# Addiction in the UK

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TAKING ACTION ADDICTION
A CAMPAIGN BY THE FORWARD TRUST

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## About The Forward Trust

The Forward Trust is a social justice charity. For over 35 years, we have helped people overcome addiction, move on from crime and transform their lives. Delivering over 80 services in prisons and communities across the UK, we support some of society's most disadvantaged people to rebuild relationships, find work, secure stable homes and rediscover a sense of purpose and belonging. We believe in the power of second chances, empowering people not only to achieve lasting recovery and change, but to go on to strengthen their communities and inspire others to do the same.

## About Crest Advisory

We are crime and justice specialists - equal parts research, strategy and communication. From police forces to public inquiries, from tech companies to devolved authorities, we believe all these organisations (and more) have their own part to play in building a safer, more secure society. As the UK's only consultancy with this focus, we are as much of a blend as the crime and justice sector itself.



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# Foreword

**It is my pleasure and privilege to present this first edition of 'Addiction in the UK'. As Chair of The Forward Trust, I am immensely proud of all that the charity does to help some of the most marginalised people in our society who are struggling with addiction.**

We also see it as our duty to raise public and policy awareness of addiction, the impact it has on individuals and communities, and people's capacity for recovery. We do that through our 'Taking Action on Addiction' campaign.

I speak from experience. For most of my career as a professional footballer, I was addicted to alcohol. In 1996, following an almighty binge that started with England's elimination from our home European Championships, I somehow found the determination, inspiration and support to get and stay sober. I haven't touched alcohol in the last 30 years. I have lost many good people to alcohol and drugs, and I have had the privilege to witness and help thousands more to find recovery.

This report aims to inform the national conversation on addiction – it collates data and analysis of the levels of addiction in our society, the associated harms, and our experience so far with policies and programmes introduced in response.

This first edition focuses on addiction to alcohol and illegal drugs, but we are aware that there are other ways that addiction affects individuals and communities: addiction to prescription drugs, or behavioural addictions - to sex, shopping or gambling. Gambling addiction in particular is widespread and increasing in the UK, so we plan to cover this subject in more detail in the second report in this series.

Please use the material in this report to support your own conversations – with friends and family, in the workplace, and in local and national policy discussions. As our Patron HRH Princess of Wales said in support of our 'Taking Action on Addiction' campaign.

*"Please join the conversation. By talking about it in the open, together we can bring addiction and the harm it causes out of the shadows. We can reframe this issue with kindness and understanding, and we can help individuals and families coping with addiction know they are not alone."*

**Tony Adams MBE,**
**Chair of The Forward Trust**

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**takingactiononaddiction.org.uk**

# Executive summary

**Forward Trust and Crest Advisory have worked together to identify and analyse key evidence and draw together findings which reflect addiction in the UK. Our analysts have assembled research data, pored through government reports, and conducted further analysis, to bring you this publication.**

This report is the first in a series looking at how addiction affects families and communities in the United Kingdom. This report focuses only on alcohol and illegal drugs but the hope is that future reports will include behaviours such as gambling.

### Prevalence estimates

Although well-established as an internationally accepted mental health condition, there is still much debate over the terminology, and definition, of addiction. Partly because of this diversity of definition, there is no precise data on the number of UK citizens currently struggling with addiction, or who are in recovery from addiction. But we have assembled the following best estimates from surveys and official reports:

**Estimated number of UK citizens addicted to alcohol –**
**750,000** [1]

**Estimated number of UK citizens addicted to illegal drugs –**
**400,000** [2]

**Estimated number of UK citizens addicted to gambling –**
**275,000** [3]

**Estimated number of UK citizens in recovery from addiction – around –**
**700,000** [4]

Use of alcohol is widespread and culturally embedded in UK society – nearly half of adults drink at least weekly, and almost a fifth drink above the NHS safe guidelines (Drinkaware, 2025). Use of illegal drugs, while less prevalent, is still widespread – with 8.7% reporting use in the last year (likely to be an underestimate due to survey methodology). (ONS, 2025a). Meanwhile, the Office for Health Improvement and Disparities (OHID) estimate that around 24.5 million people in the UK gambled in 2018 and 0.5% of the population could be experiencing problem gambling (OHID, 2023).

In terms of international comparisons, the UK has a higher overall consumption of alcohol than most other comparable countries but is not a significant outlier. For illegal drug use, the UK has a prevalence rate of 8.7% (use in the last year), compared with a global average of 6% (ONS, 2025a, UNODC, 2025).

Most people who use alcohol or drugs, or engage in gambling, do not do so in a compulsive or addictive way, but a significant minority do progress to addictive and harmful behaviour. Opinion polls conducted on behalf of The Forward Trust for Addiction Awareness Weeks in 2024 and 2025 showed a surprising

[1] (estimated based on 608,000 adults estimated to be alcohol dependent in England in 2019/2020 (OHID, 2017) and UK population estimates)
[2] (estimated based on 310,718 people using heroin or crack in England 2022/23 (OHID, 2025a) and UK population estimates)
[3] (estimated based on OHID, 2023 and UK population estimates)
[4] (estimated based on treatment since number leaving treatment in England and not returning and UK population estimates)



but consistent result – over 10% of a representative sample of all adults claimed to be currently or previously struggling with an addiction – that would equate to around 5.5 million people across the whole population.

### Harms linked to addiction

Alcohol and drug related deaths are rising to their highest level on record – with 10,000 UK citizens dying of alcohol related causes (ONS, 2025b), and around 7,000 dying of drug related causes, in the last year for which figures are available (ONS, 2025c, NRS, 2025, NISRA, 2026). These are premature and preventable deaths that should receive more attention in public health strategies.

Harms linked to addiction are widespread:

- Over 50% of people defined as homeless report the use of illegal drugs. And over 50% report alcohol addiction. Drug and alcohol problems are both a cause and effect of homelessness (ACMD, 2019).
- Around 40% of all those people entering treatment for drug or alcohol addiction had committed crimes related to their addiction, and one study has shown that 60% of men in treatment had been perpetrators of domestic violence at some point (Hayhurst et al, 2013, O'Farrell et al, 2004).
- Although the definition of 'drug related homicide' is very broad, police figures show that, in 2021/22, around half of all homicides (360 in total) met that definition (NAO, 2023).
- Between 50% and 60% of people in treatment (figures vary from different parts of the UK) are unemployed or on long term sickness benefits (OHID, 2025b, Public Health Scotland, 2026), Northern Ireland Department of Health, 2025).
- Somewhere between 250,000 and 400,000 children in the UK are living with a parent who is struggling with a drug addiction (ACMD, 2003).

There are costs linked to the harms caused by addiction. For example, alcohol addiction is estimated to cost the UK taxpayer £21 billion per year, while illegal drug addiction is estimated to cost £20 billion per year. There is clearly a significant fiscal benefit to preventing or treating these problems (Home Office, 2020, PHE, 2016)

### Addressing addiction

The report traces the recent history of policy responses to concerns around addiction in the four countries of the UK – the contents of national strategies, the funding provided and how it has been spent, and the experience of what works, what doesn't work, and what is promising.

The report also discusses some of the progress achieved - and challenges remaining - in tackling addiction, and supporting the individuals, families and communities involved. While it is clear that rates of addiction in society remain high, the UK has much better professional and peer support systems to protect the health of people with addiction and help them move towards recovery. Each country of the UK has a national strategy that aims to limit the health, crime and social harm of alcohol and drug markets. Supply reduction and prevention efforts – very different for alcohol, or for illegal drugs - have yet to have a significant impact. But there are promising signs of reductions in overall users, and volume of use, amongst younger people.

## Areas for action

Our report concludes by suggesting some areas of activity for government departments, local authorities, and charities – that we think could reduce the impact of addiction, and better support those struggling with it. We encourage you to use this information, and these suggestions, to inform your own discussions around addiction.

- **Give renewed political leadership to the urgent challenge of reducing the number of drug and alcohol related deaths.** The fact that, every year, around 17,000 citizens die early and preventable deaths, should be a national scandal that receives much more policy and strategic attention.
- **Maintain reliable funding for the drug and alcohol treatment and recovery services in every area of the country** - so that anyone in need of help can get access to free and professional advice, practical support to stay alive and healthy, confidence and motivation to believe in change, and pathways and programme to break the cycle of addiction and find recovery.
- **Make it easier to get access to recovery programmes** – in residential, non-residential or prison settings, for people living with addiction and their loved ones. Currently, access to this support is slow, opaque, and restricted by inefficient funding and assessment mechanisms. When people are motivated to accept help, they should be able to get into treatment and recovery quickly.
- **Strengthen strategies to reduce the impact of addiction on crime and anti-social behaviour.** The mechanisms for identifying, motivating and treating addicted people in the criminal justice system have been hollowed out over the past 15 years, but can be quickly rebuilt with the right political and institutional commitment. The government's anti-social behaviour mission, and the 2026 Sentencing Act, will not achieve their objectives without determined action to improve prison treatment and recovery, and community treatment alternatives.
- **Boost efforts to limit accessibility of cheap alcohol.** Experiments with minimum unit pricing and higher taxation seem to be showing promising results, and these measures could be expanded as part of an explicit drive to reduce levels of binge or addicted patterns of drinking.

**17,000**

**The fact that, every year, around 17,000 citizens die early and preventable deaths, should be a national scandal that receives much more policy and strategic attention.**



- **Learn lessons from the development of drug and alcohol policy and grasp the opportunity provided by the Gambling Levy.** Starting in 2026, the government has the opportunity to build a new network of NHS, community and peer led services to tackle rising levels of gambling addiction. Over £100 million is being spent by government this year through a series of grant schemes, but the absence of a unified strategy behind these schemes runs the risk of undermining impact.
- **Target funding on programmes and interventions with greatest impact on priority outcomes**– reducing deaths, reducing crime, and increasing recovery. Currently the system prioritises processes such as compliance with guidance, number and speed of assessments, numbers in treatment– rather than real outcomes. This skews priorities and takes attention and resources away from a focus on impact.
- **Increase public visibility of support for people struggling with addiction** (and their families and loved ones), with a particular focus on showcasing stories of people who have successfully confronted and overcome their addiction, and signposting people to mutual aid and peer support such as that offered by the 12-step fellowships, SMART recovery, and local lived experience recovery organisations (LEROs).
- **Tackle the shame and stigma that prevent people from seeking help** by increasing public awareness of the nature and causes of addiction, and the possibilities and benefits of recovery. Forward's 'Taking Action on Addiction' campaign encourages openness about addiction and challenges society to replace stigma with understanding.

**Mike Trace,**
**CEO, The Forward Trust**

**The mechanisms for identifying, motivating and treating addicted people in the criminal justice system have been hollowed out over the past 15 years, but can be quickly rebuilt with the right political and institutional commitment.**

# 1. Introduction and context

## Purpose and scope

**This report brings together the latest research and data to identify what is known on this topic and where gaps remain in how best to tackle addiction.**

Forward Trust and Crest Advisory are collaborating on what we hope will become a regular publication. This first edition will cover the issue in three sections:

- What is known about the extent of addiction in the UK
- How addiction impacts a range of health and social challenges
- What successive governments have tried to do to reduce addiction, and treat those struggling with it

In the concluding section, we draw broad conclusions from evidence and experience so far, that we hope will help readers understand what we know about addiction in the UK, what progress has been made in addressing the real individual and social harms, and what further action is needed.

This report focuses on addiction to alcohol and illegal drugs. Our ambition is to explore other types of addiction in later reports, including gambling addiction, where evidence is new and rapidly emerging.




## Defining addiction

**Although commonly stigmatised as a moral failing or poor life choices or characterised as a disease that can be passed on genetically from parents to children, formal and authoritative definitions of addiction are contested and complex.**

The World Health Organisation's definition of 'disorders due to substance misuse or addictive behaviour' (WHO, ICD-11, 2022), provides a useful basis for understanding the complex causes and effects:

- **Biological:** withdrawal from psychoactive substances in those who have experienced neurological change and dependence as a result of prolonged alcohol or other drug use can include life-threatening heart problems and seizures, disrupted mood or consciousness, intense cravings, anxiety, depression, aches, cramps and pain, nausea and vomiting, irritability, insomnia, and disturbances to perception.
- **Psychological:** WHO describes an impaired ability to control addictive behaviours (including use of alcohol and drugs), prioritisation of addictive behaviours over other activities and experiences of strong compulsion and urges to engage in addictive behaviours as key characteristics of addiction. In addition, development of addiction is often linked to childhood experiences of neglect, abuse or trauma and frequently occurs alongside other mental health conditions. (And this corresponds with Forward Trust's own practical experience as a provider of treatment – we rarely see anyone presenting for help with addiction, whose problems do not have one of these root causes).
- **Social:** While anyone from any background can experience addiction, there is evidence that it is more prevalent amongst populations classed as deprived and people who are insecurely housed. Conversely, recovery from addiction is closely associated with positive family and social networks, safe and comfortable accommodation, meaningful employment or purpose, or the money to pay for life's essentials.

This evidence suggests that the causes of addiction are complex and inter-related. It can be helpful, therefore, to understand the condition of being addicted. For the WHO, addiction is 'an uncontrollable urge to consume a substance (alcohol or drugs) and a tendency to increase the dose, resulting in a psychological and sometimes physical dependency'. Similarly useful is the definition offered by the US National Institute on Drug Abuse (NIDA): 'Addiction is defined as a chronic, relapsing disorder characterized by compulsive drug seeking and use despite adverse consequences.' The key practical implication of these definitions is that when people are living with addiction, they will compulsively pursue their drug or behaviour of choice, even when the consequences for themselves or others are negative, even life-threatening.

One of the key themes of the Forward Trust's Taking Action on Addiction campaign is that recovery is possible for everyone and that, whatever their past or current challenges, everyone has the potential to live a positive, pro-social and fulfilling life. The term 'recovery' has also been subject to strongly contested definitions. While most official definitions of recovery talk in terms of achievement of personalised self-improvement goals (e.g. ACMD, 2013, see also definitions below), some (notably those involved in the 12-step fellowships) continue to understand recovery as abstinence from all use of psychoactive substances and compulsive behaviours (e.g. Alcoholics Anonymous, accessed 2026).

The emphasis on personal understanding of recovery has led some to criticise its imprecise definition: NIDA and the Substance Abuse and Mental Health Services Administration (SAMHSA) in the USA describe 'a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential'. For some, this concept of recovery as a process could encapsulate any activity – turning up to an appointment, attending a support group – that may not signify any real achievement of change. The UK Department of Health and Social Care uses the formulation 'Recovery is a personal, hopeful journey where individuals rebuild lives, find meaning, and live satisfying lives beyond illness, focusing on self-direction, building strengths (recovery capital), and achieving personal goals, not just symptom absence, but a holistic, empowered, and connected life.'

While these broad definitions are useful in avoiding value judgments on what is considered to be successful recovery, providers of treatment such as the Forward Trust need to assess the extent to which our services are helping people to find recovery, and we use all the three domains above in our own impact assessments. Meanwhile, from a government perspective, investment of public funds into recovery needs to be measured in terms of the reduction of harms to the individual or society – reductions in drug or alcohol related deaths, reductions in physical or mental health harms, reduction in crime, and increases in the numbers of previously addicted people who are in stable relationships, decent accommodation, and productive jobs or education.



# Methodology overview

**A systematic evidence review was conducted to identify relevant data and evidence pertaining to the scale and nature of addiction in the UK, its associated harms and policy response to addiction. All of the data and evidence referenced in this report is publicly available.**

Key research questions and relevant definitions were agreed. A search strategy was created which set out the sources to be searched, including the following search terms:

- Geographic terms
- Addiction-related terms
- Harm-related terms
- Treatment and recovery terms
- Measurement terms
- Policy and system terms

Forward Trust and Crest agreed inclusion and exclusion criteria to ensure evidence reviewed was most relevant to the project aims. UK evidence was prioritised. Where evidence from comparable countries, particularly European countries, was identified, it was included. An initial search was conducted and all relevant sources were collated.

A credibility scoring process was established to assess the strength and validity of each evidence source collated. Sources were scored based on credibility and prioritised accordingly. Analysis was conducted in two rounds. The first focused on analysing the content of evidence and data identified. In the second round, key findings identified in the first round were analysed thematically to identify key themes. Findings from the second round formed the basis of the report structure.

Across all chapters, data and evidence is drawn from varying geographies. Some data and evidence reflect the whole of the UK, other data and evidence is specific to England, Wales, Scotland or Northern Ireland. All nations report addiction-related data in different ways. This makes it difficult to make direct comparisons. Throughout the report, each data and evidence source has been labelled to explain which geographies, populations and time period they pertain to.

As similar and consistent data is not published by every nation within the UK, a patchwork approach to evidence has been followed. This means that the most pertinent available data and evidence is included to illustrate key points throughout the report. In some places, data from one nation only is referenced but in others, data and evidence from all four nations is provided. This approach intends to provide as comprehensive a picture of addiction in the UK as possible based on available data and evidence.

# 2. The scale of addiction in the UK

**In recent years, alcohol consumption has declined across the general population but the proportion of those seeking support for alcohol consumption has remained steady. Drug use has declined amongst younger cohorts but has increased amongst older cohorts (ONS, 2025a). Over the same period, there has been an increase in the number of people from all groups requiring treatment for all types of drugs and alcohol. There has been a marked increase in those in treatment for cannabis, powder cocaine and ketamine.**

Estimating the number of people in the UK with an addiction is challenging. Not everyone with an addiction seeks treatment or comes into contact with the criminal justice system. Self-reported survey data is likely to be compromised by the high levels of stigma associated with drug and alcohol use and reluctance to report use of illicit substances. So, while trend data indicate a decrease in the number of people using alcohol and drugs, and the overall proportion of people seeking support for addiction is rising, the number of people in UK drug and alcohol treatment only accounts for a tiny proportion of the overall UK population - less than 1% of the population in England and Northern Ireland - and may not accurately reflect the number of people affected by addiction or experiencing harm linked to alcohol or drug use. To give the most comprehensive and accurate estimate of the scale and nature of addiction as accurately as possible, this section analyses three data sets:

1) Data pertaining to those accessing treatment for their drug and/or alcohol use
2) Data pertaining to those hospitalised directly as a result of their drug and/or alcohol use
3) Data pertaining to deaths directly linked to drug and/or alcohol use

Reflecting on these datasets together, this chapter aims to present a comprehensive picture of those most impacted by addiction and problematic substance use. The next chapter will then consider the harms related to drug and/or alcohol addiction.

England, Scotland, Wales and Northern Ireland report most data relating to addiction independently. Some metrics are reported consistently by each country, but others vary. Where data is available only for some nations, it has been included. This means that the geographies across which the statistics are presented in the following sections vary between the UK, England, Wales, Scotland and Northern Ireland based on data availability.



## Alcohol consumption across the UK

### Frequency of drinking has remained consistent in the UK

Across the UK, nearly half of adults drink at least weekly – Drinkaware's annual UK representative 'Monitor' survey reported that 32% of respondents drank alcohol between one and three times per week and a further 14% drank four or more times per week in 2025, similar to findings in 2024 and 2023. Nearly a fifth of adults (18%) reported drinking between one and three times per month and a similar proportion (21%) report drinking less than monthly.

**How often adults in the UK drink alcohol**

| Year | Drink 4+times a week (%) | Drink 1-3 times a week (%) | Drink 1-3 times a month | Drink less often than monthly (%) | Never drink alcohol (%) |
|---|---|---|---|---|---|
| 2025 | 14 | 32 | 18 | 21 | 16 |
| 2024 | 13 | 33 | 17 | 21 | 15 |
| 2023 | 15 | 32 | 19 | 20 | 14 |

Source: Drinkaware, 2025

Frequency of drinking is broadly similar across England, Scotland, Wales and Northern Ireland. Between 2018 and 2025, there has been a 33.3% rise in the percentage of adults in the UK who never drink to 16% of all adults in 2025.

**How often adults across UK countries drink alcohol**

| Country | Drink 4+times a week (%) | Drink 1-3 times a week (%) | Less than weekly (%) | Never drink alcohol (%) |
|---|---|---|---|---|
| England | 14 | 32 | 38 | 16 |
| Northern Ireland | 8 | 32 | 43 | 17 |
| Scotland | 12 | 31 | 41 | 16 |
| Wales | 11 | 34 | 41 | 14 |

Source: Drinkaware, Scotland report, 2025

**Across the UK, nearly half of adults drink at least weekly**

## The volume of alcohol consumed has fallen

While frequency of drinking has remained consistent over the last three years, the volume of alcohol consumed on each occasion has fallen slightly. In 2025, 82% of individuals reported that they drink within healthy guidelines (Drinkaware, 2025), which was a 6.5% increase from 77% in 2018. Self-reported binge drinking has also fallen, from 15% of people reporting doing this at least weekly in 2018 to 11% in 2025. Meanwhile, those who report never binge drinking has increased from 36% to 41% in the same time.

18% of adults in England, 20% in Scotland, 16% in Wales and 17% in Northern Ireland report exceeding low risk drinking guidelines of 14 units a week. There is a slightly greater separation between the nations when considering the percentage of adults who drink seven or more units during a typical drinking day, with 13% reporting this in England and 17% in Wales compared with 20% in Scotland and 23% in Northern Ireland (Drinkaware, 2025).

Conversely, far from seeing a reduction in alcohol consumption, a Forward Trust commissioned IPSOS survey of 2,139 people in the UK found that 31% of the 235 people surveyed who had personal experience of addiction or dependency (to alcohol, drugs, medication or gambling) believed the volume of alcohol they consumed had increased since 2020 (Forward Trust and IPSOS, 2024).

## The majority of alcohol drinkers in the UK do not think their drinking is problematic

Drinkaware found that 88% of adults across the UK did not consider themselves a 'problem drinker' (89% in Scotland , 89% in Northern Ireland and 88% in Wales) (Drinkaware, Scotland, 2025; Drinkaware, Wales, 2025, Drinkaware, Northern Ireland, 2025). Although only 11% of UK adults were 'concerned' about their drinking, 40% thought they needed to make changes to their drinking habits.

Similarly, more than half of UK drinkers felt their drinking was 'fairly normal' (Drinkaware, 2025), even amongst those who reported drinking above the low risk drinking guidelines set by the Chief Medical Officer (DH, 2016).

Only 6% of UK drinkers had sought help or advice from a service or organisation about their own or someone else's drinking and 42% reported that they would not do so (Drinkaware, 2025). These findings raise questions about willingness to seek help and awareness of sources of support to mitigate potential harm caused by alcohol. This is why it is important for us to also consider the health implications of drinking, which is better illustrated through data pertaining to alcohol-related hospitalisations and deaths.

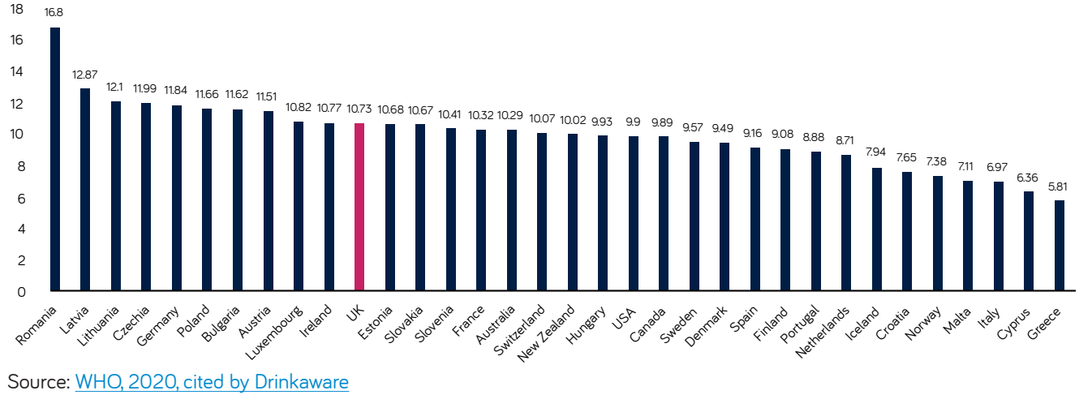

**Percentage of adults who reported drinking more than 14 units of alcohol a week**



## The UK consumes more alcohol than most comparable countries

In 2020, Drinkaware estimated that (pure) alcohol consumption per capita in the UK was 10.7 litres – which is a slight decline from 11 litres in 2010 (Drinkaware, accessed 2026). Consumption in the UK is higher than many other European countries but lower than others, including Romania, the European country with the highest recorded alcohol consumption in 2020 with 16.8 litres consumed per capita.

