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Executive Summary

This needs assessment examines the needs of young people aged less than 18 years residing in Suffolk and who access specialist substance misuse treatment services. The study is based on two main sources – the first briefly reviews the literature of what works in substance misuse treatment for young people; and second there is interpretation of pre-populated data derived from the National Drug Treatment Monitoring System (NDTMS). For this study it was not possible to undertake secondary analysis of NDTMS data or primary qualitative interviews with key stakeholders (staff and service users) and therefore the scope of the analysis was severely limited.

Main Findings

- The brief literature review identified gaps in the knowledge base on the nature of young people’s substance misuse including the variability in the definitions of a young person – including school-aged children; young people aged less than 18 years; less than 24 years and even less than 30 years.

- A number of prevalence studies focus on school-aged children and revolve around alcohol use. Drinking generally among school-aged children has declined although there is some evidence of risky drinking behaviours from some sub-groups of young person.

- The relationship between young people, alcohol consumption and their wider families has been shown to be highly nuanced and complex with evidence that young people, whilst aware of health promotion messages, tend to be sceptical about its relevance.

- Prevalence of substance misuse was shown to be higher in key segments of young people – offenders, in care, homeless, truants and runaways.

- The literature suggests that broadly treatment has a positive effect on a young person’s substance misuse and correlates (such as school attainment etc.) although there is little clarity over what the exact drivers that facilitate change are.

- The evidence suggests that cognitive therapies, motivation interviewing and brief interventions can all be effective although research has consistently suggested that use of such approaches tend to affect change in the short-term only.

- Family-based interventions are broadly seen as the ‘most promising’ type for young substance misusers.

- Theoretical models focus on behavioural systems; multiple systems and ecological family environments.
- The therapeutic alliance between worker and young person; worker skill, knowledge and experience; and use of family mediation are also seen as key drivers of effective family-based interventions.

- The evidence-base points towards key barriers that work against the development of family-based interventions including ensuring adequate funding is in place; lack of adequate supervision; lack of administrative support and workers not fully engaged or equipped to work with families.

- During 2012-13 half (50%) of all referrals into specialist substance misuse services came from the criminal justice system and of these, the majority were from the Youth Offending Service (46%).

- 29 per cent of referrals into treatment came from Children and Family Services during this period whilst there were no referrals from Looked After Children (LAC) or from acute hospital settings.

- In 2012-13, the majority of interventions provided to young people were motivational interviewing (41%) and relapse prevention (26%). Only 5 per cent (or 14 young people) received family-based support.

- Compared to national figures, Suffolk residents were significantly more likely to receive motivational interviewing and relapse prevention; but significantly less likely to receive counselling, harm reduction and ‘other’ interventions. The implications of these differences are unclear and may reflect different recording practices onto NDTMS.

- Comparison with national figures for 2012-13 show that a young person’s outcome in Suffolk was not statistically significantly different (caution is advised due to small sample sizes) although Suffolk residents were significantly more likely to be ‘transferred not in custody’. It was not possible to analyse the data directly to help predict the variables that are associated outcomes.

- Nearly three-quarters (73%) of young people who completed treatment reported a positive outcome with nearly half (49%) reporting that they were discharged as an occasional user. A further 24 per cent were discharged as drug free.

- The description of the treatment population for 2012-13 identified that the majority were male (69%); modal age 17 years (37%) although 90 per cent of all young people in treatment were aged between 15 and 17 years; and 90 per cent of young people were recorded as White which is consistent with School-based figures.

- 92 per cent of young people were in treatment for alcohol (21%) and cannabis (71%) as a primary drug suggesting an ‘AC’ treatment population.

- It was possible using NDTMS typologies to examine differences based on derived vulnerabilities. The three main vulnerabilities in Suffolk were poly-drug users; offenders and early onset users (started using substances younger than 15 years). Secondary analysis of NDTMS suggest no significant differences in the characteristics of these segments.

- For young people aged 16 and 17 years and who completed a Treatment Outcome Profile (TOP) record – there was some evidence of improvements in alcohol and cannabis use; psychological and physical health; and quality of life measures which are consistent with the literature. It was not possible to test whether these improvements were statistically significant.
## Summary of Suggested Next Steps

<table>
<thead>
<tr>
<th>Theme</th>
<th>Recommendation</th>
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<tbody>
<tr>
<td>Assess the feasibility of developing pathways from Looked After Children (LAC) services and Acute Hospitals</td>
<td>1. Assess whether it is feasible to develop effective screening and pathways across LAC and acute hospital services.</td>
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<tr>
<td>Develop Family-Based Interventions for Segments of Young People</td>
<td>2. Develop and enhance family-based interventions for key segments of young people</td>
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<td>Develop a public health intelligence function for substance misuse</td>
<td>3. Develop a range of epidemiological methods that routinely provide suitable intelligence for commissioners</td>
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<td></td>
<td>4. Consider more detailed analysis of segments of young people including understanding why some successfully engage</td>
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Introduction

This needs assessment provides an overview of the epidemiological needs of young people aged under 18 years of age residing in Suffolk County who access and require specialist substance misuse treatment (defined as encompassing both alcohol and illicit drugs) during 2012-13. The study is based on secondary analysis of existing datasets caution is advised in the interpretation of the findings from this report.

