Public Health England

The University of Manchester National Drug Evidence Centre

Department of Health

Young people's statistics from the National Drug Treatment Monitoring System (NDTMS)

1 April 2015 to 31 March 2016

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Executive summary

Specialist substance misuse services saw fewer young people in 2015-16 than in the previous year (17,077, a drop of 1,272 or 7% compared to 2014-15). This continues a downward trend, year-on-year, since a peak of 24,053 in 2008-09.

Just under two-thirds of the young people accessing specialist substance misuse services were male (65%), and just over half (52%) of all persons were aged 16 or over. Females in treatment had a lower median age (15) than males (16), with 26% of females under the age of 15 compared to 20% of males.

The most common drug that young people presented to treatment with continued to be cannabis. More than four-fifths (87%) of young people in specialist services said they have a problem with this drug compared to 86% in 2014-15. The numbers in treatment for cannabis as a primary substance have been on an upward trend since 2005-06, although numbers have dipped slightly in the last two years.

Alcohol is the next most commonly cited problematic substance with just under half the young people in treatment (48%) seeking help for its misuse during 2015-16. However, numbers in treatment for alcohol problems have been declining steadily in recent years and this figure is much lower than the two-thirds (67%) reported in 2009-10.

Alongside cannabis and alcohol, young people in specialist substance misuse services used a range of substances. Of those who were in contact with services, 1,605 cited problematic ecstasy use (9%), 1,477 cocaine use (9%), 1,152 amphetamine use (7%), and 1,056 (6%) with concerns around the use of new psychoactive substances (NPS).

Although the proportion of young people reported by specialist services as having problems with NPS rose for the second year (from 5% in 2014-15 to 6% in 2015-16), it is still relatively small. Specialist services will want to remain alert to the possibility that young people may develop problematic use of NPS in the future and ensure that services continue to be accessible and relevant to their needs.

The most common routes into specialist substance misuse services were from education provision (28%), youth justice services (26%), and children's social care (14%). The proportion of referrals from the youth justice system

has declined in recent years while the proportion of referrals from education has increased. This is the first year of reporting that referrals from education services have exceeded referrals from youth/criminal justice sources.

The majority of young people presenting to specialist substance misuse services have other problems or vulnerabilities related to their substance use (such as having mental health problems, being 'looked after'[1] or not being in education, employment or training[2]) or wider factors that can impact on their substance use (such as offending, self-harming, experiencing sexual exploitation or domestic abuse). Of the 17 vulnerability items collected via the National Drug Treatment Monitoring System (NDTMS), 83% of young people who have entered treatment in 2015-16 disclosed two or more vulnerabilities. Therefore, specialist services need to be able to work with a range of other agencies to ensure that all needs of a young person are met.

Following on from last year, data on sexual exploitation are included in this report. Six per cent (6%) of young people presenting to treatment services in 2015-16 reported experience of sexual exploitation compared to 5% in 2014-15. This proportion was higher among females (14%) than males (just over 1%).

Waiting times to gain access to specialist substance misuse services were short. The average (mean) wait for young people to start their first specialist intervention was two days. Almost all (98%) of the 17,763 first interventions starting in 2015-16 had waiting times of three weeks or under, with 79% of first interventions waiting for zero days.

Of the 11,224 young people leaving services in 2015-16, 80% (8,929) did so in a planned way, no longer requiring specialist interventions. This is the same treatment completion rate as last year and suggests that specialist substance misuse services in England are responding well to the needs of young people who have alcohol and drug problems, and are helping young people to overcome their substance misuse problems.

[1] as defined under section 20 of the Children Act 1989
[2] commonly referred to as 'NEET'

1. Background and policy context

1.1 These statistics and their use

The statistics in this report present information collected through the National Drug Treatment Monitoring System (NDTMS) about young people (those aged under 18) who receive specialist substance misuse interventions in England. The information relates to all substances young people (YP) in specialist services sought help for, including alcohol.

The statistics are used to:

- inform the commissioning of specialist services for young people with drug and/or alcohol problems
- monitor national availability and effectiveness of specialist substance misuse services for young people
- monitor trends and shifts in patterns of drug and alcohol use among young people attending specialist services to inform future local and national public health policy
- provide evidence about the benefits of attending specialist substance misuse services to young people and their families

The statistics in this report should therefore be considered as part of a wider picture around the health needs of young people and prevention services for vulnerable young people.

More detail on the methodologies used to compile these statistics and the processes in place to ensure data quality can be found at: http://www.ndtms.net/resources/secure/Quality-and-Methodology-NDTMS-2015-16.pdf

If an error is identified in any of the information that has been included in this report, then the processes described in the Public Health England (PHE) revisions and correction policy will be adhered to. The policy can be found here at: www.gov.uk/government/organisations/public-health-england/about/statistics

PHE's National Child and Maternal Health Intelligence Network (ChiMat) is also available to local authorities and provides a wide-range of authoritative data, evidence and practice related to children's, young people's and maternal health. It can be found at www.chimat.org.uk/

1.2 Specialist substance misuse services for young people

Specialist substance misuse services for young people are distinct from adult treatment services because young people's alcohol and drug problems tend to be different to those of adults and so they need a different response. This includes being child centred, considering the age and maturity of young people, supporting the young people to ensure they are not mixing with more problematic adult drug users and acting on safeguarding concerns.

The role of specialist substance misuse services is to support young people to address their alcohol and drug use, to reduce the harm it causes them and prevent it from becoming a greater problem as they get older. Services should operate as part of a wider network of universal and targeted prevention services, which aim to support young people with a range of issues and help them to build their resilience.[3]

1.3 Prevalence of alcohol and drug use among young people

NDTMS statistics do not provide an indication of the levels of need for young people's specialist substance misuse services. The main prevalence data for trends in substance use among young people is the biennial schools survey 'Smoking, drinking and drug use among young people in England'[4] for 11-15 year olds. The latest report for 2014 shows that trends in alcohol and drug use have been declining since 2003. This is good news but the report also highlights that some patterns remain concerning, with the increased risk of drug use among pupils who truant or who have been excluded from school and whose circumstances or behaviour already make them a focus of concern. The report for 2014 can be found at: www.hscic.gov.uk/catalogue/PUB17879

Although the schools survey shows a drop in the proportion of children drinking alcohol and taking drugs over the last decade, concerns remain about some young people's substance use. International comparisons show

[3] Universal services can include school-based approaches to drug and alcohol education and prevention, delivered through PSHE. Targeted services can include specific interventions delivered to young people at significant risk of developing drug or alcohol problems, such as those involved in youth justice services, or non-mainstream education.

[4] Smoking, Drinking and Drug Use among Young People in England – 2014. Health & Social Care Information Centre 2015 http://content.digital.nhs.uk/catalogue/PUB17879/smok-drin-drug-youn-peop-eng-2014-rep.pdf

that British children are more likely to get drunk than children in most other European countries.[5]

The Health Behaviour in School-aged Children (HBSC) report provides useful insights into the broader health-related behaviour of young people since 1997. Although risk behaviours have gone down dramatically over the last decade among both girls and boys, there still appears to be a small group of young people who remain vulnerable to multiple risk taking behaviours and who may be putting themselves at risk through engaging in them. Among girls, those with the lowest life satisfaction were found to be more likely to have both consumed alcohol in the last month and ever been drunk (consumed alcohol to excess), and ten times as likely to report having smoked tobacco in the last month than those with the highest life satisfaction. They were also more likely to report having ever used cannabis, having had sex, and being involved in physical fighting. The latest report can be found at: www.hbsc.org

Prevalence statistics for young adults aged 16-24 are included in the 'Drug Misuse: Findings from the 2015-16 Crime Survey for England and Wales' report. The report found that younger people are more likely to take drugs than older people. The level of any drug use in the last year was highest among 16 to 19 year olds (17.8%) and 20 to 24 year olds (18.2%). Although the latest 2015-16 report shows that there is a long term trend of decreasing drug use reported among this age group, there are indications of a slight increase in use in recent years. This can be found at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/564760/drug-misuse-1516.pdf

1.4 Other risk factors affecting young people

Acute harm from drug and alcohol use can happen to anybody, but problematic drink and drug use among under-18s rarely occurs in isolation and is frequently a symptom of wider problems.

Evidence suggests that there are a number of risk factors (or vulnerabilities) associated with young people misusing substances, being harmed by those substances and going on to develop drug or alcohol problems as adults. These risk factors include experiencing domestic abuse and sexual exploitation, truanting from school, offending, early sexual activity, antisocial

[5] Health Behaviour in School-aged Children (HBSC): World Health Organization Collaborative Cross National Study (Brooks, F. et al., 2015)

behaviour, mental health problems and being exposed to parental substance misuse.

Findings from the HBSC report also suggest that while drinking alcohol during adolescence is to some extent a normative aspect of young people's development, excessive drinking and drunkenness (and particularly early initiation to drinking) is associated with increased risk of injury, unplanned and unprotected sex, and alcohol disorders and dependency. It also reports that cannabis use during adolescence has been associated with decreased performance on learning and memory tasks, lower academic attainment, other illicit drug dependency, and suicide attempts.

1.5 Assessment of quality and robustness of 2015-16 NDTMS community data

NDTMS data is routinely collected by Public Health England (PHE). Drug and alcohol treatment providers submit a monthly extract and this is checked for data quality by local NDTMS teams. Data submissions are aggregated and reconciled against previous submissions to create a single national data submission. PHE operates a continual programme of improvement and treatment providers work with their local NDTMS team to improve each monthly submission throughout the year.

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

Table 1.5.1 provides an overview of the quality of data submitted to NDTMS by young people treatment services since 2014-15. The proportion of valid records received out of all submitted records along with the proportion of records received without errors or warnings are included as they indicate the general level of data quality across the broad spectrum of information collected at each monthly data submission. Three additional indicators are also included below that report on the proportion of duplicate or overlapping treatment interventions and episodes. These are reported as they provide a sense of how accurate and efficient record keeping is at treatment provider level. A low proportion is desirable as it demonstrates robust administrative functions at a national level.

Table 1.5.1 Data quality of NDTMS

Data quality measure	2014-15	2015-16
Proportion of submitted records that were valid	100.00%	100.00%
Proportion of records without errors or warnings	99.93%	99.95%
Proportion of duplicate treatment episodes recorded at the same provider	0.17%	0.00%
Proportion of overlapping treatment episodes recorded at the same provider	0.08%	0.04%
Proportion of duplicate treatment interventions recorded at the same provider	0.11%	0.00%

More detailed information on NDTMS data collection and full definitions for the data quality measures recorded in Table 1.5.1 can be found at http://www.ndtms.net/resources/secure/Quality-and-Methodology-NDTMS-2015-16.pdf.

In addition to the data quality checks taken at data submission, there are data quality checks and validation rules used in the production of this report. The rate of completion for report items range from 100% to 97%. Where under 100% this implies either due to missing data for that item or conflicting information has been entered for the same individual.

