THE GREATER MANCHESTER STREET DRUG SURVEY 2025/26

GMCA GREATER MANCHESTER COMBINED AUTHORITY

Manchester Metropolitan University

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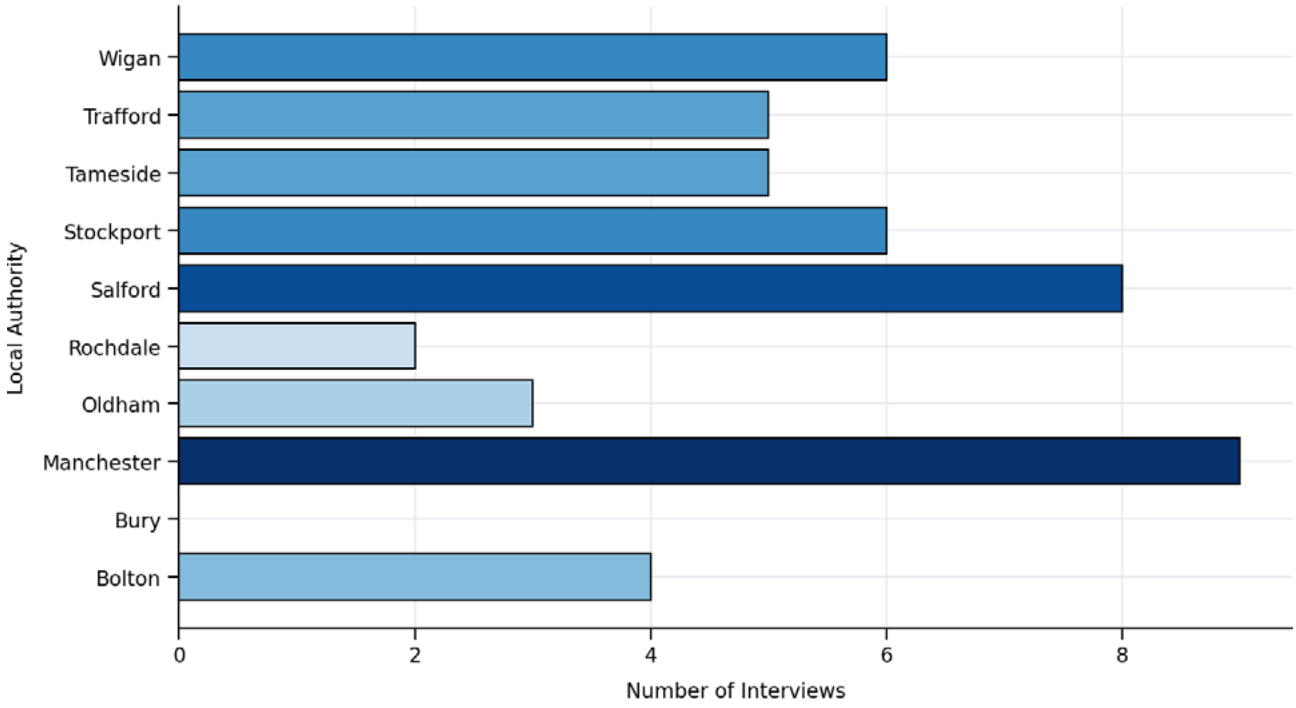
1. METHODOLOGY

This report draws on three sources: an online survey of 212 professionals, 85 in depth interviews with professionals, and interviews with 48 individuals who use 'street drugs'. Eligibility criteria required participants to be currently using at least one of the following substances: **heroin**, ***crack* cocaine**, *synthetic cannabinoids* ('Spice'), *benzodiazepines*, or **pregabalin**. The aim was to engage approximately four participants from each of the ten Greater Manchester areas. To ensure we captured the perspectives of both people in treatment and those not engaged with treatment services, recruitment was facilitated through a mix of drug treatment providers, homeless drop-in centres, homelessness charities, and supported accommodation. Thirty-nine men and nine women ranging in age from 22 to 58 were interviewed from nine Greater Manchester areas.

Chart 1. *Street Drug Interviews by Local Authority (darker = Higher)*



2. HEROIN

2.1 Market Insights

This section presents market insights from people who use **heroin** and professionals who work closely with them, focusing specifically on issues related to access, cost, and content.

2.1.1 Context

The Taliban regime's 2022 ban on **opium** production in Afghanistan leg to an estimated 95% fall in **opium** supply the following year. (UNODC, 2023). Because almost all UK **heroin** originated from Afghanistan , widespread fears emerged of a **heroin** shortage in the UK, and increased adulteration of street **heroin**. The 'drought' was predicted to come 18-24 months after the ban after existing stocks had been used. However, more than three years after the Taliban ban, there has been no reports of any local or national shortage of **heroin**. A report from the European Union Drugs Agency (EUDA) offers several explanations as to why the predicted heroin shortage has not materialised including:

- The Taliban gave producers two-month notice of the ban that allowed them to amass huge stockpiles;
- Most **heroin** produced in Afghanistan is low grade **heroin *hydrochloride*** (*crystal, spin maa*l) produced for outside Europe;
- The Afghan producers have further adulterated this low-grade product bound for outside Europe, but ensured that the best quality product '*gul*' (**heroin *base***) is protected and remains relatively free from adulteration.

Therefore, EUDA reports that Europe remains protected from Afghan adulteration as Europe is by far the most lucrative market. However, while Afghan **heroin** is still available, they report that the price has increased threefold. They also state that adulteration by European traders as a response to the increased price has been to reduce the amount of the **opium *base*** rather than adding *synthetic opioid* adulterants (EUDA, 2025).

2.1.2 Availability

In line with this 2025 European report, at the local level, heroin was still reported to be readily available.

> *"I've not heard of anybody struggle to get heroin".* (Consultant Addiction Psychiatrist, Bolton)

While **heroin** is still readily available across Greater Manchester, a few of the people that we interviewed reported that there are noticeably less dealers selling **heroin**.

> *"I've seen a lot less brown [heroin] knocking about mate".* (Stockport man, early 20s)

> *"Not many people sell heroin in the [Manchester city] centre anymore. It's just crack mainly".* (Manchester woman, early 30s)

2.1.3 Price

Both professionals and people who use **heroin** and ***crack*** often discussed multi-buy deals, such as *"three £5 deals for £10"* (i.e. a 3-for-2 offer), five £5 deals of heroin and/or crack for £20, or any five £10 deals for £40.

> *"Heroin still comes in £5 and £10 bags, still buying brown and white deals of heroin and crack. Five items for £40".* (Advanced Recovery Practitioner, Rochdale)

> *". . . cheaper deals like three £10 bags for £20".* (Bolton man, 50s)

> *"So here [Trafford], in terms of heroin you can only get £10 deals or more here. In Salford you can actually buy £5 deals of heroin [. . .] No doubt you will get dealers saying 'there's the £5, maybe its lower quality not just less weight. This ones the good one, probably got a bit of nitazenes in it' or whatever".* (Harm Reduction Worker, Trafford)

However, as suggested above, the £5 deals were often reported to be poor value. Firstly,

the small size of these £5 deals was regularly commented upon.

> *"Yeah, well it depends who you go to. People do different deals. Like you've got all the yardies, they'll do like a straight ten [pound] bag . . . straight tenners . . . some will give you a bag of gear for a fiver, but it's like £2.50s worth. So you think you're getting a deal but you're not".* (Trafford man, mid-30s).

Secondly, in addition to the small size of the £5 deals, the quality of the **heroin** sold in £5 deals was typically reported to be poor.

> *"It's five-pound bags now, but they're weak. Smaller sizes and weaker bags".* (Bolton man, 50s)

One professional reported that many people they work with will not buy £5 deals due to consistently poor quality.

> *"They won't buy it, £5 ones, they know that it's bashed with pure shit. They go to people that they know have a bit more decent quality".* (Recovery Professional, Salford)

As we outline below, while heroin was still available and for the same price, the poor quality of heroin in local circulation was one of the most consistently reported findings in the Street Drug Survey across all areas.

2.1.4 Content

While most people reported that £5 deals were poor quality, one person in Salford suggested that £5 deals are the ones most likely to contain more potent **fentanyl**.

> *"The quality of it [heroin] is pretty shit and the deals are pretty small. I don't really like using them [£5 deals], I like to use the £10. The .2s [of a gram]. The qualities a bit better. They never have the fentanyl [in them], it's always the cheap ones. The £5 ones have the fentanyl in. [. . .] It always seems to be the £5 wraps. It's always them that have got the fentanyl in, the £5 wraps. But when you get the £10, like the .2s, it's like they've got the better gear".* (Salford man, late 50s)

A small number of professionals and two people who use **heroin** that we interviewed suggested that there was still some better-quality **heroin** available if you knew where to get it.

> *"The heroin's not too bad at the moment, it's lasting and going quite well".* (Rochdale man, late 40s)

However, it was much more commonly reported across all Greater Manchester areas that the quality of **heroin** was poor.

> *"In a sense of what I've seen, I know heroin's gone shit. [. . .] I think it's getting worse. I'll say that".* (Recovery Professional, Salford)

> *"Heroin is still rife, however the quality is questionable. Heroin is being mixed with things such as car cleaner for its high, very dangerous".* (Drug and Alcohol Recovery Practitioner, Local Prison)

People who use **heroin** also consistently reported that the quality was poor.

> *"[The] gears not gear [. . .] It's shit, yeah. It looks like . . . it's like sugar".* (Trafford woman, 40s)

> *"Yeah, really shit to be honest".* (Tameside man, early 40s)

> *"Fucking bad mate, bad! It's a joke! I'd say of about 10 dealers, two of them are good . . . But even then, they get a new batch, and it could be shit".* (Salford man, 40s)

2.1.4.1 Indication of poor-quality heroin

The way that **heroin** runs – or doesn't run – was commonly discussed as evidence of poor quality.

> **"Interviewer: *And do you notice anything different, with the heroin like when you're cooking it up?*** *Yeah, it doesn't break down like literally. You're heating it up and that, and it's not even running.* **Interviewer: *So that's one of the signs then, it's not even running?*** *Yeah, it's like just frazzling on the spot. You've gotta get a bit of butter on it, have you heard people say that? . . . Yeah, I haven't really done it, but I seen someone do it the other day, put a bit of marge on it and put it on the foil and put the gear on that. It makes it go further. So I think it just helps it run".* (Trafford man, mid-30s)

In two Greater Manchester areas (Salford and Trafford) several people reported that a sign of poor-quality heroin was that the **heroin** was running red on the foil.

"It's running like dark reddy when it should be like brown like [breaks into song] 'Golden brown . . .' the [Strangler's] song, it comes from that. Well heroin is white, but it comes as a brown powder cos of all the shit in it. . . just unpredictable. I'd say the majority, 80% of it is running red all the time". (Salford man, 40s)

"Heroin, back in the day, you know, in the 90s, you could smell it, could see it, you know . . . everything. And literally the smell and the taste would knock you sick. And you know, all you needed was half a line and you could feel it. Whereas now, you're running it and it's literally running totally different. You can see it literally running off your foil, it's red and it's got a gloss to it as well. [. . .] normally like back in the day it runs brown. **Interviewer: *Do you ever get any that does run brown like it used to?*** *No, not really, I mean it is still brown but when you're running it you can see the trace behind it and it's red. [. . .] But it's not fentanyl, because you're not getting no benefit. It's not doing nothing to you".* (Trafford woman, 40s)

"I think we've all got like the same one. All street dealers are going to the ones doing the ounces whatever they do, or like the bars. The street dealers all seem to have the same batch. It's more . . . it looks like chocolate. It's like a brown cementy colour and it's like chocolate, drinking chocolate and then when you burn it. [. . .] Like you know, around the edge it's more amber red. When it's better gear, it's like black. Darker. Treacle. Whereas now it's got more like a red tinge, amber. [. . .] *It leaves a black line, a dirty line. Normally it's clear but it's like black, it's really black and it's burning like red".* (Salford man, late 50s).

As noted above, some people reported that the heroin in circulation was often a darker brown, chocolate colour. In section, 2.1.5.5 'MANDRAKE Findings' some images (see Figure 1) of the **heroin** samples tested by MANDRAKE this year illustrate this.

"It works, it does the job, but I don't think it's heroin, you don't get heroin no more. It might have a little tiny bit of heroin in it but it's all synthetics. . . . 'If it's red it's dead if it's black it's smack!' You know when you're running it. . . If it's red its full of fucking hidersine! Violin cleaner". (Salford man, late 30s)

Yet despite these frequent reports of poor quality, professionals commented that it was not deterring people they work with from using it.

"Heroin is poor quality, but still widely used". (Operational Manager, Bolton and Bury)

"Heroin [is] still plentiful, quality is rubbish, but people are still buying it!" (Advanced Recovery Practitioner, Rochdale)

Many people who use **heroin** went on to elaborate on the reasons they stated that it was 'shite'. Most people discussed not getting any kind of 'nod'[1].

"I wasn't nodding, there was none of that nodding or anything like that, it was just making me comfy, and I shut off a lot easier". (Stockport man, late 50s)

Comparisons were often made to the quality now compared to previous years.

"The heroin is just a joke, the gear. It's like we are getting addicted to some other drug. Which is probably why you are doing your research. It's just a load of shite. You know like you don't get an itch. Back in the day you could get like one bag, and it would do three of you for half a day, you were all happy. But now, you are taking like four each, five each and you are still not getting that nod, you are not getting what you want. It's like 'why do we keep doing it to ourselves?' (Salford man, 40s)

"It's absolutely shite. [. . .] you fucking get something and don't really feel nothing off it. And you think, 'have I even had anything?'. [. . .] *You're just wasting money now. I'm just taking it so I'm not ill".* (Trafford man, mid-30s)

1. The nod' or 'nodding out' refers to a frequently involuntary, opioid-induced state of extreme drowsiness, where a person shifts between being awake and drifting into a semi-conscious or unconscious state. It is a classic, short-term effect of heroin use that follows the initial euphoric 'rush.

The poor-quality **heroin** in circulation means that people who beg or commit acquisitive crime to fund their use of **heroin** have to do this more often.

> *"I just want to get what I'm paying for! You can sit there [for] three hours begging to make your money and then you are getting a load of shite! And then having to go straight back out again! But we keep doing it! But it's getting harder and harder".* (Salford man, mid-40s)

Three people commented that the quality was so poor that they or their partners were still getting **heroin** withdrawal symptoms after using heroin.

> *"But you know, an hour and a half later, his nose will be dripping so there can't be that much gear in it. Because he could get through now on two B ['brown'/heroin] a day my fella, you know what I mean? He's cut down".* (Salford woman, mid-50s)

2.1.4.2 Drug Test Results

Poor quality **heroin** in circulation was supported by one notably indicator. Professionals and people who use drugs recounted examples of users testing negative for **heroin/opiates** shortly after using '**heroin**'.

> *"Yeah, heroin's not heroin now. People are having heroin habits and not failing the fucking heroin test. So they think they've got a habit of heroin and they're not even failing for opiates! Do you know what I mean? That's strange isn't it?"* (Tameside man, late 20s)

> *"A girl who I talk to, she takes heroin. She took some heroin the other day and it didn't even come up on a piss test".* (Manchester man, 40s)

> *"I could have a bag of heroin now and not fail a drugs test. There's no heroin in the heroin".* (Tameside man, mid-20s)

These claims that the **heroin** quality was so poor that it was not leading to positive results in routine drug tests were supported by several professionals.

> *"I think what is quite concerning is when someone says they have smoked heroin or injected heroin previously and there were no opiates in the system [on drug screen]. And then you sort of worry, 'well what is it you've actually taken?'* (Recovery Worker, Criminal Justice Team, Rochdale and Oldham)

Alongside frequent reports of negative results for *opiates*, we received several reports from professionals that urine tests have returned positive for *benzodiazepines*, even though service users have insisted that they have never used them.

> *". . . they'll moan (about the quality of heroin), [. . .] the people we test who are negative for heroin but positive for benzos, but they'll still go back to the same dealer".* (Operational Manager, Bolton and Bury)

Some people who use **heroin** also suggested that it was being cut with *benzodiazepines*.

> *"It's [heroin] easy to find, just weaker. It's not as strong or pure, they're putting diazepam and all sorts in it".* (Bolton man, 50s)

In addition to *benzodiazepines*, it was suggested that **heroin** was being adulterated with a range of other prescription drugs and over-the-counter medications.

> *"It depends who you get it off, there are different dealers but some are just greedy you know what I mean? They just whack it up with whatever just to make money. As long as it runs on the foil, they don't give a shit! Codeine, paracetamol, zopi's [zopiclone], they all run. They don't give a shit mate, as long as it runs and you are tooting up the smoke they don't give a shit, you know what I mean?"* (Salford man, 40s)

In addition to citing drug screening results, one interviewee stated that police forensic analysis of local heroin confirmed the low **heroin** content.

> *"My mate got arrested for selling drugs, heroin, and they tested it, and it was 3%!"* (Tameside man, early 40s)

Similar low content was found in this year's MANDRAKE testing (see section 2.1.5.5).

2.1.5 Synthetic Opioids

2.1.5.1 Context

The presence of potent *synthetic opioids* such as *nitazenes* and *fentanyls* in the UK's drugs market has risen in recent years (HM Government, 2025). These *synthetic opioids* are typically many times stronger than **heroin** (50-500 times) and therefore, carry a much higher risk of overdose, and there is concern among government, law enforcement, public health and the treatment sector, about these substances becoming more prevalent in the future (HM Government 2025, Marland et al., 2025).

Fentanyl and other *synthetic opioids* were linked to spikes in drug-related deaths in England in 2017, 2021, and 2023 (ONS, 2025). More recently, *Nitazene compounds* have emerged in UK drug markets. Recent drug related death data from England and Wales, published in October 2025, reported 195 *nitazene* related deaths in 2024, almost four times higher than in 2023 (ONS, 2025). Although they are most commonly found in **heroin**, they are also becoming increasingly present in illicit painkillers and sedative pills. In addition to **heroin**, *nitazenes* have been detected in the UK in substances sold as other *opioids, benzodiazepines*, and **cannabis** products (WEDINOS, 2023). As well as being added to or substituted for other drugs they have been openly sold as *synthetic opioids*.

In August 2024, the government issued guidance to help local areas prepare for and respond to incidents involving potent *synthetic opioids* such as *nitazenes* and **fentanyl** (OHID, 2024). The guidance warns that *synthetic opioids* are appearing more frequently and may become widespread. Updated government guidance published in May 2025 reported that in the previous two years there had been over 450 drug-related deaths where *synthetic opioids* were present (HM Government 2025).

2.1.5.2 Reports of synthetic opioids in local circulation

We received numerous reports on the presence of *synthetic opioids* across Greater Manchester, including one from a local prison.

> *"A bottle of liquid was tested positive for nitazenes, we have not seen another, but this case was diluted into a liquid".* (Substance Use Service Manager, Local Prison)

In several areas, people who use **heroin** recounted examples of **heroin** in local circulation that was thought to contain *synthetic opioids*. The strength of the effects was reported as the reason why they suspected the **heroin** contained *synthetic opioids*.

> *"That's what the heroin was cut with down our end a couple of weeks ago, is it 'tanzines' or summat like that?* **Interviewer:** ***Nitazenes?*** *Yeah, that's it, it were cut with that. They were having a couple of lines, and they were nodding they're back out apparently! That's what I got told anyway. I went to score for me fella the other week and some girl said to me, 'don't go to blah, blah's' cos it's got what you just said in it. She said 'I had two lines of it mate and I couldn't move out of me chair! And I had to go out to work.' So I said 'right!', and I didn't go to him".* (Salford woman, 50s)

> *"Now I have tasted fentanyl, and I've tasted fentanyl on its own. It runs. They're mixing it with the gear a lot. I have it to bring me down off the crack, off a pipe, instead of being wired out me nut. I have tasted it, and two lines it's whacked me out. It fucking hammered me. It's put me in bed for five hours and I said to me mate, who I was with at the time, 'that is not fucking gear! That is fucking fentanyl!' So we have fentanyl on these streets. Just fentanyl. Sold as gear. Because this was only about three months ago, three or four months back it were. I scored twice. Five o'clock in the morning and about two o'clock. And I was talking to my mate in the garden, and I had two lines and I'm looking at it, I said, 'this is fucking fentanyl, this man, there's no dirty lines'. There's fuck all, I could taste. . . I know what gear tastes like and I'm watching his line, and I just put it away me, I'd rather go to bed. It whacked the fuck out of me".* (Oldham man, early 50s)

Some people reported that they had witnessed related overdoses.

"What's that American one called that's hit the streets that's killing everyone? **Interviewer: *What Fentanyl?*** *Yeah, I've seen it in Manchester, and I've heard dealers just start talking about it and I have to tell my friends, 'that fucking thing is going to wipe you out!' And I'm saying, to one of my dealer mates, 'what's the point of putting shit like that that's going to kill off your customer?' And he says, 'Well, the people that do it is just to fatten up the fucking thing!' There's a lot of that with the B [brown/heroin]. I had a couple like die because they do needles and stuff and they were like, it's just the other person who had it but still came out of it. And the person, they're like, 'It's just too strong. I don't know how I survived that hit'. And I'm thinking, 'wow!'"* (Oldham man, mid-40s)

Several people that we interviewed from multiple Greater Manchester areas stated that they personally know people who have overdosed or died as a result of using **heroin** that they believe contained *synthetic opioids*.

"Yeah, they're using a lot of fentanyl, I've been failing drug tests for fentanyl. And a lot of my pals have died from injecting fentanyl related things, if you know what I mean?" (Tameside man, late 20s)

"Recently there has been fentanyl in it. That's also knocking people out and killing people as well". (Manchester woman, early 30s)

One interviewee discussed how they had administered **naloxone** to their partner as a result of a suspected *synthetic opioid* in a £5 **heroin** deal they had purchased.

