Acknowledgements

Expert Group – representatives from the following organisations:

- B&NES
- Public Health England (PHE)
- NHS CAMHS
- DHI/Project 28
- Curo Housing
- Sirona
- BaNES CCG
- Avon & Somerset Police
- Bath College
- Bath Area Play Project
- Diversity Trust
- Black Families Support Group
- Mentoring Plus.

Project Manager and Lead Author:

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Thanks for the input and support from colleagues who helped produce the Substance Misuse Needs Assessment, including:

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Executive Summary

This document presents the findings of the needs assessment conducted across Bath and North East Somerset (B&NES) and reports on the future requirements for services for young people who are misusing substances, as well as those who are at risk of misusing substances. The primary purpose of this needs assessment is to identify the needs of young people requiring specialist treatment for substance misuse. It includes recommendations that not only addresses unmet treatment needs, it includes a review of early help and prevention. The inclusion of early help and prevention provides a useful opportunity to better understand the pathways into treatment, wider workforce development and ensuring effective treatment for those that require it.

Drug and alcohol misuse poses a significant risk to a young person’s physical and psychological health and development. For example, the adolescent brain is known to be particularly susceptible to alcohol. By delaying the age at which young people start drinking, they are less likely to engage in health risk behaviours, and to later become dependent on alcohol.

“While the majority of young people do not use drugs, and most of those that do are not dependent, drug and alcohol misuse can have a major impact on young people’s education, their health, their families and their long-term chances in life. It is for these reasons that Local Authorities are strongly encouraged to continue to invest in substance related service provision across the different levels of need from schools to treating young people’s substance misuse.”


Key Findings:

- Around one in eight 14/15 year olds surveyed in B&NES during 2013 reported having taken drugs in the past, with the main drug taken being cannabis (which is often used with tobacco). Rates of hospital admissions due to substance misuse among young people are significantly lower than national (during 2011/12-2013/14 the admission rate was 43.8 per 100,000 population aged 15-24 years, significantly below the comparable rate for England of 81.3). Furthermore, the latest available rate from 2011/12-2013/14 represents a fall from the previous three year period – from 50.7 per 100,000 population aged 15-24 years during 2010/11-2012/13. [see 3.2.1]

- While more children and young people are reporting they do not drink alcohol, and rates of alcohol specific admissions are falling (the latest figures for 2011/12-2013/14 were at their lowest level since at least 2006/07-2008/09), one in three 14/15 years olds surveyed in B&NES reported during 2013 they had an alcoholic drink in the past week. [see 3.2.2 and 3.3.11]

- Smoking rates have been steadily falling. However, around 1 in 25 young people surveyed in B&NES reported they were regular smokers in 2013. Smoking increases with age, becoming more prevalent as children progress through secondary school, and more girls reported they were smoking than boys in 2013 in B&NES. Regular smoking is associated with alcohol and drug use. [see 3.2.3]

- B&NES has a significantly higher rate of young people being admitted to hospital for self-harm compared to national (the rate of inpatient admissions during 2012/13 for 10-24 year
olds because of self-harm is 456.1 per 100,000, or 197 admissions – significantly higher than the England average of 346.3 per 100,000). A large proportion of these young people will also have a history of alcohol and/or drug misuse – roughly one in three during 2013/14 had a history of misusing alcohol and around one in ten had a history of drug use. [see 3.3.8]

- Project 28, the local treatment provider, continues to be a well-attended service, with the number of young people entering drug and alcohol treatment in B&NES increasing steadily over the past three years (having risen from 126 in 2011/12 to 144 in 2013/14), with by far the most common substances used being cannabis and alcohol. [see 4.2]

- The developing Early Help Strategy in B&NES will seek to identify emerging need for young people in a timely manner. This needs assessment identifies a number of young adults in treatment who stated they were using substances under the age of 18 and did not access the local young person’s treatment service, and will inform the development of the Early Help Strategy. [see 3.2.5]

- More than a quarter of adults receiving drug or alcohol treatment services in B&NES live with a child or young person under the age of 18, who may require additional support. Additionally, national and international research estimates that there are around 19 babies born every year to mothers in B&NES who may be born with Foetal Alcohol Spectrum Disorder (FASD). [see 3.3.5]

- Substance use plays a key role in identifying and responding to the needs of children at risk of Child Sexual Exploitation (CSE). The treatment service is part of the CSE Virtual Team supporting these vulnerable young people. [see 3.3.10]

- The outcomes for young people in treatment are better than national – with 94 percent successfully completing treatment during 2013/14, compared to 79 percent nationally. Furthermore, successful treatment appears to be long-lasting, with very few clients re-presenting into adult treatment – during 2012/13-2013/14, 10 out of 80 clients re-presented to the adult drug treatment service following a successful exit from the young person’s treatment service. [see 4.9]

- Whilst there were no referrals into treatment during 2013/14 for New Psychoactive Substance (NPS) misuse, there is anecdotal and survey evidence that their use has increased. [see 5.2.1]

**Key Recommendations:**

1. B&NES has recently commissioned the School and Students Health Education Unit (SHEU) to undertake two future surveys of young people – one in 2015, and another in 2017. It is recognised there is a need to harmonise some of the survey questions with national ones, and it is anticipated that this will take place in the coming months, with findings available in autumn 2015. The findings from the ‘What about YOUth?’ survey will also be reviewed alongside the SHEU survey when published.

2. It is recommended that the substance misuse workforce development prioritises the provision and delivery of training for staff working with vulnerable young people, including
for example, the provision or training for social workers, sexual health staff, and Youth Connect.

3. It is recommended that Project 28 develops links with the local Young Carer’s Service, including the provision of outreach support to the service. Additionally, a leaflet for families to sit alongside the practitioners leaflet on recognising household dangers within the home should be produced.

4. Further analysis is required to explore the local prevalence of Foetal Alcohol Spectrum Disorder (FASD). Public Health and Children’s and Adult’s Services should also work together to improve awareness of the dangers of drinking during pregnancy.

5. It is recommended that Project 28 develops links with the pilot secondary school therapeutic support/counselling service to provide substance misuse training and to ensure effective referral pathways are in place.

6. Project 28 should continue to be a part of the Child Sexual Exploitation multi-agency team and should ensure that quarterly action plans are undertaken as part of its governance structure.

7. It is recommended that the alcohol pathway from the Royal United Hospital Bath be reviewed after one year to evaluate impact of the new pathway as part of the B&NES Alcohol Strategy.

8. It is recommended that further exploration and links are developed with B&NES South Western Ambulance Service (SWAS) to help our insight into call-outs for alcohol that are not reported to police and do not go to hospital, and alcohol related calls linked to young people.

9. It will be essential to monitor capacity within treatment to be able to respond to the potential increase in demand from enhancing Early Help pathways for young people over future years. This will ensure that the service continues to be responsive to need.

10. It is recommended that B&NES works towards all young people being referred into specialist treatment services having a lead professional in place to ensure coordination of care.

11. To evaluate the DrinkThink tool with Bristol and Bath University to demonstrate that it is effective in reducing the frequency and quantity of alcohol consumption, and to analyse if there are any barriers to professionals using the tool.

12. It is recommended that there is a tailored intervention in order to respond to the needs of cannabis use (the vast majority of clients in treatment use cannabis). It is recommended that the treatment service produces a Cannabis Workbook/Tool to support the delivery of brief interventions within early help services to sit alongside the DrinkThink Tool.

13. B&NES will need to work with schools and colleges to ensure substance misuse training is provided to PSHE teachers and that young people are aware of the dangers of New Psychoactive Substances (NPS) and any subsequent change in legislation.

14. It is recommended that the Young People’s Outcome Record (YPOR) is reviewed through quarterly performance reviews with the provider and is part of a future needs assessment.
15. In order to support the Early Help Strategy it is recommended that a training plan is developed covering the following areas: (a) the current substance misuse screening tool is redesigned to facilitate improved understanding of problematic substance use, delivery of brief interventions, and when to refer; (b) the key substance misuse screening tool and DrinkThink becomes a core part of workforce development and embedded into future contracts; and (c) through workforce training ensure a consistent approach when identifying and responding to the needs of children and young people at risk of substance misuse to minimise barriers in accessing treatment.

16. It is recommended that the skills of the specialist drug & alcohol workers remain in line with best practice guidelines: the revised ‘National Occupational Standards (NOS) for Children & Young People’s Health Services’. It is recommended that all Project 28 staff meet the standards set out within this document.

An Action Plan 2015-2017 is currently being produced which will both incorporate and develop the key recommendations identified within this Needs Assessment.
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## Glossary of Terms, Acronyms and Abbreviations

