Public Health England

Protecting and improving the nation's health

Adult substance misuse statistics from the National Drug Treatment Monitoring System (NDTMS)

1 April 2017 to 31 March 2018

National Statistics

The University of Manchester

National Drug Evidence Centre

About Public Health England

Public Health England exists to protect and improve the nation's health and wellbeing, and reduce health inequalities. We do this through world-leading science, knowledge and intelligence, advocacy, partnerships and the delivery of specialist public health services. We are an executive agency of the Department of Health and Social Care, and a distinct delivery organisation with operational autonomy. We provide government, local government, the NHS, Parliament, industry and the public with evidence-based professional, scientific and delivery expertise and support.

Public Health England
Wellington House
133-155 Waterloo Road
London SE1 8UG
Tel: 020 7654 8000
www.gov.uk/phe
Twitter: @PHE_uk
Facebook: www.facebook.com/PublicHealthEngland

Prepared by: Jonathan Knight, Paul Brand, Justin van der Merwe, Brian Eastwood
For queries relating to this document, please contact:
Evidenceapplicationteam@phe.gov.uk

Published November 2018
PHE publications
gateway number: 2018575

PHE supports the UN
Sustainable Development Goals

Contents

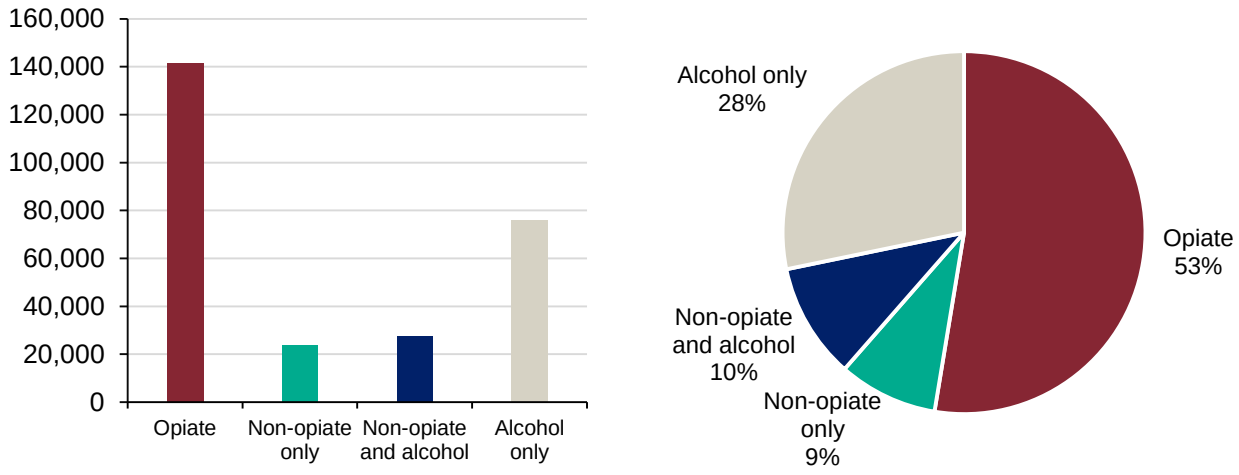
Executive summary

Overview

The National Drug Treatment Monitoring System (NDTMS) statistics report presents information on adults (aged 18 and over) who were receiving help in England for problems with drugs and alcohol during 2017-18. Many people experience difficulties with, and receive treatment for, both substances. While they often share many similarities, they also have clear differences, so this report divides people in treatment into the 4 substance groups:

- opiate –people who are dependent on or have problems with opiates, mainly heroin
- non-opiate – people who are dependent on or have problems with non-opiate drugs, such as cannabis, crack and ecstasy
- non-opiate and alcohol – people who are dependent on or have problems with both non-opiate drugs and alcohol
- alcohol only – people who are dependent on or have problems with alcohol but don't have problems with any other substances

Figure 1: Numbers in treatment by main substance group 2017-18



Trends in numbers in treatment and substance use

There were 268,390 adults in contact with drug and alcohol services in 2017-18, which is a 4% reduction from the previous year (279,793).

The number of people receiving treatment for alcohol alone decreased the most since last year falling by 6%, (80,454 to 75,787) and by 17% from the 91,651 peak in 2013-14.

There were an estimated 589,101 adults with alcohol dependency in need of specialist treatment in 2016-17. These alcohol dependency estimates have remained relatively stable over the last 5 years, which suggests that the falls in the numbers of alcohol-dependent people accessing treatment does not reflect a fall in prevalence, with only one in five of those in need of treatment currently receiving it.

People in treatment for opiates made up the largest proportion of the total numbers in treatment (53% or 141,189). This is a fall of 4% since the previous year.

The number of people entering treatment in 2017-18 who were in the non-opiate group or non-opiate and alcohol group (35,473) was broadly the same as the previous year (35,491). However, the number of people being treated for crack cocaine – people using crack but not opiates – increased by 18% since last year (3,657 to 4,301) and 44% since the year before that (2,980 to 4,301). The increase in 'crack, not opiate' treatment numbers during 2017-18 was seen in all age groups except 65 years and over.

There was also a 3% increase from 2016-17 in people entering treatment for both crack cocaine and opiate problems (21,854 to 22,411), which was seen only in those aged 35 and over. This represents over half (54%) of people entering for opiate problems in 2017-18, compared to 35% in 2005-06.

The latest published estimates of crack cocaine use in England[1] (2014-15) reported a 10% increase in the mid-point estimate of numbers using the substance since 2011-12 (166,640 to 182,828[2]).

It is likely that the recent increase in the number of people entering treatment for crack problems reflects the rise in the prevalence of crack use. The increase in the number of new users may be in part caused by changes in the purity and affordability of crack cocaine and patterns of distribution over the last few years. The latest report from the UK Focal Point on Drugs[3] has information about increases in purity.

---

[1] https://www.gov.uk/government/publications/opiate-and-crack-cocaine-use-prevalence-estimates-for-local-populations

[2] 166,640 (95% confidence interval 161,621-173,706) to 182,828 (95% confidence interval 176,675 - 190,782)

[3] https://www.gov.uk/government/publications/united-kingdom-drug-situation-focal-point-annual-report

New psychoactive substances and club drugs

There were 1,223 people who had problems with new psychoactive substances (NPS) starting treatment in 2017-18, which is a 16% decrease on the previous year (1,450) and a 40% decrease on the year before that (2,042). This fall was mainly driven by a 36% reduction in those under 25 entering treatment for NPS problems (321 in 2016-17 dropping to 206 in 2017-18).

People who start treatment with NPS problems were more likely to be homeless compared to all individuals starting treatment in the year (25% vs 8%). This has increased from 6% in 2013-14.

There was a 7% fall in the number of people entering treatment for ecstasy problems in 2017-18 (1,013 to 939), and a much larger decrease of 53% recorded in the number starting treatment for problematic mephedrone use.

Smoking

For all substance groups, the smoking rates at the start of treatment are substantially higher than the national rate of smoking among adults reported by the Office for National Statistics (ONS)[4] (14.9%). People treated for opiates had the highest reported rates of smoking when starting treatment (68%). This was closely followed by people in treatment for non-opiates and alcohol, and non-opiates only (61% and 57% respectively). Those presenting with problematic alcohol use only had the lowest rates, with 42% smoking at the start of treatment.

Age groups

People in treatment for alcohol only or opiate use tended to be older than those treated for other substances. The median age of alcohol only clients was 46 years, with 12% (8,945) aged 60 years and older. Opiate clients had a median age of 40.

There were 10,666 individuals aged 18 to 24 who started treatment in 2017-18. The majority of these had problems with cannabis (5,791 or 54%), alcohol (4,793 or 45%) or cocaine (3,131 or 29%). Overall, the number of under-25s accessing treatment has fallen by 50% since 2005-06. This reflects changes in the patterns of drinking and drug

[4] https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthandlifeexpectancies/datasets/adultsmokinghabitsinengland

use in this age group over the last 12 years, shown by Public Health England's prevalence estimates[5] and the Home Office's Crime Survey for England and Wales[6]. However, while the number of young adults in treatment is relatively low, there was a 15% increase in under 25s entering treatment for crack cocaine but not opiates from 364 to 417 people. This is the second year running that there has been a rise in people starting treatment for crack cocaine in this age group.

Gender

Males made up 69% of the entire treatment population in 2017-18. The gender split varied depending on the substances people were in treatment for. For example, 73% of people using drugs were male, compared to 60% presenting with alcohol only.

Ethnicity

Individuals recorded as white British made up the largest ethnic group in treatment, (84% or 222,775) with a further 5% from other white groups. No other ethnic group made up more than 1% of the total treatment population.

Parental status and safeguarding children

Information on the parental status of people starting treatment and on safeguarding children and young people has been introduced into the NDTMS annual statistics report for the first time this year. There were 25,593 (20%) people who started treatment in 2017-18 who said they lived with a total of 46,109 children under 18. This figure includes parents living with their biological children and those living with children of a partner or another member of the household.

There were a further 38,852 (31%) who said they were parents but did not currently live with their children. People in treatment for opiates were most likely to have children but not to be living with them (39%), compared to those with alcohol only problems (26%). The majority of parents or people living with children (44,647 or 81%) said that these children were not receiving early help services (as defined in Working Together to Safeguard Children 2018[7]) or engaging children's social care services.

Eight percent (4,409) of parents or people living with children said that a child protection plan was in place. A further 5% (2,688) reported looked after children and

[5] https://www.gov.uk/government/publications/opiate-and-crack-cocaine-use-prevalence-estimates-for-local-populations

[6] https://www.gov.uk/government/statistics/announcements/crime-in-england-and-wales-year-ending-june-2018

[7] https://www.gov.uk/government/publications/working-together-to-safeguard-children--2

3% (1,845) reported engagement with child in need services and a further 3% reported engagement with early help services (1,699).

Mental health

Information on whether a person starting treatment has a mental health need has also been introduced into this report for the first time this year. Of those starting treatment where a mental health status was recorded, 52,397 individuals (41%) said they had a mental health treatment need. People in the non-opiate and alcohol group had the highest levels of a mental health treatment need (47%) and opiate users had the lowest (39%). It is very common for people to experience problems with their mental health and alcohol or drug use at the same time and research published by the American Psychological Association[8] shows that people with these co-occurring conditions have a greater risk of other health problems and early death.

Three quarters of people reporting a mental health treatment need (75% or 38,646) also said that they were currently receiving treatment for their mental health. Just under half of those with a mental health treatment need (48% or 24,767) received treatment from their GP in Primary Care and a further 22% (11,542) were engaged with community mental health services.

Treatment exits and successful completions

There were 121,332 individuals that exited the drug and alcohol treatment system in 2017-18, with 48% (58,718) having successfully completed their treatment free of dependence. This compares to 49% the previous year.

Alcohol only clients had the highest rates of successful treatment exits, with 61% completing treatment successfully, the same proportion as the previous year. Non-opiate only clients followed this, with 56% leaving successfully, a decrease from 59%.

Opiate clients had the lowest rate of successful exits at 26%. This was the same as last year but down from a peak of 37% in 2011-12. A large proportion of the opiate users in treatment have entrenched long-term drug use, are often in ill health and less likely to have access to the personal and social resources that can aid recovery, such as employment and stable housing. This often results in opiate users being less likely to complete treatment successfully or sustain their recovery, when compared to people who use other drugs or alcohol alone.

[8] http://psycnet.apa.org/record/2011-20197-009

Deaths

The total number of people who died while in contact with treatment services in 2017-18 was 2,660 (1% of all individuals in treatment). This is similar to the previous year when there were 2,680 deaths in treatment (1% of all individuals in treatment).

The number of opiate clients who died in treatment decreased very slightly since the previous year from 1,741 to 1,712. Deaths as a proportion of all opiate clients in treatment remained at 1%. The median age of opiate clients recorded as having died in 2017-18 was 45 and 77% were male.

The number of deaths for users of other drugs rose slightly from 172 in 2016-17 to 174 in 2017-18.

Drug use is a significant cause of premature mortality in the UK, as ONS statistics have shown[9]. In England, the number of deaths from drug misuse registered in 2017 decreased by 3.2% to 2,310. This is the first decrease since 2012 and follows increases of 3.7% between 2015 and 2016, 8.5% between 2014 and 2015 and 17.0% between 2013 and 2014.

The number of registered heroin deaths decreased by 3.7% from 1,209, the highest number on record, in 2016 to 1,164 in 2017. Treatment has been demonstrated to provide some protection against drug-related deaths and these numbers would likely be even higher without the harm reduction safeguards it provides.

There were 774 deaths in 2017-18 among people accessing treatment for alcohol problems only, which was a 1% increase on the previous year. Deaths as a proportion of all people in treatment for alcohol only were 1%. The median age of these deaths was 50 and 64% were male.

[9] https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsrelatedtodrugpoisoninginenglandandwales/2017registrations

1. Background and policy context

1.1 Background to the data and other relevant data sources

This report is intended for anyone wishing to understand the availability and effectiveness of alcohol and drug treatment in England and the profile of individuals accessing treatment.

The report presents statistics submitted by services delivering structured substance misuse interventions. These services are vital components of local authority alcohol and drug treatment and recovery systems, and the interventions they deliver can improve the lives of individuals, and the life chances of their children. They also have a significant impact in reducing drug and alcohol-related ill health and death, the spread of blood-borne viruses and in reducing crime. The harmful effects of alcohol and drugs are greater in poorer communities and effective treatment services can play an important role in addressing these inequalities.

The statistics in this publication come from analysis of the National Drug Treatment Monitoring System (NDTMS), which collects data on treatment delivery from approximately 900 sites, covering every local authority in England. Treatment centres returning data to NDTMS include community-based and specialist outpatient drug and alcohol services and GP surgeries, as well as residential rehabilitation centres and inpatient units. Information is collected on the demographics and personal circumstances of those receiving treatment as well as details of the interventions delivered to them and associated outcomes. This information is analysed centrally and reported as aggregated statistics. Information on the history of specialist drug and alcohol treatment data collection can be found in chapter nine of this report.

While the activity covered in this report represents an important part of the response to substance misuse it does not reflect all it. In addition to specialist treatment recorded by NDTMS, there are a range of responses that local areas should have in place to address alcohol and drug misuse effectively. These include: effective use of licensing powers to manage access to alcohol; widespread alcohol identification and brief advice (IBA); hospital alcohol care teams; information and advice on reducing harm; needle and syringe programmes, and outreach work. There will also be broader but related support provided to those with alcohol and drug problems such as safeguarding, parenting and family support, access to housing, housing support, employment and training opportunities.

Many of those seeking help from the alcohol and drug treatment system will have experienced problems with a combination of substances in their lives and will often require treatment to address underlying issues of dependence that are not specific to

their use of any one substance. Alcohol in particular is often cited as problematic in combination with illicit drugs. Local authorities commonly commission integrated alcohol and drug treatment services and to reflect this alcohol and drug treatment is reported together.

These statistics provide information on the numbers of people accessing treatment for their alcohol and/or drug use, however they do not give an indication of treatment need or all the harms associated with drug and alcohol use.

For information on the wider harms associated with alcohol use, PHE's fingertips website contains the Local Alcohol Profiles for England (LAPE), which present a comprehensive picture of the impact of alcohol on health and social harms locally, as well as information on mortality from alcohol-related conditions: https://fingertips.phe.org.uk/profile/local-alcohol-profiles

Estimates of the number of individuals using opiates and/or crack cocaine in 2014-15 reported nationally and by local authority and the estimated number of adults with opiate dependence that have children living in the same household and the number of children, are available here: https://www.gov.uk/government/publications/opiate-and-crack-cocaine-use-prevalence-estimates-for-local-populations

Estimates of the number of adults with a dependence on alcohol in 2014-15 reported nationally and by local authority and the estimated number of adults with alcohol dependence that have children living in the same household and the number of children in that year, are available here: https://www.gov.uk/government/publications/alcohol-dependence-prevalence-in-england

The 2019-20 commissioning support pack is published here: https://www.gov.uk/government/publications/alcohol-drugs-and-tobacco-commissioning-support-pack

Information on the total number of people in alcohol and drug treatment in each local authority in England, the number commencing it each year, and the number leaving treatment can be found at: https://www.ndtms.net/

1.2 The policy context

In England in 2016-17, there were over a million hospital admissions and over 23,800 deaths from alcohol-related conditions including around 5,500 deaths from conditions that are wholly caused by alcohol. 82% of these deaths were from alcohol-related liver disease. Deaths from liver disease in England have increased 400% since 1970. Alcohol treatment supports sustained abstinence among dependent drinkers, which is a crucial factor in surviving alcohol-related liver disease or halting existing damage.

The government has committed to developing a new alcohol strategy which will set out targeted action to prevent and reduce harmful drinking, support vulnerable people affected by others' alcohol misuse and improve the pathways into treatment for people with alcohol dependence.

Ahead of the publication of the strategy work has started on a package of support for children of alcohol dependent parents. This includes a three year £4.5m innovation fund for a limited number of local authorities; £1m to allow voluntary and community sector organisations to improve capacity in the sector; and £0.5m to allow an existing helpline to extend their work with children in these circumstances.

https://www.gov.uk/government/news/new-support-to-help-children-living-with-alcohol-dependent-parents

Four out of 5 adults with alcohol dependence are currently not receiving treatment. The average level of unmet need for alcohol treatment at a national level is 82% with wide local variation. Levels of unmet need for alcohol treatment reported by local authority can be found here:
https://healthierlives.phe.org.uk/topic/public-health-dashboard

While levels of unmet need for alcohol treatment are high, there has been a significant falling trend in the number of adults entering treatment for alcohol dependence, since a peak in 2013-14. Earlier in 2018 PHE carried out an inquiry to better understand the factors behind this fall in numbers. The report on the enquiry can be found here:

Between May 2018 and March 2020, PHE is leading a randomised controlled trial of the individual placement and support (IPS) approach to employment support for people in drug and alcohol treatment. It was one of the key recommendations in Dame Carol Black's December 2016 report, 'An independent review into the impact on employment outcomes of drug or alcohol addiction, and obesity'.

In August this year the Ministry of Housing Communities and Local Government published a rough sleeping strategy. The new strategy will be updated annually and is seen by the government as the beginning of the process of meeting the manifesto commitment to halve rough sleeping by the end of this Parliament and to end it by 2027.

The strategy has a significant focus on the co-occurring substance misuse, mental health and physical health needs of rough sleepers.

https://www.gov.uk/government/publications/the-rough-sleeping-strategy

Last year the Home Office published the Government's updated 2017 Drug Strategy, which aims to do more to address the complex and evolving challenges of drug misuse, including through effective partnership working between treatment providers, the criminal justice system, housing and employment support. The Home Secretary recently announced an independent review of misuse.

https://www.gov.uk/government/publications/drug-strategy-2017

In April 2018 the Government published its Serious Violence Strategy, which sets out the government's response to serious violence and recent increases in knife crime, gun crime and homicide. It identified drugs as a key driver of recent increases in serious violence. PHE is working with closely with the Home Office to understand the factors underlying the increase in crack cocaine use and to establish and support new Heroin and Crack Action Areas (HACAAs).

https://www.gov.uk/government/publications/serious-violence-strategy

Drug-related deaths (DRDs) have risen significantly in recent years, with heroin deaths doubling from 2012-15, though the number fell slightly in 2017 it still remains at a high level. The numbers of deaths involving cocaine, NPS, gabapentinoids and opioid pain medicines have also risen. A spate of fentanyl deaths in 2016-17 prompted increased efforts to prepare for any future threat from potent opioids, including providing more naloxone.

https://www.gov.uk/government/publications/fentanyl-preparing-for-a-future-threat

PHE is launching a programme of work to improve the quality of Opioid Substitution Therapy (OST), the OST Good Practice Programme. PHE's drugs evidence review published in 2017 indicated that the English treatment system achieves outcomes comparable to, or performs better than, most other countries, but suggested areas where outcomes could potentially be improved. These areas will be the main focus of the OST Good Practice Programme which PHE will develop in collaboration with service providers, commissioners and service users.

Outside the problem of illicit drug use, there is concern about the problems caused by some prescribed medicines. PHE was commissioned to conduct a public health evidence review of available data and published evidence on dependence and withdrawal symptoms associated with benzodiazepines, Z-drugs, GABA-ergic medicines, opioid pain medicines and antidepressants, and how they can be prevented and treated. The review will report in spring 2019.

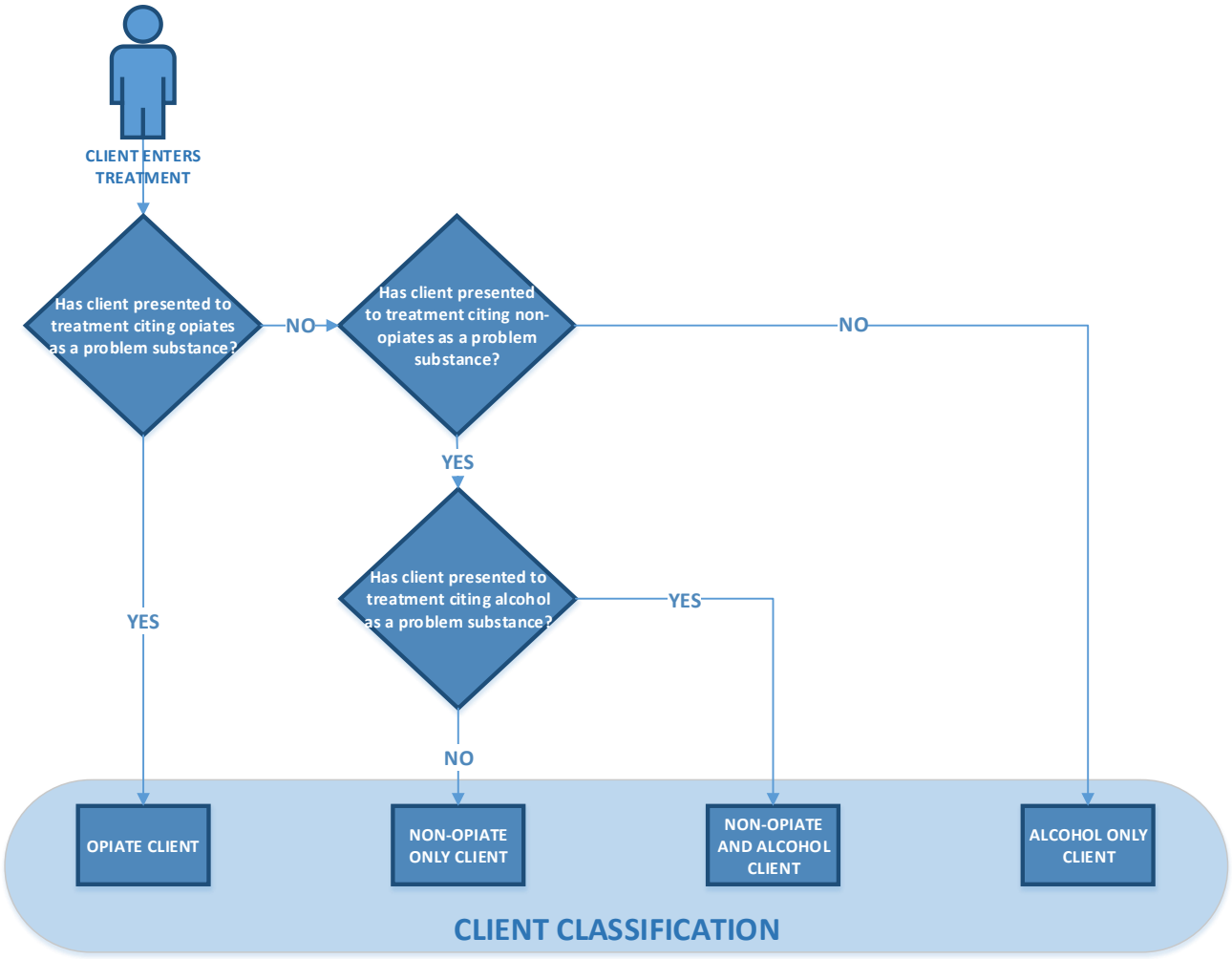
https://www.gov.uk/government/collections/prescribed-medicines-an-evidence-review

2. Client classification

Individuals presenting to adult alcohol and drug treatment services are categorised by the substances they cite as problematic at the start of treatment. They are categorised by the following hierarchal criteria:

- any mention of opiate use in any episode would result in the client being categorised as an OPIATE client (irrespective of what other substances are cited)
- clients who present with non-opiate substances (and not opiates or alcohol) will be classified as NON-OPIATE ONLY
- clients who present with a non-opiate substance *and* alcohol (but not opiates) recorded in any drug in any episode in their treatment journeys will be classified as NON-OPIATE AND ALCOHOL
- clients who present with alcohol and no other substances will be categorised as ALCOHOL ONLY

This classification method is illustrated in the diagram below.



