



Llywodraeth Cymru
Welsh Government

Substance Misuse in Wales 2011-12

Profile of substance misuse related education, health and criminal justice statistics

31st October 2012

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Profile of drug and alcohol health and criminal justice indicators in Wales 2011/12

1.1 Introduction

This report provides a summary of the routinely available substance misuse related evidence currently in Wales. Evidence is drawn from a number of data sources including information from the Patient Episode Database Wales (PEDW), the Harm Reduction Database (HRD) Wales, Office for National Statistics (ONS) information, Education, Drug Intervention Programme (DIP) and Home Office data. This report aims to provide brief summaries of, and links to, other relevant documents and reports relating to substance misuse. Numbered references in the text are listed on page 35.

1.2 Executive Summary

- The number of exclusions from schools in Wales (both permanent and fixed term) resulting from substance misuse increased by 2 per cent from 2009-10 to 2010-11.
- There were a total of 459 alcohol related deaths in Wales in 2011 according to ONS, representing a 7.1 per cent decrease from 2010. Of these deaths, 62.5 per cent occurred in Males, 37.5 per cent in Females.
- Over the five years 2007 to 2011 there has been an overall decrease of 8.4% in hospital admissions with alcohol specific primary diagnosis in Wales.
- In 2011, the number of hospital admissions with alcohol specific diagnosis (any mention of) increased by 4.4% from the previous year.
- There were 137 drug misuse related deaths in Wales in 2011. This represents a decrease of 9.9 per cent from the previous year. Regional variation was present in the relative increase or decrease in rates of drug related death per 100,000 population.
- Of the total number of drug misuse related deaths in Wales 2011, 80.3 per cent occurred in Males.
- From 2007 to 2011, admissions for mental and behavioural disorders due to opioids have increased by 29 per cent although in 2011, the number of admissions decreased in both males (by 11.3 per cent) and females (by 8.2 per cent) on the previous year.
- An increase of 19.1 per cent (n=405) was seen in hospital admissions for mental and behavioural disorders due to multiple/psychoactive drug use in 2011. Admissions for mental and behavioural disorders due to cocaine increased by 11.8 per cent (n=95) from 2010 to 2011.
- For the period 2011-12, a total of 13,655 drugs offences were reported by police forces across Wales, representing a 1.2 per cent increase from 2010-11.
- There were 13,354 seizures of controlled drugs in Wales in 2010-11 which represents a decrease of 1.0 per cent on the previous year.

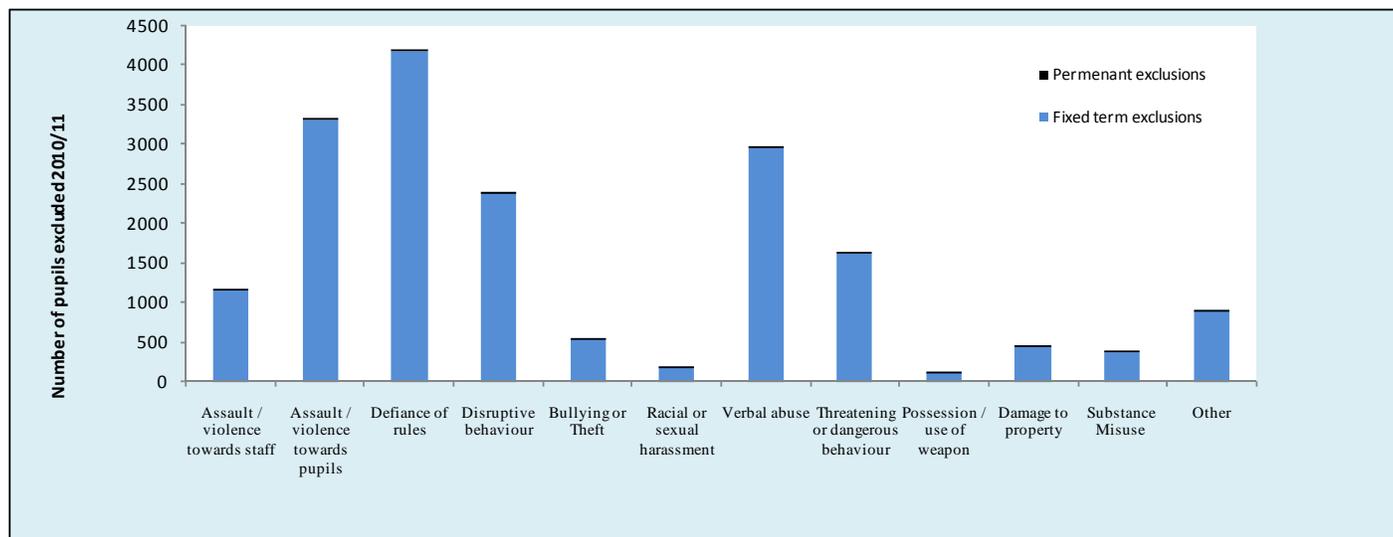
2.0 Education

In 2010/11, there were a total of 158 permanent exclusions, 16,818 fixed term exclusion of five days or less and 1,480 exclusions of 6 or more days in school children aged up to 16 years. ¹Substance misuse accounted for:

- 14.6 per cent (n=23) of the permanent exclusions, an increase on 2009-10 (n =16)²
- 1.9 per cent (n=320) of the fixed term 5 days or less, proportionally no change on 2009-10 (n=318)
- 4.5 per cent (n=67) of the fixed term exclusions of 6 or more days, a marginal proportional increase on 2008-09 (n=70)

- The number of exclusions from schools in Wales (both permanent and fixed term) specifically relating to substance misuse has increased by 2% (n=410) from 2009-10 (n=402) primarily accounted for by the increase in permanent exclusions.

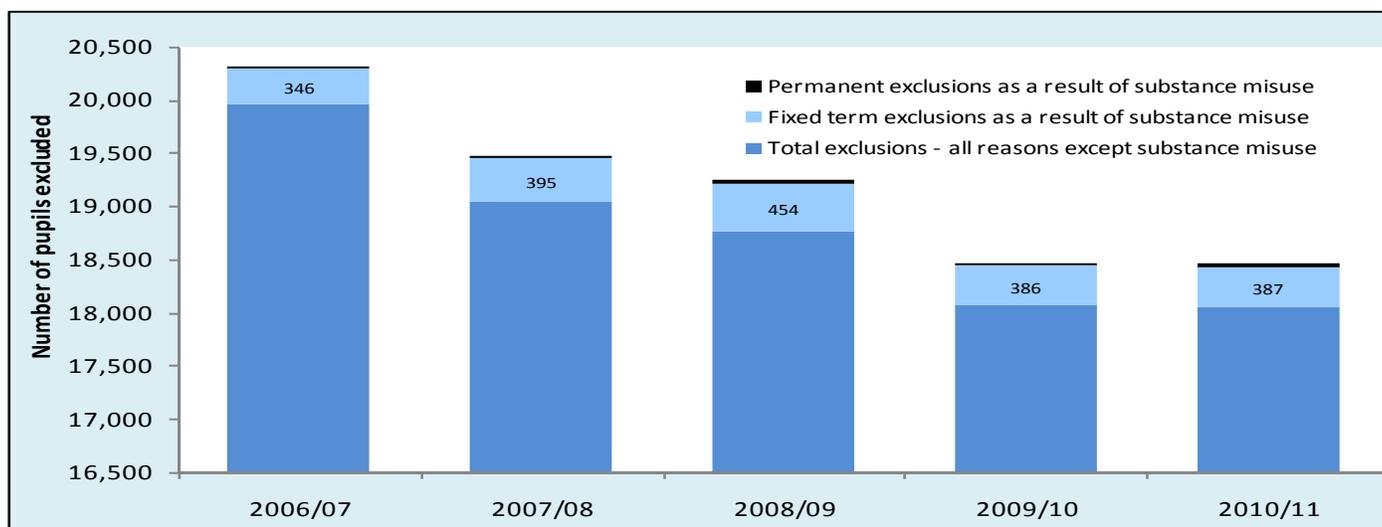
Chart 1: Number of Pupils (aged up to 16) excluded (permanently or fixed term) from schools in Wales by reason for exclusion 2010-11



Source: Exclusions from Schools in Wales 2010/11 KAS, Welsh Government

From 2009-10 to 2010-11, the total number of permanent exclusions (all reasons) decreased by 14.6%.^{1,2} The proportion permanently excluded due to substance misuse increased from 8.6 per cent in 2009-10 to 14.6 per cent in 2010-11. The total number of fixed term exclusions (all reasons) has remained stable from the previous year as has the proportion of fixed term exclusions due to substance misuse at 2.1 % for both 2010-11 and 2009-10^{1,2} as illustrated in Chart 2.

Chart 2: Number of Pupils (aged up to 16) excluded (permanently or fixed term) due to substance misuse from schools in Wales 2006-07 to 2010-11



Source: Exclusions from Schools in Wales 2006-07, 2007-08, 2008-09, 2009-10, 2010-11 KAS, Welsh Government

3.0 Alcohol

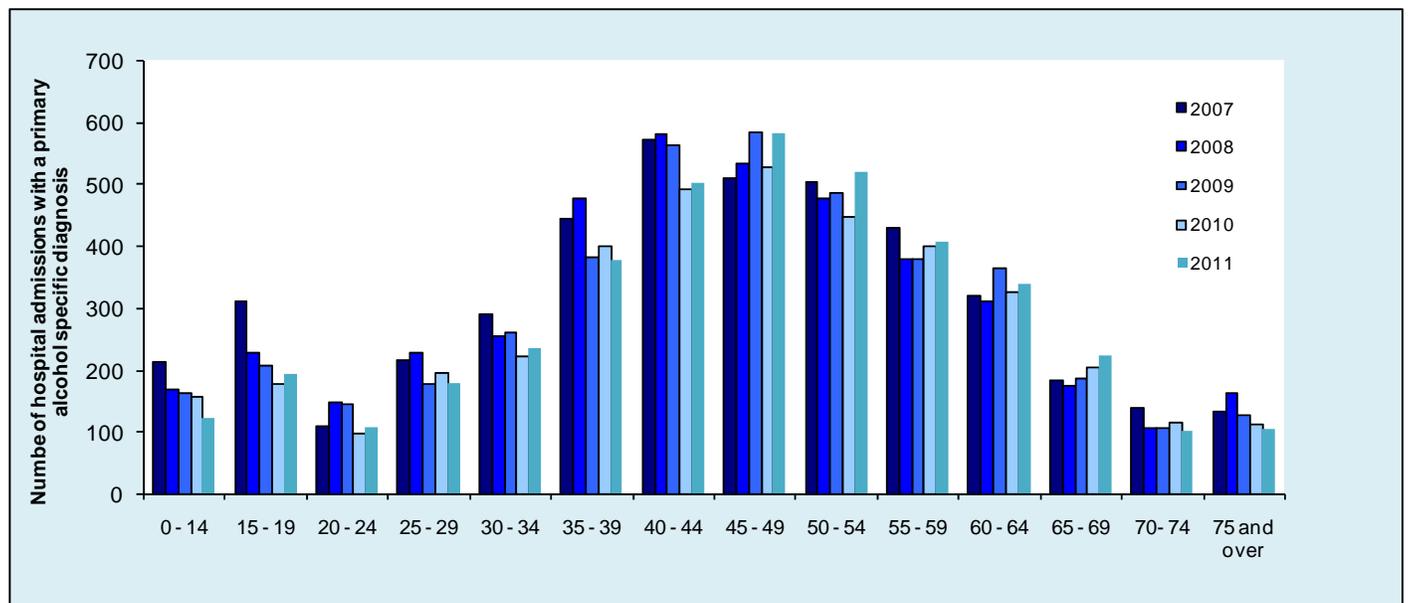
3.1 Alcohol specific disease rates

There are a number of specific acute and chronic health problems associated with alcohol misuse*. These include damage to the digestive system, mental and behavioural disorders, and liver damage including hepatitis and alcoholic cirrhosis of the liver. The patient episode database Wales (PEDW) provides information on hospital episodes within the general population in Wales. Following admission, a diagnosis of the condition to be treated is made which can be either 'primary' or 'any mention of'. When the alcohol specific diagnosis is the main condition to be treated this is considered 'primary' and where the alcohol specific diagnosis is one of the related conditions it is considered 'any mention of'.

Chart 3 indicates the total number of admissions to hospital with an alcohol specific primary diagnosis by age over the period 2007 to 2011. Over this 5 year period the total number of admissions (all ages) has decreased by 8.5 per cent (2007: n=4,380; 2011: n=4,009) although an increase of 3.2% (n=126) in admissions was recorded in the last year 2011. Increases in the number of admissions are observed in all age groups with the exception of 0-14 years, 25-29 years, 35-39 years and those aged 70 and over. Female admissions increased by 8.1% (n=112) and male admissions by 0.5% (n=12).

* Please see page 37 for definition of 'alcohol specific conditions'

Chart 3: Hospital admissions with a primary alcohol specific diagnosis by age, 2007 to 2011

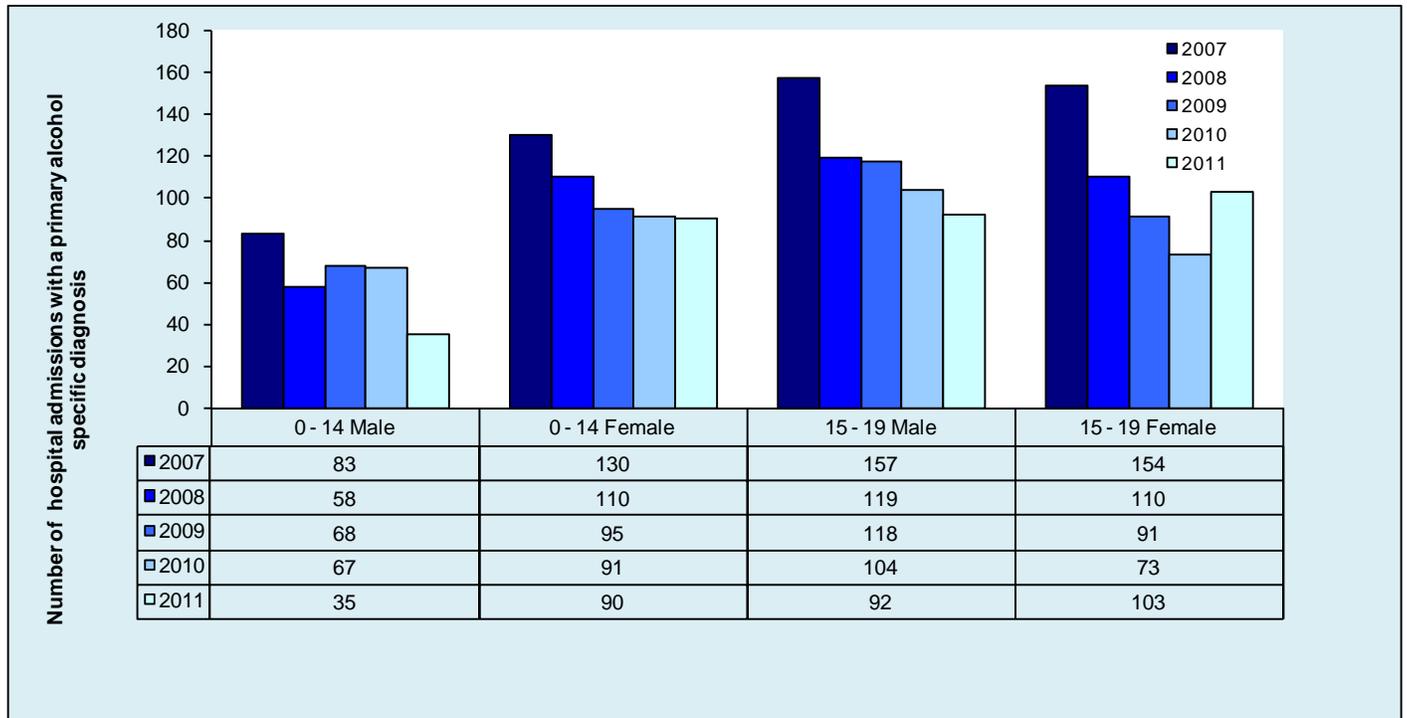


Source: PEDW – Patient Episode Database for Wales 2007 to 2011

Hospital admissions with a primary alcohol specific diagnosis in young people

In 2011, the number of admissions for males aged 0-14 decreased by 47.8 per cent (n=35) compared to the previous year (n=67) whilst the number of admissions for females aged 0-14 remained stable. Year on year consistently higher rates of alcohol specific hospital admissions are reported for females aged under 15 compared to the male cohort. In the 15-19 age group, a decrease of 11.5 per cent in admissions for males was observed, a trend consistent over the previous 5 years, however, an increase of 41.1 per cent was seen in admissions for females within this age group as indicated in Chart 4.

