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▶ Drug treatment in England 2013–14.

Public Health England.
Public Health England, 2014.

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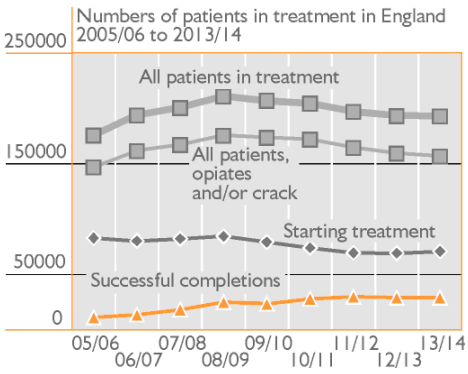
Authority responsible for promoting addiction treatment in England cautions that the gains of recent years in reduced drug use, lower demand for treatment for heroin and crack problems, improved treatment performance, and curbing drug-related harm, have all stalled or gone in to reverse.

SUMMARY Within its brief to protect and improve the nation's health and address inequalities, Public Health England promotes addiction treatment by supporting the local authorities responsible for local treatment systems. This report documents England's progress in respect of the treatment of adults (18 and over) receiving treatment for problems related to their use of illegal drugs; a corresponding report deals with alcohol. This account draws on the featured report and source data from the National Drug Treatment Monitoring System. For the treatment of under-18s see this analysis instead.

Main findings

The backdrop is a long-term downward trend in drug use over the last decade which reversed slightly during 2013/14, along with an increase in drug-related deaths. According to the 2013/14 Crime Survey for England and Wales, the proportion of adults aged 16–59 who used any illicit drug during the past year went up from 8.1% to 8.8%, and 19% of 16–24-year olds said they had used illicit drugs compared to 16% the previous year.

Despite these latest figures, overall drug use remains lower than around ten years ago, as does use of the more harmful drugs such as heroin and crack. However, if the recent increase is sustained, it may translate to more people needing treatment for drug problems.



All patients in treatment during the year

At 193,198, the number of adults treated for drug problems in England in 2013/14 was very close to the previous year's 193,575, almost halting the decline from a peak of 210,815 in 2008/09 ▶ chart. Three-quarters of the caseload were men. As (▶ below) the number of sub-30-year-olds starting or returning to treatment falls, and the number over 40 rises, the treatment population is on average becoming older. In 2013/14, 23% were aged under 30 (down from 25% last year) and 36% were aged over 40 (up from 34% last year). Over 57% of adults in treatment during the year were either parents or had children living with them.

Patients starting or returning to treatment during the year

Among the total were 70,930 patients who started or returned to treatment in 2013/14, an increase on the previous year's 69,247, reversing the consistent fall since 2008/09's peak of 84,520 ▶ chart above right. Treatment starters are on average older than in previous years. From 38,485 in 2005/06, by 2013/14 the number aged under 30 had fallen to 24,238, while over 40s rose from 12,678 to 18,889 and now constitute 27% of all starters compared to 15% in 2005/06.

Of treatment starters in 2013/14, 46,001 were being treated for problems with crack cocaine and/or opiates such as heroin, slightly up on 45,739 the previous year, which again may indicate an end to the longer term downward trend. Nevertheless, at 9,878 the number of under-25s who started treatment for opiate problems was around a third of the 26,729 who started in 2005/06. Numbers starting treatment for problem cannabis use continued to rise, from around 7,500 in 2005/06 and 2006/07 to 11,821 this year. Also up to 7782 was the number starting treatment for problems primarily relating to cocaine powder (ie, not crack), continuing the increase since 2010/11, though still below the 8522 peak in 2008/09.

Treatment entrants for 'club drugs' numbered 3543, slightly up on last year and a new high, but still just 5% of all treatment starts, and recovery rates for these users remain good. Itemised only from this year, relatively few people started treatment for problem use of novel psychoactive substances – so-called 'legal highs'. It is unclear whether small treatment numbers are because these drugs don't cause problems requiring widespread structured treatment, or because services are not relevant or accessible to users of these drugs.

