Public Health England

The University of Manchester National Drug Evidence Centre

Department of Health

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

1 April 2014 to 31 March 2015

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Executive summary

Young people's specialist substance misuse services saw fewer young people in 2014-15 than in the previous year (18,349, a drop of 777 compared to 2013-14). This continues a downward trend, year-on-year, since a peak of 24,053 in 2008-09.

The most common drug that young people need help with is cannabis. More than four-fifths (86%) of young people in specialist services say they have a problem with this drug and, although numbers have dipped slightly in 2014-15, the numbers in treatment for cannabis has been on an upward trend since 2005-06.

Alcohol is the next biggest problem substance with just over half the young people in treatment (51%) seeking help for its misuse during 2014-15. However, numbers in treatment for alcohol problems have been declining steadily in recent years and this figure is much lower than the two-thirds (67%) reported in 2009-10.

Young people accessing specialist substance misuse services use a range of substances Around 1,340 were in contact with services with problematic use of ecstasy (7%), around 1,740 with amphetamine use (9%), 1,432 with cocaine use (8%) and around 890 with concerns around the use of new psychoactive substances (NPS) (5%), also known as 'legal highs'.

Although the number of young people reporting problems with NPS rose for the second year, it is still relatively small and lower than most other problem drugs. Although NPS use has been widely reported in the media and other places, the full extent of their use is still not fully known, and people having problems with these drugs tend to present at acute services such as hospital A&E departments. However, specialist substance misuse services need to ensure they are accessible and relevant to those young people who may need more support for NPS problems.

The most common routes into specialist substance misuse services were from youth justice services (29%), education provision (26%) and children's social care (12%). The numbers referred from the youth justice system has declined in recent years while the number of referrals from education has increased.

Just under two-thirds of the young people accessing specialist substance misuse services were male (65%), and just over half (52%) of all persons

were aged 16 or over. Girls in treatment were younger, with 25% aged under 15 compared to 19% of boys.

The majority of young people in specialist substance misuse services have a range of problems or vulnerabilities related to their substance use (such as poly drug use and drinking alcohol daily) or wider factors that can impact on their substance use (such as self-harming, offending or domestic abuse). Therefore, specialist services need to be able to work with a range of other agencies to ensure that all a young person's needs are met. Girls are more likely to report mental health problems and self-harming while boys are more likely to be involved in antisocial behaviour and not be in education, employment of training (NEET).

This year, for the first time, data on sexual exploitation is being reported since this is an area of concern. Five per cent (5%) of young people presenting to treatment services in 2014-15 reported sexual exploitation. This proportion was higher among females (12%) than males (just over 1%).

Waiting times to start treatment were short. The average (mean) wait for young people to start their first specialist intervention was two days. Almost all (98%) of the 18,505 first interventions starting in 2014-15 began within three weeks of referral. Outcomes were good too: of the 12,074 young people leaving services in 2014-15, 80% did so in a planned way, no longer requiring specialist treatment. This 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 (those aged under 18) who receive specialist substance misuse interventions in England. The information relates to all substances that young people present to specialist services seeking help for, including alcohol.

The statistics are used to:

- inform the commissioning of specialist services for young people with drug or alcohol problems
- monitor national availability and effectiveness of specialist young people's substance misuse services
- 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 to young people and their families of attending specialist substance misuse services

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 that are in place to ensure data quality can be found at: www.ndtms.net/resources/secure/Quality-and-Methodology-NDTMS-2014-15.pdf

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

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

1.2 Specialist substance misuse services for young people

Specialist substance misuse services for young people are distinct from adult treatment services because young people's alcohol and drug problems tend to be different to adults' and so they need a different response. This includes considering the age and maturity of young people, being child-centred, 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 who are experiencing harm and to address their alcohol and drug use, 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.[i]

1.3 Prevalence of alcohol and drug problems 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 annual schools survey 'Smoking, drinking and drug use among young people in England' for 11-15 year olds. Although the latest report for 2014 shows declining trends in substance use overall, some patterns remain concerning. It highlights the increased risk of drug use among pupils who truant or who have been excluded from school and whose circumstances or behaviour already make them a focus of concern. The report is at:
www.hscic.gov.uk/catalogue/PUB17879

Findings from a new survey called 'What About YOUth' will be published on 8 December as part of a new government pledge to make improvements to the health of young people. It asks 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 will be available.

Other prevalence statistics for young adults aged 16-24 are included in the 'Drug misuse: findings from the crime survey for England and Wales'. The latest report, for 2014, shows small but increasing trends in drug use among this age group. The report is at www.crimesurvey.co.uk/index.html

Although the schools survey shows a drop in the proportion of children drinking alcohol and taking drugs over the last decade, serious concerns

remain about some young people's substance use. International comparisons show that British children are more likely to get drunk than children in most other European countries.[ii] Concern is also mounting around the emergence of new psychoactive substances (NPS, also frequently and misleadingly called 'legal highs') but, while they are clearly causing problems among under 18s, the extent is still unclear.

The Health Behaviour in School-aged Children (HBSC) report provides useful insights into the health-related behaviour of young people since 1997. The report confirms that while alcohol and drug use has decreased among young people over the last decade, rates are still high in comparison to other European countries.

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. It often goes hand in hand with other risk factors, such as offending or truancy.

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 abuse and neglect, truanting from school, offending, early sexual activity, antisocial behaviour and being exposed to parental substance misuse.

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

1.5 Assessment of quality and robustness of 2014-15 NDTMS community data

Data collection through NDTMS was suspended between November 2014 and February 2015 (a period of four months) to introduce security enhancements to the system.

The system was fully restored in March 2015. Providers were given up until the end of July to submit and validate data entered locally during the downtime, as well as to catch up with any backlog of data that they may have not been able to record while the systems were suspended. PHE worked closely with all providers of drug and alcohol treatment through eight regional-based teams to support this process.

While the NDTMS closure was unscheduled, it was possible to ensure that the downtime was well managed and coordinated. Through the commitment and goodwill of the treatment providers, PHE ensured that any risks to the provision of a complete 2014-15 dataset were minimised.

The intelligence gathered by PHE NDTMS teams as part of their support of treatment providers suggests that data collected for 2014-15 is reflective of activity and that all appropriate measures were put in place locally to ensure full data recovery. There is no current evidence that the downtime had any adverse long-term effects on quality or compliance. More detailed information can be found at
www.nta.nhs.uk/UKSA-data-quality-asssessment-2014-15.aspx

2. Characteristics of clients

During 2014-15, NDTMS reported 18,349 young people, aged 9-17,[iii] in contact with treatment services. This is a 4% decrease (777 individuals) compared to the previous year. Comparisons with previous years are included in section 5.

2.1 Age and gender of all young people

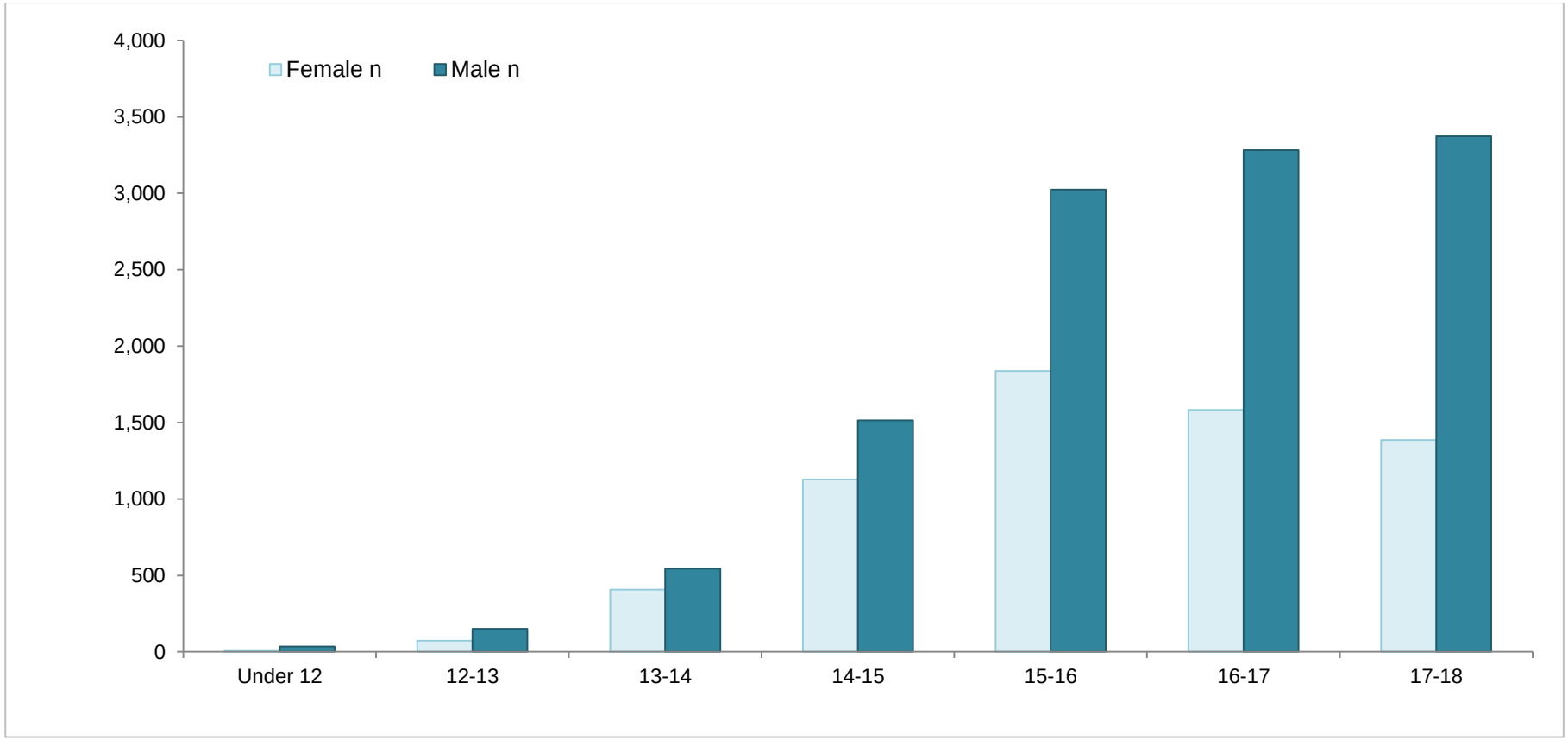
The age and gender of young people at their first point of contact with the treatment system in 2014-15 is reported in table 2.1.1 and figure 2.1.1. The majority of young people in treatment were male (65%), which is a higher percentage than in the general population of 9-17-year olds where males of the same age account for 51.3% (ONS 2014).[iv]Just over half of young people in treatment (52%) were aged 16 or over. Overall, females accessing services were younger: 25% were under 15, compared with 19% of males.

