

YOUNG PEOPLE'S NEEDS ASSESSMENT 2008

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Needs Assessment 2008

	Page
Contents	2
Executive Summary	4
Foreword	9
1. Introduction	10
2. Defining the population in Need	16
3. Current service providers	
Support @ the Junction	
Leaving and Aftercare – Substance Misuse Team	
Essex Young People’s Drug & Alcohol Service	
Healthy Schools	
4. Treatment system	
5. Intervention Modalities	
Appendix 1 – NDTMS treatment map	
Executive Summary	

Introduction

This needs assessment refresh which has been agreed by the Young people's Joint Commissioning Group has been developed and produced in response to the annual requirement by the National Treatment Agency (NTA). It aims to review the progress Essex has made against the Young People's Treatment Plan for 2008 – 2009 and to start to establish targets for the 2009 – 2010 Treatment Plan.

In addition to this, findings from Needs Assessment's or Inspection Reports from/by other organisations such as YOS, IYS and SCF and CAMHS (self audit) will be taken into account to ensure that any commonalities are linked to the subsequent Young People's Treatment Plan 2009 – 10.

This review will concentrate on the specialist treatment provision for young people, the response to the substance misuse needs of vulnerable groups including Looked After Children (LAC), Youth Offending Services (YOS), Children and Adolescent Mental Health Services (CAMHS), Young Carers and those who are excluded or persistent non attender's within education establishments. It will examine the following elements:

- Self audit and current position
- The effectiveness of the current specialist treatment service system
- Identify the treatment population and any under engaged populations
- Recommend solutions to ensure any poorly engaged populations are narrowed by way of the treatment plan 2009-2010
- To make an analysis and interpretation of the current data
- To ensure that the views of the partnerships, stakeholders and young people have been captured and incorporated in a way that is meaningful to them.
- To compare performance with other information sources such as TellUs3, Essex Needs Assessment, police and YJB data.

Treatment definition

In 2007 the National Treatment Agency (NTA) produced guidance, Commissioning Young People's Specialist Substance Misuse Treatment Services' within which had the following definition of specialist substance misuse treatment provision,

“Young people’s specialist substance misuse treatment is a care planned, medical, and psychosocial or harm reduction intervention aimed at the alleviating current harm caused by a young person’s substance misuse”

Substance Misuse Interventions

Every Child Matters Change for Children: Young People and Drugs (DfES 2005) advocated the following system of providing substance misuse interventions to young people:

Universal provision – drug education, information and advice, prevention and access to targeted and specialist services, social inclusion.

Targeted provision – early identification, assessment and care co-ordination of interventions with young people in groups vulnerable to substance misuse such as young offenders, truants and looked after children.

Specialist substance misuse treatment provision – psychosocial, pharmacological and residential interventions for those with high levels of substance misuse needs.

Defining populations

As young people’s substance misuse work can cut cross one substance misuse treatment intervention to another it was important to look at the whole system, rather than specialist treatment in isolation. To be able to make an impact on the number of young people who may require specialist treatment it is essential to ensure that universal and targeted services are available to all young people and families.

For these purposes it was important to identify those young people, who may be at risk or vulnerable to problematic substance misuse, therefore data was requested on the following:

- Young people involved with substance misuse and the criminal justice system
- Looked After Children including Leaving and Aftercare (OC2 data)
- Child protection and safeguarding data
- Young people involved in Child & Adolescent Mental Health Services
- Young people accessing treatment (NDTMS)
- Young people with substance misusing parents and who are young carers
- Accident & Emergency admissions data

Much of this data remains to be difficult to access and in some cases is not collected by the organisations involved. However, unlike last year when it was noted that organisations were not considering substance misuse in their work with young people, this has improved considerably although recording of data has started to improve and information sharing protocols are slowly being implemented with partners.

It needs to be highlighted that during late 2007 and early 2008 the main young people's providers database underwent a thorough cleansing process and the whole team received training. This has meant that the quality of data this year for young people in treatment has improved, however as the system remains to be predominately an adult system it does not capture the true journey for young people, this is planned to change in April/May 2009 when a separate database is implemented which has been driven by the National Treatment Agency (NTA).

Key point 1: Data collection continues to require development and agreement on data and information sharing across the partnership

Key point 2: NTA driven new database to be implemented April/May 2009 with accurate migration of current data with full training to be given to all staff expected to use it.

Self Assessment of current position:

The Young People's Substance Misuse Joint Commissioning Group underwent an extensive review and refresh in 2008 which led to a new membership and Terms of Reference which gave it a robust purpose and decision making process and established governance agreements. New membership includes all 5 Primary Care Trusts (PCT's), police, Looked After Children, Integrated Youth Services (IYS) and workforce development.

