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Statistics on Drug Misuse: England, 2008

Summary

This annual statistical report presents information on drug misuse among both adults and children. It includes a focus on young adults. 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
- Health outcomes related to drug misuse including hospital admissions, drug treatment and deaths related to drug misuse

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

The bulletin draws together data from a variety of different sources and presents it in a user-friendly format. Most of the data contained in the bulletin have been published previously, by The NHS Information Centre, Department of Health, the Home Office, Office for National Statistics, the Health Protection Agency or the National Treatment Agency for Substance Misuse. Previously unpublished figures on drug-related admissions to hospital are presented.

Figures presented for adult drug use were obtained from “*Drug Misuse Declared: Findings from the 2006/07 British Crime Survey*”, *The Home Office, 2007*. A limited number of the figures presented are available for 2007/08 in “*The British Crime Survey 2007/08*”, *The Home Office, 2008*. As detailed drug misuse data are not available in the 2007/08 report it was decided to use the 2006/07 report to ensure consistency. The key new figures made available in the British Crime Survey for 2007/08 and included in the report are: 9.3% of adults aged 16-59 reported using any illicit drug in the last year and 3.0% reported using a Class A drug in the last year. For adults aged 16-24, 21.3% had used any illicit drug in the last year and 6.8% had used Class A drugs. All four of these figures are significantly lower than in 2006/07. In 2007/08 7.3% of adults aged 16-24 reported frequent drug use.

Main findings:

Overall drug use has fallen in recent years for both adults and children. Hospital admissions with a primary diagnosis of a drug related mental health and behavioural disorder have decreased, while admissions with a primary diagnosis of poisoning by drugs have increased. The number in contact with structured drug treatment services have also increased while the number of drug related deaths shows no overall trend.

More men than women had used drugs in the last year, been in contact with structured drug treatment services and died as a result of drug misuse.

Drug misuse among adults

- In 2006/07 10.0% of adults aged 16 to 59 living in England and Wales had used one or more illicit drug in the last year, a decrease from 12.1% in survey year 1998.
- 5.9% had used an illicit drug in the last month, a fall from 7.1% in survey year 1998.

- Class A drug use in the year prior to interview increased from 2.7% in survey year 1998 to 3.4% in 2006/07. This is mainly due to a comparatively large increase in cocaine powder use between survey years 1998 and 2000. Between survey year 2000 and 2006/07 the use of Class A drugs overall remained stable.
- Men are more likely to take illicit drugs than women, in 2006/07 13.2% of men reported taking drugs in the last year compared with 6.9% of women.
- For younger adults aged 16 to 24, drug use in the last year fell between survey year 1998 and 2006/07, from 31.8% to 24.1%, whilst the use of Class A drug use remained stable between survey year 1998 and 2006/07.
- In 2006/07 8.3% of young adults reported frequent use of illicit drugs (taking any illicit drug more than once a month in the previous year), a fall from 11.6% in 2002/03.
- The most commonly used drug in 2006/07 among both all adults and young adults was cannabis. Cocaine was the next most commonly used.

Drug misuse among children

- In 2007, 10% of pupils in England aged 11 to 15 reported taking drugs in the last month, a fall from 12% in 2001.
- Seventeen per cent of pupils reported taking drugs in the last year, a fall from 20% in 2001 and 25% reported ever having taken drugs, a fall from 29% in 2001.
- Five per cent of pupils said that they usually take drugs at least once a month.
- Drug use increases with age; among 11 year olds 3% reported taking drugs in the last month compared with 17% of 15 year olds.
- Four per cent of pupils reported using any Class A drug in the last year, a figure that has remained stable since 2001.
- Pupils were most likely to have taken cannabis; 9% had done so in the last year, an overall decrease from 13% in 2001.
- In 2007, 36% of pupils reported ever having been offered drugs. This figure is lower than in 2001 when it was 42%.
- As in previous years, there was widespread awareness of illegal drugs among pupils. Only 2% of pupils reported that they had never heard of any of the drugs listed.
- Ten per cent of pupils thought it is OK to try taking cannabis to see what it's like.

Health outcomes

- In England in 2006/07 there were 6,743 admissions to hospital with a primary diagnosis of a drug related mental health and behavioural disorder. This number is less than in 1996/97 when there were 7,584 admissions. Where primary or secondary diagnosis was recorded there were 38,170 admissions compared with 19,018 in 1996/97.
- Where a primary diagnosis of poisoning by drugs was recorded, 10,047 admissions were reported during 2006/07, an increase from 1996/97 when the number of such admissions was 7,057.

- The SHAs with the most admissions for drug poisoning per 100,000 of population were North East SHA (38 admissions per 100,000) and North West SHA (32 admissions per 100,000).
- During 2006/07 the National Drug Treatment Monitoring System (NDTMS) reported there were 195,464 people in contact with structured drug treatment services. Over double the number reported to be in contact with services in 1998/99 (85,000).
- In 2006/07, a larger number of men accessed treatment services than women (140,077 men compared to 55,387 women).
- Overall, heroin was the main drug for which people received treatment (61% of all treatments), whilst for clients aged under 18, it was cannabis (75%).
- The total number of deaths in 2006/07 related to drug misuse in England and Wales was 1,573 in 2006. There is no overall trend for recent years.
- 79% of those who died due to drug misuse were male.



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1 Introduction

This statistical report presents a range of information on drug misuse among both adults and children, which has been drawn together from a variety of sources. The data relate to England where possible. Where data for England are not available, data for Great Britain, the United Kingdom or England and Wales have been provided.

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

Chapter 2 reports on the prevalence of drug misuse among adults, associated trends over time, and highlights the types of drugs most commonly used. Relationships between drug use and socio-demographic and lifestyles factors are also explored. This chapter also highlights drug use among young adults.

Chapter 3 focuses on the prevalence of drug misuse among children and again, explores the relationships between drug use and various socio-demographic factors. As well as presenting overall prevalence figures, this chapter also informs about behaviour, knowledge and attitudes towards drug taking among children.

Chapter 4 focuses on various health outcomes related with drug misuse. Information is included on drug treatment, drug related hospital admissions and deaths and the financial costs associated with drug misuse.

A summary highlighting key findings is presented at the end of each chapter.

Throughout the report, references to sources for further information are given. The report also contains six appendices. Appendix A explains the key sources used while appendix B describes Government targets and plans. Appendix C outlines how to interpret the logistic regression used in chapter 3. Appendix D provides editorial notes and conventions in relation to tables and Appendix E gives sources of further information and useful contacts. Appendix F provides a drugs glossary of the various illicit drugs mentioned in this report.

References

1. The Misuse of Drugs Act 1971 (modification) Order 2001. Available at: www.opsi.gov.uk/si/si2001/20013932.html



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2 Drug misuse among adults

2.1 Introduction

This chapter presents data on the prevalence of drug misuse among adults. The main source used in this chapter is the British Crime Survey publication: Drug Misuse Declared: Findings from the 2006/07 British Crime survey¹. Since 1996 the BCS has included this comparable self completion module of questions on illicit drug use. This statistical report examines the prevalence and trends of illicit drug use among 16 to 59 year olds since 1998, which marked the beginning of the Government's Drug Strategy². This report also has a particular focus on young people aged 16 to 24.

As well as the Drug Misuse Declared publication, a limited number of the figures presented are available for 2007/08 in "*The British Crime Survey 2007/08*", *The Home Office, 2008*. As detailed drug misuse data are not available in the 2007/08 report it was decided to use the 2006/07 report to ensure consistency. The key new figures made available in the British Crime Survey for 2007/08: 9.3% of adults aged 16-59 reported using any illicit drug in the last year and 3.0% reported using a Class A drug in the last year. For adults aged 16-24, 21.3% had used any illicit drug in the last year and 6.8% had used Class A drugs. All four of these figures are significantly lower than in 2006/07. In 2007/08 7.3% of adults aged 16-24 reported frequent drug use.

Some figures appearing in the 2006/07 report have had minor amendments for 2007/08; these changes will be footnoted in the commentary and relevant tables. To allow us to discuss breakdowns consistently the figures appearing in the 2006/07 report have been used here. The years the 2006/07 Home Office report referred to as 1996, 1998 and 2000 are

referred to in the 2007/08 report as 1995, 1997 and 1999. The 2007/08 report uses the year in which the drugs were taken, as opposed to the survey year. The year labelling system from the 2006/07 Home Office report is used here.

The government recently published a new Public Service Agreement (PSA), PSA Delivery Agreement 25: Reduce the harm caused by alcohol and drugs, October 2007⁴. This aims to reduce the harm caused by drugs and alcohol, to the community, to the health and well-being of those who use drugs and to the health and well-being of young people and families. Several indicators have been developed to monitor progress including; increasing the number of drug users in effective treatment; reducing the rate of drug-related offending; and perceptions of drug use being a problem to society.

A related agreement, PSA Delivery Agreement 14: Increase the number of children and young people on the path to success, October 2007⁵, contains an indicator to reduce the proportion of young people frequently using illicit drugs, alcohol or volatile substances.

Previous government strategies in this area, including the 2002 Updated Drug Strategy⁶, have also focused on reducing the harm caused by illegal drug use and in particular had the aim to '*reduce the use of Class A drugs and the frequent use of any illicit drug by all young people under the age of 25, especially by the most vulnerable groups*'. Class A drug use among young people in the 16 to 24 age group is presented in this chapter using information from the BCS while [Chapter 3](#) uses the Smoking, Drinking and Drug use Survey to present findings for those aged 11 to 15.

The BCS asks respondents about various drugs as defined by The Misuse of Drugs Act⁷. The Misuse of Drugs Act classifies illegal drugs into three categories (Class A, B and C) according to the harm that they cause. Class A drugs are considered to be the most harmful. [Appendix A](#) describes the drugs respondents were asked about as part of the BCS and their classifications under the Misuse of Drugs Act.

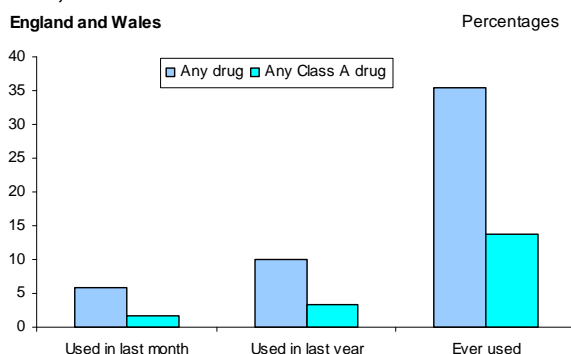
2.2 Drug misuse among adults

This section looks at the reported use of illicit drugs among adults aged 16 to 59 and identifies key trends since 1998. It identifies the extent of drug use in 2006/07, and which drugs are most commonly used. Comparisons are also made across regions and between England and Wales, and Scotland.

2.2.1 Prevalence of drug misuse

In 2006/07, the BCS reported that 10.0% of adults aged 16 to 59 had used one or more illicit drugs in the year prior to interview (estimated 3.2 million users), 5.9% had used an illicit drug in the month prior to interview (estimated 1.9 million users) and 35.5% reported using an illicit drug at least once in their lifetime (estimated 11.3 million users) ([Tables 2.1, 2.2, 2.3, 2.4, Figure 2.1](#)).

Figure 2.1 Prevalence of drug use among adults aged 16 to 59, 2006/07

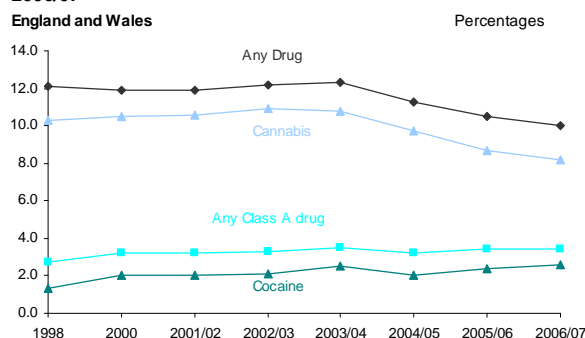


Source: Drug Misuse Declared: Findings from the 2006/07 British Crime Survey. Home Office. Copyright © 2008, re-used with the permission of the Home Office

In 2006/07, one in ten adults reported using illicit drugs at least once in the last year

Between 1998 and 2006/07, the use of any illicit drug among adults in the year prior to interview declined overall from 12.1% to 10.0%. Illicit drug use in the month prior to interview also fell in this period from 7.1% to 5.9%. The percentage who reported illicit drug use in their lifetime increased from 33.6% in 1998 to 35.5% in 2006/07 ([Figure 2.2](#)).

Figure 2.2 Use of the most prevalent drug types in the year prior to interview, among adults aged 16 to 59, 1998 to 2006/07



Source: Drug Misuse Declared: Findings from the 2006/07 British Crime Survey. Home Office. Copyright © 2008, re-used with the permission of the Home Office

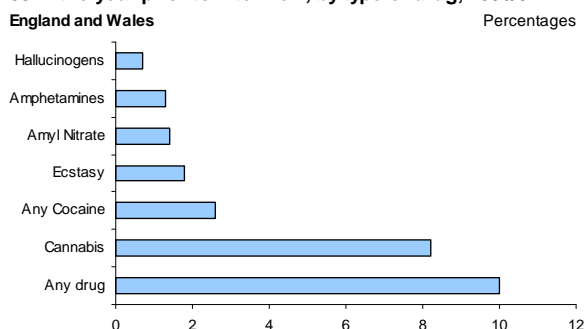
The decline in any illicit drug use reflects the decrease of cannabis use, which fell from 10.3% in 1998 to 8.2% in 2006/07 for those who reported using it in the year prior to interview, and from 6.1% to 4.8% over the same period for those who reported using it in the month prior to interview.

By contrast, Class A drug use in the year prior to interview increased from 2.7% in 1998 to 3.4% in 2006/07. This is mainly due to a comparatively large increase in cocaine powder use between 1998 and 2000. Between 2000 and 2006/07 the use of Class A drugs overall remained stable.

The use of LSD and amphetamines in the year prior to interview both decreased between 1998 and 2006/07. Ecstasy, crack cocaine and opiates use has remained stable.

As with previous years, the most commonly used drug in 2006/07 was cannabis, with 8.2% of adults reporting using the drug in the year prior to interview, and 4.8% in the month prior to interview. The next most commonly used drug was cocaine, with 2.6% of adults reporting having used cocaine (either cocaine powder or crack cocaine) in the year prior to interview. Ecstasy (1.8%), amphetamine (1.3%), amyl nitrite (1.4%) and hallucinogens (LSD and magic mushrooms) (0.7%), were the next most commonly reported drugs used.

Figure 2.3 Prevalence of drug use among adults aged 16 to 59 in the year prior to interview, by type of drug, 2006/07



Source: Drug Misuse Declared: Findings from the 2006/07 British Crime Survey. Home Office. Copyright © 2008, re-used with the permission of the Home Office

In 2006/07, it was estimated that 2.6 million adults had used cannabis, 835 thousand reported using cocaine and 567 thousand reported using ecstasy in the year prior to interview (Tables 2.1, 2.2, 2.3, 2.4, Figure 2.3).

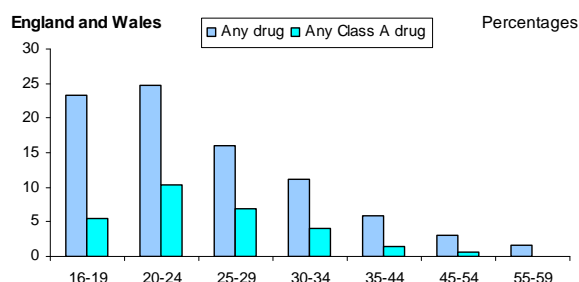
2.2.2 Age and gender

In 2006/07, the proportion of adults who had taken any illicit drug in the last year generally decreased with increasing age. Adults in the 16 to 19 and 20 to 24 age groups reported the highest levels of drug use both in the year prior to interview (23.3% and 24.8% respectively) and in the

last month (14.0% and 14.5% respectively)¹. The proportion reporting drug use in the last year was lowest (1.7%) among the oldest age group (those aged 55 to 59). Those aged 20 to 24 and 25 to 29 reported the highest levels of ever use of any drug in 2006/07 (50.7% and 50.8% respectively)¹.

Those aged 20 to 24 reported the highest levels of last year and last month use of Class A drugs in 2006/07 (10.4% and 5.5% respectively). Whereas those in the 20 to 24, 25 to 29 and 30 to 34 age groups reported the highest levels of ever using Class A drugs (22.3%, 23.6% and 22.1% respectively)¹ (Table 2.5, Figure 2.4).

Figure 2.4 Prevalence of drug use among adults aged 16 to 59 in the year prior to interview, by age group, 2006/07



Source: Drug Misuse Declared: Findings from the 2006/07 British Crime Survey. Home Office. Copyright © 2008, re-used with the permission of the Home Office

Men reported higher levels of drug use than women. For example, in 2006/07, 13.2% of men aged 16 to 59 reported using drugs in the year prior to interview compared with 6.9% of women. A similar pattern could be seen with Class A drug use, with 4.8% of men reporting using a Class A drug in the year prior to interview compared with 2.0% of women (Table 2.6).

2.2.3 Other demographic characteristics

Respondents to the BCS were asked to indicate their overall household income in the last year (from all sources before tax and other deductions) from a selection of 13 categories. These 13 categories have

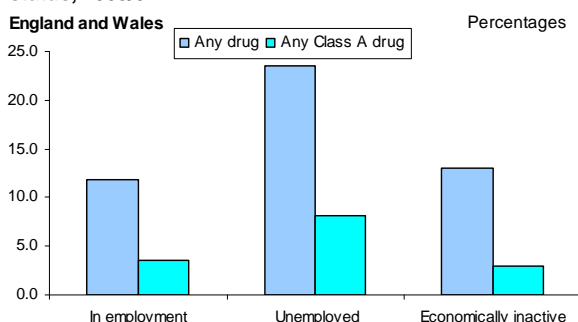
been combined into 5 different categories for the purposes of analysis.

In 2003/04, those with the lowest household income had the highest prevalence of any illicit drug use. Prevalence declines gradually as income increases, with households earning between £20,000 and £30,000 reporting the lowest prevalence of drug use. However, prevalence increases again among those earning £30,000 or more. The same pattern can also be seen for Class A drug use (Table 2.7).

When looking at employment status, those who were unemployed had much higher levels of any illicit drug use than employed and economically inactive people. For example, 23.5% of unemployed people reported having used any illicit drug in the past year, around double that for those in employment and those who were economically inactive.

Again a similar pattern can be seen for Class A drug use. Among those who were unemployed, 8.1% reported using any Class A drug, compared to 3.5% of those in employment and 3.0% of those who were economically inactive (Table 2.8, Figure 2.5).

Figure 2.5 Percentage of adults aged 16 to 59 reporting drug use in the last year, by respondent's employment status, 2003/04



Source: Drug Misuse Declared: Findings from the 2003/04 British Crime Survey. Home Office. Copyright © 2008, re-used with the permission of the Home Office

Other patterns can be seen when looking at illicit drug use and other socio-demographic indicators such as household structure, marital status, social class and education, which are explored in the Drug Misuse Declared 2003/04 report⁸. In addition, the 2005/06 report included a focus on demographic factors and cocaine use¹⁵.

The BCS also provides some information on drug use among different ethnic groups. Results from the 2001/02 BCS⁹ indicate that drug use among different ethnic groups varies. For example, those adults from a mixed background were more likely to have taken any illicit drug in the last year than other ethnic groups.

Several surveys on mental health and drug misuse among different groups of the population have been carried out. These groups have included adults living in private households¹⁰, institutions¹¹, homeless people¹² and people with psychotic disorders¹³.

2.2.4 Prevalence by region

The BCS enables levels of drug use in the last year to be compared for the different Government Office Regions (GORs) and Wales. However, none of the apparent differences between GORs or Wales and the average for England and Wales were statistically significant (Table 2.9).

2.2.5 National comparison of drug misuse

The Drugs Misuse in Scotland: Findings From the 2006 Scottish Crime and Victimization Survey¹⁴ reports on drug use in Scotland during the year 2006. We can use these results to compare with the BCS 2006/07.

Table 2.10 shows the percentage of adults aged 16 to 59 reporting drug use in the last year in Scotland and in England and Wales. The prevalence of illicit drug use in

the last year in England and Wales was 10.0%, compared to 12.6% in Scotland. Similarly, 3.4% of those in England and Wales reported using at least one Class A drug in the year prior to interview, compared to 5.2% in Scotland.

When we look at use in the last month, reported rates are lower in England & Wales (5.9%) than in Scotland (8.0%). This continues to be true for Class A drugs (1.7% and 3.0% respectively).

Drug misuse prevalence in Northern Ireland is also available from the Statistics from the Northern Ireland Drug Misuse database: 1 April 2006 – 31 March 2007 publication¹⁵. A European comparison of drug use can be found in the EMCDDA Statistical Bulletin 2007: European Monitoring Centre for Drugs and Drug Addiction¹⁶.

2.3 Drug misuse among young adults (aged 16 to 24)

This section explores drug misuse among young adults, using information from the 2006/07 BCS¹ and includes information on frequent drug use. Also included in this part of the chapter, is information on those young adults in vulnerable groups, which includes some findings from the 2003 Crime and Justice Survey¹⁷.

2.3.1 Prevalence of drug misuse

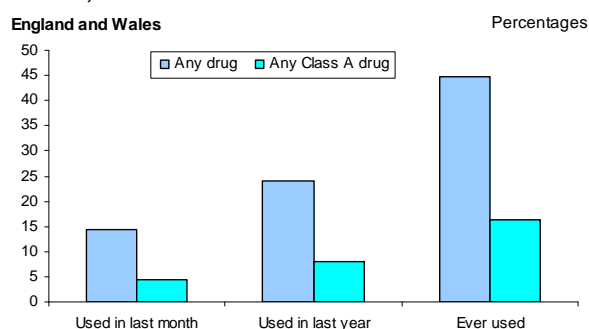
Results show that in 2006/07, 24.1% of 16 to 24 year olds reported using one or more illicit drugs in the year prior to interview (estimated 1.6 million users), 14.3% had used an illicit drug in the month prior to interview (estimated 954 thousand users) and 44.7% had ever used an illicit drug (estimated 2.9 million users). In addition to this, 8.1%[†] had used at least one Class A drug in the year prior to interview, 4.3% in

[†] The 2007/08 British Crime Survey³ reports that in 2006/07 8.0% of young adults reported using Class A drugs in the last year.

the month prior to interview and 16.3% reported that they had used a Class A drug at least once in their lifetime (Tables 2.11, 2.12, 2.13, 2.14, Figure 2.6).

24.1% of young adults reported using drugs at least once in the last year

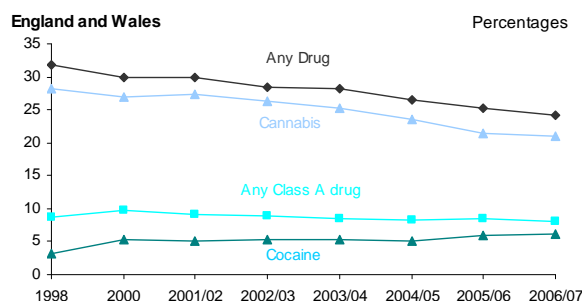
Figure 2.6 Prevalence of drug use among young adults age 16 to 24, 2006/07



Source: Drug Misuse Declared: Findings from the 2006/07 British Crime Survey. Home Office. Copyright © 2008, re-used with the permission of the Home Office

Between 1998 and 2006/07, the use of any illicit drug in the year prior to interview by young adults decreased steadily from 31.8% to 24.1%. The fall since 1998 is mainly due to the decrease in the use of cannabis from 28.2% to 20.9% in 2006/07 (Figure 2.7).

Figure 2.7 Use of the most prevalent drug type in the year prior to interview among young adults aged 16 to 24, 1998 to 2006/07



Source: Drug Misuse Declared: Findings from the 2006/07 British Crime Survey. Home Office. Copyright © 2008, re-used with the permission of the Home Office

There was no statistically significant difference between the levels of Class A

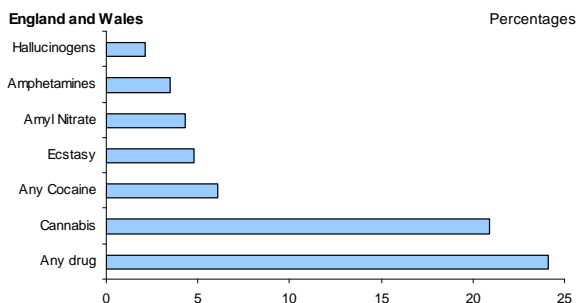
drug use in the last year in 1998 and in 2006/07. Although cocaine use (powder or crack cocaine) increased from 3.2% to 6.1% over this period, this was mainly due to the significant increase between 1998 and 2000. Since 2000 cocaine use has remained stable.

The use of hallucinogens among young adults in the year prior to interview, is lower in 2006/07 (2.1%) than it was in 1998 (5.3%) and the use of amphetamines also decreased from 9.9% to 3.5%.

As with adults aged 16 to 59, the most commonly used drug among 16 to 24 year olds in 2006/07 was cannabis. In the year prior to interview, 20.9% of 16 to 24 year olds reported using cannabis. Cocaine was the next most commonly used drug with 6.1% reporting to have used any form of it in the year prior to interview. Other more commonly used drugs were ecstasy (4.8%), amyl nitrate (4.3%[‡]), amphetamines (3.5%) and hallucinogens (LSD and magic mushrooms) (2.1%).

In 2006/07, it was estimated that 1.4 million young adults (aged 16 to 24) reported using cannabis, 375 thousand reported using cocaine and 272 thousand reported using ecstasy in the year prior to interview (Tables 2.11, 2.12, 2.13, 2.14, Figure 2.8).

Figure 2.8 Prevalence of drug use among young adults aged 16 to 24 in the year prior to interview, by type of drug, 2006/07



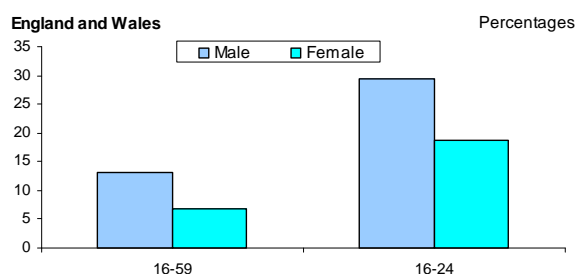
Source: Drug Misuse Declared: Findings from the 2006/07 British Crime Survey. Home Office. Copyright © 2008, re-used with the permission of the Home Office

[‡] The 2007/08 British Crime Survey³ reports that in 2006/07 4.2% of young adults reported using Amyl Nitrite in the last year.

2.3.2 Drug use by gender

Similar to findings for all adults, men aged 16 to 24 reported higher levels of drug use than women of the same age. In 2006/07, 29.5% of men aged 16 to 24 reported using an illicit drug in the year prior to interview compared with 18.8% of women. A similar pattern can be seen for Class A drug use (Table 2.15, Figure 2.9).

Figure 2.9 Prevalence of drug use among among adults aged 16 to 59 and 16 to 24 in the year prior to interview, by gender, 2006/07



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2.3.3 Frequency of drug use

Questions on the frequency of drug use in the year prior to interview were first asked of 16 to 24 year olds in the 2002/03 BCS. Respondents were asked how often in the last 12 months they had taken any type of illicit drug. Frequent use is defined as taking any illicit drug more than once a month during the previous year.

Frequent drug use among 16 to 24 year olds has decreased since 2002/03 from 11.6% to 8.3% in 2006/07 (Figure 2.10).

Figure 2.10 Frequent drug use in the last year among 16 to 24 year olds, 2002/03 to 2006/07

England and Wales	Percentages				
	2002/03	2003/04	2004/05	2005/06	2006/07
	11.6	12.4	10.3	9.5	8.3
<i>base (unweighted)</i>	3,311	5,234	6,070	5,768	5,577

Source:

Drug Misuse Declared: Findings from the 2006/07 British Crime Survey. Home Office

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Cannabis was the drug most likely to be used frequently by drug users. The 2006/07 BCS showed that 37.0% of cannabis users took the drug more than once a month during the year prior to interview. Cocaine was used frequently by around a quarter (25.7%) of users, ecstasy by 15.5% of users, amyl nitrate by 12.5% of users and amphetamines by 12.0% of users in the year prior to interview (Table 2.16).

In 2006/07, 8.3% of young adults reported frequently using illicit drugs

the use of any illicit drugs amongst reported excludees was greater than amongst those who reported that they had never been excluded (39.1% and 22.9% respectively).

The Home Office report Drug use among vulnerable groups of young people: findings from the 2003 Crime and Justice Survey¹⁶ reports on drug use among vulnerable groups of young people aged 10 to 24. The survey identifies vulnerable groups as those looked after by local authorities or in foster care, those who have ever been homeless, truants, those excluded from school, those involved in prostitution, young offenders and children from families with substance abusing parents. In 2003, those in vulnerable groups represented 28% of the young people sampled. However, they accounted for 61% of Class A drug users in the year prior to interview.

Vulnerable groups accounted for 61% of Class A drug users in the year prior to interview in 2003

2.3.4 Vulnerable groups

The 2005/06 BCS¹⁸ identifies respondents who have ever truanted or been excluded from school as vulnerable. In 2005/06, 36.4% of 16 to 24 year olds reported that they had ever truanted (skipped school without permission for a whole day). Use of illicit drugs among this group was higher than those who reported they had never truanted. Table 2.17 shows that the proportion using any illicit drug in the year prior to interview was more than twice as high among truants (39.8%) compared with non-truants (17.6%).

Furthermore, the 2005/06 BCS also reported that 16.2% of young people had ever been excluded (expelled or suspended) from school¹⁸. As with truants,

Similar results to those seen in the BCS are found. Table 2.18 shows young people who were in any vulnerable group had significantly higher drug use in the last year than those not in a vulnerable group (40.7% compared to 15.6%). Even those in only one vulnerable group had significantly higher levels of drug use than young people not in a vulnerable group. Frequent drug use in the last year for those in any vulnerable group was 23.8%, compared with 4.6% for those not in a vulnerable group.

2.4 Estimating problem drug users

While the surveys described in this chapter are an important source of information on the prevalence of drug use, it is difficult to get a complete picture of problem drug use from any one source. The 2006 Home Office report 'Measuring different aspects of problem drug use: methodological developments'¹⁹ describes how problem drug use can be estimated. This study provides a robust national estimate precise enough to allow monitoring over time. Four sources of data are used from which problem drug users (defined as those who use opiates and/or crack cocaine) can be identified. These sources of data are drug treatment, probation, police and prison data. Using these techniques it was estimated that there were 327,466 problem drug users in England, in 2004/05.

Summary: Drug misuse among adults

All Adults (aged 16 to 59)

In 2006/07, one in ten adults reported taking at least one illicit drug in the year prior to interview, with over a third reporting ever taking an illicit drug.

Overall since 1998, drug use has decreased, mainly due to the decrease in the use of cannabis. Over the same period Class A drug use has increased, overall, but has been stable since 2000.