2. Characteristics of clients

During 2015-16, 17,077 young people aged 9-17[6] reported to the NDTMS as in contact with treatment services. This is a 7% decrease (1,272 individuals) from last year. Comparisons with previous years are included in section 5.

2.1 Age and gender of all young people

The age and gender of young people at their first point of contact with the treatment system in 2015-16 is reported in table 2.1.1 and figure 2.1.1. The majority of young people in treatment were male (65%), which is a higher percentage than in the general population of 9-17 year olds where males of the same age account for 51.2% (ONS, 2015).[7] Just over half (52%) of young people in treatment were aged 16 or over. Overall, females accessing services were younger (median age of 15), compared to males (median age of 16).

Although the number of younger children (under 14) in treatment is relatively low, and decreasing (see section 5.1), any substance misuse among this age group is concerning, as they are likely to be at risk of harm. In these cases, safeguarding needs to be a priority, with wider aspects of the child's life addressed, in addition to their substance misuse.

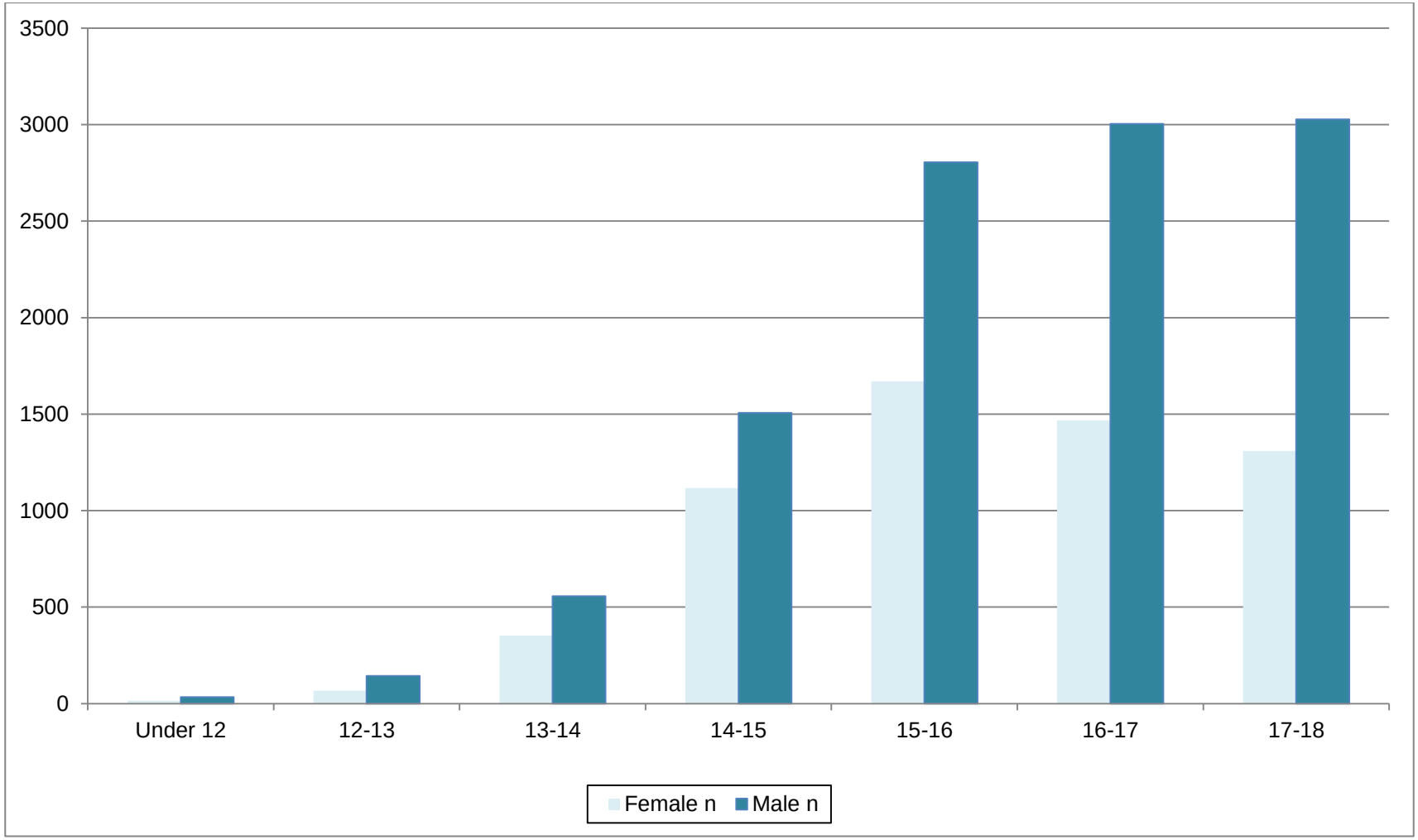
Table 2.1.1 Age and gender of all young people in treatment 2015-16

Age	Female		Male		Persons	
	n	%	n	%	n	%
Under 12	14	0%	34	0%	48	0%
12-13	67	1%	144	1%	211	1%
13-14	352	6%	557	5%	909	5%
14-15	1,117	19%	1,507	14%	2,624	15%
15-16	1,670	28%	2,806	25%	4,476	26%
16-17	1,467	24%	3,005	27%	4,472	26%
17-18	1,309	22%	3,028	27%	4,337	25%
Total clients	**5,996**	**100%**	**11,081**	**100%**	**17,077**	**100%**

[6] For age methodology please refer to the Quality and Methodology information document here: http://www.ndtms.net/resources/secure/Quality-and-Methodology-NDTMS-2015-16.pdf

[7] Annual mid-year population estimates, 2015 http://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/bulletins/annualmidyearpopulationestimates/mid2015

Figure 2.1.1 Age and gender distribution of all young people in contact with treatment services 2015-16



2.2 Ethnicity of all young people in treatment

Table 2.2.1 shows the ethnicity of young people in treatment services. Where reported, most clients (78%) were white British. This is comparable to the general population where the latest census (2011) shows that 78% of young people aged 10-17 were white British.[8] Among the remaining clients, 3% were other white and 3% were white and black Caribbean with no more than 2% reporting any other ethnicity.

Table 2.2.1 Ethnicity of all young people in treatment 2015-16

Ethnicity	n	%
White British	13,196	78%
Other White	552	3%
White & Black Caribbean	518	3%
Caribbean	386	2%
Other Mixed	339	2%
African	274	2%
Other Black	247	1%
Other	246	1%
Bangladeshi	216	1%
Pakistani	197	1%
Other Asian	165	1%
White & Asian	159	1%
Not Stated	140	1%
White & Black African	122	1%
Indian	106	1%
White Irish	103	1%
Chinese	13	0%
Total	**16,979**	**100%**
Missing or inconsistent data	98	
Total	**17,077**	

[8] Ethnic group by age in England https://www.nomisweb.co.uk/census/2011/LC2109EWLS/view/2092957699?rows=c_age&cols=c_ethpuk11

2.3 Substance use

Table 2.3.1 shows the primary substance use (the substance that brought the young person into treatment at the point of triage/initial assessment) and adjunctive substance use (other substances cited by the young person) of young people in treatment in 2015-16. If a young person was seen at multiple service providers or multiple times within the year, the substance(s) recorded at their latest treatment episode in the year are reported here (for further details, see http://www.ndtms.net/resources/secure/Quality-and-Methodology-NDTMS-2015-16.pdf).

Eighty-seven per cent (87%) of young people reported either primary or adjunctive cannabis use (compared to 86% last year). Alcohol was the second most cited substance (48%). However, numbers in treatment for alcohol misuse have been declining steadily in recent years, and this figure is much lower compared to the 67% reported in 2009-10. A number of young people citied other substances: 9% ecstasy use, 9% cocaine use and 7% amphetamine use. About 6% of young people (5% in 2014-15) cited the use of a new psychoactive substance (NPS) as either a primary or adjunctive substance.

The median age of young people in specialist services was 16 years. The small numbers in treatment for primary heroin and crack use had a higher median age of 17. Primary solvent users have the lowest median age of 15. A more detailed breakdown of substances by age is shown in table 2.3.2. Trends in presenting substances can be found in section 5.

Table 2.3.1 Substance use of all young people in treatment 2015-16

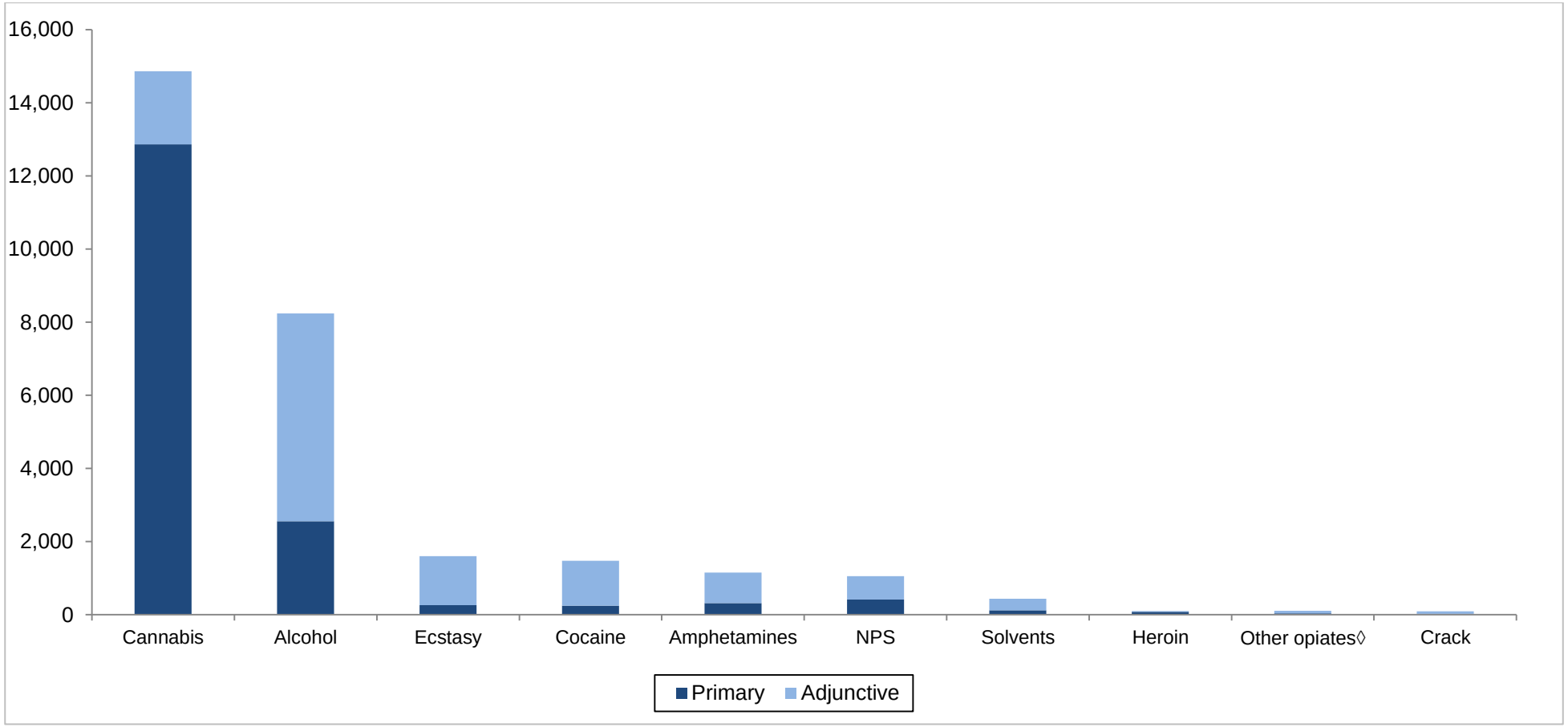
Substance	Primary		Adjunctive^		Total		Primary
	n	%	n	%	n	%	median age
Cannabis	12,863	75%	2,005	12%	14,868	87%	16
Alcohol	2,556	15%	5,682	33%	8,238	48%	16
Ecstasy	261	2%	1,344	8%	1,605	9%	16
Cocaine	251	1%	1,226	7%	1,477	9%	16
Amphetamines	317	2%	835	5%	1,152	7%	16
New psychoactive substances	420	2%	636	4%	1,056	6%	16
Solvents	121	1%	320	2%	441	3%	15
Heroin	77	0%	24	0%	101	1%	17
Other opiates◊	35	0%	70	0%	105	1%	16
Nicotine (adjunctive use only)	-	-	2,443	14%	-	-	-
Crack	21	0%	74	0%	95	1%	17
Other‡	148	1%	572	3%	-	-	16
Total	**17,070**	**100%**					**16**
Missing, misuse free or inconsistent data	7						
Total including missing	**17,077**						