Aims and Objectives

The aim of this study is to examine the needs of young people (aged under 18 years) who present to substance misuse services and to identify gaps or barriers in service provision. The study supplements an earlier assessment of needs (Suffolk DAAT, 2013) and should be read in conjunction with the adult needs assessment. Young people’s substance misuse differs markedly from adults and concepts used to frame the adult service (e.g. “recovery”) are not always applicable. Substance misuse will be at the early stage of use and the analysis of the data has been framed in some of the existing literature underpinning prevalence rates and “what works” in treatment. The assumption of this study is that young people who misuse substances (alcohol and drugs) will need access to some level of specialist service and there is a focus of this needs assessment on particular vulnerable groups of young people who may continue using drugs and alcohol problematically as adults.

Method

The study provides an epidemiological overview of the nature of presenting problem drug misuse in Suffolk based on information held on a national surveillance system - the National Drug Treatment Monitoring System (NDTMS). NDTMS captures data on substance misusers at various points during their time in community-based treatment, for example at initial engagement (triage); at start of an intervention (modality start) and at exit. This is supplemented through a formalized review process using a simple schedule (the Treatment Outcome Profile- TOP) that aims to understand how well a service user is doing during their time in treatment (although it should be noted that TOP is only used for young people aged 16 or 17 years).

The analysis for this study is based on access to specific “cuts” of NDTMS data only – in other words, secondary analysis already undertaken by Public Health England (PHE) and provided back to partnerships for interpretation in the form of pre-populated reports. The extent of data provided for use as part of the needs assessment process is relatively limited and primary analysis of data for interrogation (for example, to undertake multivariate modelling is prohibited).
In the absence of direct access to surveillance data there has been some attempt to compare and contrast the epidemiology of substance misuse in Suffolk with the national picture. These comparisons are undertaken through basic and crude tests for statistical difference which allows for a simple comparison between two groups but offers little in the way of developing hypotheses about treatment engagement and outcome measurement. The analysis has also been supplemented by a brief overview of some of the main themes within the literature.

The study is therefore limited in a number of ways. First there can be limited interrogation of the data extracts provided – as stated above it was not possible to develop a more robust and enhanced analytical approach (for example, using multivariate statistical techniques) that could determine whether any correlations or associations between factors are statistically significant. It was not possible to explore or drill-down into issues or themes that may have arisen for the data which will limit the power of the analytical method. Second, from the information provided from the cuts of data, there is little commentary on issues such as data quality and the impact this may have on the findings, although there will be a discussion on such matters in the text as they arise. Moreover, it was not in scope for this needs assessment to utilize qualitative methods to support the epidemiological analyses including service user and staff consultation events. This may create the possibility of “data artefacts” whereby trends or associations in the data may emerge but are not “real” and are a function of (for example) how information has been collected or been analyzed and presented back to partnerships back from PHE. For some of the analysis provided by PHE the automation process includes little commentary on key issues such as statistical significance and sample sizes, although there will be some discussion of these topics in the text. Therefore, the findings from this study should be treated with some caution and should be considered indicative only. Where possible, the analysis will point towards developing further research questions that may help explain particular issues within the data. The report is structured over three main chapters. Within this chapter is a brief summary of the available evidence including an overview of what constitutes effective treatment in order to place the findings from this study into context. The second chapter analyses the epidemiology of problem substance misuse among young people with a final chapter suggesting next steps for service delivery.

**Brief Summary of Evidence**

This literature review will provide the backdrop for delivering drug treatment services for children and young people aged less than 18 years of age. The review will incorporate broad national and regional evidence of trends or issues facing young people who use drugs and alcohol including an assessment of the rates or prevalence of drug use.

**Prevalence of drug and alcohol use amongst young people**

A large body of literature exists that describes the extent and nature of substance misuse amongst young people in the UK. The extent to which young people use drugs (prevalence) has traditionally been measured through survey research methods, particularly within a school–based setting.
However, there are limitations with this approach – namely that such school-based surveys exclude possible key groups such as truants and other cohorts of young people educated within a pupil referral unit (PRU) setting. In response to these limitations, a number of surveys have also been commissioned that focus on such key cohorts of young people who tend to interface with official agencies outside a traditional school setting. Another key limitation is the wide range that encompasses the definition of ‘young person’. Some studies focus on children of school age (11-15 years) and other define young people as below 18 years of age, however other studies routinely include within their analysis a young person as old as 24 years and some research even includes those aged less than 30 years. This lack of comparability seriously affects the interpretation of the evidence-base. The following section reports on the prevalence rates of substance misuse among those aged 11-15 within a school setting and among cohorts of vulnerable young people for comparison purposes.

School-based Populations

One method to determine the prevalence of drug use among young people is via a survey of the school age population; these tend to be undertaken within a school environment and therefore the evidence base tends to focus on the prevalence of drinking as a measure as opposed to illicit drug use due to its relative scarcity as an act and due to issues with disclosing illicit activities in a routine school-based survey. Despite this, the previous year’s needs assessment (Suffolk DAAT, 2013) was able to use the latest estimates to suggest that around 3,890 11-15 year olds are “regular” drinkers in Suffolk.

There is also some evidence pointing towards a general lack of awareness about the harmful effects of substance misuse upon young people’s lives - for example, a survey by Leicestershire DAAT suggested that young people aged 18 and under were not aware of the harmful effects of alcohol use including binge drinking (Home Office, 2007). Research (ibid) examining alcohol misuse found increased levels of awareness about alcohol since 2004 but identified a cohort of problem drinkers who tended to be heavy users exhibiting “low alcohol knowledge.” The characteristics of this group tended to be female, white, with low aspirations, with an offending history and episodes of being excluded from school. This cohort of ‘heavy-end’ alcohol users also tended to exhibit risky sexual health behaviours. In addition, this study was able to identify a sub-group of young Asian males using alcohol problematically and undertaking in high risk sexual behaviours.