The most commonly used drug in 2006/07 was cannabis, following trends from previous years. Cocaine was the next most reported illicit drug taken.

Among the different age groups, findings show that younger adults were more likely to take drugs than older ones, with men more likely to report using illicit drugs than women.

Young Adults (aged 16 to 24)

In 2006/07, around a quarter of young adults reported taking at least one illicit drug in the year prior to interview.

Since 1998, illicit drug use has decreased steadily over time, again mainly due to the decrease in cannabis use. Class A drug use has remained stable since 1998, showing no clear pattern, although cocaine use has increased, but as is the case with adults this increase occurred between 1998 and 2000. As with all adults, cannabis and cocaine were the most commonly used drug.

Young adults who had ever truanted or been excluded were more likely to report drug use than those who hadn't, while those in vulnerable groups were also more likely to use illicit drugs.

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Table 2.1 Percentage of adults aged 16 to 59 reporting drug use in the last year, by type and class of drug, 1996 to 2006/07

England and Wales	Percentages								
	1996 ¹	1998 ¹	2000 ¹	2001/02 ²	2002/03	2003/04	2004/05	2005/06	2006/07
Class A									
Any Cocaine	0.6	1.3	2.0	2.0	2.1	2.5	2.0	2.4	2.6
Cocaine powder	0.6	1.2	2.0	2.0	2.1	2.4	2.0	2.4	2.6
Crack cocaine	0.1	0.1	0.3	0.2	0.2	0.2	0.1	0.2	0.2
Ecstasy	1.7	1.5	1.8	2.2	2.0	2.0	1.8	1.6	1.8
Hallucinogens									
LSD	1.0	0.8	0.7	0.3	0.3	0.2	0.2	0.3	0.2
Magic Mushrooms	0.7	0.9	0.7	0.5	0.6	0.8	1.1	1.0	0.6
Opiates									
Heroin	0.2	0.1	0.3	0.1	0.1	0.1	0.1	0.1	0.1
Methadone	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1
Class A/B³									
Amphetamines	3.2	3.0	2.1	1.6	1.6	1.5	1.4	1.3	1.3
Class B/C⁴									
Tranquillisers	0.4	0.7	0.7	0.5	0.6	0.6	0.5	0.4	0.4
Class C									
Anabolic Steroids	0.3	0.3	0.2	0.1	0.1	0.1	0.1	0.1	0.1
Cannabis	9.5	10.3	10.5	10.6	10.9	10.8	9.7	8.7	8.2
Ketamine	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0.3
Not classified⁵									
Amyl Nitrate	1.3	1.5	1.3	1.2	1.3	1.3	1.2	1.2	1.4
Glues	0.2	0.2	0.2	0.1	0.1	0.1	0.1	0.1	0.2
Any Class A drug	2.7	2.7	3.2	3.2	3.3	3.5	3.2	3.4	3.4
Any drug	11.1	12.1	11.9	11.9	12.2	12.3	11.3	10.5	10.0
<i>Base⁶</i>	10,741	9,884	12,771	19,973	23,357	24,197	28,206	29,631	28,975

1. The 2007/08 British Crime Survey report refers to 1996, 1998 and 2000 as 1995, 1997 and 1999. Here the labelling convention from the 2006/07 'Drug Misuse Declared' report has been used

2. From 2001, the reporting year for the British Crime Survey data switched from calendar to financial years

3. Amphetamines can be classified as either Class A (prepared for injection) or Class B (powdered). For the purposes of calculating Class A drug use, the British Crime Survey assumes all reported amphetamine use to be of the Class B variety

4. Tranquillisers can either be classified as Class B (e.g. barbiturates) or Class C (e.g. benzodiazepines). Consequently, Class B and Class C drugs cannot be aggregated reliably because the survey does not identify which specific tranquilliser respondents used

5. The category 'not classified' indicates that it is an offence to supply these substances if it is likely that the product is intended for abuse

6 Some bases reported in the 2007/08 British Crime Survey have been amended since first reported in the 2006/07 'Drug Misuse Declared' report. In the 2007/08 BCS the base for 1998 is 9,809 and the base for 2006/07 is 28,819. The other bases remain unchanged.

Source:

Drug Misuse Declared: Findings from the 2006/07 British Crime Survey. Home Office

Table 2.2 Percentage of adults aged 16 to 59 reporting drug use in the last month, by type and class of drug, 1996 to 2006/07

England and Wales	Percentages								
	1996	1998	2000	2001/02 ¹	2002/03	2003/04	2004/05	2005/06	2006/07
Class A									
Any Cocaine	0.3	0.5	0.8	0.9	0.9	1.1	0.9	1.2	1.3
Cocaine powder	0.2	0.4	0.7	0.9	0.9	1.1	0.9	1.2	1.2
Crack cocaine	0.1	0.0	0.1	0.1	0.1	0.1	0.1	0.1	0.1
Ecstasy	0.7	0.5	0.9	1.1	0.9	0.9	0.7	0.7	0.8
Hallucinogens	0.4	0.1	0.3	0.2	0.2	0.3	0.4	0.3	0.2
LSD	0.3	0.1	0.1	0.1	0.1	0.1	0.0	0.1	0.1
Magic Mushrooms	0.1	0.1	0.2	0.2	0.1	0.3	0.4	0.2	0.1
Opiates	0.1	0.1	0.2	0.1	0.1	0.1	0.1	0.1	0.1
Heroin	0.1	0.0	0.1	0.1	0.1	0.1	0.1	0.1	0.1
Methadone	0.1	0.1	0.0	0.1	0.1	0.0	0.0	0.1	0.1
Class A/B²									
Amphetamines	1.6	1.4	0.9	0.7	0.6	0.6	0.5	0.6	0.5
Class B/C³									
Tranquillisers	0.2	0.2	0.2	0.2	0.2	0.2	0.3	0.2	0.2
Class C									
Anabolic Steroids	0.1	0.2	0.1	0.0	0.0	0.1	0.1	0.1	0.0
Cannabis	5.5	6.1	6.4	6.6	6.7	6.5	5.6	5.2	4.8
Ketamine	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0.1
Not classified⁴									
Amyl Nitrate	0.5	0.6	0.6	0.6	0.6	0.5	0.4	0.6	0.5
Glues	0.1	0.1	0.1	0.1	0.0	0.0	0.0	0.0	0.1
Any Class A drug	1.2	1.1	1.5	1.7	1.5	1.8	1.5	1.6	1.7
Any drug	6.7	7.1	7.2	7.4	7.4	7.5	6.7	6.3	5.9
<i>Base</i>	10,723	9,787	12,746	19,951	23,458	24,162	28,186	29,604	28,784

1. From 2001, the reporting year for the British Crime Survey data switched from calendar to financial years

2. Amphetamines can be classified as either Class A (prepared for injection) or Class B (powdered). For the purposes of calculating Class A drug use, the British Crime Survey assumes all reported amphetamine use to be of the Class B variety

3. Tranquillisers can either be classified as Class B (e.g. barbiturates) or Class C (e.g. benzodiazepines). Consequently, Class B and Class C drugs cannot be aggregated reliably because the survey does not identify which specific tranquilliser respondents used

4. The category 'not classified' indicates that it is an offence to supply these substances if it is likely that the product is intended for abuse

Source:

Drug Misuse Declared: Findings from the 2006/07 British Crime Survey. Home Office

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Table 2.3 Percentage of adults aged 16 to 59 reporting drug use in their lifetime, by type and class of drug, 1996 to 2006/07

England and Wales	Percentages								
	1996	1998	2000	2001/02 ¹	2002/03	2003/04	2004/05	2005/06	2006/07
Class A									
Any Cocaine	3.1	3.8	5.6	5.2	6.2	6.8	6.1	7.3	7.7
Cocaine powder	3.0	3.7	5.5	5.1	6.1	6.7	6.0	7.2	7.5
Crack cocaine	0.7	0.7	1.1	0.7	0.9	0.9	0.8	0.9	1.0
Ecstasy	3.8	4.2	5.3	5.9	6.6	6.9	6.7	7.2	7.3
Hallucinogens	7.8	8.4	9.3	8.2	9.2	9.4	8.5	9.3	9.1
LSD	5.4	5.6	6.2	5.4	5.9	6.1	5.1	5.5	5.4
Magic Mushrooms	5.3	6.0	7.0	6.1	6.8	7.1	6.5	7.3	7.1
Opiates	0.7	0.9	1.1	0.7	0.9	1.0	0.8	0.9	0.8
Heroin	0.6	0.6	1.0	0.6	0.8	0.8	0.6	0.6	0.7
Methadone	0.3	0.5	0.5	0.4	0.4	0.4	0.4	0.5	0.4
Class A/B²									
Amphetamines	9.3	10.8	12.3	11.6	12.3	12.2	11.2	11.5	11.9
Class B/C³									
Tranquillisers	3.1	3.4	3.7	3.0	3.1	3.1	2.6	2.7	2.9
Class C									
Anabolic Steroids	1.1	1.1	1.0	0.6	0.5	0.6	0.5	0.6	0.6
Cannabis	23.5	26.8	29.5	28.9	30.6	30.8	29.7	29.8	30.1
Ketamine	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	1.3
Not classified⁴									
Amyl Nitrate	6.5	7.9	7.8	7.9	8.4	8.6	8.1	8.4	9.1
Glues	2.3	2.5	2.7	2.3	2.4	2.1	2.2	2.4	2.4
Any Class A drug	9.6	10.7	12.4	11.8	13.2	13.4	12.6	13.9	13.8
Any drug	30.5	33.6	35.7	34.0	35.7	35.6	34.5	34.9	35.5
<i>Base</i>	<i>10,813</i>	<i>9,884</i>	<i>12,852</i>	<i>20,051</i>	<i>23,331</i>	<i>24,296</i>	<i>28,330</i>	<i>29,748</i>	<i>28,975</i>

1. From 2001, the reporting year for the British Crime Survey data switched from calendar to financial years

2. Amphetamines can be classified as either Class A (prepared for injection) or Class B (powdered). For the purposes of calculating Class A drug use, the British Crime Survey assumes all reported amphetamine use to be of the Class B variety

3. Tranquillisers can either be classified as Class B (e.g. barbiturates) or Class C (e.g. benzodiazepines). Consequently, Class B and Class C drugs cannot be aggregated reliably because the survey does not identify which specific tranquilliser respondents used

4. The category 'not classified' indicates that it is an offence to supply these substances if it is likely that the product is intended for abuse

Source:

Drug Misuse Declared: Findings from the 2006/07 British Crime Survey. Home Office

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Table 2.4 Estimates¹ of numbers of adults aged 16 to 59 reporting drug use in their lifetime, in last year and in the last month, 2006/07

England and Wales	Thousands		
	Ever used	Used last year	Used last month
Class A			
Any cocaine	2,444	835	405
Cocaine powder	2,398	828	396
Crack cocaine	303	58	33
Ecstasy	2,315	567	255
Hallucinogens	2,886	234	65
LSD	1,706	77	28
Magic mushrooms	2,268	201	48
Opiates	256	53	42
Heroin	227	41	31
Methadone	114	37	25
Class A/B²			
Amphetamines	3,790	421	159
Class B/C³			
Tranquillisers	936	136	67
Class C			
Anabolic Steroids	197	32	14
Cannabis	9,595	2,616	1,526
Not classified⁴			
Amyl Nitrate	2,883	440	173
Glues	764	61	29
Total			
Class A	4,389	1,074	538
Any drug	11,298	3,186	1,891

1. The figures are calculated using the population estimates provided by the Government Actuary's Department

2. Amphetamines can be classified as either Class A (prepared for injection) or Class B (powdered). For the purposes of calculating Class A drug use, the British Crime Survey assumes all reported amphetamine use to be of the Class B variety

3. Tranquillisers can either be classified as Class B (e.g. barbiturates) or Class C (e.g. benzodiazepines). Consequently, Class B and Class C drugs cannot be aggregated reliably because the survey does not identify which specific tranquilliser respondents used

4. The category 'not classified' indicates that it is an offence to supply these substances if it is likely that the product is intended for abuse

Source:

Drug Misuse Declared: Findings from the 2006/07 British Crime Survey. Home Office

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Table 2.5 Percentage of adults aged 16 to 59 reporting drug use in the last year, by type and class of drug and by age group, 2006/07

England and Wales		Percentages							
	All ages	16 to 19 ¹	20 to 24 ¹	25 to 29	30 to 34	35 to 44	45 to 54	55 to 59	
Class A									
Any Cocaine	2.6	3.4	8.4	5.9	3.4	1.2	0.4	0.0	
Cocaine powder	2.6	3.3	8.3	5.8	3.4	1.2	0.4	0.0	
Crack cocaine	0.2	0.2	0.6	0.6	0.2	0.1	0.0	-	
Ecstasy	1.8	3.3	6.1	3.5	1.9	0.5	0.3	0.0	
Hallucinogens	0.7	1.8	2.4	1.3	0.8	0.2	0.1	-	
LSD	0.2	0.6	0.9	0.6	0.3	0.0	0.0	-	
Magic Mushrooms	0.6	1.5	1.9	1.1	0.6	0.2	0.1	-	
Opiates	0.2	.	.	0.4	0.3	0.2	0.0	-	
Heroin	0.1	.	.	0.3	0.3	0.1	0.0	-	
Methadone	0.1	.	.	.	.	.	.	.
Class A/B²									
Amphetamines	1.3	2.5	4.4	2.3	1.4	0.6	0.2	0.1	
Class B/C³									
Tranquillisers	0.4	0.5	0.7	0.8	0.5	0.4	0.2	0.2	
Class C									
Anabolic Steroids	0.1	.	.	.	.	.	.	.
Cannabis	8.2	20.3	21.5	13.1	8.5	4.5	2.2	1.1	
Not classified⁴									
Amyl Nitrate	1.4	4.5	4.1	2.1	1.3	0.4	0.2	0.1	
Glues	0.2	0.8	0.5	.	.	.	.	.
Any Class A drug	3.4	5.4	10.4	6.8	4.0	1.5	0.6	0.0	
Any drug	10.0	23.3	24.8	16.0	11.1	5.9	3.0	1.7	
<i>Base</i>	<i>28,828</i>	<i>2,755</i>	<i>2,953</i>	<i>2,794</i>	<i>3,378</i>	<i>8,329</i>	<i>6,991</i>	<i>3,689</i>	

1. The 16 to 19 and 20 to 24 year old analysis includes the youth boost sample

2. Amphetamines can be classified as either Class A (prepared for injection) or Class B (powdered). For the purposes of calculating Class A drug use, the British Crime Survey assumes all reported amphetamine use to be of the Class B variety

3. Tranquillisers can either be classified as Class B (e.g. barbiturates) or Class C (e.g. benzodiazepines). Consequently, Class B and Class C drugs cannot be aggregated reliably because the survey does not identify which specific tranquilliser respondents used

4. The category 'not classified' indicates that it is an offence to supply these substances if it is likely that the product is intended for abuse

Source:

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Table 2.6 Percentage of adults aged 16 to 59 reporting drug use in the last year, by type and class of drug and gender, 2006/07

England and Wales	Percentages	
	Men	Women
Class A		
Any Cocaine	3.7	1.6
Cocaine powder	3.6	1.6
Crack cocaine	0.3	0.1
Ecstasy	2.6	1.0
Hallucinogens	1.2	0.3
LSD	0.4	0.1
Magic Mushrooms	1.0	0.3
Opiates	0.3	0.1
Heroin	0.2	0.1
Methadone	0.2	0.1
Class A/B¹		
Amphetamines	1.8	0.8
Class B/C²		
Tranquilisers	0.5	0.3
Class C		
Anabolic Steroids	0.2	0.0
Cannabis	11.1	5.5
Not classified³		
Amyl Nitrate	2.0	0.8
Glues	0.3	0.1
Any Class A drug	4.8	2.0
Any drug	13.2	6.9
<i>Base</i>	13,253	15,599

1. Amphetamines can be classified as either Class A (prepared for injection) or Class B (powdered). For the purposes of calculating Class A drug use, the British Crime Survey assumes all reported amphetamine use to be of the Class B variety

2. Tranquillisers can either be classified as Class B (e.g. barbiturates) or Class C (e.g. benzodiazepines). Consequently, Class B and Class C drugs cannot be aggregated reliably because the survey does not identify which specific tranquilliser respondents used

3. The category 'not classified' indicates that it is an offence to supply these substances if it is likely that the product is intended for abuse

Source:

Drug Misuse Declared: Findings from the 2006/07 British Crime Survey. Home Office

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Table 2.7 Percentage of adults aged 16 to 59 reporting drug use in the last year, by household income, 2003/04

England and Wales		Percentages					
	Total	Less than £5,000	£5,000 less than £10,000	£10,000 less than £20,000	£20,000 less than £30,000	£30,000 or more	
Class A							
Cocaine	2.4	2.2	2.6	2.6	1.7	2.6	
Crack	0.2	.	.	.	.	.
Ecstasy	2.0	1.9	2.3	2.0	1.3	1.9	
Hallucinogens	0.9	0.9	1.3	0.9	0.7	0.7	
LSD	0.2	0.2	0.4	0.3	0.2	0.2	
Magic Mushrooms	0.8	0.8	1.2	0.8	0.7	0.7	
Opiates	0.2	.	.	.	.	.
Heroin	0.1	.	.	.	.	.
Methadone	0.1	.	.	.	.	.
Class A/B¹							
Amphetamines	1.5	2.2	3.0	2.1	1.1	1.1	
Class B/C²							
Tranquillisers	0.6	1.0	0.7	0.9	0.4	0.5	
Class C							
Anabolic Steroids	0.1	.	.	.	.	.
Cannabis	10.8	13.1	13.7	10.6	8.7	10.2	
Not classified³							
Amyl Nitrate	1.3	1.1	1.6	1.1	0.7	1.3	
Glues	0.1	.	.	.	.	.
Any Class A drug	3.5	3.7	3.9	3.3	2.4	3.6	
Any drug	12.3	15.4	15.1	12.2	9.9	11.6	
<i>Base</i>	<i>24,197</i>	<i>1,327</i>	<i>1,806</i>	<i>4,053</i>	<i>4,205</i>	<i>8,351</i>	

1. Amphetamines can be classified as either Class A (prepared for injection) or Class B (powdered). For the purposes of calculating Class A drug use, the British Crime Survey assumes all reported amphetamine use to be of the Class B variety

2. Tranquillisers can either be classified as Class B (e.g. barbiturates) or Class C (e.g. benzodiazepines). Consequently, Class B and Class C drugs cannot be aggregated reliably because the survey does not identify which specific tranquilliser respondents used

3. The category 'not classified' indicates that it is an offence to supply these substances if it is likely that the product is intended for abuse

Source:

Drug Misuse Declared: Findings from the 2003/04 British Crime Survey. Home Office

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Table 2.8 Percentage of adults aged 16 to 59 reporting drug use in the last year, by respondents employment status, 2003/04

England and Wales	Percentages			
	Total	In employment	Unemployed	Economically inactive
Class A				
Cocaine	2.4	2.5	4.2	1.9
Crack	0.2	0.1	0.8	0.2
Ecstasy	2.0	2.0	6.7	1.4
Hallucinogens	0.9	0.8	3.5	0.9
LSD	0.2	0.2	1.4	0.2
Magic Mushrooms	0.8	0.8	3.1	0.8
Opiates	0.2	0.1	1.1	0.3
Heroin	0.1	0.1	1.1	0.2
Methadone	0.1	.	.	.
Class A/B¹				
Amphetamines	1.5	1.4	4.9	1.7
Class B/C²				
Tranquillisers	0.6	0.5	2.6	0.7
Class C				
Anabolic Steroids	0.1	0.1	0.4	0.2
Cannabis	10.8	10.3	20.0	11.5
Not classified³				
Amyl Nitrate	1.3	1.3	4.5	1.1
Glues	0.1	.	.	.
Any Class A drug	3.5	3.5	8.1	3.0
Any drug	12.3	11.8	23.5	13.0
<i>Base</i>	24,197	18,346	493	5,320

1. Amphetamines can be classified as either Class A (prepared for injection) or Class B (powdered). For the purposes of calculating Class A drug use, the British Crime Survey assumes all reported amphetamine use to be of the Class B variety

2. Tranquillisers can either be classified as Class B (e.g. barbiturates) or Class C (e.g. benzodiazepines). Consequently, Class B and Class C drugs cannot be aggregated reliably because the survey does not identify which specific tranquilliser respondents used

3. The category 'not classified' indicates that it is an offence to supply these substances if it is likely that the product is intended for abuse

Source:

Drug Misuse Declared: Findings from the 2003/04 British Crime Survey. Home Office

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Table 2.9 Percentage of adults aged 16 to 59 reporting drug use in the last year, by type and class of drug and Government Office Region, 2006/07

England and Wales	Percentages										
	England and Wales	North East	North West	Yorkshire and the Humber	East Midlands	West Midlands	East of England	London	South East	South West	Wales
Class A											
Any Cocaine	2.6	3.8	3.1	2.0	2.5	2.8	2.2	2.9	2.6	2.6	1.6
Cocaine powder	2.6	3.8	3.1	2.0	2.5	2.7	2.2	2.9	2.6	2.6	1.4
Crack cocaine	0.2	.	.	.	.	.	.	.	.	.	.
Ecstasy	1.8	1.9	2.4	1.5	1.6	2.1	1.3	2.4	1.3	1.8	1.5
Hallucinogens	0.7	0.9	0.6	0.5	0.6	0.9	0.9	0.4	0.8	1.4	0.3
LSD	0.2	.	.	.	.	.	.	.	.	.	.
Magic Mushrooms	0.6	0.8	0.4	0.4	0.5	0.9	0.7	0.3	0.8	1.4	0.3
Opiates	0.2	.	.	.	.	.	.	.	.	.	.
Heroin	0.1	.	.	.	.	.	.	.	.	.	.
Methadone	0.1	.	.	.	.	.	.	.	.	.	.
Class A/B¹											
Amphetamines	1.3	2.2	1.5	1.0	1.4	1.2	1.4	1.1	0.8	1.6	2.4
Class B/C²											
Tranquillisers	0.4	0.9	0.3	0.3	0.4	0.2	0.5	0.4	0.4	0.4	0.9
Class C											
Anabolic Steroids	0.1	.	.	.	.	.	.	.	.	.	.
Cannabis	8.2	9.1	9.3	8.2	7.6	7.6	7.7	8.4	7.5	9.6	7.2
Not classified³											
Amyl Nitrate	1.4	2.8	1.6	1.6	2.0	1.9	1.0	1.1	0.8	1.1	1.1
Glues	0.2	.	.	.	.	.	.	.	.	.	.
Any Class A drug	3.4	4.1	4.0	2.8	3.4	3.5	2.8	3.6	3.2	3.7	2.5
Any drug	10.0	10.8	11.0	9.5	10.0	9.2	9.1	10.4	9.5	11.1	9.5
<i>Base</i>	<i>28,852</i>	<i>1,965</i>	<i>3,332</i>	<i>2,722</i>	<i>3,139</i>	<i>2,815</i>	<i>3,922</i>	<i>2,279</i>	<i>3,284</i>	<i>3,098</i>	<i>2,296</i>

1. Amphetamines can be classified as either Class A (prepared for injection) or Class B (powdered). For the purposes of calculating Class A drug use, the British Crime Survey assumes all reported amphetamine use to be of the Class B variety

2. Tranquillisers can either be classified as Class B (e.g. barbiturates) or Class C (e.g. benzodiazepines). Consequently, Class B and Class C drugs cannot be aggregated reliably because the survey does not identify which specific tranquilliser respondents used

3. The category 'not classified' indicates that it is an offence to supply these substances if it is likely that the product is intended for abuse

Source:

Drug Misuse Declared: Findings from the 2006/07 British Crime Survey. Home Office

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Table 2.10 Percentage of adults aged 16 to 59 reporting drug use in the last month and last year, by type and class of drug; comparing England and Wales with Scotland, 2006/07

Great Britain	Percentages			
	In the last year		In the last month	
	England and Wales (BCS 06/07)	Scotland (SCVS 06)	England and Wales (BCS 06/07)	Scotland (SCVS 06)
Class A				
Any Cocaine	2.6	3.8	1.3	1.8
Cocaine powder	2.6	3.7	1.2	1.7
Crack cocaine	0.2	*	0.1	*
Ecstasy	1.8	3.2	0.8	1.6
Hallucinogens	0.7	N/A	0.2	N/A
LSD	0.2	0.6	0.1	*
Magic Mushrooms	0.6	0.9	0.1	*
Opiates	0.2	N/A	0.1	N/A
Heroin	0.1	0.5	0.1	*
Methadone	0.1	*	0.1	*
Class A/B¹				
Amphetamines	1.3	2.2	0.5	0.9
Class B/C²				
Tranquillisers	0.4	N/A	0.2	N/A
Class C				
Anabolic Steroids	0.1	-	0.0	-
Cannabis	8.2	11.0	4.8	6.8
Not classified³				
Amyl Nitrate	1.4	2.0	0.5	0.7
Glues	0.2	*	0.1	*
Any Class A drug	3.4	5.2	1.7	3.0
Any drug	10.0	12.6	5.9	8.0
<i>Base</i>	28,975	3,158	28,784	3,158

1. Amphetamines can be classified as either Class A (prepared for injection) or Class B (powdered). For the purposes of calculating Class A drug use, the British Crime Survey assumes all reported amphetamine use to be of the Class B variety

2. Tranquillisers can either be classified as Class B (e.g. barbiturates) or Class C (e.g. benzodiazepines). Consequently, Class B and Class C drugs cannot be aggregated reliably because the survey does not identify which specific tranquilliser respondents used

3. The category 'not classified' indicates that it is an offence to supply these substances if it is likely that the product is intended for abuse

Source:

Drug Misuse Declared: Findings from the 2006/07 British Crime Survey. Home Office

Drug Misuse in Scotland: Findings From the 2006 Scottish Crime and Victimization Survey. The Scottish Government

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Table 2.11 Percentage of young adults aged 16 to 24 reporting drug use in the last year, by type and class of drug, 1996 to 2006/07¹

England and Wales	Percentages								
	1996 ²	1998 ²	2000 ²	2001/02 ³	2002/03	2003/04	2004/05	2005/06	2006/07 ⁴
Class A									
Any Cocaine	1.4	3.2	5.4	5.1	5.2	5.4	5.1	5.9	6.1
Cocaine powder	1.3	3.1	5.2	5.1	5.1	5.2	5.1	5.9	6.0
Crack cocaine	0.2	0.3	0.9	0.5	0.5	0.4	0.1	0.4	0.4
Ecstasy	6.6	5.1	5.6	6.8	5.8	5.5	4.9	4.3	4.8
Hallucinogens	5.3	5.3	3.4	2.0	2.2	2.9	3.0	3.4	2.1
LSD	4.5	3.2	2.5	1.2	0.9	0.9	0.5	0.9	0.8
Magic Mushrooms	2.3	3.9	2.4	1.5	1.9	2.7	3.0	3.0	1.8
Opiates	0.4	0.8	0.8	0.3	0.2	0.5	0.2	0.2	0.2
Heroin	0.4	0.3	0.8	0.3	0.2	0.4	0.2	0.2	0.2
Methadone	0.1	0.6	0.1	0.0	0.2	0.3	0.0	0.1	0.1
Class A/B⁵									
Amphetamines	11.8	9.9	6.2	5.0	3.8	4.0	3.2	3.3	3.5
Class B/C⁶									
Tranquillisers	0.9	1.5	1.5	1.0	0.9	0.9	0.8	0.7	0.6
Class C									
Anabolic Steroids	0.5	0.5	0.1	0.2	0.1	0.4	0.4	0.3	0.2
Cannabis	26.0	28.2	27.0	27.3	26.2	25.3	23.6	21.4	20.9
Ketamine	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0.8
Not classified⁷									
Amyl Nitrate	4.6	5.1	3.9	3.8	4.4	4.3	3.6	3.9	4.3
Glues	0.9	1.3	1.0	0.6	0.5	0.4	0.4	0.5	0.6
Any Class A drug	9.2	8.6	9.7	9.1	8.9	8.5	8.3	8.4	8.1
Any drug	29.7	31.8	29.9	30.0	28.5	28.3	26.5	25.2	24.1
<i>Base</i>	1,420	1,246	1,468	3,995	4,227	5,351	6,196	5,892	5,706

1. The table includes revised figures for young people's drug use for the period 2001/02 to 2004/05 to reflect amendments to weighting procedures

2. The 2007/08 British Crime Survey report refers to 1996, 1998 and 2000 as 1995, 1997 and 1999. Here the labelling convention from the 2006/07 'Drug Misuse Declared' report has been used

3. From 2001, the reporting year for the British Crime Survey data switched from calendar to financial years

4. Some figures reported in the 2007/08 British Crime Survey had minor amendments since first reported in the 2006/07 'Drug Misuse Declared' report. The changes are: LSD (reported usage 0.7% in the 2007/08 report), magic mushrooms (1.7%), Amyl Nitrite (4.2%) and any Class A drug (8.0%). The figures remain unchanged.