3. Assessment of quality and robustness of 2017-18 NDTMS community data

NDTMS data is routinely collected by PHE. Drug and alcohol treatment providers submit a monthly extract that, from 2017, is automatically validated by the NDTMS collection system. Data submissions are automatically aggregated and reconciled against previous submissions to create a single national data submission. PHE operates a continual programme of improvement and treatment providers work with their local NDTMS team to improve each monthly submission throughout the year.

NDTMS data quality is extremely important as it provides PHE with assurances that the data is an accurate representation of actual activity and it is therefore usable and reliable. It also gives confidence to the user of these statistics that the appropriate checks and balances have been applied.

This report uses four new variables, three were first introduced in April 2017; clients identified as having a mental health treatment need, the mental health treatment they received and whether the children of clients were engaged with any early help. The fourth variable, family status, was introduced to NDTMS in April 2006. This has now been included as data completeness has reached a suitable level (99.4%). Data completeness of the new variables is lower than the rest of the dataset (mental health treatment need 91%, mental health treatment received 98% and children engaged in early help 86%). Data completeness is expected to rise over time for these variables as the reporting process beds in across the treatment system.

Table 3.1 provides an overview of the quality of data submitted to NDTMS from 2014-15 to 2016-17, the period prior to the new data submission process outlined above. The proportion of valid records received out of all submitted records along with the proportion of records received without errors or warnings are included as they indicate the general level of data quality across the broad spectrum of information collected at each monthly data submission. Four additional indicators are also included below that report the proportion of duplicate or overlapping treatment interventions and episodes. These are reported as they provide a sense of how accurate and efficient record keeping is at treatment provider level. A low proportion is desirable as it demonstrates robust administrative functions at a national level.

Table 3.1 Data quality of NDTMS

Data quality measure	2014-15	2015-16	2016-17
Proportion of submitted records that were valid	99.92%	99.99%	99.99%
Proportion of records without errors or warnings	99.90%	99.98%	99.90%
Proportion of duplicate treatment episodes recorded at the same provider	0.05%	0.03%	0.01%
Proportion of overlapping treatment episodes recorded at the same provider	0.05%	0.03%	0.01%
Proportion of duplicate treatment interventions recorded at the same provider	0.02%	0.01%	0.02%
Proportion of overlapping treatment interventions recorded at the same provider	0.02%	0.01%	0.01%

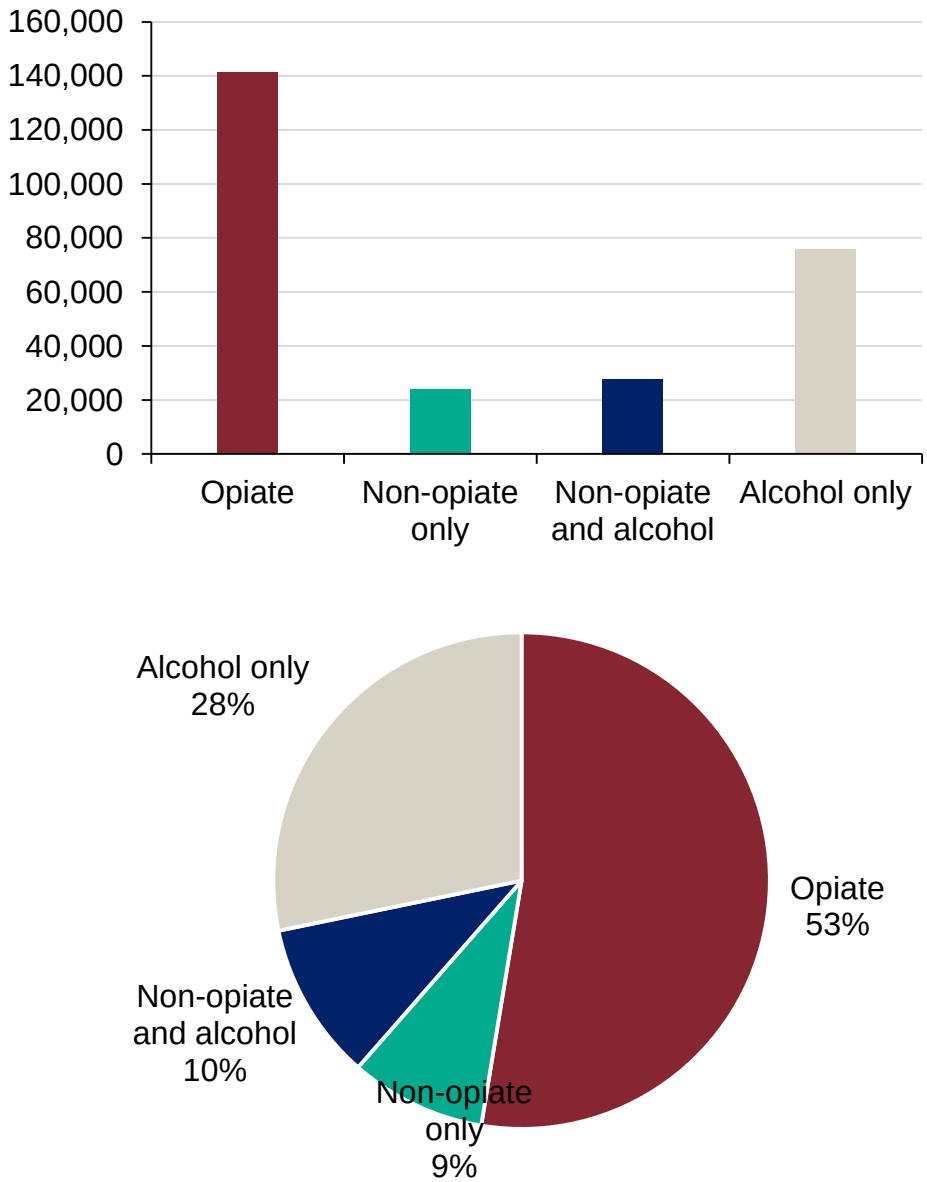
More detailed information on NDTMS data collection and full definitions for the data quality measures recorded in Table 3.1 can be found at: https://www.ndtms.net/resources/public/Quality-and-Methodology-NDTMS-2017-18.pdf

In addition to the data quality checks taken at data submission, there are data quality checks and validation rules used in the production of this report. The items in this report range from 100% completion rates to 86%. Where under 100% this is either due to missing data for a client for that item or inconsistent data where there is conflicting information for the same individual.

4. Characteristics of clients

NDTMS reported a total of 268,390 individuals aged 18 to 99 in contact with structured treatment in 2017-18. Individuals can access treatment for either problematic drug use, alcohol use or both. Throughout this report, the four main substance groups as outlined in Section 2 are used. The segmentation of individuals accessing treatment is presented in Figure 4 below. Just over half the clients in contact with treatment during the year (53%) had presented with problematic use of opiates, a further 19% had presented with problems with other drugs and just over a quarter (28%) had presented with alcohol as the only problematic substance.

Figure 4: Numbers in treatment by main substance group 2017-18



4.1 Substance use profile (all in treatment)

The distribution of substances for all individuals in treatment in 2017-18 is shown in Table 4.1.1 and Figure 4.1.1.

Nearly half (45%) of opiate clients also reported using crack cocaine and 20% reported problematic alcohol use. Other drugs reported by opiate clients included cannabis (17%) and benzodiazepines (10%). Cannabis was the main problematic illicit substance for non-opiate only clients (58%) and non-opiate and alcohol clients in treatment in 2017-18 (55%). Cocaine was reported by 36% of the non-opiate only client group and 47% of the non-opiate and alcohol group.

Overall, almost half (49%) of clients in treatment in 2017-18 presented with problematic alcohol use, the majority of whom (75,787, 58%) presented with alcohol alone. Problematic opiate use was reported by 53% of the treatment population and 26% reported crack cocaine.

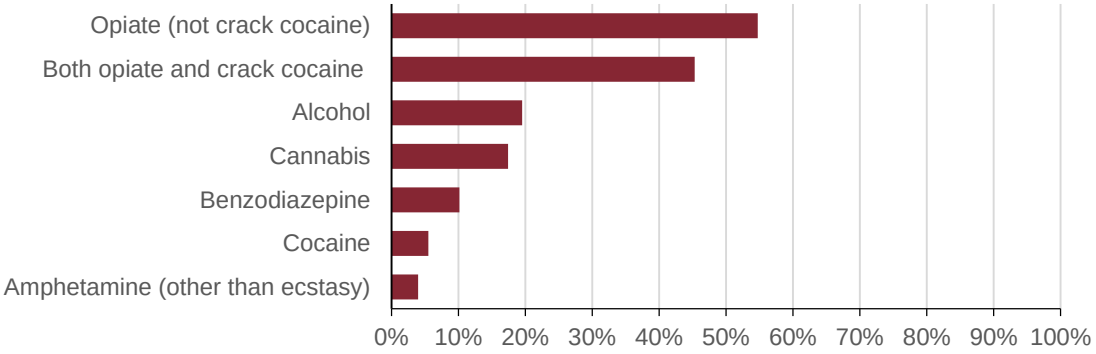
Table 4.1.1: Substance breakdown of all clients in treatment 2017-18

Substance	Opiate		Non-opiate only		Non-opiate and alcohol		Alcohol only		Total	
	n	%	n	%	n	%	n	%	n	%
Opiate and/or crack cocaine use										
Opiate (not crack cocaine)	77,248	55%	-	0%	-	0%	-	0%	77,248	29%
Both opiate and crack cocaine	63,941	45%	-	0%	-	0%	-	0%	63,941	24%
Crack cocaine (not opiate)	-	0%	3,099	13%	3,000	11%	-	0%	6,099	2%
Other drug use										
Cannabis	24,603	17%	13,688	58%	15,155	55%	-	0%	53,446	20%
Cocaine	7,789	6%	8,557	36%	13,082	47%	-	0%	29,428	11%
Benzodiazepine	14,349	10%	1,583	7%	1,112	4%	-	0%	17,044	6%
Amphetamine (other than ecstasy)	5,617	4%	2,359	10%	1,781	6%	-	0%	9,757	4%
Other drug [2]	1,874	1%	999	4%	521	2%	-	0%	3,394	1%
Hallucinogen	317	0%	670	3%	389	1%	-	0%	1,376	1%
Other prescription drug	459	0%	168	1%	142	1%	-	0%	769	0%
Anti-depressant	295	0%	27	0%	46	0%	-	0%	368	0%
Solvent	112	0%	92	0%	118	0%	-	0%	322	0%
Major tranquiliser	134	0%	30	0%	28	0%	-	0%	192	0%
Barbiturate	46	0%	7	0%	6	0%	-	0%	59	0%
Alcohol										
Alcohol	27,537	20%	-	0%	27,684	100%	75,787	100%	131,008	49%
Total number of individuals [1]	141,189	100%	23,730	100%	27,684	100%	75,787	100%	268,390	100%

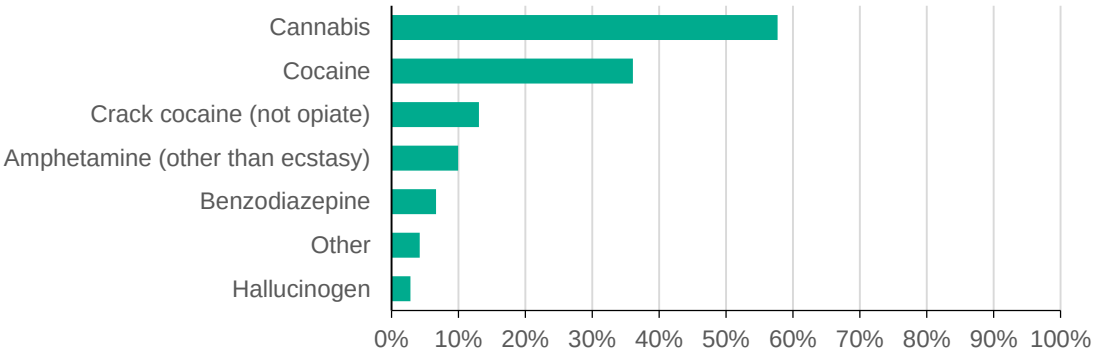
[1] The total number of individuals will be less than the sum of the reported substances as an individual may present with more than one problematic substance
[2] Other drug includes all other substances not listed in the table above except for ecstasy and NPS (see table 4.1.2)
Note: Percentages may equal 0% or not sum to 100% due to rounding

Figure 4.1.1: Substance breakdown of all clients in treatment 2017-18

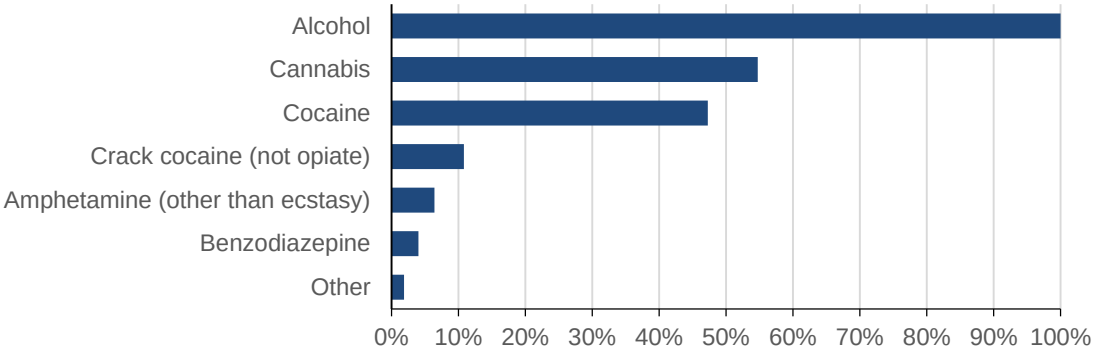
Opiate



Non-opiate



Non-opiate and alcohol



All clients

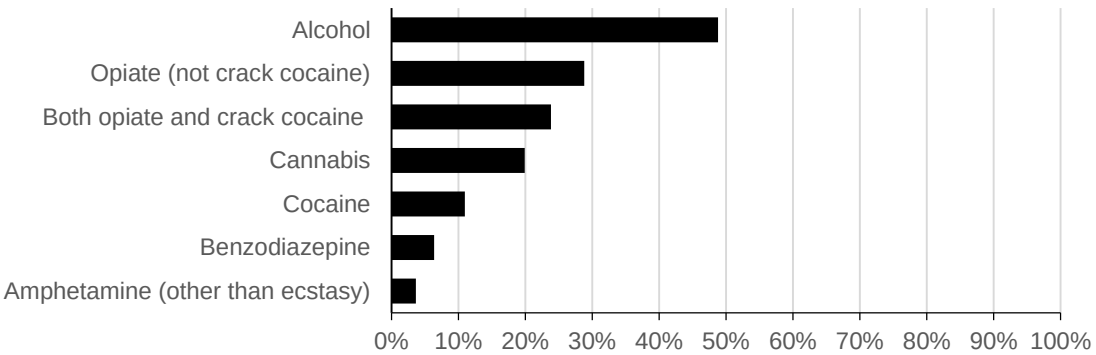


Table 4.1.2 presents a breakdown of substances that are categorised under a heading of 'club drugs and new psychoactive substances (NPS)'. NPS is a collective term for a number of different substances typically used by people in bars and nightclubs, at concerts and parties, before and after a night out. Overall, 2.2% of the treatment population reported problems with club drugs/NPS and these drugs were represented more prominently in the non-opiate only client group (10.2% of individuals) and the non-opiate and alcohol group (5.5% of individuals).

NPS was the most reported substance in this category (0.8% of the treatment population) followed by ecstasy (0.6%) and ketamine (0.4%). The actual drugs that fall under the category of NPS can change over time as new drugs are developed. As such, NDTMS collects more detailed information on NPS based on a description of the predominant effect the drug has on the user. NPS drugs with a predominantly cannabinoid effect account for more than half of individuals citing NPS (56%).

Table 4.1.2: Club drugs and new psychoactive substances breakdown of all clients in treatment 2017-18

Club drug and new psychoactive substances	Opiate		Non-opiate only		Non-opiate and alcohol		Total	
	n	%	N	%	N	%	n	%
Mephedrone	315	0.2%	255	1.1%	119	0.4%	689	0.3%
New psychoactive substances	1,103	0.8%	630	2.7%	341	1.2%	2,074	0.8%
Ecstasy	318	0.2%	734	3.1%	623	2.3%	1,675	0.6%
Ketamine	196	0.1%	600	2.5%	340	1.2%	1,136	0.4%
GHB/GBL	42	0.0%	304	1.3%	84	0.3%	430	0.2%
Methamphetamine	92	0.1%	372	1.6%	97	0.4%	561	0.2%
Further breakdown of new psychoactive substances[2]:								
Predominantly cannabinoid	631	0.4%	356	1.5%	177	0.6%	1,164	0.4%
Predominantly stimulant	89	0.1%	65	0.3%	36	0.1%	190	0.1%
Other	293	0.2%	145	0.6%	88	0.3%	526	0.2%
Predominantly sedative/opioid	63	0.0%	34	0.1%	15	0.1%	112	0.0%
Predominantly hallucinogenic	35	0.0%	30	0.1%	19	0.1%	84	0.0%
Predominantly dissociative	11	0.0%	11	0.0%	11	0.0%	33	0.0%
Total number of citations[1]	2,066	1.5%	2,895	12.2%	1,604	5.8%	6,565	2.4%
Total number of individuals[3]	2,025	1.4%	2,423	10.2%	1,516	5.5%	5,964	2.2%
Total number in treatment	141,189	100%	23,730	100%	27,684	100%	268,390	100%

[1] This is the number of club drugs/NPS substance classes cited by individuals in 2017-18
[2] This is a breakdown of the citations for the NPS clients cited above. It may sum to more than the NPS total as a client may have multiple citations.
[3] This is a count of the individual clients from the top half of the table. It may sum to less than the total of the categories above as a client may have multiple citations.
Note: Percentages may equal 0% or not sum to 100% due to rounding

4.2 Age of clients (all in treatment)

The age distribution of all individuals in treatment in 2017-18 is shown in Table 4.2.1 and Figure 4.2.1. Age is calculated on April 1st for clients already in treatment at that point or at the start of treatment for clients starting treatment in the year. The largest age group for opiate clients was 35-39 years old, representing nearly a quarter of clients

(23%). For non-opiate and alcohol clients the larget group was 30-34 years old (18%) and for non-opiate only clients it was 25-29 years old (21%). Alcohol only clients are more represented in the older age groups, with the largest being 45-49 years old (17%). In total, almost 12% of alcohol only clients were aged 60 or over, compared with less than 3% of the other drug groups combined.

When compared to the median age (the middle number in an ascending list of all ages) of the adult English general population (47 years), alcohol only clients in treatment in 2017-18 tended to be around the same age (46 years). All other groups tended to be younger, with opiate clients having a median age of 40, non-opiate only clients having a median age of 30 and non-opiate and alcohol clients having a median age of 34.

http://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/bulletins/annualmidyearpopulationestimates/mid2016

On average individuals are most likely to start using drugs in their late teens and early twenties.

The distribution of ages of individuals in treatment reflects patterns seen in estimates of prevalence of drug use, with the latest published estimates for 2014-15 showing a significant increase in those aged 35 and over who use opiates (130,628 in 2010-11 to 163,180 in 2014-15). A large proportion of heroin/opiate users in treatment in 2017-18 will have started using heroin in the epidemics of the 1980s and 1990s and are now over 40 years of age, having been using heroin for a significantly long period of time.

https://www.gov.uk/government/publications/opiate-and-crack-cocaine-use-prevalence-estimates-for-local-populations

Those who use other substances tend to be younger, as can be seen in figures 1.3, 1.4 and 1.5 in the 2017-18 Crime Survey for England and Wales. This survey shows that cannabis, ecstasy and powder cocaine are the most commonly used substances for 16-24 year olds with, for example, 16.7% having used cannabis in the last year (compared to 7.2% for the general population aged 16-59).

