



TD RESEARCH LAB

UK DRUG TRENDS INTELLIGENCE

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FIRST EDITION

*What is changing in the UK drug market
and what services need to know*



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The report and the online platform

This report brings together the national picture at a fixed cut-off. The online Drug Trends Intelligence platform provides an evolving resource between editions, with drug profiles, regional harms, sources and early-warning links. A live page may have a different review date from this publication. Check the underlying primary source for decisions.

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Contents

1.	Executive summary.....	4
2.	How to read this report.....	7
3.	UK drug market overview.....	8
4.	Cocaine and crack cocaine.....	10
5.	Ketamine.....	11
6.	Tusi and emerging mixtures.....	11
7.	Nitazenes and other synthetic opioids	13
8.	Medetomidine, xylazine and emerging adulterants	13
9.	Benzodiazepines and counterfeit medicines	15
10.	Pregabalin and gabapentin.....	15
11.	Amphetamine and methamphetamine.....	16
12.	MDMA, cathinones and other club drug signals	17
13.	Cannabis, THC vapes and synthetic cannabinoids	17
14.	Nitrous oxide and other watchlist drugs.....	18
15.	Young people and safeguarding.....	19
16.	Polysubstance use and combinations	20
17.	Drug markets, prices, purity and supply	21
18.	Wastewater intelligence.....	23
19.	Drug-related deaths.....	24
20.	Treatment and the service landscape	25
21.	Prisons, housing and sexual health settings	26
22.	County lines and child criminal exploitation.....	27
23.	A proportionate local intelligence panel.....	28
24.	Data limitations and methodology	28
25.	Glossary	29
26.	References	32
27.	Editorial and evidence note	37

1. Executive summary

The UK drug picture combines rising recorded harms, changing product composition and conflicting measures of consumption. Services need to retain their established opioid capabilities while strengthening responses to cocaine, ketamine, unknown tablets and drug combinations.

Scotland's latest mortality picture has changed. Its 2025 drug use death total rose to 1,133. National headline definitions and years differ, so they are presented separately. [1]

Cocaine harm deserves sustained prominence. Recorded mortality involvement increased again in 2024. The series does not distinguish powder from crack or establish sole causation. [2]

Ketamine requires a joint clinical response. Wastewater, treatment and enforcement evidence warrant attention, while household prevalence does not show a significant annual increase in either reported age group. Urinary and hepatobiliary harms require pathways that connect drug treatment with medical assessment. [3]

Unexpected adulterants are an operational issue. Recent UK submissions identify emerging sedatives and opioids, and substitutions in tablets and vapes. These are sample findings, not national prevalence estimates. [4]

Direction depends on the indicator. Wastewater results show opposing substance trends. [5] The substance assessments explain the comparisons.

The UK drug picture October 2026

Each row names the indicator behind the assessment. Arrows are not estimates of the number of users. “Uncertain” can accompany confirmed detections when a comparable trend series is absent. Confidence applies to the bounded assessment; a national direction can remain unknown even when a recorded count is secure.

Dashboard 1 Established harms and changing composition

Substance or signal	Current assessment	Evidence confidence	Reference period	Why it is being watched
Cocaine	↑ Recorded mortality; ↔ household prevalence	HIGH	E&W 2023–2024 deaths; YE Mar 2024–2025 survey	Survey covers powder; deaths lack powder/crack split
Crack cocaine	↔ Rounded share of adult treatment entrants	HIGH	England 2023/24–2024/25	Distinct need often overlaps recorded opioid problems
Ketamine	↑ Repeat-site wastewater and treatment signal	MODERATE	England Jan–Apr 2024–2025; under-18 treatment 2021/22–2024/25	Urinary and liver pathways need attention
Nitazenes	? UK direction; ↑ Scottish death involvement	MODERATE	Scotland 2024–2025; E&W 2024; UK provisional surveillance	Toxicology and reporting coverage vary

Substance or signal	Current assessment	Evidence confidence	Reference period	Why it is being watched
Tusi / pink cocaine	? National direction	LIMITED	UK festival 2022; export attempt 2024 (released 2 Oct 2026)	Specific export case confirms handling; no UK consumption trend
Medetomidine	? UK direction; new monitored detections	LIMITED	Scotland 2025–2026; UK review 2025	Small selected product samples and hospital sentinel signal
Xylazine	None in 2025 Scottish submissions; ? UK direction	LIMITED	Scotland 2023–2025	Selected detections; no comparable market denominator
Illicit benzodiazepines	? Market size; changing identified compounds	MODERATE	UK submissions 2025/26; Scotland 2026	Familiar tablet labels can conceal substitution

Sources: ONS, OHID, ACMD, NRS, PHS, The Loop and WEDINOS. [6, 2, 7, 3, 1, 8, 9, 10, 11, 12, 13, 4]

READ THE ARROWS ↑ Increase; ↓ decrease; ↔ broadly stable or no statistically significant change in the stated comparison; ? insufficient or conflicting evidence for a direction. “Broadly stable” does not prove that no change occurred.

Dashboard 2 Additional surveillance priorities

Substance or signal	Current assessment	Evidence confidence	Reference period	Why it is being watched
Counterfeit medicines	? Exposure; ↑ seized illegal medicines	MODERATE	UK 2025	Illegal and counterfeit categories differ
Pregabalin / gabapentin	? UK use direction; persistent combination concern	MODERATE	NI 2024 death series; UK medicine warnings 2026	Prescribed use, diversion and combinations differ
Amphetamine	↓ Same-site wastewater estimate	MODERATE	16 England sites Jan–Apr 2024–2025	Separate medicinal and metabolic contributions
Methamphetamine	↑ Same-site wastewater estimate	MODERATE	16 England sites Jan–Apr 2024–2025	Geographical concentration and unmet need uncertain
MDMA / ecstasy	↑ Same-site wastewater; ↔ household prevalence	MODERATE	16 England sites Jan–Apr 2024–2025; E&W YE Mar 2025	Content and acute harms vary by context
Cannabis / THC vapes / SCRAAs	? UK product trajectory; confirmed substitution	LIMITED	England schools 2023/24–2024/25; UK submissions 2025/26	Keep cannabis, claimed THC and SCRAAs separate
Nitrous oxide	↓ Household past-year use age 16–59	HIGH	E&W YE Mar 2024–2025	Frequent-use neurological harms can persist
Polysubstance exposure	? UK co-use trend; high multiple-drug burden	MODERATE	Scotland 2025; NI 2024	Death mentions do not reveal intention or sequence

Sources: Home Office, ONS, NRS, NISRA, MHRA and analytical studies. [5, 7, 1, 14, 4, 15, 16]

The dashboard is an editorial synthesis of specified indicators, not a formal threat score. Strong evidence within a defined dataset does not make that dataset representative of all UK drug use.

2. How to read this report

Evidence confidence

Confidence applies to the stated assessment

Label	Basis	What it does not mean
HIGH	A robust source directly measures the named indicator, with a clear population, period and definition.	No guarantee of current prevalence outside that population.
MODERATE	Several relevant observations support a judgement, or a useful series has substantial methodological or coverage limits.	No proof of cause, uniform geography or exact effect size.
LIMITED	Small selected samples, isolated reports, incomplete coverage or no comparable trend series.	No claim that the possible harm is minor.

These confidence labels are qualitative editorial judgements. They are not statistical confidence intervals, a validated score or a substitute for the original source. When indicators conflict, the judgement explains the conflict rather than selecting whichever arrow looks most dramatic.

A short guide to the measures

Different questions need different indicators

Measure	What it can establish	Main boundary
Prevalence survey	Self-reported use among the sampled population.	Not quantities consumed; household surveys miss key settings.
Wastewater	Drug residues and modelled consumption in contributing populations.	Not user numbers, identities, dependence or individual combinations.
Treatment data	Recorded needs among people who reach participating services.	Not all need or general-population prevalence.
Drug checking	Identified substances in submitted products.	Voluntary samples usually have no representative market denominator. For example, finding an unexpected substance in 20% of tested samples does not mean it is present in 20% of drugs sold nationally.
Seizures	Recorded law-enforcement interceptions.	Affected by enforcement, recording and individual consignments.
Mortality	Registered deaths meeting a specified definition; recorded drug involvement.	Delayed; multiple drugs and testing coverage affect interpretation.
Local alerts	A hazard or event requiring a local response.	Not automatically a national trend.

A USEFUL DISTINCTION “Not detected” means not detected in the specified test or sample. It does not establish absence from the market. “No significant change” means a statistical test did not establish change; it does not establish identical prevalence.

Where the figures apply

Every numerical comparison should retain its geography, reference period and population. England and Wales is not a synonym for the UK. “Children” in England’s treatment series means aged 17 and under, while a Welsh under-25 assessment group includes young adults. A service referral is not necessarily a unique person. These boundaries remain relevant even when the underlying source is authoritative.

3. UK drug market overview

The national picture contains both established markets and a growing need to understand what is inside products. Emerging opioids and sedatives add uncertainty to those markets; they do not make established harms disappear.

The NCA’s 2026 assessment describes rising drug-market and organised-crime adaptation. Its judgement about the market is an intelligence assessment. It should sit alongside, rather than replace, measured survey, treatment, mortality and laboratory indicators. [17]

Household survey baseline: England and Wales, year ending March 2025

Reported past-year use	Age 16–59	Age 16–24
Any drug	8.7%	15.1%
Cannabis	6.5%	12.5%
Powder cocaine	2.1%	2.3%
Ecstasy	1.2%	1.9%
Ketamine	0.8%	2.0%
Nitrous oxide	0.5%	1.3%

ONS CSEW. Household self-report; overlapping categories, not UK prevalence. [7]

No statistically significant annual change was established for any drug, cannabis, powder cocaine, ecstasy or ketamine. Nitrous oxide decreased. [7] Household prevalence can remain similar while service demand or harms change.

Interpreting apparently conflicting indicators

Observation	Plausible explanation to examine	Evidence needed
Treatment rises while a household survey is stable	Better access, more concentrated harm, returning clients, altered recording.	Entrant definitions, referrals, retention and local population coverage.