The Children & Young People's Strategic Partnership (CYPSP) Executive Group now holds governance responsibilities for substance misuse; the group is aligned to the Children and Young People's Strategic Partnership Board which also has responsibility for the development of the new Children and Young People's Plan 2009 - 2012

The Essex County Council, Schools, Children and Families Directorate (SCF) also went through a Joint Area Review (JAR) in September 2008, fortunately Young People's Joint Commissioning Group's processes and arrangements came under scrutiny. Initial comments have been positive from the inspectors who made no negative comments about the commissioning arrangements or services being commissioned through this process; they also thought that individual services should be held up as areas of best practice.

The Youth Offending Service inspection highlighted that the Offender Related Service (substance misuse workers within YOTs) had effective systems in place including thorough holistic assessments, planning and practice. They were effectively integrated into the YOT teams and continued to hold a level of autonomy necessary for working with young people and substance misuse.

Following the YOS inspection the Young People's Commissioning Manager was invited onto the YOS Executive Group, which ensures partnership working across all children's services working with vulnerable and at risk young people.

During 2008, a Children and Adolescent Mental Health Service Commissioning Executive Group was developed to ensure commitment to the development of joint and/or aligned commissioning across CAMHS, PCTs and Local Authority partnerships. The Commissioning Manager is a member of this group as well as remaining actively involved in the CAMHS partnership/stakeholder group.

Key point 3: To maintain Joint Commissioning arrangements and continue developing EDAAT reporting mechanisms to CYPSP Executive group, NTA, CAMHS and YOS services

Key point 4: Compliance to the Commissioning Guidance (NTA 2007) to further develop to ensure procurement and all future contracts, processes and policies follow best value and practice models.

Current Treatment System

The Health Advisory Service (HAS) 2001/04, the Essential Elements (NTA 2005) were key documents in the organisation and expectations of what substance misuse services for young people need to provide and these were again highlighted in the new Commissioning Guidelines (NTA 2007). Specialist services are expected to actively target young people who are vulnerable, at risk of misusing or already misusing substances, these include Looked After Children, young people excluded from education, involved in the criminal justice system and mental health services.

The five interventions required to be developed are:

- Psychosocial
- Family support
- Residential Care
- Pharmacological
- Specialist Harm Reduction

Looked After Children – OC2 Data

OC2 data is a statutory requirement by DCSF for an annual return on all children who have been Looked After by the Local Authority for the previous 12 months.

Substance misuse is part of this report and is defined as ‘intoxication by – or regular excessive consumption of and/or dependence on – psychoactive substances, leading to social, psychological, physical and legal problems. It includes problematic use if both legal and illegal drugs including alcohol when used with other drugs’, Clinical Excellence Guidance, NICE 2007.

In 2006-07, the OC2 results showed that 30 young people were reported to be misusing substances out of 946 children and young people. There was in-depth interrogating of this data to present as evidence to the Joint Area Review (JAR) inspectors to be able to further understand the issues and concerns of the group.

The 2008 OC2 cohort consists of all children who were looked after by the Local Authority council on 30 September 2008 and who had been looked after continuously from and including 1

October of the previous calendar year, or earlier. Of this cohort of 963 children, 31 (3.2%) were identified as having a substance misuse issue during the year ending 30th September. 12 (39%) of these 31 received an intervention and 19 (61%) were offered but refused structured interventions but did accept low level advice, information and support.

As you can see from the table below the children and young people identified as misusing were aged between 12 years and 17 years old, with the majority being in the 15 -17 year bracket, which does correspond to the NDTMS data.

There were 21 males (68%) and 10 females (32%), showing less females disclosing their substance misuse which is below the normal trend for Essex over the last 6 months, as data taken from NDTMS (Quarter 2) shows 56% male and 44% female.

The children and young people were identified from three social care teams, Assessment and Child Protection Teams with 1 young person (3.2%), Permanency with 11 young people (35%) and Leaving and Aftercare with 19 young people (61%).

There was a spread of young people across the four quadrants within social care with North Essex identifying 7 (22.5%), Mid Essex identifying 12 (39%), West Essex having 5 (16%) and South Essex identifying 7 young people (22.5%).

Structured interventions means that following a full assessment, a care plan is developed and agreed with targets and outcomes included which have been negotiated with the young person to ensure that they are realistic and achievable. Young people are seen on an ongoing regular basis and targets or goals should be measurable and evaluated and should inform planned discharges or referrals.

From the 12 young people who accepted a structured intervention, 9 (75%) were from Leaving and Aftercare services with 3 (25%) coming from permanency teams; 5 were female (42%) and 7 were male (58%) which means that fewer females are accessing structured interventions to that which is currently reported to NDTMS.

This demonstrates that having dedicated substance misuse workers within Leaving and Aftercare Teams training alongside with the development of processes and systems are in place. However, the work that has taken place has developed in isolation of the other Looked

After Services and this should be one area for future development as it is the feeling that there continues to be under reporting of substance misuse for Looked After Children.

