The Bristol
Online Drug Survey
2014

Public Health Bristol
Substance Misuse Team

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Thank you to everyone who took part in this survey for providing valuable information to help us build this picture of drug use in Bristol.

Thank you to George Jenkinson for his IT support and for sharing his knowledge and skills.

**Executive Summary**

This report presents the findings and recommendations from the second Bristol Online Drug Survey, which was live between September 1st and November 30th 2013. The survey was carried out by Public Health Bristol and the Substance Misuse Team in Bristol City Council as a follow up to the 2012 Bristol Drug and Alcohol Survey (McNally M and Smyth, 2012), which aimed to collect data showing substance use trends in Bristol.

Some changes were introduced to the 2014 survey; most notably alcohol was removed this time as a substance in its own rite. This resulted in a much smaller sample.

Information about the survey was sent out via a variety of venues and media channels that were thought most likely to generate responses from those who use a range of drugs. The sample was then self-selected from those who received this information. 261 people started the survey and 217 completed it. Targeting of the appropriate sample group was largely successful with three notable exceptions: khat use, steroid use and drug use by those under 18 were missing from the data. Heroin and crack cocaine users in contact with services were not specifically targeted because robust data about this group is already held by BCC.

The survey was completed on line using Survey Monkey. Graphs were drawn and data was extracted using the Survey Monkey analysis tools. Conclusions were then drawn from the findings.

The results showed that there has been very little change in patterns of drug use from 2012. Cannabis continues to be the most widely used substance. There is no evidence of newly emerging substances. The percentage of the sample using most individual substances was close to that found in 2012. Slight rises are thought to be due to these substances representing a larger proportion of a smaller sample group, following the removal of alcohol. There were, however, large reductions in the percentages of the sample using mephedrone and benzodiazepines. There is evidence that for most substances longer term use is falling, but for cannabis longer term use is rising.

A large majority of respondents use drugs infrequently (in the last 6 months, but not every month). There was however evidence of frequent cannabis use among the sample. 50% of weekly drug users and 78% of daily users take cannabis.

The most popular venues for most drug use are festivals, nightclubs and parties. Cannabis is used in all venues and most popularly in domestic settings. A large majority of people acquire their drugs from friends and family.

People recorded using drugs for positive reasons. Most drugs were used to have a good time and socialise with friends. The most popular reason for using cannabis was to relax.
The least common reason for taking any substances was to help deal with problems, with all substances having low levels of response in this category, although cannabis was highest with 15% of cannabis users choosing this category.

There were high levels of polydrug use, measured by use of any substance with alcohol. A very high number of respondents said that they always or usually used alcohol at the same time as other substances.

39% of people had no concerns about their drug use. Among the remaining respondents there were high levels of concern about mental and physical health. In spite of this, there were low levels of knowledge about support services and extremely low levels of contact. There appeared to be a misunderstanding about what services could offer.

From the results and conclusions drawn, the following recommendations were made:

1. Work to promote substance misuse services among a broader range of drug users will need careful planning. Cannabis use should be a particular consideration. Both the NOCU (non-opiate and crack use) group set up by the Substance Misuse Team and the ADD HIT (Addiction Health Integration Team), led by Public Health Bristol should look closely at how this support can be promoted so that all drug users recognise the services and feel that the provision is relevant to their needs.

2. A different methodology should be planned and employed in order to gather data and obtain a realistic measure of khat use in the city. This should be carried out in partnership with agencies working with the Somali population and other khat using groups.

3. Work should be set up in partnership with sport and leisure services, focusing on targeting people who use steroids and a different methodology should be used to collect data and identify need.

4. Festivals and nightclubs should be a particular focus for prevention, education and harm minimisation work. This should be set up by partnerships involving commissioners, providers and Public Health. This work should be very broad in its focus in order to include people using and supplying a broad range of substances and those involved in poly drug use.
Introduction

This report presents the findings and recommendations from the second Bristol Online Drug Survey, which was live between September 1st and November 30th 2013. The survey was carried out by Public Health Bristol and the Substance Misuse Team in Bristol City Council as a follow up to the 2012 Bristol Drug and Alcohol Survey (McNally M and Smyth, 2012), which aimed to collect data showing substance use trends in Bristol.

The key findings from the 2012 survey were:

- Frequent alcohol use was 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 substances which have not traditionally been included in the work that is provided by drug support agencies, 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 was made up of poly drug users.
- A high percentage of participants recorded concerns about their substance use. Most of these concerns 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 the findings, including informing the commissioning of Bristol ROADS (Recovery Orientated Alcohol and Drug Services), so that services could be tailored to meet the needs identified within these patterns of substance use. While many of the ROADS services are designed to respond to those using more traditionally problematic substances, specifically alcohol, heroin and crack cocaine, they are also commissioned to support those using other drugs.

