



Statistics on Drug Misuse: England, 2012

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Executive Summary

This compendia report signposts to a range of published information on drug misuse among both adults and children which has been drawn together from a variety of sources. The report also presents some new information on hospital admissions related to drug misuse. The main findings include the following:

Drug misuse among adults (16 - 59 years)

In England and Wales:

- In 2011/12 an estimated one in three adults (36.5%) had ever taken an illicit drug in their lifetime (around 12 million people), 8.9% of adults had used an illicit drug in the last year (nearly three million people) and 5.2% of adults had used an illicit drug in the last month (an estimated 1.7 million people).
- Between 1996 and 2011/12 last year use of any illicit drug fell from 11.1% to 8.9%. Any last year drug use remains around the lowest level since measurement began.
- In 2011/12 around 15.6% of adults had ever taken a Class A drug in their lifetime (around 5 million people), 3.0% had done so in the last year and 1.5% in the last month. The long term trend in Class A drug use in the last year shows no statistically significant difference between 1996 (2.7%) and 2011/12 (3.0%).
- As in previous years cannabis was the most commonly used type of drug in the last year, in 2011/12 6.9% of 16-59 years had used cannabis in the last year followed by powder cocaine (2.2%) and ecstasy (1.4%).
- In 2009/10 it was estimated that there were 306,150 opiate and/or crack users in England. This corresponds to 8.93 per thousand of the population aged 15-64.

Drug misuse among young adults (16 – 24 years)

In England and Wales:

- In 2011/12 an estimated 37.7% young adults have ever taken an illicit drug (around 2.5 million people), 19.3% had done so in the last year (nearly 1.3 million) and 11.1% in the last month (an estimated 0.7 million).
- Last year use of any illicit drug fell from 29.7% to 19.3% between 1996 and 2011/12. This was due in large part to notable declines in cannabis (26.0% to 15.7%) and amphetamine use (from 11.8% to 2.0%).
- Last year Class A drug use among 16 to 24 year olds has fallen in the long term from 9.2% in 1996 to 6.3% in 2011/12.

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 lifetime drug use fell from 29% in 2001 to 17% in 2011.
- There were also decreases in the proportion of pupils who reported taking drugs in the last year; from 20% in 2001 to 12% in 2011.

- In 2011 3% of pupils reported taking drugs at least once a month, a decline from 7% in 2003.
- Reported drug use was more common among older pupils; for example, 3% of 11 year olds said they had used drugs in the last year, compared with 23% of 15 year olds in 2011.
- As seen in previous years cannabis was the most widely used drug in 2011; 7.6% of pupils reported taking it in the last year, a long term decrease from 13.4% in 2001.
- The proportions of pupils who had ever tried drugs were generally higher in the south of England than elsewhere. In regions in the North and Midlands, between 15% and 17% reported having tried drugs but this proportion was 19% in the South East and South West and 20% in London. There was a similar but not identical pattern in the proportions of pupils who has taken drugs in the last year which varied between 10% in the East and West Midlands to 15% in the South West.
- The number of young people (aged 18 and under) accessing help for drug and alcohol misuse during 2010/11 was 21,955. The equivalent figure in 2009/10 was 23,528
- The number of young people accessing services for primary use of Class A drugs has decreased year on year. Those receiving help primarily for heroin fell from 480 in 2009/10 to 320 in 2010/11 and those receiving help for cocaine use fell from 457 to 350.
- The proportion of young people dropping out before completing a course of therapy has continued to fall, from 29% in 2005-06 to 16% last year and 13% in this year.

Health outcomes

In England (unless otherwise stated):

- In 2011/12, there were 6,173 admissions to hospital with a primary diagnosis of a drug-related mental health and behavioural disorder. This is 7% (467) less than 2010/11 when there were 6,640 such admissions. Overall, between 2000/01 and 2011/12 admissions have decreased by 23% (1854) from 8,027 to 6,173.
- In 2011/12 almost three times as many males were admitted to hospital with a primary diagnosis of drug-related mental health and behavioural disorders than females (4,558 and 1,615 respectively).
- In 2011/12 more people aged 25-34 were admitted with a primary diagnosis of drug related mental health and behaviour disorders than any other age group, accounting for 33.8% (2,084 out of 6,173) admissions.
- The Strategic Health Authority (SHA) with the most admissions for drug related mental health and behaviour disorders as the primary diagnosis was North West SHA (20 admissions per 100,000 population). The SHA with the lowest admissions was East of England SHA (6 admissions per 100,000 population).
- Where primary or secondary diagnosis was recorded there were 57,733 admissions in 2011/12, this is a 12.4% (6,380) increase from 2010/11 when there were 51,353 such admissions. Figures from this type of admission have continued to increase

year on year and are now almost twice as high as there were eleven years ago as they stood at 25,683 in 2000/2001 ^a

- In 2011/12 there were 12,344 admissions to hospital with a primary diagnosis of poisoning by drugs. This is a 1.9% (242) decrease compared to 2010/11 when there were 12,586 such admissions. Since 2000/01 there has been a long term increase of 58% (4,530) when there were 7,814 such admissions.
- Adults in the 16-24 age group reported the highest number of admissions (2,924) with a primary diagnosis of poisoning by drugs in 2011/12. Those in the 65-74 age group reported the lowest number (361).
- In 2011/12 more males were admitted to hospital with a primary diagnosis of poisoning by drugs than females (6,336 compared to 6,008).
- The SHA with the most admissions for primary diagnosis of poisoning by drugs was North East SHA (with 41 admissions per 100,000). London SHA had the lowest (13 admissions per 100,000).
- During 2011/12, there were 197,110 individuals in contact with structured drug treatment services, a 3.6% decrease from the 2010/11 figures, when there were 204,473. Most of the individuals in treatment are aged 30-34 (22% for both sexes) and 73.2% are male.
- The main type of drug for which people received treatment was opiates only (which includes heroin) at 49% of all treatments with a further 32% of treatments for those who have taken both opiates and crack.
- The total number of deaths related to drug misuse in England and Wales was 1,605 in 2011, a decrease of 179 from 2010 when there were 1,784 such deaths. This continues the downward trend seen since 2008.
- The number of male deaths related to drug misuse decreased by 14% from 1,382 in 2010 to 1,192 in 2011. However, over the same period the number of female deaths rose by 3% from 402 to 413.
- The most common underlying cause of death was from accidental poisoning accounting for 71% (1,147 out of 1,605) deaths.

^a The increase in 2011/12 may be a real change or in part may be due to changes in recording practices (in this year or previous years). This may be particularly relevant for admissions with a primary or secondary diagnosis where some of the increases may be attributable to changes in recording practice.

Introduction

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.

Most of the sources referred to in this publication are National Statistics. National Statistics are produced to high professional standards set out in the Code of Practice for Official Statistics. It is a statutory requirement that National Statistics should observe the Code of Practice for Official Statistics. The UK Statistics Authority (UKSA) assesses all National Statistics for compliance with the Code of Practice.

Some of the statistics referred to in this publication are not National Statistics and are included here to provide a fuller picture; some of these are Official Statistics, whilst others are neither National Statistics nor Official Statistics. Those which are Official Statistics should still conform to the Code of Practice for Official Statistics, although this is not a statutory requirement. Those that are neither National Statistics nor Official Statistics may not conform to the Code of Practice for Official Statistics.

A brief explanation and a short review of the quality of each of the sets of statistics used in this publication have been included in [Appendix A](#) of this publication.

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.

Chapter 1: Drug misuse among adults reports on the prevalence of drug misuse among adults (aged 16-59 and 16 and over) and the types of drugs most commonly used. Relationships between drug use and other socio-demographic and lifestyles factors are included. The chapter also focuses on young adults (aged 16-24). Figures for England and Wales presented in Chapter 1 have been obtained from; the Crime Survey for England and Wales (CSEW, formerly the British Crime Survey)^b publication: *Drug Misuse Declared: Findings from the 2011/12 Crime Survey for England and Wales*, the Home Office 2012; *Adult Psychiatric Morbidity in England, 2007: results of a household survey*, the Health and Social Care Information Centre (HSCIC) 2009; *the 2010-11 Scottish Crime and Justice Survey – Drug Use*, Scottish Government Social Research 2012; *the European Monitoring Centre for Drugs and Drug Addiction (ECMDA) 2011 Annual report of the state of drugs problem in Europe*, EMCDDA 2011; and, for the first time this year *National and Regional Estimates of the Prevalence of Opiate and/or Crack Cocaine use in 2009-10*, the National Treatment Agency for Substance Misuse (NTA), 2011.

^b From 1 April 2012, the British Crime Survey was renamed the Crime Survey for England and Wales (CSEW) to better reflect its geographical coverage.

Chapter 2: Drug misuse among children focuses on the prevalence of drug misuse among children (mostly aged 11 – 15). It also presents information on the relationship between drugs and other socio-demographic factors and includes information on behaviours, knowledge, and attitudes towards drug taking. Figures presented in Chapter 2 have been obtained from; *Smoking, Drinking and Drug Use among Young People in England in 2011*, HSCIC 2012 and the *Substance misuse among young people – The data for 2010-11*, NTA 2012 and the *2011 European School Survey Project on Alcohol and Other Drugs (ESPAD) report: Substance use among students in 36 European countries* published by the EMCDDA 2012.

Chapter 3: Outcomes of Drug Misuse presents a range of information about the health risks associated with drug misuse including hospital admissions, treatment, and drug related deaths. Figures presented in Chapter 3 have been obtained from different sources and presented in a user-friendly format. The data sources are; *Statistics from the National Drug Treatment Monitoring System (NDTM)* the NTA 2012; and *Deaths related to drug poisoning in England and Wales, 2011*, Office of National Statistics (ONS) 2012. Previously unreported figures on drug-related admissions to hospital are presented using data from HSCIC Hospital Episode Statistics (HES).

This 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*.¹ This legislation regulates controlled drugs and 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 in [Appendix A](#).

The data in this report relate to England unless otherwise specified. Where figures for England are not available, figures for England & Wales or the United Kingdom have been provided.

The main datasets presented in [Chapter 3](#) cover a time series of information over the last twelve years so it is important to put all this into context with the relevant government policies and strategies in place at the time ([see Appendix B](#)).

In November 2010, the new coalition government set out its long-term vision for the future of public health in England in the White Paper, *Healthy Lives, Healthy People: Our Strategy for Public Health in England*.² The White Paper recognises that although the number of people taking illicit drugs has declined in recent years, a new approach is needed for this to continue and to bring levels down to the rest of Europe. It also sets out examples of national level action to help tackle drug misuse. This includes:

- legislating to ban some types of drugs.
- funding streams on drug treatment services across the community and in criminal justice settings.
- use of public health professionals to work locally to prevent people from taking harmful drugs, to reduce the drug use of those already taking drugs, and to help people to be drug free, recover fully and contribute to society.

Details of the government's approach was subsequently set out in a cross-government drugs strategy *Reducing demand, restricting supply, building recovery: supporting people to live a drug-free life* in December 2010.³ The strategy is 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. The strategy is reviewed annually with the first review published in May 2012 and provides a progress update on implementation of the strategy. It includes an action plan for tackling the threat from new psychoactive substances.⁴

Throughout the report, references to sources for further information are given. This report contains six appendices. [Appendix A](#) explains the key sources used while [Appendix B](#) describes the relevant Government strategies and plans. [Appendix C](#) gives sources of further information and useful contacts. [Appendix D](#) provides a drugs glossary of the various illicit drugs mentioned in this report and [Appendix E](#) details the requirements and suggestions made by the United Kingdom Statistics Authority (UKSA) during their assessment of this publication. This year we are seeking user feedback on the ICD-10 codes used to describe NHS hospital admissions for drug poisoning. [Appendix F](#) has further details on this consultation and how to respond.

United Kingdom Statistics Authority assessment of this publication

This statistical release is a National Statistics publication. National Statistics are produced to high professional standards set out in the Code of Practice for Official Statistics. It is a statutory requirement that National Statistics should observe the Code of Practice for Official Statistics. The UKSA assesses all National Statistics for compliance with the Code of Practice.

During 2010 the *Statistics on Drug Misuse: England* publications underwent assessment by the UKSA. In accordance with the Statistics and Registration Service Act 2007 and signifying compliance with the Code of Practice for Official Statistics these statistics were recommended continued designation as National Statistics.

Designation can be broadly interpreted to mean that the statistics:

- meet identified user needs;
- are well explained and readily accessible;
- are produced according to sound methods; and
- are managed impartially and objectively in the public interest.

Once statistics have been designated as National Statistics it is a statutory requirement that the Code of Practice shall continue to be observed.

The designation of National Statistics status was subject to a number of requirements. The UKSA report also contained a number of suggestions for improvement. Further details on these requirements and suggestions, including detail on how these are being addressed are contained in [Appendix E](#).

References

1. The Misuse of Drugs Act 1971 (modification) Order 2001. Available at: <http://www.opsi.gov.uk/si/si2001/20013932.htm>
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3. Reducing Demand, Restricting Supply, Building Recovery: Supporting People to Live a Drug-free Life. The Home Office, December 2010. Available at: <http://www.homeoffice.gov.uk/drugs/drug-strategy-2010/>
4. Drug strategy 2010 - annual review May 2012. The Home Office. Available at: <http://www.homeoffice.gov.uk/publications/alcohol-drugs/drugs/annual-review-drug-strategy-2010/>

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 problem drug users as well as regional, national and European comparisons of drug misuse are presented. For the first time information on the onset and desistance of illicit drug use is included, as well regional and national estimates of problem drug users.

The main data source used in this chapter is the Crime Survey for England and Wales (CSEW, formerly the British Crime Survey)^c publication: *Drug Misuse Declared: Findings from the 2011/12 Crime Survey for England and Wales*¹ published by the Home Office in 2012. Since 1996 the CSEW has included a comparable self-completion module of questions on illicit drug use. The CSEW report examines the prevalence and trends of illicit drug use among 16-59 year olds since 1996 with a particular focus on young adults aged 16-24. Key trends in the use of different drugs and the total number of drug users are estimated. For the first time in 2011/12 the CSEW questionnaire included questions on the onset and desistance of illicit drug use. The key findings from these questions are included in this chapter under [Section 1.2.6](#).

The survey asked respondents about drug use as defined by *the Misuse of Drugs Act*² and also examined the prevalence of illicit drug use. 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. The survey is also updated to include questions on new substances appearing on the drugs market. For example in the 2006/07 survey questions about the use of ketamine were added, in 2008/09 methamphetamine (Crystal Meth) was added and in 2010/11 questions on the use of mephedrone were included.

[Appendix A](#) describes the drugs respondents were asked about as part of the CSEW and their classifications under the Misuse of Drugs Act. 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). Use of drugs in the last year has been deemed to be the best indicator to measure trends in recent drug use.

Information from the latest year is included as well as some trend data. It has not always been possible to update the information for 2011/12. Where this is the case the latest data available is presented from the British Crime Survey (BCS).

A further source of information used in this chapter is *Adult Psychiatric Morbidity in England, 2007: results of a household survey*³ (APMS) published by the Health and Social Care 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 misuse⁴ which is the use of a substance for purposes not consistent with legal or medical guidelines.

^c From 1 April 2012, the British Crime Survey was renamed the Crime Survey for England and Wales (CSEW) to better reflect its geographical coverage.

Information on drug misuse in Scotland is presented in the *2010-11 Scottish Crime and Justice Survey, Drug Use*⁵ (SCJS) published by the Scottish Government Social Research in 2012. 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 2010/11 and the *2010/11 British Crime Survey*.⁶

European comparisons of drug use are published by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), with the most recent data (collected over the period 2004 to 2009) available in: *EMCDDA 2011 Annual report on the state of the drugs problem in Europe*.⁷ This annual report is based on information provided to the EMCDDA by the EU Member States, though it should be noted that the data and estimates presented in this report are the best approximations available, but must be interpreted with caution, as many parts of the world still lack sophisticated information systems related to drug supply.

For the first time this year information from the report *National and Regional Estimates of the Prevalence of Opiate and/or Crack Cocaine use in 2009-10*⁸ published in 2011 by the National Treatment Agency have been included in this chapter. This report summarises the results of a follow-up study to a three year project to estimate the prevalence of 'problem drug use' (defined as use of opiates and/or crack cocaine) nationally (England only), regionally and locally. An overview of the national and regional estimates is presented in this report, as well as comparisons with the estimates produced by the third (2006-07) sweep of the study. Further information can be found in [Sections 1.5 and 1.6](#) of this chapter.

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 2011/12 and which drugs are most commonly used. It also looks at recently classified drugs, polydrug and polysubstance use, accessibility of drugs, onset and desistance of drug use as well as attitudes to taking drugs.

1.2.1 Extent and trends of illicit drug use in adults

[Section 1 of CSEW](#) shows the extent and trends in illicit drug use among adults aged 16 to 59 in 2011/12. The key findings from this chapter are as follows;

- An estimated one in three adults (36.5%) had ever taken an illicit drug in their lifetime (around 12 million people).
- 8.9% of adults had used an illicit drug in the last year (nearly three million people).
- 5.2% of adults had used an illicit drug in the last month (an estimated 1.7 million people).

Between the 1996 and 2011/12 surveys, last year use of any illicit drug fell from 11.1% to 8.9%. Any last year drug use remains around the lowest level since measurement began; the last fall was seen between 2008/09 (10.1%) and 2009/10 (8.6%).

In 2011/12 around 15.6% of adults had ever taken a Class A drug in their lifetime (around five million people), 3.0% had done so in the last year and 1.5% in the last month. The long term trend in Class A drug use in the last year shows no statistically significant difference between 1996 (2.7%) and the 2011/12 (3.0%) surveys. There was a gradual increase in last year use between the 1996 and

2008/09 survey (from 2.7% to 3.7%) which was followed by a decrease between 2008/09 and 2009/10 (3.7% to 3.1%).

As in previous years, cannabis was the most commonly used type of drug in the last year (6.9%) followed by powder cocaine (2.2%), and ecstasy (1.4%).

Of the individual types of drugs asked about in the 2011/12 CSEW, levels of last year usage remained at similar levels compared to last year. The only drug to show a statistically significant change between 2010/11 and 2011/12 was last year use of amphetamines which fell from 1.1% to 0.8%.

There has been long term trends in last year drug use among adults aged 16 to 59. Between 1996 and 2011/12 use of powder cocaine and methadone have increased, the use of LSD, magic mushrooms, amphetamines, cannabis and amyl nitrate have decreased and there has been no statistically significant change in the use of crack cocaine, ecstasy, heroin, tranquillisers and anabolic steroids. (Section 1 on pages 7-10 of the 2011/12 CSEW report and tables EA.01 to EA.04 from the 'illicit drug use among 16-59s' tables).

1.2.2 Frequent drug use in the last year

Frequent drug use is defined as having taken any illicit drug more than once a month on average in the last year. Further information can be found in [Section 4 of the CSEW](#).

Estimates from the 2011/12 CSEW show that 3.3% of adults aged 16 to 59 were defined as frequent drug users, the equivalent to two in five (40%) adults who reported last year drug use. This was similar to the findings in the 2009/10 survey (3.3% and 41% respectively) which was the last time the question was asked.

Frequent drug use among young people aged 16 to 24 is over twice as high (7.0%) as for 16 to 59 years olds (3.3%).

