Statistics on Drug Misuse: England, 2009

The NHS Information Centre
is England's central, authoritative source
of health and social care information.

Acting as a 'hub' for high quality, national,
comparative data, we deliver information for
local decision makers, to improve the quality
and efficiency of care.

www.ic.nhs.uk

Contents

Executive Summary

This annual statistical report presents a range of information on drug misuse amongst both adults and children. It also includes a focus on young adults. The report is primarily concerned with the use of illicit drugs. The term 'illicit drugs' is used to describe those drugs that are controlled under the *Misuse of Drugs Act 1971*.[1] The topics covered include:

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

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

Chapter 1: Adult Drug Misuse reports on the prevalence of drug misuse among adults and the types of drugs most commonly used. Relationships between drug use and other socio-demographic and lifestyles factors are also explored. The chapter also focuses on young adults (aged 16- 24). Figures for England and Wales presented in Chapter 1 have been obtained from *Drug Misuse Declared: Findings from the 2008/09 British Crime Survey, The Home Office, 2009.*

Chapter 2: Child Drug Misuse focuses on the prevalence of drug misuse among children (mostly aged 11 – 15). It also explores the relationship between drugs and other socio-demographic factors and includes information on behaviours, knowledge, and attitudes towards drug taking. Figures presented in Chapter 2 have been obtained from *Smoking, Drinking and Drug Use among Young People in England in 2008*, *The NHS Information Centre, 2009*.

Chapters 1 and 2 have been significantly reduced from last year's Drug Misuse report in order to provide an overview of the key findings from these sources, whilst maintaining useful links to each section of the reports. The figures presented include three separate measures of drug misuse based on ever having used drugs, use of drugs in the last year, and use in the last month.

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

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

Main findings:

Drug misuse among adults (16 - 59 years)

In England and Wales:

- In 2008/09, 10.1% of adults had used one or more illicit drug within the last year, compared with 9.6% in 2007/08. However, over the longer term this shows an overall decrease from 11.1% in 1996.

- In 2008/09, 3.7% of adults had used Class A drugs in the last year, compared with 3.0% in 2007/08. Over the longer term this also shows an increase from 2.7% in 1996.

- Consistent with previous findings, cannabis is the type of drug most likely to be used by adults; 7.9% of 16-59 year olds used cannabis in the last year in 2008/09.

- There have been some decreases over the longer term in the use of non-Class A drugs; between 1996 and 2008/09 use of cannabis, amphetamines and anabolic steroids within the last year among adults declined.

Drug misuse among young adults (16 – 24 years)

In England and Wales:

- In 2008/09, around 22.6% of young adults had used one or more illicit drug in the last year, which shows no change from 2007/08. This shows a long term decrease from 1996 when it was 29.7%.

- In 2008/09, 8.1% of young adults had used Class A drugs in the last year, compared with 6.9% in 2007/08. Over the long term, Class A drug use among young people has stabilised since 1996.

- Cannabis remains the drug most likely to be used by young people; 18.7% of respondents aged 16-24 had used cannabis in the last year in 2008/09.

Drug misuse among children (11 - 15 years)

In England:

- There has been an overall decrease in drug use reported by 11- 15 year olds since 2001. The prevalence of lifetime drug use fell from 29% in 2001 to 22% in 2008.

- There were also decreases in the proportion of pupils who reported taking drugs in the last year; from 20% in 2001 to 15% in 2008.

- Reported drug use was more common among older pupils; for example, 4% of 11 year olds said they had used drugs in the last year, compared with 29% of 15 year olds in 2008.

- Cannabis was the most widely used drug in 2008; 9.0% of pupils reported taking it in the last year, a long term decrease from 13.4% in 2001.

- Pupils who had truanted or been excluded from school were more likely to report taking drugs at least once a month than those who had not truanted or been excluded (11% and 1% respectively) in 2008.

- There was an overall decrease in the proportion of pupils being offered drugs from 42% in 2001 to 33% in 2008. Cannabis was the most commonly offered drug followed by volatile substances and poppers.

- Older pupils were more likely to have been offered drugs, with 11% of 11 year olds having been offered them compared with 57% of 15 year olds in 2008.

Health outcomes

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

In England (unless otherwise stated):
- In 2008/09, there were 5,668 admissions to hospital with a primary diagnosis of a drug-related mental health and behavioural disorder. This number is 15.1% less than in 2007/08 when there were 6,675 admissions. There were more male than female admissions (3,997 and 1,671 respectively).

- Where primary or secondary diagnosis was recorded there were 42,170 admissions in 2008/09 compared with 40,421 in 2007/08, which shows an increase of 4.3%. There were more male than female admissions in 2008/09 (28,289 and 13,875 respectively).

- Where a primary diagnosis of poisoning by drugs was recorded, 11,090 admissions were reported during 2008/09, an increase of 47.2% from 1998/99 when the number of such admissions was 7,533. This has remained stable since 2007/08. There were more male than female admissions (6,076 and 5,014 respectively).

- The Strategic Health Authorities (SHAs) with the most admissions for drug related mental health and behaviour disorders as the primary or secondary diagnosis were North West SHA (155 admissions per 100,000 population) and Yorkshire and The Humber SHA (98 admissions per 100,000 population).

- During 2008/09, there were 207,580 people in contact with structured drug treatment services (those aged 18 and over). This is a 10.4% increase from the 2007/08 figures, where the number was 187,978.

- In 2008/09, a larger number of men accessed treatment services than women (151,064 men compared to 56,516 women aged 18 or over).

- Those taking opiates only (which includes heroin) was the main type of drug for which people received treatment (48% of all treatments), with a further 31% of treatments for those who have taken both opiates and crack in 2008/09.

- There were 60,386 discharged episodes of treatment by the end of 2008/09 and there were 24,656 (41%) of clients exiting treatment who were no longer dependent on the substances that brought them into treatment; a further 9,002 (15%) were referred on for further interventions outside of community-structured treatment.

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

Introduction

This report presents a range of information on drug misuse among both adults and young people, which has been drawn together from a variety of sources. The information relates to England wherever possible. Where information for England only is not available, information for 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*.[1] This legislation regulates controlled drugs and divides the drugs into three classes, depending on the harm they cause. For example, Class A drugs cause the most harm and include cocaine, ecstasy, heroin and Lysergic acid diethylamide (LSD); Class B includes amphetamines and cannabis; and Class C includes tranquilisers and Gammahydroxybutrate (GHB). Under the Act there are various offences, including the unlawful possession of a controlled substance. Each source included in this report may monitor the use of illicit drug use using a slightly different selection of drugs, and may name or group them differently. Relevant details are provided in the associated chapter and/ or **Appendix A**.

The government published a revised Public Service Agreement (PSA)*, PSA Delivery Agreement 25 in June 2009, to reduce the harm caused by alcohol and drugs.[2] PSA 25 aims to reduce the harms caused by drugs and alcohol to (a) the community as a result of associated crime, disorder and anti-social behaviour, (b) the health and well-being of those who use drugs or drink harmfully and (c) the development and well-being of young people and families. Several indicators have been developed to monitor progress against PSA 25 including; increasing the number of drug users in effective treatment, reducing the rate of drug-related offending and perceptions of drug use being a problem to society.

A related PSA, *PSA Delivery Agreement 14*[3]*: Increase the number of children and young people on the path to success, 2007,* contains an indicator to reduce the proportion of young people frequently using illicit drugs, alcohol or volatile substances.

The 2008-2018 *Drug Strategy*[4] aims to reduce the harm that drugs cause to society, to communities, individuals and their families and comprises four strands of work:

- protecting communities through tackling drug supply, drug-related crime and anti-social behaviour.

- preventing harm to children, young people and families affected by drug misuse.

- delivering new approaches to drug treatment and social re-integration.

- public information campaigns, communications and community engagement.

Previous government strategies in this area, including the *2002 Updated Drug Strategy,*[5] have also focused on reducing the harm caused by illegal drug use and in particular had the aim to '*reduce the use of Class A drugs and the frequent use of any illicit drug by all young people under the age of 25, especially by the most vulnerable groups*'.

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

Chapter 2 focuses on the prevalence of drug misuse among children and again, explores the relationships between drug use and various socio-demographic factors. As well as presenting overall prevalence figures, this chapter also informs about behaviour, knowledge and attitudes towards drug taking among children using information from the 2008 Smoking, Drinking and Drug Use Survey.

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

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

References

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

2. PSA Delivery Agreement 25: Reduce the harm caused by Alcohol and Drugs. HM Government, 2009: Available at: www.hm-treasury.gov.uk/d/pbr_csr07_psa25.pdf

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

4. The Drugs Strategy. The Home Office, 2008. Available at: drugs.homeoffice.gov.uk/drug-strategy/

5. Updated Drugs Strategy 2002. The Home Office, 2004. Available at: www.crimereduction.gov.uk/drugsalcohol/drugsalcohol60.htm

1. Drug misuse among adults

1.1 Introduction

This chapter presents information on the prevalence of drug misuse among adults. The main source used in this chapter is the *British Crime Survey (BCS)* publication: *Drug Misuse Declared: Findings from the 2008/09 British Crime Survey*. This particular publication on *Drug Misuse Declared* covers information for England and Wales[1] combined.

Since 1996 the *BCS* has included a comparable self completion module of questions on illicit drug use. The *BCS report* examines the prevalence and trends of illicit drug use among 16-59 year olds since 1996. This report also has a particular focus on young people aged 16-24.

More specifically, the survey asked respondents about drug use as defined by *The Misuse of Drugs Act*[2] and also examined the prevalence of illicit drug use. Key trends in the use of different drugs and the number of drug users were estimated.

There are three separate measures in the survey based on ever having used drugs, use of drugs in the last year and use in the last month. The *BCS report* also shows information from the latest year and longer term trends from 1996 and some short term trends comparing 2007/08 to 2008/09.

This chapter presents a range of drug misuse information covering the general population (16-59 year olds), young adults (16-24 year olds), demographics and polydrug use.

1.2 General population

Chapter 2 on pages 5-17 of the *BCS report* provides estimates of the numbers and the proportion of 16-59 year olds who have used illicit drugs.

Figure 2.1 on page 6 shows the percentages of 16-59 year olds who have used Class A drugs or any illicit drug either ever, in the last year or in the last month for 2008/09.

Figures 2.2-2.5 on pages 7-10 show the proportion of drugs used in the last year for 16-59 year olds by various drug breakdowns or as a time series.

The proportion of 16-59 year olds reporting having ever used drugs, used drugs in the last year or used drugs in the last month from 1996-2008/09 can be found in **Tables 2.1-2.3** (on pages 12-14). Related information on the actual numbers reporting such drug use for 2008/09 can be found in **Tables 2.4-2.6** (on pages 15-17).

The key findings from **Chapter 2** of the *BCS report* show that:

- Around one in three (36.8%) had ever used illicit drugs, one in ten had used drugs in the last year (10.1%) and around one in 20 (5.9%) had done so in the last month.

- Levels of Class A drug use were, unsurprisingly, lower than overall drug use, with 15.6% having used a Class A drug at least once in their lifetime, 3.7% having done so in the last year and 1.8% in the last month.

- Consistent with previous findings, cannabis is the type of drug most likely to be used; 7.9% of 16-59 year olds used cannabis in the last year.

- Use of any illicit drug during the last year has shown an overall decrease from 11.1% in 1996 to 10.1% in 2008/09, due in part to successive declines in the use of cannabis between 2003/04 and 2007/08.

- Despite this long-term overall decline, there has been an increase in the number 16-59 year olds who have used Class A drugs within the last year between 1996 (2.7%) and 2008/09 (3.7%).

- Class A drug usage has remained generally stable over this period: year-on-year changes were not statistically significant until most recently; however there was a slight underlying upward trend, which is now significant over the long term.

