Public Health England

Department of Health

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

1 April 2016 to 31 March 2017

National Statistics

The University of Manchester

National Drug Evidence Centre

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Executive summary

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 received specialist substance misuse interventions in England during 2016-17 (that is, between 1 April 2016 and 31 March 2017).

Specialist substance misuse services saw fewer young people in 2016-17 than in the previous year (16,436, a decrease of 641 or 4% compared to 2015-16). This continues a downward trend, year-on-year, since a peak of 24,053 in 2008-09.

Two-thirds of the young people accessing specialist substance misuse services were male (66%) and half (50%) of all persons were aged 16 or over. Females in treatment had a lower median age (15) than males (16), with 28% of females under the age of 15 compared to 22% of males.

Although the number of younger children (under 14) in treatment is relatively low, it has increased from 1,219 in 2014-15 to 1,342 in 2016-17 (a 10% increase). The recently published schools survey 'Smoking, drinking and drug use among young people in England' indicated an increase in lifetime prevalence of drug use among 11-15 year olds in the latest year (2016). Although these findings are not directly related, they may indicate that the increasing numbers coming into treatment do reflect a change in patterns of use. However, it is too early to draw any firm conclusions and data over a longer period is needed. Any substance misuse among this age group is concerning, as they are likely to be at risk of other harms than alcohol or drug use alone. In these cases, safeguarding needs to be a priority, and wider aspects of the child's life needs to be addressed, in addition to their substance misuse.

The most common drug that young people presented to treatment with continued to be cannabis. Around 9 out of 10 (88%) of young people in specialist services said they have a problem with this drug compared to 87% in 2015-16. The proportion of young people in treatment reporting cannabis as the primary substance have been on an upward trend since 2005-06, although numbers have decreased slightly in the last 3 years.

Alcohol is the next most commonly cited problematic substance with just under half of the young people in treatment (49%) seeking help for alcohol misuse during 2016-17. However, numbers in treatment for alcohol problems have been declining steadily in recent years and this figure is much lower than the two-thirds (67%) with alcohol problems reported in 2009-10.

Alongside cannabis and alcohol, young people in specialist substance misuse services used a range of substances. Of those who were in contact with services, 1,815 cited problematic ecstasy use (11%), 1,473 cocaine use (9%), 491 amphetamine use (3%), and 585 (4%) with concerns around the use of new psychoactive substances (NPS).

The proportion of young people reported by specialist services as having problems with NPS fell by 45% (from 1,056 in 2015-16 to 585 in 2016-17). 2016-17 is the first year since data on NPS use was added to NDTMS that the number of young people in treatment with problematic NPS use has decreased. However, local areas need to ensure that services are accessible and appropriate for young people who are having problems with NPS, so they can be confident that this pattern reflects need.

The most common routes into specialist substance misuse services were from education provision (29%), youth justice services (25%), and children's social care (15%). The proportion of referrals from the youth justice system has declined in recent years while the proportion of referrals from education provision has increased.

The majority of young people presenting to specialist substance misuse services have other problems or vulnerabilities related to their substance use (such as having mental health problems, being 'looked after'[1] or not being in education, employment or training[2]) or wider factors that can impact on their substance use (such as offending, self-harming, experiencing sexual exploitation or domestic abuse). Of the 17 vulnerability items collected via the NDTMS, 80% of young people who have entered treatment in 2016-17 disclosed 2 or more vulnerabilities. Therefore, specialist services need to work effectively with a range of other agencies to ensure that all the needs of a young person are met.

Following on from the last 2 years, data on sexual exploitation are included in this report. Fourteen per cent (14%) of females presenting to treatment services in 2016-17 reported experience of sexual exploitation (the same proportion as in 2015-16). The proportion of males was much lower at 2% (a change from 1% of males in 2015-16).

Waiting times to gain access to treatment were short. The average (mean) wait for young people to start their first specialist intervention was two days. Almost all (98%) of the 17,445 first interventions starting in 2016-17 had waiting times of 3 weeks or under, with 81% receiving a first intervention on the day they were referred.

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

Of the 10,834 young people leaving services in 2016-17, 82% (8,842) did so in a planned way, no longer requiring specialist interventions. This is a 2% higher treatment completion rate than last year, which suggests that specialist substance misuse services in England are responding well to the needs of young people who have alcohol and drug problems, and are helping young people to overcome their substance misuse problems.

1. 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 health needs of young people and prevention services for vulnerable young people.

More detail on the methodologies used to compile these statistics and the processes in place to ensure data quality can be found at:
https://www.ndtms.net/resources/secure/Quality-and-Methodology-NDTMS-2016-17.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[3].

1.3 Prevalence of alcohol and drug use among young people

NDTMS statistics do not provide an indication of the levels of need for young people's specialist substance misuse services. The main prevalence data for trends in substance use among young people is the biennial schools survey 'Smoking, drinking and drug use among young people in England' for 11-15 year olds. The latest report for 2016 can be found at: digital.nhs.uk/catalogue/PUB30132

The 2016 schools survey 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. The authors noted that this increase in drug use among young people has not been observed in other data sources and therefore needs to be treated with caution.

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

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

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[4].

Prevalence statistics for young adults aged 16-24 are included in the 'Drug Misuse: Findings from the 2016-17 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. The level of any drug use in the last year was highest among 16 to 19 year olds (16.5%) and 20 to 24 year olds (21.2%). Although the latest 2016-17 report shows that there is a long term trend of decreasing drug use reported among the 16 to 24 age group, there are indications of a slight increase in use in recent years. The 'Smoking, Drinking and Drug Use' survey discussed above notes that unpublished analysis from the 2016-17 CSEW report showed that the proportion of 16 and 17 year olds reporting use in the last year was unchanged between 2014-15 and 2016-17 (14%).

The latest CSEW report can be found at: https://www.gov.uk/government/statistics/drug-misuse-findings-from-the-2016-to-2017-csew

1.4 Other risk factors affecting young people

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

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

Findings from the Health Behaviour in School-aged Children (HBSC) report[4] 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

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

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 ten times as likely to report having smoked tobacco in the last month than those with the highest life satisfaction. They were also more likely to report having ever used cannabis, having had sex, and being involved in physical fighting. The report can be found at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/621069/Health_behaviour_in_school_age_children_wellbeing_of_adolescent_girls.pdf

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: https://www.gov.uk/guidance/child-and-maternal-health-data-and-intelligence-a-guide-for-health-professionals

1.5 Assessment of quality and robustness of 2016-17 NDTMS community data

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

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

Table 1.5.1 provides an overview of the quality of data submitted to NDTMS by young people treatment services since 2014-15. The proportion of valid records received out of all submitted records along with the proportion of records received without errors or warnings are included as they indicate the general level of data quality across the broad spectrum of information collected at each monthly data submission. Three additional indicators are also included below that report on the proportion of duplicate or

overlapping treatment interventions and episodes. These are reported as they provide a sense of how accurate and efficient record keeping is at treatment provider level. A low proportion is desirable as it demonstrates robust administrative functions at a national level.

Table 1.5.1 Data quality of NDTMS

Data quality measure	2014-15	2015-16	2016-17
Proportion of submitted records that were valid	100.00%	100.00%	100.00%
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%

More detailed information on NDTMS data collection and full definitions for the data quality measures recorded in Table 1.5.1 can be found at:
https://www.ndtms.net/resources/secure/Quality-and-Methodology-NDTMS-2016-17.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.

2. Characteristics of clients

During 2016-17 (between 1 April 2016 and 31 March 2017), 16,436 young people aged 9-17[5] were reported to the NDTMS as in contact with treatment services. This is a 4% decrease (641 individuals) from 2015-16 (17,077 young people). Comparisons with earlier years are included in section 5.