"[. . .] because I've seen people going over off half a £5 bag who would normally take like, two £20 bags before, but going over off half a £5 bag. So like, whether that. . . I can't remember what it is that it's being cut with at the minute? ***Interviewer: Nitazenes?*** *Yeah, nitazenes . . . yeah. I think that it must have been cut with that because you see I had to give her the Naloxone . . . I've got some at home and I had to give it my ex, and she come back round from it . . . from half a £5 bag but she would normally be able to take a lot more. It didn't send me over luckily, because if we both went over then we would've been fucked!"* (Salford man, mid-30s)

While **naloxone** is now routinely provided to reduce the increased risk of fatal overdose from *synthetic opioids*, several people who used **heroin** expressed a reluctance to carry or receive **naloxone**, further heightening their risk of a fatal overdose.

"Interviewer: *What about any of your mates? Are they carrying it [naloxone]?* *There's no way, the drug users are not likely to carry it around . . . There's no incentive for 'em. 'So I've just spent that money on the drug and reversed all the effects?' Do you know what I mean? . . . Ask a drug user now personally, if he's gone over, he don't want to take that. He'd rather not come round. And it's sad to say because you know when you use naloxone with someone, their buzz has gone. They'll be rattling off it when they come back. Even though they've almost fucking died. They'll shout at you for doing it."* (Tameside man, late 20s)

Some people recounted their own personal experience of the effects of using **heroin** that they perceived had **fentanyl** in it.

"I've had one with fentanyl before and it's knocked me out clean. I was out for hours on the streets with no sleeping bag." (Manchester woman, early 30s)

While most users we spoke to were unaware that they had been sold *synthetic opioids,* believing it was mis-sold as **heroin**, we also received several reports of the opposite: dealers selling heroin as **fentanyl**.

"They get offered it. **Interviewer: *What they are actually being offered fentanyl?*** *Yes, cos I was shocked".* (Homeless Service Project Worker, Stockport)

Sometimes this was accompanied with a warning to people that what they were selling to them had **fentanyl** in it.

"Interviewer: Y*ou were saying before about heroin with fentanyl in it, what makes you think it's got fentanyl in it?* *Even the dealers tell you sometimes, 'look this has got fentanyl in it. Just be careful with it.'* **Interviewer: *Do they actually say that? So they're not trying to pass it off as heroin and it's got fentanyl in it, they actually will say that?*** *Yeah, some of them tell us".* (Manchester woman, early 30s)

"Interviewer: *When you're saying about the fentanyl, how do you know there is fentanyl in it? Are people selling it as fentanyl?* *Yes, course they are. Yeah! Dealer's couldn't give a fuck, I've not met a dealer now who gives a fuck what he sells you".* (Tameside man, late 20s)

In 2025, WEDINOS (Welsh Emerging Drugs and Identification of Novel Substances) reported that 110 submitted samples were profiled as containing *nitazenes* between April 2024 and March 2025. Two-fifths (40%; n=44) of *nitazenes* were found in samples submitted as **diazepam**, a quarter (26%; n=29) in **heroin**, 15% (n=17) were found in **Oxycodone** and 3.6% (n=4) in samples actually purchased as a *nitazene* (WEDINOS, 2025a). An analysis of WEDINOS data for the four months of August to November 2025 indicated that 27 submitted samples contained nitazenes. While just over half (14/27; 52%) were heroin samples, six were actually purchased as *nitazenes* or *synthetic opioids*, four as **diazepam**, two as **Oxycodone** and one as **hydrocodone** (WEDINOS, 2025b).

In line with these WEDINOS findings, a few people that we spoke to also reported that *nitazenes* and **fentanyl** were in other substances that they had taken recently.

". . . we did have some reports of nitazenes in crack in Salford. We thought that was odd, considering that it's like completely different drugs and effects". (Harm Reduction Lead, Salford and Trafford)

"I had spliff of Spice the other week. Ended up in hospital and it were fentanyl, [blood tests] come back as fentanyl. I'd had a spliff and had been walking, eating a bit of melon, and just dropped. They had to get the melon out my throat and the ambulance come, had to keep me alive. . . it was from Cheetham Hill". (Manchester man, late 40s)

"What I took? Yeah, they were fentanyl[2]. . . they were Oxycontin". (Salford man, mid 30s)

There are many different *synthetic opioids*, and their names can be difficult to remember and pronounce, and as illustrated in the previous interview extracts, we found that when referring to *synthetic opioids*, people who use **heroin** invariably tended to refer to *'fentanyl'* and rarely discussed *nitazenes.* This tendency to generically make reference to '*fentanyl'* when discussing *synthetic opioids* was also observed by treatment staff.

". . . and there is this response in Bolton with any strong gear they say there is fentanyl in it. So, I've been saying 'it is probably going to be nitazenes.'" (Harm Reduction Worker, Bolton and Bury)

2.1.5.3 Drug testing to reduce harm

Opioid test strips are another way that people who use **heroin** and other drugs can reduce their risk of fatal overdose. Test strips for *synthetic opioid*s including *fentanyls* and *nitazenes* should now be provided by treatment services. The hope is that these test strips indicate the presence of a *synthetic opioid* and in turn, lead people to decide not to use it, or to start with a very low dose (OHID, 2024). All of the treatment services that we visited were supplying these test strips to people who use drugs in their service as a way for them to check their drugs, before they decide whether and how to use them. This has led to some positive test results for both *fentanyls* and *nitazenes.*

"Nitazenes seem to be present. People are taking the testing strips that we have got and are reporting positive tests for them. [. . .] *We whack all our testing kits into one pack, so they can test for not just nitazenes. And in Bolton we have had a few positives for fentanyl".* (Harm Reduction Worker, Bolton and Bury)

However, as Marland et al. (2025) note, limited testing has been conducted on the effectiveness of these strips. In their analysis of *nitazene* immunoassay test strips**,** the strips detected

2. There are over 500 fentanyl analogues of widely varying potency. Likewise, 'nitazenes', the informal, generic name for a class of opioids known as the 2-benzyl benzimidazoles, are a diverse group of synthetic opioids that are estimated to range from 50 to 500 times more potent than morphine. Examples of nitazenes detected in the UK in recent years include: isotonitazene, metonitazene, N-pyrrolidino-etonitazene (also called etonitazepyne), etonitazene, protonitazene, N-desethyl etonitazene. While orphine analogs are the latest opioid scaffold that are emerging in forensic analysis. Orphines are the informal name for a class of opioids known as piperidinylbenzimidazolones.

over three-quarters (28 out of 36) of *nitazene* compounds. However, false positives were observed when testing seized **heroin** samples, caused by caffeine concentrations over 300 µg/ml. False negatives were also seen for eight *nitazene* compounds.

2.1.5.3.1 Test strips limitations

There is limited UK research on the effectiveness of test strips to detect synthetic opioids. Additionally, little is known about whether people who receive them actually use them, or they respond when a test returns a positive result.

Several professionals acknowledged that there are limitations to the effectiveness of testing strips, noting that it is difficult to convince people to use the tests.

> *". . . they're not testing them. And even though we give test strips out, not a lot of people use them here. They take them home and put them on the side".* (Harm Reduction Worker, Salford)

> *"A lot of them don't want to waste the gear either on testing. 'That's a five pound deal. I'm not going to put a five pound deal on a strip.'"* (Opiate Recovery Worker, Tameside)

People who use drugs similarly reported that test strips were rarely used by their peers.

> *"People don't test anything, they just use it regardless"*. (Bolton man, early 50s)

During interviews with people who use **heroin,** we were interested in finding out what people do when they suspect their heroin contains *synthetic opioids*, including what they would do if they were to get a positive test strip result. It was suggested that some people will still take the risk and use it anyway.

> "*If I tested some and it came up with fentanyl, that would stop me. But I don't know if it'd stop others*". (Bolton man, 50s)

While several professionals echoed this view that even if people do use the test strips and they report positive for a *synthetic opioid,* it does not necessarily deter people from using the **heroin**.

> "*Thing is, they don't tend to come back and go 'it's tested positive' and even if they do, they'll still use it. I'm going to say we've got people seeking it because they're like . . . 'God it's well strong!'"*. (Opiate Recovery Worker, Tameside)

> *"So we get the anecdotal stuff. People will come in and say 'I've tested it. It was positive for nitazenes'.* **Interviewer: *And do they say what they did then?*** *Well, some will not use or use in a safer way. Yeah, but it is difficult, isn't it? If your resources are really low and you've spent all morning begging or whatever to try and get your money and then you've found a nitazene. Some people are willing to take the risk, even then.* (Harm Reduction Worker, Trafford)

These views were supported by the accounts of people who use **heroin**, with a couple of people that we interviewed stating that they and others they knew were not bothered about testing their **heroin** for *synthetic opioids* as they would still use it anyway.

> *"I'd probably still use it because you're not really arsed about what drug it is as long as you're getting that hit. But I'd probably use less"*. (Salford man, mid-30s)

However, these reports that they might use less represents a meaningful reduction in overdose risk.

Others went on to explain how for people who are dependent on heroin, the need to use the **heroin** to feel well again outweighed any consideration of potential risk.

> *". . . for people that are just hooked on it, dependent on it, I think they're more looking at it like 'it's gonna stop me from rattling'. So, they're not gonna look at it like, 'Oh, this has got fentanyl in it, I'm not taking it', they're gonna think, 'I hope it has got fentanyl in it!'* [. . .] **Interviewer: *So if it did show up as positive for nitazene or fentanyl [on a test strip] would it stop you using it?*** *If it stops me from rattling, no.* **Interviewer: *You've never got any concerns that it might have something like fentanyl in it or anything like that then?*** *Don't really think about that really. I don't think anyone thinks about that really, all they think about is 'I don't want to be ill'. [. . .] for me it's just I don't want to rattle. So I'm just gonna take it. I don't really*

think about what's in it, I'm thinking about what it's going to stop me from feeling like this. You know what I mean? I use it more as a medication than a drug, if you know what I mean"? (Trafford man, mid-30s)

"Nobody cares, if they want drugs, they'll take drugs. If they're rough, they'll take anything". (Bolton man, early 50s)

"If someone told me a batch had fentanyl in it, I'd try and avoid that dealer . . . unless he was the last one in town and I was rough. Then I'd probably still go for it". (Rochdale man, early 40s)

Beyond not being deterred, some people reportedly sought out more *potent synthetic opioid*-adulterated h**eroin;** a finding supported by both professional observations and direct user accounts.

"Some people are seeking out nitazenes. There were cases in Bury as well where people were doing that, seeking out nitazenes". (Harm Reduction Worker, Salford and Trafford)

"I think it's [heroin] rubbish. I think sometimes you're praying it's got a bit of fentanyl in it because the gear's that shit". (Tameside woman, early 30s)

"*To be honest with you, you're hoping it does test positive for something 'cos at least you know there is something in it!"* (Tameside man, mid-40s)

"Some people though I know they love the fentanyl. [. . .] 'I want some more of that'. I know a girl who's on it now, she fucking thrives off it". (Oldham man, early 50s)

2.1.5.4 Other indicators of the presence of synthetic opioids in heroin

In addition to relying on synthetic opioid test strips, interviewees identified several other signs that may point to the presence of synthetic opioids or other adulterants. Several people commented on visual differences, reporting that the substance was sometimes a noticeably lighter colour than the standard brown.

"Interviewer: ***So thinking about the £5 bag that you think had the nitazenes in it, did it look any different?*** *Yeah, it looked a bit paler, maybe. It looked quite pale compared to it being the usual darker [brown] colour.* **Interviewer:** ***Okay, and did it burn any differently?*** *No 'cause I injected it . . . it looked lighter when it was liquid . . . when it was cooked up. Like it might've had something in it".* (Salford man, mid 30s)

Two people who use **heroin** in Stockport reported that a dealer sold them **heroin** that he said contained **fentanyl**. They described it as a grey, cigarette ash colour. Both felt that its effects were different, and more dangerous, when injected than when smoked.

"I've had that fentanyl, and it nearly killed me. **Interviewer:** ***What, sold to you as fentanyl?*** *Yes I've had gear sold to me as fentanyl, it looks like fag ash . . . greyish colour. I've only had it once and it sends you off your fucking napper [head]! You smoke it and you don't get that high, but you inject it and its dangerous! I've nearly gone over on that and that was the last time I had gear".* (Stockport man, mid-50s)

"Fentanyl injecting has more effect than smoking . . . There was four of us, I had one meowing like a cat, one saying he was King Arthur, walking around talking like a king saying he addresses each common wench! Then another is in the other room doing a dance and scaling the walls. Then he's going out of the house with a night-gown on but not covering any of his bits! So I thought 'what the fucking hell have they had that I've not had!' but it had that fentanyl in it! They were digging it, I only smoke it. When you smoke it it's a different effect. But you can tell, I've never seen it since, it's like fag ash in colour. You know what I mean? Not brown, more fag ash colour". (Stockport woman, 50s)

As we noted in section 2.1.4.1, changes in how **heroin** runs were commonly discussed as indicators of adulteration. The way **heroin** ran was also specifically discussed as an indication of the presence of *synthetic opioids*, along with the taste and smell.

"Apparently, it tastes a bit different, it runs a bit different. You know when you put it on your foil it turns to liquid, straight away it starts running. That always varied anyway, because of whatever it was cut with and how strong it was. The taste would vary in that sense, but it was always the same sort of taste and smell. But apparently you can tell, I mean, I don't think you'd know whether it was fentanyl or nitazenes. You could just only assume it's either or. It apparently has a slightly different feeling to it as well". (Harm Reduction Volunteer, ex-user of heroin, Salford)

Another indication, reported by a few people who use **heroin** in Tameside, is that the **heroin** cooks up milky white instead of running clear.

"Interviewer: *How can you tell [if it contains fentanyl]? Do you smoke it or inject it?* *I inject it. But you can tell when you're cooking it because it froths up dead frothy then goes like a milky white colour. So you don't even need to test it. Normally the heroin just goes like, dark water. It goes milky when it's got the nitazenes in it".* (Tameside man, early 40s)

"You can tell by the look of it because it goes white. When you're cooking it goes like a milky colour at first, and then goes, you have to do it a little bit longer. So at first it goes like a whitey colour and then usually at that point you'd stop with gear and it would be clear. Do you know what I mean? You have to keep going for like double the time. And then it goes clear. So you know if it's got fentanyl in it without testing it, because it goes white. You kind of want it to do that". (Tameside woman, early 30s)

As noted in 2.1.5.3, this woman explicitly described this visual cue as desirable rather than deterrent Some people reported that **heroin** containing *synthetic opioids* produces a noticeably different effect.

"But they are also talking about the difference in the effects. The ones that they reckon have nitazenes in them seem to have a shortage duration of time and is not quite as pleasant as what they used to refer to as heroin". (Harm Reduction Lead, Bolton and Bury)

Two people stated that the effects, although more intense, were shorter lasting than usual.

"Interviewer: *And when you're actually taking it, when say you know it's fentanyl, do you get a different feeling when you're using it? Does it feel stronger?* *Yeah, definitely yeah.* **Interviewer: *In terms of the high, is there a difference in how long it lasts and stuff?*** *Doesn't last as long and then it doesn't hold until the next day. It's not heroin, but for the short time when it is there, it's better".* (Tameside woman, early 30s)

Others reported experiencing a sicklier feeling or stated that it made them feel dizzy or sleepy.

"I wouldn't even say it's a nice feeling. I wouldn't even say it's a gouch. It's just a horrible sickly feeling. Yeah, it just makes me sick. I don't like it, do you know what I mean?" (Salford man, late 50s)

"Interviewer: *Can you tell the difference when you are smoking it?* *You can't tell the difference when you smoking it. But slowly afterwards when you get a hit you can tell that it's got fentanyl.* **Interviewer: *And what's the difference?*** *It just makes you sleepy and dizziness".* (Manchester, woman, early 30s)

One former **heroin** user reported that adulterants in **heroin** appeared to be impairing wound healing.

"Interviewer: *What about the purity?* *Oh yes that's changed, see last year, from having a lick on the [crack] pipe, see my finger here [shows hand] it just won't heal, it's all the shit that's in it now it won't heal. I keep saying to them on the streets with me now, they've got wounds that aren't healing. It's the shit it's mixed with now. So now, since I stopped the heroin last year, it's healed - all my wounds and scabs have healed again".* (Stockport man, mid-50s)

This report echoes findings from North American studies that indicate that the presence of 'Tranq dope'[3] contributes to increases in skin and soft tissue injury (see Ciccarone et al., 2025; Robertson et al., 2026).

3. Synthetic opioids and xylazine are now commonly found in street supply of heroin, in North America and Europe. This combination is commonly referred to as 'tranq dope'.

2.1.5.5 MANDRAKE Findings

The MANDRAKE forensic testing produced two overarching thematic findings that both confirm but also complicate the accounts presented above by users and professionals. First, local **heroin** is of markedly poor quality, with 71% of samples containing less than 5% **heroin**. Second, despite widespread perceptions to the contrary, none of the **heroin** samples that were tested contained **fentanyl**, *fentanyl analogues,* or *nitazenes*. Instead, the most commonly identified adulterants in these samples were **caffeine** and p**aracetamol**. These findings are presented in detail below.

Given these reports of poor-quality **heroin**, and concerns about adulteration, in particular, the emergence of more *potent synthetic opioids*, it is unsurprising that a fifth of professionals (21%; 45 out of 212) completing the survey identified **heroin** as a priority substance for MANDRAKE forensic testing this year. However, this prioritisation of **heroin** testing varied considerably by locality. No respondents from Oldham requested the prioritization of **heroin** testing, and only one respondent did so in Bury, Rochdale, and Salford. In contrast, **heroin** was prioritised for testing by five professionals in Trafford, six in both Bolton and Stockport, and eight in Manchester, Tameside, and Wigan. A treatment professional based in Manchester commented:

> *"This could really help with some myth busting and harm reduction".*

Calls for a focus on **heroin** were primarily driven by concerns regarding potential adulteration with *synthetic opioids*, including *fentanyls* and *nitazenes*. As one healthcare professional from Trafford noted, they are also present in prescription drugs:

> *"Heroin and benzodiazepines are often adulterated, but now with potent additives on occasions".*

Within the testing cycle, MANDRAKE analysed fifty-one samples, submitted from across the ten boroughs, and purported to be '**heroin**'. All the samples tested were the powder form of the product (ranging from 0.1 – 0.17 g material per wrap or snapbag), consistent with £5 to £10 deals.

Thirty-two exhibits (63%) were found to contain unadulterated **heroin** at purities ranging from 0.8 – 2.9%. The remaining nineteen (37%) samples were determined to contain **heroin** with a mixture of **caffeine** and **paracetamol.** The **heroin** purity ranged from 1 to 59% (mean purity: 30%) for 17 of these. One sample contained a mixture of **phenacetin**, **paracetamol** and **caffeine**. Though **heroin** was detected, within this sample, the level was below the limit for an accurate quantification. One sample (bottom right in below image), from Manchester only contained *Bentonite* (Clay). Conversely, one sample, linked to a drug related fatality, was determined to contain **heroin** at 89% purity and a small amount of caf**feine**. This highly potent sample is noteworthy. In a market where most **heroin** was heavily adulterated and of low purity, and users' tolerances is likely to be skewed down by products of low purity, occasional high-potency batches could easily cause fatal overdoses.

As illustrated below in ***Chart 2***, around seven in ten (71%, n=36/51) contained less than 5% **heroin.**

The quality varied by area, with the poorest quality samples coming from Stockport at approximately 2% purity. The highest quality samples came from Rochdale (two samples 10-20% and three samples >20%), Bolton (two sample 10-20%) and Tameside (two samples >20%).

The low purity of **heroin** tested this year continues the trend of lower purity from recent years. Last year's forensic analysis found that **heroin** purity ranged from 4% to 28%, with an average of 16% (**see GMTRENDS, 2024**). This represented a significant reduction in purity from the previous testing cycle when the average purity of **heroin** analysed by MANDRAKE was 42% (**see GMTRENDS, 2022**).

In addition to the **heroin** samples, MANDRAKE analysed seven exhibits, submitted from across the ten boroughs, purported to contain *synthetic opioids* (n = 6, *nitazene* derivative; n = 1, *fentanyl derivative*) and associated with drug-related fatalities. The samples tested varied from powder or tableted forms (see figure 2) and varied in colour, design and content (***see table 1***).

Figure 1 *Heroin Samples submitted to MANDRAKE*

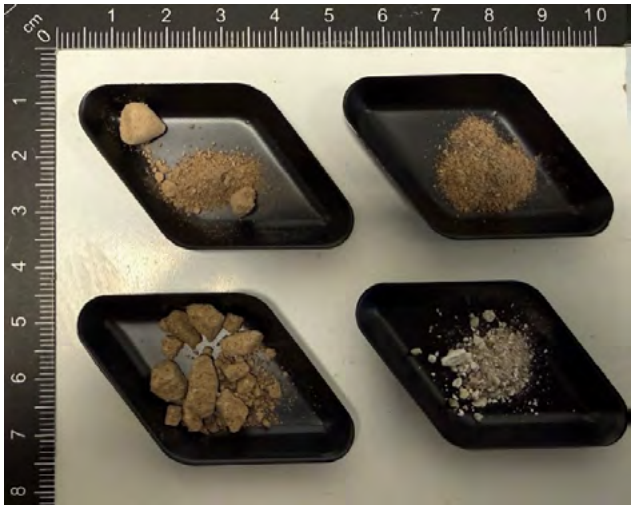


Chart 2 *Heroin Samples Submitted to MANDRAKE by Purity Range*

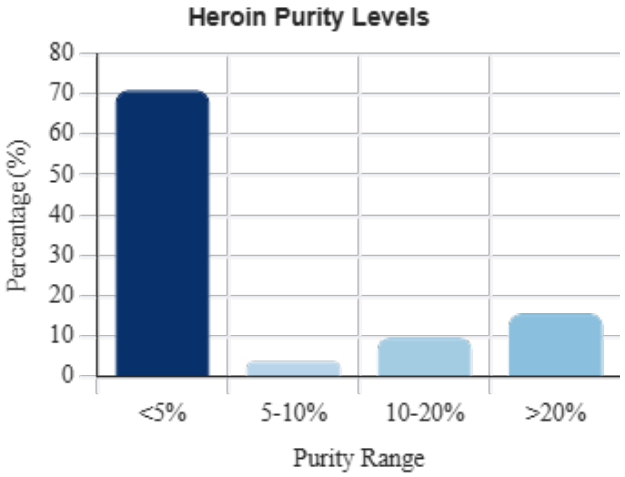


Figure 2 *Synthetic opioids-containing products seized and tested within Greater Manchester 2024/25. Source: MANDRAKE.*

Table 1: *Results of qualitative and quantitative testing of synthetic opioid-containing products seized and tested within Greater Manchester 2024/25. Source: MANDRAKE.*

1	Light beige powder (6.5 g) in plastic bag.	**Etonitazene**	95.3% (purity)
2	Light beige powder (7.7 g) in plastic bag.	**Etonitazene**	94.7% (purity)
3	7 x Dark green, circular tablets. No markings.	**Isotonitazene**	1.5 mg/tablet (content)
4	9 x Yellow, circular tablets. No markings.	**Isotonitazene**	1.5 mg/tablet (content)
5	4 x Small, blue circular tablets, embossed with “M” and “30”	**N-desethylisotonitazene**	1.9 mg/tablet (content)
6	28 x Yellow, circular tablets. No markings.	**N-desethylisotonitazene**	2.1 mg/tablet (content)
7	Purple powder (10 mg) in snapbag	**Methoxyacetyfentanyl**	84.6% (purity)

2.1.5.6 Increased Access to Drug Checking Services

Many people that we interviewed asked if we could test their drugs through MANDRAKE and offered to come back the next day with samples of ***Spice***, **heroin**, ***crack*** and *prescription drugs*. This highlights a willingness for people who are using these drugs to have them tested. As noted below, there appears more willingness from some people to get them tested this way than relying on the test strips.