5. Amphetamines can be classified as either Class A (prepared for injection) or Class B (powdered). For the purposes of calculating Class A drug use, the British Crime Survey assumes all reported amphetamine use to be of the Class B variety

6. Tranquillisers can either be classified as Class B (e.g. barbiturates) or Class C (e.g. benzodiazepines). Consequently, Class B and Class C drugs cannot be aggregated reliably because the survey does not identify which specific tranquilliser respondents used

7. The category 'not classified' indicates that it is an offence to supply these substances if it is likely that the product is intended for abuse

Source:

Drug Misuse Declared: Findings from the 2006/07 British Crime Survey. Home Office

Table 2.12 Percentage of young adults aged 16 to 24 reporting drug use in the last month, by type and class of drug, 1996 to 2006/07¹

England and Wales	Percentages								
	1996	1998	2000	2001/02 ²	2002/03	2003/04	2004/05	2005/06	2006/07
Class A									
Any Cocaine	0.6	1.0	1.9	2.2	2.3	2.8	2.2	3.0	3.2
Cocaine powder	0.5	0.9	1.8	2.2	2.1	2.7	2.1	3.0	3.1
Crack cocaine	0.2	0.0	0.2	0.1	0.3	0.2	0.1	0.2	0.3
Ecstasy	2.9	2.2	3.2	3.5	2.7	2.6	1.9	2.0	2.5
Hallucinogens	1.4	0.5	1.0	0.7	0.7	1.0	1.0	0.9	0.6
LSD	1.1	0.4	0.6	0.4	0.3	0.4	0.2	0.2	0.3
Magic Mushrooms	0.4	0.3	0.7	0.5	0.5	0.8	0.9	0.7	0.4
Opiates	0.1	0.7	0.3	0.2	0.2	0.3	0.1	0.1	0.2
Heroin	0.1	0.2	0.3	0.2	0.2	0.3	0.1	0.1	0.2
Methadone	0.1	0.5	0.0	0.0	0.1	0.1	-	0.1	0.1
Class A/B³									
Amphetamines	5.7	5.3	2.9	1.9	1.7	1.6	1.3	1.6	1.2
Class B/C⁴									
Tranquillisers	0.4	0.5	0.5	0.4	0.4	0.3	0.4	0.4	0.3
Class C									
Anabolic Steroids	0.1	0.3	0.1	0.1	0.0	0.2	0.2	0.1	0.1
Cannabis	16.1	18.0	17.4	17.6	16.6	15.8	14.1	13.0	12.0
Not classified⁵									
Amyl Nitrate	1.6	2.4	1.8	1.4	1.7	1.6	1.2	1.6	1.7
Glues	0.2	0.6	0.4	0.3	0.1	0.2	0.1	0.2	0.3
Any Class A drug	4.2	3.6	5.0	4.9	4.2	4.5	3.8	4.0	4.3
Any drug	19.2	20.8	19.0	19.3	18.1	17.5	16.4	15.1	14.3
<i>Base</i>	1,412	1,233	1,455	3,984	4,209	5,327	6,182	5,876	5,687

1. The table includes revised figures for young people's drug use for the period 2001/02 to 2004/05 to reflect amendments to weighting procedures

2. From 2001, the reporting year for the British Crime Survey data switched from calendar to financial years

3. Amphetamines can be classified as either Class A (prepared for injection) or Class B (powdered). For the purposes of calculating Class A drug use, the British Crime Survey assumes all reported amphetamine use to be of the Class B variety

4. Tranquillisers can either be classified as Class B (e.g. barbiturates) or Class C (e.g. benzodiazepines). Consequently, Class B and Class C drugs cannot be aggregated reliably because the survey does not identify which specific tranquilliser respondents used

5. The category 'not classified' indicates that it is an offence to supply these substances if it is likely that the product is intended for abuse

Source:

Drug Misuse Declared: Findings from the 2006/07 British Crime Survey. Home Office

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Table 2.13 Percentage of young adults aged 16 to 24 reporting drug use in their lifetime, by type and class of drug, 1996 to 2006/07¹

England and Wales	Percentages								
	1996	1998	2000	2001/02 ²	2002/03	2003/04	2004/05	2005/06	2006/07
Class A									
Any Cocaine	4.7	7.1	10.7	8.7	9.6	10.0	9.3	10.8	11.2
Cocaine powder	4.3	6.8	10.4	8.6	9.3	9.7	9.1	10.6	10.9
Crack cocaine	1.7	1.5	2.3	1.2	1.4	1.6	1.1	1.3	1.4
Ecstasy	11.7	10.8	11.7	12.1	12.5	11.3	10.8	10.4	10.3
Hallucinogens	16.1	16.1	14.6	9.8	9.8	8.8	8.1	9.4	7.8
LSD	13.1	12.3	11.4	7.0	6.1	4.8	3.5	3.7	3.2
Magic Mushrooms	9.8	11.2	10.2	6.5	7.1	7.0	7.0	8.3	7.0
Opiates	1.2	1.7	1.7	1.1	1.0	1.3	0.7	0.8	0.7
Heroin	0.9	0.9	1.6	0.8	0.8	1.1	0.6	0.5	0.7
Methadone	0.4	1.2	0.6	0.6	0.4	0.7	0.3	0.4	0.3
Class A/B³									
Amphetamines	18.8	21.5	21.2	16.2	15.3	13.1	11.6	11.3	11.2
Class B/C⁴									
Tranquillisers	3.9	3.4	4.5	3.3	2.7	2.9	2.2	2.6	2.3
Class C									
Anabolic Steroids	1.5	1.2	0.9	0.7	0.5	0.7	0.7	0.7	0.6
Cannabis	39.6	45.4	46.2	44.5	43.6	42.2	41.1	40.1	39.5
Not classified⁵									
Amyl Nitrate	15.7	17.5	15.3	14.8	13.5	13.5	12.2	12.1	13.4
Glues	5.9	6.2	6.9	5.5	4.5	3.2	3.6	3.6	3.7
Any Class A drug	19.4	20.5	21.0	17.9	18.0	16.6	16.1	16.9	16.3
Any drug	48.6	53.7	52.0	49.1	48.2	47.5	46.0	45.1	44.7
<i>Base</i>	1,445	1,271	1,483	4,023	4,253	5,387	6,240	5,929	5,749

1. The table includes revised figures for young people's drug use for the period 2001/02 to 2004/05 to reflect amendments to weighting procedures

2. From 2001, the reporting year for the British Crime Survey data switched from calendar to financial years

3. Amphetamines can be classified as either Class A (prepared for injection) or Class B (powdered). For the purposes of calculating Class A drug use, the British Crime Survey assumes all reported amphetamine use to be of the Class B variety

4. Tranquillisers can either be classified as Class B (e.g. barbiturates) or Class C (e.g. benzodiazepines). Consequently, Class B and Class C drugs cannot be aggregated reliably because the survey does not identify which specific tranquilliser respondents used

5. The category 'not classified' indicates that it is an offence to supply these substances if it is likely that the product is intended for abuse

Source:

Drug Misuse Declared: Findings from the 2006/07 British Crime Survey. Home Office

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Table 2.14 Estimates of numbers of adults aged 16 to 24 reporting drug use in their lifetime, in last year and in the last month, 2006/07^{1,2}

England and Wales	Thousands		
	Ever used	Used last year	Used last month
Class A			
Any cocaine	681	375	192
Cocaine powder	671	373	190
Crack cocaine	83	25	13
Ecstasy	659	272	124
Hallucinogens			
LSD	233	57	15
Magic mushrooms	523	190	46
Opiates			
Herion	34	11	4
Methadone	25	5	5
Class A/B³			
Amphetamines	714	207	102
Class B/C⁴			
Tranquillisers	163	45	23
Class C			
Anabolic Steroids	43	18	9
Cannabis	2,536	1,357	821
Not classified⁵			
Amyl Nitrate	225	29	13
Glues			
Total			
Class A	1,071	533	255
Any drug	2,851	1,597	954

1. This analysis of 16 to 24 year olds includes the youth boost sample

2. The figures are calculated using the population estimates provided by the Government Actuary's Department

3. Amphetamines can be classified as either Class A (prepared for injection) or Class B (powdered). For the purposes of calculating Class A drug use, the British Crime Survey assumes all reported amphetamine use to be of the Class B variety

4. Tranquillisers can either be classified as Class B (e.g. barbiturates) or Class C (e.g. benzodiazepines). Consequently, Class B and Class C drugs cannot be aggregated reliably because the survey does not identify which specific tranquilliser respondents used

5. The category 'not classified' indicates that it is an offence to supply these substances if it is likely that the product is intended for abuse

Source:

Drug Misuse Declared: Findings from the 2006/07 British Crime Survey. Home Office

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Table 2.15 Percentage of young adults aged 16 to 24¹ reporting drug use in the last year, by type and class of drug and gender, 2006/07

England and Wales	Percentages	
	Males	Females
Class A		
Any Cocaine	7.6	4.6
Cocaine powder	7.5	4.6
Crack cocaine	0.6	0.1
Ecstasy	6.5	3.1
Hallucinogens	3.3	1.0
LSD	1.4	0.2
Magic Mushrooms	2.6	0.9
Opiates	.	.
Heroin	.	.
Methadone	.	.
Class A/B²		
Amphetamines	4.8	2.2
Class B/C³		
Tranquillisers	1.0	0.2
Class C		
Anabolic Steroids	.	.
Cannabis	26.2	15.7
Not classified⁴		
Amyl Nitrate	5.2	3.3
Glues	0.9	0.4
Any Class A drug	10.6	5.5
Any drug	29.5	18.8
<i>Base</i>	2,704	3,005

1. This analysis of 16 to 24 year olds includes the youth boost sample

2. Amphetamines can be classified as either Class A (prepared for injection) or Class B (powdered). For the purposes of calculating Class A drug use, the British Crime Survey assumes all reported amphetamine use to be of the Class B variety

3. Tranquillisers can either be classified as Class B (e.g. barbiturates) or Class C (e.g. benzodiazepines). Consequently, Class B and Class C drugs cannot be aggregated reliably because the survey does not identify which specific tranquilliser respondents used

4. The category 'not classified' indicates that it is an offence to supply these substances if it is likely that the product is intended for abuse

Source:

Drug Misuse Declared: Findings from the 2006/07 British Crime Survey. Home Office

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Table 2.16 Frequent drug use in the last year among young adults aged 16 to 24, by type and class of drug, 2006/07¹

England and Wales	Percentages	
	More than once a month	Unweighted base
Class A		
Any Cocaine	25.7	307
Cocaine powder	25.6	302
Crack cocaine	..	18
Ecstasy	15.5	227
Hallucinogens	4.9	84
LSD	..	32
Magic Mushrooms	1.5	70
Opiates	..	11
Heroin	..	10
Methadone	..	7
Class A/B²		
Amphetamines	12.0	161
Class B/C³		
Tranquilisers	..	29
Class C		
Anabolic Steroids	..	9
Cannabis	37.0	1,069
Not classified⁴		
Amyl Nitrate	12.5	216
Glues	..	18
Any Class A drug⁵	22.7	404
Any drug	37.0	1,204

1. This analysis of 16 to 24 year olds includes the youth boost sample
2. Amphetamines can be classified as either Class A (prepared for injection) or Class B (powdered). For the purposes of calculating Class A drug use, the British Crime Survey assumes all reported amphetamine use to be of Class B variety
3. Tranquillisers can either be classified as Class B (e.g. barbiturates) or Class C (e.g. benzodiazepines). Consequently, Class B and Class C drugs cannot be aggregated reliably because the survey does not identify which specific tranquilliser respondents used
4. The category 'not classified' indicates that it is an offence to supply these substances if it is likely that the product is intended for abuse
5. Frequent users of Class A and of any Drug includes people who could have taken two different types of drugs frequently, i.e. more than once a month

Source:

Drug Misuse Declared: Findings from the 2006/07 British Crime Survey. Home Office

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Table 2.17 Percentage of young adults aged 16 to 24 reporting drug use in the last year, by type and class of drug and by whether ever truanted or been excluded, 2005/06

England and Wales	Percentages				
	Total	Truants	Non-truants	Excludes	Non-excludes
Class A					
Any Cocaine	5.9	11.2	3.0	11.5	4.8
Cocaine powder	5.9	11.1	3.0	11.4	4.8
Crack cocaine	0.4	1.0	0.0	1.0	0.3
Ecstasy	4.3	9.0	1.8	9.7	3.3
Hallucinogens	3.4	6.8	1.6	6.4	2.9
LSD	0.9	2.2	0.2	3.1	0.5
Magic Mushrooms	3.0	6.0	1.5	5.1	2.8
Opiates	0.2	.	.	.	.
Heroin	0.2	.	.	.	.
Methadone	0.1	.	.	.	.
Class A/B¹					
Amphetamines	3.3	6.9	1.3	7.5	2.4
Class B/C²					
Tranquillisers	0.7	1.7	0.2	2.3	0.5
Class C					
Anabolic Steroids	0.3	0.6	0.2	0.7	0.2
Cannabis	21.4	33.9	14.8	33.8	19.2
Not classified³					
Amyl Nitrate	3.9	7.3	2.1	6.8	3.4
Glues	0.5	1.2	0.1	1.3	0.3
Any Class A drug	8.4	15.8	4.5	14.9	7.3
Any drug	25.2	39.8	17.6	39.1	22.9
<i>Base</i>	<i>5,892</i>	<i>2,041</i>	<i>3,457</i>	<i>889</i>	<i>4,655</i>

1. Amphetamines can be classified as either Class A (prepared for injection) or Class B (powdered). For the purposes of calculating Class A drug use, the British Crime Survey assumes all reported amphetamine use to be of the Class B variety

2. Tranquillisers can either be classified as Class B (e.g. barbiturates) or Class C (e.g. benzodiazepines). Consequently, Class B and Class C drugs cannot be aggregated reliably because the survey does not identify which specific tranquilliser respondents used

3. The category 'not classified' indicates that it is an offence to supply these substances if it is likely that the product is intended for abuse

Source:

Drug Misuse Declared: Findings from the 2005/06 British Crime Survey. Home Office

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Table 2.18 Percentage of young people aged 10 to 24 reporting drug use in the last year, by whether part of a vulnerable group¹, 2003

	England and Wales				Percentages
	Not in a vulnerable group	In any vulnerable group	In only one vulnerable group	In more than one vulnerable group	
Amphetamines	0.9	6.6 ²	4.2 ²	13.3 ²	
Amyl Nitrate	1.3	6.7 ²	5.2 ²	11.8 ²	
Cannabis	14.3	36.9 ²	30.8 ²	55.2 ²	
Solvents	0.3	0.8	0.4	2.0	
Cocaine	2.9	9.8 ²	8.3 ²	14.3 ²	
Crack	0.0	1.9 ²	1.0 ²	3.0 ²	
Ecstasy	2.2	11.1 ²	8.0 ²	18.3 ²	
Hallucinogens	0.8	4.6 ²	3.3 ²	8.2 ²	
Heroin	0.0	0.7 ²	0.5	0.8	
Any drug	15.6	40.7 ²	34.1 ²	57.7 ²	
Class A	3.9	16.0 ²	12.3 ²	24.8 ²	
Frequent	4.6	23.8 ²	17.7 ²	39.4 ²	
<i>Base</i>	<i>2,894</i>	<i>1,140</i>	<i>774</i>	<i>304</i>	

1. Vulnerable groups are classed as those who have ever been in care, homeless, truants, excludeds from school and offenders

2. p<0.05 using Pearson's chi-squared test for significance on 'any vulnerable group' versus 'no vulnerable group', 'one vulnerable group' versus 'no vulnerable group' and 'more than one vulnerable group' versus 'one vulnerable group'

Source:

Drug use among vulnerable groups of young people: findings from the 2003 Crime and Justice Survey, Home Office

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3 Drug misuse among children

3.1 Introduction

This chapter presents key information about illicit drug use among secondary school children in school years 7 to 11, mostly aged between 11 and 15. Information is taken from the Drug use, Smoking and Drinking among Young People in England in 2007 (SDD07¹). This is the most recent survey in an annual series that began in 1982. Each survey since 1998 has included a core section of questions on smoking, drinking and drug use and since 2000, the remainder of the questionnaire has focused in alternate years on smoking and drinking or on drug taking. The focus of the 2007 survey was drug misuse. Drugs asked about in the survey include those as defined by The Misuse of Drugs Act². For further information on the individual drugs asked about see [Appendix A](#). SDD07 surveyed 7,831 secondary school children, from 273 schools in England during the autumn term of 2007.

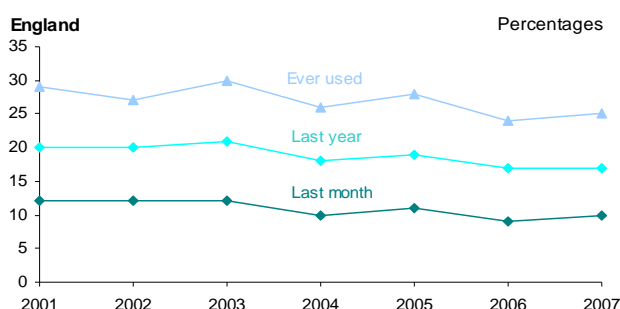
The government recently published a new Public Service Agreement (PSA) with the aim of reducing the harm caused by alcohol and drugs, PSA Delivery Agreement 25: Reduce the harm caused by alcohol and drugs, October 2007³. The aims and indicators associated with this agreement are described in [Chapter 2](#). A related agreement, PSA Delivery Agreement 14: Increase the number of children and young people on the path to success, October 2007⁴ contains an indicator to reduce the proportion of young people frequently using illicit drugs, alcohol or volatile substances.

Previous government strategies in this area, including the 2002 Updated Drug Strategy⁵, have also focused on reducing the harm caused by illegal drug use and in particular had the aim to 'reduce the use of Class A drugs and the frequent use of any illicit drug by all young people under the age of 25, especially by the most vulnerable groups'.

3.2 Prevalence of drug misuse

Figure 3.1 shows the declining trend in the proportion of pupils reporting using illicit drugs in the last month, last year and ever.

Figure 3.1 Proportion of pupils who have used drugs in the last month, last year and ever, 2001 to 2007



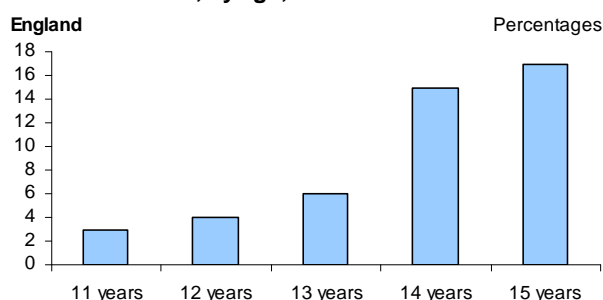
Source: Drug Use, Smoking and Drinking among Young People in England in 2007. The NHS Information Centre

The proportion of pupils reporting taking drugs in the last month fell from 12% in 2001 to 10% in 2007, while the proportion reporting taking drugs in the last year and ever fell from 20% to 17% and 29% to 25% respectively over the same period.

10% of pupils reported taking drugs in the last month

The proportion of pupils who had used drugs in the last month increased with age, 3% of 11 year olds in comparison to 17% of 15 year olds. When looking at pupils who took drugs in the last year only 6% of 11 year olds reported doing so, compared to 31% of 15 year olds. The percentage of pupils who had ever used drugs showed a similar trend to those who had used in the past year, with 11% of 11 year olds reporting ever using drugs compared to 41% of 15 year olds ([Tables 3.1, 3.2, 3.3, Figure 3.2](#)).

Figure 3.2 Proportion of pupils who have used drugs in the last month, by age, 2007



Source: Drug Use, Smoking and Drinking among Young People in England in 2007. The NHS Information Centre

All pupils are also asked how often they usually take drugs. In 2007, 5% of pupils said that they usually took drugs at least once a month, a similar proportion to previous years. Older pupils were more likely to take drugs at least once a month than younger pupils. Of those aged 15, 10% reported taking drugs at least once a month, compared to 1% of those aged 11 and 12 (Table 3.4).

As with previous years, in 2007, pupils who said that they had ever truanted or been excluded from school were more likely to report usually taking drugs at least once a month (14%), compared to pupils who had not truanted or been excluded (2%). Among those pupils who had ever truanted or been excluded from school, the proportion who usually took drugs at least once a month has fallen overall since 2003 (Table 3.5).

Pupils who reported using drugs in the last year were asked about the frequency in which they used the drugs. Thirty-four percent of pupils who used drugs in the last year repeated using drugs at least once a month. Those who took Class A drugs were most likely to take drugs at least once a month with 63% of Class A drug users reporting this. Pupils who had taken only cannabis or only volatile substances in the past year were less likely use drugs at least once a month (27% and 20% respectively) (Tables 3.6).

SDD07 also explores the relationships between drug use, smoking and drinking, to identify potential 'risk factors' for drug use. It is important to note that this analysis does not indicate causality nor the order of behaviours but does highlight a relationship.

Results of this analysis show that the odds of taking drugs in the last month was higher for smokers than non-smokers and increased with each unit of alcohol consumed in the previous week. The table also shows pupils who describe their ethnicity as Asian or mixed had higher odds of using drugs in the last month than pupils who described themselves as white.

Also pupils who thought their families would do nothing or encourage them to take drugs had higher odds of drug use in the last month than those pupils who thought their families would try to stop them (Table 3.7).

Mental Health of Children and Young People in Great Britain, 2004⁶ carried out by the Office for National Statistics on behalf of the Department of Health and the Scottish Executive, provides information on the prevalence of mental disorders among young people living in private households. The survey examined the relationship between mental disorder and aspects of children's lives, including the prevalence of drug use.

Results from the survey show that those children aged 11 to 16 with emotional, conduct and hyperkinetic disorders were more likely than other young people of the same age without disorders to take drugs. For example, a fifth (20%) of young people with emotional disorders reported taking drugs, compared with 8% of young people without an emotional disorder.

Information is also available about the mental health of young people looked after by local authorities in England⁶ including the prevalence of drug use.

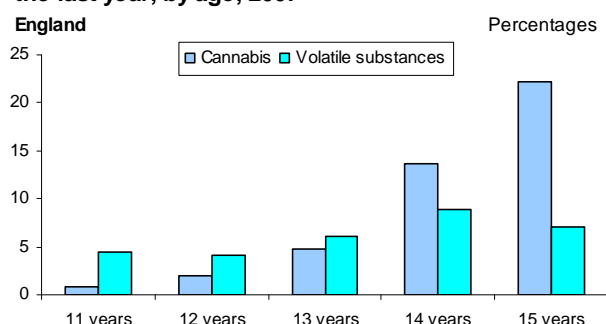
A European comparison of drug use can be found in the EMCDDA Statistical Bulletin 2007: European Monitoring Centre for Drugs and Drug Addiction⁷.

3.3 Types of drug taken

In 2007, cannabis was the most commonly reported drug taken among children, with 9.4% of pupils reporting using the drug in the year prior to interview. Cannabis use was significantly lower in 2007 than in 2001 (13.4%). Volatile substances (glue, gas, aerosols and other solvents) and poppers were the next most frequently reported drugs used in the last year (6.2% and 4.9% respectively). Overall, 4.0% of pupils reported using any Class A drug in the last year, this has remained steady since 2001 (Table 3.8).

As seen with overall drug use, patterns of individual drug use were influenced by the age of the pupil. Among 11 year olds, 0.8% of pupils reported having used cannabis in the last year, compared with 22.2% of 15 year olds, while the difference was less marked for volatile substances (Table 3.9, Figure 3.3).

Figure 3.3 Use of cannabis and volatile substances in the last year, by age, 2007



Source: Drug Use, Smoking and Drinking among Young People in England in 2007. The NHS Information Centre

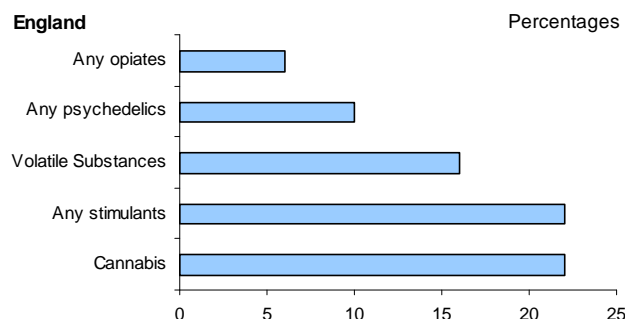
Overall, volatile substances were the most likely drug to be used when pupils were first trying drugs (reported by 50% of pupils), followed by cannabis (38%) and poppers (18%). However, the age at which a pupil first takes drugs has an influence on which

drugs they try. Seventy-seven percent of pupils who had first tried drugs at 11 years old reported trying volatile substances compared with only 11% of pupils who first tried drugs at the age of 15. Those who were older when they first tried drugs were most likely to report trying cannabis (73% of those who were 15 when first taking drugs) (Table 3.10).

3.4 Availability of drugs

In 2007, 36% of pupils reported ever having been offered drugs. This proportion has fallen since 2001 when it was 42%. Pupils were most likely to have been offered cannabis (22%), followed by volatile substances (16%), poppers (13%) and cocaine (10%). The proportion of pupils who had ever been offered cannabis has fallen from 27% in 2001 to 22% in 2007 (Table 3.11, Figure 3.4).

Figure 3.4 Whether pupils had ever been offered individual drugs, 2007



Source: Drug use, Smoking and Drinking among Young People in England in 2007. The NHS Information Centre

As might be expected a relationship can be seen between age and whether pupils had ever been offered drugs; as age increases so does the proportion of pupils ever being offered drugs. Three fifths (60%) of 15 year olds reported ever being offered drugs compared with 13% of 11 year olds. The most common drug offered to younger pupils was volatile substances, with 7% of 11 year olds, 10% of 12 year olds and 16% of 13 year olds reporting ever being offered these. However when looking at older pupils,

cannabis was the most common drug offered to them, with 31% of 14 year olds and 46% of 15 year olds ever being offered cannabis (Table 3.12).

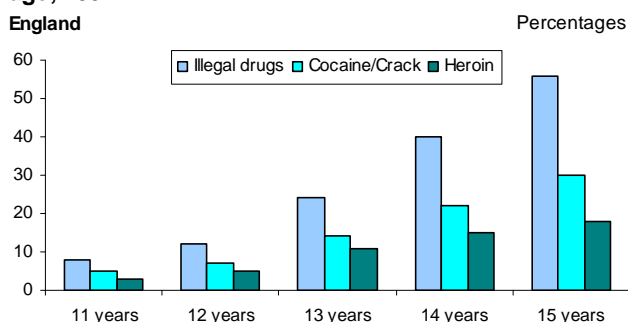
36% of pupils reported ever being offered drugs

To ascertain the perceived ease of accessing illegal drugs, all pupils were asked how easy they thought it would be to obtain illegal drugs. Overall, 30% of pupils thought it would be easy to obtain illegal drugs, with 17% believing it would be easy to access cocaine or crack and 11% thinking it would be easy to obtain heroin. Almost a half of pupils (49%) reported that they did not know how easy or difficult it would be to obtain illegal drugs in general (Table 3.13).

Three in ten pupils think it would be easy to obtain illegal drugs

Older pupils thought it would be easier to obtain illegal drugs than younger pupils. Among 15 year olds, 56% perceived it easy to obtain illegal drugs, compared to 8% of pupils aged 11 (Figure 3.5).

Figure 3.5 Perceived ease of getting illegal drugs, by age, 2007



Source: Drug use, Smoking and Drinking among Young People in England in 2007. The NHS Information Centre

As well as asking pupils questions about the perceived ease of getting drugs, those who reported ever taking drugs were also asked who they obtained drugs from. Seventy-two percent of pupils reported obtaining drugs from a friend on the first occasion they took drugs. This was more likely to be from a friend of the same age (44%), than from an older friend (25%) (Table 3.14).

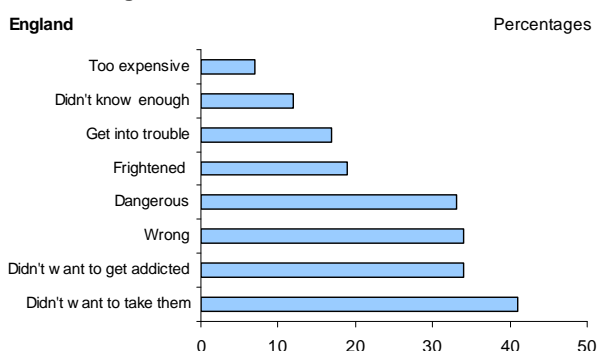
3.5 Drug taking behaviour

Thirty-five percent of pupils said they had refused drugs in 2007, 9% had never refused drugs and 55% had never been offered drugs. The figures were similar for boys and girls (Table 3.15).

35% of pupils said they had refused drugs at least once

Figure 3.6 shows the main reasons why pupils refused drugs. The most common reason given was 'I just didn't want to take them' (41%). Girls were more likely than boys to say 'I just didn't want to take them' (44% compared with 37%) or 'I thought they were dangerous' (36% compared with 31%). Boys were more likely than girls to say 'I thought I would get into trouble if I took drugs' (18% and 15% respectively) and 'They are too expensive' (9% and 6% respectively). Fourteen and 15 year olds were more likely to report 'I just didn't want to take them' (45% and 51% respectively) than 11 year olds (18%) (Table 3.16).

Figure 3.6 Reasons refused drugs among those ever offered drugs, 2007

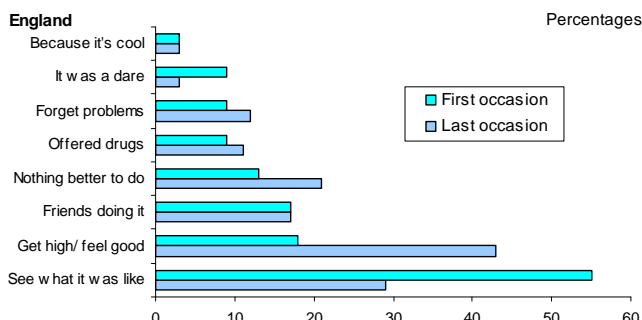


Source: Drug use, Smoking and Drinking among Young People in England in 2007. The NHS Information Centre

Pupils were asked about their reasons for taking drugs on the first occasion and, for those who had taken drugs more than once, on the most recent occasion. When looking at why pupils tried drugs on the first occasion, 55% reported taking drugs because they wanted to see what it was like (Table 3.17).

When looking at the reasons why pupils took drugs on the most recent occasion, different patterns emerge. A larger proportion of pupils reported that they took drugs 'to get high or feel good' on the last occasion than the first occasion (43% compared to 18% respectively). Younger pupils were more likely to have taken drugs on the last occasion because 'it was a dare' than older pupils (8% of 11 to 13 year olds compared with 2% of 15 year olds) (Table 3.17, 3.18, Figure 3.7).

Figure 3.7 Why pupils took drugs on the first and last occasion, 2007

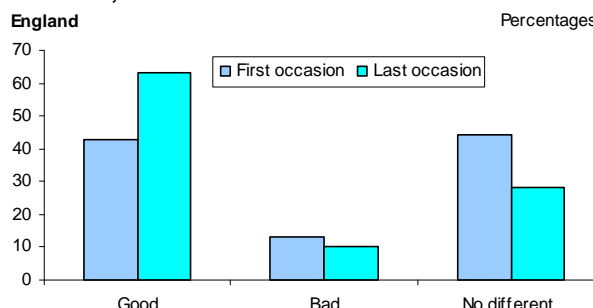


Source: Drug use, Smoking and Drinking among Young People in England in 2007. The NHS Information Centre

Pupils were also asked about their overall reaction to taking drugs, whether they felt good, bad or no different, on both the first and last occasions of drug taking. Pupils were more likely to report that they had a good experience when they first took drugs (43%), than a bad experience (13%) and a further 44% reported feeling no different. Pupils reporting their reaction on the last occasion of taking drugs were more likely than those on their first occasion to report a good experience (63%). Only 10% reported a bad reaction and 28% reported feeling no different.

On both the first and last drug taking occasion, boys were more likely to report they had had a good experience compared to girls. Overall, 45% of boys reported a good experience the first time they tried drugs, compared to 40% of girls. This was especially true amongst the youngest pupils. For those aged 11 and younger, 35% of boys said they had had a good experience the first time they tried drugs, compared to 22% of girls of the same age (Tables 3.19, 3.20, Figure 3.8).

Figure 3.8 Overall reaction to drugs on first and last occasion, 2007



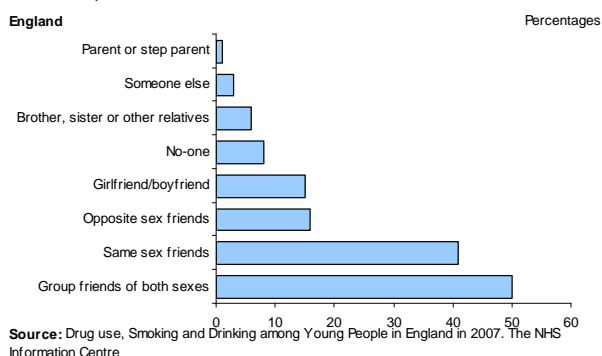
Source: Drug use, Smoking and Drinking among Young People in England in 2007. The NHS Information Centre

When looking at the different age groups, older pupils were more likely to have reported having a good experience than younger pupils. For example, 29% of those aged 11 reported a good experience on their first drug taking occasion, compared to 61% of those aged 15 (Table 3.19).

