Summary

- Drug misuse is defined by the World Health Organisation (WHO) as the use of a substance for a purpose not consistent with legal or medical guidelines, for example the non-medical use of prescription medications or the recreational use of illegal drugs.

- This chapter draws on self-completion data to profile the prevalence and trends in drug misuse and in signs of dependence in the adult population of England.

- Overall, 35.4% of men and 22.6% of women had taken an illicit drug at least once in their life. For both men and women, those aged between 25 and 34 were most likely to have ever used illicit drugs (52.9% and 35.0% respectively), declining to 3.3% of men and 2.8% of women aged 75 or over.

- Cannabis was the most commonly used drug in the past year (9.4% of men and 5.1% of women). Among 16–24 year olds, 23.7% of men and 16.2% of women had used it in the past year, followed by ecstasy, cocaine, ketamine and mephedrone. Ketamine and mephedrone were rarely reported by people in older age-groups.

- People who reported usage of particular drugs were asked about signs of dependence on that drug. The signs, or markers, asked about were: daily use for 2 weeks or more; having a sense of need or dependence; inability to abstain; increased tolerance, and withdrawal symptoms.

- Overall, 3.1% of adults showed signs of dependence on drugs, including 2.3% who showed signs of dependence on cannabis only and 0.8% with signs of dependence on other drugs (with or without cannabis dependence as well). After increases in the 1990s, the overall rate has remained stable since 2000.

- Rates varied with age and sex, and were greatest in men and in the youngest age group; 4.3% of all men showed signs of dependence on illicit drugs (compared with 1.9% of women), including 11.8% of men aged 16 to 24 and 6.6% of men aged 25 to 34.
• Signs of drug dependence varied with ethnic group, and were highest among black men. This, however, was explained by higher rates of cannabis use in this group. It should be noted that daily use of cannabis over a two-week period has been questioned as a reliable marker of dependence.

• People in receipt of Employment and Support Allowance (ESA) were more likely to report signs of drug dependence than people who did not receive this benefit. Some of these people will have been eligible for ESA due to their drug dependence and associated poor physical and mental health.

• Half (51.2%) of people with signs of dependence on drugs other than cannabis were in receipt of mental health treatment at the time of the interview. In contrast, those with signs of dependence on cannabis only (12.6%) had similar mental health treatment rates to the rest of the population (12.2%).

• Over a third of adults with current signs of dependence on drugs other than cannabis (36.2%) had received treatment, help or advice specifically because of their drug use at some point, 28.8% had received this in the past six months. This was twice the rate of those with signs only of cannabis-dependence; among whom 14.6% had ever received treatment, help or support specifically because of their drug use, and 5.5% had received this in the past six months.

• A range of new psychoactive substances (NPS) have entered the drugs market but were not assessed in this survey. Uncertainty over their content and rapid changes in what is available makes measuring the use of these substances in surveys extremely challenging and knowledge of the prevalence of their use is limited.

11.1 Introduction

The United Kingdom has quite high levels of drug use compared to many comparable countries, although overall levels of use have been declining over recent years (UKDPC 2012). In 2014/15, it was estimated that more than eleven million adults aged between 16 and 59 in England and Wales had taken illegal drugs in their lifetime, including nearly three million who had taken an illicit drug in the past year (Lader 2015).
Many drug users have taken cannabis only a few times in their lives and no other drugs (UKDPC 2012). For a minority, drug use becomes regular and prolonged, and is associated with a high degree of harm to themselves and others (Home Office 2010). Recently there has been a rapid expansion in the number of new drugs available on the drug market. These new synthetic substances, sometimes called designer drugs or legal highs, generally mimic the effects of more traditional drugs and came to prominence during a period when the ecstasy and cocaine on the market was generally of very poor quality. The new psychoactive substances (NPS) were appealing to users as they were legal, better quality and readily available. Since then action has been taken to control many of these substances, but slightly modified ones are then produced most of which are only transiently on the market. The actual content of the substances marketed under different brand names changes constantly and some are highly potent and pose serious risks to users. This uncertainty over content increases the risk but also, alongside the rapid changes in what is available, also makes measuring the use of these substances in surveys extremely challenging so our knowledge of the prevalence of their use is limited.