> *"I've come in with heroin and crack and gone like this to my worker [makes throwing action] thrown it on the table and said 'can you test that mate?' and they said 'no'. They give us these test strips, but we need it testing properly from somebody who knows what they are doing cos we need to know what shit we are sticking into our veins, know what I mean? I'm not arsed, I'll bring one [heroin] and one [crack cocaine] in and test it. I've said that to [key worker name] as well"*. (Salford man, 40s)

2.1.5.7 Overdose Prevention Centres

Finally, in relation to increasing concerns regarding the presence of *potent synthetic opioids* in local circulation, and the associated increased risk of fatal overdose, it was suggested that there is a need for overdose prevention centres to reduce the likelihood of overdoses leading to fatalities.

> *"What they need to do now is build places like this where they give you proper drugs so you know what you are taking and if anything happens, they can help you, they have Drs and nurses in case you OD, you know what I mean? . . . It will never happen.* [. . .]" (Salford man, 40s)

2.2 Reduction in heroin use

Almost a fifth (19.6%) of the 212 professionals who completed the survey reported a decrease in **heroin** use this year. Similarly, a consistent finding to emerge through speaking to professionals and people who use drugs for the Street Drug Survey, is that the number of people who use **heroin** appears to be declining.

> *"I think it's [heroin] on the decline, it's really small but there's still pockets of people".* (Homeless Service Project Worker, Stockport)

> *"Heroin's not as popular as it was . . . We've certainly got an older population now on scripts and stuff".* (Harm Reduction Worker, Salford and Trafford)

One explanation offered for the lower number of people who are currently using **heroin** is the lack of young people who are using it. The lack of young **heroin** users coming into services was noted.

> *"Only one report of a young person using heroin".* (Young Persons Resilience Worker, Tameside)

Professionals working in treatment services consistently observed that their client group had shifted from predominantly **heroin** or **heroin** and ***crack*** to ***crack*** only or primary ***crack*** with occasional use of **heroin**. This change is further discussed in section 3.

These professional insights were supported by several people who use drugs across Greater Manchester. As we outline below, the current **heroin** market has contributed to this change.

2.2.1 The impact of the current heroin quality

The consistently discussed poor quality **heroin** in circulation appears to be a significant factor for this widely reported decrease in use. We found that the current poor quality of **heroin** has led some people to either use less or stop using **heroin** completely.

"Gear, I very rarely take now cos its crap, it's rubbish! Doesn't even work, I can't even feel it. There's nowt in it! It's not worth it man, it's fucking shit!" (Stockport man, 50s)

"I've stopped using it cos it's not that good no more. You just wouldn't get anything off it". (Stockport woman, 50s)

2.2.2 Changing patterns of drug use

Several professionals also reported a shift from injection to smoking.

"Low quality heroin, probably less injecting than there was, a gradual decline over years". (Consultant Addiction Psychiatrist, Bolton)

"The people that I know that are using [heroin] at the minute are smoking it, not injecting it". (Homeless Service Worker, Manchester)

However, in contrast to these professional reports, some of the people that we interviewed who were still using **heroin**, stated that the current poor quality of **heroin** in circulation was leading them and others who would usually smoke **heroin** to inject it.

"Who wants to stick pins in your leg? You are doing that cos when you smoke it, you are wasting half of it anyway, its bubbling up on the foil, it's not running, so you have to spot it and then you think 'oh fuck it, I'll bang [inject] it!'". (Salford man, 40s)

Another reported impact of the poor-quality **heroin** in circulation is that the **heroin** is not bringing people down from the ***crack***.

"The white [crack] takes over, you know what I mean? You get a two [crack] and a one [heroin] like I do, and you are waiting to come down off the white with the heroin, but you don't, you know what I mean? The gear is just shit". (Salford man, early 40s)

As we discuss in section 3, this was reported to be leading to increased amounts of ***crack*** being used.

2.2.2.1 Alternative substances to heroin

The poor-quality **heroin** was also reported to be fuelling the use of other substances such as *prescription drugs* (see section 5) and **alcohol** by people who use ***crack***.

"You need something to bring you down [from crack] if not the gear [heroin], then maybe beer, maybe diazes, maybe pregabs". (Salford Man, late 30s)

As suggested above, many of those who have stopped or reduced their use of **heroin** because of the poor-quality are seeking out alternative substances. This was commonly reported to be **alcohol, pregabalin**, *benzodiazepines* and '***Spice***'.

"He's a gear head him, but it's only cos the gear is so shit that he's on the tablets [diazepam]". (Homeless Service Project Worker, Stockport)

"Interviewer: *So you are saying that some people are turning to Spice then because of the shit gear?* *Yes definitely! I reckon if the heroin hadn't gone the way it did then I reckon Spice wouldn't even have come about cos a lot of people in jail, they just wanna get their fucking head down mate! That's all they wanna do . . . sleep! Or get that nod, cos it's reality innit? Same on the streets, be awake and on planet earth! So I'd rather be fucked out of me brains and be happy, then wake up and do the same again".* (Salford man, early 40s)

"It's crack and maybe a bit of heroin now. **Interviewer: *And why do you think that has changed now?*** *Cos crack's better! Like I say, the gear's shit. You are not getting anything of the gear so what's the point?* **Interviewer: *So what are people doing instead of the gear?*** *Pregabs! . . . Or drinking . . . or both!"* (Stockport woman, 50s)

As noted above, it was reported that ***crack* cocaine** is becoming the primary substance of choice. The following section highlights this shift.

3. CRACK COCAINE

3.1 Prevalence

The latest estimates indicate that opiates (typically **heroin**) were the most commonly 'misused substances' across all regions of England in 2022–23, either alone or alongside ***crack***. The combined rate for people using *opiates only,* or *both opiates and crack*, exceeded 7 per 1,000 of the general population. In comparison, the rate for people *'misusing crack without opiates*' was 1.4 per 1,000[4]. However, our findings suggest that this pattern may be shifting.

In contrast to the reduction in **heroin** use reported in section 2, people who use drugs often described an increase in the use of ***crack*** **cocaine**.

> *"You see more crack heads now than you do people who have the heroin".* (Stockport man, mid-50s)

> *"It's just the crack down here mainly. There's only one or two down here in the town who are homeless [...] who are on the gear [heroin], the rest is just crack, crack, crack. [. . .] Even I'm shocked like 'Wow!' you know what I mean about how many people are using it these days".* (Stockport man, early 50s)

> *"Cocaine and crack are the main things in Wigan. [. . .] and there's a crack pandemic about to happen . . . like what happened in America in the '80s. [. . .] Kids are being told it's just cocaine on a pipe".* (Wigan man, mid-30s)

> *"I mean, I used to chill in town [Manchester City Centre] a lot and it's mainly just crack heads – people like me".* (Stockport man, early 20s)

It was also commented upon by several people that we interviewed that the use of ***crack*** in public places was becoming more commonplace.

> *"You see people having a pipe in the park! [. . .] in the middle of anywhere!"* (Salford woman, 50s)

> *"I can honestly say the crack seems to be more open than it ever has".* (Stockport man, early 50s)

These reports of increased ***crack*** **cocaine** use were supported by professionals. In the professional survey, one in six (16%, n=34) professionals from across Greater Manchester reported an increase in ***crack*** **cocaine** use, while the professionals we interviewed consistently reported the same trend.

> *"I'd say predominantly it's crack but a lot of them are heroin and crack. But crack is the main thing. [. . .] It's crazy! It's like it's the acceptable drug, it's like coke".* (Homeless Service Project Worker, Stockport)

> *"Crack's rife, yeah crack is rife".* (Opiate Recovery Worker, Tameside)

> *"Lots of crack and or crack and alcohol. Lots of people come into ABEN with crack problems".* (ABEN Manager, Wigan and Leigh)

> *"I would say [crack smoking] has increased, there are more that just primarily smoke crack, where previously it might have gone hand in hand with heroin, but we seem to have more 'crack only' people coming through, who may have been using alcohol and cocaine powder at one point, but then progressed to using crack".* (Criminal Justice Team Leader, Oldham)

In addition to traditional **heroin** and ***crack*** using populations changing to *crack only*, as noted above, several professionals reported that more people who were previously using **cocaine** ***powder*** with alcohol are switching to ***crack*** **cocaine**.

> *"Increase in powder cocaine users now using crack".* (Recovery Coordinator, Bury)

4. Department of Health and Social Care and the UK Health Security Agency

Two people we interviewed described their transition from **cocaine *powder*** to ***crack***.

3.1.1 Explanations for the increase in crack use

As highlighted in section 2, the poor-quality of **heroin** in the market was reportedly leading to heavier ***crack*** use during single sessions, as the **heroin** could no longer adequately counter the stimulant effects of the ***crack***. This in turn led to more acquisitive crime to fund the increased ***crack*** use.

> *"See if it's proper heroin, they don't chase that rush. So if they are off the heroin, they just chase that crack rush, so they are shoplifting, they are robbing people, just to chase that rush. For that little high that they are not gonna get".* (Salford man, 40s)

Furthermore, it was noted that many people who had previously used **heroin** and ***crack*** are now just using ***crack***. In many cases, it was stated that they are now often using much more ***crack*** than when they were using **heroin** and ***crack***.

> *"General trend to people using more crack".* (Nurse Consultant, Stockport)

> *"People reporting higher levels of crack use".* (Clinical Practitioner, Bolton)

Four people reported knowing individuals who had stopped using **heroin** after receiving *Buvidal* injections but continued to use ***crack*** **cocaine**, often in greater quantities than when they were using both **heroin** and ***crack***.

> *"A lot of people are on that injection [. . .] All doing really well. [name] is on it. She's not used the gear but she's spending more on crack!"* (Salford woman, 50s)

> *"So a lot of people they're having that injection [Buvidal] aren't they? But they are still using loads of crack!"* (Salford man, 40s)

Several professionals and people who use ***crack*** **cocaine** reported the vast amount of money that could quickly be spent on ***crack*** **cocaine** and the increased levels of acquisitive crime that is often required to fund ***crack*** **cocaine** compared to when people are using **heroin** or **heroin** and ***crack***.

> *"I think the crack is so moreish, you can spend thousands of pounds on it in the day and that becomes the predominant thing. People can be a bit more measured with the heroin. They're using it to be a bit softer on the [crack] come down, but you can't spend thousands of pounds on heroin in the day because you'd be dead. Obviously, you could overdose from crack, but it's a very moreish drug".* (Harm Reduction Lead, Salford and Trafford)

People who used ***crack*** **cocaine** often discussed how quickly they could spend a lot of money on smoking it.

> *"The only problem with crack is that it's more addictive and it gets a grip of you. [. . .] I pay 200 quid, 250 quid and I blast that shit off!"* (Stockport man, 50s)

> *"Seventy pounds worth of crack would probably last me an hour, half an hour. Do you know what I mean? It's ridiculous. It's crazy".* (Manchester man, mid-40s)

In addition to suggestions that ***crack*** **cocaine** use was leading to more acquisitive crime, the health risks associated with ***crack*** **cocaine** were often discussed.

3.2 Chronic Obstructive Pulmonary Disease (COPD)

Professionals frequently raised concerns about the levels of COPD in the treatment population, particularly in relation to the use of ***crack*** **cocaine**.

> *"Because obviously years and years ago the harm reduction was 'don't inject'. 'No, don't inject'. So what we see now is all these people with really bad chests, really bad breathing difficulties. COPD is rife, we've got more complications than people that were injecting. Strangely".* (Opiate Recovery Worker, Tameside)

It was also common for people who use drugs to discuss their own COPD.

> *"Because of my COPD and osteoporosis, I felt like half a man, couldn't breathe, couldn't please my partner. It broke me".* (Wigan man, mid-50s)

Others expressed concerns for partners and friends who have COPD.

> *"My boyfriend's really poorly mate through heroin and crack, but he's still using! But it's me fella, he's got emphysema, COPD, His lungs are black. [. . .] He's only about 8 stone wet through as it is!"* (Salford woman 50s)

> *"Cos a lot of people I know who smoke crack, they've all got COPD. Cos you get 'crack lungs' don't you?"* (Salford woman 40s)

The use of poor quality or make-shift *crack pipes* was raised as a contributing factor for COPD and other associated health harms. A commonly cited make-shift *crack pipe* was asthma inhalers.

> **"Interviewer: *What type of pipe do you use?***
> *I use a plastic inhaler. An asthma one, I take out the metal bit and use that. But I won't use those metal pipes, Cos they are all using the tubes with wire wool! That's hanging mate! Put a piece of card in it and burn it with a lighter. So imagine them doing that, scraping it and then all those shards of metal come out?"* (Salford woman 50s)

During interviews, people who smoked ***crack*** sometimes showed the research team their *crack pipes* which were often chipped and melted (**see Figures 3 and 4 below**) due to being heated and made from poor quality materials.

When people who smoke c***rack*** raised these types of concerns, the Safe Inhalation Pipe Provision (SIPP) pilot was mentioned,and this was often positively received.

> *"That's a good idea in't it? Will they do round here then? Wow that's good that, that's really good that. [. . .] That would be really good that if it came over here that".* (Salford woman, 50s)

Sharpe et al. (2026) highlight that people who use ***crack*** **cocaine** are often highly marginalised and experience elevated risks of homelessness, involvement in the criminal justice system, and significant barriers to accessing health and social care services (Bungay et al., 2010; Duopah et al., 2024; Home Office and Public Health England, 2019). These barriers to access can exacerbate the health risks associated with ***crack*** use (whether through injection or inhalation) while also reducing opportunities for effective harm reduction and prevention interventions (Butler et al., 2017; Restrepo et al., 2007).

Provision of ***crack*** inhalation equipment can facilitate new contacts with services among a highly marginalised population (Harris et al., 2024). The SIPP pilot aims to reduce ***crack*** use risk practices and associated health harms; including through increasing ***crack*** harm reduction awareness among service providers and peers.

Figure 3 and 4*: Crack pipe that had been used for less than two weeks.*

3.3 Market insights

3.3.1 Availability

3.3.1.1 Increased number of dealers

In some Greater Manchester areas, such as Manchester, Salford, and Stockport, it was reported that there were more people dealing ***crack*** than previously.

> *"I'll tell you though, there's that many people selling crack now . . . and coke".* (Homeless Service Project Worker, Stockport)

> *"There's too many round my way, there's loads of drug dealers.* [. . .] *They will all say, 'I've got decent bits me y'know? Proper power [high potency] white [crack cocaine]!'"* (Salford woman 50s)

> *"The purity of the crack, it's OK now. But it depends on who is washing it up. Cos there's probably about fifty people [selling it] in one area".* (Salford man, 40s)

> *"When I first used, you'd never buy heroin without crack, now most dealers sell way more crack. Maybe 20% brown [heroin] and 80% white [crack cocaine]".* (Rochdale man, early 40s)

> *"It's probably easier [to get crack now] because of how many runners there are".* (Salford man, mid-30s)

In Manchester city centre, it was noted that some sections of the street-based community seem to switch between smoking ***crack*** or ***Spice***, depending on what is available. As discussed further in section 5, ***Spice*** was noted by a couple of homeless outreach professionals to come into the town centre in batches and when it was not available for a few days, people would switch from ***Spice*** to ***crack***.

> *"We just hear all the dealers are out and about and then a couple of days later they're all back about, so it's not like a long-term thing where they've not got access to it. It's only ever a few days and then everyone seems to use a lot of crack in that time instead while they're waiting".* (Homeless Service Worker, Manchester)

It was also stated that dealers who had previously sold ***Spice*** were increasingly selling ***crack***.

> *"Crack's back on the rise in Manchester. I know a lot of Spice dealers who used to sit there with a pocket full of Spice now they're not sat there with a pocket full of Spice, they're sat there with a big rock in their pocket".* (Salford man, late 30s)

This product shift by dealers, from ***Spice*** to ***crack***, offers another explanation for the rising prevalence of ***crack*** use across Greater Manchester.

3.3.2 Price and size of deals

It was reported that dealers are now regularly selling ***crack*** for as low as £5 and providing 3-for-2 offers (three £5 deals for £10).

> *"Small, like five pounds whites yeah. . . and as well as selling five-pound bits they sell seven-pound bits".* (Stockport woman, 50s)

Most people that we interviewed discussed purchasing ***crack*** in £5, £10 and £20 deals. While prices have remained constant, deal sizes have reportedly decreased. This was particularly commented on by interviewees in Salford and Stockport.

> *"And they are doing twenty-pound whites now, and they are just like ten-pound whites! And the ten-pound whites are like five-pound whites! Just rip-offs!"* (Salford woman, 40s)

> *"The ten stones up there [Manchester] are not even a pipe! 10 [pound] stones up here you are getting three pipes. How I recall it when I was younger, they used to be like a cola cube. It depends who you get it off as well, because too many greedy people in this world are after the money. It's all about money and nice cars, jewelery and tattoos so they are not arsed what they put in it and what it does to anybody else as long as they are making the money".* (Stockport woman, 40s)

> *"You can get a 10-pound stone or you get them who do deals like 5 for 30 but obviously they are not proper £10 stones, that's why they do the deal".* (Stockport man, 50s)

"Interviewer: *What about the size of the deals?* *[Big sigh] Just a joke, you know what I mean? You get three like for 20 [pound] but they are just little five pound things you know what I mean? So for me, any deals, two for 15 and all that, it's just gonna be crap. You are best just buying a 20-pound stone. Any deals are shit. . . nasty stuff.* (Stockport man, mid-50s)

"That's just forever happening that, yeah, always getting smaller". (Salford man, 30s)

"The deals are getting smaller and smaller, they are getting greedy man! Greedy, greedy the dealers, do you know what I mean? [. . .] *The deals have got tiny, like have you seen rock salt? Like that, a tiny chip. . . . but then see if it's really good shit, they can sell that cos you just take that one lick and you're off your head".* (Stockport man, 50s)

"I have a lady that I speak to regular who [...] she shows me the amount that she gets for a tenner and I said 'wow, is that it?' Like 'how many smokes do you get out of that?' And she said 'only two, for a tenner'. In my head I was thinking 'what a waste of money'". (Harm Reduction Worker, Salford)

During interviews, a couple of people showed us the size of deals they had just purchased and discussed how small they were.

"I've got crack on there for you to see a 10 deal [shows a tiny rock of crack wrapped in rizla]. Show what you get with the rocks. You got the 10 pound each, you get two for 15, or three for 20 [pulls out a wrap of crack from his pocket]. *That's what you pay a 10 for. That's a 10 and I've just got two, 15 for two. That's the other one. Fuck all isn't it mate? That's nothing in it? It's a pipe bro. . . You're getting a fucking line for a tenner, a pipe for a tenner! It's too much. That's why junkies are struggling and they're all going to prison for shoplifting because it's definitely not sustainable".* (Tameside man, late 20s)

In addition to smaller sized deals, the amount of **cocaine** that was in these deals was often reported to have decreased.

"The stones just the same [size], it's just how much [cocaine] you're putting into it. Some is good quality, some you get like a bit wired and some it's just like it's fresh air! Its shit! Bad quality. No cocaine in it". (Salford man, late 50s)

As we outline below, almost every person that we interviewed who used ***crack* cocaine** commented on the current poor quality and raised concern regarding the content.

3.3.3 Quality

Only one person that we interviewed reported that the ***crack*** in local circulation was OK.

"The crack around here's decent really. You always want more, but the quality's not been bad recently". (Rochdale man, late 40s)

As the professional below states, it was far more common to receive reports of poor-quality ***crack* cocaine** in circulation.

"They are all saying the crack's shit . . . they all say it!" (Homeless Service Project Worker, Stockport)

In line with the above professional statement, in every area where we interviewed people who used ***crack* cocaine**, we received reports that the current quality was poor.

"You can get a quarter [of crack] for £80 now. It's fucking crap". (Tameside man, mid-30s)

"Interviewer: *What's the crack like at the moment?* *To tell you the truth shit! But I still buy it! Don't ask me why [laughs]. I have my first pipe, then another one and you know what I mean? You don't really feel it! [. . .] You shouldn't be able to have a pipe-after-pipe if its good. It's just crap! Years ago, it was never like that".* (Salford woman, 50s)

"Since I've come down here [Stockport], the last two years, it's absolutely shit! Usually if it's a good stone, you can get two or three burns from it, do you know what I mean? But the ones you are getting round here, you are putting the lighter to it and it just disappears. So it's shit, but I still do it! So the price has stuck, it's just the quality has gone down yeah". (Stockport man, 50s)

"I had a ten-pound white [crack] and it was that shit I still woke up in the morning with some left! It was that shit I just left it, I couldn't be arsed!" (Salford woman, 40s)

"To be honest like when I first started at 16 it was absolutely fucking power [high-potency]! But it depends on the area you go. As years have gone on, it's just got shitter and shitter. Crack, they are mixing it with too much shit at the moment, you know what I mean? It depends where you go and who you go to. We've got a couple of people who sell good stuff but that's it. But most of it is mainly fucking shit! Do you know what I mean?" (Stockport man, 50s)

"Same old thing isn't it. It's fucking shit. It's just shit crack, isn't it". (Tameside man, early 40s)

***"Interviewer: What's the crack like at the moment?** Crap! It's crap! . . . Like it used to be, you used to have your head in a bucket when you'd had a lick, know what I mean? You're just throwing your money away now".* (Stockport man, mid-50s)

Several people stated that they did not get the usual euphoric feeling associated with ***crack*** that they desired.