Observation	Plausible explanation to examine	Evidence needed
Seizure counts rise while weight falls	More small interceptions or fewer unusually large consignments.	Separate counts and weights, enforcement activity and recording changes.
Wastewater quantity differs from survey ranking	Quantity per person, heavy-use concentration, survey undercoverage or modelling assumptions.	Matched geography, timing, coverage and chemical source attribution.
An emerging drug appears more often in tests	Market change, broader testing panels or changed submission behaviour.	Comparable tested denominators and stable analytical methods.

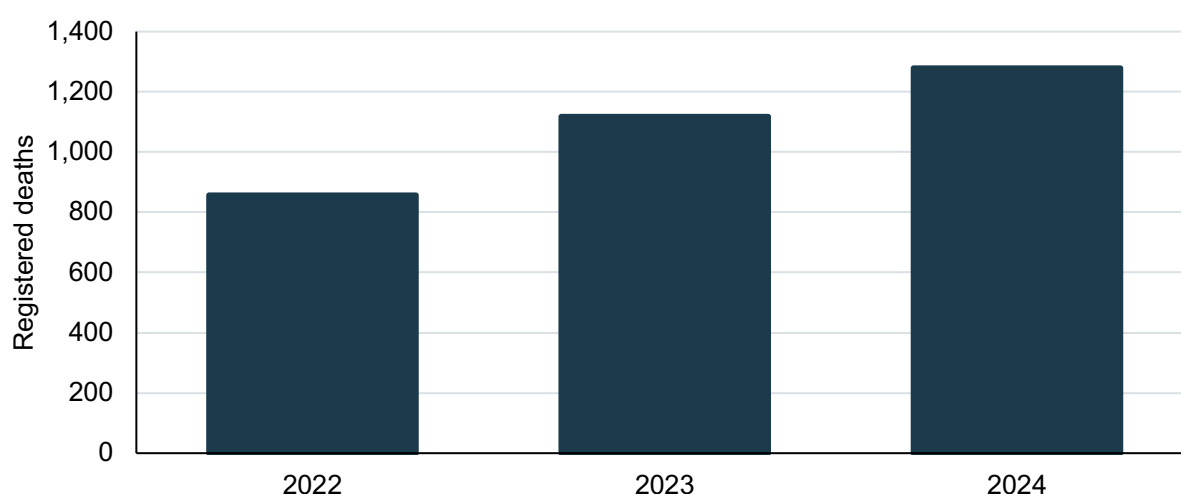
4. Cocaine and crack cocaine

CURRENT ASSESSMENT Recorded cocaine mortality is increasing; powder cocaine household prevalence was not significantly different year on year; the latest repeat-site wastewater comparison fell. Crack treatment needs require a separate assessment.

England and Wales recorded 1,279 cocaine-mentioned death registrations in 2024, compared with 1,118 in 2023, a 14.4% increase. Death certificates do not reliably provide a powder-versus-crack breakdown, and other substances may be involved. [2]

In England's 2024/25 treatment entrant data, 33,612 people reported powder cocaine and 32,399 reported crack. Powder cocaine's share rose from 19% to 20%; crack's share remained 19%. These categories can overlap with each other and with opioid problems. [6]

Figure 1 Cocaine mentions in England and Wales death registrations



ONS 2022 and 2024 registration releases. Cocaine mentions; other drugs may also be mentioned. Counts, not prevalence. [18, 2]

Avoid one overall consumption arrow

A household survey describes whether someone reports any past-year use. Wastewater describes modelled quantities in sampled catchments. A person using more often can alter quantity without adding a new survey user.

Crack and injecting

Assessment should retain route, frequency and the reason for combining substances. A cocaine entry alone cannot show whether the person smoked crack, used powder intranasally or injected a cocaine product. Services need to ask whether heroin and cocaine were used in the same injection, separately in one session, or on different days. Treatment records showing both substances do not settle that question.

A practical review of equipment provision should consider the number of injections and supplies needed per episode, not just attendees. This report does not estimate national injection frequency or equipment shortfall. Local services can use person-level accounts and distribution records to identify whether frequent injecting is being missed.

Service response

Provide a clear stimulant pathway and review psychosocial capability alongside opioid treatment if using an opioid. Ask about alcohol, sedatives used afterwards, chest symptoms, sleep, mood and episodes of unexpectedly strong effects. Use individual goals, regular contact and clinically appropriate support; opioid medication alone should not be treated as a complete cocaine intervention. [19]

PRACTICE POINT Record powder cocaine and crack separately where the person can identify the product. Preserve uncertainty when the route or composition is unclear. Build the care plan around the episode and its consequences, rather than relying on a single substance label.

5. Ketamine

CURRENT ASSESSMENT A strong priority for service development. Rising treatment and repeat-site wastewater signals coexist with household survey uncertainty about the latest annual change.

Among children in England's specialist treatment services, 1,465 reported ketamine in 2024/25, compared with 512 in 2021/22. This is a recorded treatment need among under-18s; it is not a prevalence estimate for all young people. [20]

The ACMD's January 2026 review describes urinary tract and hepatobiliary harms and recommends coordinated care. The majority recommended retaining Class B status, although this was not unanimous. Its September work-programme letter still sought the Government's response to the recommendations. Advice, implementation and legal classification are separate facts. [3, 21]

A recent local clinical signal comes from Alder Hey's first 60 referred patients aged under 16, reported in September 2026. The series includes substantial adversity and co-occurring support needs. It is a selected clinic population, and the associated clinical letter was not externally peer-reviewed. It supports attention to complex care, rather than a national prevalence or causal claim about childhood adversity. [22, 23]

Assessment and referral

Ask about urinary frequency, pain, urgency, visible blood, abdominal symptoms and the pattern of use. Symptoms should prompt an appropriate medical pathway rather than waiting for a dependence threshold. Agree who arranges assessment, how results reach the treatment team, and how the person remains supported during referral. [3]

Record days of use, pattern across the day, other substances and the person's purpose for using. Avoid judging need only from a street price or the number of transactions. A person using frequently to cope with pain or distress may require a different engagement approach from an occasional nightlife user.

OPERATIONAL IMPLICATION Create a named pathway between substance use services, primary care, emergency departments and specialist medical care. Include arrangements for young people and for those who struggle to attend conventional appointments.

6. Tusi and emerging mixtures

Tusi, tuci and tucibi are names used for mixtures often sold as pink powder. "Pink cocaine" is a misleading label: cocaine is not a reliable ingredient, and the product should not be treated as a pink version of ordinary cocaine. The Loop issued a UK alert about powder sold as pink tusi at

Lost Village in August 2022. It described variable mixtures commonly involving ketamine, MDMA, caffeine and starch. This establishes an earlier UK detection; it does not establish a nationwide increase in 2026. [8]

European evidence provides context. The EUDA and Europol describe tuci products as usually containing ketamine and MDMA, with composition varying between samples. European Early Warning System reports from 2021–2023 included several countries, particularly Spain. The similarity between the name “tuci” and “2C-B” does not establish that 2C-B is present. These findings concern European detections and cannot supply a UK prevalence estimate. [24]

An NCA release published on 2 October 2026 describes an attempted export from Liverpool to Australia of 252.8 kg of “pink cocaine”, reported to contain MDMA, ketamine and caffeine. The consignment was handed to a courier on 10 October 2024. It confirms UK organised-crime handling of that mixture in a specific export case. It does not measure UK retail availability, national prevalence or growth in consumption; its composition cannot be generalised to other tuci products. The release does not supply laboratory methods. [9]

The recommended public message is short: the name and colour do not tell you what is in the mixture. Staff should ask about expected effects, other drugs and alcohol taken during the episode, and any unexpected symptoms. Local alerts should describe the particular result without implying that every pink powder shares its contents.

Keep tuci separate from 2C-B

2C-B is a particular chemical substance; tuci is a product label used for mixtures. Combining them in a single trend category loses the distinction between the intended purchase and the tested contents. In August 2023, The Loop published a separate 2C-B alert at Boomtown, describing its availability in tablet and powder forms. This is evidence of its presence in a UK festival setting, rather than proof that 2C-B first emerged in 2026 or is currently increasing nationally. [25]

The surveillance watchlist should therefore retain three fields: reported product name, expected substance and identified substance or substances. “Tusi” and “2C-B” can remain in the vocabulary people use without being treated as interchangeable analytical categories. Training should use the same distinction, with a simple side-by-side explanation rather than a list of names implying chemical equivalence.

WATCHLIST Confirmed UK presence; current national prevalence and direction remain uncertain. UK tuci sample profiles should be reported with location, period, purchase intent and laboratory result, rather than using a fixed ingredient recipe.

7. Nitazenes and other synthetic opioids

CURRENT ASSESSMENT A serious preparedness priority with different national trajectories. The strongest new annual signal is increased Scottish nitazene involvement in 2025; a single UK direction is not defensible.

Nitazenes appeared in 195 England and Wales drug-poisoning registrations (2024) and were implicated in 247 Scottish drug use registrations (2025). [2, 1] Different years and recording systems preclude direct comparison.

NCA intelligence summarises provisional UK deaths associated with nitazenes and warns that recent totals may rise as results are finalised. Its reporting cannot be spliced into an ONS or NRS annual registration series. The variation across systems should remain visible rather than being presented as a reassuring UK decline. [17]

Product routes and detection

Preparedness should cover products purchased as heroin, opioid medicines and benzodiazepines. Product identity and expectations can differ from analytical findings. Testing panels, sensitivity, post-mortem stability and turnaround times can affect what is recorded. A death certificate without a named nitazene does not by itself prove the drug was absent; it also does not justify automatically inflating the official total. [2, 1, 26]

Beyond nitazenes

WEDINOS's latest annual report identified nitazenes in 110 samples and orphine analogues in 18, including emerging cychlorphine and spirochlorphine. These groups should remain separately labelled. "Nitazene" is not a synonym for every newly detected synthetic opioid. Detection in submitted material establishes presence but does not supply a national trend in consumption or deaths. [4]

International surveillance reinforces the need to expect further change. The EUDA reported 50 substances notified for the first time in Europe in 2025, alongside hundreds of previously known new psychoactive substances still being detected. This is European context, not a count of new drugs entering the UK. [27]

Product identity can be unreliable across several settings. Emerging sedatives and synthetic opioids require current local intelligence alongside this report's fixed cut-off. Comparable testing is needed to determine whether individual signals persist, expand or recede.

