

# Children's health in London now



## In this section...

- Patterns of health and well-being among children and young people across London are outlined
- These patterns are set in the context of the "Be Healthy" outcomes framework of *Every Child Matters*

## Introduction

Keeping children and young people well and narrowing inequalities gaps are important parts of what happens right across a whole range of sectors including education, social care, housing and transport in London. This section provides an overview of some of the factors important in assessing the state of the health of children and young people in London now. In exploring these, we relate health and ill-health data to the 'Be Healthy' indicators set out in *Every Child Matters*. These indicators relate to physical, mental and sexual health, health-related factors and children's lifestyles.

The Mayor's *State of London's Children* report (Hood, 2004) presents a summary of some of the most comprehensive data on children in London. The report indicates that:

- The pattern of childhood mortality (deaths of children aged 1-19) is similar in London to that nationally, though fewer die from road traffic accidents
- Rates of childhood immunisation are low in London compared with other cities
- The general health state of London's children is similar to children nationally, but healthier when measured by criteria of acute sickness
- Children in inner London are less likely to have good general health reports than children in outer London
- Young Londoners from black, mixed and Asian ethnic groups have marginally poorer general health reports than those from white and Chinese groups
- The prevalence of asthma is increasing, with evidence of childhood respiratory problems linked to living in a polluted area
- A pattern of restriction on children's independent mobility is commonly linked, along with dietary factors, to rises in childhood obesity (rates are particularly high in inner east London)
- Teenage pregnancy rates are higher in London than elsewhere and do not show a reducing trend, as nationally, though there are wide borough variations
- London has relatively large numbers of children affected by HIV within families
- Rates of mental ill-health amongst young people are increasing nationally, with research indicating even higher rates in inner London, particularly for boys aged 11-15.

This report takes a closer look at health-related inequalities among children and young people through the addition of borough-level, ward-level and other data.

## Every Child Matters – be healthy targets and indicators

In this section, we draw on outcomes from *Every Child Matters (ECM)*, alongside indicators currently high on the national agenda (such as obesity) or important in London such as respiratory illness and teenage sexual health.

**Table 2 'Be Healthy' targets and indicators from the ECM Outcomes Framework**

AIMS	Physically healthy	Mentally and emotionally healthy	Sexually healthy	Healthy lifestyles	Choose not to take illegal drugs
TARGETS AND INDICATORS	Infant mortality rate (DH)	Death rate from suicide and undetermined injury (DH)	U18 conception rate (DfES/DH)	% Children who are regular smokers (DH)	Harm caused by illegal drugs (HO)
	% Obese U11 (DfES/DH/DM CS)	Improvement in access to CAMHS (DH)	Diagnostic rate of new episodes of STIs among U16 & 16-19yo (DH)	% Children consuming 5 portions of fruit and veg a day (DH)	has 3 components including reduce use of Class A drugs by under 25s (HO/DfES)

## Physical health

Given that mortality (death) and morbidity (illness) are the key indicators here, we start with these.

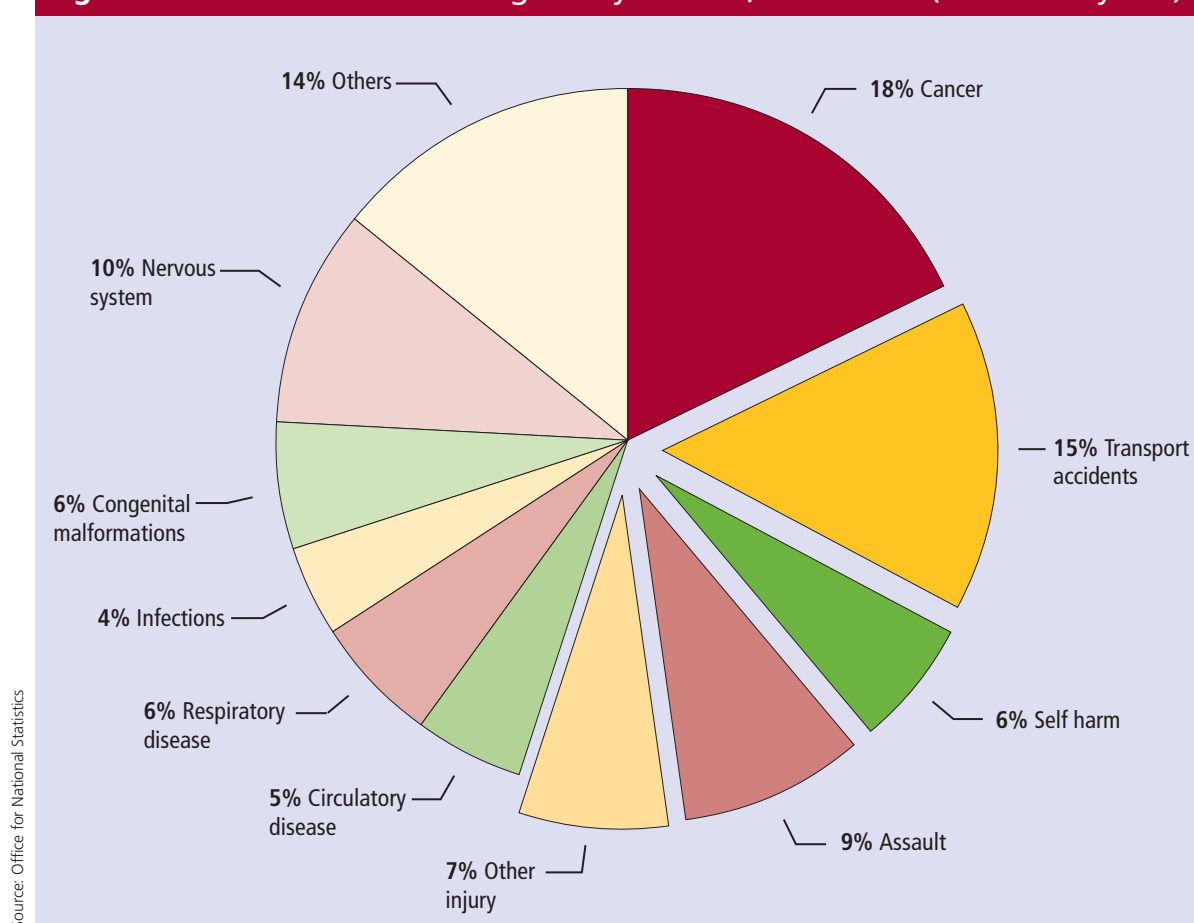
### Mortality (death)

In societies with low death rates in childhood, there is a question about how useful mortality is as a marker for health and well-being. In our view, it remains a key marker, particularly since, as we describe below, many deaths are avoidable.