### Pure alcohol consumption by litre - global comparisons




Source: WHO, 2020, cited by Drinkaware

# Drug use across the UK

### Overall reported drug use has remained steady over the last decade, but has fallen amongst younger cohorts

Across the UK, between 6% and 8% of the population report using any drug in the last year. In England and Wales, 2.9 million people aged between 16 and 59 years reported having taken any drug in the 12 months to March 2025 (ONS, 2025a). This is equivalent to 8.7% of that population - only 0.1% higher compared with March 2015, suggesting drug use has broadly remained steady over the last decade. In Northern Ireland, the most recent data available covers the year to March 2015 – 8.9% of the population reported having taken any drug in the previous year (Department of Health Northern Ireland, 2017).

While those aged 16-24 are still more likely to have taken a drug in the last 12 months compared with older cohorts, there has been a downward trend in use amongst young people 16-24 years old. In 2025, 15.1% of those aged 16-24 had reported using any drugs in the previous 12 months. Since the peak in December 1997, where 32% of this age group had reported using a drug in the previous 12 months, the rate of use by this group has been declining steadily (ONS, 2025a).

**Across the UK, between 6% and 8% of the population report using any drug in the last year**

## Drug use in England and Wales is higher than the global average

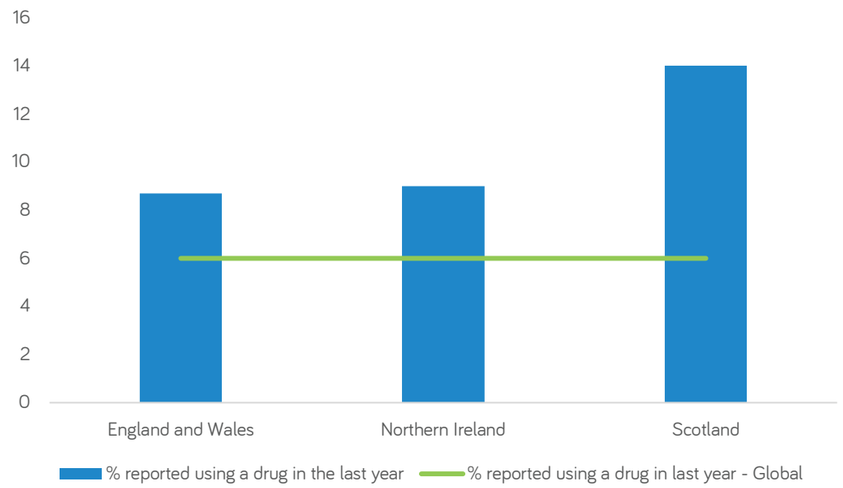
Drug use in England and Wales sits above the global average. In 2023, it was estimated that 316 million people reported having used a drug in the past year – equivalent to 6% of the global population aged between 15-64 (UNODC, 2025). At 8.7%, the percentage of the population using drugs in England and Wales is nearly 50% higher than the global average.

### Any drug use in past 12 months – UK and global prevalence (population survey data)

| | % population reporting any drug use in the past 12 months (reporting year) |
|---|---|
| England and Wales | 8.7% (2025 |
| Northern Ireland | 8.9% (2014/15) |
| Scotland | 14% (2023) |
| Global Average | 6% (2025) |

Sources: ONS, 2025, NI Department of Health, 2017, Scottish Public Health Observatory, 2023; UNODC, 2025

### Any drug use in past 12 months – UK and global prevalence (population survey data)




The UN reported an increase from 5.2% of the global population using drugs in 2013 to 6% in 2023 (UNODC, 2025). In contrast, over a similar time frame, drug use in England and Wales has remained steady.



## Cannabis and cocaine are the most commonly used illicit drugs in the UK

Across the UK, the most commonly reported drug used was cannabis. In Northern Ireland, 7.7% of people reported using cannabis in the last 12 months. In England and Wales, 6.5% of people aged 16-59 reported using cannabis in the last 12 months. This was higher amongst those aged 16-24, with 12.5% of people this age reporting using cannabis in the last 12 months (ONS, 2025a). After cannabis, the second most commonly used drug was powder cocaine. In fact, over the past decade, cocaine has consistently been the second-most-used drug in England and Wales (ONS, 2025a). In the year to March 2025, 2.1% of those aged 16-59 and 2.3% of those aged 16-24 reported using cocaine. Similar levels of use were reported in Northern Ireland, with 1.8% using it in the year to March 2015 (Department of Health Northern Ireland, 2017).

### Cannabis and powder cocaine use – UK and global prevalence (population survey data)

| | Cannabis | Powder cocaine |
|---|---|---|
| England and Wales | • 6.5% 16-59 year olds used in the last year (2025)<br>• 12.5% 16-24 year olds used in the last year (2025) | • 2.1% 16-59 year olds used in the last year (2025)<br>• 2.3% 16-24 year olds used in the last year (2025) |
| Northern Ireland | • 4.6% 15-64 year olds used in the last year (2014/15)<br>• 6.6% 15-34 year olds used in the last year (2014/15) (Belfast Health and Social Care Trust) | • 1.8% 15-64 year olds used in the last year (2014/15)<br>• 4.9% 15-34 year olds used in the last year (2014/15) (Belfast Health and Social Care Trust) |
| Scotland | • 9% adults (16+) used in the last year (2023)<br>• 21% 16-24 year olds used in the last year (2023) | • 3% adults (16+) used in the last year (2023)<br>• 6% 16-24 year olds used in the last year (2023) |
| Global | • 4.6% 16-54 year olds used in the last year (2025) | • 0.5% 16-54 year olds used in the last year (2025) |

Sources: ONS, 2025, NI Department of Health, 2017, Scottish Public Health Observatory, 2023; UNODC, 2025

Cannabis use had fallen from 6.5% of 16-24 year olds reporting use in the last 12 months compared with 16.4% a decade previously. Similarly, 2.3% of this age group had reported using powder cocaine in the last year in 2025, compared with 4.7% in 2015. A larger fall was reported for ecstasy – with 1.9% of those aged 16-24 reported taking ecstasy in the last 12 months compared with 5.3% of this group in 2015. The only drug where reported use had increased amongst the general population was ketamine. 0.8% of those aged 16-59 reported using ketamine in the year to March 2025, which was 0.3% higher compared to a decade before (ONS, 2025a).

Dame Carol Black's Review of Drugs (Home Office, 2020) concluded that the UK has the highest prevalence of cocaine use amongst people aged 15 and 34 in the EU – in fact, it is double the EU average. The report attributed this to cocaine being cheaper in the UK compared with most of the EU. A similar conclusion was drawn around MDMA for this age group, where use in the UK was found to be twice the EU average and the third highest in the EU overall. Interestingly, however, cannabis use in the UK was found to be lower than many EU countries and lower than the EU average (Home Office, 2020)

### The vast majority of those reporting drug use are infrequent users

In England and Wales, 71.8% of everyone aged between 16 and 59 who used drugs in the year to March 2025 were infrequent users, reporting using drugs either once a month, every couple of months or once or twice a year (ONS, 2025). This suggests that the vast majority of drug users in England and Wales do not meet the threshold we have set for living with an addiction. Only 2% of those aged 16-59 in England and 3.5% of those aged 16-24 in England reported 'frequent' or 'problematic' drug use. This is helpful in contextualising the size of the 'addiction' cohort that the remainder of this report will focus on.

## Adults in treatment for alcohol and drug use

### Less than 1% of the population were in treatment for alcohol and/or drug use

In the year ending March 2025, 329,646 people aged 18 and over in England were engaged with specialist drug and alcohol treatment – equivalent to 0.7% of the population.[5] This is the highest number of adults in treatment since reporting began and represents a 6% rise compared with the previous year (OHID, 2025b). In Northern Ireland, 3,889 people presented to treatment for drugs and/or alcohol in the year ending March 2025 (Department of Health Northern Ireland, 2025), equivalent to 0.2% of the population.[6]

By comparison, numbers of new presentations to treatment in Scotland, Wales and England suggest a mixed picture across the different nations of the UK. A total of 169,542 people started a new episode of treatment in England in the year ending March 2025 – 51% of all people in treatment. From the year ending March 2017 until the year ending March 2022, the number of people entering treatment for the first time was relatively stable. In the last three years, however, this figure has increased year on year (OHID, 2025b). Referrals in Wales have remained roughly steady in the last 10 years. There were 15,959 assessments completed by substance misuse services in Wales in 2023/24 – a decrease of 16.7% compared to five years earlier, where 19,157 assessments were made in 2019/20 (Public Health Wales, 2025). In Scotland, 16,507 people completed an initial assessment for specialist alcohol and drug treatment to the year ending March 2024 (ScotPHO, 2025), compared to 16,936 people in the previous year (Public Health Scotland, 2023). Trends in numbers of people receiving treatment are likely to reflect availability, ease of access and levels of funding, rather than an indication of overall prevalence of problem drug or alcohol use. In theory, as funding levels rise, support services are able to expand, increasing capacity to support greater numbers of people with treatment needs.

[5] Calculated using ONS, 2026

[6] Calculated using Northern Ireland Statistics and Research Agency, 2025



**Number of people in treatment/new presentations to treatment and (crude/unweighted) rate per population**

| | Total people in treatment between April 2024 and March 2025 | Rate per 100,000 population | New presentations to treatment between April 2024 and March 2025 | New presentations to treatment per 100,000 population |
|---|---|---|---|---|
| England | 329,646 | 709 | 169,542 | 16 |
| Scotland | Not available | Not available | 17,578 | 17 |
| Wales | Not available | Not available | 15,068 | 16 |
| Northern Ireland | Not available | Not available | 3,889 | 14 |

Sources: Office for Health Improvement and Disparities, 2026 - https://www.gov.uk/government/statistics/substance-misuse-treatment-for-adults-statistics-2024-to-2025, Public Health Scotland, 2026 - Drug and Alcohol Information System, Digital Health and Care Wales, 2026 - https://dhcw.nhs.wales/data/statistical-publications-data-products-and-open-data/drug-alcohol-usage/quarterly-reports1/ (sum of 'treatment started' Apr-Jun 2024, July-Sep 2024, Oct-Dec 2024 (provisional data) and Jan-Mar 2025 (provisional data), Department of Health, 2025 - Statistics from the Northern Ireland Substance Misuse Database 2024-25, Office for National Statistics, 2025 - Estimates of the population for the UK, England, Wales, Scotland, and Northern Ireland - Office for National Statistics

A crude comparison of new presentations to treatment across European nations also suggests disparity that may reflect variations in availability of funding for treatment provision, although some differences may be attributable to anomalies such as availability of reliable treatment data and differences in population structure and distribution.

### Number of people in treatment/new presentations to treatment and (crude/unweighted) rate per population

| Country | New presentations to treatment 2023 | New presentations per 100,000 population |
|---|---|---|
| Austria | 4,531 | 50 |
| Belgium | 13,979 | 119 |
| Bulgaria | 1,962 | 30 |
| Croatia (all in treatment) | 1,998 | 52 |
| Cyprus | 791 | 83 |
| Czechia | 7,283 | 67 |
| Denmark | 8,819 | 149 |
| Estonia | 441 | 32 |
| Finland | 376 | 7 |
| France | 6,3717 | 93 |
| Germany | 42,527 | 51 |
| Greece | 4,579 | 44 |
| Hungary | 4,091 | 43 |
| Ireland | 12,597 | 239 |
| Italy | 38,100 | 65 |
| Latvia | 453 | 24 |
| Lithuania | 457 | 16 |
| Luxembourg | 219 | 33 |
| Malta | 2,311 | 426 |
| Netherlands | 12,727 | 71 |
| Norway | 5,950 | 108 |
| Poland | 3,897 | 11 |
| Portugal | 3,621 | 34 |
| Romania | 3,377 | 18 |
| Slovakia | 2,558 | 47 |
| Slovenia | 209 | 10 |
| Spain | 45,853 | 95 |
| Sweden (all in treatment) | 37,106 | 353 |
| Türkiye | 11,022 | 13 |

Sources: EUDA Entrants to treatment - https://www.euda.europa.eu/data/stats2025/tdi_en#displayTable:TDI-0002
Eurostat data (population estimates) [demo_pjan] Population on 1 January by age and sex



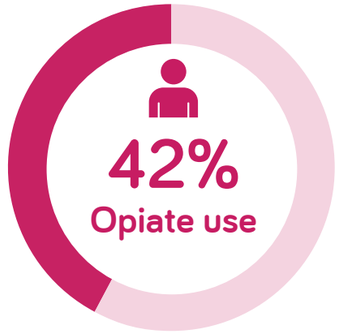
### People in treatment are most often seeking support for opiate use and alcohol

Across all four nations in the UK, opiates are the most commonly cited reason people require treatment support. In England 42% of adults in treatment cited problems with opiate use at assessment (OHID, 2025b). While people citing problematic opiate use currently account for the largest group in treatment in England, the proportion is decreasing – in 2024, they accounted for 48% of everyone in treatment. Similarly, in Wales, the number of treatment assessments in which opiates were recorded as the primary problematic substance decreased by 20.7% in 2023/24 compared with the previous year (Public Health Wales, 2025).

In England in the year ending March 2025, 8,445 individuals started treatment for crack cocaine use – 5% of all individuals starting treatment that year. In the same period, 23,954 individuals (14% of people starting treatment) started treatment for both opiates and crack cocaine. Compared to the previous year, the proportion of people who were using crack with opiates decreased from 15% to 14% but the proportion of those who are using crack without opiates increased from 4% to 5%. While nearly half of all adults in treatment said they had a problem with opiates, crack or both substances (46%), only 4% used crack without opiates (OHID, 2025b).

In England, the second largest group in treatment are those seeking help for alcohol use, accounting for nearly a third (30%) of the overall treatment population in the year to March 2025. While the number of people in this group has grown from 86,257 in the year ending March 2024 to 94,173 in the year ending March 2025, their proportion in the overall treatment population has remained relatively stable. In Wales, there was a slightly higher proportion of individuals in treatment primarily for alcohol, with 46.3% of the total treatment population in this group in the year ending March 2024 (Public Health Wales, 2025). More closely aligned to the proportion in England, in Northern Ireland, 38% of the treatment cohort in the year ending March 2025 were seeking treatment for alcohol use only (Department of Health, 2025).

By comparison, 13% of the treatment population in the year ending March 2025 in England were seeking support for non-opiate drugs only and a further 15% of the population required support for a combination of non-opiate drug and alcohol use.




**In England 42% of adults in treatment cited problems with opiate use at assessment**


**In England, the second largest group in treatment are those seeking help for alcohol use, accounting for nearly a third (30%)**

### A substantial proportion of the treatment population were there to address cannabis use

Cannabis use was widely cited by those in treatment in all UK regions. Similar proportions were reported in the English treatment population for the year ending March 2025, with 21% of the entire treatment population reporting problematic use of cannabis and 22% of first-time entrants to treatment. This was also the case in Northern Ireland, where nearly half (49.4%) of the treatment population reported taking cannabis (Northern Ireland Department of Health, 2025).

### There has been an increase in the number of people seeking treatment for cocaine use

A fifth (20%) of new entrants to treatment in England in the year to March 2025 started treatment for powder cocaine (OHID, 2025b). While this represents an increase on the year before (from 19%), it is the highest proportion of those entering treatment for powder cocaine since records began. Of the whole treatment population, 16% were seeking treatment for powder cocaine use. In Scotland cocaine was the most commonly reported main drug used by people starting specialist drug treatment (30%). For the first time, cocaine was more commonly reported than heroin (28%) ScotPHO, 2025. This data highlights that those accessing treatment for cocaine have increased substantially – in Northern Ireland cocaine was the second most commonly reported drug used by those in treatment, affecting 48.8% of this group (Northern Ireland Department of Health, 2025).

### Those seeking treatment for ketamine use are a small proportion of the overall treatment population but this cohort has increased considerably in recent years

Recent years have seen a steep increase in presentations to treatment for support with ketamine use. 5,365 individuals in England started ketamine treatment in the year ending March 2025. This is now more than 12 times higher than it was a decade ago and has been slowly increasing year on year recently, with a 2.3% increase between year ending March 2022 and 2023, and a further 3.2% increase to March 2024. Northern Ireland treatment services reported a 413% increase in the number of clients needing treatment for ketamine use between 2016-17 and 2024-25 (see data tables, Northern Ireland Department of Health 2025). In England, 58% of all those in treatment who cited problematic use of club drugs or psychoactive substances and 64% of new entrants reported a problem with ketamine.

**5,365**

**Individuals in England started ketamine treatment in the year ending March 2025**

**20%**

**A fifth (20%) of new entrants to treatment in England in the year to March 2025 started treatment for powder cocaine**



# Drug and alcohol harm indicators

**Deaths and hospitalisations associated with alcohol and drug use are useful indicators of levels of harm across the UK and provide insight into patterns of drug and alcohol use and public health impact.**

## *Deaths linked to alcohol and drugs*

### Alcohol-related deaths are the highest on record across the UK

Across the UK, there were 10,473 deaths from alcohol-specific causes[7] in 2023 – this is the highest number on record (ONS, 2025b). However, the rate of alcohol-specific deaths (15.9 per 100,000 people) has decreased slightly compared with the previous year (16.6 deaths per 100,000 people) (ONS, 2025b). Between 2001 and 2019, alcohol-specific death rates fluctuated between 10.6 and 11.8 deaths per 100,000 people, with a peak of 12.7 deaths per 100,000 people in 2008. Since 2019, there has been a sharp increase year-on-year to 16.6 deaths per 100,000 people in 2022 in the UK.

Scotland and Northern Ireland continued to report the highest rate of alcohol-specific deaths (22.6 and 18.5 deaths per 100,000 people, respectively, in 2023). This rate has remained steady in Scotland but decreased in Northern Ireland compared with the previous year. While the rate of alcohol-specific deaths in England and Wales – 15.0 and 17.7 deaths per 100,000 people, respectively – were lower in 2023, they have increased compared to the previous year (ONS, 2025b).

**10,473**

**Deaths from alcohol-specific causes across the UK in 2023.**

**16.6 deaths per 100,000**

**Since 2019, there has been a sharp increase year-on-year to 16.6 deaths per 100,000 people in 2022 in the UK.**

[7] Alcohol-specific deaths only include those health conditions where each death is a direct consequence of alcohol

## Drug deaths in England and Wales are also the highest on record but have slightly declined in Scotland and Northern Ireland

Deaths from drug poisoning registered in 2024 were the highest on record in England and Wales with 5,565 deaths related to drug poisoning – equivalent to 93.9 deaths per million people, around a 1% increase from a rate of 93.0 deaths per million people in the previous year (ONS, 2025c). In Wales alone, 417 deaths, 140.4 deaths per million, were related to drug poisoning, an increase from 129.2 deaths per million the previous year. The rate of drug poisoning deaths in England and Wales has increased every year since 2012 and is now more than double the rate recorded in 2012 (ONS, 2025c). Drug poisoning deaths registered in 2024 in England and Wales were the highest since records began in 1993.

In Scotland, in 2024, 1,017 drug misuse deaths were reported (ScotPHO, 2025). This was a 13% decrease on the previous year and the lowest figure registered since 2017. Following a peak in 2020, there has been an overall downwards trend in drug misuse deaths despite a slight increase in figures in the few years following COVID. The 2024 figures potentially indicate a return to a declining trend. Northern Ireland saw a peak in drug-related deaths in 2020 (218 deaths), an intervening downward trend and, in 2024, a new peak of 251 drug-related deaths were recorded (NISRA, 2026).

| | England & Wales | Scotland | Northern Ireland |
|---|---|---|---|
| **Drug poisoning/drug-related death** (includes deaths where the underlying cause is a mental or behavioural disorder related to drug use, accidental or intentional self-poisoning by drugs, poisoning by drugs through assault, or poisoning by drugs where intent was unclear. | 5,565 deaths registered in 2024 | 1,330 registered in 2023 | 251 deaths registered in 2024 |
| **Rate per population** | 9.39 deaths per 100,000 population | 25.1 deaths per 100,000 population | 13 deaths per 100,000 population (based on 3-year rolling calculation) |
| **Deaths from drug misuse** (a subset of drug poisoning/drug related deaths where either the underlying cause is drug dependence (mental or behavioural disorders linked to opioids, cannabinoids, sedatives or hypnotics, hallucinogens, or other psychoactive substances) or substances controlled under the Misuse of Drugs Act 1971 are involved). | 9,697 deaths registered 2022-2024 | 1,017 deaths registered in 2024 | 219 deaths registered in 2024 |
| **Rate per population** | 5.8 deaths per 100,000 population | 19.1 deaths per 100,000 population | 11.4 deaths per 100,000 population (based on 3-year rolling calculation) |

Sources: ONS,2020, NISRA, accessed 2026, NRS, 2025, ONS, 2025c, DHSC, accessed 2026, NISRA, 2026



## Drug-related deaths remain substantially higher compared with a decade ago

While there are varying trends around drug-related deaths in recent years in the UK, drug-related deaths remain substantially higher than they were a decade ago. In England, since 2012, the rate of drug-related deaths has increased every year. In 2024, the rate is now more than double the rate recorded in 2012, which was 46.5 deaths per million (ONS, 2025c). In Scotland, there were 19.1 drug misuse deaths per 100,000 people in 2024, which was 3.6 times as high as when records began (National Records of Scotland, 2025). Similarly, in Northern Ireland, drug-related deaths were 47% higher in 2023 than a decade ago (NISRA, 2025).

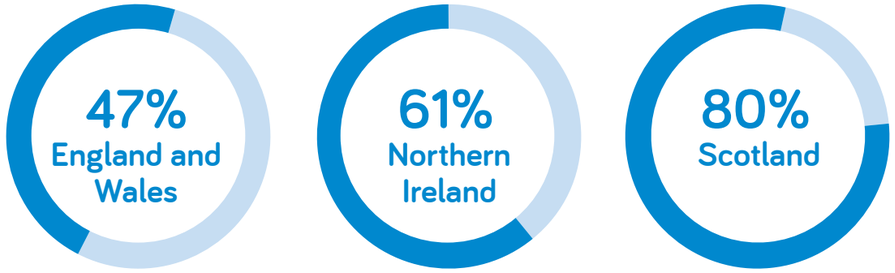
## Opiates were the most common drug-type involved in drug-related deaths

In England and Wales, just under half (47.1%) of drug-poisoning deaths registered in 2024 involved opiates (ONS, 2025c). This was higher in Northern Ireland at 61% – where opioids were the most commonly mentioned drug in drug-related deaths (based on data reported in NISRA, 2025) – and even higher in Scotland at 80% of all drug-related deaths (ScotPHO, 2025).

## While still a smaller proportion overall, an increasing number of drug-related deaths involved cocaine and benzodiazepines

Cocaine was a key substance mentioned in deaths in Northern Ireland that involved only one drug. While cocaine featured in only 5.9% of drug-related deaths overall, where only one drug was involved in a death, cocaine was noted in 35.7% of these deaths (NISRA, 2025). In Scotland, 47% of deaths involved cocaine, a total of 479 deaths which remained the highest cocaine-related deaths on record (ScotPHO, 2025).

Across the UK, drug deaths involving benzodiazepine had risen considerably. In England and Wales, this represented the second sharpest increase after cocaine. In Scotland, 56% of deaths involved benzodiazepines (ScotPHO, 2025).




**Percentage of opiate-related drug poisoning deaths**


**In Scotland, 47% of deaths involved cocaine, a total of 479 deaths which remained the highest cocaine-related deaths on record.**

## *Hospitalisations linked to alcohol and drugs*

### Alcohol-related hospital admissions have recently decreased in Scotland and Wales but slightly increased in England

Hospital admissions relating to alcohol have recently decreased in both Scotland and Wales. In the year ending March 2024, 8,147 unique individuals were admitted to hospital in Wales with an alcohol-specific condition – equivalent to 258 individuals per 100,000 population – and accounting for a total of 12,236 admissions (Public Health Wales, 2025). The number of unique individuals admitted for alcohol-specific conditions has decreased by 17.8% over the last 5 years (Public Health Wales, 2024). In the year ending March 2024, there were 7,426 admissions for alcohol-specific conditions in Northern Ireland (Angus, 2025). Given their population size relative to Wales, it looks like there is a roughly similar rate of admissions in Northern Ireland.[8]

In Scotland in the year ending March 2025, there were 29,430 hospital admissions for conditions wholly attributable to alcohol, involving 19,314 individuals. This is equivalent to 536.6 hospital admissions per 100,000 population — approximately 10% lower than the rate in 2023/24 at 594.3 admissions per 100,000 and 42% lower than the peak in the year ending March 2008, with a rate of 927.8 admissions per 100,000 (Public Health Scotland, accessed 2026).