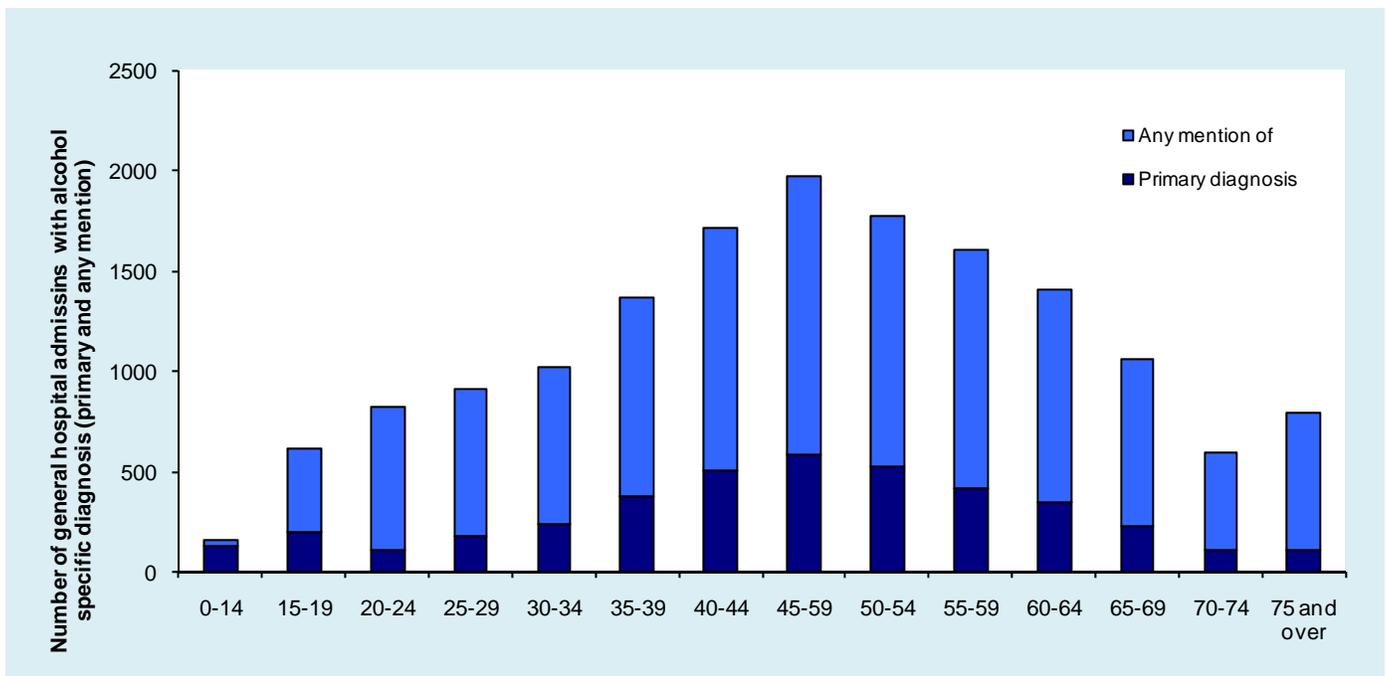
Chart 4: Hospital admissions with an alcohol specific primary diagnosis in males and females aged under 15 and 15-19 years 2007 to 2011



Source: PEDW – Patient Episode Database for Wales 2007 to 2011

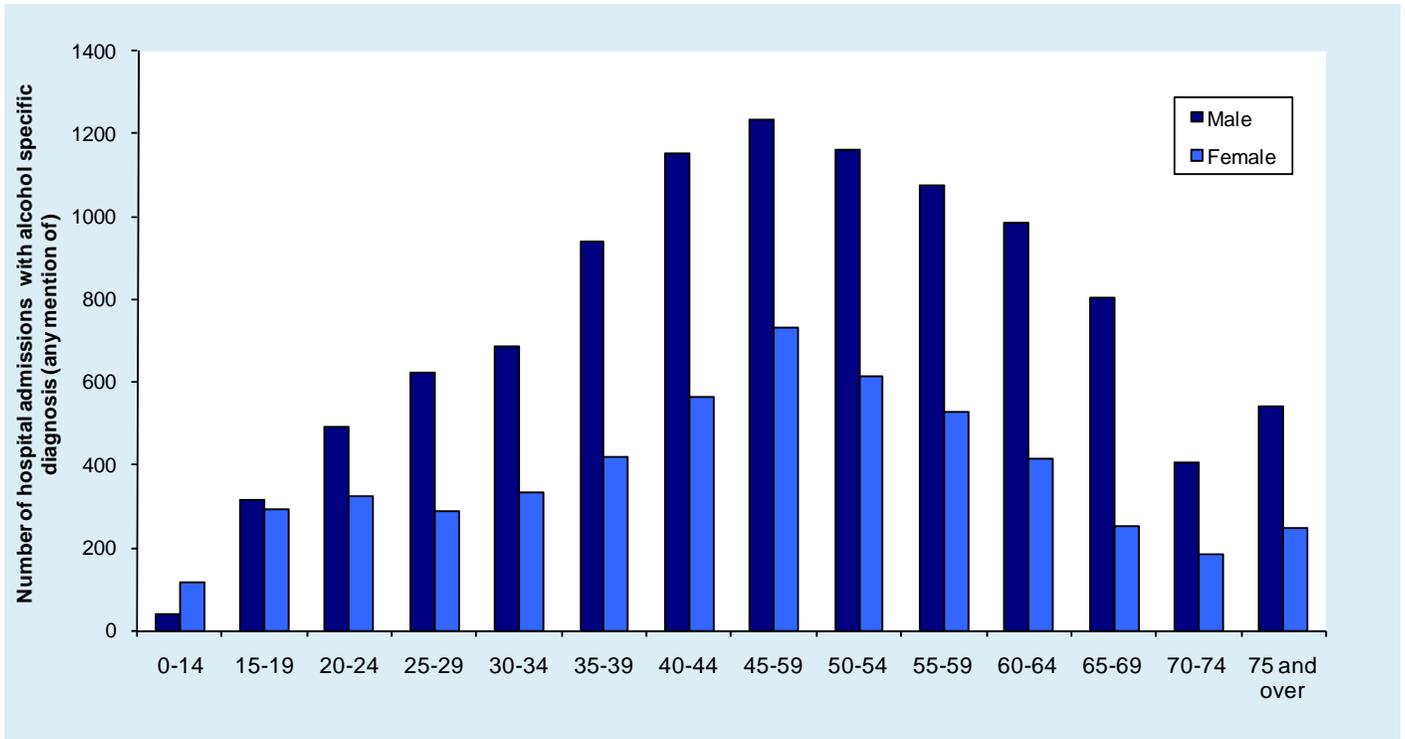
The number of primary alcohol specific admissions represents a small proportion of the overall alcohol specific admissions as indicated in Chart 5. The number of hospital admissions with an alcohol specific diagnosis (any position) have increased by 4.2% over the year 2010 to 2011 (female admissions increased by 4.5% and male admissions by 4%).

Chart 5: Hospital admissions with an alcohol specific diagnosis (primary and any mention of) by age in 2011



With the exception of those aged under 15 years, higher rates of admissions are seen in males. Chart 6 indicates the age and gender profile of alcohol specific admissions (any position) for 2011. The proportion of male to female admissions has remained relatively steady over the previous five years with around half the number of female admissions (n=5,327) to male admissions (n=10,462) .

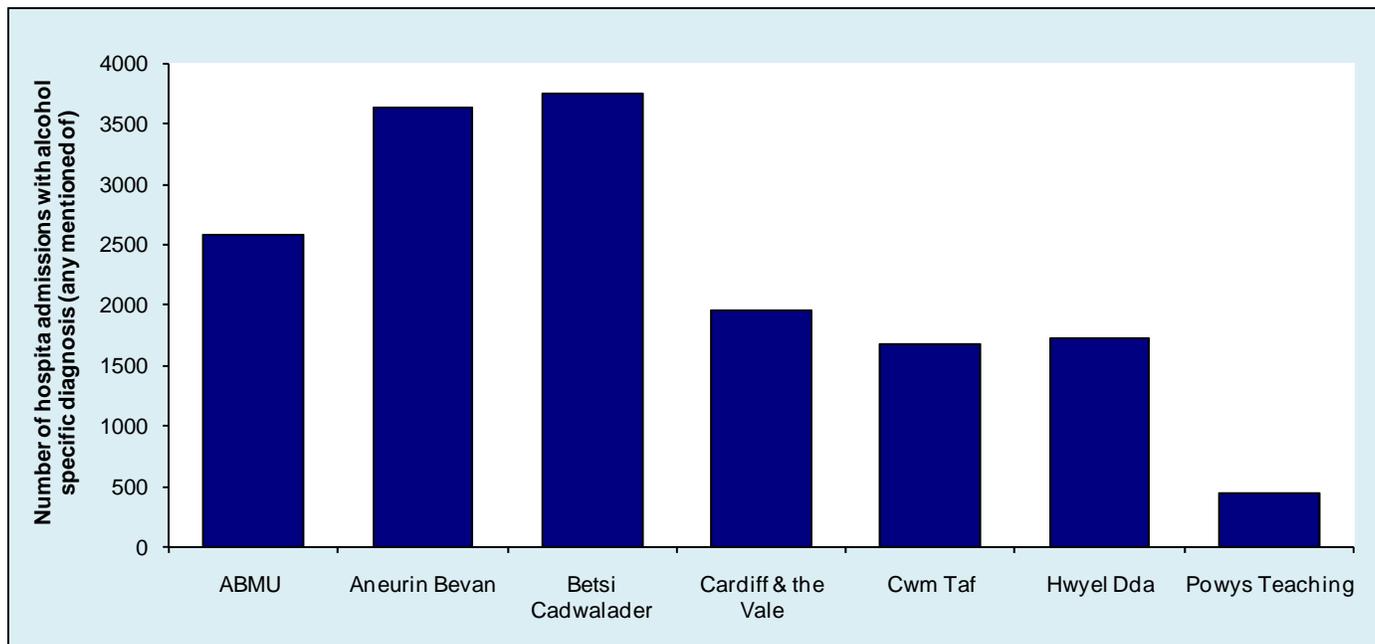
Chart 6: Hospital admissions with an alcohol specific diagnosis (any position) by age and gender 2011



Source: PEDW – Patient Episode Database for Wales 2011

Regional variation is apparent in the number of hospital admissions for alcohol specific diagnosis as indicated in Chart 7.

Chart 7: Hospital admissions with an alcohol specific diagnosis (any position) by Health Board 2011



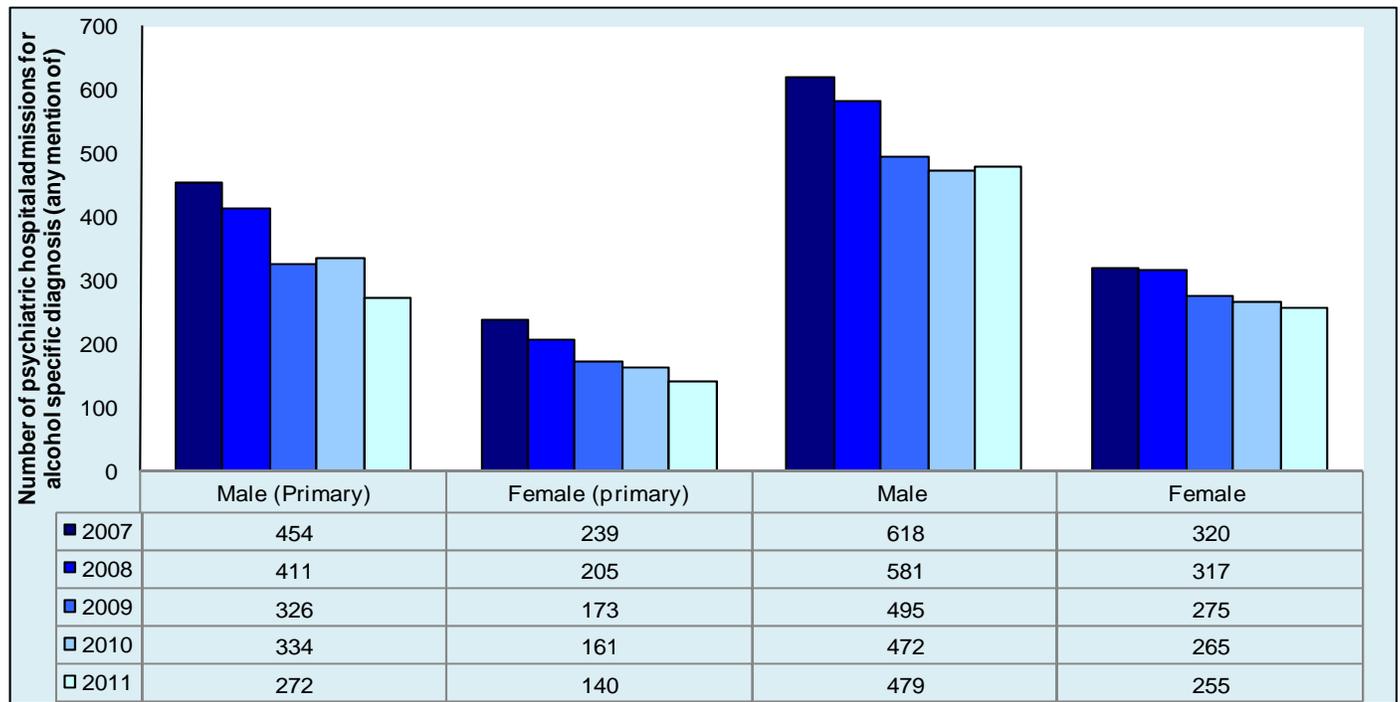
Source: PEDW – Patient Episode Database for Wales 2011

	Number of hospital admissions 2011	% increase or decrease on previous year
ABMU	2,582	3.4%
Aneurin Bevan	3,642	11.0%
Betsi Cadwalader	3,751	0.5%
Cardiff & the Vale	1,967	-13.1%
Cwm Taf	1,677	21.9%
Hwyl Dda	1,731	10.7%
Powys Teaching	439	7.9%

3.2 Psychiatric hospital admissions for patients with an alcohol specific diagnosis

Admissions to psychiatric hospitals for patients with an alcohol specific diagnosis have dropped year on year over the previous 5 years (2007 to 2011) as shown in Chart 8.

Chart 8: Psychiatric hospital admissions with an alcohol related diagnosis (primary and any position) by gender 2007 to 2011

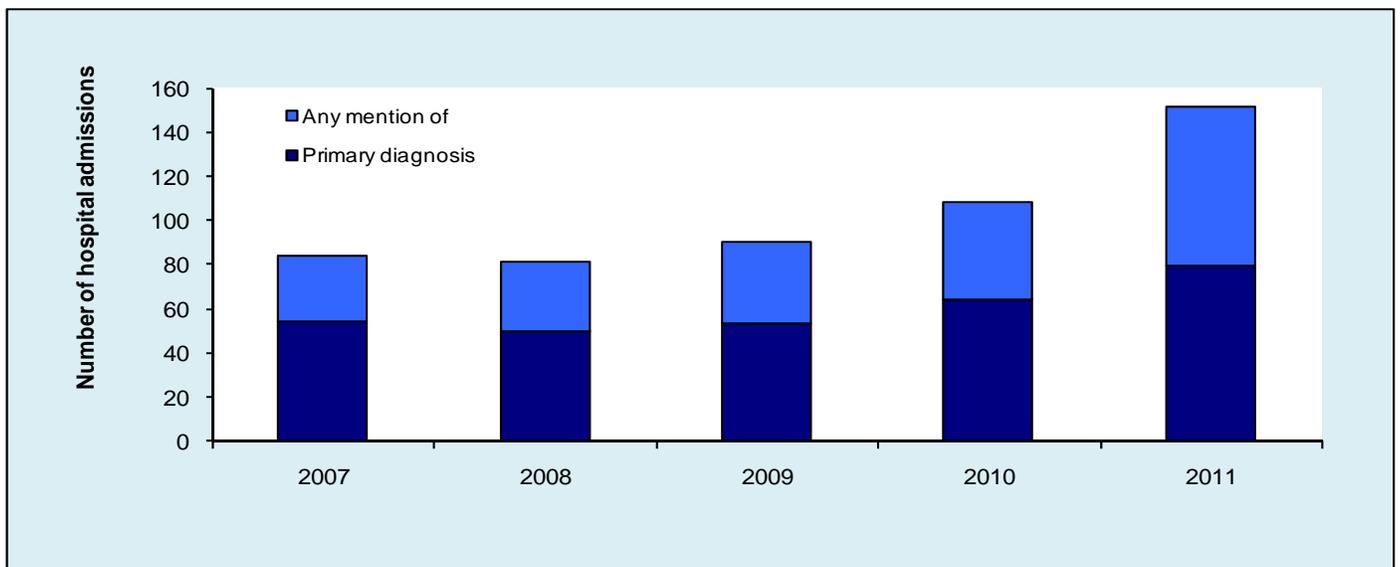


Source: PEDW – Patient Episode Database for Wales 2007 to 2011

3.3 Conditions originating in the perinatal period including foetal alcohol syndrome

The number of hospital admissions for babies born with conditions relating to maternal substance use including foetal alcohol syndrome in Wales increased by 39.8 per cent in 2011. There were a total of 151 admissions (primary and any position) in 2011, representing the highest number observed in the previous 5 years as indicated in Chart 9.

Chart 9: Hospital admissions for conditions originating in the perinatal period (P961 & Q86) (primary diagnoses and any mention of) for 2007 to 2011

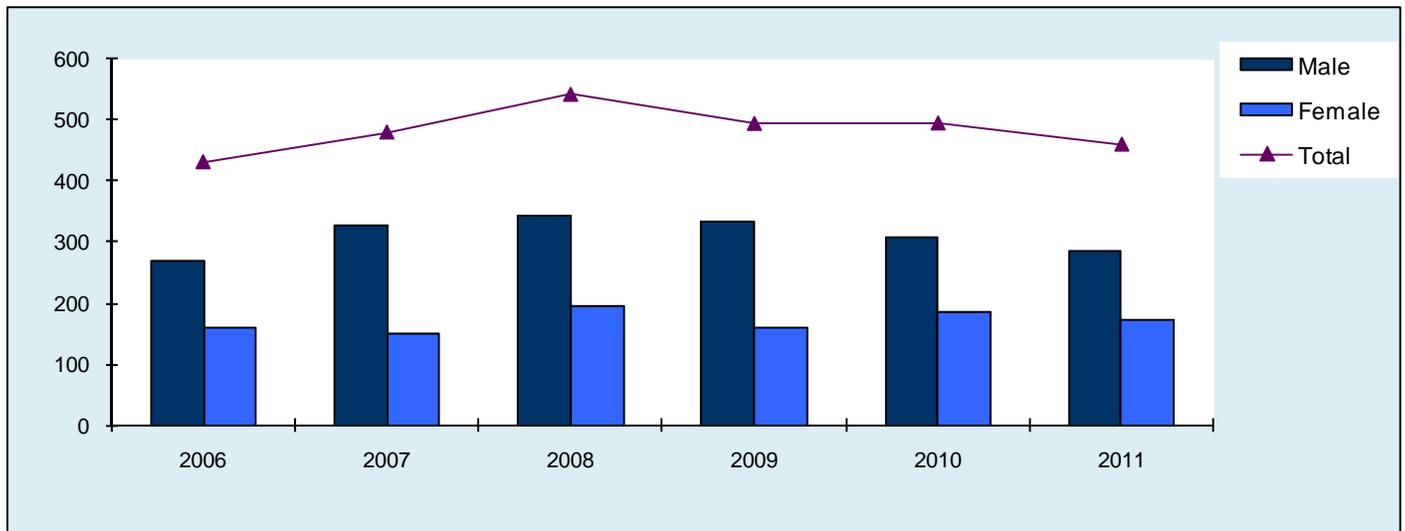


Source: PEDW – Patient Episode Database for Wales 2007 to 2011

3.4 Alcohol related deaths

In 2011, within Wales there was an overall decrease of 7.1 per cent in the number of alcohol related deaths in the last year (from 494 deaths in 2010 to 459 in 2011). The number of recorded alcohol related deaths in 2011 represents the lowest number of annual deaths since 2006 as indicated in Chart 10. Alcohol related deaths decreased in both males and females.

