Health Needs Assessment of Children and Young People's Substance Misuse in Kent

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1 Executive Summary

- Kent's population is growing, with under 24 year making up a 25% of residents and including a substantial university student population of around 30,000–35,000 that shapes local demand for children and young people's services.
- From 2009/10 to 2024/25, the number of children aged 17 and under in treatment in Kent fell from a peak of around 600 to 229, while young adults aged 18–29 declined from over 1,500 to 825, with both groups showing long-term downward trends and only slight recent recovery.
- Among children aged under 17, cannabis remains the most commonly cited substance, with alcohol steadily declining over time and all other substances—such as ecstasy, cocaine, amphetamines, and opiates remaining low and relatively stable, indicating a narrow but persistent pattern of use dominated by cannabis. Among young adults aged 18–24, alcohol remains the leading substance in new presentations, with cannabis and cocaine also prominent, while opiate and crack use has steadily declined, reflecting a shift toward more socially accepted and stimulant-linked patterns of use. Other substances including ecstasy, cocaine, amphetamines, and ketamine remain low and stable. These patterns reflect a shift toward more socially normalised and stimulant-linked use, with emerging risks requiring targeted harm-reduction and engagement strategies.

1.1 Key Points (Children aged 17 and under in treatment in Kent) based on NDTMS data

- 227 children aged 17 and under were in treatment in 2024/25, continuing a long-term decline from a peak of around 600 in 2010, with a small recent uptick in 2024–25.
- Most young people in treatment remain engaged in mainstream education, though numbers dipped sharply around 2021; those in alternative provision or excluded from school form a consistent minority linked to higher vulnerability.
- Engagement in employment, training, or voluntary work is very low, with a small but persistent group who are Not in Employment or Education or Training or economically inactive due to health needs, underscoring wider social and wellbeing challenges.
- Cannabis and alcohol dominate as primary substances, with cannabis peaking in 2018 before declining; other substances (e.g., cocaine, ecstasy, ketamine) remain low and stable, and heroin/crack use is rare.

- Education settings are the most common referral route, alongside social care and youth justice, highlighting the central role of safeguarding and school-based identification.
- Referrals from health services and specialist substance misuse services remain low, signalling missed opportunities for earlier intervention.

- Successful completion is the most frequent treatment outcome, though rates have declined since 2017; dropouts remain low but variable, indicating the need to strengthen retention and support pathways.

1.2 Key Points (Young adults aged 18–29 in treatment in Kent) based on NDTMS data

- 825 young adults aged 18–29 were in treatment in 2024/25, continuing a long-term decline from over 1,500 in 2010, despite a small recent rise.
- Both 18–24 and 25–29 age groups show falling engagement over time, with a particularly sharp drop among 18–24 year olds, signalling reduced access or changing patterns of need.
- Alcohol remains the most common substance, followed by cannabis and cocaine, while opiate and crack presentations have steadily declined, indicating a shift toward more socially normalised and stimulant-linked use.
- Self, family, and friends are the dominant referral route, while referrals from criminal justice, health services, and specialist services have declined or remained low, highlighting gaps in professional pathways.
- Most young adults spend under one year in treatment, with longer treatment durations remaining consistently low, suggesting reliance on short-term interventions.
- Use of community-based interventions peaked around 2015 and has since fallen, with pharmacological support declining and psychosocial interventions less visible in recent years, pointing to potential reductions in structured therapeutic provision.
- Kent saw a modest 1% rise in children and young people in treatment over the past year, contrasting with a national decline, while access and planned exit rates remain strong at 100% and 84% respectively. Local treatment numbers peaked in 2017 but declined steadily until 2022, with only partial recovery, suggesting slower re-engagement compared to national trends. Cannabis remains the dominant substance, with alcohol use declining and stimulant use (e.g. amphetamines,

cocaine) showing gradual increases locally. Kent consistently outperforms national completion rates, though dips around 2020–21 reflect pandemic disruption. Re-presentation rates are more volatile locally than nationally, indicating potential gaps in follow-up support and discharge continuity.

1.3 Findings summary

- The known cohort in structured treatment is under 1,100 young people, but modelling suggests 4,000+ at risk and eligible for support, meaning most local need remains unmet.
- East Kent (Thanet, Dover, and Folkestone) has consistently higher rates of admission and early help—indicating more complex, concentrated need.
- Waiting times for Children and Young People seen within 3 weeks is 85% in Kent and it exceeds national average.
- Planned service exit: 87% Kent vs 60–75% national.
- Referral rates from education are lower in Kent (22%) than England (32%), suggesting missed cases among school populations.
- Referrals rates from social care are higher (31%) than (23%) national average.
- Self-harm as comorbidity: 44% Kent vs 30% England

1.3.1 Early Initiation and High-Risk Patterns Among Vulnerable Groups

Young people in Kent are starting to use substances at a younger age than the national average, with 92% starting under 15 years compared to 77% nationally, and a higher rate of poly-drug use (88% in Kent vs 57% England). Vulnerable groups including looked after children, children exposed to domestic abuse, those who self-harm, and girls continue to show particularly high prevalence and complexity of need, underlining the importance of early, targeted prevention and partnership working.

1.3.2 Declining Referrals and Gaps in Universal Prevention Services

There is a concerning reduction in the number of young people being referred to specialist substance misuse services, especially from schools and acute hospital settings (education referrals are only 22% in Kent vs 32% nationally). This highlights significant gaps in universal screening, school-based prevention, and community awareness that need to be addressed to prevent escalation and ensure earlier engagement with support.

1.3.3 Need for Stronger Strategic Coordination and Whole-System Prevention

Kent lacks a cross-sector, strategic oversight group for young people's substance misuse, apart from contract monitoring meetings. The report recommends establishing a multi-agency commissioner's forum, expanding prevention (including trauma-informed and community-based models), and mainstreaming joint protocols with mental health and social care partners all in line with national best practice and more systematically addressing adverse childhood/community experiences as root drivers of risk.

These three issues high early risk, declining proactive intervention, and the need for whole-system partnership are consistently identified across the executive summary, key findings, and recommendations sections of the report.

1.4 Recommendations

The needs assessment identifies a strong local treatment response for children and young people who access services, including timely treatment entry and high planned-exit rates. However, it also identifies substantial unmet need, earlier initiation of substance use, high levels of polysubstance use and co-occurring vulnerabilities, lower-than-expected education and health referrals, geographical inequalities, and risks of disengagement among young adults and at transition points.

The following eight recommendations provide a single, prioritised framework for commissioning, partnership delivery and performance monitoring over the lifetime of the strategy. They should be implemented through a phased delivery plan, with clear leads, measurable outcomes and meaningful involvement of children, young people and families throughout.

These recommendations should be delivered through the following overarching principles:

- Prevention before escalation: combine universal education-based prevention with targeted early help for those experiencing vulnerability or early signs of harm.
- No wrong door: any professional or service encountering substance-related risk should be able to identify need, offer brief advice and make a straightforward referral.
- Trauma-informed and non-stigmatising practice: particularly important for care-experienced CYP, those affected by domestic abuse, self-harm, exploitation or parental substance use.
- Equity-led commissioning use deprivation, district, age and vulnerability data to direct investment rather than relying only on treatment activity.
- Co-produced services: involve CYP in the design of communications, outreach, access routes, workforce training and service evaluation.

Priority	Recommendation	Evidence from the needs assessment	Suggested measures of progress
1	**Establish a Kent CYP Substance Misuse Partnership Board** to provide strategic oversight across public health, education,	The report identifies no established cross-system strategic oversight beyond contract-monitoring	Board established with agreed terms of reference and delivery plan; quarterly performance dashboard; annual

Priority	Recommendation	Evidence from the needs assessment	Suggested measures of progress
	children's social care, NHS, CAMHS, acute trusts, youth justice, police, district partners, providers, VCS and young people. The Board should agree a delivery plan, monitor outcomes and lead the response to emerging drug trends.	arrangements. It also identifies variation in need, gaps in referral routes and the need for more coordinated prevention, safeguarding and data intelligence.	review of progress and priorities.
2	**Strengthen universal and targeted prevention in education and community settings**, with a consistent, skills-based and age-appropriate offer across schools, alternative provision, FE colleges and universities. Target additional support to pupils at risk of exclusion, persistent absence, NEET status and those with safeguarding concerns.	Earlier initiation is a concern: 92% of Kent CYP in treatment reportedly began using substances before age 15, compared with 77% nationally. Education referrals are lower in Kent than England (22% versus 32%), despite schools being a major route into treatment	Proportion of schools and alternative provisions delivering an agreed prevention offer; staff trained; education referral rate; uptake among priority groups; pupil feedback and knowledge/confidence outcomes.
3	**Improve early identification, referral and rapid access across health, education and safeguarding pathways.** Implement clear referral protocols, training and routine prompts for primary care, urgent and emergency care, paediatrics, CAMHS, sexual health, maternity services where relevant, schools and social care.	Referrals from health services and acute settings are low despite rising or persistent substance-related hospital activity. Kent has good treatment access once referral occurs, so the principal opportunity is earlier identification and referral.	Referral volumes and conversion rates by source; proportion starting treatment within three weeks; acute-care referrals receiving follow-up within an agreed timeframe; district-level variation.
4	**Develop an integrated,**	CYP entering	Proportion of eligible

Priority	Recommendation	Evidence from the needs assessment	Suggested measures of progress
	trauma-informed offer for CYP with multiple vulnerabilities, particularly care-experienced children, children in need, those affected by domestic abuse, self-harm, exploitation, parental substance use and mental health need. Joint working arrangements should include shared care planning, risk escalation and access to specialist consultation.	treatment in Kent have high levels of co-occurring vulnerability: self-harm is 44% compared with 30% nationally; domestic-abuse exposure is 26% versus 17%; and criminal exploitation is 12% versus 9%.	CYP receiving joint assessment/care planning; outcomes for care-experienced CYP; self-harm and safeguarding-related presentations; feedback from CYP and families.
5	**Reduce geographical inequalities and unmet need through targeted outreach and place-based provision.** Prioritise East Kent—particularly Thanet, Dover and Folkestone & Hythe—while investigating low engagement in Maidstone, Swale and Tunbridge Wells to distinguish lower prevalence from access barriers or under-identification.	The report identifies higher acute harm, early-help involvement and complex need in East Kent, while other areas show low treatment engagement. It estimates that fewer than 1,100 CYP/young adults are known to services, compared with around 4,000 who may be at risk and eligible for support.	District-level treatment, early-intervention and referral rates; outreach contacts and onward engagement; acute admissions; unmet-need estimates; access and outcome equity by district and deprivation.
6	**Provide a flexible, visible and developmentally appropriate service model for 16–24-year-olds, including robust transition arrangements from CYP to adult**	Treatment engagement has fallen most sharply among 18–24-year-olds. The report identifies a risk of disengagement at transition points and	Numbers and rates of 16–24-year-olds accessing support; transition completion and retention; self-referrals; engagement by college/university/wor

Priority	Recommendation	Evidence from the needs assessment	Suggested measures of progress
	services. This should include outreach in colleges, universities, workplaces and digital spaces; self-referral; youth-friendly drop-ins; and joint transition planning from age 17, including for care leavers.	notes Kent's substantial student population as an important factor in future service demand.	kplace outreach; planned exits and re-presentations.
7	**Maintain an effective, evidence-informed treatment and harm-reduction offer matched to current patterns of use.** Ensure provision addresses cannabis and alcohol as dominant substances, alongside cocaine/stimulants, ketamine, nitrous oxide and polysubstance use; includes psychosocial interventions, relapse prevention, family support and prompt follow-up after acute incidents or discharge.	Cannabis dominates CYP treatment presentations, alcohol remains prominent among young adults, and stimulant use is increasing locally. Poly-drug use is reported at 88% in Kent treatment presentations compared with 57% nationally. Kent has strong planned-exit performance but variable re-presentation rates, indicating a need for consistent aftercare and continuity.	Intervention offer audited annually; planned exits; re-presentation within six and 12 months; uptake of harm-reduction and family support; substance-specific trends and acute presentations.
8	**Embed co-production, workforce development and data intelligence in commissioning and quality assurance.** Routinely involve young people and families in service design, procurement and performance review; build workforce capability in trauma-informed	The report calls for stronger youth involvement, peer approaches, feedback loops, workforce training and more timely linked data. It also identifies the need to benchmark Kent against England, the South East and local	CYP advisory mechanism in place; routine experience measures at entry, review, exit and follow-up; workforce training completion and confidence; dashboard published quarterly; performance reviewed by age,

Priority	Recommendation	Evidence from the needs assessment	Suggested measures of progress
	practice, emerging substances, safeguarding and dual diagnosis; and develop an integrated dashboard segmented by age, district, gender and vulnerability.	district variation.	geography and protected/vulnerability characteristics.