^ Adjunctive percentages are out of all young people in treatment (17,077)

◊ 'Other opiates' include methadone.

‡ 'Other' incorporates a number of different substance categories which are not shown elsewhere in the table. A single young person may be counted under both primary and adjunctive 'other' if the substances are from different categories. Therefore, primary and adjunctive users cannot be summed to give a total number of users.

Figure 2.3.1 Substance use of all young people in treatment (any citation – primary and adjunctive) 2015-16^



^ Figure 2.3.1 excludes young people citing other substances as primary and adjunctive use cannot be summed. Please see note ‡ under table 2.3.1

Table 2.3.2 Substance use (primary and adjunctive combined) by age of all young people in treatment 2015-16^

Substance	Under 13∆		13-14		14-15		15-16		16-17		17-18	
	n	%	n	%	n	%	n	%	n	%	n	%
Cannabis	185	71%	762	84%	2,297	88%	3,992	89%	3,944	88%	3,688	85%
Alcohol	109	42%	426	47%	1,339	51%	2,113	47%	2,198	49%	2,053	47%
Ecstasy	5	2%	32	4%	166	6%	441	10%	494	11%	467	11%
Cocaine	5	2%	18	2%	104	4%	302	7%	440	10%	608	14%
Amphetamines	7	3%	29	3%	114	4%	303	7%	334	7%	365	8%
New psychoactive substances	10	4%	42	5%	143	5%	298	7%	285	6%	278	6%
Solvents	27	10%	42	5%	84	3%	109	2%	118	3%	61	1%
Opiates ‡	0	0%	*	-	15*	1%*	40*	1%*	55*	1%*	100*	2%*
Crack	*	-	*	-	5	0%	12	0%	18	0%	57	1%
Total▼	**259**	**100%**	**909**	**100%**	**2,624**	**100%**	**4,476**	**100%**	**4,472**	**100%**	**4,337**	**100%**

^ Primary and adjunctive use are combined in this table, therefore a young person may be counted for more than once in this table. See table 2.3.1 for a breakdown of primary and adjunctive use.

▼ Total number of individuals in the corresponding age group, not the sum of all instances in the column

∆ Due to very low numbers for some substances, the 'under 12' and '12-13' age groups are combined in this table.

‡ Due to low numbers when breaking down by age, figures for heroin, methadone and other opiates are collapsed into a single opiates category in this table. A single young person may therefore be counted as both a primary and adjunctive opiate user, and therefore the sum of primary and adjunctive opiate users may be greater than the total number of opiate users.

* All numbers under five have been suppressed. Where totals could be derived, figures have been rounded to the nearest five and marked with an asterisk.

2.4 Source of referral into treatment (for treatment episodes)

Table 2.4.1 shows a breakdown of episodes of treatment in the financial year by source of referral. Information about source of referral was provided for 18,603 (99.8%) episodes of treatment in 2015-16. An individual may have more than one treatment episode in the year and all episodes are counted. Therefore, the total number reported in this section differs from the total number of young people in treatment in 2015-16.

The most common route into specialist treatment services was via education services (28%). The youth justice system was the second most common referral source (26%), with youth offending teams being the single largest source (23%), although this has been declining in recent years. This is the first year of reporting that referrals from education services have exceeded referrals from youth/criminal justice sources.

Referrals from children and family services accounted for 10%, and self-referrals made up 7% of all recorded referrals. Accident and emergency (A&E) referrals account for 1%, while referrals from child and adolescent mental health services (CAMHS) account for 4%. These may be lower than expected, based on the available hospital admissions data and evidence about the links between young people's mental health and substance misuse and the use of these services by young people.[9,10,11]

[9] Future in mind, Promoting, protecting and improving our children and young people's mental health and wellbeing, DH, NHS England 2015'

[10] www.chimat.org.uk

[11] PHE/Royal College of Emergency Medicine Young people's hospital alcohol pathways: Support pack for A&E departments 2014 www.nta.nhs.uk/uploads/young-peoples-hospital-alcohol-pathways-support-pack-for-ae-departments.pdf

Table 2.4.1 Source of referral of all treatment episodes 2015-16

Referral Source	n	%
Mainstream education	3,878	21%
Alternative education	698	4%
Education service	617	3%
Other	25	0%
Education total	**5,218**	**28%**
YOT	4,265	23%
YP secure estate	145	1%
Other	454	2%
Youth / criminal justice total	**4,864**	**26%**
Children and family services	1,893	10%
Looked after child services	418	2%
Social services	255	1%
Social care total	**2,566**	**14%**
Self	1,216	7%
Relative, family, friend or concerned other	945	5%
Self, family & friends total	**2,161**	**12%**
Substance misuse total	**1,546**	**8%**
GP	192	1%
A&E	229	1%
School nurse	246	1%
CAMHS	689	4%
Hospital	138	1%
Other	87	0%
Health total	**1,581**	**8%**
YP housing	344	2%
Other	323	2%
Total (episodes)	**18,603**	**100%**
Missing or inconsistent data	33	
Total (episodes)	**18,636**	

2.5 Education and employment status

Table 2.5.1 shows the education and employment status at presentation to treatment. This was reported for 11,771 (97%) young people who entered treatment in 2015-16.

Of these, over half (54%) were recorded as being in mainstream education (such as schools and further education colleges), followed by a further 20% in alternative education (such as schooling delivered in a pupil referral unit or home setting). A further 17% were recorded as not in employment, education or training (NEET).

Table 2.5.1 Education and employment status of all young people starting treatment in 2015-16

Education and employment status	n	%
Mainstream education	6,394	54%
Alternative education	2,314	20%
Not in employment or education or training (NEET)	1,966	17%
Apprenticeship or training	538	5%
Employed	321	3%
Persistent absentee or excluded	208	2%
Economically inactive – health issue or caring role	24	0%
Voluntary work	6	0%
Total	**11,771**	**100%**
Missing or inconsistent data	420	
Total new presentations	**12,191**	

2.6 Accommodation status

The housing situation of 16,741 (98%) young people in treatment in 2015-16, recorded at treatment entry, is shown in table 2.6.1.

Of these, 13,969 (83%) were recorded as living with their parents or other relatives, while a further 3% reported living independently in settled accommodation. Seven per cent (7%) of young people stated that they were living in care, with less than 1% living in secure care.

Table 2.6.1 Accommodation status of all young people in treatment 2015-16

Accommodation status	n	%
Living with parents or other relatives	13,969	83%
YP living in care	1,228	7%
YP supported housing	789	5%
Independent – settled accommodation	453	3%
Independent – unsettled/housing problem	183	1%
YP living in secure care	57	0%
Independent – no fixed abode	62	0%
Total	**16,741**	**100%**
Missing or inconsistent data	336	
Total	**17,077**	

2.7 Vulnerabilities

Young people can enter specialist substance misuse services with a range of problems or vulnerabilities relating to their substance use (such as having mental health problems, being 'looked after' or having a NEET status) or wider factors that can impact on their substance use (such as self-harming, sexual exploitation, offending or domestic abuse).

Seventeen vulnerability factors are identified within the NDTMS dataset, the details of which are shown in table 2.7.1. These are the range of risk factors that are most likely to be associated with problematic substance misuse among young people.

Table 2.7.1 Description of vulnerability factors identified via NDTMS

Vulnerability factor	Criteria
Early onset	Began using primary substance under the age of 15
Poly substance user	Reported using two or more substances in combination (poly substance use)
Antisocial behaviour	Young person has been involved in antisocial behaviour or committed a criminal act on more than one occasion in the past six months (this is the offending behaviour disclosed by the individual, not convictions)
Affected by others' substance misuse	Is affected by others' substance misuse in their close family and/or members of the household
Affected by domestic abuse	Has been affected by domestic abuse
Mental health problem	Reported a mental health problem
Self-harm	Reported self-harming behaviour
NEET	Is not in education, employment or training
Looked after child	Has a 'looked after child' status (see section 7.2)
Child protection plan	the young person is subject to a child protection plan
Child in need	Is a child in need
Sexual exploitation	Reported sexual exploitation
High-risk alcohol user	Drinks almost daily, or in excess of eight units (males) or six units (females) on an average drinking day when drinking 13 or more days of the month
Housing problem	Reports unsettled accommodation status or has no fixed abode
Pregnant and/or parent	Is pregnant or a parent
Opiate and/or crack use	Reported using opiates and/or crack among their presenting substances
Injecting	Has ever injected (currently or previously)

Table 2.7.2 shows the number of young people reporting each of the vulnerabilities listed above. Vulnerabilities are reported only for new clients entering specialist services during the year and therefore the total number reported (12,191) is lower than the total number of young people in treatment in 2015-16. An individual young person may report multiple vulnerabilities and therefore the percentages in this table may sum to more than 100%.

The most commonly reported vulnerability was early onset of substance misuse, with 92% reporting use of their primary substance under the age of 15, followed by 60% reporting poly drug use. Thirty two per cent (32%) reported antisocial behaviour, while 23% reported that they were affected by others' substance misuse and 21% reported being affected by domestic abuse. The least commonly reported vulnerability was injecting (1%). Females in treatment tend to present to services with a different range of vulnerabilities to boys. Females are more likely to present with self-harm issues, high-risk alcohol use, sexual exploitation (see section 2.8) or domestic abuse, and less likely to present with antisocial behaviour or be NEET.

