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Drug Treatment
Monitoring Unit

NHS

DTMU Analysis

AACCE and PDU Clients in the South East:

Exploring patterns of drug use among different age groups

2008/2009

Delivered by Solutions for Public Health

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March 2011

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Executive summary

Key messages:

- Clients are defined as 'AACCE' if they seek drug treatment for a non-opiate substance including alcohol, amphetamines, cannabis, cocaine and ecstasy, unless they report a problematic substance as a primary, secondary or third drug.
- Clients are defined as a Problematic Drug User (PDU) if they seek drug treatment for a problematic substance such as heroin, other opiates or crack.
- In the South East, 47% of the drug treatment population were identified as AACCE and over the last four years, there has been a slight increase in the proportion of clients who have an AACCE profile.
- When clients with a primary drug of alcohol have been excluded, AACCE clients tend to be generally younger than opiate using clients. The average age of AACCE clients has dropped slightly over the last four years.
- Although there has been a year on year increase in the number of clients seeking drug treatment, the proportion of AACCE and PDU clients within each age group has remained broadly similar from year to year.
- The data shows variation in primary drug by age group. A greater proportion of clients from older age groups reported their primary drug as alcohol, whereas clients aged under 18 reported cannabis as a primary substance.
- There was variation according to where AACCE and PDUs lived. For example, there were fewer numbers of AACCE clients in drug treatment resident in Reading and Brighton and Hove.
- AACCE clients were more likely to be referred into structured drug treatment from 'other' referral sources, such as education services or through outreach. AACCE clients aged under 25 were more likely to have been referred into drug treatment through the criminal justice system as well as through 'other' referral sources, such as family and friends or primary care trusts.
- The analysis shows that between 2005/06 and 2007/08, there was a year on year increase in the proportion of both AACCE and PDU clients that left treatment in a planned way.
- The data show that although the majority of PDU and AACCE clients stay in treatment for 12 weeks or more, PDU clients had longer treatment journeys.

Introduction

On the whole, the nature of drug usage amongst different populations in society is fluid and is open to change. Different drugs are popular at different times and national drug policy needs to keep up-to-date with these trends and respond accordingly. According to the National Treatment Agency (NTA), there has been a shift in the nature and pattern of drug use (NTA, 2009). Last year the NTA reported that over the last 4 years, the proportion of 18 to 24 year olds presenting with heroin and crack has declined and that the clients who use opiates are generally older (NTA, 2009). This year the NTA have reported a drop in heroin use, especially amongst the 15 -24 and 25 – 34 age groups (NTA, 2010).

In this report, a comparison is made between clients who report mainly opiate or crack use (PDUs) and clients who use other substances, in order to explore differences between these two groups. This report aims to show whether there are differences in terms of age, substance use, DAAT of

residence, referral source and length of treatment. The report will end with a discussion on whether there is any evidence to suggest that drug services need to ensure that their services meet the needs of problematic drug users (PDU) and of clients whose main substance is alcohol, amphetamine, cannabis, cocaine or ecstasy.

What is an AACCE Client?

The term ‘AACCE’ was first introduced by Howard Parker to illustrate that clients aged under 18 were less likely to present with either heroin or other opiates. He hypothesed that although government policy around drug issues is to focus mainly on drug users who present the most harm (heroin/crack injectors), attention should be paid to the growing number of under 18s who used alcohol, cannabis, cocaine and ecstasy.

The AACCE profile refers to clients stating non-opiate substance use incorporating alcohol, amphetamines, cannabis, cocaine and ecstasy (AACCE). However, some clients using other drugs, including hallucinogens and solvents, can be included within the analysis.

Methodology

The National Drug Treatment Monitoring System (NDTMS) records data from tier 3 and 4 drug agencies services which facilitates analysis on clients and their treatment journeys. This report presents NDTMS data for clients in contact with the treatment system between 2005/06 and 2008/09.

For the purposes of this report, clients have been selected on the basis of their most recent episode, within each financial year. This means that clients who appeared in drug treatment in subsequent financial years could be counted more than once in this analysis, but only once for each financial year. To determine how old a client is, a client’s age at triage has been used throughout this report.

Clients are categorised into two distinct groups: opiate clients (referred to as PDUs) and non-opiate clients (referred to as AACCE clients). Clients are referred to as a PDU if they report their primary, secondary or tertiary drug to be heroin, methadone, other opiates or crack. Clients with alcohol as a primary drug are incorporated within the AACCE profile unless otherwise stated.

Clients are referred to as ‘AACCE’ if they report any non opiate (excluding crack) substance as a primary, secondary or third drug. Clients with primary drug alcohol but with a problematic second or third drug are treated as an ‘AACCE’ client rather than a PDU. However, clients who report an AACCE substance but are also stating a problematic primary, secondary or tertiary drug are classified as PDU.

In terms of data collection, agencies were not always required to submit data to NDTMS for clients who reported alcohol as a primary drug. In was only from 1st April 2008 that it became mandatory for data to be collected on clients reporting alcohol as a primary drug. This means that between 2005/06 and 2007/08, alcohol was collected but not for all agencies, which means any changes in alcohol treatment might not be an accurate reflection on the extent of alcohol treatment amongst both client groups.

The following clients were excluded from the analysis:

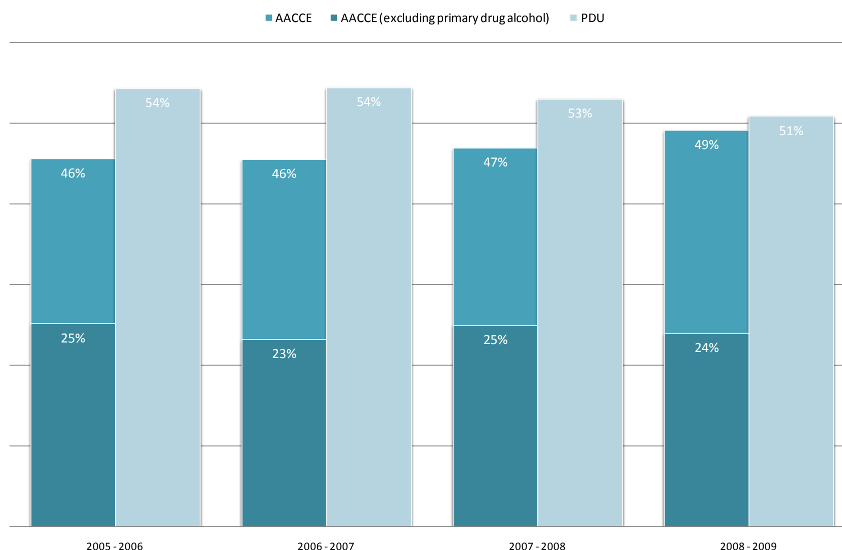
- Clients with no primary drug recorded on NDTMS
- Clients with an invalid age at triage (e.g. clients age recorded as; 0,1,2,3)

Demographics of clients in contact with structured drug treatment

Between 2005/06 and 2008/09, there were 111,937 clients (all ages) in contact with structured drug treatment services in the South East. Of these, 52,620 (47%) were classed as an AACCE client and 59,317 (53%) were classified as PDU based on the primary, secondary and third drug stated at their most recent treatment episode. Two-thirds of clients (68%) were male and 32% were female. When looking at only females, slightly more were classified as AACCE (53%) than PDU (47%). For males the reverse was true as slightly more males were classified as PDU (56%) than AACCE (44%).