Although the number of younger children in treatment is relatively low, and decreasing (see section 5.1), 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, addressing every aspect of the child's life, not just the substance misuse.

Table 2.1.1 Age and gender of all young people in treatment 2014-15

Age	Female		Male		Persons	
	n	%	n	%	n	%
Under 12	7	0%	36	0%	43	0%
12-13	74	1%	151	1%	225	1%
13-14	407	6%	544	5%	951	5%
14-15	1,128	18%	1,515	13%	2,643	14%
15-16	1,837	29%	3,025	25%	4,862	26%
16-17	1,583	25%	3,283	28%	4,866	27%
17-18	1,387	22%	3,372	28%	4,759	26%
Total clients	**6,423**	**100%**	**11,926**	**100%**	**18,349**	**100%**

Figure 2.1.1 Age and gender distribution of all young people in contact with treatment 2014-15



2.2 Ethnicity of all young people in treatment

Table 2.2.1 shows the ethnicity of young people in treatment. Where reported, most clients (79%) were white British, 3% were other white and 3% were white and black Caribbean. This is comparable to ethnicity in the general population where the latest census (2011) shows that 78% of young people aged 10-17 were white British.[v]

Table 2.2.1 Ethnicity of all young people in treatment 2014-15

Ethnicity	n	%
White British	14,422	79%
Other white	552	3%
White and black Caribbean	536	3%
Caribbean	390	2%
Other mixed	344	2%
African	262	1%
Other black	251	1%
Bangladeshi	237	1%
Pakistani	222	1%
Other	217	1%
Other Asian	174	1%
White and Asian	159	1%
Not stated	145	1%
White and black African	117	1%
Indian	103	1%
White Irish	102	1%
Chinese	16	0%
Total	**18,249**	**100%**
Inconsistent/missing	100	
Total	**18,349**	

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 2014-15. 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 is used (for further detail see Quality and methodology information).

Eighty-six per cent (86%) of young people reported either primary or adjunctive cannabis use. Alcohol was the second most cited substance (51%). A number of young people citied other substances: 9% amphetamine use, 8% cocaine use and 7% ecstasy use. Just under 5% of young people cited the use of a new psychoactive substance (NPS) as either a primary or adjunctive substance.

Primary cannabis and alcohol users had a median age of 16 (the middle number in an ascending list of all ages). Primary opiate and crack users had a slightly higher median age of 17. The majority of young people in treatment with these primary substances were aged 16 or over (82%). Primary solvent users have the lowest median age of 14. A more detailed breakdown of substances by age is shown in table 2.3.2.

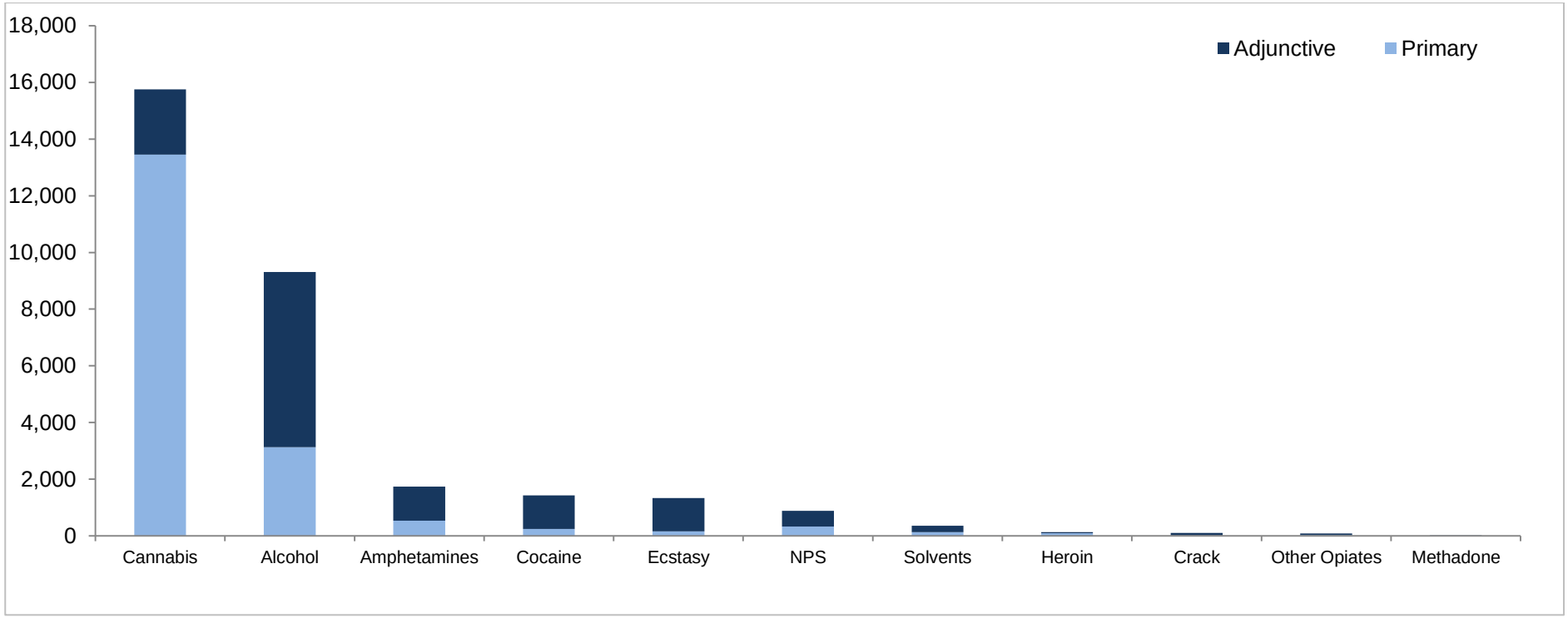
Trends in presenting substances can be seen in section 5.

