The Bristol Drug & Alcohol Online Survey 2012

Bristol Substance Misuse Team
Safer Bristol

Mark McNally
Substance Misuse Projects Officer

Geraldine Smyth
Senior Health Promotion Specialist
## Contents

Executive Summary ........................................................................................................... 5
Introduction ......................................................................................................................... 6
Method ................................................................................................................................ 7

### Section 1: Demographics of Participants .................................................................... 9
- Gender ............................................................................................................................. 9
- Age .................................................................................................................................. 10
- Ethnicity .......................................................................................................................... 11
- Sexual Orientation .......................................................................................................... 11
- Disability ........................................................................................................................... 12
- Religion ............................................................................................................................. 13

### Section 2: Substance Misuse by all Respondents ......................................................... 14
- Substances taken .............................................................................................................. 14
- Length of time participants have taken substances ....................................................... 16
- Frequency of substance use ........................................................................................... 18
- Reasons for using substances ......................................................................................... 21
- Concerns about substance use ......................................................................................... 23
- Reducing and stopping substance use ............................................................................ 25
- Poly substance use ......................................................................................................... 26

### Section 3: Substance Misuse by Bristol Respondents ................................................ 28
- Substances taken .............................................................................................................. 29
- Awareness of services ..................................................................................................... 30
- Contact with services ...................................................................................................... 32

### Section 4: Prevalence & Patterns of Substance Misuse by Demographics ............... 34
- Gender ............................................................................................................................. 34
- Age .................................................................................................................................. 35
- Ethnicity .......................................................................................................................... 36
- Sexual Orientation .......................................................................................................... 37
- Disability ........................................................................................................................... 38
- Religion ............................................................................................................................. 39
Executive Summary

This report has been produced by the Substance Misuse Team at Safer Bristol. It details the findings from a survey that was carried out to investigate new drug and alcohol trends. It will be used to inform future commissioning so that services are able to respond to newly emerging patterns of substance use.

Data was collected through an online survey. This method was chosen in order to capture a wide range of participants, particularly young adults. The survey was open from 01st September to 31st October 2011. It was started by 748 participants and completed by 592. Findings were related to a range of demographic groups in order to look at different trends of substance use.

Key findings:
- High levels of alcohol use were recorded for all groups.
- Cannabis, ecstasy/MDMA, nitrous oxide and cocaine were also frequently recorded.
- There were extremely low levels of heroin and crack use recorded.
- There was evidence of newly emerging substances, including nitrous oxide, ketamine and benzodiazepines.
- The substance used on a daily basis by the highest number of participants was cannabis.
- 60% of the sample were poly substance users.
- A high percentage of participants recorded concerns about their substance use. Most of these related to physical and mental health.
- There were low levels of awareness about Bristol substance misuse services, particularly among those who did not use opiates and crack.
- Respondents also recorded low levels of contact with substance misuse services.
- Comparison between Bristol residents and non Bristol residents in the sample showed higher levels of use of a range of substances for those living in Bristol.
- The groups showing the highest levels of substance use were young adults aged 18-24, gay men and those identifying as bisexual.

Recommendations were made according to these findings to tailor services to meet the needs within these changing patterns of substance use and to inform prevention and education interventions.
Introduction

This report presents findings from an online drug and alcohol survey that was conducted by the Substance Misuse Team (equivalent to other area Drug & Alcohol Action Teams) at Safer Bristol between September and October 2011. The survey was carried out to gain a greater understanding of substance use trends in Bristol.

Bristol is the largest city in the South West of England and the eighth largest city in England with an estimated population of 441,300 (Bristol City Council, 2012). It is the largest centre of culture, employment and education in the South West region.

A diverse range of substance misuse services have been set up in Bristol which have been particularly successful in targeting opiate, crack and alcohol users. The Substance Misuse Team at Safer Bristol commission and performance manage these services through central funding from the National Treatment Agency (NTA) and other local funding sources. This helps to reduce drug related crime and to improve public health outcomes.

The annual Bristol Needs Assessment 2010/11 showed that 95% of those in drug treatment were heroin and/or crack cocaine users. This is a very high figure when compared to the national average of 84% and may identify a gap in provision for those using other substances.

The NTA (2011) showed that there has been a national decline in heroin and crack use, particularly among younger age groups. This is an encouraging trend, however cannabis use has emerged as a concern among younger people with National Drug Treatment Monitoring System (NDTMS) figures showing that in 2010 it overtook heroin as the biggest single category of drug for those aged 18 – 24 coming into treatment. It was hoped that a survey on local drug trends would identify whether similar changing needs are happening in Bristol and help to inform commissioning decisions.

In addition to this, the National Drug Strategy 2010 stresses the need to tackle dependence of all drugs including “legal highs”, prescription drugs and over the counter medicines. There has been a general acceptance that there are a wider number of substances now available to the public, with a recent increased focus from the media on these substances. In 2010 Avon & Somerset Police saw an emergence in use of ‘Legal Highs’ in Bristol (Safer Bristol 2011). Anecdotal evidence has also suggested that some drug trends are specific to Bristol, for example a high number of ketamine users. These figures have not been reflected in drug treatment data and the prevalence of new drug trends emerging locally has remained unclear. This survey aimed to provide a more accurate picture of changing trends.

The results from this survey will be used as an evidence base to inform commissioning decisions around drug and alcohol services and help to develop local public health work around substance use in Bristol.

