careful consideration.[177] Many questions remain unanswered, and the UK's mental health and addiction services are already under significant strain. All factors considered, legislation of cannabis that would not reliably protect public health.

Decriminalisation

One of the rationales behind decriminalisation is to reduce stigma by treating drug use and dependence as a health and social issue rather than a criminal justice concern.[178] Although often perceived as a successful legal framework, decriminalisation is not a silver bullet. There are several health concerns this policy alone fails to address.

No criminal charges are applied when drug use and possession are decriminalised. However, it is still illegal to possess and distribute more than a personal amount of drugs. Selling and manufacturing drugs still carries criminal penalties.

Some evidence suggests decriminalisation alone is associated with further harms to drug users and the wider community.[179] The opportunity to offset harms is dependent on the extent to which jurisdictions implement targeted measures to reduce the prevalence of addiction, which is achieved by both preventing addiction and promoting recovery.[180] The conclusion reached by the Stanford-Lancet Commission suggests decriminalisation is linked to increased drug consumption, as well as associated harms affecting both drug users and the broader community, such as poisonings among infants and young children.[181]

A recent literature review suggests that drug decriminalisation is linked to both potential harms and benefits. Positive outcomes for drug users largely stem from the implementation of evidence-based resources that support recovery from addiction,[182] elements that are not always included in decriminalisation models. This aligns with the United Nations General Assembly Special Session on the World Drug Problem, which recognised that drug dependence has "social causes and consequences that can be prevented and treated".[183]

175 Rishi Malkani, *Clearing the smoke: insights into Canada's illicit cannabis market,* 2023.

176 Roberts E. What impact could the legalisation of recreational cannabis have on the health of the UK? Lessons from the rest of the world. Br J Psychiatry. 2024 Apr;224(4):117-118. doi: 10.1192/bjp.2024.4. PMID: 38268114; PMCID: PMC7615739.

177 Ibid.

178 Joint United Nations Programme on HIV/AIDS (UNAIDS) *Health, rights, and drugs: Harm reduction, decriminalization and zero discrimination for people who use drugs.* Available at www.unaids.org/sites/default/files/media_asset/JC2954_UNAIDS_drugs_report_2019_en.pdf.

179 Moniruzzaman, Akm, Stefanie N. Rezansoff, and Julian M. Somers. "The Relationship between the legal status of drug possession and the criminalization of marginalized drug users: A literature review." *Journal of Community Safety and Well-Being* 7.4 (2022): 140-147.

180 Ibid.

181 Humphreys, K., Shover C. L., Andrews C. M., Bohnert A. S. B., Brandeau M. L., Caulkins J. P., Chen J. H., Cuellar M.-F., Hurd Y. L., Juurlink D. N., Koh H. K., Krebs E. E., Lembke A., Mackey S. C., Ouellete L. L., Suffoletto B., & Timko C. (2022). Responding to the opioid crisis in North America and beyond: Recommendations of the Stanford-Lancet Commission. Lancet (London, England), 399(10324), 555–604. doi.org/10.1016/S0140-6736(21)02252-2

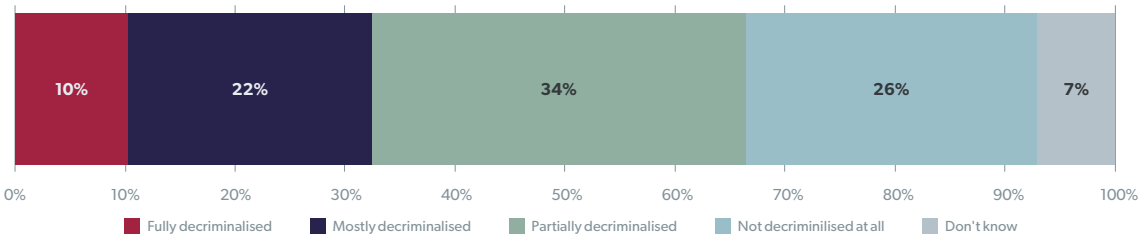
182 Moniruzzaman, Akm, Stefanie N. Rezansoff, and Julian M. Somers. "The Relationship between the legal status of drug possession and the criminalization of marginalized drug users: A literature review." *Journal of Community Safety and Well-Being* 7.4 (2022): 140-147.

183 UNODC, *UN General Assembly Special Session on the World Drug Problem,* 2016, p.6.

In the UK, controlled drugs are not decriminalised. Public polling from YouGov shows most of the public believes the decriminalisation of hard drugs would lead to more drug use,[184] damaging health behaviours[185] and contribute to an increase in crime.[186]

However, results of the CSJ's polling of police officers (n = 253) regarding the criminal status of cannabis reveal a striking division in perceptions of enforcement practices and legal frameworks. Almost a third (32 per cent) of officers believe cannabis is fully or mostly decriminalised, while 60 per cent view it as only partially or not decriminalised,[187] reflecting the ambiguity and inconsistency in how cannabis laws are interpreted and enforced on the ground.

Figure 28: Police perceptions of current cannabis decriminalisation status.



Source: CSJ commissioned polling from Opinium of 253 police officers in the United Kingdom, October 2024.

These results suggest the need for clearer, more uniform policy directives regarding cannabis enforcement. Without this, law enforcement risks a growing inconsistency that may undermine public confidence in both the police and the legal system. It also presents an opportunity for policymakers to reassess the current cannabis laws and how they are enforced, to ensure that there is alignment between legislation, policing practice, and public health objectives.

Case Study: British Columbia, Canada

Drug toxicity is the second highest cause of death in British Columbia (BC).[188] Fentanyl and other synthetic opioids are the main drivers of illicit drug toxicity deaths. In response to this epidemic, the BC Government has taken a number of responses to curb drug related deaths, such as take-home naloxone programmes,[189] medication-assisted treatments, prescribed alternatives to toxic drugs, and overdose prevention and supervised consumption sites.[190]

In January 2023, BC received an exemption from the Controlled Drugs and Substances Act, decriminalising the possession of small amounts of illicit drugs. The purpose of this decriminalisation pilot is to reduce stigma associated with drug use, thus encouraging people to access health and social services.[191] While there has been a 77 per cent decrease in drug possession offences,[192] concerns arise

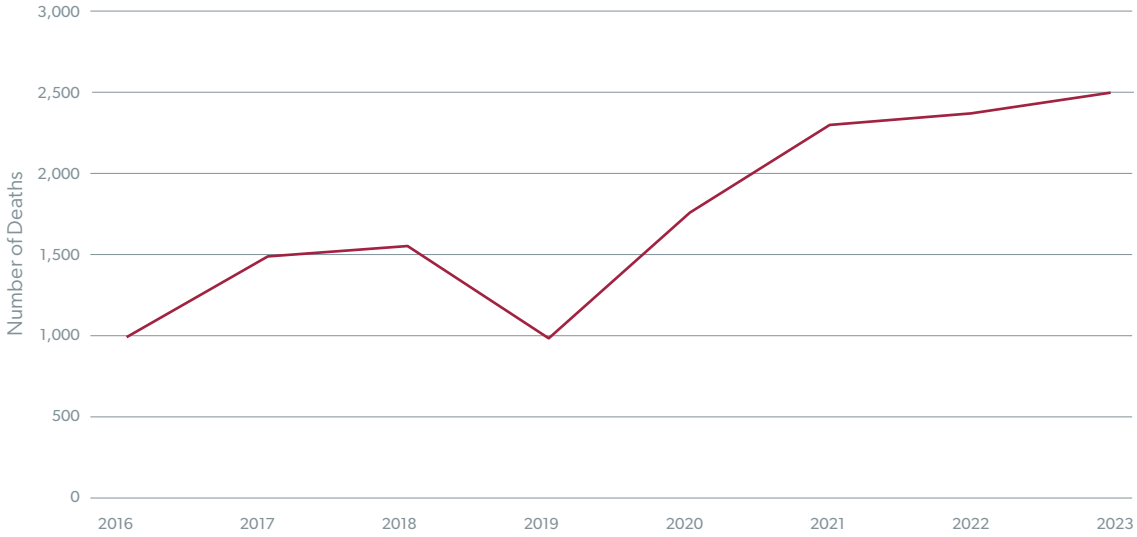
184 YouGov, Would the decriminalisation of hard drugs lead to more drug use?, May 2024.
185 YouGov, Would the decriminalisation of hard drugs result in people damaging their health?, May 2024.
186 YouGov, *Would the decriminalisation of hard drugs lead to more or less crime*?, May 2024.
187 Centre for Social Justice, *Opinium police polling*, October 2024.
188 BC Centre for Disease Control, *BCCDC Mortality Context App*, June 2024.
189 Towards the Heart, *Take Home Naloxone*.
190 Ministry of Mental Health and Addictions, *Adult Substance Use System of Care Framework, and in the Ministry of Mental Health and Addictions data snapshot*, December 2022.
191 BC Centre for Disease Control, *Decriminalization in B.C., n.d.*
192 Ibid.

regarding the potential link between unhoused deaths and drug use, and the argument that stigma may have increased post-decriminalisation.[193]

A year since the pilot began, drug deaths have reached their highest point with more than 2,500 lives lost in 2023.[194] This equates to an average of 6.9 deaths per day and a 5 per cent increase from the previous year.

In England and Wales, the drug misuse death rate stands at 9.3 people per 100,000.[195] This past year, the British Columbia death rate was 45.7 per 100,000 residents.[196]

Figure 29: Illicit drug toxicity deaths in British Columbia from 2016 – 2023



Source: BC Gov News, More than 2,500 lives lost to toxic drugs in 2023, January 2024; British Columbia Coroners Service, Illicit Drug Toxicity Deaths in BC, March 2023.

Importantly, decriminalisation cannot be considered solely as the causal effect of the increase in drug misuse deaths. Many factors are at play. However, the recent increase in overdose deaths indicate that removing criminal penalties for personal use of narcotics has not aided in mitigating the overdose crisis.

In an interview with The Telegraph, Fiona Wilson, Deputy Chief Constable of the Vancouver Police Department, contends that recent policy changes have significantly constrained law enforcement capabilities throughout the city, thereby potentially compromising public safety.[197] Despite the seizure of over 1,000 kilograms of fentanyl from dealers in 2023, officers find themselves unable to act when witnessing drug use in public spaces.[198]

Wilson argues, "The decriminalisation measures have posed substantial challenges for the police by eliminating our capacity to arrest individuals engaged in public drug use. In the absence of other criminal behaviour, there are no legal grounds for us to approach individuals consuming illicit substances."[199]

193 BBC, *Success of failure? Canada's drug decriminalisation test faces scrutiny,* March 2024.
194 BC Gov News, *More than 2,500 lives lost to toxic drugs in 2023,* January 2024.
195 Office for National Statistics, *Deaths related to drug poisoning in England and Wales: 2023 registrations, October 2024.*
196 BC Gov News, *More than 2,500 lives lost to toxic drugs in 2023,* January 2024.
197 The Telegraph, *How decriminalisation made Vancouver the fentanyl capital of the world,* July 2024.
198 Rebecca Paulsen, *British Columbia police officer perceptions of mandatory drug treatment within the context of decriminalization,* 2024.
199 The Telegraph, *How decriminalisation made Vancouver the fentanyl capital of the world,* July 2024.

A criticism of BC's decriminalisation pilot is the lack of referral pathways out of the addiction cycle. Earlier this year, the BC Government pledged funding to 180 new detox treatment beds.[200]

However, internal health authority data, obtained by The Globe and Mail, reveal that dozens of detox beds in BC remain empty due to a critical shortage of addiction physicians and nurses.[201] In Vancouver, this shortage has resulted in up to 50 per cent of the available spaces at 24- and 18-bed withdrawal management facilities being left vacant, despite substantial waiting lists.[202] Similarly, in the interior region, 25 detoxification beds were unoccupied for the same reason. The total number of detox beds available and occupied across the province was not disclosed. This shortage of addiction care professionals in BC is reflective of a broader, long-standing healthcare workforce crisis that has impacted Canada for several years.

In response to these challenges, the introduction of innovative programs such as the Road to Recovery at St. Paul's Hospital in Vancouver represents a promising model for supporting individuals with substance use disorders.[203] The programme will be fully implemented by 2025, and aims to provide an integrated, long-term approach to addiction recovery, offering continuous care from detox through to community-based treatment for up to five years. By expanding from 14 to 50 detox beds and offering patients a seamless transition into further care, this initiative addresses a critical gap in treatment continuity that many individuals face.[204] Patients are connected to a care team that follows them throughout their recovery journey, significantly improving their chances of long-term success.

A central component of the Road to Recovery program is the integration of peer support workers, such as those with lived experience of addiction, who play a vital role in offering emotional and social support.[205]

The provincial Government's commitment to scaling up this model across BC represents a significant step in tackling addiction, particularly considering the concurrent drug decriminalisation policies. However, to fully realise its potential, it will be crucial to address the systemic shortage of physicians and nurses, which continues to undermine the availability of recovery services across the province.

Only a year and a half into the pilot, the final outcomes of decriminalisation in BC remain to be seen.

Case Study: Portugal

Most research on the effects of decriminalisation focuses on Portugal's 2001 policy change, driven by a heroin crisis in the 1990s. Portugal decriminalised the consumption, acquisition, and possession of narcotic drugs and psychotropic substances for personal use.[206] Instead of prison sentences, offenders now face administrative fines and are encouraged to seek treatment. This approach aims to reduce stigma and improve health and social outcomes by treating addiction as a public health issue rather than a criminal one.[207]

Overdose deaths sharply declined after decriminalisation. Although they later climbed, the overdose death rate remains well below the European average.[208] This policy initiative incorporated an influx

200 CBC News, *180 new publicly-funded addiction treatment beds announced for B.C.*, January 2024.

201 The Globe and Mail, *Detox beds in B.C. routinely sit empty because of staff shortages*, June 2024.

202 Ibid.

203 British Columbia Centre on Substance Use, *Road to Recovery, n.d.*

204 Denise Ryan, The Vancouver Sun, *New St. Paul's program offers fast, long-term help to those seeking addiction recovery*, August 2024.

205 BC Gov News, *Innovative model of addictions care expands throughout B.C., July 2024.*

206 Allen, Laurence, Mike Trace, and Axel Klein. "Decriminalisation of drugs in Portugal: a current overview." *A DrugScope briefing paper for the Beckley Foundation Drug Policy Programme* 6 (2004).

207 Tiago S. Cabral, "The 15th Anniversary of the Portuguese Drug Policy: Its History, Its Success and Its Future," Drug Science, Policy and Law 3 (2017).

208 "Drug Decriminalisation in Portugal: Setting the Record Straight," Transform Drug Policy Foundation, May 13, 2021.

of treatment services. Between 2000 and 2009, the number of outpatient treatment units in Portugal increased by 58 per cent.[209] The number of people in treatment rose from 24,000 in 1998 to 39,000 in 2008, a 63 per cent increase.[210]

While some studies suggest minor fluctuations in overdose deaths,[211] the most robust evidence indicates minimal impact on health outcomes.[212]

Portuguese Commissions for the Dissuasion of Drug Addiction

The Commissions for the Dissuasion of Drug Addiction were established with a dual purpose: to enforce administrative sanctions on drug users, ensuring compliance with international drug laws, and to evaluate the risk of addiction by assessing various aspects of the individual's life, including health, social, professional, and economic factors, thus fulfilling a social, medical, and preventive role.[213]

The Commissions for the Dissuasion of Drug Addiction, managed by the Ministry of Health, represent a significant innovation in the Portuguese Drug Policy and Programme Model (PDPM). By removing law enforcement from the implementation of non-criminal measures, these Commissions aim to shift the focus away from punitive security-driven approaches.[214]

The Commissions employ multidisciplinary teams focused on psychosocial intervention. These teams are responsible for psychological assessments, technical support for deciding on suspensive or sanctioning measures, referrals to health services, and overseeing the implementation and follow-up of these measures.[215] *Meanwhile, police forces continue to play a key role in detecting drug use and referring cases to the Commissions.*

The Commissions' primary aims are to encourage adherence to treatment or the decision to abstain from drug use. While referrals into treatment are optional, those caught with drugs are obligated to present themselves in front of the Committee.[216] *Operating independently from the criminal justice system, Commissions assess each case individually. If they determine that drug use does not pose a significant problem, they may dismiss the case without applying sanctions. Alternatively, they can impose administrative penalties such as fines, social work, or group therapy.*

Most individuals who appear before the Commissions for the Dissuasion of Drug Addiction are found to use drugs non-problematically and receive a provisional suspension of proceedings, which is dropped if they are not caught with drugs again within six months.[217] *For those with frequent and problematic drug use, the Commissions recommend voluntary treatment and apply administrative sanctions—such as revoking a driving license or requiring community service, however only if treatment is refused.*[218]

209 Stevens, A. and Hughes, C. (2016). Dépénalisation et santé publique: politiques des drogues et toxicomanies au Portugal. Mouvements 86. cairn.info/revue-m…

210 Hannah Laqueur, "Uses and Abuses of Drug Decriminalization in Portugal," Law & Social Inquiry 40, no. 3 (Summer 2015): 746–81.

211 Sónia Félix, Pedro Portugal, and Ana Sofia Tavares, "Going After the Addiction, Not the Addicted: The Impact of Drug Decriminalization in Portugal," IZA discussion paper no. 10895 (July 2017).

212 Antonio Laplana, "Beyond the War on Drugs: Evidence from Portugal's Drug Decriminalization Reform and the Retornados Migration," Aug. 28, 2023.

213 Moury, Catherine, and Mafalda Escada. "Understanding successful policy innovation: The case of Portuguese drug policy." *Addiction* 118.5 (2023): 967-978.

214 RÊGO, X., OLIVEIRA, M.J., LAMEIRA, C. *et al.* 20 years of Portuguese drug policy - developments, challenges and the quest for human rights. *Subst Abuse Treat Prev Policy* 16, 59 (2021). doi.org/10.1186/s13011-021-00394-7

215 Ibid.

216 Ibid.

217 Drug Policy Alliance, *Drug Decriminalization in Portugal Learning from a Health and Human-Centered Approach*, August 2023.

218 Ibid.

A recent increase in drug use in Portugal coincides with a fall in funding of drug treatment programmes.[219] Portugal's original approach went beyond decriminalising the personal use of drugs by redefining addiction as a medical concern rather than a criminal justice one. Expanding treatment and recovery support and diverting people away from the judicial system and towards professional care are all elements of this policy. To effectively address the root causes of drug use, if criminal sanctions are removed, they must be paired with comprehensive medical, psychological, and social support. This includes tackling issues such as homelessness and unstable housing, mental health challenges, poverty, racial inequalities, and insufficient access to healthcare, all of which can contribute to drug dependency.

> *"Decriminalization is not a silver bullet. If you decriminalize and do nothing else, things will get worse. The most important part was making treatment available to everybody who needed it for free. This was our first goal."*
>
> **João Castel-Branco Goulão, Portugal s National Coordinator on Drugs, Drug Addiction and the Harmful Use of Alcohol General-Director of SICAD.**

Addressing addiction in the UK requires a comprehensive, multi-faceted approach that extends beyond simplistic solutions like legalisation or decriminalisation. This is fundamentally a health crisis that demands coordinated efforts across multiple sectors, including healthcare, law enforcement, social services, and community support. Addiction is deeply entrenched in societal issues, and resolving it will be a gradual process, requiring sustained commitment and investment.

> *"If 2.5g was the limit, I would have just made sure I was always under that and would tell myself I don't have a problem because I always under the legal limit. The reality would be that I'm still an addict, I'm just making sure I have less on me than I would have."*
>
> **CSJ Focus Group Participant 2, Wakefield, March 2024**

Focusing purely on punitive measures has proven insufficient. While law enforcement plays a crucial role in dismantling organised crime, this must be part of a broader strategy that also addresses the social determinants of addiction, such as housing, employment, family support, and access to healthcare. Funding cuts to essential services exacerbate the problem, leading to increased fatalities and further straining already overstretched resources.

Decriminalisation alone is, of course, not sufficient in solving an addiction crisis. The example of Portugal demonstrates that treating addiction as a public health issue can reduce harm, but success depends on a comprehensive package of reforms that include robust support systems and prevention measures.

219 Lancet, The. "Drug decriminalisation: grounding policy in evidence." *Lancet (London, England)* 402.10416 (2023): 1941.

RECOMMENDATION

The Government should take an evidence-based, phased approach, studying international examples and their real-world implications before committing to significant policy changes regarding drug use. This includes assessing both the short- and long-term impacts of such approaches on crime rates, recovery outcomes, public health costs, and broader societal effects. A careful, informed strategy will ensure that any harm reduction policies adopted are both effective and sustainable in the UK's unique social and legal context.

Lessons from Home

Scotland

Scotland has one of the highest drug death rates in the developed countries. Drug deaths peaked at 1,339 in 2020 before falling slightly in 2021 and then dropping by about a fifth in 2022 to 1,051.[220] Data from the National Records of Scotland (NRS) for 2023 indicate that 1,172 people died, representing a 12 per cent rise from the year prior.[221] Drug deaths are recognised as one of the biggest contributors to Scotland's falling life expectancy.

Men in their late 30s and 40s living in the most deprived areas of Scotland are disproportionately likely to experience a drug-related death.[222] In 2021, people in the most deprived parts of Scotland were 15 times as likely to have a drug-related death as those in the least deprived areas.[223]

Robert's Story

This case study outlines Robert's experiences with addiction and the prison system in Scotland. Robert was supported by Teen Challenge, a drug and alcohol treatment offering help to those struggling with addiction.

I am 46 years old and had a good upbringing with both parents in Port Glasgow. I wasn't interested in achieving anything at school and left with no qualifications – I just wanted a good laugh and to smoke cannabis.

At 16 years of age, I left home and started dabbling with other drugs. I spent 7 and a half years in prison. Most of my teenage years were spent there. I was carrying a lot of resentment, anger, anxiety, and depression. This is where I started to get into heavier drugs, and I soon realised my drug taking began to get a grip of me. I started smoking heroin in prison. On leaving prison I realised that drug addiction started to control my life. I had no hope in life, no direction. I really wanted to change my life, but I didn't know how to. All I knew was prison life and a life of addiction —drugs seemed to help me forget my problems. Alcohol then got a grip of me too.

One night when in a drunken state I fell flat on my face causing a serious injury to it—the next morning when I looked in the mirror and saw how bad my face was, I realised that I had hit rock bottom. I stood in front of the mirror in tears, saying to myself that that I needed help and needed to change.

220 National Records of Scotland, *Drug-related deaths in Scotland in 2022*, August 2022.
221 National Records of Scotland, *Drug misuse deaths increase*, August 2024.
222 Ibid.
223 Ibid.
224 Names have been changed to protect identities.

It was then that I remembered the name of a man from the youth club that I used to attend in the local church hall. He had said to me that if I ever needed help, I could let him know. I didn't think anything about this until I was standing in front of the mirror – so after all these years, I thought to myself that I would try and get hold of him. I found his number and told him that I needed help, and he replied, "I have been praying for you for years, son".

In 2010 Roy referred me to Whitchester House, the Teen Challenge rehab near the Scottish Borders. I intended to stay a few weeks to get clean and then leave but there was a really bad snowstorm and we were snowed in for weeks. I went on to complete the 18-month programme, became a staff member there and obtained qualifications—SVQ level 3 in Health & Social Care!

I now work as a Schools worker at Teen Challenge Strathclyde, have been married for 10 years and have two lovely daughters. I visit schools giving 'drugs awareness' talks to the pupils encouraging them to make good choices in life. I try to get into as many schools as possible to reach out to the young people and let them know there is a life worth living that is a lot better than a life of addiction.

I look back over the last 14 years that I have been free from addiction, and I can say that I am so blessed to have Jesus as my Lord and Saviour — without Him none of this would be possible. Isaiah 55:8-9 says:

"For my thoughts are not your thoughts,
neither are your ways my ways, declares the Lord.
For as the heavens are higher than the earth,
so are my ways higher than your ways
and my thoughts than your thoughts."

Drug Policy in Scotland

The Scottish National Party (SNP) has launched a national mission to reduce drug-related deaths and harms, supported by an additional £50 million annually.[225] This initiative emphasises the engagement of third-sector organisations in frontline service delivery and the empowerment of grassroots and community groups. Central to the SNP's strategy is the inclusion of individuals with lived experience of drug misuse in policy design, facilitated through a 'national collaborative.' The Government also links addiction policy with measures addressing poverty, deprivation, and trauma, recognising the need to support people with multiple, complex needs, such as homelessness and mental health issues. Additionally, there is a strong focus on providing support for children and families affected by problematic drug use. The SNP's approach includes the controversial establishment of Safe Drug Consumption Facilities (SDCFs), the first of which was approved to be run in Glasgow, allowing users to consume drugs under medical supervision without facing prosecution. The SNP advocates for the decriminalisation of all drugs for personal use, asserting that criminalisation exacerbates harms.

The Scottish Conservatives support testing safe consumption rooms but emphasise the need for robust evidence base and caution against funding them at the expense of other critical services. They have proposed a Right to Recovery Bill aimed at expanding the focus from harm reduction to treatment,

225 Improving Scotland's Health, *National Mission on Drug Deaths: Plan 2022 – 2026*, August 2022.

prevention, dissuasion, and reintegration of users into society.[226] While open to considering the safe consumption room pilot as part of a broader strategy, they have serious reservations about its effectiveness and urge support for the Right to Recovery Bill to ensure legal access to addiction treatment.

Scottish Labour has called for a Royal Commission to develop a public health approach to substance misuse, focusing on harm reduction rather than criminalisation. They advocate for better integration of addiction services with mental health treatment and for restoring funding to previous levels. They proposed legislation for Overdose Prevention Centres, now bolstered by the Lord Advocate's statement that drug users in safe consumption facilities will not be prosecuted.[227]

The Scottish Liberal Democrats have criticised budget cuts to addiction services and called for the establishment of specialist drugs commissions, widespread safe consumption rooms, and decriminalisation of drug misuse to prioritise treatment over imprisonment. Alex Cole-Hamilton MSP has sought international intervention for Scotland's drug crisis and has consistently advocated for increased funding and legislative reform, including support for medical cannabis[228] and innovative harm reduction initiatives like mobile overdose prevention centres.[229]

Harm Reduction

Harm reduction is a broad term encompassing various strategies aimed at minimising the negative consequences of drug use. Harm Reduction International defines it as "policies, programmes and practices that aim to minimise the negative health, social and legal impacts associated with drug use, drug policies and drug laws."[230]

Some harm reduction practices, such as naloxone distribution, have been rigorously tested and proven effective in saving lives and should continue to be implemented. Harm reduction can be a crucial step in saving lives and providing a pathway to recovery, but should not be viewed as an end in itself.

Rather than being at odds with abstinence, some aspects of harm reduction can complement it. Some harm reduction advocates believe that abstinence may only be successful when it eventually works for an individual, highlighting the importance of offering multiple options, sometimes over a long period of time and also of keeping the individual alive until they are in a position to engage with and benefit from recovery and treatment support. By utilising various harm reduction tools alongside recovery strategies, we can provide a flexible and supportive path for individuals dealing with drug dependence, helping them move towards healthier lives.