2.1 Age and gender of all young people

The age and gender of young people at their first point of contact with the treatment system in 2016-17 are reported in table 2.1.1 and figure 2.1.1. The majority of young people in treatment were male (66%), which is a higher percentage than in the general population of 9-17 year olds where males of the same age account for 51% (ONS, 2016)[6]. Half of all young people in treatment were aged 16 or over. Overall, females accessing services were younger (median age of 15), compared to males (median age of 16).

Although the number of younger children (under 14) in treatment was relatively low, it has increased since 2014-15 (see section 5.1). Any substance misuse among this age group is concerning, as they are likely to be at risk of harm. In these cases, safeguarding needs to be a priority, with wider aspects of the child's life addressed, in addition to their substance misuse.

The recently published schools survey 'Smoking, drinking and drug use among young people in England' indicated an increase in lifetime prevalence of drug use among 11-15 year olds in the latest year (2016), against a longer term falling trend. This finding is not directly related to the increased numbers of younger children in treatment reported here, as the data sources differ in terms of methodology, the time period and the age range in which the increase was observed. In addition, the survey authors noted that the increase in drug use among young people they identified has not been observed in other data sources and therefore needs to be treated with caution. It is therefore too early to draw any firm conclusions about whether the increasing numbers coming into treatment in this age group do reflect a change in patterns of use. Data over a longer period is needed to establish this.

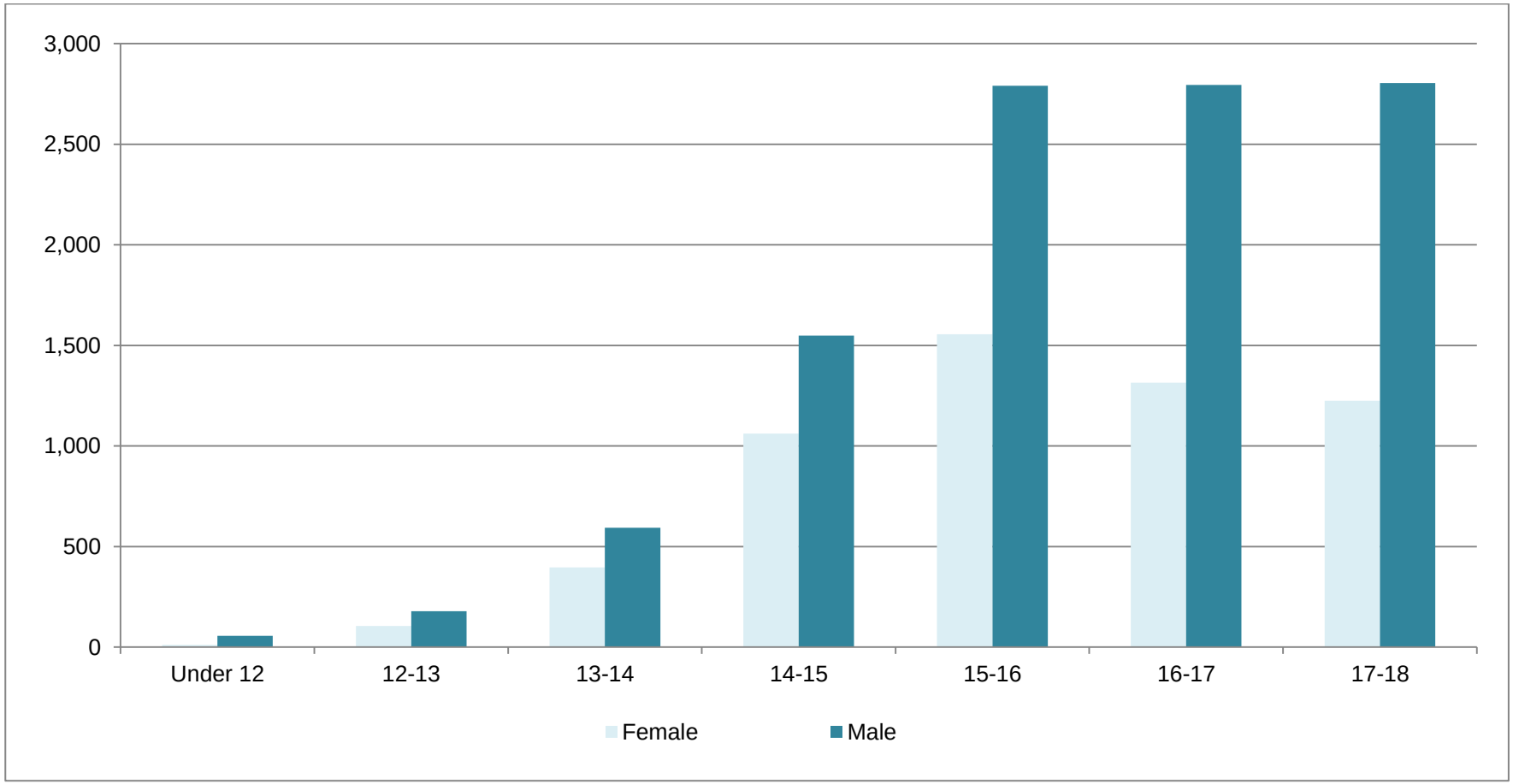
[5] For age methodology please refer to the Quality and Methodology information document here: https://www.ndtms.net/resources/secure/Quality-and-Methodology-NDTMS-2016-17.pdf

[6] Annual mid-year population estimates, 2016 http://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/bulletins/annualmidyearpopulationestimates/mid2016

Table 2.1.1 Age and gender of all young people in treatment 2016-17

Age	Female		Male		Persons	
	n	%	n	%	n	%
Under 12	12	0%	56	1%	68	0%
12-13	105	2%	179	2%	284	2%
13-14	396	7%	594	6%	990	6%
14-15	1,061	19%	1,549	14%	2,610	16%
15-16	1,555	27%	2,791	26%	4,346	26%
16-17	1,315	23%	2,794	26%	4,109	25%
17-18	1,225	22%	2,804	26%	4,029	25%
Total clients	**5,669**	**100%**	**10,767**	**100%**	**16,436**	**100%**

Figure 2.1.1 Age and gender distribution of all young people in contact with treatment services 2016-17



2.2 Ethnicity of all young people in treatment

Table 2.2.1 shows the ethnicity of young people in treatment services. Where reported, most clients (76%) were white British. This is comparable to the general population where the latest census (2011) showed that 78% of young people aged 10 to 17 were white British.[7] Among the remaining clients, 4% were other white, 3% were white and black Caribbean and 3% Caribbean with no more than 2% reporting any other ethnicity.

Table 2.2.1 Ethnicity of all young people in treatment 2016-17

Ethnicity	n	%
White British	12,458	76%
Other White	610	4%
White & Black Caribbean	522	3%
Caribbean	460	3%
Other Mixed	321	2%
African	302	2%
Not Stated	243	1%
Other Black	224	1%
Other	220	1%
Bangladeshi	181	1%
Pakistani	180	1%
Other Asian	170	1%
White & Asian	152	1%
White Irish	103	1%
White & Black African	100	1%
Indian	98	1%
Chinese	7	0%
Total	**16,351**	**100%**
Missing or inconsistent data	85	
Total	**16,436**	

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

2.3 Substance use

Table 2.3.1 shows the primary substance use (the substance that brought the young person into treatment at the point of triage/initial assessment) and adjunctive substance use (other substances cited by the young person) of young people in treatment in 2016-17. If a young person was seen at multiple service providers or multiple times within the year, the substance(s) recorded at their latest treatment episode in the year are reported here (for further details, see https://www.ndtms.net/resources/secure/Quality-and-Methodology-NDTMS-2016-17.pdf).