Of those 19 young people who refused structured interventions there were 5 (26%) female and 14 (74%) male; they originated from the three main teams, Assessment and Child Protection had 1 (5%), Permanency had 8 (42%) and Leaving and Aftercare had 10 (53%). The areas they came from were Mid Essex 8 (42%), North Essex 4 (21%), West Essex 3 (16%) and South Essex 4 (21%)

Similar to the findings for the 2007, those refusing structured interventions did however go onto receive advice, information and support involving harm reduction information often during one off pieces of work.

Age	OC2 Cohort			Substance Misuse Cohort			% of Cohort		
	Female	Male	Total	Female	Male	Total	Female	Male	Total
1	19	20	39	0	0	0	0	0	0
2	10	14	24	0	0	0	0	0	0
3	10	9	19	0	0	0	0	0	0
4	17	20	37	0	0	0	0	0	0
5	13	15	28	0	0	0	0	0	0
6	19	15	34	0	0	0	0	0	0
7	15	16	31	0	0	0	0	0	0
8	18	21	39	0	0	0	0	0	0
9	27	25	52	0	0	0	0	0	0
10	25	27	52	0	0	0	0	0	0
11	25	36	61	0	0	0	0	0	0
12	39	32	71	1	0	1	2.56	0	1.41
13	30	51	81	0	0	0	0	0	0
14	38	59	97	1	2	3	2.63	3.39	3.09
15	39	69	108	0	7	7	0	10.14	6.48
16	47	53	100	5	6	11	10.64	11.32	11.00
17	34	56	90	3	6	9	8.82	10.71	10.00
Total	425	538	963	10	21	31	2.35	3.90	3.22

Table 2: OC2 data spreadsheet with substance misuse included

Unfortunately, the data from the NDTMS database does not correspond with the 31 young people identified as substance misusing, especially those young people within Leaving and Aftercare Services despite the expectation that they report to NDTMS.

The table below shows the breakdown of the OC2 data of those young people misusing substances, those that accepted treatment and those that refused.

Areas/quadrant	Total Misusing	Accepted treatment	Not accepted treatment
Mid Essex	12	4	8
North Essex	7	3	4
West Essex	5	2	3
South Essex	7	3	4
Total	31	12	19

Table 1: shows the breakdown of the quadrants where the 31 young people were identified.

Ages 1 to 11 years – no reported substance misuse, there is an assumption from the OC2 guidance (appendix 3) that although substance misuse information should be collected from all children regardless of age, there is an understanding of treatment data which suggests that substance misuse problems develop from the age of 10 years onwards. However, there is a need to start to consider the number of children where families are involved in substance misuse and where substance misuse was a factor in them becoming looked after children

Safeguarding: Children of substance misuse

Looked after children i.e. those children who are looked after by the county council either through a voluntary arrangement or court order are, by definition, vulnerable children. There is a particular responsibility therefore on the county council to provide these children with a safe and secure childhood.

Nationally, Looked After Children are seven times more likely than their peers to suffer from mental health problems. 20% have a statement of special educational need (compared with 3% of the general population). Young people who were looked after at one point are twice as likely to become teenage parents. Looked after young people are over-represented in the youth justice system and it approximately a quarter of adult population in prison were looked after as a

child. Between a quarter and one third of rough sleepers were looked after at one point in their lives.

Key point 4: Through contract negotiations with current suppliers assurance needs to be given to further development and deliver robust services to **all** Looked After Children’s Services for substance misuse possibly using the YOS model

Key point 5: To support the future development of Safe Guarding policy, including SET procedures to include young people’s own substance misuse and to support safeguarding & substance misuse training strategy.

Key point 6: Accurate reporting of all Looked After Children who are identified and assessed as misusing substances by dedicated substance misuse workers/services.

Children and Young People’s Schools Surveys:

This information that has been added here is taken from the draft Schools, Children and Families Directorate Needs Assessment that has directly been incorporated in the Joint Strategic Needs Assessment (JSNA).

Schools Health Education Unit (SHEU):

School phase	Primary	Secondary	Total
Age	7 - 11	12 - 18	
Boys	2854	1865	4719
Girls	2672	762	4434
Total	5526	3627	9153

Table 3: Shows the breakdown of age group and gendered taking part in the SHEU 2008

Information from the SHEU survey in 2008 shows that 32% of secondary school pupils said they drink alcohol occasionally or regularly, although 17% said that they have never drunk alcohol. 12% of Years 7-8 boys said they drink alcohol occasionally or regularly, but this rises to 32% of Years 9-10 boys and 57% of Years 11-13 boys (this profile is similar to that for girls). 16% of pupils who drink had consumed seven or more units of alcohol in the last week. 21% of the girls and 13% of the boys who drink said that they had been very drunk at least once in the last month while 23% of pupils said that they had been very drunk at least once in the past six months and 5% in the last week. It is assumed that the older the pupil, the more likely they are to report being very drunk in the past month. When asked what would encourage them not to get drunk, the top answers included health reasons, if they or a friend got hurt or into trouble, unable to buy it or more things to do in the area.