As well as asking where pupils obtained their drugs, they were also asked who they took their drugs with. Overall, 88% reported taking drugs with friends on the last occasion they took drugs, 15% with boyfriends/girlfriends, 8% by themselves and 6% with brothers/ sisters or other relatives. Boys were more likely to have taken drugs with friends of the same sex than with girls (51% compared with 31% respectively), while girls were more likely than boys to have taken drugs with a group of friends of both sexes (57% compared with 44%). Girls were also more likely than boys to have taken drugs with a boyfriend or girlfriend on the last occasion (21% of girls compared with 8% of boys).

Among the different age groups, pupils aged 15 were more likely to have taken drugs with friends than younger pupils (94% of 15 year olds, compared to 76% of 11 to 13 year olds). Younger pupils were more likely to have taken drugs on their own than older pupils, with 5% of 15 year olds and 15% of 11 to 13 year olds reporting this (Table 3.21, Figure 3.9).

Figure 3.9 Who pupils took drugs with on the most recent occasion, 2007

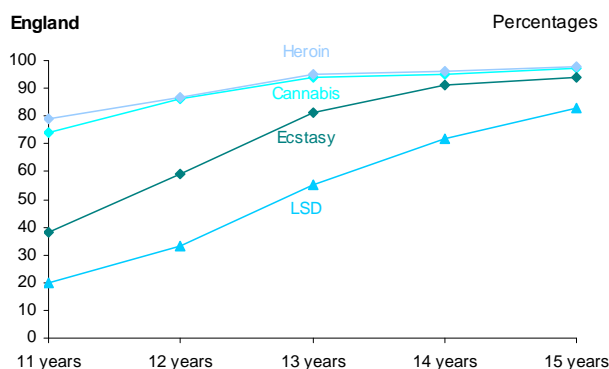


3.6 Awareness and attitudes of drugs

SDD07 asked pupils about their awareness of individual drugs and attitudes towards taking them as well as how useful they felt lessons at school about drugs were.

Overall awareness of illicit drugs was high, with 9 in 10 pupils reporting that they had heard of cocaine, heroin, cannabis and crack. Older pupils were more aware of individual drugs than younger pupils, however awareness among younger pupils was still generally high, for example among those aged 11, 86% had heard of cocaine, 79% had heard of heroin and 74% had heard of cannabis. Older pupils were much more aware than younger pupils of some drugs though. For example, only 38% of 11 year olds had heard of ecstasy compared with 94% of 15 year olds (Table 3.22, Figure 3.10).

Figure 3.10 Awareness of individual drugs, by age, 2007



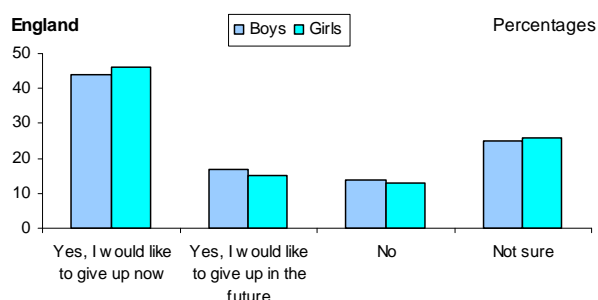
In SDD07, when looking at how pupils felt school lessons on drugs helped them, 95% said the lessons had helped them think about the risks of taking drugs, while 90% said they helped them find out more about drugs and 84% felt that the lessons had helped them realise that taking drugs is against the law (Table 3.23).

The pupils were also asked whether they thought it was OK to try certain drugs. Ten per cent of pupils thought it was acceptable to try cannabis to see what it's like, 9% thought it was OK to try sniffing glue to see what its like, and 3% thought it was OK to try cocaine. When asked if it was OK to take these substances once a week, proportions agreeing were lower (Table 3.24).

23% of 15 year olds think it's OK to try cannabis and 13% think it's OK to take once a week

Among pupils who had taken drugs in the year prior to interview, 45% said they would like to give up now, 16% reported that they would like to give up in the future and 14% said they didn't want to give up, the remaining 26% were not sure. Results were similar amongst boys and girls (Table 3.25, Figure 3.11).

Figure 3.11 Whether pupils would like to stop taking drugs, by gender, 2007



Source: Drug use, Smoking and Drinking among Young People in England in 2007. The NHS Information Centre

Summary: Drug misuse among children

The proportion of pupils who have ever used drugs has decreased in the period 2001 to 2007, although one-in-ten of pupils reported taking drugs in the last month.

Cannabis was the most commonly reported drug taken in 2007 among pupils who reported using drugs in the year prior to interview. This was reflected by the fact that one in ten pupils thought it was acceptable to try cannabis.

Volatile substances were the most likely drug to be used when pupils were first trying drugs, followed by cannabis and poppers, although this varied among age groups.

Overall awareness of illicit drugs remains high even among younger children. Over a third of pupils reported ever being offered drugs in 2007, a fall from 2001. Three-in-ten pupils thought it would be easy to obtain illicit drugs. The main source of drugs for pupils trying them for the first time was friends.

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Table 3.1 Percentage of pupils¹ who have used drugs in the last month, by gender and age, 2001 to 2007^{2,3}

England	Percentages						
	2001	2002	2003	2004	2005	2006	2007
All pupils							
All aged 11-15	12	12	12	10	11	9	10
11 years	3	3	4	3	3	3	3
12 years	4	4	5	4	4	3	4
13 years	10	8	9	7	8	6	6
14 years	16	17	17	15	16	13	15
15 years	24	22	23	21	20	17	17
Boys							
All aged 11-15	13	13	13	11	11	10	10
11 years	4	4	4	4	4	4	4
12 years	4	5	5	4	5	4	4
13 years	11	9	11	8	8	7	5
14 years	17	19	17	17	16	15	14
15 years	25	26	25	21	22	18	19
Girls							
All aged 11-15	11	10	12	9	10	8	9
11 years	2	3	3	1	3	3	2
12 years	4	3	5	4	4	3	4
13 years	9	8	8	7	8	6	7
14 years	15	15	18	13	16	12	15
15 years	22	19	22	20	19	16	16
Bases							
<i>All pupils</i>							
All aged 11-15	8,799	9,145	9,658	9,086	8,408	7,523	7,133
11 years	1,537	1,545	1,616	1,566	1,339	1,134	1,091
12 years	1,798	1,865	1,990	1,837	1,676	1,544	1,457
13 years	1,800	1,847	2,002	1,849	1,756	1,523	1,475
14 years	1,763	1,824	1,880	1,810	1,774	1,509	1,404
15 years	1,901	2,064	2,170	2,024	1,863	1,813	1,706
<i>Boys</i>							
All aged 11-15	4,360	4,672	4,840	4,664	4,208	3,657	3,663
11 years	778	794	810	792	672	552	551
12 years	861	941	973	954	851	764	772
13 years	887	950	1,005	952	891	722	745
14 years	852	910	951	932	853	764	727
15 years	982	1,077	1,101	1,034	941	855	868
<i>Girls</i>							
All aged 11-15	4,439	4,473	4,818	4,422	4,200	3,866	3,470
11 years	759	751	806	774	667	582	540
12 years	937	924	1,017	883	825	780	685
13 years	913	897	997	897	865	801	730
14 years	911	914	929	878	921	745	677
15 years	919	987	1,069	990	922	958	838

1. Children in secondary school years 7 to 11, mostly aged 11-15 years old

2. Because of changes to the questionnaire in 2001, estimates of the prevalence of drug use from surveys in this series carried out between 1998 and 2000 are not comparable with those shown here. Data from the earlier surveys have consequently been omitted from this table; they are available in the 2006 report: *Fuller E (ed) Smoking, drinking and drug use among young people in England in 2006*

3. Estimates from 2002 have been revised since their original publication

Source:

Drug Use, Smoking and Drinking among Young People in England in 2007. The NHS Information Centre

Table 3.2 Percentage of pupils¹ who have used drugs in the last year, by gender and age, 2001 to 2007²

England	Percentages						
	2001	2002	2003	2004	2005	2006	2007
All pupils							
All aged 11-15	20	20	21	18	19	17	17
11 years	6	6	8	5	6	6	6
12 years	9	8	10	8	9	7	8
13 years	19	16	18	14	15	12	12
14 years	27	27	28	25	26	23	24
15 years	39	37	38	32	34	29	31
Boys							
All aged 11-15	21	21	22	18	19	17	18
11 years	7	7	8	6	7	7	8
12 years	8	10	11	8	11	8	8
13 years	20	17	19	16	15	13	11
14 years	26	29	27	27	26	23	24
15 years	41	39	39	33	34	28	32
Girls							
All aged 11-15	19	18	20	17	19	16	17
11 years	4	6	7	4	6	5	4
12 years	9	6	9	8	8	6	7
13 years	18	16	17	13	14	12	14
14 years	27	25	29	23	27	23	24
15 years	36	34	36	32	34	30	30
Bases							
<i>All pupils</i>							
All aged 11-15	8,852	9,203	9,721	9,126	8,476	7,569	7,186
11 years	1,538	1,550	1,620	1,566	1,341	1,136	1,095
12 years	1,804	1,872	1,996	1,843	1,685	1,548	1,467
13 years	1,809	1,863	2,016	1,852	1,769	1,532	1,483
14 years	1,776	1,837	1,900	1,822	1,794	1,522	1,414
15 years	1,925	2,081	2,189	2,043	1,887	1,831	1,727
<i>Boys</i>							
All aged 11-15	4,394	4,706	4,876	4,683	4,253	3,681	3,697
11 years	779	797	812	792	673	553	554
12 years	865	945	976	958	858	765	780
13 years	894	960	1,012	953	899	727	750
14 years	860	916	964	936	867	770	735
15 years	996	1,088	1,112	1,044	956	866	878
<i>Girls</i>							
All aged 11-15	4,458	4,497	4,845	4,443	4,223	3,888	3,489
11 years	759	753	808	774	668	583	541
12 years	939	927	1,020	885	827	783	687
13 years	915	903	1,004	899	870	805	733
14 years	916	921	936	886	927	752	679
15 years	929	993	1,077	999	931	965	849

1. Children in secondary school years 7 to 11, mostly aged 11-15 years old

2. Estimates from 2002 have been revised since their original publication

Source:

Drug Use, Smoking and Drinking among Young People in England in 2007. The NHS Information Centre

Table 3.3 Percentage of pupils¹ who have ever used drugs, by gender and age, 2001 to 2007²

England	Percentages						
	2001	2002	2003	2004	2005	2006	2007
All pupils							
All aged 11-15	29	27	30	26	28	24	25
11 years	12	12	15	11	14	10	11
12 years	17	15	17	14	16	12	14
13 years	28	24	27	22	22	19	20
14 years	36	35	38	34	36	32	33
15 years	48	46	49	43	45	40	41
Boys							
All aged 11-15	30	29	31	26	28	24	26
11 years	13	12	16	11	15	10	13
12 years	16	18	17	14	16	13	15
13 years	30	24	28	24	22	19	20
14 years	35	39	37	36	36	32	35
15 years	51	49	49	44	46	40	42
Girls							
All aged 11-15	28	25	30	25	27	24	24
11 years	12	12	15	10	13	10	8
12 years	17	12	17	15	15	11	12
13 years	27	24	27	20	23	19	21
14 years	37	32	38	32	36	31	32
15 years	45	43	48	42	44	40	41
Bases							
<i>All pupils</i>							
All aged 11-15	8,909	9,245	9,793	9,174	8,548	7,613	7,247
11 years	1,544	1,557	1,631	1,573	1,350	1,139	1,100
12 years	1,816	1,879	2,003	1,848	1,700	1,556	1,475
13 years	1,822	1,873	2,036	1,862	1,781	1,542	1,499
14 years	1,786	1,846	1,914	1,834	1,810	1,535	1,428
15 years	1,941	2,090	2,209	2,057	1,907	1,841	1,745
<i>Boys</i>							
All aged 11-15	4,435	4,734	4,921	4,713	4,296	3,707	3,733
11 years	782	803	820	795	680	553	558
12 years	877	950	980	962	864	769	783
13 years	902	968	1,024	960	904	734	758
14 years	866	921	974	944	881	781	745
15 years	1,008	1,092	1,123	1,052	967	870	889
<i>Girls</i>							
All aged 11-15	4,474	4,511	4,872	4,461	4,252	3,906	3,514
11 years	762	754	811	778	670	586	542
12 years	939	929	1,023	886	836	787	692
13 years	920	905	1,012	902	877	808	741
14 years	920	925	940	890	929	754	683
15 years	933	998	1,086	1,005	940	971	856

1. Children in secondary school years 7 to 11, mostly aged 11-15 years old

2. Estimates from 2002 have been revised since their original publication

Source:

Drug Use, Smoking and Drinking among Young People in England in 2007. The NHS Information Centre

Table 3.4 Percentage of pupils¹ who usually take drugs at least once a month², by gender and age, 2003 to 2007

England	Percentages				
	2003	2004	2005	2006	2007
All pupils					
All aged 11-15	7	5	6	4	5
11-12 years	1	1	1	1	1
13 years	5	4	3	2	3
14 years	10	7	8	5	7
15 years	15	11	13	8	10
Boys					
All aged 11-15	7	5	5	4	4
11-12 years	1	1	1	2	1
13 years	4	3	3	3	3
14 years	10	8	7	5	7
15 years	16	12	13	8	9
Girls					
All aged 11-15	6	5	6	4	5
11-12 years	1	1	1	1	1
13 years	5	4	4	2	2
14 years	9	5	9	6	7
15 years	13	11	12	8	10
Bases					
<i>All pupils</i>					
All aged 11-15	10,033	9,497	8,784	7,949	7,514
11-12 years	3,796	3,617	3,225	2,876	2,729
13 years	2,087	1,931	1,841	1,618	1,566
14 years	1,945	1,870	1,831	1,584	1,469
15 years	2,205	2,079	1,887	1,871	1,750
<i>Boys</i>					
All aged 11-15	5,040	4,896	4,448	3,890	3,868
11-12 years	1,889	1,878	1,651	1,427	1,416
13 years	1,051	997	947	768	795
14 years	984	959	897	812	774
15 years	1,116	1,062	953	883	883
<i>Girls</i>					
All aged 11-15	4,993	4,601	4,336	4,059	3,646
11-12 years	1,907	1,739	1,574	1,449	1,313
13 years	1,036	934	894	850	771
14 years	961	911	934	772	695
15 years	1,089	1,017	934	988	867

1. Children in secondary school years 7 to 11, mostly aged 11-15 years old

2. The answer categories for usual frequency of drug use were slightly different in 2004. In every other year the question included the categories 'I take drugs most days' and 'I take drugs at least once a week'. In 2004 there were two further categories covering drug use once a month or more: 'I take drugs two or three times a month' and 'I take drugs once a month'. In all other years this has been replaced by a single category 'I take drugs once or twice a month'

Source:

Drug Use, Smoking and Drinking among Young People in England in 2007. The NHS Information Centre

Table 3.5 Percentage of pupils¹ who usually take drugs at least once a month², by whether ever truanted or been excluded, 2003 to 2007

England	Percentages				
	2003	2004	2005	2006	2007
All pupils ³	7	5	6	4	5
Truanted or excluded	21	17	18	11	14
Never truanted or excluded	3	2	2	1	2
<i>Bases</i>					
All pupils ³	10,033	9,497	8,784	7,949	7,514
Truanted or excluded	2,073	1,896	1,998	1,920	1,736
Never truanted or excluded	7,767	7,470	6,651	5,926	5,654

1. Children in secondary school years 7 to 11, mostly aged 11-15 years old

2. The answer categories for usual frequency of drug use were slightly different in 2004. In every other year the question included the categories 'I take drugs most days' and 'I take drugs at least once a week'. In 2004 there were two further categories covering drug use once a month or more: 'I take drugs two or three times a month' and 'I take drugs once a month'. In all other years this has been replaced by a single category 'I take drugs once or twice a month'

3. The total row includes those who did not answer the questions about whether they had truanted or been excluded from school

Source:

Drug Use, Smoking and Drinking among Young People in England in 2007. The NHS Information Centre

Table 3.6 Usual frequency of drug use, by type of drugs taken in last year, 2007

	Percentages				
	All pupils ¹	Cannabis only	Volatile substances only	Any Class A drugs ²	Other drugs
Most days	5	2	4	12	2
At least once a week	10	7	3	23	7
Once or twice a month	19	18	12	28	23
<i>At least once a month</i> ³	<i>34</i>	<i>27</i>	<i>20</i>	<i>63</i>	<i>31</i>
A few times a year	23	31	17	19	26
Once a year or less often	14	12	20	8	13
Took drugs in last year, but only ever taken drugs once	29	30	43	10	29
<i>Bases</i> ⁴	<i>991</i>	<i>231</i>	<i>209</i>	<i>241</i>	<i>253</i>

1. Total column includes pupils who did not answer the questions about which drugs they had taken in the last year

2. See Appendices for a definition of Class A drugs

3. At least once a month is the sum of 'Most days', 'At least once a week' and 'Once or twice a month'. Individual categories may not add to the total due to rounding

Source:

Drug Use, Smoking and Drinking among Young People in England in 2007. The NHS Information Centre

Table 3.7 Estimated odds ratios for drug use in the last month, by individual and school-level measures¹, 2007

Variable ²	N	Odds ratio	p-value	Numbers	
				95% Confidence interval	
				Lower	Upper
England					
Gender (p=0.017)					
Boys	3,663	1			
Girls	3,470	0.78	0.017	0.63	0.96
Age in years³	7,133	1.17	0.001	1.07	1.28
Ethnicity (p=0.011)					
White	5,766	1			
Mixed	269	1.92	0.004	1.23	2.99
Asian	531	1.86	0.018	1.11	3.09
Black	223	1.39	0.319	0.72	2.68
Other	50	1.51	0.554	0.38	5.98
Not given	294	1.76	0.018	1.10	2.82
Units of alcohol in the last week⁴	7,133	1.05	<0.001	1.03	1.06
Smoking status (p<0.001)					
Non-smoker	6,233	1			
Occasional smoker	366	6.21	<0.001	4.44	8.71
Regular smoker	466	9.69	<0.001	7.21	13.01
Not given	68	4.15	<0.001	2.04	8.46
Ever truanted (p<0.001)					
No	5,731	1			
Yes	1,240	2.37	<0.001	1.88	2.98
Not given	162	3.21	0.008	1.36	7.58
Ever excluded from school (p<0.001)					
No	6,254	1			
Yes	750	1.68	<0.001	1.28	2.20
Not given	129	2.57	0.415	1.23	5.38
Family attitudes to pupils taking drugs (p<0.001)					
Try to stop me	4,905	1			
Try to persuade me not to take drugs	742	1.54	0.003	1.16	2.03
Do nothing/encourage me to take drugs	73	9.97	<0.001	5.22	19.03
Don't know	542	2.82	<0.001	2.03	3.90
Not given	871	0.89	0.548	0.60	1.31

1. Variables included in the model which were not significant predictors of drug use in the last year in the last are not shown (see appendices for a complete list)

2. P-value for each variable excludes missing values

3. Odds ratio indicates change in odds for each additional year of age

4. Odds ratio indicates change in odds for each additional unit

Source:

Drug Use, Smoking and Drinking among Young People in England in 2007. The NHS Information Centre

Table 3.8 Percentage of pupils¹ who had used individual drugs in the last year, 2001 to 2007^{2,3}

England	Percentages						
	2001	2002	2003	2004	2005	2006	2007
Cannabis	13.4	13.2	13.3	11.3	11.7	10.1	9.4
Any stimulants	5.6	6.2	6.1	5.4	6.2	6.2	6.9
Poppers	3.4	4.3	4.0	3.4	3.9	4.2	4.9
Cocaine	1.2	1.3	1.3	1.4	1.9	1.6	1.8
Ecstasy	1.6	1.5	1.4	1.4	1.5	1.6	1.3
Crack	1.1	1.0	1.2	1.1	1.0	0.8	1.0
Amphetamines ⁴	1.1	1.2	1.2	1.3	1.2	1.2	1.0
Any psychedelics⁵	2.4	1.8	2.4	2.3	2.4	2.2	1.9
Magic Mushrooms	2.1	1.5	2.1	2.0	1.8	1.4	1.2
LSD	0.7	0.7	0.6	0.7	0.6	0.7	0.6
Ketamine ⁶	..	..	..	..	0.4	0.5	0.4
Any opiates	0.8	0.8	0.9	0.7	0.9	0.7	0.7
Heroin	0.7	0.7	0.8	0.7	0.8	0.5	0.5
Methadone	0.2	0.2	0.2	0.1	0.2	0.3	0.2
Glue, gas, aerosols or solvents	7.1	6.3	7.6	5.6	6.7	5.1	6.2
Tranquillisers	0.5	0.4	0.5	0.4	0.4	0.4	0.4
Anabolic steroids	0.2	0.2	0.2	0.2	0.3	0.5	0.4
Other drugs	0.6	0.4	0.7	0.4	0.6	0.2	0.5
Any Class A drug⁷	4.3	3.7	4.3	3.9	4.4	4.3	4.0
Any drug	20.4	19.7	21.0	17.6	19.1	16.5	17.3
Any drug (excluding volatile substances)	16.1	15.9	16.3	14.0	15.0	13.4	13.3
<i>Bases⁸</i>	9,357	9,830	10,371	9,666	9,174	8,132	7,813

1. Children in secondary school years 7 to 11, mostly aged 11-15 years old

2. Estimates are shown to one decimal place because of generally low prevalence rates

3. Because of changes to the questionnaire in 2001, estimates of the prevalence of drug use from surveys in this series carried out between 1998 and 2000 are not comparable with those shown here. Data from the earlier surveys have consequently been omitted from this table; they are available in the 2006 report: *Fuller E (ed) Smoking, drinking and drug use among young people in England in 2006*

4. Since 2004, the survey has asked about 'speed and other amphetamines'

5. From 2005, estimates for psychedelics include ketamine

6. Ketamine was measured for the first time in 2005

7. See appendices for definition of Class A drugs

8. Bases show numbers of pupils with valid responses for at least one of the fifteen drugs or types of drug asked about

Source:

Drug Use, Smoking and Drinking among Young People in England in 2007. The NHS Information Centre

Table 3.9 Percentage of pupils¹ who had used individual drugs in the last year, by age, 2007²

England	Percentages					
	All pupils	11 years old	12 years old	13 years old	14 years old	15 years old
Cannabis	9.4	0.8	1.9	4.7	13.7	22.2
Any stimulants	6.9	0.6	1.9	4.0	10.7	14.7
Poppers	4.9	0.3	1.0	2.8	7.8	11.0
Cocaine	1.8	0.3	0.4	1.1	2.5	4.3
Ecstasy	1.3	0.2	0.1	0.9	1.8	2.9
Amphetamines	1.0	0.3	0.2	0.4	1.7	2.2
Crack	1.0	0.3	0.7	0.6	1.9	1.3
Any psychedelics	1.9	0.5	0.2	0.9	3.4	3.9
Magic Mushrooms	1.2	0.3	0.2	0.5	2.1	2.4
LSD	0.6	0.3	-	0.2	1.4	1.2
Ketamine	0.4	0.2	0.1	0.2	0.6	0.8
Any opiates	0.7	0.3	0.4	0.7	1.2	0.7
Heroin	0.5	0.3	0.3	0.6	1.0	0.6
Methadone	0.2	0.3	0.1	0.1	0.2	0.2
Glue, gas, aerosols or solvents	6.2	4.4	4.1	6.1	8.8	7.1
Anabolic steroids	0.4	0.3	0.1	0.1	0.7	0.8
Tranquillisers	0.4	0.3	0.2	0.1	0.7	0.6
Other drugs	0.5	0.2	0.3	0.3	0.5	1.0
Any Class A drug³	4.0	0.8	1.3	2.4	6.2	7.9
Any drug	17.3	6.1	7.7	12.4	24.2	31.1
Any drug (excluding volatile substances)	13.3	1.8	4.1	7.5	19.2	28.7
<i>Bases⁴</i>	7,813	1,211	1,628	1,627	1,522	1,825

1. Children in secondary school years 7 to 11, mostly aged 11-15 years old

2. Estimates are shown to one decimal place because of generally low prevalence

3. See Appendices for a definition of Class A drugs

4. Bases show numbers of pupils with valid responses for at least one of the fifteen drugs or types of drug asked about.

Source:

Drug Use, Smoking and Drinking among Young People in England in 2007. The NHS Information Centre

Table 3.10 Drugs tried at age first tried drugs^{1,2}, by age first tried drugs, 2007

England	Percentages					
	All pupils ³	11 years old or younger	12 years old	13 years old	14 years old	15 years old
Glue, gas, aerosols or other solvents	50	77	58	42	27	11
Cannabis	38	11	29	47	62	73
Poppers	18	4	12	24	30	37
Magic mushrooms	3	3	2	3	4	4
Cocaine	2	1	2	4	3	3
Crack	2	2	2	3	4	3
Ecstasy	2	1	3	2	3	1
Anabolic steroids	1	1	1	2	1	1
Amphetamines	1	1	1	1	2	1
Heroin	1	1	1	1	1	1
Ketamine	1	1	-	1	1	1
LSD	1	1	-	1	1	1
Tranquillisers	1	1	0	-	1	1
Methadone	0	1	0	0	0	-
<i>Bases</i>	<i>1,824</i>	<i>551</i>	<i>305</i>	<i>352</i>	<i>355</i>	<i>151</i>

1. Children in secondary school years 7 to 11, mostly aged 11-15 years old

2. Percentages may sum to more than 100 because pupils could give more than one answer

3. The 'All pupils' column includes pupils who did not answer the questions about the age at which they first used drugs

Source:

Drug Use, Smoking and Drinking among Young People in England in 2007. The NHS Information Centre

Table 3.11 Percentage of pupils¹ who had ever been offered individual drugs, 2001 to 2007²

England	Percentages						
	2001	2002	2003	2004	2005	2006	2007
Cannabis	27	28	27	25	25	23	22
Any stimulants	22	21	23	20	22	20	22
Poppers	10	12	12	11	12	12	13
Cocaine	9	9	9	8	9	9	10
Crack	9	7	9	8	8	7	8
Ecstasy	10	9	9	7	8	7	7
Amphetamines ³	7	6	6	7	7	6	6
Any psychedelics⁴	12	11	12	12	13	11	10
Magic Mushrooms	10	9	10	10	11	8	8
LSD	6	5	5	4	5	4	4
Ketamine ⁵	..	..	..	..	2	2	2
Any opiates	8	7	8	6	6	6	6
Heroin	7	6	7	5	6	5	6
Methadone	2	2	2	2	1	2	2
Glue, gas, aerosols or solvents ⁶	20	17	19	14	18	14	16
Tranquillisers	4	3	3	3	3	2	3
Anabolic steroids	2	2	2	2	2	2	2
Other drugs	2	1	2	1	1	1	1
Any drug⁶	42	40	42	36	39	35	36
<i>Bases⁷</i>	9,357	9,859	10,390	9,715	9,175	8,132	7,813

1. Children in secondary school years 7 to 11, mostly aged 11-15 years old

2. Because of changes to the questionnaire in 2001, estimates of the prevalence of drug use from surveys in this series carried out between 1998 and 2000 are not comparable with those shown here. Data from the earlier surveys have consequently been omitted from this table; they are available in the 2006 report: *Fuller E (ed) Smoking, drinking and drug use among young people in England in 2006*

3. Since 2004, the survey has asked about 'speed and other amphetamines'

4. The 2005 estimate for psychedelics includes Ketamine

5. Ketamine was measured for the first time in 2005

6. The 'Any drug' figure is the percentage of pupils who reported being offered at least one type of drug. This is different from the way the percentage of pupils who had never been offered drugs is calculated in table 3.15. This figure in this table and table 3.12 should be considered definitive

7. Bases show numbers of pupils with valid responses for at least one of the fifteen drugs or types of drug asked about

Source:

Drug Use, Smoking and Drinking among Young People in England in 2007. The NHS Information Centre

Table 3.12 Percentage of pupils^{1,2} who had ever been offered individual drugs, by age, 2007

England	Percentages					
	All pupils	11 years old	12 years old	13 years old	14 years old	15 years old
Cannabis	22	3	6	14	31	46
Any stimulant	22	5	10	17	29	43
Poppers	13	2	3	8	18	30
Cocaine	10	3	5	8	12	20
Ecstasy	7	1	3	5	10	16
Amphetamines	6	1	2	4	9	14
Crack	8	3	4	7	12	13
Any psychedelic	10	2	4	7	14	21
Magic mushrooms	8	2	3	5	11	16
LSD	4	1	1	2	6	9
Ketamine	2	1	1	1	2	5
Any opiate	6	3	4	6	9	10
Heroin	6	3	3	5	8	8
Methadone	2	1	1	1	2	2
Glue, gas, aerosols or solvents	16	7	10	16	21	23
Tranquillisers	3	1	2	2	3	5
Anabolic steroids	2	1	1	1	3	5
Other drugs	1	0	1	1	1	3
Offered any drugs³	36	13	20	32	48	60
<i>Bases⁴</i>	7,813	1,210	1,628	1,627	1,522	1,826

1. Children in secondary school years 7 to 11, mostly aged 11-15 years old

2. Pupils who have ever taken drugs

3. The 'Any drug' figure is the percentage of pupils who reported being offered at least one type of drug. This is different from the way the percentage of pupils who had never been offered drugs is calculated in table 3.15. This figure in this table and table 3.12 should be considered definitive

4. Bases show numbers of pupils with valid responses for at least one of the fifteen drugs or types of drug asked about.

Source:

Drug Use, Smoking and Drinking among Young People in England in 2007. The NHS Information Centre

Table 3.13 Perceived ease of getting illegal drugs¹, by age², 2007

England	Percentages		
	Illegal drugs	Cocaine/Crack	Heroin
All pupils			
Easy ³	30	17	11
Difficult	21	25	27
Don't know	49	58	62
11 years			
Easy ³	8	5	3
Difficult	27	27	28
Don't know	66	68	69
12 years			
Easy ³	12	7	5
Difficult	25	27	28
Don't know	63	65	67
13 years			
Easy ³	24	14	11
Difficult	22	25	26
Don't know	54	60	63
14 years			
Easy ³	40	22	15
Difficult	20	23	25
Don't know	40	55	60
15 years			
Easy ³	56	30	18
Difficult	15	23	27
Don't know	30	47	55
<i>Bases</i>			
<i>All pupils</i>	<i>7,453</i>	<i>7,459</i>	<i>7,452</i>
<i>11 years</i>	<i>1,120</i>	<i>1,118</i>	<i>1,120</i>
<i>12 years</i>	<i>1,518</i>	<i>1,521</i>	<i>1,517</i>
<i>13 years</i>	<i>1,559</i>	<i>1,561</i>	<i>1,558</i>
<i>14 years</i>	<i>1,474</i>	<i>1,474</i>	<i>1,473</i>
<i>15 years</i>	<i>1,782</i>	<i>1,785</i>	<i>1,784</i>

1. The term 'illegal drugs' was the wording used in the question and open to the pupils' own interpretation

2. Children in secondary school years 7 to 11, mostly aged 11-15

3. The 'Easy' category combines pupils who perceived it 'very easy' or 'fairly easy' to get drugs; 'difficult' category combines pupils who perceived it 'very difficult' or 'fairly difficult'

Source:

Drug Use, Smoking and Drinking among Young People in England in 2007. The NHS Information Centre

Table 3.14 Who pupils¹ got drugs from on the first occasion, by age of first use and gender, 2007

England	Percentages					
	All pupils ²	11 years old or younger	12 years old	13 years old	14 years old	15 years old
All pupils						
Any friend	72	59	74	76	83	89
A friend of the same age	44	38	39	44	47	68
An older friend	25	17	30	29	31	19
Someone knew of, but not personally	6	5	8	6	9	4
A younger friend	1	2	1	1	2	2
Brother or sister	4	5	3	5	2	2
Boyfriend or girlfriend	2	2	4	1	3	1
Parent or step parent	2	5	2	1	-	1
A stranger	2	0	3	3	1	1
Someone else	14	26	11	9	4	3
Boys						
Any friend	69	60	68	73	82	88
A friend of the same age	45	38	37	46	54	68
An older friend	21	18	29	24	24	18
Someone knew of, but not personally	8	6	11	7	10	4
A younger friend	1	2	1	2	2	-
Brother or sister	3	4	2	3	2	1
Boyfriend or girlfriend	2	2	2	1	1	1
Parent or step parent	3	5	2	1	-	1
A stranger	2	1	3	5	1	1
Someone else	15	24	14	11	5	4
Girls						
Any friend	75	58	80	78	85	[92]
A friend of the same age	42	38	41	43	40	[67]
An older friend	28	16	32	35	38	[20]
Someone knew of, but not personally	5	3	5	4	8	[4]
A younger friend	1	2	1	-	1	[4]
Brother or sister	4	6	3	7	3	[2]
Boyfriend or girlfriend	3	3	6	1	5	-
Parent or step parent	2	5	1	1	-	-
A stranger	1	-	3	1	1	-
Someone else	12	28	8	7	3	[2]
Bases						
<i>All pupils</i>	1551	435	258	279	308	122
<i>Boys</i>	845	245	139	145	152	73
<i>Girls</i>	706	190	119	134	156	49

1. Children in secondary school years 7 to 11, mostly aged 11-15 years old

2. Total column includes pupils who did not answer the questions about which the age at which they first took drugs

[] Signifies the figure has a base inbetween 30 and 50

Source:

Drug Use, Smoking and Drinking among Young People in England in 2007. The NHS Information Centre

Table 3.15 Whether pupils^{1,2} had ever refused drugs, by gender, 1999 to 2007

England	Percentages				
	1999	2001	2003	2005	2007
All pupils					
Yes	31	35	39	37	35
No	3	5	10	9	9
Never been offered any drugs	66	61	51	53	55
Boys					
Yes	32	37	41	38	37
No	3	5	11	10	10
Never been offered any drugs	64	58	48	52	53
Girls					
Yes	30	32	37	37	34
No	3	4	10	9	9
Never been offered any drugs	67	63	54	55	57
<i>Bases</i>					
<i>All pupils</i>	9,225	9,222	10,088	8,749	7,422
<i>Boys</i>	4,721	4,618	5,059	4,398	3,806
<i>Girls</i>	4,504	4,604	5,029	4,351	3,616

1. Children in secondary school years 7 to 11, mostly aged 11-15 years old

2. Pupils who had ever been offered drugs

3. 'Never been offered any drugs' is an option on the question on refusing drugs. This is different from the way the percentage of pupils who have been offered drugs is calculated in table 3.11 and 3.12. The figures for ever been offered drugs in tables 3.11 and 3.12 should be considered definitive.