Eighty-eight per cent (88%) of young people reported either primary or adjunctive cannabis use compared to 87% last year. Alcohol was the second most cited substance (49%). However, numbers in treatment for alcohol misuse have been declining steadily in recent years, and this figure is much lower compared to the 67% reported in 2009-10. The proportion of young people citing ecstasy has increased to 11% in 2016-17 from 9% in 2015-16, while the proportion citing amphetamines has decreased to 3% from 7% and the proportion citing new psychoactive substances (NPS) has decreased to 4% from 6%. Nine per cent (9%) of young people cited powder cocaine use and this was similar to 2015-16.

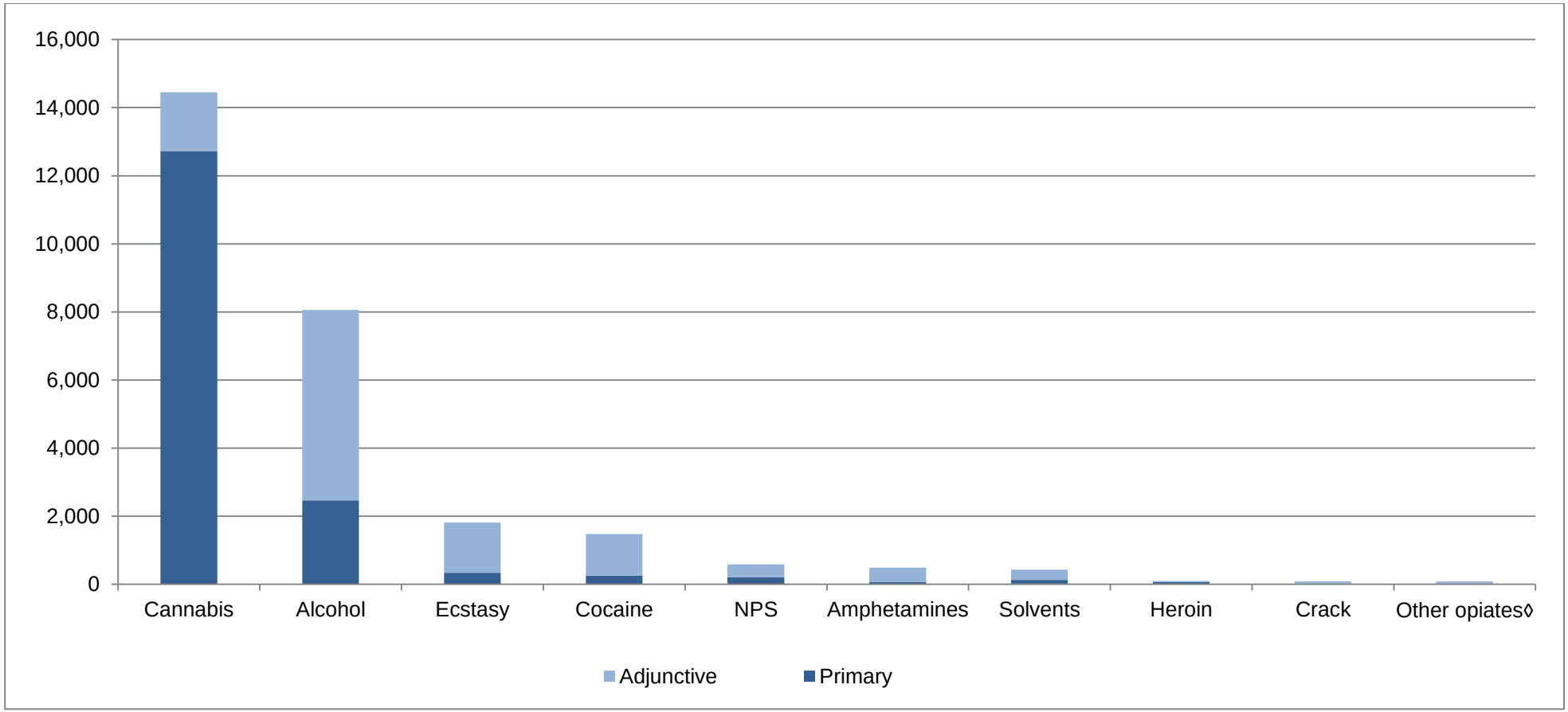
The median age of young people in specialist services was 15 years. The small numbers in treatment for primary heroin and crack use had a higher median age of 17. Primary cannabis, alcohol, ecstasy and solvent users have the lowest median age of 15. A more detailed breakdown of substances by age is shown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

Table 2.3.1 Substance use of all young people in treatment 2016-17

Substance	Primary		Adjunctive^		Total		Primary
	n	%	n	%	n	%	median age
Cannabis	12,712	77%	1,737	11%	14,449	88%	15
Alcohol	2,465	15%	5,593	34%	8,058	49%	15
Ecstasy	340	2%	1,475	9%	1,815	11%	15
Cocaine	254	2%	1,219	7%	1,473	9%	16
New psychoactive substances	213	1%	372	2%	585	4%	16
Amphetamines	71	0%	420	3%	491	3%	16
Solvents	128	1%	302	2%	430	3%	15
Heroin	71	0%	27	0%	98	1%	17
Crack	16	0%	67	0%	83	1%	17
Other opiates◊	23	0%	60	0%	83	1%	16
Other‡	133	1%	563	3%	-	-	16
Nicotine (adjunctive use only)	-	-	2,711	16%	-	-	-
Total	**16,426**	**100%**					
Missing, misuse free or inconsistent data	10						
Total including missing	**16,436**						

^ Adjunctive percentages are out of all young people in treatment (16,436)
◊ 'Other opiates' include methadone.
‡ 'Other' incorporates a number of different substance categories which are not shown elsewhere in the table. A single young person may be counted under both primary and adjunctive 'other' if the substances are from different categories. Therefore, primary and adjunctive users cannot be summed to give a total number of users.

Figure 2.3.1 Substance use of all young people in treatment (any citation – primary and adjunctive) 2016-17^



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

Table 2.3.2 Substance use (primary and adjunctive combined) by age of all young people in treatment 2016-17^

Substance	Under 13[Δ]		13-14		14-15		15-16		16-17		17-18	
	n	%	n	%	n	%	n	%	n	%	n	%
Cannabis	247	70%	807	82%	2,261	87%	3,921	90%	3,682	90%	3,531	88%
Alcohol	175	50%	473	48%	1,352	52%	2,095	48%	2,000	49%	1,963	49%
Ecstasy	18	5%	64	6%	257	10%	494	11%	503	12%	479	12%
Cocaine	8	2%	28	3%	117	4%	305	7%	412	10%	603	15%
New psychoactive substances	10	3%	21	2%	75	3%	142	3%	164	4%	173	4%
Amphetamines	*	-	10*	1%*	60*	2%*	120*	3%*	145*	3%*	155*	4%*
Solvents	31	9%	32	3%	81	3%	129	3%	84	2%	73	2%
Opiates [‡]	0	0%	*	-	13	0%	28	1%	50	1%	85	2%
Crack	0	0%	*	-	*	-	11	0%	20	0%	48	1%
Total[▼]	**352**	**100%**	**990**	**100%**	**2,610**	**100%**	**4,346**	**100%**	**4,109**	**100%**	**4,029**	**100%**

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

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

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

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

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

2.4 Source of referral into treatment (for treatment episodes)

Table 2.4.1 shows a breakdown of episodes of treatment in the financial year by source of referral. Information about source of referral was provided for 17,703 (99.9%) episodes of treatment in 2016-17. An individual may have more than one treatment episode in the year and all episodes are counted. Therefore, the total number reported in this section differs from the total number of young people in treatment in 2016-17.

Education services (29%) continue to be the most common route into specialist treatment services, with mainstream education being the single largest source of referral (22%). The youth justice system was the second most common referral source (25%), although this has been declining as a proportion of referrals in recent years (39% in 2010-11). Youth offending teams were the single largest source (21%) within this category.