Death in childhood in London is not a common event, but every child's death is a tragedy. In London between 2001-03 there were 1,047 deaths of children aged 1-19 years. The main cause of death among children who were sick was cancer, equivalent to 18% of deaths. Diseases of the nervous system accounted for 10% of deaths, respiratory diseases 6% and infections 4% (Figure 2).

However, the majority of deaths were not the result of illness, but of injury. Road traffic injuries, self-harm, assault and other injuries resulted in a total of 37% (383) of all deaths in 1-19 year olds. Of these, 156 (15%) were transport accidents. They are not, however, entirely 'accidental' as the patterns of deaths by social class indicate. A poor child or young person is much more likely to be killed in a road traffic accident or a house fire than a 'better off' child. Self-harm resulted in 6% of deaths and assault 9%. Seven per cent of deaths related to other injuries.

At the national level, a child from the poorest background is 16 times more likely to die in a house fire as well as being five times more likely to die as a pedestrian than a child from a 'better off' household (Towner et al, 2005 [http://www.hda.nhs.uk/documents/injuries\\_in\\_children\\_inequalities.pdf](http://www.hda.nhs.uk/documents/injuries_in_children_inequalities.pdf)) This is an area where wealth and health

**Figure 2 Cause of death among 1-19 year olds, 2001-2003 (combined years)**

can be seen in operation in a very stark way.

### **Morbidity (illness) indicators**

Most illness, serious or less serious, is dealt with in the home by parents, usually mothers. Hospital admission usually, though not invariably, denotes more rather than less serious problems. Most children who become ill, including those who become seriously ill, recover.

### **Emergency admissions to hospital**

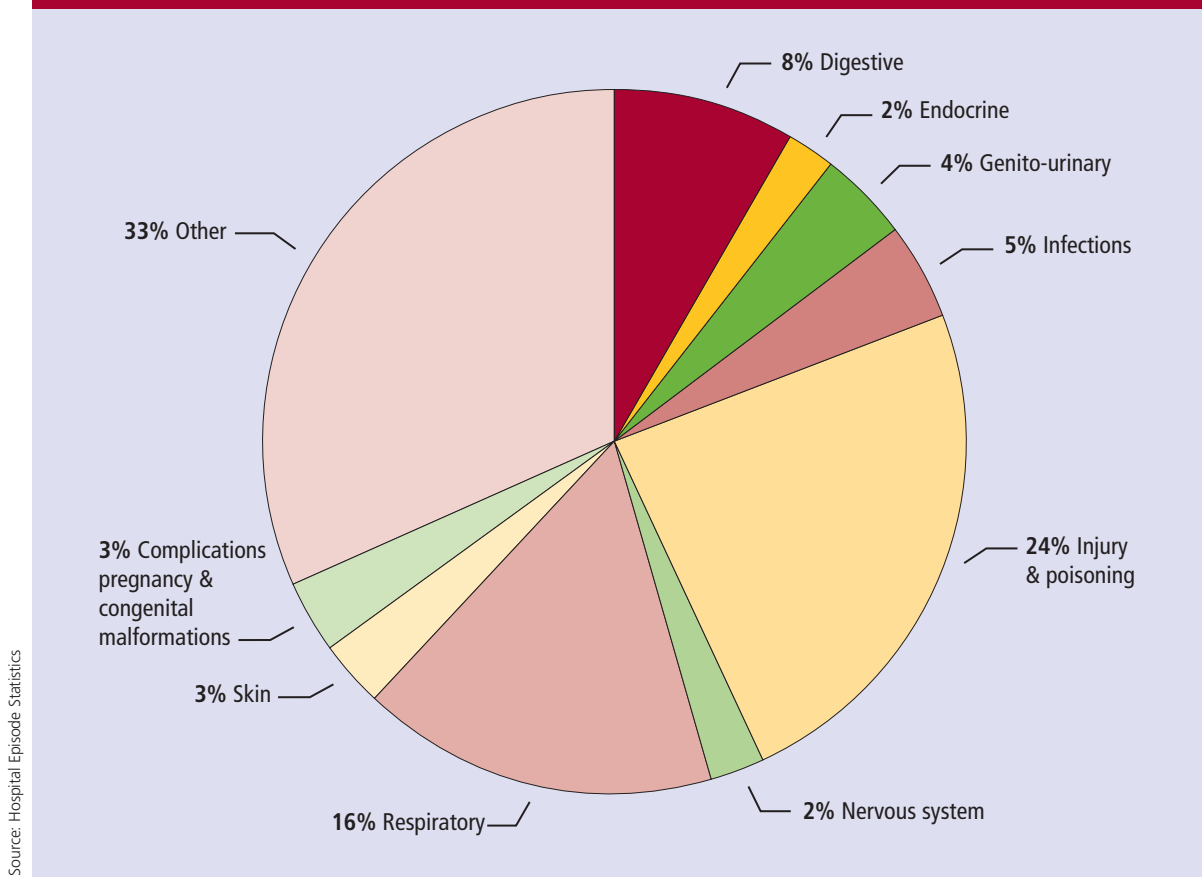
The rate of emergency hospital admissions is highest among children under one year of age. Illness in babies can be sudden and severe (and recovery often fast). Emergency admission rates for under one year olds are highest in Hackney, Islington and Tower Hamlets, and lowest in Havering, Hillingdon and Kensington

and Chelsea. Emergency admission rates for 1-19 year olds are highest in Hackney and lowest in Kensington and Chelsea. Emergency admission to hospital can depend on a number of factors in addition to the severity of illness. These can include proximity of hospital, levels of anxiety of medical staff or parents and in some cases, home circumstances.

The kinds of problems which cause 1-19 year olds to be admitted to hospital as an emergency are shown in Figure 3. Of those where we know the cause, injury and respiratory problems are the most common causes of admission.

In a report with a special focus on inequalities in children, it is particularly important to see whether deprivation plays a part in hospital admission. Are children in deprived boroughs more or less likely to be admitted to hospital? Map 1 suggests that in the inner

**Figure 3 Hospital emergency admission by cause among 1-19 year olds, 2003/04**



London boroughs of Hackney, Islington and Tower Hamlets, 1-4 year olds are more likely to be admitted to hospital in an emergency than children in other boroughs. In outer London, 1-4 year olds from Havering and Richmond are least at risk of hospital admission.

