Public Health England

Protecting and improving the nation's health

Young People's Statistics from the National Drug Treatment Monitoring System (NDTMS)

1 April 2017 to 31 March 2018

National Statistics

The University of Manchester

National Drug Evidence Centre

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Executive summary

This National Drug Treatment Monitoring System (NDTMS) statistics report presents information about young people under the age of 18 who received specialist substance misuse treatment in England between 1 April 2017 and 31 March 2018.

The number of young people in alcohol and drug specialist services

There were 15,583 young people in specialist substance misuse services in 2017-18. This was a 5% decrease from 2016-17 (16,436) and a continuation of a year on year downward trend. There has been a 35% decrease since a peak in 2008-09 when 24,053 young people received treatment.

There are several factors which may have influenced this downward trend including the possibility that it reflected historic declining prevalence. However, there is recent evidence that the number of young people using drugs has started to increase, so the more recent decreases in young people accessing treatment services may not reflect the actual need.

The latest NHS Digital survey of school age children 'Smoking, drinking and drug use among young people in England',[1] conducted in 2016 showed nearly a fifth (18%) of pupils said that they had taken drugs in the last year. Excluding new psychoactive substances and nitrous oxide (newly added to the drug prevalence measure in 2016), 15% said they had taken drugs in the last year, up from 10% in 2014.

The Crime Survey for England and Wales 2017-18[2] also showed an increase in any class A drug use in the last year among 16-24 year olds, going from 6.8% in 2007-08 to 8.4% in 2017-18.

In addition to these surveys, Department for Education data for 2016-17[3] showed school exclusions for alcohol and drug use have increased substantially in recent years with fixed term exclusions up by 34% since 2012-13 and permanent exclusions up by 95% since 2010-11.

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[1] Smoking, drinking and drug use among young people in England. NHS Digital 2017
digital.nhs.uk/data-and-information/publications/statistical/smoking-drinking-and-drug-use-among-young-people-in-england/2016

[2] Drug misuse: findings from the 2017 to 2018 Crime Survey for England and Wales. Home Office 2018
www.gov.uk/government/statistics/drug-misuse-findings-from-the-2017-to-2018-csew

[3] Permanent and fixed period exclusions in England: 2016 to 2017. Department for Education 2018
www.gov.uk/government/statistics/permanent-and-fixed-period-exclusions-in-england-2016-to-2017

Problem substances

Cannabis remained the most common drug by far that young people came to treatment for. The majority (88%) of young people in specialist services said they had a problem with this drug. The proportion of young people in treatment saying that cannabis is their main problem substance has been on an upward trend since 2007-08. Although total numbers have decreased slightly in recent years, the proportion of young people in treatment who have cannabis problems has remained stable in the last 2 years at 77%.

The next most commonly reported problematic substance was alcohol. There were 7,206 young people in treatment for alcohol problems (46%). The number of young people receiving help for alcohol problems continues to steadily decline from the peak in 2008-09 when 16,047 were treated for alcohol.

The number of young people entering treatment for problems with ecstasy in 2017-18 increased by 16% from the previous year (1,815 to 2,112) and has almost doubled since 2013-14. The increase in ecstasy treatment numbers was seen across all age groups.

There was also an 18% increase in young people in treatment for crack problems over the same period, although the numbers were much lower (83 in 2016-17 and 98 in 2017-18). There was also a rise in adults being treated for crack over the same period.[4]

Benzodiazepine treatment is reported for the first time in this report. Young people who had problems with benzodiazepines at the start of treatment almost doubled from the previous year (161 in 2016-17 and 315 in 2017-18). Alprazolam (most commonly called Xanax) was the benzodiazepine which saw the biggest increase, (8 in 2016-17 to 53 in 2017-18).

Young people entering treatment for problems with new psychoactive substances (NPS) more than halved since the previous year (585 in 2016-17 and 270 in 2017-18) and is 74% lower than 2015-16 when 1,056 reported problematic use. Similar falls were seen in adults starting treatment over the same period, particularly in those under 25.[5]

[4] Adult substance misuse statistics from the National Drug Treatment Monitoring System (NDTMS) 2017-18
www.gov.uk/government/statistics/substance-misuse-treatment-for-adults-statistics-2017-to-2018
[5] Adult substance misuse statistics from the National Drug Treatment Monitoring System (NDTMS) 2017-18
www.gov.uk/government/statistics/substance-misuse-treatment-for-adults-statistics-2017-to-2018

Gender and age

Two-thirds of the young people accessing specialist substance misuse services were male (66%). Around three-quarters (74%) were aged 15 or over. The median age for both female and male was 15 years old. Only 43% of females were aged 16 or over compared to nearly half (49%) of males.

While the number of younger children (under 14) in treatment remains relatively low, it has increased from last year (1,342 in 2016-17 to 1,422 in 2017-18).

Any substance misuse among young people – particularly the younger age groups – is concerning because they are likely to be at risk of other harms as well as their alcohol or drug use. Safeguarding needs to be a priority and the other risks and harms need to be addressed.

Referral route

Education services was the most common route into specialist treatment services, with 5,178 (31%) young people being referred from these. Mainstream education was the single largest source of referral, accounting for over a quarter of all referrals (26%, or 4,432). The proportion referred by education services has increased over recent years (24% in 2012-13), while referrals from the youth justice system continue to decline (34% in 2012-13 to 22% in 2017-18).

Vulnerabilities

The majority of young people in specialist substance misuse services have other problems or vulnerabilities related to their substance use, such as:

- having mental health problems
- being in contact with children's social care
- not being in education, employment or training (NEET)
- offending
- self-harming
- experiencing sexual exploitation
- domestic abuse

There are 17 vulnerability items collected via the NDTMS. Almost all (96%) of young people who entered treatment in 2017-18 disclosed 1 or more vulnerability, and 55% said they had 3 or more. This shows that specialist services need to work effectively with a range of other agencies to ensure that all the needs of a young person are met.

The number and proportion of young people reporting they had experienced sexual exploitation reduced in 2017-18 compared to the previous year (562 or 5% in 2017-18 and 688 or 6% in 2016-17). However, this proportion varied greatly by gender: over 8 out of 10 sexual exploitation reports were by females (470 female compared to 92 male), accounting for 13% of all females starting treatment and 1% of males. While these figures suggest a difference between genders, Barnardo's research[6] found that boys tended not to disclose experience of sexual exploitation or abuse as much as girls.

Mental health needs

Information on whether a young person starting treatment has a mental health need was introduced into this report for the first time this year. Of all the young people starting treatment in 2017-18, who had given a mental health status, 2,954 (27%) said they had a mental health treatment need. There was a greater proportion of females reporting this than males (37% compared to 22%).

Around 7 out of 10 of young people who reported a mental health treatment need also said that they were currently receiving treatment for their mental health (70% or 2,023). This proportion was broadly similar for males and females (72% of females and 69% of males). Most of the young people that recorded a mental health treatment need were either engaged with community mental health services (57%, or 1,648) or receiving treatment from their GP (9%, or 252).

Waiting times and reasons for leaving specialist services

Young people continued to be able to access treatment quickly in 2017-18. The mean waiting time for young people to start their first specialist intervention was around 2 and a half days. Nearly all (97%) of the 16,330 first interventions started by young people in 2017-18 had a wait of 3 weeks or under and 77% of first interventions started on the day the young people were referred.

Most (81%) young people that left services in 2017-18 did so in a planned way, no longer requiring specialist treatment interventions. Although this proportion is slightly lower than last year (82%), it still suggests that specialist substance misuse services in England are responding well to the needs of young people who access them, and are helping young people to overcome their substance misuse problems.

[6] 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

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 under the age of 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
- inform the Government drug strategy

The statistics in this report should therefore be considered as part of a wider picture around the 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: www.ndtms.net/resources/public/Quality-and-Methodology-NDTMS-2017-18.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

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.[7]

1.3 Policy context

Last year the Home Office published the Government's updated 2017 Drug Strategy, which aims to prevent the onset of drug use and its escalation at all ages, through universal action combined with more targeted action for the most vulnerable. This includes placing a greater emphasis on building resilience and confidence to young people to prevent the range of risks they face, e.g. drug and alcohol misuse, crime, exploitation and unhealthy relationships:
www.gov.uk/government/publications/drug-strategy-2017

In April 2018 the Government published its Serious Violence Strategy, which sets out the government's response to serious violence and recent increases in knife crime, gun crime and homicide. It identified drugs as a key driver of recent increases in serious violence:
www.gov.uk/government/publications/serious-violence-strategy

In December 2017 the Government published the Mental Health Green Paper Transforming Children and Young People's Mental Health. The actions in the Green Paper will provide a step towards a far more joined up approach to mental health support, not just across health and education but also other services – a multi-agency approach focused on collectively understanding and meeting the needs of children and young people:
www.gov.uk/government/consultations/transforming-children-and-young-peoples-mental-health-provision-a-green-paper

Department for Education (DfE) is proposing to introduce statutory relationships education in primary schools, relationships and sex education in secondary schools and health education across both primary and secondary schools in September 2020

[7] 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.

and to have early adopter schools that are willing to start teaching the new subjects from 2019. We expect regulations will be laid in the House, alongside final draft guidance, allowing for a full and considered debate in the first half/quarter of 2019. The final statutory guidance will be published once the regulations have been passed: consult.education.gov.uk/pshe/relationships-education-rse-health-education

1.4 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' for 11-15 year olds.

The last survey which was conducted in 2016 reported an increase in lifetime prevalence of drug use, from 15% in 2014 to 24% in 2016, following a longer term falling trend. Part of this increase in overall drug use can be explained by the addition of questions on nitrous oxide (NO) and new psychoactive substances (NPS). However, even allowing for these, the estimate for 2016 is 21% which remains a large increase from 15% in 2014. One-tenth (10%) of pupils said that they had taken drugs in the last month, up from 6% in 2014. Although cannabis was the most commonly used drug among 11 to 15 year olds (with 7.9% reporting that they had used it in the last year), there was also an increase in the proportion reporting Class A drug use, from 2.0% in 2014 to 3.2% in 2016.

The schools survey shows that 44% of pupils had ever drunk alcohol. By the age of 15, 73% of teenagers had tried alcohol and almost a quarter of 15 year olds reported that they had an alcoholic drink in the last week. This figure is not comparable with earlier surveys due to a change in methodology, but is regarded by the authors as more accurate than estimates of lifetime prevalence from previous iterations of this survey. It is important to note that 9% of pupils said they had been drunk in the last 4 weeks, including 7% of pupils who had been drunk once or twice, and 2% more often. Girls (11%) were more likely to have been drunk in the last 4 weeks than boys (7%). England, however, still has a relatively high incidence of regular drinking, drunkenness and cannabis use among 15 year olds compared to other European countries.[8]

The latest Smoking, drinking and drug use among young people in England report for 2016 can be found at: digital.nhs.uk/catalogue/PUB30132

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

Prevalence statistics for young adults aged 16-24 are included in the 'Drug Misuse: Findings from the 2017-18 Crime Survey for England and Wales' (CSEW) report. The report has consistently found that younger people are more likely to have taken drugs in the last year than older people. Around 1 in 5 (19.8%) adults aged 16 to 24 had taken a drug in the last year. This proportion was more than double that of the wider age group, and equates to around 1.2 million people. There is an upward trend in the use of Class A drugs among 16 to 24 year olds with a statistically significant rise from 6.8% in 2007/08 to 8.4% in 2017/18.