Evidence suggests that young people may engage in high risk behaviours following excessive alcohol consumption. Adolescent binge drinking is a risk behaviour associated with significant later adversity and social exclusion. By the time the teenage binge drinkers reach 30 they are 60% more likely to be an alcoholic, nearly twice as likely to have a criminal conviction, 40% more likely to use illegal drugs, 40% more likely to suffer mental health problems and 60% more likely to be homeless. They are also 40% more likely to have suffered accidents, almost four times as likely to have been excluded from school and 30% more likely to have gained no qualifications leading to poor outcomes in childhood and adulthood also continued concerns can result in young people having minimal aspirations.

9% of 15 year olds surveyed by SHEU in 2008 said that they had taken drugs in the last month (this was 16% in the 2007 survey). 6% of all secondary pupils reported that they had taken an illegal drug in the last month, 9% in the last year and 12% more than a year ago. The most popular drug was cannabis while the second most common were poppers. Within the last year only 1% of Years 7-8 pupils had taken cannabis, but this rose to 8% of Years 9-10 pupils and 16% of Years 11-13 pupils.

The 2008 SHEU survey also showed that 69% of secondary school pupils said they have never smoked a cigarette. However, 8% of boys and 12% of girls had smoked in the last week, and 17% of 15 year olds had smoked in the last week. 10% of all secondary school pupils said that they smoke occasionally or regularly. When asked if anything would encourage them to give up, the top answers included having poor health, smelling of smoke and finding out about the effects on health.

Both truancy and exclusion are associated with increased likelihood of smoking, drinking and drug use: pupils who have truanted in the last 12 months are between two and two and a half times as likely to have smoked, drunk or taken drugs in the last month. A third of all problem drug users are homeless or in need of housing support.

Young people are faced by a range of needs, not all drug-related. There are some specific vulnerable groups who are more at risk of substance misuse, including: looked after children; young carers; young offenders; exploited young people; teenagers becoming pregnant/parents; young people with mental health issues; and truants/excluded pupils.

Key point 7: To have a range of children and youth services that can support and advise young people about smoking, substance misuse and related issues, these should also include diversionary activities and groups.

TellUs 3 Schools Survey 2008:

There are some specific vulnerable groups who are more at risk of substance misuse, including: looked after children; young carers; young offenders; exploited young people; teenagers becoming pregnant/parents; young people with mental health issues; and truants/excluded pupils.

National research evidence suggests that young people may engage in high risk behaviours following excessive alcohol consumption. Adolescent binge drinking is a risk behaviour associated with significant later adversity and social exclusion. Young people sometimes say that they drink because there is nothing else for them to do in their spare time. National evidence

shows that participating in high quality, constructive out of school activities has a preventative impact on alcohol use by young people.

According to the 2008 TellUs3 survey, 11% of young people in ECC and 9% of young people in Thurrock said that they had ever taken drugs, compared to 11% of young people nationally. (There was no response available for Southend due to incomplete coverage – only data for Year 6 pupils is available. However, the 2007 TellUs2 survey reported that 85% of young people in Southend had never taken drugs and 4% preferred not to say if they had.) According to the SHEU survey in 2008, 17.6% of secondary school pupils in ECC districts said that they have ever taken drugs. The highest percentages of young people were in Brentwood and Harlow while the lowest were in Colchester and Basildon.

In the TellUs3 survey 16% of pupils in ECC and 13% in Thurrock said that they had been drunk once or more in the last four weeks, compared to 16% nationally. In Southend, 18% of pupils said this in 2007. 38% of pupils in ECC and 37% in Thurrock said that they have never been drunk, compared to 35% nationally. 20% of pupils in ECC and 22% in Thurrock said that they had never had an alcoholic drink, compared to 25% nationally. Information from the 2008 SHEU survey showed that 12.8% of all secondary school pupils across ECC districts said that they drink regularly. The districts with the highest percentage of young people saying they drink alcohol regularly were Maldon, Chelmsford and Colchester while the districts with the lowest percentages were Castle Point and Tendring.

76% of pupils in ECC and 77% in Thurrock said that they have never smoked a cigarette, compared to 75% nationally (the figure was 78% for Southend in 2007). 4% of pupils in both ECC and Thurrock said that they smoke cigarettes regularly/every day, compared to 5% nationally. The 2008 SHEU survey showed that although 69% of secondary school pupils in ECC districts said they have never smoked a cigarette, 6.7% said that they smoke regularly. The highest percentages of young people saying they smoke regularly are in Castle Point, Maldon and Harlow while the districts with the lowest percentages are Braintree and Rochford.

Some 10% of secondary school pupils in ECC districts (according to the TellUs3 survey) said that they take drugs or alcohol frequently (defined as at least twice in the last four weeks), suggesting a total of around 12,000 young people in ECC districts aged 11-18. Drug & Alcohol Action Team (DAAT) data shows that in 2006/07, 153 young people were in tier 3 structured counselling and 599 in tier 2 one to one work, suggesting a mismatch between prevalence and treatment.

