Statistics on Drug Misuse: England, 2010
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Executive summary

This annual statistical report presents a range of information on drug misuse amongst both adults and children. It also includes a focus on young adults. The report is primarily concerned with the use of illicit drugs. The term ‘illicit drugs’ is used to describe those drugs that are controlled under the Misuse of Drugs Act 1971. The topics covered include:

- Prevalence of drug misuse, including the types of drugs used;
- Trends in drug misuse over recent years;
- Patterns of drug misuse among different groups of the population; and
- Health outcomes related to drug misuse including hospital admissions, drug treatment and numbers of deaths.

This bulletin also summarises Government plans and targets in this area, as well as providing sources of further information and links to relevant documents.


Chapter 3: Outcomes of drug misuse presents a range of information about the health risks associated with drug misuse including hospital admissions, treatment, drugs harm index, and drug related deaths. Figures presented in Chapter 3 have been obtained from a number of sources and presented in a user-friendly format. Most of the data contained in the chapter have been published previously by the Home Office, Office for National Statistics or the National Treatment Agency for Substance Misuse. Previously unpublished figures on drug-related admissions to hospital are presented using data from The NHS Information Centre’s Hospital Episode Statistics.

Footnote:
Main findings:

Drug misuse among adults (16 - 59 years)

In England and Wales:

- In 2009/10, 8.6% of adults had used one or more illicit drug within the last year, compared with 10.1% in 2008/09. Over the longer term this shows an overall decrease from 11.1% in 1996.
- In 2009/10, 3.1% of adults had used Class A drugs in the last year, compared with 3.7% in 2008/09. Over the longer term this also shows an increase from 2.7% in 1996.
- Consistent with previous findings, cannabis is the type of drug most likely to be used by adults; 6.6% of 16-59 year olds used cannabis in the last year in 2009/10, compared with 7.9% in 2008/09.

Drug misuse among young adults (16 – 24 years)

In England and Wales:

- In 2009/10, 20.0% of young adults had used one or more illicit drug in the last year, which shows a decrease compared with 2008/09 when the figure was 22.6%. This shows a long term decrease from 1996 when it was 29.7%.
- In 2009/10 7.3% of young adults had used Class A drugs in the last year, compared with 8.1% in 2008/09. Over the long term, Class A drug use among young people has stabilised since 1996.
- Cannabis remains the drug most likely to be used by young people however its use in the last year has decreased; 16.1% of respondents aged 16-24 had used cannabis in the last year in 2009/10 compared with 18.7% in 2008/09.

Drug misuse among children (11 - 15 years)

In England:

- There has been an overall decrease in drug use reported by 11- 15 year olds since 2001. The prevalence of having ever used drugs fell from 29% in 2001 to 22% in 2009 although the figure remains unchanged since 2008.
- There were also decreases in the proportion of pupils who reported taking drugs in the last year; from 20% in 2001 to 15% in 2009 although this figure remains unchanged since 2008.
- Reported drug use was more common among older pupils; for example, 5% of 11 year olds said they had used drugs in the last year, compared with 30% of 15 year olds in 2009.
- Cannabis was the most widely used drug in 2009; 8.9% of pupils reported taking it in the last year, a long term decrease from 13.4% in 2001.
- Pupils who had truanted or been excluded from school were more likely to report taking drugs at least once a month than those who had not truanted or been excluded (14% and 1% respectively) in 2009. Although the percentage of vulnerable pupils taking drugs at least once a month has fallen from 21% in 2003 the figure has risen three percentage points from the 11% reported in 2008.
There was an overall decrease in the proportion of pupils being offered drugs from 42% in 2001 to 33% in 2009. Cannabis was the most commonly offered drug followed by volatile substances and poppers.

Boys were more likely to have been offered drugs than girls, with 35% of boys having been offered them compared with 31% of girls.

Health outcomes

Individuals who take illicit drugs face potential health risks, as the drugs are not controlled or supervised by medical professionals. As well as health risks, drugs can become addictive and lead to long term damage to the body. Illicit drug users are also at risk of being poisoned by drugs and overdosing which can lead to a fatality.

In England (unless otherwise stated):

- In 2009/10, there were 5,809 admissions to hospital with a primary diagnosis of a drug-related mental health and behavioural disorder. This number is 2.5% more than in 2008/09 when there were 5,668 admissions. There were more male than female admissions (4,184 and 1,618 respectively).

- Where primary or secondary diagnosis was recorded there were 44,585 admissions for a drug-related mental health and behavioural disorder in 2009/10 compared with 42,170 in 2008/09, which shows an increase of 5.7%. There were more male than female admissions in 2009/10 (29,730 and 14,848 respectively).

- Where a primary diagnosis of poisoning by drugs was recorded, 11,618 admissions were reported during 2009/10. This number is 4.8% more than in 2008/09 when there were 11,090 admissions, and 51.0% more than in 1999/2000 when the number of such admissions was 7,695. There were more male than female admissions (6,139 and 5,478 respectively).

- The 16-24 age group reported the highest number of admissions (2,880) with a primary diagnosis of poisoning by drugs in 2009/10 with those aged 25-34 reporting slightly less (2,734).

- The Strategic Health Authorities (SHAs) with the most admissions for drug related mental health and behaviour disorders as the primary or secondary diagnosis were North West SHA (168 admissions per 100,000 population) and Yorkshire and The Humber SHA (105 admissions per 100,000 population). The SHA with the lowest was South Central (41 admissions per 100,000 population).

- During 2009/10, there were 206,889 people in contact with structured drug treatment services (those aged 18 and over). This is a 0.5% decrease from 2008/09, where the number was 207,580.

- In 2009/10, a larger number of men accessed treatment services than women (151,351 men compared to 55,538 women aged 18 or over).

- Those taking opiates only (which includes heroin) was the main type of drug for which people received treatment (50% of all treatments), with a further 31% of treatments for those who have taken both opiates and crack in 2009/10.

- There were 62,685 discharged episodes of treatment for drug dependency during 2009/10. 23,680 (38 per cent) of these were for those no longer dependent on the substances that brought them in; a further 9,352 (15 per cent) were referred on for
further interventions outside of community-structured treatment. The remaining 29,653 either dropped out of treatment or were discharged for other reasons.

- The total number of deaths related to drug misuse in England and Wales was 1,738 in 2008; 78% of those who died were male. The most popular underlying cause of death was from accidental poisoning for both males and females (597 and 166 respectively).
Introduction

This report presents a range of information on drug misuse among both adults and children, which has been drawn together from a variety of sources. The information relates to England only where possible however some information is provided at England & Wales or Great Britain level.

The report is primarily concerned with the use of illicit drugs. The term ‘illicit drugs’ is used to describe those drugs that are controlled under the Misuse of Drugs Act 1971. This legislation regulates controlled drugs and divides the drugs into three classes, depending on the harm they cause. For example, Class A drugs cause the most harm and include cocaine, ecstasy, heroin and Lysergic acid diethylamide (LSD); Class B includes amphetamines and cannabis; and Class C includes tranquillisers and Gammahydroxybutrate (GHB). Under the Act there are various offences, including the unlawful possession of a controlled substance. Each source included in this report may monitor the use of illicit drug use using a slightly different selection of drugs, and may name or group them differently. Relevant details are provided in the associated chapter and/ or Appendix A.

This report includes information that relate to a number of targets that were in place over the period - many of these relate to targets/policies set by the previous government.

The new coalition government has, in December 2010, released a high level drugs strategy entitled ‘Reducing demand, restricting supply, building recovery: supporting people to live a drug-free life’. The strategy was based around recovery and aims to put more responsibility on individuals to seek help and overcome dependency; places emphasis on providing a more holistic approach, by addressing other issues in addition to treatment to support people dependent on drugs or alcohol, such as offending, employment and housing; aims to reduce demand; takes an uncompromising approach to crack down on those involved in the drug supply both at home and abroad and puts power and accountability in the hands of local communities to tackle drugs and the harms they cause.

In October 2007 the then government published a Public Service Agreement (PSA), PSA Delivery Agreement 25: Reduce the harm caused by alcohol and drugs. This aimed to reduce the harm caused by drugs and alcohol, to the community, to the health and well-being of those who use drugs and to the health and well-being of young people and families. Several indicators were developed to monitor progress including; increasing the number of drug users in effective treatment, reducing the rate of drug-related offending and perceptions of drug use being a problem to society.

A related PSA also introduced by the then government, PSA Delivery Agreement 14: Increase the number of children and young people on the path to success, October 2007, contained an indicator to reduce the proportion of young people frequently using illicit drugs, alcohol or volatile substances.

The 2008-2018 Drug Strategy introduced by The Home Office aims to reduce the harm that drugs cause to society, to communities, individuals and their families and comprises four strands of work:

- protecting communities through tackling drug supply, drug-related crime and anti-social behaviour
- preventing harm to children, young people and families affected by drug misuse
• delivering new approaches to drug treatment and social re-integration

• public information campaigns, communications and community engagement

Further previous government strategies in this area, including the 2002 Updated Drug Strategy⁶, have also focused on reducing the harm caused by illegal drug use and in particular had the aim to 'reduce the use of Class A drugs and the frequent use of any illicit drug by all young people under the age of 25, especially by the most vulnerable groups'.

Chapter 1 of this publication reports on the prevalence of drug misuse among adults, associated trends over time, and highlights the types of drugs most commonly used. Relationships between drug use and socio-demographic and lifestyles factors are also explored. This chapter also highlights drug use among young adults (those aged 16 to 24).

Chapter 2 focuses on the prevalence of drug misuse among children and again, explores the relationships between drug use and various socio-demographic factors. As well as presenting overall prevalence figures, this chapter also informs about behaviour, knowledge and attitudes towards drug taking among children using information from the 2009 Smoking, Drinking and Drug Use Survey, whilst also showing the number of young people (under-18s) receiving treatment for substance misuse using information from the 2008/09 Substance Misuse Report by the National Treatment Association and the prevalence of drug taking by children in years 8 and 10 at school, taken from the TellUs4 National Report.

Chapter 3 focuses on various health outcomes related with drug misuse. Data is included on drug related hospital admissions, drug treatment, the Drugs Harm Index and drug related deaths.

Throughout the report, references to sources for further information are given. The report also contains six appendices. Appendix A explains the key sources used while Appendix B describes the relevant Government’s targets and plans. Appendix C provides information on the use of logistic regression models in Chapters 1 and 2. Appendix D contains the editorial notes. Appendix E gives sources of further information and useful contacts. Appendix F provides a drugs glossary of the various illicit drugs mentioned in this report.

References


3. PSA Delivery Agreement 25: Reduce the harm caused by Alcohol and Drugs. HM Government, 2007: Available at: www.hm-treasury.gov.uk/media/B/1/pbr_csr07_psa25.pdf

4. PSA Delivery Agreement 14: Increase the number of children and young people on the path to success. HM Government, 2007. Available at: www.hm-treasury.gov.uk/media/1/1/pbr_csr07_psa14.pdf


1 Drug misuse among adults

1.1 Introduction

This chapter presents information on the prevalence of drug misuse among adults. A range of drug misuse information covering the general population (16-59 year olds), young adults (16-24 year olds), demographics and polydrug use are presented along with information on drug use among vulnerable groups.

The main data source used in this chapter is the British Crime Survey (BCS) publication: Drug Misuse Declared: Findings from the 2009/10 British Crime survey published by the Home Office 2010. This particular publication of Drug Misuse Declared covers information for England and Wales. Since 1996 the BCS has included a comparable self-completion module of questions on illicit drug use. The BCS report examines the prevalence and trends of illicit drug use among 16-59 year olds since 1996. This report also has a particular focus on young adults aged 16-24. More specifically, the survey asked respondents about drug use as defined by the The Misuse of Drugs Act and also examines the prevalence of illicit drug use. Key trends in the use of different drugs and the number of drug users were estimated. There are three separate measures in the survey based on ever having used drugs, drug use in the last year (year prior to interview) and use in the last month (month prior to the interview). The BCS report also provides detailed information from the latest year and includes some trend data.

A further source of information used in this chapter is Adult Psychiatric Morbidity in England, 2007: results of a household survey (APMS) published by the NHS Information Centre 2009, which presents information on drug use among adults aged 16 and over in England. The main focus of this survey was to collect data on mental health among adults living in private households in England. One area of the survey was to collect data on the prevalence of drug misuse and dependence, with the data collected by a self-completion questionnaire. The APMS uses the World Health Organisation definition of drug misuse which is the use of a substance for purposes not consistent with legal or medical guidelines.

The new coalition Government, elected in May 2010, has recently published a high level drug strategy entitled ‘Reducing demand, restricting supply, building recovery: supporting people to live a drug-free life’. The targets below were set by the previous Government but have been included as they were relevant at the time the data was collected.

In 2007 the then government published a Public Service Agreement (PSA), PSA delivery Agreement 25: reduce the harm caused by alcohol and drugs, October 2007. This aimed to reduce the harm caused by alcohol and drugs and to the health and well-being of young people and families. Several indicators have been developed to monitor progress including: increasing the number of drug users in effective treatment; reducing the rate of drug-related offending; and perceptions of drug use being a problem in society.

A related agreement published by the then government, PSA delivery Agreement 14: Increase the number of children and young people on the path to success, October 2007, contained an indicator to reduce the proportion of young people frequently using illicit drugs, alcohol or volatile substances.

Previous government strategies in this area, including the 2002 Updated Drug Strategy, have also focused on reducing the harm caused by illegal drug use and in particular had the aim to ‘reduce the use of Class A drugs and the frequent use of any illicit drug by all young people under the age of 25, especially by the most vulnerable groups’. Class A drug use among young people in the 16 to 24 age group is presented in this chapter using information from the BCS while Chapter 3 uses the Smoking, drinking and drug use survey to present findings for those aged 11 to 15.
The BCS asks respondents about various drugs as defined by *The Misuse of Drugs Act*. The Misuse of Drugs Act classifies drugs into three categories (Class A, B and C) according to the harm that they cause. Class A drugs are considered to be the most harmful. Appendix A describes the drugs respondents were asked about as part of the BCS and their classifications under the Misuse of Drugs Act.

**1.2 Drug misuse among adults**

This section looks at the reported use of illicit drugs among adults aged 16-59 and identifies key trends since 1996. It identifies the extent of drug use in 2009/10 and which drugs are most commonly used. Comparisons are also made across regions and between England and Wales, and Scotland.

**1.2.1 Prevalence of drug misuse**

Chapter 2 of the BCS report on pages 5 to 27 shows the prevalence of illicit drug use in adults aged 16-59 in 2009/10. The prevalence of ever having taken illicit drugs has increased from 30.5% in 1996 to 36.4% in 2009/10. Drug use in the last year and drug use in the last month have both decreased since 1996, drug use in the last year has decreased from 11.1% in 1996 to 8.6% in 2009/10 and drug use in the last month has decreased from 6.7% to 5.0% over the same period. Figure 2.1 on page 7 shows the estimated numbers of 16 to 59 year olds reporting ever using drugs, drug use in the last year and the last month.

Fifteen per cent of adults aged 16-59 have ever taken Class A drugs. Whilst, Class A drug use in the last year was lower in 2009/10 (3.1%) than in 2008/09 (3.7%), levels of last year Class A use are now at similar levels to 1996 (2.7%). Class A drug use in the last month was 1.4% in 2009/10.

As in previous years, cannabis was the most commonly used type of drug in the last year (6.6%), followed by powder cocaine (2.4%). Of the individual types of drugs asked about in the BCS, there were decreases in the last year use of powder cocaine, amphetamines, cannabis, tranquillisers and amyl nitrite between 2008/09 and 2009/10; levels of last year usage remained at similar levels for the other types of drugs. (Chapter 2, on pages 6 to 11 and Tables 2.1 to 2.4 on pages 17 to 20 of the BCS report)

**1.2.2 Frequency of drug taking**

For the first time in 2009/10 questions on frequency of drug taking were asked of all adults aged 16-59 in the BCS. Frequent drug use is defined as using any illicit drug more than once a month on average during the last year.

Estimates from the BCS 2009/10 show that 3.3% of adults were defined as frequent drug users in the last year. That is around two in five of all last year drug users (41%).

Cannabis was the drug most frequently taken in the last year; almost half of 16-59 year old cannabis users (45%) took the drug more than once a month during the last year. (Section 2.6 on page 14 and Tables 2.2 on page 18 and 2.5 on page 21 of the BCS)

**1.2.3 Age and gender**

Men reported higher levels of drug use than women. For example, in 2009/10, last year use of any illicit drugs among men (11.9%) was around twice as high as that for women (5.4%). There has been a decrease in the level of last year use among both men and women since 1996, prevalence in men fell from 13.6% in 1996 to 11.9% and in women from 8.6% to 5.4% (further details are available in Section 3.4 on pages 32 to 33 of the BCS).

Detailed information on illicit drug use by age is presented on pages 30 to 32 of the BCS. Last year illicit drug use was highest among adults aged 16-19 (22.3%). Levels of illicit drug use then decreased with increasing age, from 18.1% of those ages 20-24 to 1.5% of 55-59 year olds. (Figure 3.1 on page 30 of the BCS and Table 3.1 on page 40)
Levels of use of any illicit drug use in the last year fell between 1996 and 2009/10 (from 11.1% to 8.6%); most of these falls in drug use have occurred in the youngest age groups (16-29 year olds) where use is highest. For example, around one in three (31.6%) of 16-19 year olds used an illicit drug in the last year in 1996 compared with around one in five (22.3%) in 2009/10. (Figure 3.2 on page 31 of BCS).

1.2.4 Other demographic characteristics

The BCS collects information on the personal, household and area characteristics and lifestyles factors of respondents, which can be used to explore variations in drug use (for full details see Section 3.5 on pages 33 to 39 and Tables 3.1, 3.2, 3.5 and 3.10 on pages 40 to 49 of the BCS).

Single adults were more likely to have taken any drugs or any Class A drug in the last year; for example last year Class A drug use was higher for single adults (6.4%) compared with either co-habiting (4.4%) or married adults (0.8%).

In the 2009/10 BCS, adults from a White ethnic group (9.0%) generally had higher levels of any drug use than those from non-White background (5.8%). (Table 3.1 on page 40 of the BCS)

Adults living in a household in the lowest income group (£10,000 or less) had the highest levels of any last year drug use (12.4%) and last year Class A drug use (4.0%) compared with all other income groups (for example, compared with 7.1% and 2.9% respectively of adults living in a household with an income of £50,000 or more). (Table 3.2 on page 41 of the BCS)

1.2.5 Prevalence by region

Table 3.2 on page 41 of the BCS presents information on drug use in the last year by Government Office Region (GOR), in 2009/10.

Prevalence of last year use of specific illicit drugs by GOR is presented in Table 3.10 on page 49 of the BCS.

1.2.6 Polydrug and polysubstance use

Chapter 4 of the BCS presents information on polysubstance and polydrug use. Polydrug use is defined as two or more illicit drugs being taken in the last year. Polysubstance use is defined as having taken two or more types of illicit drugs or at least one illicit drug and alcohol in the last year.

Among adults aged 16-59 the prevalence of polydrug use in the last year was 3.3% and the estimate of polysubstance use was 8.1%.

Cannabis was the drug most commonly used by last year polydrug users (83% had taken it in the last year). Powder cocaine was the next most commonly used drug among polydrug users (65%), with 46% taking ecstasy and 26% taking amphetamines in the last year. (Chapter 4 on pages 51 to 64 of the BCS)

1.2.7 Prevalence of drug dependence

The Adult Psychiatric Morbidity in England Survey (APMS) 2007 report presents information on drug misuse and dependency in England; where drug dependency is defined as a cluster of behavioural, cognitive, and physiological phenomena, such as a sense of need or dependence, impaired capacity to control substance-taking behaviour and persistent use despite evidence of harm. Chapter 10 on pages 175 to 197 of the APMS report gives full details of the drug information collected and includes details of the methods used to assess drug dependence in the respondents.

