



# **Young Person's Substance Misuse Needs Assessment**

**November 2009**

**Version 1.1**

**Kent Drug and Alcohol Action Team  
Young Persons Substance Misuse Needs Assessment  
November 2009**

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**Version History:**

<b>Version Number</b>	<b>Date</b>
1.0	30 November 2009
1.1	8 February 2010

## Table of Contents

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<b>1. Introduction .....</b>	<b>4</b>
<b>2. Patterns of substance misuse by young people .....</b>	<b>5</b>
2.1. TellUs Survey .....	5
2.2. Children and Young People of Kent Survey.....	8
2.3. Consultation with young people and their parents and carers: .....	12
2.4. Alcohol Specific Hospital Admissions .....	12
2.5. National Trends .....	14
2.5.1. <i>National 11-15 year old pupil survey:</i> .....	14
2.5.2. <i>British Crime Survey</i> .....	15
<b>3. Evidence Summary for Young People’s Needs Assessment.....</b>	<b>18</b>
3.1. Tackling Alcohol Misuse in Teenagers:.....	18
3.2. Review of Evidence on Reducing Risk Taking Behaviours:.....	19
3.3. Recreational Settings.....	20
3.4. Drawing together the evidence on prevention.....	21
<b>4. Vulnerable Groups .....</b>	<b>22</b>
4.1. Prevalence Model .....	22
4.2. Consultation with young people regarding risk taking behaviour .....	28
4.3. Vulnerabilities .....	28
4.4. Substance Misusing Parents .....	30
4.5. Young Offenders.....	31
<b>5. Specialist Treatment .....</b>	<b>33</b>
5.1. Client Profile .....	33
5.2. Substances .....	36
5.3. Age of First use of Primary substance (at triage):.....	37
5.4. Feedback from young people in Specialist Community Treatment: .....	40
5.5. Treatment Journeys.....	40
5.6. Retention and transition .....	43
<b>6. Communities .....</b>	<b>45</b>
<b>7. Recommendations .....</b>	<b>48</b>

## 1. Introduction

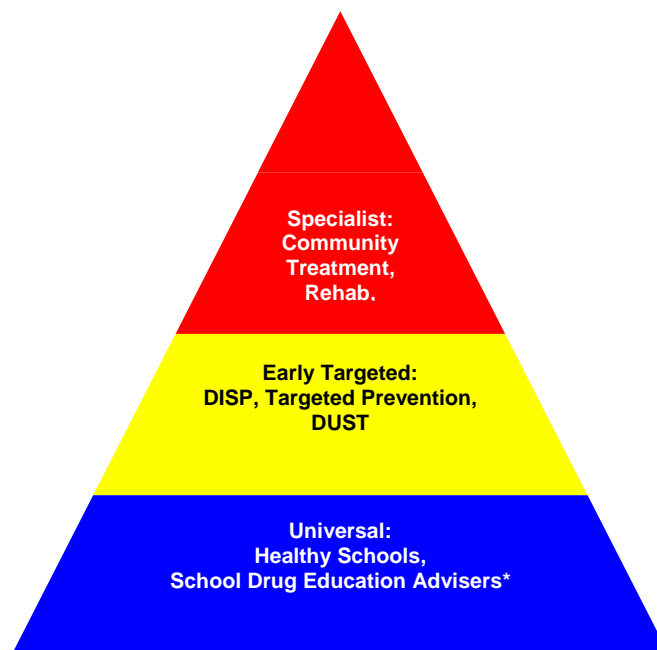
This needs assessment is a refresh of the needs assessment conducted by KDAAT Young People's Service in 08-09. KDAAT Young People's Service is required by the National Treatment Agency to provide a needs assessment each year with a comprehensive needs assessment undertaken every 3 years.

This needs assessment compliments and informs the Children and Young People's Needs Assessment for Kent and the Joint Strategic Needs Assessment for Children in Kent. Reference is made to Hidden Harm within this document, however this issue is specifically referred to in a Hidden Harm Needs Assessment.

The focus of this needs assessment is specialist community treatment, ensuring that it the commissioning of specialist treatment is fit for purpose, that young people have access to specialist community treatment, that it is effective in treating young people and that young people are appropriately discharged to targeted youth support or are successful in their transition to adult services. This needs assessment is not required to question the model of specialist community treatment based as it is on clear definitions provided the National Treatment Agency<sup>1</sup> and standards outlined in Essential Elements.

This needs assessment has presented a range of evidence in relation to the prevention of alcohol misuse. Prevention both intervenes to reduce the harms of substance misuse and therefore reduce the future pressure on specialist treatment and conversely is able to identify and refer the smaller number of young people who are problematically using and will benefit from specialist community treatment.

### **A systems approach to the provision of young people drug and alcohol use:**



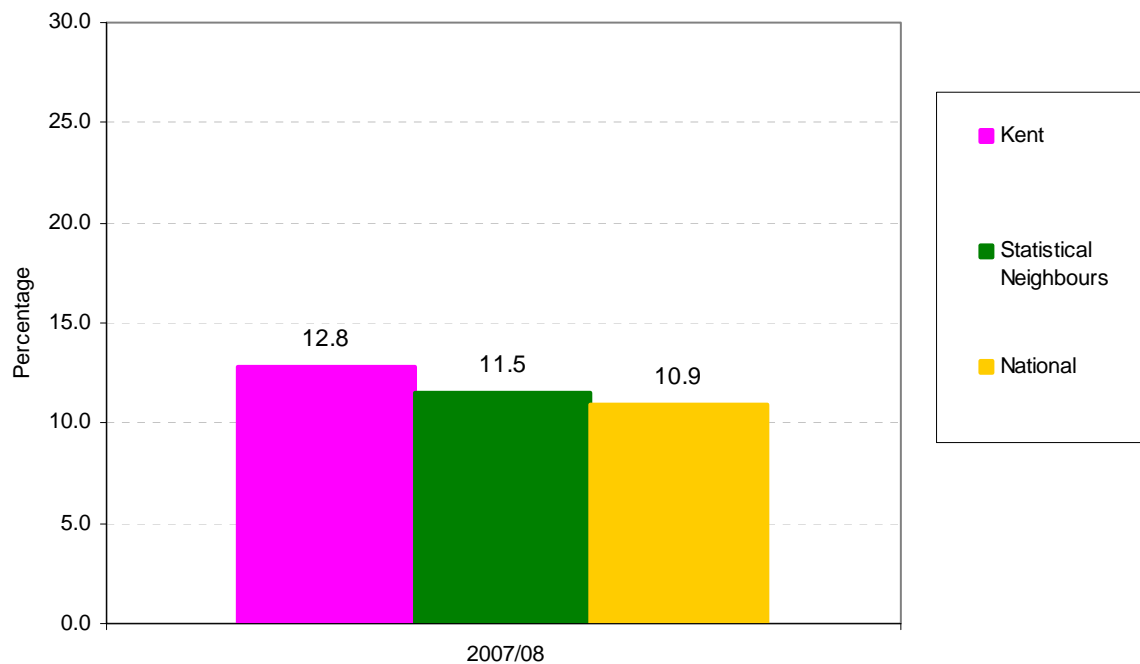
<sup>1</sup> See NTA ( 2009) ' Exploring the Evidence' insert websi \* funded by KCC

## 2. Patterns of substance misuse by young people

### 2.1. TellUs Survey

Ofsted's national *TellUs 3* survey was undertaken with children in Years 6, 8 and 10 and was weighted in relation to gender, age, proportion of children eligible for free school meals and type of school. The TellUs survey is used to calculate the national indicator that is used as the main performance indicator for young people's substance misuse services (NI 115). The TellUs3 survey gave an overall score of 12.8% for Kent which was higher than the national level (10.9%) and Kent's statistical neighbours (11.5%).

Figure 1: NI 115 Substance misuse by young people



Source: Ofsted, *Tellus3 Survey, Spring 2008*

Base: All respondents - Kent (1,168)

Using weighted scores, the survey revealed that:

- **12%** have been drunk at least twice in last 4 weeks
- **4.8%** have taken cannabis, volatile substances or other drugs at least twice in last 4 weeks

This shows that by far the majority of those qualifying against the NI 115 measure do so because of alcohol consumption rather than drug use. Only 0.7% qualify for the NI 115 measure due to drug use alone. This indicates that those who do take drugs tend to drink alcohol as well.

The tables below show the survey results for the various substance misuse related questions in the TellUs 3 survey:

Table 1: Ofsted's *TellUs3*<sup>2</sup> Survey Results on Drug Use

<b>Which of these drugs, if any, have you taken in the last four weeks?</b>	<b>Kent (%)</b>	<b>National (%)</b>
I have never taken any drugs	81	86
Prefer not to say	5	4
I haven't taken any Cannabis in the last four weeks	86	89
Prefer not to say	6	4
I haven't taken any Solvents in the last four weeks	89	92
Prefer not to say	5	4
I haven't taken any Other drugs (Cocaine, LSD, Ecstasy, Heroin, speed, magic mushrooms etc) in the last four weeks	92	92
Prefer not to say	5	4

Table 2: The Ofsted *Tellus3* Survey, reporting the number of times pupils are drunk each week:

<b>Have you ever had alcohol?</b>	<b>Kent (%)</b>	<b>National (%)</b>
I have never drunk an alcoholic drink	19	25
I have never been drunk	36	35
I have been drunk but only once or twice and not recently	18	17
I have been drunk once within the last four weeks	7	6
I have been drunk twice within the last four weeks	5	4
I have been drunk three or more times in the last four weeks	8	6
I prefer not to say	8	8

It is important to note that only Years 8 and 10 were asked questions about drugs – the analysis has been conducted assuming that Year 6 pupils DO NOT take drugs (i.e. they are included in the analysis as non-drug takers).

Changes in the questions asked in the TellUs2 and TellUs3 surveys mean that it is difficult to carry out a meaningful analysis of trends in substance misuse over time. However, comparison of the two surveys does indicate that levels of drug use and drinking are similar:

- % who have never taken drugs 82% in TellUs2 and 81% in TellUs3
- % drunk at least once in last 4 weeks 19% in both TellUs2 and TellUs3

<sup>2</sup>

[http://www.ofsted.gov.uk/reports/pdf/?inspectionNumber=3008&providerCategoryID=0&fileName=\\TELLUS\\tellus\\_2008\\_886.pdf](http://www.ofsted.gov.uk/reports/pdf/?inspectionNumber=3008&providerCategoryID=0&fileName=\\TELLUS\\tellus_2008_886.pdf)

Analysis of the TellUs3 survey results for Kent show that children and young people with the following characteristics are more likely to drink and/or take drugs:

**Demographics**

- Older pupils (NI115 is just 2.3% for Year 6, 6.8% for Year 8 but as high as 24.9% for Year 10).

**Health**

- Those who feel that they are ‘not very healthy’
- Those reporting not eating fruit/vegetables
- Those reporting lower levels of exercise (for drinking)

**Emotional health**

- Those without one or more good friends (very large difference)
- Those who can’t talk to their mum/dad when worried (smaller difference)
- Those who don’t feel happy about their life at the moment

**Outlook**

- Those who ‘never’ enjoy school
- Those not indicating an intention to go on to university

**Environment**

- Those with negative views about the availability of things to do in their local area
- Those who feel that their local area is ‘very poor’ as a place to live

There are no major differences by:

- Gender
- Whether or not they experience bullying
- Whether or not they have given their views about their local area

Apparent differences by participation in ‘positive activities’ can be explained by the differences by age (i.e. they are not present when looking at Year 10’s only).

Table 3 below shows the TellUs3 survey results on Healthy Living

Table 3: Ofsted’s TellUs3 Survey Results on Healthy Living

<b>Do you think of the information and advice you get on the following things is good?</b>	<b>Kent (%)</b>	<b>National (%)</b>
Eating healthy food	76	76
Alcohol	65	67
Smoking	70	70
Drugs	66	67
Sex and relationships	52	55

## 2.2. Children and Young People of Kent Survey

In addition to the national TellUs survey, Kent County Council also undertakes its own annual Children and Young People of Kent survey. This survey included questions about drinking behaviour for pupils aged between 11 and 19 and the results showed that:

- **8.8%** of 11-19s smoke at least once a week
- **16.8%** drink alcohol at least once a week
- **8.9%** get drunk at least once a week

Comparing the 2007 and 2008 studies, it appears that:

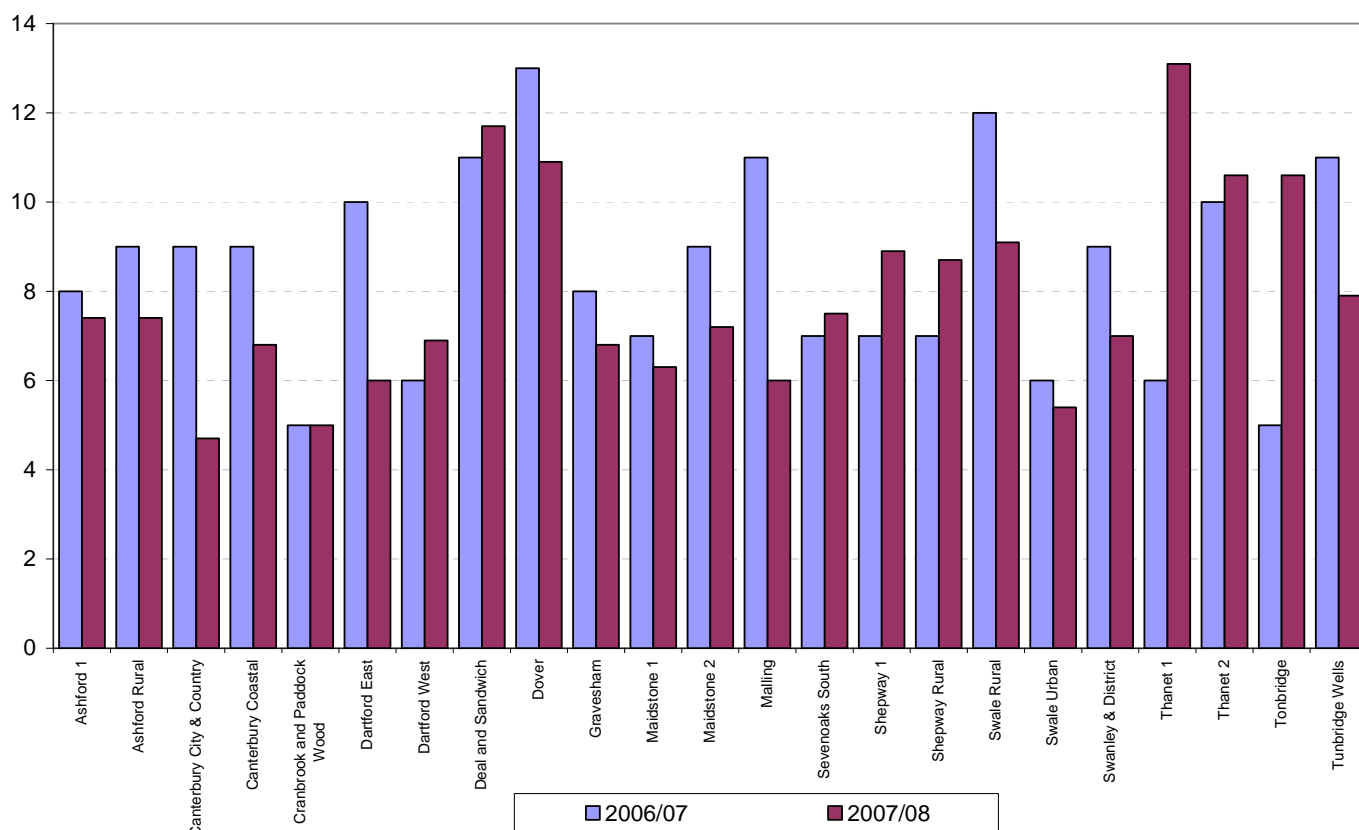
- Levels of smoking are similar (9.2% smoked at least once a week in 2007)
- Levels of drinking have decreased (17.9% drank at least once a week in 2007)
- Those drinking 'most days' has also decreased to 3.6% in 2008 from 4.4% in 2007
- Levels of Children and Young People 'getting drunk' are relatively similar.

The survey also revealed did show variation amongst the Local Children Services Partnership areas in the proportion of children and young getting drunk regularly.