Cannabis was the most prevalent drug taken in the last year among adults aged 16 to 59 (6.9%) and among young people aged 16 to 24 (15.7%). ([Section 4 on pages 21 - 23 of the 2011/12 CSEW report and tables F.01 and F.02 from the 'frequent drug use' tables](#)).

1.2.3 Recently Classified Drugs

Data on recently classified drugs including mephedrone, gammahydroxybutrate (GHB), benzylpiperazine (BZP), Spice and khat can be found in [Section 3 of the CSEW report](#).

Last year use of mephedrone among adults aged 16 to 59 fell from 1.4% in 2010/11 to 1.1% in 2011/12. In 16 to 24 year olds the decrease over the same time period was from 4.4% to 3.3%. Estimates of use of the other recently classified drugs in the last year were all between 0.1% and 0.2% ([Section 3 on page 17 of the 2011/12 CSEW report and table N.01 from the 'new CSEW measures of drug use' tables](#)).

1.2.4 Polydrug and polysubstance use

Polydrug use is considered to be the use of more than one type of drug being taken either at the same time (simultaneous use) or more than one type of drug being taken within the same period of time, for example, in the last year (concurrent use). The corresponding measure of polysubstance use includes the use of alcohol alongside drugs and is classified in the same way. Information on polysubstance and polydrug was measured in the 2010/11 and 2011/12 CSEW. As numbers of polydrug and polysubstance users are small these two years of survey data have been combined in the analysis. Further information can be found in [Section 8 of the CSEW](#).

The key facts from this section are as follows;

In the 2010/11 and 2011/12 surveys, seven per cent of respondents who used drugs in the last year said that the last time they used drugs, they used more than one drug at the same time. 61% of respondents who used drugs in the last year used alcohol at the same time the last time they used drugs.

Almost all (95%) cases of simultaneous polydrug use involved the use of cannabis (73%), powder cocaine (49%), ecstasy (37%) and/or amphetamines (19%).

The highest rates of simultaneous polydrug use were found among those who had used methadone (58%), ecstasy (49%), ketamine (48%) and amphetamines (43%) the last time they had used drugs. The lowest rate of simultaneous polydrug use was found among those who had used cannabis the last time they had used drugs (7%).

1.2.5 Accessibility of drugs

Respondents who had used any illicit drugs in the last year were asked questions on the location the most recent drugs were obtained and their source, and the ease, or perceived ease of obtaining illegal drugs. Further information on accessibility can be found in [Section 7 of the CSEW report](#). The key findings from these questions are as follows;

Of those adults who had taken drugs in the last year, the majority obtained the most recently taken illicit drugs under domestic circumstances (58%); that is nearly two in five (37%) of adults obtained drugs at someone else's home and a further one in five (22%) obtained drugs at their own home.

Around two-thirds (63%) of adults obtained the last drugs they took from someone else well known to them (e.g. a friend, neighbour or work colleague).

Around four in five adults (78%) who had taken any illicit drug in the last year thought that it was very, or fairly easy for them to personally get illegal drugs when they wanted them. Adults who had not taken any illicit drug in the last year perceived a slightly lower level of ease for obtaining illegal drugs if they wanted them (75% perceived it to be very or fairly easy to do so).

This information plus more in depth analysis can be found in [Section 7 on pages 35 to 38 of the 2011/12 CSEW report](#) and in tables A.01 to A.04 from the 'Accessibility of drugs' tables.

1.2.6 Onset and desistance of illicit drug use

For the first time in 2011/12 questions were asked about the onset and desistance of illegal drug use among adults. These questions were asked to understand more about the length of time in, and the age of leaving the drug taking population. The findings from these questions can be found in [Section 6 of the CSEW](#). The key findings are as follows;

The most commonly reported age for first taking cannabis was 16 years and for powder cocaine and ecstasy was 18 years. Among those who were no longer regular drug users, the most commonly reported age for stopping taking cannabis was 18 and for powder cocaine and ecstasy it was 25.

The average length of time that adults had been in the cannabis taking population was 6.2 years, higher than the estimates for those having desisted from taking powder cocaine (4.4 years) or ecstasy (3.9 years). ([Section 6 on pages 29 to 33 of the 2011/12 CSEW report](#) and tables C.01 to C.05 from the 'Onset and desistance of illicit drug use among adults aged 16 to 59' tables).

1.2.7 Attitudes

In the 2010/11 BCS questionnaire respondents were asked whether they thought it was acceptable for people of their age to frequently or occasionally get drunk, take cannabis, cocaine or heroin. Information on attitudes and acceptability of taking these drugs is presented in [Section 3.3 of the 2010/11 BCS \(pages 36 to 38 and Tables 3.1 and 3.2 on pages 40 and 41\)](#). Questions on attitudes were not included in the 2011/12 questionnaire.

In 2010/11 a third (33%) of adults aged 16 to 59 believed it was acceptable to take cannabis occasionally whilst almost two thirds (65%) of adults thought it was never acceptable to ever take cannabis. There was less acceptability towards taking cocaine and heroin. Around one in ten (9%) adults thought it was acceptable to take cocaine occasionally whilst around nine in ten (91%) thought it was never acceptable. Around one in 50 (2%) of adults thought it was acceptable to take heroin occasionally whilst the vast majority (98%) thought it was never acceptable.

Acceptability of taking drugs varies with age. Younger respondents (16 to 19) and older respondents (45 to 59) tended to be less tolerant in their acceptability of the behaviours asked about. For example 29% of 16 to 19 year olds thought that it is acceptable to take cannabis occasionally compared to 40% aged 30 to 34 and 25% aged 55 to 59. A greater proportion of men believed that it was acceptable to occasionally take cannabis (38%) and cocaine (11%) compared with women, (27% and 6% respectively).

Acceptability of drug taking compared with drug use in the last year is presented on [pages 37 to 38 of the 2010/11 BCS](#). The survey showed that more people thought that it was acceptable to take the drugs than actually took them. For example; while a third (33%) of adults aged 16 to 59 believed that it was acceptable to take cannabis occasionally; only 6.8% of this age group had actually done so in that

year. A similar pattern was observed for cocaine although there was less acceptability of taking this drug and the prevalence figures were lower.

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

1.3.1 Extent and trends of illicit drug use in young adults

[Section 2 of the CSEW report](#) shows the extent and trends in illicit drug use among young adults aged 16 to 24 in 2011/12. The key findings from this chapter are as follows;

- An estimated 37.7% of 16 to 24 year olds had ever taken an illicit drug (around 2.5 million people)
- 19.3% had done so in the last year (nearly 1.3 million)
- 11.1% had done so in the last month (an estimated 0.7 million people)

Last year use of any illicit drug fell between 1996 and 2011/12 (from 29.7% to 19.3%) due in large part to notable declines in cannabis (from 26.0% to 15.7%) and amphetamine use (from 11.8% to 2.0%). Any last year drug use among 16 to 24 years olds remains at the lowest level since measurement began; the last time there was a statistically significant fall was between the 2008/09 (22.6%) and 2009/10 (20.0%) surveys. ([Page 12 of the report and table EY.02 from the 'illicit drug use among 16-24s' tables](#)).

Last year Class A drug use among 16 to 24 year olds has fallen in the long term from 9.2% in 1996 to 6.3% in 2011/12. The gradual decline is partly a result in falls in last year usage of ecstasy (from 6.6% to 3.3%) and hallucinogens (from 5.3% to 1.4%) which have partly been offset by an increase in powder cocaine use (from 1.3% to 4.2%).

As in previous years, in 2011/12 cannabis was the most commonly used type of drug among young people in the last year (15.7%) followed by powder cocaine (4.2%) and ecstasy (3.3%). There have been no statistically significant changes in levels of last year use of any individual drugs between the 2010/11 and 2011/12 surveys.

In the 2011/12 CSEW the level of cannabis use (15.7%) was not significantly different to the 17.1% estimated in 2010/11 or 16.1% in 2009/10. Thus levels remain the lowest since measurement began in 1996. The proportion has fallen notably since 1996 (from 26.0%) but levels have been stable since 2009/10.

Levels of powder cocaine use have increased since 1996 (1.3%) but between 2009/10 and 2011/12 there has been a statistically significant fall from 5.5% to 4.2%. ([Section 2 on pages 13 and 14 of the 2011/12 CSEW report and table EY.02 from the 'illicit drug use among 16-24s' tables](#)).

1.3.2 Vulnerable groups

The 2005/06 BCS⁹ is the latest survey that 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*¹⁰ 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 Demographics of Illicit Drug Use

The CSEW collects information on the personal, household, area characteristics and lifestyle factors of respondents which can be used to explore variations in drug use. Full details can be found in [Section 5 of the CSEW report](#).

1.4.1 Age and Gender

The key findings from the 2011/12 CSEW survey show that levels of any drug use in the last year were highest among the 16 to 19 (19.6%) and 20 to 24 (19.0%) age groups. Class A drug use was highest among 20 to 29 year olds (7.2% of 20 to 24 year olds and 5.9% of 25 to 29 year olds) This pattern of higher drug use among younger age groups has been consistently observed since the 1996 survey.

Since 1996 levels of any last year drug use, Class A drug use and the use of individual drugs has been higher for men than women. For example in 2011/12 men were more than twice as likely as women to have used any drug (12.4% of men and 5.5% of women) and any Class A drug (4.4% of men and 1.6% of women). ([Pages 24 to 26 of the 2011/12 CSEW and Table D.01](#)).

1.4.2 Marital Status

Single adults were more likely to have taken any drugs or any Class A drug in the last year than any other marital status. Last year drug use was 17.4% in single adults, compared to 10.3% of co-habiting and 3.2% of married adults. Class A drug use was 6.0% in single adults compared

with 3.8% in co-habiting or 0.9% in married adults. (Table D.01).

1.4.3 Ethnicity

Information on drug use and ethnicity can also be found in Table D.01 of the 2011/12 CSEW report. Adults from a White ethnic group generally had higher levels of any drug use (9.5%) than those from non-White background (5.4%).

1.4.4 Household income

Adults living in a household in the lowest income group (£10,000 or less) had the highest levels of any last year drug use (13.6%) and last year Class A drug use (3.8%) compared with all other income groups (for example, compared with 7.4% and 3.0% respectively of adults living in a household with an income of £50,000 or more). (Table D.02).

This information and more can be found in Section 5 on pages 24 to 28 of the 2011/12 CSEW report and tables D.01 to D.10 of the 'illicit drug use by demographics tables'.

1.5 Problem drug users

While the surveys described in this chapter are an important source of information on the prevalence of drug use, they may not present a complete picture of 'problem drug users' (defined as users of opiates and/or crack cocaine).

Direct enumeration of those engaged in problem drug use can underestimate the number of users. Household surveys for example, can miss some small groups with potentially high rates of problem drug use; for example, the homeless, those living in institutions such as prisons or users whose lives may be hectic so they are either not at home or are unable to take part in an interview.

The National Treatment Agency report; *National and Regional Estimates of the Prevalence of Opiate and/or Crack Cocaine use in 2009-10* uses indirect techniques to measure the prevalence of problem drug users, making use of various data sources to offer a more reliable way of calculating prevalence estimates. This report summarises the results of a follow-up study to a three year project to estimate the prevalence of 'problem drug use' nationally (England only), regionally and locally. Further information on the methodology used in this report can be found in Appendix A of this compendium.

1.5.1 Prevalence of drug dependence

In 2009-10 it was estimated there were 306,150 opiate and/or crack users in England, this equates to 8.9 per thousand of the population aged 15-64.

There has been a statistically significant decrease in the national estimate of problem drug use between 2008-09 and 2009-10. There were statistically significant decreases in the younger (15-24) and middle (25-34) age groups but no decrease in the older (35-64) age group. Between 2006-07 and 2009-10 there was a statistically significant decrease in the national estimates of drug injecting. (Table 2 and Table 7 on pages 3 to 6 of the *National and Regional Estimates of the Prevalence of Opiate and/or Crack Cocaine Use 2009-10: A Summary of Key Findings* report).

The 2006 Home Office report; *Measuring different aspects of problem drug use: methodological developments*¹¹ also describes how problem drug use can be estimated. Four sources of data are used from which problem drug users 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.

The *Adult Psychiatric Morbidity in England Survey (APMS) 2007* report also 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 and Table 10.2 on page 187](#)).

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). ([Table 10.5 on page 190 of the APMS](#)).

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 4.8% of Black women to 0.2% of South Asian 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 although 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](#)).

1.6 Regional, National and European Comparisons of Drug Misuse

1.6.1 Prevalence by region

The National Treatment Agency report; *National and Regional Estimates of the Prevalence of Opiate and/or Crack Cocaine use in 2009-10* summarises the results of a follow-up study to a three year project to estimate the prevalence of 'problem drug use' (defined as use of opiates and/or crack cocaine) nationally (England only), regionally and locally.

In terms of regional differences, North West Government Office Region (GOR) had the highest prevalence of opiate and/or crack use at 11.08 users per thousand population aged 15-64, followed by the North East at 10.84 and Yorkshire and the Humber at 10.75. The East of England and the South East had the lowest prevalence of opiate and/or crack use at 6.44 and 6.56 per thousand respectively. ([Table 2 on page 3 of the National and Regional Estimates of the Prevalence of Opiate and/or Crack Cocaine Use 2009-10: A Summary of Key Findings](#)).

Information on drug use in the last year by Region can be also found in the [CSEW 2011/12 report. Table D.01 of the 'illicit drug use by demographics' tables](#) details drug use in the last year by English region and Wales from 1996 to 2011/12.

1.6.2 National comparisons of drug misuse

Information on drug misuse in Scotland is presented in the *2010-11 Scottish Crime and Justice Survey, Drug Use*⁵ (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 2010/11 and the *2010/11 British Crime Survey*⁶.

Self-reported illicit drug use ever in Scotland (SCJS 2010/11) was significantly lower than across England and Wales among 16-59 year olds (31.4% compared with 36.3% for England and Wales).

However, self-reported illicit drug use in the last year and in the last month were similar (not significantly different) in Scotland to that across England and Wales. In England and Wales 8.8% of 16-59 year olds reported taking drugs in the last year and 4.8% said they had in the last month (compared with 9.1% and 4.8% respectively in Scotland). (Chapter 2 on page 14 of the SCJS).

1.6.3 European comparisons of drug misuse

European comparisons of drug use are published by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), with the most recent data (collected over the period 2004 to 2009) available in: *EMCDDA 2011 Annual report on the state of the drugs problem in Europe*.⁷ It should be noted that the data and estimates presented in this report are the best approximations available, but must be interpreted with caution, as many parts of the world still lack sophisticated information systems related to drug supply.

The 2011 report shows that cannabis remained the most popular illicit drug in Europe with about 6.7% (22.5 million) European adults aged 15-64 using the drug in the last year. There are large differences in the last year use of cannabis between the countries that submit a return to EMCDDA. Prevalence ranges from 0.4% in Romania to 14.3% in Italy.

Lifetime use of cannabis in 15-64 year olds was estimated at 23.2% (78 million) ranging from 1.5% in Romania to 32.5% in Denmark. The United Kingdom was the fourth highest in lifetime prevalence of cannabis use at 30.6%. (Table 4 on page 43 of the EMCDDA 2011 Annual report).

The second most popular illicit drug was cocaine. Comparisons of cocaine use between countries which submit a return to EMCDDA can be found in table 9 on page 64 of the report. Approximately 1.2% (4 million) of European adults 15-64 year olds used cocaine in the last year. Again there are large differences in prevalence between the countries that submit a return to EMCDDA ranging from 0.0% in Romania to 2.7% in Spain. The United Kingdom had the second highest prevalence at 2.5%.

Lifetime use of cocaine in 15-64 year olds was estimated at 14.5 million (4.3%) ranging from 0.1% in Romania to 10.2% in Spain. The United Kingdom has the second highest lifetime prevalence at 8.8%. (Table 9 on page 64 of the EMCDDA 2011 Annual report).

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2 Drug misuse among children

2.1 Introduction

This chapter contains information on drug taking, drug dependence and treatment as well as regional and European comparisons of drug misuse among children.

Information about illicit drug use among young people is taken from three sources. The main source of information is the *Smoking, Drinking and Drug use among Young People in England in 2011*¹ (SDD11) survey covering the period September to December 2011 for secondary school children in school years 7 to 11, mostly aged between 11 and 15. The SDD11 is the most recent survey in an annual series that began in 1982 and includes the publication of more up-to-date regional analysis of the data. The findings from this analysis can be found in [Section 2.4.1](#). This new regional analysis replaces the information previously sourced from *Smoking, drinking and drug use among young people in England – Findings by region, 2006 to 2008*² report.

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 2011 survey was on drugs. The type of drugs asked about in the survey includes those as defined by The Misuse of Drugs Act³.

The report; *Substance misuse among young people report – the data 2010/11*⁴ by the National Treatment Agency for Substance Misuse (NTA) presents data on children under the age of 18 who have accessed specialist substance misuse services in England during 2010/11. This

report is the 6th annual report produced by the NTA. The NTA started to collect Young Persons (under 18 years of age) data from 2005/06. Between 2005/06 and 2006/07 the NTA main statistical reports on adult drug treatment included some young people's figures. The NTA published stand-alone data on specialist under-18s substance misuse interventions for the first time in December 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.

Data is also sourced from *the 2011 European School Survey Project on Alcohol and Other Drugs (ESPAD) report: Substance use among students in 36 European countries*⁶ published by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) in 2012. ESPAD collects comparable data on substance use among 15-16 year old European students in order to monitor trends within, as well as between countries. In 2011 more than 100,000 students took part in 37^d different countries. This is the fifth data-collection conducted in the project. To provide as comparable data as possible the surveys are conducted with common questionnaires and according to a standardised methodology. Data are mainly collected during the spring and the 2011 target population was students born in 1995, with a mean age of 15.8 years at the time of data collection.

^d In 2011 37 countries collected data however the results are only available for 36 countries.

2.2 Drug Taking

2.2.1 Prevalence and frequency of drug use

Section 2.2 of the SDD11 provides information on the prevalence and frequency of drug use among pupils as well as the types of drugs taken within the last year.

The key findings show that in 2011;

Around one in six (17%) pupils had ever taken drugs. This has declined over time from 2001 when 29% of young people reported that they had ever taken drugs. Drug use in the last year has also decreased from 20% in 2001 to 12% in 2011.

Drug use in the last year increased with age; 3% of 11 year olds reported taking drugs in the last year, and this increased to 23% amongst 15 year olds. Drug use in the last year was reported by similar proportions of boys and girls.

As in previous years, pupils were more likely to have taken cannabis than any other type of drug. 7.6% of pupils reported having taken cannabis in the last year, down from 13.4% in 2001 (the first year of comparable data). (Section 2.2 on pages 21 to 23 and tables 2.1 to 2.9 on pages 44 to 56 of the SDD11).

Section 2.3 of the SDD11 provides information on frequency of drug use. Pupils were asked questions about their drug use in general; specifically how many times they had taken drugs and how often they took them. In 2011 3% of pupils reported taking drugs at least once a month. This has declined from 7% in 2003 (the first year of comparable data). (Section 2.3 on page 24 and tables 2.10 to 2.17 on pages 57 to 63 of the SDD11).