In a similar school-based survey of 15 and 16 year olds also across the North West region (Hughes et al, 2008), decreases in alcohol use were noted, however this was tempered by increases in frequency of consumption and drinking in public places (such as bars or public parks). This study equated binge drinking with deprivation and highlighted the links with alcohol-related violence. This sub-group has also been identified as a priority nationally including awareness of young people who deliberately drink to get drunk. This includes evidence that 35% of 11-15 year olds who had drunk alcohol in the past month did so to get inebriated including episodes where drinking 5 or more units in a single occasion were reported (BMA, 2008). This increased rate of consumption is linked to evidence of increased use of higher strength alcoholic drinks. Research (Fuller, 2008) suggests that the main source of alcohol is from parents – of 11-15 year olds who reported drinking 14+ units in the last week, the majority were given alcohol by their parents directly (with a large proportion admitting taking alcohol from their parents covertly). However, despite these trends a summary from a Joseph Rowntree Foundation research programme suggested that young people’s alcohol use was in fact relatively nuanced – young people stated that they were aware of existing health promotion messages but treated some of these sceptically and saw alcohol use as a secondary priority (Sondhi & Turner, 2011).
Moreover, this research highlighted the interaction between parental perceptions of alcohol use and those of their children (ibid).

Vulnerable Groups

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

Moreover, young people with multiple issues reported a much higher prevalence of Class A use with reported rates of 25% last year use of Class A drugs amongst those in multiple vulnerable groups compared to 12% who were not (Douglas & Plugge, 2006). The research cited above highlights the greater use of cannabis, cocaine and ecstasy (in some research amphetamines and/or solvents are prominent) amongst all groups of vulnerable people. Research (McCryystal et al, 2007) in Belfast found similar findings among a sample of surveyed school excludees and found links with other key factors such as poor communication with parents/guardians; greater engagement with the criminal justice system (CJS) and these young people tended to reside in communities characterised by neighbourhood disorganisation. Moreover, the literature suggests differentials between segments of young people. For example, younger females within the criminal justice system are shown to have a greater prevalence of mental and physical health issues (including self-harm) alongside a greater vulnerability to sexual exploitation (Douglas & Plugge, 2007; Galahad SMS, 2004).

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

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

Among a national sample in 2006 of young offenders aged between 10-19 defined as “delinquent youth groups”, these young people were shown to be three times more likely to use any drug compared to a comparison non-offending group (45% to 15%); nearly four times more likely to use a Class A drug (11% to 3%) and twice as likely to use heroin or crack-cocaine (4% to 2%) and more likely to be caught in alcohol-related offending - from 25% to 6% (Sharp et al, 2006). This suggests that there is a need to target offenders not just because of the influence of substances on their offending behaviour, but also because of their heightened risk to the health consequences of substance use. The research looked at a 10-16 year-old sub-group and concluded that lifestyle factors such as greater levels of alcohol and drug use greatly contributed to offending and their participation within a gang or delinquent youth group.
Treatment Approaches for Young People

As part of this review of the literature, it was possible to assess some of the evidence relating to treatment interventions or modalities used to treat children and young people for their drug use. This section is meant to be illustrative rather than exhaustive partly due to the paucity of a robust UK evidence base. The scarcity of the evidence base has been highlighted as an issue (NTA, 2009; Jones et al, 2006) but despite this, substance misuse treatment in its widest sense suggests that treatment can have long to medium terms gains in terms of reduced drug use and improvements in other indices such as reductions in offending, improvements in school attendance alongside general physical and mental well-being (cf. NTA, 2009; McIntosh et al, 2006) although there is little evidence to suggest which treatment best suits which segment of young person.

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

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

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

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

A national study exploring the evidence suggested that CBT is largely considered as “effective” including in group settings and BI used as a one-off session or to facilitate engagement in more structured treatment (NTA, 2009). This study suggested the importance of the therapeutic alliance alongside practical support as a means of enhancing engagement with treatment. Overall, the research (Hides et al, 2011; Jones et al, 2006) suggests that BI and MI produces a short-term effect in the use of alcohol, cannabis and tobacco.
The authors of an Australian study of 60 young people receiving CBT/MI alongside “standard care” compared to a comparison sample of 28 young people receiving standard care only found significant improvements in depression and reductions in cannabis use (alongside increased social contact) at the three-month period, but found that the comparison group “caught up” at six-months whereby an differences in outcome vanished (Hides et al, 2011). The authors concluded that these interventions may accelerate treatment gains in the immediate-term.