Table 2.7.2 Individual vulnerabilities identified among all young people starting treatment in 2015-16

Vulnerability	Female		Male		Persons	
	n	%	n	%	n	%
Early onset of substance misuse	3,917	93%	7,325	92%	11,242	92%
Poly drug user	2,752	65%	4,581	57%	7,333	60%
Antisocial behaviour	815	19%	3,074	39%	3,889	32%
Affected by others' substance misuse	1,188	28%	1,559	20%	2,747	23%
Affected by domestic abuse	1,162	28%	1,439	18%	2,601	21%
Mental health problem	1,043	25%	1,233	15%	2,276	19%
Self-harm	1,407	33%	704	9%	2,111	17%
NEET	546	13%	1,474	18%	2,020	17%
Looked after child	587	14%	843	11%	1,430	12%
Child Protection Plan	463	11%	429	5%	892	7%
Child in need	406	10%	384	5%	790	6%
Sexual exploitation	598	14%	106	1%	704	6%
High risk alcohol user	319	8%	202	3%	521	4%
Pregnant and/or parent	102	2%	125	2%	227	2%
Opiate and/or crack use	93	2%	113	1%	206	2%
Housing problem	70	2%	115	1%	185	2%
Injecting	56	1%	57	1%	113	1%
Total new presentations	**4,215**	**100%**	**7,976**	**100%**	**12,191**	**100%**

A number of young people reported multiple vulnerabilities at treatment start. Individuals with substance misuse problems are more likely to experience a wide range of interrelated social exclusion problems such as poor health, crime, unemployment and community deprivation.[12]

Table 2.7.3 shows the number of vulnerabilities reported by young people starting treatment in 2015-16, with the majority (83%) reporting multiple vulnerabilities. Thirty eight per cent (38%) reported four or more vulnerabilities, with 46% reporting either two or three, 15% reported one, and just 2% reported none.

Table 2.7.3 Multiple vulnerabilities reported by young people starting treatment in 2015-16

Number of vulnerabilities reported (of total of seventeen)	n	%
Zero	186	2%
One	1,870	15%
Two	2,977	24%
Three	2,570	21%
Four or more	4,588	38%
Total new presentations	**12,191**	**100%**

2.8 Sexual exploitation

Child sexual exploitation (CSE) is a form of child sexual abuse. Sexual exploitation of children and young people under 18 involves exploitative situations, contexts and relationships where young people (or a third person or persons) receive 'something' (e.g. food, accommodation, drugs, alcohol, cigarettes, affection, gifts, money) as a result of performing, and/or another or others performing on them, sexual activities.[13] CSE has important health and wellbeing implications for children and young people and a number of reports[14] have highlighted that substance misuse could be an indicator of child sexual exploitation and abuse. Young people's substance misuse services need to ensure that they are responding appropriately.

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[12] Neale, J. (2006) Social Exclusion, Drugs and Policy. In R. Hughes, R. Lart & P. Higate (Eds.), Drugs, Policy and Politics (pp. 1-17). England: Open University Press.

[13] DCSF. (2009). Safeguarding Children and Young People from Sexual Exploitation Supplementary Guidance to Working Together to Safeguard Children. London: HM Government. A revised definition is being developed by the Home Office and Department for Education at the time of writing.

[14] Office of the Children's Commissioner, Inquiry into Child Sexual Exploitation In Gangs and Group, Health Working Group Report on Child Sexual Exploitation, DH Child Sexual Exploitation Advice for Health and Social Care Professionals NHS England www.nhs.uk/aboutNHSChoices/professionals/healthandcareprofessionals/child-sexual-exploitation/Pages/cse-guide-for-professionals.aspx

Table 2.8.1 shows the breakdown by age and gender of young people who presented to treatment services and reported sexual exploitation, compared to all young people newly presenting to services in 2015-16. Overall, 6% of young people reported sexual exploitation. However, the proportion is much higher among females (14%) than males (just over 1%). Although these figures suggest a large difference between sexual exploitation experienced by boys and girls, research from Barnardo's[15] has highlighted difficulties in identifying sexual exploitation of boys and young men because they often do not disclose abuse. The median age of young people reporting sexual exploitation was 15, compared to 16 for all new presentations, reflecting the high proportion who was female.

Table 2.8.1 Age and gender breakdown of young people starting treatment in 2015-16 and reported sexual exploitation

Age	Sexual exploitation				Total new presentations			
	Female		Male		Female		Male	
	n	%	n	%	n	%	n	%
Under 14[Δ]	63	11%	8	8%	348	8%	578	7%
14-15	123	21%	19	18%	834	20%	1,172	15%
15-16	162	27%	25	24%	1,175	28%	2,050	26%
16-17	129	22%	24	23%	939	22%	2,015	25%
17-18	121	20%	30	28%	919	22%	2,161	27%
Total new presentations	**598**	**100%**	**106**	**100%**	**4,215**	**100%**	**7,976**	**100%**

[Δ] Due to low numbers when breaking down by age and gender, age groups under 14 are combined in this table.

[15] Research on the sexual exploitation of boys and young men A UK scoping study Summary of findings August 2014 Barnardo's 2014 www.natcen.ac.uk/media/530798/16134-su-cse-young-boys-summary-report-v3.pdf

3. Access to services

3.1 Waiting times for first and subsequent treatment interventions

The table below shows a breakdown of waiting times under and over three weeks by first and subsequent interventions (i.e. where a client who is already receiving an intervention is referred to start another type of treatment). Of the 17,763 first interventions beginning in 2015-16, 17,424 (98%) had waiting times of three weeks or under, with 79% of first interventions waiting zero days. There were 1,143 subsequent interventions, of which 1,116 (98%) waited within three weeks of referral. Overall the average (mean) wait to commence treatment (first interventions only) was two days.

Table 3.1.1 Waiting times: first and subsequent interventions 2015-16

Intervention	3 weeks or under		Over 3 weeks		Total	
	n	%	n	%	n	%
First Intervention	17,424	98%	339	2%	17,763	100%
Second Intervention	1,116	98%	27	2%	1,143	100%
Total Interventions	**18,540**	**98%**	**366**	**2%**	**18,906**	**100%**

3.2 Treatment interventions

As part of a young person's treatment package, an individual may receive more than one intervention (i.e. more than one type of treatment) while being treated at a service and may attend more than one service for subsequent interventions. For example, the young person might receive a one-to-one intervention such as motivational interviewing in addition to a family intervention.

From 1 November 2013, the way interventions were recorded on NDTMS was changed to include three high-level structured intervention types (psychosocial, harm reduction and pharmacological) and an intervention setting.

Tables 3.2.1 and 3.2.2 show the breakdown of intervention types received by young people in contact with structured treatment. The vast majority (15,502 young people, 92%) received psychosocial intervention(s). Psychosocial interventions (sometimes known as 'talking therapies') use psychological, psychotherapeutic and counselling skills to encourage change. Many young people received harm reduction interventions (9,965, 59%), with 8,573 (50%) receiving both psychosocial and harm reduction interventions. Structured harm reduction includes support to manage risky behaviour associated with substance misuse, overdose and accidental injury through substance misuse. Ninety-nine (99) young people received a pharmacological intervention (0.6%).

Pharmacological interventions for young people cover a wide range of medication prescribed by a clinician, and may involve detoxification, stabilisation, symptomatic relief from substance misuse and relapse prevention, as well as substitute prescribing for opiate and alcohol misuse

Table 3.2.1 shows the number of clients who received a pre-November 2013 dataset change intervention that cannot be mapped directly to the current method of recording (see section 6.2 for more detail on this change). Individuals are counted once for each intervention type they received.

Table 3.2.1 Interventions received by young people in treatment in 2015-16 (pre-November 2013 dataset change interventions)

Intervention	n
Inpatient detoxification	*
Other YP intervention	46

* All numbers under five have been suppressed. Where totals could be derived, figures have been rounded to the nearest five and marked with an asterisk.

Table 3.2.2 provides information on interventions commenced after the changes to the core dataset on 1 November 2013. It shows the number of young people who received interventions based on the post November 2013 intervention codes and intervention settings. If an individual's intervention features in table 3.2.2, and can be directly mapped between tables, it is not featured in table 3.2.1 above to avoid double counting.

Table 3.2.2 Interventions received by young people in treatment 2015-16 (post November 2013 dataset change interventions)

Setting	Intervention type			Total individuals with this setting[Δ]	Percentage of total individuals with this setting
	Psychosocial (n)	Harm reduction (n)	Pharmacological (n)		
Community	15,061	9,637	85	**16,347**	**97%**
YP Inpatient unit	*	*	*	*****	*****
YP Residential unit	20	16	0	**27**	**0%**
Home	502	342	8	**596**	**4%**
Adult setting	10	*	6	**13**	**0%**
No setting recorded	*	*	0	*****	*****
Total individuals[‡]	**15,502**	**9,965**	**99**	**16,838**	**100%**
% of total individuals with this intervention	**92%**	**59%**	**1%**		

[‡] This is the total number of individuals receiving each intervention type and not a summation of the columns.

[Δ] This is the total number of individuals receiving at least one intervention type in each setting and not a summation of the rows.

* All numbers under five have been suppressed. Where totals could be derived, figures have been rounded to the nearest five and marked with an asterisk

3.3 Length of latest treatment episode

The majority of young people's most recent episodes were 26 weeks or less in duration (74%). The average (mean) time of an individual's most recent episode of treatment during 2015-16 was just over five months (153 days).