Key point 8: To ensure that referral and care pathways are available to professionals and organisations to use when young people have an identified substance misuse need and for services to be commissioned to address the need.

Key point 9: For schools and TASCC teams to receive training and awareness of substance misuse and referral/care pathways to compliment the work carried out in schools.

Population of Essex

Essex is a large county with a variety of urban and rural areas and each have definite distinct needs. There is a total population of nearly 1.33 million with young people aged 0 to 18 years amounting to approximately 315,000 with the percentage with minority ethnic heritage being approximately 6.5 % which is significantly lower than the national average.

There are 479 nursery, infant, junior and primary schools: 80 secondary schools and 22 special schools (those schools that teach children and young people who have special educational needs, emotional behavioural difficulties).

There are approximately 174,000 pupils aged 5 to 16 years in school.

Treatment journey:

Screening: will be undertaken by any professional using Drug Use Screening Tool (DUST), Common Assessment Framework (CAF) or the EYPDAS screening tool. If this indicates substance misuse that requires an intervention that they do not feel confident/competent in doing then they will be referred for triage/further assessment.

Triage Assessment: this is undertaken by those with more substance misuse experience and assessment skills to assess the most appropriate support or treatment intervention to best meet the identified needs.

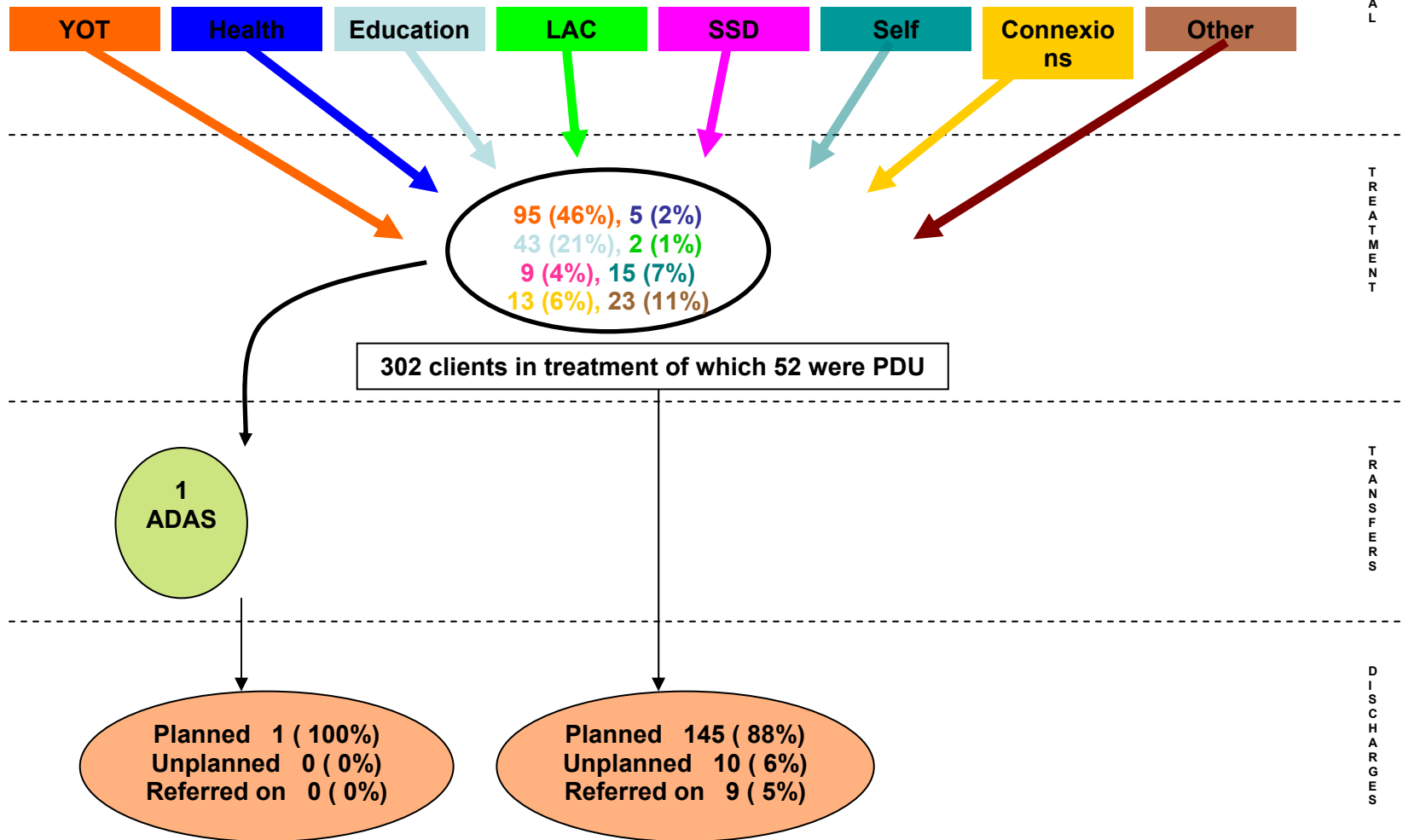
Assessment: follows on from the triage and will be carried out by a specialist substance misuse service. This will identify other support structures/factors that the young person has in their life, other needs such as mental health into the care package. Up to two appointments are given before a young person is entered onto the NDTMS data base and is therefore recognised as in structured treatment.

