



NDTMS Themed Report

AACCE (non-opiate) substance use in the North West of England - The changing profile of substance users engaged in treatment and its implications for future provision

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Introduction

Cannabis, along with amphetamines, ecstasy and cocaine, are the most popular illicit drugs in the UK and across the European Union as a whole (EMCDDA, 2008). The British Crime Survey (BCS) in 2007/08 found that, amongst 16-59 year olds, 7.4% had used cannabis in the last year, with 2.3% having used

cocaine, 1.5% ecstasy, and 1.0% amphetamines (Hoare & Flatley, 2008). Overall, use of illicit drugs during the previous year by 16-59 year olds decreased from 12.1% in 1997 to 9.3% in 2007/08, mainly due to the successive decline in the use of cannabis since 2003/04. Whilst the use in the last year of cannabis decreased from 10.3% in 1997 to 7.4% in 2007/08, it remained the most popular drug in Britain.

Table 1: Estimated number of individuals aged 16-59 having used amphetamines, cannabis, cocaine and ecstasy (thousands)*

Drug	Used ever	Used in the last year	Used in the last month
Amphetamines	3741	329	113
Cannabis	9637	2382	1339
Cocaine	2408	734	320
Ecstasy	2394	470	164

* Source: BCS, 2007/08

When only 16-24 year olds were considered, the proportion of individuals using these drugs in the last year was higher (see table 2). The use of cocaine in the last year amongst this age group

increased from 3.1% in 1997 to 6.0% in 2006/07, with a slight decrease to 5.0% in 2007/08.

Table 2: Percentage of 16-24 year olds and 16-59 year olds stating the last year use of amphetamines, cannabis, cocaine and ecstasy

Drug	Used in the last year (%)		Used in the last year, North West only (%)	
	16-24	16-59	16-24	16-59
Amphetamines	2.4	1.0	3.0	1.1
Cannabis	17.9	7.4	20.6	8.1
Cocaine	5.0	2.3	7.0	2.6
Ecstasy	3.9	1.5	6.0	1.8

* Source: BCS, 2007/08

When the North West of England was considered, the BCS revealed that use of amphetamines, cannabis, cocaine and ecstasy in the last year was higher when compared to England as a whole, both in 16-24 and 16-59 year olds.

Whilst amphetamines, cannabis, cocaine and ecstasy are the most used illicit drugs in Britain, in particular amongst 16-24 year olds, the Drug Strategies of 1998 and 2002, along with the new Drug Strategy, *Drugs: protecting families and communities* (2008), puts a priority on the treatment of those drug users who use opiates and/or crack cocaine. Through the current drug

strategy, there is particular focus on those drug-misusing offenders who enter treatment through the Drug Interventions Programme (DIP) and those leaving prison or completing the Drug Rehabilitation Requirement (DRR) of a community sentence or a period on licence.

Structured drug treatment services (tier 3 and 4 services as defined by Models of Care, National Treatment Agency, 2002 & 2006) are dominated by individuals presenting for treatment for problems associated with heroin use. In England, the majority of individuals in contact with structured drug treatment during 2007/08 stated the problematic use of heroin (65%), usually as their primary problematic drug (61%). Whilst the primary problematic use of cannabis amongst those in treatment was common, this was far more prevalent amongst under 18s (78%) in comparison to those aged 18 and over (7%). The primary problematic use of amphetamines (3%), cocaine (6%) and ecstasy (1%) was low amongst those in contact with these services. The dominance of opiate specific users within drug treatment services is also evidenced by the finding that 74% of individuals in contact with treatment in 2007/08 were accessing a *GP* or *specialist prescribing* intervention for drug misuse (NTA, 2008a).

The 'ACCE' Profile

In May 2007, Howard Parker wrote an article published by Drink and Drug News (Parker, 2007) urging government and the National Treatment Agency to recognise significant age related shifts in the primary drug of presentation at specialist under 18s substance misuse services, amongst young adults at tier 3 and amongst younger offenders processed by the Drug Interventions Programme (DIP). He coined the term 'The ACCE Profile' which has now become widely adopted in the field and particularly amongst North West England commissioners and providers.

Originally ACCE, as an acronym, focussed on Alcohol, Cannabis,

Whilst cannabis, along with amphetamines, cocaine and ecstasy, are the most popular illicit drugs in the UK, alcohol use is far more prevalent. Over 90% of the adult population in England drink alcohol (Goddard, 2008), with approximately a third of people drinking once or twice a week (Information Centre, 2008). Approximately 7.1 million residents in England are thought to be hazardous or harmful users of alcohol (WHO, 2006), with around 1.1 million being alcohol dependent (DH, 2004) (for full definition of harmful, hazardous, dependent and binge drinking see MoCAM, DH 2006). United Kingdom youths have among the highest levels of alcohol consumption and binge drinking in the European Union (Hibell et al., 2004). Associated problems of alcohol use including anti-social behaviour (Best et al., 2006) and unintended pregnancy (Naimi et al., 2003) are also high in the UK. School pupils (aged 11-15) are more likely to have had an alcoholic drink than to have taken drugs or smoked, with the average weekly alcohol consumption amongst those who drink alcohol in this age group increasing from 5 units in 1990 to 11 units in 2006 (Fuller, 2006). Of 140 schools surveyed in 19 local authorities in the North West, 84% of pupils consumed alcohol and, of those who reported drinking, over half reported consuming more than 10 units in a typical week (Hughes et al., 2008).

Cocaine and Ecstasy as these substances were the most identified for under 18s around 2006. The basic proposition was that in many regions in England young people's services were primarily intervening with under 18s around alcohol, followed by cannabis, with cocaine and ecstasy also appearing. Fewer under 18s were primary heroin/opiate presenters. In line with the heroin cycle epidemiology, he predicted that under 18s services would continue to see fewer young heroin users and more ACCERs. This changing epidemiology would in turn occur for 18-24 year olds and eventually 25-30 year olds. The classic heroin/crack 'PDUs' (problematic drug users) would get older and behind them would be young people with the ACCE profile.

The National Drug Treatment Monitoring System (NDTMS)

The National Drug Treatment Monitoring System (NDTMS) collects 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 the key source for monitoring the number of people in contact with drug treatment services.

This report details the demographic profile, referral sources in, and the exit status upon leaving, of those individuals in contact

with structured treatment stating non-opiate substance use, incorporating Alcohol, Amphetamines, Cannabis, Cocaine and Ecstasy (AACCE). Analysis was conducted to compare this AACCE group to those in treatment who have entered due to opiate use to determine whether AACCE clients are a distinct group when compared to opiate users, who constitute the majority of those in structured drug treatment. This themed report attempts to evidence the scale and pace of change in presentations to tier 3 and 4 services in the North West. The final section will outline the implications for commissioning, service development, and workforce training.

AACCE clients

Whilst Parker (2007) refers to ACCE as alcohol, cannabis, cocaine and ecstasy users, within this report, an individual was deemed to be an AACCEr if they stated alcohol, amphetamines, cannabis, cocaine or ecstasy as a problematic substance.

'AACCE' should be seen as shorthand for non-opiate substance use. In some areas amphetamine use is high and ecstasy use in decline in respect of prompting treatment entry. Similarly other drugs like anabolic steroids (McVeigh & Evans-Brown, 2008) and, anecdotally, ketamine are becoming increasingly prominent. The AACCE term is metaphorical rather than literal because substance misuse trends continuously evolve and there are time lapse and regional differences to be factored in.

During 2007/08, individuals who stated the primary problematic usage of alcohol were not included in NDTMS. Therefore, alcohol AACCE clients are only included if they stated alcohol as a secondary or tertiary substance. All clients who stated opiates (heroin, methadone or other opiates) as a problematic substance were excluded from the analysis, even if they stated an AACCE substance as one or more of their problematic substances. These clients have been termed opiate clients within this report. A small proportion of clients did not meet either substance use profile above; they stated hallucinogens, solvents, crack or

benzodiazepines within their drug profile and as such were included with the AACCE clients due to their non-opiate profile.