The first survey also informed Public Health prevention and education work. A recommendation was included to repeat the survey on a two yearly basis so that changing need could be identified at the earliest opportunity. The 2014 survey was carried out in response to that recommendation.
Aims of the 2014 Online Drug Survey

This second survey aims to provide follow up evidence from the 2012 survey and to test whether the trends identified there have continued. The findings will be used as evidence for commissioners and substance misuse service providers to support work aimed at building recovery. They will also inform public health work in order to help reduce demand for drugs in Bristol, in line with the aims of the National Drug Strategy (HM Government, 2010). In addition, they will provide a useful measure to test whether the relevant recommendations from the first survey have been implemented successfully.
Methodology

Sample

The survey was designed using the same methodology as was employed in 2012, using a purposive rather than a random sample. Data was collected from people who actively use drugs in order to identify patterns of use and to gain an understanding of the needs of this group. The results were therefore not intended to reflect the whole population of Bristol, but rather to represent the drug using population. Recurrent studies show that the highest level of drug use occurs among those aged 16-24 (CSEW, 2011-12 and CSEW, 2012-13) and therefore the recruitment methods focused on ensuring that this group would be well represented in the sample. There are also known to be proportionately higher levels of drug use among those who attend night clubs (CSEW 2012), and among gay and bisexual groups (Buffin et al, 2012). Efforts were therefore made to target these groups for inclusion within the sample.

Bristol has a very successful record in attracting heroin and crack cocaine users into support services and there is therefore a broad and detailed knowledge about the prevalence and needs of this group. Sampling was therefore not specifically targeted at those already receiving support from ROADS.

Details about the purpose, nature and how to take part in the survey were distributed in flyer packs at a variety of venues that were thought most likely to generate responses from those who use a range of drugs. These included nightclubs, local festivals and other music events. Wider groups were targeted by giving out information on local radio, Facebook, Twitter and other appropriate social media sites, including the Bristol City Council website. The information gave assurances that the survey was confidential and that no data which identified individuals would be used in the report. Respondents were then self-selected, opting in once they were satisfied with the information they received.

As with all self-selected samples, some caution should be taken with the data, although it is likely to be the best available evidence of patterns of drug use among adults in Bristol.

Data Collection and Analysis

The survey was distributed and completed on line via SurveyMonkey. Prospective respondents were directed to the appropriate website in the information that they received about the survey. SurveyMonkey was used successfully in the previous study and a rationale for using an on-line survey with young adults can be found in the previous survey report (McNally M and Smyth, 2012).

Analysis was completed using the SurveyMonkey analysis tools and conclusions were drawn from the graphs produced. This was triangulated with data from other studies where appropriate, in order to strengthen the findings.
Gaps in the Methodology

This sampling method was successful in recruiting people who were using a range of substances. However, it appears that it was unsuccessful in recruiting some specific groups of drug users. There are anecdotal reports of high levels of khat use among the Somali population within Bristol. Efforts were made to capture this within the data by requesting support with sample recruitment from colleagues working with Somali and other East African groups. These attempts were not successful and responses about khat use were very low. This suggests that a different methodology needs to be adopted to reach this group and to test responses against the anecdotal evidence.

There are also reports of high levels of use of steroids and other image and performance enhancing drugs (IPEDS). Data held by Bristol City Council shows that in the first quarter of 2014-15 27% (n= 172) out of 640 clients using the needle exchange provided at BDP, were steroid users. These substances are frequently used in gyms and other sport related environments and therefore a request was made for colleagues working in sport and leisure services to promote the survey to this group. Again, responses were very low. This suggests that a different method of recruitment may be helpful to capture use of steroids.

The survey also failed to get any responses from those under 18. Although youth support agencies were contacted for support in recruiting this age group and information about the survey was sent out via these routes, the main targeting methods, focusing on night clubs and other adult venues, were probably inappropriate. The Pupil Voice survey, which is part of the Healthy Schools programme, will provide some useful data about drug use among young people in Bristol and some thought should be given on how to build on this to measure local patterns of use among this age group.

Changes in the 2014 survey

Following the evaluation of the previous online survey, some changes were made to the 2014 questions. The main difference was that alcohol was no longer included as a distinct substance, as it was felt that it was difficult to differentiate between lower risk and higher risk patterns of drinking within this type of survey. It was also felt that there are more reliable ways of mapping alcohol use across the city and a robust needs assessment and alcohol strategy are already in place. Questions about alcohol were therefore confined to whether each participant used alcohol at the same time as other substances. As the alcohol using population is much larger than those who use other drugs, this meant that the sample for the 2014 survey was much smaller than that in 2012.

On this occasion questions were also included about where each substance was used, which meant that higher risk venues and settings could be identified.