EMERGENCY RESPONSE Call 999 for unresponsiveness or breathing problems. Give naloxone when opioid overdose is suspected, following training and product instructions. Persistent sedation or poor breathing still requires emergency support. [28, 10, 19]

8. Medetomidine, xylazine and emerging adulterants

Medetomidine and xylazine are sedatives used in veterinary medicine. They are not opioids, although they may occur alongside opioids in illicit products. The ACMD's October 2025 review reported medetomidine in samples from several UK evidence streams, including material purchased as heroin in England. Some samples also contained nitazenes or other sedatives. The counts supplied by different agencies should not be added together because samples may overlap. [10]

Routine analysis may not distinguish medetomidine from medically administered dexmedetomidine. Treatment history is therefore needed when interpreting a biological detection. Emergency response is covered in the healthcare section. [10]

UK detections warrant active attention. Available evidence does not establish UK prevalence comparable with North America or replacement of xylazine across the UK. Serious local harm can occur while a substance remains infrequently detected nationally.

In August 2026, The Forward Trust relayed local intelligence concerning medetomidine in Sutton, South West London. The notice supplies no sample denominator or detailed laboratory methods. It adds a recent local alert to the picture, but cannot quantify local market penetration. [29]

Scottish product and hospital evidence

Public Health Scotland's February 2026 medetomidine alert records five Scottish WEDINOS detections between September and December 2025. Four were white tablets purchased as diazepam or Valium, with medetomidine the only substance identified. One was a brown powder purchased as heroin, with several other components. These results demonstrate that exposure cannot be assumed to occur only in products bought as opioids. They concern submitted samples rather than a representative survey of Scottish supplies. [11]

The July 2026 RADAR report adds newer evidence. Of 35 Scottish samples purchased as heroin and tested by WEDINOS between March and June 2026, seven contained medetomidine, 14 contained a nitazene, and two contained both. These are overlapping groups within a small, selected sample. Medetomidine was also detected for the first time in the ASSIST hospital study in its February–May 2026 quarter. [12]

This combination of product testing and a hospital detection supports an emerging surveillance signal. It does not mean that one fifth of all Scottish heroin contains medetomidine, or that its contribution to deaths has been measured.

Xylazine requires a separate assessment

The same Scottish alert reports 34 WEDINOS xylazine detections in samples sold as heroin between October 2023 and December 2024, with none in Scottish submissions during 2025. Scottish post-mortem detections peaked earlier and were lower by the period covered in the alert. This is a different observed pattern from the more recent medetomidine signal. It is not evidence that xylazine has disappeared from the Scottish or UK market. [11]

Reports should avoid grouping every veterinary sedative under a single “tranq” trend. The shared broad drug class is useful for understanding potential sedation, but the substances, evidence periods and known complications differ. In particular, established concern about xylazine-related wounds should not be presented as proof that medetomidine causes the same clinical pattern.

A sensible service priority is accessible wound assessment alongside overdose preparedness, with unusual findings passed to the appropriate local health and drug-warning arrangements. Record what is observed before attributing it to an emerging chemical. Early, careful reporting is more useful than assigning a substance name without analytical evidence.

DATA LIMITATION The 35 Scottish purchased-as-heroin submissions discussed here were a small voluntary sample. Their percentages must not be read as the share of all Scottish or UK heroin containing these compounds.

9. Benzodiazepines and counterfeit medicines

Public Health Scotland's February 2026 alert identifies ethylbromazolam as a newly emerging benzodiazepine, first detected by WEDINOS in the UK in January 2025 and in Scotland in March 2025. By December 2025 it had been detected in eight Scottish NHS board areas, most often in tablets sold as diazepam. Clonazolam, an older substance, had also re-emerged. Reliable strength and duration estimates for ethylbromazolam were unavailable in the cited alert. [13]

WEDINOS's April 2025–March 2026 annual report analysed 8,209 submitted samples and identified 22 different benzodiazepines. Across all samples, ethylbromazolam was identified 460 times and bromazolam 277 times. Among community submissions with usable purchase-intent information, 36.6% lacked the expected substance and 7.7% contained it alongside additional psychoactive substances. These percentages describe eligible submissions, not the proportion of all UK purchases that are mis-sold. [4]

The latest Scottish picture also cautions against a simple “bromazolam is disappearing” message. July RADAR reports increased detections in its latest quarter after a broader decline in 2024–2025. It records continuing ethylbromazolam detections and clobromazolam in Scottish submissions and prison monitoring. [12]

Counterfeit and illegal supply

The MHRA reported almost 20 million doses of illegally traded medicines seized in 2025, compared with 17 million in 2024. The 2025 total included 9.9 million doses of sedatives and 4.1 million doses of painkillers. The agency warns that products not authorised for UK sale may contain incorrect amounts or harmful additional ingredients. “Illegally traded”, “unlicensed” and “counterfeit” are related concerns but are not identical categories. [15]

The enforcement totals show substantial activity and a sizeable intercepted supply. They do not reveal how many people used these products, what proportion contained unexpected substances, or whether consumption grew by the same proportion. A large consignment or a change in enforcement can change seizure totals.

A separate May 2025 Loop alert concerned nitazene-containing tablets resembling oxycodone and associated with two recent deaths. Purchase intent was unknown. Their appearance does not establish purchase intent or that nitazenes were the only cause of death. [30]

PRACTICE POINT Ask about source, tablet branding, intended effect, medicines, opioids and alcohol. Describing a product as diazepam may reflect the purchase intention rather than confirmed contents. Dependence or withdrawal concerns need a clinically supported response.

10. Pregabalin and gabapentin

CURRENT ASSESSMENT Persistent concern about recorded involvement and combinations; insufficient evidence for one current UK prevalence arrow.

MHRA announced stronger warnings about addiction, dependence, withdrawal and tolerance for gabapentinoids, benzodiazepines and Z-drugs in January 2026. Prescribed medicines require individual review; people should not abruptly stop treatment based on mortality statistics. [31]

Some death releases report pregabalin and gabapentin separately; the Scottish headline groups gabapentin and/or pregabalin. Northern Ireland's 2024 release reports particularly frequent pregabalin mentions among drug-related deaths. A mention can include prescribed or non-prescribed exposure, and it does not identify source, dose or sole causation. [2, 1, 14]

Pregabalin and gabapentin have medicine-safety warnings about severe respiratory depression. Concern is greater with other central nervous system depressants and in people with relevant clinical vulnerabilities. The guidance describes pharmacological hazards, not current illicit-market prevalence. [32, 33]

Questions that improve assessment

Ask whether the medicine is prescribed, obtained elsewhere or shared; how it is taken; what the person hopes it will do; and whether opioids, alcohol or benzodiazepines are involved. Record dispensing information separately from a person's account of use. A prescribing record confirms supply through that route, not every dose actually taken.

The same person may use a prescribed product appropriately at one time and a non-prescribed tablet at another. Collapsing these into "pregabalin misuse" can conceal the care question. A neutral discussion gives the prescriber and treatment team a better basis for reviewing sedation, dependence and withdrawal concerns.

Operational response

Connect substance use assessment with the prescribing clinician or pharmacist where appropriate and authorised. Review duplicate supply, unexpected sedation and loss of contact without assuming that a detected medicine is the only cause. Where a gradual change to prescribed treatment is needed, use the relevant clinical guidance and a supported plan.

WHAT SERVICES SHOULD WATCH Changes in locally identified product contents; non-prescribed supply; sedation involving opioid or benzodiazepine combinations; and failures to connect treatment teams with prescribing care.

11. Amphetamine and methamphetamine

CURRENT ASSESSMENT The latest repeat-site wastewater estimates show amphetamine decreasing and methamphetamine increasing. They do not establish a UK-wide change in user numbers.

Interpreting the apparent mismatch

Updated WAND results show a falling monitored amphetamine estimate. [5] A large quantity and a rising trend are different claims. The wastewater section gives the comparisons and uncertainty.

Methamphetamine can be metabolised partly to amphetamine, while both substances remain measurable in urine. It is incorrect to say that methamphetamine simply turns into amphetamine and therefore cannot be detected as methamphetamine. A controlled human study establishes the metabolic route, but cannot quantify its contribution to a mixed wastewater catchment. [34]

Prescribed lisdexamfetamine is converted to dexamfetamine, and amphetamine-related material is excreted in urine. This establishes a plausible medicinal contribution to an amphetamine signal; it does not establish the fraction attributable to prescriptions. ADHD medicines should not all be treated as chemically equivalent sources of amphetamine. [35]

Service implications

Assess the product, route, frequency, sleep, mental health, functioning and combinations. Ask whether use occurs in sexual settings without assuming that all methamphetamine use is chemsex. Support needs can be concentrated in populations that household surveys cover

poorly. More testing or treatment visibility can reveal an existing need rather than prove a newly growing market.

PRACTICE POINT Keep amphetamine, methamphetamine and prescribed stimulant exposure separate in recording. Preserve the person's own account of perceived benefit while assessing next-day functioning, sleep and adverse consequences. Subjective relief alone does not demonstrate improved functioning.

12. MDMA, cathinones and other club drug signals

MDMA needs survey, wastewater and product evidence read together. The survey did not establish a significant annual change for ecstasy. [7] Reported use, estimated quantity and submitted composition describe different aspects of the market.

Product information and acute harm

The name of a tablet, its logo or a powder's appearance cannot verify identity or strength. Local testing results should specify whether they describe identification, measured concentration or another property. An alert about one tablet should not imply that every product with the same branding has identical contents.

Nightlife and festival services should link to on-site welfare, emergency escalation, and credible drug-checking information where available. Seek urgent medical help for serious symptoms rather than relying on a presumed product name.