Naloxone

Naloxone is a medication that can reverse opioid overdoses and potentially save lives. It is not an addictive medication. As a prescription-only drug regulated under the Human Medicines Regulations 2012 (HMRs), there are specific controls on its administration, sale, and supply.[231]

226 The Scottish Parliament, *Proposed Right to Addiction Recovery (Scotland) Bill*, October 2021.
227 BBC News, *No Prosecution Plan for Drug Consumption Rooms,* September 2023.
228 Edinburgh News, *Why is it so hard to get hold of medical cannabis? Alex-Cole Hamilton,* June 2021.
229 Scottish Liberal Democrats, *Cole-Hamilton calls for fresh measures to tackle drug deaths crisis,* September 2024.
230 Harm Reduction International, *What is harm reduction?*, n.d.
231 The Human Medicines Regulations 2012.

However, there are exceptions to these regulations, which have facilitated the distribution of both injectable and nasal naloxone by some drug treatment services in recent years. Despite these exceptions, barriers to accessing naloxone remain.[232]

During the Drugs Ministerial Meeting on 17 September 2020, the Parliamentary Under Secretary of State for Prevention, Public Health, and Primary Care pledged to consider revising the HMRs to improve naloxone accessibility for those at risk of opioid overdose. This sentiment was shared by ministers across the UK, who agreed that the existing legislation needed review.

In response, the Department of Health and Social Care (DHSC), along with other regional health departments, consulted on proposals to broaden naloxone access. These proposals aim to expand the range of settings and individuals authorised to distribute naloxone without a prescription or written instruction.

Since the consultation, the UK Government has introduced a new 10-year drugs strategy, which includes £533 million for England. This funding is intended to enhance the treatment and recovery system for those with drug and alcohol dependency, ensuring a comprehensive range of evidence-based interventions, including naloxone, are available across all areas.

Starting soon, naloxone will be available for home use without a prescription, marking a major shift from previous regulations where only drug and alcohol treatment services could provide it.[233] This policy change aims to address the high rates of opioid-related deaths in the UK, which are predominantly caused by drugs such as heroin and synthetic opioids like fentanyl. The new regulations will allow a broader range of professionals, including police officers, social workers, and probation officers, to distribute naloxone, thereby increasing accessibility for those at risk of overdose.

Critically, naloxone's role extends beyond harm reduction. By preventing fatal overdoses, it provides individuals with a critical opportunity to seek and engage in recovery services. The availability of naloxone can be seen as an essential step on the path to recovery, creating a bridge for those struggling with addiction to access treatment and support. Its presence in community settings, alongside other recovery-focused interventions, reflects a balanced approach that integrates harm reduction with comprehensive recovery strategies.

Thus, while naloxone itself does not address the root causes of addiction, its use aligns with a broader, holistic approach towards drug policy. It offers immediate protection and stability, allowing individuals the chance to pursue long-term recovery and healthier lives. This constructive collaboration between harm reduction and recovery underscores the importance of integrating immediate life-saving measures with ongoing support and treatment services to effectively address the multifaceted challenges of substance use and addiction.

RECOMMENDATION

The Government should continue to expand the distribution of naloxone to first responders and the police, with an emphasis on high-risk areas, to reduce the incidence of fatal overdoses.

232 Department for Health and Social Care, *Expanding access to Naloxone,* August 2021.

233 Dominic Hughes, BBC News, *Life-saving overdose drug to be given without prescription,* May 2024.

Administering naloxone, however, is limited in improving public health. Conflicting evidence from the United States suggests no effect of laws expanding naloxone access on overdose death rates.[234] Reversing an overdose will save a life, but not necessarily address the underlying causes of the overdose: the use, often compulsive, of deadly drugs. Even so, overdose reversals are important. Nonfatal opioid overdoses can cause a range of lasting health outcomes.[235] Though an important step in intervening drug related harms, naloxone is not enough to mitigate a public health crisis. A multi-pronged approach that reaches beyond overdose reversal is paramount.

Glasgow WAND (Wound care, Assessment of injecting risk, Naloxone, Dry blood spot testing)

The WAND (Wound care, assessment of injection risk, naloxone, dry blood spot testing) initiative, developed to address drug-related harms among people who inject drugs (PWID) in Glasgow, offers a harm reduction package and incentivises engagement with cash vouchers.[236]

Analysing data from September 2020 to August 2021, WAND engaged 831 individuals, predominantly male and aged 40 or older.[237] Compared to the Needle Exchange Surveillance Initiative (NESI) participants, WAND participants reported higher rates of cocaine injecting, benzodiazepine use, recent overdose, and skin and soft tissue infections.[238]

Among those who engaged in WAND within the first six months, 40 per cent re-engaged by August 2021.[239] Re-engagement was associated with increased intervention coverage, including higher rates of bloodborne virus testing and naloxone carrying.

These findings suggest that WAND effectively reached a substantial number of high-risk PWID during the pandemic and facilitated short-term behaviour change. This initiative is not without its operational and implementation issues such as the high price and location of availability.[240]

Further research is needed to assess its long-term impact and scalability.

234 Rosanna Smart, Bryce Pardo, and Corey S. Davis, "Systematic Review of the Emerging Literature on the Effectiveness of Naloxone Access Laws in the United States," Addiction 116, no. 1 (January 2021): 6–17.

235 Jon Zibbell et al., "Non-Fatal Opioid Overdose and Associated Health Outcomes: Final Summary Report," RTI International, September 2019.

236 INHSU, *A Novel Contingency Management Intervention in the Context of a Syndemic of Drug-Related Harms in Glasgow: First Year of the 'WAND' Initiative*, 2022.

237 Scottish Government, *National Mission on Drugs: annual report 2021 to 2022*, November 2022.

238 Ibid.

239 Ibid.

240 Ibid.

Safer Drug Consumption Facility

Glasgow City is initiating Scotland's first safer drug consumption facility (SDCF), set to open in 2024, which is designed as a supervised healthcare setting where individuals can consume drugs in a clean, controlled environment under the supervision of trained health professionals.[241] The stated primary goals of the SDCF are to mitigate the negative impact of public drug injecting on local communities, reduce the health risks associated with drug use, and connect individuals with appropriate healthcare services.

The proposal for an SDCF in Glasgow follows a health needs assessment titled 'Taking Away the Chaos,' which identified a population of approximately 400 to 500 people who regularly inject drugs in public spaces within the city centre.[242] The report found that this public injecting increases risks of infection, overdose, and poses dangers to the public through discarded needles.

The proposed location for the SDCF in the south-eastern area of Glasgow city centre is chosen to maximise accessibility for the target population, as this area has a high concentration of public drug injecting activity. The Scottish Government is contributing £2.3 million per year to the pilot, in addition to funding already committed to rehabilitation services.[243]

There are several concerns regarding their implementation. One major apprehension is the possibility that these facilities might normalise or even encourage drug use. Critics argue that the presence of an SDCF could be perceived as tacit approval of drug consumption, potentially undermining broader efforts to combat drug abuse.

Another concern is the impact on the surrounding community. Residents and business owners worry that an SDCF could attract more drug users to the area, leading to increased loitering and potentially higher crime rates. There is also the fear that the facility might become a focal point for drug-related activities, thereby exacerbating public safety issues rather than alleviating them.

Additionally, there are financial considerations. The cost of establishing and maintaining an SDCF is estimated at £2.3 million per year, and some question whether this investment is the best use of limited public health funds. Some argue that resources could be more effectively allocated to preventive measures, such as education and rehabilitation programmes, which aim to reduce drug use in the long term.

Lastly, the legal and ethical implications of SDCFs are subjects of debate. Since drug use remains illegal, the operation of such facilities raises questions about their alignment with existing laws and the message it sends about law enforcement priorities. In 2021, a decision by the Lord Advocate meant that people caught with Class A drugs in Scotland could be given a police warning instead of facing prosecution.[244] This was criticised as "de-facto decriminalisation." The proposal leaves prosecution up to the officers' discretion and expands the warnings issued for Class B and Class C drugs to all illicit substances.[245] This tension between harm reduction and legal compliance continues to be a contentious issue among policymakers, law enforcement, and the public.

241 BBC News, *UK's first consumption room for illegal drugs given go-ahead*, September 2023.

242 Ibid.

243 BBC News, *UK's first drugs consumption room to open in October*, August 2024.

244 BBC News, *Scottish government wants drug possession to be decriminalised*, July 2023.

245 BBC News, *Warnings instead of prosecution for Class A drug users,* September 2021.

The Role of Scottish Law Enforcement

In a 2021 letter to the Criminal Justice Committee, the Scottish Police Federation (SPF) addressed the complexities of the police's role in tackling drug misuse, focusing on the pilot trial of Naloxone by Police Scotland. The SPF criticises the approach of equipping officers with Naloxone spray as an insufficient response to the drug death crisis, deeming it a "sticking plaster" solution.[246] They argue that while police officers encounter the tragic consequences of drug misuse, their role should not encompass medical interventions. The SPF raises concerns about the lack of evidence supporting the effectiveness of police-administered Naloxone and highlights the potential risks and legal jeopardy officers face when administering the drug, especially without statutory protections.[247] They caution against the potential for adverse outcomes and emphasise that drug overdoses should primarily be managed by medical professionals.

The SPF underscores that the broader issue of drug misuse is deeply rooted in societal issues like poverty, and that focusing on reactive measures diverts attention from addressing these root causes. They also note a perceived imbalance in policing efforts, with a disproportionate focus on high-level dealers and individual users, rather than local dealers.[248]

The SPF calls for a clearer definition of the police's role in the drug crisis, advocating for a reassessment of responsibilities to avoid the overlap of duties such as education, medical intervention, and enforcement.

Although Scotland faces a more acute state of the addiction crisis compared to the rest of the UK, its distinctive approaches to drug policy offer valuable insights. By observing Scotland's initiatives, such as its national mission to reduce drug-related deaths and the implementation of Safe Drug Consumption Facilities, we can gather crucial information about the effectiveness or - lack thereof – of various strategies. Both the UK and the Scottish Government will need to carefully assess the long and short-term impacts of SDCFs, considering not just overdose rates, but also overall addiction rates, local crime, community support for the measures and the impact on the legal framework. This knowledge exchange can help inform better practices, enhance our understanding of the crisis, and ultimately contribute to more effective solutions across the UK.

Drug Consumption Rooms

In examining the role and impact of Drug Consumption Rooms (DCRs), it is essential to consider their place in the broader context of drug policy. DCRs are designed to offer a safe environment for individuals to consume drugs under supervision, which can reduce the risk of fatal overdoses.

To assess the effectiveness of DCRs, several factors need to be evaluated. Firstly, funding and success rates must be scrutinised. This includes examining how resources are allocated and the extent to which these facilities contribute to getting individuals into recovery programmes. Additionally, understanding the geographical distribution of DCRs is crucial. For instance, a facility in a densely populated urban area, like Glasgow, may have different outcomes compared to one in a more sparsely populated region. The effectiveness of DCRs may vary based on local demographics and drug use patterns.

The current discourse on DCRs raises valid questions about their operational model. There is a concern about the necessity of providing a space for drug consumption as a means of support. Critics argue that the focus should not solely be on providing a controlled environment for drug use but should also address

246 The Scottish Parliament, *The Role of the Scottish Criminal Justice Sector in Tackling the Misuse of Drugs,* November 2021.
247 Ibid.
248 Ibid.

broader support needs such as access to healthcare, welfare services, and fundamental necessities. This approach would address the diverse needs of individuals who use drugs, rather than focusing exclusively on those using heroin or similar substances.

Moreover, there is a need for a comprehensive assessment of the financial aspects and overall impact of DCRs. This includes a detailed analysis of expenditure, the allocation of funds across local authorities, and the availability of funded recovery places. It is important to understand the role of charitable organisations in this context and to evaluate whether the current investment in DCRs is proportionate to the outcomes achieved.

While the status quo in drug policy may not be working effectively, a careful evaluation of DCRs—considering funding, geographic applicability, and broader support structures—is essential. Testing new models requires a thorough understanding of their financial implications and practical impacts to ensure they complement existing recovery strategies and address the needs of all individuals affected by substance use.

Case Study: OnPoint

OnPoint New York City (NYC) was established in 2021 through the merger of New York Harm Reduction Educators and the Washington Heights Corner Project. The organisation serves communities in Upper Manhattan and the Bronx, providing crucial support to individuals who use drugs and those who sell sex. In response to a growing public health crisis, OnPoint NYC opened the first publicly recognised Overdose Prevention Centres (OPCs) in the United States on 30 November 2021.

OnPoint NYC operates under a 'closed-loop service provision' model through Harm Reduction Wellness Hubs. These centres offer an environment where individuals can consume drugs under medical supervision, aiming to prevent overdose deaths, connect people to care, and reduce public drug use and hazardous waste. Although primarily focused on drug-related issues, the centres also address broader health concerns such as untreated wounds and other injuries, functioning similarly to an accident and emergency department for those disconnected from traditional healthcare.

A significant challenge to effective addiction treatment is the limitation imposed by Medicaid, the public health insurance for low-income persons in the US, which restricts the number of rehabilitation visits per year. OnPoint addresses this by providing care and comfort for individuals who have exhausted their allotted visits, offering alternative treatments such as acupuncture while they wait for official rehab opportunities.

Harm reduction services like OnPoint are often criticised for potentially enabling addiction without providing a clear pathway to recovery. However, OnPoint emphasises that harm reduction and abstinence are not mutually exclusive. The organisation states that it works to place individuals into detox programmes upon request and aims to expand its capacity for detox beds to support this transition in a familiar environment.

The presence of an OPC in a neighbourhood can be contentious. Some residents and experts believe the neighbourhood is oversaturated with harm reduction programmes. This saturation has led to concerns about the impact on the community, particularly with local law enforcement's perceived disengagement. Initially, OnPoint requested minimal police involvement, but rising inter-dealer crime and violence have prompted a call for a more active police presence.

The consumption room at OnPoint resembles a hospital waiting area, with booths where individuals can use drugs. The facility includes a drug testing machine, though its use is voluntary and limited to once a week, leaving many to take risks with untested substances. Naloxone, an overdose reversal medication, is available but used only as a last resort to avoid precipitative withdrawal.

While OnPoint's services are a vital component of harm reduction, they are not a comprehensive solution to the overdose crisis. The organisation's focus remains on preventing deaths, recognising that ending addiction will require more extensive and coordinated efforts across the healthcare and social services systems.

It is evident that harm reduction should not be viewed as a standalone solution but as part of a broader, evidence-based drug policy. A balanced approach is needed, integrating prevention, treatment, enforcement, and recovery support alongside harm reduction strategies. This comprehensive method aims to address the complexities of drug addiction and its impact on both individuals and communities.

RECOMMENDATION

When evaluating the impact of the SDCFs, the Scottish Government should ensure it measures metrics including overall drug dependency, recovery rates, crime rates in the surrounding area and potential inconsistencies in the legal framework.

Part 3:

Opportunities for Change

The previous chapter has demonstrated that drug liberalisation produces mixed outcomes, with both positive and negative implications that necessitate a cautious approach. As such, it is recommended that the government delay pursuing similar policies domestically. This chapter explores immediate opportunities for reform within the treatment sector, the criminal justice system, and through preventive measures—key areas where targeted improvements can enhance support for those affected by addiction while upholding public safety.

This section of the report will address addiction through a health-focused lens, examine barriers to accessing treatment, and underscore the importance of involving family in the recovery process. It will also consider interventions for substance misuse, the complexities of the illegal drug trade, and the role of law enforcement. The CSJ conducted 14 focus groups across England with individuals with lived experience. Further detail on focus groups and analysis of the transcripts are in the appendix. The following subsections will include overarching themes from focus groups.

Recognising that this is a multifaceted issue, the discussion will highlight the necessity of a multi-pronged approach, acknowledging that aspects such as housing and unemployment are also critical factors that need to be addressed to create a comprehensive and effective strategy for supporting those struggling with addiction.

Roadblocks to Recovery

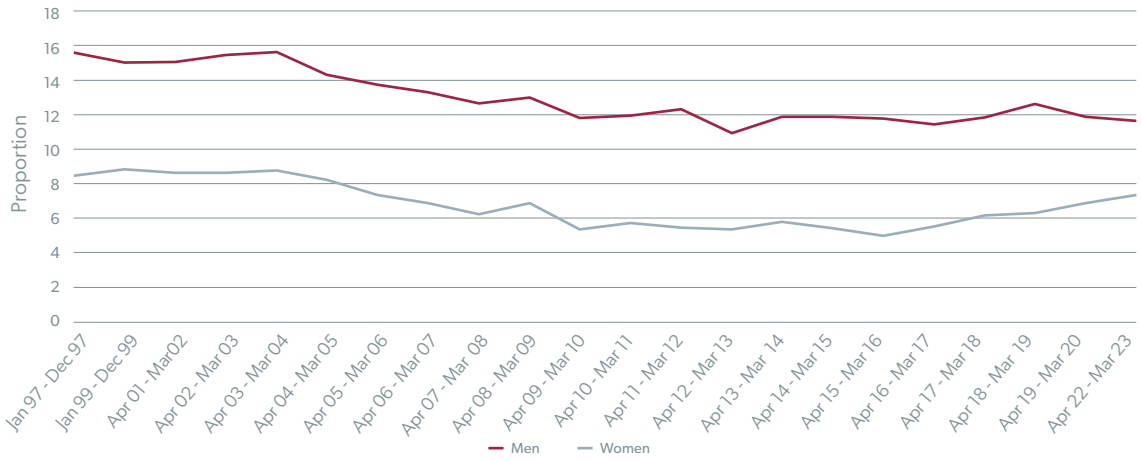
Barriers to accessing support

Accessing treatment for addiction and substance misuse is a universal challenge, but for many vulnerable individuals these challenges are compounded by additional barriers. While everyone navigating the path to recovery encounters difficulties, these groups often experience unique hurdles that can impede their access to vital care. By exploring these barriers, we can better understand the complexities of treatment access and identify ways to create more inclusive and effective support systems for all.

Barriers for Women

The proportion of men who use drugs is 1.6 times higher than the proportion of women.[249]

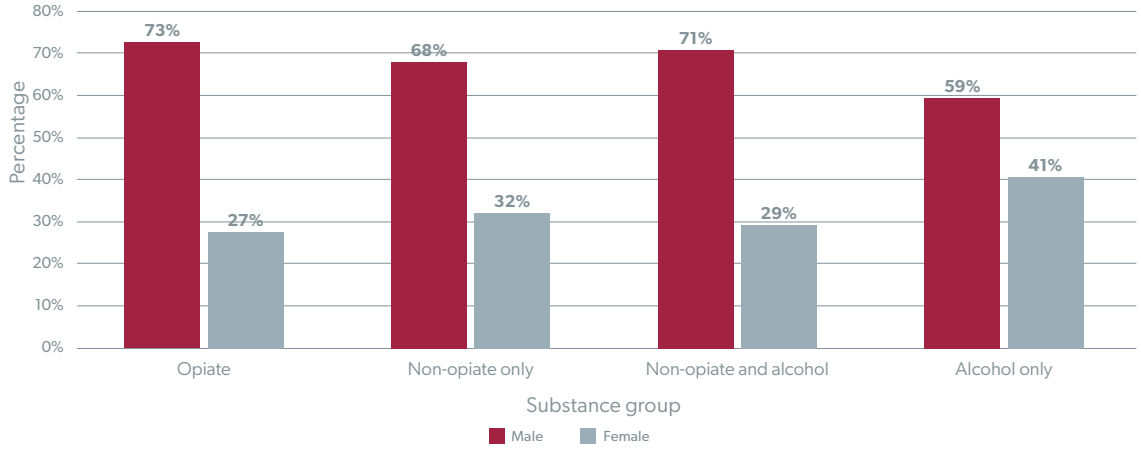
Figure 30: Proportion of men and women reporting drug use from 1997 – 2022.



Source: Office for National Statistics, Drug misuse in England and Wales - Appendix table, Table 3.04, December 2023.

The National Drug Treatment Monitoring System data reveals that males made up approximately 70 per cent of those in substance abuse treatment.[250] Women account for almost 40 per cent of drug users (7.34 out of 18.99 total), but only represent 30 per cent of those in treatment.[251] Conversely, men account for approximately 60 per cent of drug users (11.65 out of 18.99 total) but constitute 70 per cent of those receiving treatment. This disparity highlights the underrepresentation of women in drug treatment programmes relative to their proportion of drug users.

Figure 31: Breakdown of people in treatment by sex and substance group.



Source: Public Health England, 'Adult substance misuse statistics from the National Drug Treatment Monitoring System (NDTMS), Adult substance misuse treatment statistics 2022 to 2023: report, December 2023.

249 Office for National Statistics, *Drug misuse in England and Wales - Appendix table*, Table 3.04, December 2023.

250 Public Health England, 'Adult substance misuse statistics from the National Drug Treatment Monitoring System (NDTMS), *Adult substance misuse treatment statistics 2022 to 2023: report*, December 2023.

251 Ibid.

Women who use drugs and alcohol face unique challenges compared to men, including greater stigma, higher incidences of child care responsibilities, and trauma from domestic abuse, making recovery in male-dominated treatment environments difficult. Furthermore, the Government's 2021 Drugs Strategy lacks specific measures to address women's needs.

Research conducted in the West Midlands on women using community drug and alcohol treatment services highlights the significant barriers facing them in seeking support. The study, led by Staffordshire University and Expert Citizens CIC, found that women often experience stigma, such as being perceived as "lying drug addicts," which forces them to constantly prove their honesty.[252] This stigma, along with instances of professionals misrepresenting case notes and making mistakes, exacerbates emotional trauma and hinders access to appropriate support. Additionally, women are at risk in mixed-sex treatment services, which can be chaotic and unsafe.[253]

RECOMMENDATION

The DHSC should prioritise the development and expansion of sex-specific treatment services that address the unique needs of women. This could involve the creation of women-only treatment groups and spaces, which provide a safe and supportive environment for recovery. Additionally, childcare support should be integrated into treatment programmes to remove barriers for mothers seeking help.

Ethnic and Cultural Barriers

Limited awareness of available services and hesitancy to seek help due to stigma might result in the underrepresentation of people from ethic minority backgrounds in treatment programmes, compared to the number of people from ethnic minority backgrounds with drug dependencies. Additionally, a perceived lack of cultural understanding and instances of racism within these services are also obstacles to accessing treatment.[254] While participants primarily may struggle with personal recovery capital and ongoing substance use, Black and Asian participants face these struggles in addition to significant cultural challenges and difficulties accessing mainstream services.[255] This catalyses the underrepresentation of people from ethnic minority backgrounds in drug treatment programmes relative to their proportion of those in need of treatment.

> *"There's that shame and guilt thing still in the community, that even with my own family, we don't talk about it but in these four walls, I feel comfortable, not judged and should be like the outside, not just in these four walls, more safe spaces."*
>
> **CSJ Focus Group Participant, Male, Ethnic Minority Background, May 2024.**

252 Page, S.; Fedorowicz, S.; McCormack, F.; Whitehead, S., *Women, Addictions, Mental Health, Dishonesty, and Crime Stigma: Solutions to Reduce the Social Harms of Stigma*. Int. J. Environ. Res. Public Health 2024, 21, 63.

253 Ibid.

254 Douglass CH, Win TM, Goutzamanis S, Lim MSC, Block K, Onsando G, Hellard M, Higgs P, Livingstone C, Horyniak D. Stigma Associated with Alcohol and Other Drug Use Among People from Migrant and Ethnic Minority Groups: Results from a Systematic Review of Qualitative Studies. J Immigr Minor Health. 2023 Dec;25(6):1402-1425. doi: 10.1007/s10903-023-01468-3. Epub 2023 Mar 28. PMID: 36976449; PMCID: PMC10632266.

255 Shahid, S., & Best, D., *Exploring cultural dynamics of Black Asian Minority Ethnic (BAME) women in addiction recovery: a comparison of three women from different ethnic backgrounds*. Drugs: Education, Prevention and Policy, 1–12, 2024.

Cultural barriers, including shame and stigma, often discourage help-seeking behaviours and may compel families to seek treatment abroad.[256] Consequently, many ethnic minority women conceal their substance use, further burdening closely-knit communities where privacy is limited.[257] This situation is exacerbated for women who use drugs.[258]

RECOMMENDATION

The Government should review the commissioning process for drug treatment and recovery services for ethnic minority communities with specific focus on the establishment of ringfenced funding for the provision of specialist services for ethnic minority groups; and developing guidance for commissioners, co-produced with ethnic minority-led organisations. This guidance should promote the inclusion of specialist organisations throughout the entire commissioning cycle, ensuring that partnerships with specialist organisations during both the bidding process and contract delivery are fair and equitable.

Peer support and the contagion of recovery

A lack of peer support remains a significant barrier to recovery. CSJ focus group participants highlighted the strong influence of environmental factors, family dynamics, and peer pressure in encouraging substance use, noting the challenges these pose in overcoming addiction.

Despite these barriers, there are examples of good practice within the current support infrastructure. The sense of community found within rehabilitation services was identified as a key contributor to successful recovery, in addition to being lauded for their flexibility, short waiting times, and ability to assist with abstinence. One participant emphasised this point, suggesting that increasing the availability of rehabilitation facilities would reduce pressure on the police and health services, decrease incarceration rates, and lead to meaningful employment opportunities:

> *"More of these places around, can you imagine the benefit to society… It's just a win-win."*
>
> **CSJ Focus Group Participant 1, Loughborough, March 2024.**

The importance of individuals with lived experience of addiction was consistently highlighted. Participants noted that workers who had personal experience with addiction were crucial for creating empathetic connections and supporting others in their recovery journey. There was a strong call for the inclusion of lived experience not only in recovery services but also in wider sectors like the criminal justice system.

256 Gainsbury, S. M., *Cultural competence in the treatment of addictions: Theory, practice and evidence*. Clinical Psychology & Psychotherapy, 24(4), 987–1001. 2017.
257 Lee, N., & Boeri, M. *Managing stigma: Women drug users and recovery services. Fusio: The Bentley Undergraduate Research Journal*, *1*(2), 65–94. 2017.
258 Shahid, S., *What will people say? Drink and Drugs News*, 6-7, July 2023.

> *"The only way out of this… for everything is lived experience. Because speaking your own language and been through it, they can really empathise."*
>
> **CSJ Focus Group Participant 6, Middlesbrough, March 2024.**

Similarly, community support emerged as another essential element in maintaining recovery. Participants frequently referred to the benefit of the consistent, safe environment provided by recovery services. One individual reflected on how their regular attendance at such services provided both emotional stability and a safeguard against relapse:

> *"I know that I come here regularly, weekly, and I look forward to it. I need it. I always feel better. But also, when you're at a really low point or you're really struggling you know that this is a safe place if you're close to potentially relapsing."*
>
> **CSJ Focus Group Participant 3, Manchester, May 2024.**

Finally, the idea of long-term support was briefly mentioned but aligned with the broader consensus on the need for sustained assistance, such as supported living arrangements. This was echoed in the UK Life in Recovery survey, which found that 79 per cent of people in stable recovery reported volunteering in their local communities, twice the rate of the general UK population.[259] This underscores the concept of community recovery capital, where those in recovery not only benefit from community involvement but actively contribute to it.