Source:

Drug Use, Smoking and Drinking among Young People in England in 2007. The NHS Information Centre

Table 3.16 Reasons pupils¹ refused drugs among those ever offered drugs, by age and gender, 2007

England	Percentages					
	All pupils ²	11 years old	12 years old	13 years old	14 years old	15 years old
All pupils						
I just didn't want to take them	41	18	27	38	45	51
I didn't want to get addicted	34	19	29	37	35	37
I thought they were dangerous	33	24	33	32	34	35
I think that taking drugs is wrong	34	32	32	38	35	33
I was frightened of taking them	19	15	17	21	21	19
I thought I would get into trouble if I took drugs	17	13	18	19	19	14
I didn't know enough about the drugs	12	9	11	10	12	14
They are too expensive	7	2	5	7	9	9
Never refused drugs	21	46	33	23	15	12
Boys						
I just didn't want to take them	37	16	27	35	41	47
I didn't want to get addicted	34	21	28	37	36	38
I thought they were dangerous	31	23	33	29	33	32
I think that taking drugs is wrong	34	33	33	36	35	33
I was frightened of taking them	16	13	15	15	20	14
I thought I would get into trouble if I took drugs	18	14	19	17	21	17
I didn't know enough about the drugs	11	9	10	9	12	12
They are too expensive	9	2	6	8	11	11
Never refused drugs	21	44	31	24	17	12
Girls						
I just didn't want to take them	44	21	27	43	49	54
I didn't want to get addicted	33	17	29	37	34	36
I thought they were dangerous	36	27	33	36	35	39
I think that taking drugs is wrong	34	31	31	40	35	33
I was frightened of taking them	23	19	19	27	22	25
I thought I would get into trouble if I took drugs	15	13	16	21	17	12
I didn't know enough about the drugs	12	8	11	10	12	16
They are too expensive	6	3	3	5	7	6
Never refused drugs	21	48	36	23	13	13
Bases³						
All pupils	3,317	300	471	630	770	1,146
Boys	1,780	175	268	337	418	582
Girls	1,537	125	203	293	352	564

1. Children in secondary school years 7 to 11, mostly aged 11-15 years old

2. Percentages may sum to more than 100 because pupils could give more than one answer

3. Bases are shown for pupils who gave a valid answer to the first option on the questionnaire 'They are too expensive'. Bases for other reasons may vary slightly

Source:

Drug Use, Smoking and Drinking among Young People in England in 2007. The NHS Information Centre

Table 3.17 Why pupils^{1,2} took drugs on the first occasion, by age first took drugs and gender, 2007³

England	Percentages					
	All pupils ^{3,4}	11 years old or younger	12 years old	13 years old	14 years old	15 years old
All pupils						
I wanted to see what it was like	55	43	56	64	68	74
I wanted to get high or feel good	18	15	18	23	20	20
Because my friends were doing it	17	15	19	18	19	17
Just because I was offered	9	6	11	11	11	13
I wanted to forget my problems	9	7	11	11	11	11
I had nothing better to do	13	11	15	14	13	8
It was a dare	9	13	8	6	5	8
Because it's cool	3	3	2	3	2	-
Other reasons	14	22	11	9	9	8
Don't remember	3	6	1	2	2	1
Don't know	3	4	4	1	2	-
Boys						
I wanted to see what it was like	55	45	57	62	68	69
I wanted to get high or feel good	18	17	14	21	19	22
Because my friends were doing it	16	16	21	16	14	16
Just because I was offered	9	5	10	13	9	16
I wanted to forget my problems	7	6	9	7	7	8
I had nothing better to do	13	10	15	16	13	10
It was a dare	9	13	8	7	5	6
Because it's cool	3	3	3	5	3	-
Other reasons	14	20	11	9	8	8
Don't remember	2	4	1	1	1	-
Don't know	2	3	2	1	3	-
Girls						
I wanted to see what it was like	56	41	55	66	69	81
I wanted to get high or feel good	19	14	23	25	21	17
Because my friends were doing it	18	14	16	21	23	19
I had nothing better to do	12	12	16	12	13	4
Just because I was offered	10	6	13	9	13	10
I wanted to forget my problems	12	9	14	14	14	15
It was a dare	9	13	9	5	5	10
Because it's cool	2	3	1	1	2	-
Other reasons	15	25	9	10	10	8
Don't remember	4	8	-	3	2	2
Don't know	3	4	6	-	2	-
Bases⁵						
All pupils	1,671	467	276	307	323	129
Boys	893	258	148	152	158	77
Girls	778	209	128	155	165	52

1. Children in secondary school years 7 to 11, mostly aged 11-15 years old

2. Pupils who had ever taken drugs

3. Percentages may sum to more than 100 because pupils could give more than one answer

4. The 'All pupils' column includes pupils who did not answer the question about age at which they first took drugs

5. Bases are shown for pupils who gave a valid answer to the first option on the questionnaire 'I wanted to get high or feel good'. Bases for other reasons may vary slightly

Source:

Drug Use, Smoking and Drinking among Young People in England in 2007. The NHS Information Centre for health and social care

Table 3.18 Why took drugs on the most recent occasion, by age¹ and gender, 2007

England	Percentages			
	All pupils ²	11 to 13 years old	14 years old	15 years old
All pupils				
I wanted to get high or feel good	43	31	39	50
I wanted to see what it was like	29	30	36	25
I had nothing better to do	21	20	20	22
Because my friends were doing it	17	21	18	14
Just because I was offered	11	14	9	12
I wanted to forget my problems	12	10	15	11
Because it's cool	3	4	2	4
It was a dare	3	8	3	2
Other reasons	12	15	8	12
Don't remember	2	4	3	1
Don't know	3	7	2	3
Boys				
I wanted to get high or feel good	43	35	41	49
I wanted to see what it was like	34	36	42	28
I had nothing better to do	23	20	20	27
Because my friends were doing it	17	26	16	14
Just because I was offered	11	14	12	10
I wanted to forget my problems	9	6	9	10
Because it's cool	4	2	3	5
It was a dare	4	9	3	2
Other reasons	10	15	4	11
Don't remember	2	5	2	-
Don't know	1	1	1	1
Girls				
I wanted to get high or feel good	42	28	38	51
I wanted to see what it was like	24	25	28	22
I had nothing better to do	19	21	20	18
Because my friends were doing it	16	17	21	14
Just because I was offered	12	14	5	14
I wanted to forget my problems	15	14	21	12
Because it's cool	2	5	-	3
It was a dare	3	7	3	2
Other reasons	13	15	13	13
Don't remember	2	2	3	2
Don't know	5	13	2	4
Bases³				
<i>All pupils</i>	<i>718</i>	<i>168</i>	<i>198</i>	<i>352</i>
<i>Boys</i>	<i>354</i>	<i>81</i>	<i>106</i>	<i>167</i>
<i>Girls</i>	<i>364</i>	<i>87</i>	<i>92</i>	<i>185</i>

1. Children in secondary school years 7 to 11, mostly aged 11-15 years old

2. Percentages may sum to more than 100 because pupils could give more than one answer

3. Bases are shown for pupils who gave a valid answer to the first option on the questionnaire 'I wanted to get high or feel good'. Bases for other reasons may vary slightly

Source:

Drug Use, Smoking and Drinking among Young People in England in 2007. The NHS Information Centre

Table 3.19 Overall reaction to drugs on the first occasion, by age¹ first took drugs and gender, 2007

England	Percentages					
	All pupils ²	11 years old or younger	12 years old	13 years old	14 years old	15 years old
All pupils						
Good	43	29	46	53	49	61
Bad	13	17	12	9	14	6
No different	44	54	41	38	38	34
Boys						
Good	45	35	46	56	50	65
Bad	12	16	11	9	9	4
No different	43	50	43	35	41	31
Girls						
Good	40	22	47	50	47	54
Bad	14	18	14	9	18	8
No different	45	60	40	41	35	38
<i>Bases</i>						
All pupils	1,643	459	269	306	320	127
Boys	880	256	145	153	155	77
Girls	763	203	124	153	165	50

1. Children in secondary school years 7 to 11, mostly aged 11-15 years old

2. The 'All pupils' column includes pupils who did not answer the question about the age at which they first took drugs

Source:

Drug Use, Smoking and Drinking among Young People in England in 2007. The NHS Information Centre

Table 3.20 Overall reaction to drugs on last occasion (last year, not first occasion), by gender and age¹, 2007

England	Percentages			
	All pupils	11 to 13 years old	14 years old	15 years old
All pupils				
Good	63	46	65	70
Bad	10	15	11	6
No different	28	40	24	24
Boys				
Good	66	51	69	71
Bad	8	11	8	6
No different	27	38	24	23
Girls				
Good	60	41	62	69
Bad	11	18	14	7
No different	29	41	24	25
<i>Bases</i>				
<i>All pupils</i>	<i>714</i>	<i>169</i>	<i>196</i>	<i>349</i>
<i>Boys</i>	<i>353</i>	<i>81</i>	<i>105</i>	<i>167</i>
<i>Girls</i>	<i>361</i>	<i>88</i>	<i>91</i>	<i>182</i>

1. Children in secondary school years 7 to 11, mostly aged 11-15 years old

Source:

Drug Use, Smoking and Drinking among Young People in England in 2007. The NHS Information Centre

Table 3.21 Who pupils¹ took drugs with on the most recent occasion, by age and gender, 2007²

England	Percentages			
	All pupils	11 to 13 years old	14 years old	15 years old
All pupils				
Any friend	88	76	90	94
Group friends of both sexes	50	41	48	56
Same sex friends	41	39	40	42
Opposite sex friends	16	11	18	19
Girlfriend/boyfriend	15	12	17	15
Brother, sister or other relatives	6	8	8	4
Parent or step parent	1	2	-	0
Someone else	3	6	4	2
No-one	8	15	8	5
Boys				
Any friend	89	74	93	93
Group friends of both sexes	44	37	43	47
Same sex friends	51	42	53	54
Opposite sex friends	14	4	16	18
Girlfriend/boyfriend	8	6	10	9
Brother, sister or other relatives	5	4	8	3
Parent or step parent	1	4	-	-
Someone else	3	5	1	2
No-one	8	17	5	6
Girls				
Any friend	88	77	86	94
Group friends of both sexes	57	44	54	64
Same sex friends	31	36	25	31
Opposite sex friends	19	17	20	19
Girlfriend/boyfriend	21	17	25	21
Brother, sister or other relatives	7	11	8	5
Parent or step parent	1	1	-	1
Someone else	4	7	7	2
No-one	8	13	12	4
<i>Bases</i>				
<i>All pupils</i>	717	169	197	351
<i>Boys</i>	353	81	105	167
<i>Girls</i>	364	88	92	184

1. Children in secondary school years 7 to 11, mostly aged 11-15 years old

2. Percentages may sum to more than 100 because pupils could give more than one answer

Source:

Drug Use, Smoking and Drinking among Young People in England in 2007. The NHS Information Centre

Table 3.22 Percentage of pupils who were aware of individual drugs, by age¹, 2007

England	Percentages					
	All pupils	11 years old	12 years old	13 years old	14 years old	15 years old
Cannabis	90	74	86	94	95	97
Any stimulants	97	91	94	98	98	99
Cocaine	94	86	90	96	97	99
Crack	89	68	83	93	96	97
Ecstasy	75	38	59	81	91	94
Amphetamines	65	28	44	68	85	89
Poppers	52	23	34	49	65	77
Any psychedelics	81	51	67	87	94	97
Magic mushrooms	76	43	60	82	91	95
LSD	55	20	33	55	72	83
Ketamine	30	12	16	25	35	53
Any opiates	93	81	89	96	97	98
Heroin	92	79	87	95	96	98
Methadone	55	34	44	58	65	69
Tranquillisers	71	52	60	72	79	83
Anabolic steroids	60	41	49	60	69	75
Other drugs	2	1	2	3	2	4
Never heard of any of the drugs	2	6	3	1	1	0
<i>Bases</i>	<i>7,818</i>	<i>1,211</i>	<i>1,630</i>	<i>1,628</i>	<i>1,523</i>	<i>1,826</i>

1. Children in secondary school years 7 to 11, mostly aged 11-15 years old

Source:

Drug Use, Smoking and Drinking among Young People in England in 2007. The NHS Information Centre

Table 3.23 How pupils¹ felt school lessons on drugs had helped them, 2007

England	Percentages
	All pupils
They helped me think about the risks of taking drugs	95
They helped me find out more about drugs	90
They helped me realise that taking drugs is against the law	84
They helped me to avoid drugs	80
They helped me think about what I would do if someone offered me drugs	77
They helped me find out where to go to get information or help about drugs	72
They helped me understand why people take drugs	68
They helped me see that not as many young people take drugs as I thought	39
<i>Bases²</i>	<i>3,541</i>

1. Children in secondary school years 7 to 11, mostly aged 11-15 years old

2. Bases shown for pupils who gave answer to whether lessons helped me to think about the risks of taking drugs; other bases may vary slightly

Source:

Drug Use, Smoking and Drinking among Young People in England in 2007. The NHS Information Centre

Table 3.24 Whether it's OK to take different substances, by gender and age¹, 2007

England	Percentages					
	All pupils	11 years old	12 years old	13 years old	14 years old	15 years old
All pupils						
OK to try taking cannabis to see what it's like	10	1	2	5	14	23
OK to try sniffing glue to see what it's like	9	4	6	9	12	12
OK to try taking cocaine to see that it's like	3	1	1	3	6	6
OK to take cannabis once a week	6	1	1	3	8	13
OK to sniff glue once a week	4	3	3	5	6	4
OK to take cocaine once a week	2	1	1	1	3	3
Boys						
OK to try taking cannabis to see what it's like	10	1	2	5	15	24
OK to try sniffing glue to see what it's like	8	5	6	8	12	10
OK to try taking cocaine to see that it's like	3	1	1	2	6	5
OK to take cannabis once a week	6	1	1	3	9	13
OK to sniff glue once a week	4	3	2	4	6	3
OK to take cocaine once a week	2	1	1	1	3	2
Girls						
OK to try taking cannabis to see what it's like	9	0	1	5	12	21
OK to try sniffing glue to see what it's like	10	4	6	11	12	15
OK to try taking cocaine to see that it's like	4	0	1	3	5	8
OK to take cannabis once a week	5	0	1	2	7	13
OK to sniff glue once a week	4	3	4	5	5	5
OK to take cocaine once a week	2	0	1	1	3	3
<i>Bases¹</i>						
<i>All pupils</i>	7,628	1,159	1,582	1,585	1,499	1,803
<i>Boys</i>	3,936	579	848	803	788	918
<i>Girls</i>	3,692	580	734	782	711	885

1. Bases shown for pupils who answered whether it was OK to try cannabis once; other bases may vary slightly

Source:

Drug Use, Smoking and Drinking among Young People in England in 2007. The NHS Information Centre

Table 3.25 Whether pupils¹ would like to stop taking drugs, by age and gender, 2007

England	Percentages			
	All pupils	11 to 13 years old	14 years old	15 years old
All pupils				
Yes, I would like to give up now	45	61	43	36
Yes, I would like to give up in the future	16	9	16	20
No	14	6	18	15
Not sure	26	24	22	29
Boys				
Yes, I would like to give up now	44	61	40	37
Yes, I would like to give up in the future	17	10	23	18
No	14	7	15	17
Not sure	25	22	22	29
Girls				
Yes, I would like to give up now	46	61	47	36
Yes, I would like to give up in the future	15	8	9	22
No	13	5	22	13
Not sure	26	26	22	29
<i>Bases²</i>				
<i>All pupils</i>	961	262	263	436
<i>Boys</i>	484	130	134	220
<i>Girls</i>	477	132	129	216

1. Children in secondary school years 7 to 11, mostly aged 11-15 years old

2. Pupils who took drugs in the last year

Source:

Drug Use, Smoking and Drinking among Young People in England in 2007. The NHS Information Centre

4 Outcomes of drug misuse

4.1 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 and the financial costs associated with drug misuse.

The government recently published a new Public Service Agreement (PSA) with the aim of reducing the harm caused by alcohol and drugs, PSA Delivery Agreement 25: Reduce the harm caused by alcohol and drugs, October 2007¹. Several indicators have been developed to monitor progress including treatment performance information provided by the National Drug Treatment Monitoring System (NDTMS)² – data from the NDTMS yearly publication can be found in [tables 4.10](#) through to [4.13](#).

Data on NHS hospital admissions are available from the Hospital Episode Statistics (HES) databank³. This chapter presents NHS hospital admissions in England where there was a primary or secondary diagnosis of drug related mental health and behavioural disorders or a primary diagnosis of drug poisoning. These data are based on the tenth revision of the International Classification of Diseases (ICD-10). The most recent data available is for the financial year 2006/07.

Information on infections acquired through injecting illicit drugs is taken from the Health Protection Agency's Unlinked Anonymous Prevalence Monitoring Programme

(UAPMP)⁴. Data from the NDTMS provides information on the number of people being treated for drug misuse².

The most recent information on the numbers of deaths due to drug misuse is available from the Office for National Statistics (ONS) publication Health Statistics Quarterly 36⁵ (HSQ), published in winter 2007.

There are various social and economic costs associated with drug misuse. This chapter includes estimates taken from 'The economic and social costs of Class A drug use'⁶, produced by the Home Office.

4.2 Drugs Harm Index

The Drug Harm Index (DHI)⁷ has been developed by the Home Office to measure the following aim of the Drugs Strategy⁸: *'reduce the harm caused by illegal drugs including substantially increasing the number of drug misusing offenders entering treatment through the criminal justice system'*. The DHI captures the harms generated by the problematic use of any illegal drug by combining robust national indicators into a single figure time series index. There are 19 harms included in the DHI which include drug-related crime, community perceptions of drug problems, drug nuisance, and the various health consequences that arise from drug abuse (e.g. HIV, overdoses, deaths). Full details of all the harms included in the DHI can be found in [Appendix A](#).

To enable a single index to be formulated, the relative importance of each of the harms in the DHI is captured by the economic and social costs they generate. Any change in the DHI will be due to the level or volume of harms (e.g. the number of new HIV cases) and the change in their economic or social cost (e.g. change in cost per new HIV case). The DHI should be considered alongside

other indicators, in order to determine which particular types of harm are becoming dominant, or are being moderated.

The baseline figure for DHI is 2002. The latest DHI results available are for 2005. The value of the DHI fell from 89.1 to 83.8 between 2004 and 2005, a 5.9% decrease, compared to a 18.2% reduction between 2003 and 2004 and a 7% reduction between 2002 and 2003⁷.

4.3 Hospital admissions

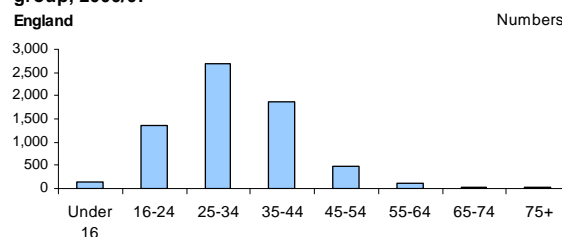
4.3.1 Drug-related mental health and behavioural disorders

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

Table 4.1 shows that in 2006/07 there were 6,743 admissions to hospital in England with a primary diagnosis of a drug-related mental health and behavioural disorder. This is less than in 2005/06 when there were 7,757 admissions.

During 2006/07 more people aged between 25 and 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 nearly 40% of all such admissions in that year. Those aged 65 and over had the lowest number of admissions (Table 4.1, Figure 4.1).

Figure 4.1 NHS hospital admissions with a primary diagnosis of drug related mental health and behavioural disorders, by age group, 2006/07



Source: Hospital Episode Statistics, HES. The NHS Information Centre

In 2006/07, more than twice as many males were admitted to hospital with a primary diagnosis of drug-related mental health and behavioural disorders than females (4,715 and 2,019 respectively) (Table 4.2).

More than twice as many males were admitted to hospital with a primary diagnosis of drug-related mental health and behavioural disorders than females

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 provided later in this section as number of admissions per 100,000 population.

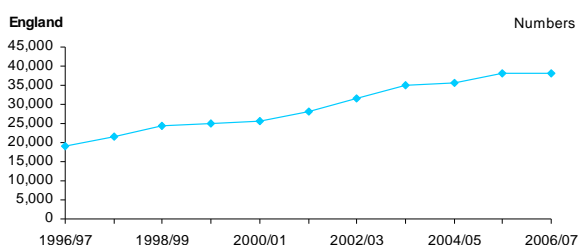
Among SHAs, North West recorded the highest number of admissions with a primary diagnosis of drug-related mental health and behavioural disorders (1,352), followed by London (1,244). The North East reported the lowest number of such admissions (262). When looking at admissions per 100,000 population the North West and London still had the highest rates of admissions (20 and 17 admissions per 100,000 of the population respectively) but East of England had the lowest (7 admissions per 100,000 population) (Table 4.2).

Among PCTs, these admissions ranged from Liverpool (208) to North Tyneside (6). There

were several other PCTs below 10 admissions, these included Gateshead PCT, South Tyneside PCT, Western Cheshire PCT, North East Lincolnshire PCT, South Gloucestershire PCT, Swindon PCT, Bath and North East Somerset PCT (Table 4.3).

There were 38,170 admissions where there was a primary or secondary diagnosis of drug-related mental health and behavioural disorders in 2006/07, twice as many than in 1996/97 (19,018) and slightly higher than in 2005/06 (38,005) (Figure 4.2).

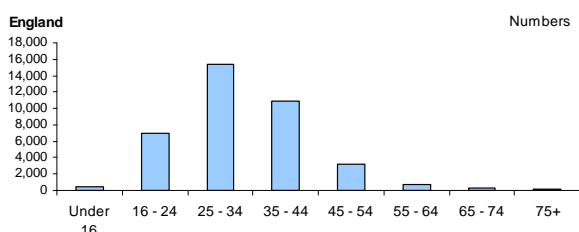
Figure 4.2 NHS hospital admissions where there was a primary or secondary diagnosis was of drug related mental health and behavioural disorders, 1996/97 to 2006/07



Source: Hospital Episode Statistics, HES. The NHS Information Centre

As seen with primary diagnosis, those in the 25 to 34 age group had the greatest number of admissions with a primary or secondary diagnosis of drug-related mental health and behavioural disorders than any other age group (15,330 admissions were recorded in 2006/07). Those in the 75+ age group had the lowest number of admissions (183) (Table 4.4, Figure 4.3).

Figure 4.3 NHS hospital admissions where there was a primary or secondary diagnosis of drug related mental health and behavioural disorders, by age group, 2006/07



Source: Hospital Episode Statistics, HES. The NHS Information Centre

As with primary diagnoses, there were more males admitted to hospital for a primary or

secondary diagnosis of drug-related mental health and behavioural disorders (25,650) than females (12,505).

Among SHAs, North West again showed the largest number of admissions (9,550) with a primary or secondary diagnosis of drug-related mental health and behavioural disorders. This was also the case when looking at admissions per 100,000 population (139) (Table 4.5).

Among PCTs, admissions ranged from 1,558 (Liverpool) to 49 (Harrow) (Table 4.6).

4.3.2 Poisoning by drugs

In this section admissions with a primary diagnosis of poisoning by drugs are described. In 2006/07, 10,047 admissions were recorded with this diagnosis, an increase from 7,057 in 1996/97.

Adults in the 16 to 24 age group reported the highest number of admissions with a primary diagnosis of poisoning by drugs in 2006/07 (2,674), with those aged between 25 to 34 reporting slightly less (2,579). Those in the 65 to 74 age group reported the lowest number of such admissions (186) (Table 4.7).

In 2006/07, more males were admitted to hospital with a primary diagnosis of poisoning by drugs than females (5,491 males compared to 4,554 females). The difference was less than that seen for admissions related to mental health and behaviour disorders.

When looking at SHAs, the North West showed the largest number of admissions with a primary diagnosis of poisoning by drugs in 2006/07 (2,184), more than twice the number reported by other SHAs with the exception of Yorkshire and the Humber. South Central reported the least number of admissions (530). However, the North East had the highest number of admissions per 100,000 population (38 per 100,000 population) and South Central was only one

of three SHAs who had admission rates below 14 per 100,000 population (Table 4.8).

Leeds PCT had the largest number of admissions with a primary diagnosis of poisoning by drugs in 2006/07 (236), whereas Bassetlaw PCT and Richmond and Twickenham PCT had the lowest (12) (Table 4.9).

4.4 Injecting drug users

Injecting drug users (IDUs) who share needles are at risk of contracting serious diseases such as hepatitis and HIV. The Unlinked Anonymous Prevalence Monitoring Programme (UAPMP⁴), conducted by the Health Protection Agency (HPA) includes information on HIV, Hepatitis B and C prevalence among IDUs. The UAPMP survey of IDUs monitors HIV and Hepatitis B and C in those in contact with specialist services such as needle exchanges or treatment programmes. Further information on the UAPMP can be found in Appendix A.

Levels of reported needle and syringe sharing increased in the late 1990s, and have remained elevated since⁹. In 2006, almost a quarter (23%) of current injectors reported sharing injecting equipment in the previous month. The transmission of HIV, Hepatitis B and C continues among IDUs in the UK. Overall, nearly half of IDUs have been infected with hepatitis C and around one in four have been exposed to hepatitis B. The prevalence of HIV infections among IDUs in England & Wales has increased since the beginning of the decade with about one in seventy-five now infected. By the end of 2006 there had been a total of 4,662 HIV diagnoses reported in the UK where infection was thought to have been acquired through injecting drug use, these accounted for 5.4% of all HIV diagnoses.

4.5 Treatment for drug misuse

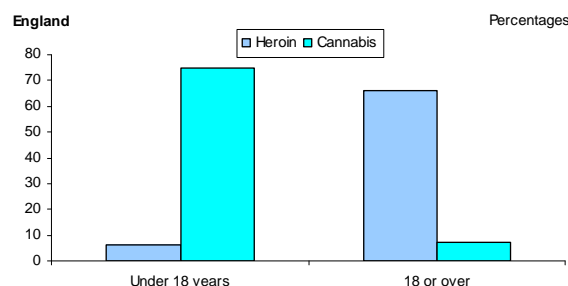
The most recent figures from the NDTMS covering the period 1st April 2006 to 31st March 2007, report that 195,464 individuals were in treatment contact with structured drug treatment services. This is a 10% increase from the 2005/06 figures, where the number was 177,055, over double the number in 1998/99 (85,000)². Four in ten (41%) of those in treatment were aged between 25 and 34 and seven in ten (72%) were male (Table 4.10).

Around six in ten clients in drug treatment in 2006/07 were being treated for heroin

In 2006/07 61% of clients in treatment had heroin reported as their main problem drug. A further 13% of clients had cannabis use as the main reason for their treatment.

