Public Health England

Protecting and improving the nation's health

# Young people – substance misuse JSNA support pack 2017-18: commissioning prompts

## Good practice prompts for planning comprehensive interventions

# About Public Health England

Public Health England exists to protect and improve the nation's health and wellbeing, and reduce health inequalities. It does this through world-class science, knowledge and intelligence, advocacy, partnerships and the delivery of specialist public health services. PHE is an operationally autonomous executive agency of the Department of Health.

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# Introduction

This document outlines four key principles and useful prompts that local areas might consider when commissioning universal and targeted drug, alcohol and tobacco prevention interventions, and specialist interventions for young people already experiencing harms.

It also directs local areas to national data sources on the use of alcohol, drugs and tobacco by young people.

## Overview of national prevalence and data trends

Patterns of drug and alcohol use by young people often change, which means that services need to be flexible and respond effectively to changing needs. Most of the recent data tells us that cannabis and alcohol are the most common substances that young people say they have a problem with when they present to specialist substance misuse services. A very small minority will present with class A drug problems (such as heroin and cocaine).[1]

Young people's behaviour is influenced by the world they grow up in, and smoking role models[2] and cheap illicit tobacco increase the likelihood of smoking uptake.[3] Reducing the prevalence of smoking in adults and restricting access to cigarettes are among the most effective measures to prevent young people from starting to smoke.

Organisations working with young people should be prepared to deal with all substances, including tobacco and increasingly new psychoactive substances (NPS), also formally known as 'legal highs'.[4]

Prevalence data for trends in alcohol, drug and tobacco use among young people from the 'Smoking, drinking and drug use among young people in England'[5] survey shows a continued whole population decrease in the prevalence of drug, alcohol and tobacco use among school pupils aged 11-15.

However, the survey also finds that young people who truant or have been excluded from school are much more likely to have experimented with substances including tobacco.

Similarly, the strongest risk factors for a pregnancy before the age of 18 include persistent school absence by Year 9 and slower than expected academic progress between ages 11-14.[6]

Local authority level data on drug, alcohol and tobacco use from the 'What about YOUth 2014' survey was published in December 2015.[7]

Evidence suggests that approximately 207,000 children aged 11-15 are likely to start smoking each year in the UK[8] and data from the most recent Smoking, Drinking and Drug Use Among Young People in England survey showed that 18% of 15-year olds were regular or occasional smokers.

Despite recent declines, the proportion of children in the UK drinking alcohol remains well above the European average. The UK ranks among the countries with the highest levels of consumption among those who do drink, and British children are more likely to binge drink or get drunk compared to children in most other European countries.[9] Data from the Smoking, Drinking and Drug Use survey indicates that girls are drinking more from an earlier age and experiencing more harm than boys.[10]

E-cigarettes have become the most popular stop smoking aid among adults in England.[11] As e-cigarette use among adults has increased, so too has experimentation among young people, with around one in ten of 11–18 year olds having tried them.[12] However, regular e-cigarette use among young people is rare—around 2% using them at least monthly and 0.5% weekly. E-cigarette use was almost entirely confined to those who had already smoked. Among young people who had never smoked, regular use (at least monthly) was 0.3%. Smoking rates among young people have continued to decline and there is no evidence so far that e-cigarettes are acting as a route into smoking for young people.

## Other data on children and young people

The Association for Young People's Health, with support from Public Health England (PHE), has published 'Key data on adolescence 2015,'[13] a compendium of important data on young people's health.

The Child and Maternal Health Observatory (ChiMat) website provides information and intelligence about the health of young people at local authority level.[14] ChiMat have produced the Benchmarking Tool[15], which presents a selection of indicators that are most relevant to the health and wellbeing of children and young people in an easily accessible way to support local decision making.

## Risks and protective factors

Evidence suggests that a number of risk factors (or vulnerabilities) increase the likelihood of young people using drugs, alcohol or tobacco.

Prevention approaches for young people are usually not drug, alcohol or tobacco specific but are focused more on reducing risks and building resilience. The more risk factors young people have, the more likely they are to misuse substances. Risk factors include experiencing abuse and neglect (including emotional abuse), truanting from school, offending, early sexual activity, antisocial behaviour and being exposed to parental substance misuse.[16,17]

In relation to smoking, young people are more likely to smoke if they have a parent, carer or sibling who smokes. Lower socio-economic status, higher levels of truancy and substance misuse are all associated with higher rates of youth smoking.