Respondents to the 2007 APMS reported similar prevalence of drug misuse as reported within the BCS, with 9.2% of adults reporting they had taken illicit drugs in the last year. Drug use was higher among men than women with 29.9% of men and 21.8% of women having taken an illicit drug at least once, and drug use was more common in young adults.
and decreased with age. (Section 10.3.1 and Figure 10A on pages 178 to 179 of the APMS)

The prevalence of drug dependence in 2007 was 3.4% (4.5% of men and 2.3% of women). Most dependence was on cannabis only (2.5%), rather than on other drugs (0.9%). Symptoms of drug dependence were most commonly reported by adults aged between 16 and 24 (13.3% of men and 7.0% of women in this age group).

The prevalence of drug dependence varied with ethnicity. In men, Black men were most likely (12.4%) and South Asian men were least likely (1.5%) to report symptoms of dependence. In women dependence ranged from 0.2% of South Asian women to 4.8% of Black women. (Section 10.3.5; Figure 10D on page 181 and Table 10.7 on page 192 of the APMS)

Drug dependence was also related to household income. In men, the prevalence of drug dependence increased as equivalised household income decreased, ranging from 2.1% of those in the highest income quintile to 9.6% of those in the lowest quintile. A similar pattern was seen in women though the highest prevalence of drug dependence was found in the second lowest income quintile (4.6%). Only 0.1% of women in the highest income quintile were assessed as drug dependent. (Section 10.3.5; Figure 10E on page 182 and Table 10.9 on page 194 of the APMS)

1.2.8 National comparisons of drug misuse

Information on drug misuse in Scotland are presented in the 2008-09 Scottish Crime and Justice Survey, Drug Use (SCJS). This survey of drug use is representative of all adults aged 16 and over living in private households in Scotland. Where comparisons are made between Scotland and England and Wales, the SCJS data have been filtered to only include adults aged 16-59. Comparisons are made between the SCJS 2008/09 and the BCS 2008/09.

Illicit drug use ever among 16-59 year olds was lower in Scotland (33.5%) than in England and Wales (36.8%). Whereas, estimates of illicit drug use in the last year and last month were similar in Scotland to those in England and Wales. In England and Wales, 10.1% of 16-59 year olds reported having taken drugs in the last year and 5.9% said they had in the last month compared with 10.3% and 6.0% respectively in Scotland (page 19 of the SCJS).

Information on drug misuse prevalence in Northern Ireland is available from the Statistics from the Northern Ireland Drug Misuse database: 1 April 2009 – 31 March 2010.

European comparisons of drug use are published by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), with the most recent data available in: EMCDDA 2009 Annual report on the state of the drugs problem in Europe.

1.3 Drug misuse among young adults (aged 16-24)

This section explores drug misuse among young adults, including information on frequent drug use. Also included in this part of the chapter is information on those young adults in vulnerable groups.

1.3.1 Prevalence of drug misuse

The 2009/10 BCS estimates that 40.7% of young adults aged 16-24 have ever used illicit drugs. One in five young people have used one or more illicit drug in the last year (20.0%) and around one in nine have used drugs in the last month (11.6%). Use of illicit drugs in the last year has decreased since 1996 (29.7%) and since 2008/09 (22.6%), this decrease is largely due to the slow decline in cannabis use throughout most of the decade.

The use of Class A drugs was less common with 16.4% of young adults having ever used a Class A drug, 7.3% had done so in the last
year and 3.7% in the last month. The use of Class A drugs has remained at similar levels since 1996 when it was 9.2%. (Section 2.5; Figure 2.6 on pages 11 and 12 and Tables 2.6 to 2.9 on pages 22 to 25 of the BCS)

Information on trends in drug use by individual types of drugs are presented on pages 13 and 14 on the BCS and in Figure 2.7.

1.3.2 Frequency of drug use

Questions on the frequency of drug use in the last year have been included in the BCS for 16-24 year olds since 2002/03. Frequent drug use is defined as using an illicit drug more than once a month on average during the last year.

Estimates from the BCS show that frequent drug use among 16-24 year olds is more than twice as high (7.3%) as for 16-59 year olds (3.3%). There has been a decrease in frequent drug use in young adults since 2002/03 (11.6%).

Cannabis continues to be the drug most likely to be frequently used by young adults; 43% of cannabis users frequently used the drug in the last year. (Section 2.6; Figure 2.8 on page 14 and Tables 2.7 on page 23 and 2.10 on page 26)

1.3.3 Vulnerable groups

The 2005/06 BCS presents information on illicit drug taking in vulnerable groups, where respondents aged 16-24 were asked if they had ever truanted (skipped school without permission for a whole day) or been excluded from school. In 2005/06, the survey results showed that the prevalence of illicit drug use in the last year was more than twice as high among truants (39.8%) compared with non-truants (17.6%). (Chapter 6 on pages 39 to 43 of the BCS 2005/06)

The Home Office report Drug use among vulnerable groups of young people: findings from the 2003 Crime and Justice Survey reports on drug use among vulnerable young people aged 10 to 24. It identifies vulnerable groups as those who have ever been in care, those who have ever been homeless, truants, those excluded from school and serious or frequent offenders. In 2003, while those in vulnerable groups represented 28% of the young people sampled, they accounted for 50% of any drug and 61% of Class A drug users in the year prior to interview.

1.4 Estimating problem drug users

While the surveys described in this chapter are an important source of information on the prevalence of drug use, it is difficult to get a complete picture of problem drug use from any one source. The 2006 Home Office report Measuring different aspects of problem drug use: methodological developments describes how problem drug use can be estimated. This study provides a robust national estimate precise enough to allow monitoring over time. Four sources of data are used from which problem drug users (defined as those who use opiates and/or crack cocaine) can be identified. These sources of data are drug treatment, probation, police and prison data. Using these techniques it was estimated that there were 327,466 problem drug users in England, in 2004/05.

References


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2 Drug misuse among children

2.1 Introduction

This chapter presents key information about illicit drug use among young people, taken from four sources. The main source of the information is the *Smoking, Drinking and Drug use among Young People in England in 2009*¹, covering the period September to December 2009 (SDD09) for secondary school children in school years 7 to 11, mostly aged between 11 and 15. The SDD09 is the most recent survey in an annual series that began in 1982. Each survey since 1998 has included a core section of questions on smoking, drinking and drug use and since 2000, the remainder of the questionnaire has focused in alternate years on smoking and drinking or drug taking. The focus of the 2009 survey was drug use. The type of drugs asked about in the survey includes those as defined by The Misuse of Drugs Act².

The *Smoking, drinking and drug use among young people in England – Findings by region, 2006 to 2008*³ uses a two-stage probability sample designed to be representative of young people aged between 11 to 15 years of age. The report provides key findings by Government Office Region (GOR) based on data from 3 survey years (2006, 2007 and 2008) for the Smoking, drinking and drug use among young people in England survey, combined and weighted to be regionally representative.

The *Substance misuse among young people report – the data 2008/09*⁴ by the NHS National Treatment Agency for Substance Misuse includes children under the age of 18 that have accessed specialist substance misuse services in England during 2008/09. This report is the 3rd annual report produced by the NHS National Treatment Agency. The NHS National Treatment Association (NTA) started to collect Young Persons (under 18 years of age) data from 2005/06. Between 2005/06 and 2006/07, NTA main statistical reports on adult drug treatment, included some young people’s figures. The NTA published stand alone data on specialist under-18’s substance misuse interventions for the first time in January 2009. The publication of *Getting to Grips with substance misuse treatment*⁵ which reported on activity in 2007/08 coincided with the first year that NTA took full responsibility for providing targeted support and treatment to under-18s with substance misuse problems.

The *TellUs4 National Report*⁶ which represents young people in school years 6, 8 and 10 (drugs section only covers years 8 and 10) covering the period 5th of October to the 20th of November 2009 and is delivered online. The TellUs4 National Report represents the views of 253,755 children and young people in school years 6, 8 and 10 in 3,699 schools.

The new coalition Government, elected in May 2010, has recently published a high level drug strategy entitled ‘Reducing demand, restricting supply, building recovery: supporting people to live a drug-free life’. The targets below were set by the previous Government but have been included as they were relevant at the time the data was collected.

In 2009 the then government published a Public Service Agreement (PSA) with the aim of reducing the harm caused by alcohol and drugs, *PSA Delivery Agreement 25: Reduce the harm caused by alcohol and...*
The aims and indicators associated with this agreement are described in Chapter 2 of the PSA. A related agreement, PSA Delivery Agreement 14: Increase the number of children and young people on the path to success, October 2007, contained an indicator to reduce the proportion of young people frequently using illicit drugs, alcohol or volatile substances.

Previous government strategies in this area, including the 2002 Updated Drug Strategy, have also focused on reducing the harm caused by illegal drug use and in particular had the aim to 'reduce the use of Class A drugs and the frequent use of any illicit drug by all young people under the age of 25, especially by the most vulnerable groups'.

The following paragraphs contain a range of information from all sources including information on the taking of drugs, dependence and treatment of drug misuse, attitudes and beliefs about drugs and also where pupils and young people get information about drugs.

### 2.2 Drug Taking

#### 2.2.1 Prevalence and frequency of drug use

Section 2.2 on pages 21 to 24 and Tables 2.1 to 2.16 on pages 43 to 61 of the SDD09 provide information on the prevalence and frequency of drug use among pupils along with the types of drugs taken within the last year.

Figure 2.1 on page 22 shows the number of pupils that had taken drugs in the last month, last year and ever from 2001 to 2009 by year and Figure 2.2, also on page 22, shows the number of pupils that have taken drugs in the last month, last year and ever, by age.

Section 2.2 on pages 21 to 24 of the SDD09 shows that there has been an overall decline in the proportion of pupils who reported ever having taken drugs from 29% in 2001 to 22% in 2009.

The proportion of pupils that reported taking drugs in the last year also decreased from 20% in 2001 to 15% in 2009 along with the proportion of pupils who reported having taken drugs in the last month, which decreased from 12% in 2001 to 8% in 2009.

In 2009 boys were more likely than girls to have taken drugs ever (23% and 21% respectively), in the last year (16% and 14%) and in the last month (9% and 7%).

Prevalence of drug use increased with age with the proportion of pupils having ever taken drugs rising from 9% for 11 year olds to 40% for 15 year olds. Similar increases in the proportions of pupils having taken drugs in the last year (increasing with age from 5% of 11 year olds to 30% of 15 year olds) and the last month (increasing with age from 2% of 11 year olds to 17% of 15 year olds) were also observed.

As with previous years the most likely drug to have been taken in the last year in 2009 was cannabis, having been taken by 8.9% of pupils which continues the decrease in use from 13.4% in 2001.

Section 2.5.3 on pages 32 to 34 of the TellUs4 National Report shows there had been an increase of 3 percentage points between 2008 (85%) and 2009 (88%) of young people reporting that they had not taken drugs. The section also shows older
pupils were more likely to have taken drugs with 13% of Year 10 pupils having taken drugs compared with 4% of Year 8 pupils.

Table 2.8 on page 34 of the TellUs4 National Report shows that of the young people who had taken drugs, cannabis or skunk (49% having taken it one or more times) was more likely to have been taken than solvents (25%) or other drugs (28%).

The Drugs use section of the SDD06-08 regional on page 4 along with Table 6 shows the prevalence of drug use in the last year by Government Office Region (GOR) and sex and shows that the proportion of 11 to 15 year olds who have taken drugs at least once varies from 15% in the South West to 20% in the North West. There is no significant difference in any of the regions based on gender. The section also states that the most commonly used drug by 11 to 15 year olds is cannabis (10% in 2006, 9% in both 2007 and 2008) however use varies by region from 8% in the North East to 12% in the North West in 2008.

2.2.2 Vulnerable pupils and drug use

Section 2.4 of the SDD09 on pages 25 to 26 along with Tables 2.18 and 2.19 and Figure 2.6 on pages 62 and 63 show information on drug use by vulnerable pupils as a time series from 2003 to 2009. Vulnerable pupils are defined as those who have ever truanted or been excluded from school. Figure 2.6 shows the proportion of pupils that had reported that they usually take drugs at least once a month by whether the pupils are classed as vulnerable.

Vulnerable pupils are more likely to take drugs at least once a month than those who are not classed as vulnerable (14% and 1% respectively). Overall the proportion of vulnerable pupils taking drugs at least once a month has fallen from 21% in 2003 to 14% in 2009; however this proportion has risen by 3 percentage points since 2008 when the figure was 11%.

2.2.3 Pupils first and most recent experience of drug use

Section 2.5 of the SDD09 report on pages 26 to 29 along with Tables 2.20 to 2.30 on pages 63 to 69 as well as Figures 2.7, 2.8 and 2.9 found on pages 27 to 29 provide information on pupils’ first experience of drug use, discussing the type of drugs taken at the age pupils first took drugs, the first source of drugs, why pupils first took drugs and their reactions to the first instance of drug taking. In Tables 2.20 to 2.30 this information is presented by age and individual drug. The percentage of pupils for each category is presented from 2001 to 2009 in 2 year intervals.

This chapter shows that a pupil would be most likely to have sniffed volatile substances (55%) or taken cannabis (41%) when they first tried drugs. Poppers were the third most likely drug to have been tried (9%).

On the first occasion a pupil took drugs they were most likely to have got them from a friend (73%) with 45% of those reporting that the friend was of the same age. The most common reason pupils provided for trying drugs for the first time was ‘to see what they were like’ with 56% of pupils reporting this as their reason.

Among pupils who had ever taken drugs 45% reported they felt good, 11% said they felt bad and 44% reported that they felt no different the first time they took drugs.

Pupils whose first experience with drugs was positive were more likely to have taken drugs in the last year than those who had reported a bad or indifferent experience; 81% of pupils who had reported they had felt good the first time they took drugs had taken drugs in the last year whilst 50% had...
2.2.4 Factors associated with drug use

Section 2.15 on pages 39 to 41 of the SDD09 report provides odds ratios which show the relationship between drug use and characteristics and environment of pupils in the last year, using logistic regression.

The SDD09 report explains its use of the logistic regression model on page 39 section 2.15.1 and it states that “A logistic regression model was used to explore which pupil and environmental characteristics were associated with having taken drugs in the last year. The model allows each characteristic to be considered independently by controlling for the effects of the other, sometimes related, factors. For example, drug use is associated with increased age, and with smoking. But older pupils are more likely to smoke. The model allows an evaluation of the strength of the relationship between each of these variables and pupils’ drug use.

The model shows associations, not causes; in other words, factors which identify pupils with an increased or decreased risk of having taken drugs in the last year. These variations in risk are expressed as odds ratios relative to a reference category, which is given a value of 1. Odd ratios greater than 1 indicate higher odds (increased risk), and odds ratios less than 1 indicate lower odds (reduced risk). Also shown are 95% confidence intervals for the odds ratio. Where the interval does not include 1, this category is significantly different from the reference category.”

Further information on the logistic regression modelling is available in Appendix B of the SDD09, found on page 171 of the report.

Both smoking and drinking were associated with drug taking. Pupils who reported being occasional or regular smokers were more likely to have taken drugs in the last year, as were pupils who reported that they had drunk alcohol.

Pupils who had truanted or been excluded from school were more likely to have taken drugs in the last year. Whether or not a pupil had taken drugs in the last 12 months was also related to their perceptions on how their family would view their drug taking with an increased likelihood of having taken drugs as their perceived strength of their families disapproval reduced.

2.2.5 Dependence on drugs

Section 2.7 on page 32 of the SDD09 report, along with Tables 2.48 to 2.53 on pages 80 to 82 shows information on whether pupils wanted to give up taking drugs and whether pupils felt that they needed treatment. The tables show the proportion of pupils that would like to give up taking drugs and the proportion of pupils that felt they needed help or treatment for their drug use by year, by age and gender and by drug type taken.

Section 2.7 shows that 43% of pupils that had taken drugs in the last year would like to give up now and 18% reported that they would like to give up in the future with similar proportions of boys and girls reporting that they would like to give up either now or in the future (43% and 42% respectively).
Younger pupils who had taken drugs in the last year were more likely than older pupils to report that they wanted to give up drugs now with 59% of 11 to 13 year olds compared to 36% of 15 year olds reporting this.

Five percent of pupils said that they had, at some point, felt that they needed help or treatment for their drug use.

The Substance misuse among young people – the data 2008/09 report shows that that in England during 2008/09 24,053 under 18s accessed specialist substance misuse services in England which was an increase of 150 when compared to 2007/08.

Of the 24,053 young people accessing these services almost 9 out of 10 are receiving help for the misuse of alcohol and/or cannabis with cannabis accounting for 12,642 individuals and alcohol 8,799.

The report also shows a steady decline in the number of under 18s having problems with hard drugs – the number of under 18s treated for heroin and crack cocaine use has fallen from 1,081 in 2005/06 to 657 in 2008/09.

2.3 Attitudes and beliefs about drugs
2.3.1 Availability and refusal of drugs

Sections 2.8 and 2.9 on pages 33 to 35 of the SDD09 report along with Tables 2.54 to 2.63 on pages 83 to 91 and Figures 2.11 to 2.13 on pages 33 to 35 contain information on the availability and refusal of drugs. These chapters contain information on whether pupils have been offered drugs, whether or not all pupils offered drugs go on to take them, how many pupils have refused drugs and why they refused them.

The tables show the proportion of pupils that have been offered individual drugs each year from 2001 to 2009 as well as the 2009 proportions split by age and gender. In addition to this the tables also show the proportions of 15 year old pupils offered drugs that went on to take them for all drugs, cannabis and Class A drugs from 2001 to 2009 as well as the 2009 proportions split by gender. The tables also show the proportion of pupils that had refused drugs and the reasons why for every other year from 2003 to 2009 by gender and the 2009 proportions by age and gender.

These sections show that 33% of pupils had been offered drugs at least once, a decrease of 9 percentage points since 2001 when the figure was 42%. This reduction is largely due to the proportion of pupils being offered cannabis falling from 27% to 21% in the same time period.

Boys were more likely than girls to report that they had been offered drugs (35% of boys and 31% of girls).

In 2009 56% of 15 year olds had been offered drugs and of that proportion 66% had taken drugs at least once, with boys and girls equally likely to have taken drugs at least once if they have been offered them.

Thirty-two percent of pupils reported that they had refused an offer of drugs at least once, a 7 percentage point decrease from 39% in 2003. Eight percent of pupils reported that they have never refused drugs whilst the remaining 60% had never been offered drugs, which is an increase since 2003.

When asked why they refused drugs 41% of peoples reported that ‘I just didn’t want to take them’, other common reasons for refusing drugs include the belief that taking them was wrong (34%), concerns about
addiction (32%) and the dangers of taking drugs (32%).

2.3.2 Perceived ease of getting drugs

Section 2.10 on pages 35 to 36 of the SDD09 report along with Tables 2.64 to 2.69 on pages 92 to 94 and Figure 2.14 on page 36 contains information on the perceived ease of getting individual drugs and illegal drugs in general.

The tables show the proportion of pupils that believe it would be easy to obtain any illegal drug, specifically heroin or crack cocaine by age and gender for every other year from 2001 to 2009 as well as providing the same figures by whether or not the pupil had ever been offered the drugs.

The section shows that 49% of pupils were unaware whether it would be easy or not to obtain illegal drugs. Of the pupils that did express a view on how easy it would be to obtain illegal drugs 28% thought it would be easy as opposed to 23% who thought it would be difficult.