"It's not the same craving. It's not the same because now it basically sends you numb. I mean, whereas before you'd have a pipe and the buzz would last fucking hours. But the thing is you're satisfied. That's why it lasts hours. So a stone would last all day. Whereas today you grab it, and you'll blow all your money in one go". (Oldham man, late 40s)

"Crack's been fucking crap. You have it now and it just makes you feel scatty now. It's nothing like you're supposed to feel". (Tameside man, mid-30s)

"The crack's crap now, though. It's not like it used to be, what they're putting in it makes you feel hollow". (Wigan woman, mid 40s)

"You can taste something different. It makes you feel sick, not high". (Rochdale man, late 40s)

While we reported in the previous section that the **heroin** quality was so poor, that it was not effective in bringing people down from the high of ***crack***, one interviewee noted that the ***crack*** quality had dropped so much that she no longer needed **heroin** to manage the come-down.

"You don't need the heroin cos it's that crap, you're not even going up to come down! You know what I means? [laughs]. *Last week I tried to crumble it, cos I don't like putting it all on me pipe, I like to do it bit-by-bit, but it stuck to me glass table cos it was so damp. It's not even dried out, you know what I mean? They are just cooking it up and bashing it out! So there's no strength in it when its damp".* (Salford woman, 50s)

3.3.4 Content

The content of the local ***crack*** supply was widely debated. We only came across one person who was not concerned or critical about the content.

"I'm not worried about the content 'cos crack is the purest form of coke. People who use coke look down on people who use crack but if you look at the reality of it, coke is bashed up with amphetamine, E's[ecstasy] MDMA, and all that shit. You take crack, and it's just pure coke, 96%, 97%, something like that". (Stockport man, 50s)

The actual purity of the ***crack* cocaine** analysed by MANDRAKE in the current testing cycle is much more variable (see section 3.3.4.1). As we outline below, the remaining 47 interviewees were more critical about the current content.

Several people stated that the ***crack*** was more of a white colour now which they viewed as a visible indicator of poor quality.

"Interviewer: *Can you tell the difference in the rock or is it only once you've hit it that you can feel it?* *Yeah, you can't really tell until you do it. Sometimes it's got a lot of like, glitter in it. Do you know what I mean? That shit. And you can, sometimes it's got a tinge to it, like proper crack. But you don't really get that anymore. Now it's just white".* (Tameside woman, early 30s)

"Interviewer: *So you can tell the quality by looking at it?* *Yeah, I can tell just by looking at it before I take it. If it's white, its crap. If it's crystally, light, its good".* (Stockport woman, 40s)

"And novocaine, they always do that. But I can tell when it's got that in it. Sometimes it's too white. The rock is too white. Like chalk type of thing. I know that's 'magic' [i.e. a crack adulterant]. (Oldham man, mid-40s)

Two clear themes emerged: first, that ***crack*** was being adulterated, particularly with 'magic' or 'crunch'. Second, that it was increasingly being 'washed' with ammonia instead of bicarbonate of soda, leading to headaches.

3.3.4.1 Adulteration: Perceptions and analysis

One of the main reasons provided for the perceived drop in quality was that ***crack*** was being adulterated with what was most commonly believed to be ***crystal*** **MDMA** ('magic') or 'crunch'.

> *"It's cut with 'magic', it's usually damp and doesn't look right. That's when you know it's poor quality".* (Rochdale man, late 40s)

> *"There is a lot with what they call 'crunch'".* (Oldham man, early 50s)

It was often stated that ***crack*** that contained adulterants believed to be 'magic' or 'crunch' failed to provide the same euphoria, 'buzz', or other traditionally associated effects.

> *"I have a pipe, a crack pipe, every now and then but the crack up here is shite.* [. . .] *It sparkles, yeah. Like a sparkler. If your crack pipe sparkles like a sparkler, it's crunch! It's not crack. That's how you can tell. And if you have a pipe as well, the smoke's there but not the euphoria".* (Manchester man, 40s)

Although **MDMA** can be smoked, it is rarely used in this way because the compound tends to break down when heated, meaning it usually does not produce the desired psychoactive effects.

> *"It's shite, I think it's just magic in it. It's not like cocaine. You know what I mean? I dunno why I do it to be fair, it makes me feel horrible, you know what I mean? It doesn't taste like crack. It doesn't give you the same buzz. And when you've actually got crack, because when you have a pipe before I even blow it out, you know that it doesn't make you feel that horrible. And it tastes nice, do you know what I mean?"* (Tameside woman, early 30s)

Others noted how you can tell because of the way it burns, staying 'crunchy' on the pipe.

When discussing 'magic' as evidenced below, it was often reported that 'magic' referred to **MDMA *crystal*.**

> *"Of course it has all the magic that's in it. It's just crap, it's just crap. Total crap. It is in the crack, and it's messed the crack up . . . basically in the last five years magic's come along. People quit because of that. Do you know what I mean? If they had the original stuff, they wouldn't be quitting. See normally it feels like, even coke, makes you horny and stuff. And you don't get that. You know what I mean?* [. . .] *They'll tell you it's pure but what they're doing is putting half full of magic in it. Its dried-up liquid ecstasy basically. [. . .] You can tell [the crack is different] by smoking it. I can tell by the feeling of it, in my fingers. It turns into a bit of a chalky [substance] rather than a crack. So instead of a click, do you know what I mean?"* (Oldham man, late 40s)

> *"I think's it mixed with 'magic', it makes you trippy and the taste of it as well. It tastes different. So the reason I know when crack's got magic in it is when I was in prison, I bought some off a girl and then I wrote a letter to [partner] saying 'come on a visit commando style!' and all that and you are not supposed to get like that off crack! So when I read the letter back the next day I thought 'thank god I never posted that!' It looks just the same as crack, it does look like crack, it breaks the same".* (Stockport woman, 50s)

In addition to reports of the effects feeling more like **MDMA**, we received several other reports that the effects people experienced were noticeably different from the typical effects that they associate with ***crack***.

> **"Interviewer: *Yeah, people are talking about 'magic' being mixed in with***. . . *With the crack? Yeah, they're mixing MDMA with it, yeah*. **Interviewer: *Right okay, because we spoke to some people who have said that 'magic' isn't MDMA. OK, so can you tell the difference with that?*** *Yeah, so you get like. . . you go a bit weird after you had it and you'll start like rooting round for stuff and looking through bags and that".* (Salford man, 30s)

> **"Interviewer: *People keep saying there's magic in it.*** *Yeah, I've had that down near like Failsworth, Miles Platting. You know down there?* **Interviewer: *You know when***

you say magic, is it MDMA? *Yeah, its MDMA innit. It's like crystals, like crystals, and you just get that wide eye wired but yeah, it's a horrible feeling. It's like fentanyl, when you get fentanyl in your gear. I don't like it".* (Salford man, late 50s)

It was also suggested that a combination of not getting the desired euphoric effects and/or feeling 'hyper' or 'wired' was leading to people using increased amounts of ***crack.***

"You keep hearing that its being cut with magic. That's a big one these days, with the MDMA, which is shit because normally crack already gets you fucking . . . do you know what I mean? So with that added on top. You know what MD does to your head? So it just makes you keep smoking and keep smoking. Even though as a smoker I know its shit. . . . All this magic, just keeps you hyper. The stone's already making you hyper, and the MDMA just lights it up. It leaves your system quicker, but that's the thing you think 'I didn't get it. Nothing, I didn't get it'. You're not satisfied. And I've seen people blow hundreds of pounds on shite just because it's been cut with magic". (Oldham man, mid-40s)

However, despite the widely held belief that 'magic' referred to **MDMA** and was commonly adulterating the ***crack*** supply, there were alternative views, with some categorically stating that it is not **MDMA**. Two people said it was **mephedrone** while three others stated that it was something added to bulk out deals that had the same texture and formed crack-like rocks rather than for its stimulant effects. In addition, there were other suggestions that ***crack*** was adulterated with other drugs, including **ketamine**, ***'monkey dust'***[5], rat poison, and the *synthetic opioid* **fentanyl**.

3.3.4.2 MANDRAKE chemical analysis: An opposing picture

MANDRAKE analysed 18 samples purported to be '***crack* cocaine**' or '**cocaine *freebase'*** from across the ten boroughs during this year's testing cycle. In direct contrast to the user reports above, none of the samples contained **MDMA**, **fentanyl** (or its analogues), or *nitazenes*. Sixteen exhibits (89%) were found to contain unadulterated **cocaine *freebase*** at purities ranging from 12.0 to 93.3% (mean purity: 53%). The remaining two (11%) samples contained **cocaine *freebase*** in combination with **phenacetin**[6] (**cocaine** purity: 22.7 to 38.7%). In comparison, during the last GMTRENDS testing cycle (see GMTRENDS 2024), 14 samples of ***crack* cocaine** were tested by MANDRAKE with purity ranging from a low of 35% to a high of 95% (average: 65%). However, the average purity of ***crack* cocaine** tested by MANDRAKE in 2022 was the same as this year at 53% (see GMTRENDS 2022).

3.3.4.3 The Ammonia versus Bicarbonate Soda debate

Crack *cocaine* is produced by converting **cocaine *hydrochloride*** (*powder cocaine*) into a smokable 'base' form through a chemical processing stage often referred to colloquially as 'washing up'. This process involves combining **cocaine** *hydrochloride* (powder) with commonly available alkaline agents, such as *sodium bicarbonate* or *ammonia,* and applying heat[7].

There was extensive discussion throughout the research regarding current practices for converting ***powdered* cocaine** into ***crack* cocaine**, as well as differing views on what constitutes the best or most effective of these two main methods. These conversations reflected a range of experiences and opinions.

5. 'Monkey dust' is a street term used to describe a range of synthetic cathinones. 3,4-methylenedioxypyrovalerone (MDPV) is one of the most frequently associated compounds sold as 'monkey dust' although it can contain other synthetic cathinones, such as MDPHP, or mixtures of substances. This variability increases the unpredictability of effects and harms.

6. Phenacetin was used as an analgesic and fever-reducing drug in both human and veterinary medicine for many years until it was implicated in kidney disease (nephropathy) and was subsequently withdrawn from the market in the 1980s. Phenacetin also was previously used as a stabilizer for hydrogen peroxide in hair-bleaching preparations.

7. Although the specific steps differ slightly depending on the reagent used, both methods follow the same underlying principle: an alkaline substance is used to free the cocaine base, which then separates as an oily layer before hardening into solid fragments. The active compounds evaporate at temperatures just below 200°C. The chemical reaction separates the cocaine base from the solution, resulting in solidified pieces of crack cocaine once cooled.

"Ammonia, if you do it right, it's better than bicarb. It's not pure white, it's yellow. When it's cooked right it's a better high. If you use bicarb, you can make more money of it". (Stockport man, 50s)

Using the bicarbonate method, two parts **cocaine** are mixed with up to one part sodium bicarbonate in a deep spoon with sufficient water, then heated. During heating, carbon dioxide foam forms and gradually subsides, leaving the c**ocaine *base*** floating as an oily layer. Contact with a cold metal object, such as a knife tip, causes the oil to solidify into white chunks. The water is poured off, and the base is reheated to remove residual moisture.

It was suggested here that bicarb leads to better profit as up to a third of the ***crack*** is actually bicarb following the two-parts **cocaine *powder,*** one part sodium bicarbonate method outlined above. However, it was repeatedly stated to be harder to get it right compared to using the simpler ammonia method.

"Ammonia's better for me. The bicarb, they bulk it out a little bit more. **Interviewer: *What's the difference then?*** *With ammonia, it's a chemical reaction, so the way I used to do it, I'd put an ounce of coke in it, probably about 900 quid. You'd put an ounce of coke in, in the pyrex, you bubble it up. There's no bicarb in it so you're not adding something to make that weight, you know what I mean? Bicarb is shit! Well, if you do it right then yeah, it's OK, but there are not many people who know how to do it right. You lose about 2 grams of an ounce, I used to lose about a gram and half, two maximum, when I washed up an ounce of coke with ammonia. But you are getting 17 batches at 10 pound a patch so you are making 700 quid on a grand or 800 quid if you are paying 900 for your ounce of coke. So you are making a good profit but now they are just getting greedier, greedier and greedier".* (Salford man, 40s)

In the ammonia method, **cocaine** is submerged in a small amount of ammonia solution and heated. The **cocaine *base*** quickly separates and floats as an oil, which solidifies upon contact with a cold metal object. Any remaining ammonia is poured off, and the base is reheated in clean water to remove residual ammonia.

Additional drying needs to take place, for example using a coffee filter, to further reduce the ammonia content, although traces often remain within the cocaine base (Mainline, 2025).

"Use ammo, ammonia or bicarb. I've been doing ammonia for years. It used to be bicarb, cos it's a better wash bicarb, it's cleaner. **Interviewer: *In what way?*** *Because, when you wash it with ammonia, once it goes hard, you have to wash it off, you have to wash the ammonia out of it. Otherwise, its harsh and you get a headache. But the bicarb is cleaner, and it doesn't do that.* **Interviewer: *So if you was washing yourself would you use bicarb?*** *Yeah, oh yeah. Ammonia is easier to wash with, you just put your ammonia in, put your powder in and heat it up. Where with bicarb, you've got to get your measurements right".* (Stockport woman, 50s)

As noted above, ammonia-based ***crack*** **cocaine** can give people who use it headaches if not washed through and we interviewed three people who discussed recently getting headaches from smoking ***crack*** that was ammonia based.

"Interviewer: *So what do you think is in the crack then?* *[big sigh], I dunno, but not crack [laughs]. It's more ammonia based now, and that gives me a headache. They are not cooking it up right, they are not draining it or whatever, cos it is a strong chemical ammonia.* **Interviewer: *Can you tell the difference if it's made with ammonia or bicarb?*** *Yeah, yeah, as soon as you put a flame to it, I'd know. For one, the ammonia it doesn't crackle but with the bicarb, it crackles don't it? Cos that's what it's supposed to innit – crack. If that's what it's supposed to do then why doesn't it do that with ammonia? So yeah, it's just crap basically, even though I'll still buy it! They don't give a shit you know, they don't engage in conversation. They won't say 'this is ammonia, there you go, you'll like this.' You know what I mean? They don't even say anything like that".* (Stockport male, mid-50s)

3.3.4.4 Processing ('washing up') cocaine powder

These concerns regarding increasingly poor-quality, adulterated ***crack* cocaine** in circulation or preferences for bicarb- or ammonia-based ***crack* cocaine** has led to an increase in reports of people purchasing **cocaine *powder*** and processing this into ***crack*** or *freebase* themselves – what was referred to was 'washing up' **cocaine**.

> *"I've heard that recently in Salford and Swinton, they've bought their own and based it up themselves because it's so easy to do. It's just dead easy isn't it".* (Harm Reduction Worker, Salford)

> **"Interviewer: *We've had a lot of conversations with people who are saying they're buying coke and washing it up is that* . . . *Yeah, a lot of people are doing that. I don't do it, but a lot of people do do it. Like quite a lot".*** (Salford man, 30s)

Knowing exactly what was in it was the most commonly reported reason for this.

> "*Some people are starting to buy their own coke and cook it up at home now because they don't trust what they're getting".* (Rochdale man, early 40s)

> *". . . she said she free bases it herself all the time, she knew how to do it. She said, 'I'd rather know what's in it, what I'm getting'".* (Harm Reduction Worker, Salford)

> *"Everyone's talking about it being cut or made stronger, some even rock it up themselves now, using ammonia or bicarb".* (Wigan man, early 50s)

Alongside concerns about the current content, participants also reported choosing to do so because it was perceived to be a cheaper option.

> "*I know that a lot are just basically buying coke and rocking it up themselves because that's cheaper".* (Trafford woman, 40s)

One interviewee suggested that 'washing up' **cocaine *powder*** into ***crack*** was one way that people were transitioning from ***powdered* cocaine** to ***crack* cocaine**.

> *"Even people who never injected before are starting to make their own, that's how a lot of my mates got into crack".* (Rochdale man, late 40s)

Many of the people we interviewed who use ***crack* cocaine** reported that they 'wash-up' their own ***crack* cocaine** from ***powder cocaine***.

> **"Interviewer: *So you said the crack's shit?*** *Yeah, you're better getting it and washing it yourself, better getting the cocaine and making it yourself.* **Interviewer: *What do you think's changed about it, the crack?*** *The cocaine in it, there's no coke in it. That's what it is. Yeah, that's all I can say.* **Interviewer: *So is that what you're doing then, doing it yourself?*** *Mmm yeah, that's what I do now. I'd rather do it that way, you know what's in it then. You say that, like 'oh but what about coke?', but you cook everything out don't you when you're washing it so any impurities and that comes out when you're washing it".* (Trafford man, mid-30s)

> *"Sometimes I just do it myself because I'm a chef. . . But that's for myself and nothing else".* (Manchester man, late 30s)

> *"It's fucking crap! I can get some [coke] and make it myself, do you know what I mean? . . . But I don't sell it, just use it".* (Male Service User, mid-30s, Tameside)

> *"It's all garbage. I'm not going to lie, I buy coke and just cook it myself. There's some decent coke about now. It's easier to cook yourself and you're getting better stuff then".* (Tameside man, early 40s)

While this was often discussed as something they did for personal use, a couple of people mentioned that they had done this for other people who did not know how to do it themselves.

> *"Somebody got some sniff [cocaine powder] and asked me to wash it up".* (Stockport woman, 40s)

While washing up **cocaine *powder*** appears increasing common, some people stated that they didn't trust themselves to do it correctly.

> *"I know a few people who do their own [cooking up], but I don't trust myself to make it right. I've seen people mess it up . . . [it's] not worth the hassle".* (Rochdale man, late 40s)

Others suggested that the initial outlay for **cocaine *powder*** was prohibitive.

> *"A lot of people are washing it now themselves, but it's dear that coke innit?"* (Tameside woman, 30s)

Therefore, despite the commonly reported dissatisfaction with the current quality, the demand for ***crack*** from street dealers remains strong.

In summary, although user reports indicate a decline in ***crack*** quality, there appears to be growing numbers of people using ***crack***, with a shift from traditional patterns of combined **heroin** and ***crack*** use toward more '***crack***-only' use. Among those using ***crack***, frequency and quantity of use are reportedly increasing. This escalation is attributed either to reduced **heroin** use or poor quality **heroin** that is no longer effective in bringing people down from euphoric ***crack*** high, or from perceptions of adulteration with other stimulants (e.g., **MDMA** or s*ynthetic cathinones*), prompting people to use more. However, despite the widespread perception among users that adulterants have undermined the local ***crack*** market, MANDRAKE forensic analysis of local ***crack*** samples did not support those assumptions. While average purity had dropped from 65% in 2024 to 53%, this was the same average purity that MANDRAKE testing reported in 2022.

4. CRYSTAL METHAMPHETAMINE

4.1 Prevalence

Given the widespread dissatisfaction with the current quality of ***crack cocaine***, we examined whether users were turning to alternative substances, in particular, ***crystal* methamphetamine**. As outlined in the 2023 adult trends focus, the price of ***crystal* methamphetamine** has decreased substantially to approximately £40 per gram, with use becoming more established within the chemsex context. In that report, we recommended ongoing monitoring of the availability and consumption of ***crystal* methamphetamine** beyond men who have sex with men (MSM) and the chemsex scene. Several participants in the current street drug survey - specifically those working in homeless services, living in supported accommodation or accessing homeless day services – reported its accessibility within street level drug markets.

"Yeah well the thing with the crystal meth is that the price had really come down for crystal meth. . . obviously I'm gay, but I go to some parties and I can't believe how big it is. And when I used to do crack and you have it on a pipe, they'll look down at you like you're a crack head. But then they're all doing fucking T on a pipe! But this is on the street now". (Manchester Man, mid-40s)

> "*We have had a report of one or two popped up, only in the last couple of weeks [. . .] he'd started using crystal meth, he couldn't get hold of crack, this was in the rough sleeper cohort".* (Operations Manager, Wigan and Leigh)

In several cases, access to it was reported to have been through MSM links through existing friendships or family connections.

> "*It's up here, it depends on what circles you move in. I have had it, I got it off my ex. [. . .] Her brother, he's gay and he was on it. He gave it me, so I've had it a couple of times. I smoked it in a bottle thing, and I injected it as well".* (Salford man, late 50s)

As highlighted below, it was suggested that it was being used in other populations.

> "*I smoke crystal meth. An amazing drug! . . . Crystal meth makes crack look like kids' sweets, put it that way! You can smoke a bowl, the same amount of crystal meth you can put into a glass crack pipe bowl and like you can smoke that six or seven times! You take a hit, you are up for two days straight! But you can't chill on it, you don't know what to do with yourself. Eyes twitching, you get a mad feeling like a euphoria. It's moved beyond that (chemsex scene) ages ago, it's everywhere now, you wouldn't think it but its spread. It's all over town, it's all over Stockport, it's all over Hillgate, you can get it everywhere now.* [. . .] *My mates a DJ and he takes it cos he says it helps him with his DJing and stuff. [. . .] It's so far beyond that chemsex scene, it's everywhere man".* (Stockport man, 20s)

Although limited to five respondents, these accounts of ***crystal meth*** use beyond the chemsex scene necessitates close monitoring over the next year.

The same person went on to report that it was available for as little as £20 a gram and that it was being made locally in Stockport.