- The increase in Class A drug usage since 1996 can be understood in terms of an increase in the number of people who have used cocaine powder within the last year (from 0.6% to 3.0%), partly offset by a decrease over the same period in the use of LSD (from 1.0% to 0.2%).

- In 2008/09 methamphetamine was included for the first time but this has no visible impact on the overall prevalence of Class A drug use in that survey year.

- There have been some decreases over the longer term in the use of non-Class A drugs; between 1996 and 2008/09 use of cannabis, amphetamines and anabolic steroids within the last year among 16-59 year olds declined.

Looking at more recent years, key changes between 2007/08 and 2008/09 showed:

- The overall proportion of 16-59 year olds who have used any illicit drug within the last year remained stable (9.6% in 2007/08 compared with 10.1% in 2008/09) but there was an increase in Class A drug use within the last year (from 3.0% to 3.7%).

- For individual types of drug, increases were seen in the use within the previous year of cocaine powder, ecstasy, tranquillisers, anabolic steroids and ketamine.

1.3 Young people

Chapter 3 on pages 19-33 of the *BCS report* focuses on the use of illicit drugs by young people aged 16-24 years old.

Figure 3.1 on page 20 shows the percentages of 16-24 year olds who have used Class A drugs either in the last year, the last month or ever for 2008/09. Related information showing these percentages as a time series can be found in **Tables 3.1-3.3** on pages 27-29 and similar information showing actual numbers for 2008/09 can be found in **Tables 3.4- 3.6** on pages 30-32.

Figures 3.2-3.5 on pages 21-24 show the proportion of drugs used in the last year for 16-24 year olds by various drug breakdowns or as a time series. **Figure 3.6** on page 25 shows the proportion of this age group classified as frequent drug users as a time series. Related information on frequent drug use in the last year among 16-24 year olds can be found in **Tables 3.7 and 3.8** on page 33 as a time series for any drug and by drug type for 2008/09.

The key findings from **Chapter 3** of the *BCS report* show that:

- Around two in five young people (42.9%) have ever used illicit drugs, nearly one in four had used one or more illicit drugs in the previous year (22.6%) and around one in eight in the last month (13.1%).

- Levels of Class A drug use were, unsurprisingly, lower than overall drug use, with 16.9% of young people having ever used a Class A drug, 8.1% having done so within

the last year and 4.4% in the last month.

- Cannabis remains the drug most likely to be used by young people; 18.7% of respondents aged 16-24 had used cannabis in the previous year.

Long and short-term trends for young people aged 16-24 show:

- The proportion of 16-24 year olds having used drugs in the last year fell from 29.7% in 1996 to 22.6% in 2008/09, due in large part to the gradual decline in cannabis use. Latest figures show no change between 2007/08 and 2008/09.

- The general trend for having used Class A drugs in the last year for young people shows a slight decline since 1996.

- However, Class A drug use rose from 6.9% to 8.1% between 2007/08 and 2008/09; hence Class A drug use among young people is now stable over the long term. In 2008/09 methamphetamine was included for the first time but this has no visible impact on the overall prevalence of Class A drug use in that survey year.

Recent trends in types of drugs used show that between 2007/08 and 2008/09:

- There was an increase in use of cocaine powder within the last year (from 5.1% to 6.6%) and ketamine (from 0.9% to 1.9%).

- Use of methadone within the last year, and hence opiates, fell (these figures are based on small numbers).

1.4 Demographics

Chapter 4 on pages 35-53 of the *BCS report* focuses on demographic and socio-economic variations in drug use.

Figures 4.1- 4.6 on pages 36-40 show the proportions reporting use of any drug and Class A drugs in the last year by different age groups or gender from 1996-2008/09.

Related information for different age groups can be found in **Tables 4.5- 4.8** on pages 50 -53.

Figures 4.7 and 4.8 on pages 41-42 show levels of drug use compared with frequency of alcohol consumption and number of times visited a nightclub in the last month. Related information on the proportion of 16-59 and 16-24 year olds reporting having used drugs in the last year by personal, household and area characteristics can be found in **Tables 4.1-4.4** on pages 46-49.

Figure 4.9 on page 44 shows the proportion of 16-59 year olds reporting use of any drug or any Class A drug in the last year by ACORN[3] type.

The logistic regression model showing the relationship between different socio-economic characteristics and any illicit drug use in the last year can be found in **Table 4.9** on page 54.

The key findings from **Chapter 4** in the BCS report show that:

- The youngest age groups (16-19 and 20-24 year olds) reported the highest levels of drug use in the last year (22.2% and 22.9% respectively) compared with all older age groups.

- A broadly similar pattern can be seen for Class A drug use, but with the peak for drug use in the last year shifting slightly later to also include the 25-29 age group, with usage then decreasing with increasing age.

- Men continued to report higher levels (around twice as high) than women of drug use in the last year of any illicit drug or any Class A drug use.

Looking at trends since the survey began, the self-report drug use data collection in 1996 shows there is a decrease in drug use in the last year for the 16-19 year olds which decreased from 31.7% in 1996 to 22.2% in 2008/09 and, for those aged 20-24, fell from 28.1% to the latest figure of 22.9%.

In general, between 1996 and 2008/09, year-on-year changes in levels of Class A drug use in the last year use were not statistically significant until most recently; however, there was a slight underlying upward trend which is now significant over the long term.

There were increases in Class A drug use within the following age groups between 1996 and 2008/09: 25-29 year olds (3.9% to 8.4%), 30-34 year olds (1.9% to 5.2%) and 35-44 year olds (0.5% to 1.7%).

Looking at change over the last year:

- There were no statistically significant changes in prevalence of any drug use overall in the last year between 2007/08 and 2008/09 for any age group.

- There was a statistically significant rise between 2007/08 and 2008/09 in the proportion of 16-24 (6.9% to 8.1%), 25-29 (6.4% to 8.4%) and 30-34 year olds (3.8% to 5.2%) who took Class A drugs in the last year.

Use of any illicit drug in the last year among men aged 16-59 was fairly stable between 1996 and 2008/09, while for women usage fell from 8.6% to 7.0% over the same period. There were no significant changes in overall illicit drug use between 2007/08 and 2008/09 for either men or women aged 16-59.

Class A drug use in the last year among both men and women aged 16-59 has increased in both the long (since 1996) and short term (between 2007/08 and 2008/09).

Logistical regression was carried out to see which characteristics besides age and gender were independently associated with illicit drug use; lifestyle and related personal characteristics remain the strongest characteristics associated with patterns of illicit drug use in the last year, such as:

- marital status, in particular, being single;

- pub visits in the last month;

- being a victim of crime in the last 12 months.

1.5 Polydrug use among the general population

Chapter 5 on pages 55-71 of the *BCS report* focuses on the use of more than one illicit drug (polydrug use) in the last year among adults aged 16-59.

Figure 5.1 on page 57 shows the proportion of 16-59 year old drug users who have ever used drugs, have used them in the last year and used them in the last month by the number of drugs taken. **Figures 5.2 and 5.4** on pages 58-60 show similar information for illicit polydrug users and stimulant drug users.

Figure 5.5 shows the proportion of 16-59 year old drug users who have used drugs in the last year by frequency of pub visits and number of illicit drugs used. The proportions, prevalence and trends in the use of more than one drug by 16-59 year olds from 2006/07 to 2008/09 can be found in **Tables 5.1-5.4** on pages 63-66.

The personal, household and area characteristics of 16-59 year old drug users can be found in **Tables 5.5-5.8** on pages 67 -70.

The logistic regression model showing the relationship between socio-economic characteristics and illicit polydrug use in the last year can be found in **Table 5.9** on page 71.

Findings from **Chapter 5** of the *BCS report* show an overall prevalence rate of 4% for use of more than one illicit drug (polydrug use) in the last year amongst adults aged 16-59.

Of the adults who used any illicit drug in the last year, two out of five (40%) reported using more than one type of drug. Thus the majority of last year drug users only used one illicit drug.

Cannabis was taken by the majority of polydrug users who had used drugs in the last year (88%) but nevertheless, over half of cannabis users (56%) did not report using any other drug. Cocaine powder was the next most commonly-used drug for polydrug users (66%), while 44% took ecstasy and around a quarter (28%) took amphetamines in the last year, reflecting their relative prevalence rates.

For the commonly taken drugs that weren't cannabis, it was found that the majority of users (around 9 in 10) used at least one other drug as well in the last year (mainly cannabis or other stimulant drugs).

Just under half (45%) of those who used any stimulant drug in the last year reported using more than one type of stimulant drug.

Among the group using more than one type of stimulant drug, cocaine powder was most likely to be taken with nine in ten (89%) reporting using this in the last year and around eight in ten (78%) taking ecstasy in the last year.

The variation in personal, household and area characteristics relating to polydrug users was investigated with respect to those using three or more illicit drugs in the last year (a more 'extreme' group of polydrug users). It was found that:

- Drug users aged 16-34 were more likely to have used three or more illicit drugs in the last year compared with the older age groups.

- Male drug users were more likely to have taken three or more drugs in the last year than female users (22% compared with 18%).

- There was little difference between adult drug users who were single or cohabiting in terms of taking three or more illicit drugs in the last year (both 23%) and both groups were considerably more likely to take three or more illicit drugs than those who were married (married couples accounting for 8% of those who used three or more illicit drugs in the last year).

- The proportion of adult drug users who took three or more drugs in the last year increased with increasing frequency of pub or nightclub visits in the past month.

Logistic regression was carried out to see which characteristics were independently associated with polydrug use; lifestyle and related personal characteristics remain the strongest characteristics associated with patterns of illicit polydrug use in the last year, such as:

- nightclub and pub visits in the last month;

- being single, young, male and from a white ethnic group; and

- being a victim of crime in the last year.

References

1. Drug Misuse Declared: Findings from the 2008/09 British Crime Survey. The Home Office, 2009. Available at: http://www.homeoffice.gov.uk/rds/pdfs09/hosb1209.pdf

2. Misuse of Drugs Act. The Home Office, 1997: Available at:

drugs.homeoffice.gov.uk/drugs-laws/misuse-of-drugs-act/

3. ACORN is the leading geo-demographic tool used to identify and understand the UK population. Available at: http://www.caci.co.uk/ACORN/acornmap.asp

2. Drug misuse among children

2.1 Introduction

This chapter presents key information about illicit drug use among secondary school children in school years 7-11, mostly aged between 11-15. Information is taken from the *Smoking, Drinking and Drug use Survey among Young People in England*, covering the period September to December 2008 (*SDD08*).[1] 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 drug taking. The focus of the 2008 survey was smoking and drinking. The type of drugs asked about in the survey include those as defined by *The Misuse of Drugs Act.*[2]

Reducing drug use by young people was described by the Government as 'highest priority'. In particular, the Government hope to reduce the use of Class A drugs and the frequent use of any illicit drug by all people under the age of 25, and although this survey examines drug use by young people up to the age of 15, *The British Crime Survey*[3] (see **Chapter 1**) measures drug use among adults ages 16-59 with particular emphasis on young adults aged 16-24.

This chapter contains a range of information from *SDD08* on prevalence and frequency of drug use, drug use among vulnerable pupils, the availability and awareness of drugs, sources of helpful information about drugs, lessons about drugs, school policies on drugs and factors associated with drug use in the last year.

2.2 Prevalence and frequency of drug use

Chapter 4.2 on pages 128-131 and **Tables 4.1- 4.15** on pages 138-156 of the *SDD08* provides information on prevalence and frequency of pupils' drug use.

Figure 4.1 on page 129 shows the proportion of children who have used drugs: ever, in the last year; and in the last month, from 2001 to 2008. **Figure 4.2** also on page 129 presents the information by age for 2008.

Figures 4.3 and 4.4 on page 130 show proportions of pupils using the most common drugs as a time series or by age group. **Figure 4.5** on page 131 shows the frequency of drug use by age.