Drug misuse is not necessarily problematic, though it can never be considered risk-free (ACMD 2008). More people take cannabis than any other drug, but problematic drug use, particularly dependence, is most frequently associated with opiates (NCCMH 2008). For example, Public Health England report that opiates, (mainly heroin) were the main problem substance for 52% of the 295,224 people aged 18 or over in contact with drug and alcohol treatment services in 2014/15 (PHE 2015). However, the number of young people with heroin problems entering treatment has been declining in recent years and the proportion of those in treatment for other substances has been increasing.

A number of adverse health outcomes have been associated with drug misuse. Injecting drug users are vulnerable to thrombosis, abscesses, blood-borne diseases (particularly hepatitis B and C and HIV), and respiratory problems (Coulthard et al. 2002). Frequent cannabis use has also been associated with respiratory problems (PHE 2015).

Problematic use of one drug often co-occurs with misuse of or dependence on other drugs and alcohol (Farrell et al. 2002). Alcohol dependence and tobacco also
cause major health and wider problems and are dependence-producing, alcohol is considered further in Chapter 10. Drug misuse and drug dependence are more prevalent in adults with various psychiatric problems, from common mental disorders to personality disorders and severe psychotic illness (Coulthard et al. 2002; CMH et al. 2011). For example, cannabis use has been linked to the development of acute and long-term psychotic symptoms, though the causal pathways for the latter remain unclear (Moore et al. 2007). In prisoners in England and Wales, severe dependence on cannabis or stimulants, such as amphetamines or cocaine, was associated with an increased risk of psychosis (Farrell et al. 2002). Significant proportions of those being treated as inpatients or in the community for severe mental illness have substance misuse problems, and this has treatment implications that are not always satisfactorily addressed (Menezes et al. 1996; Phillips and Johnson 2003; Weaver et al. 2003). The 2002 Comorbidity of Substance Misuse and Mental Illness Collaborative study concluded that 75% of users of drug services and 85% of users of alcohol services were experiencing mental health problems (Weaver et al 2003). Comorbidity, including with drug dependence, is considered in Chapter 13 of this report.

The number of admissions to NHS hospitals with a primary diagnosis of drug-related mental health or behavioural disorder has risen since 2012/13 but is still lower than ten years ago; in 2013/14 there were 7,104 (HSCIC 2014). This is an 8.5% (555) increase from 2012/13 when there were 6,549 such admissions. Overall, however, between 2003/04 and 2013/14 admissions have decreased by 11%.

In 2014, there were 2,248 drug misuse deaths involving illegal drugs registered in England and Wales. This was a marked increase from 2013 and equates to a mortality rate of 39.9 deaths per million population, the highest ever recorded (ONS 2015). From 2003 to 2007 drug misuse deaths in England increased but this was followed by a period of stabilisation and decline between 2008 and 2012, before the recent steep rise. Opiates are the drugs most commonly associated with drug misuse deaths, followed by benzodiazepines and alcohol is quite often found in combination with illicit drugs (PHE 2016).

Though the health impacts of drug dependence are significant, the harm to society of drug-related crime is also great (MacDonald et al. 2005). It has been estimated that between a third and a quarter of acquisitive crime – including burglary, theft, fraud and the sale of sex – is drug-related (Home Office 2010).
Surveys of offenders have shown high rates of recent heroin and cocaine use, and made explicit the link between criminal behaviour and the need to get money to buy drugs (Boreham et al. 2006). Other types of crime are less strongly linked to drug use, although drug dealing may be linked to high levels of community violence (UKDPC 2012; Lupton et al. 2002).