However, in England, alcohol-specific hospital admissions have increased slightly. In the year ending March 2024, there were 339,916 alcohol-specific hospital admissions in England (OHID, 2025c).[9] This is 14.5% higher than when records began in 2016-17 but remains 2% less than the peak in the year ending March 2020, at 345,920 admissions. 280,747 individuals were admitted to hospital in the same year, where an alcohol-related condition was the primary diagnosis. This is 8% higher than when records began in 2016-17. Hospital admissions for this category peaked in the year ending March 2020 at approximately 280,180 admissions (NHS Digital, 2022). This fell to approximately 247,970 in the following year and has since increased year-on-year. The 280,747 admissions in the year ending March 2024 is 0.2% lower compared with the peak four years previously (Department of Health and Social Care (DHSC), 2024).

**29,430**

**Hospital admissions in Scotland for conditions wholly attributable to alcohol, involving 19,314 individuals.**

[8] Time trend data not available in comparable format

[9] Where the primary diagnosis or any of the secondary diagnoses are an alcohol-specific (wholly attributable) condition



### Drug-related hospital admissions have generally decreased across the UK but in the last year have slightly increased in Scotland

Across the UK, drug-related hospitalisations have also decreased in recent years. In the year ending March 2023, there were 9,690 admissions to hospital for poisoning by drug misuse in England. This is equivalent to 17.3 admissions per 100,000 population, a 24% decrease on the previous year, where there were 18,053 admissions. This is also 47% lower than the highest ever recorded number of admissions, which was in the year ending 2016 with 18,128 admissions (NHS Digital, 2023).

In Wales, over the same timeframe, there is a similar trend. In the year ending March 2023, there were 4,342 hospital admissions related to illicit drugs involving 3,445 unique individuals. The number of hospital admissions due to drug poisoning in Wales has decreased by 10.6% compared to the previous year. Since the year ending March 2019 there has been a 27.6% decrease in illicit drug admissions to hospital (Public Health Wales, 2024). This decreasing trend continued again in 2023/24, with 3,850 hospital admissions for poisoning by illicit drugs, affecting 3,077 (Public Health Wales, 2025). Interestingly, in the year ending March 2024, there were 607 individuals admitted to hospital where multiple drugs were recorded. This accounts for 19.7% of all individuals admitted to hospital for drug-related reasons. The number of admissions in which multiple drugs were recorded has declined by 20.7% since 2019/20 (Public Health Wales, 2025).

In Scotland, in the year ending March 2024, there were 11,136 drug-related hospital stays, equivalent to 212 stays per 100,000 population. This was 14% higher than the previous year, where there was a rate of 186 stays per 100,000 population but remains below the 2021/22 level which was 242 stays per 100,000 population (Public Health Scotland, 2025). This follows a similar trend to both England and Wales as set out above. While there is not comparable data in England or Wales for the year ending March 2024, it is interesting to note the upturn in Scottish hospital stays which were drug-related, particularly where drug-related deaths for the approximately equivalent period have decreased.

### As with drug-related deaths, opiates are the most common drug-type involved in drug-related hospital admissions

The most common illicit drug type involved in drug-related hospital admissions was opioids in Wales and Scotland. In Wales for the year ending March 2024, opioids continued to be the substance group related to the highest number of individuals admitted to hospital and the highest number of admissions for illicit drugs but the proportion of illicit drug-related hospitalisations involving opioids continues to fall. This impacted 1,124 individuals, a decrease of 17% compared with the previous year (Public Health Wales, 2025). In Scotland, opioids were also the most commonly cited drug in drug-related hospitalisations at a rate of 91 per 100,000 population. However, in contrast to Wales, this was a 9.6% increase on the previous year, where the rate had been 83 per 100,000 population. Despite this increase, the rate of opioid-related hospitalisations was 36.8% lower than the peak in 19/20, where the rate of hospitalisation was 144 per 100,000 (Public Health Scotland, 2025.)

### Similarly, drug-related hospitalisations are increasingly involving cocaine

This increase is also reflected in drug poisoning data. Drug poisonings in England and Wales involving cocaine have increased more sharply than any other drug – 2024 was the 13th consecutive year where deaths involving cocaine had increased. With 1,279 deaths involving cocaine registered in 2024, this is 14.4% higher than the previous year and 11 times higher than in 2011 (ONS, 2025c). Wales also reported the largest increase in hospitalisations as those admissions linked to cocaine overall. For the 2023/24 year, there were 356 individuals hospitalised linked to cocaine. This continues a five-year trend in which admissions have slightly decreased, remaining relatively stable overall. This follows the period between 2014/15 and 2019/20 where cocaine-related admissions more than doubled from 9.1 admissions per 100,000 population to 19.1 (Public Health Wales, 2025).

## Drug use in prison

### The level of drugs in prison has been classified as being at 'endemic levels' and is seeing an evolving threat of drones being used to deliver drugs

Demand for drugs amongst prisoners is much higher than the general population – 49% of prisoners had problems with drugs in 2021, compared to 3% who reported drug use in the general population in 2024/25 (Justice Committee, 2025, ONS, 2025a). The Chairman of the Justice Committee called on the government to make urgent reforms to end the 'endemic levels of drugs in our prisons' (Justice Committee, 2025). As well as more traditional entry routes for drugs into prison such as visits or post, 'throwovers' (i.e. throwing packages over the prison walls or fences), other prisoners and/or staff corruption there has been increasing use of drones being used to deliver drugs. There has been a 43% increase of drone incidents between April 2024 to March 2025 at prisons across England and Wales (MoJ and Lord Timpson, 2025). The Justice Committee are concerned that such incidents are reliant on staff sightings which the HMPPS recognise makes it difficult to understand the scale of the problem (HMPPS, 2025; Justice Committee, 2025). The Committee concluded that 'the system is failing, and the human cost is unacceptable' (Justice Committee, 2025).



### The human cost of drugs in prison can include overdoses and death

Investigating the 833 deaths in prison between December 2022 and December 2024, the Prisons and Probation Ombudsman found 16% (136) were classified as drug related (Prisons and Probation Ombudsman, 2025). Within 14 days of prison release, 61% (83) of the 137 post-release deaths have been classified as drug-related between September 2021 and December 2023 (Prisons and Probation Ombudsman, 2025). The Justice Committee describes the increasing use of synthetic cannabinoids and synthetic opioids by prisoners as particularly concerning (Justice Committee, 2025). New psychoactive substances were linked to over half (57%) of drug-related deaths in prisons between 2015 and 2021 (Duke and MacGregor, 2025). Notably, in a three-week period in 2024, HMP Parc recorded four drug-related deaths linked to synthetic opioid nitazenes (Prisons and Probation Ombudsman, 2024). Further, in the year ending March 2025, the Independent reported that 48 people had died after taking drugs in jails in England and Wales, based on data not in the public domain obtained from the Prisons and Probation Ombudsman (The Independent, 2026).

Increases in drug-related incidents such as overdoses and prisoners collapsing or having difficulty breathing are thought to be linked to new psychoactive substances such as 'Spice' (a synthetic cannabinoid) which is commonly found in prisons (Black, 2024; Justice Committee, 2025).

### Drug finds in prison continue to increase with psychoactive substances accounting for the largest increase of all drug types found in prisons in England and Wales

In the year ending March 2025, the number of incidents where drugs were found in prisons has reached the highest levels since the year ending March 2017 and has increased over the last two years (HMPPS, 2025). Class B drug types, such as cannabis and ketamine, accounted for most drug finds in prisons in the period. New psychoactive substances had the largest increase in finds in prisons in England and Wales with a 45% increase compared to the previous year.

### Prison culture normalises drug trade and use

The HM Chief Inspector of Prisons for England and Wales' (HMIP) 2024 survey found that 39% of adult male prisoners thought that accessing drugs in prison was 'easy' (HMIP, 2025). In 2021, nearly half of all prisoners (49%) in England and Wales reported having a pre-existing drug or alcohol problem when they arrived in prison (MoJ and DHSC, 2025). Normalisation of drug use, pre-existing addictions, boredom in the prisons with up to 22 hours in a cell, and pre-existing mental health and trauma contribute to high demand for drugs in prison (Justice Committee, 2025, HMIP, 2025). This number can be significantly higher in some prisons. For example, on some wings at HMP Ranby 38% of prisoners reported having developed a drug problem after entering prison (HMIP, 2025). A 2025 report from the Justice Committee suggested drug trade and use in prisons was normalised, making it 'almost impossible for prisoners to escape the problem or for prisons to deal with it' (Justice Committee, 2025).

**In 2021, nearly half of all prisoners (49%) in England and Wales reported having a pre-existing drug or alcohol problem when they arrived in prison**

### Drugs in prison negatively impacts on both prisoners' rehabilitation and staff

The presence of drug dealing and consumption in most prisons is a major factor in the increase in violence, intimidation and self-harm in prisons, and is a major inhibitor of any rehabilitation activity designed to reduce reoffending. The HM Chief Inspector of Prisons warned the 'overwhelming ingress of illegal drugs is destabilising prisons and preventing rehabilitation' (HMIP, 2025).

> *"I cannot overstate my concern about the rapid and widespread ingress of illicit drugs, which is severely impacting the essential work of staff in reducing the risk of prisoners' reoffending. Only when the prison service is able to keep drugs out of jails so that staff can focus on getting prisoners involved in genuinely purposeful activity, can we expect to see them play a meaningful role in rehabilitating, rather than simply warehousing, the men and women they hold."*
>
> **HM Inspectorate of Prisons press release published: July 8, 2025**

Staff needing to react and treat the physical effects of drug use in prisons has a knock-on effect as it results in restrictions to activities and time spent in cells (Justice Committee, 2025). This removes the opportunity for valuable rehabilitation programmes and heightens boredom which in turn increases the demand for drugs (Justice Committee, 2025). Additionally, the working environment becomes more challenging when dealing with unpredictable behaviour as a result of prisoner drug use as well as secondary drug exposure (Justice Committee, 2025).




# Characteristics of those experiencing addiction to alcohol and/or drugs

## *Age*

### A large proportion of those in treatment are aged between 30 and 50

Approximately half of those in treatment for alcohol and/or drugs are aged between 35-49. In England, this age group made up 47% of the treatment population (OHID, 2024) but in Scotland, this was slightly lower at 39% (Public Health Scotland, 2023).

### There has been an increase in older groups accessing treatment for alcohol and drug use

In England, 29% of those in treatment in the year ending March 2025 were aged 50 or older, compared with only 12% in 2010 (OHID, 2025b). In Northern Ireland, between 2016-17 and 2024-25 there has been a 22% and 29% decrease in those under the age of 18 and those aged 18-25, respectively, seeking support for drug use (Northern Ireland Department of Health, 2025). There has also been a decline in these age groups seeking support for alcohol over this period, by 49% and 23%, respectively (Northern Ireland Department of Health, 2025). In comparison, for those aged 26-39 years old and those aged 40 or over, there has been an 18% and 22% increase in those seeking drug treatment and, for alcohol treatment, a 20% rise and no change, respectively (Northern Ireland Department of Health, 2025).

This may be partially explained by an aging opiate user population. Across the European Union, the number of opioid users entering treatment has declined but the average age of those retained has increased, which is similar to the UK (ACMD, 2019). The number of individuals in England in treatment for primary opiate problems under the age of 30 declined substantially between 2007-08 and 2017-18, from around 55,000 to less than 13,000. By 2017-18, only 9% of treatment opiate users were under the age of 30. The proportion aged 40 or older has continued to increase. (ACMD, 2019)

Over time, opiate use only has decreased for all age groups. For those aged 15-24 and 25-34 the decrease is more substantial at 13% and 30%, respectively. While there was also a decrease for those aged 35-64, it was less at only 3% (Public Health England, 2023). When you look at the 'opiate and/or crack cocaine' user population, there is a decrease in use amongst younger groups (5% for those aged 15-24 and 12% for those 25-34) but an increase in 11% for those aged 35-64 (Public Health England, 2023). It is likely that this increase can be attributed to crack cocaine use. Between 2016-17 and 2019-20, use of crack only increased 15% for those aged 25-34 and 31% for those aged 35-64. While there has been an increase in younger cohorts, treatment workers were clear that most new crack users already had an established heroin habit and that it was rare for users to move from powder cocaine to crack cocaine (Public Health England and Home Office, 2019).

**29%** **In England, 29% of those in treatment in the year ending March 2025 were aged 50 or older, compared with only 12% in 2010.**

### Those seeking treatment for opiate use or alcohol consumption were generally older than those seeking treatment for non-opiate drug use

Across the UK, it was found that there is an age split in the type of substance individuals seek treatment for. Those seeking treatment for alcohol or opiate and crack use tend to be older compared with those seeking treatment for non-opiate drugs. To the year March 2023, only 5% of those in treatment for opiates only and 8% of those in treatment for alcohol only were under 30 in England (OHID, 2023).

This is particularly clear in the English treatment population data. In the year ending March 2024, the median age of the treatment population was 43 (OHID, 2024). This was similar in Scotland in the year ending March 2023, with a median age of 41 for those beginning treatment (Public Health Scotland, 2023). However, in England, the median age for those reporting problematic use of non-opiate drugs was considerably younger at 32 and for non-opiate drugs and alcohol consumption issues together was 36. The median age for opiate use was higher at 44 and even higher at 47 for just alcohol (OHID, 2024).

Similarly, in Northern Ireland, amongst those in treatment for drugs misuse only, 45.3% were aged 26-39. For those in treatment for drug and alcohol misuse, 43% were this age. However, those accessing services for alcohol misuse were older, with 72.8% 40 years old and over (Northern Ireland Department of Health, 2025). Comparable data is not available for Wales but their hospital admissions data suggests a similar picture. In Wales, 67% of all hospital admissions for alcohol-specific conditions were 50 years old or older. In contrast, only 29.8% of those admitted to hospital linked to illicit drug use were in that age group. 53.6% were aged between 25 and 49 years old (Public Health Wales, 2025).

5% under 30 - Opiates

8% under 30 - Alcohol

**To the year March 2023, only 5% of those in treatment for opiates only and 8% of those in treatment for alcohol only were under 30 in England.**

### All other drugs, however, were of greater concern for younger cohorts

Northern Ireland treatment services reported that cannabis, cocaine and ecstasy impacted for those aged 18-25 disproportionately compared with older age groups. 58% of this age group reported misusing cannabis (compared with 49.4% of the whole treatment population) and 51% cocaine (compared with 48.8% of the whole treatment population). Ketamine especially was 2.5 times as high at 10.2% (compared with 4.1% of the whole treatment population). Heroin was an exception – in Northern Ireland, heroin was nearly half as prevalent in the 18-25 cohort compared with the whole treatment population (Department of Health, 2025).

It is not only those aged 18 and above for whom alcohol and drug misuse is a problem. Wales reported a total 939 school exclusions on the grounds of alcohol or drug use in 2022-23, This is the highest number of school exclusions since 2011/12, which suggests misuse of drugs and alcohol has risen in this cohort (Public Health Wales, 2025).



## *Gender*

### Men account for the majority of those in treatment for drugs and/or alcohol use

Men make up approximately two thirds of the population in substance misuse treatment across the UK. In the year ending March 2025, 68% of those in treatment in England were men and 32% female (OHID, 2025b). In Scotland, for the year before, the proportion of men and women starting treatment was exactly the same (Public Health Scotland, 2023).

Amongst those in treatment for drug misuse only, 72% were male and 28% female in Northern Ireland in the year ending March 2025. This was similar in England in the same year. Those in treatment for opiates only were 73% male and 27% female and non-opiates 69% male and 31% female (OHID, 2025b).

### Women are increasingly represented in groups seeking treatment, particularly for alcohol

There is a slightly higher proportion of women in treatment for alcohol compared with all treatment groups. In England, of those in treatment for alcohol-specific concerns in the year ending March 2025, 60% were male and 40% female (OHID, 2025). In Northern Ireland, 66% were male and 34% female (Department of Health, 2025). Between 2016-17 and 2024-25, there was a 6% increase in women in treatment for alcohol. Over the same time period, there was a 3% decrease in men in treatment for alcohol (Department of Health, 2025).

Despite this, there has been little change in alcohol-specific death rates for males and females. In Scotland, the rate of alcohol-specific deaths for males was approximately double the rate of females at 29.6 and 13.1 deaths per 100,000 people, respectively (National Records of Scotland, 2025). This was similar across the whole of the UK in 2023, where alcohol-specific deaths for males were also around double the rate for females (21.9 and 10.3 deaths per 100,000 people, respectively) ONS, 2025b.

There is evidence that women are increasingly represented in drug treatment. Results from the most recent Adult Psychiatric Morbidity Survey found that amongst 25-34 year olds, men were twice as likely as women to self-report signs of dependence but amongst the 16-24 year old cohort, signs of drug dependence were similarly common in men and women. This is the first time that young men have not consistently shown higher levels of drug dependence (Wigmore, 2025). While this is the first time young women are showing as likely as men to have drug dependence, and the sample of 16-24 years olds was relatively small, it will be interesting to see if this trend continues going forward and is identified in Scotland, Wales or Northern Ireland.

Men: 68% | Women: 32%

**In the year ending March 2025, 68% of those in treatment for substance misuse in England were men and 32% female**

## *Ethnicity*

### More people in treatment in the UK identify as white compared with the general population

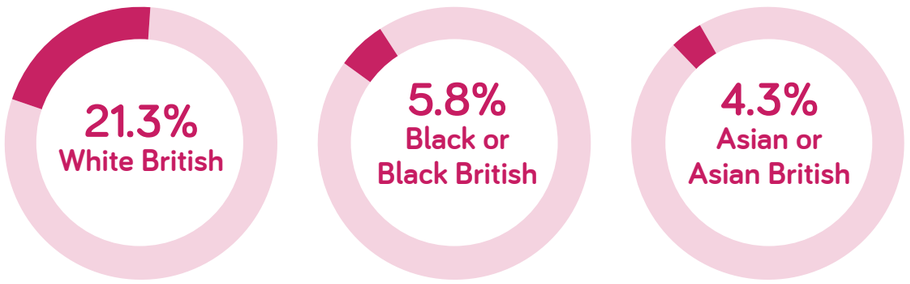
Across the UK, the vast majority of people in treatment identify as White British or White Other – 87% of the treatment population in England (OHID, 2025b) and 99% in Scotland[10] (Public Health Scotland, 2023). This is slightly higher than the proportion of the general people in England and Scotland who identify as white at 81.7% (ONS, 2022) and 96% (Scotland's Census, 2025), respectively.

Collective Voice (2023) have been clear that a limited presence of minority ethnic groups in treatment does not necessarily translate as a lack of substance misuse support required within these groups. Instead, they point to significant stigma within some ethnic minority groups around substance misuse and a reluctance to discuss drug and alcohol-related issues, which may prevent individuals from these ethnic minority groups seeking help. They also pointed to evidence which suggests some treatment services as failing to meet their needs or being delivered in a way which they felt was not culturally appropriate (Collective Voice, 2023).

### Alcohol consumption across ethnicities

Self-report survey data identified that White British adults were more likely to drink at levels classed as hazardous, harmful or dependent compared with adults from all other ethnic groups – in England, 21.3% of White British adults reported drinking at hazardous levels or above in the past year, compared with 5.8% of adults identifying as Black or Black British and 4.3% of adults identifying as Asian or Asian British (NHS England, 2025).

Alcohol consumption and ethnicity is collected in official surveys in Wales, Scotland and Northern Ireland but is not published due to small numbers. This means our understanding of prevalence is poor (Institute of Alcohol Studies, 2020). Available data does suggest that where ethnic minority groups had consumed lower levels of alcohol compared with White groups in the past, the gap has narrowed among younger generations.




**Percentage of adults who reported drinking at hazardous levels or above in the past year**

[10] 89% 'White Scottish' and '7% White Other British'



### Drug use amongst ethnic minority populations

The same NHS England self-report survey referenced in the section above identified signs of drug dependence in the year to March 2024 as highest amongst those who identified as 'mixed' race or having 'multiple' ethnicities, with 7.8% of this group showing signs of drug dependence. 6% of those identifying as 'White British' and 5.3% identifying as 'White Other' showed similar signs, with only 4.8% of those identifying as 'Black' or 'Black British' and 1.4% of those identifying as 'Asian' or 'Asian British' reporting similar signs. This is interesting to reflect on the treatment data above which suggests that those identifying as either 'White British' or 'White Other' are more likely to access treatment compared with other groups, despite those identifying as Black or Black British showing only a slightly smaller proportion of individuals with signs of drug dependency and those identifying as 'mixed' race or as having 'multiple' ethnicities reporting a higher proportion of dependency (NHS England, 2025).

There is a particular gap in understanding addiction across ethnic minority groups. This is particularly true where other aspects of identity overlap with ethnicity. Data is not consistently published so comparisons to recent treatment cohorts is not possible. It is clear however that there are concerns in the sector around evidence in this space but also access to treatment. This is something that warrants further analysis to understand more comprehensively the experience of those from ethnic minority backgrounds with addiction.

*"The needs of Punjabi and other new communities are neglected across the recovery modalities of medicine, therapy, residential rehabilitation, policy development and community services resulting in more significant obstacles to personal recovery for those of Punjabi heritage. The barriers to recovery are not just external to Punjabi communities but exist within them.*

*"Community attitudes and distortions prevent people from asking for help. Judgement separates us, and misunderstanding encourages silence. As a result of these community attitudes, families and individuals suffer in silence, struggle to find the support they need, and in some cases, never reach out for help."*

*"We can overcome these distortions through community conversations and positive examples of recovery. Understanding and compassion allow us to grow together."*

**Navraj Dhesi – founder, No More Pretending**

## *Sexual orientation*

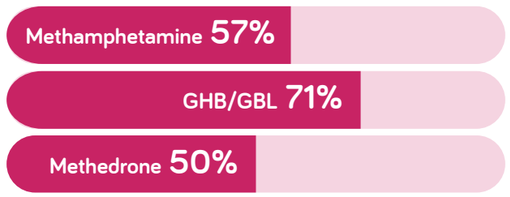
### While the majority of those in treatment for drugs and alcohol were heterosexual, this was in line with their proportion in the general population

The vast majority (89.5%) of those in treatment in England identified as heterosexual, only 3% identified as gay or lesbian and slightly less, at 2.7%, identified as bisexual (OHID, 2025b). Interestingly, the proportion of the treatment population identifying as heterosexual, gay, lesbian or bisexual is roughly proportionate to their relative share in the general population. The 2021 census found that 89.4% of people in England and Wales identified as heterosexual and 3.2% identified as either gay or lesbian or bisexual (ONS, 2023), suggesting that according to sexuality, the treatment population is largely proportionate to the general population.

### Individuals identifying as gay, lesbian or bisexual were more likely to seek support for non-opiate drug use and alcohol

Treatment data in England in the year ending March 2025 suggests that those identified as gay, lesbian or bisexual were more likely to be seeking support with non-opiate drug use or alcohol (OHID, 2025b). 8.1% of those seeking treatment for non-opiate drug use only and 7.1% of non-opiate drug use and alcohol identified as gay, lesbian or bisexual. Only 3.9% of those accessing support for opiate use identified as gay, lesbian or bisexual. The vast majority of those seeking treatment for non-opiate or alcohol use were heterosexual (OHID, 2025).

Across the male population who reported seeking treatment for methamphetamine, GHB/GBL[11] and mephedrone, the majority identified as gay, at 57%, 71% and 50%, respectively (OHID, 2025b). Most men who reported using ketamine, however, were heterosexual (85%), which reflects the treatment population more closely (OHID, 2025b).




**Across the male population who reported seeking treatment for methamphetamine, GHB/GBL[11] and mephedrone, the majority identified as gay, at 57%, 71% and 50%, respectively.**

[11] Gamma hydroxybutyrate and gamma butyrolactone. Both drugs are depressants, which can produce a high with small doses, and cause sedation with only slightly higher doses. People report that G makes them feel euphoric, with a loss of inhibitions, increased confidence, and a higher sex drive. (NHS Directory, accessed 2026)



### Individuals identifying as LGBTQ+ were more likely to binge drink

Drinkaware compared UK-wide self-report survey data between those who identified as LGBTQ+ and those who identified as cis-heterosexual adults. They found that, overall, both groups reported drinking the same frequency and level of alcohol overall (Drinkaware, 2024).