Referrals from social care services went up from 10% of all recorded referrals in 2012-13 to 15% in 2016-17 (from 2,275 to 2,727). Children and family services referrals accounted for 12% in 2016-17 and self-referrals made up 6%. Accident and emergency (A&E) referrals account for 1%, while referrals from child and adolescent mental health services (CAMHS) account for 4%. 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[8,9,10].

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

[9] www.gov.uk/guidance/child-and-maternal-health-data-and-intelligence-a-guide-for-health-professionals

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

Table 2.4.1 Source of referral of all treatment episodes 2016-17

Referral Source	n	%
Mainstream education	3,972	22%
Alternative education	769	4%
Education service	420	2%
Other	7	0%
Education total	**5,168**	**29%**
YOT	3,803	21%
YP secure estate	182	1%
Other	373	2%
Youth / criminal justice total	**4,358**	**25%**
Children and family services	2,095	12%
Looked after child services	327	2%
Social services	305	2%
Social care total	**2,727**	**15%**
Self	1,091	6%
Relative, family, friend or concerned other	882	5%
Self, family & friends total	**1,973**	**11%**
Substance misuse total	**1,267**	**7%**
CAMHS	742	4%
School nurse	324	2%
A&E	238	1%
GP	168	1%
Hospital	112	1%
Other	69	0%
Health total	**1,653**	**9%**
YP housing	294	2%
Other	263	1%
Total (episodes)	**17,703**	**100%**
Missing or inconsistent data	20	
Total (episodes)	**17,723**	

2.5 Education and employment status

Table 2.5.1 shows the education and employment status at presentation to treatment. This was reported for 11,392 (97%) young people who entered treatment in 2016-17.

Of these, over half (56%) were recorded as being in mainstream education (such as schools and further education colleges), followed by a further 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 2015-16.

Table 2.5.1 Education and employment status of all young people starting treatment in 2016-17

Education and employment status	n	%
Mainstream education	6,389	56%
Alternative education	2,199	19%
Not in employment or education or training (NEET)	1,788	16%
Apprenticeship or training	432	4%
Employed	329	3%
Persistent absentee or excluded	228	2%
Economically inactive – health issue or caring role	15	0%
Voluntary work	12	0%
Total	**11,392**	**100%**
Missing or inconsistent data	361	
Total new presentations	**11,753**	

2.6 Accommodation status

Table 2.6.1 shows the housing situation of 16,169 (98%) young people in treatment in 2016-17, recorded at treatment entry.

Of these, 13,500 (83%) were recorded as living with their parents or other relatives, while a further 3% reported living independently in settled accommodation. Eight per cent (8%) 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). This profile was broadly similar to 2015-16.

Table 2.6.1 Accommodation status of all young people in treatment 2016-17

Accommodation status	n	%
Living with parents or other relatives	13,500	83%
YP living in care	1,292	8%
YP supported housing	654	4%
Independent – settled accommodation	467	3%
Independent – unsettled / housing problem	153	1%
Independent – no fixed abode	59	0%
YP living in secure care	44	0%
Total	**16,169**	**100%**
Missing or inconsistent data	267	
Total	**16,436**	

2.7 Vulnerabilities

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

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

Table 2.7.1 Description of vulnerability factors identified via NDTMS

Vulnerability factor	Criteria
Early onset	Began using primary substance under the age of 15
Poly substance user	Reported using two or more substances in combination (poly substance use)
Antisocial behaviour	Young person has been involved in antisocial behaviour or committed a criminal act on more than one occasion in the past 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 problem	Reported a mental health problem
Self-harm	Reported self-harming behaviour
NEET	Is not in education, employment or training
Looked after child	Has a 'looked after child' status (see section 7.2)
Child protection plan	The young person is subject to a child protection plan
Child in need	Is a child in need
Sexual exploitation	Reported sexual exploitation
High-risk alcohol user	Drinks almost daily, or in excess of 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)

Table 2.7.2 shows the number of young people reporting each of the vulnerabilities listed above. Vulnerabilities are reported only for new clients entering specialist services during the year and therefore the total number reported (11,753) is lower than the total number of young people in treatment in 2016-17. An individual young person may report multiple vulnerabilities and therefore the percentages in this table may sum to more than 100%.

The most commonly reported vulnerability was early onset of substance misuse, with 84% reporting use of their primary substance under the age of 15, followed by 58% reporting poly substance use (using more than one substance). Thirty two per cent (32%) reported antisocial behaviour, while 23% reported that they were affected by others' substance misuse and 21% reported being affected by domestic abuse. The least commonly reported vulnerability was injecting (1%). Females in treatment tend to present to services with a different range of vulnerabilities to males. Females are more likely to present with self-harm

issues, sexual exploitation (see section 2.8) or domestic abuse, while males are more likely to report antisocial behaviour.

There were broadly similar proportions of vulnerabilities reported between 2015-16 and 2016-17, with the exception of early onset of substance misuse, which fell from 92% to 84%.

Table 2.7.2 Individual vulnerabilities identified among all young people starting treatment in 2016-17

Vulnerability	Female		Male		Persons	
	n	%	n	%	n	%
Early onset of substance misuse	3,386	86%	6,467	83%	9,853	84%
Poly substance user	2,527	64%	4,290	55%	6,817	58%
Antisocial behaviour	740	19%	3,009	39%	3,749	32%
Affected by others' substance misuse	1,110	28%	1,597	20%	2,707	23%
Affected by domestic abuse	1,093	28%	1,411	18%	2,504	21%
Mental health problem	947	24%	1,161	15%	2,108	18%
Self-harm	1,225	31%	719	9%	1,944	17%
NEET	512	13%	1,357	17%	1,869	16%
Looked after child	542	14%	858	11%	1,400	12%
Child Protection Plan	451	11%	477	6%	928	8%
Child in need	388	10%	469	6%	857	7%
Sexual exploitation	565	14%	123	2%	688	6%
High risk alcohol user	230	6%	184	2%	414	4%
Pregnant and/or parent	104	3%	123	2%	227	2%
Opiate and/or crack use	92	2%	129	2%	221	2%
Housing problem	62	2%	106	1%	168	1%
Injecting	43	1%	51	1%	94	1%
Total new presentations	**3,949**	**100%**	**7,804**	**100%**	**11,753**	**100%**

A number of young people reported multiple vulnerabilities at treatment start. Individuals with substance misuse problems are more likely to experience a wide range of interrelated social exclusion problems such as poor health, crime, unemployment and community deprivation.[11]

Table 2.7.3 shows the number of vulnerabilities reported by young people starting treatment in 2016-17, with the majority (80%) reporting multiple vulnerabilities. Thirty six per cent (36%) reported 4 or more vulnerabilities, with 44% reporting either 2 or 3, 16% reported 1, and just 4% reported none.

[11] 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.

Table 2.7.3 Multiple vulnerabilities reported by young people starting treatment in 2016-17

Number of vulnerabilities reported (of total of seventeen)	n	%
Zero	436	4%
One	1,887	16%
Two	2,884	25%
Three	2,334	20%
Four or more	4,212	36%
Total new presentations	**11,753**	**100%**

2.8 Sexual exploitation

Child sexual exploitation (CSE) is a form of child sexual abuse. It occurs where 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 (a) in exchange for something the victim needs or wants, and/or (b) 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: https://www.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 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, which can be found at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/629315/PHE_child_exploitation_report.pdf

Table 2.8.1 shows the breakdown by age and gender of young people who presented to treatment services and reported sexual exploitation, compared to all young people newly presenting to services in 2016-17. The proportion reporting sexual exploitation is much higher among females (14%) than males (2%). Although these figures suggest a large difference between sexual exploitation experienced by boys and girls, research from Barnardo's[12] has highlighted difficulties in identifying sexual exploitation of boys and young

[12] 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

men because they often do not disclose abuse. The median age of young people reporting sexual exploitation was 15, the same as for all new presentations.