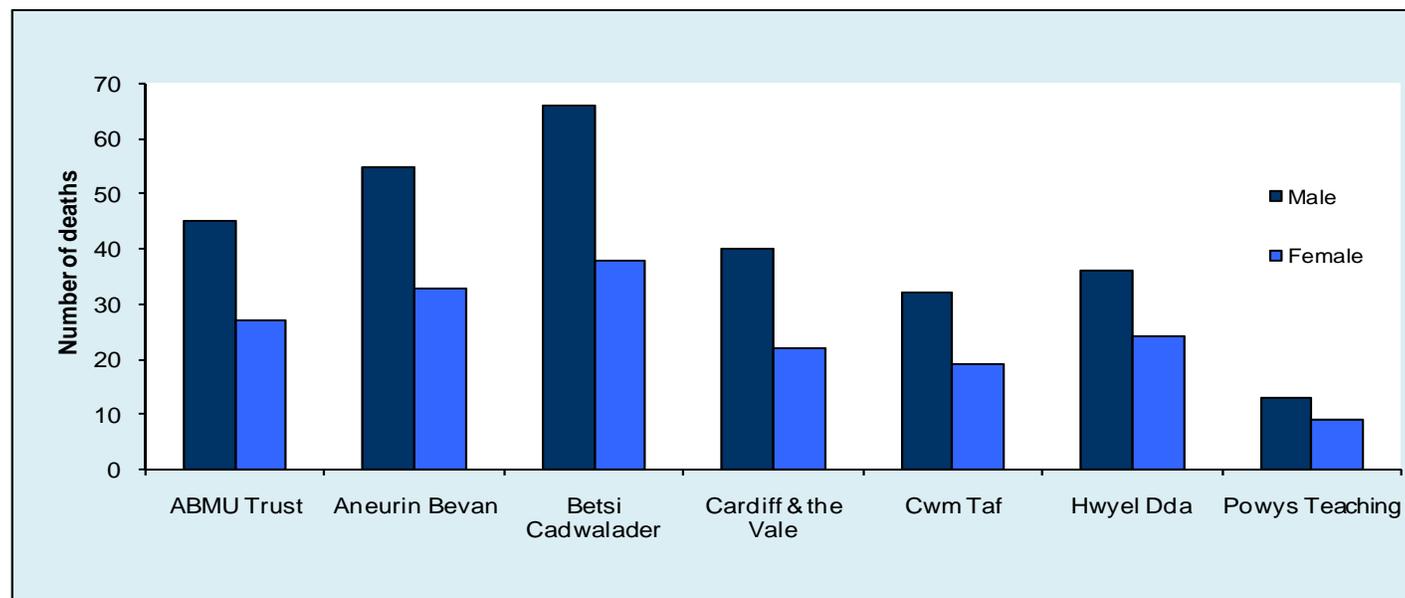
Chart 10: Alcohol related deaths in Wales by gender 2007 to 2011



Source: ONS, 2012

Across Wales, there was regional variation in the number of alcohol related deaths recorded in 2011 with 22.7 per cent of alcohol related deaths recorded within Betsi Cadwaladr Health Board residents as indicated in Chart 11.

Chart 11: Alcohol related deaths in Wales by gender and Health Board in Wales 2011



Source: ONS , 2012

Table 1 provides the number of alcohol related deaths and rate per 100,000 population in 2011 by Health Board of residence. The highest rates per 100,000 population are seen in the Cwm Taf area for both males and females.

Table 1: Alcohol related deaths by gender and area of residence 2011 (c)

Health Board of residence	Number		Rate (a) 2011	Rate increase or decrease 2010 to 2011	Rate increase or decrease 2010 to 2011	
	Male	Female			Male	Female
Abertawe Bro Morgannwg University	45	27	15.32	-5.12	8.98	-0.19
Aneurin Bevan	55	33	17.03	0.82	8.65	0.77
Betsi Cadwaldr	66	38	17.21	-0.08	9.09	-2.17
Cardiff & Vale University	40	22	17.86	-6.22	9.15	0.59
Cwm Taf	32	19	18.52	-3.55	11.48	-8.35
Hwyl Dda	36	24	17.09	-2.45	10.39	-0.17
Powys Teaching	13	9	15.75	5.13	9.95	6.7

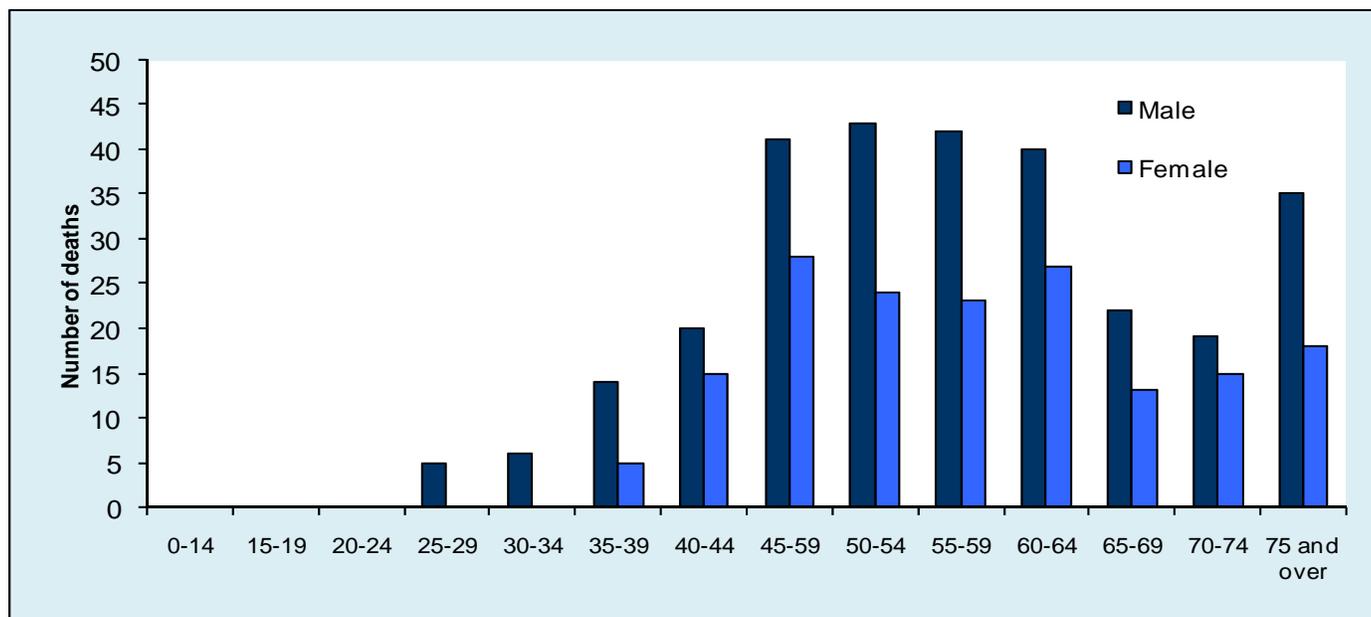
(a) European Standardised rate per 100,000 population. Based on 2011 Census mid year estimates.

(b) Rate increase or decrease (i) per 100,000 population from 2010 death rates.

(c) The rates may be revised by ONS in January 2013.

The age group with the largest proportion of alcohol related deaths in Wales (15 per cent) was ages 45-49 years. Unlike the previous year, no alcohol related deaths were recorded in the under 25 year age groups. There is some gender variation in alcohol related deaths by age group, with deaths in Males only within the 25-29 and 30-34 age group as indicated in Chart 12.

Chart 12: Alcohol related deaths in Wales by age group and gender 2011



Source: ONS, 2012

4.0 Drugs and injecting drug use

4.1 Prevalence estimate of problematic drug use in Wales 2009-10

Public Health Wales (PHW) undertook a capture-recapture study designed to provide an estimate of the prevalence of problematic drug use in Wales. Capture-recapture is a technique that is used with epidemiological studies of hard to reach populations e.g. problematic drug users. By comparing data from several independent overlapping samples, it is possible to adjust for missing cases (or individuals who are not represented on the existing datasets) and to generate estimates of prevalence.³

Problematic drug use in this context refers to injecting drug use or long duration or regular use of heroin, other opioids, cocaine and crack cocaine. Datasets were drawn from the Police Forces and Probation Services in Wales and the Welsh National Database for Substance Misuse Wales (including DIP referrals). The prevalence estimates are based on the 15 – 64 year old population of Wales.

The information outlined in the table below refers to the period 2009-10. It should be noted that an estimate of injecting drug use could not be provided as this information is not routinely recorded within the datasets used.

Exploration of alternative techniques for estimating the prevalence of problematic drug use in Wales are underway using the data for 2009-10 with the aim of establishing a more robust mechanism for the estimation of prevalence of both problematic drug use and injecting drug use in future years.

Table 2: Estimate of problem drug use 2009-10

Estimate of problem drug use 2009/10	Observed	Assumed	Total	population	Rate per 1000	Profile of primary drug type – rate per 1,000 population		
						Stimulant	Opioid	Both
BCU Trust								
Males 15 - 29	498	953	1,451 (1,163-1,862)	6,1771	23.5 (18.8-30.1)	11.6(9.3-14.9)	10.1(8.1-13.0)	1.7(1.4-2.2)
Males 30-64	765	545	1,310 (1,080-1,304)	150,982	8.7 (7.2 – 10.2)	1.1(0.9-1.3)	6.8(5.6-8.0)	0.8(0.6-0.9)
Females 15-29	134	196	330 (215-610)	57,239	5.8 (3.8 – 10.7)	1.2(0.8-2.1)	4.2(2.7-7.8)	0.4(0.3-0.7)
Females 30-64	198	110	308 (249-436)	157,495	2.0 (1.6 – 2.8)	0.1(0.1-0.2)	1.7(1.4-2.4)	0.1(0.1-0.2)
BCU Trust Total	1,595	1804	3,399 (2,707-4,212)	427,487	8.0 (6.3 – 10.4)	1.9(1.5-2.5)	5.4(4.3-7.1)	0.6(0.5-0.8)
POWYS								
Males 15 - 29	58	59	117 (73-234)	10,202	11.5 (7.2 – 22.9)	5.9(3.7-11.9)	4.9(3.1-9.9)	0.6(0.4-1.2)
Males 30-64	75	27	102 (79-242)	29,979	3.4 (2.6 – 8.1)	0.4(0.3-1.0)	2.7(2.1-6.4)	0.3(0.2-0.8)
Females 15-29	22	5	27 (23-50)	9,023	3.0 (2.5 – 5.5)	0.5(0.5-1.0)	2.2(1.9-4.0)	0.3(0.2-0.5)
Females 30-64	12	10	31 (14-243)	30,876	1.0 (0.5 – 7.9)	0.1(0.0-0.7)	0.8(0.4-6.6)	0.1(0.0-0.7)
Powys Totals	167	110	277 (189-769)	80,080	3.5 (2.4 – 9.6)	0.9(0.6-2.5)	2.3(1.6-6.3)	0.3(0.2-0.7)
HYWEL DDA								
Males 15 - 29	278	277	555 (469-617)	34,770	16.0 (13.5 – 17.7)	6.1(5.2-6.8)	8.3(7.0-9.2)	1.6(1.3-1.7)
Males 30-64	290	200	490 (419-599)	80,068	6.1 (5.2 – 7.5)	1.4(1.2-1.7)	4.4(3.8-5.4)	0.3(0.3-0.4)
Females 15-29	83	63	146 (106-242)	33,175	4.4 (3.2 – 7.3)	0.5(0.4-0.9)	3.6(2.6-6.0)	0.3(0.2-0.4)
Females 30-64	77	84	161 (115-249)	86,216	1.9 (1.3 – 2.9)	0.3(0.2-0.4)	1.5(1.1-2.4)	0.1(0.1-0.1)
Hwyel Dda Totals	728	624	1,352 (1,109-1,707)	234,229	5.8 (4.7 – 7.3)	1.5(1.3-1.9)	3.8(3.1-4.8)	0.4(0.3-0.5)
ABMU Trust								
Males 15 - 29	705	998	1,703 (1,379-2,183)	52,717	32.3(26.2 – 41.4)	7.1(5.7-9.0)	23.5(19.0-30.1)	1.8(1.4-2.3)
Males 30-64	874	708	1,582 (1,369-1,885)	110,974	14.3(12.3 – 17.0)	1.5(1.3-1.8)	12.1(10.5-14.4)	0.6(0.5-0.7)
Females 15-29	298	246	544 (425-774)	48,445	11.2(3.7 – 11.8)	0.7(0.5-1.0)	10.1(7.9-14.3)	0.5(0.4-0.7)
Females 30-64	225	627	852 (426-1359)	115,004	7.4(3.7 – 11.8)	0.3(0.1-0.5)	6.9(3.5-11.1)	0.2(0.1-0.3)
ABMU Total	2,102	2579	4,681 (3,599-6,201)	327,140	14.3 (11.0 – 19.0)	1.9(1.4-2.5)	11.8(9.1-15.6)	0.6(0.5-0.9)
Cwm Taf								
Males 15 - 29	256	257	513 (416-669)	29,736	17.3 (14.0 – 22.5)	5.7(4.6-7.4)	11.0(8.9-14.3)	0.6(0.5-0.8)
Males 30-64	343	401	744 (549-1,122)	63,817	11.7 (8.6 – 17.6)	1.0(0.7-1.4)	10.2(7.5-15.3)	0.5(0.4-0.8)
Females 15-29	120	78	198 (162-266)	28,592	6.9 (5.7 – 9.3)	0.4(0.3-0.5)	6.3(5.1-8.5)	0.2(0.2-0.3)
Females 30-64	113	141	254 (177-423)	66,978	3.8 (2.6 – 6.3)	0.1(0.1-0.2)	3.6(2.5-6.0)	0.0 (0.0-0.1)
Cwm Taf Total	832	877	1,709 (1,304-2,480)	189,123	9.0 (6.9 – 13.1)	1.3(1.0-1.9)	7.4(5.6-10.7)	0.3(0.2-0.5)

Table 2 (continued): Estimate of problem drug use 2009-10

Estimate of problem drug use 2009/10	Observed	Assumed	Total	population	Rate per 1000	Profile of primary drug type – rate per 1,000 population		
						Stimulant	Opioid	Both
Cardiff and the Vale								
Males 15 - 29	612	1020	1,632 (1,349-2,024)	60,973	26.8 (22.1 – 33.2)	9.7(8.0-12.0)	14.7(12.1-18.2)	2.4(2.0-2.9)
Males 30-64	677	369	1,046 (967-1,145)	96,814	10.8 (10.0 – 11.8)	1.6(1.5-1.7)	8.2(7.6-8.9)	1.0(1.0-1.1)
Females 15-29	179	149	328 (251-489)	61,428	5.3 (4.1 – 8.0)	0.6(0.5-0.9)	4.1(3.2-6.1)	0.6(0.5-0.9)
Females 30-64	175	78	253 (221-307)	99,546	2.5 (2.2 – 3.1)	0.3(0.3-0.4)	2.0(1.7-2.4)	0.3(0.2-0.3)
Cardiff and the Vale Total	1,643	1,616	3,259 (2,788-3,965)	318,761	10.2 (8.7 – 12.4)	2.3(1.9-2.7)	7.0(6.0-8.5)	1.0(0.8-1.2)
Aneurin Bevan								
Males 15 - 29	450	1,083	1,533 (1,067-2,351)	53,739	28.5 (19.9 – 43.7)	13.0(9.0-19.9)	12.4(8.6-19.0)	3.2(2.2-4.9)
Males 30-64	458	445	903 (723-1207)	124,565	7.2 (5.8 – 9.7)	0.9(0.7-1.2)	5.6(4.5-7.5)	0.7(0.6-1.0)
Females 15-29	130	132	262 (196-393)	51,489	5.1 (3.8 – 7.6)	0.9(0.6-1.3)	3.8(2.9-5.8)	0.4(0.3-0.6)
Females 30-64	112	102	214 (168-295)	130,450	1.6 (1.3 – 2.3)	0.1(0.1-0.2)	1.3(1.0-1.8)	0.2(0.1-0.3)
Aneurin Bevan Total	1,150	1,762	2,912 (2,154-4,246)	360,243	8.1 (6.0 – 11.8)	2.1(1.5-3.0)	5.2(3.8-7.5)	0.8(0.6-1.2)

Notes: Authors: Josie Smith, Simon Cottrell and Dr Mark Temple

Notes:

1. It was not possible to report a separate estimate of injecting drug use as this item was not routinely recorded within the datasets.
2. Some of the underlying assumptions of the model may have been violated and led to biased results – e.g. different case definitions between the data sources, lack of independence between datasets
3. The lack of independence between data sets for particular areas in Wales impacted on the application of best fitting models to assess the estimate of the unobserved population of problematic drug users (those not represented on the databases from police, probation or treatment services). As indicated in the table above, the models were particularly poor fitting for males and females 15 – 29 years in the BCU Health Board area, males 15 – 29 years in ABMU area and Powys all ages

4.2 Prevalence of injecting drug use – Findings from the Harm Reduction Database

The harm reduction database (HRD) is a national web-based data collection system for the recording of all needle and syringe programme (NSP) activity across Wales including the provision of sterile, and return of used, injecting equipment; substances used and injecting behaviour; and, referral and signposting to relevant health and substance misuse services. The HRD went live in all statutory and voluntary sector needle syringe programme (NSP) sites on September 1st 2010. Roll-out of the HRD in all other NSP services i.e. community pharmacy based services is to be implemented from 1st April 2013.

The harm reduction database is currently operational in 46 statutory and voluntary sites across the seven area health boards of Wales. During the first 18 months of data collection that is covered by this report (01/10/2010 – 31/03/2012) the NSP's in Powys and Hwyl Dda health board area relied primarily on pharmacy NSP provision, as a result there is very low activity recorded for these areas on the HRD. Data is therefore presented on a Wales-wide basis. Regional (Health Board area / APB / CSP) reports are available from the regional HRD Co-ordinators.

Data quality

Only those individuals registered on the HRD who have accessed NSP services twice or more during this period, or those who were new registrants during the period 01/03/2012 – 31/03/2012 are included in the analysis to ensure that this report includes only those who are current NSP service users. It is not possible at present to quantify the number of people who inject drugs who do not access NSP services personally. This report does not include individuals who only access pharmacy based NSP services.

Demographics

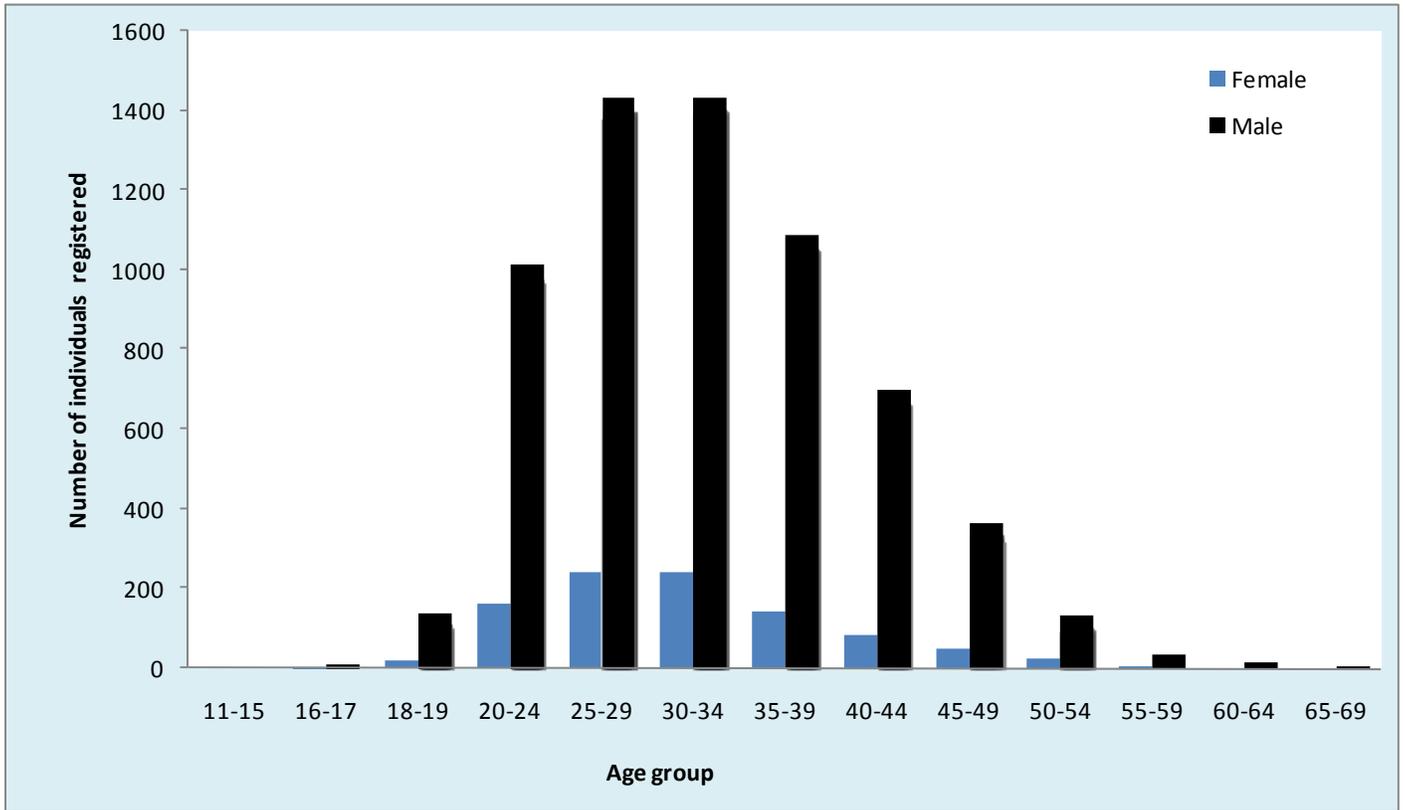
Gender profile:

Within the criteria outlined above a total of 7,343 unique individuals registered on the HRD as current injectors. Of these: 13.3% female (n=977) and 86.7% male (n=6,366).