Some extra substances were added to the list of drugs within the 2014 survey, such as DMT and n-bomb. These were anecdotally highlighted as an area of growing concern by researchers at a national conference on newly emerging drugs and it was felt to be important that the survey adapted along with emerging national evidence.

Other questions and areas of interest remained the same as for the last survey.
Results

261 people started the 2014 survey and 217 completed it. The sample was much smaller than that in the 2012 survey, when there were 748 responses. There are two probable reasons for this. The first is that alcohol was included in 2012 but was removed in 2014. Alcohol use is much higher than the use of any other substance, with 95% of the 2012 sample recording any alcohol use (n=689) and 34% of the same sample recording that they used alcohol only (n=252). The removal of alcohol was therefore likely to result in a significant reduction in sample size for the 2014 survey.

The second probable reason was that in 2012 a significant proportion of the sample (21%, n=142) were from outside of Bristol city. In the 2014 survey a much smaller proportion (16%, n=44) recorded postcodes from outside Bristol. This may have been because the 2014 survey made it clearer that the results would only affect work in Bristol and others may have felt that the survey was less relevant to them.

In spite of the fact that the sample size was so much lower than in 2012, it should also be noted that the sample for the 2014 On Line Drug is the third largest out of 85 on the Safer Bristol Survey Monkey site.

In displaying these results in this report, percentages have been calculated according to the number of people who responded about each individual substance. Numbers have also been included because some substances had a very low number of respondents, meaning that in these cases percentages alone could be misleading.
Characteristics of the sample

1. Sex

*Fig 1.*

The sample consisted of slightly more males (54%) than females (43%). This is in line with other evidence which shows that slightly more males than females use drugs. (CSEW 2012-13).

2. Ethnicity

*Fig 2.*

The majority of respondents (82%) identified themselves as White English/Welsh/Scottish/Northern Irish/British. This is slightly higher than the White British population as reported by Bristol City Council (2013), which is 77.9%. When the BME
population is considered generally, drug use is always higher among the White population than among the BME population (CSEW, 2011-12, CSEW 2012-13). However, when BME participants are divided into more diverse groups, drug use is consistently reported to be highest among those who describe themselves as from mixed ethnicity (CSEW, 2011-12, Beddoes D. et al 2010). This is mainly because of higher levels of cannabis use. Numbers of respondents in this survey from all ethnic groups other than White English/Welsh/Scottish/Northern Irish/British are recorded in Fig 3. BCC records that 3.6% of the population of Bristol is from a mixed ethnic group. The proportion of respondents in this survey who record their ethnicity within a group that could be interpreted as mixed is 6.4% (n=12). Again this may show successful targeting of some ethnic groups to reach those who are most likely to use drugs. However, this survey did not collect any reliable evidence on some substances which are specifically linked to ethnicity, such as khat, indicating that the Somali population and other East African groups have been poorly targeted.

Fig 3.
The sample did not contain anyone aged 17 and under, suggesting inappropriate targeting of younger age groups. All other age groups were represented in the sample and the results show drug use decreasing sequentially with age, with those aged 18-24 making up by far the largest proportion (47%) and those aged 65 and over making up the smallest group (2%). The method of recruitment distributing information via night clubs, festivals etc. would be expected to bias the sample towards those in younger age groups. However other surveys (CSEW 2013, CSEW 2014) show that drug use is higher among the 16-24 age group, suggesting that this survey has been successful in targeting those who are most likely to use drugs.
4. Sexual orientation

187 people responded to this question. 15% (n=29) described themselves as lesbian, gay or bisexual (LGB). This is a small number of people, but relatively high percentage of the sample. There is some difficulty in identifying the proportion of the population who are lesbian, gay or bisexual (Aspinall 2009) with the government estimate, from a synthesis of available data, falling between 5 – 7%, while the ONS (2012) puts the figure at 1.5%. In either case the proportion within this sample is high. There is known to be a high proportion of drug users within the LGB group (Buffin et al, 2012) so this may indicate good targeting of the survey at those who use drugs. ONS (2012) also demonstrates that younger age groups are more likely to identify themselves as LGB. Almost half of the sample for the Bristol Drug Survey (47%) was aged 24 or under.
6% of respondents (n=11) considered themselves to be disabled. This is low compared to CSEW (2012-13) where 9.2% of those who recorded a longstanding illness or disability had used any drug within the last year. This may reflect the young age of the sample group, or it may mean that the online survey was not the best way of reaching some people with disabilities. It should be noted however that problematic use of some substances, especially heroin and crack cocaine, is sometimes the underlying reason for long term limiting illness so the CSEW (2012-13) report may have been weighted by this feature.
6. Religion

Fig 7.

A large majority of the sample (72%, n=132) identified themselves as having no religion.

