# Drug and Alcohol Needs Assessment

# For

# Children and Young People in Kent

# June 2016

**Authors:**

**Jessica Mookherjee Consultant in Public Health KCC**

**Linda Smith PH Specialist, KCC**

# 1 Introduction

This needs assessment provides an overview of the epidemiological needs of young people aged under 18 years of age residing in Kent County who access and require specialist substance misuse treatment (defined as encompassing both alcohol and illicit drugs) during 2012-13-14. However, where possible the needs of 18-24 year olds are also taken into account due to issue of transition to adult services.
The needs assessment is based on secondary analysis of existing datasets and as data is limited – it is important that caution is applied in interpretation of the data and interpretation must be linked with other assessments of children and young people's needs that exist in Kent.

The aim of this report is to examine the needs of young people (aged under 18 years) presenting to substance misuse services and to identify gaps or barriers in service provision. This report should be read in conjunction with the Adult Drug and Alcohol Needs Assessments for Kent.

Young people's substance misuse differs markedly from adults and concepts used to frame the adult service (e.g. "recovery") are not always applicable. Substance misuse will be at the early stage of use and the analysis of the data has been framed in some of the existing literature underpinning prevalence rates and "what works" in treatment.

The assumption made in this report is that young people who misuse substances (alcohol and drugs) will need access to some level of specialist service and there is a focus of this needs assessment on particular vulnerable groups of young people who may continue using drugs and alcohol problematically as adults.

In the absence of direct access to surveillance data there has been some attempt to compare and contrast the epidemiology of substance misuse in Kent with the national picture. The analysis has also been supplemented by a brief overview of some of the main themes within the literature.

The definition of the term 'substances' or 'drugs' is taken from the DfE and ACPO guidance (Jan 2012) and includes alcohol, tobacco, illegal drugs, medicines, novel psychoactive substances ("legal highs") and volatile substances, unless otherwise specified. However as 'smoking tobacco' is described elsewhere in the Kent raft of needs assessments that contribute to the JSNA, this report will omit it.

**Caveats and Limitations of the Data:**

First there can be limited interrogation of the data extracts provided – as it was not possible to develop a enhanced analytical approach (for example, using multivariate statistical techniques) that could determine whether any correlations or associations between factors are statistically significant.

Second, from the information provided from the cuts of data, there is little commentary on issues such as data quality and the impact this may have on the findings, although there will be a discussion on such matters in the text as they arise.

Thirdly there are some limitations in the service data due to changes in the Public Health England (NDTMS) data set and certain restrictions that were in place until December 2015 as well as one or two errors in the data set. The data are also hampered by the recent change in the NDTMS provider code in Kent – where the referrals code has been set to an erroneous category.

Moreover, it was not in scope for this needs assessment to utilize qualitative methods to support the epidemiological analyses including service user and staff consultation events.

Therefore, the findings from this study should be treated with some caution and should be considered indicative only. Where possible, the analysis will point towards developing further research questions that may help explain particular issues within the data.

The report is structured over three main chapters. Within this chapter is a brief summary of the available evidence including an overview of what constitutes effective treatment in order to place the findings from this study into context.

The second chapter analyses the epidemiology of problem substance misuse among young people with a final chapter suggesting next steps for service delivery.

**Recommendation: Kent Public Health work closely with providers and PHE to produce a more helpful data set for analysis.**

# 2 What is Known- Prevalence of drug and alcohol use amongst young people

## 3.1 Background

Drug and alcohol misuse pose a significant risk to a young person's physical and psychological health and development. In particular the adolescent brain is known to be highly susceptible to alcohol harms. By delaying the age at which young people start drinking, they are less likely to engage in health risk behaviours and be less likely to become dependent on alcohol.

**The Government's Chief Medical Officer recommends that no one aged 15 years or under should drink alcohol.**

The consumption of alcohol by young people also has wider impacts on society. Alcohol consumption in young people is associated with violence, committing offences, absenteeism and exclusion from school, increased use of drugs and decreased use of contraceptives.

National and local evidence suggests that the majority of young people who misuse substances are likely to be using alcohol or cannabis, although current policy models are being challenged by the growth of the new **psychoactive substances or 'legal highs'** market. These are substances that have been synthesised to cause similar reactions to controlled substances and which *until recently* have been marketed as legal alternatives.

## 3.2 Epidemiology

The population characteristics and demography of children in Kent is described in many needs assessments and will not be replicated here. This link will provide the Health and Social Care Maps for Children in Kent.

http://www.kpho.org.uk/__data/assets/pdf_file/0020/45344/Children-Kent-CCGs.pdf
The extent to which young people use drugs (prevalence) has traditionally been measured through survey research methods, particularly within a school–based setting. However this can miss out key groups who are not engaged with school e.g young offenders and those in pupil referral units. Evidence is presented from specialist national surveys commissioned to fill in these gaps.

Another limitation is the wide definition of '*young person'*. Some studies focus on children of school age (11-15 years) and other define young people as below 18 years of age, however other studies routinely include people up to 24 years and older.

This lack of comparability affects the interpretation of the evidence-base. The following section reports on the prevalence rates of substance misuse among those aged **11-15** within a school setting and among cohorts of vulnerable young people for comparison purposes. The tables 1 and 2 show the national estimates for Drugs and Alcohol in young people 11-15 and 16-24 years – applied to the Kent and NHS CCG areas.

(Table 1 and 2). The tables show the difference between the levels of drug use, ie having had some drug in the last year through to more regular use (in the last week). The prevalence estimates for young people's drug and alcohol behaviour are taken from national studies and applied to Kent's population. It is worth noting that almost a predicted 9000 11-15 year olds reported having alcohol in the last week.

## 3.3 Prevalence Estimates for Kent and Kent NHS CCGs.

### Young People Aged 11 -15 year olds (HISCIS estimates)

**Table 1**

| | **12% Drugs (in last year)** | **6% Drugs (in last week)** | **10% Alcohol In last week** |
|---|---|---|---|
| **Kent** | **10,620** | **5,310** | **8,850** |
| NHS Ashford CCG | 946 | 472 | 788 |
| NHS Canterbury & Coastal CCG | 1,316 | 658 | 1097 |
| NHS Dartford, Gravesham & Swanley CCG | 1771 | 886 | 1476 |
| NHS South Kent Coast CCG | 1328 | 664 | 1106 |
| NHS Swale CCG | 800 | 400 | 667 |
| NHS Thanet CCG | 954 | 477 | 795 |
| NHS West Kent | 3502 | 1751 | 2918 |

### Young People Aged 16- 24 year olds (Home Office and ONS estimates)

**Table 2**

| | **16.3% Drugs (in last year)** | **5.1% Frequent Users** | **2% Frequent Drinkers(5 days a week or more)** |
|---|---|---|---|
| **Kent** | **27,031** | 8616 | 3379 |
| NHS Ashford CCG | 2060 | 645 | 253 |
| NHS Canterbury & Coastal CCG | 5776 | 1,807 | 708 |
| NHS Dartford, Gravesham & Swanley CCG | 4425 | 1384 | 543 |
| NHS South Kent Coast CCG | 3325 | 1060 | 415 |
| NHS Swale CCG | 2017 | 631 | 248 |
| NHS Thanet CCG | 2447 | 765 | 300 |
| NHS West Kent CCG | 7287 | 2323 | 910 |

## 2.4 **School Age population**

The use of drugs and alcohol are particularly harmful to adolescents given that the brain and body is still in development during this time. Adolescents who have turbulent family lives or exhibit behavioural problems in childhood are more likely to engage in psychoactive substance use. (Fisher et al ) [i], (Sawyer 2012)[ii]

One way to show the prevalence of drug use among young people is via a survey of the school age population; these tend to be undertaken within a school environment and therefore the evidence base tends to focus on the prevalence of drinking as a measure as opposed to illicit drug use due to its relative scarcity as an act and due to issues with disclosing illicit activities in a routine school-based survey.

### 2.4.1 **How Many School Children Take Alcohol and/or Drugs in Kent?**

The Health and Social Care Information Centre (HSCIC, 2014) is the best source of population estimates for substance misuse in young people. These 2013 levels are similar to those of 2011 and 2012. But if a longer trend is taken we can see that between 2003 and 2011 drug use in secondary school age children declined. This may indicate that drug use in young people has declined since 2003 but may have levelled off in the last few years.

The HSCIC Study ('The Smoking, Drinking & Drug use Among Young People in England 2012 – secondary schools in England with children aged 11-15yrs') gives the following estimates:

- **43%** of pupils said that they had ever drunk alcohol at least once. This continues the downward trend since 2003, when 61% of pupils had drunk alcohol.
- **10%** of pupils had drunk alcohol in the last week. The prevalence of recent drinking has reduced significantly since 2003, when 26% of pupils had drunk in the last week, and is lower than in 2011 (12%).
- Boys and girls were equally likely to have drunk alcohol. The proportion of pupils who had drunk alcohol increased with age from **12% of 11 year olds to 74% of 15 year olds (Figure 1).**
- **16%** of 11 to 15 year olds report having taken drugs
- Of the young people reporting taking drugs - 11% had taken them in the last year and 6% had taken them in the last month.
- Pupils who had drunk in the last week had drunk an average (mean) of 12.5 units. Median consumption – which gives a more representative indication of how much pupils drink – was lower (8.0 units).
- Most pupils who had drunk alcohol in the last week had consumed more than one type of drink. Compared with boys, girls were less likely to have drunk beer, lager or cider, and more likely to have drunk, spirits, alcopops or wine. Both boys and girls consumed the majority of their alcohol intake in the form of beer, lager or cider.

- **33%** of pupils said that they had obtained alcohol in the last week. This continues the downward trend since 2004 when 49% said they had obtained alcohol in the last week. The most common ways of obtaining alcohol were to be given it by parents (19%), given it by friends (19%), to ask someone else to buy it (13%), or to take it from home (13%).

**KEY FACT**

**19% of 11-15 year olds in UK got their alcohol from their Parents.**

- Under half of pupils who drank alcohol (44%) said they bought it.
- Pupils who had bought alcohol had usually done so from friends (53%),
- someone other than family or friends (34%), off-licences (32%) or shops or supermarkets (24%).
- Pupils who drank alcohol were most likely to do so in their own home (54%),
- someone else's home (48%), at parties with friends (47%), or somewhere outside (18%).
- Since 2006, there has been an increase in the proportions who usually drink at home or in other people's homes or at parties with friends, and a reduction in the proportion drinking outside.

- Half (50%) of pupils who had drunk alcohol in the last four weeks said that they had been drunk at least once during that time.
- Although 61% said that they had deliberately tried to get drunk, 39% said they had not.

Pupils are more likely to drink if they live with other people who drink alcohol. 83% who lived with no one who drank alcohol had never had a drink of alcohol, compared with 30% of pupils who lived with three or more drinkers.

### 3.4.2 Social Norm

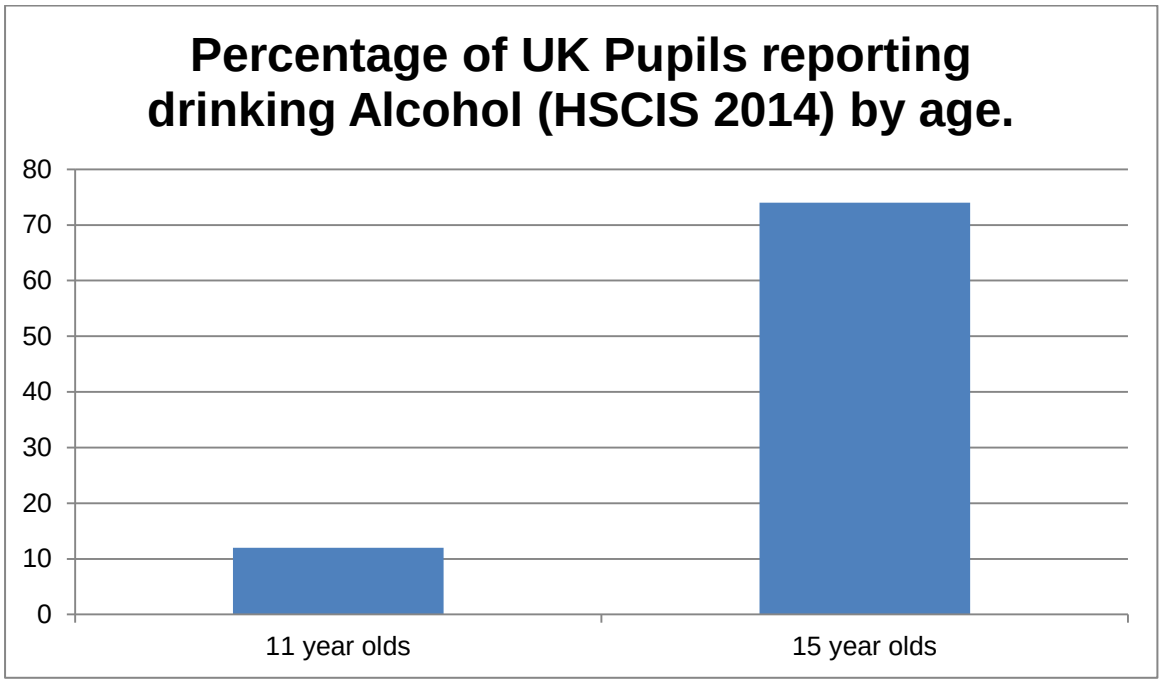
This data indicates to what extent alcohol remains an entrenched issue in British society, with binge drinking and young people getting drunk not necessarily seen as an issue for young people themselves. It also indicates some of the possible social norms that children and young people are brought up with, hence of particular note that younger pupils were most likely to drink with family members and an increasing proportion of children who drink at home. However Table 3 shows that in 2012/3 a sizable fewer younger children aged 7-11, are reported that they have ever drank alcohol compared with 2003.

