

Young people's drug and alcohol treatment at the crossroads

What it's for, where
it's at and how to
make it even better

Young people's drug and alcohol treatment at the crossroads: what it's for, where it's at and how to make it even better

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DrugScope is the national membership body for the drug sector. Our aim is to inform policy development and reduce drug-related harms – to individuals, families and communities.

We provide quality drug information, promote effective responses to drug use, advise on policy-making and good practice, encourage informed debate (particularly in the media) and speak for our members working in drug treatment, education and prevention and other areas.

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DrugScope incorporates the London Drug and Alcohol Network (LDAN), a membership network for drug and alcohol agencies in London.

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Foreword

The catalyst for our 2009 report about adult drug treatment, *Drug treatment at the crossroads*, was negative media reporting of the effectiveness and cost-effectiveness of treatment and an increasingly polarised debate between 'abstinence-based' interventions and 'harm reduction' or 'stabilisation'. The report, drawing on a series of discussions with DrugScope members, treatment providers, commissioners, service users and other experts in the field, argued that the system needed to better reflect the needs of individuals and be flexible in response to developing trends – noting that the majority of young people using drugs in a problematic way are not users of heroin and crack cocaine.

The political and policy contexts for young people's treatment are less contentious and media reporting less high profile – but there are nonetheless challenges and policy issues to address. How do we explain and understand, for example, the increase in the number of under-18s accessing specialist treatment when overall illegal drug use among young people has been falling? What does 'treatment' mean for young people when substance use and problem use is different than for most adults?

A key message for this report is that a neat line cannot be drawn between the needs of young people under 18 and those aged 18 to 24 who have to access the adult treatment system. It considers how trends in drug and alcohol use among young people and young adults do not fit the concepts on which much of the treatment system is based – and highlights the fact that there are already many over 18 whose needs are not being met by the adult system.

In 2008, the UK government published a new ten year drug strategy taking us to 2018. A key strand of the strategy is 'preventing harm to children, young people and families affected by drug misuse.' And a critical component of success is stated as 'better tailoring of the drug treatment system to meet young people's needs'. To that we would add the need to recognise that young adults need better support as they move out of services for young people or seek help from the treatment system for the first time. This year we have a general election – whatever the complexion of the next government, vulnerable young people have the right to expect that the commitments of 2008 will be honoured.



Martin Barnes, Chief Executive, DrugScope

Executive summary

Key messages

Young people's specialist drug and alcohol treatment is 'at a crossroads'. There are different directions it could take, particularly at a time of political change, high octane public debate and tight public finances. Against this background, DrugScope embarked on a consultation process in 2009 with people working in young people's treatment. These are some of the things we found out from those on the frontline.

Working with young people in treatment is not only about problem drug or alcohol use, but multiple needs. Most young people who enter specialist drug or alcohol treatment have other, often multiple needs, such as mental health issues, involvement with the criminal justice system, social exclusion, or lack of education, training or employment opportunities.

A lot of the work done by specialist drug and alcohol services is not 'treatment' in the narrow medical sense. Most young people who access specialist drug and alcohol services do not need to be prescribed substitute drugs and very few indeed would benefit from residential treatment. Some do not even need structured therapy related to their substance use. Almost all, however, need support on other issues in their lives. Young people's treatment needs to be holistic.

Work with young people and young adults requires a wider conception of problem drug and alcohol use. It is clear that the drugs that cause the most problems for young people and young adults are cannabis and alcohol – and that today's younger substance users are mixing and matching different (and new) drugs. Polydrug use creates a new challenge for services.

Young people's services should not be judged by the same targets as adult services. Subjecting young people's services to the same measurements as adult services is of limited value. The client groups are different and the systems set up to evaluate a service user's progress in an adult service will often be less appropriate for use with younger clients.

A key challenge is the gap between young people's and adult services and the issues of transition this raises. Currently the adult and young people's treatment systems work with two different notions of substance misuse problems, different interventions, different approaches to alcohol, different lead departments in Government and different targets and outcomes. This all leads to large and often unbridgeable gaps for someone leaving young people's drug treatment aged 18 who needs further support – with adult services frequently not the right place.

Young people with drug problems may be involved in drug supply and services need to address this relationship. The same things that make young people vulnerable to problems with drug use can make them vulnerable to involvement in the supply of drugs. Workers need to be able to recognise and support young people at risk of offending and to help create exit strategies for those who are already involved in drug supply or gang-related activity.

We need investment in community and social regeneration as well as one-to-one support. It is important not to frame young people's substance misuse in exclusively individual and therapeutic terms and fail to invest in community resources. Employment and meaningful activity, decent accommodation and access to leisure activities for young people are all vital.

What you get is too dependent on where you live. Frontline workers reported services for young people are often patchy, with variation in funding allocations, problems servicing rural areas and the strength of relationships with other children's services all impacting on equity of provision.

Recommendations

DrugScope has subsequently reflected on what we have learned during consultation with members, service users and other stakeholders and has developed six key recommendations for the future direction of specialist drug and alcohol treatment for young people and young adults.

The Department of Health/NTA should lead a review of the basic assumptions and frameworks of the drug treatment system to take account of changing patterns of substance misuse, particularly among young people and young adults. We need to review the definition of 'problem drug use' as the use of heroin and crack cocaine as we move into an era when these drugs are becoming less common and polydrug use, including the use of alcohol, is coming to the fore.

The Government should review monitoring instruments such as the British Crime Survey, and invest in research, to ensure our policy and services are adapting to shifting patterns of drug and alcohol problems. More detailed information is needed on patterns of problematic and harmful substance use and different user populations to inform the development of responsive policy and services. For example, there is a clear information gap

around the problematic use of – and dependency on – skunk cannabis among young people.

A national ‘radar’ service should be established to provide early warning of new drug trends, enabling policy makers and service providers to respond to them quickly and effectively. Patterns of substance misuse are becoming more fluid and flexible, with evidence to suggest that the use of new substances like GHB/GBL, ketamine and mephedrone are on the increase. A bottom-up system is needed to inform policymakers, treatment services and mainstream services of new trends, particularly as many new substances will not be controlled under the Misuse of Drugs Act.

The next Government should develop a national policy framework for young adult services, which could take the form of a Green Paper. It would be helpful if the NTA and the DCSF produced a policy framework for 16 to 25 year olds, with a focus on transitional processes and arrangements. We would urge such a review to consider the merits of a new type of service platform for young adults, potentially extending young people’s services to encompass a wider age group, or possibly creating a new service platform for young people and young adults who are developing more serious substance use problems that do not correspond to existing concepts of ‘problem drug use.’

Low visibility, high threshold services should be balanced by a network of high visibility, low threshold services working in local communities. We would support a feasibility study to investigate the cost-effectiveness of developing a new kind of ‘High Street’ drug and alcohol service, that could offer a range of support, including harm reduction information, assessment, brief interventions, information about local services and about different treatment approaches and referral to other services where appropriate.

With the introduction of the new funding formula for young people’s treatment, the DCSF and the NTA should undertake a joint review of the availability and quality of young people’s treatment services, with a particular focus on local variations. This review should look at the impact of different relationships between Children’s Trusts, Drug Action Teams and the NTA on local provision of specialist drug and alcohol treatment services for young people, at the role of local commissioners, and at the outcomes that they are commissioning young people’s services to deliver. It should review the effectiveness of the current mechanisms for identifying and applying minimum standards and the case for developing a new national inspection regime for young people’s substance misuse services, possibly using the Care Quality Commission model.

Introduction

If you read the newspapers, you might get the impression that young people's drug use is spiralling out of control, and that illegal drug use is an everyday part of their lives. In reality, most young people don't use drugs, only small numbers take the most harmful drugs, and only a minority of this group develop serious drug problems. The trends appear to be heading in broadly the right direction too. Fewer young people appear to be using drugs now than in the mid-1990s. The picture on alcohol use is less clear, and perhaps less positive. For example, the latest research from the NHS Information Centre reports that fewer school age children in the 11–15 year age group are drinking alcohol than in the past, but those who are seem to be drinking more heavily.

What has increased in recent years, however, is the number of under-18s getting help from specialist drug and alcohol services, which now stands at around 25,000 a year. What is driving this increase, if not more drug and alcohol use? The National Treatment Agency for Substance Misuse (NTA) claims that 'the reality is that specialist misuse services all over the country are managing to identify and engage with many more of the stable and declining population of users'. This is part of the truth, but we actually know very little about regular or dependent use among young people. Moreover, our research suggests that many young people in specialist substance misuse treatment are not in fact dependent users of drugs or alcohol. In a survey conducted in December 2009, DrugScope contacted 43 services providing young people's treatment services in England and asked what proportion of the people they worked with they would describe as having 'serious drug and/or alcohol problems'. Only 14 per cent said 'all' their clients fitted this profile, 28 per cent said the 'majority', 23 per cent 'half', 33 per cent a 'minority', and 2 per cent 'very few'.¹

The purpose of this report is to examine the recent development and expansion of treatment services for under-18s, as well as provision for young adults in their late teens and early 20s. It is being published at a time when concerns

1 DrugScope conducted this survey in December 2009, contacting young people's treatment services which are DrugScope members or have otherwise been involved with our work. We received 43 responses from services across England, including large and small providers. Fifteen responded by e-mail and 28 took part in telephone interviews. Further details of the survey results are available from DrugScope, contact Dr Marcus Roberts, DrugScope's Director of Policy and Membership, e-mail: marcusr@drugscope.org.uk

are growing over new types of drug use among these client groups. Professor Howard Parker has observed that 'alcohol is cheaper and more available, cannabis is far stronger, cocaine is half the price it used to be and you can get a dozen ecstasy tablets for £10', and concludes that when you put all this together 'you've got just as serious a problem for health, family life and society as heroin'.¹ New substances such as GBL, BZP, Spice and mephedrone are also entering the picture. 37 per cent of services contacted for DrugScope's telephone and e-mail survey said 'legal highs' were an emerging trend for their services, including one in five (20 per cent) who specifically mentioned mephedrone (with one service saying that use of legal highs was currently the most common substance misuse problem for them). These sorts of developments raise fundamental questions for drug and alcohol policy – and the relationship between the two.

While this report is about young people and young adults, it necessarily addresses a range of general questions for substance misuse policy posed in the concluding pages of DrugScope's report *Drug treatment at the crossroads* (2009)², which focused on adult treatment. This report argued that the public debate about drug treatment – and, specifically, the respective merits of substitute prescribing and 'abstinence' – was really a debate about heroin addiction, because that is what methadone and buprenorphine are predominantly used to treat. It concluded with a call to broaden out the discussion of treatment, arguing that if we persist with a narrow conception of problem drug use we will lack the flexibility to meet new challenges as drug trends change. 'Those young people gearing up to be the next generation of "problem drug users"', it concluded, 'appear to be developing problems linked to cheap alcohol and cannabis, maybe along with cocaine, ecstasy and tranquillisers'. It asked whether drug policy and drug services are equipped to deal with shifts in patterns of drug use. In a sense, this report picks up where that report left off.

If anything, these issues have come into even sharper focus since we published the first *Crossroads* report. In October 2009 the NTA reported a dramatic fall in heroin use among young adults aged 18 and over who are seeking treatment and proclaimed a 'generational shift in patterns of drug dependence in England' – while reporting an increase in the numbers of young adults seeking help for powder cocaine use.³ Further NTA data on young people aged under 18 published in December 2009⁴ notes a fall in the already very small numbers of this age group being treated for heroin and/or crack use, concluding that this 'may be a further indication that the heroin epidemic has peaked'.⁵ A 2009 report from the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) claimed that 'in Europe today, polydrug patterns are the norm, and the combined use of different substances is responsible for, or complicates, most of the problems we face'⁶. And in September 2009, *Druglink*, DrugScope's

1 Interview on BBC Newsbeat, 8 June 2008

2 DrugScope (2009): *Drug treatment at the crossroads*, available to download at www.drugscope.org.uk

3 NTA (2009) *Annual Report*

4 NTA (2009) *Substance misuse among young people: the data for 2008/09*

5 NTA Press release (2009) *Positive signs that teenagers increasingly shun the most problematic drugs*

6 EMCDDA (2009) *Annual report on the state of the drugs problem in Europe*

bimonthly magazine, published its *Annual Street Drug Trends Survey*, concluding that 'younger, recreational users are now swapping or combining cocaine, ketamine, GHB, ecstasy, cannabis and alcohol on a night out'.¹

A key factor in this emerging picture is the use of illicit drugs in combination with alcohol, often as an aspect of the night-time economy. A study of clubbers in South East England in 2003 describes two thirds of clubbers interviewed by researchers as 'hazardous drinkers' and notes that 'a third of the sample ... was using both drugs and alcohol on the night of the survey'.² The 2005 British Crime Survey found that young adults who visited the pub more than three times a week were twice as likely to have used cocaine in the last month as those who went to the pub less frequently.³ An analysis carried out by the National Addiction Centre in 2006 revealed strong links between cocaine use and long, heavy drinking sessions.⁴ These are the sorts of challenges that are now facing services working with teenagers and people in their early 20s.