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<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>A&amp;E</td>
<td>Accident and Emergency</td>
</tr>
<tr>
<td>ARBD</td>
<td>Alcohol-Related Birth Defects</td>
</tr>
<tr>
<td>ARND</td>
<td>Alcohol-Related Neurodevelopmental Disorder</td>
</tr>
<tr>
<td>ASD</td>
<td>Autistic Spectrum Disorders</td>
</tr>
<tr>
<td>B&amp;NES/BaNES</td>
<td>Bath and North East Somerset</td>
</tr>
<tr>
<td>BASE</td>
<td>Barnardo's Against Sexual Exploitation</td>
</tr>
<tr>
<td>BRI</td>
<td>Bristol Royal Infirmary</td>
</tr>
<tr>
<td>CAF</td>
<td>Common Assessment Framework</td>
</tr>
<tr>
<td>CAMHS</td>
<td>Child and Adolescent Mental Health Services</td>
</tr>
<tr>
<td>CASH</td>
<td>Contraception and Sexual Health Service</td>
</tr>
<tr>
<td>CCG</td>
<td>Clinical Commissioning Group</td>
</tr>
<tr>
<td>CCQI</td>
<td>Royal College of Psychiatrists’ Centre for Quality Improvement</td>
</tr>
<tr>
<td>CSE</td>
<td>Child Sexual Exploitation</td>
</tr>
<tr>
<td>CYP</td>
<td>Children and Young People</td>
</tr>
<tr>
<td>DfE</td>
<td>Department for Education</td>
</tr>
<tr>
<td>DHI</td>
<td>Developing Health &amp; Independence</td>
</tr>
<tr>
<td>DrinkThink tool</td>
<td>The leading screening tool in B&amp;NES to identify and respond to the needs of young people drinking.</td>
</tr>
<tr>
<td>FAE</td>
<td>Foetal Alcohol Effects</td>
</tr>
<tr>
<td>FAS</td>
<td>Foetal Alcohol Syndrome</td>
</tr>
<tr>
<td>FASD</td>
<td>Foetal Alcohol Spectrum Disorder</td>
</tr>
<tr>
<td>HMRC</td>
<td>Her Majesty's Revenue and Customs</td>
</tr>
<tr>
<td>IBA</td>
<td>Identification and Brief Advice</td>
</tr>
<tr>
<td>JSNA</td>
<td>Joint Strategic Needs Assessment</td>
</tr>
<tr>
<td>LSCB</td>
<td>Local Safeguarding Children Board</td>
</tr>
<tr>
<td>MARAC</td>
<td>Multi Agency Risk Assessment Conference – a local, multi-agency victim-focused meeting where information is shared on the highest risk cases of domestic violence and abuse between different statutory and voluntary sector agencies.</td>
</tr>
<tr>
<td>M-CAT</td>
<td>Mephedrone</td>
</tr>
<tr>
<td>NDTMS</td>
<td>National Drug Treatment Monitoring System</td>
</tr>
<tr>
<td>NEET</td>
<td>Not in Education, Employment or Training</td>
</tr>
<tr>
<td>NICE</td>
<td>National Institute for Health and Care Excellence</td>
</tr>
<tr>
<td>non-White-British</td>
<td>Examples include: Irish, French, Polish, Romanian, Turkish, Pakistani, American, Australian.</td>
</tr>
<tr>
<td>NTA</td>
<td>National Treatment Agency (no longer exists and functions transferred to PHE on 1st April 2013)</td>
</tr>
<tr>
<td>NPS</td>
<td>New Psychoactive Substances</td>
</tr>
<tr>
<td>ONS</td>
<td>Office for National Statistics</td>
</tr>
<tr>
<td>PCSO</td>
<td>Police Community Support Officer</td>
</tr>
<tr>
<td>pFAS</td>
<td>partial Foetal Alcohol Syndrome</td>
</tr>
<tr>
<td>PHE</td>
<td>Public Health England</td>
</tr>
<tr>
<td>PP</td>
<td>Pupil Premium</td>
</tr>
<tr>
<td>Project 28</td>
<td>A locally commissioned service in B&amp;NES which provides a range of both specialist and targeted substance misuse interventions for young people.</td>
</tr>
<tr>
<td>PSHE</td>
<td>Personal Social Health and Economic Education</td>
</tr>
</tbody>
</table>
What about YOUth? is a new study which aims to make improvements to the health of young people across England.

<table>
<thead>
<tr>
<th>RUH</th>
<th>Royal United Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>SHEU</td>
<td>Schools and students Health Education Unit</td>
</tr>
<tr>
<td>SWAS</td>
<td>South Western Ambulance Service</td>
</tr>
<tr>
<td>TNT</td>
<td>‘Street’ name of the drug fentanyl</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organisation</td>
</tr>
<tr>
<td>YOS</td>
<td>Youth Offending Service</td>
</tr>
<tr>
<td>YPOR</td>
<td>Young People’s Outcome Record, which is a national tool that captures a full range of data on outcomes for young people who access specialist substance misuse services.</td>
</tr>
</tbody>
</table>
1.0 Introduction

The primary purpose of this needs assessment is to identify the needs of young people requiring specialist treatment for substance misuse. It includes recommendations that not only address unmet treatment needs, but also seek to incorporate wider substance misuse prevention alongside alcohol and smoking, thus ensuring young people have access to early targeted help.

Drug and alcohol misuse pose a significant risk to a young person’s physical and psychological health and development. For example, regular cannabis use, the most common drug used by young people, predicts an increased risk of schizophrenia. Furthermore, the adolescent brain is known to be particularly susceptible to alcohol. By delaying the age at which young people start drinking, they are less likely to engage in health risk behaviours, and to later become dependent on alcohol.

The official advice from the chief medical officers across the UK is that no children should be given alcohol until they are at least 15 years old, and alcohol should only be given to older teenagers under supervision of a carer or parent, never on more than one day a week, and should not exceed the maximum daily units for adults on a regular basis (females: 2-3 units; males: 3-4 units).

The potential stages of substance use have been described as follows:

- experimental;
- social;
- early ‘at risk’;
- late ‘at risk’ (substance use is not dominating mental state);
- harmful use or substance abuse; and
- dependence (only a rare minority of young people progress to this stage).

The following quote from Public Health England (PHE) highlights the need for local authorities not only to invest in targeted services for those most at risk, but also for the provision of services for all children, i.e. universal approaches.

“While the majority of young people do not use drugs, and most of those that do are not dependent, drug and alcohol misuse can have a major impact on young people’s education, their health, their families and their long-term chances in life. It is for these reasons that Local Authorities are strongly encouraged to continue...”

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1 Hall, W. and Degenhardt, L. (2008), Cannabis use and the risk of developing a psychotic disorder, World Psychiatry, 7:2, pp. 68-71.
4 Ibid.
to invest in substance related service provision across the different levels of need from schools to treating young people’s substance misuse.”

The findings of this needs assessment will inform the treatment planning process for substance misuse for the future, including the production of an Action Plan. It will also contribute to, and inform the Children and Young People’s Plan and Early Help Strategy.

1.1 Demographic Overview

The latest population estimates as at mid-2013 estimates the total population of Bath & North East Somerset (B&NES) to be 182,000. There are an estimated 41,100 children and young people under 20 years of age, which make up 22.6 percent (roughly one in four) of the population of B&NES.

The main populations at risk are:

- 10-14 year olds – 9,200
- 15-19 year olds – 12,800

B&NES has a higher proportion of residents (10.6 percent) aged 20-24 that nationally (7.9 percent), this can be attributed to the high student population due to the two universities that are located in B&NES.

At the time of the 2011 national census around one in ten of the resident B&NES population were non-White-British. A similar proportion of the children and young people B&NES school on-roll ‘population’ are also estimated to be non-White-British – 13 percent of primary school pupils and 10 percent of secondary school pupils. After White British, the second most common ethnic group in B&NES is ‘White Other’ (i.e. from other European countries such as Poland).

According to HM Revenue and Customs’ 2012 snapshot of children in low income families, 12 percent of children under-16 years of age in B&NES were in low income families (compared to 15

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percent in the South West and 19 percent in England). The wards in B\&NES where the highest proportions of children are thought to live in poverty are: Twerton with 32 percent (around one in three); Southdown with 26 percent (around one in four); and Radstock with 22 percent (around one in five). According to the Campaign to End Child Poverty, approximately 12 percent of children in B\&NES live in poverty, i.e. the same as the most recent HMRC figures.

1.2 Overview of Existing Commissioning Arrangements

The current treatment service has been commissioned alongside the adult treatment service from 1st April 2013 to 31st March 2016.

1.3 Why Invest in Substance Misuse Services for Young People?

There are a variety of poor outcomes associated with different types of substance misuse, which are costly for individuals (in terms of lost earnings potential, poorer mental and physical health, etc.), and a variety of public services (in terms of additional cost of healthcare to the NHS, social services, etc.); thus making prevention, early identification and treatment cost effective when applied to the savings incurred to the total public purse.

The Department for Education has produced a cost benefit analysis for the treatment of young people within specialist drug and alcohol services. The following is a summary of the findings:

“Overall, the study has shown that the immediate and long-term benefits of specialist substance misuse treatment for young people are likely to significantly outweigh the cost of providing this treatment. In particular, we have estimated a benefit of £4.66-£8.38 for every £1 spent on young people’s drug and alcohol treatment. Furthermore, our central case estimates are based on a conservative set of assumptions. Therefore, the benefit of specialist drug and alcohol treatment for young people may be larger than we report here.”

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11 Ibid.


1.4 Purpose

This is the fourth B&NES Young People’s Substance Misuse Needs Assessment, which builds on the most recent one, undertaken in 2010. This needs assessment has been compiled by a multi-agency Expert Group, in accordance with PHE guidance. This year’s needs assessment includes a review of early help and prevention, alongside treatment, and addresses in greater depth some of the issues and questions that were identified in 2010. The inclusion of early help and prevention provides a useful opportunity to better understand the pathways into treatment, wider workforce development and ensuring effective treatment for those that require it.

The purpose of this needs assessment is to consider whether in B&NES:

- progress has been made since the previous needs assessment;
- to contribute to preventative services Early Help Strategy and commissioning arrangements ensuring effective and consistent early intervention (see section 3.1 for further information);
- to ensure practitioners inform local priorities contributing to year two of the Children and Young People’s Plan 2014-17;
- to review national evidence of effective practice and define good systems to assess ourselves against;
- to ensure alignment of our Children and Young People’s Plan and Joint Health and Well-being Strategy; and
- to support current and future commissioning.

This needs assessment feeds into core council strategies, these include:

- The Children and Young People’s Plan 2014-17.
- The Joint Health and Wellbeing Strategy.
- The Sexual Health Strategy 2015.
- Early Help Strategy (under development).

In B&NES, the majority of young people’s specialist treatment is delivered by Developing Health and Independence (DHI) Project 28. Project 28 is a commissioned service which provides a range of both specialist and targeted substance misuse interventions for young people.

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16 Which has been refreshed and is currently awaiting sign-off.
18 Which will soon be going out for consultation.
1.5 Methodology

This substance misuse needs assessment will use a combination of two approaches:

- Epidemiological; and
- Corporate.

1.5.1 Epidemiological

This information is based on the available data and analytical sources including, but not limited to:

- A range of data sources, mainly from 2013/14 NDTMS.
- The mapping and evaluation of the current treatment and intervention provision (desk-top review);
- Service user profiles (desk-top review);
- Review of research evidence, for example, researching the evidence of effective interventions (desk-top review); and
- National and local contextual data, for example, mapping geographical locations where populations are at greater risk of substance misuse (desk-top review).