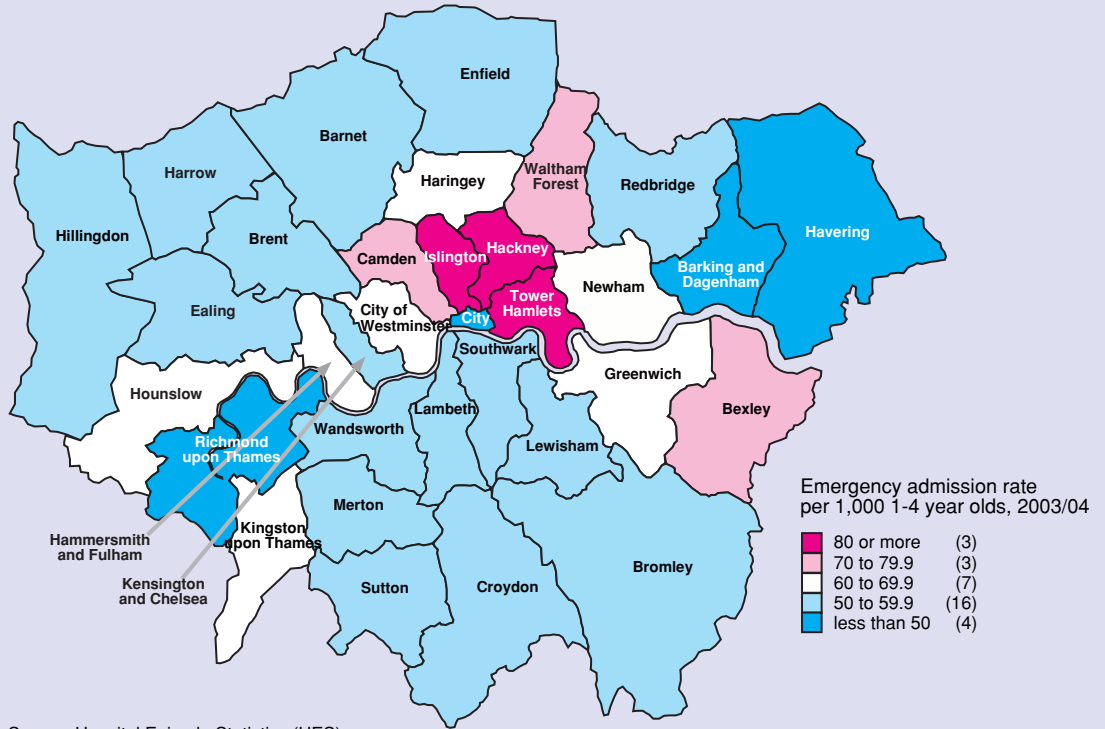
To understand these patterns better, we would need to know more about the number of children at risk of admission (i.e. how many children become ill with similar complaints), and how many of them come to the hospital's attention.

Respiratory illness is a particular cause for concern in London, and many emergency hospital admissions are related to asthma. Map 2 shows hospital admission rates for respiratory disease by borough and indicates that there are variations across boroughs. Whether this is related to differences in prevalence of

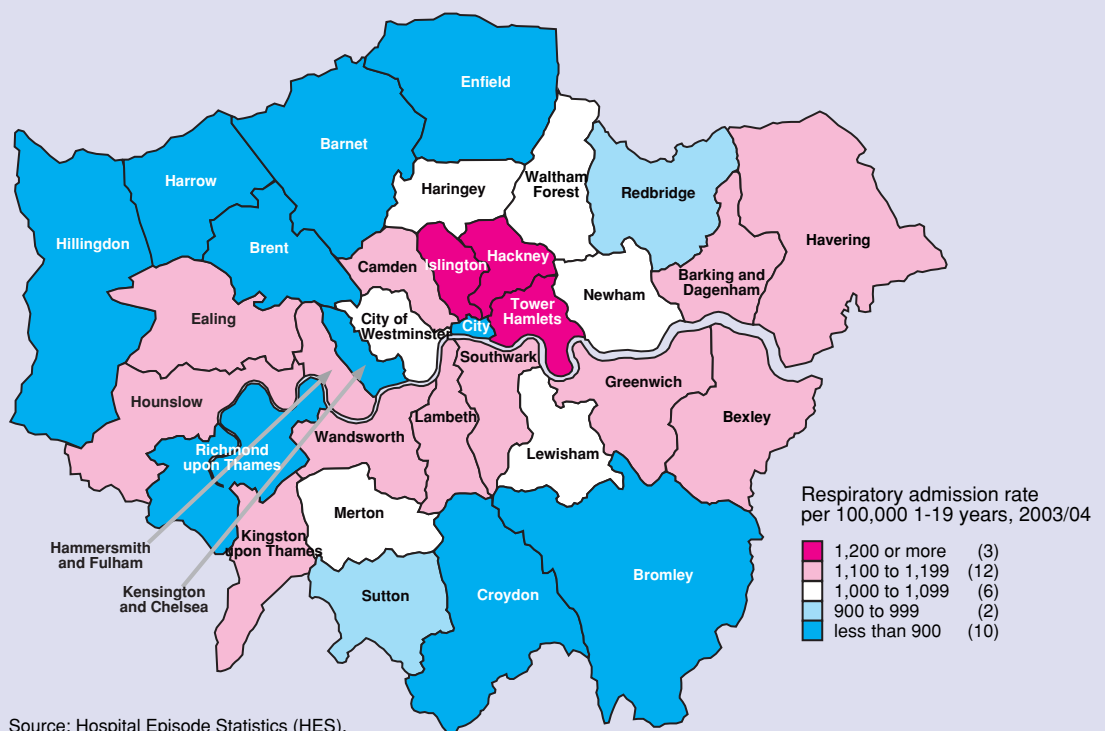
respiratory problems or difference in the management of those problems by professionals, parents and young people is difficult to determine.

There may be many contributory factors related to the development of respiratory illness such as asthma which are a result of changing lifestyles. We are more likely to have centrally heated homes with fitted carpets and little ventilation – ideal conditions for the house-dust mite, a very common asthma trigger that lives in soft furnishings. Our diets now include fewer fresh foods although evidence suggests that eating plenty of fruit and vegetables can help to reduce asthma symptoms. Other theories include less exposure of young children to infections than previously, which might explain why younger siblings and children who attend day nurseries seem to have a lower risk of developing asthma.

