



Drug treatment in the North West of England

2006/07

Results from the National Drug Treatment Monitoring System [NDTMS]

Published by:

Centre for Public Health

Faculty of Health and Applied Social Sciences

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*National Treatment Agency
for Substance Misuse*



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Key Points

- During 2006/07 there were 37396 individuals in contact with structured drug treatment services in the North West of England.
- There has been a 5.43% increase in the number of individuals in contact with treatment services in comparison to 2005/06 when the equivalent number was 35469.
- There were differences in the number of individuals in contact with structured drug treatment dependent on D(A)AT of residence from 704 in Trafford to 4929 in Lancashire.
- Regionally, 1.18% of 15-44 year olds were in contact with structured drug treatment services. The prevalence of those in contact with treatment varied from 7.11 per thousand population aged 15-44 (0.71%) in Trafford to 25.05 per thousand of the equivalent age range in Blackpool (2.51%).
- The mean age of those in contact with treatment services during 2006/07 was 33.51 years, significantly older than the in treatment population in 2005/06. In comparison to previous years (2001/02, 2003/04 and 2005/06), there were proportionately more young (under 18) and older (35+) individuals. There were also proportionately fewer 25-35 year olds during 2006/07 in comparison to previous years.
- The majority of individuals in contact with structured drug treatment services stated the problematic use of heroin (67.68%). The problematic usage of cannabis was stated by 22.19% of individuals, methadone by 15.70% of individuals and cocaine by 11.89% of individuals. Whilst crack cocaine was stated as a main problematic drug by 2.69% of individuals, the level of use of this drug rose to 23.65% when all problematic usage was considered.
- The largest referral source into treatment during 2006/07 came via self-referrals (35.32% of referrals for all episodes of treatment). There has been a slight decrease in the proportion of referrals from Criminal Justice Services (CJS) (22.16%) in comparison to 2005/06 (22.52%), however the actual number of referrals from CJS has increased from 11243 in 2005/06 to 11509 in 2006/07.
- The most common adult modality of treatment accessed during 2006/07 was specialist prescribing (48.71%). Within young persons modalities of treatment, psychosocial interventions accounted for 66.56% of modalities.
- The majority of latest treatment episodes were ongoing at the end of 2006/07 (65.90%). Of those that had completed their final episode of treatment, 5011 (39.87%) had a successful completion, with 7018 (55.84%) resulting in an unplanned discharge.

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This report, along with previous NDTMS reporting by The Centre for Public Health, Liverpool John Moores University, is available on the CPH website www.cph.org.uk/ndtms. The NDTMS regional team, based within the North West Public Health Observatory at the Centre for Public Health, Liverpool John Moores University, also produces monthly reports providing timely information from the NDTMS dataset, along with quarterly themed reports, based on particular aspects of the data. These reports are also available on the website.

The Centre for Public Health, Liverpool John Moores University would welcome feedback on the contents of the report. Any comments or queries should be directed to the following person:

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This publication details the results of the National Drug Treatment Monitoring System (NDTMS) in the North West of England during 2006/07. The NDTMS was introduced in April 2001 to collect data on all clients in contact with structured treatment services (i.e. high threshold tier 3 and 4 services as defined by the Models of Care, see National Treatment Agency (NTA), 2002). NDTMS figures are used as a key source for monitoring the number of people in contact with drug treatment services, whilst also being the basis for examining the success of the Government's commitment to double the number of people in drug treatment between 1998 and 2008. This report provides an overview of the NDTMS data for the region and also provides some comparisons to previous years; 2001/02, 2003/04 and 2005/06. Therefore, this report offers supplementary detailed information to build on the

Developments to NDTMS

There have been several developments to the NDTMS dataset during the 2006/07 financial year. New data items were introduced, including the date referred to modality and date of first appointment offered. These new modality fields have been used to monitor NTA waiting time targets. The NTA also introduced a new measure of retention during the 2006/07 financial year, to make use of the ability of NDTMS to track individuals through simultaneous and consecutive treatment episodes (see http://www.nta.nhs.uk/areas/facts_and_figures/Retention_definition_Dec06.pdf).

The Centre for Public Health, Liverpool John Moores University, introduced themed NDTMS reports during the 2006/07 financial year, to focus on specific issues within the NDTMS dataset (see www.cph.org.uk/publications.asp). These themed

national figures quoted by the National Drug Evidence Centre (NDEC) and the NTA. The report only includes data for those resident within the region who were in contact with treatment services within the North West. The NTA will produce official 2006/07 figures for numbers in treatment in October 2007, using the July 2007 dataset. More detailed results, described at Drug (and Alcohol) Action Team (D(A)AT) level, are published on the NDTMS regional website at www.cph.org.uk/ndtms.

The results of this report were compiled by the NDTMS regional team, based within the North West Public Health Observatory at the Centre for Public Health, Liverpool John Moores University. This regional team collects data from all structured drug treatment providers in the North West on behalf of the NTA.

reports will continue during 2007/08, to include priority topics as identified by the NDTMS regional stakeholder group, such as individuals stating alcohol as a secondary or tertiary drug, deaths of injectors and non-injectors in contact with treatment and individuals in contact with Tier 4 treatment modalities. The Centre for Public Health will also introduce additional supplementary D(A)AT reports providing a snapshot of D(A)AT profiles in comparison to the regional average.

During 2007/08, additional fields will be added to the NDTMS to accommodate the introduction of the Treatment Outcomes Profile (TOP). The TOP is the NTAs new national outcomes monitoring tool and will be used with every client aged 16 and over who enters structured treatment. The NTA also plan to start monitoring structured alcohol treatment, within specific alcohol services and drug services, within the NDTMS, leading to routine monitoring of alcohol treatment in 2008/09.

Regional results

During 2006/07 there were 37396 individuals in contact with drug treatment services. There has been a 5.43% increase in levels of treatment engagement from 2005/06, when the equivalent figure was 35469 (Khundakar et al., 2006a) and a rise of 33.99% from 2003/04 (n=27909) (Bullock et al., 2005). There was an increase in the number of new presentations to treatment in 2006/07 (n=17663) in comparison to 2005/06 (n=17057), 2003/04 (n=14745) and 2001/02 (n=10472). Of those that stated their previous contact history with treatment services, 43.37% indicated that they had never had prior contact with a tier 3 or 4 agency (structured community based drug treatment services and residential service for drug and alcohol misusers).

Variations between local areas within the region

There were considerable variations between the number of residents from the 22 D(A)ATs in contact with structured drug treatment services, ranging from 704 in Trafford to 4929 in Lancashire. There were also variations in the number of new and ongoing clients in each of the D(A)ATs. The proportion of new clients varied from 29.04% in

Wirral to 61.27% in Knowsley. Whilst the proportion of new clients rose in several areas between 2005/06 and 2006/07 (for example in Knowsley the proportion of new clients rose from 50.55% in 2005/06 to 61.27% in 2006/07), it fell in areas such as Bolton (58.61% in 2005/06 to 51.34% in 2006/07).

Table 1 shows the number of individuals in contact with structured drug treatment services according to D(A)AT of residence. This table includes deprivation scores for the North West D(A)ATs. These scores have been included as deprivation may be one contributory factor in determining the number of problematic drug users in an area (ACMD, 1998). Table 1 reveals that several areas with high deprivation levels also had a high number of its population in contact with drug treatment services. D(A)ATs with high levels of deprivation, such as Liverpool and Manchester had a relatively high prevalence of those in contact with drug treatment. Whilst those areas with high levels of deprivation had comparable levels of drug users in drug treatment, areas with low levels of deprivation, such as Cheshire, Stockport and Trafford, also had low prevalence levels of those in treatment per 1000 population (8.14, 7.59 and 7.11 per 1000 population respectively).

Table 1: Number of people in contact with treatment services in 2006/07, prevalence, deprivation scores and ranks, by D(A)AT of residence

D(A)AT	New		Ongoing ¹		Total in contact ²		Prevalence (per 1000 aged 15-44) ³	Deprivation score ⁴	Deprivation rank (1 = highest, 22 = lowest)
	No.	Row %	No.	Row %	No.	Col %			
Blackburn with Darwen	581	53.35	508	46.65	1089	2.79	16.96	32.28	8
Blackpool	861	57.06	648	42.94	1509	3.87	25.05	33.91	6
Bolton	960	51.34	910	48.66	1870	4.79	15.91	29.41	13
Bury	511	50.64	498	49.36	1009	2.59	12.03	23.53	16
Cheshire	1003	42.96	1332	57.04	2335	5.99	8.14	15.06	22
Cumbria	672	41.77	937	58.23	1609	4.13	7.96	21.57	18
Halton	488	54.04	415	45.96	903	2.32	16.46	34.29	5
Knowsley	753	61.27	476	38.73	1229	3.15	17.88	46.57	3
Lancashire	2590	52.55	2339	47.45	4929	12.64	9.65	21.80	17
Liverpool	2168	53.37	1894	46.63	4062	10.42	16.75	49.78	1
Manchester	1349	37.33	2265	62.67	3614	9.27	13.47	48.91	2
Oldham	535	47.47	592	52.53	1127	2.89	11.06	30.73	10
Rochdale	1018	56.87	772	43.13	1790	4.59	18.02	33.69	7
Salford	645	52.27	589	47.73	1234	3.16	11.45	38.19	4
Sefton	792	51.30	752	48.70	1544	3.96	13.06	26.12	9
St Helens	555	49.07	576	50.93	1131	2.90	14.73	31.95	15
Stockport	469	49.01	488	50.99	957	2.45	7.59	18.06	21
Tameside	516	45.58	616	54.42	1132	2.90	11.69	29.81	12
Trafford	333	47.30	371	52.70	704	1.81	7.11	20.15	19
Warrington	363	37.73	599	62.27	962	2.47	10.96	19.39	20
Wigan and Leigh	667	45.94	785	54.06	1452	3.72	10.72	29.26	14
Wirral	816	29.04	1994	70.96	2810	7.20	20.83	30.06	11

While there has been an increase in the number of people in contact with drug treatment services in all D(A)ATs across the North West between 2001/02 and 2006/07, the proportional rise has not been consistent. Table 2 and figure 1 demonstrate that the percentage rise in the number of clients contacting treatment services between 2001/02 and 2006/07 varied from 23.73% in Trafford to 278.59% in

Cumbria. Halton and Knowsley D(A)ATs also experienced a substantial percentage increase of those in contact with treatment services from 2001/02 to 2006/07 (188.50% and 174.94% respectively). Lancashire and Liverpool D(A)ATs had the largest increase in individuals between 2001/02 and 2006/07 (1819 and 1712 individuals respectively).