2.2.2 Vulnerable pupils and drug use

Some young people have shown to be vulnerable to problematic drug use. These include those who truant or have been excluded from school. Section 2.4 of the SDD11 provides information on vulnerable pupils and drug use.

In line with findings from previous years, pupils who had ever played truant or who had been excluded from school were more likely to report taking drugs at least once a month; 12% of pupils who said they had ever truanted or been excluded said they usually take drugs once a month compared with 1% of pupils who have never truanted or been excluded.

The prevalence of frequent drug use of this kind amongst this vulnerable group has declined gradually over time from 21% in 2003 to 12% in 2011. (Section 2.4 on page 25 and tables 2.18 and 2.19 on pages 63 and 64 of the SDD11).

2.2.3 Pupils' experiences of drug use

The SDD11 report also presents information on pupils' experiences of drug use.

Section 2.5 looks at pupils' first experience of drug use including, the age pupils first took drugs, what drugs were taken and where, where drugs were sourced, why they were taken and their reactions to first drug use.

The key findings from this section show that the type of drugs pupils took the first time they tried drugs varied by the age at which they first tried drugs. Pupils who tried drugs at an earlier age were more likely to report sniffing volatile substances (glue, gas, aerosols or solvents) the first time they tried drugs, whereas pupils who first experience of drugs was at an older age were most likely to have tried cannabis.

When asked how they felt the first time they took drugs, 45% reported feeling good and a similar proportion (44%) said they felt no different.

Further information on pupils' first experience of drug use can be found in [Section 2.5 on pages 25 to 29 and tables 2.20 to 2.33 on pages 64 to 70 of the SDD11](#).

[Section 2.6 of the SDD11](#) looks at pupils' most recent experience of drug use. In order to explore whether the experience of drug use changes over time, pupils who had only taken drugs on one occasion are excluded from this analysis, as are pupils who had not taken drugs in the last year.

Pupils who had taken drugs on more than one occasion were most likely, on the most recent occasion they took drugs, to have taken cannabis only (61%), compared with 17% who sniffed volatile substances only and 13% who took a Class A drug.

The most common reason for taking drugs on the first occasion was to 'see what it was like' (54%). In contrast, pupils were most likely to report taking drugs on the most recent occasion 'to get high or feel good' (47%).

Further information on pupils' most recent experience of drug use can be found in [Section 2.6 on pages 29 to 32 and Tables 2.34 to 2.62 on pages 70 to 82 of the SDD11 report](#).

2.2.4 Dependence on drugs

Information on drug dependence is reported in [Section 2.7 of the SDD11](#).

Pupils who had taken drugs in the last year were asked if they wanted to give them up. 41% of pupils reported that would like to give up now and 17% said they would like

to give them up in the future. It is likely that some pupils did not 'take' drugs as such but had tried them once and did not want to do so again. There has been little change in these proportions in recent years. ([Section 2.7 on pages 32 to 33 and Tables 2.57 to 2.62 on pages 80 to 82 of the SDD11 report](#)).

2.2.5 Availability of drugs and perceived ease of obtaining drugs.

Pupils were asked about the types of drugs they have been offered, whether they had taken the drugs they were offered and how easy or difficult they thought it would be to obtain drugs. Further information can be found in [Sections 2.8, 2.9 and 2.10 of the SDD11 report](#).

In 2011, less than a third (29%) of pupils had ever been offered drugs, down from 42% in 2001. Pupils were most likely to have been offered cannabis (19%) or volatile substances (10%). ([Section 2.8](#)).

[Section 2.8](#) of the report also explores whether pupils try the drugs offered to them. To control for different reference periods and levels of drug use by age, the analysis is restricted to 15 year olds. In 2011, almost half (49%) of 15 year olds had been offered at least one of the drugs asked about. Over half (56%) of the 15 year olds who had been offered drugs had taken them at least once. ([Section 2.8 on pages 33 and 34 and tables 2.63 to 2.67 on pages 33 to 34 of the SDD11](#)).

[Section 2.9](#) looks at pupils who refuse drugs they had been offered. Amongst those pupils who had ever been offered drugs 75% had refused them at least once. Further data on pupils refusing drugs and the reasons why they refused them can be found in [Section 2.9 on pages 24 to 35 and tables 2.68 to 2.72 on pages 87 to 91 of the SDD11](#).

The survey also asked pupils how easy or difficult they thought it would be to obtain illegal drugs. This is reported in [Section 2.10](#). In 2011 more pupils thought it would be easy (28%) than difficult (25%) to get illegal drugs. Nearly half of all pupils did not know how easy it would be to get any illegal drugs (48%). This pattern is similar to previous years. ([Section 2.10 on pages 35 to 36 and tables 2.73 to 2.75 on pages 91 to 92 of the SDD11](#)).

2.2.6 Awareness of individual drugs

[Section 2.11](#) looks at awareness of individual drugs. There is widespread awareness of drugs among pupils. In 2011, nine out of ten pupils had heard of cocaine (94%), heroin (91%) and cannabis (89%). Only 3% of pupils reported they had not heard of any of the drugs asked about. ([Section 2.11 on pages 36 and 37 and in tables 2.78 and 2.79 on pages 93 and 94 of the SDD11](#)).

2.2.7 Beliefs and attitudes about drugs

Pupils were asked about their attitudes to drug use, beliefs about drugs use among their peers and perceived family attitudes on drug use. The findings from these questions can be found in [Section 2.12 on pages 37 and 38 of the SDD11 report as well as in tables 2.80 to 2.88 on pages 94 to 99](#).

A minority of pupils thought that it would be OK for someone of their age to try drugs to see what it was like or to take drugs every week. Pupils were slightly more tolerant of cannabis use by someone of their age (9% thought it was OK to try once, 4% to do once a week) than glue sniffing (7% thought it OK to try once, 2% once a week). Cocaine was the least acceptable of the drugs asked about (2% thought it OK to try once, 1% once a week).

Almost all pupils thought their families would either try to stop them taking drugs (87%) or would try to persuade them to stop (12%). There was a strong relationship between drug use and families attitudes; pupils who thought their families had a more lenient attitude to their drug taking were more likely to have taken drugs than those who thought their families would try to stop them.

2.2.8 Sources of information about drugs

Pupils were asked about where they had received helpful information about drugs. This included whether they had any lessons, videos or discussions in class on drugs in the last twelve months. [Section 2.13](#) looks at sources of helpful information whereas [Section 2.14](#) focuses on lessons on drugs.

Teachers, parents and TV were most likely to be seen as helpful sources of information about drugs (69%, 66% and 64% respectively). Sources pupils found helpful varied with sex, age and their experience of drug taking. ([Section 2.13 on pages 38 to 39 and tables 2.89 to 2.90 on pages 91 to 92 of the SDD11](#)).

Most pupils who recalled lessons about drugs felt they helped them think about the risks of taking drugs (96%). Pupils also believed that lessons helped them to find out more about drugs (92%) and to realise that taking drugs was against the law (88%). Smaller proportions said lessons had helped them to avoid drugs (82%), think about what they would do if they were offered drugs (77%), helped them to find out where they could get advice or information about drugs (71%) and to understand why people take drugs (66%). Pupils were least likely to say that lessons helped them to see that not as many young people take drugs as they thought (38%). This and further information on lessons about drugs can be found in [Section 2.14](#)

on pages 39 to 40 and in tables 2.92 to 2.96 on pages 101 to 103 of the SDD11.

2.2.9 Factors associated with drug use

Section 2.15 on pages 40 to 41 and Table 2.97 on page 104 of the SDD11 report provide odds ratios, which show the relationship between drug use and characteristics and environment of pupils in the last year, using logistic regression.

Section 2.15.1 on page 40 of the SDD11 report explains its use of the logistic regression model. Logistic regression was used to model factors associated with drug use in the last year. This allows each factor to be considered separately by controlling for the effects of other, sometimes related, factors. For example, drug use is associated with increased age, and so is 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 demonstrates 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 and expressed relative to a reference category, which is given a value of 1. Odds 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 SDD11, on pages 179 and 180](#).

After controlling for other factors, girls were less likely than boys to have taken drugs in

the last year (odds ratio = 0.76). The odds of having taken drugs in the last year also increased with age; for each additional year of age the odds of having taken drugs in the last year increased by 1.17.

Compared with White pupils, pupils of Black ethnicity were more likely to have taken drugs in the last year (odds ratio = 2.13).

As in previous years, smoking and drinking were strongly associated with drug taking. Both regular and occasional smokers were more likely to have taken drugs in the last year (odds ratios = 17.45 and 7.71 respectively). Compared with non-drinkers, pupils who had drunk alcohol were more likely to have taken drugs in the last year (odds ratio 7.13 for pupils who had drunk alcohol in the last week, 2.62 for those who had drunk alcohol but less recently).

Pupils who had truanted from school were more likely to have taken drugs in the last year compared with pupils who had never truanted (odds ratio = 2.30 for pupils who had truanted but not in the last year; odds ratio = 1.85 for pupils who had truanted in the last year). Similarly, pupils who had been excluded from school in the last year were more likely to have taken drugs in the last year compared with pupils who had never been excluded (odds ratio = 3.11 for pupils who had been excluded in the last year), although there was no such relationship for pupils who had been excluded but not in the last year.

Pupils whose wellbeing score^e was 9 or less were considered to have relatively low

^e Wellbeing was measured using a validated scale developed by the Children's Society, based on Huebner's life satisfaction scale. See Rees G, Bradshaw J, Goswami H, Keung A. (2010) *Understanding children's well-being: a national survey of young people's well-being*. Children's Society, London.
http://www.childrensociety.org.uk/sites/default/files/tcs/rese_arch_docs/Understanding%20children%27s%20wellbeing.pdf

levels of wellbeing. They were more likely than others to have taken drugs in the last year (odds ratio = 1.65).

Pupils at schools in the West Midlands and the South West were more likely to have taken drugs in the last year compared with pupils in the North East (odds ratio = 2.02 and 2.36 respectively). (The North East was the reference category).

2.3 Young people receiving help for substance misuse

The *Substance misuse among young people report – the data 2010/11*⁴ shows the number of young people (aged under 18) and young adults (18-24) receiving help for drug and alcohol misuse. The key findings from this report show;

- The number of under-18s accessing specialist services for substance misuse in England in 2010/11 fell to 21,955. In 2009/10 this figure was 23,528.
- The number of young people being treated primarily for Class A drugs such as heroin and cocaine continued to fall to fewer than 800.
- Alcohol and cannabis remains by far the main substances for which under 18s access specialist services in England.
- More young people than ever are completing their therapy successfully – the figure has reached 75%.
- The number of young people dropping out of specialist services fell to an all-time low of just 13%.

Graph 1 on page 3 of the report provides information on the number of under-18s accessing specialist services between 2005 and 2011. The number of under-18s needing help for substance misuse in England began declining a few years ago and has continued to fall from a peak of 24,053 in 2008-09, to 23,528 in 2009-10 and 21,955 in 2010-11.

Graph 2 on page 4 shows the number of young people accessing services by primary drug from 2005 to 2011. The most common drug under-18s access services for is cannabis which accounts for 12,784 admissions. The number of young people accessing services for primary use of Class A drugs has decreased year on year. Those receiving help primarily for heroin fell from 480 in 2009-10 to 320 in 2010-11 and cocaine from 457 to 350. Overall the proportion of young people now being treated primarily for Class A drugs (4%) is almost a third of the level five years ago (11%). The only drug category to see any increase compared to last year is amphetamines (including mephedrone).

Graph 3 on page 5 shows the number of under-18s by exit type from 2005-11. The proportion of young people dropping out before completing a course of therapy has continued to fall from 29% in 2005-06 to 16% last year and 13% in this year.

Figure 4 on page 5 shows the common types of treatment that specialist services provided in 2010-11. More than 80% of the young people seeing specialist services received a psychosocial intervention (also known as a 'talking therapy').

The report also contains demographic data; those aged 15 to 17 accounted for 78% of all young people in specialist treatment in 2010-11; 64% were male and 84% White British. Further information on demographics as well as referral routes, and waiting times can also found in the report.

2.4 Regional and European Comparisons of Drug Misuse in children

2.4.1 Regional drug use

Section 6.4 of the SDD11 report presents estimates of drug use by the nine English regions. This analysis is based on 2010 and 2011 data combined.

The key findings from this analysis show that the proportions of pupils who had ever tried drugs were generally higher in the south of England than elsewhere. In regions in the North and Midlands, between 15% and 17% reported having tried drugs but this proportion was 19% in the South East and South West and 20% in London. There was a similar but not identical pattern in the proportions of pupils who has taken drugs in the last year which varied between 10% in the East and West Midlands to 15% in the South West. There was little variation between regions in the proportion of pupils who had taken drugs in the last month. (Section 6.4 on pages 164 and 165 and tables 6.6 to 6.8 on pages 168 and 169 of the SDD11).

2.4.2 European comparisons of drug misuse among school students.

The European School Survey Project on Alcohol and Other Drugs (ESPAD) ⁶ collect and publish comparable data on substance use among 15-16 year old European students. The publication looks at trends in young people's substance misuse within, as well as between countries.

The key findings from this publication show that there are only a few countries where the proportion having tried illicit drugs is lower in 2011 than in was in 1995. The most prominent case is Ireland, where 37%

had tried illicit drugs in 1995 but only 19% in 2011 had.

Reported use of illicit drugs varies considerably between the countries. The average lifetime use of illicit drugs across the countries measured was 18%. In the Czech Republic however almost half (43%) of the students admitted to such use, and relatively as many (about 39%) did so in France and Monaco. By contrast only 6% reported illicit drug use in Bosnia and Herzegovina, the Faroe Islands, Moldova, Montenegro and Norway. In the United Kingdom this figure was 27%.

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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 and drug-related deaths.

Information on outcomes of drug misuse is taken from three sources. Data on NHS hospital admissions are available from the *Hospital Episode Statistics (HES) databank*¹ which is hosted by the Health and Social Care Information Centre (HSCIC). 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)*.² We are currently consulting on the ICD-10 codes used to describe NHS hospital admissions for drug poisoning. Further information on the consultation and how to respond can be found in [Section 3.2](#) and [Appendix F](#) of this report.

HES figures are available from 1989/90 onwards. The quality and coverage of the data have improved over time. These improvements in information submitted by the NHS have been particularly marked in the earlier years and need to be borne in mind when analysing time series. Some of the increase in figures for later years (particularly 2006/07 onwards) may be due to the improvement in the coverage of independent sector activity. Changes in NHS practice also need to be borne in mind when analysing time series. This may be particularly relevant for

admissions with a primary or secondary diagnosis where some of the increases may be attributable to changes in recording practice.

*Statistics from the National Drug Treatment Monitoring System (NDTMS)*³ published by the National Treatment Agency (NTA) provide information on the number of referrals and people being treated for drug misuse. NDTMS data are gathered from treatment providers by regional NDTMS centres, provided to NTA, and then forwarded to the National Drug Evidence Centre (NDEC) for analysis, processing and verification. The results of these analyses are then supplied to the NTA for publication. The latest information available is for 2011/12 and only includes information for those aged 18 and over (previously it had included information on those aged under 18).

The most recent information on the numbers of deaths due to drug misuse is available from the *Office for National Statistics (ONS) Statistical Bulletin Deaths related to drug poisoning in England and Wales, 2011*⁴, published in August 2012. This bulletin presents the latest figures on deaths related to drug poisoning (involving both legal and illegal drugs) and drug misuse (involving illegal drugs) in England and Wales using the *General Mortality Registers (GMR)*, derived from medical death certificates. Deaths related to drug misuse are those defined as 'deaths where the underlying cause is drug abuse or drug dependence or deaths where the underlying cause is drug poisoning and where any of the substances controlled under the *Misuse of Drugs Act* are involved' and are coded using ICD-10.

In January 2011 ONS introduced a new version of ICD-10 (version 2010) which replaced version 2001.2. This means that some figures for 2011 will not be directly comparable to figures for 2001 to 2010. Further information can be found in [Appendix A](#) and [Section 3.4](#) of this chapter.

3.2 Hospital admissions

This section describes admissions to NHS hospitals where the primary, or primary or secondary diagnosis was related to drug-related mental health and behavioural disorders, as well as admissions to NHS hospitals where the primary diagnosis was related to drug poisoning.

Data on NHS hospital admissions are sourced from the *Hospital Episode Statistics (HES) databank*¹. The most recent data available are for the financial year 2011/12.

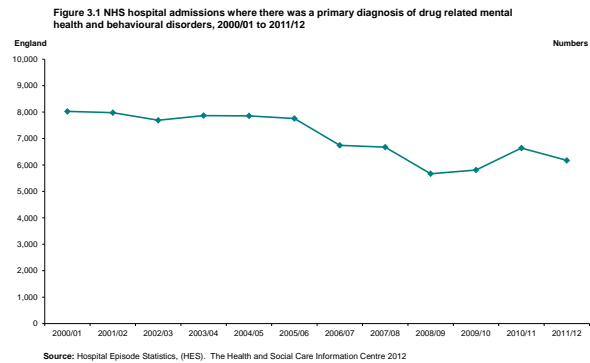
The ICD-10 codes used to produce these tables are based on drugs classified under the 1971 Misuse of Drugs Act. A full list of these codes can be found in [Appendix A](#).

We have sought the latest coding advice from the NHS Classifications Service⁵ on the ICD-10 codes that should be used to calculate these admissions. No changes were recommended for admissions with a diagnosis of drug-related mental health and behavioural disorders. However, it was suggested that we may wish to add some additional codes to the list used to describe admissions with a diagnosis of drug poisoning. We are seeking feedback from users to determine whether the inclusion of these additional codes would be beneficial. For full details of this consultation and how to respond please see [Appendix F](#). We welcome any comments you may have.

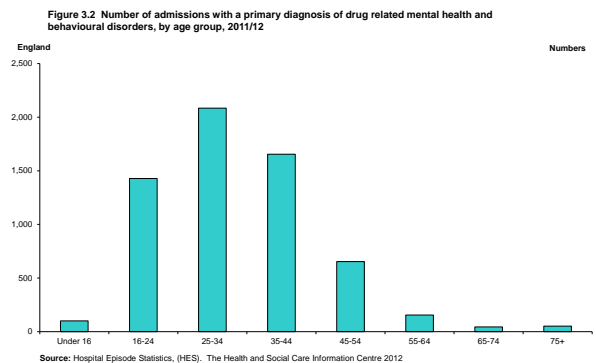
3.2.1 Drug-related mental health and behavioural disorders

[Table 3.1](#) shows that in England, in 2011/12 there were 6,173 admissions to hospital with a primary diagnosis of a drug-related mental health and behavioural disorder. This is 7% (467) less than in 2010/11 when there were 6,640 such admissions.

Overall, between 2000/01 and 2011/12 admissions have decreased by 23% (1854) from 8,027 to 6,173. Between 2000/01 and 2008/09 admissions decreased by 29% (2359) from 8,027 to 5,668 after which they have fluctuated slightly. ([Table 3.1](#) and [Figure 3.1](#)).



During 2011/12 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 33.8% (2,084 out of 6,173) of all such admissions in that year. Those in the 65-74 age group had the lowest number of admissions accounting for less than 1% of such admissions (44). ([Table 3.1](#) and [Figure 3.2](#)).