The latest CSEW report can be found at:
assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/729249/drug-misuse-2018-hosb1418.pdf

DfE publish data on the number of permanent and fixed term exclusions where alcohol or drug use is recorded as the reason for exclusion. The number of fixed term exclusions for alcohol or drug use has risen from 7,360 in 2011/12 to 8,820 in 2016/17. Permanent exclusions for alcohol or drug use have risen from 330 to 565 over the same period.

The latest DfE data on school exclusions can be found at:
www.gov.uk/government/statistics/permanent-and-fixed-period-exclusions-in-england-2016-to-2017

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

Findings from the Health Behaviour in School-aged Children (HBSC) report4 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.

An analysis of the HBSC survey for England carried out for PHE showed that 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 10 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 report can be found at: www.gov.uk/government/uploads/system/uploads/attachment_data/file/621069/Health_behaviour_in_school_age_children_wellbeing_of_adolescent_girls.pdf

The Mental Health of Children and Young People in England, 2017, has been published by NHS digital. Risky health behaviours were more common in young people with a mental disorder. Alcohol use was more common in 11 to 16 year olds with a mental disorder. They were also more likely to drink more frequently. Illicit drug use was 3 times more likely in 11 to 16 year olds with a mental disorder (13.9%) than in those without one (4.1%). Girls aged 11 to 16 with a disorder were 5 times more likely to have tried drugs (14.2%) than girls without a disorder (2.6%). The report can be found at: digital.nhs.uk/data-and-information/publications/statistical/mental-health-of-children-and-young-people-in-england/2017/2017

PHE's National Child and Maternal Health Intelligence Network 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. A guidance page which explains how health professionals can use child and maternal health data and intelligence to help make decisions about the planning and provision of services is available here: www.gov.uk/guidance/child-and-maternal-health-data-and-intelligence-a-guide-for-health-professionals

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

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

The data quality of NDTMS 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.

As part of the Core Dataset N (CDSN) changes that were introduced in April 2017, young people with an identified mental health problem was replaced by mental health treatment need and the types of treatment received by clients for their mental health needs were added to the core dataset. Data completeness of these new variables is lower than the rest of the dataset, but is expected to increase over time for these variables as the reporting process beds in across the treatment system.

Table 2.1.1 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.

More detailed information on NDTMS data collection and full definitions for the data quality measures recorded in Table 2.1.1 can be found at:
www.ndtms.net/resources/public/Quality-and-Methodology-NDTMS-2017-18.pdf
In addition to the data quality checks taken at data submission, there are data quality checks and validation rules used in the production of this report. The rate of completion for report items range from 100% to 97%. Where items are under 100% this implies it is either due to missing data for that item or conflicting information has been entered for the same individual.

Table 2.1.1 Data quality of NDTMS

Data quality measure	2014-15	2015-16	2016-17
Proportion of submitted records that were valid	100%	100%	100%
Proportion of records without errors or warnings	99.93%	99.95%	99.96%
Proportion of duplicate treatment episodes recorded at the same provider	0.17%	0.00%	0.00%
Proportion of overlapping treatment episodes recorded at the same provider	0.08%	0.04%	0.01%
Proportion of duplicate treatment interventions recorded at the same provider	0.11%	0.00%	0.00%

3. Characteristics of clients

NDTMS reported a total of 15,583 young people aged 9-17[9] in contact with specialist substance misuse treatment services from 1 April 2017 to 31 March 2018. This is a decrease of 5% (853 individuals) from 2016-17 (16,436 individuals). A comparison over the years is provided in section 6.

3.1 Age and gender of all young people in treatment

The age and gender of young people at their first point of contact with the treatment system in 2017-18 is reported in Table 3.1.1 and Figure 3.1.1. In 2017-18, two-thirds (66%) of young people in treatment were male, which is the same proportion as in 2016-17, but is higher than the proportion in the general population in England where 51% of 9-17 year old are male.[10]

About 1 in 4 (26%) young people in treatment were under the age of 15. Although the number of younger children under the age of 14 in treatment was comparatively lower than other age groups, it has increased by 6% from last year (1,342 in 2016-17 to 1,422 in 2017-18). The median age for both female and male was 15 years old. Only 43% of females were aged 16 or over compared to nearly half (49%) of males.

The 2016 Smoking, Drinking and Drug use among young people survey (SDD)[11] showed an increase in lifetime prevalence of drug use among 11 to 15 years olds in 2016. It is important to note that the findings from the 2016 SDD survey and what has been observed on NDTMS are not directly related due to the differences in the methodologies. However any substance use in this age group is a concern as they are likely to be at a greater risk of harm. Safeguarding should be a priority for these individuals and their wider needs should be addressed alongside their substance misuse.

[9] For age methodology please refer to the quality and Methodology information document at www.ndtms.net/resources/public/Quality-and-Methodology-NDTMS-2017-18.pdf

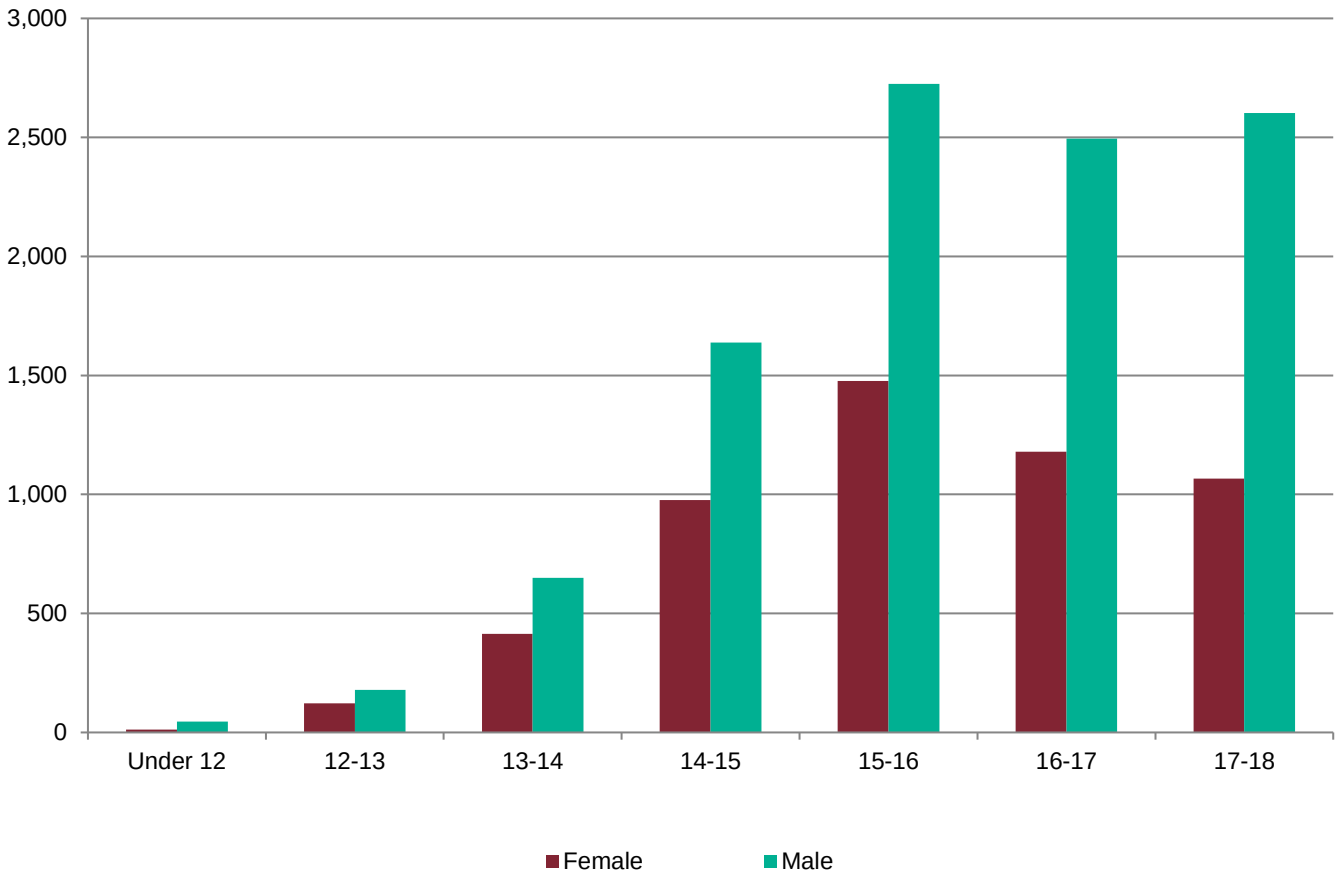
[10] Annual mid-year population estimates, 2017 www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/bulletins/annualmidyearpopulationestimates/mid2017

[11] Smoking, Drinking and Drug Use Among Young People in England – 2016 digital.nhs.uk/data-and-information/publications/statistical/smoking-drinking-and-drug-use-among-young-people-in-england/2016

Table 3.1.1 Age and gender of all young people in treatment 2017-18

Age	Female		Male		Total	
	n	%	n	%	n	%
Under 12	12	<1%	46	<1%	58	<1%
12-13	122	2%	179	2%	301	2%
13-14	414	8%	649	6%	1,063	7%
14-15	977	19%	1,638	16%	2,615	17%
15-16	1,477	28%	2,725	26%	4,202	27%
16-17	1,180	22%	2,495	24%	3,675	24%
17-18	1,067	20%	2,602	25%	3,669	24%
Total clients	**5,249**	**100%**	**10,334**	**100%**	**15,583**	**100%**

Figure 3.1.1 Age and gender distribution of all young people in treatment 2017-18



3.2 Ethnicity of all young people in treatment

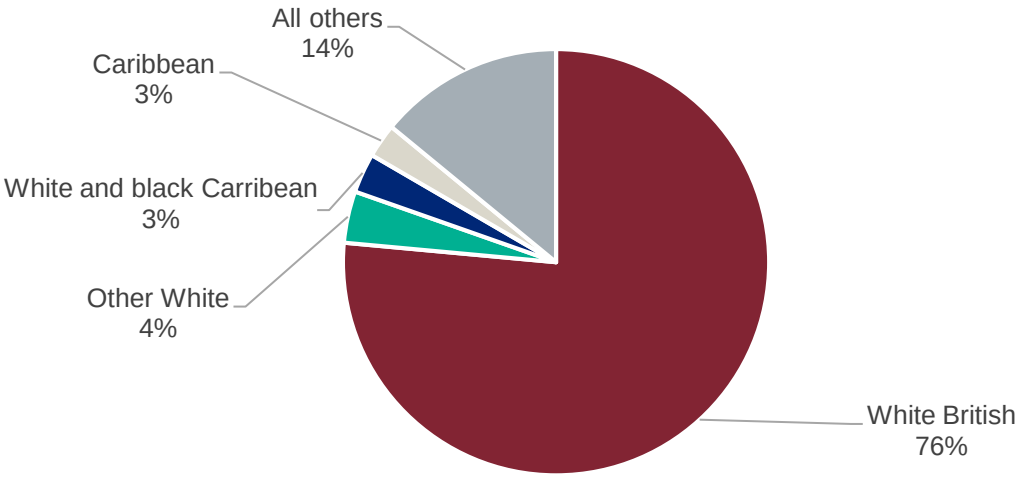
Table 3.2.1 and Figure 3.2.1 show the ethnicity of young people in treatment in 2017-18. Where reported, the majority of young people (76%) in treatment services were white British. This is similar to the general population, where 78% of young people aged 10 to 17 were white British according to the 2011 census.[12] For the remaining clients, 4% were other white and 3% were white and black Caribbean or Caribbean. No more than 2% reported any other ethnic group.