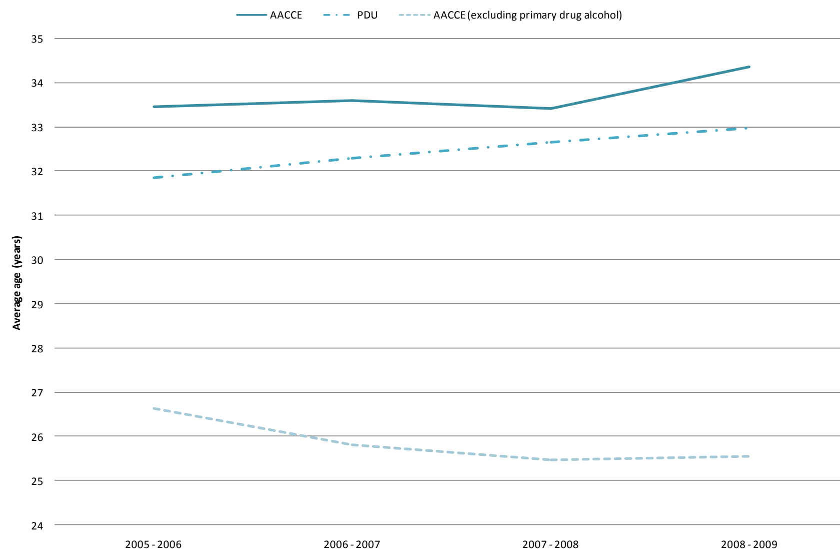
Figure 1 shows there appears to have been a slight increase in the proportion of clients classified as AACCE over the last four years, ranging from 10,307 AACCE clients (46%) in 2005/06 to 16,480 (49%) in 2008/09. The proportion of AACCE clients that did not state alcohol as a primary drug remained relatively stable between 2005/06 and 2008/09. For example, there was a quarter (25%) of AACCE clients without primary drug alcohol in 2005/06, compared to 24% in 2008/09.

Figure 1: Proportion of AACCE and PDU clients, 2005/06 – 2008/09



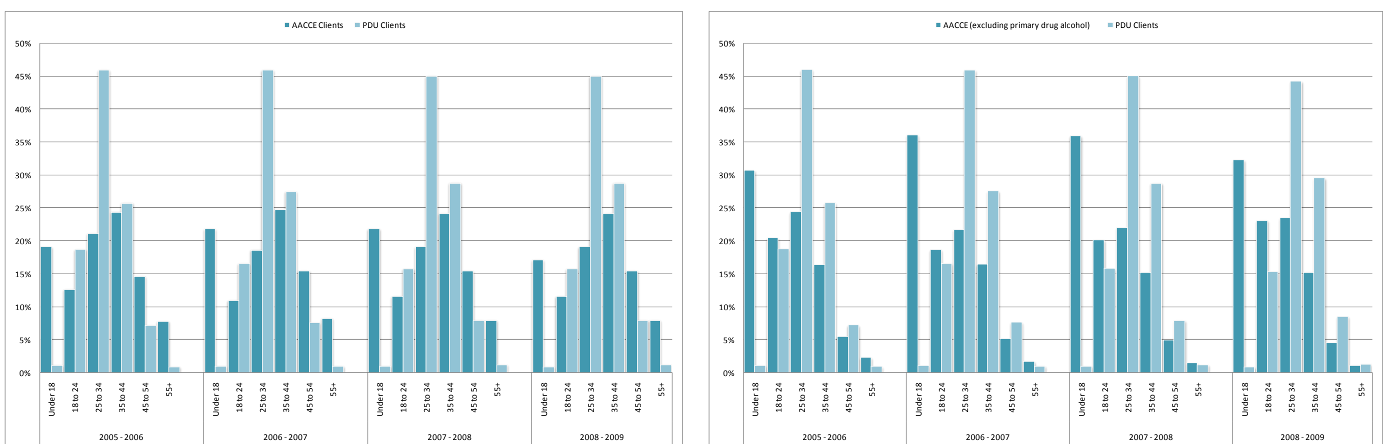
The average age of AACCE clients in contact with the treatment system between 2005/06 and 2008/09 was 34 years, older than the average age of PDU clients whose average age was 33 years. Interestingly, the average age of AACCE clients dropped to 26 years when clients with a primary drug alcohol was excluded. Figure 2 shows that for AACCE clients with alcohol excluded, the average age fell from 27 years in 2005/06 to 26 years in 2008/09. Conversely, the opposite was true for PDU clients, whose average age rose from 32 years in 2005/06 to 33 years in 2008/09.

Figure 2: Average age of AACCE and PDU clients, 2005/06 – 2008/09



There has been a year on year increase in the number of clients who are in contact with the drug treatment system, illustrating that the drug treatment system in England has expanded and is more effective. The two charts in Figure 3 shows that the overall proportions of PDU and AACCE clients within each age band have remained consistent between 2005/06 and 2008/09. These charts also compare differences in terms of age group between AACCE clients who report alcohol as a primary drug and AACCE clients that do not. It can be seen that there was a higher proportion of AACCE clients aged between 15 and 24 years amongst those who did not report alcohol as a primary drug. Just over half of all AACCE clients (excluding alcohol) were aged under 24 in each financial year. For PDUs, around 45% were aged between 25 and 34 years in each financial year. There were also very few PDU clients amongst the under 18 and over 55 age groups.

Figure 3: AACCE and PDU clients in treatment by age group and year, 2005/06 – 2008/09



This means that any changes in the patterns of drug use amongst different age groups cannot be explained purely by an increase in the number of clients entering structured drug treatment. Other factors, such as gender, age, DAAT of residence may reveal further differences and changes in patterns of drug use between AACCE and PDU clients.

The data show that between 2005/06 and 2008/09, of the 27,120 individuals aged under 25, 16,714 (62%) had an AACCE profile. For individuals aged 35 and over, 54% were AACCE and 46% were PDU. The majority of AACCE and PDU clients were white British (85%).

