

## **Joint Strategic needs Assessment for Substance Misuse Services in Nottinghamshire (2013)**

This Joint Strategic Needs Assessment contributes to identifying need and quality service delivery of substance misuse services to young people in the Nottinghamshire County Council. This report contributes to the identification of strategic need for planning, in line with the JSNA for Commissioners, and within the time-frame of delivering drafts plans and latest needs assessment by March 2013.

A joint strategic needs assessment (JSNA) analyses health needs of populations to inform and guide commissioning of health, well-being and social care services within a local authority area. Producing an annual JSNA has been a statutory requirement for the NHS and local authorities since 2007. The Health and Social Care Bill 2011 proposes a central role for JSNAs so that health and well-being board partners jointly analyse current and future health needs of populations.

Local authority-based public health will become responsible for commissioning drug and alcohol prevention, treatment and linked recovery support in April 2013.

This Needs Assessment focuses on drug and alcohol use by children and young people within Nottinghamshire and the impact of parent/carer use on children and young people. The purpose is to identify the level of need within the population and review the effectiveness of current services with a view to making recommendations to inform strategy and commissioning decisions for 2012/13.

## Executive Summary

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Structure of the JSNA

Domain: Demography for Substance Misuse

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## **Strategic Summary**

### **Outline of Key Findings**

#### **Identification of key priorities for the partnership for year or longer**

- 1. Overall direction and purpose of the local partnership strategy for drug and alcohol treatment**
- 2. The likely demand for open-access, abstinence-based, harm reduction interventions and other structured drug and alcohol treatment interventions and alcohol brief interventions**
- 3. The likely demand for in-patient and residential services**

#### **4. The key findings of the current needs assessment**

#### **5. Improvements to be made in outcomes**

#### **6. Key priorities for developing reintegration opportunities for those in drug and alcohol treatment (including access to accommodation, education and employment)**

#### **7. Advances in integrating local treatment services with peer-led mutual aid and other community assets; and establishing local recovery communities**

#### **8. Arrangements for commissioning fully integrated, recovery focused substance misuse provision in prisons (where relevant)**

#### **9. Robust continuity of care arrangements for service users moving between custody and community settings.**

#### **Domain: Demographic.**

#### **Profile of Nottinghamshire**

#### **Profile of Substance Misuse Amongst young people.**

#### **Domain: Policy.**

## **1. National Picture**

### **Context**

Although treatment services across the NHS, private and voluntary sectors, offer combined service provision for drugs and alcohol misuse, strategies to tackle these substance misuses have utilised different approaches. The threat of HIV and rising drug related crime rates prompted the Government in 1998 to consider a 10 year strategy to combat drug misuse, which focused on containment of the problem and measures to prevent the spread of HIV. The problem of increasing levels of alcohol misuse in the UK has emerged over more recent years with the publication of the Alcohol Harm Reduction Strategy for England (PMSU, 2004). Drug and alcohol misuse present differing challenges to the NHS although it is recognised that co-morbidity exists between the two substances.

### **Drug Misuse**

There are approximately 330,000 problem drug users in England (UK) and societal costs attributed to drug use are estimated at £15 billion a year, of which £13.9 billion is due to drug-related crime (House of Commons Committee of Public Accounts, 2010). In 1998, the British Government through the Home Office introduced a 10-year strategy to tackle problem drug use and central and local government have collectively spent £1.2 billion a year over the last decade to deliver the measures set out in the strategy (Department of Health, 1998; Commons Committee of Public Accounts, 2010). This strategy included the funding of treatment services that aimed to 'reduce drug users' offending, to improve their health and to reintegrate them into society' (House of Commons Committee of Public Accounts, 2010:1). There is some evidence to suggest the investment has delivered benefits to society. Drug users engaging in treatment has increased from 85,000 in 1998 to 195,000 in 2006/07; drug-related crime

has reduced by 20% since 2003 and the sharp increases in drug-related deaths identified in the 1990s have been curtailed (DOH, 2008).

Despite the significant investment in drug misuse, The Commons Public Accounts Committee (2010:1) suggested that the Home Office 'does not know how to effectively tackle problem drug use', has not undertaken evaluation of the measures in the strategy and does not know the overall effect of the investment in reducing problem drug use and associated crimes. A new 'Drug Strategy 2010' (DOH, 2010) was introduced, which puts recovery at the heart of its approach by re-focusing away from conventional treatment approaches and onto an approach that reduces demand, restricts the supply of drugs, focuses on building recovery and promoting abstinence. The new strategy also seeks to establish treatment services that are outcome focused and reflective of research, which ascertains 'what works' and which shares best practice (DOH, 2010).

### **Alcohol Misuse**

Alcohol consumption now represents an increasing public health challenge. Statistics on drinking in the UK suggest that 26% of the population, 8.2 million people in England, have an alcohol use disorder (DOH, 2005) with deaths from alcohol having doubled from 4,144 in 1991 to 8,386 in 2005 (DOH, 2006). Alcohol misuse is estimated to cost the NHS £2.7 billion per annum (DOH, 2008) with alcohol related hospital admissions now representing 7% of all admissions and rising at around 11% a year. Like drugs misuse, alcohol misuse contributes to crime, disorder and destruction of family life.

In the past seven years the Government has published two alcohol strategies. In 2004, the Alcohol Harm Reduction Strategy for England (PMSU, 2004) outlined a series of initiatives to tackle drinking primarily based around communication of excess alcohol consumption. A follow up publication, Safe, Sensible, Social-Next Steps in the National Alcohol Strategy (DOH, 2007) has produced a sharper focus on tackling alcohol consumption with public information campaigns, consultation on alcohol pricing and promotion and local initiatives to tackle alcohol related crime. Other information based campaigns such as the Alcohol Effects (DOH, 2009) have focused on hard hitting information and alcohol labelling. Other initiatives include communication to GPs to offer early interventions.

Although these strategies go further in defining alcohol as part of the new public health agenda, there is the view that it has side-lined the need and demand for alcohol treatment as it suggests that many harmful and dependent drinkers are unable to modify their drinking levels without the need for professional treatment (Alcohol Concern, 2007). The recent Government Drug Strategy 2010 (DOH, 2010) has also identified recovery as the new objective for alcohol dependency as this approach is perceived as a way of reducing costs of approximately £1.6 billion per year in benefits expenditure, which is additional to costs to the NHS, cost of crime, public disorder and general society from drugs and alcohol misuse.

### **Substance Misuse Treatment Services**

Unlike many medical conditions the treatment pathways for problem drug and alcohol misuse are not clear. For drugs treatment, patients can enter into treatment through numerous channels; GPs, A&E admissions, self-referral to specialist services such as the John Storer Clinic (JSC) in Nottingham, voluntary organisations such as the Alcohol Problems Advisory Service (APAS) and through the criminal justice system. There are a number of drug awareness campaigns such as FRANK aimed at young drug users and school programmes such as DARE (Drug Abuse Resistance Education). The co-ordination between services is not always apparent and continuity of care is an issue (National Mental Health Development Unit, 2011). The number of service providers inevitably produces

competition for funding rather than collaboration and service provision can appear disparate and unwieldy to navigate.

There are 1.1 million problem drinkers in England and Wales who may need specialist treatment but a study to assess national alcohol needs for England and Wales concluded that there was a 'large gap between the need for alcohol treatment and actual access to treatment'. (DOH, 2005:11). Only 5.6% of problem drinkers currently access specialist alcohol treatment and there is consensus that needs are not being met (DOH, 2005). Only one person in 18 who needs help for problem drinking receives it and only a third of all problem drinkers referred for specialist treatment actually access the service (Day, 2006). A study looking at the effectiveness of alcohol treatment (Raistrick, et al., 2006:9) suggests that 'treatment effectiveness may be as much about how treatment is delivered'.

The East Midlands caters for 1 in 16 seeking treatment for problem drinking, which is ahead of the national average. There are around 23 alcohol treatment services in Nottingham but their approaches can differ and services often compete rather than complement one another reflecting differences in treatment philosophy and competition for funding (Resnick and Griffiths 2011; Resnick and Griffiths 2009, 2009a).

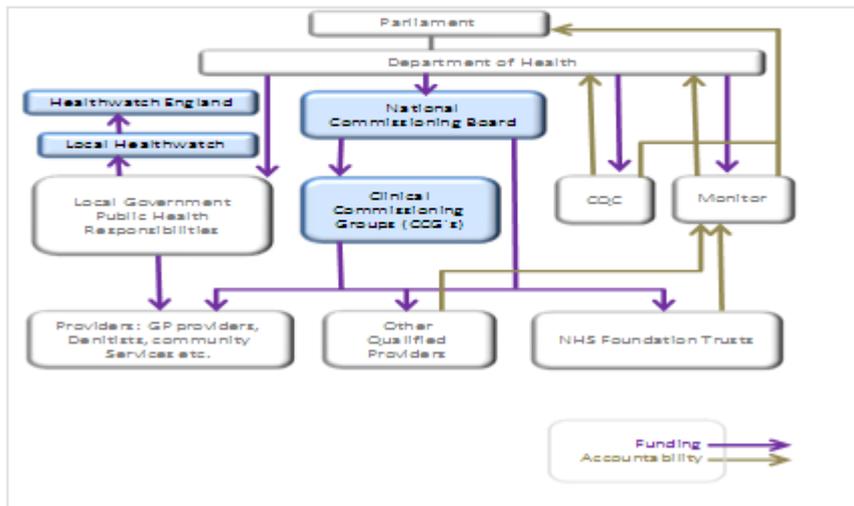
### **Public Health Structure**

As indicated in the new public health structure this JSNA is focused on local activity on alcohol and drug misuse services for young people. The Public health structure suggests the Substance Misuse Team is mainly funded out of the Pooled Treatment Budget (PTB) which comes from the National Treatment Agency for Substance Misuse (which will be subsumed within Public Health England under the current reforms) and not the PCTs. The team are currently hosted within the PH Directorate on behalf of all partners (NHS, LAs, Police, Probation, Fire and Rescue) who have agreed that the team will move to Notts CC as part of the restructured PH directorate in parallel with the NHS reforms). The pooled treatment budget of £313 000.

The transition in the NHS organisational landscape is represented in the following:



## Proposed NHS organisational landscape April 2013



### Health, the NHS Reforms and Health and Wellbeing Board Health - the new landscape

#### Commissioning

- Local and General
- **Public Health**
- Specialized
- Mental Health

#### Education Innovation and Improvement

- Deaneries
- Local Education and Training Boards
- Academic Health Science Networks
- NHS Improvement and Innovation Trust

#### Delivery

- Acute and Secondary
- Primary
- Mental Health
- Community Services
- Dental, Opticians et al

#### Governance and Scrutiny

- NHS Commissioning Board Regional and Local Teams.
- Clinical Senates
- Local Authorities Overview and Scrutiny
- Healthwatch

## Key Tipping Points or Developmental Breakthroughs in national policy gradually based upon Public Service Theory

- The requirement to achieve Best Value, facilitate continuous improvement and encourage collaborative working (1998 Crime and Disorder Act, 1999 Health Act and 1999 Local Government Act)
- Comprehensive Performance Assessments, and Standards for Better Health; the inclusion of the Health “block” in LAA pilots (2003) and the Duty to Cooperate in Community Strategies and LAAs (2007 Act).
- Increasing awareness of public health issues, recognition of the World Health Organisation “social” or “wider” determinants of health and the health inequalities agenda (2005 onwards).
- The 2008 Quality, Innovation, Productivity and Prevention (QIPP) programme issued by Department of Health to the NHS and the Nicholson Challenge in 2010.
- The Health and Social Care Act 2012 NHS reform and Public Health England.

This changed landscape of public services has been driven by legislative change and a progressive and keen desire by Nottingham and Nottinghamshire practice.

Both are “**Building not Re-inventing**”, complimenting their early adoption of the need for action.

Built upon strong relationships developed between PCTs and LAs in previous LSPs with robust challenge and scrutiny (accountability) allied to mutual respect and individual and collective acceptance of responsibility.

Committed to re-iterative, web based, detailed, substantial and growing evidence bases built around the JSNAs but with open access and multi-agency “ownership”. Both areas had historically strong recognition and commitment to acknowledging and addressing the wider determinants of health, and have been particularly strong mutual collaborators since the two PCTs were “clustered” with one Board and one Executive team.

The conclusions from this reordering comes from :

The transfer of responsibility for Public Health and Health and Wellbeing is actually progressing satisfactorily in the case study areas. It is becoming theoretically coherent and pragmatically progressed “on the ground”.

Both individual and collaborative organisational infrastructures are in place or are being developed, although this is being achieved in a less supportive environment than previously existed under Community Strategies/CAA/LAA.

This challenge has been exacerbated by the loss of AC, IDeA, and related improvement and innovation infrastructure which has resulted in a significant loss of advocacy, advice, capacity and guidance. **The reordering of these arrangements will need a period of ‘bedding in’ and the emergent priorities in leadership, scrutiny and opportunities assessed.**

Despite these challenges the service provision if focused on improvements in service quality issues. Zeithaml et al. (1990, p. 19) defined service quality as the “discrepancy between customers’ expectations or desires and their perceptions”. Service quality can also be conceptualised as an evaluation or an attitude about a service and “closes the loop between evaluation and the choice process” (Bateson 1995: 558). Evaluating healthcare services can be difficult and

the literature suggests that in professional services, customers have “fuzzy” expectations about what they expect from service providers, and are often unsure whether services have met their expectations (Ojasalo, 2001).

## **2. Domain: Literature.**

### **Young Peoples' Consumption and Substance Misuse**

Mapping consumption patterns and identifying cross-cultural comparisons reveals critical patterns in young peoples' substance misuse. It demonstrates that consumption and problems are shaped by forces greater than the relationship between the substance and the individual. Young people's consumption occurs within a wider context of dynamic historical and cultural forces (Harris 2013: vix). Placing young people's drug and alcohol consumption in the context of dynamic historical and cultural force opens up new terrain in understanding the process of intoxication and subsequent behaviours. It also offers critical insight into approaches that hope to ameliorate these problems. Substance misuse does not simply occur at random points in a young person's life but operates at key moments within the life course (Harris 2013).

The majority of diagnostic criteria have been developed to identify the needs of those adults who have gravitated to the severest level of problematic consumption. Young peoples' consumption has not always reached this stage and is seldom a linear process. Harris (2013) suggests 'adult criteria represents a poor fit' for young people who are under or over diagnosed in problematic use. Challenging these taken for granted assumptions built into substance misuse services suggests alternative frameworks for assessment and care planning to meet young peoples' needs and enhancing their treatment outcomes. Adopting an historical vantage point Harris (2013) uncovers many of the myths and assumptions in preventative models in substance misuse, whilst retaining the value of prevention and education in providing 'up-stream' benefits from the point of delivery where modest gains at delivery result in disproportionately larger gains over time.

Addressing the impact of treatment on young people, Harris (2013) suggests the central driver for positive outcomes is the 'working alliance between the practitioner and young person'. Harris (2013) also suggests critical elements necessary for a comprehensive treatment framework and specific modalities that are effective. The role of the family in supporting young people and the neglected area of aftercare is also discussed. Harris (2013) suggests treatment systems are developed that are based on political agendas rather than the clinical needs of those they try to help; and because evolving treatment systems that do not account for the specific needs of the people within them will always end in failure. It is a call for commissioners to orientate their approaches towards what is possible with young people, in what time frames, and to how best to assess the effectiveness of the services that they procure.

The use of substance is a unique phenomenon for individuals taking substances and every individual's use is derived from a complex range of factors. Recent literature on substance misuse focuses on drugs policy and substance misuse handbooks for practitioners (Babor 2010; Barlow 2010; Emmet 2006; Grahame-Smith 1995, Rassool 2009). Examinations of substance misuse stretch from national audits (Institute for the Study of Drug Dependence 1992; Youth Justice Board for England and Wales 2003), psychological determinants (Kassel 2010) to practice (Miller 2007). Children and Young People's experience of substance misuse is discussed by Crome (2004), their needs (Cleaver 2011), the secret of growing up with parental misuse (Harbin and Murphy 2006) and hearing their 'voice' (Gorin 2004). Parental substance misuse (Forrester 2012; Forrester and Harwin 2011; Sawyer 2012) and its possible implication for safeguarding (Cleaver 2007; Kroll 2003; Philips 2004; Sloane 1998) and the symptoms and signs of misuse (Stark 2003) are also discussed.

Crome (2001) conclusions from reviewing the literature on dual diagnosis in the last 10 years suggests that comorbidity is a heterogeneous condition, with unexplored areas around prevalence, course and treatment outcome. The models used (such as explanatory and prevalence) are not unified and provide a competing picture depending on substance, geography, symptoms and settings. The terminology is contested (comorbidity, dual-diagnosis, co-occurrence, polysubstance). 'The assessment process, including a comprehensive history is the best foundation for best treatment' (Crome 2001: 55) with abstinence as the difficult if not unachievable outcome. Screening instruments and tools are constantly evolving. Staff attitudes, can be negative particularly from a medical setting. Major psychiatric disorders (bipolar affective disorder, schizophrenia, personality disorder and post-traumatic stress disorder) and groups (women, children, violence and suicide) all have received attention (Crome 2001).

Although extensive work has been done on substance misuse the picture emerging from the literature present a less than transparent landscape. **Further systematic reviews of substance misuse literature would enhance the national and local picture, and the various stakeholders involved in substance misuse.**

### 3. Joint Strategic Needs Assessment.

#### Lifestyle and Risk Factors

#### The National Treatment Agency has reported a fall in

Paul Hayes, Chief Executive of the NTA said: "The NTA is handing over to PHE and local authorities a world class drug treatment system, with rapid access to evidence-based interventions and increasing rates of recovery. Since 2006, 104,879 people have been helped to overcome their drug dependency. The benefits have spread far beyond the individuals themselves, to their families, their communities and the wider economy.

"The drug treatment system in England has delivered on all these fronts and the investment, which has been continued by the Coalition Government, has paid off. The new public health landscape presents both opportunities and challenges. Local authorities are well placed to bring together all the support people need to help them recover from addiction, including access to housing, employment and social networks. However the strong recovery ambition called for in the Government's 2010 Drug Strategy, and the investment in treatment, must be maintained if we are to consolidate and build on the gains we have made." (NTA Press Release 2013).

Period	2004-05	2005-06	2006-07	2007-08	2008-09	2009-10	2010-11
Estimate	327,466	332,090	328,767	N/A	321,229	306,150	298,752

What this fall in the numbers using 'hard' drugs New form of synthetic drugs, most of them stimulants, are peddled as 'bath salts' or "spice" concoctions ... has irrevocably changed the face of international drug dealing and the rise of synthetic drugs like M/Cat represent a shift in drug use.