Table 4: Percentage of young people getting drunk at least once or twice a week (Children and Young People of Kent Survey)

<b>LCSP</b>	<b>2006/07</b>	<b>2007/08</b>
Ashford 1	8.0	7.4
Ashford Rural	9.0	7.4
Canterbury City & Country	9.0	4.7
Canterbury Coastal	9.0	6.8
Cranbrook and Paddock Wood	5.0	5.0
Dartford East	10.0	6.0
Dartford West	6.0	6.9
Deal and Sandwich	11.0	11.7
Dover	13.0	10.9
Gravesham	8.0	6.8
Maidstone 1	7.0	6.3
Maidstone 2	9.0	7.2
Malling	11.0	6.0
Sevenoaks South	7.0	7.5
Shepway 1	7.0	8.9
Shepway Rural	7.0	8.7
Swale Rural	12.0	9.1
Swale Urban	6.0	5.4
Swanley & District	9.0	7.0
Thanet 1	6.0	13.1
Thanet 2	10.0	10.6
Tonbridge	5.0	10.6
Tunbridge Wells	11.0	7.9
<b>Kent (School based)</b>	<b>10.0</b>	<b>8.9</b>

Figure 2: Percentage of young people getting drunk at least once or twice a week (Children and Young People of Kent Survey)



The 2008 survey also found that the following groups are more likely drink and/or get drunk:

### ***Demographics***

- Older pupils (drinking and getting drunk rises steeply with age)
- Those receiving free school meals and those with special educational needs slightly more likely to get drunk frequently

### ***Health***

- Those reporting not eating fruit/vegetables
- Those reporting lower levels of exercise
- Those eating takeaways frequently

### ***Emotional health***

- Those who don't have an adult at home (and to a lesser extent an adult at school/college) that they can talk to
- Those who report not enjoying their life
- Those who report not feeling positive (particularly those strongly disagreeing)
- Those who feel sad or depressed most days
- Those who feel that they can't make a difference to their own life

### ***Outlook***

- Those who think that 'qualifications are a waste of time'
- Those who agree that it is 'OK to miss school/college if I feel like it'
- Those who feel that they are not doing very well at school

### ***Environment***

- Those who feel that their local area is 'not a good place to live'

There are no major differences by:

- Gender (although boys very slightly more likely to drink frequently, girls and boys equally likely to get drunk at least once a week)
- Whether or not they experience bullying (apparent difference at overall level due to difference in incidence of bullying by age)

Pupils with the following characteristics were more likely to smoke:

### ***Demographics***

- Older pupils (smoking rises steeply to Year 10 and then remains fairly stable from Year 11 onwards)
- Girls more likely to smoke
- Those receiving free school meals, those with special educational needs and looked after children are more likely to smoke

### ***Health***

- Those reporting not eating fruit/vegetables
- Those reporting lower levels of exercise
- Those eating takeaways frequently

### ***Emotional health***

- Those who don't have an adult at home (and to a lesser extent an adult at school/college) that they can talk to
- Those who report not enjoying their life
- Those who report not feeling positive (particularly those strongly disagreeing)
- Those who feel sad or depressed most days
- Those who feel that they can't make a difference to their own life

### ***Outlook***

- Those who think that 'qualifications are a waste of time'
- Those who agree that it is 'OK to miss school/college if I feel like it'
- Those who feel that they are not doing very well at school

### ***Environment***

- Those who feel that their local area is 'not a good place to live'

There are no major differences by whether or not they experience bullying

The survey also asked whether young people understand the dangers of smoking and drinking. The results showed that:

- The vast majority of 11-19s agree that 'getting drunk can be dangerous' (strong agreement highest amongst Years 7 and 8).
- More than 90% of 11-19s agree that 'smoking causes health problems' (Strongly agreement highest amongst Years 7 and 8)

It also asked whether young people feel that they are getting enough information on smoking, alcohol and drugs. The results showed that:

- Around three-quarters of 11-19s indicated that they felt that they did get enough information on smoking, and a similar proportion on alcohol/drugs.
- Opinions were similar across the age groups

Kent County Council conducted a mosaic analysis of the 2007 Children and Young People of Kent survey and found that young people from less affluent socio-economic groups are more likely to get drunk regularly and those from more affluent groups are slightly more likely to never get drunk. Exceptions to this rule were the Twilight Subsistence and Rural Isolation groups<sup>3</sup>. The report highlights clear social differences in drinking behaviour among different age groups. It found that "the more affluent Mosaic groups contribute a much larger proportion to the post 16 profile than to the pre 16s and the reverse is true for the less affluent groups. This suggests young people from more affluent backgrounds start getting drunk at an older age than those from a less affluent background."<sup>4</sup>

Qualitative research conducted with young people living in Kent found that:

"...those who smoke or drink, described their behaviour as unhealthy because they are *told* it is unhealthy, rather than necessarily *seeing* the bad effects for themselves. There was a feeling that it was only as they grew older (i.e. fifteen plus) that they gain the maturity to understand the negative implications of smoking, which was already too late for those who'd taken it up when they were too young to know any better.

Those who had been smoking and drinking regularly from an early age were beginning to connect their lifestyle with the way they *feel* rather than just the way they *look* (although this was heightened by visual signs as well). Some as young as sixteen expressed a strong willingness to quit smoking, but feared that it was already too late for them."

Source: Evaluating the Every Child Matters Outcomes, Qualitative research conducted with young people living in Kent  
Ipsos MORI

<sup>3</sup> Alcohol Use amongst young people in Kent – A Mosaic analysis, January 2009, KCC

<sup>4</sup> Ibid.

### 2.3. Consultation with young people and their parents and carers:

A focus group was undertaken with children and young people and their parent in order to identify ways in which they thought substance misuse amongst young people could be reduced. The feedback is provided below:

- Focus on information giving to parents and children in schools as part of PHSE and parents meetings – parent/carer involvement is key
- Shocking images, drug users telling their stories, sniffer dogs,
- Opportunities for dialogue and interaction ( integral part of PHSE and the whole school approach)
- Recognised that information we provide for young people regarding alcohol in particular is conflicting – moving from notion of sensible drinking CMO recommendation: Consistent messages are important
- Young people and parents report the links between drug and alcohol use and access to positive activities as well as under 18 club nights
- Recognise young people’s use of alcohol ( in particular but drugs for some) is linked with parents use, and parental use sets the culture for young people’s use and can also impact on parenting

### 2.4. Alcohol Specific Hospital Admissions

Hospital Episode Statistics for 2005/06, 2006/07 and 2007/08 show that rates of alcohol specific hospital admissions for under 18s vary between the twelve districts in Kent. Table 5 below outlines the alcohol specific hospital admissions aggregated over the three years. Thanet had the highest number of hospital admissions with 89 over the three year period and the highest rates per 100,000 of the under 18 population (104.3).

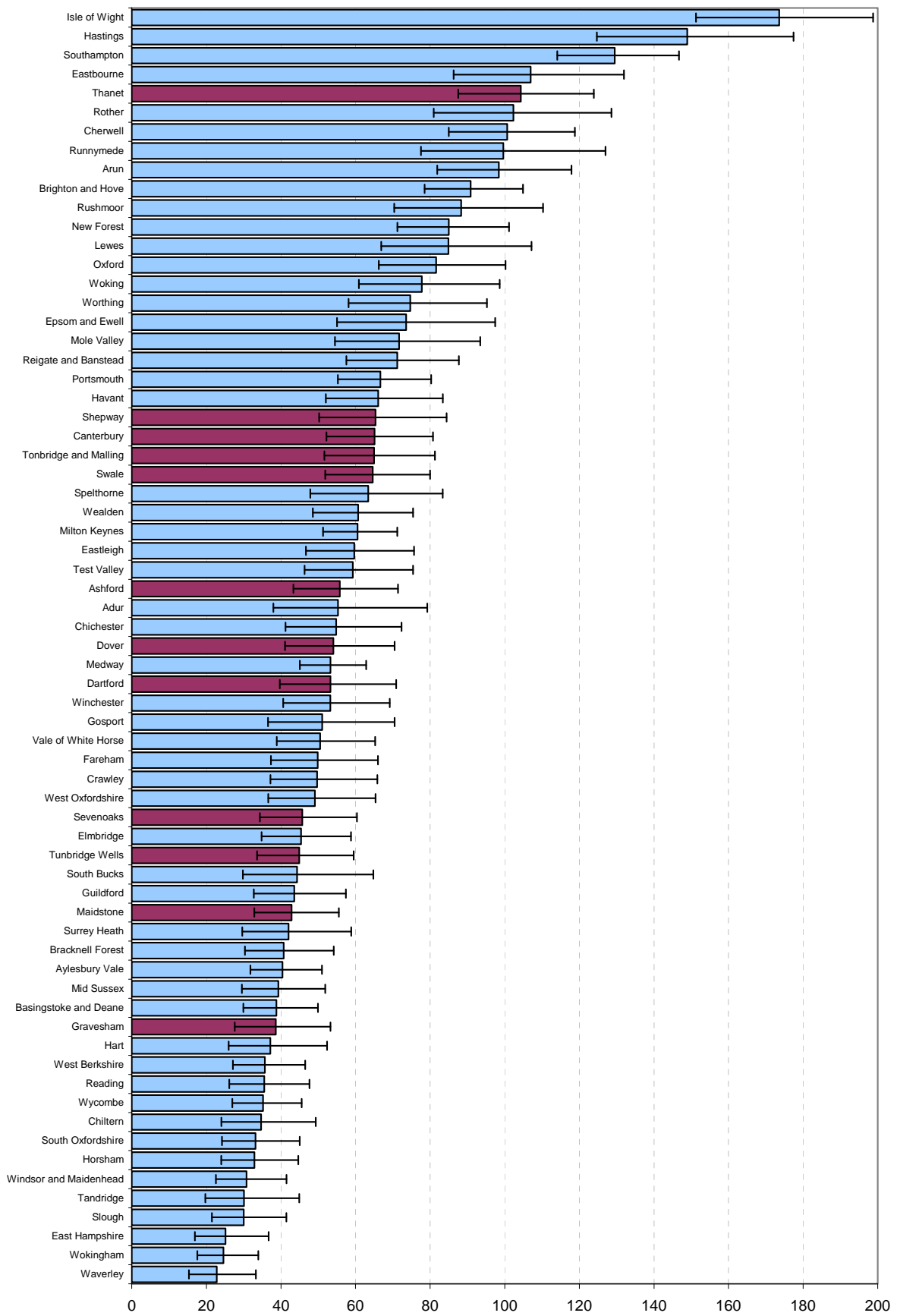
It should be noted that these figures refer only to those young people who are actually admitted to hospital: some young people may be treated in A&E or outpatient clinics and then discharged, and would therefore not appear in these figures.

Table 5: Alcohol Specific Hospital Admissions (Under 18s) for 2005/09 to 2007/08

Local authority	Measure	Rank (national)	Number	Lower Confidence Limit	Upper Confidence Limit	Average admissions per year
Thanet	104.30	273	89	87.57	123.86	29.7
Shepway	65.36	181	41	50.27	84.38	13.7
Canterbury	65.08	180	57	52.19	80.75	19.0
Tonbridge and Malling	64.97	179	53	51.66	81.29	17.7
Swale	64.58	175	58	51.90	79.98	19.3
Ashford	55.82	145	44	43.34	71.41	14.7
Dover	54.04	133	38	41.11	70.48	12.7
Dartford	53.29	128	33	39.68	70.89	11.0
Sevenoaks	45.75	101	35	34.38	60.35	11.7
Tunbridge Wells	44.91	96	34	33.60	59.49	11.3
Maidstone	42.86	86	40	32.85	55.51	13.3
Gravesham	38.60	66	26	27.61	53.29	8.7

Figure 3 below sets these district level figures against the other local authorities in the South East region.

Figure 3: Alcohol Specific Hospital Admissions (Under 18s) for 2005/09 to 2007/08 by Local Authority

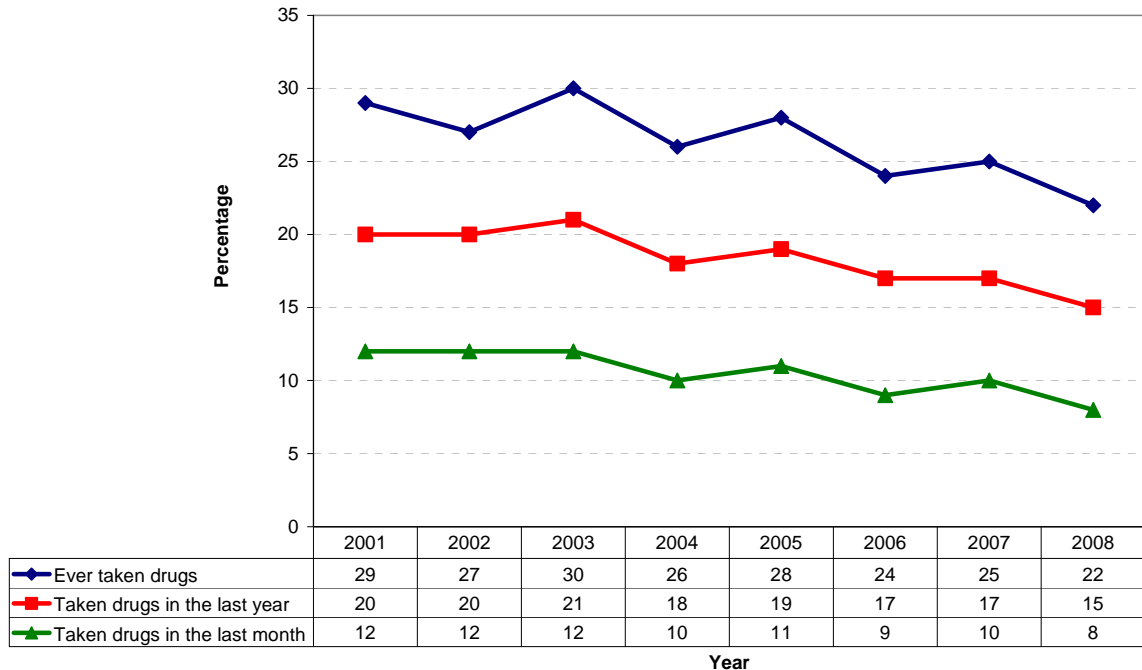


## 2.5. National Trends

### 2.5.1. National 11-15 year old pupil survey<sup>5</sup>:

The 11-15 year old pupil survey reported a fall in drug use on all three measures in 2008 compared to 2007. This is in line with the general downward trend since 2001.

Figure 4: Graph of the proportion of pupils reporting using illicit drugs in the past month, last year and ever, 2001 to 2007.

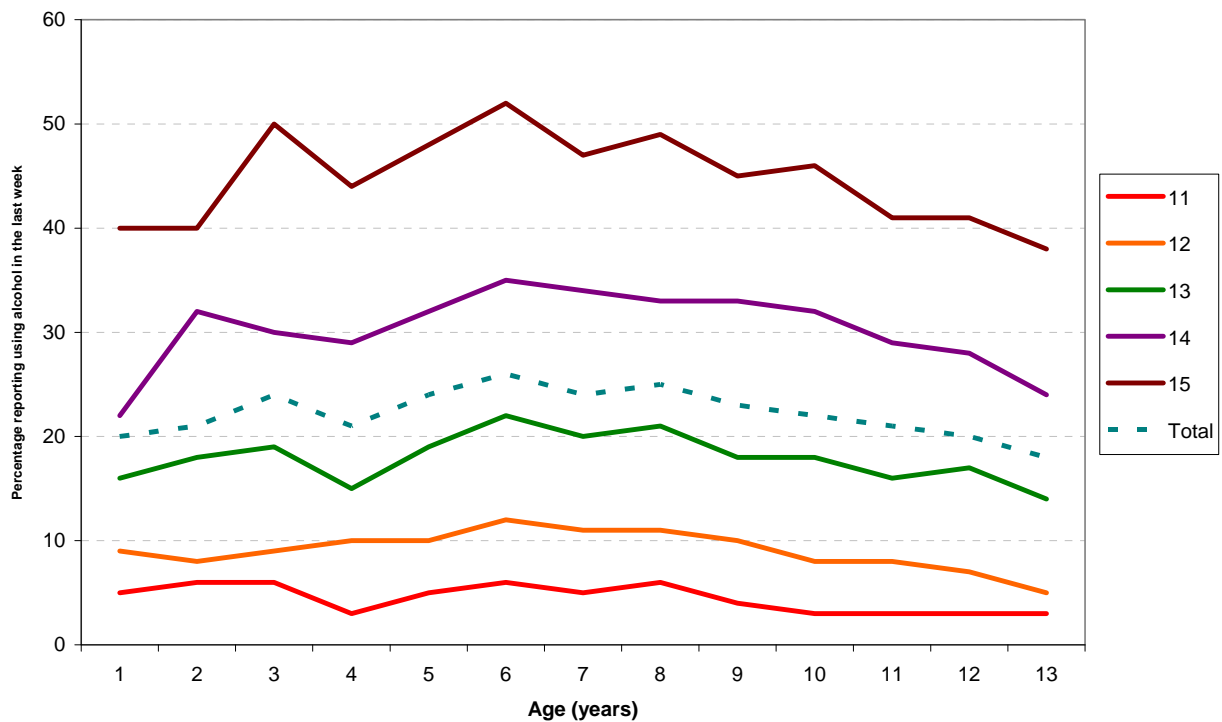


Source: *Drug Use, Smoking and Drinking among Young People in England 2007*. The NHS Information Centre.

The survey also found that between 2007 and 2008, levels of use of most individual drugs remained at similar levels apart from falls in the prevalence of sniffing volatile substances and poppers. The survey also found a slight reduction in the proportion of young people who reported consuming alcohol within the past week. Figure 5 provides an age breakdown of these figures.

<sup>5</sup> Smoking, drinking and drug use among young people in England in 2008, NHS Information Centre, [http://www.ic.nhs.uk/webfiles/publications/sdd08fullreport/SDD\\_England\\_2008\\_full\\_report.pdf](http://www.ic.nhs.uk/webfiles/publications/sdd08fullreport/SDD_England_2008_full_report.pdf)

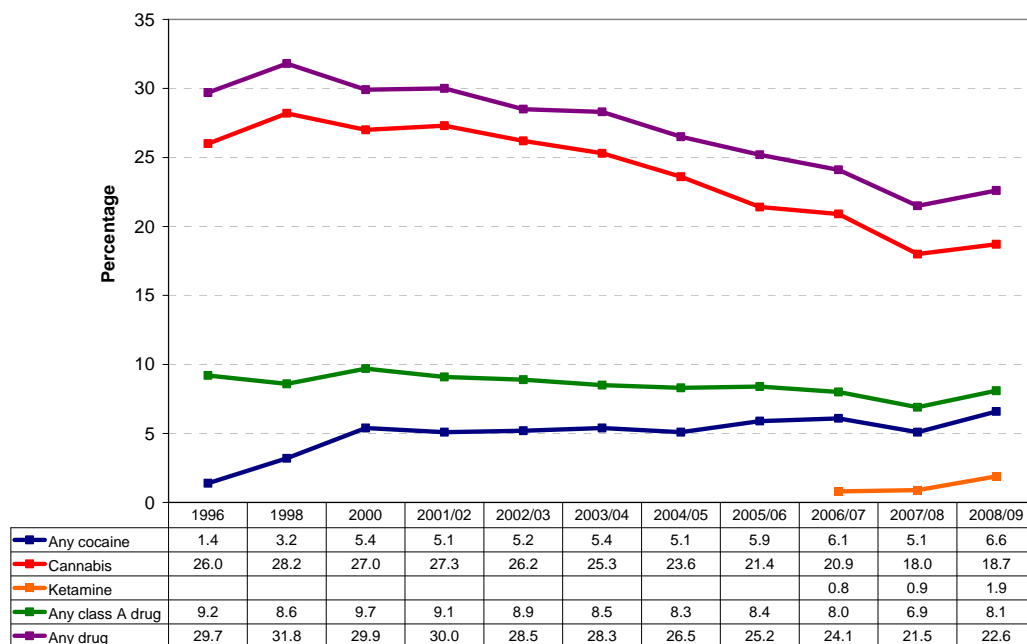
Figure 5: Graph of the proportion of pupils reporting using illicit drugs in the past month, last year and ever, 2001 to 2007.



