Young People and Substance Misuse in Suffolk: Health Needs Assessment

April 2018

Lead author:
Dr Eleanor Powers, Public Health Registrar

Project supervisors:
Sharon Jarrett, Head of CYP Health Improvement & Sexual Health
Nicki Cooper, Senior Health Improvement Commissioner - Children and Young People

Lead consultant:
Dr Mashbileg Maidrag, Public Health Consultant
Suffolk speaks:

In order to best represent the voices of those surveyed, survey responses have been reproduced verbatim in the text, regardless of spelling and grammar.

“Newer style drugs in our area have yet to take hold, most youths still stick to the old standbys cannabis, alcohol and cocaine”

“We had a real problem with Ketamine and legal highs a couple of years ago. Cannabis is still the most used drug by YP, but with the use of weed the YP will want to try other drugs”

Professional’s views on substance use in Suffolk

Young people: Why did you first drink alcohol at that age, or why have you never drunk alcohol?

Drank, Problems, Age, Holiday, Friends, Gave, Christmas, Young
Wanted, Offered, Drink, Dad, Alcohol, Peer Pressure
Party, Social, Parents, Curious, Family, Dunno, Taste
Never Drunk, Occasion, Body, Fun, Reasons, Sip

Illegal, Mind, Think, Able, They’re, Medical, Body, Never, Appealed, Point
Effects, Life, Health, Drugs, Peer Pressure
Never Wanted, Wrong, Risk, Friends, Cause, Fun, Stupid
Money, Dangerous, Believe, Kill

Young people: Motivations for taking specific drugs:

“I smoke cannabis to help with sleep, I have a mental health diagnosis and struggle with sleep even with prescribed medication”

“Taking cannabis with depression, to help my issues”

“Young people often feel the need to follow there peers, at my school many people in my year smoke and I feel like it’s a natural part of growing up, trying new things. Also if you don’t do anything like that you get called frigid which is the reason why I tried smoking in the first place”
Young people: How would you rate the help at your school around drugs and alcohol:

“We have had one or two assemblies and one of the was really helpful”

“I was given a brief explanation of all the main substances in year 8, though I wish they had given further insight into how the drugs affected the body.”

“Information is good. Handling of cases is poor as they don’t care if it wasn’t on their land”

“It would be more helpful if the school actually taught you more about it instead of just saying don’t do it… yes there is the school nurse but shes only in on Thursdays and thats not good enough for the amount of people in this school.”

“They don’t care. If you ever do drugs or drink alcohol and publicise it you’re villainised and made to look like an idiot which in my opinion is dangerous because it just leads to you using those substances more which can lead to addiction”

Young people's views about seeking help and support:

“I feel as if I would be frowned upon and judged if I asked for help, people would never know that I take drugs, I work full time”

“my parents have told me to go to turning point …Trouble is I just want the consequences to stop, I don’t want to stop using - I like the way it makes me feel”

“I don’t know what help is available”

Professionals’ views about seeking help and support:

“More training would be helpful about what services there are and how we can support young people in the early stages of drug use.”

“better working with social worker or more support and befriending workers who could support YPs to engage with services. More cascading of service and ‘micro’ intervention that social workers could use themselves with YPs.”

…and referrals:

“After the referral was made, there was little communication about whether the client had been seen and what the proposal for treatment would be. There was little evidence of joint working. Like most services, the thresholds for treatment are so high and many young people fall through the net.”
The aim of the young people’s substance misuse Health Needs Assessment (HNA) is to establish whether the current services relating to drugs and alcohol meet the needs of substance misusers and those at risk of substance misuse up to the age of 25 (‘young people’).

- Misuse of legal and illegal mood-altering substances by young people has the potential to cause significant harm, both in the immediate and longer term. Substance misuse may be a symptom or consequence of other issues and vulnerabilities in a young person’s life.\(^1\)
- 2016 population estimates indicate that there were 118,837 people aged between 10 and 24 years old. All young people are potentially vulnerable to substance misuse issues.
- Using national figures applied to Suffolk’s population, an estimated 21,000 young people aged 11 to 24 may have ever taken drugs (17% of the total population in this age band). Using national figures applied to Suffolk’s population, 3,200 young people age 16-24 are estimated to be ‘frequent’ drug users.
- In the Suffolk survey of young people (n=356), 80% had ever drunk alcohol and around 16% had ever taken drugs.
- The rolling total of young people in Suffolk in substance misuse treatment in the most recent 12 months was between 99 and 167 people. This is much lower than would be expected if the national figures are applied to Suffolk’s population (using this approach 224 young people would be estimated to be in specialist substance misuse services per year).
- There has been a statistically significant increase between 2012/13 and 2016/17 of rates and absolute numbers of young people in Suffolk attending A&E for overdose and poisoning.
- Within vulnerable populations in Suffolk, prevalence of substance misuse varies considerably. However, the extent of vulnerabilities in relation to substance misuse appears to be rising in Suffolk and this is a key point that needs to be taken forward.
- In Suffolk social care assessments of young people who are in need, subject to a child protection plan, or are in care, 6 – 9% of all young people had a reported substance misuse issue. This is approximately 3x higher than the general population- and evidently a much higher prevalence than in the wider population in Suffolk, or even in children referred to CAF or MASH.
- There is limited evidence on suitable interventions for young people at risk of, or undertaking, substance misuse.
- There were concerns amongst the young people that schools stigmatised – and led other pupils to stigmatise – drug users as ‘idiots’, reducing the likelihood of seeking help.
- 4% of young people responding to the online Suffolk survey indicated that they had felt a need for specialist substance services in their lives, whether they had then sought it out or not. Modelled across the Suffolk population age 13-24, this represents about 3,700 young people. This is a lifetime indication, not a point prevalence, but is still notable for being 10 times higher than the numbers in services.
- Lack of awareness of available services, and of how these have changed over recent years, and lack of confidence within young people, professionals and others working with young people about how to access them may be an important issue in explaining gaps in service access.
- In Suffolk, no referrals come to specialist substance misuse services from A&E departments, despite the rising rates of attendance for overdose and poisoning related incidents.
- Universal prevention and information messages do not appear to meet the needs of young people accessing them.
- Suffolk offers a specialist substance misuse service for young people, to which barriers to access appear to exist, or are certainly perceived by some professionals. This includes lack of awareness of the service and a perception that it must have a high threshold for service users.
EXECUTIVE SUMMARY

Misuse of legal and illegal mood-altering substances by young people has the potential to cause significant harm, both in the immediate and longer term. Substance misuse may be a symptom or consequence of other issues and vulnerabilities in a young person’s life.¹

Although most young people will use substances – especially alcohol – during their adolescence, only a small proportion will go on to develop long term addiction.¹ However, most adult addicts began misusing substances as young people, making prevention in the earlier part of the lifecourse key.²

The likelihood of substance use becoming substance misuse increases with younger age of substance use initiation. Substance misuse can have important consequences besides addiction, and more young people than ever need specialist substance misuse services, a transient period of substance misuse may lead to situations they later regret.

Suffolk

2016 population estimates indicate that there were 118,837 people aged between 10 and 24 years old. 20% live in Ipswich local authority, with smaller percentages across the other six county districts and boroughs.

All young people are potentially vulnerable to substance misuse issues, and some contextual data indicate sources of vulnerability in Suffolk. 16% of all under-16s in Suffolk live in low-income families, this is significantly better than the England average, however in 2015/16, only 53.8% of Suffolk young people achieved 5 GCSEs at grade A*-C, significantly worse than the England average.³ Over 20% of rural wards in Suffolk are among the bottom 10% in England in terms of the gap between expected and achieved rates of progression to Higher Education.⁴ Rural Suffolk youth in particular have described feelings of being powerless and disconnected.⁴ Although educational attainment has been prioritised by Suffolk County Council in recent years, and has shown signs of improvement, not all young people will yet have benefited.

Suffolk is one of the counties which has developed challenges relating to ‘County Lines’ drugs supply.⁵ County Lines Networks are the supply class of A drugs from an urban hub into rural towns or county locations. A key feature of county lines drug supply is the use of a
branded mobile phone line. The exploitation of young and vulnerable persons is a common feature. Around 15-20 young people in Ipswich are considered directly affected.

Although this represents a very small percentage of the total population, it is a severe risk to some of the most vulnerable young people, being particularly associated with care leavers.\textsuperscript{5} Care leavers and those in care may be more vulnerable (and also experience issues that increase vulnerability further – such as mental ill health. They can be perceived as easy to target and recruit – and more easy to exploit.\textsuperscript{6}

**The needs assessment**
The aim of the young people’s substance misuse Health Needs Assessment (HNA) is to establish whether the current services relating to drugs and alcohol meet the needs of substance misusers and those at risk of substance misuse up to the age of 25 (‘young people’).

This report draws on national and local datasets. For this report, a suite of surveys have also been undertaken to generate a novel dataset. 55 professionals working with young people, 21 voluntary and charitable sector (VCS) workers and 356 young people have responded to share their opinions and experiences regarding substance use and misuse.

**Results**

**The prevalence**

- For two decades, the prevalence of self-reported substance use amongst young people has apparently declined nationally, although substance use in 11 to 15 year olds has shown an upward trend in the most recent reporting of these data.\textsuperscript{7}
- Using national figures applied to Suffolk’s population, an estimated 21,000 young people aged 11 to 24 may have ever taken drugs (17% of the total population in this age band).
- Using national figures applied to Suffolk’s population, 3,200 young people age 16-24 are estimated to be ‘frequent’ drug users.
- Using national figures applied to Suffolk’s population, 224 young people are estimated to be in specialist substance misuse services per year (0.3% of the population aged 9 to 17 years). However, when this is compared with the actual rolling total of young people in treatment in the most recent 12 months, the Suffolk figure was much lower - between 99 and 167 people. Although some variation is expected from national to local estimations (e.g. due to differences in local prevalence), this is still a lot lower than expected.
In the Suffolk survey of young people (n=356), 80% had ever drunk alcohol and around 16% had ever taken drugs, a number which aligns with the 17% figure derived from modelling national data. 19% of the entire sample said that alcohol or drug use had led to at least one situation they regretted.

There has been a statistically significant increase between 2012/13 and 2016/17 of rates and absolute numbers of young people in Suffolk (10 to 24) attending A&E for overdose and poisoning (which will include, but not be limited to, substance misuse harms).

There has been no statistically significant change since 2012/13 in rates and absolute numbers of hospital admissions of young people in Suffolk relating to their use of drugs and alcohol.

Amongst surveyed professionals working with young people (n=55), 50% felt that substance misuse in young people in Suffolk had increased compared to 5 years ago. Only 8% thought it had decreased.

Two thirds thought that the harm to users from substance misuse was the same or worse than it had been 5 years ago. Amongst Voluntary and Community Sector (VCS) workers engaging with young people. (n=21), 39% felt substance misuse in those they worked with had increased, 39% that it was the same as 5 years ago.

The majority of substance use and misuse nationally in young people relates to alcohol and cannabis, and this is the same in Suffolk. The next most prevalent substance reported in the survey by young people, and echoed by comments in the VCS survey, was solvents/gas/aerosols.

Suffolk young people in specialist substance misuse services are statistically significantly more likely to be poly (multi) substance users than the national group.

2.4% of the young people in the survey reported daily drug use, either cannabis or solvents/gas/aerosols, and several in free text comments related this to mental health issues. Applying this proportion to the whole population suggests that around 2,200 young people in Suffolk may use substances daily at a given point in time.
The characteristics

- Within vulnerable populations in Suffolk, prevalence of substance misuse varies considerably.
- The extent of vulnerabilities in relation to substance misuse appears to be rising in Suffolk and this is a key point that needs to be taken forward. The following section identifies some of these findings.
- In the survey of Suffolk young people:
  - Males were more likely than females to report use of any substance including alcohol.
  - The most common age of those who reported having used drugs was 15 years and the average age of first using drugs was 14.5 years. This aligns with national data.
  - All but one of those who had used drugs were in school, college or full-time employment.
  - 8 of the 44 who had indicated that they took a substance also ticked ‘I have never used drugs’, suggesting that certain substances – solvents and new psychoactive substances (former ‘legal highs’) - are not regarded as ‘drugs’ by some in this population.
  - Reasons for first use of drugs generally referred to peer group influence - ‘everyone was doing it’ - but also discussed mental health issues and life challenges – ‘I went off the rails after my dad died’. Several of the young people who responded to the online survey discussed the lack of options for young people in Haverhill as an explicit trigger for drug and alcohol misuse.
- An opportunity to examine the characteristics of all referred young people, not just those that took up treatment, has been provided by an evaluation of the DUST screening tool by Public Health Suffolk in 2017. This provides a picture of all referrals to specialist services in Suffolk from April 2013 to March 2016 (n=376), including those where the young person did not want to engage with the service after being assessed. Notable findings include: 44% of those referred had difficulty sleeping and 20% reported headaches and blackouts. Around a third had mental health problems, and a quarter reported self-harm.
- Prevalence of substance misuse as a concern for children recorded in the Suffolk MASH and CAF datasets is around 1 – 2%, potentially slightly higher than the wider population although this may relate to the fact that these children are more closely scrutinised. The rate of citation of substance misuse issues in CAF assessments has risen since 2013/14, although total numbers of all referrals have fallen. The most commonly co-occurring risk factor was ‘CYP Mental Health/Emotional Wellbeing’.
Over 50% of cases of young people in the Suffolk CAF database with substance and alcohol misuse recorded, had co-existing mental health, emotional wellbeing and parent/child relationship needs. It is important to note that more than two co-occurring needs can be recorded per young person, however this does appear to highlight a specific need around emotional wellbeing and family relationships for those misusing substances.

In Suffolk, from social care assessments of young people who are in need, subject to a child protection plan, or are in care, 6 – 9% of all young people had a reported substance misuse issue. This is approximately 3x higher than the general population- and evidently a much higher prevalence than in the wider population in Suffolk, or even in children referred to CAF or MASH.

In annual health assessments of children in care (CiC), around 2-4% are recorded as having a substance misuse issue. A large caveat exists for this figure, this is likely to be an underestimate due to low rates of return. Additionally, young people that do not stay in care for a whole year will not receive an annual health assessment.

CiC are about 0.5% of the population of young people but account for 20% of the specialist substance misuse service caseload.

Around 12% of all referrals to specialist services are regarding CiC, but 20% of cases in treatment are CiC. This may reflect a greater likelihood of a CiC being followed-up (e.g. by social worker) to motivate attendance, compared to an average young person.

In young people having youth justice board assessments, substance misuse issues are recorded around ten times more frequently than in any other vulnerable population. Nonetheless, the same substances (cannabis and alcohol) predominate. High ascertainment in this population may be partially driven by co-located substance misuse workers within the YOS team.

In 2016/17 in Suffolk, 63% of those young people completing youth justice board assessments (n=176) had a substance misuse issue. 78% of these individuals were male and the most common substance issue was cannabis. 39% of these individuals were assessed via the Drug Use Screening Tool (DUST) and the majority were eligible for referral to specialist services.

In none of the MASH / CAF/ CIN or CPP populations is there any indication that prevalence of substance misuse is falling.

The services

There is limited evidence on suitable interventions for young people at risk of, or undertaking, substance misuse. NICE advocate a universal approach to improve social and emotional wellbeing, focussing on resilience, together with alcohol misuse prevention initiatives in schools and targeted interventions for those at increased harm of drug misuse.
Suffolk Public Health has enabled 13 Suffolk schools to deliver the ‘Risk Avert’ initiative in the past two years. This intervention identifies those at increased risk of harmful behaviour and targets them with interventions to improve resilience. Unfortunately, the Public Health funding for this initiative is no longer offered, although the service can be purchased through School Choice. Some schools may be continuing using independent funds.

The opinion of young people about PSHE regarding substances in their schools was generally lukewarm, scoring an average 2.8 out of 5 (58%). 37 young people commented that they had never had drugs and alcohol related education in schools at all.

There were concerns amongst the young people that schools stigmatised – and led other pupils to stigmatisate – drug users as ‘idiots’, reducing the likelihood of seeking help. 5 respondents described needing help for drug or alcohol related issues but not seeking it, 3 of whom were using drugs. This was explicitly linked to fear of stigma.

Turning Point is the only commissioned specialist substance misuse service for young people in Suffolk. Five Turning Point staff work with young people. Turning Point can be accessed via referral or self-referral, including ‘drop in’ at specific locations, although none of these are now youth bases.

The online survey of young people suggested many did not know of the availability of the Turning Point service.

The Public Health Suffolk evaluation of the DUST assessment tool, including an online survey and focus groups, found that many professionals were also unaware of how to access Turning Point, or lacked confidence in completing referrals. The online survey of professionals suggested several did not know that the service was now Turning Point, not Matthew Project, indicating lack of recent engagement. Others also referenced locations – such as 4YP – where Turning Point no longer has workers.

4% of young people responding to the online survey indicated that they had felt a need for specialist substance services in their lives, whether they had then sought it out or not. Modelled across the Suffolk population age 13 to 24, this would represent about 3,700 young people. This is a lifetime indication, not a point prevalence as with the NDTMS data, but is still notable for being 10 times higher than the numbers in services.

Lack of awareness of available services, and of how these have changed over recent years, and lack of confidence within young people, professionals and others working with young people about how to access them may be an important issue in explaining gaps in service access.

**The processes of referral**

Referral to Turning Point involves completion of the DUST screening tool, however this is not itself a referral form and should be used with or without a prior intent to refer. Previous
assessment has established a low rate of awareness of this tool and its use among professionals working with young people in Suffolk.\(^8\)

- In Suffolk, no referrals come to specialist substance misuse services from A&E departments, despite the rising rates of attendance for overdose and poisoning related incidents.
- In Suffolk, a very high number of referrals come from the Youth Justice Service, compared to national data. This may positively reflect Suffolk’s offer of a Turning Point worker co-located with this team.
- A range of opinions on Turning Point were generated by the professionals in the online surveys, who gave Turning Point an aggregate rating of 3.33 out of 5 (67%). Praise for a smooth process from some was combined with confusion from others about how the process worked and some specific complaints about the service being unable to cope with load. This was much the same amongst the VCS respondents, with a mixture of positive experiences and less positive ones. Turning Point workers, meanwhile, have described that low referral rates mean they are able to accept a greater percentage of referrals than in previous times.

