Towards a Safer Drug Policy

July 2017
Drug addiction can seem far detached from our lives if we’ve never had any experience of the misery that it inflicts. There’s a tendency for people to turn a blind eye to drug addiction because it doesn’t immediately affect their lives, because they think it could never happen to their happy, ‘normal’ family. However, this is denial. Drug addiction doesn’t discriminate: it could affect anyone and anyone’s family. The repercussions of drug abuse are far-reaching, and it would be naïve to think that our families and loved ones are too sensible to make a mistake that could send them on the road to destruction.

I have spoken to too many grieving families who lost their children to drug addiction, and I have attended the scenes of too many drug overdoses during my policing career. These kinds of devastating incidents have the power to bring about change and we all should care enough to want to help. I am passionate about my objective to influence Government to implement informed policies which will reduce the harm within our communities, and the harm to individuals. Drug addiction is often a silent battle. The continuing description of drug addicts as criminals rather than people who are unhealthy or sick prevents them from getting well and consigns their family to years of misery, often destitution.

The war on drugs is as disastrous today as it was 46 years ago when President Richard Nixon officially declared the ‘war on drugs’. We recently interviewed two recovering addicts who had been arrested after an undercover policing operation which had lasted six months, cost over £0.5m and led to the arrest of over 30 people involved in the supply of Class A drugs. When we asked how long we had strangled the supply of heroin, one estimated four hours, and the other two. From a policing operation, it was really successful. Significant arrests may ensure that criminals are brought to justice and prison, but did it stop drugs being sold on the streets? No. The policy has failed. It clearly does not restrict the supply of drugs.

It is time for a change. It is time to look beyond the statistics. Behind every number there’s a person. Every addict is a person with beliefs, a life full of good and bad experiences, feelings of failure, insecurity and depression. The list goes on. How can we help people recover and offer them support, not blame, to break their addiction?

Current policy is causing more harm than good. Punishment is not working. Renowned addiction expert, Gabor Maté, once said: “Ask, not why the addiction, but why the pain?” Helping people to heal from their life experiences and their pain, and showing them that they
are capable of leading healthier, successful lives in the future will not just create safer streets, it will deliver benefits to the economy, the health service, and policing.

The time has come to review current drug policy in the UK, to ask questions of its effectiveness at reducing harm, and to see what measures we could take to achieve better outcomes. It’s time for a safer drug policy.

Ron Hogg
Police, Crime and Victims’ Commissioner for Durham
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Executive Summary

This report sets out an ambitious journey over the next few years. My vision, and the ultimate goal of the journey, will be to contribute to a healthier and safer society, through better informed drug policy and action. This is based on focused analysis; in particular, on our community’s needs and a critical review of our present approach.

It is my view that our current approach to tackling illicit drugs isn’t working and is increasingly unsustainable. Implementing this new, long-term strategy would ensure that my work as Police, Crime and Victims’ Commissioner reflects the reality that our community faces, with respect to drug use and the evolving needs. In making these commitments, I am mindful of the challenges ahead of us. However, these challenges, whether they are political, economic, and the increasingly innovative means that the drug market employs, make me even more aware of the importance of this work. Reflecting the multiagency dimension of the drug phenomenon, this strategy demands partnership working. I set out below a set of proposals. We should:

1. **Hold a fundamental review of the Misuse of Drugs Act 1971, and of UK Drug Policy**
   The effectiveness of the Misuse of Drugs Act 1971 has never been formally evaluated, despite overwhelming indications of failure. The current legal framework is confusing for the public, and does not correlate with evidence-based assessment of relative drug harm. I am calling for a fundamental review of the entirety of the Misuse of Drugs Act 1971, which takes into account the effectiveness of the current policy, evaluates governance arrangements, and results in a policy which is evidence-based and achieves better outcomes. The review should consider all international experiences in order to ascertain a more effective way forward.

2. **Ensure that our approach is firmly based on evidence**
   We must ensure that decisions are based upon the facts that confront us in order to ensure that money and time are better spent. Our approach must be evidence-based, in order to create cost-effective policies that could improve the lives of many people who are directly and indirectly affected by drug problems.

3. **Support fully funded effective education and prevention.**
   The provision of drugs education that is available to all young people must be in line with best practice. Prevention measures with a strong evidence base need to be promoted in schools and our community in order to build resilience and reduce the harm to young people. Adequate investment in prevention helps prevent today’s troubled young people becoming tomorrow’s dependent alcohol and drug users.

4. **Develop effective responses to reduce the harm.**
   The current UK drug strategy based upon education, enforcement and supply reduction has not been effective in reducing harm, and whilst I do not support that we abandon these principles, we need to nuance our approach. Policies should aim to
minimise the social, psychological, and physical harm to those who use drugs and to society at large.

5. **promote cost-effective specialist drug treatment and recovery as a proven way to reduce crime and make communities safer.**
   If the aim is to reduce demand and make our communities safer, we must encourage and support people to receive treatment and recover from their addiction. Reductions in substance misuse service budgets in the short term will only result in long-term costs for the health, social care, and Criminal Justice systems. A thorough review of the process for determining budgets for commissioning substance misuse services in England is required.

6. **protect the vulnerable by supporting alternatives to the criminalisation of people who use drugs and focus efforts on tackling the organised crime groups**
   Alternatives to punishment and the protection of vulnerable drug addicts and their families - the victims of the organised crime groups - are the pathways to liberate both individuals and communities from the grip of organised crime. We must intervene at the earliest opportunity and provide credible alternatives to prosecution so that we can improve their life chances, whilst focusing resources on tackling the organised crime groups - the real criminals making money and causing harm from others’ misery.
**Introduction**

Throughout history, drugs, legal or otherwise, have been used by all societies and we must accept that drug use is never going to be eliminated. The vast majority of people use drugs, such as alcohol, in a reasonable way. There are some, however, who use drugs in a risky way and end up harming themselves and their communities. Drug use, whether experimental, recreational or dependent, can have a damaging effect not only on the user, but also on the user’s family and friends.

Illegal drugs, specifically, cause much more harm to the user; they have to rely on the criminal market whose interest is in ‘getting them hooked’ and turning the highest profits at the risk of a lengthy sentence if caught. The combination of being involved in the criminal drug market and being criminalised by the state is particularly harmful and degrading for people who become addicted to drugs and those who use them to self-medicate. Our current policy criminalises those who would intend to do no harm to others and punishes those who are suffering when they need treatment and social integration.

The illegal drugs market is also having an increasingly harmful effect on society at large, mainly because of two problems: health and crime. Under prohibition, illegal drugs tend to become more toxic and more costly, consequently leading to users becoming unhealthier and more likely to steal and deal. Powerful criminal organisations are involved in the drugs market and a significant proportion of acquisitive crime is committed by dependent drug users who commit crimes to feed their addiction, resulting in unfortunate victims in our communities.

In recent years, the drugs problem has been largely associated with the use of illegal drugs. Consequently, the problems caused by legal drugs, for example alcohol, tobacco, and prescribed medication can tend to be ignored. And yet, between them, these substances cause the loss of thousands of lives every year and more harm for both users and non-users of these drugs.

The use of legal drugs, namely alcohol, tobacco, and prescribed medication, is generally accepted in society and they are widely promoted through advertising, sponsorship, and the industries themselves. As a result, efforts to control the use of such drugs rely on a combination of education, taxation, restriction of sale to adults, sale from specific places, and voluntary sanctions.

This report presents a top-level overview of the drug situation in the United Kingdom, covering drug use, public health problems, drug supply, drug-related crime, as well as drug policy and responses. Whilst the main focus is on illicit drugs, it must be acknowledged that legal drugs can cause as much harm as illicit drugs to individuals and society, this report only touches upon that.

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1 The Home Office estimates that 45% of acquisitive offences (excluding fraud) are committed by regular heroin/crack cocaine users
Chapter 1 Drugs, Health and Social Harm

“Addicts should be treated and supported into recovery. Their entrapment in the Criminal Justice System is a waste of police time, a waste of the state’s money, and dissuades addicts from revealing themselves for treatment for fear of the criminal consequences”

Michael Barton, Chief Constable, Durham Constabulary

This chapter aims to provide an overview of prevalence of illicit drug use in the UK and, the number of users in treatment in the UK. It also covers the rising public health harms and costs to society caused by illicit drug use, namely; hospital admissions, number of infectious diseases, and number of deaths.

1.1 Understanding Drug Use in the UK

Drugs are used by many different people and in many situations. Drug use is complex and the extent of drug use varies. Whilst many use drugs and cause no harm to others, those who use drugs compulsively cause harm to themselves and to those around them. Drug addiction goes hand in hand with poor health, homelessness, family breakdown, and offending. This is why it is so important to place emphasis on drug addiction.

It is important to understand that drug addiction is rare but concentrated. According to the National Treatment Agency for Substance Misuse, 1.2m people are affected by drug addiction in their families and 120,000 children have a parent currently engaged in treatment services. The consequences of having addicted parents can be hard to bear for the children. These children can grow to emulate their parents so continuing the cycle of poverty, addiction, and poor money management. The annual cost of looking after children who have been taken into care because of their parent’s drug using activities is estimated to be £42.5m.

Drug use and misuse tend to be clustered; for example, areas of relatively high social deprivation have a higher prevalence of illicit opiate and crack cocaine use and larger numbers of people in treatment. This link between areas of deprivation and the high prevalence of drug use indicates that addressing issues to do with health inequality and social exclusion, unemployment and housing problems are fundamental to improving treatment outcomes, and to helping people to recover from their drug addiction.

1.12 Extent and trends in drug use in England and Wales

Drug use is difficult to measure given its illicit nature, but the Home Office rely heavily on large-scale household surveys. The latest statistics from the Home Office Crime Survey for England and Wales (CSEW) 2015/16 suggest that among people aged 16-59, self-reported use of most illicit drugs has been decreasing for several years. Drugs included in the Crime Survey for England and Wales are

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3 National Treatment Agency, 2014-now Public Health England
4 Public Health England, 2014
5 Public Health England Evidence Review, 2017
6 Drug Misuse: Findings from the 2015/16 Crime Survey for England and Wales (PDF), Home Office
either classified under the Misuse of Drugs Act 1971 as Class A, B, or C, or the Psychoactive Substances Act 2016. The prevalence rates below are taken directly from the findings of the 2015/16 CSEW:

In 2015/16, around 1 in 12 (8.4%) adults aged 16 to 59 had taken a drug in the last year. **This is around 2.7 million people.** This level of drug use is similar to the 2014/15 survey (8.6%), but significantly lower than a decade ago (10.5% in the 2005/06 survey). A large proportion of this fall is due to reduced prevalence of cannabis use, with the use of Class A drugs remaining relatively stable. The figure below shows the overall trajectory of drug use over the last 20 years:

![Graph showing drug use trends](image)

The figure above shows that around **1 in 5 (18%)** young adults 16-24 had taken an illicit drug in the last year. This proportion is more than double that of the wider age group and equates to around 1.1 million people, indicating that drug use is not evenly distributed amongst age groups. It is this younger age group that largely drives the trend seen in the wider group of adults aged 16 to 59. The figures in **Appendix 1** look at the prevalence of specific illicit drugs.

In 2014, **15% of pupils (11-15 year olds)** in England said they had taken drugs at some point in their lives. The decrease of self-reported drug use amongst children aged 11-15 has continued, but at a slower rate.

Over **one-third (35.0%)** of adults aged 16 to 59 had taken drugs at some point during their lifetime. 3.3% of all adults aged 16 to 59 were classed as frequent drug users. This equated to around **1.1 million people.**

Men are more likely to take drugs than women. Around 1 in 8 (11.8%) men aged 16 to 59 had taken any drug in the last year, compared with 1 in 20 (5.0%) women. Use of any Class A drug in the last year was higher among men than women in the same age groups. For example, 10.2% of men aged 20 to 24 and 9.4 per cent of men aged 25 to 29 reported using any Class A drug in the last year, compared with 4.3% of women aged 20 to 24, and 2.8% of women aged 25 to 29. However, there has been a consistent and steady increase in the estimated number of opiate and/or crack users over the age of 35. The rise in this older age group is due to increasing age among the sub-population who started using heroin in the 1980s and early 1990s. These figures make the case for targeted interventions, and specifically the need to educate young males.

People living in urban areas reported higher levels of drug use than those living in rural areas. Around 1 in 11 (8.8%) people living in urban areas had used any drug in the last year compared with 1 in 16 (6.3%) of those living in rural areas.

Increased levels of drug use are associated with increased frequency of visits to pubs, bars, and nightclubs. For example, use of any Class A drug in the last year was around 10 times higher among those who had visited a nightclub at least 4 times in the past month (17.6%) compared with those who had not visited a nightclub in the past month (1.7%). A similar
pattern was found for those visiting pubs and bars more frequently.