**Map 1 Hospital Emergency Admission Rates for 1-4 year olds, 2003-04**



**Map 2 Hospital Admission Rates for respiratory disease per 100,000 for 1-19 year olds, 2003-04**



Asthma develops more commonly in children whose parents smoke (Royal College of Physicians, *Smoking and the Young*, London 1992). Although both tobacco smoke pollution and other air pollution can cause or exacerbate symptoms in people who already have asthma, there is no evidence that air pollution other than tobacco smoke actually causes asthma (LHO overview, see [http://www.lho.org.uk/HIL/Disease\\_Groups/RespiratoryDisease.aspx](http://www.lho.org.uk/HIL/Disease_Groups/RespiratoryDisease.aspx)).

Seasonal variations in admissions appear to be largely due to respiratory problems (Damiani and Dixon, 2001) with six clinical conditions implicated:

- chronic obstructive airway disease (COAD)
- pneumonia
- other acute respiratory tract inflammations
- asthma
- bronchiolitis
- upper respiratory tract infections.

While young children occupy a high number of bed days, the average length of stay is generally very low – 2-3 days. For more information see LHO website at [http://www.lho.org.uk/HIL/Disease\\_Groups/RespiratoryDisease.aspx](http://www.lho.org.uk/HIL/Disease_Groups/RespiratoryDisease.aspx)

## Obesity

A particular public health concern at present nationally and internationally is obesity. Being overweight in childhood presages poor health outcomes in the longer term. Being overweight and obese are more common in more deprived areas and there has been a steady upward trend in the prevalence of obesity. Unfortunately, there are currently no overall data on obesity at a borough level in London, although there are important studies which collect data in some boroughs, such as the RELACHS study described overleaf.

A London boost to the *Health Survey for England* is to be commissioned in order to obtain these data, as there is an urgent requirement for more data on obesity at borough level. While there is a commitment in the government White Paper on public health, *Choosing Health* to measuring obesity, there are concerns that focusing on individuals rather than on a whole school/community approach to tackling the problem may be unhelpful.

### *A note on definitions*

Measuring obesity among children uses different methodology from measuring obesity among adults. Different growth patterns among boys and girls at each age mean that a universal categorisation cannot be used. Each sex and age group therefore needs its own level of classification for obesity (Jotangia et al, 2005). There is currently a lack of consensus on the classification of the UK National Body Mass Index (BMI) in children. The UK National BMI percentile classification has been the most commonly used measure in the past for reporting on obesity, for example, the *Chief Medical Officer's 2002 Annual Report* and most recently in the 2005 data from Jotangia et al. This uses the 85th and 95th percentiles of the 1990 UK (UK 90) data cut-off points for overweight and obesity respectively.

An alternative method is the International Obesity Task Force (IOTF) international classification using data collected from six countries using 190,000 subjects in total aged from 0-25 (UK, Brazil, Hong Kong, The Netherlands, Singapore and the United States). This has the advantage of enabling international comparisons and the IOTF cut-off points for overweight and obesity.

*Percentage of obesity (in under-11 year olds)*

The most recent national data (Jotangia et al, 2005) indicate that compared with the overall level of childhood obesity, only London and the North East Region had significantly different rates of obesity to the average (Table 3). The report presents key information for 1995 to 2003 on obesity among children aged under 11 living in England. Results and analysis are based on data from the *Health Survey for England* (HSE).

The report uses the data for 2001 and 2002 combined when analysing the relationships between social demographic factors and obesity. It uses the UK National Body Mass Index (BMI) percentile classification to describe childhood overweight and obesity among children aged 2-10. Prevalence of obesity in London (18%) was three percentage points higher than the national average (15%) using UK 90 definitions (Jotangia et al, 2005).

The authors also report that between 1995 and 2003, the prevalence of obesity

among children aged 2-10 rose from 10% to 14% and the percentage of children aged 2-10 who were overweight (including those who were obese) rose from 23% in 1995 to 28% in 2003, also using the UK 90 definitions.

### **Ethnicity and childhood obesity**

Few studies have examined ethnicity and overweight in UK children or adolescents. In 1999, the HSE found that 23% of English children and young adults aged 2-20 years were overweight or obese (24% of females, 22% of males), and 6% obese using IOTF cut-offs. African-Caribbean and Pakistani girls were more likely to be overweight (Saxena et al, 2004).

In London, data showing a relationship between ethnicity and weight in adolescents can be found in the RELACHS study (*Research in East London Adolescents Community Health Survey*) study, which is a longitudinal school based survey of adolescents. Cross-sectional (2001) data from this study indicated that a quarter of the respondents then aged 11-14 years in three deprived London boroughs (Hackney, Tower

**Table 3 Obesity prevalence among children, by Government Office Region**

Aged 2-10 with valid BMI	2001-2002								
BMI status	Government Office Region								
	North East	North West	Yorkshire & Humber	East Midlands	West Midlands	East England	London	South East	South West
Obese	18.3	15.0	11.4	14.5	15.8	14.1	18.2	13.4	14.0
Bases (weighted)									
Aged 2-10	394	950	750	615	748	791	830	1077	683
Bases (unweighted)									
Aged 2-10	355	806	634	540	636	693	701	922	588

Hamlets and Newham) were overweight, and 7-10% obese using IOTF cut-offs. Two per cent were extremely obese.

Obesity and overweight were common across ethnic groups, although there were some ethnic group differences, with Indian boys at increased risk compared to white British males. Although there were significant differences in BMI between ethnic groups, high levels of overweight were seen in all ethnic groups. No associations between BMI and measures of socio-economic status were found (Taylor et al, 2005), but this may be explained by the high level of deprivation in the whole area surveyed, with every ward in the bottom quintile of the DETR deprivation index (Fitzpatrick and Jacobson, 2001).

### **Percentage of children consuming five portions of fruit and vegetables a day**

In 2002, children and young people in London had the highest fruit and vegetable consumption of any English region (mean 3.1 daily portions aged 5-15 and 16-24 years), but this still falls short of the recommended five daily portions.

The proportion of young people eating five or more daily portions of fruit and vegetables was 19% of boys and 17% of girls aged 5-15, and 19% of males and 22% of females aged 16-24 years (Sproston & Primatesta, 2003 – Health Survey for England, 2002).