The risk factors for drug use are similar to those for a number of unhealthy as well as criminal behaviours, and include social and economic deprivation, inequality and family breakdown (UKDPC 2012). In young people, truancy, exclusion from school, serious or frequent offending and homelessness are linked to an increased risk of frequent drug use and the use of Class A drugs (Becker and Roe 2005; Fuller et al. 2015). The harm caused by problematic drug use also extends to the families of drug users and to the communities in which they live. The children of problematic drug users have been described as being at risk from conception to adulthood, from multiple and cumulative harms to their mental and physical health, and to their social, emotional and educational development (ACMD 2003). Already-deprived communities are most at risk of drug-related harm, through the direct effect on users, as well as increased rates of crime and antisocial behaviour (Home Office 2010). The annual social and economic cost of Class A drug use has been estimated at £15.4 billion a year; 99% of this is accounted for by problem drug use (Home Office 2010).

The major source of data on the prevalence of drug use by adults aged 16 and over in England is the annual Crime Survey for England and Wales (CSEW), funded by the Home Office and previously called the British Crime Survey. The 2014/15 CSEW estimated that 8.6% of adults aged between 16 and 59 in England had taken drugs in the past year. Cannabis was the most commonly used drug; 6.8% of adults had taken cannabis in the past year while 3.2% had taken a Class A drug in the same time period (Lader 2015).

This chapter presents the prevalence of reported drug misuse and signs of dependence in the English adult general population and examines some associations, including those with use of treatment and services. It is important to note that using a household survey to measure drug use and dependence will underestimate several key groups whose patterns and levels of drug use may be atypical. These include students in halls of residence, the homeless, and those living in institutional settings,
including hospitals and prisons (Singleton et al. 1998). Additionally, problematic drug users living in private households may be less likely to participate in surveys, given that they may lead chaotic lives which make them less available, able or willing to answer survey questions (Lader 2015). Hence household surveys are likely to underestimate the number of dependent drug users (UKDPC 2012).

11.2 Definitions and assessment

Drug misuse
Drug misuse is defined by the WHO as the use of a substance for a purpose not consistent with legal or medical guidelines, for example the non-medical use of prescription medications or the recreational use of illegal drugs (ACMD, 2008). It may lead to problematic drug use, including dependence.

Dependence syndrome is defined in the International Classification of Diseases, 10th edition (ICD-10) as ‘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, persistence 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’ (WHO 1992). Diagnostic criteria for dependent drug use are covered by the substance dependency codes F10 to F19 of the ICD-10, and are very similar to the criteria specified in the fourth Diagnostic Statistical Manual (DSM-IV; APA 1994). A threshold of three or more of the following occurring in the past 12 months is required for a diagnosis:

- Preoccupation with substance use
- Sense of need or dependence
- Impaired capacity to control substance-taking behaviour
- Increased tolerance
- Withdrawal symptoms, and
- Persistent substance use despite evidence of harm.
DSM-5 was launched after APMS 2014 was in development. The drug dependence questions used in the survey series were designed to DSM-IV criteria.

**Measuring drug use and dependence**

Questions about drug use were asked using a computer-assisted self-completion interview (CASI), as in the 2000 and 2007 surveys. They covered lifetime experience of 15 types of named drug, together with use in the past year. The drugs asked about are those considered to be mostly widely used and about match those included on the CSEW, with the additional inclusion of volatile substances. For the reasons outlined in the introduction, new psychoactive substances (NPS) were not included.

For each of eight drug types (cannabis, amphetamines, crack, cocaine, ecstasy, tranquillisers, opiates and volatile substances), reported use in the past year was followed by five questions based on the Diagnostic Interview Schedule and designed to assess symptoms of drug dependence (Malgady et al. 1992). These questions asked about the past month and year, and covered:

- Daily use for 2 weeks or more
- Sense of need or dependence
- Inability to abstain
- Increased tolerance, and
- Withdrawal symptoms.