Interventions:

- Pharmacological
- Psychosocial
- Family
- Specialist Harm Reduction Services
- Residential services – assessment units ?private

The treatment map above shows the number of young people receiving structured treatment interventions within Essex during 2007 – 2008; the data was taken from the National Drug Treatment Monitoring System (NDTMS) and represents the work that Essex Young People's Drug and Alcohol (EYPDAS) work carried out throughout that year. The Leaving and Aftercare Service data remained unchanged throughout the year leading us to believe that either they are not reporting or that the numbers are for young people over 17 years and therefore captured within adult NDTMS returns.

EYPDAS DRUG TREATMENT MAP NHS YEAR 2007 - 08



REFERRAL

TREATMENT

TRANSFERS

DISCHARGES

	In treatment 2007/08		In treatment over 2 years	
	n	%	n	%
Gender				
Male	182	60	14	82
Female	120	40	3	18
Ethnic group				
White	288	97	17	100
Asian or Asian British	0	0	0	0
Black or Black British	0	0	0	0
Other	10	3	0	0
Age on 30th September 2007				
Under 13	11	4	0	0
13	9	3	1	6
14	43	14	1	6
15	85	28	1	6
16	70	23	2	12
17	84	28	12	71
Main drug				
Alcohol	79	26	3	18
Cannabis	186	62	14	82
Opiates	3	1	0	0
Crack	1	0	0	0
Other stimulants	17	6	0	0
Other	15	5	0	0
Injecting Status				
Current	0	0	0	0
Previous	0	0	0	0
Never	275	100	17	100
Total	302		17	

Table 4: Shows the breakdown of the demographic information for the 302 young people in specialist treatment during 2007- 08

There were a total of **302** young people receiving structured treatment over the year, **52** Problematic Drug Users (PDUs) see definition below:

The term **Problematic Drug User** (PDU) in this study refers to someone who uses opiates (e.g. heroin, morphine, codeine) and/or crack cocaine. It will encompass those who 'use' as well as those that 'misuse' or 'abuse' these types of drugs. Opiates and/or crack cocaine may not be the primary drugs in use and those who also use other types of drugs in addition to opiates and crack cocaine will be included. This definition does not include people who *only* use other types of drug, such as powder cocaine, amphetamines, ecstasy, hallucinogens or cannabis. The definition was carefully chosen as one that was robustly measurable. The choice was influenced by the source data available for use and it is intended to focus on those who use the drugs commonly regarded as causing most harm to individuals and communities.

The estimates refer to those aged 15-64 years old. The PDU and opiate estimates are further broken down into three age groups: 15-24 years, 25-34 years, 35-64 years (there was insufficient data to do the same for crack cocaine users and those who inject). Separate estimates are also available for men and women.

Within the data sources used for the estimates there were only a few recorded cases of under-18 year olds using opiates or crack cocaine and therefore it was not possible to provide estimates for that age group. However, although it is not possible to breakdown the 15-24 age group any further it can be assumed that the vast majority of problematic drug users in the youngest age group are 18 or over.

With only 52 young problematic drug users entering treatment over a twelve month period it could suggest that this group is under represented within specialist services. It could also suggest that substance misuse is not the primary reason for young people to present at services; substance misuse is often secondary to more serious issues such as lack of housing, criminal

justice involvement or mental health concerns. This group also tend to be more chaotic with more complex needs and are more likely to be supported or receiving services from social care, Youth Offending Services, possible be excluded from education and Child and Adolescent Mental Health Services (CAMHS).

Due to the complexities of this cohort of young people the data can not demonstrate the time and difficulties it often takes to engage as they are often resistant to gaining support or treatment and have preconceptions about treatment and counselling. Their chaotic live styles could cause on going difficulties with attending regular appointments times or even having a mobile phone or direct address presents services with its own problems about being able to contact clients.

Problematic Drug Users often associate with adult drug users or have peers that 'hang' around with older users; obviously there are young people who have parents who are drug misuser's. Therefore adult drug services need to be aware of their own client social groups that may include young people; also service users who have children/adolescents living with them.

In some cases young people who are misusing substances may be better engaged in adult services as their drug use or experience suggests that an adult service model is better placed to meet the needs if substitute prescribing is required. However, linking with a young people's service may benefit the young person when a discharge plan is being discussed as diversionary activities, education or outreach services are needed.