The upshot of these trends is a changed drug profile of people starting treatment. In 2005/06 the 59,642 presenting with opiate problems represented 72% of all treatment entrants. By 2013/14 these figures had fallen to 43,453 and 61%, largely due to the steep decrease in the number of newly presenting opiate users aged 18–24 from 11,309 in 2005/06 to 3,142 in 2013/14. This fall mirrors the general population trend in the estimated number of under-25s using opiates and/or crack, down from 72,838 in 2004/05 to 32,628 in 2011/12.

The average waiting time for a first appointment fell from five days the previous year to three days, and, as previously, 98% of referrals waited under three weeks.

Treatment settings and modalities

Before treatment setting/modality categories changed on 1 November 2012, at least 79% of patients were recorded as being prescribed medications, usually methadone for the treatment of opiate addiction. Under the new system, in 2013/14 147,841 patients were recorded as being prescribed medications, 77% of the total. Of these, just over a quarter (26%) had been prescribed medications without a break for at least five years, but over a third (37%) for less than a year. For several years the proportion of the treatment caseload in residential rehabilitation at some time during the year has remained at around 2–3% of the total, numbering 3,935 in 2013/14.

Indicators of treatment success

The proportion of patients who had been in treatment for at least 12 weeks, or had left having completed free of dependence, has remained at 93–94% since 2009/10 (in this latest year the figure was 94%), after rising from 82% in 2005/06.

In 2013/14, 29,150 patients 'successfully completed' their treatment – defined as no longer in treatment at the end of the year

having left free of dependence, judged no longer in need of treatment, and not using heroin or crack cocaine ▸ chart above right. Of these, 71% were recorded as not using any illegal drug. At 15%, the proportion of all patients in treatment successfully completing during the year has remained static for three years, but represents a considerable advance on the 6–7% recorded in 2005/06 and 2006/07. Another 20,147 patients dropped out or otherwise left treatment without completing it, 10% of all patients in treatment that year compared to last year's 18,253 and 9%, an upturn which ended the fall from 21% in 2005/06.

Younger users tend to start treatment for problems with cannabis (43% of new starts for 18–24-year olds) and generally recover and leave treatment. On the other hand, users aged over 40 mostly come into treatment for heroin and/or crack (78% of new starts in 2013/14) and tend to have far more entrenched problems. This, and their often worsening health and limited social resources, means it is more difficult for them to successfully exit treatment – though for many, being *in* treatment helps stabilise their lives, reduce the risk of serious harm and overdose, and improve their chances of recovering.

The long view

Because it often takes more than a year to recover from drug problems, a longer view is needed to assess the success of drug services. Since 1 April 2005, 33% of the total of 416,026 people who had come into treatment had successfully completed it and were no longer in treatment on 31 March 2014. Another 37% had left without completing and 30% were still or back in treatment, among whom were 11% who had remained in treatment without an appreciable break.

These figures include patients who started treatment before 2005/06. A more contemporary analysis focuses on the 330,022 who entered treatment for the first time since April 2005, of whom 55% were treated for their use of opiate-type drugs like heroin. By the end of 2013/14, 36% were no longer in treatment after having successfully completed, 39% were no longer in treatment but had left without successfully completing, and 25% were still in treatment, either because they had stayed continuously or left and returned. Just 7% of people treated for use of drugs other than opiates had stayed in or returned to treatment; when drug problems included opiate use, the figure was 40%.

Drug-related harm

A key area of concern during the year has been deaths from drug misuse, up in 2013 in England from 1,492 in 2012 to 1,812, a 21% increase. Heroin/morphine remains the most common substance involved in drug-poisoning deaths – in England and Wales, 765 in 2013, up from 579 in 2012, a 32% increase. Tramadol, an opiate-like painkiller, has also been responsible for a sharp rise in deaths in recent years – 220 this year compared to 87 in 2009.

Blood-borne viruses such as HIV and hepatitis spread easily among drug users who share injecting equipment. The number of injectors who reported sharing equipment fell by a quarter between 2003 and 2008, but this figure has not changed over the past five years, and two-fifths of injectors (39%) said they engaged in this risky behaviour in 2013. Sharing is more common among those who began injecting in the last three years and may be increasing: nearly half (46%) of this group reported they had shared equipment in 2013.