The second largest group were Christian, making up 13% of the sample (n=24). The third largest group were those who preferred not to say (5%, n=10).

7. Area of residence

217 (83%) of respondents recorded a Bristol City postcode. The findings were therefore highly relevant to the Bristol population.

Those from outside of Bristol were from a wide range of geographical locations and were not unified enough as a group to be able to make any comparison between Bristol and non-Bristol data.
Drug using behaviour

1. Substances used

Fig 8.

The substance used by most people in the past 12 months was cannabis, recorded by 61% of respondents (n=136), compared to 53% from last Bristol survey. This is unlikely to signal a rise in cannabis use, as this change has not been recorded elsewhere (CSEW, 2012-13). It is more likely to reflect the fact that alcohol has been removed from the survey, which reduced the size of the sample. In the last survey 34% (n=252) of clients used alcohol only. In the 2014 survey therefore, those who use cannabis, which is by far the most frequently used illegal substance, made up a higher proportion of a much smaller sample.

Fig 8 also shows that other NPS that had been specifically added in to the survey this year were recorded with low levels of use. DMT was recorded by only 6 respondents, n-bomb by only 2 people, and PMA also by 2 people. Of these three substances, only DMT was recorded in the previous survey and then it was recorded by 9 people.
Cocaine use continues to be relatively high among respondents, with 39% (n=85) saying they have used it in the last 12 months, compared to 37% in the last survey.

MDMA/ecstasy use was recorded by 49% in 2014 (n=106) compared to 45% from the previous survey.

National figures have consistently shown cocaine use to be slightly higher than use of MDMA. In Bristol, however, it appears that MDMA use is higher as recorded in both 2012 and 2014.

Use of some new psychoactive substances (NPS) was relatively low. These substances are sometimes called legal highs, although they are not always legal. Mephedrone, which had the highest level of use among this group of substances, was recorded by 12% of the sample (n=24). This was lower than the level in the last Bristol drug survey, which was 16%. This fall in use reflects national data (CSEW, 2012-13).

Ketamine use is high, recorded by 23% of respondents (n=49). This is almost level with the result of the 2012 sample which was 24%.

Nitrous oxide was recorded by 39% (n=81), exactly level with the previous finding.

Amphetamine use was recorded by 25% (n=60) compared to 23% from the previous survey.

Benzodiazepines were recorded by a much smaller proportion than last time with 11% (n=25) reporting use in this survey, compared to 18% from last time.

Among other substances there was very little change in use. Most substances show a very slight increase in proportional use, which again may reflect a smaller sample following the removal of alcohol.
Very few respondents recorded using substances that were not named on the survey questions. The additional substance identified by most respondents within the last 12 months was salvia, but only four people recorded this. All other additional substances were named by single respondents only, with the exception of legal highs, which were recorded by two people. Some of these substances were specifically named, e.g. zopiclone, others were described by group names or general purpose, e.g. laxatives and sedatives. With some others it was difficult to know whether they were new substances or misspelled names of known substances e.g. subotex. Where possible these substances were added in to pre-existing categories e.g. some were easily included as benzodiazepines.
2. New Use and Longer Term use of Substances

For the purposes of this report, new use is defined as first use of any substance during the past 12 months and longer term use is any use before the past 12 months. This was measured in order to identify any changing patterns.

The substances showing the highest percentage increase in new users, were cocaine (19% of a total of 85 users, n=16) amphetamine (23% of a total of 59 users, n=14), ketamine (28% out of a total of 49 users, n=14), benzodiazepines (27% of a total of 26 users, n=7) and the 2C drugs (33% of a total of 20 users, n=7).

Other substances showing a high proportion of new users (steroids, PMA and DMT) all had a very small number of users overall, so the level of new use was not thought to be significant.

There was no evidence of any new use of heroin, methadone, GHB/GBL, solvents, n-bomb or methamphetamine with very low levels of use (n<5) for each of these substances.

Fig 12 compares longer term use of individual substances recorded in 2014 with longer term use recorded in 2012, showing that many substances have decreasing percentages of long term users in 2014. Some decreases are significant. For example longer term ketamine use has decreased by 13% from 85% in 2012 to 72% in 2014. This may suggest that longer term use of many substances is falling. However the numbers of users within some categories are relatively small so care should be taken when drawing conclusions based on percentages.

It is important, however, to track these substances in terms of increase and decrease in future surveys.
The proportion of long term cannabis users in 2014 was particularly high (97% of a total of 136 users, n=132). This compares to 93% in the previous survey, suggesting that longer term cannabis use is a strong factor among a high proportion of respondents.

Fig 12.
3. Reasons why respondents use specific substances

Fig 13.