Commissioning Priorities Table

Priority Area	Why This Matters (Evidence & Need)	Commissioning Priority	Key Delivery Activities
1. Early identification & prevention in education	Mainstream education - Schools remain the main referral route CYP in Persistent Absentee/excluded settings show higher vulnerability.	Strengthen prevention and referral pathways in education settings.	• Staff training on substance use risks • Screening tools in schools • Targeted support for pupils at risk of exclusion • Stronger links with alternative provision
2. Health-service referral pathways	Health referrals remain low despite high contact with at-risk CYP.	Improve early detection and referral from health services.	• Routine screening in primary/urgent care • Referral prompts in clinical systems • Co-location of specialist workers in Child and Adolescent Mental Health Service and paediatrics units
3. Multi-agency safeguarding for vulnerable CYP	CYP who are NEET, excluded, or with health-related inactivity face multiple risks.	Strengthen coordinated safeguarding responses.	• Joint case discussions • Shared risk assessments • Multi-agency support plans
4. Engagement of	Sharpest decline in	Develop tailored	• Outreach in Further

18–24 year olds	treatment access among younger adults.	engagement strategies for young adults.	Education (colleges, sixth-form colleges, apprenticeships, vocational training, and foundation courses) and Higher Education settings (university-level) and workplaces • Digital engagement campaigns • Young-adult-friendly drop-ins
5. Harm-reduction for alcohol, cannabis & stimulants	Cannabis dominates and alcohol declining among CYP under 17 years; stimulant use rising locally.	Expand targeted harm-reduction interventions.	• Brief interventions in youth/community settings • Workshops on stimulant risks • Integrated harm-reduction advice
6. Psychosocial & pharmacological pathways	Decline in psychosocial interventions; reduced pharmacological support.	Rebuild structured psychosocial provision and review medication pathways.	• Increase access to evidence-based therapies • Review pharmacological pathways • Standardise therapeutic offers across Kent
7. Retention & completion rates	CYP completion rates strong but declining; re-presentation variable.	Improve retention and completion outcomes.	• Personalised care planning • Consistent key working • Proactive follow-up for missed appointments
8. Transitions for	Risk of	Strengthen	• Joint transition

17–25 year olds	disengagement at transition points.	continuity between CYP and adult services.	planning from age 17 • Shared handover meetings • Flexible pathways up to age 25
9. Visibility & accessibility of services	Local recovery slower than national; need for easier access.	Increase reach and accessibility of specialist services.	• Community outreach • Co-location in youth hubs and education settings • Partnerships with universities and FE colleges
10. Commissioning aligned to population growth	Kent's population rising; 30–35k university students shape demand.	Align capacity and service models with demographic change.	• Demand modelling • Capacity planning • Tailored provision for student populations

1.5 Conclusion

- Kent should maintain targeted and universal prevention, strategic multiagency oversight, and regular benchmarking alongside continued investment in integrated services.
- Recommended actions are responsive to new and persistent trends, with a clear focus on evidence-informed policy and practice.

2 Introduction

This needs assessment supports the commissioning of substance misuse services for children and young people (CYP) aged up to 25 in Kent, using the latest national benchmarks and comparative best practice. It evaluates prevalence across key age groups, assesses service performance, and sets out recommendations for future strategy and multi-agency partnership.

2.1 The Kent Population Context

The population of Kent (Kent County Council area, excluding Medway) is estimated at 1,639,000 in 2024, with an average age of 41.3 years. Kent's population is projected to grow steadily over the coming years, increasing by around 7–8% by 2040. Children and young people aged 0–15 make up approximately 18% of Kent's population, which is slightly lower than the national average. Young adults aged 16–24 account for around 10%, again below the England average. Kent hosts several higher-education institutions, including the University of Kent, Canterbury Christ Church University, and the University for the Creative Arts. Collectively, these institutions support around 30,000–35,000 university students across the county.

The chapter 2.2 below is based on NDTMS report to support improved decision-making and more effective planning of alcohol and drug misuse treatment services.

2.2 Drug and alcohol statistics of children aged 17 and under in treatment in Kent

2.2.1 Number of children aged 17 and under in treatment in Kent[1]

There are 227 children aged 17 and under in treatment services in Kent for 2024/25 year.

[1] NDTMS - ViewIt - Young People

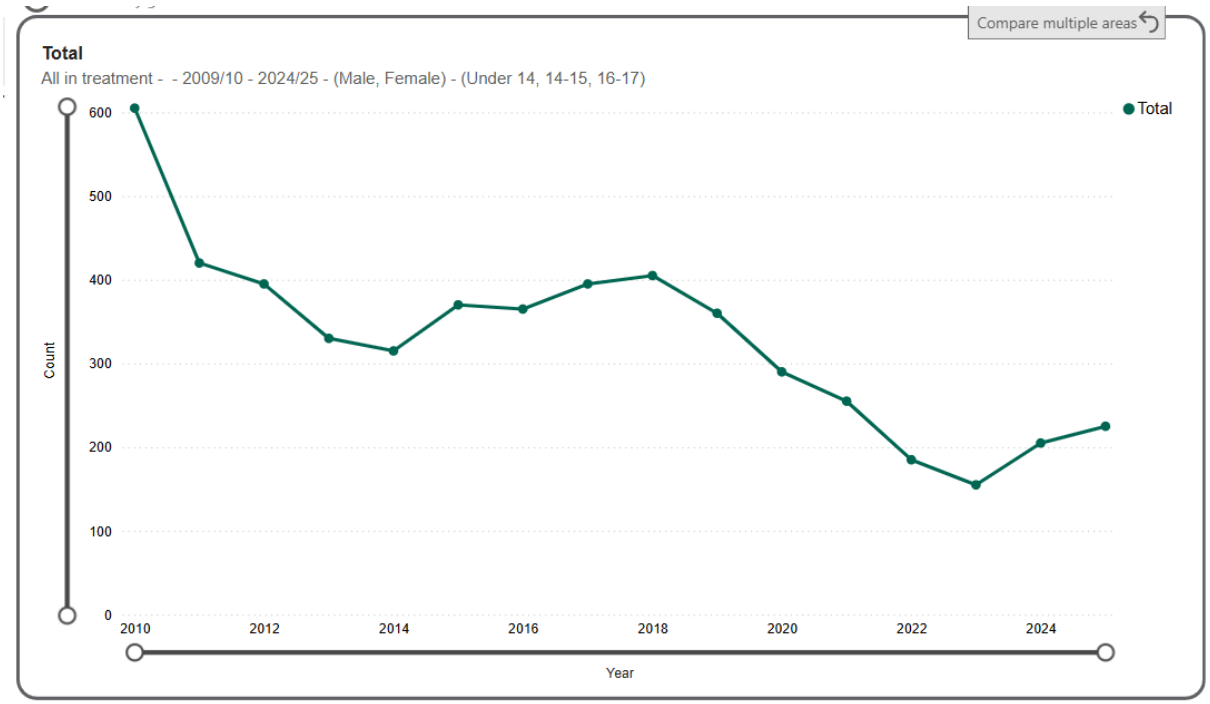

Figure 1 Children aged 17 and under in treatment in Kent from 2009/10 to 2024/25

The graph above shows a clear long-term decline in the number of young people (under 18) receiving treatment for substance misuse in Kent. The number of young people in treatment peaked at around 600 in 2010, declined steadily to below 200 by 2023. However, there is a modest uptick in 2024 and 2025.

2.2.2 Education and employment status of children aged 17 and under in Kent

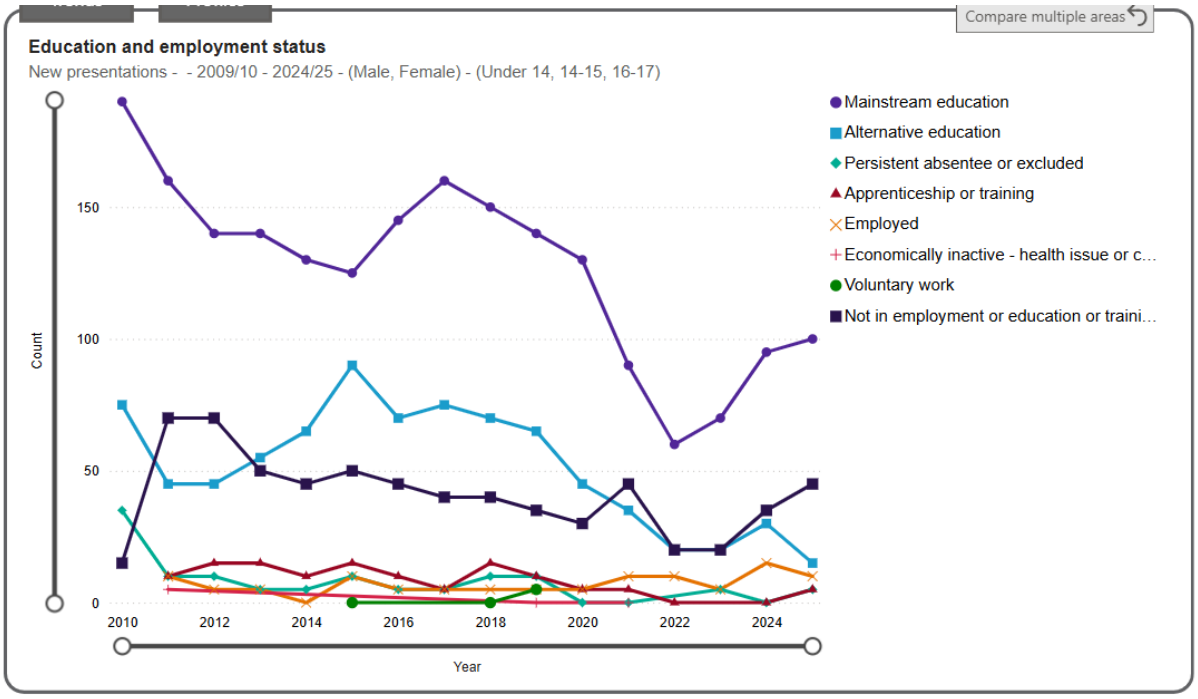

Figure 2 Education and employment status of children aged 17 and under in treatment in Kent from 2009/10 to 2024/25[2]

Among young people entering treatment for substance use in Kent, the majority are engaged in mainstream education, though this group saw a notable decline around 2021 before partially recovering. Presentations from those in alternative education or excluded from school remain moderate but fluctuate, highlighting links between educational disengagement and substance use risk.

Engagement in employment, training, or voluntary work is consistently low, while a small but persistent number of young people present as Not in Employment or Education or Training (NEET) or economically inactive due to health conditions. It highlights the need for integrated support that addresses both substance use and wider social vulnerabilities.