[Table 3.2](#) shows that in 2011/12, almost three times as many males were admitted to hospital with a primary diagnosis of drug-related mental health and behavioural disorders than females (4,558 and 1,615 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 rates of admissions with a primary diagnosis of drug-related

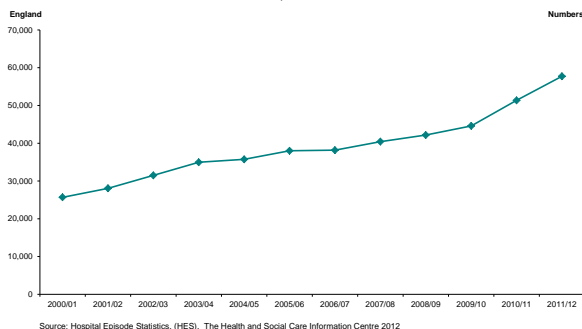
mental health and behavioural disorders with 20 admissions per 100,000 of the population. East of England SHA had the lowest number at 6 admissions per 100,000 population.

Table 3.3 shows hospital admissions where there was a primary diagnosis of drug related mental health and behavioural disorders by PCT.

Table 3.4 shows that there were 57,733 admissions where there was a primary or secondary diagnosis of drug-related mental health and behavioural disorders in 2011/12, which is 12.4% (6,380) higher than the 51,353 admissions in 2010/11. Figures from this type of admission have continued to increase year on year and are now almost twice as high as they were eleven years ago when they stood at 25,683 in 2000/2001. (Figure 3.3).

It should be noted that comparisons over time using primary and secondary diagnosis codes are complicated by changes in recording practices over the period. All hospital episodes have a primary diagnosis, but the number of secondary diagnoses used depends on the circumstance. At a national level there has been an increase in the coding of secondary conditions. It is likely that increases in secondary diagnoses are at least partly due to improvements in diagnosis and improvements in recording which will need to be taken into consideration when looking at this time series.

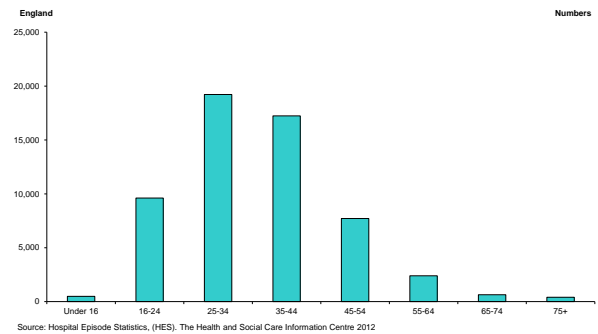
Figure 3.3 NHS hospital admissions where there was a primary or secondary diagnosis of drug related mental health and behavioural disorders, 2000/01 to 2011/12



As seen with primary diagnosis, Table 3.4 shows that those in the 25-34 age group had the greatest number of admissions (19,220) with a primary or secondary diagnosis of drug-related mental health and behavioural

disorders than any other age group. This age group accounted for 33.3% of all such admissions in that year. Those in the 75+ age group had the lowest number of admissions accounting for less than 1% of such admissions (406). (Table 3.4 and Figure 3.4).

Figure 3.4 NHS hospital admissions where there was a primary or secondary diagnosis of drug related mental health and behavioural disorders, by age group, 2011/12



As with primary diagnoses, more males were admitted to hospital for a primary or secondary diagnosis of drug-related mental health and behavioural disorders than females. More than twice as many males were admitted than females (38,826 and 18,904 respectively). (Table 3.5).

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 192 admissions per 100,000 population. South East Coast SHA and South Central SHA had the lowest number at 67 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 the primary diagnosis was related to drug poisoning. We are currently seeking feedback from users on the ICD-10 codes we use to describe these admissions. For further information see Appendix F.

Table 3.7 shows that in 2011/12, 12,344 admissions were recorded with this diagnosis, 1.9% (242) less than in 2010/11 when there were 12,586 admissions. Since 2000/01, there has been a long term increase in the number of admissions from 7,814. An increase of 58% (4,530) over the period. (Figure 3.5).

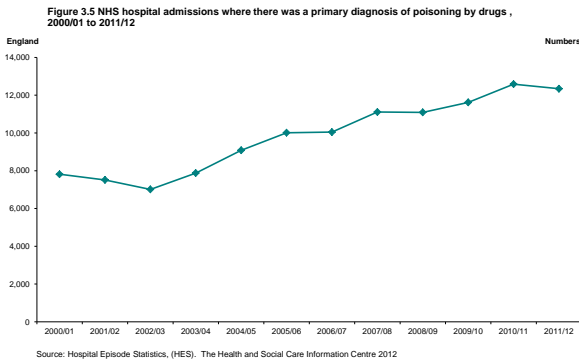


Table 3.7 shows that adults in the 16-24 age group reported the highest number of admissions (2,924) with a primary diagnosis of poisoning by drugs in 2011/12. Those in the 65-74 age group reported the lowest number of such admissions in 2011/12 (361).

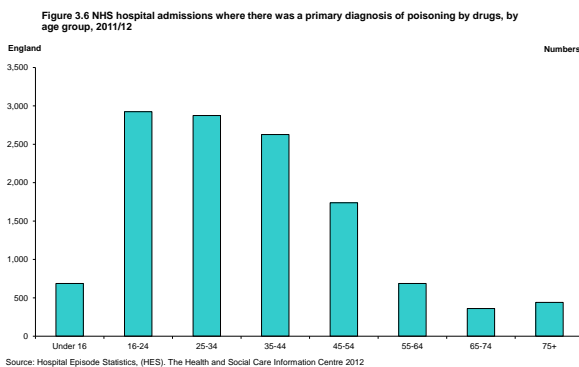


Table 3.8 shows that in 2011/12, more males were admitted to hospital with a primary diagnosis of poisoning by drugs than females (6,336 males compared to 6,008 females).

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 of 41 admissions 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 there was a primary diagnosis of drug poisoning by PCT.

3.3 Treatment for drug misuse

Statistics from the *National Drug Treatment Monitoring System (NDTMS)*³ provide information on the number of people being treated for drug misuse and referrals. The latest information available is for 2011/12 and includes information for those aged 18 and over.

Table 3.10 shows that in 2011/12, 197,110 individuals were in contact with structured drug treatment services. This is a 3.6% decrease from the 2010/11 figures, where the number was 204,473.⁶ Most of these individuals in treatment are aged 30-34 (22% for both sexes) and 73% are male. (Figure 3.4).

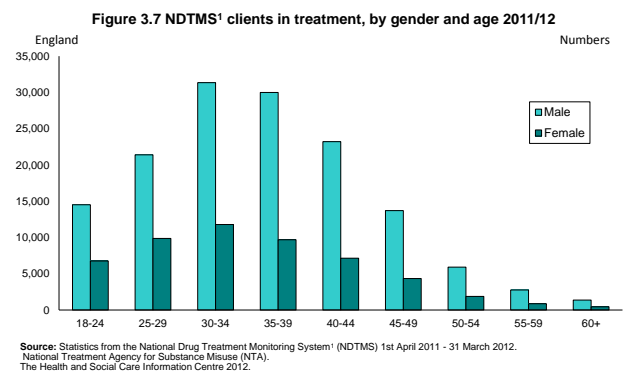


Table 3.11 shows that in 2011/12, the main type of drug for which people received treatment was opiates only (which includes heroin) at 49% of all treatments with a further 32% of treatments for those who have taken both opiates and crack.

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 63,020 discharged episodes of treatment by the end 2011/12 and that there were 29,855 (47%) clients exiting treatment who were no longer dependent on the substances that brought them into treatment; a further 15,648 (25%) were referred on for further interventions outside of community-structured treatment.

The NDTMS also report on referral sources for episodes of treatment. A client may have had more than one episode of treatment in a year (see [Appendix A](#) for more information on episodes). [Table 3.13](#) shows that the most frequent source of referral in 2011/12 was self-referrals accounting for 40% (27,779) of the 68,625 new presentations.

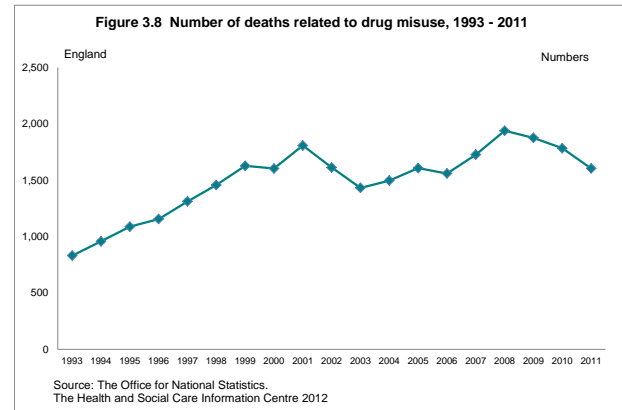
The NDTMS also report on people in treatment by Government Office Regions (GORs). This information has not been updated this year however figures for the 2009/10 period are available via the *Drug Misuse in England: 2010 report*⁷. ([Section 3.3](#) and [Figure 3.4](#) on page 28 and [Table 3.13](#) on page 44).

3.4 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) *Statistical Bulletin Deaths related to drug poisoning in England and Wales, 2011*⁴, published in August 2012.

In January 2011 ONS introduced a new version of ICD-10 (version 2010) which replaced version 2001.2. This means that not all the figures for 2011 will be directly comparable to figures for 2001 - 2010. Analysis to assess the impact of the new coding has showed that the number of deaths coded as mental and behavioural disorders due to drug use (ICD-10 codes F11–F16 and F18-F19) decreased by 84% in v2010, compared to v2001.2. This decrease is due to these deaths being allocated to accidental poisonings by drugs (ICD-10 code X40-X44) which consequently increased by 44%. The new version of ICD-10 caused very little change in the number of deaths being coded as intentional self-poisoning by drugs, or poisoning by drugs, undetermined intent. Overall, therefore, the coding changes have little impact on the total number of deaths only by the underlying cause of death. Further information can be found on pages 4 - 5 of the *Deaths related to drug poisoning in England and Wales, 2011*⁴ Statistical Bulletin.

[Table 3.14](#) shows the number of deaths related to drug misuse. In 2011, there were 1,605 deaths reported as being due to drug misuse, a decrease of 179 from 2010 when there were 1,784 such deaths. This continues the downward trend seen since 2008 when deaths peaked at 1,939. ([Figure 3.6](#)).



The number of male deaths decreased by 14% from 1,382 in 2010 to 1,192 in 2011. However over the same period the number of female deaths rose by 3%, from 402 in 2010 to 413 in 2011. The highest numbers of deaths due to drug misuse occurred in the 30 to 39 age group for males (396 deaths) and in the 40-49 age group for females (117 deaths), closely followed by the 30-39 age group (108 deaths).

[Table 3.15](#) shows the analysis of the underlying causes of death due to drug misuse. Due to the new version of ICD-10 introduced this year figures for mental and behavioural disorders due to drug use and accidental poisoning by drugs are not comparable to figures for previous years.

In 2011 accidental poisoning is the most common cause of death related to drug misuse accounting for 71% (1,147 out of 1,605) deaths. For each underlying cause of death more males than females die, with over five times the number of males dying from mental and behavioural disorders than females (82 out of 1,192 and 16 out of 413 respectively). This pattern was also evident in deaths due to accidental poisoning (884 male and 263 female), intentional self-poisoning of undetermined intent (224 male and 134 female) and assault by drugs (2 male and 0 female).

An alternative source of data on drug-related deaths is the national programme on *Substance Abuse Deaths (np-SAD)*⁸. This programme's principal aim is to reduce and prevent drug-related deaths in the UK due to the misuse of drugs, both licit and illicit, by collecting, analysing and disseminating information on the extent and nature of death.

An annual report *Drug-related death in the UK*⁹ published by the International Centre for Drug Policy at St George's University of London analyses drug-related deaths that have occurred in the preceding calendar year and comments on emerging trends. Information presented in the *np-SAD* publication is based on data provided by coroners, as part of the *Special Mortality Register (SMR)*.

Some of the key findings from this report are as follows;

- There were 1,883 notifications of drug-related deaths in 2010 in the UK and Islands^f, this represents a decrease of 299 (13.7%) over the same reporting period in 2009.
- The highest rates of drug-related deaths per 100,000 population aged 16 and over in 2010 were in the following areas; Brighton & Hove (14.8); City of Manchester (13.4); Blackpool & The Flyde (11.8), Fife (10.3) and Lothian & Borders (10.0).
- The principle demographic characteristics of those dying have remained consistent with previous reports. The majority of cases were males (74%), under the age of 45 years (70%) and White (96%). Most deaths (77%) occurred at a private residential address.

^f Channel Islands and Isle of Man

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Table 3.1 NHS hospital admissions^{1,2} where there was a primary diagnosis³ of drug related mental health and behavioural disorders⁴, by age group, 2000/01 to 2011/12^{5,6,7,8,9}

England	Numbers								
	Total ¹⁰	Under 16	16-24	25-34	35-44	45-54	55-64	65-74	75+
2000/01	8,027	130	2,488	3,442	1,474	361	60	30	39
2001/02	7,978	152	2,290	3,416	1,578	355	83	47	53
2002/03	7,691	135	2,084	3,217	1,688	401	99	37	28
2003/04	7,869	141	2,072	3,185	1,884	399	91	46	47
2004/05	7,857	156	1,952	3,231	1,870	446	95	58	46
2005/06	7,757	164	1,740	3,180	1,987	443	151	41	46
2006/07	6,743	139	1,364	2,680	1,864	476	104	37	35
2007/08	6,675	113	1,502	2,605	1,813	440	108	42	48
2008/09	5,668	65	1,176	2,207	1,558	476	97	40	43
2009/10	5,809	93	1,197	2,176	1,582	550	119	41	34
2010/11	6,640	96	1,423	2,286	1,882	669	138	57	51
2011/12	6,173	101	1,428	2,084	1,655	654	155	44	52

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 20 (14 prior to 2007-08 and 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. The quality and coverage of HES data have improved over time. These improvements in information submitted by the NHS have been particularly marked in the earlier years and need to be borne in mind when analysing time series. Some of the increase in figures for later years (particularly 2006-07 onwards) may be due to the improvement in the coverage of independent sector activity. Changes in NHS practice also need to be borne in mind when analysing time series.

10. Includes admissions where the age was unknown.

Source:

Hospital Episode Statistics, HES. The Health and Social Care Information Centre

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Table 3.2 NHS hospital admissions^{1,2} where there was a primary diagnosis³ of drug related mental health and behavioural disorders⁴, by Strategic Health Authority⁵ and gender, 2011/12^{6,7}

England

			Total ⁸	Number of admissions per 100,000 population ⁹	Male	Female
England^{10,11}			6,173	12	4,558	1,615
Q30	E18000001	North East	246	9	190	56
Q31	E18000002	North West	1,392	20	1,019	373
Q32	E18000003	Yorkshire and the Humber	618	12	464	154
Q33	E18000004	East Midlands	452	10	345	107
Q34	E18000005	West Midlands	397	7	288	109
Q35	E18000006	East of England	334	6	242	92
Q36	E18000007	London	1,432	17	1,043	389
Q37	E18000008	South East Coast	413	9	289	124
Q38	E18000009	South Central	279	7	203	76
Q39	E18000010	South West	414	8	298	116

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 20 (14 prior to 2007-08 and 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. Strategic Health Authority (SHA) in which the patient is normally resident, based on the patient's postcode.

6. Counts exclude admissions where the SHA of residence is unknown.

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 population all ages use estimated resident population mid-2010 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 of residence was England but not further specified.

11. Counts include people resident in England SHAs only.

Source:

Hospital Episode Statistics, HES. The Health and Social Care Information Centre

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Table 3.3 NHS hospital admissions^{1,2} where there was a primary diagnosis³ of drug related mental health and behavioural disorders⁴, by Strategic Health Authority^{5,6,7} and Primary Care Trust⁸, 2011/12⁹

England		<i>Numbers</i>
		<i>Total</i>
England		6,173
North East Strategic Health Authority	Q30	246
County Durham PCT	5ND	43
Darlington PCT	5J9	27
Gateshead PCT	5KF	11
Hartlepool PCT	5D9	13
Middlesbrough PCT	5KM	22
Newcastle PCT	5D7	18
North Tyneside PCT	5D8	15
Northumberland Care Trust	TAC	17
Redcar and Cleveland PCT	5QR	15
South Tyneside PCT	5KG	19
Stockton-on-Tees Teaching PCT	5E1	13
Sunderland Teaching PCT	5KL	33
North West Strategic Health Authority	Q31	1,392
Ashton, Leigh and Wigan PCT	5HG	61
Blackburn With Darwen Teaching Care Plus Trust PCT	TAP	36
Blackpool PCT	5HP	81
Bolton PCT	5HQ	66
Bury PCT	5JX	43
Central and Eastern Cheshire PCT	5NP	44
Central Lancashire PCT	5NG	82
Cumbria PCT	5NE	57
East Lancashire Teaching PCT	5NH	77
Halton and St Helens PCT	5NM	80
Heywood, Middleton and Rochdale PCT	5NQ	30
Knowsley PCT	5J4	68
Liverpool PCT	5NL	215
Manchester PCT	5NT	91
North Lancashire PCT	5NF	53
Oldham PCT	5J5	34
Salford PCT	5F5	54
Sefton PCT	5NJ	44
Stockport PCT	5F7	27
Tameside and Glossop PCT	5LH	40
Trafford PCT	5NR	16
Warrington PCT	5J2	29
Western Cheshire PCT	5NN	21
Wirral PCT	5NK	43
Yorkshire & The Humber Strategic Health Authority	Q32	618
Barnsley PCT	5JE	34
Bradford and Airedale Teaching PCT	5NY	38
Calderdale PCT	5J6	35
Doncaster PCT	5N5	56
East Riding Of Yorkshire PCT	5NW	17
Hull Teaching PCT	5NX	55
Kirklees PCT	5N2	58
Leeds PCT	5N1	98
North East Lincolnshire Care Trust Plus PCT	TAN	27
North Lincolnshire PCT	5EF	13
North Yorkshire and York PCT	5NV	44
Rotherham PCT	5H8	15
Sheffield PCT	5N4	72
Wakefield District PCT	5N3	56

Table 3.3 NHS hospital admissions^{1,2} where there was a primary diagnosis³ of drug related mental health and behavioural disorders⁴, by Strategic Health Authority^{5,6,7} and Primary Care Trust⁸, 2011/12⁹ - Continued