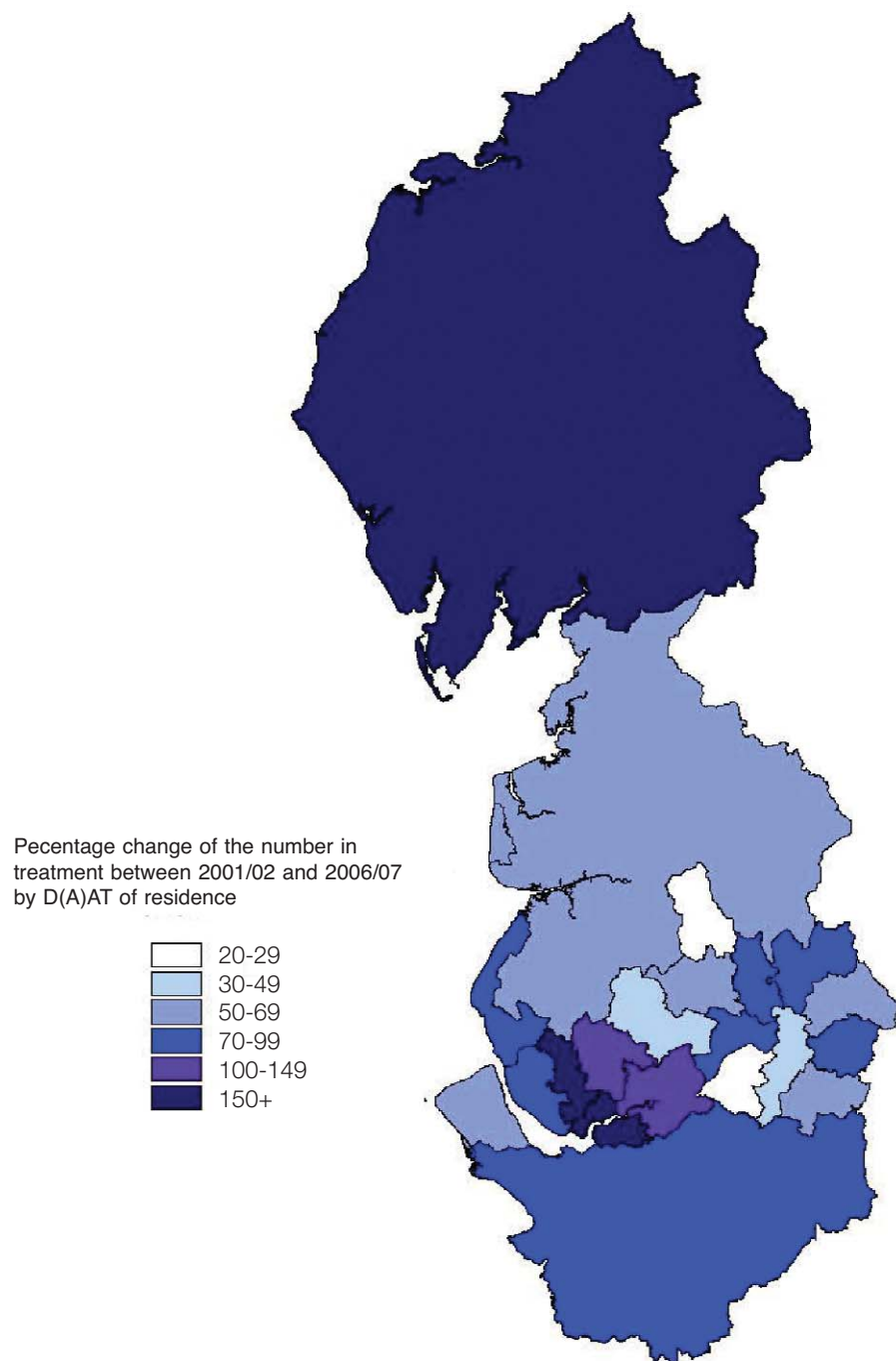
Table 2: Percentage increase of number in treatment 2001/02 to 2006/07 by D(A)AT of residence

D(A)AT	2001/02	2003/04	2005/06*	2006/07	Increase in individuals 01/02 to 06/07	% Increase 01/02 to 06/07
Blackburn with Darwen	755	765	935	1089	334	44.24
Blackpool	920	1086	1628	1509	589	64.02
Bolton	1228	1179	1875	1870	642	52.28
Bury	541	853	1083	1009	468	86.51
Cheshire	1187	1773	2196	2335	1148	96.71
Cumbria	425	926	1412	1609	1184	278.59
Halton	313	538	713	903	590	188.50
Knowsley	447	694	904	1229	782	174.94
Lancashire	3110	3782	4720	4929	1819	58.49
Liverpool	2350	2771	4120	4062	1712	72.85
Manchester	2481	2722	3216	3614	1133	45.67
Oldham	671	812	1141	1127	456	67.96
Rochdale	938	1333	1594	1790	852	90.83
Salford	701	1357	1121	1234	533	76.03
Sefton	882	1158	1607	1544	662	75.06
St Helens	492	797	1004	1131	639	129.88
Stockport	580	616	987	957	377	65.00
Tameside	630	969	1165	1132	502	79.68
Trafford	569	511	778	704	135	23.73
Warrington	449	606	841	962	513	114.25
Wigan and Leigh	1008	1451	1561	1452	444	44.05
Wirral	1797	2117	2635	2810	1013	56.37

*JMU figures equivalent to NTA figures in April 2006. Official NTA figures for numbers in treatment in 2005/06 were finalised in October 2006 and superseded the figures produced on 28th April 2006.

^{1, 2, 3, 4} For explanation and methodological notes please refer to methodological section at end of report

Figure 1: Percentage increase in the number of individuals contacting drug treatment services (by D(A)AT of residence) between 2001/02 and 2006/07



The identification of the actual number of those in treatment residing within each D(A)AT is an essential element of monitoring progress in the development of drug treatment provision. However, it fails to take into consideration the number in treatment in relation to the general population of each D(A)AT. Therefore, table 3 and figure 2 display the prevalence levels of people in contact with treatment (aged 15-44) per 1000 of the general population in each D(A)AT

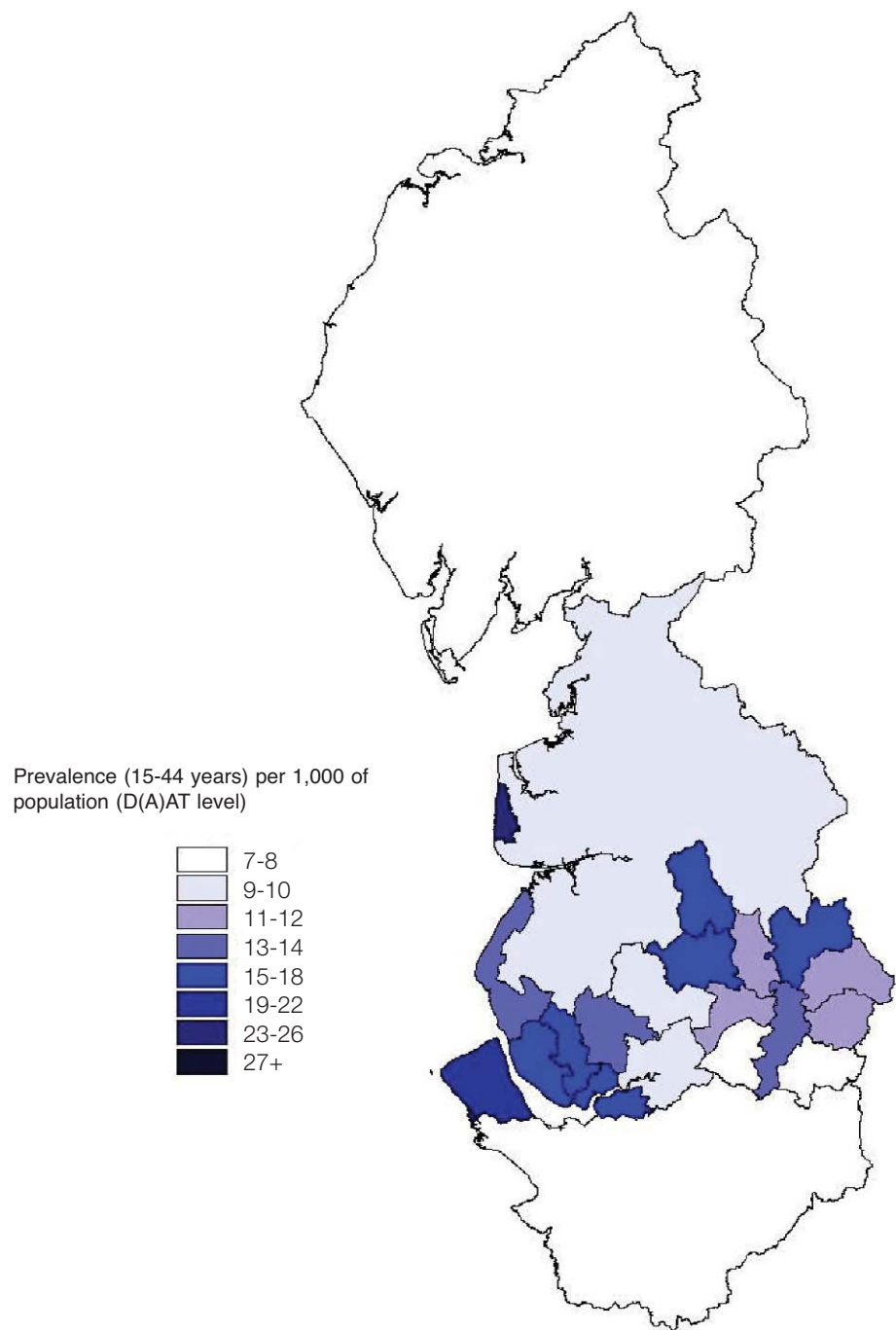
for 2005/06 and 2006/07. Whilst regionally, 1.18% of the population aged between 15-44 were in contact with treatment services, figure 2 shows that the prevalence rates of those in contact with treatment varied considerably between North West D(A)AT areas. In Trafford 7.11 (0.71%) of every thousand residents aged 15-44 were in contact with treatment services. In contrast, 25.05 per thousand (2.51%) of Blackpool's population, aged 15-44, were in contact with services.

Table 3: Prevalence levels of those in contact (15-44) 2005/06 and 2006/07 per 1000 population

DAAT	Prevalence 2005/06 15-44†	Prevalence 2006/07 15-44††
Blackburn with Darwen	14.82	16.96
Blackpool	28.01	25.05
Bolton	16.26	15.91
Bury	13.06	12.03
Cheshire	7.78	8.14
Cumbria	7.17	7.96
Halton	13.33	16.46
Knowsley	12.99	17.88
Lancashire	9.47	9.65
Liverpool	18.20	16.75
Manchester	13.00	13.47
Oldham	11.10	11.06
Rochdale	16.21	18.02
Salford	10.58	11.45
Sefton	13.83	13.06
St Helens	13.02	14.73
Stockport	8.02	7.59
Tameside	12.29	11.69
Trafford	8.04	7.11
Warrington	9.50	10.96
Wigan and Leigh	11.53	10.72
Wirral	19.86	20.83

† Prevalence rate calculated from 2003 D(A)AT population estimates
 †† Prevalence rate calculated from 2005 D(A)AT population estimates

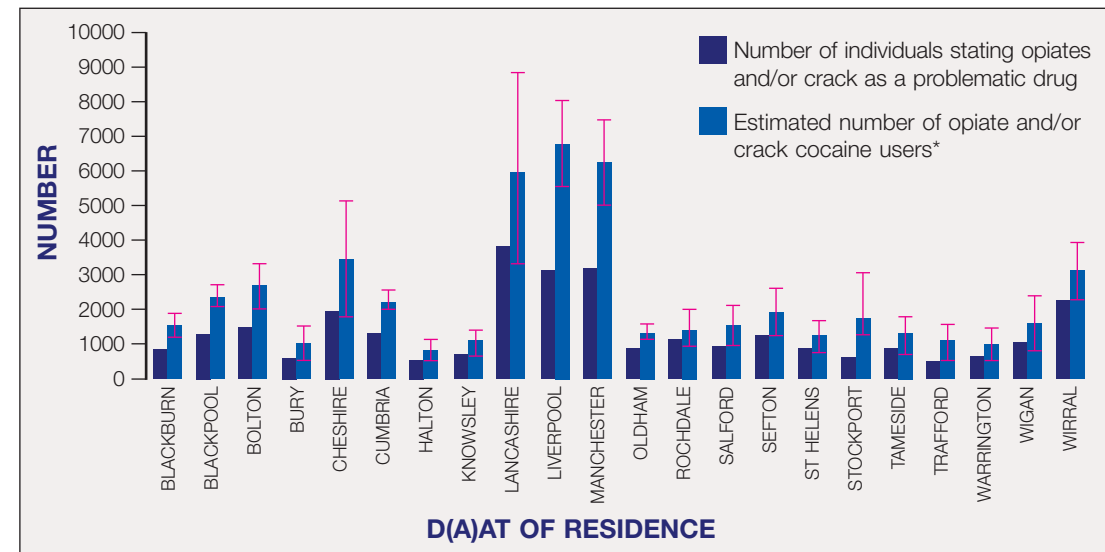
Figure 2: Prevalence levels for the number of 15-44 year olds in contact with treatment services per 1000 of D(A)AT population, 2006/07



D(A)AT prevalence levels produced in this report reflect the proportion of the general population (aged 15-44) in contact with treatment services. They do not illustrate penetration levels of problematic drug using populations in contact with treatment services. Quantifying the 'hidden' population of drug users (i.e. those Problematic Drug Users (PDUs) not in contact with treatment services), poses problems due

to the illicit, covert nature of the activity. Estimates of the number of PDUs (using opiates and/or crack cocaine) by D(A)AT have been produced (Hay et al, 2006). Whilst these estimates are calculated from 2004/05 data, figure 3 shows that there are variations in the penetration levels of problematic users entering treatment dependent on D(A)AT of residence, from 35.49% in Stockport to 76.61% in Rochdale.