As frequency of alcohol consumption increased, so did the level of drug use. Adults aged 16 to 59 who reported drinking alcohol 3 or more days per week in the last month were more than twice as likely to have used any drug (13.2% compared with 5.0%) and over 5 times more likely to have used a Class A drug (5.6% compared with 1.0%) in the last year than those who reported drinking less than once a month (including non-drinkers).

Those who reported being a victim of any crime in the last year were more likely to report use of any drug and any Class A drug. For example, 12.4% of those who reported being a victim of any CSEW crime in the last year also reported using any drug in the last year, compared with 7.5% of those who did not. Victim services need to take this into account when considering appropriate support to address their needs.

Drug use decreases as life satisfaction increases: 16.7% of those who reported low levels of life satisfaction also reported drug use in the last year, compared with 10.4% of those who reported medium life satisfaction, 8.7% for high life satisfaction, and 5.0% for very high life satisfaction.

1.13 Type of drug use in lifetime

For all adults aged 16 to 59, the drug most commonly reported as ever used was cannabis, with around 3 in 10 (29.4%) adults reporting using this drug at some point during their lifetime. Furthermore, around 1 in 10 adults aged 16 to 59 said that they had used amphetamines (10.3%), powder cocaine (9.7%) or ecstasy (9.4%) and 1 in 12 said they had used amyl nitrite (8.3%) at some point in their lives. Overall, 2.7% of adults had used an NPS in their lifetime.

Among adults aged 16 to 59, 15.4 per cent (5 million) had taken a Class A drug in their lifetime. This is a statistically significant increase from 9.6 per cent in the 1996 survey and from 14.1 per cent in the 2005/06 survey a decade ago.

Although cannabis has retained its position as the most commonly used drug in the UK, other drugs have proven to be popular in different socio-economic groups. Cannabis, combined with volatile substances, are the most commonly used substances among school children in England, whereas ecstasy has proved the most popular stimulant amongst club-goers, followed by cocaine. Research carried out in so-called ‘gay friendly’ clubs indicates that mephedrone is the drug of choice in such environments.

With this information to hand, commissioners and policy-makers should use this to inform substance treatment services. By understanding the scope, scale, and other information about drug use and the popular drugs of choice, we can design more effective prevention and treatment programs.

1.14 Drug dependence

Between 1993 and 2000, there was an increase in the proportion of adults (16-64) reporting signs of dependence in the last year. Since then, the overall prevalence of signs of dependence has remained stable. There are an estimated 306,000 people in England who are dependent on heroin and/or crack.

More people are having problems with other drugs including the emerging trend of novel psychoactive substances (NPS), and image and performance-enhancing drugs (IPEDs). There is also a growing concern about dependence on prescribed and over-the-counter medicines. The figures in Appendix 1 show that 7.5% of adults aged 16 to 59 had taken a prescription-only painkiller not prescribed to them, and
reasons for taking them included medical reasons, or the feeling or experience it gave them. Treatment services need to be fit for purpose and have adequate treatment options available to deal with the increase in dependence of NPS and prescription, and over-the-counter drugs.

1.2 Treatment population

The Public Health England (PHE) Evidence Review\(^7\) states that around 75% of people in drug treatment in England are receiving help for problems related to the use of opiates, mainly heroin. It estimates that the proportion of people in treatment with entrenched dependence and complex needs will increase and the proportion who successfully complete treatment will therefore continue to fall. The proportion of older heroin users, aged 40 and over, in treatment with poor health has been increasing in recent years and is likely to continue to rise.

The figure below shows that the overall number in drug treatment peaked in 2008–2009 and has fallen since then. This decrease is mainly due to the decline in the number of opiate users presenting to treatment\(^8\). The total number of non-opiate users in treatment has remained relatively stable since 2007–2008.

The number of individuals in drug treatment for problems with prescribed, or over-the-counter, medicines alone increased between 2009-2010 and 2015-2016. The proportion of those in treatment who use these substances has also increased, though they only make up a small percentage of the total number of people in treatment. It is accepted, however, that not all people who use medications problematically are currently accessing treatment.

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\(^7\) Public Health England Evidence Review, 2017

\(^8\) Ibid
Towards a Safer Drug Policy

Data from the EMCDAA\(^9\) indicates that 288,843 individuals were in contact with drug and alcohol services in 2015/16. The graph below shows that more people were treated for opiates than the other three categories combined.

There were 202,039 drug users in specialised treatment centres, 45,528 in drug treatment in prisons, and 9,961 in general/medical health care centres. There were 2732 in hospital-based residential drug treatment and 2573 in residential drug treatment in 2015.

Opioid substitution treatment (OST) remains the most common treatment in the United Kingdom for opiate users. It is mainly offered through specialist outpatient drug services, commonly in shared care arrangements with general practitioners. Oral methadone is the most commonly prescribed drug for OST, although buprenorphine has also been available since 1999. Furthermore, prescribed injectable methadone and diamorphine are also available in England, but are rarely provided\(^{10}\).

Just under half of all clients were primary opioid users, although this figure rises to 64% among those who had been treated previously. Cannabis is the most frequently reported primary drug among first treatment presentations, and has increased in importance in recent years.

The UK is the European country reporting the highest number of clients starting treatment for opioids; in addition, the numbers of clients reported to be entering treatment for primary use of crack cocaine and synthetic cathinones is higher than in other European countries.

The age profile of opiate-users was older than those using only non-opiates. Those who are older tend to have greater health problems as they have been taking illicit drugs for very long periods, and have a higher risk of premature mortality than the general population. As the opiate using population is ageing, this increased risk has been increasing year-on-year and the number of people who die whilst in drug treatment is likely to increase. Thus, the PHE Evidence Review 2017 recommends that drug treatment will need to respond to a range of age-related, long-term health conditions and actively support referrals for primary and specialist care. This trend is also likely to impact on the number of people successfully completing treatment, as treatment services are more likely to have a higher proportion of older, entrenched drug users who have received treatment numerous times.

\(^9\) EMCDAA, 2017

\(^{10}\) Ibid
The number of young people attending specialist substance misuse services was 17,077\(^{11}\), down 7% from the previous year\(^{12}\).

The number of young people in treatment for cannabis continues to fall despite it being the most common drug used.

Localised data on County Durham and Darlington’s prevalence and treatment populations can be found in Appendix 2.

1.3 Drug Misuse and treatment in Prisons

The Public Health England Review\(^{13}\) indicates that there are approximately 85,000 people in prisons at any one time. 81% of adult prisoners report using illicit drugs at some point prior to entering prison, including almost two-thirds (64%) within the month before entering prison. Rates of heroin and crack cocaine users are 49% (female) and 44% (male).

In all, 60,254 adults were in contact with drug and alcohol treatment services within secure settings during 2015-16. Most (56,803) of these were within a prison setting, with 3,124 within YOIs (Youth Offending Institutions) and 327 within IRCs (Immigration Removal Centres)\(^{14}\).

The figure below shows that just under half (48%) of those in contact with treatment in adult settings presented with problematic use of opiates, a further 37% presented with problems with other drugs (non-opiates) and 14% presented with alcohol as their only problem substance. Clients accessing treatment in IRCs were mostly opiate clients (77%), while YOIs mostly treated non-opiate drugs (79%)\(^{15}\).

1.4 Public attitudes to drug use

Results from the Crime Survey for England and Wales found that:

The majority of adults thought that it was acceptable to get drunk occasionally. Around three-quarters (74%) of adults aged 16 to 59 thought that it was acceptable for people of their own age to get drunk occasionally;

- The majority of adults believed that it was never acceptable to take cannabis. Almost two-thirds (65%) of adults aged 16 to 59 thought that it was never acceptable for people of their own age to take cannabis, while one-third (33%) thought that it was acceptable to do so.

- The majority of adults did not think that it was ever acceptable to take either cocaine or ecstasy. The majority (91%) of adults aged 16 to 59 thought that it was never acceptable for people of their own age to take cocaine; only 9% thought that it was acceptable to do so. The proportions for ecstasy were similar;

- 38% of adults aged 16 to 59 thought that it would be very or fairly easy for them personally to get drugs within 24 hours if they wanted them.

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\(^{11}\) NHS Digital, Statistics on Drug Misuse 2017

\(^{12}\) NDTMS, 2015/16

\(^{13}\) Public Health England Review, 2017

\(^{14}\) Secure setting statistics from the NDTMS 2015 to 2016, PHE

\(^{15}\) Ibid
If the aim of a drug policy is to restrict supply, then the current policy is not the answer. The availability and accessibility of illicit drugs appears to not be an issue and despite enforcement efforts, people appear to be able to access illicit drugs fairly easily.

1.5 Public Health Harms

Drug addiction is associated with a range of harms including poor physical and mental health, unemployment, homelessness, family breakdown and criminal activity\textsuperscript{16}. The health and wellbeing of family members and carers can also be affected.

Opioids, particularly heroin, remain associated with the highest health and social harm caused by illicit drugs in the UK. There are current concerns about changes in the patterns of drug injection in the UK, in particular the increased injection of amphetamines and the emergence of injection of NPS. While it appears that there had been a decline in the injection of opioids and crack cocaine in England, opioids remain the most commonly injected drug\textsuperscript{17}.

1.52 Drug misuse related hospital admissions

There has been a rise in drug–related hospital admissions, indicating that the harm caused by drug use is increasing. The North East is in the second-highest group for hospital admissions with a primary diagnosis of poisoning by illicit drugs. The North East has the second-lowest regional group for hospital admissions with a primary diagnosis of drug-related mental and behavioral disorders\textsuperscript{20}.

\textsuperscript{16} Royal Society for Public Health, 2016: Taking a new line on drugs
\textsuperscript{17} EMCDAA, 2017
\textsuperscript{18} EMCDAA, 2017
\textsuperscript{19} EMCDAA, 2017
\textsuperscript{20} Statistics on drug misuse, England, 2017 (based on 2015/16 HES)
As can be seen from the graph below, there were 81,904 hospital admissions with a primary or secondary diagnosis of drug-related mental and behavioral disorders in 2015/16\textsuperscript{21}. This is 9% more than 2014/15 and over double the level in 2005/06.

In 2015/16, there were 8,621 hospital admissions with a primary diagnosis\textsuperscript{22} of drug-related mental health and behavioral disorders. This is 6% more than 2014/15 and 11% more than 2005/6. The table below compares local figures to the England average:

<table>
<thead>
<tr>
<th>NHS hospital finished admission episodes with a primary or secondary diagnosis of drug related mental health and behavioural disorders, by region and Local Authority (LA)</th>
<th>Total admissions per 100,000 population</th>
<th>Male admissions per 100,000 population</th>
<th>Female admissions per 100,000 population</th>
</tr>
</thead>
<tbody>
<tr>
<td>England</td>
<td>148</td>
<td>208</td>
<td>89</td>
</tr>
<tr>
<td>North East</td>
<td>186</td>
<td>264</td>
<td>109</td>
</tr>
<tr>
<td>County Durham</td>
<td>151</td>
<td>210</td>
<td>94</td>
</tr>
<tr>
<td>Darlington</td>
<td>238</td>
<td>361</td>
<td>121</td>
</tr>
</tbody>
</table>

There were 15,074 hospital admissions with a primary diagnosis of poisoning by illicit drugs. This is 6% more than 2014/15 and 51% more than 2005/6.

\textsuperscript{21} Ibid

\textsuperscript{22} The primary diagnosis provides the main reason why the patient was admitted to hospital. As well as the primary diagnosis, there are up to 19 secondary diagnosis fields in Hospital Episode Statistics.
Despite a reduction in the number of people saying they use illicit drugs, the figures above show that more people are ending up in hospital due to drug-related health problems. Figures show the number of cases resulting in primary or secondary diagnoses of mental health and behavioural disorders has more than doubled. These contrasting figures are an indication of our failed drug policy. More people are suffering serious harm to their health because of their drug use than ever before.

**Drug related deaths**

Drug-related deaths are the 5th most common cause of preventable death among 15-49 year olds in the UK\(^{23}\). These deaths are related to drug misuse (England and Wales) and are attributable to illicit drug use i.e. poisonings or overdoses. The drug-induced mortality rate among adults in the United Kingdom (aged 15-64 years) was 60.3 deaths per million in 2014, almost **three times the most recent European average** of 20.3 deaths per million. Fewer than 1% of all adults use heroin, but every year about 1% of them die (10 times the equivalent death rate in the general population). The figure below shows that deaths related to drug misuse are at their highest level since comparable records began in 1993:

The figure below shows that in 2015, there were 2,479 registered deaths which were related to drug misuse. This is an increase of 10% on 2014 and 48% higher than 2005.

\(^{23}\) EMCDAA, 2017
In 2015, 79% of deaths (1,964) were due to accidental poisoning by drugs, medicaments and biological substances. Over three quarters (1,536) of these were for males. 4 deaths were for assault by drugs, medicaments and biological substances.