The key findings from **Chapter 4.2** of the *SDD08* show an overall decrease in drug use reported by 11-15 year olds since 2001. The prevalence of lifetime drug use fell from 29% in 2001 to 22% in 2008.

There were also decreases in the proportion of pupils who reported taking drugs in the last year (from 20% in 2001 to 15% in 2008) and in the last month (from 12% to 8%).

Similar proportions of boys and girls reported having ever used drugs and having used drugs in the last year. Boys were more likely than girls to have used drugs in the last month.

Reported drug use was more common among older pupils; for example, 4% of 11 year olds said they had used drugs in the last year, compared with 29% of 15 year olds.

Cannabis was the most widely used drug; 9.0% of pupils reported taking it in the last year, a long term decrease from 13.4% in 2001.

The prevalence of Class A drug use within the last year has remained relatively stable since 2001; in 2008 3.6% of pupils had used at least one Class A drug.

Three per cent of pupils said that they usually took drugs at least once a month. This is a smaller proportion than that reported in most previous survey years, though similar to that recorded in 2006.

2.3 Drug use among vulnerable pupils

Chapter 4.3 of the *SDD08* report and Tables 4.16- 4.17 (on pages 156 and 157) show information on drug use of vulnerable pupils as a time series (2003-2008). Vulnerable pupils are defined as those who had ever truanted or been excluded from school. Figure 4.6 on page 132 shows the proportion of pupils using drugs at least once a month by whether they were vulnerable pupils or not.

The key findings from Chapter 4.3 of the *SDD08* show that pupils who had truanted or been excluded from school were more likely to report taking drugs at least once a month than those who had not truanted or been excluded (11% and 1% respectively). The same trend can be seen for Class A drug use, with 12% of vulnerable pupils having used them in the last year compared to 1% of pupils who had not truanted or been excluded. The proportion of vulnerable pupils who were frequent drug users has seen an overall fall from 21% in 2003 to 11% in 2008.

2.4 Availability and awareness of drugs

Chapter 4.4 on page 132 and Tables 4.18-4.20 on pages 157-161 of the *SDD08* provide information on awareness of drugs and the availability of drugs by gender and age.

The drugs availability information can be found in Tables 4.18-4.19c showing the proportion of pupils who have been offered drugs and which drugs they have been offered. It is reported overall for 2001-2008 and broken down by age and gender.

Pupils' awareness of drugs information from 2001 to 2008 can be found in Table 4.20.

The key findings from Chapter 4.4 of *SDD08* show that in 2008 there was an overall decrease in the proportion of pupils being offered drugs when compared to 2001 (from 42% in 2001 to 33% in 2008). Cannabis was the most commonly offered drug followed by volatile substances and poppers.

Similar proportions of boys and girls have ever been offered drugs; it was found that older pupils were more likely to have been offered drugs, with 11% of 11 year olds having been offered them compared with 57% of 15 year olds.

Pupils displayed a high level of awareness of illegal drugs; with 94% having heard of cocaine (94%) heroin (92%) and cannabis (90%).

There was found to be no correlation between awareness of individual drugs and the prevalence of their use.

2.5 Sources of helpful information about drugs

Chapter 4.5 on page 133 and Tables 4.21-4.22 on page 162 of the *SDD08* provide information on sources of helpful information about drugs by gender and age.

The key findings from Chapter 4.5 of the *SDD08* states that when pupils were asked where they obtained helpful information about drugs, pupils were most likely to cite television (65%), teachers (64%) and parents (61%). Girls were found to report newspapers and magazines as helpful sources more often, whereas boys cited the police, their GP and other relatives.

2.6 Lessons about drugs

Chapter 4.6 on page 133 and Tables 4.23-4.27 on pages 162-164 of the *SDD08* provides information on recollection of lessons about drugs by gender, age and school year.

13

The proportion of pupils who remembered receiving lessons about drugs in the last year was reported by school year and the total recollection is compared from 1998 to 2008 in **Table 4.23**.

How pupils felt lessons on drugs had helped them by gender, school year and recent drug use can be seen in **Tables 4.25-4.27.**

It was reported in **Chapter 4.6** of *SDD08* that the proportion of pupils who remembered having lessons about any drug in the last year varied from year to year, with pupils in the later years being more likely to recall a lesson about drugs (44% in Year 7 compared with 74% of Year 10 pupils).

Ninety five per cent of pupils who recalled lessons about drugs said that the lesson had helped them think about the risks of taking drugs and 91% reported that lessons had helped them to find out more about them.

Most pupils felt that school lessons had helped them realise that taking drugs was against the law, and they should avoid taking drugs and to think what they would do if they were offered drugs (85%, 81% and 79% respectively).

2.7 School policies

Chapter 4.7 on page 133 and **Tables 4.28-4.29** on page 164 of the *SDD08* provide information on whether schools have drugs policies and actions taken for pupils caught using drugs on school premises.

The research outcomes in **Chapter 4.7** of *SDD08* state that in all the schools except one, pupils are taught about taking drugs (both illegal and prescribed) and 93% had written a policy to manage incidents involving pupils taking drugs.

The actions most commonly taken against pupils for taking drugs on school premises were to record a note on the pupils' record

(98%), contact the pupil's parents (97%) or temporarily exclude the pupil (94%).

2.8 Factors associated with drug use in the last year

Chapter 4.8 on page 134 and **Table 4.30** on page 165 of the *SDD08* provides odds ratios, which shows the relationship between drug use and characteristics and environment of pupils in the last year, using logistic regression.

From the key findings of **Chapter 4.8** in *SDD08*, it can be seen that gender was significantly associated with drug use in the last year. Girls were less likely to have used drugs in the last year than boys and the likelihood of having used drugs in the last year was found to increase with age.

Regular smokers and pupils who have consumed more units of alcohol in the previous week were very much more likely to have used drugs in the last year.

There were no associations between drug use and ethnicity, other pupil characteristics or school characteristics.

References

1. Smoking Drinking and Drug use among Young People in England in 2008. The NHS Information Centre, 2009. Available at:

http://www.ic.nhs.uk/pubs/sdd08fullreport

2. Misuse of Drugs Act. The Home Office, 1997: Available at:

drugs.homeoffice.gov.uk/drugs-laws/misuse-of-drugs-act/

3. Drug Misuse Declared: Findings from the 2008/09 British Crime Survey. The Home Office, 2009. Available at:
http://www.homeoffice.gov.uk/rds/pdfs09/hosb1209.pdf

3. Outcomes of drug misuse

3.1 Introduction

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

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

Previously information on infections acquired through injecting illicit drugs was presented from the Health Protection Agency's *Unlinked Anonymous Prevalence Monitoring Programme (UAPMP).*[1] This information has not been updated by the Health Protection Agency so it has not been included in this publication.

Similarly, information taken from '*Measuring different aspects of problem drug use: methodological developments*'[2] report has not been updated by the Home Office so not included in this report.

3.2 Hospital admissions

Data on NHS hospital admissions are available from the *Hospital Episode Statistics (HES) databank.*[3] This section presents NHS hospital admissions in England where there was a primary or secondary diagnosis of drug-related mental health and behavioural disorders or a primary diagnosis of drug poisoning. These data are based on the tenth revision of the International Classification of Diseases (ICD-10).[4] The most recent data available are for the financial year 2008/09.

3.2.1 Drug-related mental health and behavioural disorders

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

Table 3.1 shows that in 2008/09 there were 5,668 admissions to hospital in England with a primary diagnosis of a drug-related mental health and behavioural disorder. This is 15.1% less than in 2007/08 when there were 6,675 admissions.

During 2008/09 more people aged 25-34 were admitted with a primary diagnosis of drug-related mental health and behaviour disorders than any other age group. This age group accounted for nearly 40% of all such admissions in that year. Those in the 65-74 age group had the lowest number of admissions (40). See **Figure 3.1**.

Figure 3.1 Number of admissions with a primary diagnosis of drug related mental health and behavioural disorders, by age group, 2008/09
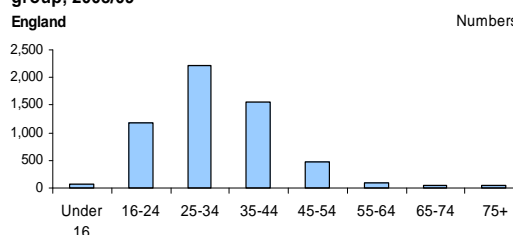
Source: Hospital Episode Statistics, HES. The NHS Information Centre

Table 3.2 shows that in 2008/09, more than twice as many males were admitted to hospital with a primary diagnosis of drug-related mental health and behavioural

disorders than females (3,997 and 1,671 respectively).

When analysing figures at Strategic Health Authority (SHA) and Primary Care Trust (PCT) level it is important to note that SHAs and PCTs vary greatly in both size and structure of population. To help account for this, information is therefore also provided as number of admissions per 100,000 population in the relevant tables.

Table 3.2 shows that among SHAs, London SHA and North West SHA had the highest rates of admissions with a primary diagnosis of drug-related mental health and behavioural disorders at 16 and 15 admissions per 100,000 of the population respectively. North East SHA had the lowest number of 4 admissions per 100,000 population.

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

Table 3.4 shows that there were 42,170 admissions where there was a primary or secondary diagnosis of drug-related mental health and behavioural disorders in 2008/09, which is 4.3% higher than 40,421 admissions in 2007/08. See **Figure 3.2**.

Figure 3.2 NHS hospital admissions where there was a primary or secondary diagnosis was of drug related mental health and behavioural disorders, 1998/99 to 2008/09

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

As seen with primary diagnosis, **Table 3.4** shows that those in the 25-34 age group had the greatest number of admissions (15,817) with a primary or secondary diagnosis of drug-related mental health and behavioural

disorders than any other age group. Those in the 75+ age group had the lowest number of admissions (212). (See **Figure 3.3**).

Figure 3.3 NHS hospital admissions where there was a primary or secondary diagnosis of drug related mental health and behavioural disorders, by age group, 2008/09
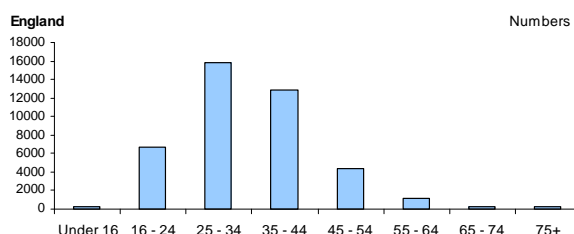
Source: Hospital Episode Statistics, HES. The NHS Information Centre

As with primary diagnoses, there were over twice as many males than females admitted to hospital for a primary or secondary diagnosis of drug-related mental health and behavioural disorders with 28,289 males and 13,875 females.

Table 3.5 shows that among SHAs, North West SHA showed the largest number of admissions with a primary or secondary diagnosis of drug-related mental health and behavioural disorders at 155 admissions per 100,000 population followed by Yorkshire and The Humber SHA with 98 per 100,000 population. South Central SHA had the lowest number of 40 admissions per 100,000 population.

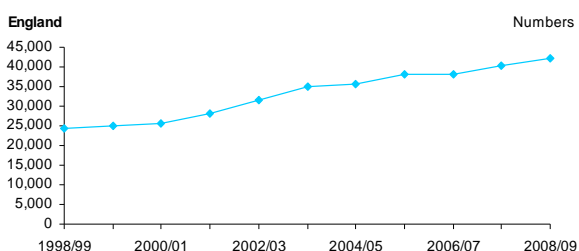**Table 3.6** shows hospital admissions where there was a primary or secondary diagnosis of drug-related mental health and behavioural disorders by PCT.

3.2.2 Poisoning by drugs

This section describes admissions to NHS hospitals where drug poisoning was related to the primary diagnosis. **Table 3.7** shows that in 2008/09, 11,090 admissions were recorded with this diagnosis, which has remained relatively stable in recent years (11,110 in 2007/08). Since 1998/99, there has been a long term increase in the number of admissions of 47.2% (7,533).