A positive response to any of the items was used as an indicator of possible drug dependence. This is a lower threshold than that recommended by ICD-10 and DSM-IV, and the set of questions does not include the diagnostic criteria of preoccupation and persistent use despite evidence of harm. However, the same approach and wording was used in the 1993, 2000 and 2007 surveys and comparability has been maintained. Because people can be dependent on more than one type of drug, and because the nature of cannabis use is widely considered to be different from the other drugs asked about, dependence was grouped into three categories, those:

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1 In particular it has been argued that daily use of cannabis for a two week period does not sufficiently differentiate between recreational use and dependency (see Singleton et al., 1998).
• With no dependence

• Who were dependent on cannabis only, and

• Who were dependent on another drug (including those who were also dependent on cannabis).

11.3 Results

Prevalence of illicit drug use, by age and sex
Lifetime experience of illicit drug use was strongly related to age and sex. Overall, 35.4% of men and 22.6% of women had taken an illicit drug at least once in their life. For both men and women, those aged between 25 and 34 were most likely to have ever used illicit drugs (52.9% and 35.0% respectively), declining to 3.3% of men and 2.8% of women aged 75 or over.

Figure 11A: Ever used an illicit drug, by age and sex
Base: all adults
Men and women in most age groups were more likely to have tried cannabis than other drugs. Overall, 31.6% of men had used cannabis, compared with 11.0% who had used cocaine, 8.3% amphetamines and 8.1% ecstasy (the next most commonly used drugs). Among women, 20.6% had used cannabis. The next most commonly used drug, cocaine, had been taken by 5.0% of women.

The age profile of users varied with type of drug. Ketamine and mephedrone were the fourth and fifth most cited drugs taken by 16–24 year olds, their reported lifetime use then declined steeply with age.

**Figure 11B: Ever taken ketamine or mephedrone, by age and sex**

*Base: all adults*

<table>
<thead>
<tr>
<th>Age</th>
<th>Ketamine (men)</th>
<th>Mephedrone (men)</th>
<th>Ketamine (women)</th>
<th>Mephedrone (women)</th>
</tr>
</thead>
<tbody>
<tr>
<td>16–24</td>
<td>7</td>
<td>8</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>25–34</td>
<td>6</td>
<td>7</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>35–44</td>
<td>5</td>
<td>6</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>45–54</td>
<td>4</td>
<td>5</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>55–64</td>
<td>3</td>
<td>4</td>
<td>0.5</td>
<td>2</td>
</tr>
<tr>
<td>65–74</td>
<td>2</td>
<td>3</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>75+</td>
<td>1.5</td>
<td>2.5</td>
<td>0.2</td>
<td>1</td>
</tr>
</tbody>
</table>

Lifetime use of many other drugs (such as ecstasy, amphetamines, magic mushrooms, LSD, and amyl nitrite) was highest among 35–44 year olds. These figures relate to a complex mix of period, generational and age group associations. Recall could be a factor in the very low levels of reported lifetime use among those in the oldest age groups. **Table 11.1**
11.3% of men and 6.0% of women had used at least one illicit drug in the past year. Illicit drug use in the past year was most common in young people (26.4% of men and 17.1% of women aged 16 to 24) and declined sharply with age to 0.5% of men aged 75 or over. It was not reported by any female participants in this age-group.