[2] NDTMS - ViewIt - Young People

2.2.3 Substance use and behaviour of children aged 17 and under in Kent

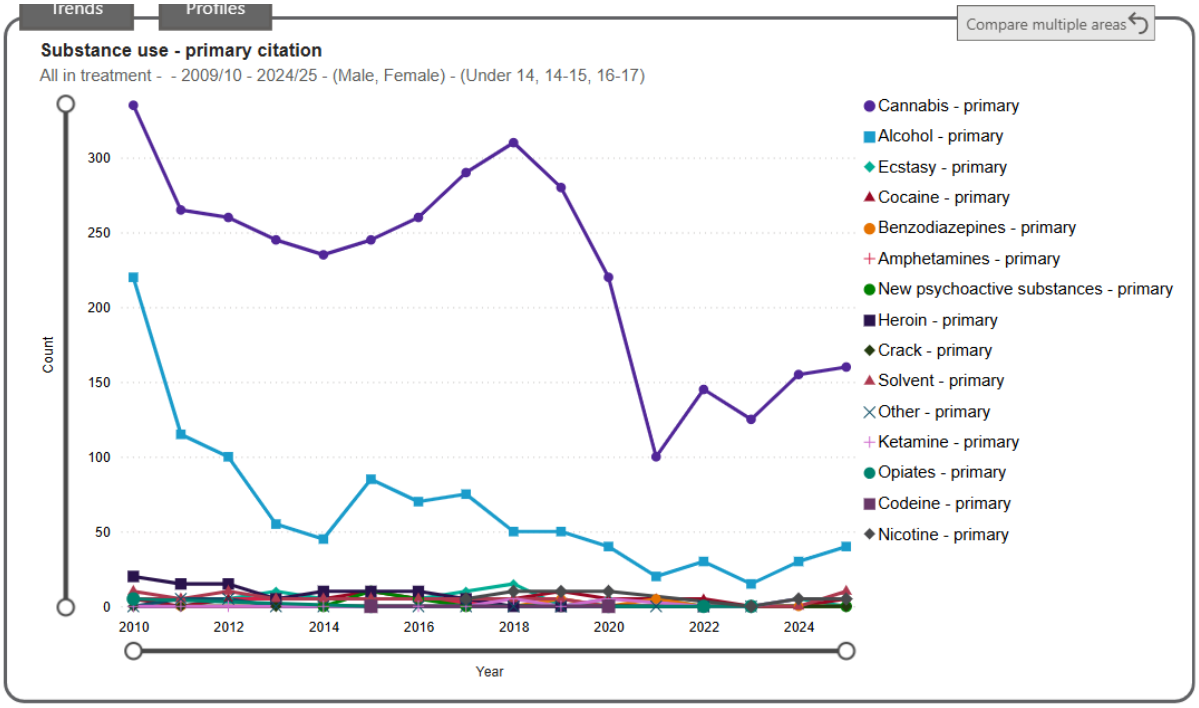

Figure 3 Substance use and behaviour of Children aged 17 and under in treatment in Kent from 2009/10 to 2024/25[3]

Among young people in treatment for substance use in Kent, cannabis and alcohol remain the most commonly cited primary substances, with cannabis peaking around 2018 before declining sharply and then slightly rising in recent years, while alcohol shows a steady long-term decline.

Other substances such as ecstasy, cocaine, ketamine, and benzodiazepines appear at much lower levels and remain relatively stable, while heroin, crack, and solvents are rarely cited. These patterns suggest that most young people in treatment are engaging with widely available and socially normalised substances, with emerging risks linked to newer psychoactive drugs and the need for responsive, targeted interventions.

[3] NDTMS - ViewIt - Young People

2.2.4 Routes into treatment of children aged 17 and under in Kent

Routes into treatment for young people in Kent show that **education settings remain the most common source of referral**, consistently accounting for the highest number of new presentations[4].

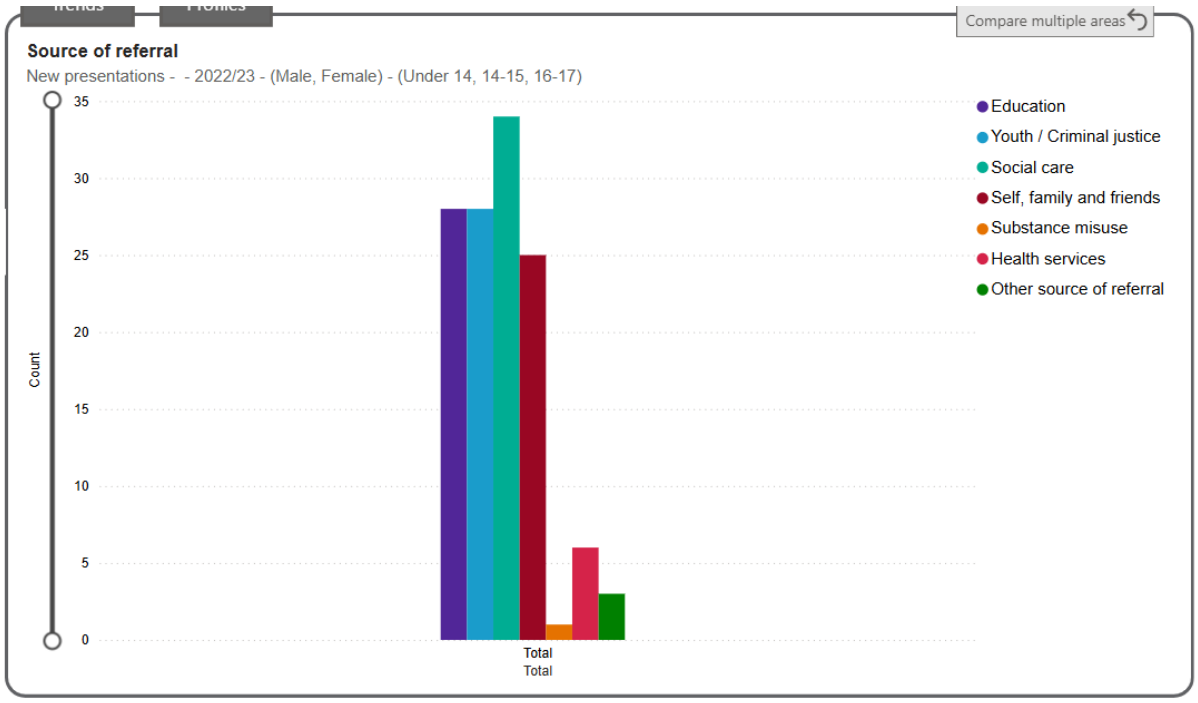

Figure 4 Routes into treatment of children aged 17 and under in Kent in 2022/23

In 2022/23, the most common sources of referral for young people entering substance use treatment in Kent were **social care**, **education**, and **youth/criminal justice services**, each contributing over 25 new presentations. Referrals from **self, family, and friends** also played a notable role, while **health services**, **substance misuse services**, and **other sources** accounted for significantly fewer cases. This distribution reinforces the importance of safeguarding and school-based pathways in identifying at-risk young people, while highlighting underutilised opportunities for earlier intervention through health and specialist services.

Referrals from **youth and criminal justice services** dropped sharply after 2010 and have remained low, while **social care referrals fluctuated**, peaking around 2020 likely reflecting increased safeguarding concerns.

Referrals from **health services**, **substance misuse services**, and **self, family or friends** remain modest and stable, suggesting limited engagement from clinical and informal pathways. These patterns highlight the central role of schools in identifying risk and the need to strengthen multi-agency referral routes for earlier intervention.

[4] NDTMS - ViewIt - Young People

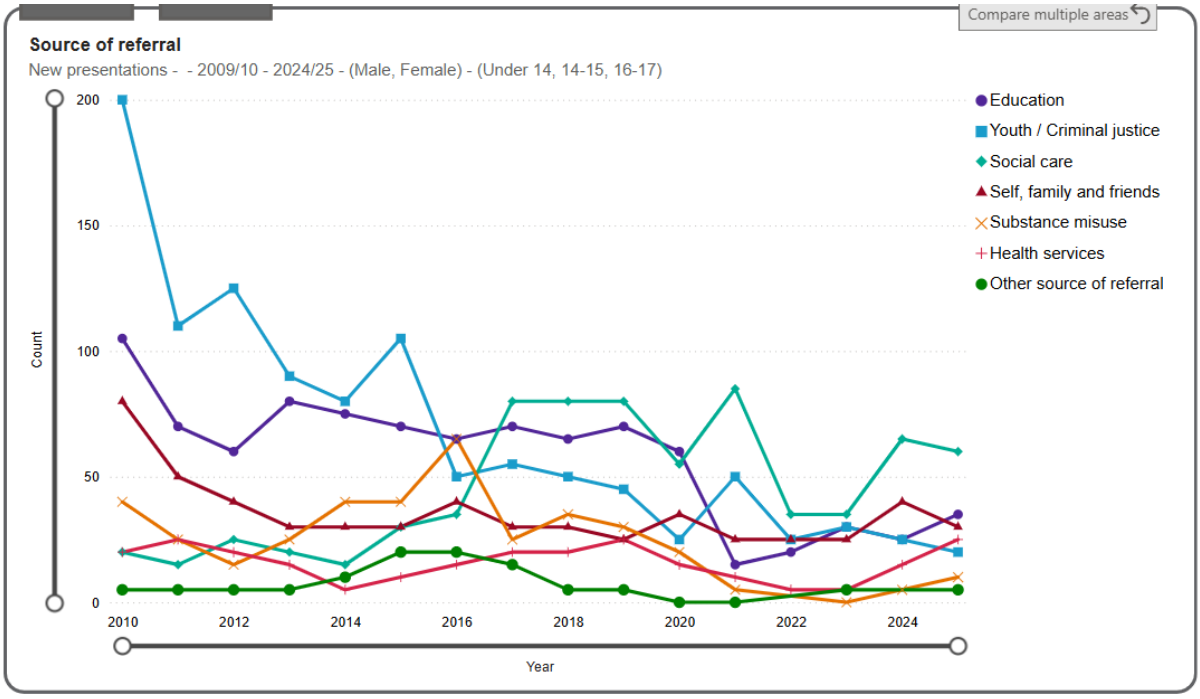

Figure 5 Trends of routes into treatment of children aged 17 and under in Kent from 2009/10 to 2024/25[5]

2.2.5 Outcome of treatment received by children aged 17 and under in Kent

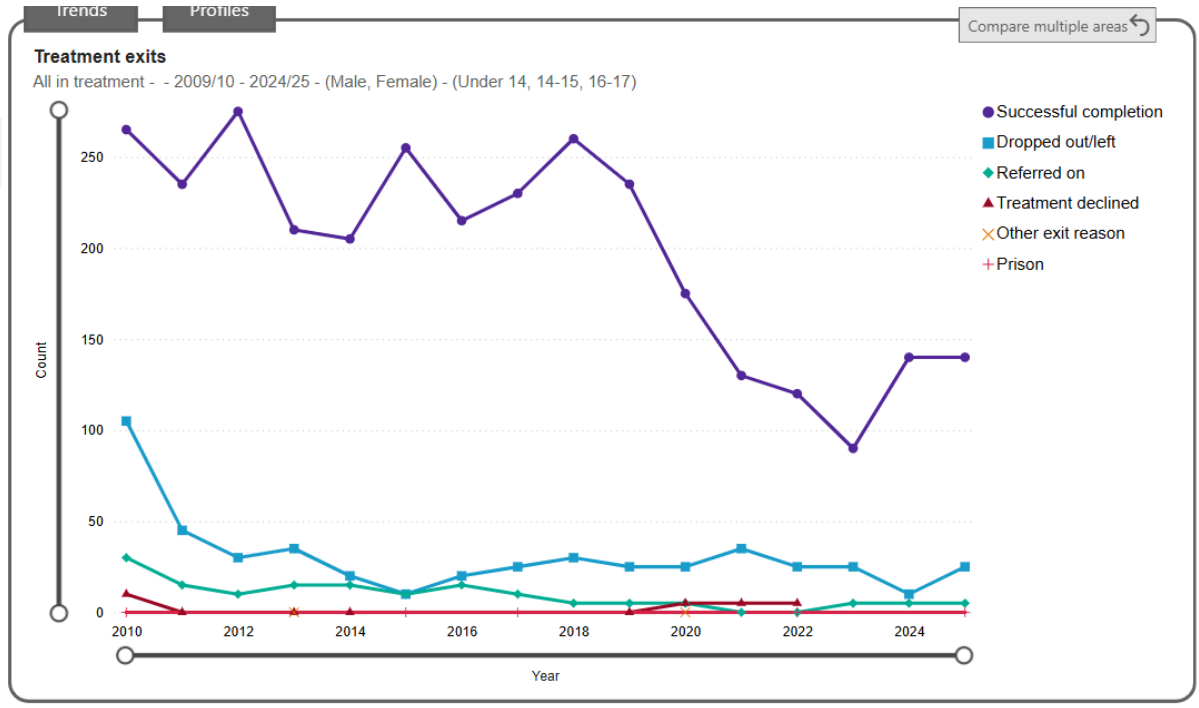

Figure 6 Outcome of treatment of children aged 17 and under in Kent from 2009/10 to 2024/25

[5] NDTMS - ViewIt - Young People

Among young people exiting substance use treatment in Kent, the most common route remains **successful completion**, which peaked around 2017 before declining through to 2023, followed by a slight recovery. **Dropout rates** fell sharply after 2010 and have remained lower but variable, while **referrals onward**, **declined treatment**, and **exits due to prison or other reasons** have consistently accounted for a small proportion of cases. These patterns suggest that while most young people complete treatment successfully, there is a need to monitor retention and strengthen pathways for those at risk of disengagement.

2.3 Drug and alcohol statistics of young adults aged 18-29 years in treatment in Kent

The chapter 2.3 below is based on NDTMS report to support improved decision-making and more effective planning of alcohol and drug misuse treatment services[6].

2.3.1 Number of young adults aged 18-29 years in treatment in Kent[7]

There are 825 young people aged 18-29 years in treatment services in Kent for 2024/25 year.