We have seen a dramatic upward trend in drug-related deaths. In 2015, there were 3,674 registered deaths from drug-related poisoning, of which 54% of these were related to opioids. The majority of deaths are male.

The number of deaths involving heroin was 2725 in England and Wales between 2013-15, a 27% increase from 2012-14. There were 32 deaths in Durham between 2013-15, an increase of 52% from 2012-14. The number remained the same for Darlington.

Heroin is involved in the majority of deaths, and other drugs commonly associated with deaths from illicit substance use include benzodiazepines, cocaine and amphetamines.

The number of deaths linked to NPS use is relatively low, but has increased greatly since 2010. In England, there were 107 NPS-related deaths in 2015, compared with 82 in 2014.

The number of adults who died while in contact with treatment services in a secure setting in 2015-16 was 41, representing 0.1% of adults accessing treatment. Most of these deaths were from the opiate drug group (22 deaths), followed by alcohol only clients (11 deaths). Females accounted for 12% (5 deaths) of the total deaths amongst adults in treatment.

PHE recently carried out an inquiry into the recent increases in drug-related death and concluded that there were multiple OR complex factors contributing to these increases, such as the ageing cohort who experience poor physical and mental health, increasing suicides, increasing deaths among women, improved reporting, an increase in poly-drug and alcohol use, and an increase in the prescribing of some medicines24. Some of these could also be attributed to the rising purity of heroin.

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1.6 International comparators

Although self-reported drug use has fallen in recent years in England and Wales, it remains high compared to other European countries.

England and Wales has one of the highest rates of drug-related deaths in Europe, with 2015’s figures on heroin and morphine deaths the highest since records began, based on the European Monitoring Centre for Drugs and Drug Addiction report, 2017.

Compared to the rest of the European countries, Britain has Europe’s highest proportion of heroin addicts- almost 1 in 3 drug overdoses in Europe are recorded in the UK (31%) and this is continuing to rise. Section 1.53 looked at patterns of drug-related deaths in England and Wales.

Britain also has a higher proportion of problem drug users within the adult population than any of its European neighbours.

Britain also has the highest rate of high risk opioid users- about 8 in every 1,000 Britons are high risk opioid users.

1.7 Social and economic costs of drug misuse

The costs to society are significant. Latest estimates by the Home Office suggest that the cost of illicit drug use in the UK is £10.7bn (or £11.4bn in 2015/16 prices). This figure includes drug-related crime, enforcement, health service use and deaths linked to eight illicit substances: amphetamines, cannabis, crack, ecstasy, heroin, LSD, ‘magic mushrooms’ and powder cocaine. The figure below shows a breakdown of the estimated social and economic costs of illicit drug use for 2011/12:

The overall cost of drug addiction is huge. Given that drug-related harm is now more extensive than the costs captured in 2011/12, it is highly probable that the current figure is an underestimate. If you also include the societal costs which can be indirectly attributed to drug use; such as unemployment costs or housing benefit costs, this figure is a lot greater. Other research claims that every year Class A drugs costs society £15.4 billion. This includes costs to the public, to businesses, the NHS, and the Criminal Justice System.

Copello et al carried out research for the UK Drug Policy Commission (UKDPC) and estimated the annual cost to the family members and carers of heroin and/or crack cocaine users to be £2bn. The researchers considered the costs of being a victim of crime, lost employment opportunities, and health service use, as well as financial support given to relatives.

Heroin and cocaine are associated with the majority of social costs associated with drug

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misuse and heroin dependence continues to be the most common problem treated in England. People with heroin dependence usually develop a tolerance through daily use, which can result in an expensive addiction and a motivation to commit crime. For example, Jones et al. estimated in 2009 that adult drug users not in treatment typically spent £94/£231 (median/mean) a week in current prices on drugs.

In 2008, Hay and Bauld estimated that 80% of heroin and/or crack cocaine users in treatment in England accessed welfare benefits in 2006; approximately 267,000 benefit claimants (6.6% of all working age claimants) were heroin/crack cocaine users. Just 20 drug and/or alcohol misusers generate welfare benefit expenditure costs of approximately £1.6bn per annum, or £1.7bn in today’s prices, according to the Government. Drug users thus add a huge cost to the welfare system and we need to stabilise them and get them into treatment and recovery, in order to get them into employment, and therefore reduce the number of drug addicts who access welfare benefits.

The estimated costs just to the NHS of illicit drug use can be divided into five parts:

i. mental and behavioural health due to illicit drug use;
ii. overdoses and poisoning due to illicit drug use;
iii. neonatal diagnoses due to illicit drug use;
iv. HIV/AIDS for injecting drug users; and
v. deaths due to illicit drug misuse in terms of lost productivity, the human cost and medical and ambulance costs.

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Towards a Safer Drug Policy

i. Mental and behavioural health due to illicit drug use

Illicit drug use can lead to mental illness such as psychotic disorders. The costs to the NHS include the cost of intensive care of patients with drug-related mental illness as well as acute care and rehabilitation.

ii. Cost of illicit drug overdoses

In 2010/11 there were over 16,000 drug-related overdoses in England and Wales. Only overdoses of illicit drugs have been included, but some categories included poisoning resulting from prescribed drugs as well as from legal drugs with potential for misuse.

iii. Costs of neonatal diagnoses due to illicit drug use

A foetus or newborn can be affected by maternal use of illicit drugs. The costs to the NHS of treating drug-related neonatal diagnoses such as babies suffering from withdrawal of addictive drugs are estimated using the 2010/11 NHS reference costs of treating major and minor neonatal diagnoses.

iv. Costs of injecting drug users

Injecting drug users bring additional costs. Sharing needles can lead to the transmission of infectious diseases including Hepatitis C and HIV. The Health Protection Agency estimates that around half of injecting drug users in the UK have been infected by Hepatitis C and one-sixth with Hepatitis B. An estimated 91,500 people were living with HIV in the UK in 2010, including 2,300 people (3%) who inject illicit drugs.

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33 Hall, 1998
34 HES, 2010/11 and Patient Episode Data for Wales
v. Costs of deaths due to drug misuse

The cost of a death is taken from the Department for Transport’s (2011) cost of a fatal casualty in a road accident. This is a widely used figure and, while the cost of a drug-related death is not directly comparable with the cost of a road traffic accident death, it was considered the best available estimate.

### Key points

1. 2.7 million adults had taken an illicit drug in 2015-16.
2. 1 in 5 young adults (16-24) had taken an illicit drug in 2015-16.
3. 15% of pupils (11-15 year olds) had taken an illicit drug in England.
4. There are 294,000 heroin and crack users in England.
5. The most common drug of choice is cannabis.
6. The drug which causes the most harm was heroin; opiate users are recognised nationally as the group with the most complex problems, with a correspondingly greater impact on the community and the individual.
7. 40% of prisoners have used heroin.
8. Heroin poisonings have more than doubled.
9. Drug dependency leads to significant harms to the individual and to our society—impacting on health, social care, crime and the economy.
10. One adult problematic drug user costs society £44,231 per year.
11. In the absence of treatment, one young drug and alcohol user is estimated to cost around £4,000 per year due to crime and a further £179 per year in healthcare costs.
12. Although fewer people are self-reporting drug use than 10 to 15 years ago, an increase in hospital admissions and drug-related deaths indicate that drug-related harms are increasing.

__Sources are references elsewhere in this Chapter.____
Chapter 2 Drugs, Crime and Policing

“Success is the absence of crime not the evidence of the police dealing with it”
Robert Peel, 1829

This chapter provides an overview of the extent of drug-related offences, drug-related crime, supply and costs to the Criminal Justice System.

The relationship between illicit drug use and crime is complex but well-established. Not everyone who takes drugs commits crime. For some, drug use preceded criminality, but for others, crime preceded drug use. Some will commit crime even if they stop taking drugs.

Class A drug misuse (primarily heroin and crack cocaine) in England and Wales alone costs society an estimated £15.4 billion a year\(^{39}\) (£44,231 per problematic user). This figure is predominantly accounted for by the social and economic costs associated with drug-related crime – £13.86 billion in 2003/04, with fraud (£4.87 billion) and burglary (£4.07 billion) the costliest criminal acts\(^{40}\). Drug arrests alone cost £535 million a year. Of the remainder, £488 million goes on the cost of drug-specific and drug-related mortality and morbidity to the NHS, in providing both acute treatment for the primary effects of drug use, and treatment for secondary effects such as behavioural and mental disorders. Addaction, estimated that illegal drug use is costing the UK taxpayer £16.4 billion a year; the medical costs have hit £560 million while taking criminals through the courts added £2.6 billion\(^{41}\).

Heroin and cocaine (in particular) are costly illicit drugs and a significant minority of people resort to crime to support their dependence. A typical heroin user spends around £1,400 per month on drugs, 2.5 times the average mortgage payment\(^{42}\).

The Home Office Modern Crime Prevention Strategy 2016 lists six key drivers on crime and demand upon police forces and the Criminal Justice System; two of them relate to drugs:

1. Drugs - heroin and crack cocaine addiction are responsible for 43% of acquisitive crime (more than 2million offences, and 33% of fraud, as addicts strive to feed their habit).
2. Profit - the illegal drug trade is an essential cash flow into organised crime groups.

2.1 Drug-related crime

There is a strong association between drugs and acquisitive crime. The Home Office estimates that drug-related crime costs £13.9bn per year\(^{43}\) and that offenders who use heroin, cocaine or crack cocaine commit between a third and a half of all acquisitive crimes\(^{44}\). As a result, reducing drug-related crime is one of the main objectives of the Government’s drug strategy.

Many commit crime to pay for their drugs. This might include acquisitive crimes such as shoplifting, burglary, robbery, or other financially motivated crimes such as soliciting and begging. A typical addict not in treatment

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\(^{40}\) Ibid

\(^{41}\) Addaction, 2008

\(^{42}\) National Treatment Agency, 2012


\(^{44}\) Home Office Modern Crime Prevention Strategy, 2016
commits crime costing an average £26,074 a year.45

“Heroin, cocaine, or crack users commit up to half of all acquisitive crime—shoplifting, burglary, robbery, car crime, fraud, drug dealing”
National Treatment Agency

However, this is just the tip of the iceberg. The drug market is lucrative and the principle reason is money. Thus, it is associated with other crimes, such as those in the image below:

2.2 Drug-offences

82% of drug offences are in relation to possession, at a global level.47

According to statistics on crime in England and Wales, there were 139,278 drug offences committed in 2016, a fall of 8% compared to the previous year. Of these, 24,638 offences were for the trafficking of drugs and 114,640

45 National Treatment Agency for Substance Misuse, 2012
46 Mick Creedon, Chief Constable of Derbyshire, National Policing Lead for Serious Organised Crime
47 Global Commission on Drug Policy, 2016.
48 ONS, 2017

Cannabis warnings could be issued to adults from 2004, while khat warnings could be issued to adults from June 2014. According to the Ministry of Justice 2016 statistics, there were 36,300 cannabis and khat warnings issued in the latest year, a decrease of 6,300 (15%) from the previous year.

After increasing between 2006/07 and 2010/11, the number of arrests for drug law offences has decreased in recent years, although they remain higher than the levels before 2006/07. The figure below shows that in 2014, 128,260 convictions or cautions for drug offences were reported in England, Wales, Scotland and Northern Ireland.
Of the offences in which the drug involved was recorded (in England, Wales, and Scotland), 50.8% were cannabis related, 14.5% were cocaine related (excluding crack cocaine), and 8.9% were heroin related.\(^49\)

Treasury data (included in Appendix 3) shows the potential amount of time and money spent across officer ranks on each outcome for possession or supply of cannabis: 46 hours per supply offence (£1464), 16 hours arrest and preparation for court (£456), 10 hours per arrest and caution (£282), 2 hours per penalty notice for disorder, and 2 hours per cannabis warning (£54). This is in addition to court costs, prison costs, and probation costs.

Based on Ministry of Justice 2015 figures\(^50\), three quarters of a total of 75,207 cases of cannabis possession are dealt with by warnings (51%, including khat), penalty notices (11%), or cautions (13%). By contrast, 81% of all Class B drug supply arrests end up in court.

### 2.3 Drug Seizures

Cannabis is the most frequently seized drug in the United Kingdom, followed by cocaine. As UK drug seizure data have not been available on a consistent basis for the last six years, data from England and Wales are used to comment on trends. The long-term trend indicates an increase in seizures of herbal cannabis until 2011/2012 and a steady drop thereafter.

The United Kingdom reports seizures of both cocaine powder and crack cocaine, with powder being seized more frequently. The number of heroin seizures has decreased since 2007/08, with the largest decrease between 2009/10 and 2010/11. Nevertheless, the United Kingdom reports some of the highest numbers of heroin and cocaine seizures and quantities seized of both substances in Europe.