However, LGBTQ+ drinkers were more likely to binge drink. As a result, LGBTQ+ individuals were more likely to score positive for hazardous drinking both on the Alcohol Use Disorders Identification Test (AUDIT) and its short form version (Drinkaware, 2024). This was linked to higher alcohol-related harms being experienced by LGBTQ+ individuals, particularly from other's drinking behaviours. Drinkaware (2024) suggests this could be down to discrimination and stigma LGBTQ+ communities experience as well as their social networks including a higher proportion of hazardous drinkers, compared with heterosexual people, which may increase their exposure to hazardous drinkers, both in public and within their own social circles.

There were also different levels of hazardous drinking identified with the LGBTQ+ cohort. Men identifying as gay, bisexual or pansexual tended to be more frequent drinkers and likely to exceed the drinking guidelines compared to women who identified as lesbian, bisexual or pansexual, who drink less and less often. Despite this, bisexual and pansexual women experience significantly more negative impacts and harms from other's drinking, and as a result are more likely to experience poorer mental health and face barriers accessing alcohol support (Drinkaware, 2024).

*"Across the UK, a quiet crisis continues to unfold—one that is too often hidden behind stigma, isolation, and silence. Recent data from the Office for National Statistics showed that LGBTQ+ people are more than twice as likely to die from suicide and almost three times as likely to die from drug-related causes than their heterosexual peers. These are not abstract figures. They represent lives of friends, partners, and chosen family cut short, and communities left grieving."*

*"For too long, the scale of loss in our community has been under-recognised and under-addressed. While progress has been made in visibility and rights, many LGBTQ+ people continue to face deep-rooted challenges: loneliness, discrimination, internalised stigma, body image pressures, and a culture that can sometimes prioritise surface over substance. These factors, combined with gaps in culturally competent mental health and drug support services, contribute to a crisis that is both complex and preventable."*

**Marc Svensson, founder, You Are Loved and the 'Ask Bobby' directory**

## *Deprivation*

There is a correlation between deprivation and drug and alcohol addiction. Dame Carol Black (2020) identified a clear divide between drug addiction and harms in the North of England, where there is a greater concentration of deprived areas, compared with the South (MHCLG, 2025). Black identified the lowest drug-related harms as in the South East with the highest in the North West. Where there was particularly high harm in southern parts of England, she concluded that they were areas which were particularly affected by serious and multiple deprivation (Home Office, 2021). A similar pattern was identified by the National Records of Scotland, where people living in the most deprived areas of Scotland were 12 times more likely to die as a result of addiction to illicit drugs compared to people in the least deprived areas, while only twice as likely to die from other causes of death (NRS, 2024).

### Hospital admissions and deaths related to alcohol or drugs were much higher in deprived areas

In England, in the year ending March 2023, admissions to hospital for drug-related mental and behavioural disorders was eight times more likely in the most deprived areas (19.8%) compared with the least deprived areas (2.5%) (NHS England, 2024). Those in the most deprived areas were five times more likely to be hospitalised for poisoning by drug misuse (NHS England, 2024). In the most deprived areas of Scotland, people were 12 times as likely to have a drug misuse death compared to people in the least deprived areas (National Records of Scotland, 2025). This is particularly interesting, given that across all causes of death, people in the most deprived areas are only twice as likely to die as those in the least deprived areas. This was similar in Wales, with 6.4 times more patients admitted to hospital in relation to illicit drug use living in the most deprived areas compared with the least deprived (Public Health Wales, 2025).

Looking across England, Wales and Scotland, alcohol-specific deaths were more than three times higher for those living in the 20% most deprived areas compared with the least deprived 20% of areas (35.6 deaths per 100,000 compared with 10.0 deaths) (Health Foundation, 2025).

It is similar looking at alcohol-related hospital admissions. In England, in the year to March 2024, there were inequalities identified in alcohol admissions, with rates 1.5 to 2 times higher in the 10th most deprived lower tier local authorities compared with the 10th least deprived in England (OHID, 2025). In Wales, this was similar, with the proportion of all patients admitted for alcohol-specific conditions living in the most deprived areas was 2.8 times higher than those in the least deprived (Public Health Wales, 2025).

In Scotland, in the following year, individuals in the most deprived areas were more than six times more likely to be admitted to hospitals for conditions wholly attributable to alcohol compared with those in the least deprived areas (Public Health Scotland, 2024).

**People living in the most deprived areas of Scotland were 12 times more likely to die as a result of addiction to illicit drugs compared to people in the least deprived areas.**



### Those in deprived areas were more likely to report experiencing harm from alcohol and less likely to successfully complete treatment

This is interesting to consider because the Adult Psychiatric Morbidity Survey found in the year up to March 2024, 23.5% of adults living in the least deprived quartile of areas drank at a hazardous level or above, compared with 16.5% of adults in the most deprived areas (NHS England, 2025). Despite this, the survey also identified that those in the most deprived areas were no less likely to have a harmful or dependent level of alcohol use. This suggests that individuals may be at greater risk of experiencing alcohol harms linked to their socioeconomic status (see Puddephatt et al., 2021)[12] - the 'alcohol harm paradox'.

Deprivation is not only correlated with rates of addiction but also with treatment outcomes. Dame Carol Black (Home Office, 2021) identified lower rates of successful completion of treatment by opiate users correlate with higher levels of deprivation in England and Wales. In fact, the report highlighted how as the index of multiple deprivation rises, there is a gradual decline in the proportion of people successfully completing treatment.

*"….the most harmful patterns of substance misuse are strongly associated with other factors such as deprivation, trauma, adverse childhood experiences and mental ill health. The challenge that we have at the moment is that in our communities we are seeing all those issues increasing. We have had a generation of kids born in the middle of the 2000s who have never known anything but disruption in their lives, with the 2008 banking crash and the austerity for the last decade. All the infrastructure and support networks that were available to families, and particularly families from more disadvantaged backgrounds in those communities, have been eroded."*

**Alice Wiseman, Addictions Lead, The Association of Directors of Public Health (ADPH)**

**Public Accounts Committee. Oral evidence: Reducing the harm from illegal drugs, HC 72**

**Thursday 30 November 2023**

[12] This is also often associated with reporting poorer mental health. Those from lower socioeconomic groups often are more likely to report poor mental health, which may be connected to their alcohol consumption.

## *Disability*

In England, 41% of those who presented to treatment services for the first time reported having a disability. There was not a substantial variation in those with disabilities between the three main treatment cohorts: those seeking support for opiate use, non-opiate use or alcohol (OHID, 2025b). In Scotland in 2024/25, only 12% of those in treatment for drugs and/or alcohol use who provided disability information reported having a disability (Public Health Scotland, 2023), 30% reported no disability and 65% did not report whether they had a disability or not, making it difficult to compare between the two nations. Disability status is not published in Wales and Northern Ireland's treatment reports.

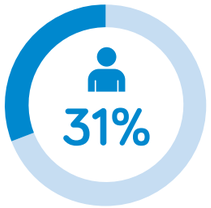
## *Employment*

### The majority of those in treatment were not in employment

In Scotland, just less than a third of those new to treatment for drugs and/or alcohol were in employment, education or training at 31%. Similarly, 28% of all people in treatment in Northern Ireland report being employed but 35% report having worked in the last 12 months. A further 6% were students or on a training scheme (Northern Ireland Department of Health, 2025). Interestingly, a larger proportion of the treatment cohort in Northern Ireland reported being unemployed compared to those presenting to treatment for the first time in Scotland (61% versus 43%).

There is mixed evidence around the relationship between addiction and employment. Evidence suggests that unemployment can create specific health risks, the impact of which can be exacerbated by alcohol misuse (PHE, 2016). A survey of 2,139 respondents aged 16 - 75 in the UK found 45% of those who had experienced addiction or dependency were in full-time employment, which suggests the slightest majority surveyed were either in part-time employment or unemployed (Forward Trust and IPSOS, 2024). Some evidence suggests that problematic drinking can escalate after people are made unemployed (PHE, 2016; Popovici and French, 2014). Harmful drinking can also be associated with higher prevalence of mental health issues, which, together, can make it difficult for those with alcohol dependence to find consistent employment (PHE, 2016).

Regardless of how addiction and unemployment are linked, for both drugs and alcohol addiction, unemployment has been identified as exacerbating the risk of relapse post-treatment both those in drug treatment (PHE, 2017). Conversely, evidence shows employment is a protective factor in supporting and maintaining recovery (Barbieri et al, 2016; Silverman et al, 2017).




**In Scotland, just less than a third of those new to treatment for drugs and/or alcohol were in employment, education or training at 31%.**



## *Housing*

### Most people in treatment had stable housing

The majority of those in treatment had established housing, whether that was owning their own property or renting. In Scotland, of those new to treatment for drug and/or alcohol use, 86% fell into this category. Only 6% of the treatment population reported being homeless, whether temporarily or permanently roofless (Public Health Scotland, 2023). Amongst those in England who first accessed treatment for drug and/or alcohol addiction in 2024/25, 79% reported having a permanent housing arrangement, including owning or renting their own home or living with family or friends permanently (OHID, 2025b).

### However, those in treatment for opiate drug use were considerably more likely to not have a current home

Of all people presenting to treatment services for the first time in England, 21% reported not having a current home of their own. This included those temporarily living with friends or family as a short term guest as well as those sleeping on the streets or 'sofa surfing'. This was higher, at 41%, amongst those seeking support for their opiate use. This was comparatively lower for those seeking support with non-opiate drug use (18%), non-opiate drug and alcohol use (21%) and alcohol use only (11%) (OHID, 2025b).


**Of people seeking support for their opiate use in England, 41% reported not having a current home of their own. (2025)**

## *Criminality*

### Treatment data suggests only small proportion of those in treatment were involved in criminality, but referral from the criminal justice system was more likely amongst those seeking treatment for opiate use

While available treatment data describing involvement in offending appears to point to a majority of those in treatment not involved in criminal proceedings, these data may present only a partial picture. In Scotland, reports based on treatment data found that 89% of those in treatment had not been to prison in the previous 12 months: only 5% had been in prison or a young offender institution in the previous 12 months and 6% were currently in prison or a young offender institution (Public Health Scotland, 2023). Similarly, Northern Ireland reported that, of those in treatment, just under 80% (77.8%) of the total treatment population had no current legal status (Northern Ireland Department of Health, 2025).

However, referral from the criminal justice system was more than twice as likely for opiate users in treatment compared with those in treatment for non-opiate use or alcohol. In England, referrals into treatment from criminal justice agencies were considerably higher for those in treatment for opiate use (31%) compared with those in treatment for non-opiate use (16%), non-opiate use and alcohol consumption (14%) and alcohol only (7%) (OHID, 2025b).

No broader or more comprehensive information about involvement in offending are available and it is not clear whether involvement in offending data collected are based solely on self-reporting by those presenting to treatment. As a result, these figures may not reflect a true picture of involvement in criminality amongst treatment populations in Scotland and Northern Ireland. No data are currently published about involvement in offending in drug treatment data in England and Wales. Evidence examining prevalence and impact of offending related to drug use suggests a significant minority of those in drug treatment, particularly those using opiates, may be involved in offending, particularly acquisitive crime (Hayhurst et al, 2013, Stewart et al, 2000, MOJ and PHE, 2017, Gossop et al, 2002).


**In Scotland, reports based on treatment data found that 89% of those in treatment had not been to prison in the previous 12 months**


**Referrals in England into treatment from criminal justice agencies**



## *Severe and multiple disadvantage*

Analysis published in 2015 examined the overlap between those involved in offending, substance misuse and homelessness (Lankelly Chase, 2015). They identified 58,000 people who experienced all three, 99,000 people who experienced substance misuse and offending and 34,000 people who experienced homelessness and substance issues in England. Areas in England with high rates of unemployment, poverty, housing markets with higher concentrations of smaller properties (generally bedsits and small flats) and poor health profile across the local population were more likely to have higher levels of severe and multiple disadvantages. This analysis identified that outcomes from drug treatment categories were generally poorer for those who experienced all three multiple disadvantages. This is useful in highlighting how the various demographic, protected and socioeconomic characteristics discussed in this chapter overlap and, where they do, how entrenched addiction can become.

## *Parents*

### Most people seeking treatment did not have children

Available data suggests that most people with addiction in England, Scotland and Wales do not have children. In Scotland, two-thirds of those starting treatment did not have any children (68%). The minority had children – 15% had one, 10% had two and only 6% had three or more (Public Health Scotland, 2023). Despite this, Trouble Families estimated that 15.6% families in England had an individual dependent on drugs or alcohol (Ministry of Housing, Communities and Local Government, 2019). In Scotland, in the early 2000s, it was estimated that between 4-6% of all children under the age of 16 who had a parent with problem drug use. This was estimated to affect between 41,000 and 59,000 children in Scotland (ACMD, 2011).

### Where this cohort did have children, most did not live with their children

Data suggests that where those with addiction did have children, the majority also did not live with them. The more serious their drug use, the less likely it was that parents still lived with their children (ACMD, 2011). In England, 17% of the treatment population were parents who lived with their children. This was higher amongst those seeking treatment for alcohol only (21%) and non-opiates only (21%) but lower for those accessing treatment for opiate use (8%). It was estimated, however, that mothers with addiction (64%) were twice as likely to live with their children compared with fathers with addiction (37%) (ACMD, 2011).

In Wales, it was reported that in the year ending March 2023, there were 5,190 children receiving support due to parental substance misuse. This represents nearly a third (29.6%) of the wider cohort of children receiving care and support in Wales (Public Health Wales, 2025). The analysis which considered severe and multiple deprivation identified that only a fifth of substance treatment adult population in England were parents living with their own children, a further 14% were living with other people's children, most often their partner's children. A further fifth (20%) maintained contact with their own children while they were not living with them (Lankelly Chase, 2015).

**5,190**

**In Wales, it was reported that in the year ending March 2023, there were 5,190 children receiving support due to parental substance misuse.**

*Veterans*

### There was limited data on veteran-status amongst this population

Across the four nations, the only nation that reported on veteran status was Scotland – only 3% of those who were in treatment had served in the armed forces. Of those that had, 40% had served between 1 and 4 years, 28% between 5 and 10 years and 20% 11 or more years. The median age of veterans was 47 (Public Health Scotland, 2023).

A report from the Office for Veterans Affairs (2024) concluded that most ex-serving personnel do not experience adverse mental health or alcohol use problems (67%). However, a substantial minority do experience mental health challenges and/or alcohol misuse. Overall, they reported that the rate of alcohol misuse amongst this population had fallen from 15% between 2004-08 to 8% in 2022/23, and had since remained stable at this level.

Op Courage was announced in 2021 by the Government to provide a single point of access to mental health services for veterans. As part of this, treatment for substance misuse and addictions would be prioritised (House of Commons Library, 2024).

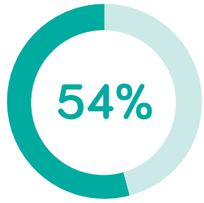


# 3. Impacts of Addiction

**The consequences of addiction extend beyond the individual. Dependence on alcohol or drugs affects a person's health, their housing situation, their ability to work, their relationships, and their engagement with public services.**

These impacts also carry costs for families and the state. Public Health England highlights risks of premature death from poisoning, impact on mental and physical health, risks of bloodborne virus transmission, liver disease, cancers and cardiovascular disease (PHE, 2016, PHE, 2017). Respondents to Forward Trust's own IPSOS poll of a representative sample of UK adults found that more than half (54%) of those who have experienced addiction or dependency say that their physical health (e.g. tiredness, loss of sleep, reduced self-care, overdose, liver damage, pancreatitis) has been negatively affected as a result. This is closely followed by emotional or psychological distress e.g. suicidal thoughts, mental health issues, shame (53%), alongside financial e.g. debt, financial insecurity, reduced disposable income (46%) and relationship problems e.g. conflict or breakdown with partner, friends or family (41%).

This chapter draws on the available research and data to describe those consequences across six domains: health, housing and homelessness, criminality, employment and economic non-participation, family and overall economic and societal costs.




**Respondents to Forward Trust's own IPSOS poll of a representative sample of UK adults found that more than half (54%) of those who have experienced addiction or dependency say that their physical health has been negatively affected as a result.**

# Health consequences

**The health consequences of addiction fall broadly into two categories: physical and mental. Although in practice these frequently overlap.**

## *Physical health impacts*

The physical health impacts are quite different across injecting and non-injecting drug use and alcohol. To reflect this, the following section is split between three addiction types.

### Alcohol

**Alcohol continues to have a severe impact on physical health**

Alcohol has been identified as a causal factor in more than 60 different medical conditions (PHE, 2016). Hospital admissions labelled as 'alcohol-related' were attributed to 333,014 cases in 2013/14, an increase of 1.3% from the previous year (IAS, 2015). Liver disease which is largely understood to be alcohol related, has more than doubled since 1980 (PHE, 2016). Compared to the other major diseases, liver disease is the only one increasing during this period (PHE, 2016). Along with liver disease, addictive alcohol use has been attributed to other poor health outcomes such as:

- Cancers (i.e. lip, oral cavity, pharynx, oesophagus, larynx, colon, rectum, liver and intrahepatic bile ducts, breast)
- Cardiovascular disease (hypertension, stroke, heart disease, atrial fibrillation)
- Diseases of the central nervous system (alcohol related brain damage, peripheral neuropathy, epilepsy) (DHSC, 2025).

Alcohol was the third out of 67 biggest risk factors for death and disability in England after smoking and obesity. In 2012, alcohol accounted for 1.4% of all deaths registered in England and Wales (PHE, 2016). It is thought that alcohol addiction is a major cause of preventable premature deaths (PHE, 2016).

**333,014**

**Hospital admissions labelled as 'alcohol-related' were attributed to 333,014 cases in 2013/14, an increase of 1.3% from the previous year.**



### Injecting drug use

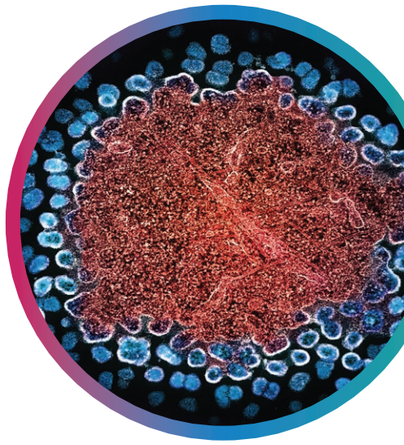
**Homeless people who inject drugs face significant physical health impacts, with homelessness itself compounding the health harms of injecting drug use**

Injecting drugs requires the use of a needle entering the skin. This is most associated with opiate and crack cocaine use. Blood-borne viruses such as hepatitis C and HIV, spread through shared needles and injecting equipment.

People who are homeless and inject drugs are twice as likely to carry a blood-borne virus as those with a stable home (ACMD, 2019). Hepatitis C has been tracked in injecting populations for decades. Studies in the early 2000s reported prevalence of 41% amongst people who were injecting drugs in some parts of the country (NTA, 2006). Although prevalence of hepatitis C has declined over the last 20 years, falling to 5.2% amongst all people who inject drugs in 2024 (UKSHA, 2026), some evidence points to higher rates of hepatitis C and HIV amongst homeless drug users as well as increasing serious bacterial infections characterised by an over-representation of the homeless community in hospitalisation data (ACMD, 2019). Almost four in five people who develop skin and soft tissue infections (SSTIs) have experienced homelessness (PHE, 2020). SSTIs can include abscesses, ulcers, endocarditis, necrotising fasciitis, and septic arthritis leading to sepsis and can lead to limb amputation or death (PHE, 2020).

The risk of SSTI increases for:

- 45-year-olds and over
- Injected for more than 8 years and/or inject more than 4x a day
- Injected in the last day
- Inject into neck, legs, groin or feet (PHE, 2020).



**Almost four in five people who develop skin and soft tissue infections (SSTIs) have experienced homelessness. (2020)**

**SSTIs can include abscesses, ulcers, endocarditis, necrotising fasciitis, and septic arthritis leading to sepsis and can lead to limb amputation or death.**

## Other drug use

### Opiate and crack cocaine use, whether through injecting or not, has a detrimental impact on users' health and life outcomes

Between 2012 - 2015 across all four nations, there was an increase in the number of deaths involving opioid drugs (ACMD, 2016). England has seen the biggest increase with a 58% increase, followed by Northern Ireland (47%), with Wales and Scotland at nearly half of that increase with 23% and 21%, respectively (ACMD, 2016).

| | Drug misuse deaths (2015) | Opioid-related deaths (2015) | % change in opioid-related deaths |
|---|---|---|---|
| England | 2,300 | 1,842 | 58% |
| Wales | 168 | 141 | 23% |
| Scotland | 706 | 606 | 21% |
| Northern Ireland | 114 | 88 | 47% |

Source: ACMD, 2016

People in drug treatment who have used opiates are six times more likely to die prematurely than the general population, and the risk is highest in the weeks immediately after leaving treatment or prison (DHSC, 2017). Opiate drugs themselves can cause fatal respiratory failure; but the statistics tell us that 60% of opiate users who die while in treatment die from causes that are not directly drug-related such as heart disease, respiratory illness, or cancer (Home Office, 2021).




### Nitazenes are potentially driving a surge in UK drug deaths

Alongside long-standing dangers of accidental overdose and heightened health risk associated with heroin and other opioid use, pervasive new and emerging deadly synthetic opioids are increasingly used in the composition of illicit drugs in the UK. One class of synthetic opioids in particular, nitazenes, recognised to be hundreds of times as potent as heroin, have caused hundreds of UK deaths, with the full extent of harm likely to be underestimated as a result of insufficient post-mortem testing. In 2024, the National Crime Agency (NCA) reported that 333 fatalities across the UK were linked to nitazenes, but researchers at King's College London have since found evidence that only a small percentage of nitazene present at the time of overdose was likely to be detected through toxicology tests. As a result, the true number of these deaths is believed to have been underreported by up to a third with public health responses consequently significantly underfunded (King's College London, 2026). Urgent public health action is required to reduce nitazene-related harms.

> *"If nitazenes are degrading in post-mortem blood samples, then we are almost certainly undercounting the true number of deaths that they are causing. That means we're trying to tackle a crisis using incomplete data. When we don't measure a problem properly, we don't design the right interventions – and the inevitable consequence is that preventable deaths will continue. "The harm caused by nitazenes is likely being significantly underestimated. Because these drugs degrade in post-mortem blood, we may be missing up to a third of the deaths they are involved in, meaning public health responses are being designed and funded for only two-thirds of the real problem. "Behind this undercount are people dying suddenly from extremely potent opioids, families left without answers, and communities facing a growing but largely hidden toll."*
>
> **Dr Caroline Copeland, UK National Programme on Substance Use Mortality (NPSUM)**
> **King's College London Press Release 8th February 2026**

Nitazene is still an emerging drug trend, with evidence for its impact currently limited, but one that is highly consequential for people who use drugs, their families and the services that support them. As a result, experiences of nitazenes are important to document in this report and, therefore, the case studies below have been included to explore perspectives and experiences of nitazenes.

## Nitazene case study 1

"I've been drug-tested here before, and more times than not, nitazene has come up, it's in everything. You can't get away from it, every time you're buying heroin, they are buying nitazene most likely.

The landscape has so changed now that you can't guarantee anymore what you're buying off the street.

I'm very lucky to be alive, it's really a miracle, because so many people I know have died because of it. Good friends I've known for a long time have died because of it. It sucks, and it's messed up that drug dealers are doing that — but it's cheaper for them to get [nitazenes] and cut it [into drugs]." **'K'**

## Nitazene case study 2

"Previously our service would receive a report of one overdose a fortnight in the local area, but ever since nitazenes emerged as a threat in 2021, staff at the clinic have seen a startling level of harm in their community. In a single weekend last year, staff received reports of 32 overdoses.

They're dancing with death while they're using at the moment, it's been devastating that we've lost people that we've come to know and work with for such a long period of time and people that were quite hardy, that knew their stuff, that were well-informed."

**Criminal Justice Team Leader**

## Alex

"I had never heard of nitazenes when a police officer knocked at her door in the early hours of 17 July 2023 and said my 23-year-old son Alex had been found dead at his student flat.

Alex had been preparing for a career as an opera singer and had been accepted for a two-year masters course. Watching him sing was one of the biggest joys in my life ever.

It was initially suspected the cause of his death was sudden adult death syndrome, but eight months later we learned he had taken a substance contaminated with a nitazene. Phone records suggested he had tried to buy tablets usually sold as Xanax, which are only available with a private prescription in the UK. He was doing so because he often struggled with sleeping while taking medication for his attention deficit hyperactivity disorder.