A survey conducted by the Office for Health Improvement and Disparities in England (May–June 2022) assessed the allocation of resources by English local authority commissioners toward recovery support services (RSS) within alcohol and drug treatment budgets. Findings revealed that less than 5 per cent of local treatment budgets were directed toward RSS, highlighting a significant underfunding relative to broader treatment and recovery spending.[260] Notably, specific allocation details per RSS type were limited due to the survey's use of spending ranges rather than exact amounts, precluding a precise average estimate.

The survey further underscores the importance of funding structures that bolster the independence of peer-led recovery organisations, known as Lived Experience Recovery Organisations (LEROs). Effective procurement practices, as recommended, include supporting peer-delivered initiatives in maintaining autonomy, ensuring alignment with their cultural values, and fostering sustainability.[261] For instance, a commissioner choosing to separate treatment and LERO contracts—despite pressures to integrate them—reported this approach enabled the LERO to operate as a "critical friend," providing balanced oversight to both commissioner and treatment services. Other examples of collaborative governance emerged, such as arrangements where the LERO serves as the landlord for treatment providers, facilitating cooperative decision-making with commissioners.[262]

259 David Best, *UK Life in Recovery Survey,* September 2015.
260 Office for Health Improvement and Disparities, *Guidance Part 3: how to develop systems of care that support recovery*, October 2024.
261 Ibid.
262 Ibid.

The College of Lived Experience Recovery Organisations (CLERO) has created a national map identifying LEROs throughout the UK and Ireland.[263] Currently, more than 50 LEROs are active across over 70 local authorities in England, covering fewer than half of all local authorities in the country.

Map of LEROs in the UK and Ireland

263 College of Lived Experience Recovery Organisations, *National Map of LEROs*, n.d.

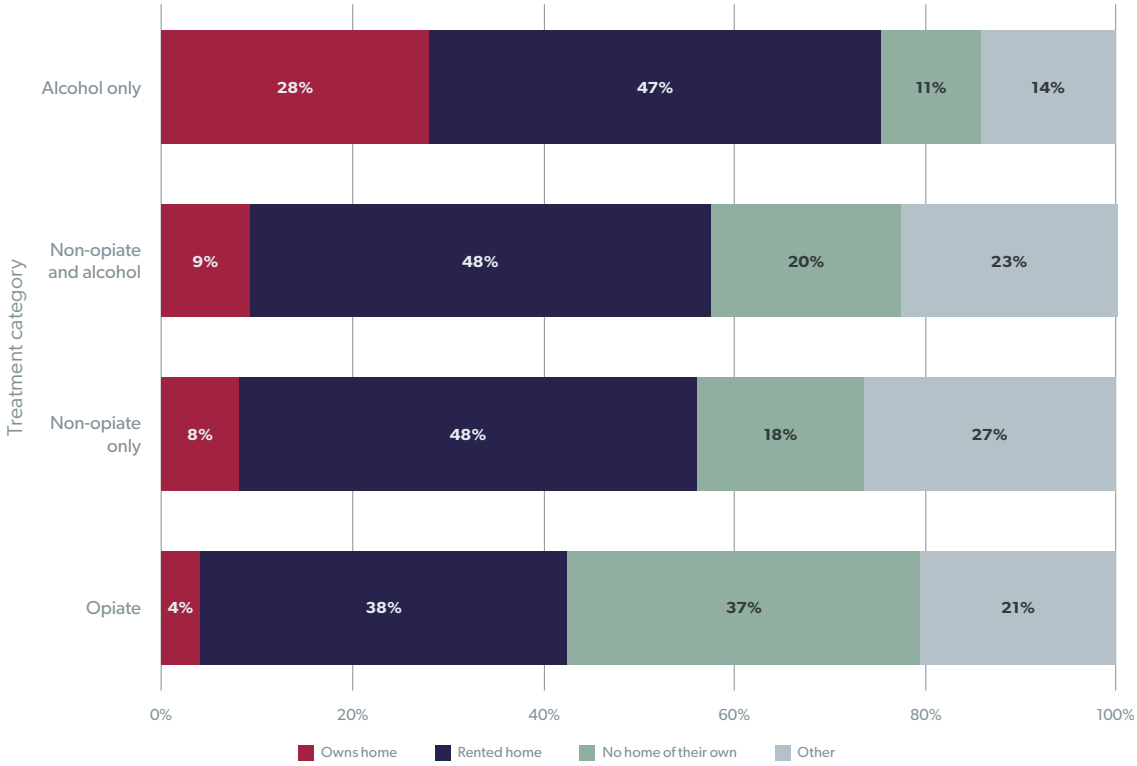
Leaving Treatment Unhoused

Housing plays a critical role in addiction recovery, particularly for those who are homeless or vulnerably housed, as they face disproportionately high rates of drug use and barriers to accessing support. Permanent Supportive Housing has been linked to reductions in substance use, homelessness, emergency room visits, and hospitalisations.[264] CSJ focus group participants emphasised that housing instability is a significant barrier to sustained recovery.

> *"When I left treatment, and all my friends were still using, I was unemployed, I had lost my house and was homeless, and I just thought, you know what... I might as well be high."*
>
> **CSJ Focus Group Participant 6, Rochdale, May 2024.**

The latest treatment statistics reveal that 37 per cent of people starting treatment with opiate problems had insecure housing.[265] The 'other' category includes long term supported accommodation or living with friends and family permanently.

Figure 32: Housing categories of people starting treatment in 2022 to 2023.

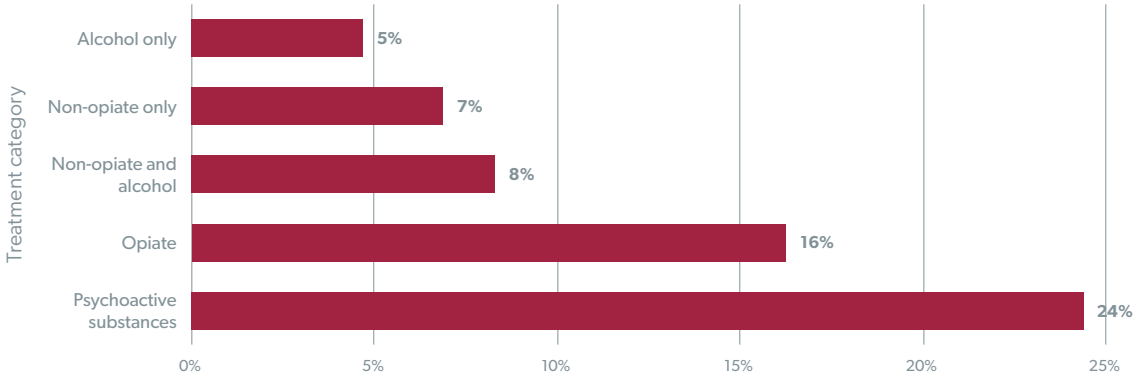


Source: Office for Health Improvements and Disparities, Adult substance misuse treatment statistics 2022 to 2023: report, Updated 21 December 2023.

264 Sahvanah Prescott, *How Stable Housing Supports Recovery from Substance Use Disorders*, John Hopkins Bloomberg School of Public Health, 2022.
265 Office for Health Improvements and Disparities, *Adult substance misuse treatment statistics 2022 to 2023: report*, Updated 21 December 2023

More than 1 in 12 people starting treatment were at risk of homelessness in the next 8 weeks.[266] 16 per cent of those with opiate problems were at risk of homelessness while only 5 per cent of those in the alcohol only category was the same.[267] Those reporting problems with psychoactive substances, mainly synthetic cannabinoids, were at the highest risk of becoming homeless at 24 per cent.[268]

Figure 33: Risk of homelessness in the next 8 weeks for all substance groups and psychoactive substances, starting treatment in 2022 to 2023.



Source: Office for Health Improvements and Disparities, Adult substance misuse treatment statistics 2022 to 2023: report, Updated 21 December 2023.

The CSJ's 2017 report, *Housing First,* identified that homelessness should be viewed on a continuum.[269] For instance, someone may experience several episodes of hidden homelessness or stay in a hostel before sleeping rough. One may move between sleeping rough and staying with friends. While the distinction between those enduring rough sleeping and those in inappropriate accommodation will always be a meaningful one worthy of our consideration, any accommodation that is marked by instability and risk to health is to be regarded as not conducive to prospect of recovery.

For individuals battling addiction, supportive housing offers a more holistic solution than just securing a home. As argued by the CSJ, the most effective way to transform the lives of rough sleepers with complex support needs is through a national Housing First programme.[270] Since the CSJ's 2017 *Houring First* report, the Government adopted and piloted this programme, and the evaluation found that half of Housing First clients received treatment for drug dependency since entering the programme.[271]

Furthermore, in 2023, the Conservative Government pledged £53 million to support housing for people in recovery across 28 local authorities in England. This funding aims to break the cycle of addiction and improve health outcomes by providing housing combined with access to essential social services.[272]

However, the scale of ambition does not yet match the extent of the rough sleeping problem. As we know from the case of Finland, when properly funded, Housing First can have a dramatic impact and nearly eradicate rough sleeping altogether.[273]

266 Ibid.
267 Ibid.
268 Ibid.
269 Centre for Social Justice, *Housing First,* March 2017.
270 Ibid.
271 Department for Levelling Up Housing and Communities, *Evaluation of the Housing First Pilots,* January 2024.
272 Department of Health and Social Care, Department for Levelling Up, Housing and Communities, Neil O'Brien MP, The Rt Hon Steve Barclay MP and Felicity Buchan, *£53 million cash boost to improve housing support for drug and alcohol recovery,* February 2023.
273 As reported by World Economic Forum, *Here's how Finland solved its homelessness problem*, February 2018.

Addiction is a Health Issue

Addiction is increasingly recognised as a complex health issue with profound implications for individuals and society in the UK. Far beyond mere willpower or personal choice, addiction involves intricate interactions between biological, psychological, and social factors. The impact of addiction extends across various dimensions of health, including mental well-being, physical health, and social stability, affecting not only those struggling with dependency but also their families and communities.

In recent years, there has been a growing acknowledgement of addiction's role in contributing to broader health inequalities, particularly in disadvantaged areas. The strain on healthcare services, coupled with the social and economic repercussions of addiction, underscore the importance of adopting a health-centric approach to address these challenges.

As the UK grapples with persistent high rates of substance misuse and its associated harms, recognising addiction as a health issue is crucial for developing effective policies and interventions.

How the Medical System Itself Impedes Access to Support

John's Story

This case study follows the story of John (name has been changed to protect identity), a recovering addict who struggled with substance misuse and accessing treatment. John found support in the Moses Project, one of the CSJ's alliance charities that provides guidance, mentoring and support to hundreds of adult males with past and current addictions to drugs and alcohol.

I became an addict at the age of 11. I started with cannabis and quickly escalated to harder drugs like acid, mushrooms, and ecstasy - what's classified as the "social party drug scene." By the time I was 13, I was also selling drugs. I grew up in one of the worst estates in Teesside in the 1980s, where violence, drugs, and crime were an everyday occurrence. I would sell drugs around my school, even setting up a makeshift tuckshop to cover the demand. I also set up fraudulent bank accounts to launder the money I was making.

By the time I was 16, I was selling ecstasy and cocaine around the nightclubs and was a heroin addict. I was involved in a lot of drug dealing, violence, fraud, and manipulation of people. I was a small fish in a very big pond, but the people I worked for had a lot of control over the drug distribution in the Teesside and Northeast region. There were also many people on the payroll who would turn a blind eye to what we were doing, allowing us to get away with a lot.

When I tried to get off heroin, I encountered methadone treatment programmes that were more focused on managing my addiction rather than helping me overcome it. The methadone dosages they prescribed were far too high - at one point I was on nearly 100 mg of methadone. I went to the doctor and was told I had liver and kidney problems directly caused by the methadone I was taking. Even though I was no longer using any other drugs at that point, the methadone was wreaking havoc on my body. I was advised to stop taking the methadone, but you can't just walk away from a 95 mg dosage - it has such a physical control over you. The methadone dictated my life more than the drug addiction did. It felt like there was no point in trying to stay off the drugs if all I was going to do was get put back on methadone, which was causing me so much physical harm. This fed into a negative mindset where I felt like this was the best my life was ever going to get.

The violence and greed eventually took a toll on me, and I remained a heroin addict for 20 years until I went into rehab in 2018. That was the first time I was completely drug-free. Before that, I had tried to get off heroin a few times, but the methadone treatment programmes I encountered were more focused on managing my addiction rather than helping me overcome it.

It wasn't until I went to another rehab that I was able to truly address the root causes of my addiction, which stemmed from the trauma and stress of being a young carer for my disabled parents. Once I was able to accept and work through that, the rest of the addiction just fell away. It's been a long and difficult journey, but I'm now married, educated, and actively involved in the community - something I never would have imagined for myself as a young kid on the streets. I am thankful for the Moses Project for all of their support and help.

Stigma

There is substantial evidence that clinicians often hold more negative attitudes toward individuals with substance use disorder compared to those with other mental or physical health conditions.[274] This may be due to several factors, including limited exposure to people in recovery, insufficient time and resources to provide adequate care, and the perception of substance misuse as a moral failing rather than a health condition.[275]

Prolonged stigmatisation of people with substance use disorders can result in their reluctance to seek medical assistance, leading to missed opportunities for early intervention. This stigma can also result in a lower quality of care, further marginalising these individuals.[276] Additionally, it may contribute to increased drug use and reduced access to harm reduction measures such as naloxone distribution, needle exchange programmes, and immunisation against blood-borne diseases.[277]

The influence of stigma held by health professionals towards addiction was a common theme throughout focus groups conducted by the CSJ. Almost all participants had some experience of being stigmatised by a medical profession. The CSJ was told that this catalysed both isolation and a reluctance to engage with recovery services. Participants noted the negative stigma they faced from external sources due to their struggles with substance addiction, and how that created barriers to entry surrounding accessing support services and receiving support from others.

> *"Also, the stigma, I found for 50 years I was a proper patient, and now I'm just defined as that person with a problem. That's how I feel each time I speak to my GP. It makes me feel ashamed and embarrassed and everything else is forgotten. It's like I am just defined as that person with a drug problem."*
>
> **CSJ Focus Group Participant 9, Middlesbrough, March 2024.**

A systematic review found that physicians who struggle to help patients with addiction often attribute their challenges to institutional barriers and personal limitations in skill, knowledge, cognitive capacity, and confidence in the effectiveness of interventions.[278] Researchers analysed 283 international studies involving 66,732 physicians, revealing that 61.5 per cent cited a lack of knowledge, 61.1 per cent pointed to insufficient institutional support, 60.1 per cent mentioned inadequate skills, 48.1 per cent noted limited cognitive resources, and 46.6 per cent expressed doubts about the potential benefits of treatment.[279] Some evidence suggests that educating healthcare providers about addiction as a medical chronic disease and implementing stigma-focused training could improve their attitudes and help reduce stigma.[280]

274 Yang LH, Wong LY, Grivel MM, Hasin DS. Stigma and substance use disorders: an international phenomenon. Curr Opin Psychiatry. 2017 Sep;30(5):378-388. doi: 10.1097/YCO.0000000000000351. PMID: 28700360; PMCID: PMC5854406.

275 Avery JD, Avery JJ, eds. *The Stigma of Addiction*. Springer International Publishing; 2019. doi:10.1007/978-3-030-02580-9

276 Madden EF, Prevedel S, Light T, Sulzer SH. Intervention Stigma toward Medications for Opioid Use Disorder: A Systematic Review. *Substance Use & Misuse*. 2021;56(14):2181-2201. doi:10.1080/10826084.2021.1975749

277 Volkow ND, Gordon JA, Koob GF. Choosing appropriate language to reduce the stigma around mental illness and substance use disorders. *Neuropsychopharmacol*. 2021;46(13):2230-2232. doi:10.1038/s41386-021-01069-4

278 Campopiano von Klimo M, Nolan L, Corbin M, et al. Physician Reluctance to Intervene in Addiction: A Systematic Review. *JAMA Netw Open*. 2024;7(7):e2420837. doi:10.1001/jamanetworkopen.2024.20837

279 Ibid.

280 Cazalis A, Lambert L, Auriacombe M. Stigmatization of people with addiction by health professionals: Current knowledge. A scoping review. Drug Alcohol Depend Rep. 2023 Oct 24;9:100196. doi: 10.1016/j.dadr.2023.100196. PMID: 38023342; PMCID: PMC10656222.

Referrals from health and social care accounted for 19 per cent of all addiction treatment referrals, with GPs playing a notable role, particularly in cases involving alcohol.[281] However, the lower rate of healthcare referrals for opiate users (9 per cent) highlights a potential gap in the healthcare system's response to this group. The Government should enhance training and support for healthcare providers to ensure they can effectively identify and refer individuals struggling with opiate use.

The stigma that individuals with substance use disorders face from healthcare professionals creates significant barriers to recovery and well-being. Ultimately, judgment from healthcare providers can discourage people from seeking vital medical care, perpetuating a cycle of neglect and harm.

RECOMMENDATION

NHS England should implement comprehensive stigma-focused training for GPs, emphasising addiction as a chronic medical condition. Additionally, the Government should enhance training and support for healthcare professionals to improve their ability to identify and refer individuals struggling with opiate addictions.

Dual Diagnosis

Individuals seeking treatment for substance misuse often require both addiction treatment and mental health services simultaneously. This is known as dual diagnosis.

Those who are dependent on drugs are more likely to use services for mental or emotional health, especially if they exhibited symptoms of dependency on drugs other than cannabis. However, it's noteworthy that at least half of these adults, regardless of the type of dependency, did not seek assistance from such services.[282]

The National Institute for Health Excellence (NICE) guidelines recommend comprehensive assessments, developing tailored care plans, and ensuring continuity of care throughout the person's journey support for individuals with coexisting severe mental illness and substance misuse.[283] Despite clear guidance from NICE, the CSJ has seen evidence indicating that in practice, mental health issues can pose a significant barrier to receiving help.

> *"You receive medication for mental health, but it's like, I've always struggled with substance abuse and mental health. Coming off an illegal drug, switching to a prescribed drug—it feels arbitrary. They replace one drug with another, just different kinds, one for the other."*
>
> **CSJ Focus Group Participant 2, Middlesbrough, March 2024.**

281 Office for Health Improvement and Disparities, *Adult substance misuse treatment statistics 2022 to 2023*, December 2023.

282 NHS England, *Adult Psychiatric Morbidity Survey*, September 2016.

283 National Institute for Health and Care Excellence, *Coexisting severe mental illness and substance misuse: community health and social care services*, November 2016.

The impact of mental ill health, dual diagnosis and trauma were recurring themes throughout focus groups with individuals with lived experience. All the focus groups corroborated on the importance of mental ill health in maintaining recovery and encouraging or sustaining addiction.

> *"Addiction is often a symptom of an undiagnosed mental health issue... so autism,*[284] *bipolar. In my son's case it's bipolar. I think that they're both hand in hand, you need to tackle both, you can't just try one; you have to look at both or you end up chasing two rabbits and catching none."*
>
> **CSJ Focus Group Participant 3, Mansfield, March 2024.**

Dame Carol Black's review of drugs states "trauma (physical, sexual or psychological) and mental ill-health are the drivers and accompaniment of much addiction. They are co-morbidities rather than separate problems for a 'dual diagnosis'."[285] Given the recognised importance of dual diagnosis from those with lived experience and its emphasis throughout the independent review, it is imperative that practice aligns with NICE guidelines on dual diagnosis.

RECOMMENDATION

The Care Quality Commission should give sufficient focus to clinical practice in relation to dual diagnoses. NHS Trusts must provide clear guidance to staff on the identification and management of patients who are not engaging with services, this must include how engagement will be monitored and reviewed.

Neonatal Abstinence Syndrome

Drug-related deaths often capture headlines, but drug misuse also devastates lives in numerous other ways. One particularly tragic consequence is Neonatal Abstinence Syndrome (NAS).

NAS is a cluster of conditions that occur when a neonate experiences withdrawal from certain substances to which they were exposed in utero.[286] NAS is predominantly associated with maternal use of opioids during pregnancy, but can also result from the use of antidepressants, barbiturates, or benzodiazepines. These substances can cross the placental barrier, which nourishes the foetus and supplies oxygen via the umbilical cord, leading to significant health issues for the neonate.[287]

284 Autism is not a mental health issue, but people with autism can experience mental health problems. The CSJ recognises that autism is a developmental and neurological disorder that affects how people interact, communicate, learn, and behave. Quotes have not been altered to accurately reflect the participant's contribution.

285 Dame Carol Black, *Review of drugs part two: prevention, treatment, and recovery,* August 2021.

286 Jilani, S.M., Jordan, C.J., Jansson, L.M. et al. *Definitions of neonatal abstinence syndrome in clinical studies of mothers and infants: an expert literature review.* J Perinatol 41, 1364–1371 (2021).

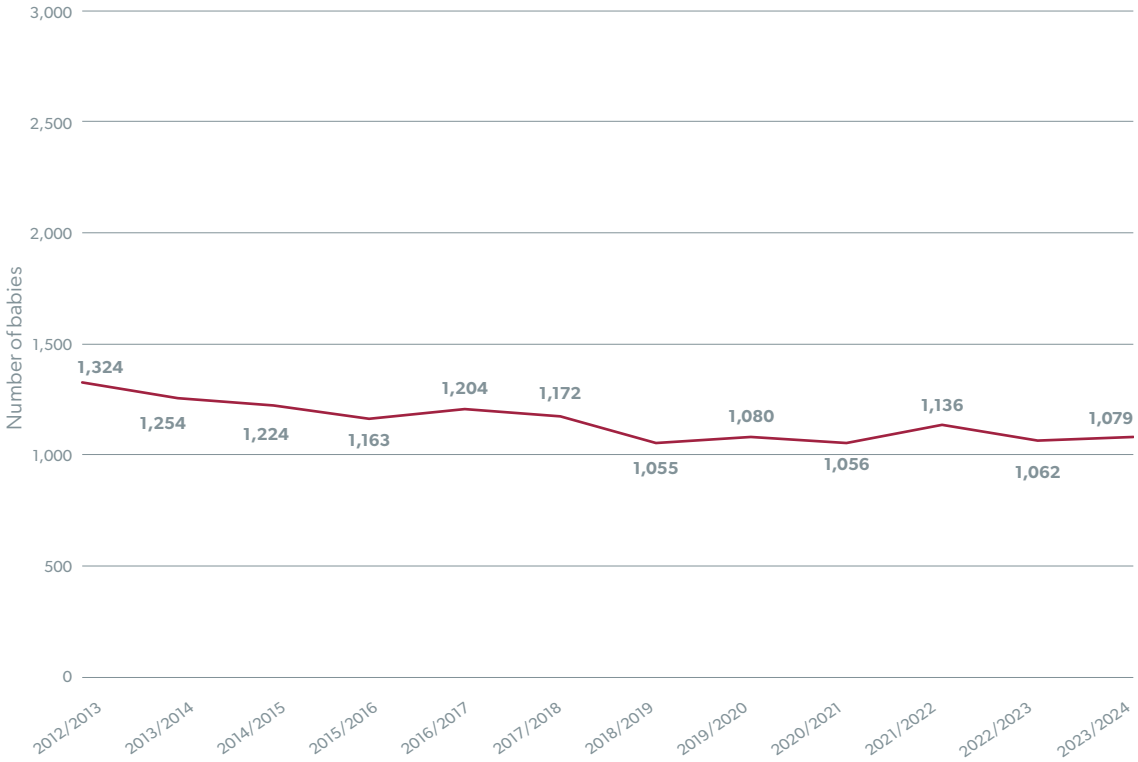
287 Anbalagan S, Falkowitz DM, Mendez MD. *Neonatal Abstinence Syndrome.* [Updated 2024 Apr 1], January 2024.

The CSJ submitted a freedom of information (FOI) request to NHS England for the number of babies born with the following ICD diagnoses:

- P04.4 Foetus and newborn affected by maternal use of drugs of addiction
- P96.1 Neonatal withdrawal symptoms from maternal use of drugs of addiction
- Z03.6 (Observation for suspected toxic effect from ingested substance – NAS observation)

Since 2012/12, 13,809 babies were born in England with neonatal withdrawal symptoms from maternal use of drugs.[288]

Figure 34: The number of babies born with NAS from 2012/13 to 2023/24.

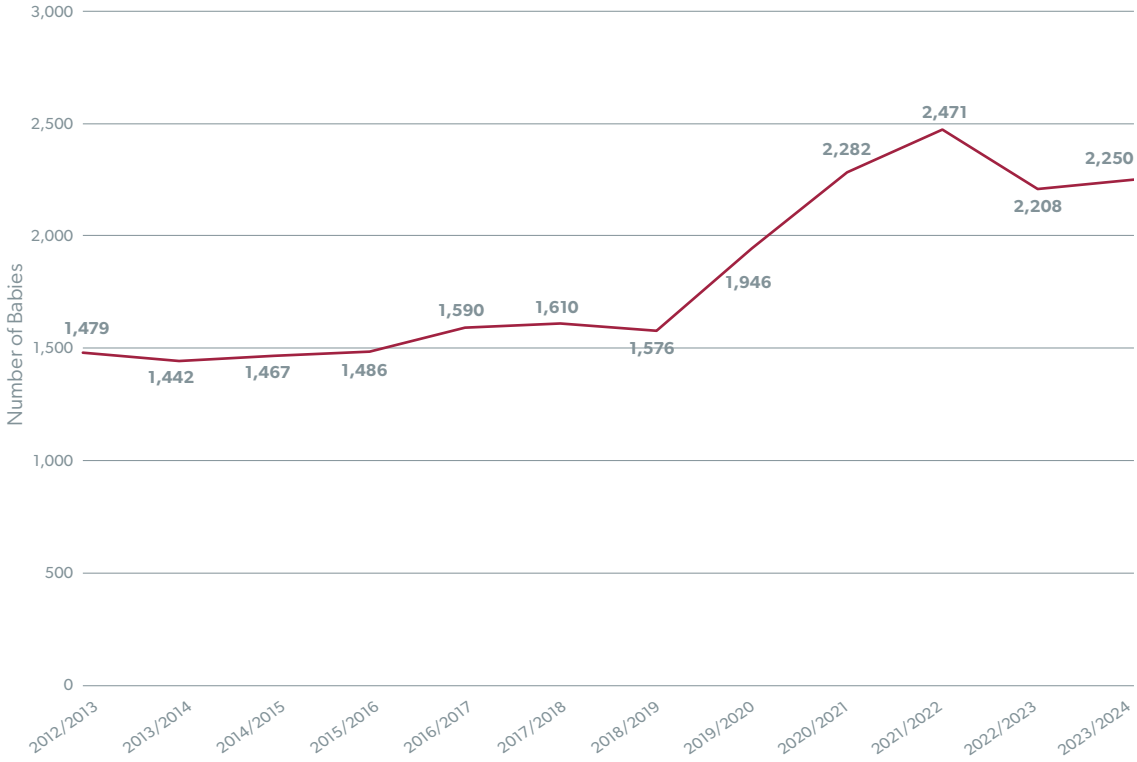


Source: CSJ Freedom of Information Request of NHS Digital, July 2024.

However, medical practitioners observed an increase of 1.5x the number of babies with suspected toxic effect from ingested substance (NAS observation) over the past decade.

288 Centre for Social Justice, *Analysis of NHS England Freedom of Information Request*, July 2024.

Figure 35: The count of finished consultant episodes with a primary or secondary diagnosis of neonatal withdrawal symptoms from 2012/12 to 2023/24 including observation.