Boys were more likely than girls to think it would be easy to obtain illegal drugs (30% of boys compared with 26% of girls) whilst the proportion of pupils that thought that it would be easy to obtain illegal drugs increased with age from 4% of 11 year olds to 55% of 15 year olds.

2.3.3 Awareness of individual drugs

Section 2.11 on page 36 of the SDD09 report and Tables 2.70 to 2.71 on pages 95 to 96 shows information regarding pupils’ awareness of individually named drugs.

The tables show the percentage of pupils that are aware of each type of drug for the years 2001 to 2009 as well as the 2009 figures by age.

The section shows that more than 9 out of 10 pupils had heard of cocaine (94%), heroin (93%) and cannabis (91%) whilst 49% had heard of poppers and 54% had heard of LSD. Only 2% of pupils reported that they had never heard of any of the drugs asked about.

Awareness of drugs increased with age, for example 21% of 11 year olds had heard of poppers compared to 72% of 15 year olds.

2.3.4 Beliefs and attitudes about drugs

Section 2.12 on pages 36 to 38 of the SDD09 report along with Tables 2.72 to 2.80 on pages 96 to 101 and Figure 2.15 on page 38 contain information on pupils’ attitudes to drug use, beliefs about drug use among their peers and perceived family attitudes.

The tables show the percentage of pupils that believe it is ‘OK’ to try certain drugs for each year from 1999 to 2009 by age and gender as well as the pupils’ perceptions of how many pupils of their age are taking drugs by age and gender. The tables also show the pupils’ perceived family attitudes towards drugs.

The section shows that less than 10% of pupils thought it was ‘OK’ to try cannabis, cocaine or sniffing glue once to see what it was like or to take these substances once a week.

The percentage of pupils who thought it was OK to try cannabis increased with age from 1% of 11 year olds to 23% of 15 year olds with similar increases with age for all other types of drug use.

Pupils most common response when asked how many of their peers were taking drugs was ‘only a few’ (49%) with the second
most common response being 'none of them' (37%).

Almost all pupils reported that their family would not approve of them taking drugs with 84% saying that their family would try to stop them and 15% felt that their family would try to persuade them not to take drugs. The proportion of pupils that felt their parents would try to stop them taking drugs reduced with age, 87% of 11 year olds felt their family would try to stop them and 81% of 15 year olds reported the same.

There is a strong relationship between drug use and family attitudes. Pupils who thought their parents had a more lenient attitude towards their drug taking were more likely to have taken drugs than those who thought there family would try to stop them taking drugs.

2.4 Information about drugs

2.4.1 Sources of helpful information on drugs

Section 2.13 on page 38 of the SDD09 report contains information on where pupils get their helpful information on drugs from. In addition to this, Tables 2.81 to 2.83 on pages 101 to 102 show the proportion of pupils that get their information from each named source for 2009 split by age and gender and when the pupil last took drugs.

The section shows that pupils were most likely to get helpful information about drugs from the TV (71%) and from parents and teachers (both 63%). Helplines were least likely to be reported by a pupil as a source of helpful information about drugs (18%). Boys were more likely to report family members (parents, siblings and other relatives) whilst girls were more likely to report newspapers and magazines as a source of useful information about drugs.

2.4.2 Lessons about drugs

Section 2.14 on page 39 of the SDD09 report contains information on pupils' recollections of lessons on drugs in school. Tables 2.84a – 2.85 on page 103 show the percentage of pupils who remember receiving health education lessons about drugs in the last year from 1998 to 2009 for all pupils and by school year.

The section show that 59% of pupils said they remembered receiving lessons at school about drugs; this figure has remained fairly consistent since this question started to be asked in 2004.

Ninety-six percent of pupils who recalled lessons about drugs felt it had helped them to think about the risks of taking drugs and 85% of pupils reported that the lessons helped them to realise that taking drugs was against the law. Pupils also reported that the lessons helped them think about what they would do if they were offered drugs (76%) and helped them find out where they could get advice or information about drugs (72%).

Section 2.5 and Table 2.9 on pages 29 to 34 of the TellUs4 National Report shows that of pupils in Year 10, drug use was higher among those who had not received information on drugs. Twenty-one percent of those young people who did not find the advice they received helpful had used drugs and another 21% of those who said they had not received any information on drugs had used drugs. In comparison, 88% of Year 10 pupils who said they had received helpful advice had not taken drugs.
References


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3. Outcomes of drug misuse

3.1 Introduction

Individuals who take illicit drugs face potential health risks, as the drugs are not controlled or supervised by medical professionals. As well as health risks, drugs can become addictive and lead to long term damage to the body. Illicit drug users are also at risk of being poisoned by drugs, and overdosing which can lead to a fatality.

This chapter presents a range of information about the health risks associated with drug misuse including hospital admissions, treatment, drugs harm index and drug-related deaths.

Previously information on infections acquired through injecting illicit drugs was presented from the Health Protection Agency’s Unlinked Anonymous Prevalence Monitoring Programme (UAPMP). This information has not been updated by the Health Protection Agency, and therefore no update been included in this publication.

Similarly, information taken from ‘Measuring different aspects of problem drug use: methodological developments’ report has not been updated by the Home Office and is also not included in this report.

3.2 Hospital admissions

Data on NHS hospital admissions are available from the Hospital Episode Statistics (HES) databank which is hosted by The NHS Information Centre. This section presents NHS hospital admissions in England where there was a primary or secondary diagnosis of drug-related mental health and behavioural disorders or a primary diagnosis of drug poisoning. These data are based on the tenth revision of the International Classification of Diseases (ICD-10). The most recent data available are for the financial year 2009/10.

3.2.1 Drug-related mental health and behavioural disorders

This section describes admissions to NHS hospitals where drug-related mental health and behavioural disorders were related to either the primary or secondary diagnosis. Admissions where drug-misuse was related to the primary diagnosis are described first, followed by trends in these admissions over time and then admissions where drug-misuse was related to either the primary or secondary diagnosis.

Table 3.1 shows that in 2009/10 there were 5,809 admissions to hospital in England with a primary diagnosis of a drug-related mental health and behavioural disorder. This is 2.5% more than in 2008/09 when there were 5,668 admissions.

During 2009/10 more people aged 25-34 were admitted with a primary diagnosis of drug-related mental health and behaviour disorders than any other age group. This age group accounted for 37.5% of all such admissions in that year. Those in the 75+ age group had the lowest number of admissions (34). See Figure 3.1.

Table 3.2 shows that in 2009/10, more than twice as many males were admitted to hospital with a primary diagnosis of drug-related mental health and behavioural disorders than females (4,184 and 1,618 respectively).
When analysing figures at Strategic Health Authority (SHA) and Primary Care Trust (PCT) level it is important to note that SHAs and PCTs vary greatly in both size and structure of population. To help account for this, information is therefore also provided as number of admissions per 100,000 population in the relevant tables.

Table 3.2 shows that among SHAs, North West SHA had the highest rate of admissions with a primary diagnosis of drug-related mental health and behavioural disorders at 17 admissions per 100,000 of the population. East of England SHA had the lowest number of admissions per 100,000 population.

Table 3.3 shows hospital admissions where there was a primary diagnosis of drug-related mental health and behavioural disorders by Primary Care Trust (PCT).

Table 3.4 shows that there were 44,585 admissions where there was a primary or secondary diagnosis of drug-related mental health and behavioural disorders in 2009/10, which is 5.7% higher than 42,170 admissions in 2008/09. See Figure 3.2.

As seen with primary diagnosis, Table 3.4 shows that those in the 25-34 age group had the greatest number of admissions (16,089) with a primary or secondary diagnosis of drug-related mental health and behavioural disorders than any other age group. Those in the 75+ age group had the lowest number of admissions (243). (See Figure 3.3).

Table 3.5 shows that among SHAs, North West SHA showed the largest number of admissions with a primary or secondary diagnosis of drug-related mental health and behavioural disorders at 168 admissions per 100,000 population followed by Yorkshire and The Humber SHA with 105 per 100,000 population. South Central SHA had the lowest number of admissions per 100,000 population.

Table 3.6 shows hospital admissions where there was a primary or secondary diagnosis of drug-related mental health and behavioural disorders by PCT.

3.2.2 Poisoning by drugs

This section describes admissions to NHS hospitals where drug poisoning was related to the primary diagnosis. Table 3.7 shows that in 2009/10, 11,618 admissions were recorded with this diagnosis, which has remained relatively stable in recent years (11,110 in 2007/08 and 11,090 in 2008/09). Since 1998/99, there has been a long term increase in the number of admissions of 54.2% (7,533).

Table 3.7 also shows that adults in the 16-24 age group reported the highest number of admissions (2,880) with a primary diagnosis of poisoning by drugs in 2009/10 with those aged between 16-24 years.
25-34 reporting slightly less (2,734). This represents a change from 2008/09 when the 25-34 age group had the most admissions (2,773) compared to 2,741 admissions in the 16-24 age group. Those in the 65-74 age group reported the lowest number of such admissions in 2009/10 (281).

Table 3.8 shows that in 2008/09, more males were admitted to hospital with a primary diagnosis of poisoning by drugs than females with 6,076 males compared to 5,014 females.

Table 3.8 also shows that when looking at SHAs, North East SHA had the highest number of admissions with a primary diagnosis of poisoning by drugs per 100,000 population at 41 per 100,000 population while London SHA had the lowest number of 13 admissions per 100,000 population.

Table 3.9 shows hospital admissions where drug poisoning was related to the primary diagnosis by PCT.

3.3 Treatment for drug misuse

Data from the National Drug Treatment Monitoring System (NDTMS) provides information on the number of people being treated for drug misuse and referrals. The latest information available is for 2009/10 and only includes information for those aged 18 and over (previously it had included information on those aged under 18).

Table 3.10 shows that in 2009/10, 206,889 individuals were in contact with structured drug treatment services. This is a 0.3% decrease from the 2008/09 figures, where the number was 207,580. Most of these individuals in treatment are aged 40+ (26.4%) and 73.2% are male.

Table 3.11 shows that in 2009/10, the main type of drug for which people received treatment was opiates only (which includes heroin) at 47% of all treatments with a further 31% of treatments for those who have taken both opiates and crack.

The NDTMS also report referral sources for episodes of treatment. A client may have more than one episode in a year (see Appendix A for more information on episodes). This information has not been updated this year however figures for the 2008/09 period are available via last years Drug Misuse in England report which can be found on the NHS Information Centre’s website.

Table 3.12 shows the reasons why clients were discharged from treatment. A discharge is classed as successful if an individual is said to have completed their course of treatment (whether drug free or otherwise), or if the individual is referred to another agency.

Table 3.12 shows that there were 62,685 discharged episodes of treatment by the end 2009/10 and that there were 23,680 (38%) clients exiting treatment who were no longer dependent on the substances that brought them into treatment; a further 15,697 (25%) were referred on for further interventions.

Table 3.13 shows that among Government Office Regions (GORs), North West GOR reported the highest number of people in treatment at 38,550 followed by London GOR at 34,850. North East GOR reported the lowest number of people in treatment (14,304). See Figure 3.4.

3.4 Drug Harm Index

The Drug Harm Index (DHI) has been developed by the Home Office to measure the effectiveness of the Drugs Strategy. The DHI captures the harms generated by the problematic use of any illegal drug by combining robust national indicators into a single figure time series index. There are 19 harms included in the DHI which include drug-related crime, community perceptions of drug problems, drug nuisance, and the various
health consequences that arise from drug abuse (e.g. HIV, overdoses, deaths). Full details of all the harms included in the DHI can be found in Appendix A.

To enable a single index to be formulated, the relative importance of each of the harms in the DHI is captured by the economic and social costs they generate. Any change in the DHI will be due to the level or volume of harms (e.g. the number of new HIV cases) and the change in their economic or social cost (e.g. change in cost per new HIV case). The DHI should be considered alongside other indicators, in order to determine which particular types of harm are becoming dominant, or are being moderated.

The latest DHI results available are for 2006 and incorporate revised data for earlier years where 1998 forms the baseline (1998 = 100). The value of the DHI fell by 11.7 points (from 80.5 to 68.8) between 2005 and 2006. This is a more pronounced fall than between 2004 and 2005 where the DHI fell by 4.9 points, and is partly due to the larger decrease in all crime types in 2006 than in 2005. Many of the drivers in change of the 2006 DHI are:

- The largest downward impact came from drug-related crime, particularly burglary, shoplifting and 'other theft'.
- Unlike the previous year, drug-related deaths decreased from 1,608 in 2005 to 1,573 in 2006, and thus contributed to the greater downward fall in the 2006 index.
- The only upward influence on the DHI in 2006 came from the British Crime Survey (BCS) perception of drug nuisance, although this did not substantially impact on the DHI overall.

3.5 Drug-related deaths

The most recent information on the numbers of deaths due to drug misuse is available from the Office for National Statistics (ONS) publication, Health Statistics Quarterly 43 (HSQ), published in Autumn 2009. The most recent data available is for 2008. This data was previously included in Statistics on Drug Misuse, 2009 and is included below as it remains the latest information available.

The HSQ defines drug-related deaths as ‘deaths where the underlying cause is poisoning, drug abuse or drug dependence and where any of the substances controlled under the Misuse of Drugs Act are involved’ (See Appendix A for further information).

Table 3.14 shows the number of deaths related to drug misuse. In 2008, there were 1,738 deaths reported as being due to drug misuse. Of those who died, 78% were male. Compared to 1993 the number of male deaths has increased by around 136% in 2008 compared to a 48% increase for females. In recent years however no overall trend is apparent. The highest numbers of deaths due to drug misuse occurred in the 30 to 39 age group for both males and females (490 and 112 respectively).

Table 3.15 shows the analysis of the underlying causes of death due to drug misuse where more males than females die for each underlying cause of death with over five times the number of males dying from mental and behavioural disorders than females (578 and 107 respectively). This pattern was evident in deaths due to accidental poisoning (597 male and 166 female) and intentional self poisoning of undetermined intent (182 male and 99 female). No overall trend in recent years is apparent between genders in the changes of numbers dying with underlying causes of death. However, compared with 1993, males have experienced greater increases than females for all underlying causes of death (excluding assault by drugs).

An alternative source of data on drug-related deaths is published by the national programme on Substance Abuse Deaths (np-SAD) and is used as an indicator of the extent and nature of drug problems and misuse, and makes a contribution towards the prevention of substance abuse problems. Unlike the HSQ, which uses the General Mortality Registers (GMR), derived from medical death certificates, information presented in the np-SAD publication is based on data provided by coroners, as part of the Special Mortality Register (SMR). Overall, trends from the np-SAD and HSQ are similar.
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<tr>
<td>3.2</td>
<td>NHS hospital admissions where there was a primary diagnosis of drug-related mental health and behavioural disorders, by Strategic Health Authority and gender, 2009/10</td>
</tr>
<tr>
<td>3.3</td>
<td>NHS hospital admissions where there was a primary diagnosis of drug-related mental health and behavioural disorders, by Strategic Health Authority and Primary Care Trust, 2009/10</td>
</tr>
<tr>
<td>3.4</td>
<td>NHS hospital admissions where the primary or secondary diagnosis was of drug-related mental health and behavioural disorders, by age group, 1998/99-2009/10</td>
</tr>
<tr>
<td>3.5</td>
<td>NHS hospital admissions where there was a primary or secondary diagnosis of drug-related mental health and behavioural disorders, by Strategic Health Authority, 2009/10</td>
</tr>
<tr>
<td>3.6</td>
<td>NHS hospital admissions where there was a primary or secondary diagnosis of drug-related mental health and behavioural disorders, by Strategic Health Authority and Primary Care Trust, 2009/10</td>
</tr>
<tr>
<td>3.7</td>
<td>NHS hospital admissions to hospital where there was a primary diagnosis poisoning by drugs, by age group, 1998/99-2009/10</td>
</tr>
<tr>
<td>3.8</td>
<td>NHS hospital admissions to hospital where there was a primary diagnosis of poisoning by drugs, by Strategic Health Authority and gender, 2009/10</td>
</tr>
<tr>
<td>3.9</td>
<td>NHS hospital admissions where a primary diagnosis of poisoning by drugs, by Strategic Health Authority and Primary Care Trust, 2009/10</td>
</tr>
<tr>
<td>3.10</td>
<td>NDTMS clients in treatment, by gender and age, 2009/10</td>
</tr>
<tr>
<td>3.11</td>
<td>Primary drug use of all clients in NDTMS, 2009/10</td>
</tr>
<tr>
<td>3.12</td>
<td>Treatment exit reasons for individuals not retained in treatment reported to NDTMS, 2009/10</td>
</tr>
<tr>
<td>3.13</td>
<td>People in treatment by Government Office Region and age reported to NDTMS, 2009/10</td>
</tr>
<tr>
<td>3.14</td>
<td>Number of deaths related to drug misuse by gender and age group, 1993-2008</td>
</tr>
<tr>
<td>3.15</td>
<td>Number of deaths related to drug misuse by gender and underlying cause of death, 1993-2008</td>
</tr>
</tbody>
</table>
Table 3.1 NHS hospital admissions\(^1,2\) where there was a primary diagnosis\(^3\) of drug related mental health and behavioural disorders\(^4\), by age group, 1998/99 to 2009/10\(^5,6,7,8\)

<table>
<thead>
<tr>
<th>England</th>
<th>Numbers</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total(^9)</td>
</tr>
<tr>
<td>1998/99</td>
<td>9,131</td>
</tr>
<tr>
<td>1999/00</td>
<td>8,453</td>
</tr>
<tr>
<td>2000/01</td>
<td>8,027</td>
</tr>
<tr>
<td>2001/02</td>
<td>7,978</td>
</tr>
<tr>
<td>2002/03</td>
<td>7,691</td>
</tr>
<tr>
<td>2003/04</td>
<td>7,869</td>
</tr>
<tr>
<td>2004/05</td>
<td>7,857</td>
</tr>
<tr>
<td>2005/06</td>
<td>7,757</td>
</tr>
<tr>
<td>2006/07</td>
<td>6,743</td>
</tr>
<tr>
<td>2007/08</td>
<td>6,675</td>
</tr>
<tr>
<td>2008/09</td>
<td>5,668</td>
</tr>
<tr>
<td>2009/10</td>
<td>5,809</td>
</tr>
</tbody>
</table>

1. The data includes private patients treated in NHS hospitals (but not private patients in private hospitals)
2. A finished admission episode is the first period of in-patient care under one consultant within one healthcare provider. Please note that admissions do not represent the number of in-patients, as a person may have more than one admission within the year.
3. The primary diagnosis is the first of up to 14 (7 prior to 2002-03) diagnosis fields in the Hospital Episode Statistics (HES) dataset and provides the main reason why the patient was in hospital.
4. The data is based on the tenth revision of the International Classification of Diseases (ICD-10), Codes F11-F16, F18, F19.
5. Counts include people resident in England Strategic Health Authorities (SHAs) only.
6. Total counts exclude admissions where the SHA of residence is unknown.
7. Total counts include admissions where the SHA or residence was England but not further specified.
8. Figures have not been adjusted for shortfalls in data.
9. Includes admissions where the age was unknown.