**Figure 11D: Illicit drug use in the past year, by age and sex**
*Base: all adults*
Cannabis was the most commonly used drug in the past year; 9.4% of men and 5.1% of women had used it in the past year, including 23.7% of men and 16.2% of women aged 16 to 24. The use of other drugs in the past year was relatively uncommon, except in young adults where cocaine and ecstasy were the next most likely to be mentioned. Ketamine was included in the survey for the first time in 2014, and among young adults aged 16 to 24, particularly men, it was the next most commonly reported drug used in the past year. Table 11.2

**Illicit drug use in the past year, by ethnic group and region**

The analysis by ethnicity was standardised to account for the different age profiles of the ethnic groups, and the age-standardised rates are referred to here. Black/Black British adults were the most likely to have taken drugs in the past year (14.3% of men; 9.7% of women), and Asian/Asian British adults were the least likely to have done so (5.9% of men; 0.4% of women). The higher rate of drug use among Black men was explained by higher rates of cannabis use in this group. Table 11.3

**Figure 11E: Illicit drug use in the past year (age-standardised), by ethnic group and sex**

*Base: all adults*
The proportion of adults who had taken illicit drugs in the past year did not vary significantly across English regions. Table 11.4

Prevalence of drug dependence, by age and sex
The prevalence of signs of drug dependence was measured for each of eight types of drug: cannabis, amphetamines, cocaine, crack, ecstasy, opiates (heroin and methadone), tranquillisers and volatile substances (glue, gas, aerosols or solvents). For each drug, sign of dependence was defined as endorsing at least one of five questions about use of the drug (see Section 11.2). Dependent users were grouped into those who were dependent on cannabis only and those who were dependent on other drugs (including those who were also dependent on cannabis).

Overall, 3.1% of participants showed signs of dependence on illicit drugs, with the true rate in the wider population likely to be between 2.6% and 3.6% (95% confidence interval (CI)). This includes 2.3% who showed signs of dependence on cannabis only (95% CI: 1.9% to 2.8%) and 0.8% with signs of dependence on other drugs (with or without cannabis dependence as well) (95% CI: 0.6% to 1.2%). Rates varied with age and sex, and were greatest in men and in the youngest age group; 4.3% of all men showed signs of dependence on illicit drugs (compared with 1.9% of women), including 11.8% of men aged 16 to 24 and 6.6% of men aged 25 to 34. Table 11.5

Figure 11F: Signs of drug dependence in the past year, by age and sex
Base: all adults
Of the five signs of drug dependence asked about, the most commonly reported was two weeks of daily use (1.7%, data not shown). The table below shows that, overall, 1.1% of people reported just one sign of dependence, 0.7% reported two, and 1.2% reported three or more (1.6% of men and 0.9% of women). The latter is closer to the threshold for drug dependence according to ICD-10. This chapter focuses on all those reporting at least one sign, an approach consistent with previous surveys in the series.

### Number of signs of drug dependence reported

<table>
<thead>
<tr>
<th></th>
<th>Men</th>
<th>Women</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td>%</td>
<td></td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>0</td>
<td>95.7</td>
<td>98.1</td>
<td>96.9</td>
</tr>
<tr>
<td>1</td>
<td>1.6</td>
<td>0.6</td>
<td>1.1</td>
</tr>
<tr>
<td>2</td>
<td>1.1</td>
<td>0.4</td>
<td>0.7</td>
</tr>
<tr>
<td>3–5</td>
<td>1.6</td>
<td>0.9</td>
<td>1.2</td>
</tr>
</tbody>
</table>

The highest rates of dependence were on cannabis; 3.7% of men and 1.6% of women. Rates of dependence in the survey sample were 0.5% or lower for other drugs. The prevalence of dependence on heroin/methadone was almost the same as the prevalence of use in the last year, suggesting that almost all users showed signs of dependence. No participants reported signs of dependence on volatile substances. For most age groups, dependence was most likely to be on cannabis only. Dependence on other drugs was largely restricted to younger men. There was almost no overlap in women between signs of dependence on cannabis and on other drugs.