All young people are potentially at risk of misusing alcohol and or drugs. However, evidence suggests that young people in certain vulnerable groups are more at risk of misusing substances. *Every Child Matters* (DoE, HO and DoH 2005) identified the following groups:

- Children affected by parental drug use; the Hidden Harm Report in 2003 by the Advisory Council on the Misuse of Drugs estimates that there are between 250,000 and 350,000 children in England and Wales who have a parent with a problematic drug problem. It is widely accepted that this is an underestimate.
- Persistent Truants and school excluses; Evidence tells us that children who fall into this category are much more likely to be involved with substances and so suitable provision should be put in place to support this cohort.
- Looked after children; are four times more likely to use substances than children raised in a household (DoH 2007)
- Young people in contact with the criminal justice system; Evidence tells us that this cohort report more substance use than any other vulnerable group.
- Other groups: homeless, involved in prostitution, teenage mothers and those not in education, employment or training; All of these and the above groups are potentially all linked with other factors, such as living within the most deprived communities also being a factor.

Children may be affected by any number of these vulnerabilities and so this will likely increase their risk. Clinical experience suggests a considerable overlap in these factors in the individual case. Professionals working in substance misuse services have an unrivalled opportunity to intervene in the developmental trajectory of these children at risk and play a significant role in the early identification and treatment of substance misuse (NTASM 2008).

### **The National Picture for Young Peoples' Substance Misuse**

- 1 The number of under-18s accessing specialist services for substance misuse in England fell to 20,688 (down from 21,955 last year).
- 2 Those treated for primary use of Class A drugs (heroin, cocaine, crack and ecstasy) fell again, to 631, and has dropped by two-thirds since 2006-07
- 3 Alcohol and cannabis remain the main substances for which under-18s access specialist services
- 4 More young people than ever are leaving having completed their programme successfully – the percentage has reached 77% (NTASM 2011: 2).

National findings from Smoking, Drinking and Drug Use among young people in 2011 from school surveys. This survey suggests:

- There has been a decline in drug use among 11 to 15 year olds since 2001
- Cannabis is the most commonly used drug by 11 to 15 year olds
- Most pupils who take drugs do so infrequently
- The prevalence of smoking among 11 to 15 year olds is at the lowest level since the survey began
- The prevalence of regular smoking has also declined
- The proportion of pupils who have ever drunk alcohol has declined over time

### **Nottinghamshire Picture.**

Nottinghamshire's Children and Young Peoples' Partnership Plan has a vision to 'work together to provide integrated services for all children and young people in Nottinghamshire to improve their life chances and to help them maximise their potential'. In order to realise this vision Nottinghamshire is a two-tier authority with seven district or borough councils, as well as the County Council. There are Local Strategic Partnerships (LSP) groups in each of the districts or boroughs.

Nottinghamshire County Council, Bassetlaw PCT and NHS Nottinghamshire County have also developed a Joint Commissioning Framework (JCF), responding to the 2008 Joint Strategic Needs Assessment (JSNA) to meet five aspirations of: reducing teenage pregnancy, reducing obesity, improving mental health and well-being, improving services for children and young people with additional needs, and reducing the negative impact of substance use and smoking on young children. The Local Area Agreement (LAA) and Joint Commissioning framework have unified priorities in improving the emotional well-being of children, young people and families, and to reduce the problems caused by drugs and alcohol for children, young people and families and communities.

The Mid Year population estimates 2010 published by the Population Estimates Unit, ONS: Crown Copyright, are now available and show:

<b>District</b>	<b>Mid 2009</b>	<b>Mid 2010</b>
Ashfield	116,400	117,000
Bassetlaw	111,600	111,800
Broxtowe	111,500	111,800
Gedling	112,700	113,200
Mansfield	99,700	99,600
Newark and Sherwood	113,000	113,600
Rushcliffe	111,700	112,800
Nottinghamshire	776,600	779,900
Nottingham	300,800	306,700

Of this population Young people from number 0-17 yrs 162,303 (NCC 2012).

### **Include Nottinghamshire YP and JSNA Commissioners**

#### **Nottinghamshire County Council Public Health Profile.**

<http://www.nottinghaminsight.org.uk/insight/jsna/jsna-public-health-outcomes.aspx>

## **Review of Substance Misuse Services.**

The contract between Nottinghamshire county Council and Nottingham Trent University is to provide analytical support to substance misuse services. This requires quarterly reporting. This report is the evaluation for the first and second quarter of the Substance Misuse project, located within Nottinghamshire County Council sites in the East Midlands. The report includes data from the quarterly reporting cycles for 2010 – 2011 and quarterly reporting 3, 2 and 1 of 2011. The parameters of the data used to inform the report are the time scale of 2010-2011, the geographical area of Nottinghamshire (E06B) and the two identified service providers Face It (National Treatment Agency for Substance Misuse (NTASM) Agency code T0336) and Head 2 Head (NTASM Agency code T0399).

Quarterly reports will be provided to Commissioners and service providers to:

- Assist in the understanding and interpretation of the data provided by the National Treatment Agency for substance misuse;
- Locate this within the context of national data where available;
- Promote a participatory approach to service development and improvement.

Nottinghamshire Targeted Support and Youth Justice Service (TS&YJ) are providers and commissioners of services for vulnerable children and young people. Nottingham Trent University is independent of the substance misuse service delivery sector and will thus provide analytical products and accompanying support. This will enable the successful performance management of the currently commissioned providers and to ensure that information is available to drive service improvements and to plan future care provision.

Each quarterly report will provide information to understand:

- Pathways into care and treatment
- What happens to young people during care and treatment
- Exit and referral routes

By understanding the pathway and the issues that arise with the data at each stage improvements can be made in respect of:

- Data recording and monitoring to provide more meaningful information
- Improvements in networks with other services
- Improvements in the quality and timeliness of interventions
- Comparisons of Nottinghamshire's data with the national picture

The parameters of the report are provided by the time-line and data sources. The time-line is for 2010-2011 data from the National Treatment Agency for Substance Misuse and Quarterly performance reports on the National Treatment Data Monitoring System. These reports are for service providers, residency and all activity. Qualitative data is provided by minutes from Targeted Support and Youth Justice meetings, and meetings with service providers Face It and Head 2 Head. Future analysis is developed via focus groups and interviews with service users.

Key issues identified with the analysis of the data will be reported back to the service providers and commissioner to inform the future development of the project. Recommendations will be reported as they emerge from the key information sets (KIS). The following section discusses access to services. Recommendations will be highlighted as they emerge from the presentation of the data and summarised at the end of the report.

### **Specialist Substance Misuse Treatment System.**

#### **1. Pathways into Care and treatment Access to Services**

This section examines pathways into care and access to services to provide a picture of the scale of services provided and number of individuals in treatment. The most current figures are presented first with comparisons available from 2010.

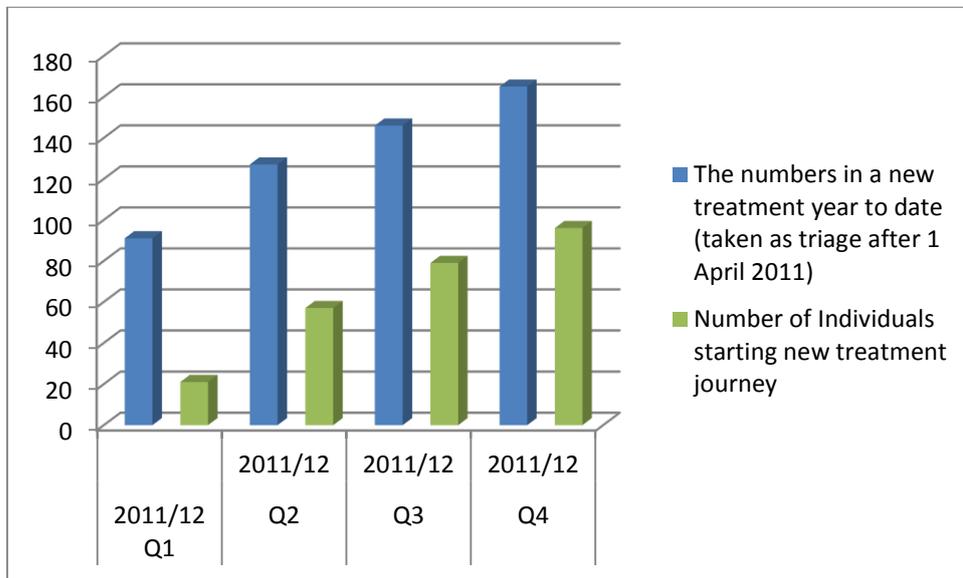
**2011**

The National Drug Treatment Monitoring Service provide figures for Quarter 1,2, 3 and 4 for 2011-12.

**Table 1. Access to Services Head 2 Head 2011**

	Q1 2011/12	Q2 2011/12	Q3 2011/12	Q4 2011/12
The numbers in a new treatment year to date (taken as triage after 1 April 2011)	91	127	146	165
Number of Individuals starting new treatment journey	21	57	79	96

**Figure 1. Access to Services Head 2 Head 2011**



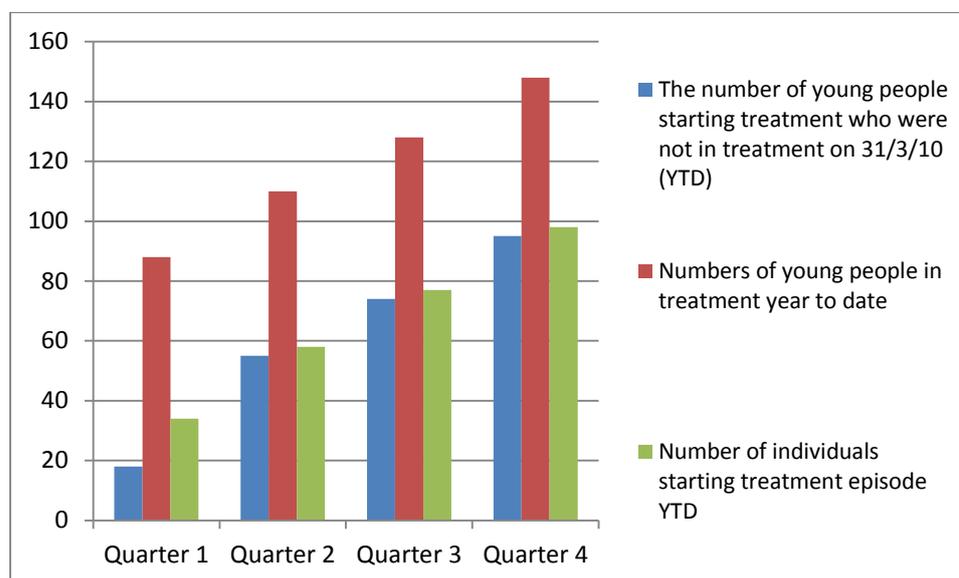
Head to Head have 165 individuals accessing treatment in the last Quarter 4 of 2011. This is comparable to 150 for the same period in 2010/11. This represents a 10% increase in access from 2010 to 2011.

**Table 2. Head 2 Head T0399 for 2010**

	Quarter 1	Quarter 2	Quarter 3	Quarter 4
The number of young people starting treatment who were not in treatment on 31/3/10 (YTD)	18	55	74	95
Numbers of young people in treatment year to date	88	110	128	148

Number of individuals starting treatment episode YTD	34	58	77	98
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**Figure 2. Head 2 Head T0399 for 2010**



Head 2 Head had 150 individuals accessing treatment in 2010.

These figures are from quarterly reports for 2010/11 from service providers to the National Treatment Agency for Substance Misuse. The figures show suggest a cumulative increase across the quarters.

The first report identified questions/ anomalies that need to be addressed. These were:

- New presentations and performance dates are the same for all 4 reporting periods but numbers are different
- In treatment year to date figure suggests cumulative total
- New treatment episode is not broken down into young people new to treatment and those who are re-entering treatment
- The titles of the data spreadsheets are misnamed (e.g. Q3 and Q4 all are labelled 'Q1').
- The data needs to be clearly comparable between 'residence' reports and 'all activity' reports.

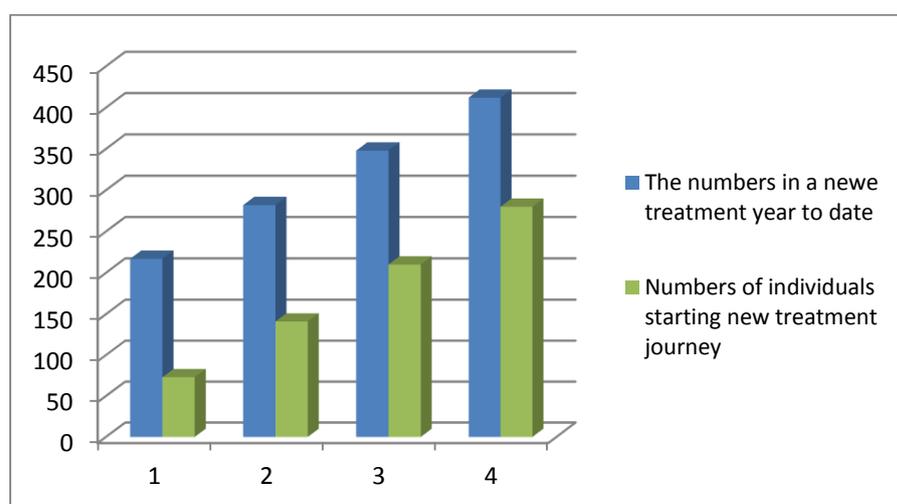
To address these questions and anomalies the National Drug Treatment Monitoring Data System data for 2010 and 2011 were used. This added a level of standardised to data to analyse and demonstrates different and cumulative presentations to treatment for the different quarters. The 'new treatment' episodes remain opaque as young people new to treatment are not differentiated from those who are re-entering treatment. Using this standardised NDTMS has also addressed the issues of data being misnamed. The comparison between 'residence' reports and 'all activity' reports still produces different figures but adopting the 'all activity' reports have provided a consistency in data that allows comparison between and within the service.

An identical process has been adopted for Face It (which has been re-named the 'Young People Targeted Support Service').

**Table 3. Access to Services Face It 2011**

	Q1 2011/12	Q2 2011/12	Q3 2011/12	Q4 2011/12
The numbers in a new treatment year to date (taken as triage after 1 April 2011)	217	282	348	412
Number of Individuals starting new treatment journey	73	141	210	280

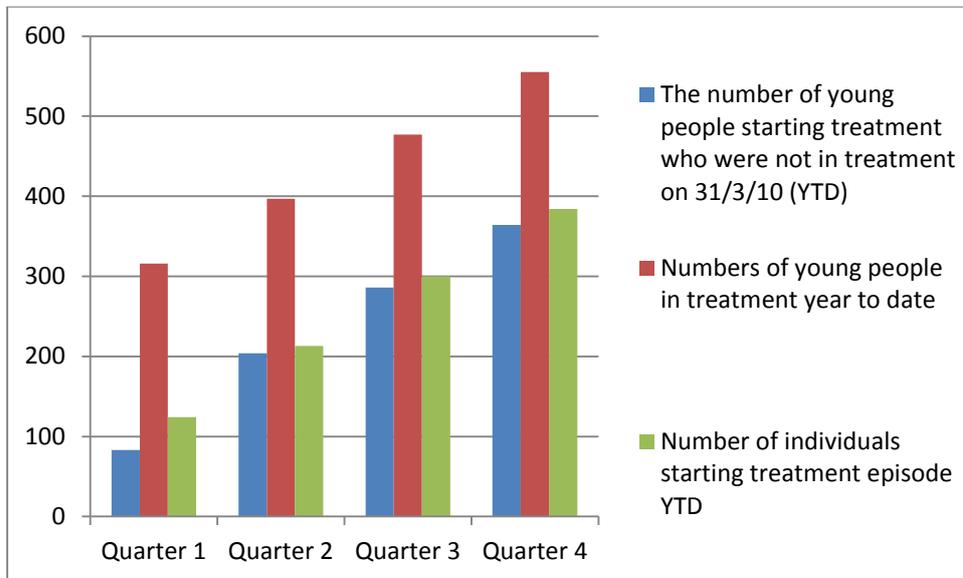
**Figure 3. Access to Services Face It 2011**



**Table 4. Face It T0399 for 2010**

	Quarter 1	Quarter 2	Quarter 3	Quarter 4
The number of young people starting treatment who were not in treatment on 31/3/10 (YTD)	83	204	286	364
Numbers of young people in treatment year to date	316	397	477	555
Number of individuals starting treatment episode YTD	124	213	300	384

**Figure 4. Face It T0399 for 2010**



Face it have 555 individuals accessing treatment in 2010. Young People Targeted Support Service' have approximately two and half times the numbers as Head 2 Head although this is to be expected as Young People Targeted Support Service' provides a Tier 1 and tier 2 treatment to the more specialist Tier 3 and 4 treatment of Head 2 Head.

Questions/ anomalies that need to be addressed are:

- In treatment year to date figure suggests cumulative total
- New treatment episode is not broken down into young people new to treatment and those who are re-entering treatment
- The data needs to be clearly comparable between 'residence' reports and 'all activity' reports.

Addressing these questions reiterates the cumulative total, that treatment episodes are not broken down by re-entry or re-referral and 'all activity reports were used.

Young People Targeted Support Service had 412 individuals in treatment in 2011. This is compared to 364 in 2010. This suggests a 13% increase from 2010 to 2011.

Head 2 Head report similar numbers to 2010 with 146 individuals accessing treatment. This is similar to the numbers accessing services in 2010 although the figures collated by NDTMS no longer report upon 'individuals starting treatment episode'.

NTU has attended a weekly allocation meeting at Head 2 Head where 10 new cases were presented. This format of meeting provide a rotated opportunity for staff to discuss a particular case. General comments from the staff were that the RIO (online system) and the 'green form' had 'no meaning to them at all' and the staff do not find the online system useful and see it more as a protocol, rather than a tool that they can learn from. The usual method of collecting information about access to treatment and treatment journeys is paper notes. There is no strategic allocation system for new cases and many referrals are found 'left on desks'. Many case notes and referral summaries were illegible due to handwriting. And there were issues with those who were referred under the age of 18 but then turned 18 during the allocation process. In terms of access to services and the recording of data a more robust system of accurate data capture would be of benefit.

NTU attended a meeting with Face It to obtain narrative data on the service's performance. Workers at Face It considered service evaluation was conducted in terms of quantity rather than quality of outcomes and the service's performance was driven by healthcare models rather than being viewed more broadly to achieve better outcomes. The identification of wider needs of presenting individuals was not discernible from the available data. Similarly, the breakdown of data for 'representations' was not available.

These findings are supported and confirmed by attendance at team meetings (such as Bassetlaw 10.9.12). This suggests 'there is lack of understanding of the NTA/RIO data and the casework is more useful to "frontline staff"'.

Pathologising individuals was seen as counterproductive and the diversity of interventions matched the individual needs of service users for example according to needs, gender and ethnicity. How this links to pathways into the service was not addressed. The individual difference in different workers was also identified providing different types of intervention once in the care delivery system. For example, some workers were strict whilst others adopted a befriending approach. The clear identification of required and desired outcomes and objectives from access to services and interventions would provide a fuller picture. Subsequent meeting with the Young Persons' Substance Misuse Team have suggested that current use of the medical model to approach young drug users is not as useful as the engagement model.