Source:
Hospital Episode Statistics, HES. The NHS Information Centre for Health and Social Care

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Table 3.2 NHS hospital admissions\(^{1,2}\) where there was a primary diagnosis\(^{3}\) of drug related mental health and behavioural disorders\(^{4}\), by Strategic Health Authority\(^{5,6}\) and gender, 2009/10\(^{7}\)

<table>
<thead>
<tr>
<th>Region</th>
<th>Total(^{8})</th>
<th>Number of admissions per 100,000 of population(^{9})</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>England(^{10,11})</td>
<td>5,809</td>
<td>11</td>
<td>4,184</td>
<td>1,618</td>
</tr>
<tr>
<td>North East</td>
<td>154</td>
<td>6</td>
<td>112</td>
<td>37</td>
</tr>
<tr>
<td>North West</td>
<td>1,144</td>
<td>17</td>
<td>807</td>
<td>337</td>
</tr>
<tr>
<td>Yorkshire and the Humber</td>
<td>498</td>
<td>9</td>
<td>358</td>
<td>140</td>
</tr>
<tr>
<td>East Midlands</td>
<td>523</td>
<td>12</td>
<td>391</td>
<td>131</td>
</tr>
<tr>
<td>West Midlands</td>
<td>587</td>
<td>11</td>
<td>417</td>
<td>170</td>
</tr>
<tr>
<td>East of England</td>
<td>273</td>
<td>5</td>
<td>199</td>
<td>74</td>
</tr>
<tr>
<td>London</td>
<td>1,258</td>
<td>16</td>
<td>907</td>
<td>350</td>
</tr>
<tr>
<td>South East Coast</td>
<td>376</td>
<td>9</td>
<td>285</td>
<td>91</td>
</tr>
<tr>
<td>South Central</td>
<td>350</td>
<td>9</td>
<td>245</td>
<td>105</td>
</tr>
<tr>
<td>South West</td>
<td>528</td>
<td>10</td>
<td>365</td>
<td>163</td>
</tr>
</tbody>
</table>

1. The data include private patients treated in NHS hospitals (but not private patients in private hospitals).

2. A finished admission episode is the first period of in-patient care under one consultant within one healthcare provider. Please note that admissions do not represent the number of in-patients, as a person may have more than one admission within the year.

3. The primary diagnosis is the first of up to 14 (7 prior to 2002-03) diagnosis fields in the Hospital Episode Statistics (HES) dataset and provides the main reason why the patient was in hospital.

4. The data is based on the tenth revision of the International Classification of Diseases (ICD-10), Codes F11-F16, F18, F19.

5. Total counts exclude admissions where the SHA of residence is unknown.

6. SHA in which the patient is normally resident, based on the patient’s postcode.

7. Figures have not been adjusted for shortfalls in data.

8. Includes admissions where the gender was unknown.

9. The number of admissions per 100,000 of population all ages use estimated resident population mid-2009 figures based on the 2001 census published by the Office for National Statistics (ONS). Information on ONS Population data is available at: http://www.statistics.gov.uk/census2001/default.asp

10. Includes admissions where the SHA or residence was England but not further specified.

11. Counts include people resident in England Strategic Health Authorities (SHAs) only.

Source:
Hospital Episode Statistics, HES. The NHS Information Centre for health and social care

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Table 3.3 2010 hospital admissions1,2 where there was a primary diagnosis3 of drug related mental health and behavioural disorders4, by Strategic Health Authority5,6,7,8 and Primary Care Trust9,10, 2009/1011

<table>
<thead>
<tr>
<th>Strategic Health Authority</th>
<th>Numbers</th>
</tr>
</thead>
<tbody>
<tr>
<td>North East Strategic Health Authority</td>
<td>3,026</td>
</tr>
<tr>
<td>North West Strategic Health Authority</td>
<td>2,334</td>
</tr>
<tr>
<td>South West Strategic Health Authority</td>
<td>936</td>
</tr>
<tr>
<td>East Midlands Strategic Health Authority</td>
<td>535</td>
</tr>
<tr>
<td>West Midlands Strategic Health Authority</td>
<td>347</td>
</tr>
<tr>
<td>East of England Strategic Health Authority</td>
<td>226</td>
</tr>
<tr>
<td>London Strategic Health Authority</td>
<td>1,438</td>
</tr>
</tbody>
</table>

1. This data does not include patients treated in A&E department who did not have a hospital admission episode.
2. This data includes patients who are resident in England only.
3. This data includes patients who are resident in England only.
4. This data includes patients who are resident in England only.
5. This data includes patients who are resident in England only.
6. This data includes patients who are resident in England only.
7. This data includes patients who are resident in England only.
8. This data includes patients who are resident in England only.
9. This data includes patients who are resident in England only.
10. This data includes patients who are resident in England only.
11. This data includes patients who are resident in England only.

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Table 3.4 NHS hospital admissions¹,² where the primary³ or secondary diagnosis⁴ was of drug related mental health and behavioural disorders⁵, by age group, 1998/99 to 2009/10⁶,⁷,⁸,⁹

<table>
<thead>
<tr>
<th>England</th>
<th>Numbers</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total¹⁰</td>
</tr>
<tr>
<td>1998/99</td>
<td>24,236</td>
</tr>
<tr>
<td>1999/00</td>
<td>24,974</td>
</tr>
<tr>
<td>2000/01</td>
<td>25,683</td>
</tr>
<tr>
<td>2001/02</td>
<td>28,063</td>
</tr>
<tr>
<td>2002/03</td>
<td>31,490</td>
</tr>
<tr>
<td>2003/04</td>
<td>34,957</td>
</tr>
<tr>
<td>2004/05</td>
<td>35,737</td>
</tr>
<tr>
<td>2005/06</td>
<td>38,005</td>
</tr>
<tr>
<td>2006/07</td>
<td>38,170</td>
</tr>
<tr>
<td>2007/08</td>
<td>40,421</td>
</tr>
<tr>
<td>2008/09</td>
<td>42,170</td>
</tr>
<tr>
<td>2009/10</td>
<td>44,585</td>
</tr>
</tbody>
</table>

1. The data include private patients treated in NHS hospitals (but not private patients in private hospitals).
2. The data is based on a finished admission episode which is the first period of in-patient care under one consultant within one healthcare provider. Please note that admissions do not represent the number of in-patients, as a person may have more than one admission within the year.
3. These figures represent the number of episodes where the diagnosis was recorded in any of the 20 (14 from 2002-03 to 2009-10 and 7 prior to 2002-03) primary and secondary diagnosis fields in a Hospital Episode Statistics (HES) record. Each episode is only counted once in each count, even if the diagnosis is recorded in more than one diagnosis field of the record. It is not possible to identify whether the drugs were medically prescribed or not.
4. As well as the primary diagnosis, there are up to 13 (6 prior to 2002-03) secondary diagnosis fields in Hospital Episode Statistics (HES) that show other diagnoses relevant to the episode of care.
5. The data is based on the tenth revision of the International Classification of Diseases (ICD-10), Codes F11-F16, F18, F19.
6. Counts include people resident in England Strategic Health Authorities (SHAs) only.
7. Total counts exclude admissions where the SHA of residence is unknown.
8. Total counts include admissions where the SHA or residence was England but not further specified.
9. Figures have not been adjusted for shortfalls in data.
10. Includes admissions where the age was unknown.

Source:
Hospital Episode Statistics, HES. The NHS Information Centre for health and social care

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Table 3.5 NHS hospital admissions\(^1,2\) where there was a primary\(^3\) or secondary\(^4\) diagnosis of drug related mental health and behavioural disorders\(^5\), by Strategic Health Authority\(^6,7\), 2009/10\(^8\)

<table>
<thead>
<tr>
<th></th>
<th>Number of admissions per 100,000 of population(^9)</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>England</td>
<td></td>
<td>44,585</td>
<td>86</td>
</tr>
<tr>
<td>North East</td>
<td></td>
<td>2,373</td>
<td>92</td>
</tr>
<tr>
<td>North West</td>
<td></td>
<td>11,601</td>
<td>168</td>
</tr>
<tr>
<td>Yorkshire and the Humber</td>
<td></td>
<td>5,526</td>
<td>105</td>
</tr>
<tr>
<td>East Midlands</td>
<td></td>
<td>3,410</td>
<td>77</td>
</tr>
<tr>
<td>West Midlands</td>
<td></td>
<td>4,133</td>
<td>76</td>
</tr>
<tr>
<td>East of England</td>
<td></td>
<td>2,655</td>
<td>46</td>
</tr>
<tr>
<td>London</td>
<td></td>
<td>5,880</td>
<td>76</td>
</tr>
<tr>
<td>South East Coast</td>
<td></td>
<td>2,373</td>
<td>55</td>
</tr>
<tr>
<td>South Central</td>
<td></td>
<td>1,674</td>
<td>41</td>
</tr>
<tr>
<td>South West</td>
<td></td>
<td>4,118</td>
<td>79</td>
</tr>
</tbody>
</table>

1. The data include private patients treated in NHS hospitals (but not private patients in private hospitals)
2. A finished admission episode is the first period of in-patient care under one consultant within one healthcare provider. Please note that admissions do not represent the number of in-patients, as a person may have more than one admission within the year.
3. These figures represent the number of episodes where the diagnosis was recorded in any of the 20 (14 from 2002-03 to 2006-07 and 7 prior to 2002-03) primary and secondary diagnosis fields in a Hospital Episode Statistics (HES) record. Each episode is only counted once in each count, even if the diagnosis is recorded in more than one diagnosis field of the record. It is not possible to identify whether the drugs were medically prescribed or not.
4. As well as the primary diagnosis, there are up to 13 (6 prior to 2002-03) secondary diagnosis fields in Hospital Episode Statistics (HES) that show other diagnoses relevant to the episode of care.
5. The data is based on the tenth revision of the International Classification of Diseases (ICD-10), Codes F11-F16, F18, F19.
6. Strategic Health Authority (SHA) in which the patient is normally resident, based on the patient's postcode.
7. Counts exclude admissions where the SHA of residence is unknown
8. Figures have not been adjusted for shortfalls in data.
9. Total counts include admissions where the gender was unknown.
10. The number of admissions per 100,000 of population all ages use estimated resident population mid-2009 figures based on the 2001 census published by the Office for National Statistics (ONS). Information on ONS Population data is available at: http://www.statistics.gov.uk/census2001/default.asp
11. Includes admissions where the SHA or residence was England but not further specified
12. Counts include people resident in EnglandSHAs only.

**Source:**
Hospital Episode Statistics, HES. The NHS Information Centre for health and social care

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<table>
<thead>
<tr>
<th>Strategic Health Authority</th>
<th>Figures</th>
</tr>
</thead>
<tbody>
<tr>
<td>South West Strategic Health Authority</td>
<td>Q39</td>
</tr>
<tr>
<td>East of England Strategic Health Authority</td>
<td>Q35</td>
</tr>
<tr>
<td>South East Coast Strategic Health Authority</td>
<td>Q37</td>
</tr>
<tr>
<td>East Midlands Strategic Health Authority</td>
<td>Q33</td>
</tr>
<tr>
<td>London Strategic Health Authority</td>
<td>Q36</td>
</tr>
<tr>
<td>Yorkshire &amp; The Humber Strategic Health Authority</td>
<td>Q32</td>
</tr>
<tr>
<td>West Midlands Strategic Health Authority</td>
<td>Q34</td>
</tr>
<tr>
<td>North West Strategic Health Authority</td>
<td>Q31</td>
</tr>
</tbody>
</table>

1. The data include private patients treated in NHS hospitals (but not private patients in private hospitals). Secondary suppression has been used for this particular table. However, the total still includes these numbers.

2. Figures have not been adjusted for shortfalls in data.

3. This is the SHA in which the patient is normally resident, based on the patient’s postcode.

4. As well as the primary diagnosis, there are up to 13 secondary diagnosis fields in Hospital Episode Statistics (HES) that show other diagnoses relevant to the episode of care.

5. The data is based on the tenth revision of the International Classification of Diseases (ICD-10), whether the drugs were medically prescribed or not.

6. The diagnosis is recorded in more than one diagnosis field of the record. It is not possible to identify the number of in-patients, as a person may have more than one admission within the year.

7. Codes F11-F16, F18, F19.

8. The data for this diagnosis is based on the International Classification of Diseases (ICD-10). It is not possible to identify the number of in-patients, as a person may have more than one admission within the year.

9. The data is based on the International Classification of Diseases (ICD-10), whether the drugs were medically prescribed or not.

10. Where PCT’s have less than 6 admissions recorded over the year, these figures have been suppressed to protect patient confidentiality. Secondary suppression has been used for this particular table. However, the total still includes these numbers.

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Table 3.7 NHS hospital admissions to hospital\textsuperscript{1,2} where there was a primary diagnosis\textsuperscript{3} of poisoning by drugs\textsuperscript{4}, by age group, 1998/99 to 2009/10\textsuperscript{5,6,7,8}

<table>
<thead>
<tr>
<th>England</th>
<th>Total</th>
<th>Under 16</th>
<th>16-24</th>
<th>25-34</th>
<th>35-44</th>
<th>45-54</th>
<th>55-64</th>
<th>65-74</th>
<th>75+</th>
</tr>
</thead>
<tbody>
<tr>
<td>1998/99</td>
<td>7,533</td>
<td>670</td>
<td>2,579</td>
<td>2,328</td>
<td>1,102</td>
<td>453</td>
<td>173</td>
<td>97</td>
<td>113</td>
</tr>
<tr>
<td>1999/00</td>
<td>7,695</td>
<td>670</td>
<td>2,454</td>
<td>2,361</td>
<td>1,205</td>
<td>562</td>
<td>185</td>
<td>94</td>
<td>149</td>
</tr>
<tr>
<td>2000/01</td>
<td>7,814</td>
<td>683</td>
<td>2,483</td>
<td>2,330</td>
<td>1,209</td>
<td>587</td>
<td>219</td>
<td>139</td>
<td>139</td>
</tr>
<tr>
<td>2001/02</td>
<td>7,513</td>
<td>829</td>
<td>2,272</td>
<td>2,073</td>
<td>1,294</td>
<td>563</td>
<td>214</td>
<td>108</td>
<td>142</td>
</tr>
<tr>
<td>2002/03</td>
<td>7,011</td>
<td>774</td>
<td>1,994</td>
<td>1,873</td>
<td>1,302</td>
<td>536</td>
<td>237</td>
<td>132</td>
<td>151</td>
</tr>
<tr>
<td>2003/04</td>
<td>7,876</td>
<td>918</td>
<td>2,001</td>
<td>2,106</td>
<td>1,518</td>
<td>706</td>
<td>266</td>
<td>145</td>
<td>199</td>
</tr>
<tr>
<td>2004/05</td>
<td>9,084</td>
<td>841</td>
<td>2,470</td>
<td>2,373</td>
<td>1,836</td>
<td>809</td>
<td>353</td>
<td>169</td>
<td>227</td>
</tr>
<tr>
<td>2005/06</td>
<td>10,012</td>
<td>814</td>
<td>2,616</td>
<td>2,608</td>
<td>2,129</td>
<td>973</td>
<td>394</td>
<td>185</td>
<td>279</td>
</tr>
<tr>
<td>2006/07</td>
<td>10,047</td>
<td>839</td>
<td>2,674</td>
<td>2,579</td>
<td>2,042</td>
<td>1,033</td>
<td>424</td>
<td>186</td>
<td>255</td>
</tr>
<tr>
<td>2007/08</td>
<td>11,110</td>
<td>861</td>
<td>3,030</td>
<td>2,720</td>
<td>2,270</td>
<td>1,121</td>
<td>528</td>
<td>229</td>
<td>331</td>
</tr>
<tr>
<td>2008/09</td>
<td>11,090</td>
<td>711</td>
<td>2,741</td>
<td>2,773</td>
<td>2,510</td>
<td>1,225</td>
<td>520</td>
<td>249</td>
<td>310</td>
</tr>
<tr>
<td>2009/10</td>
<td>11,618</td>
<td>688</td>
<td>2,880</td>
<td>2,734</td>
<td>2,501</td>
<td>1,461</td>
<td>648</td>
<td>281</td>
<td>384</td>
</tr>
</tbody>
</table>

1. The data include private patients treated in NHS hospitals (but not private patients in private hospitals).
2. The data is based on a finished admission episode is the first period of in-patient care under one consultant within one healthcare provider. Please note that admissions do not represent the number of in-patients, as a person may have more than one admission within the year.
3. The primary diagnosis is the first of up to 14 (7 prior to 2002-03) diagnosis fields in the Hospital Episode Statistics (HES) dataset and provides the main reason why the patient was in hospital.
4. The data is based on the tenth revision of the International Classification of Diseases (ICD-10), Codes T40.0 - T40.9, T43.6
5. Counts include people resident in England Strategic Health Authorities (SHAs) only.
6. Total counts exclude admissions where the SHA of residence is unknown.
7. Total counts include admissions where the SHA or residence was England but not further specified.
8. Figures have not been adjusted for shortfalls in data.
9. Includes admissions where the age was unknown.

Source:
Hospital Episode Statistics, HES. The NHS Information Centre for health and social care

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Table 3.8 NHS hospital admissions to hospital\(^{1,2}\) where there was a primary diagnosis\(^{3}\) of poisoning by drugs\(^{4}\), by Strategic Health Authority\(^{5,6}\) and gender, 2009/10\(^{7}\)

<table>
<thead>
<tr>
<th>England(^{10,11})</th>
<th>Number of admissions per 100,000 of population(^{9})</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total(^{9})</td>
<td></td>
<td></td>
</tr>
<tr>
<td>England(^{10,11})</td>
<td>11,618</td>
<td>22</td>
<td>6,139</td>
</tr>
<tr>
<td>North East</td>
<td>1,051</td>
<td>41</td>
<td>574</td>
</tr>
<tr>
<td>North West</td>
<td>2,363</td>
<td>34</td>
<td>1,161</td>
</tr>
<tr>
<td>Yorkshire and the Humber</td>
<td>1,378</td>
<td>26</td>
<td>740</td>
</tr>
<tr>
<td>East Midlands</td>
<td>993</td>
<td>22</td>
<td>515</td>
</tr>
<tr>
<td>West Midlands</td>
<td>1,217</td>
<td>22</td>
<td>669</td>
</tr>
<tr>
<td>East of England</td>
<td>875</td>
<td>15</td>
<td>457</td>
</tr>
<tr>
<td>London</td>
<td>1,000</td>
<td>13</td>
<td>580</td>
</tr>
<tr>
<td>South East Coast</td>
<td>779</td>
<td>18</td>
<td>387</td>
</tr>
<tr>
<td>South Central</td>
<td>668</td>
<td>16</td>
<td>325</td>
</tr>
<tr>
<td>South West</td>
<td>1,081</td>
<td>21</td>
<td>544</td>
</tr>
</tbody>
</table>

1. The data include private patients treated in NHS hospitals (but not private patients in private hospitals).
2. The data is based on a finished admission episode which is the first period of in-patient care under one consultant within one healthcare provider. Please note that admissions do not represent the number of in-patients, as a person may have more than one admission within the year.
3. The primary diagnosis is the first of up to 14 (7 prior to 2002-03) diagnosis fields in the Hospital Episode Statistics (HES) dataset and provides the main reason why the patient was in hospital.
4. The data is based on the tenth revision of the International Classification of Diseases (ICD-10), Codes T40.0 - T40.9, T43.6.
5. Counts include people resident in England Strategic Health Authorities (SHAs) only.
6. This is the SHA in which the patient is normally resident, based on the patient's postcode.
7. Figures have not been adjusted for shortfalls in data.
8. Total counts include admissions where the gender was unknown.
9. The number of admissions per 100,000 of population all ages use estimated resident population mid-2009 figures based on the 2001 census published by the Office for National Statistics (ONS). Information on ONS Population data is available at: http://www.statistics.gov.uk/census2001/default.asp
10. Total counts include admissions where the SHA or residence was England but not further specified.
11. Total counts exclude admissions where the SHA of residence is unknown.