Table 3.7 also shows that adults in the 25-34 age group reported the highest number of admissions (2,773) with a primary diagnosis of poisoning by drugs in 2008/09 with those aged 16-24 reporting slightly less (2,741). Those in the 65-74 age group reported the lowest number of such admissions (249).

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

Table 3.8 also shows that when looking at SHAs, North East SHA had the highest number of admissions with a primary diagnosis of poisoning by drugs per 100,000 population at 38 per 100,000 population while East of England SHA and London SHA both had the lowest number of 13 admissions per 100,000 population.

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

3.3 Treatment for drug misuse

Data from the *National Drug Treatment Monitoring System (NDTMS)*[5] provides information on the number of people being treated for drug misuse and referrals. The latest information available is for 2008/09 and only includes information for those aged 18 and over (previously it had included information on those aged under 18).

Table 3.10 shows that in 2008/09, 207,580 individuals were in contact with structured drug treatment services. This is a 10.4% increase from the 2007/08 figures, where the number was 187,978.[6] Most of these individuals in treatment are aged 40+ (24%) and 73% are male.

Table 3.11 shows that in 2008/09, the main type of drug for which people received treatment was opiates only (which includes heroin) at 48% of all treatments with a further

31% of treatments for those who have taken both opiates and crack.

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). **Table 3.12** shows that the most frequent source of referral in 2008/09 for every SHA (except Yorkshire and The Humber SHA) was a self-referral. East of England SHA had the highest percentage of self referrals at 53%. The criminal justice system was the most frequent source of referrals for Yorkshire and The Humber SHA at 34% (which was the second most popular source for all the other SHAs).

Table 3.13 shows the reasons why clients were discharged from treatment. A discharge is classed as successful if an individual is said to have completed their course of treatment (whether drug free or otherwise), or if the individual is referred to another agency.

Table 3.13 shows that there were 60,386 discharged episodes of treatment by the end 2008/09 and that there were 24,656 (41%) of clients exiting treatment who were no longer dependent on the substances that brought them into treatment; a further 9,002 (15%) were referred on for further interventions outside of community-structured treatment.

Table 3.14 shows that among Government Office Regions (GORs), North West GOR reported the highest number of people in treatment at 38,552 followed by London GOR at 36,353. North East GOR reported the lowest number of people in treatment (14,190). See **Figure 3.4**.

Figure 3.4 People in treatment by Government Office Region reported to National Drug Treatment Monitoring System (NDTMS), 2008/09
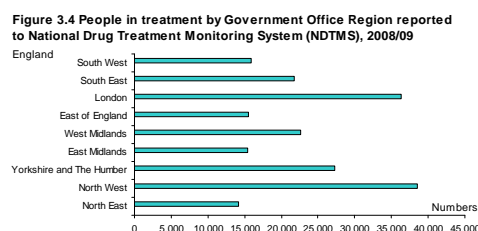
Source: Statistics from the National Drug Treatment Monitoring System (NDTMS) April 2008 - 31 March 2009. National Treatment Agency for Substance Misuse (NTA).
Copyright © 2009, re-used with the permission of the NDTMS

3.4 Drugs Harm Index

The *Drug Harm Index (DHI)*[7] has been developed by the Home Office to measure the effectiveness of the *Drugs Strategy*.[8] The *DHI* captures the harms generated by the problematic use of any illegal drug by combining robust national indicators into a single figure time series index. There are 19 harms included in the *DHI* which include drug-related crime, community perceptions of drug problems, drug nuisance, and the various health consequences that arise from drug abuse (e.g. HIV, overdoses, deaths). Full details of all the harms included in the *DHI* can be found in **Appendix A**.

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

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

- The largest downward impact came from drug-related crime, particularly burglary, shoplifting and 'other theft'.

- Unlike the previous year, drug-related deaths decreased from 1,608 in 2005 to 1,573 in 2006, and thus contributed to the greater downward fall in the 2006 index.

- The only upward influence on the *DHI* in 2006 came from the *British Crime Survey (BCS)* perception of drug nuisance, although this did not substantially impact on the *DHI* overall.

3.5 Drug-related deaths

The most recent information on the numbers of deaths due to drug misuse is available from the *Office for National Statistics (ONS)* publication, *Health Statistics Quarterly 43 (HSQ)*,[9] published in Autumn 2009. The most recent data available is for 2008.

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

Table 3.15 shows the number of deaths related to drug misuse. In 2008, there were 1,738 deaths reported as being due to drug misuse. Of those who died, 78% were male. Compared to 1993 the number of male deaths has increased by around 136% in 2008 compared to a 48% increase for females. In recent years however no overall trend is apparent. The highest numbers of deaths due to drug misuse occurred in the 30 to 39 age group for both males and females (490 and 112 respectively).

Table 3.16 shows the analysis of the underlying causes of death due to drug misuse where more males than females die for each underlying cause of death with over five times the number of males dying from mental and behavioural disorders than females (578 and 107 respectively). This pattern was evident in deaths due to accidental poisoning (597 male and 166 female) and intentional self poisoning of undetermined intent (182 male and 99 female). No overall trend in recent years is apparent between genders in the changes of numbers dying with underlying causes of death. However, compared with 1993, males

have experienced greater increases than females for all underlying causes of death (excluding assault by drugs).

An alternative source of data on drug-related deaths is published by the national programme on *Substance Abuse Deaths (np-SAD)*[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.

References

1. Supplementary data tables of the Unlinked Anonymous Prevalence Monitoring Programme (UAPMP): data to the end of 2006, surveillance update 2007. The Health Protection Agency, 2007. Available at: www.hpa.org.uk/web/HPAwebFile/HPAweb_C/1202115534719

2. Measuring different aspects of problem drug use: methodological developments. The Home Office, 2006. Available at: www.homeoffice.gov.uk/rds/pdfs06/rdsolr1606.pdf

3. Hospital Episodes Statistics (HES). The Information Centre, 2009. The HES data included in this bulletin are not routinely published, but are available on request. Available at: www.hesonline.org.uk

4. International Classification of Diseases, 10th revision (ICD-10). World Health Organisation. Available at: www.who.int/classifications/icd/en/

5. Statistics from the National Drug Treatment Monitoring System (NDTMS) 1 April 2008 - 31 March 2009, 2009. Available at: www.nta.nhs.uk/areas/facts_and_figures/0809/docs/ndtms_annual_report_200809.pdf

6. Statistics from the National Drug Treatment Monitoring System (NDTMS) 1 April 2007 - 31 March 2008, 2008. Available at: www.nta.nhs.uk/areas/facts_and_figures/0708/docs/ndtms_annual_report_2007_08_011008.pdf

7. Measuring the harm from illegal drugs: a summary of the Drug Harm Index 2006. The Home Office, 2009. Available at: www.homeoffice.gov.uk/rds/pdfs09/horr13.pdf

8. The 2008-2018 Drug Strategy, The Home Office, 2007. Available at: drugs.homeoffice.gov.uk/drug-strategy/

9. Health Statistics Quarterly 43. The Office for National Statistics, 2009. Available at: www.statistics.gov.uk/downloads/theme_health/HSQ43.pdf

10. Drug-related deaths in the UK. National Programme on Substance Abuse Deaths (np-SAD), International Centre for Drug Policy (ICDP), St. George's, University of London, UK, 2006. Available at: http://www.sgul.ac.uk/about-st-georges/divisions/faculty-of-medicine-and-biomedical-sciences/mental-health/icdp/website-pdfs/Executive%20Summary%20np-SAD%20AR%202009.pdf

List of tables

Table 3.1 NHS hospital admissions where there was a primary diagnosis of drug related mental health and behavioural disorders, by age group, 1998/99 to 2008/09

England   Numbers

	Total	Under 16	16-24	25-34	35-44	45-54	55-64	65-74	75+
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
2007/08	**6,675**	113	1,502	2,605	1,813	440	108	42	48
2008/09	**5,668**	65	1,176	2,207	1,558	476	97	40	43

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

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

3. These figures represent the number of episodes where the diagnosis was recorded in any of the 20 (14 from 2002-03 to 2006-07 and 7 prior to 2002-03) primary and secondary diagnosis fields in a Hospital Episode Statistics (HES) record. Each episode is only counted once in each count, even if the diagnosis is recorded in more than one diagnosis field of the record. It is not possible to identify whether the drugs were medically prescribed or not.

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

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

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

7.Total counts include admissions where the age was unknown.

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

9. Total counts include admissions where the SHA or residence was England but not further specified.

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

Table 3.2 NHS hospital admissions where there was a primary diagnosis of drug related mental health and behavioural disorders, by Strategic Health Authority (SHA) and gender, 2008/09

England				Numbers
	Total	Number of admissions per 100,000 of population	Male	Female
England	**5,668**	**11**	**3,997**	**1,671**
North East	99	4	72	27
North West	1,052	15	734	318
Yorkshire and the Humber	515	10	357	158
East Midlands	384	9	279	105
West Midlands	651	12	455	196
East of England	307	5	222	85
London	1,240	16	896	344
South East Coast	344	8	240	104
South Central	357	9	254	103
South West	626	12	418	208

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

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

3. These figures represent the number of episodes where the diagnosis was recorded in any of the 20 (14 from 2002-03 to 2006-07 and 7 prior to 2002-03) primary and secondary diagnosis fields in a Hospital Episode Statistics (HES) record. Each episode is only counted once in each count, even if the diagnosis is recorded in more than one diagnosis field of the record. It is not possible to identify whether the drugs were medically prescribed or not.

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

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

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

7. Total counts include admissions where the gender was unknown.

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

9. Total counts include admissions where the SHA or residence was England but not further specified.

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

11. The number of admissions per 100,000 of population all ages use estimated resident population mid-2008 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

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

Table 3.3 NHS hospital admissions where there was a primary diagnosis of drug related mental health and behavioural disorders, by Strategic Health Authority (SHA) and Primary Care Trust (PCT), 2008/09

