

# Tier 4 services for young substance users in Plymouth

An examination of needs and options

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on behalf of Plymouth DAAT

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## Executive summary

1. The consensus among those consulted was that a proportion of young people in Plymouth do use substances and that for a minority this use will become problematic as they get older.
2. There was recognition that this minority struggle with combinations of difficulties, the nature of which varies from one individual to another. Enlisting all relevant agencies to provide a joined up response was, people agreed, desirable and achievable in the City.
3. Views varied about how often and how much substance misuse featured in these combinations of problems some young people were up against. The impression gained in this study was that substance misuse was less likely to be identified in educational settings, and more likely to be identified by agencies when young people were in care or leaving care, were homeless, or had offended.
4. Alcohol, cannabis and amphetamines were the substances mentioned as most frequently impacting on young lives, by CAMH services or the Youth Offending Team, for example. There is some evidence, however, that those most at risk find access to services most difficult. Harbour YPS works with some young heroin users, for example, but at this point it would be rash to assume this represents the full extent of heroin users by under 18s in the City.
5. Most agencies agreed there remains plenty of room for services to develop further in line with the needs of their young clients, especially in how they recognize and response to issues of substance misuse. Those agencies, particularly Social Services, who had accessed the Harbour training programmes said this had done much to foster shared understandings between services as well as boosting individual practitioners' levels of expertise and confidence.
6. Enhancements to what services provide within the City and how they work together provide the obvious routes to more effective working with young drug misusers. Some options to advance this process are discussed in the final chapter.
7. Even so, it is probable a small minority find engaging with services and making positive changes very difficult while they still use substances. Access to resources away from the community should be retained as an option for these few when circumstances locally – such as substance misuse embedded in the family home, the peer group and the neighbourhood – conspire against them.
8. How more intensive interventions, in or out of the community, are to be funded remains largely unresolved. Because substance misuse will be accompanied by other domains of difficulty, there is room for agencies to contest responsibility. Only a collective approach, such as that underpinning the Child Concern Model for example, towards service provision and commissioning seems a realistic basis for the City to fulfil obligations to every one of its young people without exception.

## 1. 0 Introduction

### Aims

This study was commissioned by the Plymouth Young People's DAAT to contribute to an understanding of young people's needs for intervention and any gaps in service. The aims of this study, in line with the national objective of preventing today's young people becoming tomorrow's problematic drug users, were essentially twofold:

- estimate how many young substance users have levels of needs best served by access to Tier 4 levels of service
- explore a range of options for how these levels of service could reasonably be delivered.

### Vocabulary

The term *children* is applied to all those under the age of 18. *Young people*, in this survey, applies generally to children of secondary age and above.

*Substances* is used to include drugs and alcohol.

*Drug use, drug taking* are used as relatively neutral terms, albeit with recognition that all use of substances is potentially risky and harmful for this age group (Health Advisory Service, 2001). *Misuse, or problematic use* are distinct from experimental or recreational use. *Abuse* and *dependence* are mentioned only when they fit the diagnostic criteria (American Psychiatric Association, 1994).

The *Tiers 1 to 4* descriptions follow the Health Advisory Service guidance for design of young people's services, and not the NTA formulation which applies to adult models (HAS 2001; Models of Care, 2002).

Thus the term *Tier 4* describes "a complex package of care for a particular period rather than necessarily a particular setting", deploying specialized interventions to support work at Tiers 2 and 3, rather than replacing them. There may be a residential component, or there may not (HAS, 2001).

This model is quite distinct from Tier 4 substance misuse services for adults, which are assumed to take place in residential settings. This has led to some confusion, not least because, since the publication of Models of Care (2002), some intensive, highly structured programmes delivered on a day programme basis would vigorously assert their status as Tier 4 providers.

## Methodology

Till recently, very little was known about the numbers of young people using drugs problematically, although research is beginning to fill some of the gaps. There continue to be a number of obstructions, for example:

- where there is a strong anti-drugs culture in the home, young people will be reluctant to risk parental disapproval by speaking openly
- where drugs are used in the home, families may be strongly averse to contact with outside agencies
- families may be anxious that drug use by their younger members will reflect badly on them in the community
- children who have fled home may be wary of contact with professionals as leading to repercussions they prefer to avoid
- children with the biggest problems may have the biggest difficulties in accessing or sustaining contact with services.

It was decided therefore, in this report, not to chase data from young people at first hand because within the target group – young people using substances at the most problematic end of the spectrum – the above considerations would apply the most forcefully.

Furthermore, those who work with young people generally agree that serious drug use in the age group does not occur in isolation, but in combination with other problems and difficulties. Working through substance issues means recognizing there are other problems and planning some steps for their resolution too.

Working effectively thus means, for these young people with an array of inter connected problems, working together. Hence this study is as much a review of services, and how well they work together, as a review of vulnerable young people. Three approaches were adopted to tackle these questions.

1. Semi-structured interviews with representatives of children's services in Plymouth. In the text, quotations from these interviews appear in italics. Those consulted were asked to describe

- the remit of their agency
- the nature and incidence of drug and alcohol use among those young people with whom their agency had contact
- inward and onward referral mechanisms
- unmet needs and gaps in service

2. Pertinent management data and previous analyses of client characteristics were requested, with personal identifiers removed.

3. National and regional databases were trawled for research data that could be used to contextualize local findings.

## 2.0 Overview of young people's substance use

Practitioners in adult services are used to hearing stories of substance use surfacing in the very early stages of adolescence. Only quite recently has it been possible to set these individual narratives against a background of young people's drug taking nationally.

The picture emerging in the mid 1990s was that the numbers of young drug users were entirely disproportionate to the services available. The following offers an overview of what we know generally about young people's use of drugs and alcohol in this country. This will allow some comparison of young people's use of substances in Plymouth with what is known nationally.

### Smoking

- the proportion of 11-15 year olds who smoke has remained stable since 1998, at about 10%
- the prevalence of smoking was strongly linked to age: 1% of 11 year olds were regular smokers, compared to 23% of 15 year olds
- girls were slightly more likely than boys to be regular smokers – 11% against 9% – but tended to smoke less.

(ONS 2002)

### Drinking

- twenty four per cent of 11-15 year olds said they had drunk alcohol in the previous week
- the prevalence of drinking was strongly linked to age: 5% of 11 year olds, compared to 47% of 15 year olds, had drunk in the previous week
- for those who had drunk in the previous week, consumption had risen steadily between 1990 and 2001, from 5.7 to 10.6 units for boys, and from 4.7 to 8.9 units for girls.

(ONS 2002)

### Drug taking

- prevalence of having ever taken drugs in this age group fell from 29% to 26% between 2001 and 2002; drug taking during the last year also fell, from 20% to 18% over the same period. In 1998, however, just 11% were recorded as having taken drugs in the preceding year; this percentage rose steadily until 2001
- Cannabis was by far the most widely reported drug used by 11-15 year olds; 13% had used it in the previous year
- Corresponding figures for other substances were: solvents, 6%; stimulants, 6%; psychedelics, ie mushrooms or LSD, 2%; cocaine, 1%; opiates, chiefly heroin, 1%
- Prevalence of drug taking was strongly associated with age: 1% of 11 year olds reported cannabis use in the previous year, against 31% of 15 year olds

- There was a similar, if somewhat less striking, trend with class A drugs, from 1% of 11 year olds to 8% of 15 year olds. Four per cent of 11-15 year olds overall reported using a class A drug in the previous year.

(ONS 2002)

### **Drug taking by 16 to 24 year olds**

The association noted above, between age and substance use, is largely borne out by surveys of 16-24 year olds:

- thirty per cent had used drugs in the last year; 19% in the previous month
- cannabis had been used by 27% in the previous year; class As by 9%
- the proportion that had used drugs was similar in each bi-annual survey of this age group since 1994
- however the numbers who had taken ecstasy during the previous twelve months rose from 4% to 7% since 1994; the proportion who had taken cocaine rose from 1% to 5%

(DoH, 2003; cited Horton, 2003)

### **Ethnicity and substance misuse**

- white and mixed race pupils were more likely to have drunk, smoked or taken drugs than black or Asian pupils
- these differences were most pronounced for alcohol, followed by smoking, then drugs
- Asian pupils were the least likely to have used drugs in the previous month

(ONS 2002)

Overall, about one in four children aged 11-15, and about one in two children aged 15-16 will drink alcohol once a week or more. About one in ten children aged 11-15 will have taken drugs in the previous month. As children get older, they become more likely to use drugs and more likely to drink alcohol.

Parker and colleagues used the word *normalisation* to describe how drugs and drug users have become incorporated into young people's everyday realities (Parker et al, 1998). This is not to say that drug use is normal, but that it is so widespread that sooner or later most young people will be exposed to it in some form or another. A recent survey, for example, revealed that up to 62% of young people aged 14-15 are "fairly sure" or "certain" they know a drug user (SHEU, 2003).