The strongest single predictor of the severity of young people's substance misuse problems is the age at which they start using substances.[18]

Evidence shows that physical and mental wellbeing, and good social relationships and support are all protective factors. Important predictors of wellbeing are positive family

relationships, a sense of belonging at school and in local communities. Other factors include good relationships with adults outside the home, and positive activities and hobbies.[19]

Most recent advice from the Chief Medical Officer in 2009[20] is that an alcohol-free childhood is the healthiest and best option and that if children do drink alcohol it should not be until at least the age of 15 years.

From 1 October 2015, the sale of e-cigarette products to under-18s in England and Wales has been prohibited. It is illegal for an adult to purchase e-cigarettes for someone under 18.

# Commissioning principles

## 1. Effective universal and targeted evidence-based interventions to prevent young people's use of drugs, alcohol and tobacco are commissioned

At a universal level, evidence suggests that prevention approaches for young people which focus on reducing risk and increasing resilience are more effective than those that focus on topic specific programmes and interventions. [21] Focusing on factors such as raising educational achievement, training and employment, promoting positive health and wellbeing, positive relationships and meaningful activities are all valuable objectives to pursue as part of a local drug misuse prevention strategy.

Approaches that the evidence base suggests are least effective include:[22] [23]

- scare tactics and images
- knowledge-only approaches
- ex-users and the police as drug educators where their input is not part of a wider prevention programme
- peer-mentoring schemes that are not evidence-based

At a school level, NICE recommends that 'whole school approaches' to alcohol are most effective,[24] where the formal personal and social health education (PSHE) and sex and relationship education (SRE) curriculum is complemented by other actions, including promoting a positive ethos and environment, and engagement with parents and carers.

Evidence shows that school-based interventions are effective in reducing smoking uptake and NICE has published a series of recommendations[25,26] that sets out clear guidelines for commissioners. However, the impact of these interventions are considered more effective when also delivered as a package of cross-cutting tobacco control measures aimed at adults in the community.

There is some evidence that multi-component prevention programmes for preventing substance misuse in young people can be effective.[27] These are approaches that deliver interventions in multiple settings, for example, in school, community and family settings, typically combining the school curriculum with a parenting intervention.

## What questions should you ask to check that you are following the evidence and best practice?

### 1.1. Universal prevention

1.1.1. Do young people locally have universal access to accurate, relevant and timely information about the health harms of alcohol, drugs and tobacco?

1.1.2. Do young people locally have universal access to accurate and relevant information about the health harms of new psychoactive substances?

1.1.3. Are schools implementing intelligence-led, targeted sessions at all stages within the school environment, adopting a 'whole school approach' to prevention?

1.1.4. Are schools equipping children and young people with the knowledge, skills and attributes that they need to keep themselves healthy and safe, and prepared for life and work, through the effective delivery of PSHE?[28]

1.1.5. Do prevention programmes use the European drug prevention quality standards (EDPQS)?

1.1.6. Have commissioners built good links with local schools in order to develop the drugs and alcohol education agenda?

1.1.7. Do schools have a drugs, alcohol and tobacco policy, that includes the need for external providers delivering drugs and alcohol education programmes to be appropriately qualified?

1.1.8. Do schools include evidenced based and quality marked drugs, alcohol and tobacco education as part of the PSHE curriculum, such as the Mentor ADEPIS resources and/or those quality assured by the PSHE association?

1.1.9. Are schools discouraged in the use of approaches that are proven to be least effective, such as the use of scare tactics, ex-users and knowledge-only approaches?

1.1.10. Are parents and carers offered information and advice to enable them to support their children to stay safe from harm?

1.1.11. Is tobacco prevention work in schools evidence-based and linked to NICE PH23 and alcohol school-based interventions to NICE PH7?

1.1.12. Are national resources that provide information (FRANK) and build resilience (Rise Above) considered as part of the local approach to prevention?