Table 2.3.1 Substance use of all young people in treatment 2014-15

Substance	Primary		Adjunctive^		Total		Primary
	n	%	n	%	n	%	Median age
Cannabis	13,454	73%	2,297	13%	15,751	86%	16
Alcohol	3,133	17%	6,181	34%	9,314	51%	16
Amphetamines	540*	3%	1,200	7%	1,740*	9%	16
Cocaine	250*	1%	1,185*	6%	1,432	8%	16
Ecstasy	165*	1%	1,174	6%	1,340*	7%	16
New psychoactive substances (NPS)	334	2%	555*	3%	890*	5%	16
Solvents	135	1%	222	1%	357	2%	14
Heroin	97	1%	37	0%	134	1%	17
Crack	24	0%	78	0%	102	1%	17
Other opiates	30	0%	56	0%	86	0%	17
Methadone	7	0%	13	0%	20	0%	17
Other‡	165	1%	2,866	16%	-	-	16
Total	**18,334**	**100%**	**15,860**	**86%**	**18,334**	**100%**	**16**
Missing, misuse free or inconsistent data	15						
Total	**18,349**						

* All numbers under five have been suppressed. Where totals could be derived, figures have been rounded to the nearest five and marked with an asterisk
^ Adjunctive percentage is of all clients in treatment (18,349)
‡ '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) 2014-15^



^ 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 by age of all young people in treatment 2014-15*

Substance	Under 13[Δ]		13-14		14-15		15-16		16-17		17-18	
	P	A	P	A	P	A	P	A	P	A	P	A
Cannabis	183	13	662	99	1,973	300	3,694	593	3,603	625	3,339	667
Alcohol	53	60	234	263	515	882	759	1,753	761	1,667	811	1,556
Amphetamines	*	7	8	27	39	132	136	309	174	364	182	361
Cocaine	0	*	*	17	17	77	49	250	65	375	116	462
Ecstasy	0	0	*	19	15	112	44	312	54	355	49	376
New psychoactive substances (NPS)	5	*	12	35	33	92	83	156	100	141	101	128
Solvents	20	7	22	21	30	38	28	73	20	47	15	36
Opiates ‡	0	0	*	*	*	10	20	17	35	33	76	41
Crack	0	*	*	*	*	*	*	13	*	18	15	43
Total	**268**	**132**	**951**	**625**	**2,643**	**2,055**	**4,862**	**4,264**	**4,866**	**4,383**	**4,759**	**4,399**

P = primary substance A = adjunctive substance

* All numbers under five have been suppressed. Where totals could be derived, figures have been rounded to the nearest five and marked with an asterisk. Figures relating to the 'Other' substance category and individuals where primary substance cannot be determined are not shown in this table, but are included in the totals.

[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.

2.4 Source of referral into treatment (for new treatment episodes)

Table 2.4.1 shows a breakdown of new episodes of treatment starting in the financial year by source of referral (ie, the routes by which people accessed treatment). Information about source of referral was provided for 20,348 (99.6%) new episodes of treatment in 2014-15. An individual may have more than one new treatment episode starting in the year (or none) and all episodes are counted. Therefore the total number reported differs from the total number of young people in treatment in 2014-15.

The most common route into specialist services continues to be via the youth justice system (29%), with youth offending teams the single largest source (26%), although this has been declining in recent years. Education was the second most common referral source (26%).

Referrals from children and family services accounted for 9%, and self-referrals made up 7% of all recorded referrals. Referrals from A&E account for 1% while referrals from child and adolescent mental health services (CAMHS) account for 3%. These may be lower than expected, based on the available hospital admissions data and evidence about the links between young people's mental health and substance misuse and the use of these services by young people.[viviiviii]

Table 2.4.1 Source of referral of all new treatment episodes 2014-15

Referral source	n	%
YOT	5,308	26%
YP secure estate	155	1%
Other	518	3%
Youth / criminal justice total	**5,981**	**29%**
Mainstream education	3,958	19%
Alternative education	720	4%
Education service	656	3%
Other	40	0%
Education total	**5,374**	**26%**
Children and family services	1,748	9%
Looked after child services	364	2%
Social services	267	1%
Social care total	**2,379**	**12%**
Self	1,368	7%
Relative, family, friend or concerned other	906	4%
Self, family and friends total	**2,274**	**11%**
Substance misuse services total	**1,913**	**9%**
GP	256	1%
A&E	260	1%
School nurse	299	1%
CAMHS	630	3%
Hospital	146	1%
Other	85	0%
Health total	**1,676**	**8%**
YP housing	395	2%
Other	356	2%
Total (episodes)	**20,348**	**100%**
Missing or inconsistent data	83	
Total (episodes)	**20,431**	

2.5 Education and employment status

Table 2.5.1 shows the education and employment situation at presentation to treatment. This was reported for 12,612 young people (96%) who entered treatment in 2014-15. The total reported is therefore lower than the total number of young people in treatment in 2014-15.

Of these, over half (53%) 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 17% were recorded as not in employment, education or training (NEET).

Table 2.5.1 Education and employment status of all young people starting treatment 2014-15

Education and employment status	n	%
Mainstream education	6,718	53%
Alternative education	2,425	19%
Not in employment or education or training (NEET)	2,196	17%
Apprenticeship or training	681	5%
Employed	309	2%
Persistent absentee or excluded	253	2%
Economically inactive – health issue or caring role	18	0%
Voluntary work	12	0%
Total	**12,612**	**100%**
Missing or inconsistent data	515	
Total	**13,127**	

2.6 Accommodation status

The housing situation of 17,944 (98%) young people in treatment in 2014-15, recorded when they first entered treatment, is shown in table 2.6.1.

Of these, 14,750 (82%) were recorded as living with their parents or other relatives, while a further 3% reported living independently in settled accommodation. Seven per cent (7%) of young people stated that they were living in care, with 1% living in secure care.

Table 2.6.1 Accommodation status of all young people in treatment 2014-15

Accommodation status	n	%
Living with parents or other relatives	14,750	82%
YP living in care	1,187	7%
YP supported housing	995	6%
Independent – settled accommodation	537	3%
Independent – unsettled/housing problem	269	1%
YP living in secure care	113	1%
Independent – no fixed abode	93	1%
Total	**17,944**	**100%**
Missing or inconsistent data	405	
Total	**18,349**	

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 poly drug use and drinking alcohol daily) or wider factors that can impact on their substance use (such as self-harming, offending or domestic abuse).

Seventeen vulnerability factors are identified via 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 drug user	Reports using two or more drugs in combination (poly drug use)
Antisocial behaviour	Reports antisocial behaviour
Affected by others' substance misuse	Is affected by others' substance misuse
Affected by domestic abuse	Has been affected by domestic abuse
Mental health problem	Reports a mental health problem
Self-harm	Reports self-harming
NEET	Is not in education, employment or training
Looked after child	Has a 'looked after child' status
Child protection plan	Reports a child in need status
Child in need	Is a child in need
Sexual exploitation	Reports sexual exploitation
High-risk alcohol user	Drinks almost daily, or in excess of eight units (males) or six units (females) on an average drinking day when drinking 13 or more days of the month
Housing problem	Reports unsettled accommodation status or has no fixed abode
Pregnant and/or parent	Is pregnant or a parent
Opiate and/or crack use	Reports using opiates and/or crack among their presenting substances
Injecting	Reports injecting (currently or previously)

Table 2.7.2 shows the number reporting each of the vulnerabilities listed above. Vulnerabilities are reported for just new clients entering specialist services during the year and therefore the total number reported (13,127) is lower than the total number of young people in treatment in 2014-15. 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, with 93% reporting use of their primary substance under the age of 15, followed by 61% reporting poly-drug use. Thirty two per cent (32%) reported antisocial behaviour, while 21% reported that they

were affected by others' substance misuse and 20% reported being affected by domestic abuse. The least commonly reported vulnerability was injecting (just 1%), followed by opiate and/or crack use (2%). Girls in treatment tend to present with a different range of vulnerabilities to boys with girls being more likely to present with self-harm issues, high-risk alcohol use and domestic abuse, and less likely to present with antisocial behaviour or be NEET.

Table 2.7.2 Individual vulnerabilities identified among all young people starting treatment in 2014-15

Vulnerability	Female		Male		Persons	
	n	%	n	%	n	%
Early onset	4,110	93%	8,044	93%	12,154	93%
Poly drug user	2,950	67%	5,060	58%	8,010	61%
Antisocial behaviour	875	20%	3,285	38%	4,160	32%
Affected by others' substance misuse	1,198	27%	1,583	18%	2,781	21%
Affected by domestic abuse	1,152	26%	1,517	17%	2,669	20%
Mental health problem	970	22%	1,319	15%	2,289	17%
Self-harm	1,475	33%	801	9%	2,276	17%
NEET	558	13%	1,696	20%	2,254	17%
Looked after child	626	14%	903	10%	1,529	12%
Child protection plan	452	10%	421	5%	873	7%
Child in need	368	8%	446	5%	814	6%
Sexual exploitation	513	12%	112	1%	625	5%
High-risk alcohol user	389	9%	200	2%	589	4%
Housing problem	101	2%	172	2%	273	2%
Pregnant and/or parent	130	3%	129	1%	259	2%
Opiate and/or crack use	118	3%	124	1%	242	2%
Injecting	59	1%	85	1%	144	1%
Total new presentations	**4,436**	**100%**	**8,691**	**100%**	**13,127**	**100%**

A number of young people report a range of risky behaviours at the same time. Research has shown that the clustering of multiple risky behaviours in youth predicts worse outcomes.[ix]

Table 2.7.3 shows the number of vulnerabilities reported by young people starting treatment in 2014-15. Thirty seven per cent (37%) reported four or more of these, with 47% reporting either two or three, 15% reporting one, and just 2% reporting none. Therefore, the large majority of young people (84%) starting treatment report multiple vulnerabilities.