Figure 3: Estimates of number of problematic opiate and/or crack cocaine users (2004/05 estimate) and actual number in contact with treatment in 2006/07 by D(A)AT of residence



* Estimates of prevalence from Hay et al (2006)

Treatment prevalence by postcode area⁵

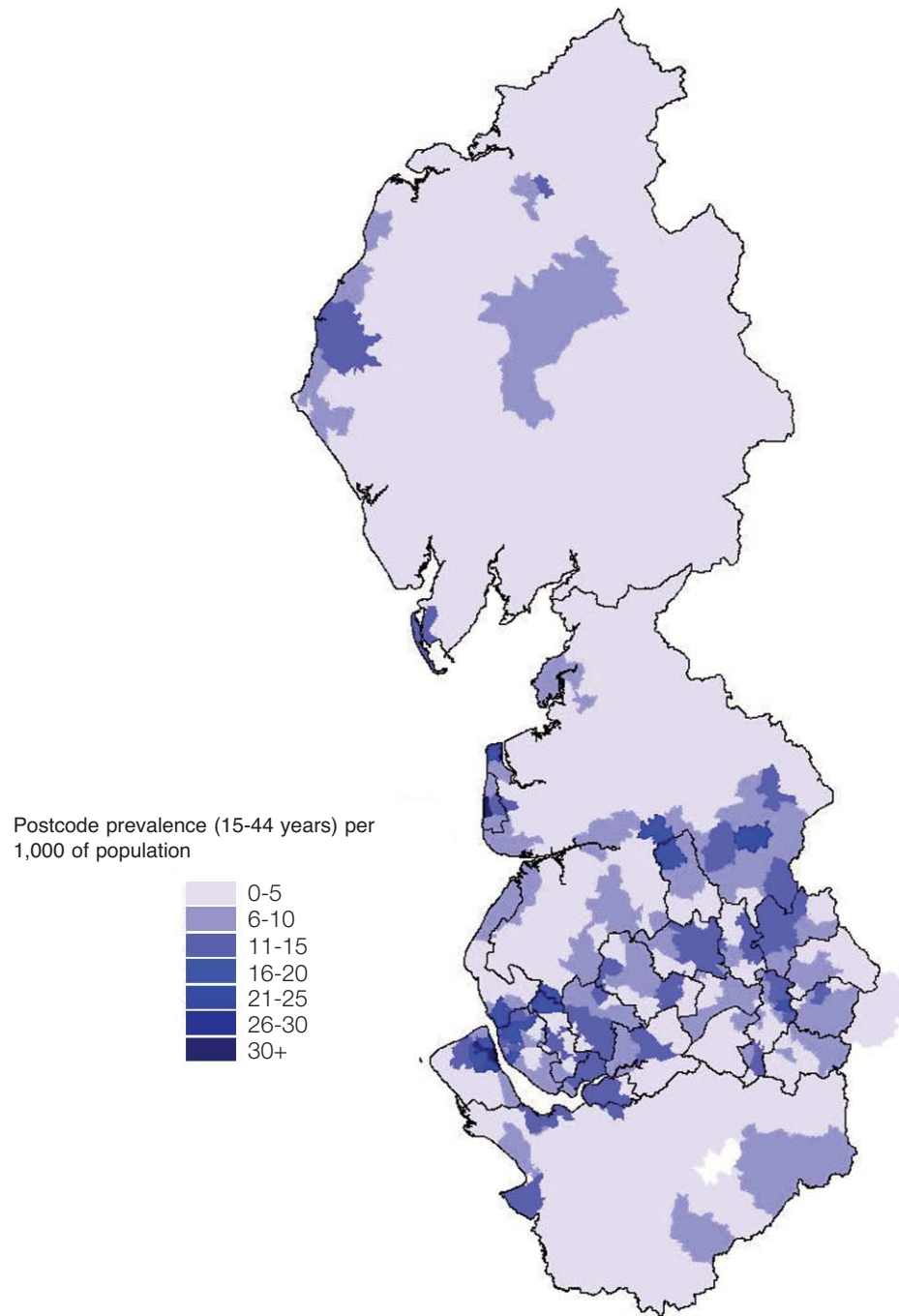
Variations in levels of deprivation occur within D(A)ATs as well as between D(A)ATs in the North West. Some D(A)AT areas contain certain areas with high levels of deprivation, whilst also housing particular areas with low levels of deprivation (ODPM, 2004). There are also variations in the prevalence of those in treatment per 1000 of population within D(A)AT areas themselves. Therefore, prevalence levels of those in contact with treatment services per 1000 population in all North West postcode areas have also been incorporated in this report.

district ('incodes' e.g. BB1 or L1) in the region in contact with treatment services during 2006/07. Clients who lived in more than one postcode district during the year are counted in each of the areas in which they lived. The map demonstrates high concentrations of people in contact with services around areas such as Merseyside and Greater Manchester. The postcode area of CH41 in the Birkenhead area of Wirral had the highest proportion of clients per thousand of the 15-44 year old population (38.33 per 1000 population), followed by FY1 in Blackpool (31.55 per 1000 population). When only males aged 15-44 were considered, the highest postcode district prevalence level rose to 62.49 per thousand (6.25%) of the male population within this age range.

Figure 4 illustrates the number of people per 1000 of population (aged 15-44) from each postcode

⁵For explanation and methodological notes please refer to methodological section at end of report

Figure 4: Number of people in contact with drug treatment services per 1000 of the population (aged 15-44) of postcode districts (with D(A)AT boundaries overlaid), 2006/07



Demographics of treatment population⁶

This section describes the demographic characteristics of North West residents in contact with structured drug treatment services in the North West in 2006/07. A person may be counted more than once if they were resident in more than one D(A)AT area during the reporting year (n= 39001 including double counting).

Table 4 provides a summary of results for each of the 22 North West D(A)ATs in terms of gender, ethnicity, age and referral source.

Table 4: Gender, ethnicity, age and Criminal Justice referral (2006/07), by D(A)AT area

DAT of Residence	Male		White†		Under 25		Total individuals*		CJS referrals		Total episodes**
	No.	%	No.	%	No.	%	No.	No.	%	No.	
Blackburn with Darwen	856	78.60	917	94.34	194	17.81	1089	517	36.18	1437	
Blackpool	1048	69.45	1501	99.60	202	13.39	1509	695	28.96	2406	
Bolton	1342	71.76	1765	94.69	344	18.40	1870	846	32.58	2632	
Bury	717	71.06	931	92.73	342	33.89	1009	392	31.28	1255	
Cheshire	1718	73.58	2230	98.37	391	16.75	2335	432	15.20	2895	
Cumbria	1068	66.38	1517	97.56	274	17.03	1609	419	19.58	2153	
Halton	636	70.43	896	99.33	179	19.82	903	191	15.17	1260	
Knowsley	886	72.09	1191	97.86	249	20.26	1229	144	8.82	1639	
Lancashire	3398	68.94	4546	96.33	840	17.04	4929	1838	26.37	7049	
Liverpool	2809	69.15	3827	96.62	392	9.65	4062	778	14.23	5731	
Manchester	2586	71.56	3124	88.12	364	10.07	3614	1069	22.92	4714	
Oldham	834	74.00	968	86.20	216	19.17	1127	265	20.53	1386	
Rochdale	1255	70.11	1660	93.89	519	28.99	1790	545	22.60	2484	
Salford	921	74.64	1160	95.08	241	19.53	1234	325	18.98	1717	
Sefton	1088	70.47	1524	98.83	194	12.56	1544	594	26.05	2318	
St Helens	856	75.69	1125	99.47	224	19.81	1131	344	22.05	1570	
Stockport	711	74.29	902	95.65	211	22.05	957	271	22.81	1211	
Tameside	819	72.35	1065	96.38	178	15.72	1132	377	27.50	1459	
Trafford	516	73.30	612	90.00	151	21.45	704	244	30.20	875	
Warrington	727	75.57	954	99.17	172	17.88	962	165	12.28	1347	
Wigan and Leigh	1071	73.76	1434	98.83	285	19.63	1452	433	23.30	1916	
Wirral	2071	73.70	2775	99.14	347	12.35	2810	625	18.18	3444	
Regional total*	26751	71.53	35088	95.71	6336	16.94	37396	11509	22.16	52898	

*The regional total does not equal the sum of the D(A)AT figures as some individuals were resident in more than one D(A)AT but are only counted once in the regional figure

** Each individual resident within a D(A)AT may have received one or more episodes of care at one or more treatment agencies during 2006/07

† Ethnicity percentages calculated from total treatment population where ethnicity is stated

⁶For explanation and methodological notes please refer to methodological section at end of report

Gender

Over two-thirds (71.53%) of all individuals resident in the region who were in contact with a treatment service in the North West during 2006/07 were male. The gender composition of those in contact with treatment services was consistent with previous regional findings in 2001/02 to 2005/06. Table 4 demonstrates that there was some variation from this rate between the 22 D(A)ATs, from 66.38% males in Cumbria to 78.60% males in Blackburn with Darwen.

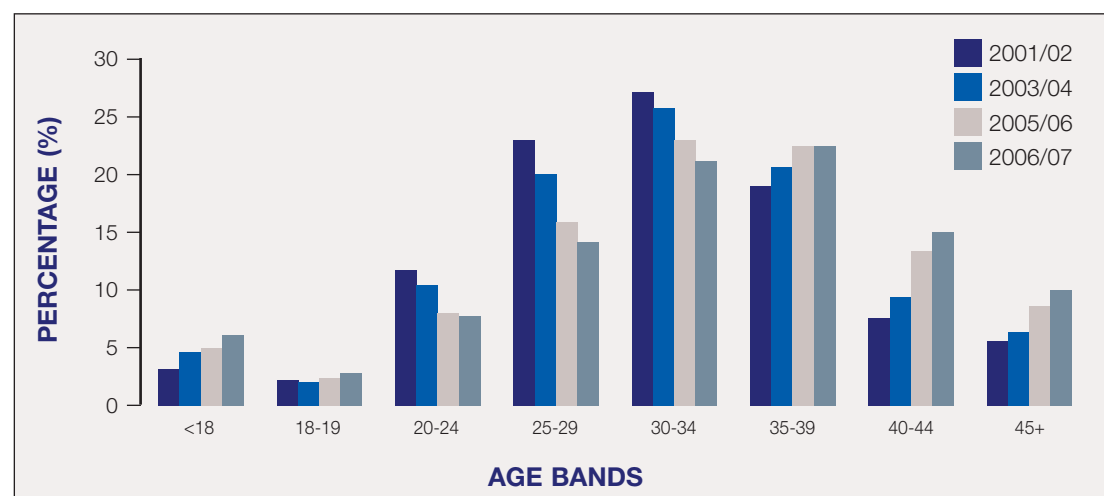
Age⁷

The average (mean) age of individuals in contact with treatment services in 2006/07 was 33.51. The majority of individuals in contact with services in 2005/06 were over 30 (n= 25726, 68.79%), with 43.65% (n=16322) in their thirties. Of those in contact with services during 2006/07, 25.15% (n=9404) were 40 years or above. Those in their twenties accounted for 21.92% (n=8199) of those in treatment, with 6.27% (n=2343) under 18 years

of age. Only 3.02% of those in contact with treatment services were aged 18 or 19 (n=1128). The proportions of people in contact with treatment services in 2006/07 according to age band are presented in figure 5. Figure 5 also offers comparisons of the proportion of individuals in each age band in 2001/02, 2003/04, 2005/06 and 2006/07.