Table 2.8.1 Age and gender breakdown of young people starting treatment in 2016-17 and reported sexual exploitation

Age	Sexual exploitation				Total new presentations			
	Female		Male		Female		Male	
	n	%	n	%	n	%	n	%
Under 14[Δ]	66	12%	16	13%	413	10%	683	9%
14-15	116	21%	21	17%	782	20%	1,201	15%
15-16	156	28%	26	21%	1,094	28%	2,081	27%
16-17	120	21%	37	30%	826	21%	1,853	24%
17-18	107	19%	23	19%	834	21%	1,986	25%
Total new presentations	**565**	**100%**	**123**	**100%**	**3,949**	**100%**	**7,804**	**100%**

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

3. Access to services

3.1 Waiting times for first and subsequent treatment interventions

The table below shows a breakdown of waiting times under and over 3 weeks by first and subsequent interventions (that is where a client who is already receiving an intervention is referred to start another type of treatment). Of the 17,445 first interventions beginning in 2016-17, 17,050 (98%) had waiting times of 3 weeks or under, with 81% of first interventions starting on the same day as referral. There were 696 subsequent interventions, of which 671 (96%) waited no more than 3 weeks. Overall the average (mean) wait to commence treatment (first interventions only) was two days.

Table 3.1.1 Waiting times: first and subsequent interventions 2016-17

Intervention	3 weeks or under		Over 3 weeks		Total	
	n	%	n	%	n	%
First Intervention	17,050	98%	395	2%	17,445	100%
Subsequent Intervention	671	96%	25	4%	696	100%
Total Interventions	**17,721**	**98%**	**420**	**2%**	**18,141**	**100%**

3.2 Treatment interventions

As part of a young person's treatment package, an individual may receive more than one intervention (more than one type of treatment) while being treated at a service and may attend more than 1 service for subsequent interventions. For example, the young person might receive a 1 to 1 intervention such as motivational interviewing in addition to a family intervention.

From 1 November 2013, the way interventions were recorded on NDTMS was changed to include 3 high-level structured intervention types (psychosocial, harm reduction and pharmacological) and an intervention setting.

Tables 3.2.1 and 3.2.2 show the breakdown of intervention types received by young people in contact with structured treatment. The vast majority of young people (15,012, 93%) received psychosocial intervention(s). Psychosocial interventions (sometimes known as 'talking therapies') use psychological, psychotherapeutic and counselling skills to encourage change. Many young people received harm reduction interventions (9,846, 61%), with 8,627 (52%) receiving both psychosocial and harm reduction interventions only. Structured harm reduction includes support to manage risky behaviour associated with substance misuse, overdose and accidental injury through substance misuse. Seventy-nine (79) young people received a pharmacological intervention (0.5%). Pharmacological

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

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

Table 3.2.1 Interventions received by young people in treatment in 2016-17 (pre-November 2013 dataset change interventions)

Intervention	n
Inpatient detoxification	*
Other YP intervention	45

* 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.

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

Table 3.2.2 Interventions received by young people in treatment 2016-17 (post November 2013 dataset change interventions)

Setting	Intervention type			Total individuals with this setting[Δ]	Percentage of total individuals with this setting
	Psychosocial (n)	Harm reduction (n)	Pharmacological (n)		
Community	14,541	9,533	67	**15,710**	**97%**
Home	542	335	8	**594**	**4%**
YP Residential unit	14	10	0	**16**	**0%**
Adult setting	12	*	6	**14**	**0%**
YP Inpatient unit	6	*	0	**8**	**0%**
No setting recorded	0	0	0	**0**	**-**
Total individuals[‡]	**15,012**	**9,846**	**79**	**16,189**	**100%**
% of total individuals with this intervention	**93%**	**61%**	**0.5%**		

[‡] This is the total number of individuals receiving each type of intervention and not a summation of values within the column.
[Δ] This is the total number of individuals receiving at least one type of intervention in each setting and not a row total.
* 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

3.3 Length of latest treatment episode

The majority of young people's most recent episodes were 26 weeks or less in duration (74%). The average (mean) time of an individual's most recent episode of treatment during 2016-17 was around 5 months (151 days).

Table 3.3.1 Length of latest episode 2016-17

Episode Length	n	%
0 (zero) to 12 weeks	6,928	43%
13 to 26 weeks	5,000	31%
27 to 52 weeks	3,122	19%
Longer than 52 weeks	1,150	7%
Total	**16,200**	**100%**

4. Treatment exits

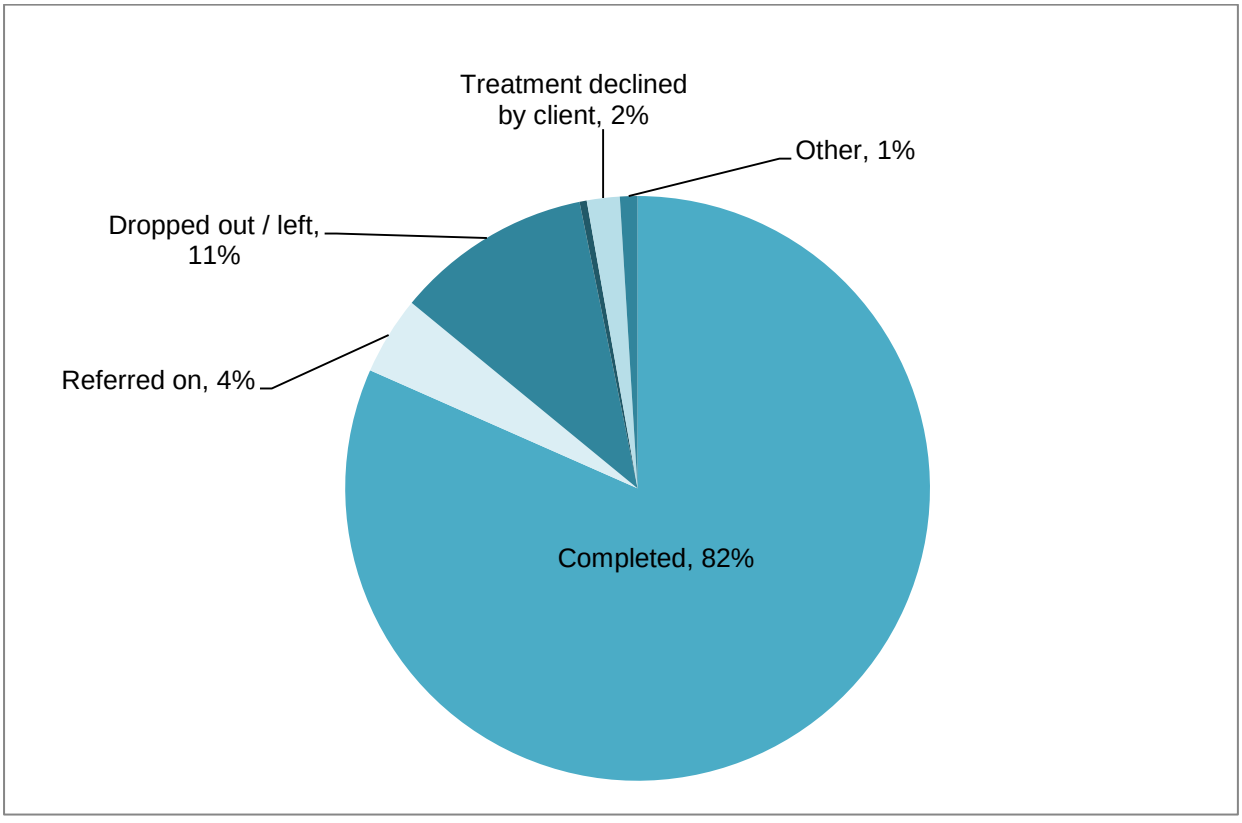
4.1 Treatment exits

Table 4.1.1 and figure 4.1.1 report on the treatment exit reasons for young people exiting in 2016-17. There were 10,834 treatment exits in 2016-17, representing 66% of the 16,436 young people in treatment in the year. The remaining 5,602 young people (34%) were retained in treatment on 31 March 2017. Among those who exited treatment, 8,842 (82%) did so after completing specialist treatment in a planned way.