If you require support around substance use, contact details of local services are provided in Appendix 1
Methodology

In order to reach a range of groups and individuals throughout Bristol it was decided that an online survey would be the most effective way of targeting participants.

Smith & Flatley (2011) show that young adults in the 16 – 24 age group have high levels of drug use compared to all adults (20.4% and 11.1% respectively). It was therefore felt that young adults should be a particular focus of the survey. Ramo et al (2010) showed that online surveys effectively reach young adults and it was therefore decided to use this method to collect data.

Conversely this methodology may limit participation from certain groups, for example older people, who may be less likely to use/have access to the internet, but given the focus of the study it was felt to be the most appropriate method.

Additional strengths of an online survey include getting a higher response rate from participants than the more traditional research methods, such as questionnaires and interviews (Thompson et al, 2003). This method is also seen as the most time focused approach by way of having a set deadline for the survey where data could then be more easily analysed and prepared (Garton et al, 1999).

Given the nature of the survey, where participants would be asked to disclose their illegal drug use, an anonymous and secure online survey was regarded as the most appropriate form of data collection where participants would also be most likely to give honest responses (Joinson, 1999). In addition to this, the internet has been identified as an important source of information for substance users (Stetina et al, 2004).

A concerted marketing campaign took place by Safer Bristol to encourage participation. The survey received radio promotion from BBC Radio Bristol, Heart FM and other local radio stations. A print campaign also took place where flyers were sent out with club promotional packs (Don’t Panic) throughout Bristol and an advertisement was placed in Skint, a Bristol student magazine. An online promotional campaign was carried out through social networking sites, such as Facebook and Twitter, and also through local online music forums, such as Hijack Bristol. These forms of promotion were seen as an effective way of attracting a younger demographic of participants to the survey to inform us of current drug and alcohol trends.

The Substance Misuse Team devised a set of questions to ask each participant which would provide information of up to date drug and alcohol trends in Bristol. The survey was set up to ask each participant if they had used any substances from a list over the past 12 months (see appendix 2 for list of substances included). Because the aim of the survey was to find out about emerging drug trends in Bristol, questions were based on use within the past 12 months rather than whether they had ever taken these substances in their lifetime.

If a participant answered ‘Yes’ to using a given substance in the past 12 months a new page would open containing a set list of questions on that substance. The questions attempted to measure levels of substance use, levels of concern around substance use, any engagement with substance misuse services etc (see appendix 3 for an example of the formatting of questions in the survey). These questions and responses were standardised for every substance recorded, with minor differences depending on the substance (e.g. how long have you been drinking alcohol compared to how long have you been using cannabis). If the respondent answered ‘No’ to a substance, they would be directed to the next page asking them whether they had used another substance in the past 12 months. This process would be repeated for each substance.

An additional page was added for participants to record any other substances that they had used in the past 12 months that had not been listed in the survey.

Questions were also asked about whether they had tried to contact any drug or alcohol services in Bristol for the substances that they had recorded. If they responded ‘No’ to this it led them to another page asking them why they had not tried to access support.
Finally a set of equalities questions were asked, based on Bristol City Council guidelines. (see appendix 4 for list of equalities questions included).

Bristol's User Feedback Organisation (UFO), which is made up of both current and ex-users of Bristol's drug & alcohol treatment services, were consulted about the questions, and the survey was also piloted with 20 Bristol residents. Feedback from these groups helped to inform the final survey questions.

The online survey went live on 01st September 2011 and closed on 31st October 2011. During this period the survey was started by 748 participants and finished by 592, giving a completion rate of 79%. The data from the participants who did not fully complete the survey have been included in the final results. This means that although similar numbers of respondents may have recorded using different substances, percentages may vary because the drop out rate increased at each point in the survey. Percentages have been rounded up to the nearest whole number when analysing the results from this survey.

The primary focus for the survey was Bristol residents but non Bristol residents who completed the survey were not excluded. This allowed a comparison to be made between Bristol and non Bristol residents.
Section 1: Demographics

This section gives a breakdown of the demographic data of participants who took part in the survey. Where possible this data has been compared to local and national averages for each demographic group. See section ‘Prevalence and patterns of substance use by demographics’ for patterns of substance use by each demographic group.

- Gender

Fig 1.1

There were a slightly higher percentage of females (52%) taking part in the survey than males (47%). According to the Office for National Statistics (ONS 2011), the gender split for England and Wales was 50.7% females to 49.3% males. Whilst Bristol has 50.1% females to 49.9% males.

A question was also asked about whether they were transgendered. Two respondents in the survey answered ‘Yes’ to this. There is no recent research on how common transgender is, but nationally, referrals to gender clinics suggest that approximately one in 30,000 men and one in 100,000 women seek gender reassignment surgery (Stewart, G. 1998). However, the Gender Identity Research and Education Society estimates that there are about 15,000 people in the UK receiving some form of medical help for gender dysphoria, which is about one in 4,000 of the whole population (Counselling Directory, 2012).
The largest proportion of participants (39%) fell into the ‘25 to 34’ age category. However, it must be noted that there was also a large proportion of participants (24%) in the ‘18 to 24’ age category which has a smaller range of ages to the other age categories (7 year range compared to 10 year range).

According to ONS (2011) the largest age group in Bristol based on the above age categories (not including Under 18) is ‘25 to 34’ group (20.5%), this is followed by ‘18 to 24’ group (14.4%). National data based on the same age categories show that the largest groups are ‘35 to 44’ (14.3%) and ‘45 to 54’ (13.6%).
### Ethnicity

**Fig 1.3**

- The percentage of all respondents who classified themselves as Black or Minority Ethnic (BME) for this survey was 12.1%. The BME figures drop to 10% when looking at Non Bristol residents.
- ONS (2011) state that 13.5% of the Bristol population belong to a BME group. This drops to 5.9% when looking at the whole of England.