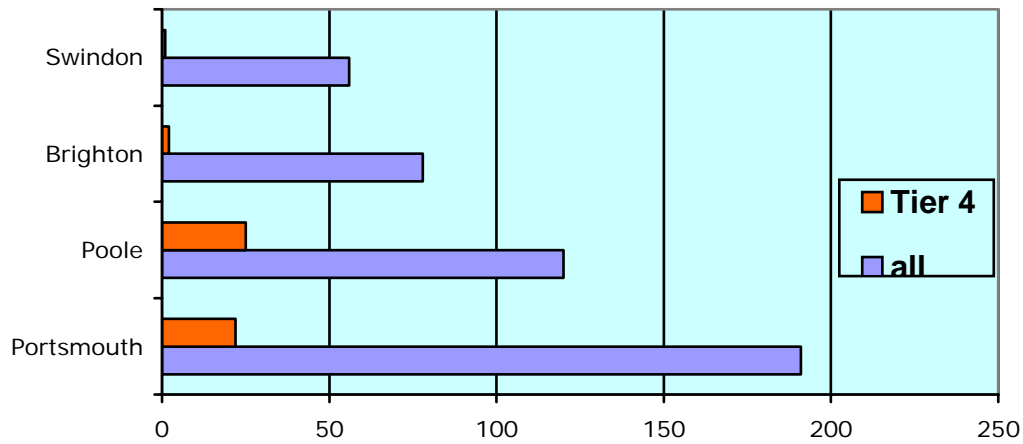
## Problematic use

There is broad agreement here, on the basis of these and similar studies, on how many young people take drugs, but much less agreement about how much of this use is problematic. This seems to be influenced by a number of obscuring factors:

- It may be hard to separate out drugs misuse from other problems, in terms of either causes or consequences. Hammersley and colleagues, for example, find the diagnostic criteria for substance abuse and dependence in adults based on a presumption of the substance causing or worsening the problems. This model may fail to capture subtle distinctions in how young people move into, and out of, periods of intensive use of drugs (Hammersley et al, 2003).
- Young people with the biggest problems may constitute invisible, or hidden populations. Such might be the case, for example, with runaways under the age of 16, or young people inveigled into the sex industry, where there might be strong disincentives not to contact services.
- How young people's substance use needs are assessed and measured may be influenced by the availability of services. Practitioners may be strongly opposed to assessing for a service they cannot access, or cannot fund.
- Willingness to identify a young person's drug use, and ability to do so, may vary between individuals and their host agencies. This may depend on the quality and availability of local training, or on different organisational cultures.
- Attributing behaviour to drug use may not be straightforward. Take a pupil in year 10 who arrives at school late and doesn't engage in the classroom. He was up till 3 am the night before smoking large amounts of cannabis with his mates. What drives this lack of engagement – drugs misuse, negative peer influence, or lack of parental supervision?
- Intervention at one level constitutes prevention at another. For example, properly resourced, thought through responses to address a young person's needs at Tier 2 level should substantially reduce the likelihood of their needing Tier 3 services later on. Conversely, pressure on Tier 4 services might signal inadequate delivery by other Tiers. Managers and practitioners may be tempted to depress measures of need in case they are thought to reflect badly on their agencies.

Some or all of these factors may have had a bearing on a questionnaire based survey of DAT areas in the UK during the winter of 2003-04. Young people's leads were asked to estimate how many under 18s were receiving interventions related to their drug use from Tier 2 and 3 agencies, and to estimate the numbers that would benefit from access to a Tier 4 resource. The table below gives a sample of the striking variety in responses:

Number of young people < 18 presenting to substance misuse agencies by area/numbers assessed as meriting T4 response:



(Taylor, 2004)

Demographic explanations alone do not account for these striking differences in numbers of potential Tier 4 candidates as a proportion of service users. Differences in resources, cultures and personalities are probably reflected, as much as differences in how drugs were being used locally.

In this study, therefore, assessing the needs and numbers of Plymouth's young, more problematic users involved learning how each agency viewed its young people, as much as learning about the young people themselves. Moreover, this would have direct bearing on the second task of this study. Clearly any discussion of appropriate options needs to take close account of what aspects of service each agency would be willing, and sufficiently resourced, to provide.

### 3.0 Risk factors

Although substances now widely available, and many young people take them, it is clear that for most this use is experimental or recreational. The emphasis on providing children with clear information, as part of prevention and harm reduction strategies within mainstream services, seems therefore to make obvious good sense.

In the UK, research into why some of these young people go on to use substances problematically, while the majority do not, has pursued various overlapping lines of enquiry.

#### **Risk factors**

The first explores personal and environmental factors which seem to encourage susceptibility to a range of negative behaviours. The same cluster of factors seems to predict both offending and substance misuse, according to a body of research cited by Hammersley and colleagues. Once these behaviours develop, they may become mutually reinforcing, prolonging drug using or offending careers or both. These underlying factors include:

- disrupted family background and low parental supervision
- associating with delinquents
- poor social skills
- low psychological well-being
- a history of age inappropriate behaviour
- difficulties with school
- having been in care
- having been abused

(Hammersley et al, 2003)

Spooner and colleagues find a similar range of factors influencing the later development of substance misuse, including

- genetic vulnerability
- poor family relationships and impaired parenting abilities
- childhood physical and sexual abuse
- social and economic deprivation
- poor school relationships
- anti-social behaviour
- being labelled a drug abuser

(Spooner et al, 1996).

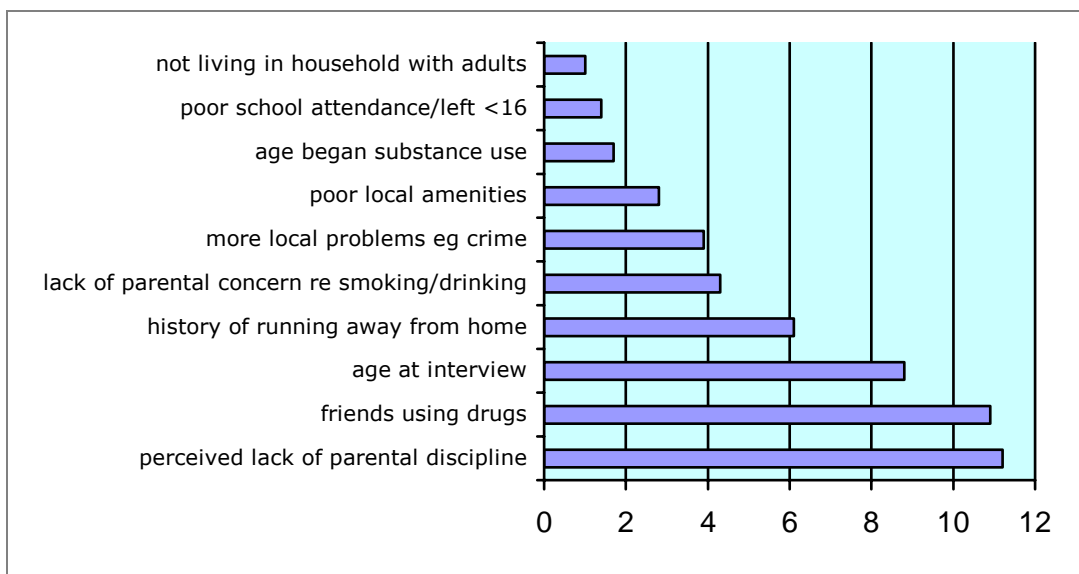
McArdle and McLeod highlight three factors with a bearing on the risk of developing substance misuse

- early onset ADHD, associated with a range of later difficulties. Families where resources are stretched can easily become fraught and unsupportive
- conduct disorder, again associated with a range of problems including high risk of substance misuse.
- association with drug using peer groups. These researchers take the view that "the availability of drugs through peer groups is virtually a necessary condition for drug use and misuse".

(McArdle and McLeod, 2004)

An important study by Beckett and colleagues interviewed 103 young drug users in contact with services, to discover the relative importance of different risk factors linked to problematic drug use. The results are summarized in the table below.

Hierarchy of risk factors among 103 service users in Stoke and Newcastle on Tyne



(Beckett et al, 2004)

Bearing in mind that only young drug users in contact with services were surveyed, the researchers found that these factors could account only for about half of the variance in drug use among the group. The following points are highlighted:

- attempts to lower young people's problematic drug use should take account of the hierarchy of these risk factors
- the balance of psychological and social exclusion factors should be carefully weighed in considering possible interventions. While 60% of the sample came from areas of moderate to high deprivation, the level of deprivation was not associated with individual levels of problematic drug use. Such drug use, however, was associated with individual circumstances such as running away from home and truancy

- problematic drug use was the culmination of several years of drug use, during which peer group influence was pivotal in reinforcing drug using identity and behaviour
- hence social learning theory should be considered in planning effective interventions.

(Beckett et al, 2004)

### **At risk groups**

These studies unanimously stress that young people who use drugs, or use drugs problematically, can not be considered as a homogeneous group, and that the factors disposing young people to try, and continue taking, substances combine in different and complex ways in different individuals.

It is, however, well established (eg HAS, 2001) that particular groupings confers extra layers of risk on young people who join them. Within these groupings, the risk factors discussed above seem more likely to cluster together and thereby add impetus to substance misuse.

The following chapter views how individual agencies in Plymouth assess the needs and characteristics of young people in these vulnerable groups.

## 4.0 Vulnerable groups

### 4.1 Looked after children

#### Background

Abundant research describes how looked after children are more susceptible to disadvantages and difficulties during adolescence and as young adults.

For example, 23% of adult prisoners and 38% of young prisoners have been in state care as a child (Horton, 2003); those in state care are more likely to have run away from home (SEU, 2002), more likely to experience later periods of homelessness (Randall, 1998), and less likely to pass school exams (DH, 2003) than their counterparts in the general population.

Within this general picture of disadvantage is an increased likelihood of developing problems with drugs and alcohol (HAS, 2001), but how often this happens remains unclear. There are several factors behind this, but one of the most interesting is that adults' perceptions of whether children use substances seem to be strongly related to their role. A study of those taken into care by Essex Social Services, for example, found that children's foster carers were very much less likely to think they were taking drugs than either residential care workers or their social workers (Hamilton et al, 2001).

There is no evidence that, of itself, being in care causes problems with substance use – in fact for the majority of children being in care is a positive experience. But, prior to being in care, these children will very often have had to endure the same sort of problems at home that feature so commonly in the stories adult substance misusers tell about their childhoods. Only about one in twenty is in care as a result of their own actions.