In terms of the scale of the service provision the specialist Children's' and Adolescent Mental Health Service as a Tier 3 and Tier 4 provider has 146 individuals and Face it as a Tier 1 and Tier 2 service has 348 from the latest published figures for 2011 (Quarter 3 reports from NDTMS). This is to be expected.

Incorporating the most up to date data, the NDTMS provides Quarter 4 data for Face It and Head 2 Head. This suggests that the numbers in the new treatment year to date are 412 for Face It with the number of individuals starting a new treatment journey as 280.

If this is compared to the 'Young Person's Regional Partnership', 'Young People Partnership Performance Report – 2011/12, Quarter 4 Nottinghamshire (E06B) this suggests:

'Numbers in treatment year to date' = 378

'Numbers of Young People in young people's services' = 377

Numbers of Young People starting a new treatment journey YTD' = 272.

A further comparison can be made by 'Young People Provider By Residence Performance Report - 2011 / 2012, Quarter 4 Face It (T0336), Residents of Nottinghamshire (E06B)'. This suggests

Numbers in treatment year to date (25 and under) = 392

Number of Individuals starting a new Treatment Journey YTD = 262.

Although marginal discrepancies, the 'numbers in treatment' are given as 412, 378, and 392 depending on which measure is used, and 'new treatment journeys' are given as 280, 272, and 262.

Similar concerns have been raised on the NDTMS forum. There is a tension between the time it takes for producing the data to be returned to NDTMS and the impact this has on delivering interventions rather than data collection. However, there is a real need for robust forms of data collection and analysis to make informed decisions about the delivery about services. For example, Child and Adolescent Mental Health data is 'patchy' and 'uneven' at a national level that limits useful comparison to national indicators. This is an on-going issue.

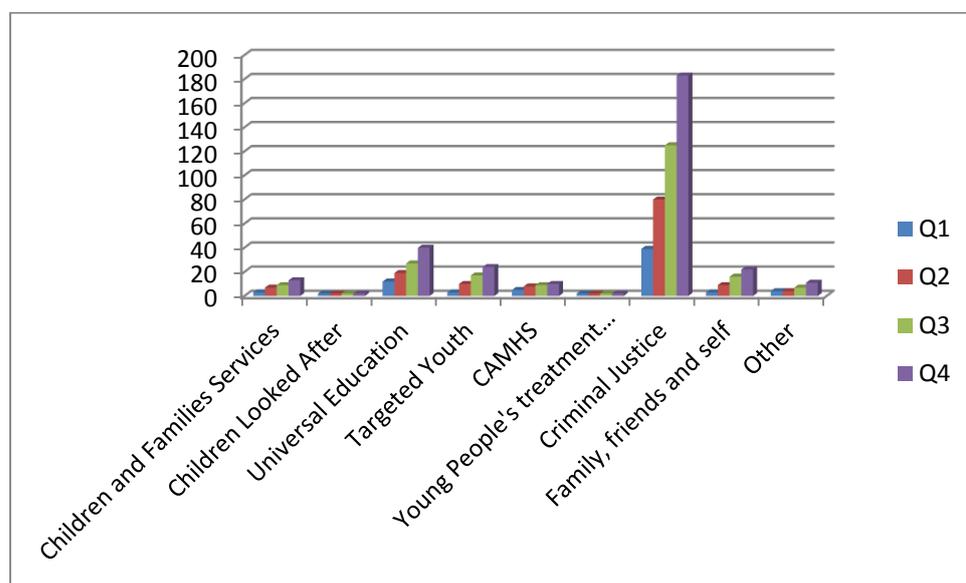
### **Recommendations for both services**

1. Achieve and maintain meaningful data capture with thought given to the collection of data.
2. Record data on 're-presentations' to identify 'gaps' and 'blockages'
3. Identify wider needs of presenting individuals at access to treatment (for example, the involvement of family and carers).

Referral routes into treatment are reported upon below.

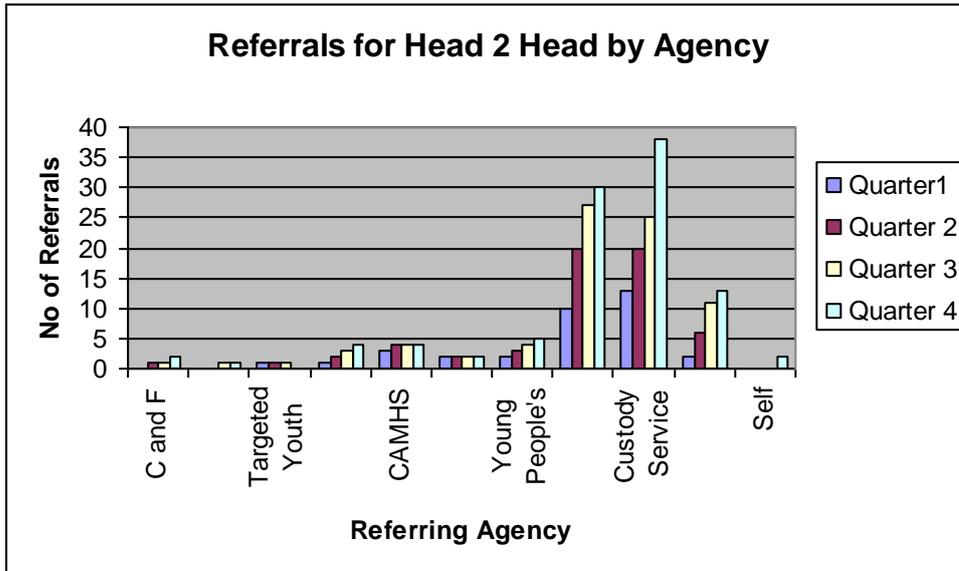
## Referral Routes

### Referral Routes for Head 2 Head for 2011



Referral routes using the Young People Provider (All Activity) Quarterly Performance Report 2011/2012, Quarter 4, 3, 2 and 1 for Head 2 Head suggest the referral routes were overwhelmingly from the Criminal Justice System of the Youth Offending Team and Custody Service. This pattern and trend is repeated from previous years for 2010.

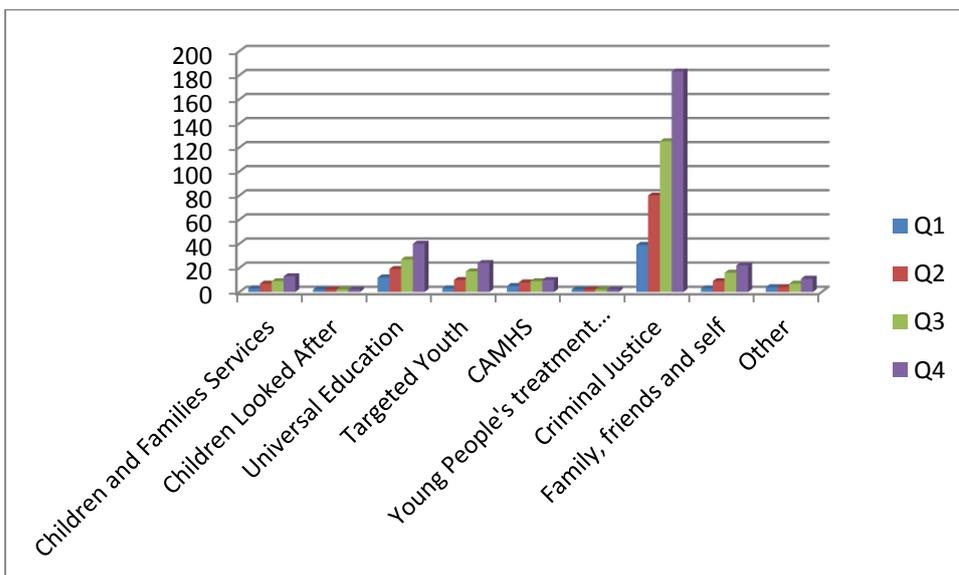
**Figure 5. Referral Routes for Head 2 Head for 2010 by quarter**



**Table 5. Referrals Routes for Face It 2011**

	Q1	Q2	Q3	Q4
Children and Families Services	3	7	9	13
Children Looked After	2	2	2	2
Universal Education	12	19	27	40
Targeted Youth	3	10	17	24
CAMHS	5	8	9	10
Young People's treatment provider	2	2	2	2
Criminal Justice	39	80	125	183
Family, friends and self	3	9	16	22
Other	4	4	7	11

**Figure 6. Referrals Routes for Face It 2011**



Qualitative examination of meetings with service providers suggest matters to do with interprofessional working and partnership working were identified. For example, a good working relationship with Youth Offending Teams (YOT) was identified by Face It although differences in approaches to service delivery and evaluation were noted between the YOT and Face It. Head 2 Head reported a different experience working with the Youth Offending Team in Nottingham City. There was also the identification of geographical differences with the Head 2 Head service addressing needs within the city of Nottingham and Face It addressing county wide need. There were issues raised about the appropriateness of the RIO and NTA model for young people as it was perceived as being an adult model. The reworking of assessment forms to inform case notes and ease the population of RIO was also identified.

The collection of data also raised a range of issues. For example, the targets set for referral routes by commissioners into the Face It service suggest that less time would be spent on 'promotion' activities and more time spent on securing referral routes such as from General Practitioners. The need and importance to facilitate 'self-referrals', rather than Criminal Justice as a referral route into treatment, was also identified by Face It. Similarly, the very useful tool for visualisation 'ViewIt' of treatment services provided by the NDTMS, only has information on 18+ years olds so provides very limited data for comparison for Young People's services.

### **Recommendations**

1. Compile geographical differences in need to identify 'hot-spots' of substance misuse
2. Examine assessment forms to capture and record data of access to treatment and journey in treatment to discharge and exit
3. Examine ways of facilitating 'self-referrals' into treatment

The re-naming of services such as Face It now being named Young People Targeted Support Service presents issues with accessibility. The website for 'Face It' is currently offline and undergoing maintenance. It contains the message 'Please check back later for an update'.

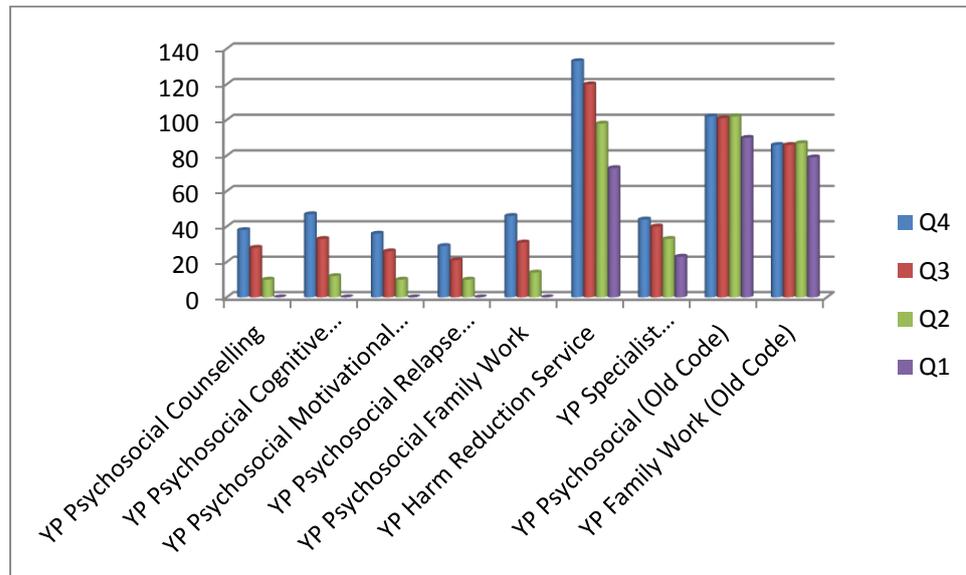
In the changing policy environment, the quality and professionalism of staff involved in substance misuse provision is commendable at both Young People Targeted Support Service and Head 2 Head.

**2. Young People’s Experience During Care and Treatment – Treatment System Delivery.**

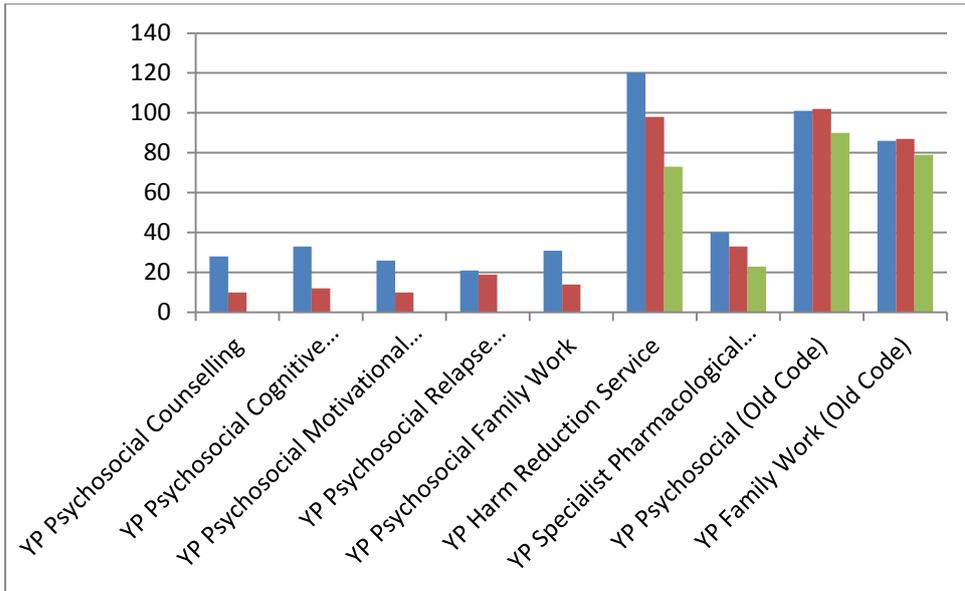
**Interventions provided**

The National Drugs Treatment Monitoring Service, Young People Executive Report For CAMHS All Activity Quarter 3 report for 2011/12 allows the charting the trends over 2011. This shown in the tables below, from Quarter 3, 2 and 1 for 2011 with the most current figures first. Figure 9 has the cumulative total for the three available quarters for 2011.

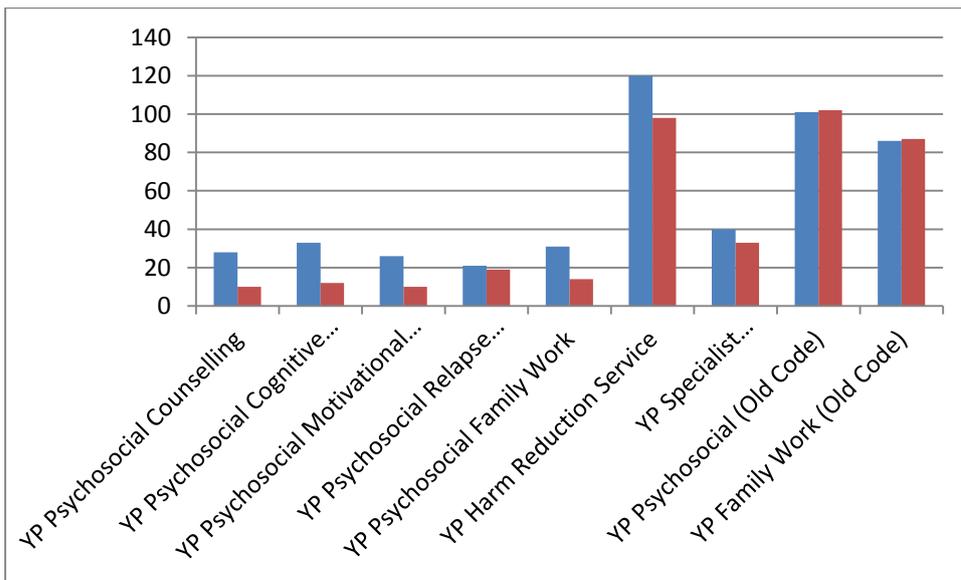
**Figure 7. Head 2 Head Interventions provided (Q4,Q3,Q2,Q1)**



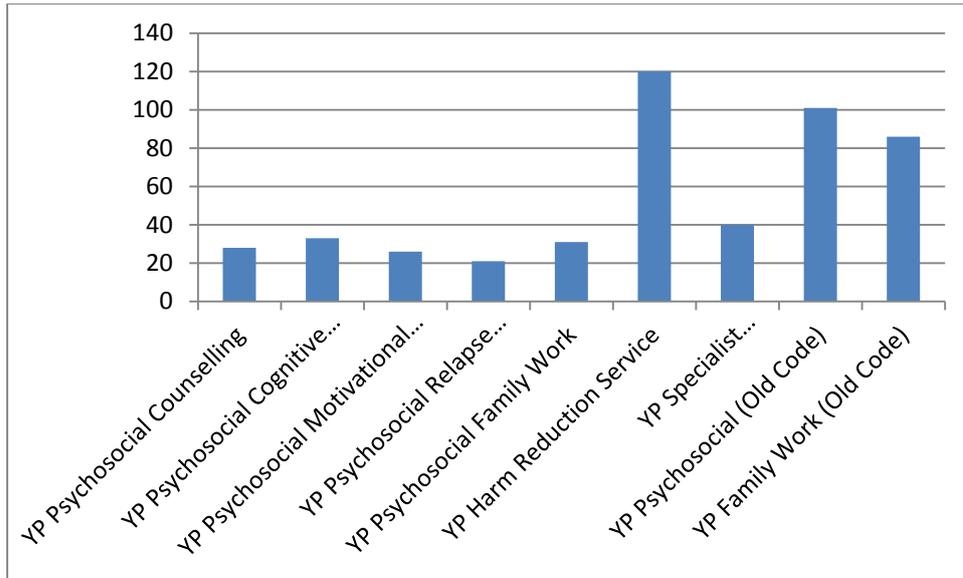
**Figure 8. Head 2 Head Interventions provided (NDTMS Q3, 2, 1 2011/12)**



**Figure 9. Head 2 Head Interventions provided (NDTMS Q3 and 2 2011/12)**



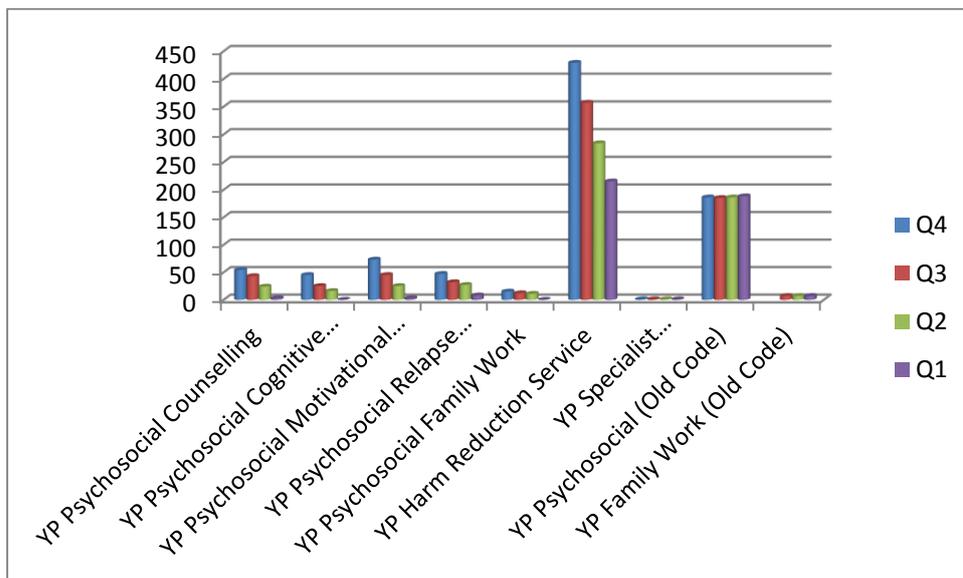
**Figure 10. Head 2 Head Interventions provided (NDTMS Q3 2011/12)**