### 2.5.2. British Crime Survey

A Home Office analysis of the 2008/09 British Crime Survey found that 'last year' drug use among 16-24 year olds had fallen from 29.7% in 1996 to 22.6% in 2008/09. As shown in Figure 5 below, this longer term decrease in young people's drug use is largely due to the gradual decline in cannabis use. The chart also shows an increase in the proportion of 16-24 year olds reporting that they had used cocaine or ketamine within the past year.

Figure 6: Proportion of 16-24 year olds reporting drug use within the last year (1996-2008/09)



Source: *Drug Misuse Declared: findings from the 2008/09 British Crime Survey*

A Mosaic analysis of the British Crime Survey found that the following groups were more likely to indicate that they had taken cannabis:

- **“Economically successful singles, many living in privately rented inner city flats” (E29)** (79% more than expected nationally). Within Kent, this population are indicated mainly in Tunbridge Wells, and in smaller amounts in Maidstone and Sevenoaks.
- **“Well educated singles and childless couples colonising inner areas of provincial cities” (E31)** (77% more than expected nationally). Within Kent, this population is found in varying degrees across Kent, but the largest number (quite significantly) was in Canterbury followed by Maidstone.
- **“Young professionals and their families who have gentrified terraces in pre 1914 suburbs” (E30)** (69% more than expected nationally). Not a total coverage of Kent, but present mainly in Tunbridge Wells and Sevenoaks, with a presence in Tonbridge & Malling, Canterbury, Dover and Maidstone.

The following mosaic groups that were more likely to indicate that they had taken cocaine:

- **“Economically successful singles, many living in privately rented inner city flats” (E29)** (292% more than expected nationally). Populations indicated mainly in Tunbridge Wells, and in smaller amounts in Maidstone and Sevenoaks.
- **“Neighbourhoods with transient singles living in multiply occupied large old houses” (E28)** (203% more than expected nationally). There is quite a low population of E28 across Kent, less than 150 each in Maidstone, Tunbridge Wells, Canterbury and Thanet.
- **“Financially successful people living in smart flats in cosmopolitan inner city locations” (A01)** (181% more than expected nationally). There is a relatively low

population in Kent and mainly in the west of the county in Tunbridge Wells, and a small number in Maidstone.

Those more likely to indicate that they had taken ecstasy were:

- **“Economically successful singles, many living in privately rented inner city flats” (E29)** (292% more than expected nationally). Population indicated mainly in Tunbridge Wells, and in smaller amounts in Maidstone and Sevenoaks.
- **“Young people renting hard to let social housing often in disadvantaged inner city locations” (F35)**. (136% more than expected nationally). Population not present in every district; main districts are Maidstone, Tunbridge Wells, Gravesham, Shepway, Thanet, Dartford and Ashford.
- **“Well educated singles and childless couples colonising inner areas of provincial cities” (E31)** (121% more than expected nationally). Within Kent, this population is found in varying degrees across Kent, but the largest number (quite significantly) was in Canterbury followed by Maidstone.

### **3. Evidence Summary for Young People's Needs Assessment**

A number of evidence reviews have been commissioned in 09-10 in Kent, which refer to the prevention of alcohol misuse and other risk taking behaviours. Those are:

- Billings J. (2009) 'Tackling Alcohol Misuse in Teenagers: What Works and How Can Practice Develop?' Web reference
- Gladstone B. (2009) ' Review of Evidence on Reducing Risk Taking Behaviours' EISS University of Kent
- Saffin K. (2009)' What evidence exists for the work of Alcohol Interventions with young people in recreational settings' PHRU

#### **3.1. Tackling Alcohol Misuse in Teenagers:**

Billings (2009) identifies the promising findings of the Strengthening Families Strengthening Communities Programme in the prevention of alcohol misuse amongst young people.

Billings recognised the uncertainty around the effectiveness of many alcohol misuse prevention programmes for young people but relayed Foxcroft's<sup>6</sup> notion of a precautionary principle which supports the continuation of alcohol prevention in the absence of clear guidance<sup>7</sup>.

In school settings, interventions need to be orientated towards life skills and delivered in an interactive way including the use of CD ROMs. Taking into account age, ethnicity and gender is key as well as ensuring that the intervention is not too long or elaborate so disengaging young people and staff. Harm minimisation techniques are an important element, as abstinence based programmes are not well received. Booster sessions should also be provided.

In community settings, the engagement of the whole community and the simultaneous delivery in interventions over the long term with an aim to intervene before young people start using alcohol frequently are all elements which will ensure success.

Billings also notes the success of brief motivational interventions in reducing alcohol misuse amongst hazardous and harmful drinkers. These young people are less likely to be motivated to change and seek help to do so. They can be identified through 'opportunistic screening'. She identifies that they can take place in a range of settings and can be delivered by non specialist staff who are trained. Billings notes that brief interventions can also be delivered to families and are effective.

Billings study has a particular emphasis on the role of social marketing to influence alcohol use amongst young people. Billings identified that many of the programmes used social marketing principles in the deliver of the prevention initiative. Those principles were identification of a clear goal with a target audience, research with the target audience to build their understanding of their motivations and influences and

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<sup>6</sup>

<sup>7</sup> NICE guidance on the prevention of alcohol misuse is pending publication in March 2010.

making interventions fun. Continual feedback and testing was also key. The presence of social marketing was most evident in the delivery in community settings.

### **3.2. Review of Evidence on Reducing Risk Taking Behaviours:**

Gladstone (2009) reported:

“There is a growing body of research evidence in the area of interventions to prevent or reduce risk of young people in regards to smoking, drug taking, teenage pregnancy, alcohol abuse and offending. However, a lot of the robust evaluated evidence comes from the USA and may have limited applicability to Kent. Researchers highlight the fact that there remain wide gaps in the evidence on the process and effects of interventions on single issues and multi-component programmes.

There have been a number of reviews of the evidence base in recent years, including reviews by the European Institute of Social Services (EISS) at the University of Kent, by NICE, by the EPPI centre and by the Cochrane and Campbell collaborations. The most relevant findings of these reviews can be summarised as follows:

- There are known risk factors which make some young people more vulnerable to substance misuse, teenage pregnancy, smoking and offending.
- These risk factors include poor engagement and performance in school, negative peer relationships, difficult family relationships and environmental deprivation especially when combined with easy availability of cigarettes, alcohol and illicit drugs, and the absence of good quality sex education.
- There are also some factors that have been associated with resilience to problem behaviours. These include:
  - Having fewer problems with peers
  - Higher IQ
  - Greater enjoyment of school
  - Lower family adversity.
- There are a number of promising interventions that can reduce the risk factors and boost the protective factors, and thereby reduce risk behaviours around substance misuse, teenage pregnancy, smoking and offending. These include:
  - Integrated packages of support in educational settings, based on careful assessment, and including social care, housing, education/training/employment.
  - Curriculum development packages which teach conflict resolution, empathy and emotional competence.
  - School based programmes that teach social skills in the context of resisting substance misuse and smoking.
  - Some brief interventions, including motivational interviewing.
  - Youth development programmes which combine outreach to vulnerable young people with voluntary service and social development classes.

- Interventions focused on the family, including multi-systemic family therapy and family functional therapy.
- There are other promising interventions, which do not yet have rigorous evidence of positive effect with this age group. They include youth inclusion and support panels, family group conferencing, using incentives to reward people for positive behaviours, therapeutic foster care and mentoring.
- There are some interventions which have been proven not to work, such as boot camps, scared straight programmes, juvenile curfews and sexual abstinence programmes.
- It also seems that smoking cessation programmes have limited effects with young people unless an emphasis is placed on smoking prevention at an early stage. A general lesson from the literature on what does not work in preventing risky behaviour by young people is to avoid concentrating young people with behavioural problems in groups without positive role models and structured activities.

### 3.3. Recreational Settings

In relation to alcohol use by young people in recreational settings. The evidence base for interventions in recreational settings is less developed than in schools settings.

Saffin ( 2009) reported

'We found no evidence that clearly provides a basis for either brief or longer structured interventions with young people in recreational settings. Thus the following key points are derived from literature that addresses either the effectiveness of interventions with young people or those delivered in recreational settings.

- Overall, the literature suggests that brief alcohol interventions have a small but significant effect for young people.
- Motivational interviewing appears to be one of the most common types of intervention and further review could focus on specific brief interventions.
- Brief interventions are reported as cost-effective and as likely to achieve positive outcomes after 6-12 months as longer term programmes.
- In addition they may have benefits where the population is mobile and less likely to engage with established services for a variety of reasons.
- In the context of recreational settings, Van Beurden et al (2000) suggest that attractively presented material and personal feedback may reach customers in bars and taverns. However, their work was with adults and it remains to be seen whether young people would respond in the same way, especially in areas where they may have much in common with the disenfranchised homeless population of Peterson et al's study (2006).
- The intervention seems most likely to be delivered by a counsellor or psychologist with a Master's degree, although all the examples quoted are from the USA or Australia and there may be important differences in the UK.

- There is no evidence that longer term structured interventions will provide better outcomes than brief interventions. Such interventions may have value for those experiencing extensive problems such as homelessness, mental health problems, and poly substance use.
- The additional review of structured interventions suggests that such investment is most likely to yield benefits as part of a broad school and community programme.'

Saffin concludes, 'Overall, a number of reviews are critical of the quality of many trials and the limited period of follow up; however, there is a thread throughout the reviews and trials which suggests that a broad multi-agency approach that involves schools, colleges, community groups and families is the most likely to achieve change.

There is no clear evidence for the effectiveness of any intervention specifically in recreational settings. However, drawing on other settings suggests that Brief Interventions may be effective (in terms of impact on drinking behaviour) in these settings.'

### **3.4. Drawing together the evidence on prevention**

There is undoubtedly a strong evidence base for 'Strengthening Families, Strengthening Communities'. This is referred to in the evidence reviews commissioned in Kent and in national literature<sup>8</sup> including NICE guidance on preventing substance misuse. One of the key barriers to the success of family interventions is recruiting and retaining parents<sup>9</sup>. Vellerman (2009) suggests that this is because parents do not have a strong sense in parental influence and the positive impact that they can have by modelling positive behaviour and suggests that parents need to be targeted and educated about this.

The added effect of intervening with the family as well as peers, and the wider community is reported in Billings (2009) who notes the success of simultaneous activity in communities to affect alcohol misuse and the role of social marketing principles in shaping and targeting those interventions.

Brief interventions are identified as effective means of changing the behaviour of hazardous and harmful alcohol mis users who are not motivated to seek help and also with families. These are cost effective in recreational settings.

In schools, a life skills approach which is interactive and appropriate to age , ethnicity and gender will be more successful. Community and family components may maximise the impact (as above).

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<sup>8</sup> Vellerman R. ( 2009)' Alcohol Prevention Programmes' Joseph Rowntree Foundation

<sup>9</sup> Ibid page 5

## **4. Vulnerable Groups**

### **4.1. Prevalence Model**

National and local guidance recognises that certain groups of young people are more vulnerable to substance misuse. The Home Office has produced a tool for estimating the prevalence of substance misuse amongst vulnerable groups. Table 6 and Table 7 present the prevalence estimates for looked after young people, refugees and asylum seekers and young offenders for each district within East & Coastal Kent and West Kent NHS areas. The tables and the charts below also highlight the potential gap in service provision for these vulnerable young people.

Table 6: Substance Misuse Prevalence Model (East Kent)

	Ashford	Canterbury	Dover	Shepway	Swale	Thanet
<b>Number of children and young people aged 10 - 17</b>	<b>11,900</b>	<b>14,500</b>	<b>11,600</b>	<b>9,800</b>	<b>14,200</b>	<b>14,200</b>
Number of Looked After Children	74	85	78	90	111	217
Number of looked after children predicted to be using class A drugs or using frequently	6	7	6	7	9	17
Number of Looked After Children accessing specialist community treatment	2	-	7	5	7	14
Predicted gap in specialist services for Looked After Children	-4	-7	1	-2	-2	-3
Number of Looked After Children predicted to have misused substances at least once in the last year	12	14	12	14	18	35
Number of Looked After Children accessing targeted prevention services	123	19	8	17	14	37
<b>Predicted gap in targeted prevention services for Looked After Children</b>	<b>111</b>	<b>5</b>	<b>-4</b>	<b>3</b>	<b>-4</b>	<b>2</b>
Number of Young Offenders	312	388	319	310	390	531
Number of Young Offenders predicted to be using class A drugs or using frequently	90	113	93	90	113	154
Number of Young Offenders accessing specialist community treatment	8	23	21	17	23	46
Predicted gap in specialist services for Young Offenders	-82	-90	-72	-73	-90	-108
Number of Young Offenders predicted to using substances	30	37	31	30	37	51
Number of Young Offenders accessing targeted prevention services	102	172	160	148	50	99
<b>Predicted gap in targeted prevention services for Young Offenders</b>	<b>72</b>	<b>135</b>	<b>129</b>	<b>118</b>	<b>13</b>	<b>48</b>
Number of Refugees and Asylum seekers	61	39	3	39	13	18
Number of Refugees and Asylum seekers who are not in school predicted to be using class A drugs or using frequently	21	14	1	14	5	6
Number of Refugees and Asylum seekers accessing specialist community treatment	-	-	-	-	-	-
Predicted gap in specialist services for refugees and asylum seekers	-21	-14	-1	-14	-5	-6
Number of refugees and asylum seekers predicted to misusing substances at least once in the last year	34	21	2	21	7	10
Number of refugees and asylum seekers accessing targeted prevention services	100	57	-	18	3	9
<b>Predicted gap in targeted prevention services for refugees and asylum seekers</b>	<b>66</b>	<b>36</b>	<b>-2</b>	<b>-3</b>	<b>-4</b>	<b>-1</b>
Total number of young people in specialist community treatment	34	76	51	46	42	81
Total number of young people in who have accessed targeted prevention services	605	792	544	730	525	373
Total number of young people who have accessed DISP services	12	44	12	11	11	34
Ratio of young people in treatment to general population of children and young people (10 – 18 yrs) - 1 in:	350	191	227	213	338	175
Ratio of young people who have received a drugs service to general population of children and young people (10 – 18 yrs) - 1 in:	19	17	21	13	26	35

Table 7: Substance Misuse Prevalence Model (West Kent)

	Dartford	Gravesham	Maidstone	Sevenoaks	Tonbridge & Malling	Tunbridge Wells
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<b>Number of children and young people aged 10 - 17</b>	<b>9,500</b>	<b>10,500</b>	<b>14,200</b>	<b>11,800</b>	<b>13,000</b>	<b>12,600</b>
Number of Looked After Children	42	67	59	40	35	39
Number of looked after children predicted to be using class A drugs or using frequently	3	5	5	3	3	3
Number of Looked After Children accessing specialist community treatment	4	2	-	1	1	-
Predicted gap in specialist services for Looked After Children	1	-3	-5	-2	-2	-3
Number of Looked After Children predicted to have misused substances at least once in the last year	7	11	9	6	6	6
Number of Looked After Children accessing targeted prevention services	3	19	57	4	6	149
<b>Predicted gap in targeted prevention services for Looked After Children</b>	<b>-4</b>	<b>8</b>	<b>48</b>	<b>-2</b>	<b>0</b>	<b>143</b>
Number of Young Offenders	222	262	397	187	227	192
Number of Young Offenders predicted to be using class A drugs or using frequently	64	76	115	54	66	56
Number of Young Offenders accessing specialist community treatment	23	20	14	4	8	9
Predicted gap in specialist services for Young Offenders	-41	-56	-101	-50	-58	-47
Number of Young Offenders predicted to using substances	21	25	38	18	22	18
Number of Young Offenders accessing targeted prevention services	17	183	87	31	62	32
<b>Predicted gap in targeted prevention services for Young Offenders</b>	<b>-4</b>	<b>158</b>	<b>49</b>	<b>13</b>	<b>40</b>	<b>14</b>
Number of Refugees and Asylum seekers	5	31	46	1	10	27
Number of Refugees and Asylum seekers who are not in school predicted to be using class A drugs or using frequently	2	11	16	0	4	9
Number of Refugees and Asylum seekers accessing specialist community treatment	-	-	-	-	-	-
Predicted gap in specialist services for refugees and asylum seekers	-2	-11	-16	0	-4	-9
Number of refugees and asylum seekers predicted to misusing substances at least once in the last year	3	17	25	1	6	15
Number of refugees and asylum seekers accessing targeted prevention services	-	21	40	1	-	145
<b>Predicted gap in targeted prevention services for refugees and asylum seekers</b>	<b>-3</b>	<b>4</b>	<b>15</b>	<b>0</b>	<b>-6</b>	<b>130</b>
Total number of young people in specialist community treatment	45	37	29	13	23	28
Total number of young people in who have accessed targeted prevention services	43	319	546	79	223	228
Total number of young people who have accessed DISP services	7	10	42	25	25	21
Ratio of young people in treatment to general population of children and young people (10 – 18 yrs) - 1 in:	211	284	490	908	565	450
Ratio of young people who have received a drugs service to general population of children and young people (10 – 18 yrs) - 1 in:	190	32	24	113	52	51