> *"It's cheap, you can get it for as little as twenty quid, and that's for a whole gram! See people round here now, they are making it in bottles – 'shake and bake'[8]. Kind of the same way as making crack but a lot more chemicals and shit. Round here you are not getting the good shit, the big glass shards. You have to get that online. Round here it's brown, it looks like cola a little bit. It doesn't taste as nice, and the effect isn't that good but it's there".* (Stockport man, 20s)

MANDRAKE has analysed eight samples submitted from across the ten boroughs during this year's testing cycle purported to be '**methamphetamine**', '***crystal* methamphetamine**' or '***crystal meth***'. All eight exhibits were found to contain, unadulterated extremely high purity **methamphetamine** ranging from 89.1 – 99.9% (mean purity: 95%).

8. 'Shake and bake' refers to a simplified method of methamphetamine production, also known as small-capacity production labs (SCPLs) or the 'one-pot' method. In the shake and bake method, chemicals are mixed in a soda bottle, rather than a lab.

5. SYNTHETIC CANNABINOIDS 'SPICE'

5.1 Prevalence and patterns of use

Reported current ***Spice*** prevalence varied more markedly than for any other substance. Overall, almost a fifth (18%) of the 212 professional who completed the survey reported a decrease in the use of *synthetic cannabinoids* (***'Spice'***) in the past year, though with significant variation between boroughs.

> *"I've not seen Spice round here for absolutely ages! It's left our area".* (Stockport Homeless Service Project Worker)

> **"Interviewer: *Are people still using Spice?*** *Not so much in Stockport, no".* (Stockport woman, 50s)

> *"It was around at one point, but slowly it's drifted now out of Stockport. Because it hit Stockport that Spice. It did hit Stockport really hard, really bad. It kind of hit this town and then drifted, just as quick as it had come.* [. . .] *I don't know anyone who uses round here. In Manchester and prison is the place for Spice".* (Stockport man, 50s)

> *"No Spice use in treatment".* (Operational Manager, Bolton and Bury)

Spice was often viewed as being more of a 'prison drug'.

> *"It's gone out of fashion. The only place it's in fashion is when it's dipped in sheets of paper and sold as a £25 bank card [in jail]. [. . .] And god knows what's on those pieces of paper! But when they come out, Spice is not a thing at all. Even the bag heads, they're just on the hunt for B and white. No one touches Spice anymore".* (Oldham man, mid-40s)

> "*The Spice? No, I don't really hear about it. I don't really hear about it. I don't hear about Spice. So it is almost like it's a substance just in prisons".* (Opiate Recovery Worker, Tameside)

In contrast to reports of declining use elsewhere, ***Spice*** was frequently described as remaining popular in Manchester, especially within the city centre street-based community.

> *"Not much Spice around Bolton, it's a Manchester thing. Bolton's always a bit behind".* (Bolton man, early 50s)

> *"Spice isn't big in Wigan, mainly Manchester. You just don't see it much anymore".* (Wigan man, mid 40s)

> **"Interviewer: *Is there still a lot of people using it?*** *Yeah, it's still rife!* **Interviewer: *What in Salford?*** *More around town [Manchester City Centre]".* (Salford Man, late 30s)

Rising levels of use were also reported in Salford.

> *". . . particularly Manchester and Salford, I've been asked to go into Loaves and Fishes to do some Spice training for their volunteers and their staff because they've had a load of people just, literally, going over in the car park and that. They've gone outside for a smoke, and they've had two guys they've had to go and pick up off the floor. I would say, the last six months".* (Harm Reduction Worker, Salford)

> *"Lots of people are on that Spice now, someone died near me a couple of days ago and that was off that Spice. A lad in his 30s mate, I don't touch it, it's too dangerous!"* (Salford woman 50s)

> *"I thought it had died out to be quite honest with you when I moved to Swinton and Eccles, I think it died off a bit, but it's come back again with a vengeance. It's taking over again".* (Salford man, 40s)

In Wigan, it was reported that it tends to go away and then appear again in waves.

> *"Spice every now and again comes in waves in hostels. [. . .] Specifically last year during the cold weather period . . . Probably about 70% of our residents on site were actively smoking Spice . . . it came out of nowhere . . . then died down again now".* (ABEN Manager, Wigan and Leigh)

As we outline in section 5.2 below, local prevalence was linked to its availability.

5.1.1 Alternative to heroin and crack cocaine

Six interviewees suggested that ***Spice*** was displacing **heroin** and/or ***crack* cocaine** use among people they knew.

> *"Spice is the main one that's taking off. It's taking people off heroin, it's taking people off crack. I can't turn around and say [anything] positive about it because it's Spice, but it's saving people. It's got me off the heroin. It's got me off the crack.* **Interviewer: *So why have you moved over to Spice? Is that because of the quality of heroin?*** *It's a bit because of the quality, but it's also maybe stigma. Heroin's just got a bad reputation".* (Manchester man, early 40s)

> *"Spice and crack is now the main drug in Manchester and Salford. It's not heroin.* **Interviewer: *Why's that? Why do you think people aren't using heroin?*** *Because they've replaced it with Spice! It's weird, the trend went from everyone being on heroin and crack. They all went onto Spice. It was mad, it's crazy now. They've all gone from Spice back to crack, but they don't touch heroin now, it's like the Spice has replaced the heroin use.* [. . .] *I know a [redacted] bloke who was bad on opium when he come over here. Got injecting, started taking heroin. But he's not touched heroin now, he religiously had heroin every day and he's not touched it for nearly seven years since he's been in this country. As soon as he had a drag of Spice, he packed the heroin in".* (Salford man, late 30s)

In addition to reports of transitions from **heroin** to ***Spice***, respondents also stated that some individuals who had traditionally used ***crack* cocaine** had switched to ***Spice***.

> *"Yeah, Spice has got people off their [crack] rocks".* (Manchester man, late 30s)

5.1.2 Spice used as detox from heroin

In Manchester, both professionals and people living street-based lifestyles frequently described people using Spice to self-detox from heroin.

> *"I know a couple of lads who have done a heroin rattle on it, so the Spice is stronger than heroin".* (Manchester man, 40s)

> *I" know people are using it [Spice] as a heroin substitute because you don't really hear of heroin addicts no more. I just think it's substituted everything. And now that's all they chase".* (Volunteer, Manchester Homeless Day Centre)

> *"I know people that are coming off crack and the heroin and not even taking nothing to come off it by using Spice, you know what I mean? Not having withdrawals off the heroin now because of Spice.* (Manchester man, early 30s)

We interviewed two people, both from Manchester, who reported self-detoxing from heroin using ***Spice***.

> *"I just did it myself. I just stopped using heroin by smoking Spice. I didn't want to go to services, didn't want no methadone or tablets. So now I'm on the Spice, I'd like to come off that of course. But it's better than heroin, I'm more stable. I'm in here [supported accommodation]. I'm fit and healthy, I'm going to the gym, I'm cooking. I just have a [£5] bag a day".* (Manchester man, early 40s)

5.1.3 Spice dependency

While some participants discussed ***Spice*** positively as a means of supporting self detoxification from **heroin**, several individuals with experience of using **heroin**, ***crack* cocaine** and ***Spice*** stated that ***Spice*** was more 'addictive'.

> *"Yeah . . . it's so addictive like I've smoked crack before and it's [Spice] so much more addictive than crack. Like, you know mentally. It really is like I smoked crack for years and I never found it to be any kind of addiction, but this is, it's mental torture. When you've not got it, you're thinking about it 24/7. Yeah, it's horrible".* (Trafford man, 40s)

> *"Nowadays, its mad, you're having a spliff half an hour's gone before you're back round, and you want another. Which I think is encouraging it to be more addictive as well isn't it, in that aspect. It's more moreish. It's actually physically waking you up now, you're wanting it more".* (Salford man, 30s)

Psychological cravings and physical withdrawal

symptoms were reported to be contributing to increases in acquisitive crime and serious violence.

> *"What Spice is doing is turning them from human into just this Spice chaser. Do you know what I mean? And it's a sort of drug that where everyone's doing it. That's why everyone's phones are going missing and everyone's robbing everyone for this five-pound bag of Spice. . . People are getting murdered because of it".* (Volunteer, Manchester Homeless Service)

5.2 Market Insights

5.2.1 Availability

In several areas, it was reported that lower levels of use were partly attributed to reduced access to ***Spice***, with individuals describing traveling into Manchester city centre to obtain it.

> *"But Spice is harder to get now as well".* (Tameside man, early 40s)

Where local availability was reported, respondents stated that ***Spice*** was being supplied from Manchester or Oldham.

> *"There's definitely Spice around here. Quite a few people sell it and it's easy to get in Rochdale centre.* [. . .] *Yeah, there's a fair bit of Spice knocking about, people bring it in from Manchester or Oldham and start selling it here".* (Rochdale man, late 40s)

As noted in the previous ***crack* cocaine** section, access to ***Spice*** was widely reported to be greater in Manchester city centre than elsewhere in Greater Manchester; however, reports suggested an unstable market, with intermittent availability and gaps of several days or a week between supplies.

> *"Spice is different. . . It's not easily accessible, when it's there it's only there for a few hours and then sold out for a week or two".* (Manchester man, 40s)

One interviewee stated that *synthetic cannabinoids* were available for sale in crystal form in Manchester city centre, which was perceived to carry increased risks.

> *"I mean people buying the crystals in town and that was killing them. Or overdosing on them. What they do is they get the crystals and then boil it down, put in boiling water. Then put it in a spray bottle and spray it onto paper and smoke the paper. [. . .] To be honest, in town, if you wanted to buy a Spice like it used to be, you can still buy it like it used to be. Just like a fake, I don't know, it's potpourri or something".* (Tameside man, early 40s)

5.2.2 Price

'***Spice'*** is still available in £5 deals.

> *"It's usually a fiver a bag for like a plant leaf, not paper like in prison".* (Rochdale man, late 40s)

However, it can also be purchased by the ounce and in quarter and half ounce deals.

> *"It's 25 quid for a quarter [of Spice]. Or you get three five-pound bags for a tenner. [I get] two spliffs [out of a £5 bag]. Me and my friend get a spliff each out of a 5-pound bag. Normally I'll get through 3 or 4 bags a day".* (Manchester man, 40s)

In the previous GMTRENDS report (2024), an ounce of 'Spice' was reported to cost as little as £40 to £50. However, current reports suggest prices have increased, with an ounce typically ranging from £60 to as much as £80 per ounce.

> **"Interviewer: *Is an ounce still about £40, £50 now?*** *That's a bit cheap. I pay about £70. You should get a quarter for £20 which is about 7 grams, but you get about 5 grams for £20".* (Trafford man, 40s)

It was suggested by a couple of people who use ***Spice*** that most of what is sold in Manchester comes from Yorkshire.

> *"Sheffield or Leeds. There's only one or two places. See an ounce in town now would cost you £50 to £60. Or between £60 to £80. I could get up now, get a train there, pay £35 on the train and go and pick up two ounces for £50 from my mate in Leeds".* (Salford man, late 30s)

> *"Um, everyone's trying to make it*

themselves, aren't they? It's a load of crap. Up and down. Decent stuff's coming from Sheffield at the minute. **Interviewer: *So you say you think it's stronger coming from Sheffield than Manchester?*** *Yeah, yeah, I do, the people who smoke it are mainly buying it in Sheffield, Leeds, Bradford. You can't buy it in Manchester".* (Trafford man, 40s)

5.2.3 Content

There were reports of variation of quality from batch-to-batch.

> *"Sometimes they mention that there's a bit of a dodgy batch out there and people are having a bit of a bad time on it. You sort of hear that a little bit. [. . .] nothing major really. They'll just say, 'oh, there's dodgy batch out there'".* (Homeless Service Worker, Manchester)

A couple of people who regularly used ***Spice*** reported occasional occurrences of unusually potent batches.

> "*I had some yesterday and I went under. I had to sit down on the floor next to a bus stop. I had people coming over to me going 'you alright? you alright?' So I thought 'shit, I better get up and go here'.* **Interviewer: *Yeah, so would you say it's more potent?*** *Yeah, I only had three drags and I was fucked, I couldn't remember where I lived or anything.* **Interviewer: *And your usual tolerance is . . .*** *Yeah, it's fine, I'm usually fine.* **Interviewer: *Okay, is there anything different about how it looks? The one you had yesterday?*** *I didn't see it 'cause it was already rolled, but I've seen some recently and maybe it might've been a bit more crystally".* (Salford man, mid-30s)

Echoing accounts from the ***crack* cocaine** section, some users suggested that ***Spice*** was being sold prematurely, before the manufacturing process was complete.

> *"That's another thing as well if you get it nowadays, they're not even drying it out. So, you're getting it soaking. So the people that are actually addicted to the stuff, they're not just smoking the Spice cause the acetone is vaporised. They're sat they're smoking the chemical… the acetone chem as well. I made a spliff the other week, cause some guy gave me some. I made a spliff the other week and it turned my rizla green. It dyed my rizla green. I just went like that, tipped it all back out the rizla and put it on the table and let it dry for a bit. Because I knew, you're just smoking acetone really.* ***Interviewer: So why do you think that is?*** *Demand! Yeah, there's that much demand and no one's making it quick enough".* (Salford man, early 40s)

> *"Yeah, if I get it off one person it'll be soaking wet. Like it'll be soaked in acetone and the chemical and I always get it off him that way. But if I get it off someone else it'll be same, different base but like bone dry and well stronger".* (Trafford man, late 30s)

We continued to receive reports suggesting that ***Spice*** contained *opiates*. These reports first emerged in 2016 in Manchester following the 2016 Psychoactive Substances Act that moved the supply of '***Spice***' from high street shops to the street market.

> *"I know it's a synthetic opiate, because I've done the drug test myself. I've peed in a jar, and it flashes up saying, you know, it's opiate use.* **Interviewer: What, when you've had Spice?** *Yeah, it comes up [as] opiate use. So they're mixing opiates into it I know that for a fact".* (Salford man, late 30s)

Another man we interviewed stated that after being hospitalised after using ***Spice***, he tested positive for **fentanyl**.

> *"I had spliff of Spice the other week. Ended up in hospital and it were fentanyl, come back as fentanyl. I'd had a spliff. Had been walking, eating a bit of melon and just dropped. They had to get the melon out my throat and the ambulance come, had to keep me alive, it was from Cheetham Hill".* (Manchester man, 40s)

Likewise, the street-rumours that ***Spice*** contains a substance administered to fish to anesthetise them, that emerged in 2017 still persist[9].

> *"I never touch that, it stinks! Stinks like fish*

9. 2-phenoxyethanol is a commonly used anesthetic and sedative for fish.

don't it? That's what it isn't it? Something for cleaning fish tanks out or something?" (Salford woman 50s)

Finally, we had one suggestion that ***Spice*** contained rat-poisoning.

"But they put rat poisoning in it [Spice] now as well. That's what's killing people. **Interviewer: *Is that what people have been saying?*** *Yeah, that's getting around. So 'be careful' and stuff. Yeah, but that's what it's cut with and that, yeah".* (Manchester woman, early 30s)

The reoccurring claim from users that ***Spice*** containing *opiates*, **fentanyl,** fish anesthetics, or rat poison, have not been supported by MANDRAKE's forensic testing. Over more than a decade of testing local '***Spice***' samples since February 2017, MANDRAKE has not detected any batches containing anything other than *synthetic cannabinoids*. Once again, there are clear disparities regarding the contents and purity of drugs and users' beliefs.

In this year's testing cycle, MANDRAKE analysed twenty-two samples submitted from across the ten boroughs, purported to be '***Spice***'. All the samples tested were the herbal form of the product. Notably, none of the e-liquids or vape products that were submitted during the cycle were found to contain *synthetic cannabinoids*. Twelve exhibits were found to contain **MDMB-4en-PINACA** at concentrations ranging from 0.99 – 3.3%, with one obtained from Manchester City Centre, containing levels of **MDMB-4en-PINACA** at 11.2%. The remaining ten samples were determined to contain either **5F-ADB** (n = 8, 1.6 – 3.9%), ADB-PINACA (n = 1, 1.0%) and in one case a mixture of **MDMB-4en-PINACA** (major, 2.8%) and 5F-ADB (minor, 0.97%) respectively.

6. BENZODIAZEPINES & PREGABALIN

6.1 Prevalence

6.1.1 Diazepam prevalence

Several professionals reported that *benzodiazepine* use has increased over the past year, with several professionals describing it as a significant and growing issue.

> *"The benzo use in our service group is huge, absolutely huge and definitely something we've seen an increase of in the last few years".* (Practitioner, Wigan and Leigh)

> *"Benzo use has gone up, particularly in the last two years . . . people flat out denying benzos use but it's testing positive in the urine. But also, I would say the benzo use has gone up, particularly in the last two years".* (Opiate Team Leader, Rochdale)

As noted in section 2.1.4.2, positive results for *benzodiazepine* in the routine urine tests of people who use **heroin** were frequently reported.

6.1.2 Pregabalin prevalence

Two professionals noted a decrease in the use of **pregabalin**, both of whom attributed this to a reduced prescribing.

> *"Pregabalin use seems to have disappeared. They put this down to educating the young doctors who start in the hospital about prescribing to people who use drugs".* (Dual Diagnosis Specialist Nurse, Rochdale)

> *"Slight reduction in Pregabalin use, probably less available, and less prescribing".* (Consultant Addiction Psychiatrist, Bolton)

However, accounts from people who use drugs indicated that non prescribed use of *prescription medications* was dominated by **pregabalin**, which was widely reported to have overtaken the use and demand for **diazepam** and other *benzodiazepines*.

> *"Literally no one wants the gear, they're asking 'can you get me any pregabs, can you get me any pregabs?' Don't want gear. And you're talking about users that've been on 'em for years. I don't know, they're just asking for pregabs. So no diazes or anything like that, they just want pregabs. It's because there's a massive crave with them".* (Trafford woman, 40s)

> *"See a lot of people are on pregabs".* (Salford woman, 50s)

It was suggested that they are particularly popular amongst people who use ***Spice*** and heroin.

> *"Pregabs are the big thing at the moment, loads of people are on them, [they] don't really care where they get them.* [. . .] *I try to stay away from them myself, but plenty of people are taking them, especially those already using Spice".* (Rochdale man, late 40s)

> *"They're blowing up! [. . .] Everybody wants them, all the bag heads [people who use heroin], they want that".* (Oldham man, mid-40s)

> *". . . the opiate clients like their pregabalin".* (Recovery Coordinator, Bury)

6.1.2.1 Motivations for Pregabalin use

As we highlighted in GMTRENDS 2021, a key reason for their popularity is their ability to stave off withdrawal symptoms from **heroin**.

> *"Or if they haven't got the money for heroin and crack, what they'll do is they will go and buy some tablets, the pregabs and all that, to back them up. So that's what they are doing, they are buying more pregabs or diazes to not feel that shit!"* (Salford man, 40s)

> *"But it's like sometimes, if you haven't got no gear, you'll have a pregab and that'll hold you. So, you can have like a day off the gear, if you've got no dough for like two days or something until you get your money back or you get some money. Then you*

can score then, do you know what I mean? **Interviewer: *Yeah. So people are using pregabs to kind of stop the rattle then?*** *Yeah, yeah. To hold you. I mean it does work, I've done it. Pregabs could hold me, and I wouldn't use as much when I have a pregab do you know what I mean? So I could have a 300[mg pregabalin] and say have one bag [of heroin] whereas normally I'd have 4 bags, 3 or 4 bags a day, do you know what I mean?"* (Salford man, 50s)

They also represent a more affordable substitute for **heroin,** which, as outlined in Section Two, is presently characterised by reduced quality and smaller deal sizes.

"Pregabs . . . have become more popular than heroin . . . they're cheaper and stronger". (Bolton man, 50s)

6.1.3 Prescription drug use in custodial settings

While this report focuses on the street drug market, it is noteworthy that local prisons have also reported an increase in prescription drug use.

"Prescription drugs are thriving, anything that is 'illicit' will be abused. Subutex, Benzos, even painkillers like Co-Codamol and Codeine". (Prison Drug and Alcohol Recovery Practitioner)

"We've seen a lot of the Pregabs in prison finds lately". (Prison Recovery Worker)

Although prescription drug use in custodial settings is well established, such substances have generally been used as substitutes for preferred drugs that are scarce in custody, rather than drugs routinely used in the community.

"There has been an increase in illicit tablet use in the last 6 to 8 months, more people coming in with problems of prescription tablets, benzos, pregabalin and buprenorphine rather than picking it up inside prisons". (Manager, Prison Substance Use Service)

The rise in individuals entering custody with prescription medication dependencies is a significant development and reflects their popularity outside in the wider community.

6.2 Market Insights

6.2.1 Availability

6.2.1.1 The impact of Operation Vulcan

In November 2022, Greater Manchester Police (GMP) launched *Operation Vulcan* to clear the areas of Cheetham Hill and Strangeways of the counterfeit goods trade and associated organised crime. In one operation, alone, over one million suspected counterfeit pills were seized by Operation Vulcan officers during a search of a business premises in the Strangeways area of Manchester. By the end of October 2024, over 200 shops selling counterfeit goods had been closed and 2.4 million class C drugs seized.

We explored the impact of *Operation Vulcan* with professionals and people who use these drugs and received numerous reports that it had reduced the availability of diazepam and pregabalin.

"It has made a big difference yeah, they're not as easy to get hold off". (Tameside man, early 40s)

"Interviewer: *Has Operation Vulcan trying to shut down the shops that sell it on Bury New Road made much difference?* *Yes it has! It is harder to get them now, a lot harder. That was dead convenient man, know what I mean? So convenient, you walk down the street 'boom', you get approached. Now you have to go looking for them and it's a ballache, know what I mean?"* (Stockport man, 50s)

The impact of *Operation Vulcan* has benefited frontline services who are based in this area.

"Interviewer: *Because of where you're based, have you noticed any difference with this since Operation Vulcan has been trying to shut down all the shops and that here?* *I think it's been a huge difference. We used to have a lot of the guys just standing outside the building next to the takeaway, ready to pass stuff out to people coming along the queue dealing stuff. [. . .] Dealing around the corner. [. . .] Yeah, we'd find people's stash at the side of our building. We'd find stashes of drugs, carrier bags of tablets. And now we're not seeing anything or very rarely see anything".* (Homeless Service Workers, Manchester)

The impact on access to d**iazepam** was frequently mentioned.