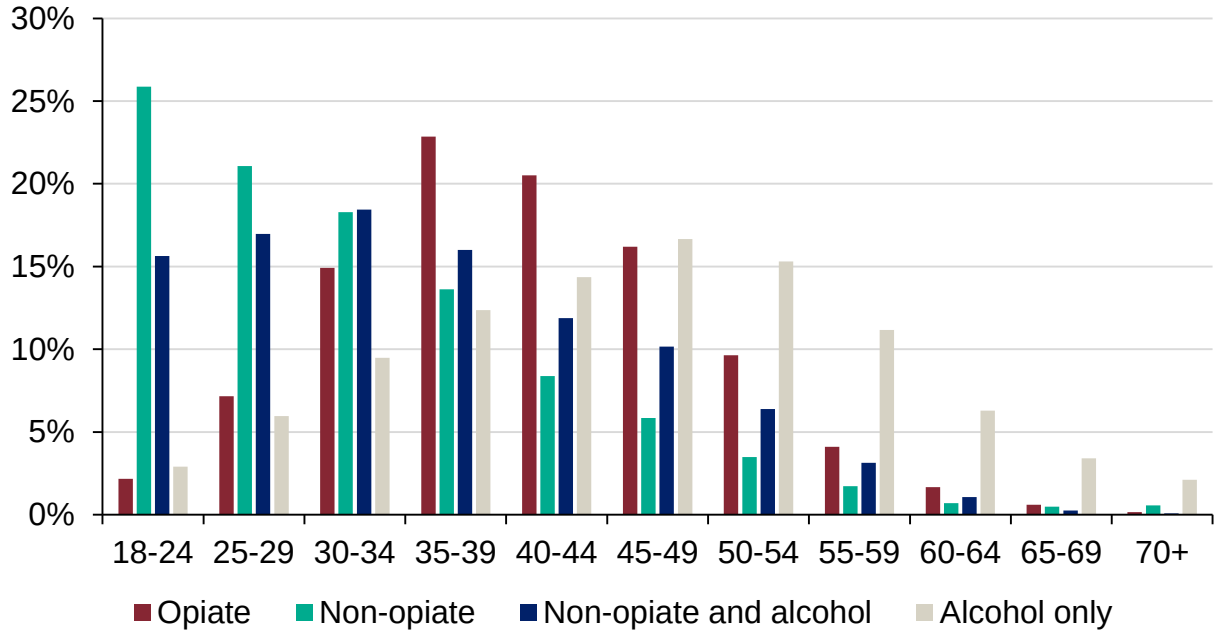
https://www.gov.uk/government/statistics/drug-misuse-findings-from-the-2017-to-2018-csew

Table 4.2.1: Age of all clients in treatment 2017-18

Age	Opiate		Non-opiate only		Non-opiate and alcohol		Alcohol only		Total	
	n	%	n	%	n	%	n	%	n	%
18	116	0%	948	4%	721	3%	204	0%	1,989	1%
19	184	0%	829	3%	483	2%	176	0%	1,672	1%
20-24	2,772	2%	4,361	18%	3,122	11%	1,824	2%	12,079	5%
25-29	10,114	7%	5,001	21%	4,698	17%	4,516	6%	24,329	9%
30-34	21,067	15%	4,337	18%	5,106	18%	7,184	9%	37,694	14%
35-39	32,263	23%	3,234	14%	4,431	16%	9,369	12%	49,297	18%
40-44	28,968	21%	1,987	8%	3,288	12%	10,880	14%	45,123	17%
45-49	22,876	16%	1,388	6%	2,813	10%	12,624	17%	39,701	15%
50-54	13,612	10%	827	3%	1,770	6%	11,602	15%	27,811	10%
55-59	5,784	4%	408	2%	869	3%	8,463	11%	15,524	6%
60-64	2,350	2%	165	1%	295	1%	4,761	6%	7,571	3%
65-69	850	1%	113	0%	68	0%	2,579	3%	3,610	1%
70+	233	0%	132	1%	20	0%	1,605	2%	1,990	1%
Total	141,189	100%	23,730	100%	27,684	100%	75,787	100%	268,390	100%

Note: Percentages may equal 0% or not sum to 100% due to rounding

Figure 4.2.1 Age distribution of all clients in treatment 2017-18



4.3 Gender of clients (all in treatment)

The gender distribution for all clients in treatment, segmented by the four substance groups, is shown in Table 4.3.1. Almost three quarters of opiate clients were male (73%), which broadly reflects the estimated prevalence of opiate users throughout England (76%).

https://www.gov.uk/government/publications/opiate-and-crack-cocaine-use-prevalence-estimates-for-local-populations

However, in terms of alcohol only, females represented 40% of those in treatment compared with an estimated prevalence of 23% in the problematic alcohol using population in England.

https://www.gov.uk/government/publications/alcohol-dependence-prevalence-in-england

Non-opiate only and non-opiate and alcohol clients were mostly male (72% and 73% respectively), which may reflect findings from the 2017-18 Crime Survey for England and Wales where almost twice as many males aged 16 to 59 (11.8%) had taken an illicit drug in the last year, compared to 6.2% of females.

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/729249/drug-misuse-2018-hosb1418.pdf

Table 4.3.1: Gender of all clients in treatment 2017-18

Substance category	Male		Female		Persons
	n	% of gender	n	% of gender	n
Opiate	102,803	73%	38,386	27%	141,189
Non-opiate	17,120	72%	6,610	28%	23,730
Non-opiate and alcohol	20,279	73%	7,405	27%	27,684
Alcohol only	45,668	60%	30,119	40%	75,787
Total	185,870	69%	82,520	31%	268,390

4.4 Ethnicity of clients (all in treatment)

The ethnic breakdown of all individuals in treatment in 2017-18 is shown in Table 4.4.1. Almost all clients (98.3%) provided this information and, of those who did, most individuals (84%) were white British (compared to 80% of the English population[10]). This ranged from 85% of opiate only and alcohol only clients to 79% of non-opiate only clients. The 'other white' group was the next most common ethnicity (4%) compared to 5% of the English population. No non-white ethnic group accounted for more than 1% of the overall total, although those identifying as Caribbean made up 4% of the non-opiate only and the non-opiate and alcohol groups.

[10] For ethnicity data please see: 2011 Census: KS201EW Ethnic group, local authorities in England and Wales https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/employmentandemployeetypes/bulletins/keystatisticsandquickstatisticsforlocalauthoritiesintheunitedkingdom/2013-12-04

Table 4.4.1: Ethnicity of all clients in treatment 2017-18

Ethnicity	Opiate		Non-opiate only		Non-opiate and alcohol		Alcohol only		Total	
	n	%	n	%	n	%	n	%	n	%
White British	117,280	85%	18,762	79%	22,782	83%	63,951	85%	222,775	84%
Other white	5,579	4%	851	4%	860	3%	3,057	4%	10,347	4%
Not stated	1,782	1%	645	3%	549	2%	1,716	2%	4,692	2%
White Irish	1,420	1%	179	1%	355	1%	1,174	2%	3,128	1%
Indian	1,593	1%	191	1%	280	1%	1,260	2%	3,324	1%
Caribbean	1,185	1%	571	2%	490	2%	492	1%	2,738	1%
White and black Caribbean	1,232	1%	393	2%	416	2%	402	1%	2,443	1%
Pakistani	1,514	1%	347	1%	169	1%	277	0%	2,307	1%
Other Asian	1,349	1%	219	1%	153	1%	549	1%	2,270	1%
Other	1,208	1%	215	1%	163	1%	442	1%	2,028	1%
Other black	779	1%	332	1%	293	1%	390	1%	1,794	1%
African	401	0%	295	1%	343	1%	639	1%	1,678	1%
Other mixed	742	1%	261	1%	237	1%	317	0%	1,557	1%
Bangladeshi	928	1%	137	1%	82	0%	105	0%	1,252	0%
White and Asian	415	0%	90	0%	100	0%	162	0%	767	0%
White and black African	277	0%	102	0%	80	0%	134	0%	593	0%
Chinese	38	0%	14	0%	8	0%	26	0%	86	0%
Total	137,722	100%	23,604	100%	27,360	100%	75,093	100%	263,779	100%
Inconsistent/missing	3,467		126		324		694		4,611	
Total	141,189		23,730		27,684		75,787		268,390	

Note: Percentages may equal 0% or not sum to 100% due to rounding

4.5 Disability (new presentations)

NDTMS allows for up to three self-defined disabilities to be recorded per client and these are shown in Table 4.5.1 for those who started treatment during 2017-18. Around one in five (21%) clients reported at least one disability, which was broadly similar across the four substance groups and is similar to the most recent census data (2011/12 covering England and Wales) where 18% cited at least one impairment11. Behaviour and emotional disability was the most common disability type and was reported by 10% of those starting treatment. The next most common disability reported was mobility and gross motor (5%).

[11] For disability data please see: 2011 Census: England and Wales. https://visual.ons.gov.uk/disability-census/

Table 4.5.1: Disability, new presentations to treatment 2017-18

Disability	Opiate		Non-opiate only		Non-opiate and alcohol		Alcohol only		Total	
	n	%	n	%	n	%	n	%	n	%
Behaviour and emotional	4,352	11%	1,834	11%	2,181	12%	4,725	9%	13,092	10%
Hearing	217	1%	102	1%	138	1%	466	1%	923	1%
Manual dexterity	206	1%	51	0%	68	0%	254	1%	579	0%
Learning disability	857	2%	641	4%	561	3%	970	2%	3,029	2%
Mobility and gross motor	1,969	5%	430	3%	596	3%	2,830	6%	5,825	5%
Perception of physical danger	97	0%	15	0%	42	0%	88	0%	242	0%
Personal, self-care and continence	168	0%	36	0%	66	0%	221	0%	491	0%
Progressive conditions and physical health	1,456	4%	333	2%	470	3%	1,787	4%	4,046	3%
Sight	269	1%	77	0%	104	1%	444	1%	894	1%
Speech	41	0%	27	0%	23	0%	85	0%	176	0%
Other	1,146	3%	333	2%	439	2%	1,282	3%	3,200	3%
Not stated	3,149	8%	1,073	6%	1,214	6%	3,494	7%	8,930	7%
Total citations[1]	13,927		4,952		5,902		16,646		41,427	
No disability	28,405	69%	11,228	67%	12,709	68%	35,070	69%	87,412	69%
Any disability	9,035	22%	3,300	20%	3,879	21%	10,827	21%	27,041	21%
Not stated	2,875	7%	1,004	6%	1,079	6%	3,105	6%	8,063	6%
Inconsistent/missing	863	2%	1,184	7%	1,090	6%	1,654	3%	4,791	4%
Total individuals	41,178	100%	16,716	100%	18,757	100%	50,656	100%	127,307	100%

[1] The total number of disabilities cited can be greater than the total number of individuals as people can report more than one disability

4.6 Religion (new presentations)

The self-reported religion of new presentations to treatment is shown in Table 4.6.1. Of the 96% who provided this information, over half (53%) reported no religion. The most common religion was Christian, reported by around a quarter (26%), followed by Muslim (2%). This contrasts with figures from the 2011 census[12] where only 25% of the general population reported no religion and 59% identified as Christian.

[12] For religion data please see: 2011 Census: England and Wales.
https://www.ons.gov.uk/peoplepopulationandcommunity/culturalidentity/religion/articles/religioninenglandandwales2011/2012-12-11

Table 4.6.1: Religion, new presentations to treatment 2017-18

Religion	Opiate		Non-opiate only		Non-opiate and alcohol		Alcohol only		Total	
	n	%	n	%	n		n	%	n	%
Baha'i	8	0%	2	0%	1	0%	5	0%	16	0%
Buddhist	243	1%	50	0%	78	0%	169	0%	540	0%
Christian	9,522	24%	3,126	20%	3,958	22%	14,943	30%	31,549	26%
Hindu	138	0%	40	0%	59	0%	329	1%	566	0%
Jain	5	0%	1	0%	2	0%	6	0%	14	0%
Jewish	49	0%	31	0%	23	0%	45	0%	148	0%
Muslim	1,298	3%	571	4%	377	2%	508	1%	2,754	2%
Pagan	104	0%	36	0%	33	0%	85	0%	258	0%
Sikh	341	1%	52	0%	81	0%	460	1%	934	1%
Zoroastrian	7	0%	1	0%	-	0%	1	0%	9	0%
Other	1,194	3%	425	3%	543	3%	1,420	3%	3,582	3%
None	21,610	54%	9,142	59%	10,198	58%	24,514	50%	65,464	53%
Decline	1,736	4%	669	4%	836	5%	2,322	5%	5,563	5%
Unknown	3,941	10%	1,326	9%	1,420	8%	4,430	9%	11,117	9%
Total	40,196	100%	15,472	100%	17,609	100%	49,237	100%	122,514	100%
Inconsistent/missing	982		1,244		1,148		1,419		4,793	
Total	41,178		16,716		18,757		50,656		127,307	

4.7 Sexual Orientation (new presentations)

The sexual orientation of clients starting treatment in 2017-18 is shown in Table 4.7.1. The majority of clients (89%) reported a heterosexual orientation, which is slightly below the rate in the general population (93%)[13]. A further 2% identified as being gay/lesbian and a similar proportion identified as being bisexual.

Table 4.7.1: Sexual orientation, new presentations to treatment 2017-18

Sexual orientation	Opiate		Non-opiate only		Non-opiate and alcohol		Alcohol only		Total	
	n	%	n	%	n	%	n	%	n	%
Heterosexual	36,582	90%	13,761	87%	15,763	88%	44,734	90%	110,840	89%
Gay/Lesbian	565	1%	520	3%	559	3%	1,315	3%	2,959	2%
Bisexual	724	2%	314	2%	381	2%	511	1%	1,930	2%
Client asked and does not know or is not sure	75	0%	41	0%	42	0%	100	0%	258	0%
Not Stated	2,481	6%	921	6%	945	5%	2,812	6%	7,159	6%
Other	345	1%	184	1%	142	1%	413	1%	1,084	1%
Total	40,772	100%	15,741	100%	17,832	100%	49,885	100%	124,230	100%
Inconsistent/missing	406		975		925		771		3,077	
Total	41,178		16,716		18,757		50,656		127,307	

[13] For sexuality data please see: Sexual identity, UK: 2016.
https://www.ons.gov.uk/peoplepopulationandcommunity/culturalidentity/sexuality/bulletins/sexualidentityuk/2016

4.8 Source of referral into treatment (new presentations)

Table 4.8.1 shows a breakdown of the routes by which clients accessed treatment, known as the source of referral. Information about the source of referral was provided for 126,705 (99.5%) of all new presentations to treatment in 2017-18 and most (58%) were self-referrals or from family and friends.

Alcohol only clients had the highest proportion of clients referred to treatment from health services and social care (24%), which was almost three times the proportion of opiate client referrals (9%) from this source. In contrast, 26% of opiate clients were referred from the criminal justice system (18% were referrals following release from prison), while only 6% of alcohol only clients were referred via this pathway.

Overall, substance misuse services accounted for 6% of referrals into treatment (ranging from 3% for non-opiate only clients to 8% for opiate clients).

Table 4.8.1: Source of referral into treatment, new presentations to treatment 2017-18

Referral Source	Opiate		Non-opiate only		Non-opiate and Alcohol		Alcohol only		Total	
	n	%	n	%	n	%	n	%	n	%
Self, family and friends										
Self	21,542	53%	9,747	59%	10,891	58%	29,842	59%	72,022	57%
Other family and friends	450	1%	364	2%	327	2%	700	1%	1,841	1%
Self, family and friends subtotal	21,992	54%	10,111	61%	11,218	60%	30,542	61%	73,863	58%
Health services and social care										
GP	2,167	5%	1,287	8%	1,725	9%	6,975	14%	12,154	10%
Hospital	718	2%	162	1%	371	2%	2,039	4%	3,290	3%
Social services	205	1%	580	3%	390	2%	969	2%	2,144	2%
Health – other	795	2%	768	5%	886	5%	2,150	4%	4,599	4%
Other community health	432	1%	311	2%	380	2%	774	2%	1,897	1%
Psychiatry	168	0%	280	2%	259	1%	548	1%	1,255	1%
A&E	90	0%	39	0%	126	1%	560	1%	815	1%
Syringe Exchange	27	0%	3	0%	5	0%	24	0%	59	0%
Community care assessment	44	0%	13	0%	23	0%	59	0%	139	0%
Children social services	34	0%	122	1%	93	0%	185	0%	434	0%
Health services and social care subtotal	3,885	9%	2,797	17%	3,372	18%	12,133	24%	22,187	18%
Criminal justice										
Arrest referral/DIP	1,119	3%	618	4%	393	2%	477	1%	2,607	2%
Prison	7,302	18%	300	2%	242	1%	287	1%	8,131	6%
Probation	679	2%	421	3%	489	3%	783	2%	2,372	2%
Criminal justice – other	1,462	4%	816	5%	892	5%	1,460	3%	4,630	4%
ATR	24	0%	7	0%	240	1%	721	1%	992	1%
DRR	502	1%	344	2%	139	1%	29	0%	1,014	1%
Community rehabilitation company	127	0%	83	0%	105	1%	175	0%	490	0%
Liaison and diversion	8	0%	6	0%	14	0%	25	0%	53	0%
Other criminal justice	801	2%	376	2%	394	2%	510	1%	2,081	2%
Criminal justice subtotal	10,562	26%	2,155	13%	2,016	11%	3,007	6%	17,740	14%
Substance misuse service										
Drug service statutory	1,204	3%	201	1%	270	1%	598	1%	2,273	2%
Drug service non-statutory	2,037	5%	272	2%	445	2%	1,363	3%	4,117	3%
Community alcohol team	95	0%	40	0%	127	1%	636	1%	898	1%
Substance misuse service subtotal	3,336	8%	513	3%	842	5%	2,597	5%	7,288	6%
Other										
Other	1,162	3%	1,082	6%	1,219	7%	2,164	4%	5,627	4%
Other	1,038	3%	636	4%	727	4%	1,790	4%	4,191	3%
Other YP	32	0%	338	2%	339	2%	92	0%	801	1%
Job centre plus	16	0%	23	0%	44	0%	110	0%	193	0%
Employment service	29	0%	22	0%	29	0%	81	0%	161	0%
Other sex worker project	28	0%	5	0%	4	0%	10	0%	47	0%
Other treatment provider	6	0%	21	0%	37	0%	5	0%	69	0%
Connexions	4	0%	2	0%	13	0%	11	0%	30	0%
Education service	3	0%	10	0%	13	0%	35	0%	61	0%
LAC	-	0%	16	0%	11	0%	6	0%	33	0%
Employer	6	0%	7	0%	2	0%	24	0%	39	0%
Other helplines & websites	-	0%	2	0%	-	0%	-	0%	2	0%
Other subtotal	1,162	3%	1,082	6%	1,219	7%	2,164	4%	5,627	4%
Total	40,937	100%	16,658	100%	18,667	100%	50,443	100%	126,705	100%
Inconsistent/missing	241		58		90		213		602	
Total	41,178		16,716		18,757		50,656		127,307	

Note: Percentages may equal 0% or not sum to 100% due to rounding

4.9 Presenting substance and age (new presentations)

The distribution of substances for individuals presenting to treatment in 2017-18 is shown in Table 4.9.1. Overall, the most reported problematic substance was alcohol (60%), followed by opiates (32%), crack cocaine (21%) and cannabis (20%). In terms of alcohol, most clients (66%) did not present with a coexisting drug problem.

More than half (54%) of opiate clients also presented with problematic crack cocaine use and 17% reported a problem with alcohol. Cannabis was the most reported drug for the non-opiate only and non-opiate and alcohol groups (57% and 53%, respectively), followed by cocaine (38% and 50%, respectively).

Table 4.9.1: Substance breakdown of new presentations to treatment 2017-18

Substance	Opiate		Non-opiate only		Non-opiate and alcohol		Alcohol only		Total	
	n	%	n	%	n	%	n	%	n	%
Opiate and/or crack cocaine use										
Opiate (not crack cocaine)	18,767	46%	-	0%	-	0%	-	0%	18,767	15%
Both opiate and crack cocaine	22,411	54%	-	0%	-	0%	-	0%	22,411	18%
Crack cocaine (not opiate)	-	0%	2,279	14%	2,022	11%	-	0%	4,301	3%
Other drug use										
Cannabis	5,685	14%	9,566	57%	9,918	53%	-	0%	25,169	20%
Cocaine	2,055	5%	6,402	38%	9,339	50%	-	0%	17,796	14%
Amphetamine (other than ecstasy)	1,065	3%	1,547	9%	1,073	6%	-	0%	3,685	3%
Benzodiazepine	2,484	6%	910	5%	663	4%	-	0%	4,057	3%
Other[2]	498	1%	646	4%	320	2%	-	0%	1,464	1%
Alcohol										
Alcohol	6,984	17%	-	0%	18,757	100%	50,656	100%	76,397	60%
Total number of individuals[1]	41,178	100%	16,716	100%	18,757	100%	50,656	100%	127,307	100%

[1] The number of individuals will be less than the total of the reported substances as an individual may present with more than one problematic substance
[2] Other includes all other substances not specifically stated in the table above

Figure 4.9.1 and Table 4.9.2 provide an overview of how substance use for new presentations varies by age. For younger clients (i.e. those aged 18-24), the most reported substances were cannabis (54%), alcohol (45%) and cocaine (29%), with 16% presenting for opiate use. The percentage of individuals presenting with problems for cannabis and cocaine use decreased with age, falling steadily to 2% of those aged 65 and over reporting cannabis and less than 1% reporting cocaine. In contrast, the prevalence of problematic alcohol use increased with age with most clients (91%) aged 65 presenting to treatment reporting problematic alcohol use.

Figure 4.9.1 Age and presenting substance distribution of new presentations to treatment 2017-18

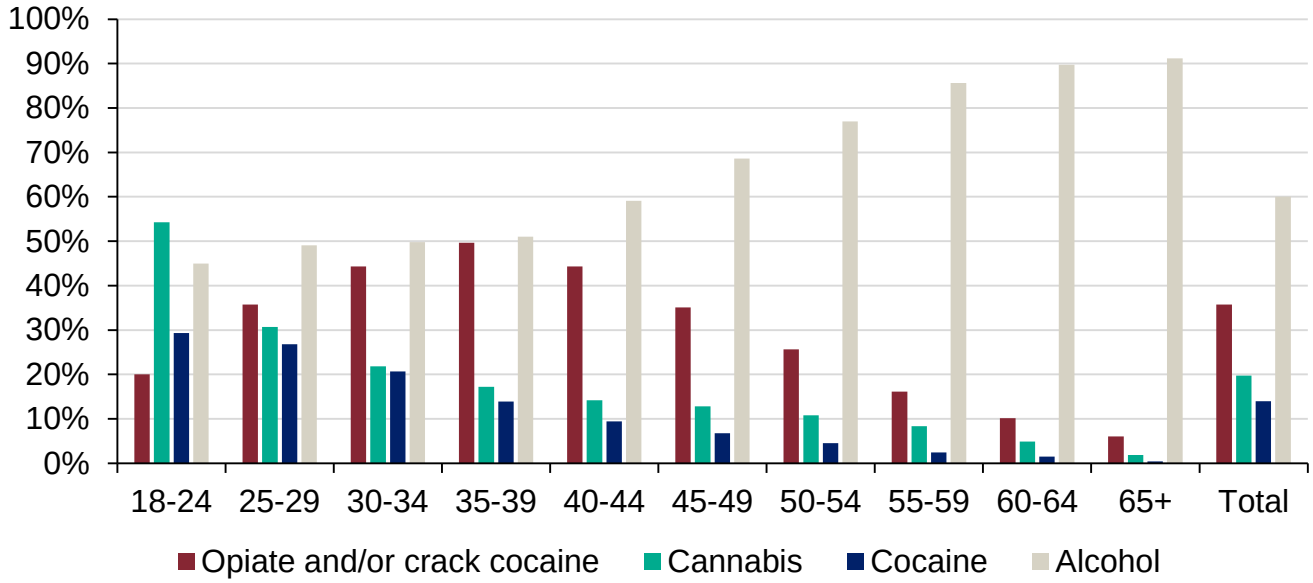


Table 4.9.2: Age and presenting substance of new presentations to treatment 2017-18

Substance	18-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65+	Total
Opiate and/or crack cocaine use											
Opiate (not crack cocaine)	887	2,094	3,390	4,297	3,311	2,453	1,396	585	214	140	18,767
	8%	14%	17%	20%	18%	15%	12%	8%	6%	4%	15%
Both opiate and crack cocaine	832	2,439	4,529	5,665	4,118	2,816	1,389	447	133	43	22,411
	8%	16%	23%	26%	23%	17%	12%	6%	4%	1%	18%
Crack cocaine (not opiate)	417	759	872	798	585	418	272	146	28	6	4,301
	4%	5%	4%	4%	3%	3%	2%	2%	1%	0%	3%
Other drug use											
Cannabis	5,791	4,544	4,333	3,725	2,568	2,072	1,289	609	179	59	25,169
	54%	31%	22%	17%	14%	13%	11%	8%	5%	2%	20%
Cocaine	3,131	3,972	4,094	3,010	1,708	1,095	542	176	55	13	17,796
	29%	27%	21%	14%	9%	7%	5%	2%	1%	0%	14%
Amphetamine (other than ecstasy)	324	525	777	733	540	397	244	105	30	10	3,685
	3%	4%	4%	3%	3%	2%	2%	1%	1%	0%	3%
Benzodiazepine	470	563	707	832	599	424	238	92	52	80	4,057
	4%	4%	4%	4%	3%	3%	2%	1%	1%	3%	3%
Other[1]	145	229	313	221	202	143	86	41	32	52	1,464
	1%	2%	2%	1%	1%	1%	1%	1%	1%	2%	1%
Alcohol											
Alcohol	4,793	7,272	9,874	11,047	10,695	11,113	9,178	6,263	3,305	2,857	76,397
	45%	49%	50%	51%	59%	69%	77%	86%	90%	91%	60%
Total number of individuals[2]	10,666	14,807	19,827	21,660	18,094	16,195	11,928	7,314	3,683	3,133	127,307

[1] Other includes all other substances not specifically stated in the table above
[2] The number of individuals will be less than the total of the reported substances as an individual may present with more than one problematic substance. Note: Percentages may equal 0% or not sum to 100% due to rounding

4.10 Injecting behaviour (new presentations)

Data on the injecting status of clients was recorded for 124,676 individuals (98%) who entered treatment in 2017-18 and is shown in Table 4.10.1. Three quarters (76%) of clients entering treatment had never injected, although this varied substantially by substance group. Nearly 4 in 10 of opiate clients (39%) reported that they had never injected, while 91% of non-opiate only and non-opiate and alcohol clients and almost all (97%) alcohol only clients had never injected.