There was a 5.43% increase of individuals in contact with treatment services in comparison to 2005/06. This has resulted in an increase of individuals in contact in each age band during 2006/07 in comparison to 2005/06. Whilst there has been an increase in individuals across all age bands, this increase has not been consistent across each band. Figure 5 demonstrates that there has been a downward trend in the proportion of those in contact with treatment aged 20-34 between 2001/02 and 2006/07 but an increase in the proportion aged over 35 during the same period. During 2001/02, 7.74% of those in contact with treatment were aged 40-44. This percentage rose to 15.05% in 2006/07.

Figure 5: Age distribution of North West structured drug treatment clients, 2001/02, 2003/04, 2005/06 and 2006/07



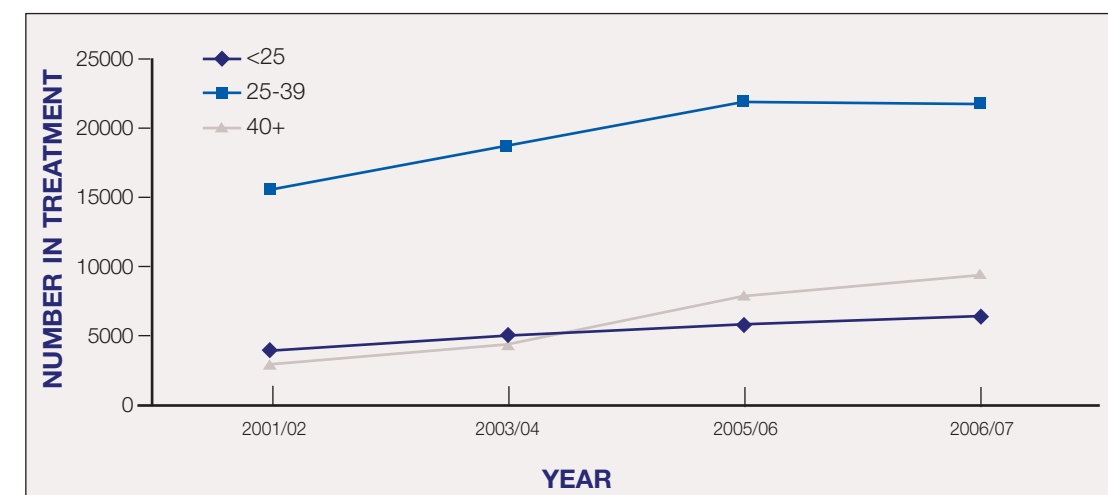
This proportional increase in the age of clients between 2005/06 and 2006/07 was statistically significant ($t=-4.55$ $p<0.001$). This trend indicates an ageing treatment population within drug services in the North West of England. This finding is corroborated by research indicating an ageing population of people in contact with treatment services and syringe exchange services. An ageing treatment population may have implications for future public health policy in the area, as there may be changing requirements within the client group (Beynon et al., in press).

Figure 6 displays the actual number of individuals in contact with treatment aged under 25, 25-39 and 40 and above. Whilst year on year, the actual number of under 25s and over 40s has increased, figure 6 shows that this increase has not been

proportionate between these two age groups. The number of over 40s has increased at a faster rate in comparison to the under 25s, and in the 25-39 age group there has been a decrease in actual numbers of individuals between 2005/06 and 2006/07

The average (mean) age of those in contact with treatment services varied dependent on D(A)AT of residence. The mean age of those in contact with treatment services resident in Bury D(A)AT (mean age 29.83) was low in comparison to other D(A)ATs such as Wirral (mean age 36.02) and Manchester (mean age 35.57). Liverpool, with the highest deprivation score in the North West, also had the highest mean age of those in contact with treatment services in the region (mean age 36.33). However, the correlation between average age and deprivation score was not significant.

Figure 6: Number of individuals in contact with treatment aged <25, 25-39 and 40+ during 2001/02, 2003/04, 2005/06 and 2006/07



⁷For explanation and methodological notes please refer to methodological section at end of report

Table 5: Average (mean) age of individuals in contact with treatment by D(A)AT of residence and deprivation score

D(A)AT of Residence	Average (mean) age	Deprivation score
Blackburn with Darwen	32.06	32.28
Blackpool	33.72	33.91
Bolton	31.73	29.41
Bury	29.83	23.53
Cheshire	33.01	15.06
Cumbria	31.99	21.57
Halton	32.81	34.29
Knowsley	32.77	46.57
Lancashire	32.70	21.80
Liverpool	36.33	49.78
Manchester	35.57	48.91
Oldham	33.49	30.73
Rochdale	31.74	33.69
Salford	32.74	38.19
Sefton	35.27	26.12
St Helens	32.45	31.95
Stockport	32.61	18.06
Tameside	32.51	29.81
Trafford	33.67	20.15
Warrington	32.56	19.39
Wigan and Leigh	31.68	29.26
Wirral	36.02	30.06

Figure 7: Age bands by North West D(A)AT areas (ordered by level of deprivation), 2006/07

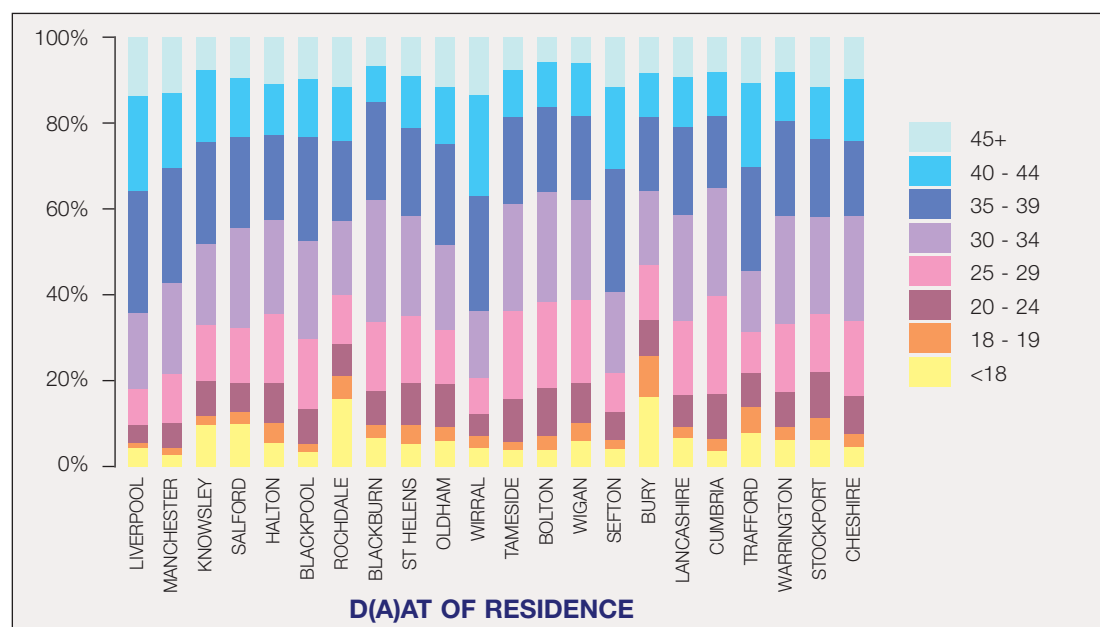


Figure 7 reveals that the distribution of age ranges were not consistent throughout all North West D(A)ATs. Whilst Bury and Rochdale D(A)AT areas had a relatively high proportion of those aged less than 20 in contact with services (25.97 and 21.28% respectively), Liverpool and Manchester D(A)ATs had a relatively low proportion of under 20s in treatment services (5.64 and 4.59% respectively). Whilst only 14.60% of clients in Blackburn with Darwen were aged over 40, this age group accounted for 35.97% and 37.22% of the treatment population in Liverpool and Wirral respectively. This disparity in the proportion of young people in contact with treatment across D(A)ATs may be a reflection of the historical characteristics of drug use within different areas in the North West. Research suggests that central urban areas experienced an earlier epidemic of drug use in comparison to more rural areas. Drug use trends commonly emerge in urban centres and then diffuse to surrounding areas (McVeigh et al., 2003). This may explain why certain urban centres with earlier epidemics of drug use, such as Liverpool, Wirral and Manchester, now have a smaller proportion of younger people in treatment in comparison to areas with relatively recent increases in levels of problematic drug use. However, it should also be noted that Liverpool and Manchester still have the third and fifth highest numbers of under 25s in treatment in the North West (n= 392 and 364 respectively).

Ethnicity⁸

The vast majority (95.71%) of all individuals were recorded as White. This figure is similar to previous regional NDTMS reporting (Khundakar et al., 2006a; Bullock et al., 2005; Jones and Beynon, 2003). Regionally, no other ethnic group accounted for more than one percent of those in contact with treatment services. This is consistent with reporting that showed that, whilst the North West had the highest treatment rate amongst all ethnic groups in England as a whole, it was not apparent in individual ethnic groups (for example, the South West had the highest rates amongst Black populations, with the West Midlands and South West having the highest rates among the Mixed ethnicity populations) (Association of Public Health Observatories, 2005).

Whilst, on the whole, there were a very low percentage of Black and Minority Ethnic (BME) individuals in contact with treatment services, there was greater ethnic diversity among the residents of some D(A)ATs. In D(A)ATs such as Halton and Wirral, less than one percent of all clients fell into BME categories. In contrast, there were considerably more people from BME groups in contact with treatment services from Manchester (11.88%), Oldham (13.80%), and Trafford (10.00%).

Of those individuals that stated their ethnicity as BME, greater proportions were aged under 25 (21.65%) in comparison to those classed as White (16.73%). This difference in average age between the two groups was significant (t= 4.33 p<0.001).

Table 6: Age bands of individuals in contact with treatment by ethnicity, 2006/07

Age Bands	Ethnicity			
	White	%	BME	%
<18	2171	6.19	133	8.47
18-19	1050	2.99	52	3.31
20-24	2649	7.55	155	9.87
25-29	4972	14.17	250	15.91
30-34	7414	21.13	331	21.07
35-39	7972	22.72	285	18.14
40-44	5332	15.20	192	12.22
45+	3528	10.05	173	11.01

⁸ For explanation and methodological notes please refer to methodological section at end of report

Table 7 reveals that, amongst some particular ethnicities, there was a high proportion aged under 25 in comparison to those who stated their ethnicity as White. Of those individuals that stated their ethnicity as African, 32.05% were under 25 and in those stated

as Bangladeshi, 45.37% were under 25. Whilst the numbers within these particular ethnic groups were low, this may demonstrate that these groups may have different treatment needs and access issues in comparison to White populations (Fountain et al., 2003).