Figure 7: Looked After Children accessing targeted prevention services

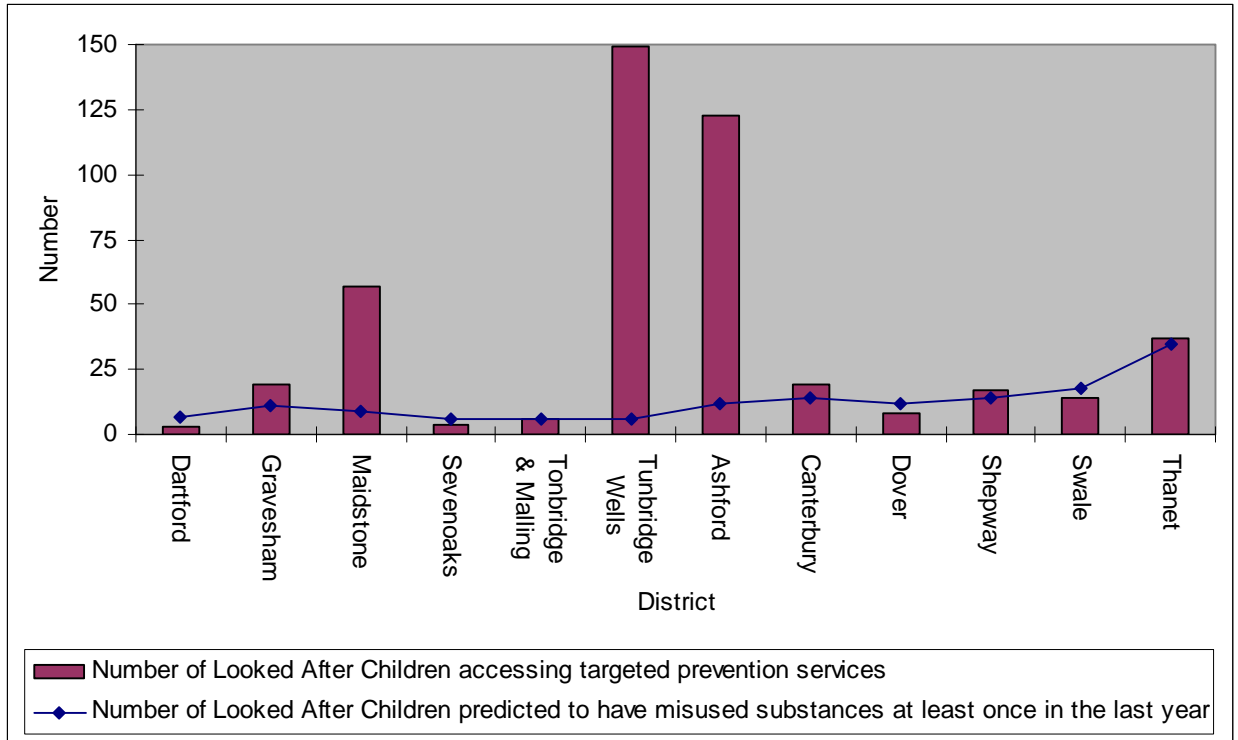


Figure 8: Looked After Children accessing specialist community treatment

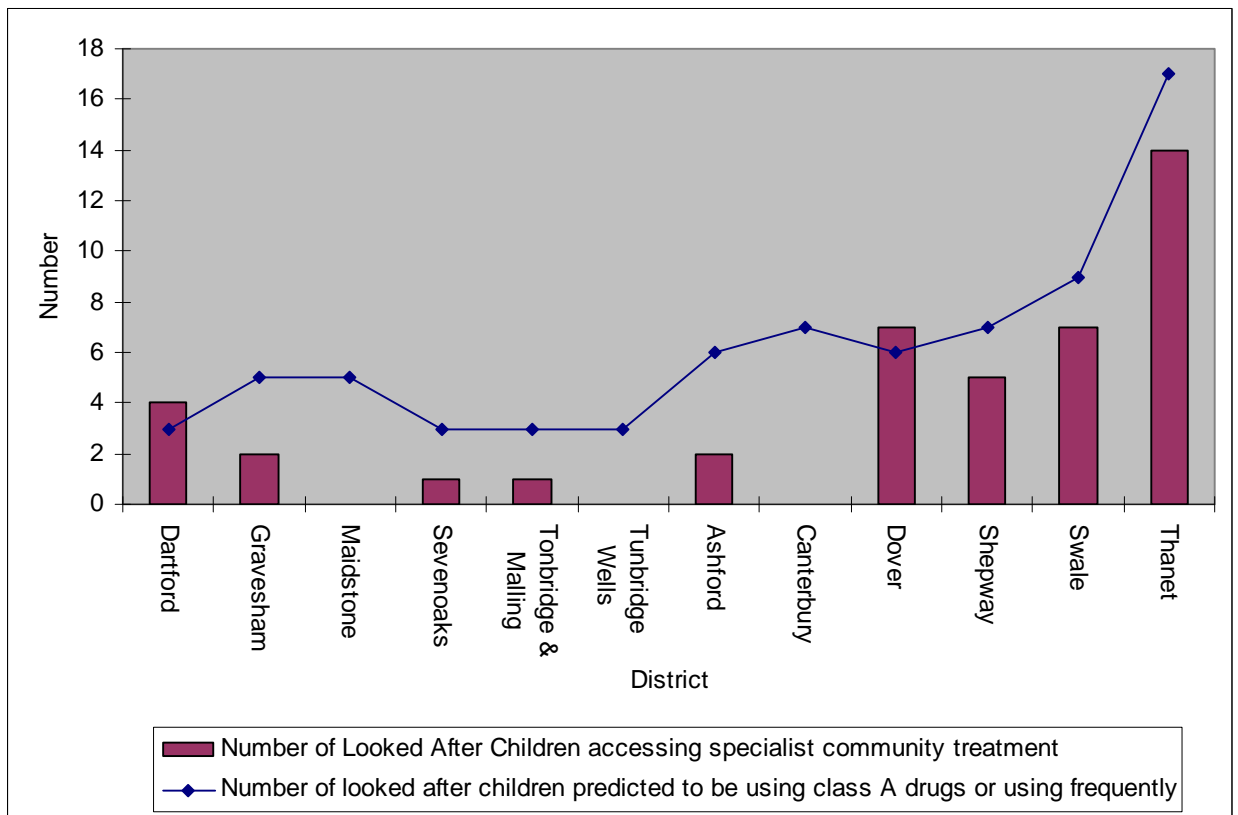


Figure 9: Young Offenders accessing targeted prevention services

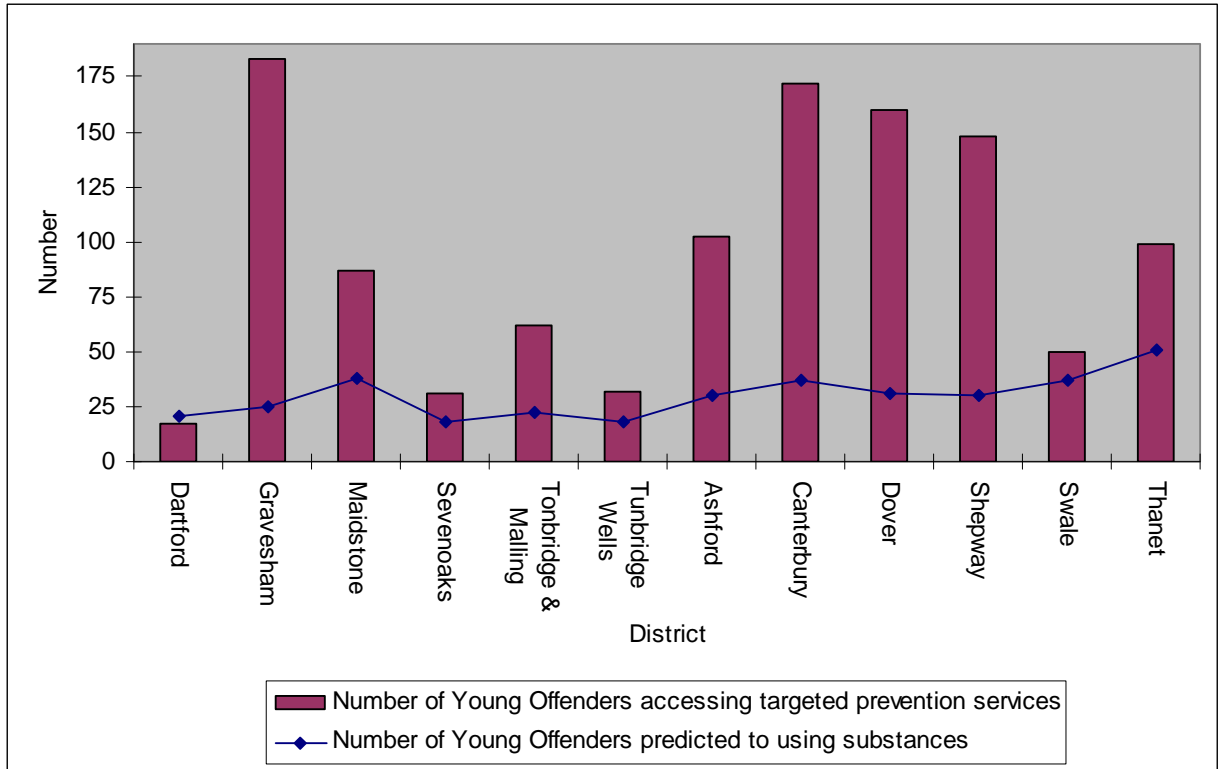


Figure 10: Young Offenders accessing specialist community treatment

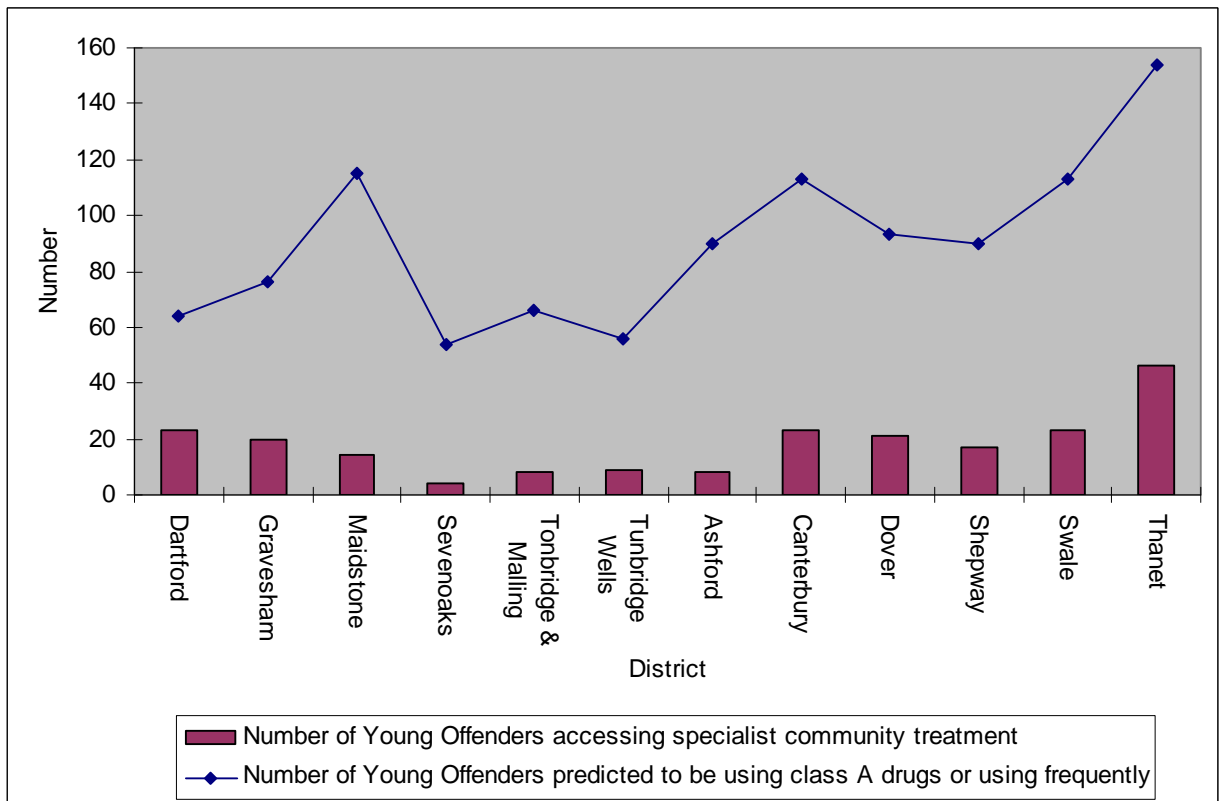


Figure 11: Refugees and asylum seekers accessing targeted prevention services

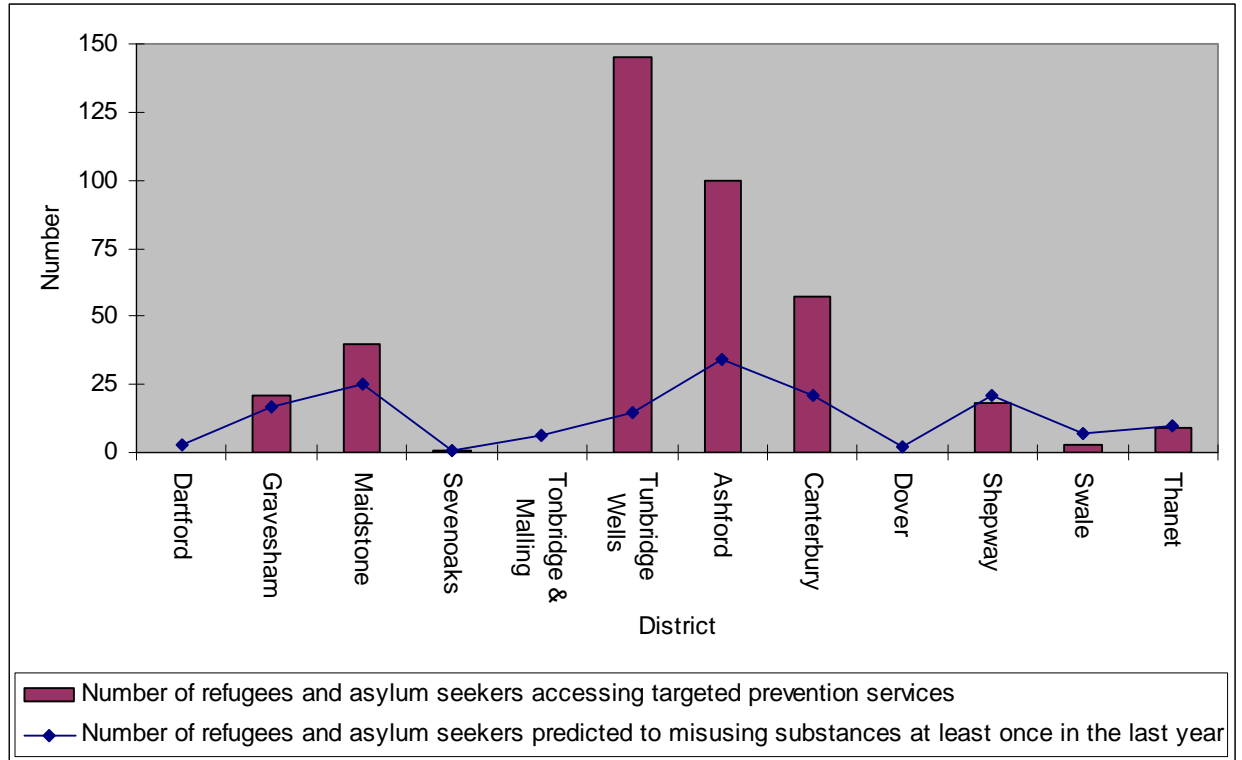
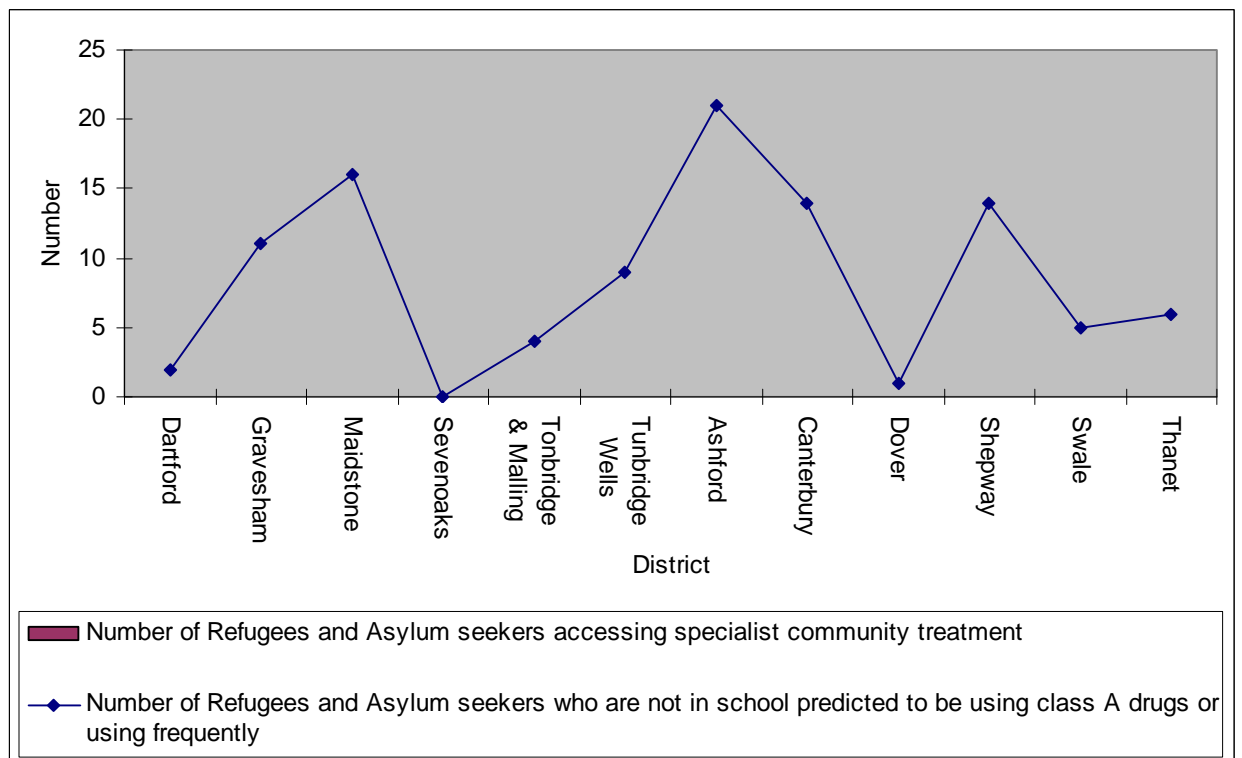


Figure 12: Refugees and asylum seekers and specialist community treatment<sup>10</sup>



<sup>10</sup> Note: There were no specialist community treatment clients under the age of 18 with a recorded vulnerability of 'Refugee or Asylum Seeker'

#### 4.2. Consultation with young people regarding risk taking behaviour

Participatory research was undertaken with young people in a range of settings in order to inform the development of RiskKit. RiskKit is a multi component programme designed to reduce risk taking behaviour including substance misuse, crime, teenage pregnancy and smoking. RiskKit is delivered in schools and is currently being evaluated.