The traces of nitazenes were only detected after I queried with police why earlier tests had not looked for them. If I hadn't pushed for better answers in the middle of massive grief, then to this day I would have no idea how he actually died. Unless we're testing for them, how is anyone going to be aware and informed of the dangers?"

**Anne Jacques (Alex's Mum)**



### Increasing chronic ketamine use is contributing to rising drug-related harm

Another important trend in drug-related harm is the increasing level of harm from ketamine use, with rising deaths, polydrug use, and growing prevalence among young people. Illicit ketamine use has increased markedly in the last ten years, particularly amongst younger age groups including school-aged children and university students (ACMD, updated 2026) and an increase in presentations to drug treatment services indicates that many are experiencing problematic use. Although deaths from ketamine are relatively rare, ketamine use is associated with bladder damage (sometimes requiring surgery), kidney and abdominal problems, and chronic psychological harm, including depression. Evidence that regular and prolonged ketamine use is associated with dependence and experiences of withdrawal on cessation is considerable and growing (ACMD, updated 2026, ACMD, 2013, Drugwise, accessed 2026). Barney's mum, Deborah, illustrates the harm her son, Barney, experienced using ketamine.

## Barney

"The first time I caught my son using ketamine is a moment I will never forget. I pushed open the bedroom door and he was just sitting in his bed with this terrible, terrible look in his eyes and he could hardly speak. The bedside table was covered in powder. My heart was just in my mouth. I remember just scooping it up and pulling the flush on the toilet.

What had begun as a dabble with drugs at Reading Festival at the age of 17 had escalated into a serious problem which was getting out of hand. Even then, as I took him to a psychiatrist to help him stop using the powerful horse tranquilliser and anaesthetic, I had no idea of the tsunami that was going to hit us as a family.

Over the years that followed, we spent every penny we had. I borrowed money to send him abroad to private rehab.

He said "if I had cancer I wouldn't feel such shame. But I have a terrible disease which most people don't understand".

Barney's regular ketamine use caused irreversible damage known as 'ketamine bladder' that led to incontinence and painful symptoms, which left him using the toilet up to 20 times a night. He knew the only cure was a urostomy bag.

By 2018, he had hit rock bottom after losing his job as a van driver. He just came here and said 'nothing's worked, I have been to rehab and it hasn't worked. You and Dad spent all your money that hasn't worked.' He had this really awful inner narrative where he said 'Everyone's going to laugh at me, everyone's going to think I'm a complete waste because I haven't been able to achieve anything.' By this point, it was just terrible. He was using every day. Just lying in bed, lying in the bath. I discovered that he was going round different A&Es presenting different tales, collecting painkillers.

We were the laughable middle-class family. If anyone said to me it was going to happen when he was 11, I would have said 'are you joking?! The image that you have got when you think about addiction is someone on the street jacking up, and it's so much more than that.

At times, I'd sleep on the floor next to his bed, fearing he was so deep in a 'k-hole' he would fall down the stairs and break his neck if he woke in the night. Barney would lie in the bath for hours, showering warm water on his stomach to soothe his bladder symptoms. He turned to ketamine for help with the agonising stomach cramps, which only fuelled the cycle of drug abuse. He used to describe it as having the 'worst case of cystitis you have ever had'. He would be in bed, and every 20 minutes, he would get up because you think you're desperate to pee.

Having exhausted our funds for private care, we turned to the NHS drug and alcohol treatment services and begged for help, but was told there was nowhere to send him and he needed to prove he could do well in an outpatient setting. He was offered an appointment the following Tuesday, but did not live long enough to attend.

The night he took his own life, he told me he was going to a Narcotics Anonymous meeting, but returned having used. We sat on the sofa and he said 'Mum, if this is living I don't want it. I want to wake up in the morning not craving drugs.' He had these terrible side effects from the ketamine.

I was the last person to see him alive. I went to bed, and when I woke up in the morning, he had killed himself.

It was such a waste, Barney was 21. He was such a lovely, lovely boy – he was kind, he was funny. He had so many friends."

**Deborah Casserly (Barney's Mum)**

## *Mental health impacts*

There is a high prevalence of co-morbidity in those attending mental health services and drug and alcohol treatment services. 44% of community mental health patients have reported problem drug use or harmful alcohol use (PHE, 2016).

The relationship between addiction and mental health is complex. The relationship can be broadly understood within three categories:

- Substance misuse can cause or exacerbate mental health problems
- Substance misuse can be used to self-medicate mental health problems
- Withdrawal from substance misuse can mimic mental health problems (i.e. deaths in treatment can be reported as a suicide) (Drug and Alcohol Findings, 2020).

The three categories can all be experienced within the same person or a mix of them or only one (Drug and Alcohol Findings, 2020).

### There is a recognised link between mental health and addiction however availability of dual-treatment can be patchy

Data from England shows 74% of all those in drug treatment have an identified mental health need (OHID, 2025b). There is a slight difference in prevalence across the different substance types. For example, amongst those using drugs other than opiates and crack cocaine and alcohol the prevalence is 73% (OHID, 2025b). It is lower at 71% for those using opiates and crack cocaine (OHID, 2025b). However, poly-substance misusers, using non-opiate/crack cocaine and alcohol, have the highest prevalence at 79% (OHID, 2025b).

Dame Carol Black's Review of Drugs highlighted that mental health problems and trauma are intrinsically linked to addiction, often serving as the primary drivers of drug and alcohol dependency rather than merely separate problems (Home Office, 2021). People who are misusing substances and have poor mental health are less likely to experience a positive treatment outcome (OHID, 2025b). When it comes to receiving treatment for mental health, 22% of those beginning drug treatment were not receiving mental health support (OHID, 2025b). People who are addicted to alcohol are most likely to get mental health support through a GP (72%) whilst people using illicit drugs are less likely (59%) (OHID, 2025b). People using drugs other than opiates and crack cocaine are disproportionately likely to have engaged with community or other mental health services (28%) compared with people who use alcohol (20%) or non-opiate drugs and alcohol (24%) (OHID, 2025b). People using opiates and crack cocaine have the lowest percentage among these at 16% (OHID, 2025b). This complements the prevalence of identified mental health needs when in drug treatment.

The support available for those with co-occurring mental health and substance misuse, often referred to as dual diagnosis, is patchy as there are limited services providing the required support. Public Health England asserted that better care for this cohort was needed and advocates for commissioners and service providers to operate on a "'no wrong door' for accessing support and it is 'everyone's job' on the other side of the door to help" principle (PHE, 2017). This approach is supported in Black's review (2021), which strongly advocates for the integration of mental



health support in addiction treatment. However, services are often not available as a result of an unprecedented crisis in mental health provision and loss of mental health specialists (Hughes, 2015). Black's (2021) Drugs Review also recognises the workforces challenges experienced in the addiction support sector and the need for well-trained professionals who understand both mental health and addiction. Mental health services and drug treatment services sometimes place conditions on who can access their service (MEAM, 2022; Scottish Government, 2022). This is acutely experienced by those with dual diagnosis (MEAM, 2022; Scottish Government, 2022). For example, if someone has schizophrenia and also uses drugs, a mental health service might refuse access to the service until problems with drug use have been resolved.

Data shows alcohol misuse with mental health needs negatively impacts physical health outcomes. There is a strong association between alcohol misuse and suicide. A study found alcohol misuse was in the histories of 45% of suicides among patient population between 2002 - 2011 (PHE, 2016).

## *Costs of health impacts of addiction*

### Physical and mental impacts of substance addiction have a profound financial cost on the NHS

The estimated cost of alcohol addiction to the NHS is £3.5 billion per year (PHE, 2016). Whilst Black's report (Home Office, 2020) estimated that hospital admissions directly attributable to drugs cost around £37 million in associated harms. This figure covers admissions linked to mental and behavioural disorders, overdoses and poisonings and neonatal conditions caused by drug exposure. When broader, partially drug-related hospital admissions are factored in, the total harm costs rise significantly to an estimated £156 million (Home Office, 2020). Studies indicate that providing treatment to people who use drugs can cut drug-related hospital attendance costs by nearly a third (Home Office, 2020).

**'H'**

"My recovery journey started with a conversation on London Bridge. I called the Samaritans and I asked the operator what drowning felt like.

I was on the phone for 45 minutes and I was talked down. Four days later I spoke with someone who gave me a phone number for a helpline and on the 29th of January 2020.

My sobriety date is the 6th of June 2020. I've not had a drink or a drug a day at a time since.

The conversation that sparked it all on London Bridge saved my life. I wouldn't be here and what I have found is that connection is the opposite of this illness of addiction.

And if I don't connect on a daily basis to other people and have conversations every day where I listen and I take part and I share, then I won't be here."

### The physical and mental health consequences of addiction are profound, wide-ranging, and deeply interconnected

From the life-threatening bacterial infections and blood-borne viruses associated with injecting drugs use, to the liver disease, cardiovascular conditions, and cancers linked to alcohol misuse, the physical toll on individuals is severe and can be fatal. These harms are compounded by the high prevalence of co-occurring mental health conditions, with nearly three quarters of people in drug treatment carrying an identified mental health need yet facing fragmented services ill-equipped to treat both simultaneously. The cumulative effect of these unmet physical and mental health needs places an enormous and growing burden on the NHS. The evidence is clear: addiction is not merely a personal health crisis, but a systemic one with significant financial consequences for public services. Crucially, investment in effective treatment offers a meaningful return where studies suggest that treating people who use drugs can reduce drug-related hospital attendance costs by nearly a third. Addressing addiction holistically, through integrated physical and mental health support, is therefore not only a moral imperative but a fiscally responsible one.

## Housing and homelessness

**There is an established relationship between addiction and housing instability. Housing instability can increase the risk of substance misuse as substance misuse can make it harder to sustain employment, tenancy, and maintain relationships which can lead to housing instability.**

### Substance misuse and homelessness are closely linked and carry significant cost

In England, approximately half of the homeless population use substances (92,000 out of 186,000) (ACMD, 2019). This is a similar picture for alcohol where again half of the homeless population are alcohol dependent (ACMD, 2019). The estimated indirect cost of homelessness associated with people with drug problems is £31 million per year (Home Office, 2020).

### The homeless population faces higher rates of premature deaths than the general population

There is a higher rate of drug-related deaths, infections and multiple morbidities with the homeless population (ACMD, 2019). Homeless people face high rates of premature deaths compared to the general population. The causes of premature deaths can be due to:

- Substance misuse
- Drug-related deaths
- Suicide
- Unintentional injuries
- Infectious diseases
- Mental health conditions (ACMD, 2019)

**92,000**

**In England, approximately half of the homeless population use substances (92,000 out of 186,000).**



### Heroin and morphine account for the majority of drug poisoning deaths among homeless people

There was a 52% increase in drug-related deaths among homeless people between 2012 and 2017 compared to a 45% increase of the general population (ACMD, 2019). According to the ONS (2018), of the 597 deaths of homeless people recorded in England and Wales, half were attributed to drug poisoning, liver disease or suicide. Drug poisoning accounted for 32% of all deaths among homeless people, compared to just 1% in the general population (ONS, 2018). The majority of these poisoning deaths, 76%, had heroin or morphine recorded on the birth certificate (ONS, 2018).

### Homeless people who misuse substances are predominantly older males, though women face distinct and significant vulnerabilities

The homeless substance misuse population is predominantly male and getting older (ACMD, 2019). In Scotland, the proportion people using opiates and crack cocaine who have recently experienced homelessness aged over 35 rose from 35% in 2008 to 57% in 2018 (ACMD, 2019). Homeless ex-service personnel have increased risk of substance misuse, in particular alcohol (ACMD, 2019). Women who are homeless and use drugs face particular risks (ACMD, 2019). They experience high levels of stigma, verbal and physical assault, and an increased risk of sexual violence (ACMD, 2019). Many women have experienced domestic abuse prior to losing their homes (ACMD, 2019). Mental health challenges are common among people who misuse substances and are also homeless. 25-30% of street homeless and those in direct-access hotels had a serious mental illness (i.e. depression, schizophrenia and bipolar) (ACMD, 2019).

### Housing instability is common among those entering drug treatment but can present as a barrier to effective care

One in five adults starting addiction treatment in 2019 reported a housing problem (Home Office, 2021). For people who use opiates and crack cocaine, this figure rose to a third and 16% had an 'urgent housing need' (Home Office, 2021). Treatment data across England consistently shows that people who use opiates or crack cocaine are far more likely than other substance misusers to have no stable home (OHID, 2025b). The most recent treatment data from 2024/25 show 41% of opiate users report having no home of their own at the time of starting treatment while this is the case to a lesser extent for people using drugs other than opiates and crack cocaine, people using non-opiate drugs/crack cocaine and alcohol and people using alcohol with 18%, 21% and 11%, respectively. (OHID, 2025b).[13]

Housing instability adds another layer of complexity when delivering treatment. The Advisory Council on the Misuse of Drugs (ACMD, 2019) has described treating homeless people for drug misuse as exceptionally difficult unless their housing needs are addressed at the same time. Such difficulties include practical barriers in accessing services such as healthcare and substance use treatment with no-fixed abode and the day-to-day nomadic and often unsafe environment of the homeless population makes consistent engagement with treatment challenging and requires a different, more flexible approach (ACMD, 2019).

[13] Percentages have been rounded to the nearest whole number

### Effective treatment requires a holistic approach that meets the multifaceted needs of people with addiction

The relationship between addiction and housing and homelessness is cyclical and self-reinforcing. For example, substance misuse destabilises housing, and housing instability deepens addiction, making both conditions significantly harder to treat in isolation. The evidence drawn in this section indicates the scale of the problem is considerable and the consequences are stark. The indirect costs of homelessness associated with drug problems are estimated at £31 million per year, yet this figure alone understates the true burden when compounding costs of repeated hospital admissions, mental health crises, and failed treatment are considered. Achieving positive outcomes and reducing relapse in this population requires more than clinical intervention, it demands stable housing as a prerequisite for effective treatment. Accessing services present a barrier to those of no fixed abode facing practical and systemic obstacles that standard service models are often poorly equipped to address. The evidence points firmly towards an integrated approach, one that treats housing, addiction, and mental health not as separate concerns to be sequenced, but as interconnected needs to be addressed simultaneously. Only then can treatment deliver the sustained recovery outcomes that reduce long-term reliance on public services, and ultimately, the wider cost to society.

**£31 million**

**The indirect costs of homelessness associated with drug problems are estimated at £31 million per year, yet this figure alone understates the true burden when compounding costs of repeated hospital admissions, mental health crises, and failed treatment are considered.**

## Criminality

**Research typically identifies three broad categories of relationship between crime and addiction: offending to fund addiction, offending committed under the influence of substances, and offences related to the supply of drugs. Each operates differently which is evidenced below. The cost of drug use is largely evidenced by Black's 2020 report, which estimates drug use is costing £9.3 billion per year for crime and criminal justice system-related services.**

Within the treatment cohort, individuals with the following characteristics were found to be more likely to offend than their counterparts:

- Males
- Black and ethnic minorities
- Homeless
- Current or lifetime history of injecting (MOJ and PHE, 2017)



### *Offending to fund addiction*

### More people with substance use disorders than the general population are committing crimes but this is still a minority of the addiction population

Treatment data from 2006 - 2007 found 40% of those receiving treatment between these dates had committed an acquisitive crime, such as burglary, theft and robbery in the previous month (Hayhurst et al, 2013), while the remaining 60% had not. Hayhurst and colleagues' findings correspond with other evidence that suggests that a high level of (particularly acquisitive) crime is perpetrated by a large minority of people in drug treatment, particularly amongst people who use opiates (Stewart et al, 2000, MOJ and PHE, 2017, Gossop et al, 2002)

Research has indicated an associated link between acquisitive crime and opiates and crack use, poly-drug use and young age among other factors (Hayhurst et al, 2013). Treatment data shows 35% of people starting treatment in 2012 had committed a crime in the last two years, this rises to nearly half (47%) amongst people who use opiates and crack cocaine (MOJ and PHE, 2017) while there is also a sizable proportion of people who use opiates and crack cocaine that do not offend (Home Office, 2014). Prior offending in those who are alcohol dependent was much less at 23% (MOJ and PHE, 2017). Treatment data from 2016 shows most common offending type amongst people who use opiates and crack cocaine is theft from shops at 30% (MOJ and PHE, 2017).

Analysis of crime trends in England and Wales found that the rise in the number of people using opiates and crack cocaine in the 1980s and 1990s contributed to the increase in acquisitive crime during that period (Home Office, 2014). Evidence from the UK and internationally, indicates there is a causal relationship between opiates and crack cocaine use and acquisitive crime (Home Office, 2014). Meaning that the increase in opiate and crack cocaine use makes the increase in acquisitive crime happen. This suggests that a fall in acquisitive crime could indicate a decrease in opiate and crack cocaine use. Evidence would suggest that at least for some, heroin and crack cocaine is a catalyst for offending. However, Hayhurst et al, 2013 found behavioural factors (such as risk taking) and demographic factors (such as age) were more closely linked with drug-users committing acquisitive crimes rather than its funding their addiction as the main driver.

**40%**

**Treatment data from 2006 - 2007 found 40% of those receiving treatment between these dates had committed an acquisitive crime, such as burglary, theft and robbery in the previous month.**

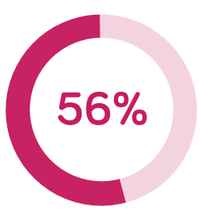
**30%**

**Treatment data from 2016 shows most common offending type amongst people who use opiates and crack cocaine is theft from shops at 30%.**

## Treatment can reduce the number of offences committed

While recognising that it is a minority of the addiction population committing crimes, evidence suggests treatment reduces the number of offences committed. Out of all the people who committed offences before receiving treatment (46,166 people), 56% (25,876 people) reoffended within two years of starting the treatment (MOJ and PHE, 2017). However, even though more than half of those people did reoffend, the total number of offences dropped by 33% (MOJ and PHE, 2017). Meaning that while over half of the people in the studied cohort still reoffended, they were committing fewer crimes each than they had before treatment.

People who are older and receiving treatment for drug use other than opiates are less likely to reoffend. People treated for opiate addiction had the weakest response to treatment in terms of crime reduction, with 31% fewer people reoffending and the total number of offences falling by 21% (MOJ and PHE, 2017). These were the smallest improvements of any group. In comparison, people treated for alcohol-only addiction had the strongest response with 59% fewer people reoffending and the total offences dropped by 49% (MOJ and PHE, 2017). This suggests alcohol-only treatment results in a more positive outcome than for people who use opiates and crack cocaine in terms of reducing reoffending.




**Out of all the people who committed offences before receiving treatment (46,166 people), 56% (25,876 people) reoffended within two years of starting the treatment.**

### *Crimes committed under the influence of substances*

**Research suggests crime committed under the influence largely falls within four theories: courage to offend, pharmacological effect, amplification of crime, crime by association (Bennett et al, 2004).**

#### 1. Courage to offend

**Some people use substances to lower inhibitions and commit premeditated crimes**

The person deliberately uses substances (more often alcohol) to give themselves the confidence to commit a crime they might have already decided to commit. It is a choice, not an accident. (For example, the case of Northern Ireland v Gallagher who bought a knife to kill his wife, consumed most of a bottle of whisky and murdered his wife (Ormerod and Laird, 2021).)

#### 2. Pharmacological effects

**The substance itself directly causes criminal behaviour through its chemical impact on the brain**

The drug changes how the person acts. For example, alcohol can make someone aggressive, which then leads to violent crime (Popovici et al, 2013).



#### 3. Amplification of crime

**The person would have offended anyway, but drug use makes it worse**

Situations like this might be through committing crimes more frequently or more seriously than they would without drug use. Interviews with young people aged between 14 and 25 years old taken across six European countries showed cocaine use increased aggression and subsequently offending behaviour (Rolando et al, 2021).

**The link between alcohol use and domestic abuse perpetration and victimisation continues to be evidenced**

Research undertaken by Alcohol Change (2019) found there was a strong association between alcohol use and intimate partner violence (IPV) perpetration and victimisation in heterosexual relationships. The Home Office (2024) analysis of Domestic Homicide Reviews: October 2022-September 2023 found that problem alcohol use was an identified vulnerability for 24% of victims and 26% of perpetrators. The Alcohol Change (2019) research identified that women were at greater risk of IPV by a male partner who had been drinking than the other way around. An earlier study showed 60% of men in alcohol or drug treatment were violent to their partners in the preceding year (O'Farrell et al, 2004). One of the seven police force pilots drug testing individuals arrested for a domestic abuse offence, found nearly 85% (127/150) of domestic abuse offenders arrested and drug tested were positive for cocaine and/or opiates (NPCC, 2023). However, it is unclear from the research presented here whether they represent courage to offend, pharmacological effects or amplification of crime.

#### 4. Crime by association

**Drug users are part of the drug environment**

Being part of the drug environment and operating within it means being surrounded by criminal networks, situations and pressures. A meta-analysis drawing on 30 studies found that individuals misusing substances were between 2.8 and 3.8 times more likely to engage in criminal activity than those who did not use drugs (Bennett et al, 2008). The findings demonstrated that this association was not uniform across substances; with crack cocaine users having the strongest association who were about six times more likely when compared to non-users, this was followed by heroin users at roughly three times more likely than non-users to engage in criminal activity (Bennett et al, 2008).

**A meta-analysis drawing on 30 studies found that individuals misusing substances were between 2.8 and 3.8 times more likely to engage in criminal activity than those who did not use drugs.**

## *Supply-related offences*

**The previous two sections explored the relationship between addiction and criminal behaviour. This section covers supply-related drug crime. Meaning the criminal activity driven by the demand for drugs which addiction has a part in creating.**

The supply of illicit drugs are by their nature a criminal offence. Supply-related offences then do not include adults who are alcohol dependent.

### Drug supply networks are intrinsically linked to violence and exploitation and has the potential to attribute drug-related homicides

The systemic model provides an explanation of how supplying drugs can lead to further criminality. The model suggests that drug distribution networks are intrinsically linked to violent crime (Hassan et al, 2016). The violence largely comes from the operational nature of the drug trade. This includes territorial disputes between rival distributors or gangs, internal enforcement of rules, and transaction-related crimes such as debt collection, and disagreements over product quality or quantity (Hassan et al, 2016). Criminality related to supplying drugs can often be linked to drug-related homicides (Blumstein, 1995). Beyond direct dealing activity, drug markets contribute to broader community disorganisation, weakening social norms and generating crime that extends beyond the drug trade itself (Blumstein, 1995).

County lines, a model coined by the National Crime Agency (NCA) in which organised criminal networks exploit young people and vulnerable adults using mobile phones to distribute drugs across counties, responds to the demand in drugs and ensures the supply is owned by a certain gang (NCA, 2015). People with substance use disorders play a crucial role in increasing drug demand. Despite the length of time this model has been established children and young people are still being exploited and experiencing harm so gangs can supply the drugs to meet the demand and hold the largest distribution area. The Children's Commissioner's 2019 report on keeping children safe, estimated there were 27,000 children in England who identified as a gang member and 2,000 London teenagers identified as being involved in county lines (Home Office, 2020; Children's Commissioner, 2019). According to Black's (2020) review on drugs, the supply of the heroin and crack cocaine markets have shifted to using the county lines model to reach outside the bigger cities which have a decline in heroin and crack cocaine use.

Supporting the systemic model of drug supply, violence and homicide, Black's report states the heroin and crack cocaine market is the most violent and likely the reason for the homicide rate among victims aged 16 to 24 almost doubling between 2015/16 and 2017/18 (Home Office, 2020). The report highlighted a 58% increase in drug-related homicides in England and Wales between 2011/12 and 2021/22 (360 drug-related homicides), accounting for approximately half of all murders reported in that period (NAO, 2023). Published reports about drug-related homicides must be interpreted with care: the Office for National Statistics (ONS) emphasises that figures include any case where Police believed either the victim or suspect routinely used or sold illicit drugs, or had taken a drug, had a motive to steal drugs or proceeds from the sale of drugs, or that was related to drugs in any way. Between April 2018 and March 2023, the largest proportion of 'drug-related homicides' (52% of drug-related homicides and 25% of all homicides) had only an 'ambiguous' link to drugs (ONS, 2024).