Current cathinone substitution signal

The Loop's May 2026 London update reported 161 submitted substances, around one fifth bought as cathinones such as mephedrone. Almost two-thirds of the cathinone submissions were described as mis-sold: more than half were different cathinones, and around one in ten contained other drugs. The proportions are rounded, and the subgroup is small. This is a current signal of identity problems within London submissions, not a national estimate of cathinone use. [36]

Earlier UK festival alerts establish a longer history of cathinone detections. The Loop reported 4-CMC at Lost Village in 2022 and, citing Lincolnshire Police testing, dipentylone in a small amount of powder at Lost Village in 2023. These detections support keeping individual cathinones on the watchlist; they do not demonstrate a 2026 national increase in either substance. [37, 38]

The assessment question is not just whether a stimulant was used. It is whether the effects, timing and product identity matched expectations. The proposed surveillance priority is better separation of mephedrone, 3-MMC, 4-CMC and other identified cathinones, with the reported purchase name retained. An undifferentiated "research chemicals" category can hide substitution.

WATCHLIST Cathinones and 2C-B require continued surveillance with chemical identity, setting and denominator retained. Evidence of presence should not be promoted into an unsupported UK growth rate.

13. Cannabis, THC vapes and synthetic cannabinoids

Cannabis products and synthetic cannabinoids need distinct descriptions. THC is a principal intoxicating compound in cannabis. Synthetic cannabinoids are manufactured chemicals acting on cannabinoid receptors; semi-synthetic cannabinoids are chemically modified compounds derived from cannabis. FRANK warns that vape liquids and sweets sold as THC may contain

these substances instead. Possible adverse effects include agitation, confusion, hallucinations, chest symptoms and seizures. Potency and composition vary, and evidence for newer semi-synthetic compounds is limited. Branding, flavour, colour and familiar packaging cannot confirm contents. [39]

A preprint by Andrews and colleagues, posted on 7 September 2025, analysed 1,933 confiscated e-cigarettes and liquids from 114 schools across seven police force areas in England, pooling the 2023/24 and 2024/25 school years. SCRAAs were detected in 183 samples (9.5% of the pooled sample). The reported 12.9% is an unweighted mean of area percentages, not the pooled detection rate. Area results also span different years: London 23.1% refers to 2023/24 and Lancashire 27.0% to 2024/25. The cited version is a preprint; no later or peer-reviewed version was identified by the cut-off. Confiscation and school participation select the sample; these findings do not estimate vape contents for all pupils. Online product classifications are separate from laboratory-confirmed contents. [16]

Respond to unknown contents

Schools, youth services and treatment teams should record the claimed product separately from any tested result. An account of using a THC vape should prompt questions about where it came from, the effect, frequency, shared use and sudden adverse reactions. Preserve uncertainty when laboratory confirmation is unavailable.

Commission a clear route for safeguarding, clinical escalation and lawful product testing. Staff need a brief shared explanation of the difference between nicotine vapes, cannabis products and synthetic cannabinoids. Avoid an education message suggesting all vapes contain spice: that would misstate the evidence and obscure the specific risk from unregulated products.

DATA LIMITATION Confiscated products, suspicious submissions and people seeking care are selected samples. A high proportion within those samples is a warning about the tested material, not a proportion of all young people's products.

14. Nitrous oxide and other watchlist drugs

Reported past-year nitrous oxide use fell from 0.9% to 0.5% among people aged 16–59 in England and Wales (years ending March 2024–2025). [7] This does not measure severe neurological presentations or quantities used by frequent users.

Nitrous oxide can inactivate vitamin B12, causing nerve and spinal cord damage. The ACMD's 2023 review describes substantial clinical harms from repeated exposure and cautions that B12 supplementation while use continues does not reliably prevent neurological injury. The review lacked a comprehensive UK count of patients treated for these harms. Its local case series cannot establish a national 2026 trend. Persistent numbness, tingling, weakness or difficulty walking should therefore trigger prompt medical assessment and a direct question about nitrous oxide. [40]

Immediate risks differ from delayed neurological injury. FRANK warns that inhalation directly from pressurised canisters can damage the throat and lungs. Too much gas can cause unconsciousness or suffocation, and cold exposure can cause injury. Large canisters make consumption harder to track; brief effects can encourage repeated dosing. These hazards persist even if fewer people report using the substance. [41]

Follow symptoms and consumption

Ask about container type, how long it lasts, frequency, time spent using and symptoms between sessions. A balloon count without container size or repeated-session information can give a poor picture of exposure. Record nitrous oxide separately where possible, rather than relying on an inhalants category.

Other products on the watchlist

The watchlist includes emerging synthetic opioids, individual cathinones, 2C-B and newer cannabinoid products where UK evidence is limited. GHB/GBL belongs in targeted assessment where relevant, especially within sexual health and nightlife pathways. A watchlist entry means structured monitoring is justified; it does not imply equal prevalence, severity or certainty.

For these substances, local product analysis and clinical reports may become available before national estimates. Keep the substance identity, reporting period, geography and selection mechanism attached to each observation. Avoid inferring a new market from social-media visibility alone.

15. Young people and safeguarding

The most recent retrieved England school survey describes 2023, not October 2026. Among secondary school pupils, mostly aged 11 to 15, 9% reported using a drug in the preceding year and 6% reported cannabis use. Cannabis prevalence was the same as in 2021. Ever-use fell, but the move to online collection may have contributed a small part of that change. School surveys also miss some children outside mainstream education. These findings do not support a claim that drug use is increasing among all children. [42]

A different pattern appears among children receiving specialist support. In England, 16,212 under-18s were in alcohol and drug treatment in 2024/25, 13% more than the previous year. Cannabis was reported by 86%; ketamine by 1,465 children, or 9%, compared with 512 in 2021/22. The 919 solvent/inhalant cases include nitrous oxide but cannot be presented as nitrous-only cases. Among children starting treatment, 53% reported polydrug use and 48% a mental health treatment need. These are service populations: greater access, recognition and recording can contribute to changing numbers. [20]

Build access around the young person

Commissioners should review whether referral routes and opening times fit the local young-adult population. A service designed around an older opioid caseload may need different entry points for a student using ketamine, cocaine or an unknown vape. Review transitions between children's services, adult treatment, CAMHS and adult mental health together, identifying the person who retains responsibility during each handover.

Frontline assessment should ask what the person hoped the drug would do: help them sleep, manage anxiety, concentrate, feel connected or escape distress. Record that account without assuming the product works as intended. Ask about school or college attendance, sleep, money, family safety and other substances. Use accessible explanations and allow communication adjustments. These are practical proposals for acting on the evidence, not proven population-wide solutions.

ASSESSMENT POINT Ask about the purpose of use, the actual episode and any control exerted by other people. Support should remain accessible when mental health, neurodiversity, education or housing difficulties coexist.

16. Polysubstance use and combinations

A list of drugs is an incomplete account of exposure. Different combinations, routes and sequences can sit behind the same record. This edition treats polysubstance assessment as a core service capability because multiple substances can appear in products, reported behaviour, laboratory results and deaths, while those observations answer different questions.

ESTABLISHED CLINICAL HAZARD Opioids combined with benzodiazepines or gabapentinoids can increase the risk of respiratory depression, severe sedation, coma and death. Concurrent stimulant use can mask opioid sedation while overdose and respiratory-depression risks remain. Assess all substances and medicines, and obtain emergency support for breathing problems or unresponsiveness. [32, 33, 44, 45, 61]

More than one drug was implicated in 78% of Scottish drug use deaths registered in 2025. [1]

Terms that should remain separate

Term	What it means	What cannot be assumed
Co-use	A person reports using two or more substances within a stated window.	That they were taken in the same episode.
Simultaneous use	Substances were taken together at the same time or administration event, as established by the account or evidence.	That their interaction caused a particular outcome.
Sequential use	One substance was used after another.	That the first had fully cleared or that effects did not overlap.
Co-presence	Two substances were identified in one product or specimen.	Intentional purchase, precise timing, dose or route.
Toxicological detection	A laboratory detected a substance or marker in a biological specimen.	Sole causation, intended use or necessarily intoxication at a given time.
Causal interaction	The effect of one exposure differs depending on another exposure, on a specified outcome scale and supported by appropriate causal evidence.	That any two mentions demonstrate such an interaction.

Combinations services should assess

Questions to ask about the episode

Combination or pattern	Assessment focus	Recording improvement
Opioid and benzodiazepine / gabapentinoid	Sedation, prescribing, tablet source, dependence and overdose history.	Retain each medicine and its route of supply.
Heroin and crack / cocaine	Route, same-injection versus separate use, frequency and purpose.	Distinguish reported timing from a monthly substance list.

Combination or pattern	Assessment focus	Recording improvement
Cocaine and alcohol	How drinking changes craving or continued use, amount, symptoms and next-day effects.	Include alcohol in stimulant assessments.
Stimulant followed by sedative	What is taken to sleep or manage a comedown; overlap and unexpected sedation.	Record sequence and approximate timing.
Ketamine and stimulant	Expected effects, frequency, distress, urinary symptoms and other drugs.	Avoid a single “club drugs” entry.
Unknown tablet or mixture	Purchase intention, name, packaging, actual or untested contents and symptoms.	Separate expected composition from analytical confirmation.

These questions are assessment proposals. A list of combinations is not a quantified ranking of fatality risk. Risk depends on the actual compounds, quantities, timing, health, tolerance and setting, and the available surveillance does not consistently identify these features.

OPERATIONAL IMPLICATION A monthly record of “heroin and cocaine” is useful for service planning but cannot establish snowballing. An episode account can distinguish simultaneous injection, separate injections, smoking alongside opioid use, or use on different days. That distinction changes the assessment and equipment questions.

17. Drug markets, prices, purity and supply

This edition reports market signals with their provenance. It does not provide a table of precise UK street prices for all substances: the available evidence does not justify treating anecdotal deals, local samples and national supply intelligence as one uniform price series.