Source:
Hospital Episode Statistics, HES. The NHS Information Centre for health and social care

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Table 3.9 NHS hospital admissions\(^{1,2}\) where a primary diagnosis\(^{3}\) of poisoning by drugs\(^{1,2}\) by Strategic Health Authority\(^{1,2,3,4}\) and Primary Care Trust\(^{5,6}\), 2009/10\(^{7}\)

<table>
<thead>
<tr>
<th>Strategic Health Authority</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>England</td>
<td>11,618</td>
</tr>
<tr>
<td>North East Strategic Health Authority</td>
<td>1,051</td>
</tr>
<tr>
<td>North West Strategic Health Authority</td>
<td>4,363</td>
</tr>
<tr>
<td>Yorkshire &amp; The Humber Strategic Health Authority</td>
<td>4,320</td>
</tr>
<tr>
<td>South Central Strategic Health Authority</td>
<td>668</td>
</tr>
<tr>
<td>East Midlands Strategic Health Authority</td>
<td>993</td>
</tr>
<tr>
<td>West Midlands Strategic Health Authority</td>
<td>1,217</td>
</tr>
<tr>
<td>London Strategic Health Authority</td>
<td>3,378</td>
</tr>
</tbody>
</table>

---

1. Counts include people resident in England SHAs only.
2. The data is based on a finished admission episode which is the first period of in-patient care under one consultant within one healthcare provider. Please note that admissions do not represent the number of in-patients, as a person may have more than one admission in a year.
3. Codes T40.0 - T40.9, T43.6.
4. The data is based on the tenth revision of the International Classification of Diseases (ICD-10), Codes T40.0 - T40.9, T43.6.
5. This is the Strategic Health Authority (SHA) in which the patient is normally resident, not the SHA in which the patient was treated.
6. Counts exclude admissions where the SHA of residence is unknown.
7. Counts include people resident in England SHAs only.
8. Codes T40.0 - T40.9, T43.6.
9. Counts exclude admissions where the residence is unknown but the SHA of residence is known.
10. Codes T40.0 - T40.9, T43.6.
11. Where PCT’s have less than 6 admissions recorded over the year, these figures have not been plotted to avoid data disclosure issues.
12. Counts include people resident in England SHAs only.
13. Codes T40.0 - T40.9, T43.6.
14. Counts exclude admissions where the SHA of residence is unknown.
15. Where PCT’s have less than 6 admissions recorded over the year, these figures have not been plotted to avoid data disclosure issues.
16. Counts include people resident in England SHAs only.
17. Codes T40.0 - T40.9, T43.6.
18. Counts exclude admissions where the SHA of residence is unknown.
19. Where PCT’s have less than 6 admissions recorded over the year, these figures have not been plotted to avoid data disclosure issues.
20. Counts include people resident in England SHAs only.
21. Codes T40.0 - T40.9, T43.6.
22. Counts exclude admissions where the SHA of residence is unknown.
23. Where PCT’s have less than 6 admissions recorded over the year, these figures have not been plotted to avoid data disclosure issues.
### Table 3.10 NDTMS\(^1\) clients in treatment, by gender and age\(^2\), 2009/10

<table>
<thead>
<tr>
<th>England</th>
<th>Numbers / percentages (^3)</th>
<th>Total</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>All clients</td>
<td></td>
<td>206,889</td>
<td>151,351</td>
<td>55,538</td>
</tr>
<tr>
<td>18-24</td>
<td></td>
<td>27,071</td>
<td>18,069</td>
<td>9,002</td>
</tr>
<tr>
<td>25-29</td>
<td></td>
<td>40,485</td>
<td>28,496</td>
<td>11,989</td>
</tr>
<tr>
<td>30-34</td>
<td></td>
<td>44,964</td>
<td>33,137</td>
<td>11,827</td>
</tr>
<tr>
<td>35-39</td>
<td></td>
<td>39,719</td>
<td>30,157</td>
<td>9,562</td>
</tr>
<tr>
<td>40+</td>
<td></td>
<td>54,650</td>
<td>41,492</td>
<td>13,158</td>
</tr>
</tbody>
</table>

2. Age is based on the client's age at the start of the financial year (1st April 2009) if their treatment commenced before that point, otherwise their age at commencement of treatment is used.
3. Percentages are rounded to the nearest per cent. Totals may not add up to 100 due to rounding.

**Source:**
Statistics from the National Drug Treatment Monitoring System (NDTMS) 1 April 2009 - 31 March 2010. National Treatment Agency for Substance Misuse (NTA)
### Table 3.11 Primary<sup>1</sup> drug use of all clients<sup>2</sup> in NDTMS, 2009/10

<table>
<thead>
<tr>
<th>England</th>
<th>Numbers / percentages&lt;sup&gt;3&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total</strong></td>
<td>206,889</td>
</tr>
<tr>
<td><strong>PDU&lt;sup&gt;4&lt;/sup&gt; Total</strong></td>
<td>173,760</td>
</tr>
<tr>
<td>Opiates Only (PDUs)</td>
<td>102,598</td>
</tr>
<tr>
<td>Crack Only (PDUs)</td>
<td>6,560</td>
</tr>
<tr>
<td>Opiates &amp; Crack (PDUs)</td>
<td>64,602</td>
</tr>
<tr>
<td><strong>Non PDU Total</strong></td>
<td>32,690</td>
</tr>
<tr>
<td>Benzodiazepines</td>
<td>1,179</td>
</tr>
<tr>
<td>Amphetamines (excluding ecstasy)</td>
<td>3,858</td>
</tr>
<tr>
<td>Cocaine (excluding Crack)</td>
<td>10,915</td>
</tr>
<tr>
<td>Hallucinogens</td>
<td>513</td>
</tr>
<tr>
<td>Ecstasy</td>
<td>273</td>
</tr>
<tr>
<td>Cannabis</td>
<td>14,306</td>
</tr>
<tr>
<td>Solvent</td>
<td>116</td>
</tr>
<tr>
<td>Barbiturates</td>
<td>11</td>
</tr>
<tr>
<td>Major Tranquilisers</td>
<td>24</td>
</tr>
<tr>
<td>Anti-depressants</td>
<td>82</td>
</tr>
<tr>
<td>Other Drugs</td>
<td>845</td>
</tr>
<tr>
<td>Poly Drug</td>
<td>31</td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td>536</td>
</tr>
<tr>
<td>Misuse Free</td>
<td>440</td>
</tr>
</tbody>
</table>

---

1. To define primary drug, users of opiates and/or crack cocaine are identified in the first instance, if a person is not using opiates and/or crack cocaine they are reported by their primary drug.
2. Clients are all 18 years of age or above.
3. Percentages are rounded to the nearest per cent. Totals may not add up to 100 due to rounding.
4. PDU is the acronym for Problem Drug Users.

**Source:**

Statistics from the National Drug Treatment Monitoring System (NDTMS) 1 April 2009 - 31 March 2010. National Treatment Agency for Substance Misuse (NTA)

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### Table 3.12 Treatment exit reasons for individuals with completed episodes of treatment on 31st March 2010 reported to NTDMS\(^1\)

<table>
<thead>
<tr>
<th>England</th>
<th>Numbers / percentages(^2)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total (episodes discharged)</strong></td>
<td>62,685</td>
</tr>
<tr>
<td><strong>Total successful completions</strong></td>
<td>23,680</td>
</tr>
<tr>
<td>Treatment completed free of dependency</td>
<td>15,568</td>
</tr>
<tr>
<td>Treatment completed drug free</td>
<td>8,112</td>
</tr>
<tr>
<td>Transferred - not in custody</td>
<td>9,352</td>
</tr>
<tr>
<td>Transferred - in custody</td>
<td>5,266</td>
</tr>
<tr>
<td>Referred on</td>
<td>1,079</td>
</tr>
<tr>
<td>Dropped out/ left</td>
<td>17,023</td>
</tr>
<tr>
<td>Prison</td>
<td>1,811</td>
</tr>
<tr>
<td>Treatment declined</td>
<td>1,869</td>
</tr>
<tr>
<td>Treatment withdrawn</td>
<td>1,121</td>
</tr>
<tr>
<td>Moved away</td>
<td>178</td>
</tr>
<tr>
<td>Died</td>
<td>1,076</td>
</tr>
<tr>
<td>Other(^3)</td>
<td>121</td>
</tr>
<tr>
<td>Not known</td>
<td>33</td>
</tr>
<tr>
<td>No appropriate treatment</td>
<td>76</td>
</tr>
</tbody>
</table>

2. Percentages are rounded to the nearest per cent. Totals may not add up to 100 due to rounding.
3. Where the provider recorded that they did not know the reason for the discharge.

**Source:**

Statistics from the National Drug Treatment Monitoring System (NDTMS) 1 April 2009 - 31 March 2010. National Treatment Agency for Substance Misuse (NTA)

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### Table 3.13 People in treatment by Government Office Region\(^1\), age\(^2\) and gender reported to NDTMS\(^3\), 2009/10

<table>
<thead>
<tr>
<th></th>
<th>England</th>
<th>North East</th>
<th>North West</th>
<th>Yorkshire and The Humber</th>
<th>East Midlands</th>
<th>West Midlands</th>
<th>East of England</th>
<th>London</th>
<th>South East</th>
<th>South West</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>All adults</strong></td>
<td>206,889</td>
<td>14,304</td>
<td>38,550</td>
<td>25,479</td>
<td>15,750</td>
<td>22,969</td>
<td>15,475</td>
<td>34,850</td>
<td>21,390</td>
<td>18,122</td>
</tr>
<tr>
<td>18-24</td>
<td>27,071</td>
<td>2,586</td>
<td>4,012</td>
<td>5,264</td>
<td>2,684</td>
<td>2,283</td>
<td>3,619</td>
<td>2,338</td>
<td>411</td>
<td>327</td>
</tr>
<tr>
<td>25-29</td>
<td>40,485</td>
<td>3,715</td>
<td>5,254</td>
<td>5,876</td>
<td>3,867</td>
<td>3,733</td>
<td>3,973</td>
<td>2,913</td>
<td>5676</td>
<td>4147</td>
</tr>
<tr>
<td>30-34</td>
<td>44,964</td>
<td>3,491</td>
<td>7,654</td>
<td>6,792</td>
<td>3,805</td>
<td>5,393</td>
<td>3,318</td>
<td>5,983</td>
<td>4,464</td>
<td>4,074</td>
</tr>
<tr>
<td>35-39</td>
<td>39,719</td>
<td>2,397</td>
<td>9,131</td>
<td>5,364</td>
<td>2,737</td>
<td>3,892</td>
<td>2,805</td>
<td>6,026</td>
<td>3,822</td>
<td>3,545</td>
</tr>
<tr>
<td>40+</td>
<td>54,650</td>
<td>2,125</td>
<td>12,499</td>
<td>4,963</td>
<td>3,058</td>
<td>4,332</td>
<td>4,101</td>
<td>13,054</td>
<td>5,680</td>
<td>4,838</td>
</tr>
<tr>
<td><strong>Men</strong></td>
<td>151,351</td>
<td>10,638</td>
<td>27,864</td>
<td>18,463</td>
<td>11,649</td>
<td>17,260</td>
<td>11,157</td>
<td>25,970</td>
<td>15,502</td>
<td>12,848</td>
</tr>
<tr>
<td>18-24</td>
<td>18,069</td>
<td>1.811</td>
<td>2,833</td>
<td>1,657</td>
<td>1,499</td>
<td>2,405</td>
<td>1,489</td>
<td>2,927</td>
<td>2190</td>
<td>1,258</td>
</tr>
<tr>
<td>30-34</td>
<td>33,137</td>
<td>2,630</td>
<td>5,328</td>
<td>5,010</td>
<td>2,881</td>
<td>4,220</td>
<td>2,420</td>
<td>4,463</td>
<td>3,203</td>
<td>2,982</td>
</tr>
<tr>
<td>35-39</td>
<td>30,157</td>
<td>1,910</td>
<td>6,703</td>
<td>4,148</td>
<td>2,159</td>
<td>3,090</td>
<td>2,096</td>
<td>4,464</td>
<td>2,928</td>
<td>2,659</td>
</tr>
<tr>
<td>40+</td>
<td>41,492</td>
<td>1,656</td>
<td>9,449</td>
<td>3,811</td>
<td>2,339</td>
<td>3,388</td>
<td>3,077</td>
<td>9,901</td>
<td>4,268</td>
<td>3,603</td>
</tr>
<tr>
<td><strong>Women</strong></td>
<td>55,538</td>
<td>3,666</td>
<td>10,686</td>
<td>7,016</td>
<td>4,101</td>
<td>5,709</td>
<td>4,318</td>
<td>8,880</td>
<td>5,888</td>
<td>5,274</td>
</tr>
<tr>
<td>18-24</td>
<td>9,002</td>
<td>775</td>
<td>1,179</td>
<td>1,027</td>
<td>784</td>
<td>1,214</td>
<td>849</td>
<td>1,184</td>
<td>1,087</td>
<td>903</td>
</tr>
<tr>
<td>25-29</td>
<td>11,989</td>
<td>1,084</td>
<td>1,703</td>
<td>1,839</td>
<td>1,096</td>
<td>1,576</td>
<td>838</td>
<td>1,461</td>
<td>1,234</td>
<td>1,158</td>
</tr>
<tr>
<td>30-34</td>
<td>11,827</td>
<td>851</td>
<td>2,326</td>
<td>1,782</td>
<td>924</td>
<td>1,173</td>
<td>898</td>
<td>1,520</td>
<td>1,261</td>
<td>1,092</td>
</tr>
<tr>
<td>35-39</td>
<td>9,562</td>
<td>487</td>
<td>2,428</td>
<td>1,216</td>
<td>578</td>
<td>802</td>
<td>709</td>
<td>1,562</td>
<td>894</td>
<td>886</td>
</tr>
<tr>
<td>40+</td>
<td>13,158</td>
<td>469</td>
<td>3,050</td>
<td>1,152</td>
<td>719</td>
<td>944</td>
<td>1,024</td>
<td>3,153</td>
<td>1,412</td>
<td>1,235</td>
</tr>
</tbody>
</table>

1. Government Office Region of residence. Regional figures derived by summing figures for their constituent Partnership Areas. England figures derived by summing the Regional figures; hence movement of clients between Partnership Areas results in multiple counting of individuals.
2. Age is based on the client's age at the start of the financial year (1st April 2009) if their treatment commenced.
3. National Drug Treatment Monitoring System (NDTMS)

**Source:**
Substance Misuse (NTA)

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Table 3.14  Number of deaths related to drug misuse by gender and age group, 1993-2008

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td>829</td>
<td>958</td>
<td>1,089</td>
<td>1,156</td>
<td>1,312</td>
<td>1,457</td>
<td>1,628</td>
<td>1,604</td>
<td>1,805</td>
<td>1,613</td>
<td>1,432</td>
<td>1,495</td>
<td>1,608</td>
<td>1,573</td>
<td>1,604</td>
<td>1,738</td>
</tr>
<tr>
<td><strong>Males</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All ages</td>
<td></td>
<td>577</td>
<td>718</td>
<td>840</td>
<td>936</td>
<td>1,041</td>
<td>1,142</td>
<td>1,321</td>
<td>1,329</td>
<td>1,450</td>
<td>1,269</td>
<td>1,118</td>
<td>1,177</td>
<td>1,260</td>
<td>1,250</td>
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<td>53</td>
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<td>75</td>
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<td>29</td>
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</tr>
<tr>
<td>20-29</td>
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<td>224</td>
<td>292</td>
<td>341</td>
<td>385</td>
<td>456</td>
<td>453</td>
<td>477</td>
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<td>503</td>
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<td>353</td>
<td>346</td>
<td>336</td>
<td>338</td>
<td>343</td>
<td>328</td>
</tr>
<tr>
<td>30-39</td>
<td></td>
<td>167</td>
<td>213</td>
<td>253</td>
<td>297</td>
<td>299</td>
<td>379</td>
<td>502</td>
<td>492</td>
<td>537</td>
<td>479</td>
<td>456</td>
<td>480</td>
<td>521</td>
<td>481</td>
<td>498</td>
<td>490</td>
</tr>
<tr>
<td>40-49</td>
<td></td>
<td>75</td>
<td>97</td>
<td>115</td>
<td>125</td>
<td>140</td>
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<td>179</td>
<td>239</td>
<td>247</td>
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<td>187</td>
<td>197</td>
<td>239</td>
<td>270</td>
<td>296</td>
<td>350</td>
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<tr>
<td>50-69</td>
<td></td>
<td>44</td>
<td>44</td>
<td>51</td>
<td>44</td>
<td>51</td>
<td>41</td>
<td>64</td>
<td>71</td>
<td>75</td>
<td>63</td>
<td>108</td>
<td>114</td>
<td>103</td>
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</table>

1. As defined by the headline indicator on drug misuse - see Appendix A for further information.
2. Data in this table have been compiled based on deaths registered in each calendar year. Previous years have been based on deaths occurring in each calendar year.
3. As the indicator is based on the current list of drugs controlled under the Misuse Drugs Act, earlier years' data have been updated to reflect additional substances.

Source:
Health Statistics Quarterly 43. The Office for National Statistics (ONS)

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Table 3.15 Number of deaths related to drug misuse by gender and underlying cause of death, 1993-2008

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</table>

1. As defined by the headline indicator on drug misuse - see Appendix A for further information.
2. The mental and behavioral disorders data is based on the tenth revision of the International Classification of Diseases (ICD-10), Codes F11-F16, F18, F19 and excludes alcohol and tobacco.
3. The accidental poisoning by drugs data is based on ICD-10 codes X40-X44 and includes accidental poisoning by medicaments and biological substances.
4. The intentional self-poisoning data etc is based on ICD-10 codes X60 - X64 and Y10 - Y14 and includes intentional self-poisoning/ poisoning by medicaments and biological substances.
5. The assault by drugs data is based on ICD-10 code X85 and includes assault by medicaments and biological substances.

Source:
Health Statistics Quarterly 43. The Office for National Statistics (ONS)

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Appendix A: Key Sources

- Drug Misuse Declared: Findings from the 2008/09 British Crime survey
- Smoking Drinking and Drug use among Young People in England in 2008
- Hospital Episode Statistics
- The National Drug Treatment Monitoring System
- Health Statistics Quarterly

The British Crime Survey

The British Crime Survey (BCS) is a large, nationally representative survey of adults living in private households in England and Wales. Since 1996, the BCS has included a self-completion module of questions on illicit drug use and comparable results are available for 1996, 1998, 2000, 2001/02, 2002/03, 2003/04, 2004/05, 2005/06 and 2006/07. Main findings regarding drug misuse from the BCS can be found in the yearly ‘Drug Misuse Declared’ publications.

From April 2000, the BCS moved from a biennial to a continuous survey and the sample size was increased significantly to provide a more effective tool for monitoring the Government’s strategy for tackling drug misuse. Since 2001/02, the BCS has reported on a financial year basis, rather than a calendar year.

Results from the 2008/09 survey were published in July 2009. The figures in this report are based on interviews conducted between April 2008 and March 2009. A final sample size of 28,604 respondents completed the drugs module.

The BCS is a household survey and, therefore, does not cover all groups of society, some of which may be considered potentially important in terms of having high levels of drug use. Particular groups which are not covered by the survey are the homeless and those living in certain institutions such as prisons or student halls of residence. It is also believed that a household survey is not the best vehicle for reaching problematic drug users who may be difficult to contact. Since 1996, those aged 60 or over have not been asked to complete the drugs component of the BCS (the decision to exclude those aged 60 or over was an economy measure, reflecting the very low prevalence of illicit drug use in this age group).

Table A1 on the following page shows the current classification of illicit drugs and the penalties for being caught either in possession of or dealing them.
Table A1: Drugs that respondents were asked about in the BCS and their classification under the Misuse of Drugs Act.