A large majority of responses showed that people use most substances for reasons of enjoyment. Over 400 responses were received to show that the main reason for using substances was to feel good. Most substances had their highest number of responses within this category. The most popular substances that people took to feel good were MDMA, with 83% of MDMA users (n=87) and cocaine, with 66% of cocaine users (n=56) saying that they took it for this reason. In addition, high percentages of amphetamine users (n=41, 69% of users), magic mushroom users (n=22, 71% of users) and nitrous oxide users (n=56, 70%) cited this as a reason for using these substances.

Cannabis was an exception to this and received its second highest number of responses in this category (n=65, 48%). The main reason that people cited for using cannabis was to relax (n=89, 65% of cannabis users). This was by far the most popular answer in this category, with only benzodiazepines also getting their highest scores here (n=13, 50% of benzodiazepine users).

The second highest reason for substance use was to socialise with friends, with 360 responses in this category. The highest were nitrous oxide (n=38, 48% of nitrous oxide users), ketamine (n=25, 51% of ketamine users) MDMA (n=70, 75% of MDMA users), cocaine (n=54. 64% of cocaine users) and cannabis (n=80, 59% of cannabis users).

The third most popular reason for using substances was to escape reality. However, on reflection this was probably not a very helpful category as there was no measure of people’s experience of ‘reality’ at the beginning and whether this meant that they used specific substances to cope with a very difficult real life situation or to induce pleasure-seeking hallucinogenic experiences.
Answers within the ‘other’ category covered a range of reasons, many of which could have been re-categorised as ‘To feel good’ and ‘To socialise with friends’. Others focussed on the physical effects of some substances such as:

‘To help me sleep after taking MDMA’

‘To keep me awake’

‘To party’

‘dancing’

‘To enjoy the music more and to keep me awake longer’

‘huge amounts of energy for all night partying’

Some respondents emphasised the pleasure of polydrug use:

‘Enhance my intoxicated state’

‘to enhance the effects of other drugs esp. ketamine’

The least common reason for taking any substances was to help deal with problems, with all substances having low levels of response in this category. The highest response in this category was for cannabis (n=21). However, this represents 15% of cannabis users, suggesting that for those who are looking for a substance to support them to deal with problems, cannabis is the most popular choice.

In addition, when qualitative data was extracted, showing other reasons why people used cannabis, there were some comments which suggested that there is an unmet need for support within this group:

‘Increase appetite otherwise would not eat’

‘To reduce alcohol consumption’

‘SO I DONT BATTER PEOPLE’
4. Where Respondents Use Substances

Fig 15 shows the drugs which were used by more than 20 respondents and where they are most frequently used. Other drugs were used by too few people to ensure reliability.

The most likely places for respondents to use substances are festivals and house parties followed by nightclubs and the least likely places are pubs and bars.

Cannabis is the drug used most commonly used across most settings, the exceptions being nightclubs and pubs and bars. This is presumably because of the smoking ban and because it would be very easily detected due to its strong smell. In spite of this, 19 respondents recorded using it in some of these settings. This may be in specified smoking areas such as gardens. Cannabis is most frequently used in domestic settings, at home or in friends’ houses. This suggests that it is becoming a normalised part of domestic life for some. Other settings named by cannabis users were all outside environments such as parks and in the street. There is therefore a heightened risk of arrest or caution for this group.

Nitrous oxide is also frequently recorded as being used across all settings, again the exception being pubs and bars. Nitrous oxide is most frequently used at festivals, but also has high levels of use in both domestic and other celebratory settings.

Amphetamine, cocaine, ketamine and MDMA are clearly identified as party drugs with all of these substances showing greater numbers in nightclubs, festivals and house parties. They are also recorded as being used by many respondents at friends’ homes, adding to their image as ‘sociable drugs’.

Benzodiazepines are most frequently used at home and this is the only environment in which they are used by a noticeable number of people (n=21). Use in all other settings is very small.
2C drugs are most frequently used at festivals and this is the only environment in which they are used by a notable number of people (n=15). Use in all other environments is very small.

Use of magic mushrooms is also very small, with the highest recorded use also being at festivals (n=16).

Table 1 uses this data to identify settings which have higher levels of drug use, making it possible to plan targeted education and prevention work. Settings which were recorded by between 1-10 respondents against a particular substance were categorised as having low levels of use in that substance. Settings that were recorded by between 11-20 respondents were categorised as having medium levels of use and those that had 21 or more were categorised as having high levels of use. Low level use of each substance was then given a score of 1, medium carried a score of 2 and high level use carried a score of 3. Scores were then calculated for each setting, with those achieving the highest score having the highest level of drug related risk. This gives a map of settings in which Public Health work should be targeted.