This report also considers the need to support young people – and particularly the most vulnerable – in the transition from adolescence to adulthood. A report on 'transitions' for young adults with complex needs, published by the Social Exclusion Unit in 2005⁵, commented on the lack of service provision to 'address the needs of 16 to 25 year olds in the round' or 'to ensure effective transition from youth to adult services'. This has particular relevance for drug and alcohol policy. At present, when someone in a young person's drug and alcohol service hits 18 they may be expected to transfer to adult services that operate along very different lines with a very different client group if they want to continue with specialist treatment – or they may drop out of services altogether.

Finally, the report highlights the links between substance misuse and other problems, a key theme for our first *Crossroads* report. A high proportion of young people in specialist drug and alcohol services have other issues in their lives, including problems at school, experiences of poverty and marginalisation and lack of access to training and employment. One in ten of over two thousand 16 to 25 year olds interviewed for the YouGov Youth Index last year claimed that unemployment drove them to alcohol or drugs, according to a report published by the Prince's Trust in 2010⁶. The links between joblessness and substance misuse problems have been a recurring theme for young people who have spoken to DrugScope.

We might expect substance misuse problems among young people to increase during a period of recession and high youth unemployment. A recognition of the relationships between substance misuse and social exclusion has been a more central feature of the development of young people's than adult treatment services.

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- 1 DrugScope (2009) *Druglink Street Drug Trends Survey*, further details at: http://www.drugscope.org.uk/ourwork/pressoffice/pressreleases/Street_drug_trends_2009
 - 2 Home Office (2003), *Recreational drug use among clubbers in South East England*.
 - 3 Home Office (2006) *Drug Misuse Declared: Findings from the 2005/06 British Crime Survey*
 - 4 Gossop M et al (2006), 'Concurrent use of alcohol and cocaine', *Alcohol and Alcoholism* 2006, 41(2): 121–125.
 - 5 Social Exclusion Unit (2005) *Transitions: Young adults with complex needs – a Social Exclusion Unit final report*
 - 6 Prince's Trust (2010) *The Prince's Trust YouGov Youth Index 2010*

About this report

Young people and young adults

While this report sets out to look at young people's treatment services, which are for under-18s, many issues it raises are also pertinent to older teenagers and people in their early 20s. Indeed, some of the key questions it poses are about the validity of the current divisions between young people's and adult services and the age boundaries that they are based upon. To further complicate matters, some key data sets deal in age bands that do not correspond to those operating within the treatment system – for example, the British Crime Survey data treats 16 to 24 year olds as a single group.

To avoid confusion, this report uses the term **'young people'** to refer to under-18s and **'young adults'** to refer to 18 to 24 year olds. Where it is discussing a wider age group – for example, 16 to 24 year olds – this is made clear in the text.

Drugs and alcohol

When talking about young people and young adults, illegal drug use needs to be considered alongside alcohol use. We need to develop more integrated approaches to substance misuse if we are to address the new challenges facing both young people's and adult services. If this report has more detailed information and analysis of illegal drug use than alcohol use, this simply reflects DrugScope's primary area of expertise. It should not be taken to imply that we underestimate the significance of alcohol and we hope the report does have useful things to say to alcohol specialists, particularly on alcohol misuse as an aspect of polydrug use.

Geographical scope

The NTA is concerned with England only, and the data it collects is England-specific. The British Crime Survey reports on England and Wales. Much of the research discussed in this report has been conducted in England, as has the bulk of DrugScope's own consultation work. However, we hope that some of its key themes and proposals will be of equal interest to policy makers in Wales, Scotland and Northern Ireland.

Deep dives and coming up for air

This report does not dive into the finer details of policy, commissioning, local strategies or service delivery. We know that discussions about many of the issues highlighted in this report are on-going, both in Government and elsewhere and we hope the messages from DrugScope members contained in this report can help to shape and inform these discussions. But our focus is on the bigger picture. This report is not aimed primarily at specialist providers of young people services, but at policy-makers, opinion formers and others who want a broad insight into the development of young people's drug and alcohol services, and some of the questions it raises.

The consultation process

DrugScope is the national membership organisation for the drug sector, representing over 600 members right across Britain, and incorporating the London Drug and Alcohol Network (LDAN). The majority of our members provide frontline drug services, and many of them work with young people.

This report is built on discussions with our members and other key stakeholders. In particular, we held consultation events in 2009 in Gateshead, York, London and Birmingham. We discussed the issues with members of LDAN's Young People's Drug and Alcohol Workers Forum. In December, we conducted a telephone and e-mail poll with 43 DrugScope members delivering treatment for young people, which provided important insights into the experience of services. We also interviewed service users at two young people's services.

Acknowledgements

DrugScope would like to thank colleagues who peer reviewed this report, including Professor Howard Parker, Gabriella Chalk and Tom Aldridge. We hope that they will welcome the final report although their involvement should not be taken as endorsement of the report's contents.

We are particularly grateful to the young people at Newham Create in East Ham, London and Compass in Brixton, London who met with us in summer 2009 to talk about their experiences. We appreciated their time and insight, and have drawn on what they had to say to us throughout the report.

We would also like to thank all those who attended our consultation events and participated in our telephone survey. Your input has been invaluable.



1

Drug use and drug treatment for young people: patterns, problems and perspectives

'It's important that we realise that the young people's treatment system has moved in the last five to ten years from being conceptualised as a sort of mini-adult treatment system to a system in its own right that is focussed on children and children's needs. If DrugScope had invited people to a meeting six or seven years ago, it would have been a very different sort of field and we would have had people working in adult treatment telling us how we should be treating young people.'

Young People's Lead, NTA, DrugScope Consultation, London 2009

1.1

New generation, new definitions

A particular idea of 'problem drug use' has been at the core of the UK drug strategy since 1998, driving and shaping the expansion in drug treatment that has occurred in the last ten years. A 'problem drug user' (PDU) is defined as somebody who is using heroin and/or crack cocaine. So-called 'problem drug users' are the priority for adult services. Drug services get twice as much funding for treating a 'problem drug user' as a non-'problem drug user'. The focus on this group is justified by the individual, social and economic costs associated with heroin and crack dependence. In particular, the rise in investment in adult drug treatment has been viewed as a means of cutting acquisitive (and other) crime linked to addiction.

"We need to get to grips with the new challenges emerging for drug services as we enter a new decade."

DrugScope's 2009 *Crossroads* report said that we should not underestimate the challenges of 'problem drug use' or its negative impact on individuals and communities. With drug treatment currently in the spotlight, it is critical that we do not surrender the substantial progress that has been made since 1998 in getting more adults with serious drug problems into treatment and reducing harm. Recent NTA figures suggest that we are making real inroads in tackling 'problem drug use'. This is not an excuse for relaxing our guard, however – not least, because we need to get to grips with the new challenges emerging for drug services as we enter a new decade. This is particularly pertinent for work with teenagers and young adults.

The young people's treatment system provides an alternative model, working with a very different notion of 'problematic' substance misuse. There are very few under-18s who could be classed as 'problem drug users' in the adult sense. Crime reduction objectives have not driven its growth to the same extent as the adult treatment system and there has been a clearer focus on health, mental health and social inclusion.

It is a different story for young adults. For example, the 1 in 5 clients in the 18 to 24 age group seeking help from adult services for powder cocaine problems in 2008–09 were not 'problem drug users'. The fact that they are finding their way into services is encouraging, as is the developing role of psychosocial interventions in the adult system. But adult services are often inhospitable to young adults, and may be able to offer only limited help for some of the problems they have. A clear example is the split between drug and alcohol services, which is ill-suited to work with polydrug users.

To a significant degree, the treatment of both young people and young adults challenges some of our fundamental assumptions and structures. It invites us to rethink what we understand by 'problem drug use', how we assess need, what outcomes we should aim for and how we set about achieving them. It also calls into question the age boundaries that divide services. Does it make sense that services for 19 year olds work so differently from those for 17 year olds? What changes to the adult system might help to narrow this gap and keep people on a coherent care pathway as they move into adulthood? Do we need to think about a new kind of drug and alcohol treatment service, perhaps for 16 to 25 year olds?

1.2

Drug and alcohol misuse – trends and trajectories

“While a significant minority of under-18s will experiment with or use illegal drugs occasionally (often in conjunction with alcohol), most illicit drug use is short-term cannabis use. Alcohol use in young people is generally experimentation or episodic bingeing. Fewer under-18s use drugs regularly, or to an extent where drugs and alcohol have a harmful impact on their lives. While most drug and alcohol use carries increased risks, few young people experience significant harm. Some do experience harm, related to intoxication or excessive consumption, but dependence (especially opiate or stimulant dependence) and drug injecting are uncommon.”

‘The Orange Book’¹

How many young people and young adults are using drugs and alcohol? Is the problem getting worse or better?

According to the 2008–09 British Crime Survey, about 3 million young people in England and Wales aged 16–24 have tried an illegal drug at some time in their life.² Most have not, and may never do so. Most who try drugs will not do so very often, very frequently or over a long time period. Most will not use the most harmful drugs. Around one in five of this age group say they have used cannabis in the last year, accounting for 84 per cent of past year drug use for this age group. Less than 0.1 per cent say they have used opiates in the last year; around 0.2 per cent say they have used crack.³

Nine per cent of school pupils aged 11 to 15 told the NHS Information Centre in 2008 that they’d taken cannabis in the last year, compared with 3.6 per cent who said that they had tried Class A drugs. The use of volatile substances –

- 1 NTA (2007), *Drug Misuse and Dependence: UK Guidelines on Clinical Management* (commonly known as *The Orange Book*)
- 2 Hoare, J (2009), *Drug misuse declared: Findings from the 2008/09 British Crime Survey – England and Wales*, Home Office, London, p. 30.
- 3 *Ibid*, p. 22–23.

such as glue, gas, aerosols and other solvents – was more common than Class A drug use among this younger age group, with 5 per cent reporting use in the last year.¹ The NTA notes that ‘very few pre-teens need help for harmful drug or alcohol use’ and the numbers using Class A drugs are small.² In 2006, the Advisory Council on the Misuse of Drugs (ACMD) *Pathways to Problems* report concluded that ‘while many young people first use tobacco, alcohol or other drugs in their early and mid-teens, hazardous use often starts in the late teens and early 20s’.

Alcohol remains a particular concern. A 2005 Social Exclusion Unit report cites research that shows that men aged between 16 and 24 are the heaviest drinking group and a study of dependency amongst young adults claimed that nearly 15 per cent of 16–25 year olds are dependent on alcohol.³ People aged 16–24 are also more likely than any other age group to ‘binge drink’. It is a similar picture for tobacco. A 2008 Department of Health consultation document on tobacco control reported that smoking by young people has declined over the last decade, but that one in five 16 to 19 year olds smoke and 31 per cent of young people aged 20–24 smoke, which is the highest smoking rate of any age group.⁴

Fewer young people are using illegal drugs today than in the mid-1990s. The British Crime Survey 2008–09⁵ reports falls in young people’s use of ‘any drug’, ‘any stimulant drug’, hallucinogens, ecstasy, LSD, amphetamines and cannabis in the last decade. Only the figures for last year use of cocaine powder have increased for 16–24 year olds in the period from 1996, from 1.3 per cent to 6.6 per cent of respondents.

Overall, these trends are encouraging. However, as one participant in DrugScope’s London consultation pointed out, we should be a bit cautious in interpreting these statistics. She argued that “we shouldn’t be sanguine that school surveys and the British Crime Survey... are a reliable indication of drug problems in our society”. It is true that these surveys are self-reporting studies, and that they have limitations. They do not tell us much about trends in substance misuse among the most vulnerable and marginalised young people who may be most at risk of developing problems, and not everyone will respond reliably to a stranger’s questions about an illegal activity. But these are the best indicators available, and provide useful measures.

What kinds of substance misuse problems affect young people? What should we be most worried about?

The NTA report on young people’s substance misuse for 2008–09 concludes that 657 under 18 year olds were treated for heroin and crack use, representing three per cent of the total number of young people receiving help⁶. We should be concerned about young people who are developing problems with heroin

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- 1 Fuller, E (2009), *Smoking, drinking and drug use among young people in England in 2008*, NHS Information Centre, London, p. 125.
 - 2 NTA (2009), *Substance misuse among young people – the data for 2008–09*, p. 4
 - 3 Social Exclusion Unit (2005), *Transitions – Young adults with complex needs*, p. 24.
 - 4 Department of Health (2008), *Consultation on the Future of Tobacco Control*
 - 5 Home Office (2009) *Drug Misuse Declared: Findings from the 2008/09 British Crime Survey*
 - 6 NTA (2009) *Substance misuse among young people: the data for 2008/09*

and crack cocaine – the numbers are low, but we are talking about hundreds of badly damaged lives (and many more when you include parents and carers, families and friends). What is striking, however, is the numbers of young people seeking help for other kinds of substance misuse problems.