Source: CSJ Freedom of Information Request of NHS Digital, July 2024.

NAS is associated with several significant risks and long-term complications. Infants with NAS often experience developmental delays, affecting their motor skills, learning abilities, and behaviour.[289] These children may face ongoing challenges with nutrition and growth, impacting their overall health and development. Additionally, problems with hearing and vision are common among those affected by NAS. Recent analysis suggests the direct annual cost of care was £10,440,444 with a median cost of £7,715 per infant with NAS.[290]

The home environment can also exacerbate these issues. Infants born with NAS may grow up in settings where harmful substances are used, further complicating their health and developmental outcomes. These combined factors underscore the critical need for comprehensive care and support for children with NAS and their families.

It is important to note that babies exposed to illicit drugs during pregnancy may not exhibit symptoms immediately after birth. These symptoms may become apparent days later, after the mother and baby have been discharged from the hospital. This means that the definitive number of babies affected by their mothers' drug use is likely to be higher than the number of official diagnoses recorded by the NHS.

289 March of Dimes, *Neonatal Abstinence Syndrome (NAS)*, 2024.

290 Rees P, Carter B, Gale C, Petrou S, Botting B, Sutcliffe AG. Cost of neonatal abstinence syndrome: an economic analysis of English national data held in the National Neonatal Research Database. Arch Dis Child Fetal Neonatal Ed. 2021 Sep;106(5):494-500. doi: 10.1136/archdischild-2020-319213. Epub 2021 Feb 24. PMID: 33627328.

Identifying pregnancies at risk of illicit drug exposure is crucial to enable appropriate and timely treatment for the neonate. This can be done through a variety of methods, including screening pregnant women for substance use and providing them with access to treatment and support services. Currently, pregnant women are only screened when suspected of illicit drug use or if they admit to using drugs in the past.[291] By addressing this issue, we can help to reduce the number of babies affected by their mothers' drug use and improve their long-term health and well-being.

RECOMMENDATION:

In line with NICE guidelines on pregnancy and complex social factors, NHS England should ensure that all pregnant women are routinely screened for substance use and receive coordinated care, integrating detox services into antenatal care. Providers must address barriers by offering tailored information, combining care plans, and assigning a named midwife or doctor with specialised experience. Staff should be trained to communicate sensitively, and additional support, including transport and referrals, should be provided to ensure attendance and continuity of care.

Methadone

While methadone prescription is an appropriate option in specific circumstances as part of opioid substitution treatment (OST), there is a concern that a reliance on methadone could be causing undesirable outcomes and inhibit recovery for vulnerable individuals who may benefit from alternative treatment and support. Policy options should be explored across Government to ensure that, wherever possible, the root causes of addiction are addressed, and treatment options are offered to those who would benefit.

National data, collected in 2018, shows that 145,602 people in England and 1,966 in Wales received opioid substitution therapy (OST), primarily methadone but also buprenorphine. In Scotland, 25,375 people were prescribed methadone at least once during the 2017/18 year, although this is likely an underestimation due to data quality issues. In Northern Ireland, 984 people received OST during the same period, with methadone and buprenorphine prescribed at similar rates.[292]

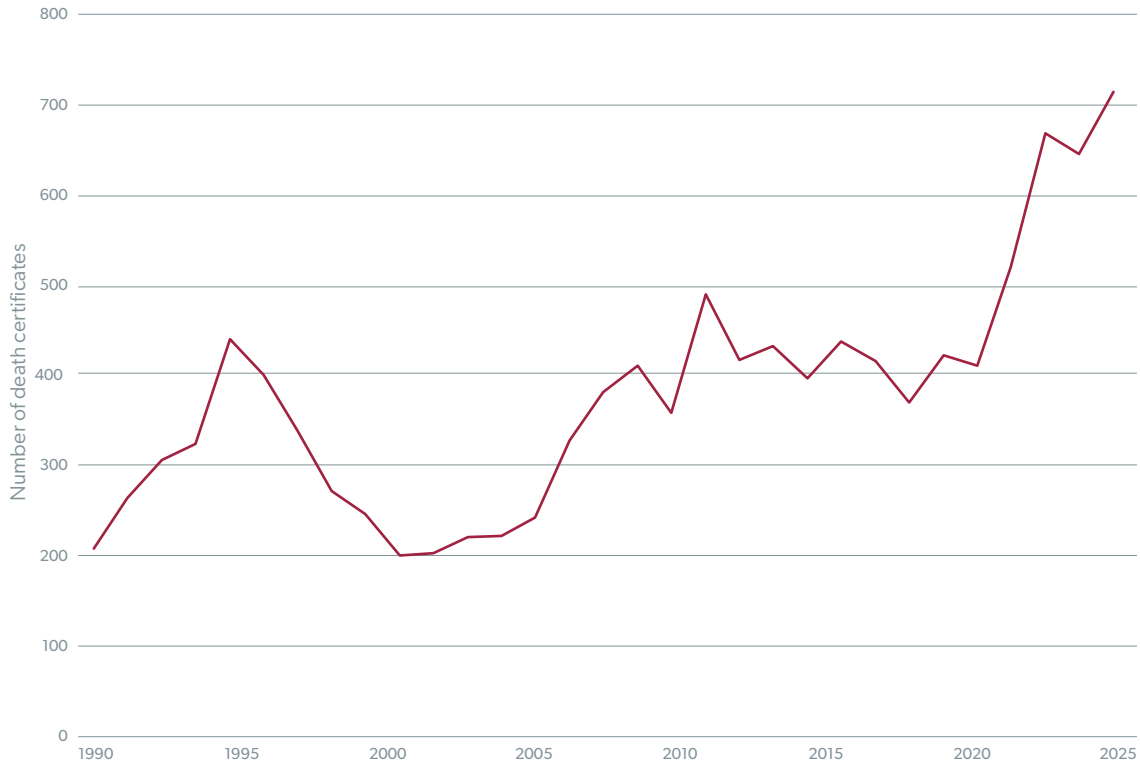
Deaths involving methadone remain high. Latest ONS statistics reveal 709 deaths involving methadone registered in 2023, 74 per cent higher than pre-pandemic levels and 244 per cent higher than when data collection started in 1993.[293]

291 NHS Health Research Authority, *Investigating Substance Misuse in Pregnancy in a Combined Trust*, May 2022.

292 Home Office, *United Kingdom drug situation 2019: Focal point annual report*, March 2021.

293 Office for National Statistics, *Deaths related to drug poisoning in England and Wales: 2023 registrations, October 2024.*

Figure 36: Number of death certificates with mention of methadone from 1993 – 2023.



Source: ONS, Deaths related to drug poisoning in England and Wales: 2023 registrations, October 2024.

Academics contend that administering methadone to those with opioid use disorders without proper counselling and a structured opioid reduction plan can exacerbate their addiction issues.[294] Some argue that the prolonged effects of methadone can lead to dependency on the treatment itself. During interviews and focus groups, the CSJ was told that methadone can be a barrier to accessing treatment, as many rehabilitation facilities only accept new patients if their prescription is 40 mg or less. The CSJ spoke to several individuals who were on 80 mg or more and were struggling to reduce their prescription in order to enter treatment.

Furthermore, methadone use is often stigmatised. The CSJ found that those prescribed methadone feel marginalised and devalued, particularly due to the indiscreet dispensing practices at pharmacies.

Negative experiences of methadone were a recurring theme throughout the CSJ's 14 focus groups of individuals with lived experience. Participants criticised methadone for failing to actively assist them in dealing with their substance addiction, having harsh withdrawals, the damage it caused to users, being more addictive than the substances they were taking methadone to become abstinent from, and a lack of progression off the medication when requested. One participant mentioned having thousands of pounds worth of methadone at his house that was unaccounted for. Participants also discussed how once on methadone, there was little support or incentive to get off the prescription, and as a result many had personally been, or knew individuals who were, on methadone for decades.

294 Dematteis, M., Auriacombe, M., D'Agnone, O., Somaini, L., Szerman, N., Littlewood, R., … Soyka, M. (2017). Recommendations for buprenorphine and methadone therapy in opioid use disorder: a European consensus. *Expert Opinion on Pharmacotherapy*, *18*(18), 1987–1999. doi.org/10.1080/14656566.2017.1409722

> *"Often the method on it was about keeping you sustained, there was no plan moving forward. I've known people who've been on Methadone for 30/40 years, their life is gone. They've never experienced the quality of life that they should have experienced."*
>
> *CSJ Focus Group Participant 2, Manchester, May 2024.*

Participants also discussed the inefficiency of methadone, noting that the drug essentially became another addiction and replaced the drugs they were abusing or that methadone would be used alongside other drugs.

Positive experiences with OSTs were also discussed throughout the focus groups. Buprenorphine was the most approved medicine for OST among focus group participants. The use of Subutex, a brand of buprenorphine, over methadone was praised by one focus group participant who quoted:

> *"I started doing Subutex instead, but it took me 18 months to go through and once I decided I want to come off it was when I was off everything else, they helped me with that... it'll be coming up a year since I've done anything."*
>
> *CSJ Focus Group Participant 1, Stockton-on-Tees, March 2024.*

Supervised consumption of OSTs is not legally required under the Misuse of Drugs Regulations 2001.[295] A proactive strategy by NHS England to designate supervised consumption of OSTs as a core essential service within the Terms of Service—requiring all pharmacies to provide it—or to implement it.[296] The national COVID-19 vaccination programme was delivered as a NES, commissioned by NHS England and NHS Improvement, which allowed for nationwide agreement on service specifications and remuneration. A similar approach for OSTs could offer significant public health benefits.

OSTs play an essential role in the treatment and recovery of some individuals struggling with opioid dependence. While these medications can sustain a form of dependency, they are not inherently detrimental when prescribed appropriately. Instead, they are often indispensable tools that help individuals stabilise their lives, reduce harm, and potentially work towards recovery.

Methadone, a long-established opioid agonist, is effective in reducing cravings and withdrawal symptoms, allowing individuals to regain stability.[297] However, it is more sedating than buprenorphine and carries a higher risk of overdose, especially when combined with other sedating substances.[298] Methadone's long half-life requires careful titration over an extended period, making dose reductions challenging and withdrawal symptoms more pronounced compared to buprenorphine. Despite these challenges, methadone remains widely used to manage opioid dependence.

295 Community Pharmacy England, *Dispensing Controlled Drugs,* 2013.

296 Ibid.

297 National Academies of Sciences, Engineering, and Medicine; Health and Medicine Division; Board on Health Sciences Policy; Committee on Medication-Assisted Treatment for Opioid Use Disorder; Mancher M, Leshner AI, editors. Medications for Opioid Use Disorder Save Lives. Washington (DC): National Academies Press (US); 2019 Mar 30. 2, The Effectiveness of Medication-Based Treatment for Opioid Use Disorder. Available from: www.ncbi.nlm.nih.gov/books/NBK541393/

298 National Institute for Health and Care Excellence, *Substance dependence., n.d.*

Buprenorphine, on the other hand, is less sedating and safer when used alongside other medications.[299] It offers the advantage of milder withdrawal symptoms, making dose reductions easier and lowering the risk of overdose. Additionally, buprenorphine's ability to be administered every other day in higher doses, and its shorter drug-free period before transitioning to naltrexone hydrochloride, make it a flexible option in OST. Nevertheless, buprenorphine carries the risk of precipitated withdrawal if administered while other opioids are still active in the patient's system, requiring careful management during initiation and dose adjustments.[300]

One of the key considerations in OST is recognising that recovery is not a one-size-fits-all process. The duration and approach to using substitute medications like methadone or buprenorphine will vary significantly between individuals. Some may achieve stability and be encouraged towards abstinence, while others, particularly those who are older or have diminished social or health resources, may rely on these medications for an extended period, possibly for life. It is crucial that these individuals are supported without pressure, allowing them to progress at their own pace.

The healthcare system must also ensure that those capable of moving beyond medication dependence are encouraged to do so. Unfortunately, there are instances where individuals on OST feel abandoned by a system that sees continued medication as an endpoint rather than a step in the recovery journey. The CSJ has witnessed numerous cases where individuals were left on methadone prescriptions without adequate encouragement or support to tackle their addiction more holistically. This lack of proactive engagement, especially in cases where individuals continue to use illicit substances alongside their OST, reflects a failure of the system to fully support those in need.

Treatment completion, while important, need not come at the expense of long-term care for individuals dependent on OSTs. The 10-year drug strategy's emphasis on a "world-class treatment system" implies an integrated approach that prioritises long-term support, not just treatment completion. In fact, the Strategy aims to ensure that individuals remain engaged with services through enhanced integration with health and criminal justice systems.[301] The Government's additional funding for treatment services can provide the flexibility needed to retain individuals in OST programmes without prematurely ending their treatment. Retention should be balanced with recovery goals, with individualised care plans central to that process.

The pursuit of abstinence should be a recognised and supported goal within addiction treatment. Where apathy leads to a stagnant approach, with no meaningful encouragement for recovery beyond medication, the system fails its patients. Methadone and buprenorphine, when used appropriately, are powerful tools in the fight against opioid addiction. Still, they should be part of a broader, more dynamic strategy that actively supports and encourages individuals towards a life free from dependency.

299 Ibid.

300 Ibid.

301 Home Office, Department of Health and Social Care, Ministry of Justice, Department for Work and Pensions, Department for Education and Department for Levelling Up, Housing and Communities, *From Harm to Hope: A 10 year drug plan to cut crime and save lives,* December 2021.

RECOMMENDATION

In accordance with NICE guidelines, individuals receiving opioid substitution therapy should also be provided with integrated psychological support. This approach ensures that mental health issues, which often underpin substance use disorders, are addressed concurrently, fostering a more comprehensive and effective recovery process. By partnering with mental health services and offering psychological interventions alongside opioid substitution therapy, we can improve patient outcomes, support long-term recovery, and reduce the risk of relapse.

RECOMMENDATION

The Department of Health and Social Care should ensure channels are developed for patients who wish to transition from methadone to alternative treatments like buprenorphine. This can be supported by broadening the HEE and PHE programme BOOST so that it is mandatory rather than optional.

RECOMMENDATION

The Care Quality Commission should give sufficient focus to clinical practice in relation to the balance between different forms of OSTs in its regulation of services.

Tracking non-fatal overdoses

Tracking non-fatal overdoses offers numerous benefits and is a crucial public health policy. It acts as an early warning system, identifying hotspots of drug use and signalling the presence of particularly dangerous substances. This enables timely interventions and public warnings, contributing to a comprehensive understanding of the epidemiology of substance use disorders. This includes insights into the demographics most affected and the substances most involved.

Fatal overdoses are recorded in the ONS, [302] and the NHS annually reports on drug misuse related hospital admissions.[303]

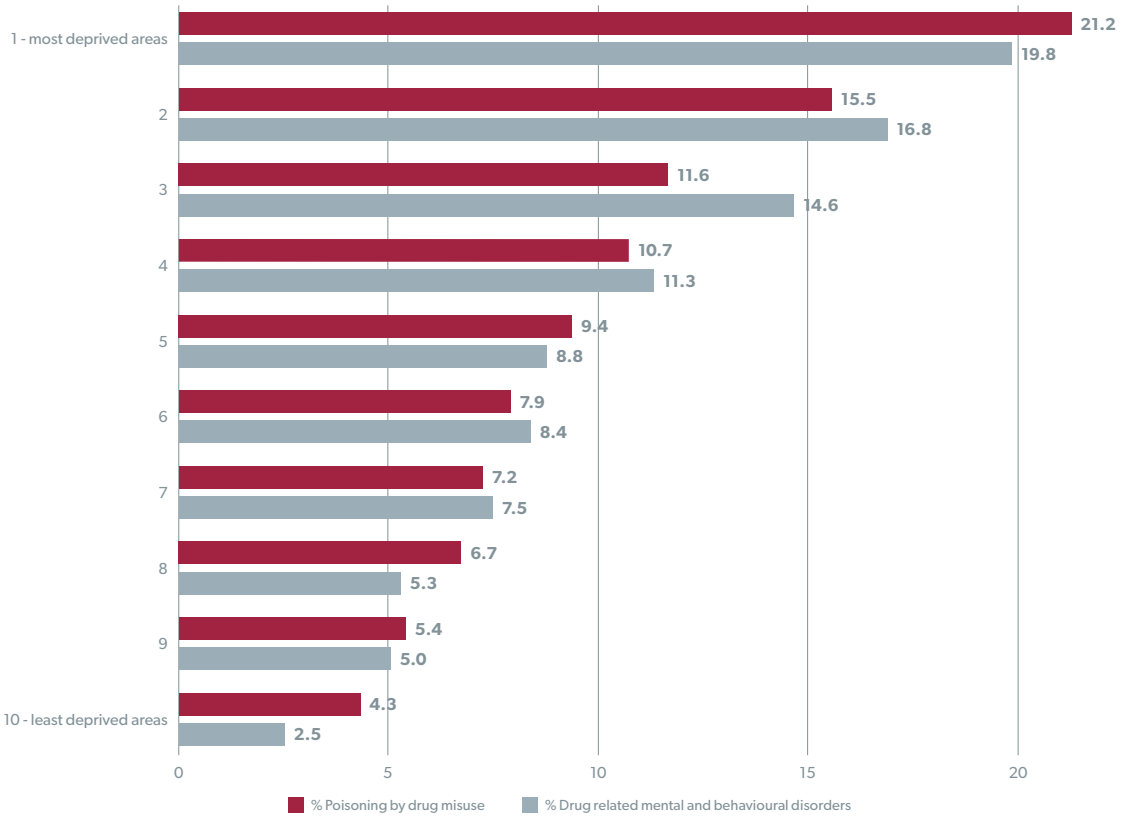
NHS admissions rates for drug-related mental health and behavioural disorders and for poisoning by drug misuse increase with the level of deprivation. Drug-related mental health and behavioural disorders are almost eight times more likely in the most deprived areas.[304] Drug misuse hospital admissions are five times more likely.

302 Office for National Statistics, *Deaths related to drug poisoning in England and Wales: 2023 registrations*, October 2024.

303 NHS England, *Statistics on Public Health*, August 2024.

304 Ibid.

Figure 37: Percentage admissions for drug-related mental health and behavioural disorders, and for poisoning by drug misuse by deprivation decile.



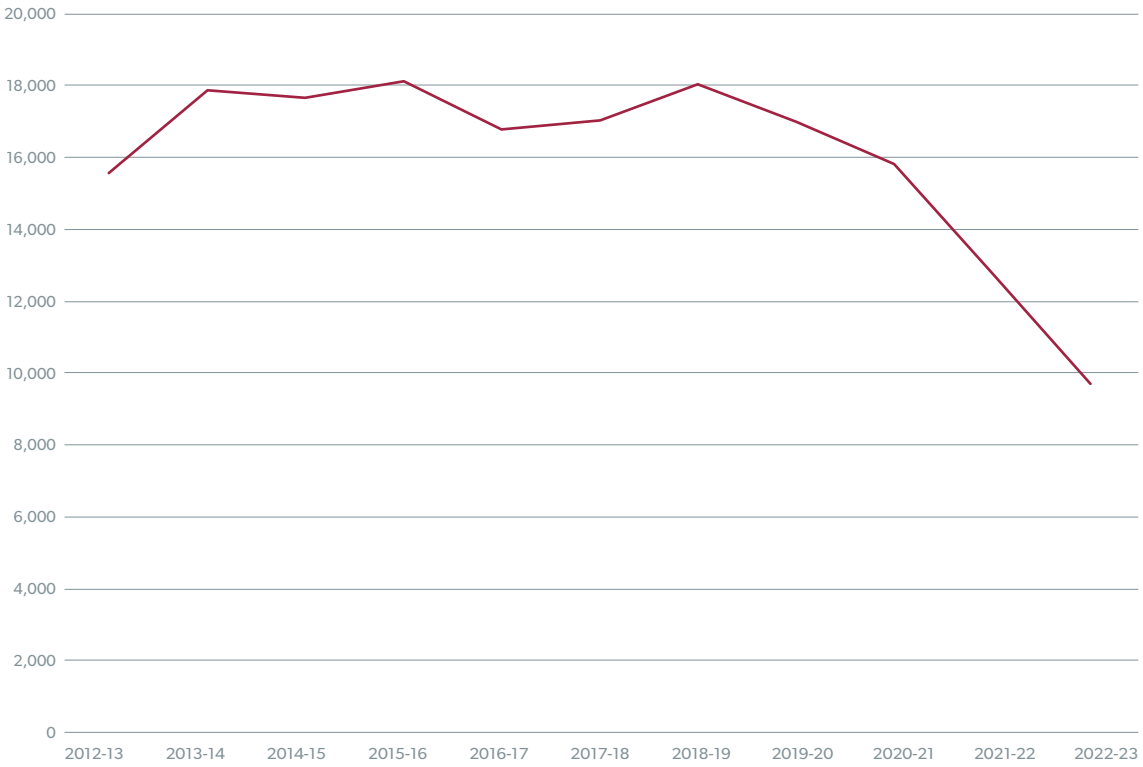
Source: NHS Statistics on Public Health, England 2023, August 2024.

Last year, there were 9,690 admissions for poisoning by drug use. Since its height in 2015/16, admissions have decreased by 47 per cent.[305] This is in direct contrast to ONS figures on drug deaths due to drug poisoning which reached their highest peak last year at 5,448, an increase of 84 per cent since 2013.[306]

305 Ibid.

306 Office for National Statistics, *Deaths related to drug poisoning in England and Wales: 2023 registrations*, October 2024. And Office for National Statistics, *Deaths Related to Drug Poisoning in England and Wales, 2013*, September 2014.

Figure 38: NHS hospital admissions for poisonings by drug misuse over from 2012/12 - 2022/23.



Source: NHS Statistics on Public Health, England 2023, August 2024.

NHS hospital admission statistics reflect inpatient settings only. These results are a small proportion of all overdoses that occurred last year. Many people who experience drug poisonings may be rough sleeping, isolated in their homes, or far away from an NHS hospital. Even so, a recovered addict is estimated to cost the NHS £2,024 a year less.[307]

The Unlinked Anonymous Monitoring Survey of HIV and viral hepatitis among people who inject drugs collects information on non-fatal overdoses.[308] The latest results reveal nearly a quarter of those who had injected drugs in the past year experienced a non-fatal overdose to the point of losing consciousness. This is a 16 per cent increase from 2013. Results were similar amongst those who entered treatment and those who had not.[309] These results are focused on those who inject drugs and may not include individuals who ingest illicit substances through other means, such as smoking.

In March 2024, the Government announced the launch of an early warning system to track wastewater testing and overdoses reported by emergency services.[310] The DHSC, OHID and the NCA have started monitoring deaths associated with the use of illicit potent synthetic opioids.[311] Data from ambulance trusts, lab-tested police seizures, drug checking services, and hospital admissions are included in this report.

307 David Frayman, Christian Krekel, Richard Layard, Sara MacLennan and Isaac Parkes, *Value for Money,* September 2024.

308 UK Health Security Agency, *Unlinked Anonymous Monitoring (UAM) survey of HIV and viral hepatitis among people who inject drugs (PWID): 2023 report,* January 2024.

309 Ibid.

310 Gwyn Wright, *Early warning system will detect opioids to help prevent US-style fentanyl crisis in Britain*, The Telegraph, March 2024.

311 Office for Health Improvement and Disparities, *Deaths linked to potent synthetic opioids,* October 2024.

However, with the expansion of naloxone to police forces, there are opportunities to include information on police-administered naloxone incidents. The full implementation of this promise remains to be seen.

Non-fatal overdoses present critical opportunities for intervention. Individuals can be connected to treatment and support services, potentially preventing future overdoses. Addressing non-fatal overdoses also helps in reducing the stigma associated with drug use, encouraging more individuals to seek help. Furthermore, the data can raise public awareness about the risks of drug use and the importance of intervention. Communities can develop targeted educational and prevention programmes based on specific patterns identified through overdose tracking.

In the United States of America, the Centre for Disease Control's (CDC) Drug Overdose Surveillance and Epidemiology (DOSE) system captures non-fatal overdose data.[312] This system facilitates timely interventions, enhances resource allocation, and supports evidence-based policy making, ultimately contributing to the reduction of overdose incidents and improving public health outcomes.

The use of ambulance service data represents a largely untapped resource that could be more proactively utilised for overdose prevention. In Australia, ambulance data is used to identify potential hotspots within the heroin market, highlighting its potential for improving targeted interventions and preventive measures.[313] For instance, tracking non-fatal overdose ambulance data in Melbourne revealed a direct association between non-fatal overdose and subsequent overdose mortality.[314] Increased mortality risk was associated with being male, over the age of 35 years old, and attending multiple times for previous non-fatal overdoses.[315] Ambulance data can also be utilised to identify drug market hot spots.

Adopting this policy is a proactive approach. It shifts the focus from merely addressing fatal overdoses to preventing them by intervening earlier. This comprehensive understanding of the drug crisis is vital, as many overdoses do not result in death but still represent severe health issues. Intervening in cases of non-fatal overdoses improves outcomes by preventing future incidents and reducing healthcare costs. It also enhances public safety by helping law enforcement and public health officials reduce the availability of dangerous substances.

Tracking non-fatal overdoses is a cost-effective, critical component of a robust public health strategy, offering significant benefits for individuals and communities alike.

312 Centre for Disease Control, *DOSE Dashboard: Nonfatal Overdose Syndromic Surveillance Data,* September 2024.

313 Matheson C. The importance of non-fatal overdose in reducing drug related deaths characteristics of non-fatal overdoses and associated risk factors in patients attending a specialist community-based substance misuse service. Br J Pain. 2022 Aug;16(4):358-360. doi: 10.1177/20494637221115985. Epub 2022 Aug 16. PMID: 36032348; PMCID: PMC9411758.

314 Stoové, M. A., Dietze, P. M., & Jolley, D., *Overdose deaths following previous non-fatal heroin overdose: record linkage of ambulance attendance and death registry data*. Drug and alcohol review, 28(4), 347-352., 2009.

315 Ibid.

Figure 39: Overdose data Surveillance and Sharing Collective Impact of Stakeholders.

Source: Surveillance & Sharing of Overdose Data for Action Summit, June 2020. The image above illustrates many of the stakeholders that interact with individuals experiencing overdose in the short to long term, but this is a non-comprehensive list. Each stakeholder plays an important role in the fight to end the drug overdose epidemic, but when stakeholders collaborate – and share a unified mission – the impact is far greater.

RECOMMENDATION

ONS should continue to explore large-scale data linkage of death registrations with NHS and other administrative data sources, such as prescriptions, and design both cross-sectional and longitudinal analyses to contribute to understanding of the patterns of drug misuse, causal relationships, and the individual pathways of those who die of drug-related causes.

RECOMMENDATION

As part of local drug processes, directors of public health, senior responsible officers in combating drugs partnerships, and partners in the commissioning and delivery of services for people who use drugs and alcohol, including voluntary and NHS services should collaborate to "deep dive" fatal overdoses and non-fatal overdoses, as outlined in the OHID's guidance, "Preventing drug and alcohol deaths: partnership review process." Directors should keep and publish findings and actions directors' annual reports and understanding factors that contributed to overdoses in the past, so we can prevent them from occurring in the future.