Table 3.2.1 Ethnicity of all young people in treatment 2017-18

Ethnicity	n	%
White British	11,848	76%
Other white	607	4%
White and black Caribbean	465	3%
Caribbean	398	3%
Other mixed	333	2%
African	256	2%
Not stated	240	2%
Other black	225	1%
Other	203	1%
Pakistani	190	1%
White and Asian	166	1%
Other Asian	142	1%
White and black African	125	1%
Bangladeshi	123	1%
Indian	93	1%
White Irish	75	<1%
Chinese	6	<1%
Total	**15,495**	**100%**
Missing or inconsistent data	88	
Total	**15,583**	

[12] 2011 Census - ONS
www.ons.gov.uk/census/2011census

Figure 3.2.1 Ethnicity all young people in treatment 2017-18



3.3 Substance use

The substance(s) cited by young people in specialist treatment in 2017-18 are reported in Table 3.3.1 and Figure 3.3.1 and are broken down by primary and adjunctive use. Primary substance use is the substance that brought the young person into treatment at the point of triage (initial assessment) and adjunctive substance use is any other substance(s) cited by the young person. If a young person was seen at more than 1 service provider or was in treatment multiple times within the year, only the substance(s) recorded in the latest treatment episode is (are) reported in this section. For further details of the methodology, see: www.ndtms.net/resources/public/Quality-and-Methodology-NDTMS-2017-18.pdf

The majority (88%) of young people reported cannabis as either a primary or adjunctive problematic substance in 2017-18, which was the same proportion as last year. The second most cited substance was alcohol (46%), which was slightly lower than the proportion reported in 2016-17 (49%). Ecstasy was cited by 14% of young people in 2017-18, which is an increase from 2016-17 (11%). The proportion who cited cocaine also increased slightly to 10% in 2017-18 (from 9% in 2016-17).

Benzodiazepines are reported separately from the 'other substances' category for the first time this year. There were 315 (2%) young people who needed help with problematic benzodiazepine use in 2017-18, which was almost double the number in 2016-17 (161). The proportion of young people reporting nicotine (adjunctive use only) as a problematic substance was the same as in 2016-17 (16%).

The proportion of young people citing new psychoactive substances (NPS) decreased from 4% in 2016-17 to 2% in 2017-18. The proportion of young people reporting amphetamines decreased from 3% in 2016-17 to 2% in 2017-18. The number of young people reporting crack increased from 83 in 2016-17 to 98 in 2017-18, accounting for

around 1% of those in treatment. Individuals citing heroin decreased from 98 in 2016-17 to 66 in 2017-18 while the number reporting other opiates, increased from 83 in 2016-17 to 120 in 2017-18.

The median age of young people in specialist services was 15 years, which is the same as last year. In 2016-17, the median age of young people in treatment for primary cannabis, alcohol, ecstasy and solvents use was 15 years and those in treatment for primary heroin and crack use had a higher median age of 17 years. More information on substance use by age is shown in Table 3.3.2 and the trends in presenting substances can be found in section 6.

Table 3.3.1 Substance use of all young people in treatment 2017-18

Substance	Primary		Adjunctive[1]		Total[1]		Primary
	n	%	n	%	n	%	median age
Cannabis	12,066	77%	1,647	11%	13,713	88%	15
Alcohol	2,265	15%	4,941	32%	7,206	46%	15
Ecstasy	454	3%	1,658	11%	2,112	14%	15
Cocaine	287	2%	1,208	8%	1,495	10%	16
Other[2]	105	1%	573	4%	678	4%	16
Solvents	102	1%	285	2%	387	2%	15
Benzodiazepines[3]	75	<1%	240	2%	315	2%	16
Amphetamines	39	<1%	232	1%	271	2%	16
New psychoactive substances	73	<1%	197	1%	270	2%	16
Other opiates[4]	37	<1%	83	1%	120	1%	16
Crack	31	<1%	67	<1%	98	1%	17
Heroin	39	<1%	27	<1%	66	<1%	17
Nicotine (adjunctive use only)	-	-	2,486	16%	-	-	-
Total	**15,573**						
Missing, misuse free or inconsistent data	10						
Total including missing	**15,583**						

[1] Adjunctive and the total percentages are out of all young people in treatment (15,583)

[2] '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.

[3] Benzodiazepine is reported separately from 'other' substances this year

[4] 'Other opiates' includes ethoheptazine, Oxycodone, Opium and Fentanyl.

Figure 3.3.1 Substance use of all young people in treatment 2017-18 (primary and adjunctive substances)

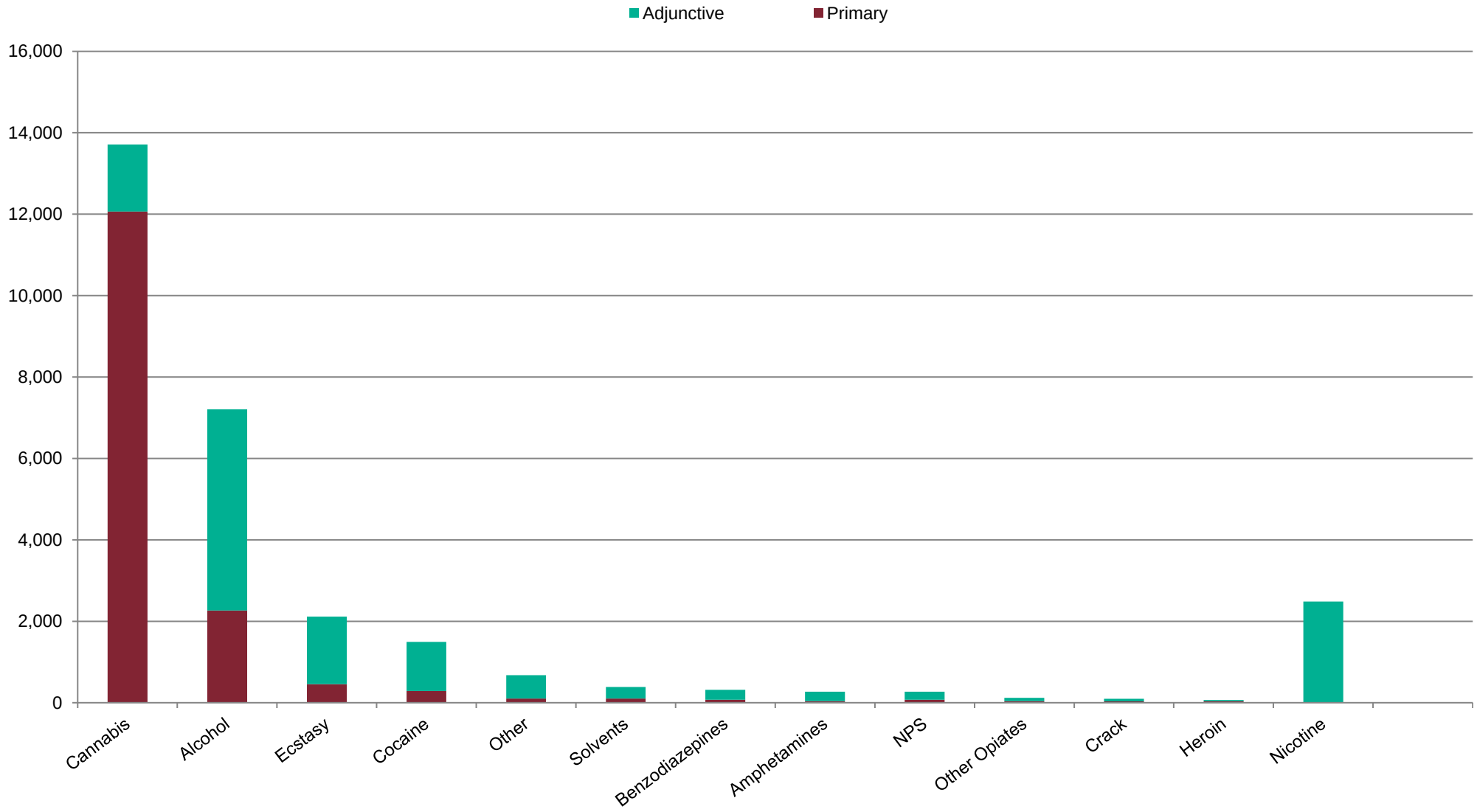


Table 3.3.2 Substance use (primary or adjunctive)[1] of all young people in treatment 2017-18 by age group

Substance	Under 13[2]		13-14		14-15		15-16		16-17		17-18	
	n	%	n	%	n	%	n	%	n	%	n	%
Cannabis	261	73%	874	82%	2,268	87%	3,790	90%	3,330	91%	3,190	87%
Alcohol	162	45%	468	44%	1,243	48%	1,939	46%	1,644	45%	1,750	48%
Ecstasy	22	6%	112	11%	334	13%	575	14%	547	15%	522	14%
Cocaine	9	3%	33	3%	135	5%	326	8%	410	11%	582	16%
Solvents	22	6%	35	3%	77	3%	118	3%	73	2%	62	2%
Benzodiazepines	*	-	5	<1%	45*	~2%	69	2%	86	2%	110	3%
Amphetamines	*	-	10*	~1%	24	1%	73	2%	75	2%	87	2%
New psychoactive substances	*	-	20*	~2%	38	1%	60	1%	68	2%	82	2%
Opiates[3]	0	0%	7	1%	19	1%	35	1%	58	2%	68	2%
Crack	0	0%	*	-	*	-	15	<1%	26	1%	52	1%
Total[4]	**359**		**1,063**		**2,615**		**4,202**		**3,675**		**3,669**	

[1] Primary and adjunctive use are combined in this table, therefore a young person may be counted more than once.
Refer to Table 3.3.1 for a breakdown of primary and adjunctive use.
[2] Due to very low numbers for some substances, young people under the age of 12 and those from 12 to 13 years old have been grouped together to 'under 13' years old.
[3] 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.
[4] Total in this table is the total number of individuals in the corresponding age group and not the sum of all instances in the column
* All numbers under 5 have been suppressed. Where these could be derived, the next age group figures have been rounded to the nearest 5 and marked with an asterisk.

3.4 Source of referral into treatment (for treatment episodes)

Figure 3.4.1 and Table 3.4.1 show the breakdown of treatment episodes in 2017-18 by the source of referral. The source of referral was provided for 16,837 (99.9%) episodes of treatment. An individual may have more than 1 treatment episode in the year and all episodes are counted. Therefore, the total number reported in this section is different from the total number of young people in treatment in 2017-18.

Education (31%) was the most common route into specialist treatment services, with mainstream education being the single largest source of referral accounting for over a quarter of all referrals (26%). The youth justice system was the second most common referral route (22%), although this has been declining as a proportion of referrals in recent years (39% in 2010-11). Youth offending teams (YOT) were the single largest source of referral (18%) within this category.