### Sexual Orientation

**Fig 1.4**

- The percentage of all respondents who described their sexual orientation as lesbian, gay or bisexual (LGB) totalled 8% (n=50). 87% described their sexual orientation as heterosexual.
- 5 – 7% of the UK population describe themselves as lesbian, gay or bisexual (Dept of Trade and Industry, 2003). It is estimated that one in fifteen people living in Great Britain is homosexual or bisexual (National Audit Office, 2004).
2.5% of respondents who took part in the survey considered themselves to be disabled.

According to the 2001 Census, 17.3% of the population of Bristol are recorded as having a limiting long term illness (often used as a proxy measure for the number of disabled people). There are approximately 10 million disabled people in Britain which represents around 18% of the population. (Office for Disability Issues, 2008).

Therefore, those who consider themselves as disabled are under represented in this survey. It is worth noting that the prevalence of disability increases rapidly with age. Approximately 75% of men and women in Bristol aged 85 and over, have a limiting long term illness (2001 Census). As the majority of participants in this survey are aged under 35 (65%) we would expect a lower percentage of clients who consider themselves to be disabled.

Participants who considered themselves to be disabled were also asked what impairment(s) they had. There were 20 responses to the impairment groups listed, showing that some of the 15 respondents who classified themselves as disabled have more than 1 impairment.

Numbers in all of the groups were low but the most frequently recorded impairments were ‘physical impairment’, ‘hearing impairment’ and ‘a health condition’.
68% of respondents classified themselves as having no religion. This is significantly higher than both local and national figures and may be a reflection of the age group answering this survey.

Almost all religious groups represented in the sample were significantly smaller than local levels. The only exceptions were Buddhist respondents (1.2% of participants, compared to 0.4% of the Bristol population) and Jewish respondents (0.3% of participants, compared to 0.2% of the Bristol population).

A higher proportion of people in Bristol recorded ‘No Religion’ (24.5%) in the 2001 Census than nationally (14.8%).
Section 2: Substance misuse by all respondents

This section looks at data that was collected from all respondents who took part in the survey.

- **Substances Taken**

**Fig 2.1**

- The substance used by most respondents was alcohol, which was recorded by 95% (n=689) of all participants.
- The second highest substance was cannabis (53%, n=347), followed by ecstasy/MDMA (45%, n=284), nitrous oxide (39%, n=241) and cocaine (37%, n=240).
- Other substances that were recorded by relatively high numbers of respondents included ketamine (24%, n=153), amphetamines (23%, n=146), benzodiazepines (18%, n=113) and mephedrone (16%, n=100).
- Use of all other substances was relatively low with each being used by fewer than 100 respondents. This includes crack cocaine (3%, n=18), heroin (3%, n=16) and methadone (1%, n=5).
In addition to the substances listed in the survey, participants also recorded use of other drugs. 15 extra substances were recorded on 73 occasions.

Each of these substances were recorded by relatively few participants, with those included in the 2C group showing the highest level of use (5%, n=29). This was followed by prescribed/over the counter medication (3%, n=17) and DMT (1%, n=9).
Length of time participants have taken substances

Participants who had identified using individual substances in the last 12 months were asked how long they had been using them. This data is illustrated in Fig 2.3, which shows the substances that they have started to use during the last five years, and Fig 2.4, which shows the substances that they have used for more than five years. Comparison between the two charts shows recent changes in patterns of substance use. It is likely that the younger age cohort who took part in this survey will have influenced this as they would have been using substances over a shorter period of time.

Fig. 2.3

- Nitrous oxide has the highest number of participants who started using this substance during the past 5 years (n= 156). Ketamine (n=110), ecstasy/MDMA (n=105) and mephedrone (n=97) also have high numbers of people who have started using more recently.
- A high number participants started using benzodiazepines within the past year (n=33). This is the highest number among all substances with the exception of nitrous oxide (n=35).
This chart shows that among respondents who have been using substances for longer than 5 years, alcohol has the highest number of respondents in each category relating to length of time used (n=589). Cannabis (n=258), cocaine (n=142) and ecstasy (n=175) also show relatively high levels of longer term use among participants.
Frequency of substance use

The data shows very different patterns of frequency of use between alcohol and cannabis and all other substances. It has therefore been displayed in separate charts allowing frequency of use of other substances to be seen more clearly. More frequent substance use is illustrated in Fig. 2.5 and Fig. 2.6 whilst less frequent use is shown in Fig. 2.7 and Fig. 2.8. Within this survey more frequent use has been classified as using at least weekly. It should be noted that this does not necessarily equate with high risk use. For example, participants using alcohol for three to four days a week may still be drinking within government guidelines depending on the number of units consumed on each occasion. It is likely, however, that respondents who use any substance as frequently as this, especially those who are involved in daily use, may be involved in higher levels of risk.

Fig. 2.5

- The substance used by most respondents on a frequent basis is alcohol, with 520 using this substance at least once a week.
- Frequent cannabis use was recorded by fewer respondents, with 146 participants reporting using this substance at least weekly.
- Among those reporting daily use, the substance that is most frequently used is cannabis, with 17% of cannabis users reporting daily use (n=58). This compares to only 6% of alcohol users reporting daily use of alcohol (n=41).
- In all other categories of frequent use, alcohol shows significantly higher levels of use.
Very few respondents recorded frequent use of any other substance. Daily use was recorded by fewer than five respondents for all substances other than benzodiazepines (n=8).