RECOMMENDATION

As promised by the previous Government, the Minister of State for Crime, Policing and Fire should expand a national system to track non-fatal overdoses. This system should gather data from NHS trusts, police, ambulance services, and emergency departments to monitor trends and identify high-risk areas. Drawing on models like the U.S. Drug Overdose Surveillance and Epidemiology (DOSE) system, this initiative would enhance situational awareness, guide resource allocation, and inform public health interventions aimed at reducing drug-related harm. Accurate tracking of non-fatal overdoses is essential for understanding the full impact of substance use disorders and improving community health outcomes.

RECOMMENDATION

The DHSC should update its current tracking synthetic opioid deaths system to include police data where naloxone has been administered.

RECOMMENDATION

As promised by the previous Government, the Minister of State for Crime, Policing and Fire should expand wastewater testing as an early warning system. This will aid in understanding the changing drug market as well as the prevalence of drug misuse.

Why Family Matters

Case Study: BAC O'Connor

I was living with addiction for years. My wife was an alcoholic, and my daughter was a heroin addict. I felt totally and utterly isolated because I had no one to talk to about it. My friends and family didn't want to hear the same story from me over, and over again, and they even told me to just kick my wife and daughter out and move on with my life. But I couldn't do that - I loved them too much.

That's when I got a letter inviting me to come to the family group meetings. Walking in for the first time was really nerve-wracking because I didn't know what to expect. I thought they were going to tell me how to cure my addicted loved ones, but I quickly learned that this group was really about me and helping me reclaim my own life. Listening to the stories of the other people in the group was so valuable. I realised we all had very similar experiences and struggles. The group provided wise counsel and support, even if they had to give me a nudge or a kick in the backside sometimes. There were many nights I drove home thinking I wouldn't go back, but by the time I got home I realised they were just telling me the truth. The group encouraged me to write my own "life story" about how addiction had impacted me. It was an ongoing process, but it really helped me start looking at myself and my own recovery.

I learned that I was addicted to my addict's behaviour, and the group helped me break that addiction in myself. It's been a hard but important journey, and I'm so grateful for the support of this family group.

Family Support

For every one person in addiction, there is at least one other person affected by it.

Addiction is a pervasive issue that not only affects individuals but also deeply impacts their families, often leaving a trail of emotional, financial, and psychological challenges. In the UK, where substance misuse and behavioural addictions are prevalent, families frequently find themselves grappling with the consequences of a loved one's addiction. The ripple effects can strain relationships, disrupt family dynamics, and lead to long-term trauma for all involved.

The importance of family support in addressing addiction cannot be overstated. Families play a crucial role in both the onset and recovery process, often being the first to notice signs of addiction and the primary source of support.[316] Almost 60 per cent of individuals are either self-referred or are referred by family and friends into treatment, underscoring the importance of public awareness and accessibility of treatment services.[317] This suggests that individuals and their support networks play a critical role in seeking help, potentially due to insufficient early intervention by healthcare professionals.

The burden placed on family members of those struggling with addiction can be immense, making it essential for them to receive appropriate support and resources.

316 Lander L, Howsare J, Byrne M. The impact of substance use disorders on families and children: from theory to practice. Soc Work Public Health. 2013;28(3-4):194-205. doi: 10.1080/19371918.2013.759005. PMID: 23731414; PMCID: PMC3725219.

317 Office for Health Improvement and Disparities, *Adult substance misuse treatment statistics 2022 to 2023*, December 2023.

In England, where the NHS and various support organisations provide avenues for treatment, there is a growing recognition of the need to prioritise family support as a fundamental component of addiction recovery. This was recognised throughout the 10-year drug strategy.[318] By empowering families with the knowledge, tools, and emotional support they need, it becomes possible to create a more resilient environment that not only aids the individual in recovery but also fosters healing and strength within the entire family unit.

An example of good practice: Addiction Family Support

The charity Addiction Family Support (formerly DrugFam) provides free-of-charge support services to individuals who are affected by a loved one's problem drug use, alcohol consumption, or gambling behaviour. This support helps people who often face isolation, loneliness, prejudice, and disownment from their communities, accompanied by feelings of guilt, shame, helplessness, and fear. Those bereaved by addiction also experience a unique and complex form of grief.

The charity's mission is to assist those impacted by another person's addiction and aims to create a future without the stigma associated with addiction.[319] They aim to engage with partners across education, recovery, rehabilitation, treatment, and family support sectors to achieve their goals.

Case Study: Addiction Family Support[320]

I have two daughters, one of whom is a heroin addict and has been since the age of 18 (she is now 40 years old). I have battled on trying to support her for the last 22 years. In this time, she has been sectioned on several occasions, tried to take her own life twice and has been abusive towards me on and off for this whole period of time with no let up. I did my best to understand her problems and tried to support her, but she was not willing to be helped.

I received no support at all and was obviously feeling very alone and isolated trying to deal with an addict with no clue as to how to go about helping her and myself, as a result of years of abuse and feeling a failure as a mother, my mental health suffered and I became very withdrawn and anxious.

She had stolen items and money from her sister and my family as and when she could. As a result, they refused to have anything more to do with her which left me feeling even more isolated and weak as I had no one I could talk to about my problems. Over the period of 22 years, I had been supporting her financially as I was naturally worried about her not paying her rent and being evicted which had happened in the past. I also bought all her shopping to make sure she was eating properly but now I realise I was just enabling her to carry on with the most important thing in her life, heroin.

At the end of July 2022, I reached the end of my tether and realised I could not carry on like this. I do not work and only receive a state pension. All my money was being spent on her habit and I knew it had to stop. I told her there would be no more money which I have said in the past but this time I truly meant it. She was very abusive as you can imagine and eventually she refused to have anything more to do with me and has blocked me on all our usual methods of contact.

318 Home Office, Department of Health and Social Care, Ministry of Justice, Department for Work and Pensions, Department for Education and Department for Levelling Up, Housing and Communities, *From Harm to Hope: A 10 year drug plan to cut crime and save lives,* December 2021.

319 Addiction Family Support, *Annual Report*, 2023.

320 Case Study provided by Addiction Family Support, August 2024.

For the next few months, I was really struggling and knew I needed help, that's when I discovered AFS and Elizabeth Burton-Phillips. The support they offered was amazing. I met up with Elizabeth on a one to one and she told me I am not alone, there are lots of mothers out there suffering the same experience as myself and that I should not feel a failure. She reiterated none of this was my fault and that I had done the right thing and should concentrate on myself and my wellbeing. She gave me confidence to move forward. I joined the support group and every Monday I took part, listening to parents and families suffering just like myself. Slowly, slowly, I began to get my confidence back so much so that I now do voluntary work and have reached out to [a local] Wellbeing at the Hub and the [local] college which has been amazing.

This is all thanks to AFS and their amazing work they do for families affected by addiction. I cannot praise them enough. This along with the support group, has helped me move forward.

In a society where the social fabric is tightly knit, ensuring the well-being of families dealing with addiction is not just a compassionate choice, but a societal imperative.

RECOMMENDATION

The DHSC alongside the DfE is advised to introduce adequate support of families and others affected by someone else's drug and alcohol use, including children and young people.

Family's Preventative Role: Supporting Families

A 2011 study commissioned by the Department for Education (DfE) revealed that out of 3,675 families enrolled in Family Intervention Projects (FIPs), 85 per cent experienced positive results, such as resolving parenting and family conflicts, reducing involvement in crime, improving health, preventing exclusion, and addressing issues with alcohol/drug misuse.[321] However, the report highlighted that not all improvements were maintained over time. Specifically, regarding health, 39 per cent of families did not sustain their positive outcomes 9 to 14 months after completing the intervention. The Troubled Families Programme (TFP) drew upon the evidence gathered from FIPs.[322]

The United Nations Office on Drugs and Crime (UNOCD) identified five reviews that have documented findings regarding this intervention.[323] These studies indicate that family-based universal programmes can effectively prevent tobacco, alcohol, drug, and substance use among young people, with the impact generally persisting into the medium and long term (beyond 12 months).[324] More intensive programmes facilitated by trained professionals demonstrate greater and more consistent efficacy compared to single-session or computer-based programmes. Additionally, sex-specific interventions, particularly those targeting mothers and daughters, have shown effectiveness. The evidence summarised originates from

321 Department for Education, *Monitoring and evaluation of family intervention services and projects between February 2007 and March 2011*, December 2011.

322 David Foster, *Supporting Families Programme*, House of Commons Library, March 2023.

323 United Nations Office on Drugs and Crime, World Health Organisation, *International Standards on Drug Use Prevention*, September 2020.

324 Ibid.

family-based prevention interventions conducted in Africa, Asia, the Middle East, Europe, Australia, and North America.[325]

The World Health Organization (WHO) also endorses parenting skills programmes to foster positive development, prevent youth violence, manage behavioural disorders in children and adolescents,[326] and prevent child maltreatment.[327] Furthermore, parenting interventions that promote mother-infant interactions, especially when integrated into ongoing mother and child health programmes for malnourished, frequently ill, or other at-risk children, are recommended to enhance child development outcomes.[328]

Supporting mothers with learning opportunities to improve parenting skills is advised in conjunction with effective treatment and psychosocial support for mothers with depression or other mental, neurological, or substance use conditions, aiming to improve child development outcomes. Lastly, caregiver skills training is recommended for managing children and adolescents with developmental disorders, including intellectual disabilities and pervasive developmental disorders such as autism.[329]

Handle with Care

Children who are exposed to a parent struggling with addiction are more likely to develop an addiction themselves.[330] The NSPCC's latest review of Serious Case Reviews involving substance misuse found a "lack of professional curiosity, sometimes influenced by overoptimism about the parents'/carers' capacity to change," lead to incidences where a child was seriously harmed or died.[331]

In response to the increasing exposure of children and youth to potentially traumatic events, the *Handle With Care* (HWC) programme was developed by the West Virginia Center for Children's Justice in 2013.[332] This school-community partnership aims to ensure that children exposed to trauma receive the necessary support to succeed in school. The programme facilitates collaboration among local agencies, such as law enforcement and schools, to identify students who have experienced trauma and provide them with appropriate care.[333] When first responders identify a child at a traumatic event, they notify the school with a discreet message, "Handle [child name] with care," allowing the school to provide trauma-sensitive support.

The programme's latest iteration, *Handle With Care 2.0*, developed in partnership with SRI Education and Berkeley County Schools, focuses on improving coordination between local agencies, enhancing training for school staff, and building capacity for programme monitoring and continuous improvement. An evaluation of the programme found that schools implementing *Handle With Care 2.0* saw significant improvements in school climate and the use of trauma-sensitive practices.[334] Although no immediate impacts on student outcomes were observed, the findings suggest the programme holds promise for long-term benefits to students' emotional, behavioural, and academic development.

325 Ibid.

326 WHO (2017), Global Accelerated Action for the Health of Adolescents (AA-HA!), Guidance to Support Country Implementation

327 WHO (2016), INSPIRE: seven strategies for ending violence against children

328 World Health Organisation, *Maternal mental health interventions to improve child development*, Evidence profile, 2012.

329 Ibid.

330 Biederman, J., Faraone, S. V., Monuteaux, M. C., & Feighner, J. A. (2000). Patterns of alcohol and drug use in adolescents can be predicted by parental substance use disorders. Pediatrics, 106(4), 792–797. 10.1542/peds.106.4.792

331 NSPCC, *Parents with substance use problems: learning from case reviews,* December 2023.

332 West Virginis Centre for Children's Justice, *Handle With Care,* n.d.

333 Ibid.

334 Klute, M. M., Araoz, C., Perez, N., Chow, K., Burkander, P., & Tiruke, T. (2022). *Evaluation of Handle With Care 2.0: Final Report.* SRI International.

Critics of the HWC model argue that the programme can undermine parents' abilities to parent effectively, perpetuating stigma and potentially leading to the criminalisation of families rather than providing the necessary support. There is a risk that the involvement of external authorities, like police or parole officers, could lead to lowered expectations for the child's behaviour and academic performance, further entrenching negative outcomes. These unintended consequences highlight the importance of ensuring that trauma-informed care does not inadvertently harm the families it is meant to support.

To address these challenges, several policy safeguards have been suggested. These include ensuring that support resources are local, affordable, and accessible, and that the HWC programme expands care rather than punitive responses. Additionally, there is a call for better training for police and school staff, improved confidentiality measures, and greater involvement of parents in the process. Engaging families as stakeholders in their own success, similar to approaches like The Promise in Scotland, is essential to creating a system that supports, rather than stigmatises.[335]

While the HWC programme represents a well-intentioned effort to create trauma-sensitive school environments, its implementation must be carefully managed to avoid unintended consequences. Ongoing evaluation and adaptation of the programme, with input from families and communities, are crucial to ensuring that it meets its goals without causing additional harm.

By identifying trauma early through initiatives like HWC, there is a crucial opportunity to intervene not only in the child's immediate experience but also to break the cycle of addiction that may span generations. Adult-facing services, such as addiction treatment and social care, are often the first to recognise the challenges within a household, making them vital touchpoints for identifying children in need of support. Integrating these services with child-focused interventions can help ensure that families receive comprehensive care, preventing trauma from taking root and reducing the likelihood that children exposed to addiction will follow the same path.

RECOMMENDATION

The Government should integrate adult-facing services, such as addiction treatment and social care, with child-focused services to ensure that children exposed to parental addiction receive timely, trauma-informed support.

335 *The Promise Scotland*, n.d.

The Role of Law Enforcement

In England, over 300,000 individuals are addicted to heroin and crack cocaine.[336] Collectively, they account for nearly half of all burglaries, robberies, and other acquisitive crimes.[337] The significant involvement of the criminal justice system in referrals, particularly for opiate users (25 per cent), underscores the strong link between substance use and criminal activity.[338] While offenders must be held accountable for their actions, they also need opportunities to overcome their addictions and transform their lives. Law enforcement professionals have a unique opportunity to assist people into recovery rather than perpetuating the cycle of addiction.

Rory's Story

The following case study illustrates Rory's experiences with battling addiction and interactions with the criminal justice system. Rory is supported by Reflection's House, a male only social enterprise providing 24/7 supported accommodation in a residential setting. Reflections House is a member of the CSJ Alliance, a 700-strong network of charities, social enterprises and other organisations.

Over the course of my life, I've had nothing but negative experiences with law enforcement. I've been in prison a total of 15 times, and my entire life has been consumed by active addiction. Whenever I've been arrested, there's been no real help or support provided at the police stations. At most, there might be a drug worker who comes to chat with me and makes an appointment for local services, but I never end up attending those appointments. And then once I've gone to prison, it's even worse. There are more drugs available in prison than there are on the streets. I'd try to talk to the drug workers in prison, and they'd try to help, but the prisons are just so overwhelmed. When they release me, they just send me back out onto the streets with a pocket full of money and no real plan or support. It's no wonder I'd end up relapsing and ending up back in the cycle of arrest and incarceration 14 out of those 15 times.

336 Home Office, Department of Health and Social Care, Ministry of Justice, Department for Work and Pensions, Department for Education and Department for Levelling Up, Housing and Communities, *From Harm to Hope: A 10 year drug plan to cut crime and save lives,* December 2021.

337 Ibid.

338 Office for Health Improvement and Disparities, *Adult substance misuse treatment statistics 2022 to 2023*, December 2023.

339 Names have been changed to protect identities.

The one time that was different was when the place I work at now came and did an assessment with me while I was in jail. They promised they'd have a bed ready for me on my release date and would come pick me up. Having that support and plan in place made all the difference - I was able to stay clean for a couple months that time. But even then, I eventually relapsed and ended up back in prison for another year before finally getting the help I needed. The interactions with police are always the same - they just throw me in a cell, let me dry out, and then send me to court the next day, often straight back to prison. There's no real effort to understand the underlying issues or provide any kind of diversion or alternative. It's just a revolving door of arrest, incarceration, and relapse. I wish the system was set up to actually help people like me, rather than just punishing us over, and over again.

The Underlying Legal Frameworks

Importing, producing, supplying, or possessing a controlled drug in the UK is an offense. The Misuse of Drugs Act 1971 (MDA) oversees the regulation of controlled drugs' production, supply, and possession.[340]

Controlled drugs are divided into three classes (Class A, B, and C) based on their level of harm. The Advisory Council on the Misuse of Drugs (ACMD) offers recommendations on how drugs should be categorised under the MDA and advises UK governments on drug-related matters.[341] The Psychoactive Substances Act 2016 governs the production and supply of psychoactive substances that are not already regulated under the MDA.[342] The Government can ban new drugs for one year under a 'temporary banning order' while they decide how the drugs should be classified.

Figure 40: Illegal drugs by class.

Class A	Class B	Class C
cocaine	amphetamines	anabolic steroids
crack cocaine	barbiturates	benzodiazepines (diazepam)
ecstasy (MDMA)	cannabis	khat
heroin	codeine	nitrous oxide (laughing gas)
LSD	gamma hydroxybutyrate (GHB)	piperazines (BZP)
magic mushrooms	gamma-butyrolactone (GBL)	
methadone	ketamine	
methamphetamine (crystal meth)	methylphenidate (Ritalin)	
	synthetic cannabinoids	
	synthetic cathinones (for example mephedrone, methoxetamine)	

Source: Gov.uk, Drug Penalties.

340 The Misuse of Drugs Act 1971.
341 Advisory Council on the Misuse of Drugs.
342 Psychoactive Substances Act 2016.

Individuals may face charges for possessing an illicit substance if apprehended with drugs, regardless of whether the person charged intends to use the drugs themselves or not.[343] If the suspect is under 18, law enforcement has the authority to inform parents, guardians, or caregivers of the drug-related incident. Penalties are determined by several factors, including the drug's classification and quantity, the location of the arrest, the individual's criminal history (including prior drug offenses), and any other relevant mitigating or aggravating circumstances. In the case of cannabis or khat possession, police have the discretion to issue a warning or an immediate fine of up to £90.[344] Payment of the fine may be possible without receiving a formal warning or caution. Repeat offenses involving cannabis or khat may result in varying penalties, ranging from treatment to the maximum penalty for possession.

If involved in supplying drugs (including dealing, selling, or sharing), the resulting penalty is more severe. Law enforcement is likely to pursue charges if there is suspicion of drug supply.[345] The severity of the penalty is influenced by factors such as the quantity of drugs discovered and the individual's criminal record.

Figure 41: Drug penalties for possession and supply and production.

	Maximum penalty for possession	Maximum penalty for supply and production
Class A	Up to 7 years in prison, an unlimited fine or both	Up to life in prison, an unlimited fine or both
Class B	Up to 5 years in prison, an unlimited fine or both	Up to 14 years in prison, an unlimited fine or both
Class C	Up to 2 years in prison, an unlimited fine or both (except anabolic steroids - it's not an offence to possess them for personal use)	Up to 14 years in prison, an unlimited fine or both
Temporary class drugs	None, but police can take away a suspected temporary class drug	Up to 14 years in prison, an unlimited fine or both

Source: Gov.UK, Drugs and Penalties.

The Illegal Drug Trade

The value of the illicit drugs market in the UK has an estimated value of £9.4 billion.[346] Due to the complex supply chains involved in the illicit drugs market, enforcement of drug laws requires the involvement of multiple agencies:

- Border Force is the lead agency preventing the importation of drugs at UK borders.
- National Crime Agency (NCA) is the leading agency in the UK for tackling organised crime, trafficking and economic crime across regional and national borders.
- Regional Organised Crime Units (ROCU) are partnerships across England and Wales between police forces to manage organised crime taking place across police force borders. Scotland and Northern Ireland also have Organised Crime Units.
- Police forces lead enforcement of drug supply and possession offences at the local level.

343 Gov.uk, *Drug Penalties,* n.d.
344 Ibid.
345 Ibid.
346 Dame Carol Black, *Review of drugs: phase one report,* February 2020.

Routes into the UK

While much of the illegal drug supply in the UK is sourced from overseas,[347] not all drugs are imported. A portion is manufactured or grown domestically, often in concealed operations within urban and rural areas alike. Cannabis farms, hidden in residential properties or industrial spaces, have become increasingly common, with large-scale cultivation networks producing substantial amounts of the drug within the UK.[348] In addition, the illicit production of drugs such as methamphetamine, occurs in underground laboratories, some of which are operated by organised crime groups.[349]

While domestically produced drugs contribute to the UK's illegal drug market, the majority of illicit drugs are still imported from abroad via trafficking networks.

According to the NCA, the most common routes drugs are trafficked into the UK are:[350]

- Container shipping
- Yachts and small boats
- Light aircraft
- Vehicle traffic from continental Europe
- Airline passengers
- The post and fast parcels

Drug Seizures

In the year ending March 2023, police forces and Border Force in England and Wales collectively conducted 191,623 drug seizures, marking a 1 per cent increase from the previous year's 188,929 seizures.[351]

Border Force achieved a seizure count of 25,834, indicating a 24 per cent rise from the preceding year.

There was a 4 per cent increase in seizures of powder cocaine by both police forces and Border Force, rising from 18,228 to 18,978 seizures.[352]

Police forces alone seized a record quantity of powder cocaine, amounting to 3.36 tons, marking a 100 per cent increase from the previous year. However, the combined seizure of powder cocaine by both police forces and Border Force decreased by 1 per cent to 18.58 tons.

The amount of heroin seized decreased by 33 per cent, from 1.41 tons to 0.95 tons, between March 2022 and March 2023, reverting to levels prior to 2019-2020. The total number of heroin seizures also decreased by 6 per cent in the same period.

Border Force recorded the highest total cannabis seizures ever. This is largely influenced by 165 per cent increase in herbal cannabis seizures, rising from 7,221 to 19,105 seizures.[353] Similarly, the majority of police reported drug possession offences related to cannabis (71 per cent).[354]

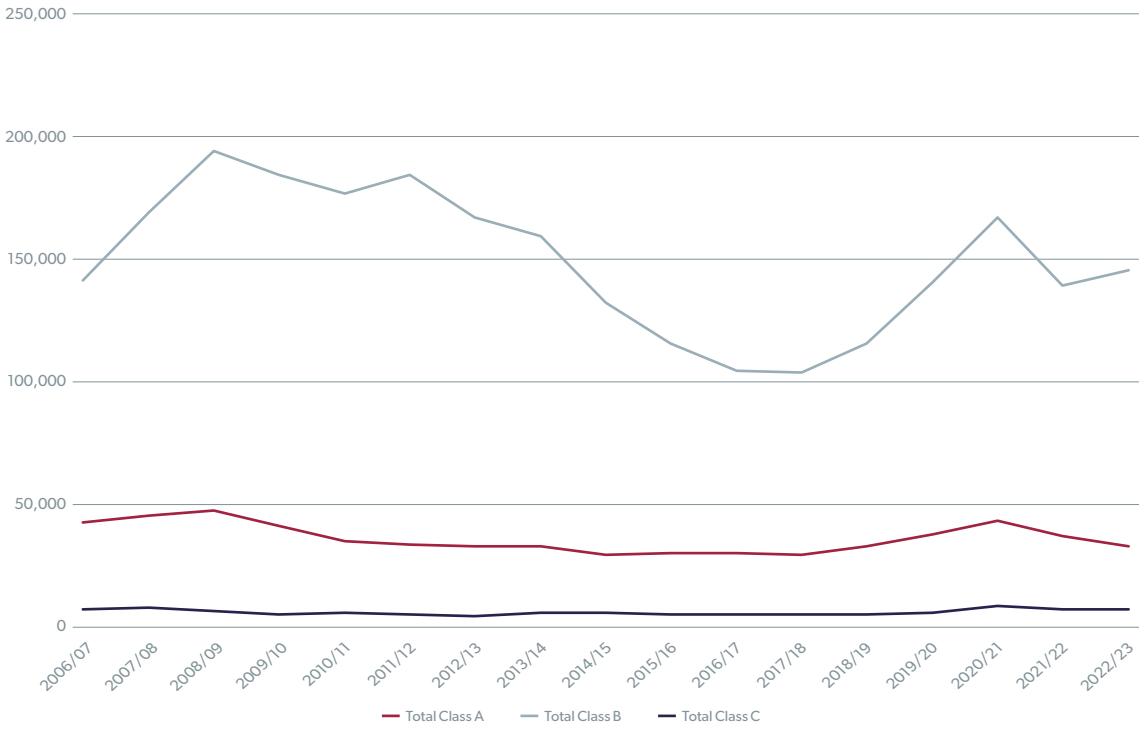
347 NCA, *Drug Trafficking*, n.d.
348 Hywel Griffith, *Drug production booming in UK's empty high streets*, BBC News, August 2024.
349 Jonny Humphries, *Huge amphetamine lab discovered in police raids*, BBC News, June 2024.
350 National Crime Agency, *Drug Trafficking*, n.d.
351 Home Office, *Seizures of drugs in England and Wales, financial year ending 2023*, March 2024.
352 Ibid.
353 Ibid.
354 Home Office, *Crime outcomes in England and Wales 2023 to 2024*, July 2024.

Both police forces and Border Force collectively seized the largest amount of herbal cannabis[355] on record in March 2023, marking a 96 per cent increase from the previous year.[356]

Police forces recorded the highest quantity of ketamine seizures ever, a 189 per cent increase from the previous year, while Border Force ranked second highest in ketamine seizures.

The total quantity of ecstasy seized saw a 161 per cent increase, reaching 1.56 million doses, despite a 36 per cent reduction in the number of ecstasy seizures.[357]

Figure 42: Number of drug seizures by class, years ending March 2007 to March 2023.



Source: Home Office, Seizures of drugs in England and Wales, financial year ending in 2023, Summary Table 1, March 2024.

Police forces accounted for 87 per cent of the total number of seizures. Border Force played a more prominent role in the quantity of drugs seized, such as 82 per cent of powder cocaine, 87 per cent of ecstasy, and 91 per cent of GHB.[358] Annual totals of quantity of drugs seized can be greatly influenced by a small number of large seizures. As with the number of drug seizures, any large quantity of drugs seized should not be taken as an indication of drug use prevalence or availability.

The NCA is intensifying efforts against drug suppliers following a significant increase in cannabis smuggling attempts at UK airports, resulting in 378 arrests and the seizure of 15 tonnes of cannabis so far this year, over three times higher than last year's total.[359]

355 Boarder Force defines cannabis into three categories; herbal cannabis; cannabis resin, and cannabis plants. Most cannabis seizures were herbal (87%). Cannabis resin seizures increased by 60% and cannabis plant seizures decreased by 3% from the previous year.

356 Home Office, *Seizures of drugs in England and Wales, financial year ending 2023*, March 2024.

357 Ibid.

358 Ibid.

359 National Crime Agency, *It's not worth the risk – jail warning for passengers flying to the UK after increase in cannabis arrests - National Crime Agency,* August 2024.

Project ADDER

Project ADDER (Addiction, Diversion, Disruption, Enforcement, and Recovery) is an initiative that was launched ahead of the Government's Drug Strategy. Championed by the CSJ[360] and spearheaded by the Home Office and OHID, with collaboration from various government bodies, its primary objectives revolve around diminishing drug-related crime, fatalities, and substance abuse.[361]

This project integrates law enforcement operations with expanded diversion programmes and treatment and recovery services, including support in housing and employment. Beginning its phased rollout in November 2020, Project ADDER received a £59 million investment lasting until March 2023. Additional funding for Project ADDER's criminal justice initiatives has extended support until March 2025.[362]

Initially piloted in five localities—Blackpool, Hastings, Middlesbrough, Norwich, and Swansea Bay—Project ADDER has since grown.[363] In July 2021, the government announced its expansion to Bristol, Newcastle, Wakefield, two London boroughs (Hackney and Tower Hamlets), and three local authorities in the Liverpool City Region (Knowsley, Liverpool City, and Wirral), building upon the successful framework established by the original pilot areas.