<table>
<thead>
<tr>
<th>Class A drugs</th>
<th>Penalties for possession: Up to seven years in prison or an unlimited fine. Or both</th>
</tr>
</thead>
<tbody>
<tr>
<td>Include: Ecstasy, LSD, heroin, cocaine, crack, magic mushrooms (whether prepared or fresh), methylamphetamine (crystal meth)</td>
<td>Penalties for dealing: Up to life in prison or an unlimited fine. Or both</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Class B drugs</th>
<th>Penalties for possession: Up to five years in prison or an unlimited fine. Or both</th>
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</thead>
<tbody>
<tr>
<td>Include: Cannabis, amphetamines, Methylphenidate (Ritalin), Pholcodine</td>
<td>Penalties for dealing: Up to 14 years in prison or an unlimited fine. Or both</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Class C drugs</th>
<th>Penalties for possession: Up to two years in prison or an unlimited fine. Or both</th>
</tr>
</thead>
<tbody>
<tr>
<td>Include: Tranquilisers, some painkillers, GHB (Gamma hydroxybutyrate), ketamine</td>
<td>Penalties for dealing: Up to 14 years in prison or an unlimited fine. Or both</td>
</tr>
</tbody>
</table>

Smoking, Drinking and Drug Use among Young People in England, in 2009

Smoking, Drinking and Drug use Survey among Young People in England in 2009 is the latest in the series of surveys of secondary school children in England which provides the national estimates of the proportions of young people aged 11 to 15 who smoke, drink alcohol or take illegal drugs.

The first survey in the series, carried out in 1982, measured the prevalence of smoking among pupils and described their smoking behaviour.

Trends in smoking were monitored by similar surveys carried out every two years. Questions on alcohol consumption were added to the survey in 1988; the 1998 survey was the first to include questions on the prevalence of drug use. Since 2000, the survey has been carried out annually by the National Centre for Social Research (NatCen) and since 2005 it has been funded by The NHS Information Centre, The Home Office and Department for Education (previously The Department for children, schools and families).

The 2009 survey achieved a sample of 7,674 pupils aged between 11 and 15 in 247 schools.
Hospital Episode Statistics

HES is a data warehouse containing details of all admissions to NHS hospitals in England. It includes private patients treated in NHS hospitals, patients who were resident outside of England and care delivered by treatment centres (including those in the independent sector) funded by the NHS. HES also contains details of all NHS outpatient appointments in England as well as detailed records of attendances at major A&E departments, single specialty A&E departments, minor injury units and walk-in centres in England.

HES is the data source for a wide range of healthcare analysis for the NHS, government and many other organisations and individuals. The HES Service and website (see below) are run by Northgate Information Solutions on behalf of the NHS Information Centre.

www.hesonline.nhs.uk

HES data are classified using International Classification of Diseases (ICD). The ICD is the international standard diagnostic classification for all general epidemiological and many health management purposes. It is used to classify diseases and other health problems recorded on many types of health and vital records including death certificates and hospital records. The International Classification of Diseases, Tenth Revision (ICD-10), published by the World Health Organisation (WHO) is currently in use.

The ICD-10 codes which are included in this statistical bulletin in Chapter 3 are as follows:

**Admissions for mental and behavioural disorders due to psychoactive substance use**
- F11 Mental and behavioural disorders due to use of opioids
- F12 Mental and behavioural disorders due to use of cannabinoids
- F13 Mental and behavioural disorders due use of sedatives or hypnotics
- F14 Mental and behavioural disorders due to use of cocaine
- F15 Mental and behavioural disorders due use of other stimulants including caffeine
- F16 Mental and behavioural disorders due to use of hallucinogens
- F18 Mental and behavioural disorders due to the use of volatile solvents
- F19 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances

**Admissions for primary diagnosis of poisoning by drugs**
- T40 Poisoning by narcotics and psychodysleptics (Hallucinogens)
- T43.6 Poisoning by psychotropic drugs not else classified
  - T40.0 (Opium)
  - T40.1 Heroin
  - T40.2 Other Opioids
  - T40.3 Methadone
  - T40.4 Other synthetic narcotics
  - T40.5 Cocaine
  - T40.6 Other and unspecified narcotics
  - T40.7 Cannabis
  - T40.8 Lysergide
  - T40.9 Other and unspecified psychodysleptics (hallucinogens)
Some caution is necessary when looking at these data as, drug misuse may only be suspected and may not always be recorded by the hospital and, where drug misuse is recorded it may not be possible to identify when drug(s) may be involved.

The primary diagnosis is the first of up to 14 (7 prior to 2002-03) diagnosis fields in the Hospital Episode Statistics (HES) data set and provides the main reason why the patient was in hospital.

As well as the primary diagnosis, there are up to 13 (6 prior to 2002-03) secondary diagnosis fields in Hospital Episode Statistics (HES) that show other diagnoses relevant to the episode of care.

HES data on hospital admissions can be found in Chapter 3.

Please exercise care when comparing HES figures for different years.

Fluctuations in the data can occur for a number of reasons, eg organisational changes, reviews of best practice within the medical community, the adoption of new coding schemes and data quality problems that are often year specific. These variations can lead to false assumptions about trends.

We advise users of time series data to carefully explore the relevant issues before drawing any conclusions about the reasons for year-on-year changes.

The National Drug Treatment Monitoring System (NDTMS)

Up until 31 March 2001, data on the numbers of people presenting to services with problem drug misuse were collected by the Regional Drug Misuse Databases (RDMDs) in England. Following a strategic review of the structure and operation of the RDMDs, the National Drug Treatment Monitoring System (NDTMS) was introduced in England and Wales from 1 April 2001. Reporting to the NDTMS is voluntary and trends can be affected by reporting practices. Data collection methods were improved in 2004/05, resulting in more treatment providers reporting to NDTMS.

The NDTMS reports the number of people receiving tier 3 or 4 treatment for drug misuse in England (i.e. structured community based services, or residential and inpatient services), in order to monitor progress towards the Government’s targets for participation in drug treatment programmes. Responsibility for managing the NDTMS was transferred from the Department of Health to the National Treatment Agency for Substance Misuse (NTA) on 1 April 2003.

NDTMS data were collected from providers by regional NDTMS centres, and forwarded to the National Drug Evidence Centre (NDEC) for data analysis, processing and verification. The results of the analysis were then passed back to the NTA for publication. The most recent full report available is Statistics from the National Drug Treatment Monitoring System (NDTMS) 1 April 2009 – 31 March 2010. The analysis for 2009/10 is based on data provided to the National Drug Treatment Monitoring System up to 31st March 2010.

Regional analyses refer to the client’s local Drug Action Team (DAT), regardless of whether the client was treated within this DAT. This use of the ‘DAT of residence’ method, which is considered to give the best representation of regional activity, marks a change in methodology since the 2003/04 report, which used the DAT of treatment in regional analyses due to the
considerable amount of missing DAT of residence in that year’s data. DAT of treatment was used as a proxy where DAT of residence was not provided.

A client may attend one or more modalities/ interventions (or types) of treatment during the same episode of treatment. A client may also have more than one episode in a year. A client is included in the results if any part of an episode occurs within the year. Where several episodes were collected for an individual, attributes such as ethnicity, main drug etc. are based on the first valid data available for that individual.

Information from the NDTMS reports can be found in Chapter 3.


Health Statistics Quarterly

Health Statistics Quarterly, published by the Office for National Statistics (ONS) presents information on the latest trends in the UK’s health, including data on drug related deaths in England and Wales. In this report data have been compiled based on deaths registered in each calendar year. In previous reports, data have been compiled based on deaths occurring in each calendar year. The decision by ONS to change the reporting is because, over the last few years delays in registering deaths from drug poisoning have been increasing, as the time between death and inquest lengthens. This has resulted in the annual occurrences files becoming increasingly incomplete for these deaths, since they are frozen nine months after the year end to which they refer (e.g. the annual file for 2004 closed in September 2005). In contrast, the annual death registrations files, being based on all deaths that were registered in the year, regardless of when they occurred, can be closed earlier (April following the year end) and are always complete.

In 2000 the Advisory Council on the Misuse of Drugs published a report, Reducing Drug Related Deaths. In response to this report’s recommendations on improving the present system for collecting data on drug-related deaths, a technical working group was set up. This group, consisting of experts across government, the devolved administrations, coroners, toxicologists and drugs agencies, proposed a headline indicator for drug-related deaths as part of the ’s Action Plan to reduce the number of these deaths. This indicator also takes into account the information needs of the European Monitoring Centre for Drugs and Drug Addiction. The definition of the indicator is deaths where the underlying cause is poisoning, drug abuse or drug dependence and where any of the substances controlled under the Misuse of Drugs Act (1971) are involved. This definition has been adopted across the UK. The baseline year for monitoring deaths related to drug misuse was set as 1999.

The cause of death categories included in the headline indicator of drug-related deaths (the relevant codes from ICD-10 are given in brackets) are shown below:

a) deaths where the underlying cause of death has been coded to the following categories of mental and behavioural disorders due to psychoactive substance use (excluding alcohol, tobacco and volatile solvents):
(i) opioids (F11);
(ii) cannabinoids (F12);
(iii) sedatives or hypnotics (F13);
(iv) cocaine (F14);
(v) other stimulants, including caffeine (F15);
(vi) hallucinogens (F16); and
(vii) multiple drug use and use of other psychoactive substances (F19)

b) deaths coded to the following categories and where a drug controlled under the Misuse of Drugs Act 1971 was mentioned on the death record:
(i) Accidental poisoning by drugs, medicaments and biological substances (X40–X44);
(ii) Intentional self-poisoning by drugs, medicaments and biological substances (X60–X64);
(iii) Poisoning by drugs, medicaments and biological substances, undetermined intent (Y10–Y14);
(iv) Assault by drugs, medicaments and biological substances (X85);
(v) Mental and behavioural disorders due to use of volatile solvents (F18)

Data from this publication can be found in Chapter 3.

Adult Psychiatric Morbidity in England, 2007: results of a household survey

The Adult Psychiatric Morbidity Survey (APMS) 2007 is the third survey of psychiatric morbidity among adults living in private households. It was carried out by the National Centre for Social Research (NatCen) in collaboration with the University of Leicester, and was commissioned by The NHS Information Centre for health and social care.

The main aim of the 2007 survey was to collect data on mental health among adults aged 16 and over living in private households in England. It is the primary source of information on the prevalence of both treated and untreated psychiatric disorders and their associations: data which cannot be obtained from other sources. As with the surveys of adult psychiatric morbidity conducted in 1993 and 2000, a two-phase approach was used.

The first phase interviews included structured assessments serving diagnostic criteria and screening instruments for a range of mental disorders, as well as questions on topics such as general health, service use, risk factors and demographics. The second phase interviews were carried out by clinically trained research interviewers. A subsample of phase one respondents were invited to take part in a second phase interview. The assessment of conditions such as psychosis and personality disorder required a more flexible interview than was possible at the first phase, and the use of clinical judgement in ascertaining a diagnosis.

Each chapter of this report focuses on a different mental disorder or behaviour. The chapters present disorder (or screen positive) prevalence by various characteristics, including age, sex, ethnicity, marital status, region, and the level and nature of treatment and service use. Where comparable data exist from the 1993 and 2000 surveys, changes in rate are also considered.
2008-09 Scottish crime and justice survey – Drug Use

The Scottish Crime and Justice Survey is a continuous survey measuring adults’ experience and perceptions of crime in Scotland. This is an annual survey which is based on 16,000 interviews which are carried out in home, face-to-face with adults aged 16 or over which live in private households in Scotland. The report shows the extent of illicit drug use ever, in the last year and in the last month whilst also questioning the user’s experience of first drug use and drug use in the last month.


TellUs4 National Report

In October 2008, the Department for Children, Schools and Families (DCSF) commissioned the National Foundation for Educational Research (NFER), to develop and deliver the Tellus4 survey.

The Tellus4 survey was completed in October and November 2009 by 253,755 children and young people in Years 6, 8 and 10 in 3,699 primary, secondary, special schools and Pupil Referral Units (PRU) across 151 local authorities. In addition, 11 Service Children’s Education schools took part in the survey.

The survey was developed and completed entirely online.

Recently it was announced that the TellUs survey has been stopped in an attempt to reduce the data collection burden placed on schools.

http://publications.education.gov.uk/eOrderingDownload/DCSF-RR218.pdf
Appendix B: Government plans and targets

The new Government (elected in May 2010) have released a high level Drug Strategy in December 2010, entitled ‘Reducing demand, restricting supply, building recovery: supporting people to live a drug-free life’ is linked below however the rest of the following links and detail are relating to the policies and targets set by the previous Government as they were applicable when the data used in the report was collected.

‘Reducing demand, restricting supply, building recovery: supporting people to live a drug-free life’

http://www.homeoffice.gov.uk/drugs/drug-strategy-2010/

Public Service Agreement 14 and 25

In April 2008, the then Government agreed to new Public Service Agreements (PSAs) which envisaged a long-term and sustainable reduction in the harms associated with drugs. The main aims of these PSAs were to reduce the harm caused by Alcohol and Drugs and increase the number of people on the path to success.

The vision in PSA 25 was to produce a long-term and sustainable reduction in the harms associated with alcohol and drugs, where:

- fewer people develop drug problems; where there is early intervention to prevent and reduce the harms caused by substance misuse, particularly amongst the most at risk children, young people and families; where people who do have drug problems receive the effective treatment and support they need; where communities are relieved of drug-related crime and associated nuisance; and where organised criminal enterprises are prosecuted and their assets are recovered; and

- there is a safe, sensible and social drinking culture where violent and anti-social behaviour is not tolerated; where young people are prevented from experiencing poor outcomes resulting from alcohol misuse; where those who drink alcohol are aware of the risks involved; and where those that are drinking too much receive the advice and support they need.

The vision in PSA 14 was that all young people should be on the path to success and achieve the five outcomes set out in Aiming high for young people: A ten year strategy for positive activities, the then Government would ensure that all young people:

- have opportunities to take part in activities that develop their resilience and the social and emotional skills they need for life;
• have access to learning that motivates participation and encourages achievement in education, employment training and positive activities;
• have opportunities to gain new life skills and be empowered to take part in decisions which affect them;
• are encouraged to mix with others from different faith and ethnic backgrounds; and
• can better cope with the problems life throws at them and make the right choices – both within school and college and outside it.

Public Service Agreement 14 can be found at:

Public Service Agreement 25 can be found at:
http://www hm-treasury.gov.uk/d/pbr_csr07_psa25.pdf

‘Drugs: protecting families and communities’

In 2008 the then Government introduced a ten year strategy which aimed to restrict the supply of illegal drugs and the demand for them. The strategy comprised of four main elements:

• Protecting communities through tackling drug supply, drug-related crime and anti-social behavior
• Preventing harm to children, young people and families affected by drug misuse
• Delivering new approaches to drug treatment and social re-integration
• Public information campaigns, communications and community engagement


Updated Drug Strategy 2002

The Updated Drug Strategy launched in December 2002, aimed to build upon the original drugs strategy to improve its effectiveness. It concentrated on policies and interventions to reduce the harm that drugs cause to communities, individuals and families. There was a focus on persuading potential drug users not to use drugs, with an emphasis on young people, through a programme of education and support. The updated strategy arose from a review conducted by the Home Affairs Select Committee, which found, that while the then Government’s drug policy covered the right areas, a stronger emphasis was needed on preventing and stopping problematic drug use, reducing the harms from drug misuse and on developing more focused and measurable targets.


Tackling Drugs, Changing Lives

In November 2004, the then Government published ‘Tackling Drugs Changing Lives’, which provided an update of progress made on the Drugs Strategy as well as summarising future planned action.
NHS Plan

This was a Plan for reform with far reaching changes across the NHS. The purpose and vision of the NHS Plan was to give the people of Britain a health service fit for the 21st century: a health service designed around the patient. The aims set out in the NHS Plan for drug misusers were:

- Targeting education and prevention activity to intervene before people develop the habits which do so much damage;
- Strengthening treatment services for drug misusers by setting up a new National Treatment Agency accountable to the Department of Health. It will have a budget that pools resources spent on services for drug misusers, from health and other agencies;


Young People's substance misuse strategy

The Home Office have been working with the Department for Education (formerly the Department for Children, Schools and Families) on a cross-government approach to young people and drugs, which began implementation in April 2005. A main aim of the strategy is to prevent young people from becoming tomorrow's problem drug users. A key aim under the Every Child Matters 'Be Healthy' outcome for children and young people is to encourage young people not to take illegal drugs.

http://drugs.homeoffice.gov.uk/young-people/strategy/

FRANK

FRANK is a joint initiative of the Department of Health and Home Office that was launched in May 2003. The free helpline, 0800 776600, offers confidential advice, information and support to anyone concerned about drug and solvent/volatile substance misuse, including drug users, their families, friends or carers.

www.talktofrank.com

Drug Intervention Programme

The Drug Intervention Programme (DIP) was set up in 2003 to develop and deploy processes to move drug-misusing offenders out of crime and into treatment. The Home Office and the then Department for Education and Skills (DfES) shared a target to reduce the use of Class A drugs and the frequent use of any drugs among all young people under the age of 25, especially by the most vulnerable. DIP’s pilots for children and young people contributed to the delivery of both this programme, and the overall Drug Strategy by, at various points of the youth justice system:
• Identifying children and young people who have, or are at risk of developing, substance misuse problems;
• Assessing their needs; and facilitating appropriate support and treatment services.

http://drugs.homeoffice.gov.uk/publication-search/dip/moving-up-a-gear

The Misuse of Drugs Act

The Misuse of Drugs Act 1971 is the main piece of legislation covering drugs and categorises drugs as Class A, B or C. Under the Act the main offences are to unlawfully: possess a controlled substance and/or have intent to supply it; supply a controlled drug; and to allow premises you occupy or manage to be used for the purpose of drug taking.

www.opsi.gov.uk/si/si2001/20013932.htm

The Drugs Act

The Drugs Act 2005 introduced new police powers to test for Class A drugs, as well as aiming to get more offenders into treatment and clarifying existing legislation in relation to magic mushrooms.

Appendix C: Logistic Regression

Logistic regression modelling was used in Chapters 4 and 5 of ‘The Drug Misuse Declared: Findings from the British Crime survey’ to examine the factors associated with drug use after adjusting for other factors which are referenced in Chapter 1. The model included a variety of explanatory variables relating to both individual characteristics (e.g. age, sex, smoking, drinking, pub visits, employment, ethnicity) and household and area characteristics (household income, structure of household, area classification).

In addition, the models show the relative odds of the outcome of interest (e.g. regular smoking) for each category of the explanatory variable (e.g. gender). For categorical variables, odds are expressed relative to a reference category, which has a given value of 1. Odds ratios greater than 1 indicate higher odds (increased likelihood), and odds ratios less than 1 indicate lower odds (reduced likelihood). 95% confidence intervals for the odds ratios are shown. Where the interval does not include 1, this category is significantly different from the reference category. For continuous variables, there is a single p-value. Continuous variables do not have a reference category; the odds ratio represents the change in odds associated with each additional point in the range (for example each extra year of age, or unit of alcohol drunk). Again, the 95% confidence interval is shown, and the odds ratio is significant if the interval does not include 1.
Appendix D: Editorial notes

For the purpose of clarity, figures in the bulletin are shown in accordance with the NHS Information Centre publication conventions.

These are as follows:
- .. not available
- - zero
- 0 less than 0.5

Percentages greater than or equal to 0.5 are rounded up to the nearest integer. Percentages smaller than 0.5 are rounded down.

Percentages do not always sum to 100 due to rounding.

Changes commented on in the text are statistically significant at the 95% level unless otherwise stated.