**Family-Based Interventions**

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

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

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

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

The design of ‘intensive family-based interventions’ equally covers a wide range of theoretical and conceptual approaches. For young people with substance misuse or with behavioural issues, family work has been seen to worthy of further development. A UK review of the evidence-base for young people with substance misuse needs concluded that the greatest reductions in drug and/or alcohol use can be evidenced for “family therapy”, followed by cognitive behaviour therapy (CBT), motivational enhancement therapy (MET), MET behaviour therapy and pharmacological treatment for the few young people addicted to opiates (Ahuja et al, 2013). In this review, the cornerstones of effective family-based treatment includes the need for holistic assessments that examine the wider context of a young person’s life and related psychological and physical issues that they may have, alongside being able to help navigate the young person across the myriad of services that they are likely to engage with.
Yet, we ask why engage the family? What is it about “family therapy” that is effective and so imperative for commissioners and service providers to develop programmes of care? The predominately US-based research has increasingly been able to illustrate a young person’s progression into substance misuse is both initiated and facilitated through interactions with the family (cf. Hawkins et al, 2005) and that familial factors often predict the start of drug-using behaviours, its sustainability and often escalation. Tober & Komro (2010) were able to point towards key variables:

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

The evidence suggests a symbiotic relationship between relationship dysfunction and substance misuse, with the notion that increasing stress and conflict that permeates within a family, the greater probability for an individual to be susceptible to using drugs or alcohol. For offenders in general, the desistance literature clearly provides a link in longitudinal studies between high levels of family dysfunction and criminality (Bonta et al, 2008) and shows the impact of poor parenting on future offenders. The desistance literature places a high premium on family-based factors that are associated with higher prevalence of anti-social behaviour and offending to include “family processes” such as attachment, affection (including extent of “emotional neglect” including a lack of attachment to others); and the level of parental supervision (for younger offenders).

For substance misuse specific services and interventions, family-based treatment is at the forefront of innovative research practice that aims to integrate the family into a young person’s treatment (cf. Williams & Chang, 2000; AACAP, 2005). Stanton & Shadish’s (1999) meta-analysis of family therapies suggested that use of family-based therapies was “encouraging” and the use of these interventions point toward better outcomes compared to other, non-family approaches (especially if used as an adjunct to clinical treatment interventions). A more recent meta-analysis (Baldwin et al, 2012) comparing the effects of family therapies on young people’s offending and substance misuse compared a range of therapeutic models (which are explained below) against a treatment-as-usual, alternative therapy or control group. The meta-analysis found that by pooling three family therapies into one block against the three alternatives found statistically significant, but modest effects compared to treatment-as-usual, or alternative therapies ($d=0.21; k=11$). The study suggested that the comparisons of the pooled family therapies group against controls was stronger ($d=0.7; k=4$) but lack statistical significance. The study was able to point towards family therapies as an important approach for treatment young people’s substance misuse and offending.

For wider anti-social behaviour and offending, the broad consensus demonstrates the efficacy of family interventions at reducing criminality although Latimer’s (2001) meta-analysis argued that whilst there was prima-facie evidence that family interventions appear effective, when the methodologically is critically examined, these positive outcomes cannot be legitimized. Fraser et al (2010) supports this conclusion by arguing that the “family should not be the sole focus of any intervention work” and to look at wider societal contexts. Moreover, there is an argument to suggest that the evidence underpinning family-based interventions is focused exclusively on US-based research with little contemporaneous studies from the UK (McQueen et al, 2008). Despite these reservations, other authors have maintained that family-based approaches do offer some promise.
Woolfenden et al’s (2002) found family interventions had a strong impact on young offenders whilst Farringdon & Welsh’s (2003) meta-analysis of 40 family-based crime prevention initiatives concluded that there was evidence of reduced offending seen in behavioural parental training; home-visiting; day-care support for infants in pre-school; home/community support; multi-systemic therapy. The authors concluded that the most effective intervention aimed at reducing crime among young people was intensive behavioural training for parents. Downden and Andrews (2003) suggested that interventions need to be focused on medium- to high-risk offenders and suggested that ‘family affection/communication’ alongside the level of parental monitoring and supervision all predict offending. Therefore taking the evidence in the round, family interventions have been perceived to be a sine qua non among experts with the suggestion that “the theoretical and clinical rationale for involving families in the drug abuser’s treatment now seems self-evident” (Rowe, 2012; p60).

So what does family therapy look like? As Ahuja et al (ibid) and other authors point out, these studies are predominantly based around US research with some emerging evidence from the UK. In general, family therapy incorporates manual-based approaches in which the young person (substance misuser or low-level offender) and at least one parent or guardian is involved in some way in their treatment sessions. Howlett et al's (2012) review of the evidence identified five US approaches that were deemed “promising”:

1. Multi-Dimensional Family Therapy (MDFT)

The MDFT model encompasses a number of key stages as part of its manual-based approach (see Rowe, 2012 for a review). MDFT courses range between 16 and 25 sessions over a four- to six- month period and sessions may occur a number of times during the week in any suitably conducive environment (at home; in clinic; over the phone and even on-line). MDFT encompasses four main strands of activity (Bonnaire et al, 2013) including (a) interventions with the adolescent (hereafter young person); (b) interventions with the family; (c) interventions that explore the parent-young person inter-familial interaction and (d) extra-familial discourse which may include interactions with other non-immediate family members and individuals or groups external to the family.

MDFT has a wide-ranging and significant evidence-base from which to draw from. MDFT was cited as one of four most “promising” drug treatment interventions as part of the US Cannabis Youth Treatment multisite clinical trials. A randomized controlled trial (RCT) comparing MDFT against individual cognitive behavioural therapy (CBT) -based interventions for 224 male, Afro-American young people referred for substance misuse treatment found “more rapid and sustained reduction” in their drug use compared to the control (Liddle et al, 2008). A similar RCT comparing MDFT against manualised CBT and peer group treatment approaches found the model was able to demonstrate better outcomes in terms of greater levels of abstinence and fewer “problems” at the 12-month follow-up (Liddle et al, 2009).