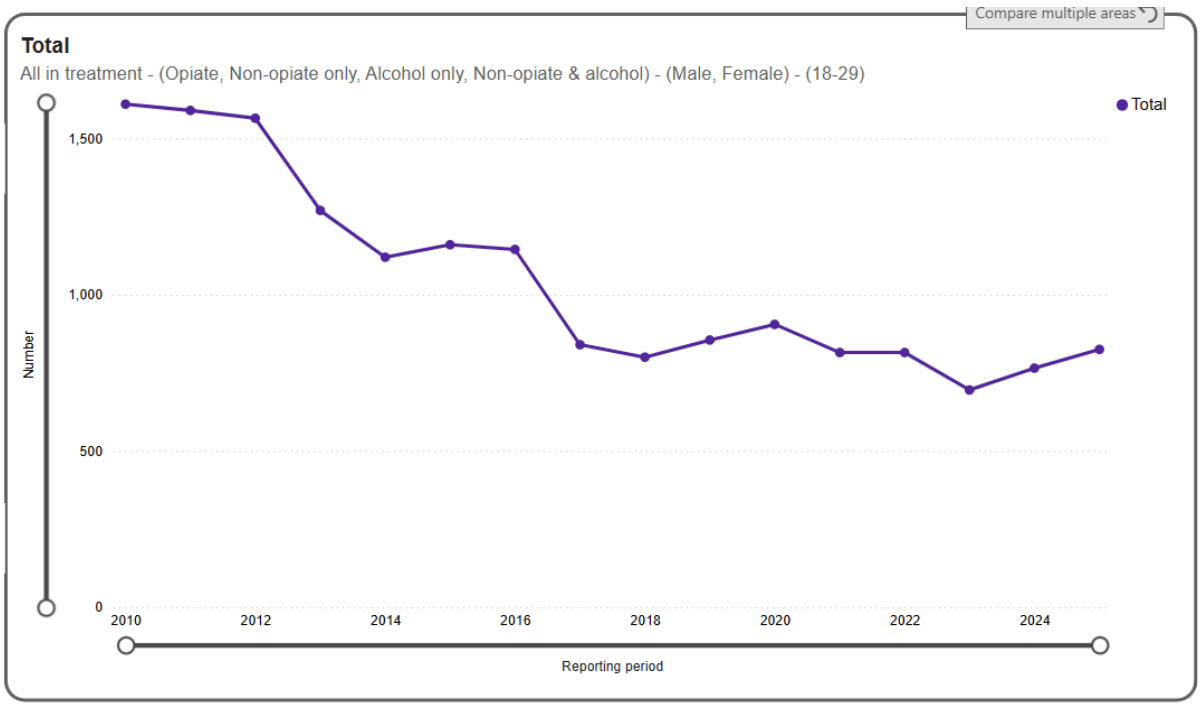

Figure 7 Young adults aged 18-29 years in treatment in Kent from 2009/10 to 2024/25

The graph illustrates a sustained decline in the number of 18–29 year olds (male and female) receiving treatment for substance use in Kent. The trend was beginning above

[6] NDTMS - ViewIt - Adult
[7] NDTMS - ViewIt - Adult

1,500 in 2010 and falling below 1,000 by 2017, followed by a period of fluctuation between 2017 and 2024 marked by dips and partial recoveries.

Although recent years show a modest increase, treatment levels remain significantly lower than the 2010 peak. This downward trend may be attributed to reduced engagement or access to services, evolving substance use patterns such as a shift of substance and changes in commissioning or referral pathways.

2.3.2 Age distribution of young adults aged 18-29 years in treatment in Kent[8]

The graph shows treatment trends for substance use among young adults in Kent, specifically those aged 18–24 and 25–29, from 2010 to 2025.

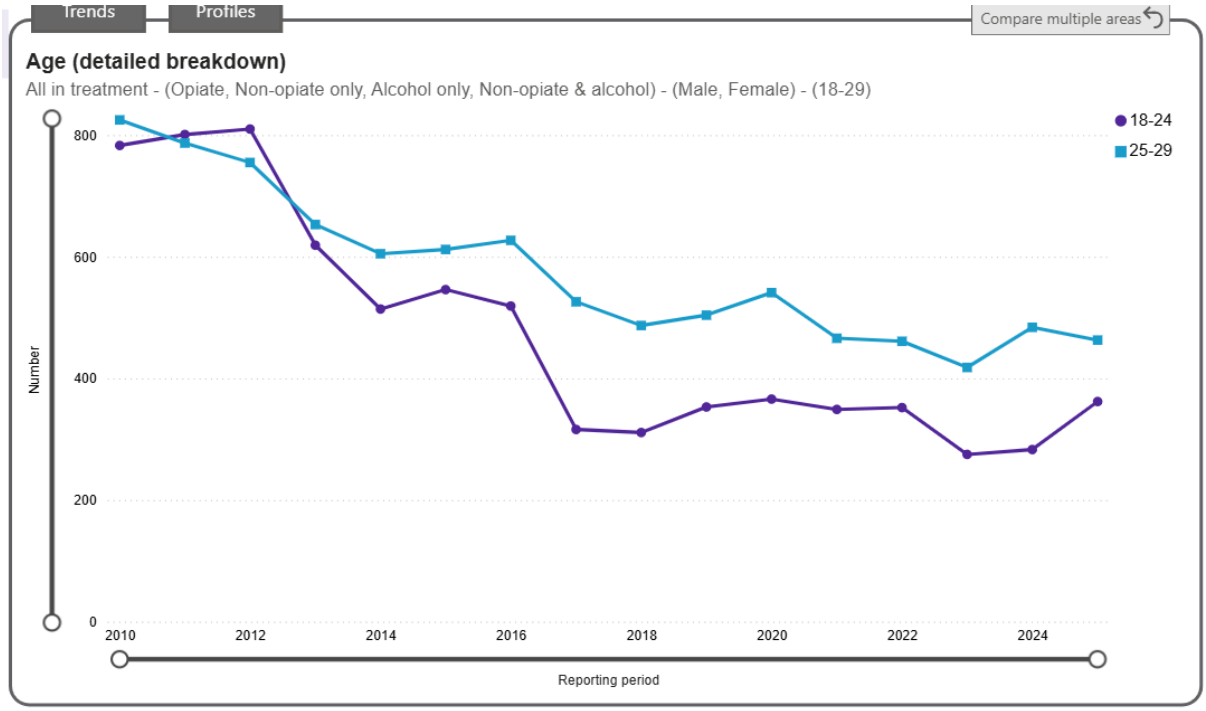

Figure 8 Age distribution of Children and young people in treatment in Kent from 2010 to 2025

Among young adults in Kent receiving treatment for substance use, those aged 25–29 consistently outnumber the 18–24 group, with both age bands showing a long-term decline in treatment engagement since 2010. The drop is particularly sharp for the 18–24 cohort around 2016, while the 25–29 group has declined more gradually and remained relatively stable in recent years. These patterns suggest reduced engagement or access among younger adults and highlight the need for age-specific outreach strategies to address emerging risks and service gaps.

[8] NDTMS - ViewIt - Adult

2.3.3 Substance use of young adults aged 18-29 years in treatment in Kent[9]

The graph shows substance use trends among young adults aged 18–24 and 25–29, from 2010 to 2025 in Kent.

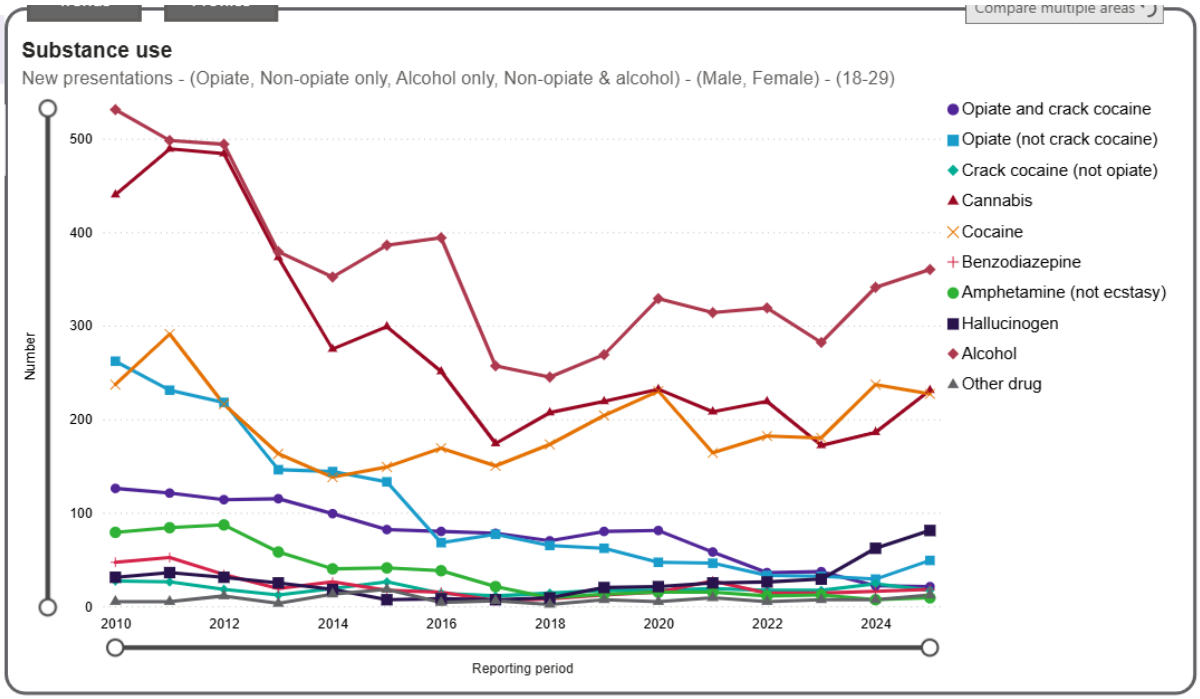

Figure 9 Substance use of young adults aged 18-29 years in treatment from 2010 to 2025 in Kent

Among 18–29 year olds in Kent entering treatment for substance use, **alcohol remains the most commonly cited substance**, peaking around 2010 and declining steadily until 2018, followed by fluctuations. **Cannabis and cocaine** also feature prominently, with cannabis showing an early peak and subsequent decline, while cocaine trends fluctuate. Presentations for **opiates and crack cocaine** have declined over time, and other substances such as benzodiazepines, amphetamines, hallucinogens, and newer drugs remain low but stable.

These patterns suggest a shift away from opiates toward more socially normalised substances like alcohol and cannabis, with emerging risks linked to stimulant and poly-substance use.

[9] NDTMS - ViewIt - Adult

2.3.4 Routes into treatment of young adults aged 18-29 years in treatment in Kent[10]

The graph shows source of referral trends among young adults aged 18–24 and 25–29, from 2010 to 2025 in Kent.