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*Drug seizures in the United Kingdom: trends in number of seizures (left) and quantities seized (right). Source: Country Drug Report, EMCDAA, 2017.*
2.4 Organised crime involvement in drug trafficking

“The illicit drugs trade in the UK alone is worth roughly £7 billion a year. To put that in perspective, total annual spend on unemployment benefits is around £4.9 million. That is £7 billion transferred straight into the pockets of the gangsters I had spent my life chasing down. Even worse, the costs of policing drugs are an additional £7 billion per year. With 90% of users managing to consume drugs without wrecking their lives, it seems like an act of actual wilful self-destruction to spend £7 billion a year criminalising those who do have a problem—thus ensuring they are unable to get the help they need”

Neil Woods, former undercover police officer

Organised criminality exploits those who use these drugs; they engage in a range of criminal behaviour including violence, coercion and gun crime - and they make vast criminal profit. Any strategy that reduces their opportunities is welcome. As much as we lock up the individuals and gangs, they are replaced with the next generation of importers, traffickers and street dealers who continue the industry, who are often more violent.

Law enforcement agencies estimated that there were around 5,800 organised crime groups (40,000 people) which impacted the UK in 2014\(^{51}\). They also estimate that organised crime costs society at least £24 billion a year\(^{52}\).

The UK illegal drugs market remains extremely attractive to organised criminals. The prices charged at street level are some of the highest in Europe, and are sufficient to repay the costs of smuggling the drugs into the UK.

Every year, Drugscope, a charity in the UK, surveys police forces, drug workers, treatment services, drug expert witnesses and members of the Drug Expert Witness and Valuation Association from around the UK. Results from the 2016 survey\(^ {53}\) indicated the following average UK prices:

- Herbal cannabis (standard)- £37 per qtr oz
- Herbal cannabis (high strength)- £55 per qtr oz
- Spice- varies widely £30-60 in central London, £20 for 3.5g in Manchester
- Heroin per bag- £10 average weight 0.1g
- Cocaine- £30-40 per gram
- Crack- £10-20 per rock
- Ecstasy- £5-15 per pill
- MDMA powder/crystal- £40 per gram
- Amphetamine- £5 upwards per gram
- Methamphetamine- £200 per gram
- Ketamine- £20-30 per gram
- Diazepam- £0.67 per pill

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\(^{51}\) Home Secretary’s Speech, 2015.  
\(^{52}\) Ibid.  
\(^{53}\) Drugscope DrugWise Street Drug Trends Survey 2016 (published in 2017)
The traditional distinction between international importers and the UK-based wholesalers is becoming more blurred, with some regional wholesalers travelling to the continent to arrange their own imports.

British organised criminals are active at all levels of the UK drugs trade, from importing to street-level distribution. A large number of foreign nationals are also heavily involved in the illegal drugs trade in the UK. Some have cultural and familial ties to the countries the drugs come from or travel through. This makes it easier for them to take major roles in the trade. EMCDAA data\textsuperscript{54} indicates that:

**Heroin trafficking**

The amount of heroin estimated to be imported annually into the UK is between 18-23 tonnes. The vast majority of this is derived from Afghan opium.

**Cocaine trafficking**

The amount of cocaine estimated to be imported annually into the UK is between 25-30 tonnes.

**Cannabis trafficking**

Cannabis is still the most widely used illegal drug in the UK and the UK wholesale cannabis market is worth almost GBP 1 billion a year. The NCA estimates that 270 tonnes of cannabis is needed to satisfy annual UK user demand. Most of this is herbal skunk cannabis. Despite increasing domestic cultivation most cannabis in the UK is still imported via all modes of transport.

The nature of drug supply is changing. Drones are already being used to deliver drugs and other contraband into UK prisons. Bitcoin (a number of virtual currencies) is also being used for online payment for illicit drugs.

### 2.5 Understanding the costs of organised crime

The social and economic costs\textsuperscript{55} of organised crime to the UK amount to many billions of pounds. Drugs supply (£10.7 billion), has a major impact on the UK, and other less visible crimes also cause substantial harm. The next section of this chapter outlines evidence\textsuperscript{56} on organised acquisitive crime types, organised child sexual exploitation, counterfeit currency, drugs supply, organised environmental crime, firearms, organised fraud, organised immigration crime, organised intellectual property crime, and organised wildlife crime, which all cause harm to the UK\textsuperscript{57}. The figures will inevitably, and to differing degrees for each crime type, underestimate both the scale and the impact of organised crime on the UK.

#### 2.51 Drugs Supply

Drug trafficking is considered to be the most profitable sector of transnational criminality and to pose the single greatest organised crime threat to the UK. Organised crime groups and networks produce, supply, and distribute illicit drugs within the UK. There will be some exceptions, for example, where cannabis is grown and used by the same person, but this is best assessments of the less tangible impacts of crime, such as the emotional and physical impact on victims.

\textsuperscript{54} EMCDAA, 2017

\textsuperscript{55} The term “social and economic costs” are used in this report as in Brand and Price (2000) to include costs imposed on individuals, households, businesses or institutions by crimes they suffer directly (private costs) and wider impacts on society as a whole through, for example, responses to the perceived risk of crime (external costs). The term “social costs” is used in its economic sense to include both financial costs reflected in expenditure, and notional costs reflecting

\textsuperscript{56} Home Office, Understanding organised crime, 2013

\textsuperscript{57} Home Office, Understanding organised crime, 2013
unlikely to affect either scale or cost estimates in a significant way.

The scale of organised drugs supply captures the amount of money spent by drug users on buying illicit drugs. The costs of organised drug supply include the harms resulting from the use of illicit drugs. This includes the costs of acquisitive crimes committed to fund addiction, costs of drug offences under the Misuse of Drugs Act 1971, costs of health harms resulting from drug use, the costs of drug treatment, and public spend directly aimed at tackling illegal drugs supply and demand in the UK.

The scale of the illicit drugs supply is best estimated by considering the demand for illicit drugs. This is defined as the money spent by drug users on certain illicit drugs. During 2003/04 the size of the UK illicit drug market was estimated to be £5.3 billion. Drug-related health costs include hospital admissions, neonatal care, and the costs of treating drug-related HIV. The social and economic costs of illicit drugs in the UK are estimated to be £10.7 billion, of which almost £6 billion is the result of drug-related crime.

Legitimately prescribed drugs are not produced or supplied by organised crime groups and are therefore excluded from the scope of this report. Similarly, there is an absence of evidence to suggest that any trade in unprescribed methadone uses organised crime networks. The scale of illicit drug supply in the UK, is shown in the graph below.

The social and economic costs considered in this chapter are the consequences of the supply of illicit drugs. These include the costs of drug-related acquisitive crime, health costs, drug treatment, and the cost of enforcing drug offences.

The costs of drug-related acquisitive crime are estimated using data from the OCJS and the Arrestee Survey to determine the proportion of acquisitive crime that is committed by users of certain drugs in order to support drug use. It does not include broader offences closely associated with drugs use such as psychopharmacological offending, or violence due to a lack of suitable data. An estimated 44 per cent of all acquisitive crime in England and Wales is drug-related. The total cost of drug-related acquisitive crime in the UK in 2010/11 is estimated to be approximately £5.8 billion. The table below shows the estimated proportions of drug-related crime by crime type and the associated costs.

<table>
<thead>
<tr>
<th></th>
<th>England and Wales (£m)</th>
<th>UK (£m)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amphetamines, ecstasy, LSD and magic mushrooms</td>
<td>£240</td>
<td>£270</td>
</tr>
<tr>
<td>Cannabis</td>
<td>£1,110</td>
<td>£1,200</td>
</tr>
<tr>
<td>Crack cocaine and heroin</td>
<td>£1,110</td>
<td>£1,300</td>
</tr>
<tr>
<td>Powder cocaine</td>
<td>£810</td>
<td>£920</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>£3,300</strong></td>
<td><strong>£3,700</strong></td>
</tr>
</tbody>
</table>

Source: Offending Crime and Justice Survey Data; Arrestee Survey Data. Notes: Figures may not sum due to independent rounding. All outputs have been rounded to two significant figures.

58 Due to data availability this report considers the supply of amphetamines; cannabis; crack cocaine; ecstasy; heroin; LSD; magic mushrooms; and powder cocaine.
59 UK Drug Policy Commission, 2008
Towards a Safer Drug Policy

2.52 Cost of Drug-related acquisitive crime

<table>
<thead>
<tr>
<th>Category</th>
<th>Drug-related proportion</th>
<th>Unit cost of crime</th>
<th>Cost of drug-related crime (England and Wales £m)</th>
<th>Cost of drug-related crime (UK £m)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vehicle Theft</td>
<td>24%</td>
<td>£450</td>
<td>£490</td>
<td></td>
</tr>
<tr>
<td>• Theft of vehicle</td>
<td>16%</td>
<td>£4,970</td>
<td>£100</td>
<td>£110</td>
</tr>
<tr>
<td>• Theft from vehicle</td>
<td>33%</td>
<td>£1,034</td>
<td>£350</td>
<td>£370</td>
</tr>
<tr>
<td>Burglary</td>
<td>47%</td>
<td></td>
<td>£2,600</td>
<td>£2,800</td>
</tr>
<tr>
<td>• In a dwelling</td>
<td>57%</td>
<td>£3,925</td>
<td>£1,600</td>
<td>£1,700</td>
</tr>
<tr>
<td>• Not a dwelling</td>
<td>43%</td>
<td>£4,608</td>
<td>£1,100</td>
<td>£1,100</td>
</tr>
<tr>
<td>Robbery</td>
<td>25%</td>
<td></td>
<td>£680</td>
<td>£710</td>
</tr>
<tr>
<td>• Personal</td>
<td>19%</td>
<td>£8,810</td>
<td>£560</td>
<td>£580</td>
</tr>
<tr>
<td>• Commercial</td>
<td>36%</td>
<td>£9,372</td>
<td>£130</td>
<td>£130</td>
</tr>
<tr>
<td>Theft from a person</td>
<td>39%</td>
<td>£1,016</td>
<td>£250</td>
<td>£260</td>
</tr>
<tr>
<td>Theft from a shop</td>
<td>66%</td>
<td>£124</td>
<td>£400</td>
<td>£450</td>
</tr>
<tr>
<td>Other theft</td>
<td>14%</td>
<td>£763</td>
<td>£195</td>
<td>£210</td>
</tr>
<tr>
<td>Fraud</td>
<td>35%</td>
<td></td>
<td>£730</td>
<td>£830</td>
</tr>
<tr>
<td>• Benefit fraud</td>
<td>23%</td>
<td></td>
<td>£250</td>
<td>£250</td>
</tr>
<tr>
<td>• Credit fraud</td>
<td>40%</td>
<td></td>
<td>£150</td>
<td>£150</td>
</tr>
<tr>
<td>• Identity fraud</td>
<td>-</td>
<td></td>
<td>£420</td>
<td>£420</td>
</tr>
<tr>
<td>Total</td>
<td>44%</td>
<td></td>
<td>£5,300</td>
<td>£5,800</td>
</tr>
</tbody>
</table>

Source: Offending Crime and Justice Survey data; Arrestee Survey data

2.53 Law-enforcement costs

There were over 70,000 drug offences resulting in court proceedings in England and Wales in 2010. The costs of these offences, scaled up to the UK using population data, are approximately £680 million.

The research suggests that applying this proportion to the police budget in 2010/11 indicates that the costs of drug enforcement to the police is approximately £362 million for England and Wales. The research scaled this up to UK level by population suggests an estimated £370 million spent by the police enforcing drug offences. The total costs of drugs enforcement in the UK is approximately £1.1 billion. The breakdown of these costs can be seen in the table below. The 2010/11 figure does not include enforcement costs resulting from Serious Organised Crime Agency (SOCA), UK Border Force, or Ministry of Defence enforcement activity. While the entire SOCA budget is a cost in response to organised crime, the research couldn’t break it down to drug-related activity.