Children looked after in England at 31 March 2001, by category of need (excluding agreed series of short term placements)

Category of need	Number	Percentage
Abuse or neglect	37,100	62
Parental illness or disability	3,700	6
Family in acute stress	4,100	7
Family dysfunction	6,200	10
Low income	90	0.2
Absent parenting	4,300	7
Disability	2,300	4
<i>Total</i>	59,700	100

(DH 2003)

For a minority of children, however, and their carers, the challenges of settling into a new home may be beyond them. Those children from a history of poor parenting may struggle to adapt to placements, with carers feeling pushed to their limits. Children exposed to a succession of placements are known to be even more vulnerable to a realm of disadvantages.

## Plymouth

About one in 200 of the national population under 20 live in Plymouth, as shown in the table below:

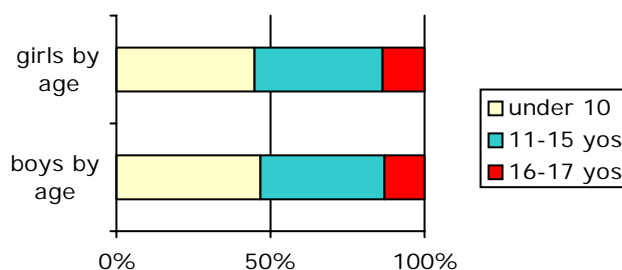
Number of children and young people 0-19 in England

	England	SW Region	Plymouth
Number	12,310,418	1,171,263	60,573
As a percentage	100	9.51	0.49

Derived from Census 2001

In 2004, about 515 Plymouth children were in care. Within this group, there is an even balance of boys and girls. Those of ethnic origin make up 3.83% of the total, suggesting a degree of over representation.

Male-female distribution among looked after children



Ethnic origin among looked after children

White	496
Mixed	9
Black/black British	7
Other ethnic	3
Total	515

Locations of  
looked after children

Foster placement	381
Children's home	32
Secure unit	2
Hostels	3
Residential schools	3
Other residential settings	6
Placed for adoption	31
Placed with own parents	48
In lodgings or similar	8
Other placement	1
total	515

### **Social Services: Child and Family Services**

The Child and Family Services team estimated that 60% of these looked after children came from backgrounds where drug use was endemic in the household, and that among these children there would be very high rates indeed of experimental drug and alcohol use.

A minority of these children would be vulnerable to a range of potential difficulties in which substances might well be significant.

*By age 10 to 12 you've certainly got a handful of young people with the potential for major harm. By 16 or 17 they're likely to have a multitude of problems, such as initial poor parenting, multiple placements, limited if not zero education. They may be completely disengaged. Quite a few will end up in the care leavers service, and again these are at high risk.*

*In a year there might be 8 males, maybe 2 females, with a combination of difficulties including mental health issues, learning disabilities, and patterns of association with known drug users and dealers.*

The table below shows the current individual cases of looked after children, nineteen in all, where the risk of substance misuse was assessed as more than mild. The scoring system, applied across all domains, is based on the following: 0 = no risk; 1 = slight risk; 2 = some risk; 3 = moderate risk; 4 = severe risk.

Age	Placement	subs misuse	Known offender	Low school achieve	Regular school absence	Emotional disturbed	ASB	Behav- ioural concern	Lacks parent super- vision
16	HMP	3	y	3	4	2	4	3	1
17	Supported	3	y	3	1	3	2	3	1
13	Vol Acc.	3	n	3	1	2	3	3	1
17	Vol Acc.	3	n	1	1	2	2	1	1
15	Remand	4	y	4	4	2	4	1	4
14	Children's Home	3	y	2	4	4	4	4	4
16	Family	3	y	4	4	3	2	2	4
12	Placement	2/3	n	4	4	3	3	4	4
13	Residential	4	n	2	4	4	4	4	4
14	Independ't	2/3	y	4	0	4	4	4	0
14	Placement	2/3	y	4	4	3	3	4	4
14	Family	3	n	4	2	4	0	2	2
16	Residential	4	y	4	0	4	4	4	0
13	PWP Reg	4	y	4	4	4	4	4	4
15	Residential	3	y	3	4	3	4	4	3
15	Foster	4	n	4	4	4	1	1	2
16	Sp. Res.	4	warning	4	4	4	4	4	4
17	Foster	3	y	2	2	2	2	2	2
17	Care Leaver	4	n	0	4	4	4	4	4

Extracted from Plymouth Social Services record of Looked After Children over five

These data seem to confirm that high risk of substance misuse is usually, perhaps always, accompanied by high risks in other areas of a young person's life.

There were other groups attracting high levels of concern within this agency;

- Young people with ASBOs: likely to end up in poor accommodation, perhaps bed and breakfast, which they may have to vacate during the day. These are often located in disadvantaged areas with poor access to amenities and good access to negative peer cultures

- Children missing or excluded from school: a range of concerns are expressed about where they are, who they are with, and what they are doing. At an age when they may be experimenting sexually, they may lose access to guidance and information and be more likely to take risks if substances are available. Drugs use can provide a pathway towards exploitation by adults – possibly sexual, especially in the case of girls. The opinion was that there were six or so adults that actively recruited, or tried to recruit, boys as runners in the drug trade.
- There was somewhat less concern about young runaways, at least as a group. Most were girls, and most were running to be with boyfriends – in most cases, their destinations were known. One or two looked after children were reported missing each month, but this number had dwindled to one or two in total over the previous year.

### **Social Services: Advice and Assessment Team**

This team came into being in May 2004 as part of overall service re-organisation and improvement. This is the initial point of contact for any young person in the city under the age of 18 about whom there are concerns.

The view expressed was that "substance misuse features extremely heavily" in the lives of these young people. Both drugs and alcohol feature prominently – the comment was that it would be a mistake to over separate these two issues, "the effects are just as appalling".

There had been no systematic analysis of how prevalent these effects were, but the perception was that Plymouth reflected the national picture of problematic substance misuse in families, described so powerfully in *Hidden Harm* (ACMD, 2002).

However, a straw poll in 2003 gave a snapshot view of approximately 176 children then on the child protection register. The three main reasons given for calling a case conference were drugs and alcohol misuse, domestic violence, and parental mental health issues.

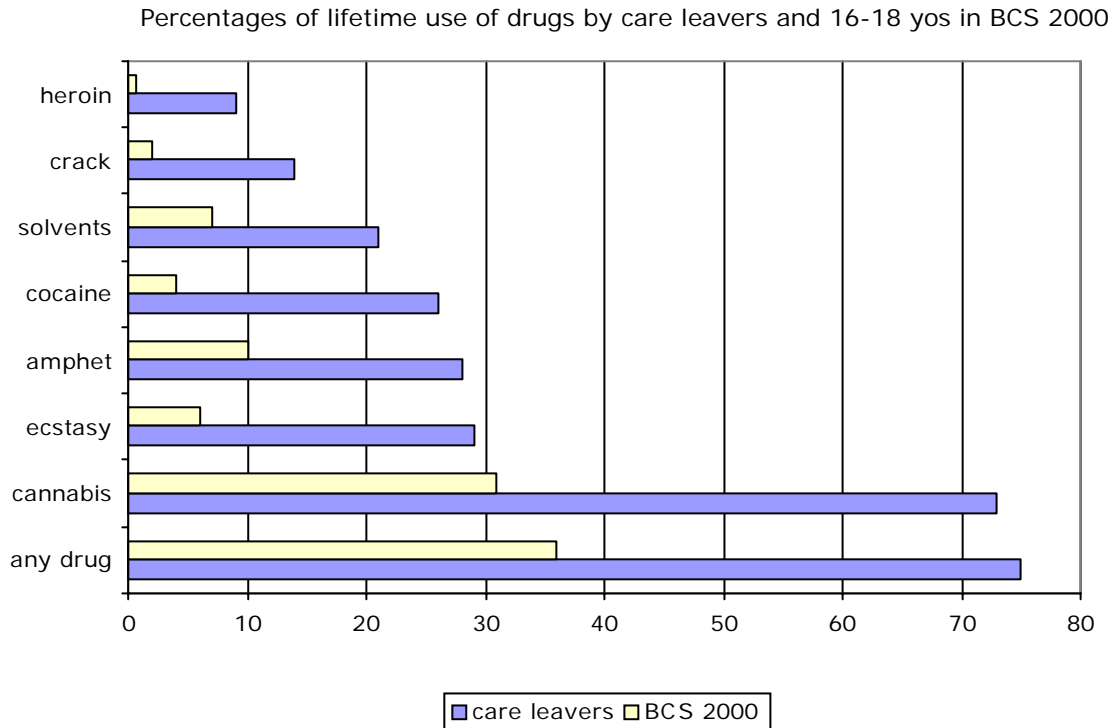
*I would be very surprised if these were not the prevailing issues now – and with children taken into care.*

## **4.2 Care Leavers**

### **Background**

Various studies have noted care leavers are disproportionately more likely both to leave school without qualifications and to face problems with housing and employment (DH, 1999). They have also been widely supposed to be vulnerable to a range of poor life outcomes, including problems with drugs.

Ward and colleagues (2003) confirmed that age for age, drug use is much more likely to feature in the lives of care leavers than in the general population. The table below compares lifetime drug use by the 200 respondents in their survey with 16 to 18 year olds in the British Crime Survey, 2000.



(Ward et al, 2003)

While differences between the two groups are marked across the range, these researchers note that it is in their use of class A drugs – ecstasy, cocaine, crack and heroin – that these differences are most conspicuous.

Ward and colleagues attribute this enhanced vulnerability to drug use by care leavers to various factors, covering the extra difficulties they will have faced before, during, and after the care experience. They found that most care leavers who had used drugs had experienced few problems, or problems which tended to die away as they succeeded in stabilizing other areas of their lives. Stability took the form of securing their own accommodation, or rekindling family relationships.

A small group within the sample, however, struggled to make progress:

A minority, who had developed persistent and worrying patterns of substance misuse, would need the support and assistance of specialist services and professionals for some time to come

(Ward et al, 2003)

Stein (forthcoming; cited in Allard et al 2004) finds a close association between the resilience of care leavers and their experiences both before and during care. He suggests three loose knit groups according to their resources to meet challenges:

The moving on group are likely to have had stability and continuity in their lives, are highly resilient, welcome increasing independence and are able to make good use of the help offered them.