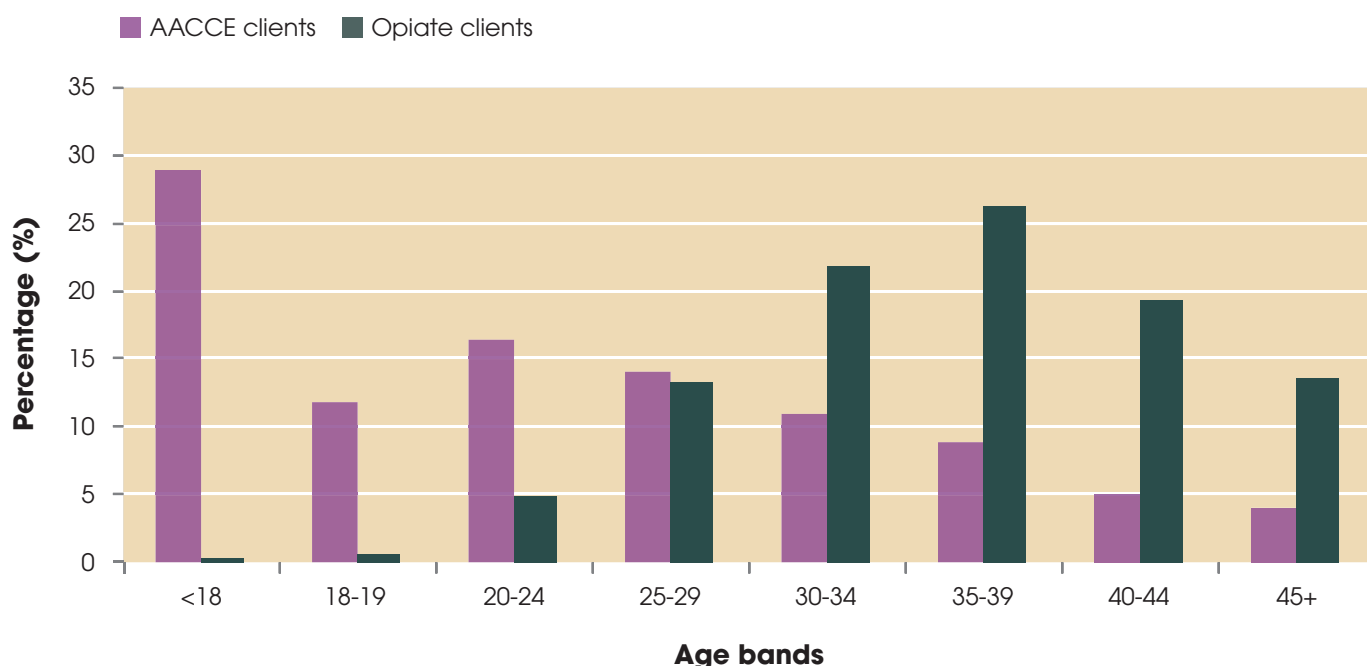
Results: AACCE clients

Demographics of AACCE clients in contact with structured drug treatment

During 2007/08, there were 38573 individuals in contact with structured drug treatment services in the North West of England. Of these, 8911 (23.10%) were classed as an AACCE client due to their substance profile within their most recent episode of treatment. The majority of AACCEs were male (75.33%), and stated their ethnicity as white¹ (n= 8420, 95.27%).

The mean (average) age of AACCEs in contact with treatment during 2007/08 was 22.48 years, significantly younger than those opiate clients in treatment (36.41 years, $t=-115.97$, $p<0.001$). The majority of AACCE clients were aged under 25 (n=5091, 57.13%), with only 9.04% of these clients aged 40 and older. In contrast, a higher proportion of the opiate clients were aged 40 and older (n=9784, 32.98%). During 2007/08, of the 6760 individuals aged under 25, 5091 (75.31%) had an AACCE profile, demonstrating that younger individuals in contact with drug treatment are far less likely to use opiates in contrast to their older counterparts. In contrast, of the 26622 individuals aged 30 and over, only 9.65% were AACCEs.

Figure 1: Age bands of AACCE and opiate clients in contact with treatment, 2007/08



¹ Data were missing from 1.6% of ethnicity records.

Substance Use

The NDTMS records the primary problematic substance of those in contact with structured drug treatment services, along with possible secondary and tertiary problematic substances. Regionally, approximately half of AACCEs in contact with treatment in 2007/08 stated cannabis as their primary problematic substance (n=4524, 50.77%), with 31.04%

(n=2766) stating cocaine. Of those AACCEs that stated a secondary problematic substance, around half identified alcohol (n=2599, 51.52%), suggesting that a large proportion of AACCE primary problematic substance users also had issues surrounding alcohol use.

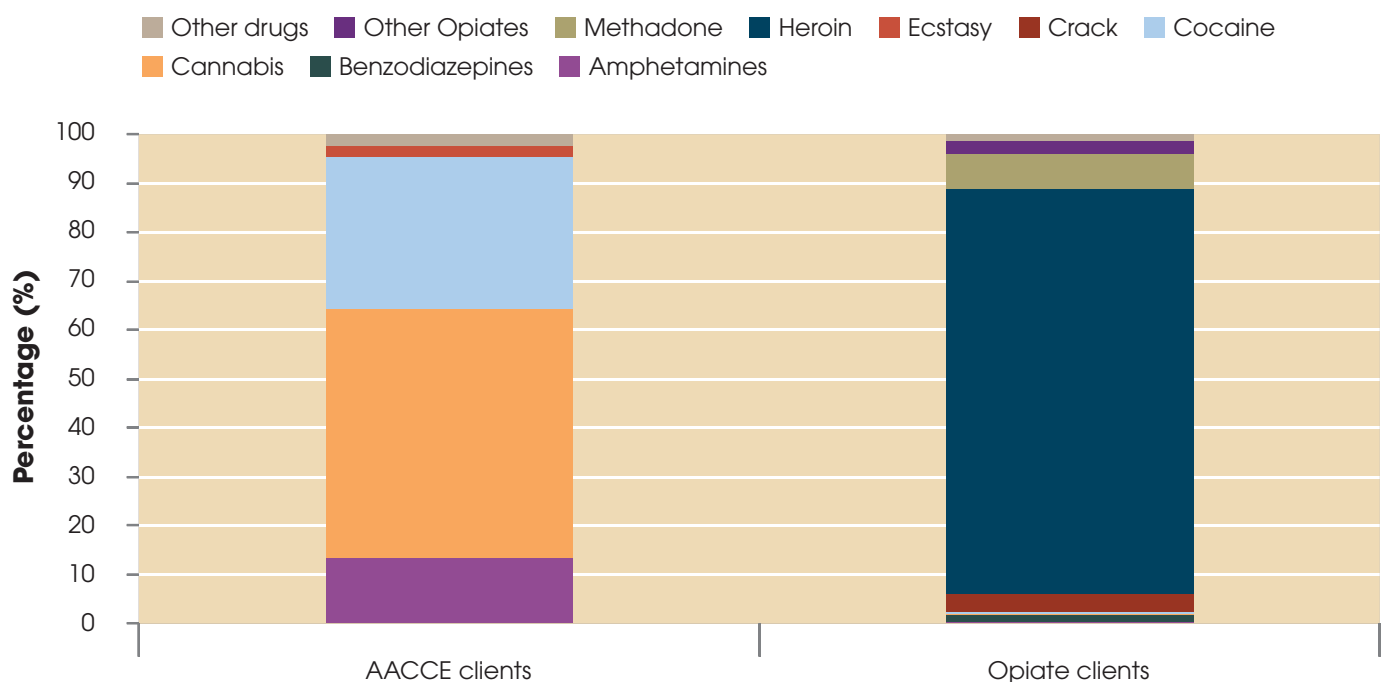
Table 3: Primary, secondary and tertiary problematic substances of AACCE clients in contact with treatment, 2007/08

Problematic substance	Primary substance		Secondary substance		Tertiary substance	
	Number	%	Number	%	Number	%
Alcohol	0	0.00	2599	51.52	583	29.12
Amphetamines	1203	13.50	264	5.23	149	7.44
Benzodiazepines	0	0.00	111	2.20	47	2.35
Cannabis	4524	50.77	888	17.60	322	16.08
Cocaine	2766	31.04	507	10.05	359	17.93
Crack	0	0.00	124	2.46	49	2.45
Ecstasy	215	2.41	345	6.84	304	15.18
Solvents	91	1.02	16	0.32	29	1.45
Other Drugs	112	1.26	191	3.79	160	7.99

The vast majority of opiate clients in contact with treatment stated heroin as their main problematic drug (n=24539, 82.73%) with

7.22% stating methadone and 2.66% stating other opiates (see figure 2).