<table>
<thead>
<tr>
<th>Category</th>
<th>Costs (England and Wales, £m)</th>
<th>Total Costs (UK, £m)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policing</td>
<td>£360</td>
<td>£370</td>
</tr>
<tr>
<td>Criminal Justice System</td>
<td>£610</td>
<td>£680</td>
</tr>
<tr>
<td>UK Border Agency</td>
<td>-</td>
<td>£70</td>
</tr>
<tr>
<td>Total</td>
<td>£1,100</td>
<td></td>
</tr>
</tbody>
</table>

Source: Various

Total costs

The total social and economic costs of organised illicit drug supply in the UK are estimated at £10.7 billion. The breakdown of these costs can be seen in the table below:

<table>
<thead>
<tr>
<th>Type</th>
<th>Total Costs (£m)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drug-related crime</td>
<td>£5,800</td>
</tr>
<tr>
<td>NHS Costs</td>
<td>£80</td>
</tr>
<tr>
<td>Drug-related deaths</td>
<td>£3,000</td>
</tr>
<tr>
<td>Drug treatment</td>
<td>£720</td>
</tr>
<tr>
<td>Enforcement costs</td>
<td>£3,500</td>
</tr>
<tr>
<td>Total</td>
<td>£10,700</td>
</tr>
</tbody>
</table>

Key points

- It is acknowledged that many people are taking drugs, however their detection is a lottery. There were 70,000 drug offences in 2010, yet 1.1 million young people (16-24) alone have said they had taken an illicit drug in the last year (see page 9).
- Drug use (and enforcement) have significant consequences, placing strain on health and criminal justice systems and incurring huge social and economic costs.
- Class A drug misuse (primarily heroin and crack cocaine) in England and Wales alone costs society an estimated £15.4 billion a year – £44,231 per problematic user in 2003/4. This figure will have risen significantly since then. Other less visible crimes also cause substantial harm.
- The annual cost of drug-related crime is £13.9bn -- with fraud costing approximately £4.9bn, burglary £4bn, robbery £2.5bn, shoplifting £1.9bn and drug arrests £0.5bn.
- Any addicted person not in treatment commits crime costing an average £26,074 a year.
- Drug users are estimated to commit between a third and a half of all acquisitive crime.
- Each year, 75,000 problem drug users enter the prison system.
- There were 128,260 drug offences in 2014 in England and Wales: 65% of these were for possession offences.
- The UK illegal drug market is estimated to be worth between £4bn and £6.6bn a year.
- The top 5 drugs seized in the UK:
  1. Herbal Cannabis
  2. Cannabis resin
  3. Cocaine
  4. Heroin
  5. Amphetamine

64 Sources referenced in other parts of this chapter.  
65 LBBD JSNA 2012
Chapter 3 Drug Policy

The next chapter sets out how the UK has attempted to deal with illegal drugs to date, contrasts this with global drug policy developments and suggests why the UK needs to think again about how we can achieve better outcomes.

National Drug Strategy

The UK policy paper, *Reducing Demand, Restricting Supply, Building Recovery: Supporting People to Live a Drug Free Life*[^66^], was published in December 2010 under the 2010 to 2015 Conservative and Liberal Democrat coalition government. This strategy is still current, however a refreshed version is due shortly.

The UK’s Drug Strategy 2010, Reducing Demand, Restricting Supply, Building Recovery addresses illicit drugs and has two overarching aims: i) to reduce illicit and other harmful drug use; and ii) to increase the number of people recovering from their dependence. These aims are addressed through three approaches: a) reduce demand, b) restrict supply, and c) building recovery in communities.

The UK Government is responsible for the strategy and its delivery in the devolved administrations only in matters where it has reserved power. Within the strategy, policies concerning health, education, housing and social care are confined to England, while those for policing and the criminal justice system cover both England and Wales.

A number of powers are devolved to Northern Ireland, Scotland, and Wales and each of these countries has its own strategy and action plans. Both the current Welsh strategy, Working Together to Reduce Harm: The Substance Misuse Strategy for Wales 2008-18 and Scotland’s strategy, The Road to Recovery: A New Approach to Tackling Scotland’s Drug Problem, were adopted in 2008. Northern Ireland’s policy, New Strategic Direction for Alcohol and Drugs Phase 2: 2011-16, was launched in 2011. Strategies in Northern Ireland and Wales address both illicit drugs and alcohol.

The current strategy has not been formally evaluated, but a framework for evaluating the UK’s strategy focused on costs and benefits was published in 2013.

In the UK, the Home Office has lead responsibility for the coordination of the delivery of the UK drug strategy on behalf of the government and chairs the Inter-Ministerial Group on Drugs. The Department of Health has lead responsibility for the 2012 Alcohol Strategy.

Public Expenditure

No budgets are allocated under the UK’s drug strategies. Budget allocations are provided annually to the entities in charge of providing services. Often, however, the majority of drug-related expenditure is not identified as such.

In 2010, total drug-related expenditure, including some indirect consequences of drug use, was around 8.4 billion euros and represented 0.5% of gross domestic product (GDP), with 64.9 % financing public order and safety, 22.5 % for social protection and 11.7 % for health.

National drug laws

The Misuse of Drugs Act 1971

The Misuse of Drugs Act 1971, with amendments, is the main law regulating drug control in the UK. It divides controlled substances into three classes (A, B and C), which provide a basis for attributing penalties for offences.

Offences under the Act include:
- Possession of a controlled drug unlawfully.
- Possession of a controlled drug with intent to supply it.
- Supplying or offering to supply a controlled drug (even where no charge is made for the drug).
- Allowing premises to occupy or manage to be used unlawfully for the purpose of producing or supplying controlled drugs.

The penalties for each offence are shown below:

<table>
<thead>
<tr>
<th>Offence</th>
<th>Court</th>
<th>Class A</th>
<th>Class B/Temporary Class</th>
<th>Class C</th>
</tr>
</thead>
<tbody>
<tr>
<td>Possession</td>
<td>Magistrates</td>
<td>6 months/£5,000 fine</td>
<td>3 months/£2,500 fine</td>
<td>3 months/£500 fine</td>
</tr>
<tr>
<td>Crown</td>
<td>7 years/unlimited fine</td>
<td>5 years/unlimited fine</td>
<td>2 years/unlimited fine</td>
<td></td>
</tr>
<tr>
<td>Supply</td>
<td>Magistrates</td>
<td>6 months/£5,000 fine</td>
<td>6 months/£5,000 fine</td>
<td>3 months/£2,000 fine</td>
</tr>
<tr>
<td>Crown</td>
<td>Life/unlimited fine</td>
<td>14 years/unlimited fine</td>
<td>14 years/unlimited fine</td>
<td></td>
</tr>
</tbody>
</table>

The Drug Trafficking Act 1994 defines drug trafficking as transporting or storing, importing or exporting, manufacturing or supplying drugs covered by the Misuse of Drugs Act 1971.

In addition, temporary class drug orders were introduced through the Police Reform and Social Responsibility Act 2011 to allow a faster legislative response to new psychoactive substances (NPS) supply offences.

For forty six years, the Misuse of Drugs Act 1971 has been the foundation for drug policy in the UK. The emergency of psychoactive substances during the past fifteen years has challenged the drug control system and raised questions about how best to protect the vulnerable from unknown and unsafe drugs. The current legal framework in itself has had a profound impact on the emergence of new psychoactive substances.

In 2016, the Psychoactive Substances Act criminalised the production, supply or possession with intent to supply of any

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69 http://www.legislation.gov.uk/ukpga/2016/2/contents
psychoactive substance knowing that it is to be used for its psychoactive effects.

Supply offences are aggravated by proximity to school, using a minor as a courier or being carried out in a custodial institution. Simple possession of NPS does not constitute an offence unless it takes place within a custodial institution.

**The Drugs Act 2005**

This Act came into force on 1st January 2006 and includes the following clauses:

- A reversal of the burden of proof in cases where suspects are found in possession of a quantity of drugs greater than that which would be required for personal use.
- Compulsory drug-testing of arrestees where police have “reasonable grounds” for believing that Class A drugs were involved in the commission of an offence.
- The inclusion of fresh Liberty Cap or “magic” mushrooms in Class A of the Misuse of Drugs Act. Before this Bill, only dried or prepared mushrooms were considered illegal.
- The Act has also linked drug legislation with measures to deal with Anti-Social Behaviour so that anyone given an Anti-Social Behaviour Order must undergo compulsory testing and drug treatment.

**Third Annual review of the 2010 drug strategy**

The third annual review of the 2010 drug strategy was published in 2015 and provided a progress update on implementation of the strategy, and included key priorities for the year ahead. According to the review:

- There has been a long term downward trend in drug use
- More people are recovering from their dependency
- The Police and Border Force continue to seize significant quantities of drugs off the streets and borders

**Reflections**

**National Drug Policy**

We must examine these 3 outcomes and ask ourselves whether they are the right ones for an effective drug policy. An effective drug policy should:

- Protect the young and vulnerable;
- Reduce crime;
- Improve health;
- Promote security;
- Provide good value for money;
- Protect human rights.

There are several problems with claiming that the welcome downward trend in drug use is, in itself, an indicator of the success of current policy.

Firstly, it is important to note that the Crime Survey for England and Wales does not cover some small groups such as the homeless and those living in prisons which are potentially important, given that they may have relatively high rates of drug use. It may also be impossible for any household survey to reach those problematic drug users whose lives are so busy or chaotic that they are hardly ever at home or don’t have a home. As a result of these possible limitations, the CSEW is likely to underestimate the overall use of drugs.

Secondly, levels of drug use are not the same as levels of total harm related to drug use, which

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71 http://www.homeoffice.gov.uk/publications/alcohol-drugs/drugs/annual-review-drug-strategy-2010/
72 Transform: Getting Drugs under control
is the more important indicator of success. The vast majority of people who use illicit drugs are causing harm by their drug use. Given this, it could well be the case that if harm related to individual use is increasing then reductions in levels of drug use don’t necessarily lead to reductions in the overall harm caused by drugs, and a thorough assessment of this would be required.

It fails to recognise the complexity of the drug market, and gives insufficient regard to the harms that current drug policy causes to individuals. Drug policies which criminalise people for possessing drugs for personal use generate higher levels of unemployment, homelessness, and undermine people’s health as it acts as a barrier to accessing treatment.

It is also imperative to note that we still have some of the highest levels of drug use in Europe, as well as some of the highest prevalence rates of high-risk users. According to the most recent figures reported to the EMCDAA:

- The UK had the highest rate of heroin use in Europe (out of 21 reporting countries)
- The UK had the highest rate of cocaine use in Europe (out of 26 reporting countries)
- The UK had the highest rate of ecstasy use in Europe (out of 25 reporting countries)
- The UK had the 4th highest rate of amphetamine use (out of 25 reporting countries)
- The UK had the 6th highest rate of cannabis use (out of 27 reporting countries)

Although fewer people are using drugs than 10 years ago, an increase in hospital admissions, infectious diseases, and drug-related deaths indicate that drug-related harms are continuing to increase. We have the third highest death rate in Europe, and in absolute terms about one in three deaths in Western Europe happen in the UK. This relates partly to the size of the at-risk populations in these countries.

Whilst the numbers of people in recovery is increasing, there is more that needs to be done. The evidence suggests that we have a small but growing number of vulnerable, older entrenched heroin users, with poor physical and mental health, indicating the need to improve all other integrated services such as housing, in order to enable such users to recover. And whilst 60% of all opioid users are in treatment in England—a figure which is one of the highest reported in Europe, the number of users continuing to use opiates/heroin after starting treatment is also increasing. This does not lend itself to reduced harm.

Despite all efforts to tackle the supply, and continuous seizures and major operations, drugs remain on our streets. Drug-related crime is increasing, and as a nation, we have failed in reducing the drug supply in prisons. The prison crisis is building up in the UK with overcrowding, increasing violence and suicides, and illicit drug taking. This is driven by the high number of people being imprisoned for drug-offences in England, compared to any other place in Western Europe, but also a lot of synthetic cannabinoid use. Despite prisons being the only place where possession of psychoactive substances is controlled and illegal, the number of people taking such drugs is high.

Paradoxically, we have seen that banning one substance can drive innovation in the drugs markets, creating even more harmful and dangerous substances. Locking up a dealer also results in another one, even more violent,
taking over, causing greater misery to communities.

Psychoactive Substances Act 2016

Despite helping officers close head-shops and disrupt the supply chain for ‘formerly ‘legal highs’, the new Psychoactive Substances legislation has also brought new challenges for policing. As was predicted, this action had the side effect of pushing the NPS market underground-prompting a serious intelligence gap. The Act is also believed to have led to an increase in the use of NPS and synthetic cannabinoids in certain communities, and they are now being sold in the same manner as Class A drugs. Although the Act banned the supply of NPS, it did not introduce any enforcement powers for possession of the substances. It also introduced new powers for conducting stop and searches for NPS than those contained under the Misuse of Drugs Act. The reclassification of synthetic cannabinoids such as spice, as Class B, clarified which NPS can be seized, but it has led to some officers seizing NPS under the Misuse of Drugs Act and vice versa.