Table 2.7.3 Multiple vulnerabilities reported by young people starting treatment in 2014-15

Number of vulnerabilities reported (of total of seventeen)	n	%
Zero	205	2%
One	1,909	15%
Two	3,335	25%
Three	2,824	22%
Four or more	4,854	37%
Total	**13,127**	**100%**

2.8 Sexual exploitation

Child sexual exploitation is a form of child sexual abuse. As with all types of abuse, it can have a devastating impact on the child or young person who is being exploited. A number of reports[x] have highlighted that substance misuse could be an indicator of child sexual exploitation and abuse.

Table 2.8.1 shows the breakdown by age and gender of young people who present to treatment services and report sexual exploitation, compared to all young people newly presenting to services in 2014-15. Overall 5% of young people report sexual exploitation. However, the proportion is much higher among females (12%) than males (just over 1%). Although these figures suggest a large difference between sexual exploitation experienced by boys and girls, research from Barnardo's[xi] has highlighted difficulties in identifying sexual exploitation of boys and young men because they often do not disclose abuse. The median age for young people reporting sexual exploitation is 15, compared to 16 for all new presentations.

Table 2.8.1 Age and gender breakdown of young people reporting sexual exploitation (figures are out of all young people starting treatment in 2014-15)

Age	Sexual exploitation				Total new presentations			
	Female		Male		Female		Male	
	n	%	n	%	n	%	n	%
Under 12	0	0%	*	*%	5	0%	26	0%
12-13	10	2%	*	*%	64	1%	123	1%
13-14	37	7%	*	*%	317	7%	437	5%
14-15	112	22%	21	19%	852	19%	1,166	13%
15-16	139	27%	31	28%	1,290	29%	2,244	26%
16-17	134	26%	24	21%	966	22%	2,304	27%
17-18	81	16%	30	27%	942	21%	2,391	28%
Total	**513**	**100%**	**112**	**100%**	**4,436**	**100%**	**8,691**	**100%**

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

3. Access to services

3.1 Waiting times for first and subsequent treatment interventions

The table below shows a breakdown of waiting times under and over three weeks by first and subsequent intervention. Of the 18,505 first interventions beginning in 2014-15, 18,114 (98%) began within three weeks of referral. There were 1,481 subsequent interventions (i.e. where a client who is already receiving an intervention is referred to start another type of treatment), of which 1,455 (98%) began within three weeks of referral. Overall the average (mean) wait to commence treatment (first interventions only) was two days.

Table 3.1.1 Waiting times, first and subsequent interventions 2014-15

Intervention	Under three weeks (n)	%	Over three weeks (n)	%	Total
First intervention	18,114	98%	391	2%	18,505
Second intervention	1,455	98%	26	2%	1,481

3.2 Treatment interventions

As part of a young person's treatment package, an individual may receive more than one intervention (ie, more than one type of treatment) while being treated at a service and may attend more than one service for subsequent interventions.

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 (16,661 young people, 92%) received psychosocial intervention(s). Psychosocial interventions (sometimes known as 'talking therapies') use psychological, psychotherapeutic and counselling skills to encourage change. Many young people received harm reduction interventions (9,968, 55%), with 8,503 (46%) receiving both psychosocial and harm reduction interventions. Structured harm reduction includes support to manage risky behaviour associated with substance misuse, overdose and accidental injury through substance misuse. One hundred and forty-four (144) young people received a pharmacological intervention (0.8%). Pharmacological interventions for young people cover a wide range of medication prescribed by a clinician, as well as substitute prescribing for opiate and alcohol addiction, such as prescribing for detoxification, stabilisation, symptomatic relief from substance misuse and relapse prevention.

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

Table 3.2.1 shows the number of clients who received an old intervention type that cannot be mapped directly to the new method of recording (types that were current prior to 1 November 2013, 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 2014-15, old intervention types

Intervention	n
Inpatient detoxification	*
Other YP intervention	70

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

Table 3.2.2 provides information on new 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 new intervention codes and intervention setting. 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 2014-15, new interventions

Setting	Intervention type			Total individuals
	Psychosocial	Harm reduction	Pharmacological	
Community	15,809	9,335	127	17,120[Δ]
Home	497	316	*	587[Δ]
YP residential unit	29	23	*	39[Δ]
YP inpatient unit	5	6	*	9[Δ]
Adult setting	10	0	9	14[Δ]
No setting recorded	494	376	*	529[Δ]
Total	**16,661[‡]**	**9,968[‡]**	**144[‡]**	**18,036[‡]**

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

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

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

3.3 Length of latest treatment episode

The majority of young people's most recent episodes were 26 weeks or less in duration (74%). The average (mean) time of an individual's most recent episode of treatment during 2014-15 was just over five months (154 days).

Table 3.3.1 Length of latest episode 2014-15

Episode length	n	%
0 (zero) to 12 weeks	7,636	42%
13 to 26 weeks	5,744	32%
27 to 52 weeks	3,263	18%
Longer than 52 weeks	1,403	8%
Total	**18,046**	**100%**

4. Treatment exits

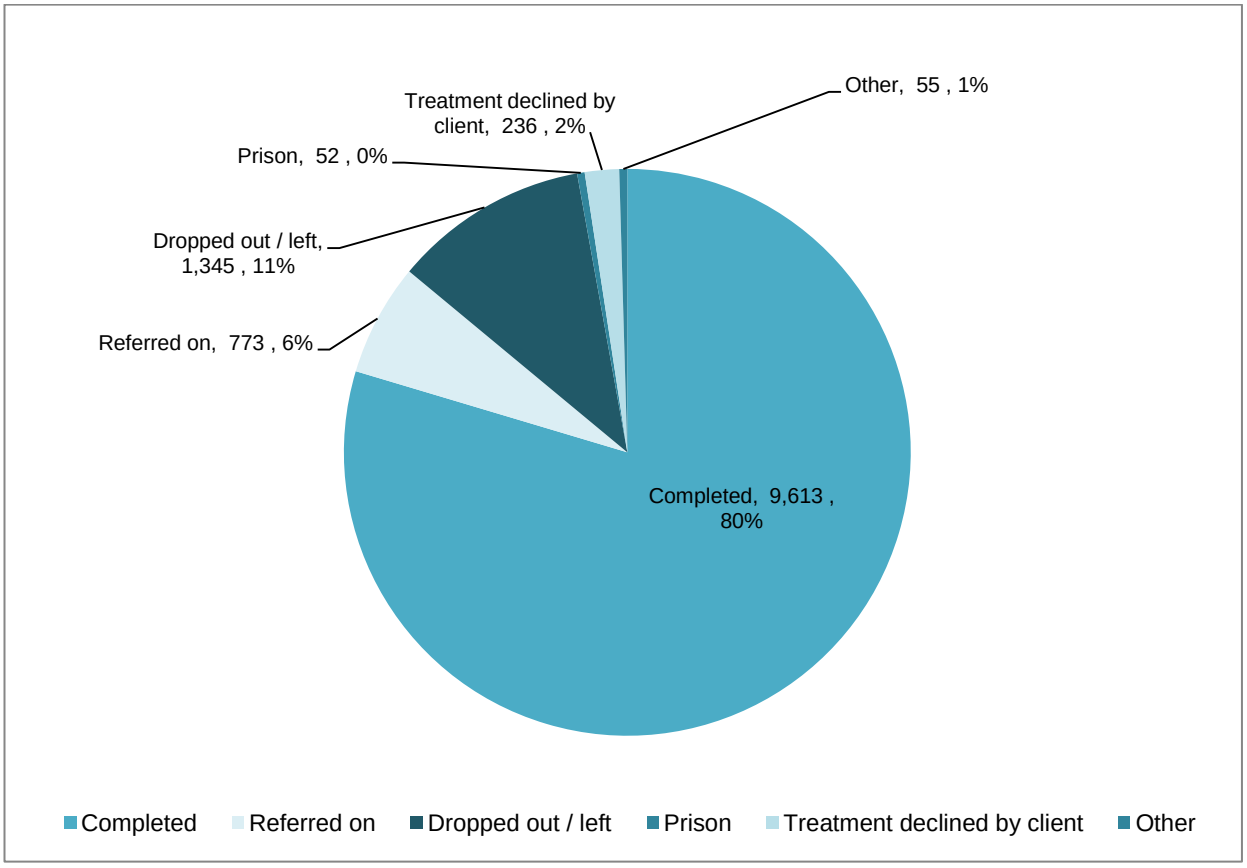
4.1 Treatment exits

Figure 4.1.1 reports treatment exit reasons for young people exiting in 2014-15. This year, 12,074 individuals left treatment, with 9,613 (80%) of these exiting in a planned way and no longer requiring specialist treatment (completed). These 12,074 young people represent 66% of the 19,126 young people in treatment in the year. The remaining 6,275 young people (34%) were retained in treatment on 31 March 2015.