**27,000**

**The Children's Commissioner's 2019 report on keeping children safe, estimated there were 27,000 children in England who identified as a gang member.**



### The relationship between addiction and criminality is multifaceted and requires a multi-agency approach to respond

While it is important to note that the majority of people with addiction do not commit crimes, the evidence is clear that addiction, particularly involving opiates and crack cocaine, is a significant driver of acquisitive crime, domestic abuse, and community harm. The consequences extend well beyond the individual: the non-addicted population bears a considerable burden as victims of theft, violence and the broader social disorder generated by drug markets. Most acutely. The county lines model demonstrates how addiction-driven demand fuels the systematic exploitation of children and vulnerable adults, with drug-related homicides among 16 to 24 year olds almost doubling in three years. The financial scale of these harms is vast. Yet the evidence also offers a clear direction: treatment works, reducing both the number of people reoffending and the total volume of offences committed. Addressing addiction effectively is therefore not only a health intervention but a crime reduction strategy, one that protects victims, reduces exploitation, and significantly cuts the cost burden on the criminal justice system and wider society.

## Employment

**Addiction is associated with reduced employment resulting in economic non-participation (not spending into the economy). The relationship between addiction and employment is not one-directional. Substance misuse can make it harder to sustain employment and unemployment, particularly where it is prolonged, can contribute to increased alcohol or drug use.**

In 2024/25, 29% of people starting treatment in the community in England and Wales reported working in paid employment or participating in education in the previous month (OHID, 2025b) Among people in treatment in Scotland, 31% were in paid employment or education at the time of assessment. Around 43% were unemployed,13% were classified as long-term sick or disabled, 7% were in prison, and 6% were carers, working in voluntary roles or retired (Public Health Scotland, 2026). In Northern Ireland, over 60% of those in treatment were unemployed (Northern Ireland Department of Health, 2025). These figures reflect a population for whom participation in the labour market is frequently impeded by the cumulative effects of addiction and related disadvantage.

**60%**

**In Northern Ireland, over 60% of those in treatment were unemployed.**

### The relationship between addiction and unemployment is bidirectional

On one hand, addiction can materialise after unemployment. Public Health England (2016) research indicated that harmful drinking tends to escalate after unemployment, and that the mental health difficulties associated with alcohol dependence make it harder for people to return to work. On the other hand, substance dependency can lead to someone losing a job or not being able to work. Lankelly Chase 2015 found that physical health consequences of long-term drug use, such as chronic illness, disability, and repeated hospitalisation, are frequently cited by people with severe and multiple disadvantages as the primary reason for not working. Losing a job or being unemployed can cause feelings of low self-worth and purpose and can be a stressful time, all of which can lead to people using substances and alcohol as a coping mechanism (Bauld et al, 2010).

### The impact of addiction on employment is heightened when there are multiple disadvantages

Lankelly Chase 2015 research developed a statistical profile using existing data looking into the most severe and multiple disadvantages (i.e. experiencing homeless, substance misuse and involved in the criminal justice system), the research found combinations of homelessness, substance misuse, and criminal justice involvement (estimated 58,000 people), unemployment accounts for over half of those at 60% and employment rates are very low at 6.4%.

### The relationship between addiction and unemployment carries substantial and increasing costs for the UK welfare system

People who are unemployed in the UK can receive UK benefits, eligibility depending. The Lankelly Chase research found 93% of respondents to the multiple exclusion homelessness survey were receiving UK benefits. The HM Government, 2010 estimated that drug and/or alcohol misusers generate a welfare benefit expenditure costs of approximately £1.6 billion per annum or £1.7 billion in today's prices. A decade on Black (Home Office, 2020) estimates drug misuse has a social and economic loss of approximately £4.5 billion, this includes direct costs such as prescriptions of medicines due to dependency, mental health and homelessness and an indirect cost which was the most substantial cost implications was unemployment.

### The bidirectional relationship between addiction and employment has significant consequences at both an individual and societal level

For the individual, unemployment strips away more than income, it removes the sense of identity, routine, and contribution to society that work affords, whilst simultaneously making stable housing harder to maintain and financial independence impossible to achieve. For society, the cost is substantial, with welfare benefit expenditure, healthcare, mental health services, and homelessness support all escalating in the absence of employment. Sustainable employment is not merely an economic outcome, it is a protective factor against relapse, a pathway to stable housing, and a means by which individuals can reclaim purpose and contribute meaningfully to society.



## Family and relationship impact

### Addiction can play a key role in relationship breakdowns

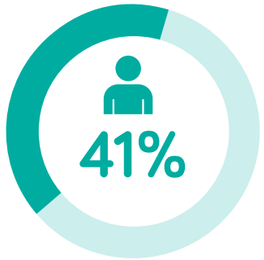
Addiction can cause strain, conflict, distrust and breakdowns as well as physical and mental abuse (Lander et al, 2013; UK Addiction Treatment Centres, n.d.). Taking Action on Addiction and IPSOS' 2024 survey of 2,139 UK adults aged 16 to 75 found just under half (41%) had been affected by relationship problems due to addiction whether that was conflict or breakdown with a partner, friends or family (Forward Trust and IPSOS, 2024). The early months of COVID-19, between 31st March and 31st August 2020, saw an increase, with nearly one in four, of divorce petitions citing drinking or alcohol abuse as the key reason for filing for divorce (Divorce-online, 2020). This has subsequently dropped in the years proceeding but has remained in the top 10 reasons for filing divorce. Richard Nelson LLP, analysed available data collected over six months which accumulated 37,965 divorce cases and ranked addiction as the 6th (4.87%) most common reason for divorce in the UK with the most common being adultery at 32.77% of the cases (Nelson, 2025).

**'R'**

"The impact on my family was horrendous. Financially it ruined them. My dad cashed in pension earlier. My wife, I've put her through endless worry - it wasn't about the money for her, it was the lies. The pure worries. I've put her through so much. The last time I went on a bender, I wrote a suicide note.

My wife said she felt helpless. She could see I was a good person, but I just had this addiction I couldn't shake. She said it was like living with Jekyll and Hyde. They did everything they could for me, but it was up to me. It was a hard journey. This is the longest I've ever been clean and without a bet.

I lost everything but I got it all back. I get to be the dad and the husband I wanted to be, but because of my addiction I just couldn't."




**A 2024 survey of 2,139 UK adults aged 16 to 75 found just under half (41%) had been affected by relationship problems due to addiction.**

## Addiction can also impact children in households where a parent or carer has a substance use problem

These effects are described in the research as affecting children's physical health, emotional wellbeing, education, and long-term outcomes.

Estimates, from ACMD (2003), suggest that between 200,000 and 300,000 children in England and Wales are living with a parent who has a drug problem which equates to around 2-3% of all children under 16 years old. In Scotland, the equivalent estimate is between 41,000 and 59,000, representing 4-6% of children under 16 years old (ACMD, 2003). Fewer than 40% of fathers and around 64% of mothers with problem drug use were still living with their children (ACMD, 2003). The more severe the drug problem, the less likely the parent was to be living with their children and 5% of these children were in care (ACMD, 2003).

Research from ACMD (2003) identified a range of commonly occurring difficulties (listed below) for children in households with a parent or parents who have a drug problem. These difficulties can be described as adverse childhood experiences (ACE). Children commonly experience these ACEs simultaneously as they tend to compound one another over time. These included:

- Poverty
- Physical & emotional abuse
- Neglect
- Inadequate supervision
- Inappropriate parenting practices
- Intermittent or permanent separation
- Inadequate accommodation; frequent changes in residences
- Unsatisfactory education & socialisation; social isolation
- Exposure to criminal/inappropriate behaviour

Children and young people shared the emotional impact that they experienced due to having a parent(s) who have a drug problem. They have described their feelings of hurt, sadness, shame, anger, and a sense of isolation from being unable to discuss their home life with others (ACMD (2003).

**The more severe the drug problem, the less likely the parent was to be living with their children and 5% of these children were in care.**



Public Health England (PHE, 2016) research has shown that children affected by parental alcohol misuse are more likely than their peers to have physical, psychological and behavioural problems. Parental alcohol misuse is associated with family conflict, domestic abuse, and child abuse. Alcohol is estimated to be a factor in 25-33% of known child abuse cases (PHE, 2016). Among young people who were both offending and misusing alcohol, 78% had a history of parental alcohol misuse within the family (PHE, 2016). This intergenerational pattern is documented across multiple studies.

For pregnant women using drugs, particularly opiates, the effects can begin before birth. Fetal development can be disrupted as a result of fetal alcohol spectrum disorders and neonatal abstinence syndrome, which means the baby experiences withdrawal from the substance its mother was taking (ACMD, 2003; DHSC, 2025). The baby can also be at risk of contracting HIV and hepatitis and other infections (ACMD (2003).

## The financial costs to families and carers are substantial

The annual cost to family members and carers of people who use opiate drugs and crack cocaine has been estimated at approximately £2 billion, including lost employment, financial support provided to relatives, the cost of being a victim of crime, and health service use (PHE, 2017). The impact is concentrated among those supporting people who use opiates and crack cocaine, who account for around 71% of total costs to families (Home Office, 2020). Black estimated the cost to children's social care because of drug-related individual and societal harms was £616 million a year.

### Addiction within a family or relationship can have a long-term effect

The impact of addiction on families, and on children in particular, represents one of the most profound and far-reaching consequences of substance misuse, with effects that begin before birth and can last a lifetime. Children living with a parent with a drug or alcohol problem are exposed to adverse childhood experiences (ACEs), including neglect, abuse, poverty, and instability. These can cause lasting damage to their physical health, emotional wellbeing, and long-term life outcomes. Most critically, the intergenerational dimension of addiction means that without intervention, the cycle is likely to repeat, where children having grown up in households with parents with substance misuse are at a measurably greater risk of misusing substances themselves, perpetuating the same patterns of harm into the next generation. The cost to the state is considerable, both in terms of children's social care, including the financial and human costs of removing children from parental care, and the broader burden on health, education and criminal justice services as the consequences of ACEs manifest across a child's development.

**£2 billion**

**The annual cost to family members and carers of people who are using opiates and crack cocaine has been estimated at approximately £2 billion, including lost employment, financial support provided to relatives, the cost of being a victim of crime, and health service use.**

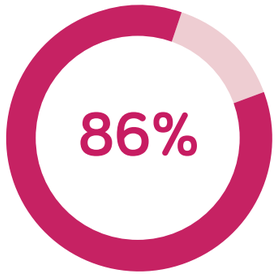
# Economic costs

**The section above set out the societal costs and harms associated with addiction. There are also direct economic impacts of drug and alcohol addiction, which this section will outline.**

## Drug addiction imposes and economic and societal burden on the UK, with heroin and crack cocaine dependence accounting for the majority of these costs

A number of estimates have been produced of the total economic and societal cost of addiction in the UK. The total annual cost to society of illegal drug use in England has been estimated at approximately £20 billion per year and £600 million being spent on treatment and prevention (Home Office, 2020; NAO, 2023). The largest component is drug-related crime, estimated at around £9.3 billion, followed by harms associated with drug-related deaths and homicides at approximately £6.3 billion (Home Office, 2020). Drug treatment and prevention service cost an estimated £533 million (Home Office, 2020). The cost of enforcement and the criminal justice system accounts for a further £680 million and £733 million, respectively (Home Office, 2020).

In England, around 86% of all drug-related costs are estimated to be attributable to those dependent on heroin and/or crack cocaine which equates to approximately 300,000 people (Home Office, 2020). The average annual cost associated with one person in this group is estimated at around £58,000, compared with under £1,000 per person for those using other drugs (Home Office, 2020). Heroin dependence is the most commonly treated condition in England's specialist drug treatment system, and carries the largest associated costs.




In England, around 86% of all drug-related costs are estimated to be attributable to those dependent on heroin and/or crack cocaine which equates to approximately 300,000 people


The total annual cost to society of illegal drug use in England has been estimated at approximately £20 billion per year



## The cost of alcohol misuse to society exceeds that of drug addiction

The total annual cost of alcohol misuse to society has been estimated at £21 billion (PHE, 2016). This includes approximately £11 billion attributable to alcohol-related crime, £7 billion in lost productivity through unemployment and sickness absence, and £3.5 billion in costs to the NHS (PHE, 2016). PHE analysis noted that more working years of life are lost in England due to alcohol-related deaths than from a combined list of common cancers (PHE, 2016). Estimates place the broader annual cost of alcohol at between 1.3% and 2.7% of GDP, and note that a substantial portion of these costs are paid by taxpayers rather than by the individual (PHE, 2016).

## Public service expenditure on the addiction population is large and concentrated in crisis response

For people experiencing severe and multiple disadvantages, defined here as the combination of homelessness, criminal justice involvement and substance misuse, the cumulative cost to public services is estimated at over £10 billion per year, with a total cumulative cost for the current cohort estimated at between £45 - £48 billion (Lankelly Chase 2015). A large proportion of this expenditure is concentrated in high-cost crisis services such as mental health inpatient care, prison, emergency housing and hospital admissions (Lankelly Chase 2015). Preventive or earlier-stage interventions represent a relatively small share of total spending on this population (Lankelly Chase 2015).

Children's social care costs attributable to drug use have been estimated at approximately £630 million per year, reflecting the significant proportion of child protective cases in which parental substance misuse is a factor (Home Office, 2020).


The total annual cost of alcohol misuse to society in England has been estimated at £21 billion


Children's social care costs attributable to drug use have been estimated at approximately £630 million per year

# 4. State Response to Addiction in the UK

**Forty years of national drug and alcohol strategies:**

**Despite the fact that prevalence of drug use and addiction had been increasing since the 1950's, the first comprehensive national strategy for tackling drugs was only introduced in the mid-1990's (Home Office, 1998). Drug use and addiction steadily expanded in the UK from 1975 – the estimated number of people with heroin dependence increased from 5,000 to more than 300,000 across England and Scotland in the mid-2000s. From 2000, increase in drug use and addiction slowed, stabilising at historically high levels UKDPC, 2007. As a result, the policy response to addiction, particularly for drugs, became increasingly focused over this time.**

The first strategy for addressing alcohol related harm did not follow until years later in 2004 (Prime Minister's Strategy Unit, 2004), mirroring the national drug strategy's focus on reducing harm and costs to society.

This section will, first, provide an overview of drug and alcohol policy approaches since the 1980s, next, describe alcohol policies and policy interventions introduced in the UK since the 2000s, and, finally, describe differences in the approaches and strategies used in the four nations of the UK.

## Drug policy

### Earliest drug policy responses

In 1984, the government set up the first cross-government Ministerial Group on the Misuse of Drugs to consider the growing drug problem in the UK.[14] A year later, they produced the first written summary of government strategy on Tackling Drug Misuse. The 1985 Tackling Drug Misuse strategy had five key pillars:

1. Reducing supply from abroad
2. Tightening controls on drugs produced & prescribed in the UK
3. Making policing more effective
4. Strengthening deterrence
5. Improving prevention, treatment and rehabilitation (Stimson, 1987)

The strategy's fifth pillar set out ambition for investment in new treatment infrastructure based in community settings and delivered alongside voluntary sector support. Since then, most drug strategies published since have followed a similar structure, although there has been notable variation in whether they prioritised reducing supply through policing and criminalisation or increasing funding for treatment.

[14] This involved input from the Home Office, Department of Health and Social Services, Customs and Excise, Department of Education and Science, Foreign and Commonwealth Office, Overseas Development Administration, Department of the Environment, Scottish Office, Welsh Office and Department of Health and Social Services Northern Ireland - see (Stimson, 1987)



### A SHORT HISTORY OF SUBSTANCE MISUSE TREATMENT IN THE UK

**The most fundamental elements of drug and alcohol treatment in the UK have roots in the early twentieth century and were a part of the health and care landscape long before formal national drug or alcohol strategies were conceived. The UK has a proud history of early adoption, and planned expansion, of two effective forms of addiction treatment:**

**Opiate substitution treatment (OST)** – the prescribing of safer, medical quality, forms of opiate (such as methadone or buprenorphine) as an alternative to street heroin – was pioneered in the UK and was originally known as the 'British System'. The Rolleston Report in 1926 established the role of doctors in prescribing these substitutes which, until the late 1960's, was largely undertaken by individual doctors (Berridge, 2013). Following some scandals related to overprescribing, the Dangerous Drugs Act of 1967 introduced a licensing system for doctors prescribing for addiction, and established specialist Drug Dependency Units, which gradually took over OST provision for the growing number of people addicted to heroin through the 1970s and 1980s (HM Government, 1967). Since that time, OST has been the frontline treatment in the UK for primary opiate users and has been shown in several research studies to be effective in improving health and reducing crime (Gossop, Marsden, Stewart and Kidd, 2002, Donmall, Jones, Davies and Barnard, 2009).

**Residential therapeutic communities** - Although most of the early development of residential centres that offered abstinence based therapeutic programmes were in the USA, several centres were opened in the UK in the 1950's and 1960's – notable early experiments were in Phoenix House in London, The Ley Community in Oxfordshire, and Alpha House in Hampshire (Kooyman, 2001, in (eds) Rawlings and Yates Therapeutic Communities for the Treatment of Drug Users). These centres established models of group-based therapy and immersive communities that led to a proliferation of these facilities (both public and privately funded) through the 1980s and 1990s. At its height in the early 2000s, approximately 6,000 places in residential treatment programmes for support with drug use and 4,000 for support with alcohol use were taken up each year in the UK, and evidence reviews demonstrated good completion rates, and effectiveness in facilitating long term abstinence and recovery (Department of Health (DH)/National Treatment Agency for Substance Misuse (NTA), 2008, 2007, 2006, 2011, 2010).

In 1982, the Central Funding Initiative (CFI) – a multi-million-pound programme to fund services for drug users – was established. This prioritised a localised, multidisciplinary approach to tackling drug use, including services from residential rehabilitation to street-based counselling (Mold and Berridge, 2009). With the CFI, emphasis was placed on social as well as medical consequences of drug use and aimed ultimately to improve services for drug users across England. Under this Initiative, statutory and voluntary bodies were awarded funding, via local authorities, to provide services for drug users in England. Clinics, drug screen equipment, nurse training courses, counselling services, telephone helplines, rehabilitation hostels and therapy services for drug users and their families were funded (Stimson, 1987). Similar schemes were set up in Scotland and Wales around this time.

Through the 1980s and throughout the 1990s, there was an increasing focus on criminalising illegal drug use. Criminal convictions increased for minor drug possession offences – which more than doubled by the end of the 1990s – and heavy fines and prison sentences were used to stop raves under the 1990 Entertainments (Increased Penalties) Bill and then the Criminal Justice and Public Order Act in 1994 (Transform Drug Policy Foundation, Accessed 2026).

## In the mid-1990s, drug treatment began to be recognised as beneficial to individuals as well as wider society

In 1994, Chairman of a Government Task Force commissioned research into the effectiveness of national drug addiction treatment services – this became the National Treatment Outcomes Research Study (NTORS) (Gossop, 2015). NTORS examined treatment provided in in-patient centres, residential rehabilitation, methadone reduction and methadone maintenance. They found there were reductions in drug use, injecting and criminal behaviours as well as improvements in mental and physical health. This prompted the Government to increase funding for treatment.

In 1998 the first comprehensive national Drugs Strategy was published, with plans for significant new investment. There was an increased emphasis on expanding treatment and recovery services in order to reduce drug related deaths and crime and wider social harm (HM Government, 1998). This 1998 drug strategy 'Tackling Drugs to Build a Better Britain' set out the following aims:

1. Helping young people resist drug misuse in order to achieve their full potential in society
2. Protecting our communities from drug-related anti-social and criminal behaviour
3. Enabling people with drug problems to overcome them and live healthy and crime-free lives
4. Stifling the availability of illegal drugs on our streets

It established central accountability and oversight to locally delivered programmes by establishing the National Treatment Agency for Substance Misuse (NTA). This was jointly accountable to ministers from the Home Office and Department for Health.



This strategy was accompanied by significant investment in treatment. Between 1997 and 2001, during the first Blair government, budgets for treatment and recovery increased from around £200 million per year to around £1 billion by 2005 (ACMD, 2017). This funded a comprehensive menu of services commissioned across England and Wales, through local authority-led partnerships (Drug Action Teams). Similar local authority-led structures were in place in Scotland and Northern Ireland. This strategy was updated in 2002, which introduced greater focus on criminal justice and focus on areas of greatest need.

## The treatment landscape was conflicted on what 'recovery' looked like, whether that was long-term substitute medication treatment or complete abstinence

Under the 1998 Strategy, prescription of substitute medications was endorsed and largely accepted as a key approach in tackling drug addiction (HM Government, 1998). In the 2010 UK Drug Strategy, substitute prescriptions were described as "the first step on the journey to recovery" and the strategy described a need to move people through treatment to complete abstinence. Some commentators reflected that this was an unclear and unrealistic goal (Hickman, 2011) and, in practice, substitution treatment has remained the primary treatment pathway offered to people addicted to opiates.

## Funding and system response changes have placed challenges in treatment delivery

Under the 2010 Drug Strategy, the NTA was disbanded and its responsibilities absorbed by Public Health England. This led to a weakening of Whitehall oversight of the national drug and alcohol treatment system, and the level of funding soon decreased substantially - as much as 40% in some local authorities (Home Office, 2020). Reduced funding and a lack of political focus led to an overstretched and fragmented system. There was reduced access to services and worsening outcomes between 2010 and 2020 this period.

In theory, the full menu of local services created in the late 1990s are largely available today. In reality, however, there is significant variation in service delivery and accessibility between different areas as commissioning decisions are led by local decision-making and budgets, rather than being dictated by central government. More recently, there has been a move towards integrated whole system contracts – held usually by large national charities – that provide more of the range of services through a single contract in each area. While this may increase consistency in services available to each area, smaller and community-based providers are often unable to meet provision requirements and are therefore excluded from commissioning.

In 2017, The Advisory Council on the Misuse of Drugs (ACMD) concluded that drug and alcohol treatment was facing disproportionate decreases in resources and raised concerns around poorer recovery outcomes for service users (ACMD, 2017). Concerns around lack of funding were also raised by Dame Carol Black, who identified a 14% reduction in health funding between 2014/15 and 2017/18, a period when funding through the Home Office and Ministry of Justice also reduced. Black concluded that as funding pressures have increased, some services have been disbanded whilst others have been rationed (Home Office, 2020).

## Dame Carol Black's landmark review in 2020 and 2021, along with successful lobbying from charities has resulted in an increase in funding to effectively respond and support the addiction population

The independent review led by Dame Carol Black, published in two parts in 2020 and 2021, provided clear evidence that the treatment and recovery system had been weakened by years of underinvestment and poor strategic direction. The review estimated the total cost of illegal drugs to England and Wales to be around £20 billion per year. In contrast, only £600 million was spent at the time on treatment and prevention. Spending had undergone a substantial reduction in the previous ten years, contributing to significant unmet need and treatment services being decommissioned (Home Office, 2021). The UK Government Strategy published in 2021 recognised that the treatment system capacity was insufficient to meet the demand for treatment – nearly half of those using opiate and crack were not engaged in treatment, and it was higher amongst other drug user groups (HM Government, 2021). The review called for substantial new funding and a renewed focus on recovery outcomes. Following the review, political campaigning intensified. Organisations such as The Forward Trust, alongside other charities and advocacy groups, lobbied ministers to ensure the recommendations were implemented. In October 2021, more than 60 parliamentarians from across political parties publicly urged the government to fully fund the proposals. This marked a key moment where expert evidence and political pressure combined. In December 2021, the government responded by launching a new ten-year drug strategy together with additional funding - a milestone that reflected the success of sustained political campaigning in elevating addiction treatment onto the national agenda and securing tangible policy outcomes.

## However, this significant uplift in funding is thought to be insufficient to reverse years of sector disinvestment

Dame Carol Black was clear that funding cuts had left services unable to meet demand and achieve successful outcomes (Home Office, 2021). In response, government strategies published in England, Scotland, Wales and Northern Ireland committed additional funding in the early 2020s. The UK Government 2021 strategy promised £780 million extra funding over three years to rebuild drug treatment and recovery services, including for young people and offenders, including £533 million over three years to top up current public health grants, £15 million over three years under the rough sleeping drug and alcohol treatment grant and £53 million over three years to fund housing support. The strategy also recognises that this money should be used to recruit staff to support delivery and reduce caseloads. This represents one of the most comprehensive funding investments since the 1990s and brings total spend to £2.8 billion over three years. It may be that this goes someway to addressing the funding deficit created in the previous decade but it remains to be seen. After years of disinvestment across the sector, increasing caseloads and greater administrative tasks, it may not be sufficient in creating additional capacity in treatment services (Holland et al, 2022). In 2025, the Department of Health and Social Care announced consolidation of these different grants, which may generate some efficiencies in local areas.