Overall, four RCTs have been able to demonstrate that the model significantly reduces “delinquent behaviours” and “affiliation with delinquent peers” (Rowe, 2010). A summary of two RCTs examining the efficacy of MDFT with “higher-severity substance-abusing” young people (higher levels of drug use and greater mental health issues) found significant improvements among those accessing the family-based therapy compared to individually-based interventions with a focus on CBT (Henderson et al, 2010). Rowe’s review of family-based interventions (2012) and specifically for MDFT also found significant improvement for young people who accessed the programme in terms of school behaviours (attendance, behavioural issues and exam grades along with enhanced levels of “school bonding”).
Rowe (2010) was also able to point towards fewer unprotected sex acts committed by young people on the programme and a further two studies demonstrating a greater impact on depression and anxiety symptoms.

**TABLE 1:** Summary of “promising” family-based interventions, Rowe (2012)

<table>
<thead>
<tr>
<th>Theoretical Concept</th>
<th>Description</th>
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<tbody>
<tr>
<td>Multi-Systemic Theory (MST)</td>
<td>MST aims to provide comprehensive and intensive family- and community-based (e.g. in school) sessions of between four- and six-months duration. This model places the young person as central with a series of complex, dynamic and inter-connected systems that encompass the young person, family and wider ecology (including the local community, peers and school). MST also appears to effective in reducing substance misuse and offending in young people with extensive and acute social issues including young people with violent tendencies (quoted in Howlett et al, ibid).</td>
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<tr>
<td>Brief Strategic Family Therapy (BSFT)</td>
<td>The theory underpinning BSFT posits the concept that a young person’s problematic behaviours that include substance misuse and/or offending is a function of poor familial interactions and therefore, seeks to alter how the family interacts as a means to ameliorate the presenting problem.</td>
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<td>Functional Family Therapy (FFT)</td>
<td>FFT typically involves two intervention phases, the first involves engaging the whole family in the young person’s treatment and aims to enhance the individual’s motivation to change; and the second effecting behavioural changes in family functioning though the use of a range of psychosocial interventions (ranging from problem-solving to contingency management)</td>
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<tr>
<td>Adolescent Community Reinforcement Approaches (a-CRA)</td>
<td>A-CRA integrates the treatment offer to both families and the young person in question by leveraging a wide range of family, social, community and education re-inforcers to support pro-social activities. Assertive Continuing Care (ACC) is a home-based psychosocial intervention that integrates a-CRA and a case-management approach for a period of around 12-14 weeks to help engage young people discharge from treatment to help maintain progress and positive outcomes.</td>
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Four meta-analyses and reviews have examined the viability of a number of these models and overall interventions defined as “family-based therapies” are distinguished by methodological rigour and widely enhanced treatment outcomes, often in comparison to alternative approaches (Rowe; 2010; 2012):

- Vaughn & Howard’s (2004) meta-analysis concluded that MDFT and CBDT were the most efficacious approaches
- Becker & Curry (2008) review concluded that multi-systemic models work best including MDFT; MST; CBT and brief motivational interviewing

- Waldron & Turner (2008)’s review suggested that only three (out of 46) young people’s drug treatment approaches or interventions were considered “well-established” (MDFT; FFT and CBT) with BSFT; MST and BSFT seen as “probably efficacious”

- Austin et al (2005) review of young people with substance misuse problems found that MDFT and BSFT were “probably efficacious” and MST/FFT and BSFT were “possibly efficacious”

Yet even a cursory examination of the models suggests close synergies between a number of them in terms of emphases and themes. Rowe’s (2012) review of the evidence-base posited three theoretical perspectives underpinning substance misuse specific interventions:

**TABLE 2**: Theoretical perspectives underpinning family-based interventions, Rowe (2012)

<table>
<thead>
<tr>
<th>Theoretical Concept</th>
<th>Description</th>
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<tbody>
<tr>
<td><strong>Behavioural Models</strong></td>
<td>This model emphasizes the role of the family unit to reinforce behaviours and attitudes towards the use of substances with an emphasis on abstinence as a means to repair familial dysfunction.</td>
</tr>
<tr>
<td><strong>Family System Models</strong></td>
<td>This approach aims to address dysfunctional family relationships by improving how the family unit functions individually and together as a whole.</td>
</tr>
<tr>
<td><strong>Multiple System – Ecologically-based Family Models</strong></td>
<td>Covers a number of related areas including gaining the support and leverage of the family to encourage an individual’s desistance from their substance misuse and to support any associated lifestyle changes. The model(s) also aim to affect the problematic aspects of a family environment to create more suitable conditions for stable relationships to occur.</td>
</tr>
</tbody>
</table>
The mechanisms that underpin change have also been explored (Rowe, 2012) and these in essence, link to three key factors although there is an awareness that the drivers that deliver change remain a mystery as researchers do not “know how it works” (ibid, p.69):

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

In addition, other interesting research has focused on possible organizational barriers that prevent the effective implementation of family-based approaches (Fals-Stewart et al, 2004) that include a lack and variable level of funding to support the development of various models, low supervision or administrative support and attitudes of workers who may not have fully engaged with the family agenda. Despite these potential problems, Rowe (ibid, p73) concluded that: “reviews of both adolescent and adult drug abuse now consistently include family-based models among the most highly regarded and most strongly supported approaches [to treatment]”. 
Epidemiology

The extent and nature of young people’s substance misuse has been derived from a variety of sources derived from NDTMS. The first component will look at the ‘treatment map’ which examines pathways into and out of specialist substance misuse services. The section describes the overall in-treatment population with a specific focus on young people considered to be most vulnerable.