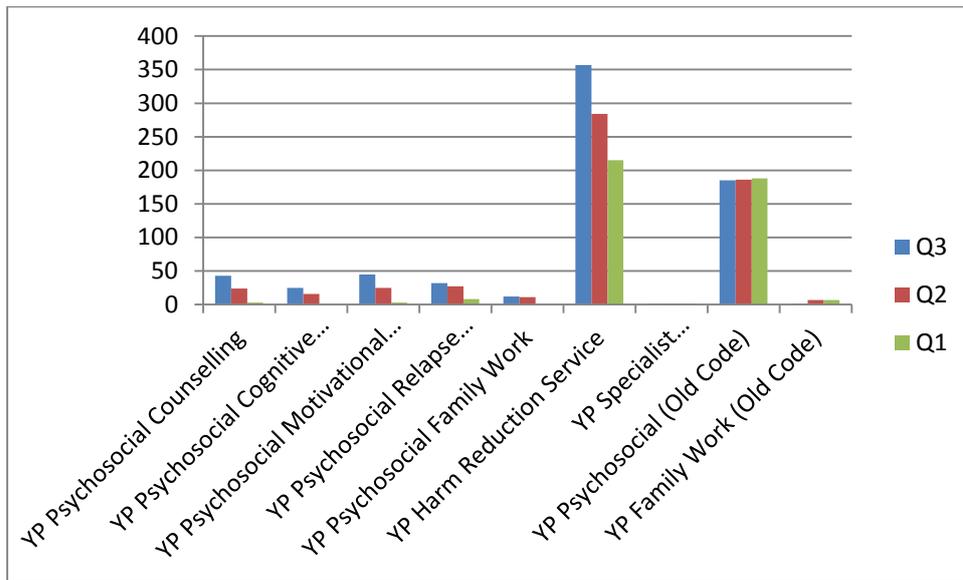
Issues with the data presented suggest that the Harm Reduction, the old code for Psychosocial and Family Work interventions characterise the service provided by Head 2 Head. There are some anomalies that are presented by the NDTMS data. For example, Young Peoples' Psychosocial Interventions are recorded as Q4 102, Q3 101, Q2 102, Q1 90. It is unlikely that this consistent but marginally fluctuating total reflects accurate data collection but rather the decision about coding the type of intervention.

A similar picture emerges for Face It.

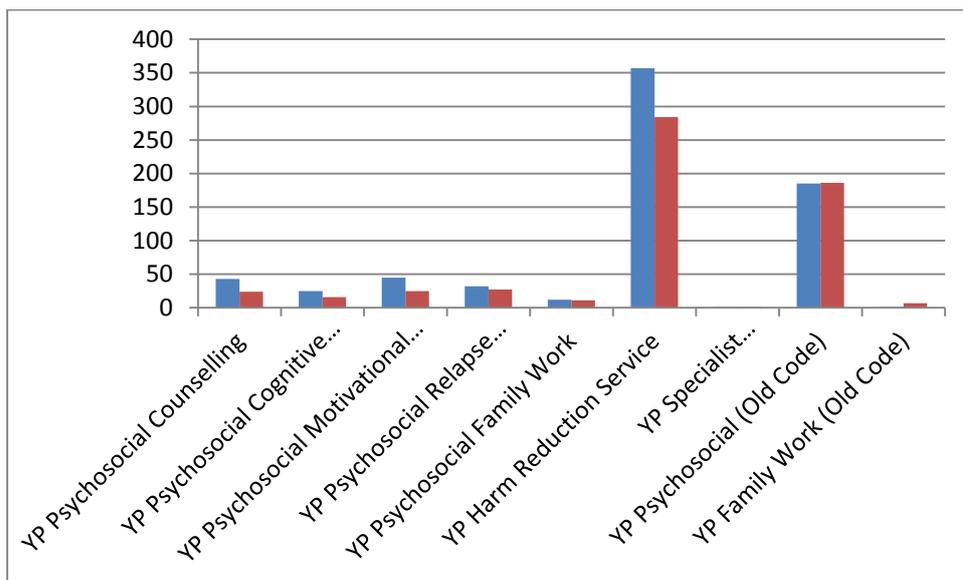
**Figure 11. Face It Interventions Provided (Q4, Q3, Q2, Q1)**



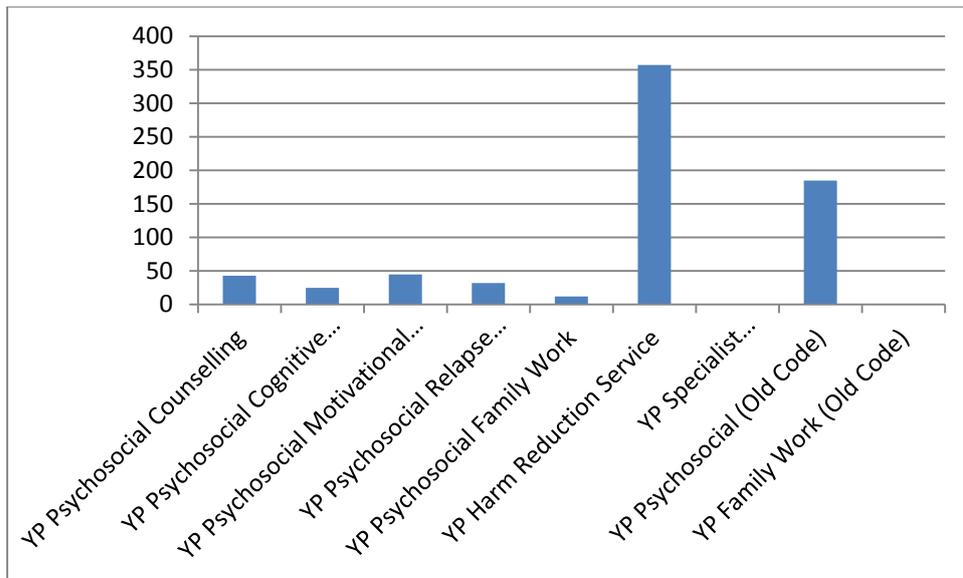
**Figure 12. Face It Interventions provided (NDTMS Q3, 2, 1 2011/12)**



**Figure 13. Face It Interventions provided (NDTMS Q3 and 2 2011/12)**



**Figure 14. Face It Interventions provided (NDTMS Q3 2011/12)**

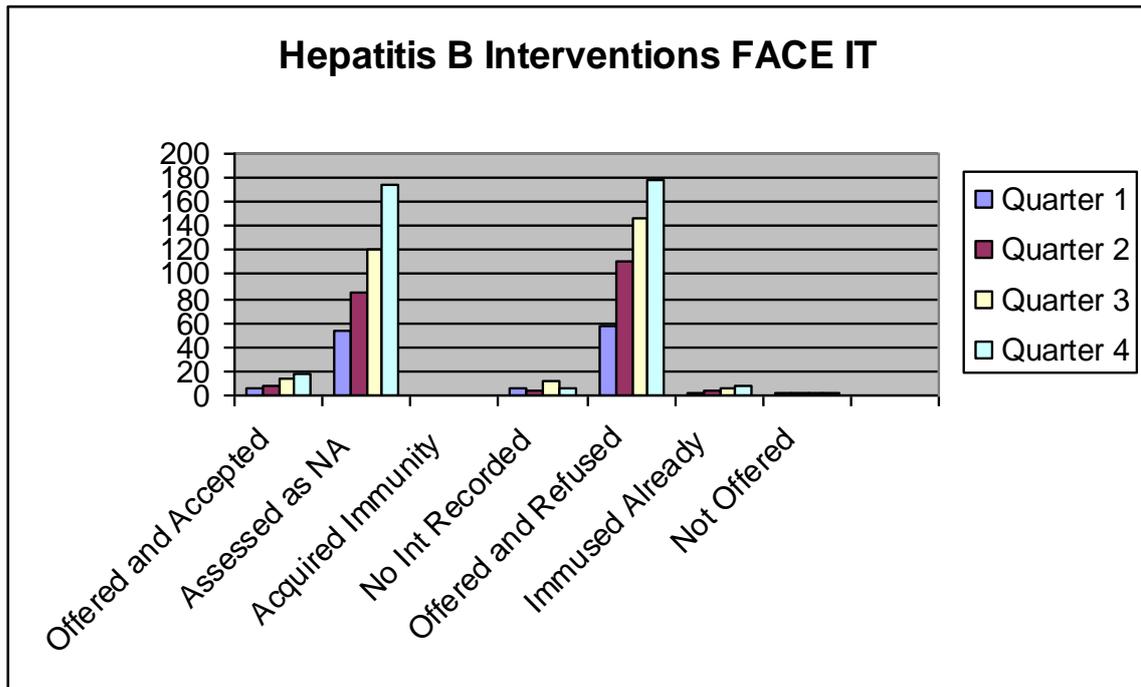


Trends identified in the data presented suggest that the Harm Reduction, the old code for Psychosocial and Family Work interventions characterise the service provided by Face It (429 out of 857 i.e. 50%).

These treatment interventions show a clustering around harm reduction and psychosocial work. The nature, extent and type of intervention remain unclear and the available data does not allow a comparison of whether the interventions match the service users' needs or reflect workers specialisms. For example, interventions range from formal treatments to gym memberships. Qualitative data from service provider meetings suggests that other interventions such as safeguarding, are not dealt with as the staff do not have the necessary skills and expertise. The knowledge and understanding of the policies, procedures and governance arrangements to address safeguarding were not in the forefront of workers' minds. Examples of failure in treatment where in the transition process between receiving support from young peoples' services like Face It, turning 18, and being referred onto adult services.

Residential placements are overwhelmingly not offered with 95% of interventions being non-residential.

**Figure 15. Face It Interventions for Hepatitis B.**



Reviewing the interventions data it would suggest:

- Young people are receiving more than 1 intervention but further data is needed on interventions profile to assess intervention delivered by whom to whom and how this matches with assessed need
- The clustering of the 'old codes' around psychosocial and family work require further examination to examine interventions provided
- Waiting times data needs further examination

#### **Recommendations**

1. Interventions and modalities of treatment profile requires further examination
2. Waiting times need further examination
3. Knowledge, understanding, skills and expertise of Safeguarding arrangements to be reviewed

#### **Length of Time in Treatment**

The waiting times (in weeks) for first intervention is provided by NDTMS for Quarter 3 Head 2 Head and Face it for 2011. This shows all modalities and interventions were 'valid' waits of under 15 days.

Young People Provider All Activity Performance Report - 2011 / 2012 for Head 2 Head shows a 100% match between 'mutually agreed exit plans' with no 'client

unilateral unplanned exit’ and no ‘withdrawn intervention’. Face It, for the same period, provides a more complex picture but mostly with mutually agreed exit plans and limited unplanned exit.

**Figure 16. Head 2 Head Waiting times (in weeks) by first intervention.**

Treatment Type	Number of Valid Waits	Number of waiting times 15 days and under	Average waiting time	Longest wait in an intervention	Number of Waiting Times 6 weeks and over
Adult Modality	0	0	-	-	0
YP Psychosocial Counselling	9	9	0.00	0	0
YP Psychosocial Cognitive Behavioural Therapy	13	13	0.00	0	0
YP Psychosocial Motivational Interviewing	8	8	0.00	0	0
YP Psychosocial Relapse Prevention	7	7	0.00	0	0
YP Psychosocial Family Work	12	12	0.00	0	0
YP Harm Reduction Service	12	12	0.00	0	0
YP Specialist Pharmacological Intervention	4	4	0.00	0	0
YP Psychosocial (Old Code)	0	0	-	-	0
YP Family Work (Old Code)	0	0	-	-	0

The average waiting time demonstrates that interventions are provided promptly with Care plans starting within two weeks of the treatment intervention start date.

- Case study data is required to understand young peoples’ experience of waiting times particularly those who wait longer than 15 days

## Recommendations

4. Track individual treatment journeys to construct a ‘treatment journey picture’

5. Aggregate data using Treatment Outcome Profiles for a 'snap shot' picture of treatment journeys and allow national comparisons.

### **3. Exit and Referral Routes Following Treatment – Leaving Specialist Treatment.**

#### **Discharges**

A similar pattern emerges for the planned discharges from treatment that is consonant with the speed of the interventions provided. The exit from the treatment system is overwhelmingly through planned discharge with a modest number of unplanned discharges.

**Figure 17. Head 2 Head 'Agency discharges'.**

Presenting Drug	Total numbers exiting the treatment system	Numbers completed - care planned discharge		Number unplanned discharge	
		Number	Percent	Number	Percent
Opiates / Crack	6	6	100%	0	0%
Other Stimulants	1	1	100%	0	0%
Cannabis	64	62	97%	2	3%
Alcohol	31	31	100%	0	0%
Other	7	6	86%	1	14%
Total	109	106	97%	3	3%

**Figure 18. Head 2 Head Intervention Exit Status.**

Treatment Type	Number of Interventions ending	Mutually agreed planned exits		Client Unilateral unplanned exit		Intervention withdrawn	
		Number	Percent	Number	Percent	Number	Percent
Adult Modality	0	0	-%	0	-%	0	-%
YP Psychosocial Counselling	-	-	-%	-	-%	-	-%
YP Psychosocial Cognitive Behavioural Therapy	27	27	100%	0	0%	0	0%
YP Psychosocial Motivational Interviewing	22	21	95%	0	0%	0	0%
YP Psychosocial Relapse Prevention	20	20	100%	0	0%	0	0%
YP Psychosocial Family	28	28	100%	0	0%	0	0%

## Work

YP Harm Reduction Service	92	90	98%	1	1%	0	0%
YP Specialist Pharmacological Intervention	34	29	85%	1	3%	4	12%
YP Psychosocial (Old Code)	72	71	99%	1	1%	0	0%
YP Family Work (Old Code)	61	60	98%	1	2%	0	0%

The Intervention Exist Status suggests all interventions except the Specialist Pharmacological Intervention are above 95% in their agreed and planned exits. This is the same for Q 3, Q 2 and Q 1.

### Figure 19. Face It Agency Discharges

Presenting Drug	Total numbers exiting the treatment system	Numbers completed - care planned discharge		Number unplanned discharge	
		Number	Percent	Number	Percent
Opiates / Crack	3	2	67%	1	33%
Other Stimulants	4	3	75%	1	25%
Cannabis	148	110	74%	38	26%
Alcohol	125	109	87%	16	13%
Other	4	4	100%	0	0%
Total	284	228	80%	56	20%

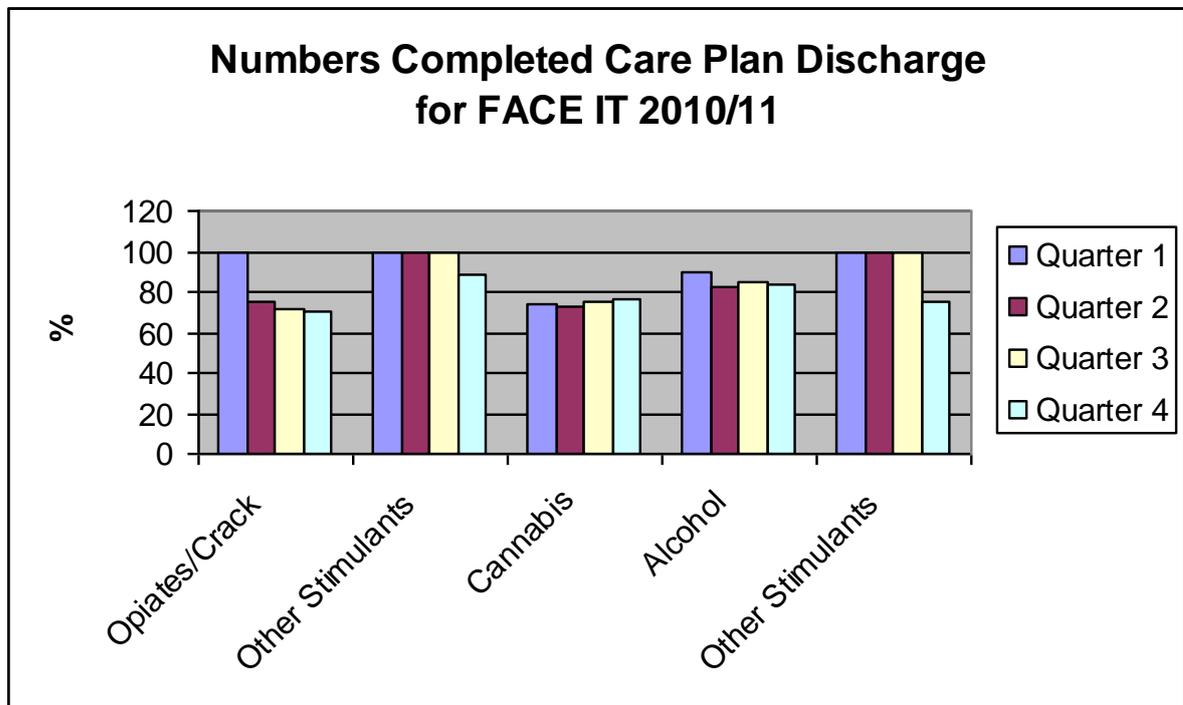
Face It discharges show a higher number of unplanned discharges but still with a good (70+%) of completed and planned discharges. A similar pattern is displayed by Intervention Exit Status for Q 4 of 2012.