Misuse of Drugs Act 1971

The aim of the 1971 Misuse of Drugs Act was to classify drugs based on the harms caused by each drug, and allow for classification changes, based on new evidence and knowledge. However, there is a reluctance for downgrading drugs, resulting in certain drugs such as ecstasy and cannabis to be inappropriately classified, despite them being less harmful. It is not evident that a drug’s legal classification has any effect on its level of availability or use, and the impact of classification changes is not monitored by the Government. The rationale of the current classification system is that more harmful drugs should carry greater penalties, thereby more strongly deterring use and supply. However, the Royal Society for Public Health ‘Taking a new line on drugs’ report indicates that in practice:

- Maximum penalties for both use and supply are very poorly correlated with the level of harm associated with illegal drugs.
- Harsher penalties for illegal drug use do not appear to deter use, a point supported by evidence from international comparisons.
- Only one in 10 UK adults say that a drug’s legal classification has any influence on how likely they are to use it.
- Penalising use is too blunt a tool to address the nuanced harm associated with substance misuse, and causes further harm to those who are criminalised.

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78 Royal Society for Public Health, 2016
82 Home Office International Comparators, 2014.
83 Survey of 2,090 UK adults carried out on behalf of RSPH by Populus, 12-14 February 2016.
The graph to the right, taken from the Science Select Committee, shows the level of harm and classification of each drug, suggesting that under the current classification framework, the classification of some drugs, and consequently the penalty, isn’t proportionate to the level of harm.

The next section seeks to provide a snapshot on international drug policy and briefly profiles some of the countries that have adopted alternative drug policies.

*Khat was reclassified to Cat C in 2014.*
International Drug Policy

Policy in the UK, and across the world, has been substantially driven by the UN Drug Conventions of 1961, 1971 and 1988 with little or no evidence at the time to indicate that these policies were evidence based and would make the world ‘drug free’.

The Global Commission on Drug Policy issued their 2011 report “War on Drugs”, urging the World to recognise that the war on drugs has failed, with devastating consequences for individuals and societies across the globe. Since then, a number of countries have explored and adopted alternative policies.

“As I have said before and I repeat, I believe that drugs have destroyed many lives, but wrong government policies have destroyed many more. A criminal record for a young person for a minor drug crime can be a far greater threat to their wellbeing than occasional drug use”

Kofi Annan, former UN Secretary General, Chairman of the Kofi Annan Foundation, member of the Global Commission on Drug Policy

Across the world, there has been an unprecedented wave of drug policy reforms.

Governments have realised the need for a more health-centred approach, from adoption of de facto decriminalisation by police, opioid substitution therapy, harm reduction interventions such as needle exchange and drug testing services, to the regulation of cannabis.

The map below indicates the legal status of cannabis around the world:

Source: [http://media.indiatimes.in/media/content/2015/05/26/wikimedia6_14308758801.jpg](http://media.indiatimes.in/media/content/2015/05/26/wikimedia6_14308758801.jpg)

UK drug laws lag behind the drug policies of a number of European countries, such as Spain, Estonia, Czech Republic and Portugal. These countries have decriminalised the possession of drugs for personal use. Others had never criminalised the possession of small quantities of drugs.

More than 90 countries – including the Netherlands, Canada, Switzerland, Uruguay, Spain, Australia and some US States – have adopted an approach to drug policy that specifically includes a focus on harm reduction84. Countries that have long subscribed to heavy enforcement and punishment for those caught using drugs are beginning to reconcile elements of harm reduction within their frameworks, or pioneering totally new frameworks, with encouraging results. These policies have come with positive outcomes and the evidence shows no significant increase in drug use in countries that have adopted non-punitive responses to drug use85.

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85 Eastwood, A quiet revolution
The UK Government has acknowledged this, stating in their 2014 UK Home Office, International Comparators Report\(^86\), which reviewed the drug policies of thirteen countries who took different approaches to tackling drug use, that the deterrent effect of criminalisation is negligible.

“Looking across different countries, there is no apparent correlation between the toughness of a country’s approach and the prevalence of adult drug use”.

The report concluded that drug use was influenced by factors ‘more complex and nuanced than legislation and enforcement alone’\(^87\).

The evidence from around the world is fairly conclusive. Wherever drug policy has been moved away from law enforcement, the positive outcomes have overwhelmingly outweighed the negative. The following section offers a snapshot of drug policies in practice around the world.

**Portugal**

In 2000, Portugal decriminalised the use of illicit drugs, and developed new policies on prevention, treatment, harm reduction and reintegration. Together with its decriminalisation legislation, lawmakers also refocused Portugal’s drug policies on a public health model, with significant financial investment from the State, and money was diverted from law enforcement to treatment and recovery\(^88\). Use is no longer a crime, but it is prohibited. Users are referred to ‘Commissions for Drug Addiction Dissuasion’ where they are given treatment. Portugal saved 18% in social costs over the first 10 years of decriminalisation\(^89\). In the last 15 years, they have witnessed significant declines in HIV transmission rates, increased numbers in treatment and have one of the lowest rates of drug-related deaths in Europe. They also saw reduced illicit drug use among adolescents, at least since 2003, reduced number of young problem drug users compared to neighbouring countries, reduced burden of drug offenders on the criminal justice system, reductions in the prevalence of injecting drug use, increases in the amounts of seized drugs, reductions in the retail prices of drugs, and increased efficiency of Police and Customs.

**Czech Republic**

Similarly to Portugal, possession of illicit drugs is still illegal, but possession for small quantities for personal use are treated as an ‘administrative offence’, punishable with a fine. The Home Office report found that worse health outcomes were observed when drug use was criminalised, and there was no evidence of reduced use.

A 2002 cost-benefit CJ analysis found that the penalisation of drug use had not affected the availability of illicit drugs; there was an increase in the levels of drug use within the country; and the social costs of illicit drug use increased significantly\(^90\).

**Uruguay**

In 2013, Uruguay became the first country in the world to legalise cannabis, despite its previous policy resulting in around 10% of the prison population being for small drug offences.

**Netherlands**

Whilst possession remains illegal, police and courts operate a policy of tolerance. The

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\(^{86}\) Home Office International Comparators, 2014  
\(^{87}\) Home Office International Comparators, 2014  
\(^{88}\) Eastwood, N 2012, A quiet revolution: drug decriminalisation policies in practice across the globe  
\(^{89}\) Drugs, crime and decriminalisation: Assessing the impact, 2014, Magson, J.  
\(^{90}\) Eastwood, N 2012, A quiet revolution: drug decriminalisation policies in practice across the globe
reported number of deaths related to the use of drugs is one of the lowest in Europe.

**Japan**

Japan operates the toughest drug laws in the developed world and has a zero-tolerance policy. Possession of even small amounts of what is known as cold and flu medication in the UK, is punishable by lengthy imprisonment. Few people seek treatment in Japan, and whilst drug use is low, the Home Office report couldn’t ascertain the link with harsher criminal sanctions, or a cultural opposition to drug use.

**USA**

24 states in the USA and the District of Columbia allow the use of medical cannabis on prescription. California introduced cannabis decriminalisation in 1976, and in the first six months of implementation, they saved $12.6 million in enforcement costs. In 2012, Washington State and Colorado legalised the recreational use of cannabis. Colorado as an example, since the regulation of cannabis, has benefited from a decrease in crime rates, a decrease in traffic fatalities, an increase in tax revenue and economic output from retail cannabis sales, and an increase in jobs.

**Denmark**

Similar to Germany and Switzerland, Denmark has opened supervised consumption rooms to allow serious addicts to consume and inject their drugs safely in a supervised environment, aimed at reducing the number of drug-related deaths. They have achieved this.

**Canada**

From January 2017, Canada became the first G7 country to legalise the use of medical cannabis became legal.

**China**

Drug possession for personal use is a minor administrative offence, but punishment can be harsh. The Government can also send drug addicts to compulsory detoxification centres.

**Philippines**

The Philippines still use the death penalty for low-level drug offences and carry out executions of suspected drug users and those involved in the trade.
Chapter 4 Pledge

Around the world, increasing numbers of policy-makers are assessing their current drug policies and considering the alternatives. We all have a role to play in ensuring that our policies are the most effective at protecting the vulnerable and achieving just and healthy policy outcomes. In this chapter, I set out my rationale and a set of proposals intended to reduce the harm caused by drugs, based on the analysis in the previous chapters. The time has come to review current drug policy in the UK, to ask questions of its effectiveness in reducing harm, and to see what measures we could take to deliver better outcomes.

Our current legislation has created an environment where the link between organised criminals and the most vulnerable is strong and almost freely exploitative. Despite all the efforts to reduce the supply and the demand, drug misuse continues, and we must ask: what can we do differently? If the aim is to stop people taking drugs, and stop people committing crime in order to fund their habit, we must follow the evidence and support people to recover rather than send them to prison.

Enforcement agencies, over time, have had pockets of success in seizing significant quantities of drugs, but this has not limited the long-term supply. This is largely due to the fact that the criminals have altered their supply routes and methods, and exploited changing technologies such as the dark web and postal services and it is now more common for suppliers to exploit the postal service by sending drugs more frequently in smaller quantities: no longer do we see over 100kg seizures of Class A drugs entering the UK.

As a former police officer, I have lost count on the number of large scale early morning raids that I have participated in. Yet, the simple truth is that these activities—which take months, sometimes years in the planning—do no more than disrupt the supply market for the very shortest of periods. The principal reason is supply, demand and profit. With steady demand from addicted people, dealers move into the market place.

And even if we do succeed in reducing the supply of drugs, the demand is still there. We must reduce demand.

What we need is a means of making the market in controlled drugs less lucrative. This requires a different approach; one that reduces demand for the product. Addicts should be treated and supported into recovery, removing them as consumers. Their entrapment in criminal justice is a waste of police time, a waste of public spend, does not help addicts to recover, provides a continued market to dealers, and dissuades addicts from revealing themselves for treatment for fear of the criminal consequences.

It is my view that our present approach to illicit drugs is increasingly unsustainable. Our policy should protect the young and vulnerable and reduce crime, it should improve health, promote security and safety, it must provide good value for money, and it needs to protect human rights. In working towards achieving these outcomes, we should:

1. **Hold a fundamental review of the Misuse of Drugs Act 1971, and of UK Drug Policy**

   The effectiveness of the Misuse of Drugs Act 1971 has never been formally evaluated, despite overwhelming indications of failure. I am calling for a fundamental review of the entirety of the Misuse of Drugs Act 1971, which takes into account the effectiveness of the current policy, evaluates governance arrangements, and results...
in a policy which is evidence-based and achieves better outcomes. The review should consider all international experiences in order to ascertain a more effective way forward.

It is important to challenge the assumption that a stronger response is necessarily a more effective response. Such evidence as there is on the impact of drug policy on prevalence, availability and harms points strongly to the ineffectiveness of the current drug strategy in these respects even though they have emphasised strongly enforcement and supply-side interventions in their statement and activities.

A royal commission or a similar body would be established to review currently controlled drug classifications, after wide consultation, include a review of national governance of drug policy and the respective roles of each key department.

A drugs strategy must reflect the reality that drugs are not just those substances that are currently illegal. They also include socially-embedded legal substances, such as alcohol and tobacco, used by the majority of people in the UK.

In the UK, there are significant signs that opinions are shifting on drug policy. A recent UKDPC poll on MPs found that 77% of MPs believe UK drug policies are not working\(^1\). A YouGov poll in 2011 found 53% of people rated existing policy towards illegal drugs ineffective\(^2\).

At least two thirds of politicians agreed that the process of making policy about illegal drugs should make more use of evidence and research than it currently does\(^3\).

2. **ensure that our approach is firmly based on evidence**

We must ensure that decisions are based upon the facts that confront us in order to ensure that money and time are better spent. Our approach must be evidence-based, in order to create cost-effective policies that could improve the lives of many people who are directly and indirectly affected by drug problems.

We should proceed incrementally, basing policy developments on what is shown to work positively to enable us to provide a safer society. Drug policy should be evidence-based and subject to evaluations. We need to capture much better evidence about the substances in question, the ills we’re trying to cure and the effectiveness or otherwise of the remedies applied. We must learn all we can in collaboration with other countries.

Our approach to crime prevention is based on targeting what the evidence suggests: reducing the number of heroin and crack users is likely to have the largest impact upon crime levels in volume terms\(^4\). The Government’s Advisory Council on the Misuse of Drugs (ACMD), made up of 20 leading drug

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\(^2\) Alice Moran (2011): The drugs policies don’t work: June 2011 Yougov website
\(^4\) Home Office Modern Crime Prevention Strategy, 2-16
experts appointed by the Home Secretary, has recommended decriminalising possession, Supervised Injectable Facilities and Heroin Assisted Treatment and we must consider what the experts suggest. The Durham force area is at the forefront of much of the evidence on Heroin-Assisted Treatment (HAT) as seen by early analysis revealing the effectiveness of the Darlington pilot RIOTT (Randomised Injectable Treatment Trial) project between 2006 and 2011. The UK pilot\textsuperscript{95} saw crimes per user fall by two-thirds. In the month before the scheme started, patients in the heroin injecting group reported carrying out 1,731 crimes in the 30 days prior to the start of the program. After six months, this fell to 547 - a reduction of more than two-thirds.