**Trends in signs of drug dependence, 1993 to 2014**

The prevalence of drug dependence in 1993, 2000, 2007 and 2014 can be assessed for adults aged 16 to 64 (the upper age limit of the 1993 survey). Between 1993 and 2000 there was an increase in the proportions of adults reporting signs of dependence on drugs other than cannabis, as well as signs of dependence on cannabis but not other drugs. Between 2000 and 2014 the overall level of signs
of dependence has remained stable. This was true both for signs of dependence on cannabis only, and for signs of dependence on other drugs (with or without cannabis as well). Table 11.6

**Figure 11G: Signs of dependence on any drug, on cannabis only, and on other drugs in the past year, 1993 to 2014**

*Base: 16–64 year olds, living in England*

This pattern of overall stability in rates of drug dependence is interesting given the wider context of declining rates in drug use. There are also indications of possible different trends within age-groups. Although not statistically significant, it appears that rates of drug dependence in 16–34 year olds may have started to fall, while rates in 35–54 year olds are sustained, suggesting a possible generational effect. This is consistent with patterns observed in the alcohol chapter (Chapter 10). Table 11.6
Drug dependence by other characteristics

Ethnic group

Like the pattern observed for drug use, the prevalence of reported signs of drug dependence also varied between ethnic groups. Using age-standardised data, the proportion showing signs of dependence was highest (at 7.5%) among adults in the Black/Black British group. This may be explained by their higher rates of cannabis use, and could reflect reporting of daily use. Table 11.7
Household type
Household type was also associated with drug dependence. Signs of drug dependence were highest in those aged less than 60 who lived alone (6.7%). Table 11.8

Employment status
Among people aged 16–64, the prevalence of drug dependence varied with employment status. In men, signs of drug dependence were most common in those classed as economically inactive (9.6%). For women, the highest prevalence was found in the unemployed (4.4%). Prevalence was lowest in both men and women who were in employment (4.5% of employed men, 2.1% of employed women). This is a different pattern to that found for drinking alcohol at hazardous levels, where rates are highest among those in employment (see Chapter 10). Table 11.9
**Benefit status**

Recipients of benefits were more likely to show signs of dependence than those not receiving benefits, and the differences were most pronounced for Employment and Support Allowance (ESA). People with drug dependence may be in receipt of ESA as a result of their dependence and associated comorbid physical and mental health problems. For ESA, there was a significant interaction between sex and receipt of this type of benefit. The difference between the levels of drug dependence for those in receipt of ESA and those not was larger for women than men, around eight times for women compared with around double for men. Due to small base sizes these figures should be viewed with caution. **Table 11.10**
Levels of drug dependence in different English regions did not vary significantly.

**Table 11.11**

**Treatment and service use, by type of drug dependence**

Estimates in this section should be treated with caution: the sample of drug-dependent adults was very small, in particular for those showing signs of dependence on drugs other than cannabis (44 people). Furthermore, the treatment tables in this chapter were not age-standardised, despite drug dependence being strongly associated with age.
Psychoactive medication and psychological therapy

Adults who reported signs of dependence on drugs other than cannabis were more likely than other adults to be receiving treatment for a mental or emotional problem, although this treatment was not necessarily for a drug problem. Half (51.2%) of people with signs of dependence on drugs other than cannabis were in receipt of mental health treatment at the time of the interview. In contrast, those with signs of dependence on cannabis only (12.6%) had similar mental health treatment rates to the rest of the population (12.2%). Table 11.12

Figure 11L: Treatment currently received for a mental or emotional problem, by level of drug dependence in past year

Base: all adults

Compared with other adults, those with signs of dependence on drugs other than cannabis were more likely to be taking psychotropic medication; 40.7% compared with 10.2% of those dependent on cannabis and 10.8% of those who reported no signs of drug dependence. Adults with signs of drug dependence were also more likely to use psychological therapy; 5.5% of those dependent on cannabis and 30.7% of those dependent on other drugs, compared with 2.6% of other adults. Tables 11.13, 11.14
Health care
People with signs of drug dependence were also more likely than others to access health care services for a mental or emotional problem. 21.7% of adults with signs of cannabis dependence only and 54.4% of those with signs of dependence on other drugs had spoken with a GP for this reason in the past year, compared with 11.7% of other adults. 4.6% of cannabis-dependent adults and 19.8% of ‘other’ drug-dependent adults had spoken with a GP about a mental or emotional problem in the past two weeks, compared with 2.0% of other adults. Table 11.15