### Figure 20. Face It Agency Discharges

Treatment Type	Number of Interventions ending	Mutually agreed planned exits		Client Unilateral unplanned exit		Intervention withdrawn	
		Number	Percent	Number	Percent	Number	Percent
Adult Modality	0	0	-%	0	-%	0	-%
YP Psychosocial Counselling	-	-	-%	-	-%	-	-%
YP Psychosocial Cognitive Behavioural Therapy	19	16	84%	2	11%	1	5%
YP Psychosocial Motivational Interviewing	33	25	76%	7	21%	1	3%

YP Psychosocial Relapse Prevention	30	22	73%	8	27%	0	0%
YP Psychosocial Family Work	11	8	73%	2	18%	1	9%
YP Harm Reduction Service	290	228	79%	57	20%	5	2%
YP Specialist Pharmacological Intervention	1	1	100%	0	0%	0	0%
YP Psychosocial (Old Code)	164	137	84%	24	15%	3	2%
YP Family Work (Old Code)	5	5	100%	0	0%	0	0%

**Figure 20. Care Plan Discharges for Face it 2010/11**



The questions / issues presented:

- Need to know more about discharge destination and how these map onto referrals
- Categories need to be matched between presentation of need, substance misuse, intervention provided and discharge and exit from treatment
- Exit and destination data would allow examination of which referrers service users are they more likely to go back to? Particularly significant for Head 2 Head because large numbers going back to referrers
- Are Head 2 Head referring back as they have no alternative?
- Does this system contribute to the revolving door?
- What is defined under 'other' for substance misuse

- Narratives/case notes to support care plans/ no care plans

Discussions with Face It suggest referrals back to the original referring agency were seen as rare. If individuals were referred back to the referrer such as the Youth Offending Team this would be to improve the engagement with the substance misuse service. However, there is no formal recording of 'repeat' referrals and this is an area that should be addressed.

Head 2 Head frequently refer back to Youth Offending Team (YOT) in Nottingham City as they consider some of the referrals not appropriate. In the meeting Head 2 Head said they had fed back to the YOT the issues but that inappropriate referrals were still forthcoming.

Face It suggest the recording of information on service users' treatment episodes and journey were seen as different from the National Treatment Agency (NTA) and the Service had no systematic way of evaluating and recording outcomes and progress. These are not recorded on NTA or through Face It. Recording of different information between services, it was suggested, also skews the data.

Face It measure their outcomes and evaluate their progress through:

- ❖ Feedback sheets from the young people who have finished intervention. Low numbers are returned.
- ❖ Physically visiting the young person and their new life.
- ❖ Whether the referral is seen within '2 weeks' / '10 day working period' – Face It indicated confusion over how 'seen' is defined and the differences in recording this between Face It and H2H.
- ❖ Exit interview and 'Treatment Outcome Profile' with a sliding scale.

The Face It service has to provide an exit plan that will 'tick the box' for providing an agreed discharge plan which looks good on paper. However, the quality of the support that the young person now receives is not recorded through National Treatment Agency. The Face It service could provide minimal information or clarification on the NTA/Green form.

## **Recommendations**

1. Access case-files to examine how discharge destinations map onto referrals to match categories and highlight inappropriate referrals in order to devise an action plan to address this
2. Examine care plans to chart and track onward referral and discharge.

### **Qualitative Findings from the research.**

The case-file analysis makes a strong case for the quality of service provision from Face it and Head 2 Head. From Face It files, various information and data was collected from open (still in treatment) and closed (treatment ended) and is included in the appendices. The demographics of the case-files shows the majority of service users were white males with a prevalence of alcohol and cannabis use. This supports the Young People's Substance Misuse Needs Assessment (2010/2011) which states, 'cannabis and alcohol remain the primary substances of use in the County' (p.4).

ADHD was a recurrent theme that emerged in the case-file review as a dual diagnosis (people who have emotional and mental health problems and who also (mis)use substances). For example, every third child referred to CAMHS' Head 2 Head have a diagnosis or a potential diagnosis of ADHD. Referral routes were predominantly from Criminal Justice services. 42% of young people were re-referred by Face It whilst 50% of young people were re-referred by Head 2 Head. The case-file review contains a case-study of an individual treatment journey to illustrate a snap-shot picture of the process and journey individuals undertake. Interventions are also considered to provide a more richly detailed picture of the treatment journey. This picture also presents safeguarding issues for workers in 'Ryan's' case.

**Tellus3 (2008) data for NI115: Substance misuse by young people, from the Department of Children, Schools and Families, shows 891 Nottinghamshire at 10.7.**

**The purpose of the TSS (2012) is to allow commissioners to have accurate and timely information on quality and effectiveness of treatment, to understand need and plan for the future. In addition, to identify young people in need or target and specialist support and get them the right support as quickly as possible.**

**The purpose of this JSNA is to identify current trends and emerging priorities.**

**Future Directions current trends and emerging priorities.**

**A new screening tool to aid identification for social workers (TSS 2012).  
Stronger and effective links to Accident and Emergency departments  
(TSS 2012).**

**The majority of substance misuse treatment referrals come from a youth justice route but there have historically been problems with the thresholds applied to referrals being too high. We will quality assure the screenings on a regular basis and take corrective action where it is needed. We will work to strengthen our links with substance misuse workers in police custody suites and work with the police on alternatives to formal action for first time drug offenders through referral for intervention or treatment (TSS 2012).**

**TSS (2012) will ensure that adult services continue to identify and support young people affected by parental substance misuse, WAM? (What About Me?).**

**Contributions.**

Placement with BA (H) Social Work Students.

Placements with Associate Professionals from BA (H) Health and Social Care.

**Social Determinants of Mental Health.**

**Cognitive Behavioural Therapy's transition to cognitive Behavioural Psychotherapy.**

**Treatment has developed pharmaceutically and psychologically, although integrated treatment with demonstrable impact has limitations in addressing the heterogeneity of dual diagnosis.**

There are three areas for development. A better picture including intervention studies, training, and policy for changing comorbidity. Crome (2001: 56) suggests 'the prevalence of substance use in our communities is constantly changing. Dual diagnosis populations are heterogeneous, so there are many combinations of substance use and mental illness to be the subject of research studies. There are opportunities for research by all professionals working in the field, in order to build up a bigger picture of dual diagnosis'. Intervention studies are particularly required.

Substance use and mental health should be core topics in the training of all staff, at undergraduate and postgraduate levels, both in statutory and non-statutory drug and mental health related services.

Mental health policy makers equally need to be aware that the population being seen by mental health services is considerably different in terms of comorbidity now compared to 10 years ago. This must be reflected in future strategies (Crome 2001).

**Quarterly reporting has identified a range of recommendations around process mapping, needs assessment, service development, and understanding treatment journeys.**

**Process Mapping**

1. Achieve and maintain meaningful data capture
2. Record data on 're-presentations' to identify 'gaps' and 'blockages'
3. Examine assessment forms to capture and record data of access to treatment and journey in treatment to discharge and exit
4. Examine facilitating 'self-referrals' into treatment
5. Interventions and modalities of treatment profile requires further examination

#### **Needs Assessment**

6. Identify wider needs of presenting individuals at access to treatment (for example, the involvement of family and carers).
7. Compile geographical differences in need to identify 'hot-spots' of substance misuse

#### **Service Development**

8. Waiting times need further examination
9. Knowledge, understanding, skills and expertise of Safeguarding arrangements to be reviewed
10. Access case-study files from Head 2 Head and Face It to provide more detailed data on outliers for entry into treatment and waiting times

#### **Understanding Treatment Journeys**

11. Track individual treatment journeys to construct a 'treatment journey picture'
12. Access case-files to examine how discharge destinations map onto referrals to match categories and highlight inappropriate referrals in order to devise an action plan to address this
13. Examine care plans to chart and track onward referral and discharge.
14. Identify multiagency working and complex referrals.
15. Map NDTMS quarterly reports data to national comparator and to Child Well-Being Index (CWI).

### **Findings from National Drug Treatment Monitoring Service (Jan 2013)**

#### **All Providers**

<b>Month</b>	<b>No. In Treatment</b>	<b>New Presentations</b>	<b>No. In Treatment - YTD</b>	<b>Discharges</b>
Apr 2012	115	22	115	14
May 2012	133	36	146	20
Jun 2012	131	18	163	21
Jul 2012	139	26	186	21
Aug 2012	148	29	212	10
Sep 2012	155	18	226	37
Oct 2012	157	36	258	29
Nov 2012	161	30	283	38
Dec 2012	143	24	297	23

Jan 2013	139	21	315	15
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### Face It

Month	No. In Treatment	New Presentations	No. In Treatment - YTD	Discharges
Month	No. in treatment	New Presentations	No. in treatment YTD	Dicharges
Apr 2012	98	15	98	12
May 2012	109	23	121	17
Jun 2012	106	14	135	18
Jul 2012	110	22	154	11
Aug 2012	120	21	174	6
Sep 2012	127	14	186	30
Oct 2012	129	31	216	21
Nov 2012	133	25	238	31
Dec 2012	119	17	251	17
Jan 2013	116	14	265	13

### CAMHS Head 2 Head Service

Month	No. In Treatment	New Presentations	No. In Treatment - YTD	Discharges
Apr 2012	28	8	28	2
May 2012	39	13	41	3
Jun 2012	40	4	45	3
Jul 2012	41	4	49	10
Aug 2012	38	7	56	4
Sep 2012	39	5	61	7
Oct 2012	37	5	66	8
Nov 2012	35	6	71	8
Dec 2012	34	7	77	5
Jan 2013	35	6	83	2

**From the National Drugs Treatment Monitoring Service (Jan 2013) the combined numbers in service suggest 348 (plus 1 from Mary Magdalene and 1 from Nottinghamshire Dual Diagnosis Team). This compares to 315 from all providers. This is compared to national figures for young people treatment performance reports for NDTMS Jan. 13 as 15 964.**

## **Tools**

'Asset' does not represent an acronym, but is a shortened form of 'assessment tool'. It is a lengthy, qualitative and quantitative questionnaire which assembles a 'Core Profile' of each young offender and, as such, characterises a prototype managerial instrument. Introduced in April 2000, it yields actuarial data concerning young offenders in order to predict their propensity towards reoffending. Its construction was based upon a review of meta-analysis which analysed 'risk' factors. Its completion by practitioners may necessitate the effectuation of a whole host of companion 'Asset' documentation dependent upon the enumeration of the result of the original Core Profile.

Cost Effectiveness Tool (CET) provides local and benchmark information on the cost of treating adult drug users and supporting them during their recovery. By identifying how to use existing resources more efficiently, CET can help you to improve your system's cost-effectiveness. It also builds on the local value for money tool, which shows that crime falls and health improves when people are in drug treatment, complete successfully, and do not return. For Young People's Substance Misuse it is a limited tool for assessing the cost effectiveness of interventions although offers some interesting insight.

Recovery Diagnostic Toolkit (RDT), provides a detailed picture of who you have in treatment and what interventions might benefit them most on their road to recovery. It draws on the latest NDTMS research and analysis to reveal the client characteristics that predict success and to expose the common barriers to recovery. It also offers clinical prompts to help you respond effectively to clients' needs – based on the best available evidence, these suggest which interventions will give people the greatest chance of overcoming dependence.

'SQIfA' stands for 'Screening Questionnaire Interview for Adolescents'. It canvasses 8 frequent mental health problems manifested in adolescence including alcohol use, drugs, depression, traumatic experiences, anxieties/excessive worries/stress, self-harm, ADHD/hyperactivity and psychotic symptoms. If the 'SQIfA' generates a score greater than 2, practitioners are required to fill in a 'SIfA' (full Screening Interview for Adolescents). If this subsequently reveals identified mental health needs, the young person may continue to be supported by YOT personnel, or may be referred to the Child and Adolescent Mental Health Services (CAMHS).

What these tools neglect is a strengths-based perspective such as Resilience Project Checklist (Grotberg, 1997), and the Good Lives Model (Ward and Marshall, 2004) which focuses dually on risk management and psychological well-being.

Treatment Outcomes Profile (TOP) offers a four stage examination of a base-line measurement in comparison with time specific subsequent TOPs. TOPs allow Quarterly Outcome Report Commentary to provide, at a glance, how well a client and the treatment programme is working. It includes more detailed outcomes information on all of the items collected on the TOP form: drug use, injecting status, crime, work, education, housing, health and employment. The uptake of TOP information provided by the National Drug Treatment Monitoring Service suggests this process is becoming embedded. It would also contribute to after care and post-treatment exit for a more sustained long-term picture of how a client is doing.

**Recommendation: Assess the usefulness and meaningfulness of diagnostic toolkits such as TOP, CET, RDT, ASSET.**

## Discussion

The review of specialist substance misuse treatment services has produced a range of findings regarding:  
the changing landscape of provision of service by mapping the national picture;  
the need for systematic reviews of substance misuse literature;  
the review of substance misuse services including pathways into care and treatment, access to services and referral routes; Young People's experience during care and treatment and treatment system delivery with interventions provided and length of time in treatment; and exit and referral routes following treatment to leave specialist treatment.  
Qualitative findings from the review and reporting suggest .....

The qualitative research included case file reviews (in the appendices) and interviews conducted with young people (in the appendices).

The Case file review of both services suggest that there is referrals from criminal justice such as referral orders, Youth Offending Team but also referrals from school and parents. There is evidence of timely and appropriate interventions with comprehensive risk assessment, (Strengths and Difficulties Questionnaires, HoNOS-CA, Asset Profiles) and differing modalities of intervention that that are focused on need such as motivational interviewing, harm reduction, cognitive dissonance, pharmaceutical and psycho-social, harm reduction/minimisation and relapse prevention. The recording and running records of individual is well kept with the majority of information being expressed in the multi-disciplinary records. Care plans are well recorded with initial assessment and outline of treatment interventions. The patient journey records of 'written records by patient' and 'career's notes on patient's pathway' are consistently absent. The complexity of individuals lives are a recurrent feature.

The improvement to early and preventative interventions, and to treatment, from the two services reviewed, suggests that once referral has taken place there are a range of interventions and treatment support that are appropriate to need and the stage of the recovery journey.

The delivery of treatment and provision of services is recovery orientated, effective, high quality and protective. The evidence base to support this, require further work. The involvement of families, careers and the wider community is also an area for extension.

The treatment interventions delivers continued benefit and achieves recovery-orientated outcomes. The length of time and success of these achievements supporting peoples recovery requires further examination. The continuity of care, after care plans and follow up to treatment recovery was difficult to discern and future work could be dedicated to follow up studies.

Encountering and working with all the staff, they were found to be energetic, passionate, imaginative and highly skilled in translating the complexities of adult life into the emergent understanding of young people.

### Safeguarding

# Evidence of What Works.

National Evidence and information;

- [Every Child Matters: Change for Children, Young People and Drugs](#)
- [Reducing demand, restricting supply, building recovery](#)
- [The Government's Alcohol Strategy \(2012\)](#)
- [Guidance on commissioning young people's specialist substance misuse services](#)
- [The role of CAMHS and addiction psychiatry in adolescent substance misuse services](#)
- [Young People's Specialist Substance Misuse Treatment: Exploring the Evidence](#)
- [Young People's Substance Misuse Treatment Services – Essential Elements](#)
- [Assessing Young People for Substance Misuse](#)
- [Hidden Harm Report, Advisory Council on the Misuse of Drugs \(2003\)](#)
- [Bottling it Up: The effects of alcohol misuse on children, parents and families \(2006\)](#)
- [Guidance on the consumption of alcohol by children and young people](#)
- [Smoking, drinking and drug use among young people in England 2010](#)

Local Guidance and information;

- [Nottingham Alcohol Needs Assessment 2010/11](#)
- [Nottingham Young People and Children's Substance Misuse Needs Assessment 2010](#)
- [Nottingham Children's Partnership: Family Support Pathway 2010-14](#)
- [Nottingham Children and Young People's Plan 2010-14](#)
- [Nottingham Safeguarding Children's Board, Drug and Alcohol Using Parents Practice Guidance for all agencies, 2004 \(revised 2008\)](#)

## **Electronic Resources.**

**Nottingham Insight**

**Palce2Be**

**MindFull**

## **Nottingham Insight**

- A lack of detailed information about the number and needs of children and young people in the County that have drug and alcohol issues that are not already in specialist treatment (especially 16-17 year olds)
- A lack of detailed information about the number of children and young people affected by parental or carer drug and alcohol issues
- Limited variation in the referral sources to treatment
- Development of the pathway, specifically; secure estate, emergency departments, targeted support services
- Young women, Asian and problematic alcohol users appear to be under represented in treatment and Black and Mixed young people appear to be over represented in treatment
- The successful transition from young people to adults treatment services is not transparent to identify unsuccessful transfers
- The rate of unplanned discharge from young people's substance misuse varies between each service
- Changes to the workforce development structure has meant there has been a limit to training available for the workforce

- Lack of evidence to identify the links between ASB, young people, alcohol and drugs
- Consultation with young people on this agenda and involving them in the strategy and commissioning process.
- Up to date information on emerging drugs and the impact locally

### **Recommendations for Commissioners** Commissioning and System Management.

- To establish robust levels of need in relation to substance use among young people and children
- To review and align all commissioned services against needs identified in the needs assessment and evaluate effectiveness
- Strengthen the strategic, commissioning and governance across children's commissioning and the work of the CDP to ensure alignment of delivery
- Scope user involvement at a commissioning level to inform system and service design
- Continue to invest in workforce development across all partners with contact with young people to ensure early identification and appropriate referral
- More detailed analysis of the risk of harm vulnerabilities for young people in treatment
- Further analysis of new emerging drugs and the impact locally

### Specialist Substance Misuse Treatment System

- Map referral pathways to identify gaps in referrals, such as sexual health clinics, GP's, further education, Police, the Secure Estate, considering the family support pathway and estate for service provision
- Continue to support prevention work whilst identifying ways to provide robust evidence of the long term success measures and evaluation of the scheme.
- The pathway for children into support for those affected by parental use should be strengthened with further integration between adult and children's services

### Treatment System Delivery

- Implement formal mechanisms to improve joint working across substance misuse services to including performance management meetings and frameworks
- Ensure that appropriate links are being made locally between services for domestic and sexual violence, young people and substance misuse and safeguarding agendas

### Leaving Specialist Treatment

- Implement a transparent transition process into adult treatment for young people to identify blockages within the pathway

1. Who's at risk and why?
2. The level of need in the population.
3. Current Services in relation to need
4. Projected service use and outcomes in 3-5 years and 5-10 years
5. Evidence of what works
6. User views
7. Equality Impact Assessments

8. Unmet needs and service gaps
9. Recommendations for consideration by commissioners
10. Further need assessment required
  - A lack of detailed information about the number and needs of children and young people in the County that have drug and alcohol issues that are not already in specialist treatment (especially 16-17 year olds)
  - The successful transition from young people to adults treatment services is not transparent to identify unsuccessful transfers – the evidence of transition to adult services is a planned discharge rather than an ongoing treatment
  - Lack of evidence to identify the links between ASB, young people, alcohol and drugs
  - Up to date information on emerging drugs and the impact locally

Children and Young Peoples' Partnership. (2011) *Children and Young Peoples' Plan*. Nottingham: Children and Young Peoples' Partnership.