The current approach also limits scientific research about the possible medical uses of illicit substances and builds obstacles to the prescription of pain relief and palliative medication.

3. support fully funded effective education and prevention.

The provision of drugs education that is available to all young people must be in line with best practice. Prevention measures with a strong evidence base need to be promoted in schools and our community in order to build resilience and reduce the harm to young people. Adequate investment in prevention helps prevent today’s troubled young people becoming tomorrow’s dependent alcohol and drug users.

It is vitally important that we are able to provide our community, especially our young people, the appropriate tools and knowledge they need to enable them to make informed choices about all drugs, and reduce harm. Specific interventions also need to be targeted at those people who are at particularly high risk of drug misuse, for instance young offenders, children of substance misuse parents, and homeless people.

The role of the police is not just to tackle crime, but to prevent it from happening in the first place. We must work, in particular, with young people to ensure that they are prevented from making poor choices early on which then affect their futures.

The ACMD has previously warned ministers that many popular prevention techniques are ‘ineffective at changing behaviour’ and ‘may even increase the risks of drug use’ and called on officials to consider holding back funding programmes unless there is clear evidence that they work: “The ACMD regards evaluation an important part of any prevention project as international evidence suggests many popular types of prevention activity are ineffective at changing behaviour, and a small number may even increase the risks of drug use”\textsuperscript{96}. Targeting of information/education must be commensurate with the harm different drugs do to the individual or to society. The evidence-base on educational activities and preventive services must be considered.


\textsuperscript{96} ACMD, 2012.
4. **develop effective responses to reduce harm**

The current UK drug strategy based upon education, enforcement and supply reduction, has not been effective in reducing harm, and whilst I do not support that we abandon these principles, we need to nuance our approach. Policies should aim to minimise the social, psychological and physical harm to those who use drugs and to society at large.

The current strategy has been counterproductive, it has led to the creation of an illicit market, an increase in consumption of more harmful drugs due to pyramid selling, and the criminalisation and marginalisation of those who use drugs. Pyramid selling is similar to a pyramid scheme business model that recruits members via a promise of payments or services for enrolling others into the scheme. In the drugs market, the top person sells in bulk to people further down the chain, who then sell to others and so forth. Only the person at the top of the pyramid makes money, whilst others at the bottom become trapped in a vicious circle. They are often user-dealers who generally use more than they make in profit. But do it to get their fix cheaper. It criminalises those who do no harm to others and punishes those who are suffering, when they need treatment and social integration. Our approach to drug-taking should be increasingly to move away from criminal justice based solutions to health based solutions in order to reduce drug harm.

Drug policy discourse has tended to view legal and illegal drugs differently, when the evidence suggests that there are similarities in the harm they cause to health and wellbeing. Indeed in some cases certain illegal drugs may cause lower levels of harm than some legal substances. And it has left the public confused about drug harm, which could undermine efforts to encourage individuals to reduce the risks to their health and wellbeing. Alcohol causes significant harm to individuals and to communities and alcohol is the drug which causes most problems for the police service. Alcohol and tobacco use alone costs society more than all Class A drugs combined, and our policy priorities should reflect this.

A study called “Drug harms in the UK: a multi-criteria decision analysis” by David Nutt, Leslie King and Lawrence Phillips on behalf of the Independent Scientific Committee on Drugs, published in the Lancet medical journal in 2010, indicates that alcohol is the most harmful drug in Britain, to others, and the fourth most harmful to the individual, behind heroin, crack, and methamphetamine (crystal meth). The results from this study are indicated below:
5. **promote cost-effective drug treatment and recovery as a proven way to reduce crime and make communities safer.**

If the aim is to reduce demand and make our communities safer, we must encourage and support people to receive treatment and recover from their addiction. Reductions in substance misuse service budgets in the short term will only result in long-term costs for the health, social care, and Criminal Justice systems. A thorough review of the process for determining budgets for commissioning substance misuse services in England is required. We need to encourage people to seek treatment, but in doing so, we must also protect budgets for treatment services and increase the availability of treatment options.

Drug treatment has a significant impact on reducing drug-related offending and this crime reduction dividend is the rationale behind the need to invest in treatment. Home Office research\(^97\) estimated that 50% of the marked rise in crime that occurred in the 1980s and 1990s is attributable to the successive waves of heroin epidemics. It also attributed 30% of the reduction in crime since 2000 to the reduction of heroin addiction, and the increasing availability of treatment since 2001.

Public Health England (PHE) estimates that providing ready access to treatment for around 200,000 individuals (more than twice as many as in 2001) prevents 4.9m crimes each year\(^98\). The PHE Drugs Review, 2017, highlighted that with every £1 spent on treatment a £2.50 saving is recuperated on the social costs of drug misuse, making sound sense for local authorities to continue to invest in helping people to get into recovery.

Harm Reduction and treatment: getting users into treatment is key, as being in treatment itself reduces their offending\(^99\). The Modern Crime Prevention Strategy states that “Full recovery from dependence should be the aim of treatment and evidence suggests that recovery is more likely to be achieved and sustained if users are given support to improve their ‘recovery capital’—particularly around housing and meaningful employment\(^100\). For a small cohort of entrenched, long-term opiate users who have not achieved recovery through optimised oral substitution treatment, there is evidence that heroin assisted treatment reduces crime\(^101\).

In England, the National Treatment Outcome Research Study of community prescribing and residential treatment matched clinical data on 799 participants to the Home Office Offenders’ Index and reported on changes in criminal convictions in the year before treatment admission, and at one, two and five-year follow-up\(^102\). In the year before treatment, 34% of the

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sample group were convicted of one or more offences. Then at the time of each follow up, the percentage of the sample with one or more convictions was: one year (28%), two years (26%) and at five years, the conviction rate was approximately half that of the pre-treatment level (18%).

We must therefore remove barriers to accessing treatment. There are a number of reasons why the focus should be on treatment. It:

- makes communities safer
- reduces crime
- reduces drug litter
- stabilises troubled families
- protects public health
- prevents drug-related deaths
- restricts blood-borne viruses (HIV, HEPATITIS C)
- reduces the burden on the NHS
- helps drug users overcome addiction
- has public support: 75% think drug treatment is a sensible use of public money, 80% believe drug treatment makes society better and safer, 66% fear crime would increase without drug treatment\textsuperscript{103}.

6. protect the vulnerable by supporting alternatives to the criminalisation of people who use drugs and focus efforts on tackling organised crime

Alternatives to punishment, and the protection of vulnerable drug addicts- the victims of the organised crime groups- are the pathways to liberate both individuals and communities from the grip of organised crime. We must intervene at the earliest opportunity and provide credible alternatives to prosecution. By diverting them away from the Criminal Justice System we can improve their life chances, whilst focusing resources on tackling the organised crime groups-the real criminals making money and causing harm out of others’ misery.

Organised criminality exploits those who use these drugs; they engage in a range of criminal behaviour including violence, coercion and gun crime. At the same time, they make vast criminal profit.

Organised Crime Groups (OCGs) cause immense damage and undermine our ability to protect the most vulnerable. They create a sub-culture of crime confronted neighbourhoods. In some communities, they gain control of certain economic sectors or regions, acting as an ‘alternative government’. They instil fear and violence and take control of such communities. They shatter people’s lives, infiltrate businesses and corrupt societies. Through corruption, they infiltrate political, economic and social levels, threatening our national security. “In Central America, efforts by gang members to corrupt law enforcement personnel and members of the judiciary has resulted in the erosion of the rule of law and a reluctance by the judicial system to prosecute gang members”\textsuperscript{104}. The vulnerable people who they control are victims themselves. They are the men and women who are often traded as modern slaves and the children who

\textsuperscript{103} National Treatment Agency, 2012

\textsuperscript{104} Boulton, Michael, 2011: Living in a World of Violence: An Introduction to the Gang Phenomenon. UNHCR
are being sexually exploited and passed from abuser to abuser by organised gangs, for profit. These are the most vulnerable people in society who often succumb to abuse, rape and torture.

Any strategy that reduces their opportunities is welcome. As much as we lock up the individuals and gangs, they are replaced with the next generation of importers, traffickers and street dealers who continue the industry. Consequently, the activities of the gangs and the OCGs become more violent. An increase in competing OCGs is said to be influencing the criminal demand for and use of firearms\textsuperscript{105}. They blend criminality, violence and tactics associated with terrorism. Unfortunately, the children and the families of drug users often become the targets of such gang-related violence.

One of the key objectives in the Modern Crime Prevention Strategy is "to make it harder for criminals, particularly organised criminals, to benefit financially from their crimes". The crux of the strategy we are working towards should be to redefine the problem-individual drug addiction- as a health and community safety issue, not a criminal justice issue, whilst the police continue to target the organised criminals who seek to make a profit by shattering the lives of others. We must remain committed to restricting the supply of drugs and tackling the organised crime groups behind the drugs trade, widening the gap between the OCGs and the addicts.

There is a sufficiently strong case in the interests of protecting users and society, for decriminalising possession for personal use of all drugs, as has been for NPS. With decriminalisation we can distinguish between socially integrated consumers, who are using drugs recreationally and marginalised users, whose multiple problems include chronic drug dependence. Everyone who develops a drug problem should quickly be offered treatment and sustained support. Not only is this approach backed by evidence, but public opinion for this approach is also growing. 59% of Britons consider that people who use illegal drugs but have not committed any other crime should be treated as people who may need treatment and support\textsuperscript{106}.

The drug market is complex and consideration needs to be given to those low-level actors in the drug trade, including those engaged in the social supply of drugs, drug couriers, and cultivators of illicit crops. Individuals engage in the drug market for a number of reasons, and not all are inherently evil. Many engage in low level, non-violent trade and many do so out of economic desperation. The user-dealer often deals in order to support their problematic drug use and there is limited research to suggest that they might engage in this activity in order to avoid other criminal income streams such as acquisitive crime, or sex work. Drug couriers are often vulnerable and come from marginalised parts of society who are often manipulated into carrying larger amounts than agreed, in the

\textsuperscript{105}National Crime Agency: National Strategic Assessment of Serious and Organised Crime 2016.

\textsuperscript{106}Public Survey, 2011 https://yougov.co.uk/news/2011/06/16/drugs-policies-dont-work/
pursuit of greater profit, and other drugs, leaving the courier open to receiving a lengthier sentence if caught. In contrast, professional traffickers often carry less, since they understand the punishments that go with the weight of the drugs they are transporting.

Cultivators tend to act out of economic desperation. Effective alternatives to punishment for these groups, such as diversion schemes would mitigate the harms of unnecessary and disproportionate approaches as well as remove barriers to meaningful and sustainable development. OCGs often push their dangerous products onto the vulnerable, who often face threats of violence against their loved ones if they don’t comply. The Criminal Justice System rarely takes into account these factors when prosecuting low-level actors, who are vulnerable to facing severe punishment.

Durham Constabulary is at the forefront of evidence-based policing and we must follow the evidence and support initiatives which work. In 2014, Durham Constabulary introduced a diversion scheme called Checkpoint¹⁰⁷, which redirects low-level offenders away from the Criminal Justice System to community-based services. It is a culture changing initiative for the police and partners. It aims to provide a credible alternative to prosecution by intervening at the earliest opportunity to prevent someone from offending again. It offers a ‘contract to engage’ for the arrested person, based on the critical pathways of offending. Specialist navigators identify underlying lifestyle issues linked to offending and signpost them on to appropriate services. Failure to engage or complete the contract triggers the prosecution procedures to continue as they would normally do.

We should do much more to tackle the social pathologies that lead to drug abuse and address the causes of crime. Through ‘Checkpoint’, we aim to address the underlying causes of offending, by encouraging them to engage with services designed to address their problems instead of receiving a caution or going to court. There is evidence that brief interventions at early contact points in health, criminal justice and social care can help prevent escalation for those in the early stages of drug use, and we should continue to do so. A criminal record can have a detrimental effect on someone’s employment, housing and family life. They may lose their current job, face numerous barriers to moving on including access to colleges and universities, training, employment, housing, personal finance and travel¹⁰⁸. Research in the UK estimated that a criminal record for a cannabis offence reduces lifetime earnings by 19%¹⁰⁹. We all have a responsibility to remove the barriers to employment for ex-addicts and the diversion of drug users from the Criminal Justice System should be encouraged.

¹⁰⁷ https://www.durham.police.uk/Information-and-advice/Pages/Checkpoint.aspx
CONCLUSION

“Current drugs legislation is not working, but treating drug addiction as an illness could signpost the way to socially responsible policing”

Ron Hogg. Police, Crime and Victims’ Commissioner for Durham

All drugs are dangerous including prescription, and over-the-counter drugs, unless taken under medical guidance and supervision. Alcohol is a continuing problem, and yet the response to that is different.