Figure 2: Primary problematic substance of AACCE and opiate clients in contact with treatment, 2007/08



The majority of AACCEs aged under 18 stated cannabis as a primary problematic substance (n= 2173, 84.39%), with very few identifying primary problematic use of cocaine (n=173, 6.72%). The use of cocaine steadily increased in 18-29 year olds with approximately half of 25-29 year olds stating the primary problematic use of this drug (n=649, 51.92%). This proportion decreased with each increasing age band beyond the age of 30. Conversely, the proportion of those stating amphetamines increased with each increasing age band from 18-44 years (see figure 3).

Whilst the majority of AACCEs aged under 18 in contact with treatment stated cannabis as a primary problematic substance, this does not take into consideration the number of young people entering treatment who stated alcohol as their primary problematic substance. Unlike adult services during 2007/08, young people's specific services were able to capture information within the NDTMS on those presenting to treatment with alcohol as a primary problematic substance. During 2007/08, 1544 primary alcohol users aged under 18 presented to young people's services, illustrating the extent of alcohol use as an issue within these services.

Figure 3: Primary problematic substance of AACCE clients by age band, 2007/08

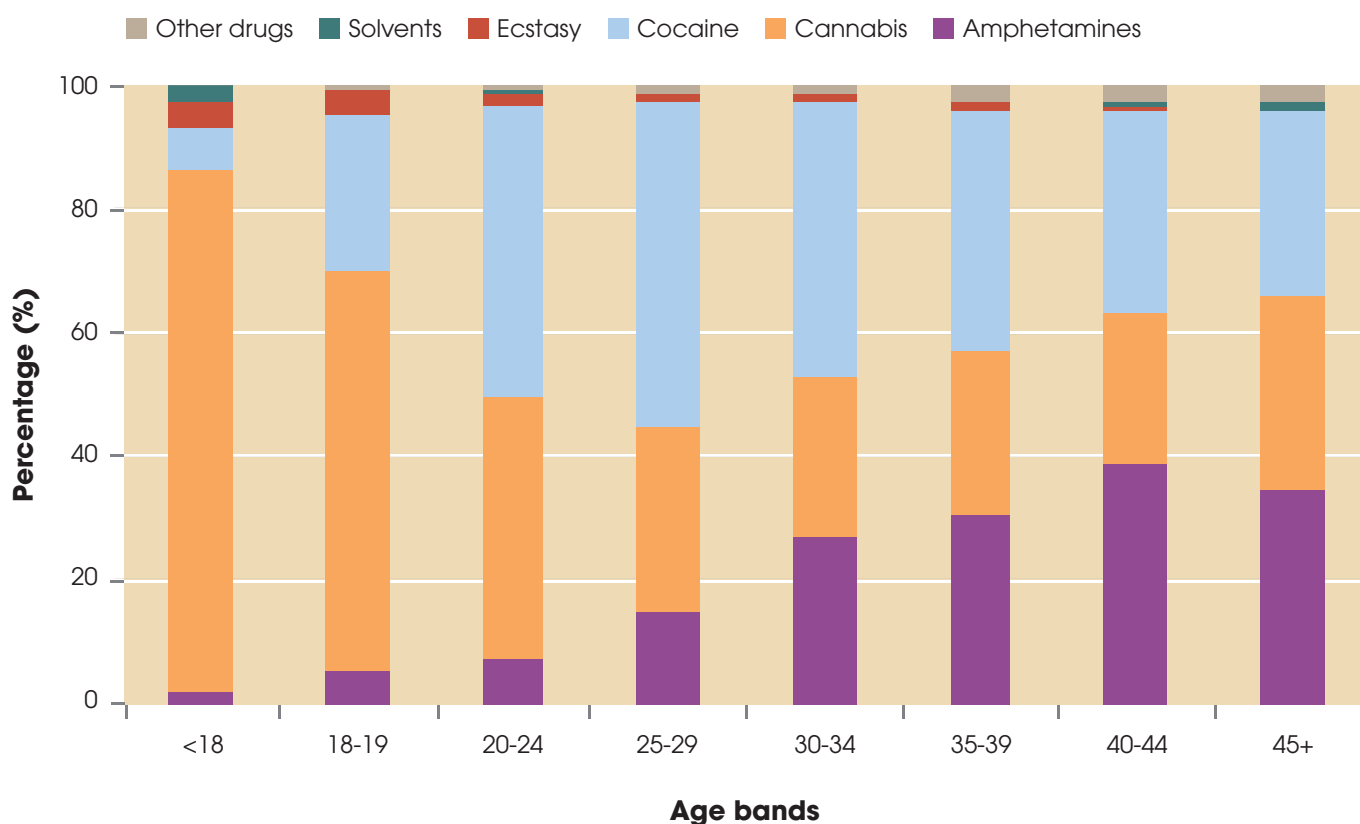


Table 4 shows the primary and secondary substance use of AACCEs in contact with structured drug treatment. Of those that stated cocaine as a primary problematic substance, 23.25% (n=643) stated alcohol as secondary substance. The concomitant use of alcohol and cocaine poses significant health

issues due to increased toxicity from the simultaneous use of these substances (EMCDDA, 2007). A high proportion of those who stated cannabis as a primary problematic substance also stated alcohol as a secondary problematic substance (n=1664, 36.78%).

Table 4: Primary and secondary substance profile of AACCE clients, 2007/08

Secondary substance*	Primary substance					
	Amphetamines	Cannabis	Cocaine	Ecstasy	Solvents	Other Drugs
No secondary substance stated	604	1932	1248	37	32	13
Alcohol	176	1664	643	65	26	25
Amphetamines	1	153	92	11	0	7
Benzodiazepines	44	24	28	2	1	12
Cannabis	236	8	546	46	25	27
Cocaine	61	397	0	40	1	8
Crack	19	35	50	10	0	10
Ecstasy	45	174	120	0	2	4
Solvents	3	9	3	0	0	1
Other Drugs	14	128	36	4	4	5

* Some substances may be stated as both substance 1 and 2 due to the use of parent groups to describe a number of different substances

All stated problematic substance use

The next section of this report records the substance profile of AACCEs (incorporating primary, secondary and tertiary recorded problematic substance use). When all substances were considered, the majority of AACCEs

identified cannabis use (n=5717, 64.16%). In contrast, problematic cannabis use was relatively low amongst opiate using clients (n=2821, 9.51%). A large proportion of AACCE clients stated cocaine (40.76%), with 35.59% stating the problematic use of alcohol. Although included in the AACCE profile, only 1615 AACCE individuals stated amphetamines (18.12%).