Table 7: Proportion of under 25s and 25 and over in contact with treatment by ethnicity, 2006/07

Ethnicity	Age group			
	<25	%	25+	%
White British	5792	16.78	28721	83.22
White Irish	26	10.79	215	89.21
Other white	52	15.57	282	84.43
White and black Caribbean	46	25.00	138	75.00
White and black African	12	22.64	41	77.36
White and Asian	18	28.57	45	71.43
Other mixed	32	24.81	97	75.19
Indian	15	23.44	49	76.56
Pakistani	47	19.67	192	80.33
Bangladeshi	49	45.37	59	54.63
Other Asian	26	18.84	112	81.16
Caribbean	23	18.70	100	81.30
African	25	32.05	53	67.95
Other black	15	8.98	152	91.02
Chinese	7	38.89	11	61.11
Other	25	12.08	182	87.72

Drug use⁹

The NDTMS records the primary problematic drug of those in contact with drug treatment services, along with possible secondary and tertiary problematic substances. Regionally, the majority of individuals in contact with treatment services who identified a main problematic drug stated heroin (n=23446, 63.89%). This was followed by cannabis (n=4342, 11.83%) and methadone (n=2331, 6.35%).

Of the 37396 individuals in contact with treatment services, 21802 stated a secondary problematic drug and 7754 stated a tertiary problematic drug. Whilst only 2.69% of individuals (n=988) stated crack cocaine as their main problematic substance,

table 8 shows that a large minority of individuals stated this substance as a secondary problematic drug (n=6898, 31.79% of stated secondary use). There was a strong interaction between individuals stating heroin as their primary problematic substance and those stating crack cocaine as their secondary problem drug. Of those stating crack as a secondary drug, 6581 (95.40%) stated heroin as their primary problematic drug. Alcohol¹⁰ was stated as a secondary problematic substance by 14.26% of those that stated more than one problematic drug. For a more detailed analysis of the rate of alcohol use in treatment clients see Khundakar et al., in press. and McVeigh et al., 2006.

Table 8: Main, secondary and tertiary problematic drugs for those in contact with treatment during 2006/07

Drug Stated	Drug 1	Percentage of stated drug 1 (%)	Drug 2	Percentage of stated drug 2 (%)	Drug 3	Percentage of stated drug 3 (%)
Alcohol	0	0.00	3094	14.26	1038	13.55
Amphetamines	1444	3.93	1033	4.76	425	5.55
Anti-depressants	19	0.05	39	0.18	43	0.56
Barbiturates	2	0.01	3	0.01	2	0.03
Benzodiazepines	421	1.15	1900	8.76	1234	16.11
Cannabis	4342	11.83	2365	10.90	1532	20.00
Cocaine	2303	6.28	1489	6.86	606	7.91
Crack	988	2.69	6898	31.79	850	11.10
Ecstasy	251	0.68	441	2.03	368	4.80
Hallucinogens	19	0.05	34	0.16	39	0.51
Heroin	23446	63.89	1395	6.43	206	2.69
Methadone	2331	6.35	2482	11.44	1021	13.33
Other Drugs	111	0.30	81	0.37	75	0.98
Other Opiates	919	2.50	418	1.93	179	2.34
Poly Drug	7	0.02	8	0.04	2	0.03
Solvents	96	0.26	16	0.07	35	0.46
Tranquillisers	0	0.00	5	0.02	6	0.08

⁹ For explanation and methodological notes please refer to methodological section at end of report

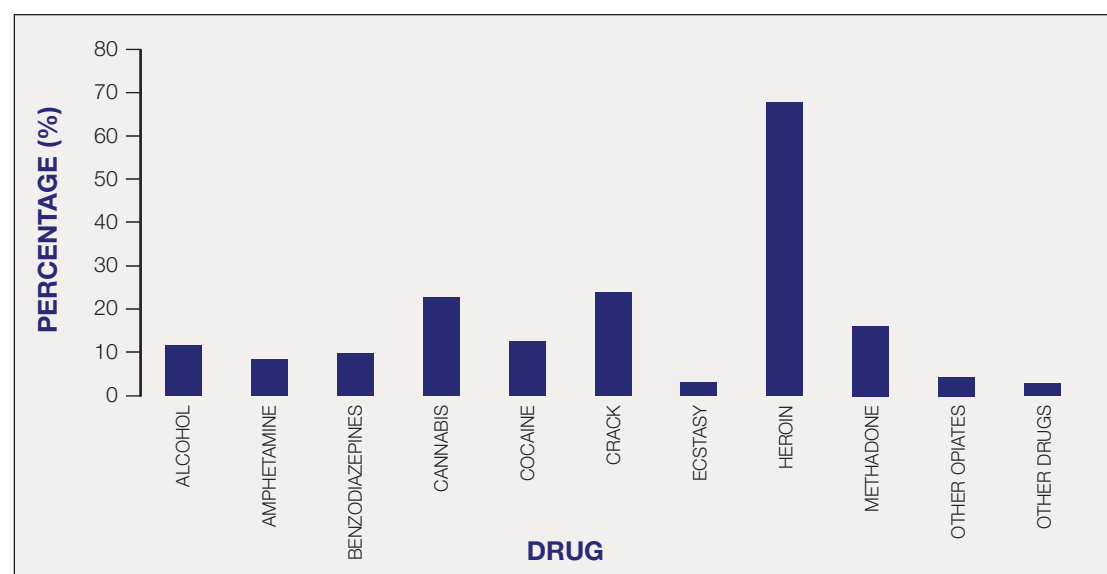
¹⁰ For explanation and methodological notes please refer to methodological section at end of report

Whilst the NDTMS records the main problematic drug of those in contact with treatment services, analysis of an individual's main drug does not reflect the fact that the majority of those entering drug treatment use more than one drug (EMCDDA, 2005). Therefore, analysis of the impact of drug use needs to take into account the complex picture of inter-related drug consumption. For this reason, the next section of the report records the drug profile of individuals (incorporating primary, secondary and tertiary recorded drugs) to gain a better understanding of polydrug use in the area.

All stated drug use

Whilst 2.69% of main problematic drug usage was attributed to crack cocaine use, this figure rose to 23.65% (n=8679) when all problematic drug usage was considered. The proportion of individuals stating crack as a problematic drug has risen from 2005/06 (n=6599, 20.46%). A large proportion of those in contact with treatment services stated heroin as one of their problematic drugs (n= 24838, 67.68%). Cannabis use contributed to 22.19% (n=8145) of all stated drug use, with 15.70% of individuals reporting the problematic use of methadone (n= 5760). There has been an increase in the proportion of clients stating the problematic use of cocaine between 2005/06 (n=3371, 10.45%) and 2006/07 (n=4365, 11.89%).

Figure 8: All stated problematic drugs of individuals in contact with treatment services, 2006/07



Drug use and age

The majority of individuals aged under 18 stated cannabis as a problematic drug (n= 2086, 89.95%). Only 1.47% (n= 34) of under 18s stated heroin to be a problematic drug. Table 9 reveals that, whilst

the proportion of individuals stating cannabis as a problematic substance drops with increasing age, the proportion of those stating heroin, crack cocaine (with the exception of over 40s) and methadone as a problematic substance increases with each older age group. This is similar to previous reporting years (see Khundakar et al, 2007 a).

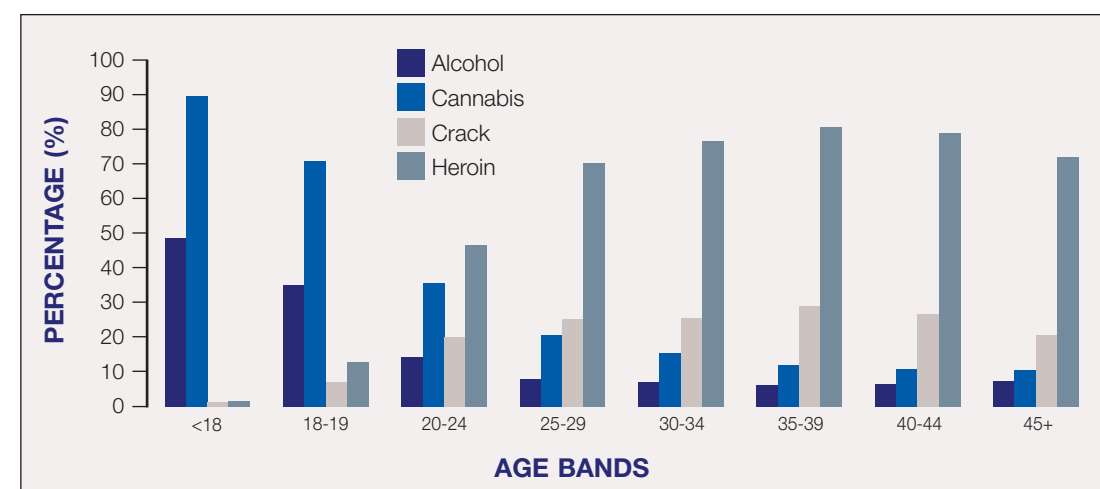
Table 9: All problematic drugs by age group of North West structured drug treatment clients, 2006/07

Stated Drug	Age Bands (%)							
	<18	18-19	20-24	25-29	30-34	35-39	40-44	45+
Alcohol	48.99	35.63	14.31	8.28	7.25	6.36	6.44	7.35
Amphetamine	6.81	11.64	10.21	8.32	7.14	7.37	7.45	7.57
Benzodiazepines	0.52	2.95	8.02	11.06	11.60	10.42	8.47	9.77
Cannabis	89.95	70.81	35.54	20.61	15.17	12.00	11.33	10.59
Cocaine	16.69	32.86	26.67	15.00	10.19	8.02	7.18	6.01
Crack	1.21	7.07	20.17	25.35	26.11	29.02	27.06	20.69
Ecstasy	16.26	16.20	6.36	2.32	1.25	0.61	0.54	0.47
Heroin	1.47	12.80	47.23	70.20	77.04	80.41	79.60	72.09
Methadone	0.17	1.97	7.81	14.18	18.10	18.11	20.28	20.58
Other opiates	0.78	1.07	3.21	4.22	4.31	4.18	4.21	5.98
Other	10.31	4.57	1.98	1.43	1.58	1.44	1.27	2.52

Heroin accounted for a larger proportion of problematic use in those aged 25 and over in comparison to under 25s. Whilst heroin was reported as a problematic drug for 24.16% (n=1514) in under 25s, this proportion rose to 76.64% (n=23324) in over 25s. Problematic cannabis use was reported in larger proportions amongst under 25s (n=3883, 61.96%) in comparison to over 25s (n=4262, 14.00%).

Those who reported the use of heroin were significantly older (mean age 35.58 years) than those who did not report the use of this drug (mean age 29.42 years of non heroin users, $t= 63.83$ $p<0.001$). Conversely, those who reported the use of cannabis (mean age 26.71 years) were significantly younger in comparison to those who did not report its use (mean age of non cannabis users, 35.41 years, $t=- 81.09$ $p<0.001$).

Figure 9: Proportion of alcohol, cannabis, crack and heroin by age bands, 2006/07



Drug use and ethnicity

A significantly greater proportion of clients identified as BME reported the problematic use of crack (n=442, 28.26% in comparison to n=8196 23.70% of those identified as White) ($\chi^2=19.05$, $p<0.001$). A significantly greater proportion of those identified as BME also stated cannabis as a main problematic drug (n=386, 24.68% of reported drug use by BME, n=7660, 22.16% of White problematic users) ($\chi^2=$

6.59, $p<0.05$). In contrast, the proportion of individuals reporting the problematic use of heroin was higher amongst those stated as White (n=23454, 67.84% of Whites, n=1029, 65.79% of BME population), however this was not statistically significant. Findings are consistent with research that has found considerable variation in patterns of drug use across different ethnic groups (Bashford et al., 2003, Wanigaratne et al., 2003).