For 90 per cent of under-18s in treatment the 'primary substance' causing them problems is either alcohol (36 per cent) or cannabis (53 per cent). The number of under 18s seeking treatment for powder cocaine use increased by more than a half between 2005–06 and 2008–09.

Some young people are mixing and matching a range of drugs – often in combination with cheap, strong alcohol. We still have much to learn about the effects of some of the drugs they are using, for example, ketamine and GHB/GBL¹. It is too early to predict the impact of prolonged use or what the longer term harms will be. For some 'new drugs', notably mephedrone², our knowledge is even more limited. And we have a lot to learn about the impact of mixing different substances.

Professor Howard Parker of Manchester University has highlighted the rise of the so-called 'ACCE' profile among young drug users. ACCE stands for alcohol, cannabis, cocaine and ecstasy. In September 2009, DrugScope published the *Druglink Street Drug Trends Survey*, which concluded that 'drug users are now more likely to mix and match from a variety of substances on the drug menu rather than stick to one drug'.³ In November 2009, the Annual Report from the European Monitoring Centre on Drugs and Drug Addictions (EMCDDA), Europe's official drug monitoring body, questioned the usefulness of continuing to think about drug policy in 'substance specific' ways. 'In Europe today', it concluded, 'polydrug patterns are the norm'. It expressed particular concern about alcohol, 'legal highs', synthetic drugs and the misuse of prescription medicines, concluding that 'among the young, multiple substance consumption can increase the risks of acute problems and is predictive of developing a chronic drug habit later in life'. Such drug combinations can increase the risk of adverse effects. In particular, the EMCDDA notes that 'intensive alcohol use is often a major, but overlooked, component of polydrug use. For example, stimulant drugs such as cocaine may enable users to consume large quantities of alcohol over a long period of time'.⁴

The patterns of substance misuse characteristic of young people and young adults are not the only relevant factor. Use of drugs and alcohol by young

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- 1 GBL – a colourless, odourless liquid with legitimate use as a cleaning fluid – was made a Class C drug in December 2009 after worries over its growing use as a recreational drug. Prior to GBL being outlawed, it was seen by many users as a legal alternative to the Class C drug GHB due to the body quickly converting GBL into GHB after ingestion. For more, see: <http://www.drugscope.org.uk/resources/drugsearch/drugsearchpages/ghb.htm>
 - 2 Mephedrone (4-methylmethcathinone), a cathinone-derivative, is closely related to amphetamine. A stimulant drug, it reportedly gives users an experience similar to ecstasy, cocaine or amphetamine. Currently legal (February 2010), the drug is causing concern due to its popularity and increasing prevalence. The ACMD is due to report on mephedrone and other related cathinone-derivatives in 2010. For more information, see: <http://www.drugscope.org.uk/resources/drugsearch/drugsearchpages/mephedrone.htm>
 - 3 DrugScope (2009) *Druglink Street Drug Trends Survey*, further details at: http://www.drugscope.org.uk/ourwork/pressoffice/pressreleases/Street_drug_trends_2009
 - 4 EMCDDA (2009) *Annual report on the state of the drugs problem in Europe*

CASE STUDY: RESPONDING TO NEW DRUG CHALLENGES

The South London and Maudsley (SLaM) NHS Trust runs the UK's only dedicated treatment service for GBL and GHB addiction. The service was set up in 2009 amid concerns over the lack of support available from mainstream GP and drug treatment services for users experiencing problems with their GBL/GHB use. Addiction to the drugs can occur rapidly and users report severe withdrawal symptoms including psychosis, severe anxiety and insomnia.

SLaM's service offers outpatient detox treatment for clients seeking help for their GBL/GHB addiction. Users are treated with a combination of baclofen, and high doses of benzodiazepines to stave off withdrawal – with medication normally required for about five to seven days. The clinic also holds weekly follow-up meetings with clients to support them through the post-detox period, when the chance of relapse is particularly high.

By February 2009, SLaM had treated thirteen clients for GBL/GHB addiction – the majority being young males in their early and mid-twenties. The service invites referrals from across London and is working closely with drug treatment services and GPs in the city to promote awareness of the support they have available.

For further information please contact Dr James Bell, Consultant in Addictions at SLaM (www.slam.nhs.uk)

“There is a lot that we do not know about the impact of drug and alcohol misuse on the physiological and psychological development of young people.”

people is different from use by adults – that, for example, is why it is illegal for young people to buy alcohol. This is because they are developing – mentally, physically and socially – in ways that can mean that they have a greater susceptibility to harm. There is a lot that we do not know about the impact of drug and alcohol misuse on the physiological and psychological development of young people. They may also be at particular risk because of the context in which they use alcohol and drugs, for example, the risk of teenage pregnancy, victimisation or sexual exploitation.

Can we predict which young people will develop drug or alcohol problems?

There is well-established evidence for a link between substance misuse problems among young people and family breakdown, neighbourhood poverty (including ‘the poverty of place’), emotional and psychological problems and socio-economic deprivation. The first ten year drug strategy, published by the Home Office in 1998, stated that ‘for older teenagers and people in their twenties, there are strong links between drug problems and unemployment, homelessness, prostitution and other features of social exclusion’.

The ACMD's *Pathways to Problems* report (2006) states that ‘from the late teens onwards, heavy smoking and problem drinking or drug use are strongly linked to socio-economic disadvantage, often with disastrous results. Multiple drug use and drug injecting are common in disadvantaged communities, in many of which problem drug use has become an inescapable feature of life’. A 2009 report for the Department of Children, Schools and Families (DCSF) on the ‘Impact of Alcohol Consumption on Young People’ concludes that

“The young people who spoke to DrugScope about their own drug problems were clear about how it all connected up in their own lives. You can end up smoking skunk all day when it is readily available in your neighbourhood, your friends are using it, and you’ve got nowhere to go and nothing else to do.”

the risks associated with alcohol misuse in children and young people include physical and sexual abuse, early behavioural problems, anti-social behaviour and interpersonal problems and family history of alcohol problems.¹

The young people who spoke to DrugScope about their own drug problems were clear about how it all connected up in their own lives. You can end up smoking skunk all day when it is readily available in your neighbourhood, your friends are using it, and you’ve got nowhere to go and nothing else to do. Getting ‘out of it’ is one way of coping with going back to a run down flat in an unsafe neighbourhood. Drug dealing and gang membership can provide money and status when other – legitimate – avenues are not available.

While evidence of links between social exclusion and substance misuse problems may partly reflect a greater likelihood that children at risk will be identified as having substance misuse problems and will be engaged with services, we do have plenty of independent evidence that disadvantaged young people and young adults are more likely to use drugs.

CASE STUDY: HOLISTIC SUPPORT IN A CHALLENGING SETTING

Kids Company provides practical, emotional and educational support to vulnerable inner-city children and young people across London. The charity offers a range of services which includes two street-level centres, an early intervention therapy house and an over 16s educational academy and a ‘Schools programme’ which is delivered within 38 inner-city schools.

Most of the children who come to Kids Company present with severe emotional, behavioural and social difficulties resulting from experiences of significant trauma and neglect. Independent research shows that the charity’s clients face the following problems: homelessness (84 per cent); criminal involvement (81 per cent); substance misuse (82 per cent); emotional and mental health difficulties (87 per cent); sustained trauma during childhood (83 per cent). The organisation currently supports 14,000 vulnerable children.

Kids Company promotes and supports emotional well-being; teams work with each individual to build a package of support and care. Independent research demonstrates that as a result of the organisation’s interventions, the young people who they work with: have improved relationships (95 per cent); have been reintegrated into education (91 per cent); have reduced their level of substance misuse (94 per cent) and have reduced their involvement in criminal activity (90 per cent).

For further information, please go to www.kidsco.org.uk

However, the sort of polydrug use identified in *Druglink’s* Annual Street Drug Trends Survey and by the recent EMCDDA report is going on in clubs and bars across the country, often at hazardous levels. It is not only disadvantaged young people who use drugs and misuse alcohol, and it is implausible to think

¹ Department for Children, Schools and Families (2009), *Impact of alcohol consumption on young people – a systematic review of published research*, Research Report DCSF-RR067.

that young people from other backgrounds do not also develop problems that would benefit from some form of specialist intervention. For example, Home Office research published in 2003 found that 79 per cent of a sample of young clubbers in the South East had taken drugs at some time. While most had not developed serious problems, it concluded – in particular – that many had problematic and potentially dangerous drinking habits. As the EMCDDA argues, this is all linked to wider cultural trends and developments which impact on a broad social demographic of young people and young adults, including ‘a dynamic and expanding drug market’, ‘the expansion of the leisure and alcohol industry’ and ‘new technologies’ (including the internet) that ‘have ... facilitated communication about drugs, their effects, and where and how to get them’.

1.3

Drug treatment, young people and young adults

“Every Child Matters recognised that young people who were accessing substance misuse services were not only receiving help and support for their drug or alcohol use, but for the problems that frequently underlie it.”

What explains the rise in young people’s specialist drug treatment?

A recent report from the NTA points to an ‘enormous expansion’ in specialist drug treatment for young people. Government spending on these services went up from £15.3 million in 2003–04 to £24.7 million in 2007–08, with numbers in treatment increasing from 17,001 in 2005–06 to 23,905 in 2007–08 and 24,053 in 2008–09.

What motivated this expansion in treatment and funding? There is no evidence that an overall rise in young people’s drug and alcohol use was the catalyst, as evidence suggests use has been falling. This said, we would not necessarily expect to find a relationship between overall drug use and access to specialist treatment – as most young people who experiment with drugs do not use them frequently or heavily. We know very little about trends in these more ‘problematic’ patterns of use. Be this as it may, the expansion seems due less to an increase in drug and alcohol use and more to developments within children’s policy.

A key turning point was the publication of a comprehensive children’s strategy in 2004, *Every Child Matters*, followed in 2005 by *Every Child Matters – Change for Children: Young People and Drugs*. The document highlighted the links between substance misuse and other problems. It prioritised children of problem drug users, persistent truants and school excludees, looked after children, young people in contact with the criminal justice system, homeless young people, those involved in prostitution, teenage parents and young people not in employment, education or training (NEETs). Perhaps most importantly, however, it observed that ‘many specialist [substance misuse] services offer a multi-agency approach which ensures that the young person has all their needs considered and addressed in the round e.g. housing, learning, family problems, sexual health and other health needs’. *Every Child Matters* recognised that young people who were accessing substance misuse services were not only receiving help and support for their drug or alcohol use, but for the problems that frequently underlie it.

The Treasury and key government departments have agreed a programme of activity to ‘increase the number of young people on the path to success’ (Public

CASE STUDY:**MULTI-AGENCY WORKING AND COMMUNITY ENGAGEMENT**

Spark is Newham's Young People's substance misuse prevention service. It offers drug education, information and training for young people aged between 5 and 25 as well as access to professionals from the areas of social work, youth work, statutory and children's services and the criminal justice sector.

Through the development of strong local partnerships with community led groups and consultation with young people, the organisation has been able to engage hard to reach groups across the Borough. These have included local Muslim clerics, African French-speaking young people and young people working with the youth offending team.

The project maintains a high level local presence through hosting regular health promotion events across the Borough, which is an important opportunity for engaging young people as well as highlighting the range of other support services that are available in Newham. It continually develops strategies to improve its delivery of the service through reviewing protocol and conducting small research projects on its impact. Additionally, it has developed a young people's guidance group.

For further information, please go to www.spark-newham.org.uk

"DrugScope members report a lack of consistency across the country in commissioning and service structures. One explained that 'in some areas we have services commissioned by children's commissioners and in others they are still commissioned by the DATs'."

Service Agreement 14, or PSA 14 for short). This includes a target 'to reduce the proportion of young people frequently using illicit drugs, alcohol or volatile substances' (Indicator 3). The Treasury Guidance explains this commitment by highlighting the links between frequent drug and alcohol use by young people and 'crime, disorder, truancy, school failure, physical and mental health problems and other poor outcomes, in addition to the risk of becoming a problem drug user in the future'. It is these links, above all, that have helped to push young people's drug treatment up the policy agenda.

Who is responsible for young people's drug and alcohol treatment?

The 'mainstreaming' of substance misuse issues is reflected in processes and structures for under-18s. Locally, Drug Action Team (DAT) chairs and Directors of Children's Services are supposed to meet together to agree priorities, ensure an integrated and holistic approach and share responsibility for delivery. Anecdotal evidence suggests that this is working better in some areas than others. DrugScope members report a lack of consistency across the country in commissioning and service structures. One explained that 'in some areas we have services commissioned by children's commissioners and in others they are still commissioned by the DATs'. They also reported 'differences in the use of the Common Assessment Framework and substance misuse screening tools, meaning the commissioning and delivery of services is more innovative and progressive in some areas than in others'. On the ground, this means that the services available to young people vary enormously depending on where they live.