The survivors group have experienced more instability, movement and disruption. Positive outcomes for this group are likely to rely much more heavily on the quality of aftercare support that they receive.

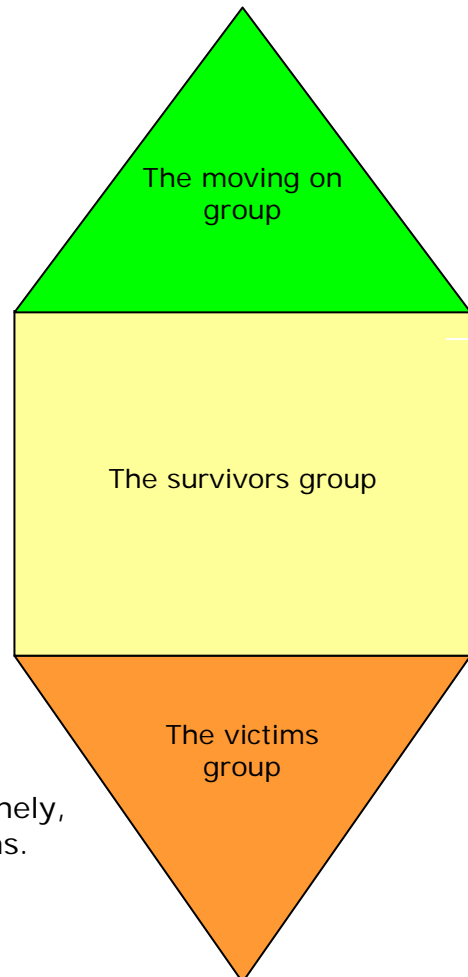
The victims group have had the most damaging pre-care experiences and care was unable to compensate fully for this. They are the most likely to be unemployed, homeless, lonely, isolated, and suffer from mental health problems. Aftercare support was unlikely to help them overcome their poor starting points, but was very important to them.

(Stein, forthcoming; cited in Allard et al 2004)

Allard finds support for this view in her 2002 study, quoting for example the view of one project manager:

I mean you can divide the leaving care population up. There's the 20% at the top who have been in a secure foster placement for years and years, are doing A levels and will probably go back to the foster carers and they're fine and sorted. There's the 60% in the middle that struggle a bit and have a hard time, had a few placements, and I think they're the ones we really make the difference with. And then there's the 20% who are really hard to engage, really damaged and will struggle, will always struggle post 21, whatever we do. I hope we can improve the quality of their life and their life chances, I hope we can, but I think there's realistically a limit to what we can achieve.

(Allard, 2002)



## Care leavers in Plymouth

The views of the Plymouth Care Leavers Team broadly coincided with those expressed above. There are currently about 200 care leavers registered with the team.

*The majority are doing ok. If they are doing drugs, they're not causing problems.*

However, the service identified a number of care leavers – between ten and twenty – with very complex individual needs. Working with these needs should involve addressing multiple issues, such as criminal involvement, anger management, emotional damage, poor social functioning, poor educational achievement, and drugs misuse.

*Any Tier 4 service for these young people would need to address all of these issues together.*

The team predicts about five young people with this level of need will be entering the service over each of the next five years.

### *Case study*

*One particular young person in care I'm thinking of, being in care contained him, but it didn't address the underlying issues. Probably only limited services were offered, and if more had been available there would have been a struggle for him to engage. It now looks like there's three probable options waiting him in the future– death, prison or a mental health setting.*

*When he came out of care it all went horribly wrong. He'd rejected the idea of remaining in care so, working with Supporting People, we managed to come up with a last ditch attempt to accommodate him. We got him a two bedroom flat, which the Care Leavers Team sourced and furnished for him. We arranged 24/7 floating support for him too. Then a drug user and his drug using girlfriend moved into the flat too and before long it was completely trashed.*

*The next step was to move him out of there and into a one bedroom property. Currently the team are door stepping him to keep in touch, we'll keep him till he's 18 and our duty of care expires. He'll probably be sofa surfing or rough sleeping as he's not likely to be able to sustain the tenancy, and most likely end up in jail.*

*The biggest difficulty for him isn't what happened while he was in care, though there could have been multiple placements. It's the ten years of shit he had to go through before he got into care – how do you dig through that?*

## 4.3 children excluded or missing from education

### background

Schools play a pivotal role in young people's journeys towards maturity and citizenship. Education encompasses aspects of social, physical, emotional and intellectual growth and development considered indispensable for a successful transition to the adult world. This view is fundamental to the vision of five key outcomes at the heart of *Every Child Matters*.

For a significant minority of children, use of substances will materially hamper these developmental processes. Substance use can undermine children's motivation, restrict their engagement with peers and with staff, encourage affiliation to negative social groupings, cause them to behave unacceptably, and lead to truancy or exclusion.

Whether or not substance use has been a factor in a young person's exclusion, the evidence is clear it is much more likely to play a part once that young person is no longer attending school.

For example, the Health Advisory Service Review found that

- excluded children were almost twice as likely to drink regularly
- sixty per cent reported use of cannabis and 20% use of amphetamine and ecstasy – more than four times the rates for school attenders.

(HAS, 2001)

A survey of 258 excluded children found rates of drug use within this group were very much higher than for this age group of schoolchildren generally.

- Eighty per cent had used cannabis; many were using it daily
- sixteen per cent had used cocaine
- twelve per cent had used crack cocaine
- four per cent had used heroin.

Interestingly, drug related incidents were identified as the reason for exclusion in only five of the entire sample (Powis and Griffiths, 2001).

The details of just how absence from school impacts on a young person's susceptibility to substance misuse will vary with individuals. A major concern must be around what they do and who they are with in their time away from education. It is well known, for example, that both temporary and permanent exclusions are associated with a three times greater risk of offending (Graham and Bowling, 1995), while half of all school age offenders have been excluded from school (Horton, 2003). The likelihood, for many, is that positive influences will diminish, leaving room for negative influences, such as peer groups involved in substance use and offending, to assert themselves.

## Exclusion statistics

The school year 2001-02 saw a total of 9,519 children permanently excluded from school in England. Eighteen per cent of these were girls. Fifteen per cent were from ethnic minority groups, though there was marked variation across the groups: 41 in every 10,000 black Caribbean pupils were excluded, the highest rate for any ethnic group, with only two in 10,000 Chinese pupils excluded, the lowest rate.

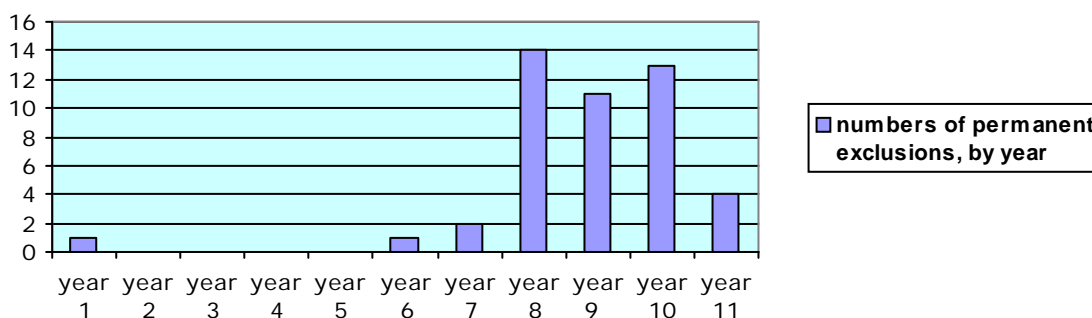
There were a total of 7,740 pupils permanently excluded from secondary schools, and 1,450 from primary schools. Exclusions were most common for 13 and 14 year olds, who represented half the total number (Horton, 2003).

## Plymouth

The number of permanent exclusions reported in Plymouth is substantially lower than the national average, with a total of 46 for the year 2003-04. three of these exclusions were from special schools, two from primary schools, and the remainder from secondary schools.

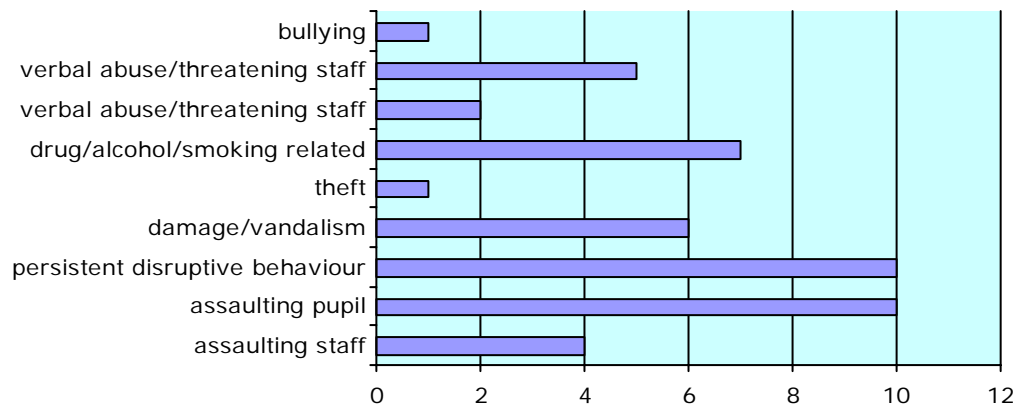
There were also a total of 53 managed transfers in the same period. Three of these were between special schools, eight between primary schools, and the remainder between secondary schools.