Table 5: All stated substance use of AACCE and opiate clients, 2007/08²

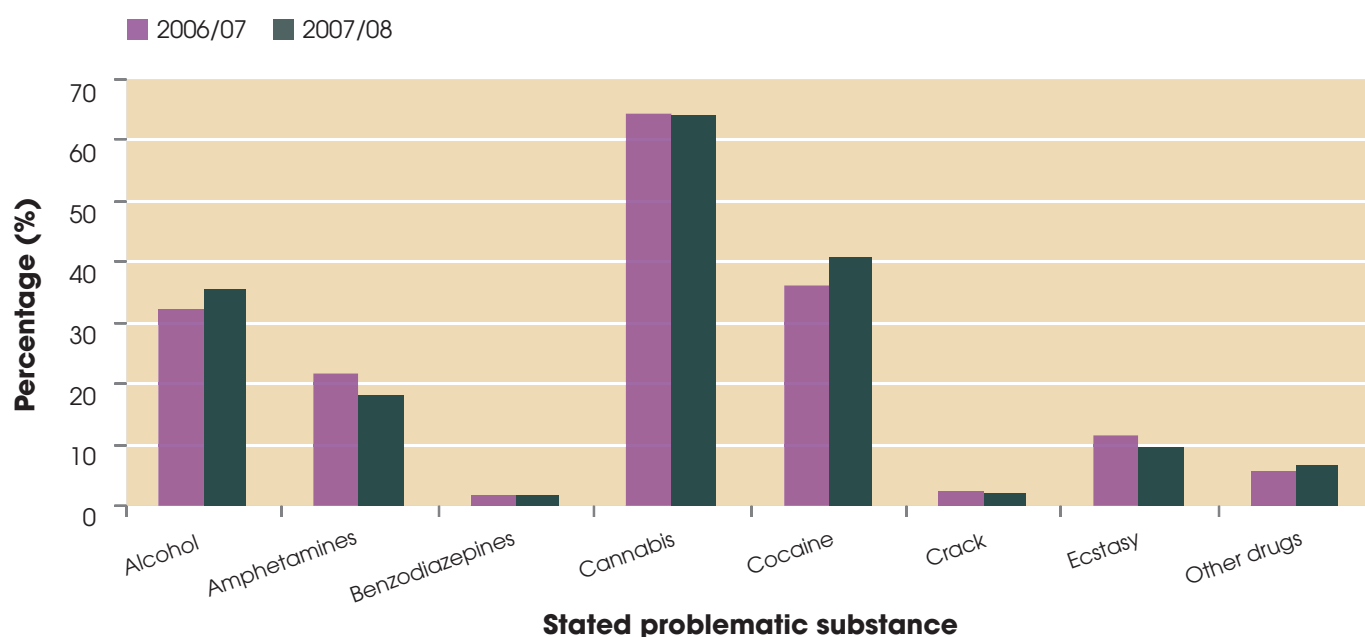
Problematic substance	AACCE clients	%	Opiate clients	%
Alcohol	3171	35.59	1761	5.94
Amphetamines	1615	18.12	1160	3.91
Benzodiazepines	157	1.76	3401	11.47
Cannabis	5717	64.16	2821	9.51
Cocaine	3632	40.76	1259	4.24
Crack	173	1.94	9596	32.35
Ecstasy	863	9.68	67	0.23
Heroin	0	0	25945	87.47
Methadone	0	0	5601	18.88
Other Opiates	0	0	1306	4.40
Solvents	136	1.53	40	0.13
Other Drugs	458	5.14	814	2.74

During 2006/07, 8445 of the 37396 individuals in contact with treatment had an AACCE profile (see figure 4). There has been an increase in the proportion of AACCEs stating the problematic use of cocaine and alcohol between 2006/07 (36.15% and

32.23% respectively) and 2007/08 (40.76% and 35.59% respectively). In contrast, there has been a decrease in the use of amphetamines and ecstasy between 2006/07 (21.55% and 11.56% respectively) and 2007/08 (18.12% and 9.68% respectively).

² Data not specified for 0.43% of drug records. Due to inability to determine main drug use, individuals classed as opiate clients

Figure 4: All stated substances of AACCE clients, 2006/07 and 2007/08



AACCE clients and D(A)AT of residence

Analysis revealed a low proportion of AACCEs (in the drug treatment populations) residing in Blackpool (11.73%) and

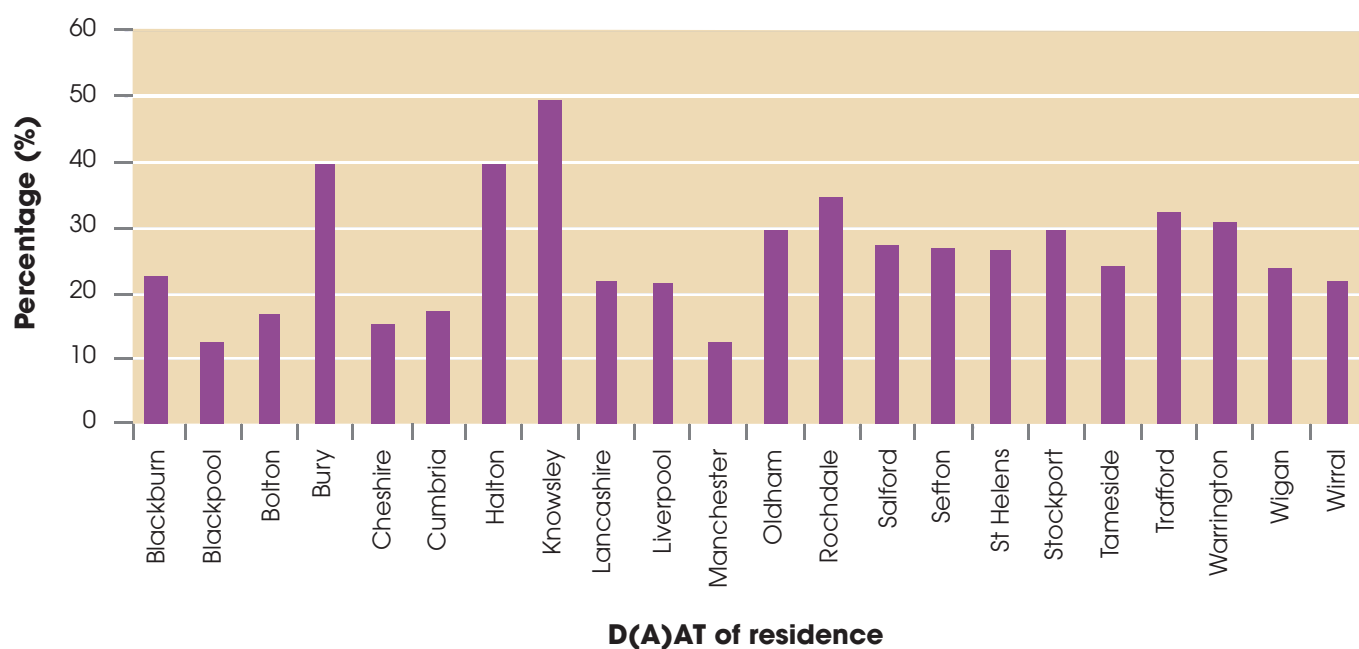
Manchester (12.60%), while AACCE clients residing in Knowsley accounted for almost half of the drug treatment population (45.20%). The highest number of AACCE clients were to be found in Lancashire (n=1116), reflecting the large population of the DAAT, rather than a high proportion of drug treatment clients (21.21%).

Table 6: Number of AACCE clients in contact with treatment by D(A)AT of residence, 2007/08

D(A)AT of residence	Number of AACCE clients	Overall number in contact with treatment (ALL SUBSTANCES)
Blackburn with Darwen	214	1055
Blackpool	186	1586
Bolton	291	1784
Bury	361	942
Cheshire	362	2334
Cumbria	316	1827
Halton	325	862
Knowsley	602	1332
Lancashire	1116	5261
Liverpool	925	4386
Manchester	460	3650
Oldham	347	1188
Rochdale	556	1670
Salford	283	1174
Sefton	459	1697
St Helens	287	1128
Stockport	275	923
Tameside	266	1155
Trafford	230	779
Warrington	254	905
Wigan and Leigh	378	1586
Wirral	592	2839
Regional Total³	8911	38573

³ 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

Figure 5: Percentage of treatment population stated as AACCE client by D(A)AT of residence, 2007/08



The mean age of AACCEs in contact with treatment varied across the region, from 20.50 in Oldham to 28.13 in Halton.

AACCEs in Bury, Cheshire, Oldham and Rochdale D(A)ATs had mean ages that were below the regional average of 22.48 years.