Substances used

Individuals who seek treatment for substance misuse can report up to three substances which are recorded on NDTMS. As stated in the methodology, clients reporting an AACCE substance but a problematic (opiates or crack) primary, secondary or tertiary drug have been classed as a PDU, unless they have reported their primary drug as alcohol. Table 1 shows that the majority of AACCE clients reported alcohol as their primary drug. Almost twenty per cent of AACCE clients report cannabis as a primary drug. In terms of secondary drug, over a third of clients reported alcohol, a third reported cannabis and over 11% report cocaine. Not accounting for clients that report no third drug, around 20% of AACCE clients reported cocaine as a tertiary drug. Please see table 3 for the same information included in table 1 but excluding alcohol as a primary drug.

Table 1: Primary, secondary and tertiary problematic substance of AACCE clients in structured treatment, 2005/06 – 2008/09

	Primary Drug		Second Drug		Third Drug	
	Number	%	Number	%	Number	%
Alcohol	33533	63.7%	5950	34.3%	1146	17.1%
Cannabis	10301	19.6%	5349	30.9%	1139	17.0%
Cocaine	4427	8.4%	1941	11.2%	1354	20.2%
Amphetamines	1732	3.3%	871	5.0%	643	9.6%
Other Drugs	1308	2.5%	1087	6.3%	764	11.4%
Benzodiazepines	816	1.6%	487	2.8%	220	3.3%
Ecstasy	325	0.6%	750	4.3%	953	14.2%
Solvents	178	0.3%	80	0.5%	113	1.7%
Crack	0	0.0%	287	1.7%	216	3.2%
Heroin	0	0.0%	329	1.9%	100	1.5%
Methadone	0	0.0%	96	0.6%	23	0.3%
Other Opiates	0	0.0%	102	0.6%	36	0.5%

Table 2 shows that the majority of PDU clients report heroin as a primary drug. Just over a third of PDUs reported crack as a secondary drug. Cannabis was stated as a tertiary drug for a quarter of PDU clients. Please note that totals for each column will not be equal. This is because not all clients report a secondary or tertiary drug and the percentages are calculated excluding this missing data.

Table 2: Primary, secondary and tertiary problematic substance of PDU clients in structured treatment, 2005/06 – 2008/09

	Primary Drug		Second Drug		Third Drug	
	Number	%	Number	%	Number	%
Heroin	48892	82.4%	2014	6.5%	330	2.3%
Methadone	3587	6.0%	3092	9.9%	879	6.2%
Crack	3106	5.2%	11369	36.5%	1933	13.7%
Other Opiates	2369	4.0%	1401	4.5%	925	6.5%
Cannabis	497	0.8%	3787	12.1%	3555	25.2%
Cocaine	353	0.6%	2412	7.7%	709	5.0%
Benzodiazepines	188	0.3%	2701	8.7%	2251	15.9%
Amphetamines	183	0.3%	650	2.1%	523	3.7%
Other Drugs	121	0.2%	451	1.4%	513	3.6%
Ecstasy	13	0.0%	103	0.3%	161	1.1%
Solvents	8	0.0%	20	0.1%	7	0.0%
Alcohol	0	0.0%	3184	10.2%	2338	16.6%

Table 3 shows that by excluding AACCE clients who state alcohol as a primary drug[1], the majority of AACCE clients reported cannabis as a primary drug (54%), followed by cocaine (23%).

Table 3: Primary substance of AACCE clients in structured treatment, excluding alcohol, 2005/06 – 2008/09

	Primary Drug	
	Number	%
Cannabis	10301	54.0%
Cocaine	4427	23.2%
Amphetamines	1732	9.1%
Other Drugs	1308	6.9%
Benzodiazepines	816	4.3%
Ecstasy	325	1.7%
Solvents	178	0.9%

The proportion of AACCE clients stating alcohol as a primary drug has slightly increased over the last four years (as shown in Figure 4). In 2005/06, 60% of AACCE clients reported their primary drug as alcohol, this increased to 67% in 2008/09. This could reflect changes in reporting rather than actual changes because agencies were required to report on alcohol treatment to NDTMS from April 2008 and onwards. Cannabis use amongst AACCE clients has remained around 20% of clients reporting it as a primary substance. In addition, 8% of AACCE clients have reported cocaine as their primary substance.

[1] This is the approach adopted by the North West and Eastern NDTMS regions

Figure 4: Primary substance of AACCE clients in structured treatment, 2005/06 – 2008/09

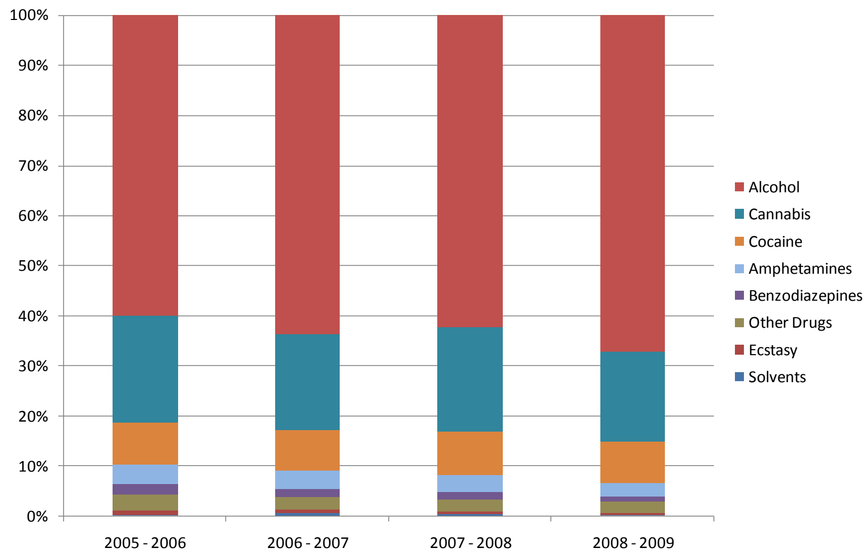
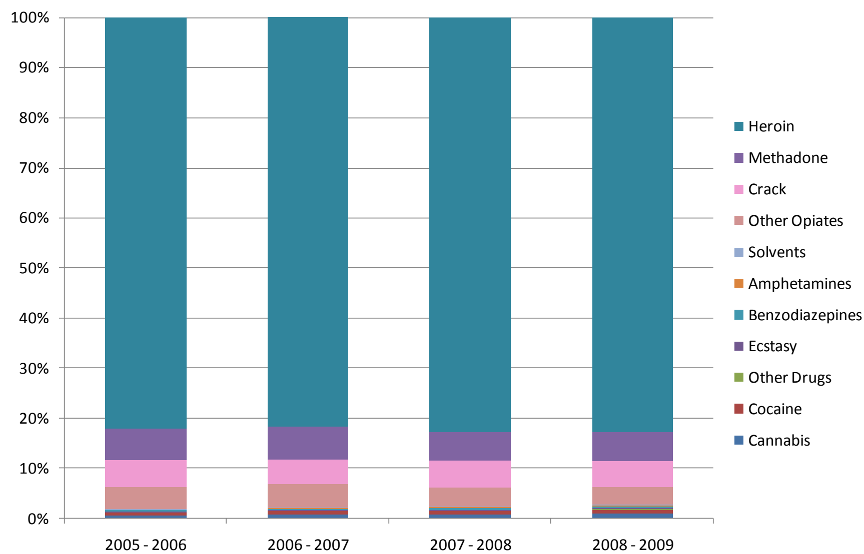