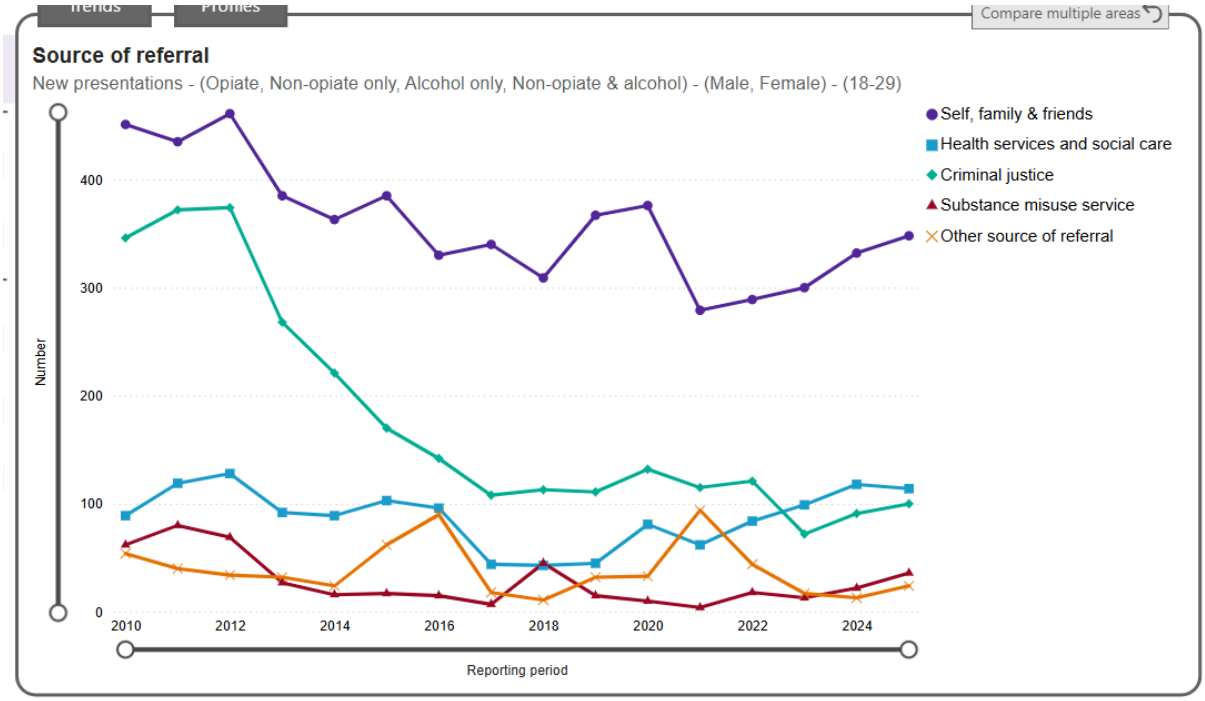

Figure 10 Routes into treatment of young adults aged 18-29 years in treatment from 2010 to 2025 in Kent

Among 18–29 year olds in Kent entering treatment for substance use, the most common referral route is **self, family, and friends**, peaking around 2010 and declining steadily until 2020, followed by a modest rise. Referrals from **criminal justice services** dropped significantly between 2010 and 2016 and have since stabilised, while **health services and social care** show relatively stable trends with minor fluctuations. **Substance misuse services** and **other sources** consistently account for the lowest referral numbers. These patterns suggest that informal networks remain central to help-seeking, while engagement from clinical and justice pathways has declined, highlighting opportunities to strengthen professional referral routes.

[10] NDTMS - ViewIt - Adult

2.3.5 Outcomes of treatment received by young adults aged 18-29 years in Kent[11]

The graph shows outcomes of treatment received by young adults aged 18–24 and 25–29, from 2010 to 2025 in Kent.

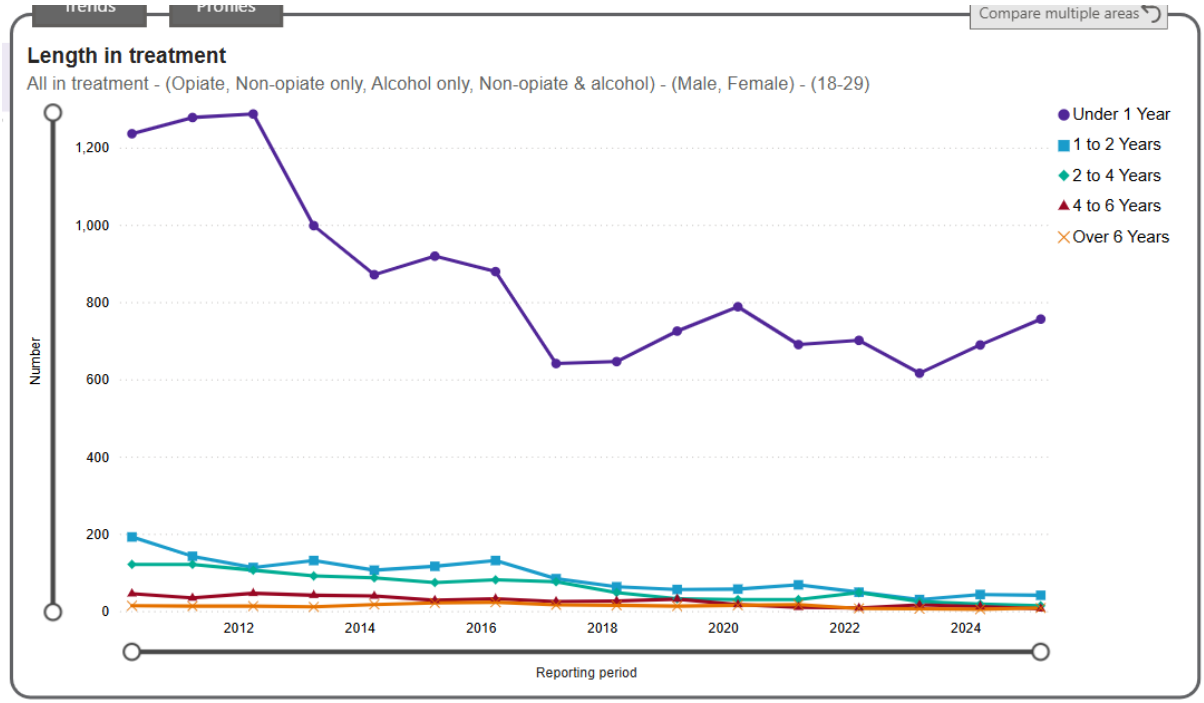

Figure 11 Outcomes of treatment received by young adults aged 18-29 years from 2010 to 2025 in Kent

Among 18–29 year olds in Kent undergoing treatment for substance use, the majority spend **less than one year** in treatment, with numbers peaking around 2011 and gradually declining until 2018, followed by a modest rise. Longer treatment durations—**1 to 2 years**, **2 to 4 years**, and **over 4 years**—remain consistently low and stable across the period. This pattern suggests that most young adults engage with short-term interventions, highlighting the importance of ensuring treatment is effective and accessible within a limited timeframe, while also recognising the need for sustained support for those with more complex needs.

[11] NDTMS - ViewIt - Adult

2.3.6 Type of intervention received by young adults aged 18-29 years in Kent[12]

The graph shows the type of intervention received by young adults aged 18–24 and 25–29, from 2010 to 2025 in Kent.

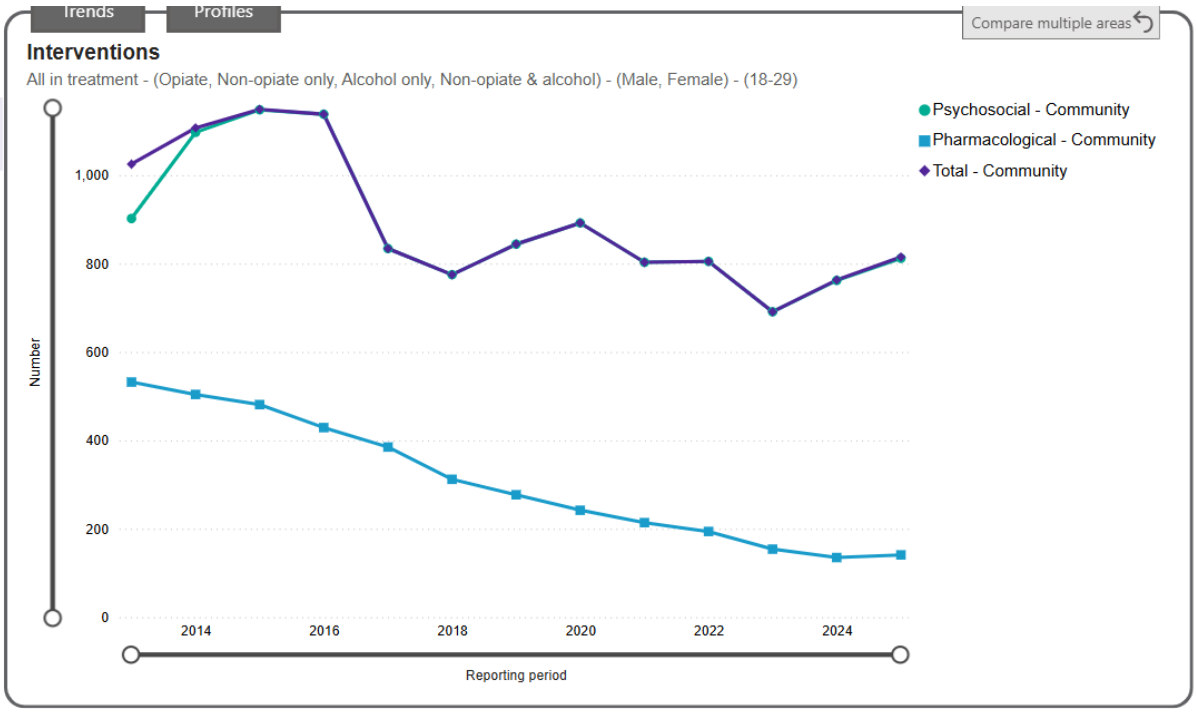

Figure 12 Type of intervention received by young adults aged 18-29 years from 2010 to 2025 in Kent

Among 18–29 year olds in treatment for substance use in Kent, the number receiving **community-based interventions** peaked around 2015 and has since declined, with fluctuations through to 2025. **Pharmacological interventions** show a consistent downward trend, while **psychosocial interventions** were more prominent in earlier years but are not visible in later data. This suggests a shift away from medication-based approaches and a possible reduction in structured psychosocial support, highlighting the need to review intervention availability and ensure that treatment pathways remain responsive to the needs of young adults.

[12] NDTMS - ViewIt - Adult

2.4 Young People under the age of 18 in specialist treatment for substance misuse

The chapter 2.4 provides detailed information on young people under the age of 18 in specialist treatment for substance misuse. The age of young people is taken at the start of treatment (earliest intervention start date of the treatment journey or triage date if this is missing) or the start of the reporting period, whichever is later.

2.4.1 Headline Information [13]

Numbers in treatment	
up 1%	229
down -3%	15423

Waits less than 3 weeks		
	4%	100%
	0%	97%

Planned Exits		
	1%	84%
	0%	84%

Figure 13 The latest 12 months data compared to 31/03/2025

In the latest 12-month period compared to the position at 31 March 2025, Kent saw a 1% increase in children and young people in treatment (229), while treatment numbers nationally declined by 3% to 15,423.
Access performance remains strong, with 100% of CYP in Kent and 97% of CYP nationally starting treatment within three weeks.
Planned exits are stable at 84% for both locally and nationally, with a slight improvement for CYP, indicating good retention and structured discharge outcomes across services.

2.4.2 Rolling 12-month trends for young people since 1 April 2013[14]

The graphs below show the rolling 12-month trends for young people since 1 April 2013.

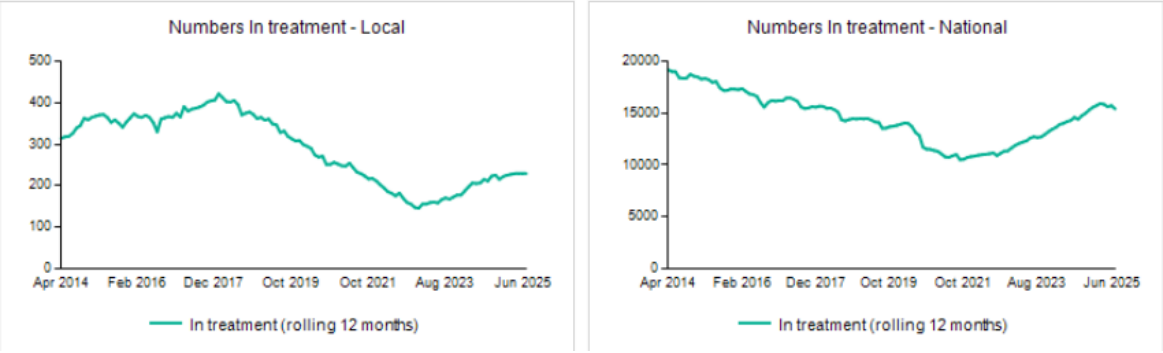

Figure 14 Number of young people in specialist substance misuse services within the community on a rolling 12-month basis.

[13] YP Executive Summary NDTMS - GetReport
[14] YP Executive Summary NDTMS - GetReport

Figure 14 compares the number of individuals in treatment for substance use on a rolling 12-month basis, showing that local treatment numbers in Kent peaked in late 2017 before declining steadily until 2022, with a slight recovery thereafter. In contrast, national figures show a more gradual decline from 2014 to 2021, followed by a clearer upward trend.

This suggests that while national engagement is rebounding, local recovery in Kent has been slower, highlighting potential gaps in access, commissioning, or referral pathways that may require targeted attention.