Table 3.3.1 Length of latest episode 2015-16

Episode Length	n	%
0 (zero) to 12 weeks	7,034	42%
13 to 26 weeks	5,353	32%
27 to 52 weeks	3,204	19%
Longer than 52 weeks	1,257	7%
Total	**16,848**	**100%**

4. Treatment exits

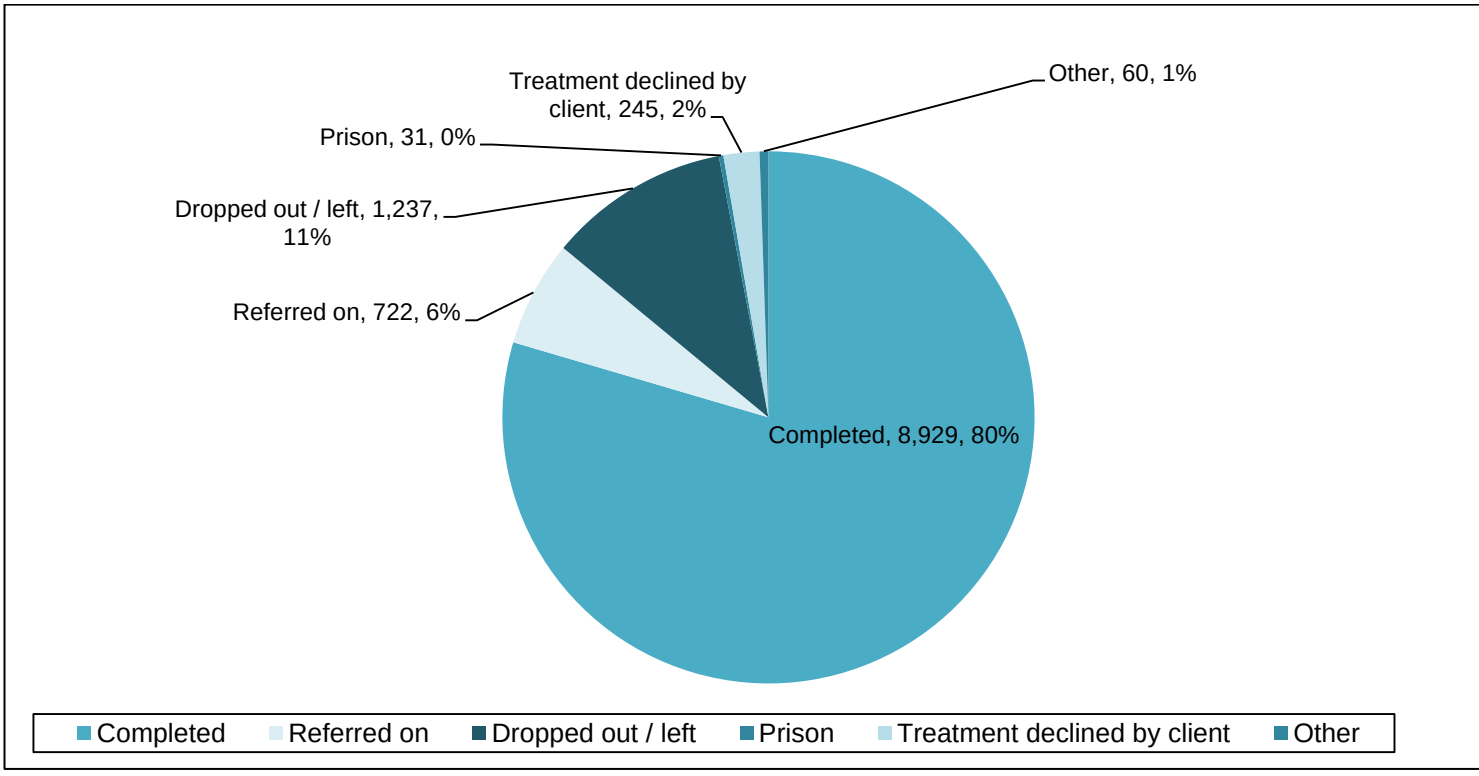
4.1 Treatment exits

Table 4.1.1 and figure 4.1.1 report on the treatment exit reasons for young people exiting in 2015-16. This year, 11,224 individuals left treatment, representing 66% of the 17,077 young people in treatment in the year. The remaining 5,853 young people (34%) were retained in treatment on 31 March 2016. Among those who exited treatment, 8,929 (80%) did so in a planned way (having completed specialist treatment).

Table 4.1.1 Treatment exit reasons of all young people exiting treatment 2015-16

Treatment exit reason	n	%
Completed	8,929	80%
Referred on	722	6%
Dropped out / left	1,237	11%
Prison	31	0%
Treatment declined by client	245	2%
Other	60	1%
Total	**11,224**	**100%**

Figure 4.1.1 Treatment exit reasons of all young people exiting treatment 2015-16



5. Trends over time

5.1 Trends in age and numbers in treatment

The number of young people attending specialist substance misuse services during 2015-16 was 17,077, a decrease of 1,272 (7%) from 18,349 in 2014-15, and a reduction of 6,976 (29%) since the peak of 24,053 in 2008-09. Falling alcohol and drug use among young people in general may in part explain this decline, although it is also possible that any reduction in the provision of youth support services may affect the number of referrals. Although the numbers of the younger age groups are consistently falling year on year, the proportion of young people in these groups has remained fairly stable. Any substance misuse among this age group is concerning and they are likely to be at risk of harm. In these cases, safeguarding needs to be a priority, with every aspect of the child's life addressed, not just the substance misuse.

Table 5.1.1 Number of young people in treatment by age (2005-06 to 2015-16)

Age	2005-06		2006-07		2007-08		2008-09	
	n	%	n	%	n	%	n	%
Under 12	212	1%	233	1%	227	1%	193	1%
12-13	358	2%	457	2%	467	2%	442	2%
13-14	1,040	6%	1,253	6%	1,476	6%	1500*	6%
14-15	2,380	14%	2,961	14%	3,466	14%	3550*	15%
15-16	3,884	23%	4,953	23%	5,658	24%	5,574	23%
16-17	4,347	26%	5,315	25%	5,987	25%	6,133	25%
17-18	4,780	28%	6,019	28%	6,624	28%	6,663	28%
Total	**17,001**	**100%**	**21,191**	**100%**	**23,905**	**100%**	**24,053**	**100%**

Age	2009-10		2010-11		2011-12		2012-13	
	n	%	n	%	n	%	n	%
Under 12	155*	1%	128	1%	110	1%	56	0%
12-13	380*	2%	315	1%	323	2%	310	2%
13-14	1,396	6%	1,234	6%	1,129	5%	1,130	6%
14-15	3,300*	14%	3,092	14%	3,009	15%	2,936	15%
15-16	5,770	25%	5,445	25%	5,097	25%	5,097	25%
16-17	5,823	25%	5,657	26%	5,297	26%	5,040	25%
17-18	6,701	28%	6,084	28%	5,723	28%	5,463	27%
Total	**23,528**	**100%**	**21,955**	**100%**	**20,688**	**100%**	**20,032**	**100%**

Age	2013-14		2014-15		2015-16	
	n	%	n	%	n	%
Under 12	46	0%	43	0%	48	0%
12-13	227	1%	225	1%	211	1%
13-14	1,008	5%	951	5%	909	5%
14-15	2,785	15%	2,643	14%	2,624	15%
15-16	4,922	26%	4,862	26%	4,476	26%
16-17	5,092	27%	4,866	27%	4,472	26%
17-18	5,046	26%	4,759	26%	4,337	25%
Total	**19,126**	**100%**	**18,349**	**100%**	**17,077**	**100%**

* All numbers under five have been suppressed. Where totals could be derived, figures have been rounded to the nearest five and marked with an asterisk.

5.2 Trends in primary substance

Figure 5.2.1 shows the number of young people in treatment in each given year and the primary problematic substance recorded when they presented to treatment.

Since 2005-06, young people have been increasingly likely to seek help for problems with cannabis compared to other substances. During 2015-16, 12,863 presented to specialist services with cannabis as their primary substance (75% of all those receiving help during the year). Although there was a 7% fall in the number of young people in treatment in 2015-16, the proportion of young people citing primary cannabis use increased slightly (from 73% in 2014-15 to 75% in 2015-16).

The proportion of young people citing alcohol as a primary substance has decreased, with 2,556 young people (15% of the total in treatment) seeking help during 2015-16. This dropped from 3,133 (17%) last year and is significantly lower than the 2008-09 peak of 8,799 (37%). It is now at its lowest ever level since recording began.

Findings from the 2015-16 Crime Survey for England and Wales show that Cannabis use peaks in the late teens/early 20s.[16] Alcohol use for those in treatment is falling in line with the prevalence statistics.

Figure 5.2.2 reports in more detail on the 'all other substances' category referred to in figure 5.2.1. This shows that the number in treatment for primary amphetamine use has fallen in the last three years. Numbers of young people in treatment for opiates and crack cocaine have fallen markedly over the last ten years and now represent 0.7% and 0.1% respectively of the young treatment population compared to 5.3% and 1.2% respectively in 2005-06.

[16] Drug misuse: findings from the 2015/16 Crime Survey for England and Wales. Home Office 2016 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/564760/drug-misuse-1516.pdf

Figure 5.2.1 Number of young people in treatment by primary substance (2005-06 to 2015-16)

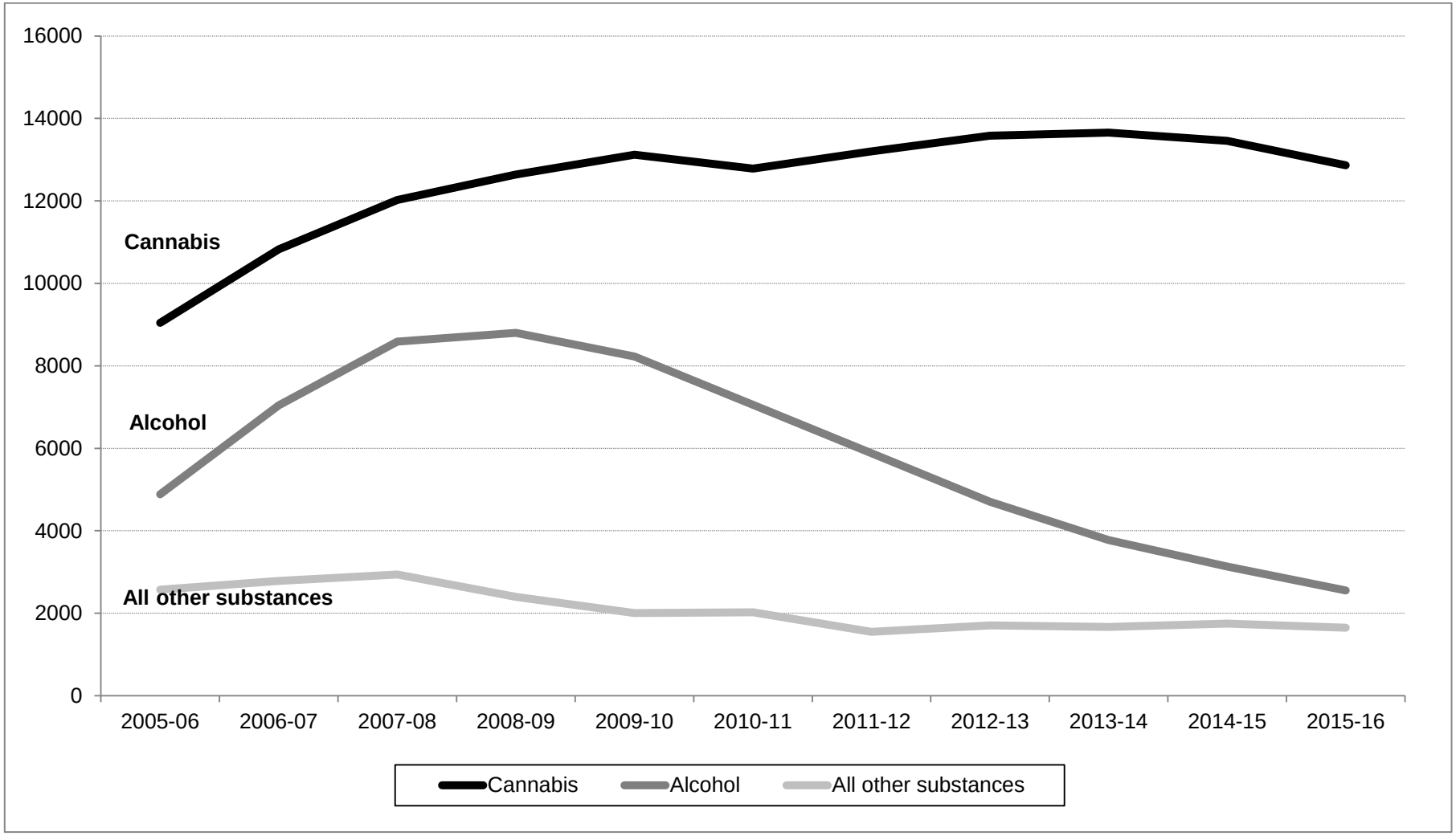


Figure 5.2.2 Number of young people in treatment by selected primary substances (excluding primary cannabis or alcohol use) 2005-06 to 2015-16