Of the 46 permanently excluded, 14 were girls and 32 were boys. Numbers of exclusions peaked with the 13 to 15 age group, as shown in the table below:



[derived from pupil movement data 2003-04, Department for Lifelong learning]

Available data on the reasons for these permanent exclusions are summarized in the table below:



[derived from pupil movement data 2003-04, Department for Lifelong learning]

These charts give little hard information on how substance misuse is featuring in the lives of these excluded children. For example the figures for alcohol, drugs and smoking are aggregated – smoking at age 11 or 12 may well be a predictor of later substance misuse, but smoking at age 14 or 15 is more likely to be one of several possible symptoms of adolescent rebellion.

Again, outbreaks of aggression may or may not be directly linked to use of substances.

What is clear is that children are very much more likely to be excluded around the ages of 12 to 15. This is the stage of early adolescence when changes in every aspect of young lives are at their most rapid, when there is the most likelihood of tensions and conflicts at home, and when they are at most risk of sowing the seeds of negative attitudes and behaviours.

The full impact of a young person's exclusion from school may not be immediately apparent. Berridge and colleagues, for example, found that excluded children were more likely to become offenders, but this transition could occur over the course of a year or so while associations with negative sub cultures developed (Berridge et al, 2001).

A similar process may be at work as excluded children become initiated into more risky drug taking behaviour. This would help to explain why, in the Powis and Griffiths study, the great majority had used drugs but substance use was cited in so few cases as the reason for exclusion (Powis and Griffiths, 2001).

### **Pupil Referral Units**

In September 2004, there were about 90 pupils registered with pupil referral units, with this number expected to double over the course of the school year. It includes children from a variety of backgrounds: some are children who refuse to attend school; some are children not responding to

mainstream provision and enrolment with the PRU may, if they do not respond there, be a step along the way to exclusion; some have been previously excluded; some will have arrived in Plymouth during year 11, the GCSE year when schools may be reluctant to accept new entrants.

At the time of consultation, 133 were registered. The majority of these were attending the 5 days a week programme for small groups of pupils. However, reflecting the variety of needs and circumstances in the excluded group, 16 were booked for one to one tutoring, and a further 13 on New Start programmes. Twelve were described as refusers and held on an alternative register.

PRU staff said that of the 133, one had been excluded as the result of cannabis use, one – aged 15 – was an alcoholic, and one or two more were using more serious drugs. One other had arrived at the PRU smoking cannabis. Pupils under the influence of substances are not allowed to attend.

Further data on substance use by this group was not readily available. The PRU itself does not screen for substance use. If substance use was the cause of a particular exclusion, then this would be stated in the paperwork, but trawling individual files would be the only way to get this information.

Snapshot PRU register,  
January 2005

Total excludees	133
One to one tutoring	16
New Start	13
School refusers	12
Number with substance issues known to staff	4

## Connexions

Connexions now collects data on clients' use of substances including alcohol, as outlined below.

Peninsular 13-19 year olds known to Connexions at 31 December 2004

area	Known to service	Substance use identified as a factor
Plymouth	24,149*	24
Cornwall	41,323	51
Torbay	12,046	24
Devon	52,186	21

\*this figure includes some young people from outside the city boundary

It is clear immediately that these figures also do not reflect the prevalence of substance use described in national surveys of this age group. Those surveys would suggest incidence rates in the order of 1:10, rather than the 1:1000 or 1:2000 estimated here.

The figures again take us to the heart of some of the problems in trying to learn more about the target group's substance use.

- First, addressing substance related issues is not what the service was set up to do. Resources are limited: there are about 250 personal advisers available in the peninsula to work with 130,000 or so young people.
- These issues may get discussed, but are more likely to surface as barriers to progress in other areas rather than in their own right. There is recognition that substance use may be important, but it has to take its place along with other competing problem areas.
- If the issues do surface, they are not recorded unless the young person consents.
- Staff may feel uncomfortable with these issues
- How they approach collecting such information will vary between personal advisers.

Overall, the perception of managers was that one should be very cautious in drawing conclusions from these broad indicators, which show only "the tip of the iceberg".

By contrast, the statistics on how young people are occupied point to a substantial number who are neither in work nor training. A proportion of those will have additional domains of problems, including vulnerability to substance misuse, though how many this would apply to remains unclear. The following table shows Plymouth 13-19 year olds known to Connexions at 31 December 2004:

Pre 16 education	11,059
Post 16 education	7,647
In supported work based learning	755
In employment training	1,101
In employment, without training	2,223
Engaged in voluntary work or personal development	44
In custody	12
New deal	38
Not engaged in ETE, ie unemployed	482
Not engaged in ETE, ie not available	216
Status not known, ie lost touch	709
Discontinued contact	74
Total	24,360

\* the totals for Plymouth in these two tables depend on how they are counted; the figures supplied by schools include pupils from catchment areas that may extend beyond the city boundaries.

#### 4.4 Young Offenders

Evidence continues to gather that young drug misusers are more likely to commit offences, and that young offenders are more likely to be misusing drugs, than their counterparts in the general population.

While with adults there may be good reasons to link drugs misuse causatively with certain types of offending – acquisitive crime funding daily heroin use, for example – these issues may be less clearly cut in the lives of young people. Current research tends to identify different risk factors and examine how, in certain groups of young people, these risk factors are more likely to combine in an overall picture of vulnerability, with substance misuse more likely to be playing its part.

Thus a survey of 186 referrals to the Wolverhampton Youth Offending Team found prevalence of drug use well in excess of the national average:

- more than half described themselves as current smokers [59%] and drinkers of alcohol [55%]
- over half the smokers reported first use at age 12 or under, as did the drinkers
- nearly half the young people reported having taken an illegal drug [47%] and half of these [49%] had first done so at age 12 or under
- the most commonly used illicit drug was cannabis, two thirds [65%] of those who had used any drug had only used cannabis
- one in six had tried more than one drug. Of these all had used cannabis, 46% amphetamines, and nearly one third crack, heroin and solvents [32% for each]

(Green et al, 2000)

Early first use of tobacco, alcohol and cannabis has been linked in previous studies to an increased likelihood of developing substance related problems in adolescence (Blenkinsop et al, 2002). The vulnerability of this group is further enlarged by a range of personal, social and environmental factors. Green and colleagues found that:

- over half were not in school, training or employment – only a third [36%] were attending school regularly. Teachers’ ratings were that 35% were below average performers at school – 15% of the young people rated themselves as having difficulties with concentration, reading and writing skills
- nearly a third [30%] were not living with either of their natural parents, and 12% did not feel safe where they were living
- nearly one in five [18%] were living in families where drugs were used regularly, and one in 6 [15%] had been exposed to violence
- nearly one in five [19%] of the young people had previously endured sexual and/or physical abuse
- over half of the young people [55%] reported that they had lost a close relative
- one in ten [11%] of all the young people interviewed had either been pregnant or, in the case of young men, had been responsible for a pregnancy. Over a third of all the young women [34%] had been pregnant at least once. Five percent were parents themselves and two of them each had three children at the time of interview
- living in an “unstable” environment was significantly associated with drug taking, as was infrequent school attendance
- there were strong associations between previous experience of sexual or physical abuse and subsequent polydrug taking.

(Green et al, 2000)

This research confirms that, as a group, young offenders are susceptible to a deeper and wider range of needs than, age for age, their law abiding equivalents in the population at large. How well these needs can be addressed in the community will bear on their futures. One danger, for those whose criminal careers develop, is that once in custody substance misuse issues are less likely to be addressed and more likely to become entrenched. The number of young people is substantial, and seemingly still on the rise:

Population of prisoners aged 17 and under, on 30 June 2002 (England and Wales)

Population of 15 – 17 year olds	All custody types	Detention and training order	Section 90-92, Powers of Criminal Courts Act 2000
Males	1,980	1,561	419
Females	104	85	19
Total	2,084	1,646	438

(Home Office, 2002)

For example, a 2001 survey of minority prisoner groups examined the needs of 80 male young offenders known to have substance misuse issues. These needs proved to be wider and more pressing than those of young people generally, with mental health issues particularly prominent.

- 76% were assessed as dependent on one or more drugs
- 42% were dependent on crack or heroin or both
- 94% used cannabis; 10% were dependent on it
- one in five were injecting; one in 20 had shared injecting equipment
- one third had had contact with mental health services outside prison and a similar proportion received help inside
- one in four had self harmed
- one in five had tried to take their own lives
- many had been victims of assault, many had been exposed to violence within the family
- over half said that most or all of their family or friends had problems related to alcohol use.

[Borrill et al, 2001].

The authors are clear that these young men “had a range of psychological and emotional problems needing to be addressed in parallel with attempts to manage their substance misuse”. [ibid, 2001]. With concern continuing to mount about the safety and welfare of children in penal settings (eg NACRO, 2005), measures to address these needs within the community should be prioritised.

## **Plymouth**

The background evidence, then, indicates young offenders are likely to be affected by a range of problems, in which mental health needs and substance issues are prominent. Once in the secure estate, it seems, these needs are less likely to be identified and less likely to be addressed.

Plymouth YOT statistics for the year ending 31 December, 2004, show the police took action against 883 young people, aged 17 or under, who had committed an offence.

Action taken against offenders under the age of 18, year ending 31 Dec 2004

Action	White	Ethnic minority	Male	Female	Total
Reprimand or warning			292	103	395
Community sentence	468	8	410	66	476
Of which, detention orders	12	0	11	1	12
			713	170	883

From quarterly returns to Home Office, 2004, Plymouth Youth Offending Team

About half of those receiving a community based sentence will be required to work with the YOT. All of these will be screened for substance misuse, with 20 or 30 per cent receiving or referred on for an appropriate level of intervention.

	April-June 2004	July-Sept 2004
Number of young offenders	60	70
Screened for substance misuse	60	70
Those with identified needs requiring s/m assessment	23	17
Those requiring Tier 2 early intervention and treatment	18	9
Those requiring Tier 3 early intervention and treatment	5	8
Those requiring Tier 4 early intervention and treatment	0	0

Quarterly statistics, Plymouth YOT

Team members have a variety of professional backgrounds and have undergone training in Tier 2 levels of intervention. The team funds a substance misuse worker, located within the Harbour young people's service, which is relied upon to provide further intervention and support at the Tier 3 level. There is therefore a good basis for identifying and responding to the needs of the client group in respect of substance use.