At the time of the report in 2012, there was widespread awareness of illegal drugs such as cocaine, heroin and cannabis. Few had heard about other drugs such as mephedrone, ketamine and poppers. It is unknown to what extent subsequent media coverage and popularity of NPS have altered these perceptions.

A strong relationship between drug use and the attitude of families was found; those who thought their families had a more lenient attitude towards their drug use were more likely to have taken drugs that those who thought their families would

disapprove. The most likely sources of helpful information about drugs continue to be teachers (69%) and parents (68%) but that TV was seen as the most helpful of media tools (59%).

Figure 1




Source: HSCIS 2014

Table 3: The Number of 7-11 year olds reporting drinking alcohol.

| | Kent Population 7-11 year olds | Reporting drinking alcohol at least once % | Number Reporting drinking alcohol at least once |
|---|---|---|---|
| 2014 | 88,762 | 39% | **34,617** |
| 2003 | 89,364 | 61% | 54,512 |

Public Health England has highlighted the fact that young people who start drinking alcohol at an early age tend to drink more frequently and more in total than those who start drinking later in their life; as a result, they are more likely to develop alcohol problems in adolescence and adulthood.

**As a result, in 2009 The Chief Medical Officer for England issued guidance that young people under 15 should not drink alcohol at all.**

### 3.4.3 Risky Behaviours

The Survey "What About YOUth?" was carried out in 2014/15 across the UK among young people aged 15 years old. The survey showed Kent had 18% of it's 15 year olds engaging in over 3 risky behaviours (Table 4). Kent also had higher then England average on 15 year olds smoking and drinking alcohol and smoking cannabis (Table 5 & 6 )

**Table 4. Percentage of Young People (aged 18 and under) with Three or More Risky Behaviours (2013/4)**

| Area | Value | Lower CI | Upper CI |
|---|---|---|---|
| **England** | 15.9 | 15.6 | 16.1 |
| South East region | 17.2 | 16.5 | 17.9 |
| Bracknell Forest | 13.6 | 11.2 | 16.1 |
| Brighton and Hove | 23.7 | 21.2 | 26.2 |
| Buckinghamshire | 13.2 | 11.2 | 15.2 |
| East Sussex | 22.6 | 20.2 | 25.1 |
| Hampshire | 16.8 | 14.5 | 19.0 |
| Isle of Wight | 18.8 | 16.4 | 21.2 |
| Kent | 18.0 | 15.8 | 20.3 |
| Medway | 18.4 | 16.2 | 20.7 |
| Milton Keynes | 15.7 | 13.6 | 17.9 |
| Oxfordshire | 19.8 | 17.4 | 22.3 |
| Portsmouth | 16.2 | 13.8 | 18.7 |
| Reading | 14.1 | 11.9 | 16.4 |
| Slough | 6.1 | 4.6 | 7.7 |
| Southampton | 17.9 | 15.5 | 20.3 |
| Surrey | 17.0 | 14.8 | 19.3 |
| West Berkshire | 14.0 | 12.0 | 15.9 |
| West Sussex | 17.6 | 15.4 | 19.8 |
| Windsor and Maidenhead | 15.3 | 13.0 | 17.5 |
| Wokingham | 11.9 | 10.1 | 13.7 |

*Source: What About YOUth (WAY) survey, 2014/15*

**Table 5 Kent results on Smoking, Alcohol and Drugs from the "What about YOUth" Survey 2014/5 compared to England average.**


| Indicator | Period | Kent | | Region | England | England | | |
|---|---|---|---|---|---|---|---|---|
| | | Count | Value | Value | Value | Worst/ Lowest | Range | Best/ Highest |
| Percentage of current smokers | 2014/15 | - | 10.5% | 9.0% | 8.2% | 14.9% | | 3.4% |
| Percentage of regular smokers | 2014/15 | - | 7.3% | 5.8% | 5.5% | 11.1% | | 1.3% |
| Percentage of occasional smokers | 2014/15 | - | 3.2% | 3.2% | 2.7% | 7.6% | | 0.6% |
| Percentage who have tried e-cigarettes | 2014/15 | - | 19.7% | 16.7% | 18.4% | 33.9% | | 7.2% |
| Percentage who have tried other tobacco products | 2014/15 | - | 16.7% | 16.1% | 15.2% | 28.8% | | 5.5% |
| Percentage who have ever had an alcoholic drink | 2014/15 | - | 69.3% | 66.7% | 62.4% | 77.6% | | 14.6% |
| Percentage of regular drinkers | 2014/15 | - | 6.1% | 6.2% | 6.2% | 12.3% | | 1.0% |
| Percentage who have been drunk in the last 4 weeks | 2014/15 | - | 15.8% | 15.9% | 14.6% | 27.0% | | 2.6% |
| Percentage who have ever tried cannabis | 2014/15 | - | 12.1% | 11.7% | 10.7% | 24.2% | | 4.9% |
| Percentage who have taken cannabis in the last month | 2014/15 | - | 6.1% | 5.5% | 4.6% | 14.4% | | 1.6% |
| Percentage who have taken drugs (excluding cannabis) in the last month | 2014/15 | - | 1.3% | 1.0% | 0.9% | 4.2% | | 0.1% |

Table 6. Percentage who have used Cannabis in the last month 2014/15

| Area | Value | Lower CI | Upper CI |
|---|---|---|---|
| **England** | 4.6 | 4.5 | 4.8 |
| South East region | 5.5 | 5.0 | 5.9 |
| Bracknell Forest | 3.5 | 2.2 | 4.8 |
| Brighton and Hove | 14.4 | 12.3 | 16.4 |
| Buckinghamshire | 2.0 | 1.2 | 2.8 |
| East Sussex | 7.1 | 5.6 | 8.6 |
| Hampshire | 4.7 | 3.4 | 6.0 |
| Isle of Wight | 6.0 | 4.5 | 7.5 |
| Kent | 6.1 | 4.7 | 7.5 |
| Medway | 5.0 | 3.7 | 6.3 |
| Milton Keynes | 6.1 | 4.7 | 7.5 |
| Oxfordshire | 6.8 | 5.3 | 8.3 |
| Portsmouth | 4.7 | 3.4 | 6.0 |
| Reading | 6.2 | 4.7 | 7.8 |
| Slough | 1.7 | 0.9 | 2.5 |
| Southampton | 5.1 | 3.8 | 6.4 |
| Surrey | 4.5 | 3.3 | 5.7 |
| West Berkshire | 3.8 | 2.7 | 4.9 |
| West Sussex | 6.2 | 4.9 | 7.6 |
| Windsor and Maidenhead | 6.6 | 5.1 | 8.1 |
| Wokingham | 2.9 | 2.0 | 3.8 |

*Source: What About YOUth (WAY) survey 2014/15*

**Table 7 Alcohol Specific Alcohol Admissions: Pooled 4 years data 2011/12/13/14 crude rate per 100,000.**

Table 2

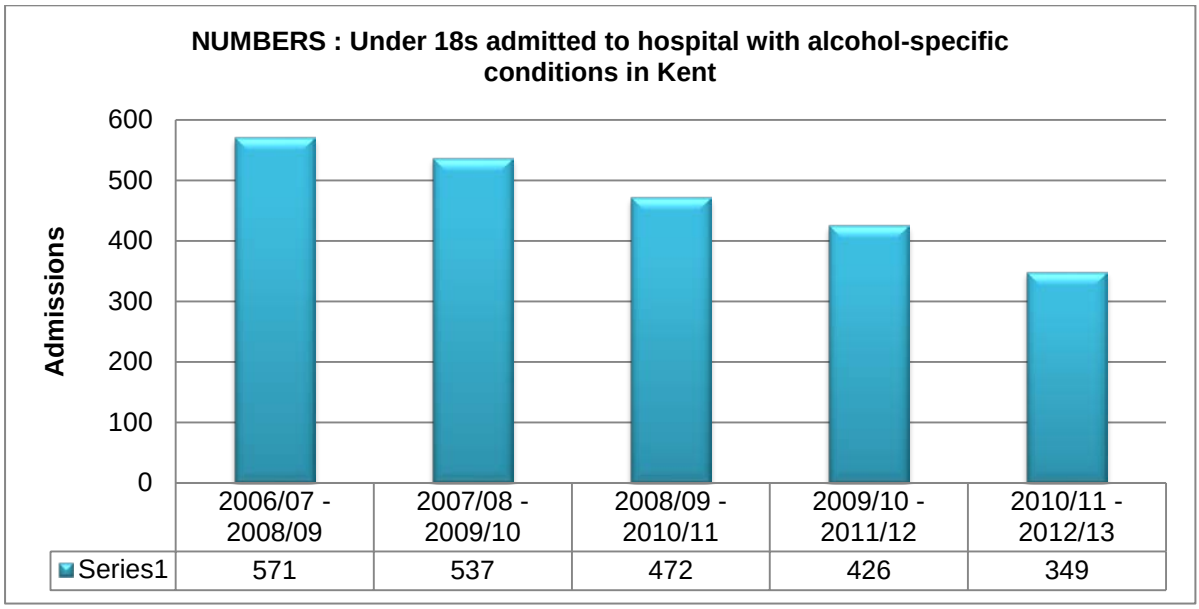
| Area | Value | Lower CI | Upper CI |
|---|---|---|---|
| **England** | 40.1 | 39.4 | 40.7 |
| South East region | 35.6 | 34.1 | 37.2 |
| Bracknell Forest | 16.1 | 8.6 | 27.5 |
| Brighton and Hove | 63.1 | 51.0 | 77.1 |
| Buckinghamshire | 22.0 | 17.4 | 27.5 |
| East Sussex | 42.7 | 35.8 | 50.6 |
| Hampshire | 36.7 | 32.7 | 41.0 |
| Isle of Wight | 90.0 | 70.2 | 113.7 |
| Kent | 34.5 | 30.9 | 38.4 |
| Medway | 29.9 | 22.5 | 38.9 |
| Milton Keynes | 16.9 | 11.6 | 23.9 |
| Oxfordshire | 41.9 | 35.9 | 48.6 |
| Portsmouth | 37.6 | 27.7 | 49.8 |
| Reading | 17.5 | 10.4 | 27.7 |
| Slough | 18.3 | 11.3 | 28.0 |
| Southampton | 87.1 | 72.4 | 104.0 |
| Surrey | 33.5 | 29.5 | 37.9 |
| West Berkshire | 20.6 | 12.9 | 31.2 |
| West Sussex | 36.4 | 31.3 | 42.1 |
| Windsor and Maidenhead | 22.3 | 14.0 | 33.8 |
| Wokingham | 20.4 | 12.8 | 30.8 |

*Source: Calculated by Public Health England: Knowledge and Intelligence Team (North West) using data from the Health and Social Care Information Centre - Hospital Episode Statistics (HES) and Office for National Statistics (ONS) - Mid Year Population Estimates*

There appears to be a relatively encouraging picture for Alcohol related admissions for young people in England as a whole. The most recent County and regional data released with regard to alcohol specific hospital mirrors this with Kent being around the regional average. (Table 7; Figure 2). However Kent is a large and diverse county and when districts are compared – large variations are visible (Figure 3). The district variations show that Thanet and Canterbury have a value of 58 admissions per 100,000– which approaches Brighton & Hove's rate and would be marked 'red' if compared regionally.

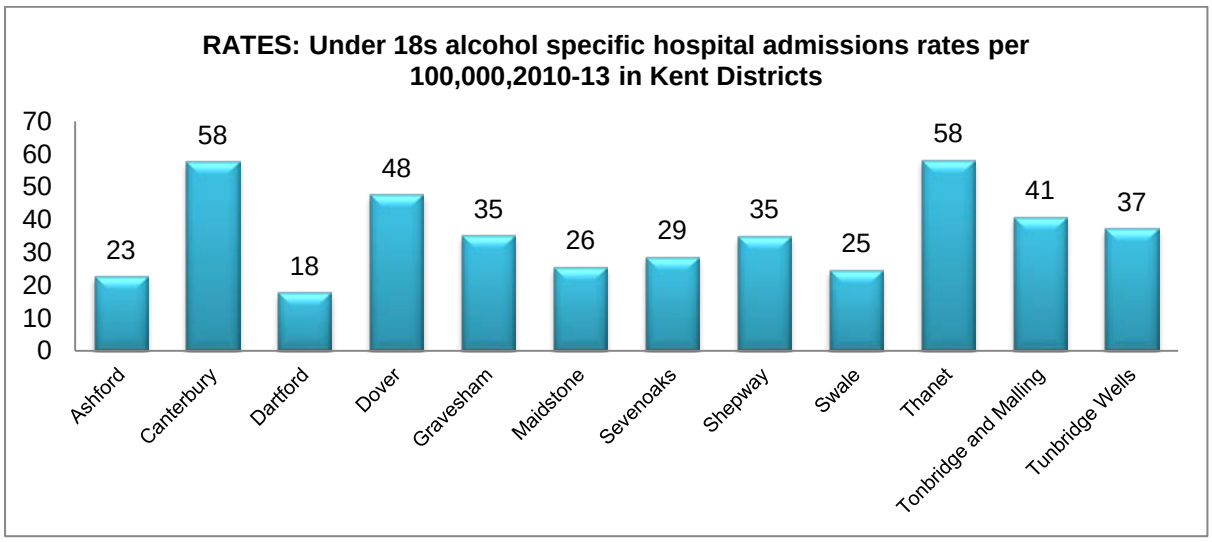
**This marks out young people's drinking alcohol behaviour as a priority for East Kent Health and Well Being Boards**.