Key priority 9: For adult services practitioners to be aware of young people and the skills and model of working with young people.

Key priority 10: For a joint working and transition protocol between both treatment services to be developed and agreed by both adult and young people's Joint Commissioning Group and services.

Referrals:

The referrals to specialist services come from a variety of sources, with Youth Offending Services referring 95 (46%) of total, this may be primarily due to each Youth Offending Team having a substance misuse worker within the multidisciplinary teams; there is robust referral process in place which ensures that young people are escalated when more complex substance misuse is identified. All staff teams receive regular training to ensure they recognise substance misuse and how to manage low level misuse, as the YOTs are multidisciplinary which gives practitioners direct access to mental health, education and social care staff and the substance misuse workers have access to the EYPDAS assessment and counselling team for further ongoing work. The workers carry a further case load of young people with the more complex needs.

However, there is a need to consider those young people who do not engage in current available services, to question if they are from the PDU population who are have more entrenched substance misuse and linked behaviours. As 52 problematic drug users were seen throughout the year and with 95 young people being seen within criminal justice services and with the correlation between criminal activity and substance misuse you could assume that these young people are more difficult to engage for long enough leading to them not being recorded on NDTMS. The group may require further active engagement and positive persuasion with outreach appointments in to their community or further support to families or carers.

Key priority 11: To ensure services are actively engaging and seeking young people for treatment – with flexible and creative service delivery

Education referred 43 (21%) young people which is the second largest referral agency where substance misuse workers are regularly engaged with schools with a special focus on PRUs and Alternative Education Groups which Integrated Youth Services operate as young people attending these are

often more vulnerable as they are out of mainstream services. Social Care including Leaving and Aftercare services having referred 11 (5%) and Health services, PCT & GPs 5 (2%) which suggests a poor engagement with substance misuse agenda.

Key priority 12: Through current commissioning and service focused groups to encourage health and social care services to become more engaged with agenda, referral and care pathways and further training maybe necessary.

Demographics:

The gender split of 40% females and 60% males reflects that of the other DAAT areas, it also mirrors the 11 -13 year old male age group of the 32% of secondary school pupils identified in the SHEU Survey 2008 and continues to suggest that the younger age groups are aware of services and will access support and treatment interventions when either their own or someone else's substance is causing distress to normal life and behaviour.

The current data indicates that 288 (97%) young people's ethnicity was recorded as white, with 10 (3%) being recorded as other. However, from the 302 young people in treatment, 298 had their ethnicity recorded which means that 4 (1%) young people's ethnicity is missing. We therefore can not guarantee that the current treatment population reflects Essex as shown in the JAR evidence of 8% of the 0 – 19 age group.

Key priority 13: To ensure data quality by all service providers to include ethnicity, age, substance misuse and living arrangements

Access to treatment:

The data shows that 17 young people stayed in treatment over 2 years; with 3 (18%) young people aged 13 to 15 years remaining for shorter periods, these are often brief therapies with harm reduction support and information being

part of the intervention. However, 2 (12%) 16 year olds and 12 (71%) 17 years olds are more commonly retained in treatment for over two years and given that the primary substance misuse is 14 (82%) cannabis and 3 (18%) alcohol would imply that the young people are presenting with these substances have further complex issues that may indicate that either joint working is being delivered or else that other young people's services are not involved or young people have not been appropriately assessed.

Young people who present with alcohol or cannabis should rarely stay in treatment for over 2 years; if more complex needs are identified then referrals should be made to more appropriate services.

Young people misusing opiates including crack and other stimulants would commonly be more problematic and chaotic in their presentation and would need a robust care plan developed and implemented which would involve other services and possibly adult services. These young people are often known to services for longer as they tend to much more complex needs and need continued support to achieve their aspirations.

Key priority 13: To develop robust referral and care pathways are in place between children's services to ensure that young people receive appropriate screening & assessments that identify all needs and have access to all those services that can support them.

Key priority 14: To use the quarterly NDTMS green reports to monitor service provision including retention, referrals onwards to understand the demographics and needs of those in treatment for longer than twelve months.

Specialist harm reduction interventions including needle exchange:

Out of a total of 302 young people in treatment, 275 young people have disclosed that they have never injected, all 17 of these who have been retained in treatment for longer than two years having never injected. This suggests that 27 (9%) of those in treatment have not had the route of

substance misuse recorded and given that 3 (1%) of young people stated their primary drug as heroin (opiates), 1 young person using crack and 17 (6%) misusing other stimulants which can be injected in certain circumstances and 15 (5%) recorded as misusing 'other' and therefore unknown substances. This would suggest an under recording of young people who are or have injected drugs at some point, leading to an under estimation of injecting young people by commissioners, future strategic treatment planning and the NTA. For example, young people who disclose injecting behaviours suggest other health needs to be addressed these maybe overlooked if route of intake is not identified, young people should be encouraged and supported in attending a full health care check which will include Blood Borne Virus (BBV) work to establish HIV and Hepatitis C as well as screening for Sexually Transmitted Infections where unprotected sex has been disclosed. Young people who are injecting or who are associating with other drug users should also be encouraged to receive the Hepatitis B vaccination.