Table 7: Mean age of AACCE clients in contact with treatment by D(A)AT of residence, 2007/08

D(A)AT of residence	Mean Age
Blackburn with Darwen	23.22
Blackpool	25.35
Bolton	26.73
Bury	21.87
Cheshire	21.27
Cumbria	25.42
Halton	28.13
Knowsley	25.63
Lancashire	23.20
Liverpool	27.53
Manchester	26.52
Oldham	20.50
Rochdale	21.30
Salford	24.56
Sefton	25.73
St Helens	25.70
Stockport	27.37
Tameside	24.76
Trafford	24.51
Warrington	26.24
Wigan and Leigh	27.07
Wirral	26.32
Regional average	22.48

Substance use profile of AACCE clients by D(A)AT of residence

Blackburn with Darwen, Blackpool, Bolton, Cumbria and Wigan D(A)ATs had high proportions of stated amphetamine use (30.37%, 38.71%, 30.93%, 31.96% and 33.07% respectively) in comparison to areas such as Liverpool and Sefton (4.76% and 6.97% respectively, see table 8). Whilst Liverpool and Sefton had low stated use of amphetamines, cocaine use was high in these areas (61.84% and 60.35% respectively). The higher level of

cocaine in certain areas maybe a result of central urban areas experiencing an earlier epidemic of cocaine use. This cocaine use would then defuse to surrounding areas later, as occurred with crack cocaine use (McVeigh et al., 2003). Areas with a relatively high proportion of amphetamine use also tended to have high levels of reported ecstasy use. Problematic use of cannabis varied from 47.35% in Wigan to 81.27% in Oldham. Table 7 shows that the mean age of AACCEs in Oldham was lower (20.50 years) than in Wigan (27.07 years), suggesting that younger individuals were more likely to state cannabis as a problematic substance.

Figure 6: All stated substance use of AACCE clients by D(A)AT of residence, 2007/08

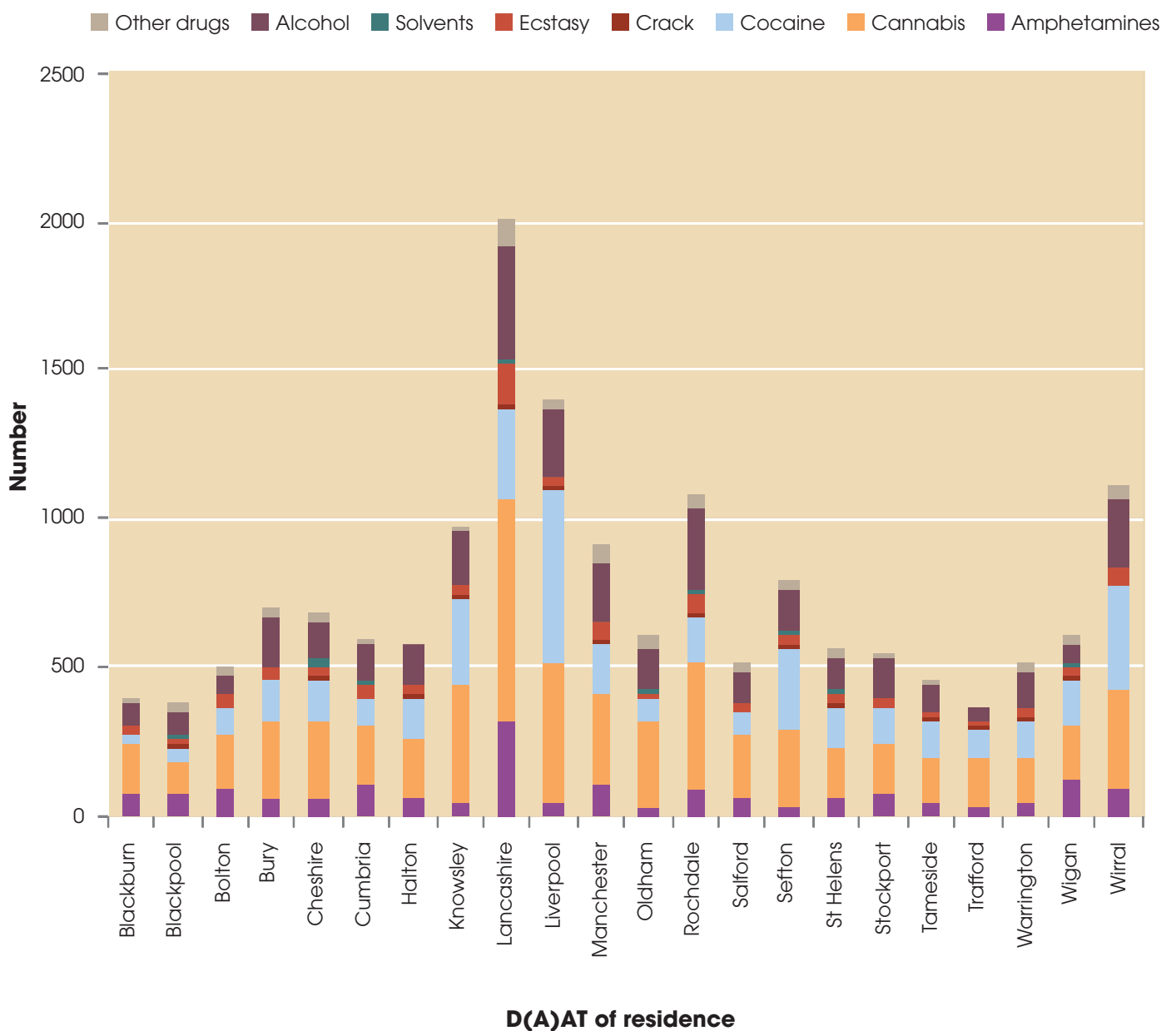


Table 8: Percentage of all stated substance use in AACCE clients by D(A)AT of residence, 2007/08

D(A)AT of residence	%							
	Alcohol	Amphetamines	Cannabis	Cocaine	Crack	Ecstasy	Solvents	Other Drugs ⁴
Blackburn with Darwen	34.58	30.37	80.84	14.02	2.34	11.68	2.80	4.21
Blackpool	44.09	38.71	60.22	22.58	3.76	13.44	7.53	12.37
Bolton	22.34	30.93	59.45	33.68	2.75	13.06	1.03	8.93
Bury	46.54	13.85	73.96	36.01	0.83	14.96	0.55	8.03
Cheshire	36.19	15.75	70.44	40.61	2.49	10.50	5.52	6.63
Cumbria	38.61	31.96	62.03	29.75	1.58	14.87	2.53	6.65
Halton	39.38	18.77	58.77	45.54	2.46	9.23	1.23	3.69
Knowsley	30.56	7.48	65.95	48.67	1.33	5.15	0.50	0.83
Lancashire	34.23	28.67	66.40	27.69	1.43	12.01	1.25	8.42
Liverpool	24.65	4.76	51.14	61.84	1.84	3.35	0.65	3.14
Manchester	41.74	23.70	64.57	37.61	3.91	11.52	1.52	13.91
Oldham	38.04	9.51	81.27	21.90	2.02	4.90	2.31	13.54
Rochdale	50.90	15.29	78.60	26.98	1.80	11.51	1.44	7.55
Salford	36.75	20.85	73.14	26.86	1.77	8.83	1.77	9.54
Sefton	32.03	6.97	56.21	60.35	0.87	8.71	0.87	5.66
St Helens	41.11	19.51	59.58	49.13	3.48	11.85	1.39	6.97
Stockport	45.82	25.45	61.82	42.91	2.91	9.82	1.45	9.82
Tameside	34.59	15.04	59.40	46.62	1.88	7.52	1.50	6.77
Trafford	21.74	9.13	78.26	36.96	5.65	6.52	0.00	1.74
Warrington	44.88	13.78	63.39	49.61	1.18	16.14	1.18	9.45
Wigan and Leigh	18.78	33.07	47.35	41.53	1.59	9.26	2.12	6.88
Wirral	38.85	13.85	57.09	58.61	1.52	9.63	0.51	6.08
Regional average	35.59	18.12	64.16	40.76	1.94	9.68	1.53	6.90

Referral source of AACCE clients in contact with treatment

During 2007/08, each individual in treatment may have received more than one episode of treatment at one or more treatment agency. Therefore, to provide the fullest possible understanding of the ways in which people are referred into service, results for each recorded referral are presented here.