**Figure 2**




Source LAPE 2014

Figure 3




Source LAPE 2014

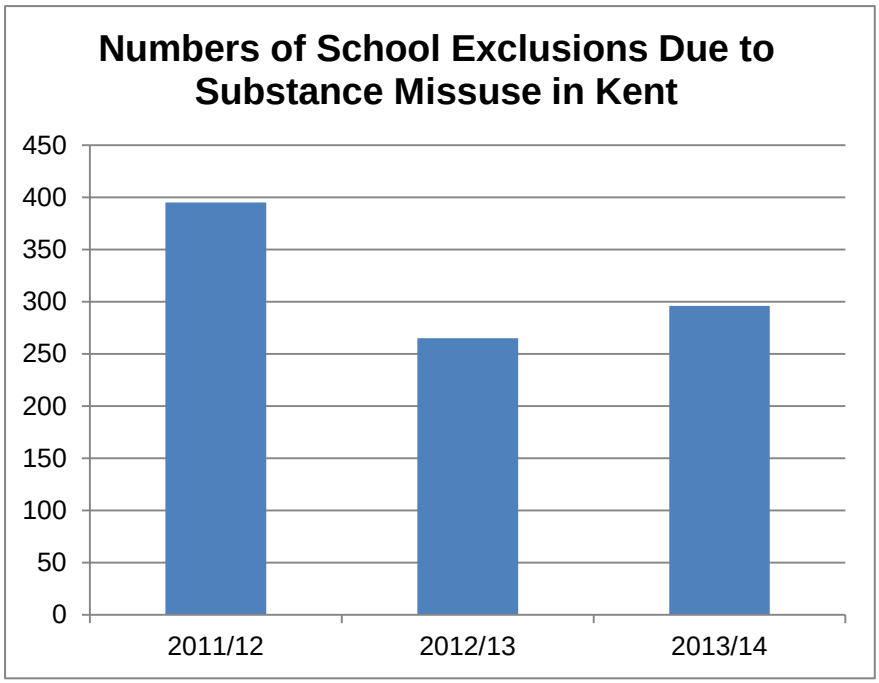
There has been a steady reduction of alcohol related hospital admissions for people under 18 from 2006 to 2013 ( Figure 2) however the 3 year rolling average rates of admissions to people under 18 across Kent districts show marked variation (Figure 3), with Canterbury, Thanet and Dover having the highest admissions in Kent, and Tonbridge and Malling having the highest admission rates in West Kent.

### 3.4.4 School Exclusions due to Drug and Alcohol Problems

In 2013/14 there were296 school exclusions due to either a drug or alcohol problem. In 2012/13, **265** pupils received fixed period exclusions in Kent due to drug and/or alcohol use. This was a reduction from **395** pupils in 2011/12. (Figure 4)

In 2012/13 in Kent the rate of pupils being excluded for a fixed period for substance misuse was **0.123%**, although overall the rate was low (the main reason being conduct),it is statistically significantly *higher* than the England rate of **0.093%** Psychological distress and psychiatric disorder are associated with exclusion from school.

Figure 4




Source ONS

### 3.4.5 Children Exposed to Drug and Alcohol Risks and Harm

There is nearly a sevenfold increase in the risk of developing schizophrenia from high usage of cannabis in adolescence. (Zammit 2002)[iii].

In a 10-year cohort study of young people aged 14 to 24 at baseline, cannabis use was found to be a risk factor for the development of incident psychotic symptoms, with continued cannabis use associated with an increased risk for psychotic disorder by increasing on the persistence of symptoms.

Nationally there is also some evidence pointing towards a general lack of awareness about the harmful effects of substance misuse upon young people's lives - for

example, a survey by Leicestershire Drug and Alcohol Commissioners suggested that young people aged 18 and under were not aware of the harmful effects of alcohol use including binge drinking (Home Office, 2007).

Research (ibid) examining alcohol misuse found increased levels of awareness about alcohol since 2004 but identified a cohort of problem drinkers who tended to be heavy users exhibiting “low alcohol knowledge.” The characteristics of this group tended to be female, white, with low aspirations, with an offending history and episodes of being excluded from school. This cohort of ‘heavy-end’ alcohol users also tended to exhibit *risky sexual health behaviours*.

Research (Fuller, 2008) suggests that the main source of alcohol is from **parents** – of 11-15 year olds who reported drinking 14+ units in the last week, the majority were given alcohol by their parents directly (with a large proportion admitting taking alcohol from their parents covertly).

However, despite these trends a summary from a Joseph Rowntree Foundation research programme suggested that young people’s alcohol use was in fact relatively nuanced – young people stated that they were aware of existing health promotion messages but treated some of these sceptically and saw alcohol use as a secondary priority (Sondhi & Turner, 2011). Moreover, this research highlighted the interaction between parental perceptions of alcohol use and those of their children (ibid).

- One-in-four deaths amongst 16-24 year olds are related to alcohol.
- Children who drink are at a greater risk of brain damage.
- They are also at greater risk of developing problems with alcohol in later life including dependency.
- Young people also have a higher risk of being involved in road traffic accidents.

### 3.4.6 Toxic Trio

In 2015 there was a Kent report was commissioned to investigate on the exposure to children from the Toxic Trio of Substance misuse, Domestic Violence and mental health problems. The conclusion of this report found that

Research suggests that of the **308,200** children living in Kent in 2014 approximately **22%** lived with a parent who misuses alcohol (hazardous), **2.5%** lived with a parent who misuses alcohol (harmful), **8%** lived with a parent who misuses drugs, 6% have been exposed to parental domestic violence and 18% lived with a parent with mental ill-health. Of this only a small number are known to targeted or specialist services in Kent.

It is noted that:

- If a parent suffers from the toxic trio it does not on its own automatically indicate that children are at risk of abuse or neglect.
- A large number of children will be of the same cohort – they will have a parent suffering from two of more factors within the toxic trio.
- The toxic trio is often not the presenting factor or need, and is often hidden reflecting the reluctance for families to admit a history of problem drinking or drug use, mental illness or domestic violence, for example resistance in fear of social

workers taking punitive action.[68] National research shows that the indication of the toxic trio in parents is very low at the referral stage
- Large numbers of parents will be accessing support other than those provided by Kent County Council which could prevent the parent, or potentially the child, escalating to Early Help or Social Care in Kent..
- The numbers presented will be an underestimate, as many more may be known to services but are not reported in a manner which is extractable.

***"Young people who live in deprived areas are more likely to drink alcohol, drink at an earlier age, and to drink to excess. This relationship was stronger for young women than young men. The effects of higher alcohol consumption in areas of deprivation are likely to be compounded by inequalities which affect nutrition, exercise and emotional well-being" (IAS, 2014).***

### 3.4.7 Which Young People are most at risk of substance misuse?

The NICE Guidance (2014) states: Factors that influence substance misuse among vulnerable and disadvantaged children and young people (CYP) include:

- environment (for example, availability of drugs)
- family (for example, sibling and/or parental substance misuse and lack of discipline)
- individual experience (for example, early sexual encounters and peer group pressure to misuse substances)
- mental health (for example, low self-esteem, depression)
- education (for example, parental expectations)

**Those at particular risk include:**

- those who are – or who have been – looked after by local authorities, fostered or homeless, or who move frequently
- those whose parents or other family members misuse substances
- those from marginalised and disadvantaged communities, including some black and minority ethnic groups
- those with behavioural conduct disorders and/or mental health problems
- those excluded from school and truants
- young offenders (including those who are incarcerated)
- those involved in commercial sex work
- those with other health, education or social problems at home, school and elsewhere
- those who are already misusing substances

Previous prevalence estimates of substance misuse amongst young people have been informed by a number of tools. These have included a tool developed by the

Home Office for estimating the prevalence of substance misuse amongst vulnerable groups and a Children and Young People of Kent Surrey. Neither of these is currently available.

As a proxy for estimating prevalence in Kent, we can use the number of children in 'at risk' groups in Kent. At February 2015, Kent County Council had corporate responsibility for:

- 1899 looked after children
- 743 Unaccompanied Asylum Seeking Children
- 1003 children had a parent who is accessing substance misuse service (2013/14).*
- 5389 school pupils had permanent or fixed exclusions (2013/14)

*This only reflects those parents who sought and engaged in treatment for their substance misuse and so is an underestimate the true number in Kent.

This is a total of **9,034** vulnerable young people in Kent. However this figure is likely include a large number of duplicate entries across categories and its use may be limited. It is difficult to predict the need for drug and alcohol services for this group as the same child is often bound to be in multiple categories. However it is known in literature that these groups have often 50% higher need than young people not in these groups.

**Table 8 Estimated Needs Vulnerable Young People in Kent (Snapshot February 2015) ( crude estimate 60%)**

| | |
|---|---|
| **Looked After Children** | 1899 |
| **Unaccompanied Asylum Seeking Children** | 743 |
| **children had a parent who is accessing substance misuse service** | 1003 |
| **school pupils had permanent or fixed exclusions (2013/14)** | 5389 |
| **Total** | **9,034** |

Recommendation: Services must be proactive and responsive to people falling into the above categories.

### 3.4.8 Vulnerable Groups

**Key Fact: Target Offenders, Target Excluded Young People, Target Children in Care.**

Research has consistently highlighted the higher prevalence of alcohol and drug use (especially Class A use) amongst vulnerable groups of young people including: young offenders (Hammersley et al, 2003); those in care (Ward et al, 2003); those sleeping rough or who are homeless (Mallett et al, 2005: Wincup et al, 2003); serial runaways; school truants and excludees (Becker & Roe, 2005; Goulden & Sondhi, 2001).

Moreover, young people with multiple issues reported a much higher prevalence of Class A use with reported rates of 25% last year use of Class A drugs amongst those in multiple vulnerable groups compared to 12% who were not (Douglas & Plugge, 2006).

The research cited above highlights the greater use of cannabis, cocaine and ecstasy (in some research amphetamines and/or solvents are prominent) amongst all groups of vulnerable people.

Research (McCrystal et al, 2007) in Belfast found similar findings among a sample of surveyed school excludees and found links with other key factors such as poor communication with parents/guardians; greater engagement with the criminal justice system (CJS) and these young people tended to reside in communities characterised by neighbourhood disorganisation. Moreover, the literature suggests differentials between segments of young people. For example, younger females within the criminal justice system are shown to have a greater prevalence of mental and physical health issues (including self-harm) alongside a greater vulnerability to sexual exploitation (Douglas & Plugge, 2007; Galahad SMS, 2004).

The main findings from the literature (Case & Haines, 2008; Dillon et al, 2007; Frischer et al, 2007; ACMD, 2006; EIU, 2005; Beckett et al, 2004; point to a number of key factors associated with young people's drug use that juxtapose with vulnerability. These include (but are not limited to):

- Anti-social behaviour including minor or petty offending;
- Family behaviour and circumstances including a lack of supervision;
- Problems at school;
- Early smoking habits;
- Isolation

Among a national sample in 2006 of young offenders aged between 10-19 defined as "delinquent youth groups", these young people were shown to be **three times more likely** to use any drug compared to a comparison non-offending group (45% to 15%); nearly four times more likely to use a Class A drug (11% to 3%) and twice as likely to use heroin or crack-cocaine (4% to 2%) and more likely to be caught in alcohol-related offending - from 25% to 6% (Sharp et al, 2006).

This suggests that there is a need to target offenders not just because of the influence of substances on their offending behaviour, but also because of their heightened risk to the health consequences of substance use. The research looked at a 10-16 year-old sub-group and concluded that lifestyle factors such as greater levels of alcohol and drug use greatly contributed to offending and their participation within a gang or delinquent youth group.

### 3.4.9. Predicted Prevalence of Alcohol and Drug Misuse in Youth Offending

In 2014, for every 100,000 10-17 year olds in the population of Kent, **448.7** received their first reprimand, warning or conviction. The England value is 409.1, making Kent have a higher then national average rate of young people at risk of entering the criminal justice system (Table 9) .

Many children and young people who come into contact with the Youth Justice System (YJS) have health and social care needs which go unrecognised and unmet (Chief Medical Officer 2012). While these are not the cause of offending behaviour, they are often linked to issues of self-esteem, emotional well-being and other factors that influence behaviour more generally (HM Government, 2009).

Young people in contact with the YJS have high levels of problem drinking, use of illegal drugs and use of volatile substances (HM Government, 2009). These increase the risk of young people committing an offence as well as having a detrimental effect on their general health and well-being.

Table 9

**Rates of young people aged 10-17 receiving their first reprimand, warning or conviction.**

| | First time entrants to the youth justice system (2010) | First time entrants to the youth justice system (2011) | First time entrants to the youth justice system (2012) | First time entrants to the youth justice system (2013) | First time entrants to the youth justice system (2014) |
|---|---|---|---|---|---|
| **Kent** | 1,029.7 | 876.1 | 583.9 | 478.7 | 448.7 |
| **South East** | 871.2 | 612.5 | 483.3 | 398.8 | 348 |
| **England** | 901.7 | 725.6 | 556 | 440.9 | 409.1 |

Source: Department for Education. Further information:
www.education.gov.uk/rsgateway/DB/STR/d000895/index.shtml

^ top ^

National Research carried out for the Youth Justice Board into alcohol and drug misuse among children and young people in the secure estate (age 12-18) found that **44%** fell into the highest category of problematic substance misuse. In the period before entering custody, two thirds (66%) reported binge drinking once a week, while a quarter (25%) considered their drinking to have been out of control.(Youth Justice Board 2009).[iv]

### 2.4.10 **Predicted prevalence of substance misuse for young people in and leaving Care**

It is estimated that **11** per cent of care leavers have problematic alcohol use, whilst some studies put problematic drug use as high as **21** per cent[v]. A Home Office report in 2003 showed that Care leavers are roughly twice as likely to have used illegal drugs than the general population.