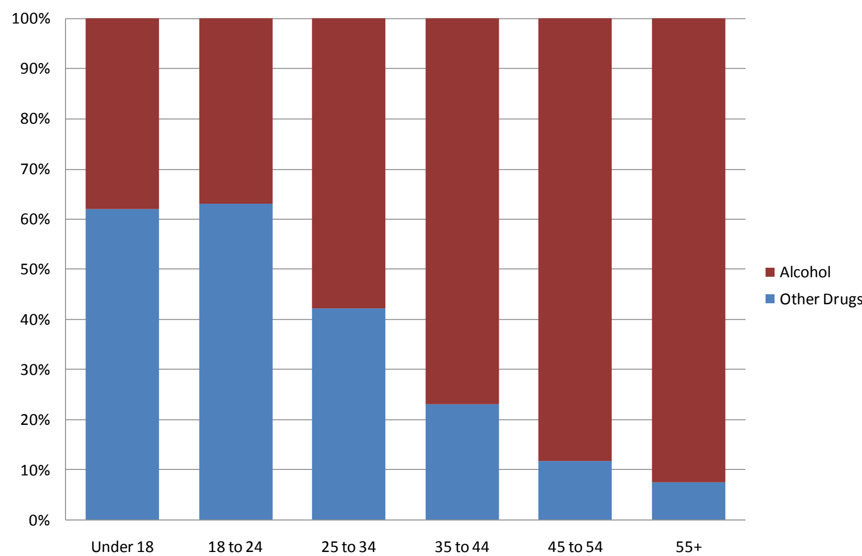
Figure 5 shows that the proportion of PDU clients who state heroin as a primary substance has remained relatively unchanged over the last four years. Around 82% of PDUs report heroin as a primary drug each year. Similarly, the proportions of clients reporting other substances as their primary drug, for example methadone or crack, also remained stable over the four year period.

Figure 5: Primary substance of PDU clients in structured treatment, 2005/06 – 2008/09



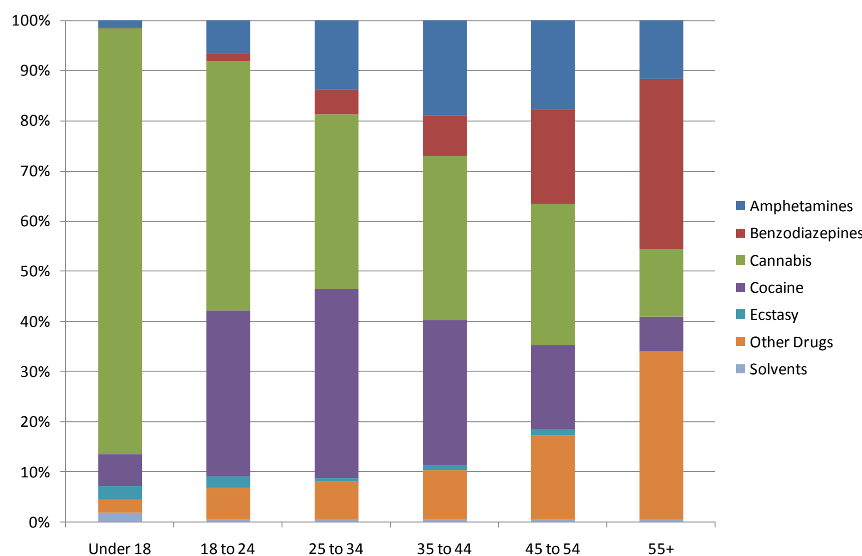
There appears to be differences in terms of primary drug amongst AACCE clients according to age group. The majority of AACCE clients aged under 18 stated cannabis as their primary drug (53%), and a significant proportion of clients under 18 reported alcohol as their primary drug (38%). Figure 6 shows that AACCE clients from older age groups reported more alcohol use.

Figure 6: Primary substance of AACCE clients in structured treatment by age group, 2005/06 – 2008/09



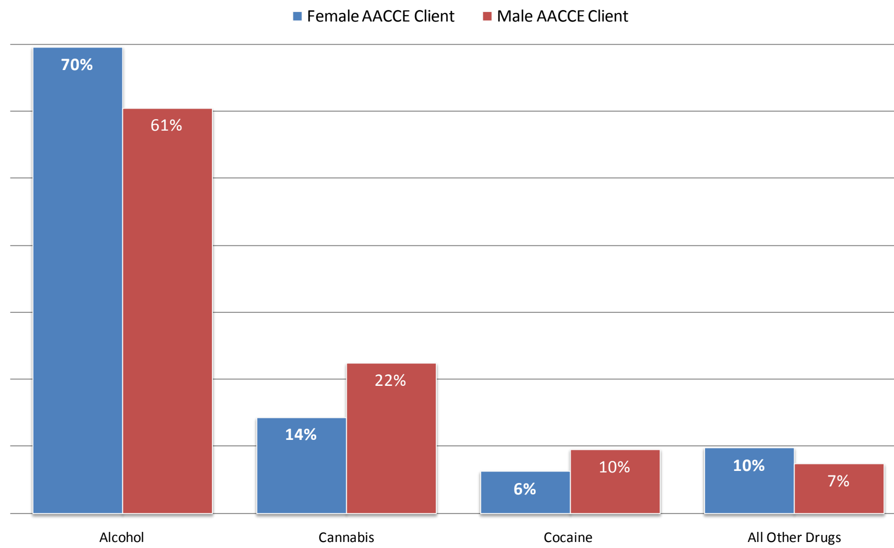
By removing alcohol as a primary drug from this analysis, further patterns in drug use between the differing age groups can be seen. Figure 7 shows that the proportion of AACCE clients reporting cannabis as a primary drug is highest in the younger age groups. Benzodiazepines appear to be a primary drug more commonly associated with the older age groups. Clients stating cocaine as a primary substance were aged between 18 and 44 years.