**The processes of identification**

- The majority of VCS and professional workers with young people express confidence in identifying young people who are at risk of or who are misusing substances, although there may be responder bias in terms of those choosing to answer the surveys for this needs assessment, who may have increased awareness of substance misuse issues.
- Many would like more information about services and how best to refer.

**Service and data gaps**

- There is a gap in awareness amongst young people, professionals and the voluntary sector around how to access information and support services for substance misuse in Suffolk.
- Universal prevention and information messages do not appear to meet the needs of young people accessing them.
- The challenges around data in the area of young people and substance misuse in Suffolk are, broadly speaking, the same challenges which exist nationally. Many, such as disaggregating those with substance misuse issues from those who have ever used substances, will likely never be fully resolved.
- Putting the voice of young people themselves into the data has been achieved in this needs assessment through the use of an online survey. Via the Suffolk Healthwatch annual school-based survey of young people initiative, there is a possibility to obtain and compare such data year on year. Any capacity to gather more data from young people who have used specialist substance misuse services would be valuable.
Conclusions

- Suffolk offers a specialist substance misuse service for young people, to which barriers to access appear to exist, or are certainly perceived by some professionals. This includes lack of awareness of the service and a perception that it must have a high threshold for service users.

- Equally concerning is the gap around universal prevention, and early prevention options for those with early substance misuse issues. The offer in schools appears variable, and young people are not fully aware of the sources of information and support. That some users of solvents or cannabis do not regard themselves as having used drugs indicates a phenomenological gap between professionals and young people.

Recommendations

<table>
<thead>
<tr>
<th>One</th>
</tr>
</thead>
<tbody>
<tr>
<td>There is evidence that the level of need around substance misuse in Suffolk is not decreasing, and may in fact be increasing. Although this may reflect increased harm occurring to a smaller number of individuals, it nonetheless indicates an ongoing need for specialist, targeted and universal substance misuse services. Substance misuse services for young people should be protected, and expanded as far as possible.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Two</th>
</tr>
</thead>
<tbody>
<tr>
<td>A plausible reason for the decrease in referrals to the specialist service in Suffolk is lack of awareness on the part of professionals and young people. Following on from some awareness raising undertaken as part of the DUST screening tool assessment, it is important to publicise the service and the means of access, and train people in how to refer appropriately. Part of this work may involve addressing some of the conceptions around Turning Point highlighted in this report.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Three</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suffolk specialist substance misuse services have negligible rates of referral from hospital and A&amp;E settings, despite increasing attendance with related issues. It would be valuable to liaise with local hospitals, and all those working with young people, about how to signpost correctly as a minimum offer.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Four</th>
</tr>
</thead>
<tbody>
<tr>
<td>Universal provision in Suffolk should aim to improve. Improving PSHE delivery around drugs and alcohol in schools should be part of the initiative to improve Suffolk school standards.</td>
</tr>
</tbody>
</table>
### Five

Risk Avert, or an equivalent programme to improve young people’s resilience to engaging in risk behaviour, should be undertaken in Suffolk schools once more when financially feasible.

### Six

Cannabis use is the most prevalent illegal substance issue. Young people and those working with them frequently identify substance misuse as related to or co-occurring with poor mental health. Substance misuse and mental health teams should have stronger links to try and address this issue from both sides.

### Seven

Solvent/gas/aerosol misuse is the third most prevalent issue in Suffolk, and appears to be off the radar of professionals. Those working with young people should be aware of this issue and targeted education may be necessary.

### Eight

The voluntary sector represents a potentially untapped body of eager individuals to deliver brief interventions around substance misuse. Offers of increased education and information to professionals working with young people should be advertised and made open to voluntary and third sector organisations as appropriate, especially online training.

### Nine

The results of the survey of young people undertaken for this needs assessment are a large dataset which it has not been possible to fully analyse. If capacity can be located, time should be devoted to a more comprehensive analysis including statistical tests, to gain further insights.

### Ten

The young people survey may be repeated in the next financial year (2017/18) via inclusion in the Healthwatch Suffolk school-based survey of young people. This opportunity should be exploited this year and annually if possible to track trends.
**GLOSSARY**

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>A&amp;E</td>
<td>Accident and emergency department</td>
</tr>
<tr>
<td>AYPH</td>
<td>Association for Young Peoples’ Health</td>
</tr>
<tr>
<td>CAF</td>
<td>Common Assessment Framework</td>
</tr>
<tr>
<td>CAMHS</td>
<td>Child and adolescent mental health services</td>
</tr>
<tr>
<td>CIC</td>
<td>Child in care</td>
</tr>
<tr>
<td>CIN</td>
<td>Child in need</td>
</tr>
<tr>
<td>CPP</td>
<td>Child protection plan</td>
</tr>
<tr>
<td>CSEW</td>
<td>Crime Survey for England and Wales</td>
</tr>
<tr>
<td>CYP</td>
<td>Children and young people</td>
</tr>
<tr>
<td>CYPS</td>
<td>Children and young people’s service</td>
</tr>
<tr>
<td>DUST</td>
<td>Drug Use Screening Tool</td>
</tr>
<tr>
<td>HNA</td>
<td>Health Needs Assessment</td>
</tr>
<tr>
<td>JSNA</td>
<td>Joint Strategic Needs Assessment</td>
</tr>
<tr>
<td>MASH</td>
<td>Multi-Agency Safeguarding Hub</td>
</tr>
<tr>
<td>NDTMS</td>
<td>National Drug Treatment Monitoring System</td>
</tr>
<tr>
<td>NEET</td>
<td>Not in education, employment or training</td>
</tr>
<tr>
<td>NPS</td>
<td>New psychoactive substances</td>
</tr>
<tr>
<td>PCSO</td>
<td>Police Community Support Officer</td>
</tr>
<tr>
<td>ONS</td>
<td>Office of National Statistics</td>
</tr>
<tr>
<td>PHE</td>
<td>Public Health England</td>
</tr>
<tr>
<td>PSHE</td>
<td>Physical Social Health Education</td>
</tr>
<tr>
<td>YOS</td>
<td>Youth Offending Service</td>
</tr>
<tr>
<td>VCS</td>
<td>Voluntary and charitable sector</td>
</tr>
</tbody>
</table>

**AUTHORS’ NOTE**

In order to best represent the voices of those surveyed, survey responses have been reproduced verbatim in the text, regardless of spelling and grammar.
Contents

Summary on a page .......................................................... 4
Executive summary ......................................................... 5
Glossary ........................................................................ 14
Authors’ note .................................................................. 14

1 Introduction .................................................................. 17
   1.1 What is this needs assessment about? ....................... 17
   1.2 Why is this issue important to Suffolk? .................... 22
   1.3 Aims and objectives ............................................... 23
       1.3.1 The aim ......................................................... 23
       1.3.2 The objectives ............................................... 23
       1.3.3 Scope .......................................................... 24

2 Methods of data collection ............................................ 25
   2.1 National routine datasets ....................................... 25
       2.1.1 The Smoking, Drinking and Drug Use among Young People in England 2016 report .................. 25
       2.1.2 The Drug Misuse: Findings from the 2015/16 Crime Survey for England and Wales statistical bulletin .................................................................................. 25
       2.1.3 Young People’s Statistics from the National Drug Treatment Monitoring System (NDTMS): 1 April 2016 to 31 March 2017 .................................................. 25
   2.2 Local routine datasets .............................................. 25
       2.2.1 NHS Digital: Hospital admissions and A&E attendances .................................................. 25
       2.2.2 NDTMS local data ............................................ 26
       2.2.3 Data from Turning Point in Suffolk ................. 26
       2.2.4 Data from other specialist services for children and young people (CYP) in Suffolk ............. 26

2.3 Non-routine data gathered for other purposes ............... 26

2.4 Data gathering for this report .................................... 27

3 Results ....................................................................... 28
   3.1 Results by objective ............................................... 28
       3.1.1 Prevalence of drug and alcohol misuse by young people within Suffolk compared with the national picture, and considering how this has changed over the past 3-5 years .................................................. 28
           3.1.1.1 Prevalence of any drug and alcohol use ................... 28
               3.1.1.1.1 National datasets and Suffolk modelling ...... 29
               3.1.1.1.2 Suffolk datasets ................................... 35
               3.1.1.1.3 Suffolk data gathered for this needs assessment ... 40
           3.1.1.2 Prevalence of any use of specific substances .. 44
               3.1.1.2.1 National datasets ................................ 44
               3.1.1.2.2 Suffolk datasets .................................. 46
       3.1.2 Describe the characteristics of those young people misusing substances in Suffolk, considering at-risk and vulnerable groups and the prevalence within these sub-populations ................................................................. 49
           3.1.2.1 Characteristics of young people using substances .... 50
               3.1.2.1.1 National datasets ................................... 50
               3.1.2.1.2 Suffolk datasets .................................. 54
3.1.2.1.2.1 Reasons for first use of drugs and alcohol............................... 56
3.1.2.2 Prevalence of substance misuse in specific vulnerable populations...... 60
  3.1.2.2.1 MASH dataset ........................................................................ 60
  3.1.2.2.2 CAF dataset ........................................................................... 61
  3.1.2.2.3 Assessments for CIN, CPP, CiC .............................................. 64
  3.1.2.2.4 CiC Annual Health Assessments ............................................ 64
  3.1.2.2.5 Youth Offending Service ....................................................... 65
3.1.3 Identify the services currently available to young people in Suffolk, including
  universal awareness and education, and review the effectiveness of these services in
  preventing and treating drug and alcohol misuse ........................................ 67
  3.1.3.1 What works? ............................................................................. 67
  3.1.3.2 Universal services ...................................................................... 69
  3.1.3.3 Specialist services – not substance focussed ............................. 69
  3.1.3.4 Specialist services for substance misuse .................................... 70
  3.1.3.5 Experiences of service use ....................................................... 70
    3.1.3.5.1 Universal services and PSHE .............................................. 70
    3.1.3.5.2 Specialist help for drug or alcohol use ................................. 72
      3.1.3.5.2.1 Feedback from Turning Point service users .................... 74
  3.1.3.6 Ways to improve the services available ...................................... 75
3.1.4 Identify and review the processes by which young people are referred to
  specialist treatment services by other professionals working with young people, or via
  self-referral, considering whether this meets the needs of young people ............ 77
3.1.5 Identify and review the processes by which those working with young people
  identify and assist young people with substance misuse issues ..................... 80
4 Discussion ........................................................................................... 81
  4.1 Strengths of this needs assessment .................................................. 81
  4.2 Limitations of this needs assessment ................................................ 81
5 Conclusions .......................................................................................... 82
6 Appendices ........................................................................................... 82
7 Appendix 1: Systematically structured search methods .............................. 84
  7.1 Literature search .............................................................................. 84
8 Appendix 2: Young people survey: characteristics of sample ...................... 99
9 References ............................................................................................. 100
1 INTRODUCTION

1.1 WHAT IS THIS NEEDS ASSESSMENT ABOUT?

‘Substance misuse’ is generally defined as the use of substances when this leads to harmful effects. Although this definition could include a very broad range of items (sugar, for example), it is generally understood to mean addictive and/or mood-altering substances, generally illegal, but also including alcohol, tobacco and solvents.

‘Young people’ can be defined using a variable range of ages. It generally includes some or all teenagers but may expand to younger children or to those in their mid-twenties in various literature, encompassing the potential range of puberty and adolescence. The Association for Young People’s Health (AYPH) defines ‘young people’ as those aged 10 to 24 years.9 In the context of Suffolk’s Young People’s Substance Misuse Service, the definition of young people is as follows:

“Young people aged up to their 19th birthday, including children aged under 13 years if they are referred and subsequently assessed as requiring specialist interventions.

“Young adults aged up to their 25th birthday if assessment identifies that their level of maturity or need indicates they will not be able to successfully engage with an adult service delivery model, e.g. young people with additional needs or complex, chaotic life circumstances.”9
Defining ‘substance misuse’ in young people has additional challenges, and may differ from how misuse is defined in adults. It has been suggested that drug and alcohol misuse among teenagers is usually a symptom rather than a cause of vulnerability, and compounds other problems in their lives, including poor educational attainment and mental health issues.\textsuperscript{10}

The misuse of legal and illegal substances by young people is an important public health issue. In childhood and adolescence, critical developmental and cognitive changes can lay the foundation for life-long habits.\textsuperscript{11} As well as potentially indicating other vulnerabilities, substance misuse may be a harm in and of itself, or act as a risk factor for other problem behaviours. Single episodes of misuse can lead to lifelong harm or even death, either directly through the physiological effects of the substance or due to actions or choices made under the influence. Entering substance dependency may also occur. Early intervention and prevention may avoid progression to more serious problems and minimise the burden of healthy life years lost.\textsuperscript{10}

**Box 1: Reasons to invest in young people’s health. Extracted from Hagell et al (2017)**

<table>
<thead>
<tr>
<th>Reasons to invest in young people’s health</th>
</tr>
</thead>
<tbody>
<tr>
<td>The first signs of many serious longterm conditions emerge at this age, including three quarters of lifetime psychiatric disorders</td>
</tr>
<tr>
<td>Adolescence is a time when risk taking behaviours begin and life-long health behaviours are set in place</td>
</tr>
<tr>
<td>Adolescent health is not improving enough compared to other age groups</td>
</tr>
<tr>
<td>Ignoring chronic adolescent disease costs money for many years into the future</td>
</tr>
<tr>
<td>Young people say they are not getting the health services or information they require, and their accounts are often less positive than those of other age groups</td>
</tr>
<tr>
<td>The effects of poor healthcare in adolescence can last a lifetime so it is critical to get it right at this time</td>
</tr>
<tr>
<td>Investing in adolescent wellbeing has benefits that extend well beyond health into many other aspects of life</td>
</tr>
</tbody>
</table>

Source: Association for Young People’s Health (2017)

The likelihood of substance *use* becoming substance *misuse* increases with younger age of substance use initiation – those who begin drinking before age 15 have four to six times the rate of lifetime alcohol dependence than those who remain abstinent from alcohol use until
age 21. The majority of adults who have a substance use disorder started using before age 18.¹ Most young people who have developed a substance misuse problem are not at the point of dependence.¹ Those presenting to services are more likely to need harm reduction, psychosocial and family interventions than the addiction treatment required by adults. At the same time, many adolescents will use substances without misuse, and the majority do not experience harm.³ Identifying those at risk of harmful use and intervening appropriately is a significant challenge. (Table 1)
<table>
<thead>
<tr>
<th>Stage</th>
<th>Motive</th>
<th>Setting</th>
<th>Frequency</th>
<th>Emotional Impact of Taking Substance</th>
<th>Behaviour</th>
<th>Impact on functioning</th>
<th>Suggested Interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Experimental stage</td>
<td>Curiosity and risk taking</td>
<td>Alone or with peer group</td>
<td>Rarely or very occasionally</td>
<td>Effect of alcohol or drugs is usually very short term</td>
<td>No active alcohol or drug seeking behaviour</td>
<td>Relatively little; may rarely result in dangerous consequences.</td>
<td>Universal prevention (Drug and alcohol education – formal or informal)</td>
</tr>
<tr>
<td>Social stage</td>
<td>Social acceptance/ the need to fit in</td>
<td>Usually with peer group</td>
<td>Occasional</td>
<td>Mind altering effects of drugs are clearly recognized</td>
<td>No active alcohol or drug seeking behaviour</td>
<td>Usually no significant problems, - but some can go on to show features of the early at risk stage</td>
<td>Universal prevention (Drug and alcohol education – formal or informal)</td>
</tr>
<tr>
<td>Early ‘At Risk’ stage</td>
<td>Social acceptance / peer pressure / beliefs valuing substance-led experiences, based on pleasurable early experiences</td>
<td>Facilitated by peer group</td>
<td>Frequent, but variable, depending on peer group</td>
<td>Mind altering effects of drugs are clearly recognized and sought</td>
<td>No active alcohol or drug seeking behaviour</td>
<td>Associated with significant dangers problems associated with acute intoxication (e.g. accidents related to recurrent binge drinking)</td>
<td>*Targeted intervention/treatment by non-specialist services (e.g. GP, school health worker, young people’s counselling services, health care staff working in CAMHS, pediatrics etc)</td>
</tr>
<tr>
<td>Late at risk stage (substance use is not dominating mental state)</td>
<td>Cope with negative emotions or enhancing pleasure through wider experimentation</td>
<td>Alone or with an altered/selected (e.g. drug or alcohol using) peer group</td>
<td>Frequent / regular use</td>
<td>Uses alcohol or drugs to alter mood or behaviour</td>
<td>Active alcohol or drug seeking behaviour is a key indicator of this stage</td>
<td>May be impairment in functioning in some areas (e.g. school and family)</td>
<td>Treatment by specialist services (see below) – for both mental health issues and progression of substance use to further serious stages</td>
</tr>
<tr>
<td>Stage of harmful use or substance abuse (similar to ICD-10 or DSM-IV)</td>
<td>Alcohol or drug use is the primary means of recreation, coping with stress or both</td>
<td>Alone or with an altered (alcohol or drug using) peer group</td>
<td>Regular use, despite negative consequences</td>
<td>Negative effects on their emotions and ability to function</td>
<td>Active alcohol or drug seeking behavior, despite negative consequences across many areas of life</td>
<td>Impairment in almost all areas of life and or distress within families or close relationships</td>
<td>*Treatment by specialist services (e.g. Specialist substance misuse treatment services for young people and specialist substance misuse professionals within CAMHS)</td>
</tr>
<tr>
<td>Stage of dependence (Similar to ICD-10 and DSM-IV) (Only a rare minority of YP progress to this stage)</td>
<td>To deal with withdrawal symptoms, and stop craving.</td>
<td>Alone or with like-minded peer group</td>
<td>Compulsive, regular or often daily use to manage withdrawal symptoms</td>
<td>Emotional impacts of alcohol or drugs are very significant. Withdrawal symptoms prominent</td>
<td>Active alcohol or drug seeking behaviour, often loss of control over use, pre-occupation with alcohol/drug use, craving, and behaviour may involve criminality</td>
<td>Physical and psychological complications, impairment in all areas of life</td>
<td>*Treatment by specialist services including detoxification and for some residential rehabilitation</td>
</tr>
</tbody>
</table>

*For some the involvement of agencies and services, other than substance misuse services, may be required.
Substance misuse frequently co-exists with other vulnerabilities and may be a cause or consequence of other health and wellbeing needs. The UK government states that up to 70% of people in community substance misuse treatment also experience mental illness and there is a high prevalence of drug use among those with severe and enduring conditions such as schizophrenia and personality disorders. Amongst young people, those accessing specialist substance misuse services are usually experiencing other problems such as self-harm or other manifestations of poor mental health, truanting, offending and sexual exploitation which may be driving the young person’s substance misuse.