Around a third (34%) of opiate clients had previously injected and around a quarter (26%) were currently injecting, with opiate clients making up 94% of all new presentations who reported this status.

Sharing of injecting equipment is the single biggest factor in blood-borne virus transmission among individuals who use and inject drugs, it also elevates the risk of premature mortality.

Table 4.10.1: Injecting status of new presentations to treatment 2017-18

Injecting Status	Opiate		Non-opiate only		Non-opiate and alcohol		Alcohol only		Total	
	n	%	n	%	n	%	n	%	n	%
Never injected	16,165	39%	14,289	91%	16,263	91%	48,501	97%	95,218	76%
Previously injected	14,022	34%	1,092	7%	1,407	8%	1,303	3%	17,824	14%
Currently injecting	10,670	26%	382	2%	185	1%	108	0%	11,345	9%
Declined to answer	110	0%	25	0%	38	0%	116	0%	289	0%
Total	40,967	100%	15,788	100%	17,893	100%	50,028	100%	124,676	100%
Missing/inconsistent	211		928		864		628		2,631	
Total	41,178		16,716		18,757		50,656		127,307	

Note: Percentages may equal 0% or not sum to 100% due to rounding

4.11 Housing situation (new presentations)

The housing status of individuals at the time that they presented to treatment is shown in Table 4.11.1. Of the 99% of individuals who reported their housing status, 8% reported an urgent housing problem, usually no fixed abode (NFA), with a further 11% reporting some form of current housing problem (such as staying with friends or family as a short-term guest or residing at a short-term hostel). Opiate clients had the lowest proportion reporting no housing problem (68%) and alcohol only clients had the highest proportion (89%).

Individuals who presented to treatment using NPS were much more likely to have an urgent housing problem compared to those not using these substances at the start of treatment (25% vs 8%). More information on trends in available in section 7.3.

Particularly high rates of housing need (59%) were reported by presenting clients citing both opiates and NPS at the start of treatment, compared to 31% for opiate clients overall.

Table 4.11.1: Housing situation of new presentations to treatment 2017-18

Housing situation	Opiate		Non-opiate only		Non-opiate and alcohol		Alcohol only		Total	
	n	%	n	%	n	%	n	%	n	%
No problem	27,931	68%	13,097	79%	14,514	78%	44,733	89%	100,275	80%
Housing problem	6,272	15%	1,793	11%	2,291	12%	3,681	7%	14,037	11%
Urgent housing problem (NFA)	6,463	16%	767	5%	1,013	5%	1,524	3%	9,767	8%
Other	116	0%	832	5%	774	4%	219	0%	1941	2%
Total	40,782	100%	16,489	100%	18,592	100%	50,157	100%	126,020	100%
Inconsistent/missing	396		227		165		499		1,287	
Total	41,178		16,716		18,757		50,656		127,307	

Note: Percentages may equal 0% or not sum to 100% due to rounding

4.12 Parental status and safeguarding children (new presentations)

Table 4.12.1 shows the parental status of individuals starting treatment in 2017-18. Overall, of those for whom data was available (99.4% of new presentations to treatment), almost half (49%) were not a parent and did not have children living with them. NDTMS defines ‘no contact’ as children that were not living with the individual in treatment.

There were 25,593 people who started treatment in 2017-18 (20% of the total starting treatment) who lived with children. This figure includes parents living with their biological children and those living with children of a partner or another member of the household. There were a further 38,852 (31% of the total) who said they were parents but did not currently live with their children.

People in treatment for opiates had the highest rates of not living with their children (39%), compared to those with alcohol only problems (26%). A further breakdown of substance group by gender can be found in the supporting tables.

Table 4.12.1: Parental status of new presentations to treatment 2017-18

Parental status	Opiates		Non-opiates only		Non-opiate and alcohol		Alcohol only		Total	
Parent living with children	3,919	10%	3,272	20%	3,004	16%	10,060	20%	20,255	16%
Other contact living with children	1,678	4%	748	5%	1,005	5%	1,907	4%	5,338	4%
Parents not with children	15,988	39%	4,608	28%	5,350	29%	12,906	26%	38,852	31%
Not parent no contact with children	19,366	47%	7,954	48%	9,303	50%	25,468	51%	62,091	49%
Total	40,951	100%	16,582	100%	18,662	100%	50,341	100%	126,536	100%
Incomplete data	227		134		95		315		771	
Total	41,178		16,716		18,757		50,656		127,307	

As shown in Table 4.12.2, there were 46,109 children living with individuals starting treatment in 2017-18, defined as those that stated they were a parent living with children or were living with children who were not their own (25,593, Table 4.12.1). On average (mean) individuals lived with around two children (1.8) and this was broadly similar across all four substance groups.

Table 4.12.2: Number of children living with individuals starting treatment 2017-18

Children	Opiates	Non-opiates only	Non-opiate and alcohol	Alcohol only	Total
Number of children	10,328	7,424	7,453	20,904	46,109
Number of individuals living with children	5,597	4,020	4,009	11,967	25,593
Average number of children living with people in treatment	1.8	1.8	1.9	1.7	1.8

All individuals who were parents or were living with children (64,445, Table 4.12.1) were asked whether any of those children were engaged with early help and family support services or with children's social care services, and this is shown in Table 4.12.3. Around four in five (81%) of these individuals reported that their children were not receiving any form of early help. A total of 8% (4,409) of parents or those living with children reported that at least one of those children were subject to a child protection plan whereby the local authority has taken action to protect the individual because of a continuing risk of significant harm. Non-opiate only clients had the highest proportion with a child protection plan (15%). A further 5% reported that at least one of their children were placed in care by the local authority, such as foster care or a children's home, termed 'looked after child'.

Table 4.12.3: Clients' children receiving early help or in contact with children's social care

Early help	Opiates		Non-opiates only		Non-opiate and alcohol		Alcohol only		Total	
	n	%	n	%	n	%	n	%	n	%
Early help	299	2%	343	5%	278	3%	779	4%	1,699	3%
Child in need	390	2%	410	5%	311	4%	734	4%	1,845	3%
Child protection plan	1,070	6%	1,125	15%	780	9%	1,434	7%	4,409	8%
Looked after child	1,287	7%	460	6%	368	4%	573	3%	2,688	5%
No early help	15,534	84%	5,237	69%	6,493	79%	17,383	83%	44,647	81%
Total	18,580	100%	7,575	100%	8,230	100%	20,903	100%	55,288	100%
Missing	3,005		1,053		1,129		3,970		9,157	
Total	21,585		8,628		9,359		24,873		64,445	

4.13 Mental health (new presentations)

Table 4.13.1 reports the mental health treatment need and the type of treatment received for individuals who started treatment in 2017-18. A total of 52,397 individuals (41%) reported a mental health treatment need. There was variation between the four substance groups with opiate clients reporting the lowest proportion (39%) and non-opiate and alcohol clients reporting the highest (47%).

Three quarters (75%) of those that reported a treatment need and for whom data was available (98.4%) also reported that they were receiving treatment. Almost half (48%) were receiving treatment from their GP in Primary Care and just over a fifth (22%) were receiving treatment from their community or other mental health services.

Table 4.13.1: Mental health treatment need and treatment received 2017-18

Mental health treatment need[1]	Opiates		Non-opiates only		Non-opiate and alcohol		Alcohol only		Total	
	n	%	n	%	n	%	n	%	n	%
Community or other mental health services	2,939	19%	2,086	31%	2,248	26%	4,269	21%	11,542	22%
Improving Access to Psychological Therapies (IAPT)	196	1%	176	3%	204	2%	534	3%	1,110	2%
Primary care mental health treatment	7,282	46%	2,631	39%	3,815	44%	11,039	54%	24,767	48%
NICE recommended mental health treatment	322	2%	163	2%	275	3%	514	3%	1,274	2%
Identified space in a health based place of safety for mental health crises	112	1%	59	1%	76	1%	147	1%	394	1%
Total individuals receiving any treatment for mental health	10,726	68%	5,087	75%	6,512	76%	16,321	80%	38,646	75%
No treatment received for a mental health treatment need	4,948	32%	1,725	25%	2,090	24%	4,146	20%	12,909	25%
Total[2]	15,674	100%	6,812	100%	8,602	100%	20,467	100%	51,555	100%
Missing	302		95		123		322		842	
Total individuals needing mental health treatment	15,976	39%	6,907	41%	8,725	47%	20,789	41%	52,397	41%
Total number of new presentations	41,178	100%	16,716	100%	18,757	100%	50,656	100%	127,307	100%

[1] Individuals were first asked if they had a mental health treatment need before being asked about the kind of treatment they may be receiving, and a small proportion of individuals with a treatment need did not have data for the kind of treatment being received.

[2] The total number of mental health treatments types received can be more than the total number of individuals receiving any treatment as some individuals may receive more than one type of mental health treatment

5. Access to services

5.1 Waiting times for first and subsequent treatment interventions

Waiting times are calculated as the time between being first identified as having a treatment need and being offered an appointment to start a treatment intervention, and these are reported in Table 5.1.1. Overall, nearly all individuals (98%) waited three weeks or less from first being identified as having a treatment need to being offered an appointment to start an intervention, which was similar for each substance group. The average waiting time reported was 2.2 days, with opiate clients having the shortest wait (1.7 days) and alcohol only clients waiting the longest (2.6 days). The majority of clients starting a subsequent intervention did so within three weeks (96%), although this was lower for non-opiate and alcohol clients (90%) and alcohol only clients (93%).

Table 5.1.1: Waiting times, first and subsequent interventions 2017-18

Substance	First intervention					Subsequent intervention			
	3 weeks or under		Over 3 weeks		Average waiting time	3 weeks or under		Over 3 weeks	
	n	%	n	%	days	n	%	n	%
Opiate	61,147	99%	765	1%	1.7	54,545	97%	1,653	3%
Non-opiate only	17,097	98%	279	2%	2.1	1,461	97%	47	3%
Non-opiate and alcohol	19,229	98%	371	2%	2.5	4,878	90%	553	10%
Alcohol only	51,701	98%	1,152	2%	2.6	15,316	93%	1,191	7%
Total	149,174	98%	2,567	2%	2.2	76,200	96%	3,444	4%

5.2 Treatment interventions

During their time spent in treatment individuals can undergo one or more types of treatment, known as interventions. These interventions can occur one after the other, such as when moving from a pharmacological to a psychosocial intervention, or can happen at the same time, and can be offered to a client at more than one treatment provider.

There was a change to the way NDTMS records these interventions on 1 November 2012 (see section 9.2 for more detail on this change). Prior to this date, there were six structured treatment intervention types. The intervention types that cannot be directly mapped to the new codes are shown in Table 5.2.1 and these codes apply to clients who entered treatment prior to the change or had records submitted to NDTMS using the pre-2012 codes. Individuals are only counted once for each intervention type they received.

From 1 November 2012, the number of intervention types was reduced to three, namely psychosocial, pharmacological and recovery support interventions. The setting in which

the interventions occur was also made available on NDTMS. Table 5.2.2 shows the breakdown of pharmacological and psychosocial interventions segmented by substance group and setting.

Table 5.2.1: Interventions received by clients in treatment 2017-18, pre November 2012 data set change interventions

Intervention	Opiate	Non-opiate	Non-opiate and alcohol	Alcohol only	Total
Inpatient	1,962	2	8	19	1,991
Structured day programme	4,690	4	10	12	4,716
Residential rehabilitation	460	1	7	12	480
Other structured intervention (OSI)	12,427	25	44	58	12,554
Young Person intervention code	4	7	0	0	11

Note: Individuals may have more than one type of intervention and so may appear on more than one row

Table 5.2.2: Interventions received by clients in treatment 2017-18, post November 2012 data set change interventions

Substance	Setting	Intervention type				
		Psychosocial		Pharmacological		
		n	%	n	%	Total[1]
Opiate	Community	129,994	97%	124,392	99%	136,023
	Inpatient unit	4,308	3%	4,749	4%	4,923
	Primary care	13,466	10%	23,078	18%	23,820
	Residential	2,060	2%	948	1%	2,196
	Recovery house	95	0%	151	0%	199
	Missing	2,276	-	6,547	-	7,399
	Other	6	0%	2	0%	6
	Total[1]	136,253	100%	131,875	100%	140,643
Non-opiate only	Community	22,678	98%	1,285	84%	22,806
	Inpatient unit	89	0%	84	5%	91
	Primary care	383	2%	189	12%	443
	Residential	235	1%	20	1%	237
	Recovery house	12	0%	4	0%	13
	Missing	3	-	7	-	7
	Other	40	0%	1	0%	41
	Total[1]	23,173	100%	1,537	100%	23,302
Non-opiate and alcohol	Community	26,288	97%	2,536	67%	26,401
	Inpatient unit	1,141	4%	1,201	32%	1,214
	Primary care	250	1%	130	3%	316
	Residential	1,101	4%	329	9%	1,154
	Recovery house	32	0%	12	0%	34
	Missing	1	-	2	-	3
	Other	29	0%	3	0%	29
	Total[1]	27,026	100%	3,784	100%	27,143
Alcohol only	Community	71,351	97%	10,703	72%	72,007
	Inpatient unit	3,738	5%	3,881	26%	3,974
	Primary care	1,185	2%	520	4%	1,391
	Residential	1,692	2%	782	5%	1,913
	Recovery house	91	0%	57	0%	101
	Missing	0	-	0	-	0
	Other	6	0%	0	0%	6
	Total[1]	73,701	100%	14,805	100%	74,402
Total	Community	250,311	97%	138,916	96%	257,237
	Inpatient unit	9,276	4%	9,915	7%	10,202
	Primary care	15,284	6%	23,917	16%	25,970
	Residential	5,088	2%	2,079	1%	5,500
	Recovery house	230	0%	224	0%	347
	Missing	2,280	-	6,556	-	7,409
	Other	81	0%	6	0%	82
	Total[1]	260,153	100%	152,001	100%	265,490

[1] This is the total number of individuals receiving each intervention type and not a summation of the psychosocial and prescribing columns. Percentages may equal 0% or not sum to 100% due to rounding.

Data from tables 5.2.1 and 5.2.2 can be summed where overlap in definition exists to arrive at the total number of individuals receiving each intervention in 2017-18. No overlap exists for structured day programmes or other structured interventions thus the total number of clients can only be reported up to the 31 October 2012.

A count of the total number of individuals by setting/intervention where it is possible to sum the overlap between tables 5.2.1 and 5.2.2, can be found in table 5.2.3 below.

Table 5.2.3: Total number of individuals in settings (overlap between 5.2.1 and 5.2.2)

Setting	Total number of individuals
Inpatient unit	12,193
Residential	5,980

The length of time clients were in receipt of pharmacological interventions is shown in Table 5.2.4. This is provided for all individuals reported in Table 5.2.2 as being in receipt of a pharmacological intervention. The majority of individuals either received prescriptions as part of opiate substitution therapy or to enable safe withdrawal from alcohol dependence. Prescriptions to help with relapse prevention make up the majority of those remaining.

Almost half of all individuals (44%) had been in receipt of prescriptions for less than 12 months. This proportion was lowest for opiate clients (37%) and highest for alcohol only clients (93%). More than one in five (22%) opiate clients were in continuous receipt of a pharmacological intervention for five or more years.

Table 5.2.4: Length of time in prescribing for clients in continuous prescribing treatment 2017-18

Length of time[1]	Opiate		Non-opiate only		Non-opiate and alcohol		Alcohol only		Total	
	n	%	n	%	n	%	n	%	n	%
Less than 12 months	48,827	37%	1,040	68%	3,448	91%	13,803	93%	67,118	44%
1-2 years	20,289	15%	242	16%	205	5%	723	5%	21,459	14%
2-3 years	15,405	12%	98	6%	57	2%	153	1%	15,713	10%
3-4 years	11,363	9%	45	3%	29	1%	58	0%	11,495	8%
4-5 years	6,801	5%	28	2%	18	0%	41	0%	6,888	5%
5 years +	29,190	22%	84	5%	27	1%	27	0%	29,328	19%
Total	131,875	100%	1,537	100%	3,784	100%	14,805	100%	152,001	100%

[1] Percentages may equal 0% or not sum to 100% due to rounding

5.3 Engagement

The majority (92%) of clients were either retained in treatment for at least 12 weeks or had completed treatment free of dependence within this timeframe, as shown in Table 5.3.1. Non-opiate only clients had the lowest proportion (84%) and opiate clients had the highest proportion (95%).

Table 5.3.1: Clients retained in treatment for at least 12 weeks or successfully completing treatment earlier 2017-18

Substance	Number in contact with treatment services	Number retained in treatment for at least 12 weeks or successfully completing treatment earlier	
	n	n	%
Opiate	141,189	133,784	95%
Non-opiate only	23,730	20,048	84%
Non-opiate and alcohol	27,684	23,852	86%
Alcohol only	75,787	67,897	90%
Total	268,390	245,581	92%

6. Treatment and recovery outcomes

6.1 Treatment exits and successful completions

The reasons for clients exiting treatment in 2017-18 are shown in Table 6.1.1. Overall, a total of 121,332 individuals exited treatment between 1 April 2017 and 31 March 2018. On average (mean), individuals who completed treatment did so within a year of starting treatment (332 days). The average time in treatment for opiate clients was nearly three years (1074 days) and around six months for the other substance groups (168 days for non-opiate only clients, 196 days for non-opiate and alcohol clients and 198 days for alcohol only clients).

Almost half of those that left treatment (48%) were discharged as ‘treatment completed’. This is determined by clinical judgement that the individual no longer has a need for structured treatment, having achieved all the care plan goals and having overcome dependent use of the substances that brought them into treatment and any pharmacological interventions have ceased. The proportion of each substance group successfully completing treatment is shown in Figure 6.1.1 and indicates that opiate clients had the lowest rate of successful completions (26%) and alcohol only clients had the highest rate (61%).

The next largest discharge reason was ‘dropped out/left’, which indicates that clients exited the treatment system without completing their treatment. Overall around a third (35%) of clients exited with this reason. Opiate clients had the hightest proportion (40%) and alcohol only clients had the lowest proportion (30%). Overall, 7% of clients were transferred to another treatment provider within the community but were not picked up within 21 days and 4% were transferred to treatment in prison. Opiate clients made up the biggest proportion of these transfers (68%).

There were 2,660 recorded deaths in treatment, which represented 2% of all of those discharged from the treatment system. There were 1,712 deaths among the opiate group (64% of all deaths) and 774 deaths among the alcohol only clients (29% of all deaths). In contrast, non-opiate and alcohol and non-opiate only clients made up only a small percentage of deaths (5% and 2%, respectively). Alcohol only clients tended to be older, with a median age of 50 years old at the time of death, followed by opiate clients (45 years old). Non-opiate and alcohol clients had a median age of 42 at the time of death and non-opiate only clients were the youngest, with a median age of 35.

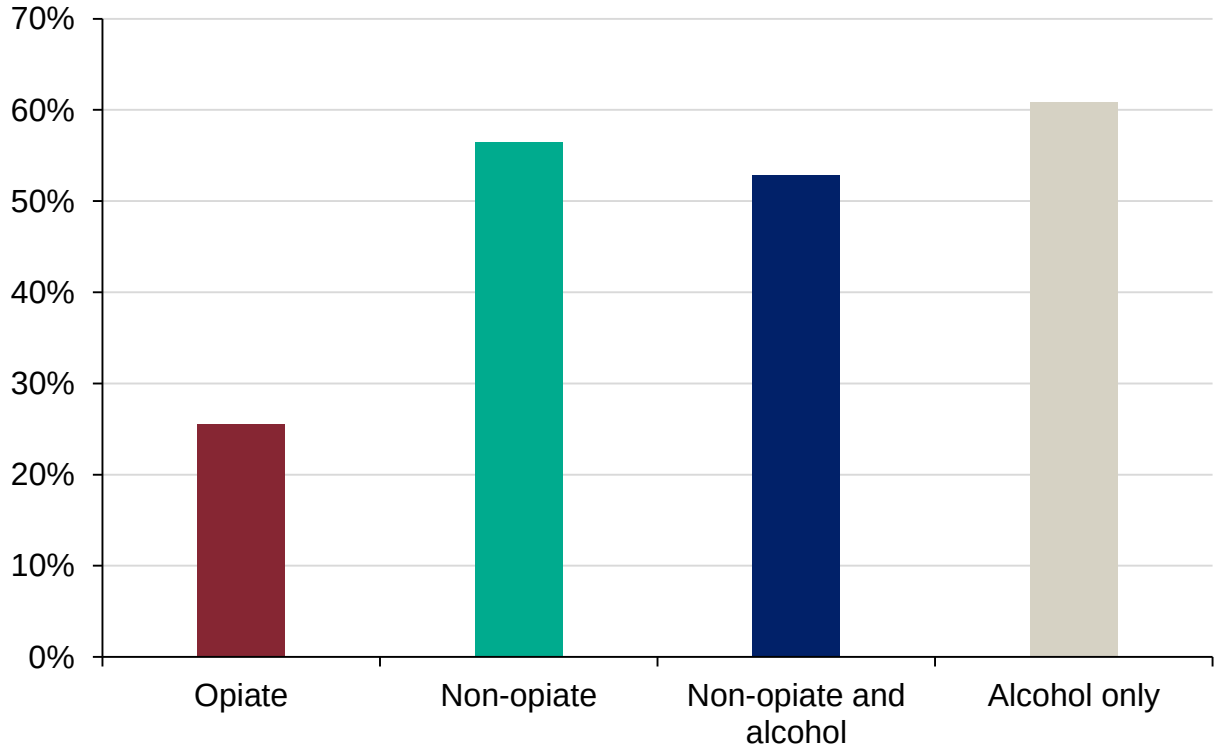
Of all the clients that died while in contact with treatment 73% were male, ranging from 64% for alcohol only clients and 79% for non-opiate only clients. For the opiate group 77% of deaths were males.