Table 10: All problematic drug by ethnicity, 2006/07

Main problematic drug	Ethnicity			
	No. White	%	No. BME	%
Alcohol	3891	11.25	166	10.61
Amphetamine	2767	8.00	62	3.96
Benzodiazepines	3353	9.70	60	3.84
Cannabis	7660	22.16	386	24.68
Cocaine	4135	11.96	166	10.61
Crack	8196	23.70	442	28.26
Ecstasy	990	2.86	52	3.32
Heroin	23454	67.84	1029	65.79
Methadone	5566	16.10	150	9.53
Other opiates	1330	3.85	104	6.65
Other	781	2.26	30	1.92

Drug use and type of treatment service entered¹¹

During 2006/07 a proportion of those in contact with treatment services accessed numerous types of services (e.g. receiving a prescription and attending counselling services). The following section details the main problematic drug use and the stated drug use of those entering treatment and the type of service they entered. All episodes of treatment have been included, as individuals may have accessed

more than one type of service over the financial year (n=52898).

Table 11 details the type of service entered by the main problematic drug stated. Table 11 shows that those who stated heroin as a main problematic drug were most likely to enter a community prescribing intervention (72.61%). In contrast, the majority of episodes with crack as a main problematic drug entered a non-prescribing intervention (58.19%)

Table 11: Main problematic drug use by type of service entered (all episodes of treatment)

Main problematic drug	Type of treatment service entered					
	CJS	Community prescribing	Inpatient	Non prescribing	Residential rehab	YP
Amphetamines	3.22	34.79	1.06	53.85	0.42	6.65
Benzodiazepines	1.64	49.45	2.00	44.55	0.55	1.82
Cannabis	8.33	10.99	0.02	31.68	0.25	48.73
Cocaine	7.57	27.80	0.18	52.05	1.26	1.15
Crack	7.27	23.99	4.11	58.19	3.56	2.88
Ecstasy	4.29	19.14	0.00	20.13	0.00	56.44
Heroin	6.66	72.61	1.60	17.51	1.24	0.37
Methadone	1.51	65.82	4.91	25.90	1.51	0.35
Other Opiates	0.84	56.14	1.37	36.61	4.27	0.76
Other drugs	0.62	20.68	0.62	42.90	0.93	34.26

Table 11 and 12 show that, whilst those episodes of treatment involving crack as a main problematic drug entered a non-prescribing intervention, episodes with crack as a stated drug (either drug 1,2

or 3) were more likely to enter a community prescribing intervention (59.91%). This reflects the fact that the majority of those stating crack cocaine as a secondary drug state heroin as a primary problematic drug (n=6581, 95.40%).

Table 12: All problematic drug use by type of service entered (all episodes of treatment)

Stated problematic drug	Type of treatment service entered					
	CJS	Community prescribing	Inpatient	Non prescribing	Residential rehab	YP
Alcohol	5.55	19.44	2.14	39.22	2.70	30.95
Amphetamines	3.44	45.96	1.01	40.77	0.66	8.15
Benzodiazepines	2.58	75.69	2.36	17.64	0.98	0.74
Cannabis	5.88	34.62	1.18	30.29	0.85	27.18
Cocaine	7.31	40.39	0.80	37.70	1.28	12.52
Crack	9.34	59.91	2.40	25.41	2.16	0.77
Ecstasy	3.22	16.49	0.08	30.67	0.23	49.31
Heroin	6.49	70.98	1.79	18.99	1.32	0.43
Methadone	2.41	68.33	5.76	21.72	1.46	0.33
Other Opiates	0.87	58.47	1.30	34.04	3.62	1.69
Other drugs	1.15	27.03	0.96	37.06	0.86	32.95

¹¹ For explanation and methodological notes please refer to methodological section at end of report

Drug use by D(A)AT

As shown in table 13, there were differences in the

proportion of certain drugs dependent on D(A)AT of residence.

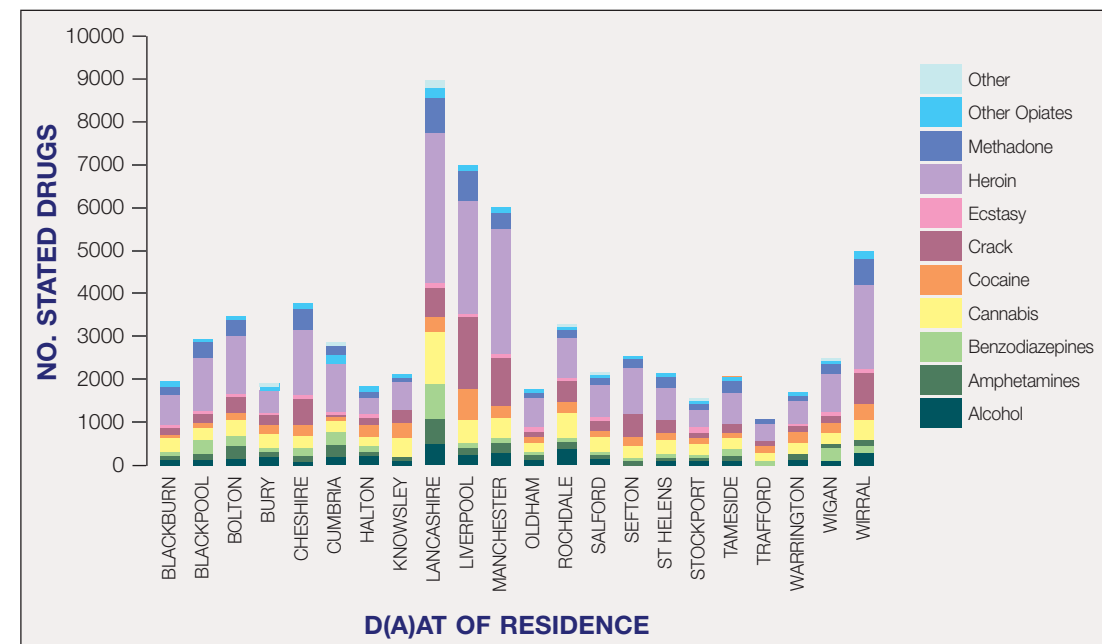
Table 13: All problematic drug use by D(A)AT of residence, 2006/07

D(A)AT	Stated Drug										
	Alcohol	Amphetamine	Benzodiazepines	Cannabis	Cocaine	Crack	Ecstasy	Heroin	Methadone	Other Opiates	Other
Blackburn with Darwen	96	116	135	283	71	177	24	775	171	80	34
Blackpool	154	103	335	288	88	279	19	1259	325	50	30
Bolton	161	270	264	399	152	366	73	1323	300	106	45
Bury	213	108	56	389	153	245	73	552	50	14	38
Cheshire	106	130	127	360	203	632	29	1608	464	73	11
Cumbria	205	199	388	248	89	47	51	1156	219	168	59
Halton	264	70	77	301	189	234	32	411	163	33	67
Knowsley	128	63	46	385	320	341	23	629	102	27	8
Lancashire	500	559	824	1217	362	668	140	3459	844	189	164
Liverpool	290	78	106	581	703	1689	48	2684	672	120	39
Manchester	322	183	119	510	224	1190	62	2876	385	85	31
Oldham	137	101	109	204	90	176	25	775	97	36	24
Rochdale	367	148	134	569	234	475	95	927	250	32	68
Salford	169	92	79	346	111	241	72	769	182	58	35
Sefton	79	35	60	232	259	507	15	1130	148	33	12
St Helens	98	86	105	287	168	326	28	734	244	36	17
Stockport	129	111	45	226	161	144	32	446	157	49	34
Tameside	126	87	176	242	110	206	25	740	242	71	25
Trafford	76	32	20	172	111	161	27	372	91	27	13
Warrington	167	42	83	270	253	123	44	543	159	42	18
Wigan and Leigh	123	246	103	353	168	165	58	927	230	51	55
Wirral	297	111	194	487	290	822	83	1977	546	177	28

There were regional variations in the level of problematic heroin and cannabis use reported to the NDTMS. In Blackpool, 83.43% (n=1259) of individuals stated problematic use of heroin. In contrast, only 45.51% (n=411) of stated problematic use in Halton was attributed to the use of heroin. In Bury, over a third (n= 389, 38.78%) of problematic use was attributed to cannabis use, with high proportions also found in Rochdale (32.24% n=

568). The high proportions of cannabis use in these D(A)AT areas are linked to the high levels of young people in contact with treatment in these areas. Liverpool D(A)AT had a high proportion of clients stating crack as a problematic drug (n=1689, 44.03%) in comparison to other D(A)ATs such as Wigan (n=165, 11.39%). Whilst Liverpool accounts for 10.42% of drug treatment clients, 18.33% of those stating crack as a problematic drug were resident in Liverpool D(A)AT.

Figure 10: Stated problematic drugs by D(A)AT, 2006/07



Referral sources, modality types and treatment outcomes

During 2006/07, each individual in treatment (n=37396) may have received one or more episodes of care at one or more treatment agency. In turn, each agency may have provided the individual with one or more modality of treatment. Therefore, to provide the fullest possible understanding of the ways in which people are referred into services, the types of treatment provided and the outcomes of individuals within services, results for each recorded episode are presented here (n=52898).

Referrals

In this section of the report, all episodes of treatment in 2006/07 are recorded, regardless of whether an individual entered treatment on more than one occasion over the year (n= 52898 including double counting). Of the treatment 'episodes' recorded by the NDTMS in the North West in 2006/07, the largest source (35.97%) of referral was 'self', followed by referrals via the Criminal Justice System (22.16%). Whilst there has been a slight decrease in the proportion of CJS referral between 2005/06 (22.52%)

and 2006/07 (22.16%), there has been an increase in actual referrals from the CJS between 2005/06 (n=11243) and 2006/07 (n=11509).

Figure 11: Referral source of those in contact with drug treatment in the North West, 2006/07

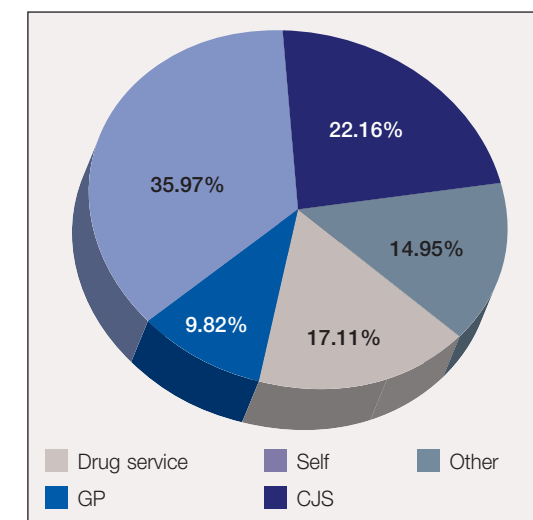


Table 14 reveals that the proportion of episodes referred from the CJS varied from 8.82% in

Knowsley to 36.18% in Blackburn with Darwen.

Table 14: Referral source by D(A)AT (all treatment episodes)

D(A)AT	Referral Source %				
	Drug service	GP	Self	CJS	Other
Blackburn with Darwen	6.44	7.56	36.32	36.18	13.51
Blackpool	43.36	1.87	18.41	28.95	7.41
Bolton	12.17	4.77	41.62	32.58	8.86
Bury	12.76	8.85	28.63	31.26	18.50
Cheshire	8.51	10.90	55.17	15.19	10.23
Cumbria	11.45	30.65	22.20	19.58	16.12
Halton	22.40	8.98	37.25	15.17	16.20
Knowsley	16.35	7.53	38.03	8.82	29.27
Lancashire	12.22	6.79	39.76	26.33	14.90
Liverpool	27.71	25.26	19.42	14.23	13.39
Manchester	17.66	4.22	34.50	22.91	20.70
Oldham	8.44	7.90	53.52	20.53	9.60
Rochdale	12.26	8.00	37.74	22.58	19.43
Salford	14.11	4.20	46.65	18.95	16.09
Sefton	34.78	7.76	23.11	26.05	8.29
St Helens	10.90	6.99	45.64	22.05	14.42
Stockport	15.45	4.20	46.68	22.75	10.92
Tameside	8.31	7.36	44.83	27.48	12.03
Trafford	13.49	7.18	31.81	30.20	17.33
Warrington	25.30	6.62	45.46	12.28	10.34
Wigan and Leigh	9.31	3.28	56.21	23.29	7.91
Wirral	15.07	12.95	28.43	18.18	25.37
Regional Percentage	17.11	9.82	35.97	22.16	14.95

Referral source and age

Whilst regionally, the main source of referral into drug treatment was via self-referral, the proportion of people referred via this route was dependent on age. Nearly a quarter (24.33%, n= 1956) of episodes in under 25 age range self-referred into treatment services, whilst 38.10% (n=16728) of episodes amongst 25 and over were referred via this source. The majority of episodes of treatment for under 18s

came from 'other' referral sources, including Connexions, Social Services, and education services. A large proportion of under 25 referrals came from the Criminal Justice System (CJS) (n=2731, 33.96%). Those referred via the CJS were significantly younger (mean age 30.87 years) than those referred via drug services (mean age 35.53 years t= 40.15 p<0.001), GPs (mean age 36.89 t=42.43 p<0.001) and self-referral (mean age 34.44 t= 36.45 p<0.001).