2.4.3 Substances cited are from any episode in the past 12 months prior to the month[15]

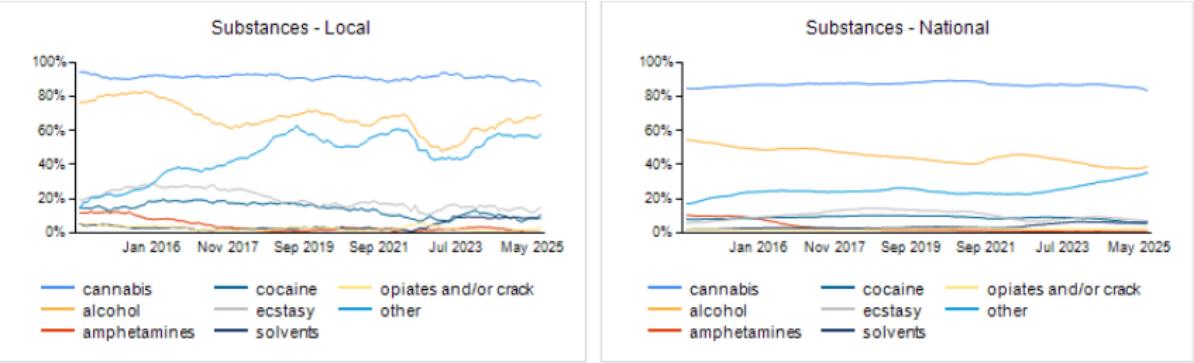

Figure 15 Substances cited are from any episode in the past 12 months prior to the month

Figure 15 compares the prevalence of different substances among young people in treatment locally and nationally from 2016 to 2025. Cannabis remains the most commonly cited substance in both datasets, consistently accounting for 80–90% of cases.

Alcohol shows a declining trend, particularly in Kent, falling from around 70% to below 60%. Amphetamines and cocaine show gradual increases locally, while other substances such as ecstasy, solvents, and opiates/crack remain low and stable.

These patterns suggest that local trends broadly mirror national ones, with cannabis dominance and declining alcohol use, but Kent shows slightly sharper shifts in stimulant use, indicating emerging risks that may warrant targeted local responses.

[15] YP Executive Summary NDTMS - GetReport

2.4.4 Completion rates (planned exits) are out of all exits for the rolling 12-month period[16]

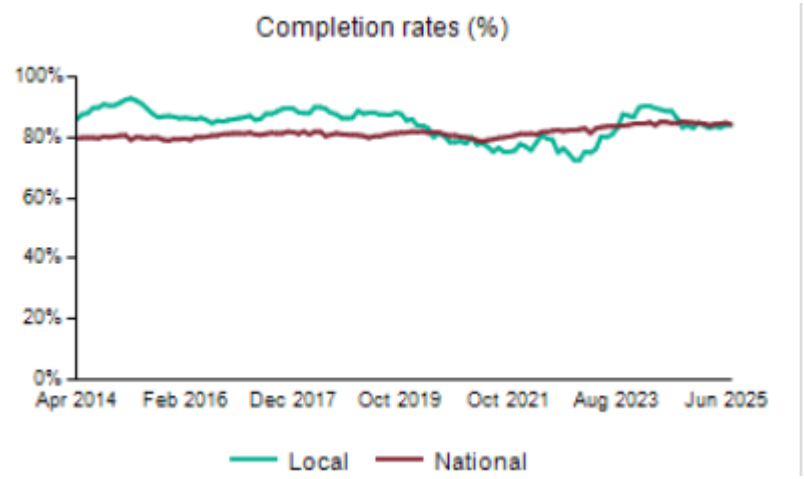

Figure 16 Completion rates (planned exits) are out of all exits for rolling 12-month period

Figure 16 compares local and national treatment completion rates from April 2014 to June 2025. Kent consistently outperforms the national average, with local completion rates generally higher across the period.

While both trends show fluctuations, Kent experienced noticeable dips around 2020–2021, likely reflecting pandemic-related service disruption. The overall pattern suggests stronger local performance but also highlights the need to maintain resilience and continuity in treatment pathways during system pressures.

2.4.5 Re-presentation rates are out of all planned exits for the re-presentation period[17]

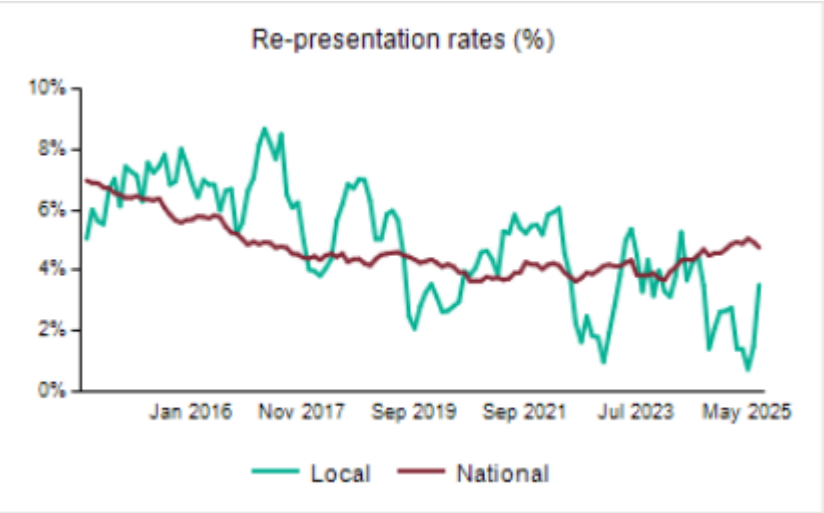

Figure 17 Re-presentation rates are out of all planned exits for the re-presentation period

[16] YP Executive Summary NDTMS - GetReport
[17] YP Executive Summary NDTMS - GetReport

Figure 17 compares re-presentation rates locally and nationally from 2016 to 2025. Kent's rates show greater variability, with noticeable peaks and troughs, while the national trend is more stable and gradually declining, falling from around 6% to 4%.

This suggests that local re-engagement with services is less predictable, potentially reflecting differences in discharge practices, follow-up support, or local service pressures.

3 Trends of substance use among young people in Kent

In England, between April 2023 and March 2024, 14,352 children and young people (aged 17 and under) received alcohol and drug treatment a 16% rise from the previous year's total of 12,418. Despite this increase, the figure remains 41% lower than the peak of 24,494 recorded in 2008–2009[18].

3.1 Age Groups for Benchmarking

- **School age (11–15 years):** Focus on first use, peer influence, and early vulnerability.
- **Adolescents/young adults (16–24 years):** Main segment for analysing hazardous or dependent patterns, drug and alcohol misuse.
- **Service cohort (13–18 years):** Those accessing structured treatment in Kent, used for performance and outcome monitoring.
- **Transitional young adults (18–24 years):** For prevalence tracking, service transitions, and cross-agency planning.

3.2 Substance misuse rates in Kent

Substance misuse rates in Kent mirror national and South East trends, with some areas of higher need and inequity, notably in East Kent (Thanet, Dover, Folkestone)[19].

Recent years show a rise in complex cases (poly-drug use, co-occurring mental health), despite declining or plateauing population prevalence in younger teens[20]. Kent sees successful engagement, short waiting times, and high planned exit rates, but persistent gaps remain in prevention, education, and equity of access[21'22].

[18] Children and young people's substance misuse treatment statistics 2023 to 2024: report - GOV.UK
[19] Substance Misuse (Drug and Alcohol) strategy 2023 to 2028 (PDF, 776.2 KB)
[20] National Drug Strategy: "From Harm to Hope"
[21] Drug Needs Assessment
[22] Alcohol Needs Assessment

3.2.1 NDTMS reports that

- In 2023–24, 14,352 Children and Young People (<18) were in treatment in England; Kent's proportion aligns but local admissions for substance-related harm (15–24) have risen faster.
- Cannabis remains the most common drug; ketamine and nitrous oxide rising.
- Mean age at first use decreasing: 7% of Kent cases started under age 13 (vs 4% England).

3.2.2 Alcohol Prevalence and Demand (16–24 Year Olds) in Kent

- Estimated 41,600 young people in Kent drink at hazardous levels and 25,000–35,000 regularly binge drink (8 units for males, 6 for females per sitting).
- 14% of Kent 11-year-olds report having tried alcohol; 70% of 15-year-olds.
- The highest rates of hospital admissions for alcohol use are in Thanet, Dover, and Folkestone, with Kent's rates for young people's alcohol-related admissions now higher than England and South East averages.

3.2.3 Drug Prevalence in School-Aged CYP (11–15 Year Olds)

- Drug use by age: About 9% of Kent 15-year-olds have tried cannabis; 38% of 15-year-olds have tried any drugs.
- Class A drug use (e.g., ecstasy, cocaine) increasing, especially in 15-year-olds (3.9% in England; similar for Kent estimates).

3.2.4 Type of substance reported among young people in Kent

The table below compares key substance use indicators between England and Kent, highlighting notable trends and areas of concern among young people[23].

Table 1. Substance use indicators between England and Kent

Indicator	England (%)	Kent (%)	Notable Issue
Ever tried alcohol (11–15)	44	~44	Declining trend
Ever tried drugs (11–15)	24	Similar	Class A rising (3.9)
Drug use (16–24 annual)	18.6	~19	Cannabis dominates
Binge drinking (16–24)	14–20	Comparable	Declining but persistent
Poly-drug use (in treatment)	57	88	Higher Kent risk
Started using under 15	77	92	Need for earlier prevention

[23] NDTMS - View It - Young People

Around 44% of 11–15-year-olds have tried alcohol, with a declining trend. Drug experimentation in this age group mirrors England's 24%, but Class A drug use is rising (3.9%).

Among 16–24-year-olds, annual drug use is ~19%, dominated by cannabis, and binge drinking remains persistent despite decline.

Alarmingly, 88% of young people in treatment report poly-drug use significantly higher than the national 57%.

Moreover, 92% began using substances before age 15, highlighting an urgent need for earlier prevention and targeted interventions to address Kent's elevated risk profile.

3.2.5 Prevalence and trends of substance in Kent and England

The table below compares prevalence and trends by 5-year age bands in England and Kent

Table 2. Prevalence and Trends by 5-Year Age Bands in England and Kent

Age Band	Kent (%)	South East (%)	England (%)	Recent Trend	Notes
11-15	Alcohol: 8.54	~8.5	~9	Steady/decline	Boys/Girls equal
16-20	Drug: 12-164	13	14	Rising, esp. cannabis	
21-24	Alcohol: 19-224	20	21	Plateau	High-risk users

Kent generally matches national prevalence and trends but shows higher rates for poly-drug use and early substance onset, suggesting a need for intensified primary prevention and educational outreach. Best practice from other UK areas highlights integrated health, education and youth justice approaches, routine school screening, and strategic review cycles.

3.2.6 Service performance and outcomes of substance among young people in Kent

The table below shows the service and outcomes in Kent, South East and England

Table 3. Service and outcomes in Kent, South East and England

Service and Outcomes Benchmarking Metric	Kent	South East	England	Comments
Wait time <3wks	85%	70%	74%	Kent leads
Planned exits	87%	75%	60–75%	Good exit rates
Poly-drug use	88%	60%	57%	Above average risk
Mental health need	46%	50%	50%	Slightly lower

- **Waiting times:** The majority (85%) of young people in Kent are seen within three weeks, which exceeds the national average and marks Kent as high performing for service access.
- **Planned treatment exits:** 87% of cases in Kent exit services in a planned way, compared to a national benchmark of 60–75%. This suggests effective retention and treatment completion locally.
- **Poly-drug use:** Kent shows a significantly higher rate of poly-drug use (88%), indicating elevated risk and complexity among service users.
- **Mental health needs:** Mental health needs are slightly lower at 46%, though still substantial and requiring integrated support.

3.2.7 Wider Vulnerabilities (Kent vs. England)[24]

The table below shows wider vulnerabilities at entry to treatment in Kent and England

Table 4. Wider Vulnerabilities at entry to treatment (Kent vs. England)

Vulnerability	Kent %	England %
Anti-social behaviour	20	30
Self-harm	44	30
Affected by other's substance misuse	25	23
Domestic abuse	26	17
Criminal exploitation	12	9
Looked after child	11	11

[24] NDTMS

Self-harm at entry to treatment is much higher in Kent (44%) than national average (30%), particularly for girls (60% of females in treatment self-harm). Individuals entering treatment in Kent show higher rates of domestic abuse exposure (26%) compared to the national averages in England (17%).

Kent also reports slightly elevated levels of being affected by others' substance misuse (25%) and criminal exploitation (12%), though the proportion of looked after children matches the national figure at 11%. Interestingly, anti-social behaviour is less prevalent in Kent (20%) than in England overall (30%).