Table 9: Referral source into treatment of AACCE and opiate clients, 2007/08

Referral source	AACCE clients		Opiate clients	
	Number	%	Number	%
Drug service	933	9.26	9546	22.57
GP	503	4.99	4008	9.47
Self	2998	29.74	16066	37.98
CJS	2668	26.47	8981	21.23
Other ⁵	2978	29.54	3701	8.75

⁴ Other Drugs= Anti-depressants, Barbiturates, Hallucinogens, Major Tranquillisers, Poly Drugs, Prescription Drugs and Other Drugs

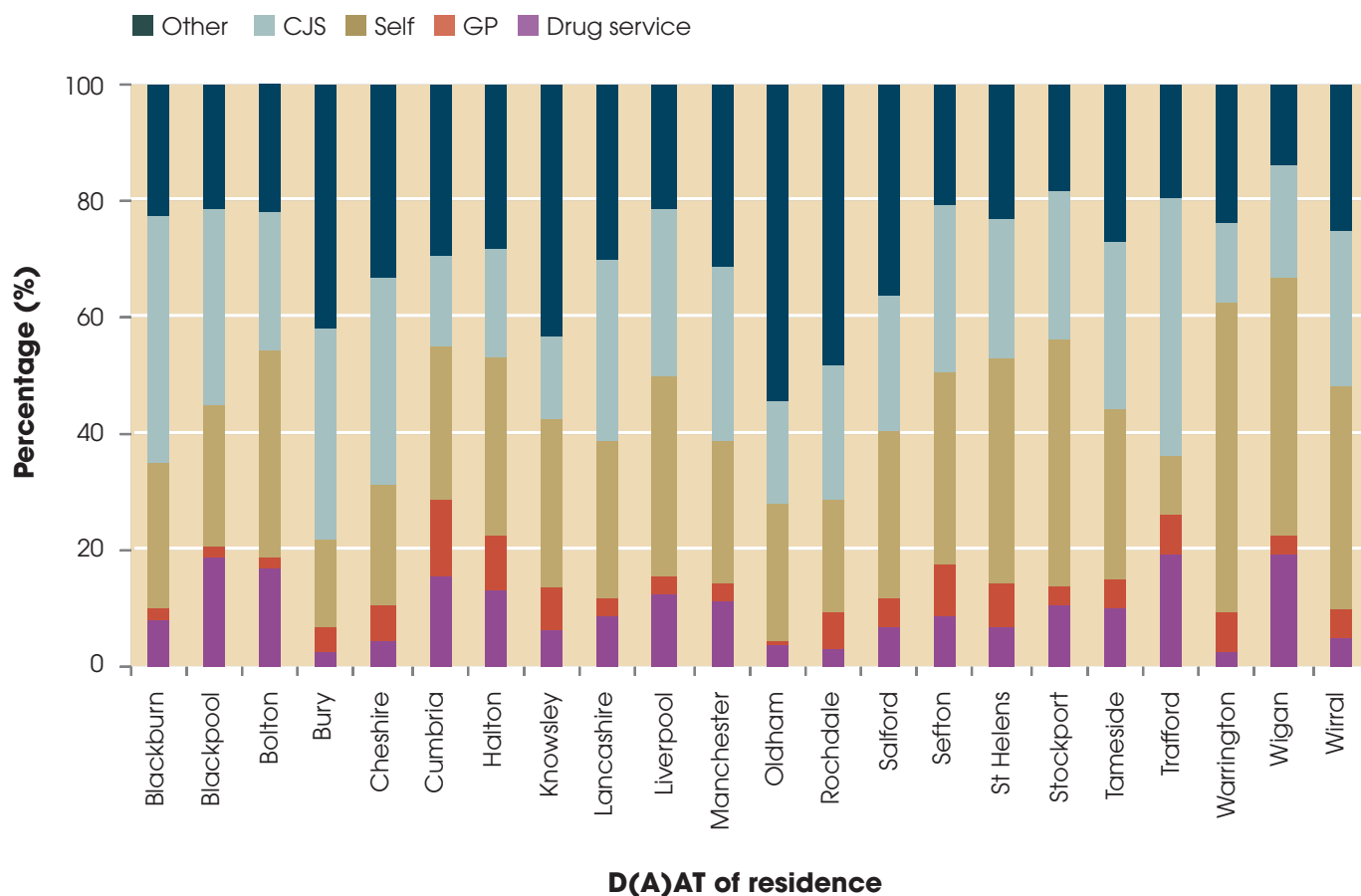
⁵ Other includes A&E, syringe exchange, psychiatry, Community Care Assessment (CCA), employment services, education services, Pupil Referral Unit (PRU), connexions, Social Services, sex worker projects, general hospital, relative, concerned other, psychological services, Child and Adolescent Mental Health Services (CAMHS) and Looked After Children (LAC)

AACCEs were more likely to be referred into treatment via the Criminal Justice System (CJS, 26.47%) and from 'other' referral sources (29.54%) in comparison to opiate clients (21.23% and 8.75% respectively, see table 9). In contrast, opiate clients were more likely to be referred from other drug services into treatment (22.57%) in comparison to AACCE individuals (9.26%).

Blackburn with Darwen and Trafford DATs had a high proportion of AACCE referrals via the CJS (42.24% and 44.22% respectively) in comparison to Knowsley DAT (14.46%). Warrington and Wigan DATs had relatively high proportions of self

referrals into treatment services (53.41% and 44.50% respectively), whereas in Trafford only 9.96% of AACCE referrals were classed as self referrals (see figure 7). Oldham and Rochdale D(A)ATs had a high proportion of referrals from 'other' referral sources (54.35% and 47.98% respectively), whilst also having a low mean age of AACCE clients in treatment (20.50 and 21.30 years respectively). 'Other' referral sources include several sources from young peoples services, such as education services, looked after children, connexions and pupil referral units.

Figure 7: Referral source of AACCE clients by D(A)AT of residence, 2007/08



Modalities of treatment of AACCE and opiate clients⁶

During 2007/08, 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 for both AACCE (n=11833) and opiate clients (n=48243). According to NTA guidelines (see http://www.nta.nhs.uk/areas/ndtms/core_data_

[set_page.aspx](#)); Young persons' (YP) specific services have separate YP modalities of treatment. These YP modality codes for tier 3 and 4 treatment interventions 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 to reflect these different modalities. Amongst AACCE clients, 43.11% of all modalities involved a YP treatment intervention. In contrast, only 0.79% of opiate client interventions involved YP treatment interventions.

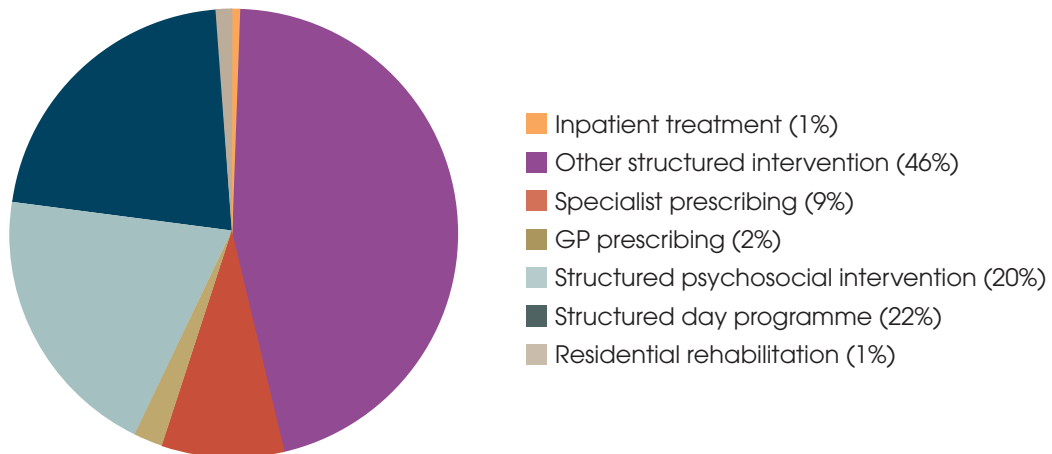
⁶ 2.18% of records did not state a modality due to either a client not commencing a modality of treatment or non recording of data

Adult treatment modalities

Figures 8 and 9 show that AACCEs were more likely to enter an *other structured intervention* of treatment (n=2979, 45.87%) in