Table 4.1.1 Treatment exit reasons of all young people exiting treatment 2014-15

Treatment exit reason	n	%
Completed	9,613	80%
Referred on	773	6%
Dropped out/left	1,345	11%
Prison	52	0%
Treatment declined by client	236	2%
Other	55	0%
Total	**12,074**	**100%**

Figure 4.1.1 Treatment exit reasons of all young people exiting treatment 2014-15



5. Trends over time

5.1 Trends in age and numbers in treatment

The number of young people attending specialist substance misuse services during 2014-15 was 18,349, down by 777 (4%) from 19,126 in 2013-14, and a reduction of 5,704 young people since the peak in 2008-09 (a fall of 24%). Falling alcohol and drug use among young people in general may explain this small decline, although it is also possible that a reduction in the provision of youth support services may have affected the number of referrals. Although the numbers of the younger age groups are consistently falling year on year, the proportion of young people in these groups has remained fairly stable. Any substance misuse among this age group is concerning and they are likely to be at risk of serious harm. In these cases, safeguarding needs to be a priority, addressing every aspect of the child's life, not just the substance misuse.

Table 5.1.1 Number of young people in treatment by age (2005-06 to 2014-15)

Age	2005-06		2006-07		2007-08		2008-09		2009-10	
	n	%	n	%	n	%	n	%	n	%
Under 12	212	1%	233	1%	227	1%	193	1%	155*	1%
12	358	2%	457	2%	467	2%	442	2%	380*	2%
13	1,040	6%	1,253	6%	1,476	6%	1,500*	6%	1396	6%
14	2,380	14%	2,961	14%	3,466	14%	3,550*	15%	3,300*	14%
15	3,884	23%	4,953	23%	5,658	24%	5,574	23%	5,770	25%
16	4,347	26%	5,315	25%	5,987	25%	6,133	25%	5,823	25%
17	4,780	28%	6,019	28%	6,624	28%	6,663	28%	6,701	28%
Total	**17,001**	**100%**	**21,191**	**100%**	**23,905**	**100%**	**24,053**	**100%**	**23,528**	**100%**

Age	2010-11		2011-12		2012-13		2013-14		2014-15	
	n	%	n	n	n	%	n	%	n	%
Under 12	128	1%	110	1%	56	0%	46	0%	43	0%
12	315	1%	323	2%	310	2%	227	1%	225	1%
13	1,234	6%	1,129	5%	1,130	6%	1,008	5%	951	5%
14	3,092	14%	3,009	15%	2,936	15%	2,785	15%	2,643	14%
15	5,445	25%	5,097	25%	5,097	25%	4,922	26%	4,862	26%
16	5,657	26%	5,297	26%	5,040	25%	5,092	27%	4,866	27%
17	6,084	28%	5,723	28%	5,463	27%	5,046	26%	4,759	26%
Total	**21,955**	**100%**	**20,688**	**100%**	**20,032**	**100%**	**19,126**	**100%**	**18,349**	**100%**

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

5.2 Trends in primary substance

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

Young people are still most likely to seek help for problems with cannabis. During 2014-15, 13,454 presented to specialist services with cannabis as their primary substance (73% of all those receiving help during the year). Since 2005-06, the general trend in the number of young people in treatment for cannabis has been increasing and, although there was a slight fall in numbers in treatment in 2014-15, the proportion of all young people in treatment with cannabis as their primary substance increased slightly.

Alcohol was the next most common problem substance, with 3,133 young people (17% of the total in treatment) seeking help during 2014-15. This is down from 3,776 (20%) last year and is significantly lower than the 2008-09 peak of 8,799 (37%). It is now at its lowest ever level.

Prevalence estimates do not indicate that cannabis use in the general population of young people is rising.[xii] Alcohol use for those in treatment is falling in line with the prevalence statistics as is opiate use, which is falling across all ages but especially in the younger groups.

Figure 5.2.1 Number of young people in treatment by primary substance (2005-06 to 2014-15)

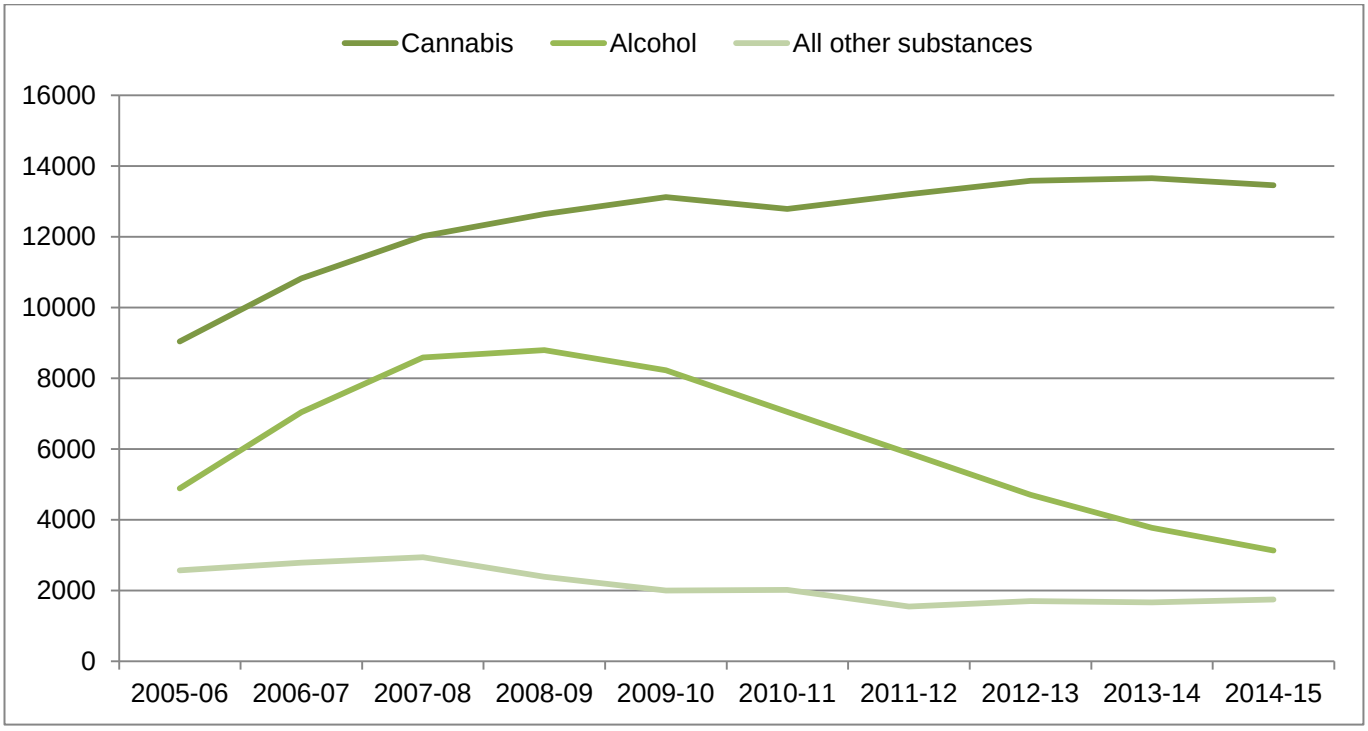


Figure 5.2.2 reports in more detail the young people in figure 5.2.1 citing 'all other substances' and the substances they cited. This shows that the number in treatment for amphetamine use rose in 2010-11, when mephedrone was added to NDTMS, but has fallen in the last two years. Numbers of young people in treatment for opiates and crack cocaine have fallen markedly over the last ten years and now represent 0.7% and 0.1% respectively of the young people's treatment population compared to 5.3% and 1.2% respectively in 2005-06.