Nationally, the Department for Children, Schools and Families (DCSF) and the NTA are signed up to a Memorandum of Understanding (MoU). The MoU aims to improve young people's substance misuse treatment systems and to ensure that these services 'are commissioned and delivered within an integrated children's services framework'¹. The DCSF has lead responsibility for young people and substance misuse issues, including specialist treatment. The role of the NTA is to support best practice, help with local needs assessment and produce data and performance reports. However, the NTA is currently restructuring and will no longer have a full time national young person lead. Specialist treatment for young people will be championed by the DCSF and 'mainstreamed' in the work of NTA regional teams. This raises issues about national oversight to address the inconsistencies in local practice identified above.

Furthermore, it seems as if the significant increases in the young people's treatment budget seen overall in the period 2003 – 2009 are soon to end. According to the notes of an NTA Board Meeting (6 October 2009), only modest increases in funding are projected in 2010–11 – to £25.4 million – with no further increase in 2011–12. Locally, some areas will see their funding from the young people's treatment budget rise in 2010, while others will experience falls as a result of the application of a new funding formula aimed at addressing the current variations in local investment, and attempting to allocate resources on the basis of local need. According to the NTA papers, some areas will see funding from the young people's budget drop by up to 25 per cent while others will see it rise by up to 60 per cent (although this may result in the withdrawal of money they have previously received from adult budgets).

There are no comparable structures and processes to address the specific needs of young adults in the 18 to 24 year age group. Overall targets and objectives that shape adult provision, as reflected in the priorities of local commissioners, tend to marginalise this group (for example, high levels of funding for 'problem drug users'), and we need a proactive strategy to ensure a sufficient focus on their needs. While the numbers of under-18s in treatment in England rose by 12 per cent over two years, according to figures published in June 2009, the numbers of 18 to 24 year olds in adult treatment has fallen from 18,216 in 2005–06 to 16,270 in 2008–09. As substance misuse problems tend to increase as young people move into their late teens and early twenties, it is unlikely this can be explained solely, if at all, by a lower level of need. It is more likely to reflect problems with the availability and accessibility of appropriate treatment for young adults and the existing referral pathways.

There are wider concerns about the extent and quality of provision of services for young adults, powerfully expressed by the Transition to Adulthood (T2A) Alliance² in its recent paper *Coping with Kidulthood – the hidden truth behind*

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- 1 For the full text of the Memorandum of Understanding, see: http://www.nta.nhs.uk/areas/young_people/Docs/DCFS_NTA_memorandum_of_understanding_final.pdf
 - 2 The Transition to Adulthood (T2A) Alliance is a broad coalition of organisations and individuals working to improve the opportunities and life chances of young people in their transition to adulthood, who are at risk of committing crime and falling into the criminal justice system. DrugScope is a member of the Alliance. For more and to download *Coping with Kidulthood*, see www.t2a.org.uk

“When we talk about ‘specialist treatment’ for young people, we are talking about a multitude of things. These range from residential rehabilitation, substitute prescribing and needle exchange for a tiny minority, through to services that offer a combination of ‘motivational’, ‘psychosocial’ and ‘harm reduction’ interventions for the majority.”

Britain’s abandoned adolescents: ‘While there is recognition that under 18s deserve support and are worth investing in, there is a complete attitudinal change once they are over 18. While those from marginalised communities are left to fend for themselves, young adults from supportive backgrounds receive a turbo charge from the state to propel them into adulthood ... Our society seems to expect those with the greatest needs to make a “fast track” into adulthood with little or no help’.

What are we talking about when we talk about young people’s treatment?

The NTA and the DCSF are signed up to an agreed definition of ‘young people’s specialist substance misuse treatment’ as ‘a care planned medical, psychosocial or specialist harm reduction intervention aimed at alleviating current harm caused by a young person’s substance misuse’. Recent debate on adult drug treatment has been fixated on the high numbers of people receiving what would be classed under this definition as a ‘medical’ and/or ‘harm reduction’ treatment – i.e. the numbers prescribed methadone, and other substitute drugs, often over long periods of time.¹ In contrast, pharmacological treatments are rare even for the small numbers of young people using heroin, because most will not have used the drug for long enough or in sufficient quantities to warrant this. The precise number of young people on substitute prescriptions is uncertain due to a lack of data. Similarly, only a small number of young people inject drugs and require access to needle exchange services to reduce the risk of infection and blood borne viruses. Again, there is a lack of reliable information on how many young people use these services, under what circumstances and for how long. But the numbers are very low.

Provision for specialised residential treatment for young people is also limited, partly reflecting the low number of clients aged under 18 who develop opiate or alcohol dependency. Currently there are very few facilities that offer medically supervised detoxification. However, there are residential services that work with young people experiencing substance misuse problems, mainly within a broader remit that would count substance misuse as one of a number of complex needs, in situations where temporary removal from the family is deemed necessary. Typically these services offer a range of interventions including cognitive behavioural therapy (CBT), counselling, complementary therapy and family mediation.

So when we talk about ‘specialist treatment’ for young people, we are talking about a multitude of things. These range from residential rehabilitation, substitute prescribing and needle exchange for a small minority, through to services that offer a combination of ‘motivational’, ‘psychosocial’ and ‘harm reduction’ interventions for the majority. Most specialist treatment shares many of the features of traditional youth clubs, social work and counselling, encompassing a range of activities, some of which do not address drug and alcohol use directly. Young people receive counselling and therapy, help and support with other issues in their lives and information and advice on drug-related harms and how to reduce them. Much of it is directed at ‘alleviating

1 NTA: In 2007–08, 131,110 adults in drug services were prescribed substitute drugs.

current harm', but often it is looking to the future as well: to preventing young people progressing to problems in adulthood, and helping them to work towards a drug-free future (or one where their drug use is less harmful). Their treatment journey will start with an assessment, should be guided by a 'care plan' and it will often involve work with other services – on issues like education, work, debt, housing and mental health. Where appropriate, parents, carers and family members may also be involved with treatment.

"A high proportion of young people in services are involved with other children's services (particularly the youth justice system) and have other significant problems in their lives."

Who uses services?

Of the 24,053 under-18s treated for substance misuse in England in 2008–09, 547 were being treated for primary use of heroin and opiates (2 per cent) and 110 for crack (less than 1 per cent). A further 3 per cent identified powder cocaine as the primary substance that they needed help with. The overwhelming majority – nearly 9 out of every 10 – were in treatment because they were using cannabis and/or alcohol.

Only around 1 in 35 are 'problem drug users' in the adult sense. The NTA reports that 'young people rarely become physically and psychologically dependent on a substance in the same way adults can'.¹ A high proportion of young people in services are involved with other children's services (particularly the youth justice system) and have other significant problems in their lives. Who accesses services will partly reflect the routes by which people come into services, and the main sources of referral.

It is also pertinent to note that the latest data on young adult's treatment (18 to 24 year olds) has prompted the NTA to herald a shift in profile of 'problem drug users'. In 2008–09, 53 per cent of 18 to 24 year olds in drug treatment were 'problem drug users', compared to 68 per cent in 2005–06.

Why are they in services?

A young person who is smoking a lot of cannabis, or a young adult involved in weekend polydrug use, will have very different motivations for entering treatment to someone with a long-term heroin or crack problem. Older adults tend to access drug treatment at a point of crisis and/or when they are beginning to experience severe, long-term harms. Typically, they will consider themselves as 'addicted' or 'dependent', and will be seeking help to manage and/or overcome dependency. Often their first contact with services will be for help that is direct and of immediate value to them – such as needle exchange, or the prescription of a substitute drug. Generally, the evidence suggests that young people and young adults do not fit this profile.

From our consultation with service users, our experience is that many young people are motivated to address drug and alcohol issues because they see them as a barrier to achieving other goals. Substance misuse becomes a problem because of its impact on other areas of their lives. These included education and training, finding work, improving relationships and parenting responsibilities.

¹ NTA (2009), *Getting to grips with substance misuse among young people – The data for 2008–09*

Some say they've had enough of the 'lifestyle'. Some are worried that they might progress to more serious problems in adulthood. Many are attracted by other benefits and opportunities provided to them by drug and alcohol services – such as a positive relationship with a key worker, access to computers or musical equipment or simply to meet up with other young people in safe and stimulating environments.

The overwhelming majority of under-18s in treatment services have been referred by other young people's services, with the highest numbers being referred through the youth justice system, and less than 10 per cent as a result of 'self-referral'. Currently, a lot of young people in specialist drug and alcohol services have been in trouble with the law. Around one third of referrals in 2007–08 were from Youth Offending Teams, partly reflecting the development of a formal agreement between the NTA and the Youth Justice Board. The NTA has highlighted the need to increase referrals from other young people's services, including the looked after system and primary care.

Increasingly, young people under 18 are being referred into specialist drug and alcohol services through the Common Assessment Framework (CAF). This was introduced by Government as a key part of the *Every Child Matters* agenda, and enabled people working across the whole range of frontline children's services to conduct assessments of the young people that they work with using a standardised approach, enabling them to pick up on problems and needs, and refer them through to the other services. This raises questions about how assessments are made by other services, and how good the tools and training available to them are. It may also mean that young people identified as 'at risk' under the auspices of *Every Child Matters*, and who are consequently already in touch with other children's services, will be more likely to be referred for specialist substance misuse treatment than their peers.

Seventy nine per cent of respondents to DrugScope's telephone and e-mail survey felt that young people's drug and alcohol services in their area were effectively reaching and engaging with young people with drug problems, compared to 16 per cent who did not feel this was the case. The picture was less positive when it came to engaging young people with alcohol problems, with a quarter of respondents (24 per cent) saying that this was not happening effectively in their area. A number of people identified particular sections of their local communities who they feared were being missed by services. For example, one commented on a 'distinct lack of services' for young Bangladeshi males in his community. He added 'I strongly feel that LGBT youth are a group that mainstream services simply don't cater for and are unskilled to deal with'. Others commented on the 'assumption that clients from certain cultural backgrounds are immune to issues relating to alcohol use' and the low numbers of BME young people accessing their service.

The high number of referrals that come from the criminal justice system is also evident among 18 to 24 year olds who are accessing adult services, with 10,743 young adults coming into services through Arrest Referral Schemes or the Drug Intervention Programme (DIP), a further 4,990 via prisons and 1,351 on Drug Rehabilitation Requirements (DRRs) handed out by the court. Only 40 came

through the 'looked after children' system, 72 from Connexions and 51 from education services.¹

It is possible that there are significant numbers of young adults who are not accessing specialist support at all, but who would benefit from it. The barriers to 18 to 24 year olds accessing adult services voluntarily were spelt out in a recent report on young adults' perceptions of drug treatment services in Liverpool, which concluded that the types of drugs used was a primary reason for reluctance to engage with services, with respondents explaining that, for them, 'sharing a service with more problematic drug users (e.g. dependent users of heroin and crack cocaine) was difficult and that there was a certain amount of stigma attached to attending a drug service', adding that 'the difference between having a problem with drugs such as cannabis or cocaine and being dependent on a drug such as heroin was evident'.²

Does treatment work?

Part of the answer to this question is to ask another one: what is treatment for and what outcomes are we looking for? According to Clinical Guidance published by the NTA 'drug treatment goals for young people who regularly misuse substances should be to reduce immediate harms from substance misuse, stabilise the young person and enable them to move to abstinence from illegal drug misuse (though some drug use may still occur)'. It adds that 'given the shorter history of substance misuse in the under-18s, and their continuing development and maturation, there is often the potential for rapid improvements to be made'.³

A more recent review of data on young people's treatment from the NTA concludes that 'since the effects of drug and alcohol misuse for young people tend to be personal and social, this is where the benefits of intervention are more likely to be seen – for example, with better attendance at school or college, less involvement in offending and anti-social behaviour, and improved family relationships. Successful intervention and support can help shift the young person's focus away from substance misuse, improve their social and life skills and raise their motivation'.⁴

We know that specialist interventions for young people can reduce substance use. They can bring other benefits too, such as less problem behaviour, greater confidence and self-esteem, reduced offending, better mental health, better family relations, improved school attendance and school work. Things that help include motivational interviewing, cognitive behavioural therapy (CBT), multi-dimensional family therapy and multi-systemic therapy. We know that these kinds of interventions must be undertaken by trained people with professional

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- 1 Department of Health/NTA (2009), *Statistics from the NDTMS – 1 April 2008 to 2009*, p. 16.
 - 2 Wareing M et al (2007), *Young people and substance misuse: Characteristics, needs and perception of treatment services of drug users aged 18 to 25 in Liverpool*, Centre for Public Health, Liverpool John Moores University.
 - 3 NTA (2007), *Drug Misuse and Dependence: UK Guidelines on Clinical Management* (commonly known as *The Orange Book*)
 - 4 NTA (2009), *Getting to grips with substance misuse among young people – The data for 2007–08*, p. 24.