As such, the prevention and treatment of young people's substance misuse will involve Youth Offending Teams, wider children's services, Ofsted, children's homes, and wider services aiming to reduce the number of young people not in education, employment or training.

The government, in their 2017 Drug Strategy, set out:

“We are clear that reducing the harms caused by drugs needs to be part of a balanced approach. This means acting at the earliest opportunity to prevent people from starting to use drugs in the first place and prevent escalation to more harmful use, as well as providing evidence-based treatment options that can be tailored to individual need, to provide people with the best chance of recovery.”

Acting ‘at the earliest possible opportunity’ will naturally encompass preventive practice within the population of young people, and address substance misuse of the younger population. The first key theme of the 2017 Drug Strategy is the reduction of demand for drugs. The strategy sets out:

“We will take action to prevent the onset of drug use, and its escalation at all ages, through universal action combined with more targeted action for the most vulnerable. This includes placing a greater emphasis on building resilience and confidence among our young people to prevent the range of risks they face (e.g. drug and alcohol misuse, crime, exploitation, unhealthy relationships).”

As reflected in this strategy, preventive action applied across the entire cohort of young people (universal), needs to be combined with the provision of high-quality and accessible specialist substance misuse services for those who need them (targeted).
1.2  Why is this issue important to Suffolk?

In 2016, the county of Suffolk had a population of 118,837 people aged between 10 and 24 years old. 20% of them live in Ipswich local authority, with smaller percentages across the other six county districts and boroughs.

Some of the risk factors that may make people more likely to misuse substances are outlined below:

- 16% of all under-16s in Suffolk live in low-income families, statistically significantly better than the England average. However in 2015/16, 53.8% of Suffolk young people achieved 5 GCSEs at grade A*-C, statistically significantly worse than the England average. The crude rate of hospital admissions for under-18s for alcohol-related conditions is similar to the England average at 34.2 per 100,000 population. The crude rate of under-18 conceptions is 15.6 per 1,000 females aged 15 to 17 years, which is similar to the England average.\(^3\)
- 36% of young people in Suffolk progress to higher education (HE) – comparable to rates regionally and nationally. However, when actual rates of participation are compared against expected rates the county does not appear to be fulfilling its potential. 22% of rural wards in Suffolk are among the bottom 10% in England in terms of the gap between expected and achieved rates of progression to HE - i.e. among the 10 per cent of wards in England with the worst participation gaps (between actual and expected progression)\(^4\).
- A survey of 6,800 young people across 8 schools in Suffolk in 2017 found the average Short Warwick-Edinburgh Mental Wellbeing Scale (SWEMWBS) score was 22.6. This is at the lower end of ‘average’ when compared to the Population Norms in Health Survey for England (23.6).\(^12\) Rural youth in particular have described feelings of being powerless and disconnected.\(^4\) Although educational attainment has been prioritised by Suffolk County Council in recent years, and has shown improvement, not all young people will benefit.
- Young people in Suffolk, are as likely as any to be vulnerable to the harms of substance misuse.

Worsening the risk for the young people of Suffolk, is that Suffolk is one of the counties which has developed challenges relating to ‘County Lines’ drugs supply.\(^5\) This is the term used by police to refer to urban gangs supplying Class A drugs to suburban areas, rural areas, market and coastal towns using dedicated mobile phone lines (“deal lines”). Gangs typically use children and young people as runners to move drugs and money to and from the urban area and this often involves them being exploited through deception, intimidation,
violence, debt bondage, grooming and/or trafficking by the gang. Around 15-20 young people in Ipswich are considered directly affected. Although this represents a very small percentage of the total population, it is a severe risk to some of the most vulnerable young people, being particularly associated with care leavers.\textsuperscript{5} It may also represent an increased availability of illegal substances in Suffolk.

In Suffolk, as elsewhere in the UK, there has been a decline in the numbers of referrals of young people to specialist substance misuse services. Data over the last decade has seemed to indicate that absolute numbers of young people engaging in substance misuse has been declining in the UK. This, however, conflicts with the impression of frontline workers and those interacting with young people that service need remains high. It is important to understand as much as possible of the true needs of young people around substances, to ensure the correct primary, secondary and tertiary prevention services are in place in Suffolk to minimise harm.

1.3 AIMS AND OBJECTIVES

1.3.1 The aim

The aim of the young people’s substance misuse Health Needs Assessment (HNA) is to establish whether the current drug and alcohol services meet the needs of substance misusers and those at risk of substance misuse up to the age of 25 (‘young people’).

1.3.2 The objectives

1. Describe the prevalence of drug and alcohol misuse by young people within Suffolk compared with the national picture, and consider how this has changed over the past 3-5 years.

2. Describe the characteristics of those young people misusing substances in Suffolk in connection with substance misuse, considering at-risk and vulnerable groups and the prevalence of substance misuse within these groups.

3. Identify the services currently available to young people in Suffolk, including universal awareness and education, and review the effectiveness of these services in preventing and treating drug and alcohol misuse.

4. Identify and review the processes by which young people are referred to specialist treatment services by other professionals working with young people, or via self-referral and consider whether this meets the needs of young people.

5. Identify and review the processes by which those working with young people identify and assist young people with substance misuse issues.

6. Identify service and data gaps.
7. Make recommendations based on the evidence.

1.3.3 Scope
Substance misuse in young people is often part of a complex picture of need and vulnerability, with connections to many sectors and services. Distinguishing substance use and substance misuse in adolescents may be challenging. This health needs assessment (HNA) will aim to consider substance misuse, with the understanding that the distinction between use and misuse will often blur. Generally it will be accepted that substance use which has been captured in a routine dataset e.g. A&E, police, discussed with school by young person, indicates a level of harm.

This HNA will consider alcohol, illegal drugs and illegal use of legal drugs (such as abuse of solvents). These mood and perception altering substances have the potential to cause significant medical and psychological damage in the immediate term, or involve a young person in criminality. Smoking in young people is a very important public health issue, but will be considered outside the scope of this HNA. This refers to the definition of ‘misuse’ as discussed above.

Gang related drugs activity and associated criminality is an important part of understanding drug misuse in young people. It is out of the scope of this HNA to study the prevalence of gang activity, or the services and systems in place to mitigate it.

Young people may be harmed by substance misuse in their immediate family. However, for the purposes of this HNA, substance-related harm will be limited to the effects on the user, i.e. to cases where the harm to the young person comes from their own use of drugs, not that of their parents.

Young people are defined as an age group in various ways, which will be accepted by this HNA as a necessary artefact of comprehensive data capture. In Suffolk, the specialist substance misuse service Turning Point takes referrals up to the age of 18 but will continue working with a young person until the age of 25 in cases of specific vulnerability, and may in certain circumstances be considered a more appropriate place of referral for a person between 19 and 25. Where possible, this HNA will consider data up to the age of 25, but will not attempt to describe or evaluate service provision exclusively for the over-18s.
2 METHODS OF DATA COLLECTION

Data for this needs assessment have been collated from a variety of sources. Routine data have been combined with data collected for other purposes and data specifically gathered for this piece of work.

2.1 NATIONAL ROUTINE DATASETS

2.1.1 The Smoking, Drinking and Drug Use among Young People in England 2016 report

This report from NHS Digital/ The Health and Social Care Information Centre is the latest of a series of annual surveys of secondary school pupils in England in school years 7 to 11 (mostly aged 11 to 15). 12,051 pupils in 177 schools completed questionnaires in the autumn term of 2016.

2.1.2 The Drug Misuse: Findings from the 2015/16 Crime Survey for England and Wales statistical bulletin

This report from the Office for National Statistics (ONS) and the Home Office, reports from a nationally representative sample of 16 to 59 year olds resident in households in England and Wales, and is based on results from the 2015/16 Crime Survey for England and Wales (CSEW). Where possible, local figures have been modelled from both these national sources.

2.1.3 Young People’s Statistics from the National Drug Treatment Monitoring System (NDTMS): 1 April 2016 to 31 March 2017

These data are published annually by Public Health England (PHE) from returns by all local areas on specialist treatment for substance misuse. An annual report is published specifically regarding young people. These data are informed by local data to which this needs assessment has separate access, therefore these data have not been used for modelling.

2.2 LOCAL ROUTINE DATASETS

2.2.1 NHS Digital: Hospital admissions and A&E attendances

Local data have been extracted from NHS Digital regarding A&E attendances and hospital admissions relating to substance misuse in young people age 10 – 24 years from 2012/13 to 2016/17. These data relate to Ipswich Hospital, West Suffolk Hospital and James Paget Hospital but also capture Suffolk residents admitted to any other hospital in England with the
relevant codes. Due to coding issues at James Paget hospital, Waveney data is often incomplete and overall rates may be an underestimate.

2.2.2 NDTMS local data
The NDTMS, via Public Health England (PHE), reports quarterly on specialist substance misuse services in each county. The specialist services submit their routine data on service users to PHE, who extract and summarise chosen aspects and report this back to local stakeholders. These reports are available for Suffolk County from 2015 onwards.

2.2.3 Data from Turning Point in Suffolk
Additional data from the Suffolk specialist substance misuse service, Turning Point, has been collated where possible.

2.2.4 Data from other specialist services for children and young people (CYP) in Suffolk
Several specialist services that interact with young people collect data regarding substance use and misuse. The data holders for these services were approached to extract the relevant items, de-identified, to feed into this needs assessment. Data were extracted from:

- Multi-Agency Safeguarding Hub (MASH) assessments
- Common Assessment Framework (CAF) assessments
- The database of the Youth Offending Service (YOS)
- Assessments undertaken by social services on children and young people who may be, or need to become, Children in Need (CIN), subject to a child protection plan (CPP) or a child in care (CiC)
- Annual health assessments undertaken on CiC who have been in care for at least a year

2.3 Non-routine data gathered for other purposes
‘Risk Avert’ is a harm prevention initiative in which school children in year 8 (12-13 years old) are surveyed to establish their risk of harmful behaviour and those meeting a threshold referred for focussed education on resilience and choices. This initiative was funded by Public Health Suffolk in 13 schools in Suffolk, reaching 2,173 young people. A dataset aggregating these Suffolk responses was made available to this report ahead of publication.

Additional Suffolk data on the mental wellbeing of young people, contextualising this report, was gathered by Healthwatch Suffolk in their ‘My Health, Our Future’ report of November 2017, drawing on a survey of 6,800 young people across 8 schools in Suffolk.
Other studies specifically on the youth of Suffolk, in relation to gang activity⁵, and to rural progression⁴, are also considered.

This report also draws on, and should be read in conjunction with, Public Health Suffolk’s evaluation of the DUST screening tool as used by services in Suffolk to assess young people.⁶

2.4 DATA GATHERING FOR THIS REPORT

Qualitative and subjective quantitative data have also been elicited from a variety of sources using online surveys. Turning Point staff, professionals in wider children and young people’s services (including School Nurses, Child and Adolescent Mental Health Service (CAMHS) workers, Police Community Support Officers (PCSOs), social workers and sexual health nurses), teachers, voluntary and charitable sector workers engaging with young people, and young people themselves have been invited to comment on lived experience. This has been supplemented by focus group engagement with professionals regarding referral to specialist services, and with young people via the Suffolk County Council CYPS Engagement hub.

- **CYPS workers professionals survey**
  - 45 respondents
  - Cascaded to social workers, CAMHS workers, PCSOs, sexual health nurses via email links

- **School nurses survey**
  - 5 respondents
  - School nurses

- **Voluntary and charitable sector survey**
  - 21 respondents
  - Distributed to contacts at VCS organisations listed on Suffolk InfoLink or identified by reference group members

- **Schools survey**
  - 5 respondents
  - Head teachers

- **Turning Point professionals survey**
  - 5 respondents
  - Workers employed at Turning Point engaging with young people

- **Young people’s survey**
  - 356 respondents
  - Cascaded through CYP engagement
3 RESULTS

3.1 RESULTS BY OBJECTIVE

3.1.1 Prevalence of drug and alcohol misuse by young people within Suffolk compared with the national picture, and considering how this has changed over the past 3-5 years

3.1.1.1 Prevalence of any drug and alcohol use

As has been stated above, disaggregating drug and alcohol use from drug and alcohol misuse – or that with the potential to become misuse – is challenging in young people. We know that many adult substance misusers are aware that their problems began when they were young, but this does not mean young users are aware they may have continuing problems.

It is possible to take the viewpoint that any use of illegal drugs is misuse, not least because it necessitates involvement with criminal suppliers somewhere along the line. However, this does not account for the fact that some will use illegal drugs on a few occasions without apparent actual harm despite the risk of it, and that some legal substances can be misused very harmfully (for example, solvent abuse).

The main national datasets on substance use in young people – based on representative survey data – measure prevalence of any use. It cannot be known what subset of this prevalence is or will become ‘misuse’ and to use the total numbers would be an overestimate. By contrast, the datasets of the National Drug Treatment Monitoring System (NDTMS) capture those who have had treatment for a substance misuse issues, and whilst all in the data will represent misuse, these numbers are likely to be an under-estimate, because engagement with treatment services is generally voluntary and relies on the young person acknowledging they have a need.

Other datasets are harder to assess. The surveys undertaken for this piece of work defined ‘misuse’ and asked respondents to bear this definition in mind, but nonetheless this is subjective and will be taken differently by different individuals. For example, one person might regard a 15-year-old drinking heavily one night and collapsing in the street as misuse, whilst another might regard it as normal use providing there are no long-lasting harms. The datasets around A&E attendance and hospital admissions are likely to represent ‘misuse’ as the harm is whatever has led the person to the hospital. However, coding
practices in these data mean that not every person included in the numerator will have ‘a substance misuse problem’ as defined for this piece of work. For example, some of those attending A&E with poisoning will have taken an intentional overdose without a substance misuse history. Existing episode codes do not allow the two to be differentiated.

These limitations must be borne in mind whilst reviewing the following data. However, trends in data may be more reliable than overall percentages, as there is no reason to assume any one of these limitations would be more pronounced in one year than another (i.e. if x% of all substance use is misuse in 2013/14, this may well be the same in 2016/17 even without knowledge of x).

3.1.1.1 National datasets and Suffolk modelling

The Drug Misuse: Findings from the 2015/16 Crime Survey for England and Wales\textsuperscript{13} statistical bulletin suggests that, nationally, in the last 20 years, a given 16-24 year old is more likely than the wider age group of adults (16-59) to have used any class of drug.

However, the rate of decline of use in 16-24 year olds is sharp, moving from a third having used in the last year 20 years ago, to around a fifth in 2015/16. Nonetheless, the percentage of those in this age group having used a Class A drug in the last year remains much the same as it was 20 years ago. The reasons for the decline in use are likely to be multifactorial in nature, with a complex combination of social, cultural and economic factors that, together, have combined to progressively reduce prevalence\textsuperscript{16}.

A fifth of Suffolk young people (16-24) having used drugs in the last year equates to around 14,000 individuals. Further modelled data for Suffolk is presented in Table 2. This survey does not determine what percentage of respondents had sought specialist services for drug or alcohol problems.
<table>
<thead>
<tr>
<th>Indicator</th>
<th>% in 1996</th>
<th>% in 2015/16</th>
<th>Estimated number in Suffolk (16-24 year old MYE population ~70,000 persons)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have used drugs in the last year (16-24 year olds)</td>
<td>29.6</td>
<td>18.0</td>
<td>12,600</td>
</tr>
<tr>
<td>Have used cannabis in the last year (16-24 year olds)</td>
<td>25.8</td>
<td>15.8</td>
<td>11,400</td>
</tr>
<tr>
<td>Have used ecstasy in the last year (16-24 year olds)</td>
<td>6.6</td>
<td>4.5</td>
<td>3,200</td>
</tr>
<tr>
<td>Have used cocaine in the last year (16-24 year olds)</td>
<td>1.4</td>
<td>4.4</td>
<td>3,200</td>
</tr>
<tr>
<td>Have used NPS in the last year (16-24 year olds)</td>
<td>No Data</td>
<td>2.6</td>
<td>1,800</td>
</tr>
<tr>
<td>Is a frequent drug user (16-24 year olds)</td>
<td>No Data</td>
<td>4.7</td>
<td>3,200</td>
</tr>
<tr>
<td>Feels it is acceptable for people of their own age to get drunk frequently (16-24 year olds)</td>
<td>No Data</td>
<td>12.0</td>
<td>8,500</td>
</tr>
<tr>
<td>Feels it is acceptable for people of their own age to take cannabis (frequently or occasionally) (16-19 year olds)</td>
<td>No Data</td>
<td>33.0</td>
<td>11,000</td>
</tr>
<tr>
<td>Feels it is acceptable for people of their own age to take cannabis (frequently or occasionally) (20-24 year olds)</td>
<td>No Data</td>
<td>44.0</td>
<td>17,000</td>
</tr>
</tbody>
</table>

The reported prevalence of cannabis, ecstasy and powder cocaine use in the past year across this age group was significantly lower than in the same age group 10 years ago. (Figure 1)
The Smoking, Drinking and Drug Use among Young People in England 2016 report identified that amongst 11-15 year olds, 44% had ever drunk alcohol and 24% had ever taken drugs. 10% had drunk alcohol in the last week and 10% had taken drugs in the last month. This represents an increase in 'ever having taken drugs' compared to the previous survey (2014) where the figure was 15% (see Figure 2). The authors question whether the apparent increase is a true finding, as part of the increase since 2014 may be explained by the addition of questions on nitrous oxide and NPS. The authors advise this result should be treated with caution, as an estimate from the next survey (in 2018) is required before they can be confident that these survey results reflect a genuine trend in the wider population.