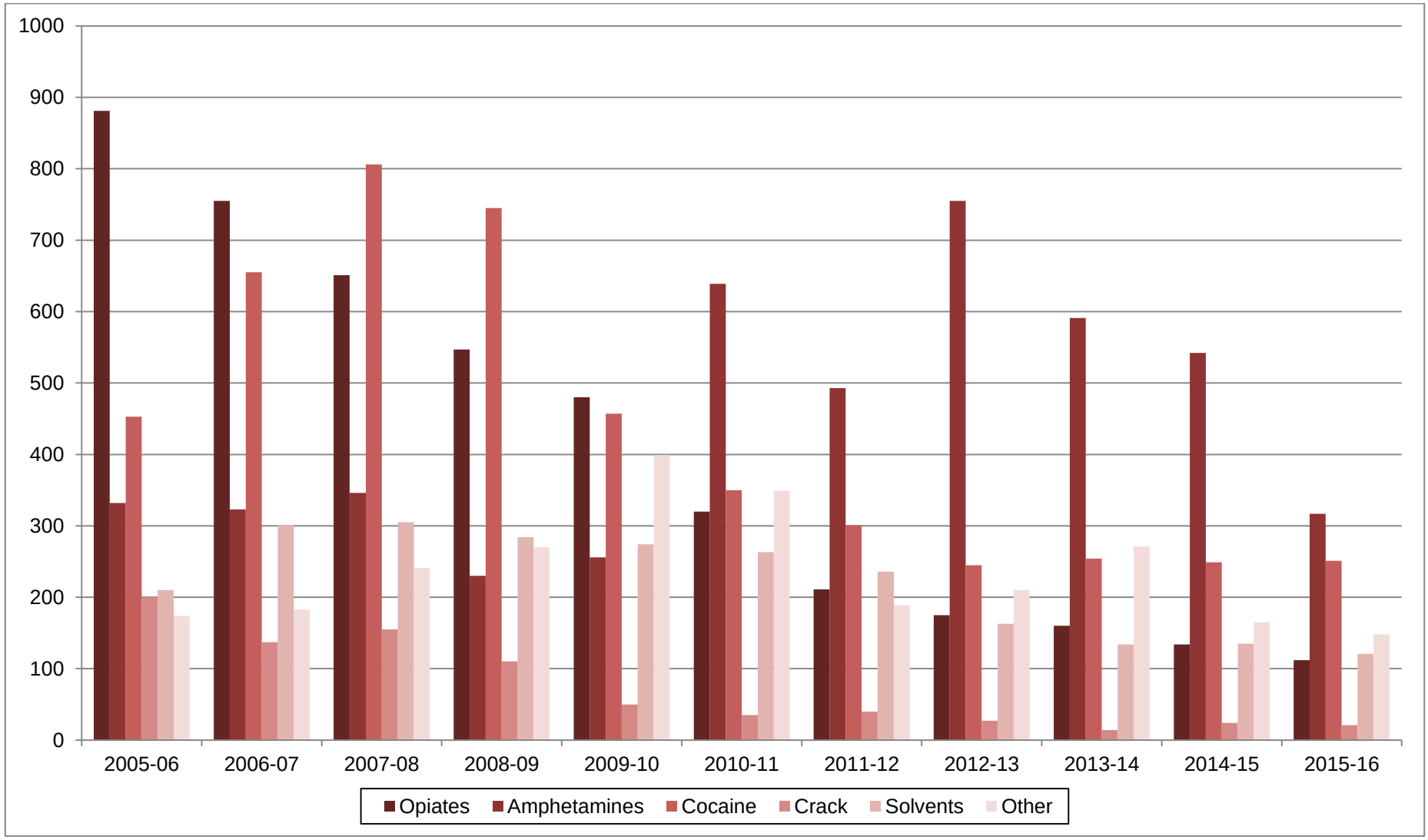


Table 5.2.1 Number of young people in treatment by primary substance (2005-06 to 2015-16)

Substance	2005-06		2006-07		2007-08		2008-09	
	n	%	n	%	n	%	n	%
Opiates	881	5%	755	4%	651	3%	547	2%
Amphetamines	332	2%	323	2%	346	1%	230*	1%
Cocaine	453	3%	655	3%	806	3%	745*	3%
Crack	200	1%	137	1%	155	1%	110	0%
Ecstasy	325	2%	432	2%	438	2%	210*	1%
Cannabis	9,043	55%	10,824	52%	12,021	51%	12,642	53%
Solvents	210	1%	301	1%	305	1%	284	1%
Alcohol	4,886	30%	7,039	34%	8,589	36%	8,799	37%
NPS	-	-	-	-	-	-	-	-
Other‡	174	1%	183	1%	241	1%	270*	1%

Substance	2009-10		2010-11		2011-12		2012-13	
	n	%	n	%	n	%	n	%
Opiates	480*	2%	320*	1%	211	1%	175*	1%
Amphetamines	256	1%	639	3%	493	2%	755*	4%
Cocaine	457	2%	350*	2%	301	1%	245*	1%
Crack	50*	0%	35*	0%	40	0%	27	0%
Ecstasy	90*	0%	65*	0%	79	0%	130*	1%
Cannabis	13,123	56%	12,784	58%	13,200	64%	13,581	68%
Solvents	274	1%	263	1%	236	1%	163	1%
Alcohol	8,227	35%	7,054	32%	5,884	29%	4,704	24%
NPS	-	-	-	-	-	-	-	-
Other‡	399	2%	349	2%	189	1%	210*	1%

Substance	2013-14		2014-15		2015-16	
	n	%	n	%	n	%
Opiates	160*	1%	134	1%	112	1%
Amphetamines	591	3%	540*	3%	317	2%
Cocaine	254	1%	250*	1%	251	1%
Crack	14	0%	24	0%	21	0%
Ecstasy	124	1%	165*	1%	261	2%
Cannabis	13,659	71%	13,454	73%	12,863	75%
Solvents	134	1%	135	1%	121	1%
Alcohol	3,776	20%	3,133	17%	2,556	15%
NPS	120*	1%	334	2%	420	2%
Other‡	271	1%	165*	1%	148	1%

* All numbers under five have been suppressed. Where totals could be derived, figures have been rounded to the nearest five and marked with an asterisk.

‡ From 2014-15, codes relating to prescribed opiates have been moved from the 'Other' category to 'Opiates'. This affects a very small number of young people and the change has not been backdated.

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

Figure 5.3.1 reports the number of young people aged under-18 in treatment in each year from 2005-06 to 2015-16, where the individual has cited club drug and/or NPS use.

'Club drug use' incorporates a number of different substances typically used by young people in bars and nightclubs, at concerts and parties, before and after a night out, and in place of other drugs. Data on club drug use for young people was first used in the 2012 report 'Club drugs: emerging trends and risks' (www.nta.nhs.uk/uploads/clubdrugsreport2012[0].pdf) and has been reported via this report for each year since.

NPS are chemical substances that produce similar effects to 'established' drugs (like cocaine, cannabis and ecstasy). Originally created to side-step legislation, an increasing number are controlled under the Misuse of Drugs Act 1971 but all remaining are now covered by the Psychoactive Substances Act 2016. Data on NPS use is reported here for the third year using a series of new drug codes describing NPS according to their predominant effect. The full breakdown of young people in treatment citing club drug and NPS use is shown in table 5.3.1.

The number of young people in treatment citing ecstasy use increased by 20% between 2014-15 and 2015-16 to 1,605. This was below the peak of 2,281 in 2007-08, but more than double than 2011-12, when 732 young people in treatment said they had problems with ecstasy.

The number of young people citing ketamine use fell by 45% between 2014-15 and 2015-16 to 125. Mephedrone use decreased by 54% compared to the peak of 1,788 in 2012-13. The numbers of young people citing GHB/GBL and methamphetamine were too small to be presented in figure 5.3.1: less than five for GHB/GBL and nine for methamphetamine in 2015-16.

The number of young people reporting problems with NPS rose for the second year to 1,056; the numbers are lower compared to ecstasy use (1,605). However, specialist substance misuse services need to ensure they continue to be accessible and relevant to those young people who may need more support for NPS problems, in particular those young people who may be most vulnerable to developing problems with these drugs, such as young people with mental health problems and homeless young people.

Figure 5.3.1 Number of young people in treatment by club drug and/or NPS use (2005-06 to 2015-16)