The Home Office publication ‘Drug Misuse Declared’ provides percentages correct to 1 decimal place and this bulletin has followed the same convention in Chapter 1. Other conventions used for tables in Chapter 1 are:

- .. indicates that data are not reported because the unweighted base is less than 50.
- - indicates no response (to that particular category)
- . indicates that although the unweighted base under analyses was more than 50 there were insufficient drug users in the sample to enable robust subgroup analyses
Appendix E: Further information

This annual report draws together information on drug misuse among both adults and children. This report forms part of a suite of statistical reports. Other bulletins cover smoking, drinking, obesity, physical activity and diet.

Constructive comments on this report would be welcomed. Any questions concerning the data in this publication, or requests for further information should be addressed to:

The Contact Centre
The NHS Information Centre
1 Trevelyan Square
Boar Lane
Leeds
West Yorkshire
LS1 6AE

Tel: 0845 300 6016
Email: enquiries@ic.nhs.uk

The 2006 - 2009 reports, also published by The NHS Information Centre can be found at:


Previous editions of this report were published by the Department of Health. Information about their statistics and surveys is available on the Department of Health’s website at:

Readers may find the following organisations and publications useful for further information regarding drug use among adults and children.

### Crime in England and Wales

This report is the main annual volume in a series of publications produced by the Home Office on the latest levels and trends in crimes in England and Wales, including drug related crime. The report is based on two sources of statistics, the British Crime Survey (BCS) and police recorded crime data. The BCS and police recorded crime statistics are complementary series, and together these two sources provide a more comprehensive picture of crime than could be obtained from either series alone.

[http://rds.homeoffice.gov.uk/rds/crimeew0405.html](http://rds.homeoffice.gov.uk/rds/crimeew0405.html)

### Department of Health

The Department of Health (DH) provides various guidance and resources on substance for a wide range of professionals and managers involved in preventing and treating drug misuse.


### Department of Health, Social Services and Public Safety, Northern Ireland

Provides statistics and publications for Northern Ireland.


### Drug Action Teams

Drug action teams (DATs) are the partnerships responsible for delivering the drug strategy at a local level. DATs are partnerships combining representatives from local authorities (education, social services, housing) health, probation, the prison service and the voluntary sector. They ensure that the work of local agencies is brought together effectively and that cross-agency projects are co-ordinated successfully.

DATs take strategic decisions on expenditure and service delivery within four aims of the National Drugs Strategy; treatment, young people, communities and supply. Their work involves:

- Commissioning services, including supporting structures;
- Monitoring and reporting on performance;
- Communicating plans, activities and performance to stakeholders.

Combined funding from the Home Office and the Department of Health, known as the Pooled Treatment Budget (PTB), for drug treatment services is allocated annually to DATs. Allocations to DATs are made on a formula basis that recognises key deprivation factors, ensuring the money goes to the areas most in need. DATs then commission treatment services to meet the assessed needs of individuals in their area. Funding from PTB
allocations is supplemented by mainstream funding from the National Health Service. For further information on PTB please follow the links below

Drug Drive

Drug Drive has been set up as part of THINK! road safety, from the Department of Transport, to give 17 to 35 year olds information on how different drugs can impair their driving.
http://www.dft.gov.uk/think/drugdrive/

Drug Education Forum

The Drug Education Forum is open to any national organisation that has an interest in the delivery of effective drug education in England and includes national organisations from health, education, police and voluntary sectors. A full list of members can be found at:
http://www.drugeducationforum.com/about/

The Forum tries to influence public policy and to disseminate the best research on what is effective in drug education. It produces easily digestible briefings for members - and a wider audience - and responds to consultations on policy.

www.drugeducationforum.com/

Drug Misuse in Pregnancy

Drug Misuse in Pregnancy in the Northern and Yorkshire Region report, produced by the North East Public Health Observatory, provides an overview of drug misuse in pregnancy and was prompted by concerns about an increase in the numbers of drug dependent babies being born in the region. It reports the findings of a study undertaken in the former Northern and Yorkshire NHS Region of England into the prevalence of drug misuse in pregnancy and the response of maternity services.

Drug Misuse Information Scotland

The Drug Misuse Information Scotland (DMIST) website provides information, statistics and research on drugs misuse in Scotland. Target users are policy makers, professionals, researchers, employers and the wider community.

www.drugmisuse.isdscotland.org

DrugScope

DrugScope is the UK’s leading independent centre of expertise on drugs. They aim to inform policy development and reduce drug-related risk. DrugScope provides quality drug information, promotes effective responses to drug taking, undertakes research at local, national and international levels, advises on policy-making, encourages informed debate and speak for their
member organisations working on the ground. The DrugScope Information Service allows access to a multi-disciplinary library of over 100,000 documents.

www.drugscope.org.uk/

**European School Survey Project on Alcohol and Other Drugs (ESPAD) Report 2007**

This is the fourth report published within the ESPAD project. It presents data on more than 100,000 European students. The surveys are planned to be repeated every fourth year, thus providing long-term data on changes in alcohol and drug consumption among young people. The next survey is due to be carried out in 2011.

A main purpose of the ESPAD project is to collect comparable data on substance use among 15 and 16 year old European students in order to monitor trends as well as between countries. The studies are conducted as school surveys by researchers in each participating country, during the same period of time and with a common methodology. By adopting this ESPAD format, comprehensive and comparable data on alcohol, tobacco and drug use among European students are produced.

As in earlier studies, the surveys were conducted with a standardised methodology and a common questionnaire to provide as comparable data as possible. Data were mainly collected during spring 2007 and the target population was students born in 1991, (with a mean age of 15.8 years at the time of the data collection).

Data were collected by group-administered questionnaires. The students answered the questionnaires anonymously in the classroom with teachers or research assistants functioning as survey leaders. With two exceptions the class-samples are nationally representative.

Data from the ESPAD Report 2007 is available at:

**European Monitoring Centre for Drugs and Drug Addiction**

The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) is the central reference point for drug information in the European Union (EU). It was set up in 1993 and its role is to provide the EU and its member states with objective, reliable and comparable information on drugs and drug addiction. It is one of the EU’s decentralised agencies. The information collected, analysed and disseminated by the Centre includes the state of the drugs problem, solutions applied to drug related problems and the development of tools and instruments to facilitate Member States and the European Commission in the monitoring and evaluation of their drug policy.

www.emcdda.europa.eu/
European Monitoring Centre for Drugs and Drug Addiction statistical bulletin 2010

The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) statistical bulletin 2010 is a companion publication to the EMCDDA annual report. The bulletin presents information on drug use using information provided by the European Union (EU) Member States as well as Norway and Croatia.

There remain some differences in methodology between countries (e.g. face-to-face interview, mail questionnaires) and small differences between countries should be interpreted with caution. Results presented in this annual report are based in the last year available for each country, but it should be noticed that it is not the same year for all countries (in most cases the latest surveys were conducted between 2004 and 2008).

The general population surveys tables and graphics in the Statistical bulletin are organised by age group (all adults — 15–64 years, young adults — 15–34 years and 15–24 year olds), gender, type of prevalence (lifetime prevalence, last year prevalence and last month prevalence) and in case of graphics, also according to drug of use (cannabis, amphetamines, ecstasy, and cocaine).


Home Office: Research Development and Statistics Directorate (RDS)

This directorate produces a variety of publications on a wide range of Home Office issues, including drug misuse. Lists and downloads of their recent publications are available.

rds.homeoffice.gov.uk/rds

The mental health of young people looked after by local authorities in England

This report presents data from the first national survey of the mental health of young people looked after by local authorities in England. The primary purpose of the survey was to produce prevalence rates of three main categories of mental disorder: conduct disorder, hyperactivity and emotional disorders by child and placement characteristics. The second aim of the survey was to determine the impact and burden of children's mental health problems in terms of social impairment and adverse consequences for others. The third main purpose of the survey was to examine service utilisation. The examination of service use requires the measurement of contextual factors (lifestyle behaviours and risk factors, including drug use).

National Programme on Substance Abuse Deaths

An alternative source of data on drug related deaths to that provided by the Office for National Statistics is published by the national programme on Substance Abuse Deaths (np-SAD), based at the International Centre for Drug Policy, St. George’s University of London.

The Annual Report on drug-related deaths in the United Kingdom published by the national programme on Substance Abuse Deaths (np-SAD) is used by the UK Government, national and international agencies, academics, and commissioners and service providers as an indicator of the extent and nature of drug misuse, and makes a contribution towards the prevention of substance abuse problems.

The information included in the report takes the form of an annual review of information received from coroners in England and Wales, Northern Ireland, the Isle of Man and Channel Islands, Police forces in Scotland; and the Northern Ireland Statistics and research Agency.

An np-SAD case is defined as a relevant death where any of the following criteria are met at a completed inquest, fatal accident inquiry or similar investigation:

- One or more psychoactive substances directly implicated in death;
- History of dependence or abuse of psychoactive drugs;
- Presence of controlled drugs at post mortem; or
- Cases of deaths directly due to drugs but with no inquest.


National Assembly for Wales

Provides statistics and publications for Wales.
http://new.wales.gov.uk/topics/statistics/?lang=en

National Drug Strategy

This is a cross-government website to support the National Drug Strategy and the work of Drug Action Teams. It contains information for Drug Action Teams and interested individuals to find out about the Government’s Drug Strategy. It includes links to reports, publications and research that are relevant to the National Drugs Strategy.
http://www.homeoffice.gov.uk/drugs/

National Institute for Clinical Excellence

The National Institute for Health and Clinical Excellence (NICE) is an NHS organisation, responsible for ensuring everyone has equal access to medical treatments and high quality care from the NHS - regardless of where they live in England and Wales. Guidance on substance misuse published in March 2007 is based on community-based interventions to reduce substance misuse among vulnerable and disadvantaged children and young people calls for
anyone who works with young people to identify those who are vulnerable to drug problems and intervene at the earliest opportunity.

www.nice.org.uk

**National Treatment Agency**

The National Treatment Agency (NTA) is a special health authority set up by the Government in 2001, to improve the availability, capacity and effectiveness of treatment for drug misuse in England.

www.nta.nhs.uk

**National Treatment Outcome Research Study**

The National Treatment Outcome Research Study (NTORS) is the largest prospective longitudinal cohort study of treatment outcome for drug misusers ever conducted in the UK. It monitors the progress of clients recruited into one of four treatment modalities which were delivered in either residential or community treatment settings. The residential modalities were specialist inpatient treatment, and rehabilitation programmes. The community treatments were methadone maintenance, and methadone reduction programmes. The most recent publication from NTORS, published in June 2005, provides findings on changes in offending behaviour after drug misuse treatment. Drug users in the NTORS reported a very large number of crimes prior to starting drug treatment. Shoplifting was the most common type of acquisitive crime, both in total number of offences and in percentages of drug users committing that offence. Drug selling offences were also common.


**North West Public Health Observatory**

The North West Public Health Observatory (NWPHO) fulfils a regional public health information and intelligence function supporting the work of public health professionals, local authorities and providers of healthcare and other services relevant to health of the North West population.

As an integrated part of public health intelligence in the Centre for Public Health at Liverpool John Moores University and the North West region, the NWPHO is also a member of a national network of other public health observatories across England, Wales, Ireland and Scotland (the Association of Public Health Observatories - APHO). They are the leading observatory for alcohol, drugs misuse, crime and violence and dental health.

http://www.nwph.net/nwpho/

**Positive Futures**

Positive Futures is a national social inclusion programme using sport and leisure activities to engage with disadvantaged and socially marginalised young adults.

http://www.positivefutures.info/PFPro/AboutUs.aspx
Psychiatric morbidity and drug use

Several surveys on psychiatric morbidity and drug misuse among different groups of the population have been carried out. These groups have included adults living in private households, institutions, homeless people and people with psychotic disorders.


Scottish Executive

Provides statistics and publications for Scotland. www.scotland.gov.uk/Publications

Seizures of Drugs

The Seizures of Drugs England and Wales 2010 publication presents figures for drug seizures made by law enforcement agencies in England and Wales during 2009 / 2010. The statistics in this publication relate to drugs controlled under The Misuse of Drugs Act 1971. These statistics cover seizures made during the year by police in England and Wales (including British Transport Police), together with information from the UK Border Agency (including seizures from HM Revenue and Customs). Drug seizure data from the Serious Organised Crime Agency (SOCA) are not included within this publication. http://rds.homeoffice.gov.uk/rds/pdfs10/hosb1710.pdf

The Arrestee Survey

The Arrestee Survey is the first nationally representative survey of drugs and crime among arrestees in England and Wales. Three sweeps of the data have been collected in 2003-04, 2004-05 and 2005-06. While the main focus of this report is on the latest (2005-06) sweep, it also provides an overview of key trends across all three years of the Arrestee Survey, providing comparisons between the baseline (2003–04), the second year (2004–05) and the third year (2005–06). The report focuses on the:

- Socio-demographic characteristics of the respondents;
• Self-reported substance misuse;
• Previous contact with the Criminal Justice System;
• Offending behaviour;
• Treatment;
• Availability/supply of drugs.

The first year of the survey was carried out in a national sample of 60 custody suites. In total 7,535 arrestees were interviewed. The interview consisted of a 20-minute computerised interview with a substantial self-completion section, which contained the most sensitive questions about offending behaviour, drug and alcohol use and treatment for drugs. In addition, arrestees were asked to provide an oral fluid sample for analysis of recent drug use. There are various problems associated with interviewing in police custody suites, with implications for survey response, despite non-response weighting being applied, that are discussed within the survey report in detail.

The Arrestee Survey Annual Report: 2003 – 2006. Available at:
http://rds.homeoffice.gov.uk/rds/pdfs07/hosb1207.pdf

The impact and effectiveness of mandatory drug testing in prisons

‘The impact of mandatory drug testing in prisons’ publication summarises the key findings from a study on the extent and type of drug use in prisons, as part of the Mandatory Drug Testing (MDT) programme. Included in the publication are results from a survey of prisoners which was carried out in a sample of prisons to gather information on episodes of drug use in prisons, prisoners’ experience of drug use prevention measures in prison and the impact of these on attitudes and behaviours in relation to drug use. In this survey, information was collected from prisoners on their drug use prior to coming to prison, at any time within prison, and drug use within the current prison, on each day in the past week, in the past month and at any time. In addition to information on self-reported use, some prisoners also provided biological samples (oral fluid (OF) and/or hair) for testing for cannabis and opiates.

The impact and effectiveness of mandatory drug testing in prisons. Available at:
http://rds.homeoffice.gov.uk/rds/pdfs05/rdsolr0305.pdf

The Society for the Prevention of Solvent and Volatile Substance Abuse

Re-Solv is a national charity dedicated to the prevention of solvent and volatile substance abuse (VSA), operating throughout the UK. There is an information line: 01785 810 762.
www.re-solv.org
Tobacco, Alcohol and Drug Use and Mental Health

The Office for National Statistics report on ‘Tobacco, Alcohol and Drug Use and Mental Health’, is based on a survey of psychiatric morbidity carried out between March and September 2000, among adults aged 16 to 74 living in private households in Britain. The report specifically looks at tobacco, alcohol and other drug use and dependence and their relationship to psychiatric morbidity.

www.statistics.gov.uk/downloads/theme_health/Tobacco/etc_v2.pdf

UK Drug Situation report

The UK Focal Point's Annual Report provides information on the drug situation in the UK. It provides additional information to the data contained in standard tables and structured questionnaires. In particular it provides a discussion of the main trends and a description of the responses to the situation. Each Member State's report follows a common structure, which covers national policies on drugs, prevalence, prevention, problem drug use, drug-related treatment, health correlates and consequences, social correlates and consequences and drug markets.

In addition, a number of selected issues are chosen for in-depth consideration each year. Previous topics include gender differences, drug driving, alternatives to prison and drugs in recreational settings.


United Nations Office on Drugs and Crime

The United Nations Office on Drugs and Crime (UNODC) works to educate the world about the dangers of drug abuse and to strengthen international action against drug production, trafficking and drug-related crime through alternative development projects, illicit crop monitoring and anti-money laundering programmes. UNODC also provides accurate statistics through the Global Assessment Programme (GAP) and helps to draft legislation and train judicial officials as part of its Legal Advisory Programme.

www.unodc.org/unodc/index.html

Youth Offending Team Substance Misuse Worker Grant Funding 2008/09 - 2010/11

In March 2008, the Department for Education (DfE), Home Office and the Department of Health changed how their contributions to the former Young People’s Substance Misuse Partnership Grant are dispersed to local areas in England.

As such, the £8m Home Office contribution to the funding allocation per year from 2008/09 – 2010/11 is now issued directly to Youth Offending Teams (YOTs) in the form of a Youth Justice Board (YJB) grant. The grant provides funding to ensure that YOTs have in place the capacity and capability for effective service delivery of the Government’s 2008 drug strategy Drugs: protecting families and communities which sets out the action the Government will take to tackle the harm caused by drugs, which includes performance reporting and management.
It is important to note that the Home Office has specified that distribution should be via YOT boundaries as opposed to local authority boundaries. Therefore, for those YOTs that serve more than one area, it is entirely a matter for the partnership to establish the most efficient approach to allocation and service delivery.

http://www.yjb.gov.uk/en-gb/practitioners/Health/Substancemisuse/
Appendix F: Drugs glossary

Amphetamines/ Speed

Speed is the street name for a range of amphetamines. Like cocaine it is a stimulant that people take to keep them awake and alert. It’s often taken along with Ecstasy.

Also known as:
Amphetamine Sulphate, Phet, Billy, Whizz, Sulph, Base, Amphetamine, Paste, Dexamphetamine, Daxies, Dexedrine, Uppers, Amph, Chalky, Flour, Footballs, Walkers, Crystal, Crank, Black Beauties, Bennies, 357 magnums, Leapers, Black Hollies, Cartwheels,

Appearance and use
Amphetamines like speed are usually sold in ‘wraps’ like cocaine. The powder is off-white or pinkish and can sometimes look like small crystals. ‘Base’ speed is purer and is a pinkish-grey colour and feels like putty. Crystal Meth (Methamphetamine or Methylamphetamine) is processed speed that looks like off-white rocks or crystals. Both Speed and Crystal Meth are amphetamines although Crystal Meth is able to be smoked, it is much stronger and dangerous and more likely to lead to dependence. Prescription amphetamines like dexamphetamine are usually small white pills. Speed’s either dabbed onto the gums or sniffed in lines like cocaine using a rolled up bank note. Sometimes it’s rolled up in cigarette paper and swallowed. This is called a speedbomb. It can be mixed in drinks, or injected and methamphetamine can be smoked in its ‘crystal’ form. The effects ‘kick in’ after about half an hour if ingested but much quicker if injected or smoked (methamphetamine) and can last for up to six hours. It depends on the quality of the speed. The ‘high’ is followed by a long slow comedown.

Amyl nitrate/ Poppers

Poppers are small bottles filled with liquid chemicals called Amyl Nitrates. They were used at the turn of the century for people suffering from chest pains. Nitrites like Amyl Nitrite dilate the blood vessels and allow more blood to get to the heart. They’re usually sniffed straight from the bottle and deliver a short, sharp high. Poppers are sold in sex shops, clubs and bars.

Also known as:
Amyl nitrite, butyl nitrite, isobutyl nitrite, Ram, Thrust, Rock Hard, Kix, TNT, Liquid Gold

Appearance and use
Nitrites originally came as small glass capsules that were popped open, hence the name. Nowadays they’re available in small bottles with brand names like Ram, Thrust and Rock Hard. One sniff and the effects can be felt. The effects fade after a couple of minutes.