Referrals from social care services accounted for 16% of all recorded referrals in 2017-18. The proportion for this referral route has increased from 10% in 2012-13 (from 2,275 to 2,734). Children and family services referrals was the largest single referral source in this group and accounted for 14% of all referrals. Accident and emergency (A&E) referrals accounted for 1%, while referrals from child and adolescent mental health services (CAMHS) accounted for 5%. Referrals from A&E and CAMHS 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.[13] [14] [15]

[13] Future in mind, Promoting, protecting and improving our children and young people's mental health and wellbeing, DH, NHS England, 2015.
[14] www.gov.uk/guidance/child-and-maternal-health-data-and-intelligence-a-guide-for-health-professionals
[15] 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

Figure 3.4.1 Source of referral of all treatment episodes 2017-18

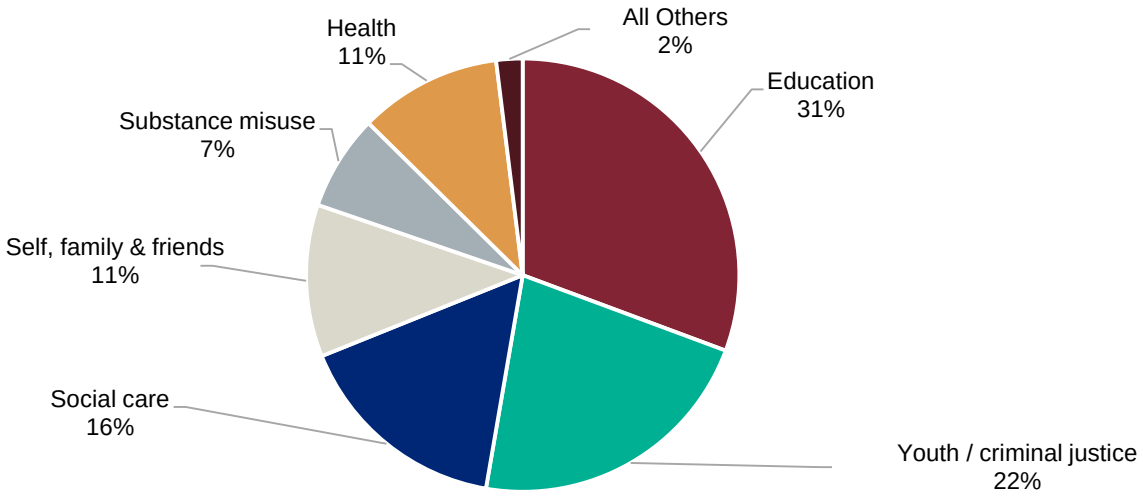


Table 3.4.1 Source of referral of all treatment episodes 2017-18

Referral Source	n	%
Mainstream education	4,432	26%
Alternative education	702	4%
Education service and other	44	<1%
Education total	**5,178**	**31%**
YOT	3,042	18%
YP secure estate	273	2%
Other	408	2%
Youth / criminal justice total	**3,723**	**22%**
Children and family services	2,425	14%
Looked after child services	293	2%
Social services	16	<1%
Social care total	**2,734**	**16%**
Self	938	6%
Relative, family, friend or concerned other	979	6%
Self, family & friends total	**1,917**	**11%**
Substance misuse total	**1,204**	**7%**
CAMHS	784	5%
School nurse	373	2%
A&E	251	1%
GP	182	1%
Hospital	134	1%
Other	73	<1%
Health total	**1,797**	**11%**
YP housing	259	2%
Other	25	<1%
Total (episodes)	**16,837**	
Missing or inconsistent data	48	
Total (episodes)	**16,885**	

3.5 Education and employment status of new presentations to treatment

Figure 3.5.1 and Table 3.5.1 show the education and employment status at presentation to treatment of new presentations. In 2017-18, 10,843 (98%) young people provided information about their education and employment status when they entered treatment. Of these, 57% were recorded as being in mainstream education (such as schools and further education colleges) and nearly a fifth (19%) in alternative education (such as schooling delivered in a pupil referral unit or home setting). A further 16% were recorded as not in employment, education or training (NEET). This profile was broadly similar to 2016-17.

Figure 3.5.1 Education and employment status of all young people starting treatment in 2017-18

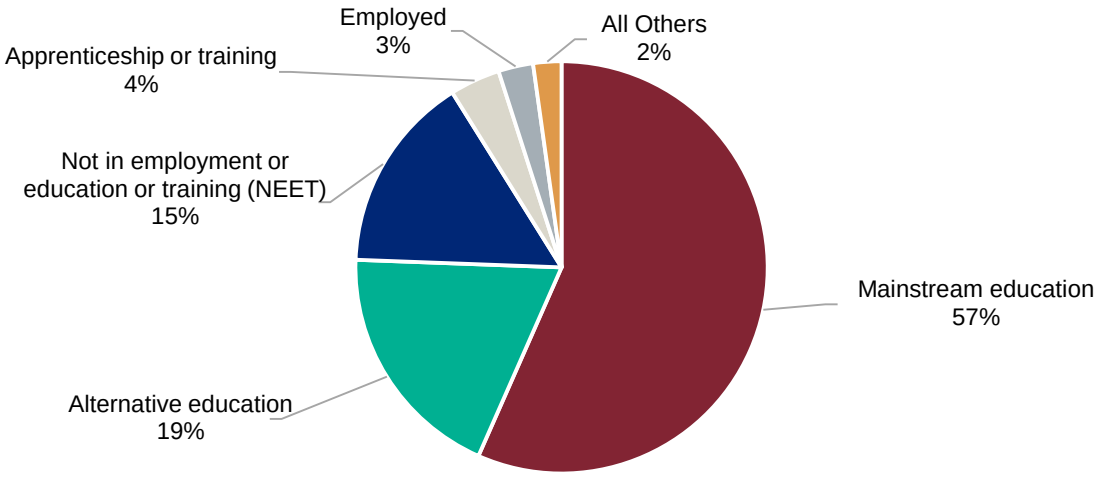


Table 3.5.1 Education and employment status of young people starting treatment in 2017-18

Education and employment status	n	%
Mainstream education	6,138	57%
Alternative education	2,058	19%
Not in employment or education or training (NEET)	1,683	16%
Apprenticeship or training	428	4%
Employed	296	3%
Persistent absentee or excluded	212	2%
Economically inactive – health issue or caring role	17	<1%
Voluntary work	11	<1%
Total	**10,843**	
Missing or inconsistent data	209	
Total new presentations	**11,052**	

3.6 Accommodation status

Table 3.6.1 shows the housing situation at treatment entry of young people in treatment. This was recorded for 15,355 (99%) young people in treatment in 2017-18.

The majority of young people in treatment who reported their accommodation status (85%) were living with their parents or other relatives, while a further 3% reported living independently in settled accommodation. Seven per cent of young people stated that they were living in care, with less than 1% living in secure care (accommodation within any secure setting where a young person has been placed). The proportions were broadly similar to 2016-17.

Table 3.6.1 Accommodation status of all young people in treatment 2017-18

Accommodation status	n	%
Living with parents or other relatives	13,107	85%
YP living in care	1,093	7%
YP supported housing	551	4%
Independent – settled accommodation / no housing problem	389	3%
Independent – unsettled accommodation / housing problem	127	1%
Independent – no fixed abode	45	<1%
YP living in secure care	43	<1%
Total	**15,355**	
Missing or inconsistent data	228	
Total	**15,583**	

3.7 Vulnerabilities

Young people often enter specialist substance misuse services with a range of problems or vulnerabilities relating to or in addition to their substance use, such as using multiple substances, having mental health treatment need, being a 'looked after child' or having a NEET status. Apart from these vulnerabilities, other wider risk factors can also impact on their substance use (such as self-harming behaviour, sexual exploitation, offending or domestic abuse).

The NDTMS collects information on 17 vulnerability factors and the details of these items are shown in Table 3.7.1. These are the range of risk factors that are most likely to be associated with problematic substance misuse among young people.

Table 3.7.1 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 2 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 1 occasion in the past 6 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 treatment need	The young person has indicated that they have a mental health treatment need
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 8 units (males) or 6 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)

Vulnerabilities are reported only for new clients entering specialist services during the year and therefore the total number of clients in this section (11,052) is lower than the total number of young people in treatment in 2017-18. An individual young person may report multiple vulnerabilities and therefore the percentages in this table may sum to more than 100%. Table 3.7.2 shows the vulnerabilities reported by young people entering treatment in 2017-18.

Similar to last year, the most commonly reported vulnerability was early onset of substance misuse, with 77% reporting use of their primary substance under the age of 15. This was a 7% decrease compared to last year, where 84% reported this. The second most commonly reported vulnerability factor was poly substance use, a

common term for using more than 1 substance (57%). Approximately one-third of young people entering treatment since April 2017 (32%) reported involvement in antisocial behaviour or criminal activity. This was similar to the proportion in 2016-17 (32%). Twenty-seven per cent (27%) indicated that they had a mental health treatment need.

Over one-fifth of young people (22%) reported that they were affected by others' substance misuse and 19% were affected by domestic abuse. The least commonly reported vulnerability was injecting (1%). Females presenting to treatment services were likely to cite a different range of vulnerabilities compared to males. Females were more likely to report increased instances of self-harm, sexual exploitation (see section 3.8), mental health treatment need (see section 3.9) or domestic abuse, while males were more likely to report antisocial behaviour (38% of males compared to 20% of females).

Table 3.7.2 Individual vulnerabilities identified among young people starting treatment in 2017-18

Vulnerability	Female		Male		Total	
	n	%	n	%	n	%
Early onset of substance misuse	2,903	80%	5,651	76%	8,554	77%
Poly drug user	2,327	64%	3,994	54%	6,321	57%
Antisocial behaviour	721	20%	2,797	38%	3,518	32%
Mental health treatment need	1,339	37%	1,615	22%	2,954	27%
Affected by others' substance misuse	994	27%	1,424	19%	2,418	22%
Affected by domestic abuse	913	25%	1,175	16%	2,088	19%
NEET	458	13%	1,296	17%	1,754	16%
Self-harm	999	28%	595	8%	1,594	14%
Looked after child	455	13%	749	10%	1,204	11%
Child in need	400	11%	557	8%	957	9%
Child Protection Plan	389	11%	440	6%	829	8%
Sexual exploitation	470	13%	92	1%	562	5%
High risk alcohol user	184	5%	120	2%	304	3%
Opiate and/or crack use	90	2%	151	2%	241	2%
Pregnant and/or parent	94	3%	126	2%	220	2%
Housing problem	70	2%	72	1%	142	1%
Injecting	37	1%	41	1%	78	1%
Total new presentations	**3,627**		**7,425**		**11,052**	

The number of vulnerabilities reported by young people in 2017-18 is reported in Table 3.7.3. Individuals with substance misuse problems are more likely to experience other

social exclusion problems such as poor health, crime, unemployment and community deprivation.[16]

The majority (96%) of young people entering treatment in 2017-18 reported at least 1 vulnerability item. In 2017-18, there was a reduction in the proportion of young people reporting 2 or more vulnerability factors compared to 2016-17 (80% in 2016-17 and 79% in 2017-18). Thirty-five per cent of young people reported 4 or more vulnerabilities, 44% cited 2 or 3, 17% reported 1 item and only 4 % reported no vulnerabilities in 2017-18. These proportions were broadly similar to 2016-17.