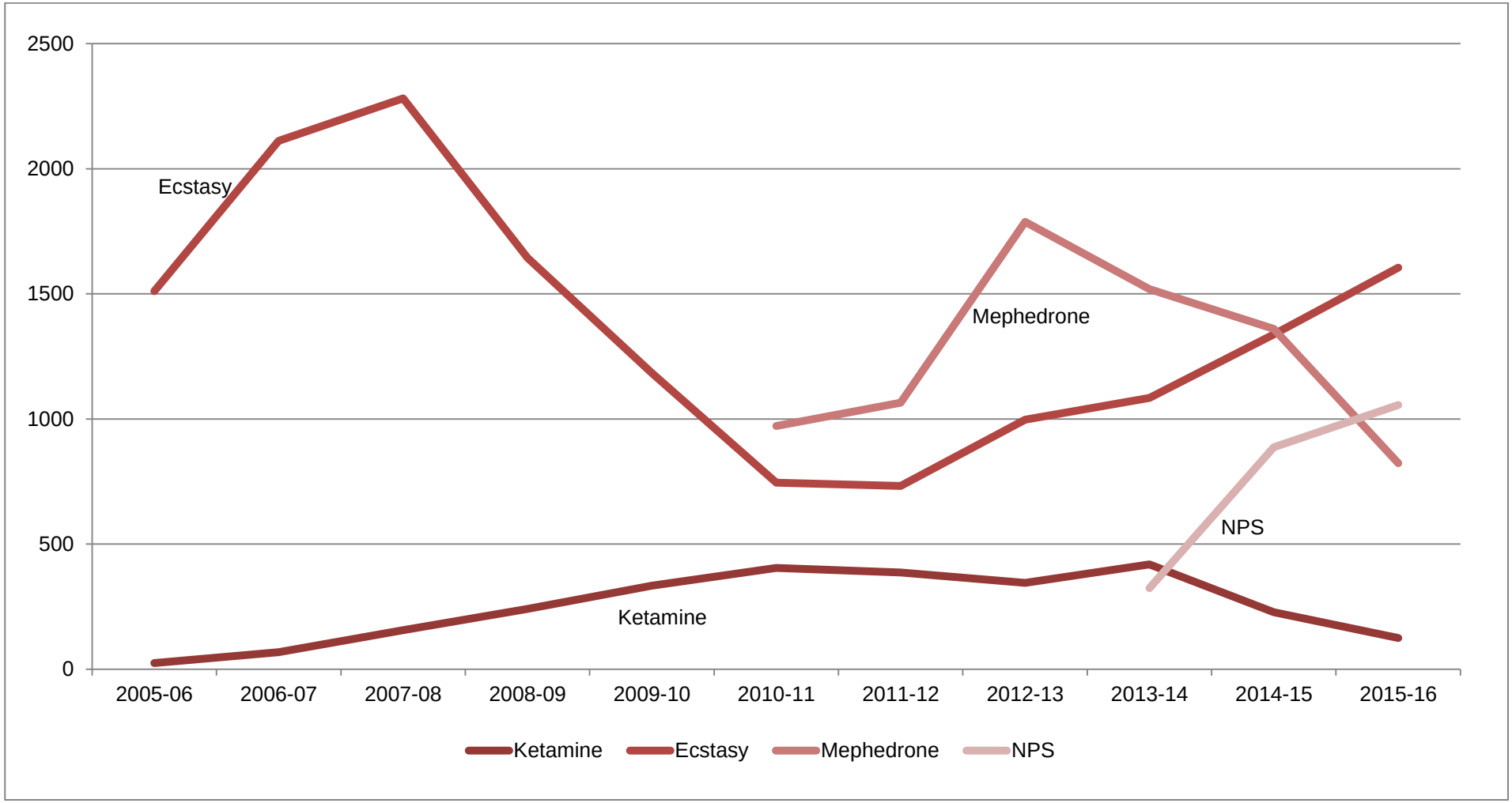


Table 5.3.1 Trends in numbers presenting to treatment citing club drug and/or NPS use

Substance	2005-06	2006-07	2007-08	2008-09	2009-10	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16
Ketamine	25	68	156	241	334	405	387	345	419	228	125
Ecstasy	1,511	2,112	2,281	1,644	1,183	746	732	997	1,084	1,338	1,605
Mephedrone♦	-	-	-	-	-	972	1,065	1,788	1,519	1,360	823
NPS (any) ‡	-	-	-	-	-	-	-	-	324	887	1,056
NPS - Predominantly stimulant ‡	-	-	-	-	-	-	-	-	60	154	121
NPS - Predominantly hallucinogenic ‡	-	-	-	-	-	-	-	-	29	46	37
NPS - Predominantly dissociative ‡	-	-	-	-	-	-	-	-	*	5	32
NPS - Predominantly sedative/opioid ‡	-	-	-	-	-	-	-	-	*	9	13
NPS - Predominantly cannabinoid ‡	-	-	-	-	-	-	-	-	203	557	695
NPS – other ‡	-	-	-	-	-	-	-	-	39	139	175
Any club drug cited	1,534	2,168	2,390	1,831	1,556	1,975	2,007	2,834	2,993	3,448	3,312
Percentage of all in treatment citing a club drug and/or NPS	9%	10%	10%	8%	7%	9%	10%	14%	16%	19%	19%

* All numbers under five have been suppressed. Where totals could be derived, figures have been rounded to the nearest five and marked with an asterisk.

♦ A code for mephedrone was added to the NDTMS core data set in 2010-11. Any individuals reporting mephedrone prior to this are counted in the 'Any club drug cited' total but no separate total is given for mephedrone.

‡ Codes for NPS were added to the NDTMS core data set in 2013-14. Any individuals reporting NPS prior to this are counted in the 'Any club drug cited' total but no separate totals are given for NPS. An individual may report more than one NPS drug and therefore the sum of individual NPS drugs may exceed the total reported for NPS (any).

5.4 Trends in treatment exit reasons

Table 5.4.1 reports treatment exit reasons for clients in the years 2005-06 to 2015-16. In 2009, a new discharge coding system was introduced that tightened the way 'treatment completed' was recorded. For further details see http://www.ndtms.net/resources/secure/Quality-and-Methodology-NDTMS-2015-16.pdf. These changes mean it is not possible to directly compare treatment exit data from 2009-10 onwards with previous years.

Treatment completions, as a proportion of exits, have increased annually over this period, from 69% in 2009-10 to 80% in 2015-16. However, there has been a plateauing of completion rates in recent years and the proportion completing treatment in 2015-16 remained the same as in 2014-15.

Table 5.4.1 Trends in treatment exit reasons

Treatment exit reason	2005-06		2006-07		2007-08		2008-09	
	n	%	n	%	n	%	n	%
Complete	4,105	48%	5,726	50%	8,073	57%	9,546	65%
Referred on	572	7%	701	6%	938	7%	510	3%
Dropped out / left	2,525	29%	2,902	25%	2,529	18%	2,253	15%
Prison	200	2%	285	2%	339	2%	371	3%
Treatment declined by client	*	0%	246	2%	703	5%	620*	4%
Not known	102	1%	202	2%	98	1%	71	0%
Other	1,108	13%	1,448	13%	1,401	10%	1,250	9%
Total	**8,615***	**100%**	**11,510**	**100%**	**14,081**	**100%**	**14,620***	**100%**

Treatment exit reason	2009-10		2010-11		2011-12		2012-13	
	n	%	n	%	n	%	n	%
Complete	10,160	69%	10,507	75%	10,118	77%	10,208	79%
Referred on	856	6%	793	6%	841	6%	760	6%
Dropped out / left	2,408	16%	1,851	13%	1,630	12%	1,530	12%
Prison	183	1%	139	1%	97	1%	66	1%
Treatment declined by client	529	4%	440	3%	326	2%	278	2%
Not known	51	0%	16	0%	0	0%	0	0%
Other	478	3%	260	2%	175	1%	105	1%
Total	**14,665**	**100%**	**14,006**	**100%**	**13,187**	**100%**	**12,947**	**100%**

Treatment exit reason	2013-14		2014-15		2015-16	
	n	%	n	%	n	%
Complete	9,852	79%	9,613	80%	8,929	80%
Referred on	852	7%	773	6%	722	6%
Dropped out / left	1,440	12%	1,345	11%	1,237	11%
Prison	62	0%	52	0%	31	0%
Treatment declined by client	244	2%	236	2%	245	2%
Not known	0	0%	0	0%	0	0%
Other	60	0%	55	0%	60	1%
Total	**12,510**	**100%**	**12,074**	**100%**	**11,224**	**100%**

* All numbers under five have been suppressed. Where totals could be derived, figures have been rounded to the nearest five and marked with an asterisk.

6. History

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

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

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

NDTMS has been reorganised over the years, bringing the definition of drug treatment recorded by the system further into line with 'Models of care for treatment of adult drug users' (see www.nta.nhs.uk/publications/documents/nta_modelsofcare_update_2006_moc3.pdf).

Since 2003-04 data collection has been consistently collected by treatment services, submitting a core data set of their clients' information as a database extract. The dataset and data collection methods have also changed. Code sets for the core data set can be found in NDTMS reference data document (see www.nta.nhs.uk/areas/ndtms/core_data_set_page.aspx).

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

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

NDEC is part of the Centre for Epidemiology, which is one of six centres in the Institute of Population Health, University of Manchester.

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

6.1 Relevant web links and contact details

Monthly web-based NDTMS analyses
www.ndtms.net/

Public Health Outcomes Framework indicators 2.15i, 2.15ii, 2.15iii and 2.15iv
http://www.phoutcomes.info/public-health-outcomes-framework

National Drug Evidence Centre (NDEC)
www.medicine.manchester.ac.uk/healthmethodology/research/ndec/

Public Health England
www.gov.uk/government/organisations/public-health-england

General enquiries

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

Policy

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6.2 Comparability of data to previous reports

Since 1 November 2013, PHE made substantial changes to the core dataset with regards to young people and the coding of intervention type. Prior to this, intervention codes were restricted to eight categories: harm reduction, pharmacological, psychosocial (counselling), psychosocial (cognitive behaviour therapy), psychosocial (motivational interviewing), psychosocial (relapse prevention), psychosocial (family work). The setting where the interventions were being delivered was not recorded.

Following consultations with clinicians, treatment providers and other key stakeholders a new method of recording interventions types and setting was introduced alongside the ability for providers to record the non-structured multi-agency working interventions that they were delivering. These changes enable a better understanding of the different interventions being provided nationally and in local areas, which will in turn benefit commissioning and service planning as well as influencing national policy setting.

From 1 November 2013, all registered young people's treatment providers are registered with one of seven setting types: community, home, secure estate, in-patient (substance misuse specific), in-patient (not substance misuse specific), residential (substance misuse specific) and residential (not substance misuse specific), which have now been incorporated to PHE's regular reporting. Clients in secure estate settings are not reported on in this document. Definitions of these settings can be found in section 7.2 and the business definitions guide at http://www.nta.nhs.uk/uploads/yp-treatment-business-definition-v11.06-wn-comments.pdf. Intervention types have been split in to four high-level categories: pharmacological interventions, psychosocial interventions, harm reduction interventions and multi-agency working interventions. Multi agency working interventions are not reported on in the present report.

Other changes to the core dataset with regards to young people also occurred in the dataset change on 1 November 2013. Valid responses to accommodation status and education and employment status were changed at this time. For more details please see the latest business definitions at http://www.nta.nhs.uk/uploads/yp-treatment-business-definition-v11.06-wn-comments.pdf.

The final change following the consultations with clinicians, treatment providers and other key stakeholders was to introduce a new set of questions to capture vulnerabilities, risk and resilience factors at the start of treatment.

6.3 Drug treatment collection and reporting timeline

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

April 2001 to March 2004 NDTMS – statistics reported annually by the Department of Health (DH)

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

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

6.4 Other sources of statistics about drugs

6.4.1 Prevalence of substance use

Information is available relating to the prevalence of drug use among secondary school pupils aged 11 to 15 from the Smoking, Drinking and Drug Use Survey among young people in England. This is a survey carried out for the NHS Information Centre by the National Centre for Social Research and the National Foundation for Educational Research. The survey interviews school pupils, and has been in place since 2001. It reported annually up to 2014-15 and will now report every two years with the next report due in 2017 reporting for 2016-17. The data and further information are available at www.hscic.gov.uk/catalogue/PUB17879

Findings from a survey called 'What About YOUth' were published in December 2015. It asked 15-year olds about a range of subjects including what they eat, what they do in their free time, bullying and whether they smoke, drink alcohol or have taken drugs. Local level data on drug and alcohol use is available at: www.whataboutyouth.com/

NDTMS collects data on drug and alcohol treatment for young people, and produces official statistics bulletins, which can be found at www.nta.nhs.uk/statistics.aspx.