3.2.8 Unmet need and substance misuse service issues among young people in Kent

- **Service reach:** The total known cohort in Kent is under 1,100, while modelled estimates suggest over 4,000 young people are at risk and could benefit from some form of intervention.
- **Group outcomes:** Positive risk reduction scores consistently reach or exceed the 90% target for early intervention, with rates even higher than national targets.
- **Length of engagement:** Young people in Kent typically spend less time in treatment than nationally, but planned exits are higher, indicating efficiency and responsiveness
- **Referrals:** Education 22% in Kent (vs 32% national), social care 31% (vs 23% national).
- **Self-harm as comorbidity:** 44% Kent vs 30% England
- **Referrals:** Education referrals are lower in Kent than nationally (22% vs 32%), with higher reliance on social care (31% vs 23%). This points to gaps in school partnership and preventative identification.
- **District disparities:** East Kent (Thanet, Dover, Folkestone) shows higher rates of substance-related harm, admissions, and needs than West Kent, with Canterbury and Thanet notable for higher treatment engagement rates.
- **Complexity of cases:** Kent has much higher poly-drug use (88%), younger ages at first use (92% under 15), and higher rates of co-occurring self-harm (44% in Kent vs 30% in England), indicating that many young people entering services are at higher risk and require intensive support.
- **Hospital referrals:** These remain very low, despite increased presentations with related issues, suggesting under-recognition within health settings and missed opportunities for intervention.

3.2.9 Comparison with Other Services

- National waiting times, exit rates, and quality outcomes in Kent generally outperform national averages.

- Unmet need, dictated by district deprivation and lack of school partnership, is greater than would be expected given the local population, and indicates missed opportunities for earlier engagement and universal prevention.
- The depth of early intervention, education partnership, and aftercare varies, with some Kent districts falling short compared to best practice in other UK regions and localities.

Table 5. Service engagement in districts in Kent

District	Early Intervention Group Rate	Structured Treatment Rate	Active Treatment Rate	Exits Rate
Canterbury	Highest	Very high	Very high	Highest
Thanet	High	Very high	Very high	High
Dover	High	Above average	Above average	Average
Folkestone & Hythe	Moderate	Below average	Below average	Low
Maidstone/Swale/Tunbridge Wells	Lowest	Lowest	Lowest	Lowest

- Canterbury and Thanet consistently show higher treatment engagement and exits rates, indicating both higher prevalence and better access. Maidstone, Swale, and Tunbridge Wells demonstrate lower rates of engagement, suggesting possible unmet need or access barriers[25].
- The breakdown of prevalence rates and unmet need for drug and alcohol services across Kent districts reveals significant local variation and gaps compared to overall Kent and national benchmarks.
- Kent's current children and young people's substance misuse service ("With You") performs well against many national and regional benchmarks, but notable unmet need and disparities remain within the county, especially in vulnerable groups and deprived localities.

[25] NDTMS - Home

3.2.10 Hospital Stays and Acute Trends

- Hospital drug/alcohol admissions for 15–24s are falling nationally/South East but are steady or rising in Kent, underlining persistent unmet need especially in deprived districts[26].
- Highest acute admissions in Thanet, Dover, Folkestone/Hythe, with data caveats due to recording practices.

3.3 Needs and Gaps Summary

- Significant district-level disparity: East Kent districts most affected; West Kent districts show lower need and engagement.
- Risk factors—self-harm, domestic abuse, criminal exploitation—cluster in areas of higher prevalence.
- While service performance (waiting times, planned exits) is strong, large numbers remain at risk, particularly in districts with lower school and service engagement.

These data show not only prevalence and trends, but also how unmet need and access to support vary greatly across districts in Kent, with East Kent especially requiring enhanced investment and early intervention.

3.4 Internal Kent Inequities

- East Kent (Thanet, Dover, Folkestone) shows higher rates of early help cases, social care involvement, substance-related admissions (hospital data) and drug-poisoning admissions.
- Deprivation linked with higher rates and more complex vulnerability clusters (mental health, self-harm, safeguarding concerns);
- Girls self-harm rates in treatment: 61% vs boys 46%

[26] NDTMS

4 Needs and unmet substance misuse needs of young people in the care or needing the care system in Kent

Young people in the care system (including Looked After Children, Children in Need, and those receiving social care support) in Kent have significant unmet substance misuse needs and are demonstrably more vulnerable to harmful drug and alcohol use than their peers.

4.1 Prevalence and Risk

- **Looked After Children (LAC):** 11% of young people in Kent specialist substance misuse treatment are LAC, which matches the national proportion but indicates high relative risk given their small overall share of population.
- **Domestic abuse, self-harm, and affected by others' substance misuse:** These vulnerabilities are much more common in the treatment group—domestic abuse affects 26% of Kent treatment cases (vs 17% England); self-harm at entry is 44% Kent, higher for girls (60%)[27].

Co-occurring needs: Care system youth are markedly more likely to have mental health needs, safeguarding concerns, and are often exposed to adverse childhood experiences (ACE) such as neglect, violence, and toxic home or community environment.

4.2 Unmet Need

- **Referral gap:** Many care-involved young people are not referred to specialist treatment despite evidence of need. Only a minority actively engage with services, and lower education-based referrals in Kent may mean more CYP in care are missed.
- **Access barrier:** Fear of social services, stigma, and lack of trauma-informed approaches act as barriers. Parental substance use and concern about child removal can also deter engagement with support.
- **Early help:** Most deprived districts (Thanet, Dover, Folkestone, Canterbury) have higher early help involvement and substance-related harm—but unmet need remains greatest where deprivation and care involvement overlap.
- **Mental health:** Over 50% of CYP in care and substance misuse treatment have additional mental health needs, often with difficulties accessing timely CAMHS or joint interventions; dual diagnosis is common but complex to manage.

[27] NDTMS

4.3 Needs

- **Specialist and trauma-informed support:** These young people require integrated care for substance misuse, mental health, and safeguarding, ideally with tailored interventions tied to their care history and vulnerabilities.
- **Enhanced education and prevention:** Universal and targeted prevention in schools, social care settings, and residential placements is needed, with a focus on life skills, resilience, and harm minimisation strategies.
- **Multi-agency working:** The most effective models in Kent and nationally involve close collaboration between social services, substance misuse teams, CAMHS, youth justice, and voluntary sector providers, with joint protocols, safeguarding frameworks, and regular partnership review.
- **Accessible and destigmatised services:** Services must be trauma-informed, easy to access, open to self-referral, family or professional referral, and actively promoted in the care system.

Table 6. Treatment needs of young people in the care or needing the care system in Kent and England

Vulnerability	Kent % in Treatment	England %	Comments
Looked After Child	11	11	High-risk, small group
Domestic Abuse	26	17	Large care system overlap
Self-harm	44	30	60% for girls in care
Criminal exploitation	12	9	Linked with care status
Child Protection Plan	12	8	Safeguarding concern
Mental health need	46	50	Often unmet, complex

Kent's care-involved young people require coordinated, trauma-informed partnership approaches current service models perform well for those who access care, but substantial unmet need persists, especially among the most vulnerable and least engaged groups.

5 Best Practice and Recommendations

Kent should maintain and further develop its strengths in access, exit rates, and risk reduction, but urgently expand universal prevention, improve referral pathways in schools and hospitals, and address inequities in service engagement for the most deprived districts and vulnerable groups.
Investment in strategic oversight, partnership protocols, and trauma-informed workforce development remain crucial to reducing unmet need and matching best UK practice.

5.1 Inpatient, Rehab & Acute Trends

- Substance-related inpatient admissions (15–24): Plateau nationally, rising Kent.
- Kent admissions per 100k pop now higher than England/South East (recent years)—possible recording bias, but persistent unmet need suggested.
- Drug poisoning admissions: East Kent highest.
- Rehab/detox demand seen in qualitative and service data; full detail in local hospital episode statistics (appendix).

5.2 Needs Analysis & Unmet Need (NDTMS)

- NDTMS data (2023–24)[28]: 1,067 CYP in Kent known to services but estimated 4,000+ at risk (using South East prevalence applied to census).
- Referrals: Lower % from education sector in Kent (22% vs 32% England), higher from social care (31% vs 23%).
- High proportion report multiple vulnerabilities (NEET, mental health, safeguarding, offending).
- Girls in treatment younger than boys, likely reflecting referral patterns and comorbidity.

To strengthen support for young people in Kent, it is important to identify gaps by comparing local NDTMS data with national best practices and broader trends. The following outlines key areas where Kent could enhance its approach to youth safety, informed by leading national and international evidence. This comparison helps spotlight opportunities for improvement and targeted interventions[29].

Kent's services are strong in treatment access, planned exits, and service outcomes, but several gaps persist compared to best national and international practice, NDTMS data, and recent prevention research.

[28] NDTMS
[29] WHO/ UK.GOV best practice, NICE

5.3 What is Missing in Kent's Approach?

- **Universal School-Based Prevention:** National and international evidence (ACMD, NICE, EU-DAP) consistently shows best impact where specialist, interactive, skills-based prevention programmes are embedded universally within education, not selectively delivered or dependent on local funding.
- **Consistent whole-school approach** and continuous PSHE, supported by professionally developed curricula, helps change behaviour—not just deliver information.
- **Early Years and Family Engagement:** Family-based interventions lead to better outcomes in vulnerable groups. Kent could strengthen joint working with early help, social care, and family hubs, integrating drug and alcohol prevention in parenting offers and early years support.
- **Targeted and Indicated Prevention:** NICE and ACMD highlight a need for targeted support across high-risk groups (looked after children, care leavers, NEET, YOT, mental health) through multi-agency protocols, not only after escalation to crisis.
- **Digital and Community Outreach:** Use of validated apps, online peer support, and campaigns are best practice elsewhere but underdeveloped locally; social norms marketing, digital peer advice, and youth-led campaigns show impact internationally.
- **Consistent Data Sharing and Intelligence:** NDTMS and school/health data should be linked and analysed routinely for vulnerable groups and transitions, enhancing real-time response. Kent could build more live dashboards for early identification, district benchmarking, and workforce planning.
- **Transition & Aftercare Support:** Nationally, gaps remain for young adults 18–24—Kent could adopt best practice protocols from regions with joint CAMHS-substance misuse transitions and proactively target care leavers.

5.4 Key Areas for Kent to Improve

- Expand universal and targeted school/college PSHE and skills-based programs (unplugged/EU-DAP) to reach all CYP.
- Connect family, community, and social care agencies for joint early intervention and prevention, with more routine screening and safeguarding triggers.
- Strengthen digital service offer and innovative youth-led campaigns to counter peer risk and raise engagement.
- Invest in workforce capability—national framework now recommends regular CPD, joint supervision, trauma-informed training, and multi-agency skills exchange.
- Routinely benchmark data at district, county, and vulnerable group levels, link service data to school, health, and care system dashboards.

- Improve transition support for care leavers and 18–24 year-olds via joint protocols, risk screening, and outreach.
- Address barriers in education and acute health settings: improve professional awareness, screening, and referral, particularly in districts with lower school referrals and higher acute admissions.

5.5 National Guidance & Best Practice Principles

- Emphasise early help, trauma-informed approaches, and holistic support.
- Integrated working: Commission joined-up approaches between substance misuse, mental health, youth justice, and social care teams.
- Invest in staff training, partnership with education and voluntary sectors.
- Use regular, robust strategic review to ensure consistency and responsiveness.

5.6 Learning from National and International Data

- International experience (EU-DAP, UNODC) supports social and emotional skill-building, universal community-based prevention, family engagement, and positive youth development within healthy, safe environments.
- National ACMD, NICE, and NDTMS data all point to the effectiveness of multi-component, multi-agency prevention systems tied to regular, strategic oversight—not only isolated interventions.
- Data-driven targeting—routine collection, analysis, and reporting by age, gender, district, and vulnerability—drives local resource allocation, workforce focus, and partnership strategies.

Kent already performs well on outcomes for engaged CYP, but future progress depends on expanding universal/systematic prevention, targeting vulnerability, and building whole-system partnerships to address both unmet need and emerging substance misuse trends.

5.7 Tackling emerging threats of Ketamine and Nitrous Oxide

Given new and emerging threats of Ketamine and Nitrous Oxide rapid literature search – PubMed was conducted to evaluate the best evidence internationally for tackling these.

Internationally, several programmes and interventions have shown effectiveness in reducing youth ketamine and nitrous oxide misuse, especially in East Asia and parts of Europe. Evidence is still emerging, but several key approaches have demonstrated results.