Anabolic steroids

The male hormone, testosterone, is an anabolic steroid. The effects of the other anabolic steroids are often very similar to the effects of testosterone. The anabolic steroids can be used in medicine to treat anaemia and muscle weakness after surgery. They shouldn’t be confused with the other main kind of steroids, corticosteroids, which are used to treat other medical conditions, such as asthma, eczema and skin inflammations.
Also known as:
Roids. Product names include Sustanon 250, Deca-Durabolin, Dianabol, Anavar, Stanozolol

Appearance and use:
A user can quickly become psychologically dependent (meaning they develop an increased desire to keep taking the drug even in spite of possible harmful effects). Anabolic steroids can be bought as tablets to be swallowed or as a liquid which is injected.

They are often used by bodybuilders, athletes and other sports people because of the performance enhancing effects. Some people at times consume 10-100 times the medical dose.

Cannabis

This is the most widely used illegal drug in Britain. It’s a naturally occurring drug made from parts of the cannabis plant. It’s a mild hallucinogen and often gives sedative like effects that make some people feel ‘chilled out’ and others feel sick. It’s not very expensive and widely available.

Also known as:
Bhang, black, blast, blaze, blow, blunts, Bob Hope, bud, bush, chronic, dope, draw, ganja, grass, green, hash, hashish, hay, hemp, herb, jive, joint, marijuana, Mary Jane, pot, puff, Northern Lights, nugget, resin, sensi, sinsemilla, skunk, smoke, soap, solid, spliff, tea, wacky backy, weed, zero. Some names are based on where it comes from – Afghan, homegrown, Moroccan etc.

Appearance and use:
Cannabis comes in different forms. Hash is a black or brown lump made from the resin of the plant. It’s quite often squidgey. Grass or weed is the dried leaves and flowering parts of the female plant. It looks like tightly packed dried garden herbs. Less common is sinsemilla. This is bud grown in the absence of male plants and has no seeds. And cannabis oil that is dark and sticky and comes in a small jar. Most people mix cannabis up with tobacco and smoke it as a spliff or a joint. Some people put it in a pipe. Others make tea with it or put it in food like cakes.

Cocaine

Cocaine and crack are both stimulants with powerful, but short-lived effects. Snorted powder cocaine is absorbed more slowly. Hence, smoked freebase or crack tends to be much stronger and more addictive than snorted powder cocaine. However, all forms of cocaine prepared for injection (whether powder cocaine or crack) can also reach the brain rapidly in high doses and so can be very addictive too.

Also known as:
Cocaine is also known as blast, big C, booth, coke, charlie, C, divits, flake, happy dust, heaven, ivory flakes, marching powder, mobbeles, line, nose candy, railers, ringer, rocks, star dust, white, white dust, Percy, snow, toot, gold dust, sherbert, cecil, white girl, jelly, choo choo, snort, sniff.

Appearance and use:
Coke is a white powder that’s usually divided into lines on a smooth surface and snorted up the nose with a rolled up bank note or a straw. It can be smoked and is sometimes made into a solution and injected.

Crack

Crack is a smokeable form of Cocaine that’s made into small lumps or rocks. It’s called crack because it makes a crackling sound when it’s being burnt. It’s a stimulant with virtually immediate but short-lived effects and it’s very addictive.

Also known as:
Crack is also known as rocks, wash, stones, pebbles, base, freebase, scud, micro.

Appearance and use:
A rock of crack is about the size of a raisin. It's usually smoked in a pipe, glass tube, plastic bottle or in foil. Most people take it this way and it's known as freebasing although it can be injected.

Crystal meth

Methamphetamine (commonly referred to as methamphetamine) is one of a group of a psychostimulant drugs called amphetamines that act on the brain and nervous system.

Also known as:
Methamphetamine, Methylamphetamine, Ice, Glass, Tina, Christine, Yaba, Crazy medicine, P’s.

Appearance and use:
Illicit methylamphetamine is produced in tablet, powder, or crystalline forms. These products are taken orally, snorted or can be prepared for injection, but unlike amphetamine, methylamphetamine can also be smoked. The powder is sometimes referred to as ‘crystal meth’, but this term is more often used for the purer crystalline form, also known as ‘ice’, ‘glass’, ‘tina’ and ‘christine and can be easily smoked and can rapidly lead to high blood levels. It’s also long-acting compared to crack so it’s an extremely powerful and addictive stimulant. The tablet form is sometimes referred to as ‘yaba’.

Ecstasy

Ecstasy is often referred to as the original designer drug because of its synonymous relationship with the rave culture in the early 90s. Clubbers took it to stay awake and dance for hours. There’s a lot of controversy about the long-term side effects of Ecstasy. Some evidence suggests it can damage the brain causing long-term problems.

Also known as:
Adam, E, pills, brownies, burgers, disco biscuits, hug drug, ‘Mitsubishi’s’, ‘Rolexes’, ‘Dolphins’, XTC, doves, Damons (Damon Hill / Pill), Eckies, M&Ms, Mitsi’s.

Appearance and use
Pure Ecstasy is a white crystalline powder known to chemists as MDMA. Ecstasy sold on the street is usually in tablet form although it’s getting more common to see it sold as powder. Es come in all sorts of colours and some of them have pictures or logos stamped into them. They are usually swallowed although some people do smoke or snort them. The effects take about
half an hour to ‘kick in’ and tend to last between three and six hours, followed by a gradual comedown

Gases, glues and aerosols

Solvents cover a huge number of substances:
Gas lighter refills, aerosols containing hairspray, deodorants and air fresheners, tins or tubes of glue, some paints, thinners and correcting fluids, cleaning fluids, surgical spirit, dry-cleaning fluids and petroleum products. When inhaled, solvents have a similar effect to alcohol. They make people feel uninhibited, euphoric and dizzy.

Also known as:
Gases, Aerosols, Glue, Thinners, Volatile Substances

Appearance and use:
All sorts of famous household names contain different substances that cause different effects when abused. Solvents are sniffed from a cloth, a sleeve or a plastic bag. Some users put a plastic bag over their heads and inhale that way. Gas products can be squirted directly into the back of the throat which makes it difficult to control the dose.
The majority of users are between 11 and 16.

GHB and GBL

GHB (Gammahydroxybutyrate) and GBL (Gammabutyrolactone) are closely related, dangerous drugs with sedative and anaesthetic effects. GBL converts to GHB shortly after entering the body. GBL and GHB have much the same effects. Both can kill and are particularly dangerous when used with alcohol and other depressant or sedative substances including recreational drugs.

Also known as:
GHB, GBH, Liquid Ecstasy, gammahydroxybutrate, GLB, gammabutyrolactone, 1, 4-BD

Appearance and use
Both GHB and GBL are usually sold as an odourless liquid in small bottles or capsules. iGHB does come in powder form but is rarer. It tastes slightly salty. A teaspoon or a capful is a normal dose although strength of GHB varies so it can be very difficult for people to know how much they are taking. The effects start between ten minutes and one hour after taking it and can last up to seven hours.

GBL is a colourless, oily liquid with a weak odour. It is a common solvent used in products like paint strippers and stain removers.

Heroin

Heroin is a natural opiate. It’s made from the morphine which is extracted from the opium poppy. Like many drugs made from opium, including the synthetic opioids like methadone, heroin is a very strong painkiller. Heroin is highly addictive. Over time, effects of heroin on the brain cause 'craving' and a strong psychological desire to keep on using. Heroin sold as ‘brown’ is sometimes used by clubbers as a ‘chill out’. Brown is still heroin but some people mistakenly think it’s not as addictive.

Also known as:
Smack, brown, skag, H, horse, gear, china white, fix, whack, mother pearl, junk, B’s, darks, anti-freeze, black tar, boy, brown sugar, crank, dope, dragon, elephant, Harry, Harry morphine, hell dust, lady, morph, mud, poison, train, thunder

**Appearance and use**

Heroin comes as a white powder when it's pure (diamorphine). There are a range of substances it's 'cut with' and therefore street heroin can be anything from brownish white to brown.

It can be smoked, dissolved in water, injected and snorted if high purity.

**Ketamine**

Ketamine is a short-acting but powerful general anaesthetic which has been used for operating on humans and animals which. It depresses the nervous system and causes a temporary loss of body sensation and has powerful hallucinogenic qualities. Ketamine first appeared on the streets in the US in the 70s.

*Also known as:*

Green, K, special K, super K, vitamin k

**Appearance and use:**

Legally produced ketamine comes in liquid form which is usually injected. The illegally produced version usually comes as a grainy white powder which is usually snorted but can be obtained as a tablet.

**Khat**

Khat (Catha edulis) is a herbal substance containing many different compounds. Its main effects are due to two compounds with stimulant properties. Although it's a stimulant, many users report a feeling of calm if it's chewed over a few hours. Some describe it as being 'blissed out'. It comes from a leafy green plant of the same name. Used mostly in Africa, Khat is becoming more common in Europe. Khat is not an illegal drug in the UK. It can be used or traded without penalty. Khat is an illegal substance in many other countries like the US. Taking khat into the US could attract a heavy prison sentence.

*Also known as:*

quat, qat, qaadka, chat.

**Appearance and use:**

Khat is a leaf which is chewed over a number of hours

**Ivory Wave**

Ivory Wave is the 'brand' name of a product currently being sold as a 'legal high'. The active ingredient previously found in Ivory Wave was MDPV, which is a cathinone that was made a Class B drug in April. It seems that the content may have been changed recently in response to this, and early indications from limited testing suggest that Ivory Wave contain the drug 2-DPMP. 2-DPMP is an amphetamine-type stimulant that is reported as being similar to Ritalin. Although we can’t say for sure what is in any particular product sold as Ivory Wave, it is known that the effects reported recently are those of a strong stimulant – with similar effects to amphetamines (speed) and MDMA (ecstasy). These effects can include feelings of euphoria, alertness, talkativeness and feelings of empathy. Such substances can also cause anxiety,
agitation, paranoid and psychotic states and there is a risk of overstimulating the heart and circulation, and risk overstimulating the nervous system and possibly causing fits. There is also a risk of dangerous overheating of the body.

Also known as:
Ivory Coast, Purple Wave and Vanilla Sky.

Appearance and use:
Reported as a white or off-white powder, which is usually snorted like cocaine or swallowed / 'bombed' in wraps of paper.

Legal Highs

‘Legal Highs’ are substances which produce the same, or similar effects, to drugs such as cocaine and ecstasy, but are not controlled under the Misuse of Drugs Act. They are however, considered illegal under current medicines legislation to sell, supply or advertise for “human consumption”. To get round this sellers refer to them as research chemicals, plant food, bath crystals or pond cleaner.

LSD

LSD or Lysergic Acid Diethylamide is a hallucinogenic drug (which means you’re likely to experience a distorted view of objects and reality, including in the form of hallucinations). It originally derived from ergot, a fungus found growing wild on rye and other grasses. LSD is commonly called ‘acid’. The experience is known as a ‘trip’ and these trips can be good or bad. A trip can take from 20 minutes to an hour to start and usually lasts about 12 hours. Once it’s started you can't stop it. And until you take a tab of acid you can't tell how strong it is or how it's going to affect you. How the trip goes can be affected by who you are, how you're feeling and how comfortable you are with the people you’re with.

Also known as:
Acid, blaze, blotter, cheer, dose, dots, drop, flash, fry, gel, hawk, L, lightening flash, liquid acid, Lucy, micro dot, paper mushrooms, purple haze, pyramid, rainbows, smiles, stars, tab, trips, tripper, window. Sometimes LSD is known by the pictures on them e.g. strawberries.

Appearance and use
As a street drug it's usually sold as tiny squares of paper with pictures on them. But it can be found as a liquid or as tiny pellets.

Magic mushrooms

Magic Mushrooms are mushrooms which grow in the wild that produce similar hallucinogenic-type effects to LSD when eaten. There are two main types and they are both very different. The most common form is a species called psilocybe or 'liberty cap', the other more potent variety is amanita muscaria or 'fly agaric'. There are deadly poisonous species of amanitas.

Also known as:
Mushies, magics, shrooms, liberties, liberty cap, fly agaric, amani

Appearance and use:
Psilcybin mushrooms are small and tan coloured and bruise blue when they’re touched. Amanita Muscaria are more like the red and white spotted toadstools in fairytale books. After
picking, they're often eaten raw or dried out and stored. Most people take between 1–5 grams. The fly agaric mushrooms tend not to be consumed raw as they can cause severe nausea.

**Mephadrone**

A stimulant drug belonging to the chemical family of cathinones which is a group of drugs that are ‘cousins’ of the family of amphetamine compounds. The drugs include amphetamine itself (speed), methamphetamine and ecstasy (MDMA), among many others. Mephedrone produces euphoria, alertness, talkativeness and feelings of empathy. It can also cause anxiety and paranoid states and risks overstimulating the heart and circulation, and it risks overstimulating the nervous system to cause fits. There is developing evidence on the risk of death from using mephedrone.

*Also known as:* meph, MC, MCAT, m-cat, 4-MMC, Miaow, Meow Meow, Bubbles, Bounce, Charge, Drone, White Magic

*Appearance and use:* A fine white, off-white or yellowish powder - usually snorted like cocaine or swallowed ‘bombed’ in wraps of paper. It can be smoked and in rare cases is injected and also comes in capsules and pills

**Methadone**

Opiates are derived from the opium poppy. Opium is the dried milk of the opium poppy. It contains morphine and codeine, both effective painkillers. Methadone is one of a number of synthetic opiates (also called opioids) that are manufactured for medical use and have similar effects to heroin. These include dihydrocodeine (DF118s), pethidine (often used in childbirth), diconal, palflum and temgesic. Methadone and subutex (buprenorphine) are used as substitutes for heroin in the treatment of heroin addiction.

*Also known as:* Dollies, methadone mixture, meth, linctus, physeptone. Other synthetic opiates include: DF118 (dihydrocodeine), pethidine, diconal (containing dipipanone), palflum (dextromoramide) and temgesic or subutex (buprenorphine).

*Appearance and use* The methadone that’s prescribed to people trying to ‘come off’ heroin is usually a syrup which is swallowed but it can come in tablet or injectable form. Pethidine, dihydrocodeine (DF118s), diconal, palflum, temgesic and also some types of methadone come in tablet or injectable form. Effects can start quickly and can last several hours but this varies with how much is taken and how much the drug is taken.

**Naphyrone**

Naphyrone is a stimulant drug closely related to ‘cathinone derivatives’ including mephedrone, and like mephedrone is a group of drugs that are ‘cousins’ of the family of amphetamine compounds which include amphetamine, methamphetamine and ecstasy (MDMA), among many others. Naphyrone does not have a long history of use, so there is little evidence of its long term effects or on the risks from using it. However, due to its similarity to other ‘cathinone
derivatives’, naphyrone is likely to share the same risks such as anxiety, paranoia, overstimulation of the heart and circulatory system and overexcitation of the nervous system (with the risk of fits). The high potency of naphyrone by comparison with other cathinones like mephedrone suggests that it is likely to be associated with a higher risk of accidental overdose. The effects could include feelings of euphoria, alertness, talkativeness and empathy.

Also known as:
NRG-1, NRG1, Energy-1, Energy1, Rave

Appearance and use
A fine white or off-white/yellow powder – usually snorted like cocaine or swallowed ‘bombed’ in wraps of paper.

Nexus (C2B and 2-CT-7)

C2B and 2-CT-7 are hallucinogens and have effects somewhere between ecstasy and LSD and so can also act as stimulants and cause changes in your emotions. Most people take several at a time and effects can last from 4-8 hours. The more you take, the more intense and uncontrollable the experience. They’re not widely available in the UK but have been reported in a number of European countries.

Also known as:
T-7, 7-up, seventh-heaven and Tripstacy.

Appearance and use
The drugs are sold as white powder or tiny 5mg pills. Normally swallowed, they can also be snorted. Other routes, such as by smoking, appear to be less common

Piperazine

Substituted piperazines are a broad class of chemical compounds. Best known as recreational stimulants are BZP (Benzylpiperazine), TFMPP, DBZP and mCPP which mimic the effects of MDMA and used to be referred to as ‘Legal highs’. Piperazine itself is used as an effective worming agent for pets and farm animals. Before it became illegal, it was sold online and from some specialist shops as a recreational drug and often wrongly promoted as a natural or herbal high. Its effects are amphetamine or speed-like but not as potent producing feelings of arousal, euphoria, wakefulness and wellbeing that can last up to 6 – 8 hours.

Also known as:

Appearance and use
BZP comes in various forms and shapes. Pills can be in various colours and may carry various impressions. BZP is also sold as an off-white powder, in capsules and as a liquid. BZP was originally evaluated as an anti-depressant drug. Now it is found mainly on the recreational drugs scene as a substitute for MDMA and was marketed as ‘Legal Ecstasy’

PMA
PMA looks very similar and has been sold as ecstasy. The effects are much the same as an E, but PMA is much stronger and can cause a fatal rise in body temperature. The effects of PMA also take longer to happen. Some users have taken a fatal overdose by mistakenly taking pill after pill thinking nothing is happening. There are a number of ‘designer’ or ecstasy-like drugs on the market with PMA providing a model as to how this may increase risks especially when substituted unknowingly for ecstasy.

Also known as:
Chicken yellow, chicken fever, double stacked, mitsubishi turbo, red mitsubishi, killer, para-methoxyamphetamine, paramethoxymethamphetamine, PMMA.

Appearance and use
PMA is usually a white pressed tablet and often underscored, 7mm in diameter and 6mm thick. They weigh about 230mg. Unusually thick compared to ecstasy; they've been nicknamed 'double stacked'. Like ecstasy, PMA is swallowed.

Salvia

Salvia is made from the soft leaves of the Mexican plant Salvia Divinorum and contains psychoactive chemicals. Sold on the internet and in ‘headshops’ as herbal ecstasy, salvia is one of a number of substances marketed as ‘herbal highs’.

Also known as:
Mexican magic mint, holy sage, eclipse.

Appearance and use
Salvia is sold in dried leaf form and as a refined extract in concentrations from 5x to 50x. The psychoactive chemicals in contains produce hallucinations when chewed or when dried and smoked.

Synthetic Cannabinoids

These mimic the psychoactive effects of THC (tetrahydrocannabinol), the active principle in cannabis, and are found in ‘herbal’ smoking mixtures commonly sold as ‘Spice’ on the internet and in specialist ‘headshops’. Synthetic cannabinoid compounds are sprayed on to a mix of inert plant ingredients, usually free of tobacco or cannabis, to produce these smoking mixtures. It is not certain that every product sold as Spice will contain synthetic cannabinoids, only forensic testing will tell.

Also known as:
Spice Silver, Spice Gold, Spice Diamond, Spice Arctic Synergy, Spice Tropical Synergy, Spice Egypt, Spice Yukatan Fire, San Pedro Cactus, EcSess, Amsterdam Gold, Devil’s Weed, Hyper X

Appearance and use
Spice products are packaged very professionally in small, often colourful sachets with labels describing the contents as incense or herbal smoking mixture and almost always stating: 'Not for human consumption'.

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Tranquillisers

Tranquillisers are manmade drugs produced to treat anxiety, depression and insomnia. Manufactured to be prescribed by a doctor, they're designed to reduce anxiety and promote calmness, relaxation and sleep. There are hundreds of different tranquillisers around but most common are the Benzodiazepines. Benzos, as they're sometimes called, come in over 50 different forms. Some people extract the liquid from temazepam capsules and inject it as a substitute for heroin. This is extremely dangerous as the thick liquid easily blocks veins and can lead to limb amputations.

*Also known as:*

Jellies, benzos, eggs, norries, rugby balls, vallies, moggies, mazzies, roofies, downers.

*Appearance and use:*

Tranquillisers come as tablets, capsules, injections or suppositories (tablets you put up your bum). They're often used as 'chill out' drugs on the club scene. Some people use them to 'come down' from acid, speed or ecstasy.