> *"We cannot expect a reduction in demand without reversing the recent disinvestment in treatment and recovery services. To achieve and sustain recovery people need, alongside treatment, somewhere safe to live and something meaningful to do (a job, education or training). Too many people are in and out of treatment for years or even decades, without turning their lives around for good."*
>
> **Professor Dame Carol Black**
>
> **Independent report. Review of drugs part two: prevention, treatment, and recovery. Updated 2 August 2021**

## While the 2021 drug strategy contained 'tough' language, it focused on the same themes as previous strategies

Criticism of the 2021 drug strategy has centred on its punitive language, seemingly designed to deter drug use rather than employ a public health approach (Holland et al, 2022), despite calls from the UN to promote public health approaches to drugs which put people, health and human rights at the centre (UN, 2021). In practice, however, the 'tough' language of the 2021 strategy has not been accompanied by a corresponding change in approach: both existing and significant new investment is subject to unchanged funding arrangements and priorities.

Broadly, the 2021 strategy focused on the same themes as previous strategies – reducing demand, disrupting supply and improving treatment and recovery for those most acutely impacted by addiction. Supply reduction efforts were UK-wide, and largely centred on enforcement activity around making the UK a more difficult place for organised crime groups to operate and to cut the supply of illegal drugs (Home Office, 2020). The other two strands – reducing demand and supporting treatment and recovery – pertain only to England.

> *"I set Government and local authorities a very difficult task. It is a very complex picture, and I was asking them to change their culture and to start to work together in a collaborative and integrated way to deliver a whole-systems change, which they did not have before. I was asking them to do this in collaboration with the police and education. It was a completely different way of working, not more of the same. I asked them to do it at a time when, due to almost 12 years of austerity, I found in my report, as you know, that it could not have got much worse as far as treatment and recovery was concerned. We had a broken system. We had demoralised staff. Indeed, most of the protective factors that had protected young people from ever taking up drugs had been destroyed or diminished. I was writing a report at a very difficult time. That really must be said."*
>
> **Professor Dame Carol Black**
>
> **Public Accounts Committee. Oral evidence: Reducing the harm from illegal drugs, HC 72 Thursday 30 November 2023**

# Alcohol policy

While national UK drug policies became a focus initially in 1985 and then in a more comprehensive strategy from 1998 onwards, equivalent national UK alcohol policies were not introduced until the 2000s. England's first strategy focusing on reducing alcohol-related harm was published in 2004 (Prime Minister's Strategy Unit, 2004). In 2009, Scotland published 'Changing Scotland's Relationship with Alcohol: A Framework for Action) and Wales and Northern Ireland introduced combined drug and alcohol strategies (Northern Ireland Department of Health, 2006, Welsh Assembly Government, 2008) at around the same time. The most recent updated Alcohol Strategy was published by the UK Home Office in 2012 (Home Office, 2012).

Since the early 2000s' policy initiatives targeting alcohol-related harm have called for more treatment and recovery for those struggling with addiction - and the state funded treatment system now explicitly covers both alcohol and illegal drugs – but levels of 'unmet need' or the 'treatment gap' (the proportion of people with addictions not engaged with services) is much higher for people who need support for alcohol use. This has raised concerns about a 'two-tier' treatment system, where those struggling with illegal drug use were prioritised over those experiencing alcohol addiction. Debates around mechanisms for funding of alcohol treatment in England continued throughout this period with some ringfencing for drug treatment and commissioning gradually loosened over time (House of Commons, 2009, Community Care, 2002). Since the 2000s, Scotland, Wales and Northern Ireland have addressed this problem by producing substance misuse strategies, which explicitly combine efforts to tackle both drug and alcohol misuse. England is the only nation that has not explicitly included alcohol in its drugs strategy.

## Other policy interventions to address alcohol use and harm

Alongside formal published policies, a range of policy levers have been used in the UK to manage and reduce alcohol consumption and harm. As a legal substance, the methods for addressing alcohol use, addiction and related harms, are different to illegal drugs, particularly in the areas of supply and demand reduction. While some prevention and treatment efforts are combined with those for illegal drugs, supply reduction revolves less around law enforcement against trafficking and organised crime, and more around restrictions on advertising, sale to minors, and taxation policy. We summarise below the current state of evidence and experience with these efforts to manage the legal market for alcoholic products.

**While national UK drug policies became a focus from 1998 onwards, equivalent national UK alcohol policies were not introduced until the 2000s. England's first strategy focusing on reducing alcohol-related harm was published in 2004.**



### Taxation

**Alcohol taxation is an effective way to reduce alcohol-related harm, however this has limited effect when alcohol has become increasingly affordable in the UK**

The World Health Organisation recognises that raising the price of alcohol as one of three best-evidenced ways of reducing alcohol harm. In the UK, affordability of alcohol has steadily increased in recent years. In 2016, Public Health England estimated that it was 60% more affordable than 30 years earlier. In 2008, the UK introduced an 'alcohol duty escalator' which increased alcohol taxation by 2% above inflation every year. It was removed from beer in 2013 and then for all other drinks in 2014. By 2020-21, the real alcohol duty rate for beer was nearly 20% lower, 12% lower for cider and spirits and 3% lower for wine. Following analysis which showed anomalies in the tax applied to specific products – which the Institute for Fiscal Studies called "a mess" in 2017 – the government reformed the alcohol duty to tax alcohol products according to their strength, where stronger drinks receive a proportionally higher tax. The reformed system was estimated to generate £12.5 billion revenue in 2024/25, expecting to rise to £14.1 billion by 2030-31.

### Minimum unit pricing

**Applying minimum unit pricing in silo does not necessarily lead to a positive outcome, however combining this with taxation provides a better chance of the desired outcome**

Scotland introduced a minimum unit price of £0.50 per unit of alcohol in 2018. Before this was introduced, it was established that all off-trade alcohol was established to have been sold under this unit price. In the two and a half years following its implementation, Scotland reported a 13.4% reduction in deaths wholly attributable to alcohol, in Scotland compared to England. There was also a 4.1% reduction in hospitalisations wholly attributable to alcohol. There is however less evidence that the minimum pricing benefited any wider social outcomes, such as alcohol-related crimes or children and young people affected by the drinking of family members.

The Welsh Government also introduced a minimum unit price of £0.50 per unit of alcohol in 2020. An evaluation found that this had reduced the sale of cheaper and higher strength alcohol.  It was also found to have reduced the number of alcohol units purchased by households. Interestingly, immediately after the minimum pricing was introduced there was no statistically significant change in higher socioeconomic groups purchasing levels. There was a small initial increase in purchasing amongst those from lower socioeconomic groups. Over the slightly longer term, more of decline in purchasing was observed by higher socioeconomic groups compared with those in lower socioeconomic groups.

**13.4%**

**In the two and a half years following minimum unit price implementation in 2018, Scotland reported a 13.4% reduction in deaths wholly attributable to alcohol, in Scotland compared to England.**

In September 2024, the Scottish Government increased the minimum unit price to £0.65 per unit of alcohol. While it is too early to evaluate its impact, early modelling using the Sheffield Tobacco and Alcohol Policy Model indicated that this increase could lead to reductions in harmful drinking, deaths and hospitalisations linked to alcohol. The estimated impact is largest amongst those living in deprived areas and the heaviest drinkers.

Public Health England (2016) were clear that combining an increase in taxation alongside the implementation of minimum unit pricing is thought to lead to a more substantial reduction in harm – more so than minimum unit pricing alone.

## Regulating availability

### Increasing availability of alcohol has shown an increase in consumption

The first significant regulation of alcohol sales came during World War I as part of The Defence of the Realm Act 1914. Pub opening hours were restricted to keep workers and soldiers productive in the war effort. Many elements of these restrictions were maintained after the end of World War I under the Licensing Act 1921. In the 1970s and 1980s, licensing acts were passed in Scotland and England and Wales which provided more flexibility around opening hours.

In the early 2000s, England and Scotland introduced acts which abolished fixed national opening hours and permitted premises to apply for hours required by their businesses. Premise and personal licences were introduced and managed by local authorities. Scotland also reduced the hours retailers could sell alcohol to between 10am and 10pm – the most restrictive opening hours across the UK. Northern Ireland permits off-licences and shops between 8am and 11pm Monday to Saturday and between 10am and 10pm on Sundays. There are opportunities to apply for an extension license, which permits sales out of these times. Across England and Wales, shops can sell alcohol for the time they are open. There are no universal time restrictions.

Where the opportunities for alcohol sales have increased, evidence suggests it has led to an increase in alcohol consumption. Public Health England (2016) points to 10 studies which provide consistent evidence that where opening hours are increased by two hours or more, alcohol-related harm, including road traffic crashes and injury, increases. A systematic review of evidence sources, although largely in the US, identified that as alcohol outlet density increased, so did assaults, self-reported injuries, motor vehicle accidents, domestic violence and child abuse. Alcohol Focus Scotland and Scottish Health Action on Alcohol Problems have called for further shortening of these opening hours to minimise harm further.

**In September 2024, the Scottish Government increased the minimum unit price to £0.65 per unit of alcohol. While it is too early to evaluate its impact, early modelling using the Sheffield Tobacco and Alcohol Policy Model indicated that this increase could lead to reductions in harmful drinking, deaths and hospitalisations linked to alcohol.**



## Reducing alcohol advertising

### Marketing alcohol has been found to increase consumption, especially among young people and high-risk groups

The World Health Organisation (2022) argues that the marketing of alcohol increases alcohol consumption, particularly where it is targeted at young groups or those who are heavy drinkers. They are particularly concerned that digital marketing tools are now enabling alcohol products to increasingly be marketed across national borders. They are clear that more regulation is required to reduce alcohol-related harm increasing across the world.

In 2005, the Committees of Advertising Practice (CAP) within the Advertising Standards Authority (ASA) – the UK's regulator of advertising – introduced strict rules around marketing of alcohol. This meant alcohol could not be portrayed as having therapeutic qualities, helping people overcome problems or helping people display tough or daring behaviour. Crucially, there were restrictions around younger populations, where marketing could not target those under the age of 18 or use models who appear younger than 25.

Public Health England (2016) is clear that there is little evidence that reducing alcohol marketing and advertising and improving population-level education is effective in reducing consumption and, as a result, alcohol-related harms.

Where there is little evidence that a restriction in marketing leads to a restriction in alcohol consumption, there is evidence that increased marketing increases alcohol consumption. Anderson et al. (2009) conducted a systematic review of longitudinal studies which measured exposure to advertising and promotion of alcohol. They concluded that these studies identified that exposure to media and commercial advertising on alcohol is associated with increased drinking and increased likelihood that adolescents will start to drink alcohol. Another evidence review concluded that alcohol marketing is particularly impactful amongst those at an increased risk of problematic alcohol consumption.

# Policy responses in UK nations

**Implementation of both drug and alcohol policies has varied across the nations of the UK. The following section describes current status in each of the four nations.**

## England

### Initial signs of positive partnerships forming post strategy but there is room for improvement

The National Audit Office (2023) reflected on progress made against the 2021 drug strategy since it was published. They concluded that the government had established new structures – including the Joint Combating Drugs Unit (JCDU) which sits across multiple departments to coordinate and oversee implementation of the strategy and a ministerial role to provide leadership. They have also attempted to strengthen local partnership working, which the NAO believe have strengthened cross-government working and established responsibilities for tackling substance misuse across health and criminal justice partners. They are clear, however, that the maturity of these partnerships is variable, with only 30% of partnerships having completed a local delivery plan. Beyond this, however, they conclude that the strategy has not yet led to a shift in how departments are approaching the complex causes of drug harm (National Audit Office, 2023).

The Local Government Association (2024) found that Combating Drugs Partnerships (CDPs) – which were mandated under the strategy – were found to be particularly useful in improving collaboration and communication between partners and coordinating a joined-up approach to drug treatment.

### The strategy ignores dual-addiction and prevention which creates a treatment gap

Local authorities had reflected however, that the absence of a national strategy for alcohol treatment had limited the reach of drug treatment services. In recognising the crossover in population experiencing both drug and alcohol problems, their needs were only partly met. There were also restrictions on how much of the funding allocated to local areas could be spent on alcohol treatment, limiting their availability or putting pressure on local authorities who tried to fund them directly (Local Government Association, 2024). Local authorities also noted the absence of a prevention focus in the national strategy. Despite this being a key priority for them, its absence from the strategy meant that often they were limited in how much they could spend on prevention activities (Local Government Association, 2024).

In 2020, the Home Office launched 'Project ADDER', which aimed to utilise a 'whole systems' approach where those impacted by addiction were supported and given treatment, while law enforcement partners targeted supply into the UK. Under Project ADDER, various interventions were tailored to combat drug misuse in the 13 most impacted areas in England and Wales (Home Office, Updated 2025).

Towards the end of 2025, the Department of Health and Social Care consolidated previously separate grants which focused on substance misuse, rough sleeping, housing support and inpatient detoxification into a single grant to local authorities to purchase local services (Department of Health and Social Care, Updated 2025).



## Scotland

### Scotland's tackling addiction strategy applied a public health approach

In 2018, the Scottish Government published 'Rights, Respect and Recovery', which set out their strategy for tackling drug and alcohol addiction. This reflected a public health approach which sought to tackle addiction within the wider context of poverty, inequality and health challenges and prioritised prevention and early intervention. It was also the first strategy that aimed to tackle the harms caused by alcohol and drugs together (Scottish Government, 2018).

Since the strategy was published, and in response to Scotland having recorded the highest rate of drug related deaths in Europe, the Scottish government has taken action to establish a drug deaths taskforce in July 2019, appointed a Drug Policy Minister to lead work in reducing harms linked to drug misuse in December 2020 and provided £250 million funding to support their mission to reduce drug-related deaths and harms (Audit Scotland, 2022). They have also supported action which directly supports those with addiction, distributing take-home naloxone kits for those at risk of overdose and improved practice in the use of medication such as opioids to support recovery alongside psychological and social support. Of the £250 million investment, £100 million was reserved for funding residential rehabilitation. While this marks an increase in funding, critics have noted that the investment only brings funding levels back to what they were six years previously, with no real term increase.

### Despite the public health approach, investment in prevention and a clear path to improve outcomes was limited

While Scotland was pursuing a public health prevention approach, Audit Scotland (2022) concluded that the Scottish Government had not invested in prevention enough to achieve strong outcomes. This was particularly the case around inequalities and root causes of drug addiction in communities (Audit Scotland, 2022). Given that the Scottish Drugs Forum identified poverty as the key root cause, it is vital this is addressed (Scottish Drug Forum, 2019).

Questions have also been raised about the extent to which complexities in how funding is allocated and partnership delivery have made accountability for outcomes difficult. Audit Scotland (2022) suggested a clearer plan was required to demonstrate how investment and service delivery was likely to improve outcomes (Audit Scotland, 2022).

Alongside the 2018 strategy, the Scottish Government published a new alcohol framework, which set out their 20 actions they would take to reduce consumption and harm linked to alcohol consumption. This was broadly found to be aligned to the evidence base available (Drug and Alcohol Findings, 2015), focusing on minimum unit pricing, targeted advertising, improving education and supporting families most impacted (Scottish Government, 2018).

### Scotland's new strategic plan to tackle alcohol and drug harms criticised for insufficient funding to meet increasing need

In 2026, the Scottish Government published a new strategic plan to tackle alcohol and drug harms. Again, this adopted a public health approach which recognised substance misuse as one of multiple challenges facing individuals which required a comprehensive and coordinated multi-agency response. It also promised greater access to treatment that supported those with addiction including residential rehabilitation, crisis care and safer drug consumption facilities. While the overall approach was largely welcomed, concerns have been raised about the limited impact of previous strategies and whether the new funding is sufficient to tackle increasingly concerning alcohol-deaths and drug-deaths, which continue to rise in Scotland.

## Wales

### Wales' strategy has successfully called for a holistic approach to harm reduction

The Welsh Government published a joint substance misuse strategy which covered the decade between 2008 and 2018. It aimed to prevent harm, support substance misusers to improve their health and move into recovery, support families impacted and reduce availability of substances via enforcement activity. This approach prioritised an explicitly harm reduction approach, which has largely been achieved. Under the strategy, evaluators found that there had been a shift to a more holistic and increasingly distinctive Welsh approach to health and social care. The introduction of Area Planning Boards (APBs) aimed to establish more effective regional commissioning that was less fragmented than the previous structure. As the APBs were aligned to the new Local Health Boards (LHBs), responsibilities for substance misuse delivery moved from being the responsibility of community safety to health. The alignment of APBs and LHBs were also thought to benefit improved partnership working (Livingstone et al, 2018).

Evaluators concluded that the Welsh strategy generated a reduction in overall harms, improved data collection and the introduction of the Take Home Naloxone programme. These successes largely concentrated on harm reduction and harmful users of illegal drugs. In contrast, less progress was identified around tackling harmful drinking habits or the misuse of prescription drugs (Livingstone et al, 2018).

In 2019, the Welsh Government published a three year Substance Misuse Delivery Plan, which committed to increasing funding to APBs by more than 10% between 2019-20. In 2020-21, the Welsh Government invested approximately £54 million to deliver commitments around substance misuse (Welsh Government, 2020). Services funded included Take Home Naloxone and needle exchanges as well as longer-term programmes such peer-led recovery community – Recovery Cymru – which aims to make recovery more sustainable and referrals for those in recovery from substance misuse to the Out of Work Service, which aims to improve employability (Welsh Government, 2020).



## Northern Ireland

### Northern Ireland's substance misuse strategy also follows a public health approach

In 2021, Northern Ireland published their most recent substance misuse strategy. Similarly to the strategies detailed above, Northern Ireland focuses on reducing availability of substances, reducing the harm caused by substance use, improving access and quality of treatment and partnership working (Northern Ireland Department of Health, 2021). Taking a public health approach, similar to both Scotland and Wales, Northern Ireland recognised the need to address drivers of substance misuse, particularly health inequalities, trauma and ACEs.

The Northern Ireland Audit Office (2022) concluded that before this strategy was published, there had been a lack of strategic focus on tackling substance misuse and collaboration within the health and social care sector, and with voluntary and third sector organisations, had not always been strong (Northern Ireland Assembly, 2022). They recommended both be addressed to support the delivery of activity against this strategy. They suggested also that additional funding be considered to facilitate the implementation of this strategy. Evidence is not yet available about whether it has been successful, but the Northern Ireland Audit Office (2022) were encouraged by the opportunity afforded by the strategy to re-focus on efforts to tackle the causes of and harms associated with substance misuse.

### ADDICTION TREATMENT IN PRISONS

Although some advice and treatment programmes have been available to prisoners with drug problems since the 1980's, delivery before the mid-1990s was inconsistent and relied on local initiative and funding (Home Affairs Select Committee, 1998). The first comprehensive national drug strategy, published in 1998, which set out plans for prisons to work in partnership with Police, Probation, health and local authority partners to reduce availability and access to drugs and introduced funding to support delivery (HM Government, 1998). Prisons were required to have a drug strategy overseen by a multi-disciplinary team that included supply reduction efforts, healthcare provision, and individual and group programmes for treatment and recovery (Home Office, 2005). In the early days of this strategy, most expansion of services in prisons was of individual advice and case management, self-help and fellowship groups, group-based recovery programmes (such as the RAPT 12-step programme), therapeutic communities, and prison staff-led courses.

While opiate substitution treatment (OST) had expanded in community drug services during this period, delivery in prisons was variable and people entering prison with opiate dependence were commonly provided with default short-term detoxification. The 'Integrated Drug Treatment System' (IDTS) approach was introduced into prisons in the late 2000's and set out plans for seamless continuation of treatment, particularly OST, between community and prison (Marteau, Palmer and Stover, 2010, NTA, 2006). Responsibility for prison healthcare, including drug and alcohol treatment, was transferred to NHS England in 2013 and included a focus on parity of treatment between community and prison and continuity of care for people who transfer between settings (NHS England, 2013). As focus shifted towards medical care for prisoners with drug or alcohol problems availability of structured recovery programmes, many of which showed positive impacts on prison behaviour and reoffending rates (Kopak and Dean, 2014), declined and funding for prison-based drug recovery programmes reduced (Black, 2024). In the early 2010's, there were over 100 treatment programmes in prisons across the country. These were often small scale and of varying quality, but efforts to improve them were halted when funding was cut through the 2010's. The prison service has more recently tried to regenerate this model – promoting what are called Drug Recovery Wings and 'Incentivised Substance Free Living Units'. These are promising ideas, but at the moment most are poorly implemented and starved of resources.

Recently, a 2024 review has highlighted ongoing inadequate commissioning arrangements that fail to drive improvement, poor accountability, and limited involvement of prison governors in designing and supporting service delivery. The report has highlighted a lack of focus on treatment and recovery and poor access to mental health support, trauma-informed care, peer mentoring, and recovery programmes (Black, 2024). Further, a National Audit Office (NAO) report concludes that prisons and healthcare services are facing increasing challenges from illicit drug use, particularly linked with the increasing prevalence of synthetic drugs and the use of drones to smuggle contraband into prisons (NAO, 2026) and has identified substantial underspending by HM Prison and Probation Service (HMPPS) on programmes intended to reduce drug-related harms. The NAO concluded that more effective prioritisation of resources and stronger collaboration between prison and health services are required to address drug-related harms within prisons.

The Justice Select Committee Inquiry heard evidence of some examples of effective practice have been identified, including at HMP The Mount and HMP Cardiff, where drug-free wings have reportedly succeeded because they target prisoners with addiction issues, maintain a recovery-focused environment, and are supported by trained staff. There were also calls for stronger incentives to encourage prisoners with substance dependence to engage in treatment and recovery programmes, recognising participation in recovery as a positive behaviour worthy of reward.



*"I have come across two examples of what the team have thought are effective drug free wings, one at HMP The Mount, near Hemel Hempstead, and one at HMP Cardiff. They are drug free. It is essential that they are selecting the right prisoners, i.e. prisoners with addiction issues, for the wings; that they are properly focused on recovery; and that staff are trained and have the right expertise.*

*"We have some examples where things are working well, but in a lot of prisons we find that those drug-free wings are not drug free, staff have not been properly trained and quite often they are being used as glorified enhanced wings for well-behaved prisoners rather than those who have addiction issues."*

**Charlie Taylor, Chief Inspector, His Majesty's Inspectorate of Prisons. Justice Committee Oral evidence: Tackling Drugs in Prisons, HC 557. Tuesday 25 February 2025**

As the drug market in prisons has expanded over the last 15 years, with dealing becoming normalized and endemic in most prisons and a range of synthetic substances widely available, availability and funding for treatment responses has declined, leading commentators to call for a renewed ambition to tackle drug problems in prisons.

## Public health approach to addiction

### UK addiction strategies apply a public health approach but fall short in practice, prioritising harm reduction and enforcement over tackling the root causes of addiction

All the most recent strategies across the UK are explicit in saying they take a public health approach to tackling addiction, but do not set out with clarity how the methodology should be applied in practice. Plans for implementation are more clearly defined in Scotland, Wales and Northern Ireland, where their strategies explicitly reference the underlying drivers associated with substance misuse, including deprivation, inequalities, trauma and ACEs. While understanding root causes is vital to establishing a robust public health approach to tackling substance misuse, early evidence, particularly from Wales and Scotland, suggests that service delivery has focused largely on reducing immediate harm amongst those misusing substances and less so on tackling these systemic drivers.

> *"The national policy needs to be focused much more on prevention, treatment, recovery and harm reduction instead of supply and enforcement. That is not because I do not think supply and enforcement are important. Those are important priorities particularly in terms of enabling opportunities to safeguard some of our more vulnerable communities.*
>
> *I have never seen any evidence that a focus on crime and enforcement has reduced the supply of drugs in a local area. I have seen that it moves, as you have described. There is also a risk that we disrupt supply in a way that means we end up with worse drugs than we had had previously.*
>
> *From a public health perspective - my focus would be on working with those people who are using substances: I do think alcohol needs to be part of this conversation as well. A lot of people arrested for domestic abuse were using alcohol and cocaine at the same time.*
>
> *We should not shy away from the fact that we are worried about the supply of illicit drugs because of the illegal nature of them, but we should also be worried about the supply of alcohol in our communities and the impact that that has."*
>
> **Alice Wiseman, Addictions Lead, The Association of Directors of Public Health (ADPH)**
>
> **Public Accounts Committee. Oral evidence: Reducing the harm from illegal drugs, HC 72 Thursday 30 November 2023**

Across the whole of the UK, it is the Home Office in Westminster that leads on drug law and drug policy. In most European countries leadership around drugs harm sits in health departments. Some believe a Home Office lead encourages policy makers to view drug harms and addiction through the lens of crime as opposed to health. While the response strategies have been explicit about a public health approach, they each have a core component which focuses on enforcement to reduce the availability of drugs.