Among clients younger than 18 years, the most frequently reported main problem drug was cannabis (75%) while 6% reported heroin as the main problem drug. For clients aged 18 years or over, the most frequently reported main problem drug was heroin (66%) with 7% reporting cannabis (Table 4.11, Figure 4.4)

Figure 4.4 Main problem drugs of clients in treatment, by age group, 2006/07



Source: The National Drug Treatment Monitoring System (NDTMS) 1 April 2006 - 31 March 2007. National Treatment Agency for Substance Misuse (NTA). Copyright © 2008, re-used with the permission of the NDTMS

The NDTMS also report on referral sources for episodes of treatment. A client may have

more than one episode in a year (see [Appendix A](#) for more information on episodes). The most frequent source of referral in 2006/07 was a self-referral (34%). The criminal justice system provided 24% of referrals and a further 11% of episodes were referred from General Practice².

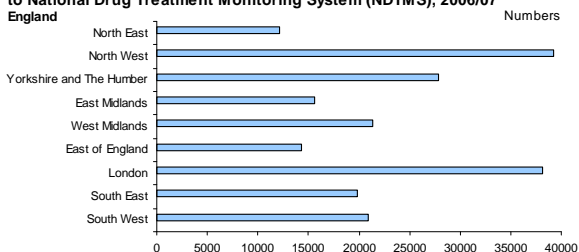
[Table 4.12](#) shows the reasons why clients were discharged from treatment. Of the 293,325 episodes of treatment which were current for some part of the year in 2006/07, 119,769 were discharged by the end of the year.

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.

There were 52,186 (44%) completed episodes recorded as having a successful completion in 2006/07. Thirty-three per cent of episodes (39,988) resulted in the client having dropped out or left treatment ([Table 4.12](#)).

Among Government Office Regions (GORs), the North West reported the highest number of people in treatment (39,240), followed by London (38,133). The North East reported the lowest number of people in treatment (12,177) ([Table 4.13](#), [Figure 4.5](#)).

Figure 4.5 People in treatment by Government Office Region reported to National Drug Treatment Monitoring System (NDTMS), 2006/07



Source: Statistics from the National Drug Treatment Monitoring System (NDTMS) April 2006 - 31 March 2007. National Treatment Agency for Substance Misuse (NTA). Copyright © 2008, re-used with the permission of the NDTMS

4.6 Drug-related deaths

Health Statistics Quarterly 36 (HSQ⁵) produced by the Office for National Statistics defines drug-related deaths as 'deaths where the underlying cause is poisoning, drug abuse or drug dependence and where any of the substances controlled under the Misuse of Drugs Act are involved' (See [Appendix A](#) for further information).

[Table 4.14](#) shows the number of deaths related to drug misuse. In 2006, there were 1,573 deaths reported as being due to drug misuse. Of those who died, 79% were male. For males compared to 1993 the number of deaths has increased by around 117% compared to a 28% increase for females. In recent years however no overall trend is apparent. The highest numbers of deaths due to drug misuse occurred in the 30 to 39 age group for both males and females (481 and 92 respectively).

There were 1,573 deaths related to drug misuse in 2006

Analysis of the underlying causes of death due to drug misuse shows that more men than women die for each underlying cause of death with over six times the number of males dying from mental and behavioural disorders than females (639 and 100 respectively). This pattern was evident in deaths due to accidental poisoning (426 male and 114 female) and intentional self poisoning of undetermined intent (180 male and 107 female). No overall trend in recent years is apparent between genders in the changes of numbers dying with underlying causes of death. However compared with 1993 males have experienced greater increases than females for all underlying causes of death (excluding assault by drugs) ([Table 4.15](#)).

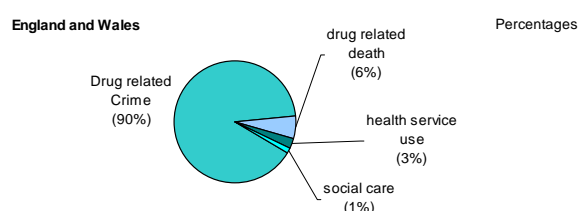
An alternative source of data on drug-related deaths is published by the national programme on Substance Abuse Deaths (np-SAD)¹⁰ and is used as an indicator of the extent and nature of drug problems and misuse, and makes a contribution towards the prevention of substance abuse problems. Unlike the HSQ, which uses the General Mortality Registers (GMR), derived from medical death certificates, information presented in the np-SAD publication is based on data provided by coroners, as part of the Special Mortality Register (SMR). Overall, trends from the np-SAD and HSQ are similar.

4.7 Financial costs

The publication 'Measuring different aspects of problem drug use: methodological developments'⁶ produced in 2006 by the Home Office provides estimates of problem drug use for 2003/04. The report was created to provide a measure of the total costs of Class A drug misuse to society. The report estimates that there are 327,466 problem Class A drug users in England. A problem drug user is defined as a person whose drug use is no longer controlled or undertaken for recreational purposes and where drugs have become a more essential element of the individual's life.

In 2003/04 problem drug users were estimated to being responsible for a total economic and social cost of around £15.4 billion. This equates to £44,231 per year per problem Class A drug user. Drug-related crime accounts for 90% of this cost (£13.9 billion), drug-related deaths 6% (£923 million), health service use 3% (£488 million) and social care 0.4% (£69 million)⁶(Figure 4.6)

Figure 4.6 Estimated total cost of Class A drug use by type of cost, 2003/04



Source: Measuring different aspects of problem drug use: methodological developments. The Home Office. Copyright © 2008, re-used with the permission of the Home Office

Of the various costs that make up the health care cost, inpatient care is the highest and accounts for £198 million of health care costs for Class A drug users.

Summary: Outcomes of drug misuse

Admissions to NHS hospitals where the primary diagnosis was of drug-related mental health and behavioural disorders decreased between 2005/06 and 2006/07. Over twice as many males were admitted to hospital with a primary diagnosis of drug-related mental health and behavioural disorders than females. People aged between 25 and 34 accounted for four in ten of these admissions.

Admissions with a primary diagnosis of poisoning by drugs have increased in the last 10 years and again males were more likely to be admitted than females, but the difference was less pronounced.

The age group 16 to 24 had the highest number of admissions to NHS hospital with a primary diagnosis of poisoning by drugs in 2006/07.

More than double the number of people were in contact with NTA structured drug treatment services in 2006/07 compared with 1998/99. Heroin was the most common drug that clients over 18 were in drug treatment for. Whereas three quarters of those under the age of 18 reported cannabis as their main problem drug.

Males accounted for almost four-fifths of deaths related to drug misuse in 2006.

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Table 4.1 NHS hospital admissions^{1,2} where there was a primary diagnosis³ of drug related mental health and behavioural disorders⁴, by age group, 1996/97 to 2006/07^{5,6,7,8}

England	Numbers								
	Total ⁹	Under 16	16-24	25-34	35-44	45-54	55-64	65-74	75+
1996/97	7,584	152	2,691	3,240	1,004	282	69	60	61
1997/98	8,209	140	2,828	3,727	1,080	280	58	36	52
1998/99	9,131	129	3,033	4,108	1,331	335	90	47	50
1999/00	8,453	124	2,676	3,627	1,450	373	73	47	77
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

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

Source:

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

Table 4.2 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} and gender, 2006/07⁷

England	Numbers			
	Total ⁸	Number of admissions per 100,000 of population ⁹	Male	Female
England^{10,11}	6,743	13	4,715	2,019
North East	262	10	205	57
North West	1,352	20	908	437
Yorkshire and the Humber	623	12	391	232
East Midlands	552	13	411	141
West Midlands	653	12	468	185
East of England	381	7	250	131
London	1,244	17	867	377
South East Coast	467	11	339	127
South Central	359	9	276	83
South West	669	13	445	223

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

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

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

4. ICD-10 Codes F11-F16, F18, F19

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

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

7. Figures have not been adjusted for shortfalls in data

8. Includes admissions where the gender was unknown

9. The number of admissions per 100,000 of population all ages use estimated resident population mid-2006 figures based on the 2001 census published by the Office for National Statistics (ONS).

Information on ONS Population data is available at:

<http://www.statistics.gov.uk/census2001/default.asp>

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

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

Source:

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

Table 4.3 NHS hospital admissions^{1,2} where there was a primary diagnosis³ of drug related mental health and behavioural disorders⁴, by Strategic Health Authority^{5,6,7,8} and Primary Care Trust^{9,10}, 2006/07¹¹

England		Numbers
		Total
England		6,743
North East Strategic Health Authority	Q30	262
County Durham PCT	5ND	70
Darlington PCT	5J9	29
Gateshead PCT	5KF	9
Middlesbrough PCT	5KM	26
Newcastle PCT	5D7	10
North Tees PCT	5E1	15
North Tyneside PCT	5D8	6
Northumberland Care Trust	TAC	21
Redcar and Cleveland PCT	5QR	33
South Tyneside PCT	5KG	9
Sunderland Teaching PCT	5KL	31
North West Strategic Health Authority	Q31	1,352
Ashton, Leigh and Wigan PCT	5HG	73
Blackburn With Darwen PCT	5CC	41
Blackpool PCT	5HP	61
Bolton PCT	5HQ	65
Bury PCT	5JX	52
Central and Eastern Cheshire PCT	5NP	30
Central Lancashire PCT	5NG	77
Cumbria PCT	5NE	33
East Lancashire Teaching PCT	5NH	75
Halton and St Helens PCT	5NM	58
Heywood, Middleton and Rochdale PCT	5NQ	55
Knowsley PCT	5J4	50
Liverpool PCT	5NL	208
Manchester PCT	5NT	131
North Lancashire PCT	5NF	42
Oldham PCT	5J5	38
Salford PCT	5F5	62
Sefton PCT	5NJ	24
Stockport PCT	5F7	43
Tameside and Glossop PCT	5LH	54
Trafford PCT	5NR	25
Warrington PCT	5J2	25
Western Cheshire PCT	5NN	9
Wirral PCT	5NK	22
Yorkshire & The Humber Strategic Health Authority	Q32	623
Barnsley PCT	5JE	135
Bradford and Airedale Teaching PCT	5NY	92
Calderdale PCT	5J6	14
Doncaster PCT	5N5	40
East Riding Of Yorkshire PCT	5NW	19
Hull Teaching PCT	5NX	30
Kirklees PCT	5N2	23
Leeds PCT	5N1	66
North East Lincolnshire PCT	5AN	7
North Lincolnshire PCT	5EF	12
North Yorkshire and York PCT	5NV	26
Rotherham PCT	5H8	49
Sheffield PCT	5N4	87
Wakefield District PCT	5N3	23

Table 4.3, continued... NHS hospital admissions^{1,2} where there was a primary diagnosis³ of drug related mental health and behavioural disorders⁴, by Strategic Health Authority^{5,6,7,8} and Primary Care Trust^{9,10}, 2006/07¹¹

England		Numbers
		Total
England		6,743
East Midlands Strategic Health Authority	Q33	552
Bassetlaw PCT	5ET	20
Derby City PCT	5N7	31
Derbyshire County PCT	5N6	73
Leicester City PCT	5PC	70
Leicestershire County and Rutland PCT	5PA	59
Lincolnshire Teaching PCT	5N9	47
Northamptonshire Teaching PCT	5PD	40
Nottingham City PCT	5EM	126
Nottinghamshire County Teaching PCT	5N8	85
West Midlands Strategic Health Authority	Q34	653
Birmingham East and North PCT	5PG	38
Coventry Teaching PCT	5MD	40
Dudley PCT	5PE	27
Heart Of Birmingham Teaching PCT	5MX	29
Herefordshire PCT	5CN	16
North Staffordshire PCT	5PH	35
Sandwell PCT	5PF	23
Shropshire County PCT	5M2	30
Solihull Care Trust	TAM	14
South Birmingham PCT	5M1	28
South Staffordshire PCT	5PK	57
Stoke On Trent PCT	5PJ	101
Telford and Wrekin PCT	5MK	47
Walsall Teaching PCT	5M3	19
Warwickshire PCT	5PM	95
Wolverhampton City PCT	5MV	30
Worcestershire PCT	5PL	24
East of England Strategic Health Authority	Q35	381
Bedfordshire PCT	5P2	12
Cambridgeshire PCT	5PP	40
East and North Hertfordshire PCT	5P3	32
Great Yarmouth and Waveney PCT	5PR	19
Luton PCT	5GC	18
Mid Essex PCT	5PX	37
Norfolk PCT	5PQ	30
North East Essex PCT	5PW	39
South East Essex PCT	5P1	30
South West Essex PCT	5PY	27
Suffolk PCT	5PT	30
West Essex PCT	5PV	27
West Hertfordshire PCT	5P4	37
London Strategic Health Authority	Q36	1,244
Barking and Dagenham PCT	5C2	16
Barnet PCT	5A9	30
Bexley Care Trust	TAK	28
Brent Teaching PCT	5K5	21
Bromley PCT	5A7	26
Camden PCT	5K7	19
City and Hackney Teaching PCT	5C3	38
Croydon PCT	5K9	76
Ealing PCT	5HX	21
Enfield PCT	5C1	59
Greenwich Teaching PCT	5A8	62
Hammersmith and Fulham PCT	5H1	22
Haringey Teaching PCT	5C9	49
Havering PCT	5A4	22
Hillingdon PCT	5AT	16
Hounslow PCT	5HY	26
Islington PCT	5K8	26
Kensington and Chelsea PCT	5LA	11
Kingston PCT	5A5	24
Lambeth PCT	5LD	128
Lewisham PCT	5LF	99
Newham PCT	5C5	42
Redbridge PCT	5NA	37
Richmond and Twickenham PCT	5M6	18
Southwark PCT	5LE	118
Sutton and Merton PCT	5M7	62
Tower Hamlets PCT	5C4	46
Waltham Forest PCT	5NC	17
Wandsworth PCT	5LG	59
Westminster PCT	5LC	23

Table 4.3 continued... NHS hospital admissions^{1,2} where there was a primary diagnosis³ of drug related mental health and behavioural disorders⁴, by Strategic Health Authority^{5,6,7,8} and Primary Care Trust^{9,10}, 2006/07¹¹

England		Numbers
		Total
England		6,743
South East Coast Strategic Health Authority	Q37	467
Brighton and Hove City PCT	5LQ	61
Eastern and Coastal Kent PCT	5QA	64
East Sussex Downs and Weald PCT	5P7	21
Hastings and Rother PCT	5P8	52
Medway PCT	5L3	35
Surrey PCT	5P5	109
West Kent PCT	5P9	65
West Sussex PCT	5P6	57
South Central Strategic Health Authority	Q38	359
Berkshire East PCT	5QG	27
Berkshire West PCT	5QF	23
Buckinghamshire PCT	5QD	13
Hampshire PCT	5QC	146
Isle Of Wight NHS PCT	5QT	24
Milton Keynes PCT	5CQ	12
Oxfordshire PCT	5QE	23
Portsmouth City Teaching PCT	5FE	79
Southampton City PCT	5L1	15
South West Strategic Health Authority	Q39	669
Bath and North East Somerset PCT	5FL	8
Bournemouth and Poole PCT	5QN	89
Bristol PCT	5QJ	16
Cornwall and Isles Of Scilly PCT	5QP	47
Devon PCT	5QQ	113
Dorset PCT	5QM	88
Gloucestershire PCT	5QH	108
Plymouth Teaching PCT	5F1	32
Somerset PCT	5QL	115
South Gloucestershire PCT	5A3	8
Swindon PCT	5K3	7
Torbay Care Trust	TAL	25
Wiltshire PCT	5QK	10

1. The data includes private patients treated in NHS hospitals (but not private patients in private hospitals)
2. A finished admission episode is the first period of in-patient care under one consultant within one healthcare provider. Please note that admissions do not represent the number of in-patients, as a person may have more than one admission within the year
3. The primary diagnosis is the first of up to 14 (7 prior to 2002-03) diagnosis fields in the Hospital Episode Statistics (HES) data set and provides the main reason why the patient
4. ICD-10 Codes F11-F16, F18, F19
5. SHA in which the patient is normally resident, based on the patient's postcode.
6. Counts include people resident in England Strategic Health Authorities only
7. Counts exclude admissions where the SHA of residence is unknown
8. Includes admissions where the residence was England but the PCT of residence is unknown
9. Some PCT's may have been removed from this table to protect patient confidentiality. This is due to the PCT having less than 6 admissions recorded over the year. However, the SHA totals and the main total still includes these numbers
10. Due to boundary and confidentiality issues, the sum of PCTs may add up to be different from the specified SHA total.
11. Figures have not been adjusted for shortfalls in data

Source:

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

Table 4.4 NHS hospital admissions^{1,2} where the primary³ or secondary diagnosis⁴ was of drug related mental health and behavioural disorders⁵, by age group, 1996/97 to 2006/07^{6,7,8,9}

England	Numbers								
	Total ¹⁰	Under 16	16-24	25-34	35-44	45-54	55-64	65-74	75+
1996/97	19,018	272	5,964	8,229	3,049	888	181	184	200
1997/98	21,596	262	6,743	9,752	3,339	976	219	114	154
1998/99	24,236	266	7,236	10,850	4,066	1,220	258	141	162
1999/00	24,974	273	7,028	11,027	4,634	1,363	271	144	196
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

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
3. The primary diagnosis is the first of up to 14 (7 prior to 2002-03) diagnosis fields in the Hospital Episode Statistics (HES) data set and provides the main reason why the patient was in hospital
4. ICD-10 Codes F11-F16, F18, F19
5. As well as the primary diagnosis, there are up to 13 (6 prior to 2002-03) secondary diagnosis fields in Hospital Episode Statistics (HES) that show other diagnoses relevant to the episode of care.
6. Counts include people resident in England Strategic Health Authorities only
7. Counts exclude admissions where the SHA of residence is unknown
8. Counts include admissions where the SHA or residence was England but not further specified
9. Figures have not been adjusted for shortfalls in data
10. Includes admissions where the age was unknown

Source:

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

Table 4.5 NHS hospital admissions^{1,2} where there was a primary³ or secondary diagnosis⁴ of drug related mental health and behavioural disorders⁵, by Strategic Health Authority^{6,7}, 2006/07⁸

England	Numbers			
	Total ⁹	Number of admissions per 100,000 of population ¹⁰	Male	Female
England^{11,12}	38,170	75	25,650	12,505
North East	2,153	84	1,394	759
North West	9,550	139	6,398	3,141
Yorkshire and the Humber	4,622	90	3,020	1,602
East Midlands	2,610	60	1,737	873
West Midlands	3,687	69	2,348	1,339
East of England	2,361	42	1,522	839
London	4,930	66	3,406	1,522
South East Coast	2,128	50	1,558	569
South Central	1,476	37	978	498
South West	3,637	71	2,460	1,176

1. The data includes private patients treated in NHS hospitals (but not private patients in private hospitals)
2. A finished admission episode is the first period of in-patient care under one consultant within one healthcare provider. Please note that admissions do not represent the number of in-patients, as a person may have more than one admission within the year
3. The primary diagnosis is the first of up to 14 (7 prior to 2002-03) diagnosis fields in the Hospital Episode Statistics (HES) data set and provides the main reason why the patient was in hospital
4. As well as the primary diagnosis, there are up to 13 (6 prior to 2002-03) secondary diagnosis fields in Hospital Episode Statistics (HES) that show other diagnoses relevant to the episode of care.
5. ICD-10 Codes F11-F16, F18, F19
6. Counts exclude admissions where the SHA of residence is unknown
7. SHA in which the patient is normally resident, based on the patient's postcode.
8. Figures have not been adjusted for shortfalls in data
9. Includes admissions where the gender was unknown
10. The number of admissions per 100,000 of population all ages use estimated resident population mid-2006 figures based on the 2001 census published by the Office for National Statistics (ONS). Information on ONS Population data is available at: <http://www.statistics.gov.uk/census2001/default.asp>
11. Includes admissions where the SHA or residence was England but not further specified
12. Counts include people resident in England Strategic Health Authorities only

Source:

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

Table 4.6 NHS hospital admissions^{1,2} where there was a primary³ or secondary diagnosis⁴ of drug related mental health and behavioural disorders⁵, by Strategic Health Authority^{6,7,8,9} and Primary Care Trust^{10,11}, 2006/07¹²

England		Numbers
		Total
England		38,170
North East Strategic Health Authority		
	Q30	2,153
County Durham PCT	5ND	323
Darlington PCT	5J9	114
Gateshead PCT	5KF	250
Hartlepool PCT	5D9	103
Middlesbrough PCT	5KM	244
Newcastle PCT	5D7	222
North Tees PCT	5E1	177
North Tyneside PCT	5D8	113
Northumberland Care Trust	TAC	171
Redcar and Cleveland PCT	5QR	148
South Tyneside PCT	5KG	77
Sunderland Teaching PCT	5KL	211
North West Strategic Health Authority		
	Q31	9,550
Ashton, Leigh and Wigan PCT	5HG	366
Blackburn With Darwen PCT	5CC	292
Blackpool PCT	5HP	367
Bolton PCT	5HQ	447
Bury PCT	5JX	228
Central and Eastern Cheshire PCT	5NP	355
Central Lancashire PCT	5NG	510
Cumbria PCT	5NE	291
East Lancashire Teaching PCT	5NH	496
Halton and St Helens PCT	5NM	452
Heywood, Middleton and Rochdale PCT	5NQ	396
Knowsley PCT	5J4	264
Liverpool PCT	5NL	1,558
Manchester PCT	5NT	927
North Lancashire PCT	5NF	254
Oldham PCT	5J5	286
Salford PCT	5F5	297
Sefton PCT	5NJ	387
Stockport PCT	5F7	269
Tameside and Glossop PCT	5LH	294
Trafford PCT	5NR	112
Warrington PCT	5J2	212
Western Cheshire PCT	5NN	113
Wirral PCT	5NK	387
Yorkshire & The Humber Strategic Health Authority		
	Q32	4,622
Barnsley PCT	5JE	385
Bradford and Airedale Teaching PCT	5NY	480
Calderdale PCT	5J6	142
Doncaster PCT	5N5	550
East Riding Of Yorkshire PCT	5NW	117
Hull Teaching PCT	5NX	454
Kirklees PCT	5N2	137
Leeds PCT	5N1	711
North East Lincolnshire PCT	5AN	128
North Lincolnshire PCT	5EF	117
North Yorkshire and York PCT	5NV	324
Rotherham PCT	5H8	333
Sheffield PCT	5N4	590
Wakefield District PCT	5N3	154

Table 4.6 continued... NHS hospital admissions^{1,2} where there was a primary³ or secondary diagnosis⁴ of drug related mental health and behavioural disorders⁵, by Strategic Health Authority^{6,7,8,9} and Primary Care Trust^{10,11}, 2006/07¹²

England		Numbers
		Total
England		38,170
East Midlands Strategic Health Authority	Q33	2,610
Bassetlaw PCT	5ET	179
Derby City PCT	5N7	214
Derbyshire County PCT	5N6	312
Leicester City PCT	5PC	314
Leicestershire County and Rutland PCT	5PA	218
Lincolnshire Teaching PCT	5N9	302
Northamptonshire Teaching PCT	5PD	222
Nottingham City PCT	5EM	437
Nottinghamshire County Teaching PCT	5N8	402
West Midlands Strategic Health Authority	Q34	3,687
Birmingham East and North PCT	5PG	302
Coventry Teaching PCT	5MD	98
Dudley PCT	5PE	246
Heart Of Birmingham Teaching PCT	5MX	357
Herefordshire PCT	5CN	117
North Staffordshire PCT	5PH	145
Sandwell PCT	5PF	193
Shropshire County PCT	5M2	109
Solihull Care Trust	TAM	96
South Birmingham PCT	5M1	305
South Staffordshire PCT	5PK	198
Stoke On Trent PCT	5PJ	492
Telford and Wrekin PCT	5MK	122
Walsall Teaching PCT	5M3	196
Warwickshire PCT	5PM	243
Wolverhampton City PCT	5MV	154
Worcestershire PCT	5PL	314
East of England Strategic Health Authority	Q35	2,361
Bedfordshire PCT	5P2	129
Cambridgeshire PCT	5PP	395
East and North Hertfordshire PCT	5P3	117
Great Yarmouth and Waveney PCT	5PR	118
Luton PCT	5GC	158
Mid Essex PCT	5PX	96
Norfolk PCT	5PQ	351
North East Essex PCT	5PW	126
Peterborough PCT	5PN	157
South East Essex PCT	5P1	133
South West Essex PCT	5PY	120
Suffolk PCT	5PT	257
West Essex PCT	5PV	99
West Hertfordshire PCT	5P4	105
London Strategic Health Authority	Q36	4,930
Barking and Dagenham PCT	5C2	121
Barnet PCT	5A9	117
Bexley Care Trust	TAK	76
Brent Teaching PCT	5K5	96
Bromley PCT	5A7	92
Camden PCT	5K7	256
City and Hackney Teaching PCT	5C3	194
Croydon PCT	5K9	193
Ealing PCT	5HX	144
Enfield PCT	5C1	164
Greenwich Teaching PCT	5A8	199
Hammersmith and Fulham PCT	5H1	170
Haringey Teaching PCT	5C9	157
Harrow PCT	5K6	49
Havering PCT	5A4	92
Hillingdon PCT	5AT	100
Hounslow PCT	5HY	89
Islington PCT	5K8	212
Kensington and Chelsea PCT	5LA	107
Kingston PCT	5A5	90
Lambeth PCT	5LD	443
Lewisham PCT	5LF	203
Newham PCT	5C5	174
Redbridge PCT	5NA	157
Richmond and Twickenham PCT	5M6	74
Southwark PCT	5LE	374
Sutton and Merton PCT	5M7	133
Tower Hamlets PCT	5C4	244
Waltham Forest PCT	5NC	134
Wandsworth PCT	5LG	126
Westminster PCT	5LC	150

Table 4.6 continued... NHS hospital admissions^{1,2} where there was a primary³ or secondary diagnosis⁴ of drug related mental health and behavioural disorders⁵, by Strategic Health Authority^{6,7,8,9} and Primary Care Trust^{10,11}, 2006/07¹²

England		Numbers
		Total
England		38,170
South East Coast Strategic Health Authority	Q37	2,128
Brighton and Hove City PCT	5LQ	369
Eastern and Coastal Kent PCT	5QA	232
East Sussex Downs and Weald PCT	5P7	174
Hastings and Rother PCT	5P8	181
Medway PCT	5L3	185
Surrey PCT	5P5	340
West Kent PCT	5P9	275
West Sussex PCT	5P6	367
South Central Strategic Health Authority	Q38	1,476
Berkshire East PCT	5QG	187
Berkshire West PCT	5QF	161
Buckinghamshire PCT	5QD	75
Hampshire PCT	5QC	457
Isle Of Wight NHS PCT	5QT	79
Milton Keynes PCT	5CQ	65
Oxfordshire PCT	5QE	165
Portsmouth City Teaching PCT	5FE	209
Southampton City PCT	5L1	83
South West Strategic Health Authority	Q39	3,637
Bath and North East Somerset PCT	5FL	87
Bournemouth and Poole PCT	5QN	277
Bristol PCT	5QJ	748
Cornwall and Isles Of Scilly PCT	5QP	213
Devon PCT	5QQ	409
Dorset PCT	5QM	278
Gloucestershire PCT	5QH	361
North Somerset PCT	5M8	162
Plymouth Teaching PCT	5F1	219
Somerset PCT	5QL	366
South Gloucestershire PCT	5A3	154
Swindon PCT	5K3	122
Torbay Care Trust	TAL	133
Wiltshire PCT	5QK	108

1. The data includes private patients treated in NHS hospitals (but not private patients in private hospitals)
2. A finished admission episode is the first period of in-patient care under one consultant within one healthcare provider. Please note that admissions do not represent the number of in-patients, as a person may have more than one admission within the year
3. The primary diagnosis is the first of up to 14 (7 prior to 2002-03) diagnosis fields in the Hospital Episode Statistics (HES) data set and provides the main reason why the patient was
4. As well as the primary diagnosis, there are up to 13 (6 prior to 2002-03) secondary diagnosis fields in Hospital Episode Statistics (HES) that show other diagnoses relevant to the episode of care.
5. ICD-10 Codes F11-F16, F18, F19
6. SHA in which the patient is normally resident, based on the patient's postcode.
7. Counts include people resident in England Strategic Health Authorities only
8. Counts exclude admissions where the SHA of residence is unknown
9. Includes admissions where the residence was England but the PCT of residence is unknown
10. Some PCT's may have been removed from this table to protect patient confidentiality. This is due to the PCT having less than 6 admissions recorded over the year. However, the SHA totals and the main total still includes these numbers
11. Due to boundary and confidentiality issues, the sum of PCTs may add up to be different from the specified SHA total.
12. Figures have not been adjusted for shortfalls in data

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

Table 4.7 NHS hospital admissions to hospital^{1,2} where there was a primary diagnosis³ of poisoning by drugs⁴, by age group, 1996/97 to 2006/07^{5,6,7,8}

England	Numbers								
	Total ⁹	Under 16	16-24	25-34	35-44	45-54	55-64	65-74	75+
1996/97	7,057	596	2,544	2,130	967	435	165	97	106
1997/98	7,365	595	2,600	2,242	1,098	418	183	96	107
1998/99	7,533	670	2,579	2,328	1,102	453	173	97	113
1999/00	7,695	670	2,454	2,361	1,205	562	185	94	149
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

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

Source:

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

Table 4.8 NHS hospital admissions to hospital^{1,2} where there was a primary diagnosis³ of poisoning by drugs⁴, by Strategic Health Authority^{5,6} and gender, 2006/07⁷

England	Numbers			
	Total ⁸	Number of admissions per 100,000 of population ⁹	Male	Female
England^{10,11}	10,047	20	5,491	4,554
North East	973	38	550	423
North West	2,184	32	1,184	998
Yorkshire and the Humber	1,211	24	641	570
East Midlands	795	18	425	370
West Midlands	938	17	565	373
East of England	660	12	342	318
London	960	13	547	413
South East Coast	673	16	347	326
South Central	530	13	260	270
South West	938	18	479	459

1. The data includes private patients treated in NHS hospitals (but not private patients in private hospitals)
2. A finished admission episode is the first period of in-patient care under one consultant within one healthcare provider. Please note that admissions do not represent the number of in-patients, as a person may have more than one admission within the year
3. The primary diagnosis is the first of up to 14 (7 prior to 2002-03) diagnosis fields in the Hospital Episode Statistics (HES) data set and provides the main reason why the patient was in hospital
4. ICD-10 Codes T40.0 - T40.9, T43.6
5. Counts exclude admissions where the SHA of residence is unknown
6. SHA in which the patient is normally resident, based on the patient's postcode.
7. Figures have not been adjusted for shortfalls in data
8. Includes admissions where the gender was unknown
9. The number of admissions per 100,000 of population all ages use estimated resident population mid-2006 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 Strategic Health Authorities only

Source:

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

Table 4.9 NHS hospital admissions^{1,2} where a primary diagnosis³ of poisoning by drugs⁴, by Strategic Health Authority^{5,6,7,8} and Primary Care Trust^{9,10}, 2006/07¹¹