England		<i>Numbers</i>
		<i>Total</i>
England		6,173
East Midlands Strategic Health Authority	Q33	452
Bassetlaw PCT	5ET	14
Derby City PCT	5N7	34
Derbyshire County PCT	5N6	59
Leicester City PCT	5PC	52
Leicestershire County and Rutland PCT	5PA	47
Lincolnshire Teaching PCT	5N9	47
Northamptonshire Teaching PCT	5PD	41
Nottingham City PCT	5EM	82
Nottinghamshire County Teaching PCT	5N8	73
Tamside and Glossop PCT	5LH	3
West Midlands Strategic Health Authority	Q34	397
Birmingham East and North PCT	5PG	26
Coventry Teaching PCT	5MD	6
Dudley PCT	5PE	24
Heart Of Birmingham Teaching PCT	5MX	17
Herefordshire PCT	5CN	17
North Staffordshire PCT	5PH	44
Sandwell PCT	5PF	24
Shropshire County PCT	5M2	9
Solihull PCT ¹⁰	5QW	6
South Birmingham PCT	5M1	16
South Staffordshire PCT	5PK	19
Stoke On Trent PCT	5PJ	65
Telford and Wrekin PCT	5MK	7
Walsall Teaching PCT	5M3	16
Warwickshire PCT	5PM	14
Wolverhampton City PCT	5MV	36
Worcestershire PCT	5PL	51
East of England Strategic Health Authority	Q35	334
Bedfordshire PCT	5P2	18
Cambridgeshire PCT	5PP	31
Great Yarmouth and Waveney PCT	5PR	15
Hertfordshire PCT	5QV	31
Luton PCT	5GC	22
Mid Essex PCT	5PX	30
Norfolk PCT	5PQ	42
North East Essex PCT	5PW	18
Peterborough PCT	5PN	23
South East Essex PCT	5P1	27
South West Essex PCT	5PY	26
Suffolk PCT	5PT	34
West Essex PCT	5PV	17

Table 3.3 NHS hospital admissions^{1,2} where there was a primary diagnosis³ of drug related mental health and behavioural disorders⁴, by Strategic Health Authority^{5,6,7} and Primary Care Trust⁸, 2011/12⁹ - Continued

England	<i>Numbers</i>	
		<i>Total</i>
England		6,173
London Strategic Health Authority	Q36	1,432
Barking and Dagenham PCT	5C2	44
Barnet PCT	5A9	12
Bexley Care Trust	TAK	65
Brent Teaching PCT	5K5	47
Bromley PCT	5A7	78
Camden PCT	5K7	49
City and Hackney Teaching PCT	5C3	43
Croydon PCT	5K9	64
Ealing PCT	5HX	26
Enfield PCT	5C1	28
Greenwich Teaching PCT	5A8	110
Hammersmith and Fulham PCT	5H1	19
Haringey Teaching PCT	5C9	30
Harrow PCT	5K6	28
Havering PCT	5A4	20
Hillingdon PCT	5AT	29
Hounslow PCT	5HY	25
Islington PCT	5K8	47
Kensington and Chelsea PCT	5LA	34
Kingston PCT	5A5	17
Lambeth PCT	5LD	80
Lewisham PCT	5LF	65
Newham PCT	5C5	46
Redbridge PCT	5NA	35
Richmond and Twickenham PCT	5M6	23
Southwark PCT	5LE	69
Sutton and Merton PCT	5M7	75
Tower Hamlets PCT	5C4	67
Waltham Forest PCT	5NC	43
Wandsworth PCT	5LG	75
Westminster PCT	5LC	39
South East Coast Strategic Health Authority	Q37	413
Brighton and Hove City PCT	5LQ	67
Eastern and Coastal Kent PCT	5QA	73
East Sussex Downs and Weald PCT	5P7	39
Hastings and Rother PCT	5P8	29
Medway PCT	5L3	31
Surrey PCT	5P5	69
West Kent PCT	5P9	56
West Sussex PCT	5P6	49
South Central Strategic Health Authority	Q38	279
Berkshire East PCT	5QG	7
Berkshire West PCT	5QF	5
Buckinghamshire PCT	5QD	8
Hampshire PCT	5QC	110
Isle Of Wight NHS PCT	5QT	20
Milton Keynes PCT	5CQ	9
Oxfordshire PCT	5QE	15
Portsmouth City Teaching PCT	5FE	77
Southampton City PCT	5L1	28

Table 3.3 NHS hospital admissions^{1,2} where there was a primary diagnosis³ of drug related mental health and behavioural disorders⁴, by Strategic Health Authority^{5,6,7} and Primary Care Trust⁸, 2011/12⁹ - Continued

England		<i>Numbers</i>
		<i>Total</i>
England		6,173
South West Strategic Health Authority	Q39	414
Bath and North East Somerset PCT	5FL	7
Bournemouth and Poole PCT	5QN	51
Bristol PCT	5QJ	27
Cornwall and Isles Of Scilly PCT	5QP	62
Devon PCT	5QQ	29
Dorset PCT	5QM	49
Gloucestershire PCT	5QH	101
North Somerset PCT	5M8	7
Plymouth Teaching PCT	5F1	16
Somerset PCT	5QL	47
South Gloucestershire PCT	5A3	2
Swindon PCT	5K3	7
Torbay Care Trust	TAL	2
Wiltshire PCT	5QK	7

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 20 (14 prior to 2007-08 and 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 SHA only.

6. Counts exclude admissions where the SHA of residence is unknown.

7. Counts include admissions where the residence was England but the Primary Care Trust (PCT) of residence is unknown.

8. PCT of residence is based on patient postcode of residence. SHA and PCT geographical areas of responsibility are not all coterminous, some PCTs cross SHA boundaries. Postcode of residence is not used to assign patients to SHA of responsibility. PCT data has been aggregated to the SHA of responsibility.

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

10. On 15/04/2011 Solihull Care Trust (TAM) was renamed to as Solihull PCT (5QW)

Source:

Hospital Episode Statistics, HES. The Health and Social Care Information Centre

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Table 3.4 NHS hospital admissions^{1,2} where there was a primary³ or secondary diagnosis⁴ of drug related mental health and behavioural disorders⁵, by age group, 2000/01 to 2011/12^{6,7,8,9,10}

England	Numbers								
	Total ¹¹	Under 16	16-24	25-34	35-44	45-54	55-64	65-74	75+
2000/01	25,683	292	6,904	11,357	5,112	1,426	254	116	137
2001/02	28,063	329	7,136	12,355	6,034	1,543	290	151	146
2002/03	31,490	358	7,399	13,772	7,324	1,899	412	118	146
2003/04	34,957	374	7,861	15,061	8,670	2,137	418	156	194
2004/05	35,737	396	7,547	14,872	9,388	2,414	598	204	235
2005/06	38,005	445	7,495	15,752	10,314	2,817	688	181	197
2006/07	38,170	402	6,983	15,330	10,941	3,158	793	232	183
2007/08	40,421	350	7,348	15,540	11,792	3,664	924	270	191
2008/09	42,170	318	6,721	15,817	12,815	4,385	1,181	272	212
2009/10	44,585	344	6,685	16,089	13,773	5,228	1,480	324	243
2010/11	51,353	376	7,760	17,337	16,238	6,457	1,831	484	332
2011/12	57,733	492	9,614	19,220	17,241	7,714	2,402	643	406

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 prior to 2007-08 and 7 prior to 2002-03) primary and secondary diagnosis fields in a Hospital Episode Statistics (HES) record. Each episode is only counted once, 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 19 (13 prior to 2007-08 and 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 of residence was England but not further specified.
9. Figures have not been adjusted for shortfalls in data.
10. The quality and coverage of HES data have improved over time. These improvements in information submitted by the NHS have been particularly marked in the earlier years and need to be borne in mind when analysing time series. Some of the increase in figures for later years (particularly 2006-07 onwards) may be due to the improvement in the coverage of independent sector activity. Changes in NHS practice also need to be borne in mind when analysing time series. This may be particularly relevant for admissions with a primary or secondary diagnosis where some of the increases may be attributable to changes in recording practice.
11. Includes admissions where the age was unknown.

Source:

Hospital Episode Statistics, HES. The Health and Social Care Information Centre

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Table 3.5 NHS hospital admissions^{1,2} where there was a primary³ or secondary⁴ diagnosis of drug related mental health and behavioural disorders⁵, by Strategic Health Authority⁶ and gender, 2011/12^{7,8}

England				Numbers	
		Total ⁹	Number of admissions per 100,000 population ¹⁰	Male	Female
England^{11,12}		57,733	109	38,826	18,904
Q30	E18000001 North East	3,473	134	2,316	1,156
Q31	E18000002 North West	13,557	192	9,135	4,422
Q32	E18000003 Yorkshire and the Humber	7,716	146	5,080	2,636
Q33	E18000004 East Midlands	4,109	91	2,686	1,423
Q34	E18000005 West Midlands	4,894	87	3,194	1,700
Q35	E18000006 East of England	4,071	69	2,756	1,315
Q36	E18000007 London	7,884	96	5,420	2,464
Q37	E18000008 South East Coast	3,019	67	2,011	1,006
Q38	E18000009 South Central	2,789	67	1,925	864
Q39	E18000010 South West	4,992	94	3,269	1,723

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 prior to 2007-08 and 7 prior to 2002-03) primary and secondary diagnosis fields in a Hospital Episode Statistics (HES) record. Each episode is only counted once, 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 19 (13 prior to 2007-08 and 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 population all ages use estimated resident population mid-2010 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 of residence was England but not further specified

12. Counts include people resident in England SHAs only.

Source:

Hospital Episode Statistics, HES. The Health and Social Care Information Centre

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Table 3.6 NHS hospital admissions^{1,2} where there was a primary³ or secondary⁴ diagnosis of drug related mental health and behavioural disorders⁵, by Strategic Health Authority^{6,7,8} and Primary Care Trust⁹ 2011/12¹⁰

England		Numbers
		Total
England		57,733
North East Strategic Health Authority	Q30	3,473
County Durham PCT	5ND	566
Darlington PCT	5J9	226
Gateshead PCT	5KF	272
Hartlepool PCT	5D9	210
Middlesbrough PCT	5KM	404
Newcastle PCT	5D7	314
North Tyneside PCT	5D8	207
Northumberland Care Trust	TAC	344
Redcar and Cleveland PCT	5QR	212
South Tyneside PCT	5KG	181
Stockton-on-Tees PCT	5E1	205
Sunderland Teaching PCT	5KL	332
North West Strategic Health Authority	Q31	13,578
Ashton, Leigh and Wigan PCT	5HG	675
Blackburn With Darwen Teaching Care Plus Trust PCT	TAP	558
Blackpool PCT	5HP	555
Bolton PCT	5HQ	511
Bury PCT	5JX	295
Central and Eastern Cheshire PCT	5NP	368
Central Lancashire PCT	5NG	732
Cumbria PCT	5NE	526
East Lancashire Teaching PCT	5NH	744
Halton and St Helens PCT	5NM	635
Heywood, Middleton and Rochdale PCT	5NQ	390
Knowsley PCT	5J4	389
Liverpool PCT	5NL	2,091
Manchester PCT	5NT	1,292
North Lancashire PCT	5NF	408
Oldham PCT	5J5	412
Salford PCT	5F5	412
Sefton PCT	5NJ	469
Stockport PCT	5F7	379
Tameside and Glossop PCT	5LH	498
Trafford PCT	5NR	189
Warrington PCT	5J2	245
Western Cheshire PCT	5NN	222
Wirral PCT	5NK	583
Yorkshire & The Humber Strategic Health Authority	Q32	7,711
Barnsley PCT	5JE	446
Bradford and Airedale Teaching PCT	5NY	858
Calderdale PCT	5J6	240
Doncaster PCT	5N5	816
East Riding Of Yorkshire PCT	5NW	206
Hull Teaching PCT	5NX	844
Kirklees PCT	5N2	550
Leeds PCT	5N1	1,130
North East Lincolnshire Care Trust Plus PCT	TAN	211
North Lincolnshire PCT	5EF	147
North Yorkshire and York PCT	5NV	579
Rotherham PCT	5H8	423
Sheffield PCT	5N4	916
Wakefield District PCT	5N3	345

Table 3.6 NHS hospital admissions^{1,2} where there was a primary³ or secondary⁴ diagnosis of drug related mental health and behavioural disorders⁵, by Strategic Health Authority^{6,7,8} and Primary Care Trust⁹ 2011/12¹⁰ - Continued

England		Numbers
		Total
England		57,733
East Midlands Strategic Health Authority	Q33	4,093
Bassetlaw PCT	5ET	231
Derby City PCT	5N7	371
Derbyshire County PCT	5N6	629
Leicester City PCT	5PC	350
Leicestershire County and Rutland PCT	5PA	361
Lincolnshire Teaching PCT	5N9	601
Northamptonshire Teaching PCT	5PD	325
Nottingham City PCT	5EM	521
Nottinghamshire County Teaching PCT	5N8	704
West Midlands Strategic Health Authority	Q34	4,894
Birmingham East and North PCT	5PG	418
Coventry Teaching PCT	5MD	261
Dudley PCT	5PE	312
Heart Of Birmingham Teaching PCT	5MX	539
Herefordshire PCT	5CN	150
North Staffordshire PCT	5PH	173
Sandwell PCT	5PF	320
Shropshire County PCT	5M2	182
Solihull PCT ¹¹	5QW	84
South Birmingham PCT	5M1	405
South Staffordshire PCT	5PK	305
Stoke On Trent PCT	5PJ	391
Telford and Wrekin PCT	5MK	106
Walsall Teaching PCT	5M3	255
Warwickshire PCT	5PM	274
Wolverhampton City PCT	5MV	284
Worcestershire PCT	5PL	435
East of England Strategic Health Authority	Q35	4,071
Bedfordshire PCT	5P2	353
Cambridgeshire PCT	5PP	527
Great Yarmouth and Waveney PCT	5PR	207
Hertfordshire PCT	5QV	553
Luton PCT	5GC	218
Mid Essex PCT	5PX	121
Norfolk PCT	5PQ	544
North East Essex PCT	5PW	152
Peterborough PCT	5PN	302
South East Essex PCT	5P1	239
South West Essex PCT	5PY	223
Suffolk PCT	5PT	449
West Essex PCT	5PV	183

Table 3.6 NHS hospital admissions^{1,2} where there was a primary³ or secondary⁴ diagnosis of drug related mental health and behavioural disorders⁵, by Strategic Health Authority^{6,7,8} and Primary Care Trust⁹ 2011/12¹⁰ - Continued

England		Numbers
		Total
England		57,733
London Strategic Health Authority	Q36	7,884
Barking and Dagenham PCT	5C2	173
Barnet PCT	5A9	260
Bexley Care Trust	TAK	209
Brent Teaching PCT	5K5	231
Bromley PCT	5A7	276
Camden PCT	5K7	328
City and Hackney Teaching PCT	5C3	309
Croydon PCT	5K9	272
Ealing PCT	5HX	291
Enfield PCT	5C1	273
Greenwich Teaching PCT	5A8	442
Hammersmith and Fulham PCT	5H1	191
Haringey Teaching PCT	5C9	262
Harrow PCT	5K6	126
Havering PCT	5A4	107
Hillingdon PCT	5AT	221
Hounslow PCT	5HY	216
Islington PCT	5K8	393
Kensington and Chelsea PCT	5LA	156
Kingston PCT	5A5	133
Lambeth PCT	5LD	382
Lewisham PCT	5LF	336
Newham PCT	5C5	288
Redbridge PCT	5NA	149
Richmond and Twickenham PCT	5M6	132
Southwark PCT	5LE	346
Sutton and Merton PCT	5M7	281
Tower Hamlets PCT	5C4	309
Waltham Forest PCT	5NC	278
Wandsworth PCT	5LG	263
Westminster PCT	5LC	251
South East Coast Strategic Health Authority	Q37	3,015
Brighton and Hove City PCT	5LQ	386
Eastern and Coastal Kent PCT	5QA	508
East Sussex Downs and Weald PCT	5P7	226
Hastings and Rother PCT	5P8	215
Medway PCT	5L3	253
Surrey PCT	5P5	522
West Kent PCT	5P9	454
West Sussex PCT	5P6	451
South Central Strategic Health Authority	Q38	2,788
Berkshire East PCT	5QG	176
Berkshire West PCT	5QF	203
Buckinghamshire PCT	5QD	160
Hampshire PCT	5QC	872
Isle Of Wight NHS PCT	5QT	872
Milton Keynes PCT	5CQ	166
Oxfordshire PCT	5QE	387
Portsmouth City Teaching PCT	5FE	450
Southampton City PCT	5L1	246

Table 3.6 NHS hospital admissions^{1,2} where there was a primary³ or secondary⁴ diagnosis of drug related mental health and behavioural disorders⁵, by Strategic Health Authority^{6,7,8} and Primary Care Trust⁹ 2011/12¹⁰ - Continued

England		Numbers
		Total
England		57,733
South West Strategic Health Authority	Q39	4,997
Bath and North East Somerset PCT	5FL	143
Bournemouth and Poole PCT	5QN	330
Bristol PCT	5QJ	854
Cornwall and Isles Of Scilly PCT	5QP	553
Devon PCT	5QQ	442
Dorset PCT	5QM	307
Gloucestershire PCT	5QH	447
North Somerset PCT	5M8	155
Plymouth Teaching PCT	5F1	481
Somerset PCT	5QL	453
South Gloucestershire PCT	5A3	192
Swindon PCT	5K3	237
Torbay Care Trust	TAL	175
Wiltshire PCT	5QK	228

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 prior to 2007-08 and 7 prior to 2002-03) primary and secondary diagnosis fields in a Hospital Episode Statistics (HES) record. Each episode is only counted once, 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 19 (13 prior to 2007-08 and 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 (SHA) only.

7. Counts exclude admissions where the SHA of residence is unknown.

8. Counts include admissions where the residence was England but the PCT of residence is unknown.

9. PCT of residence is based on patient postcode of residence. SHA and PCT geographical areas of responsibility are not all coterminous, some PCTs cross SHA boundaries. Postcode of residence is not used to assign patients to SHA of responsibility. PCT data has been aggregated to the SHA of responsibility.

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

11. On 15/04/2011 Solihull Care Trust (TAM) was renamed to as Solihull PCT (5QW)

Source:

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Table 3.7 NHS hospital^{1,2} admissions where there was a primary diagnosis³ of poisoning by drugs⁴, by age group, 2000/01 to 2011/12^{5,6,7,8,9}

England	Numbers								
	Total ¹⁰	Under 16	16-24	25-34	35-44	45-54	55-64	65-74	75+
2000/01	7,814	683	2,483	2,330	1,209	587	219	139	139
2001/02	7,513	829	2,272	2,073	1,294	563	214	108	142
2002/03	7,011	774	1,994	1,873	1,302	536	237	132	151
2003/04	7,876	918	2,001	2,106	1,518	706	266	145	199
2004/05	9,084	841	2,470	2,373	1,836	809	353	169	227
2005/06	10,012	814	2,616	2,608	2,129	973	394	185	279
2006/07	10,047	839	2,674	2,579	2,042	1,033	424	186	255
2007/08	11,110	861	3,030	2,720	2,270	1,121	528	229	331
2008/09	11,090	711	2,741	2,773	2,510	1,225	520	249	310
2009/10	11,618	688	2,880	2,734	2,501	1,461	648	281	384
2010/11	12,586	731	3,202	2,860	2,648	1,675	654	353	400
2011/12	12,344	688	2,924	2,875	2,627	1,739	688	361	441

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 20 (14 prior to 2007-08 and 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. We are currently seeking user feedback on the codes used. Please see [Appendix F](#) for further details

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 of residence was England but not further specified.

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

9. The quality and coverage of HES data have improved over time. These improvements in information submitted by the NHS have been particularly marked in the earlier years and need to be borne in mind when analysing time series. Some of the increase in figures for later years (particularly 2006-07 onwards) may be due to the improvement in the coverage of independent sector activity. Changes in NHS practice also need to be borne in mind when analysing time series. Further years' data may be required to aid interpretation of these statistics.