Figure 7: Primary substance of AACCE clients in structured treatment by age group excluding alcohol, 2005/06 – 2008/09



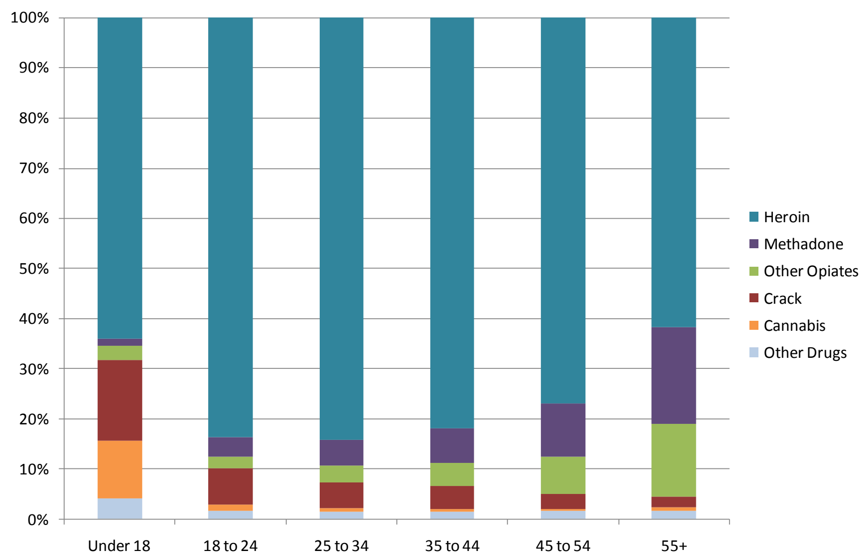
In terms of gender differences, figure 8 shows that more female AACCE clients reported alcohol as a primary substance and slightly more male AACCE clients reported cannabis as a primary drug.

Figure 8: Primary substance of AACCE clients in structured treatment by gender, 2005/06 – 2008/09



The majority of PDUs reported heroin as a primary drug. Of the small proportion of PDU clients who were aged under 18 (see figure 3), 64% reported heroin as a primary substances and 16% reported crack as a primary substance. Clients from older age groups reported less use of crack and more use of methadone and other opiates. Very few PDUs reported cannabis as a primary drug.

Figure 9: Primary substance of PDU clients in structured treatment by age group, 2005/06 – 2008/09

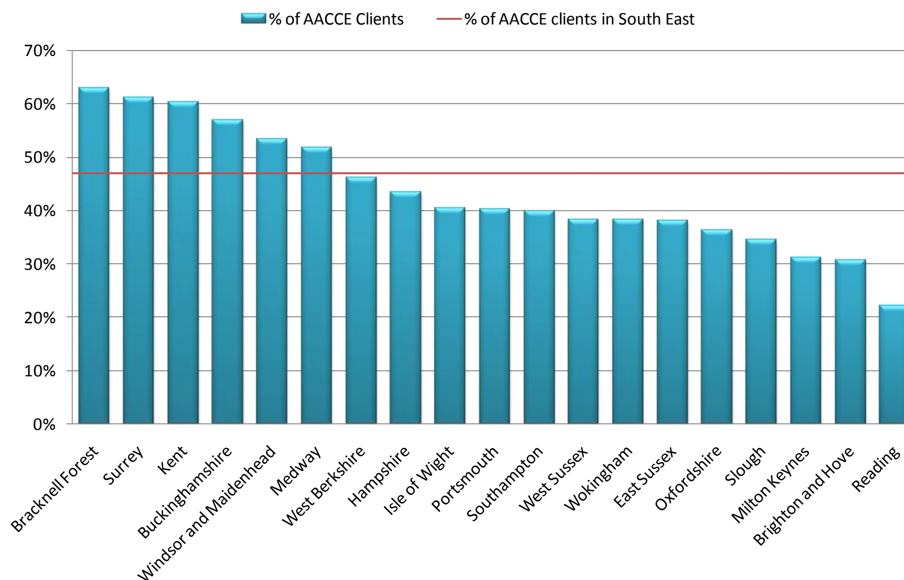


AACCE Profile and DAAT of residence

The data show a wide variation in the proportion of clients classified as AACCE across the South East. As shown in figure 10, there are relatively low numbers of clients in drug treatment classified as AACCE resident in Reading (22%), Brighton and Hove (31%) and Milton Keynes (31%). For individuals living in Bracknell Forest, 63% of clients in structured drug treatment were classified as AACCE.

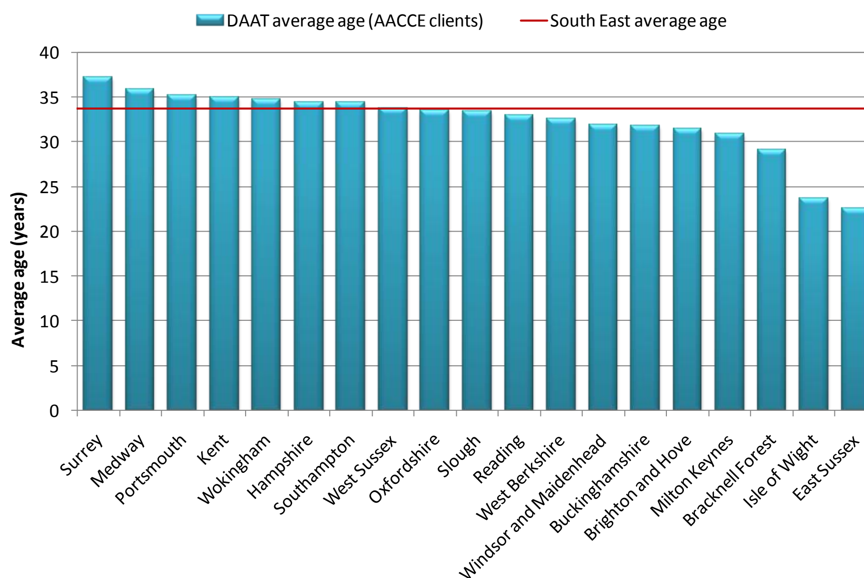
These findings could reflect the nature of the treatment service within that area. For example, it might be the case that services that focus on AACCE or PDU clients are commissioned differently in DAAT areas or that there are differences in terms of availability of these services. There could also be differences in terms of who is accessing drug treatment in specific DAAT areas. Some DAAT areas could have a larger proportion of clients accessing tier 2 treatment and are therefore not reflected on NDTMS as NDTMS only records clients in structured drug treatment (tier 3 or tier 4).

Figure 10: Proportion of AACCE clients by DAAT of residence, 2005/06 – 2008/09



AACCE clients' average age varies across the South East. AACCE clients were older in Surrey (37 years), Medway (36 years) and Portsmouth (35 years). The average age for AACCE clients in structured drug treatment living in East Sussex was 23 years. AACCE clients living in the Isle of Wight had an average age of 24 years.