1.1.13. Are the appropriate authorities working in partnership to prevent underage sales and proxy sales? Is action being taken against premises that regularly sell alcohol to people who are underage or making illegal purchases for others?[29]

1.1.14. Does the local authority undertake test purchases to ensure compliance with the law on underage sales for alcohol, tobacco and e-cigarettes?[30]

## 1.2 Targeted prevention

1.2.1. Are young people at increased risk of harm being targeted, with the aim of strengthening their resilience?

1.2.2. Are alcohol, drugs and tobacco prevention approaches aligned with other services serving the same 'at risk' groups (such as sexual and reproductive health services and services supporting young parents, eg, maternity services, family nurse partnerships, health visiting and children's centres)?

1.2.3. Have multi-component programmes been considered, involving a combination of schools and parenting interventions, with support for individuals and families? These may require joined up commissioning and planning locally and may be universal or targeted.

1.2.4. Does the JSNA include a section on the needs of vulnerable young people that reflects the links between substance misuse and a range of other risk factors, such as offending and sexual and reproductive health and the need for integrated commissioning?

1.2.5. Are commissioners in the public health team working with the NHS England local area team that is responsible for offender health commissioning, to agree a joint approach for substance misuse services in the young people's secure estate?

1.2.6. Are commissioners working with police and crime commissioners to discuss plans for investing in preventing substance-misuse related youth crime and commissioning early interventions that can prevent risk and harm from escalating?

1.2.7. Does the JSNA take into account the needs of young people who suffer from domestic abuse, sexual assault and sexual exploitation, who are more likely to be vulnerable to substance misuse? Does the JSNA look at this group by gender?[31]

1.2.8. Have additional funding streams been identified for early identification and interventions to provide targeted support for specific groups of young people deemed to be more at risk than others of developing substance misuse problems? This may be from the police and crime commissioners to support the targeted substance misuse interventions provided by the youth offending teams or from wider local authority funding.

1.2.9. Are hospital care pathways in place for young people presenting to A&E with alcohol-related problems including those jointly presenting with a mental health problem?

1.2.10. Do local clinical and safeguarding leads review and support the design and delivery of specialist substance misuse services?

1.2.11. Is there engagement with the local troubled families' team?

## Benefits of investing in prevention

School-based prevention interventions, including those delivered as part of the curriculum, derive cost-benefits for society. For example, interventions to tackle emotional learning save money in the first year by reducing costs for social services, the NHS and criminal justice system, and have recouped £50 for every £1 spent.[32]

## Further resources

### Schools

- mentor-adepis.org/
- PSHE Association
- Alcohol Education Trust resources for schools and parents
- Promoting children and young people's emotional health and wellbeing: a whole school and college approach (PHE 2015)
- Education Select Committee Inquiry into PSHE and SRE in schools: written evidence submitted by PHE
- School-based interventions to prevent smoking. NICE public health guidance 23.
- The link between pupil health and wellbeing and attainment: a briefing for head teachers, governors and staff in education settings (PHE 2014)

### Prevention

- mentor-adepis.org/
- EMCDDA best practice portal
- PHE document mapping UNODC international standards on drug use prevention to provision in England
- European drug prevention quality standards
- Interventions to reduce substance misuse among vulnerable young people: NICE public health guidance 4
- Young people's health and wellbeing framework (PHE 2015)
- A framework for supporting teenage mothers and young fathers, PHE 2016
- Against Violence and Abuse (AVA)
- Royal Society for Public Health Youth Health Movement

### Alcohol and tobacco

- Young people's hospital alcohol pathways (PHE 2014)
- Contributions of alcohol use to teenage pregnancy and sexually transmitted infections rates (NWPHO and LJMU, 2010)

- Preventing the uptake of smoking by children and young people. NICE public health guidance 14

## 2. A full range of specialist drug alcohol and tobacco interventions are available to young people in need

Specialist substance misuse interventions are individual packages of care-planned support, which can include medical, psychosocial or specialist harm-reduction interventions that build young people's resilience and reduce the harm caused by substance misuse.

Specialist substance misuse services help young people to stop using drugs and alcohol, to reduce the harm they cause themselves and others, to develop their resilience, and to manage the risks they face, ensuring that when they leave services they can sustain their progress. This might include giving support to parents and carers to help the young people with healthy decision making.

Girls face a number of specific issues, including increased risk of alcohol problems. A recent report[33] reinforces the understanding that responses to adversity, including abuse, tend to be differentiated by gender, with boys more likely to externalise problems (and to act out anger and distress through antisocial behaviour) and girls to internalise their responses in the form of depression and self-harming. Substance misuse services for young people may therefore need to consider these gender issues.