England		Numbers
		Total
England		**5,668**
North East Strategic Health Authority	**Q30**	**99**
County Durham PCT	5ND	20
Darlington PCT	5J9	9
Gateshead PCT	5KF	-
Hartlepool PCT	5D9	11
Middlesbrough PCT	5KM	14
Newcastle PCT	5D7	7
North Tees PCT	5E1	10
North Tyneside PCT	5D8	9
Northumberland Care Trust	TAC	6
Redcar and Cleveland PCT	5QR	-
South Tyneside PCT	5KG	-
Sunderland Teaching PCT	5KL	-
North West Strategic Health Authority	**Q31**	**1,052**
Ashton, Leigh and Wigan PCT	5HG	58
Blackburn With Darwen PCT	5CC	26
Blackpool PCT	5HP	35
Bolton PCT	5HQ	49
Bury PCT	5JX	27
Central and Eastern Cheshire PCT	5NP	26
Central Lancashire PCT	5NG	77
Cumbria PCT	5NE	21
East Lancashire Teaching PCT	5NH	47
Halton and St Helens PCT	5NM	54
Heywood, Middleton and Rochdale PCT	5NQ	26
Knowsley PCT	5J4	77
Liverpool PCT	5NL	223
Manchester PCT	5NT	73
North Lancashire PCT	5NF	31
Oldham PCT	5J5	16
Salford PCT	5F5	27
Sefton PCT	5NJ	36
Stockport PCT	5F7	21
Tameside and Glossop PCT	5LH	28
Trafford PCT	5NR	12
Warrington PCT	5J2	31
Western Cheshire PCT	5NN	11
Wirral PCT	5NK	24
Yorkshire & The Humber Strategic Health Authority	**Q32**	515
Barnsley PCT	5JE	63
Bradford and Airedale Teaching PCT	5NY	70
Calderdale PCT	5J6	27
Doncaster PCT	5N5	24
East Riding Of Yorkshire PCT	5NW	13
Hull Teaching PCT	5NX	27
Kirklees PCT	5N2	42
Leeds PCT	5N1	43
North East Lincolnshire PCT	TAN	10
North Lincolnshire PCT	5EF	14
North Yorkshire and York PCT	5NV	30
Rotherham PCT	5H8	35
Sheffield PCT	5N4	50
Wakefield District PCT	5N3	67
East Midlands Strategic Health Authority	**Q33**	384
Bassetlaw PCT	5ET	7
Derby City PCT	5N7	38
Derbyshire County PCT	5N6	70
Leicester City PCT	5PC	53
Leicestershire County and Rutland PCT	5PA	45
Lincolnshire Teaching PCT	5N9	43
Northamptonshire Teaching PCT	5PD	30
Nottingham City PCT	5EM	53
Nottinghamshire County Teaching PCT	5N8	41
West Midlands Strategic Health Authority	**Q34**	651
Birmingham East and North PCT	5PG	26
Coventry Teaching PCT	5MD	70
Dudley PCT	5PE	36
Heart Of Birmingham Teaching PCT	5MX	31
Herefordshire PCT	5CN	-
North Staffordshire PCT	5PH	25
Sandwell PCT	5PF	19
Shropshire County PCT	5M2	42
Solihull Care Trust	TAM	-
South Birmingham PCT	5M1	28
South Staffordshire PCT	5PK	50
Stoke On Trent PCT	5PJ	61
Telford and Wrekin PCT	5MK	31
Walsall Teaching PCT	5M3	21
Warwickshire PCT	5PM	153
Wolverhampton City PCT	5MV	24
Worcestershire PCT	5PL	24
East of England Strategic Health Authority	**Q35**	307
Bedfordshire PCT	5P2	12
Cambridgeshire PCT	5PP	23
East and North Hertfordshire PCT	5P3	32
Great Yarmouth and Waveney PCT	5PR	15
Luton PCT	5GC	29
Mid Essex PCT	5PX	25
Norfolk PCT	5PQ	29
North East Essex PCT	5PW	16
Peterborough PCT	5PN	12
South East Essex PCT	5P1	24
South West Essex PCT	5PY	20
Suffolk PCT	5PT	36
West Essex PCT	5PV	16
West Hertfordshire PCT	5P4	18

Table 3.3 continued NHS hospital admissions where there was a primary diagnosis of drug related mental health and behavioural disorders, by Strategic Health Authority (SHA) and Primary Care Trust (PCT), 2008/09

England		Numbers
		Total
England		**5,668**
London Strategic Health Authority	**Q36**	**1,240**
Barking and Dagenham PCT	5C2	43
Barnet PCT	5A9	24
Bexley Care Trust	TAK	41
Brent Teaching PCT	5K5	27
Bromley PCT	5A7	42
Camden PCT	5K7	17
City and Hackney Teaching PCT	5C3	35
Croydon PCT	5K9	68
Ealing PCT	5HX	25
Enfield PCT	5C1	19
Greenwich Teaching PCT	5A8	84
Hammersmith and Fulham PCT	5H1	12
Harrow PCT	5K6	11
Haringey Teaching PCT	5C9	24
Havering PCT	5A4	27
Hillingdon PCT	5AT	24
Hounslow PCT	5HY	21
Islington PCT	5K8	21
Kensington and Chelsea PCT	5LA	16
Kingston PCT	5A5	25
Lambeth PCT	5LD	97
Lewisham PCT	5LF	83
Newham PCT	5C5	57
Redbridge PCT	5NA	31
Richmond and Twickenham PCT	5M6	37
Southwark PCT	5LE	116
Sutton and Merton PCT	5M7	72
Tower Hamlets PCT	5C4	31
Waltham Forest PCT	5NC	47
Wandsworth PCT	5LG	40
Westminster PCT	5LC	23
South East Coast Strategic Health Authority	**Q37**	**344**
Brighton and Hove City PCT	5LQ	56
Eastern and Coastal Kent PCT	5QA	82
East Sussex Downs and Weald PCT	5P7	17
Hastings and Rother PCT	5P8	24
Medway PCT	5L3	18
Surrey PCT	5P5	63
West Kent PCT	5P9	43
West Sussex PCT	5P6	41
South Central Strategic Health Authority	**Q38**	**357**
Berkshire East PCT	5QG	15
Berkshire West PCT	5QF	36
Buckinghamshire PCT	5QD	11
Hampshire PCT	5QC	125
Isle Of Wight NHS PCT	5QT	17
Milton Keynes PCT	5CQ	20
Oxfordshire PCT	5QE	25
Portsmouth City Teaching PCT	5FE	75
Southampton City PCT	5L1	33
South West Strategic Health Authority	**Q39**	**626**
Bath and North East Somerset PCT	5FL	8
Bournemouth and Poole PCT	5QN	74
Bristol PCT	5QJ	47
Cornwall and Isles Of Scilly PCT	5QP	33
Devon PCT	5QQ	130
Dorset PCT	5QM	71
Gloucestershire PCT	5QH	146
North Somerset PCT	5M8	28
Plymouth Teaching PCT	5F1	-
Somerset PCT	5QL	48
South Gloucestershire PCT	5A3	9
Swindon PCT	5K3	-
Torbay Care Trust	TAL	14
Wiltshire PCT	5QK	9

1. The data include private patients treated in NHS hospitals (but not private patients in private hospitals).
2. The data is based on a finished admission episode which is the first period of in-patient care under one consultant within one healthcare provider. Please note that admissions do not represent the number of in-patients, as a person may have more than one admission within the year.
3. These figures represent the number of episodes where the diagnosis was recorded in any of the 20 (14 from 2002-03 to 2006-07 and 7 prior to 2002-03) primary and secondary diagnosis fields in a Hospital Episode Statistics (HES) record. Each episode is only counted once in each count, even if the diagnosis is recorded in more than one diagnosis field of the record. It is not possible to identify whether the drugs were medically prescribed or not.
4. The data is based on the tenth revision of the International Classification of Diseases (ICD-10), Codes F11-F16, F18, F19.
5. Figures have not been adjusted for shortfalls in data.
6. Counts include people resident in England SHAs only.
7. Counts exclude admissions where the SHA of residence is unknown.
8. Counts include admissions where the residence was England but the PCT of residence is unknown.
9. This is the SHA in which the patient is normally resident, based on the patient's postcode.
10. Where PCT's have less than 6 admissions recorded over the year, these figures have been suppressed to protect patient confidentiality. However, the total still includes these
11. Due to boundary issues, the sum of PCTs may add up to be different from the specifed SHA total.

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

Table 3.4 NHS hospital admissions where the primary or secondary diagnosis was of drug related mental health and behavioural disorders, by age group, 1998/99 to 2008/09

England   Numbers

	Total	Under 16	16-24	25-34	35-44	45-54	55-64	65-74	75+
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
2007/08	**40,421**	350	7,348	15,540	11,792	3,664	924	270	191
2008/09	**42,170**	318	6,721	15,817	12,815	4,385	1,181	272	212

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

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

3. These figures represent the number of episodes where the diagnosis was recorded in any of the 20 (14 from 2002-03 to 2006-07 and 7 prior to 2002-03) primary and secondary diagnosis fields in a Hospital Episode Statistics (HES) record. Each episode is only counted once in each count, even if the diagnosis is recorded in more than one diagnosis field of the record. It is not possible to identify whether the drugs were medically prescribed or not.

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

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

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

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

8. Total counts includes admissions where the age was unknown.

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

10. Total counts include admissions where the SHA or residence was England but not further specified.

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

Table 3.5 NHS hospital admissions where there was a primary or secondary diagnosis of drug related mental health and behavioural disorders, by Strategic Health Authority (SHA), 2008/09

England   Numbers

	Total	Number of admissions per 100,000 of population	Male	Female
England	**42,170**	**82**	**28,289**	**13,875**
North East	2,130	83	1,382	748
North West	10,659	155	7,178	3,481
Yorkshire and the Humber	5,129	98	3,355	1,774
East Midlands	3,104	70	2,027	1,077
West Midlands	4,244	78	2,761	1,483
East of England	2,597	45	1,730	867
London	5,304	70	3,669	1,635
South East Coast	2,349	54	1,620	729
South Central	1,629	40	1,097	532
South West	4,127	79	2,758	1,364

1. The data include private patients treated in NHS hospitals (but not private patients in private hospitals)
2. The data is based on a finished admission episode which is the first period of in-patient care under one consultant within one healthcare provider. Please note that admissions do not represent the number of in-patients, as a person may have more than one admission within the year.
3. These figures represent the number of episodes where the diagnosis was recorded in any of the 20 (14 from 2002-03 to 2006-07 and 7 prior to 2002-03) primary and secondary diagnosis fields in a Hospital Episode Statistics (HES) record. Each episode is only counted once in each count, even if the diagnosis is recorded in more than one diagnosis field of the record. It is not possible to identify whether the drugs were medically prescribed or not.
4. As well as the primary diagnosis, there are up to 13 (6 prior to 2002-03) secondary diagnosis fields in Hospital Episode Statistics (HES) that show other diagnoses relevant to the episode of care.
5. The data is based on the tenth revision of the International Classification of Diseases (ICD-10), Codes F11-F16, F18, F19.
6. Figures have not been adjusted for shortfalls in data.
7. Counts include people resident in England Strategic Health Authorities (SHAs) only.
8. Total counts include admissions where the gender was unknown.
9. Total counts exclude admissions where the SHA of residence is unknown
10. Total counts include admissions where the SHA or residence was England but not further specified
11. This is the SHA in which the patient is normally resident, based on the patient's postcode.
12. The number of admissions per 100,000 of population all ages use estimated resident population mid-2008 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

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

Table 3.6 NHS hospital admissions where there was a primary or secondary diagnosis of drug related mental health and behavioural disorders, by Strategic Health Authority (SHA) and Primary Care Trust (PCT), 2008/09