1.5.2 Corporate

To consult with, and elicit the views of, key stakeholders via the Expert Group. The Expert Group consists of representatives from the following:

- B&NES;
- Public Health England (PHE);
- NHS CAMHS;
- DHI/Project 28;
- Curo Housing;
- Sirona;
- BaNES CCG;
- Avon & Somerset Police;
- Bath College;
- Bath Area Play Project;
- Diversity Trust;
- Black Families Support Group; and
- Mentoring Plus.

There have been two meetings of the Expert Group – 6th October 2014 and 12th January 2015. Feedback from these two events is outlined in Section 5.2.

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20 Epidemiological information is used to plan and evaluate strategies to prevent illness and as a guide to the management of patients in whom disease has already developed.
## 2.0 Progress against the 2010 Needs Assessment

A number of key recommendations were made following the 2010 Needs Assessment, which are summarised below alongside work undertaken to address these key areas:

<table>
<thead>
<tr>
<th>Key Recommendation 2010 Needs Assessment</th>
<th>Progress Against Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>To address how the treatment needs of young people receiving a custodial sentence are met both in Prison and on release.</td>
<td>Processes are in place to support a young person and their family through the court process, including joint work with the Youth Offending Service (YOS) and an appropriate adult on arrest. This is reflected in the increase in referrals from the YOS. Whilst there is a Secure Unit, there is no longer a local young offender’s prison. However, prior to any release joint work is undertaken.</td>
</tr>
<tr>
<td>To continue to get good harm reduction messages to young people in schools and colleges and elsewhere via outreach;</td>
<td>A dedicated schools and college worker from Project 28 is in place with outreach, harm reduction and prevention taking place. Joint planning for PSHE development is in place alongside the LA PSHE coordinator.</td>
</tr>
<tr>
<td>To ensure the national drug treatment monitoring service (NDTMS) data reflects the range of interventions delivered by Project 28 and the good outcomes it achieves.</td>
<td>The national database system (NDTMS) has been developed and enhanced since 2010, e.g. B&amp;NES is now able to analyse key vulnerabilities. B&amp;NES has also introduced a new case management system for young people and adults. Through this system the long term impact of YP treatment can now be analysed. The monitoring of treatment outcomes through a Young People’s Outcome Record (YPOR) has recently been established with analysis of this building into a future commissioning process.</td>
</tr>
<tr>
<td>A review of ‘treatment naïve’ young people aged 18-24 in the adult treatment system.</td>
<td>There is currently no national research on understanding why some young people never access young people’s services. However this 2015 needs assessment will look at research from South Gloucestershire which has interviewed young people and also a review of B&amp;NES data to establish how many young people have not accesses young people’s treatment who later went onto use.</td>
</tr>
<tr>
<td>The extent to which young people’s substance misuse features in family problems and whether there are opportunities for social workers and other professionals to intervene at an earlier stage to prevent the need for specialist treatment.</td>
<td>Training the workforce has been an integral aspect of the work which Project 28 delivers. This continues to be of high importance and the 2015 needs assessment explores this further with a dedicated chapter on early help, prevention and also workforce development. Since 2010 there has been the development of Connecting Families team which seeks to support families and provides an opportunity for joint work.</td>
</tr>
</tbody>
</table>
A review of the DrinkThink Tool’s potential wider application.

The DrinkThink Tool continues to be used across B&NES and has been included in key contracts such as the Contraception and Sexual Health Service (CASH) contract for sexual health services. Further work needs to be done to ensure it is embedded in all early help services. The DrinkThink tool will be evaluated from March 2015-December 2016 by the University of Bristol through the School for Public Health Research, in conjunction with Bath University, who will lead on the qualitative aspects of the research.

Exploring other opportunities to deliver brief interventions at hospitals and in other health settings.

Prior to 2014 referrals into treatment for young people came through the local Child and Adolescent Mental Health Services (CAMHS) service. The hospital pathway was reviewed and amended in 2014 with the local hospital now making a direct referral into Project 28. This has seen an increase in referrals to the service.
3.0 Prevention and Early Help

3.1 Introduction

Evidence shows that ‘Early Help’ both leads to better outcomes for children and young people, and is cost-effective. Effective early help means providing support as soon as problems arise, at any stage in a child’s life. Early Help relies upon all adult and children’s services to identify those children and families that would benefit from early help; undertaking a comprehensive assessment of the need for early help and providing help to address need/s and improve outcomes.

3.2 Patterns of substance misuse

3.2.1 Drug Use

Around one in eight 14/15 year olds surveyed in B&NES during 2013 reported having taken drugs in the past, with the main drug taken being cannabis (which is often used with tobacco, see 3.2.3). Rates of hospital admissions due to substance misuse among young people are significantly lower than national (during 2011/12-2013/14 the admission rate was 43.8 per 100,000 population aged 15-24 years, significantly below the comparable rate for England of 81.3). Furthermore, the latest available rate from 2011/12-2013/14 represents a fall from the previous three year period – from 50.7 per 100,000 population aged 15-24 years during 2010/11-2012/13.

3.2.2 Alcohol Use

While more children and young people are reporting they do not drink alcohol, and rates of alcohol specific admissions are falling (see 3.3.11), one in three 14/15 years olds surveyed in B&NES reported during 2013 they had an alcoholic drink in the past week.

3.2.3 Smoking

Smoking rates have been steadily falling. However, around 1 in 25 young people surveyed in B&NES reported they were regular smokers in 2013. Smoking increases with age, becoming more prevalent as children progress through secondary school, and more girls reported they were smoking than boys in 2013 in B&NES. Regular smoking is associated with alcohol and drug use.
Very few people start smoking as adults – two-thirds (66 percent) of adults who were either current smokers or who had smoked regularly at some time in their lives had started smoking before they were 18 years of age; and two-fifths (40 percent) had started smoking regularly before the age of 16 even though it has been illegal to sell cigarettes to people aged under 16 since 1908 and has recently become illegal to sell cigarettes to people under 18 years of age.\(^{21}\)

### 3.2.4 Future Child Health-Related Behaviour Surveys

Data from the Child Health-Related Behaviour Survey in B&NES has provided valuable intelligence on prevalence and trends for alcohol, drugs and tobacco. However, B&NES is not yet able to compare the results from this local survey data with findings from the national Smoking, Drinking and Drug Use among Young People in England Survey. Additionally, a survey, called ‘What about YOUth?’, has been launched as part of the previous Coalition government’s pledge to make improvements to the health of young people.\(^{22}\) It asks 15-year olds about important subjects including what they eat, what they do in their free time, bullying and whether they smoke, drink alcohol or have taken drugs. Local authority level data will be available from late 2015.

**Recommendation 1:** B&NES has recently commissioned the ‘School and Students Health Education Unit’ (SHEU) to undertake two future surveys of young people – one in 2015, and another in 2017. It is recognised there is a need to harmonise some of the survey questions with national ones, and it is anticipated that this will take place in the coming months, with findings available in autumn 2015. The findings from the ‘What about YOUth?’ survey will also be reviewed alongside the SHEU survey when published.

### 3.2.5 Adults in Treatment without previous engagement in Project 28

Figure 1 shows a breakdown by type of substance of 309 young people under the age of 25 who entered treatment with adult services without any prior engagement with young people’s treatment service. This demonstrates that screening and training (particularly for vulnerable young people or those with multiple needs – Table 1) needs to be further developed within B&NES to improve early identification and early intervention (see 6.3).

**Figure 1: Presenting substance of clients under the age of 25 years who have entered treatment with adult services without any prior engagement with young people’s treatment, B&NES, November 2014**

Source: Project 28 ILLY Systems Database, 1\(^{st}\) April 2012- 31\(^{st}\) Dec 2014.

Notes: This is a snapshot of clients in treatment at November 2014.

\(^{21}\) ONS (2013), Chapter 1 - Smoking (General Lifestyle Survey Overview - a report on the 2011 General Lifestyle Survey), available from the following link: [http://www.ons.gov.uk/ons/dcp171776_302558.pdf](http://www.ons.gov.uk/ons/dcp171776_302558.pdf)

\(^{22}\) For further information: [http://www.whataboutyouth.com/](http://www.whataboutyouth.com/)
3.3 Identifying Young People at Risk of Substance Misuse

3.3.1 Vulnerability Factors

There are a number of factors that put young people at risk of substance misuse ranging from problems in a young person’s life to local norms. The National Treatment Agency’s ‘Substance Misuse among Young People 2010-11’ highlights that drug and alcohol misuse among teenagers “is usually a symptom rather than a cause of their vulnerability”, and compounds other problems in their lives such as family breakdown, inadequate housing, offending, truancy, anti-social behaviour, poor educational attainment and mental health concerns such as self-harm.23

In 2003, 24 percent of vulnerable young people nationally reported using illicit drugs frequently during the preceding 12 months, compared with 5 percent of their less vulnerable peers.24 There were significantly higher levels of drug use among those who belonged to more than one vulnerable group. Becker and Roe define five groups of vulnerable young people:

i. those who have ever been in care;
ii. those who have ever been homeless;
iii. truants;
iv. those excluded from school; and
v. serious or frequent offenders.

NICE Guidance from 2007 titled ‘Interventions to reduce substance misuse among vulnerable young people’25 highlights vulnerable and disadvantaged children and young people aged under 25 who are at risk of misusing substances include:

- those whose family members misuse substances;
- those with behavioural, mental health or social problems;
- those excluded from school and truants;
- young offenders;
- looked after children;
- those who are homeless;
- those involved in commercial sex work; and
- those from some black and minority ethnic groups.

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25 NICE (2007), Interventions to reduce substance misuse among vulnerable young people, NICE guidelines [PH4], available from the following link: https://www.nice.org.uk/guidance/ph4
Conversely, there are a number of protective factors which seemed to make certain young people less likely to develop drug problems including:

- a supportive family environment;
- a positive personality and intelligence;
- a caring relationship with at least one adult; and
- other systems of support that encourage positive values.\(^\text{26}\)

**Figure 2: Key needs identified in Early Help Common Assessment Framework (CAF) assessments received by B&NES Council, 2013/14**

![Pie chart showing key needs identified in Early Help CAF assessments](image)


Note: Early Help CAF is a form of Early Help Assessment and is one of a number of tools and processes which help practitioners in B&NES to assess and address the needs of a child or young person at the earliest stage.