10. Includes admissions where the age was unknown.

Source:

Hospital Episode Statistics, HES. The Health and Social Care Information Centre

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Table 3.8 NHS hospital^{1,2} admissions where there was a primary diagnosis³ of poisoning by drugs⁴, by Strategic Health Authority^{5,6} and gender, 2011/12⁷

England		Numbers			
		Total ⁸	Number of admissions per 100,000 population ⁹	Male	Female
England^{10,11}		12,344	23	6,336	6,008
Q30	E18000001 North East	1,064	41	563	501
Q31	E18000002 North West	2,531	36	1,271	1,260
Q32	E18000003 Yorkshire and the Humber	1,577	30	837	740
Q33	E18000004 East Midlands	1,007	22	493	514
Q34	E18000005 West Midlands	1,245	22	626	619
Q35	E18000006 East of England	874	15	425	449
Q36	E18000007 London	1,038	13	535	503
Q37	E18000008 South East Coast	804	18	369	435
Q38	E18000009 South Central	736	18	380	356
Q39	E18000010 South West	1,232	23	645	587

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 20 (14 prior to 2007-08 and 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. We are currently seeking user feedback on the codes used. Please see [Appendix F](#) for further details

5. Strategic Health Authority (SHA) in which the patient is normally resident, based on the patient's postcode.

6. Counts exclude admissions where the SHA of residence is unknown

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 population all ages use estimated resident population mid-2010 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 of residence was England but not further specified.

11. Counts include people resident in England SHAs only.

Source:

Hospital Episode Statistics, HES. The Health and Social Care Information Centre

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Table 3.9 NHS hospital admissions^{1,2} where a primary diagnosis³ of poisoning by drugs⁴, by Strategic Health Authority^{5,6,7} and Primary Care Trust⁸ 2011/12⁹

England		Numbers
		Total
England		12,344
North East Strategic Health Authority		Q30
		1,064
County Durham PCT	5ND	165
Darlington PCT	5J9	57
Gateshead PCT	5KF	81
Hartlepool PCT	5D9	51
Middlesbrough PCT	5KM	104
Newcastle PCT	5D7	98
North Tyneside PCT	5D8	83
Northumberland Care Trust	TAC	101
Redcar and Cleveland PCT	5QR	91
South Tyneside PCT	5KG	37
Stockton-on-Tees PCT	5E1	77
Sunderland Teaching PCT	5KL	119
North West Strategic Health Authority		Q31
		2,541
Ashton, Leigh and Wigan PCT	5HG	121
Blackburn With Darwen Teaching Care Plus Trust PCT	TAP	88
Blackpool PCT	5HP	130
Bolton PCT	5HQ	97
Bury PCT	5JX	63
Central and Eastern Cheshire PCT	5NP	106
Central Lancashire PCT	5NG	125
Cumbria PCT	5NE	149
East Lancashire Teaching PCT	5NH	153
Halton and St Helens PCT	5NM	144
Heywood, Middleton and Rochdale PCT	5NQ	77
Knowsley PCT	5J4	58
Liverpool PCT	5NL	154
Manchester PCT	5NT	176
North Lancashire PCT	5NF	89
Oldham PCT	5J5	51
Salford PCT	5F5	150
Sefton PCT	5NJ	68
Stockport PCT	5F7	66
Tameside and Glossop PCT	5LH	138
Trafford PCT	5NR	38
Warrington PCT	5J2	52
Western Cheshire PCT	5NN	79
Wirral PCT	5NK	169
Yorkshire & The Humber Strategic Health Authority		Q32
		1,577
Barnsley PCT	5JE	70
Bradford and Airedale Teaching PCT	5NY	168
Calderdale PCT	5J6	84
Doncaster PCT	5N5	96
East Riding Of Yorkshire PCT	5NW	64
Hull Teaching PCT	5NX	128
Kirklees PCT	5N2	119
Leeds PCT	5N1	296
North East Lincolnshire Care Trust Plus PCT	TAN	47
North Lincolnshire PCT	5EF	31
North Yorkshire and York PCT	5NV	167
Rotherham PCT	5H8	78
Sheffield PCT	5N4	85
Wakefield District PCT	5N3	144

Table 3.9 NHS hospital admissions^{1,2} where a primary diagnosis³ of poisoning by drugs⁴, by Strategic Health Authority^{5,6,7} and Primary Care Trust⁸ 2011/12⁹ - Continued

England		Numbers Total
England		12,344
East Midlands Strategic Health Authority	Q33	997
Bassetlaw PCT	5ET	51
Derby City PCT	5N7	80
Derbyshire County PCT	5N6	175
Leicester City PCT	5PC	49
Leicestershire County and Rutland PCT	5PA	80
Lincolnshire Teaching PCT	5N9	142
Northamptonshire Teaching PCT	5PD	232
Nottingham City PCT	5EM	79
Nottinghamshire County Teaching PCT	5N8	109
West Midlands Strategic Health Authority	Q34	1,245
Birmingham East and North PCT	5PG	110
Coventry Teaching PCT	5MD	102
Dudley PCT	5PE	78
Heart Of Birmingham Teaching PCT	5MX	72
Herefordshire PCT	5CN	21
North Staffordshire PCT	5PH	24
Sandwell PCT	5PF	84
Shropshire County PCT	5M2	55
Solihull PCT ¹⁰	5QW	50
South Birmingham PCT	5M1	123
South Staffordshire PCT	5PK	141
Stoke On Trent PCT	5PJ	55
Telford and Wrekin PCT	5MK	44
Walsall Teaching PCT	5M3	62
Warwickshire PCT	5PM	110
Wolverhampton City PCT	5MV	26
Worcestershire PCT	5PL	88
East of England Strategic Health Authority	Q35	874
Bedfordshire PCT	5P2	50
Cambridgeshire PCT	5PP	119
Great Yarmouth and Waveney PCT	5PR	47
Hertfordshire PCT	5QV	141
Luton PCT	5GC	28
Mid Essex PCT	5PX	41
Norfolk PCT	5PQ	145
North East Essex PCT	5PW	26
Peterborough PCT	5PN	84
South East Essex PCT	5P1	31
South West Essex PCT	5PY	28
Suffolk PCT	5PT	93
West Essex PCT	5PV	41

Table 3.9 NHS hospital admissions^{1,2} where a primary diagnosis³ of poisoning by drugs⁴, by Strategic Health Authority^{5,6,7} and Primary Care Trust⁸ 2011/12⁹ - Continued

England	Numbers	
		Total
England		12,344
London Strategic Health Authority	Q36	1,038
Barking and Dagenham PCT	5C2	27
Barnet PCT	5A9	38
Bexley Care Trust	TAK	32
Brent Teaching PCT	5K5	27
Bromley PCT	5A7	23
Camden PCT	5K7	28
City and Hackney Teaching PCT	5C3	37
Croydon PCT	5K9	39
Ealing PCT	5HX	43
Enfield PCT	5C1	25
Greenwich Teaching PCT	5A8	36
Hammersmith and Fulham PCT	5H1	47
Haringey Teaching PCT	5C9	28
Harrow PCT	5K6	20
Havering PCT	5A4	45
Hillingdon PCT	5AT	58
Hounslow PCT	5HY	38
Islington PCT	5K8	43
Kensington and Chelsea PCT	5LA	24
Kingston PCT	5A5	7
Lambeth PCT	5LD	45
Lewisham PCT	5LF	39
Newham PCT	5C5	47
Redbridge PCT	5NA	27
Richmond and Twickenham PCT	5M6	14
Southwark PCT	5LE	28
Sutton and Merton PCT	5M7	43
Tower Hamlets PCT	5C4	35
Waltham Forest PCT	5NC	47
Wandsworth PCT	5LG	29
Westminster PCT	5LC	19
South East Coast Strategic Health Authority	Q37	804
Brighton and Hove City PCT	5LQ	118
Eastern and Coastal Kent PCT	5QA	218
East Sussex Downs and Weald PCT	5P7	42
Hastings and Rother PCT	5P8	23
Medway PCT	5L3	50
Surrey PCT	5P5	122
West Kent PCT	5P9	117
West Sussex PCT	5P6	114
South Central Strategic Health Authority	Q38	736
Berkshire East PCT	5QG	60
Berkshire West PCT	5QF	45
Buckinghamshire PCT	5QD	49
Hampshire PCT	5QC	241
Isle Of Wight NHS PCT	5QT	30
Milton Keynes PCT	5CQ	42
Oxfordshire PCT	5QE	100
Portsmouth City Teaching PCT	5FE	95
Southampton City PCT	5L1	74

Table 3.9 NHS hospital admissions^{1,2} where a primary diagnosis³ of poisoning by drugs⁴, by Strategic Health Authority^{5,6,7} and Primary Care Trust⁸ 2011/12⁹ - Continued

England		Numbers
		Total
England		12,344
South West Strategic Health Authority	Q39	1,232
Bath and North East Somerset PCT	5FL	36
Bournemouth and Poole PCT	5QN	86
Bristol PCT	5QJ	121
Cornwall and Isles Of Scilly PCT	5QP	149
Devon PCT	5QQ	137
Dorset PCT	5QM	49
Gloucestershire PCT	5QH	134
North Somerset PCT	5M8	31
Plymouth Teaching PCT	5F1	93
Somerset PCT	5QL	122
South Gloucestershire PCT	5A3	31
Swindon PCT	5K3	114
Torbay Care Trust	TAL	32
Wiltshire PCT	5QK	97

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 20 (14 prior to 2007-08 and 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. We are currently seeking user feedback on the codes used. Please see [Appendix F](#) for further details

5. Counts include people resident in England SHAs only.

6. Counts exclude admissions where the SHA of residence is unknown.

7. Counts include admissions where the residence was England but the PCT of residence is unknown.

8. PCT of residence is based on patient postcode of residence. SHA and PCT geographical areas of responsibility are not all coterminous, some PCTs cross SHA boundaries. Postcode of residence is not used to assign patients to SHA of responsibility. PCT data has been aggregated to the SHA of responsibility.

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

10. On 15/04/2011 Solihull Care Trust (TAM) was renamed to as Solihull PCT (5QW)

Source:

Hospital Episode Statistics, HES. Health and Social Care Information Centre

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Table 3.10 NDTMS¹ clients in treatment, by gender and age², 2011/12

England	<i>Numbers / percentages³</i>					
	Total		Male		Female	
All clients	197,110	100	144,295	100	52,815	100
18-24	21,290	11	14,526	10	6,764	13
25-29	31,289	16	21,408	15	9,881	19
30-34	43,151	22	31,364	22	11,787	22
35-39	39,685	20	29,998	21	9,687	18
40-44	30,363	15	23,213	16	7,150	14
45-49	18,045	9	13,706	9	4,339	8
50-54	7,812	4	5,925	4	1,887	4
55-59	3,651	2	2,780	2	871	2
60+	1,824	1	1,375	1	449	1

1. National Drug Treatment Monitoring System (NDTMS).

2. Age is based on the client's age at the start of the financial year (1st April 2011) 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 2011 - 31 March 2012. National Treatment Agency for Substance Misuse (NTA)

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Table 3.11 Primary¹ drug use of all clients² in NDTMS³, 2011/12

England	<i>Numbers / percentage⁴</i>	
Total	197,110	100
PDU⁵ Total	164,671	84
Opiates Only (PDUs)	96,343	49
Crack Only (PDUs)	5,129	3
Opiates & Crack (PDUs)	63,199	32
Non PDU Total	32,439	16
Benzodiazepines	1,085	1
Amphetamines (excluding ecstasy)	3,860	2
Cocaine (excluding Crack)	9,640	5
Hallucinogens	567	0
Ecstasy	175	0
Cannabis	15,194	8
Solvent	127	0
Barbiturates	11	0
Major Tranquilisers	15	0
Anti-depressants	36	0
Other Drugs	723	0
Poly Drug	4	0
Prescription Drugs	790	0
Misuse Free	212	0

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. National Drug Treatment Monitoring System (NDTMS).

4. Percentages are rounded to the nearest per cent. Totals may not add up to 100 due to rounding.

5. Problem Drug Users (PDU).

Source:

Statistics from the National Drug Treatment Monitoring System (NDTMS) 1 April 2011 - 31 March 2012. National Treatment Agency for Substance Misuse (NTA)

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Table 3.12 Treatment exit reasons for individuals not retained in treatment reported to the NDTMS¹ on 31st March 2012

England	<i>Numbers / percentages²</i>	
Total (episodes discharged)	63,020	100
Total successful completions	29,855	47
Treatment completed free of dependency (no drug use)	21,810	35
Treatment completed free of dependency	8,045	13
Transferred - not in custody	8,524	14
Transferred - in custody	7,123	11
Referred on	1	0
Dropped out / left	13,499	21
Prison	916	1
Treatment declined	1,234	2
Treatment withdrawn	641	1
Moved away	0	0
Died	1,227	2
Other ³	0	0
Not known	0	0
No appropriate treatment	0	0

1. National Drug Treatment Monitoring System (NDTMS).

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 2011 - 31 March 2012.
National Treatment Agency for Substance Misuse (NTA)

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Table 3.13 Source of referral into treatment, new journeys 2011-12

England	<i>Numbers / percentages¹</i>	
Total²	68,625	100
Accident and Emergency	182	0
Arrest Referral/Drug Interventions Programme (DIP)	8,881	13
Counselling, Assessment, Referral, Advice and Throughcare Services (CARATS) /Prison	6,330	9
Community Care Assessment	171	0
Connexions	22	0
Drug Rehabilitation Requirements (DRR)	1,200	2
Drug Story Non-statutory	4,840	7
Drug Service Statutory	3,831	6
Education Service	39	0
Employment Service	115	0
GP	4,363	6
Probation	3,727	5
Psychiatry	594	1
Self	27,779	40
Social Services	825	1
Syringe Exchange	67	0
Other	5,659	8

1. Percentages are rounded to the nearest per cent. Totals may not add up to 100 due to rounding.

2. Total figure does not include records where the source of referral is missing.

Source:

Statistics from the National Drug Treatment Monitoring System (NDTMS) 1 April 2011 - 31 March 2012. National Treatment Agency for Substance Misuse (NTA)

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Table 3.14 Number of deaths related to drug misuse by gender and age group, 1993 - 2011

England and Wales																			Numbers
	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
Total	831	958	1,088	1,156	1,312	1,458	1,628	1,604	1,808	1,613	1,432	1,497	1,608	1,560	1,727	1,939	1,876	1,784	1,605
Males																			
All ages	577	718	839	936	1,041	1,142	1,321	1,329	1,451	1,269	1,118	1,179	1,260	1,238	1,387	1,506	1,512	1,382	1,192
Under 20	39	47	54	53	75	74	74	53	56	49	40	26	29	34	27	40	29	24	22
20-29	224	292	341	385	456	453	477	456	504	482	353	346	336	331	370	359	354	277	216
30-39	167	213	253	297	299	379	502	492	537	479	456	481	521	478	535	541	544	544	396
40-49	75	97	115	125	140	176	179	239	248	167	187	198	239	270	323	393	404	340	363
50-69	44	44	51	44	51	41	64	68	70	75	63	108	114	103	117	145	160	166	167
70 and over	28	25	25	32	20	19	25	21	36	17	19	20	21	22	15	28	21	31	28
Females																			
All ages	254	240	249	220	271	316	307	275	357	344	314	318	348	322	340	433	364	402	413
Under 20	11	15	13	19	15	24	19	21	20	21	13	18	12	14	13	13	10	11	11
20-29	47	40	58	60	82	77	83	64	97	81	72	80	66	71	65	69	61	57	50
30-39	42	47	63	48	47	87	80	72	90	84	87	77	107	90	107	130	97	105	108
40-49	40	38	31	29	46	53	39	48	63	63	55	64	83	56	72	119	87	106	117
50-69	54	52	42	30	43	41	41	38	45	58	51	47	53	63	55	79	75	86	94
70 and over	60	48	42	34	38	34	45	32	42	37	36	32	27	28	28	23	34	37	33

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 this indicator is based on the current list of drugs controlled under the Misuse of Drugs Act, earlier years' data have been updated to reflect additional substances.

4. 2010 data were reviewed and revised back to 1993. This was due to difficulties found with the coding compound analgesics, deaths mentioning intravenous drugs and multiple drug use. When age standardised rates for drug misuse are calculated there is no significant impact on the time trend. Further information can be found in the background notes of the 2010 Statistical Bulletin;

<http://www.ons.gov.uk/ons/rel/subnational-health3/deaths-related-to-drug-poisoning/2009/deaths-related-to-drug-poisoning-in-england-and-wales--2009.pdf>

Source:

The Office for National Statistics (ONS)

<http://www.ons.gov.uk/ons/rel/subnational-health3/deaths-related-to-drug-poisoning/2011/stb-deaths-related-to-drug-poisoning-2011.html>

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Table 3.15 Number of deaths related to drug misuse by gender and underlying cause of death, 1993 - 2011

England and Wales	Numbers																		
	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
Total	831	958	1,088	1,156	1,312	1,458	1,628	1,604	1,808	1,613	1,432	1,497	1,608	1,560	1,727	1,939	1,876	1,784	1,605
Males																			
All ages	577	718	839	936	1,041	1,142	1,321	1,329	1,451	1,269	1,118	1,179	1,260	1,238	1,387	1,506	1,512	1,382	1,192
Mental and behavioural disorders due to drug use ⁷	185	252	303	398	438	562	654	656	737	685	629	629	682	627	652	694	575	498	82
Accidental poisoning by drugs ⁷	226	313	380	359	435	405	451	452	471	378	313	368	389	426	528	612	736	694	884
Intentional self-poisoning/ poisoning of undetermined intent	162	149	156	174	159	168	212	207	231	196	175	177	184	180	200	193	196	186	224
Assault by drugs	4	4	0	5	9	7	4	14	12	10	1	5	5	5	7	7	5	4	2
Females																			
All ages	254	240	249	220	271	316	307	275	357	344	314	318	348	322	340	433	364	402	413
Mental and behavioural disorders due to drug use ⁷	46	45	54	68	79	107	103	90	126	109	126	117	122	98	118	138	101	93	16
Accidental poisoning by drugs ⁷	69	77	75	67	72	90	102	85	107	105	75	78	103	115	125	177	150	193	263
Intentional self-poisoning/ poisoning of undetermined intent	138	116	119	84	119	116	100	99	120	125	112	123	121	107	97	116	113	116	134
Assault by drugs	1	2	1	1	1	3	2	1	4	5	1	0	2	2	0	2	0	0	0

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.