Age profile:

The majority of registered individuals, both male and female were in the 20 to 24, 25 to 29 and 30 to 34 age ranges and indicated in Chart 13. There were a total of 174 individuals who were aged under 20: 13 individuals aged 11-17 years and 161 aged 18 to 19 years.

Chart 13 – Age and gender profile of current NPS service users across Wales

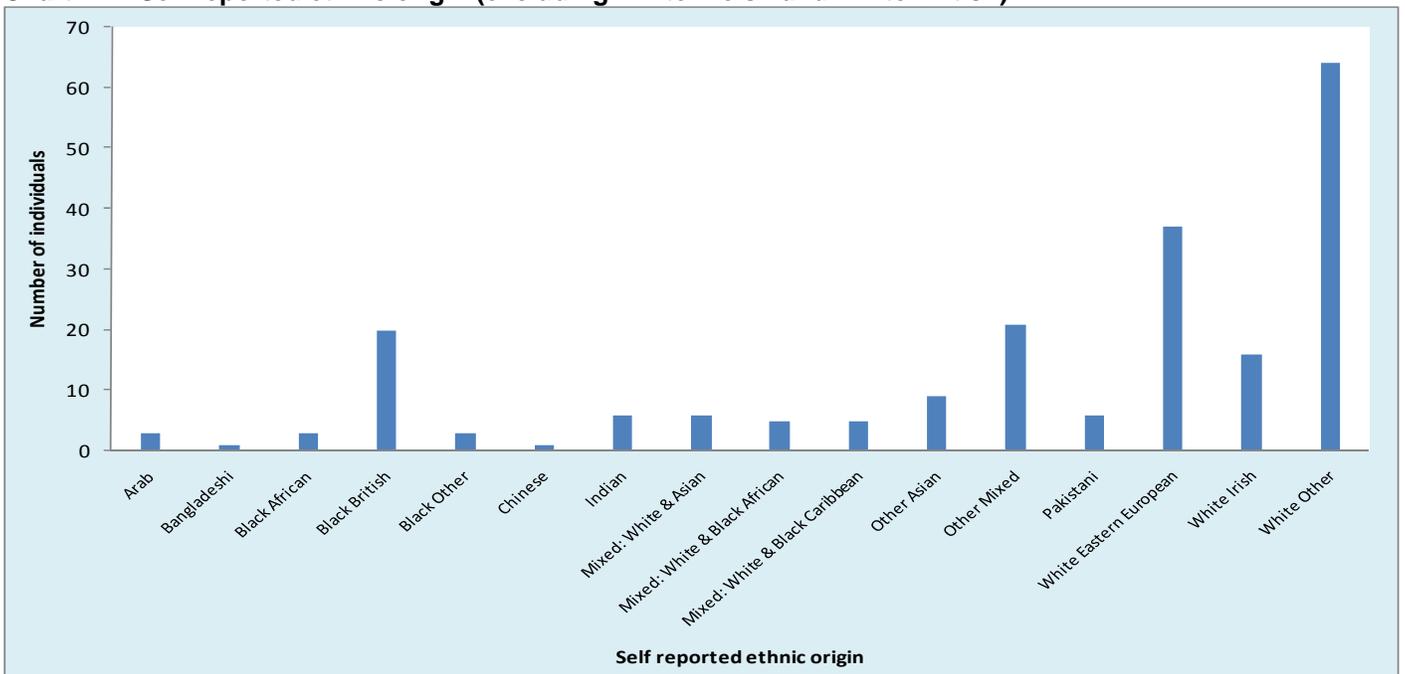


Source: Harm Reduction Database Wales 2012

Ethnicity:

Ethnicity was recorded for 58.3% of individuals (n=4,280). The majority (95.2%) were White Welsh or White British. The ethnic profile of the remaining 4.8% is shown in Chart 14.

Chart 14 – Self reported ethnic origin (excluding White Welsh and White British)



Source: Harm Reduction Database Wales 2012

Housing Status:

Housing status was recorded for 50% (n=3,721) of registrations as shown in Table 3. Housing status has implications for an injecting drug user in relation to the ability to access clean and safe injecting environments, clean water and for safe storage of injecting equipment. As indicated, 14.2% reported temporary housing (B&B or Hostel) or no fixed address (NFA).

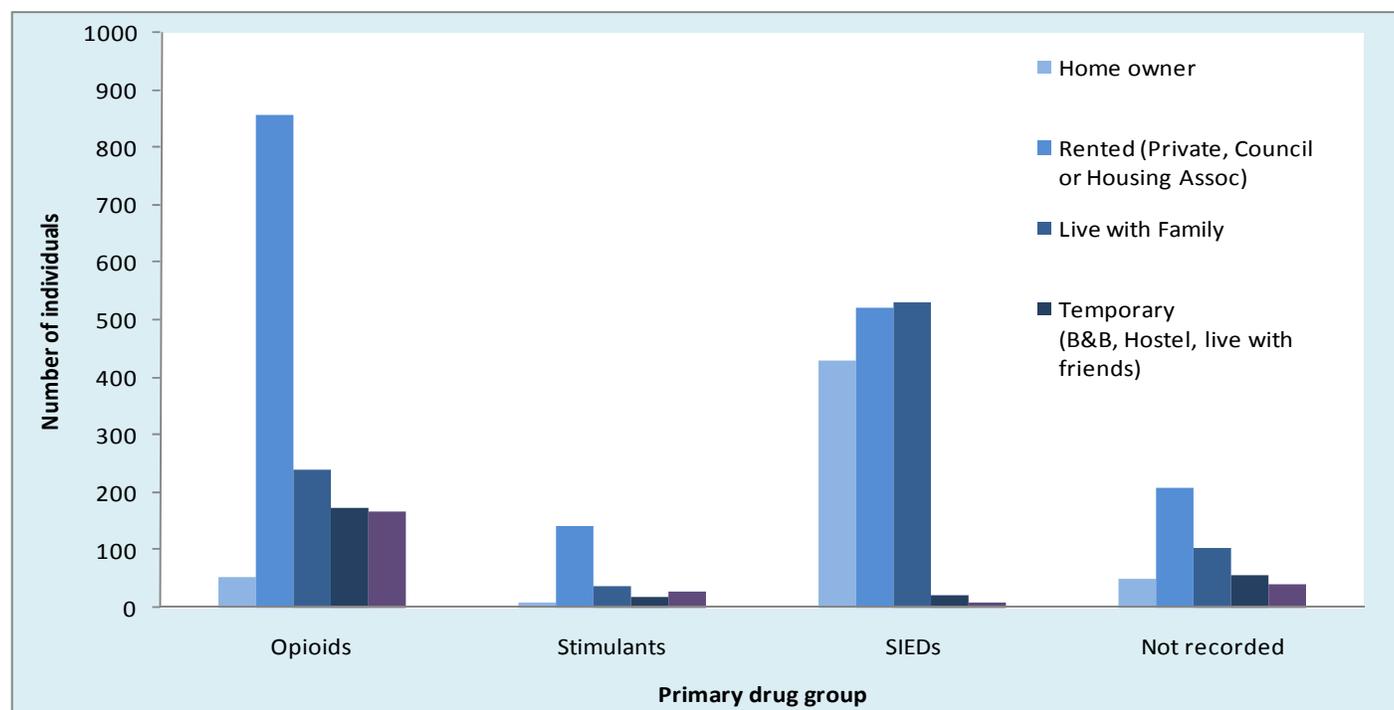
Table 3 – Self-reported housing status of current service users accessing NSP services

Housing Status	Total
Owner	546
Private rented	835
Council rented	692
Housing Association rented	205
Live with family	914
B & B	43
Hostel	159
Hostel - probation	10
Live with friends	70
NFA – Friends House	90
NFA – Mixed	40
NFA – Relatives House	24
NFA – Squat	2
NFA – Street Homeless	91
Grand Total	3,721

However, housing status varied by primary drug group with a higher number of primary opioid users reported being in temporary accommodation or NFA as indicated in Chart 15.

Chart 15 – Housing status by primary drug group injected.

(SIEDs refers to steroids and image enhancing drugs)



Source: Harm Reduction Database Wales 2012

Substances Used

Primary substance

Of the total number of individuals registered, primary substance was recorded for 73% (n=5,354). This means that for 27% of individuals accessing NSP services on two or more occasion, information relating to the substance being injected had not been recorded and as such represents a clear issue for quality service delivery. Table 4 indicates the profile of primary drug recorded by drug group:

- Opiates, which include heroin, methadone, prescribed diamorphine etc
- Stimulants, which include cocaine powder, crack cocaine and amphetamine etc
- Steroid and image enhancing drugs (SIEDs), which include steroids, human growth hormone and other peptides.

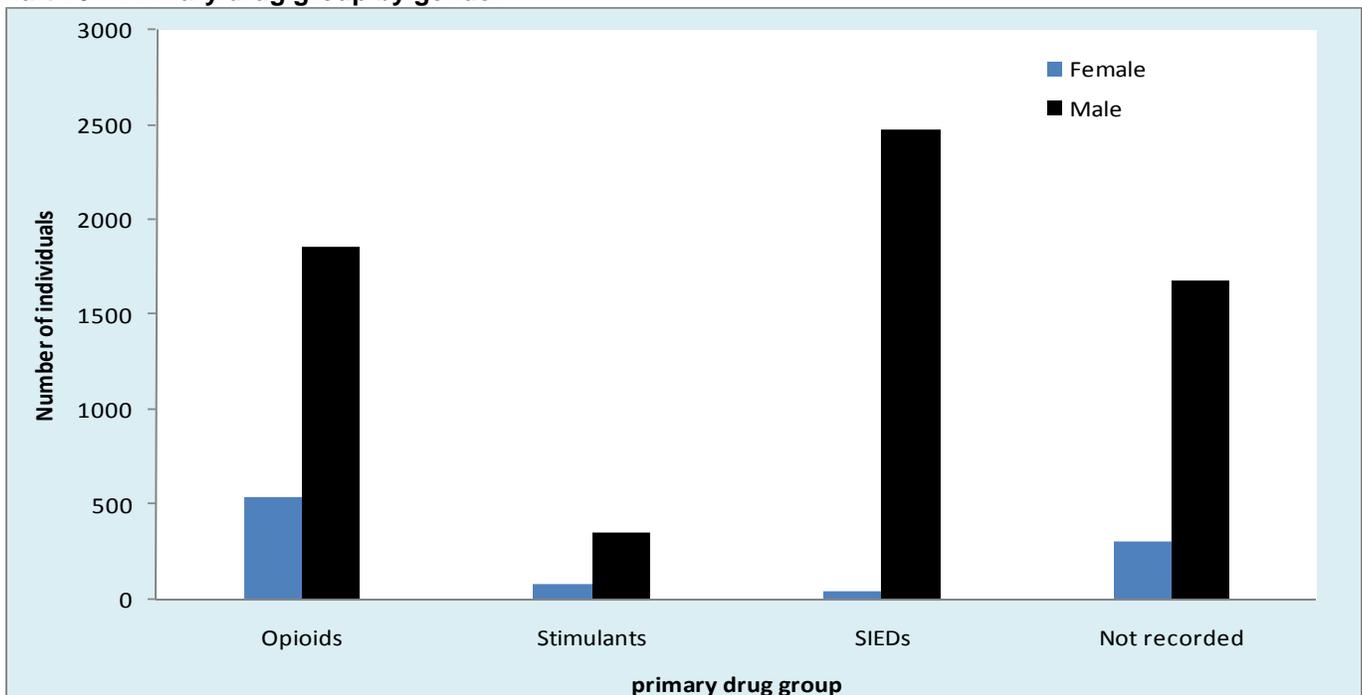
Table 4 – Profile of primary drug type

	n	%
Opioids	2,399	32.7%
Stimulants	431	5.9%
SIEDs	2,524	34.3%
Not recorded	1,989	27.1%

Source: Harm Reduction Database Wales 2012

As indicated in Chart 16, there is considerable variation in the ratio of males to females dependant on primary drug group. Amongst primary opioid injectors the ratio of male to female is 3.4:1, whereas amongst primary SIEDS users the ratio is 52:1. It is not possible to establish the nature of primary drug use where primary substance is not recorded, however, the authors believe that the rates of primary stimulant users may be underreported.

Chart 16 – Primary drug group by gender

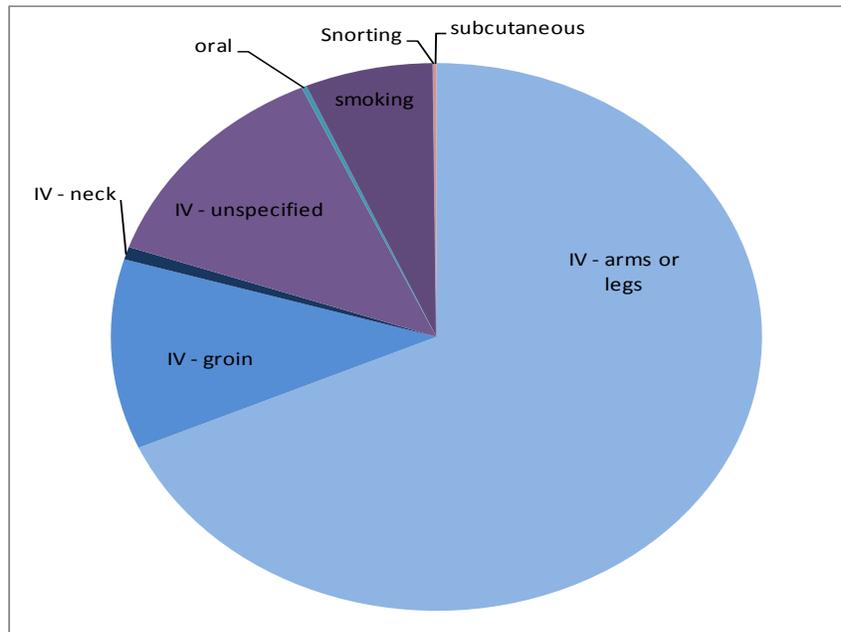


Source: Harm Reduction Database Wales 2012

Route of administration of primary drug

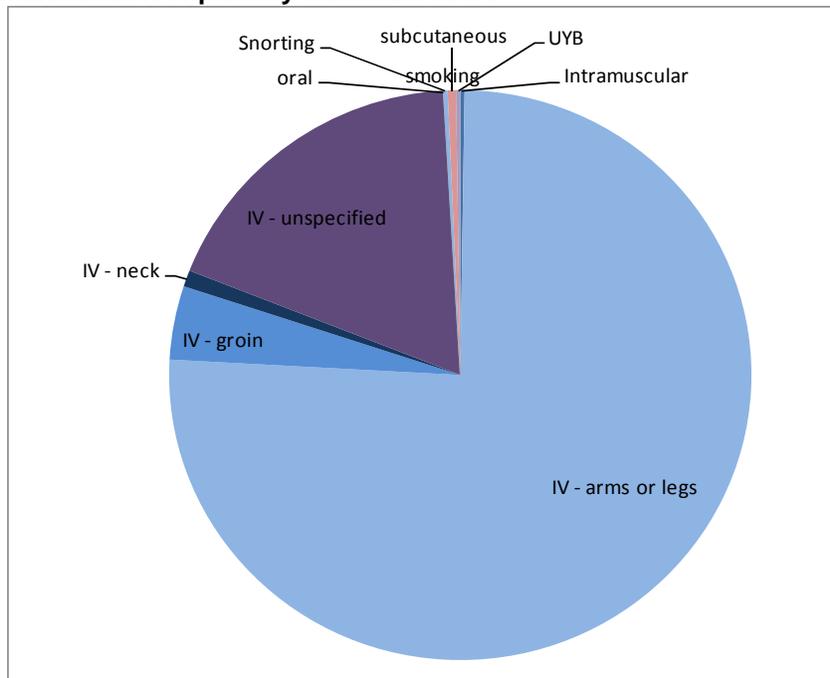
Route of administration impacts greatly on the health consequences of substance use, particularly in relation to injecting. Route of administration for primary drug was recorded for 72.9% (n=5,353) of individuals. However, information was incomplete (i.e. IV - unspecified) for 279 cases - representing a clear data quality issue to be addressed. SIEDs users inject oil or water based steroids via intramuscular injection, and peptides/hormones via subcutaneous injection. Chart 17 and 18 indicate the route of administration reported amongst current primary opioid users and primary stimulant users respectively.