**How long young people have to wait for assessment and treatment?**

**• How many young people need treatment and what for?**

**The number of young people who entered treatment in 2011 to 2012 were 412. The treatment they required were interventions for substance misuse.**

**• Where substance misuse referrals come from?**

**The majority of referrals come from the Criminal Justice System and Youth Offending teams.**

**• How well are we involving families and carers when a young person has a substance misuse problem?**

**The involvement of families and careers is an area that could be developed.**

**• What drugs young people are using and what difference treatment makes to what, how and how much they are taking.**

**The drugs that most people were using cannabis and use of alcohol. There is little evidence on the use of hard drugs such as heroin and crack, however, there is an indication that the use of synthetic drugs such as MCat is an emerging trend.**

**• Whether the treatment on offer meets a young person's individual needs.**

**The treatments offered were tailored to meeting a young person's needs and the modalities of intervention or treatment addressed the presenting need.**

**• Whether young people leave treatment in a planned manner or drop out of contact with services.**

**The majority of young people left treatment in a planned manner although there is evidence of 'drop outs' from service.**

**• Whether young people come back to services for further treatment.**

**The issue of re-referral or revolving doors and onward referral requires greater focus.**

**a common alcohol screening tool (AUDIT2)**

**The Alcohol Use Disorders Identification Test-**

[http://whqlibdoc.who.int/hq/2001/who\\_msd\\_msb\\_01.6a.pdf](http://whqlibdoc.who.int/hq/2001/who_msd_msb_01.6a.pdf)

**Over-reliance on average waiting times as headline treatment data items (JSNA 2012)**

**(2012) *Joint Strategic Needs Assessment Support Pack for Strategic Partners: Technical Definitions for the Alcohol Data.* National Treatment Agency for Substance Misuse.**

**Greater screening of comorbidity of dual diagnosis (Crome 2001: 7).**

Crome (2001: 16) suggests the evaluation of treatment progress or outcome measure is presented as follows.

1. Pre-engagement. The person (not client) does not have contact with a case manager, mental health counsellor or substance abuse counsellor.
2. Engagement. The client has had contact with an assigned case manager or counsellor but does not have regular contacts. The lack of regular contact implies lack of a working alliance.
3. Engagement. The client has regular contacts with a case manager or counsellor but has not reduced substance use more than a month. Regular contacts imply a working alliance and a relationship in which substance abuse can be discussed.
4. Late persuasion. The client is engaged in a relationship with a case manager or counsellor, is discussing substance use or attending a group, and shows evidence of reduction in use for at least one month (fewer drugs, smaller quantities, or both). External controls (e.g. antabuse) may be involved in reduction.
5. Early active treatment. The client is engaged in treatment, in discussing substance use or attending a group, has reduced use for at least 1 month, and is working toward abstinence (or controlled use without associated problems) as a goal, even though he or she may be abusing.
6. Late Active Treatment. The person is engaged in treatment, has acknowledged that substance abuse is a problem, and has achieved abstinence (or controlled use without associated problems), but for less than six months.
7. Late Active Treatment. The client is engaged in treatment, has acknowledged that substance abuse is a problem, and has achieved abstinence (or controlled use without associated problems), but for less than six months.
8. In remission or recovery. The client has had no problems related to substance use for over one year and is no longer in any type of substance abuse treatment.

## **Methodology**

### **Evaluation of research teams involvement.**

"Working with NTU to assess the effectiveness of our drug and alcohol services for young people (.....) has brought real value to my organisation. Marrying academic rigour and an independent view with the intelligence gathered from local professionals and service users is giving us a much clearer picture of how to make improvements to our service delivery and to improve outcomes for individuals and communities" (Notts CC Commissioner).

"It was a pleasure to help sort this out and such a relief you guys could actually relate to the young people at the right level .....you wouldn't believe some researchers"  
(Face It Worker).

## **Recommendations.**

**A vision of emerging need from the reordered substance misuse services and their roles and responsibilities under the new arrangements (page 9).**

**Systematic Review of substance misuse literature (page 11).**

**Recommendation (page 13) dual diagnosis and comorbidity of substance misuse and mental health difficulties require further investigation of intervention studies, training, and changing populations in need.**

### **Recommendation: Process mapping**

3. Achieve and maintain meaningful data capture with thought given to the collection of data.
4. Record data on 're-presentations' to identify 'gaps' and 'blockages'
5. Identify wider needs of presenting individuals at access to treatment (for example, the involvement of family and carers).

### Recommendations

6. Compile geographical differences in need to identify 'hot-spots' of substance misuse
7. Examine assessment forms to capture and record data of access to treatment and journey in treatment to discharge and exit
8. Examine ways of facilitating 'self-referrals' into treatment
  
9. Interventions and modalities of treatment profile requires further examination
10. Waiting times need further examination
11. Knowledge, understanding, skills and expertise of Safeguarding arrangements to be reviewed
  
12. Track individual treatment journeys to construct a 'treatment journey picture'
  
5. Aggregate data using Treatment Outcome Profiles for a 'snap shot' picture of treatment journeys and allow national comparisons.

**Referral routes from Accident and emergency departments.**

**Clinical perspective on referral and treatment.**

Children and young people focused interventions and services

Greater involvement in substance misuse provision from all members of the community including Black and Minority Ethnic Groups. For example, the qualitative data analysis was predominantly representative of UK white British respondents.

Recommendation: After care plans require further investigation.

**Recommendation: Assess the usefulness and meaningfulness of diagnostic toolkits such as TOP, CET, RDT, ASSET.**

Recommendations: Extension of community engagement supporting the relationship between NTU and NCC Substance Misuse.

Recommendations: Transitions between young people's care and adult substance misuse services require further investigation to ensure the transition of care is smooth, seamless and meeting needs.

Recommendations: From Q3 and Q4 report.

Identified need of increased MCAT usage amongst young people

Networks of Not in Employment, Education or Training (NEET) groups.

Culture, Language and Experience.

Explore possibilities of a Knowledge Transfer Partnership between the Substance Misuse and Nottingham Trent University to address issues.

Cost up creating a role for a Research Assistant attached to Nottinghamshire County Council to conduct discrete pieces of work.

### **Methodology**

Work is to be done on the assessment tools used in substance misuse and the efficacy of Treatment Outcome Profiles (TOP) and assess the usefulness and meaningfulness of diagnostic toolkits such as CET, RDT, ASSET.

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# Case File Analysis: Targeted Support

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## **Introduction**

The young people's service targeted support (TS), formally known as 'Face It' is a specialist tier 3 service specifically aimed at young people who are using substances or are at risk of using substances in the future. TS aims to provide a free and confidential specialist drug and alcohol service for young people up to the age of 18 years of age, and 21 years for care leavers. TS offers advice, support, interventions and treatment for substance misuse in the County of Nottinghamshire (Nottinghamshire Healthcare, 2012).

The TS team aims to provide available and holistic substance interventions for young people, accepting referrals from the Youth Offending Service (YOS), school referrals, and self-referrals and from other sources provided consent from the young person has been obtained. TS pride themselves in working with young people who are vulnerable, without judgement of their current situation or behaviour.

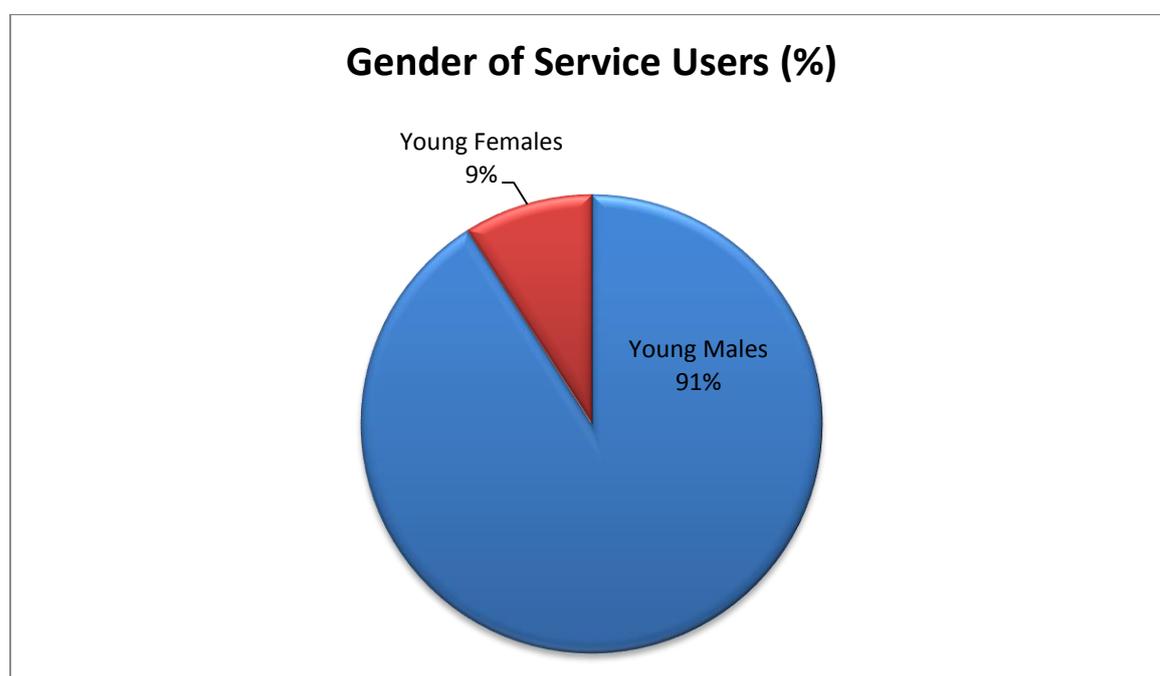
Many successful interventions have been through referrals made from local schools on a contractual basis with the young person. When a pupil from school is punished for drug use or possession on school premises, the young person will be offered to exchange exclusion days by agreeing to attending a set number of sessions with a drug youth worker. This is an example of just one of the successful holistic interventions that TS prides themselves in (see case study 2).

## **Case File Sample**

To gain a sense of the service users that the frontline staff work with, the research team felt it important to sift through a number of open (still in treatment) and closed (treatment ended) young people's case files. The majority of cases files stored in depth information on the young person, from the first date that they first received any form of intervention or treatment. The research team collected various information and data including: demographics; substance use; referral history; time line of referral and treatment; interventions used; and any social or child protection issues. All the

data was collected in a simple table format that could be easily accessible and analysed (see appendix \_).

A total of 23 (N=23) case files were randomly sampled and the file data collated and analysed. The ethnicity of service users was recorded, with figures illustrating that the majority of service users were White British (White British=92%; Non White British=4%; Non Disclosed=4%). The referral age of young people ranged from 12-18 years, and represented an average referral age of 14.5 years. Of these 23 cases, two service users were female (n=2) and 21 service users male (n=21). Based on these figures, analysis suggests that approximately 91% of service users referred to TS are males (see figure \_).

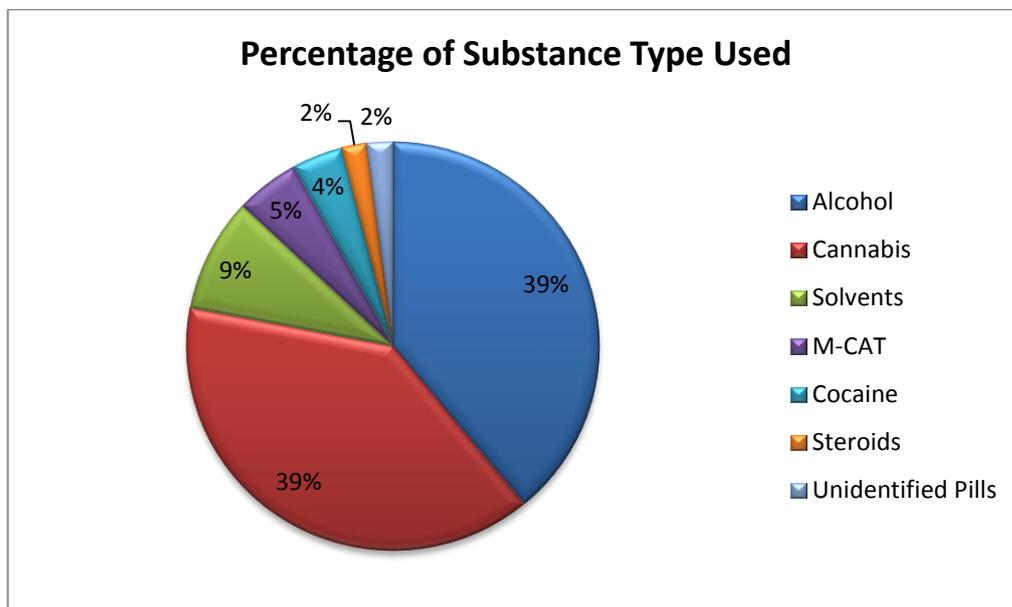


### **Prevalence of Substance Use**

Analysis of the case files demonstrated that all 23 of the young service users disclosed using one or more substance at a time (dual diagnosis). Alcohol (39%) and cannabis (39%) were the most prevalent substances used by young people, with all but one service user using alcohol and cannabis simultaneously.

The following substances were used at an extremely lower level in comparison with alcohol and cannabis, and were often used in conjunction with other substances. Solvents (9%) were the next prevalent substance used by the service users, closely followed by MCAT (5%), cocaine (4%) steroids through injection (2%) and the use of 'pills' (2%). As the pill content cannot be identified, for the purpose of this report, this

will be referred to as 'unidentified pills'. Figure --- demonstrates the proportion of substance type used by the service users.



### ADHD and Service Users

ADHD is a behavioural syndrome that demonstrates common symptoms such as hyperactivity, impulsivity and inattention. These symptoms can be experienced together or individually. ADHD can also overlap with other conditions and disorders, which can create difficulties in diagnosing the syndrome.

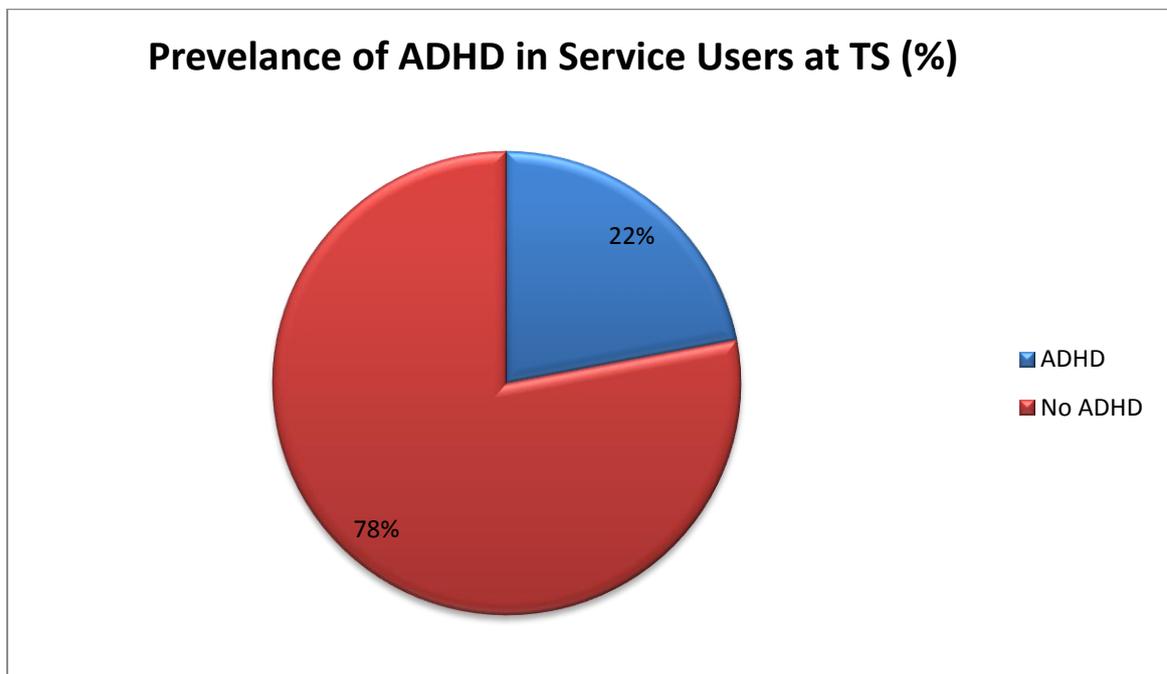
Children and young people who are diagnosed with ADHD often experience conditions such as: mood; conduct; learning; and anxiety disorders. Many young people diagnosed with ADHD will often experience emotional and social difficulties, and show an increased likelihood of involvement in crime. Adults with ADHD are also found to experience personality disorders, obsessive compulsive disorder (OCD) and can often experience issues with substance misuse. Therefore, it cannot be ruled out that young people (aged 12-18) also experience difficulties with substance misuse.

Furthermore, ADHD is a persisting disorder; where many children and young people who are diagnosed with ADHD will go on to experience similar symptoms in adulthood. Therefore, identification of young people with ADHD who are using substances is vital to ensure that early interventions can be applied so that substance misuse does not continue into adulthood.

Several studies have shown a strong connection between ADHD and substance use, with figures showing that around 1 in 4 adults treated for substance abuse, have a formal diagnosis or demonstrating symptoms of ADHD. This can be thought to be linked to the impulsive nature and hasty behaviour of people with ADHD, both of which can contribute to drug and alcohol abuse.

Research has shown that people with ADHD typically begin to have problems with drugs and alcohol at an earlier age than people without the condition. This could be explained by the increasing use of marijuana as a form of self-medication by many people with ADHD to relieve the symptoms of their condition.

Formal interventions for people with ADHD who are misusing substances include a 12-step program.



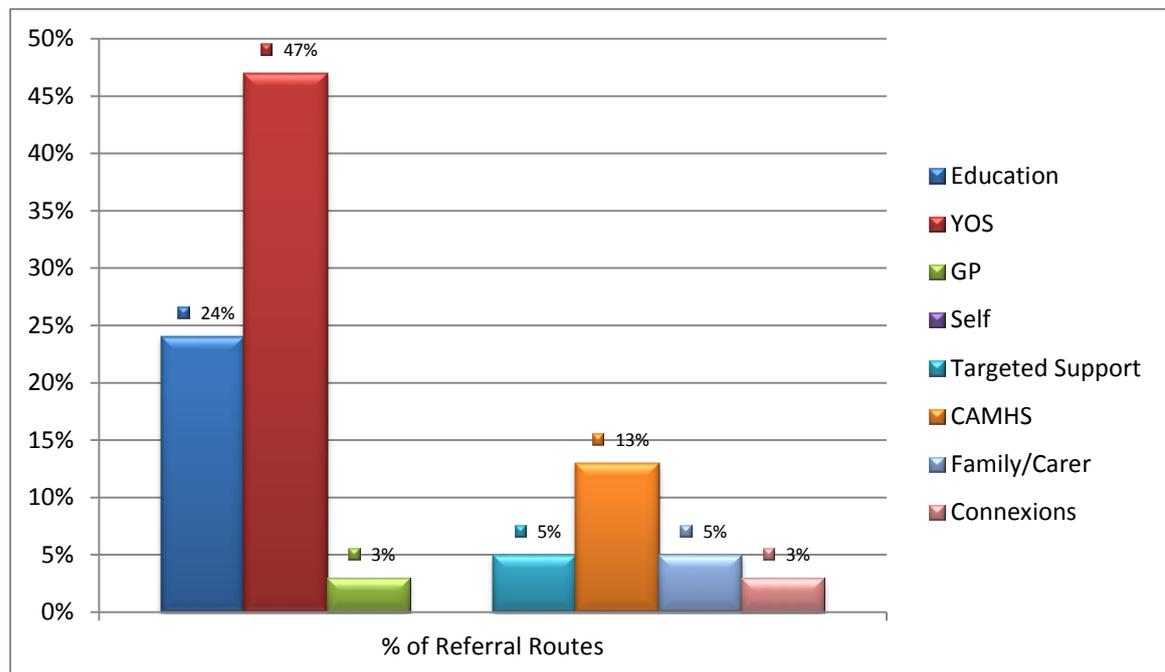
## Referrals

The research team felt that for suitable recommendations to be made, in order to improve the service, it was important to generate an accurate understanding of where the original referrals were being made and to identify potential referral routes that were not being utilized accordingly.