Treatment Mapping

The pathways into and out of specialist substance misuse treatment during 2012-13 is shown overleaf in Figure 1. Half (50%) of all young people enter treatment from the criminal justice including the largest population (46%) directly from Youth Offending Teams with the next highest grouping - 29 per cent of young people enter treatment from Children and Family Services. There were no referrals from Looked After Children (LAC) services or from Emergency Departments (Accident and Emergency). These maybe potential gaps in referral pathways as the literature review above identified higher prevalence rates for children in care as a vulnerable segment of young people, and last year’s needs assessment (ibid) identified that for under 18 year olds, the rate of alcohol-related admissions was higher than the East of England average (39.1 per 100,000 population compared to an average of 37.6).

The interventions received by young people was also explored and the majority receive either motivational interviewing (41%, n=117) or relapse prevention (26%, n=74). Given its importance identified in the literature, only 14 young people or 5 per cent of the total received a family-based intervention. It was possible to undertake a crude comparison between Suffolk interventions for young people and the national picture. This analysis suggests the following:

- Young people in Suffolk were significantly more likely to in receipt of MI (41% compared to 27% nationally; $\chi^2=28.9; p<0.0001$) and relapse prevention (26% compared to 10% nationally; $\chi^2=80.7; p<0.0001$) compared to their national counterparts

- Young people in Suffolk were significantly less likely to receive a counselling intervention compared to nationally (3% in Suffolk compared to 11% nationally; $\chi^2=18.4; p<0.0001$); harm reduction (16% in Suffolk compared to 26% in England; $\chi^2=15.9; p<0.0001$) and “other” interventions (none in Suffolk compared to 7% nationally; $\chi^2=20.8; p<0.0001$)

There were no statistically significant differences between the numbers receiving a family-based intervention and pharmacological support (none in Suffolk for 2012-13). Without further primary research it is hard to draw any firm conclusions from this analysis. The differences may reflect recoding issues – for example, the difference between MI, relapse prevention and harm reduction may be one of interpretation.
A similar analysis was undertaken on treatment outcomes at discharge. Nearly half (49%, n=63) were discharged during 2012-13 having successfully completed treatment as an occasional user of substances and a further quarter (24%, n=31) were discharged drug free. One fifth (19%, n=24) reported an unplanned or “unknown” treatment outcome. Comparisons with the national picture suggested no major significant differences other than a higher rate of ‘transferred not in custody’ (7% in Suffolk compared to 4% nationally; $\chi^2=15.8; p<0.0001$). It should be noted that whilst there are differences in the percentages reported nationally the fact that the differences are not statistically significant is also a reflection of the relatively low numbers reported in Suffolk from which to base comparisons on.

The limitations of the analysis are that it was not possible to interrogate the data further to understand the interaction between various explanatory variables and treatment outcome. For example, it was not possible to undertake a more detailed analysis to explain the factors that may predict non-engagement with treatment. Are any specific segments of young people (e.g. by referral pathway, demographic) predictors of whether a young person does well in treatment? It is therefore recommended that future needs assessments examines the causal relationship between treatment outcomes and for instance, client characteristics.
FIGURE 1: Treatment Pathway Mapping Suffolk 2012-13

- Children & Family Services: N=40; 29%
- Looked After Children (LAC): N=0; 0%
- Emergency Departments: N=0; 0%
- Health and Mental Health Services: N=14; 10%
- Criminal Justice System: N=5; 4%
- Youth Offending Teams: N=63; 46%
- Friends and Family: N=11; 8%
- Other: N=3; 2%

- In Treatment 2012/13:
  - Counselling (n=8)
  - CBT (n=28)
  - MI (n=117)
  - Relapse Prevention (n=74)
  - Family (n=14)
  - Harm reduction (n=45)

- Completed drug free: N=31; 24%
- Completed occasional user: N=63; 49%
- Transferred not in custody: N=9; 7%
- Unplanned - prison: N=2; 2%
- Unplanned and Not Known: N=24; 19%
Description of the Treatment Population

The demographics of young people in treatment (n=136) was examined and a summary is presented below in Table 3.

**TABLE 3:** Summary of the treatment demographics of young people in treatment, 2012-13

<table>
<thead>
<tr>
<th>Demographic</th>
<th>Percentage/Number</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gender</strong></td>
<td></td>
</tr>
<tr>
<td>- Male</td>
<td>69% N=94</td>
</tr>
<tr>
<td>- Female</td>
<td>31% N=42</td>
</tr>
<tr>
<td><strong>Age</strong></td>
<td></td>
</tr>
<tr>
<td>- 12 years</td>
<td>1% N=1</td>
</tr>
<tr>
<td>- 13 years</td>
<td>2% N=3</td>
</tr>
<tr>
<td>- 14 years</td>
<td>7% N=9</td>
</tr>
<tr>
<td>- 15 years</td>
<td>23% N=31</td>
</tr>
<tr>
<td>- 16 years</td>
<td>30% N=41</td>
</tr>
<tr>
<td>- 17 years</td>
<td>37% N=51</td>
</tr>
<tr>
<td><strong>Ethnicity</strong></td>
<td></td>
</tr>
<tr>
<td>- White</td>
<td>90% N=123</td>
</tr>
<tr>
<td>- Non-White</td>
<td>10% N=13</td>
</tr>
<tr>
<td>**Primary Drug *</td>
<td></td>
</tr>
<tr>
<td>- Cannabis</td>
<td>71% N=97</td>
</tr>
<tr>
<td>- Alcohol</td>
<td>21% N=29</td>
</tr>
<tr>
<td>- Cocaine</td>
<td>1% N=1</td>
</tr>
<tr>
<td>- Amphetamines</td>
<td>1% N=1</td>
</tr>
<tr>
<td>- Solvents</td>
<td>1% N=2</td>
</tr>
<tr>
<td>- Other</td>
<td>2% N=3</td>
</tr>
</tbody>
</table>