The key needs of emotional support, parental capacity/support, domestic abuse (past or present), and challenging behaviour at school all followed closely as identified needs which have led to the initiation of an Early Help Assessment. From a total of 608 identified cases, 3 percent involved substance misuse (within the 8 per cent ‘other’ needs category) as the main need identified (Figure 2). However, substance misuse may be secondary factors in many more of the needs.

In addition to the CAF’s identified above, the Connecting families team undertakes family CAF’s. Connecting Families Team was established in April 2013, as Bath and North East Somerset Council’s (B&NES) response to the Government’s Troubled Families Initiative. B&NES Council has successfully completed phase one of the programme and has been chosen as an early starter for phase two; with the aim to ‘turn around’ 710 vulnerable families by 2020. The criteria for the programme are:

- parents and children involved in crime or anti-social behaviour;
- children who have not been attending school regularly;
- children who are at risk and need additional help;
- adults out of work or at risk of financial exclusion and young people at risk of worklessness;
- families affected by domestic violence and abuse; and
- parents and children with a range of health problems.

The core purpose of the programme is to enable families with multiple complex needs to receive the services they need to change and support them to achieve resilience, health and wellbeing within their community.

Criteria for identifying eligible families for phase two include the following:

- an adult with a drug or alcohol issue and who has parenting responsibilities, or a child with a drug or alcohol issue; and
- adults with parenting responsibilities of children who are referred by professionals as having any mental, physical and/or substance misuse health issues.

Outcomes for families eligible for the programme are measured and assessed against a payment-by-results system.

The number of families identified as having a substance misuse need following assessment during 2014/15 is 29 out of 57 families, or 51 percent (this includes both alcohol and drug misuse for families assessed by a Connecting Families keyworker).

Table 1: Vulnerability factors of newly presented ‘In Treatment’ cohort, B&NES 2014/15

<table>
<thead>
<tr>
<th>Factor</th>
<th>Young Peoples' Treatment, Project 28 2014/15 (67)</th>
<th>National Average 2014/15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Looked After Child a</td>
<td>16% (11)</td>
<td>12%</td>
</tr>
<tr>
<td>Child in Need b</td>
<td>SUP c</td>
<td>6%</td>
</tr>
<tr>
<td>Domestic Abuse a</td>
<td>39% (26)</td>
<td>21%</td>
</tr>
<tr>
<td>Mental Health problem a</td>
<td>18% (12)</td>
<td>17%</td>
</tr>
<tr>
<td>Child Sexual Exploitation a</td>
<td>13% (9)</td>
<td>5%</td>
</tr>
<tr>
<td>Self-Harm a</td>
<td>36% (24)</td>
<td>17%</td>
</tr>
<tr>
<td>NEET</td>
<td>10% (7)</td>
<td>17%</td>
</tr>
<tr>
<td>Housing problems b</td>
<td>SUP c</td>
<td>2%</td>
</tr>
<tr>
<td>Parental status / pregnant b</td>
<td>SUP c</td>
<td>2%</td>
</tr>
<tr>
<td>Child Protection Plan b</td>
<td>10% (7)</td>
<td>7%</td>
</tr>
<tr>
<td>Anti-social behaviour/criminal act a</td>
<td>33% (22)</td>
<td>31%</td>
</tr>
<tr>
<td>Affected by others’ substance misuse a</td>
<td>36% (24)</td>
<td>21%</td>
</tr>
</tbody>
</table>

Note: ‘In Treatment’ cohort includes all those young people receiving treatment for substance misuse during the financial year 2014/15 (which also applies for the national figures).
Codes: (a) Shaded grey to indicate where B&NES is higher compared to national (no significance test has been applied). (b) Italics text where it is not possible to determine whether the local figure is higher or lower than national (due to suppression). (c) ‘SUP’ – suppressed due to small numbers.

Table 1 shows the vulnerability factors of 67 new presentations to treatment during the period 1st April 2014 to 31st March 2015. For eight out of the nine vulnerabilities listed in Table 1, where local...
figures were not suppressed, the local figure is higher than the comparable national figure. This suggests that the 'In Treatment' cohort in B&NES may be a more vulnerable cohort compared to national. However, given the small numbers, this is not likely to be statistically significant.

### 3.3.2 Young Offenders and the YOS Diversionary Project

A third (33 percent) of young people presenting into treatment during 2014/15 were identified by the treatment provider as having been involved with anti-social behaviour and/or criminality, roughly the same as national (31 percent) (Table 1).

Nine percent of referrals between 1st April 2013 and 31st March 2014 to the local B&NES treatment service (Project 28) were from the Youth Offending Service (YOS) (compared to 29 percent nationally). However, only 13 percent of young people in treatment jointly worked with the YOS (compared to 15 percent nationally).

In January 2015 Project 28 began delivering a Diversionary Project in partnership with the Youth Offending Service, where young people are offered support and assessment around their drug/alcohol use and offending. Project 28 seeks to provide holistic packages of care to young people in the project. This service is in partnership with the YOS and runs every Tuesday evening, with a total of 13 young people being referred to date (as at April 2015).

### 3.3.3 Looked After Children (LAC)

As at 31st March 2014 there were around 100 children looked after who had been looked after for at least 12 months in B&NES. Of these, there were between 1 and 4 children looked after identified as having a substance misuse problem during the year.

Twenty-two percent of referrals into the drug and alcohol treatment service during 2013/14 were from children and family services (Table 3), which includes LAC. When considering the vulnerabilities of young people in treatment (Table 1), 16 percent of young people in treatment were identified as being LAC, a higher proportion compared to national (12 percent).

The workforce development section recommends developing a workforce strategy (see 6.3), which includes Social Care workers receiving regular training and development to ensure young people are referred through into Project 28. This is particularly crucial given the wide range of vulnerabilities identified within Table 1.

### 3.3.4 Children Excluded from School

During the 2012/13 academic year there were between 1 and 4 school pupils permanently excluded from state-funded primary, secondary and special schools in B&NES due in part to smoking, drug and/or alcohol use. During the 2012/13 academic year there were 59 fixed-period exclusions from state-funded primary, state-funded secondary and special schools in B&NES which were smoking, and/or...
drug and/or alcohol related. Even though there has been a large reduction in the number of fixed-period exclusions from the previous academic year (105 in 2011/12), there were 53 fixed-period exclusions in the 2010/11 academic year.

### 3.3.5 Hidden Harms

The Advisory Council on the Misuse of Drugs (ACMD) *Hidden Harm* report in 2003 estimated that there were between 250,000 and 300,000 children with at least one parent who had a serious drug problem – representing 2-3 percent of children under 16 nationally. The report highlighted that children of parents that misuse substances are more likely to experience a range of negative outcomes and potentially face serious harm at every stage of their life from conception through to adulthood.

More recently, the 2011 Munro Review of child protection found that many services (including substance misuse agencies) were too focused on adults and not enough on the children affected by adults’ problems.

There were a total of 1,057 adults in drug and alcohol treatment services in B&NES in the period of 1st April 2014 to 31st March 2015. Of these, 301 (29 percent) are recorded as living with a child or young person under the age of 18, which is similar to the national picture. The proportion of these adults who successfully complete and leave alcohol treatment in B&NES is significantly higher at 60 percent than the national average at 39 percent.

The National Treatment Agency, which is now part of Public Health England (PHE), recommends that links are developed between drug and alcohol services and children services in order to respond to the needs of hidden harm. The previous Coalition government produced a document to support local partnerships to develop joint local protocols between the drug and alcohol partnerships, and children and family services. A leaflet for practitioners has recently been developed in collaboration between Children’s Social Care and Drug and Alcohol Services to increase practitioner’s awareness of dangers in the home. This will be further developed in 2015 to include a leaflet for families. In addition, there is a Young Carer’s service within B&NES which is able to support young people affected by parental substance misuse.

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39 Ibid.
40 Ibid.
42 Ibid.
Related to the theme of hidden harm is the issue of Foetal Alcohol Spectrum Disorder (FASD), a preventable cause of alcohol-related birth defects which is a direct result of prenatal alcohol exposure. FASD is an umbrella term that covers Foetal Alcohol Syndrome (FAS), Alcohol-Related Neurodevelopmental Disorder (ARND), Alcohol-Related Birth Defects (ARBD), Foetal Alcohol Effects (FAE) and partial Foetal Alcohol Syndrome (pFAS). Its effects range from reduced intellectual ability and Attention Deficit Disorder to heart problems. FASD may not be detected at birth but can become apparent later in life and carries lifelong implications. FASD is a result of alcohol consumption during pregnancy. Alcohol is a teratogen – a substance that causes malformations in a foetus and interferes with its development.

The incidence of FASD in the UK and internationally is not accurately known. Many children born with FASD are not diagnosed, or do not receive a correct diagnosis, which makes calculating the prevalence of the condition extremely difficult. However, a recent study in Alberta, Canada estimated the incidence of FASD to be between 14.2 and 43.8 per 1,000 births, depending on the length of follow-up. Furthermore, the prevalence of FASD was estimated to be 11.7 (range 8.2 to 15.1) per 1,000 population. A further American study estimated the prevalence rate of FASD at 24 to 48 per 1,000 children, or 2.4 percent to 4.8 percent (midpoint, 3.6 percent). The evidence appears to be settling on a figure of about one percent of live births, but with some variability and more frequent in higher risk communities. Applying this to live births in Bath & North East Somerset – around 1,850 live births per annum – provides an estimate of around 19 babies with FASD born every year.

Data from the B&NES specialist Drug & Alcohol Service showed there were between 1 and 4 pregnant women known to its service who were misusing alcohol between 1st April 2014 and 31st March 2015. Data from DHI showed there were between 1 and 4 pregnant women in treatment as at 31 March 2015 who were misusing alcohol (there will be overlaps between these two sources of data).