A huge majority (47%) of the referrals to TS were made from Youth Offending Services (YOS) following involvement in criminal activity where a compulsory

referral order is normally made by the court services. Further exploration is required into whether other referral routes can be made, prior to the young person reaching the criminal justice system.

A high number of referrals are also made from the educational provision that the young people attend (24%). This is either through the teachers at the school or college or through the healthcare team on the school site. Approximately 3% of referrals are made by the independent educational and career agency ‘Connexions’. A low number of referrals were received from targeted support (5%) as well as from family or carers (5%), and sadly no case files demonstrated that a self-referral had been made.



Through analysing the case file data collated from TS, it can be suggested that 42% of young people are re-referred to other services during their whole treatment journey, with approximately 13% of referrals made to TS from CAMHS (H2H).

### Referral to Treatment End Time Period

When reviewing the case files, the research team felt that establishing the overall time period from treatment entry to treatment exit was fundamental to identify the needs of the service. The sample of closed files analysed showed a treatment journey range from less than 1 month in treatment to a maximum of 11 months in treatment (<1 month- 11 months). This indicates that young people are in treatment for an average of 6 months (M=6 months). Analysis of closed files illustrated a much longer

treatment range (<1 month – 21 months) with an average time of 3.5 months in treatment (M=3.5 months).

### Case Study 1: Open File

#### CASE STUDY

#### Service User Treatment Journey: Jack\* Male; 15 years old; White British; Case Open

##### Referral History

Jack was originally referred to CAMHS (Head 2 Head) in April 2011 by his GP following hospitalisation due to excessive alcohol use which resulted in Jack's stomach being pumped. CAMAHS denied Jack intervention until he had attended an impending court case against him, where the YOS team would refer Jack to an appropriate service.

Following the court hearing in August 2011, Jack was sentenced to a 6 month referral order for Actual Bodily Harm (ABH). Four months later and following a breach of this order through disengagement with the service, the case file was closed.

In December 2011, Jack was re-referred to the services by the YOS team following a conviction for cannabis possession. Jack was required to attend intervention sessions with staff members, however failed to attend seven sessions. Two weeks later, Jack was referred back to the service by YOS following a further conviction for possession of a class B drug. Jack received a six month Youth Rehabilitation Order (YRO) with supervision to ensure that Jack attends the substance intervention sessions.

Jack's engagement with the service has been recently successful attending 12 sessions in total, and is due to end his treatment journey soon.

##### Interventions

1. Motivational Interviewing (stages of change)
2. Celebrating accomplishments and achieved changes
3. Cognitive dissonance
4. Psychological support
5. Relapse prevention and long-term plan making

##### Concerns

Jack has an ASSEST score of 18 which suggests that he has a medium to high percentage of reconviction. There do not appear to be any child welfare issues; however Jack has disclosed that his substance use is putting strain on his relationship with his mother.

\* The name Jack was chosen as a pseudonym by the research team in order to provide the service user with anonymity

Bobby has disclosed that he frequently smokes cannabis and drinks alcohol. Bobby is also a regular smoker and his Dad also uses cannabis on a regular basis.

**Referral History**

Bobby was referred to TS by his school following being in the possession of cannabis on school property. In a contractual agreement between Bobby, his school and the TS team, it was decided that Bobby's original punishment of 15 days exclusion, could be reduced to just five days if Bobby agreed to attend and cooperate with the TS drug workers on the school premises. All parties agreed and Bobby fully attended all five sessions, resulting in his exclusion days reduced, and his treatment work complete.

**Interventions**

1. Informational and educational advice
2. Motivational Interviewing
3. Relapse prevention
4. How to identify drug use behaviour
5. Celebrating accomplishments and achievements

**Concerns**

No concerns.

\* The name Bobby was chosen as a pseudonym by the research team in order to provide the service user with anonymity

**Interventions**

TS advertise their agency as providing alternative interventions for young substance users. This section provides an overview of the types of interventions quoted in the case files analysed. These include psychosocial, cognitive behavioural, therapeutic and knowledge based interventions.

**Psychosocial****Talking Therapies**

‘Talking Therapies’ are often known as psychosocial therapies and tackle the underlying causes and behaviours associated with drug addiction. A range of approaches for tackling drug dependency is preferred so that the many complex needs and mental health issues can be addressed. Effective ‘talking therapies’ can improve the likelihood that drug misusers will overcome dependency and lead stable lives, but also require practical support with reintegration into society so they can lead lives free from dependency.

### Motivational Interviewing

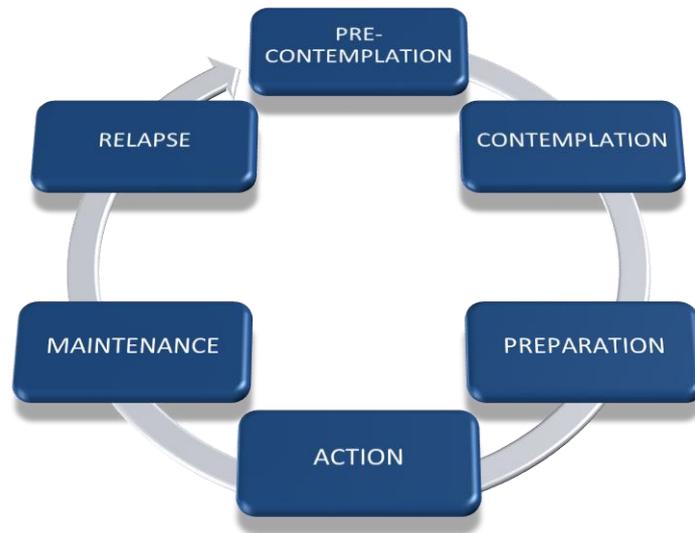
Motivational interviewing was established as evidence based practice in the treatment of individuals with substance use disorders. Motivational Interviewing focuses on exploring and resolving ambivalence and centres on motivational processes within the individual that facilitate change. The method differs from more “coercive” or externally driven methods for motivating change as it does not impose change (that may be inconsistent with the person's own values, beliefs or wishes); but rather supports change in a manner that correlate with the person's own values and concerns. The most recent definition of Motivational Interviewing (2009) is: "a collaborative, person centred form of guiding to elicit and strengthen motivation for change."

Three features of MI include:

1. MI is a particular kind of conversation about change (counselling, therapy, consultation, Method of communication)
2. MI is a collaborative (person centred, partnership, honours autonomy, not expert recipient)
3. MI is evocative (seeks to call forth the person’s own motivation and commitment)

### Transtheoretical Model of Change

This model of encouraging change of behaviour is arguably the dominant model of health behaviour change, having received unprecedented research attention. There are five stages in this cycle, each holding their own techniques to encourage the service user.



#### Stage 1: Pre-contemplation.

This stage usually finds the service users unwilling to change, with techniques employing evaluation and exploration of the person's current behaviour, as well as personalizing the risk of the behaviour.

#### Stage 2: Contemplation.

This stage sees the service user thinking of changing their behaviour, but may experience some hesitation, which will prevent their change in the immediate future. Techniques employed include the encouragement of considering the 'pros and cons' of their behaviour change, as well as identifying positive outcome expectations following treatment.

#### Stage 3: Preparation

The service user is now ready to change in the immediate future. The service user will be encouraged to make small steps and begin to make positive actions.

#### Stage 4: Action

Changes to behaviour are now being made, and measures to prevent relapse should be made. During this stage, it is vital that the service user has fundamental support and

techniques to deal with feelings of anxiety and frustration that they may experience during this period.

#### Stage 5: Maintenance

This stage ensures that the positive changes to behaviour are maintained and on-going, particularly ensuring that the service user does not relapse and those positive reinforcements continue. During this stage it is also vital to inform the service users on how to cope if they do relapse, and that relapse does not equate to failure.

### **Cognitive Behavioural**

#### Substance Use Diary

The World Health Organisation (WHO) suggests that a substance use diary helps the service user to identify factors connected to their desire to use drugs. This self-help intervention aims to empower the individual to take responsibility and control of their own drug use. The diary can help to: identify the situations in which drug use takes place; the consequences of the drug taking; and the total amount of money spent on substances. Through identify situations which may be 'high risk' to the service user, where they may be more inclined to take drugs (for example: following a family argument, after bad day at school, going to a particular friend's house) can enable the beginning of changing the behaviour that relates to the drug use (Andrews & Jenkins, 1999).

#### Harm minimisation/reduction

Harm reduction (or harm minimisation) refers to a range of [public health](#) policies designed to reduce the harmful consequences associated with human behaviours. The concept of harm reduction and minimisation for drug users was born in 1986 with the realisation that the HIV virus was being spread through the sharing of syringes amongst heroin injecting users, as well as increased criminal activity. In an attempt to reduce harm, needle exchanges were introduced. Further harm reduction aims to ensure that reckless behaviour is reduced to a minimum whilst under the influence of substances.

#### Cognitive Dissonance

For service users, many may feel cognitive dissonance regarding their substance misuse. Many young people may be aware of the health risks; the effects that using substances can have on their lives and the illegal act of drug use, however, many will provide justifications for their drug use. This cognitive dissonance acts to eliminate the feelings of unease or tensions that young people may experience when they misuse substances. This intervention tries to highlight these justifications with the young people and uncovers the truth behind the cognitions.

### Anger Management

Anger and frustration can often be a reason for drug use, or it can be caused through drug use. Thus issues such as anger management are important to address in drug use interventions to promote the cessation of drug use. This intervention mainly employs the use of Cognitive behavioural therapy (CBT). There are four main elements to CBT when treating anger disorders: Relaxation interventions which target emotional and physiological components of anger; Cognitive interventions which target the thinking patterns of the individual; Communication skills which encourages better communication with loved ones and alternatives to resolving issues; and Combined interventions which utilize two or more of the interventions (Deffenbacher, 1996, 1999).

## **Therapeutic**

### Acupuncture

This alternative intervention has been used in conjunction with other interventions that TS offer. Research, particularly in the USA, has demonstrated that acupuncture treatment can aid in substance users recovery. Acupuncture illustrates a biological competent that encourages the body to rid itself of the toxins as well as providing a holistic angle by improving mental clarity and the ability to focus. It also provides the young people with a sense of calmness which in turn leaves the service user more likely to engage with other interventions. While acupuncture may not be a cure for substance use and cannot promise prevention from relapse, it can aid a service user who is experiencing a lifestyle change or who is experiencing anxiety over their impending behaviour change.

## **Knowledge Based**

### Education/ Information Giving/Advice

A knowledge based intervention aims to aid the young person is gaining a clearer understanding of the effects that substances could impact on their lives now, and in the future. This intervention tends to be informal, personalised and offered in a supportive, non-judgemental manner. This intervention can be quite successful due to the on-going nature of the relationship the worker has with the young people, especially if they have been through the system before. This allows for a rapport to be made, allowing the drug worker to show sincere and genuine concern for the young person, as well as for discussion of sensitive topics with a person who they may trust. This intervention also allows for great flexibility, as it can be gently implemented during general treatment sessions and does not appear to be a rigid intervention. The fundamental element of this intervention is to provide information about the harmful impact that substance use can have. It is not aimed to scare the young people, but to educate them with the hope that the individual will make an independent decision to change their behaviour (Henry-Edwards et al, 2003).

## Case File Analysis: Qualitative Themes

All 23 case files (open=10; closed=13) were analysed by the research team using thematic analysis to demonstrate the umbrella of issues surrounding young people and substance misuse. Thematic analysis is a process of identifying reoccurring themes, ideas, patterns and behaviours that occur repeatedly in the text and in this case, across the case files. Once cores themes have been identified then subthemes can be created to add weight and context to the main themes identified. There were a total of four themes identified for the TS case files, which are all discussed below.

### **1. Exclusion**

#### School Exclusion

A large majority of the case files indicated a high proportion of school exclusion. This was either directly due to drug use on school premises or related to behavioural issues during class time. Although the use of school exclusions maintain to be a disciplinary action, it can also be extremely socially excluding to the young person and lead to future consequences. The Social Exclusion Unit (SEU) (1998: 1) highlights that ‘The

thousands of children not in school on most school days have become a significant cause of crime. Many of today's non-attenders are in danger of becoming tomorrow's criminals and unemployed. No one knows exactly how many children are out of school in England at any time because of (. . .) exclusion. But each year (. . .) over 100,000 are temporarily excluded. Some 13,000 are permanently excluded.' This would suggest that young people who are using substances and who are excluded from school could increase the likelihood of them using substances during their exclusion and becoming involved in wider criminal activity. An example of good practise to overcome this issue is illustrated in case study 2.

### Social Exclusion

Whilst school exclusion may inadvertently create a form of social exclusion for young people, the case files suggest that many of the young service users who are referred to TS experience other forms of social exclusion independent from school. Young people that are in local authority and foster care are likely to feel particularly socially excluded. For these service users, it is unlikely that they will be adequately prepared for the opportunities and skills that young people who are not in LA or foster care would receive. Many of these young people will have already come from vulnerable or isolated families and will now be separated further from family, friends, and their familiar life.

For other service users, having a parent in prison can also be particularly isolating. Following the parents imprisonment, the young person may have to take on extra responsibilities to help the day-to-day running of the house and may also be expected to take care of younger siblings. Of course, the young person themselves may be stigmatised against for having a parent in prison and may experience feelings of fear, shame, guilt and low self-esteem (Robertson, 2007).

As well as high numbers of young people with ADHD who are excluded from school for 'persistent disruptive behaviour', a high number of these individuals will also experience social exclusion from society. They may have experienced negative reactions regarding their behaviour and suffer socially and educationally. These issues will often continue into adulthood where they may experience substance misuse, unemployment and become involved in crime.

On a more positive note, many of the young people whose case files were reviewed were involved in many extracurricular activities, with many of the young people

attending cadets, youth clubs, or sport clubs. This dramatically increases their inclusion in society through participating in positive social activities.

## ***2. Family & Social Support***

For almost all of the 23 case files that were analysed, young people appeared to be experiencing or had experienced issues at home. Breakdown of the family unit appeared to be the most common family issue with the majority of young people's parents separated. Naturally, family breakdowns can lead to relationship difficulties with others, with many young people quoting complications with their parents. In addition, a high number of case files revealed the young people parents were also misusing substances, either alcoholism or cannabis use. This was also cited as having consequences on the family finances which caused concern amongst the young people.

For those who were not living with their parents, young people were either accommodated: with foster parents; in supported lodging under local authority care; or had been adopted at a young age. Those who did not live with their biological parents cited particular relationship difficulties in comparison to those who did live with their biological parents, even if the family unit had broken down.

Nonetheless, all the case files illustrated that the service users had access to a parent, carer, or guardian, providing an opportunity to develop the building of relationships during interventions.

## ***3. Protective Factors***

A protective factor is defined by Clayton (1992) as “an individual attribute, individual characteristic, situational condition, or environmental context that inhibits, reduces, or buffers the probability of drug use or abuse or a transition in level of involvement in drugs”. Protective factors does not automatically prevent a young person from taking drugs but can be seen as encouragement to an individual to resist from drug use through considering the positive aspects that they have in their life.

For many of the young people, their lives appeared to be ever-changing and quite chaotic, which could be labelled as ‘risk factors’. However, a large number of the young people did appear to maintain at least one constant aspect in their lives for a significant period; a protective factor. Many of the young people were in seemingly

stable relationships and identified their partner as the person that they were closest to during mapping activities. Other 'constants' in the young people's lives included education, employment, hobbies and accommodation. These protective factors could be employed during intervention work to encourage the individual to substance abuse recovery.

#### ***4. Child Welfare and Vulnerability***

The case file review highlighted that many young people were biologically vulnerable from the day they were born. Case file notes highlighted that a number of the mothers experienced prenatal difficulties during the pregnancy of the young people, which has then been attributed to behavioural difficulties in toddler age and above.

A high proportion of the young people's case file notes indicate that many had been subject to physical abuse, neglect and sexual abuse throughout their short lives and at a young age. Most of the young people had not reported these claims to the police but had confided in the TS works during intervention sessions. Such experiences as these are sure to have an impact on the young people's lives and may result in them being more susceptible to drug use, particularly as a method of coping and dealing with these experiences. Further vulnerabilities may include peer pressure from others to experiment with substances, particularly if the young person's social crowd is non-age appropriate.

Further vulnerabilities include the risky environment that the young people are placing themselves in when they are under the influence. Some of the female service users reported being sexually active and disclosed actively trying to conceive. Issues surrounding practising safe sex and information regarding high risk situations would be vital for these young girls.

# Case File Analysis: CAMHS (Head2Head)

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## **Introduction**

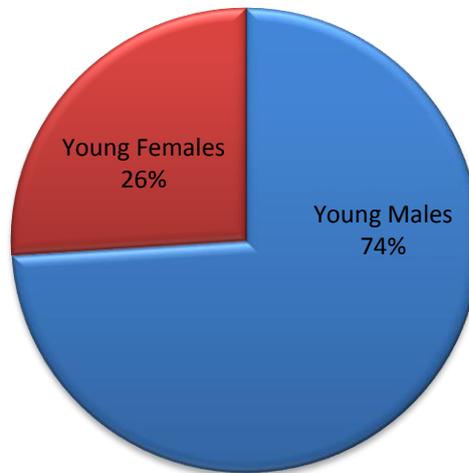
Within Children and Adolescent Mental Health Services (CAMHS) and Nottinghamshire healthcare, a specialist service (Head2Head) provide confidential advice, intervention and treatments for young people up to 18 years of age whose substance use is impacting on their mental and emotional health - also known as dual diagnosis (Nottinghamshire Healthcare, 2012).

The Head 2 Head team provides mental health assessments and interventions for young people who are either: involved with the criminal justice system; who have emotional and mental health problems; and who also use/misuse substances (dual diagnoses). Head2Head also offer services to those who are not using substances, but are affected by those around them who are substance users.

## **Case File Sample**

A total sample of 19 case files were randomly sampled and analysed by the research team, of these, five were case files of female services users and fourteen male (N=19; females n=5; males n=14). From this data, statistics illustrate that 74% of service users were male and 26% female. The age of service users at referral ranged from 14 –18 years, and illustrated an average referral age of 16.4 years (M=16.4). A higher proportion of white British young people access services at Head2Head (White British=89%) compared to non-white British young people (Non-White British=11%).