> **"Interviewer: *So Bury New Road, like the increased policing of that area, has that made any difference?*** *Yeah, I think it has made a bit of a difference. Yeah, I think they are a bit harder to get hold of now. Benzos, can't get hold of benzos at the minute. I like benzos, but I cannot get hold of benzos for love nor money.* **Interviewer: *And that's to do with the way they targeted all the shops on Bury New Road?*** *Yeah, yeah, yeah, definitely".* (Tameside woman, early 30s)

Shortages of pregabalin were also frequently discussed.

> **"Interviewer: *So you know how the police have tried to shut down the shops on Bury New Road . . .*** *Yeah, they've done a good job of that as well the bastards! [laughs] Yeah, it's made a big difference but now, if you can get pregabs, they are nearly always from a chemist – proper!"* (Salford man, late 30s)

> **"Interviewer: *Has the police operation on Bury New Road had any impact on the availability of tablets such as pregabs and benzos?*** *It has made a big difference yeah, they're not as easy to get hold of. [. . .] To be honest, I've not in the last month or two, I've not even seen any pregabs. I've not heard anyone say. Usually, you get people offering them. But no one seems to have any in at the moment".* (Tameside man, early 40s)

> **"Interviewer: *Is it harder to get? Like Operation Vulcan, tried to shut all the shops and street dealing on Bury New Road, has that made a difference?*** *I think it has, yeah. I think it's made it harder for people to get them. [. . .] No one can get hold of them. In fact, there's two people in the space of one week who've asked me can I get any pregabs".* (Trafford woman, 40s)

6.2.1.2 The harm reduction benefits of Operation Vulcan

There was recognition that the prescription drug market around Bury New Road needed to be addressed, as drugs sourced from this area were frequently linked to drug-related deaths.

> *"A lot of them died [. . .] they knew Cheetham Hill was a bit dodgy for pregabs because people were saying on the grapevine about overdoses, and we lost so many people. But they are still using but it's just not as chaotic as it was [before Operation Vulcan]".* (Opiate Recovery Worker, Tameside)

> *"They had to shut [the shops on Bury New Road] down though, too many people were dying".* (Manchester man, 40s)

There was frequent discussion of deaths associated with non prescribed **diazepam** and **pregabalin** linked to the Bury New Road prescription drug market.

> *"I guess when I first arrived here, which was about six, seven years ago, they used to bring it from Cheetham Hill Road, and I've known people to die of it and stuff like that. But yeah, like I said, they closed all the shop down".* (Manchester woman, early 30s)

The belief that these drugs were not of UK pharmaceutical standard was described as encouraging higher dosing and repeated redosing, increasing risk.

> "*Nobody's mentioned Bury New Road for ages actually. It's one of them, it were bad up there want it? Like people were dying. I've had a few friends, well associates, and they've gone down there, took too many, done something fucking stupid and died! You know what I mean? Cos they've not let them kick in! You know, normal tablets it's like half an hour, when you should be getting the effects of 'em in your system but they are only waiting like 15 minutes or summat and then they are doubling up. And then BANG [slaps hands] it all hits you at once then, you know what I mean? And you're dead!"* (Salford man, 40s)

> *"But that one strip [of tablets], I mean, when Bury New Road [open drug market] was open, we bought a load and cos they weren't tasting like diazepam tastes we took a few more and by the time we got to Piccadilly Gardens that was it, we woke up in hospital a few days later. I've never done it since then, that was my bloody warning!* [. . .] *I would never take a diaze' of anybody else cos you don't know what's in them. It's the same as the pregabs, I've heard of so many deaths from these diazes and pregabs that are dodgy".* (Stockport woman, 50s)

6.2.2 Current access

Despite the positive impact of *Operation Vulcan* in curbing illicit access to *prescription medications*, many participants reported that **diazepam** and **pregabalin** remained readily accessible.

> *"People still get 'em, I don't think here [Stockport] it's an issue getting hold of them".* (Stockport man, early 20s)

> *"Benzos and pregabs [are] still there, local market".* (Operations Manager, Wigan and Leigh)

> *"Pregabs are still really easy to get".* (Wigan woman, mid-40s)

6.2.2.1 Displacement

Interviews paid particular attention to potential displacement, with many professionals and people who use street drugs reporting the existence of local prescription drug suppliers operating from a variety of premises.

> *"In Wigan there is a gym that is notorious for the supply of street benzos, and everyone knows about it. . . it started as diazepam, but there is significant pregabalin and temazepam as well".* (Practitioner, Wigan and Leigh)

> *"I believe there are shops selling benzodiazepines in Bolton, but I don't know where they are".* (Consultant Addiction Psychiatrist, Bolton)

One interviewee suggested a displacement of the Manchester market from Cheetham Hill to Rusholme.

> *"All I know is that they're buying them [tablets] from the 'curry mile'[10] now, people are going up there. Pregabs and that. It's just moved up the road. All I know is people go to up the curry mile for them now. [. . .] they come in a car now. They come in a boot. It's just gone mobile".* (Manchester man, 40s)

Several other interviewees suggested a shift of the market towards online platforms.

> *"They are online aren't they? They are getting them online".* (Stockport man, 50s)

> *"You can even get them online [Diazepam and Pregabalin] . . . black market stuff".* (Bolton man, early 50s)

> *"You can get them online quite easy, the tablets. Like I've got a few websites that I've ordered off before and they just come through the door".* (Salford man, mid-30s)

> *"It's all gone online, hasn't it?* **Interviewer:** ***So people are accessing them online?*** *Yeah, 100%. They've not shut it down, they've just displaced it to another shop online. You know, a storefront that can't be busted".* (Harm Reduction Lead, Salford and Trafford)

We interviewed people who were accessing them via Facebook.

> *"You can get them just as easy on Facebook, just as easy on the web, you can go on there now and put in 'diazepam' on [Facebook] Messenger and they will come up with multi-buys and deals and all that. And you can buy in bulk, we've got a guy who sells 12 strips for 100 quid".* (Stockport woman, 50s)

The *Telegram* messaging app was also mentioned.

> *"It's gone to the internet. . . they closed the business, but they've not stopped what's going on, it'll always be a problem. Telegram, you go on there you get what you want".* (Recovery Support Worker, Salford)

Others suggested that the local dealers were purchasing them online to sell on the streets.

> *"I know of one person who will get them posted from China. I think it's £20 for a pack of 36".* (Wigan man, mid-40s)

However, as detailed in the next subsection, the most common means of access was prescriptions obtained legally or that had been diverted.

10. The 'Curry Mile' is a nickname for the part of Wilmslow Road running through the centre of Rusholme in south Manchester. The name comes from the large number of restaurants, takeaways and kebab houses specialising in the cuisines of South Asia and the Middle East.

6.2.2.2 Diverted prescriptions

The combined impact of *Operation Vulcan* and concerns about drug content and overdose appears to have reduced the street market for these drugs. However, in its place we received increased reports of people accessing **diazepam** and, in particular, **pregabalin** through GP prescribing.

> *"I'm more benzos and pregabs myself than heroin.* **Interviewer: *Where are you getting them?*** *I don't buy the fake ones. I'd rather pay more money and buy the doctor ones. At least you know what you are fucking buying.* [. . .] **Interviewer: *So how do you know it's the proper prescription stuff then?*** *Because I get it from the fucking doctor. Do you know what I mean?* **Interviewer: *Are you prescribed it yourself?*** *No.* ***Or are you getting it from someone who's prescribed them?*** *Yeah, but then they sell that script, which is awful really isn't it?"* (Tameside man, late 20s)

Several professionals reported that **pregabalin** was more likely to be prescribed than b*enzodiazepines*, potentially reflecting shifts in prescribing practice.

> *"Pregabalin is prescribed to a lot of our patients, and it is prescribed legitimately. Without a doubt they are far more likely to get (prescribed) pregabalin than benzos".* (Recovery Coordinator, Bury)

Access to **pregabalin** was most often reported to involve diverted p**regabalin** prescriptions belonging to other individuals.

> *"It's fucked a lot of people up 'ant it? [Operation Vulcan] You can't get them from there [Bury New Road] anymore.* **Interviewer: *So what are people doing now then?*** *Try to buy them from someone who's on a script, like someone who gets them off the Doctors and they will buy a box of 50 for fifty quid or eighty quid.* [. . .] *I mean everyone keeps asking me in the Village, 'Do you know where I can any pregabs or diazepam?'"* (Salford woman 50s)

> *"We know a few lads who sell their scripts, people prefer those to the fake ones".* (Rochdale man, early 40s)

> *"People are selling their prescriptions, their own scripts"*. (Bolton man, early 50s)

The association between the Bury New Road market and drug related deaths led many users to express a clear preference for diverted prescription drugs over ones suspected of being counterfeit.

> *"Pregabs, I buy them off people I know that are on them. So they are real ones, cos they are killers them, they are killers. If you are not getting the real ones, they are not worth taking, you know what I mean? Diazes are not that bad but it's the pregabs you've got to watch for".* (Stockport man, 50s)

Interviewees reported that sellers were typically supplying diverted prescriptions rather than 'fake' or imported products.

> *"There is a few people that do snides [fakes] but most of them are proper prescribed. Do you know what I mean?"* (Salford man, 50s)

This was supported by several professionals, who described a buoyant market for prescription medications obtained through GP prescribing.

> *"I've found that more and more people are going to their GPs for pregabs rather than buying. I don't know if the GPs are cracking down on it now or whatever, but there's a lot more what I would call 'maneuvering around' with pregabs. You'll get them from the GP, you'll sell them to him, he'll sell them to you. There's a lot of what I would call 'under dealing'. You know, 'I've got a hundred pregabs, give us a couple of bags [of heroin]' or 'give us a couple of stone [crack cocaine]'. And I think there's a lot of side trading going on as well, from what I can gather. I mean, it's always happened, it did back in my day. You're always gonna find that, 'he's got methadone' or 'he's got pregabs'. Do you know what I mean? 'Have you got anything to keep me going during the day?'"* (Harm Reduction Worker, Salford)

These professional accounts were supported by people who use drugs, who described an informal trade in prescribed **pregabalin** in exchange for a**lcohol**, ***Spice***, **heroin** and *crack* **cocaine**.

"Like my mate there, he sells Spice, but he now swaps Spice for pregabs. But when it started out, he was strictly money. 'I need money, I'm homeless'. But now if you've got a strip of pregabs you'll get half [an] ounce [Spice] off him. (Salford man, late 30s)

"Some people get the 300s [300 mg pregabalin] and sell them. I don't get mine prescribed, I'm not on them. Other people will get them and sell theirs. They want drink [alcohol], they're more drinkers. You know what I mean? So they want a drink. You get more like the alcoholics get the pregabs to sell for the beer. Literally like once a week. [. . .] They get them prescribed for their nerves, like their back or whatever, but then they'll sell theirs to buy alcohol. I do know people on Salford Precinct who do that. Sell the pregabs for alcohol. **Interviewer: *So it's more that people are selling their scripts now than like what it used to be, people getting them from Bury New Road?*** *Yeah, yeah. That's what they do, get them on a script and then sell it on for alcohol. I know a few people who do that".* (Salford man, 50s)

Although the selling or trading of prescribed **pregabalin** was commonly reported, a small number of participants stated that it was becoming harder to access these drugs through prescription.

"*I've got a friend now, her Doctor is giving her one a day for a week so she can't flog 'em! That's what they are doing. That's what they've been doing at the Doctors. And they've been cutting down on giving out the pregabs. Not willy nilly you know what I mean? Cos they do go mad on them don't they?"* (Salford woman 50s)

Some professionals raised concerns about clinical prescribing practices, particularly the prescription of **pregabalin** to people they supported who were using heroin.

"It would be interesting to look at a cohort of opioid clients and see what percentage are prescribed pregabalin from their GP, because it is high. And a lot of them say they have noticed it's another addiction. And one of my guys has tried to stop it and the withdrawal was horrendous apparently. And we did a clinical review and wrote to his GP to discuss getting him off it, but he's very hesitant to come off it. The opiate clients like their pregabalin". (Recovery Coordinator, Bury)

6.2.2.3 Emerging alternatives to diazepam

In light of reports that **diazepam** and **pregabalin** had become harder and more expensive to source illicitly, and that prescribing, (particularly for **diazepam**) was seen as increasingly restricted, participants were asked about alternative prescription medications.

One interviewee reported that **lorazepam** was being used as an alternative to **diazepam**.

"Interviewer: *Are there any prescription drugs that people are using then?* *Yeah, what are they fucking called, I can't remember, 'Lorazepam'; or something stupid. It's got a 'pam' at the end of it and anything with a 'pam' you know it's alright".* (Salford man, 40s)

A small number of participants also reported that diverted **methadone** continued to be available.

"Interviewer: *So if the benzo's and pregabs are harder to get hold of now, are there any other prescription drugs people are using?* *Obviously, there is still your methadone knocking about".* (Salford Man, late 30s)

While prescribed **methadone** and *benzodiazepines* have long been subject to diversion, two participants in Salford noted that the antidepressant drug **Mirtazapine** has recently emerged in the diverted medication market. It was suggested that these medications were being used to aid sleep.

"Interviewer: *That's really interesting. We were just talking a little bit earlier about Mirtazapine, so you have heard about people diverting . . . selling that?* *Yeah, I have heard about that. I used to be on it. [. . .] like as a sleeper".* (Salford man, mid-30s)

Compared to *benzodiazepines* and **pregabalin**, **mirtazapine** was described as significantly easier to obtain through GP consultation.

"Because the Mirtazapine, basically, everyone is on them because the doctors are firing them out to people. Because a general practitioner doesn't know about mental health, isn't a qualified mental health practitioner. So as soon as you sit there in front of a general practitioner and say 'I've got mental health issues' he's stumped. He's stumped. Now the basis is you give that guy suffering from depression, you give him antidepressants. One of the most common antidepressants now is Mirtazapine. So you go to the doctor, ask the doctor, the doctor gives you Mirtazapine. What's the most common drug you've got in your pocket that will sell? Mirtazapine. People start, 'these Mirtazapine are great, they knock me out for days'. 'Oh yeah, how much do you want a tablet then?' Then he goes like that, cause in his head this tablets going to knock him asleep. If he falls asleep off that tablet he tells his mate, who tells his mate. Then he tells his mate, 'Mirtazapine, this new tablet the doctors are giving. It's putting you to sleep, it's making you feel wavey and that'". (Salford man, late 30s)

In addition to alternative prescription drugs, one professional at a homeless drop-in service reported that service users were replacing prescription drug use with ***Spice*** and ***crack cocaine***.

"I think part of it though is a lot of the guys that I'm speaking with and working with, have gone from using tablets to other stuff by now. [. . .] they've moved on to something else. **Interviewer: *And what is that 'something else'?*** *Spice and crack".* (Homeless Service Worker, Manchester)

6.2.3 Price

As we have previously reported (see GMTRENDS 2021, GMTRENDS2022) **diazepam** and **pregabalin** reportedly cost around 50p or less per tablet when Cheetham Hill shops and street dealers sold them by the box. However, following the closure of the Bury New Road market prescription drugs are now typically sold individually or by the strip, with participants this year reportedly paying £1 to £3 per tablet.

6.2.3.1 Diazepam

"[The] Street market a couple of years ago, it used to be a pound a pill. Now it's about £2.50 a pill, something like that. Basically, if you can get prescription drugs, you are the man in town! [. . .]. The stuff they know the doctor's put drugs into". (Salford man, late 30s)

While they were still reported by some to be £1 a pill, this often involved purchasing them in bulk and these were more likely to be non-prescribed with variable content.

"Interviewer: *How much are you paying for them now?* *A pound a tablet but if you get a oner's worth (£100) you get 20 free. You get strips of 10 so he gives me an extra two then".* (Stockport man, 50s)

6.2.3.2 Pregabalin

Although previous GMTRENDS reports indicated that **diazepam** and **pregabalin** were priced similarly (typically around 50p per tablet when bought by the box, or £1 when purchased individually), more recent accounts suggest that **pregabalin** now often commands a higher price, commonly ranging from £2 to £3 per 300 mg capsule.

"People pay around £1 per tablet [diazepam], *£2.50 for a 300mg* [pregabalin]". (Bolton man, mid-30s)

"People pay about £20 a strip for pregabs, usually 10 or 12 tablets". (Rochdale man, early 40s)

"Interviewer: *What do they go for then?* *They're about a pound. It depends, or they'll do a strip. Say there's 14 300s [300mg Pregabalin], they'll do like a strip for 20 quid".* (Salford man, 50s)

Interviewer: *What's the going rate per tablet at the minute then?* *Pregabs? I think you can get like a strip for a tenner, so about 10 for a tenner, but I've seen some 20 quid for 10 so it depends on who you go to really. Diazes about a pound each".* (Salford man, mid-30s)

While purchasing larger quantities was reported to reduce prices, these remained more than double the levels previously associated with the Bury New Road market prior to *Operation Vulcan*, suggesting a sustained price shift following GMP's enforcement action.

> *"Pregabs I get three strips of 14 for fifty quid and you can sell one for three quid, know what I mean?"* (Stockport man, 50s)

As discussed above, the price for one 300mg **pregabalin** could be as much as £3 and it was noted that for many people, they only want to buy one or two to stop them withdrawing from **heroin**.

> *"People buy them, but they always want to buy one or two. People are selling strips, but people only want to buy one or two because it's not the actual drug what they want. It's like they're only buying it to stop themselves withdrawing or something like that, so they'll only buy one or two instead of wanting to buy the strips if you know what I mean?"* (Salford man, mid-30s)

6.2.4 Content: Pregabalin

As illustrated below, there was a commonly held view that the non-prescribed *benzodiazepines* and pregabalin were responsible for drug related deaths.

> *"People are dying left, right and centre! They're putting metals and toxic stuff in tablets. I'd rather have real ones, fake ones kill you".* (Bolton man, early 50s)

> *"I've used pregabs myself, they were everywhere, but it was the fake ones killing people, mixed with other stuff".* (Wigan man, mid-40s)

Within this testing cycle, MANDRAKE analysed 80 samples, submitted from across the ten boroughs, and purported to be '**pregabalin**'. All the samples tested were obtained as either red-white capsules with a content of either 75 mg/capsule (n = 4) or 300 mg/capsule (n = 71) on their blister packaging; orange '143 J' embossed capsules (n = 1, 200 mg/capsule) or beige/peach '150 TEVA' capsules (n = 4, 150 mg/capsule). All 75 samples were found to contain **pregabalin** at levels consistent with their stated content(s) indicating that they had derived from diverted medical/pharmaceutical sources. As such, the local market following *Operation Vulcan* appears to be dominated by diverted medications. Three additional samples, obtained in powder form in snap bags, were received from drug-related incidents and confirmed to contain high purity **pregabalin** (n = 2, 97.2 – 98.3% purity) or **gabapentin** (n = 1, 96.4% purity), however the lack of packaging means that the purchase intent of these products remains undetermined.

6.2.5 Content: Diazepam

When discussing street-based **diazepam**, it was very common for people to raise concerns about the variable content.

> *"I'm a tablet animal you know what I mean? Diazes, sometimes you get good ones, sometimes you get shit ones with the diazes, I mean last night, yesterday, I necked 90 of them, diazes, in one day! Strip-after-strip, done 10, next, 10, I'll do it every 20 minutes, 'I'll have another strip, fuck it!'. But you know, I had a good night's kip, that was it, nothing, not that smashed like, you know what I mean? The batch at the moment is shit. They are from abroad and they have foreign writing . . . Spanish . . . or Arabic or whatever.* [. . .] *I've got a kid now [who is selling diazepam] but the last two times I've scored off him they've been shit! But before that they've been alright. The last couple of weeks they've gone shit again. I can taste it straight away the diazes by the taste, you know what I mean?"* (Stockport man, mid-50s)

> *"I took 46 blues [10mg Diazepam] at once. They don't do nothing to me.* [. . .] *I have to have at least eight a day. I had some today and they were strong, do you know what I mean. But I can handle it. That's why I'm talking like this now".* (Tameside man, mid-30s)

There was a widespread perception that many of these tablets contained no **diazepam**.

> *"A lot of diazepam instead [of it containing diazepam] there'll be some other sedating drug in there".* (Opiate Recovery Worker, Tameside)

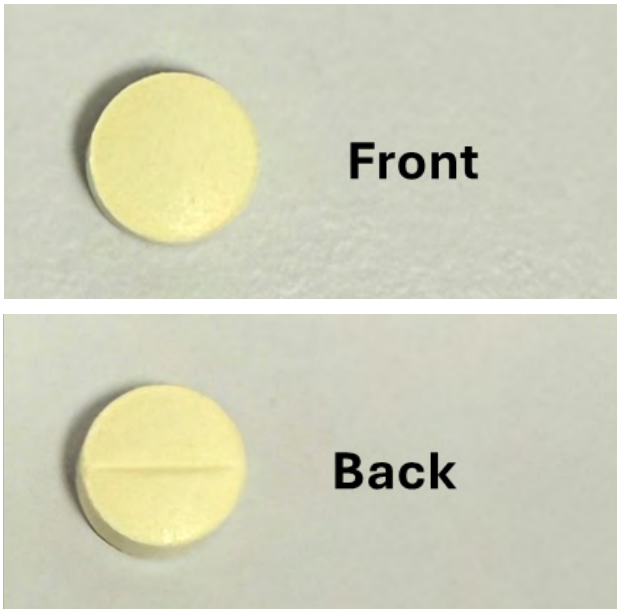
Others perceived that the content was responsible for deaths.

> *"People are dying from fake ones [diazepam], they've got diazepam and god knows what else in them. No one tests them"*. (Wigan man, mid-40s)

MANDRAKE has analysed 57 samples from across the ten boroughs, purported to be '**diazepam**', '**alprazolam**' or '**zopiclone**'. All the samples tested were tablets. In the case of the suspected **diazepam** products (n = 38), these were encountered as white (n = 2, 10 mg/tablet), blue (n = 13, 10 mg/tablet) or yellow (n = 23, 5 mg/tablet), circular tablets.