Recommendation 3: It is recommended that Project 28 develops links with the local Young Carer’s Service, including the provision of outreach support to the service. Additionally, a leaflet for families to sit alongside the practitioners leaflet on recognising household dangers within the home should be produced.

Recommendation 4: Further analysis is required to explore the local prevalence of Foetal Alcohol Spectrum Disorder (FASD). Public Health and Children’s and Adult’s Services should also work together to improve awareness of the dangers of drinking during pregnancy.
3.3.6 Homelessness and Housing Need

Nationally, households with dependent children accepted as statutorily homeless, as well as families with children in temporary accommodation (including Bed & Breakfast), have once again been rising.\(^47\)

Homelessness compounds a number of the problems faced by young people. This is particularly evident with mental health problems and/or the onset of (or exacerbation of existing) substance misuse problems.\(^48\) Nationally, 2 percent of young people entering treatment have housing problems (Table 1). During the two years 1\(^{st}\) April 2013 to 31\(^{st}\) March 2015 B&NES Housing Services received 5 homeless applications from 16/17 year olds – 4 out of the 5 had identified drug use.\(^49\)

During 2013/14, 90 percent (128) of young people in drug and alcohol treatment in B&NES were living at home or with their parents.\(^50\)

3.3.7 Not in Education, Employment or Training (NEETs)

At the end of 2014 in B&NES there were estimated to be 20 sixteen year olds (1.3 percent) and 50 seventeen year olds (3.1 percent) not in education, employment or training (NEET).\(^51\)

Nationally, around 1 in 6 young people entering treatment (17 percent) are identified as NEET (Table 1). This is higher than the local comparable figure of 7 percent during the same period (Table 1).

It will remain essential to ensure that, as detailed within the workforce development section (Section 6), staff alongside the wider workforce receives on-going training to ensure effective screening and referral into treatment.

3.3.8 Mental Health (including Self-Harm)

The World Health Organisation recognises that poor mental health can have an important effect on the wider health and development of adolescents and is associated with several health and social outcomes such as higher alcohol, tobacco and illicit substances use, adolescent pregnancy, school drop-out and delinquent behaviours.\(^52\) Five percent of referrals into treatment in B&NES during 2013/14 were from Child and Adolescent Mental Health Service (CAMHS), which was above 3 percent witnessed nationally (Table 3).\(^53\) As at 30\(^{th}\) September 2014, almost a quarter of clients coming into treatment stated self-harm (36 percent), which compares to 17 percent nationally (Table 1). This higher proportion locally may be due to an effective local working partnership which

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\(^{49}\) E-mail from Homeless Review and Policy Officer, Housing Services, Bath and North East Somerset Council dated 15\(^{th}\) July 2015.

\(^{50}\) NDTMS.net Young Peoples’ Quarterly Activity Report Q4 2013-14.


\(^{53}\) NDTMS.net Young Peoples’ Quarterly Activity Report Q4 2013-14.
is in place to jointly work across substance misuse and the CAMHS service. However, this difference may also be due to a higher prevalence of young people locally who self-harm (as is suggested by higher rates of self-harm related hospital admissions locally compared to nationally\textsuperscript{54}).

During 2013/14, roughly 1 in 3 young people (16-21 years) from B&NES presenting for self-harm at the RUH emergency department also had a history of misusing alcohol.\textsuperscript{55} Misuse of illicit drugs was less common, at about 10 percent of presentations.\textsuperscript{56} The self-harm may have taken a different form such as cutting or over-dose of tablets, but the alcohol or drug misuse was noted as a background risk factor.

CAMHS and Project 28 hold monthly meetings to discuss partnership working of cases to ensure effective case management. When required, CAMHS and Project 28 will hold joint triage assessments when a mental health need is identified. An early intervention psychosis pilot project has been commissioned which will support those with a dual mental health and substance misuse diagnosis. A key aim of the service will be to improve links between substance misuse services, developmental disorder (e.g. ASD) services, CAMHS, and Youth Connections. It will also involve Bath College, other Higher Education providers, police (regarding NPSs) and the RUH (Self-Harm Register). This pilot should prevent the future use of more specialist mental health and emergency services.

In order to try and prevent more serious mental health illnesses/conditions from developing among young people (which in turn should reduce the risk of substance misuse), B&NES council has recently commissioned two pilot therapeutic support/counselling services in primary and secondary schools. The primary school service is provided by Place2Be (a national organisation), delivering school based counselling and mental health support in six primary schools. The new locally commissioned secondary school counselling service is being provided for one year from September 2015, with ‘wrap-around’ care being provided by mental health practitioners from the local Child and Adolescent Mental Health Service (CAMHS).

\textbf{Recommendation 5}: It is recommended that Project 28 develops links with the pilot secondary school therapeutic support/counselling service to provide substance misuse training and to ensure effective referral pathways are in place.

\textsuperscript{54} The rate of inpatient admissions during 2012/13 for 10-24 year olds because of self-harm is 456.1 per 100,000, or 197 admissions – significantly higher than the England average of 346.3 per 100,000. \textbf{Source}: 2014 Child Health Profile for B&NES, available from the following link: \url{http://www.chimat.org.uk/profiles}

\textsuperscript{55} Carroll, R. and Harrison, A. (2015), \textit{RUH (Bath \& North East Somerset and Wiltshire) Self-harm Register: 1 April 2013 – 30 April 2014}, School of Social \& Community Medicine, University of Bristol and Avon \& Wiltshire Mental Health Partnership NHS Trust.

\textsuperscript{56} \textit{Ibid.}
3.3.9 Smoking

As young people become adults, they are more likely to smoke if they misuse alcohol or drugs or live in poverty.\(^{57}\)

The Tobacco Action Network for B&NES oversees delivery of the local ‘Tobacco Control Strategy 2013-2018’.\(^{58}\) A key aim of the Strategy is to reduce inequalities in health by preventing young people from starting to smoke and reducing the harm from exposure to second hand smoke. The most effective policies are those at a population level involving regulation and enforcement of price, sale, marketing and promotion. Priorities for local action include:

- the promotion of smoke free environments including homes, play areas, children’s centres, sports clubs and cars;
- working with schools and colleges to address smoking through policy development, training, campaigns and peer education programmes;
- supporting adult smokers to quit and in particular smokers who are pregnant;
- raising awareness of illegal tobacco and its impact on communities;
- carrying out test purchasing to ensure compliance with underage sales law; and improving local intelligence on access to illegal tobacco and e-cigarette usage by young people.

3.3.10 Child Sexual Exploitation

Substance use also plays a role in Child Sexual Exploitation (CSE), until recently a frequently hidden issue, which is when children and young people receive something (such as food, accommodation, drugs, alcohol, cigarettes, affection, gifts, or money) as a result of performing, and/or others performing on them, sexual activities. Children and young people may also be ‘groomed’ online. In B&NES, a virtual team – the Willow Project – was established in January 2014 to coordinate referral and ensure an effective multi agency response. During Q3 2014/15 21 young people were identified at risk of CSE – 7 reached a Multi-Agency Risk Assessment Conference (MARAC) and went to Panel on the waiting list to the new CSE virtual team/Willow project or were referred to BASE (Barnardo’s Against Sexual Exploitation), and the remaining 14 young people continued to work with project 28 on issues such as raising awareness of sexual exploitation, group work, video awareness raising, relationship work and controlling identification.\(^{59}\)

Project 28 submits a quarterly action plan to the Performance Delivery Group as part of the BaNES Clinical Commissioning Group (CCG) role in monitoring progress for the Local Safeguarding Children Board (LSCB) in addressing CSE needs. Such governance structures are in place to ensure any concerns regarding quality and progress against the services action plan are effectively monitored.

**Recommendation 6:** Project 28 should continue to be a part of the Child Sexual Exploitation multi-agency team and should ensure that quarterly action plans are undertaken as part of its governance structure.

\(^{57}\) Mental Health Foundation (2015), *Smoking and Mental Health*, accessed from the following link: http://www.mentalhealth.org.uk/help-information/mental-health-a-z/s/smoking/


\(^{59}\) Project 28 Quarterly Reporting on the CSE Action Plan, Q4 2014/15.
3.3.11 Alcohol Specific Hospital Admissions

In terms of children and young people (under-18 years) hospital alcohol specific admissions in B&NES, during the three rolling financial years 2011/12-2013/14, the rate is 52.1 per 100,000 population aged under 18, or a total of 55 admissions over the three years. This represents a decrease compared to the previous rolling three year period from 2010/11 to 2012/13, when the rate was 69.2 per 100,000 population aged under 18, or a total of 70 admissions over the previous rolling three years. The latest figures for 2011/12-2013/14 were also at the lowest level since at least 2006/07-2008/09 (Figure 3). Furthermore, for the first time since then, the rate is not statistically different to the comparable national rate (40.1 per 100,000 aged under 18 population) (Figure 3).

Local analysis of 107 hospital admissions (representing 100 individuals) for alcohol specific conditions in under-18 year olds resident in B&NES between 2010/11 and 2014/15 found the following:60

- There were 5 individuals who were admitted more than once for alcohol specific conditions during this 5 year period (5 percent).
- When analysed by month, there were no clear seasonal trends.
- Nearly half (52.49%) of these 107 admissions had a primary diagnosis of ‘mental and behavioural disturbances caused by alcohol’, or acute intoxication.
- 55 percent of admissions over this time period were for 16 and 17 year olds. There were 48 admissions for under-16 year olds (55 percent).
- Admission rates over time for both genders have fallen over the time period of this analysis. However, admission rates have fallen more for females compared to males, with the male admission rate having remained unchanged between 2011/12-2013/14 and 2012/13-2014/15.

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60 Addendum: 2nd November 2015.
• There has been a consistently higher number of alcohol specific hospital admissions for females than males in B&NES between 2010/11 and 2014/15. However, statistical analysis of rates per 100,000 derived from these numbers show there is no statistically significant difference between the genders.

• While young people living in the most deprived areas in B&NES experienced the highest rate of admissions, none of the deprivation quintiles are statistically different from each other.