Chart 17 – Route of administration of primary opioid users



Source: Harm Reduction Database Wales 2012

Chart 18 – Route of administration of primary stimulant users



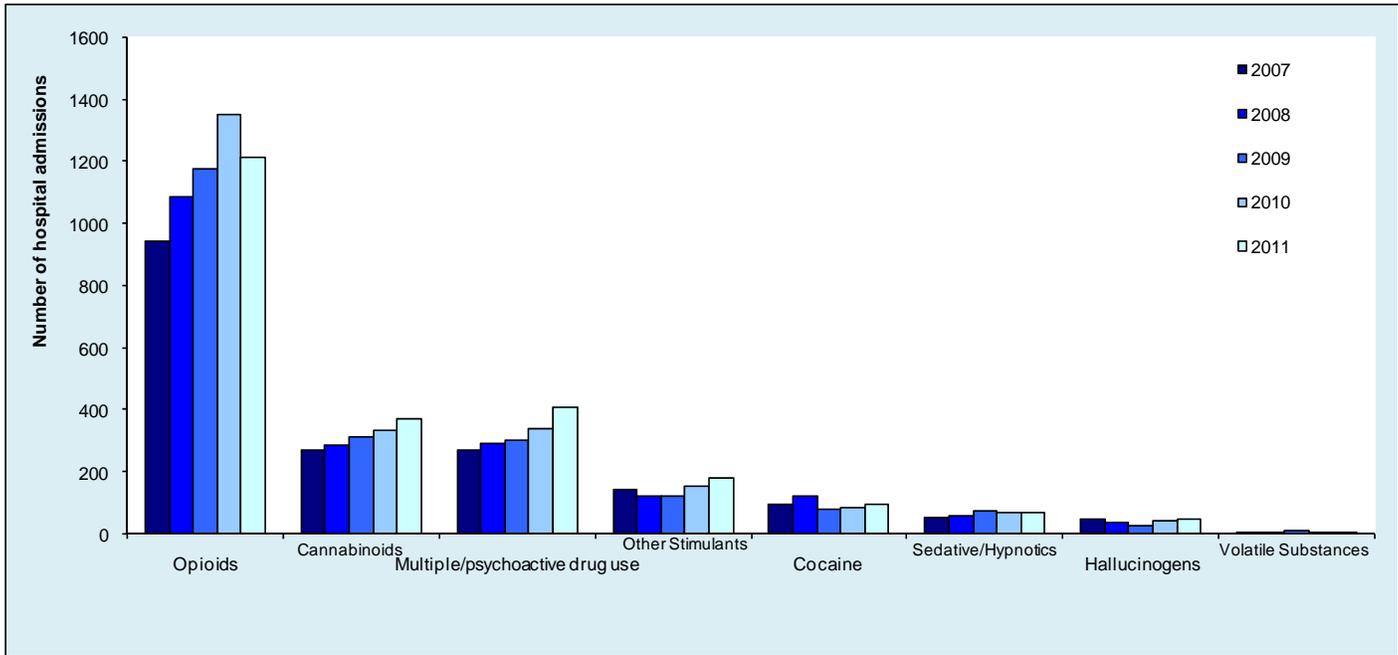
Source: Harm Reduction Database Wales 2012

Rates of groin or femoral injecting are higher amongst primary opioid users, accounting for 12% of those injecting. Over and above the risks associated with IV injecting, the increased risks associated with groin injecting include Deep Vein Thrombosis (DVT), increased risk of arterial bleeds and the development of fistula. Likewise neck injecting carries significant risk as the arteries, veins, tendons and nerves are all very close together in this area.

4.3 Drug related admission rates

Hospital admissions for illicit drug use may include a range of diagnoses including mental and behavioural disorders resulting from named drug use or by poisonings with named illicit drugs. Chart 19 indicates a decrease in the number of admissions for mental and behavioural disorders due to opioids in the last year following a year on year increase in the previous four years. A continued rise in admissions due to cannabinoids, multiple/psychoactive substances, other stimulants and cocaine is also observed over the period 2008-2011.

Chart 19: Hospital admissions for mental or behavioural disorders due to named illicit drugs 2007 to 2011 (any mention of)

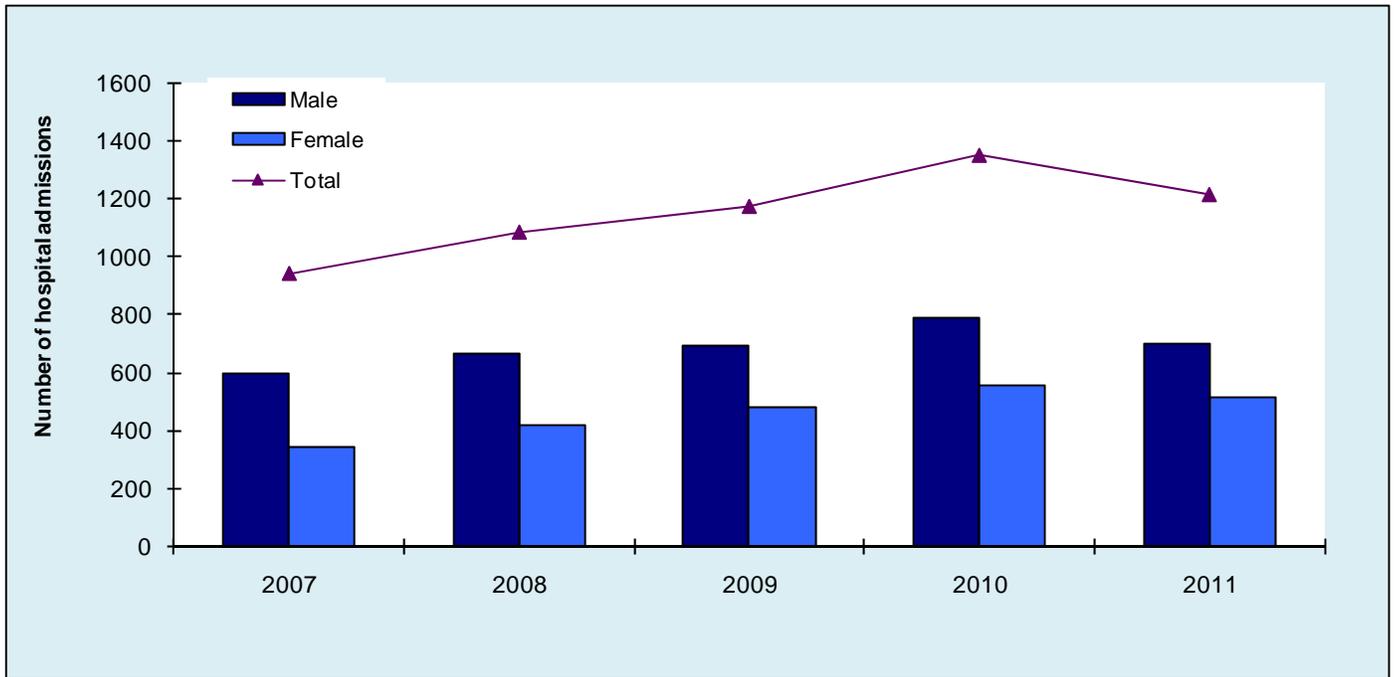


Source: PEDW – Patient Episode Database for Wales 2007 to 2011

Hospital admissions due to multiple/psychoactive drug use have increased by 19.1 per cent (n=405) in the last year and admissions in 2011 are at the highest level seen the last 5 years. Likewise, hospital admissions for other stimulant drug use have increased by 19.9 per cent in 2011 (n=181), the highest number since 2006.

Over the period 2006 to 2010, admissions for mental and behavioural disorders due to opioids increased overall by 53.2 per cent (44.4 per cent in males and 68.1 per cent in females), however, a decrease of 10 per cent (from 1,351 in 2010 to 1,215 in 2011) was recorded in the last year as indicated in Chart 20.

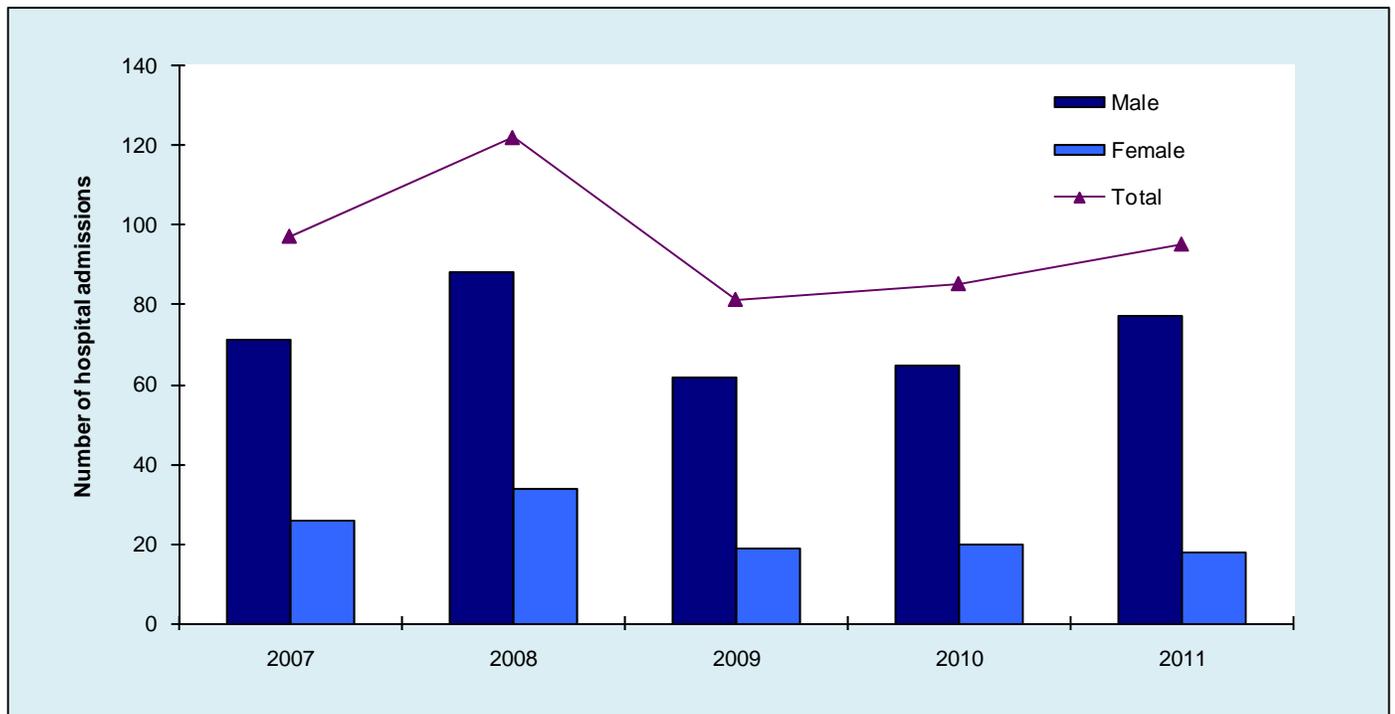
Chart 20: Hospital admissions for mental or behavioural disorders due to opioid use 2007 to 2011 (any mention of)



Source: PEDW – Patient Episode Database for Wales 2006 to 2011

Admissions for mental and behavioural disorders due to cocaine increased by 11.8 per cent from 2010 to 2011 (from 85 to 95 admissions), however, numbers of admissions over the last three years remain lower than those reported in 2007 and 2008 as indicated in Chart 21.

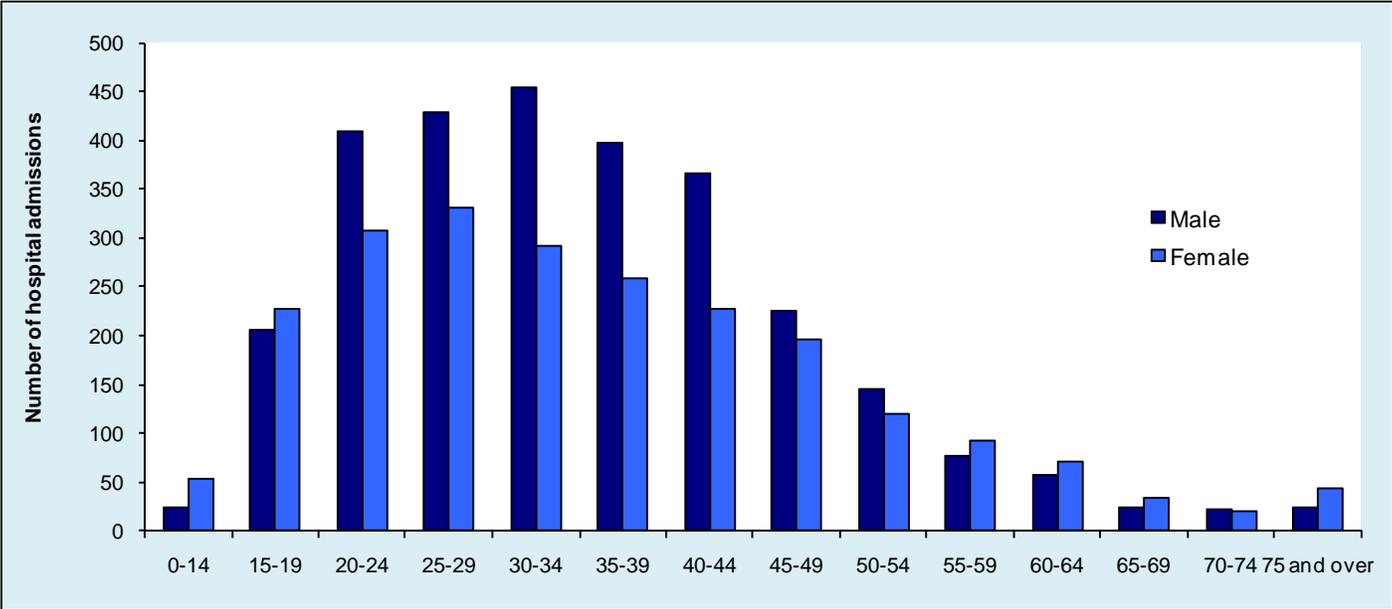
Chart 21: Hospital admissions for mental or behavioural disorders due to cocaine use 2007 to 2011



Source: PEDW – Patient Episode Database for Wales 2006 to 2011

Admissions for poisonings with drugs includes overdose with narcotics (opium, heroin, other opioids, cocaine), psychodysleptics (hallucinogens), antiepileptics, sedative-hypnotics (including benzodiazepines) and psychotropic drugs not elsewhere mentioned. There were a total of 5,136 hospital admissions for poisonings with drugs (any mention of) in 2011, an increase of 4.6 per cent on the previous year. As indicated in Chart 22, overall the highest number of admissions during 2011 were seen in the 25-29 age group but admissions remain elevated in the 20-24, 30-34, 35-39 and 40-44 year age groups.

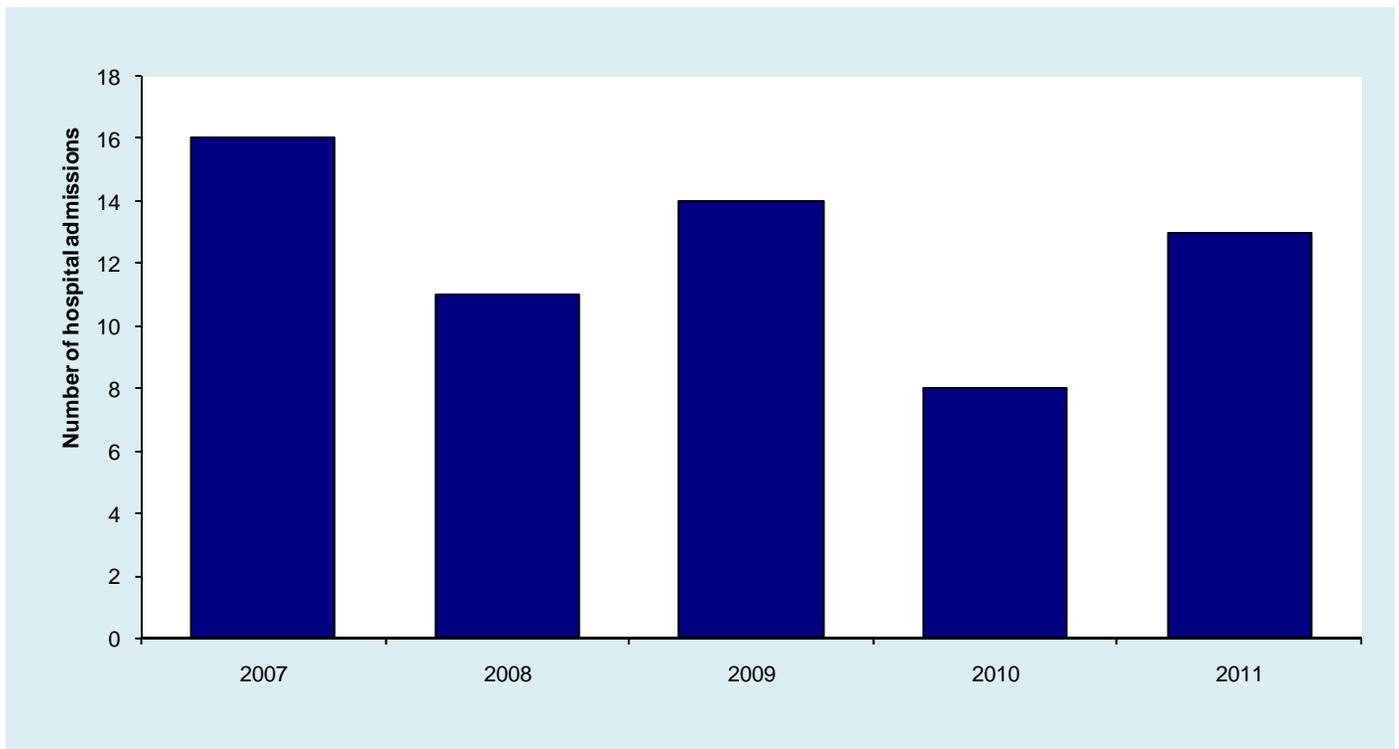
Chart 22: Hospital admissions for poisoning with drugs by age and gender 2011



Source: PEDW – Patient Episode Database for Wales 2006 to 2011

The number of fetuses and newborns affected by maternal use of drugs of addiction increased in 2011 following the lowest number observed in a five year period recorded in 2010 as indicated in Chart 23. The number of cases per year does not appear to be following a consistent trend, however, numbers remain relatively low.

Chart 23: Foetus and newborn affected by maternal use of drugs of addiction in Wales 2007 to 2011

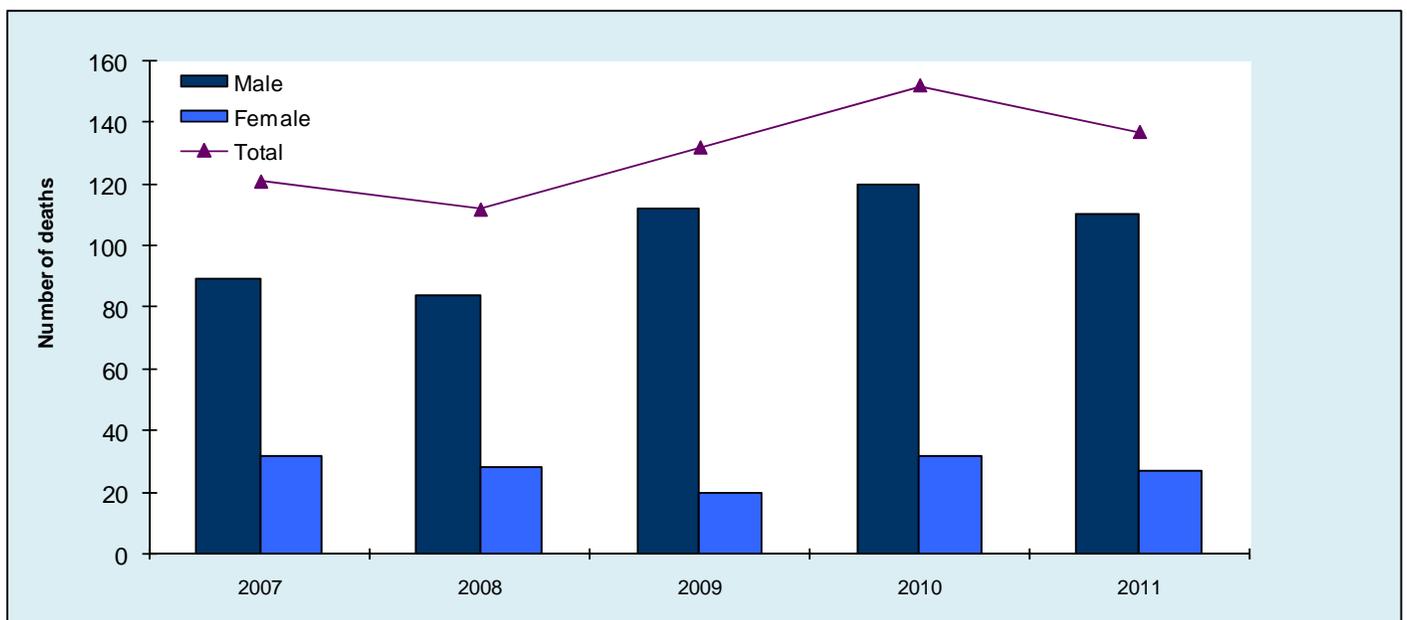


Source: PEDW – Patient Episode Database for Wales 2006 to 2011

4.4 Drug misuse related deaths

There were a total of 1,605 deaths related to drug misuse in England and Wales in 2011 (1,192 male and 413 female (1,382 male and 402 female) representing an overall decrease of 10 per cent on the previous year (13.7% decrease in males, 2.7% increase in females).⁴ In Wales, the number of deaths has decreased overall from a total of 152 in 2010 to 137 in 2011, a decrease of 9.9 percent, as indicated in Chart 24.