A number of studies have shown that there are a cluster of characteristics that increase a young care leaver's chances of developing substance misuse problems:

- Coming from a children's home
- Early exits from care (lack of adult supervision)
- Mental health problems
- Childhood abuse and/or neglect. In 2013 in UK 62% of all children in care were there due to abuse or neglect.

"I had one young person who I still think about. She had a borderline personality disorder, was addicted to drugs and engaged in sex work (although she wouldn't admit it). She turned 21 and her case was closed. We couldn't transfer her to adult services to get help with her mental health problems whilst she was addicted to drugs. I really wish I'd had longer to try and help her.' Quote from **Survival of the Fittest": Improving Life Chances of Children in Care. 2014, Centre for Social Justice.** **http://www.centreforsocialjustice.org.uk/UserStorage/pdf/Pdf%20reports/CSJ_Care_Report_28.01.14_web.pdf**

## 4. Evidence of effectiveness and guidance for best practice

As part of this review of the literature, it was possible to assess some of the evidence relating to treatment interventions or modalities used to treat children and young people for their drug and alcohol use. This section is meant to be illustrative rather than exhaustive partly due to the paucity of a robust UK evidence base.

For further evidence drawn from UK and international research of effective interventions for families and by substance group e.g. NPS please see Adults Drugs Needs Assessment (KPHO).

The scarcity of the evidence base has been highlighted as an issue (NTA, 2009; Jones et al, 2006) but despite this, substance misuse treatment in its widest sense suggests that treatment can have long to medium terms gains in terms of reduced drug use and improvements in other indices such as reductions in offending, improvements in school attendance alongside general physical and mental well-being (cf. NTA, 2009; McIntosh et al, 2006) although there is little evidence to suggest which treatment best suits which segment of young person.

Moreover, the National Institute of Clinical Excellence (NICE) has highlighted the deficiencies in the evidence-base encompassing (NICE, 2007):

- A reliance on short-term studies
- Few rigorous UK-based studies
- Little research examining practitioner attributes across different service models
- Few studies looking at vulnerable groups
- No clear concept of what at-risk means
- Little evidence on wider treatment outcomes

The extent of need relating to pharmacological support suggests a low level of national demand – figures from Public Health England (PHE) suggest that during 2012-13 there were 191 young people in receipt of pharmacological support out of a total treatment population of 21,270 (or less than 1 per cent). There is little UK-based evidence on the efficacy of ‘traditional’ clinical prescribing models including use of residential treatment for young people, although NICE (2007b) guidance highlights the complexities of incorporating a wholly medical model without specialist interventions from a range of services.

Other forms of intervention also lack a suitably robust evidence-base, but the international literature suggests brief interventions (BI); motivational interviewing (MI) and cognitive behavioural therapies (CBT) can be seen to have discrete and viable impacts including engagement with specialist services for problem substance misusers (NTA, 2009; Tevyaw & Monti, 2004; McCambridge et al, 2004), those within an acute setting such as Accident and Emergency (Tait et al, 2005) or within the criminal justice system (Stein et al, 2006). However, a word of caution is advised as a national evaluation of young people’s arrest referral pilots (Matrix MHA, 2007) provided ambiguous evidence for its effectiveness. Here, qualitative evidence suggested a positive outcome which was not borne out in terms of reductions in recorded crime rates and reduced drug use.

A national study exploring the evidence suggested that CBT is largely considered as “effective” including in group settings and BI used as a one-off session or to facilitate engagement in more structured treatment (NTA, 2009). This study suggested the importance of the therapeutic alliance alongside practical support as a means of enhancing engagement with treatment. Overall, the research (Hides et al, 2011; Jones et al, 2006) suggests that BI and MI produces a short-term effect in the use of alcohol, cannabis and tobacco

The authors of an Australian study of 60 young people receiving CBT/MI alongside “standard care” compared to a comparison sample of 28 young people receiving standard care only found significant improvements in depression and reductions in cannabis use (alongside increased social contact) at the three-month period, but found that the comparison group "caught up” at six-months whereby an differences in outcome vanished (Hides et al, 2011). The authors concluded that these interventions may accelerate treatment gains in the immediate-term.

### 4.1 Family-Based Interventions

The wider children and young people literature highlight the need for parents or guardians to engage with the therapeutic process for interventions broader than substance misuse (DfES, 2007). In Exploring the Evidence, (NTA, 2009) the study highlights the role of the “family” as a catalyst for improvements in a young person’s substance misuse and to assist parents who are substance misusers (Jones et al, 2006). Yet the concept of ‘family’ based interventions encompasses a myriad of approaches and theoretical designs.

In the UK, the term family-based interventions is often synonymous with the ‘troubled families’ agenda whereby families known to multiple services, often for anti-social behavioural reasons, are intensely case-managed by the state who provide a worker to engage in many aspects of their lives. Programmes such as the Family Intervention Programme have shown some promising outcomes in terms of reductions in anti-social and other forms of ‘problematic’ behaviours with studies showing the potential for improvements in outcomes when families are effectively engaged (Clark et al, 2005; NICE, 2007). Moreover, a study examining the outcomes of Family Intervention Projects (FIPs) found reductions (from 32% at the beginning to 17% at exit) in the number of families reporting drug misuse as an issue following extensive family work (NCSR, 2009).

In substance misuse treatment, there is an increasing desire to engage holistically with families to provide support for both adults and young people who misuse drugs and/or alcohol. For adults in specialist substance misuse treatment, Copello et al (2012) was able to break down in general terms what is meant by family-based work and he concluded that there were five broad and generic groupings:

- Responses in non-specialist settings e.g. recognition of initial need
- Assessment of need
- Services to family members in their own right
- Engaging family members into treatment

- Intensive family-based interventions

The design of ‘intensive family-based interventions’ equally covers a wide range of theoretical and conceptual approaches. For young people with substance misuse or with behavioural issues, family work has been seen to worthy of further development.

A UK review of the evidence-base for young people with substance misuse needs concluded that the greatest reductions in drug and/or alcohol use can be evidenced for “family therapy”, followed by cognitive behaviour therapy (CBT), motivational enhancement therapy (MET), MET behaviour therapy and pharmacological treatment for the few young people addicted to opiates (Ahuja et al, 2013). In this review, the cornerstones of effective family-based treatment includes the need for holistic assessments that examine the wider context of a young person’s life and related psychological and physical issues that they may have, alongside being able to help navigate the young person across the myriad of services that they are likely to engage with.

**Headline: Treatment Providers Must Engage the Families**

The predominately US-based research has increasingly being able to illustrate a young person’s progression into substance misuse is both initiated and facilitated through interactions with the family (cf. Hawkins et al, 2005) and that familial factors often predict the start of drug-using behaviours, its sustainability and often escalation. Tober & Komro (2010) were able to point towards key variables:

• Parental psychopathology
• Conflict between partners
• The distance (or lack of closeness) within a relationship
• Parenting deficits

The evidence suggests a symbiotic relationship between relationship dysfunction and substance misuse, with the notion that increasing stress and conflict that permeates within a family, the greater probability for an individual to be susceptible to using drugs or alcohol.

For offenders in general, the desistance literature clearly provides a link in longitudinal studies between high levels of family dysfunction and criminality (Bonta et al, 2008) and shows the impact of ***poor parenting*** on future offenders. The desistance literature places a high premium on family-based factors that are associated with higher prevalence of anti-social behaviour and offending to include “family processes” such as attachment, affection (including extent of “emotional neglect” including a lack of attachment to others); and the level of parental supervision (for younger offenders).

**4.2 Headline: Prioritise Family Therapies**

For substance misuse specific services and interventions, family-based treatment is at the forefront of innovative research practice that aims to integrate the family into a young person’s treatment (cf. Williams & Chang, 2000; AACAP, 2005). Stanton & Shadish’s (1999) meta-analysis of family therapies suggested that use of family-based

therapies was “encouraging” and the use of these interventions point toward better outcomes compared to other, non-family approaches (especially if used as an adjunct to clinical treatment interventions).

A more recent meta-analysis (Baldwin et al, 2012) comparing the effects of family therapies on young people’s offending and substance misuse compared a range of therapeutic models (which are explained below) against a treatment-as-usual, alternative therapy or control group.

The meta-analysis found that by pooling three family therapies into one block against the three alternatives there was a statistically significant, but modest effect compared to treatment-as-usual, or alternative therapies. The study suggests that the comparisons of the pooled family therapies group against controls was stronger but lacked statistical significance. The study was able to point towards family therapies as an important approach for treatment young people’s substance misuse and offending.

For wider anti-social behaviour and offending, the broad literature consensus demonstrates the efficacy of family interventions at reducing criminality. However Fraser et al (2010) adds that the “family should not be the sole focus of any intervention work” and to look at wider societal contexts. Much of the family intervention evidence is  focused exclusively on US-based research with little contemporaneous studies from the UK (McQueen et al, 2008). Despite these reservations, other authors have maintained that family-based approaches do offer some promise.
Downden and Andrews (2003) suggested that interventions need to be focused on medium- to high-risk offenders and suggested that ‘family affection/communication’ alongside the level of parental monitoring and supervision all predict offending. Therefore taking the evidence in the round, family interventions have been perceived to be a essential among experts with the suggestion that “the theoretical and clinical rationale for involving families in the drug abuser’s treatment now seems self-evident” (Rowe, 2012; p60).

**Headline: the literature consensus is that family-based approaches are important interventions and somewhat effective in tackling broader anti-social behaviour and offending.**

The mechanisms that underpin change have also been explored (Rowe, 2012) and these in essence, link to three key factors although there is an awareness that the drivers that deliver change remain a mystery as researchers do not “know how it works” (ibid, p.69):

•The therapeutic alliance between families and workers/treatment providers
•Therapist/worker abilities and ability to adhere to systematic or manualised approaches and
•The role of mediation in family relationships

Research has focused on possible organizational barriers that prevent the effective implementation of family-based approaches (Fals-Stewart et al, 2004) that include a lack and variable level of funding to support the development of various models, low supervision or administrative support and attitudes of workers who may not have fully

engaged with the family agenda. Despite these potential problems, Rowe (ibid, p73) concluded that: "*reviews of both adolescent and adult drug abuse now consistently include family-based models among the most highly regarded and most strongly supported approaches [to treatment]".*

This means that Substance Misuse services can not be stand alone – they must be commissioned and monitored (and provided) alongside the raft of Children and Young People's Services, Early Help and CAMHS.

**Substance Misuse should form an integral part of School Health Services, and a key facet in the Children and Young People's Emotional Well Being Strategy for Kent.**

### 4.3 Prevention Focused

Preventive approaches are commonly categorised as universal, targeted and specialist. Universal interventions include fiscal policies, drug and alcohol education in schools to environmental factors such as action to address alcohol marketing and licensing. Targeted interventions include programmes aimed at building resilience in individuals or groups. Specialist (treatment) services are for young people who are currently experiencing harm as a result of their substance misuse (PHE, 2014)[1]
A CYP commissioning strategy should be structured around universal, targeted and specialist approaches:

- life-course orientated inclusive
- inclusive and integrated safeguarding policy and protocol
- representative across the wider children's agenda
- underpinned by supportive data sharing protocols
- use existing tools and local data sources to identify children and young people who are misusing, or at risk of misusing, substances
- should be based on the local profile of target populations. The profile should include their age, factors that make them vulnerable and other locally agreed characteristics e.g. offending behaviour, domestic abuse, sexual assault and sexual exploitation.
- be supported by a local evidence-based service model that defines the role of local agencies and practitioners, the referral criteria and referral pathways .
- work with parents and carers and other organisations involved with CYP to provide support and refer them to other services as appropriate.
- offer motivational interviews to those who are misusing substances.
- offer group-based behavioural therapy to children aged 10–12 years who are persistently aggressive or disruptive – and deemed at high risk of misusing substances.
- Offer their parents or carers group-based parent skills training
- offer a family-based programme of structured support to children aged 11–16 years who are disadvantaged and deemed at high risk of substance misuse
- service provision should be flexible to meet the changing levels of resilience of CYP in specialist services particularly and overall meet standards of quality

[1] PHE Young people's substance misuse: JSNA support pack Good practice prompts for planning comprehensive interventions in 2015-16