5.7.1 Taiwan Family-Oriented Programme:

A family-focused treatment model in Taiwan for ketamine-using youth (12–18) combined weekly group-relapse prevention/motivational enhancement for young people with parallel parenting skills training for caregivers. This improved motivation, reduced use, built protective factors, and helped maintain abstinence.

5.7.2 Crisis Accommodation Programme (CAP), Hong Kong:

Short-term hospitalized youth allowed rapid psychosocial, motivational, and lifestyle interventions, followed by structured community support from NGOs post-discharge. This model reduced drug use, anxiety, and improved readiness for change among young ketamine users.

- **Targeted Outreach to High-Risk Groups:**
  US studies show that focused interventions for homeless youth, frequent clubbers, and high-risk IDUs—including referral, motivational interviewing, and community outreach—effectively reduce injecting and persistent misuse.

- **Educational System Data Integration:**
  In Taiwan, integration of education, law enforcement, health and social data has enabled persistent follow-up and earlier identification, linked with counselling and casework for youth caught using ketamine.

5.7.3 Nitrous Oxide Misuse: International Responses

- **Public Health and Legislative Controls:**

  Several European countries (e.g., Netherlands, France) have implemented public awareness campaigns, legislative restrictions on over-the-counter sales, and school-based prevention activities to address rising adolescent nitrous oxide misuse. Education targeting specific harms and high-risk populations (nightlife, festival attendees) has seen modest reductions in use rates.

- **School-Based Health Education:**

  Prevention programmes included tailored sessions in schools combining psycho-education, harm awareness, and peer-peer communication. Brief interventions by school nurses, student welfare teams, and attendance at substance misuse clinics showed positive effects.

- **Multi-Agency Early Interventions:**

  Linking acute hospital presentations with early mental health and addiction assessment, including vitamin B12 supplement protocols, alongside psychosocial interventions and community support post-event, are recommended in recent clinical guidelines and public health reviews.

5.7.4 Common Effective Elements

- **Motivational enhancement and relapse prevention** (for ketamine) in confidential, non-judgmental group settings.
- **Family and caregiver engagement** to support sustained abstinence and address underlying adversity.
- **Integrated data intelligence and referral** (education, health, social care linkage) to target persistent or recidivist youth use
- **Legislative controls, targeted awareness, and school-based interventions** (for nitrous oxide), paired with clinical management and aftercare for at-risk youth.
- **Rapid linkage to community support** immediately following hospitalization or acute incident

5.7.5 Lessons for Kent

Kent could learn from these international models by:

- Scaling up multi-agency rapid response and aftercare following acute/ER presentations.
- Integrating education, social care, and health data to identify high-risk youth and facilitate persistent outreach.
- Expanding family-inclusive and skills-based interventions in parallel to direct youth motivational programmes.
- Strengthening legislative, social norms, and media campaigns targeting nitrous oxide, paired with active, school-based brief interventions and clinical follow-up.

In summary, the strongest evidence internationally supports multi-component, community-based, and family-oriented approaches for both ketamine and nitrous oxide, with particular benefit from coordinated data, outreach, and rapid engagement following initial misuse episodes.

5.7.6 Local Youth & Service User Voices in Kent

- **Kent Needs Assessment:** The assessment incorporates direct feedback where possible, with 97% of young people leaving With You (the Kent service) in a planned way reporting high satisfaction and willingness to recommend the service.
- **Post-treatment follow-up:** A formalised six-week follow-up after a planned exit measures ongoing substance use and experience, with a majority reporting abstinence or safer use, and feedback about tailored support, confidentiality, and genuine relationships with workers.

- **KYDIS (Kent Youth Diversionary Intervention Scheme):** Young people completing the intervention report positive impacts on behaviour and offending; non-attendees have higher re-offending.
- **Service Engagement:** The assessment notes service users value flexible, community-based, trauma-informed support and that young people prefer services that are accessible "in their own space" rather than in traditional settings.

5.7.7 Recommendations for Stronger Youth Involvement

- **Expand primary consultation:** The needs assessment recommends greater routine involvement of young people in service planning, contract monitoring, and needs assessment—via interviews, focus groups, and survey models.
- **Peer involvement models:** Best practice from the UK and internationally involves youth peer advisors, co-production of materials, and regular structured consultation with current and former service users to help shape service delivery and access.
- **Service user involvement in staff training:** An innovative approach recommended is using service users or actors in simulation training scenarios for professionals, to build insight and empathy and offer real-time feedback about referral pathways, barriers, and engagement.

5.7.8 Learning from Other Areas

- **Peer-led outreach:** Programmes in London, Manchester, and internationally (e.g. 'peer educators') show better engagement, reach, and trust among high-risk young people—this is not yet routine in Kent's model.
- **Feedback loops:** High-performing services routinely gather anonymous user feedback at multiple points (first contact, review, discharge, and post-discharge) to inform improvement.
- **Youth forums and governance:** Youth advisory boards and steering groups play a role in ongoing quality assurance, local adaptations, and addressing emerging trends.

5.8 Summary:

Kent's assessment includes some service user voices and follow-up, but scaling up direct youth and user involvement—through routine consultation, peer roles, feedback loops, and user input into professional training and service design—is recommended, according to both local feedback and national/international best practice. This would ensure services are more responsive, accessible, and effective for all young people.

5.9 Recap, Best Practice for YP Substance Misuse Services

- Trauma-informed, strengths-based, person-centred care central.
- Close links between CYP substance misuse and mental health needed, with clear dual diagnosis protocols and transition planning from child to adult services.
- Systematic education/prevention in schools via PSHE, targeted for age 11–14 and most vulnerable groups.
- Involvement of voluntary sector and peer support; outreach focus on deprived and high-need areas.
- Service workforce development: new NHS capability framework recommends multi-agency upskilling, regular supervision, case conferencing

5.10 Recommendations Overview

The needs assessment identifies a strong local treatment response for children and young people who access services, including timely treatment entry and high planned-exit rates. However, it also identifies substantial unmet need, earlier initiation of substance use, high levels of polysubstance use and co-occurring vulnerabilities, lower-than-expected education and health referrals, geographical inequalities, and risks of disengagement among young adults and at transition points.

The following eight recommendations provide a single, prioritised framework for commissioning, partnership delivery and performance monitoring over the lifetime of the strategy. They should be implemented through a phased delivery plan, with clear leads, measurable outcomes and meaningful involvement of children, young people and families throughout.

These recommendations should be delivered through the following overarching principles:

- Prevention before escalation: combine universal education-based prevention with targeted early help for those experiencing vulnerability or early signs of harm.
- No wrong door: any professional or service encountering substance-related risk should be able to identify need, offer brief advice and make a straightforward referral.
- Trauma-informed and non-stigmatising practice: particularly important for care-experienced CYP, those affected by domestic abuse, self-harm, exploitation or parental substance use.
- Equity-led commissioning use deprivation, district, age and vulnerability data to direct investment rather than relying only on treatment activity.
- Co-produced services: involve CYP in the design of communications, outreach, access routes, workforce training and service evaluation.

Priority	Recommendation	Evidence from the needs assessment	Suggested measures of progress
1	**Establish a Kent CYP Substance Misuse Partnership Board** to provide strategic oversight across public health, education, children's social care, NHS, CAMHS, acute trusts, youth justice, police, district partners, providers, VCS and young people. The Board should agree a delivery plan, monitor outcomes and lead the response to emerging drug trends.	The report identifies no established cross-system strategic oversight beyond contract-monitoring arrangements. It also identifies variation in need, gaps in referral routes and the need for more coordinated prevention, safeguarding and data intelligence.	Board established with agreed terms of reference and delivery plan; quarterly performance dashboard; annual review of progress and priorities.
2	**Strengthen universal and targeted prevention in education and community settings**, with a consistent, skills-based and age-appropriate offer across schools, alternative provision, FE colleges and universities. Target additional support to pupils at risk of exclusion, persistent absence, NEET status and those with safeguarding concerns.	Earlier initiation is a concern: 92% of Kent CYP in treatment reportedly began using substances before age 15, compared with 77% nationally. Education referrals are lower in Kent than England (22% versus 32%), despite schools being a major route into treatment	Proportion of schools and alternative provisions delivering an agreed prevention offer; staff trained; education referral rate; uptake among priority groups; pupil feedback and knowledge/confidence outcomes.
3	**Improve early identification, referral and rapid access across health, education and safeguarding pathways.** Implement clear referral protocols, training and routine prompts for	Referrals from health services and acute settings are low despite rising or persistent substance-related hospital activity. Kent has good	Referral volumes and conversion rates by source; proportion starting treatment within three weeks; acute-care referrals receiving follow-up within an agreed

Priority	Recommendation	Evidence from the needs assessment	Suggested measures of progress
	primary care, urgent and emergency care, paediatrics, CAMHS, sexual health, maternity services where relevant, schools and social care.	treatment access once referral occurs, so the principal opportunity is earlier identification and referral.	timeframe; district-level variation.
4	**Develop an integrated, trauma-informed offer for CYP with multiple vulnerabilities**, particularly care-experienced children, children in need, those affected by domestic abuse, self-harm, exploitation, parental substance use and mental health need. Joint working arrangements should include shared care planning, risk escalation and access to specialist consultation.	CYP entering treatment in Kent have high levels of co-occurring vulnerability: self-harm is 44% compared with 30% nationally; domestic-abuse exposure is 26% versus 17%; and criminal exploitation is 12% versus 9%.	Proportion of eligible CYP receiving joint assessment/care planning; outcomes for care-experienced CYP; self-harm and safeguarding-related presentations; feedback from CYP and families.
5	**Reduce geographical inequalities and unmet need through targeted outreach and place-based provision.** Prioritise East Kent—particularly Thanet, Dover and Folkestone & Hythe—while investigating low engagement in Maidstone, Swale and Tunbridge Wells to distinguish lower prevalence from access barriers or under-identification.	The report identifies higher acute harm, early-help involvement and complex need in East Kent, while other areas show low treatment engagement. It estimates that fewer than 1,100 CYP/young adults are known to services, compared with around 4,000 who may be at risk and eligible for support.	District-level treatment, early-intervention and referral rates; outreach contacts and onward engagement; acute admissions; unmet-need estimates; access and outcome equity by district and deprivation.

Priority	Recommendation	Evidence from the needs assessment	Suggested measures of progress
6	**Provide a flexible, visible and developmentally appropriate service model for 16–24-year-olds, including robust transition arrangements from CYP to adult services.** This should include outreach in colleges, universities, workplaces and digital spaces; self-referral; youth-friendly drop-ins; and joint transition planning from age 17, including for care leavers.	Treatment engagement has fallen most sharply among 18–24-year-olds. The report identifies a risk of disengagement at transition points and notes Kent's substantial student population as an important factor in future service demand.	Numbers and rates of 16–24-year-olds accessing support; transition completion and retention; self-referrals; engagement by college/university/workplace outreach; planned exits and re-presentations.
7	**Maintain an effective, evidence-informed treatment and harm-reduction offer matched to current patterns of use.** Ensure provision addresses cannabis and alcohol as dominant substances, alongside cocaine/stimulants, ketamine, nitrous oxide and polysubstance use; includes psychosocial interventions, relapse prevention, family support and prompt follow-up after acute incidents or discharge.	Cannabis dominates CYP treatment presentations, alcohol remains prominent among young adults, and stimulant use is increasing locally. Poly-drug use is reported at 88% in Kent treatment presentations compared with 57% nationally. Kent has strong planned-exit performance but variable re-presentation rates, indicating a need for consistent aftercare and continuity.	Intervention offer audited annually; planned exits; re-presentation within six and 12 months; uptake of harm-reduction and family support; substance-specific trends and acute presentations.
8	**Embed co-production, workforce development and data intelligence in commissioning and**	The report calls for stronger youth involvement, peer approaches,	CYP advisory mechanism in place; routine experience measures at entry,

Priority	Recommendation	Evidence from the needs assessment	Suggested measures of progress
	quality assurance. Routinely involve young people and families in service design, procurement and performance review; build workforce capability in trauma-informed practice, emerging substances, safeguarding and dual diagnosis; and develop an integrated dashboard segmented by age, district, gender and vulnerability.	feedback loops, workforce training and more timely linked data. It also identifies the need to benchmark Kent against England, the South East and local district variation.	review, exit and follow-up; workforce training completion and confidence; dashboard published quarterly; performance reviewed by age, geography and protected/vulnerability characteristics.

5.11 Conclusion

- Kent should maintain targeted and universal prevention, strategic multiagency oversight, and regular benchmarking alongside continued investment in integrated services.
- Recommended actions are responsive to new and persistent trends, with a clear focus on evidence-informed policy and practice