Daily use of benzodiazepines (n=8), heroin (n=2) and methadone (n=1) suggests physical dependence by a small number of respondents.

Within this category of weekly or more frequent use, most respondents recorded using a substance 1-2 days each week, although the numbers reporting this level of use are very small. Ecstasy/MDMA is recorded by the highest number with 26 people reporting using this substance 1-2 times a week. Other substances recorded as being used 1-2 days a week by more than 10 respondents are cocaine (n=17), amphetamine (n=15), nitrous oxide (n=14) and ketamine (n=10).
Monthly or less frequent use of other substances is recorded by much higher numbers of respondents than those recording weekly or more frequent use.

The data continues to show that ecstasy/MDMA is the most popular substance in this group and is the only substance with over 100 participants (n=125) recording using them on 1-2 days a month. Over 50 respondents also recorded using cocaine (n=71) and nitrous oxide (n=87) on 1-2 days a month.

Among those who reported infrequent use of these substances, (not using them in the past month), the highest numbers again reported using cocaine (n=98), ecstasy/MDMA (n=94) and nitrous oxide (n=94). In addition 66 respondents reported using ketamine not in the past month and 50 reported using amphetamines.
**Reasons for using substances**

Participants were asked why they had used the substances that they recorded. They were invited to choose as many reasons as were relevant to their pattern of use. Individuals therefore may appear in more than 1 category.

*Fig. 2.9*

The most popular reason why participants used any substance was to socialise with friends (29%). The next largest group said that they used substances ‘to feel good’ (23%). 14% said that they used substances to help them relax.

All other reasons for substance use were identified by less than 10% of participants in the survey.
There are some points of interest when the reasons for using different substances are analysed. A high proportion of most substances are used to ‘socialise with friends’. The most notable exception to this is benzodiazepines.

Alcohol, cannabis and benzodiazepines were the most popular substances to help participants relax. Not surprisingly stimulant drugs, such as cocaine and amphetamines, were rarely used for this purpose.

There were a higher proportion of participants who recorded using ketamine, mephedrone and methamphetamine to see what they were like.

Other reasons given by participants for the most commonly recorded substances include: using out of habit (alcohol and cannabis), helping to stay awake (amphetamines and cocaine) and taking at clubs/parties (ecstasy/MDMA and nitrous oxide).
**Concerns about substance use**

Respondents were asked to record their concerns about the substances that they had used in the past 12 months. They were invited to record as many concerns as were relevant and therefore the number of concerns for each substance may add up to more than the number of respondents using a particular substance.

Fig. 2.11

- 25% of respondents had no concerns about their substance use.
- The highest percentage of concerns were recorded in relation to physical health (24%) followed by concerns about mental health (21%).
- All other concerns about substance use were identified by less than 4% of participants in the survey.
The substances which related to the highest number of concerns were alcohol (n=732), cannabis (n=488), ecstasy/MDMA (n=396), cocaine (n=298) and amphetamine (n=203). All of these substances had more than 200 concerns recorded against them.

The substances with the highest percentage of respondents recording concerns were methadone (100%), methamphetamine (100%), solvents (86%) and heroin (81%). However, the numbers recording use of these substances in this survey were extremely low, with fewer than 10 respondents recording using any of them. The only exception to this was heroin, which was recorded by 16 participants.

High levels of concerns were also recorded about the most commonly used substances. 64% of those using alcohol, 71% of those using cannabis, 67% of those using ecstasy/MDMA and 64% of those using cocaine expressed concerns. The exception to this is nitrous oxide, which was the fourth highest recorded substance, but only 32% of users expressed concerns. This was the lowest percentage of respondents recording concerns about any substance.

The substances with the lowest percentage of respondents recording concerns were nitrous oxide (32%), magic mushrooms (38%), poppers (46%), benzodiazepines (48%) and steroids (50%).

‘Other’ concerns identified by participants using the most commonly recorded substances included: financial problems (alcohol and cannabis) and unknown long term effects (nitrous oxide)
Reducing and stopping substance use

Respondents were asked whether they had considered reducing or stopping the substances that they had used in the past 12 months. An average of 65% of respondents had considered reducing or stopping.

Fig. 2.13

- The substances with the highest percentage of participants who had considered reducing or stopping were methadone (100%), khat (83%), methamphetamine (80%) and heroin (75%). Again it must be noted that all of these substances had very low levels of recorded use.
- Among the substances recorded by most people, over half of those using alcohol (56%) and cannabis (62%) had considered reducing or stopping using these substances. Just under half of those using cocaine (47%) and ecstasy/MDMA (41%) had considered reducing or stopping.
- The substances with the lowest percentage of users who had considered reducing or stopping are steroids (0%), magic mushrooms (9%) and nitrous oxide (15%).
Poly substance use

Poly substance use is defined as having taken two or more types of illicit drugs or at least one illicit drug and alcohol in the last year (The Health and Social Care Information Centre, 2011). Participants were asked whether they had used substances in the past 12 months and therefore the rate of poly substance use could be measured according to this definition.