The NCA reports lower cocaine prices in 2025 than 2024 while wholesale purity remained consistent. Wholesale findings do not verify the purity of every retail purchase. Price may also change through deal size, geography or composition. [17]

Home Office annual figures for England and Wales illustrate why counts and weights should be separate. Powder cocaine seizures increased from 21,548 to 24,492 in the year ending March 2025, while the total weight fell from 28.27 to 18.46 tonnes. Ketamine seizure counts reached 3,382. Recording and enforcement changes, and large individual operations, affect these measures. [46]

A later Border Force release reports 1,298 kg of ketamine seized in January–March 2026, compared with nearly 915 kg in the preceding quarter. It is UK-border operational intelligence, distinct from the annual England and Wales seizure series. The interception does not quantify domestic consumption. [47]

PSNI’s annual release, published on 2 October 2026, recorded 7,533 drug-seizure incidents in Northern Ireland in 2025/26, up 8.4% from 6,951. Ketamine incidents changed from 106 to 104, while the converted quantity fell from 18.3 kg to 3.9 kg; one seizure accounted for around 92% of the preceding year’s total. The series excludes Border Force and NCA seizures and not all drugs were forensically tested. These enforcement measures do not estimate consumption or availability. [48]

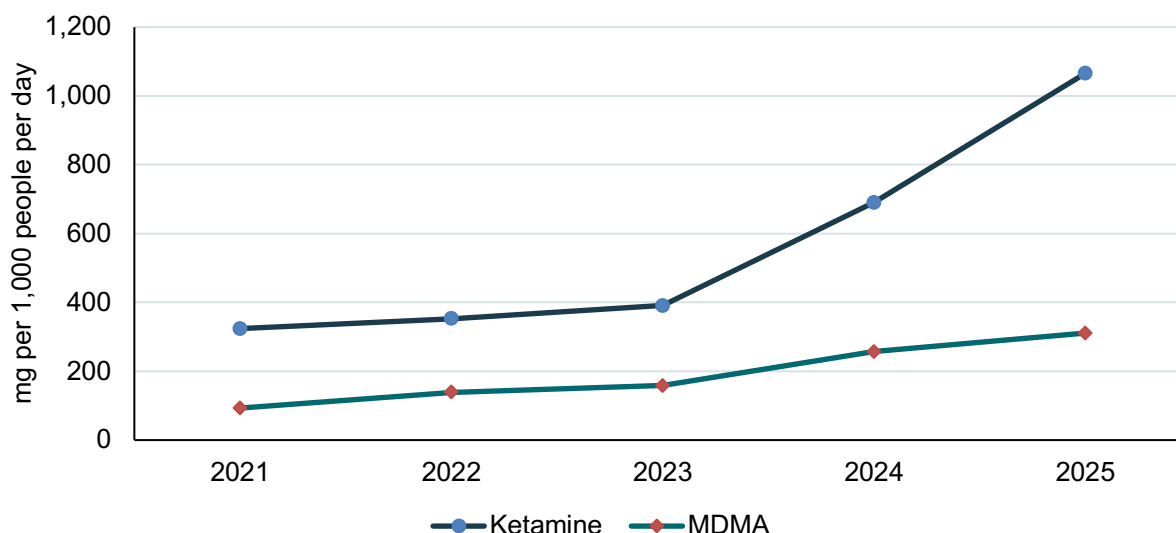
Market evidence used in this edition

Market	Supported signal	Boundary
Cocaine and crack	National supply assessment, annual seizures and separate treatment needs.	No single retail price or purity estimate applied to all UK purchases.
Heroin and synthetic opioids	Established heroin market with confirmed composition hazards in tested products.	No uniform national purity-collapse estimate or one-event causal explanation.
Ketamine and MDMA	Interceptions, consumption estimates and product information.	Large consignment or branded tablet is not a prevalence measure.
Cannabis and illicit vapes	Survey and selected product-testing evidence.	Claimed THC and confirmed SCRA are distinct.
Benzodiazepines and other medicines	Illegal supply and chemically substituted submissions.	“Illegal”, “unlicensed” and “counterfeit” are not interchangeable.
Methamphetamine and emerging synthetics	Limited but important surveillance signals.	No invented precise UK price range or national penetration estimate.

18. Wastewater intelligence

WAND's repeat-site series covers 16 England sites and 18% of its population. [5] It adds a quantity-based indicator.

Figure 2 Ketamine and MDMA estimates at the same England sites



WAND Table 2: Jan–Apr 2021–2025, England; mg/1,000 people/day, retail-purity-adjusted. [5]

Table 1 Comparable-site estimates and reported standard errors

Substance	2021	2022	2023	2024	2025
Cocaine	3,206 ± 109	4,164 ± 62	4,328 ± 156	4,975 ± 201	4,045 ± 98
Ketamine	324 ± 8	353 ± 5	391 ± 15	691 ± 34	1,066 ± 30
Heroin	1,921 ± 267	1,138 ± 104	1,289 ± 72	1,421 ± 204	1,154 ± 271
MDMA	93 ± 7	139 ± 7	158 ± 11	257 ± 25	311 ± 28
Amphetamine	2,711 ± 144	2,167 ± 111	3,978 ± 333	3,311 ± 833	1,978 ± 111
Methamphetamine	149 ± 6	135 ± 4	157 ± 5	192 ± 8	240 ± 8

WAND: units as Figure 2; means ± standard errors of the mean (SEM). [5]

2024–2025: cocaine/heroin –19%; ketamine +54%; MDMA +21%; amphetamine –40%; methamphetamine +25%. [5] These are site comparisons, not UK estimates.

What the uncertainty covers

Standard errors describe the precision of the mean estimates; they do not remove selection or measurement bias. The table retains these uncertainty measures so that point estimates are not presented as exact quantities. Heroin estimates require particular caution because their biomarker is unstable and inconsistently detected. [5]

National quantities answer a different question

National quantity estimates and repeat-site comparisons are different analyses. This edition emphasises the latter and does not rank prevalence by kilograms. A larger quantity can reflect more users, higher frequency, more per episode or a combination of these.

Population residues do not directly identify users, age, dependence, route or individual combinations. Product analysis and episode accounts answer different questions. The chemical marker and model also need checking before an inference about a particular substance.

What services can do with it

Use wastewater to identify questions for other systems, especially changes within consistently monitored catchments. Compare the same period and locality with treatment, emergency and product-testing data before making a local inference. A high catchment average can reflect many occasional users, fewer frequent users or both.

DATA LIMITATION The updated method supersedes older wastewater figures. Do not compare a revised 2025 estimate with an older 2024-method result as if both were generated identically. Keep the series, coverage and units attached to any chart.

19. Drug-related deaths

A parallel national view

Latest available national headline releases

Geography	Latest period and release	Headline count and definition	Interpretation
England and Wales	2024 registrations; 17 Oct 2025	5,565 drug poisoning; 3,736 drug misuse	Broader and narrower definitions; substantial registration lag.
Scotland	2025 registrations; 23 Sep 2026	1,133 drug use deaths	Headline relates to defined drug use deaths; ↑11% from 2024.
Northern Ireland	2024 registrations; 13 May 2026	251 drug-related; 219 drug misuse	Broader and narrower definitions, not a 2025 total.

Sources: ONS, NRS and NISRA. Different years and definitions; do not sum these headline counts into a UK total. [2, 1, 14]

England and Wales

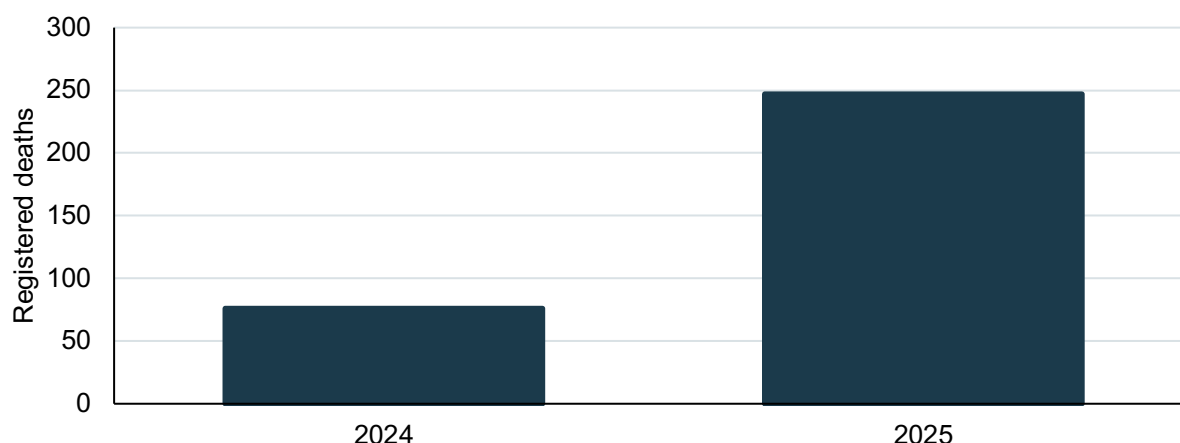
In 2024, 62.8% of ONS drug-poisoning registrations concerned earlier deaths; 1,192 records (21.4%) named no specific drug. [2] Registration dates and incomplete substance information therefore affect interpretation. Drug poisoning is broader than drug misuse; indirect harms can fall outside these definitions. [49]

Scotland

Scotland’s unchanged definition is now called “drug use deaths”. In 2025, cocaine was implicated in 589 and nitazenes in 247 registrations. Opiates/opioids were implicated in 881 of the 1,133

drug use deaths (78%), including heroin/morphine in 468 (41%); these categories overlap. Implication is distinct from simple detection. [1]

Figure 3 Scottish nitazene-implicated registrations



NRS, Scotland 2025: nitazene-implicated drug use registrations. Routine etonitazene testing expanded in May 2025; exposure change and improved detection cannot be separated here. [1]

Northern Ireland

NISRA's 2024 release reports 251 drug-related death registrations, including 219 classed as drug misuse. Pregabalin was mentioned in 40.2% and five or more drugs in 21.9% of the broader drug-related deaths. These are overlapping involvement measures; they do not establish that pregabalin caused the death alone or that all drugs were knowingly taken together. [14]

Wales and regional interpretation

Wales recorded 417 drug-poisoning registrations in 2024, including 288 drug misuse deaths. The Public Health Wales analysis reports opioid involvement in 200 of the drug misuse deaths (69.4%) and more than one substance recorded in 179 (62.2%). These involvement categories overlap. [50]

Wales can be examined within ONS's England and Wales release using the same definition and units. National and regional rates should use the specified age standardisation and denominator. Counts can rise because the population changes; crude rates can differ because age structures differ. A valid geographical comparison requires matched definitions, periods and rate methods.