Table 3.7.3 Number of vulnerabilities reported by young people starting treatment in 2017-18

Number of vulnerabilities reported (of total of seventeen)	n	%
Zero	441	4%
One	1,896	17%
Two	2,640	24%
Three	2,170	20%
Four or more	3,905	35%
Total new presentations	**11,052**	**100%**

3.8 Sexual exploitation

Child sexual exploitation (CSE) is a form of child sexual abuse.[17] It occurs when an individual or group takes advantage of an imbalance of power to coerce, manipulate or deceive a child or young person under the age of 18 into sexual activity in exchange for something the victim needs or wants and/or for the financial advantage or increased status of the perpetrator or facilitator.

The victim may have been sexually exploited even if the sexual activity appears consensual. Child sexual exploitation does not always involve physical contact; it can also occur through the use of technology. Department for Education have produced guidance around CSE, including this definition, which can be found at: assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/591903/CSE_Guidance_Core_Document_13.02.2017.pdf

CSE has important health and wellbeing implications for children and young people and a number of reports have highlighted that substance misuse could be an indicator of

[16] 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.
[17] Child sexual exploitation: definition and guide for practitioners: www.gov.uk/government/publications/child-sexual-exploitation-definition-and-guide-for-practitioners

child sexual exploitation and abuse. Young people's substance misuse services need to ensure that they are responding appropriately. PHE has published guidance on how public health can support prevention and intervention. The guidance can be accessible at:
www.gov.uk/government/uploads/system/uploads/attachment_data/file/629315/PHE_child_exploitation_report.pdf

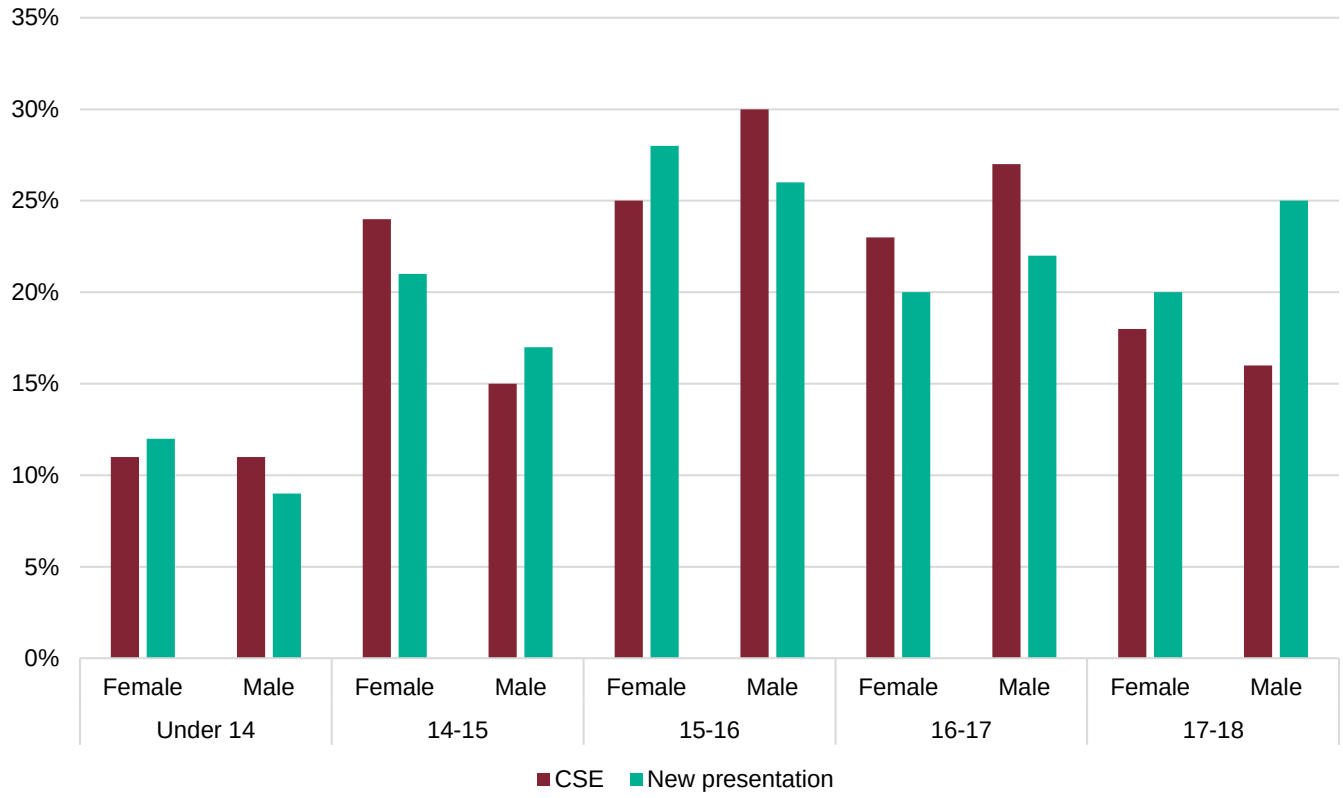
The age and gender breakdown of young people reporting CSE compared with all new presentations is shown in Table 3.8.1 and Figure 3.8.1. There were 562 individuals who reported CSE in 2017-18 compared to 688 in 2016-17. There was a higher proportion of females starting treatment in 2017-18 who reported CSE than males (13% and 1%, respectively). It is important to note that identifying CSE in boys and young men may be difficult as they are less likely to disclose abuse[18] and the rate of CSE, particularly in males, may be higher than reported. Females who report CSE were more likely to be under the age of 15 (35%) compared to males (26%). The majority of males who reported CSE were aged 15 (30%) and one-quarter (25%) of females in the same age group reported CSE.

Table 3.8.1 Age and gender breakdown of young people starting treatment in 2017-18 who reported sexual exploitation

Age	Sexual exploitation				Total new presentations			
	Female		Male		Female		Male	
	n	%	n	%	n	%	n	%
Under 14	51	11%	10	11%	433	12%	687	9%
14-15	112	24%	14	15%	745	21%	1,274	17%
15-16	117	25%	28	30%	1,010	28%	1,924	26%
16-17	107	23%	25	27%	723	20%	1,667	22%
17-18	83	18%	15	16%	716	20%	1,873	25%
Total new presentations	**470**	**100%**	**92**	**100%**	**3,627**	**100%**	**7,425**	**100%**

[18] 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.

Figure 3.8.1 Gender breakdown of young people starting treatment in 2017-18 who reported sexual exploitation



3.9 Mental health treatment need

Table 3.9.1 shows the gender breakdown of young people who started treatment in 2017-18 and reported a mental health treatment need and the type(s) of treatment they received for their mental health needs.

In 2017-18, a total of 2,954 (27%) young people reported a mental health treatment need at treatment start. The proportion of females who started treatment in the year with a mental health treatment need was higher than males (37% compared to 22%). The majority (70%) of young people with a mental health treatment need received some form of treatment for their treatment need(s). Over half (57%) of young people with a mental health treatment need were engaged in treatment with community mental health teams or other mental health services and 9% were in mental health treatment with their GP.

Table 3.9.1 Mental health treatment need in 2017-18

Mental health treatment need	Female		Male		Total	
	n	%	n	%	n	%
Engaged with community mental health team or other mental health services	764	59%	884	56%	1,648	57%
Mental health treatment from GP	114	9%	138	9%	252	9%
NICE recommended mental health treatment	35	3%	35	2%	70	2%
Engaged with Improving Access to Psychological Therapies (IAPT)	10	1%	18	1%	28	1%
Identified space in a health based place of safety for mental health crises	8	1%	17	1%	25	1%
Total individuals receiving any form of mental health treatment	931	72%	1,092	69%	2,023	70%
Mental health treatment need identified but no treatment received	367	28%	484	31%	851	30%
Total	**1,298**	**100%**	**1,576**	**100%**	**2,874**	**100%**
Missing	41		39		80	
Total individuals with mental health treatment need	**1,339**	**37%**	**1,615**	**22%**	**2,954**	**27%**
Total new presentations	**3,627**		**7,425**		**11,052**	

4. Access to services

4.1 Waiting times for first and subsequent treatment interventions

The time between being first identified as having a treatment need and being offered an appointment to start treatment intervention is known as the waiting time for an intervention. Table 4.1.1 reports the breakdown of waiting times up to and over 3 weeks by first and subsequent interventions, i.e. where a client who is already receiving an intervention is referred on to start another type of treatment. Overall, nearly all young people (97%) waited no more than 3 weeks from first being identified as having a treatment need to being offered an appointment to start an intervention and 77% of first interventions started on the day the young people were referred. There were 983 subsequent interventions of which 955 (97%) waited no more than 3 weeks. The average (mean) waiting time to commence treatment (first intervention only) was about 2 and a half days.

Table 4.1.1 Waiting times: first and subsequent interventions 2017-18

Intervention	3 weeks or under		Over 3 weeks		Total	
	n	%	n	%	n	%
First Intervention	15,907	97%	423	3%	16,330	100%
Subsequent Intervention	955	97%	28	3%	983	100%
Total Interventions	**16,862**		**451**		**17,313**	

4.2 Treatment interventions

When young people spend time in treatment, they can undergo 1 or more types of treatment, known as interventions, and may attend more than 1 service for subsequent interventions. For instance, the young person might receive a one-to-one intervention, such as motivational interviewing, in addition to a family intervention.

From 1 November 2013, there was a change to the way NDTMS records these interventions. There are now 3 high-level structured intervention types (psychological, specialist harm reduction and pharmacological). To each high-level intervention, an intervention setting is recorded.

The intervention types received by young people in contact with structured treatment is shown in Tables 4.2.1 and 4.2.2. Table 4.2.1 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. Section 7.2 of this report contains more detail on this change. Individuals are counted once for each type of intervention they received.

Table 4.2.2 provides information on interventions that commenced after the changes to the core dataset on 1 November 2013. If an individual's intervention can be directly mapped to the current method of reporting, it is shown in Table 4.2.2 and is removed from Table 4.2.1 above to avoid double counting.

Overall, psychosocial interventions are the most common form of treatment with 93% of the total number of young people receiving them (14,308). Psychosocial interventions (also known as 'talking therapies') use psychological, psychotherapeutic and counselling skills to encourage change. Structured harm reduction interventions, on the other hand, include support to manage risky behaviour associated with substance misuse, such as overdose and accidental injury through substance misuse. In 2017-18, there were 9,612 (63%) young people receiving these interventions and 8,548 (55%) young people received both psychosocial and harm reduction interventions only. Only 71 (less than 1%) young people received a pharmacological intervention in 2017-18. These interventions 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 opiates.

Table 4.2.1 Interventions received by young people in treatment in 2017-18 (pre-November 2013 dataset change interventions)

Intervention	n
Inpatient detoxification	0
Other YP intervention	14

Table 4.2.2 Interventions received by young people in treatment 2017-18 (post November 2013 dataset change interventions)

Setting	Intervention type			Total individuals with this setting[1]	Percentage of total individuals with this setting
	Psychosocial (n)	Harm reduction (n)	Pharmacological (n)		
Community	13,906	9,254	62	**14,904**	**97%**
Home	423	358	6	**488**	**3%**
YP Residential unit	29	17	*	**36**	**<1%**
Adult setting	5	0	5	**5**	**<1%**
YP Inpatient unit	8	*	0	**8**	**<1%**
No setting recorded	0	0	0	**0**	**-**
Total individuals[2]	**14,308**	**9,612**	**71**	**15,340**	**100%**
% of total individuals with this intervention	**93%**	**63%**	**<1%**		

[1] This is the total number of individuals receiving at least 1 intervention type in each setting and not a summation of the rows.
[2] This is the total number of individuals receiving each type of intervention and not a summation of the columns.
* All numbers under 5 have been suppressed. Where totals could be derived, figures have been rounded to the nearest 5 and marked with an asterisk.