## **Mental and emotional health**

A major national survey of the mental health of 5-15 year olds in the UK found that rates of mental disorder were higher in inner London than in other areas of

the UK, and particularly high for boys aged 11-15 years. Addressing emotional well-being for London children is clearly an important issue. While the medicalisation of distress can be unhelpful, we report here some of what is happening at the most serious end of the spectrum, before looking at the generalised lack of well-being that can be so corrosive for young people, and damage childhoods.

Mental health is more profoundly affected by socio-economic factors than many other dimensions of health (Carr-Hill et al, 1994).

### **Suicide**

Over the last century, there has been a large increase nationally in the proportion of deaths among young people attributable to injury and suicide. This toll of suicides, particularly among young men, together with the increase in mental health problems in children and young people, demonstrates the urgent need to focus on improving social and emotional health.

There were 13 suicides during 2001-2003 in people aged under 15 years in London. Given the small numbers, further analysis of these deaths has not been undertaken. Suicide in young people is generally associated with older children and adolescents. Moving to the 15-19 year age group, there were 59 deaths from suicide and undetermined injury (41 males, 18 females) during 2001-03. This comprises 3% of the total in London. This rises to 142 (7.4% of the London total) in people aged 20-24 years.

### **Self-harm**

Young people may deliberately harm themselves in a variety of ways including substance abuse, the use of alcohol, overdosing and cutting or burning themselves with cigarettes.

**Table 4 Deaths from suicide and injury of undetermined intent in London residents aged 15-24 years**

	Male	Female	Total	% Total suicide deaths in London	% Total suicide deaths in England
Under 15	–	–	13	–	–
15-19	41	18	59	3.1	3.2
20-24	109	33	142	7.4	6.6
All ages	1,379	537	1,916	100	100

Source: ONS mortality data analysed by LHO

As Figure 4 shows, there are quite large disparities between boroughs on hospital admissions rates for self-harm with Waltham Forest, Lewisham, Islington and Hillingdon showing particularly high rates, and Bexley and Sutton the lowest rates. However, these differences will be partly due to variations in the quality of hospital diagnoses coding between hospitals.

### Mental health

An Office of National Statistics (ONS) report in 2000 collected data on mental health problems among children and young people. They used the term mental disorder to refer to a clinically recognisable set of symptoms and behaviours associated in most cases with considerable distress and substantial interference with personal functions. The survey concentrated on the three common groups of disorder: emotional disorders such as anxiety, depression and obsessions; hyperactivity disorders involving inattention and over-activity; and conduct disorders characterised by awkward, troublesome, aggressive and anti-social behaviours (Meltzer et al, 2000).

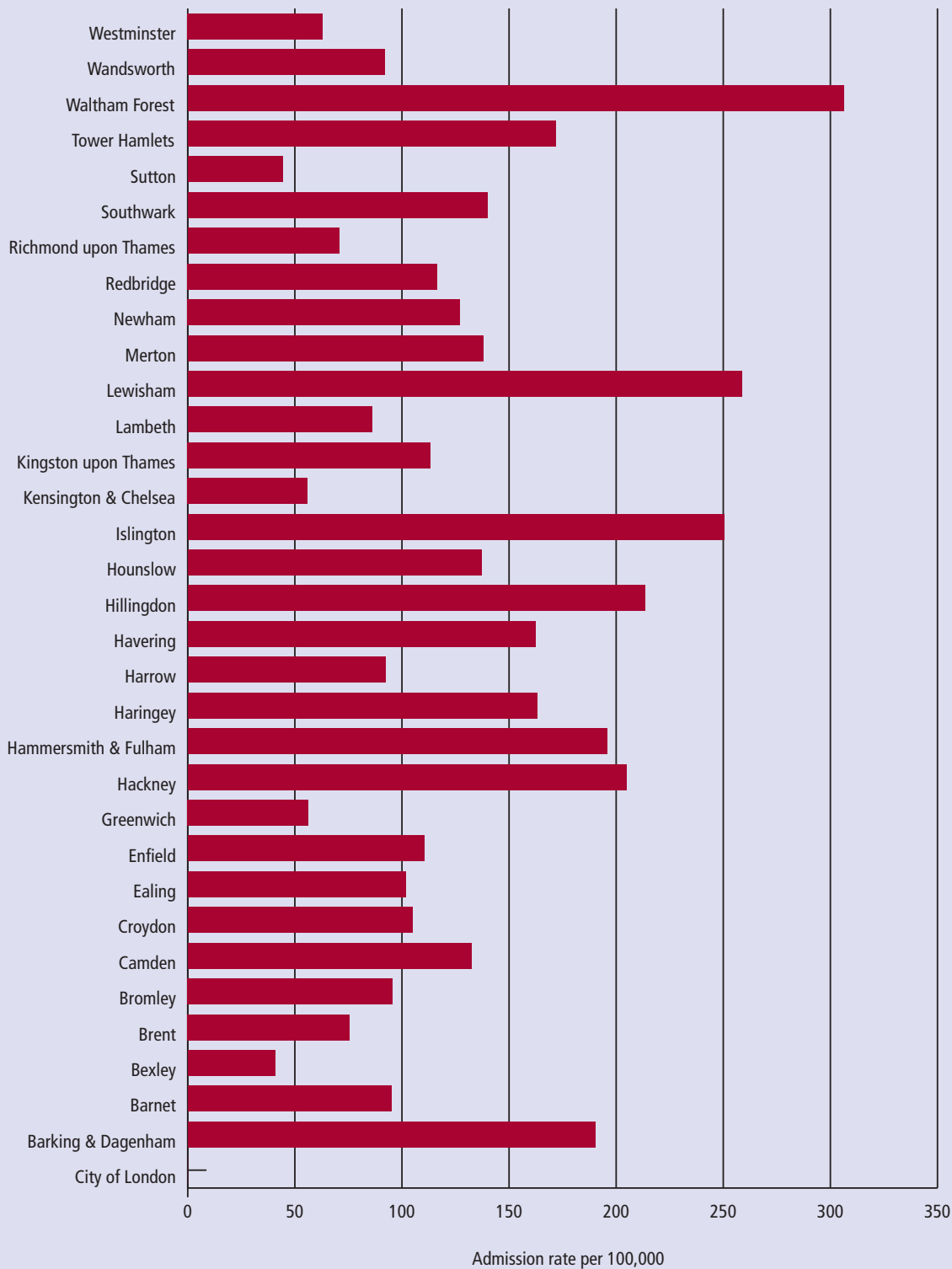
The importance of collecting these kinds of data are that they allow decisions to be made about the provision of mental

health services for children, and give a picture of the burden on children and others of mental health problems. Table 5 shows that while children in London aged 5-10 have much the same level of mental health problems as children in the rest of the country, 11-15 year old boys in inner London in particular have much greater difficulties than boys of the same age elsewhere in England.