Figure 11: AACCE clients by average age and DAAT of residence, 2005/06 – 2008/09



Referral source of AACCE and PDU clients

Clients enter structured drug treatment in a number of different ways. It could be that they recognise their drug problem and seek help or they are referred into treatment by other people, for example a general practitioner or a family member. For the purposes of this report, clients have been selected on the basis of their most recent episode, which means that previous treatment episodes could have had a differing referral source than the one stated.

Table 4: Referral source of PDU and AACCE clients, 2005/06 – 2008/09

	AACCE Clients		PDU Clients	
Referral Source	Number	%	Number	%
Self Referral	17,580	34%	25,991	45%
Other[2]	11,318	22%	5,144	9%
Criminal Justice System (CJS)	8,204	16%	10,922	19%
General Practitioner (GP)	7,793	15%	5,350	9%
Drug Service	6,641	13%	10,165	18%

The data in table 4 show that although a higher proportion of AACCE and PDU clients self referred into structured drug treatment, a slightly greater proportion of PDU clients (45%) self referred into

[2] 'Other referral source includes; A&E, Adult treatment provider, alternative education, CAMHS, Children and Family Services, Community Alcohol Team, Community Care Assessment, Concerned Other, Connexions, Education Services, Family and Friends, Hospital, LAC, Non treatment substance misuse, other, Outreach, Primary Care Trust, psychiatry, psychological services, relative, Sex worker project, social services, syringe exchange, targeted youth support, universal educational, young people's treatment provider

drug treatment compared to AACCE clients (34%). The reason for this difference warrants further investigation that is beyond the scope of this analysis.

AACCE clients were more likely to be referred into structured drug treatment from an 'other' referral source (22%) such as education services or through outreach, in comparison to PDU clients (9%). AACCE clients were also more likely to be referred into structured drug treatment by their general practitioner. Results like these could reflect differences in terms of the age distribution of AACCEE and PDU clients. Table 5 shows the referral source for AACCE and PDU clients by age group.

Table 5: Referral source of PDU and AACCE clients by age group, 2005/06 – 2008/09

	AACCE	PDU	AACCE	PDU	AACCE	PDU	AACCE	PDU	AACCE	PDU	AACCE	PDU
Age Group	**Under 18**		**18 to 24**		**25 to 34**		**35 to 44**		**45 to 54**		**55+**	
CJS	42%	22%	26%	22%	11%	21%	6%	17%	4%	10%	2%	6%
Drug Service	3%	11%	10%	17%	15%	18%	17%	18%	17%	18%	14%	21%
GP	2%	6%	9%	8%	16%	9%	19%	10%	23%	12%	26%	17%
Other	46%	36%	20%	9%	15%	8%	15%	9%	16%	10%	15%	9%
Self	7%	25%	35%	44%	43%	44%	42%	47%	39%	50%	43%	47%

AACCE clients aged under 25 were more likely to have been referred into drug treatment though the criminal justice system or through an 'other' referral source. AACCE clients aged 18 or over were more likely to self refer into treatment than AACCE clients aged under 18. Interestingly, PDUs aged under 18 were also more likely to have a referral source as 'other', compared to PDUs from older age groups.

Treatment outcomes

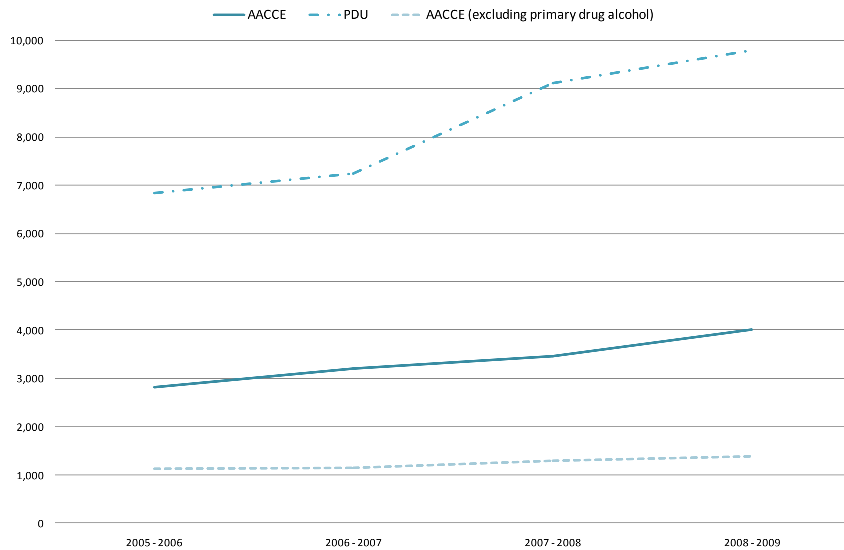
All clients, regardless of whether they are classified as PDU or AACCE, can leave their treatment for a variety of reasons; these are grouped into planned and unplanned discharge reasons. Planned discharges from a treatment agency include clients who completed treatment, completed treatment drug free and clients who have been referred on[3]. Unplanned discharges include occasions where the client has dropped out or has died, gone into prison or has moved or where the treatment has been withdrawn[4].

Within this analysis, clients with no discharge date and/or discharge value stated were assumed to be still accessing structured drug treatment. As can be seen in the data completeness section, improvements in data quality have meant that very few clients will have a discharge value with no corresponding discharge date. In addition, the NTA required all drug treatment agencies to undertake a data audit in 2009/10 to ensure that client's data was recorded accurately. Agencies had to confirm that clients who were no longer accessing drug treatment had a relevant discharge date provided. This analysis is based on data made available prior to the data audit.

[3] From April 2008, 'referred on' was no longer valid as a planned discharge value.
[4]Unplanned discharges include; dropped out, moved away, treatment withdrawn, prison, transferred, died, no appropriate treatment, inappropriate referral and treatment declined by client,

Looking only at clients with no discharge date, Figure 12 shows the number of clients that were accessing treatment in this four year period. Overall, around a quarter of all AACCE clients (26%), over half of PDU clients (56%) and around half of AACCE clients – excluding alcohol (26%) were still in treatment between 2005/06 and 2008/09.

Figure 12: AACCE and PDU currently accessing treatment, 2005/06 – 2008/09



Excluding clients who are either still in treatment or have an unknown discharge reason, Figure 13 looks at the proportion of clients who left their last treatment episode in a planned or unplanned way. The data show that almost 6 out of 10 AACCE clients compared to around 4 out of 10 PDUs left structured drug treatment in a planned way. A higher proportion of PDUs (59%) left drug treatment in an unplanned way. There was little variation in terms of discharge reason between AACCE clients with and without alcohol as a primary drug.