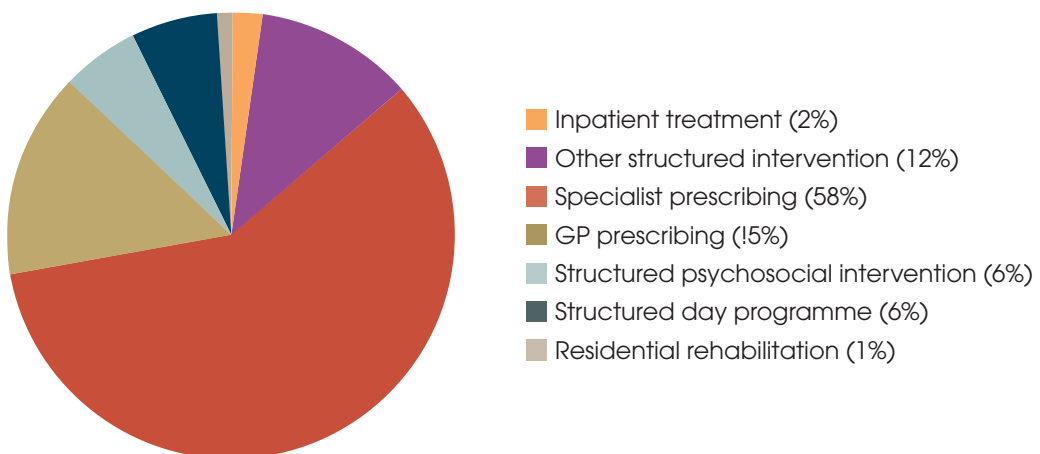
comparison to opiate clients (n=5459, 11.59%). The majority of opiate using modalities of treatment were involved in *specialist prescribing* (n=27558, 58.49%), with 14.69% (n=6923) involving *GP prescribing*. In contrast, only 8.98% (n=583) of AACCE modalities involved *specialist prescribing* interventions.

Figure 8: Adult AACCE clients modalities of treatment, 2007/08*



* Numbers total over 100% due to rounding

Figure 9: Adult opiate clients modalities of treatment, 2007/08



YP treatment modalities

Amongst AACCE YP modalities, the majority involved YP *psychosocial interventions* (n=3196, 64.93%). In contrast, less

than half of YP modalities of treatment in opiate clients involved YP *psychosocial interventions*. In opiate YP interventions, 13.33% (n=50) involved YP *specialist pharmacological interventions*.

Figure 10: YP AACCE clients modalities of treatment, 2007/08⁷

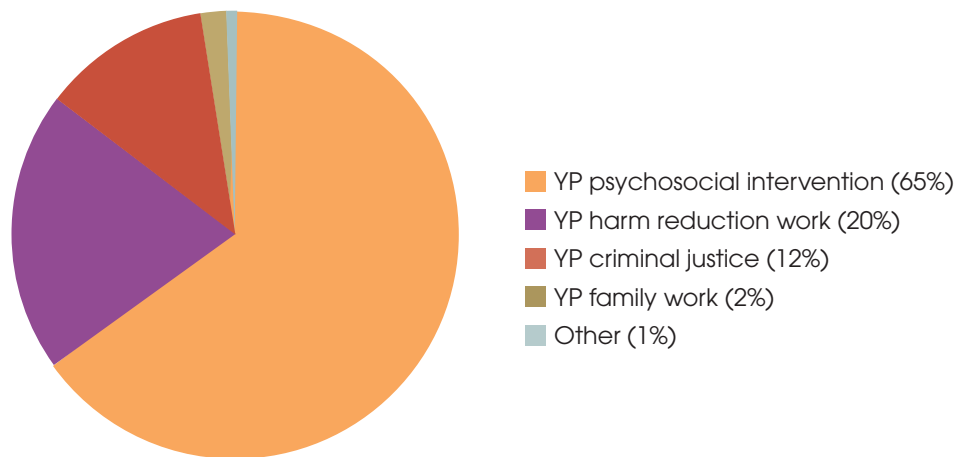
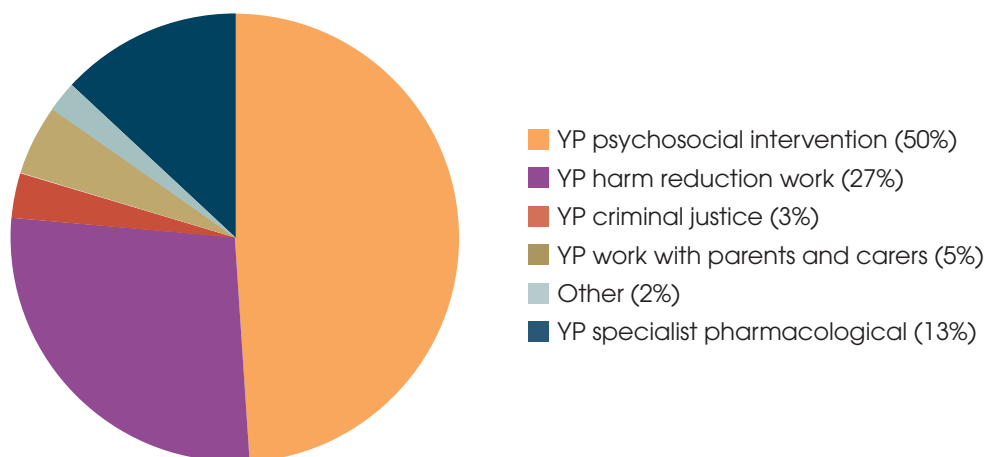


Figure 11: YP opiate clients modalities of treatment, 2007/08⁸



⁷ Other YP modalities of treatment = YP work with parents or carers, YP shared care schemes, YP specialist pharmacological interventions, YP inpatient interventions

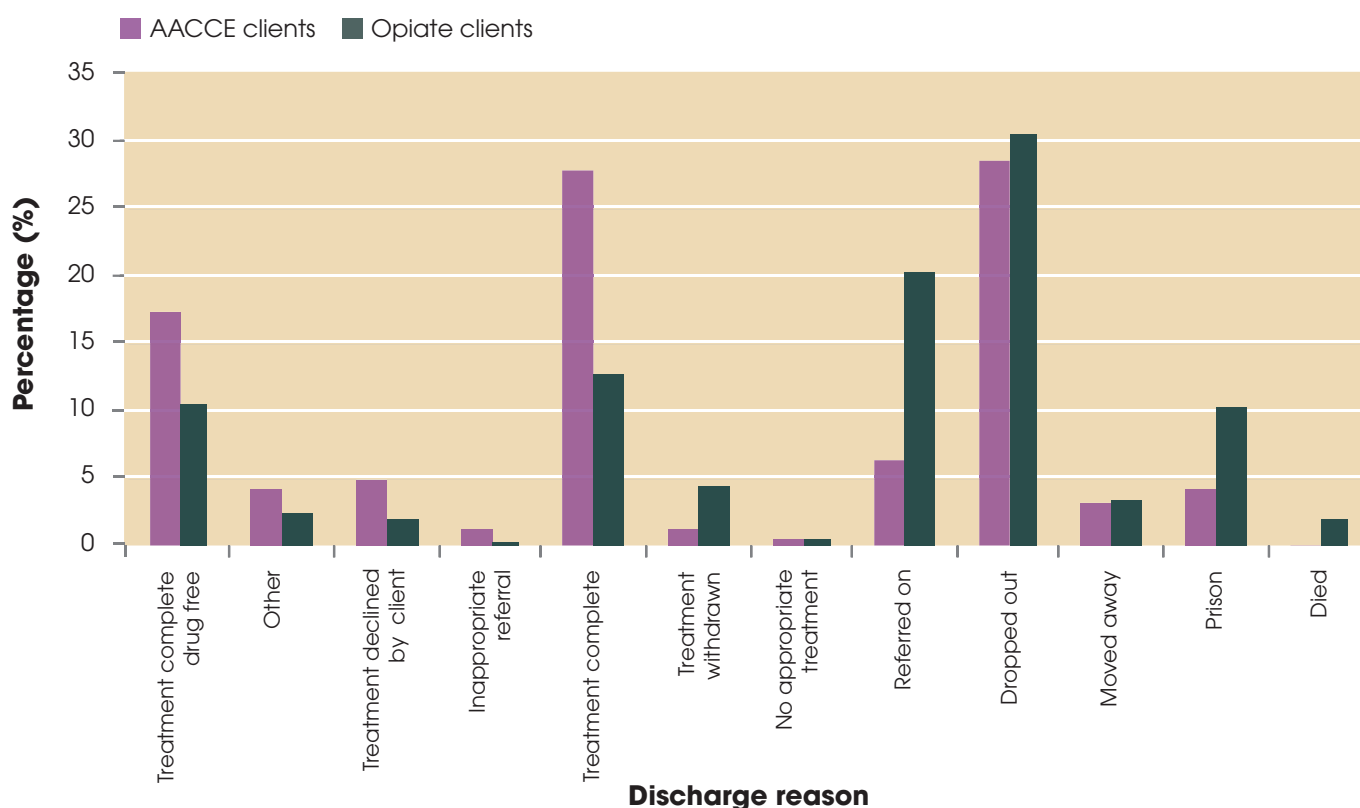
⁸ Other YP modalities of treatment = YP shared care schemes, YP inpatient interventions