6. 2010 data were reviewed and revised back to 1993. This was due to difficulties found with the coding compound analgesics, deaths mentioning intravenous drugs and multiple drug use. When age standardised rates for drug misuse are calculated there is no significant impact on the time trend. Further information can be found in the background notes of the 2010 Statistical Bulletin;

<http://www.ons.gov.uk/ons/rel/subnational-health3/deaths-related-to-drug-poisoning/2009/deaths-related-to-drug-poisoning-in-england-and-wales--2009.pdf>

7. In January 2011 ONS introduced a new version of ICD-10 (version 2010) which replaced version 2001.2. This means that figures for 2011 will not be directly comparable to figures for 2001 - 2010. Analysis to assess the impact of the new coding has showed that the number of deaths coded as mental and behavioural disorders due to drug use (ICD-10 codes F11-F16 and F18-F19) decreased by 84% in v2010, compared to v2001.2. This decrease is due to these deaths being allocated to accidental poisonings by drugs (ICD-10 code X40-X44) which consequently increased by 44%. The new version of ICD-10 caused very little change in the number of deaths being coded as intentional self-poisoning by drugs, or poisoning by drugs, undetermined intent. Further information can be found on pages 4 - 5 of the 2012 Statistical Bulletin;

http://www.ons.gov.uk/ons/dcp171778_276681.pdf

Source:

The Office for National Statistics (ONS)

<http://www.ons.gov.uk/ons/rel/subnational-health3/deaths-related-to-drug-poisoning/2011/stb-deaths-related-to-drug-poisoning-2011.html>

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Appendix A: Key Sources

This section gives further details on the main data sources used in this publication.

- **Adult Psychiatric Morbidity in England, 2007: results of a household survey**
- **Deaths related to drug poisoning in England and Wales**
- **Drug Misuse Declared: Findings from the Crime Survey for England and Wales**
- **EMCDDA Annual report on the state of the drugs problem in Europe**
- **European School Survey Project on Alcohol and Other Drugs (ESPAD) report: Substance use among students in 36 European countries**
- **Hospital Episode Statistics**
- **National Drug Treatment Monitoring System**
- **National and Regional Estimates of the Prevalence of Opiate and/or Crack Cocaine**
- **Scottish Crime and Justice Survey – Drug Use**
- **Smoking, Drinking and Drug Use among Young People in England**
- **Substance misuse among young people report**

Most of the sources referred to in this publication are National Statistics. National Statistics are produced to high professional standards set out in the Code of Practice for Official Statistics. It is a statutory requirement that National Statistics should observe the Code of Practice for Official Statistics. The United Kingdom Statistics Authority (UKSA) assesses all National Statistics for compliance with the Code of Practice.

Some of the statistics included in this publication are not National Statistics and are included here to provide a fuller picture; some of these are Official Statistics, whilst others are neither National Statistics nor Official Statistics. Those which are Official Statistics should still conform to the Code of Practice for Official Statistics, although this is not a statutory requirement. Those that are neither National Statistics nor Official Statistics may not conform to the Code of Practice for Official Statistics. Unless otherwise stated, all sources contained within this publication are considered robust. A brief explanation and short review of the quality of each of the main sets of statistics used in this publication are provided below.

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 Health and Social Care Information Centre.

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 sub-sample 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.

Information from the APMS can be found in Chapter 1

Adult Psychiatric Morbidity in England, 2007: results of a household survey. The Health and Social Care Information Centre. Available at: www.ic.nhs.uk/pubs/psychiatricmorbidity07

This is a National Statistic

Deaths related to drug poisoning in England and Wales

The Statistical Bulletin; 'Deaths related to drug poisoning in England and Wales, 2011', published by the Office for National Statistics (ONS) presents information on deaths related to drug poisoning (involving both legal and illegal drugs) and drug misuse (involving illegal drugs) in England and Wales for the period 2006 to 2011.

The data in this report have been produced using a database of deaths related to drugs poisoning. The database is extracted from the National Mortality database for England and Wales and deaths are included if the underlying cause of death is regarded as drug-related, according to the National Statistics definition.

Almost all deaths on the drug poisoning database had a coroner's inquest. For each death the database includes information about the causes of death and substances involved in addition to other information about the deceased. For each death the database of drug related poisonings includes:

- The ICD codes for underlying cause of death and other causes mentioned on the death certificate.
- Every mention of a substance recorded by the coroner in the cause of death section or elsewhere on the coroner's certificate after inquest (Form 99(REV)).
- An indicator to show if alcohol is mentioned. This includes a wide variety of scenarios ranging from evidence of alcohol consumption around the time of death (for example an empty vodka bottle found at the scene or alcohol found after toxicology tests) to long-term alcohol abuse and cirrhosis of the liver.
- Other information recorded at death registration such as age, sex, marital status, occupation and place of usual residence.

Definition of a drug-related death

The ICD-10 codes used to define these deaths related to drug poisoning are shown below;

ICD-10 code	Description
F11–F16, F18–F19	Mental and behavioural disorders due to drug use (excluding alcohol and tobacco)
X40–X44	Accidental poisoning by drugs, medicaments and biological substances
X60–X64	Intentional self-poisoning by drugs, medicaments and biological substances
Y10–Y14	Poisoning by drugs, medicaments and biological substances, undetermined intent
X85	Assault by drugs, medicaments and biological substances

In January 2011 ONS introduced a new version of ICD-10 (version 2010) which replaced version 2001.2. This means that not all figures for 2011 will be directly comparable to figures for 2001 - 2010. Analysis to assess the impact of the new coding has shown that the number of deaths coded as mental and behavioural disorders due to drug use (ICD-10 codes F11–F16 and F18-F19) decreased by 84% in v2010, compared to v2001.2. This decrease is due to these deaths being allocated to accidental poisonings by drugs (ICD-10 code X40-X44) which consequently increased by 44%. The new version of ICD-10 caused very little change in the number of deaths being coded as intentional self-poisoning by drugs, or poisoning by drugs, undetermined intent. Further information can be found on pages 4 - 5 of the *Deaths related to drug poisoning in England and Wales, 2011* Statistical Bulletin.

Definition of a death related to drug misuse

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 government'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 drug poisoning, drug abuse or drug dependence. This definition has been adopted across the UK. The baseline year for monitoring deaths related to drug misuse was set as 1999. The definition of the headline indicator using ICD-10 codes is shown below;

Cause of death categories included in the headline indicator of drug misuse deaths (the relevant ICD-10 codes are given in brackets):

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):

- opioids (F11)
- cannabinoids (F12)
- sedatives or hypnotics (F13)
- cocaine (F14)
- other stimulants, including caffeine (F15)
- hallucinogens (F16)
- 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:

- Accidental poisoning by drugs, medicaments and biological substances (X40–X44)
- Intentional self-poisoning by drugs, medicaments and biological substances (X60–X64)
- Poisoning by drugs, medicaments and biological substances, undetermined intent (Y10–Y14)
- Assault by drugs, medicaments and biological substances (X85)
- Mental and behavioural disorders due to use of volatile solvents (F18)

Information on this report can be found in Chapter 3.

Deaths related to drug poisoning in England and Wales, 2011. The Office of National Statistics. Available at: <http://www.ons.gov.uk/ons/rel/subnational-health3/deaths-related-to-drug-poisoning/2011/stb-deaths-related-to-drug-poisoning-2011.html>

This is a National Statistic

Drug Misuse Declared: Findings from the Crime Survey for England and Wales

The Crime Survey for England and Wales (CSEW), formerly the British Crime Survey⁹ is a large, nationally representative survey of adults living in private households in England and Wales. Since 1996, the CSEW has included a self-completion module of questions on illicit drug use and comparable results are available for 1996 onwards. Main findings regarding drug misuse from the CSEW can be found in the yearly 'Drug Misuse Declared' publications. Results from the 2011/12 survey were published in July 2012. The figures in this report are based on interviews conducted between April 2011 and March 2012.

From April 2000, the CSEW 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 CSEW has reported on a financial year basis, rather than a calendar year.

Development of the CSEW questionnaire takes place on an annual basis and aims to reflect emerging issues. Questions about use of mephedrone, simultaneous drug use, the source and location when obtaining drugs and attitudes to the acceptability of taking certain drugs and using alcohol were added to the 2010/11 CSEW questionnaire. In 2011/12 a question on the ease, or perceived ease, of obtaining illegal drugs was added.

As a household survey, the CSEW provides an effective measure of the more commonly used drugs for which the majority of users are contained within the household population. However, the CSEW does not cover some small groups, potentially important given that they may have relatively high rates of drug use: notably the homeless and those living in certain institutions such as prisons. Nor, in practice, will any household survey necessarily reach those problematic drug users whose lives are so busy or chaotic that they are hardly ever at home or are unable to take part in an interview. As a result, the CSEW is likely to underestimate the overall use of drugs such as opiates and crack cocaine and possibly also frequent cocaine powder users, where the majority of users are concentrated within small sub-sections of the population not covered or reached by the survey.

⁹ From 1 April 2012, the British Crime Survey was renamed the Crime Survey for England and Wales to better reflect its geographical coverage

However, this is likely to have only a marginal impact on overall estimates of drug use within the household population.

Further information on this and other possible limitations to the survey can be found in the [User Guide to Drug Misuse Declared: Findings from the Crime Survey for England and Wales \(PDF file - 255kb\)](#)

Table A1 shows the drugs included in the main CSEW and their classification under the Misuse of Drugs Act (as at July 2012).

Table A1: Drugs respondents were asked about in the CSEW and their classification under the Misuse of Drugs Act (as at July 2012)	
Class A	Powder cocaine Crack cocaine Ecstasy LSD Magic mushrooms Heroin Methadone Methamphetamine Amphetamines (if prepared for injection)
Class B	Amphetamine (in powdered form) Cannabis (Since January 2009; due to reclassification)
Class B/C	Tranquilisers
Class C	Anabolic steroids Ketamine (since April 2006)
Not classified	Amyl nitrite

Information from the CSEW reports can be found in Chapter 1

Drug Misuse Declared: Findings from the Crime Survey for England and Wales 2011/12. The Home Office. Available at: <http://www.homeoffice.gov.uk/publications/science-research-statistics/research-statistics/crime-research/drugs-misuse-dec-1112/drugs-misuse-dec-1112-pdf>

This is a National Statistic.

European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) – Annual report on the state of the drug problem in Europe in 2011

European comparisons of drug use are published by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), with the most recent data (collected over the period 2004 to 2009) available in: *EMCDDA 2011 Annual report on the state of the drugs problem in Europe*. This annual report is based on information provided to the EMCDDA by the EU Member States, though it should be noted that the data and estimates presented in this report are the best approximations available,

but must be interpreted with caution, as many parts of the world still lack sophisticated information systems related to drug supply.

The EMCDDA, in close collaboration with national experts, has developed a set of core items for use in adult surveys (the 'European Model Questionnaire' — EMQ). This protocol has now been implemented in most EU Member States. However, there are still differences in the methodology used and year of data collection, and this means that small differences, in particular between countries, should be interpreted with caution.

Information on this report can be found in Chapter 1.

EMCDDA 2011 Annual report on the state of the drugs problem in Europe. European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). Available at: <http://www.emcdda.europa.eu/publications/annual-report/2011>

This is not a National Statistic

European School Survey Project on Alcohol and Other Drugs (ESPAD) report: Substance use among students in 36 European countries

The European School Survey Project on Alcohol and Other Drugs (ESPAD) collects comparable data on substance use among 15–16-year-old European students in order to monitor trends within as well as between countries. So far, five data-collection waves have been conducted in the framework of the project. The first study was carried out in 26 countries in 1995, while data collection in 2011 was performed in 37 countries. However, results for 2011 are available only for 36 countries, since the Isle of Man collected data but unfortunately did not have the possibility to deliver any results.

To provide as comparable data as possible, the surveys are conducted with common questionnaires and according to a standardised methodology. Data are mainly collected during the spring, and the 2011 target population was students born in 1995, with a mean age of 15.8 years at the time of data collection. In the 2011 ESPAD data collection, more than 100,000 students took part in the following countries: Albania, Belgium (Flanders), Bosnia and Herzegovina (Republic of Srpska), Bulgaria, Croatia, Cyprus, the Czech Republic, Denmark, Estonia, the Faroe Islands, Finland, France, Germany (five Bundesländer), Greece, Hungary, Iceland, Ireland, the Isle of Man, Italy, Latvia, Liechtenstein, Lithuania, Malta, Moldova, Monaco, Montenegro, Norway, Poland, Portugal, Romania, the Russian Federation (Moscow), Serbia, Slovakia, Slovenia, Sweden, Ukraine and the United Kingdom.

Information on this report can be found in Chapter 2.

European School Survey Project on Alcohol and Other Drugs (ESPAD) report: Substance use among students in 36 European countries. The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) 2012. Available at: <http://www.espad.org/en/Reports--Documents/ESPAD-Reports/>

This is not a National Statistic

Hospital Episode Statistics

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 Health and Social Care Information Centre.

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^h

- 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)

^h We are currently seeking feedback from users on the ICD-10 codes used to describe admissions where the primary diagnosis was related to drug poisoning. For further information see [Appendix F](#)

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 20 (14 from 2002-03 to 2009-10 and 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 19 (13 from 2002-03 to 2009-10 and 6 prior to 2002-03) secondary diagnosis fields in Hospital Episode Statistics (HES) that show other diagnoses relevant to the episode of care.

Interpretation of changes in HES admissions over time should be done carefully and with an awareness of the inherent data issues. Fluctuations in the data can occur for a number of reasons other than an actual change in the number of admissions due to a particular condition. These include organisational changes, review of best practice within the medical community, adoption of new coding schemes and data quality problems that are year specific. We therefore advise that users of time series data carefully explore the relevant issues before they adopt the view that the data provides a reliable indication of an underlying change or come to a conclusion around causality.

HES data on hospital admissions can be found in Chapter 3. www.hesonline.nhs.uk

Statistics from the National Drug Treatment Monitoring System (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 2011 – 31 March 2012. The analysis for 2011/12 is based on data provided to the National Drug Treatment Monitoring System up to 31st March 2012.

For further details of the methodology see the technical notes; <http://www.nta.nhs.uk/uploads/statisticsfromndtms201112vol2technicalnotesfinal.pdf>

Information from the NDTMS report can be found in Chapter 3

Statistics from the National Drug Treatment Monitoring System (NDTMS). The National Treatment Agency for Substance Misuse. Available at: <http://www.nta.nhs.uk/statistics.aspx>

This is a National Statistic

National and Regional Estimates of the Prevalence of Opiate and/or Crack Cocaine

This report summarises the results of the second follow-up study to a three-year project to estimate the prevalence of opiate and/or crack use (also defined as 'problem drug use') nationally (England only), regionally, and locally. This second follow-up was carried out three years after the final sweep of the original project, so could therefore be considered as 'sweep 6'. An overview of the national and Government Office Region estimates are presented in this report, as are comparisons with the estimates produced by the first follow-up (2008-09) sweep of the study.

Direct enumeration of those engaged in a largely covert activity such as the use of Class A drugs is difficult and standard household survey techniques tend to underestimate the extent of such activity. Indirect techniques making use of various data sources offer a more reliable way of calculating prevalence estimates for the use of opiates and/or crack cocaine. The estimates presented in this report are derived using two indirect measurement techniques: the capture-recapture method (CRC); and the multiple indicator (MIM) method – these methods are described in detail in Hay et al., 2006 and Hay et al., 2007a. Methodological developments throughout the course of the previous three sweeps are discussed elsewhere (Hay et al., 2007b, Hay et al., 2008).

The individuals covered by this study were people aged 15 to 64 and resident in each Drug Action Team (DAT) area, and known to be using heroin, methadone, other opiate drugs, or crack cocaine.

Information from this report can be found in Chapter 1

Statistics from the National Drug Treatment Monitoring System (NDTMS). The National Treatment Agency for Substance Misuse. Available at:

<http://www.nta.nhs.uk/uploads/prevalencestats2009-10fullreport.pdf>

A summary of the report can be found here;

<http://www.nta.nhs.uk/uploads/prevalencesummary0910.pdf>

This is not a National Statistic

Scottish Crime and Justice Survey – Drug Use

The Scottish Crime and Justice Survey (SCJS) is an annual survey measuring adults' experience and perceptions of crime in Scotland. Information on experience of illicit drug use was collected through the self-completion section of the questionnaire, which was completed by 10,999 (85%) of the 13,010 respondents to the main SCJS questionnaire.

The SCJS was sampled from private residential addresses in Scotland using the Royal Mail Postcode Address File (PAF). One adult aged 16 years or over per household was then randomly selected for interview. As the survey only included private residential addresses, it is acknowledged that it can under-represent key groups who are likely to use illicit drugs.

Questions on illicit drug use were included in the self-completion section of the questionnaire, which was undertaken at the end of the main SCJS interview. Respondents were handed the interviewer's tablet computer and guided by the interviewer through a series of practice questions which explained how to use the computer. Where respondents were unable or unwilling to use the tablet computer themselves, interviewers administered the interview, showing the respondent the screen and helping them to input their answers.

Information from the SCJS can be found in Chapter 1

2010/11 Scottish Crime and Justice Survey: Drug Use. The Scottish Government. Available at: <http://www.scotland.gov.uk/Publications/2012/03/2775>

This is a National Statistic

Smoking, Drinking and Drug Use among Young People in England, in 2011

Smoking, Drinking and Drug use Survey among Young People in England in 2011 (SDD11) 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 2011 survey achieved a sample of 6,519 pupils aged between 11 and 15 in 219 schools.

Since 2000, the survey has been carried out annually by NatCen Social Research and since 2005 it has been funded by the Health and Social Care Information Centre, The Home Office and the Department for Education (previously The Department for children, schools and families).

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. Each survey now includes a core section of questions covering the following:

- Pupils' experience of smoking, drinking and drug use;
- Consumption of cigarettes and alcoholic drinks in the last week; and
- Awareness and availability of specific named drugs.

As well as these core measures, questionnaires since 2000 have included more detailed questions, with the focus alternating between smoking and drinking in one year and drug use the next. The focus in 2011 was drug use, and this report reflects that.

Following consultation with survey users, the design of the sample was changed in 2010. For surveys between 2000 and 2009, the sample of schools was stratified by school type and sex of intake, and selected across regions in proportion to the distribution of the population of 11 to 15 year olds. In 2010, the sample was stratified by Strategic Health Authority (SHA); within each SHA an equal number of schools was sampled. This design was also used in 2011, although stratified by nine Government Office Regions rather than by ten Strategic Health Authorities. This change was designed to enable the publication of more up-to-date regional analyses of the data than was possible with the original design.

Information from the SDD reports can be found in Chapter 2

Smoking, drinking and drug use among young people in England in 2011. The Health and Social Care Information Centre. Available at: <http://www.ic.nhs.uk/pubs/sdd11fullreport>

This report is a National Statistic.

Substance misuse among young people report

The National Treatment Agency for Substance Misuse also produces an annual report on the number young people (under 18) who are in contact with drug treatment agencies and general practitioners in England.

The results are produced by the Manchester University National Drug Evidence Centre (NDEC) from the data collected by the National Drug Monitoring System and form part of National Statistics. Further information on the methodology used to produce this report can be found on the Treatment Agency for Substance Misuse website.

Information from this report can be found in Chapter 2

Substance Misuse among Young People: The data for 2010-11. The National Treatment Agency for Substance Misuse. Available at: <http://www.nta.nhs.uk/uploads/yp2011commentaryfinal.pdf>

This is a National Statistic

Appendix B: Government strategies and plans

This appendix presents in chronological order (starting with the present) the relevant government plans related to drug misuse over the last ten years. The previous government's plans have been included as they were applicable when the data used in the report (particularly in Chapter 3) was collected and so provides some context. Those plans highlighted with an asterisk (*) are effective under the present coalition government.