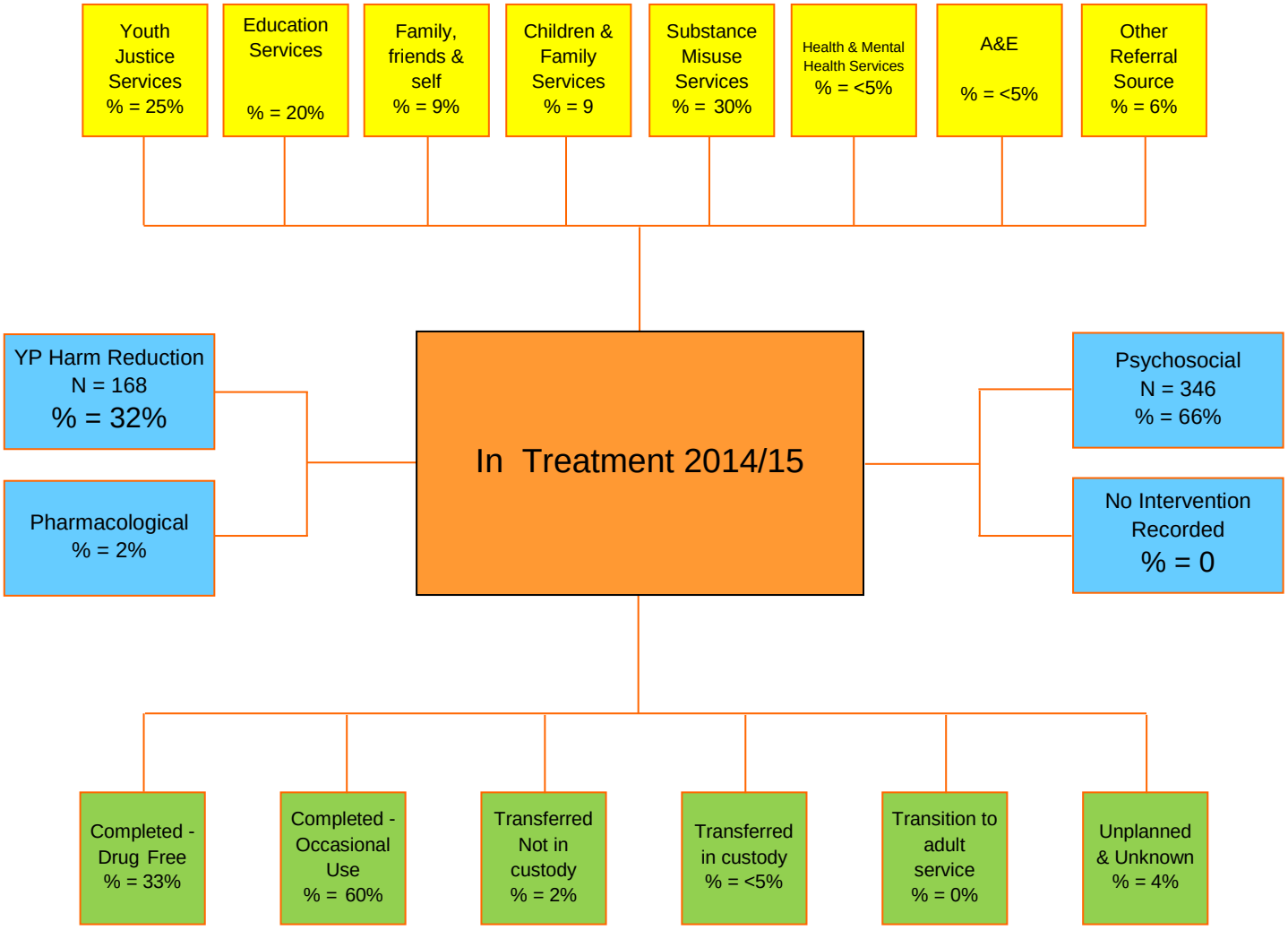
assurance, staff competency, case load capacity, risk management and legal obligations

## 5. Treatment Services

The current available data will be skewed due to new treatment services taking time to reconcile their systems.

Commissioners must ensure that this is clearly stated in contracts that the data systems need to be uniform and available.

**Fig 10**
**Treatment Mapping for Children and Young People's Substance Misuse Service**




**Source:** *JSNA Supporting Data for Young People, NTA, PHE*

| Referral Routes into Structured treatment (episodic – not at client level. U18 only) | | | | |
|---|---|---|---|---|
| Referral | **2012/13** | **2013/14** | **2014/15** | **Trend** |
| Youth Justice | 119 | 96 | 120 | ⇔ |
| Education Services | 104 | 111 | 95 | ⇩ |
| Self, Family and Friends | 45 | 35 | 43 | ⇔ |
| Children and Family Services | 29 | 23 | 41 | ⇧ |
| Other Substance Misuse Services | 30 | 47 | **142**** | ⇧ |
| Health and Mental Health Services | 19 | 11 | ≤10 | ⇩ |
| A&E | 0 | 0 | ≤10 | ⇧ |
| Other | ≤10 | 14 | 27 | ⇧ |
| **Total** | **356** | **336** | **488** | |

**** Indicates transfer of existing clients to new commissioned service**

**Table 10**

It is difficult to get an accurate picture of referral routes for this assessment as there have been coding errors in transferring clients from one service to another. In future Commissioners must ensure that data codes are clear in any transfer of care from one provider to another.

### 5.1 Description of the Population of Children and Young People in Treatment

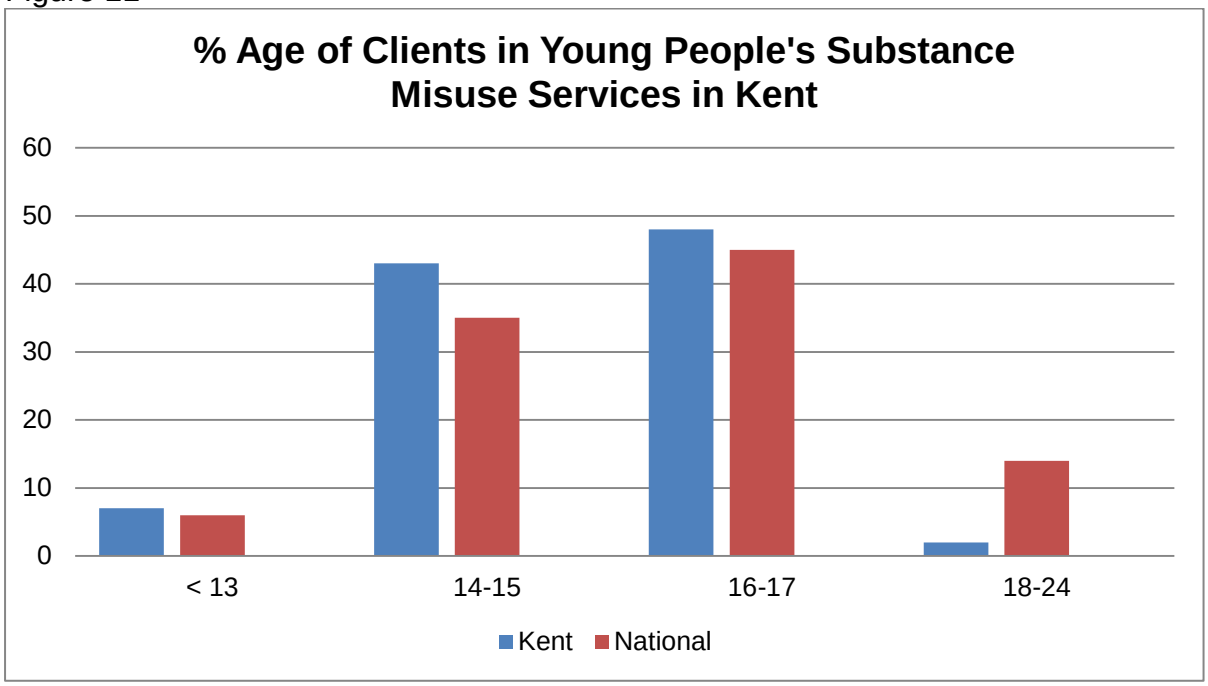
In 2014/2015 there were 381 people in substance misuse treatment services in Kent.

**Table 11 Age of Young People in Structured Treatment**

| 2014/15 – Age | Kent Total | Kent % | National % |
|---|---|---|---|
| ≤ 13 years old | 27 | **7%** | **6%** |
| 14 – 15 years old | 164 | **43%** | **35%** |
| 16 – 17 years old | 182 | **48%** | **45%** |
| 18 – 24 years old | 8 | **2%** | **14%** |

The population of young people in specialist treatment services in Kent has more young people in the 14 to 17 age bracket then seen Nationally (Table 11 & Figure 11). There are a total of **509** young people aged 18-24 in Adult Structured treatment in Kent (10% of total adults in treatment). The relatively high number of young people in Adult services shows Kent is at National levels for this age group also.

Figure 11




Source NDTMS 2014/5

Table 12 Gender of Young People in Kent Substance Misuse Service

| | 2012/13 | 2013/14 | 2014/15 | DoT |
|---|---|---|---|---|
| **Number of YP (aged under 18) in specialist Services** | | | | |
| Female | 118 | 128 | 146 | ⇧ |
| Male | 215 | 187 | 227 | ⇧ |
| **Total** | **333** | **315** | **373** | ⇧ |

Although there are more males in structured treatment then females in Kent, the numbers of females has increased each year since 2012/13. This is shown in in Fig 12 , here we see a 25% percentage increase in females accessing treatment services from 2012. The ethnicity of young people accessing treatment services is predominately (93%) described as white (Figure 13). This broadly reflects Kent's ethnicity however it will be important to note that young black and mixed race people are over represented on youth offending and further analysis will need to condicted to see whether there are any equity issues in access. Also the 'white' category says little about the origin of the young people – as there maybe young people in East European new communities who may have different needs to the general population.

Figure 12

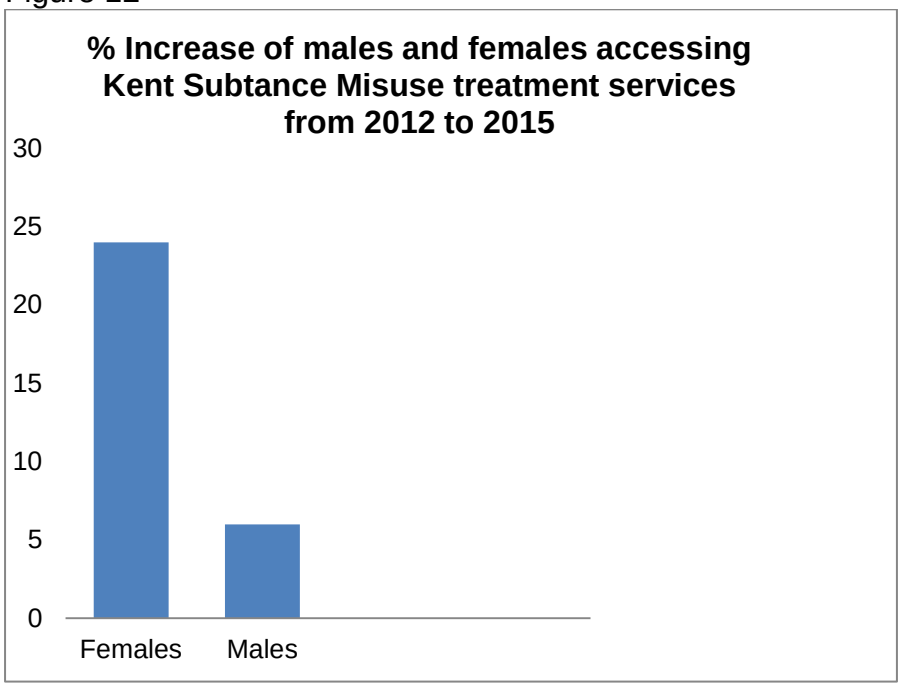
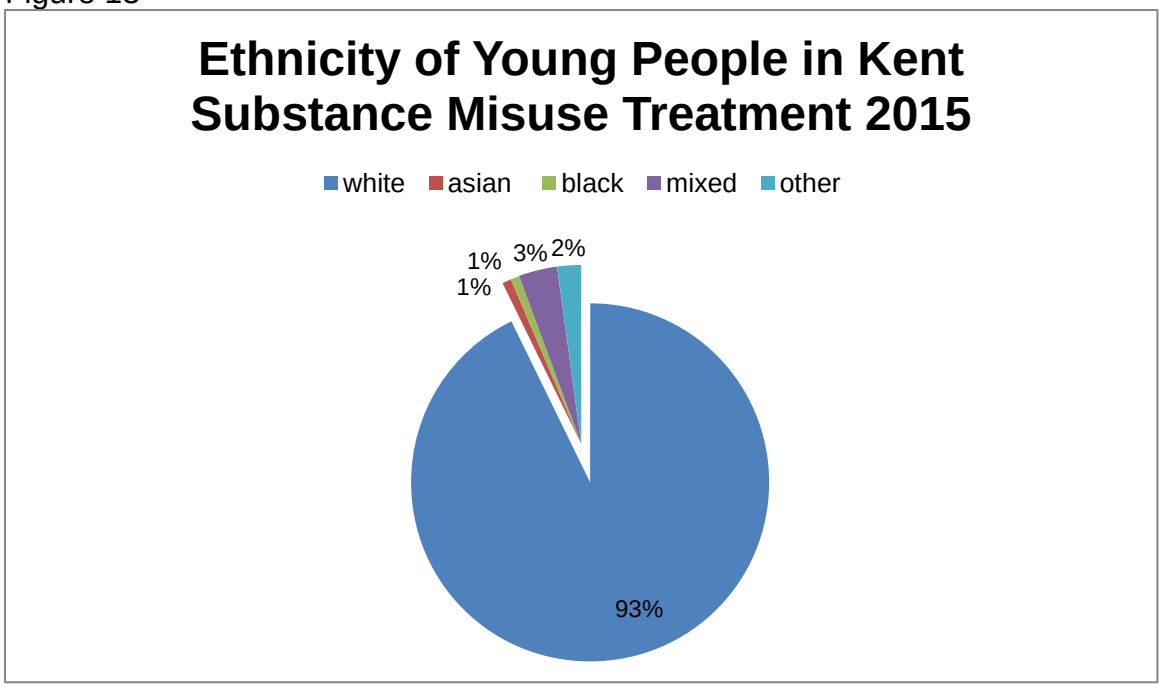