Young people's substance misuse services also need to have the knowledge to understand, identify and respond to child sexual exploitation and abuse, because of the links to the use of alcohol and drugs.

All frontline workers should ask young people if they smoke and advise that the most effective form of quitting is with a combination of behavioural support and stop smoking medications. If a young person expresses motivation to quit, he or she should be referred to the local stop smoking service. The period between expressed motivation to quit and access to the local stop smoking service should be minimal. These principles should apply even when the young person is also experiencing or presenting with other health issues, for example mental health problems. Nicotine replacement therapy is licensed for use for young people aged 12 and over.

## What questions should you ask to check that you are following the evidence and best practice that supports the principle?

### 2.1 Ensuring delivery of high-quality evidence-based interventions

2.1.1. Is the full range of evidence-based treatment available to young people in need?

2.1.2. Is there a quality governance framework in place that sets out expectations for:

- appropriate specialist interventions
- quality standards
- risk management
- staff competence
- case load management
- clinical supervision
- compliance with local safeguarding policies
- compliance with legal requirements, which require services to be child-centred and appropriate to the young person's age and maturity
- development of the young person, to take account of individual vulnerabilities

2.1.3.  Do young people receive a range of interventions that vary in intensity and duration according to changing needs? Does this reflect changes in their risk and resilience factors?

2.1.4.  Are the interventions in line with relevant NICE guidance (eg, PH4 Interventions to reduce substance misuse among vulnerable young people,[34] CG115 Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence)?[35]

2.1.5.  Are the interventions appropriate to the age and development of young people?

2.1.6.  Do services and commissioners regularly review the range and type of interventions available, who receives them, and which service is best placed to deliver them depending on risk and harm levels?

2.1.7.  Do young people with multiple vulnerabilities or a high risk of substance misuse-related harm get extra support? This includes young people affected by child sexual exploitation and abuse, parental substance misuse, experiencing domestic violence, early problematic misuse, class A users, looked-after children, those with a mental health problem, those not in education, employment or training, and those involved in crime.

2.1.8.  Are services tailored to the needs of vulnerable girls, for example, are girls offered the option of a female keyworker?

2.1.9.  Are services tailored to the needs of young people who identify as lesbian, gay, bisexual or transgender?

2.1.10. Are young people who smoke offered advice and referral to local stop smoking services by frontline workers?

2.1.11. Is there easy access to an evidence-based stop smoking service for everyone who smokes or uses tobacco in any other form?

2.1.12. Is the stop smoking service accessible for young people?

2.1.13. Do local agencies have a good understanding of young people's use of new psychoactive substances (NPS) in their area, and use this knowledge to develop local responses?

## 2.2 Psychosocial interventions

2.2.1. Do interventions include evidence-based psychological, psychotherapeutic or counselling-based techniques to help young people change their behaviour and lifestyles, and to improve their coping skills?

2.2.2. Do these also include evidence-based interventions such as motivational interventions, cognitive behavioural interventions, relapse prevention and structured family interventions?

2.2.3. Do appropriately competent staff deliver these interventions?

## 2.3 Harm-reduction

2.3.1. Are all needle and syringe programmes, including those provided in pharmacies, operating in line with NICE PH52 guidance on needle and syringe programmes and working to policies that have been agreed by the local safeguarding children's board?[36]

2.3.2. Do all young people receive age-appropriate advice and information on:
- the spread of blood-borne viruses
- sexual and reproductive health including local chlamydia screening, condom provision, early pregnancy testing and unbiased pregnancy options advice
- overdose
- health harms and reducing risky behaviour

2.3.3. Are care pathways in place for young people to access age-appropriate sexual health services and testing and treatment for blood-borne viruses?

2.3.4. Does harm reduction advice include new psychoactive substances (NPS)?

## 2.4 Pharmacological interventions

2.4.1. Do these include prescribing for detoxification, stabilisation and symptomatic relief of substance misuse as well as medication to prevent relapse?

2.4.2. Are pharmacological interventions delivered alongside and appropriately integrated with specific psychosocial interventions?

2.4.3. Are pharmacological interventions delivered in an age-appropriate manner and in the context of a clear clinical governance framework which sets out how prescribing should happen?