Project outcomes are measured by self-reported management data, police record crime data, and safeguarding intervention data.

Table 1: Self-reported management data

	2021				2022				2023			
	Jan - Mar	Apr - Jun	Jul - Sep	Oct - Dec	Jan - Mar	Apr - Jun	Jul - Sep	Oct - Dec	Jan - Mar	Apr - Jun	Jul - Sep	Oct - Dec
OCG* disruptions	73	152	199	214	284	454	498	502	743	678	761	705
Cash seized, £	151,843	815,782	986,115	1,597,220	1,141,842	1,144,272	1,243,367	1,346,142	1,391,953	868,603	831,119	1,272,425
Arrests	954	2413	3510	3307	3655	3215	3626	2799	2474	2987	3186	2961

*Organised Crime Group

Table 2: Police record crime data

	2021				2022				2023			
	Jan - Mar	Apr - Jun	Jul - Sep	Oct - Dec	Jan - Mar	Apr - Jun	Jul - Sep	Oct - Dec	Jan - Mar	Apr - Jun	Jul - Sep	Oct - Dec
Drug trafficking offences	272	948	892	965	957	967	1,011	1,043	1,133	1,194	1,108	N/A
Drug trafficking charges	106	571	447	538	609	528	466	549	514	445	463	N/A
Drug possession offences	744	4,172	3,773	3,631	4,116	4,069	3,921	3,599	3,657	3,377	3,727	N/A
Drug possession charges	218	963	932	851	972	888	923	942	1,001	936	977	N/A
Possession of weapons offences	212	876	885	836	912	940	1,044	882	915	1,033	953	N/A
Possession of weapons charges	95	345	371	344	429	371	428	381	392	384	430	N/A
Out of court disposals: common unity resolutions for drug possession offences	36	1,045	913	1,008	1,387	1,797	1,555	1,467	1,496	1,292	1,484	N/A

360 Centre for Social Justice, *Road to Recovery*, August 2019.

361 Home Office, *Project ADDER, March 2024.*

362 Ibid.

363 Ibid.

The figures in Table 2 show that since January 2021, across Project ADDER and Accelerator sites there were:

- 5,263 OCG disruptions
- £12.8m of cash seized
- 35,724 arrests
- 10,495 drug trafficking offences
- 5,135 drug trafficking charges
- 38,792 drug possession offences
- 9,604 drug possession charges
- 9,488 possessions of weapons offences
- 3,968 possessions of weapons charges
- 13,478 out of court disposals: community resolutions for drug possession offences

Table 3: Safeguarding intervention data

	2021				2022				2023
	Jan - Mar	Apr - Jun	Jul - Sep	Oct - Dec	Jan - Mar	Apr - Jun	Jul - Sep	Oct - Dec	Jan - Mar
Out of Court Disposals	170	657	1,604	1,894	2,581	2,866	2,752	2,599	N/A
Safeguarding interventions by police	23	231	254	405	556	438	547	442	N/A
Drug treatment interventions by outreach workers	101	2,080	3,792	4,639	5,854	6,511	7,352	6,598	N/A
Naloxone kits distributed outside of treatment services	84	512	1,256	949	1,811	2,044	20,14	2,226	N/A
Naloxone kits distributed outside of treatment services – revised data	12	261	887	659	1,084	1,066	1,137	1,325	1241

The figures in Table 3 show that since January 2021, across Project ADDER and Accelerator sites there were:

- 15,123 out of court disposals;
- 2,896 safeguarding interventions by police;
- 36,927 drug treatment interventions by outreach workers;
- 10,896 Naloxone kits distributed outside of treatment services – original data; and
- 7,672 Naloxone kits distributed outside of treatment services – revised data.

The arrival of novel substances in the UK signals a new phase in the drug crisis, marked by heightened risks and challenges. Fentanyl's potency means that even small miscalculations in dosage can lead to fatal overdoses, while xylazine's presence not only complicates the treatment of opioid addiction but also introduces new risks of severe tissue damage and infection. As drug traffickers adapt their methods and substances to evade detection and maximise profit, the UK's response must also evolve. Addressing this dynamic threat requires a concerted effort involving public health initiatives, law enforcement, and community support to mitigate the devastating impact of these emerging drugs on individuals and society.

RECOMMENDATIONS

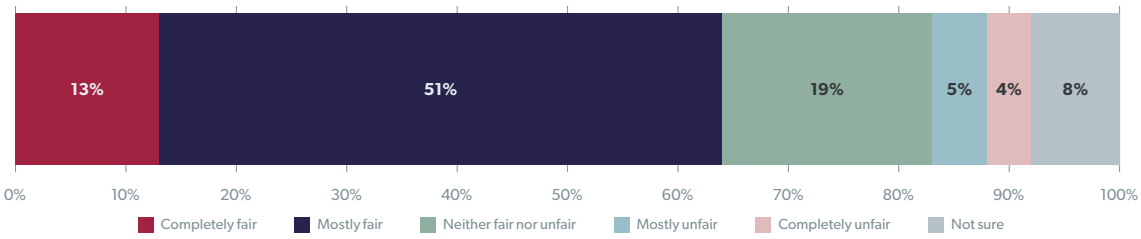
The Home Office should publish the independent evaluation of Project ADDER in order to inform decision making about the projects future funding, due to end in March 2025. This includes the cost-effectiveness of the scheme.

Drug Offense Outcomes

The Home Office's latest crime statistics found that drug possession offences received a higher proportion of charge/summons outcomes (20 per cent) than drug trafficking offences (18 per cent).[364] The majority (71 per cent) of drug possession offences this year were related to cannabis whilst the remaining 28 per cent of offences accounted for all other drug types.

Approximately 55 per cent of drug offences resulted in either a formal or informal criminal justice sanction, with about 19 per cent leading to a charge or summons and almost twice as many (36 per cent) resulting in an out-of-court disposal (OOCDs).[365] An OOCD is a method for resolving minor crimes and anti-social behaviour without court involvement, aimed at reducing re-offending. Pre-court disposals enable the police to address minor offenses swiftly and proportionately, serving as an evidence-based method for early intervention to prevent repeat offenses. CSJ polling found that 64 per cent of police officers in the UK believe OOCDs are a fair outcome for drug offences, and only nine perceive them as unfair.[366]

Figure 43: Do you think Out-of-Court Disposals are a fair or unfair outcome for drug possession offences?



Source: CSJ commissioned polling from Opinium of 250 police officers in the United Kingdom.

The types of OOCDs include:

- community resolutions;
- conditional cautions;
- simple cautions;
- cannabis or Khat warnings; and
- penalty notices for disorder.

The Legal Aid Sentencing and Punishment of Offenders Act 2012 replaced reprimands and final warnings with youth cautions, youth conditional cautions, and non-statutory community resolutions.[367] These measures aim to intervene early in a child's offending career and address their behaviour holistically, particularly for low-level offenses, to avoid costly court appearances and potential stigmatisation.

Possession of cannabis has a much lower charge or summons rate (16 per cent) compared to other drugs (31 per cent), often being addressed with a Cannabis Warning or Community Resolution for small amounts intended for personal use.[368]

364 Home Office, *Crime outcomes in England and Wales 2023 to 2024*, July 2024.

365 Ibid.

366 Original polling conducted by Opinium for The Centre for Social Justice of 250 police officers in the UK, between 14th October and 19th October, 2024. Opinium is a member of the British Polling Council.

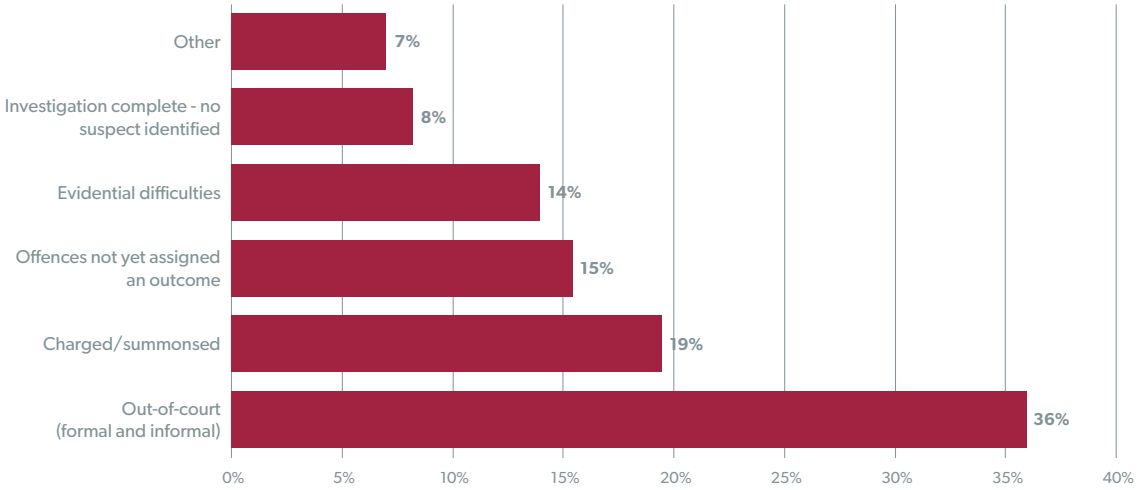
367 Peter Neyroud, *Out of Court Disposals managed by the Police: a review of the evidence*, National Police Chief's Council of England and Wales, University of Cambridge, 2018.

368 Home Office, *Crime outcomes in England and Wales 2023 to 2024*, July 2024.

Police forces maintain different protocols for OOCDs for cannabis possession. Avon and Somerset and Lancaster, for instance, do not use cannabis/khat warnings for possession offences but use community resolutions where appropriate.

Police activities, such as stop and search, significantly influence drug offence statistics. Over half (51 per cent) of arrests following section 1 stop and searches were due to suspicion of drug possession.[369] This often provides sufficient evidence for applying either a formal or informal sanction. Informal sanctions, like those for possessing small amounts of cannabis for personal use, require the suspect to admit guilt for these outcomes to be applied.

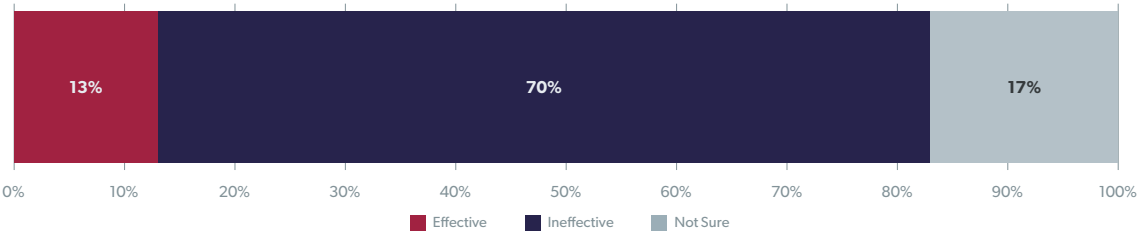
Figure 44: Percentage of drug offence outcomes assigned by offence type and outcome group, for the year ending March 2024 in England and Wales.



Source: Home Office, Crime Outcomes in England and Wales 2023 – 2024, July 2024.

Despite being the second most common outcome for drug offences (19 per cent), charges/summons are overwhelmingly perceived as ineffective by the police. CSJ polling found that 70 per cent of police officers view charges/summons as ineffective in reducing drug use in the communities the police serve.

Figure 45: How effective or ineffective are charges/summons in reducing drug use in the community you serve?

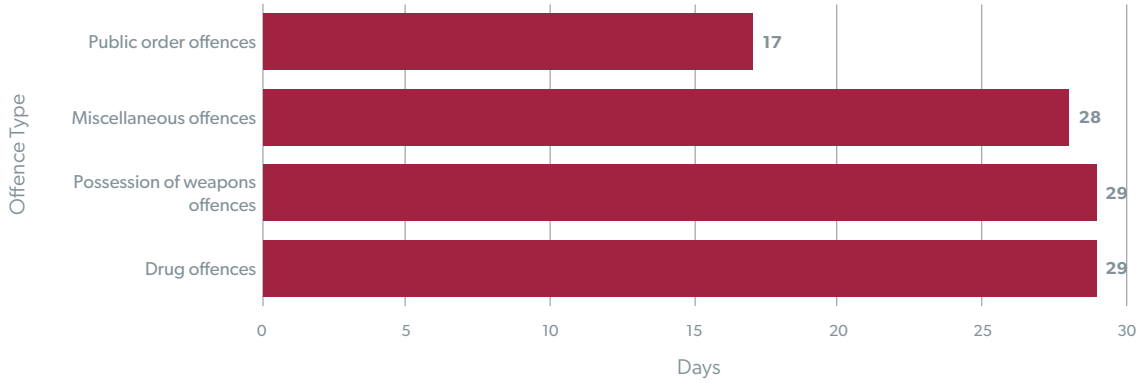


Source: CSJ commissioned polling from Opinium of 250 police officers in the United Kingdom.

369 Ibid.

Assigning an investigative outcome for a crime classed as non-victim-based, such as drug possession, can be lengthy. The average amount of time to a charge/summons outcome increased from 59 to 61 days in 2024.[370] To assign an outcome for all drug offences, the average length of time rose from 25 to 29 days last year.

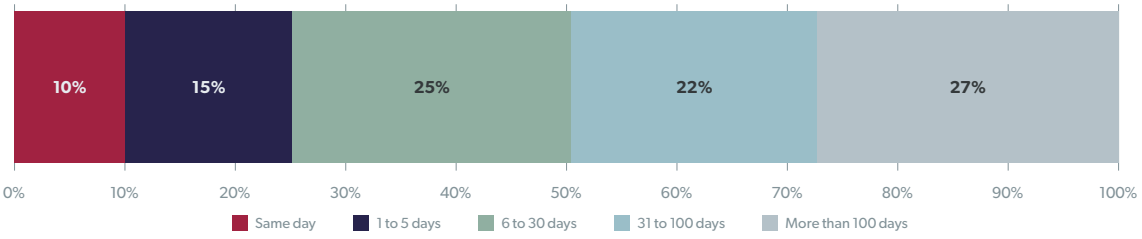
Figure 46: Average length of time taken to assign an outcome by offence group, non-victim-based offences for the year ending March 2024 in England and Wales.



Source: Home Office, Crime Outcomes in England and Wales 2023 – 2024, July 2024.

Only 10 per cent drug offenses were assigned an outcome on the same day the offence was recorded last year.[371] Half of drug offenses were assigned an outcome in the first 30 days and 27 per cent took more than 100 days for an outcome to be assigned.

Figure 47: Length of time between drug offences and drug offence outcomes being recorded in the year ending in March 2024.



Source: Home Office, Crime Outcomes in England and Wales 2023-2024, Table 3.8, July 2024.

When administering an outcome for a drug possession offence, all suspected illicit substances must be sent for a forensic test to confirm the contents of the seizure and its relevant classification.[372] Cannabis is the only exception to this rule. As a result, a backlog of forensic examinations is one of the key factors in delayed outcome times. This includes analysing items such as mobile phones to confirm evidence of drug dealing and testing the drugs that were seized.[373]

370 Ibid.
371 Ibid.
372 Crown Prosecution Service, *Drug Identification and Drug Testing Kits*, June 2024.
373 Ibid.

RECOMMENDATION

To reduce outcome wait times and enhance drug testing capabilities, every police force in the UK should be equipped with Home Office approved drug testing devices to better identify and respond to drug-related offenses. This will support law enforcement in tackling the distribution and use of illegal substances effectively, saving time, reducing backlog in the criminal justice system, and increase the speed and capacity of forensic testing.

A two-tiered OOCD framework

Rehabilitative programmes, such as those addressing drug addiction, mental health issues, and anger management can effectively reduce re-offending rates. According to meta-analyses referenced in a Cambridge University evidence review, a well-developed OOCD framework that channels offenders into effective treatment programmes has the potential to impact re-offending positively.[374]

The previous Government simplified the system by abolishing the six existing statutory OOCDs and replacing them with two, Diversionary and Community Cautions.[375] This is the two-tier OOCD framework. However, they did not alter the range of non-statutory disposals, known as community diversion, utilised by police forces. The framework abolishes the Adult Simple Caution, the Adult Conditional Caution, Penalty Notices for Disorder, and Cannabis and Khat Warnings.[376] These changes fall under the Police, Crime, Sentencing, and Courts Act 2022.

When assigned, Diversionary and Community Cautions must have one or more conditions associated with them. Conditions are aimed at rehabilitation and/or reparation. The only punitive condition that may be assigned is a financial penalty. The proposed framework places greater emphasis on individual case-by-case decision making.[377] Accordingly, obligation to record the full rationale behind decisions will be strengthened.

Figure 48: Out of Court Disposal Comparison:[378]

Disposal	Diversionary Caution	Community Caution	Community Resolution
Use	Can be used for any offence. In the case of indictable only offences – only in exceptional circumstances and with consent of the Director of Public Prosecutions.	Can be used for any offence – other than an excluded offence. (Excluded offences are indictable-only and either way or summary only offences as prescribed in regulations	No statutory restrictions on use. Use is in line with National Police Chiefs Council policy and guidance.
Enforcement	Non-compliance with conditions can result in the offender being prosecuted for the original offence. Power of arrest and detention following non-compliance.	Non-compliance cannot be prosecuted. Authorised user can rescind the condition and attach a financial penalty (if this was not originally a condition). If this penalty remains unpaid, it can be registered for enforcement as a court fine. No power of arrest or detention following non-compliance.	Non-compliance with a Community Resolution is not enforceable. No power of arrest or detention following non-compliance.

Source: Ministry of Justice, Diversionary and Community Cautions Draft Code of Practice, August 2023.

374 Peter Neyroud, *Out of Court Disposals managed by the Police: a review of the evidence*, National Police Chief's Council of England and Wales, University of Cambridge, 2018.

375 Home Office, *Reforms to the adult out of court disposals framework in the Police, Crime, Sentencing and Courts Bill: Equalities Impact Assessment*, August 2023.

376 Ministry of Justice, *Diversionary and Community Cautions: Draft Code of Practice*, August 3023

377 Ibid.

378 Ministry of Justice, *Diversionary and Community Cautions: Draft Code of Practice, Part 6 of the Police Crime, Sentencing and Courts Act 2022*, August 3023

The key difference between Diversionary and Community Cautions is the consequences of breaching conditions. A Community Caution is a final disposal, meaning that once administered, no further prosecution for the original offense can occur. In contrast, a Diversionary Caution is not case ending; if the offender fails to comply with the attached conditions, prosecution for the original offense may still proceed in the event of a breach.

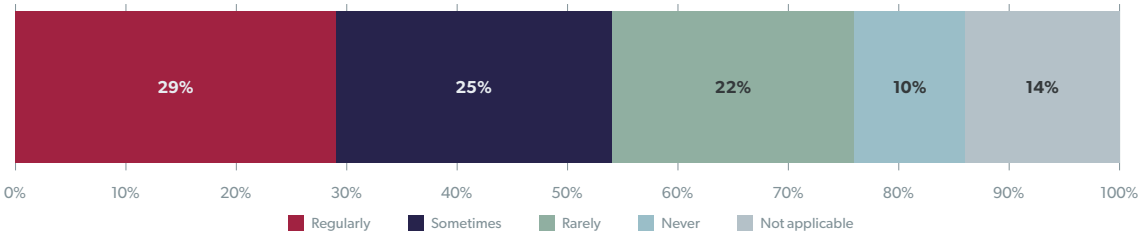
Non-statutory Community Resolutions continue to be available within the OOCD framework, alongside Diversionary and Community Cautions. Decisions regarding the issuance of a caution should be made within the broader context of this framework, carefully considering how the desired outcomes can be best achieved by authorised persons or prosecution authorities. This decision-making process should consider the views of the victim as well as the needs of the offender.

Offenders will not be given community cautions for importing, exporting, producing, supplying and possession with intent to supply to another Class A drugs.[379] A draft code of practice has been issued to guide the implementation of this new system.

In September 2024, the Ministry of Justice (MoJ) published a commissioned report by RAND Europe on how police in England and Wales use out-of-court options to help adults with health-related vulnerabilities.[380] Results suggest OOCD processes vary significantly between forces. The use of OOCD scrutiny panels, which independently review anonymised cases, varied greatly across forces. Definitions of compliance also varied, even within some police forces.[381] At the frontline level, vulnerability assessments and input from Liaison and Diversion services were rarely used in the OOCD process.[382] There is also a lack of meaningful data on offender engagement and compliance, making it difficult to assess effectiveness.

The CSJ's polling of police officers, results found 54 per cent regularly or sometimes collaborate with healthcare professionals or social workers when dealing with cases of drug use.[383] Almost a third (32 per cent) of all officers polled reported rarely or never collaborating with healthcare or social workers. This is a surprising finding given the frequency of ambulance presence on a police scene. Results suggest this is more common among female officers (61 per cent) than male officers (47 per cent).[384]

Figure 49: Police frequency of collaboration with healthcare and social workers when dealing with cases of drug use.



Source: CSJ commissioned polling from Opinium of 253 police officers in the United Kingdom, October 2024.

379 Ministry of Justice, *Diversionary and Community Cautions: Draft Code of Practice, 2022,* August 3023

380 Lucy Strang, Jack Cattell, Eddie Kane, Emma Disley, Brenda Gonzalez-Ginocchio, Alex Hetherington, Sophia Hasapopoulos, Emma Zürcher RAND Europe, *Police use of Out of Court Disposals to support adults with health vulnerabilities,* Ministry of Justice, September 2024.

381 Ibid.

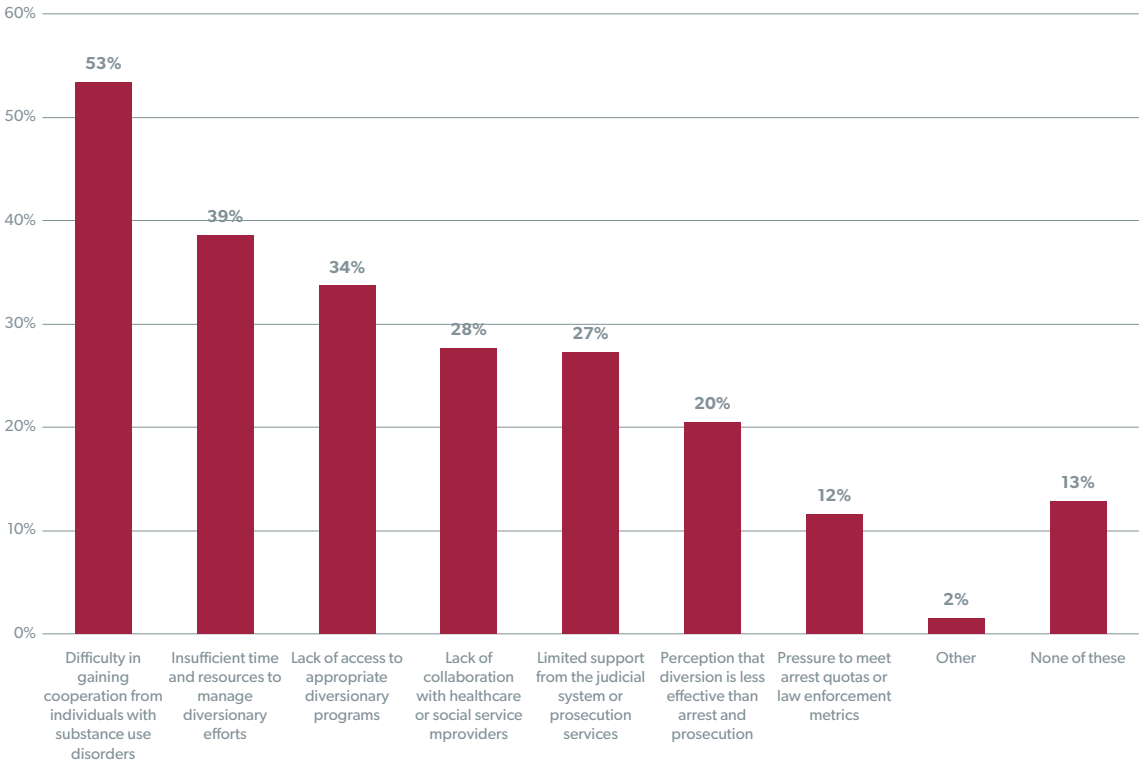
382 Ibid.

383 Centre for Social Justice, *Opinium police polling*, October 2024.

384 Ibid.

The results from the CSJ's police officer poll provide valuable insights into the barriers law enforcement faces when attempting to engage individuals with substance use disorders in diversionary outcomes, including OOCDs.

Figure 50: Barriers police face when engaging individuals in diversionary schemes.



Source: CSJ commissioned polling from Opinium of 249 police officers in the United Kingdom, October 2024.

The most significant barrier identified is the challenge of securing cooperation from individuals with substance use disorder (53 per cent). This suggests that many individuals involved in drug-related offences may have complex needs, which can affect their willingness or ability to engage with diversionary schemes. Substance dependence often comes with issues such as distrust of authority, mental health problems, and a chaotic lifestyle, all of which can hinder participation in rehabilitation-focused alternatives to traditional prosecution. This highlights the need for more specialised training for officers to engage individuals effectively and a stronger partnership with healthcare professionals to manage addiction-related behaviours.

A lack of time and resources was the second most commonly reported barrier (39 per cent), indicating systemic pressures within the police force. Officers are often overwhelmed with various responsibilities, and without adequate support, diversionary schemes can be perceived as burdensome or secondary to immediate policing duties. This suggests a need for greater investment in infrastructure and staffing to support diversionary efforts. Additionally, policy reforms could be considered to streamline the process and make it more accessible for officers to integrate into their routine work.

Over a third of respondents (34 per cent) pointed to a lack of appropriate diversionary programs as a barrier, underscoring a gap in available services. This reflects a structural shortfall in the availability of programs that address the needs of individuals with substance use disorders. Inadequate program

availability means that even when police are willing to divert individuals away from prosecution, there may be few, if any, suitable options. This points to a broader issue of underfunded or insufficiently scaled public health services that can work in tandem with law enforcement. Expanding access to community-based, evidence-led programs would be crucial in addressing this gap.

Despite the small sample size (n = 253), this poll's results highlight the interconnected nature of barriers to effective diversionary schemes for drug-related offences. The lack of cooperation from individuals with substance use disorders, combined with insufficient time, resources, and access to programs, creates a cycle where diversion becomes difficult to implement and sustain. These findings suggest the need for a multi-faceted response that includes enhanced officer training in substance abuse issues, increased funding for diversion programs, and closer collaboration between law enforcement and public health services. Structurally, this points to the necessity of reforming diversionary frameworks to ensure they are adequately resourced, accessible, and designed to meet the complex needs of individuals with substance use disorders. Without these changes, diversionary efforts risk being underutilised and ineffective, limiting their potential to reduce reoffending and support recovery.

As unveiled by the Ministry of Justice's commissioned report on OOCD procedures,[385] forces with a dedicated OOCD team or independent entity had more consistent and well-applied processes.