Figure 5.2.2 Number of young people in treatment by primary substance (not including primary cannabis or primary alcohol use, 2005-06 to 2014-15)

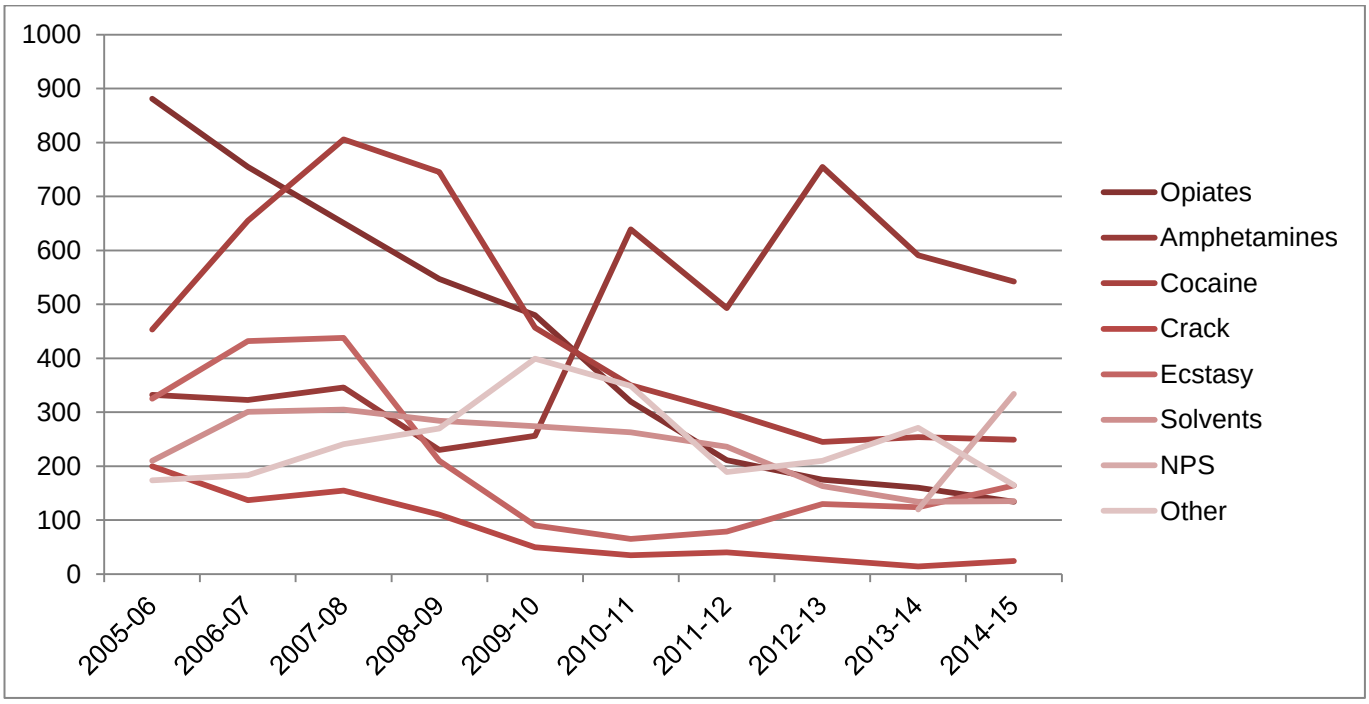


Table 5.2.1 Number of young people in treatment by substance (2005-06 to 2014-15)

Substance	2005-06		2006-07		2007-08		2008-09		2009-10	
	n	%	n	%	n	%	n	%	n	%
Opiates	881	5%	755	4%	651	3%	547	2%	480*	2%
Amphetamines	332	2%	323	2%	346	1%	230*	1%	256	1%
Cocaine	453	3%	655	3%	806	3%	745*	3%	457	2%
Crack	200	1%	137	1%	155	1%	110	0%	50*	0%
Ecstasy	325	2%	432	2%	438	2%	210*	1%	90*	0%
Cannabis	9,043	55%	10,824	52%	12,021	51%	12,642	53%	13,123	56%
Solvents	210	1%	301	1%	305	1%	284	1%	274	1%
Alcohol	4,886	30%	7,039	34%	8,589	36%	8,799	37%	8,227	35%
New psychoactive substances	-	-	-	-	-	-	-	-	-	-
Other	174	1%	183	1%	241	1%	270*	1%	399	2%

Substance	2010-11		2011-12		2012-13		2013-14		2014-15‡	
	n	%	n	%	n	%	n	%	n	%
Opiates	320*	1%	211	1%	175*	1%	160*	1%	134	1%
Amphetamines	639	3%	493	2%	755*	4%	591	3%	540*	3%
Cocaine	350*	2%	301	1%	245*	1%	254	1%	250*	1%
Crack	35*	0%	40	0%	27	0%	14	0%	24	0%
Ecstasy	65*	0%	79	0%	130*	1%	124	1%	165*	1%
Cannabis	12,784	58%	13,200	64%	13,581	68%	13,659	71%	13,454	73%
Solvents	263	1%	236	1%	163	1%	134	1%	135	1%
Alcohol	7,054	32%	5,884	29%	4,704	24%	3,776	20%	3,133	17%
New psychoactive substances	-	-	-	-	-	-	120*	1%	334	2%
Other	349	2%	189	1%	210*	1%	271	1%	165*	1%

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

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

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

Figure 5.3.1 reports the number of clients aged under 18 in treatment in each of the years 2005-06 to 2014-15, where the person reported using one or more club drugs or NPS.

'Club drug and NPS use' incorporates a number of different substances typically used by young people in bars and nightclubs, at concerts and parties, before and after a night out, and in place of other drugs. Data on club drug use for young people was first used in the 2012 report 'Club drugs: emerging trends and risks' (www.nta.nhs.uk/uploads/clubdrugsreport2012[0].pdf) and has been reported via this report for each year since. Data on NPS use is reported here for the second year using a series of new drug codes describing NPS according to their predominant effect. The full breakdown of young people in treatment citing club drug and NPS use is shown in table 5.3.1.

Numbers of young people reporting problems with mephedrone fell by 10.5% between 2013-14 and 2014-15, the second successive decrease following a 15% fall between 2012-13 and 2013-14. However, the number of young people in treatment citing ecstasy use increased by 23% between 2013-14 and 2014-15 to 1,338. This was well below the peak of 2,281 in 2007-08, but an increase of 83% from 2011-12, when 732 young people in treatment said they had problems with ecstasy. The rise in treatment numbers for ecstasy between 2013-14 and 2014-15 is mirrored by the findings of the Crime Survey for England and Wales, which reported a significant increase – 3.9% to 5.4% – in the number of people aged 16 to 24 using ecstasy in the last year.[xiii]

The number of young people citing ketamine use fell by 45% between 2013-14 and 2014-15 to 228, after having increased slightly in 2013-14. The numbers of young people citing GHB/GBL and methamphetamine are also considered but are not presented in figure 5.3.1 because the numbers were so small: ten for GHB/GBL and 11 for methamphetamine in 2014-15.

Although the numbers of young people reporting problems with NPS rose for the second year, the numbers are still relatively small, and fall behind the more established ecstasy and mephedrone. Although NPS use has been widely reported in the media and other places, the full extent of its use is still not fully known, and people having problems with these drugs tend to present at acute services such as hospital emergency departments. Specialist substance misuse services need to ensure they are accessible and relevant to those who may need more support.

Figure 5.3.1 Number of young people in treatment by club drug and/or NPS use (2005-06 to 2014-15)

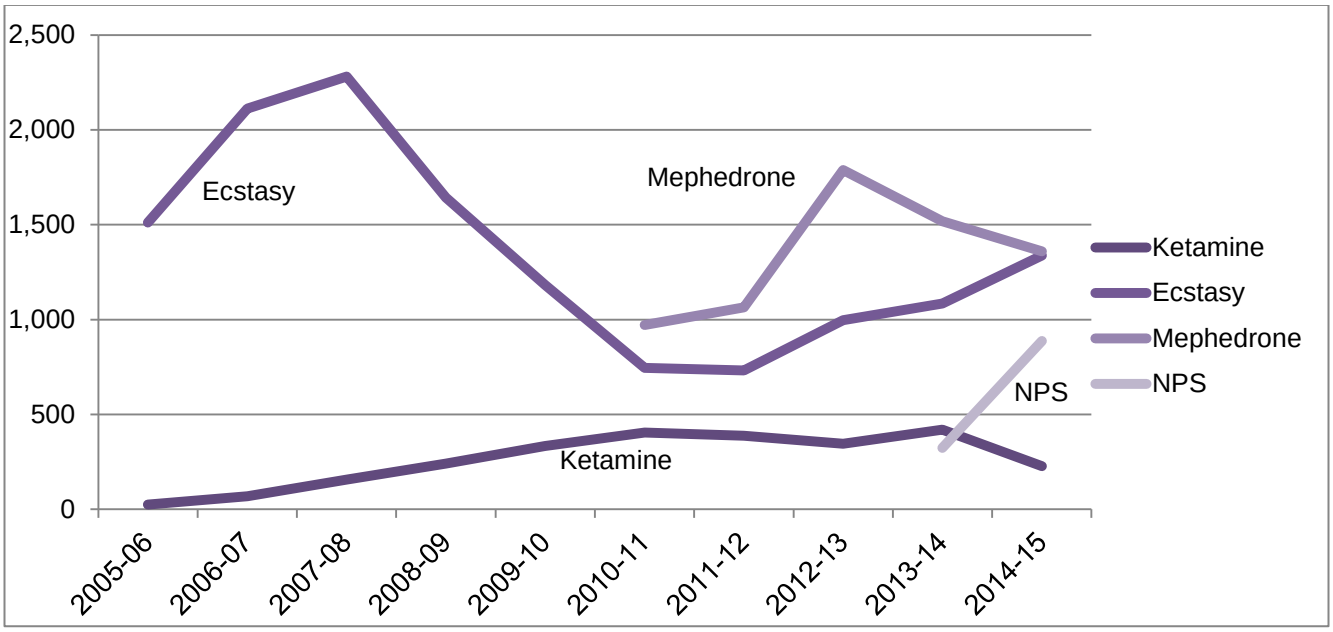


Table 5.3.1 Trends in numbers presenting to treatment citing club drug and/or NPS use

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

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

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

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

5.4 Trends in treatment exit reasons

Table 5.4.1 reports treatment exit reasons for clients in the years 2005-06 to 2014-15. In 2009 a new discharge coding system was introduced that tightened the way 'treatment completed' was recorded. For further details see Quality and Methodology information. These changes mean it is not possible to directly compare treatment exit data for some codes from 2009-10 onwards with previous years.