We tell our children that if they take drugs it will ruin their lives and encourage them to desist. And yet if they seek help, they run the risk of criminalisation which will also ruin their lives. We must move away from the criminalisation of addicts, and focus on treatment and recovery. We should be focusing on the best way to minimise harm and help these people recover from their addiction. That way, we can improve their life chances, help them make a positive contribution to society, and cut off the income streams of the organised crime groups—the real criminals making money out of others’ misery.

The continuing description of drug addicts as criminals rather than people who are unhealthy or sick prevents them from getting well and consigns their family to years of misery and often destitution.

International organised crime has capitalised on drug trafficking to the point where the money generated is a key contributor to the GDP of some countries. It is the demand for drugs that has made trafficking so profitable. With a steady supply of addicted people, dealers move into the market place.

The prohibition of alcohol in America (1920-1933) resulted in alcohol becoming more dangerous to consume, crime increased and became “organised”, the Criminal Justice System was stretched to the breaking point, and corruption of public officials was widespread.

Drugs are a complex and evolving problem. In this report I have set out an ambitious journey for the next few years. My vision, and the ultimate goal of the journey, will be to contribute to a heathier and safer County Durham and Darlington, through better informed drug policy and action. Getting our approach right is crucial to tackling the crime and wider health and social harms and costs to society drugs cause. Our continued focus is to prevent and reduce crime, attack criminality and protect the vulnerable. We have to provide this against a backdrop of delivering value for money.

That’s my agenda for drug policy. If change was not too difficult for the Portuguese, the Swiss, and the New Zealanders, does it have to be too difficult for us? It’s time for a safer drug policy.
Appendix 1

Class A

3% of adults aged 16 to 59 had taken a Class A drug in the last year, equivalent to just under 1 million people. The North East rate was 2.8%. The consistent rates for Class A drug use make it hard to make the case that current drug policy has been effective at deterring people from using those drugs deemed to be the ‘most harmful’ under the current classification system.

6.6% of young adults aged 16 to 24 had taken a Class A drug in the last year, equating to 407,000 young people. The apparent fall compared with the 2014/15 CSEW (7.5%) was not statistically significant, but this trend has fallen significantly compared with a decade ago (8.4%) and 1996 (9.2%).

Cannabis

As in previous years, cannabis was the most commonly used drug, with 6.5% of adults aged 16 to 59 having used it in the last year (around 2.1 million people, 5.4% in the North East), similar to the 2014/15 survey (6.7%; see figure).

Among younger adults aged 16 to 24, cannabis was also the most commonly used drug, with 15.8% having used it in the last year (around 975,000 young adults). This was similar to the 2014/15 estimate (16.4%), but showed statistically significant falls compared with the 2005/06 survey (21.4%) and the 1996 survey year (25.8%). Similar to the trend for the wider age group, the trend in cannabis use among young adults has been relatively flat since the 2009/10 survey year, although showing more fluctuation.

Men aged 16-59 in England and Wales were more than twice as likely to report using cannabis in the last year than women (9.1% of men compared with 3.8% of women).

Powder cocaine

As in recent years, the next most commonly used drug in the last year (after cannabis) among adults aged 16 to 59 was powder cocaine (2.2% in the 2015/16 survey, equating to around 725,000 people, 2.3% in the North East). By contrast, powder cocaine is the third most commonly used drug among young adults aged 16 to 24 (4.4% or 274,000 young adults) after cannabis and ecstasy (see below). Both proportions have remained similar to the previous year (2.3% among 16 to 59 year olds and 4.8% among 16 to 24 year olds in the 2014/15 survey).

Ecstasy - The level of last year ecstasy use by adults aged 16 to 59 in the 2015/16 survey (1.5%, or 492,000 people, 1% in the North East) was similar to the previous year (1.7%), and to that seen in the 1996 survey year (also 1.7%). Generally, the proportion of 16 to 59 year olds using ecstasy in the last year has been relatively flat throughout the lifetime of the survey, fluctuating between 1 and 2 per cent since measurement began in 1996 (see figure).

In the 2015/16 survey, the proportion of 16 to 24 year olds reporting ecstasy use in the last year was 4.5%, equating to around 279,000 young adults. Estimates in the last 3 years have been higher, and last year ecstasy use among young people is similar to the level 10 years ago (4.3%).

Other drugs

There were statistically significant falls in the use of most drug types compared with a decade ago (2005/06 CSEW). There were also statistically significant changes between the 2014/15 and 2015/16 survey years for a number of drug types, outlined below.

LSD use fell, driven largely by a fall among young adults aged 16 to 24. The fall for 16 to 59 year olds was from 0.4% to 0.2%, the difference representing around 58,000 fewer people than last year. Use among 16 to 24 year olds halved, falling from 1.2% to 0.6%—a difference of 42,000 fewer people compared with last year.
Mephedrone use fell, driven largely by a fall among young adults aged 16 to 24. The fall for 16 to 59 year olds was from 0.5% to 0.3% (around 73,000 fewer people than the previous year). This was largely accounted for by a fall from 1.9% to 0.9% among 16 to 24 year olds – 60,000 fewer people than in the 2014/15 survey.

Ketamine use fell among 16 to 59 year olds, from 0.5% to 0.3%. The 2015/16 CSEW showed that around 94,000 adults had used ketamine in the last year.

Anabolic steroid use fell among 16 to 24 year olds. Steroid use among this age group fell from 0.5% to 0.1% of 16 to 24 year olds (equating to around 4,000 young adults who had used anabolic steroids in the last year).

Khat became a controlled Cat C substance on the 21st June 2014. The 2015/16 CSEW found that 0.06% of adults aged 16 to 59 had used khat in the last year; this equates to around 20,000 people. This is similar to the 0.05% per cent estimated in 2014/15, but a statistically significant fall compared with 0.2% in the previous two survey years. However, it should be noted that a household survey such as the CSEW may underestimate the use of substances such as khat is used particularly among emigrants and refugees from countries such as Somalia, Ethiopia and the Yemen.

Some New Psychoactive Substances (NPS) were previously legal to buy, but all are now illegal to supply under the Psychoactive Substances Act 2016, which came into effect on 26 May 2016. Robust data on the prevalence of NPS use in England is limited, as is evidence on long-term harms. There is increasing evidence that NPS are being used by increasingly diverse groups, many of who are from vulnerable groups, including the homeless and people with coexisting mental health problems. NPS have also been identified as a significant issue in some prisons and attributed to significant mental health and behavioural reactions among users.

Fewer than 1 in 100 (0.7%) of adults had used an NPS in the last year which is similar to the estimate from 2014/15. Men were significantly more likely to have used an NPS than women (1.1% compared with 0.4% of women). Overall, 2.7% of adults had used an NPS in their lifetime.

Around 1 in 40 (2.6%) young adults aged 16-24 in the last year had used an NPS which is similar to the estimate from 2014/15. Among men aged 16-24, 3.6% had used an NPS in the last year compared to 1.6% of young women.

Painkillers - The 2015/16 survey estimated that in the last year 7.5% of adults aged 16 to 59 had taken a prescription-only painkiller not prescribed to them: 7.4% (around 2.4 million adults) said that they had taken the painkillers purely for medical reasons, while a small proportion (0.2%, or 33,000 adults) said it was just for the feeling or experience it gave them. This tendency was also true for young adults aged 16 to 24.

Of the 16 to 59 year olds who had reported misuse of prescription-only painkillers, 15.3% reported having taken another drug in the last year, suggesting that those who misuse painkillers do not tend to use other drugs.
Appendix 2

Prevalence and treatment population in County Durham and Darlington

County Durham has an estimated prevalence of 2,155 dependent opiate (1,992) and crack users (545), with 1,076 injecting Opiate and Crack Users (OCU’s)\textsuperscript{110}. Around 68% of those are actively engaged in treatment services.

In 2015/16, there were 1483 opiate users in treatment, 360 non-opiates users, 281 alcohol and non-opiate users, and 1069 alcohol users\textsuperscript{111}.

<table>
<thead>
<tr>
<th>Substance</th>
<th>2014/15</th>
<th>2015/16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opiates</td>
<td>1456</td>
<td>1483</td>
</tr>
<tr>
<td>Non-Opiates</td>
<td>432</td>
<td>360</td>
</tr>
<tr>
<td>Alcohol and Non-Opiates</td>
<td>224</td>
<td>281</td>
</tr>
<tr>
<td>Alcohol</td>
<td>1201</td>
<td>1069</td>
</tr>
<tr>
<td>Young People</td>
<td>133</td>
<td>-</td>
</tr>
</tbody>
</table>

*Numbers in treatment and successful completions in County Durham 2015/16\textsuperscript{119}*

Darlington has an estimated prevalence of 635 opiate users\textsuperscript{112}, 1,357 cocaine powder users, 3,954 cannabis users, and 531 novel psychoactive substances users\textsuperscript{113}.

Local figures on prevalence and treatment show that the majority of opiates users in Darlington are known to the treatment system. This is supported by the proportion of people entering prison dependent on drugs, who are not known to community treatment, which is lower than the national average. However there are indications that there has been a slight increase in younger, treatment naïve, opiates users (aged 18+) accessing treatment-counter to the national trend\textsuperscript{114}.

The Crime Survey for England and Wales, and local police intelligence suggest that there are high levels of cocaine powder use, and cannabis use, which are not represented in the treatment system. It is likely that these individuals present for treatment in lower numbers because they do not self-identify as needing treatment and they do not impact on health, social care and criminal justice resources in the same way and so are not identified via these routes\textsuperscript{115}. Treatment data suggests that service users in Darlington are more likely to use amphetamines and more likely to inject than the national average.

<table>
<thead>
<tr>
<th>Substance</th>
<th>2014/15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opiates</td>
<td>481</td>
</tr>
<tr>
<td>Non-Opiates (nc. Alcohol)</td>
<td>96</td>
</tr>
<tr>
<td>Young People\textsuperscript{104}</td>
<td>123</td>
</tr>
</tbody>
</table>

*Number in treatment and successful completions in Darlington, 2014/15*

\textsuperscript{110} Public Health England, 2011/12
\textsuperscript{111} NDTMS, 2015/16
\textsuperscript{112} Public Health England, 2011-12
\textsuperscript{113} Public Health England, 2014-15
\textsuperscript{114} www.darlington.gov.uk/media/1187972/Section-4-Drug-and-Substance
\textsuperscript{115} www.darlington.gov.uk/media/1187972/Section-4-Drug-and-Substance
The table\textsuperscript{116} below shows that the successful completion levels for County Durham and Darlington follow below the England average. The percentage of people engaging successfully in treatment following release from prison is noticeably higher than the England average.

<table>
<thead>
<tr>
<th>Outcomes 2015</th>
<th>England</th>
<th>County Durham</th>
<th>Darlington</th>
</tr>
</thead>
<tbody>
<tr>
<td>Successful completion of drug treatment - opiate users (%)</td>
<td>6.7</td>
<td>5.4</td>
<td>5.3</td>
</tr>
<tr>
<td>Successful completion of drug treatment - non-opiate users (%)</td>
<td>37.3</td>
<td>29.2</td>
<td>25.7</td>
</tr>
<tr>
<td>Successful completions of drug treatment – alcohol users (%)</td>
<td>38.4</td>
<td>33.2</td>
<td>27.5</td>
</tr>
<tr>
<td>Adults with a substance misuse treatment need who successfully engage in community-based structured treatment following release from prison (%) 2015-16</td>
<td>30.3</td>
<td>42.6</td>
<td>34.8</td>
</tr>
</tbody>
</table>

The recent findings from the What about YOUth? Survey 2014 show that 10.7% of 15 year olds had tried cannabis, and 2.5% had tried any other drug. This compares to 11.5%, and 10.7% for County Durham, and 2.9% and 1.5% for Darlington, respectively.

\textsuperscript{116}Public Health Outcomes Framework, 2015
Appendix 3


<table>
<thead>
<tr>
<th>Type of police action</th>
<th>Constable hours*</th>
<th>Sergeant hours*</th>
<th>Inspector hours*</th>
<th>Total cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arrest leading to caution</td>
<td>8</td>
<td>2</td>
<td>0</td>
<td>£282</td>
</tr>
<tr>
<td>Arrest leading to court</td>
<td>12</td>
<td>4</td>
<td>0</td>
<td>£454</td>
</tr>
<tr>
<td>Supply offence</td>
<td>24</td>
<td>12</td>
<td>10</td>
<td>£1,464</td>
</tr>
<tr>
<td>Cannabis warning / Penalty Notice for Disorder</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>£54 cannabis warning, £0 PND (gross of fine income. On average 60% of fine income is recovered (Home Office)</td>
</tr>
</tbody>
</table>

*Cost

Constable: £27/hour
Sergeant: £33/hour
Inspector: £42/hour