The introduction of a standardised role or team to address compliance in every area presents a significant opportunity to bridge the longstanding gap between health and social services with law enforcement in tackling drug-related issues. With only 29 per cent of officers reporting regular collaboration with healthcare or social workers,[386] the implementation of this role could foster more integrated responses to addiction, enabling better coordination between police, health professionals, and local authorities.

OOCD teams, by focusing on engagement and ensuring compliance, could help address the biggest barrier police face in assigning diversionary outcomes. With 53 per cent of officers citing a lack of cooperation from individuals with substance use disorders as the main challenge, these teams play a vital role in overcoming this hurdle.[387]

The overwhelming support for this role—evidenced by 73 per cent of police officers endorsing its potential benefits—underscores the growing recognition within law enforcement that addiction cannot be addressed through punitive measures alone.[388] The role could act as a bridge, ensuring that frontline officers are better equipped to understand and navigate the complex health and social dimensions of drug misuse. In turn, this could lead to a more holistic approach, reducing reoffending and supporting long-term recovery, while easing the pressure on the police to act as first responders to public health crises. This collaborative approach aligns with the broader goal of creating a more effective and compassionate drug policy.

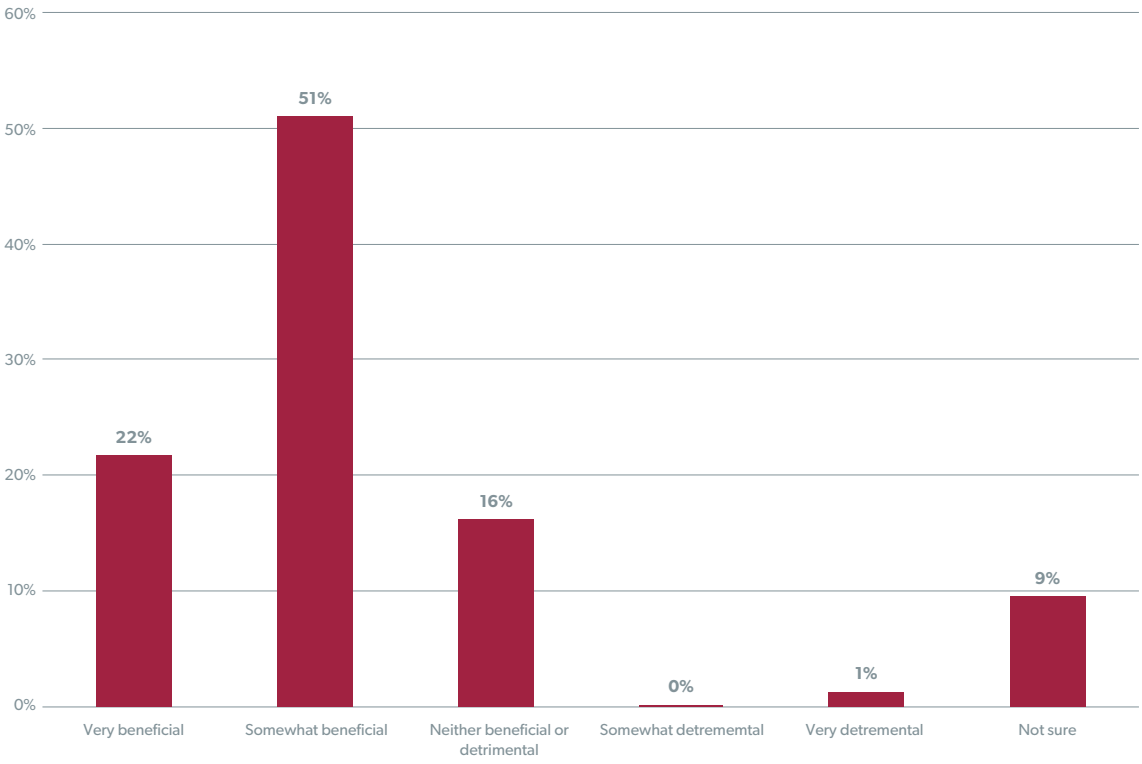
385 Lucy Strang, Jack Cattell, Eddie Kane, Emma Disley, Brenda Gonzalez-Ginocchio, Alex Hetherington, Sophia Hasapopoulos, Emma Zürcher RAND Europe, *Police use of Out of Court Disposals to support adults with health vulnerabilities,* Ministry of Justice, September 2024.

386 Centre for Social Justice, Opinium police polling, October 2024.

387 Ibid.

388 Ibid.

Figure 51: Impact of a Dedicated OOCD team or caseworker in every police force.



Source: CSJ commissioned polling from Opinium of 253 police officers in the United Kingdom, October 2024.

Criticisms of the proposed framework

Critics of the proposed 2-Tier OOCD Framework argue it has too narrow of a scope. The proposed guidance does not tailor interventions for specific groups such as young adults, women who have experienced trauma, and individuals from marginalised communities.[389] Other concerns include a lack of victim support and insufficient clarity on framework assessment.

There are additional concerns over treating all drug possession offenses under a single category without considering individual circumstances.[390] Some argue that diversion and enforced treatment may not benefit those found in possession of cannabis or other substances.[391] While uniformity in enforcement is important, a one-size-fits-all approach may not consider the complexities of addiction. Tailoring responses to individual circumstances can lead to better outcomes, particularly in reducing recidivism.

Using drug treatment as a punishment undermines trust and overlooks drivers of addiction like poor quality or lack of housing and limited employment opportunities, reducing its effectiveness. However, successful court-mandated programmes, such as drug courts, demonstrate that combining treatment with legal obligations can significantly reduce recidivism and improve recovery rates.

389 Centre for Justice and Innovation, *Painting half the picture: The draft code of practice on diversionary and community cautions,* 2023.

390 Release, *Release's response to the MoJ Consultation,* 2023.

391 Ibid.

Ultimately, the existing evidence suggests OOCDs can help address health vulnerabilities, such as drug misuse, and reoffending.[392]

RECOMMENDATION

The Ministry of Justice should renew its commitments to the implementation of the 2-Tier Out of Court Disposal Framework, ensuring that it provides clear guidelines and support for police forces nationwide. This framework should also account for existing diversion schemes already in place in some regions, ensuring a smooth integration and maintaining the effectiveness of these local initiatives.

RECOMMENDATION

To ensure consistent communication across service providers and compliance assessment, Ministry of Justice's national rollout of the 2-Tier Out of Court Disposal Framework should ensure that forces should establish a dedicated out of court disposal team.

Addiction and Crime

The CSJ endorses the argument that convictions for simple drug possession (when an individual possesses a small amount of drugs for personal use) can disproportionately impact on one's future, particularly affecting young offenders, who often struggle to access rehabilitation programmes. [393]

Research suggests that "around 40 per cent of offenders find it difficult or are unable to benefit from and access programmes which are verbally mediated, such as anger management, substance misuse or drug rehabilitation".[394] Furthermore, on average, a recovered addict saves the criminal justice system £946 a year.[395]

Interactions with the Police

The CSJ's focus groups revealed varied experiences with law enforcement among participants. Instances of positive police experience were noted. Participants appreciated police officers who effectively directed them to recovery and healthcare services and showed empathy towards their addiction, resulting in fairer treatment and reduced criminal consequences.

392 Lucy Strang, Jack Cattell, Eddie Kane, Emma Disley, Brenda Gonzalez-Ginocchio, Alex Hetherington, Sophia Hasapopoulos, Emma Zürcher RAND Europe, *Police use of Out of Court Disposals to support adults with health vulnerabilities*, Ministry of Justice, September 2024.

393 Centre for Social Justice, *Written evidence from the Centre for Social Justice*, 2018.

394 Karen Bryan, *Prevalence of speech and language difficulties in young offenders*, International Journal of Language and Communication Disorders. 39, pp.391–400, 2004, as cited in RCSLT in Justice Evidence Base.

395 David Frayman, Christian Krekel, Richard Layard, Sara MacLennan and Isaac Parkes, *Value for Money*, September 2024.

> *"The police referred me to treatment because obviously what led me to get into trouble was drugs. I accessed recovery through that, and I think yeah, first time experiences with the police are adaptive."*
>
> **CSJ Focus Group Participant 6, Birkenhead, May 2024.**

However, negative experiences were more prevalent, with mentions of negative police experiences and stigma from police. Participants reported insensitivity towards their mental health and addiction issues, frequent discrimination, and even physical abuse from police officers.

> *"The police, unfortunately, from my experience, don't help much to deal with that because of the labels they put on us."*
>
> **CSJ Focus Group Participant 1 Stockton-on-Tees, March 2024.**

The lack of police training on addiction and mental health was echoed across all focus groups, contributing to the negative stigma and poor treatment of vulnerable individuals.

> *"I think there's a lack of awareness with the police. Because the police just look, they see a criminal they don't see an addict. Addiction is an illness."*
>
> **CSJ Focus Group Participant 9, Leicestershire, March 2024.**

The progression from addiction to criminal activity was a recurring theme across CSJ focus groups. Some participants described turning to crime, such as drug dealing, to support their addiction. The cycle of reoffending, though mentioned only twice, was significant, with addiction being a key factor in the tendency to reoffend after release from prison. These findings echo Dame Carol Black's claim that nearly half of all burglaries, robberies and other acquisitive crime are catalysed by heroine and crack cocaine addiction.[396]

Police Perceptions

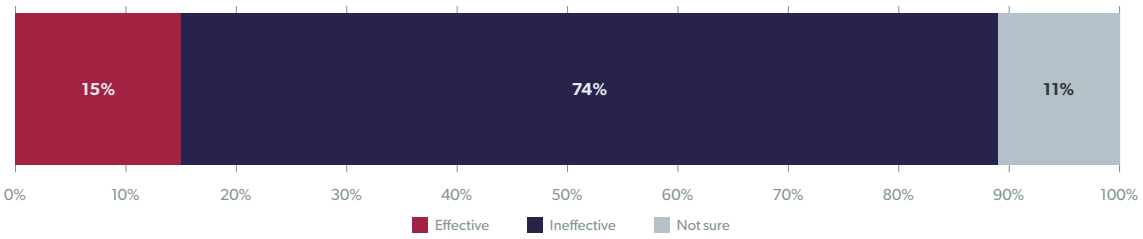
Given the clear link between addiction and crime, understanding police perceptions is critical.

The CSJ's polling of police officers across the UK revealed that, on balance, 74 per cent of police officers feel as though the current drug possession policies and strategies are ineffective in the communities they serve.[397]

396 Home Office, Department of Health and Social Care, Ministry of Justice, Department for Work and Pensions, Department for Education and Department for Levelling Up, Housing and Communities, *From Harm to Hope: A 10 year drug plan to cut crime and save lives,* December 2021.

397 Centre for Social Justice, *Opinium police polling*, October 2024.

Figure 52: How effective or ineffective are the current drug possession policies and strategies in the community you serve?



Source: CSJ polling commissioned by Opinium, October 2024.

As previously stated, the same poll found that 70 per cent of police officers believe charges/summons are ineffective in reducing drug use.[398]

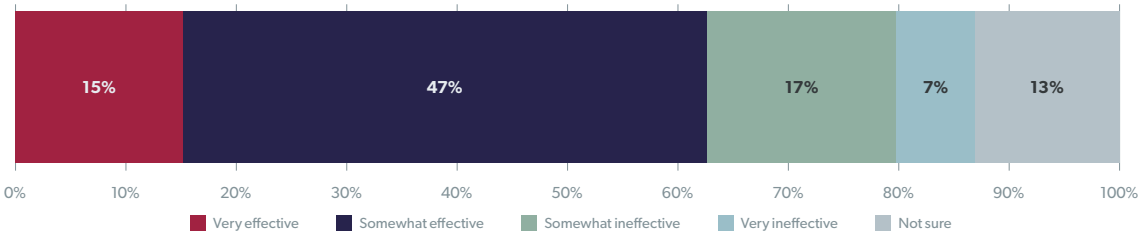
CSJ polling found that, while 62 per cent of officers find their training at least somewhat effective (with only 15 per cent rating it "very effective"), the majority express confidence in their guidance on determining drug offences outcomes.[399] However, the low "very effective" rating points to a need for stronger, more comprehensive training.

Significantly, nearly a quarter (24 per cent) of officers deem their training ineffective. This suggests gaps in preparing officers for the complexities of drug-related cases, especially when dealing with individuals facing addiction or using diversionary schemes. These findings underscore the need for better training to equip officers for these challenges.

Additionally, 13 per cent of officers responded, "not sure," suggesting a lack of clarity or understanding regarding the impact of their training. This uncertainty could stem from inconsistent application of training principles, or perhaps a lack of real-world scenarios where officers can confidently apply their training.

The findings suggest that while the majority of police officers view their training as somewhat effective, a significant portion, (one in four), find it inadequate in determining the outcomes of drug-related offences. This raises concerns about the preparedness of officers to handle the complexities of drug enforcement, especially in an evolving landscape where diversion, public health approaches, and legal ambiguities play a role.

Figure 53: Efficacy of police training on determining a drug-related offence outcome.



Source: CSJ commissioned polling from Opinium of 253 police officers in the United Kingdom, October 2024.

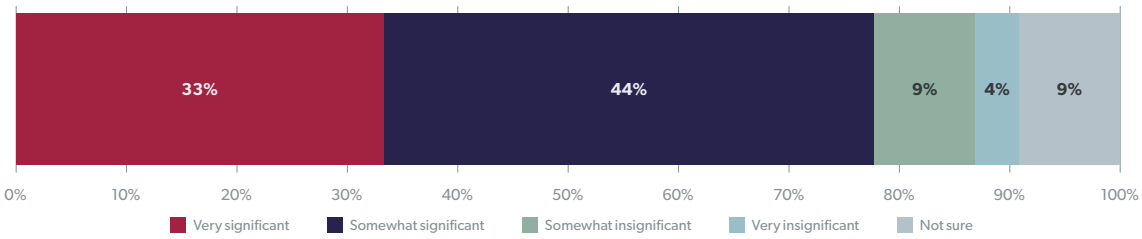
398 Ibid.
399 Ibid.

Effective training and police policies are crucial, given the significant time officers spend on drug-related crime. In fact, 77 per cent of officers report that drug-related crime and disorder are either "very significant" or "somewhat significant" in their team's workload.[400] A third of officers (33 per cent) reported that drug-related crime and disorder are a "very significant" part of their team's workload. This highlights the broad impact of drug-related issues on policing operations, emphasising the ongoing strain drug offences place on law enforcement resources.

A minority of officers (13 per cent combined) view drug-related crime as either "somewhat insignificant" or "very insignificant" in terms of their team's overall workload.[401] This suggests that, for certain police units or in specific geographic areas, drug-related crime is a smaller concern or handled by specialised teams. These officers may be based in areas where drug use is less visible or where drug-related incidents have been deprioritised due to the focus on other types of crime.

The 9 per cent of officers who were unsure about the significance of drug-related crime could reflect variability in exposure to drug offences across teams or confusion regarding the extent of resource allocation for drug-related work.

Figure 54: Significance of drug related crime on police workload.



Source: CSJ commissioned polling from Opinium of 253 police officers in the United Kingdom, October 2024.

Despite high approval of OOCDs and 70 per cent of officers viewing charges/summons as ineffective, almost half (46 per cent) of the officers believe that prosecuting people for personal drug use would increase public safety. Officers holding this view may believe that prosecution sends a clear message about the legal consequences of drug possession, thereby reducing drug-related crimes, and preventing the escalation of personal use into more harmful behaviours or serious criminal activities.

A close second, 43 per cent of officers feel that prosecuting individuals for personal drug use would make no difference to public safety. This suggests a recognition that criminalising personal use might not effectively address the underlying causes of drug use and addiction. Officers with this perspective may be more aware of the limitations of punitive approaches and the need for alternative measures, such as diversion programs, treatment, and rehabilitation.

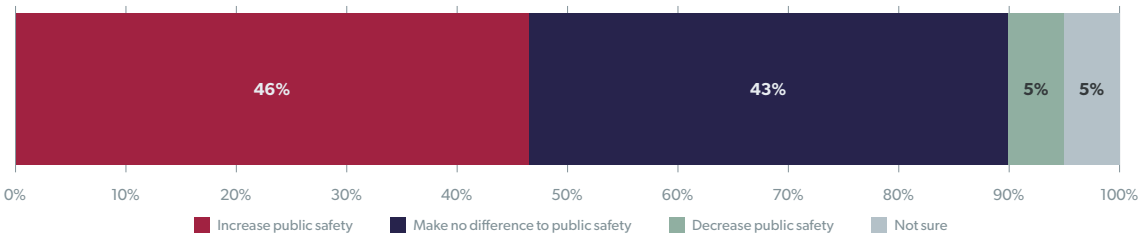
A small minority (5 per cent) believe that prosecuting personal drug use could decrease public safety. This could be attributed to the view that criminalising drug use pushes individuals further into the margins of society, making them more likely to engage in risky behaviours, avoid seeking help, or be pulled into more serious criminal activities.

400 Ibid.
401 Ibid.

The remaining 5 per cent were uncertain, indicating that some officers may feel unclear about the relationship between prosecution and public safety. This uncertainty might reflect the complexity of the issue and the lack of definitive evidence on whether prosecuting personal drug use improves or worsens public safety.

These results highlight a split among law enforcement regarding the role of prosecution in drug-related public safety. While many officers (46 per cent) still see value in a punitive approach, a significant proportion (43 per cent) question its effectiveness in enhancing public safety. This divide suggests that the conversation around drug policy within the police force is shifting, with growing support for alternative approaches that move away from prosecution and towards diversion.

Figure 55: Public safety and the prosecution of personal drug use.



Source: CSJ commissioned polling from Opinium of 253 police officers in the United Kingdom, October 2024.

By helping those affected by addiction recover, we can reduce crime, disorder, and violence in the communities they inhabit. If the Government is serious about delivering its mission to 'Take Back Our Streets' and to crack down on antisocial behaviour, tackling addiction and drug misuse, the root causes of many crimes, must be addressed.

Diversion Schemes

> *"[P]eople found to be in possession of drugs (any) for personal use... should not be processed through the criminal justice system but instead be diverted into drug education / awareness courses...with concomitant assessment for treatment needs."*
>
> **ACMD, 2011**

Too many people with mental health disorders and severe drug or alcohol dependencies are sent to prison, when diversion into secure treatment would be far more effective. Public Health England endorses investing in diversion, stating "drug treatment reflects a return on investment of £4 for every £1 invested, which increases to £21 over 10 years. [402]

Diversion schemes are designed to create opportunities for individuals to engage with support services, without acquiring a declarable criminal record that could hinder their prospects.

Diversion can occur both pre-arrest and post-arrest. Pre-arrest diversion happens on the street, where individuals are redirected to less severe out-of-court disposals, such as Community Resolutions or deferred court summonses, which, if conditions are met, result in no further police action. Post-arrest diversion applies to individuals likely to be convicted in court, offering a deferred prosecution while they engage with either formal or informal out-of-court disposals. Successful completion of the conditions leads to the prosecution being dropped and no criminal record being recorded.

Diversion schemes are rapidly expanding in England and Wales. Current schemes operate in Durham, Avon and Somerset, and Thames Valley.

Durham Constabulary: Checkpoint

Durham Constabulary operates the "Checkpoint" scheme, an arrest diversion programme for low-level offenses, including possession of illegal drugs and minimal quantities of controlled drugs for personal use or minor supply driven by drug dependency.[403] Prosecution is deferred and potentially dropped if the offender completes required assessments and engages with drug and other support services, along with commitments such as refraining from reoffending for a specified period. Additionally, Durham runs "Checkpoint 3D," a pre-arrest scheme offering direct referrals to support services.

Results of an evaluation of Checkpoint found a 10.3 per cent reduction in re-offending on the basis of prevalence and a 30 per cent reduction in the risk of reoffending compared to a control group who received traditional criminal justice disposals.[404] Participants in the divergence scheme reported improved outcomes in substance misuse, mental health, and alcohol misuse.[405]

402 Public Health England, *Alcohol and drug prevention, treatment and recovery: why invest?*, February 2018.

403 Kevin Weir, Gillian Routledge, Stephanie Kilili, *Checkpoint: An Innovative Programme to Navigate People Away from the Cycle of Reoffending: Implementation Phase Evaluation*, Policing: A Journal of Policy and Practice, Volume 15, Issue 1, Pages 508–527, March 2021.

404 Centre for Justice and Innovation, *Checkpoint*, 2019.

405 Kevin Weir, Gillian Routledge, Stephanie Kilili, Checkpoint: An Innovative Programme to Navigate People Away from the Cycle of Reoffending: Implementation Phase Evaluation, *Policing: A Journal of Policy and Practice*, Volume 15, Issue 1, March 2021, Pages 508–527, doi.org/10.1093/police/paz015

Avon and Somerset: Drug Education Programme (DEP)

Avon and Somerset's "Drug Education Programme" (DEP) is a pre-arrest street diversion initiative for individuals caught possessing any illegal drug. Instead of a court summons, participants must attend a drug education program, like a speeding awareness course.[406] After a successful pilot, the programme was expanded force-wide in 2019, processing over 1,000 individuals annually. Avon and Somerset also initiated a diversion scheme targeting young people involved in street drug supply, especially those from families with intergenerational involvement in the drug trade.

Thames Valley Police: Diversion Programmes

Thames Valley Police (TVP) operates multiple pre-arrest street diversion programmes for individuals caught with any illegal drug.[407] One model involves a Community Resolution, which does not appear on background checks, and includes voluntary assessments leading to treatment referrals, education courses like the DEP, and support services such as social, mental health, and housing assistance. Additionally, TVP is implementing a deferred summons model that requires engagement with an assessment and a schools diversion scheme. Evaluation of the voluntary diversion pilot for adults found a 40 per cent completion rate, exceeding the national average by 10 per cent, despite logistical issues such as limited service hours conflicting with work schedules.[408] The youth drug diversion scheme has been highly effective, with 88 per cent positive engagement and an over 80 per cent completion rate, providing a community resolution that avoids a criminal record and encourages positive change.[409]

Investing in evidence-based prevention and diversion is crucial, as recent advancements in knowledge highlight the effectiveness of interventions like social skills training, relationship violence prevention, and cognitive behavioural therapy in reducing crime.[410] Stable and consistent resourcing of early prevention, especially for children, is essential in offering equal access to opportunities that steer them away from crime and the justice system.

Police officers serve not only as enforcers but also as first responders, and they should view themselves as key players in helping individuals access necessary treatment. Providing police with naloxone was a measure taken by the previous Government. However, referring individuals to treatment after an overdose, or diverting them to treatment instead of arrest or prosecution, presents a valuable opportunity for police to take a leading role in addressing drug-related issues.

406 Centre for Justice and Innovation, *The Drug Education Programme (DEP)*, 2018.
407 Policinginsight, *Thames Valley Police Journal: Diversion – Going soft on drugs?*, December 2019.
408 Centre for Justice and Innovation, *Thames Valley Drug Diversion Scheme*, 2020.
409 Ibid.
410 Youth Endowment Foundation, *Arrested Children: how to keep children safe and reduce reoffending*, 2023.

RECOMMENDATION

To ensure effective standardisation, the Home Office and the Ministry of Justice should establish a unified framework for diversion schemes that accounts for existing regional programmes and integrates the proposed two-tier Out-of-Court Disposal framework. This framework should be codified into legislation to ensure consistency across all police forces, thereby preventing disparities in the application of conditional cautions, community resolutions, and other diversionary measures.

Intensive Supervision Courts

Drug courts, also referred to as Problem Solving Courts or Intensive Supervision Courts, are effective when adequately funded and evidence based. These court models involve the use of treatment or social services to affect offender behaviour and address multiple-complex needs. The CSJ supports the implementation of Problem-Solving Courts (PSCs), a policy recently endorsed by the UK Government through pilots for Substance Misuse Intensive Supervision Courts (ISCs).[411]

Participants in Baltimore City's Drug Treatment Court (BCDTC) had significantly fewer arrests, charges, and convictions over a 15-year period compared to those in traditional adjudication, with the Circuit drug court showing better outcomes than the District drug court. However, BCDTC participation did not significantly affect the total days of incarceration, indicating potential for long-term reductions in criminal offending.[412]

A systematic review and meta-analysis of 56 studies found that problem-solving courts with judicial supervision significantly reduced rearrests compared to conventional justice processes.[413] Mental health courts and those with individualised treatment and frequent judicial supervision showed larger treatment effects. However, the high variability in study outcomes highlights the need for more rigorous and detailed research to better understand these effects.

Despite strong international evidence, the UK's data on ISC effectiveness is limited due to inconsistent implementation and evaluation.[414] However, the cost-saving implications are substantive. Analysis by the Centre for Justice and Innovation highlights that the Family Drug and Alcohol Courts (FDAC) model, which costs £18,000 per case, yields an average saving of £74,068 per case, demonstrating significant economic advantages over standard care proceedings.[415]

RECOMMENDATION

Building on current initiatives, such as Family Drug and Alcohol Courts, the Government should urgently review these models and develop a comprehensive, cross-jurisdictional plan for their widespread implementation. To ensure optimal implementation, a thorough, independent review of the pilots is recommended, including data collection on re-offending and abstinence rates.

411 Aikaterini Mentzou, Natasha Mutebi, *Problem-Solving Courts,* UK Parliament POST, July 2023.

412 Kearley, B. & Gottfredson, D. (2020). Long term effects of drug court participation: Evidence from a 15-year follow-up of a randomised controlled trial. Journal of Experimental Criminology, 16, 27-47.

413 Trood, M., Spivak, B., & Ogloff, J. (2021). A systematic review and meta-analysis of the effects of judicial supervision on recidivism and well-being factors of criminal offenders. Journal Of Criminal Justice, 74, 101796.

414 Centre for Justice and Innovation, *Problem-solving courts: an evidence review,* September 2016.

415 Centre for Justice and Innovation, *FDAC: The case for investment,* July 2024.

While it is true that punitive measures can exacerbate stigma,[416] there is also evidence that effective law enforcement and deterrence can reduce drug demand in certain contexts.[417] The CSJ advocates for a balanced approach with diversion schemes and out-of-court disposals that divert individuals from the criminal justice system into treatment. These schemes, if implemented properly, can mitigate the harms of punitive-only policies while maintaining a deterrent effect, which is important for reducing first-time use and discouraging drug-related crime. Tackling stigma is indeed essential, but reducing demand also requires strong societal signals that drug use is harmful.

Prison

While this report does not focus extensively on the prison system, it is important to acknowledge its significant role in the broader criminal justice framework and the pathways from justice into treatment. Prisons, as a setting where substance misuse is prevalent, must be considered within a coherent, systems-wide approach to drug rehabilitation.[418]

Our focus groups revealed that drugs remain a persistent issue within prisons. Participants highlighted the ease with which inmates could access drugs, despite being in a controlled environment, and the failure of authorities to secure these institutions. One participant noted that prisoners could continue to manage criminal operations from within their cells.