4.3 Length of latest treatment episode

In 2017-18, there were 11,543 (75%) young people whose most recent episodes lasted for 26 weeks or less. Only 7% (1,053) of individuals were in treatment for longer than a year, which is the same proportion as in 2016-17. The average (mean) time was at least 5 (4.9) months. The results are shown in Table 4.3.1 below.

Table 4.3.1 Length of latest episode 2017-18

Episode length	n	%
0 (zero) to 12 weeks	6,658	43%
13 to 26 weeks	4,885	32%
27 to 52 weeks	2,745	18%
Longer than 52 weeks	1,053	7%
Total	**15,341**	**100%**

5. Treatment exits

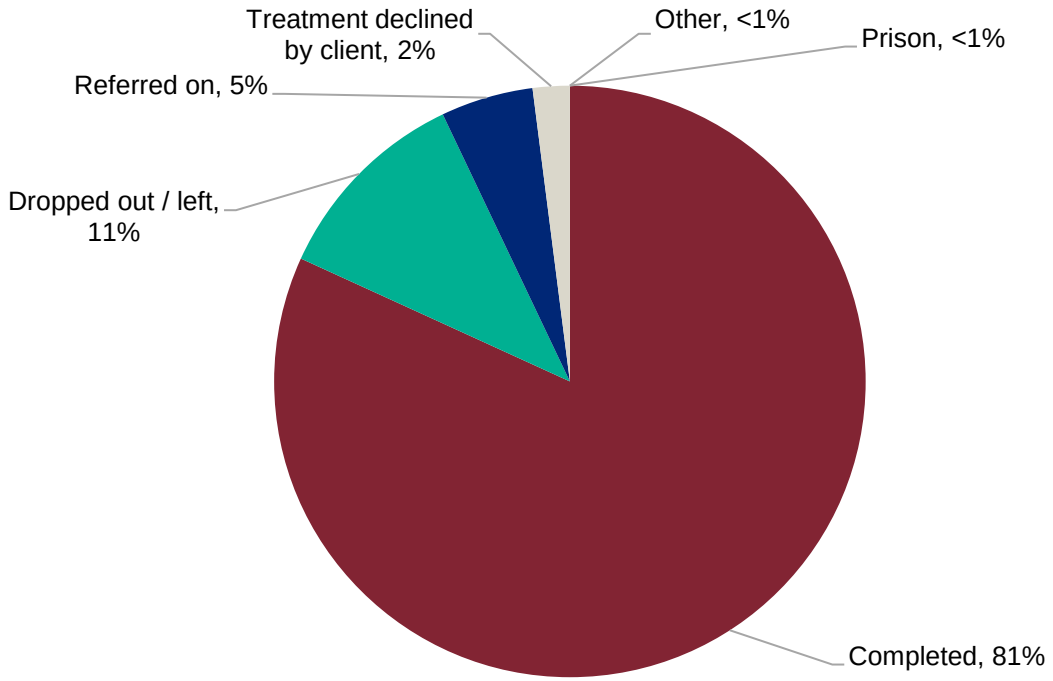
5.1 Treatment exits

The exit reasons for young people no longer in treatment at 31 March 2018 are reported in Table 5.1.1 and Figure 5.1.1. In 2017-18, 10,537 young people exited treatment, 68% of the total number of young people in treatment for the year (15,583). There were 8,511 (81%) young people exiting treatment in a planned way after completing specialist treatment and 1,206 (11%) leaving treatment in an unplanned way. This profile is roughly similar to 2016-17.

Table 5.1.1 Treatment exit reasons of all young people exiting treatment 2017-18

Treatment exit reason	n	%
Completed	8,511	81%
Dropped out / left	1,206	11%
Referred on	559	5%
Treatment declined by client	196	2%
Other	41	<1%
Prison	24	<1%
Total	**10,537**	

Figure 5.1.1 Treatment exit reasons of all young people exiting treatment 2017-18



6. Trends over time

6.1 Trends in age and numbers in treatment

The number of young people attending specialist substance misuse services has fallen year-on-year, and has reduced by 35% when compared to 2008/09 (15,583 in 2017-18 and 24,053 in 2008/09). This year, the number of young people attending services decreased by 5% from the previous year (16,436 in 2016-17 compared to 15,583 in 2017-18). The numbers of young people in treatment from 2005-06 for each age group is shown in Figure 6.1.1 and Table 6.1.1.

Despite an overall decrease in the number of young people in treatment since 2008-09, there was an increase in the younger age groups. There were 3,952 clients under the age of 15 in treatment in 2016-17 and this increased in 2017-18 to 4,037. The proportion of clients in the 14-15 age group increased from 14% in 2014-15 to 17% in 2017-18.

Figure 6.1.1 Number of young people in treatment by age group (2005-06 to 2017-18)

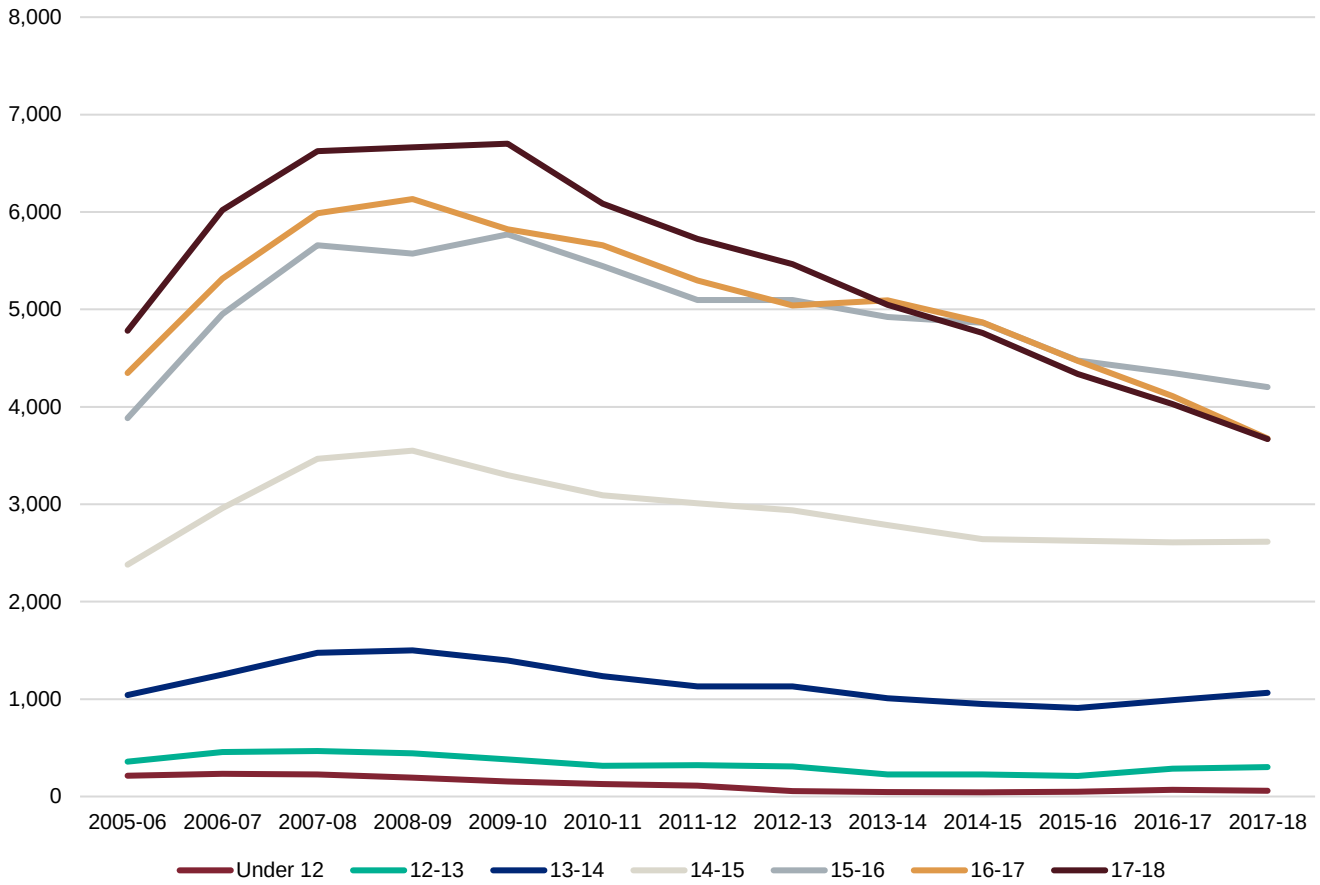


Table 6.1.1 Number of young people in treatment by age group (2005-06 to 2017-18)

Age	2005-06		2006-07		2007-08		2008-09		2009-10		2010-11		2011-12	
	n	%	n	%	n	%	n	%	n	%	n	%	n	%
Under 12	212	1%	233	1%	227	1%	193	1%	155*	1%	128	1%	110	1%
12-13	358	2%	457	2%	467	2%	442	2%	380*	2%	315	1%	323	2%
13-14	1,040	6%	1,253	6%	1,476	6%	1500*	6%	1,396	6%	1,234	6%	1,129	5%
14-15	2,380	14%	2,961	14%	3,466	14%	3550*	15%	3,300*	14%	3,092	14%	3,009	15%
15-16	3,884	23%	4,953	23%	5,658	24%	5,574	23%	5,770	25%	5,445	25%	5,097	25%
16-17	4,347	26%	5,315	25%	5,987	25%	6,133	25%	5,823	25%	5,657	26%	5,297	26%
17-18	4,780	28%	6,019	28%	6,624	28%	6,663	28%	6,701	28%	6,084	28%	5,723	28%
Total	**17,001**	**100%**	**21,191**	**100%**	**23,905**	**100%**	**24,053**	**100%**	**23,528**	**100%**	**21,955**	**100%**	**20,688**	**100%**

Age	2012-13		2013-14		2014-15		2015-16		2016-17		2017-18	
	n	%	n	%	n	%	n	%	n	%	n	%
Under 12	56	<1%	46	<1%	43	<1%	48	<1%	68	<1%	58	<1%
12-13	310	2%	227	1%	225	1%	211	1%	284	2%	301	2%
13-14	1,130	6%	1,008	5%	951	5%	909	5%	990	6%	1,063	7%
14-15	2,936	15%	2,785	15%	2,643	14%	2,624	15%	2,610	16%	2,615	17%
15-16	5,097	25%	4,922	26%	4,862	26%	4,476	26%	4,346	26%	4,202	27%
16-17	5,040	25%	5,092	27%	4,866	27%	4,472	26%	4,109	25%	3,675	24%
17-18	5,463	27%	5,046	26%	4,759	26%	4,337	25%	4,029	25%	3,669	24%
Total	**20,032**	**100%**	**19,126**	**100%**	**18,349**	**100%**	**17,077**	**100%**	**16,436**	**100%**	**15,583**	**100%**

* All numbers under 5 have been suppressed. Where totals could be derived, figures have been rounded to the nearest 5 and marked with an asterisk.