“The number of young people transferring into appropriate adult services at 18 does not appear to be picked up in any way by the official NTA data on outcomes for those leaving young people’s services. The young people’s system is presented as a self-contained bubble.”

supervision. We know that involvement of families and carers is often beneficial. What we do not know is what interventions are best – or best for this person now.¹

The NTA’s 2009 report *Exploring the evidence* explains that ‘there is too little research to make strong statements about definite treatment decisions.’ It concludes that ‘much more research needs to be done before firm statements can be made about what is, or is not, effective in young people’s treatment’, adding that ‘it is not possible to find quality studies on some interventions’.² Specific areas we know little about include the usefulness of pharmacological interventions for drug dependence and withdrawal in young people and the impact of residential treatment for those with the severest problems. (Nor do we know what the impact of, say, a course of therapy is compared with, say, getting a job or a college place or a place to live.) Assessing effectiveness also depends, of course, on clarity about the goals of services and realism about the time-frames for achieving them. These will be very different to those for older problem drug users.

The NTA figures on outcomes for those leaving young people’s services from 2005–06 to 2008–09 provide further evidence of effectiveness for current provision. In 2008–09 over two thirds of young people in treatment (65 per cent) were recorded as ‘completing’ according to the goals set out in their care plan, compared to under half (48 per cent) in 2005–06. Dropout rates declined over this same period, from 29 per cent in 2005–06 to 15 per cent in 2008–09. This is encouraging. However, what it means in practice will all depend on the quality of care planning. It is also notable that the number of young people transferring into appropriate adult services at 18 does not appear to be picked up in any way by the official NTA data on outcomes for those leaving young people’s services. The young people’s system is presented as a self-contained bubble.

Some of the interventions best supported by the available evidence are working closely with families, carers and others to mobilise protective factors and resources in the young person’s environment. Between 2006–09, the charity Addaction – a DrugScope member – piloted ‘Young Addaction Plus’ in five areas in England, with a particular focus on the involvement of and support for families – for example, five family workers were appointed. The *Closing the Gaps* (2009) report shows very positive outcomes, with the majority of young people involved in these pilots reducing drug-related harms, avoiding crime, making changes in their lives in order to secure stable housing and engaging in meaningful activity, such as accessing education or taking up sports or hobbies. Intensive work and family involvement are identified as the key to good outcomes, and it is noted that ‘commissioning of services must take account of

1 NTA (2009), *Young People’s specialist substance misuse treatment: exploring the evidence*.

2 Ibid

the time needed to deliver successful outcomes'.¹

Young people's treatment is also about early intervention and prevention. By identifying and working with teenagers who may be at risk of developing more serious drug problems later on, it can help to ensure that the number of adult 'problem drug users' seeking help continues to decline. It is more difficult to measure its effectiveness here, but this will be an important aspect – in particular – in making the case for cost-effectiveness and justifying public investment.

When DrugScope asked respondents to our telephone and e-mail survey what single thing had the greatest impact in helping the young people they worked with to tackle substance misuse, the most popular answer was a positive relationship between the service user and staff, which was mentioned by 33 per cent of respondents. Twenty three per cent said advice and information and 14 per cent talked about the importance of integrating services.

1 These findings are also relevant for adult services, particularly with the increased focus on recovery and social (re)integration. In 2009, DrugScope and Adfam published a briefing paper called 'Recovery and drug dependency – A new deal for families', based on a consultation event in Autumn 2008. It argued that families often play a critical role in supporting family members with drug problems, with benefits not only for the individual concerned, but for their communities and society as a whole, but that this has not always been recognised or supported. It concluded that the potential contribution of families to recovery should be at the centre of drug policy, not its margins, and that more should be done to support this.

1.4

Mind the gap – the question of transition

“When people in young people’s services reach their eighteenth birthday, they may have no option but to drop out of the system, or to move over to adult treatment services that work very differently.”

In 2005, the Social Exclusion Unit published a landmark report called *Transitions*, with a focus on 16 to 25 year olds with complex needs.¹ It argued that the transition from childhood to adulthood was becoming increasingly difficult and risky, particularly for young people coping with issues like poor housing, homelessness, substance misuse, mental health issues, poor health, poor education and long-term unemployment. It argued that ‘policy structures have tended to lag behind the reality of people’s lives, the ways in which young people become adults has become more complicated and diverse but policies have generally failed to keep up with such changes. The age structuring on which many policies are based is often complex, inconsistent, and working against the principle of resources following need’.²

These conclusions are especially relevant to drug and alcohol treatment. Young people who spoke to researchers conducting a recent review of treatment services for 18 to 25 year olds in Liverpool told them that they ‘were concerned about the age limits of current young people’s services, as once they reached the age of 18 years they had to move on to adult services when they may not necessarily be ready to do so’.³

DrugScope was closely involved in the development of the section on drug and alcohol use for the manifesto of the Transition to Adulthood (T2A) Alliance, which was published in 2009. This noted that young adults have the highest prevalence of excessive drinking, and are three times more likely to use illicit drugs, than any other age group. It is strange, to say the least, that appropriate and accessible specialist treatment provision appears to be least well developed for this age group. When people in young people’s services reach their eighteenth birthday,

- 1 Social Exclusion Unit (2005) *Transitions: Young adults with complex needs – a Social Exclusion Unit final report*
- 2 This is an issue for the full range of services working with teenagers and young adults. In 2009, for example, the Government highlighted the whole issue of transition from adolescence to adulthood in the mental health strategy document, *New Horizons*. It stated that wide consultation had ‘reinforced the view that transition between CAMHS and adult mental health services must be improved’, highlighting the importance of working with other agencies through Children’s Trust partnerships, and the role of local authorities, Primary Care Trusts or PCT’s and commissioners.
- 3 Wareing M et al (2007), op cit.

they may have no option but to drop out of the system, or to move over to adult treatment services that work very differently.

It is important to take account of the complex needs of the many young people in specialist treatment services, and the different way that services for under-18s are set up to work. Many young people in contact with young people's treatment agencies do not arrive with serious drug or alcohol problems, so, in a sense, transition to adult services could imply an escalation in their substance misuse and the failure of earlier intervention.

What most of them do have are other problems in their lives that are linked in some way to their drug or alcohol use. A successful transition to adult services for things like housing, employment and mental health might be a more appropriate measure of success than a smooth transfer into adult drug treatment. Young adults often have similar substance misusing profiles to younger teenagers, with the same links to other problems. So, the T2A manifesto observes that 'young adults in more than one vulnerable group (including truanting; exclusion from school; time spent in care; homelessness; a background of offending) are more than four times as likely than other young adults to misuse drugs, and eight times more likely to be frequent users'. This would suggest that this age group would be better dealt with by extending the reach of the current young people's system beyond 18, than adapting an adult system that has less experience of working effectively with this kind of profile.

CASE STUDY: MAKING TRANSITIONS THAT MATTER

Mosaic is Stockport's young people's drug and alcohol service working with young people up to the age of 25 years. The project offers advice, information, help and support about drugs, alcohol and tobacco to all young people. Mosaic works with young people as well as their family and carers to deal with the complex range of support needs that they may have in their lives.

By providing a service beyond the age of 18 years, Mosaic seeks to provide transitional support to young adults throughout a challenging time in their lives. For some clients, this will mean onward referral and support into adult services, whilst for others they won't require further drug treatment. Mosaic has strong links and partnership arrangements with other local treatment services so as to ensure that clients needing further treatment are supported in making the transition.

The Mosaic project offers individual counselling, complementary therapy, a stop smoking service and access to a weekly GP. Mosaic also offers a specialist medical service for clients who may be using alcohol or drugs on a daily basis and need immediate help to stop. For young people wanting more structured support, they can access the 9-week group work programme.

The Mosaic family service helps young people to talk about their concerns about drug use within their family. Mosaic also has a drug prevention outreach service that operates across 14 schools in the Stockport area.

To find out more about the work of Mosaic, please go to www.stockportdrugservices.org



2

Young people's drug and alcohol treatment at the crossroads: key messages from the frontline

Young people's specialist treatment is 'at a crossroads'. There are different directions that it could take, particularly at a time of political change, high octane public debate and tight public finances. It is against this background that DrugScope embarked on a consultation process in 2009 with people involved with young people's services – national policy specialists and commentators, commissioners, service managers, staff and young people in services.

The key messages from the front line are summarised and discussed in this section of the report. It draws, in particular, on consultation events we held with DrugScope members and other key stakeholders in Gateshead (28 April 2009), York (4 June), London (29 June) and Birmingham (16 July), and on interviews with young people at Newham Create in East Ham, London (5 August) and Compass in Brixton, London (18 September). It is also informed by the telephone and e-mail survey conducted in December 2009.

2.1

Working with young people in treatment is not only about problem drug or alcohol use, but multiple needs

“The Government need to start helping the young people around here, instead of thinking they’re worthless. In life, yeah, people can come to a lot of bad moments and in those situations they can take drugs. One of my friends went to the police station because she got kicked out of her house and they said they couldn’t do nothing for her, then they tried to put her in a bed and breakfast but there was no room, so basically she just took drugs.”

Service User, East Ham

“I don’t think there is the right infrastructure of support services in place for young people in order for them to have complete wraparound services for their social care needs. A good case is the shortage of supported housing provision. This has a huge impact on how they engage in treatment. There is also the question of whether staff in those settings get the training and support so they are geared up to the challenge of those young people and the behaviours that they will exhibit.”

Service Commissioner, Gateshead

An NTA report on the role of Child and Adolescent Mental Health Services (CAMHS) and addiction psychiatrists observes that ‘many young people who misuse drugs and alcohol have multiple antecedent and co-occurring mental health problems and disorders, unrecognised learning disabilities, and deeply entrenched social problems’.¹

This message was echoed at DrugScope consultation events, with concerns expressed that the necessary links between services are not yet being made in some places. One local commissioner at our North East meeting commented that “there is a lot of confusion around eligibility for young people in accessing

¹ NTA (2008), *The role of CAMHS and addiction psychiatry in adolescent substance misuse services*

"I wonder whether the staff don't just give up on clients. If you look at the thresholds for acceptable behaviour, there are lots of reasons for exclusion from projects. For a lot of our young people this effectively means they don't stand a chance and are instead being set up to fail."

dual diagnosis services in this region. At present, if a child or young person doesn't have a diagnosed psychosis, they aren't considered for CAMHS services." At York a service provider commented "we have a holistic approach to assessment – which is good, but then we can find it hard to actually do holistic work, because it isn't easy to get other services involved."

We heard positive stories too. In Northumberland, they had commissioned a community based CAMHS service with a focus on substance misuse, and this was reported to be reaching more young people, as a result of outreach work, a focus on particular high risk groups (especially looked after children and ex-offenders) and word of mouth.

The findings of DrugScope's telephone and e-mail survey of 43 young people's drug and alcohol services suggest that relationships with CAMHS are improving in many areas. Seventeen per cent of respondents to this survey rated the relationship with mental health services in their locality as 'excellent', 44 per cent said they were 'good', 49 per cent 'satisfactory' and only 10 per cent 'poor'.

A number put the improvement down to greater integration; for example, attributing 'excellent' relationships to the fact that 'the substance misuse team is embedded with the local CAMHS', or to the presence of a CAMHS worker within the drug and alcohol service (including, in a couple of cases, as a 'placement' for one day a week). Others welcomed 'regular joint assessments' and 'joint planning and development'. Where the links were less good, some respondents said that this had more to do with the lack of funding for CAMHS (and therefore capacity), than any lack of local integration as such. Some were less positive. One commented: 'There have historically been poor links between mental health and drug services in our locality, resulting in very little onward referral or co-working. Often there appears to be confusion over whether mental health or substance misuse should take priority. Some mental health provisions work well for our drug agency but that appears to be based more on individual personalities than institutional practice'.

A young persons specialist working for the NTA in Yorkshire and Humberside commented that "there needs to be more work ... with young people around benefits and financial management and debt", explaining that "young people who aren't in work, training, and school and aren't getting any money from their parents may start 'scamming' to pay for their drug use, which is a gateway to normalising the link between drug use and committing crime."

Workforce development in other sectors is an important issue. In Gateshead we were told that some staff in supported housing services working with young people and young adults were "not skilled up to work with residents with complex needs." One participant commented: "I wonder whether the staff don't just give up on clients. If you look at the thresholds for acceptable behaviour, there are lots of reasons for exclusion from projects. For a lot of our young people this effectively means they don't stand a chance and are instead being set up to fail."