The Young People’s Statistics from the National Drug Treatment Monitoring System (NDTMS) report for 2016/17 notes that whilst overall numbers of young people in specialist treatment have been decreasing year on year since 2008, there has been a 10% increase in
attendance by young people under 14 years old in 2016/17 compared to 2015/16. They
query whether this may reflect the same cohort and be evidence of a true trend.14

Figure 2: Ever taken drugs, by year, amongst 11-15 year olds in Smoking, Drinking
and Drug Use among Young People in England 20167

Indicators from this survey have again been modelled onto Suffolk population data for the
same period (Table 3).
Table 3: Estimates for prevalence of drug and alcohol use in 11 to 15 year olds, Suffolk County, modelled on data from the *Smoking, Drinking and Drug Use among Young People in England* 2016 report

<table>
<thead>
<tr>
<th>Indicator</th>
<th>% from 2016 Smoking, Drinking and Drug Use report (11-15 year olds)</th>
<th>Modelled numbers in Suffolk County (11-15 year olds)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ever been offered drugs</td>
<td>36.0</td>
<td>14 500</td>
</tr>
<tr>
<td>Ever drunk alcohol</td>
<td>44.0</td>
<td>17 800</td>
</tr>
<tr>
<td>Ever taken drugs</td>
<td>24.0</td>
<td>9 700</td>
</tr>
<tr>
<td>Drunk alcohol in the last week</td>
<td>10.0</td>
<td>4 000</td>
</tr>
<tr>
<td>Taken drugs in the last month</td>
<td>10.0</td>
<td>4 000</td>
</tr>
<tr>
<td>Taken cannabis in the last year</td>
<td>8.0</td>
<td>3 200</td>
</tr>
<tr>
<td>Taken volatile substances in the last year</td>
<td>4.0</td>
<td>1 600</td>
</tr>
<tr>
<td>Taken NPS in the last year</td>
<td>2.0</td>
<td>800</td>
</tr>
<tr>
<td>Feels it's OK to drink alcohol to see what it's like</td>
<td>50.0</td>
<td>20 000</td>
</tr>
<tr>
<td>Feels it's OK to get drunk to see what it's like</td>
<td>19.0</td>
<td>7 700</td>
</tr>
<tr>
<td>Feels it's OK to get drunk once a week</td>
<td>7.0</td>
<td>2 800</td>
</tr>
<tr>
<td>Feels it's OK to take cannabis to see what it's like</td>
<td>11.0</td>
<td>4 500</td>
</tr>
<tr>
<td>Feels it's OK to take cocaine to see what it's like</td>
<td>3.0</td>
<td>1 200</td>
</tr>
<tr>
<td>Feel it's OK to take cannabis once a week</td>
<td>6.0</td>
<td>2 400</td>
</tr>
</tbody>
</table>

Combining the results of the two surveys in a crude manner, it can be estimated that across Suffolk young people aged 11 to 24 years, around 21,000 may have taken drugs in the last year. This would represent about 17% of the total population across this age group. Of these, about 14 000 may have taken cannabis (12%) and about 1 500 an NPS (1%).

In terms of harmful substance use – i.e. misuse – the National Drug Treatment Monitoring System (NDTMS) dataset for young people (aged under 18) who receive specialist substance misuse interventions in England has been released for the financial year (FY) 2016/17, although more recent figures are available locally. During 2016-17, 16,436 young people aged 9-17 reported to the NDTMS as in contact with treatment services across
England. This represents around 0.3% of the total population of England in this age group in this period (nearly six million individuals). If the same percentage in the same age group were accessing treatment in Suffolk, this would represent about 224 individuals, a small fraction of those who are likely to have ever used drugs, but somewhat more than the rolling total in treatment at any given time over the last year (range 99 – 167 individuals).

88% of the young people in services across England were misusing cannabis (including poly drug users). 92% of the young people in services had started misusing substances before the age of 15 and 60% were using more than one substance.

The number of young people attending specialist substance misuse services across England during 2015-16 was a 7% decrease from the previous year, and an absolute reduction of 6,976 (29%) since the peak of 24,053 in 2008-09. Public Health England theorises that this may represent a genuine fall in alcohol and drug use among young people, and thus lower demand for services leading to lower usage. However, they state it is also possible that reduction in the provision of youth support services during recent budgetary cuts across local authorities may have affected the number of referrals, indicating instead increasing unmet need.

**Figure 3: Trends in numbers of young people (age 9-17 years) in specialist substance misuse treatment in England over 10 years, based on data in the Young People’s Statistics from the National Drug Treatment Monitoring System (NDTMS) 1 April 2016 to 31 March 2017**
3.1.1.1.2 Suffolk datasets

In Suffolk NDTMS data for Q4 of 2016/17 (the most recent publishable data) there were 114 young people in treatment in Suffolk. This represented a 15% increase compared to the same period in 2015/16 whereas nationally numbers were lower compared to 2015/16 at the same time. This is only about half of those that might be expected if Suffolk rates of usage were the same as national rates (224 individuals, see above). Applying national rates to Suffolk may not be legitimate for several reasons (differences in underlying population structure, risk factors and patterns of practice) but similarities between modelled data and the young people’s survey in terms of prevalence of lifetime drug use may indicate Suffolk is in fact seeing fewer young people in specialist services than would be expected from prevalence modelling.

Figure 4: Numbers of young people in specialist substance misuse services in Suffolk (rolling total) 2013/14 to 2017

It can be considered that any substance use which results in an A&E attendance or hospital admission is robust evidence of harm. It may also be evidence of expressed need for services relating to substance use by young people.

The way in which episodes of treatment are coded in Accident and Emergency and Hospital Admissions data do not allow detailed analysis of specific harms from drugs and alcohol. The code ‘poisoning (including overdose)’ for a range of plausible drugs, separated by pharmacological type rather than legality or context, must be used. Therefore a young person accidentally overdosing on recreational heroin as part of substance misuse, and a young person who has overdosed on prescription opiates attempting to end their life, which would not be per se a substance misuse problem, are both counted in the same way.
However, these data are relatively robust because acute episodes of harm are relatively likely to present to A&E equally across population strata, compared to differential access of lower tier services by different groups. Unlike surveys, which may not reach the most vulnerable, this data should capture young people otherwise not ‘in the system’.

Data from NHS Digital show that in Suffolk, amongst 10-24 year olds, rates of A&E attendance for poisoning (including overdose) via a range of substances, and of hospital admission for poisoning or toxic effects of drugs and alcohol, are rising. This rise is statistically significant. Rates of hospital admission for mental health disorders secondary to drugs or alcohol, however, appear to be falling.

*Note: For charts 5-8 chart ‘Y’ axes are variable*

**Figure 5: Rates of attendance at A&E by 10-24 year olds with diagnoses relating to substance use, Suffolk County, FY 2012/13 – 2016/17, per 100,000 population of 10-24 year olds**
Figure 6: Rates of admission to hospital for conditions relating to drugs and alcohol of all 10 – 24 year olds, Suffolk County, FYE 2012/13 – 2016/17, per 100,000 population of 10-24 year olds

![Graph showing rates of admission to hospital for conditions relating to drugs and alcohol]

Figure 7: Rates of admission to hospital for mental disorders resulting from drugs and alcohol of all 10 – 24 year olds, Suffolk County, FYE 2012/13 – 2016/17, per 100,000 population of 10-24 year olds

![Graph showing rates of admission to hospital for mental disorders]

The denominator population has not changed much across the period, and thus graphs of the absolute numbers are very similar in appearance.
The absolute numbers suggest that in financial year 2016/17, there were 494 first A&E attendances by persons aged between 10 and 24 in Suffolk with any diagnosis of poisoning (including overdose). This is about 0.4% of all those in this age group. Looking at the modelled total numbers in this age group who may ever have taken drugs (n= 21,000), this would only represent about 2% of these young people, and in fact since these attendances will include both drugs and alcohol, the proportion of those ever taking drugs who attend A&E may well be smaller than this. Nonetheless, although it is possible that the 100 or so people who are in specialist substance misuse services attend 4 or 5 times each, accounting for all the cases, but it is also possible that this represents a separate cohort, and approximately 4 times the numbers which attend specialist substance misuse services.

The rise in A&E usage in general, across all age groups and presenting complaints, was posited as an explanation for the trend in the first graph. This was investigated by measuring the overall trend in A&E attendance in all persons 10-24 in Suffolk. The overall trend in A&E attendance had also risen but 2016/17 numbers were 9% higher than 2012/13, whereas in specific poisoning attendances in this age group the rise was 78%.

Figure 8: Rates of attendance at A&E by 10-24 year olds any diagnosis, Suffolk County, FY 2012/13 – 2016/17, per 100,000 population of 10-24 year olds
This may cohere with findings from a 2014 rapid evidence synthesis of information around alcohol usage by young people in the UK, which concluded that although the overall proportion of 15–16 year olds who ‘do not’ drink is increasing, those who do drink tend to start drinking at a younger age and are drinking much greater quantities. Alcohol-specific and alcohol related harm is continuing to rise in the UK despite the overall population level of alcohol use falling. A similar trend has also been observed in Sweden and Australia. It is possible that the UK is becoming polarised with more abstainers and occasional drinkers, alongside more heavy consumption amongst those children and adolescents who are regular drinkers. However, this interpretation must be treated with caution as this is only a small number of individuals, and extrapolates an adult trend to a child cohort.

Data from Suffolk young people in school year 8 (12-13 year olds) collected as part of the harm prevention initiative ‘Risk Avert’ covered 2,173 persons over two years. These proportions may be underestimates, and could be biased. For example, if a young person knew about the survey in advance they may be less likely to attend school. Additionally, a young people with substance misuse issue or other vulnerabilities may be less likely to attend school overall.

In answer to the question ‘In the past year, on how many occasions have you had a few sips of a drink containing alcohol, without adult supervision?’ 81% of respondents answered that this had never happened, 14.5% that it had happened 1 to 5 times, 2.3% that it had
happened 6 to 11 times and 2.1% that it had happened more than 11 times. Understandably this is a lower percentage of ever-drinkers than in the wider age group going up to age 15. Applied across Suffolk 12 to 13 year olds, this would suggest around 3,300 had ever had an alcoholic drink, and around 300 on more than 11 occasions. This is likely to be an underestimate across the whole population.

3.1.1.1.3 Suffolk data gathered for this needs assessment
The online survey of professionals who work with children and young people attracted 45 responses.

Half of responses came from social workers, the next biggest group was sexual health professionals. There were also responses from PCSOs, CAMHS workers and school nurses. The most common area for the professionals to say they worked in was Waveney and/or Lowestoft, followed by Ipswich. Although some worked Suffolk-wide, relatively fewer worked in the rural and more affluent areas. It is important to bear this in mind in interpreting results. Offered the options of saying substance misuse prevalence had increased, decreased or stayed the same since 2012 (or ‘don’t know’) 50% thought it had increased. Only a third of the respondents stated that the young people they worked with were a group that largely did misuse substances.

**Figure 10: Answers to question by CYPS ‘Among young people you work with, what percentage misuse substances compared to 5 years ago?’**

About a third thought that ‘amongst those that misuse substances, use is more harmful now than 5 years ago’, with the next greatest proportion thinking it was roughly the same.
The survey to school nurses had 5 responses. School nurses may see a more universal picture of need than CYPS workers addressing populations with higher need. However, 60% of the school nurses felt that substance misuse had increased compared to five years ago, and none felt it was smaller.

Figure 11: Answers to question by School Nurses ‘Among young people you work with, what percentage misuse substances compared to 5 years ago?’

The survey to voluntary and charitable sector attracted 21 responses. Most responding organisations were open to all young people, but 3 dealt solely with specific populations – family carers, learning difficulties and LGBT youth. The most commonly used word for describing their organisation’s goal was ‘support’. All of the organisations were open access for young people to self-refer or ‘drop in’, although some took referrals from elsewhere such as colleges. As with the professionals survey, the most represented area was Lowestoft and Waveney, followed by Ipswich.

Amongst the VCS respondents 39% thought young people’s substance misuse had increased in the past 5 years and 39% thought it had stayed the same.
The survey of young people, which was open to all up to the age of 25 in Suffolk and promoted on social media, received 356 meaningful responses (responses reporting physiological impossible rates of drug usage, or where all the free text responses implied the responder was fabricating responses to the survey were excluded).

The most common age of respondents was 14 years old. The relatively smaller numbers of those over 16 may lead to underestimation of drug and alcohol usage across the entire 10-24 cohort, as usage generally increases with age.

Figure 13: Ages of respondents to the young people’s online survey, by percentage of the total sample represented
For more demographic details of the young people answering the survey, please see Appendix 2.

In view of this age distribution, unsurprisingly 80% of respondents had a work/school situation of being in school or college full time. 4 respondents (1%) were excluded from school. Approximately two thirds were female. Over 80% were 'White British' and over 80% were 'heterosexual'. More respondents lived in the town or city than in a village or countryside.

80% of respondents had ever drunk alcohol. The most common age to have first drunk alcohol was 13 years old. 16% of respondents said that they had ever taken drugs. The most common age to have first taken drugs was 15 years old.

Substance misuse might be considered as substance use that leads to situations the user regrets afterwards. 19% of all respondents said that drug or alcohol had led to at least one situation that they regretted.

If we assume that the survey result is generalisable to the wider Suffolk population (which is not necessarily the case), this would mean 1 in 5 young people aged 10 to 24 has been involved in a situation they regret due to drugs or alcohol. This would be about 17,000 young people.

**Figure 14: Responses to the question ‘Has there ever been a time that use of drugs and alcohol lead to a situation you regret?’ amongst those responding the online survey of young people**
Conclusions

- The observed national trend of decreasing self-reported substance use, and decreasing referral to specialist substance misuse services may not reflect diminishing need for services.

- Data from NHS Digital show that in Suffolk, amongst 10-24 year olds, rates of A&E attendance for poisoning (including overdose) via a range of substances, and of hospital admission for poisoning or toxic effects of drugs and alcohol, are rising. This rise is statistically significant.

- Most professionals and VCS sector workers in the frontline with young people feel that substance use is the same or higher now compared to 5 years ago.

- Modelling from national data, around 21,000 young people aged 11 to 24 in Suffolk may have ever taken drugs (17% of the total population in this age band).

- This aligns with a survey of 356 young people, in which 16% reported ever having taken drugs.

- Nationally, 0.3% of young people aged 9 to 17 access specialist substance misuse services. In Suffolk this would suggest around 220 individuals should be accessing services, whereas current numbers in treatment are approximately half this number.

3.1.1.2 Prevalence of any use of specific substances

3.1.1.2.1 National datasets
As can be seen in the data above, alcohol and cannabis are consistently reported as the most commonly used substances in young people across England. Volatile substances, which can be purchased legally, (solvents, gases and aerosols) are more common than Class A drugs.
More young people have ever drunk alcohol than have ever used cannabis, but more young people are in treatment for cannabis usage. It is notable that whilst the general proportions of 16-24 year olds using cannabis appears to have decreased in the CSEW since 2005/06, the numbers of young people in treatment for cannabis issues has increased. This may reflect the different denominator populations from where this data is derived (as previously stated, those answering the CSEW are a selected group).

Figure 16: Proportion of adults using cannabis in the last year, 16 to 59 and 16 to 24 year olds, 1996 to 2015/16 CSEW

Figure 17: Number of young people (9-17 years) in specialist substance misuse treatment by primary substance (2005/06 to 2016/17). Extracted from Young People’s
3.1.1.2.2 Suffolk datasets

The data on specialist substance services in Suffolk in the past 4 years reflects the national picture, with cannabis used by the majority of those attending specialist substance misuse services in the 9-17 year age group.

Figure 18: Percentage of young people (9-17 years) in specialist substance misuse treatment in Suffolk who use each substance (2013/14 to 2016/17, quarterly)
Alcohol is the next most common substance used by young people in specialist services and appears to be decreasing. However, 83% of Suffolk young people in specialist services are poly substance users, which is significantly higher than the national picture.

The survey of CYPS workers (n=50) reported cannabis as the substance most frequently misused by young people, with alcohol second and new psychoactive substances third. The survey of the VCS (n=21) reported alcohol misuse most frequently, followed by cannabis, then solvents and then NPS. This may reflect the different levels of risk within the populations seen.

“School holidays & peer groups spend time drinking alcohol & smoking weed… Amongst the <25 yr employed males, peer group use of cocaine is surprisingly common”
CYPS #21 (Ipswich)

“Newer style drugs in our area have yet to take hold, most youths still stick to the old standbys cannabis, alcohol and cocaine”
CYPS #36 (Location not given)

“More cocaine”
CYPS #46 (Ipswich)

“increase in MDMA and legal highs although cannabis use remains”
CYPS #5 (West Suffolk)

“We had a real problem with Ketamine and legal highs a couple of years ago, Cannabis is still the most used drug by YP, but with the use of weed the YP will want to try other drugs”
VCS #7 (Waveney)

“Ketamine featured high 5 years ago. Legal highs and gases are more common now.”
VCS #5 (Mid Suffolk)

In the survey of young people, because of issues with the survey form which were only resolved after the survey opened, there were 293 responses in which usage rates of different drugs could be assessed. Of these 293 individuals, 2 skipped this part of the survey. Of 291 respondents, a quarter (n=74) (25.4%) said they had never taken alcohol or any drugs, legal or illegal.
In the remaining 217 respondents, 173 (59.5% of the original 291) had only ever had alcohol. No person reported alcohol use more frequently than once a week.