The research with young people concluded that young women and young men both identified the same risks, which they saw in both negative and positive terms. However, young women were more concerned with early pregnancy and young men were more concerned with violence. They recognized the interrelationship between the different risk taking behaviours and identified alcohol use in particular as a being a common theme. The research found that young people were already very aware of the risks and used to talking about them but were less confident about putting into place strategies that would reduce the negative aspects.

Young people did not recognise that their parents or their school settings had a role in affecting risk taking behaviour. Finally, they did not recognise abstinence as a goal. They recognised that risk taking would continue to happen but the harms of these behaviours could be reduced. They focused on strategies that reduced the quantity of the behaviour, reduced the risks associated with the behaviour or finally diverted young people from the behaviour by doing something else instead.

#### 4.3. Vulnerabilities

KCA's Young People's Services Annual report (ending March 2009) provides information on the number of vulnerable young people accessing specialist substance misuse treatment. Due to the relatively small numbers the LCSP areas have been combined geographically to allow more meaningful analysis. It should be noted that although some of these will be the district not all are some LCSPs are not coterminous within one district.

Table 8: Number of Referrals to KCA Young People's Specialist Treatment Service

Area of Residence	Number of referrals in 2008/09
Ashford	34
Canterbury	76
Dartford & Swanley	50
Dover, Deal & Sandwich	51
Gravesham	37
Maidstone	29
Sevenoaks	8
Shepway	46
Swale	42
Thanet	81

<b>Area of Residence</b>	<b>Number of referrals in 2008/09</b>
Tonbridge & Malling	23
Tunbridge Wells, Cranbrook & Paddock Wood	28

Thanet had the highest number of referrals for young people with one or more vulnerabilities followed by Canterbury. There is wide variation across the areas of residence with only eight Sevenoaks residents being referred, only one tenth of the number in Thanet.

Within each area the majority of referrals were for males, except in Dover, Deal and Sevenoaks and in Tunbridge Wells, Cranbrook & Paddock Wood where there were slightly more females being referred.

The main referral route was via Community Sentence (23%) followed by Sentence Requirement (16%) and then by Universal Education (14%).

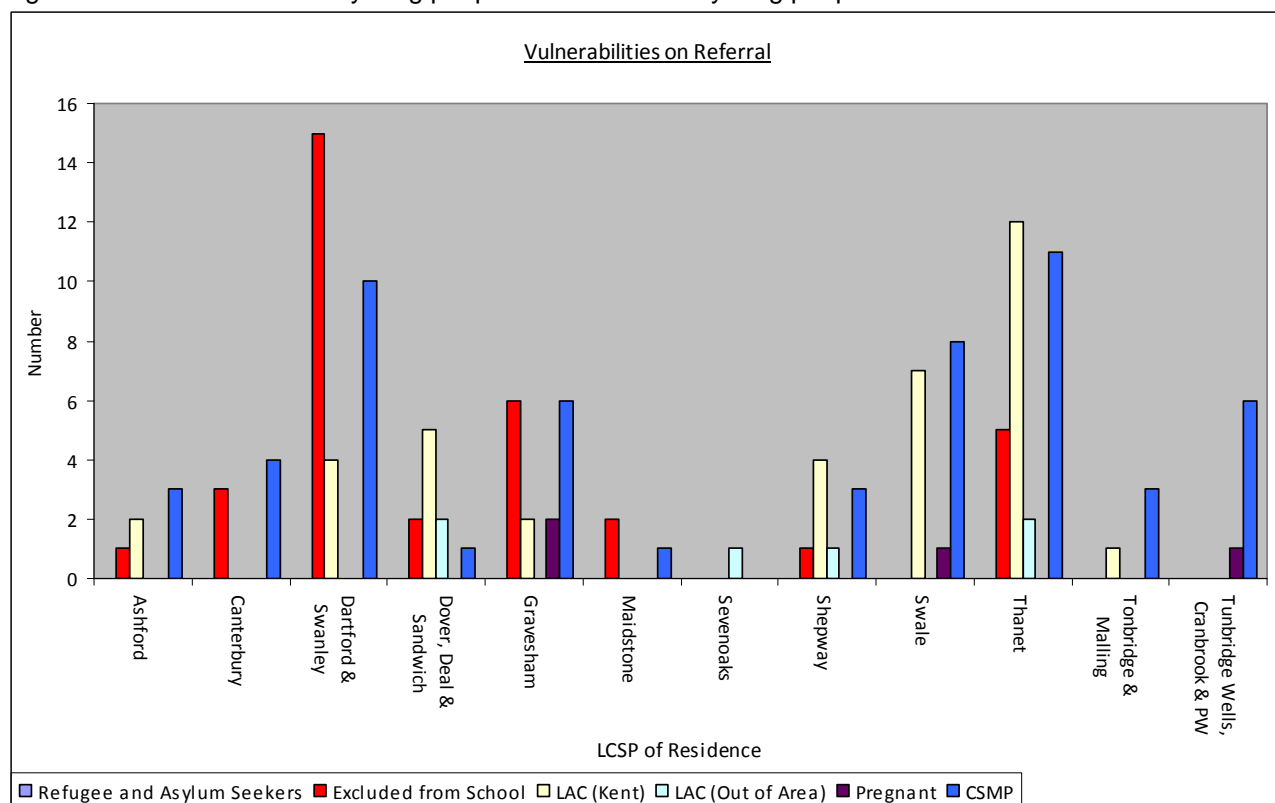
Table 9: Number of Referrals to KCA Young People's Specialist Treatment Service

<b>Area of Residence</b>	<b>Referral Route – most indicated</b>
Ashford	Sentence Requirement & Self
Canterbury	Universal Education
Dartford & Swanley	Community Sentence
Dover, Deal & Sandwich	Universal Education & Sentence Requirement
Gravesham	Community Sentence
Maidstone	Community Sentence
Sevenoaks	Community Sentence
Shepway	Community Sentence & Universal Education
Swale	Community Sentence
Thanet	Community Sentence & Sentence Requirement
Tonbridge & Malling	Community Sentence
Tunbridge Wells, Cranbrook & Paddock Wood	Community Sentence

Figure 6 below shows the numbers of vulnerabilities recorded for young people referred to KCA's young people's treatment services in 2008/09. Any vulnerability associated with the young person are indicated at the time of their referral. The most indicated vulnerability overall was that of 'Child of a Substance Misusing Parent', followed by 'Looked After Child (Kent resident)' and 'Excluded from School'. It should be noted that a young person can have more than one of these vulnerabilities and the figures that are presented does not necessarily reflect the number of referrals of the number of clients. It should also be noted that young offenders are classed as a vulnerable group as well as a referral source.

There were no young people referred to KCA YPS with the identified vulnerability of refugee and Asylum Seekers in 2008/09.

Figure 13: Vulnerabilities of young people referred to KCA young people's service 2008/09



KCA referrals data show that:

- Dartford & Swanley had a noticeable number of referrals that were excluded from school
- For Sevenoaks residents, the only vulnerability identified was looked after child (out of area).
- Thanet had a noticeable number of looked after children from Kent as well as children of substance misusing parents.
- Canterbury may have been one of the areas with the highest number of referrals but it had a low number of vulnerabilities identified.
- Cannabis was the most commonly indicated drug of choice (55%) followed by alcohol (38%). There were much smaller numbers involved but other drugs of choice indicated include – heroin, cocaine, amphetamines, solvents, ketamine, ecstasy, crack cocaine, LSD and poppers.
- There was not much variation with cannabis as the most indicated by area of residence except for in Shepway where an equal number of young people indicated alcohol and in Tonbridge & Malling and swale where alcohol was the most indicated.

#### 4.4. Substance Misusing Parents

The vulnerabilities information in the young people's treatment does not reflect the true level of children of substance misusing parents across the county as there will be a large number of these children and young people who are not

substance misusers themselves and of the age where substance misuse is likely. . Adults treatment data can therefore help to give further guide about the possible numbers of children of substance misusing parents in the county. NDTMS data for adults in treatment records the parental status of the client at the time of triage.

In 2006/07 the quality of this data was poor with 42% of the clients not having any parental status recorded. Data quality has since improved and parental status is now recorded for 95% of clients in treatment in 2008/09. Table 10 below shows the breakdown of parental status recorded for all Kent resident clients over the age of 18 that accessed structured treatment in 2008/09.

Table 10: Parental Status of clients in treatment in 2008/09

<b>Parental Status</b>	<b>2008/09</b>	<b>Percentage</b>
Not a Parent	1856	49.7%
Children Living With Client	668	17.9%
All the children live with client	4	0.1%
Some of the children live with client	3	0.1%
None of the Children live with client	6	0.2%
Children Living With Other Family Members	191	5.1%
Children Living With Partner	580	15.5%
Children In Care	121	3.2%
Client Pregnant	6	0.2%
Other	118	3.2%
Blank/Missing	182	4.9%
<b>Total</b>	<b>3735</b>	

The NDTMS data show that there were 1579 clients in structured treatment in 2008/09 that indicated they were a parent regardless of the living arrangements. Further analysis of this data has shown that 9% of clients with a housing problem indicated that they had children living with them (64 clients) highlighting a group with a high level of vulnerability.

#### **4.5. Young Offenders**

Previous KDAAT Young People's Services Needs Assessments have highlighted the link between substance misuse and offending by children and young people. ASSET is the assessment framework that is used by youth offending teams to assess a young person's risk of re-offending at the start and end of their youth justice intervention in relation to twelve criminogenic factors including substance use. Figure 7 below highlights the average start ASSET scores for substance misuse for young people who had an ASSET completed by Kent Youth Offending Service between 2006/07 and 2008/09. Figure 8 shows the number of ASSETs that have had a score of 3 or 4 recorded for Substance Use.

The data show that substance misuse tends to be more problematic for young people on community penalties and custodial sentences than for those on first tier penalties such as referral orders or pre-court final warning interventions. This pattern has remained relatively consistent over the three year period.

Figure 14: Average Start ASSET scores

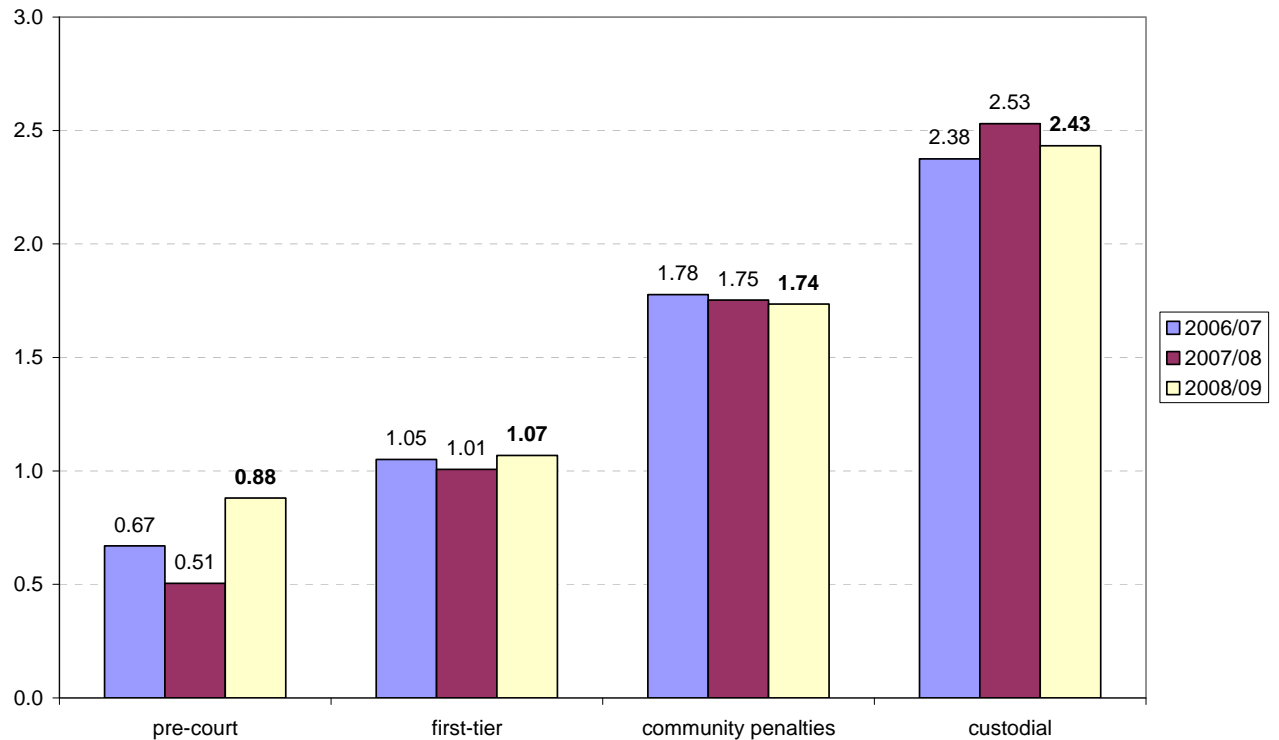
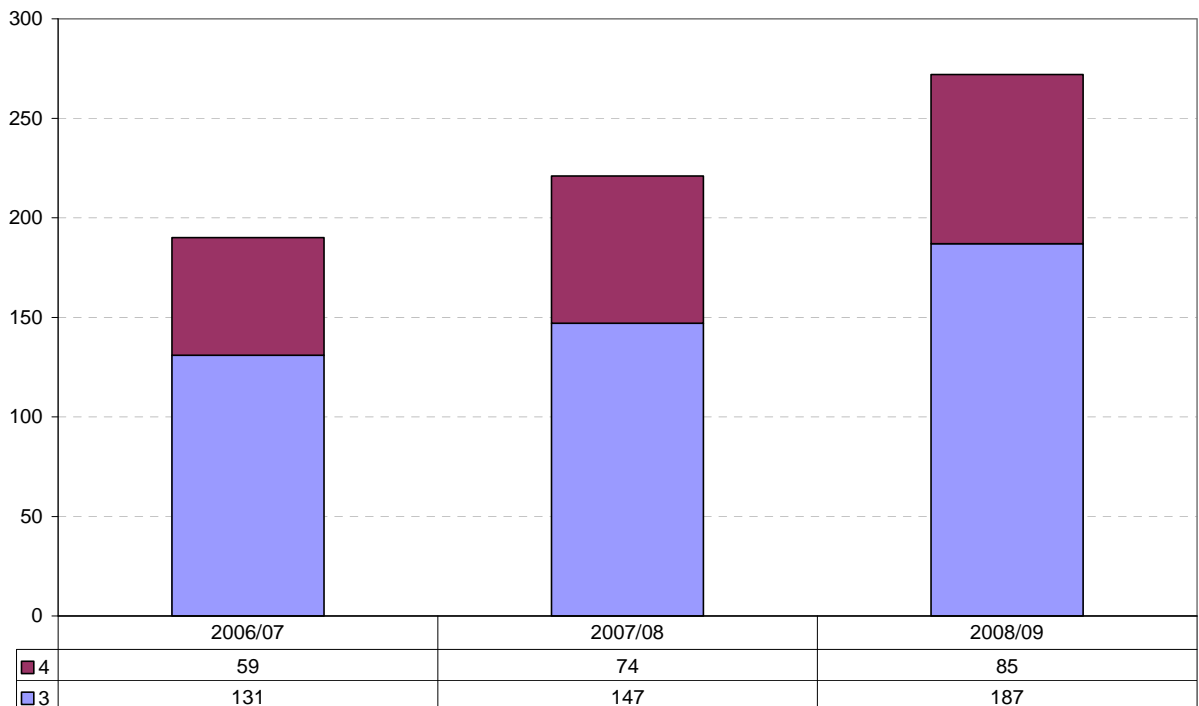


Figure 15: Number of YOS ASSETs completed with score of 3 or 4 for Substance Use



## 5. Specialist Treatment

### 5.1. Client Profile

Analysis of the young person's treatment data provided to the National Drug Treatment Monitoring System (NDTMS) between 2006/07 and 2008/09 reveals a relatively consistent demographic profile of Kent young people who have accessed specialist treatment in the past three years.

The key profiles of those accessing KCA's Young People's Services are:

- 61% were male and 39% were female.
- 95% were White British and 4% were Other.
- The age of the clients as at the mid point of the year indicated a concentration of those aged 14 to 17 years old; 27% were aged 16, 26% were aged 17 and 23% aged 15 years old.
- 52% of the clients indicated cannabis as their primary substance at triage, followed by 39% for alcohol. Other primary substances were opiates, crack, other stimulants and other.
- 99% of the clients indicated that they had never injecting – less than 5 clients indicated that they were currently injecting at the point of triage.