Having a drugs worker located away from the YOT had advantages and disadvantages; some team members had said they would prefer this worker to be on site.

Alcohol was reckoned to be more of a problem than drugs, and featured more often in cases of violence.

Although Tier 4 referrals did not feature in the data examined for this report, there were some interesting reflections on those clients with the severest level of needs.

*There's a small number – maybe four or five in a year – that agencies are most worried about. These people are both least inclined to access services, and least in a position to do so. How do services make themselves more accessible, and how do you link with other services to address other needs?*

*Effective practice tells you to work with the whole range of needs. But first you have to stabilize them. They've probably either exhausted services, or not accessed them, and they may have picked up a diagnosis of 'untreatable'.*

*If you send people away they may stabilize, once you've isolated the external factors – the home environment may actually have been reinforcing an offending lifestyle.*

#### **4.5 homeless young people**

The needs of the homeless, especially under 18s, have been generally under-represented in the research literature. Emerging research shows that not having somewhere to live may badly hamper life chances generally, and escalate the chances of developing substance related problems.

In a survey of adults using substance misuse services in Gloucestershire, homelessness was reported as the number one problem associated with their drug use (Clark, 2002). Substance misuse may both precipitate homelessness, by encouraging the breakdown of tenancies or family relationships at home, and prevent its resolution.

Examining the circumstances of 160 homeless young people aged 16 to 25, Wincup and colleagues found

- the most commonly reported factor behind their homelessness was family conflict and experiences of abuse, followed by substance use
- a high proportion had slept rough at some point
- drug use among the sample was high: 95% had used drugs, 43% had used heroin and 38% crack cocaine
- ninety five per cent had committed an offence – a quarter linked their offending to alcohol and a quarter linked it to drugs

- seventy per cent had concerns about their mental health, or had been diagnosed with mental health problems
- many had been victimised; most believed that homelessness had adversely affected their physical health.

(Wincup et al, 2003).

This research endorsed an earlier study of young people aged 16 to 18, which found clear links between homelessness and a cluster of problems including school exclusions, mental health issues and substance use:

- eighty per cent of men in one location and 91% in another had used drugs, mainly cannabis, within the last year
- the corresponding figures for young women were lower, at 46% and 73%
- figures for heroin use in the past year, at 10% and 21%, were significantly higher than for this age group in the population at large
- anxiety and depression affected a substantial minority
- half the sample in one location, and 30% in the other, had experienced school exclusion

(Adamczuk, 2000)

Again, there is no suggestion that homelessness *causes* substance misuse; in fact the researchers found many young homeless taking positive steps to address their predicaments. However there is little doubt that as a notional group, homeless young people may have little resources or support to fall back on, a variety of unmet needs, and be exposed to a spectrum of risks. These factors may provide fertile ground for substance misuse to take root.

## **Plymouth**

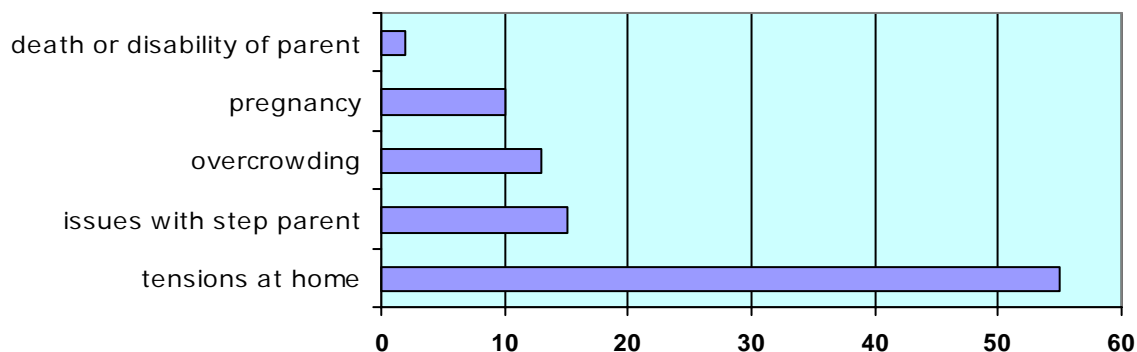
Information, advice and support in respect of housing needs is one of the core services provided by the Youth Enquiry Service (YES). While the Care Leavers Team and YOT undertake housing assessments for their own clients, housing assessments for all other young people age 16 and over<sup>1</sup> will be carried out by YES.

In the 12 months to the end of March, 2004, 401 young people presented to YES with an accommodation issue. Of these, 221 were considered actually homeless and their housing needs assessed.

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<sup>1</sup> If under 16, the statutory requirement is for Social Services to be informed. Nationally, the usual outcome is for the young person to be returned "home". In practice, where someone has fled an untenable situation, this may well deter them from contact with services.

Reasons given for accommodation issues, by percentage, to 31 March 2004



Except for pregnancy, these presenting issues look within the range of difficulties one would associate with the transitions of adolescence, when family relationships may come under strain. However, the more detailed assessments carried out by the YES team reveal a larger spectrum of need and vulnerability, demonstrated in the table below:

Needs of 221 homeless young people aged 16 to 17 presenting to YES in year to 31 March 04

Additional needs identified	number	percentage
experience of neglect or emotional abuse	63	29
experience of physical abuse	59	27
learning disability	26	12
time in care (but not care leavers defined by Children Leaving Care Act 2000)	26	12
offending history	25	11
mental health issues, including depression and self harm	23	10
parental substance misuse	16	7
own substance misuse	11	5
experienced sexual abuse	6	3

It is probably best not to read too much into the data within this table on substance misuse. Young people may be reluctant to disclose this information, even when the consultation is handled sensitively and within a young person friendly setting, as discussed at the beginning of this report. They may reason that reporting substance misuse will work against their own perceived interests or those of their family. In addition, there may not be an agreed understanding of what is meant by the term "misuse".

Neither can one derive a clear picture of whether these additional needs are evenly spread across the group, or whether they tend to cluster together in a relatively small number of individuals.

What is clear is that potentially severe problems may loom large in the lives of young people in Plymouth who are, or are about to become, homeless. While none of these problems should be taken to cause substance misuse, they clearly occupy the general domain of difficulties which render young people vulnerable. If the issue of accommodation remains unaddressed, it seems likely that these vulnerabilities will intensify or combine with others, in some cases increasing the risk of substance misuse.

#### **4.6 young people with mental health issues**

An ONS survey in 1999 found mental disorder occurring in 10% of boys and 6% of girls aged five to 10 years, and in 13% of boys and 10% of girls aged 11 to 15 years. These disorders cover a range of symptoms and behaviours associated with distress and substantial interference with personal functions (NCH/Guardian 2004).

Some of these conditions – such as eating disorders, and self-harming – may, at least in part, be children's attempts to cope with unsustainable relationships and situations, often in the home. The numbers affected are colossal. A&E departments have reported that self-harm related admissions surged from 1.54% of total attendances in 1991 to 2.42% in 1997, with further increases since (Observer, 2004).

Links between substance misuse and mental health issues in adolescence have been documented, particularly in the USA, but fall largely outside the scope of this present study. It is worth mentioning, however, some of the emergent themes:

- self-medication of psychiatric symptoms has been identified as one of the reasons young people take drugs (Ghodse, 2004)
- drug use may interfere with normal cognitive, emotional and social development
- drug use may obstruct the progress of mental health treatments, making it more difficult to keep appointments, for example, or more difficult to engage with professionals
- both using substances and discontinuing their use may induce symptoms usually associated with a psychiatric diagnosis
- young people committing suicide are more likely to have used alcohol or drugs
- psychiatric disorders that begin in childhood have a strong likelihood of continuing into adulthood. Early signs of such disorders may be difficult to distinguish if drugs are being used
- affective disorders, personality difficulties, eating problems and ADHD are associated with vulnerability to substance misuse

(Crome, 2004)

## **Plymouth - CAMHS**

A CAMHS commissioned study investigated the mental health needs of young people for a Tier 4 service; unfortunately this report was not made available to inform the present study.

The local CAMHS catchment area extends far beyond the city boundaries. In theory the service is open to all ages up to 18; in practice, there are very few referrals under the age of five and an upper cut off point of about 17 and a half, since there is a waiting list of about six months.

The service takes about 2,000 referrals a year, of which about 1,200 enter the service, based on an assessment of who will benefit. Each referral will receive an average of seven sessions, though this will vary between a minimum of two sessions and a protracted working relationship over several years. About 50 will be referred on to in-patient units over a 12 month period.

The view of the manager was that, in the course of a year, perhaps four or five young people would have needs beyond the scope of the existing service. Perhaps half of these go to secure units; the remainder would be diagnosed with either eating disorders, or severe dependence.

Currently, no systematic attempt is made across the service to assess how often substance use features in the lives of young people accessing CAMHS, although

*In my view drug use is frequently present in their lives: maybe half are from families where drugs are being used problematically.*

For a host of reasons, more often than not, questions about substance use do not get asked. The reasons cited include:

- *There has been a normalisation of drug use*
- *There's a lack of training in addressing this issue*
- *Substance use is just one item in the constellation mix of problems you are dealing with*
- *It's a matter for individual practitioners to address*
- *There is no official coding for this question so you can't record the data*
- *Children under 13 will be seen in company with their parents.*

However, substances did sometimes feature in the course of working with particular young people. As far as the in-patients were concerned, alcohol and cannabis – used in harmful amounts – were those most commonly noted, followed by ecstasy and amphetamines.

For the rest of the client group, nicotine and alcohol were the substances most likely to figure, followed by cannabis, ecstasy, and amphetamines.