England		Numbers
		Total
England		**42,170**
North East Strategic Health Authority	**Q30**	**2,130**
County Durham PCT	5ND	336
Darlington PCT	5J9	121
Gateshead PCT	5KF	206
Hartlepool PCT	5D9	119
Middlesbrough PCT	5KM	232
Newcastle PCT	5D7	284
North Tees PCT	5E1	138
North Tyneside PCT	5D8	162
Northumberland Care Trust	TAC	240
Redcar and Cleveland PCT	5QR	86
South Tyneside PCT	5KG	61
Sunderland Teaching PCT	5KL	145
North West Strategic Health Authority	**Q31**	**10,659**
Ashton, Leigh and Wigan PCT	5HG	458
Blackburn With Darwen PCT	5CC	258
Blackpool PCT	5HP	402
Bolton PCT	5HQ	414
Bury PCT	5JX	227
Central and Eastern Cheshire PCT	5NP	355
Central Lancashire PCT	5NG	591
Cumbria PCT	5NE	314
East Lancashire Teaching PCT	5NH	571
Halton and St Helens PCT	5NM	562
Heywood, Middleton and Rochdale PCT	5NQ	401
Knowsley PCT	5J4	378
Liverpool PCT	5NL	1,834
Manchester PCT	5NT	1,055
North Lancashire PCT	5NF	352
Oldham PCT	5J5	241
Salford PCT	5F5	328
Sefton PCT	5NJ	323
Stockport PCT	5F7	247
Tameside and Glossop PCT	5LH	336
Trafford PCT	5NR	144
Warrington PCT	5J2	200
Western Cheshire PCT	5NN	171
Wirral PCT	5NK	516
Yorkshire & The Humber Strategic Health Authority	**Q32**	**5,129**
Barnsley PCT	5JE	310
Bradford and Airedale Teaching PCT	5NY	660
Calderdale PCT	5J6	166
Doncaster PCT	5N5	481
East Riding Of Yorkshire PCT	5NW	113
Hull Teaching PCT	5NX	373
Kirklees PCT	5N2	223
Leeds PCT	5N1	676
North East Lincolnshire PCT	TAN	176
North Lincolnshire PCT	5EF	120
North Yorkshire and York PCT	5NV	394
Rotherham PCT	5H8	364
Sheffield PCT	5N4	802
Wakefield District PCT	5N3	271
East Midlands Strategic Health Authority	**Q33**	**3,104**
Bassetlaw PCT	5ET	182
Derby City PCT	5N7	301
Derbyshire County PCT	5N6	473
Leicester City PCT	5PC	384
Leicestershire County and Rutland PCT	5PA	281
Lincolnshire Teaching PCT	5N9	315
Northamptonshire Teaching PCT	5PD	262
Nottingham City PCT	5EM	377
Nottinghamshire County Teaching PCT	5N8	510
West Midlands Strategic Health Authority	**Q34**	**4,244**
Birmingham East and North PCT	5PG	314
Coventry Teaching PCT	5MD	272
Dudley PCT	5PE	296
Heart Of Birmingham Teaching PCT	5MX	528
Herefordshire PCT	5CN	95
North Staffordshire PCT	5PH	129
Sandwell PCT	5PF	200
Shropshire County PCT	5M2	164
Solihull Care Trust	TAM	68
South Birmingham PCT	5M1	315
South Staffordshire PCT	5PK	238
Stoke On Trent PCT	5PJ	402
Telford and Wrekin PCT	5MK	109
Walsall Teaching PCT	5M3	230
Warwickshire PCT	5PM	336
Wolverhampton City PCT	5MV	167
Worcestershire PCT	5PL	381
East of England Strategic Health Authority	**Q35**	**2,597**
Bedfordshire PCT	5P2	189
Cambridgeshire PCT	5PP	412
East and North Hertfordshire PCT	5P3	120
Great Yarmouth and Waveney PCT	5PR	117
Luton PCT	5GC	177
Mid Essex PCT	5PX	84
Norfolk PCT	5PQ	389
North East Essex PCT	5PW	88
Peterborough PCT	5PN	212
South East Essex PCT	5P1	198
South West Essex PCT	5PY	112
Suffolk PCT	5PT	262
West Essex PCT	5PV	96
West Hertfordshire PCT	5P4	141

Table 3.6 continued NHS hospital admissions where there was a primary or secondary diagnosis of drug related mental health and behavioural disorders, by Strategic Health Authority (SHA) and Primary Care Trust (PCT), 2008/09

England		Numbers
		Total
England		**42,170**
London Strategic Health Authority	**Q36**	**5,304**
Barking and Dagenham PCT	5C2	140
Barnet PCT	5A9	98
Bexley Care Trust	TAK	97
Brent Teaching PCT	5K5	113
Bromley PCT	5A7	160
Camden PCT	5K7	222
City and Hackney Teaching PCT	5C3	224
Croydon PCT	5K9	207
Ealing PCT	5HX	237
Enfield PCT	5C1	103
Greenwich Teaching PCT	5A8	244
Hammersmith and Fulham PCT	5H1	178
Haringey Teaching PCT	5C9	169
Harrow PCT	5K6	80
Havering PCT	5A4	106
Hillingdon PCT	5AT	154
Hounslow PCT	5HY	149
Islington PCT	5K8	210
Kensington and Chelsea PCT	5LA	120
Kingston PCT	5A5	88
Lambeth PCT	5LD	306
Lewisham PCT	5LF	234
Newham PCT	5C5	181
Redbridge PCT	5NA	115
Richmond and Twickenham PCT	5M6	114
Southwark PCT	5LE	374
Sutton and Merton PCT	5M7	206
Tower Hamlets PCT	5C4	152
Waltham Forest PCT	5NC	145
Wandsworth PCT	5LG	180
Westminster PCT	5LC	198
South East Coast Strategic Health Authority	**Q37**	**2,349**
Brighton and Hove City PCT	5LQ	466
Eastern and Coastal Kent PCT	5QA	398
East Sussex Downs and Weald PCT	5P7	219
Hastings and Rother PCT	5P8	152
Medway PCT	5L3	198
Surrey PCT	5P5	333
West Kent PCT	5P9	255
West Sussex PCT	5P6	327
South Central Strategic Health Authority	**Q38**	**1,629**
Berkshire East PCT	5QG	134
Berkshire West PCT	5QF	160
Buckinghamshire PCT	5QD	81
Hampshire PCT	5QC	461
Isle Of Wight NHS PCT	5QT	80
Milton Keynes PCT	5CQ	89
Oxfordshire PCT	5QE	250
Portsmouth City Teaching PCT	5FE	234
Southampton City PCT	5L1	141
South West Strategic Health Authority	**Q39**	**4,127**
Bath and North East Somerset PCT	5FL	120
Bournemouth and Poole PCT	5QN	259
Bristol PCT	5QJ	877
Cornwall and Isles Of Scilly PCT	5QP	275
Devon PCT	5QQ	553
Dorset PCT	5QM	228
Gloucestershire PCT	5QH	428
North Somerset PCT	5M8	204
Plymouth Teaching PCT	5F1	277
Somerset PCT	5QL	327
South Gloucestershire PCT	5A3	140
Swindon PCT	5K3	141
Torbay Care Trust	TAL	151
Wiltshire PCT	5QK	147

1. The data include private patients treated in NHS hospitals (but not private patients in private hospita
2. The data is based on a finished admission episode which is the first period of in-patient care under one consultant within one healthcare provider. Please note that admissions do not represent the number of in-patients, as a person may have more than one admission within the year.
3. These figures represent the number of episodes where the diagnosis was recorded in any of the 20 (14 from 2002-03 to 2006-07 and 7 prior to 2002-03) primary and secondary diagnosis fields in a Hospital Episode Statistics (HES) record. Each episode is only counted once in each count, even if the diagnosis is recorded in more than one diagnosis field of the record. It is not possible to identify whether the drugs were medically prescribed or not.
4. The data is based on the tenth revision of the International Classification of Diseases (ICD-10), Codes F11-F16, F18, F19.
5. Figures have not been adjusted for shortfalls in data.
6. Counts include people resident in England SHAs only.
7. Counts exclude admissions where the SHA of residence is unknown.
unknown.
9. This is the SHA in which the patient is normally resident, based on the patient's postcode.
10. Where PCT's have less than 6 admissions recorded over the year, these figures have been suppressed to protect patient confidentiality. Secondary suppression has been used for this particular table. However, the total still includes these numbers.
11. Due to boundary issues, the sum of PCTs may add up to be different from the specifed SHA

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

Copyright © 2009. The NHS Information Centre, Lifestyle Statistics. All rights reserved

Table 3.7 NHS hospital admissions to hospital where there was a primary diagnosis of poisoning by drugs, by age group, 1998/99 to 2008/09

England   Numbers

	Total	Under 16	16-24	25-34	35-44	45-54	55-64	65-74	75+
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
2007/08	**11,110**	861	3,030	2,720	2,270	1,121	528	229	331
2008/09	**11,090**	711	2,741	2,773	2,510	1,225	520	249	310

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

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

3. These figures represent the number of episodes where the diagnosis was recorded in any of the 20 (14 from 2002-03 to 2006-07 and 7 prior to 2002-03) primary and secondary diagnosis fields in a Hospital Episode Statistics (HES) record. Each episode is only counted once in each count, even if the diagnosis is recorded in more than one diagnosis field of the record. It is not possible to identify whether the drugs were medically prescribed or not.

4. The data is based on the tenth revision of the International Classification of Diseases (ICD-10), Codes T40.0 - T40.9, T43.6

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

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

7. Total counts include admissions where the age was unknown.

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

9. Total counts include admissions where the SHA or residence was England but not further specified.

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

Table 3.8 NHS hospital admissions to hospital where there was a primary diagnosis of poisoning by drugs, by Strategic Health Authority (SHA) and gender, 2008/09

England   Numbers

	Total	Number of admissions per 100,000 of population	Male	Female
England	**11,090**	**22**	**6,076**	**5,014**
North East	977	38	567	410
North West	2,177	32	1,094	1,083
Yorkshire and the Humber	1,316	25	724	592
East Midlands	1,001	23	500	501
West Midlands	1,177	22	668	509
East of England	755	13	434	321
London	993	13	613	380
South East Coast	817	19	439	378
South Central	574	14	313	261
South West	1,090	21	554	536

1. The data include private patients treated in NHS hospitals (but not private patients in private hospitals).
2. The data is based on a finished admission episode which is the first period of in-patient care under one consultant within one healthcare provider. Please note that admissions do not represent the number of in-patients, as a person may have more than one admission within the year.
3. These figures represent the number of episodes where the diagnosis was recorded in any of the 20 (14 from 2002-03 to 2006-07 and 7 prior to 2002-03) primary and secondary diagnosis fields in a Hospital Episode Statistics (HES) record. Each episode is only counted once in each count, even if the diagnosis is recorded in more than one diagnosis field of the record. It is not possible to identify whether the drugs were medically prescribed or not.
4. The data is based on the tenth revision of the International Classification of Diseases (ICD-10), Codes T40.0 - T40.9, T43.6.
5. Figures have not been adjusted for shortfalls in data.
6. Counts include people resident in England Strategic Health Authorities (SHAs) only.
7. Total counts include admissions where the gender was unknown.
8. Total counts exclude admissions where the SHA of residence is unknown.
9. Total counts include admissions where the SHA or residence was England but not further specified.
10. This is the SHA in which the patient is normally resident, based on the patient's postcode.
11. The number of admissions per 100,000 of population all ages use estimated resident population mid-2008 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

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

Table 3.9 NHS hospital admissions where a primary diagnosis of poisoning by drugs, by Strategic Health Authority (SHA) and Primary Care Trust (PCT), 2008/09