2.2

A lot of the work done by specialist drug and alcohol services is not 'treatment' in the narrow medical sense

'The whole idea of what constitutes drug treatment for adults has been very hitched to ideas of addiction and dependency – with a 'medical' evidence base – but actually dependency as such is quite rare among young people in treatment. So what treatment means for young people is partly a question of what treatment means in the absence of dependency and addiction.'

Contributor to DrugScope's London seminar

'When you ask young people in our services what they want often they say something like they want a girlfriend or boyfriend or a job or a flat. Normal things. We need to be careful how we determine if drug and alcohol use – even quite heavy use – belongs to a rite of passage or is genuinely problematic. We don't want to be pathologising loads of young people unnecessarily by drawing them into drug and alcohol services when they are only passing through a stage of life. But there are also people who do need that help.'

Service Provider, Birmingham seminar

For the most part, the young people we spoke to were not receiving 'treatment' in the narrow medical sense of that term. They were not being prescribed drugs. Some did not appear to be involved in more structured forms of therapy. The focus of the support they were getting from services was on other issues in their lives, such as family relationships, financial issues, education and housing. There was work with families and others to mobilise existing support networks and protective resources. Some had stopped or substantially reduced their drug or alcohol use. Others said they were still using drugs frequently, while benefiting from harm reduction advice and support from key workers. Most talked about other benefits from services, such as access to facilities and relationships with peers and staff. This reflects the development of a treatment system for young people that aspires to be 'change focussed'. Ideally, it works with young people

on care plans that identify the outcomes that will motivate change for them and will remove the barriers to them achieving their wider goals. These often focus on outcomes that are not directly about substance misuse, but where tackling drug and alcohol issues is nonetheless important.

These issues were brought into focus in discussion of the role of residential treatment, against the background of the potential closure of the Lincolnshire service Middlegate Lodge, described in media coverage as 'Britain's only residential rehabilitation centre for children fighting addictions to drink and drugs'. At a time when the adult system was under fire from critics for what were seen as high levels of substitute prescribing and low levels of residential rehabilitation provision, the threat to Middlegate attracted a lot of media attention. In an article in *The Times*, Professor Neil McKeganey, Director of the Centre for Drug Misuse Research at the University of Glasgow, and a prominent critic of methadone prescribing in the adult system, said that it would be a "scandal" if the facility closed.

At our consultations, the role of residential treatment of young people was an issue on which opinion was divided. At our London seminar, a contributor from the Centre for Policy Studies emphasised the need for "range and choice", and argued that "this means rescuing some children from their homes and communities and we must do that ... and that means ring fencing enough residential care for that rescue job". Others agreed that some children with substance misuse issues needed "rescuing from highly dysfunctional families", but argued that "they should be looked after in specialist foster care or in specialist children's homes not in drug and alcohol residential treatment facilities", and that this required "massive investment in social services rather than massive investment in residential substance misuse services."

The evidence-base on residential treatment for substance misuse for young people is not encouraging, but it is largely based on studies in the USA of highly structured, disciplined and hierarchical models. According to a recent NTA review, there is some evidence 'to suggest that young people with a dual diagnosis ... and/or those who regularly use heroin, cocaine or alcohol may achieve better outcomes in residential settings.'¹ But other studies suggested similar outcomes could be achieved in the community.

A very small number of young people may have – predominantly – heroin and/or alcohol problems that are sufficiently advanced and entrenched that they are motivated to engage with – and could benefit from – residential detoxification and rehabilitation services. The arguments for adequate provision for this group are the same as for adults. There are other young people with drug and alcohol issues who it would not be appropriate to consider for residential rehabilitation but who may need to be removed temporarily from families. This group need social service intervention and access to generic children's services with skills and capacity to work on substance misuse issues. And there is, perhaps, a third category of young people whose needs fall below this threshold, but who would benefit from a break from their environment. A participant in our Birmingham event drew attention to young people she was in contact with

1 NTA (2009) *Young people's specialist substance misuse treatment: exploring the evidence*

“who need to get away” from where they live. Residential services of some kind may have a role to play with this group, alongside the sort of projects that take young people out of their normal environments to engage with specific activities, run by voluntary organisations like the Prince’s Trust.

If it is right that specialist substance misuse services for young people need to be child-centred and integrated with mainstream children’s services, then similar considerations will apply to residential care. The majority of young people who may benefit from residential support will need services that can provide safety, security and protection, while working with complex needs, including mental health problems, learning disability, offending behaviour and social deprivation. Some will need protection from neglect and abuse. This has implications for the way we understand and develop residential provision for young people with drug and alcohol problems.

2.3

Work with young people and young adults requires a wider conception of problem drug and alcohol use

"I only smoke marijuana. I don't even drink much ... During the period when my mum and dad were breaking up it was really bad ... I got so depressed and I smoked weed. I used it as an anti-depressant ... Every day, if I get a bit upset, I use weed. My addiction now can go right up to £40 a day ... I don't know how I get the money most of the time ... I don't want to become a crack head, I don't want to take cocaine ... I know so many people where that's their life – when you become a weed addict, yeah, your daily life is weed – every one of my friends we live our lives around that one drug."

Service User, East Ham

"Most young people in our service see cannabis as a barrier to them achieving in education, a cause of a breakdown with their parents and themselves, so....they may not see it as a problem in the same way as crack or as heroin but they do see it as a barrier to them achieving something, so we do what we can to help them – often the focus is on minimising their use."

Service Manager, Brixton

In 2008, the ACMD published a report on cannabis.¹ The Council found the evidence on mental health 'confused', and concluded – on the best current evidence – that cannabis 'plays only a modest role' in the development of psychotic conditions, including schizophrenia. Nor did it find convincing evidence that cannabis is a 'gateway' to 'hard' drugs. If this is true, there is no reason to assume that most people in touch with young people's substance misuse services will ever graduate to become 'problem drug users' in the adult sense. It concluded that cannabis was less harmful than drugs like

1 ACMD (2008): *Cannabis: Classification and Public Health*

amphetamines and barbiturates, and should remain a Class C substance – advice rejected by the Government, which has since moved it up to Class B.

But, while this is what grabbed the attention of the media, it was not all that the ACMD had to say. It said that cannabis dependency was real and important. It discussed research that found that one ‘cluster’ of cannabis users – usually young men – spent large sums of money in pursuit of high levels of intoxication. It added that, while cannabis use among young people entering treatment in Britain ‘rarely involved dependency’, there is research identifying other harms, such as low academic attainment and poorer relationships with parents. In particular, it highlighted how little we know about levels of dependence, or, for example, the links between cannabis problems and social exclusion. It called for research on the sociology of cannabis, as well as on dependency and its consequences.

“DrugScope’s consultation work confirms that there are many young people in treatment services who are using cannabis in high quantities, often on a daily basis. Some describe themselves as dependent, and others do not, but are concerned with its impact on other areas of their lives.”

DrugScope’s consultation work confirms that there are many young people in treatment services who are using cannabis in high quantities, often on a daily basis. Some describe themselves as dependent, and others do not, but are concerned with its impact on other areas of their lives. We also met young people who were in specialist services, but whose drug and alcohol use appeared to be much more moderate. Of the 43 respondents to DrugScope’s telephone and e-mail survey of young people’s drug and alcohol treatment services, two thirds (66 per cent) said that, in their experience, more potent strains of cannabis were resulting in greater harm to young people, compared to 15 per cent who said this was not the case.¹ Among those who agreed that ‘skunk’ was causing ‘greater harm to young people’ in contact with their services, 88 per cent said it was contributing to mental health problems, 81 per cent to relationship problems, 72 per cent to financial problems, 88 per cent to problems with education and employment and 70 per cent to further addiction. (These figures refer to the small minority of young people coming into contact with specialist drug and alcohol services.)

There appears to be a link between high levels of cannabis use and other problems, like social exclusion. Clear data on this is lacking. It is indicative of the gaps in our understanding of these issues in current policy that the British Crime Survey’s measure of ‘frequency’ of use among 16 to 24 year olds is using any illicit drug at least once a month in the last year. At best, this can provide only a highly approximate and unreliable indicator of how many young people are using drugs heavily or in dependent ways.

New profiles, new challenges

We did not encounter many people in the London services that we visited who said they were polydrug users – most said they used alcohol and cannabis (and mainly cannabis). One young person in Brixton said that from his experience of local drug markets it was people from more affluent areas who bought drugs like ecstasy and cocaine in order to enhance leisure activity, while him and his friends used cannabis habitually to kill a “lot of time”. One participant at our

1 19 per cent did not know.

“Drugs and alcohol impact on young people’s lives in different ways, and services have to work with that complexity.”

York event said he was working with young people fitting the ACCE profile (alcohol, cocaine, cannabis and ecstasy), but that this group was mainly coming in via the criminal justice system. Another questioned if some of the young people being routed into drug services in this way would really benefit from them. His experience was that young powder cocaine users were picked up by arrest referral schemes, including recreational and occasional users unlikely to benefit from treatment. This may well be the case, but with these clients services could consider a different approach – for example, a brief one-off intervention that focuses on harm reduction, which may not be treatment but might open the door if in the future that person were to get into trouble with their drug use.

Clearly, services are working with clients with a range of substance misuse issues, interacting in a variety of ways with other issues in their lives. The people walking through their doors can vary from young people using cannabis to self-medicate and who are becoming dependent, to binge drinkers who are losing friends, damaging relationships and getting into trouble at school or college, to a first time user of cannabis who has been referred by the school who found her in possession. Drugs and alcohol impact on young people’s lives in different ways, and services have to work with that complexity.

Young people using heroin and crack

We must not to lose sight of the fact that heroin and crack are much more harmful than cannabis and alcohol, and that there is a small number of young people using them. Some will only be experimenting, others are at an early point in their use of these drugs, so dependency is likely to be less entrenched than for adults. A key challenge is to identify these young people, find ways to pull them into services and motivate change. We need to know more about the barriers that prevent young people from coming forward for help – for example, is it a fear of being taken into care?

At DrugScope events in York and the North East, it was claimed that a high proportion of young people using the most harmful drugs were from families where adults have drug problems. One contributor who had worked in both adult and young people’s services commented “there is a strong tendency for young people experimenting with opiates to come from families where others have first hand experience of using these drugs. When I worked in adult drug services, it never occurred to me to ask questions about adults using with their children. We need to be asking these sorts of questions – we might find there is a hidden population out there who are at high risk of ending up in adult services later on.” One service had been involved in distribution of metal foil as a harm reduction initiative (encouraging users to smoke heroin, not inject, while encouraging them into contact with services) and had found this had attracted a group of young people who do not normally engage with drug services.

2.4

Young people's services should not be judged by the same targets as adult services

"The Quality Assurance Frameworks for young people post 16 are the same as for adults whereas the policy and guidance is increasingly focusing on articulating the differences between these two groups of people. This needs to be reflected in better convergence of the quality assurance systems. And that applies to the data and the types of information that we are being asked to gather about how we work, whom we work with and what is achieved – which in turn is being used to judge our performance."

Service Manager, York

One service manager commented at DrugScope's London consultation event that "building therapeutic relationships with young people depends on being realistic about goals and objectives. Actually announcing that you are going to get them off drugs is often not a good way of getting them into a service, beginning a therapeutic relationship or managing a therapeutic interaction." In York it was commented that "when services are working with the most challenging, chaotic and complex of young people, it is very difficult to actually engage them and to meet the management targets that are often set out as funding requirements by commissioners", because the targets identified by commissioners may not be the outcomes that engage young people and motivate them to change.

Public Service Agreement 25 sets the ultimate goals for reducing harms caused by drugs and alcohol use, including a target for numbers of drug users in 'effective treatment', which requires that they are retained in treatment for a minimum of 12 weeks. It also has a focus on reducing drug-related offending. Neither of these policy objectives apply to young people in the same way. Drug-related crime is primarily linked to dependent use of heroin and crack cocaine ('problem drug use') and it is often not feasible to retain young people in treatment for 12 weeks, nor necessary in order to have a beneficial impact. This retention target is based on research on adult treatment. It does not have a scientific basis applied, for example, to a teenager using cannabis or a young

“If you’re 16 and you’ve contacted a drug service – often with trepidation – because your cannabis use is escalating, how will you feel when things kick off with questions about injecting risk behaviour or offending?”

adult whose recreational use of powdered cocaine is causing problems.

Only 40 per cent of respondents to DrugScope’s survey of young people’s services agreed that ‘retaining young people in services for at least 12 weeks’ was an appropriate and realistic goal for them, compared to 55 per cent who said that it was not. While 45 per cent felt that it was realistic for services to aim to stop young people using drugs, 48 per cent did not. Most believed that services should work with young people to reduce drug-related harms, and to moderate their drug use. Nine out of ten said that the key outcomes for their service included enabling young people to progress with their lives in other ways, as well as to reduce offending and anti-social behaviour.¹

The NTA introduced the Treatment Outcome Profile (or TOP) in 2007. This assesses need and measures progress using 20 indicators in the four broad categories of substance use, injecting risk behaviour, crime and health and social functioning. It is required to be completed at regular intervals by a key worker for every service user aged 16 or over. Additional information is required by the National Drug Treatment Monitoring System (or NDTMS), initially developed to monitor adult services. The specific data set for young people within the NDTMS was revised in 2008 following extensive consultation with the treatment field. Additional targets may be set by local commissioners and other funders (including targets for work with children under 16). While the NTA has worked with the sector to develop appropriate measures, and there is a clear need for appropriate data collection and outcome monitoring, the suitability of TOPs for young people was questioned by a number of the professionals we spoke to.