Key priority 15: Full involvement and endorsement of the new Essex Harm Reduction Strategy with clear action points for young people's services. To also include the Inequality Action Plan developed by Public Health/Primary Care

Key priority 16: Young people's specialist treatment services to ensure full & appropriate assessment and recording of young people's substance misuse. New database tool planned for April/May 2009

Discharges and Transitions:

The treatment map shows that 164 (54%) young people were discharged from treatment which would suggest that 138 (46%) remained in treatment post March 31st 2008. Of the 54% who ended treatment 145 (88%) were planned discharges, 9 (5%) were referred onto other services; however the data shows only one (0.3%) young person being referred to another agency

(adult tier 2 drug service) and 10 (6%) were unplanned discharges. It could be assumed that with a PDU population of 52 with young people living more chaotic lifestyles and with more complex needs and with life experiences that have not prepared them for structured interventions and they may find it difficult to cope with a planned ending and therefore may choose to leave early; those young people living extremely chaotic lives may not have the capacity to cope with structured interventions or to attend appointments, they may not be ready to address their personal and substance misuse issues.

With 21 (7%) young people misusing opiates, crack or other stimulants and 15 (5%) misusing undisclosed substances it could be suggested that the level of complexity of some young people would warrant a referral or involvement from other services both adult and young people. The adult service that the one young person was referred to is a tier 2 service and therefore does not provide substitute prescribing and with 3 young people having disclosed opiate misuse it would have been expected to see at least referral so adult drugs services for substitute prescribing along with psychiatric input if appropriate.

It should also be assumed that referrals & joint working took place to CAMHS, social care and Integrated Youth Services including Connexions.

Work is being undertaken to explore the needs and experiences of young people aged 17-23 year old which is considered to be the transitional period and initial feedback and findings would be that adult drug services do not always consider young people's needs and in some cases lack the skills to engage with young people.

Key priority 17: To ensure discharges are planned where appropriate and young people are supported to manage them, to actively seek and engage with young people who leave treatment early.

Key priority 18: To ensure that transitional arrangements are in place with both adult and young people's services. These should include roles and responsibilities for each service with the expectation by strategic management and operational service providers adhere to the processes.

Key priority 19: to ensure that adult services receive training and awareness that will increase their understanding of young people needs.

Clinical Governance:

The current treatment and performance monitoring systems across young people's substance misuse services give some consideration to clinical governance issues; these include professional qualifications and subsequent training & development, recruitment and retention, inductions, supervision and safeguarding awareness and systems.

However, further work needs to be developed to ensure that clinical governance is grounded and integrated in all aspects of future service delivery, which is guided by the 7 pillars of governance that are highlighted by Standards for Better Health. These are:

- Staff management
- Education and Training
- Information and IT
- Risk Assessment
- User involvement
- Clinical audit
- Clinical effectiveness

Key priority 20: To ensure services adhere to the new clinical governance policy/protocol in 2009 which will inform performance reviews and audit processes

Appendix A

Public Service Agreements' (PSA)

These also go some way to setting scene and were agreed within the recent Comprehensive Spending Review process, they go on to provide the key priority outcomes that the Government wants to achieve over the following 3 years. There are two PSA's that have been identified to drive forward the work on young people and substances and each PSA has its own indicators to measure success:

- PSA 14, which will be trying to increase the number of children and young people on the path to success.

The indicators are closely linked to the Every Child Matters outcomes.

1. Reduce the number of 16 – 18 years olds not in education, employment or training (NEET)
2. More participation in positive activities
3. Reduce the proportion of young people frequently using illicit drugs, alcohol or volatile substances
4. Reduce the under-18 conception rate
5. Reduce the number of first-time entrants to the Criminal Justice System ages 10-17

- PSA 25, which is aimed at reducing the harm caused by alcohol and drugs

The indicators are mostly attributed to adult substance misuse but as Essex services provide interventions for 18 to 24 years old in some cases they are relevant.

1. The number of drug users recorded as being in effective treatment
2. The number of alcohol – related hospital admissions
3. The rate of drug related offending
- 4 & 5. The percentage of the public who perceive drug use, dealing or drunk and rowdy behaviour to be a problem in their area.

NB: For the purpose of this document the following definitions apply (Young Peoples' Substance Misuse Treatment Essential Elements, NTA 2005):

Frequent use - is described as regular use within the last four weeks, which is taken as a proxy for misuse.

Misuse – This is defined as the use of any substance which results in harm, such as poor outcomes, school exclusion, criminal involvement, health problems etc

Substances – This refers to the illicit drugs, consumption of alcohol and volatile substances such as solvents, glue or gas.