Table 15: Referral source by age group (all treatment episodes)

Age bands	Referral Source (%)				
	Drug service	GP	Self	CJS	Other
<18	2.05	0.91	7.78	36.46	52.80
18-19	6.59	3.40	19.32	40.64	30.05
20-24	12.12	5.80	37.51	29.94	14.63
25-29	16.46	7.25	39.64	25.88	10.75
30-34	18.02	9.25	39.01	22.71	11.01
35-39	19.66	11.07	36.94	19.66	12.67
40-44	19.71	13.83	37.02	15.85	13.58
45+	21.08	16.13	38.02	11.11	13.65

* Other includes A&E, syringe exchange, psychiatry, Community Care Assessment (CCA), employment services, education services, Pupil Referral Unit (PRU), Connexions, Social Services and Looked After Children (LAC)

Referral source and ethnicity

There were variations in the proportion of referrals from certain sources dependent on the ethnicity of the client entering treatment. Those who classed their ethnicity as White were more likely to have been referred via their GP (9.96%) in comparison to those classed as BME (5.72%). Contrastingly, those classed as BME were more likely to self refer (40.26%) in comparison to their White counterparts (35.85%).

Referral source and drug use

There were variations in the proportion of referrals stating heroin as a problematic drug, dependent on referral route into treatment. Referrals from drug

services and GPs were more likely to state heroin as a problematic drug (76.61 and 78.11% respectively) in comparison to referrals from CJS and other referral sources (69.81 and 54.61% respectively). Within an episode of treatment, an individual can state more than one problematic drug. Referrals from CJS and other referral sources are significantly younger in comparison to drug service and GP referrals. Individuals who stated heroin as a problematic drug were significantly older in comparison to those who do not state this drug (t=63.83 p<0.001). Therefore, age is likely to be a factor in the level of heroin use in comparison to referral source.

Table 16: Drug use by referral source

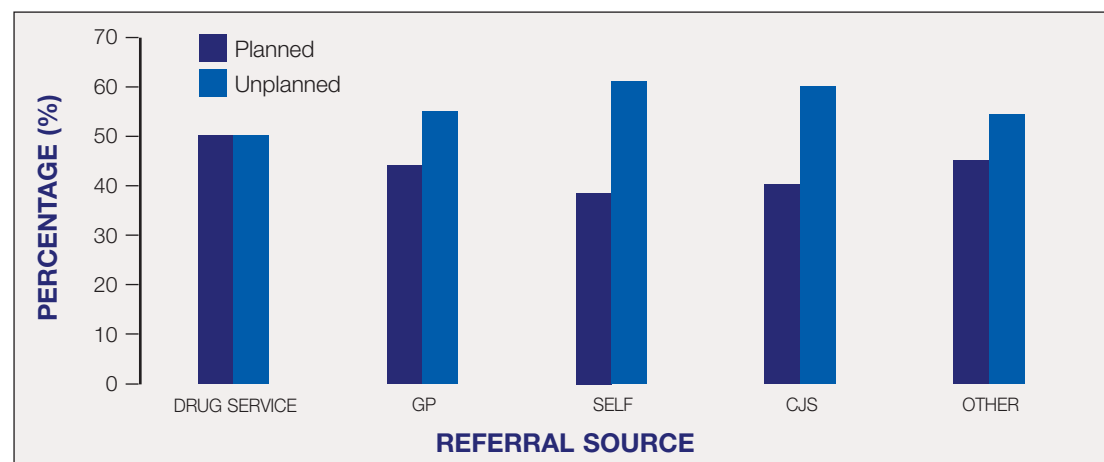
	Referral Source									
	Drug service	%	GP	%	Self	%	CJS	%	Other	%
Alcohol	686	7.81	243	4.84	1372	7.48	1451	12.94	1387	18.28
Amphetamines	480	5.47	268	5.34	1457	7.94	890	7.94	707	9.32
Benzodiazepines	850	9.68	589	11.73	1953	10.64	1026	9.15	517	6.81
Cannabis	1144	13.03	631	12.57	3218	17.54	2832	25.25	2561	33.75
Cocaine	796	9.07	415	8.27	1996	10.88	1312	11.70	893	11.77
Crack	2586	29.45	1303	25.96	4562	24.87	3397	30.29	1590	20.95
Ecstasy	112	1.28	61	1.22	314	1.71	358	3.19	446	5.88
Heroin	6726	76.61	3921	78.11	13978	76.19	7828	69.81	4144	54.61
Methadone	2221	25.30	835	16.63	2832	15.44	1184	10.56	947	12.48
Other Opiates	362	4.12	253	5.04	711	3.88	382	3.41	246	3.24
Other Drugs	153	1.74	74	1.47	329	1.79	161	1.44	321	4.23

Referral source and discharge reasons

As shown in figure 12, treatment episodes sourced from the CJS and via self-referral were less likely to result in a successful completion (40.64 and 38.92% respectively) in comparison to those from drug services (50.13%) and GPs (44.51%). There was a significant difference in the proportion of successful and unplanned discharges between those referred from the CJS and drug services ($\chi^2 = 81.80$ $p < 0.001$) and CJS and GP services ($\chi^2 = 5.59$ $p < 0.001$). Historical data suggests that those coerced into treatment via the CJS are more likely to drop out in comparison to referrals from other routes. While this may bring into question the ability of coercive

measures to facilitate successful outcomes (Beynon et al, 2006) it may also be indicative of clients that are referred on from settings such as other drug services or GPs, being at a later stage of their care pathway or presenting with different drug profiles. Whilst there was a significant difference in the proportion of planned and unplanned discharges between CJS referrals and drug service and GP referrals, these significant differences were also found between self-referrals and these other referral sources ($\chi^2 = 122.22$ $p < 0.001$ and $\chi^2 = 12.13$ $p < 0.001$ respectively), suggesting that the success of self-referrals and CJS referrals may be comparable (Khundakar et al, 2007).

Figure 12: Proportion of successful completions and unplanned discharges by referral source (all episodes of treatment), 2006/07

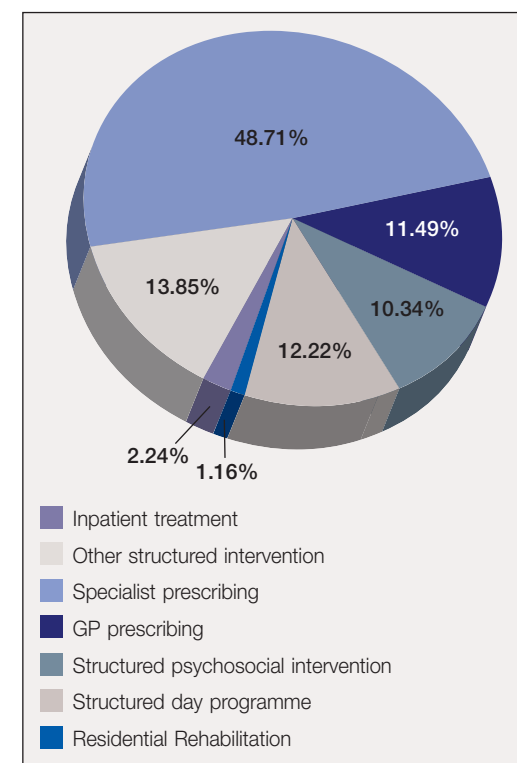


Modalities of treatment¹²

During 2006/07 a proportion of those in contact with treatment accessed numerous types of services (e.g. receiving a prescription and attending counselling). The following section details the modalities of treatment entered (n=59716) during 2006/07. According to NTA guidelines (see <http://www.nta.nhs.uk/areas/ndtms/docs/core%20d>

ata%20set/ndtms_core_data_set_guidance_yp_services_v5.0.pdf), young persons' (YP) specific services have separate YP specific modalities of treatment. These YP modality codes for tier 3/ 4 modalities of treatment are only used in specific YP services, with adult services only using adult modality codes. Therefore, this section of the report has been divided between adult and YP modalities.

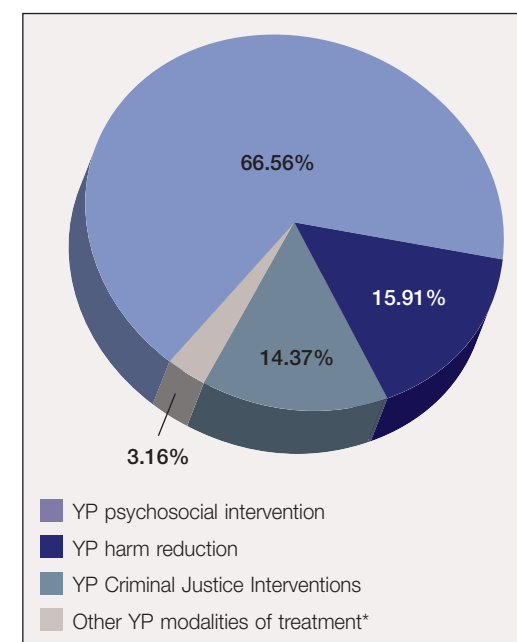
Figure 13: Adult treatment modalities, 2006/07



Adult treatment modalities

Almost half of the modalities of treatment during 2006/07 in the North West of England involved specialist prescribing (n=22856, 48.71%). Relatively few modalities of treatment involved tier 4 treatment (Inpatient treatment, n=1051 2.24%, residential rehabilitation, n=542, 1.16%).

Figure 14: YP treatment modalities, 2006/07



YP modalities of treatment

The majority of YP treatment modalities involved YP psychosocial interventions (n=3159, 66.56%), with 682 YP Criminal Justice Interventions (14.37%). Very few treatment interventions involved YP inpatient treatment (0.15%) or YP residential rehabilitation (0.13%).

*Other YP modalities of treatment= YP work with parents and carers, YP shared care schemes, YP specialist pharmacological interventions, YP inpatient interventions

¹² For explanation and methodological notes please refer to methodological section at end of report

Treatment outcomes¹³

The following section details the discharge reasons for individuals exiting their final episode of treatment during 2006/07. The majority of individuals in the North West were still engaged in an ongoing treatment episode at the end of 2006/07 (65.90%). Successful treatment completions accounted for 13.59% of outcomes during 2006/07, with 19.04% of latest episodes resulting in an unplanned discharge.

Table 17 reveals that latest treatment episode outcomes varied across the 22 North West D(A)ATs. Whilst episode sustention was the most common outcome across all D(A)ATs, levels of this particular outcome varied from 78.98% in Wirral to 53.37% in Salford. The level of successful episode completion varied across D(A)ATs from 7.46% in Cumbria to 22.25% in St Helens. The proportion of unplanned discharges varied from 9.88% in Halton to 29.60% in Tameside.