The opinion stated was that in 15 years only 2 or 3 youngsters had been seen who were prescribed methadone; there had been no heroin, no cocaine, and almost zero crack cocaine to address.

*There is a sense that these are largely entry level drugs, so by age 16 or 17 mental health issues are lost in the general array of problems. Lives become so chaotic that you won't see these issues, and if you did, you probably couldn't change anything.*

#### **4.7 young people in households where substances are misused**

Anecdotal evidence from those working with adult substance misusers suggests that children's attitudes to drug and alcohol consumption are profoundly influenced by what they see taking place in their family household, with second and now third generation misusers seeking treatment.

The 2001 HAS review of young people's needs acknowledged children of drug using households as a vulnerable group. Other studies since have confirmed that substance misuse by parents or older family members may strongly influence children's attitudes and behaviour with substances.

Forrester, for example, found that parents misused substances in more than one third of cases dealt with by Social Services, and that the more serious the child welfare concern, the more likely the parents were to misuse substances. Forrester found 40% of cases on the child protection register and 62% of those subject to care proceedings involved substance misuse (Forrester, 2003).

Ward and colleagues, in their survey of care leavers, found that the presence during childhood of a family member who used drugs more than doubled the likelihood of someone developing problems with substance use when they were older - 31% against 15% (Ward et al, 2003).

The ground-breaking *Hidden Harm* survey (ACMD, 2003), which paid very careful attention to children's views on the matter, examined how parental drug misuse impacts upon young lives. Areas highlighted include:

- uncertainty, sometimes chaos, in family lives where drug use is predominant
- children witnessing drug use, despite parental attempts to conceal it
- exposure to drug related criminal activity
- disruption of education, for example having to care for parents or younger children
- living with fear, of public disapproval or separation
- a pervasive feeling that parents "were not there for them"
- underlying feelings of hurt, rejection, shame, sadness and anger about their parents' drug use.

(ACMD, 2003)

Again, the picture is of substantial numbers of children affected in various and complex ways by drug use in the family. These children are more likely both to be exposed to an extra range of difficulties, and, because children learn from the adults around them, to be acquiring maladaptive and risky approaches to resolving problems.

Not least is that parents who misuse substances are less likely to be living with their children. *Hidden Harm* estimated that only 37% of fathers and 64% of mothers in the survey had remained at home.

There will be many drug using parents who care very deeply about the welfare of their children. Overall, however, drugs misuse in the family may substantially contribute to a young person's vulnerability to an array of problems (ACMD, 2003).

## **Plymouth**

The *Hidden Harm* Team estimated that between two and three hundred thousand children in England and Wales are living in households where drugs are being used problematically, with a corresponding estimate of two million for parental misuse of alcohol. If such households were spread evenly across the country, one would expect the number of children in Plymouth potentially exposed to problematic substance within the family to be something in the region of 1,000 or 1,500.

It has not been possible to compare such an estimate with other sources to gauge its accuracy. Harbour (adult services) is currently redesigning its database to collect information on the needs of the families of drug users, and this should be a valuable data resource for the future.

However, some very interesting related material on the subject has been collected at neighbourhood level by health visitors. This material covers 26 factors documented as having significant bearing on the long term risks to health of individual families. One should bear in mind that health visitors work only with children under the age of five, and that the main purpose of assessing these factors is to inform the allocation of primary care resources.

Two of these factors relate to either parent misusing drugs or alcohol, as shown in the table below. The bottom three categories, from most deprived to least deprived, give a benchmark against which to compare the figures for individual localities.

parents of children aged 0-4, by neighbourhood: percentage who abuse alcohol or drugs

neighbourhood	Parent(s) abuses alcohol	Parent(s) abuses drugs
Barne Barton	3.4	5.9
City Centre	6.0	6.7
Devonport	5.1	5.8
Efford	2.6	2.9
Ham	2.8	2.1
Honicknowle	2.6	4.6
Keyham	3.5	4.6
Morice Town	1.7	5.6
North Prospect	7.4	6.8
Stonehouse	4.9	4.6
Whitleigh	3.8	5.0
<i>Most deprived – average score</i>	3.7	4.5
<i>Middle group – average score</i>	1.8	1.8
<i>Least deprived – average score</i>	1.2	0.5

Health Visitor Data 2004: Plymouth Neighbourhood Report

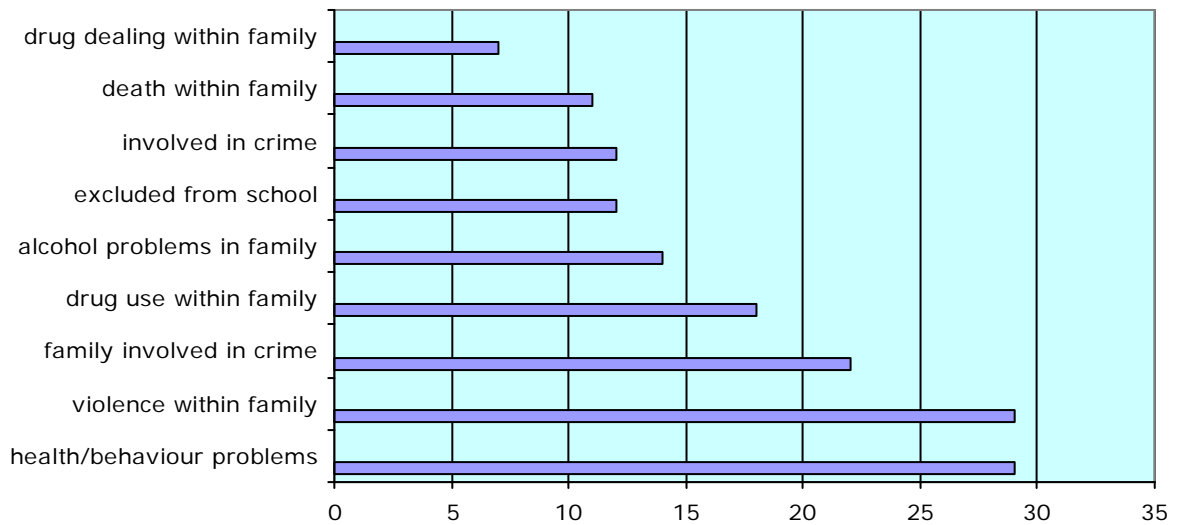
This does not enable us to quantify how many young people of an older group, for example secondary school age children, have parents who misuse substances. It is clear though that young people will be much more likely to be exposed to parental substance misuse in some neighbourhoods than in others. One could guess that in these same neighbourhoods there are more likely to be subcultures where substances are more available and where their use is more tolerated.

#### **4.8 young people attending substance related programmes**

##### **Hamoaze**

Hamoaze House offers a range of structured programmes during school holidays for children who use drugs, or are at risk of drug use. The following table examines the prevalence of other problem areas in the lives of the over 11 client group:

Presenting issues of attenders aged 12-16 at Hamoaze summer programme 2004  
(n=32)

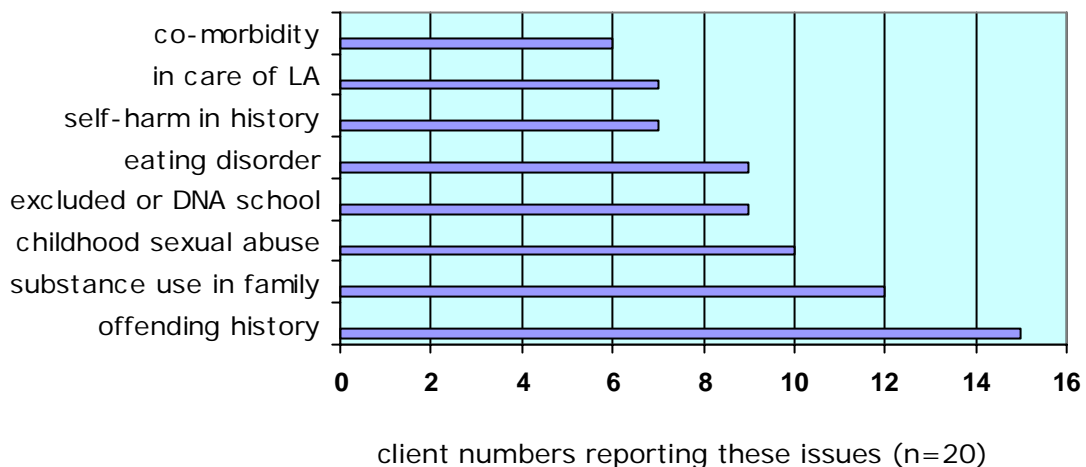


Again, there is a similar constellation of problems to those observed in the various vulnerable groups, the preponderance of issues within the home perhaps reflecting the age group.

### Longreach

Longreach is registered as a female only residential care home for adults and younger adults, that is young people aged 16 and 17. Although few if any referrals of this age group are made from within the city, a subject returned to in the next section, the agency has considerable experience in working with the needs of young substance misusers. The table below gives a broad view of the salient issues recorded alongside these clients' use of substances.

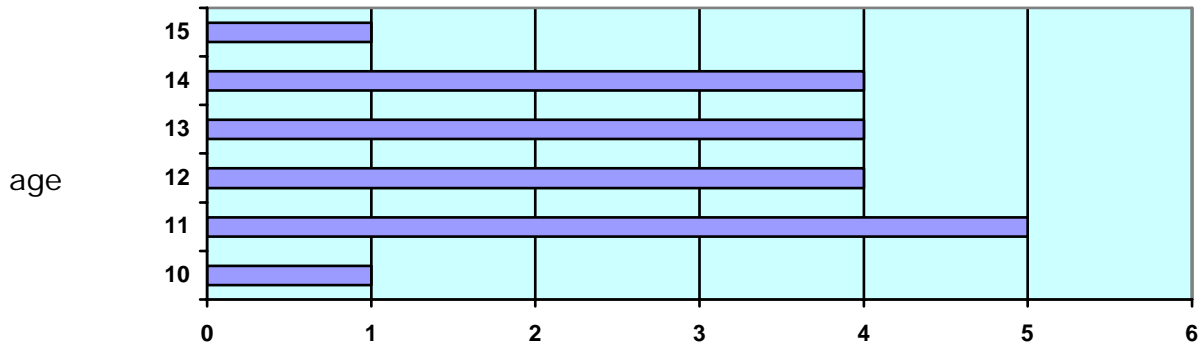
Difficulties reported by 16-17 yos attending substance intervention programme  
(n=20)



Again, we see broad confirmation that substance misuse in this age group occurs together with a multitude of other problems. One could speculate that children who experience harm early on, within the family home say, and are then taken into care, are at risk of a succession of disadvantages on top of their original misfortune.