20. Treatment and the service landscape

England's community drug and alcohol services recorded 329,646 adults in treatment in 2024/25, up 6% from 310,863. The total included 99,955 treated for alcohol alone. The population is ageing: 61% were aged 40 or over and 29% aged 50 or over. Treatment activity measures services used, rather than all unmet need or treatment effectiveness. [6]

The December 2025 DHSC and NHS England framework calls for integrated adult mental health and substance use care. Its principles include joint responsibility and a no-wrong-door approach, rather than excluding people from one service until the other problem is resolved. It identifies fragmented pathways, exclusion criteria, workforce gaps and data-sharing difficulties as barriers. The framework applies to England; UK-wide implementation cannot be assumed. [51]

National service measures

Scotland's latest waiting-time release, published 29 September 2026, covers April to June 2026. Reporting community services recorded 11,290 referrals and 7,095 treatment starts; 93.6% of starts were within three weeks. At quarter end, 2,288 community referrals were still waiting, including 359 beyond three weeks. We excluded Western Isles and Shetland, along with three of the 190 remaining services, including two prison services. Waiting-time calculation changed with this release. These referral measures cannot be added to England's annual people-in-treatment total. [52]

Northern Ireland's 2024/25 Substance Misuse Database recorded 3,889 presentations: 1,476 for alcohol only, 1,299 for drugs only and 1,114 for both. Among clients using drugs, cannabis was reported by 49.4%, cocaine by 48.8%, pregabalin by 13.5% and benzodiazepines by 11.7%. These overlapping percentages describe presenting clients. The database records first presentations or returns after at least six months; 70 clients were recorded twice. All prison-treatment records were excluded because most were unavailable. It is neither a complete annual treatment caseload nor a general-population survey. [53]

Wales's annual profile and quarterly reporting use different units for assessment and referral measures than England's annual caseload. The latest DHCW quarterly release, dated 19 August 2026, covers data up to March 2026. Do not create a UK treatment total by adding Welsh referrals, Scottish starts, Northern Irish presentations and English people in treatment. [54]

Treatment series are not interchangeable

Nation	Indicator used	Population or unit	Main comparison constraint
England	Community drug and alcohol treatment, adults 2024/25	Adults in contact with drug and alcohol treatment	All-treatment caseload, with returning and new entrants analysed separately.
Scotland	Community waiting times Apr–Jun 2026	Referrals and starts in reporting services	Different unit; exclusions and calculation changes.
Wales	Assessment / referral returns	Recorded service activity	Referrals, assessed people and caseload differ.
Northern Ireland	SMD 2024/25	First presentations / qualifying returns	Not all current clients; prison records excluded.

OPERATIONAL IMPLICATION Measure access and continuity as well as total activity. A growing caseload can coexist with gaps for people using stimulants, ketamine or unknown tablets, and for people whose needs cross mental health and substance use services.

21. Prisons, housing and sexual health settings

Prisons and release

English secure settings recorded 52,401 adults in alcohol and drug treatment in 2024/25, 5% more than the previous year. Among eligible prison releases, 57% engaged in community treatment within three weeks, up from 53%. Take-home naloxone was provided on release to 54% of people treated for opiate problems in prison. These measures describe treatment and

handover; they do not estimate drug use among all prisoners or prove that every release received adequate support. [55]

The HMPPS 2025/26 digest covers England and Wales. It reports 56,679 random mandatory drug tests, but insufficient consistent testing to estimate drug prevalence robustly. Drug-find incidents increased 1% to 26,630; psychoactive-substance finds increased 12% to 7,772. Finds are influenced by detection and recording, and the psychoactive-substance category cannot be treated as laboratory-confirmed synthetic cannabinoids alone. A prison-prevalence trend arrow would therefore be unjustified. [56]

Housing insecurity

Housing status can affect whether care is accessible and whether a person can safely use, store medicines or attend appointments. Avoid merging temporary accommodation, sofa surfing and rough sleeping into one category. Local service records should identify the actual situation and the support required.

A practical review should include medication continuity, access to wound and infection care, overdose support, routes to treatment and the ability to maintain contact when accommodation changes. The report does not provide a nationally representative drug-use estimate for rough sleeping populations.

Sexual health and chemsex

A UKHSA and UCL study published in April 2026 analysed an online community survey completed by 2,758 UK-resident men and gender-diverse people having sex with men in November and December 2024. Eight per cent reported past-year chemsex-associated drug use. This convenience sample was recruited through social media and dating applications, with many London participants; it is not representative of national prevalence or a measure of trend. The drug-use category does not itself establish use during sex. Sexual health service attendance was common among this group, supporting those services as an access point for help

Public Health England's established commissioning briefing identifies chemsex as drug use before or during sex and describes links between sexual health and alcohol and drug services. It discusses methamphetamine, GHB/GBL and mephedrone, including injecting. The briefing dates from 2015, so its historical prevalence material should not be presented as current evidence. [58]

Connect sexual health, drug care and wellbeing

Where local need warrants it, create confidential routes between sexual health, drug treatment and mental health services. Ask about the actual substances, timing, injecting, loss of consciousness, consent, sleep and distress. Do not assume that every person using one of these drugs engages in chemsex or that everyone reporting chemsex requires dependence treatment.

22. County lines and child criminal exploitation

Home Office guidance describes county lines as drug supply using deal lines, frequently involving coercion of children and vulnerable adults to move or store drugs and money. Vulnerability can include insecure housing, debt, mental health difficulties, care experience or neurodivergence, but these factors do not cause exploitation. People without known risk factors can also be targeted. Local drug supply exploitation requires a safeguarding response even without cross-county travel. Immediate danger requires emergency action; otherwise, follow local safeguarding routes and check that the referral was acted on. [59]

The County Lines Programme reports 4,556 line closures and 6,939 individuals referred by police to safeguarding between July 2024 and March 2026. These are programme outputs. They cannot establish how many exploited people exist, whether total drug availability has fallen or whether closures prevented replacement lines or permanently reduced supply. An operational increase may reflect more activity and better identification rather than a population increase in exploitation. [60]

Ask about control, not only consumption

Ask sensitively whether anyone controls the person's phone, money, accommodation or supply; whether there are debts they cannot explain; and whether they feel able to stop meeting particular people. Consider coercion when the apparent choices are constrained by threats, dependency or access to shelter.

Services should know the local child and adult safeguarding routes, who can support a modern-slavery referral, and how to obtain urgent help. Avoid judging exploitation from sex, appearance or a single risk factor. Managers should review safeguarding follow-through and access to support, rather than measuring only the number of referrals submitted.

Digital and local supply

Deal lines, online contact and recruitment should be examined as part of the person's actual experience. Exploitation can occur within a locality as well as across boundaries. A route-of-supply record should include coercion and control where disclosed, without assuming that every online purchase represents exploitation.

SAFEGUARDING POINT A person may describe participation while facing debt, threats or dependency. Ask about freedom to leave the situation, safe contact and the actions required by local child or adult safeguarding procedures.

23. A proportionate local intelligence panel

Bring treatment, public health, emergency care, safeguarding, pharmacy, laboratories and criminal justice together around a concise shared record. Record source, period, geography, denominator, confidence and proposed action. The panel's purpose is to convert relevant observations into care and preparedness, while retaining uncertainty about wider trends.

24. Data limitations and methodology

This report is a structured intelligence synthesis of published primary evidence available by 4 October 2026. It is not a systematic review, a new prevalence survey or a causal statistical model. It combines official national releases, experimental estimates, authoritative reviews, primary research, and appropriately labelled drug-checking and local intelligence.

Source selection

National statistical bodies and UK health, law-enforcement and medicines agencies were prioritised. EUDA and other international sources provide explicitly labelled context. Local alerts and submitted samples establish specific signals. Publication date, reference period, geography, population and key limitations were retained separately. Later surveillance releases were excluded; the dated wastewater technical correction is identified separately.

A later publication can contain older observations. For example, a paper published in 2026 may analyse wastewater collected in 2022. The latest release must therefore be checked for its data period and whether it supersedes an earlier method. A current publication date cannot make an older population estimate a 2026 figure.

Trend and confidence judgements

Arrows apply to a named indicator and comparison. A national direction is left uncertain where evidence is sparse, incompatible or divergent. Statistical significance is retained where the source supplies it. Confidence is judged from directness, coverage, consistency, quality and methodological limitations; it is not calculated from a numerical threat score.

Comparability and ascertainment

Mortality definitions, drug testing, registration lags, treatment eligibility, age bands and geographical coverage vary. More detections can arise from broader testing; more referrals from improved access; more seizures from enforcement or recording changes. These are alternative explanations to examine, not reasons to disregard a confirmed signal.

Analysis and visualisation

Charts reproduce specified source series. Arithmetic checks retain the relevant baseline and distinguish percentage change from percentage-point change. Zero was used as the baseline for positive count charts. Overlapping drug categories were not displayed as parts of a mutually exclusive whole. Native Word charts contain editable data workbooks, and source tables retain the numerical values.

Challenge review

The evidence was reviewed for outdated releases, contradictory indicators, unsupported national generalisation, causal overstatement, denominator errors and changes in detection. Mortality and wastewater figures received a separate interpretation check. Editorial and document checks addressed language, citations, automatic contents, pagination and accessibility. These production checks are not external peer review.

25. Glossary

Definitions are written for reading this report. Where a statistical body uses a specific operational definition, that definition governs its figures.

Scientific and intelligence terminology

Term	Plain-language explanation
Adulterant	A substance added to a product; the evidence may not show why it was added.
Age-standardised rate	A rate adjusted to a standard age distribution so populations with different ages can be compared more fairly.
Alpha-2 agonist	A drug acting at alpha-2 adrenergic receptors; this class includes xylazine and medetomidine, with different pharmacology.
Ascertainment	How a system identifies and records an event or exposure.