Table 5.4.1 Trends in treatment exit reasons

Treatment exit reason	2005-06		2006-07		2007-08		2008-09		2009-10	
	n	%	n	%	n	%	n	%	n	%
Complete	4,105	48%	5,726	50%	8,073	57%	9,546	65%	10,160	69%
Referred on	572	7%	701	6%	938	7%	510	3%	856	6%
Dropped out/left	2,525	29%	2,902	25%	2,529	18%	2,253	15%	2,408	16%
Prison	200	2%	285	2%	339	2%	371	3%	183	1%
Treatment declined by client	*	0%	246	2%	703	5%	620*	4%	529	4%
Not known	102	1%	202	2%	98	1%	71	0%	51	0%
Other	1,108	13%	1,448	13%	1,401	10%	1,250	9%	478	3%
Total	**8,615***	**100%**	**11,510**	**100%**	**14,081**	**100%**	**14,620***	**100%**	**14,665**	**100%**

Treatment exit reason	2010-11		2012-13		2012-13		2013-14		2014-15	
	n	%	n	%	n	%	n	%	n	%
Complete	10,507	75%	10,118	77%	10,208	79%	9,852	79%	9,613	80%
Referred on	793	6%	841	6%	760	6%	852	7%	773	7%
Dropped out/left	1,851	13%	1,630	12%	1,530	12%	1,440	12%	1,345	11%
Prison	139	1%	97	1%	66	1%	62	0%	52	0%
Treatment declined by client	440	3%	326	2%	278	2%	244	2%	236	2%
Not known	16	0%	0	0%	0	0%	0	0%	0	0%
Other	260	2%	175	1%	105	1%	60	0%	55	0%
Total	**14,006**	**100%**	**13,187**	**100%**	**12,947**	**100%**	**12,510**	**100%**	**12,074**	**100%**

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

6. History

NDTMS figures for England are produced by The National Drug Evidence Centre (NDEC) at Manchester University, which also collates these with those for Scotland, Wales and Northern Ireland, into a UK return for use by the European Monitoring Centre for Drugs and Drug Addiction (see www.emcdda.europa.eu/index.cfm), and for the United Nations.

Separate statistics on young people accessing substance misuse services were published by the National Treatment Agency for Substance Misuse (NTA) in 2007-08 and have been published each year since. NDTMS adult reports for 2005-06 and 2007-08 included clients under 18, who then comprised around 6% of the total treatment population.

In November 2011, the UK Statistical Authority served notification under Section 16 of the Statistics and Registration Services Act (2007) that its view was that both young people's data and alcohol data should be put forward for assessment as National Statistics. The Secretary of State for Health submitted a formal assessment request in February 2013. Meanwhile the NTA and PHE have worked with DH Statistics head of profession to ensure that the reports since 2010-11, including this report for 2014-15, are produced in accordance with the code of practice for Official Statistics.

On 1 April 2013, responsibility for production of these statistics transferred from NTA, to Public Health England.

6.1 Relevant web links and contact details

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

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

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

General enquiries

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

Policy

Drug policy team, PHE
EvidenceApplicationteam@phe.gov.uk

Data and statistics

Martin White, programme manager, PHE
Martin.White@phe.gov.uk

Solina Li, information analyst, PHE
Solina.Li@phe.gov.uk

Andrew Jones, research Fellow, NDEC
Andrew.Jones@manchester.ac.uk

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Stefan.Jahr@manchester.ac.uk

6.2 Comparability of data to previous reports

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

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

From 1 November 2013, all registered young people's treatment providers are registered with a setting type. There are seven settings: community, home, secure estate, in-patient (substance misuse specific), in-patient (not substance misuse specific), residential (substance misuse specific) and residential (not substance misuse specific) which have now been incorporated to PHE's regular reporting. Clients in a secure estate setting are not reported on in this document. Definitions of these settings can be found in section 7.2 and the business definitions guide at www.nta.nhs.uk/uploads/yptreatmentbusinessdefinitionv11.03.pdf. Intervention types

have been split in to four high-level categories: pharmacological interventions, psychosocial interventions, harm reduction interventions and multi-agency working interventions. Multi agency working interventions are not reported on in the present report. 2014-15 is the first full year of reporting following the implementation of these changes and therefore the figures shown in tables 3.2.1 and 3.2.2 are not comparable to previous years.

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.nta.nhs.uk/uploads/yptreatmentbusinessdefinitionv11.03.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. 2014-15 is the first year of complete data using the revised list of seventeen vulnerabilities shown in section 2.7 and the figures on multiple vulnerabilities in table 2.7.3 are not comparable to those reported for previous years.

For 2014-15, use of prescription opiates reported to NDTMS has been moved to the 'opiates' category in the reporting by substance shown in sections 2.3 and 5.2, having previously been counted under 'other'. In table 2.3.1 these are included under the category 'Other and prescribed opiates'. There are a very small number of young people with these substances reported and trend figures shown in table 5.2.1 from previous years' reports have not been refreshed to take into account this change.

6.3 Drug treatment collection and reporting timeline

1989 to March 2001 Regional Drug Misuse Database (RDMD) – statistics reported in six monthly bulletins by DH from 1993 to 2001

April 2001 to March 2004 NDTMS – statistics reported annually by DH

April 2004 to March 2013 NDTMS – managed by NTA reporting statistics annually up to March 2012

April 2013 to date NDTMS – managed by PHE reporting statistics annually from April 2012

6.4 Other sources of statistics about drugs

6.4.1 Prevalence of substance use among young people

Information is available relating to the prevalence of drug use among secondary school pupils aged 11 to 15 from 'Smoking, drinking and drug use 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 annual survey interviews school pupils, and has included questions on drug use since 2001. The most recent statistics are at www.hscic.gov.uk/catalogue/PUB17879

An annual estimate of the prevalence of drug use is undertaken through the Crime Survey for England and Wales (CSEW; formerly the British Crime Survey). This section of the survey has been in place since 1996, annually since 2001, and has tracked the prevalence of the use of different drugs over this time. This does not include information on all young people but does show the data for the age group 16-24. www.gov.uk/government/uploads/system/uploads/attachment_data/file/462885/drug-misuse-1415.pdf

A second method for estimating the prevalence of crack cocaine and heroin use is produced for each local authority area in England by Liverpool John Moores University. These estimates include a sub-sample of young people, reporting on those aged 15-24. Estimates are available for 2006-07, 2008-09, 2009-10, 2010-11 and 2011-12. The estimates are produced through a mixture of capture-recapture and Multiple Indicator Methodology (MIM), and rely on NDTMS data being matched against and/or analysed alongside probation and Home Office data sets. The data and further information are at www.nta.nhs.uk/facts-prevalence.aspx

Findings from a survey called 'What About YOUth' will be published on 8 December as part of a new government pledge to make improvements to the health of young people. It asks 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 will be at www.whataboutyouth.com/

6.4.2 International comparisons

The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) publish an annual report (the European Drug Report) that describes and compares aspects of drug use and drug policy within European states, as well as providing detailed comparative statistics. The most recent report can be found at www.emcdda.europa.eu/edr2015

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/stats13#tdi:displayTables

The European School Survey Project on Alcohol and Other Drugs (ESPAD) collects comparative data on substance use among 15-16 year old students across a number of European countries. The results of these surveys can be found at www.espad.org/

The UK Focal Point on Drugs is the national partner of EMCDDA and provides comprehensive information to the centre on the drug situation in England, Northern Ireland, Scotland and Wales. The UK Focal Point on Drugs is now part of PHE.