Data from the ONS survey on the mental health of 'looked after' children aged 5-17 years found that 45% of those interviewed (1,039) were assessed as having mental health problems and 37% had symptoms that warranted a clinical diagnosis. Those in care were five times more likely to have a mental disorder (42% compared with 8%), with particularly notable differences in conduct disorder.

The RELACHS study, referred to previously, reported rates of psychological distress in east London considerably higher than national rates. High levels of psychological distress measured by the *Strengths and Difficulties Questionnaire* were reported by 16% of boys and girls in year 7. In year 9, high levels of

**Figure 4 Hospital admission rates for self-harm per 100,000 aged 10-19 year olds, by borough 2003/04**



Source: Hospital Episode Statistics

psychological distress were reported by 12% of boys and 18% of girls. Boys had higher rates of psychological distress at 11-12 years than 13-14 years, while for girls the reverse was the case. Girls had more emotional disorders and boys more

conduct disorders in both age groups. Part of the explanation for higher rates in east London may be methodological but this is unlikely to explain these differences entirely (Institute of Community Health Sciences, 2003).

**Table 5 Prevalence of Mental Disorders, by region, sex and age, 2000**

	Inner London %	Outer London %	Other Met England %	Non Met England %	England %
<b>Boys</b>					
5-10 years	9.1	10.2	11.5	10.5	10.8
11-15 years	20.4	13.9	11.2	13.4	13.1
All boys	14.8	11.6	11.4	11.7	11.8
<b>Girls</b>					
5-10 years	6.1	8.2	6	5.5	5.9
11-15 years	8	5.8	11.1	9.3	9.6
All girls	6.9	7.1	9.3	7.2	7.5
<b>All Children</b>					
5-10 years	7.5	9.2	8.7	8	8.3
11-15 years	14.6	9.4	11.2	11.3	11.3
All	10.9	9.3	9.8	9.4	9.6

Source: Adapted from ONS Survey: the mental health of children and Adolescents in Great Britain, 2000, (taken from State of London's Children Report, GLA, 2004)

### Improvement in access to child and adolescent mental health services (CAMHS)

There are no comprehensive London data currently available, although a mapping exercise across London is currently taking place.

This will cover partnership working, strategy, commissioning, multi-agency provision of comprehensive CAMHS, workforce, specialist CAMHS infrastructure, and the appropriateness, accessibility and acceptability of interventions.

### Sexual health

The areas of sexual health that this report covers – under-18 conception rate and sexually transmitted infections – are two which show marked inequalities and can affect the health of children and young people both now and in the future.

### Under-18 conception rate

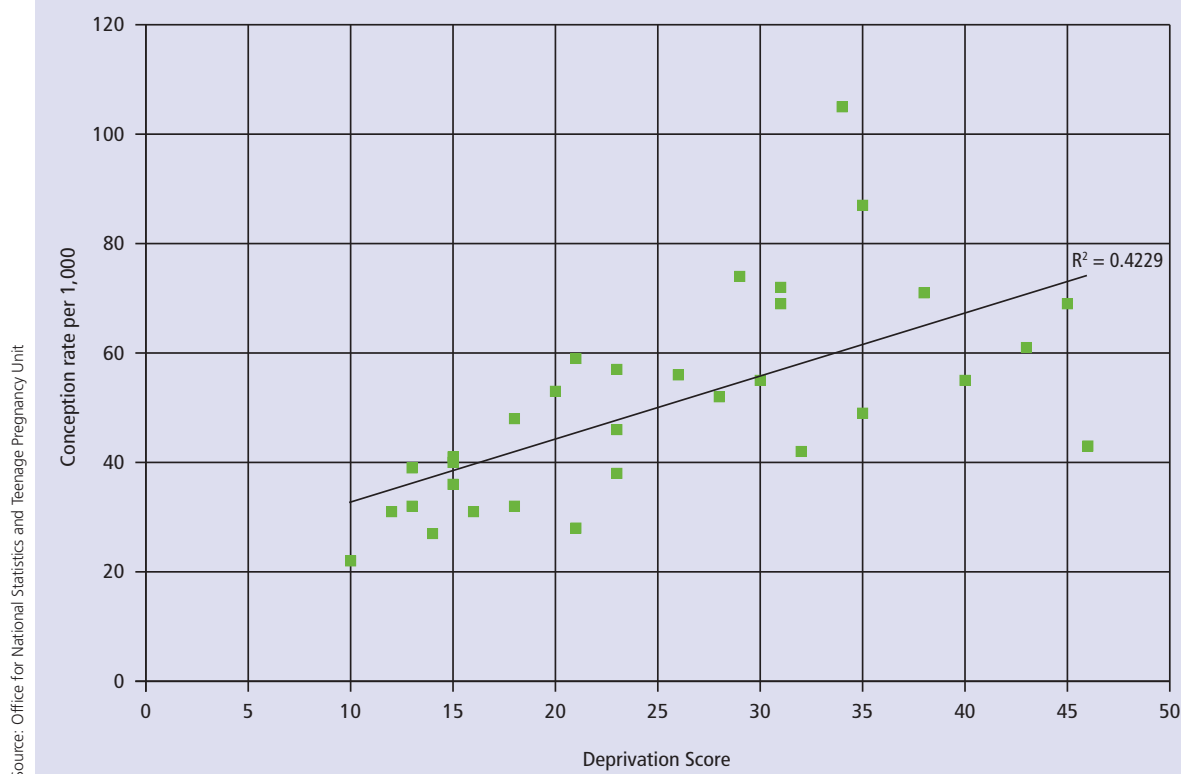
Conception and birth rates in the UK are the highest in Europe and second only to the United States in the developed world.

In 2003, London had an under-18 conception rate of 51 per 1,000 – 21% higher than the rate for England (42 per 1,000), and the second highest regional rate behind the North West (52 per 1,000). London boroughs have both the highest and lowest under-18 conception rates in England – over 100 per 1,000 in Lambeth, and less than 30 per 1,000 in Richmond and in Harrow.

For younger girls, London has the highest under-16 conception rates in England with 10 conceptions per 1,000 girls aged 13-15 years, compared to an England average of 8 per 1,000.