### Table 1. Substance use in specific settings

<table>
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<th>Substance</th>
<th>Clubs</th>
<th>Pubs/ bars</th>
<th>Festival</th>
<th>Home</th>
<th>Friends’ Houses</th>
<th>House parties</th>
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**L=Low** = 1-10 respondents  
**M=Medium** =11-20 respondents  
**H=High** =21+ respondents

This gives a clear picture of respondents using substances in a party or celebration environment. The most high risk environment is festivals, with a total score of 25 and a total of 6 substances carrying a high score. House parties, clubs and friends’ houses also score highly on this scale.
5. Frequency of Substance Use

Fig 15.

Fig 15 shows that the majority of respondents tend to use most substances infrequently. The highest number of responses was for having used individual substances ‘within the past 6 months, but not every month’ (n=300). Total responses in this category were significantly higher than for all other categories. Almost all substances had their biggest response within this category, including MDMA (n=51, 48% of users), nitrous oxide (n=41, 51% of users), ketamine (n=31, 63% of users), benzodiazepines (n=16, 61% of users), 2C drugs (n=12, 60% of users) and amphetamines (n=29, 49% of users). The next most frequent overall use of a specific substance was ‘within the last 12 months but not in the last 6 months’ (n=153), followed by ‘at least once a month, but not every week’ (n=136). Only 48 respondents said they had used a substance at least once a week and 37 said they used a substance daily. However within these relatively small groups of weekly and daily users there are two large groups of cannabis users with 18% of cannabis users (n=24) saying that they use this substance weekly and 21% (n=29) saying they use it daily. Those who use cannabis therefore make up 50% of weekly drug users and 78% of daily users. Inspite of this, the data showed that no one recording daily use of cannabis was in contact with drug support services. The most common reason given for this was that these respondents were not concerned about their drug use. One person said that they only used drugs in moderation, inspite of recording daily use.

Very small numbers of respondents recorded daily use of substances other than cannabis. There were two individuals who recorded using both crack cocaine and heroin on a daily basis. Both were in contact with services.
Two people recorded using benzodiazepines on a daily basis. Both are aware of services, but only one was in contact. One person recorded daily use of mephedrone and was also in contact with support services.

*Fig 16.*

27% of the sample (n=72) said they use substances between Monday and Thursday. Most (72%, n=188) use only on Friday and Saturday. Again this shows most respondents having some control over when they use drugs and their use being associated with social, weekend events.
Almost all substances are usually obtained from friends and family, with 445 responses saying that people obtain a range of drugs in this way. Total numbers are higher than the number of respondents because of poly drug use and because some people will obtain substances from more than one source. It is important that there is adequate advice and information for people who may be unaware of the risk of arrest for supplying classified substances.

The second highest means of obtaining drugs is from a dealer. 335 responses said that this was how people obtained their drugs. There are only four substances that score slightly higher in this category. These are amphetamines (dealer n=38, friends n= 34), MDMA (dealer n=76, friends n=69) heroin (dealer n=4, friends n=0) and crack cocaine (dealer n=3, friends n=0).

Very few respondents obtain substances via the internet (n=43). Numbers within this category are very small for almost all substances (n=<5). The only exception to this is Nitrous Oxide (n=23), which can easily be ordered in bulk online and because it is legal to use for catering purposes, the level of availability is high.

Other methods of obtaining drugs are slightly higher than the internet. This category also had small numbers for all drugs, except nitrous oxide (n=17), which can be bought over the counter in specialist shops (sometimes called head shops). There are also a small number of responses for benzodiazepines (n=4), which are available on prescription but can then be
misused, and for cannabis and magic mushrooms, which can be cultivated at home. Crack cocaine is also included in this category by one respondent. This substance is relatively easy to make from powder cocaine and some other household products.
Polydrug use was shown to be very common among the sample in the 2012 survey with alcohol being identified as the most likely substance to be used with other drugs. In 2014, respondents were asked whether they used alcohol at the same time as other individual substances. Combinations of alcohol and other drugs can be very dangerous. A significant proportion of deaths and medical emergencies from drug poisoning are caused by alcohol taken in combination with other drugs. The risks associated with cocaine, benzodiazepines, ketamine, many 2C drugs and unknown substances are increased substantially when used with alcohol.

Fig 18 shows that a significantly high proportion of responses (58%, n=365) are from those who say that they always or usually use alcohol other substances. Nitrous oxide, cocaine, MDMA and amphetamines all have significantly higher number of respondents in this category.

The substance which has the highest number of respondents reporting that they always or usually use it with alcohol is MDMA, with 74 respondents classifying their use within this category. This is almost 3 times as many as those who use it sometimes or not often (n=26) and 18 times as many as those who never use alcohol when they use MDMA (n=4).