Focal Point works closely with the Home Office, other government departments and the devolved administrations. In addition to contributing to the EMCDDA annual report, it collates an extensive range of data in the form of standard tables and responses to structured questionnaires, which are submitted regularly to EMCDDA. It also contributes to other elements of EMCDDA's work such as the development and implementation of its five key epidemiological indicators, the Exchange on Drug Demand Reduction Action (EDDRA) and the implementation of the council decision on new psychoactive substances. The most recent reports can be found at www.nta.nhs.uk/focalpoint.aspx

The Welsh government publishes substance misuse statistics, which include treatment statistics from the Welsh National Database for Substance Misuse, as well as other information available from other routine data sources. Age groups of 10-14 and 15-19 are included in this report. The most recent statistics are at gov.wales/topics/people-and-communities/communities/safety/substancemisuse/impact/stats/?lang=en

Statistics about drug misuse in Scotland (under 20s) are published by Drug Misuse Information Scotland and are at www.scotpho.org.uk/behaviour/drugs/introduction

Statistics about drug misuse treatment in Northern Ireland (under 18s) are published by the Northern Ireland's Executive's Department of Health, Social Services and Public. The most recent of these is at www.northernireland.gov.uk/index/media-centre/news-departments/news-dhssps/news-dhssps-071015-publication-of-statistics.htm

NDTMS figures for England are collated by NDEC, with those for Scotland, Wales and Northern Ireland, into a UK return for use by EMCDDA (see www.emcdda.europa.eu/index.cfm), and for the United Nations.

The Health Behaviour in School-aged Children (HBSC) research network collects data every four years on 11, 13 and 15-year-old boys' and girls' health and wellbeing, social environments and health behaviours. More information is at www.hbsc.org/

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 used in collecting the data and in subsequently in reporting it.

6.4.3 Youth justice statistics

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

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'.[xiv]

6.4.5 Drug-related deaths

The Office for National Statistics publish an annual summary of all deaths related to drug poisoning (involving 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: www.ons.gov.uk/ons/rel/subnational-health3/deaths-related-to-drug-poisoning/england-and-wales---2014/deaths-related-to-drug-poisoning-in-england-and-wales--2014-registrations.html

6.4.6 Hospital admissions statistics

The Local Alcohol Profiles for England (LAPE), published by PHE, feature an indicator on rates of hospital admission for alcohol-specific conditions for under-18s. These are reported for each local authority, enabling comparisons with the England average and other local authorities, at fingertips.phe.org.uk/profile/local-alcohol-profiles (indicator 5.01). The most recent figures relate to the three-year period from 2011-12 to 2013-14.

Rates of hospital admission for substance misuse are published by ChiMat as part of the Children and Young People's Health Benchmarking Tool. These are reported for each local authority, enabling comparisons with the England average and other local

authorities, at fingertips.phe.org.uk/profile/cyphof. The most recent figures relate to the three-year period from 2011-12 to 2013-14.

6.4.7 Other statistics

The NHS Information Centre produced an annual report on drugs and drug use. The report draws on statistics from a number of sources including treatment statistics from NDTMS, and has three sections: drug misuse in young adults, drug misuse among children and outcomes of drug misuse. The latest report can be found at www.hscic.gov.uk/catalogue/PUB15943/drug-misu-eng-2014-rep.pdf

7. Abbreviations and definitions

7.1 Abbreviations

A&E	Accident and emergency department
ACMD	Advisory Council on the Misuse of Drugs
CAMHS	Child and adolescent mental health services
DP	Drug partnership
EMCDDA	European Monitoring Centre for Drugs and Drug Addiction
NDEC	National Drug Evidence Centre (University of Manchester)
NDTMS	National Drug Treatment Monitoring System
NTA	National Treatment Agency for Substance Misuse
PHE	Public Health England
YOT	Youth offending team
YP	Young people

7.2 Definitions

Agency/provider	A provider of services for the treatment of substance misuse. They may be statutory (ie, NHS) or non-statutory (ie, third sector, charitable).
Agency/provider code	A unique identifier for the treatment provider (agency) assigned by the regional NDTMS centres – eg, L0001.
Adjunctive drug use	Substances additional to the primary substance used by the client, NDTMS collects secondary and tertiary substances.
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 partnership
: The partnerships responsible for delivering the drug strategy at a local level (also known as drug and alcohol action team, or DAAT).

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.

Harm reduction intervention
: Specialist harm reduction interventions should include services to manage injecting, overdose and substance misuse-related accidental injury

In contact
: Clients are counted as being in contact with treatment services if their date of presentation (as indicated by triage), intervention start, intervention end or discharge indicates that they have been in contact with a provider during the year.

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.

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.

Intervention — A type of treatment, eg, structured counselling, community prescribing, etc.

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.

Looked after child — The definition of a looked after child (from the Children Act 1989[xv]) 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"

Opiate — A group of drugs including heroin, methadone and buprenorphine

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.

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 care setting

Structured substance misuse treatment is provided in a primary care setting by a general practitioner, often with a special interest in addiction treatment.

Primary care trust — A PCT was a type of NHS trust, part of the NHS in England. PCTs were largely administrative bodies, responsible for commissioning primary, community and secondary health services from providers.

Primary drug/substance

The substance that brought the client into treatment at the point of triage/initial assessment.

Psychosocial Intervention

These interventions use psychological, psychotherapeutic, counselling and counselling based techniques to encourage behavioural and emotional change; the support of lifestyle adjustments and the enhancement of coping skills. They include motivational interviewing, relapse prevention and interventions designed to reduce or stop substance misuse, as well as interventions that address the negative impact of substance misuse on offending and attendance at education, employment or training.

Referral date — The date the client was referred to the provider for this episode of treatment.

Residential unit (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.

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.

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.

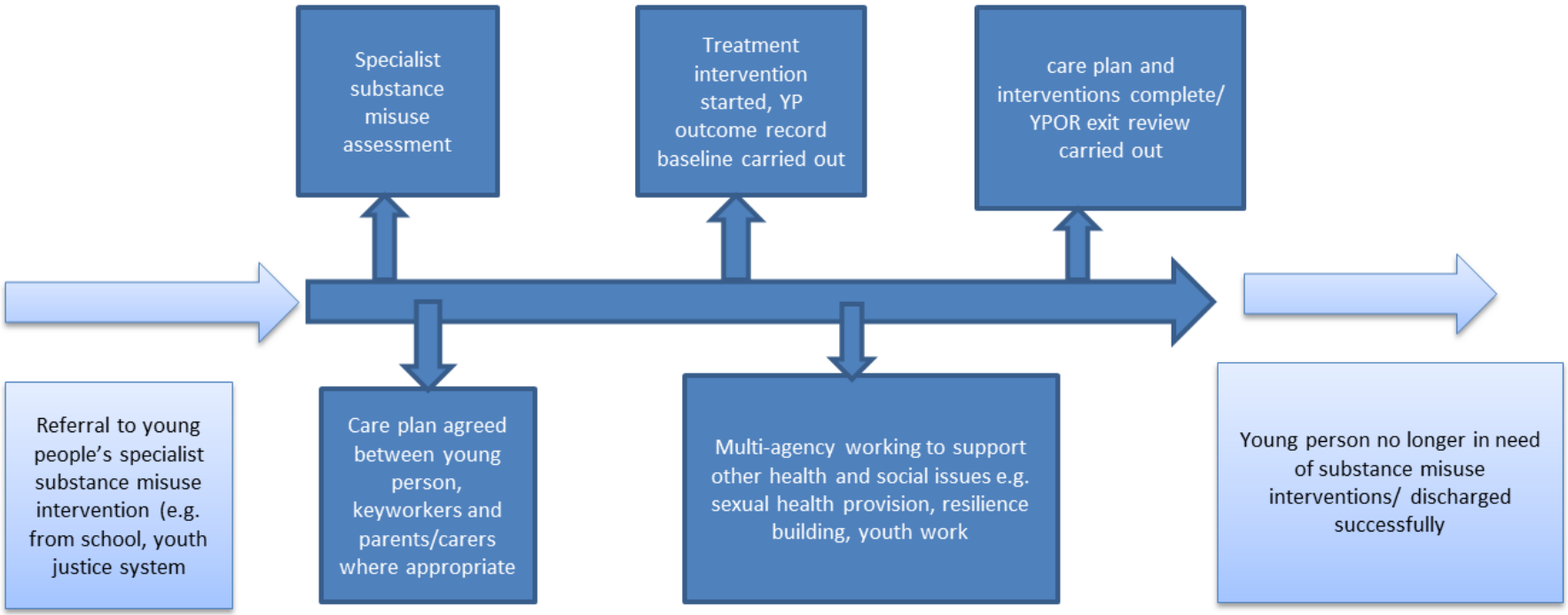
Triage	An initial clinical risk assessment performed by a treatment provider. A triage includes a brief assessment of the problem as well as an assessment of the client's readiness to engage with treatment, in order to inform a care plan.
Triage date	The date that the client made a first face-to-face 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	Under 18 years old.
YP secure estate	Establishments that house young offenders who have been remanded or sentenced, they include young offender institutes (YOIs), 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.



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[v] Ethnic group by age in England www.nomisweb.co.uk/census/2011/LC2109EWLS/view/2092957699?rows=c_age&cols=c_ethpuk11
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[xv] The Children's Act 1989 can be found here; www.legislation.gov.uk/ukpga/1989/41/contents