44 (15.1% of the original 291) reported having ever taken illegal drugs or misused legal substances. 14 young people reported using alcohol and cannabis only, and none of them used cannabis more than once per month. 11 reported the use of class A drugs (3.8% of the original 291). Although 6 of these 11 were 18 years old or over, the youngest was 14 (this individual reported using cocaine ‘once or twice’ and that they had started using drugs at age 14).

**Figure 19: Frequency of individuals reporting each individual drug used in young person’s survey (note that individuals may have reported more than one drug)**

10 individuals reported having used more than 2 drugs (excluding alcohol). 11 individuals reported using a substance daily. 4 of these were solvents, which may possibly have been a misunderstanding of the question (and taken to refer e.g. to hairspray). 7 individuals reported daily cannabis use. They had all also used another substance besides alcohol. This was about 2.4% of the original sample.

Only 3 free text comments were received discussing the motivations for specific drugs or alcohol use. They all relate the use of cannabis to ongoing mental health issues.

“The only drug I take now is Cannibis because it helps with my anxiety and my pain”

Young person aged 20 and over
“I smoke cannabis to help with sleep, I have a mental health diagnosis and struggle with sleep even with prescribed medication.”

Young person aged 20 and over

“Taking cannabis with depression, to help my issues”

Young person aged 20 and over

<table>
<thead>
<tr>
<th>Conclusions</th>
</tr>
</thead>
<tbody>
<tr>
<td>➢ Alcohol and cannabis are consistently reported as the most commonly used and misused substances in young people, and the same is true of young people in Suffolk.</td>
</tr>
<tr>
<td>➢ The third most misused substance as reported in the young people survey was solvents/gas/aerosols, which was reflected in the answers to the VCS survey.</td>
</tr>
<tr>
<td>➢ Class A substances are of concern to professionals working with young people, but represent a smaller proportion of all usage and do not appear to be taken in isolation.</td>
</tr>
<tr>
<td>➢ Those reporting daily cannabis use were also using another substance besides alcohol. Those who only used cannabis and alcohol did not report using cannabis more frequently than once a month.</td>
</tr>
<tr>
<td>➢ Mental health issues may underlie a proportion of cannabis use in young people.</td>
</tr>
</tbody>
</table>

3.1.2 Describe the characteristics of those young people misusing substances in Suffolk, considering at-risk and vulnerable groups and the prevalence within these sub-populations

It is generally agreed that certain universal protective and risk factors exist for substance misuse in young people.
In this section, the reported characteristics of young people who we know to have used or misused substances are considered. Then, specific vulnerable populations are assessed for prevalence of substance misuse.

### 3.1.2.1 Characteristics of young people using substances

#### 3.1.2.1.1 National datasets

The CSEW reported that amongst young people aged 16 to 24, males were more likely to take drugs than females and that urban residents were more likely to take drugs than rural residents.\(^\text{13}\)

The *Smoking, Drinking and Drug Use among Young People in England 2016* report\(^\text{7}\) associated both drink and drug usage with older age amongst the 11 to 15 age group. In their multivariate regression analysis of survey responses, the factors associated with drinking in the last week were:
• Family don’t discourage drinking
• Drinkers at home
• White or mixed ethnicity
• Truancy
• Smoking
• Taking drugs
• Being older

Figure 20: Prevalence of having had an alcoholic drink in the last week by age, sex and ethnicity in the *Smoking, Drinking and Drug Use among Young People in England 2016* report

Only 3% of pupils who lived with only non-drinkers had drunk alcohol in the last week. Among pupils who lived with three or more people who drank, the proportion who had drunk alcohol in the last week rose to 21%, whilst the proportion who had never drunk fell to 31%. For having taken drugs in the last year, increasing age, truancy and use of other substances was again identified as an associated factor. However, unlike alcohol use, drug usage was more likely in those of Black or Asian ethnicity. Having taken drugs in the last year was equally likely in boys and girls.
The precise factors associated with having taken drugs in the last year on multivariate regression were:

- Family don’t discourage drug taking
- Black or Asian ethnicity
- Truancy
- Drinking alcohol
- Smoking
- Being older

Figure 21: Prevalence of having taken drugs in the last year by age, sex and ethnicity in the *Smoking, Drinking and Drug Use among Young People in England 2016* report

Regarding those who have attended specialist substance misuse services (as opposed to having ever used a substance), national NDTMS data for 2016/17 show two-thirds of the young people accessing specialist substance misuse services were male (66%) and half (50%) were aged 16 or over. Females in treatment had a lower median age (15) than males (16), with 28% of females under the age of 15 compared to 22% of males.
The ethnic breakdown of clients was similar to that in the wider population, with 76% White British. Over half (56%) were recorded as being in mainstream education (such as schools and further education colleges), followed by a further 19% in alternative education (such as schooling delivered in a pupil referral unit or home setting). A further 16% were recorded as not in employment, education or training (NEET). This profile was broadly similar to 2015-16. (83%) of those who supplied data about living situation were recorded as living with their parents or other relatives, while a further 3% reported living independently in settled accommodation. 8% of young people stated that they were living in care, with less than 1% living in secure care.

Young people can enter specialist substance misuse services with a range of problems or vulnerabilities relating to their substance use, seventeen vulnerability factors are identified within the NDTMS dataset. These are the range of risk factors that are most likely to be associated with problematic substance misuse among young people\textsuperscript{14}.

Table 4 highlights the number of young people reporting each of the vulnerabilities. Vulnerabilities are reported only for new clients entering specialist services during the year and therefore the total number reported (11,753) is lower than the total number of young people in treatment in 2016-17. An individual young person may report multiple vulnerabilities and therefore the percentages in this table may sum to more than 100%. 

---

**Figure 22**: Age and gender distribution of all young people in contact with treatment services 2016-17. Extracted from *Young people’s statistics from NDTMS 2016/17*\textsuperscript{14}, p14
The most commonly reported vulnerability was early onset of substance misuse, with 84% reporting use of their primary substance under the age of 15, followed by 58% reporting poly substance use (using more than one substance).

Table 4: Individual vulnerabilities identified among all young people in England starting specialist substance misuse treatment in 2016-17. Extracted from *Young people’s statistics from NDTMS 2016/17*, p25

<table>
<thead>
<tr>
<th>Vulnerability</th>
<th>Female</th>
<th>Male</th>
<th>Persons</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early onset of substance misuse</td>
<td>3,386</td>
<td>6,467</td>
<td>9,853</td>
</tr>
<tr>
<td>Poly substance user</td>
<td>2,527</td>
<td>4,290</td>
<td>6,817</td>
</tr>
<tr>
<td>Antisocial behaviour</td>
<td>740</td>
<td>3,009</td>
<td>3,749</td>
</tr>
<tr>
<td>Affected by others’ substance misuse</td>
<td>1,110</td>
<td>1,597</td>
<td>2,707</td>
</tr>
<tr>
<td>Affected by domestic abuse</td>
<td>1,093</td>
<td>1,411</td>
<td>2,504</td>
</tr>
<tr>
<td>Mental health problem</td>
<td>947</td>
<td>1,161</td>
<td>2,108</td>
</tr>
<tr>
<td>Self-harm</td>
<td>1,225</td>
<td>719</td>
<td>1,944</td>
</tr>
<tr>
<td>NEET</td>
<td>512</td>
<td>1,357</td>
<td>1,869</td>
</tr>
<tr>
<td>Looked after child</td>
<td>542</td>
<td>858</td>
<td>1,400</td>
</tr>
<tr>
<td>Child Protection Plan</td>
<td>451</td>
<td>477</td>
<td>928</td>
</tr>
<tr>
<td>Child in need</td>
<td>388</td>
<td>469</td>
<td>857</td>
</tr>
<tr>
<td>Sexual exploitation</td>
<td>565</td>
<td>123</td>
<td>688</td>
</tr>
<tr>
<td>High risk alcohol user</td>
<td>230</td>
<td>184</td>
<td>414</td>
</tr>
<tr>
<td>Pregnant and/or parent</td>
<td>104</td>
<td>123</td>
<td>227</td>
</tr>
<tr>
<td>Opiate and/or crack use</td>
<td>92</td>
<td>129</td>
<td>221</td>
</tr>
<tr>
<td>Housing problem</td>
<td>62</td>
<td>106</td>
<td>168</td>
</tr>
<tr>
<td>Injecting</td>
<td>43</td>
<td>51</td>
<td>94</td>
</tr>
</tbody>
</table>

**Total new presentations**

<table>
<thead>
<tr>
<th></th>
<th>Female</th>
<th>Male</th>
<th>Persons</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>3,949</td>
<td>7,804</td>
<td>11,753</td>
</tr>
</tbody>
</table>

3.1.2.1.2 Suffolk datasets

In the Risk Avert survey undertaken by 2,173 individuals in Suffolk schools in Year 8, pupils were asked ‘How wrong do your parents / carers feel it would be for you to drink alcohol regularly (at least once or twice a month)?’. 86% said their parents would find it ‘wrong’ or ‘very wrong’, 10% ‘a little bit wrong’ and 3% ‘not wrong at all’. Asked ‘How wrong do your parents / carers feel it would be for you to smoke cannabis?’, 98% said they would find it ‘wrong’ or ‘very wrong’, 1% ‘a little wrong’ and 1% ‘not wrong at all’.

In the separate Suffolk online survey of young people, of the 44 young people who reported ever having used a substance besides alcohol:

- The mean average age of the respondent (counting those using ‘20 or older’ as 20) was 16.4 years, and the most common age was 15 years
The average age of first drinking alcohol was 12 years, and the average age of first using drugs was 14.5 years.

50% were male, despite the fact that the survey was responded to by more females than males overall.

Only 2 reported a sexuality other than 'straight/heterosexual'.

Only 2 reported an ethnicity other than 'White British'.

23% (n=10) reported living in a village or countryside.

All except 1 individual (an unemployed individual beyond school or college age) were in school/college, employment or both.

**Figure 23: Prevalence of ever having used drugs in the Suffolk survey of young people**

![Figure 23](image)

**Figure 24: Breakdown of ages when first used drugs, within those who had reported that they had ever used drugs, in the Suffolk survey of young people**

![Figure 24](image)
All those who reported daily drug usage had also used at least two substances in their lives. Those who only reported alcohol and cannabis usage reported using cannabis no more frequently than once per week.

Interestingly, 8 of the 44 young people who indicated that they had taken a substance, also ticked the box ‘I have never taken drugs’ when asked about age at first drug usage. 5 of these used solvents/gas/aerosols, some of which may possibly be misunderstanding of the question. 2 had used legal highs once or twice and one had used cannabis once or twice. It is interesting that they did not perceive themselves as having ever taken drugs despite this.

3.1.2.1.2.1 Reasons for first use of drugs and alcohol

The characteristics of young people using substances include their reasons for first use. In the survey of young people, free text comments about alcohol mostly related to very limited experience (‘I had one sip’) in the context of family occasions such as Christmas, or curiosity.

Comments relating to other experiences included:

"The influence of boyfriends."
"I went to a house party and everyone did it so i did it"
"because just to see what its like"

However, most responses focussed on being allowed small sips of alcohol by parents at special occasions

Figure 25: Word cloud of most commonly occurring free text responses to the question ‘why did you first drink alcohol at that age, or why have you never drunk alcohol?’

Drank Problems Age Holiday Friends Gave Christmas Young Wanted Offered Drink Dad Alcohol Peer Pressure Party Social Parents Curious Family Dunno Taste Never Drunk Occasion Body Fun Reasons Sip

The responses around drugs were very different. In answer to the question ‘why did you take drugs the first time or why have you never taken drugs?’ most answers were that taking drugs was risky or unhealthy, and the language used about people who do take drugs was
very aggressive. Although having family members using drugs is a known risk factor for drug taking, some young people cited personal experience of seeing others struggle with drugs as their reason for never intending to take them.

**Figure 26: Word cloud of most commonly occurring free text responses to the question ‘why did you first use drugs at that age, or why have you never used drugs?’**

Illegal Mind Think Able They're Medical Body Never Appealed Point Effects Life Health Drugs Peer Pressure Never Wanted Wrong Risk Friends Cause Fun Stupid Money Dangerous Believe Kill

The stigmatisation of those who had used drugs by other young people was cited as a reason why some who had used drugs had not sought help. Certainly the opinion appeared somewhat polarised. This may reflect the generally young age of the sample – it has been found elsewhere that the acceptability of drug use by one’s age group increases with increasing age through adolescence. That some who discussed using cannabis, solvents or legal highs did not seem to think that they had ever used drugs also displayed an interesting disconnect about whether this issue is relevant to individuals.

"Because everyone else was taking them"
YP #293

"Because I fell into the wrong crowd."
YP #268

"At a festival where everyone else was using it"
YP #249

"Young people often feel the need to follow there peers, at my school many people in my year smoke and I feel like it’s a natural part of growing up, trying new things. Also if you don’t do anything like that you get called frigid which is the reason why I tried smoking in the first place”
YP #150
In terms of substance misuse in Suffolk, NDTMS data for Q4 of 2016/17 (the most recent publishable data) there were 114 people in treatment in Suffolk. This represented a 15% increase compared to the same period in 2015/16 whereas nationally numbers were lower compared to 2015/16 at the same time. As has been discussed above, this may still be lower than might be expected compared to national data.

Suffolk users were not different from the national picture in terms of most substance-misuse specific vulnerabilities, but a greater percentage of Suffolk users were poly drug users than is the case nationally and this was statistically significant (p=<0.01).

In terms of wider vulnerabilities (Box 2), the same or a greater percentage of Suffolk clients exhibited every single wider vulnerability compared to the national picture. This is an area that requires further investigation. In some cases the values were similar, but twice the percentage of Suffolk clients recorded anti-social behaviour or criminal acts, twice as many were affected by others’ substance misuse, twice as many self-harmed and nearly twice as many were looked after children.

It is possible that this reflects greater need in Suffolk, or that this reflects better recording practices in Suffolk, or that a few individuals with multiple vulnerabilities distorted the data. This is due to the relatively small numbers – i.e. a few people presenting all of the vulnerabilities will produce different results from a large number of people exhibiting just one of the vulnerabilities. It is also possible that the high level of specialist referrals which originate in Suffolk from the youth offending system select certain types of client with multiple vulnerabilities compared to areas with more referrals from universal services.

**Box 2: Wider vulnerabilities recorded in NDTMS data regarding young people accessing specialist substance misuse services**

- Looked After Child
- Child in Need
- Domestic Abuse
- Mental health problem
- Sexual exploitation
- Self harm
- NEET
- Housing problems
The numbers reported by NDTMS relate to those young people in treatment. An opportunity to examine the characteristics of all referred young people, not just those who took up treatment, has been provided by an evaluation of the DUST screening tool by Public Health Suffolk in 2017. This provides a picture of all referrals to specialist services in Suffolk from April 2013 to March 2016 (n=376), including those where the young person did not want to engage with the service after being assessed.

Of these referrals, 66% of the individuals were male. 65% were in the age group 15-17. 12% were children in care (looked after children). Around a third reported a family member using drugs or alcohol.

Around half the referrals came from young people in education, employment or training. 28% were school excluded or unemployed. 2% of referrals were linked to exploitation or abuse through sexual exploitation.

44% of those referred had difficulty sleeping and 20% reported headaches and blackouts. Around a third had mental health problems, and a quarter reported self-harm.

Conclusions

- Nationally, alcohol and drug misuse is broadly associated with increasing age, male gender and parental acceptance, and alcohol and drug misuse shows repeated association with mental health and wellbeing issues.

- Early onset of drug misuse has occurred in over 90% of young people who ultimately find themselves in specialist substance misuse treatment services.

- Amongst those who reported having used drugs in the online survey of Suffolk young people, the average age of first drug use was less than 15 years old, this is associated with increased risk of later problems.

- Drug usage appeared more common in males in the online survey.
➢ Some young people do not regard use of some substances as ‘taking drugs’ (e.g. solvent use/ cannabis/ ‘legal’ highs).

➢ Perception appears to play a role in drug use: There is an awareness that taking drugs is risky or unhealthy, as well as some individuals saying that seeing the impact of familial drug use put them off using drugs.

   However….

➢ Peer pressure and ‘what everyone else is doing’ remain strong motivators for young people to use or not use substances. Whilst some have used drugs, others are very strongly condemnatory of the behaviour, which may have the paradoxical effect of making it harder for those who have used to seek help.

➢ If those that need help feel stigmatised, and that they can’t ask for help, this could have a detrimental impact upon both physical health and mental wellbeing.

➢ Those in specialist treatment in Suffolk appear to have a greater percentage of all wider vulnerabilities and be more likely to be poly drug users than the national picture.

3.1.2.2 Prevalence of substance misuse in specific vulnerable populations

3.1.2.2.1 MASH dataset

MASH refers to Multi-Agency Safeguarding Hub. The main aim of a MASH is to improve the quality of information sharing and decision making between agencies at the earliest opportunity. This is historically a weak point in multi-agency child protection work. By combining the information held by the full range of agencies working with a child or family, the MASH process allows practitioners to build up a fuller picture of an individual child’s circumstances and history before deciding the most appropriate course of action to keep them safe.

The MASH dataset in Suffolk started in 2015/16. In that year there were 46,410 children in contact with the MASH, of whom 732 (1.6%) were highlighted with the risk factor of ‘drug’. 54% of these children were male.
In 2016/17, 42,363 children were in contact and 699 (1.7%) highlighted with the risk factor of ‘drug’. 61% of these children were male.