*Three cases recorded as not current users of any substance

The majority of young people in treatment during 2012-13 was reported as male (69%, n=94) which is largely a function of the enhanced criminal justice referral pathway (half of all referrals come from this sector) and can be shown to be slightly more male dominated that the national average (66% nationally were reported as male in 2012-13).
The modal age for treatment engagement is 17 years which a sharp increase in reports from the age of 15 years onwards. In comparison with national figures (PHE, 2013) 90 per cent of young people in Suffolk were aged 15 to 17 years compared to 77 per cent among their peers nationally. This difference is likely to be a function of the enhanced referral pathways from the criminal justice sector. In addition, 10 per cent of young people reported in treatment are from a Black and Minority Ethnic (BME) group which is similar to the reported rate (11%) for children of school age (Child Health Profile Suffolk, 2013). The drug profiles for young people who present to treatment overwhelmingly were for cannabis (71%, n=97) and alcohol (21%, n=29). This suggests a clear AC (alcohol and cannabis) profile which differs from the ACCE (alcohol, cannabis, cocaine and ecstasy) hypothesis (Parker, 2007; Hurst et al, 2009) that suggests the need to calibrate services to this specific need. The profile is closely echoed nationally (PHE, 2013) with 68 per cent reporting using cannabis and 24 per alcohol.

The majority of young people (54%, n=108) remained in treatment during 2012-13 from less than 13 weeks and around one-quarter (24%, n=48) stayed in service between 13 and 26 weeks. 22 per cent (n=43) stayed in treatment for longer than six months. The length of stay is shorter than national figures (PHE, 2013) that show 44 per cent of young people in treatment for less than 13 weeks, although it is not possible to draw any conclusions with this finding as the length of the stay for young people has not been found as a key determinant of a successful outcome as much as for adult substance misusers.

Other areas reported on nationally that were not routinely available for local analysis included discharge destination (e.g. the service or agency type that a young person moved onto) and socio-demographic issues such as accommodation status.

Vulnerabilities

The literature review has shown that vulnerable young people are a key segment with higher prevalence rates of substance misuse and allied risky behaviours including offending. It was possible to examine a typology of vulnerability based on a ready-reckoner of potential vulnerabilities based on information collected on NDTMS and provided by PHE. These include ten discrete factors and these factors are shown below in Table 4.

Three main groups of vulnerability emerge from this typology:

- Poly-drug users (n=87)
- Offenders (n=68)
- Early Onset (n=111)
### TABLE 4: Vulnerabilities as defined by PHE

<table>
<thead>
<tr>
<th>Risk / Harm</th>
<th>Vulnerabilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opiate and/or Crack User (OCU)</td>
<td>YP is using opiates and/or crack (in drug 1, 2 or 3) within the first episode of their treatment journey</td>
</tr>
<tr>
<td>Higher Risk Drinkers</td>
<td>YP is drinking at harmful limits* for 13-26 days out of the previous 28 or YP drank 27-28 days out of the previous 28 regardless of unit intake</td>
</tr>
<tr>
<td>Poly Drug User</td>
<td>YP is using two or more drugs (not including nicotine but could be any other two drugs)</td>
</tr>
<tr>
<td>NFA / Unsettled</td>
<td>YP's accommodation need is NFA or unsettled</td>
</tr>
<tr>
<td>Offending</td>
<td>YP is involved in offending and/or is in contact with the YOT</td>
</tr>
<tr>
<td>NEET</td>
<td>YP education status and employment status shows YP is not in any education, employment or training as recorded in the YP Education Status field</td>
</tr>
<tr>
<td>Early Onset</td>
<td>Age of first use of Drug 1 is under 15 (if this field is blank but clients age is under 15 Early Onset is considered to be true)</td>
</tr>
<tr>
<td>YP involved in Self Harm</td>
<td>YP involved in self harm at treatment start is answered yes</td>
</tr>
<tr>
<td>YP Pregnant and/or Parent</td>
<td>YP is pregnant and / or has a parental status stating YP is pregnant or a parent</td>
</tr>
<tr>
<td>YP is a Looked After Child (LAC)</td>
<td>YP is a Looked After Child is answered yes</td>
</tr>
</tbody>
</table>
TABLE 5: Young person’s demographic profile by vulnerability

<table>
<thead>
<tr>
<th>Demographic</th>
<th>Poly-Drug</th>
<th>Offenders</th>
<th>Early Onset</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gender</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Male</td>
<td>66% N=57</td>
<td>76% N=52</td>
<td>71% N=79</td>
</tr>
<tr>
<td>- Female</td>
<td>34% N=30</td>
<td>24% N=16</td>
<td>29% N=32</td>
</tr>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- 12 years</td>
<td>0 0 0 1% 1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- 13 years</td>
<td>2 2% 0 0 3% 3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- 14 years</td>
<td>8% 7 4% 3 8% 9</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- 15 years</td>
<td>22% 19 21% 14 24% 27</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- 16 years</td>
<td>26% 23 29% 20 27% 30</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- 17 years</td>
<td>41% 36 46% 31 37% 41</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Ethnicity</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- White</td>
<td>91% N=79 88% N=60 90% N=100</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Non-White</td>
<td>9% N=8 12% N=8 10% N=11</td>
<td></td>
<td></td>
</tr>
<tr>
<td>**Primary Drug *</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Cannabis</td>
<td>68% 59 75% 51 72% 80</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Alcohol</td>
<td>23% 20 21% 14 23% 26</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Cocaine</td>
<td>1% 1 1% 1 0% 0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Amphetamines</td>
<td>0% 0 0% 0 1% 1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Solvents</td>
<td>0% 0 0% 0 2% 2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Other</td>
<td>7% 6 3% 2 2% 2</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

There are major limitations in the interpretation of this table as there are no statistically significant differences between vulnerability and segment of young person (in part due to the small numbers reported within each group). Therefore without further interrogation of the data it is hard to draw any main conclusions from the data provided.