England		Numbers
		Total
England		**11,090**
North East Strategic Health Authority	**Q30**	**977**
County Durham PCT	5ND	199
Darlington PCT	5J9	28
Gateshead PCT	5KF	98
Hartlepool PCT	5D9	39
Middlesbrough PCT	5KM	58
Newcastle PCT	5D7	146
North Tees PCT	5E1	69
North Tyneside PCT	5D8	63
Northumberland Care Trust	TAC	81
Redcar and Cleveland PCT	5QR	43
South Tyneside PCT	5KG	43
Sunderland Teaching PCT	5KL	110
North West Strategic Health Authority	**Q31**	**2,177**
Ashton, Leigh and Wigan PCT	5HG	129
Blackburn With Darwen PCT	5CC	58
Blackpool PCT	5HP	39
Bolton PCT	5HQ	90
Bury PCT	5JX	57
Central and Eastern Cheshire PCT	5NP	92
Central Lancashire PCT	5NG	123
Cumbria PCT	5NE	117
East Lancashire Teaching PCT	5NH	136
Halton and St Helens PCT	5NM	132
Heywood, Middleton and Rochdale PCT	5NQ	76
Knowsley PCT	5J4	48
Liverpool PCT	5NL	160
Manchester PCT	5NT	164
North Lancashire PCT	5NF	55
Oldham PCT	5J5	36
Salford PCT	5F5	83
Sefton PCT	5NJ	51
Stockport PCT	5F7	67
Tameside and Glossop PCT	5LH	53
Trafford PCT	5NR	32
Warrington PCT	5J2	92
Western Cheshire PCT	5NN	80
Wirral PCT	5NK	209
Yorkshire & The Humber Strategic Health Authority	**Q32**	**1,316**
Barnsley PCT	5JE	75
Bradford and Airedale Teaching PCT	5NY	184
Calderdale PCT	5J6	55
Doncaster PCT	5N5	44
East Riding Of Yorkshire PCT	5NW	49
Hull Teaching PCT	5NX	77
Kirklees PCT	5N2	81
Leeds PCT	5N1	296
North East Lincolnshire PCT	TAN	23
North Lincolnshire PCT	5EF	22
North Yorkshire and York PCT	5NV	161
Rotherham PCT	5H8	44
Sheffield PCT	5N4	80
Wakefield District PCT	5N3	125
East Midlands Strategic Health Authority	**Q33**	**1,001**
Bassetlaw PCT	5ET	23
Derby City PCT	5N7	102
Derbyshire County PCT	5N6	176
Leicester City PCT	5PC	108
Leicestershire County and Rutland PCT	5PA	111
Lincolnshire Teaching PCT	5N9	148
Northamptonshire Teaching PCT	5PD	155
Nottingham City PCT	5EM	77
Nottinghamshire County Teaching PCT	5N8	99
West Midlands Strategic Health Authority	**Q34**	**1,177**
Birmingham East and North PCT	5PG	80
Coventry Teaching PCT	5MD	101
Dudley PCT	5PE	73
Heart Of Birmingham Teaching PCT	5MX	132
Herefordshire PCT	5CN	33
North Staffordshire PCT	5PH	36
Sandwell PCT	5PF	63
Shropshire County PCT	5M2	29
Solihull Care Trust	TAM	28
South Birmingham PCT	5M1	103
South Staffordshire PCT	5PK	101
Stoke On Trent PCT	5PJ	63
Telford and Wrekin PCT	5MK	29
Walsall Teaching PCT	5M3	49
Warwickshire PCT	5PM	116
Wolverhampton City PCT	5MV	22
Worcestershire PCT	5PL	119
East of England Strategic Health Authority	**Q35**	**755**
Bedfordshire PCT	5P2	52
Cambridgeshire PCT	5PP	98
East and North Hertfordshire PCT	5P3	37
Great Yarmouth and Waveney PCT	5PR	40
Luton PCT	5GC	31
Mid Essex PCT	5PX	35
Norfolk PCT	5PQ	125
North East Essex PCT	5PW	42
Peterborough PCT	5PN	59
South East Essex PCT	5P1	47
South West Essex PCT	5PY	35
Suffolk PCT	5PT	79
West Essex PCT	5PV	25
West Hertfordshire PCT	5P4	50

Table 3.9 continued NHS hospital admissions where a primary diagnosis of poisoning by drugs, by Strategic Health Authority (SHA) and Primary Care Trust (PCT), 2008/09

England		Numbers
		Total
England		**11,090**
London Strategic Health Authority	**Q36**	**993**
Barking and Dagenham PCT	5C2	31
Barnet PCT	5A9	25
Bexley Care Trust	TAK	19
Brent Teaching PCT	5K5	24
Bromley PCT	5A7	35
Camden PCT	5K7	33
City and Hackney Teaching PCT	5C3	19
Croydon PCT	5K9	55
Ealing PCT	5HX	46
Enfield PCT	5C1	31
Greenwich Teaching PCT	5A8	28
Hammersmith and Fulham PCT	5H1	43
Haringey Teaching PCT	5C9	35
Harrow PCT	5K6	-
Havering PCT	5A4	17
Hillingdon PCT	5AT	38
Hounslow PCT	5HY	40
Islington PCT	5K8	51
Kensington and Chelsea PCT	5LA	23
Kingston PCT	5A5	-
Lambeth PCT	5LD	32
Lewisham PCT	5LF	51
Newham PCT	5C5	32
Redbridge PCT	5NA	22
Richmond and Twickenham PCT	5M6	17
Southwark PCT	5LE	41
Sutton and Merton PCT	5M7	49
Tower Hamlets PCT	5C4	38
Waltham Forest PCT	5NC	31
Wandsworth PCT	5LG	36
Westminster PCT	5LC	33
South East Coast Strategic Health Authority	**Q37**	**817**
Brighton and Hove City PCT	5LQ	128
Eastern and Coastal Kent PCT	5QA	198
East Sussex Downs and Weald PCT	5P7	60
Hastings and Rother PCT	5P8	44
Medway PCT	5L3	54
Surrey PCT	5P5	99
West Kent PCT	5P9	112
West Sussex PCT	5P6	122
South Central Strategic Health Authority	**Q38**	**574**
Berkshire East PCT	5QG	43
Berkshire West PCT	5QF	26
Buckinghamshire PCT	5QD	34
Hampshire PCT	5QC	174
Isle Of Wight NHS PCT	5QT	25
Milton Keynes PCT	5CQ	37
Oxfordshire PCT	5QE	111
Portsmouth City Teaching PCT	5FE	63
Southampton City PCT	5L1	61
South West Strategic Health Authority	**Q39**	**1,090**
Bath and North East Somerset PCT	5FL	54
Bournemouth and Poole PCT	5QN	69
Bristol PCT	5QJ	150
Cornwall and Isles Of Scilly PCT	5QP	127
Devon PCT	5QQ	131
Dorset PCT	5QM	44
Gloucestershire PCT	5QH	89
North Somerset PCT	5M8	44
Plymouth Teaching PCT	5F1	52
Somerset PCT	5QL	106
South Gloucestershire PCT	5A3	38
Swindon PCT	5K3	49
Torbay Care Trust	TAL	43
Wiltshire PCT	5QK	94

1. The data include private patients treated in NHS hospitals (but not private patients in private hospitals)
2. The data is based on a finished admission episode which is the first period of in-patient care under one consultant within one healthcare provider. Please note that admissions do not represent the number of in-patients, as a person may have more than one admission within the year.
3. These figures represent the number of episodes where the diagnosis was recorded in any of the 20 (14 from 2002-03 to 2006-07 and 7 prior to 2002-03) primary and secondary diagnosis fields in a Hospital Episode Statistics (HES) record. Each episode is only counted once in each count, even if the diagnosis is recorded in more than one diagnosis field of the record. It is not possible to identify whether the drugs were medically prescribed or not.
4. The data is based on the tenth revision of the International Classification of Diseases (ICD-10), Codes T40.0 - T40.9, T43.6.
5. Figures have not been adjusted for shortfalls in data.
6. Counts include people resident in England SHAs only.
7. Counts exclude admissions where the SHA of residence is unknown.
8. Counts include admissions where the residence was England but the PCT of residence is unknown.
9. This is the SHA in which the patient is normally resident, based on the patient's postcode.
10. Where PCT's have less than 6 admissions recorded over the year, these figures have been suppressed to protect patient confidentiality. Secondary suppression has been used for this particular table. However, the total still includes these numbers.
11. Due to boundary issues, the sum of PCTs may add up to be different from the specifed SHA total.

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

Table 3.10 NDTMS clients in treatment, by gender and age, 2008/09

England						Numbers / *percentages*
	Total		Male		Female	
All clients	207,580	*100*	151,064	*100*	56,516	*100*
18-24	29,848	*14*	19,656	*13*	10,192	*18*
25-29	43,778	*21*	31,026	*21*	12,752	*23*
30-34	44,713	*22*	33,031	*22*	11,682	*21*
35-39	39,215	*19*	29,649	*20*	9,566	*17*
40+	50,026	*24*	37,702	*25*	12,324	*22*

1. National Drug Treatment Monitoring System (NDTMS).

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

3. Age is calculated at year midpoint (30th September 2008).

Source:

Statistics from the National Drug Treatment Monitoring System (NDTMS) 1 April 2008 - 31 March 2009. National Treatment Agency for Substance Misuse (NTA)

Table 3.11 Primary drug use of all clients in NDTMS, 2008/09

	Numbers / *percentages*	
Drug group		
Opiates Only (PDUs)	100,085	*48*
Crack Only (PDUs)	8,296	*4*
Opiates & Crack (PDUs)	64,243	*31*
PDU Total	**172,624**	***83***
Benzodiazepines	1,396	*1*
Amphetamines (excluding ecstasy)	4,442	*2*
Cocaine (excluding Crack)	12,354	*6*
Hallucinogens	394	*0*
Ecstasy	383	*0*
Cannabis	13,431	*6*
Solvent	173	*0*
Barbiturates	19	*0*
Major Tranquilisers	38	*0*
Anti-depressants	121	*0*
Other Drugs	1,106	*1*
Poly Drug	85	*0*
Prescription Drugs	491	*0*
Misuse Free	523	*0*
Non PDU Total	**34,956**	***17***
Total	**207,580**	***100***

1. PDU is the acronym for Problem Drug Users

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

3. Clients are all 18 years of age or above

Source:
Statistics from the National Drug Treatment Monitoring System (NDTMS) 1 April 2008 - 31 March 2009. National Treatment Agency for Substance Misuse (NTA)

Table 3.12 Referral source for episodes reported during 2008/09, by Government Office Region

England   *Percentages*

	North East	North West	Yorkshire and The Humber	East Midlands	West Midlands	East of England	London	South East	South West
Statutory Drug Service	6	7	8	13	7	4	6	14	12
Non-statutory Drug service	8	9	6	5	5	6	8	4	6
General Practice	5	5	11	6	8	6	6	7	13
Self Referral	38	41	33	37	40	53	42	39	40
Criminal Justice	32	27	34	31	33	21	26	27	18
Accident and Emergency	0	0	0	0	0	0	0	0	0
Other	9	10	9	9	7	9	10	7	8
Psychiatry	1	1	1	1	1	1	2	1	1
Community Care Assessment	0	0	0	0	0	0	1	0	1

1. National Drug Treatment Monitoring System (NDTMS)
2. Criminal Justice contains the sub categories: Arrest Referral/Drugs Iintervention Programme, Probation, Drug
Rehabilitation Requirement (formerly DTTO), Counselling Assessment Referral Advice and Throughcare/Prison from
3. The category 'Other' contains the sub categories: Social Services, Education Service, Employment Service,
Connexions, Looked after Children, Syringe Exchange and Other from Table 6.4.1 in the NDTMS 2008/09 report.
4. Percentages are rounded to the nearest per cent. Totals may not add up to 100 due to rounding.

Source:

Statistics from the National Drug Treatment Monitoring System (NDTMS) 1 April 2008 - 31 March 2009. National
Treatment Agency for Substance Misuse (NTA)

Table 3.13 Treatment exit reasons for individuals not retained in treatment reported to NDTMS, 2008/09

England	Numbers	*percentages*
Total (episodes discharged)	**60,386**	*100*
Total successful completions	24,656	*41*
Treatment completed free of dependency	15,676	*26*
Treatment completed drug free	8,980	*15*
Referred on	9,002	*15*
Dropped out/ left	14,822	*25*
Prison	4,383	*7*
Treatment declined	1,769	*3*
Treatment withdrawn	1,328	*2*
Moved away	1,870	*3*
Died	905	*1*
Other	980	*2*
Not known	159	*0*
No appropriate treatment	512	*1*

1. National Drug Treatment Monitoring System (NDTMS).

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

Source:

Statistics from the National Drug Treatment Monitoring System (NDTMS) 1 April 2008 - 31 March 2009. National Treatment Agency for Substance Misuse (NTA)

Table 3.14 People in treatment by Government Office Region and age reported to NDTMS, 2008/09

	England	North East	North West	Yorkshire and The Humber	East Midlands	West Midlands	East of England	London	South East	South West
All ages	**207,580**	14,190	38,552	27,221	15,449	22,670	15,497	36,353	21,709	15,939
18- 24	**29,848**	2,802	4,311	3,300	2,539	3,890	2,486	4,470	3,752	2,298
25- 29	**43,778**	4,017	5,667	6,800	4,111	6,087	3,136	6,245	4,441	3,274
30- 34	**44,713**	3,272	8,023	7,192	3,569	5,139	3,236	6,407	4,424	3,451
35- 39	**39,215**	2,206	9,236	5,302	2,571	3,696	2,823	6,545	3,822	3,014
40+	**50,026**	1,893	11,315	4,627	2,659	3,858	3,816	12,686	5,270	3,902