Recent data from the HM Chief Inspector of Prisons supports these observations, with around one-third of male prisoners and one-fifth of female prisoners reporting that it is easy to obtain illicit drugs.[419] Alarmingly, some prisons, like HMP/YOI Hindley, show extremely high rates of drug use, with 77 per cent of random tests returning positive results in 2024.[420]

These issues indicate a need for urgent reform within the prison system, alongside better integration of substance misuse treatment. A holistic approach is required, where robust treatment pathways link criminal justice interventions with long-term addiction recovery support, helping to reduce recidivism and drug dependency both inside and outside of prison walls. However, the specifics of what reform is needed is outside the scope of this report given its focus on addiction in the community

416 UK Drug Policy Commission, *Getting Serious about Stigma: the problem with stigmatising drug users,* 2010.

417 Stevens A, Hughes CE, Hulme S, Cassidy R. Depenalization, diversion and decriminalization: A realist review and programme theory of alternatives to criminalization for simple drug possession. *European Journal of Criminology* 2022;19(1):29–54.

418 Office for Health Improvement and Disparities, *Alcohol and drug treatment in secure settings 2022 to 2023: report,* January 2024.

419 HM Chief Inspector of Prisons for England and Wales, *Annual Report 2023-24* (publishing.service.gov.uk), 2024.

420 HM Chief Inspector of Prisons, *HMP/YOI Hindley – HM Inspectorate of Prisons (justiceinspectorates.gov.uk),* September 2024.

Prevention

The most effective way to combat the harms of drug use is to prevent it from occurring in the first place, making prevention strategies a critical component in addressing this issue.

> *"Drug prevention may include any policy, programme, or activity that is (at least partially) directly or indirectly aimed at preventing, delaying or reducing drug use, and/ or its negative consequences such as health and social harm, or the development of problematic drug use."* [421]

Despite the prevalence of substance use prevention programmes aimed at adolescents, many lack evidence of effectiveness.

In the US, prevention approaches that combine teaching social resistance skills with general life skills have proven highly effective in reducing the initiation of tobacco, alcohol, and marijuana use among secondary school students.[422] A school-based drug prevention programme using cognitive-behavioural skills training in junior high (12 - 14-year-olds) significantly reduced lifetime illicit drug use and related behaviours among participants, supporting the effectiveness of such universal prevention efforts.[423]

A historic focus on drug prevention activity within schools means that there has been a lack of focus on prevention provision for other groups, and in relation to these broader 'hidden' determinants of drug use.

Law enforcement's preventative role

Law enforcement officers and schools share common responsibilities, particularly regarding student safety and well-being. Schools act in loco parentis, taking on some caregiving roles of parents, while law enforcement extends their public safety duties into the school environment.[424] Both entities aim to teach students about their rights and responsibilities to foster good citizenship.

Historically, law enforcement's mission has evolved from community engagement to a more crime control-focused approach, which has sometimes resulted in increased distance between law enforcement and community members. When applied to schools, a strict crime control focus can be ineffective.[425] Instead, problem-oriented policing, which involves analysing underlying issues and collaborating with stakeholders, including schools, is recommended by the UNOCD. Additionally, having designated law

421 ACMD referencing Brotherhood, A. & Sumnall, H.R., EMCDDA, 'European drug prevention quality standards', 2011, accessed via: www.drugsandalcohol.ie/28054/1/EuropeanResponsesGuide2017_BackgroundPaper-Evidence-review-drug-interventions.pdf

422 Botvin GJ. Preventing drug abuse in schools: social and competence enhancement approaches targeting individual-level etiological factors. *Addict Behav* 2000; 25(6): 887–897.

423 Griffin KW, Botvin GJ, Scheier LM, Williams C. Long-term behavioral effects of a school-based prevention program on illicit drug use among young adults. *Journal of Public Health Research*. 2023;12(1). doi:10.1177/22799036221146914

424 United Nations Office on Drugs and Crime, *The Role of Law Enforcement Officers in Drug Use Prevention within School Settings,* May 2023.

425 Ibid.

enforcement officers for schools who are integrated into the school community, free from typical patrol duties, can enhance the effectiveness of the law enforcement-school partnership.

The Icelandic Prevention Model

> *"When I started taking drugs and drinking it was just for fun, yeah, with all my mates, we were all doing it together. We'd spend our evenings just going to a field and getting high because there was nothing else to do."*
>
> *CSJ Focus Group Participant 4, South Yorkshire, August 2024*

The Youth in Iceland Model, also known as the Icelandic Model, is a prevention model that originated from Iceland's efforts in the 1990s to address youth substance abuse and promote positive youth development. The model is primarily focused on reducing alcohol and drug use among young people.[426]

Initiated by social scientists, policymakers, and child-focused professionals, this model integrates the efforts of parents, teachers, community centres, and sports clubs to create a supportive environment for young people.[427] Grounded in both international research and local findings, the model emphasises enhancing parental support and expanding organised leisure activities to foster positive youth engagement. Notable for its rapid implementation and evaluation due to Iceland's small size, the model has significantly reduced youth drug and alcohol use since its inception. Along with these reductions in substance use, there is evidence of increased protective factors, such as spending more time at home[428] and participation in organised sports.[429]

This prevention initiative has been trialled in Dundee.[430] This project involves over 1,000 pupils from four secondary schools participating in a survey to inform local health and wellbeing improvements. The Scottish Government's £1.5 million investment aims to adapt this approach for Scotland, focusing on enhancing protective factors and involving young people in the policy-making process. Survey results of the initiative are expected imminently.

Prevention programmes can enhance their effectiveness by focusing on developmental factors, such as emotional regulation skills, which protect against substance abuse and address issues like depression, anxiety, social isolation, and academic challenges. Investing in evidence-based prevention programmes can reduce adolescent substance use and yield broader benefits for both youth and their families.

426 Sigfusdottir ID, Thorlindsson T, Kristjansson AL, Roe KM, Allegrante JP. Substance use prevention for adolescents: the Icelandic model. Health Promot Int [Internet]. 2008;24(1):16–25. Available from: academic.oup.com/heapro/article-lookup. doi.org/10.1093/heapro/dan038.

427 Sigfusdottir ID, Kristjansson AL, Gudmundsdottir ML, Allegrante JP. Substance use prevention through school and community-based health promotion: a transdisciplinary approach from Iceland. Glob Health Promot. 2011;18(3):23–6. doi.org/10.1177/1757975911412403.

428 Kristjansson AL, James JE, Allegrante JP, Sigfusdottir ID, Helgason AR. Adolescent substance use, parental monitoring, and leisure-time activities: 12-year outcomes of primary prevention in Iceland. Prev Med (Baltim) [Internet]. 2010;51(2):168–71 Available from: http://www.ncbi.nlm.nih.gov/pubmed/20478332.

429 Kristjansson AL, Mann MJ, Sigfusson J, Thorisdottir IE, Allegrante JP, Sigfusdottir ID. Development and guiding principles of the Icelandic model for preventing adolescent substance use. Health Promot Pract. 2020;21(1):62–9. doi.org/10.1177/1524839919849032.

430 Carver, H., McCulloch, P. & Parkes, T. How might the 'Icelandic model' for preventing substance use among young people be developed and adapted for use in Scotland? Utilising the consolidated framework for implementation research in a qualitative exploratory study. *BMC Public Health* 21, 1742 (2021). doi.org/10.1186/s12889-021-11828-z

RECOMMENDATION

The Department for Education should implement activity-based prevention programmes across the UK, to engage youth in positive activities and reduce the appeal of drug use. As previously recommended by the CSJ, the Government should extend the school day by an hour to give five hours extra each week for enrichment activities, provided by community groups, which includes outdoor activities. Within this every state-educated secondary school child should have a Right to Sport, which includes a minimum of 2 hours per week of sport, in addition to P.E., closing the 'activity gap' and spreading the many benefits of physical activity to a wider cohort of pupils.

Public Health Campaigns

Anti-drug education was dominated by campaigns like the Drug Abuse Resistance Education programme, launched in 1983. Taught by police officers in classrooms across the United States and Canada, it focused on the dangers of substance use, with a strong message encouraging students to simply say no to drugs.[431] This approach was reinforced by public service announcements and widely used slogans, with former First Lady Nancy Reagan leading the charge.

While abstinence-based drug education remains popular among certain groups, studies throughout the 1990s and early 2000s revealed that programmes like D.A.R.E. had little to no impact on actual drug use.[432] In some cases, there was even a slight increase in drug use among suburban students following their participation in the programme.[433]

As Dr Nora Volkow, Director of the National Institute on Drug Abuse, highlights, "It is clear that just saying no is not sufficient."[434] The exaggerated claims of early anti-drug curriculums, particularly regarding substances like cannabis, often failed to resonate with students, especially when their lived experiences contradicted the dire warnings. For instance, students were told that cannabis would destroy their brain, yet many saw peers use the drug without immediately experiencing the severe consequences they were warned about.

The disconnect between the messaging and reality eroded the credibility of drug education, making it more difficult to convey vital, life-saving information. Today's challenges, including the rise of counterfeit pills laced with fentanyl, underscore the dangerous consequences of outdated approaches.[435]

Experts now argue that drug education must evolve to meet young people where they are, rather than where educators might want them to be.[436] Combating crises like fentanyl requires a broader cultural shift, where honest conversations about drugs become commonplace across schools, families, and communities.

431 National Institute of Justice, *Program Profile: Drug Abuse Resistance Education (DARE) (1983 – 2009)*, June 2011.

432 West SL, O'Neal KK. Project D.A.R.E. outcome effectiveness revisited. Am J Public Health. 2004 Jun;94(6):1027-9. doi: 10.2105/ajph.94.6.1027. PMID: 15249310; PMCID: PMC1448384.

433 ROSENBAUM, D. P., & HANSON, G. S. (1998). Assessing the Effects of School-Based Drug Education: A Six-Year Multilevel Analysis of Project D.A.R.E. *Journal of Research in Crime and Delinquency*, *35*(4), 381-412. doi.org/10.1177/0022427898035004002

434 Lee V. Gaines & Nicole Cohen, NPR, *Just say no didn't actually protect students from drugs. Here's what could*, December 2023.

435 Friedman J, Godvin M, Molina C, Romero R, Borquez A, Avra T, Goodman-Meza D, Strathdee S, Bourgois P, Shover CL. Fentanyl, Heroin, and Methamphetamine-Based Counterfeit Pills Sold at Tourist-Oriented Pharmacies in Mexico: An Ethnographic and Drug Checking Study. medRxiv [Preprint]. 2023 May 31:2023.01.27.23285123. doi: 10.1101/2023.01.27.23285123. Update in: Drug Alcohol Depend. 2023 Aug 1;249:110819. doi: 10.1016/j.drugalcdep.2023.110819. PMID: 36747647; PMCID: PMC9901047.

436 Taylor & Francis Group, Medical Lifesciences News, *Expert calls for harm reduction to address drug overdose crisis*, February 2024.

While many traditional campaigns have focused on fear tactics, a shift is taking place in countries like Sweden, where new approaches are addressing the social and ethical dimensions of drug use.

In 2022, *Krogar Mot Knark* (Pubs Against Drugs) collaborated with the city of Trollhättan, Sweden, to create drug awareness campaign called There's No Good Excuse.[437] Instead of solely focusing on individual health risks, the campaign targeted casual drug users by highlighting the broader societal consequences of recreational drug use. The image below is an example of a campaign poster.

Source: Contagious, Swedish anti-drug campaigns appeal to ethical consumption concerns, February 2023.

Through provocative messaging like "I only sponsor gang wars when I'm with friends," the campaign draws attention to the ethical implications of drug consumption.[438] It reframes drug use as a contributing factor to violent crime, child exploitation, and environmental destruction. By linking cocaine use, for example, to deforestation and the funding of criminal organisations, the campaign aims to confront Sweden's environmentally and socially conscious youth with the real-world consequences of their actions.[439] This approach, grounded in sustainability and ethical consumption, taps into values deeply ingrained in Swedish culture, particularly among younger generations who are increasingly aware of climate change and social justice issues.[440]

437 Contagious, *Swedish anti-drug campaigns appeal to ethical consumption concerns,* February 2023.

438 Brittaney Kiefer, ADWEEK, *Provocative Anti-Drug Ads Target a New Generation Concerned With Sustainability,* January 2023.

439 Contagious, *Swedish anti-drug campaigns appeal to ethical consumption concerns,* February 2023.

440 Linda Givetash & Vladimir Banic, NBC News, *Sweden's environmental education is building a generation of Greta Thunbergs,* January 2020.

By pivoting away from the scaremongering tactics of earlier campaigns, Sweden's anti-drug efforts demonstrate the importance of aligning drug messaging with broader societal values. Such initiatives provide a stark contrast to the failures of past drug education programmes and highlight the importance of evolving strategies to meet contemporary challenges.

By acknowledging the shortcomings of historical anti-drug campaigns and adopting evidence-based, realistic approaches, we can better equip young people with the knowledge and tools to navigate the complex realities of substance use today.

RECOMMENDATION

The Government should consider supporting campaigns that leverage social responsibility. Campaigns should target casual drug users, shifting the focus from individual health risks to the broader social and environmental consequences of drug use. By aligning anti-drug messaging with younger generations' values—such as sustainability, climate change, and social justice—the UK can reshape public perception and reduce the demand for drugs.

Conclusion

The UK must adopt a comprehensive strategy to tackle addiction, addressing its root causes while integrating law enforcement, healthcare, and social services. Fragmented approaches fail. Only by aligning these sectors can we reduce the social and health-related harms addiction causes and guide individuals toward recovery.

Drug misuse persists. ONS data on frequent drug users has remained largely unchanged since 2020 and deaths have reached their highest peak on record. Deaths related to drug misuse have now reached their highest peak since records began, despite the introduction of further funding to treatment programmes.

Addiction affects every corner of society. It strains healthcare, justice, education, and housing systems. Yet, despite increasing funding, accessing treatment remains a significant challenge.

Travelling across the UK, the CSJ heard from those with lived experience of addiction that treatment services are slow, there is no continuity of care, and that they are detached from wider communities. When investigating areas of the UK where no treatment is available, the CSJ discovered that the DHSC does not even hold this information.

Families are an overlooked group, struggling not only to help their loved ones but also to support themselves. The voices of these families are essential in shaping policy solutions.

The system is broken. Rather than pursuing drug liberalisation policies with mixed results, as seen abroad, we must utilise law enforcement as a gateway to recovery. Diversion schemes, when effectively implemented, offer evidence-based solutions that benefit vulnerable individuals and save public funds.

Drug offences are slow to process, reflecting the system's inefficiency. However, instead of abandoning police involvement, we must strengthen collaboration between law enforcement and health services. This partnership connects people to the care they need while maintaining public safety. Intensive supervision courts and diversion programmes should be at the forefront of the Government's agenda if they are truly committed to addressing addiction and antisocial behaviour.

Holistic, coordinated efforts—centred on enforcement, treatment, and support—offer the only sustainable path forward. The UK has an opportunity to lead with compassion, pragmatism, and evidence-based solutions. By leveraging existing resources and aligning services, we can foster recovery, save lives, and reduce the devastating impacts of addiction across society.

Summary of Recommendations

Ensuring Addiction is Addressed Throughout the Health Sector:

1. In line with National Institute of Health and Care Excellence guidelines on pregnancy and complex social factors, NHS England should ensure pregnant women are routinely screened for substance use and receive coordinated care, integrating detox services into antenatal care. Providers must address barriers by offering tailored information, combining care plans, and assigning a named midwife or doctor with specialised experience. Staff should be trained to communicate sensitively, and additional support, including transport and referrals, should be provided to ensure attendance and continuity of care.
2. NHS England should implement comprehensive stigma-focused training for GPs, emphasising addiction as a chronic medical condition. Additionally, the Government should enhance training and support for healthcare professionals to improve their ability to identify and refer individuals struggling with opiate addictions.
3. The Care Quality Commission should give sufficient focus to clinical practice in relation to dual diagnoses. NHS Trusts must provide clear guidance to staff on the identification and management of patients who are not engaging with services. This must include how engagement will be monitored and reviewed.
4. The Care Quality Commission should give sufficient focus to clinical practice in relation to the balance between different forms of opioid substitution treatment in its regulation of services.
5. In accordance with the National Institute of Health and Care Excellence guidelines, the CSJ recommends that individuals receiving opioid substitution therapy must also be provided with integrated psychological support. This approach ensures that mental health issues, which often underpin substance use disorders, are addressed concurrently, fostering a more comprehensive and effective recovery process. By partnering with mental health services and offering psychological interventions alongside opioid substitution therapy, we can improve patient outcomes, support long-term recovery, and reduce the risk of relapse.
6. The Department of Health and Social Care should ensure channels are developed for patients who wish to transition from methadone to alternative treatments like buprenorphine. This can be supported by broadening the Health Education England and Public Health England programme BOOST so that it is mandatory rather than optional.
7. The Government should continue and expand the distribution of naloxone to first responders and the police, with an emphasis on high-risk areas, to reduce the incidences of fatal overdoses.
8. The Government should take an evidence-based, phased approach, studying international examples and their real-world implications before committing to significant policy changes. This includes assessing both the short and long-term impacts of such approaches on crime rates, recovery outcomes, public health costs, and broader societal effects. A careful, informed strategy will ensure that any harm reduction policies adopted are both effective and sustainable in the UK's unique social and legal context.

Addressing Emerging Threats:

1. As promised by the previous Government, the Minister of State for Crime, Policing and Fire should expand a national system to track non-fatal overdoses. This system should gather data from NHS trusts, police, ambulance services, and emergency departments to monitor trends and identify high-risk areas. Drawing on models like the U.S. Drug Overdose Surveillance and Epidemiology (DOSE) system, this initiative would enhance situational awareness, guide resource allocation, and inform public health interventions aimed at reducing drug-related harm. Accurate tracking of non-fatal overdoses is essential for understanding the full impact of substance use disorders and improving community health outcomes.
2. The Department for Health and Social Care should update its current tracking synthetic opioid deaths system to include police data where naloxone has been administered.
3. As promised by the previous Government, Minister of State for Crime, Policing and Fire should expand wastewater testing nationally as an early warning system. This will aid in understanding the changing drug market as well as the prevalence of drug misuse.
4. The Office for National Statistics should continue to explore large-scale data linkage of death registrations with NHS and other administrative data sources, such as prescriptions, and design both cross-sectional and longitudinal analyses to contribute to understanding of the patterns of drug misuse, causal relationships, and the individual pathways of those who die of drug-related causes.
5. As part of local drug processes, directors of public health, senior responsible officers in combating drugs partnerships, and partners in the commissioning and delivery of services for people who use drugs and alcohol, including voluntary and NHS services, should collaborate to "deep dive" fatal overdoses and non-fatal overdoses, as outlined in the Office for Health Improvement and Disparities' guidance "Preventing drug and alcohol deaths: partnership review process." Directors should include and publish findings and actions directors' annual reports. By understanding factors that contributed to overdoses in the past, we can prevent them from occurring in the future.

Bolstering the Treatment Sector:

1. The Government must re-commit to long-term, ring-fenced funding for rehabilitation and recovery services in the next multi-year spending review. This should include a three to five year funding plan to allow for better service planning, staff recruitment, training and expansion of treatment options for those in a community setting.
2. The Government should recognise the growing need for supporting those with cannabis induced psychosis. Considering the successful outcome data of the Cannabis Clinic for Psychosis, NHS Trusts should examine the needs of the catchment area they serve, request a business plan which includes initial funding, and include patients and carers in the development of further clinics.
3. The Department for Health and Social Care should prioritise the development and expansion of sex-specific treatment services that address the unique needs of women. This could involve the creation of women-only treatment groups and spaces, which provide a safe and supportive environment for recovery. Additionally, childcare support should be integrated into treatment programmes to remove barriers for mothers seeking help.

4. The Government should review the commissioning process for drug treatment and recovery services for ethnic minority communities with specific focus on the establishment of ringfenced funding for the provision of specialist services for ethnic minority groups; and developing guidance for commissioners, co-produced with ethnic minority-led organisations. This guidance should promote the inclusion of specialist organisations throughout the entire commissioning cycle, ensuring that partnerships with specialist organisations during both the bidding process and contract delivery are fair and equitable.
5. The Department for Health and Social Care alongside the Department for Education is advised to introduce adequate support of families and others affected by someone else's drug and alcohol use, including children and young people.
6. When evaluating the impact of the safer drug consumption facilities, the Scottish Government should ensure it measures metrics including overall drug dependency, recovery rates, crime rates in the surrounding area and potential inconsistencies in the legal framework.

The Role of Law Enforcement:

1. Building on current initiatives, such as Family Drug and Alcohol Courts, the Government should urgently review these models and develop a comprehensive, cross-jurisdictional plan for their widespread implementation. To ensure optimal implementation, a thorough, independent review of the pilots is recommended, including data collection on re-offending and abstinence rates.
2. To reduce outcome wait times and enhance drug testing capabilities, every police force in the UK should be equipped with Home Office approved drug testing devices to better identify and respond to drug-related offenses. This will support law enforcement in tackling the distribution and use of illegal substances effectively, saving time, reducing backlog in the criminal justice system, increasing the speed and capacity of forensic testing.
3. The Ministry of Justice should renew its commitments to the implementation of the 2-Tier Out of Court Disposal Framework, ensuring that it provides clear guidelines and support for police forces nationwide. This framework should also account for existing diversion schemes already in place in some regions, ensuring a smooth integration and maintaining of the effectiveness of these local initiatives.
4. To ensure consistent communication across service providers and compliance assessment, the Ministry of Justice's national rollout of the 2-Tier Out of Court Disposal Framework should ensure that forces should establish a dedicated out of court disposal team.
5. To ensure effective standardisation, the Home Office and the Ministry of Justice should establish a unified framework for diversion schemes that accounts for existing regional programmes and integrates the proposed two-tier Out-of-Court Disposal framework. This framework should be codified into legislation to ensure consistency across all police forces, thereby preventing disparities in the application of conditional cautions, community resolutions, and other diversionary measures.
6. The Home Office should publish the promised evaluation of Project ADDER to inform decision making about the projects future funding, due to end in March 2025. This includes the cost-effectiveness of the scheme.

Education and Prevention:

1. The Government should integrate adult-facing services, such as addiction treatment and social care, with child-focused services to ensure that children exposed to parental addiction receive timely, trauma-informed support.
2. The Department for Education should implement activity-based prevention programmes across the UK to engage youth in positive activities and reduce the appeal of drug use. As previously recommended by the CSJ, the Government should extend the school day by an hour to give five hours extra each week for enrichment activities, provided by community groups, which includes outdoor activities. Within this framework, every state-educated secondary school child should have a Right to Sport, which includes a minimum of 2 hours per week of sport, in addition to P.E., closing the 'activity gap' and spreading the many benefits of physical activity to a wider cohort of pupils.
3. The Government should consider supporting campaigns that leverage social responsibility. Campaigns targeting casual drug users, shifting the focus from individual health risks to the broader social and environmental consequences of drug use. By aligning anti-drug messaging with younger generations' values—such as sustainability, climate change, and social justice—the UK can reshape public perception and reduce demand for drugs.

Appendices

Thematic analysis

Introduction

This section presents the thematic analysis of 14 interviews conducted with individuals who have lived experience of addiction. These interviews aimed to understand their perspectives on treatment, criminal justice interactions, and prevention measures, providing a foundation for the recommendations outlined in the main report.

Utilising in-depth qualitative research design, the CSJ sought to answer the following questions:

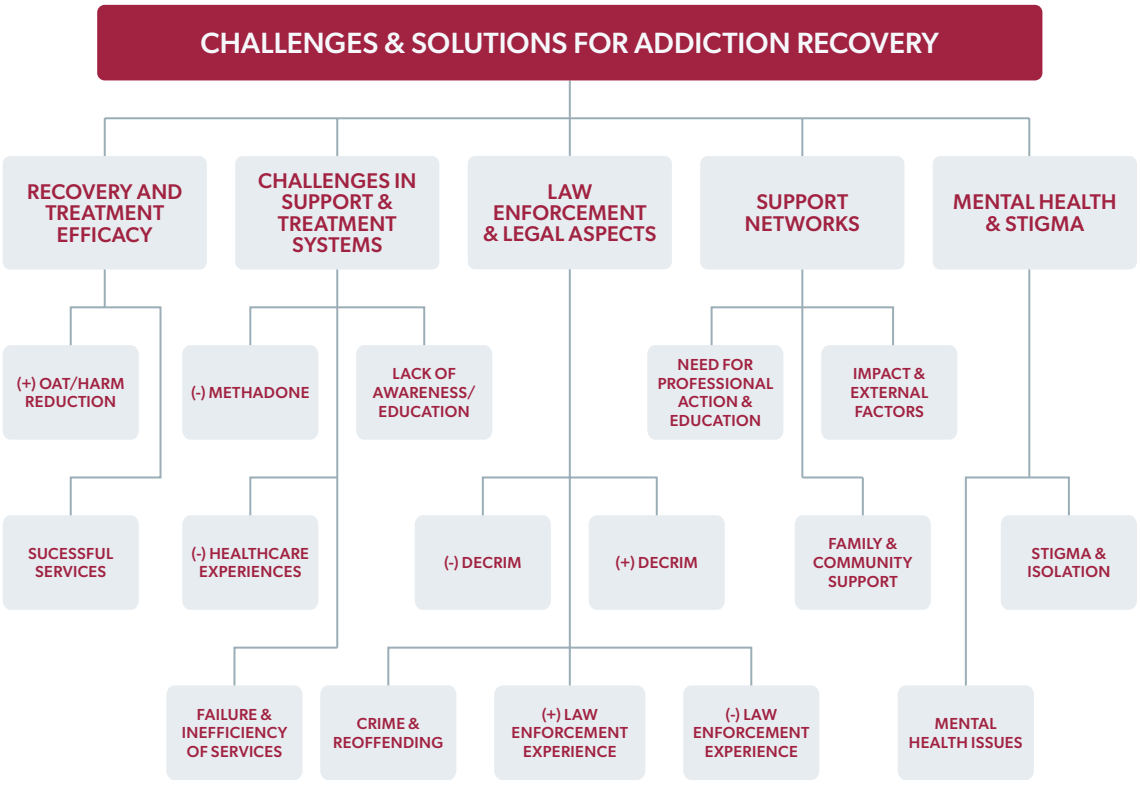
1. How do current addiction policies address the needs of individuals struggling with addiction?
2. How does law enforcement contribute to shaping attitudes and behaviours surrounding addiction within communities?
3. How do proposed changes to addiction treatment and prevention strategies aim to enhance support and resources for individuals battling addiction?

Methodology

Fourteen semi-structured focus groups including were held between March 2024 and May 2024. Participants were recruited through the CSJ's alliance of small and medium charities and social enterprises. A map of focus group locations is below.

All focus groups were recorded and transcribed. Open coding techniques were utilised to identify the thematic narratives which emerged from the data. The project lead listened to audio recordings several times and re-read transcripts to become familiar with the data and employed the constant comparative method of data analysis to identify similarities and differences in participant accounts. This process was guided by Braun and Clarke's six-phase framework for thematic analysis. Ethical considerations included ensuring anonymity and obtaining informed consent.

Results of the analysis are peppered throughout the report. A thematic map of findings is below.



Limitations

While the findings provide valuable insights, the small sample size and the focus on individuals with specific types of addiction may limit generalisability. Future research could expand this approach to include a broader range of experiences.

Conclusion

These themes highlight critical areas for reform, including reducing stigma in treatment, improving access to services, and fostering better relationships between individuals with addiction and law enforcement. They contribute to the recommendations in this report's treatment and criminal justice reform chapters.

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