Fig. 2.14

- The majority of participants had used one substance (n=254) with 99% of these respondents reporting this substance as alcohol only (n=252) in the past 12 months.
- 54 participants recorded no substance taken in the past 12 months, however it is unclear how many of these respondents accessed the survey without starting it and how many completed the survey without recording any substances.
- 60% of respondents (n=449) recorded using two or more substances and would therefore be defined as poly substance users.
- In terms of poly substance use, participants using two substances in the past 12 months (n=89) were the most commonly recorded. This was followed by three substances (n=60) and four substances (n=59) respectively.
- The graph illustrates that as the number of substances taken over the past 12 months increases the numbers of participants in turn reduce. A slight anomaly to this trend is highlighted by more participants using seven substances in the past 12 months (n=52) compared to those using five substances (n=47) and six substances (n=39).
Participants recorded a variety of combinations of substances that they had used in the past 12 months. The most common combination was alcohol and cannabis (n=51). This was also the most common combination of substances when looking at any other substance(s) recorded alongside cannabis and alcohol (n=327).
This section has a specific focus on participants who reported being Bristol residents.

Fig. 3.1

79% (n=583) of respondents recorded Bristol as their local authority while 21% (n=154) lived outside of Bristol. This allowed comparison of drug and alcohol use to be made between Bristol and non-Bristol residents.
Substances Taken

Fig. 3.2 compares use of individual substances by Bristol residents and non Bristol residents.

Fig. 3.2

A higher percentage of respondents who were Bristol residents reported use of all substances when compared to non Bristol residents. The average use among Bristol respondents was 21% compared to 15% for non Bristol residents. The one exception to this is khat, but caution must be used in this case because the total number recording khat use was very low (n=3).

The biggest difference can be seen for ecstasy/MDMA, which was recorded by 16% more participants from Bristol than those outside of Bristol. This was followed by nitrous oxide (15% higher among Bristol residents), cannabis (14% higher among Bristol residents) and cocaine (11% higher among Bristol residents).

Among the non Bristol residents no one recorded use of crack cocaine or GHB/GBL in the past 12 months. Among Bristol residents these substances were recorded by 4% and 2% of respondents respectively.
Awareness of Services

Respondents were asked if they were aware of Bristol services for the specific substances that they had recorded. Only data from Bristol residents were included in this section because non-Bristol residents would not be expected to be aware of Bristol based services.

Fig. 3.3

- Respondents’ knowledge of services varied according to which substance they were using.
Substances that were recorded in Fig. 3.3 were grouped into three categories: opiate and/or crack users, alcohol users, and those who used any other substance (Non opiate & non crack users). These are shown in Fig. 3.4.

Fig. 3.4

<table>
<thead>
<tr>
<th>Substance Type</th>
<th>Average % of participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opiate (including methadone) and/or Crack Users</td>
<td>92</td>
</tr>
<tr>
<td>Non Opiate and Non Crack Users</td>
<td>31</td>
</tr>
<tr>
<td>Alcohol Users</td>
<td>54</td>
</tr>
</tbody>
</table>

- Those using heroin, methadone and crack cocaine recorded the highest levels of awareness for services that related to these substances (92%).
- Only just over half of all alcohol users (54%) were aware of alcohol services available to them in Bristol.
- Awareness of all other substances (minus opiate, crack and alcohol) services in Bristol from participants using these substances was relatively low (31%).
- Contact with services

As before, only Bristol residents were included in this section because non Bristol residents would not be expected to contact Bristol based services.

Fig. 3.5

- A low percentage (3%) of respondents recorded having contacted Bristol drug or alcohol services for support.
- The remaining 97% were asked why they had not contacted drug or alcohol services and the responses are shown in Fig. 3.6.
The highest percentage of respondents had not contacted services because they had no concerns about their drug or alcohol use (88%). Other reasons for not contacting services were recorded by relatively low percentages of respondents.
This section looks at substance use in relation to a range of demographic characteristics.

- **Gender**

Fig. 4.1

- The breakdown of respondents according to gender can be seen in Fig. 1.1.
- In Fig. 4.1, the data was filtered according to gender and levels of use for almost all substances were higher among males than females.
- The biggest differences between male and female patterns of use were seen among 3 of the most frequently used substances. 67% of males and 40% of females reported using cannabis, 57% of males and 35% of females used ecstasy/MDMA, and 50% and 31% used nitrous oxide. There were closer levels of use for alcohol (97% male and 95% female) and cocaine (42% male and 33% female).
- The levels of use were exactly the same between males and females for benzodiazepines (16%), GHB/GBL (2%) and methadone (1%).
- The only substance in which there was a higher level of use by female respondents was methamphetamine (1% female and 0% male). However, it must be noted that only three participants reported use of this substance.
The breakdown of respondents according to age group can be seen in Fig 1.2.

In Fig. 4.2 the sample was grouped into four different categories. Due to the small number of respondents aged 35 years or older, these participants have all been put together into one group.

The general trend illustrates that substance use decreases with age for most substances for those aged 18 and over. Within this survey the group aged under 18 was very small (n=11) so caution needs to be applied when looking at percentages.

All age groups had a high percentage recording alcohol use in the past 12 months.

Of those using alcohol, the highest percentage of respondents were under 18, with 100% of this group having used this substance in the last 12 months. The highest percentage of those using cannabis (100%) and mephedrone (55%) were also under 18.

A high percentage of under 18s also used nitrous oxide (64%) and ecstasy/MDMA (55%), although those in the 18-24 age group had a slightly higher percentage recording use of both of these substances at 65% and 67% respectively.

The 18-24 age group also recorded high levels of cannabis use (79%).