Comparisons with young people in treatment across the South East region show that:

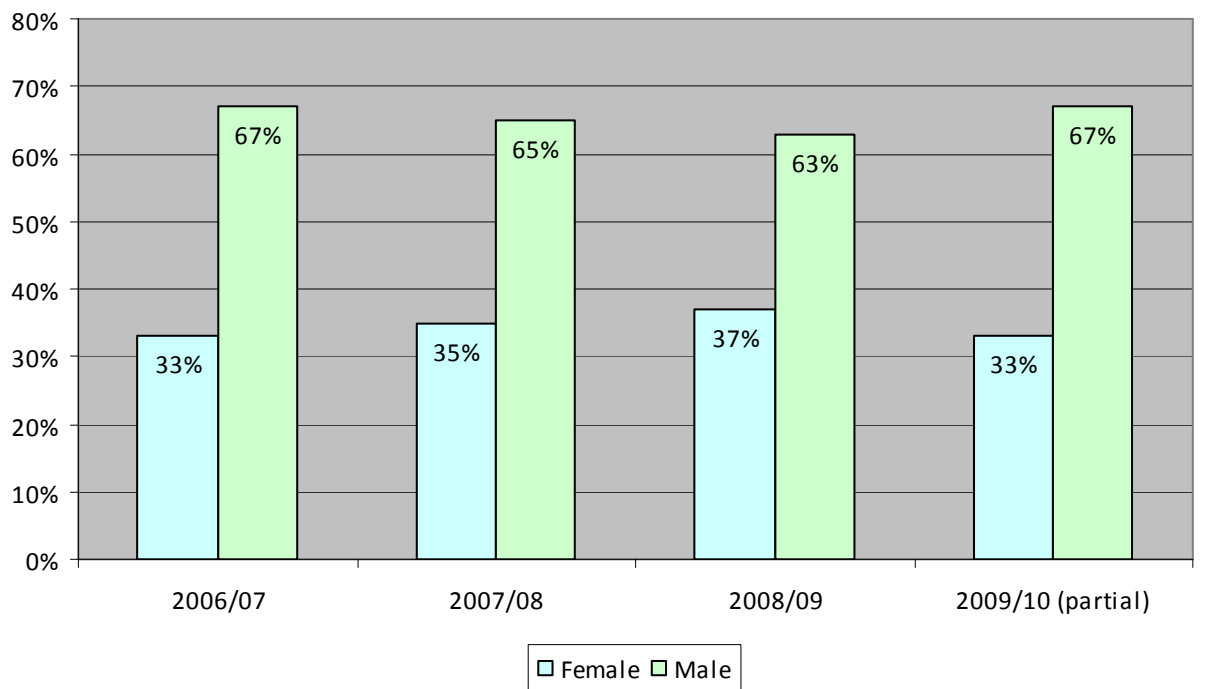
- The South East profile has the same percentage of males to females as KCA YPS.
- The South East as a whole has a slightly lower concentration of White British clients in treatment (93%).
- Although the concentration of client ages for the South East is similar to KCA YPS at 14 – 17 years old, the South East profile has a higher percentage of 17 year old (31%) and the profile percentages increase in line with the ages.
- The two main primary substances at triage are again Alcohol and Cannabis with very similar percentages at 53% for cannabis and 37% for alcohol (2% lower).
- The percentage of those never injecting is lower for the South East at 97% and 3% indicating they had previously injected whereas none at KCA YPS had indicated this.

Against the National profile the percentages are again very similar to both the KCA YPS and South East profiles, although with regards to Ethnic group there is a much lower percentage of White British at 88% and higher percentages of Asian or Asian British, Black or Black British and Other clients.

Comparisons of treatment data over the course of the three years to 2008/09 show that:

- The proportion of female clients increased slightly from 33% in 2006/07 to 37% in 2008/09. Although 2009/10 indicated a decrease in the proportion of females to 33% this is only a partial dataset and should only be used as an indication, and is subject to change.
- This overrepresentation of males is common is also reflected in specialist treatment nationally.

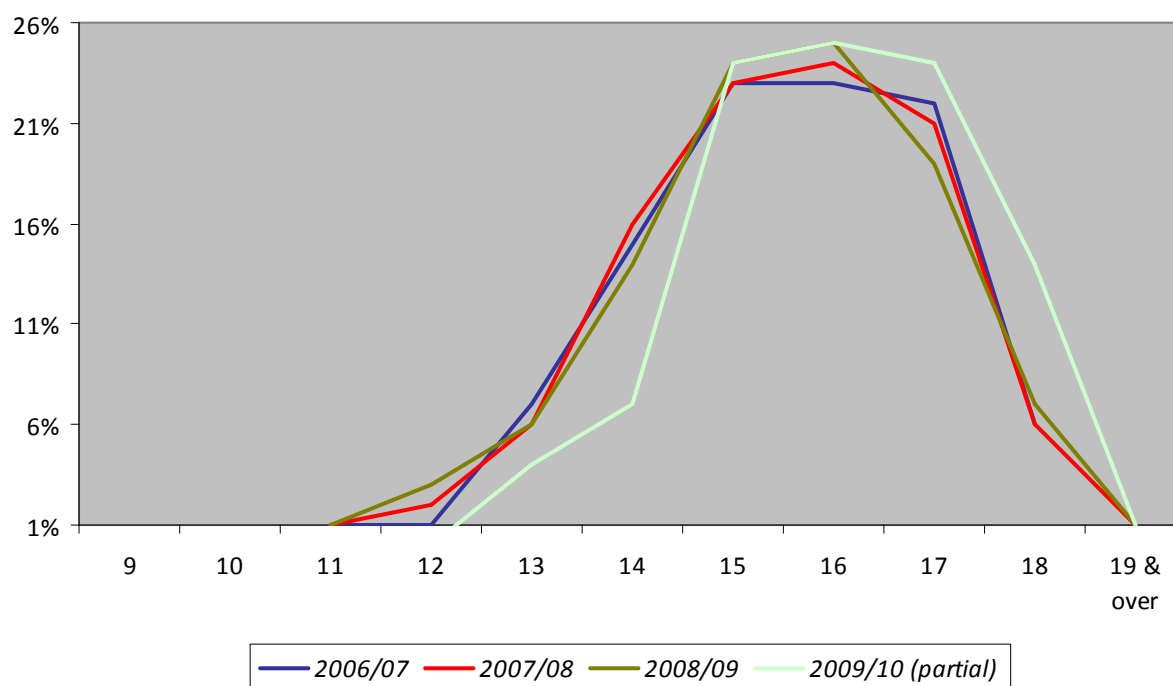
Figure 16: Gender of Kent young people in specialist treatment



The data also indicate that:

- The ages of clients at the mid point of the years of access all followed a similar pattern across the years.
- The numbers of clients increased to the ages of 15, 16 and 17 years old with a large decrease at 18 years old.

Figure 17: Age (at mid-point of the year) of Kent young people in specialist treatment



- The majority of clients indicated their ethnicity as White British, averaging 93% across the three years (2006/07 to 2008/09).

Table 11: Ethnicity profile of Kent resident young people in specialist treatment

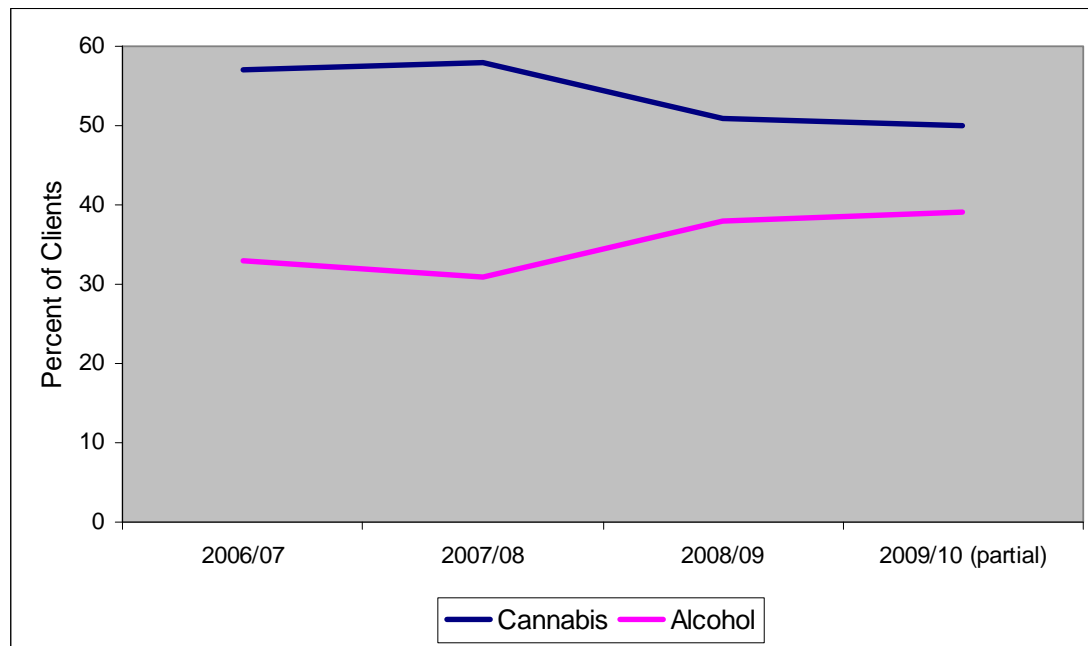
Ethnicity	2006/07		2007/08		2008/09	
	Number	Percentage	Number	Percentage	Number	Percentage
Bangladeshi	*	<1%	*	<1%	*	<1%
Caribbean	*	<1%	*	<1%	*	<1%
Chinese	-	-	*	<1%		
Indian	*	<1%	*	<1%		
Other	*	<1%	6	1%	10	2%
Other Asian	*	1%	*	1%	6	1%
Other Mixed	6	1%	6	1%	*	1%
Other White	10	2%	7	1%	7	1%
White & Asian			*	<1%		
White & Black African	*	<1%	*	<1%	*	<1%
White & Black Caribbean			*	1%	*	1%
White British	574	94%	595	93%	489	93%
White Irish	*	<1%	*	<1%	*	<1%
Missing/not stated	*	<1%	*	<1%	*	<1%

## 5.2. Substances

Looking at the primary substance that a client presents with at the time of their triage:

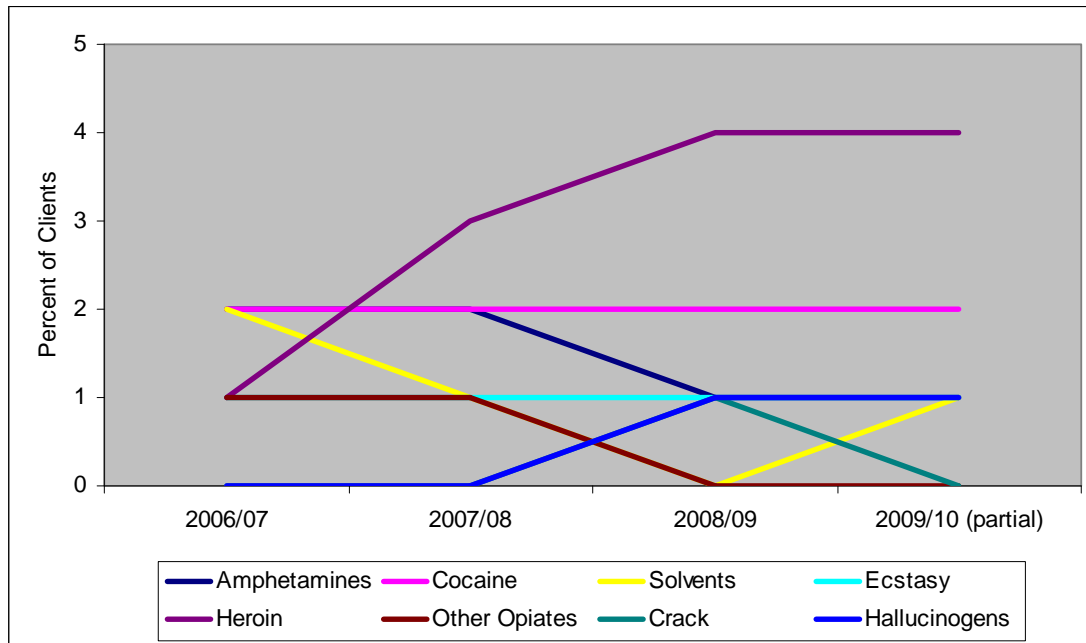
- The majority of clients are presenting with cannabis as their primary substance. In 2006/07 57% of clients indicated cannabis, after a slight increase in 2007/08 there was a drop to 51% in 2008/09. The partial data for 2009/10 also indicates of this continuing around the lower 50% mark.
- This trend is mirrored for alcohol as a primary substance, after a slight decrease in 2007/08 the percentage increased by 7% to account for 38% of the clients, again holding for the partial 2009/10 information.

Figure 18: Percentage of clients with alcohol and cannabis as primary substance



- All the other substance accounted for 10% or less of the primary substances, the majority accounting for only 1%.
- One trend to note is the increase of Heroin as a primary substance which as shown an increase of accounting for 1% in 2006/07 to 4% in 2008/09. The actual number of clients increased from 9 to 23 clients.
- Another indication in the data is the decrease in the number of clients indicating solvents as their primary substance: 11 in 2006/07 down to less than 5 in 2008/09.

Figure 19: Percentage of clients by other primary substances



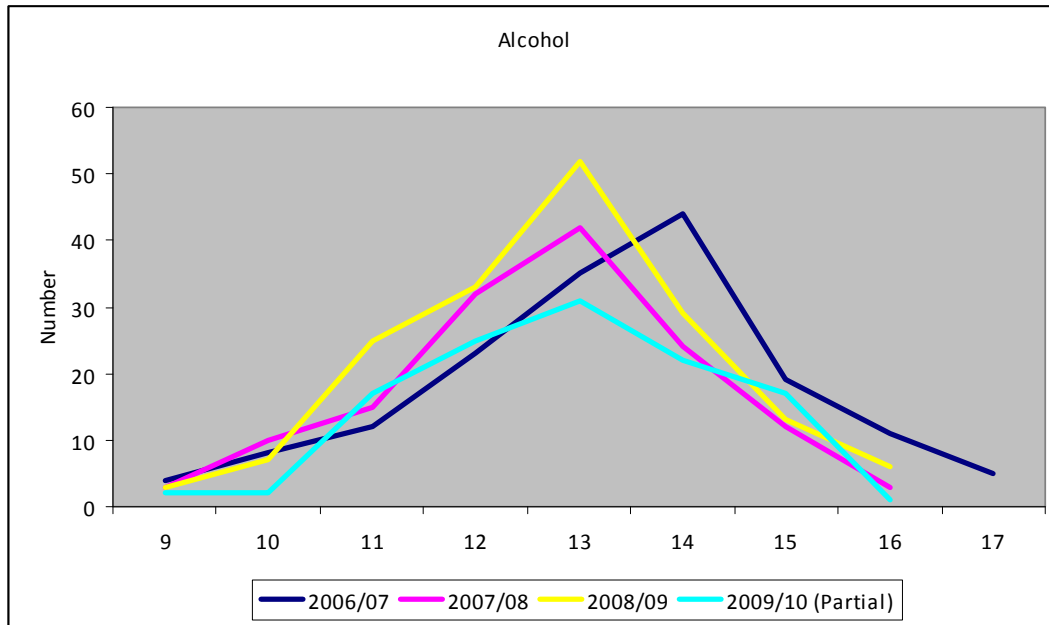
### 5.3. Age of First use of Primary substance (at triage)<sup>11</sup>:

The information given by the young person at the point of triage also shows that:

- where alcohol is indicated as the primary substance, there was a peak in the number of clients at age 14 indicating first use in 2006/07 but in 2008/09 this had dropped to aged 13, although there is a less of a peak indicated in the 2009/10 partial data.
- There is an indication that this first use has happened by the age of 15; early intervention work or awareness campaigns may be of use before this age is reached.

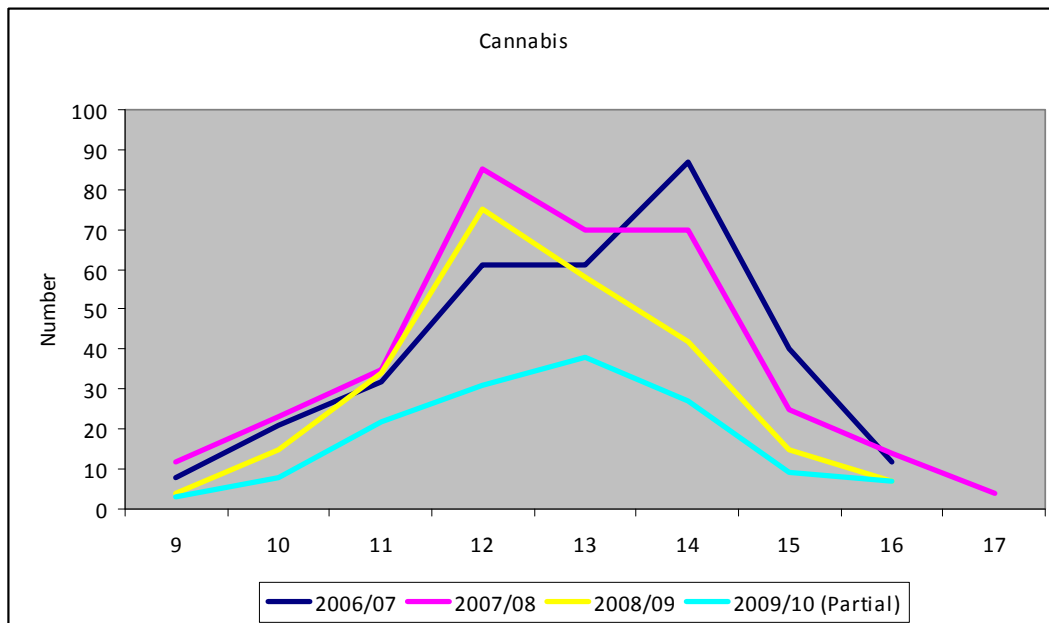
<sup>11</sup> Ages under 9 have been removed from this analysis as possible data input errors. 9 were there was a noticeable increase in indication.