England		Numbers
		Total
England		10,047
North East Strategic Health Authority	Q30	973
County Durham PCT	5ND	181
Darlington PCT	5J9	46
Gateshead PCT	5KF	86
Hartlepool PCT	5D9	32
Middlesbrough PCT	5KM	89
Newcastle PCT	5D7	123
North Tees PCT	5E1	52
North Tyneside PCT	5D8	58
Northumberland Care Trust	TAC	93
Redcar and Cleveland PCT	5QR	58
South Tyneside PCT	5KG	31
Sunderland Teaching PCT	5KL	124
North West Strategic Health Authority	Q31	2,184
Ashton, Leigh and Wigan PCT	5HG	111
Blackburn With Darwen PCT	5CC	81
Blackpool PCT	5HP	56
Bolton PCT	5HQ	87
Bury PCT	5JX	43
Central and Eastern Cheshire PCT	5NP	98
Central Lancashire PCT	5NG	127
Cumbria PCT	5NE	152
East Lancashire Teaching PCT	5NH	132
Halton and St Helens PCT	5NM	102
Heywood, Middleton and Rochdale PCT	5NQ	68
Knowsley PCT	5J4	38
Liverpool PCT	5NL	158
Manchester PCT	5NT	178
North Lancashire PCT	5NF	38
Oldham PCT	5J5	62
Salford PCT	5F5	94
Sefton PCT	5NJ	50
Stockport PCT	5F7	63
Tameside and Glossop PCT	5LH	87
Trafford PCT	5NR	53
Warrington PCT	5J2	75
Western Cheshire PCT	5NN	66
Wirral PCT	5NK	171
Yorkshire & The Humber Strategic Health Authority	Q32	1,211
Barnsley PCT	5JE	62
Bradford and Airedale Teaching PCT	5NY	155
Calderdale PCT	5J6	61
Doncaster PCT	5N5	38
East Riding Of Yorkshire PCT	5NW	44
Hull Teaching PCT	5NX	78
Kirklees PCT	5N2	77
Leeds PCT	5N1	236
North East Lincolnshire PCT	5AN	33
North Lincolnshire PCT	5EF	26
North Yorkshire and York PCT	5NV	166
Rotherham PCT	5H8	77
Sheffield PCT	5N4	63
Wakefield District PCT	5N3	95

Table 4.9 continued... NHS hospital admissions^{1,2} where a primary diagnosis³ of poisoning by drugs⁴, by Strategic Health Authority^{5,6,7,8} and Primary Care Trust^{9,10}, 2006/07¹¹

England		Numbers
		Total
England		10,047
East Midlands Strategic Health Authority	Q33	795
Bassetlaw PCT	5ET	12
Derby City PCT	5N7	61
Derbyshire County PCT	5N6	160
Leicester City PCT	5PC	112
Leicestershire County and Rutland PCT	5PA	85
Lincolnshire Teaching PCT	5N9	96
Northamptonshire Teaching PCT	5PD	137
Nottingham City PCT	5EM	52
Nottinghamshire County Teaching PCT	5N8	74
West Midlands Strategic Health Authority	Q34	938
Birmingham East and North PCT	5PG	81
Coventry Teaching PCT	5MD	51
Dudley PCT	5PE	53
Heart Of Birmingham Teaching PCT	5MX	115
Herefordshire PCT	5CN	14
North Staffordshire PCT	5PH	14
Sandwell PCT	5PF	58
Shropshire County PCT	5M2	39
Solihull Care Trust	TAM	21
South Birmingham PCT	5M1	143
South Staffordshire PCT	5PK	47
Stoke On Trent PCT	5PJ	23
Telford and Wrekin PCT	5MK	38
Walsall Teaching PCT	5M3	45
Warwickshire PCT	5PM	64
Wolverhampton City PCT	5MV	19
Worcestershire PCT	5PL	113
East of England Strategic Health Authority	Q35	660
Bedfordshire PCT	5P2	34
Cambridgeshire PCT	5PP	87
East and North Hertfordshire PCT	5P3	47
Great Yarmouth and Waveney PCT	5PR	35
Luton PCT	5GC	24
Mid Essex PCT	5PX	29
Norfolk PCT	5PQ	117
North East Essex PCT	5PW	40
Peterborough PCT	5PN	21
South East Essex PCT	5P1	34
South West Essex PCT	5PY	21
Suffolk PCT	5PT	116
West Essex PCT	5PV	21
West Hertfordshire PCT	5P4	34
London Strategic Health Authority	Q36	960
Barking and Dagenham PCT	5C2	20
Barnet PCT	5A9	29
Bexley Care Trust	TAK	19
Brent Teaching PCT	5K5	26
Bromley PCT	5A7	30
Camden PCT	5K7	35
City and Hackney Teaching PCT	5C3	36
Croydon PCT	5K9	33
Ealing PCT	5HX	33
Enfield PCT	5C1	32
Greenwich Teaching PCT	5A8	27
Hammersmith and Fulham PCT	5H1	35
Haringey Teaching PCT	5C9	29
Harrow PCT	5K6	13
Havering PCT	5A4	29
Hillingdon PCT	5AT	34
Hounslow PCT	5HY	30
Islington PCT	5K8	39
Kensington and Chelsea PCT	5LA	19
Kingston PCT	5A5	18
Lambeth PCT	5LD	82
Lewisham PCT	5LF	32
Newham PCT	5C5	30
Redbridge PCT	5NA	34
Richmond and Twickenham PCT	5M6	12
Southwark PCT	5LE	40
Sutton and Merton PCT	5M7	31
Tower Hamlets PCT	5C4	40
Waltham Forest PCT	5NC	37
Wandsworth PCT	5LG	31
Westminster PCT	5LC	25

Table 4.9 continued... NHS hospital admissions^{1,2} where a primary diagnosis³ of poisoning by drugs⁴, by Strategic Health Authority^{5,6,7,8} and Primary Care Trust^{9,10}, 2006/07¹¹

England		Numbers
		Total
England		10,047
South East Coast Strategic Health Authority	Q37	673
Brighton and Hove City PCT	5LQ	116
Eastern and Coastal Kent PCT	5QA	160
East Sussex Downs and Weald PCT	5P7	54
Hastings and Rother PCT	5P8	34
Medway PCT	5L3	39
Surrey PCT	5P5	92
West Kent PCT	5P9	91
West Sussex PCT	5P6	86
South Central Strategic Health Authority	Q38	530
Berkshire East PCT	5QG	40
Berkshire West PCT	5QF	28
Buckinghamshire PCT	5QD	38
Hampshire PCT	5QC	175
Isle Of Wight NHS PCT	5QT	21
Milton Keynes PCT	5CQ	22
Oxfordshire PCT	5QE	95
Portsmouth City Teaching PCT	5FE	67
Southampton City PCT	5L1	45
South West Strategic Health Authority	Q39	938
Bath and North East Somerset PCT	5FL	43
Bournemouth and Poole PCT	5QN	61
Bristol PCT	5QJ	139
Cornwall and Isles Of Scilly PCT	5QP	84
Devon PCT	5QQ	103
Dorset PCT	5QM	32
Gloucestershire PCT	5QH	90
North Somerset PCT	5M8	29
Plymouth Teaching PCT	5F1	64
Somerset PCT	5QL	79
South Gloucestershire PCT	5A3	35
Swindon PCT	5K3	46
Torbay Care Trust	TAL	38
Wiltshire PCT	5QK	95

1. The data includes private patients treated in NHS hospitals (but not private patients in private hospitals)
2. A finished admission episode is the first period of in-patient care under one consultant within one healthcare provider. Please note that admissions do not represent the number of in-patients, as a person may have more than one admission within the year
3. The primary diagnosis is the first of up to 14 (7 prior to 2002-03) diagnosis fields in the Hospital Episode Statistics (HES) data set and provides the main reason why the patient was in hospital
4. ICD-10 Codes T40.0 - T40.9, T43.6
5. SHA in which the patient is normally resident, based on the patient's postcode.
6. Counts include people resident in England Strategic Health Authorities only
7. Counts exclude admissions where the SHA of residence is unknown
8. Includes admissions where the residence was England but the PCT of residence is unknown
9. Some PCT's may have been removed from this table to protect patient confidentiality. This is due to the PCT having less than 6 admissions recorded over the year. However, the SHA totals and the main total still includes these numbers
10. Due to boundary and confidentiality issues, the sum of PCTs may add up to be different from the specified SHA total.
11. Figures have not been adjusted for shortfalls in data

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

Table 4.10 NDTMS¹ clients in treatment, by gender and age², 2006/07

England	Numbers / percentages ³					
	Total		Male		Female	
All ages	195,464	100	140,077	100	55,387	100
Under 16 years	6,342	3	4,298	3	2,044	4
16-17	7,338	4	5,208	4	2,130	4
18-19	6,295	3	4,204	3	2,091	4
20-24	23,636	12	15,716	11	7,920	14
25-29	39,428	20	27,884	20	11,544	21
30-34	39,924	20	29,262	21	10,662	19
35-39	32,861	17	24,334	17	8,527	15
40-44	21,238	11	15,738	11	5,500	10
45-49	10,102	5	7,445	5	2,657	5
50+	8,300	4	5,988	4	2,312	4

1. National Drug Treatment Monitoring System

2. Age is calculated at year midpoint (30th September 2006)

3. Percentages given in the tables 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 2006 - 31 March 2007. National Treatment Agency for Substance Misuse (NTA)

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Table 4.11 Main problem drugs of clients in treatment, by age¹ 2006/07

England	Numbers / percentages ²					
	All ages		Under 18 years		18 or over	
Total	193,715	100	15,355 ³	100	178,360 ³	100
Heroin	118,270	61	965	6	117,305	66
Methadone	10,852	6	30	0	10,822	6
Other Opiates	5,469	3	41	0	5,428	3
Benzodiazepines	2,164	1	47	0	2,117	1
Amphetamines	5,852	3	375	2	5,477	3
Cocaine	10,794	6	716	5	10,078	6
Crack	10,845	6	181	1	10,664	6
Hallucinogens	240	0	35	0	205	0
Ecstasy	1,052	1	477	3	575	0
Cannabis	24,669	13	11,582	75	13,087	7
Solvents	506	0	317	2	189	0
Barbiturates	22	0	0	0	22	0
Major tranquilisers	22	0	<5	0	<22	0
Anti-depressants	301	0	<5	0	<301	0
Other drugs	799	0	44	0	755	0
Poly use; no details	390	0	77	1	313	0
Drug Free at triage	1,468	1	463	3	1,005	1
<i>Missing / inconsistent data</i>	1,749		52		1,697	
<i>Total including missing / inconsistent data</i>	195,464		15,410 ³		180,060 ³	

1. Age at triage

2. Percentages given in the tables are rounded to the nearest per cent. Totals may not add up to 100 due to rounding

3. Figure rounded to the nearest 5

'<' is used where figures are less than 5 and is used to suppress exact corresponding figures to prevent young people figures being derived

Source:

Statistics from the National Drug Treatment Monitoring System (NDTMS) 1 April 2006 - 31 March 2007. National Treatment Agency for Substance Misuse (NTA)

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Table 4.12 Discharge reasons for completed episodes reported to NDTMS¹, 2006/07

England	Numbers / percentages ²	
Total (episodes discharged)	119,629	100
Total Successful completions	52,186	44
Referred on	22,821	19
Treatment completed	20,329	17
Treatment completed drug free	9,036	8
Dropped out/ left	39,988	33
Prison	8,172	7
Treatment withdrawn/ breach of contract	4,992	4
Moved away	3,480	3
No appropriate treatment available	992	1
Died	765	1
Other	6,335	5
Not known ³	2,719	2
<i>Missing / inconsistent data</i>	140	
<i>Total including missing / inconsistent data</i>	119,769	

1. National Drug Treatment Monitoring System

2. Percentages given in the tables are rounded to the nearest per cent.

3. Where the provider recorded that they did not know the reason for the discharge. Totals may not add up to 100 due to rounding

Source:

Statistics from the National Drug Treatment Monitoring System (NDTMS) 1 April 2006 - 31 March 2007. National Treatment Agency for Substance Misuse (NTA)

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Table 4.13 People in treatment by Government Office Region and age¹ reported to NDTMS^{2,3}, 2006/07

England		Numbers / percentages ⁴								
	England	North East	North West	Yorkshire and The Humber	East Midlands	West Midlands	East of England	London	South East	South West
All ages	209,486	12,177	39,240	27,871	15,578	21,388	14,318	38,133	19,828	20,953
Under 16 years	3	4	4	2	3	2	2	4	4	2
16-17	4	4	3	2	4	4	3	4	5	3
18-19	3	3	3	2	4	4	4	3	4	3
20-24	12	18	8	13	16	17	13	9	12	12
25-29	21	28	15	26	26	25	20	16	20	21
30-34	21	21	22	25	21	20	21	17	19	22
35-39	17	12	22	16	14	14	16	18	16	17
40-44	11	6	14	8	7	8	11	14	11	11
45-49	5	2	5	3	3	3	6	8	5	5
50 and over	4	2	4	2	3	3	4	7	5	4

1. Age is calculated at year midpoint (30th September 2006)

2. National Drug Treatment Monitoring System

3. Regional figures derived by summing figures for their constituent Partnership Areas. England figures derived by summing the Regional figures; hence movement of clients between Partnership Areas results in multiple counting of individuals

4. Percentages given in the tables 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 2006 - 31 March 2007. National Treatment Agency for Substance Misuse (NTA)

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Table 4.14 Number of deaths related to drug misuse¹ by gender and age group, 1993-2006²

England and Wales													Numbers	
	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
Total	829	958	1,089	1,156	1,312	1,457	1,628	1,604	1,805	1,613	1,432	1,495	1,608	1,573
Males														
All ages	577	718	840	936	1,041	1,142	1,321	1,329	1,450	1,269	1,118	1,177	1,260	1,250
Under 20	39	47	55	53	75	74	74	53	56	49	40	26	29	36
20-29	224	292	341	385	456	453	477	456	503	482	353	346	336	338
30-39	167	213	253	297	299	379	502	492	537	479	456	480	521	481
40-49	75	97	115	125	140	176	179	239	247	167	187	197	239	270
50-69	44	44	51	44	51	41	64	68	71	75	63	108	114	103
70 and over	28	25	25	32	20	19	25	21	36	17	19	20	21	22
Females														
All ages	252	240	249	220	271	315	307	275	355	344	314	318	348	323
Under 20	11	15	13	19	15	24	19	21	20	21	13	18	12	14
20-29	46	40	58	60	82	77	83	64	97	81	72	80	66	70
30-39	42	47	63	48	47	87	80	72	89	84	87	77	107	92
40-49	40	38	31	29	46	52	39	48	62	63	55	64	83	56
50-69	53	52	42	30	43	41	41	38	45	58	51	47	53	63
70 and over	60	48	42	34	38	34	45	32	42	37	36	32	27	28

1. As defined by the headline indicator on drug misuse - see Appendix A for further information

2. Data in this table have been compiled based on deaths registered in each calendar year. Previous years have been based on deaths occurring in each calendar year

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

Source:

Health Statistics Quarterly 36. The Office for National Statistics (ONS)

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Table 4.15 Number of deaths related to drug misuse¹ by gender and underlying cause of death, 1993-2006

England and Wales	Numbers													
	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
Males														
Mental and behavioural disorders due to drug use ²	185	252	304	398	438	562	654	656	735	685	629	631	682	639
Accidental poisoning by drugs ³	226	313	380	359	435	405	451	452	472	379	312	364	389	426
Intentional self-poisoning/ poisoning of undetermined intent ⁴	162	149	156	174	159	168	212	207	231	195	175	177	184	180
Assault by drugs ⁵	4	4	0	5	9	7	4	14	12	10	1	5	5	5
Females														
Mental and behavioural disorders due to drug use ²	46	45	54	68	79	107	103	90	124	109	126	117	122	100
Accidental poisoning by drugs ³	69	77	75	67	72	90	102	85	108	106	75	78	103	114
Intentional self-poisoning/ poisoning of undetermined intent ⁴	136	116	119	84	119	115	100	99	119	124	112	123	121	107
Assault by drugs ⁵	1	2	1	1	1	3	2	1	4	5	1	0	2	2

1. As defined by the headline indicator on drug misuse - see Appendix A for further information

2. Excludes alcohol and tobacco. The ICD-10 codes used to calculate this are F11-F16, F18-F19

3. Includes accidental poisoning by medicaments and biological substances. The ICD-10 codes used to calculate this are X40-X44;

4. Includes intentional self-poisoning/ poisoning by medicaments and biological substances. The ICD-10 codes used to calculate this are X60-

5. Includes assault by medicaments and biological substances. The ICD-10 codes used to calculate this are X85

Source:

Health Statistics Quarterly 36. The Office for National Statistics (ONS)

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Appendix A: Key sources

- [The British Crime Survey](#)
- [Crime and Justice Survey](#)
- [Drug Harm Index](#)
- [Drug Misuse in Scotland](#)
- [Drug Use, Smoking and Drinking among Young People in England](#)
- [Health Statistics Quarterly](#)
- [Hospital Episode Statistics](#)
- [Measuring different aspects of problem drug use: methodological developments](#)
- [Mental health of children and young people in Great Britain, 2004](#)
- [The National Drug Treatment Monitoring System](#)
- [The Unlinked Anonymous Prevalence Monitoring Programme](#)

The British Crime Survey

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

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

Results from the 2006/07 survey were published in October 2007. The figures in this report are based on interviews conducted between April 2006 and March 2007. A final sample size of 29,144 respondents completed the drugs module. In addition, the 2006/07 BCS had a youth boost of 2,089 extra 16 to 24 year olds.

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

The Misuse of Drugs Act classifies illegal drugs into three categories (Class A, B and C) according to the harm that they cause, with Class A drugs considered to be the most harmful.

Table A1 displays the drugs that respondents were asked about in the BCS and their classification under the Misuse of Drugs Act.

Table A1 Drugs asked about in the British Crime Survey and their classification under the Misuse of Drugs Act

Classification	Drug
Class A	Cocaine powder Crack cocaine Ecstasy LSD Magic Mushrooms Heroin Methadone
Class A/B	Amphetamines
Class B/C	Tranquillisers
Class C	Anabolic steroids Cannabis
Not Classified	Amyl Nitrate Glues (includes glue, solvents, gas or aerosols)

Amphetamines can be classified as either Class A (when prepared for injection) or Class B (in powdered form). For the purposes of calculating Class A drug use, the BCS assumes all reported amphetamine use to be of the Class B variety. Similarly, tranquillisers can either be classified as Class B (such as barbiturates) or Class C (such as benzodiazepines). Consequently, Class B and Class C drugs cannot be aggregated reliably because the survey does not identify which specific tranquilliser respondents used. The category 'not classified' indicates that possession of these substances is not illegal but it is an offence to supply these substances if it is likely that the product is intended for abuse.

Cannabis was reclassified from a Class B to a Class C drug on 29th January 2004. Following the Drugs Act 2005, raw magic mushrooms were classified as a Class A drug on 18th July 2005. Prior to this change in the law, only prepared magic mushrooms (such as dried or stewed) were classified as Class A drugs. The trend in Class A drug use has not been affected as magic mushrooms were categorised as Class A drugs previous to this change in the law.

There are several drug use variables reported in this publication which amalgamate use of individual drugs. These composite variables and the individual drug use variables that they include are outlined in Table A2.

Table A2 Composite drug variables

Composite	Individual drug use variables included
Any Cocaine	Cocaine powder, Crack cocaine
Hallucinogens	LSD, Magic mushrooms
Opiates	Heroin, Methadone
Class A	Cocaine powder, Crack cocaine, Ecstasy, Heroin, LSD, Magic mushrooms, Methadone
Any Drug	Amphetamines, Amyl nitrite, Anabolic steroids, Cannabis, Cocaine powder, Crack cocaine, Ecstasy, Glues, Heroin, LSD, Magic mushrooms, Methadone, Tranquilisers, Other pill, Other smoke, Other drug

The results from the BCS are weighted using calibration weighting which is designed to adjust for known differentials in response rates across age, gender and region. This weighting has been applied to results from 1996 onwards.

Questions on the frequency of drug use in the year prior to interview were first asked to 16 to 24 year olds in the 2002/03 BCS. These questions are used to monitor progress on the young people's target of the Government's Drug Strategy. Frequent use is defined as taking any illicit drug more than once a month during the previous year. This can also include those people who have taken two different types of drugs frequently.

Data from several of the Drug Misuse Declared publications for can be found in chapter 2.

- Ethnicity and drug use: key findings from the 2001/2002 British Crime Survey. Available at: www.homeoffice.gov.uk/rds/pdfs2/r209.pdf
- Drug Misuse Declared: Findings from the 2003/04 British Crime Survey. Available at: www.homeoffice.gov.uk/rds/pdfs05/hosb0405.pdf
- Drug Misuse Declared: Findings from the 2005/06 British Crime Survey. Available at: www.homeoffice.gov.uk/rds/pdfs07/hosb1807.pdf
- Drug Misuse Declared: Findings from the 2006/07 British Crime Survey. Available at: www.homeoffice.gov.uk/rds/pdfs07/hosb1807.pdf
- A limited number of the figures from the 2006/07 Drug Misuse Declared report have been updated to 2007/08 in: Crime in England and Wales: Findings from the 2007/08 British Crime Survey and police recorded crime. Available at: www.homeoffice.gov.uk/rds/pdfs08/hosb0708.pdf

Crime and Justice Survey

The 2003 Crime and Justice Survey (CJS) is a self-report offending survey of the general household population aged 10 to 65 in England and Wales. The survey provides a unique picture of the extent and nature of offending across this age range. The report 'Drug use

among vulnerable groups of young people' uses information from the 2003 CJS and focuses on drug use amongst vulnerable groups in the 10 to 24 age range.

The 2003 C&JS had a nationally representative sample of 10,079 respondents aged 10 to 65 years living in private households in England and Wales. The response rate was 74%. The 2003 CJS included a booster sample of 10 to 25 year olds also with a 74% response rate. The total sample of 10 to 25 year olds, including those in the core sample, was 4,574.

The CJS and the Offending Crime and Justice Survey (OCJS) are the same survey; after the first sweep of the CJS (in 2003) the name of the survey was changed to OCJS in order to emphasise its strong focus on offending behaviour. Information regarding OCJS can be found near the end of the appendix.

The questionnaire used in the survey has remained the same since 2003, the only methodological change being in 2003 the survey covered those aged between 10 and 65 years, whereas from 2004 only those aged between 10 and 25 were included.

Data from the 'Drug use among vulnerable groups of young people' report which uses findings from the 2003 C&JS can be found in chapter 2.

Offending in England and Wales: First results from the 2003 Crime and Justice Survey. Available at: www.homeoffice.gov.uk/rds/pdfs05/hors275.pdf

Drug use among vulnerable groups of young people: findings from the 2003 Crime and Justice Survey. Available at: www.homeoffice.gov.uk/rds/pdfs05/r254.pdf

Drug Harm Index

The Drug Harm Index (DHI) was developed in order to measure the Public Service Agreement to 'reduce the harm caused by illegal drugs' including substantially increasing the number of drug misusing offenders entering treatment through the criminal justice system. The DHI captures the harms generated by the problematic use of any illegal drug. Harms include drug-related crime, community perceptions of drug problems, drug nuisance, and the various health consequences that arise from drug abuse (e.g. HIV, overdoses, deaths etc).

www.homeoffice.gov.uk/rds/pdfs05/rdsolr2405.pdf

Drug Misuse in Scotland

This report presents the findings on self-reported drug use from the 2006 face-to-face Scottish Crime and Victimization Survey (SCVS). The principle focus of the SCVS is to monitor the extent of the victimisation in Scotland by asking respondents about their experiences of personal and household crime. In addition to this focus on experience of victimisation, there is a self-completion module at the end of the survey where respondents aged 16 to 59 are asked about their use of illicit drugs. The self-completion module has been a feature of the survey since the first sweep in 1993. The 2006 SCVS achieved a final sample size of 4,701.

Data from the Drug misuse in Scotland can be found in chapter 2.

Drug Misuse in Scotland: Findings from the 2006 Scottish Crime and Victimization Survey. Available at: www.scotland.gov.uk/Resource/Doc/198856/0053157.pdf

Drug Use, Smoking and Drinking among Young People in England

Between 1982 and 2003, surveys of secondary school children in England were carried out for the Department of Health; by the Office of Population Census and Surveys (OPCS) between 1982 and 1994, by the Office for National Statistics (ONS) between 1994 and 1999 and by the National Centre for Social Research (NatCen) and the National Foundation for Educational Research (NFER) between 2000 and 2003. Since 2004, the survey has been run by NatCen and NFER on behalf of The NHS Information Centre for Health and Social Care.

From 1982 to 1988, the survey was solely concerned with monitoring trends of young people and smoking. In 1988, questions on alcohol consumption were added and have been included in the survey ever since. The 1998 survey was also expanded to include questions on drug use. The core of the questionnaire comprises of questions about the prevalence of drug use, smoking and drinking. Since 2000, the remainder of the questionnaire focuses, in alternate years, on either smoking and drinking or drug taking. The most recent survey in the series is Smoking, Drinking and Drug Use among Young People in England in 2007 (SDD07), which focused on drug taking.

The target population for the survey is secondary school children in England, in years 7 to 11, from almost all types of school (comprehensive, secondary modern, grammar and other secondary schools), both state and public. Only special schools and hospital schools are excluded from the survey.

The survey uses a stratified design in which every eligible child has an equal chance of inclusion in the study. The survey is conducted using a confidential questionnaire, which the pupils fill in individually. Fieldwork of the most recent survey (SDD07) was carried out during the autumn term of 2007 and 273 schools agreed to take part in the survey, resulting in more than 7,831 completed questionnaires.

Table A3 lists the specific drugs which pupils were asked about in the survey and gives their classification under the Misuse of Drugs Act. This Act divides controlled drugs into three categories according to the level of harm associated with them. Class A drugs are considered to cause the most harm. SDD 07 reports on the prevalence of Class A drug use, although the following notes should be considered about the definition of Class A drug use and its reporting in the survey.

Table A3 Drugs asked about in the Smoking, Drinking and Drug Use among Young People in England and their classification under the Misuse of Drugs Act

Classification	Drug	Mode of use
Class A	Amphetamines	inject
Class A	Cocaine	sniff or inject
Class A	Crack	inject or smoke
Class A	Ecstasy	oral
Class A	Heroin	smoke, sniff or inject
Class A	LSD	oral
Class A	Magic Mushrooms ¹	oral
Class A	Methadone	oral
Class B	Amphetamines	sniff or oral
Class B/C	Tranquillisers	oral or inject
Class C	Anabolic steroids	oral or inject
Class C	Cannabis ²	smoke or oral
Class C	Ketamine	oral, sniff or inject
It is an offence to supply these substances if it is likely that the product is intended for abuse	Poppers	sniff
	Gas ³	sniff
	Glue ³	sniff

1. Raw magic mushrooms were classified as Class A drugs on 18th July 2005. Until that date, magic mushrooms were only classified as Class A if prepared (e.g. dried or stewed)

2. Cannabis was reclassified from a Class B to a Class C drug on 29th January 2004

3. It is illegal for shopkeepers to sell gas lighter refills to anyone under 18, and it is illegal to sell gases, glues and aerosols to under-18s, or people acting for them, if they suspect the product is intended for abuse

The classification of certain drugs depends on the method of delivery used. For example, amphetamines are a Class B drug if taken orally and a Class A drug if injected. Additional questions have been included in the survey from 2001 onwards to allow this distinction to be made, but in previous surveys amphetamines were not defined as a Class A drug.

The Drugs Act 2005 classified raw magic mushrooms as Class A drugs; this came into force on 18th July 2005. This was the first survey in the series since the change in the law. Previously, magic mushrooms were Class A drugs only if prepared, for example dried or stewed. The survey questionnaire has never made the distinction and magic mushrooms have always been counted as Class A drugs in the analysis.

The Class A drugs mentioned in the survey (speed and other amphetamines when injected, ecstasy, cocaine, crack, heroin, LSD, magic mushrooms, methadone) are not an exhaustive list of Class A drugs.

The questions used to monitor drug taking were changed in 2001. Since then, pupils have been asked a series of questions about each drug, whereas in previous years pupils were asked to look at a long list of drugs and then answer questions about which drugs they had heard of, been offered or had taken. Evidence from cognitive testing suggests that pupils find

answering questions on a long list of drugs more difficult than answering a series of questions on each individual drug. The wording of the questions were also changed so that pupils were asked whether they had ever “tried” rather than “used” drugs as there is evidence that pupils were interpreting the term “using” with being a regular user. Given the revision of the questionnaire, estimates from 2001 onwards are not comparable with estimates from previous surveys.

Other changes to the wording of the questionnaire include questions relating to amphetamines referred to ‘Speed and other Amphetamines’ in previous years. Further testing suggested that young people had a lack of awareness to the term ‘amphetamine’, and young people may have known the drug as ‘speed’. The decision was taken to alter the questions’ wording for the 2004 questionnaire to include the term ‘speed’. With the changes in questionnaire, data are not strictly comparable with estimates from 2003 and before.

Also in 2005, in response to a number of mentions of ketamine and GHB in the ‘Other drugs’ questions in 2003 and 2004, the questionnaire was reviewed. Following further testing with young people, ketamine was added to the list of drugs asked about. GHB was not added to the list.

Questions about the first and most recent occasions on which pupils took drugs were changed in 2003. Specifically, the new wording made clear that the definition of drugs included sniffing glue or other solvents. The definition of the last occasion of drug use was revised in the 2003 report. First-time users of drugs were excluded to avoid overlap with the ‘first occasion’ analysis. Additionally, the reference period was extended from the last month to the last year, to include a broader range of drug users. As a result of these changes, the analysis of trend data in this survey uses different bases from the analysis of the SDD05 data. More details of these changes are provided in SDD05.

Logistic regression was used to explore how certain characteristics of pupils could affect their drug use in the last year and the last month. This evaluation method allows analysts to view the strength of correlation between two factors i.e. how much influence units of alcohol drunk has on the odds of taking drugs in the last year or month.

Data from SDD07 can be found in chapter 3.

- Smoking, Drinking and Drug Use among Young People in England in 2007:
Available at: www.ic.nhs.uk/pubs/sdd07fullreport

Health Statistics Quarterly

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

annual death registrations files, being based on all deaths that were registered in the year, regardless of when they occurred, can be closed earlier (April following the year end) and are always complete.

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

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

a) deaths where the underlying cause of death has been coded to the following categories of mental and behavioural disorders due to psychoactive substance use (excluding alcohol, tobacco and volatile solvents):

- (i) opioids (F11);
- (ii) cannabinoids (F12);
- (iii) sedatives or hypnotics (F13);
- (iv) cocaine (F14);
- (v) other stimulants, including caffeine (F15);
- (vi) hallucinogens (F16); and
- (vii) multiple drug use and use of other psychoactive substances (F19)

b) deaths coded to the following categories *and* where a drug controlled under the Misuse of Drugs Act 1971 was mentioned on the death record:

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

Data from this publication can be found in chapter 4.