Term	Plain-language explanation
Association	A relationship observed between features; it does not by itself prove cause.
Benzodiazepine	A class of medicines and related compounds with sedative and other effects.
Catchment	The population or area contributing to a wastewater treatment site.
Causal interaction	The effect of one exposure differs depending on another exposure, on a specified outcome scale and supported by appropriate causal evidence.
Co-occurring needs	Mental health, substance use or other support needs present in the same person.
Co-presence	Two substances identified in the same product or specimen.
Co-use	Reported use of more than one substance within a specified time window.
Confidence interval	A statistical interval expressing uncertainty under a model; it does not remove sampling or measurement bias.
Counterfeit medicine	A product falsely represented as a genuine medicine; distinguish from all illegal or unlicensed products.
Crude rate	Events divided by the population, without adjustment for age structure.
Denominator	The population or observations used as the base of a proportion or rate.
Detection	Identification within the tested material and analytical scope.
Dexmedetomidine	One of the two stereoisomers of medetomidine, used as a medicine; therapeutic exposure can complicate interpretation.
Drug checking	Analysis of products submitted or sampled to identify substances, sometimes including concentration.
Drug mention	A substance named in a death record; the source determines what this records about involvement.
Drug poisoning	An official mortality category covering drug poisoning and selected mental and behavioural disorders due to psychoactive substance use; broader than the ONS drug misuse category. [49]
Drug misuse / drug use deaths	Defined statistical subsets of deaths; the national source's definition must be checked.
Experimental estimate	An estimate produced with developing methods and material uncertainty.
Excretion	The removal of substances or metabolites from the body, including in urine.
Gabapentinoid	A medicine class including pregabalin and gabapentin.
Hepatobiliary	Relating to the liver and bile ducts.
Incidence	New events in a population over a period, different from the proportion reporting any use.

Term	Plain-language explanation
Ketamine-induced cystitis	Bladder inflammation and injury associated with ketamine use.
Metabolite	A substance produced when another substance is processed in the body.
Naloxone	A medicine that reverses opioid effects in overdose; it does not directly reverse all non-opioid sedatives.
Nitazenes	A family of synthetic opioids; individual compounds differ and should not be assigned one universal potency ratio.
New psychoactive substance / NPS	A psychoactive substance newly appearing in drug markets, generally outside the 1961 and 1971 international drug-control conventions when first recognised. Some remain in NPS surveillance after international control. "New" does not necessarily mean newly synthesised. [62]
Occurrence year	The year an event happened, such as the date of death.
Orphine analogue	An emerging synthetic-opioid category distinct from nitazenes.
Percentage point	The arithmetic difference between two percentages, distinct from their relative percentage change.
Polysubstance exposure	Exposure to multiple substances; intention and timing may or may not be known.
Population prevalence	The proportion of a defined population reporting or meeting a definition of use during a specified period.
Provisional	Not yet final and liable to revision.
Purity	The proportion of a specified substance in a product; sampling and method determine what a figure represents.
Registration year	The year a death is formally registered, which may differ from its occurrence year.
Representative sample	A sample designed or shown to describe the specified target population.
Selection bias	Distortion caused by which observations enter a sample or service.
Sentinel surveillance	Monitoring at selected sites or populations to detect signals, often without full national coverage.
Sequential use	Use of one substance after another; effects may still overlap.
Simultaneous use	Use together at the same time or administration event; sequential use can also produce overlapping effects.
Stability	How reliably a chemical remains measurable over time or conditions.
Statistical significance	A result meeting a specified statistical test threshold; it is separate from effect size and operational significance.
Synthetic cannabinoid receptor agonist / SCRA	A manufactured compound acting at cannabinoid receptors; chemically distinct from THC.

Term	Plain-language explanation
THC	Tetrahydrocannabinol, a principal intoxicating compound in cannabis.
Toxicology	Laboratory examination of substances and their effects or presence in biological specimens.
Tusi	A marketed mixture label also written tuci or tucibi; it is not a fixed chemical recipe.
Wastewater consumption estimate	A modelled quantity derived from measured residues, population and metabolic assumptions.
WEDINOS	The Wales-led emerging-drug identification programme accepting submitted samples from across the UK.
RADAR	Public Health Scotland's Rapid Action Drug Alerts and Response surveillance system.

26. References

Publication and data periods are recorded separately. The original source check used the 4 October 2026 cut-off. Amendments and supporting definitions were checked on 9 October 2026; reference 5 identifies the 8 October technical correction. Links point to the primary release or evidence page; live pages may subsequently change.

1. **National Records of Scotland.** Drug-related deaths in Scotland, 2025. Published 23 September 2026. Data: 2025 registrations. Geography: Scotland. [Source](#)
2. **Office for National Statistics.** Deaths related to drug poisoning in England and Wales: 2024 registrations. Published 17 October 2025. Data: 2024 death registrations; selected occurrence analysis to 2023. Geography: England and Wales including non-residents. [Source](#)
3. **Advisory Council on the Misuse of Drugs.** Ketamine: an updated review of use and harms. Published 28 January 2026. Data: Review of evidence available for 2025 commission. Geography: UK review incorporating sources with different geographies. [Source](#)
4. **Public Health Wales / WEDINOS.** WEDINOS annual report: April 2025 to March 2026. Published 25 August 2026. Data: 1 April 2025 to 31 March 2026. Geography: Wales-led programme, samples from across UK. [Source](#)
5. **Home Office.** Wastewater Analysis: Estimating drug consumption. Published 13 April 2026; updated 12 June 2026 and 8 October 2026 (technical correction to uncertainty and methodology). Data: National estimates August 2024–July 2025; comparable-site Jan–Apr 2021–2025 series. Geography: England national estimates; 16 England sites for trends; 50 England and Scotland sites for patterns. [Source](#)
6. **Office for Health Improvement and Disparities.** Adult substance misuse treatment statistics 2024 to 2025: report. Published 4 December 2025. Data: 1 April 2024–31 March 2025. Geography: England. [Source](#)
7. **Office for National Statistics.** Drug misuse in England and Wales: year ending March 2025. Published 11 December 2025. Data: Year ending March 2025; last-12-month self-reported use. Geography: England and Wales household population aged 16–59 and 16–24. [Source](#)
8. **The Loop.** Powder sold as pink tusi found on-site at Lost Village 2022. Published 28 August 2022. Data: Lost Village festival, August 2022. Geography: England. [Source](#)

9. **National Crime Agency.** Liverpool crime group guilty of Australia and New Zealand drug smuggling attempts. Published 2 October 2026. Data: Consignment handed to courier 10 October 2024; case outcome reported 2 October 2026. Geography: Liverpool, UK; intended export to Castle Hill, New South Wales, Australia. [Source](#)

10. **Advisory Council on the Misuse of Drugs.** Amendment to ACMD report – Use and harms of xylazine, medetomidine and detomidine. Published 21 October 2025; page updated 16 January 2026. Data: Stakeholder evidence in 2025; older xylazine detections 2022–2023. Geography: UK, with separately identified North American clinical evidence. [Source](#)

11. **Public Health Scotland.** RADAR alert: New xylazine-type drug – medetomidine. Published 5 February 2026; page updated 14 July 2026. Data: Scottish testing mainly to December 2025; post-mortem to Q3 2025. Geography: Scotland. [Source](#)

12. **Public Health Scotland.** RADAR quarterly report, July 2026. Published 28 July 2026. Data: Multiple surveillance periods; purchased-as-heroin submissions March–June 2026; hospital February–May 2026. Geography: Scotland. [Source](#)

13. **Public Health Scotland.** RADAR alert: New benzodiazepines in Scotland. Published 5 February 2026; page updated 14 July 2026. Data: Mainly 2025 detections with trend comparisons. Geography: Scotland. [Source](#)

14. **Northern Ireland Statistics and Research Agency.** Drug-related and drug misuse deaths 2014–2024. Published 13 May 2026. Data: 2024 registrations; earlier series revised. Geography: Northern Ireland. [Source](#)

15. **Medicines and Healthcare products Regulatory Agency.** MHRA seizes illegal medicines worth almost £45m in 2025 – disrupting major criminal networks. Published 26 January 2026. Data: Calendar year 2025; 2024 comparison. Geography: UK. [Source](#)

16. **Andrews R, Fuller A, Cozier GE et al.** A Chemical and Digital Analysis of E-Cigarettes Seized from English Schools and the Social Media Marketplace. medRxiv preprint version 1. DOI: 10.1101/2025.09.04.25334826. Published 7 September 2025. Data: School confiscations 2023/24 and 2024/25 pooled; online analysis June–August 2025. Geography: Selected schools across seven police force areas in England; online listings separately studied. [Source](#)

17. **National Crime Agency.** National Strategic Assessment 2026: Harm to individuals. Published 17 March 2026. Data: 2025 intelligence context with 2024 mortality and year-ending-March 2025 seizures. Geography: UK strategic assessment; separate England/Wales component statistics. [Source](#)

18. **Office for National Statistics.** Deaths related to drug poisoning in England and Wales: 2022 registrations. Published 19 December 2023. Data: 2022 registrations. Geography: England and Wales. [Source](#)

19. **Department of Health and devolved administrations; independent expert working group.** Drug misuse and dependence: UK guidelines on clinical management. Published 14 July 2017; PDF revised 15 December 2017; page updated 13 August 2026. Data: 2017 clinical guidance. Geography: UK. [Source](#)

20. **Office for Health Improvement and Disparities.** Children's substance misuse treatment statistics 2024 to 2025: report. Published 4 December 2025. Data: 1 April 2024–31 March 2025. Geography: England children aged 17 and under. [Source](#)

21. **Advisory Council on the Misuse of Drugs.** ACMD autumn 2026 work program update (accessible version). Published 21 September 2026. Data: Status as 21 September 2026. Geography: UK policy advice. [Source](#)

22. **Goss N, Corbett HJ, Brewster L, Cowley G, Isba R.** Who are the children and young people attending the UK's first ketamine-induced uropathy clinic for under 16s?: an early insight into sociodemographic features. Archives of Disease in Childhood. Online clinical letter. DOI: 10.1136/archdischild-2026-330727. Published 22 September 2026. Data: First 60 referred clinic patients, clinic opened May 2025. Geography: Liverpool specialist under-16 clinic; selected referrals. [Source](#)