London's high rate is linked to particularly high rates in inner London, with marked differences in teenage conceptions between boroughs and

**Figure 5 Under-18 conception rate and deprivation by London borough, 2003**



wards. This is illustrated in Figure 5, which clearly demonstrates wide differences related to deprivation.

### Sexually transmitted infections (STIs)

Section 2 describes the growing number of sexually transmitted infections. Here we describe the impact of some of these in London.

Figure 6 shows the trends in the number of chlamydia and gonorrhoea diagnoses among those aged 16-19, indicating, in particular, the very steep rise in chlamydia in the last decade among 16-19 year old girls.

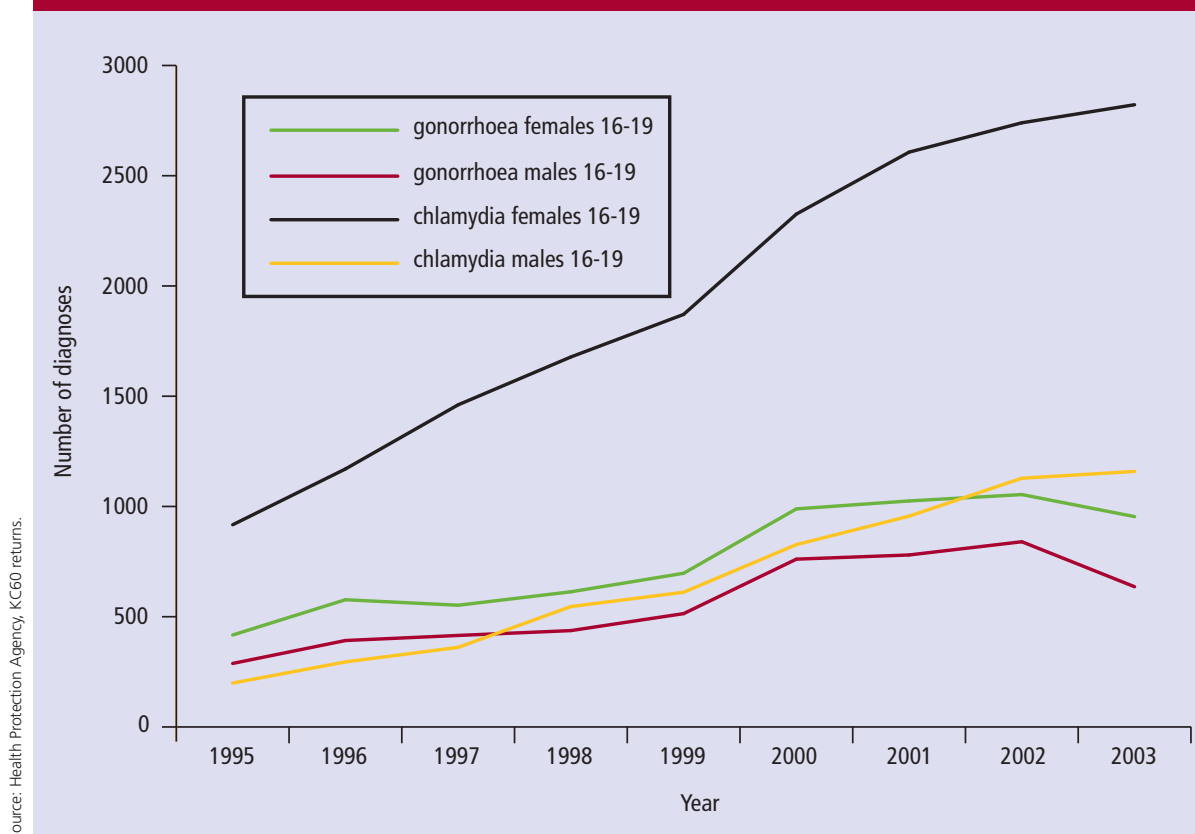
As Figure 6 also shows, levels of gonorrhoea are also a cause of concern for young people in London. While the diagnoses appear to be dropping from around mid 2002, they remain high compared with a decade ago. Diagnoses in boys and girls under 16 raise child protection as well as other health concerns.

New diagnoses of gonorrhoea also show a marked difference from the rest of England, with gonorrhoea at approximately double the England rates and particularly high levels amongst young women in north central London (Figure 7).

Sexual behaviour is a major factor determining the incidence of STIs. The second *National Survey of Sexual Attitudes and Lifestyles* shows that there have been notable changes in sexual behaviour since the first survey in 1990. These include:

- a greater number of lifetime partners
- lower median age at first intercourse
- a greater proportion of the sample with concurrent partnerships
- a greater proportion with two or more partners in the past year who did not use condoms consistently. However, there has also been an increase in the proportion who use condoms at first intercourse.

**Figure 6** Number of Chlamydia and Gonorrhoea diagnoses in London among those under 16 and aged 16-19, 1995-2003



### Contraceptive use

In terms of contraceptive use specifically, a study of teenage pregnancy in east London (Viner et al, 2005) found that:

- Young people who are having, or thinking about having, sex recognised the need to use contraception (although at times they might not do so). 83% of those who had had intercourse reported using one or more forms of contraception when they last had sex. Young women reported more unprotected sex than young men.
- No ethnic differences in types of contraceptive use were identified.
- Double protection (using a condom and the contraceptive pill) was used by only 10% of young people the last time they had sex.
- There were differences in the use of contraception both between ethnic groups, and within ethnicities commonly grouped together as 'Black'. While Black Caribbean young men were more likely to have had sex than White British young men, they appeared less likely to have unprotected sex than White British young men. In comparison to White British young men, Black British young men reported less unprotected sex, while Black African young men reported similar use of contraception to White British young men. This emphasises the importance of tailoring interventions to the needs of sub-groups and individuals rather than assuming that needs can be gauged from broad categorisations.
- Young people from 'non-White' ethnic groups were more likely to have unprotected sex if they had been in a relationship for six months or more, compared with relationships

of one month or less. This emphasises the need for interventions to address issues around continuing protection in long-term relationships.