Health Statistics Quarterly 36. The Office for National Statistics, 2008. Available at: www.statistics.gov.uk/downloads/theme_health/HSQ36.pdf

Hospital Episode Statistics

NHS hospital admissions in England have been recorded using the Hospital Episode Statistics (HES) system since April 1987. 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. Data in this bulletin are presented in financial years.

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 4 are as follows:

Admissions for mental and behavioural disorders due to psychoactive substance use

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

Admissions for primary diagnosis of poisoning by drugs

- T40 Poisoning by narcotics and psychodysleptics (Hallucinogens)
 - 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)
- T43.6 Poisoning by psychostimulants with abuse potential

Some caution is necessary when looking at these data as, drug misuse may only be suspected and may not always be recorded by the hospital and, where drug misuse is recorded it may not be possible to identify when drug(s) may be involved.

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

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

HES data on hospital admissions can be found in chapter 4.

Measuring different aspects of problem drug use: methodological developments

An understanding of the extent of drug use and its impact on different aspects of society is key to the development of appropriate policies for tackling the problem and monitoring the impact of interventions and services. However, the illegal nature of drug use and supply makes the use of traditional approaches to estimating the extent of the problems inappropriate; for example, the most problematic users lead chaotic lives so that they are unlikely to be represented in the household surveys which provide a measure of drug use in the general population. The Updated Drug Strategy 2002 drew on the information sources that were available at the time. However, these had limitations in terms of their coverage, the time periods covered and their ability to provide any local level information.

Therefore a programme of research was commenced to address these information limitations and a number of feasibility studies investigated alternative methods for measuring the size of the drug use problem from different perspectives. A number of reports have therefore been published by the Home Office that consider suitable estimation methods and give estimates of the number of problematic drug users, the size of the market for illicit drugs and the economic and social costs of class A drug use. These studies provided estimates which were the best available at the time, but they were conceived as a starting point for further developments and hence also identified a number of ways in which they needed to be improved.

Further work was commissioned to build on these early studies and to provide more robust estimates on which to base and monitor drug interventions. The results of these new studies are brought together in the 'Measuring different aspects of problem drug use: methodological developments' report. The estimates they provide will allow policy-makers and those involved in providing interventions and services to move away from reliance on the less robust and incomplete estimates from the earlier studies and to move towards more regular production of these basic data for planning and evaluation.

www.homeoffice.gov.uk/rds/pdfs06/rdsolr1606.pdf

This report is an update of 'The economic and social costs of Class A drug use in England and Wales, 2000'

This research study provides estimates of the economic and social costs of Class A drug use in England and Wales for the year 2000. This was the first real attempt at assigning monetary values of Class A drug misuse to society. Estimates of the total number of users of Class A drugs are presented as well on numbers in different groups.

www.homeoffice.gov.uk/rds/pdfs2/hors249.pdf

Mental health of children and young people in Great Britain, 2004

Mental Health of Children and Young People in Great Britain, 2004 carried out by the Office for National Statistics on behalf of the Department of Health and the Scottish Executive provides information about the prevalence of mental disorders among young people aged 5 to 16 in Great Britain living in private households. The survey examines the relationship between mental disorder and aspects of children's lives, including the prevalence of drug use. It was carried out between March and June 2004 and a sample size of around 8,000 children and young people aged 5 to 16 was achieved. It also provides profiles of children in each of the main disorder categories; emotional, conduct, hyperkinetic and autistic spectrum disorders, including comparisons with drug taking.

The report uses the term 'mental disorders' as defined by the International Classification of Diseases, tenth revision (ICD-10).

Data from Mental Health of Children and Young People can be found in chapter 3.

The Mental Health of Children and Young People in Great Britain is available at: www.statistics.gov.uk/downloads/theme_health/GB2004.pdf

The National Drug Treatment Monitoring System

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

The National Drug Treatment Monitoring System (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 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 National Treatment Agency for Substance Misuse (NTA) for publication. The most recent full report available is Statistics from the National Drug Treatment Monitoring System (NDTMS) 1 April 2006 – 31 March 2007. The analysis for 2006/07 is based on data provided to the National Drug Treatment Monitoring System up to 30th September 2006.

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

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

Information from the NDTMS reports can be found in chapter 4.

Statistics from the National Drug Treatment Monitoring System (NDTMS) 1 April 2006 - 31 March 2007. Available at:

www.nta.nhs.uk/areas/facts_and_figures/0506/docs/ndtms_stat_report%2005_06_11.06.08.pdf

Drug treatment activity in 2006/07. Available at:

www.nta.nhs.uk/areas/facts_and_figures/national_statistics.aspx

The Unlinked Anonymous Prevalence Monitoring Programme

The Unlinked Anonymous Prevalence Monitoring Programme (UAPMP), which began in 1990 and has tested nearly eight million samples, aims to measure the distribution of unrecognised (i.e. undiagnosed) infection, particularly HIV, in accessible groups of the adult population. In recent years, over 600,000 samples are irreversibly unlinked from patient identifying information and tested for HIV infection annually.

The programme provides estimates of the prevalence of HIV, hepatitis B and hepatitis C infection, among groups in whom a substantial proportion of infections are undiagnosed and therefore not ascertained by other surveillance systems. The data obtained are used to target and evaluate health promotion, to inform estimates of the numbers requiring treatment and care in the future, and to plan services for those affected by HIV/AIDS and chronic hepatitis.

As part of the UAPMP, a survey of injecting drug users was carried out. Voluntary unlinked anonymous saliva samples were collected from injecting drug users in contact with over 50 specialist agencies throughout England, Wales & Northern Ireland. These agencies provided a range of services from medical treatment to needle exchange and outreach work. The saliva specimens were tested for antibodies to HIV, hepatitis C and hepatitis B core antigen.

Behavioural information was also collected through a brief anonymous questionnaire linked to the specimen but unlinked to client identifying information. This included questions on previous HIV testing and the sharing of injecting equipment. This survey does not extend to Scotland where other methods of surveillance are used.

Data from the UAPMP can be found in chapter 4.

The Unlinked Anonymous Prevalence Monitoring Programme (UAPMP). The Health Protection Agency. Available at:

www.hpa.org.uk/web/HPAwebFile/HPAweb_C/1204186219334

Appendix B: Government policy and targets

Public Service Agreement 14 and 25

In April 2008, the government agreed to new Public Service Agreements (PSAs) which envisaged a long-term and sustainable reduction in the harms associated with drugs.

The government's main aims in these PSAs is to reduce the harm caused by Alcohol and Drugs and increase the number of children and young people on the path to success.

PSA 25 centres around the following three strands underpinned by new national alcohol and drugs strategies;

- Reducing the harms caused to the development, achievement and well-being of young people and families;
- Reducing the harms caused to the health and well-being of drug users and those using alcohol in harmful ways; and
- Reducing the harms caused to the community as a result of associated crime, disorder and anti-social behaviour.

The PSA 14 delivery agreement provides the basis for realising the government's vision for young people, that they should have access to the right opportunities and support so that they:

- Succeed in education and learning;
- Develop resilience and wider social and emotional skills;
- Can make a real contribution to their communities and wider society;
- Are physically, mentally and emotionally healthy; and
- Grow up in a safe and supportive environment.

The children's plan: building brighter futures, TSO, 2007 can be found at: www.dfes.gov.uk/publications/childrensplan/

Public Service Agreement 14 can be found at: www.hm-treasury.gov.uk/media/0/7/pbr_csr07_psa14.pdf

Public Service Agreement 25 can be found at: www.hm-treasury.gov.uk/media/A/4/pbr_csr07_psa25.pdf

'Drugs: protecting families and communities'

This year the government introduced a new ten year strategy which aims to restrict the supply of illegal drugs and the demand for them. The strategy comprises 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
- drugs.homeoffice.gov.uk/publication-search/drug-strategy/drug-strategy-2008-2018

Updated Drug Strategy 2002

The Updated Drug Strategy launched in December 2002, aimed to build upon the original drugs strategy to improve its effectiveness. It concentrates on policies and interventions to reduce the harm that drugs cause to communities, individuals and families. There is 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 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.

www.drugs.gov.uk/publication-search/drug-strategy/updated-drug-strategy-2002.pdf?view=Binary

Tackling Drugs, Changing Lives

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

drugs.homeoffice.gov.uk/drug-strategy/

Priorities and Planning Framework 2003-2006

In 2002, the Department of Health published the Priorities and Planning Framework (PPF) which set out key targets for the NHS. An objective included in the PPF is to contribute to the delivery of the national drugs strategy by reducing the harmful effects of substance misuse. Specific targets that have been set are to:

- Reduce drug-related deaths by 20% by 2004 (against a 1999 baseline);
- Increase the participation of problem drug users in drug treatment programmes by 55% by 2004 and by 100% by 2008 (against 1998 baseline), and increase year on year the proportion of users by successfully sustaining or completing treatment programmes.

www.dh.gov.uk/assetRoot/04/07/02/02/04070202.pdf

NHS Plan

This is a Plan for reform with far reaching changes across the NHS. The purpose and vision of this NHS Plan is 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 are:

- 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;

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

Young People's substance misuse strategy

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

www.drugs.gov.uk/publication-search/young-people/every-child-matters.pdf?view=Binary

FRANK

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

www.talktofrank.com

Drug Intervention Programme

The Drug Intervention Programme (DIP) was set up in 2003 to develop and deploy processes to move drug-misusing offenders out of crime and into treatment. The Home Office and the Department for Education and Skills (DfES) share a target to reduce the use of Class A drugs and the frequent use of any drug among all young people under the age of 25, especially by the most vulnerable. DIP's pilots for children and young people contribute to the delivery of both this programme, and the overall Drug Strategy by, at various points of the youth justice system:

- Identifying children and young people who have, or are at risk of developing, substance misuse problems;
- Assessing their needs; and facilitating appropriate support and treatment services.

www.drugs.gov.uk/drug-interventions-programme/strategy/

The Misuse of Drugs Act

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

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

The Drugs Act

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

www.opsi.gov.uk/acts/acts2005/20050017.htm

Appendix C: Logistic regression

Logistic regression modelling was used in the 'Drug use, smoking and drinking report' to examine the factors associated with drug use after adjusting for other factors. Some results from this are presented in Chapter 3. The model included a variety of explanatory variables relating to both individual pupil characteristics (e.g. age, sex, smoking, drinking, drug use, family deprivation) and whole-school characteristics (e.g. whether the school is single sex or mixed, the percentage of pupils receiving free school meals, whether the school has a smoking policy for adults).

The explanatory variables include categorical variables (variables in which cases are grouped into a number of discrete categories) and continuous variables (continuous ranges of values). Missing values for explanatory variables were included in the model. For categorical variables, they were coded as a single category, though not reported on. For continuous variables, they were set as the mean value of the range.

The results of the regression analyses are presented in tables showing odds ratios for the final models, together with the probability that each association is statistically significant. The explanatory variable is significantly associated with the outcome variable if $p < 0.05$. (The p-values shown for each variable exclude missing values.)

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

Table 3.7 shows the results of the logistic regression. Variables which were not statistically significant are not shown in the table. The full list of variables can be found in the Drug use, Smoking and Drinking among young people in England in 2007.

Notes and references

- 1 Because these are ratios, they do not increase in a simple linear way. For example, compared with an 11 year old, the odds of a 12 year old using drugs in the last month are multiplied by 1.17 (see Section 2.13 in Drug use, Smoking and Drinking among young people in England, 2007). Similarly, compared with a 12 year old, a 13 year old's odds of using drugs in the last month are increased by 1.17 as well. The increase in the odds of being a regular smoker for a 13 year old compared with an 11 year old are $1.17 \times 1.17 (=1.37)$.

Appendix D: Editorial notes

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

These are as follows:

- .. not available
- zero
- 0 less than 0.5

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

Percentages do not always sum to 100 due to rounding.

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

The Home Office publication 'Drug Misuse Declared' provides percentages correct to 1 decimal place and this bulletin has followed the same convention in Chapter 2. Other conventions used for tables in Chapter 2 are:

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

Appendix E: Further information

This annual report draws together information on drug misuse among both adults and children (published 14th August 2008). This report forms part of a suite of statistical reports. Other reports cover smoking, drinking, obesity, physical activity and diet.

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

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

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

This report is available on the internet at:
www.ic.nhs.uk/pubs/drugmisuse08

The 2006 and 2007 reports, also published by The NHS 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:
www.dh.gov.uk/PublicationsAndStatistics/fs/en

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

The Arrestee Survey

The Arrestee Survey is the first nationally representative survey of drugs and crime among arrestees in England and Wales, the results of which were published in November 2006 and covers findings from October 2003 to September 2004. This first annual report provides an overview and baseline on many topics including the prevalence of problematic drug misuse among arrestees; links between drug and/or alcohol consumption and offending; availability of drugs; estimated levels of demand (met and/or unmet) for drug and alcohol treatment services among the arrestee population; levels of intravenous drug use among arrestees; and the characteristics and self-reported offending histories of individuals entering the Criminal Justice System.

The survey was carried out in a national sample of 60 custody suites. In total 7535 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: Oct 2003 – Sept 2004. Available at:
www.homeoffice.gov.uk/rds/pdfs06/hosb0406.pdf

Blueprint

Blueprint is the largest research programme ever run in this country, and aims to find out what works in teaching young people about drugs and drug use. Results of the research will be used to inform the development of drug education in England and build the worldwide evidence base.

drugs.homeoffice.gov.uk/young-people/blueprint/strategy/

Crime in England and Wales

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

www.homeoffice.gov.uk/rds/crimeew0405.html

Department of Health

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

www.dh.gov.uk/en/PublicHealth/Healthimprovement/Substancemisuse/index.htm

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

Provides statistics and publications for Northern Ireland.

www.dhsspsni.gov.uk/dmd_bulletin_2005-2006.pdf

Drug Action Teams

Drug action teams (DATs) are the partnerships responsible for delivering the drug strategy at a local level. DATs are partnerships combining representatives from local authorities (education, social services, housing) health, probation, the prison service and the voluntary sector. They ensure that the work of local agencies is brought together effectively and that cross-agency projects are co-ordinated successfully. Altogether there are 150 DATs in England, one for every top tier local authority area.

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

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

www.drugs.gov.uk/dat/dat/?version=1

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

www.drugs.gov.uk/treatment/strategy/pooled-treatment-budget/

Drugdrive

drugdrive.com 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.

www.drugdrive.co.uk

<http://www.thinkroadsafety.gov.uk/campaigns/drugdriving/drugdriving.htm>

Drug Education Forum

The Drug Education Forum brings together national organisations from health, education, police and voluntary sectors that deliver or support the delivery of drug education. The forum promotes the provision of effective drug education for all children for all children and young people in England.

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.

www.dur.ac.uk/ne.pho/index.php?c=241

Drug Misuse Information Scotland

The Drug Misuse Information Scotland (DMIST) website site 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

Drug Offenders in England and Wales

Drug Offenders in England and Wales is an annual statistical bulletin on known drug offences and offenders in England and Wales. The bulletin reports on police cautions, court proceedings and HM Revenue and Customs compounding (where payment is made of a compound settlement in lieu of prosecution for minor cannabis possession offences) for drug offences. The most recent edition of this bulletin, Drug Offenders in England and Wales 2004, was published in December 2005.

Due to the reclassification of cannabis from Class B to Class C, data in the bulletin for Class B and Class C offences are distorted and should not be compared with those of previous years.

As one offender can commit multiple offences, figures for individual drugs or type of offence cannot be added together to produce totals. In the offender statistics, the offender is recorded in the year in which he or she was sentenced which will, in many cases, not be the year in which the offence was committed.

Drug Offenders in England and Wales 2004. The Home Office. December 2005. Available at: <http://www.homeoffice.gov.uk/rds/pdfs05/hosb2305.pdf>

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/

There is a table available on the DrugScope website that shows the estimated prices of illicit drugs are in different areas of the UK.

www.drugscope.org.uk/resources/fags/fagpages/how-much-do-drugs-cost.htm

European Monitoring Centre for Drugs and Drug Addiction

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

www.emcdda.europa.eu/

European Monitoring Centre for Drugs and Drug Addiction statistical bulletin 2006.

The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) statistical bulletin 2006 is a companion publication to the EMCDDA annual report. The bulletin presents information on drug use using information provided by the European Union (EU) Member States and Norway, Bulgaria and Romania. Drug use in the general population is estimated through population surveys, based on representative probabilistic samples of the whole population under study. Most Member States have conducted representative national surveys during recent years, although in some cases sample sizes are limited.

Countries were asked to report results using, as far as possible, EMCDDA standard age groups (all adults: 15 to 64, young adults: 15 to 34). In countries where age ranges are more restrictive, prevalence estimates may tend to be slightly higher. Some countries have recalculated their prevalence figures using the EMCDDA standard age groups.

There are still differences across countries in survey context, data collection methods and sampling procedures. In addition to methodological questions, several factors can contribute to differences in overall national figures. A relative proportion of urban and rural population in each country may explain in part some overall national figures. Also national figures may be explained in part by generational factors, including the different rates of convergence between the lifestyles of young males and females. Social context can also influence self-reporting of drug use. Comparative analysis across countries should be made with caution, in particular where differences are small, and formulation and evaluation of drugs policy should take carefully into consideration concrete age groups, birth cohorts, gender and urbanisation, among other criteria.

EMCDA Statistical Bulletin 2006. European Monitoring Centre for Drugs and Drug Addiction. Available at: stats06.emcdda.europa.eu/en/home-en.html

European School Survey Project on Alcohol and Other Drugs (ESPAD) Report 2003

This is the third report published within the ESPAD project. It presents data on more than 100,000 European students in numerous diagrams and maps and around 150 tables. The surveys are planned to be repeated every fourth year, thus providing long-term data on changes in alcohol and drug consumption among young people. The next survey is due to be carried out in 2007.

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

As in earlier studies, the surveys were conducted with a standardised methodology and a common questionnaire to provide as comparable data as possible. Data were mainly collected during Spring 2003 and the target population was students born in 1987. Thus, the age group studied turned 16 during the year of data collection. At the time of the data collections the average age was 15.8 years.

Data were collected by group-administered questionnaires in schools on nationally representative samples of classes, except in Russia, Germany and Turkey where there were some restrictions. Students answered the questionnaires anonymously in the classroom under written test conditions. Samples sizes varied between countries, from 555 in Greenland to nearly 6,000 in Poland. Teachers or research assistants collected the data.

Data from the ESPAD Report 2003 is available at:

www.sedqa.gov.mt/pdf/information/reports_intl_espada2003.pdf

Healthcare Commission

Drug misusers accessing treatment is one of the eight key indicators used to assess the performance of Primary Care Trusts (PCTs) in England by the Healthcare Commission. The indicator is directly related to the PSA target of increasing the number of problematic drug users in treatment. The source of the data are Local Delivery Plans from PCTs and data from the National Drug Treatment Monitoring System (NDTMS). A national review published by the Healthcare Commission and the National Treatment for Substance Misuse ref covering 149 drug action teams (DATs) looked at whether local substance misuse services prescribe drugs safely and appropriately, as well as plan treatment and coordinate services well.

ratings2005.healthcarecommission.org.uk/Trust/Overview/pct_overview.asp

The impact and effectiveness of mandatory drug testing in prisons

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

The impact and effectiveness of mandatory drug testing in prisons. Available at:

www.homeoffice.gov.uk/rds/pdfs05/r223.pdf

Home Office: Research Development and Statistics Directorate (RDS)

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

rds.homeoffice.gov.uk/rds

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

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

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

National Assembly for Wales

Provides statistics and publications for Wales.

new.wales.gov.uk/topics/statistics/?lang=en

National Drug Strategy

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

www.drugs.gov.uk

National Institute for Clinical Excellence

On 1st April 2005 the Health Development Agency (HDA), and its associated services, joined with the National Institute for Clinical Excellence to become the National Institute for Health and Clinical Excellence (NICE). NICE is an independent organisation, responsible for providing national guidance on the promotion of good health and the prevention and treatment of ill health. Recent 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 Programme on Substance Abuse Deaths

An alternative source of data on drug related deaths to that 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 of drug related deaths in the UK and the six monthly surveillance report published by np-SAD is used as an indicator of the extent and nature of drug problems and misuse, and makes a

contribution towards the prevention of substance abuse problems. 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, as well procurator fiscal for Dumbarton, the Scottish Crime and Drug Enforcement Agency (SCDEA), and the General Register Office for Northern Ireland (GRONI) on drug related deaths that actually occurred in 2005.

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.

www.sgul.ac.uk/news/archive/reduction-in-the-number-of-drug--related-deaths.cfm

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.

www.nta.nhs.uk/publications/documents/nta_drug_treatment_crime_reduction_ntors_findings_2005_rb8.pdf

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 APHO). Their lead areas for the APHO are alcohol, substance use, violence, dental health and working with the health protection agency.

www.nwph.net/nwpho/default.aspx

The Offending, Crime and Justice Survey

The Offending, Crime and Justice Survey (OCJS) was commissioned by the Home Office to measure levels of self-reported offending, anti-social behaviour and drug use in the general household population in England and Wales, particularly among children and young adults. The survey does not cover young people living in institutions, including prisons, or the homeless, and thus omits some high offending groups.

The OCJS focuses on levels and trends in youth offending, anti-social behaviour (ASB) and victimisation among young people aged from 10 to 25 living in the general household population.

The 2005 OCJS sample comprised of respondents who had previously been interviewed in 2003, 2004 or both and a fresh sample of 10 to 25 year-olds. Eighty-four per cent of those first interviewed in 2003 and 82 per cent from those first interviewed in 2004 were interviewed in 2005 giving a total 'panel' sample of 4,421 people (4,164 were aged from 10 to 25 at the time of the 2005 interview). A total of 816 new respondents aged from 10 to 25 (70% response rate) were added to give an overall sample size of 4,980 aged from 10 to 25.

The 2005 OCJS results have been weighted to be nationally representative. Trends over time are based on the fresh sample data only to ensure direct comparability with previous waves of the survey.

The OCJS was designed to take on board lessons from previous self-report offending surveys and incorporates some innovative techniques to improve the quality of the data collected. However, it is subject to the some design and methodological issues which should be considered when interpreting the findings, such as sampling errors, non-response bias and exclusions from the survey, more details of which can be found in the survey report.

The OCJS report was originally named the Crime and Justice survey, information regarding this report can be found earlier in this appendix.

Young People and Crime: Findings from the 2005 Offending, Crime and Justice Survey. The Home Office. December 2006. Available at:

www.homeoffice.gov.uk/rds/pdfs06/hosb1706.pdf

A 2006 Offending, Crime and Justice Survey is expected to be published later this year.

Positive Futures

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

www.drugs.gov.uk/young-people/positive-futures/

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;
www.statistics.gov.uk/StatBase/Product.asp?vlnk=8258&Pos=4&ColRank=1&Rank=272
- Economic Activity and Social Functioning of Residents with Psychiatric Disorders. Office of Population Censuses and Surveys, 1996. (OPCS surveys of psychiatric morbidity in Great Britain;
www.statistics.gov.uk/STATBASE/Product.asp?vlnk=7990&More=Y
- The Prevalence of Psychiatric Morbidity Among Homeless Adults. Office of Population Censuses and Surveys, 1996. (OPCS surveys of psychiatric morbidity in Great Britain: bulletin 3);
www.esds.ac.uk/findingData/snDescription.asp?sn=3642
- 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

Scottish Executive

Provides statistics and publications for Scotland.

www.scotland.gov.uk/Publications

Seizures of Drugs

The Seizures of Drugs England and Wales 2004 publication presents figures for drug seizures made by law enforcement agencies in England and Wales during 2004. 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, together with information from HM Revenue and Customs and The National Crime Squad.

www.homeoffice.gov.uk/rds/pdfs06/hosb0806.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 also a free-phone national helpline: 0800 800 2345.

www.re-solv.org

Tobacco, Alcohol and Drug Use and Mental Health

The Office for National Statistics report on 'Tobacco, Alcohol and Drug Use and Mental Health', is based on a survey of psychiatric morbidity carried out between March and September 2000, among adults aged 16 to 74 living in private households in Britain. The report

specifically looks at tobacco, alcohol and other drug use and dependence and their relationship to psychiatric morbidity.

www.statistics.gov.uk/downloads/theme_health/Tobacco_etc_v2.pdf

UK Drug Situation report

The latest UK Drug Report: United Kingdom Drug Situation: 2005 edition, provides a comprehensive overview of the drug situation in the United Kingdom. Chapters cover the prevalence of drug use, legislative changes, trends in prevention and treatment, drugs and crime, social correlates of drug use, and many other new developments and trends.

www.nwph.net/nwpho/Publications/emcdda_2005_focalpoint.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

Young People's Substance Misuse Partnership Grant

The Young People Substance Misuse Partnership Grant is a ring-fenced grant to support the development and operation of responses to children and young people's drug use at local level in line with the Every Child Matters for Children: Young People and Drugs Guidance published in March 2005.

www.drugs.gov.uk/publication-search/young-people/YPSMPG-0506?view=Standard&pubID=254618

Statistics from the Northern Ireland Drug Misuse Database: 1 April 2006 – 31 March 2007

This bulletin summarises information on people presenting to services with problem drug misuse and relates to the 12-month period ending 31 March 2007. It is the sixth bulletin reporting on information collected through the Northern Ireland Drug Misuse Database (DMD), which was established in April 2000 and which collects detailed data, including information on drugs misused and injecting behaviour, on those presenting for treatment.

<http://www.dhsspsni.gov.uk/statistics-from-ni-drugs-misuse-database-01april06-31march07.pdf>

Appendix F: Drugs glossary

Amphetamines/ Speed

Speed is the street name for Amphetamine. Like coke it is a stimulant that people take to keep them awake and alert. It's often taken along with Ecstasy.

Also known as:

Amphetamine Sulphate, Phet, Billy, Whizz, Sulph, Base, Amphetamine, Paste, Dexamphetamine, Dexies, Dexedrine

Appearance and use

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

Amyl nitrate/ Poppers

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

Also known as:

Amyl nitrite, butyl nitrite, isobutyl nitrite, Ram, Thrust, Rock Hard, Kix, TNT, Liquid Gold

Appearance and use

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

Anabolic steroids

The male hormone, testosterone, is an anabolic steroid. The effects of the other anabolic steroids are often very similar to the effects of testosterone. The anabolic steroids can be used in medicine to treat anaemia and muscle weakness after surgery. They shouldn't be confused with the other main kind of steroids, corticosteroids, which are used to treat other medical conditions, such as asthma, eczema and skin inflammations.

Also known as:

Roids. Product names include Sustanon 250, Deca-Durabolin, Dianabol, Anavar, Stanozolol

Appearance and use:

Anabolic steroids can be bought as tablets to be swallowed or as a liquid which is injected.

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

Cannabis

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

Also known as:

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

Appearance and use:

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

Cocaine

Cocaine and crack are both stimulants with powerful, but short-lived effects. The main difference is that crack is much stronger and more addictive than cocaine.

Also known as:

Cocaine is also known as coke, charlie, C, white, Percy, snow, toot.

Appearance and use:

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

Crack

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

Also known as:

Crack is also known as rocks, wash, stones, pebbles, base, freebase.

Appearance and use:

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

Crystal meth

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

Also known as:

Methamphetamine, Methylamphetamine, Ice, Glass, Tina, Christine, Yaba, Crazy medicine.

Appearance and use:

Illicit methylamphetamine is produced in tablet, powder, or crystalline forms. These products are taken orally, snorted or can be prepared for injection, but unlike amphetamine, methylamphetamine can also be smoked. The powder is sometimes referred to as 'crystal meth', but this term is more often used for the purer crystalline form, also known as 'ice', 'glass', 'tina' and 'christine'. The tablet form is sometimes referred to as 'yaba'.

Ecstasy

The original designer drug, Ecstasy shot to fame in the early 90s as the rave culture took off and clubbers took it to stay awake and dance for hours. There's a lot of controversy about the long-term side effects of Ecstasy. Some evidence suggests it can damage the brain causing long-term problems.

Also known as:

Adam, E, pills, brownies, burgers, disco biscuits, hug drug, 'Mitsubishis', 'Rolexes', 'Dolphins', XTC

Appearance and use

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

Gases, glues and aerosols

Solvents cover a huge number of substances:

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

Also known as:

Gases, Aerosols, Glue, Thinners, Volatile Substances

Appearance and use:

All sorts of famous household names. Each contain different substances with different effects. Solvents are sniffed from a cloth, a sleeve or a plastic bag. Some users put a plastic bag over their heads and inhale that way. Gas products can be squirted directly into the back of the throat which makes it difficult to control the dose.

Most users are between 11 and 16.

GHB

GHB (Gamma hydroxy butyrate) is a dangerous drug which can cause grievous bodily harm. It's hard to tell the difference between a dose that gives a pleasant buzz and an overdose that could kill.

Also known as:

GHB, GBH, Liquid Ecstasy, gammahydroxybutrate.

Appearance and use

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

Heroin

Heroin is a natural opiate. It's made from the morphine which comes from the opium poppy. Like many drugs made from opium, including the synthetic opioids like methadone, heroin is a very strong painkiller. Heroin sold as 'brown' is sometimes used by clubbers as a 'chill out'. Brown is still heroin, some people mistakenly think it's not as addictive.

Also known as:

Smack, brown, skag, H, horse, gear,

Appearance and use

Heroin comes as a white powder when it's pure. But because of the range of substances it's 'cut with', street heroin can be anything from brownish white to brown.

It can be smoked, snorted or dissolved in water and injected.

Ketamine

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

Also known as:

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

Appearance and use:

Legally produced ketamine comes in liquid form which is injected. The illegally produced version usually comes as a grainy white powder which is snorted or bought as a tablet.

LSD

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

Also known as:

Acid, 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.

Appearance and use

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

Magic mushrooms

Magic Mushrooms are mushrooms which grow in the wild that produce similar effects to LSD when you eat them. There are two main types and they are both very different. The most common form is a species called psilocybe, the other more potent variety is amanita muscaria. There are deadly poisonous species of amanitas.

Also known as:

Mushies, magics, shrooms, liberties, liberty cap, fly agaric

Appearance and use:

Psilocybin mushrooms are small and tan coloured and bruise blue when they're touched. Amanita Muscaria are more like the red and white spotted toadstools in fairytale books. After picking, they're both either eaten raw or dried out and stored. Most people take between 1–5 grams.

Methadone

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

Also known as:

methadone mixture, meth, linctus, physeptone. Other synthetic opiates include: DF118 (dihydrocodeine), pethidine, diconal (containing dipipanone), palfium (dextromoramide) and temgesic or subutex (buprenorphine).

Appearance and use

The methadone that's prescribed to people trying to 'come off' heroin is usually a syrup which is swallowed. Pethidine, dihydrocodeine (DF118s), diconal, palfium, temgesic and also some types of methadone come in tablet or injectable form.

Effects can start quickly and can last several hours but this varies with how much is taken and how much the drug is taken.

Tranquillisers

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

Also known as:

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

Appearance and use:

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

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