When average use of these substances is measured according to age, the 18-24 group showed the highest levels of use (27%). This age group showed the highest levels of use of cocaine (51%), ketamine (41%), amphetamine (37%), benzodiazepines (21%), LSD (21%), poppers (12%) and GHB (4%).
Ethnicity

Fig. 4.3

The breakdown of respondents according to ethnicity can be seen in Fig. 1.3.

In Fig. 4.3 the sample was categorised into two different groups: White British and BME. Due to the relatively small number of respondents in specific ethnic groups, these respondents have been categorised together into one group for this chart. This allows us to analyse broad trends between White British and BME participants.

However, caution should be used here as substance misuse prevalence can alter significantly between specific BME groups. For example, Hoare & Moon (2010) used British Crime Survey data to highlight higher levels of substance misuse among those from a Mixed background compared to White British. They also showed that those from Asian (Indian, Bangladeshi or Pakistani) backgrounds reported a lower level of use than White British.

In this survey the biggest percentage differences by substance between White British and BME participants were alcohol (96% and 90% respectively), cannabis (55% and 49% respectively) and magic mushrooms (13% and 7% respectively). In contrast, BME participants were more likely than White British to have used amphetamines (27% and 20% respectively), LSD (16% and 10% respectively) and heroin (10% and 2% respectively). However it must be noted that some of these substances were recorded by a small number of participants therefore caution needs to be applied when looking at percentages.

Overall, there was a very small difference in the average percentage between White British (20%) and BME participants (19%), when looking at the substances they used over the past 12 months.

The 35+ age group shows the lowest level for all substances except solvents (2%) and crack cocaine (5%). It should be noted that these substances were recorded by a very low number of participants across all age groups.
### Sexual Orientation

**Fig. 4.4**

- The breakdown of respondents according to sexual orientation can be seen in Fig. 1.4.
- When average use of these substances is measured according to sexual orientation gay participants showed the highest levels of use (30%). Bisexual participants also shown relatively high levels of use (26%). This compares to an average of 20% among heterosexual respondents and 16% of lesbian respondents.
- Those who identified as gay were more likely than bisexual participants to have used amphetamines (56% and 21% respectively), cocaine (70% and 48% respectively), mephedrone (40% and 20% respectively), LSD (20% and 8% respectively), ketamine (50% and 40% respectively) and poppers (30% and 20% respectively).
- Those who identified as bisexual were more likely than gay participants to have used cannabis (72% and 60% respectively), benzodiazepines (32% and 20% respectively) and alcohol (96% and 90% respectively).
- Those who identified as lesbian were least likely to have used any substances except alcohol, which was high across all groups, and heroin, which was low across all groups.
The breakdown of respondents according to whether they considered themselves to be disabled can be seen in Fig. 1.5. It should be noted that there were relatively few respondents who considered themselves to be disabled (n=15).

Participants who considered themselves to be disabled were less likely to use most substances. The exceptions to this were solvents and amphetamines with 13% and 30% of disabled participants having used these substances in the past 12 months respectively. This is compared to 1% and 20% of those who did not consider themselves to be disabled.

Some substances that were commonly recorded within the survey did not feature among participants who considered themselves to be disabled such as ketamine and mephedrone.

When average use of these substances is measured according to whether a participant considered themselves to be disabled the percentage is very low at 9%, compared to 20% for those who did not consider themselves to be disabled.
The breakdown of respondents according to whether they recorded a religion can be seen in Fig. 1.6.

In Fig. 4.6 the sample was categorised into two different groups: those who recorded a religion and those who recorded having no religion. Due to the relatively small number of respondents in specific religious groups, these respondents have been categorised together into one group for this chart. This allows us to analyse broad trends between religious and non religious participants.

Non religious respondents were more likely than religious respondents to have used most substances. The exceptions were benzodiazepines (equal between both groups), khat (1% and 0% respectively), solvents (2% and 1% respectively) and steroids (1% and 0% respectively).

When average use of these substances is measured according to whether a participant is religious, the figure is 15% compared to 21% among participants who are not religious.
Conclusions

- **New patterns of substance use**

Results from this survey have provided evidence of changing patterns of substance use in Bristol. The substances that were most noticeable in this context included nitrous oxide, which was the fourth highest substance recorded. A large majority of respondents also stated that they had started using this substance within the past five years, suggesting that this was part of a new trend in drug use.

There were also high proportions of ketamine and mephedrone users who had started using these substances within the last 5 years, again suggesting a relatively recent change in drug patterns. Ketamine and mephedrone have received a lot of recent media attention and this may have prompted a level of interest among potential users. The high proportion of respondents who said that they had used these substances to see what they were like supports this supposition.

A high proportion of those using benzodiazepines started to use these substances within the past 12 months, again suggesting a new trend in drug use.

There were fewer ‘legal high’/‘designer drugs’ recorded in the survey than was initially expected, suggesting that classified substances still tend to be the most frequently used. The exception to this was nitrous oxide.

The survey also highlighted very low levels of heroin and crack cocaine use among respondents. This may be partly due to the profile of those completing the survey (e.g. having access to the internet) but it also appears to support the findings from the NTA report ‘Drug Treatment and Recovery’ that detailed declining use of these substances among younger adults.

Participants using substances other than alcohol were highly likely to be involved in poly drug use. The findings support the work conducted by Howard Parker et al (2009) that young adults are increasingly accessing treatment with an AACCE (alcohol, amphetamines, cannabis, cocaine and ecstasy) profile.