In November 2014 new local guidelines were implemented which set out a pathway so that the RUH admissions process set out a referral to Project 28. Since November 2014 a total of 10 referrals have been made to Project 28, 7 of these referrals have been for alcohol.

A questionnaire completed by 32 ambulance paramedics (Appendix 2) based across South Gloucestershire, North Bristol and Gloucestershire have provided some useful detail about the nature of incidents involving young people who have been using substances. Paramedics estimated that:

• they receive 168-187 calls a month in relating to young people who have used a substance;
• 70 percent are due to intoxication, and 10 percent due to resulting injuries;
• 72 percent of the time there is no adult present;
• 75 percent are taken to hospital;
• 44 percent are taken to Frenchay, 21 percent to BRI (Children), 24 percent to BRI & 11 percent to Gloucester;
• the location of call, severity of injury and age of young person are the biggest influences on which A&E the young people are taken to;
• peak times are evening/weekends, exam or holiday times, and when the weather is warm; and
• staff identified a number of trends/concerns as a lack of parental responsibility, increases in alcohol/NPS use, house parties and use in public places.

This information is helpful when planning educational campaigns and understanding peak times of when call outs may occur.

**Recommendation 7:** It is recommended that the RUH alcohol pathway be reviewed after one year to evaluate the impact of the new pathway as part of the B&NES Alcohol Strategy.

**Recommendation 8:** It is recommended that further exploration and links are developed with B&NES South Western Ambulance Service (SWAS) to help our insight into call-outs for alcohol that are not reported to police and do not go to hospital, and alcohol related calls linked to young people.
3.4 What works?

The rationale for Early Help can be stated as follows: a
• address unmet potential by delivering substantial benefits for children and families;
• reduced demand for public services;
• improve social well-being;
• achieve greater fairness and social mobility; and
• improve productivity for the economy.

B&NES is currently developing an Early Help Strategy. Evidence shows that ‘Early Help’ leads to better outcomes for children and young people and is cost-effective. Effective early help means providing support as soon as problems arise, at any stage in a child’s life. Early Help relies upon all adult and children’s services to identify those children and families that would benefit from early help; undertaking a comprehensive assessment of the need for early help and providing help to address need/s and improve outcomes. There exists a wide range of NICE guidance and evidence to prevent and reduce tobacco, alcohol and drug use which can inform this Early Help Strategy.

3.4.1 Tobacco

NICE guidance ‘Preventing the uptake of smoking by children and young people’ (PH14), focuses on mass-media and point-of-sales measures. It says these should be combined with other prevention activities as part of a comprehensive tobacco control strategy encompassing price and regulation policies, education programmes, cessation support services and community programmes.

NICE guidance ‘School-based interventions to prevent the uptake of smoking’ (PH23) recommends:
• developing a whole-school approach;
• adult-led interventions integrating information about the health effects of tobacco use, as well as the legal, economic and social aspects of smoking, into the curriculum, particularly through PSHE;
• peer-led interventions, particularly evidence-based ASSIST programme;
• providing training for all staff who will be involved in smoking prevention work; and
• ensuring smoking prevention interventions in schools and other educational establishments are part of a local tobacco control strategy.

3.4.2 Alcohol

NICE guidelines ‘Alcohol-use disorders: preventing harmful drinking’ (PH24) recommends screening of 16 and 17 year olds thought to be at risk from their alcohol use. It also recommends brief intervention for those who have been identified via this screening process as drinking hazardously or

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61 Early Intervention Foundation, accessed from the following link: http://www.eif.org.uk/
63 NICE (2008), Preventing the uptake of smoking by children and young people, NICE guidelines [PH14], available from the following link: https://www.nice.org.uk/guidance/ph14
64 NICE (2010), School-based interventions to prevent smoking, NICE guidelines [PH23], available from the following link: https://www.nice.org.uk/guidance/ph23
65 NICE (2010), Alcohol-use disorders: preventing harmful drinking, NICE Public Health Guidelines [PH24], available from the following link: https://www.nice.org.uk/guidance/ph24
harmfully. There is limited evidence on the effectiveness of brief interventions for young people under the age of 16, with some data suggesting there could be adverse outcomes. However, the guidance nonetheless recommends that professionals who come into contact with children aged 10-15 years thought to be at risk from their alcohol use should assess them and consider the most appropriate response, which could be a caution, counselling or referral to mental health or drug treatment services.

NICE guidelines ‘School-based interventions on alcohol’ (PH7)\(^66\) recommends the following:

- alcohol education should be an integral part of the school curriculum and should be tailored for different age groups and different learning needs;
- a 'whole school' approach should be adopted, covering everything from policy development and the school environment to staff training, and parents and pupils should be involved in developing and supporting this;
- where appropriate, children and young people who are thought to be drinking harmful amounts should be offered one-to-one advice or should be referred to an external service; and
- schools should work with a range of local partners to support alcohol education in schools, ensure school interventions are integrated with community activities and to find ways to consult with families about initiatives to reduce alcohol use.

A Cochrane systematic review\(^67\) published in 2011\(^68\) consisted of 53 well-designed experimental studies that examined the effectiveness of school-based universal programs for the prevention of alcohol misuse in young people. The studies were divided into two major groups based on the nature of the prevention program: 1) programs targeting specifically prevention or reduction of alcohol misuse and 2) generic programs with wider focus for prevention (e.g., other drug use/abuse, antisocial behaviour). In the review we found studies that showed no effects of the preventive program, as well as studies that demonstrated statistically significant effects. There was no easily discernible pattern in program characteristics that would distinguish studies with positive results from those with no effects. Most commonly observed positive effects across programs were for drunkenness and binge drinking. In conclusion, current evidence suggests that certain generic psychosocial and developmental prevention programs can be effective and could be considered as policy and practice options. These include the Life Skills Training Program, the Unplugged program, and the Good Behaviour Game.

NICE quality standard ‘Alcohol: preventing harmful alcohol use in the community’ (QS83)\(^69\) sets out four key statements which are aimed at preventing harmful alcohol use in the community:

1. Local authorities use local crime and related trauma data to map the extent of alcohol-related problems, to inform the development or review of a statement of licensing policy.

\(^{66}\) NICE (2007), *School-based interventions on alcohol*, NICE Public Health Guidelines [PH7], available from the following link: [https://www.nice.org.uk/guidance/ph7](https://www.nice.org.uk/guidance/ph7)

\(^{67}\) Cochrane Reviews are systematic reviews of primary research in human health care and health policy, and are internationally recognised as the highest standard in evidence-based health care.


\(^{69}\) NICE (2015), *Alcohol: preventing harmful alcohol use in the community*, NICE Quality Standard [QS83], available from the following link: [http://www.nice.org.uk/guidance/qs83](http://www.nice.org.uk/guidance/qs83)
2. Trading standards and the police identify and take action against premises that sell alcohol to people under 18.
3. Schools and colleges include alcohol education in the curriculum.
4. Schools and colleges involve parents, carers, children and young people in initiatives to reduce alcohol use.

Key to taking forward the final two recommendations will be the provision of training for schools (see Section 6.0).

3.4.3 Drugs

New standards have been developed by the Royal College of Psychiatrists’ Centre for Quality Improvement (CCQI) in partnership with substance misuse organisations, paediatricians, psychologists and nurses. They are aimed at all staff in contact with young people aged 18 or under (in universal, targeted and specialist services) across health, social care, education, youth justice system, and the voluntary and community sector. The standards propose that services invest in the psychosocial development and well-being of young people with substance misuse problems to give them the best chance of a normal life through:

- engagement of the young person, and their family where possible;
- skilled initial analysis of the young person's difficulties, including mental disorders and developmental problems such as learning disability, and life circumstances;
- engaging local systems so that they work together;
- co-ordinated, well-led interventions that mobilise the resources of local communities as required, including safeguarding, education, training, mental health and accommodation;
- active follow-up to detect further episodes of support or intervention; and
- prioritising and delivering the training and support of staff.

NICE guidance ‘Interventions to reduce substance misuse among vulnerable young people’ (PH4), recommends the following:

- developing a local strategy;
- using existing tools (including CAF) to identify children and young people who are misusing or, at risk of misusing, substances;
- working with parents and carers and other organisations involved with children and young people to provide support and, where necessary, to refer them to other services (this includes support to parents such as motivational interviewing and skills training); and
- offering motivational interviews to those who are misusing substances.

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71 NICE (2007), op. cit.
4.0 Young People in Treatment

4.1 Introduction

In B&NES, the majority of young people’s specialist treatment is delivered by Project 28. Project 28 is a commissioned service which provides a range of both specialist and targeted substance misuse interventions for young people. This section will focus on those young people who have received treatment between 2011/12 and 2013/14.

4.2 Numbers in Treatment

More young people have been treated for substance misuse in 2013/14 in B&NES, when compared to 2011/12 – from 126 in 2011/12 to 144 in 2013/14 (Figure 4). In addition, the number of young adults who have been supported within the young people’s service has declined year on year – from 31 in 2011/12 to 11 in 2013/14 (Figure 5). This is in line with a local strategy to increase the numbers of young people being transitioned into adult services.

Figure 4: Number of young people (aged under 18 years) in specialist treatment

![Graph showing number of young people in specialist treatment from 2011-2014.]

Source: Young people’s JSNA support pack Jan 2015.

Figure 5: Number of young adults (aged 18-24) in 'young people only' specialist services

![Graph showing number of young adults supported in specialist services from 2011-2014.]

Source: Young people’s JSNA support pack Jan 2015.

Recommendation 9: It will be essential to monitor capacity within treatment to be able to respond to the potential increase in demand from enhancing Early Help pathways for young people over future years. This will ensure that the service continues to be responsive to need.
4.3 Profile of Young People in Treatment: characteristics

<table>
<thead>
<tr>
<th>Gender</th>
<th>Male</th>
<th>89</th>
<th>62%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>55</td>
<td></td>
<td>38%</td>
</tr>
<tr>
<td>Ethnicity</td>
<td>White British</td>
<td>132</td>
<td>92%</td>
</tr>
<tr>
<td></td>
<td>Non-White-British</td>
<td>12</td>
<td>8%</td>
</tr>
<tr>
<td>Total number of young people in treatment</td>
<td>144</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Source:** NDTMS.net Young Peoples’ Quarterly Activity Report Q4 2013/14.