6.2 Trends in primary substance misuse

The primary substance reported by young people for each year from 2005-06 to 2017-18 is shown in Figure 6.2.1 and Table 6.2.1. Cannabis remained the most common drug by far that young people came to treatment for. The majority (88%) of young people in specialist services said they had a problem with this drug. The proportion of young people in treatment saying that cannabis is their main problem substance has been on an upward trend since 2007-08. Although total numbers have decreased slightly in recent years, the proportion of young people in treatment who have cannabis problems has remained stable in the last 2 years at 77%. Findings from the 2017-18 Crime Survey for England and Wales show that cannabis use and prevalence is more likely to be common in the late teens/early 20s among young peoples.[19]

The number of young people receiving help for alcohol problems continues to steadily decline from the peak in 2008-09 when 16,047 were treated for alcohol. The number of young people reporting a primary substance misuse of opiates has also fallen each year since 2005-06 to 76 young people in 2017-18.

Benzodiazepine treatment is reported for the first time in this report. Young people who had problems with benzodiazepines at the start of treatment almost doubled from the previous year (161 in 2016-17 and 315 in 2017-18). Alprazolam (most commonly called Xanax) was the benzodiazepine which saw the biggest increase, (8 in 2016-17 to 53 in 2017-18).

Figure 6.2.1 shows the trend in cannabis and alcohol misuse among young people over the years since 2005-06. Section 6.3 explores trends in drug use other than cannabis and alcohol in more detail, including adjunctive use.

[19] Drug misuse: findings from the 2017/18 Crime Survey for England and Wales. Home Office 2018: www.gov.uk/government/statistics/drug-misuse-findings-from-the-2017-to-2018-csew

Figure 6.2.1 Number of young people in treatment by primary substance (2005-06 to 2017-18)

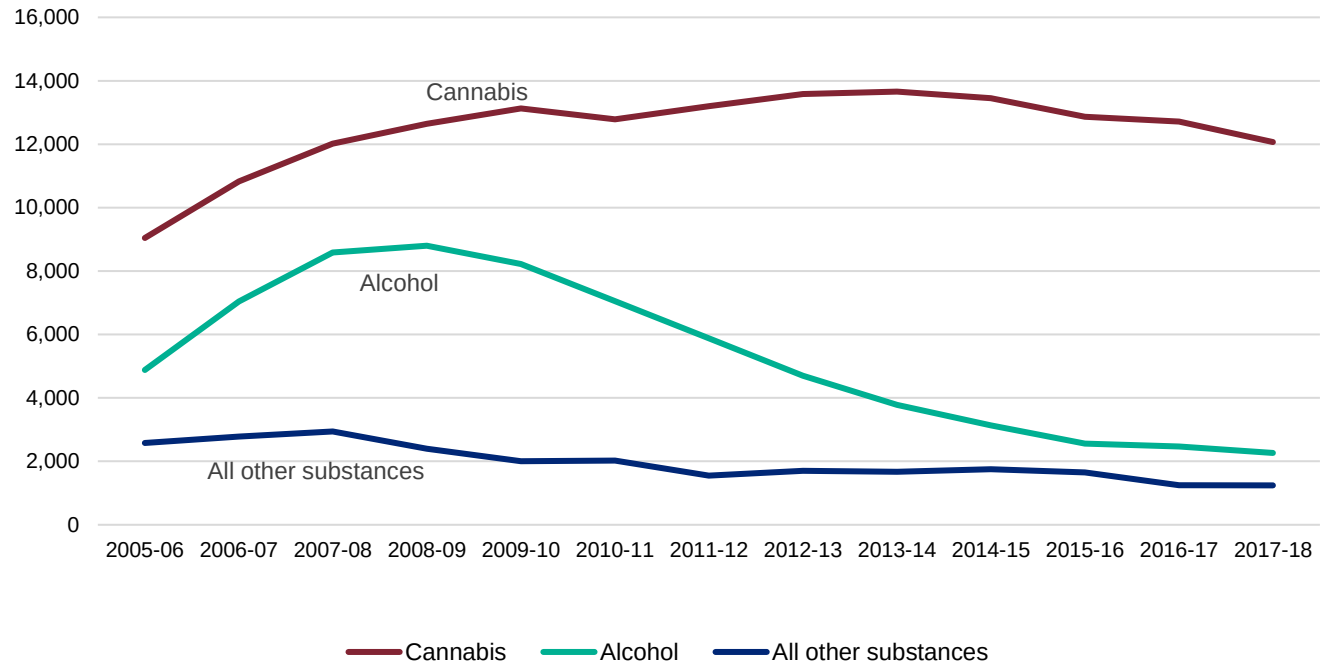


Table 6.2.1 Number of young people in treatment by primary substance (2005-06 to 2017-18)

Substance[1]	2005-06		2006-07		2007-08		2008-09		2009-10		2010-11		2011-12	
	n	%	n	%	n	%	n	%	n	%	n	%	n	%
Opiates	881	5%	755	4%	651	3%	547	2%	480*	2%	320*	1%	211	1%
Amphetamines	332	2%	323	2%	346	1%	230*	1%	256	1%	639	3%	493	2%
Cocaine	453	3%	655	3%	806	3%	745*	3%	457	2%	350*	2%	301	1%
Crack	200	1%	137	1%	155	1%	110	<1%	50*	<1%	35*	<1%	40	<1%
Ecstasy	325	2%	432	2%	438	2%	210*	1%	90*	<1%	65*	<1%	79	<1%
Cannabis	9,043	55%	10,824	52%	12,021	51%	12,642	53%	13,123	56%	12,784	58%	13,200	64%
Solvents	210	1%	301	1%	305	1%	284	1%	274	1%	263	1%	236	1%
Alcohol	4,886	30%	7,039	34%	8,589	36%	8,799	37%	8,227	35%	7,054	32%	5,884	29%
NPS	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Benzodiazepines[1]	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Other[2]	174	1%	183	1%	241	1%	270*	1%	399	2%	349	2%	189	1%

Substance[1]	2012-13		2013-14		2014-15		2015-16		2016-17		2017-18	
	n	%	n	%	n	%	n	%	n	%	n	%
Opiates	175*	1%	160*	1%	134	1%	112	1%	94	1%	76	<1%
Amphetamines	755*	4%	591	3%	540*	3%	317	2%	71	<1%	39	<1%
Cocaine	245*	1%	254	1%	250*	1%	251	1%	254	2%	287	2%
Crack	27	<1%	14	<1%	24	<1%	21	<1%	16	<1%	31	<1%
Ecstasy	130*	1%	124	1%	165*	1%	261	2%	340	2%	454	3%
Cannabis	13,581	68%	13,659	71%	13,454	73%	12,863	75%	12,712	77%	12,066	77%
Solvents	163	1%	134	1%	135	1%	121	1%	128	1%	102	1%
Alcohol	4,704	24%	3,776	20%	3,133	17%	2,556	15%	2,465	15%	2,265	15%
NPS	-	-	120*	1%	334	2%	420	2%	213	1%	73	<1%
Benzodiazepines[2]	-	-	-	-	-	-	-	-	-	-	75	<1%
Other[3]	210*	1%	271	1%	165*	1%	148	1%	133	1%	105	1%

* All numbers under 5 have been suppressed. Where totals could be derived, figures have been rounded to the nearest 5 and marked with an asterisk.

[1] Clients with missing primary substance or misuse free are not included in the breakdown and percentage calculations

[2] Benzodiazepines have been reported separately from the 'Other' category for the first time in 2017-18.

[3] 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.

6.3 Trends in other drug use (not cannabis or alcohol)

Figure 6.3.1 and Table 6.3.1 report the total number of young people reporting substances other than cannabis and alcohol, and include both primary and adjunctive substance use. Figures were not recorded for adjunctive drug use prior to 2007-08. A breakdown of new psychoactive substances (NPS) based on their predominant effect is shown in Table 6.3.1 but is excluded from Figure 6.3.1 due to low numbers.

Excluding cannabis and alcohol, ecstasy was the most cited substance in 2017-18. The number of young people entering treatment for problems with ecstasy in 2017-18 increased by 16% from the previous year (1,815 to 2,112) and has almost doubled since 2013-14. The increase in ecstasy treatment numbers was seen across all age groups.

Young people entering treatment for problems with new psychoactive substances (NPS) more than halved since the previous year (585 in 2016-17 and 270 in 2017-18) and is 74% lower than 2015-16 when 1,056 reported problematic use. Similar falls were seen in adults starting treatment over the same period, particularly in those under 25.[20] 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 fifth year using a series of new drug codes describing NPS according to their predominant effect. The full breakdown of young people in treatment citing other drug use, including NPS use is shown in Table 6.3.1.

The number of young people citing amphetamine use decreased by 45% between 2016-17 and 2017-18 to 271 individuals. Solvent use also continued to decrease slightly, from 430 clients in 2016-17 to 387 in 2016-17 with the proportion of clients being roughly similar in both years (3% in 2016-17 and 2.5% in 2017-18).

[20] Adult substance misuse statistics from the National Drug Treatment Monitoring System (NDTMS) 2017-18: www.gov.uk/government/statistics/substance-misuse-treatment-for-adults-statistics-2017-to-2018

Figure 6.3.1 Trends in numbers in treatment for other drug use, excluding cannabis and alcohol (2007-08 to 2017-18)