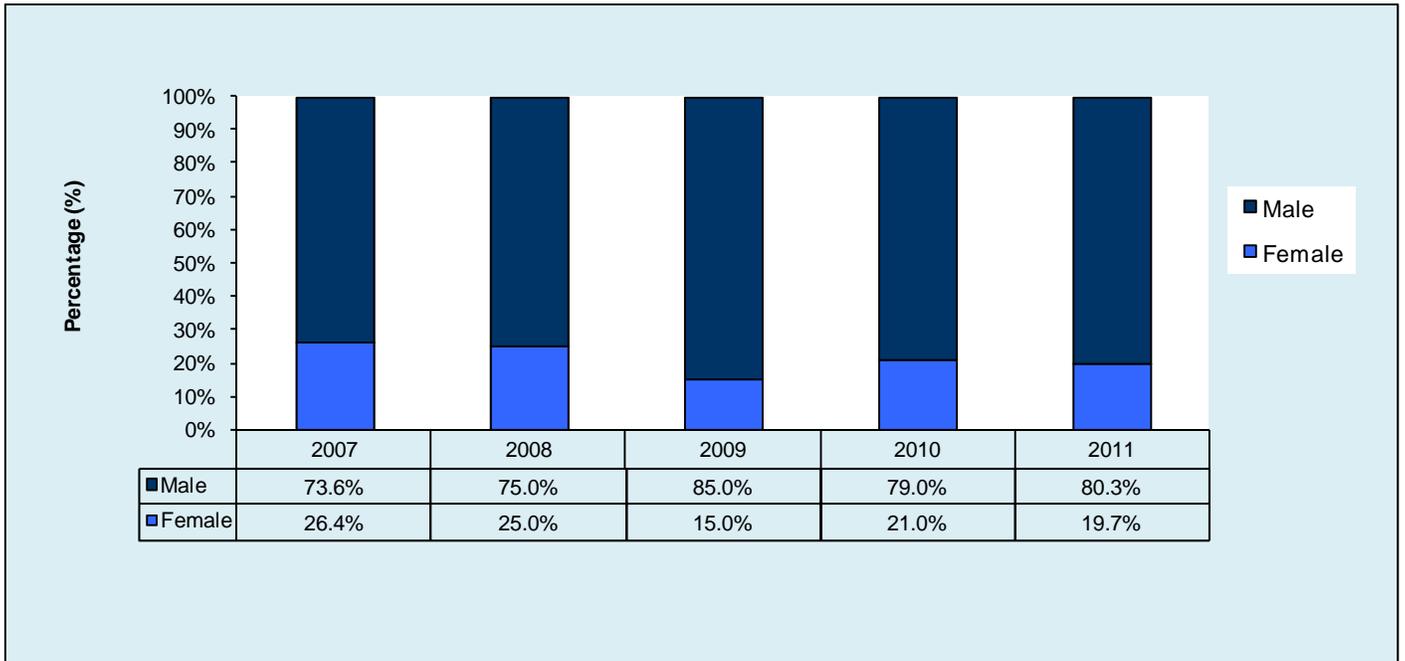
Chart 24: Deaths related to drug misuse in Wales by gender 2007 to 2011



Source: ONS, 2012

The proportion of drug misuse related deaths in females relative to males over the last five years is indicated in Chart 25.

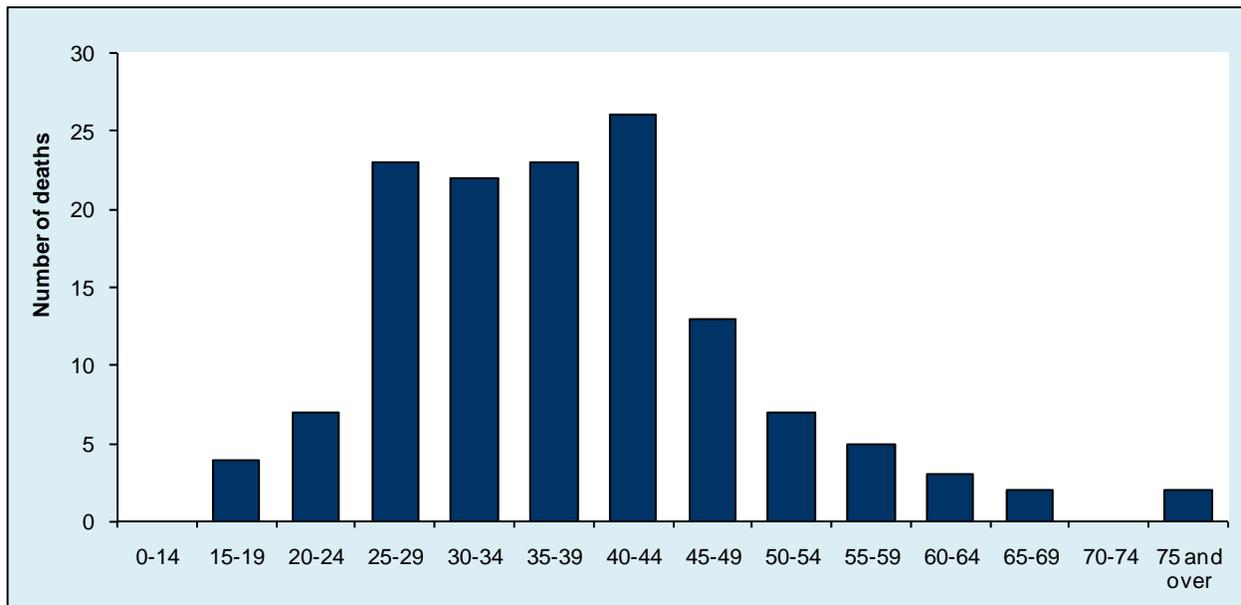
Chart 25: Proportion of male to female deaths related to drug misuse 2007 to 2011



Source: ONS 2012

The highest number of drug misuse related deaths in Wales in 2011 occurred in the 40-44 year age group as indicated in chart 26.

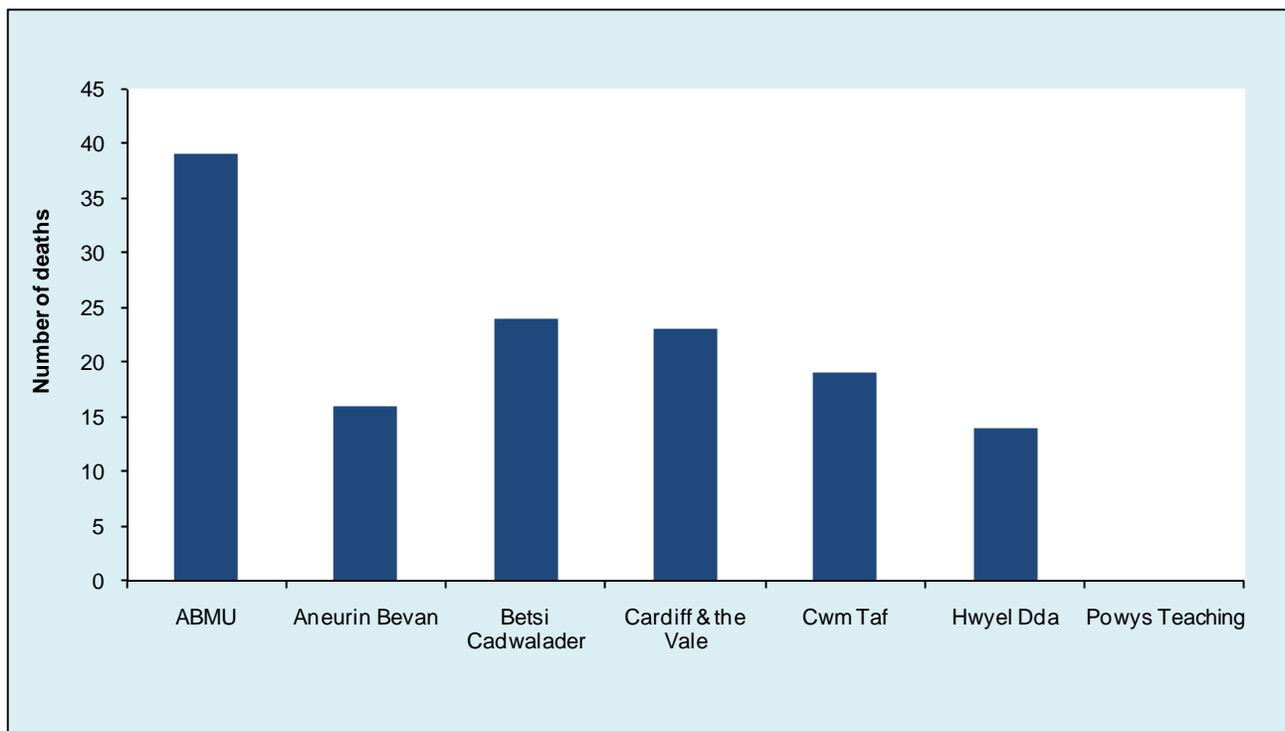
Chart 26: Drug misuse related deaths in Wales by age 2011



Source: ONS 2012

Within the overall drug misuse related death data for 2011, there is marked regional variation with 28.5 per cent of all deaths recorded within the Abertawe Bro Morgannwg University Health Board area as indicated in Chart 27.

Chart 27: Drug misuse related deaths in Wales by Health Board 2011



Source: ONS 2012

Table 5 provides the number of drug related deaths and rate per 100,000 population by Health Board of residence. The highest rates per 100,000 population in 2011 are seen within Abertawe Bro Morgannwg University Health Board area and the lowest within Powys Teaching Health Board.

Table 5: Drug related death rates per 100,000 population by Health Board area of residence 2011

Health Board of Residence	Number	Rate (a) 2011	Rate (b) 2010	Rate increase or decrease 2010 to 2011
Abertawe Bro Morgannwg University	39	7.97	7.48	0.49
Aneurin Bevan	16	3	4.13	-1.13
Betsi Cadwaldr	24	3.76	3.98	-0.22
Cardiff & Vale University	23	5.21	6.23	-1.02
Cwm Taf	19	6.85	6.28	0.57
Hywel Dda	14	4.52	6.54	-2.02
Powys Teaching	Less than 5	1.67	5.84	-4.17

(a) European age standardised rates per 100,000 population. Based on 2011 census mid year population estimates.

(b) Rate increase or decrease (-) per 100,000 population from 2010 death rates.

4.5 Injecting drug use: Risk behaviour, bacterial infections and blood borne viruses

In relation to the risks associated with injecting drug use, the practice of sharing injecting equipment, both direct (the sharing of needles and syringes) and indirect (the sharing of other injecting related equipment including spoons/cookers, filters, water) have a clear impact on rates of injecting related infections. ⁴ These infections may include bacterial infections as a result of with poor hygiene, poor injecting technique, or contamination of drugs injected and include:

- Staphylococcus aureus infections (including MSSA, MRSA)
- Group A streptococcal infections
- Clostridial infections including wound botulism, tetanus
- Blood borne viral infections:
 - hepatitis B
 - hepatitis C
 - HIV

Risk behaviour

Direct sharing (the sharing of used needles and syringes) - According to the Unlinked Anonymous Monitoring (UAM) survey of people who inject drugs (PWIDs) 2010,⁵ direct sharing (of used needles and syringes) in the previous four weeks was reported by 21 per cent of respondents. However, self-reported rates of direct sharing have decreased from 38% in 2000. Higher rates of direct sharing are reported in those aged under 25 years. Reported direct sharing in the previous four weeks was associated with;

- Injecting crack-cocaine
- Injecting cocaine
- Injecting amphetamine
- Having been homeless in the previous year ⁶

Indirect sharing (sharing injecting related equipment e.g. cookers, filters, water) - In 2010, substantial levels of indirect sharing were reported with 40% per cent of respondents reported sharing injecting equipment in the previous four weeks. ⁵

Risks of injecting site infection

The UAM 2011 survey, for the period 2010, indicated that overall 35 per cent (459 of 1,242) of current PWID respondents (injected in the previous four weeks) reported experiencing symptoms of injecting site infections in the previous year. These include having had an abscess, sore, or open wound at injection site. ⁵ This and previous UAM surveys ⁶ indicated that injecting site infections were also associated with site of injection and type of drug injected:

- Compared to those that had not injected into the following sites, higher rates of infection were reported in those who had injected in their hands, legs and/or feet.
- Higher infection symptom rates were also reported in those injecting crack-cocaine and cocaine in the previous four weeks, compared to those that had not. ⁶

Blood borne viruses

Hepatitis C

Hepatitis C remains the most important blood borne virus in relation to injecting drug users with around 80 per cent of those infected becoming chronically infected. There are an estimated 14,000 individuals infected with hepatitis C in Wales. ⁷ Where individuals have been diagnosed and indicated a risk factor, over 93 per cent of the infections resulted from injecting drug use ⁸ as indicated in Table 6. UK wide data indicates that 47% of current IDUs tested were hepatitis C antibody positive. ⁵ In 2006/07 in Wales, it was estimated that overall 26 per cent of current IDUs in Wales may be infected with hepatitis C, with far higher rates observed in Swansea (42 per cent) and Cardiff (38 per cent). ⁹ However, much hepatitis C infection remains undiagnosed. According to the UAM survey, 45% of those with hepatitis C infection were unaware of their status.⁵

Table 6: Self reported risk factor information in laboratory reports of hepatitis C infection in Wales 1996 to 2009.⁸ (Risk factor was not reported in the majority of confirmed infections)

Risk factor (where reported)	Number of reports	Percentage %
Injecting drug use	965	93.6
Transfusion	14	1.4
Blood product recipient	19	1.8
Sexual exposure	10	1
Renal failure	2	0.2
Vertical (mother to baby) or Household	6	0.6
Occupational	0	0
Other	15	1.5
Total	1,031	100

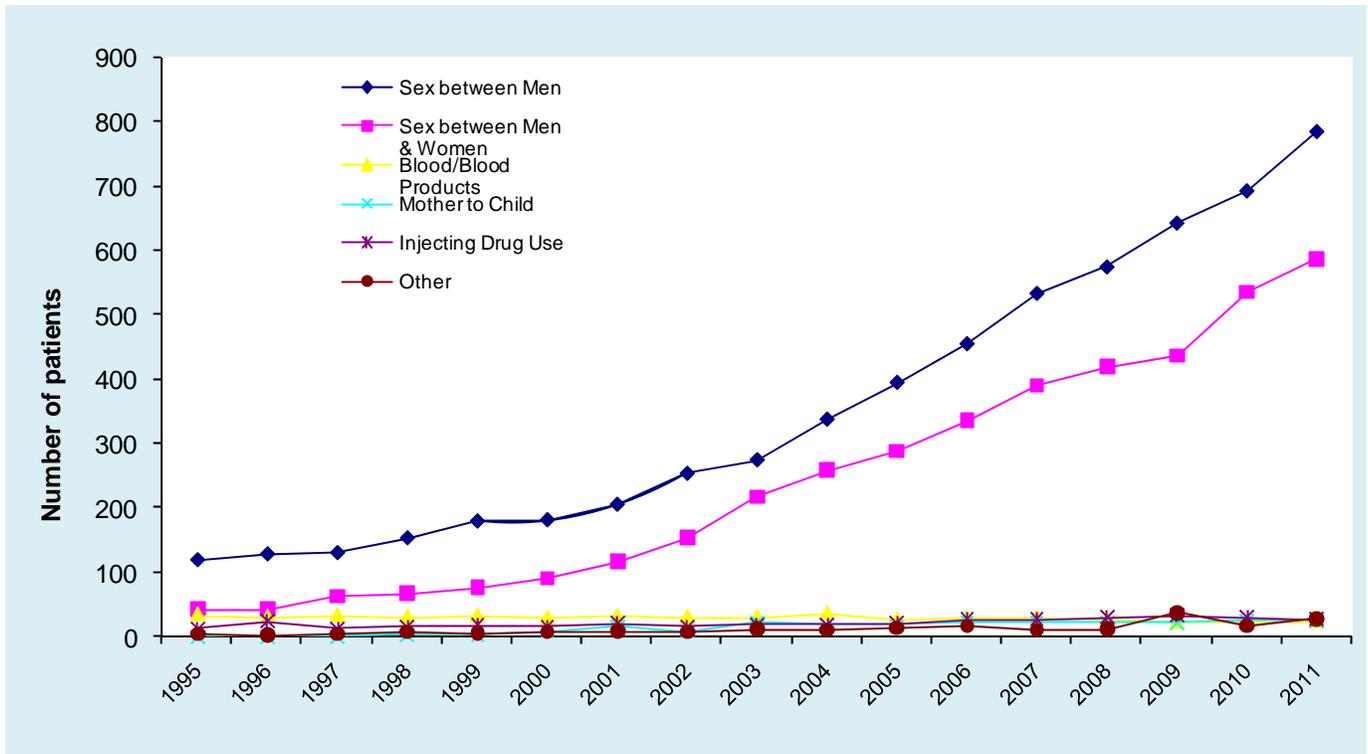
Hepatitis B

Hepatitis B vaccination provides an effective means of preventing transmission of the hepatitis B virus and is particularly important within high-risk groups including prisoners, people who inject drugs (PWIDs), commercial sex workers and individuals participating in high risk sexual behaviour. According to UAM 2010 survey data, the prevalence of Hepatitis B (previous or current hepatitis B infection) was 5.4 per cent amongst current and former injectors in Wales. The self-reported rates of hepatitis B vaccination amongst PWIDs (current and previous) in England and Wales was 74% (at least one dose of vaccine).⁵

HIV

In Wales, in 2011 there were a total of 1,471 HIV infected individuals accessing treatment, an increase of 11.4% on the previous year. Of these, 1.8 per cent (n=26) reported injecting drug use as their route of transmission.¹⁰ Rates of HIV infection among injecting drug users in Wales and in the UK remain low relative to other transmission routes as indicated in Chart 28. In 2011, there were a total of 160 new HIV diagnoses in Wales.¹¹ Where route of transmission was indicated, injecting drug use accounted for 1.9 per cent.