Table 6.1.1: Treatment exit reasons for clients not retained in treatment on 31 March 2018

Treatment exit reason	Opiate		Non-opiate only		Non-opiate and alcohol		Alcohol only		Total	
	n	%	n	%	n	%	n	%	n	%
Completed free of dependence – no drug or alcohol use	8,254	23%	5,703	34%	5,603	30%	18,407	37%	37,967	31%
Completed free of dependence	1,055	3%	3,654	22%	4,225	23%	11,817	24%	20,751	17%
Treatment completed free of dependence subtotal	9,309	26%	9,357	56%	9,828	53%	30,224	61%	58,718	48%
Dropped out/left	14,639	40%	5,778	35%	6,871	37%	14,999	30%	42,287	35%
Transferred – not in custody	5,079	14%	571	3%	777	4%	1,973	4%	8,400	7%
Transferred – in custody	4,163	11%	350	2%	360	2%	392	1%	5,265	4%
Treatment declined	531	1%	319	2%	443	2%	1,011	2%	2,304	2%
Died	1,712	5%	53	0%	121	1%	774	2%	2,660	2%
Prison	712	2%	91	1%	77	0%	104	0%	984	1%
Treatment withdrawn	175	0%	55	0%	85	0%	160	0%	475	0%
Exit reason inconsistent	118	0%	21	0%	39	0%	61	0%	239	0%
Total	36,438	100%	16,595	100%	18,601	100%	49,698	100%	121,332	100%

Note: Percentages may equal 0% or not sum to 100% due to rounding

Figure 6.1.1 Proportion of exits that are treatment completed free of dependence by the four substance groups 2017-18



Full definitions of all the treatment exit reasons below can be found in the NDTMS business definitions at: https://www.gov.uk/government/collections/alcohol-and-drug-misuse-treatment-core-dataset-collection-guidance#core-dataset-treatment-business-definitions

6.2 Six-month outcomes

Introduction

The Treatment Outcomes Profile (TOP) is a clinical tool that enables clinicians and key workers to keep track of the progress of individuals through their treatment journeys. It originally consisted of a 20 item questionnaire focusing on substance use, injecting risk behaviour, housing, employment, crime,health and quality of life. The Alcohol Outcomes Record (AOR) was introduced in November 2013 and is a condensed version of the TOP, consisting of only four items (frequency and quantity of alcohol consumption, physical health and psychological health). Treatment providers can utilise either the TOP or the AOR to monitor alcohol only clients. For all other clients, the TOP is expected to be completed.

The data in this section includes an analysis of all six-month review data from the TOP/AOR received in 2017-18 and for which there is also corresponding treatment start TOP/AOR information. Further details on the TOP/AOR reporting protocol can be found here: https://www.gov.uk/government/publications/drug-and-alcohol-treatment-outcomes-measuring-effectiveness

Briefly, the reporting protocol stipulates that an individual can have a review completed between 29 and 182 days following their initial assessment. The AOR is not specifically required to be completed for six-month in-treatment outcomes monitoring, but such instances are included here where the data is available. A total of 85,736 individuals had a review TOP/AOR occurring in 2017-18 and also had corresponding TOP/AOR data at the start of treatment, and the outcomes for these individuals are reported in this section.

Methods

A statistical approach known as the Reliable Change Index (RCI) is used here to classify the changes in substance use between the start of treatment and six-month review into one of four categories: abstinent, improved, unchanged and deteriorated. This is based on the application of methodology advanced by Jacobson and Truax (1991)[14] and verified for use in the substance misuse field by Marsden et al (2011)[15].

[14] Jacobson N. S., Truax P. Clinical significance: a statistical approach to defining meaningful change in psychotherapy research. *Journal of Consulting and Clinical Psychology* 1991; 59: 12–19. www.personal.kent.edu/~dfresco/CRM_Readings/JCCP_Jacobson_ClinSIG.pdf

[15] Marsden, J., Eastwood, B., Wright, C., Bradbury, C., Knight, J., Hammond, P. How best to measure change in evaluations of treatment for substance use disorder. *Addiction* 2011: 106(2): 294-302. onlinelibrary.wiley.com/doi/10.1111/j.1360-0443.2010.03143.x/pdf

Results

Table 6.2.1 presents the change in substance use between the start of treatment and the six-month review. It is segmented by the four substance groups and reports on the substances that were cited as problematic on presentation to treatment. There were 21,653 opiate clients in total and these reported a reduction in the average (mean) number of days using opiates in the 28-days preceding the start and review assessments, from 22.1 days to 8.6 days. Overall, 40% of opiate clients had stopped using opiates by the time of the six-month review, and this was higher for opiate clients who did not report a crack cocaine problem (48%) and lower for opiate clients who also reported a crack cocaine problem (33%). Opiate clients who were using cocaine powder achieved a 71% abstinence rate but only 21% of opiate clients using tobacco managed to stop by the six month review. More than half (54%) of opiate using injectors at the start of treatment stopped injecting by the six month review.

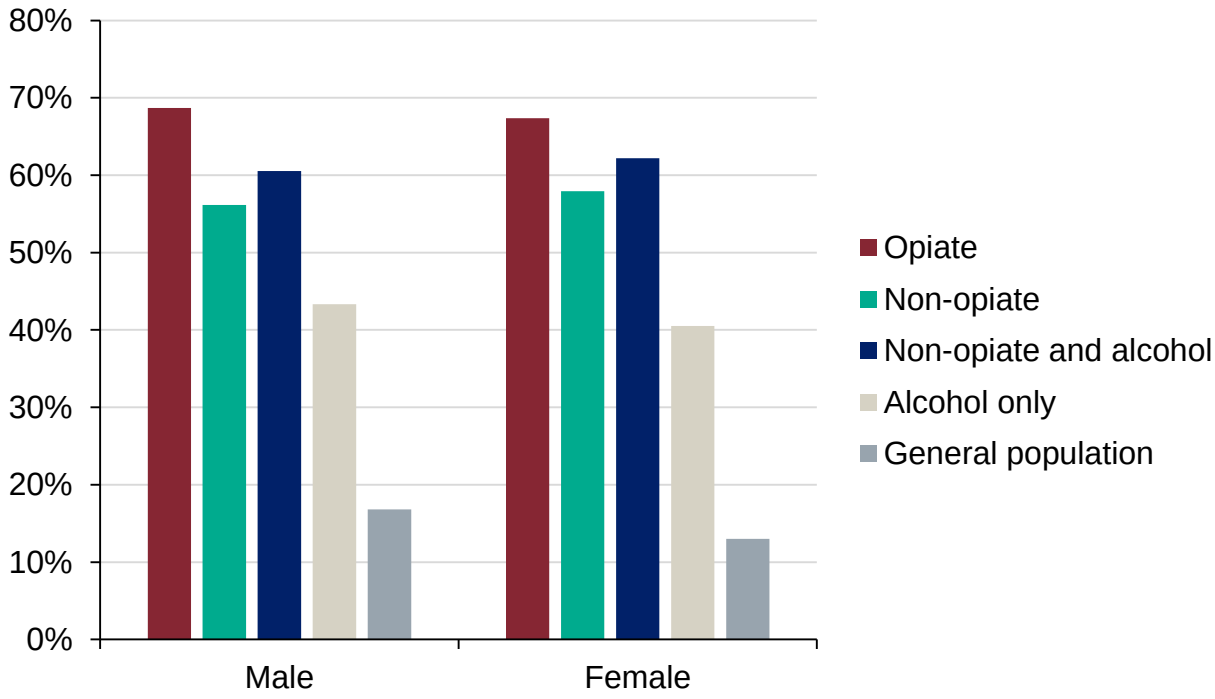
For non-opiate only clients, cannabis was the most frequently used illicit substance in the 28 days preceding the start of treatment (22.3 days) and was second only to tobacco (26.8 days). Less than a third (31%) of tobacco users became abstinent by the time of the review, compared with 37% of cannabis users and 65% of cocaine users. For non-opiate and alcohol clients, 65% of cocaine users also became abstinent while around a third (32%) achieved abstinence for tobacco and alcohol. For alcohol only clients, a similar proportion reported no longer using alcohol and tobacco at the review period (33% and 34%, respectively).

Table 6.2.1: Change in use of cited substance for clients with a review TOP/AOR in the year who reported using at the start of treatment

Substance	START OF TREATMENT		AT SIX MONTH REVIEW				
	Reviewed clients using at start	Average days of use at start	Abstinent	Improved	Deteriorated	Unchanged	Average days of use at review
	n	mean	%	%	%	%	mean
Opiate							
Opiate use (all opiate clients)	21,653	22.1	40%	25%	4%	31%	8.6
Opiate use (opiate not crack clients)	9,574	22.9	48%	23%	3%	26%	7.0
Opiate use (opiate and crack clients)	12,079	21.5	33%	26%	5%	36%	9.8
Crack use (in opiate and crack clients)	11,515	15.7	38%	18%	7%	37%	8.1
Cocaine use	691	8.0	71%	5%	2%	22%	2.1
Amphetamine use	435	12.0	50%	6%	5%	39%	6.7
Cannabis use	3,104	16.8	50%	8%	8%	34%	9.6
Alcohol use	4,218	18.2	31%	13%	8%	47%	12.7
Tobacco use	19,117	27.3	21%				21.6
Injecting	6,923	20.6	54%	13%	3%	30%	7.5
Non-opiate only							
Crack use	784	13.9	57%	9%	4%	30%	5.4
Cocaine use	2,731	10.5	65%	12%	2%	21%	2.4
Amphetamine use	594	14.3	57%	8%	2%	32%	5.7
Cannabis use	4,795	22.3	37%	17%	3%	43%	11.8
Tobacco use	5,447	26.8	31%				18.5
Injecting	216	11.4	66%	4%	3%	26%	4.2
Non-opiate and alcohol							
Crack use	699	11.4	63%	6%	2%	29%	3.8
Cocaine use	3,943	9.5	65%	10%	2%	23%	2.4
Amphetamine use	393	12.2	64%	5%	2%	30%	4.8
Cannabis use	4,709	20.0	48%	11%	3%	38%	9.8
Alcohol use	10,630	18.0	32%	18%	3%	47%	9.8
Tobacco use	6,896	26.7	32%				18.4
Injecting	100	10.2	77%	1%	1%	21%	2.9
Alcohol only							
Alcohol use	33,022	21.4	33%	20%	2%	44%	11.1
Tobacco use	14,613	26.8	34%				17.9

Figure 6.2.1 shows the proportion of clients smoking in the 28 day period prior to the start of treatment, split by drug group and gender. Overall, opiate clients had the highest rates of smoking when commencing treatment (68%), this was followed by non-opiate and alcohol and non-opiate only (61% and 57% respectively). Those presenting with alcohol only had the lowest rates with 42% smoking at the start of treatment. Across the four drug groups, males and females reported smoking at similar levels, and in all cases the level of smoking was substantially higher than the smoking rates of the general population (17% for males and 13% for females).

Figure 6.2.1 Smoking prevalence at start of treatment by the four substance groups 2017-18



The number and proportion of people that were identified as smokers at the start of treatment and who were provided with smoking cessation interventions is shown in Table 6.2.2. On NDTMS, this indicates that specific stop-smoking support has been provided by the treatment service, and/or the individual has been actively referred to a stop smoking service. Only 3% of smokers had received smoking cessation interventions and this was similar for all substance groups.

Table 6.2.2: Number and proportion of individuals who were smoking at the start of treatment and referred for smoking cessation interventions

Substance group	Clients smoking at the start of treatment	Clients that received smoking cessation interventions	%
Opiate	19,117	586	3%
Non-opiate	5,447	98	2%
Non-opiate and alcohol	6,896	277	4%
Alcohol only	14,613	467	3%
Total	46,073	1428	3%

Six-month employment, education and housing outcomes are shown in Table 6.2.3, by the four substance groups. Opiate clients were much less likely to be in paid work at either the start of treatment or at the six-month review period, compared with the other substance groups, and the rate of employment for opiate clients increased from 15% to 18%. For all substance groups combined, the employment rate increased from 26% to 27%.

Only 1% reported being in education at the start of treatment, although this was higher for non-opiate only clients (3%), and the overall rate increased to 2% by the six-month review.

At the start of treatment, opiate clients had the highest rate of acute housing problems (20%), almost double the rate of the next highest group, non-opiate and alcohol clients, at 11% and more than three times the rate of alcohol only clients (6%). All substance groups reported a decrease in acute housing problem, with opiate clients reporting the greatest reduction.

Table 6.2.3: Change in employment, education and housing status between the start of treatment and six-month review

		Opiate	Non-opiate only	Non-opiate and alcohol	Alcohol only	Total
Employment	n	28,093	9,657	11,319	34,353	83,422
Baseline work	%	15%	32%	32%	30%	26%
	Mean days	17.8	17.9	17.7	17.5	17.7
Review work	%	18%	34%	33%	30%	27%
	Mean days	17.92	18.09	18.32	17.92	18.01
Education	n	28,000	9,597	11,267	34,070	82,934
Baseline education	%	1%	3%	2%	1%	1%
	Mean days	10.5	11.0	11.4	10.8	10.9
Review education	%	1%	3%	3%	2%	2%
	Mean days	9.66	10.52	9.90	9.26	9.73
Housing problems – acute	n	28,101	9,588	11,221	33,984	82,894
Baseline	%	20%	9%	11%	6%	12%
Review	%	15%	6%	7%	4%	8%
Housing problems – risk	n	27,867	9,562	11,170	33,857	82,456
Baseline	%	9%	5%	6%	3%	6%
Review	%	7%	3%	4%	2%	4%
Housing problems – any	n	27,825	9,549	11,153	33,805	82,332
Baseline	%	22%	10%	12%	7%	13%
Review	%	16%	7%	8%	4%	9%

7. Trends over time

7.1 Trends in numbers in treatment

The change in the number of clients in contact with substance misuse treatment between 2005-06 and 2017-18 by the four main substance groups is shown in Table 7.1.1 and Figure 7.1.1. Overall, there was a 4% reduction in the number of individuals in treatment compared with the previous year (268,390 in 2017-18 compared with 279,793 in 2016-17) with all substance groups seeing a reduction.

The alcohol only client group had the greatest reduction (6%) compared with 2016-17 and is down 17% from a peak of 91,651 clients in 2013-14. There were an estimated 589,101 adults with alcohol dependency in need of specialist treatment in 2016-17. These alcohol dependency estimates have remained relatively stable over the last 5 years, which suggests that the falls in the numbers of alcohol clients accessing treatment does not reflect a fall in prevalence. With a total of 103,471 individuals in treatment for alcohol (i.e. the sum of alcohol only and non-opiate and alcohol groups), there was an estimated 82% of adults in need of specialist treatment for alcohol that were not receiving it.

https://www.gov.uk/government/publications/alcohol-dependence-prevalence-in-england

Opiate clients also saw a reduction of 4% from 2016-17 and 17% from a peak of 170,032 individuals in treatment in 2009-10. The latest prevalence estimates for the problematic opiate population in England show that 257,476 individuals aged 15-64 are in need of specialist treatment, indicating that in 2017-18 an estimated 46% of these adults had an unmet treatment need.

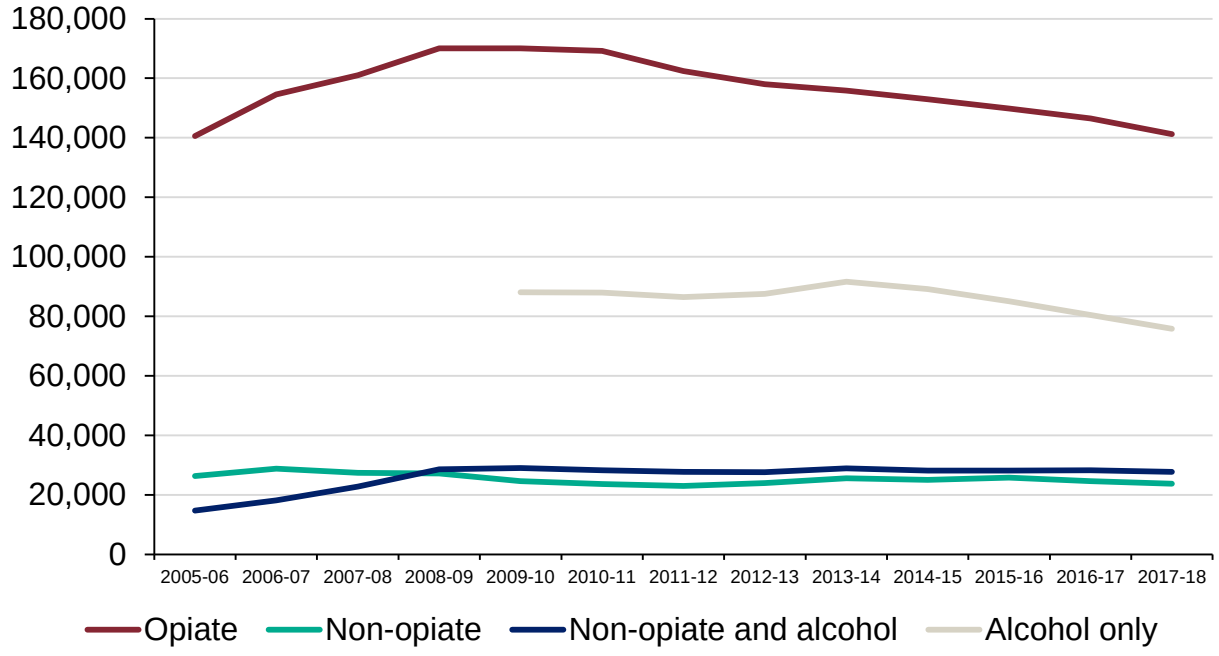
https://www.gov.uk/government/publications/opiate-and-crack-cocaine-use-prevalence-estimates-for-local-populations

Table 7.1.1: Trends in numbers in treatment

Year	Opiate		Non-opiate only		Non-opiate and alcohol		Alcohol only		Total
	n	%	n	%	n	%	n	%	n
2005-06	140,557	65%	26,287	12%	14,737	7%	35,221	16%	216,802
2006-07	154,596	64%	28,777	12%	18,154	8%	40,114	17%	241,641
2007-08	160,997	61%	27,398	10%	22,741	9%	54,696	21%	265,832
2008-09	170,005	56%	27,186	9%	28,560	9%	78,658	26%	304,409
2009-10	170,032	55%	24,557	8%	28,992	9%	88,086	28%	311,667
2010-11	169,144	55%	23,613	8%	28,223	9%	88,020	28%	309,000
2011-12	162,435	54%	22,982	8%	27,732	9%	86,416	29%	299,565
2012-13	157,959	53%	23,975	8%	27,627	9%	87,544	29%	297,105
2013-14	155,852	52%	25,570	8%	28,871	10%	91,651	30%	301,944
2014-15	152,964	52%	25,025	8%	28,128	10%	89,107	30%	295,224
2015-16	149,807	52%	25,814	9%	28,187	10%	85,035	29%	288,843
2016-17	146,536	52%	24,561	9%	28,242	10%	80,454	29%	279,793
2017-18	141,189	53%	23,730	9%	27,684	10%	75,787	28%	268,390

* Providers of specialist alcohol treatment services began to report to NDTMS in 2008-09

Figure 7.1.1 Trends in numbers in treatment



7.2 Trends in age group and presenting substances

Figures 7.2.1 and 7.2.2 show trends in the substances cited as problematic among new presentations from 2005-06 to 2017-18 and Figures 7.2.3 and 7.2.4 show the same data but for only those under the age of 25. The data behind these graphs can be found in the ‘Trends new presentations’ worksheet of the supporting Excel tables document.

There were 51,414 non-opiate only and non-opiate and alcohol clients in contact with treatment in 2017-18, which was a 3% fall since last year (52,803). Despite this overall fall in numbers in treatment for non-opiate substances, the number of individuals presenting with crack cocaine problems (not being used alongside opiates) increased by 18% (3,657 to 4,301), this follows a larger increase of 23% in crack cocaine presentations between 2015-16 and 2016-17. Overall, the of number new presentations for crack cocaine (not being used alongside opiates) has increased by 44% since 2015-16.

In 2005-06, 35% of opiate clients also presented to treatment with crack cocaine problems and in 2017-18 this proportion increased to 54%. The largest increases appear to have occurred since 2014-15 when 42% of opiate clients also reported crack cocaine and appears to coincide with the years where there was also an increase in overall crack prevalence.