The authors' conclusions

Over the past decade drug treatment services in England have helped thousands of drug users recover from their drug problems and rebuild their lives, benefiting not just these individuals and their families, but their communities and the whole of society.

While drug use has been on a long-term downward trend over the last decade, it has increased during the past year, and the decline we have seen in treatment numbers has slowed down, as have successful completion rates.

Though figures often fluctuate year to year, the increase in drug-related deaths is a major concern. Part of the answer is to do more to prevent people using drugs by building their health and social resources, and reducing inequalities. Treatment services also have a vital role to play in being available to help problem drug users. Naloxone, a drug that reverses the effects of heroin, should also be made more widely available to services and users.

The figures relating to blood-borne disease also demand action. Services need to give injecting users the advice that will keep them safe from harm, ensure injecting equipment is readily available, encourage them into treatment, and then help them stop injecting as part of their wider recovery from drug use.

New and emerging drugs are a concern, but use of heroin and crack is still by far the biggest problem, and many of the users are getting older. While the health of this large and ageing treatment group may be fragile, they should never be written off; they can and do recover, and should be given every chance to do so.

FINDINGS COMMENTARY The consistent note in this year's report is caution that the gains of recent years in reduced overall prevalence of drug use, less demand for treatment for heroin and crack problems, the performance of treatment services, and in curbing drug-related harm, have stalled, or may be proved to have gone in to reverse if the most recent trends continue. The clearest positive is what seems a wholesale turning away of young adults in England from heroin and crack. Notable too, and a departure from the reports authored by the National Treatment Agency before its absorption in to Public Health England, is the emphasis on prevention and public health, indicating that for its new national remit-holders, treatment is just one element in a broader set of concerns and responses, extending to social change to build health and social resources and reduce inequalities.

Is the system becoming more successful?

Relative austerity and the recovery agenda of government policy has focused attention away from retention towards treatment exit, in particular exits defined as 'successful' in terms of having left as planned and no longer in need of treatment. On this criterion, the year-by-year trends tell a tale of an improving treatment system, the success rate more than doubling in five years from 6% in 2005/06 to nearly 14% by 2010/11, then stabilising at 15%.

However, year-by-year statistics can only show whether if someone left treatment that year, they had to return during the *same* year. The featured report's long-view analysis adds a further rider to the indicator of success – that whenever the patient started treatment and whenever they successfully completed, they should not (presumably after relapse) be back in treatment at the end of the multi-year period covered by the analysis. Against this yardstick, since April 2005, a third of all patients were successfully treated, outpaced by the two-thirds who remained in need of treatment or beyond its protection without having successfully completed. Many of these (▸ below) will actually have been successes, having left and done well without completing, or having stabilised in treatment. Nearest to counting as 'failures' are the 19% of patients were still in treatment at the end of 2013/14 having left but then returned, presumably because their prior treatment had not worked or if it had, still they had relapsed. Even for these patients, re-engagement in treatment can be seen as a positive.

Though a step forward, the long-view analysis in the report mixes up two factors which might influence the success rate. If the treatment system is improving in the desired way, in each successive year a higher proportion of patients starting treatment for the first time should be able to complete it without having to return. But patients who started treatment in the earlier years also had longer to recover or relapse, confusing the assessment of whether it was this or year-on-year improvements which accounts for any rise in the success rate. For example, patients new to treatment in 2005/06 had nine years to recover or relapse, those entering in 2013/14, less than a year.

More informative is what proportion of new patients succeed over *the same* time period. Confirming the picture of an improving treatment system, this too has been rising, largely at the expense of presumed treatment failures who had to return after relapse ▸ chart left. If successful completion and not being in treatment five years later is a proxy for successful treatment, then the success rate increased from 20% for patients new to treatment in 2005/06, to 39% for those who started three years later. This development was at the expense of treatment retention/return, the figures for which dropped from 38% to 20% over the same period. Had this been mostly at the expense of *continuous* retention in treatment, it could not be considered entirely good news, but if anything, as the 'successes' got proportionately higher, it was the 'failures' who returned to treatment after relapse who got proportionately fewer. It remains possible that what looks like an improving treatment system was in fact one whose new patients became progressively easier to treat. Details below.