Some felt that submitting many young people entering their services to the full TOPs treatment was irrelevant to their needs and was not a good way to start a therapeutic engagement. If you’re 16 and you’ve contacted a drug service – often with trepidation – because your cannabis use is escalating, how will you feel when things kick off with questions about injecting risk behaviour or offending? There is also concern that the TOPs system is not adapted to capture the work done with young people who benefit from often brief interventions to target specific issues in their lives.

Nor will TOPs necessarily capture the contribution that substance misuse interventions can make over the long-term to the wider *Every Child Matters* targets – i.e., be healthy, stay safe, enjoy and achieve, make a positive contribution and achieve economic well-being. To what extent should the outcomes from young people’s substance misuse services be specific to them and to what extent should they be delivering on the wider vision for children’s

¹ Respondents were asked ‘Which of the following outcomes do you think are appropriate and realistic as goals for service users and for assessing the performance of your services?’ The results were as follows:

Retaining young people in services for at least 12 weeks? Yes 40%, No 55%, Don’t know 5%.
 Young people to stop using drugs? Yes 45%. No 48%. Don’t know 7%.
 Young people to moderate drug use? Yes 93%. No 2%. Don’t know 5%.
 Young people to use drugs in less harmful ways? Yes 95%. No 2.5%. Don’t know. 2.5%.
 Young people to use less harmful drugs? Yes 88%. No 5%. Don’t know 7%.
 Young people to progress in other ways? Yes 93%. No 0%. Don’t know 7%.
 Reduction in offending/anti-social behaviour. Yes 90%. No. 2.5%. Don’t know. 7.5%.

services? How we answer these sorts of questions has practical implications for local commissioners making decisions about who gets the available money and what has to be delivered. It points to the benefits from joint commissioning and budget pooling. There is the familiar challenge of balancing the need to gather data and manage performance with the risks of strangling services with red tape – and measuring outcomes in ways that detract from outcomes (if it discourages engagement or alienates service users, for example).

2.5

A key challenge is the gap between young people's and adult's services and the issues of transition this raises

Service User (Brixton): "I used to come here weekly but because I am too old to use the service now, I only get to come here for a few minutes some times."

Interviewer: "Are there other services just round here that you can use at your age that do what this service was doing?"

Service User: "Not really for my age. Under my age, yeah. Up to 19 years old, but for us there's nothing really."

"Even one of our crack users ... if we were to refer her to one of the adult services, the clientele there could potentially make her worse. I don't think she'd get the right type of supervision that we give her, or the attention we give her, or the time."

Service Manager, Brixton

"In terms of the transition and when it should be made, many services will just hold on to clients rather than move them on to adult services because I don't know if the alternative is feasible. Clients may not hit the threshold of adult services; they may not be using heroin or cocaine as their primary drugs of choice; but they often have massively high levels of need. The likely challenges of a young person being transferred across into adult services are also compounded by the likely geographical discrepancies in access to alcohol treatment services. Young people's services offer support around all drugs they may be using but when these clients move into adult services they may not receive the same level of support."

Young People's Commissioner, Gateshead

One contributor insisted at our London event that "we should be getting these kids to a point where they can run their lives and they are not spending

“Many of the young people that drug and alcohol services are working with are subject to multiple transitions between services, which may encompass – for example – substance misuse, mental health and criminal justice services.”

their lives service dependent. We have to raise the bar higher than a seamless transition to adult services or to asking how adult services have to adjust to supporting people on cannabis as opposed to heroin users.” This is, of course, right. But there will always be some young people who need help beyond the age of 18. How do we best provide it, and manage transitions to adult services?

Currently, the ‘two systems’ work with different notions of substance misuse problems, different interventions, different approaches to alcohol, different relationships with other services, different lead departments in Government and – to a significant degree – different targets and outcomes. They are informed by distinct evidence bases. So, what happens to people in young people’s specialist service when they hit 18?

Adult services won’t be able to work with many of them on the same problems and in the same ways. Many young people have negative perceptions of adult drug and alcohol treatment. They would not view it as appropriate for them and they would often be right. So how do we handle transition? Some services appear to be hanging onto clients, rather than passing them through to adult services. Some local services are working with transitional age groups. Many appear to be dropping out of substance misuse services at 18 – because there is nowhere appropriate for them to go.

There was a common view, articulated by one participant at our London event, that “it makes a lot of sense to look at services for an age group from 16 to 25.” But would that create a risk that children under 16 would not get services? Is it appropriate for school children of 16 to be dealt with alongside young adults in their 20s? Would working in this way be consistent with integration with children’s services? And what would happen at 25 – wouldn’t we be relocating, rather than resolving, the original problems? As was commented at our London consultation, “it is true that people may have a problem at 25, but many will not, and we are often able to deal with the less problematic drugs by this age. If you look at the evidence on trends of alcohol and drug use after 25, normally, even for those people who aren’t in treatment, it starts to decline naturally.”

It was also argued that there is a much wider challenge in developing services for young adults. Many of the young people that drug and alcohol services are working with are subject to multiple transitions between services, which may encompass – for example – substance misuse, mental health and criminal justice services.

Finally, as one service manager commented ‘a big barrier, of course, is that providing services for ‘non-Problem Drug Users’ is just not a priority for adult treatment services’. Another contributor to our London consultation commented that ‘if we are going to deal effectively with transition we need to look again at adult services ... and to make them better at picking up the sorts of problems that emerge from young people’s services’. A key issue was felt to be a lack of services appropriate for young adults with alcohol problems. This merely serves to highlight the insufficient provision of alcohol treatment for adults, particularly for clients who do not have a co-occurring drug problem.

2.6

Young people with drug problems may be involved in drug supply and services need to address this relationship

“Drugs is a way of life. That’s the way I see it. People not in employment sell drugs, people with bad experiences of life use drugs, there’s all different types of reason why people use drugs. To me, I see drugs as a way of life. Everyone around me sells drugs or uses drugs.”

Service User, Brixton

“Most of the young people we see in our services – well, everyone they know is using drugs or involved with drugs, and they all have similar values. That’s the world they know. Those who move on with their lives can be invisible to them – they don’t have those kinds of role models.”

Service Provider, Birmingham

“The area itself wasn’t a very good example for not just myself but for a lot of the young people, do you know what I am saying? Some people I’ve known since primary school, their lives have been taken, over the fact that they’d got a nicer, larger amount of cannabis. A drug dealer, come in this house and they shot him. Do you know what I’m saying, they shot him dead. And that sort of changed everything. And that gave me the knock, “rah, do I want that to be happening to me?”. And then for my house to get robbed, these are all signs I need to be out of here, to get away from here, what do I have to do to not be in a situation where I have to defend myself, do you know what I’m saying, as it’s all down to peer pressure and drug use.”

Service User, Brixton

The same things that make young people vulnerable to developing problems with drug use, can make them vulnerable to getting involved in the supply of drugs. This can lead them into offending careers which damage their

communities and make it more difficult for them to address other problems and move on with their lives. It can leave them vulnerable to risky relationships with adults, including potential sexual exploitation.

A key message from DrugScope's consultation was that we need to build evidence-bases, explore approaches, design services and skill up staff so they are able to discuss these issues with young people, motivate change and provide constructive support. It was pointed out at our London consultation, for example, that many young people in contact with drug services are affected by gang culture, which goes way beyond 'peer pressure' in the normal sense, and may be the context of involvement in both drug use and the drug trade. Some young people may put themselves at risk from gangs by engaging with services.

The guidance on effective treatment for young people with substance misuse problems is largely silent on extricating them from participation in drug markets or gang culture. This is perhaps unsurprising given this is an issue that needs cross-agency interventions and that specialist treatment services can only have a limited impact in isolation. But this will certainly be a key issue for significant numbers of young people entering the system and may be one of the main things motivating them to change.

2.7

We need investment in community and social regeneration as well as one-to-one support

“This service keeps youths out of trouble as well, because there aren’t no youth centres or that round here and because there is not enough youth clubs and that in the area, people start trouble and use drugs for fun. If they had youth clubs and that there would be other things to entertain them.”

Service User, East Ham

“I think drugs are around because money is so hard to get ... I was trying to get a job during college as well and it was so hard – too hard – to get a job ... it’s a one in a million chance around here, you are so lucky if you get a job. I don’t know a single one of my friends who has a job – everyone’s looking, everyone goes to the JobCentre, everyone is going to agencies.”

Service User, East Ham

Interviewer: “You said you’d been burgled a couple of times, what’s the neighbourhood like?”

Service User in Brixton: “It’s deteriorated really and truly. I don’t know why they moved me into the area. I grew up around here all my life, I love the area but I know what the area breeds, without anything for the kids to do, they just follow the older kids, yeah, let’s steal the bike, then they get other ideas, then they feed off each other and get in trouble and the police deal with them like they’re actually adults, do you know what I’m saying? Banging them up I’ve had a lot of houses over, like, the space of, like, five years, six years maybe I’ve had seven houses.”

It is important not to frame young people’s substance misuse in exclusively individual and therapeutic terms and fail to invest in community resources. Employment and meaningful activity, decent accommodation for young people and access to leisure activities are all vital.

“Rewarding young people who stay engaged with services, or make significant progress in them, with free access to local leisure and sports facilities or opportunities to participate in outings can further motivate change and have other benefits – such as better health or improved employability.”

The Government has invested substantial resources in a range of youth services (this activity is summarised in the Children’s Plan) and some of these issues are addressed in a ‘Think Family’ memorandum between the DCSF and the NTA. But there is still plenty to do.

At our consultation event in York it was argued that we need more focus in young people’s drug and alcohol services on service user involvement, opportunities to participate in social enterprises, mentoring, volunteering and other kinds of meaningful activity. Young people grow to trust service providers and will be much more willing to engage with this kind of activity when it is offered as part of the overall service. At the moment, it was felt that “there is little or no funding in drug services for those types of activities”. These kinds of opportunities could be linked to ‘contingency management’ approaches to treatment. Rewarding young people who stay engaged with services, or make significant progress in them, with free access to local leisure and sports facilities or opportunities to participate in outings can further motivate change and have other benefits – such as better health or improved employability. Gaining a qualification or learning a new skill supports young people to develop the vital self esteem and confidence necessary to achieve their goals in treatment.

2.8

What you get is too dependent on where you live

“I’ve done a lot of contract work in the last five years in this country, in a lot of different boroughs in London and it’s really amazing from my experience to see the level of inconsistency and the different levels of capacity at work.”

Drugs Worker, London

“the services that are available to young people varies enormously depending on where they live.”

Young Person’s Lead, Addaction

In her preface to a 2009 NTA report on the role of child and adolescent mental health services (CAMHS) in substance misuse treatment¹, Baroness Massey explains that a 2007 review conducted for ministers by the NTA and the then Department for Education and Skills (DfES) found that ‘treatment systems across the country varied enormously’, reflecting equally wide variations in definitions of treatment. Other headline findings were that CAMHS support for treatment was patchy and performance management systems needed to be improved.

This partly reflects the way in which funding for young people’s treatment has been allocated based simply on levels of spending in the past, which has resulted in the most generously funded area getting twenty times more per person than the least well funded (£249 compared to £4,306)². The NTA is introducing a new funding formula from 2010 based on assessment of local need, which is intended to address these disparities. However, it will result in a fall in funding in some areas, and while cities like Birmingham and Manchester will receive more money through the young people’s treatment budget, this could lead to a withdrawal of subsidies that have been received from adult treatment budgets in the past. It is too early to tell what the overall impact of these changes will be, and they will undoubtedly benefit many areas and help

¹ NTA (2009): *The role of CAMHS and addiction psychiatry in adolescent substance misuse services*
² Notes of NTA Board Meeting (6 October 2009)

“A key function of workers in other children’s services is early identification of children and young people at risk of developing substance misuse problems. There is a difficult balance to be struck here, requiring skill, judgement and experience.”

to address discrepancies in provision. However, anecdotally DrugScope has heard of cuts to some under-18 specialist services (for example, in Manchester). Nor is there any allocated budget as far as we are aware specifically to develop provision for young adults in the 18 to 24 age group.

Discussions at DrugScope’s consultation events suggest that we still have a lot to do to address a continuing variation in services for young people with substance misuse problems.