Young people in treatment in B&NES during 2013/14 were more likely to be male compared to the general population (Table 2). In terms of the ethnicity of the ‘In Treatment’ cohort, there appears to be a very slight bias towards being White British (90 percent in general population – Section 1.1). However, 7 young people (5 percent) were of mixed-white/black Caribbean ethnicity, a much higher proportion than in the local population (which at the time of the national 2011 Census stood at 0.5 percent). Nationally, adults from the mixed-white/black Caribbean have the highest drug use.

4.4 Profile of Young People in Treatment: referrals

There are a number of routes into specialist treatment, and these can be categorised into eight areas (Table 3). The highest proportion of referrals have come through family, friends and self-referrals (Table 3) – averaging out at around one in three. There has been a large rise in the proportion of referrals coming from Health – 18 per cent of referrals in the first six months of 2014/15. This is largely due to reviewing and developing the pathway from A&E into Project 28 (Section 3.3.11).

<table>
<thead>
<tr>
<th>Table 3: Referral routes into treatment, 2012/13 to Q2 2014/15</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) Children and Family Services</td>
</tr>
<tr>
<td>(2) Education Services</td>
</tr>
<tr>
<td>(3) Health (including School Health Nurses and CAMHS)</td>
</tr>
<tr>
<td>(4) Substance Misuse Services</td>
</tr>
<tr>
<td>(5) Youth Justice Services (YOS) (including the youth offending service and post custody services)</td>
</tr>
<tr>
<td>(6) Family, Friends and Self</td>
</tr>
<tr>
<td>(7) Young People’s Housing Provider</td>
</tr>
<tr>
<td>(8) Other</td>
</tr>
</tbody>
</table>

**Source:** NDTMS.net Young Peoples’ Quarterly Activity Report Q4 2012/13, Q4 2013/14 and Q2 2014/15.

**Note:** ‘SUP’ to indicate suppressed due to small numbers.

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Nationally, a much higher proportion of referrals into treatment come from YOS – 29 percent – compared to only 11 percent in B&NES. A recent Diversionary Project, established in partnership with the YOS, will provide early intervention support and brief interventions to young people, thus reducing the numbers entering into treatment (see 3.3.2).

School referrals into treatment between April 2013 and February 2015 show that 12 out of 14 secondary schools in B&NES consistently refer into young people’s treatment service (75 specialist referrals and 34 brief interventions).\(^{74}\) There were no referrals from private schools.\(^{75}\)

The Common Assessment Framework (CAF) will be a core component of the Early Help Strategy in B&NES. During 2013/14, 67 percent of young people (51 out of 76 young people entering treatment) had a lead professional prior to receiving treatment.\(^{76}\) Nine young people entering treatment during 2013/14, 12 percent, received a CAF at the start of treatment.\(^{77}\)

**Recommendation 10**: It is recommended that B&NES works towards all young people being referred into specialist treatment services having a lead professional in place to ensure coordination of care.

### 4.5 Profile of Young People in Treatment: waiting times

During 2013/14 all young people are seen within the PHE required timescale of less than 3 weeks for their assessment (compared to 99 percent nationally).\(^{78}\) Waiting times are typically very short, with local data reflecting an average waiting time of one week.

The service has seen an increase in attendance numbers over the years (Section 4.2). Project 28 has responded to this by providing regular open access drop in sessions (Mondays, Wednesdays and Fridays) and providing outreach across B&NES.

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\(^{74}\) ILY data extract Feb 2015.  
\(^{75}\) Ibid.  
\(^{76}\) NDTMS.net Young Peoples’ Quarterly Activity Report Q4 2013/14.  
\(^{77}\) Ibid.  
\(^{78}\) Ibid.
4.6 Profile of Young People within Treatment: drug type

Since the last needs assessment, there has been a notable change in drug type, as detailed in Figure 6.

**Figure 6: B&NES alcohol and cannabis use, comparison between 2009/10 and 2013/14**

![Diagram showing alcohol and cannabis use comparison between 2009/10 and 2013/14](image)

**Source:** 2009/10 Needs Assessment and NDTMS.net Young Peoples’ Quarterly Activity Report Q4 2013/14.

During 2009/10 the total number of clients in treatment were fewer (87), compared to 144 seen in 2013/14 (Figure 4). In 2009/10 clients were seen for cannabis use (61 percent), stimulant use (17 percent), alcohol use (10 percent) and opiate and crack use (3 percent). Figure 6 highlights a 50 percent point increase in young people accessing treatment for alcohol use between 2009/10 and 2013/14 (Figure 6). This mirrors a national trend of young people accessing treatment for alcohol use, and reflects the introduction of DrinkThink into early help and screening.

**Figure 7: B&NES in treatment cohort, by drug type, 2013/14**

![Diagram showing drug types in treatment cohort](image)

**Source:** NDTMS.net Young Peoples’ Quarterly Activity Report Q4 2013/14.

**Note:** individuals may have stated more than one problematic substance, so the percentages will sum to more than 100 percent.

This trend for cannabis and alcohol to be the main drugs used by young people in substance misuse treatment (Figure 7) is in line with the national trends, where cases of primary cannabis and alcohol use account for the majority of young people engaged with specialist services (during 2013/14 cannabis accounted for 85 percent and alcohol accounted for 55 percent of substances cited79). However, in B&NES alcohol is a more common substance cited compared to national – 60 percent locally (Figure 7), compared to 55 percent nationally. It is essential that preventative and treatment

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services are equipped to support young people at risk from a range of substances, and in particular, cannabis and alcohol use.

The alcohol DrinkThink tool has become the leading screening tool in B&NES to identify and respond to the needs of young people drinking. DrinkThink is a bespoke alcohol Identification and Brief Advice (IBA) tool for young people, designed with young people, with health messages relevant for young people. The tool was developed by Project 28, with support from the South West Alcohol Improvement Programme, and aims to reduce alcohol related risks among young people aged 13-19 years, particularly those accessing sexual health advice and treatment. It is the principle screening and intervention tool used in B&NES.

As detailed in Figure 7, many young people use cannabis.

**Recommendation 11:** To evaluate the DrinkThink tool with Bristol and Bath University to demonstrate that it is effective in reducing the frequency and quantity of alcohol consumption, and to analyse if there are any barriers to professionals using the tool.

**Recommendation 12:** It is recommended that there is a tailored intervention in order to respond to the needs of cannabis use. It is recommended that the treatment service produces a Cannabis Workbook/Tool to support the delivery of brief interventions within early help services to sit alongside the DrinkThink tool.

During 2013/14 there were no referrals recorded for New Psychoactive Substances (NPS), and nationally referrals represent only two percent of the total.\(^{80}\) It is recommended that the 2015 Child Health-Related Behaviour Survey results be evaluated to see whether young people report NPS use, and respond accordingly (see 3.2.4).

In the Queen’s Speech on 27 May 2015,\(^ {81}\) the government announced that new legislation will ban the new generation of psychoactive drugs.\(^ {82}\) The new bill will make it an offence to produce, supply, offer to supply, possess with intent to supply, import or export psychoactive substances; that is, any substance intended for human consumption that is capable of producing a psychoactive effect. The maximum sentence will be 7 years’ imprisonment. Additionally, the bill will provide powers to stop and search persons, vehicles and vessels, enter and search premises in accordance with a warrant, and to seize and destroy psychoactive substances.

**Recommendation 13:** B&NES will need to work with schools and colleges to ensure substance misuse training is provided to PSHE teachers and that young people are aware of the dangers of NPS and any subsequent change in legislation.

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\(^{80}\) Ibid.
4.7 Profile of Young People in Treatment: length of time in treatment and interventions delivered

Clients are in treatment for longer periods within B&NES than they are nationally (Figure 8). However, many of the young people who have had longer periods in treatment are those who are looked after and are the most vulnerable. Many of the clients in treatment in B&NES have higher complexity than the national average (Table 1).

![Figure 8: Length of time in treatment, 2013/14](image)

**Source:** Young Peoples JSNA support pack (January 2015 release date)

In order to provide effective treatment, a range of interventions needs to be provided. Figure 9 shows what interventions are being provided. Typically, psychosocial interventions are those which include motivational interviewing, cognitive and behavioural interventions (Figure 10). B&NES reflects the national picture with the range of interventions available. However, one exception to this is in relation to multi-agency working, where 52 percent of young people are multi-agency worked compared to 19 percent nationally. This complements B&NES’s high number of referrals where there is a lead professional present.

![Figure 9: Interventions in young people's treatment, 2013/14](image)

**Source:** NDTMS.net Young Peoples' Quarterly Activity Report Q4 2013/14.
The types of interventions young people are receiving in B&NES are detailed in Figure 10.

**Figure 10: Types of interventions provided in B&NES, 2013/14**

![Figure 10: Types of interventions provided in B&NES, 2013/14](image)


### 4.8 Profile of Young People in Treatment: sexual health and blood borne viruses

During 2014/15, 15 out of 67 young people in treatment reported having had unsafe sex (22 percent), which compares to 17 percent nationally. Further information can be found within the B&NES Sexual Health Needs Assessment.\(^3\)

At the previous needs assessment, during 2009/10, fewer than four young people were offered and subsequently accepted Hepatitis-B blood borne virus vaccination and Hepatitis-C testing. This compares to ten young people who have been offered and accepted Hepatitis-B vaccination and nine young people for Hepatitis-C testing during 2013/14. A specialist blood borne virus nurse attends Project 28 on a regular basis and also provides vaccinations at assessment, drop-ins and care plan reviews when required. Work has been undertaken in 2015 to improve data reporting, including vaccinations undertaken, and this will be reflected in the next subsequent data release.

\(^{83}\) At the time of writing this report, this is soon to be published here: [http://www.bathnes.gov.uk/services/your-council-and-democracy/local-research-and-statistics/wiki/sexual-health](http://www.bathnes.gov.uk/services/your-council-and-democracy/local-research-and-statistics/wiki/sexual-health)
4.9 Outcomes: effectiveness of treatment and transition to adult services

During 2013/14, 72 young people exited treatment.