The prevalence in this dataset is not dissimilar to the prevalence in the wider population.

3.1.2.2.2 CAF dataset
CAF refers to Common Assessment Framework. The CAF is a shared assessment and planning framework for use across all children’s services and all local areas in England. It aims to help the early identification of children's additional needs and promote co-ordinated service provision to meet them. The CAF is a standardised approach to conducting an assessment of a child's additional needs and deciding how those needs should be met.

In the Suffolk CAF dataset, where a need has been recorded- a decreasing number of cases has been observed year on year (from 4,096 in 2013/14 to 3,101 in 2016/17). These totals exclude CAFs with no need recorded against them. When this is calculated as a rate, the decrease is statistically significant. However, the number of cases in which the child or young person’s substance or alcohol misuse is highlighted remains steady, and the rate has increased.

Figure 27: Rate of citation of CYP alcohol/substance misuse in CAF (per 1,000 cases referred) FYE 2013/14 to 2016/17

Nonetheless the actual prevalence of substance misuse in children in the CAF dataset is about 1% to 2% each year, similar to the MASH data and not very different to the wider population.

---

\(^1\) As a CAF can be used for any member of the 0-17 population, ONS 0-17 population data for the relevant year has been used as the denominator to calculate significance. Please note the revised ONS population data has been used (published March 2018 – due to increased data accuracy)
The greatest proportion of cases with substance or alcohol misuse highlighted were in the oldest age band of 15 to 17 years.

From 2013/14 to 2016/17 there were a total of 256 cases in CAF where substance or alcohol misuse was highlighted. In these cases, the most commonly co-occurring need was ‘CYP Mental Health/Emotional Wellbeing’, which was also noted in 33% of cases.

Table 5 highlights that in over 50% of cases of young people in the CAF database with substance and alcohol misuse recorded, mental health, emotional wellbeing and parent/child relationship needs also co-existed. It is important to note that more than two co-occurring needs can be recorded per young person, however this does appear to highlight a specific need around emotional wellbeing and family relationships for those misusing substances.
Table 5: Co-occurring needs recorded in young people in the CAF database who had ‘substance misuse’ recorded as a need (n=256) (note that more than two co-occurring needs can be recorded per young person)

<table>
<thead>
<tr>
<th>Need identified</th>
<th>Number of cases where need identified (note that each case may have several needs)</th>
<th>Percentage of cases with substance or alcohol misuse need where this need was co-identified</th>
</tr>
</thead>
<tbody>
<tr>
<td>CYP Mental Health/Emotional Wellbeing</td>
<td>84</td>
<td>32.8%</td>
</tr>
<tr>
<td>Parent/Child Relationship</td>
<td>67</td>
<td>26.2%</td>
</tr>
<tr>
<td>Education Attendance</td>
<td>46</td>
<td>18.0%</td>
</tr>
<tr>
<td>Parental Boundaries/Guidance</td>
<td>46</td>
<td>18.0%</td>
</tr>
<tr>
<td>CYP Behaviour</td>
<td>41</td>
<td>16.0%</td>
</tr>
<tr>
<td>Domestic Abuse/Violence</td>
<td>41</td>
<td>16.0%</td>
</tr>
<tr>
<td>Education Attainment</td>
<td>34</td>
<td>13.3%</td>
</tr>
<tr>
<td>Risk of Offending</td>
<td>33</td>
<td>12.9%</td>
</tr>
<tr>
<td>CYP Health/Development</td>
<td>25</td>
<td>9.8%</td>
</tr>
<tr>
<td>Housing Issues - Family</td>
<td>21</td>
<td>8.2%</td>
</tr>
<tr>
<td>Relationship with Siblings</td>
<td>18</td>
<td>7.0%</td>
</tr>
<tr>
<td>Parental Mental Health</td>
<td>18</td>
<td>7.0%</td>
</tr>
<tr>
<td>Parental Alcohol/Substance</td>
<td>15</td>
<td>5.9%</td>
</tr>
<tr>
<td>CYP Accommodation</td>
<td>13</td>
<td>5.1%</td>
</tr>
<tr>
<td>Parental Divorce/Separation</td>
<td>13</td>
<td>5.1%</td>
</tr>
<tr>
<td>Relationship with Peers</td>
<td>9</td>
<td>3.5%</td>
</tr>
<tr>
<td>Risk of Child Sexual Exploitation</td>
<td>8</td>
<td>3.1%</td>
</tr>
<tr>
<td>Financial Difficulty</td>
<td>7</td>
<td>2.7%</td>
</tr>
<tr>
<td>Bereavement</td>
<td>7</td>
<td>2.7%</td>
</tr>
<tr>
<td>Inappropriate Sexual Behaviour</td>
<td>4</td>
<td>1.6%</td>
</tr>
<tr>
<td>CYP Disability</td>
<td>3</td>
<td>1.2%</td>
</tr>
<tr>
<td>Social Isolation</td>
<td>3</td>
<td>1.2%</td>
</tr>
<tr>
<td>Other Reason</td>
<td>3</td>
<td>1.2%</td>
</tr>
<tr>
<td>Gang related issues</td>
<td>1</td>
<td>0.4%</td>
</tr>
</tbody>
</table>
3.1.2.2.3 Assessments for CIN, CPP, CiC

There is a dataset of assessments carried out for children who are classed as Child in Need (CIN) or on a Child Protection Plan (CPP) or who are a Child in Care (CiC).

This dataset shows that across calendar years 2015, 2016 and 2017 (to August), there were 12,341 children assessed. In 3,176 of children’s assessments, drugs or alcohol were raised as a concern (26% of all assessments). 48% of these assessments involved parental alcohol misuse and 43% parental or carer drug misuse. The alcohol misuse by the child was a concern in 429 (14%) of cases and drug misuse in 706 (22%) of cases.

This represents a range of approximately 6%-9% of children who have assessments having concerns with drugs and/or alcohol (depending on whether one assumes the drug and alcohol misuse always coexist or never do, the real value is likely to be somewhere in the middle). This is approximately 3x higher than the general population- and evidently a much higher prevalence than in the wider population in Suffolk, or even in children referred to CAF or MASH. The most recent national data, based on a survey of care leavers in 2012, identified 11% with substance misuse issues. It is not possible to confidently compare this to Suffolk, given the time difference and the potential difference in ascertainment between routine assessments and a research survey. However, one might assume it is broadly similar.

3.1.2.2.4 CiC Annual Health Assessments

Children in Care (CiC) have annual health assessments which are intended to include information about drug or alcohol misuse. There is a general impression that these data are relatively incomplete. These checks are carried out on children who have been in the care system for at least 1 year, and represent a rolling total count of CiC with a known substance misuse issue. Receipt of a substance misuse intervention is also recorded, although it is not clear what constitutes an ‘intervention’ in this context (i.e. whether it has to be specialist substance misuse service).

The rate of individuals being recorded with substance misuse issues in CiC does not appear to have decreased over time, although it is unclear if there is any particular trend, not least as apparent increases may represent better record keeping.
12% of referrals to specialist substance misuse service in Suffolk were accounted for by looked after children over a 3 year period.

3.1.2.2.5 Youth Offending Service

Between 1 September 2016 and August 2017 there were 176 young people with a completed youth justice board assessment (AssetPlus), 63% of these young people had evidence of substance misuse. This is the highest prevalence population identified in this needs assessment. A review of these 110 individuals found that 78% were male, reflecting the general YOS population.

The most common substance of misuse was cannabis, followed by alcohol. Only 1 of the 110 individuals was using a class A drug at time of assessment (cocaine). 50.9% of young people were using or had used only 1 substance.

Of the 110 young people there were 43 DUST assessments completed that could be identified for this report. Of the viewable assessments which could be followed up, 81% of those indicating a referral to Turning Point would be appropriate had in fact been seen, with the 19% not seen due to lack of consent or engagement by the young person. Some additional referrals were made of individuals scoring below threshold on the DUST form.
Some of those young people will need to engage with the service because their offence relates to drug or alcohol misuse and engagement with Turning Point is a requirement of their sentence.

(For further details of the YOS report please see Appendix 4)

<table>
<thead>
<tr>
<th>Conclusions</th>
</tr>
</thead>
<tbody>
<tr>
<td>➢ Within vulnerable populations in Suffolk, prevalence of substance misuse varies considerably.</td>
</tr>
<tr>
<td>➢ Substance misuse within children referred to MASH or CAF is not markedly different from the wider population.</td>
</tr>
<tr>
<td>➢ Substance misuse within children assessed as CIN, CPP or CiC is around 6 to 9% and thus considerably higher than in the wider population of this age group in Suffolk. This may be similar to the national picture.</td>
</tr>
<tr>
<td>➢ The annual health assessments of CiC indicate a range around 2-4% of substance misuse, which is likely to be an underestimate given the previous finding. CiC are about 0.5% of the population of young people but account for 20% of the specialist substance misuse service caseload.</td>
</tr>
<tr>
<td>➢ Around 12% of all referrals to specialist services are regarding CiC, but 20% of cases in treatment are CiC. This may reflect a greater likelihood of a CiC being followed-up (e.g. by social worker) to motivate attendance, compared to an average young person.</td>
</tr>
<tr>
<td>➢ In none of these populations is there any indication that prevalence of substance misuse is falling.</td>
</tr>
<tr>
<td>➢ Mental health and emotional wellbeing, as well as family relationships appear prominently as co-occurring needs in the Suffolk CAF dataset alongside substance or alcohol misuse.</td>
</tr>
<tr>
<td>➢ In young people having youth justice board assessments, substance misuse issues are recorded around ten times more frequently than in any other vulnerable population. Nonetheless, the same substances (cannabis and alcohol)</td>
</tr>
</tbody>
</table>
predominate. High ascertainment in this population may be partially driven by co-
located substance misuse workers within the YOS team.

3.1.3 Identify the services currently available to young people in Suffolk, including
universal awareness and education, and review the effectiveness of these
services in preventing and treating drug and alcohol misuse

3.1.3.1 What works?
The evidence base for interventions in young people misusing substances is somewhat
limited. A systemic review in 2014 to identify relevant high-quality evidence-based guidelines
on adolescent alcohol and drug misuse concluded that the best quality guidance available is
that produced by NICE in the UK.21 A literature review undertaken for this needs assessment
(see Appendix 3) did not identify any strong evidence for one particular intervention over any
other, and noted again that most of the research in this area is published from the USA,
where social norms are rather different and limit generalisability.

NICE has produced guidelines with regard to alcohol-based school interventions.20 NICE
assert that schools must ensure alcohol education is an integral part of the national science,
Personal, Social, Health and Economic (PSHE) education curricula, in line with Department
for Children, Schools and Families (DCSF) guidance. It should aim to encourage children not
to drink, delay the age at which young people start drinking and reduce the harm it can
cause among those who do drink. Education programmes should:

- increase knowledge of the potential damage alcohol use can cause – physically,
  mentally and socially (including the legal consequences).
- provide the opportunity to explore attitudes to – and perceptions of – alcohol use
- help develop decision-making, assertiveness, coping and verbal/non-verbal skills
- help develop self-esteem.
- increase awareness of how the media, advertisements, role models and the views of
  parents, peers and society can influence alcohol consumption.
- Introduce a 'whole school' approach to alcohol, in line with DCSF guidance. It should
  involve staff, parents and pupils and cover everything from policy development and
  the school environment to the professional development of (and support for) staff.
- Where appropriate, offer parents or carers information about where they can get help
  to develop their parenting skills. (This includes problem-solving and communication
  skills, and advice on setting boundaries for their children and teaching them how to
  resist peer pressure).
Schools should also:

- Where appropriate, offer brief, one-to-one advice on the harmful effects of alcohol use, how to reduce the risks and where to find sources of support. Offer a follow-up consultation or make a referral to external services, where necessary.
- Where appropriate, make a direct referral to external services (without providing one-to-one advice).
- Follow best practice on child protection, consent and confidentiality. Where appropriate, involve parents or carers in the consultation and any referral to external services.

It also requires Head teachers, school governors, healthy school leads and school nurses to work in partnership with extended school services, children's services (including the Children's Trust/children and young people's strategic partnership), primary care trusts (PCTs) [sic, guideline c. 2007], drug and alcohol action teams, crime disorder reduction partnerships, youth services, drug and alcohol services, the police and organisations in the voluntary and community sectors to:

- support alcohol education in schools as part of the national science and PSHE education curricula.
- ensure school interventions on alcohol use are integrated with community activities introduced as part of the 'Children and young people's plan'.
- find ways to consult with families (parents or carers, children and young people) about initiatives to reduce alcohol use and to involve them in those initiatives
- monitor and evaluate partnership working and incorporate good practice into planning.

For preventing substance misuse NICE advocates universal resilience-related interventions to improve social and emotional wellbeing\(^{22}\), together with targeted interventions for people in groups at risk. The latter should be delivered through a range of existing statutory, voluntary or private services, including: health services, such as primary care services, community-based health services, mental health services, sexual and reproductive health services, drug and alcohol services, and school nursing and health visiting services specialist services for people in groups at risk, community-based criminal justice services, including adult, youth and family justice services accident and emergency services.

They advise that at routine appointments and opportunistic contacts with statutory and other services, such as those listed above, the professional should assess whether someone is vulnerable to drug misuse.
There are no NICE guidelines for substance misuse specific to young people – they advise use of the guidelines for over-16s when substance misuse is found in a young person.

### 3.1.3.2 Universal services

Young people in Suffolk have access to a range of universal services that are similar to those offered elsewhere in England. Schools are strongly recommended to include drugs and alcohol education in PSHE, and make pupils aware of reputable sources of online information such as the FRANK website.

The 'Risk Avert' initiative which aims to identify young people at increased risk of dangerous behaviours was funded by Public Health in some Suffolk schools for two years. However public funding for this program has now ended.

Pupils at schools also have access to school nurses, including via Chat Health, a confidential text based service.

Suffolk County Council oversees the young people’s website – The Source – which includes information and sources of help relating to drugs and alcohol ([http://www.thesource.me.uk/health/](http://www.thesource.me.uk/health/)).

4YP (Suffolk Young People’s Health Project) is a Suffolk charity based in Ipswich offering drop in sessions on all health related aspects including drugs and alcohol. 4YP also offers a web based chat service – Ask the Expert – for young people seeking confidential help and advice. Young people could until recently access the specialist substance misuse service, Turning Point, at the Ipswich premises of 4YP. Turning Point are still available at community hubs, but not in any youth-specific locations.

### 3.1.3.3 Specialist services – not substance focussed

Young people may also self-refer or be referred to sexual health services or child and adolescent mental health services (CAMHS) which may intersect with issues of substance misuse. They may interact with police community support officers (PCSOs) or the youth offending team. If additional needs are identified, young people may be referred to the MASH or be assessed via CAF. Children with higher levels of vulnerability would be subject to Child in Need status (CIN) or might be placed on a Child Protection Plan (CPP), or eventually become a Child in Care (CIC). In these latter groups the risk of substance misuse is increased.
A number of voluntary and charitable sector organisations offer universal and targeted services to children and young people. These range from drop-ins in local churches in village settings to LGBT outreach and street workers engaging young people in Felixstowe.

### 3.1.3.4 Specialist services for substance misuse

At any point, a child can self-refer to Turning Point or may be offered a referral by any worker engaged with them. Turning Point is the only specialist substance misuse service commissioned in Suffolk. Although private sector groups operate in the county for adults, and might be accessed by those over 18, there is no service for those young people younger than this.

Turning Point delivers support for young people misusing substances as part of an integrated service with adult provision. Turning Point’s service specification includes the provision of treatment but also advice and guidance, and brief interventions for those with lower complexity. Turning Point workers are also embedded in local Youth Offending Service teams.

### 3.1.3.5 Experiences of service use

#### 3.1.3.5.1 Universal services and PSHE

Young people replying to the Suffolk online survey were asked to rate the help at their school around drugs and alcohol out of 5 (with 1 being lowest and 5 being highest). 284 young people rated this item. The average score was 2.8 out of 5 (56%).

**Figure 30: Responses to the question ‘How would you rate the help at your school around drugs and alcohol’**
There were 162 free text comments in addition to the rating. Most of the comments (n=60) were broadly approving if not enthusiastic.

“We have had one or two assembles and one of the was really helpful”
YP aged 13, drinks alcohol about once a month

“Information is good. Handling of cases is poor as they don’t care if it wasn’t on their land”
YP aged 16, drinks alcohol about once a month

“I was given a brief explanation of all the main substances in year 8, though I wish they had given further insight into how the drugs affected the body.”
YP aged 15, drinks alcohol about once a month

37 commented to say that they did not receive drugs and alcohol related PSHE education. 12 specifically mentioned that they had assemblies on the topic but that this was insufficient. 12 explained that they had rated their school provision poorly because young people still used drugs and alcohol and they were aware of this in their peer group, therefore the school had not succeeded.

“It would be more helpful if the school actually taught you more about it instead of just saying don’t do it. Everyone gets taught you’ve gotta do things once just to try it but they should teach about addiction and how to quit. this school is f***ing useless in actually communicating with teenagers and anyone in our school, yes there is the school nurse but shes only in on Thursdays and thats not good enough for the amount of people in this school.”
YP aged 14, has drunk alcohol three or four times

“Everyone seems to smoke something now and none of them seem to ever stop”
YP aged 16, has drunk alcohol three or four times

“no one is going to talk to professionals about drugs unless they are being forced to or are worried for their health”
YP aged 16, drinks alcohol about once a week

6 discussed issues with accessing help at school due to stigma, and how a harm reduction approach might be more successful.
“would help if they used a more how to drink safely rather than abstinence approach”

YP aged 16, drinks alcohol regularly

“They don’t care. If you ever do drugs or drink alcohol and publicise it you’re villainised and made to look like an idiot which in my opinion is dangerous because it just leads to you using those substances more which can lead to addiction”

YP aged 16, has used cannabis once or twice

“I have friends who got excluded for use of drugs and alcohol in school and did not get adequate help at the time.”