Recently published estimates of crack cocaine use in England in 2014-15 reported a 10% increase in the numbers estimated to be using the substance since 2011-12 (166,640, 95% confidence interval 161,621-173,706 to 182,828, 95% confidence interval 176,675 - 190,782).

https://www.gov.uk/government/publications/opiate-and-crack-cocaine-use-prevalence-estimates-for-local-populations

Figure 7.2.1 Number of new treatment presentations for opiates and / or crack cocaine

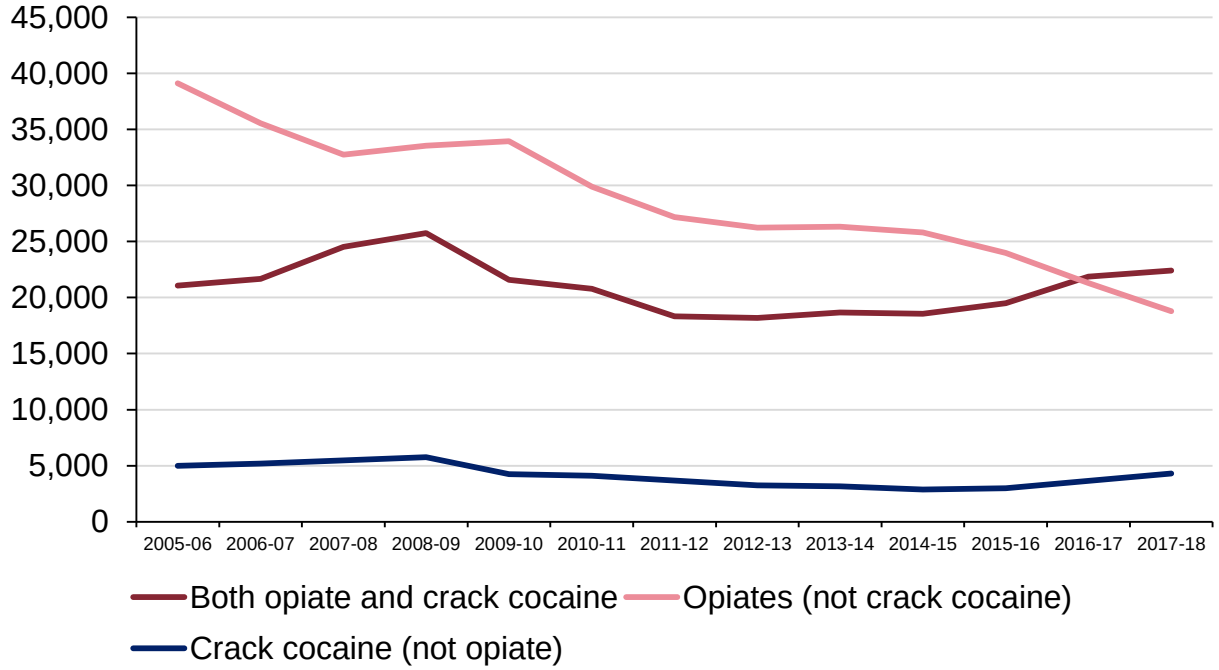
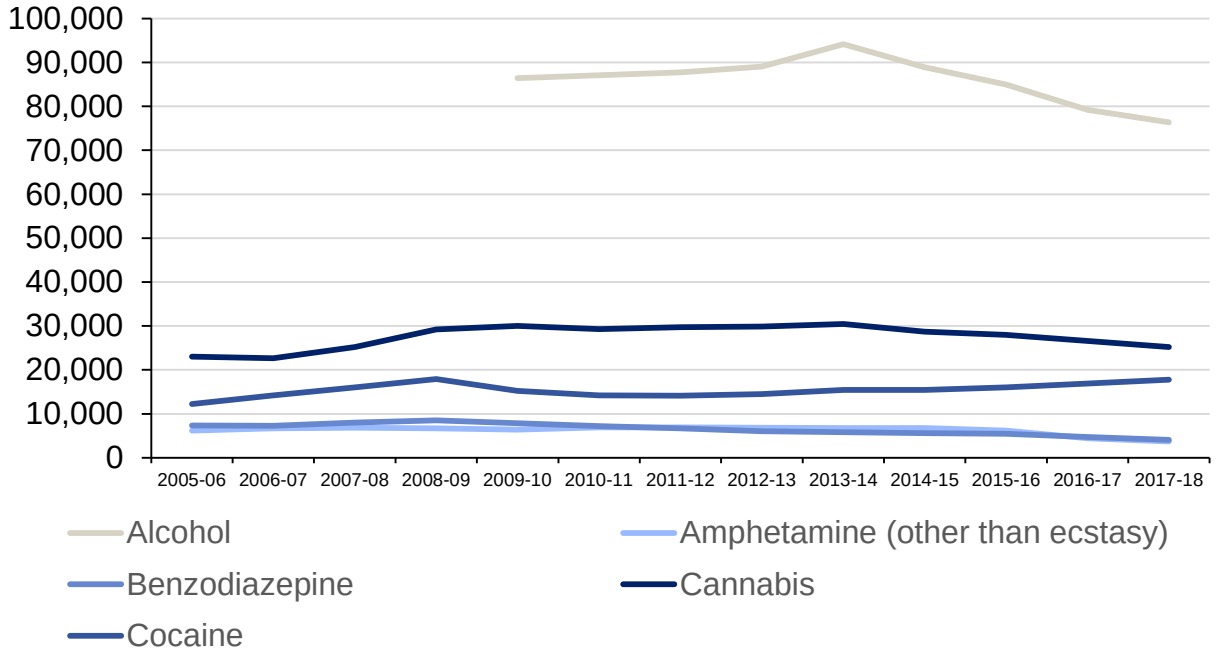


Figure 7.2.2 Number of new treatment presentations for other substances



Pre 2009-10 alcohol data is not included in Figure 7.2.2 as alcohol providers data was only fully collected from 2009-10 onwards

Figure 7.2.3 Presenting substance of under 25s for opiate and/or crack

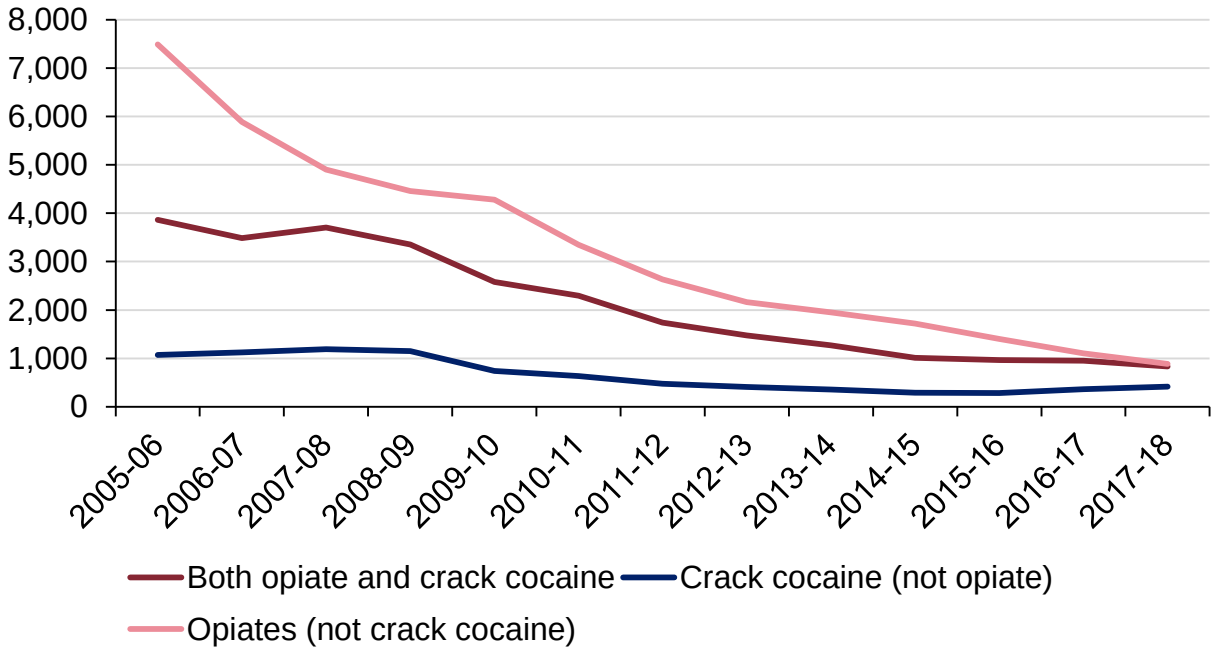
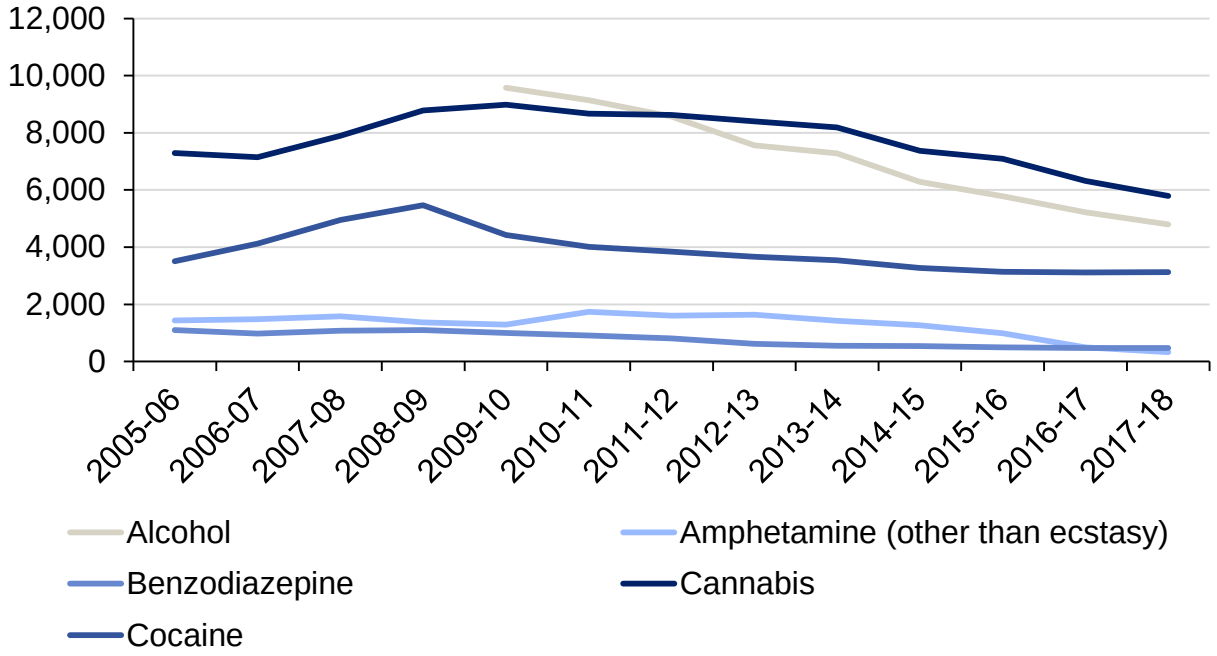


Figure 7.2.4 Presenting substances of under 25s for other substances



Pre 2009-10 alcohol data is not included in Figure 7.2.4 as alcohol providers data was only fully collected from 2009-10 onwards

Figure 7.2.5 shows that the increase in opiate and crack citation appears to be driven by an increase in the over 40s and a smaller increase among those in their 30s.

Figure 7.2.6 indicates that the increase in crack cocaine problems (not being used alongside opiates) is spread more evenly across age categories than the opiates and crack figure. The under 25s show an increase of 53 clients citing crack without opiates, an increase of 15% from 2016-17.

Figure 7.2.5 Number and age of new treatment presentations for opiates and crack cocaine

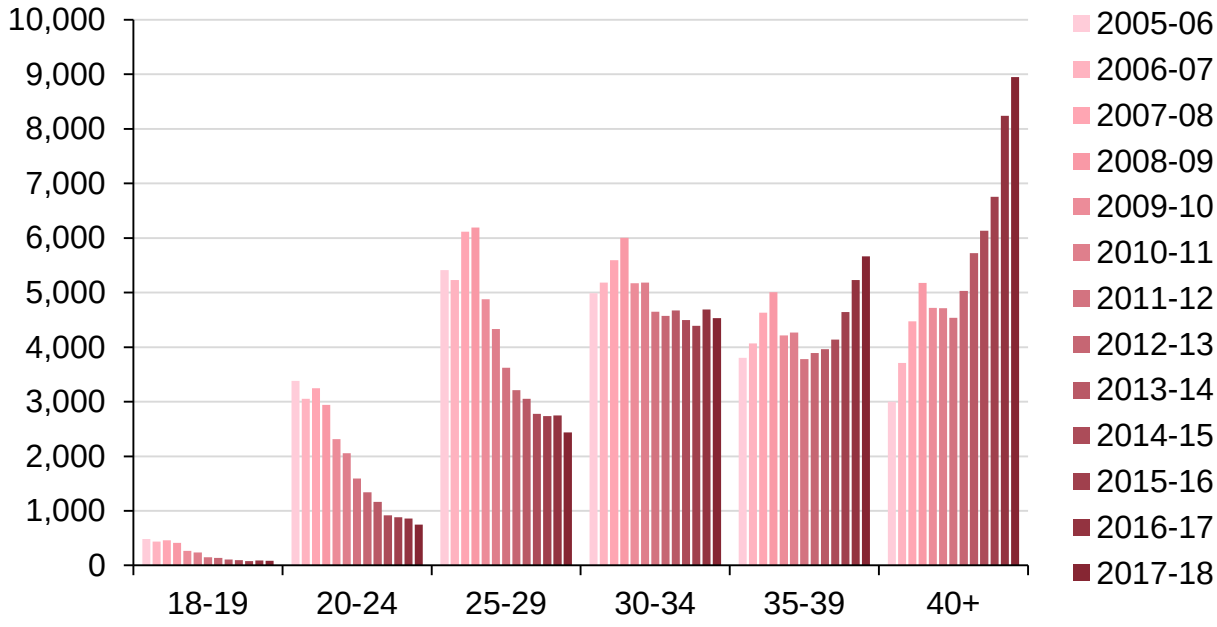
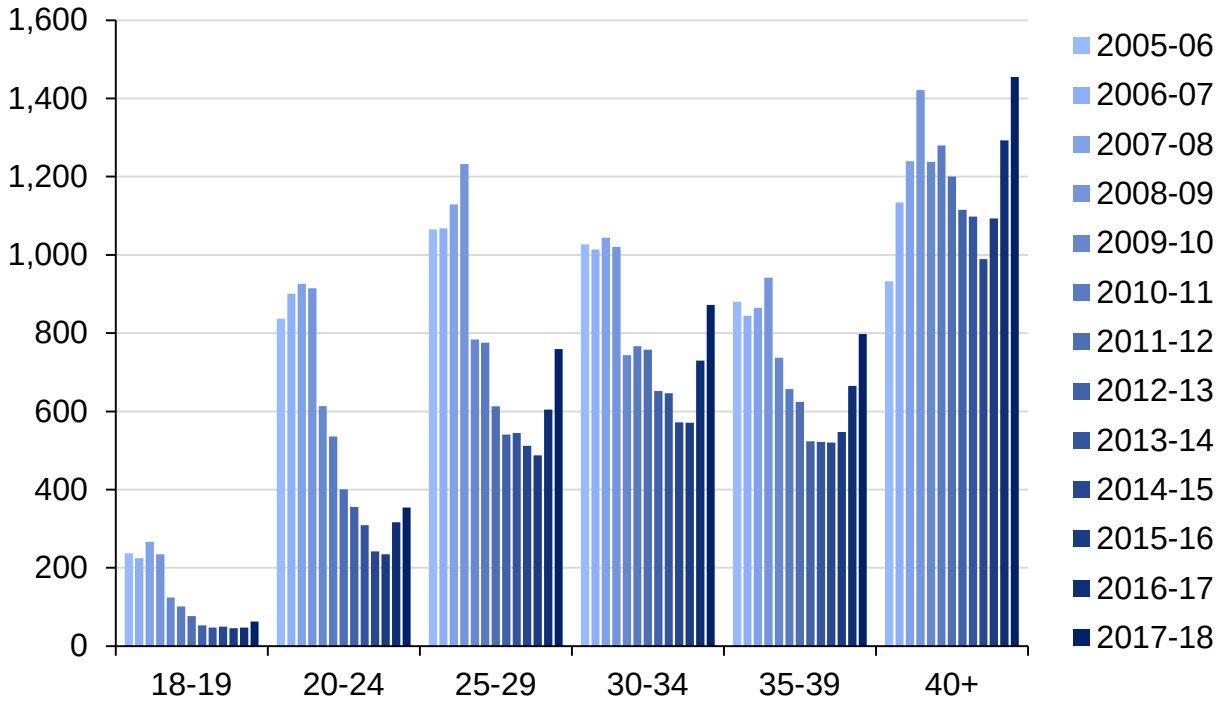


Figure 7.2.6 Number and age of new treatment presentations for crack cocaine without opiates



This fall in younger opiate users presenting for treatment mirrors the trends seen in the estimated prevalence of opiate and/or crack cocaine use among individuals aged 15-24, where the estimated (midpoint) number has fallen from 72,838 (2004-05) to 18,337 (2014-15). Prevalence estimates and the methodology can be found at the below links.

https://www.gov.uk/government/publications/opiate-and-crack-cocaine-use-prevalence-estimates-for-local-populations
http://www.gov.uk/government/publications/measuring-different-aspects-of-problem-drug-use-methodological-developments.

The number of citations for other substances in this younger age group also fell, reflecting the general reduction in the total number of younger individuals (aged 18-24) presenting for treatment over the last six years (see Figure 7.2.4). Large percentage reductions for this group were seen in citations for amphetamine (other than ecstasy) (1,432 in 2005-06 to 324 in 2017-18, a reduction of 77%) while benzodiazepine citations remained similar to 2016-17. Overall, the number of under-25s accessing treatment has fallen by 50% since 2005-06; this reflects changes in the patterns of drinking and drug use in this age group over the last 12 years.

Alcohol citations have fallen by 50% between 2009/10 and 2017/18 which reflects a general downward trend in young people's drinking, as reported in the 'Smoking, Drinking and Drug Use Among Young People in England' survey for 2016. The 2016 survey reported that 44% of 11-15 year olds had tried alcohol at least once. This is an

increase from 38% in 2014 however the 2016 figure is not comparable with previous years due to a change in the wording of the question pupils were asked.

The trends in all new treatment presentations for other drugs vary since 2005-06. Cannabis peaked in 2013-14 but has fallen by 17% over the last four years (30,422 to 25,169). Cocaine has seen a 26% increase since 2011-12 (14,115 to 17,796). Since alcohol service providers started reporting to NDTMS, alcohol citations have fallen from a peak of 94,152 in 2014/15 to 76,397 in 2017/18.

Trends in age and presenting substances among all clients in treatment can be found in the supporting tables.

Table 7.2.1: New treatment presentations by year for clients under 25

	2005-06	2006-07	2007-08	2008-09	2009-10	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18
Opiate and/or crack cocaine use													
Opiate (not crack cocaine)	7,487	5,884	4,899	4,456	4,279	3,347	2,633	2,164	1,951	1,718	1,403	1,104	887
	35%	30%	23%	20%	20%	17%	15%	13%	12%	12%	11%	9%	8%
Both opiate and crack cocaine	3,864	3,485	3,707	3,353	2,581	2,294	1,742	1,473	1,272	1,011	964	949	832
	18%	18%	18%	15%	12%	12%	10%	9%	8%	7%	7%	8%	8%
Crack cocaine (not opiate)	1,074	1,126	1,193	1,150	738	637	478	409	356	292	281	364	417
	5%	6%	6%	5%	4%	3%	3%	2%	2%	2%	2%	3%	4%
Other drug use													
Cannabis	7,290	7,147	7,895	8,781	8,987	8,672	8,620	8,399	8,188	7,369	7,095	6,322	5,791
	34%	36%	37%	40%	43%	44%	48%	51%	51%	52%	54%	54%	54%
Cocaine	3,508	4,124	4,955	5,464	4,420	4,006	3,847	3,659	3,541	3,272	3,137	3,113	3,131
	16%	21%	23%	25%	21%	21%	22%	22%	22%	23%	24%	27%	29%
Amphetamine (other than ecstasy)	1,432	1,483	1,582	1,367	1,288	1,741	1,602	1,642	1,420	1,271	983	496	324
	7%	8%	7%	6%	6%	9%	9%	10%	9%	9%	7%	4%	3%
Benzodiazepine	1,104	973	1,081	1,097	997	914	805	617	546	535	495	467	470
	5%	5%	5%	5%	5%	5%	5%	4%	3%	4%	4%	4%	4%
Other	489	299	345	247	453	367	341	394	396	347	298	178	145
	2%	2%	2%	1%	2%	2%	2%	2%	2%	2%	2%	2%	1%
Alcohol													
Alcohol	5,561	5,730	7,628	9,673	9,574	9,138	8,569	7,560	7,284	6,290	5,779	5,221	4,793
	26%	29%	36%	44%	45%	47%	48%	45%	45%	44%	44%	45%	45%
Total number of individuals	21,283	19,708	21,140	22,129	21,080	19,495	17,845	16,622	16,085	14,178	13,231	11,657	10,666

7.3 Trends in club drug and new psychoactive substance (NPS) use

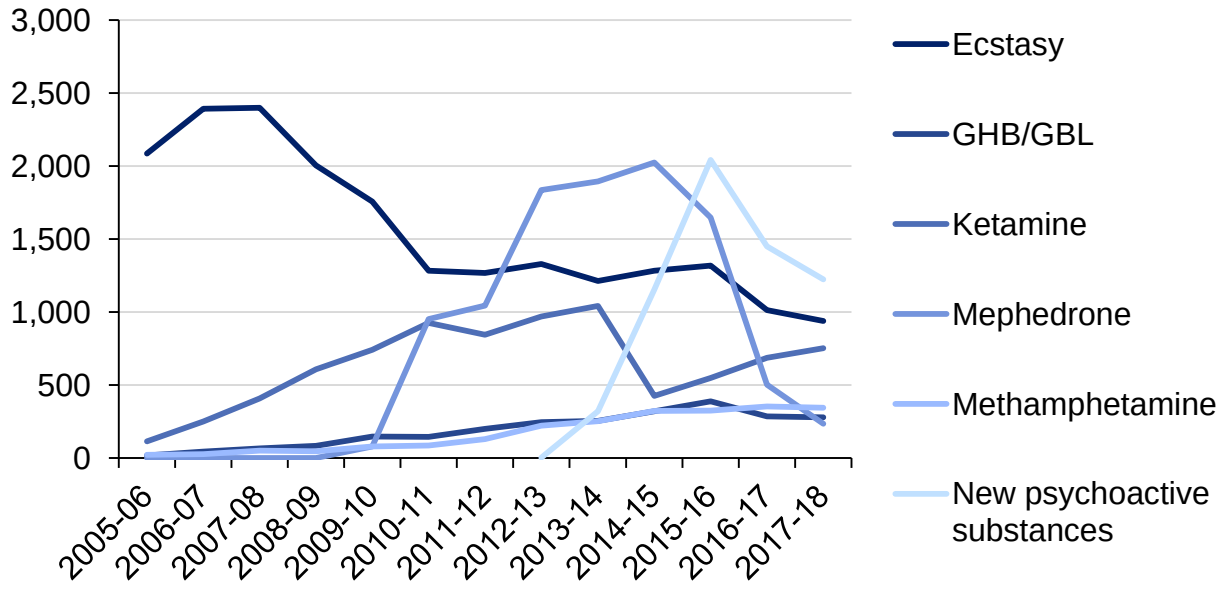
Trends in the number of adults presenting to treatment since 2005-06 that reported club drugs/NPS are shown in Figure 7.3.1 and Table 7.3.1. 'Club drugs and NPS' is a collective term for a number of different substances typically used in bars and nightclubs, concerts and parties, before and after a night out.

NPS was added to NDTMS in 2013-14 and reports increased each year until a peak of 2,042 individuals in 2015-16. However, the number of individuals reporting a problem with NPS has since fallen to 1,223 in 2017-18, a 40% reduction. Figure 7.3.3 shows this reduction separated by age group. Whilst there is a reduction for all age groups, the overall fall is driven largely by the under 25s where there has been a fall from 627 in 2015-16 to 206 in 2017-18 (67% reduction).

Mephedrone citations fell from 2,024 in 2014-15 to 236 in 2017-18, an 88% reduction. Figure 7.3.4 displays this reduction split by age groups. It displays significant reductions in all age groups with the greatest falls among the youngest groups with a 94% fall for under 25s and 91% for the 25-29 age group.

Ketamine citations rose by 66 in 2017-18, a 10% increase. This rise is smaller compared to the rise seen in 2016-17 (25% increase from 550 in 2015-16 to 686 in 2016-17) but follows a significant fall between 2013-14 and 2014-15. Methamphetamine citations have fallen by 8, this represents a decrease of 2% and is in contrast to the increasing trend seen since 2005-06. Ecstasy citations have decreased by 379 since 2015-16 (29%).