Treatment Outcomes

It was possible to access an extract of TOP data provided for 16- and 17-year olds for Quarter 4 (2012-13). It should be noted that not all of the information provided was used for this purpose as there are a number of categories with very low numbers – therefore any category with less than 27 responses at baseline (one-fifth or 20% of the total in-treatment population) was excluded from the analysis.
TABLE 6: Outcome measurement derived from TOP, 16-17 year olds, 2012-13 Quarter 4

<table>
<thead>
<tr>
<th>TOP Category</th>
<th>Number of Users</th>
<th>At Baseline</th>
<th>At Review</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cannabis users</td>
<td>57</td>
<td>49 using</td>
<td>41 using</td>
</tr>
<tr>
<td>Alcohol users</td>
<td>36</td>
<td>30 using</td>
<td>27 using</td>
</tr>
<tr>
<td>Psychological Health Score</td>
<td>65</td>
<td>13.1</td>
<td>14.3</td>
</tr>
<tr>
<td>Physical Health Score</td>
<td>65</td>
<td>12.3</td>
<td>13.6</td>
</tr>
<tr>
<td>Quality of Life</td>
<td>65</td>
<td>13.6</td>
<td>14.6</td>
</tr>
</tbody>
</table>

The data presented above suggests some modest improvement from initial baseline compared to review (which includes either 6-month review or at planned treatment exit). Improvements in outcomes confirms the findings of the literature review suggesting that treatment does have a beneficial impact on a young person’s substance misuse (ibid). However, there are limitations with the interpretation of this analysis – there is no possibility to test whether the changes were statistically significant (that is, they happened as a result of treatment and not by chance) and additionally, whether there were any segments of young person that does particularly well and conversely does less well. There may be differences in young people by referral source and their demographics (by age, gender etc.) for instance. Moreover, the data provided includes completed TOP forms at 6-month review and at planned exit – arguably these are two separate cohorts at different points in their treatment ‘journey’ and it may have been interesting to compare the changes relative to these two groups.
Suggested Next Steps

This final section will provide an overview of the suggested next steps based on the analysis provided above. The study is cautious about any generalizations made in this report – information is provided for epidemiological analysis based on a ‘cut’ of data derived from NDTMS. No secondary analysis of data was possible to test for correlations and inferences across the full range of variables collected on NDTMS including outcome data (through the use of TOP). Moreover, the study was not able to report on stakeholders’ (e.g. service users and treatment staff) perceptions of progress. Some associations for example may be due to the way information is coded on NDTMS and may reflect differing practices in Suffolk compared to other areas.

Recommendations

Assess the feasibility of developing pathways from Looked After Children (LAC) services and Acute Hospitals

The study has shown that in 2012-13 there were no referrals from LAC services and from acute medicine (such as the Emergency Department) despite evidence that there is a need for specialist drug and alcohol interventions as evidenced by high prevalence rates and higher than average hospital admission rates for young people misusing alcohol. In a study of vulnerable young people (Jones et al, 2006), the authors suggested that it was “unlikely [that LAC would] be in contact with specialist drug services”. Moreover, studies examining brief interventions for alcohol in hospital has found that whilst there is an importance of ensuring on-going contact (especially in the 48 hours after admission) following a hospital episode there were significant practical barriers to the development of effective pathways (Johnson et al, 2012).

1. Assess whether it is feasible to develop effective screening and pathways across LAC and acute hospital services.

Develop Family-Based Interventions for Segments of Young People

The evidence-base has firmly pointed towards family-based interventions as a “promising” approach for young people using illicit drugs and/or alcohol (ibid). The treatment mapping exercise suggested that only 5 per cent or 14 young people in treatment received family support. Further work is recommended in developing this intervention.
The literature however, is less clear as to which segment of young person and their family would benefit from a family-based intervention, therefore there is a need to develop assessment tools that would establish who would benefit most from such a service.

2. Develop and enhance family-based interventions for key segments of young people

Develop a public health intelligence function for substance misuse

3. Develop a range of epidemiological methods that routinely provide suitable intelligence for commissioners

4. Consider more detailed analysis of segments of young people including understanding why some successfully engage

This study has suggested that the level of information available from NDTMS to undertake a thorough and meaningful needs analysis has been curtailed through access to limited ‘cuts’ of the data. Secondary analysis on treatment engagement; segmentation of service user groups alongside use of qualitative assessments (e.g. staff and service user surveys) are also recommended. In addition, there is an opportunity to develop a wider public health function by enhancing the analysis of available data – NDTMS extracts of the data go so far, and there is a need to understand a young person’s treatment journey and what factors predict positive outcomes and conversely, what variables if any, are correlated with non- or disengagement with treatment.
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