Figure 11: B&NES Young people’s service completion rates exiting treatment, 1st April 2013 to 30th September 2014

During 2013/14, 68 young people (94 percent) successfully completed treatment (compared to 79 percent nationally); and 85 percent of young people met their goals at treatment exit (compared to 89 percent nationally). During 2013/14, 63 percent of young people left treatment drug free (compared to 33 percent leaving drug free nationally), and 32 percent left as an occasional user (compared to 45 percent leaving an occasional user nationally).

Figure 12: Young people re-presenting into treatment within 6 months of leaving, 1st April 2013 to 30th September 2014

There have been significant improvements in the reduction of re-presentations back into treatment. Typically, the first six months of leaving treatment are the most vulnerable. As at 30th September 2014, only 3 percent of young people re-present into treatment, compared to 7 percent nationally (Figure 12). However, it is essential to know that young people have longer term outcomes. Due to an integrated case management system between adult and young people’s services that was introduced in 2014, it has been possible to follow up whether or not young people who left treatment appeared later in the adult treatment service. Figure 13 shows that the majority of clients who have completed treatment at Project 28 continue to no longer need drug and alcohol services, with only 10 out of 80 clients re-presenting into adult services.

Source: NDTMS.net Young People’s Quarterly Activity Report, Q4 2013/14 and Q2 2014/15.

NDTMS.net Young People’s Quarterly Activity Report, Q4 2013/14.
Figure 13: Number of clients who have re-presented into adult treatment, 1st April 2012 to 31st March 2014

Note: number of clients who have exited treatment who are over 18 years old between 1st April 2012 and 31st March 2014.

During 2014/15 Public Health England introduced a Young People’s Outcomes Record (YPOR). This captures a full range of data on outcomes for young people who access specialist substance misuse services. It asks a series of questions about their alcohol and drug use, including their health and wellbeing, in the month before they entered treatment. By charting the changes in their behaviour and health from the time they start to the moment they leave treatment, the YPOR shows the outcomes of treatment interventions. A full year of outcome is not currently available due to its recent introduction.

Recommendation 14: It is recommended that the Young People’s Outcome Record (YPOR) is reviewed through quarterly performance reviews with the provider and is part of a future needs assessment.

Prior to 2012, it was not common practice to transfer young people to adult services and many remained with Project 28 beyond their 18th birthday. For some young people, this meant being in treatment longer than needed. A clear transitional protocol was implemented to ensure that young people transitioned appropriately. As such, Project 28 employed a transitional worker to work across young peoples and adult service. As a result, 10 young people transitioned to adult treatment services between 1st January 2012 and 31st September 2014.
5.0 Consultation

5.1 Young People's Views on Substance Misuse Service

A total of 29 feedback questionnaires were completed by clients in Project 28 during March 2015, providing the following review of the service (a number of clients provided more than one response so the totals will be above 29).

**Figure 14**: Q1 – How did you first find out about Project 28?

Figure 14 shows that there are a broad range of services that young people are in contact with prior to entering project 28. However, the most common way young people hear about the service is from their friends (Figure 14).

**Figure 15**: Q2 – What have you found most helpful about Project 28?

Project 28 has been helpful for young people in a range of ways (Figure 15).

**Figure 16**: Q3 – Is there anything you would change about the service?
The majority (57 percent) of respondents wouldn’t want to change the service (Figure 16). However, a quarter would like to see more activities provided, such as days out or diversionary activities (Figure 16).

**Figure 17: Q4 – What would help you avoid harm from alcohol and drugs in the future?**

Many of the respondents recognised that they have acquired skills during their time at Project 28, with 16 young people stating that they would apply what they have learned to avoid future harm (Figure 17).

5.2 Corporate

There have been two meetings of the Expert Group – 6th October 2014 and 12th January 2015. The following is a summary of the key findings from these two Expert Groups.

5.2.1 Emerging Trends

The following is feedback from the Expert Groups about the main emerging trends:

- **Early onset** is a key risk factor – there is some evidence of younger users from YOS/Project 28 who are aged 11 and 12.

- Project 28 see new trends in **NPS use** – was Mephedrone (sometimes called ‘meow meow’)/M-CAT, currently N-Bombs. Universal services are not getting an impression of widespread use of NPS.

- There is an increasing trend in **vaping** and a need to distinguish between nicotine and non-nicotine e-cigarettes as the latter has helped some young people quit smoking. Young people have been asking the School Nurse team for prescriptions. E-cigarettes will not be licenced for young people later in the financial year 2015-16.
5.2.2 Priorities Identified

The following is feedback from the Expert Groups about the main priorities identified:

- A need to **survey PSHE leads** to discover what is being taught, along with what is the understanding of pupil’s knowledge, skills and attitudes. *(See Section 3.24 and Section 6)*
- A need to ensure there are **links made between substance misuse, mental health and healthy relationships** *(this is explored further through section 3.3.8 and will also feature in the delivery of workforce development)*.
- There is a need to dispel a perceived widely held view that occasional and/or ‘light’ use of substances is acceptable and part of ‘normal experimentation’. In order to achieve this there is a need for increased and wider use of **screening tools**, as well as **training** in how to use them *(Section 6.0)*.
- A need for **earlier intervention** *(including brief intervention)* *(Section 6 Workforce Development and 3.0)*.
- A need to **build links/roles** of PCSOs and others, particularly CASH *(Section 6 Workforce Development)*.
- There is a need for **closer working arrangements** between CAMHS and Project 28 *(Section 3.3.8)*.
- There is a need to build the resilience in **children of substance misusing parents** *(Section 3.3.5)*.
- There is a need to audit the provision of substance misuse services to **Looked After Children**, i.e. map current practice and identify improvements *(a training plan will be developed which will identify training requirements and will develop pathways - Section 6.0)*.
- A need to ensure that the term **‘treatment’** is not used with young people *(Section 6.3)*.
- A need to **strengthen the skills** of community pharmacy and sexual health staff *(Section 6.0)*.
- A need to **link up with other campaigns**, for example, Gotya Back or National Campaigns to address the issue of safety *(there are a number of national campaigns e.g. Dry January, and talk to FRANK, International FASD awareness day etc. B&NES will agree through the alcohol strategy group and the Performance Delivery Group (PDG) what key campaigns to support and plan how this will be undertaken).*
6.0 Workforce Development

6.1 Introduction

It is expected that staff or professionals working with children and young people should have the competences to:

- identify those at risk;
- know when a more detailed assessment is required;
- be able to either conduct the assessment; and
- quickly access an appropriately skilled professional to take the next steps.\(^{85}\)

6.2 Training delivered

Project 28 provides training to services across B&NES. Table 4 outlines workforce development during 2013/14 and includes training provided by both Project 28 and B&NES’s Drug and PSHE consultant.

<table>
<thead>
<tr>
<th>Drug course</th>
<th>Who attended?</th>
<th>How many attended?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic Drugs Course</td>
<td>Youth Service</td>
<td>20</td>
</tr>
<tr>
<td>Basic Drugs Awareness course</td>
<td>PCSO’s and Police</td>
<td>14</td>
</tr>
<tr>
<td></td>
<td>Connecting Families</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>PSHE Leads</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>School Nurses</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>Bath College</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>Norton Hill school teachers</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>Health Visitors</td>
<td>9</td>
</tr>
<tr>
<td>DrinkThink Tool</td>
<td>Youth Offending Team</td>
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<tr>
<td></td>
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<td></td>
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<td></td>
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<td></td>
<td>Broadlands School</td>
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<td>A&amp;E</td>
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<td>Basic Drugs Awareness course</td>
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<tr>
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<td>Motiv8 Wilts YP Team</td>
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</tr>
<tr>
<td></td>
<td>Foster Carers</td>
<td>30</td>
</tr>
</tbody>
</table>

In addition to the above, schools Personal and Social Health Education (PSHE) leads receive quarterly training from the Drugs and PSHE consultant. There is also a programme of training available through the LSCB training programme.

### 6.3 Early Help in B&NES

B&NES is currently developing both an Early Help Strategy and a Workforce Strategy. Adopting a clear, consistent Early Help Strategy will define early help and embed screening and early intervention to ensure that the needs of young people are identified early. At present, there does not appear to be a consistent understanding about when to intervene early with alcohol and substance use, and when to refer into the specialist service. The findings from the Expert Group (see 5.2) and treatment referral statistics (see 4.5) show a need to have clearer guidelines on when and how to refer a young person into Project 28 and ensuring that terminology such as ‘referral’ and ‘treatment’ is not used, as these can be perceived as potential barriers to accessing help. The wider workforce, including staff working with vulnerable young people (Social Workers, PCSO’s, Sexual Health Workers or Youth Connect) would also benefit from support on how to deliver a brief intervention, and how to support a young person who does not want to be referred (see 3.0).

**Recommendation 15:** In order to support the Early Help Strategy it is recommended that a training plan is developed covering the following areas: (a) The current substance misuse screening tool is redesigned to facilitate improved understanding of problematic substance use, delivery of brief interventions, and when to refer; (b) the key substance misuse screening tool and DrinkThink becomes a core part of workforce development and embedded into future contracts; and (c) through workforce training ensure a consistent approach when identifying and responding to the needs of children and young people at risk of substance misuse to minimise barriers in accessing treatment.
The DrinkThink tool is now part of the School Health Nurse contract and systems are in place to measure the use of the tool from 2015.

### 6.4 Specialist Drug and Alcohol Workers

The revised ‘National Occupational Standards (NOS) for Children & Young People’s Health Services’ was launched in January 2015. This document sets out the core competencies for a specialist drug and alcohol worker to ensure effective practice. It is envisaged that the standards will be adopted and developed as a powerful resource for those delivering a skilled and high-quality children and young people’s health services.

**Recommendation 16:** It is recommended that the skills of the specialist drug & alcohol workers remain in line with best practice guidelines: the revised ‘National Occupational Standards (NOS) for Children & Young People’s Health Services’. It is recommended that all Project 28 staff meet the standards set out within this document.

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