All 38 exhibits contained **diazepam** at levels consistent with their stated content(s), indicating that they had derived from diverted medical/pharmaceutical sources (i.e. not counterfeit).

Figure 5: *Potential alprazolam-containing 'street benzo' product seized and tested within Greater Manchester 2025/26. Source: MANDRAKE.*



In contrast, one yellow circular tablet (***Figure 5***) contained alprazolam at 2.1 mg/tablet, which is consistent with the stated content for these products, however the product does not resemble any legitimate product, suggesting it may be a counterfeit/'street benzo' product.

In the case of the suspected **zopiclone** products (n = 18), these were encountered as white circular tablets at stated contents of either 7.5 mg/tablet (n = 15) or 10 mg/tablet (n = 3), and contained **zopiclone** at levels consistent with their stated content(s), indicating again that these may be from diverted medical/pharmaceutical sources.

6.2.5.1 Identification of non-prescribed 'fake' prescription drugs

Several individuals who had purchased non prescribed **diazepam** and **pregabalin** described visual indicators as signalling a product's pharmaceutical il/legitimacy, including tablet size, atypical labelling, and the colour or overall appearance of the packaging.

> *"Proper pregabs are bigger; the snide ones are smaller, you can feel the difference".* (Bolton man, early 50s)

> *"Fake ones have markings like 'El Salvador' on them. They look real but they're not".* (Bolton man, early 30s)

> *"The packaging isn't right and if you look at them from the ones that I get prescribed, they are a lot brighter than what I get. So I can tell the difference straight away".* (Stockport woman, 40s)

6.2.6 Prescription Drug Related Overdose

High variability in content substantially increases the risk of overdose, particularly given the large quantities that participants reported consuming.

> *"Tablets are just as dangerous, you'll buy them on the black market like my partner. He'll spend £100 on the diazepam, and they haven't done anything to him – nothing! In the last two days he's taken 100 and they've done nothing to him. And he's done it for two pay days on the run and lost his money both times cos they are not even real. But that next strip could be a different batch and could kill you!"* (Stockport woman, 50s)

However, there appears to be a disconnect between MANDRAKE results and these user perceptions. As outlined above, this year's MANDRAKE analysis of prescription drugs suggests that most prescription drugs in use are coming through diverted medication routes.

Nevertheless, as we highlighted in the first GMTRENDS report in 2021, individuals dependent on *opioids*, who are taking

benzodiazepines and **pregabalin** are at an increased risk of death from overdose. In this year's research, we continued to receive regular reports of overdose and deaths linked to non-prescribed use of **pregabalin** and *benzodiazepines*.

> *"I bought some diazes online once, woke up in hospital bleeding from inside. Flatlined on the machine".* (Bolton man, early 50s)

While overdoses were often attributed to 'dodgy pills', most overdoses involved polysubstance use, often involving two or more respiratory depressants.

> *"I OD'd on Christmas Day, ambulance had to be called. It was after I took pregabs and diazes".* (Wigan man, early 50s)

> *"Not prescribed. Yeah. Me and my other half, my husband, we overdosed off them as well. We got arrested funnily enough, we got arrested for something, but if we wouldn't have got arrested for that, we'd have died. Do you know what I mean? They'd actually saved us. They [the police] came through the door, and we'd already gone. Do you know what I mean? We woke up like 16 hours later, literally. You know what I mean? We'd been out for hours and hours, If we wouldn't have been arrested, we'd have died.* **Interviewer: *How much had you taken?*** *About ten pregabs and then we had a dig of heroin".* (Tameside woman, late 30s)

As illustrated above and below, this also often involved the consumption of large amounts of these prescription drugs.

> *"I overdosed on pregabalin on the fake ones. . . October. Last year. [. . .] I had 16 and woke up 14 hours later like in hospital.* **Interviewer: *Had you taken anything else with them?*** *I'd used heroin at the time as well, but nothing more than I normally do".* (Tameside man, early 40s)

The combination of *benzodiazepines* or *z-drugs* with **heroin** or other opioids increases the effect and risk of overdose (Ray, et al., 2021). **Pregabalin** reinforces the effects of **heroin** and exacerbates **heroin**-induced respiratory depression by reversing **heroin** tolerance at low doses and directly depressed respiration at higher doses (Lyndon, et al., 2017).

Furthermore, one respondent suggested that using ***crack* cocaine** alongside **pregabalin** masks their effects, contributing to increased use that is potentially more dangerous and lethal.

> *"When you take crack, you can't feel the pregabs, so people keep taking more. That's what kills them".* (Bolton man, early 50s)

In addition to these personal accounts of overdose, many participants also associated deaths with **diazepam** and **pregabalin** purchased from shops and street markets. The risk of fatal overdose was often raised in interviews.

6.2.7 Prescription Drug Related Deaths

The concurrent use of **heroin** and/or any other depressant drug is the major risk for overdose death. In 2020, the Medicines and Healthcare products Regulatory Agency (MHRA) released a reminder of the risks of potentially fatal respiratory depression when *benzodiazepines* are co-prescribed with *opioids* (MHRA, 2020).

> **"Interviewer: *So why was it that you stopped taking them?*** *Because people were dying, do you know what I mean? It's not worth dying for, is it?"* (Tameside man, mid-30s)

> *"I know loads of people who have died from tablets mate, especially pregabs and diaze's, mixing 'em together! They take a load of 'em and they're not waking up in the morning mate – dead!"* (Salford woman 50s)

> *"I won't touch dodgy pregabs. My mate died off them a few years back".* (Bolton man, Mid 30s)

At the time of writing, the Advisory Council on the Misuse of Drugs (ACMD) is reviewing evidence on the misuse and associated harms of **pregabalin** and **gabapentin** (*gabapentinoids*) in the UK. The call for evidence closed in October 2025, and the submissions of evidence will support the ACMD in developing recommendations to government on how best to reduce the risks linked to the potential misuse of these substances.

7. TREATMENT ENGAGEMENT

7.1 Non-treatment population

In December 2025, the Department of Health and Social Care and the UK Health Security Agency estimated the total number of *opiate* and/or ***crack* cocaine** users (OCU) for 2022 to 2023 in England as 310,718. The highest percentage (17.4%) were in the North West (54,206), and the estimated rate per 1,000 population of OCU by substance is higher than the national average (OHID, 2025).

As illustrated in ***Table 2*** below, the number of people in treatment in Greater Manchester in 2024/25 for *opiates and crack cocaine* was 21,561 (OHID 2025).

As illustrated in ***Table 3***, unmet treatment need across Greater Manchester varies considerably by substance type and locality. For people using *both opiates and crack cocaine*, estimated unmet need ranges from 20.1% in Tameside to 50.5% in Bury. This rises markedly for *opiates only*, from 46.3% in Tameside to 66.5% in Stockport, and is highest among those using *crack cocaine only*, reaching 89.5% in Bury and remaining above 60% across all localities (DPSC, 2025).

In light of these high estimates of unmet need, this year's Street Drug Survey asked people who used **heroin** and ***crack* cocaine** whether they, or others they knew, were currently engaged in treatment. It was common for respondents to report that most, or almost all, of the people they knew who used **heroin**, ***crack* cocaine** and '***Spice***' were not currently engaged in treatment.

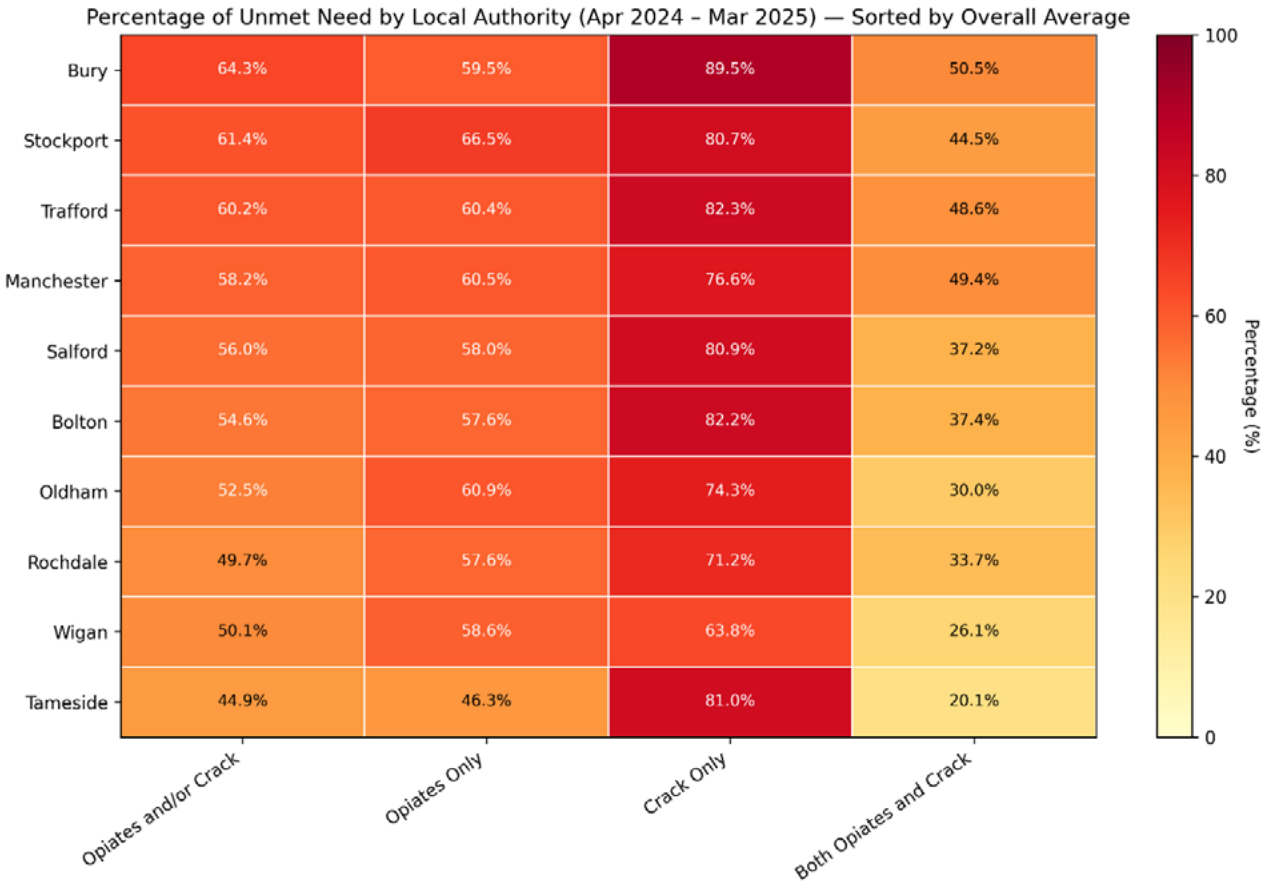
> **"Interviewer: *So the people you know that are also using crack and heroin, are many of them engaged in treatment?*** *Not really, it's very rare. . . I tell 'em me, 'get yourself on a script!'"* (Salford woman 50s)
>
> *"Most of them are out of treatment".* (Salford man, mid-30s)
>
> *"I know loads of people who are not in treatment".* (Stockport woman, 50s)
>
> **"Interviewer: *What about other people that you know and maybe use with, are they in treatment?"*** *No, most are out.* (Stockport man, 20s)
>
> **"Interviewer: *Do you know many people who are using drugs like heroin and crack that do not engage with services?"*** *Yes loads!* (Salford man, 40s)
>
> **"Interviewer: *Do you know anyone who is not engaged with treatment?*** *Yeah, yeah, all my friends apart from me! They just don't want to, they're just happy with the way their life is. Um, I don't know, it's not something you really ask your peers. It's just something if you're going to do, you go and do it. I mean I'm waiting to go to the rehab now but yeah, my friends are just happy with the life doing what they're doing.* **Interviewer: *So roughly, if you were to put a number on it, how many people would you know that are using but they're not engaged with treatment then?*** *Pretty much all of them. A number of people? 20.* **Interviewer: *And have they never been in treatment before?*** *Not that I know of!* "(Trafford man, 40s)
>
> *"Half of my mates are not [in treatment].* **Interviewer: *And they've never been in?*** *No. No. Never. I want to get them to come to the groups with me, and they go 'oh no [name], I'll do it next day, I'll do it next week.' so I've given up hope on them. I give up on them".* (Salford woman, late 50s)
>
> *"But they are not even on 'scripts, they've not got off their arse to get methadone scripts, nothing like that. They prefer to carry on begging, going that way".* (Stockport man, early 50s)

The following section outlines the reasons that people provided for why they or others do not engage with treatment.

Table 2 Greater Manchester Treatment Data 2024/25

Greater Manchester Area	Opiate users	Number of both opiate and Crack users	Number of Crack only users
Bolton	1,265	919	405
Bury	445	440	344
Manchester	2,250	2,660	1,007
Oldham	780	679	428
Rochdale	845	813	365
Salford	800	561	340
Stockport	680	656	336
Tameside	885	577	368
Trafford	355	319	164
Wigan	955	602	318
GM Total	**9,260**	**8,226**	**4,075**

Table 3 Estimated percentage of unmet need in Greater Manchester



7.2 Barriers to Treatment Engagement

Explanations were provided for why people were not accessing treatment. This section outlines general barriers to service engagement before examining barriers specific to treatment for **heroin** and ***crack* cocaine**. To protect confidentiality, the locality roles of professionals are not provided in this section.

7.2.1 Stigma

Stigma was frequently raised as a barrier to engaging with treatment, with several interviewees describing concerns about being seen entering or leaving drug and alcohol services.

> *"So, I think there's people out there who are scared to come in. I think a lot of people are like undercover they don't want people knowing, so for them to come down to a place like this. if somebody walks in here, they think 'druggie'. I'm not bothered me. I've not even been on it [heroin] that long me, only been on it a couple of years".* (Trafford man, mid-30s)

> **"Interviewer: *Why do you think people don't engage with treatment then?* *Its stigma innit. Stigma. Like with me, I didn't want to walk into this building and walk out of this building being seen by anyone that knows me, but I'm not arsed now. Everyone knows I'm in treatment. I'm bettering myself for me, that's what I'm doing it for. Theres a lot of stigma around drugs and drug users and drug use. If you're a drug user, you're a bad person. That's the way society looks at it nowadays. If you're a drug user, you're a bad person. It's hard to walk into a drug treatment centre and say, 'look I'm a user, I need help'".* (Salford man, late 30s)

Similar comments were made in relation to daily pick-up of methadone from chemists.

> **"Interviewer: *So you were saying about knowing a lot of people who won't go to treatment, they'd rather just get it [methadone] from somebody else. Why do you think that is?* *I know a couple of people who are like 'if people knew I was going to the chemist every day and drinking methadone they'd think I was a fucking . . .' you know, it's all about being noticed, if you know what I'm saying? It's like they don't want people to know. 'Oh, I've got to go to see the drugs team' like you are a druggie, a drug addict or an alcoholic, that's the shame, so they are buying tablets, keeping it stum, if they can't get the drug or they've no money.* **Interviewer: *So it's all about the stigma of it?*** *Yeah, yes it is, it is yeah, definitely".* (Salford man, 40s)

7.2.2 Pride

In addition to stigma, others discussed self-pride, viewing seeking help as a sign of weakness or failure.

> *"Many don't come to services because of stigma or pride, or they think getting on a script means failure".* (Wigan man, mid-40s)

> *"Some just prefer doing it their way".* (Rochdale man, early 40s)

Four interviewees recounted similar narratives of wanting to do it themselves. Having got themselves into dependency, they saw getting out of it as their own responsibility, without the support of treatment services.

> *"I didn't go into treatment or detox or anything like that. I just went away to my mum's in [city]. I didn't go to the doctors or nothing, it killed me, it really did. I was messing the bed, pooing, weeing the bed and all that. It took me about five weeks to start to feel normal.* **Interviewer: *I'm interested in why you didn't go to a drug service or a GP?*** *Because I got meself on it, I wanted to get meself off it.* [. . .] *It's me who got me into it so it's me who's got to get me off the drugs. Do you know what I mean?* **Interviewer: *Yeah, so have you been in treatment before?*** *No, no never, they all know who I am and all that. I could have gone to the doctors but I'm not going to a doctors or service whinging, 'I'm in pain, give me this, give me that.' I'm not like that".* (Stockport man, 50s)

In addition to pride and wanting to do it themselves, as we discuss further in section 6.2, their lack of service engagement was also driven by not wanting to replace one dependency (e.g. heroin) with another (e.g. prescribed drugs).

"And I didn't want to get myself onto other drugs, you know, tablets, methadone. You know what I mean, whatever they have, I'm not interested in all that. It was a mistake that I'd done to help get my head down, sleeping in doorways and all that". (Stockport man, 40s)

7.2.3 Readiness to change

Several interviewees attributed non-engagement with treatment among peers as being not ready for change.

"Some people aren't ready. You've got to want to change yourself, no one can tell you". (Wigan man, mid-50s)

"I think a lot of people just don't want to stop, they enjoy it, or they can't see a light at the end of the tunnel". (Rochdale man, late 40s)

It was also suggested that, for some individuals, engagement with services was driven by licence conditions rather than readiness or willingness to change.

"[The] Majority of people that come here don't want to get help. Like the other day, 'what's your reason for being here?' 'Probation'. Do you know what I mean? "(Salford man, late 30s)

7.2.4 Co-dependency

A couple of people also suggested that even when people are ready and want to engage, the co-dependency of partners, friends and acquaintances that they use drugs with can present barriers.

"Yeah, well you get people who are in relationships that can't, like might be domestic violence and that. And they can't get to a service because their partner won't let them and they're co-dependent on each other. You get a lot of co-dependency". (Salford man, mid-30s)

For some, fears of change and losing peer connections were identified as barriers to engaging with treatment.

"I mean it's sad because that's all they know and it's that being accepted, the fear of being rejected. So they stick to the same groups every day. It's all about the fear of change. That's what it comes down to. But a lot of us need that love and attention that we fight for, there's a lot out there that they probably do give a shit inside. But because they're used to this and their heads wired up on that level, they don't want to change, they're happy in doing what they're doing. Some of 'em are just hard to work with". (Oldham man, early 50s)

One professional with lived experience of **heroin** and other drug use described how peers within drug using networks may actively resist or obstruct attempts to stop.

"*In heroin circles they all talk about 'getting clean', it's just chat that goes round, round, round, round. 'Going to sort my shit out', and everyone just knows it's largely bollocks and it's not going to happen. One really tragic side of it, there's a lot of people in that scene that don't want to see people get clean because they'll lose a mate that they socialise and take drugs with and it'll make them feel more defeated because they can't get clean, if they see someone else get clean. They'll actively encourage someone who's trying to get clean. 'Oh I've got some great gear, just have a couple of lines it'll be right'.* (Professional Interviewee (1))

7.2.5 Waiting times

Delays in accessing treatment were frequently identified as an additional barrier, even when individuals were ready to engage. It was widely suggested that initial appointments should be offered on the same day, or at least within days rather than weeks.

"It's good services, but they need to move quicker. [. . .] some really need help there and then". (Bolton man, 50s)

Waiting weeks for appointments and treatment initiation was highlighted as missing a crucial window of opportunity for engagement.

". . . maybe takes two to four weeks [. . .] Sometimes people think it's an inconvenience waiting a few weeks to get a script". (Rochdale man, early 40s)

As discussed below, delays at this critical point of readiness could have fatal consequences.

"They don't help you there and then, they make you wait. You could be dead before the next appointment. It should be same-day service. People are crying for help right then, not weeks later". (Bolton man, early 50s)

In addition to highlighting barriers to engagement, several suggestions were offered to improve current levels of engagement. For professionals, this often centred on reducing waiting times and faster access to prescribing.

7.2.5.1 Faster access to treatment

The Department of Health and Social Care's 2024 updated recommendations for *opioid substitution treatment* in England state that rapid prescribing should be available, noting that: *"All appropriate patients in every locally-commissioned drug treatment system should have access to rapid prescribing, including on their first day in the service."* (DHSC, 2024). Despite this recommendation, we came across several professionals who were frustrated at the length of time it can take to access treatment.

> *". . . but when you're coming into structured treatment, because we're so big, we just don't have the money to have the staff to get them through the door. Being an ex-user, I find that annoying, to say the least. Literally, I see people all the time. I signpost them into treatment, and I want to get them done there and then. If someone makes a phone call and says like, you know, 'I'm up for it now, I'm ready'. You don't want them then to wait another month. Because while that month has gone by, they're still in that mindset. You jump whilst the irons hot don't ya?"* (Professional Interviewee (2))

> *"We have long waiting lists in the service . . . we should be picking up the assessment as the harm reduction team, so people aren't joining the queue because when people want help, they want it now. [. . .] So it's capitalising on that as well and getting them in quickly. [. . .] We've got to capitalise. One of the challenges that we need to work on as a service is getting our waiting list down".* (Professional Interviewee (3))

7.2.6 Attending appointments

The challenges and practicalities of attending appointments were also discussed.

> *"And you are fucking about with appointments, and when you come in, it's like an hour and when you're rattling that's horrible! Horrible!"* (Salford man, late 30s)

For some, a lack of daily structure and difficulties with day to day planning were key factors.

> *"I do like talking and all that, but I don't like going up there. Cos I don't like appointments, I don't think about what I'm gonna do at tea time! Tomorrow is another day, I don't think about what I did yesterday, that's already been and gone, you know what I mean?"* (Stockport man, 50s)

The need to secure drugs on a daily basis in order to feel well was widely reported as a barrier to attending services. This was often accompanied by the need to beg or engage in acquisitive crime to fund drug use, leaving individuals with limited time, stability, or capacity to prioritise service engagement.

> **"Interviewer: *Do you know people who are using, who aren't coming to any services?*** *Yeah.* **Interviewer: *So why do you reckon they don't want to come?*** *I just think it's people's mindset. It's laziness. I've done it myself. I've only been back in treatment myself for two months. You get into a routine of getting up every day and going out, making money and it takes up all your day [coming into treatment], so to miss a day to come here and do this. Then you'd miss a day making money and then you're going to be rough. So just to get here one day you could mess up a fucking few days. You know what I mean? "*(Tameside man, early 40s)

Professionals also noted that standard Monday to Friday, 9–5 opening hours presented barriers for individuals with more stable lifestyles, particularly those who were working.