- **Concerns about substance use**

Although a quarter of respondents recorded that they had no concerns about their substance use, a broad range of concerns were recorded for most substances. The majority of these related to physical and mental health and others were recorded about the impact of drug and alcohol use on work/studies and the effect on respondents’ relationships. Particularly high levels of concern were expressed about the effect of alcohol on physical health and of cannabis on mental health.

In most cases, the highest levels of concern were reported for the most frequently recorded substances. However, low levels of concern relating to benzodiazepine use may suggest a low level of knowledge about the risks involved in using this group of substances. Also, in spite of the high levels of nitrous oxide use, there were relatively few concerns among those who use this substance.

- **Support to reduce or stop substance use**

However, the proportion of respondents who had considered reducing or stopping their substance use was considerably higher than the numbers who were aware of relevant support services. This suggests that those who potentially may seek support would not know where to go for help.

There was a particular discrepancy about awareness of services between those who fitted the profile of a traditional drug service client (i.e. opiate and crack users) and those using other substances. This suggests that services are less successful in promoting support for a wider range of substance use. When asked why respondents had not contacted services for support 88% said that they had no concerns with their substance use (Fig. 3.6). This conflicts with those responses about specific concerns relating to the substances they use. The reason for this conflict is not clear but it may be because they
had no knowledge about the kinds of support that services are able to offer. Future research should investigate this further, perhaps through the use of semi-structured interviews.

- **Substance use in Bristol**

  The survey showed that Bristol respondents were more likely to have used a range of substances in the past 12 months than non-Bristol respondents. While this does show a higher need in Bristol, caution may need to be applied here. More detail is required in future surveys regarding the locality of the non-Bristol residents to investigate the significance of this finding.

- **Higher risk groups**

  The data showed patterns of substance misuse across a number of different demographic groups. The groups that were particularly evident for high levels of substance use were young adults aged 18 – 24, gay men and those who identified themselves as bisexual.

  British Crime Survey data continually shows that substance use decreases with age, with the 16 – 24 age group using higher levels of all illegal substances than the 16 – 59 age group. The Bristol survey supports these findings, with the highest levels of use among those aged under 18 and those aged 18-24. This suggests that there is a need to develop a range of services for young adults, providing advice and harm minimisation support along with structured treatment for those who develop more problematic use.
Key Recommendations

- The survey clearly establishes the need for comprehensive substance misuse services in the city.

- Drug and alcohol services need to be flexible in the support that they offer to clients and should be able to respond to changing patterns of substance use within the population.

- Those who provide education, information and advice also need to be aware of new trends and incorporate this awareness into prevention and harm minimisation programmes.

- Education on the links between substance misuse and a variety of related problems should be strengthened across a range of settings.

- The recorded levels of benzodiazepine use indicate a need for specific education about the risks associated with this group of drugs. Treatment services may also need to be aware of this and of a possible increase in the numbers becoming dependent on this substance.

- Service providers and other relevant organisations need to be able to deliver education and harm minimisation advice about the increased risks associated with poly drug use.

- Workers need to be skilled in recognising a broad range of issues relating to substance misuse, including early identification of mental and physical health needs. Pathways should be developed so that appropriate referrals are made between community health provision and drug and alcohol services.

- Services for non-opiate and non-crack users should be widely promoted using a broad range of media. This should include more online information to target younger age groups and special interest groups, in addition to professional networks, such as health professionals, and community organisations.

- The distribution of educational materials should be specifically aimed at young adults, gay men and bisexual groups, using appropriate marketing channels and resources. Again, this should include more online information to target younger age groups and special interest groups. Information should also be targeted within social settings such as nightclubs, pubs, post 16 educational settings etc in order to inform these specific groups.

- Patterns of use within these groups should be noted in order to inform educational content.

- Information promoting services to young adults and gay and bisexual groups should include a particular emphasis on the range of support that they offer.

- Services need to ensure that they are trained in diversity and awareness, particularly focusing on LGBT clients.

- The survey provided useful information about patterns of drug use that had not been measured before. It should be repeated on a 2 yearly basis so that changing need can be identified and services can respond accordingly.

- The findings of this survey should inform the annual Bristol Substance Misuse Needs Assessment 2012 and feed in to the recovery focused commissioning strategy.
References

Bristol City Council (2011) Briefing Note Estimated Resident Population Mid-2010

Bristol City Council (2011) Bristol Substance Misuse Needs Assessment 2010/11

Bristol City Council (2011) Equalities Community Profiles

Bristol City Council (2012) The Population of Bristol: January 2012 update


Home Office (2010), National Drug Strategy: reducing demand, restricting supply, building recovery: supporting people to live a drug-free life


National Audit Office (2004) Delivering Public Services to a Diverse Society


NTA (2011) Drug Treatment and Recovery in 2010-11

Office for Disability Issues (2008), Disability Prevalence Estimates


Ramo et al (2011) Reliability and validity of young adults' anonymous online reports of marijuana use and thoughts about use


1) Contacts

For more information on any of the substances included in this survey or if you are concerned about your own or someone else’s drug or alcohol use please contact FRANK on-

Telephone - 0800 776600
or email via their website at - http://www.talktofrank.com/

If you would like to access a local Bristol service you can visit Bristol Drugs Project. They have launched a new POD (for people using drugs other than opiates or crack) service at -

11 Brunswick Square
Bristol
BS2 8PE

Monday - Friday 09:30 - 17:00
Saturday 09:30 - 12:30

BDP can also be contacted by telephone on 0117 9876000 or email at info@bdp.org.uk