From an earlier report it can be calculated that five years later, 20% of patients new to treatment in 2005/06 were no longer in treatment having successfully completed. Another 42% had left without completing. The remaining 38% were still in or back in treatment. Two years later for patients new to treatment in 2007/08, the corresponding figures were 35% successfully completing, 42% leaving without completing, and 23% still in or back in treatment. From the data report for 2013/14, it can be calculated that the five-year successful completion rate for patients starting treatment in 2008/09 was 39%; another 41% had left without completing, and 20% were still or back in treatment.

The same data shows how few treatment starters are totally new to treatment, a figure which fell steadily from 64,587 in 2005/06 to 24,672 in 2012/13, only rising slightly to 25,059 the following year. It means that the great majority of patients seen in 2013/14 were not new to the system but continuing in or returning to treatment. In turn that helps explain why despite the changing drug profile of patients (re)entering treatment, the proportion of the entire treatment population whose problems primarily related to opiates (with or without crack) has remained at around 80% since 2005/06. These primarily heroin-addicted patients are the ones who stay in or relapse and have to return to treatment; 40% did so after entering treatment between 2005/06 and 2013/14 compared to 7% of patients not treated for opiate use.

Success not limited to treatment completers

The argument that increasing numbers of successful completions is evidence of increasingly successful treatment rests partly on an analysis of patients leaving treatment in 2005/06. Over the next four years, 57% who left having successfully completed avoided being officially recorded as problematic users of illegal drugs, neither being picked up by criminal justice system nets intended to identify problem drug users, nor returning to treatment on their own initiatives. This record of 57% seemingly staying recovered from their dependence contrasted with 43% among patients who left *without* having successfully completed treatment. The 14% difference is appreciable, but not as large as would be expected if successful completion correlated strongly with successful treatment leading to lasting recovery. Nevertheless it is enough to justify the assumption that successful completion is on average a better outcome than patients leaving treatment before the service considers them ready.

Whether successful completion is also a better outcome in terms of crime and health than staying *in* treatment – the usual situation within each year – is less certain. In terms of reduced convictions and presumably reduced crimes, a report from the National Treatment Agency for Substance Misuse recorded that for patients convicted in the two years before starting treatment, the greatest reductions were among those continuously in treatment for the next two years, though successful treatment leavers were not far behind (47% v. 41%). However, these figures combine big differences in the types of patients who stay and leave treatment early. When the focus was narrowed to opiate/crack users, among whom successful completers and retained patients had virtually identical pre-treatment conviction rates, the gap widened to 10% (46% v. 36%).

If successful completion *is* important, also important is understanding what it means. For the recording system, it means that as reported by the service from which the patient last exits, they are no longer seen as requiring structured drug treatment, and have left treatment (not just that service, but the system as a whole) no longer dependent on any drug, and not using opiates or crack cocaine (1 2). They may be using other illicit drugs in a non-dependent manner (though few are recorded as doing so) and may be drinking and smoking to any degree.

This system is critically dependent on the integrity and accuracy with which treatment services record the status of their departing patients. Within the reporting year 2007/08 the BBC exposed the tiny proportion of patients who within a single year left treatment drug-free, intensifying a national policy emphasis on successful completion. Since then commissioners and services have been under reputational pressure to produce more successful completions, and in recent years, under financial pressure too. If exits are indeed being promoted to meet national or local needs and ambitions rather than those of the patient, this would make the increased successful completion rate partly a marker of a worse rather than a better treatment system. The trends are also compatible with a scenario where in order to meet successful completion expectations, services cherry-pick patients most likely to be able to be able to stabilise and leave treatment, either not taking on the hardest cases or treating them in ways which keep them 'of the books' because they can be presented as not receiving treatment which is structured and care planned with clear goals and regular reviews. Arguably a patient merely being prescribed methadone with no prospect of further progress and seen infrequently could be seen as outside this definition. Increased resort to this expedient would account for falling treatment numbers, fewer new opiate and crack dependent patients, increasing numbers using easier-to-treat drugs, and falling overall numbers, as well as the rising successful completion rate. Whether this is happening is not known, but the fact that it *might* be demonstrates how vulnerable the figures are to manipulation.

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