Table 17: Treatment outcomes, by D(A)AT of residence in 2006/07

D(A)AT	Ongoing	%	Planned	%	Unplanned	%	Other	%
Blackburn with Darwen	638	58.69	206	18.95	234	21.53	9	0.83
Blackpool	886	58.75	251	16.64	298	19.76	73	4.84
Bolton	1079	58.90	214	11.68	496	27.07	43	2.35
Bury	608	60.26	167	16.55	223	22.10	11	1.09
Cheshire	1610	68.98	234	10.03	471	20.18	19	0.81
Cumbria	1068	78.94	101	7.46	174	12.86	10	0.74
Halton	640	71.03	154	17.09	89	9.88	18	2.00
Knowsley	854	69.49	163	13.26	181	14.73	31	2.52
Lancashire	2985	60.72	907	18.45	960	19.53	64	1.30
Liverpool	2503	63.24	546	13.79	834	21.07	75	1.89
Manchester	2666	74.18	244	6.79	632	17.58	52	1.45
Oldham	732	65.83	149	13.40	227	20.41	4	0.36
Rochdale	1037	58.89	301	17.09	386	21.92	37	2.10
Salford	658	53.37	267	21.65	299	24.25	9	0.73
Sefton	932	61.11	243	15.93	319	20.92	31	2.03
St Helens	667	59.13	251	22.25	200	17.73	10	0.89
Stockport	562	59.35	205	21.65	172	18.16	8	0.84
Tameside	675	60.54	108	9.69	330	29.60	2	0.18
Trafford	449	63.78	124	17.61	108	15.34	23	3.27
Warrington	663	68.92	127	13.20	168	17.46	4	0.42
Wigan and Leigh	1015	70.05	127	8.76	301	20.77	6	0.41
Wirral	2206	78.98	240	8.59	320	11.46	27	0.97

4.09% of individuals had a discharge reason of 'Not Known'

Figure 15: Discharge reason by D(A)AT of residence, 2006/07

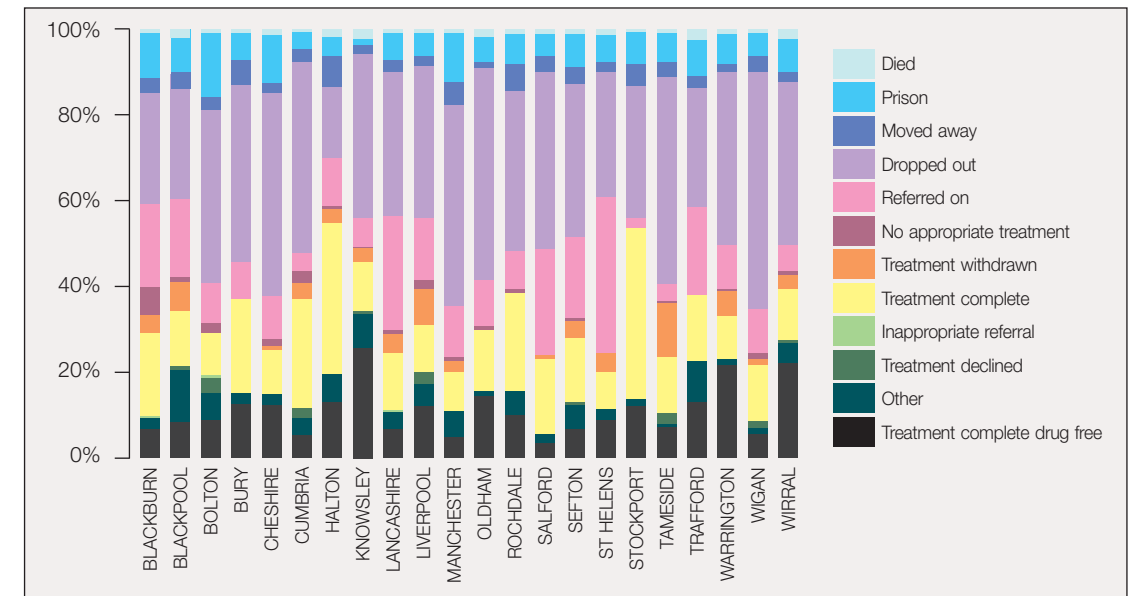


Table 18: Discharge reasons for those exiting final episode of treatment by D(A)AT

D(A)AT	Discharge reason (%)											
	Treatment complete drug free	Other	Treatment declined	Inappropriate referral	Treatment complete	Treatment withdraw	No appropriate treatment	Refer on	Drop out	Moved away	Prison	Died
Blackburn with Darwen	6.90	2.00	0.00	0.67	19.60	4.45	6.24	19.38	25.61	3.79	10.47	0.89
Blackpool	8.52	11.74	0.96	0.00	12.86	7.07	0.64	18.97	25.24	3.70	8.20	2.09
Bolton	9.03	5.71	3.32	0.80	10.09	0.13	2.26	9.30	40.24	3.05	15.14	0.93
Bury	12.22	2.74	0.50	0.00	20.95	0.50	0.00	8.48	41.65	5.74	6.48	0.75
Cheshire	11.88	2.62	0.14	0.14	10.08	0.97	1.66	10.36	46.69	2.62	11.46	1.38
Cumbria	5.26	3.51	2.81	0.00	25.26	3.86	2.46	4.91	44.21	3.16	4.21	0.35
Halton	12.64	6.90	0.00	0.00	35.25	3.07	1.15	11.11	16.48	6.90	4.21	2.30
Knowsley	25.33	8.27	0.53	0.00	11.47	3.20	0.27	6.67	38.13	2.13	1.60	2.40
Lancashire	6.94	3.31	0.10	0.47	13.46	4.40	1.09	26.57	33.66	2.59	6.73	0.67
Liverpool	11.75	5.15	2.06	0.14	11.48	8.59	2.34	14.30	35.46	2.54	5.50	0.69
Manchester	4.85	5.60	0.54	0.11	8.84	2.48	0.75	12.61	46.44	5.39	11.64	0.75
Oldham	14.21	1.05	0.00	0.00	13.95	0.53	0.79	11.05	48.95	1.84	5.53	2.11
Rochdale	9.67	5.11	0.41	0.14	22.79	0.55	0.69	9.12	37.02	6.63	6.91	0.97
Salford	3.48	1.57	0.00	0.00	17.91	0.87	0.00	25.04	41.04	3.65	5.57	0.87
Sefton	6.58	5.23	1.01	0.17	15.18	3.20	0.84	19.22	35.92	3.54	8.43	0.67
St Helens	8.89	2.17	0.00	0.00	8.89	4.12	0.22	36.66	29.07	2.39	6.29	1.30
Stockport	11.69	2.08	0.26	0.00	39.22	0.26	0.26	2.34	30.65	4.94	8.05	0.26
Tameside	7.05	0.45	2.50	0.00	13.18	12.73	0.45	4.32	47.95	3.86	6.82	0.68
Trafford	12.94	9.02	0.39	0.00	15.29	0.39	0.00	20.39	27.84	2.75	8.63	2.35
Warrington	21.40	1.34	0.00	0.00	10.37	5.35	0.33	10.70	40.47	2.01	7.02	1.00
Wigan and Leigh	5.30	1.38	1.84	0.00	13.13	1.38	0.92	10.83	55.07	3.69	5.53	0.92
Wirral	22.15	4.60	0.68	0.00	12.10	2.73	0.85	6.64	37.99	2.21	7.67	2.39

¹³ For explanation and methodological notes please refer to methodological section at end of report

Methodology and References

The NDTMS is the official national method of monitoring the prevalence of drug treatment in England. It is commissioned by the NTA and managed through nine regional centres. The system was established in March 2001 and replaced the Drug Misuse Database (DMD).

The NDTMS measures the number of people 'in contact' with structured drug treatment services (i.e. tier 3 and 4 services, as defined by Models of Care, NTA, 2002). Low threshold interventions, such as open access and syringe exchange services are not recorded.

The NDTMS measures the number of people 'in contact' with drug treatment services (i.e. those presenting to treatment, which is not necessarily the number of people in drug treatment). It is possible that there may be a period of time between presentation and the actual commencement of treatment, during which the individual may lose contact with service. Therefore, an individual presenting for treatment may actually never receive treatment. NDTMS results are, therefore, described in terms of the number of individuals in contact with services rather than numbers of people actually in treatment. For more information about the NDTMS see Beynon et al. (2003), www.cph.org.uk/ndtms or www.nta.nhs.uk.

Where analyses have been reported at D(A)AT level, the results have been presented in terms of geographic areas in which the client was resident, not the area in which the treatment was provided.

During 2006/07, data were collected using a database system. Treatment services submit a core dataset that includes information on all of their clients. This information is then provided to the North West Public Health Observatory at the Centre for Public Health, Liverpool John Moores University, for verification, analysis and reporting.

Methodological notes

1) 'New' individuals are those whose latest treatment episode began in 2006/07. New individuals may not be starting treatment for the first time but could also be returning to services after having previously been in contact. 'Ongoing' individuals are those who began their treatment episode on or before 31st March 2006.

2) The total number of clients in each D(A)AT quoted in this report differ slightly to those produced nationally by National Drug Evidence Centre (NDEC). This is due to methodological differences between North West NDTMS (CPH, Liverpool John Moores University) and NDEC. NDEC figures include North West residents who were in contact with services outside of the region. Also the two centres use different methods for the determination of residence where this is not indicated. NDEC use a method of interpolation, calculating the proportion of people resident in D(A)AT areas found in complete records and applying this to missing data. This methodology is not employed by the Centre for Health, Liverpool John Moores University.

3) Data on the population estimates by D(A)AT from the NCHOD website (<http://www.nchod.nhs.uk>) (2005 population estimates). Data sourced from the Office of National Statistics (ONS).

4) Data from North West Public Health Observatory, based within the Centre for Public Health, Liverpool John Moores University. Data sourced from the Office of National Statistics (ONS).

5) Data from North West Public Health Observatory, based within the Centre for Public Health, Liverpool John Moores University. Data derived from 2003 prevalence estimates. Data sourced from the Office of National Statistics (ONS).

6) In order to conserve space in this summary paper, the results for each of these four areas are reduced into two categories: gender: male/female; ethnicity: white/non-white; age: under 25/25+; referral source: criminal justice system (CJS) referrals/ non-CJS referrals.

7) Age was calculated from the 31st March 2007 (the final day of the reporting period). This is in contrast to the calculation of age by NDEC and the NTA. Only those clients aged between 9 and 75 inclusively were included in all analysis.

8) Data were missing from 1.53% of ethnicity records.

9) 1.86% of main problematic substance records did not state a specific drug.

10) Alcohol data were only included for individuals stating this substance as a secondary or tertiary drug. Clients who stated alcohol as a primary problematic substance were excluded from all analysis in this report.

11) Several treatment agencies in the region offer more than one type of intervention (for example, prescribing and psychosocial interventions). In this section of the report agencies have been placed into groups according to the service most commonly used by those utilising the service.

12) 13.48% of records did not state a modality due to either a client not commencing a modality of treatment or non recording of modality data.

13) The NDTMS has 12 outcome measures. In this section the data has been collapsed into four categories. These categories are Successful Completion, which incorporates 'treatment completed', 'treatment completed drug free' and 'referred on'; Unplanned Discharge which includes 'treatment withdrawn/breached', 'no appropriate treatment', 'dropped out/left', 'prison', 'moved away' and 'died'. The other two categories are Sustained, which includes all clients in contact with service on 31st March 2007, and Other. All data stated with a Not Known discharge reason have been removed from the D(A)AT percentage breakdown. The 'Not Known' category includes episode data that included a discharge date but no discharge reason. These categories differ to the criteria used in the 2003/04 report which included 'Not Known' in the Unplanned Discharge category and 'died' in the Other category and are, therefore, not comparable. Where agencies did not complete a discharge date a client was assumed to be still in contact at the end of the year.

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