Table 4.1.1 Treatment exit reasons of all young people exiting treatment 2016-17

Treatment exit reason	n	%
Completed	8,842	82%
Dropped out / left	1,178	11%
Referred on	469	4%
Treatment declined by client	197	2%
Other	105	1%
Prison	43	0%
Total	**10,834**	**100%**

Figure 4.1.1 Treatment exit reasons of all young people exiting treatment 2016-17



5. Trends over time

5.1 Trends in age and numbers in treatment

The number of young people attending specialist substance misuse services during 2016-17 was 16,436, a decrease of 641 (4%) from 17,077 in 2015-16, and a reduction of 7,617 (32%) since the peak of 24,053 in 2008-09. General decreasing trends in alcohol and drug use among young people in the last decade may in part explain this decline, although it is also possible that any reduction in the provision of youth support services may affect the number of referrals into specialist services. Although there has been a general decrease in the number of young people under 14 in treatment over time, the proportion aged under 14 (out of all young people in treatment) has remained fairly stable, and there was a small increase in the number aged under 14 in 2016-17. Any substance misuse among this age group is concerning and they are likely to be at risk of harm. In these cases, safeguarding needs to be a priority, with every aspect of the child's life addressed, not just the substance misuse.

Table 5.1.1 Number of young people in treatment by age (2005-06 to 2016-17)

Age	2005-06		2006-07		2007-08		2008-09	
	n	%	n	%	n	%	n	%
Under 12	212	1%	233	1%	227	1%	193	1%
12-13	358	2%	457	2%	467	2%	442	2%
13-14	1,040	6%	1,253	6%	1,476	6%	1,500*	6%
14-15	2,380	14%	2,961	14%	3,466	14%	3,550*	15%
15-16	3,884	23%	4,953	23%	5,658	24%	5,574	23%
16-17	4,347	26%	5,315	25%	5,987	25%	6,133	25%
17-18	4,780	28%	6,019	28%	6,624	28%	6,663	28%
Total	**17,001**	**100%**	**21,191**	**100%**	**23,905**	**100%**	**24,053**	**100%**

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

Age	2013-14		2014-15		2015-16		2016-17	
	n	%	n	%	n	%	n	%
Under 12	46	0%	43	0%	48	0%	68	0%
12-13	227	1%	225	1%	211	1%	284	2%
13-14	1,008	5%	951	5%	909	5%	990	6%
14-15	2,785	15%	2,643	14%	2,624	15%	2,610	16%
15-16	4,922	26%	4,862	26%	4,476	26%	4,346	26%
16-17	5,092	27%	4,866	27%	4,472	26%	4,109	25%
17-18	5,046	26%	4,759	26%	4,337	25%	4,029	25%
Total	**19,126**	**100%**	**18,349**	**100%**	**17,077**	**100%**	**16,436**	**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.

5.2 Trends in primary substance

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

Since 2005-06, young people have been increasingly likely to seek help for problems with cannabis compared to other substances. During 2016-17, 12,712 presented to specialist services with cannabis as their primary substance (77% of all those receiving help during the year). The number of primary cannabis presentations has decreased by 7% since 2013-14 (from 13,659 to 12,712), but this has continued to increase as a proportion of all young people in treatment (up 6% from 71% in 2013-14).

Findings from the 2016-17 Crime Survey for England and Wales show that cannabis use and prevalence peak in the late teens/early 20s[13].

The number of young people citing alcohol as a primary substance has decreased slightly from 2,556 in 2015-16 to 2,465 in 2016-17, although the proportion of the total population has remained similar (15% of all those receiving help in each year). This is, however, significantly lower than the 2008-09 peak of 8,799 (37% of the total population). The number of primary alcohol presentations has decreased consecutively each year since 2008-09.

[13] Drug misuse: findings from the 2016/17 Crime Survey for England and Wales. Home Office 2017 https://www.gov.uk/government/statistics/drug-misuse-findings-from-the-2016-to-2017-csew

Table 5.2.1 shows that the number in treatment for primary amphetamine use has fallen in the last 4 years. Numbers of young people in treatment for opiates and crack cocaine have fallen markedly over the last ten years and now represent 0.6% and 0.1% respectively of the young treatment population compared to 5.3% and 1.2% respectively in 2005-06. Section 5.3 explores trends in drug use other than cannabis and alcohol in more detail, including adjunctive use.

Figure 5.2.1 Number of young people in treatment by primary substance (2005-06 to 2016-17)

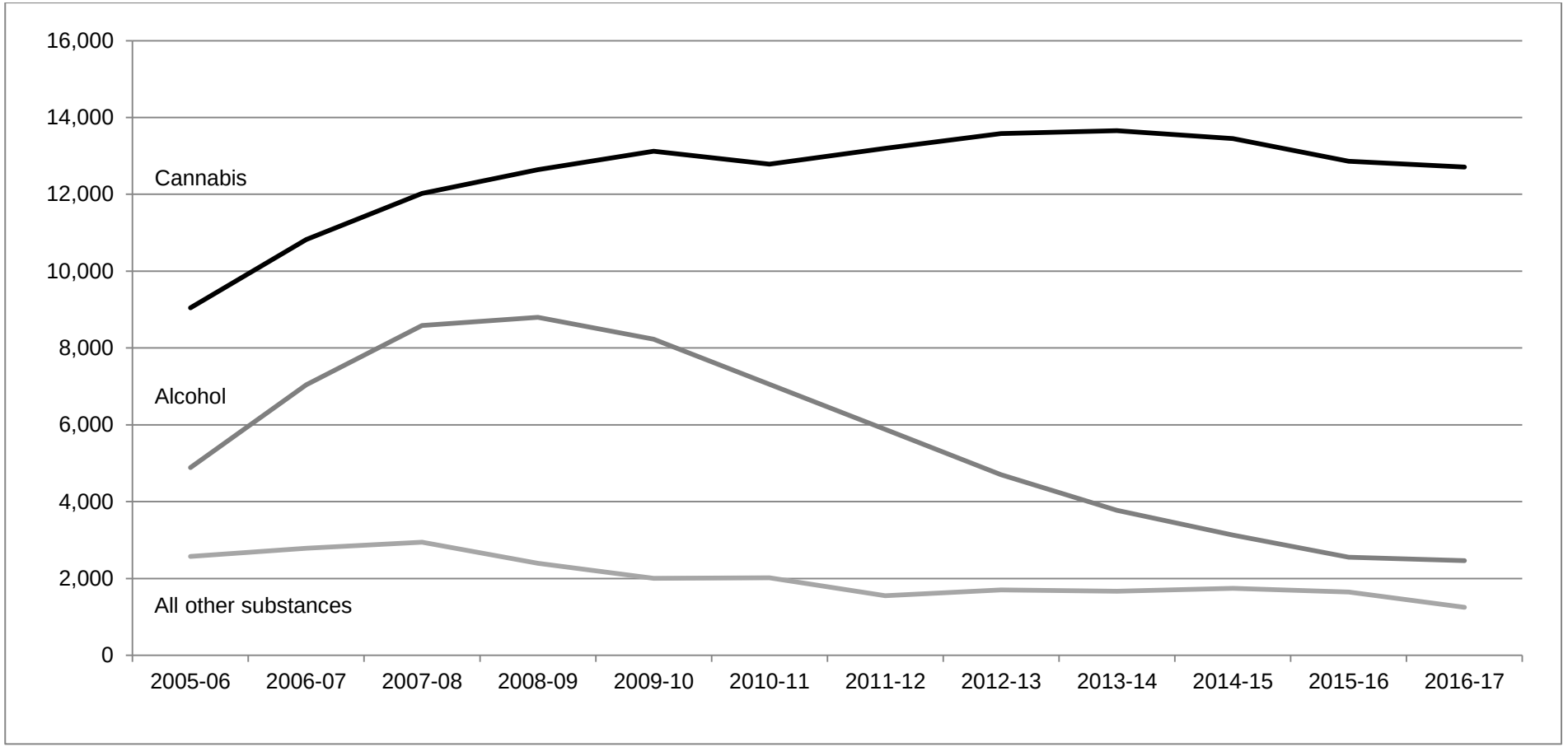


Table 5.2.1 Number of young people in treatment by primary substance (2005-06 to 2016-17)