Figure 20: Numbers of clients with alcohol as primary substance by age of first use



- For Cannabis, the outlook is slightly different than for alcohol. There are less distinct peaks at adjacent ages with first use peaking at 14 for 2006/07 with the younger age of 12 for the following two years.
- There is a gradual increase to 14 during 2006/07 whereas there are steep rises in the age of 12 from 11 in 2007/08 and 2008/09.

Figure 21: Numbers of clients with cannabis as primary substance by age of first use

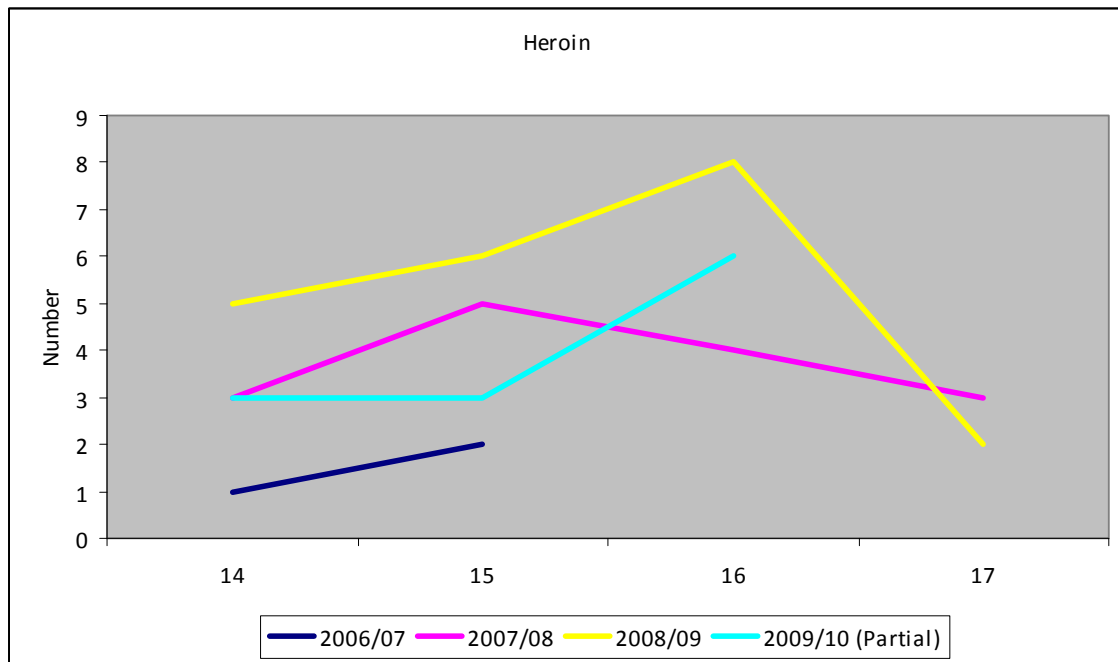


- This may indicate that 12 is the key age to focus prevention work.
- Although the actual number of clients indicating a primary substance of heroin is much lower than for alcohol and cannabis, it was decided that

due to the increase in clients presenting with heroin, the age of first use would be presented here.

- Clients were indicating a more focused range of first use ages than the other substances.
- 15 and 16 appear to be the most indicated, making this a slightly older profile than for alcohol and cannabis.

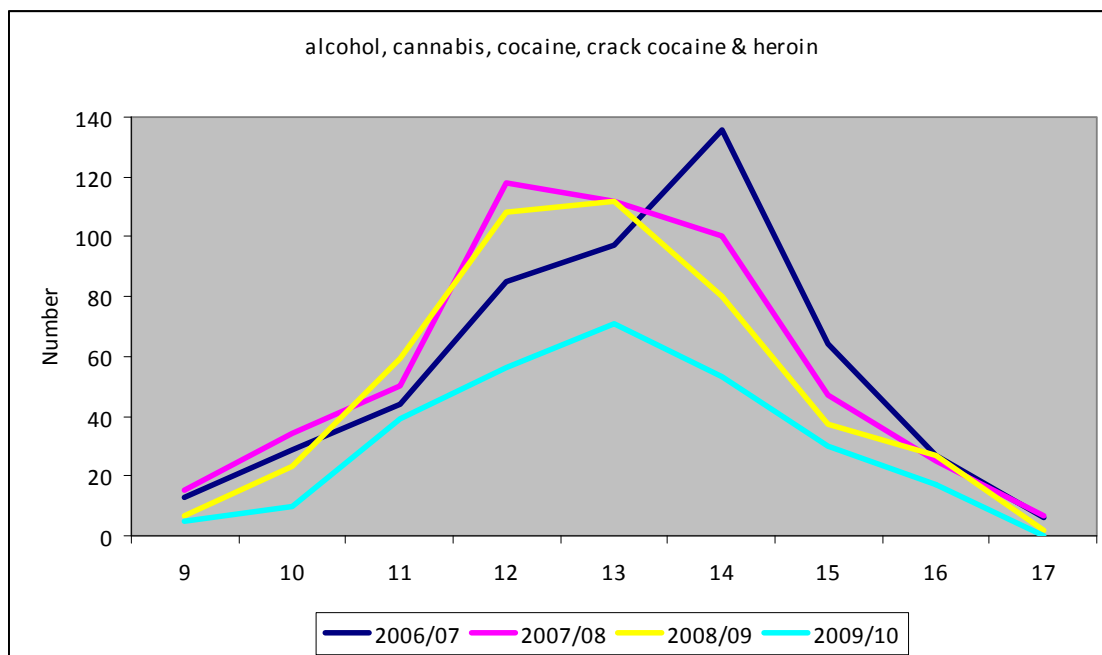
Figure 22: Numbers of clients with heroin as primary substance by age of first use



Taking the information on first use for alcohol, cannabis, cocaine, crack cocaine and heroin:

- The age of first use produces a similar chart to that of cannabis with the later years under review showing a lower age prominence; and again a drop off around the 15 years old mark.

Figure 23: Number of clients with combined primary substances by age of first use



#### 5.4. Feedback from young people in Specialist Community Treatment:

A survey was implemented across young people's specialist community treatment in March 2009. 68 young people completed the questionnaire. Overall they were highly satisfied with the almost all aspects of the service that they received. The survey also identified that 80% of recipients had reduced the use of their primary substance as a result of their engagement with KCA. The survey did identify areas for improvement. Those were firstly the ease of getting hold of a worker and secondly, communication with parents and carers. Both areas will be explored further by KCA management.

#### 5.5. Treatment Journeys

National Drug Treatment Monitoring System (NDTMS) data published by the NTA show that there were 472 Kent resident young people were in treatment during 2008/09. 337 of these were referred into treatment during 2008/09. The large majority (98%) were referred into KCA Young People's Service. The remaining 2% were referred into LAC Substance Misuse Services, E's UP YPS, KCA Thanet, KCA Canterbury, KCA Gravesend, KCA Shepway and East Sussex Under 19's SMS. There were less than 10 individuals that were transferred between agencies within the year according the NTA definition of an agency transfer.<sup>12</sup>

43% of referrals into treatment were criminal justice related, primarily from the Youth Offending Service. The next most common referral route was via Education who referred in 21% and again accounted for 21%. Looked After

<sup>12</sup> The number of individuals that have been transferred to and from treatment agencies based on the date sequence in a client's treatment journey. Transfer is used here irrespective if whether the agencies the client has moved from actually made a referral during the process.

Children Services and Substance Misuse Services accounted for only 1% the referrals.

For KCA Young People's Services, there were 268 exits, 75% of which were planned, 24% were unplanned and 1% were referred on. Of those with planned and unplanned exits, there was an indication of moving onto Adult treatment, Children looked after services, Criminal Justice, Health or Mental Health and targeted Youth support.

KCA Young People's Service had a higher percentage of planned exits compared than the overall level for the South East region where 70% had planned and 27% unplanned exits.

Looking across the client profile of those with planned or unplanned exits:

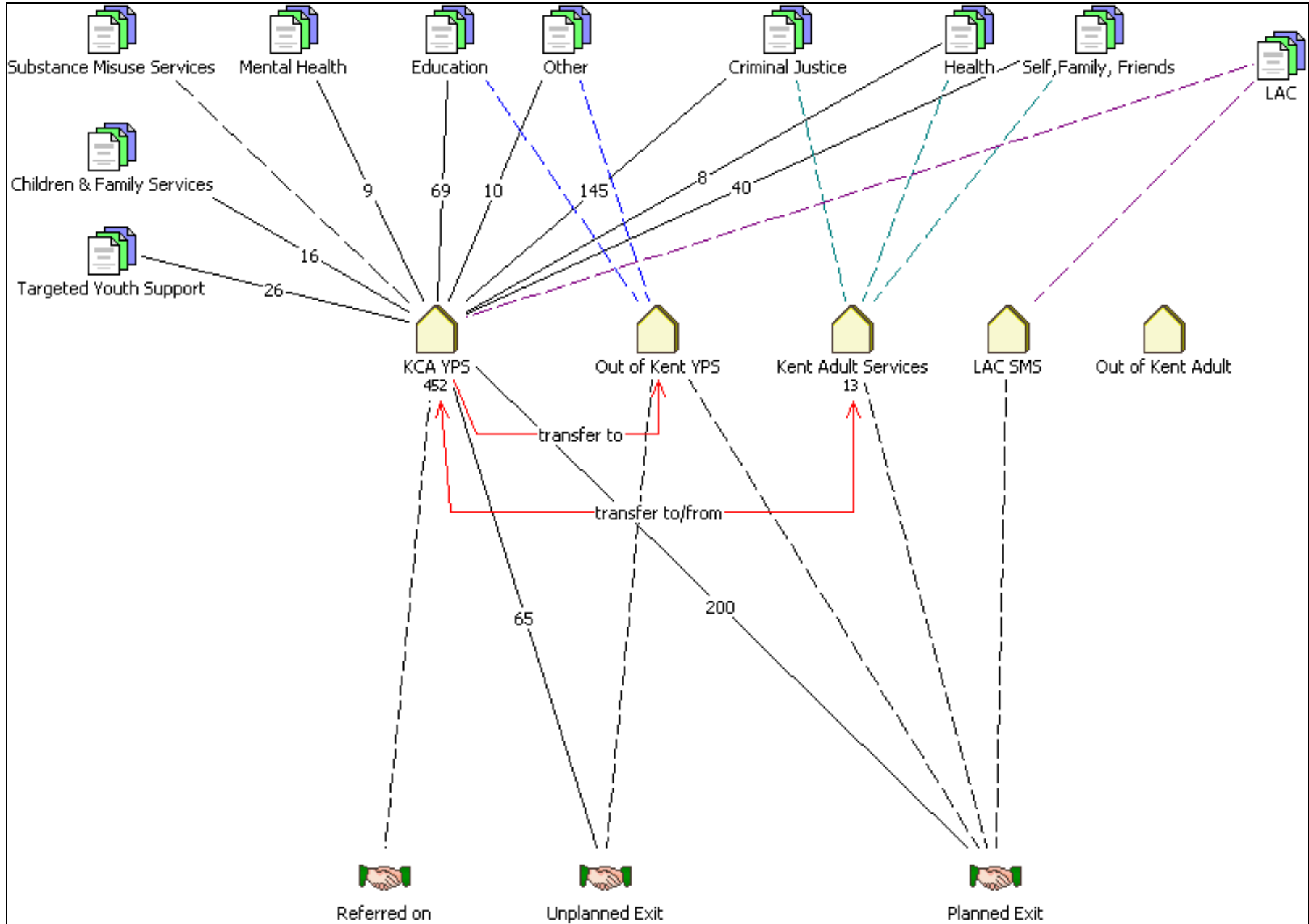
- A higher percentage of unplanned exits were male (69%) compared to the percentage of males with planned exits (53%) and the exits overall (56%). This follows the pattern of the South East although the males with unplanned exits were lower at 65%.
- Across the age groups the majority were planned exits ranging between 65% of the 17 year olds and 100% of the 13 year olds.
- 17 year old clients had the highest percentage of unplanned exits at 33% while being the most prominent age group within unplanned exits (35%). At the South east Level, the highest proportion of unplanned exits were 17 year olds as it is for Kent, but it was the of the 16 year old clients who had the largest percentage of unplanned exits.
- Across the primary substances at triage again the majority were planned exits, the exception being opiates were it was a 50:50 split of planned and unplanned exits, although it is worth noting that this refers to a low number of clients.
- Cannabis was the primary substance at triage for 50% of all exits, but accounted for 57% of the unplanned exits and only 48% of the planned
- Although a low number of those exiting triaged with a current injecting status, all were unplanned exits.

The document below presents a summary of the treatment journeys of Kent young people accessing specialist treatment in 2008/09.

Key to the chart:

- A dotted line or an absence of a number denotes that the number of clients involved was 5 or less;
- The house icon represents a treatment agency and the handshake icon represents treatment exits.
- The red line indicates where there have been inter-agency transfers - all of these involved 5 or less clients.

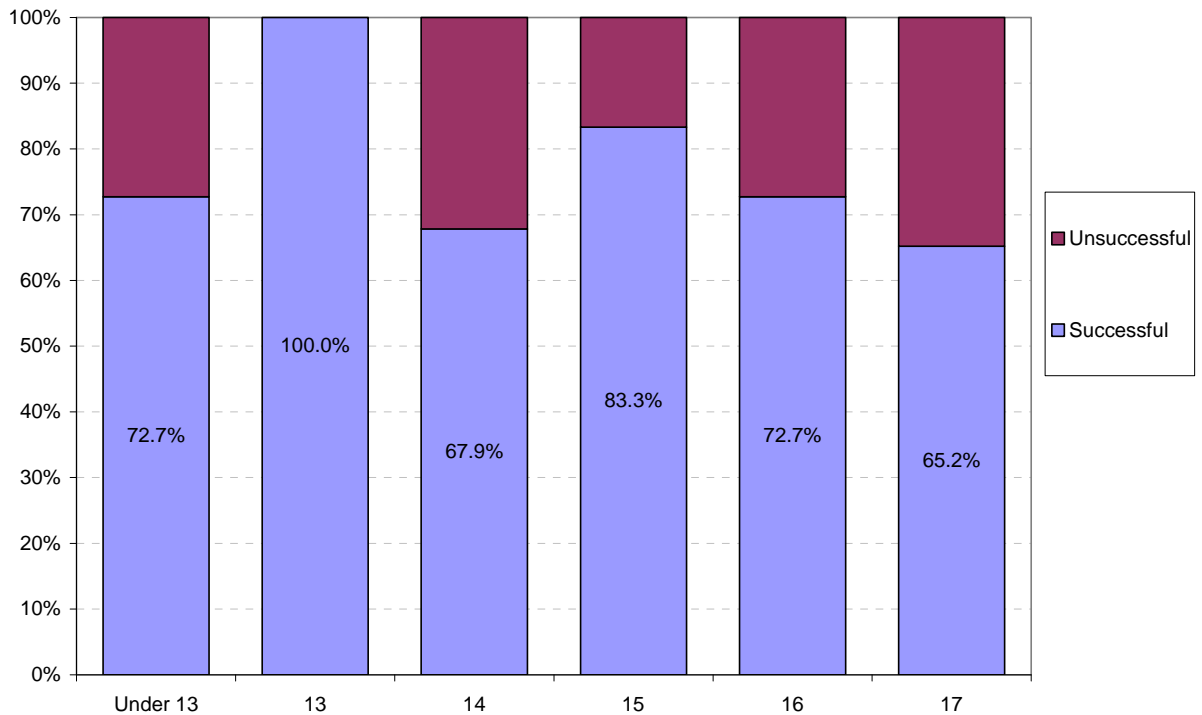
Figure 24: Treatment Map – Young People in specialist treatment 2008/09



## 5.6. Retention and transition

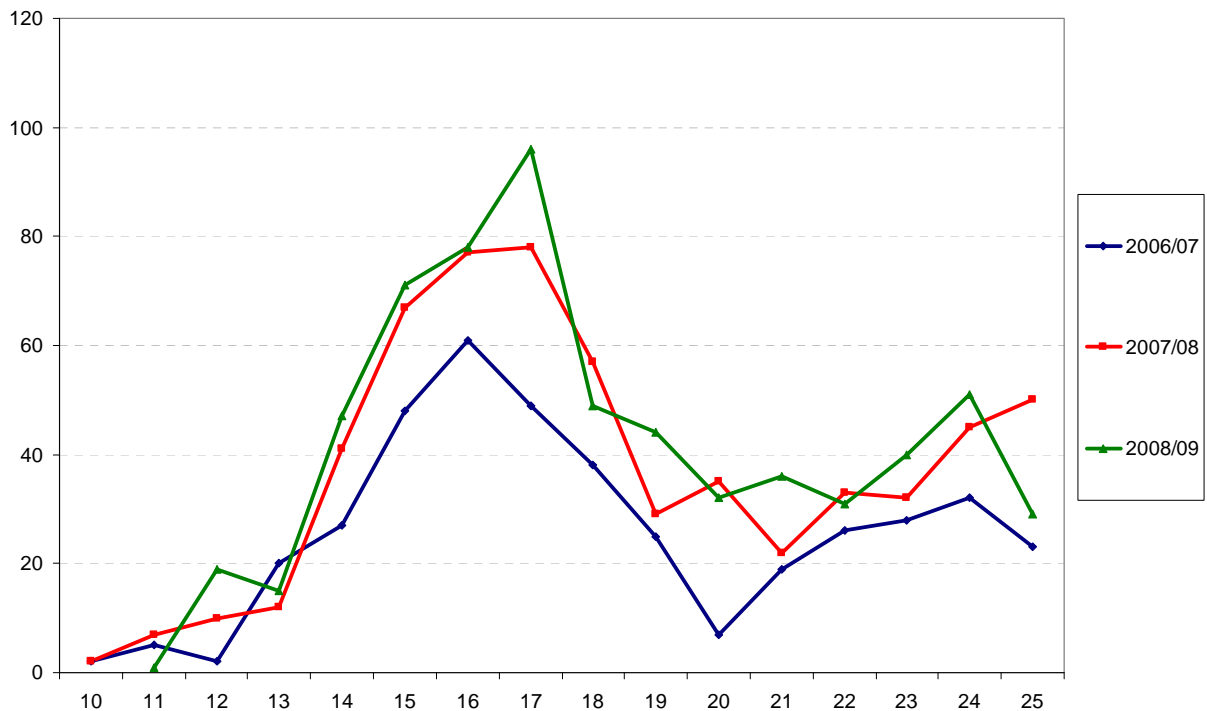
NDTMS data show that older clients were more likely to exit treatment unsuccessfully:

Figure 25: Age profile of successful and unsuccessful treatment exits 2006/07 to 2008/09



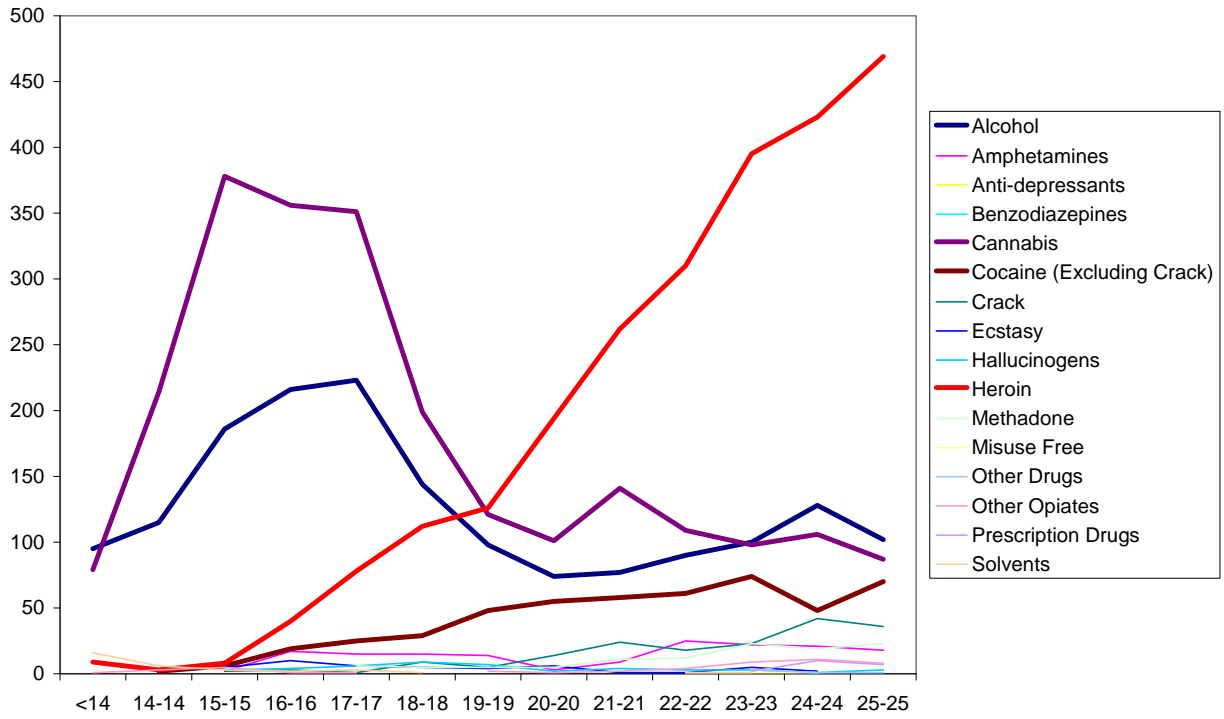
Analysis of the age profile of those in treatment reveals a peak in the number of young people in treatment at 16 and 17. Numbers then reduce between 18 and 21 and begin to rise again by 21.

Figure 26: Age profile of successful and unsuccessful treatment exits 2006/07 to 2008/09



These patterns can be partly explained by the substances that feature most prominently for these different age groups. Figure 19 below provides an age profile of the primary substances for clients under the age of 26 in structured treatment between 2006/07 and 2008/09.

Figure 27: Age profile of successful and unsuccessful treatment exits 2006/07 to 2008/09

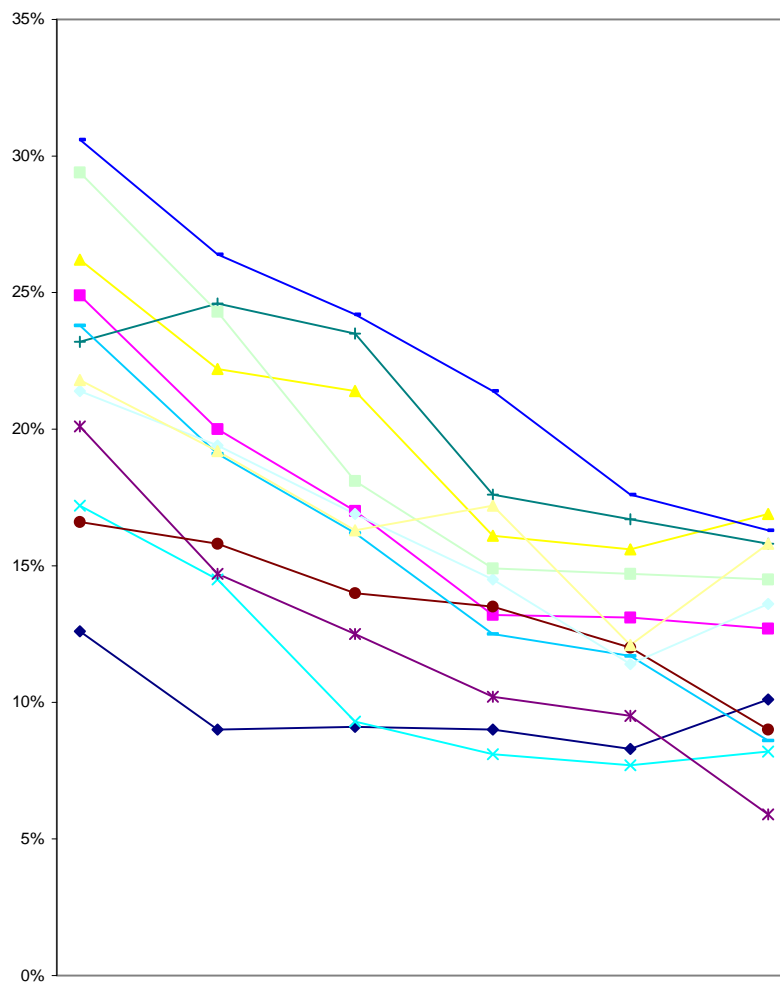


The figures show the Heroin replaces cannabis and alcohol as the primary substance for which they seek treatment for young adults between 18 and 20.

## 6. Communities

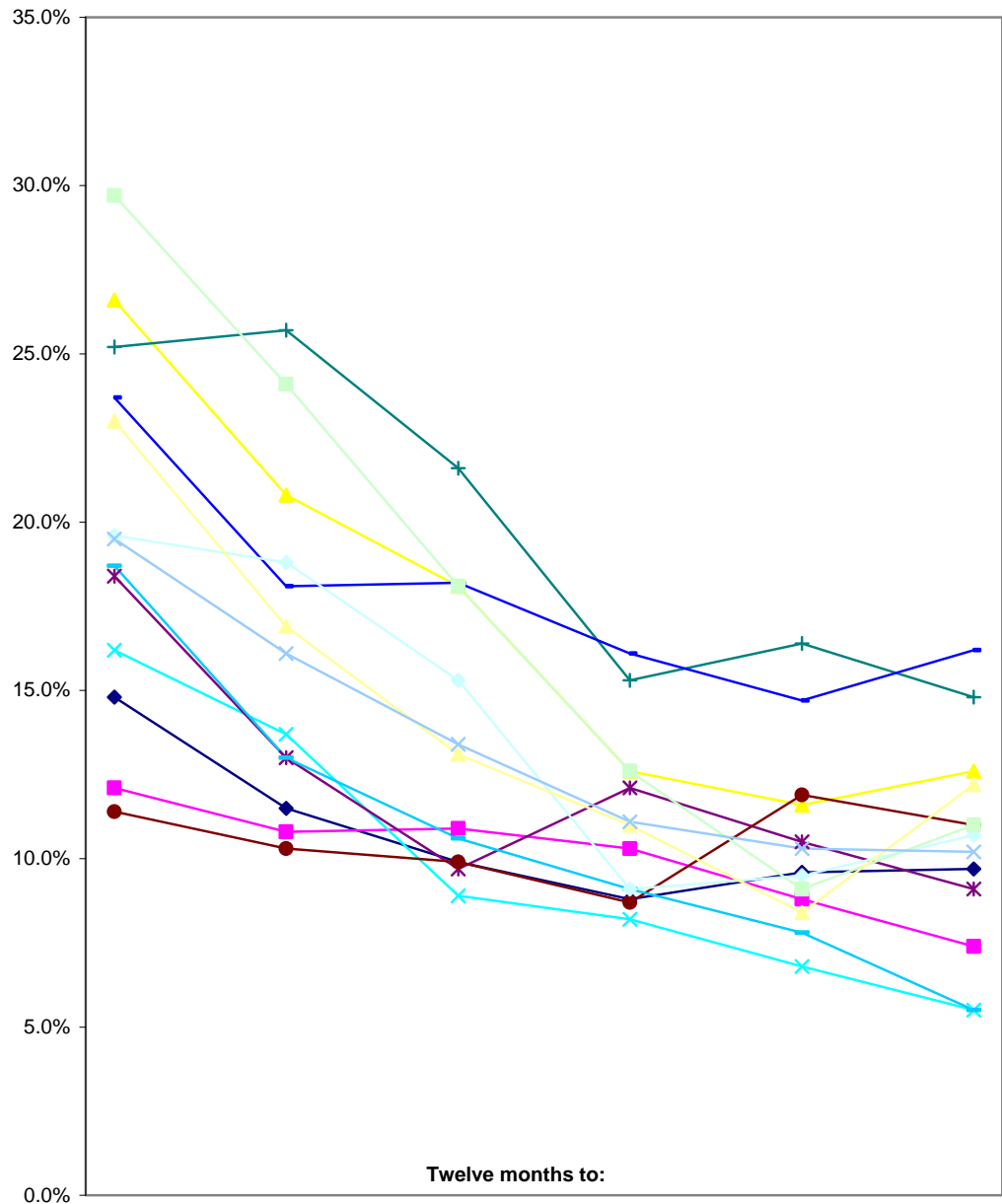
Survey data consistently show that drug and alcohol misuse in local areas is perceived as a problem by local communities within Kent. Recent data collected for the Kent Crime and Victimisation Survey (KCVS) show that that these perceptions have changed over the past twelve months with lower proportions of people viewing drunk and rowdy behaviour or drug use and dealing as a problem in local areas.

Figure 28: % of people who consider drunk and rowdy behaviour in public as a very or fairly big problem in their local area



	Jun-08	Sep-08	Dec-08	Mar-09	Jun-09	Sep-09
◆ Ashford	12.6%	9.0%	9.1%	9.0%	8.3%	10.1%
■ Canterbury	24.9%	20.0%	17.0%	13.2%	13.1%	12.7%
▲ Dover	26.2%	22.2%	21.4%	16.1%	15.6%	16.9%
✕ Maidstone	17.2%	14.5%	9.3%	8.1%	7.7%	8.2%
✱ Sevenoaks	20.1%	14.7%	12.5%	10.2%	9.5%	5.9%
● Shepway	16.6%	15.8%	14.0%	13.5%	12.0%	9.0%
+ Swale	23.2%	24.6%	23.5%	17.6%	16.7%	15.8%
— Thanet	30.6%	26.4%	24.2%	21.4%	17.6%	16.3%
— Tonbridge & Malling	23.8%	19.1%	16.2%	12.5%	11.7%	8.6%
— Tunbridge Wells	21.4%	19.4%	16.9%	14.5%	11.4%	13.6%
■ Dartford	29.4%	24.3%	18.1%	14.9%	14.7%	14.5%
▲ Gravesham	21.8%	19.2%	16.3%	17.2%	12.1%	15.8%

Figure 29: % of people who consider drug use and drug dealing a very or fairly big problem in their local area



	Jun-08	Sep-08	Dec-08	Mar-09	Jun-09	Sep-09
◆ Ashford	14.8%	11.5%	9.9%	8.8%	9.6%	9.7%
■ Canterbury	12.1%	10.8%	10.9%	10.3%	8.8%	7.4%
▲ Dover	26.6%	20.8%	18.1%	12.6%	11.6%	12.6%
✕ Maidstone	16.2%	13.7%	8.9%	8.2%	6.8%	5.5%
✱ Sevenoaks	18.4%	13.0%	9.7%	12.1%	10.5%	9.1%
● Shepway	11.4%	10.3%	9.9%	8.7%	11.9%	11.0%
✚ Swale	25.2%	25.7%	21.6%	15.3%	16.4%	14.8%
◆ Thanet	23.7%	18.1%	18.2%	16.1%	14.7%	16.2%
— Tonbridge & Malling	18.7%	13.0%	10.6%	9.1%	7.8%	5.5%
— Tunbridge Wells	19.6%	18.8%	15.3%	9.1%	9.5%	10.7%
■ Dartford	29.7%	24.1%	18.1%	12.6%	9.1%	11.0%
▲ Gravesham	23.0%	16.9%	13.1%	11.0%	8.4%	12.2%
✕ KCC	19.5%	16.1%	13.4%	11.1%	10.3%	10.2%

Mosaic analysis of the British Crime Survey indicates that the groups that more likely to indicate drug use or drug dealing as a very big problem were:

- **“Families, many single parent, in deprived social housing on the edge of regional centres” (G41)** (218% more than expected nationally) - The largest populations of G41 are resident in Canterbury and Thanet, followed by Swale.
- **“High density social housing, mostly in inner London, with high levels of diversity” (F36)**. 218% more than expected nationally, Very small population in Canterbury with this mosaic group, this may indicate that there has been a very specific problem around these households.
- **“Communities of lowly paid factory workers, many of them of South Asian descent” (D26)**. (208% more than expected nationally) As with the above mosaic group/type, there is only a very small Population in Swale with this mosaic group/type, this may indicate that there has been a very specific problem around these households.
- **“Older tenements of small private flats often occupied by highly disadvantaged individuals” (F40)**. 205% more than expected nationally, only a very small population in Dover with this mosaic group/type, this may indicate that there has been a very specific problem around these households. It is worth noting that there is a higher population in Medway than Dover with this mosaic type/group which may have skewed this indicator.

The Mosaic groups that were more likely to view drugs as the main cause of crime were:

- **“Communities of lowly paid factory workers, many of them of South Asian descent” (D26)** 45% more than expected nationally. A very small population in Swale with this mosaic group, interestingly this is the same group who were 208% more than expected nationally to indicate that drug use or drug dealing as a very big problem.
- **“Singles, childless couples and older people living in high rise social housing” (F38)**. 40% more than expected nationally, present in only a few districts in Kent with the largest number by far appearing in Thanet, with lower numbers in Gravesham and Maidstone.

## 7. Recommendations

Table 12 below summarises the themes that have been identified through the needs assessment process and the resulting recommendations:

Table 12: Themes and Recommendations

Theme	Recommendation
➤ Young people know that drug and alcohol misuse is harmful but need the skills and support to put that understanding into practice	1. Work with partners to ensure comprehensive and effective drug and alcohol education;
➤ Slight downward trend in the proportion of young people drinking regularly but those who do are drinking and 'getting drunk' more	
➤ Young people who feel unhappy and those with poor physical and emotional health are more likely to drink regularly	2. Promote risk and protective paradigm to reduce risk taking behaviour
➤ Young people's substance misuse is a cross cutting theme and should be seen in the context of other risk taking behaviours	
➤ Alcohol related harm for young people varies across the county in terms of frequency and seriousness	3. Enhance understanding of care pathways for alcohol related hospital admissions and put mechanisms in place to ensure early access to brief interventions;
➤ There is good evidence for the delivery of brief interventions when young people have experienced an alcohol related crisis	
➤ Vulnerable young people are more likely to experience problematic substance misuse	4. Support further development of targeted early intervention services that are integrated into locality based children's services
➤ Levels of engagement of vulnerable young people in early intervention varies across the county	
➤ CSMP are one of the highest vulnerable groups referred to specialist community treatment.	5. Build links with parenting and intensive family services services.
	6. Develop links with adult treatment providers to reduce the impact of substance misuse on the family.
➤ Alcohol and cannabis continue to be the most common primary substance of young people in specialist treatment	7. Continue to commission specialist treatment services to meet the needs of young people with problematic substance misuse.
➤ Recent increase in numbers of heroin users in treatment – counter to the national downward trend	8. Undertake additional analysis of ethnicity and biographies of young heroin users
	9. Improve effectiveness and clinical governance around access to pharmacological and needle exchange services

Theme	Recommendation
<ul style="list-style-type: none"> <li>➤ A number of young people in treatment are also involved in taking sexual health risks and some are involved in coercive sexual relations in exchange for drugs</li> </ul>	10. Build treatment workers understanding of working around sex and sexuality and review relevant DCSF guidance
<ul style="list-style-type: none"> <li>➤ Some young people are making themselves sexually vulnerable through use of the internet and social networking sites</li> </ul>	
<ul style="list-style-type: none"> <li>➤ Training about 'e-safety' would be valuable across all children's services including drug and alcohol services</li> </ul>	11. Review the feasibility of commissioning 'e-safety' training for children's services workers
<ul style="list-style-type: none"> <li>➤ Vulnerable young people are more likely to experience problematic substance misuse</li> </ul>	12. Work to increase access from children's social services, CAMHS and GPs
<ul style="list-style-type: none"> <li>➤ Levels of engagement of vulnerable young people in specialist treatment varies across the county.</li> </ul>	13. Focus on developments in localities
	14. Ensure effective transitions for young people who are alcohol using.
<ul style="list-style-type: none"> <li>➤ Family Based Interventions: Think Family</li> </ul>	15. Build link between young people's services and developing family based services
	16. Implement ContactPoint across relevant agencies