1. National Drug Treatment Monitoring System (NDTMS)
2. Age is calculated at year midpoint.
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

Source:

Statistics from the National Drug Treatment Monitoring System (NDTMS) 1 April 2008 - 31 March 2009. National Treatment Agency for Substance Misuse (NTA)

Table 3.15 Number of deaths related to drug misuse by gender and age group, 1993-2008

England and Wales	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	Numbers 2008
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**	**1,604**	**1,738**
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	1,287	1,364
Under 20	39	47	55	53	75	74	74	53	56	49	40	26	29	36	25	39
20-29	224	292	341	385	456	453	477	456	503	482	353	346	336	338	343	328
30-39	167	213	253	297	299	379	502	492	537	479	456	480	521	481	498	490
40-49	75	97	115	125	140	176	179	239	247	167	187	197	239	270	296	350
50-69	44	44	51	44	51	41	64	68	71	75	63	108	114	103	110	131
70 and over	28	25	25	32	20	19	25	21	36	17	19	20	21	22	15	26
Females																
All ages	252	240	249	220	271	315	307	275	355	344	314	318	348	323	317	374
Under 20	11	15	13	19	15	24	19	21	20	21	13	18	12	14	13	12
20-29	46	40	58	60	82	77	83	64	97	81	72	80	66	70	60	60
30-39	42	47	63	48	47	87	80	72	89	84	87	77	107	92	98	112
40-49	40	38	31	29	46	52	39	48	62	63	55	64	83	56	65	102
50-69	53	52	42	30	43	41	41	38	45	58	51	47	53	63	53	68
70 and over	60	48	42	34	38	34	45	32	42	37	36	32	27	28	28	20

1. As defined by the headline indicator on drug misuse - see Appendix A for further information
2. Data in this table have been compiled based on deaths registered in each calendar year. Previous years have been based on deaths occurring in each calendar year

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

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

Table 3.16 Number of deaths related to drug misuse by gender and underlying cause of death, 1993-2008

England and Wales

	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Males																
Mental and behavioural disorders due to drug use	185	252	304	398	438	562	654	656	735	685	629	631	682	639	552	578
Accidental poisoning by drugs	226	313	380	359	435	405	451	452	472	379	312	364	389	426	528	597
Intentional self-poisoning/ poisoning of undetermined intent	162	149	156	174	159	168	212	207	231	195	175	177	184	180	200	182
Assault by drugs	4	4	0	5	9	7	4	14	12	10	1	5	5	5	7	7
Females																
Mental and behavioural disorders due to drug use	46	45	54	68	79	107	103	90	124	109	126	117	122	100	96	107
Accidental poisoning by drugs	69	77	75	67	72	90	102	85	108	106	75	78	103	114	124	166
Intentional self-poisoning/ poisoning of undetermined intent	136	116	119	84	119	115	100	99	119	124	112	123	121	107	97	99
Assault by drugs	1	2	1	1	1	3	2	1	4	5	1	0	2	2	0	2

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

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

Appendix A: Key sources

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

The British Crime Survey

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

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

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

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

Table A1 shows the current classification of illicit drugs and the penalties for being caught either in possession of or dealing them.

Table A1: Drugs that respondents were asked about in the BCS and their classification under the Misuse of Drugs Act.	
Class A drugs **Include:** Ecstasy, LSD, heroin, cocaine, crack, magic mushrooms (whether prepared or fresh), methylamphetamine (crystal meth)	**Penalties for possession:** Up to seven years in prison or an unlimited fine. Or both. **Penalties for dealing:** Up to life in prison or an unlimited fine. Or both.
Class B drugs **Include:** Cannabis, amphetamines, Methylphenidate (Ritalin), Pholcodine	**Penalties for possession:** Up to five years in prison or an unlimited fine. Or both. **Penalties for dealing:** Up to 14 years in prison or an unlimited fine. Or both.

40

Class C drugs	Penalties for possession: Up to two years in prison or an unlimited fine. Or both.
Include: Tranquilisers, some painkillers, GHB (Gamma hydroxybutyrate), ketamine	Penalties for dealing: Up to 14 years in prison or an unlimited fine. Or both.

Smoking, Drinking and Drug Misuse among Young People in England 2008

Smoking, Drinking and Drug use among Young People in England in 2008 is the latest in the series of surveys of secondary school children in England which provides the national estimates of the proportions of young people aged 11 to 15 who smoke, drink alcohol or take illegal drugs.

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

Trends in smoking were monitored by similar surveys carried out every two years. Questions on alcohol consumption were added to the survey in 1988; the 1998 survey was the first to include questions on the prevalence of drug use. Since 2000, the survey has been carried out annually by the National Centre for Social Research (NatCen) and the National Foundation for Educational Research (NFER).

The 2008 survey achieved a sample of 7,798 pupils aged between 11 and 15 in 264 schools.

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 3 are as follows:

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

Admissions for primary diagnosis of poisoning by drugs
- o   T40 Poisoning by narcotics and psychodysleptics (Hallucinogens)
- o   T43.6 Poisoning by psychotropic drugs not else classified
- o   T40.0 (Opium)
- o   T40.1 Heroin
- o   T40.2 Other Opioids
- o   T40.3 Methadone
- o   T40.4 Other synthetic narcotics
- o   T40.5 Cocaine
- o   T40.6 Other and unspecified narcotics
- o   T40.7 Cannabis
- o   T40.8 Lysergide
- o   T40.9 Other and unspecified psychodysleptics (hallucinogens)

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

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

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

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

The National Drug Treatment Monitoring System (NDTMS)

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

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

NDTMS data were collected from providers by regional NDTMS centres, and forwarded to the National Drug Evidence Centre (NDEC) for data analysis, processing and verification. The results of the analysis were then passed back to the NTA for publication. The most recent full report available is Statistics from the National Drug Treatment Monitoring System (NDTMS) 1 April 2008 – 31 March 2009. The analysis for 2008/09 is based on data provided to the National Drug Treatment Monitoring System up to 31st March 2009.

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 report can be found in Chapter 3.

Statistics from the National Drug Treatment Monitoring System (NDTMS) 1 April 2008 - 31 March 2009. Available at:
www.nta.nhs.uk/areas/facts_and_figures/0809/docs/ndtms_annual_report_200809.pdf

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)

Health Statistics Quarterly 43. The Office for National Statistics, 2009. Available at:

http://www.statistics.gov.uk/downloads/theme_health/HSQ43.pdf

Data from this publication can be found in Chapter 3.

Appendix B: Government targets and plans

Public Service Agreement 14 and 25

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.

The government published a revised Public Service Agreement (PSA), PSA Delivery Agreement 25 in June 2009, to reduce the harm caused by alcohol and drugs. PSA 25 aims to reduce the harms caused by drugs and alcohol to (a) the community as a result of associated crime, disorder and anti-social behaviour, (b) the health and well-being of those who use drugs or drink harmfully and (c) the development and well-being of young people and families. Several indicators have been developed to monitor progress against PSA 25 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.

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

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

Public Service Agreement 25 can be found at:

http://www.hm-treasury.gov.uk/d/pbr_csr07_psa25.pdf

Public Service Agreement 14 can be found at:
http://younglondonmatters.org/uploads/documents/ylm1psadeliveryagreement14.pdf

'Drugs: protecting families and communities'

The government have introduced a new ten year strategy (1998-2018) 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

Full details of the ten year strategy can be found at the following:
http://drugs.homeoffice.gov.uk/drug-strategy/overview/

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.

Full details of the Updated Drug Strategy 2002 can be found at the following:

http://www.erpho.org.uk/Download/Public/8342/1/updated-drug-strategy-2002.pdf

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.

Full details of the Tackling Drugs Changing Lives update can be found at the following:

http://drugs.homeoffice.gov.uk/publication-search/communications-campaigns/drugstrategynewsletter/

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;

Full details of the NHS plan can be found at the following:
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4002960

Young People's substance misuse strategy

The Home Office have been working with the Department for Children, Schools and Families on a cross-government approach to young people and drugs, which began implementation in April 2005. A main aim of the 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.

Full details of the Young People's substance misuse strategy can be found at the following:

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

FRANK

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

Full details on the FRANK initiative can be found at the following:

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.

More information on the Drug Intervention Programme can be found at the following:
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.

The Misuse of Drugs Act can be found in full at the following:
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.

The Drugs Act can be found in full at the following:
www.opsi.gov.uk/acts/acts2005/20050017.htm

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

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.

More details can be found at the following:
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.

More details can be found at the following:
http://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.

More details can be found at the following:
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.

More details can be found at the following:
www.dhsspsni.gov.uk/dmd_bulletin_2005-2006.pdf

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

More details can be found at the following:
http://www.thinkroadsafety.gov.uk/campaigns/drugdriving/drugdriving.html

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.

More details can be found at the following:

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.

More details can be found at the following:

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

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.

More details can be found at the following:

www.drugeducationforum.com/

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.

More details can be found at the following:
www.drugmisuse.isdscotland.org

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.

More details can be found at the following:
www.dur.ac.uk/ne.pho/index.php?c=241

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:
More details can be found at the following:
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.

More details can be found at the following:
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.

More details can be found at the following:
www.drugscope.org.uk/resources/faqs/faqpages/how-much-do-drugs-cost.htm

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_espad2003.pdf

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.

More details can be found at the following:

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

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.

More details can be found at the following:

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

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.

More details can be found at the following:

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).

More details can be found at the following:

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

National Programme on Substance Abuse Deaths

An alternative source of data on drug-related deaths to that 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.

More details can be found at the following:

http://www.sgul.ac.uk/about-st-georges/divisions/faculty-of-medicine-and-biomedical-sciences/mental-health/icdp/our-work-programmes/national-programme-on-substance-abuse-deaths

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.

More details can be found at the following:

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.

More details can be found at the following:

www.nice.org.uk

National Treatment Agency

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

More details can be found at the following:

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.

More details can be found at the following:

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

Positive Futures

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

More details can be found at the following:

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

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.

More details can be found at the following:
www.nwph.net/nwpho/default.aspx

Psychiatric morbidity and drug use

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

- Psychiatric Morbidity among Adults Living in Private Households, 2000. Office for National Statistics, 2001;
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; http://www.statistics.gov.uk/downloads/theme_health/PMA_2000.pdf

- 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. More details can be found at the following:
www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsStatistics/PublicationsStatisticsArticle/fs/en?CONTENT_ID=4081143&chk=prJhUn

Scottish Executive

Provides statistics and publications for Scotland.

More details can be found at the following:

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.

More details can be found at the following:
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: 0808 800 2345.

More details can be found at the following:
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.

More details can be found at the following:
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.

More details can be found at the following:
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.

More details can be found at the following:
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.

More details can be found at the following:
www.drugs.gov.uk/publication-search/young-people/YPSMPG-0506?view=Standard&pubID=254618

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.

More details can be found at the following:
www.homeoffice.gov.uk/rds/pdfs05/r223.pdf

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

Appendix C: Logistic Regression

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

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

Appendix D: Editorial notes

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

These are as follows:

..   not available

-       zero (or suppressed where stated)

0   less than 0.5

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

Percentages do not always sum to 100 due to rounding.

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

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

..   indicates that data are not reported because the unweighted base is less than 50.

-       indicates no response (to that particular category)

.   indicates that although the unweighted base under analyses was more than 50 there were insufficient drug users in the sample to enable robust subgroup analyses

Appendix E: Further information

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

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

The Contact Centre

The NHS Information Centre

1 Trevelyan Square

Boar Lane

Leeds

West Yorkshire

LS1 6AE

Tel: 0845 300 6016

Email: enquiries@ic.nhs.uk

The 2006 - 2008 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

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, 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:

Psilcybin mushrooms are small and tan coloured and bruise blue when they're touched. Amanita Muscaria are more like the red and white spotted toadstools in fairytale books. After picking, they're 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.