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

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

Substance	2013-14		2014-15		2015-16		2016-17	
	n	%	n	%	n	%	n	%
Opiates	160*	1%	134	1%	112	1%	94	1%
Amphetamines	591	3%	540*	3%	317	2%	71	0%
Cocaine	254	1%	250*	1%	251	1%	254	2%
Crack	14	0%	24	0%	21	0%	16	0%
Ecstasy	124	1%	165*	1%	261	2%	340	2%
Cannabis	13,659	71%	13,454	73%	12,863	75%	12,712	77%
Solvents	134	1%	135	1%	121	1%	128	1%
Alcohol	3,776	20%	3,133	17%	2,556	15%	2,465	15%
NPS	120*	1%	334	2%	420	2%	213	1%
Other‡	271	1%	165*	1%	148	1%	133	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.

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

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

Figure 5.3.1 shows the number of young people in treatment in each year from 2007-08 to 2016-17, where the individual has cited drug use other than cannabis and alcohol. These substances are often adjunctive to cannabis or alcohol and are less frequently cited as the main substance young people seek treatment for. Due to low numbers, the figures for primary and adjunctive use are combined, and the 5 most commonly cited substances are reported on, as well as opiates. Figures are reported from 2007-08 as this was the earliest year in which adjunctive drug use was reported as part of these statistics.

Ecstasy was the most commonly cited substance after cannabis and alcohol in 2016-17 (1,815, or 11% of young people), followed by cocaine (1,473, or 9% of young people). The number of young people in treatment who had cited problematic ecstasy use increased by 13% from 1,605 in 2015-16 to 1,815 in 2016-17. This was below the peak of 2,281 in 2007-08, but 148% higher than in 2011-12, when 732 young people in treatment said they had problems with ecstasy. The number of young people in treatment for problematic cocaine use has been similar from 2012-13 onwards.

New psychoactive substances or 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 fourth 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 5.3.1.

The number of young people reporting problems with NPS reduced by 45% compared to 2015-16, from 1,056 to 585 in 2016-17. The numbers are lower compared to ecstasy (1,815) and cocaine (1,477) use. However, specialist substance misuse services need to ensure that they continue to be accessible and relevant to those young people who may require support for NPS problems, in particular those young people who may be most vulnerable to developing problems with these drugs, such as young people with mental health problems, special needs and homeless young people.

The number of young people citing amphetamine use decreased by 57% between 2015-16 and 2016-17 to 491 individuals. Solvent use also continued to decrease slightly, from 441 in 2015-16 to 430 in 2016-17 (2.5% reduction compared to last year).

Opiate use among young people in treatment has been decreasing since 2007-08, with 181 young people receiving help for their problematic opiate use in 2016-17, compared to 889 young people 10 years ago.

Figure 5.3.1 Number of young people in treatment for other drug use, excluding cannabis and alcohol (2007-08 to 2016-17)

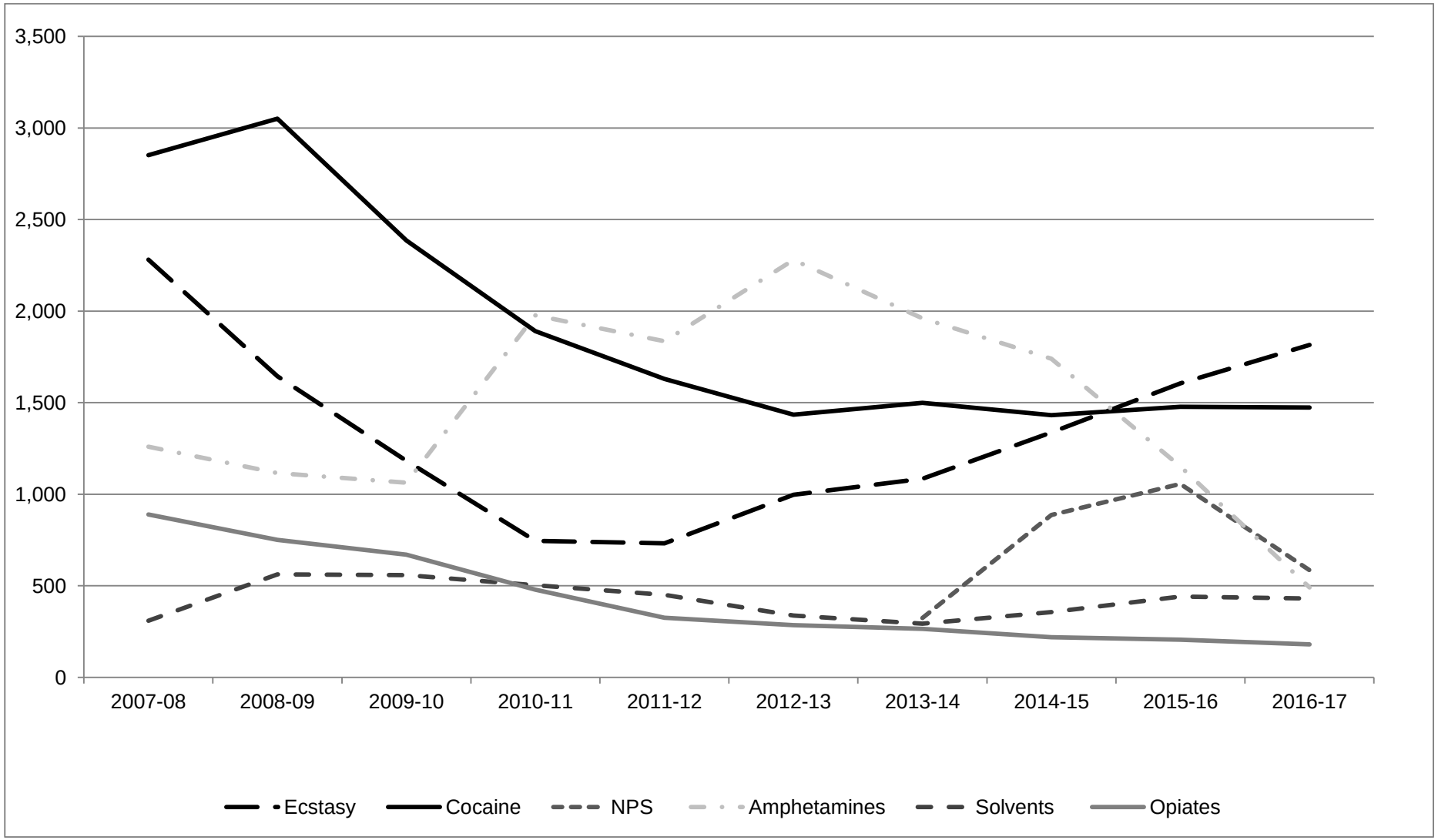


Table 5.3.1 Trends in numbers in treatment for other drug use, excluding cannabis and alcohol 2007-08 to 2016-17^

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

^ Primary and adjunctive use are combined in this table, therefore a young person may be counted for more than once in this table.
* 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.
‡ Codes for NPS were added to the NDTMS core data set in 2013-14. Any individuals reporting NPS prior to this are counted in the 'Any club drug cited' total but no separate totals are given for NPS. An individual may report more than one NPS drug and therefore the sum of individual NPS drugs may exceed the total reported for NPS (any).