*Healthy Lives, Healthy People: Our Strategy for Public Health in England

This White Paper sets out the coalition government's long-term vision for the future of public health in England. The consultation on this White Paper closed in March 2011. Further details can be found at: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_121941

*Public Health Outcomes Framework

Building on the success of the Public Service Agreements, over the past two years the present coalition government has been working with frontline professionals, the public and external experts to renew the performance management framework for the next decade. This is called the Public Health Outcomes Framework. The consultation on this framework ended in March 2011 and more details can be found via this link: http://www.dh.gov.uk/en/Consultations/Liveconsultations/DH_122962

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

The present coalition government's drug strategy, introduced in **December 2010**, sets out a fundamentally different approach to preventing drug use in our communities, and in supporting recovery from drug and alcohol dependence.

The current strategy has recovery at its heart in the following ways:

- putting more responsibility on individuals to seek help and overcome dependency
- placing 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
- aiming to reduce demand
- taking an uncompromising approach to crack down on those involved in the drug supply both at home and abroad
- putting power and accountability in the hands of local communities to tackle drugs and the harms they cause

The latest drug strategy can be found at: <http://www.homeoffice.gov.uk/drugs/drug-strategy-2010/>

*Annual review of the drug strategy 2010

The Government committed to reviewing the strategy annually and the first annual review of the drug strategy 2010 is available. It provides a progress update on implementation of the strategy and includes an action plan for tackling the threat from new psychoactive substances.

The first annual review of the drug strategy can be found at:

<http://www.homeoffice.gov.uk/publications/alcohol-drugs/drugs/annual-review-drug-strategy-2010/>

Drugs: protecting families and communities

In **February 2008**, the previous government introduced a second 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

More information on this drugs strategy can be found at:

<http://webarchive.nationalarchives.gov.uk/20100418065544/http://drugs.homeoffice.gov.uk/publication-search/drug-strategy/drug-strategy-2008>

*The Drugs Act 2005

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.

More information can be found at: www.opsi.gov.uk/acts/acts2005/20050017.htm

*FRANK

FRANK is a joint initiative of the Department of Health, Home Office and Department for Education that was launched in **May 2003**. FRANK provides impartial and confidential information and advice about drugs, via online services and a helpline.

More information can be found at the following link: www.talktofrank.com

Updated Drug Strategy 2002

The Updated Drug Strategy launched in **December 2002** (update to the 1998 strategy), 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 previous 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.

More information on this updated strategy can be found at:

<https://www.education.gov.uk/publications/standard/publicationdetail/page1/HO-Drug-Strategy>

NHS Plan

This was a Plan introduced in **2000** 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

More information about the NHS Plan can be found at:

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4002960

Public Service Agreements

Since their introduction in the **1998** Comprehensive Spending Review (CSR), Public Service Agreements (PSAs) played a vital role in galvanising public service delivery and driving major improvements in outcomes. The culmination of this work was the announcement in the Comprehensive Spending Review 2007 (CSR 2007) in October 2007 of 30 new PSAs. These set out the previous government's highest priority outcomes for the CSR 2007 period, 2008/09 to 2010/11. The two new Public Service Agreements (PSAs 14 and 25) related to drug misuse, envisaged a long-term and sustainable reduction in the harms associated with drugs and alcohol and to increase the number of children and young people on the path to success.

A small basket of national outcome-focussed performance indicators were used to measure progress towards each PSA. All other national indicators were expected to improve against baseline trends over the course of the spending period.

More information on Public Service Agreements can be found at:

http://webarchive.nationalarchives.gov.uk/+http://www.cabinetoffice.gov.uk/about_the_cabinet_office/publicserviceagreements.aspx

Tackling drugs to build a better Britain: The government's ten-year strategy for tackling drugs misuse

The previous government's first ten-year drug strategy in **1998** had four aims:

- To help young people resist drug misuse in order to achieve their full potential in society
- To protect our communities from drug-related anti-social and criminal behavior
- To enable people with drug problems to overcome them and live healthy and crime-free lives
- To stifle the availability of illegal drugs on our streets

A copy of this drugs strategy can be found at:

<http://www.archive.official-documents.co.uk/document/cm39/3945/3945.htm>

*The Misuse of Drugs Act 1971

The Misuse of Drugs Act **1971** is the main piece of legislation that still applies today 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.

More information on the Misuse of Drugs Act can be found at:

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

Appendix C: 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, drinking, smoking and obesity, physical activity and diet.

<http://www.ic.nhs.uk/statistics-and-data-collections/health-and-lifestyles/alcohol>

<http://www.ic.nhs.uk/statistics-and-data-collections/health-and-lifestyles/smoking>

<http://www.ic.nhs.uk/statistics-and-data-collections/health-and-lifestyles/obesity>

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 Health and Social Care Information Centre
1 Trevelyan Square
Boar Lane
Leeds
West Yorkshire
LS1 6AE

Tel: 0845 300 6016

Email: enquiries@ic.nhs.uk

The 2006 - 2011 reports, also published by the Health and Social Care Information Centre can be found at:

www.ic.nhs.uk/statistics-and-data-collections/health-and-lifestyles/drug-misuse

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:

<http://www.dh.gov.uk/en/Publicationsandstatistics/index.htm>

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

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.

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/DH_074485

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

Provides statistics and publications for Northern Ireland.

http://www.dhsspsni.gov.uk/index/stats_research.htm

Drug and Alcohol Action Teams

Drug and Alcohol Action Teams (DAATs) are the partnerships responsible for delivering the drug strategy at a local level. DAATs are partnerships combining representatives from local authorities (education, social services, and 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.

DAATs 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 DAATs. Allocations to DAATs are made on a formula basis that recognises key deprivation factors, ensuring the money goes to the areas most in need. DAATs 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

http://www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Dearcolleagueletters/DH_082220 or <http://www.nta.nhs.uk/200910-ptb.aspx>

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.

<http://www.nepho.org.uk/publications/445/OP6 - Drug Misuse in Pregnancy>

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/

Frank

The Talk to Frank website is an independent government funded site which offers confidential advice and information on drugs;

www.talktofrank.com

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.

www.homeoffice.gov.uk/science-research/research-statistics

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).

www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsStatistics/DH_4019442

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.

<http://www.sgul.ac.uk/about-st-georges/divisions/bms/icdp/our-work-programmes/substance-abuse-deaths%20/?searchterm=npsad>

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.

<http://www.scribd.com/doc/56702543/Nta-Drug-Treatment-Crime-Reduction-Ntors-Findings-2005-Rb8>

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/>

Northern Ireland

Information on drug misuse prevalence in Northern Ireland is available from the *Statistics from the Northern Ireland Drug Misuse database: 1 April 2011 – 31 March 2012*. This bulletin summarises information on people presenting to service with problem drug misuse.

Statistics from the Northern Ireland Drug Misuse database: 1 April 2011 – 31 March 2012. Department of Health, Social Services and Public Safety, 2012. Available at:

http://www.dhsspsni.gov.uk/dmd_bulletin_2011-12.pdf

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.

- Psychiatric Morbidity among Adults Living in Private Households, 2000. Office for National Statistics, 2001;
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsStatistics/DH_4019414
- Adults with a Psychotic Disorder Living in Private Households. Office for National Statistics, 2002.
www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsStatistics/PublicationsStatisticsArticle/fs/en?CONTENT_ID=4081143&chk=prJhUn
- Adult Psychiatric Morbidity in England 2007: Results of a Household Survey. The Health and Social Care Information Centre.
www.ic.nhs.uk/pubs/psychiatricmorbidity07

Scottish Government

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://www.homeoffice.gov.uk/publications/science-research-statistics/research-statistics/police-research/hosb1710/>

A summary of the health harms of drugs

"A summary of the health harms of drugs" has been commissioned by the National Treatment Agency on behalf of the DH, and collated by the centre for Public health at Liverpool John Moores University. The guide provides the most up to date scientific evidence on the health harms from licit and illicit substance misuse. Further information can be found here;

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_129624

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 were 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.

<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. The report is available from the ONS website;

<http://www.ons.gov.uk/ons/index.html>

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.

<http://www.nwph.net/ukfocalpoint/writedir/2009.pdf>

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

Welsh government

Provides statistics and publications for Wales.

<http://new.wales.gov.uk/topics/statistics/?lang=en>

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.justice.gov.uk/youth-justice/health/substance-misuse>

Appendix D: Drugs glossary

This section gives further details on the drugs mentioned in this report. This information has been taken from the Talk to Frank website, an independent government funded site which offers confidential advice and information on drugs. Further details on any of the drugs mentioned in this glossary or for drugs which have not been included are available at; www.talktofrank.com

Amphetamines (*Speed, Phet, Billy, Whizz, Sulph, Base, Paste, Dexies*)

'Speed' is the street name for a range of amphetamines such as amphetamine sulphate, dexedrine and dexamphetamine. Like cocaine, amphetamines are stimulants that people take to keep them awake and alert. The effect of amphetamine kicks in within half an hour of ingesting it by mouth. If you inject it you'll experience the effects quicker and these effects can last for up to six hours. The high is generally followed by a long slow comedown.

Cannabis (*Bhang, black, blow, blunts, Bob Hope, bud, bush, dope, draw, ganja, grass, hash, hashish, hemp, herb, marijuana, pot, puff, Northern Lights, resin, sensi, sinsemilla, skunk, smoke, soap, spliff, wacky backy, weed, zero. Some names are based on where it comes from. Afghan, homegrown, Moroccan etc.*)

Cannabis is the most widely used illegal drug in Britain. Made from parts of the cannabis plant, it's a naturally occurring drug. It is a mild sedative (often causing a chilled out feeling or actual sleepiness) and it's also a mild hallucinogen (meaning you may experience a state where you see objects and reality in a distorted way and may even hallucinate). The main active compound in cannabis is tetrahydrocannabinol (THC).

Crack and Cocaine (*powder cocaine – coke, Charlie, C, white, Percy, snow, toot. For crack – rocks, wash, stones, pebbles, freebase*)

Cocaine powder, freebase and crack are all forms of cocaine. They are stimulants with powerful, but short-lived, effects. Stimulants temporarily speed up the processes of your mind and body.

'Freebase' cocaine and 'crack' cocaine, can be smoked, and so can reach the brain very rapidly in high dosage. 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.

Ecstasy (*E, pills, brownies, mandy, Mitsubishi's, Rolex's, Dolphins, XTC*)

This is often called the original designer drug because of its synonymous relationship with rave culture in the early 90s. Clubbers took ecstasy to stay awake and dance for hours. The effects take about half an hour to kick in and tend to last between 3 to 6 hours, followed by a gradual comedown.

Gases, Glues and Aerosols (*Thinners, volatile substances*)

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.

Heroin (*Brown, skag, H, horse, gear, smack.*)

Heroin is a natural opiate made from morphine (opiates dull pain). Morphine is extracted from the opium poppy. Like many drugs made from opium, including synthetic opioids (e.g. methadone) heroin is a very strong painkiller. 'Street' heroin sold as 'brown' is sometimes used by clubbers as a chill out after a big night out. Brown is still heroin but some people mistakenly think it's not as addictive.

Ketamine (*Green, K, special K, super K, vitamin k*)

Ketamine is a short-acting but powerful general anaesthetic which depresses the nervous system and causes a temporary loss of body sensation. That's why it has been used for operating on humans and animals. It has powerful hallucinogenic qualities (with a distortion of objects and reality).

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. In many cases, 'legal highs' have been designed to mimic class A drugs, but are structurally different enough to avoid being classified as illegal substances under the Misuse of Drugs Act

LSD (*Acid, blotter, cheer, dots, drop, flash, hawk, L, lightening flash, liquid acid, Lucy, micro dot, paper mushrooms, rainbows, smilies, stars, tab, trips, tripper, window. Sometimes LSD is known by the pictures on them e.g strawberries*)

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.

Mephedrone (*Meph, MC, MCAT, m-cat, 4-MMC, Miaow, Meow Meow, Bubbles, Bounce, Charge, Drone, White Magic*)

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 amphetamine-like 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 over stimulating the heart and circulation, and it risks over stimulating the nervous system to cause fits. There is developing evidence on the risk of death from using mephedrone. When sold over the internet, it was often described as a plant food, research chemicals or bath salts, and not for human consumption.

Methadone (*Mixture, linctus, physeptone.*)

Methadone is one of a number of synthetic opiates (also called opioids) that are manufactured for medical use and have similar effects to heroin. Methadone and Subutex (Buprenorphine) are used as opiate substitutes for heroin in the treatment of heroin addiction.

Tranquillisers (*Jellies, benzos, eggs, norries, rugby balls, vallies, moggies, mazzies, roofies, bonsai, bonsai supersleep, downers*)

Tranquillisers are manufactured drugs produced to treat anxiety, depression and insomnia. Prescribed by a doctor, they're designed to reduce anxiety and promote calmness, relaxation and sleep. There are hundreds of different tranquilisers around but most common are the Benzodiazepines, which include: Rohypnol (also called flunitrazepam), Valium (also called diazepam), phenazepam and temazepam.

Appendix E: United Kingdom Statistics Authority Assessment of the Statistics on Drug Misuse: England publication

During 2010, the *Statistics on Drug Misuse: England* report, along with the three other publications (alcohol, smoking and obesity) that comprise the Lifestyles Compendium Publications published by the Health and Social Care Information Centre (HSCIC) underwent assessment by the United Kingdom Statistics Authority (UKSA). Following assessment, the publication was designated continued National Statistics status (see below):

The UKSA has designated these statistics as National Statistics, subject to meeting the requirements below, in accordance with the Statistics and Registration Service Act 2007 and signifying compliance with the Code of Practice for Official Statistics.

Designation can be broadly interpreted to mean that the statistics:

- meet identified user needs;
- are well explained and readily accessible;
- are produced according to sound methods; and
- are managed impartially and objectively in the public interest.

Once statistics have been designated as National Statistics it is a statutory requirement that the Code of Practice shall continue to be observed.

The designation of National Statistics status was subject to a number of requirements and the UKSA report also contained a number of suggestions for improvements. These, together with detail on how these addressed by the HSCIC are below:

Requirement 1 Take steps to develop a greater understanding of the use made of the statistics; publish the relevant information and assumptions, and use them to better support the use of the statistics (para 3.2)

A public consultation was launched by the HSCIC on 1 April 2011 and ran for 12 weeks until 24 June 2011. Responses have been collated and assessed.

www.ic.nhs.uk/work-with-us/consultations/lifestyles-statistics-compedia-publications-consultation

The consultation aimed to engage with users of the reports to develop further understanding of how the reports are used, by whom, and for what purposes in order to also ensure the reports maintain their relevance and usefulness.

We place a feedback form on each of our statistical release web pages inviting comments and suggestions for improvements to our Official Statistics. A summary of queries and comments received by the statistical production team are published alongside this report.

Requirement 2 Include an explanation of the distinction between National Statistics, other Official Statistics and statistics that are not official, and comment on the extent to which they are reliable (para 3.11).

Addressed in the 'Introduction' and Appendix A. A 'Data Quality' statement accompanies this report.

Requirement 3 Determine the most appropriate format for the compendia, in consultation with users (para 3.22).

This was determined by the public consultation launched by the Health and Social Care Information Centre and was implemented from August 2012 onwards.

Requirement 4 Include the name of the responsible statistician in the *Statistics on Drug Misuse: England* compendium (para 3.28).

Actioned in 'Statistics on Drug Misuse: England, 2010' published on 27 January 2011, and has also been included in all subsequent publications since.

Requirement 5 Complete their Statement of Administrative Sources so that it covers all the sources currently used (para 3.29).

This has been completed and is available at:

<http://www.ic.nhs.uk/statistics-and-data-collections/publications-calendar/administrative-sources>

Suggestion 1 Publish the information about users gained from the contact centre and via the website (para 3.3).

Aggregated information for this publication accompanies this report.

Suggestion 2 Seek user input into the data accuracy measures that would best meet user needs (para 3.10).

This was captured via the compendia consultation:

www.ic.nhs.uk/work-with-us/consultations/lifestyles-statistics-compendia-publications-consultation

Suggestion 3 Review the graphs and tables in the compendia in order to make presentation consistent (para 3.22).

The results are reflected in this publication wherever possible.

A copy of the full UKSA assessment report is available on the following link:

<http://www.statisticsauthority.gov.uk/assessment/assessment/assessment-reports/index.html>

Appendix F: User Consultation on the ICD-10 codes used to describe NHS hospital admissions for drug poisoning

Section 3.2 and Tables 3.1 to 3.9 of this publication describe admissions to NHS hospitals where the primary, or primary or secondary diagnosis was related to drug-related mental health and behavioural disorders, as well as admissions to NHS hospitals where the primary diagnosis was related to drug poisoning. This data is sourced from the *Hospital Episode Statistics (HES) databank* and classified using International Classification of Diseases (ICD) codes. The ICD-10 codes used to determine the diagnosis are based on drugs classified under the 1971 Misuse of Drugs Act. Further details of which drugs this list includes can be found in Table A1 in Appendix A

We have sought the latest coding advice from the NHS Classifications Serviceⁱ on the ICD-10 codes that should be used to calculate these admissions. No changes were recommended for admissions with a diagnosis of drug-related mental health and behavioural disorders (Tables 3.1 to 3.6). However, it was suggested that we may wish to add some additional codes to the list used to describe admissions with a diagnosis of drug poisoning (Tables 3.7 to 3.9). If the addition of these codes were deemed to be useful to users then the time series in Table 3.7 would be revised accordingly.

The ICD-10 codes currently used to describe admissions for primary diagnosis of poisoning by drugs are;

- **T40** Poisoning by narcotics and psychodysleptics (Hallucinogens)
 - **T40.0** Opium
 - **T40.1** Heroin
 - **T40.2** Other Opioids (Includes but is not limited to codeine and morphine)
 - **T40.3** Methadone
 - **T40.4** Other synthetic narcotics (Includes but is not limited to pethidine)
 - **T40.5** Cocaine
 - **T40.6** Other and unspecified narcotics
 - **T40.7** Cannabis
 - **T40.8** Lysergide
 - **T40.9** Other and unspecified psychodysleptics (includes but is not limited to mescaline, psilocin and psilocybine)
 - **T43.6** Poisoning by psychotropic drugs, not else classified, psychostimulants with abuse potential

It was suggested that we may also wish to include;

- **T41.2** Poisoning by anaesthetic and therapeutic gases, other than unspecified general anaesthetics (**includes but not limited to** gamma hydroxybutyrate GHB and ketamine)
- **T43.5** Poisoning by psychotropic drugs, not elsewhere classified, other than unspecified antipsychotic and neuroleptics (**includes but is not limited to** poisoning by tranquilizers)

ⁱ <http://www.connectingforhealth.nhs.uk/systemsandservices/data/clinicalcoding/>

- **T48.3** Poisoning by agents primarily acting on smooth and skeletal muscles and the respiratory system, antitussives (**includes but is not limited to** poisoning by tranquilizers)
- **T62.0** Ingested mushrooms (**includes but is not limited to** poisoning from 'magic mushrooms')

The codes above may include other types of drugs which are not classified under the 1971 Misuse of Drugs Act. It should also be noted that it is not possible in HES to determine whether drugs are taken illicitly or not.

How to Respond

Comments can be returned via email to Lifestyles@ic.nhs.uk or by post to:

Lifestyles Surveys
The Health and Social Care Information Centre
1 Trevelyan Square
Boar Lane
Leeds
LS1 6AE

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