YP age 14, has drunk alcohol three or four times

3.1.3.5.2 Specialist help for drug or alcohol use

96% of all the young people (n=356) who answered the survey about substance misuse, said they had never needed specialist help regarding drugs or alcohol. 2% said they had needed help, but had not asked for help. 2% said they had needed help and sought it out. This equates to about 4% of the overall respondent population saying they felt that they had needed substance misuse services. Modelled across the entire Suffolk 13-24 population, this might represent about 3,700 young people. This is over lifetime rather than a point prevalence, as the Turning Point NDTMS data represent, but is still around ten times higher than the rolling numbers in treatment over the last several years.

Amongst the 44 young people who reported ever having used a substance other than alcohol, 86% said they had never needed help regarding drugs or alcohol. This group included 3 of those who said they had accessed help, and 3 who had needed help but not accessed it.

These numbers are very small and potentially not generalisable, but do indicate that for every person who accesses support regarding drugs and alcohol, an equal number of people may feel that they need help, but not express this need by seeking it.

“I feel as if I would be frowned upon and judged if I asked for help, people would never know that I take drugs, I work full time”

YP aged 20+, uses cocaine once a week, has used cannabis, ecstasy, ketamine and magic mushrooms, first used drugs age 15
“i was in a really bad place on a few occasions and it changed me as a person and it even still affects me now. i have done loads of things i regret from taking drugs and alcohol. it made me depressed too. i needed help and i knew it but i couldn’t ask for it and it was really obvious however no one helped”

YP age 15, takes cannabis once a day, has used ecstasy and legal highs, first used drugs age 13

“my parents have told me to go to turning point …Trouble is I just want the consequences to stop, I don’t want to stop using - I like the way it makes me feel”

YP age 18, uses cannabis every day

Several of those who reported using substances besides alcohol said they had not needed help, but also commented in ways that suggested they may not have been aware of help.

“where is there to go?”

YP aged 18, has used cannabis once or twice, first used drugs age 16

“there’s no help”

YP age 16, has used solvents once or twice, first used drugs age 15

“I don’t know what help is available”

YP age 17, has used cannabis three or four times, first used drugs age 17

“no one helps”

YP age 15, has used cannabis three or four times, first used drugs age 15

It may be possible that some of the barriers around using specialist services are accessibility issues, as this comment may imply:

“Hardly any help is provided for drugs or alcohol in Haverhill or at school, it’s truly disgraceful because so many people I know take drugs and alcohol yet they have no one to turn to. It would be great if a youth club or a unit was placed/built in Haverhill to help kids over their addictions because these minor problems could turn big quickly. Please improve”

YP #207
3.1.3.5.2.1 Feedback from Turning Point service users

Feedback regarding the Turning Point service was gathered from service users via feedback sheets completed at the end of treatment, and some were made available for this needs assessment. One was undated, one was from 2011 and two were from 2017. They were very positive about the service. Those completing (and thus able to fill in this feedback) are likely to have had a more positive experience than early, unplanned exits.

Service User #1 (undated)

- “Changed my views on drugs”
- “Helped a lot with sorting family problems”
- “a lot of help with finding new jobs”
- “showed me it is important to keep friends if the right ones”
- Turning Point rating 7-10/10

Service User #2 (2011)

- “I’ve cut down”
- Turning Point rating 10/10

Service User #3 (2017)

- “I don’t have to smoke everyday and won’t anymore”
- “Feel better and more motivated”
- “Mental health improvement overall”
- “talking about it has helped me cut down”
- Turning Point rating 6/10

Service User #4 (2017)

- “Over the last few months I have decreased drug and alcohol use gradually”
- “I talk to family a lot more now”
- “I cope a lot better with daily tasks”
- “Sustain friendships without drugs involved”
- “the service showed me how dangerous drugs can be and opened my eyes”
- Turning Point rating 9/10

One young person responding to the online survey had also had experience with Turning Point. It is not clear whether they actually engaged in a treatment or spoke to a worker on the phone or via drop-in. It is also not clear how much of their experience relates to Turning Point and how much to their community psychiatric nurse (CPN).
“I smoke cannabis to help with sleep, I have a mental health diagnosis and struggle with sleep even with prescribed medication. I spoke to both my cpn and turning point and was treated very differently as soon as they knew about my drug use. This would 100% deter me from seeking help again, extremely judgmental”
YP #333

Another responded:
“A friend has seen someone and said it was ok. Someone at turning point helped him stop using drugs”
YP #284

3.1.3.6 Ways to improve the services available
In the online surveys of professionals, VCS and young people, comments were invited regarding ways in which services could improve to better suit the needs of all stakeholders. Echoing the findings of the DUST assessment and the subsequent focus groups, many professionals wanted more information about what services were available and how best to make use of them. There was also an appetite for more training to upskill frontline workers to put brief interventions, and reflections on the systems-wide approach needed to address young people for whom substance misuse may be a symptom rather than a cause of wider vulnerabilities.

“More training would be helpful about what services there are and how we can support young people in the early stages of drug use.”
CYPS #8 (Coastal and Ipswich)

“better working with social worker or more support and befriending workers who could support YPs to engage with services. More cascading of service and 'micro' intervention that social workers could use themselves with YPs.”
CYPS #24

“It would be helpful to have better links with my service and more information about these services - what is available and referral criteria.”
CYPS #29

“Drug use is generally one aspect of the intervention with housing, unemployment/non school attendance, and mental health all significant factors. It is hard to put interventions in place regarding drug use when housing generally becomes the most pressing issue.”
CYPS #34 (Haverhill)
“the threshold for getting support is too high. Available services should be promoted more amongst the professionals who can refer people.”
CYPS #35 ( Lowestoft)

“There isn't enough for the low level use, it appears someone has to have a significant issue before being seen”
VCS #5

<table>
<thead>
<tr>
<th>Conclusions</th>
</tr>
</thead>
<tbody>
<tr>
<td>➢ Young people in Suffolk have access to a range of universal and targeted services regarding drug and alcohol use. However, some information is not up to date and there is some lack of awareness of what services are, in fact, available.</td>
</tr>
<tr>
<td>➢ There is the possibility that in Suffolk that there are 10x more young people requiring specialist help with drugs and/or alcohol than actually access it.</td>
</tr>
<tr>
<td>➢ Young people in Suffolk do not rate their experience of PSHE around drugs and alcohol highly, with 37 commenting that they have never had lessons on this topic.</td>
</tr>
<tr>
<td>➢ There is an appetite for more in-depth information, rather than a 'just say no' message. This coheres with NICE guidance.</td>
</tr>
<tr>
<td>➢ It is unfortunate that the Risk Avert intervention, which closely follows NICE guidance on universal and targeted substance misuse prevention, is no longer commissioned in schools.</td>
</tr>
<tr>
<td>➢ Many young people in Suffolk are not aware of the help which is available to them regarding drugs and alcohol.</td>
</tr>
<tr>
<td>➢ Users who have successfully accessed and completed treatment with Turning Point appear to rate it well, however barriers evidently exist to reaching this position.</td>
</tr>
<tr>
<td>➢ Professionals also feel they do not know enough about specialist substance misuse services and how to access them, and would like more information about how to address substance misuse issues in their own practice.</td>
</tr>
</tbody>
</table>
3.1.4 Identify and review the processes by which young people are referred to specialist treatment services by other professionals working with young people, or via self-referral, considering whether this meets the needs of young people

Specialist services in Suffolk for young people are Open Access. Theoretically, any concerned individual, or a young person themselves, can initiate referral of a young person (with that young person’s consent) to the Suffolk specialist treatment service for young people, Turning Point.²²

NDTMS groups referral sources for clients into eight groups

- Children & Family Services
- Education Services
- Health & Mental Health
- Accident & Emergency
- Substance Misuse Services
- Youth Justice Services
- Self, Family & Friends
- Other (including missing)

Nearly half of all clients attending Turning Point in Suffolk had their referrals originating from the Youth Justice Services. In the most recent data this was 48% of clients. It should be noted that these data are for clients who took up the offer of the service, and that because some Youth Justice Service users are legally obliged to undertake treatment, they are perhaps more likely than other sectors to see referrals translate to attendance. However, the Public Health Suffolk assessment of the DUST screening tool (which did consider all referrals, not just those taken up) also found 50% of referrals to originate from Youth Justice Services, suggesting it is genuinely the main source. The co-location of Turning Point workers with the 4 main Suffolk Youth Offending Service teams, a feature of the service specification, may also somewhat account for this pattern.

This contrasts with the national picture, where the youth justice system makes up a smaller proportion of referrals. Nationally, the most common routes into specialist substance misuse services in 2016/17 were from education provision (29%), youth justice services (25%), and children’s social care (15%). The proportion of referrals from the youth justice system has declined in recent years while the proportion of referrals from education provision has
increased. In view of the epidemiological data assessed in the earlier part of this report, it is more likely that the numbers in Suffolk represent under-referral from other sectors in Suffolk compared to the national picture, than that the youth justice system over-refers, especially in view of the specialist workers embedded.

In Suffolk, several quarters have passed without any successfully taken up referrals from Accident and Emergency at all (0% in the last 2 measured financial quarters). Although Accident and Emergency make up only 2% of all referrals nationally, this may nonetheless represent a missed opportunity, in Suffolk and indeed across England. As has been seen earlier in this report, attendances relevant to substance misuse at Accident and Emergency have been increasing, and such encounters may represent good opportunities to identify those at risk of harm.\textsuperscript{22}

An A&E nurse contacted regarding this issue responded:

“\textit{We do not have direct access to any specific specialist services but would signpost people to 4YP when appropriate.}”

It is not clear that awareness of the referral mechanism to Turning Point, DUST tool etc is well understood in the hospital setting. By contrast, Suffolk has a rate of referral from ‘Health and Mental Health’ sector similar to national data.

The online surveys asked professionals and VCS workers about their experience of referring young people to specialist substance misuse services in Suffolk. The reader is referred to the assessment of the DUST screening tool and it’s use by Public Health Suffolk for a more thorough investigation of this issue\textsuperscript{ii}.

The school nurses (n=5) had all referred a young person for substance misuse treatment and gave the specialist services a weighted average of 4.33 out of 5 (87%).

“The services are easy to refer into and you can talk through your referral with them to make sure you are referring to the correct service the young person needs and if there is anything else they would recommend”

\textbf{SN #3}

\textsuperscript{ii} \url{https://www.healthysuffolk.org.uk/advice-services/adults/drugs-and-alcohol/drug-and-alcohol-treatment-services}
Amongst the CYPS professionals 51% (n=23) reported having ever referred a young person to specialist substance misuse services. All who had referred rated the service, giving an average 3.33 out of 5 (67%). Opinions on the experience were mixed:

“Referred to Turning point, very helpful and smooth process”
CYPS #4 (Lowestoft)

“I’ve encountered no problems with referrals.”
CYPS #28 (All Suffolk)

“After the referral was made, there was little communication about whether the client had been seen and what the proposal for treatment would be. There was little evidence of joint working. Like most services, the thresholds for treatment are so high and many young people fall through the net.”
CYPS #43 (All Suffolk)

“It wasn’t easy to find out who to refer to and how to refer. Once I found this information it was straightforward. Not entirely sure what is available and criteria for referral.”
CYPS #29 (Lowestoft)

“Too slow, never another staff to process referral. It seems at times the service is looking for a reason to stop working with the young person to manage their own case loads. Often hear back that the young person has not engaged - but little on the efforts made to engage with the YP who is known to be chaotic anyway. It seems the YP has to be functioning well, organised and proactive to gain a good service - a quality not many YP have, least those with substance misuse issues.”
CYPS #24 (Bury St Edmunds)

“I have one experience of a positive outcome but generally the services are over stretched and not fit for purpose. Many people I work with refer to turning point as a place to get a methadone script and get drug tested and not much else.”
CYPS #5 (West Suffolk)

Amongst the VCS respondents, nine said they had experience of referring a young person to specialist substance misuse services. They gave services a weighted average of 3.88 out of 5 (78%).
“always a prompt pick up of anyone I refer”
VCS #14 (Lowestoft)

“121 support was outstanding and was very practical in supporting a young person to give up using and also had a knock on effect on the family for the better.”
VCS #5 (Mid Suffolk)

“It was a mixed response as the young person is still using. They didn’t deal with the parents who were using too.”
VCS #13 (Suffolk Coastal)

“The waiting list was long and little communication”
VCS #12 (All Suffolk)

“Ease of access was an issue - as was available information about services that was didn’t rely on access to internet”
VCS #4 (Ipswich)

As is highlighted by Hogue et al in their 2014 review, which looked at international data but which may also apply to Suffolk, most of those young people who end up using specialist substance misuse services are referred by providers of another service, which usually indicates a co-occurring behavioural disorder or other vulnerability. This means that those who for whatever reason are able to avoid contact with other services may ‘fly under the radar’, creating a treatment gap between degree of normative need (which may also be felt need) and degree of service utilisation (expressed need).

3.1.5 Identify and review the processes by which those working with young people identify and assist young people with substance misuse issues

Of the 50 professionals who answered surveys for this needs assessment, 36 answered the question ‘If you were concerned about substance misuse in a young person, what might you do to access help for them?’ 36% specifically mentioned Turning Point in their reply, but only one specifically mentioned a DUST form. Most mentioned ‘local drug and alcohol services’ but it was not necessarily apparent they knew which service this was in Suffolk. One mentioned the Matthew Project, which does not now operate in Suffolk.
Of the 21 VCS workers who responded to the online survey for this needs assessment, 19 answered the question ‘How confident would you feel in dealing with a young person attending your organisation misusing substances?’. Most described feeling ‘fairly’ or ‘very’ confident. 5 specifically mentioned Turning Point, all seemed aware of the existence of a specialist service to refer to (hard to assess as many answered the question with simply ‘yes’). Several free text comments expressed interest in additional training.

It is concerning that work around the DUST screening tool indicates many professionals are unaware of the DUST screening tool. Use of a validated measure for detecting substance use and abuse is significantly more effective than unvalidated tools or provider intuition.24

4 DISCUSSION

4.1 STRENGTHS OF THIS NEEDS ASSESSMENT
This needs assessment was able to draw on a variety of data sources, including national, county and individual data to identify needs around substance misuse in young people in Suffolk. The availability of diverse sources allowed triangulation of results, increasing confidence in the accuracy of the findings. For example, national data modelling suggested about 17% of Suffolk young people aged 11-24 would ever have used drugs, and the survey of young people in Suffolk found 16% prevalence.

This needs assessment was able to undertake participatory assessment, involving key stakeholders including professionals, the voluntary sector and young people themselves. The high number of young people responding to the survey makes a valuable source of information about how the key service users feel, giving this group a voice.

This needs assessment was able to consider the universal population of young people, and those with specific vulnerabilities such as those in the MASH database.

4.2 LIMITATIONS OF THIS NEEDS ASSESSMENT
The challenges of separating substance use from substance misuse in young people are a problem for this field of research, including this needs assessment. We can be more confident in estimating use than misuse.

The figures for usage and misuse may be under-estimates where data is based on surveys that a young person would have to have been in mainstream school to reply to. This includes
the national surveys and the survey undertaken for this needs assessment. Those not in
school are also more likely to have substance misuse issues. The use of national data to
model numbers in Suffolk may also not always be appropriate due to lack of generalisability.
The figures for use of specialist services are likely to underestimate need. This is due to the
barriers, both generally and in Suffolk, to young people accessing specialist services. Lack
of awareness of the service, complex referral pathways, lack of insight into behaviour and
fear of stigma may all prevent a young person accessing the help they need.

As discussed in the relevant section, hospital data are non-specific to substance misuse.
When comparing the prevalence of substance misuse across different vulnerable groups, it
must be borne in mind that young people subject to social care assessments will be more
closely scrutinised than those in the general population, and that the rate of detection of any
issues will be higher. This may slightly overestimate the differences in prevalence between
these groups.

Although Turning Point professionals were on the steering group for this needs assessment,
and data from the Turning Point feedback sheets has been included, this needs assessment
was not able to speak directly to Turning Point service users.

5 CONCLUSIONS

Suffolk offers a specialist substance misuse service for young people, to which barriers to
access appear to exist, or are certainly perceived by some professionals. This includes lack
of awareness of the service and a perception that it must have a high threshold for service
users.

Equally concerning is the gap around universal prevention, and early prevention options for
those with early substance misuse issues. The offer in schools appears variable, and young
people are not fully aware of sources of information and support. That some users of
solvents or cannabis do not regard themselves as having used drugs indicates a
phenomenological gap between professionals and young people.
APPENDICES

Needs assessment reference group:
Alison Amstutz
Graham Beamish
Allison Chaplin
Nicki Cooper
Ruth Croft
Anita Farrant
Julia Ilott
David Jacobs
Sharon Jarrett
Robin Pivett
Eleanor Powers
Jodie Rendell
Vikki Versey

With thanks to Fran Catchpole for access to the DUST focus groups

Thanks to those who have assisted with data gathering, and Stephen Patterson for carrying out the data analysis

Supervised by Dr Mashbileg Maidrag, Public Health Consultant
7.1 LITERATURE SEARCH

A systemically structured literature search was undertaken in the Ovid MEDLINE(R) Epub Ahead of Print, In-Process & Other Non-Indexed Citations, Ovid MEDLINE(R) Daily, Ovid MEDLINE and Versions(R) database in August of 2017, to attempt to identify if early intervention was comparable to specialised services.