Figure 13: AACCE and PDU clients discharge reason, 2005/06 – 2008/09

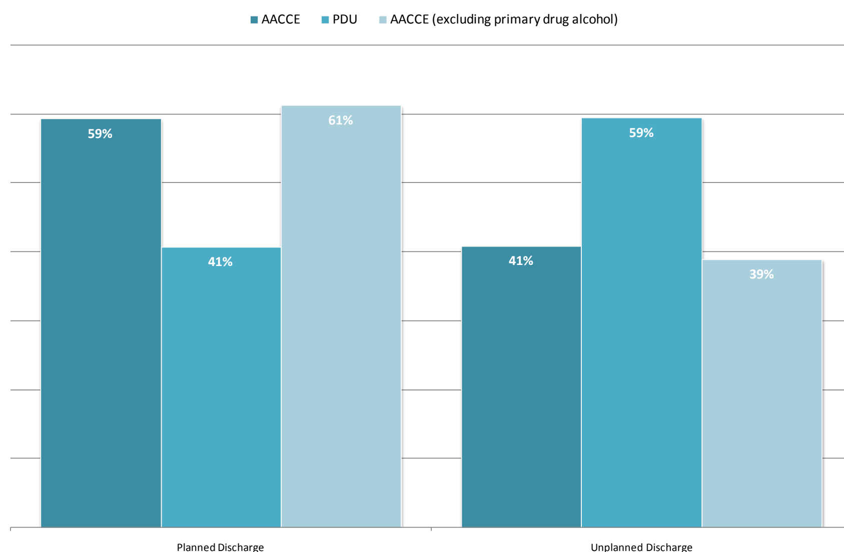
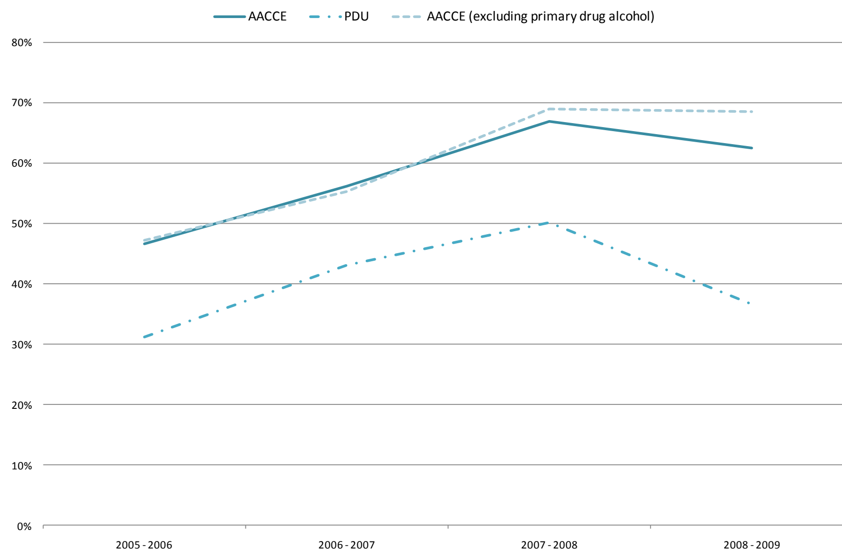


Figure 14 shows that between 2005 and 2007, there was a year on year increase in the proportion of both AACCE and PDU clients that left treatment in a planned way. This dropped slightly in 2008. The proportion of PDU clients leaving drug treatment in a planned way was lower than the corresponding proportion of AACCE clients. The data show that in 2007, around 50% of PDUs left treatment in a planned way. This dropped to 37% in 2008. Reasons for this decline warrant further investigation.

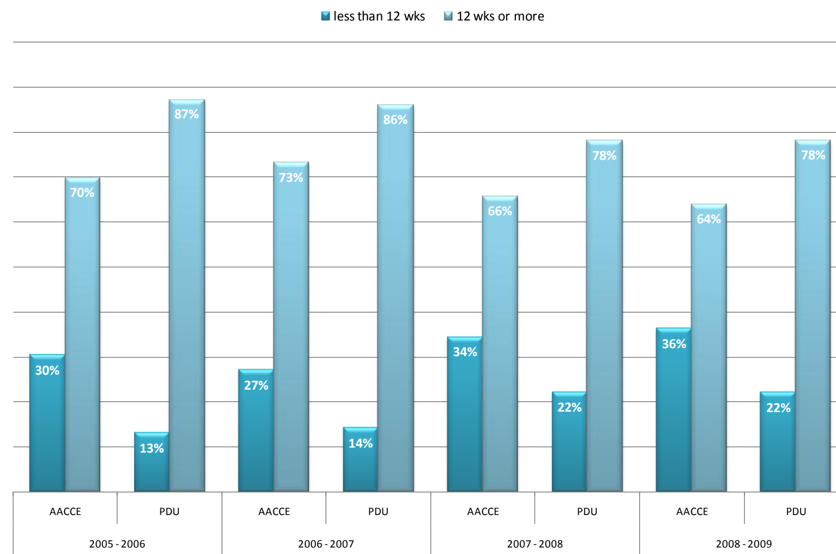
Figure 14: Proportion of AACCE and PDU clients leaving treatment in a planned way, 2005/06 – 2008/09



For treatment to be considered 'effective' clients need to be retained in treatment for a minimum of 12 weeks or leave treatment in a planned way. A client's length of treatment has been calculated from length of time in weeks from triage date to discharge date. Where a client had no discharge date, possibly because they are still in treatment, length of time was calculated to 30th June 2009. Figure 15 compares how long AACCE and PDU clients stay in treatment.

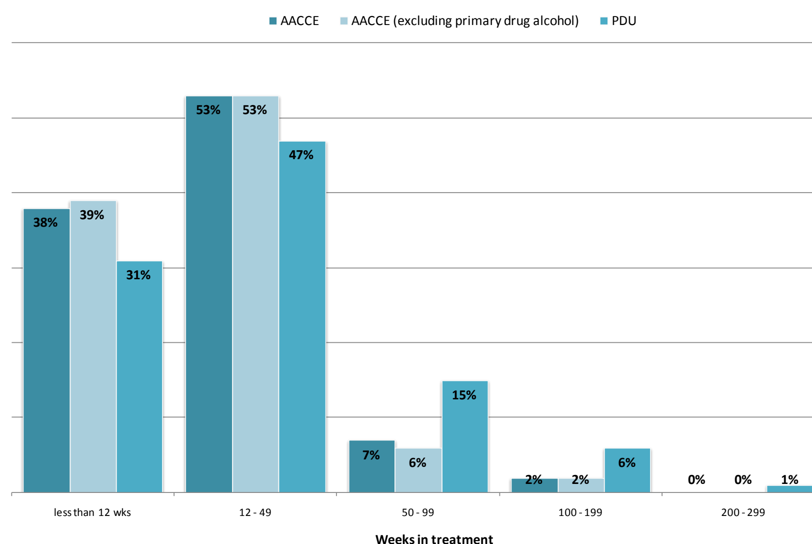
The data show that the proportion of both AACCE and PDUs either retained in treatment for less than 12 weeks or for more than 12 weeks remained similar over the four year period. Interestingly, the proportion of AACCE clients who were in treatment for less than 12 weeks was approximately double that of PDU clients. Although the majority of PDU and AACCE clients stay in treatment for 12 weeks or more, this was true for a greater proportion of PDU clients.