2.4.4. Are age-appropriate pharmacological interventions provided in line with the Department of Health's 'Guidance for the pharmacological management of substance misuse among young people' and 'Guidance for the pharmacological management of substance misuse among young people in secure environments'?

2.4.5. Are mechanisms in place to support the parent or carer's involvement in the assessment, care planning and delivery of clinical interventions as appropriate?

## 2.5 High-intensity support for the most vulnerable young people

2.5.1. Do vulnerable young people with complex needs receive multi-agency care packages?

2.5.2. Do these packages include substance misuse treatment and detoxification, along with support for housing (potentially via short term fostering arrangements) and education, if appropriate?

2.5.3. Is multi-agency funding available through complex care panel arrangements? Is this underpinned by funding protocols for young people requiring high-intensity multiagency provision?

2.5.4. Do complex care systems support the needs of 16 and 17-year olds whose substance misuse has become problematic?

2.5.5. Are joint working protocols with child and adolescent mental health services (CAMHS) in place, and do they include meeting the needs of young people with complex needs?

2.5.6. To help young people maintain links with their families and other sources of support, do professionals consider local solutions for complex cases before looking for non-local residential placements?

2.5.7. Are there arrangements to provide residential interventions away from home for the few young people it is appropriate for, such as fostering arrangements, secure units or child and adolescent mental health inpatient units?

2.5.8. Do commissioners promote a joined-up response across children's services using care and referral pathways for children who have been sexually exploited?

2.5.9. Are professionals supported and competent to identify and respond appropriately to victims of child sexual exploitation?[37]

2.5.10. Is targeted protective work undertaken with young people who are known to have significant or multiple vulnerabilities that would heighten their risk of sexual exploitation?

2.5.11. Are workers trained and supported to identify and undertake risk assessments for pregnant young women, teenage mothers and young fathers who are accessing alcohol and drug use services?[38]

## 2.6 Access and engagement

2.6.1.    Are services utilising You're Welcome standards, which provide a clear framework for ensuring services locally meet the needs of young people and improves access, particularly with vulnerable and at risk groups?[39]

2.6.2.    Are young people's specialist substance misuse services open at accessible times, in appropriate settings and locations?

2.6.3.    Do services assertively engage with young people who miss appointments or stop attending?

2.6.4.    Does the service evaluate why young people engage or fail to engage, and does it respond to the findings by adapting services?

2.6.5.    Do services enhance their response to young people who are returning for treatment and whose needs have increased?

2.6.6.    Do services ensure young people are not retained in specialist interventions any longer than necessary?

2.6.7.    Do services make appropriate use of technology (eg, texting, social media) to engage, maintain contact and follow-up young people?

## 2.7    Young people's secure estate

2.7.1.    Are there arrangements to support continuity of care for those entering, transferring within or leaving the young people's secure estate? Do they include a referral to a specialist service nearest the young person's home and a pre-release contact with a professional to encourage the young person to engage with the service after release?

2.7.2.    Is this underpinned by a formal agreement that sets out the roles and responsibilities of each agency and clarifies who is responsible for coordinating care?

2.7.3.    Are arrangements in place to monitor NDTMS reporting across the secure estate to track outcome improvements in continuing care?

## The benefits of specialist substance misuse interventions

Specialist interventions for young people's substance misuse are effective and provide value for money. A Department for Education cost-benefit analysis found that every £1 invested saved £1.93 within two years and up to £8.38 long term.[40] Specialist services quickly engage young people, the majority of whom leave in a planned way and do not return to treatment services.

### 3. Commissioning is integrated across prevention and specialist interventions and the wider children's agenda

### What questions should you ask to check that you are following the evidence and best practice?

### 3.1    Integrated commissioning

3.1.1.    Has local provision been assessed and set out in terms of universal, targeted and specialist approaches?

3.1.2.    Is there a focus locally on the life course, including early interventions; particularly generic pre-school programmes that focus on improving literacy and numeracy and that have a long-term effect of strengthening resilience in young people?

3.1.3.    Has a protocol with children's services been agreed by the local safeguarding children's board (LSCB) that covers identifying and responding to safeguarding concerns related to young people's substance misuse?

3.1.4.    Are policies and protocols in place that cover information sharing with parents and carers and with other agencies, including children's services?

3.1.5.    Do local clinical and safeguarding leads review and support the design and delivery of specialist substance misuse services?