> *"That barrier. If you're working, how are you going to get here on the 9 to 5 service if you've got a job? . . . fortnightly, we stay open until 7 [one night]. That's not regular though, is it? There's no 'come in on a Saturday', it's not that we're regularly open a little bit later for people. But they'd have the same issues with the chemist opening hours and things like that, and it's just a challenge for people.* ((Professional Interviewee (4))

7.2.6.1 Outreach

Although it was acknowledged that outreach is already provided, it was stated that there was a need for more frequent outreach.

> **"Interviewer: *What more do you feel needs to be done to make the treatment offer better?*** *More street work. More people on the streets. I know they do it now, but they need more. It's all good seeing them once a month. It needs to be more intensive, on them"*. ((Professional Interviewee (5))

Furthermore, this outreach needs to move beyond early morning, street-based patrols to throughout the day and more 'in-reach' in community settings and supported accommodation.

> **"Interviewer: *What more could be done to get ones who aren't in, in?*** *Suppose more outreach, but through the day. Because they only do the homeless outreach that's early in the morning yeah. But if they do daytime outreach that'd be better because not everyone's homeless. There's a lot that aren't homeless who've got houses, and still just struggle to get engaged with services".* (Salford man, mid-30s)

7.2.7 Assessment process

Several participants highlighted that the assessment process could act as a barrier for some individuals, particularly women, as it was often viewed as overly intrusive.

> *"No, it is just too much hassle with them. They get into too many questions and answering and stuff like that".* (Manchester woman, early 30s)

Among parents, concerns about potential social services involvement were identified as a further barrier to engagement.

> *"As much as you want to be totally 100% honest, so you can get the best out of it, I think sometimes there is that anxiety of telling everyone what is happening because what's going to happen? 'Are they going to get social workers involved?'"* (Professional Interviewee (2))

Participants also reported that the assessment process contributed to treatment engagement being experienced as bureaucratic, rather than personalised or person centred.

> *"The system's all box-ticking now, not personal like before"*. (Male Service User, 50s, Bolton)

Professionals also noted that for some people, especially those accessing services through criminal justice routes, engagement with treatment could feel controlling.

> *"A lot of people have been in prison or through the custodial system. That power can be really quite oppressive can't it? They just think, 'I don't want to be controlled anymore. I'm free, I'm out of custody. Let me live my life'. They don't need to come here . . . if they've got a perception of us being quite controlling or whatever. Or that we don't have anything to offer them".* (Professional Interviewee (3))

7.2.8 Support Offer: Group based interventions

Group based interventions were also discussed as a barrier to engagement, with several interviewees reporting that anxiety and other mental health difficulties made participation in group work particularly challenging.

> *"I don't really go to the groups. Bit of anxiety and mental health stuff puts me off sometimes".* (Rochdale man, late 40s)

> *"I ain't bothering with going up there [to the local treatment service] for support cos it's just group work and I don't like that kind of thing cos of my anxiety and all that".* (Stockport man, mid-50s)

> *"I was [in treatment] but I'm not now.* **Interviewer: *Can I ask why?*** *Cos I'm alright as I am now. On the crack.* **Interviewer: *But if you did want to try and come off the crack, would you engage with treatment again?*** *No, cos I don't want to attend the appointments and the groups. I can't be arsed with it! . . . I don't know what they would offer you for crack . . . put you in groups and all that and that's not me".* (Stockport woman, 50s)

This widely perceived limited treatment offer for ***crack* cocaine** is discussed further in section 7.2.11.

7.2.9 Heroin Substitution Options: Methadone dependency and withdrawal

Research has demonstrated that *opioid substitution treatment* (OST) is a protective factor against premature mortality (Sordo et al., 2017). However, many participants were reluctant to engage with OST services, as the treatment offer was widely perceived to be limited to **methadone**, which some felt would simply 'replace one drug addiction with another'.

Several participants with experience of **heroin** use described concerns about **methadone** prescribing, informed by what they had witnessed or heard regarding the challenges of withdrawal, as influencing their decision not to engage with treatment services.

> *"Yeah, I know lots of people that aren't on scripts.* **Interviewer: *Yeah, so why do you think that is?*** *Double habit! You get hooked on the script and people don't want that!"* (Salford man, late 30s)

> *"Because basically it, I didn't want to get another habit. Babysitting on methadone, subbies [Subutex] and all that. I've seen people on them and it's like, 'wow, I ain't going down that road!' I did the full rattle, come off it completely myself and then not got nothing to substitute. I've got nothing else to rattle . . . seeing people rattle off meth [shakes head]. So basically, all that, it's like, 'wow!', people say it's worse . . . that's what I've been told it's harder to get off the meth than it is the actual main drug itself. It's like . . . you see . . . go down towards the bottom of St. Peter Square, boom! big line [at city centre chemist for methadone pick-up]. Well, I'm not joining . . . I've never joined, you know what I mean? Because as much as it is a substitute for the heroin, I'd rather go through the cold sweats, hot sweats, rattle everything myself . . . find something to substitute the methadone".* (Manchester man, late 30s)

He discussed, how for him, this involved smoking '***Spice***' (see sections 2 and 5 for further discussion of the use of ***Spice*** to substitute **heroin**).

As the following treatment professional explains, the use of ***Spice*** as an alternative to *opioid substitution treatment* can remove several of the barriers to engagement identified in this section.

> *"I mean, to try and do things on your own can remove a lot of the barriers. It's easier to come by people on the streets who can help you with your withdrawal with the Spice and substitute them than try to get to appointments and jump through the hoops and stuff around turning up on time, being seen, then attending another appointment for your medical. It's having that control over people, isn't it? Being tied to the chemist . . ."* (Professional Interviewee (4))

As discussed below, **methadone** was frequently described by those with treatment experience as harder to come off than **heroin**.

> *"Methadone's harder to get off than gear. That puts people off going on scripts. [. . .] Methadone keeps you trapped. I've done cold turkey off it and it's horrendous".* (Bolton man, early 50s)

> *"I'm on 90ml of methadone now. People say it's harder to come off than heroin, and they're right. That's why some avoid it".* (Wigan man, early 50s)

> *"Yeah, it is hard coming of methadone yeah. Yeah. I've done it a couple of times. One time I was in Strangeways I was rattling for three-month coming off the methadone. This was like in 2001 before it was prescribed in Strangeways [HMP Manchester], I was still rattling like three months later and I was on like 70 mil then. I'm on 80 mil now. Yeah that was hard, like three months. Couldn't even eat".* (Salford man, late 50s)

Several participants stated that **buprenorphine** was a preferable option.

> *"Subbies are much easier. Go straight to Subutex instead of methadone if you can. Methadone just drags your withdrawal out forever".* (Wigan woman, mid-40s)

7.2.10 Daily methadone pick-up

Beyond concerns about methadone dependency, daily pharmacy pickup requirements were commonly cited as a barrier.

> *"Sick of going to the chemist every day".* (Bolton man, early 50s)

The National Institute for Health and Care Excellence (NICE) technology appraisal recommended that: *"People should take methadone or buprenorphine daily in the presence of their doctor, nurse or community pharmacist for at least the first three months of treatment and until they are able to continue their treatment correctly without supervision."* (NICE, TA114, 2007). However, updated Department of Health and Social Care guidance (DHSC, 2024) advises that when **buprenorphine** is prescribed, consideration should be given to providing unsupervised medication from treatment initiation, with up to seven days of oral **buprenorphine** available in appropriate circumstances.

Missing daily supervised collection was also reported to lead to disengagement from treatment.

> *"Erm, there's a few who fail. You know, they don't do the pick-up, and they drop out and then they're struggling then. So, like they go and getting money to fund that habit. It's like that three-day thing. If you don't pick up in three days you lose your treatment and then you've got to go back through it[11]. So, a few people drop out".* (Salford man, late 50s)

The restrictions that come with having to pick-up **methadone** every day from the chemist were reported by one interviewee to have restricted his ability to work.

> *"It's like me, I've worked all my life, so now it's about two years that I've not worked and it's killing me mate. I'm having to beg. I've been begging today; I've never begged before in my life. But I can't work, I have to go to the chemist every day for my pick-up. A lot of people are suffering with that cos they can't get a job".* (Salford man, 40s)

Eligibility for take home **methadone** typically requires consistent pharmacy attendance, negative tests for illicit substances, and a stable, safe, and secure environment in which to store medication. These criteria were described as particularly difficult to meet for individuals living more street-based lifestyles. As a result, the same interviewee suggested that some people who wanted access to **methadone** would prefer to obtain it informally from others rather than engage with the formal treatment system, including appointments and daily pharmacy pickup requirements.

> *"They buy it [methadone] off someone. They'd rather just buy it off somebody else".* (Salford man, 40s)

As highlighted earlier in this section, **buprenorphine** was preferred by some participants over **methadone**. In particular, many expressed a preference for ***Buvidal***, a long-acting **buprenorphine** injection. This is an increasingly used option, particularly for individuals at risk of diverting their prescriptions and/or who experience difficulties with daily adherence. Many stated that the requirement to attend appointments weekly, fortnightly, or monthly for injections was much more acceptable than the daily pharmacy attendance associated with methadone.

> *"Coming in once a month for an injection is much better than being tied to a chemist for life".* (Wigan woman, mid 40s)

> *"Methadone became too much like a safety blanket. The Buvidal injection's better, not having to go to the chemist daily makes a difference".* (Wigan man, mid 40s)

In contrast to self reported experiences of extended **methadone** dependence and difficulties in cessation, several participants spoke very positively about their experiences of *Buvidal.*

> *"It's the way forward, it really is! I've been an [heroin] addict for 39 years and I've stopped on it. I had it twice, I had two monthly's and that was it – stopped it! Like I say, I felt a bit icky, sickly, goosebumps and achey here and there but nothing I can't handle. Talk to any of them in here, they'd all tell you the same. Not in a million years would you think I'd stop using [heroin]!"* (Stockport woman, 50s)

11. Missed Doses ('3 Day Rule'): Missing 3 consecutive days of treatment requires a prescriber to review due to the rapid loss of opioid tolerance and subsequent overdose risk.

7.2.11 Limited Current Treatment Offer for Crack Cocaine

"Interviewer: Is there much support around crack? *No. There's nowt you can do for it, it's all mental. It's like smoking weed, you can't do nothing for it. There's nothing to stop you from smoking it, cause obviously you can say 'take this instead of smoking heroin'".* (Trafford man, mid-30s)

> *"You can't get any treatment for crack can you? It's just the psychosis[psychosocial] thing. They say it's in your head isn't it? It is right, but you don't get help, do you? I used to inject amphetamine, I never used to get any help. They just used to say, 'it's not an addiction, not physical. It's just mental'".* (Manchester man, 40s)

This perception is consistent with the findings of the 2019 Home Office and Public Health England inquiry into increased ***crack*** **cocaine** use, which reported ***crack*** **cocaine** users thought treatment services had nothing to offer them beyond psychosocial interventions. As stated below, it was common for people to report that most people entering treatment for their dependent drug use want some form of substitute prescribing.

> **"Interviewer:** ***So if people are just using crack, would they come into treatment services?*** *No, there's nothing! People want a substitute! Crack drives you mad, if you are a proper full-blown crack head, you can't function right but there is no substitute for it. All they can do is say 'don't do it, it's bad, don't do it!' You will get the odd person [who will come into treatment] but with stone [crack], there is never enough, it's never ending. [. . .] when stone gets people, it gets them bad, they just focus on that. It's taking all your time away and money, and there is never enough of it. Give me a stone now as big as this room and I'm gonna sit here and smoke it until one of two things happen. I'm gonna smoke it til it's gone or I'm gonna die!* **"** (Salford Man, late 30s)

As Harris et al. (2024) argue, people who smoke ***crack*** **cocaine** in England currently have little incentive to engage with harm reduction or drug treatment services, reflecting the limited and poorly aligned service offer available to them. The current limited offer for people who use ***crack*** **cocaine** was also noted by treatment professionals.

> *"We are sort of adapting our group sessions, our PSI offer. Because we can't really offer, unless somebody is wanting a detox from crack for example, which isn't common, we don't really have a lot to offer. We're seen as a detox or a script service really, aren't we? [. . .] If we can get people in and say 'we're so much more than just a prescription or a detox service. And we've got all these things, offers, we work with lots of different partners'. They're offered lots of things like employment support, moving on if they're coming to get their head in a good space. You know, you don't have to just come in, get on a script and stay with us for the rest of your life. That's not attractive to people, is it?"* (Professional Interviewee (2))

It was suggested that there was a need for some form of substitute prescribing for people who use ***crack*** **cocaine**.

> *"It is because there's no real regimen for getting them off it and getting them stable whereas with heroin there's a substitute. You know, you can put someone into safety in terms of withdrawals straight away. You can turn that heroin habit into just being stable, using Subutex, coming here once a month to see your worker and engaging in groups and go to places like Loaves and Fishes and places like that. So you can start to change your life. You might still be on opiates, which is still negative in a lot of ways, but nowhere near as much as trying to maintain a heroin addiction. Whereas with crack, the addictions a lot more ruthless. It's just a lot more complex I think because it's not addictive, but it is. You know, it's not physically addictive as such but the addiction although it's psychological is absolutely ruthless. It's harder to walk away from. If there was something, like if there was a Subutex for cocaine you know, that existed that somehow took away any of those cravings for crack, they'd be really getting somewhere. But I don't think there's anything like that and I don't think there's anything even in the pipeline, is there? That's the real difficulty".* ((Professional Interviewee (1))

Ongoing trials in the Netherlands (see Nuijten et al., 2016; Blanken et al., 2020) have reported that SR-dexamphetamine reduces cocaine use and may improve clinically relevant health-related outcomes in patients with crack cocaine dependence who are participating in heroin-assisted treatment for their co-morbid heroin dependence. However, current clinical guidelines in the UK do not recommend any substitute prescribing for **cocaine**.

8. RECOMMENDATIONS

This report has identified a need to strengthen harm reduction, treatment accessibility, and intelligence led responses to changing street drug markets across Greater Manchester. Key priorities include expanding access to effective *opioid substitution treatments*, responding to increased risks associated with *synthetic substances* and polydrug use, and reducing structural barriers to treatment engagement.

The headline findings from the Street Drug Survey were presented at a half-day stakeholder event, *GMTRENDS: From Research to Response*, held on 1 April 2026. The event was attended by over 50 stakeholders, including members of the Greater Manchester Drugs and Alcohol Transformation Board, drug and alcohol commissioners and service providers, community safety leads, Directors of Public Health, Department of Health and Social Care drugs and alcohol leads, and a wide range of frontline professionals. Two facilitated workshops focused on the co-production and prioritisation of recommendations arising from the survey findings. The recommendations co-produced through these workshops have directly informed and been incorporated into the recommendations set out below.

8.1 Heroin

Improving access to long-acting **buprenorphine** (e.g. *Buvidal*) and considering the introduction of *heroin assisted treatment* (HAT) for the most entrenched **heroin** users are central to reducing overdose risk and improving stability. These measures should be supported by enhanced out reached harm reduction, including widespread availability of **naloxone**, drug checking, and essential injecting and safer use equipment. Clearer public messaging is required to communicate the poor quality and variability of **heroin** and the growing presence of *synthetic opioids* in the local supply.

8.1.1 Increase access to long-acting **buprenorphine** (e.g. *Buvidal*) across Greater Manchester, ensuring consistent availability for people who would benefit from longer acting *opioid substitution treatment*.

8.1.2 Consider the introduction of *heroin assisted treatment* (HAT) for the most entrenched people who use **heroin**, particularly those experiencing repeat treatment failure and multiple harms.

8.1.3 Raise awareness of the current low purity and poor quality of **heroin**, drawing on MANDRAKE drug checking results. Targeted communications should highlight associated risks and encourage engagement with treatment and support services.

8.1.4 Expand access to drug checking and harm reduction equipment, including testing strip packs, ensuring these are accompanied by essential items such as distilled water, mixing equipment, and **naloxone**.

8.1.5 Ensure assertive outreach teams are equipped to distribute testing strips and **naloxone**, alongside tailored harm reduction advice for people who use **heroin**.

8.1.6 Maintain and further expand **naloxone** availability, particularly for people at heightened risk of overdose.

8.1.7 Increase awareness that *synthetic opioids* are present within the local drug supply, including **heroin** and other illicit and prescription

drugs, and communicate the heightened overdose risks this presents.

8.1.8 Prioritise MANDRAKE testing of **heroin** samples to improve intelligence on potency, adulterants, and the presence of *synthetic opioids*.

8.1.9 Respond to the reported increase in injecting **heroin**, particularly among people transitioning from smoking. Harm reduction messaging should foreground the increased risks associated with injecting, including when *synthetic opioids* are present.

8.1.10 Monitor the impact of prescribed *Buvidal* on ***crack* cocaine** use, with appropriate clinical responses.

8.1.11 Develop targeted ***crack* cocaine** support pathways for people receiving *opioid substitution treatment*.

8.2 Crack Cocaine

The report highlights the need for a strengthened and more coherent response to ***crack* cocaine**, including clearer treatment pathways, improved psychosocial support, reduced service caseloads, and consideration of evidence based harm reduction interventions such as safer inhalation provision.

8.2.1 Map and review current ***crack* cocaine** treatment provision across Greater Manchester and assess alignment with the existing evidence base.

8.2.2 Address high caseloads within services to ensure practitioners have adequate time to deliver meaningful psychosocial interventions.

8.2.3 Review whether NDTMS categorisation adequately captures patterns of ***crack* cocaine** use, including polysubstance use and episodic engagement.

8.2.4 Review and strengthen current service offers in response to the increasing number of people using ***crack* cocaine**.

8.2.5 Develop a clearer, structured ***crack* cocaine** treatment and harm reduction offer, including consideration of *Safer Inhalation Pipe Programmes* (SIPPs).

8.2.6 Support the ACMD call for evidence on amending Section 9A of the Misuse of Drugs Act to allow Drug and Alcohol Treatment services to provide safer inhalation pipes.

8.2.7 Improve awareness of adulterants found in street drugs and their potential health risks.

8.3 Crystal Methamphetamine

Continued monitoring of ***crystal* methamphetamine** and targeted responses to street-based use remain important, particularly in Manchester city centre.

8.3.1 Enhance monitoring of crystal methamphetamine, particularly within Manchester city centre and street-based communities, to identify emerging trends and associated harms.

8.4 Synthetic Cannabinoids ('Spice')

For *synthetic cannabinoids*, a coordinated harm reduction approach is recommended, with improved information sharing, ongoing monitoring of content and potency, and greater promotion of support services in high prevalence areas.

8.4.1 Develop a coordinated harm reduction response to the risks posed by synthetic cannabinoids, supported by improved intelligence sharing across services.

8.4.2 Ensure services actively promote support for people using synthetic cannabinoids, particularly in areas of high prevalence such as Manchester and Salford.

8.4.3 Continue ongoing monitoring of synthetic cannabinoid content, including changes in formulation and potency.

8.4.4 Strengthen harm reduction messaging to reflect the variability in strength and type of synthetic cannabinoid receptor agonists (SCRAs).

8.5 Prescription Drugs

Risks associated with *benzodiazepines* and **pregabalin**, especially when used alongside *opioids*, require increased awareness, improved prescribing oversight, enhanced drug testing, and stronger links between substance use treatment, physical health, and pain management services.

Benzodiazepines

8.5.1 Improve awareness of the content and variability of illicit *benzodiazepines*, including risks associated with unknown potency and adulterants.

8.5.2 Raise awareness of the heightened risks associated with combining *benzodiazepines* with other depressants, particularly **heroin**.

8.5.3 Prioritise drug checking and testing of *benzodiazepine* samples to improve early warning and harm reduction responses.

Pregabalin

8.5.4 Explore links between **pregabalin** use and drug related deaths through Greater Manchester Drug Related Death (DARD) panels.

8.5.5 Increase public and professional awareness of the risks associated with **pregabalin**, particularly when used alongside **heroin**, *benzodiazepines*, or other depressants.

8.5.6 Embed improved pain management and physical health assessments within substance use services to address underlying drivers of **pregabalin** use.

8.5.7 Review GP prescribing practices, with particular attention to repeat and longterm **pregabalin** prescriptions.

8.5.8 Prioritise testing of prescription medications appearing in the illicit drug market.

8.6 Treatment and Service Accessibility

Across the treatment system, there is a clear need for more flexible, accessible, and responsive service models. This includes expanding outreach and in-reach provision, streamlining assessment processes, enabling rapid access to prescribing, extending opening hours, and ensuring consistent availability of the full range of *opioid substitution* options. Consideration should also be given to unsupervised medication from initiation where clinically appropriate, the development of overdose prevention centres, and increasing local capacity for people who use drugs to submit samples to MANDRAKE to support early warning and surveillance.

8.6.1 Expand outreach and in-reach provision to address barriers related to stigma, appointment attendance, and conventional Monday–Friday, 9–5 service models.

8.6.2 Review and streamline assessment processes to reduce bureaucracy and delays in accessing support.

8.6.3 Improve rapid access to treatment, including same-day or expedited prescribing where clinically appropriate.

8.6.4 Increase flexibility of opening hours and appointment models, including drop-in and extended hours provision.

8.6.5 Ensure consistent access to the full range of *opioid substitution treatment* (OST) options, with clear communication to service users.

8.6.6 Consider the use of unsupervised medication from treatment initiation, where clinically safe and appropriate.

8.6.7 Ensure equitable access to long-acting **buprenorphine** (e.g. *Buvidal*) across all Greater Manchester localities.

8.6.8 Progress the development of overdose prevention centres, informed by local need and evidence.

8.6.9 Increase capacity to submit drug samples to MANDRAKE, strengthening local surveillance and early warning systems.

Collectively, these recommended actions would support a more adaptive, evidence based response to drug related harms and improve engagement, retention, and outcomes within treatment services across Greater Manchester.

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