An annual estimate of the prevalence of drug use is undertaken through the Crime Survey for England and Wales (CSEW; formerly the British Crime Survey). This section of the survey has been in place since 1996, annually since 2001, and has tracked the

prevalence of the use of different drugs over this time. This does not include information on all young people but does show the data for the age group 16-24. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/564760/drug-misuse-1516.pdf

A second method is used to produce estimates for the prevalence of crack cocaine and heroin use for each local authority area in England. Estimates are available for 2006-07, 2008-09, 2009-10, 2010-11 and 2011-12. Estimates for 2014-15 will be available towards the end of 2016-17.

The estimates are produced through a mixture of capture-recapture and Multiple Indicator Methodology (MIM), and rely on NDTMS data being matched against and/or analysed alongside Probation and Home Office data sets. The data and further information are available at: www.nta.nhs.uk/facts-prevalence.aspx.

6.4.2 Youth justice statistics

The Ministry of Justice and the Youth Justice Board for England and Wales publish annual statistics that detail the number of young people (aged 10-17) arrested, along with proven offences, criminal history, characteristics of young people, the number sentenced, those on remand, those in custody, re-offending and behaviour management: www.gov.uk/government/collections/youth-justice-annual-statistics

In addition, NDTMS collects data on drug and alcohol treatment in secure settings and will produce the first set of official statistics for 2015-16 on 12th January 2017. The report will be available at: www.nta.nhs.uk/statistics.aspx.

6.4.3 International comparisons

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

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

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

6.4.4 Adult drug and alcohol treatment

PHE also publishes annual reports regarding adults accessing drug and alcohol treatment. These can be found at www.nta.nhs.uk/statistics.aspx

Note that young people's figures are not comparable with statistics relating to adult drug or alcohol treatment. This is because access to specialist services for young people requires a 'lower severity of drug use and associated problems'.[17]

6.4.5 Drug-related deaths

The Office for National Statistics publishes an annual summary of all deaths related to drug poisoning (involving both legal and illegal drugs) and drug misuse (involving illegal drugs) in England and Wales. This covers all ages with young people forming part of the 'under 20' age group and can be found at: http://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsrelatedtodrugpoisoninginenglandandwales/2015registrations.

[17] Drug Misuse and Dependence – UK Guidelines on Clinical Management, p.85, London: Department of Health (England), the Scottish Government, Welsh Assembly Government and Northern Ireland Executive.

7. Abbreviations and definitions

7.1 Abbreviations

A&E	Accident and emergency department
CAMHS	Child and adolescent mental health services
ChiMat	Child and Maternal Health Intelligence Network
CSE	Child sexual exploitation
DCSF	Department for Children, Schools and Families
DH	Department of Health
EMCDDA	European Monitoring Centre for Drugs and Drug Addiction
GP	General practitioners
HBSC	Health Behaviour in School-aged Children
NDEC	National Drug Evidence Centre
NDTMS	National Drug Treatment Monitoring System
NEET	Not in education, employment or training
NPS	New psychoactive substances
NTA	National Treatment Agency for Substance Misuse
ONS	Office for National Statistics
PHE	Public Health England
YOT	Youth offending team

7.2 Definitions

Adjunctive drug use	Substances additional to the primary substance used by the individual, NDTMS collects secondary and tertiary substances.
Agency /provider	A provider of services for the treatment of substance misuse. They may be statutory (i.e. the NHS) or non-statutory (i.e. third sector, charitable).
Agency/provider code	A unique identifier for the treatment provider (agency) assigned by the regional NDTMS centres, e.g. L0001.
Attributor	A concatenation of a client's initials, date of birth and gender. This is used to isolate records that relate to individual clients.

Client	A drug or alcohol user presenting for treatment at a structured treatment service. Records relating to individual clients are isolated and linked based on the attributor.
Club drug	Incorporates a number of different substances typically used by young people in bars and nightclubs, at concerts and parties, before and after a night out, and in place of other drugs.
Community setting	A young person's drug and alcohol service where residence is not a condition of engagement with that service. This will include all providers delivering interventions in a non-residential setting.
Discharge date	This is usually the planned discharge date in a client's treatment plan, where one has been agreed. However, if a client's discharge was unplanned, then the date of last face-to-face contact with the provider (agency) is used.
Drug-related death / drug misuse death	Annual figures published by the Office for National Statistics (ONS) since 1993 cover deaths in England and Wales related to "drug poisoning (involving both legal and illegal drugs)" and to "drug misuse (involving illegal drugs)". The ONS's definition of a drug misuse death is "(a) deaths where the underlying cause is drug abuse or drug dependence and (b) deaths where the underlying cause is drug poisoning and where any of the substances controlled under the Misuse of Drugs Act 1971 are involved". Where people do suffer drug poisonings while in treatment, these are overwhelmingly classed as drug misuse, so this definition may be seen as more relevant to this population. However, many of those who die in treatment are not included under either definition as they die from causes other than poisoning.
Episode	A period of contact with a treatment provider (agency): from referral to discharge.
Episode of treatment	A set of interventions with a specific care plan. A client may attend one or more interventions (or types) of treatment during the same episode of treatment. A client may also have more than one episode in a year. A client is considered to have been in contact during the year, and hence included in these results, if any part of an episode occurs within the year. Where several episodes were collected for an individual, attributes such as ethnicity, primary substance etc. are based on the first valid data available for that individual.

Family work intervention	Interventions using psychosocial methods to support parents, carers and other family members to manage the impact of a young person's substance misuse and enable them to better support the young person in their family.
First/subsequent intervention	First intervention' refers to the first intervention that occurs in a treatment journey. 'Subsequent intervention' refers to interventions, within a treatment journey, that occur after the first intervention.
Home setting	The young person is being supported with specialist substance misuse interventions in his/her home by the treatment provider.
In contact	Clients are counted as being in contact with treatment services if their date of presentation (as indicated by triage/initial assessment), intervention start, intervention end or discharge indicates that they have been in contact with a provider during the year.
Inpatient unit (not substance misuse specific) setting	An inpatient unit provides assessment, stabilisation and/or assisted withdrawal with 24-hour cover. Such as a hospital unit.
Inpatient unit (substance misuse specific) setting	An inpatient unit provides assessment, stabilisation and/or assisted withdrawal with 24-hour cover from a multi-disciplinary team who have had specialist training in managing addictive behaviours. Such as paediatric ward, adult ward, child and adolescent mental health ward, etc.
Intervention	A type of treatment, e.g. structured counselling, community prescribing, etc.
Looked after child	The definition of a looked after child (from the Children Act 1989[18]) is "Children looked after includes all children being looked after by a local authority including those subject to care orders under section 31 of the Children Act 1989 and those looked after on a voluntary basis through an agreement with their parents under section 20 of the Children Act 1989".
New psychoactive substance (NPS)	Chemical substances that produce similar effects to 'established' drugs (like cocaine, cannabis and ecstasy). Originally created to side-step legislation, an increasing number are controlled under the Misuse of Drugs Act 1971 but all remaining are now covered by the Psychoactive Substances Act 2016.

[18] The Children's Act 1989 can be found here; www.legislation.gov.uk/ukpga/1989/41/contents

Opiate	A group of drugs including heroin, methadone and buprenorphine that act on opioid receptors.
Pharmacological intervention	Interventions that include prescribing for detoxification, stabilisation and symptomatic relief of substance misuse as well as prescribing to prevent relapse. For young people this intervention includes a wide range of medication prescribed by a clinician, not solely substitute prescribing for opiate addiction.
Planned discharge	A treatment exit where the discharge reason is 'treatment completed'. This includes 'Treatment completed – Drug free' and 'Treatment Completed - Occasional user' from the current core data set. It also includes any codes from previous datasets that begin with 'Treatment completed' or 'completed'.
Poly drug use	The reporting of using two or more drugs in combination.
Presenting for treatment	The first face-to-face contact between a client and a treatment provider.
Primary drug/substance	The substance that brought the client into treatment at the point of triage/initial assessment.
Psychosocial Intervention	These interventions use psychological, psychotherapeutic, counselling and counselling based techniques to encourage behavioural and emotional change; the support of lifestyle adjustments and the enhancement of coping skills. They include motivational interviewing, relapse prevention and interventions designed to reduce or stop substance misuse, as well as interventions that address the negative impact of substance misuse on offending and attendance at education, employment or training.
Referral date	The date the client was referred to the provider for this episode of treatment.
Residential unit (not substance misuse specific) setting	Anywhere where a young person is receiving interventions in their residence but that residence has not been set up specifically to deal with substance misuse, such as children's homes, supported housing etc.
Residential unit (substance misuse specific) setting	Anywhere where a young person is receiving interventions in their residence and that residence has been set up specifically to deal with substance misuse.

Specialist harm reduction intervention	Care planned substance misuse specific harm reduction is not brief advice and information; this intervention must be delivered as part of a structured care plan and after a full assessment of the young person's substance misuse and risks. Specialist harm reduction interventions should include services to manage those at risk of, or currently involved in: • injecting – these services could include needle exchange, advice and information on injecting practice, access to appropriate testing and treatment for blood borne viruses • overdose – advice and information to prevent overdose, especially overdose associated with poly-substance use, which requires specialist knowledge about substances and their interactions • risky behaviour associated with substance use – advice and information to prevent and/or reduce substance misuse related injuries and substance misuse related risky behaviours
Structured treatment	Structured treatment follows assessment and is delivered according to a care plan, with clear goals, which are regularly reviewed with the client. It may comprise a number of concurrent or sequential treatment interventions.
Triage	An initial clinical risk assessment performed by a treatment provider. A triage includes a brief assessment of the problem as well as an assessment of the client's readiness to engage with treatment, in order to inform a care plan.
Triage date	The date that the client made a first face-to-face presentation to a treatment provider. This could be the date of triage/initial assessment though this may not always be the case.
Waiting times	The period from the date a person is referred for a specific treatment intervention and the date of the first appointment offered. Referral for a specific treatment intervention typically occurs within the treatment provider, at or following assessment.
Young people	Person under 18 years old.
YP secure estate	Establishments that house young offenders who have been remanded or sentenced, they include young offender institutes, secure training centres and secure children's homes.

Note: full operational definitions can be found in the NDTMS core data set documents on: www.nta.nhs.uk/core-data-set.aspx.

Appendix A

Diagram to show an example young people's pathway

This diagram illustrates a typical journey through a young people's specialist substance misuse service. It is provided to give an indication of a possible pathway and the interventions received. Pathways will vary depending on the substances used, the support requirements of the young people, their general health needs and any other relevant issues. Young people with substance misuse problems will usually have a number of other issues that they are receiving help with, but this pathway focuses on the substance misuse.