Figure 11M: Spoken with GP about mental or emotional problem in past two weeks, by level of drug dependence in past year
Base: all adults

Community and day care
Levels of community and day care service use in the past year were the same for adults who reported no signs of drug dependence and adults who reported signs of cannabis dependence only (6.4%), while 28.9% of adults with signs of dependence on other drugs had used at least one of the community or day care services asked about in the past year. Adults with signs of dependence on other drugs had distinct patterns of service use; in particular, they were more likely than others to access psychologists (10.6%), community psychiatric nurses (8.0%) and psychiatrists (7.7%). Table 11.16
Treatment, help or advice due to drug use

All participants were also asked whether they had ever received treatment, help or advice due to drug use. Over a third of adults with current signs of dependence on ‘other’ drugs (36.2%) had received treatment, help or advice specifically because of their drug use at some point, 28.8% had received this in the past six months. This was twice the rate of those with signs only of cannabis-dependence; among whom 14.6% had ever received treatment, help or support specifically because of their drug use, and 5.5% had received this in the past six months. Table 11.17

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**Figure 11N: Community or day care service use in past year, by level of drug dependence in past year**

*Base: all adults*
Unmet treatment requests

Adults showing signs of drug dependence were more likely to have requested but not received a particular mental health treatment in the past 12 months than other adults; 5.0% of those with signs of cannabis-dependence and 4.5% of those with signs of dependence on other drugs, compared with 1.5% of other adults.

Table 11.18

Figure 11P: Requested but not received particular mental health treatment in the past 12 months, by level of drug dependence in past year
Base: all adults
11.4 Discussion

The pattern of drug use reported here is similar to that reported in the Crime Survey for England and Wales (CSEW).

Men were more likely than women to take drugs, and the prevalence of drug use was highest in early adulthood and declined thereafter. By far the most commonly used drug was cannabis. Both surveys are limited by their lack of data on new psychoactive substances (NPS).

Drug use and signs of drug dependence increased between 1993 and 2000, and have remained steady since. This also reflects trends in drug use reported elsewhere (Lader 2015). When drug use and drug dependence data are examined together, it appears that most drug users do not become dependent. There is evidence of ‘maturing out’, that is, youthful drug use does not necessarily develop into a lifetime habit. As with drug taking in general, symptoms of dependence were more common in men than in women, and most common in young adults. The prevalence of signs of drug dependence measured here varies with ethnicity, employment status, household structure, and receipt of benefits. These variations warrant further investigation.

The majority of drug users in this sample who could be described as dependent tended to be dependent only on cannabis. However, while there were very few heroin/methadone users in the sample, almost all of them reported at least one sign of dependence.

Drug dependent individuals were more likely to use services for a mental or emotional problem, particularly if showing symptoms of dependence on drugs other than cannabis. However, at least half of these adults, whatever the nature of their dependence, were not in contact with such services.

Although this indicates a link between drug dependence and recognised mental health problems, the characteristics of the dependent individuals in the sample suggest they were mostly on the edge of dependence. Ultimately, a survey of this kind cannot provide a fully representative picture of drug dependent adults in England.
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Table 11.4 Illicit drug use in the past year (age-standardised), by region and sex
Table 11.5 Drug dependence in the past year, by age and sex
Table 11.6 Drug dependence in the past year (1993, 2000, 2007, 2014), by age and sex
Table 11.7 Drug dependence in the past year (age-standardised), by ethnic group and sex
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Table 11.16 Community and day care services used in past year, by drug dependence

Table 11.17 Treatment, help or advice because of using drugs, by drug dependence

Table 11.18 Requested but not received a particular mental health treatment in the past 12 months, by drug dependence.

11.6 References