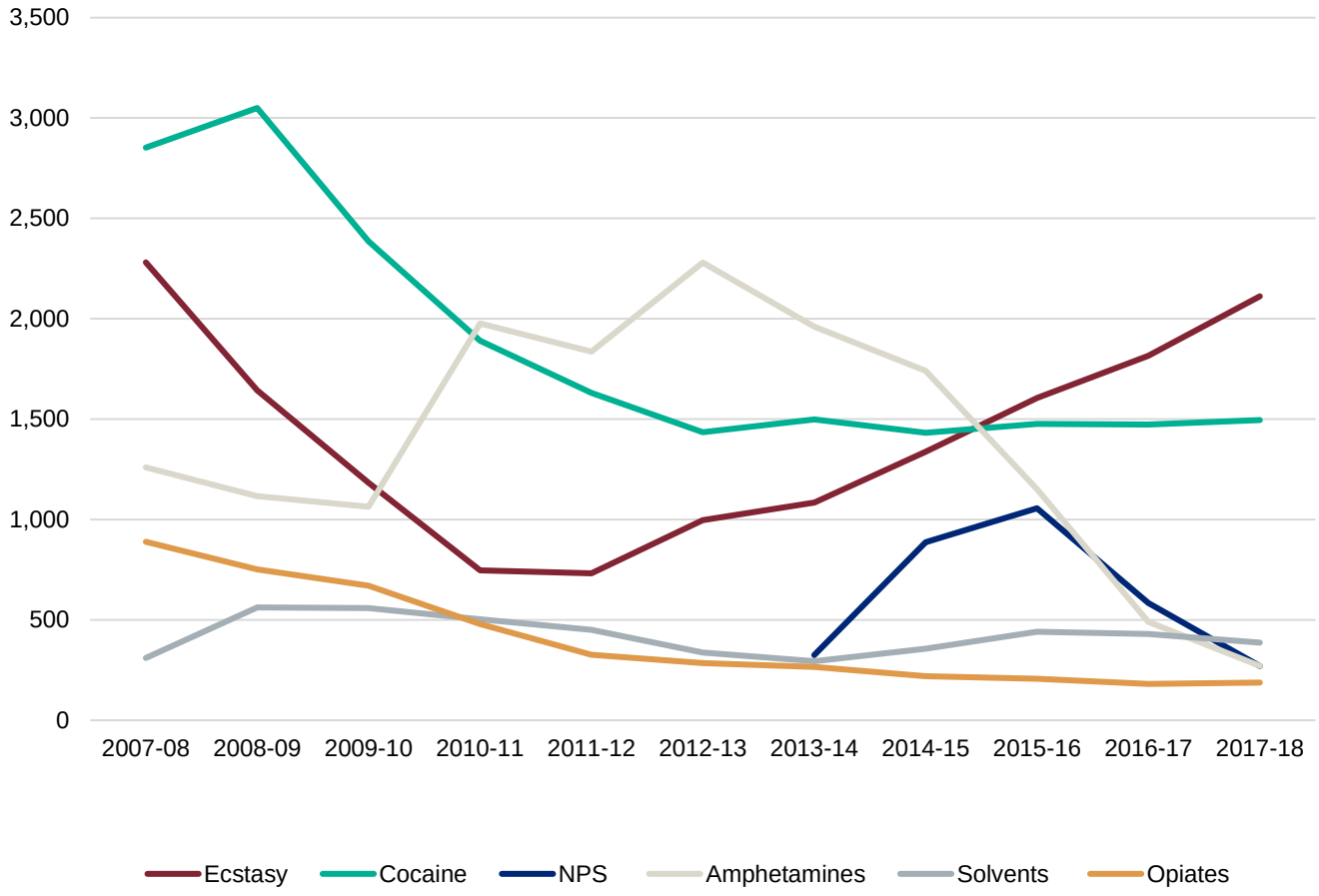


Table 6.3.1 Trends in numbers in treatment for other drug use, excluding cannabis and alcohol (2007-08 to 2017-18)[1]

Substance	2007-08	2008-09	2009-10	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18
Ecstasy	2,281	1,644	1,183	746	732	997	1,084	1,338	1,605	1,815	2,112
Cocaine	2,852	3,050	2,386	1,890*	1,630*	1,435*	1,499*	1,432	1,477	1,473	1,495
NPS (any) [2]	-	-	-	-	-	-	324	887	1,056	585	270
NPS - Predominantly stimulant [2]	-	-	-	-	-	-	60	154	121	50	33
NPS - Predominantly hallucinogenic [2]	-	-	-	-	-	-	29	46	37	18	14
NPS - Predominantly dissociative [2]	-	-	-	-	-	-	*	5	32	20	13
NPS - Predominantly sedative/opioid [2]	-	-	-	-	-	-	*	9	13	*	*
NPS - Predominantly cannabinoid [2]	-	-	-	-	-	-	203	557	695	407	168
NPS – other [2]	-	-	-	-	-	-	39	139	175	91	43
Amphetamines	1,259	1,116	1,063	1,977	1,836	2,280*	1,961*	1,740*	1,152	491	271
Solvents	310*	562	559*	503	451	338*	294*	357	441	430	387
Opiates	889	751	670	479	326	285	265	220	206	181	187

[1] Primary and adjunctive use are combined in this table, therefore a young person may be counted more than once in this table.

[2] 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 1 NPS drug and therefore the sum of individual NPS drugs may exceed the total number of clients reported for NPS (any).

* All numbers under 5 have been suppressed. Where totals could be derived, figures have been rounded to the nearest 5 and marked with an asterisk.

6.4 Trends in treatment exit reasons

Table 6.4.1 shows treatment exit reasons for young people leaving treatment between 2005-06 and 2017-18. In 2009, a new discharge coding system was introduced that tightened the way 'treatment completed' was recorded. These changes mean it is not possible to directly compare treatment exit data from 2009-10 onwards with previous years. For further details, see: www.ndtms.net/resources/public/Quality-and-Methodology-NDTMS-2017-18.pdf

Almost 4 in 5 (81%) young people discharged from treatment had completed their treatment. This is similar to the previous year (82%). A further 11% dropped out of treatment. This proportion has remained unchanged since 2014-15. Those being transferred for further structured drug and/or alcohol treatment increased slightly from 4% in 2016-17 to 5% in 2017-18.

Table 6.4.1 Trends in treatment exit reasons (2005-06 to 2017-18)

Treatment exit reason	2005-06		2006-07		2007-08		2008-09		2009-10		2010-11		2011-12	
	n	%	n	%	n	%	n	%	n	%	n	%	n	%
Completed	4,105	48%	5,726	50%	8,073	57%	9,546	65%	10,160	69%	10,507	75%	10,118	77%
Referred on	572	7%	701	6%	938	7%	510	3%	856	6%	793	6%	841	6%
Dropped out / left	2,525	29%	2,902	25%	2,529	18%	2,253	15%	2,408	16%	1,851	13%	1,630	12%
Prison	200	2%	285	2%	339	2%	371	3%	183	1%	139	1%	97	1%
Treatment declined by client	*	0%	246	2%	703	5%	620*	4%	529	4%	440	3%	326	2%
Not known	102	1%	202	2%	98	1%	71	<1%	51	<1%	16	<1%	0	0%
Other	1,108	13%	1,448	13%	1,401	10%	1,250	9%	478	3%	260	2%	175	1%
Total	**8,615***	**100%**	**11510**	**100%**	**14081**	**100%**	**14,620***	**100%**	**14,665**	**100%**	**14,006**	**100%**	**13,187**	**100%**

Treatment exit reason	2012-13		2013-14		2014-15		2015-16		2016-17		2017-18	
	n	%	n	%	n	%	n	%	n	%	n	%
Completed	10,208	79%	9,852	79%	9,613	80%	8,929	80%	8,842	82%	8,511	81%
Referred on	760	6%	852	7%	773	6%	722	6%	469	4%	559	5%
Dropped out / left	1,530	12%	1,440	12%	1,345	11%	1,237	11%	1,178	11%	1,206	11%
Prison	66	1%	62	<1%	52	<1%	31	<1%	43	<1%	24	<1%
Treatment declined by client	278	2%	244	2%	236	2%	245	2%	197	2%	196	2%
Not known	0	0%	0	0%	0	0%	0	0%	0	0%	**	-
Other	105	1%	60	<1%	55	<1%	60	1%	105	1%	41	<1%
Total	**12,947**	**100%**	**12,510**	**100%**	**12,074**	**100%**	**11,224**	**100%**	**10,834**	**100%**	**10,537**	**100%**

* All numbers under 5 have been suppressed. Where totals could be derived, figures have been rounded to the nearest 5 and marked with an asterisk.
** Due to low numbers, the number of 'Not known' cases have been grouped under the 'Other' category in 2017-18.

7. History

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

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

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

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

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

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

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

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

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

7.1 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:
fingertips.phe.org.uk/profile/public-health-outcomes-framework/data#page/0/gid/1000042/pat/6/par/E12000002/ati/101/are/E07000029

National Drug Evidence Centre (NDEC):
research.bmh.manchester.ac.uk/epidemiology/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
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7.2 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 8 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 1 of 7 setting types:

- community
- home
- secure estate
- in-patient (substance misuse specific)

- in-patient (not substance misuse specific)
- residential (substance misuse specific)
- 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 the business definitions guide at: assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/689473/Young_peoples_treatment_business_definitions_core_dataset_N.pdf

Intervention types have been split in to 4 high-level categories:

- pharmacological interventions
- psychosocial interventions
- harm reduction interventions
- 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: www.gov.uk/government/publications/business-definitions-for-young-people-drug-and-alcohol-treatment-providers

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.

The 2 main changes in this year's report are that a new section on mental health treatment need (section 2.9) has been introduced and benzodiazepines has been separated from the other substance group.

7.3 Drug treatment collection and reporting timeline

1989 to March 2001 Regional Drug Misuse Database (RDMD) – statistics reported in 6 monthly bulletins by DH from 1993 to 2001: webarchive.nationalarchives.gov.uk/20120907233254/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 to March 2013 NDTMS - managed by the National Treatment Agency (NTA) reporting statistics annually up to March 2012.

April 2013 to date NDTMS - managed by Public Health England (PHE) reporting statistics annually from April 2012.

7.4 Other sources of statistics about drugs and alcohol

7.4.1 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 the latest report for 2016-17 was published on 2 November 2017. The data and further information are available at: digital.nhs.uk/data-and-information/publications/statistical/smoking-drinking-and-drug-use-among-young-people-in-england/2016

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
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 to 24: www.gov.uk/government/statistics/drug-misuse-findings-from-the-2017-to-2018-csew

A second method is used to produce estimates for the prevalence of opiate and/or crack cocaine use for people aged 15-64 (with estimates broken down by age group, the youngest being 15 to 24) each local authority area in England. Estimates are available for 2004-05, 2005-06, 2006-07, 2008-09, 2009-10, 2010-11, 2011-12 and 2014-15.

The estimates are produced through a mixture of capture-recapture and Multiple Indicator Methodology (MIM), and rely on NDTMS (community and prison) data being matched against and/or analysed alongside Probation and Home Office data sets. The data and further information are available at:
www.gov.uk/government/collections/alcohol-and-drug-misuse-and-treatment-statistics#prevalence-data-and-analysis

7.4.2 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 to 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 next set of official statistics for 2017-18 on 17 January 2019. This will include information on young people accessing treatment in secure settings. The report will be available at: www.gov.uk/government/collections/alcohol-and-drug-misuse-and-treatment-statistics#alcohol-and-drug-treatment-statistics:-prisons-and-secure-settings

7.4.3 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: www.emcdda.europa.eu/data/stats2018_en

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/stats2018/tdi

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.

7.4.4 Adult drug and alcohol treatment

PHE also publishes annual reports regarding adults accessing drug and alcohol treatment. These can be found at: www.gov.uk/government/collections/alcohol-and-drug-misuse-and-treatment-statistics#alcohol-and-drug-treatment-statistics:-adults

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'[21].

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

[21] 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.

8. Abbreviations and definitions

8.1 Abbreviations

A&E	Accident and emergency department
CAMHS	Child and adolescent mental health services
CSE	Child sexual exploitation
CSEW	Crime Survey for England and Wales
DfE	Department for Education
DHSC	Department of Health and Social Care
EMCDDA	European Monitoring Centre for Drugs and Drug Addiction
GP	General practitioners
HBSC	Health Behaviour in School-aged Children
MIM	Multiple Indicator Methodology
NDEC	National Drug Evidence Centre
NDTMS	National Drug Treatment Monitoring System
NEET	Not in education, employment or training
NO	Nitrous oxide
NPS	New psychoactive substances
ONS	Office for National Statistics
PHE	Public Health England
TDI	Treatment Demand Indicator
YOT	Youth offending team
YP	Young people

8.2 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).

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.
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 1 or more interventions (or types) of treatment during the same episode of treatment. A client may also have more than 1 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[22]) 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.
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 2 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.

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

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.gov.uk/government/publications/business-definitions-for-young-people-drug-and-alcohol-treatment-providers

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.