Treatment outcomes for AACCE clients⁹

The following section details the discharge reasons for individuals exiting their latest treatment episode during 2007/08. Less than half of AACCEs (45.54%, n=4058) were still in treatment at the end of the year compared to nearly three-quarters (73.12%,

n=21690) of opiate clients. When only those discharged from treatment were considered, figure 12 shows that AACCEs were more likely to be discharged as treatment complete (n=1322, 27.88%) or treatment complete drug free (n=820, 17.29%), when compared to their opiate using counterparts (n=999, 12.75% and n=818, 10.44% respectively). Opiate using clients were more likely to die whilst engaged in drug treatment (n=167, 2.13%), when compared to AACCE clients (n=7, 0.15%).

Figure 12: Treatment outcomes of AACCE and opiate clients, 2007/08



Conclusions

The AACCE Profile cohort dominating younger treatment presenters

In 2007/08, the majority of individuals in contact with structured drug treatment in the North West of England entered treatment due to opiate use. However, the number of individuals stating AACCE substances grew between 2006/07 and 2007/08, with

AACCE clients more likely to state cocaine and alcohol as a problematic substance when the two years were compared. When those in treatment aged under 25 were considered, the majority were AACCEs (75.31%). Whilst those aged 30 and older were more likely to be opiate users (n=24052, 90.35%), those in treatment aged less than 25 have a different drug use pattern. Data from the NDTMS in 2007/08 revealed that YP services were dominated by individuals with cannabis and/or alcohol issues, not opiate related problems.

⁹ 0.65% of individuals had a discharge reason of 'not known'

Data issue: Primary problematic alcohol use

Whilst the original Parker hypothesis of the AACCE profile included the use of alcohol, the NDTMS during 2007/08 did not include the primary problematic usage of alcohol amongst adults. Therefore, alcohol has only been included within this report if it was stated as a secondary or tertiary problematic substance.

The NDTMS did collect information on under 18s with the primary problematic use of alcohol. Therefore, it was possible to determine that, amongst this age group, alcohol and cannabis use was predominant. However, as alcohol was not included amongst adults, it was not possible to establish the extent to which alcohol was an issue amongst 18-24 year olds. Whilst during 2007/08 the NDTMS did not capture primary alcohol use in adults, the addition of alcohol specific services to the NDTMS during 2008/09 will provide the ability to determine whether alcohol is also an issue to those young adults in contact with treatment aged 18 and over.

The AACCE hypothesis is strongly supported by all the analyses conducted. Overall for North West of England, those aged under 18 present to treatment services with alcohol, cannabis and to a lesser extent cocaine, with amphetamine and ecstasy use also evident.

Analysis of NDTMS national data for 2006/07 revealed differences in the proportion of under 25s¹⁰ stating the main problematic use of heroin and crack dependent on region of residence (see appendix 1). National data indicates a shift in the drug use of younger clients in London and the North West from opiate use to an AACCE profile. This may be due to the earlier epidemic of opiate and crack use in these areas in comparison to other areas of the country, with patterns of drug use in metropolitan centres diffusing to surrounding areas (McVeigh et al., 2003). It may be inferred that the increase in the use of AACCE substances amongst the younger cohort of individuals in treatment in the North West is an indicator of the emerging substance use of younger people in other areas of the country in the future.

Motivation to change

NDTMS analysis revealed that AACCEs were, on the whole, referred into service via differing routes to opiate clients. During 2007/08, AACCE clients were more likely to be referred into treatment via the CJS or through 'other' referral sources (including connexions, pupil referral units and education services). The high proportion of AACCE clients entering treatment via the CJS may be as a result of mandatory drug testing within custody suites. Analysis of 2007/08 custody suite drug test data in Merseyside revealed an increase in positive tests for cocaine, with 49% of positive tests indicating cocaine only. Whilst the drug test cannot

distinguish between crack and powder cocaine, a high proportion of these cocaine only positive tests occurred at weekends, suggesting that these were mainly weekend powder cocaine users (Cuddy et al., 2008). These data suggest that a substantial number of drug users other than opiate/crack cocaine users are coming into contact with DIP and potentially entering the drug treatment system.

Gearing treatment interventions to AACCE clients

Once in contact with treatment, AACCE clients entered different interventions of treatment when compared to opiate clients. The vast majority of opiate clients entered either a *specialist* (58.49%) or *GP prescribing* intervention (14.69%) of treatment. In contrast, only 8.98% of AACCE client interventions of treatment involved a *specialist prescribing* intervention. There is strong evidence from the analysis that AACCEs are receiving structured psychosocial and other non prescribing interventions, especially within YP interventions of treatment. This suggests an increase in focus on uplifting competence in psychosocial approaches within YP services, but also within adult services dealing with non opiate presenters aged between 18-30 years. In recognition of the increasing importance of psychosocial interventions amongst younger drug users, the National Institute for Health and Clinical Excellence (NICE) have produced guidelines on these interventions (NICE, 2007) with guidance on workforce development around psychosocial interventions being produced by the National Treatment Agency during 2009 (NTA, 2008b).

The commissioning challenge

Analysis of AACCE clients revealed that those individuals who did not state opiates as a problematic substance were a distinct group. This pattern is also displayed in national data (NTA, 2009). AACCE clients were significantly younger, entering treatment via different referral routes and engaged in different treatment modalities to traditional opiate users. The NTA report, *Getting to grips with substance misuse amongst young people* (NTA, 2009) recognises the distinct use and treatment needs of young people in contact with drug treatment. In terms of needs assessment, treatment planning and service development, D(A)ATs need to be aware of the growing use of AACCE substances amongst their younger service users and the potential increase in demand for non prescribing interventions of treatment. This increase in demand for non prescribing interventions may also be affected by individuals testing positive for cocaine use within custody suites. D(A)ATs should also be aware of the large proportion of under 18s entering treatment due to the problematic use of alcohol. The introduction of data collection on those adults entering drug or alcohol treatment with alcohol as their primary problematic substance will allow for the ability to judge the extent of alcohol related issues amongst those young adults who also state

¹⁰ National data used age of individuals at triage, not end of reporting year as was used in this report

AACCE substances.

If commissioning is to be 'world class', services should be continuously reconfigured in response to service user needs. The AACCE profile might trigger the following questions:

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

This agenda should be addressed by local Needs Assessments but will become a focus of scrutiny by the National Treatment Agency during 2009/10 as 18-25 year olds become a special group and each area will be required to audit its transitional arrangements and care pathways between young people's and adult provision.

There has been a gradual decline in the proportion of clients aged less than 25 years over recent years (NTA 2008a). This may be a product of the image of adult drug and alcohol services. If there are no transitional arrangements or YP services and adult drug services are both dominated and pre-occupied by heroin and crack clients it seems likely that AACCE problematic young adults will not present voluntarily. It is clear that in order for D(A)ATs to meet the needs of this younger population of substance users, services will need to be configured to reflect changing demographics, behaviours and attitudes.

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Appendix 1: Individuals aged under 25 in contact with structured drug treatment stating opiates as a main problematic drug, 2006/07

Region	Number	%
North East	1447	48.72
North West	1494	23.95
Yorkshire and Humber	2383	53.25
East Midlands	1803	50.25
West Midlands	2635	53.44
Eastern	964	35.34
London	1220	19.29
South East	1480	34.30
South West	1472	39.17

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