Alternatively you can contact the Club Drug Drop-In Clinic at Bristol Specialist Drug & Alcohol Service at-

BSDAS, Club Drug Drop-In Clinic
1 Colston Fort, Montague Place
Kingsdown, Bristol, BS6 5UB
0117 9192345
2) List of substances included

- alcohol
- amphetamine
- benzodiazepines
- cannabis
- cocaine
- crack cocaine
- ecstasy/MDMA
- GHB/GBL
- heroin
- ketamine
- khat
- LSD
- magic mushrooms
- mephedrone
- methadone
- methamphetamine
- nitrous oxide
- poppers
- solvents
- steroids
3) Example of survey format

**Amphetamines (AKA Speed)**

*9. Have you used amphetamines (AKA speed) in the past 12 months?*

- Yes
- No

If yes:

**Amphetamines (AKA Speed) Use**

*10. How long have you been using amphetamines?*

- Less than 1 year
- 1 year to less than 5 years
- 5 years to less than 10 years
- 10 years to less than 15 years
- 15 years to less than 20 years
- 20 years or more

*11. How often do you generally use amphetamines? (please choose the frequency that most closely describes your use)*

- Use daily
- Use 5 to 6 days a week
- Use 3 to 4 days a week
- Use 1 to 2 days a week
- Use 1 to 2 days a month
- Not used for the past month
- Not used for the past 6 months

*12. What are the main reasons that you use amphetamines? (tick all that apply)*

- To help me relax
- To socialise with friends
- To escape from reality
- To help deal with problems
- To increase my confidence
- To be creative
- To feel good
- To see what it was like
- Other

If "Other" (please specify):
13. What concerns do you have, if any, about using amphetamines? (tick all that apply)

- Affecting my physical health
- Affecting my mental health
- Affecting my performance at work/my studies
- Affecting my relationships (partner/family/friends)
- Getting a criminal record
- None
- Other

If 'Other' please specify

14. Have you ever considered reducing, or stopping, your amphetamine use?

- Yes
- No

15. Are you aware of services available in Bristol for amphetamine use?

- Yes
- No
4) List of Equalities Questions

Equalities Monitoring Form

Bristol City Council is committed to making equal opportunities a reality in the provision of all of our services. We need to know who our customers are to check that everyone in the city is accessing the services they are entitled to and that no-one is discriminated against unlawfully. Information provided will be treated **confidentially** and in accordance with the Data Protection Act 1998 and only used to ensure that everyone is treated fairly.

Every year, each service gathers information about its customers to check whether the service is reaching all communities and takes action if necessary. Data on uptake of council services by equalities communities is published on our website at [www.bristol.gov.uk/equality](http://www.bristol.gov.uk/equality)

All questions are voluntary and it will not make any difference to the service you receive if you do not answer them. However, by answering the questions you will help us to ensure that our services are fair and accessible to all.

1 How would you describe your ethnic origin? (Please tick)

**White**

- English/Welsh/Scottish/Northern Irish/British ( )
- Irish ( )
- Gypsy (including English, Scottish and Roma Gypsy) or Irish Traveller ( )
- Eastern European ( )
- Any other White background (please describe) ____________________________

**Mixed / multiple ethnic groups**

- White and Black Caribbean ( )
- White and Black African (non Somali) ( )
- White and Asian ( )
- Any other Mixed/multiple ethnic background (please describe) __________________

**Asian / Asian British**

- Indian ( )
- Pakistani ( )
- Bangladeshi ( )
- Chinese ( )
- Any other Asian background (please describe) ____________________________

**Black / African / Caribbean / Black British**

- African (non Somali) ( )
- Somali ( )
- Caribbean ( )
- Any other Black / African / Caribbean background (please describe) ____________________________

**Other ethnic groups**

- Arab ( )
- Iranian ( )
- Iraqi ( )
- Kurdish ( )
- Turkish ( )
- Any other ethnic group (please describe) ____________________________
- Prefer not to say ( )
2 What is your gender?
Female ( )  Male ( )  Prefer not to say ( )

3 Are you transgender?
(Is your gender identity different from the gender you were assigned at birth?)
Yes ( )  No ( )  Prefer not to say ( )

4 What is your age group?
15 or under ( ) 16 to 24 ( ) 25 to 49 ( ) 50 to 64 ( )
65 to 74 ( ) 75 and over ( )  Prefer not to say ( )

5 Do you consider yourself to be a disabled person?
Yes ( )  No ( )  Prefer not to say ( )

5b It helps us to know whether we are reaching all disabled people, please can you tick the relevant impairment (disability) group below and you are welcome to tick more than one box if appropriate.
Physical impairment ( )  Visual impairment ( )  Hearing impairment ( )
Deaf BSL user ( )  Learning difficulties ( )
Specific learning difficulties like dyslexia ( )  Mental and emotional distress ( )
A health condition e.g hiv, multiple sclerosis, cancer ( )  Prefer not to say ( )

6 Please say how you would you usually describe your sexual orientation?
Lesbian ( )  Gay ( )  Bisexual ( )
Heterosexual (straight) ( )  Prefer not to say ( )

7 What is your religion? (Each category includes all denominations and sects)
No religion ( )  Christian ( )  Buddhist ( )  Hindu ( )  Jewish ( )
Muslim ( )  Sikh ( )  Any other religion or belief (Please describe) ___________________
Prefer not to say ( )

8 I do not wish to provide any of the information requested on this form ( )