The following search strategy was employed:

<table>
<thead>
<tr>
<th></th>
<th>Description</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>exp Substance-Related Disorders/</td>
<td>260256</td>
</tr>
<tr>
<td>2</td>
<td>adolescent/ or child/</td>
<td>2618114</td>
</tr>
<tr>
<td>3</td>
<td>Young Adult/</td>
<td>630982</td>
</tr>
<tr>
<td>4</td>
<td>2 or 3</td>
<td>2901290</td>
</tr>
<tr>
<td>5</td>
<td>&quot;Early Intervention (Education)&quot;/</td>
<td>2486</td>
</tr>
<tr>
<td>6</td>
<td>early intervention.mp.</td>
<td>15837</td>
</tr>
<tr>
<td>7</td>
<td>Crisis Intervention/</td>
<td>5598</td>
</tr>
<tr>
<td>8</td>
<td>(intervention and early).mp. [mp=title, abstract, original title, name of substance word, subject heading word, keyword heading word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms]</td>
<td>71223</td>
</tr>
<tr>
<td>9</td>
<td>*Child Welfare/</td>
<td>14583</td>
</tr>
<tr>
<td>10</td>
<td>5 or 6 or 7 or 8 or 9</td>
<td>90974</td>
</tr>
<tr>
<td>11</td>
<td>1 and 4 and 10</td>
<td>1236</td>
</tr>
</tbody>
</table>

Articles were excluded if greater than 10 years old, not conducted in humans or not in English. Due to the volume of returns and the capacity of the search, results were further limited to review articles.
Table 1: Review articles regarding early interventions for substance misuse

<table>
<thead>
<tr>
<th>Lead author</th>
<th>Year</th>
<th>Conclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carney</td>
<td>2012</td>
<td>A systematic review of early interventions for adolescent substance use and behavioural outcomes. Early interventions for adolescent substance use do hold benefits for reducing substance use and associated behavioural outcomes. Interventions are most promising if delivered in an individual format and over multiple sessions. Shifting focus away from just substance misuse to wider behaviour. Nine studies in a variety of settings, including schools, juvenile prison. 8 in USA, one Australia. 8 brief motivational interviewing. This review therefore adds valuable evidence for interventions that address two risk behaviours simultaneously. This indicates the effectiveness of treating adolescents early as their substance use progresses, that is, before they need specialised treatment.</td>
</tr>
<tr>
<td>Carney</td>
<td>2014</td>
<td>There was limited quality evidence that brief school-based interventions were more effective in reducing substance use than the assessment-only condition, but were similar to information provision. The intervention should have been labelled as a BI, but could also have been defined as motivational interviewing, brief skills orientation, motivational enhancement, or other specific types of BIs, which were up to four sessions long and used BI principles to facilitate change. The focus should have been on building the individual's motivation to change. The BIs could have been offered as a stand-alone option, integrated with other intervention efforts, or as a precursor to other treatments. Only BIs that were offered to individuals in a face-to-face modality were included in this review.</td>
</tr>
<tr>
<td>Onrust</td>
<td>2015</td>
<td>The present study provides an overview of universal and targeted programmes, while distinguishing four age groups and examining which intervention characteristics are the effective components.</td>
</tr>
</tbody>
</table>
for the respective groups. The findings support our hypothesis that specific aspects of the school-based programmes are effective in some developmental stages, but not for other age groups. The differences in effectiveness are systematically related to psychological and cognitive needs and capacities.
A second systematically structured search was undertaken to attempt to identify the most effective interventions for young people who misuse substances.

A structured search was undertaken in August 2017 in the database Ovid MEDLINE(R) Epub Ahead of Print, In-Process & Other Non-Indexed Citations, Ovid MEDLINE(R) Daily, Ovid MEDLINE and Versions(R)

Search Strategy:

<table>
<thead>
<tr>
<th>Search Term</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>exp Substance-Related Disorders/</td>
<td>260207</td>
</tr>
<tr>
<td>adolescent/ or child/</td>
<td>2617495</td>
</tr>
<tr>
<td>Young Adult/</td>
<td>630417</td>
</tr>
<tr>
<td>2 or 3</td>
<td>2900407</td>
</tr>
<tr>
<td>1 and 4</td>
<td>61371</td>
</tr>
<tr>
<td>exp Therapeutics/</td>
<td>4010197</td>
</tr>
<tr>
<td>Crisis Intervention/</td>
<td>5597</td>
</tr>
<tr>
<td>treatment.mp.</td>
<td>4230276</td>
</tr>
<tr>
<td>6 or 7 or 8</td>
<td>6918808</td>
</tr>
<tr>
<td>5 and 9</td>
<td>21354</td>
</tr>
</tbody>
</table>

Articles were excluded if greater than 10 years old, not conducted in humans or not in English. Due to the volume of returns and the capacity of the search, results were further limited to review articles. 589 articles were reviewed in abstract form for relevance. Articles were only included if they reviewed original research on interventions for substance misuse and could be accessed in full text form via the NHS Athens system or the Audrey Keep Library request service. 23 papers were identified for final inclusion (Table 2)
<table>
<thead>
<tr>
<th>Author</th>
<th>Year published</th>
<th>Study topic/method</th>
<th>Results</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Merz(^{27})</td>
<td>2017</td>
<td>Brief interventions to prevent recurrence and alcohol-related problems in young adults admitted to the emergency ward following an alcohol-related event</td>
<td>Four trials (n=618) were included, comparing a brief motivational interview with usual care (2 trials), personalised feedback or an educational brochure. In two studies, motivational interview was significantly associated with a reduction in alcohol-use while two studies showed no effect attributable to the intervention.</td>
<td>The evidence is inconclusive, but the most effective interventions include at least one therapeutic contact several days after the event.</td>
</tr>
<tr>
<td>Van der Pol(^{28})</td>
<td>2017</td>
<td>The effectiveness of multidimensional family therapy in treating adolescents with multiple behaviour problems</td>
<td>Compared with other therapies, the overall effect size of MDFT was significant, albeit small in magnitude. Moderator analysis revealed that adolescents with high severity problems, including severe substance abuse and disruptive behaviour disorder, benefited more from MDFT than adolescents with less severe conditions.</td>
<td></td>
</tr>
<tr>
<td>Borus(^{24})</td>
<td>2016</td>
<td>Screening, Brief Intervention, and Referral to Treatment</td>
<td>Use of a validated measure for detecting substance use and abuse is significantly more effective than unvalidated tools or provider intuition.</td>
<td>Response to a substance use screen is intended to prevent, delay, or reduce substance use and associated risky behaviours</td>
</tr>
</tbody>
</table>
and, if indicated, encourage an adolescent to accept a referral to treatment.

<table>
<thead>
<tr>
<th>Author</th>
<th>Year</th>
<th>Title</th>
<th>Summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Goorden</td>
<td>2016</td>
<td>The cost effectiveness of family/family-based therapy for treatment of externalizing disorders, substance use disorders and delinquency</td>
<td>The quality of the identified economic evaluations of family/family-based therapy for treatment of externalizing disorders, adolescent substance use disorders and delinquency was insufficient to determine the cost-effectiveness.</td>
</tr>
<tr>
<td>Marsch</td>
<td>2016</td>
<td>Technology-based Interventions for Preventing and Treating Substance Use Among Youth</td>
<td>Interventions that leverage computer, mobile, and Web technologies are appealing to youth, require minimal cost, deliver therapeutic content in a consistent and standardized manner, minimize burden on staff, and can be tailored to different individuals and treatment settings. Technology is well suited as a means of providing universal prevention, selective prevention, and treatment interventions that can fully or partially replace face-to-face interactions with prevention or therapeutic staff (thereby reducing costs).</td>
</tr>
</tbody>
</table>
and freeing staff to attend to more patients) or augment standard services under a clinician extender model

| Passetti\textsuperscript{31} | 2016 | Continuing Care for Adolescents in Treatment for Substance Use Disorders | Assertive approaches (counsellor-initiated home or school-based continuing care) increase linkage to continuing care, and rapid initiation of continuing care makes a difference in reducing substance use. Findings suggest that continuing care is appropriate for those who successfully complete treatment. Our review found 10 outcome studies of continuing care treatment for adolescents, 6 of which used randomized designs. 5 resulted in clinical improvement for youth receiving the experimental continuing care approaches | Adolescent relapse rates during the year after treatment often exceed 60%, and many youth cycle between periods of substance use and abstinence |

| Stanger\textsuperscript{32} | 2016 | Advances in Research on Contingency Management for Adolescent Substance Use | The literature on the use of contingency management (CM) for reducing adolescent substance use continues to grow and generally shows positive effects for enhancing outcomes during treatment. | Narrative review As with other models of treatment, obtaining enduring effects post-treatment remains a challenge, and tests of innovative CM programs targeting maintenance are lacking |
Benningfield33  2015  The Role of Schools in Substance Use Prevention and Intervention

Individual treatment for SUD is effective at decreasing substance use as well as substance-related harm. In some contexts, rather than being helpful, group interventions can result in harm to participants; therefore, individual treatment may be preferred. Early interventions for adolescents using alcohol and other drugs (AOD) are generally effective in decreasing frequency and quantity of AOD use and decreasing risky behaviours.

Diestelkamp34  2015  Brief in Person Interventions for Adolescents and Young Adults Following Alcohol-Related Events in Emergency Care

Seven randomised controlled trials (RCT), 6 practice projects, 1 nonrandomised pilot study and 1 observational study were identified. Six RCTs found reductions of alcohol use for all participants. Four RCTs found effects on alcohol consumption, alcohol-related risk-behaviour or referral to treatment. Heterogeneity of study designs and effects limit conclusions on effectiveness of BIs for young ED patients following an alcohol-related event.
| **Bekkering**<sup>21</sup> | 2014 | Systematic review to identify relevant high-quality evidence-based guidelines on adolescent alcohol and drug misuse | Identified 32 relevant evidence-based guidelines on substance misuse among adolescents. Nine guidelines were judged to be of high quality; of which four had recommendations specifically on adolescents: one on school-based prevention, one on substance misuse prevention in vulnerable young people and two on alcohol misuse with specific sections for the adolescent population. There were few commonalities as guidelines focused on different target groups, professional disciplines and type and level of substance misuse. Evidence to support the recommendations was sparse, and many recommendations were based on expert consensus or on studies among adults. Also, the link between evidence and recommendations was often unclear. | The good quality guidelines were all NICE guidelines |
| **Healey**<sup>17</sup> | 2014 | Underage drinking in the UK: Changing trends, impact and | Only 7 out of 45 randomised controlled trials (RCTs) identified for this review included children and adolescents under | Alcohol-specific and alcohol related harm is continuing to rise in the UK |
interventions. A rapid evidence synthesis the age of 18 years. Most were delivered in the emergency department (ED) and involved a brief intervention. All were characterised by a wide age range of participants, heterogeneous samples and high rates of refusal and attrition. The authors conclude that whilst the ED might be the best place to identify children and adolescents at risk of harm related to alcohol use it might not be the best place to deliver an intervention.

A similar trend has also been observed in Sweden and Australia. What we might be witnessing in the UK is a polarisation with more abstainers and occasional drinkers, alongside more heavy consumption amongst those children and adolescents who are regular drinkers.

Hogue23 2014 Evidence Base on Outpatient Behavioral Treatments for Adolescent Substance Use: Updates and Recommendations 2007–2013 FBT-E is well-established, and several specific models have themselves achieved status as well-established (FFT, MDFT) or probably efficacious (BSFT, EBFT, MST). (b) Both CBT-I and CBT-G are well-established. (c) MI is probably efficacious, pending more consistent effects in long-term ASU reduction. (d) DRC is possibly efficacious and merits more research in community based settings. (e) Integrated models combining multiple evidence-based approaches have A countervailing force impeding meaningful progress is the stubbornly persistent “treatment gap”: disparity between degree of service need versus degree of service utilization within the ASU population.
enjoyed great success in both efficacy and effectiveness trials.

<table>
<thead>
<tr>
<th>Sussman&lt;sup&gt;35&lt;/sup&gt;</th>
<th>2014</th>
<th>Alcohol, Tobacco, and Other Drug Misuse Prevention and Cessation Programming for Alternative High School Youth: A Review</th>
<th>23 ATOD misuse prevention or cessation program evaluations were located. This review indicated that successful efforts have focused on instruction in motivation enhancement, life coping skills, and decision making. There is little evidence, though, that this programming is effective when delivered through other modalities such as via computer or bridging beyond the school setting.</th>
<th>Entirely concerned with USA data, in particular USA contexts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mitchell&lt;sup&gt;36&lt;/sup&gt;</td>
<td>2013</td>
<td>SBIRT for adolescent drug and alcohol use: Current status and future directions</td>
<td>The limited evidence suggests that brief interventions may be effective with adolescents, but a number of gaps in the literature were identified.</td>
<td>Entirely concerned with USA data, in particular USA contexts</td>
</tr>
<tr>
<td>Barnett&lt;sup&gt;37&lt;/sup&gt;</td>
<td>2012</td>
<td>Motivational Interviewing for adolescent substance use</td>
<td>Of the 39 studies included in this review, 67% reported statistically significant improved substance use outcomes. Chi square results show no significant difference between interventions using feedback or not, or interventions</td>
<td>MI is a client-centred counselling style directed at exploring and resolving ambivalence about changing personal behaviours. It differs from other treatments in that its purpose is not to impart</td>
</tr>
</tbody>
</table>
combined with other treatment versus MI alone.

information or skills. Rather, it emphasizes exploring and reinforcing clients' intrinsic motivation toward healthy behaviours while supporting their autonomy.

<table>
<thead>
<tr>
<th>Carey\textsuperscript{28}</th>
<th>2012</th>
<th>Face-to-Face Versus Computer-Delivered Alcohol Interventions for College Drinkers</th>
<th>Compared to controls, CDI participants reported lower quantities, frequency, and peak intoxication at short-term follow-up, but these effects were not maintained. Direct comparisons between FTFIs and CDIs were infrequent, but these trials favoured the FTFIs on both quantity and problems measures.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jackson\textsuperscript{39}</td>
<td>2011</td>
<td>Interventions to prevent substance use and risky sexual behaviour in young people: a systematic review</td>
<td>Intervention effects were mixed, with most programmes having a significant effect on some outcomes, but not others. The most promising interventions addressed multiple domains (individual and peer, family, school and community) of risk and protective factors for risk behaviour.</td>
</tr>
</tbody>
</table>
| **Winters**<sup>40</sup> | 2011 | Advances in Adolescent Substance Abuse Treatment | Expert consensus identified core elements presumed to be associated with effective drug treatment for adolescents.  
- Comprehensive assessment  
- Family involvement  
- Developmentally appropriate  
- Strategies for engagement  
- Qualified staff  
- Sensitivity to culture and gender differences  
- Aftercare support  
- Data gathering | Narrative review – expert consensus |
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Clark</strong>&lt;sup&gt;41&lt;/sup&gt;</td>
<td>2010</td>
<td>Screening and Brief Intervention for Underage Drinkers</td>
<td>Several brief screening methods have been shown to effectively identify underage drinkers likely to have alcohol use disorders.</td>
</tr>
<tr>
<td><strong>Macgowan</strong>&lt;sup&gt;42&lt;/sup&gt;</td>
<td>2010</td>
<td>Evidence for Optimism: Behavior Therapies and Motivational Interviewing in Adolescent Substance Abuse Treatment</td>
<td>This article reviewed 36 different interventions; 12 each of BTs, MI, and BT plus psychosocial approaches. Across interventions, most demonstrated significant changes from pretest to follow-ups. Although the body of research did not meet the criteria for “well established”</td>
</tr>
</tbody>
</table>
the BT interventions met the criteria for “probably efficacious”

<table>
<thead>
<tr>
<th>Tripodi$^{43}$</th>
<th>2010</th>
<th>Interventions for Reducing Adolescent Alcohol Abuse</th>
<th>Pooled effects of standardized mean differences indicate that interventions significantly reduce adolescent alcohol use. Individual only interventions had larger effect sizes than family based interventions and effect sizes decreased as length of follow-up increased. Furthermore, behaviour-oriented treatments demonstrated promise in attaining long term effects.</th>
<th>Interventions with large effect sizes include brief motivational interviewing, cognitive behavioural therapy with 12 steps, cognitive-behavioural therapy with aftercare, multidimensional family therapy, brief interventions with the adolescent, and brief interventions with the adolescent and a parent.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carey$^{44}$</td>
<td>2009</td>
<td>Computer-delivered interventions to reduce college student drinking</td>
<td>CDIs reduced quantity and frequency measures relative to assessment-only controls, but rarely differed from comparison conditions that included alcohol-relevant content.</td>
<td></td>
</tr>
<tr>
<td>Toumbourou$^{18}$</td>
<td>2007</td>
<td>We integrated findings of systematic reviews to summarise evidence for interventions aimed at prevention and reduction of</td>
<td>Evidence of efficacy was available for developmental prevention interventions that aim to prevent onset of harmful patterns in settings such as vulnerable families, schools, and communities, and Exposure to maternal substance use before birth, environmental tobacco smoke in childhood, or disrupted parenting associated</td>
<td></td>
</tr>
<tr>
<td>harms related to adolescent substance use.</td>
<td>universal strategies to reduce attractiveness of substance use. Screening and brief intervention are efficacious, but efficacy of a range of treatment approaches has not been reliably established.</td>
<td>with substance misuse within families have been implicated as early risk factors increasing the odds of subsequent progression to harmful patterns of drug use in adulthood</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
• 80% of respondents had a work/school situation of being in school or college full time. 4 respondents (1%) were excluded from school.

• Approximately two thirds of respondents were female

**Figure A: Answers selected to the question ‘what is your gender?’**

- Most respondents lived in ‘town or city’ rather than ‘village or countryside’ (geography was kept non-specific to help respondents feel safe to answer honestly) (Figure B)

**Figure B: Answers to selected to the question ‘whereabouts in Suffolk do you live?’**

- 82% of respondents described themselves as ‘White British’, with the next biggest group at 3% ‘White Other’.
84% of respondents described themselves as ‘straight/heterosexual’, with the next biggest group at 5% ‘bisexual’.

9 REFERENCES