5.4 Trends in treatment exit reasons

Table 5.4.1 reports treatment exit reasons for clients in the years 2005-06 to 2016-17. 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: http://www.ndtms.net/resources/secure/Quality-and-Methodology-NDTMS-2016-17.pdf.

Treatment completions, as a proportion of exits, have increased annually over this period, from 69% in 2009-10 to 82% in 2016-17. Those being transferred for further structured drug and/or alcohol treatment fell to 4% from 6% in 2015-16, the lowest proportion since the new coding system was introduced.

Table 5.4.1 Trends in treatment exit reasons (2005-06 to 2016-17)

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

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

Treatment exit reason	2013-14		2014-15		2015-16		2016-17	
	n	%	n	%	n	%	n	%
Complete	9,852	79%	9,613	80%	8,929	80%	8,842	82%
Referred on	852	7%	773	6%	722	6%	469	4%
Dropped out / left	1,440	12%	1,345	11%	1,237	11%	1,178	11%
Prison	62	0%	52	0%	31	0%	43	0%
Treatment declined by client	244	2%	236	2%	245	2%	197	2%
Not known	0	0%	0	0%	0	0%	0	0%
Other	60	0%	55	0%	60	1%	105	1%
Total	**12,510**	**100%**	**12,074**	**100%**	**11,224**	**100%**	**10,834**	**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. 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 drug treatment recorded by the system further into line with 'Models of care for treatment of adult drug users': www.nta.nhs.uk/publications/documents/nta_modelsofcare_update_2006_moc3.pdf

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

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

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

NDEC is part of the Centre for Epidemiology, which is one of 6 centres in the Institute of Population Health, Health Services Research & Primary Care, University of Manchester.

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

6.1 Relevant web links and contact details

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

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

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

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

General enquiries

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

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6.2 Comparability of data to previous reports

Since 1 November 2013, PHE made substantial changes to the core dataset with regards to young people and the coding of intervention type. Prior to this, intervention codes were restricted to 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 one 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 section 7.2 and the business definitions guide at http://www.nta.nhs.uk/uploads/yp-treatment-business-definition-v11.06-wn-comments.pdf. Intervention types have been split in to 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 http://www.nta.nhs.uk/uploads/yp-treatment-business-definition-v11.06-wn-comments.pdf.

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

6.3 Drug treatment collection and reporting timeline

1989 to March 2001 Regional Drug Misuse Database (RDMD) – statistics reported in 6 monthly bulletins by DH from 1993 to 2001: webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/en/Publicationsandstatistics/Statistics/StatisticalWorkAreas/Statisticalpublichealth/DH_4015620

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

April 2004 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.

6.4 Other sources of statistics about drugs and alcohol

6.4.1 Prevalence of substance use

Information is available relating to the prevalence of drug use among secondary school pupils aged 11 to 15 from the Smoking, Drinking and Drug Use Survey among young people in England. This is a survey carried out for the NHS Information Centre by the National Centre for Social Research and the National Foundation for Educational Research. The survey interviews school pupils, and has been in place since 2001. It reported annually up to 2014-15 and the latest report for 2016-17 was published on 2 November 2017. The data and further information are available at: https://digital.nhs.uk/catalogue/PUB30132

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

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

An annual estimate of the prevalence of drug use is undertaken through the Crime Survey for England and Wales (CSEW; formerly the British Crime Survey). This section of the survey has been in place since 1996, annually since 2001, and has tracked the prevalence of the use of different drugs over this time. This does not include information on all young people but does show the data for the age group 16 to 24. https://www.gov.uk/government/statistics/drug-misuse-findings-from-the-2016-to-2017-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.nta.nhs.uk/facts-prevalence.aspx.

6.4.2 Youth justice statistics

The Ministry of Justice and the Youth Justice Board for England and Wales publish annual statistics that detail the number of young people (aged 10 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 2016-17 on 18 January 2018. This will include information on young people accessing treatment in secure settings. The report will be available at: www.nta.nhs.uk/statistics.aspx.

6.4.3 International comparisons

The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) publishes an annual report that describes and compares aspects of drug use and drug policy within European states, as well as providing detailed comparative statistics. This can be found at: http://www.emcdda.europa.eu/edr2017.

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/stats2017#displayTable:TDI-0023.

While comparisons to alcohol treatment statistics from other countries can be made, care needs to be taken as the data is unlikely to be directly comparable due to differences in the

definitions and methodologies that are used in collecting the data and subsequently in reporting it.

6.4.4 Adult drug and alcohol treatment

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

Note that young people's figures are not comparable with statistics relating to adult drug or alcohol treatment. This is because access to specialist services for young people requires a 'lower severity of drug use and associated problems'.[14]

6.4.5 Drug-related deaths

The Office for National Statistics publishes an annual summary of all deaths related to drug poisoning (involving both legal and illegal drugs) and drug misuse (involving illegal drugs) in England and Wales. This covers all ages with young people forming part of the 'under 20' age group and can be found at: https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsrelatedtodrugpoisoninginenglandandwales/2016registrations.

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

7. Abbreviations and definitions

7.1 Abbreviations

A&E	Accident and emergency department
CAMHS	Child and adolescent mental health services
ChiMat	Child and Maternal Health Intelligence Network
CSE	Child sexual exploitation
CSEW	Crime Survey for England and Wales
DfE	Department for Education
DH	Department of Health
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
NTA	National Treatment Agency for Substance Misuse
ONS	Office for National Statistics
PHE	Public Health England
TDI	Treatment Demand Indicator
YOT	Youth offending team
YP	Young people

7.2 Definitions

Adjunctive drug use	Substances additional to the primary substance used by the individual, NDTMS collects secondary and tertiary substances.
Agency /provider	A provider of services for the treatment of substance misuse. They may be statutory (i.e. the NHS) or non-statutory (i.e. third sector, charitable).
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 one or more interventions (or types) of treatment during the same episode of treatment. A client may also have more than one episode in a year. A client is considered to have been in contact during the year, and hence included in these results, if any part of an episode occurs within the year. Where several episodes were collected for an individual, attributes such as ethnicity, primary substance, etc. are based on the first valid data available for that individual.
Family work intervention	Interventions using psychosocial methods to support parents, carers and other family members to manage the impact of a young person's substance misuse and enable them to better support the young person in their family.
First/subsequent intervention	First intervention' refers to the first intervention that occurs in a treatment journey. 'Subsequent intervention' refers to interventions, within a treatment journey, that occur after the first intervention.
Home setting	The young person is being supported with specialist substance misuse interventions in his/her home by the treatment provider.
In contact	Clients are counted as being in contact with treatment services if their date of presentation (as indicated by triage/initial assessment), intervention start, intervention end or discharge indicates that they have been in contact with a provider during the year.
Inpatient unit (not substance misuse specific) setting	An inpatient unit provides assessment, stabilisation and/or assisted withdrawal with 24-hour cover. Such as a hospital unit.
Inpatient unit (substance misuse specific) setting	An inpatient unit provides assessment, stabilisation and/or assisted withdrawal with 24-hour cover from a multi-disciplinary team who have had specialist training in managing addictive behaviours. Such as paediatric ward, adult ward, child and adolescent mental health ward, etc.

Intervention	A type of treatment, e.g. structured counselling, community prescribing, etc.
Looked after child	The definition of a looked after child (from the Children Act 1989[15]) 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 two or more drugs in combination.
Presenting for treatment	The first face-to-face contact between a client and a treatment provider.
Primary drug/substance	The substance that brought the client into treatment at the point of triage/initial assessment.

[15] 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.nta.nhs.uk/core-data-set.aspx.

Appendix A

Diagram to show an example young people's pathway

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