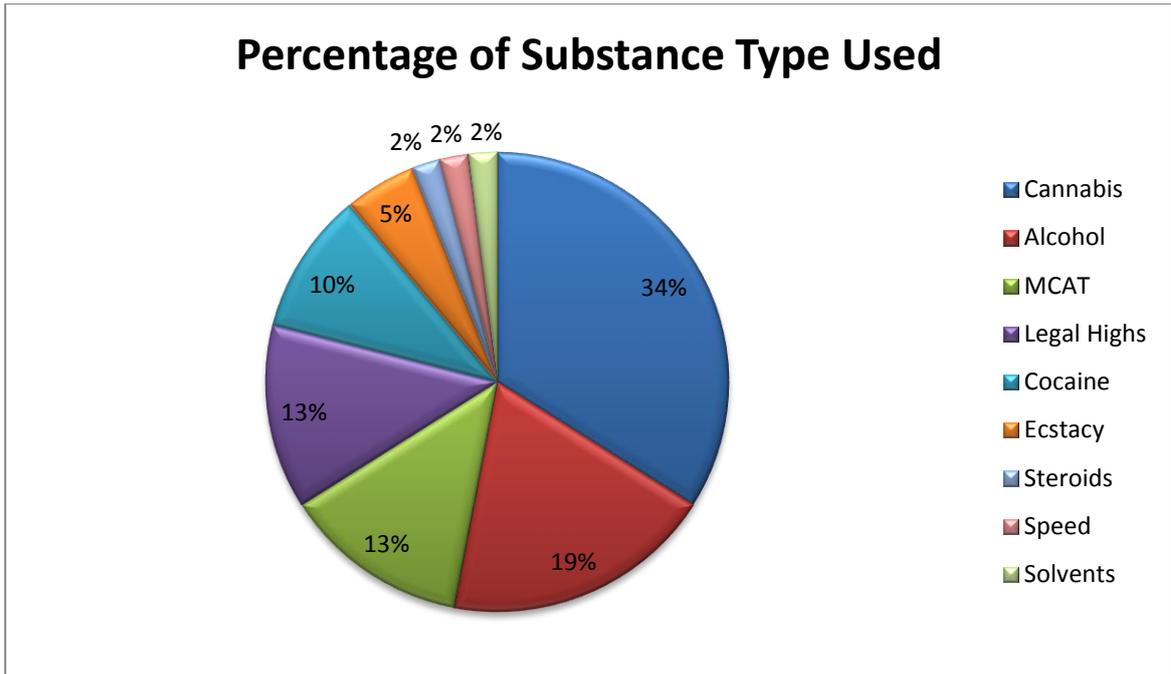
### Gender of Service Users (%)



### Prevalence of Substance Use

Analysis of the case files demonstrated that 53% of young service users only abuse one substance, with 47% demonstrating abuse of a number of substances. Cannabis was the most frequent substance used by young people (34%), followed by the use of Alcohol (19%). MCAT and unidentified legal highs showed a prevalence of use for around 13% of substance users, which was closely followed by cocaine use (10%) in service users.

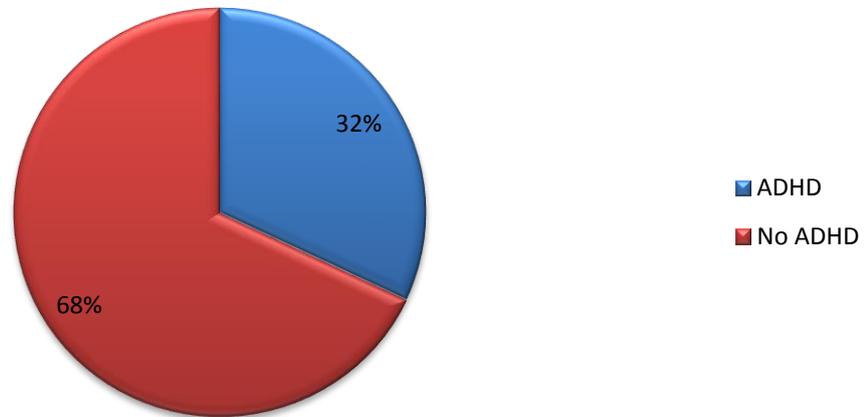
Substances such as Ecstasy were used at a much lower level (5%) by service users in comparison with alcohol and cannabis, and were often used in conjunction with other substances. Steroids (2%), Speed (2%) and solvents (2%) had the least amount of use amongst young service users at Head2Head. Figure --- demonstrates the proportion of substance type used by the service users at H2H.



### ADHD in Service Users

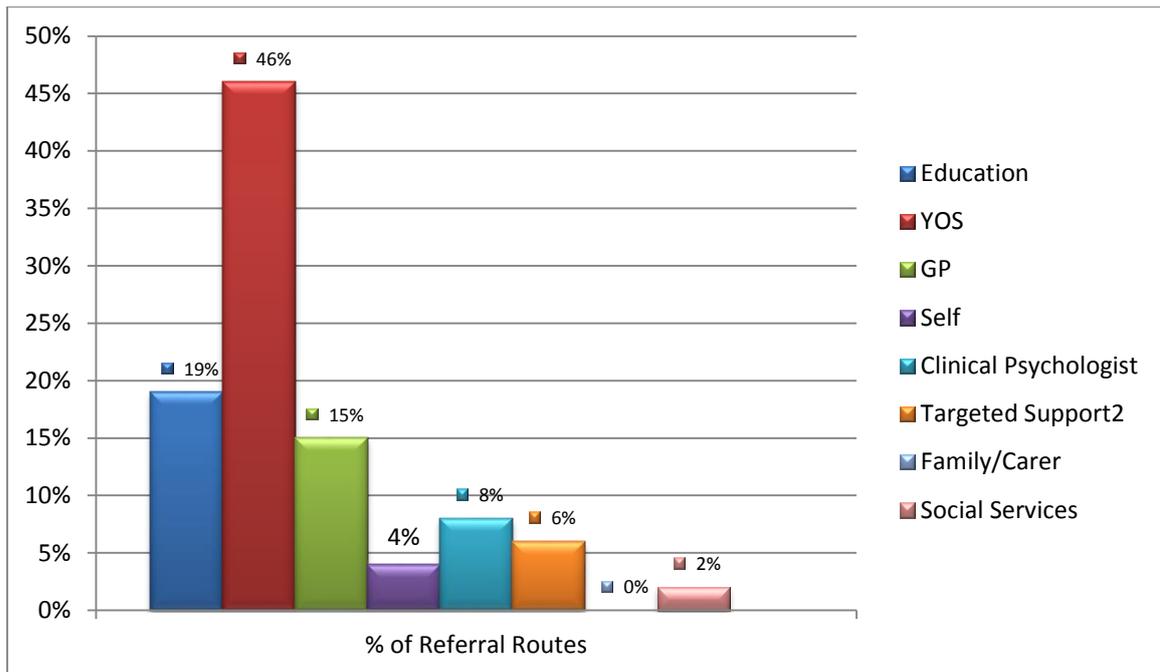
Individuals diagnosed with ADHD are believed to pose an increased risk for substance abuse. Inattention, a symptom associated with ADHD, is often linked to poor academic achievement and peer difficulties. In turn this leads to the development of often inappropriate peer groups, and often an increased involvement in a substance abuse culture. Other traits in individuals diagnosed with ADHD such as novelty seeking and impulsivity may lead to substance misuse and can often use drugs or alcohol to self-medicate the symptoms of the disorder, which in turn can lead to rapid increase of regular drug use. Stimulant therapy for ADHD sufferers has been shown to reduce the risk of drug and alcohol abuse. Analysis of the Case file from CAMHS indicates that 32% of young peoples had a formal diagnosis of ADHD or were demonstrating symptoms or behaviours of the condition.

## Prevalence of ADHD in Service Users at Head 2 Head (%)



### Referrals

A huge majority of referrals to CAMHS are made by the YOS (46%) indicating that nearly half of the young people receiving treatment have a history of offending behaviour. A much lower proportion of referrals are made through educational services (19%) or through the young people's GPs (15%). Clinical psychologists (8%) and Targeted Support (6%) make a much lower percentage of referrals. A higher number of self-referrals were made (4%) than referrals made by social services (2%). An estimated 50% of young people are suggested to have been re-referred to different services throughout their whole treatment journey.



## Interventions

### Clinical Assessments

#### The Children's Global Assessment Scale (CGAS)

The CGAS is a mental health scale used by mental health practitioners in order to assess the general functioning of children and young people.

#### The Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA)

This scale measures the health and social functioning of individuals, including children and young people suffering from mental illnesses. This scale specifically measures behaviours, impairment, symptoms, and social functioning.

#### Face Risk Assessment

This clinical risk assessment for young people with mental health issues assesses the patients' risk of certain items, such as: violence; self-harm; risk of offending; and self-neglect. From this information, youth workers can then develop appropriate care and risk management plans with the young person to manage and reduce their individual risks.

### Knowledge Based

#### Education/ Information Giving/Advice

A knowledge based intervention aims to aid the young person is gaining a clearer understanding of the effects that substances could impact on their lives now, and in the future. This intervention tends to be informal, personalised and offered in a supportive, non-judgemental manner. This intervention can be quite successful due to the on-going nature of the relationship the worker has with the young people, especially if they have been through the system before. This allows for a rapport to be made, allowing the drug worker to show sincere and genuine concern for the young person, as well as for discussion of sensitive topics with a person who they may trust. This intervention also allows for great flexibility, as it can be gently implemented during general treatment sessions and does not appear to be a rigid intervention. The fundamental element of this intervention is to provide information about the harmful impact that substance use can have. It is not aimed to scare the young people, but to educate them with the hope that the individual will make an independent decision to change their behaviour (Henry-Edwards et al, 2003).

### **Cognitive Behavioural**

#### Harm minimisation/reduction

Harm reduction (or harm minimisation) refers to a range of public health policies designed to reduce the harmful consequences associated with human behaviours. The concept of harm reduction and minimisation for drug users was born in 1986 with the realisation that the HIV virus was being spread through the sharing of syringes amongst heroin injecting users, as well as increased criminal activity. In an attempt to reduce harm, needle exchanges were introduced. Further harm reduction aims to ensure that reckless behaviour is reduced to a minimum whilst under the influence of substances.

#### Cognitive Dissonance

For service users, many may feel cognitive dissonance regarding their substance misuse. Many young people may be aware of the health risks; the effects that using substances can have on their lives and the illegal act of drug use, however, many will provide justifications for their drug use. This cognitive dissonance acts to eliminate the feelings of unease or tensions that young people may experience when they misuse substances. This intervention tries to highlight these justifications with the young people and uncovers the truth behind the cognitions.

### **Prescription**

### Fluoxetine

*Fluoxetine*, also known as selective serotonin reuptake inhibitors (SSRIs) are often used to treat depression in young people. Better treatment response and reduce in suicidal ideation.

### Atomoxetine

Atomoxetine is primarily an antidepressant but has also shown to be effective for ADHD sufferers. Atomoxetine is also known as a selective noradrenaline uptake inhibitor. This medication is thought to act on parts of the brain that help a person to control how they react to situations.

### Concerta XL

Concerta XL is another option for the treatment of ADHD by reducing the symptoms associated with the condition. This drug is suggested not to be used by those who have abused alcohol or drugs in the past, who are emotionally unstable or have had psychiatric problems.

## **Psychosocial**

### Talking Therapies

‘Talking Therapies’ are often known as psychosocial therapies and tackle the underlying causes and behaviours associated with drug addiction. A range of approaches for tackling drug dependency is preferred so that the many complex needs and mental health issues can be addressed. Effective ‘talking therapies’ can improve the likelihood that drug misusers will overcome dependency and lead stable lives, but also require practical support with reintegration into society so they can lead lives free from dependency.

Ryan had a history of alcohol abuse from a young age. He was known to social services from the age of five, due to demonstrating self-harming behaviour and expressing suicidal ideation.

**Social Factors**

Ryan's family experienced victimisation from the neighbourhood, which caused Ryan some distress. Ryan disclosed that his Father was also experiencing suicidal ideation. Ryan has a history of being bullied at school, which often triggered his abuse of alcohol and self-harming behaviour.

**Referral History**

Ryan was first referred to CAMHS from his GP at eight years old for alcohol use and self-injurious behaviour. Here Ryan received seven sessions of treatment, including interventions such as The Health of the Nation Outcome Scales for Children and Adolescents Risk Assessment (HoNOSCA RA) and the Child's Global Assessment Scale (CGAS). This referral was closed in 2002.

In 2005, Ryan was referred to the service by his school. Here Ryan received 8 more sessions of treatment using the same interventions in the previous referral. This was closed in October 2007.

In February 2008, Ryan was referred once again by his GP. Ryan only received one treatment session due to failing to attend two sessions. His case was then closed due to failure to engage. Similarly, in January 2009, Ryan was referred to the services by his school, however he failed to attend any sessions, and the case was closed one month later.

In June 2011, Ryan was referred by YOS on receiving a four month referral order for criminal damage. He only attended one session and failed to attend a further four. Meanwhile the clinical psychiatrist at the Queens Medical Hospital, where Ryan was admitted following attempted suicide, made a further referral. Ryan failed to attend any further sessions and five months later Ryan's case file was closed.

No exit route or follow up to treatment journey was made.

**Interventions**

1. The Health of the Nation Outcome Scales for Children and Adolescents Risk Assessment
2. (HoNOSCA RA) The Child's Global Assessment Scale (CGAS)

**Concerns**

Case file information illustrated that Ryan disclosed to staff members that he had been sexually abused by his Father at the age of 13. Case file dates suggest that this alleged assault would have taken place in 2006 whilst Ryan was receiving and fully attending treatment sessions. Although Ryan disclosed this information in the later years following the alleged event, he had not reported the incident to the authorities, and it is not clear what action was taken to ensure Ryan received the necessary and appropriate support.

\*The name Ryan was chosen as a pseudonym by the research team in order to provide the service user with anonymity

Max was first referred to the Targeted Support services at 14 years old for nicotine use. In 2012, Max is now being treated for a range of substances including: alcohol; amphetamine; cannabis; ecstasy; tramadol; cocaine; and DF-118. Max also has a strong history of self-harming and suicidal ideation, as well as becoming involved in offending behaviour such as arson.

**Referral History**

Max's first referral was from the YOT on a referral order. Although his attendance was sporadic, Max did eventually complete his requirement of 12 continual sessions and the case was closed. In 2012 at the age of 17, Max was re-referred by the YOT following convictions for TWOC and arson. During this time, Max had currently attended 8 sessions and appeared to be compliant with the drug workers as well as attending a fire safety course. One month into the completion of this referral, Max was admitted to the Queens Medical Centre Emergency Department, Nottingham, following severe self-harm to his thighs and demonstrating suicidal ideation. Max was once again referred to CAMHS by the hospital psychiatrist, however the case was already open, and Max was attending sessions.

**Interventions**

The main interventions used with Max were therapeutic approaches to encourage coping with stressful situations that Max might encounter. Max's mum was also encouraged to participate in the sessions and provide input to engage in a systematic approach. Max was encouraged to care for his wounds appropriately following an episode self-injury. Max was also routinely assessed using the HoNOS-CA and the CGAS.

**Concerns**

Max suffers from alopecia and has been a victim of bullying on several occasions due to this. Max stopped attending full time school at nine years old and has sporadic attendance since. Family life for Max has been difficult due to his Father's alcoholism. Max has disclosed that he has witnessed his father physically abuse his mother and claims to have been sexually abused between the ages of seven to eight, however the alleged abuser was not named. Max's brother is a heroin addict, which appears to have influenced Max's substance use behaviour. Max's parents are separated, and his Father was in a relationship with another woman, Max recently found his Father's new partner dead at her house. Max's own mother has recently suffered a stroke and is now disabled, relying on Max to care for her. In 2010, Max was involved in a fight where he suffered stab wounds to his stomach, resulting in his gall bladder being removed.

\* The name was chosen as a pseudonym by the research team in order to provide the service user with anonymity

## Case File Analysis: Qualitative Themes

All 19 case files (Open=9; Closed=10) were analysed by the research team using thematic analysis to demonstrate the umbrella of issues surrounding young people and substance misuse. Thematic analysis is a process of identifying reoccurring themes, ideas, patterns and behaviours that occur repeatedly in the text and in this case, across the case files. Once cores themes have been identified then subthemes can be created to add weight and context to the main themes identified. There were a total of five themes identified for the Face It case files, which are all discussed below.

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### 1. School

The review of the case files illustrated that many of the young people experienced difficulties during their school years. Many had poor school attendance either through being the victim of bullying at school or a lack of motivation to attend. This lack of education often led to poor education and attainment level. Most of the case files reviewed, demonstrated that most of the young people receiving intervention or

treatment from CAMHS were excluded from educational institutions periodically throughout their lives. Some of the young people demonstrated behaviour from as early as three years old and were subsequently excluded from nursery school.

## **2. Family Life & Relationships**

Reoccurring themes of the case files indicated that the young people's family lives were extremely complex and volatile. Most of the families had broken down and the young person was living with one parent, others were estranged from their family and living with friends, in local authority care or in hostel accommodation. The case files suggested that in some cases that domestic violence was a frequent occurrence in the household, and that many family members had a history of offending behaviour. Furthermore, the young people may have to deal with the demands of a family member with a mental or physical illness, which in turn leads to implications of neglect. More serious concerns include that of claims by young people of sexual abuse that appear to have not been formally reported.

Relationships with others, and particularly, inappropriate relationships with others reoccurred during the case file review. This was often due to the age gap between the young person and his/her partner, and the situations or circumstances that the young person often found themselves in with their older partner. A few of the relationships with partners could be described as 'unhealthy' with common aspects such as: verbal abuse; aggression; and negative consequences on the young person well-being. One case file illustrated overtly sexualised behaviour of a young person and the suggestion of unsafe sex practises, with the intention of becoming pregnant, as well as the young people's finding themselves in risky situations. Nevertheless, relationships with family were stated to have improved following sessions with CAMHS.

## **3. ADHD**

A diagnosis of or a suspicion of ADHD reoccurred within the 19 case files reviewed. All the young people identified as having a formal diagnosis or a suspicion of a diagnosis of ADHD had not been prescribed medication or refused to take their medication. Case files stated that further assessments into this diagnosis would be needed; however there was no record of this issue being followed up. A number of the young people linked to ADHD, also had file records of self-injurious behaviour and suicidal ideation.

#### **4. Protective Factors**

A protective factor is defined by Clayton (1992) as “an individual attribute, individual characteristic, situational condition, or environmental context that inhibits, reduces, or buffers the probability of drug use or abuse or a transition in level of involvement in drugs”. Protective factors does not automatically prevent a young person from taking drugs but can be seen as encouragement to an individual to resist from drug use through considering the positive aspects that they have in their life.

Initially from the case file review, it appears that very few of the young people maintained a protective factor. From the snapshot of a young person’s life that is gained through a case file review indicated that approximately only one young person demonstrated a protective factor (joining the army) that could be built on to deter this individual from substance abuse.