Figure 13



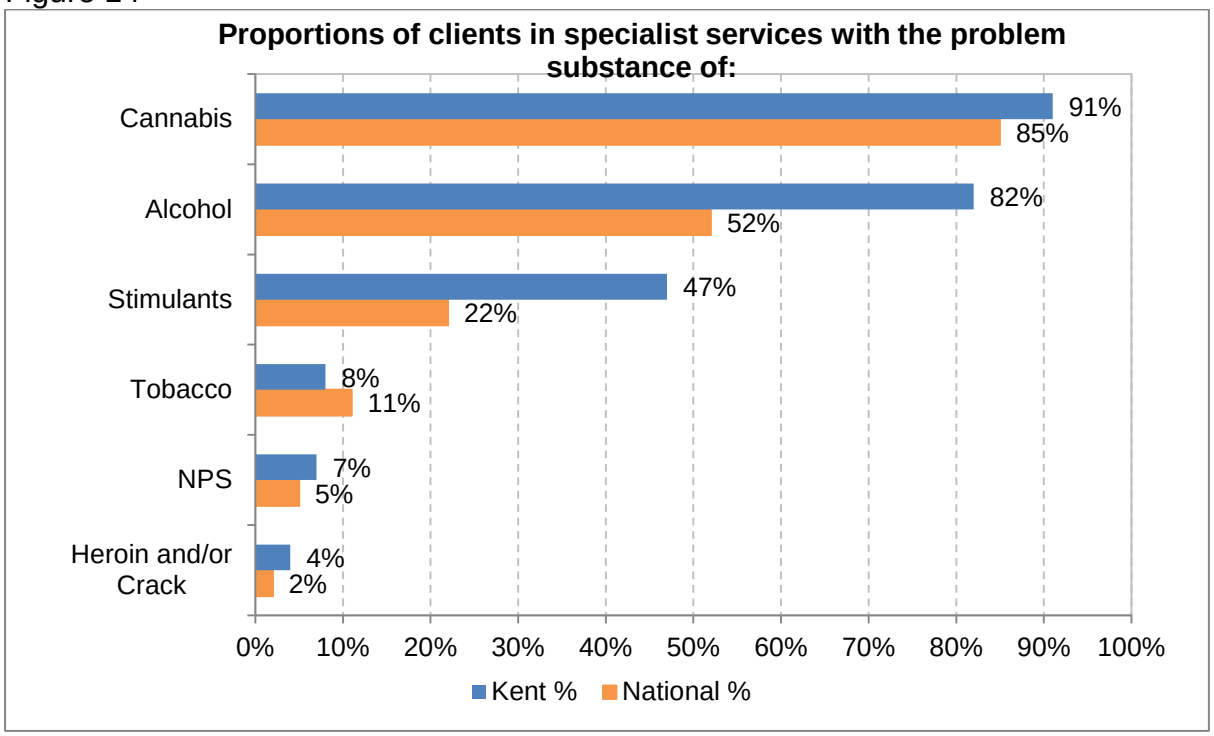

Source NDTMS 2014/5

**Table 13 Young people accessing specialist substance misuse services in the community in 2013/14; by age; by substance (NDTMS, 2014)**

| Age by substance | <=13 | 14-15 | 16-17 | 18-24 | Total (n) |
|---|---|---|---|---|---|
| Cannabis | 19 | 146 | 133 | 13 | 311 |
| Alcohol | 14 | 124 | 108 | 9 | 255 |
| Stimulants (cocaine, ecstasy, amphetamine, not crack) | 7 | 59 | 69 | 6 | 141 |
| Other drug | >5 | 25 | 16 | >5 | 45 |
| Heroin and/or crack | >5 | >5 | 11 | >5 | 15 |
| Tobacco | >5 | 7 | >5 | >5 | 10 |
| Novel psychoactive substances | >5 | >5 | >5 | >5 | >5 |
| **Total (n)** | **19** | **151** | **146** | **14** | **330** |

The main reason for accessing specialist services in Kent was for Alcohol (Table 13), with a total of 255 episodes of treatment for Alcohol. The numbers in table 13 reflect the co-morbidity and poly-drug use among young people i.e that young people with take alcohol and drugs together – which can increase risk of harm.

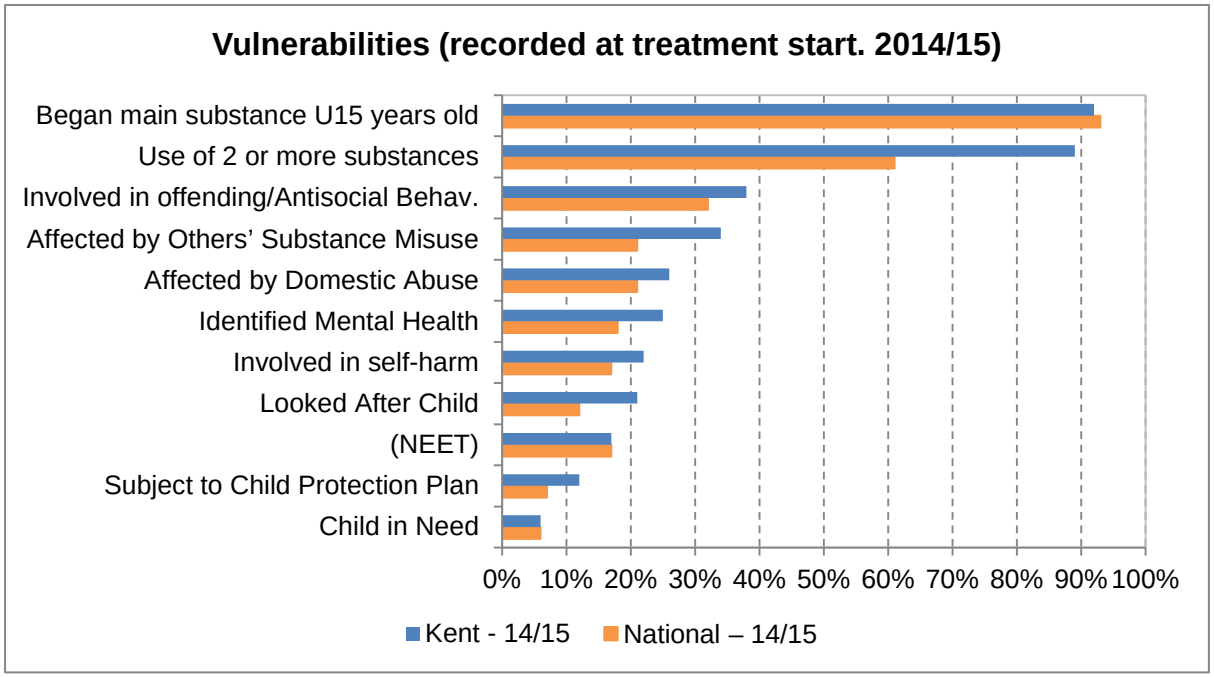
Figure 14




The extent of the poly-drug use can be seen in Fig 14 where 91% of the young people accessing services have issues with cannabis and 82% have problems with Alcohol. Very few young people are accessing services for heroin or crack. The issue of Novel psychoactive substances (NPS) is a small but increasing issue among you people. It is

interesting to note the large difference in young people taking alcohol in Kent compared to National.

### 5.2 Vulnerabilities
**Figure 15**




The vast proportion of young people accessing structured treatment in Kent began taking drugs and/or alcohol before the age of 15. Far more young people in Kent are using two or more substances (poly drug use) (Fig 15)and this is often a proxy measure for complexity **indicating that young people in Kent are presenting with more complex issues then in rest of the country.** Overall the services in Kent appear to be targeting services well compared to the need in vulnerable people compared to national data (Table 14).

Table 14

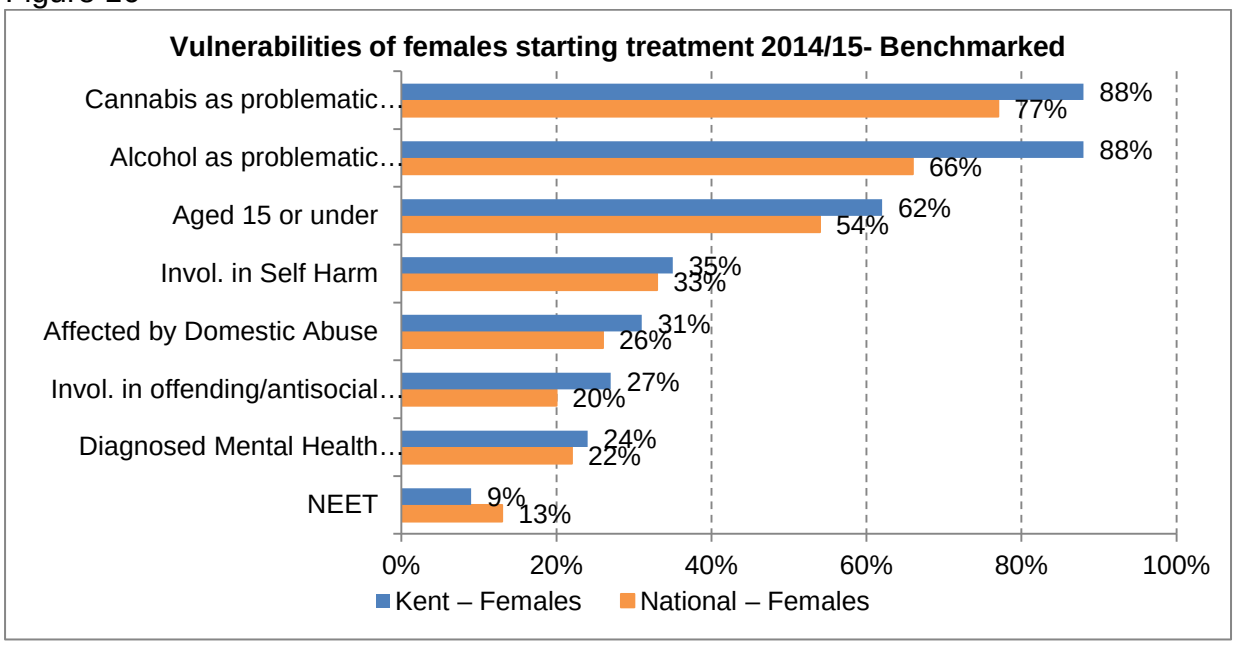
| VULNERABILITY | Type | %of Total |
|---|---|---|
| | **new presentations** | |
| **SUBSTANCE MISUSE SPECIFIC VULNERABILITIES** | *Early onset* | **92%** |
| | Injecting | **>0%** |
| | High risk alcohol user | **10%** |
| | Opiate or crack user | **<5%** |
| | *Poly drug user* | **89%** |
| **WIDER VULNERABILITIES** | Looked After Child | **20%** |
| | Child in Need | **6%** |
| | Domestic Abuse | **25%** |
| | Mental Health problem | **25%** |
| | Sexual exploitation | **0%** |
| | Self Harm | **22%** |
| | NEET | **16.5%** |
| | Housing problems | **<5%** |
| | Parental status / pregnant | **<5%** |
| | Child Protection Plan | **12%** |
| | Anti-social behaviour / criminal act | **38%** |
| | *Affected by others' substance misuse* | **34%** |

93% of young people who accessed specialist substance misuse services in the community had poly-drug use

Table 15 **Vulnerability comparison by Gender in Kent**

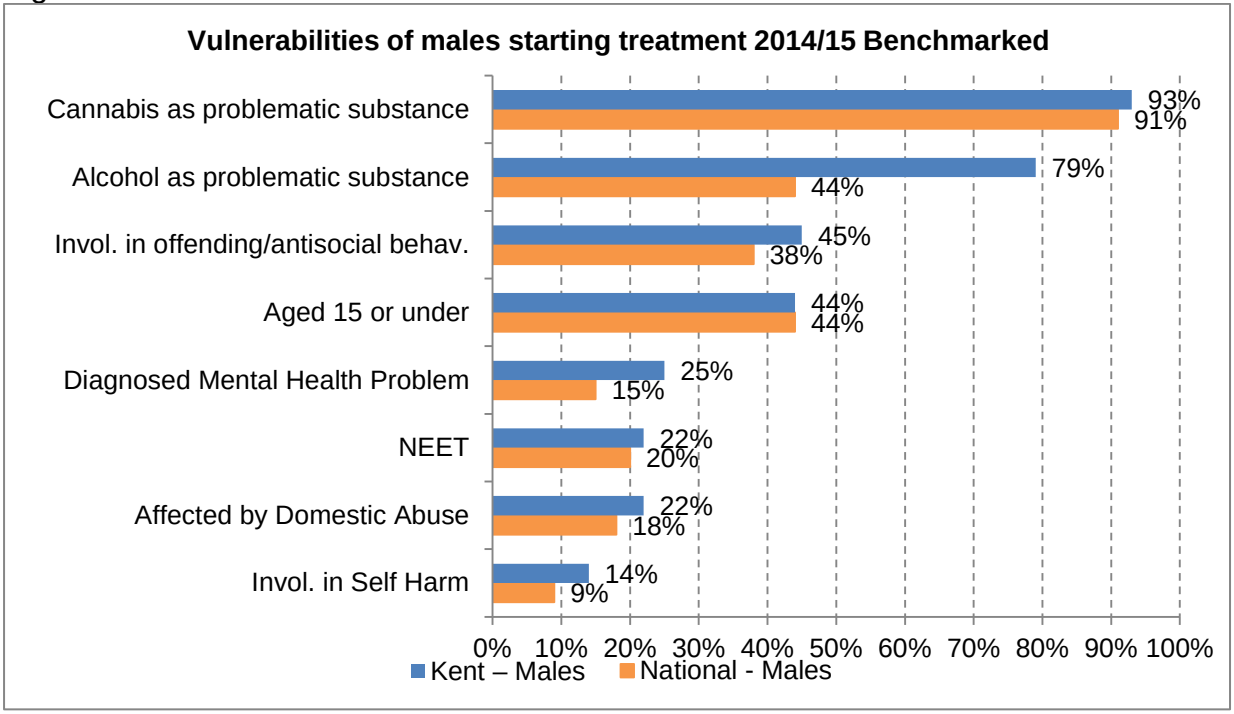
| Vulnerabilities | Kent – Females | Kent – Males |
|---|---|---|
| Affected by Domestic Abuse | 31% | 22% |
| Diagnosed Mental Health Problem | 24% | 25% |
| Involved in Sexual Exploitation | ≤5% | ≤5% |
| Involved in Self Harm | 35% | 14% |
| Not in education, employment or training | 9% | 22% |
| Involved in offending/antisocial behaviour | 27% | 45% |
| Alcohol as problematic substance | 88% | 79% |
| Cannabis as problematic substance | 88% | 93% |
| Aged 15 or under | 62% | 44% |

Figure 16




When looking at differences between males and females it is clear that females are self harming at higher rates than males and both sexes have higher then national problems with Alcohol. However the difference in males presenting with alcohol problems is marked. Almost a quarter of young people seen by Kent ‘s substance misuse services also have a mental health diagnosis (Fig 16).