3.1.6.    Is substance misuse addressed across the wider children's agenda: at the LSCB, youth offending team (YOT) management boards, at serious case reviews, within child and adolescent mental health services and across children's services more widely?

3.1.7.    Are existing local networks used for finding and sharing information with partners about new psychoactive substances?

### 3.2    Transition to other services

3.2.1.    Is a transition policy in place that sets out roles and responsibilities between different services? Does it set out expected outcomes and standards for effective transfers?

3.2.2.    To ensure an effective handover and continuity of care, are there reviews involving the current service, the young person and the service he or she is moving to (adult or other young people's service)?

3.2.3.    Are young people who have reached the upper age limit of the service, but don't need to move to adult services, informed how to access adult services later if they need to?

3.2.4.    Do universal and targeted services support young people discharged from substance misuse specialist services in order to address their wider health and social needs?

3.2.5. Do children's social care services assess young people before they turn 18 if there is significant benefit in doing so, and if it is likely those young people will need adult care and support after turning 18?[41]

## Further resources

### Specialist substance misuse interventions in the community

- Young people's specialist substance misuse treatment: exploring the evidence (NTA 2009)
- Quality criteria for young people friendly health services (Department of Health, 2011)
- Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence: NICE clinical guidelines 115 (NICE, 2011)
- Practice standards for young people with substance misuse problems (CCQI, 2012)
- Needle and syringe programme: NICE public health guidance 52 (NICE, 2014)
- Quality Network for Community CAMHS

### Interventions in youth justice settings

- When to share information: best practice guidance for everyone working in the youth justice system (DH, 2008)
- Guidance for the pharmacological management of substance misuse among young people in secure environments (Department of Health, 2009)
- Healthcare standards for children and young people in secure settings (Royal College of Paediatrics and Child Health, 2013)

### Safeguarding, domestic violence and child sexual exploitation & abuse

- Supporting information for the development of joint local protocols between drug and alcohol partnerships, children and family services (NTA, 2011)
- Working together to safeguard children (HM Government, 2013)
- NICE PH50 Domestic violence and abuse: how health services, social care and the organisations they work with can respond effectively
- University of Bedfordshire publications on responding to child sexual exploitation

### Tobacco and sexual health

- Brief interventions and referral for smoking cessation: NICE public health guidance 1 (NICE, 2006)
- Smoking cessation services: NICE public health guidance 10 (NICE, 2008)
- Tobacco harm reduction: NICE public health guidance 45 (NICE, 2013)
- Smoking cessation – acute, maternity and mental health services: NICE public health guidance 48 (NICE, 2013)
- PHE Making it work: A guide to whole system commissioning for sexual health, reproductive health and HIV (2014)

## 4. A skilled workforce is in place to provide effective interventions

The Department for Education's common core skills[42] describes the skills and knowledge that everyone who works with children and young people is expected to have. The six areas offer a single framework to support multi-agency and integrated working, professional standards, training and qualifications across the children and young people's workforce. These are:

- effective communication and engagement with children, young people and families
- child and young person development
- safeguarding and promoting the welfare of the child or young person
- supporting transitions
- multi-agency and integrated working
- information sharing

The therapeutic relationship young people have with their keyworkers is vital. Positive outcomes depend on a positive and trusting relationship between them. Research suggests that young people's feelings about the quality of their relationships with key adults and peer mentors contribute significantly to their wellbeing and positive outcomes.

Staff who delivers specialist interventions such as motivational interviewing, cognitive behavioural therapy (CBT) and multi-systemic therapy need to be appropriately qualified and competent.

### What questions should you ask to check you are following the evidence and best practice?

4.1. Are young people's substance misuse services commissioned to ensure that all staff has the core skills and knowledge necessary for working with children and young people?

4.2. Are staff appropriately trained in routinely identifying child sexual exploitation and abuse, and in ensuring that young people have access to appropriate services?

4.3. Are staff appropriately trained to support young people around poor sexual health and unplanned pregnancy?

4.4. Are staff qualified and competent to deliver the interventions they provide?

4.5. Are these skills regularly assessed and updated?

4.6. Are staff skilled in building therapeutic alliances with young people?

4.7. Are commissioning mechanisms in place to ensure services are delivered by a competent workforce?

4.8. Are these in line with national occupational standards and relevant professional standards?

4.9. Are mechanisms in place to encourage a culture of learning via peer reviews, team meetings, appraisals and supervision?