Figure 7.3.1 Trends in number of new presentations to treatment citing club drug use



The data used in Figure 7.3.1 is contained in the supporting tables

Figure 7.3.2 shows the trend in the proportion of new presentations that start treatment with either an urgent housing problem or a housing problem. An urgent housing problem for all new presentations to treatment was reported by 8% and a housing problem was reported by 11%. However, there has been a steady increase in the proportion that reported housing problems for individuals starting treatment that reported a problem with NPS. Housing problems increased from 13% in 2013-14 to 21% in 2017-18 and urgent housing problems increased from 6% to 25% over the same period.

Figure 7.3.2 Trends in the proportion of new presentations with housing problems, by NPS and all clients

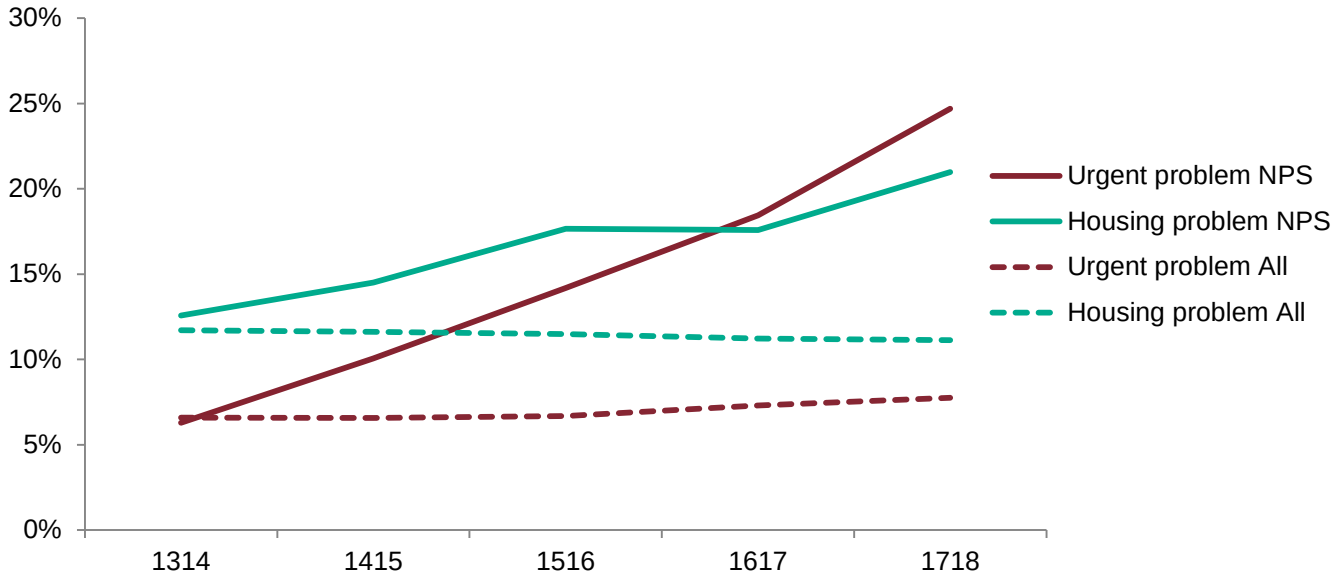


Table 7.3.1: Trends in number of new presentations citing club drugs or new psychoactive substances

Club drug and new psychoactive substances	2005-06	2006-07	2007-08	2008-09	2009-10	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18
Mephedrone[1]	-	-	-	-	80	953	1,044	1,836	1,895	2,024	1,647	502	236
New psychoactive substances[2]	-	-	-	-	-	-	-	4	320	1,154	2,042	1,450	1,223
Ecstasy	2,086	2,393	2,399	2,004	1,756	1,284	1,267	1,329	1,214	1,284	1,318	1,013	939
Ketamine	116	252	409	609	742	927	844	969	1,043	426	550	686	752
GHB/GBL	19	46	67	84	148	145	201	246	255	321	389	286	280
Methamphetamine	22	28	52	48	81	87	131	223	254	323	325	353	345
Further breakdown of new psychoactive substances:													
Predominantly cannabinoid	-	-	-	-	-	-	-	-	67	449	1,024	838	703
Predominantly stimulant	-	-	-	-	-	-	-	-	141	346	414	147	86
Other	-	-	-	-	-	-	-	3	77	262	451	346	322
Predominantly sedative/opioid	-	-	-	-	-	-	-	-	14	65	94	65	50
Predominantly hallucinogenic	-	-	-	-	-	-	-	1	19	56	83	62	53
Predominantly dissociative	-	-	-	-	-	-	-	-	12	18	27	17	23
Total number of citations[3]	2,243	2,719	2,927	2,745	2,807	3,396	3,487	4,607	4,991	5,574	6,322	4,315	3,789
Total number of individuals[4]	2,205	2,639	2,814	2,607	2,650	3,112	3,164	4,081	4,431	4,853	5,537	3,818	3,428
Total number in treatment	110,687	108,638	124,205	147,578	147,046	142,955	139,097	140,454	147,458	141,646	138,081	131,216	127,307

[1] A code for mephedrone was added to the NDTMS core dataset in 2010-11. Any clients reporting mephedrone prior to this are included in the total but no separate total is given for mephedrone.
[2] Codes for NPS were added to NDTMS core dataset in 2013-14. Any clients reporting NPS prior to this are included in the total.
[3] This total is for the substances listed in the top part of the table (excluding NPS) plus the individual citations of the NPS substances in the bottom half of the table as clients may have multiple citations for different NPS substances.
[4] This is a count of individuals as clients may cite multiple NPS substances in the same treatment journey.

Figure 7.3.3 Number and age of new treatment presentations for NPS

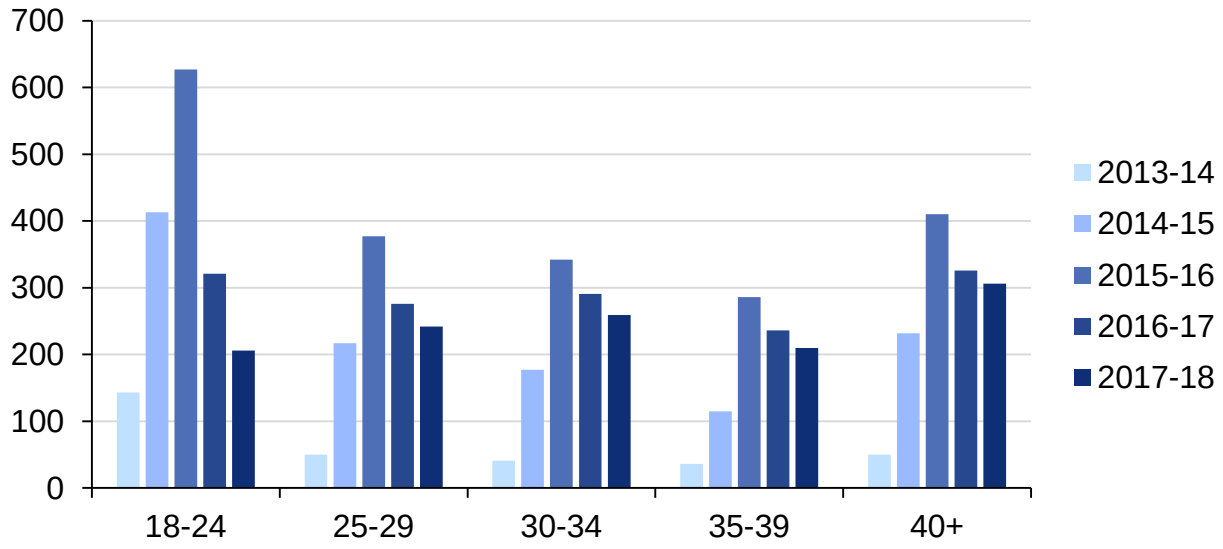
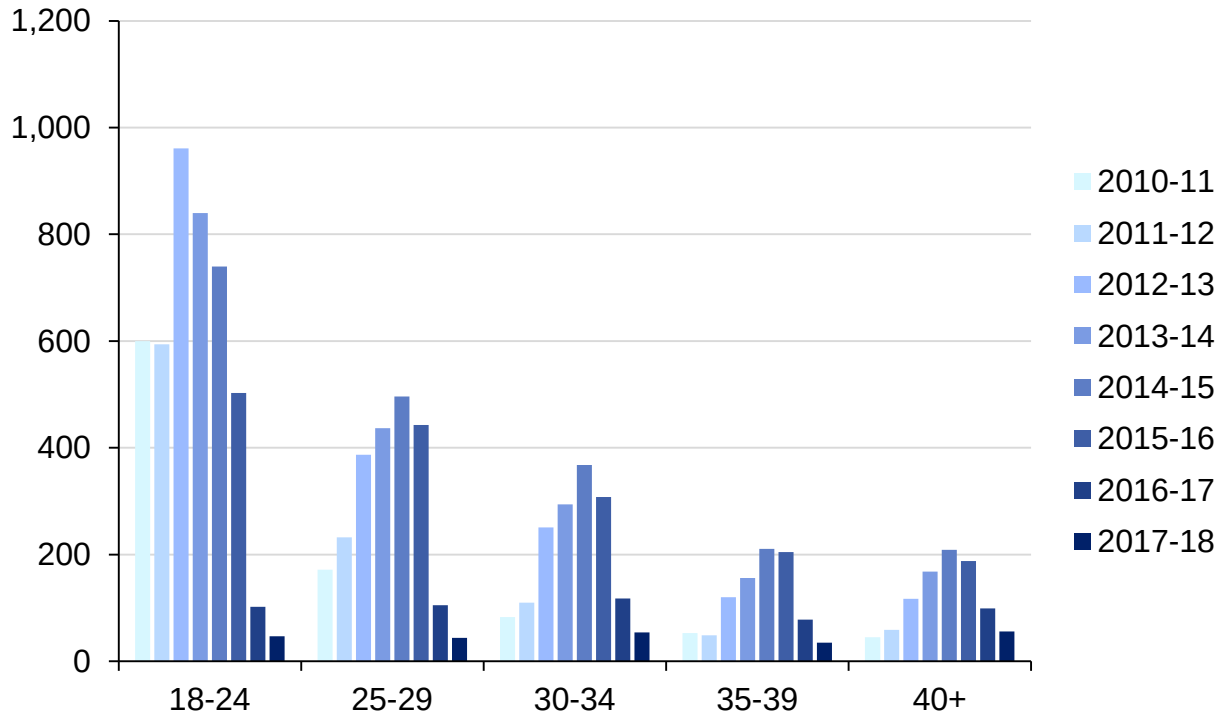


Figure 7.3.4 Number and age of new treatment presentations for mephedrone



Trends in treatment exit reasons

Table 7.4.1 reports the trend for individuals who completed treatment free of dependence since 2005-06 by the four main substance groups. Trends in all treatment exit reasons can be found in the supporting tables.

Overall, the proportion of individuals completing treatment free of dependence, out of those leaving treatment in the year, increased between 2005-06 and 2011-12 from 24%

to 53% and remained at 53% until 2013-14. The rate has fallen each year since then and was 48% in 2017/18.

Opiate clients completing treatment free of dependence reached a peak in 2011-12, but since then there has been a decrease from 37% to 26%. In comparison, the proportion of alcohol only clients in treatment completing treatment free of dependence has gradually increased from just under half (49%) in 2009-10 to 61% in 2017-18.

Table 7.4.1: Trends in treatment completed free of dependence

Year	Opiate		Non-opiate only		Non-opiate and alcohol		Alcohol only		Total	
	n	%	n	%	n	%	n	%	n	%
2005-06	6,395	18%	3,311	25%	2,044	28%	6,326	34%	18,076	24%
2006-07	7,500	21%	4,278	32%	2,755	34%	7,201	38%	21,734	29%
2007-08	9,448	25%	5,766	40%	4,470	41%	11,252	45%	30,936	35%
2008-09	12,621	33%	7,745	51%	7,654	51%	21,115	51%	49,135	45%
2009-10	10,832	27%	8,023	55%	8,414	51%	24,862	49%	52,131	43%
2010-11	13,636	33%	9,144	60%	9,418	56%	29,566	56%	61,764	49%
2011-12	14,792	37%	9,568	64%	10,060	59%	31,102	59%	65,522	53%
2012-13	13,834	36%	9,917	64%	10,186	60%	33,839	60%	67,776	53%
2013-14	12,882	33%	10,939	63%	10,578	58%	36,164	61%	70,563	53%
2014-15	11,685	30%	10,568	64%	10,376	58%	35,159	61%	67,788	52%
2015-16	10,463	28%	10,545	60%	9,955	56%	33,203	62%	64,166	50%
2016-17	10,439	26%	10,044	59%	10,035	54%	31,982	61%	62,500	49%
2017-18	9,309	26%	9,357	56%	9,828	53%	30,224	61%	58,718	48%

7.4 Trends in waiting times for first intervention

Table 7.5.1 presents trends in the number and proportion of individuals that waited three weeks and under to commence their treatment following the date of referral. Overall, the proportion waiting three weeks or less has increased from 84% in 2005-06 to 98% in 2017-18. The largest improvements in waiting times have been seen in alcohol only clients (from 73% in 2005-06 to 98% in 2017-18) and non-opiate and alcohol clients (from 84% in 2005-06 to 98% in 2017-18).

Table 7.5.1: Trends in waiting times of three weeks and under for first intervention

Year	Opiate		Non-opiate only		Non-opiate and alcohol		Alcohol only		Total	
	n	%	n	%	n	%	n	%	n	%
2005-06	25,058	87%	5,309	88%	3,300	84%	6,937	73%	40,604	84%
2006-07	49,619	87%	12,141	88%	8,089	83%	14,761	74%	84,610	84%
2007-08	55,438	91%	14,788	91%	11,964	86%	25,076	77%	107,266	87%
2008-09	59,683	93%	15,016	93%	15,828	87%	38,400	77%	128,927	87%
2009-10	57,911	94%	15,062	95%	15,832	88%	42,483	78%	131,288	88%
2010-11	53,848	96%	14,952	96%	16,219	90%	46,954	82%	131,973	90%
2011-12	51,018	97%	15,800	97%	17,545	92%	48,978	85%	133,341	92%
2012-13	54,812	98%	17,032	97%	18,079	94%	54,550	89%	144,473	94%
2013-14	63,994	98%	18,279	98%	19,625	96%	62,140	93%	164,038	96%
2014-15	64,152	98%	17,599	98%	18,648	96%	60,593	95%	160,992	97%
2015-16	62,784	98%	18,328	98%	19,067	97%	57,886	96%	158,065	97%
2016-17	63,548	99%	17,217	98%	19,399	98%	53,745	98%	153,909	98%
2017-18	61,147	99%	17,097	98%	19,229	98%	51,701	98%	149,174	98%

8. A 13-year treatment population analysis

This section presents an analysis of treatment histories for individuals across 13 years of treatment data starting from 2005-06 (the earliest point NDTMS data is considered to be sufficiently robust for comparison with subsequent years). More information on the methodological implications of this analysis compared with analysis elsewhere in the report where each year's figures are independently calculated is available. https://www.ndtms.net/resources/public/Quality-and-Methodology-NDTMS-2017-18.pdf

Over the 13-year period, a total of 919,823 unique individuals were in contact with the treatment system and by 31 March 2018 140,070 (15%) were still engaged in treatment, 354,031 (35%) left with the status 'treatment incomplete' and 45% (415,722) had completed treatment and had not returned to treatment (Figure 8.1.1).

Figure 8.1.1 Last status of all clients in treatment since 2005-06

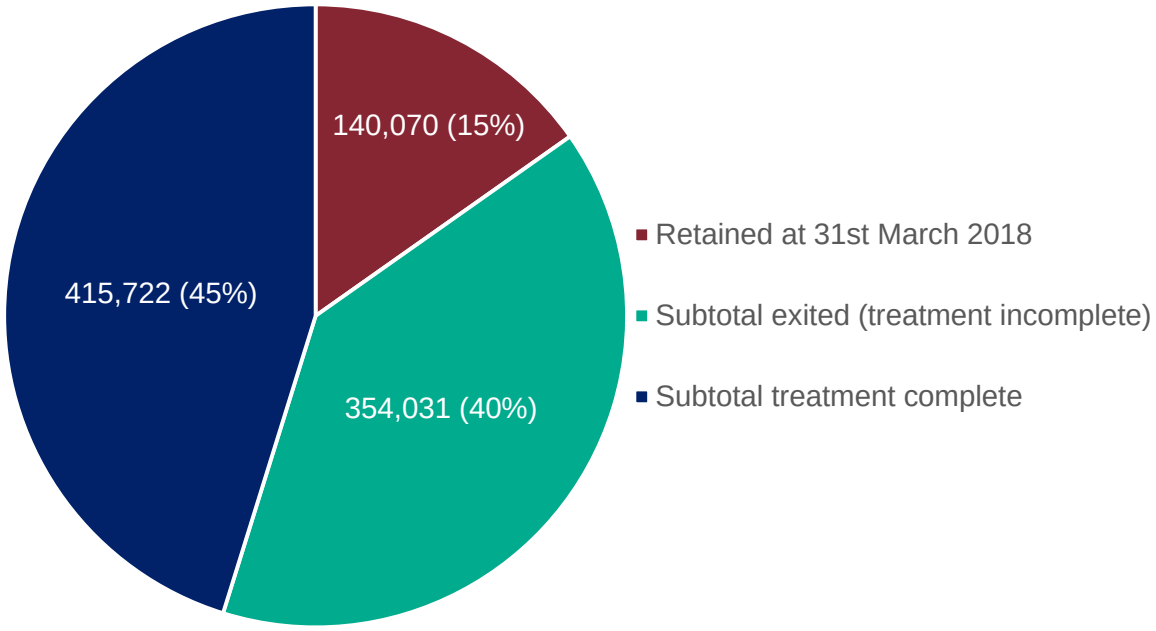
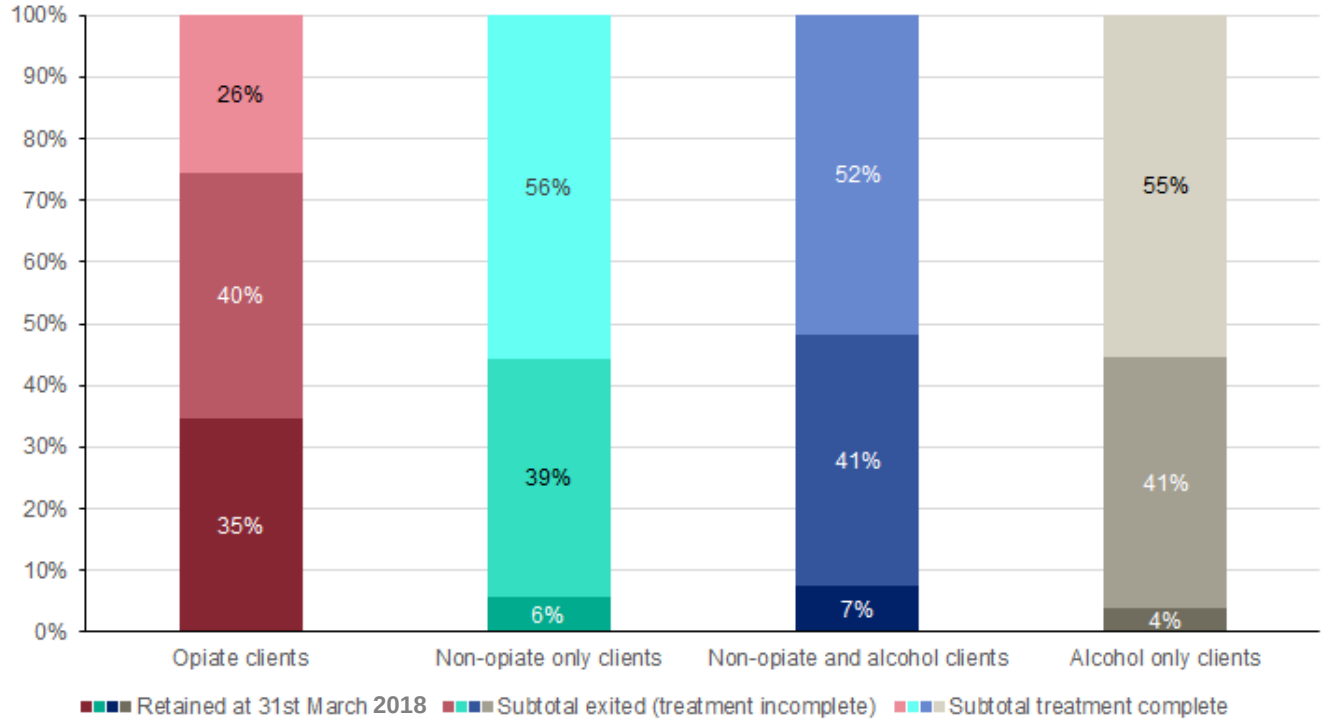


Figure 8.1.2 shows the last status based on the four substance groups. The opiate group had the highest proportion retained in treatment at the end of March 2018 (35%) and alcohol only clients had the lowest proportion (4%). In contrast, around a quarter (26%) of opiate clients completed treatment and did not return, while more than 50% of the other substance groups achieved this.

Figure 8.1.2 Treatment contact status for the four main substance groups in 2017-18



A further examination of the 140,070 individuals who were retained in treatment on the 31 March 2018 is shown in Figure 8.1.3. Just over a quarter (28%) were in treatment continuously since their initial commencement and around a fifth (21%) were on their second treatment journey. The remaining 51% had three or more attempts at treatment.