Figure 17




### 5.3 Children in Care with substance misuse problems.

This following section is taken from a Kent Needs assessment for Children Care and since that assessment there has been a change in treatment provider and but no up to date data due to data issues at transfer.
KCA was the treatment provider. KCA has since merged and is now known as Addaction.

This data Figure 18 refers to the period 2013/14. It shows that there are more boys in care accessing substance misuse services then girls. Most of the children in care starting specialist treatment for substance misuse were male and aged 16 years old. East Kent has far more children in care starting such treatment (Fig 20: 80%) then West Kent. The number of children in care seen by KCA early intervention services was highest in Canterbury and Swale (Fig 21).

**Fig 18 Number of Kent children in care starting specialist substance misuse treatment by gender (2013/14)**

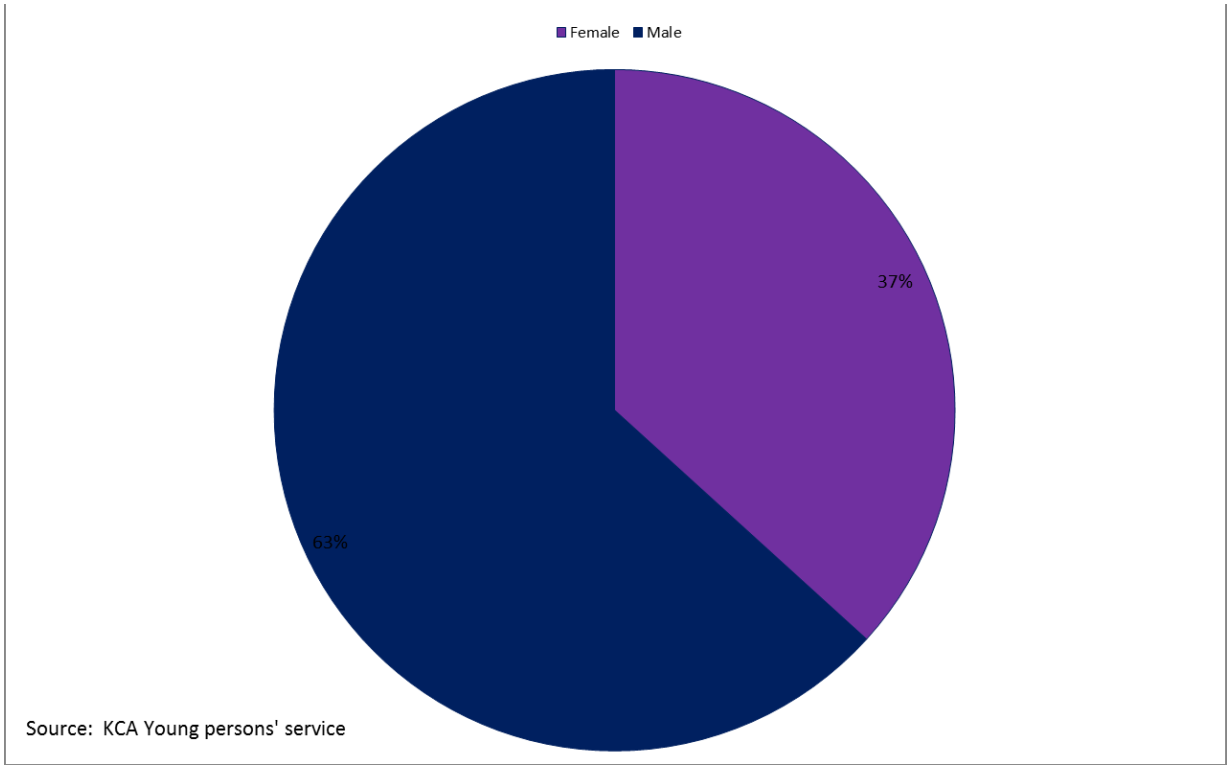


**Fig 19 Number of Kent children in care starting specialist substance misuse treatment by age (2013/14)**

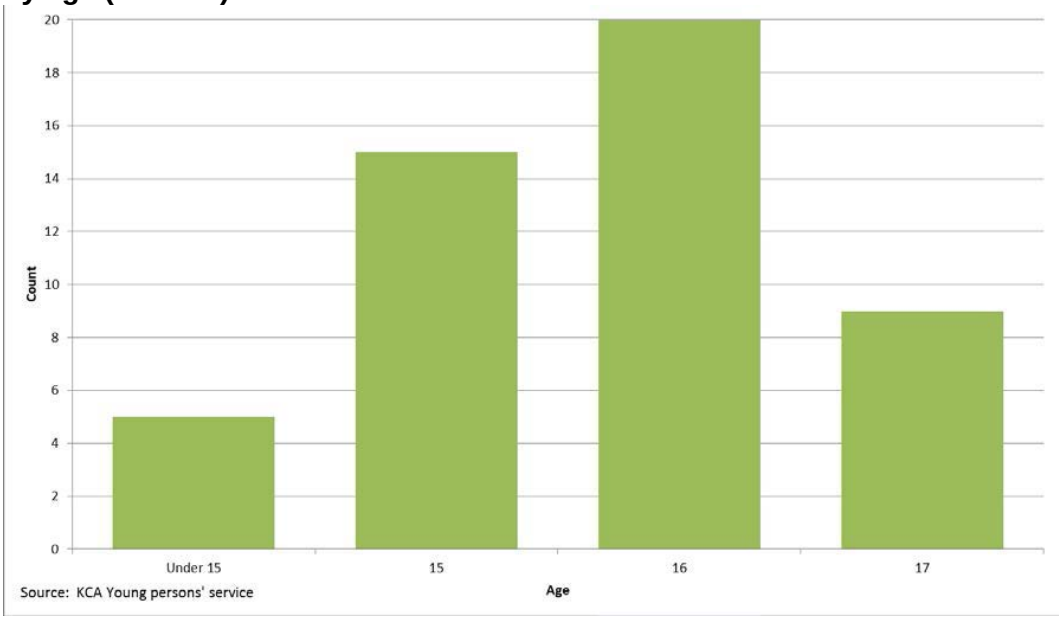
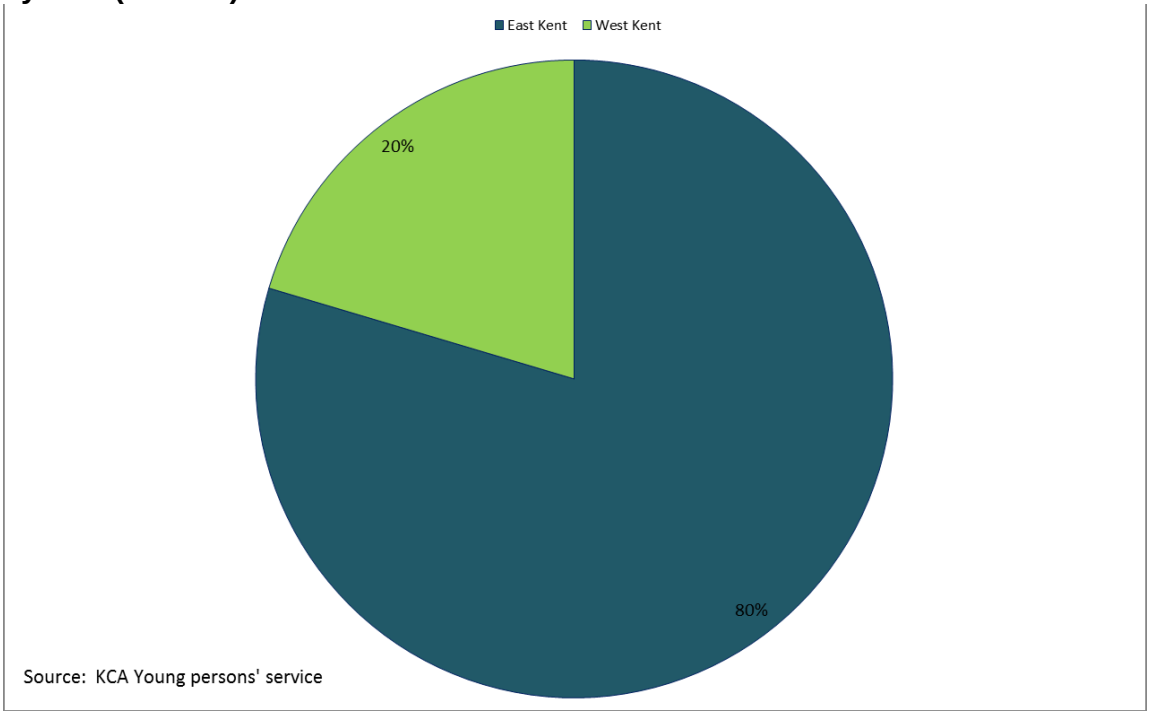
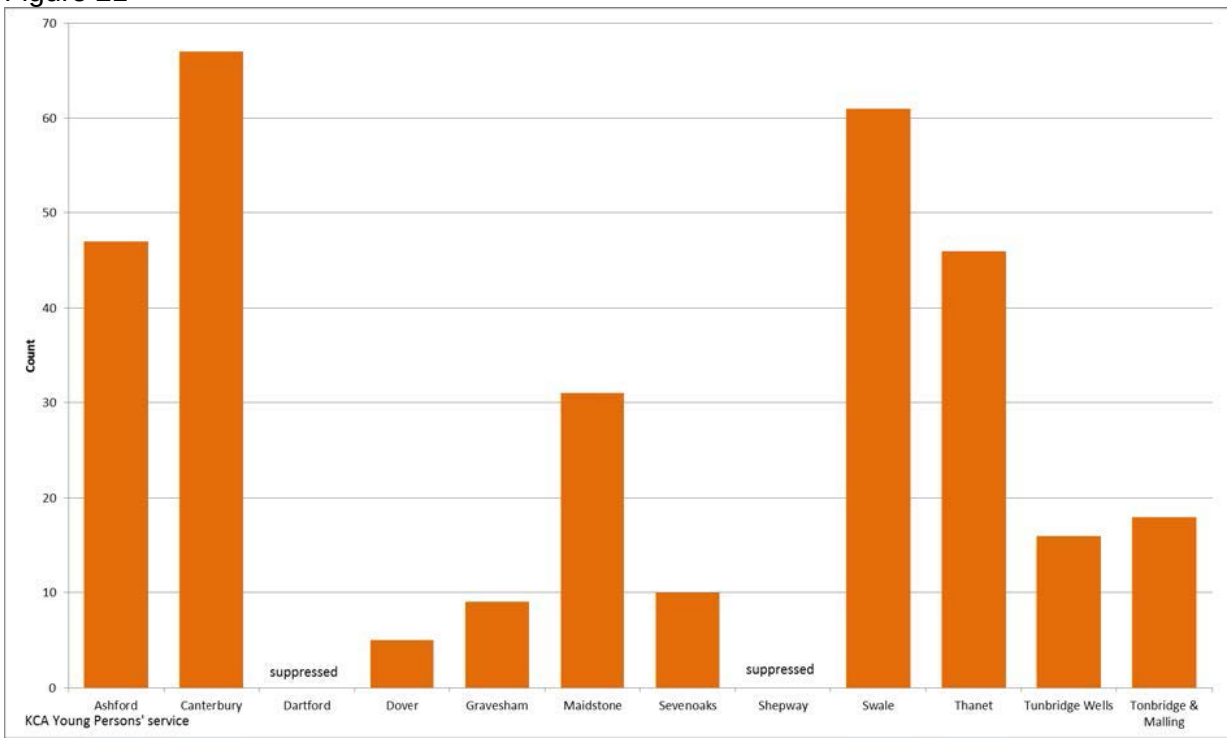



**Fig. 20 Number of Kent children in care starting specialist substance misuse treatment by area (2013/14)**




Number of Kent children in care managed by KCA substance misuse early intervention services, by district (2013/14).

Figure 21




## 5.4 Treatment Pathways for Young People in Substance Misuse in Kent

The pathways into and out of specialist children's substance misuse treatment is shown in Figure 10. The largest proportion of all reported referrals for young people enter treatment from the criminal justice including the largest population (25%) directly from Youth Offending Teams.the next highest grouping - 20 per cent of young people enter treatment from Education Services. There were no recorded referrals from Looked After Children (LAC) services or from Emergency Departments (Accident and Emergency). However it is important to note that some of the referral data is inaccurate due to transfer issues.

The literature review identified higher prevalence rates for children in care as a vulnerable segment of young people, also shown in the Kent children looked after needs assessment.