4.10. Are workers in children and family services competent to screen young people for substance misuse and refer as appropriate to specialist substance misuse care?

4.11. Are there reciprocal arrangements, such as joint working protocols, mentoring arrangements, attachments and secondments, to enable children and family workers and specialist substance misuse staff to support each other in screening and referring young people, and in responding to their wider health and social care needs?

4.12. Are staff who deliver specialist interventions able to access regular clinical supervision with appropriately qualified clinicians?

4.13. Are frontline workers in schools and youth settings trained to discuss drugs, alcohol and smoking with young people?

## Further resources

- The Royal College of Paediatrics and Child Health e-learning tools for the substance misuse workforce
- Skills for Health national children and young people's occupational standards for the CAMHS and young people's substance misuse workforce 2015
- The alcohol and drugs competency assessment framework (ADCAF) is a tool for individuals, managers and commissioners to access information on how to assess and enhance competence in the field of substance misuse
- Brook and the Department of Health, Combating child sexual exploitation: an e-Learning resource for health professionals
- Barnardo's Spot the Signs for Professionals resource on child sexual exploitation

## ANNEX A. Data sources on young people's drinking, drug use and smoking for use in needs assessments and strategic commissioning

1. Child and Maternal Health Intelligence Network (ChiMat) is part of PHE and provides a wide-range of authoritative data, evidence and practice related to children's, young people and maternal health.
2. NDTMS data including the JSNA data support pack.
3. 'Smoking, drinking and drug use among young people in England 2014' survey
4. What about YOUth survey 2014 was a one off survey designed to collect robust local authority level data on a range of health behaviours amongst 15 year-olds, including whether they smoke, drink alcohol or have taken drugs. Other topics include general health, diet, use of free time, physical activity, emotional wellbeing, and bullying. Data is available from the Health and Social Care Information Centre.
5. 'Drug misuse: findings from the 2015/16 Crime Survey for England and Wales' shows that younger people are more likely to take drugs than older people. The level of any drug use in the last year was highest among 16 to 19 year olds (17.8%) and 20 to 24 year olds (18.2%). The level of drug use was much lower in the oldest age group (2.2% of 55 to 59 year olds).
6. 'Health behaviour of school aged children' survey is a collaboration with the WHO Regional Office for Europe and is conducted every four years in 43 countries and regions across Europe and North America, gaining insight into young people's well-being, health behaviours and their social context.
7. The Schools and Student Health Education Unit is based at Exeter University and provides lifestyle surveys and research reports for those working with young people.

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[1] Young people's statistics from the National Drug Treatment Monitoring System (NDTMS): 1 April 2014 to 31 March 2015 (PHE, 2015)
[2] Exposure to parental and sibling smoking and the risk of smoking uptake in childhood and adolescence: a systematic review and meta-analysis, Jo Leonardi-Bee, Mirriam Lisa Jere, John Britton, Thorax 2011
[3] Preventing Smoking in Young People: A Systematic Review of the Impact of Access Interventions, Lindsay Richardson, Natalie Hemsing, Lorraine Greaves, Sunaina Assanand, Patrice Allen, Lucy McCullough, Linda Bauld, Karin Humphries, Amanda Amos, International Journal of Environmental Research and Public Health 2009
[4] The Psychoactive Substances Act 2016, introduced on 26 May 2016 has made new psychoactive substances illegal
[5] Smoking, Drinking and Drug Use Among Young People in England, Health and Social Care Information Centre, 2014
[6] A framework for supporting teenage mothers and young fathers (PHE & LGA 2015)
[7] What About YOUth 2014 survey
[8] Child uptake of smoking by area across the UK (Thorax 2013)

[9] Hibell B, Guttormson U, Ahlstrom S, et al (2012) The 2011 ESPAD report: substance use among students in 36 European countries

[10] Smoking, Drinking and Drug Use Among Young People in England, Health and Social Care Information Centre, 2014

[11] Smoking in England: Providing the latest information on smoking and smoking cessation in England

[12] E-cigarettes: an evidence update (PHE, 2015)

[13] Key Data on Adolescence 2015 (AYPH, 2015)

[14] National Child and Maternal Health Intelligence Network (ChiMat)

[15] Children and Young People's Health Benchmarking Tool

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