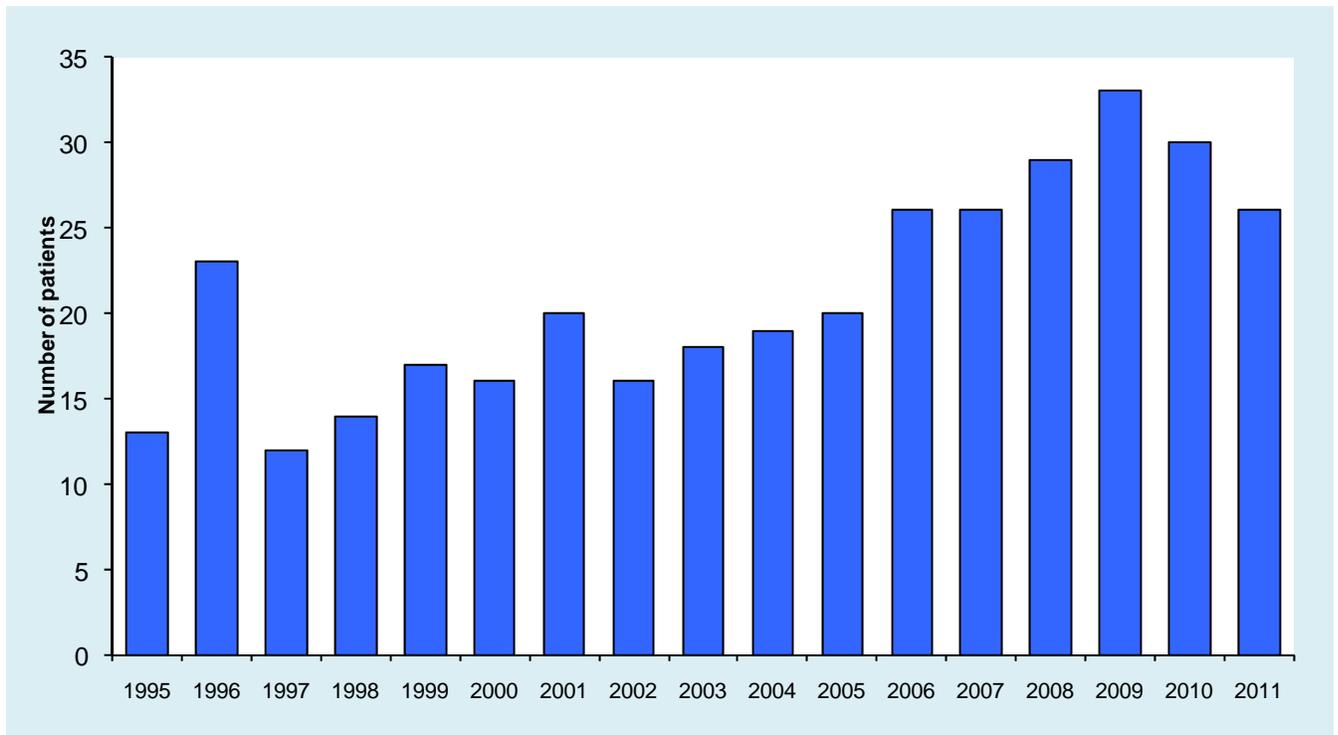
Chart 28: HIV infected patients attending for treatment in Wales by route of transmission 1995 to 2011



Source: Survey of prevalent HIV Infections Diagnosed (SOPHID), Public Health Wales 2012

The number of patients attending for HIV treatment in Wales where injecting drug use is reported as the route of is indicated in Chart 29.

Chart 29: HIV infected patients attending for treatment in Wales with injecting drug use indicated as route of transmission 1995 to 2011



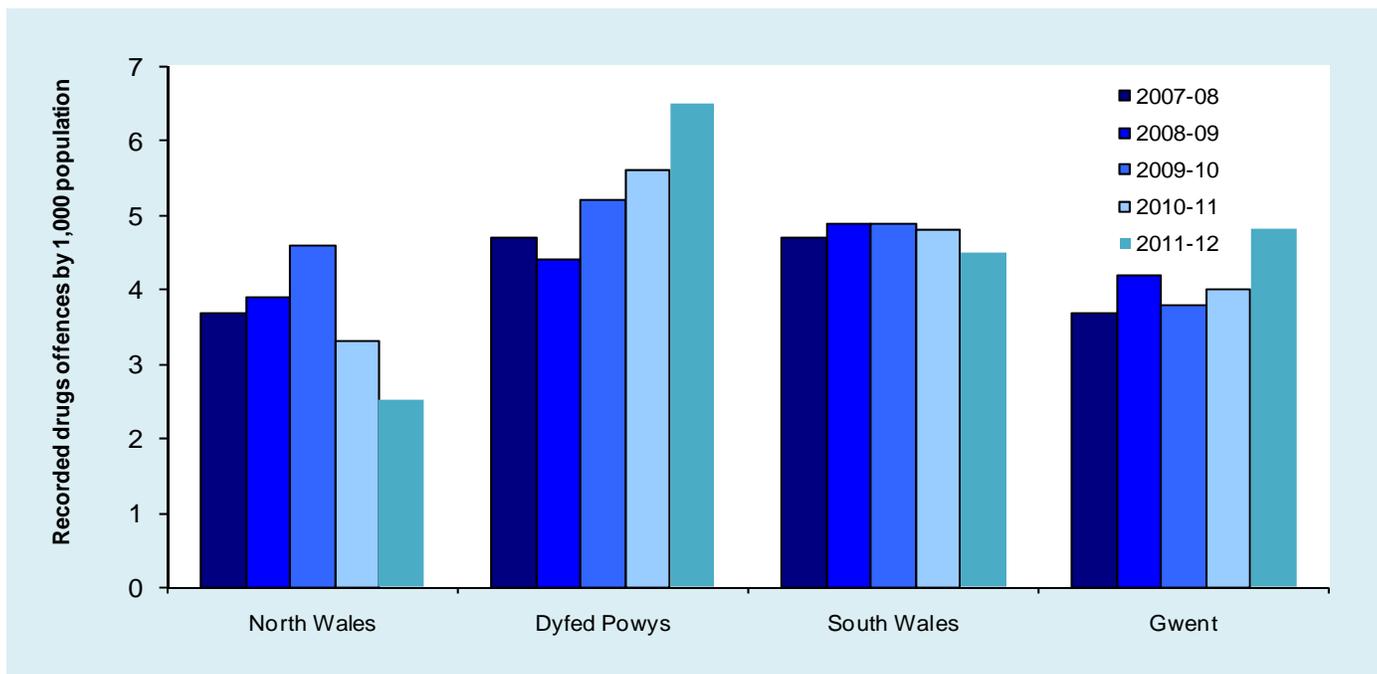
Source: Survey of prevalent HIV Infections Diagnosed (SOPHID), Public Health Wales 2012

5.0 Criminal Justice

5.1 Recorded drug offences

For 2011-12, a total of 13,655 drugs offences were reported by police forces across Wales, representing a 1.2 per cent increase from 2010-11.¹² As a proportion of total recorded crime in Wales, drug offences have increased from 6.6 per cent in 2010-11 to 7.2 in 2011-12. Chart 30 indicates the rate of drugs offences per 1,000 population by police force area in Wales.

Chart 30: Recorded drug offences by Police Force area per 1,000 population in Wales 2007-08 to 2011-12



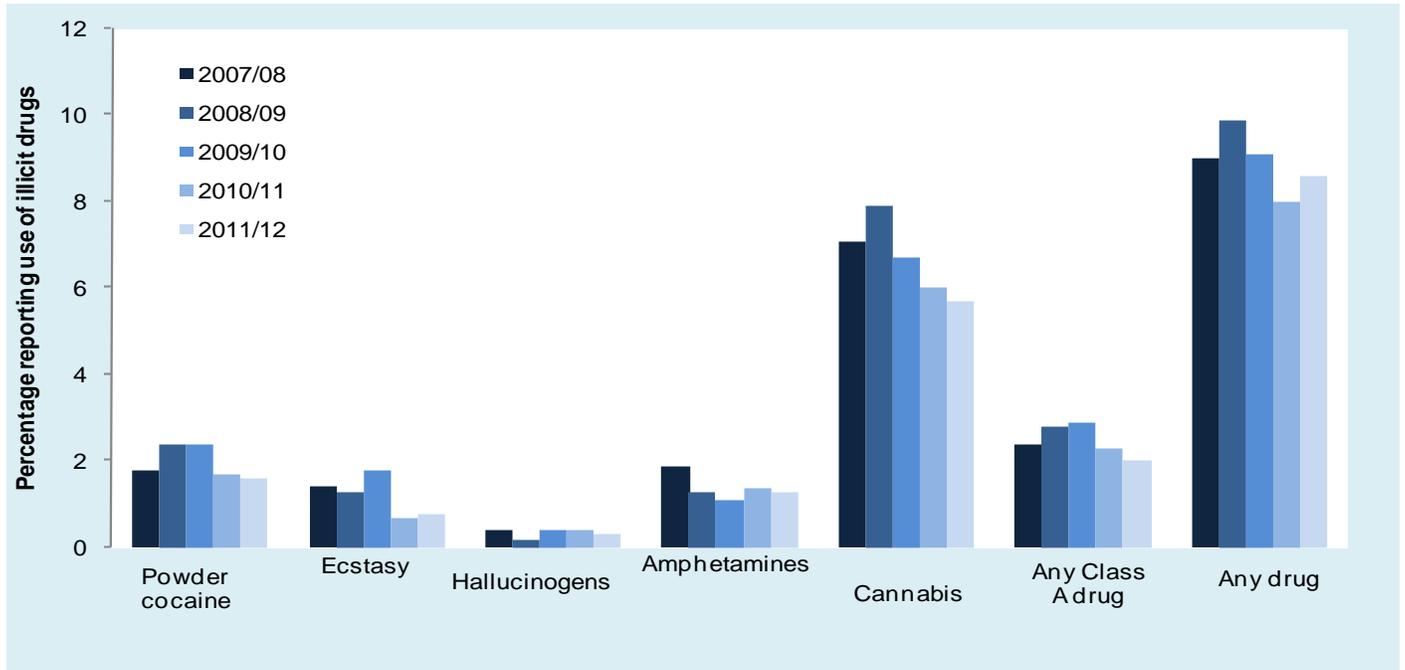
Source: Crime Survey for England and Wales 2011/12, ONS

5.2 Self reported use of illicit drugs

According to 2011/12 Crime Survey for England and Wales (previously the British Crime Survey (BCS))¹³, 8.6 per cent of adults (aged 16 – 59) in Wales self-reported using any drug in the previous year, an increase of 0.6 per cent on the previous year, with 2.0 per cent reporting any Class A drug (includes powder cocaine, crack cocaine, ecstasy, LSD, magic mushrooms, heroin, methadone, and methamphetamine). Extrapolating this latter data out to the 16-59 year population of Wales (based on 2011 mid year population estimates) this represents around 34,700 individuals. 1.6 per cent self-reported powder cocaine use in the previous year, a decrease of 0.1 per cent on the previous year.

Over the previous 5 years, self-reported use of any illicit drug by adults in Wales has decreased by 0.2 per cent. From 2007/08 to 2011/12, self-reported use of cannabis has decreased from 7.1 per cent to 5.7 per cent, as has reported amphetamine use (from 1.9 per cent to 1.3 per cent).¹³

Chart 31 - Proportion (per cent) of 16 to 59 year olds in Wales self-reporting use of illicit drugs 2007/08 to 2010/11 by named drug

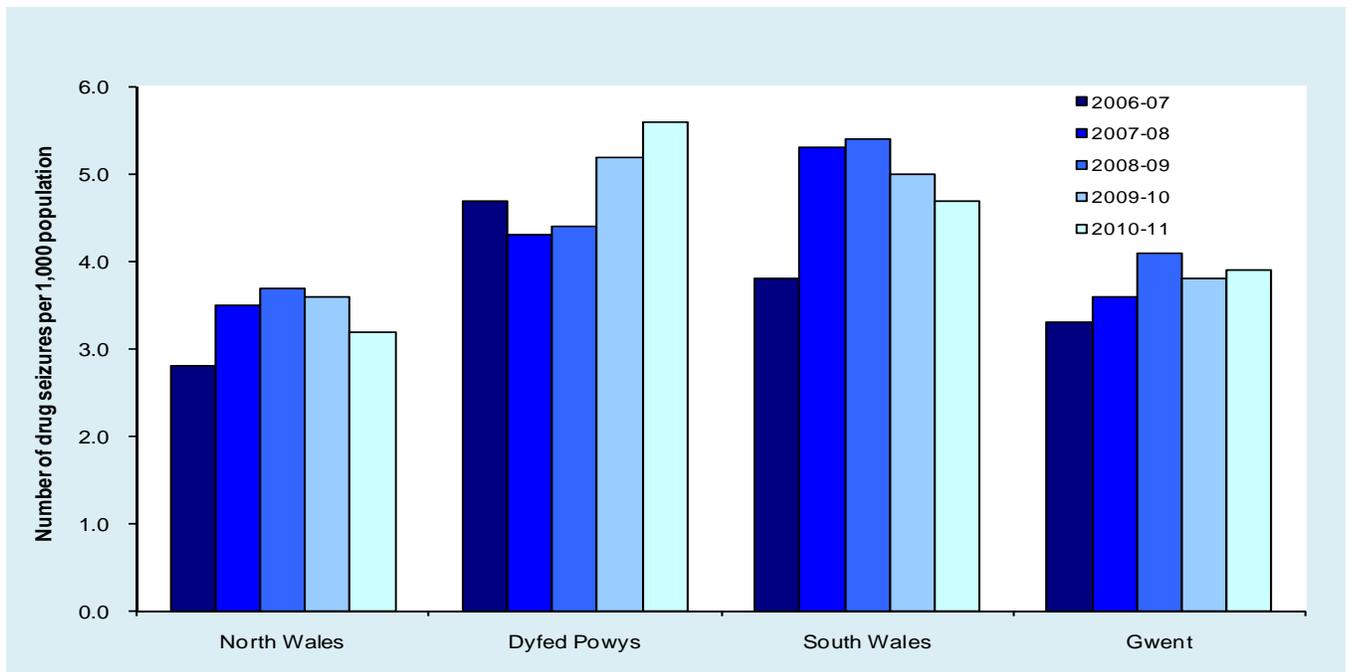


Source: Drug Misuse Declared: Findings from the 2011/12 Crime Survey for England and Wales (2nd Edition)

5.3 Seizures of controlled drugs

There were 13,354 seizures of controlled drug in Wales in 2009-10¹⁴ which represents a decrease of 1.0 per cent on the previous year. Chart 32 indicates the number of seizures of controlled drugs per 1,000 population by Police Force in Wales.

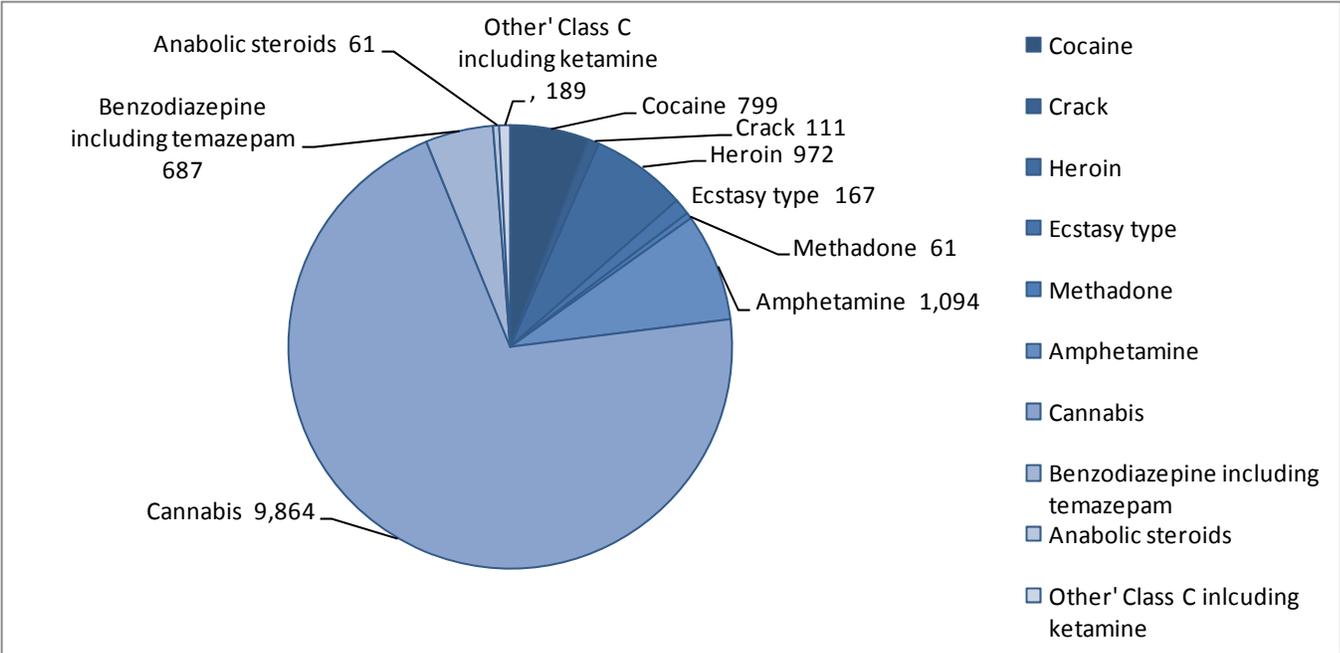
Chart 32: Seizures of controlled drugs per 1,000 population by Police Force in Wales 2006-07 to 2010-11



Source: Home Office, 2011

The profile of controlled drugs seized in 2010-11 by Welsh Police Forces is shown in Chart 32 highlighting that Cannabis remains the highest proportion of seizures.