Cocaine, which is one of the most dangerous substances to combine with alcohol, is recorded in this category by 70 respondents, almost 7 times as many as those who say they use it sometimes or not often (n=11) and 35 times as many as those who say they never combine these substances (n=2). Combinations of cocaine and alcohol can cause serious heart problems.
34% (n=212) of responses say that alcohol is used with other substances sometimes or not often. There are four substances for which the most frequent response to whether they use it with alcohol is sometimes or not often. These are cannabis, for which this pattern of use is significantly higher in this category, ketamine, for which it is slightly higher, DMT, for which the sample is too small to be reliable and unknown substances, which are discussed in section 8 below.

8% (n=49) of responses are from people who say that they never use these substances with alcohol. The only substance for which the majority of people said that they never use it in combination with alcohol is benzodiazepines, but the difference was only one person.
8. Use of Unknown and Unidentified Substances

Use of unknown substances is particularly risky because the contents and combination of substances within the product can have unexpected effects. Quantities of active ingredients can be dangerous and many substances will not have been tested to assess the effects of human consumption.

*Fig 19.*

![Bar chart showing number of respondents who have taken an unknown substance in the last 12 months.]

18% (n=36) of people said that they had taken unknown substances in the past 12 months. The data shown in Fig 21 represents more than 36 answers, showing that some respondents have taken unknown substances on more than one occasion and in more than one form.
Fig 21 shows that half of the group who had taken unknown substances during the last 12 months (n=18) said that they had done so between 2 and 5 occasions. The second largest group (n=14) said that they had done so only once. More frequent use of unknown substances was only identified by 4 people, with 3 respondents saying they had taken these substances between 6-10 occasions during the past 12 months and only one person saying that they had taken them on more than 10 occasions.

The majority of unknown substances are bought either from friends and family, or from someone identified as a dealer. The number of responses to this section (n=44) was higher than the number who identified using unknown substances (n=36), showing that people
obtain unknown substances from more than one source. One person said that they had obtained an unknown substance from the internet, which is puzzling and may be an incorrect answer as they must have identified the substance in order to make the purchase. It is possible, however that they received the wrong order but used the substance anyway.

Fig 22.

The risks involved in using unknown substances in combination with alcohol are high, because of the unknown nature of the drug. If the nature of the drug is unknown the consequences of mixing it with alcohol can be dangerous and unpredictable. Only 3 of the 36 respondents who had used an unknown substance in the last 12 months said that they never used alcohol at the same time and only 3 said they used alcohol and unknown

Fig 23.
substances together but not very often. Almost half of this group (n=17) said that they always or usually used alcohol and unknown substances at the same time.
9. Respondents’ Concerns about their Drug Use

Concerns about drug use were measured as an average percentage across all substances. 39% of respondents said that they had no concerns about their drug use.

A high proportion of respondents recorded concerns against a range of problems associated with drug use. The highest level of concern was about mental health, with 39% of respondents identifying this. Worries about physical health were also high with 33% of respondents highlighting this as a concern. 16% were anxious about finances, 15% were concerned about getting a criminal record and 15% were concerned about the impact that drug use had on work and studies. The lowest level of worries was about the impact of drugs on relationships. However at 12%, this is still a relatively high proportion of respondents who have identified this as a concern.

Fig 24.
10. Contact with Drug services

Fig 25.

Slightly more than half of respondents said that they had considered reducing or stopping their drug use (51%). This suggests that the need for support from drug services among this group would be high. However, only 4% of respondents (n=7) had had contact with drug support services in Bristol over the previous 12 months.

Fig 26.
93% of those that had not have contact with drug support services reported that this was because they had no concerns about their drug use (n=134). This is interesting when seen alongside the high levels of welfare and health concerns shown in Fig 24 and the fact that 51% were interested in stopping and reducing their drug use. This suggests that the perception of what drug services can offer may be inaccurate among this group.

One of the recommendations from the previous report was that 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. This data suggests that this recommendation has not been successful.

A small number of people (4%, n=6) felt that support was not available for the drugs they use. The percentage of respondents who believe that there is no support for the drugs that they use has risen slightly since 2012 but the actual number of respondents is almost the same as is 2012 (n=8).

10% of respondents said that they were unsure of what services could offer. This could be a factor in the low levels of contact with support services. It would be beneficial to promote services by highlighting health and welfare factors identified in fig 24, as these seem to be the issues that drug users need support with, rather than on a substance specific basis.

A very small proportion of respondents (4%, n=7) had had contact with drug support services. The figure from the previous survey was almost the same at 3%.
Respondents using heroin and crack cocaine were all aware that support services existed for people who use these substances. There was also a relatively high level of knowledge of support services for benzodiazepine users (68%). These are traditional substances for which drug agencies have always offered support. Among those who used all other substances, approximately 50% of respondents knew that they could engage with support services for these specific substances, with poppers, 2C drugs and DMT having very low levels of knowledge, although it should be acknowledged that they also have low levels of use, so these percentages may be misleading.
Summary of trends in drug use in Bristol 2012-2014

1. In 2012 frequent alcohol use was recorded for all groups. This was not specifically measured in 2014, but high levels of polydrug use involving alcohol were recorded.