Research on what works in drug policy received comparatively little funding in the UK, which means understanding how drug and alcohol-related harms can and should be tackled is limited, particularly around longer-term outcomes. This may in part explain the lack of focus on longer term, more systemic drivers of addiction.

## Funding

### The costs of severe addiction far exceed what is spent on treatment and prevention, and without early intervention, the burden will continue to compound across generations

The evidence in the previous chapter shows the greatest impact of addiction is on people who use opiate drugs and crack cocaine, who face the greatest burden, economically and socially, whilst being the smallest proportion of all people with substance use disorders. Taken together, the evidence across all six sections in the previous chapter indicates health and crime are particularly costly. Whilst the other more indirect costs of addiction to housing, welfare support, children's services and families substantially exceed the costs of treatment and prevention too.



# 5. Progress and Challenges

**This chapter sets out some of the substantial progress made in recent years in how addiction is tackled within the UK, alongside some of the remaining challenges. However, it is a complex and nuanced picture, with changes and developments across the whole sector defying clear categorisation as wholly positive or negative.**

## Tackling addiction in local communities

### Localised partnerships have been a clear success across all four nations, however they are not without room for improvements

Under the broad public health approach, there is evidence in all four nations (England, Scotland, Wales and Northern Ireland) that collaboration has been the centre of efforts to tackle addiction, where l localised and collaborative partnerships have been established. Where progress against published strategies have been evaluated, particular success has been identified in establishing these partnerships. For example, as noted above, the Joint Combating Drugs Unit (JCDU) has been established in central government and sits across multiple departments to coordinate and oversee implementation of the strategy and a ministerial role to provide leadership (National Audit Office, 2023).

This is particularly important as the UK has moved towards devolving commissioning and delivery of treatment programmes to local areas. While this has led to some examples of innovation, most nations report a lack of clarity and accountability around tracking outcomes and funding (UKDPC, 2012).

### *Recovery focused interventions*

### Commissioning is shifting toward long-term recovery outcomes, reflecting a more holistic understanding of what successful recovery looks like

Historically, commissioning in substance use services has focused primarily on treatment outputs and short-term metrics, such as compliance with delivery plans, the number of clients in treatment, timeliness of assessment or the quality of referral mechanisms. This approach emphasised quantitative measures, often overlooking the broader, long-term outcomes that define recovery (such as improvements in wellbeing, social reintegration, or sustained abstinence) and policy objectives (reducing deaths and reducing crime). While this data-driven approach provided accountability, it offered limited insight into achievement of policy objectives or the lived experiences of service users.

More recently, there has been a shift towards measuring long-term recovery outcomes. Some commissioners are now adopting metrics that capture the sustained impact of services over time, including improvements in health, housing stability, employment, and social engagement. This represents a move from purely transactional measures to a more holistic understanding of recovery, recognising that successful outcomes extend beyond immediate treatment completion.

## *Lived Experience Recovery Organisations (LEROs)*

### LEROs are invaluable in supporting sustained recovery

Peer support and mutual aid initiatives have long been recognised as useful drivers of sustained recovery, although significant investment in peer-led and lived experience support has only started to increase in the last few years.

By the end of 2025, nearly half of all local authorities in England reported having a LERO in their area (OHID, 2025c). Those who have accessed support provided by LEROs have described them as a safe community and non-judgemental space to share their experiences and concerns around maintaining their recovery. Some reported improved self-worth and confidence, while others have reported developing key social and emotional skills, practical skills and gaining insight into their own behaviours. While evidence of the impact of LEROs is limited, preliminary findings suggest they are invaluable to those in later stages of recovery (Humphreys and Finch, 2025).

The growth of lived experience recovery organisations highlights a broader transformation in the sector. These organisations not only deliver direct support but also influence service design, policy, and commissioning priorities. By embedding the voices of those with personal experience of substance use and recovery, they help ensure services are responsive, person-centred, and effective in supporting diverse recovery pathways. Their expansion signals a significant cultural shift within commissioning, recognising that recovery is not solely about treatment from external professionals, but about empowering individuals and communities to rebuild their lives.

## *Targeted outreach*

### Additional funding has enabled proactive identification and reach into often overlooked communities

Enabled largely by the additional funding allocated to addiction treatment (see section 'Forty years of national drug and alcohol strategies' above), treatment organisations have been able to actively reach out to those with problematic drug and alcohol use in the community. Previously, where there was less resource available, organisations largely relied on self-referrals or referrals from health services on behalf of those with problematic use. This meant they could not be proactive in identifying those who could benefit from addiction treatment and reaching out. This has benefited rural communities especially.



## *Safer drug consumption*

### Wider availability of naloxone kits is helping reduce opioid overdose deaths

A number of the drug strategies specify the roll out of naloxone kits. Naloxone is an emergency antidote for overdoses caused by heroin or other opioids, including fentanyl. It works by reversing the breathing difficulties which can be brought on by an overdose. Evidence suggests that where naloxone is administered, it is associated with a reduction of opioid overdose-related deaths (ACMD, 2022).

Over the last few years, take home naloxone kits have been made available across the UK. The ACMD recommended in 2022 that access to, and uptake of, naloxone kits in the community was required across the UK (ACMD, 2022). In 2024, legislation changed to expand the list of professionals and services authorised to supply naloxone with continued consultation to potentially expand the list further.

While there has been some success, there is evidence that some people chose not to carry the kits because they can then be identified as a heroin user. Some areas have also reported seeing younger populations using heroin. These users sometimes do not have access to more experienced users from whom to learn about the importance of carrying naloxone (Public Health England, 2020).

Safer Drug Consumption Facilities (SDCFs) are anticipated to improve access to supervised health support and safe and hygienic environments for people who inject drugs. The first SDCF in the UK, 'The Thistle' in Glasgow, reports that 700 individuals in the city have used its facilities on more than 28,000 occasions between opening in January 2025 and the end of April 2026. Around 70% of visits are for injection of drugs and the service reports highest use by people using cocaine (Glasgow City Health and Care Partnership, accessed 2026).

The Thistle is currently a pilot scheme and an evaluation led by the University of Glasgow and Glasgow Caledonian University will run until September 2029 (University of Glasgow, 2025). Some stakeholders, including The Forward Trust, have highlighted that SDCFs have the potential to be life-saving and pragmatic for those at the highest risk, but will be most effective if integrated into existing recovery services, rather than as a standalone facility (Forward Trust, 2025).


**Over the last few years, take home naloxone kits have been made available across the UK. The ACMD recommended in 2022 that access to, and uptake of, naloxone kits in the community was required across the UK.**

## *Opioid substitution treatment (OST)*

### Longer-acting addiction treatment alternatives show particular promise in improving retention in treatment and reducing overdose risk

The UK has a long history of OST – the prescribing of opioid-based medications, such as methadone and buprenorphine, as alternatives for heroin that ease withdrawal symptoms. It was originally trialled and introduced in the UK in the early twentieth century and became known as the 'British System'. Until the late 1960s it was prescribed largely by individual doctors. Under the Dangerous Drugs Act 1967, specialist Drug Dependency Units took over OST provision throughout the 1970s and 1980s. It has remained a core part of the UK's response to addiction since. UK guidelines maintain that OST must contain two core elements – a pharmacological element, where illicit opioids are substituted with a prescribed alternative, and a psychosocial component, where people are supported to make positive changes more holistically (Welsh Government, 2026; Department of Health and Social Care, 2017).

Evaluations of OST have largely reported benefits – including reduced risk of mortality, including by overdose, in those addicted to opioids (Sordo et al, 2017), reductions in blood-borne infections (MacArthur et al, 2012) and increased success in treatment (Havnes, Clausen and Middelthon, 2013). While these benefits of successful application of OST are well-evidenced, it is important to remember that an unknown proportion of individuals receiving substitute medication do not comply with the treatment – by selling on the medication provided, or using other drugs on top – and are therefore less likely to benefit. There are also medical risks, such as non-medical use and chance of overdose, which means that most people prescribed an OST medication must consume it during daily supervised visits. Research has identified that attending a service daily is a barrier to retention and, ultimately, their recovery (Welsh Government, 2026).

**Buvidal** – a long-acting form of buprenorphine – can be given weekly or monthly, depending on injection strength. Over recent years Buvidal has become increasingly available in services in England and Wales. When the COVID-19 pandemic began, and social distancing was required, the Welsh Government funded a rapid roll out of Buvidal across Wales. In a recent evaluation of its roll out, practitioners and service users were clear that they thought Buvidal was more effective than other form of OST because it did not require daily service attendance and, because it is partially an opioid blocker, it prevented additional or 'top up' opioid use. It was also found to reduce the risk of overdose, provided service users with clarity of mind and promoted treatment retention (Welsh Government, 2026).




## *Localised commissioning*

### Fragmented local commissioning has created inconsistent, geographically unequal treatment provision with limited or over-processed accountability or collaboration

Since commissioning of drug and alcohol treatment services was devolved to local authorities in 2012, there is perceived to be a lack of accountability in how this funding is spent and whether it is effective (Black, 2020). Local commissioning was found to be 'fractured' and lacking collaboration, despite a multi-agency approach being proven to make treatment more likely to be effective (Black, 2020).

In some areas, this has led to an increasingly bureaucratic process, with significant scrutiny around implementation and reporting against strict key performance indicators. While services generally understand the importance of being held accountable for delivery, reporting around implementation processes and key performance indicators has required increasing time and resources from services.

Commissioning approaches also vary significantly by area. Some commissioners place emphasis on clinical data and outcomes, while others commissioned based on human experience and understanding specific challenges faced by those in recovery. This can lead to geographical variation in the treatment available to those who require it. For example, the National Audit Office (2023) identified substantial variation in the make-up of CDPs. While more than 90% had police and probation represented in their membership, less than a quarter (23%) involved substance misuse treatment providers. This was thought to lead to considerable variation in the services commissioned across areas. They were clear that to understand the implications of this, in-depth analysis was required to compare progress in local areas and identify interventions which are improving outcomes (National Audit Office, 2023).

In 2022, in response to the Black review, commissioning quality standards were published for alcohol and drug treatment services. This aimed to bring consistency to the commissioning approaches used in local areas, improve transparency and increase accountability. There are no evolutions available around whether this has been improved commissioning.

## *Inconsistent funding*

### While long-term funding has improved, last minute ring-fenced grants misaligned with local priorities continue to undermine their impact

Longer term and more sustainable funding has increased following the Dame Carol Black review has been welcomed by the treatment service sector. However, some funding remains last minute, often with specific conditions attached that do not align with the strategic priorities of the sector or do not address critical issues identified locally. This minimises the impact these smaller pots of funding can have on the sector.

## *Workforce capacity and expertise*

### Critical staff shortages, high turnover, and burnout are severely undermining treatment service capacity, with workforce recovery likely to take years

Linked to funding cuts across the sector, there are not enough professionals required to support those in treatment. The Black Review (2020) conducted a survey of treatment providers in 2020. The average caseload of a drug and alcohol key worker was approximately 50 at any one time but more than 10% of providers had average caseloads above 80.

Black's (2020) survey identified a particular skills gap around psychiatrists and psychologists with cognitive behavioural and/or psychotherapeutic skills. This was identified as a critical component of drug treatment. The Welsh government reports "considerable investment in building the skills of practitioners" and note that many professionals working in drug and alcohol treatment are delivering interventions effectively (Welsh Government, 2013). They are clear that to maintain this skill and ensure consistency across practitioners skills, Service Level Agreements must specify required workforce activities, individual skills and continuous professional development (Welsh Government, 2013). Likewise, Northern Ireland is clear in their strategy that workforce development is critical to effective and successful service delivery. They have included an outcome around workforce development within their strategy to ensure it is prioritised (Department of Health, 2021).

Audit Scotland (2024) recognised that the Scottish Government has made progress in addressing gaps in drug and alcohol treatment services, notably increasing residential rehabilitation capacity and implementing national treatment standards. They note, however, that little progress has been made in implementing a workforce plan. This is critical because the workforce is "under immense strain" (Audit Scotland, 2024) They are clear that urgent action is needed as staff are undervalued, on the precipice of burnout and lack job security.

Two years following the publication of the UK drugs strategy, the National Audit Office (2023) identified that staff shortages in the treatment and recovery sector – particularly also around clinical psychologists and psychiatrists – were critical. They were clear that it would take time to rebuild capacity across services, particularly because this sector has lost capacity and skills over the last decade. Where new staff were recruited, there was also high turnover – turnover was 12% within the NHS and 27% across third-sector treatment providers. The National Audit Office (2023) also recognised that delays in allocating funding and short funding periods was creating uncertainty and reducing their capacity to onboard key professionals.

**The average caseload of a drug and alcohol key worker was approximately 50 at any one time but more than 10% of providers had average caseloads above 80.**



The UK Government has since published a 10-year strategic plan for the drug and alcohol treatment and recovery workforce which spans the decade from 2024. This sets out to improve the capacity and quality of drug and alcohol treatment with an additional investment of £532 million between 2022 and 2025 (NHS England, 2024). The strategic plan sets out how funding is intended to support expansion of the workforce with regulated medical professionals, drug and alcohol workers and strategic and commissioning teams in local authorities, including formalising qualifications and delivering regulated training. Reflecting on this, The Forward Trust recognises important work being done around the workforce transformation. However, they are largely long term. The sector requires more guidance on this. While the government has promised additional guidance, it has been delayed a number of times.

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## *Lacking treatment for non-opiate users (including alcohol)*

### Treatment has historically prioritised opiate users, leaving alcohol and non-opiate services significantly under-resourced despite growing demand

Treatment funding has typically prioritised highest need groups. Those experiencing the most acute harms of addiction are often opiate users. Treatment for this group requires significant clinical resources compared with problematic non-opiate drug or alcohol users. When treatment funding was cut in the later 2000s and 2010s, opiate services were prioritised over services dedicated to problematic non-opiate drug or alcohol use.

The Forward Trust is clear that, in recent years, there has been a steady increase in dedicated alcohol services, closing the gap between funding for services dedicated to opiates and those specific to alcohol. However, greater investment is required as current demand for services dedicated to problematic non-opiate drug and alcohol users significantly outweigh provision.

There is a legacy within treatment data reporting of splitting treatment cohorts into 'opiate users', 'non-opiate users' and/or 'alcohol users'. This is also a legacy within the treatment sector of thinking about separate treatment and recovery pathways for these groups. It is important to recognise that there are key differences between these cohorts. For example, more people engaging with Forward Trust treatment services for alcohol or non-opiate drug use go straight onto a day programme compared with opiate users. However, the needs, demographics and experiences of those within each cohort are by no means homogenous. With rising problematic cocaine and ketamine use amongst younger cohorts, bespoke services may be required which are not suitable for all non-opiate users.

## Tackling addiction in prison

### Endemic drug use in prisons is undermining rehabilitation and reducing public safety

In 2025, the Chairman of the Justice Select Committee, Andy Slaughter MP, identified "endemic levels of drugs in our prisons". The Committee concluded that "the system is failing, and the human cost is unacceptable". In the same year, Charlie Taylor – the HM Chief Inspector of Prisons – warned that an "overwhelming ingress of illegal drugs is establishing prisons and preventing rehabilitation". Tackling addiction within the prison population is vital in ensuring that crime can be reduced. However, drug use in prison – as outlined in the first chapter – presents differently to drug use out of prisons. Substances used change daily, as does their potency. This requires a reactive and bespoke policy response.

Particular challenges have been identified around tackling addiction in prisons specifically - these are outlined below. Addressing these challenges is critical in fulfilling the 2021 drug strategy's commitment to reduce drug-related crime.

1. **Pre-sentence reports**

   **Decline in pre-sentence reports reduces the opportunity to identify and divert offenders into treatment rather than prison**

   After a defendant is convicted of an offence, the Probation Service can write a pre-sentence report which details the defendant's background, risks, and rehabilitation needs to assist courts in determining the most appropriate sentence. These can be particularly useful in highlighting how their addiction may have been connected to their offending and their addiction-related need. However, there has been a significant decline in their use – between 2015 and 2022, the number of pre-sentence reports supplied fell by 42% (Hansard, 2025). This means there are fewer opportunities to identify, and meet, addiction-related needs of those entering into the criminal justice system. It also minimises opportunities to divert those directly into treatment, instead of prison, where their offending is identified as being largely related to their addiction.

2. **Increasing pressure on treatment services in the community**

   **Replacing short prison sentences with community sentences and no additional funding risks overwhelming the already stretched community treatment services**

   The Independent Sentencing Review, led by David Guake, recommended that community-based, suspended, or deferred sentences should replace short prison sentences for most offenders (Ministry of Justice, 2025). Currently, 50% of those entering prison report problematic drug use (Justice Committee, 2025). This means that if offenders are diverted away from prison, they will be unable to access prison-based treatment services. This has the potential to place increased demand on community-based treatment providers. No additional funding has been considered to meet this additional need.



# 6. Conclusion

**Cases of addiction have been documented in the UK for centuries (Berridge, 2013), but addiction has only really been understood more recently as a complex mental health condition with significant health and social consequences. Estimates from survey data, which are largely considered to under-report the problem, suggest that hundreds of thousands of people across the UK are struggling with addiction right now. The consequences ripple out far beyond the individual – addiction and related harms break up families, shape communities, strain public services and cost the economy billions of pounds every year.**

People struggling with addiction can experience severe physical health implications, including premature death, poor general health, or specific blood-borne infections such as HIV or hepatitis. The impact on children of people with substance disorders can be devastating from before birth through to experiences of neglect and trauma. Unstable housing and employment can result in a precarious existence which can either lead to or be a result of addiction. Addiction can ignite criminality whether that be linked to domestic abuse, to fund the addiction or exploitation to meet demand.

The economic and societal cost of addiction is substantial. The biggest social costs associated with addiction are health and crime. These and the indirect costs of addiction such as housing, welfare support, children's and family services, outweigh the cost of treatment and prevention activities that aim to reduce levels of addiction in our society. Most of the taxpayer money spent in this area is being spent on negative consequences of addiction (for example, hospital treatment and responding to crime). A more effective national approach to managing and reducing addiction is one that requires a balanced set of interventions that focus both on the prevention and treatment of addiction.

While many of the policies and programmes described in Section 5 (Progress and Challenges) have made a positive impact on reducing addiction related harm, it is also clear that challenges remain.

Although policymakers began to respond to the scale of this challenge in the later years of the 20th century, in the last 15 years, addiction policy, and the funding to tackle it, has been deprioritised by successive governments. In 2026, we can say there are signs of renewed commitment – an uptick in treatment funding since Dame Carol Black's Review of Drugs in 2021,

some experiments with minimum alcohol unit pricing, and the 2024 Labour Government's interest in tackling drug and alcohol related crime – but we have yet to meaningfully turn the tide on the level of addiction in our society, or its consequences. Physical and mental health harms continue to weigh on the most deprived in our communities and complex links between drug use and offending, including violent offending, accumulate heavy costs for society.

Despite this, there are some positive trends: the overall number of people using alcohol and drugs in the UK has declined; raised awareness and improvements in funding have already brought about changes; local partnerships are strengthening; treatment and support services are increasingly commissioned with a stronger recovery-focus; and recent years have seen innovations in harm reduction, including the roll out of naloxone, piloting of safer consumption facilities and long-acting OST medication.

While it is important to recognise progress, it is vital to be aware of newer and emerging threats. For example, harm linked to nitazenes and other synthetic opioids in illicit drug supplies is growing. Increasingly, people are presenting for treatment linked to powder cocaine use and ketamine. The nature of addiction has changed over time and will continue to. It is vital to understand these trends to ensure treatment provision is available for those who require it most.

Change is possible – the suffering linked to addiction is not inevitable. This report shows that where carefully planned measures are bravely implemented, progress has been made. To stimulate discussion, we offer below some suggestions on areas for priority attention if we are going to make significant progress in the coming years to reduce the impact that addiction is having across our society.



# Key messages from the report

**This report has drawn together a wide range of data and research into addiction to alcohol and drugs in the UK and provided a summary of the current extent, harm and policy environment. Findings from the report highlight the following important points.**

- **Planning and commissioning of drug and alcohol treatment is becoming more effective, but some barriers remain** - our evidence suggests local commissioning systems have made substantial changes in cross-sector collaboration, supporting opportunities for recovery, and working with people with lived experience of addiction, especially following funding increases since 2021. Effectiveness and engagement with treatment continue to be high. However, the report also highlights continuing challenges in balancing accountability, making best use of reducing local funds, developing effective local partnerships, and working constructively and supportively with drug and alcohol treatment providers.
- **There is an emerging need to respond to demand for support with alcohol and non-opiate drugs** – our findings suggest that the use of non-opiate drugs is increasing in the UK and elsewhere, particularly among younger people, alongside increasing risks of harm. However, drug and alcohol treatment continues to reflect a legacy focus on opiate use. Although alcohol treatment has gained greater attention in recent years, provision for non-opiate drug use has not kept pace with changing patterns of use.
- **Our understanding of equal access to addiction treatment is insufficient**- some minority groups– including women and people with minority ethnic backgrounds – are underrepresented in drug and alcohol treatment and our understanding about the reasons for this is limited. Better understanding of needs of less well represented groups in drug and alcohol treatment is needed to ensure equitable access and outcomes.

# Insights from Forward Trust's operational delivery and practice

**The recommendations below build on these conclusions and reflections on insights from The Forward Trust's years of experience in the sector and are focused on reducing harm from addiction, expanding access to treatment and recovery, and ensuring that investment is directed towards interventions with the greatest impact.**

- **Give renewed political leadership to the urgent challenge of reducing the number of drug and alcohol related deaths.** The fact that, every year, around 17,000 citizens die early and preventable deaths, should be a national scandal that receives much more policy and strategic attention.
- **Maintain reliable funding for the drug and alcohol treatment and recovery services in every area of the country** - so that anyone in need of help can get access to free and professional advice, practical support to stay alive and healthy, confidence and motivation to believe in change, and pathways and programmes to break the cycle of addiction and find recovery.
- **Make it easier to get access to recovery programmes** – in residential, non-residential or prison settings, for people living with addiction and their loved ones. Currently, access to this support is slow, opaque, and restricted by inefficient funding and assessment mechanisms. When people are motivated to accept help, they should be able to get into treatment and recovery quickly.
- **Strengthen strategies to reduce the impact of addiction on crime and anti-social behaviour.** The mechanisms for identifying, motivating and treating addicted people in the criminal justice system have been hollowed out over the past 15 years, but can be quickly rebuilt with the right political and institutional commitment. The government's anti-social behaviour mission, and the 2026 Sentencing Act, will not achieve their objectives without determined action to improve prison treatment and recovery, and community treatment alternatives.
- **Boost efforts to limit accessibility of cheap alcohol.** Experiments with minimum unit pricing and higher taxation seem to be showing promising results, and these measures could be expanded as part of an explicit drive to reduce levels of binge or addicted patterns of drinking.



- **Learn lessons from the development of drug and alcohol policy and grasp the opportunity provided by the Gambling Levy.** Starting in 2026, the government has the opportunity to build a new network of NHS, community and peer led services to tackle rising levels of gambling addiction. Over £100 million is being spent by government this year through a series of grant schemes, but the absence of a unified strategy behind these schemes runs the risk of undermining impact.
- **Target funding on programmes and interventions with greatest impact on priority outcomes**– reducing deaths, reducing crime, and increasing recovery. Currently the system prioritises processes such as compliance with guidance, number and speed of assessments, numbers in treatment– rather than real outcomes. This skews priorities and takes attention and resources away from a focus on impact.
- **Increase public visibility of support for people struggling with addiction** (and their families and loved ones), with a particular focus on showcasing stories of people who have successfully confronted and overcome their addiction, and signposting people to mutual aid and peer support such as that offered by the 12-step fellowships, SMART recovery, and local lived experience recovery organisations (LEROs).
- **Tackle the shame and stigma that prevent people from seeking help** by increasing public awareness of the nature and causes of addiction, and the possibilities and benefits of recovery. Forward's 'Taking Action on Addiction' campaign encourages openness about addiction and challenges society to replace stigma with understanding.

TAKING
ACTION
ADDICTION

A CAMPAIGN BY THE FORWARD TRUST

# ADDICTION AFFECTS EVERYONE BUT RECOVERY IS POSSIBLE

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