Chart 33: Profile of drugs seized by police forces in Wales 2010-11

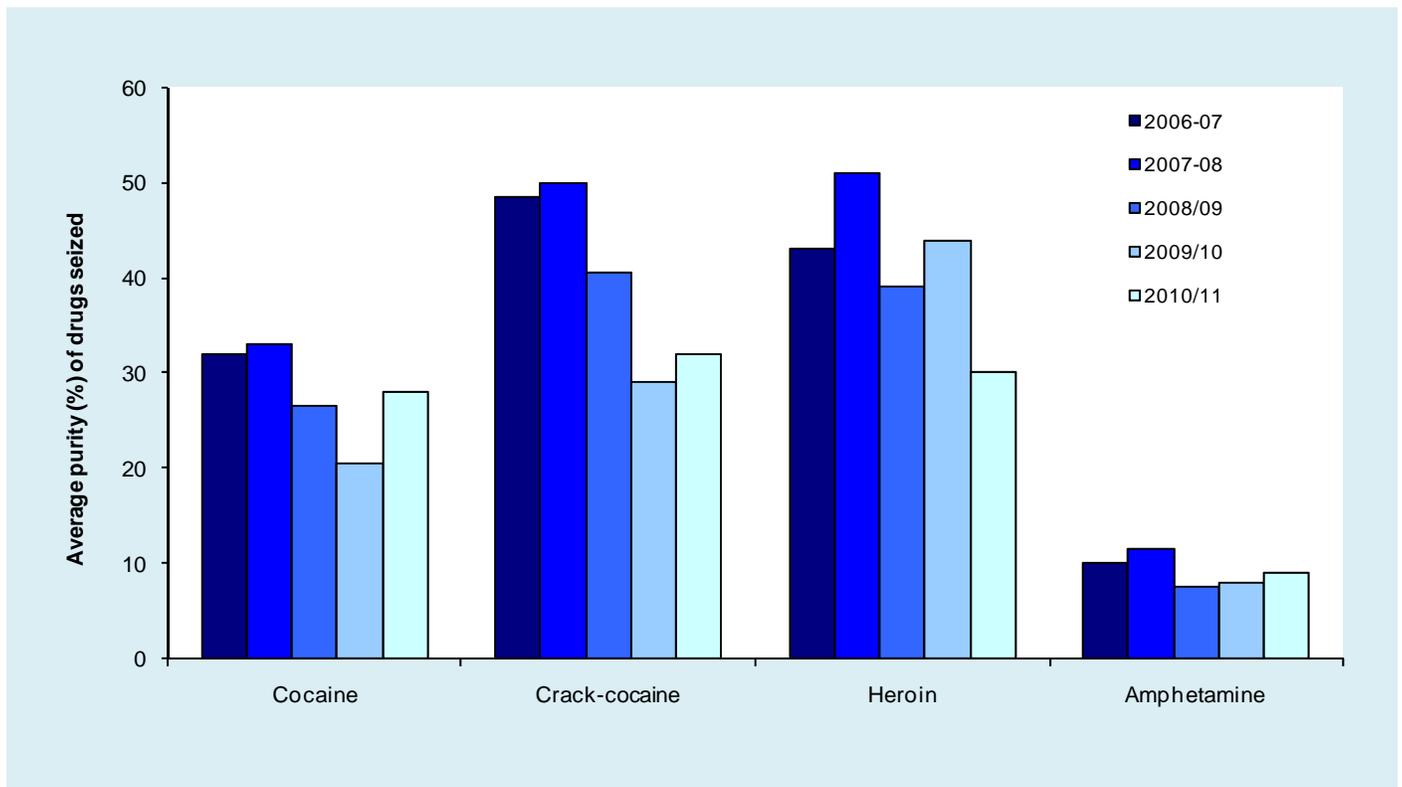


Source: Home Office, 2011

5.4 Purity of drugs seized

The purity of a drug describes the degree to which a quantity of the drug has remained free from other substances that may be added to increase the quantity and therefore resale value. The purity of a drug may be affected through the addition of adulterants (drugs that mimic or enhance the effects of a given drug e.g caffeine often found in amphetamine) or dilutants (mainly sugars such as glucose added to bulk the quantity).¹⁵ Decreases in the purity of a drug may lead to increases in the quantity of the drug required to achieve the same effect for the user. The average purity of drugs seized by police forces in Wales from 2006-07 to 2010-11¹⁴ is shown in Chart 34.

Chart 34: Average purity of drugs seized by police forces in England and Wales 2006 to 2010-11



Source: Home Office, 2011

6.0 Drug Intervention Programme (DIP)

The Drug Interventions Programme (DIP) is a crime reduction initiative, which provides a support structure to encourage offenders out of crime and into treatment. It aims to break the cycle of drug misuse, offending behaviour and custody by intervening at every stage of the criminal justice system to engage offenders in treatment and provide aftercare support.

6.1 Cases Referred and Assessed

Summary statistics for 2011-12 for the programme are provided below:

A total of 3,907 referrals were made to the programme the majority of which (54 per cent) were in the South Wales police authority area. Of these referrals 3,198 were taken on to the caseload of the programme following assessment including transfers from prison and other authorities. 81 per cent of these were male and 42 per cent were aged under 30. The age and gender split for all those on the caseload in each of the police authority areas in Wales are shown in Table 7.

Table 7: Drug intervention Programme Key Caseload Data by Police Force Area 2001-12

		North Wales	Dyfed Powys	Gwent	South Wales	Total	Number on Caseload
Gender	Male	86%	82%	85%	78%	81%	2,597
	Female	14%	18%	15%	22%	19%	601
	Total	100%	100%	100%	100%	100%	3,198
Age Group	18-24	20%	28%	17%	18%	19%	612
	25-29	16%	23%	23%	25%	23%	735
	30-34	21%	20%	4%	25%	20%	637
	35 or over	44%	29%	56%	32%	38%	1,214
	Total	100%	100%	100%	100%	100%	3,198

Source: Drug Intervention Programme, 2011-12

6.2 Drug Tests

Six areas within Wales (Cardiff, Swansea, Newport, Wrexham, Carmarthenshire and Caerphilly) took part in 'Tough Choices' a policy that gives Police the authority to 'drug test on arrest'. During April 2011 to March 2012 12,536 tests were carried out following arrest. Table 8 below shows that 3,624 (29 per cent) tested positive, of these 37 per cent tested positive for cocaine, 47 per cent for opiates and 16 per cent for both.

Table 8: Drug intervention Programme Drug tests 2011-12

Drug test	Number	Percentage
Positive	3,624	29%
Negative	8,879	71%
Not completed	46	0%
Total	12,549	100%
Of positive tests:		
Cocaine	1,348	37%
Opiates	1,709	47%
Both	567	16%

Source: Drug Intervention Programme, 2011-12

7.0 Additional substance misuse reports and data

This section highlights reports and other documents containing relevant substance misuse related data and information which the reader may find useful and which may not otherwise be referenced within this document.

The state of the drugs problem in Europe 2010 EMCDDA

The European Centre for Drugs and Drug Addiction (EMCDDA) provide an annual report on drug use across Europe drawing on available data provided by EU member states and candidate countries. Useful information and perspective is provided on a range of issues relating to drug use.

[EMCDDA | 2011 Annual report on the state of the drugs problem in Europe](#)

Shooting up – Infections among injecting drug users in the United Kingdom

This annual report uses data drawn from the Unlinked Anonymous Monitoring (UAM) survey which provides evidence for current prevalence of blood borne viruses amongst injecting drug use and information of rates of bacterial infection, risk behaviour and variables associated with elevated risk amongst this population. Current and previous reports are available at:

[HPA - Shooting Up – Infections among people who inject drugs in the UK 2010. An update: November 2011](#)

Profiles of Lifestyles and Health in Wales

This report presents information on behaviours relating to health, as well as their impact on health in Wales through outcome measures. It provides a snapshot of local patterns in Wales displayed in traffic light tables, and also contains some comparisons to other countries. The topics covered are diet, physical activity and obesity; smoking; alcohol; illicit drugs; sexual health and dental health. The report breaks down the profiles by Health Board and is available at:

[Public Health Wales Observatory | Profiles of Lifestyle and Health 2010](#)

A profile of alcohol and health in Wales.

This report, produced by the National Public Health Service for Wales and the Wales Centre for Health in 2009 provides an interesting and in-depth focus on the statistics relating to:

- alcohol-related and alcohol-attributable morbidity and mortality
- socio-economic patterns of alcohol consumption
- alcohol-related crime

The report provides clear definitions for the terms used in relation to alcohol consumption and draws upon a range of surveys containing alcohol related data including the Health Behaviour in School-aged Children survey (HBSC), the General Household Survey and the Welsh Health Survey. Information is provided at local authority and national level and, in some instances, comparison is also made between Wales and other countries, e.g. alcohol consumption estimates.

The report is available in PDF format from: [Public Health Wales Observatory | A profile of alcohol and health in Wales](#)

Influencing factors and implications of unplanned drop out from substance misuse services in Wales.

This report represents a summary of the findings from a project designed to identify the range of factors influencing unplanned drop out from, and reengagement with, drug and alcohol treatment services in Wales from both service user and service provider perspectives. The key aims of the research included:

- Determining the factors reported by both service users and service providers as influencing unplanned drop-out at various stages in the treatment process and those factors influencing reengagement, or otherwise, with substance misuse treatment services following unplanned drop out
- Identifying the ways in which unplanned drop out from treatment services impacted on service users
- Identifying operational practice that contributes to both retention in, and reducing unplanned drop out from, substance misuse treatment

The report is available at:

[http://www2.nphs.wales.nhs.uk:8080/BloodBorneVirusesDocs.nsf/3dc04669c9e1eaa880257062003b246b/be22a0587b6a00d802576f0003ccd13/\\$FILE/Influences%20and%20implications%20of%20unplanned%20drop%20out.pdf](http://www2.nphs.wales.nhs.uk:8080/BloodBorneVirusesDocs.nsf/3dc04669c9e1eaa880257062003b246b/be22a0587b6a00d802576f0003ccd13/$FILE/Influences%20and%20implications%20of%20unplanned%20drop%20out.pdf)

Drug Misuse Declared 2011-12

The annual statistical bulletin focuses on prevalence and trends in illicit drug use in the 16-59 year old population in England and Wales. The data is drawn from self-report questionnaire completed by a representative sample of the general population. The report is available at:

<http://www.homeoffice.gov.uk/publications/science-research-statistics/research-statistics/crime-research/drugs-misuse-dec-1112/drugs-misuse-dec-1112-pdf?view=Binary>

Survey of Crime in England and Wales 2011/12

This survey replaces the British Crime Survey (BCS) and draws on crimes reported to the police and self-report questionnaire.

The report is available in PDF format at: [Crime Survey for England and Wales](#)

Health Behaviour in School Aged Children (HBSC)

The HBSC survey provides information on the health and well-being of children, measuring 3 age groups: 11, 13 and 15 with currently 43 participating countries. The survey is undertaken every four years with the last being completed in 2009-10. The survey and resultant reports aim to provide information including tobacco, cannabis and alcohol use and sexual health.

The report is available in PDF format from:

<http://wales.gov.uk/docs/caecd/research/110328healthbehaviouren.pdf>

Welsh Health Survey

The Welsh Health Survey is undertaken on a continuous basis and factors impacting on health including smoking, obesity and alcohol. The report is available in PDF format at:

[Welsh Government | Welsh Health Survey, 2011](#)

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Definitions

The following definitions are used within this report:

Alcohol specific conditions

The term 'alcohol specific' conditions or diagnoses refers to conditions that are wholly related to alcohol (e.g. alcoholic liver disease or alcohol overdose). In previous years this annual report has used the measure of 'alcohol related' conditions in relation to hospital admissions. The change in methodology was implemented to ensure that rates of alcohol related health harms could be more readily assessed with other areas across the UK. The ICD-10 codes used for alcohol specific conditions are specified below. **(ICD-10 codes)**. Deaths are defined as alcohol related deaths – see page 41 for definitions.

Prevalence

Prevalence of a particular condition is the total number of cases of the condition in a population at a given time and is usually expressed as a rate per 100,000 population. For example if there are (say) 24,000 drug and/or alcohol users in Wales (which has a population of approximately 3m) then the prevalence rate is about 800 per 100,000. It is difficult to estimate the true prevalence rate because not all drug and/or alcohol users are known to the authorities. A prevalence rate based on the numbers of individuals on the database will therefore underestimate the true prevalence.

European age standardised rates

Direct standardisation removes effects due to differences in population structure and allows two areas with different demographic characteristics to be compared directly with each other. The age-standardised rate for an area is the number of events (per 100,000) that would occur in that area if the standard population lived there and the age-specific rates of the area applied.

95% Confidence Intervals (95% CI)

When an estimate of a particular characteristic for a population is based on a sample there is a degree of uncertainty about the estimate which depends on both the underlying variability of the characteristics and on the sample size. The 95% confidence interval is a measure of this uncertainty and gives the limits within which the "true" value will lie with a probability of 95 per cent. For example, an estimate of (say) 30 per cent for the prevalence of blue eyes in the population with 95% confidence limits of 25 per cent to 35 per cent means that the "true" prevalence lies between these two figures with a probability of 95 per cent. A more precise estimate can be obtained by increasing the sample size.

Rate

Rate per 100,000 population (based on ONS 2011 census mid year estimates).

Routinely collected data

Methodology, definitions and ICD-10 codes

The following acronyms and definitions are used in Section 2 of this report.

List of abbreviations

DBS	Dried blood spot test
HBV	Hepatitis B
HCV	Hepatitis C
HIV	Human immunodeficiency Virus
IDUs	Injecting drug users
SMHNA	Substance misuse and health needs assessment
UAPMP	Unlinked anonymous prevalence monitoring programme
WNDSM	Welsh National Database for Substance Misuse

ICD-10 Codes

Drug related deaths (ONS 2010)

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

Alcohol related deaths

F10	Mental and behavioural disorders due to use of alcohol
G31.2	Degeneration of nervous system due to alcohol
G62.1	Alcoholic polyneuropathy
I42.6	Alcoholic cardiomyopathy
K29.2	Alcoholic gastritis
K70	Alcoholic liver disease
K73	Chronic hepatitis, not elsewhere classified
K74 (Excluding K74.3-K74.5)	Fibrosis and cirrhosis of liver
K86.0	Alcohol induced chronic pancreatitis
X45	Accidental poisoning by and exposure to alcohol
X65	Intentional self-poisoning by and exposure to alcohol
Y15	Poisoning by and exposure to alcohol, undetermined intent

All Hospital admissions data is based on Calendar Episode End Year

Alcohol specific hospital admissions use the following ICD-10 codes:

E24.4	Alcohol-induced pseudo Cushings syndrome
F10*	Mental and behavioural disorders due to use of alcohol
G31.2	Degeneration of nervous system due to alcohol
G62.1	Alcoholic polyneuropathy
G72.1	Alcoholic myopathy
I42.6	Alcoholic cardiomyopathy
K29.2	Alcoholic gastritis
K70*	Alcoholic liver disease
K86.0	Alcohol induced chronic pancreatitis
T51.0	Ethanol poisoning
T51.1	Methanol poisoning
T51.9	Toxic effect of alcohol, unspecified
X45*	Accidental poisoning by and exposure to alcohol

*indicates that any fourth-character classification can be added to the first three characters

Drug related hospital admissions use the following ICD-10 codes:

F11*:	Mental and behavioural disorders due to use of opioids
F12*	Mental and behavioural disorders due to use of cannabinoids
F13*	Mental and behavioural disorders due to use of sedatives or hypnotics
F14*	Mental and behavioural disorders due to use of cocaine
F15*	Mental and behavioural disorders due to use of other stimulants
F16*	Mental and behavioural disorders due to use of hallucinogens
F18*	Mental and behavioural disorders due to use of volatile solvents
F19*	Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances
T40*	Poisoning by narcotics and psychodysleptics (hallucinogens)
T42*	Poisoning by antiepileptic, sedative-hypnotic and antiparkinsonism drugs
T43*	Poisoning by psychotropic drugs, not elsewhere classified

ONS definition 2010

*indicates that any fourth-character classification can be added to the first three characters

The fourth-character subdivisions for use with categories F10-F19 are:

.0 Acute intoxication

A condition that follows the administration of a psychoactive substance resulting in disturbances in level of consciousness, cognition, perception, affect or behaviour, or other psycho-physiological functions and responses. The disturbances are directly related to the acute pharmacological effects of the substance and resolve with time, with complete recovery, except where tissue damage or other complications have arisen. Complications may include trauma, inhalation of vomitus, delirium, coma, convulsions, and other medical complications. The nature of these complications depends on the pharmacological class of substance and mode of administration.

Acute drunkenness in alcoholism

"Bad trips" (drugs)

Drunkenness NOS

Pathological intoxication

Trance and possession disorders in psychoactive substance intoxication

Excludes: intoxication meaning poisoning

.1 Harmful use

A pattern of psychoactive substance use that is causing damage to health. The damage may be physical (as in cases of hepatitis from the self-administration of injected psychoactive substances) or mental (e.g. episodes of depressive disorder secondary to heavy consumption of alcohol).

Psychoactive substance abuse

.2 Dependence syndrome

A cluster of behavioural, cognitive, and physiological phenomena that develop after repeated substance use and that typically include a strong desire to take the drug, difficulties in controlling its use, persisting in its use despite harmful consequences, a higher priority given to drug use than to other activities and obligations, increased tolerance, and sometimes a physical withdrawal state.

The dependence syndrome may be present for a specific psychoactive substance (e.g. tobacco, alcohol, or diazepam), for a class of substances (e.g. opioid drugs), or for a wider range of pharmacologically different psychoactive substances.

Chronic alcoholism

Dipsomania

Drug addiction

.3 Withdrawal state

A group of symptoms of variable clustering and severity occurring on absolute or relative withdrawal of a psychoactive substance after persistent use of that substance. The onset and course of the withdrawal state are time-limited and are related to the type of psychoactive substance and dose being used immediately before cessation or reduction of use. The withdrawal state may be complicated by convulsions.

.4 Withdrawal state with delirium

A condition where the withdrawal state as defined in the common fourth character .3 is complicated by delirium as defined in F05.-. Convulsions may also occur. When organic factors are also considered to play a role in the etiology, the condition should be classified to F05.8.

Delirium tremens (alcohol-induced)

.5 Psychotic disorder

A cluster of psychotic phenomena that occur during or following psychoactive substance use but that are not explained on the basis of acute intoxication alone and do not form part of a withdrawal state.

The disorder is characterized by hallucinations (typically auditory, but often in more than one sensory modality), perceptual distortions, delusions (often of a paranoid or persecutory nature), psychomotor disturbances (excitement or stupor), and an abnormal affect, which may range from intense fear to ecstasy. The sensorium is usually clear but some degree of clouding of consciousness, though not severe confusion, may be present.

Alcoholic:

·hallucinosis

·jealousy

·paranoia

·psychosis NOS

Excludes: alcohol- or other psychoactive substance-induced residual and late-onset psychotic disorder (F10-F19 with common fourth character .7)

.6 Amnesic syndrome

A syndrome associated with chronic prominent impairment of recent and remote memory.

Immediate recall is usually preserved and recent memory is characteristically more disturbed than remote memory. Disturbances of time sense and ordering of events are usually evident, as are difficulties in learning new material. Confabulation may be marked but is not invariably present.

Other cognitive functions are usually relatively well preserved and amnesic defects are out of proportion to other disturbances.

Amnesic disorder, alcohol- or drug-induced

Korsakov's psychosis or syndrome, alcohol- or other psychoactive substance-induced or unspecified

Excludes: nonalcoholic Korsakov's psychosis or syndrome (F04)

.7 Residual and late-onset psychotic disorder

A disorder in which alcohol- or psychoactive substance-induced changes of cognition, affect, personality, or behaviour persist beyond the period during which a direct psychoactive substance-related effect might reasonably be assumed to be operating. Onset of the disorder should be directly related to the use of the psychoactive substance. Cases in which initial onset of the state occurs later than episode(s) of such substance use should be coded here only where clear and strong evidence is available to attribute the state to the residual effect of the psychoactive substance. Flashbacks may be distinguished from psychotic state partly by their episodic nature, frequently of very short duration, and by their duplication of previous alcohol- or other psychoactive substance-related experiences.

Alcoholic dementia NOS

Chronic alcoholic brain syndrome

Dementia and other milder forms of persisting impairment of cognitive functions

Flashbacks

Late-onset psychoactive substance-induced psychotic disorder

Posthallucinogen perception disorder

Residual:

· affective disorder

· disorder of personality and behaviour

Excludes: alcohol- or psychoactive substance-induced:

· Korsakov's syndrome (F10-F19 with common fourth character .6)

· psychotic state (F10-F19 with common fourth character .5)

.8 Other mental and behavioural disorders

.9 Unspecified mental and behavioural disorder