Figure 15: AACCE and PDU clients retained in treatment by weeks in treatment, 2005/06 – 2008/09



In order to calculate how long, on average, a client stays in treatment before being discharged, the number of weeks was calculated by subtracting a client's discharge date from triage date. This analysis excludes two groups of clients; those with open episodes (i.e. with no discharge date) and those with a triage date before 1st April 2004. Open episodes are excluded because it is impossible to foresee how many weeks a client will remain in drug treatment. Episodes triaged before 1st April 2004 have been excluded in order to avoid analysing data on clients who could be accessing drug treatment for prescribing rather than other modalities. Figure 16 shows the number of weeks that a client triaged on or before 01/04/2004 were in treatment before they were discharged. The data show that on average, PDU clients had longer treatment episodes.

Figure 16: AACCE and PDU clients retained in treatment, by length of stay in treatment, 2005/06 – 2008/09



Just over a third of clients remained in treatment for under 12 weeks. Interestingly, figure 16 shows that a slightly higher proportion of AACCE clients remained in treatment between 12 and 49 weeks

but more PDU clients were in treatment for 50 weeks or more. According to the NTA (2010), drug treatment, aimed at helping someone overcome their dependency on an illicit drug, is a long process that accepts that relapse and repeated attempts to engage with treatment are likely. Typically, recovery does not take place at someone's first contact with the drug treatment system. With this in mind, clients with a length of stay in treatment that is less than 12 weeks might return to treatment at a later date.

Exploring clients' length of stay in treatment warrants further analysis to investigate how many times a drug user, in contact with the drug treatment service, engages with the drug treatment system, before they leave the drug treatment system for good and are permanently off drugs and to what extent this differs between AACCE and PDU clients.

Conclusion

This report has looked at two different client groups in order to explore differences between clients who use problematic substances such as heroin and crack and clients who use any non-opiate substance, including alcohol, amphetamine, cannabis, cocaine and ecstasy.

There appear to be differences in terms of age, primary drug and also DAAT of residence. There were also differences in sources of referral. There were some similarities and differences noted between the two groups. For example, although AACCE clients were more likely to leave the drug treatment system in a planned way, both groups were often retained in treatment for longer than 12 weeks.

Analysis of NDTMS data for the South East of England has shown that since 2005, over 50,000 clients resident in the South East had an AACCE profile (19,087 AACCE clients did not report alcohol as a primary drug). For DAATs, this means there are a lot of clients who present for treatment for a non-opiate substance.

Through their analysis on NDTMS data for the North West of England, Hurst et al (2009) concluded that the AACCE profile triggered the following questions:

1. Are adult drug services equipped to deal with non-opiate clients?
2. Are adult drug services attractive and accessible for AACCE presenters?
3. Should AACCE presenters be treated separately from PDUs?
4. Should transitional AACCE services be commissioned to 'follow on' from under 18s specialist provision so alcohol and non-opiate and poly substance use can be responded to more effectively? Then, at 25 years, are there appropriate care pathways into older adult services?
5. Can hazardous and dependent drinkers aged over 18 access a tier 3 community alcohol services and is the service geared to work with them and attend to any secondary drug use?

DAATs need to ensure they meet the needs of all potential service users, which would include AACCE clients. Greater awareness about services available for non-opiate substance users need to be advertised locally to ensure that PDUs are not the only focus of drug treatment delivery.

Further analysis could be undertaken to consider whether clients who have an AACCE profile are likely to return treatment as a PDU later on in life. In addition, it would be of interest to report how frequently AACCE and PDU clients return to treatment following a previous successful discharge.

Data completeness

The NDTMS dataset is used to profile the drug treatment population, the treatment journeys of clients and the outcomes of treatment within analysis reports, needs assessments in order to support continued funding for drug treatment services and to monitor the effectiveness of the treatment system. Without a comprehensive NDTMS dataset, the data in this report will not show an accurate picture of the treatment system and treatment population.

This section is a regular feature of DTMU analysis in order to support ongoing work to improve data quality between treatment agencies, Drug Action Teams, DTMU and the NTA.

Within this report, average length was calculated from length of time in weeks from triage date to discharge date. In addition, to ascertain whether clients left in an unplanned or planned way, it was necessary for clients to have a valid discharge code. This analysis revealed that for some clients, a valid discharge value was provided, but with no corresponding discharge date. The implication is that calculating the length of treatment episode is not accurate.

The following table shows the number of clients who had a valid discharge code but no discharge date. It can be seen that over the last four years, this issue is no longer such a problem due to the fact that there has been ongoing work within DTMU and the region to improve data quality. Systematic checks are carried out every time data is submitted to the NTA to ensure accurate information is provided.

Table 6: Number of clients with a valid discharge reason, but no discharge date, 2005/06 – 2008/09

Discharge Value	2005 - 2006	2006 - 2007	2007 - 2008	2008 - 2009
Dropped out/left	96	4	2	2
Moved Away	1			
Other	2			
Prison	1			
Referred on	22			
Treatment completed	15			
Treatment completed drug free	1	3	2	2
Treatment withdrawn/breach of contract	1			

Appendices

Table 7: AAACCE clients in structured drug treatment by DAAT of residence, 2005/06 – 2008/09

DAAT of Residence	Number of AACCE Clients	% AACCE
Kent	12634	60%
Surrey	8626	61%
Hampshire	5003	44%
Oxfordshire	3748	36%
Buckinghamshire	3574	57%
Medway	2530	52%
East Sussex	2474	38%
West Sussex	2431	38%
Brighton and Hove	1999	31%
Portsmouth	1640	40%
Southampton	1548	40%
Slough	1037	35%
Windsor and Maidenhead	981	53%
Isle of Wight	979	40%
Bracknell Forest	885	63%
West Berkshire	743	46%
Milton Keynes	701	31%
Reading	697	22%
Wokingham	390	38%
South East	52620	47%

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Document purpose	For information, to support work in the field of drug treatment, to help DAATs, PCTS, Local Authorities and other services in the South East region to be more informed about the drug treatment population.
Published by	South East Public Health Observatory, South East Drug Treatment Monitoring Unit
Date published	March 2011
Useful Websites	www.nta.nhs.uk