23. **BMJ Group publisher release for Goss and colleagues' clinical letter.** Non-prescribed ketamine use may start at age 13, dedicated UK clinic data suggest. Published 22 September 2026. Data: First 60 referred patients. Geography: Alder Hey Liverpool under-16 clinic. [Source](#)

24. **EUDA and Europol.** EU Drug Market: MDMA — In-depth analysis (retail markets chapter). Published March 2025. Data: European Early Warning System detections mainly 2021–2023. Geography: Europe; international context. [Source](#)

25. **The Loop.** 2-CB in circulation. Published 13 August 2023. Data: Boomtown festival, August 2023. Geography: England. [Source](#)

26. **Chen S, Aldabergenov D, Alotaibi KS et al.** Is nitazene-related mortality underestimated? Findings from an in vivo and ex vivo rat study and pharmacoepidemiological analysis of coroner-reported deaths. *Clinical Toxicology* 64(4):311–323. DOI: 10.1080/15563650.2025.2601141. Published 8 February 2026 online; 3 April 2026 issue. Data: Experimental rat study; coronial records 2019–2023 and NPSUM extraction March 2025. Geography: Experimental model; Birmingham and Solihull coronial analysis, UK mortality context. [Source](#)

27. **European Union Drugs Agency.** New psychoactive substances – the current situation in Europe (European Drug Report 2026). Published 9 June 2026. Data: 50 first notifications in 2025; about 400 previously reported NPS detected 2024. Geography: EU/European surveillance, international context. [Source](#)

28. **NHS.** Poisoning. Last reviewed 12 June 2025. Data: Current public emergency information. Geography: UK public information. [Source](#)

29. **The Forward Trust, relaying Surrey Substance Use Partnership local intelligence.** Medetomidine found in drug supply in South West London. Published 3 August 2026. Data: Local alert in August 2026. Geography: Sutton, South West London. [Source](#)

30. **The Loop.** Pills confirmed to contain nitazenes associated with two recent deaths. Published 30 May 2025. Data: Alert in May 2025. Geography: UK alert; specific location not stated in text. [Source](#)

31. **Medicines and Healthcare products Regulatory Agency.** Improving Information Supplied with Gabapentinoids (Pregabalin/Gabapentin), Benzodiazepines and Z-Drugs. Published 8 January 2026. Data: 2026 product-information change. Geography: United Kingdom. [Source](#)

32. **Medicines and Healthcare products Regulatory Agency.** Pregabalin (Lyrica): reports of severe respiratory depression. Published 18 February 2021. Data: Current medicine safety guidance; older Yellow Card series not a current incidence estimate. Geography: United Kingdom. [Source](#)

33. **Medicines and Healthcare products Regulatory Agency.** Gabapentin (Neurontin): risk of severe respiratory depression. Published 26 October 2017; post-publication note April 2021. Data: Current medicine safety guidance. Geography: United Kingdom. [Source](#)

34. **Kim I, Oyler JM, Moolchan ET, Cone EJ, Huestis MA.** Urinary pharmacokinetics of methamphetamine and its metabolite, amphetamine following controlled oral administration to humans. *Therapeutic Drug Monitoring* 26(6):664–672. DOI: 10.1097/00007691-200412000-00013. Published December 2004. Data: Controlled human study. Geography: Small US controlled human laboratory study; not UK surveillance. [Source](#)

35. **Takeda UK Limited via electronic medicines compendium.** Elvanse 30mg Hard Capsules: Summary of Product Characteristics (SmPC). Text revised 14 January 2026; eMC updated 23 January 2026. Data: Current product pharmacology; accessed 4 October 2026. Geography: UK authorised product information. [Source](#)

36. **The Loop.** Cathinones tested by The Loop London Drug Checking Services 2026. Published 29 May 2026. Data: 2026 submissions to date of alert. Geography: London. [Source](#)

37. **The Loop.** 4-Chloromethcathinone (4-CMC) found in circulation at Lost Village 2022. Published 25 August 2022. Data: August 2022 festival. Geography: England. [Source](#)

38. **The Loop; testing attributed to Lincolnshire Police.** Dipentylone found at Lost Village 2023. Published 26 August 2023. Data: August 2023 festival. Geography: England. [Source](#)

39. **FRANK, government drug information service.** Synthetic and semi-synthetic cannabinoids. Undated; accessed 4 October 2026. Data: Current public information at cut-off. Geography: UK public information. [Source](#)

40. **Advisory Council on the Misuse of Drugs.** Nitrous oxide: updated harms assessment (accessible). Published 6 March 2023. Data: Evidence review to early 2023. Geography: UK, with international supporting evidence. [Source](#)
41. **FRANK, government drug information service.** Nitrous oxide. Undated; accessed 4 October 2026. Data: Current public information at cut-off. Geography: UK public information. [Source](#)
42. **NHS England.** Smoking, Drinking and Drug Use among Young People in England, 2023: Part 8. Published 17 October 2024. Data: Survey September 2023 to March 2024, publication labelled 2023. Geography: England; secondary school pupils mostly aged 11 to 15. [Source](#)
43. **Department of Health and Social Care.** Children and young people's alcohol and drug services: framework. Published 1 October 2026. Data: Guidance current at cut-off. Geography: England. [Source](#)
44. **Medicines and Healthcare products Regulatory Agency.** Benzodiazepines and opioids: reminder of risk of potentially fatal respiratory depression. Published 18 March 2020. Data: Current medicine safety guidance. Geography: United Kingdom. [Source](#)
45. **Public Health England.** Non-fatal overdose among people who inject drugs in England: 2018 report. Health Protection Report 12(33). Published 14 September 2018. Data: Survey 2013–2017; clinical background used here. Geography: England survey; opioid-overdose clinical background. [Source](#)
46. **Home Office.** Seizures of drugs in England and Wales, financial year ending 2025. Published 12 February 2026. Data: Year ending March 2025. Geography: Police forces and Border Force in England and Wales. [Source](#)
47. **Home Office and Border Force.** Ketamine seizures reach 15 year high. Published 28 August 2026. Data: Q1 January–March 2026 compared with Q4 2025. Geography: UK border, Border Force. [Source](#)
48. **Police Service of Northern Ireland Statistics Branch.** Trends in Police Recorded Drug Seizures and Arrests in Northern Ireland 2006/07 to 2025/26. Published 2 October 2026. Data: April 2025–March 2026; prior-year comparisons; compiled 19 August 2026. Geography: PSNI-recorded incidents in Northern Ireland; excludes Border Force and NCA. [Source](#)
49. **Office for National Statistics.** Deaths related to drug poisoning in England and Wales QMI. Last revised 13 October 2020. Data: Methodology; historical examples not current estimates. Geography: England and Wales. [Source](#)
50. **Public Health Wales.** Harm Reduction Database Wales: Drug Related Mortality, Annual report 2025 (data to end of 2024). Published 2025; publicly described in PHW news on 17 December 2025. Data: 2024; review and naloxone series to end 2024. Geography: Wales. [Source](#)
51. **Department of Health and Social Care and NHS England.** Co-occurring mental health and substance use delivery framework. Published 10 December 2025. Data: Guidance current at cut-off. Geography: England; adult mental health services scope. [Source](#)
52. **Public Health Scotland.** National drug and alcohol treatment waiting times: 1 April 2026 to 30 June 2026. Published 29 September 2026. Data: 1 April to 30 June 2026. Geography: Scotland, excluding specified areas/services. [Source](#)
53. **Department of Health Northern Ireland and NISRA.** Statistics from the Northern Ireland Substance misuse database: 2024/25. Published 11 December 2025. Data: 2024/25. Geography: Northern Ireland. [Source](#)
54. **Digital Health and Care Wales.** Quarterly Reports: substance misuse. Published 19 August 2026. Data: April 2013 to March 2026. Geography: Wales. [Source](#)
55. **Office for Health Improvement and Disparities.** Alcohol and drug treatment in secure settings 2024 to 2025: report. Published 5 February 2026. Data: 1 April 2024 to 31 March 2025. Geography: England. [Source](#)
56. **Ministry of Justice and HM Prison and Probation Service.** HMPPS Annual Digest 2025 to 2026. Published 30 July 2026. Data: Year ending March 2026. Geography: England and Wales. [Source](#)

57. **Baldry G, Habib Meriggi G, Mullen D et al.** Chemsex-associated drug use amongst men and gender-diverse people having sex with men in the UK: Findings from an online community survey, 2024. *International Journal of STD & AIDS* 37(8):884–891. DOI: 10.1177/09564624261448075. Published 28 April 2026. Data: November to December 2024 survey; preceding 12-month drug use. Geography: UK-resident online community sample. [Source](#)

58. **Public Health England.** Substance misuse services for men involved in chemsex. Published 1 November 2015. Data: Established commissioning guidance; historical contextual source. Geography: England service commissioning. [Source](#)

59. **Home Office.** Criminal exploitation of children and vulnerable adults: county lines (accessible version). Updated 20 October 2023. Data: Guidance current at cut-off. Geography: UK phenomenon; safeguarding procedures vary by nation. [Source](#)

60. **Home Office.** County Lines Programme overview. Updated 10 July 2026. Data: July 2024 to March 2026 programme activity. Geography: County Lines Programme activity; do not substitute for UK prevalence. [Source](#)

61. **European Union Drugs Agency (originally European Monitoring Centre for Drugs and Drug Addiction).** Polydrug use: health and social responses. Published 22 October 2021; page updated 17 June 2026. Data: Clinical and response guidance; no UK prevalence estimate. Geography: European guidance. [Source](#)

62. **United Nations Office on Drugs and Crime.** What are NPS? Undated; checked 9 October 2026. Data: Terminological definition; no new surveillance estimates used. Geography: International. [Source](#)

27. Editorial and evidence note

Data cut-off: 4 October 2026; the wastewater technical correction of 8 October is identified in reference 5. This first public edition is dated October 2026. The intended publication cycle is annual, with October 2027 as the next planned edition.

Primary UK official statistics and authoritative agencies were prioritised. Primary research, including clearly labelled preprints and clinical letters, drug checking, and local intelligence, supplements them with appropriate geographical and methodological labels. Source dates and observation periods remain separate.