Figure 8.1.3 Number of previous treatment journeys for those retained in treatment 31 March 2018

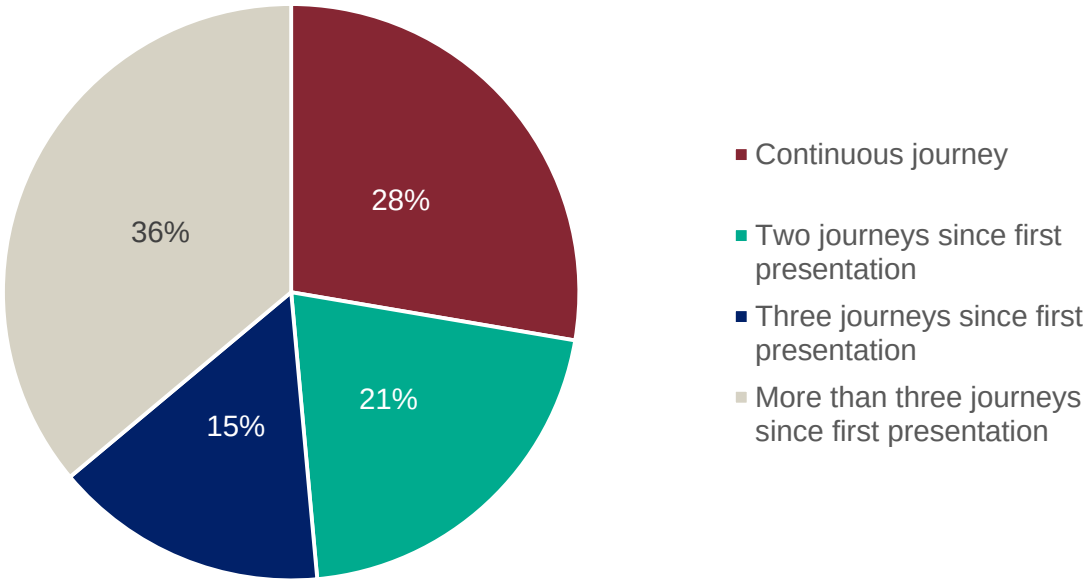


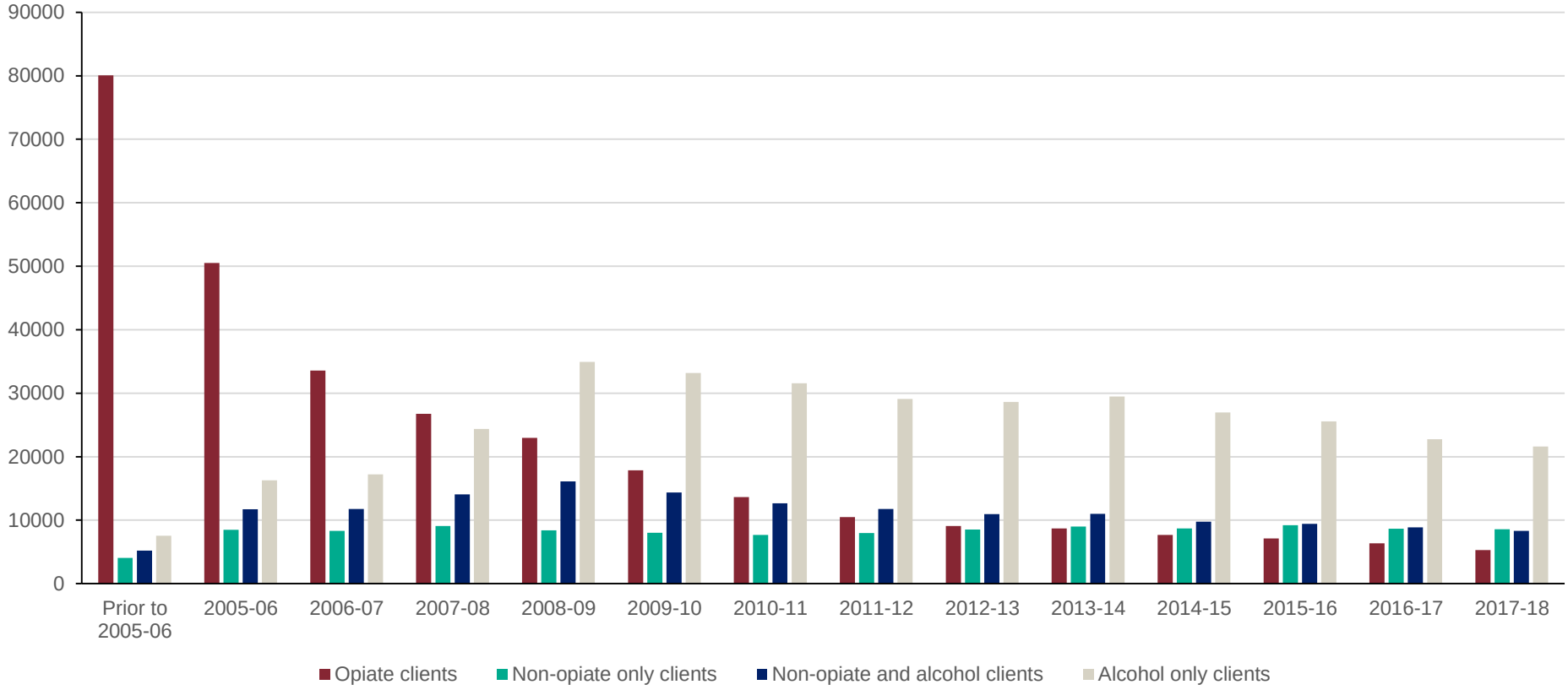
Figure 8.1.4 shows, by the four substance groups, the year in which individuals first entered the treatment system. Around 80,000 (80,052) opiate clients first made contact

with the treatment system prior to 2005-06 and around 50,000 (50,530) opiate clients first made contact with the treatment system in 2005-06. This number has fallen year on year since 2005-06 and from 2012-13 onwards there were less than 10,000 (9,070) opiate clients presenting to the treatment system for the first time.

There was a gradual increase from 2005-06 in alcohol only and non-opiate and alcohol clients presenting to treatment for the first time until a peak in 2008-09 (34,927 and 16,116 respectively) and this number has steadily fallen to 21,579 alcohol only clients and 8,311 non-opiate and alcohol clients in 2017-18. Non-opiate only clients presenting to treatment for the first time has remained relatively constant since 2005-06 (8,484 in 2005-06 to 8,555 in 2017-18).

More detail can be found in the supporting tables.
https://www.gov.uk/government/statistics/substance-misuse-treatment-for-adults-statistics-2017-to-2018

Figure 8.1.4 Number of clients starting treatment for the first time ever by substance group and year of initial contact



Note: complete coverage of alcohol treatment in England was not achieved until 2009

9. History

This report presents information relating to drug and alcohol treatment in England. The statistics are derived from data that has been collected through NDTMS. NDTMS collects activity data from drug and alcohol treatment services so that:

- the progress of individuals entering treatment may be monitored and their outcomes and recovery assessed
- trends and shifts in patterns of drug use and addiction can be monitored, to inform future planning locally and nationally
- service users' journeys from addiction to recovery can be tracked
- the impact of drug treatment as a component of the wider public health service may be measured
- they can demonstrate their accountability to their service users, local commissioners and communities
- costs can be benchmarked against data from comparable areas to show how efficiently they use resources and how they are delivering value for money

Drug treatment activity has been collected nationally for nearly 25 years and has been routinely collected through NDTMS since April 2004. NDTMS is currently managed by PHE.

NDTMS has been reorganised over the years, bringing the definition of alcohol and drug treatment recorded by the system further into line with 'Drug misuse and dependence: UK guidelines on clinical management': https://www.gov.uk/government/publications/drug-misuse-and-dependence-uk-guidelines-on-clinical-management and 'Models of care for alcohol misusers':http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4136809.pdf

Since 2003-04 data has been consistently collected by treatment services, submitting a core data set of their clients' information as a database extract. The most recent revision affecting the statistics in this document is the introduction of core dataset N for the April 2017 data submission. The core data set can be found in NDTMS reference data document: https://www.gov.uk/government/collections/alcohol-and-drug-misuse-treatment-core-dataset-collection-guidance

Periodic consulations are undertaken to revise the NDTMS dataset. Information regarding future core dataset consultations will be made availiable here: https://www.gov.uk/government/collections/alcohol-and-drug-misuse-treatment-core-dataset-collection-guidance

NDTMS figures for England are collated by The National Drug Evidence Centre (NDEC), along with those for Scotland, Wales and Northern Ireland, and combined into a UK return for use by the European Monitoring Centre for Drugs and Drug Addiction www.emcdda.europa.eu/html.cfm/index190EN.html (and for the United Nations).

This statistical release covers England only. Information on drug and alcohol treatment in Wales, Scotland and Northern Ireland is also available:
www.wales.gov.uk/keypubstatisticsforwales/topicindex/topics.htm#public (Wales)
www.scotpho.org.uk/comparative-health/profiles/online-profiles-tool (Scotland)
www.dhsspsni.gov.uk/articles/drugs-statistics (Northern Ireland)

While comparisons to drug and alcohol treatment statistics from other countries can be made, care needs to be taken when doing so, as the data is unlikely to be directly comparable due to differences in the definitions and methodologies that are used in collecting the data and in subsequently reporting it.

9.1 Relevant web links and contact details

Monthly web-based NDTMS analyses
https://www.ndtms.net
Public Health Outcomes Framework indicators 2.15i, 2.15ii, 2.15iii and 2.15iv
http://www.phoutcomes.info/public-health-outcomes-framework
National Drug Evidence Centre (NDEC)
http://research.bmh.manchester.ac.uk/epidemiology/NDEC
Public Health England
www.gov.uk/government/organisations/public-health-england

General enquiries

For media enquiries, please call 020 3682 0574 or email phe-pressoffice@phe.gov.uk
For technical enquiries, please email EvidenceApplicationTeam@phe.gov.uk

Policy

Evidence application team, PHE
EvidenceApplicationTeam@phe.gov.uk

Data and Statistics

Jonathan Knight – head of evidence application team, PHE
Jonathan.Knight@phe.gov.uk

Brian Eastwood – programme manager, PHE
Brian.Eastwood@phe.gov.uk

Andrew Jones – research fellow, National Drug Evidence Centre
Andrew.Jones@manchester.ac.uk

9.2 Comparability of data to previous reports

In 2013-14 a consultation was undertaken on combining alcohol and drug treatment journeys. Prior to this, when an adult presented to treatment with a primary alcohol treatment episode concurrent with, or followed by, a primary drug treatment episode, this was reported as two separate treatment journeys. A combined treatment journey methodology removes this anomaly and was supported by a majority of respondents to the consultation.

This method of client classification was first reported in 2014-15 and data was provided back to 2009-10. Data is now provided back to 2005-06 and is reported in section 7 of this report and the supporting tables https://www.gov.uk/government/statistics/substance-misuse-treatment-for-adults-statistics-2017-to-2018

As a result of the new reporting framework, comparisons of data in this report with previous adult drug and alcohol statistics prior to 2014-15 are not valid. Interested parties are referred to trend tables 7.1 to 7.5, appendix B and the accompanying more detailed spreadsheets published alongside this report (https://www.gov.uk/government/statistics/substance-misuse-treatment-for-adults-statistics-2017-to-2018) where data is reported back to 2005-06. A more detailed explanation of this methodological change can be found in section 2 of this report.

Since 1 November 2012, PHE made substantial changes to the core dataset with regards to the coding of intervention type. Prior to this, intervention codes were restricted to six broad categories: inpatient, residential rehabilitation, prescribing, psychosocial, structured day programme and other structured treatment. These categories did not easily allow a distinction to be made between the setting where the interventions were delivered and the interventions themselves.

Following consultations with clinicians, treatment providers and other key stakeholders, a new method of recording intervention types and settings separately was introduced, alongside the ability for providers to record the non-structured recovery support interventions that they were delivering.

As part of the changes in the coding of intervention type, from 1 November 2012 all registered treatment providers are registered with a setting type. There are six adult settings: community, inpatient, residential, recovery house, prison and primary care, which have been incorporated to PHE’s regular reporting. Clients in a prison setting are not reported on in this document. Intervention types have been split in to three high-level categories; pharmacological interventions, psychosocial interventions and recovery support interventions. Recovery support interventions are not reported on in the present report. Due to these implemented changes, most reporting of interventions is limited to those occurring on or after 31 October 2012. Therefore, the validity of comparing data to previous years, particularly in tables 5.2.1, 5.2.2 and 5.2.3, is limited.

9.3 Drug and alcohol treatment collection and reporting timeline

1989-March 2001 Regional Drug Misuse Database (RDMD) – statistics reported in six monthly bulletins by the Department of Health from 1993 to 2001 webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/en/Publicationsandstatistics/Statistics/StatisticalWorkAreas/Statisticalpublichealth/DH_4015620

April 2001-March 2004 National Drug Treatment Monitoring System (NDTMS) – statistics reported annually by the Department of Health.

April 2004-March 2013 National Drug Treatment Monitoring System (NDTMS) – managed by the National Treatment Agency (NTA) reporting statistics annually up to March 2012.

April 2013 to date National Drug Treatment Monitoring System (NDTMS) – managed by Public Health England (PHE) reporting statistics annually from April 2012.

9.4 Other sources of statistics about drugs

9.4.1 Prevalence of drug and alcohol use

An annual estimate of the prevalence of drug use is undertaken through the Crime Survey for England and Wales (CSEW, formerly the British Crime Survey (BCS)). This section of the survey has been in place since 1996, annually since 2001, and has tracked the prevalence of the use of different drugs over this time: https://www.gov.uk/government/statistics/drug-misuse-findings-from-the-2017-to-2018-csew

A second method is used to produce estimates for the prevalence of crack cocaine and heroin use for each local authority area in England. Estimates are available for 2006-07, 2008-09, 2009-10, 2010-11, 2011-12 and 2014-15: https://www.gov.uk/government/publications/opiate-and-crack-cocaine-use-prevalence-estimates-for-local-populations

The estimates are produced through a mixture of capture-recapture and Multiple Indicator Methodology (MIM), and rely on NDTMS data being matched against and/or analysed alongside Probation and Home Office data sets. The data and further information are available at: https://phi.ljmu.ac.uk/wp-content/uploads/2018/07/Estimates-of-the-Prevalence-of-Opiate-Use-and-or-Crack-Cocaine-Use-2014-15-Sweep-11-report.pdf

The prevelance estimates of alcohol dependence have been produced by the University of Sheffield and are available here: https://www.gov.uk/government/publications/alcohol-dependence-prevalence-in-england

A detailed report on the production of these estimates can be found here: https://www.sheffield.ac.uk/polopoly_fs/1.693546!/file/Estimates_of_Alcohol_Dependence_in_England_based_on_APMS_2014.pdf

9.4.2 Young people

Information is also available relating to the prevalence of drug use among secondary school pupils aged 11 to 15 from the Smoking, Drinking and Drug Use Survey among young people in England. This is a survey carried out for the NHS Information Centre by the National Centre for Social Research and the National Foundation for Educational Research. The survey interviews school pupils, and has been in place since 2001. It reports bi-annually up to 2016-17. The data and further information are available at: https://digital.nhs.uk/data-and-information/publications/statistical/smoking-drinking-and-drug-use-among-young-people-in-england/2016.

NDTMS collects data on drug and alcohol treatment for young people, and produces national statistics, the latest of which can be found at: https://www.gov.uk/government/collections/alcohol-and-drug-misuse-and-treatment-statistics

It should be noted that young people's treatment figures are not comparable with statistics relating to adult treatment. This is because access to treatment for young people requires a 'lower severity of drug use and associated problems'[16].

9.4.3 Criminal justice statistics

The Ministry of Justice produces a quarterly statistics bulletin that provides details of individuals in custody and under the supervision of the probation service. These can be found at: www.gov.uk/government/collections/offender-management-statistics-quarterly.

The Ministry of Justice also produces statistics relating to aspects of sentencing, including trends in custody, sentences, fines and other disposals. These can be found at: data.gov.uk/dataset/sentencing_statistics_england_and_wales.

[16] Drug Misuse and Dependence - UK Guidelines on Clinical Management, p85, London: Department of Health (England), the Scottish Government, Welsh Assembly Government and Northern Ireland Executive.

In addition, NDTMS collects data on drug and alcohol treatment in secure settings and published the latest set of official statistics for 2016-17 on 18th January 2018. The statistics for 2017-18 will be produced in January 2019.
https://www.gov.uk/government/statistics/substance-misuse-treatment-in-secure-settings-statistics-2016-to-2017

9.4.4 International comparisons

The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) publishes an annual report that describes and compares aspects of drug use and drug policy within European states, as well as providing detailed comparative statistics. This can be found at: http://www.emcdda.europa.eu/edr2016.

The centre also produces a treatment demand indicator (TDI), which is a collection of comparative statistics relating to individuals seeking treatment. This can be found at: www.emcdda.europa.eu/data/stats2015#displayTable:TDI-0023.

While comparisons to alcohol treatment statistics from other countries can be made, care needs to be taken as the data is unlikely to be directly comparable due to differences in the definitions and methodologies that are used in collecting the data and subsequently in reporting it.

9.4.5 Drug-related deaths

The Office for National Statistics publishes an annual summary of all deaths related to drug poisoning (involving both legal and illegal drugs) and drug misuse (involving illegal drugs) in England and Wales.

https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsrelatedtodrugpoisoninginenglandandwales/2017registrations.

10. Abbreviations and definitions

10.1 Abbreviations

AOR	Alcohol Outcomes Record
CJS	Criminal justice system
CSEW	Crime survey for England and Wales
DIP	Drug Intervention Programme
DRD	Drug-related death
EMCDDA	European Monitoring Centre for Drugs and Drug Addiction
GP	General practitioner
HACAA	Heroin and Crack Action Area
IBA	Identification and brief advice
IPS	Individual Placement Support
LAPE	Local Alcohol Profiles for England
LGA	Local Government Association
ONS	Office for National Statistics
OST	Opioid Substitution Therapy
MIM	Multiple Indicator Methodology
NDEC	National Drug Evidence Centre (University of Manchester)
NDTMS	National Drug Treatment Monitoring System
NFA	No Fixed Abode
NHS	National Health Service
NPS	New psychoactive substance
NTA	National Treatment Agency for Substance Misuse (now part of PHE)
PHE	Public Health England
RCI	Reliable Change Index
RDMD	Regional drug misuse database (1989-2001)
TDI	Treatment Demand Indicator
TOP	Treatment Outcomes Profile
YP	Young people

10.2 Definitions

Agency/provider	A provider of services for the treatment of drug and/or alcohol misuse. It may be statutory (ie, NHS) or non-statutory (ie, third sector, charitable).
Agency/provider code	A unique identifier for the treatment provider (agency) assigned by the regional NDTMS centres – eg, L0001.
Adjunctive drug use	Substances additional to the primary drug used by the client. NDTMS collects secondary and tertiary substances.
Attributor	A concatenation of a client's initials, date of birth and gender. This is used to isolate records that relate to individual clients.
Client	A drug user presenting for treatment at a structured treatment service. Records relating to individual clients are isolated and linked based on the attributor and drug partnership of residence.
Club drug	A collective term for a number of different substances typically used by people in bars and nightclubs, at concerts and parties, before and after a night out.
Community setting	A structured drug and alcohol treatment setting where residence is not a condition of engagement with the service. This will include treatment within community drug and alcohol teams and day programmes (including rehabilitation programmes where residence in a specified location is not a condition of entry).
Discharge date	Usually the planned discharge date in a client's treatment plan, where one has been agreed. However, if a client's discharge was unplanned, then the date of last face-to-face contact with the provider (agency) is used.
Drug-related death / drug misuse death	Annual figures published by the Office for National Statistics (ONS) since 1993 cover deaths in England and Wales related to "drug poisoning (involving both legal and illegal drugs)" and to "drug misuse (involving illegal drugs)". ONS's definition of a drug misuse death is "(a) deaths where the underlying cause is drug abuse or drug dependence and (b) deaths where the underlying cause is drug poisoning and where any of the substances controlled under the Misuse of Drugs Act 1971 are involved."

	Where people do suffer drug poisonings while in treatment, these are overwhelmingly classed as drug misuse, so this definition may be seen as more relevant to this population. However, many of those who die in treatment are not included under either definition as they die from causes other than poisoning.
Episode	A period of contact with a treatment provider (agency): from referral to discharge.
Episode of treatment	A set of interventions with a specific care plan. A client may attend one or more interventions (or types) of treatment during the same episode of treatment. A client may also have more than one episode in a year. A client is considered to have been in contact during the year, and hence included in these results, if any part of an episode occurs within the year. Where several episodes were collected for an individual, attributes such as ethnicity, primary substance, etc, are based on the first valid data available for that individual.
In contact	Clients are counted as being in contact with treatment services if their date of presentation (as indicated by triage), intervention start, intervention end or discharge indicates that they have been in contact with a provider during the year.
Inpatient setting	An inpatient unit provides assessment, stabilisation and/or assisted withdrawal with 24-hour cover from a multidisciplinary clinical team who have had specialist training in managing addictive behaviours. In addition, the clinical lead in such a service comes from a consultant in addiction psychiatry or another substance misuse medical specialist. The multidisciplinary team may include psychologists, nurses, occupational therapists, pharmacists and social workers. Inpatient units are for those alcohol or drug users whose needs require supervision in a controlled medical environment.
Intervention	A type of treatment, eg, structured counselling, community prescribing, etc.
First/subsequent intervention	'First intervention' refers to the first intervention that occurs in a treatment journey. 'Subsequent intervention' refers to interventions within a treatment journey that occur after the first intervention.
New psychoactive substance (NPS)	Chemical substances that produce similar effects to ‘established’ drugs (like cocaine, cannabis and ecstasy). Originally created to

	side-step legislation, an increasing number are controlled under the Misuse of Drugs Act but all remaining are now covered by the Psychoactive Substances Act
Non-opiate	Any drug other than those that act on opioid receptors (heroin, methadone, buprenorphine and others)
Opiate	A group of drugs including heroin, methadone and buprenorphine that act on opioid receptors.
Presenting for treatment	The first face-to-face contact between a client and a treatment provider.
Primary drug	The substance that brought the client into treatment at the point of triage/initial assessment.
Recovery house setting	A recovery house is a residential living environment, in which integrated peer-support and/or integrated recovery support interventions are provided for residents who were previously, or are currently, engaged in treatment to overcome their drug and alcohol dependence. The residences can also be referred to as dry-houses, third-stage accommodation or quasi-residential.
Referral date	The date the client was referred to the provider for this episode of treatment.
Referral source	The source or method by which a client was referred for this treatment episode.
Residential rehab setting	A structured drug and alcohol treatment setting where residence is a condition of receiving the interventions. Although such programmes are usually abstinence based, prescribing for relapse prevention prescribing or for medication assisted recovery are also options. The programmes are often, although not exclusively, aimed at people who have had difficulty in overcoming their dependence in a community setting.
Structured drug treatment	Structured drug treatment follows assessment and is delivered according to a care plan, with clear goals, which are regularly reviewed with the client. It may comprise a number of concurrent or sequential treatment interventions.
Successful completion	A term that describes a client that completes treatment successfully as either:

	‘treatment completed drug free’ – no longer requiring any structured drug treatment interventions and judged by the clinician not to be using heroin (or any other opioids) or crack cocaine or any other illicit drug or ‘treatment completed occasional user (not heroin and crack)’ – the client no longer requires structured drug treatment interventions and is judged by the clinician not to be using heroin (or any other opioids) or crack cocaine. There is evidence of use of other illicit drug use but this is not judged to be problematic or to require treatment.
Treatment journey	A set of concurrent or serial treatment episodes linked together to describe a period of treatment based on the clients’ attributors and DAAT of residence. This can be within one provider or across a number of different providers.
Triage	An initial clinical risk assessment performed by a treatment provider. A triage includes a brief assessment of the problem as well as an assessment of the client’s readiness to engage with treatment, in order to inform a care plan.
Triage date	The date that the client made a first face-to-face presentation to a treatment provider. This could be the date of triage/initial assessment though this may not always be the case.
Waiting times	The period from the date a person is referred for a specific treatment intervention and the date of the first appointment offered. Referral for a specific treatment intervention typically occurs within the treatment provider at, or following, assessment.

Note: full operational definitions can be found in the NDTMS core data set documents: https://www.gov.uk/government/collections/alcohol-and-drug-misuse-treatment-core-dataset-collection-guidance

Appendix A

Diagram to show flow through treatment

This diagram illustrates a typical user journey through the treatment system. It is provided to give an indication of a possible treatment pathway and the interventions received. All pathways will vary depending on the substances used and the clinical requirements of the client, their general health needs and any other relevant issues they may have that will impact on the clinical care provided.