2. In 2012 cannabis, ecstasy/MDMA, nitrous oxide and cocaine were frequently recorded. This was repeated in 2014.

3. In 2012 there were extremely low levels of heroin and crack use recorded. In 2014 there was no evidence of new use of heroin or crack cocaine. Of the few people who did record these substances, all were already receiving support.

4. In 2012 there was evidence of substances which have not traditionally been included in the work that is provided by drug support agencies, including nitrous oxide, ketamine and benzodiazepines. This was broadly the same in 2014, although benzodiazepine use seems to have reduced.

5. In 2012 the substance used on a daily basis by the highest number of participants was cannabis. This finding was repeated in 2014.

6. In 2012 60% of the sample was made up of polydrug users. This was measured in a different way in 2014, with 58% (n=365) of responses saying that these participants always or usually used alcohol alongside other specific substances and 34% (n=212) of responses saying that these participants sometimes used alcohol alongside other specific substances.

7. In 2012 a high percentage of participants recorded concerns about their substance use. Most of these concerns related to physical and mental health. This was repeated in 2014.

8. There were low levels of awareness about Bristol substance misuse services, particularly among those who did not use opiates and crack. In 2014 this was repeated.

9. Respondents recorded low levels of contact with substance misuse services in both 2012 and 2014.

10. In 2012 the groups showing the highest levels of substance use were young adults aged 18-24, gay men and those identifying as bisexual. In 2014 these groups were actively targeted to ensure reliability within the data.
Additional findings from the 2014 Survey

Proportionately, MDMA, cocaine, amphetamines and ketamine have lower levels of long term users in 2014 than in 2012.

Proportionately, long term use of cannabis has risen between 2012 and 2014.

There is no evidence of significant use of new substances such as DMT and n-bomb.

The majority of the sample use drugs infrequently and for reasons of enjoyment. However there are high levels of frequent use of cannabis.

The most high risk settings in terms of levels of use are festivals followed by house parties and night clubs

Most people get their drugs from friends and family. This is by far the highest response within this category. This puts friends and family at risk of arrest under the Misuse of Drugs Act.

There are very high levels of poly drug use, exemplified by use of alcohol with other substances. There is a considerably high proportion of the sample who say that they always or usually use alcohol with the other substances that they record.
Conclusions

The 2014 Bristol online drug survey shows that there has been very little change in patterns of drug use in Bristol. The size and characteristics of the sample were adequate to draw a range of general but reliable conclusions about the drug using population. Targeting of most drug using groups was successful, although khat users, steroid users and young people were missing from the sample.

As in 2012, the highest levels of drug use continue to be among those using cannabis, MDMA/ecstasy, cocaine, amphetamine, ketamine and nitrous oxide. Patterns of cannabis use among some of the population show more frequent, long term use than for other substances.

As in 2012, there is very little knowledge among the respondents about substance misuse services, suggesting that work needs to be done to raise awareness, not just of ROADS services but about how these agencies can offer and promote needs led support for those using a range of non-opiate substances and crack cocaine.

The report shows popular settings for drug use and highlights the fact that most drug use happens for positive reasons. This should guide training and campaigns delivered by Public Health Bristol.
Recommendations

1. Work to promote substance misuse services among a broader range of drug users will need careful planning. Cannabis use should be a particular consideration. Both the NOCU (non-opiate and crack use) group set up by the Substance Misuse Team and the ADD HIT (Addiction Health Integration Team), led by Public Health Bristol should look closely at how this support can be promoted so that all drug users recognise the services and feel that the provision is relevant to their needs.

2. A different methodology should be planned and employed in order to gather data and obtain a realistic measure of khat use in the city. This should be carried out in partnership with agencies working with the Somali population and other khat using groups.

3. Work should be set up in partnership with sport and leisure services, focusing on targeting people who use steroids and a different methodology should be used to collect data and identify need.

4. Festivals and nightclubs should be a particular focus for prevention, education and harm minimisation work. This should be set up by partnerships involving commissioners, providers and Public Health. This work should be very broad in its focus in order to include people using and supplying a broad range of substances and those involved in poly drug use.
References

Aspinall P (2009) Estimating the size and composition of the lesbian, gay, and bisexual population in Britain (Equality and Human Rights Commission)


Bristol City Council (2013), The Population of Bristol 2013


HM Government (2010), Reducing Demand, Restricting Supply, Building Recovery: supporting people to live a drug free life (Gov.UK)

McNally M and Smyth G (2012), The Bristol Drug and Alcohol Online Survey 2012 (Bristol City Council).