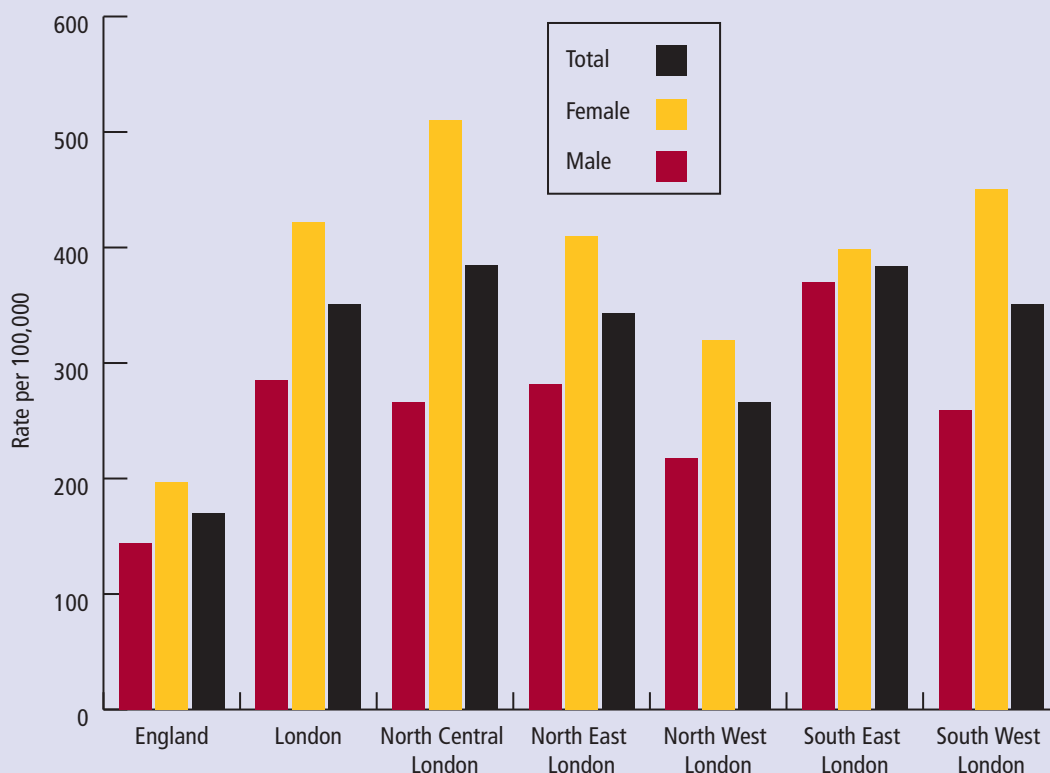
- Special needs groups such as those with learning difficulties appear to need better access to services.

## Healthy lifestyles

### Average alcohol consumption

Young Londoners appear to consume less alcohol than young people in other regions. Mean weekly units of alcohol consumed by young Londoners in 2002 was 18.4 for males and 10.3 for females. This compares with 30.9 units by young men in Yorkshire and Humber; and 18 units by young women in the North East, the highest regional rates. Young Londoners are also considerably more likely than a national sample to report that they never drink (70% of boys and 76% of girls, and 21% of young men, 24% of young women). However, nationally the prevalence of alcohol drinking amongst young people aged 11-15 years increased markedly from 1996 to 1998 and has since fluctuated. The average amounts drunk has also increased over the

**Figure 7** Rates of new episodes of gonorrhoea (per 100,000) among 16-19 year olds, by London strategic health authority, 2004



Source: Health Protection Agency, KC60 returns.

same period from 5.3 to 9.9 units (Department of Health, 2004).

There is some evidence that the levels of alcohol-related morbidity and mortality in London are greater than would be expected from the level of alcohol consumption, indicating that alcohol-related harm is not simply determined by the quantity individuals consume. In addition, children and young people may be adversely affected by parental alcohol problems and many children in London are growing up in households where at least one parent has an alcohol problem. More information about the impact of alcohol on individuals and communities in London can be found in the Mayor of London, *The London agenda for action on alcohol: Mayor of London's priorities to reduce alcohol-related harm in the capital*, November 2003  
[http://www.london.gov.uk/mayor/health/drugs\\_and\\_alcohol/index.jsp](http://www.london.gov.uk/mayor/health/drugs_and_alcohol/index.jsp)

### **Percentage of children who are regular smokers**

One in ten children aged 11-15 years in London currently smoke. This compares to one in four adults. Nationally more secondary school girls than boys smoke (11% and 7% respectively). In general, smoking prevalence is higher in more deprived areas, but in London there are also marked ethnicity and gender differences. There is a tendency for London to show lower prevalence of smoking across all age groups than other regions (*Health Survey for England*, 2002).

### **Second-hand smoke**

Children are also affected by second-hand smoking. Smoking during or after pregnancy causes one in two cot deaths (Sudden Infant Death Syndrome). Infants whose parents smoke have four times the risk of being admitted to hospital

with a respiratory infection before their first birthday. Parental smoking increases the risk of middle ear infections in childhood.

In general, smoking prevalence is higher in more deprived areas but in London there are also marked ethnicity and gender differences. Cigarette smoking is highest amongst Turkish (55-74%), Bangladeshi (44%) and Irish men (42%). Smoking rates are often, but not always, low among women from Black and minority ethnic groups: while only 1% of Bangladeshi women smoke, 45-59% of Turkish women and 39% of Irish women do so. However, a fifth of Bangladeshi women use chewing tobacco, which also carries serious, though fewer, health risks.

## **Choosing not to take illegal drugs**

### **Harm caused by illegal drugs (including use of class A drugs by under 25 year olds)**

In England the prevalence of drug taking amongst 11-15 year olds remained relatively stable between 1998 and 2003. Cannabis was the most likely drug to have been taken (13% of 11-15 year olds had taken cannabis) and 4% of young people had taken a class A drug, such as heroin and cocaine in the last year (*Survey of Drug use, smoking and drinking among young people in 2003*, Department of Health).

Because drug use is an illegal activity, it is not easy to obtain accurate information about the extent of its use. However, the annual *British Crime Surveys* provide some useful information on estimated use and show that rates of drug use in London remain consistently higher than other regions in England and Wales. The 2000 BCS reported that 31% of 16-29

year olds in London had taken an illegal drug in the previous year (Mayor of London, London: *The highs and the lows: A report from the Greater London Alcohol and Drug Alliance incorporating the findings from the London Drug Indicators Project*, February 2003)

Information collated and analysed by the Greater London Alcohol and Drug Alliance (GLADA) for the *London Crack Cocaine Strategy* highlighted the growth in use of crack cocaine and demonstrated that the scale of the crack cocaine problem in London is much larger than elsewhere in the country (Mayor of London, *The GLADA Crack Cocaine Strategy 2005-08*, December 2004.)

Although information about the impact of drug use on different communities is also limited, there is increasing evidence of a strong relationship between poverty, social exclusion and problematic drug use.