This may partly reflect the challenges of providing specialist services for young people in some locations, particularly more remote and sparsely populated areas of the country. A service provider in York championed ‘outreach work’ as a way of connecting with young people and bringing them into services, but recognised that “this is resource and time intensive[...]. When this is looked at in the context of rural service delivery, this can be a real challenge for services that may only see one client in three or four hours of staff time.”

It was argued that the identification of ‘robust national outcome measures’ was crucial as a basis for performance management and the development of the evidence base. Outcomes will not be identical to those for adult treatment. As one service manager commented, “commissioning bodies must recognise the specific needs of young people and allocate adequate resources to ensure that services are able to address these needs[...] they must take account of the time that is needed to deliver successful outcomes – raising, for example, questions of whether case loads need to be reduced to shift the focus from quantity to quality.”

There were also reported to be significant variations in the level and quality of engagement with substance misuse issues by other children’s services. It was felt that there was little if any monitoring of what support was being offered for substance misuse problems in other services (for example, in schools and colleges or by social workers), how effectively, to whom and with what impact.

A key function of workers in other children’s services is early identification of children and young people at risk of developing substance misuse problems. There is a difficult balance to be struck here, requiring skill, judgement and experience. Early identification is critical if we are to intervene early and tackle problems before they escalate, but, conversely, we must avoid ‘over-referral’ to specialist treatment services. Ideally, this should limit the numbers who end up accessing specialist treatment. But it was felt to be difficult to sell this work to commissioners, because it is difficult to measure or assess impact. One contributor commented “how do we quantify the impact of this sort of intervention? What’s successful? What’s the evidence base? If we’re saying that early intervention is important what are we doing about it and how do we monitor and evaluate how effectively we do it?”



3

Conclusions and recommendations: moving things forward

"...you do something in one area and it will have a ripple effect, it definitely, definitely will have a ripple effect. If you go into the heart of the most worst areas you can imagine and start doing something positive, eventually it will send a ripple effect, eventually it will, do you know what I'm saying like? This area, all it needs is a nudge in the right direction, places like this service to stay open."

Service User, Brixton

3.1

Conclusions

DrugScope's work on young people's treatment services shows that they are at a crossroads of a kind too – or perhaps, more accurately, a staging post. As with the adult system, the last few years have witnessed a big expansion and much progress, and there is plenty to celebrate. As with the adult system, following a period of expansion and development, it is useful to pause and to take stock. Government has initiated 'deep dives' into detail to frame aspects of young people's services, but it is helpful to come up for air: to look at broad orientations and directions of travel.

A number of points stand out from the discussion that DrugScope has had with its members and other key stakeholders in the last six months.

Young people's treatment is very different from adult treatment – it is dealing with different sorts of drug and alcohol problems in different sorts of ways. It should not be modelled on the adult system or funded or assessed by the same criteria.

The availability and quality of young people's services is variable, reflecting gaps in policy and clinical guidance, the strength of local partnerships and in the development of appropriate outcome measures and performance monitoring frameworks.

The evidence-base on 'what works' in addressing young people's drug and alcohol problems is suggestive, but incomplete – what is clear is the need to balance specialist interventions (such as therapy) with investment in things like child protection, employment and training, housing and access to youth and leisure facilities (and the need to look at issues like gang culture and young people involved in drug supply).

The policy focus on integrating specialist substance misuse treatment with other children's services is commendable, but it is the source of some key challenges too. In particular, the more child-centred drug services for young people are, the wider the gap with the adult treatment system, and the more acute the problems of 'transition'. It is also unclear how effective services are at identifying and engaging children and young people who have

substance misuse problems that may require specialist intervention, but who are not known to other children's services.

There are unresolved issues about the interaction between other children's services and specialist drug services. How do we decide, for example, whether a young person with multiple needs should have a drug issue addressed in the 'mainstream' or be referred for specialist help?

We lack levers and measures for assessing the effectiveness of the engagement of mainstream services (such as schools, the looked after system and youth services) with drug and alcohol issues. Many of these issues are already being reviewed by the relevant specialists in the NTA, DCSF and other key bodies.

It is not the intention of this report to engage in policy detail, and we know that a lot of the issues we have identified are already being taken forward within Government and by the key statutory agencies. We would, however, stress the urgency of tackling local discrepancies in provision of young people's services. This requires consistency of investment, monitoring and performance management that is co-ordinated at a national level. There is some concern, therefore, about the implications of the recent restructuring of senior positions within the NTA with the loss of a dedicated full time young person's lead and what this may mean for the NTA's role in providing leadership on specialist young people's drug and alcohol services nationally.

3.2

Recommendations

DrugScope supports the recommendations of other recent reports on young people's services, some of which we have contributed to.¹ The DrugScope recommendations that follow are intentionally focussed on broad issues and not policy detail, but we hope this report will help to inform on-going policy development with its messages from frontline services. Our recommendations have not been specifically consulted on with our members, but are the product of subsequent reflection on the issues they have raised and how we might help to move them forward. We hope they provide some new ideas for taking forward the young people's substance misuse agenda.

There has been significant progress in the last decade. But we cannot simply stay where we are in providing drug treatment – for adults or young people – but must adapt to shifting patterns of substance misuse, and a changing policy environment (including tighter public finances). We cannot assume that 'the drug problem' will be the same in 5, 10 or 20 years time as it was in 1998 or 2008 – not least, because there is evidence that the investment in treatment for adults with heroin and crack problems is starting to pay the promised dividends, and that drug and alcohol services in our communities are strengthened by engaging more with other kinds of problems and needs.

The Department of Health/NTA should lead a review of the basic assumptions and frameworks of the drug treatment system to take account of changing patterns of substance misuse, particularly among young people and young adults.

If it is true, as the NTA suggests, that we may be moving beyond the

¹ In particular, the relevant recommendations in the Social Exclusion Unit's *Transitions* report, including that NTA will continue to make it clear in 'essential guidance that 'treatment for drug misuse is dependent on need, not age'; the recommendations in Addaction's *Closing the Gap* (2009) report; the recommendations on drug and alcohol misuse in the *TZA Young Adults Manifesto* (2009 – recommendations 18, 19, 20 and 21). Recommendation 21 states that 'sentencing practice should make a greater differentiation between people who carry out social supply (buying small amounts of drugs and selling them to their friends) and those selling drugs for financial gain'. DrugScope has argued for a review of the law of social supply for many years.

'Trainspotting' generation, with a shift in patterns of problematic substance misuse, then this raises some fundamental questions for drug and alcohol policy. In particular, a need to review the definition of 'problem drug use' exclusively as use of heroin and crack cocaine, which has been the foundation of Britain's drug treatment system since 1998. We need to keep sight of the fact that these are the most harmful drugs, and acknowledge the progress made in the reduction in the numbers of young adults seeking drug treatment with this profile. But we also need to respond to the increased numbers of young adults seeking specialist help for powdered cocaine use. With the European Monitoring Centre for Drug and Drug Dependency highlighting polydrug use as a key problem throughout the continent, it is questionable whether any purely substance-specific definition of 'problem drug use' is appropriate to the challenges ahead. In particular, the challenge of polydrug use requires a closer linkage with alcohol policy and alcohol services, and increased investment in the latter. This is particularly relevant to young people and young adults, and for the issue of transition.

The Government should review monitoring instruments such as the British Crime Survey, and invest in research, to ensure our policy and services are adapting to shifting patterns of drug and alcohol problems.

Our two main sources of data on young people's and young adults' drug use – the British Crime Survey (BCS) and the NHS Information Centre's school survey – provide limited information on trends in more problematic drug and alcohol use, where these are not directly inferable from the data on use of specific substances (although, importantly, the BCS does now cover polydrug use as an issue). The BCS measure of 'frequent' drug use is use of any illicit drug at least once a month in the last year. This is of limited usefulness in measuring more serious drug use. Neither the BCS nor the annual schools' survey will necessarily capture young people most at risk of drug and alcohol problems. We need supplementary research. In particular, the ACMD found that the best evidence available 'provided little indication as to the true prevalence of cannabis dependency in young people'. It called for further research 'into the pattern of the use of cannabis, dependency and the resulting physical and physiological complications, particularly to assess how users react to more potent forms', as well as on the 'sociology' of harmful cannabis use. We support this recommendation.

A national 'radar' service should be established to provide early warning of new drug trends, enabling policy makers and service providers to respond to them quickly and effectively.

Patterns of substance misuse appear to be becoming more fluid and flexible. Drugs like ketamine, GHB/GBL and 'legal highs' such as mephedrone are being more widely used, and the availability of cheap, strong alcohol is an important factor. This is particularly true for young people and young adults. There is also evidence of regional and local variations in drug markets (for example, more use of legal highs in more remote areas that lack developed markets in illicit drugs).

Surveys like the BCS are retrospective (if only by a period of under one year) and they mostly include illicit drugs – although amyl nitrate and glues are included – and the survey does not attempt to identify new drug use unless for substances classified under the Misuse of Drugs Act. Academic research can take time to report on patterns of use and trends picked up by front line services today. We need an early warning system to help policy makers, treatment services and mainstream services (such as schools and GPs) to respond quickly and appropriately to new trends and new drugs, especially where this may vary from place to place. This should draw on the day-to-day experience of front-line services. Such a service could be linked into, inform and support, the needs assessment work of local commissioners. It could also play a critical role in determining whether new drugs needed to be covered by the Misuse of Drugs Act. Last year, the Home Secretary asked the ACMD to look at the issue of early identification of new or emerging patterns of drug use.

The next Government should develop a national policy framework for young adult services, which could take the form of a Green Paper. It would be helpful if the NTA and the DCSF produced a policy framework for 16 to 25 year olds, with a focus on transitional processes and arrangements.

Effective intervention with people in their late teens and early twenties is crucial to effective drug and alcohol policy. Issues of transition will often be multiple; including, for example, the move from Children and Adolescent Mental Health Services (CAMHS) to adult services and/or from youth offending teams to the probation service. This is a critical time in people's lives, and one when their problems are likely to have the greatest impact on families and communities. We need a political vision and a policy strategy for young adults, recognising, in the words of the T2A Alliance Manifesto, that they form a distinct group 'on account of their developmental stage, as well as the social, economic and structural factors that specifically impact on them'. The NTA should lead a review on best practice in providing specialist help with young adults. Currently, this age group is not the subject of an NTA work area, or covered in any detail in the chapter of the *Orange Book* on 'Specific Treatment Situations and Populations'. We would urge such a review to consider the merits of developing a new type of service platform for young adults, potentially extending young people's services to encompass a wider age group, or possibly creating a new service platform for young people and young adults who are developing more serious substance misuse problems that do not correspond to existing concepts of 'problem drug use'.

Low visibility, high threshold services should be balanced by a network of high visibility, low threshold services working in local communities.

Recent development of drug policy has been guided by a distinction between problematic and recreational drug use, and a corresponding distinction between general information and prevention work and high threshold, specialist treatment. What about services for people who have concerns about their own

(or others') substance misuse, who would not feel comfortable talking to a GP or college lecturer (for example), but who are unlikely to meet the thresholds for existing drug and alcohol services? What is happening to people who have real drug problems, but don't correspond with the dominant conception of the 'problem drug user'? One possibility would be the development of a new kind of 'High Street' drug and alcohol service, that could offer a range of support, including harm reduction information, assessment, brief interventions, information about local services and about different treatment approaches and referral to other services where appropriate. Another would be the development of innovative outreach work in pubs and clubs. While there would be significant costs involved in setting up these services, we believe that they could result in cost savings by providing effective early intervention. As a first step, we would welcome a feasibility study – to consider cost-effectiveness among other issues – as a prelude to piloting alternative approaches to local provision of high visibility, low threshold services. Such services could have a particular role in engaging young people who are not in contact with other children's services, but are concerned that they are developing substance misuse problems (which could include binge drinking, drug-related mental health issues or cannabis dependency).

With the introduction of the new funding formula for young people's treatment, the DCSF and the NTA should undertake a joint review of the availability and quality of young people's treatment services, with a particular focus on local variations.

This review should look at the impact of different relationships between Children's Trusts, Drug Action Teams and the NTA on local provision of specialist drug and alcohol treatment services for young people, at the role of local commissioners, and at the outcomes that they are commissioning young people's services to deliver. It should review the effectiveness of the current mechanisms for identifying and applying minimum standards and the case for developing a new national inspection regime for young people's substance misuse services, possibly using the Care Quality Commission model.

Closing comments

It is clear that there is much work still to be done to ensure that young people get appropriate help for substance misuse problems and the issues that underlie them. One overriding message from our consultation work and interviews with young people is the importance of balancing therapeutic work with individuals with investment in communities. When asked what single thing would have the biggest impact on drug use and drug markets in their neighbourhoods, a majority of the young people we met talked about jobs, education, urban renewal, family relationships, the looked after system, housing and access to leisure facilities. This was perhaps the clearest and most consistent message of all.