Mental Health needs assessments show that there are high proportions of self harm for under 24 year olds, e.g the rate of self poisoning related admissions for self harm was higher than the South East of England average (**Find the data from self harm**). This may indicate some serious issues in failing to target outreach, and the need to linkwith CYP Mental health and Early Help and prevention in schools and with parents.

As said previously in this needs assessment, the age at which young people start to misuse substances is a strong predictor of the severity of their misuse problems. The more resilient young people are, the better the likelihood is that they will successfully overcome these problems. **Lessons should be learned and linked with the Headstart Programme in Kent to improve young people's emotional resilience**.

Kent County Council (KCC) currently funds a number of programmes that aim to provide education and awareness to young people on substance misuse as part of a wider series of interventions for children and young people termed 'early help' services. These range from:

- '**Troubled Families'** programme,
- '**HeadStart**' and youth services.
- **AddAction UK** to undertake risk reduction work with young people.
- **The RisKit Project** is an early intervention programme for young people aged 14 to 16 who are vulnerable to risk taking behaviour. These risky behaviours include drug and alcohol use, early and unprotected sex and offending.
- **Prevention Focused:**
  There are also efforts to tackle the causes of substance misuse in young people. For example the HeadStart project seeks to build resilience in 10-14 year-olds; resilience being a key attribute in avoiding initial substance misuse.

### 5.4.1 Early Help: Tier 1 and Tier 2 Services (Early Help)

In 2013/14 a number of brief interventions were provided to young people at risk of developing substance misuse.

These are reported for **all substances** rather than separated into drugs and alcohol (Table 15).

Table 16

| **At Risk Group** | **Number of Children** | **% of total At Risk Population accessed Early Interventions or Specialist Services.** |
|---|---|---|
| **exclusion/excluded from school'** | **1,538** | 29% |
| Looked After Children (LAC) | **400** | 29% |
| young Refugees/Asylum Seekers. | **120** | **16%** |
| young people with parental substance misuse. | **592** | **60%** This is calculated on the reported number of adults in treatment who have a child and not the wider population of families with parental substance misuse. |
| young people at risk of reoffending. | **1,867** | TBC |

This local data strongly supports the evidence that these groups of young people are at significantly increased risk of substance misuse problems. Children's Social Services screen CYP with an alcohol and drugs questionnaire.

**Results of these questionnaires should be collated to inform future needs assessments**

**Partners should work together to ensure that referrals to support services are offered systematically *to both* CYP and their families/guardians as indicated.**

### 5.4.2 Kent Specialist Community Treatment Services

In 2014/15 a total of 381 young people accessed treatment services. The total number in treatment has fallen by 8% from 416 in 2011/12. As previously stated, 89% of the total number of young people accessing specialist substance misuse services in the community had poly-drug use and 92% had started using their main problem substance under the age of 15 whilst 7% entered services aged of 13 or younger. The number in treatment in young people's secure estate services has increased from nil to 32. These figures for Kent are comparable to national levels. Table 17 provides the detail of young people in treatment services in Kent for 2014/15.

Table 17 **Young people accessing specialist substance misuse community services in *2013/14***

| Age range | Setting | Count | % |
|---|---|---|---|
| **Under 18 years** | Community Substance Misuse services | 316 | 88% |
| **Under 18years – secure estate** | Secure estate | 30 | 8% |
| **18-24 years** | 'Young person's only' community service | 14 | 4% |
| **Total** | | **360** | |

There is no suitable estimate of the rates of dependency among young people to compare to the treatment totals. No comparison of outcomes of those receiving treatment in community substance misuse services as compared to 'young people's only' services is available at this time. A review of those entering secure estate for opportunities for earlier intervention should be reviewed e.g. were these CYP previously known to services.

Data elsewhere in this needs assessment points to differing approaches and outcomes between adult and YP services so **a comparison of service entry and outcomes between those accessing YP specific and general community services should be undertaken.**

### 5.4.3 Referrals to young person's substance misuse services in Kent

**A & E**

During 2014/15, very few young people were referred from a health setting. Less than 10 referrals were received from A&E and less than 5% came from mental health and other health settings. This compares with nationally 8% of referrals from a health setting.

We should expect a larger referral rate from health sectors as 25% of the treatment population had an identified mental health problem and 22% suffered from self-harm (35% of Females).

The reason for lower numbers referred from family in friends then adults is unknown but it may be that many of young people do not consider their substance misuse as being problematic (cultural norm), are in denial, feel services are not suited / accessible to them and so are not motivated to seek treatment.

**Youth Justice**

There are only a few number of young people referred to treatment from youth justice on release from the secure estate but none of these young people were followed-up by a community service within three weeks of their release according to Kent treatment service data.

Given the significant substance misuse related mortality of recently released prisoners, it is crucial that services are able to identify and engage with young people on their release from a secure environment back into the community.

**Education**

It is welcome to note that there is a functioning referral system for the education sector to refer young people affected by substance misuse**.**

This data should be used to direct resources to target substance misuse screening and interventions in these groups.

Commissioners should work to ensure that a functioning referral pathway is available to easily identify, refer young people to treatment services especially those in contact within healthcare settings and follow-up on release from secure estate.

### 5.4.4 Waiting times

The proportion of young people receiving treatment within three weeks in Kent (100%) and is better than the national average of 98%.

### 5.4.5 Treatment outcomes

Overall, young person's services appear successful. There are 86% of young people left services in a planned way and only 6% of these re-presented to young people's or adult specialist services within six months.

The unplanned exit rate and overall re-presentation rate is lower than that for adult services. However completion rates are higher for YP than for adults

There are many possible causes for this difference. However this difference in success gives an indication of the importance of making inventions as soon as possible (at an earlier age) in the treatment for substance misuse.

### 5.4.5 Vulnerable Groups Accessing Treatment in Kent

Young people accessing services often have wider vulnerabilities including concurrent mental health needs.

Of those in treatment in 2014/15:

- 21% were looked after children
- 25% had a identified mental health problem
- 22% suffered from self-harm (35% of Females)
- 31% of Females were affected by domestic abuse
- 38% were involved in offending
- 34% were affected by others' substance misuse

To have the best possible outcome from treatment (young people), require a combination of treatment from their substance misuse issues and any concurrent mental health illness.

**Commissioners should work to ensure that a pathway and model of care is available to meet the needs of young people with a dual diagnosis.**

## 6 Summary of Key findings

Levels of drug –taking and alcohol consumption are in decline for 11-15 year olds. However prevalence trend observed over previous years of drug taking amongst young people shows it increases with age. Girls and boys and were equally likely to have taken drugs with Cannabis being the most widely used substance (61%) with 7% of pupils reporting having taken it in the last year.

Kent has 39% of pupils aged 7 to 11, reported drinking alcohol at least once. This pattern of reported drinking alcohol and is the lowest rate since records began in 1988. This trend is also reflected in the reduction of alcohol – related hospital admissions in those aged below 18 years nationally and in Kent. There is no suitable estimate of dependency levels amongst young people to compare numbers in treatment to ascertain any potential service gaps.

Young people who live in deprived areas are more likely to drink alcohol, drink at an earlier age, and to drink to excess. This relationship was stronger for young women than young men. The effects of higher alcohol consumption in areas of deprivation are likely to be compounded by inequalities which affect nutrition, exercise and emotional well-being.

Those who thought their families had a more lenient attitude towards their drug use were more likely to have taken drugs that those who thought their families would disapprove. The most likely sources of helpful information about drugs continue to be teachers (69%) and parents (68%) but that TV was seen as the most helpful of media tools (59%).

One-in-four deaths amongst 16-24 year olds are related to alcohol. Children who drink are at a greater risk of brain damage. They are also at greater risk of developing problems with alcohol in later life including dependency. Young people also have a higher risk of being involved in road traffic accidents.

A synthetic estimate of number of children in ‘at risk’ children in Kent is 9,034. However this figure is likely include a large number of duplicate entries across categories of vulnerable children reviewed and its use may be limited. Dual diagnosis and wider vulnerabilities was more prevalent in Kent than in the national treatment population.

Waiting times are better than the national average at 100% being seen within 3 weeks. Treatment outcomes appear successful; 93% left services in a planned way and only 7% of young people leaving treatment successfully in 2014 re-presented to young people's or adult specialist services within six months.

There are 89% of young people who accessed specialist substance misuse services in the community had poly-drug use; 92% had started using their main problem substance under the age of 15 and 7% entered services aged 13 or younger.

The age at which young people start to misuse substances is a strong predictor of the severity of their misuse problems. The more resilient young people are, the better the likelihood is that they will successfully overcome these problems.

The proportion of vulnerable young people given IBA (drugs and alcohol) – LAC or excluded from school were 29% for both groups; 16% of refugees and 60% of those with parental substance misuse in treatment services.

The numbers in treatment services had fallen in recent years; however 2014/15 experienced an increase and are comparable to national figures. The number in treatment in young people's secure estate services has increased from nil to 32 (2014/15).

During 2014/15, very few young people were referred from a health setting, around 5%; this is compared to national with 8% of referrals from a health setting.

We should expect a larger referral rate from these sectors as 25% of the treatment population had an identified mental health problem and 22% suffered from self-harm (35% of Females). 9% of referrals came from children's and family services. This is lower than the national rate of 12%. 20% of referrals were via educational services that have a good referral system practices in place.

Youth Justice Services provided 25% of referrals. A small number of young people were referred to treatment on release from the secure estate but none of these young people were followed-up by a community service within three weeks of their release.
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## 7. Conclusions

The aims of the needs assessment have been largely achieved. Areas of good performance and service provision have been noted as have areas where improvement should be sought. Several service gaps have been identified for action and several sub-populations have emerged that were previously unknown or where there was little awareness.

Underpinned by a wide-ranging evidence-base and expert opinion, effective interventions are clearly available to address the harms of substance misuse – most notably the use of Identification and Brief Advice (IBA) and prompt referral to treatment services. There is good evidence of family interventions and the use of family therapy – and working with the whole family more generally and this could be a good focus in the improving outcomes in treatment services.

There is much to commend on reviewing the partnership activities and the performance of substance misuse services in Kent. Overall, services perform well however there is room for improvement which is recognised and is being addressed. New contracts for both east and west Kent for treatment service providers are being tendered for early 2016 and so there is an early opportunity to adapt services and adopt recommendations in this assessment.

To successfully achieve the aims of the current Kent Alcohol Strategy, partners are urged to undertake a concerted effort to sustain the momentum and commitment to the aims of the strategy by noting the content acting upon the recommendations in this assessment. As many of the actions pertain to the same services i.e. alcohol and drugs, this will have the benefit of health promotion for both these issues.

There is much to be encouraged about in this assessment especially that the trend for younger people misusing alcohol appears to have peaked. However, in Kent there are still pockets of significant harm for certain sub-populations which are cause for concern and should be cause for targeted action.

In addition to targeting specific sub-populations to provide health promotion and improve access to services, issues such as steroid misuse, FASD, dual diagnosis and prescription/over the counter opiates should be cause for future needs assessment.

Key challenges ahead for partners in Kent is to tackle problematic issues such as availability, new psychoactive substances, new legislation and policy implementation all within an environment of reducing means. To date, partners have been very resourceful and much progress has been made which augurs well for the future. The degree, to which substance misuse harms in Kent are mitigated and prevented, will correspond to the level of commitment and cooperation shown by partners.

To address the existing and forecasted increasing demands of substance misuse, in particular of alcohol-related harms in Kent, the following measures are recommended across all partner organisations to adopt and support:

## 8. Summary recommendations

Mass population screening should be escalated via formal and informal approaches to the population through the mobilisation of partner organisations and commissioned service providers. This can be achieved through embedding Audit C –type questionnaires as routine practice in:

Health assessments of individuals e.g. Health Checks, routine health assessments, pro-active case finding in general practice populations; pre-operative assessments; outpatient clinics; school nursing and midwifery; sexual health contracts; Making every contact count / safeguarding

Social Service Care assessments: e.g. vulnerable / 'at –risk' groups; Children and Young People care assessments / safeguarding. These are currently performed but rates could be improved upon.

Occupational health activities and active health promotion campaigns within Kent business;a particular emphasis and responsibility is upon statutory organisations given the nature and scale of these as notable large employers in Kent. The added value of having 'IBA informed' employees is that they could also act as informal 'change agents' within families and communities across Kent
Health promotion activity e.g. 'Know Your Score' and 'Dry January' campaigns; targeted campaigns e.g. steroid misuse

General health promotion e.g. opportunistic IBA; embedded in medium and large businesses as part of staff well-being programmes.

Embed the requirement for workforce IBA training and activity explicitly in commissioned contracts and training programmes as far as possible for both adult and children's services. This should include the consideration of incentive-based commissioned activity e.g. commissioning for Quality and Innovation (CQUIN) and cross-cutting themes e.g. safeguarding, domestic violence training programmes.

Monitoring and reporting of referral trends to treatment services. This will be required to ensure that at a minimum, Kent improves access to support and treatment services for vulnerable and at-risk groups and continuous quality assurance and improvement of treatment services

Improve data capture and data linkages within and between organisations to improve and assure the quality of services, treatment outcomes and service development and redesign. This will also assist partner organisations to undertake targeted locality work and systematically address challenges such as availability and licensing.

Integrated Care Pathways should be developed and extended across Kent to provide systematic and consistent advice and approaches to intervention, care provision and expedite access to services. These should be inclusive of associated conditions e.g. dual diagnosis and maternal health

Substance misuse services should be commissioned to include flexibility to respond dynamically to emergent service challenges, quality improvement measures, latest

evidence and targeting of service interventions. Services should ensure they are appealing to the wider population but in particular to those vulnerable and emergent ‘at risk’ and groups e.g. LGBT, older people, professional groups, women, veterans.

## Key contacts and acknowledgements

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