The following table illustrates the ages at which these 16 and 17 year olds first resorted to substance use.

age of first use by above group of 16-17 yos (n=20)

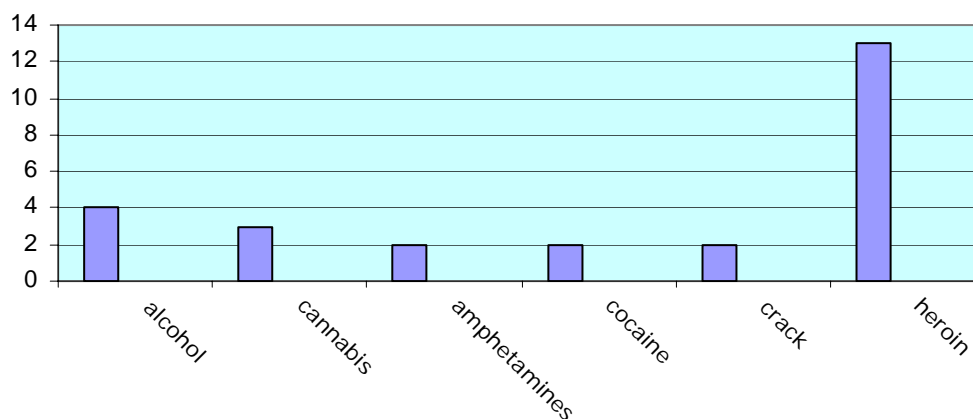


As one might expect, there is a marked clustering around the age of 11 to 14. Possible factors involved include

- greater access to drugs and alcohol, through acquaintance with older peer groups and perhaps an easing of parental supervision
- increased tensions and stress associated with onset of puberty
- increased tensions and stress associated with moving on to secondary education.

The final table shows which substances were causing most of the problems for the same intake group.

first or first equal preferred substance, declared in above group of 16-17 yos (n=20)



There are too many variables here to draw firm inferences. However, in this group, it looks as though heavy use of any of these substances may either lead, or accompany, young people into severe difficulties as early as their mid teens. Heroin use may bring this about especially quickly. Or, heroin use may serve as a passport to more intensive services, by more readily engaging the concerns of funders.

### **HARBOUR Young People's Service**

Harbour YPS was set up in the autumn of 2002 to provide a community based Tier 3 service to meet the substance related needs of under 18s. It succeeded a service called Off Base, which had combined elements of Tier 2 and Tier 3 services but without medical input. There were various factors behind the demise of Off Base, but a view expressed within the present service was that some young people in need of support may have been put off by the absence of prescribing options:

*Their view (i.e. the service attenders) might have been, If I can't get a script, why bother? That's what I need to get sorted.*

The present service does provide access to specialist prescribing, including stabilisation programmes and home based detox, generally using subutex in cases of opiate dependence. Counselling may include cognitive behavioural and motivational enhancement therapies. This generally takes place in the Youth Enquiry Service building, an environment designed around the preferences of the age group.

The emphasis throughout is on building and sustaining relationships with individual clients, with keyworkers willing to maintain contact long after presenting crises have been weathered. This aspect of Harbour's work was sometimes singled out as especially significant by members of other agencies involved in this consultation.

Another important aspect of the Harbour Service is providing Tier 2 training for staff in other services. This too was well regarded by attenders, certainly those contacted in this survey. As children's services continue to develop,

contact staff will benefit from ongoing training to screen for substance misuse before referral to more specialised services.

### Features of the client group

At the time of consultation, Harbour YPS had worked with about 60 young people over the preceding 12 month period, with 27 currently engaged. At any one point, between four and ten were likely to be on medication prescribed by the service GP.

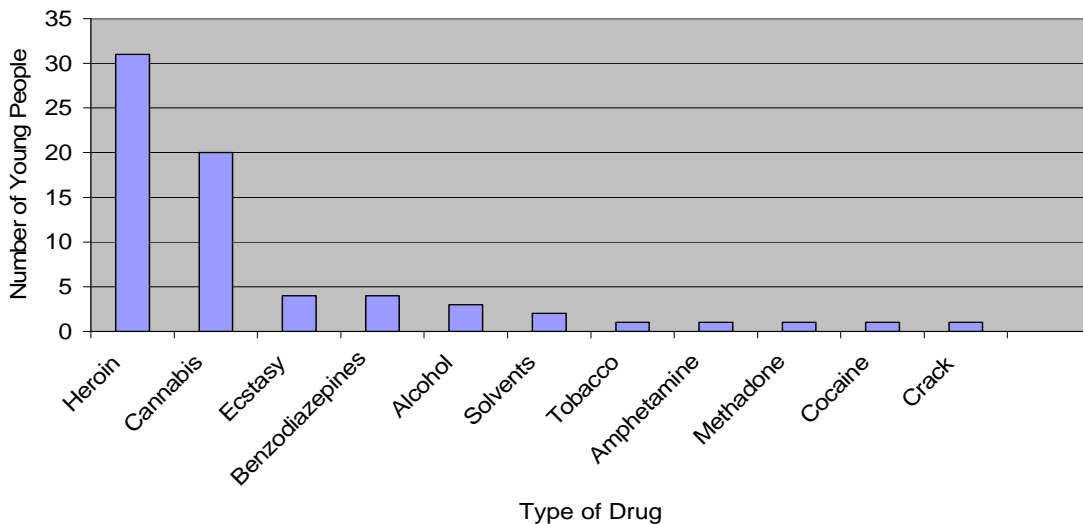
Co-existing problems of mental health issues, involvement in crime and homelessness were noted as especially important:

*These issues make it less likely the client's going to stay with you. They may be treatment weary – as an agency, we may not be able to meet these needs.*

There were grounds for concern that a few young people were linked in to the sex trade. One team member had worked with three such clients over the preceding two years, one of whom was known to be currently involved in the industry. Another member knew of a 16 year old girl with the same involvement but at the time of consultation there had been a single initial contact.

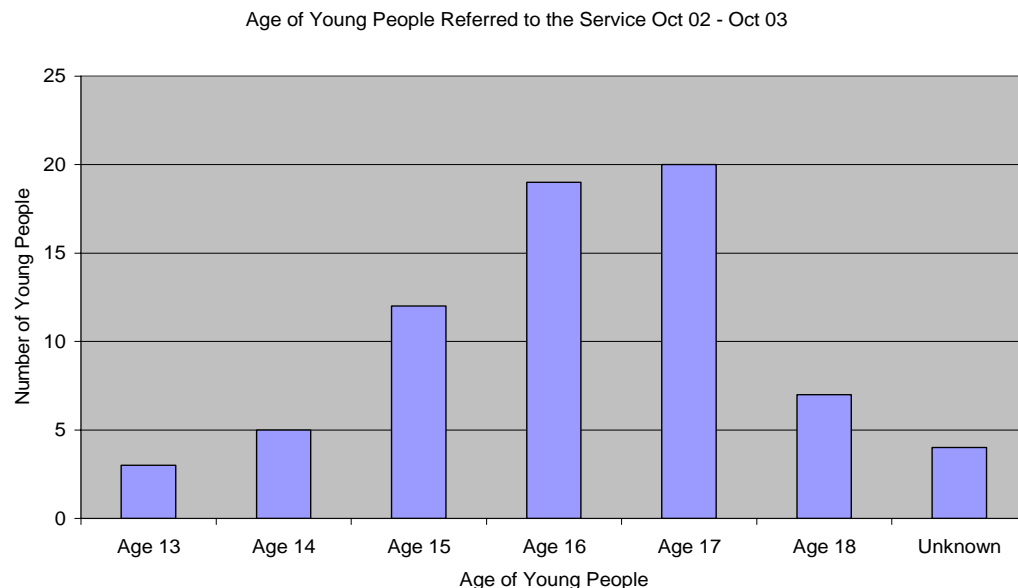
The heroin users seen by the project were all reckoned to be injectors, although most had smoked heroin to begin with. One new client aged 17 had already overdosed.

Primary Drug Use Amongst Young People Oct 02 - Oct 03



The proportion in this table of service users taking heroin is striking for a number of reasons:

- heroin is in no sense a party drug, although its use is sometimes reported by adults as a way of smoothing out the unwanted after effects of cocaine or amphetamine use. Its repeated use suggests something deeper than simply wanting to get the most out of Saturday nights
- intravenous use, usual among these service users according to staff, may imply a realm of self-harm linked to substance use, in addition to the grave possibilities of overdose and infection
- the stigma of heroin may thrust users into peer groups where the damaging use of drugs is commonplace, and away from the positive influence of family and friends.



The ages of those referred to Harbour are consistent with the idea of problematic substance use being a developmental process; the tailing off at age 18 reflects Harbour's willingness to go on working with people after they qualify for engagement with an adult service. Taking drugs and drinking alcohol, it seems, for most young people engaged with services, takes a number of years to develop into something problematic (Beckett et al, 2004).

### Gaps in service

*When we first opened, we got lots of referrals straight off – young people who knew each other through their friendship networks. However most of the more chaotic users, about 15 or so, dropped out quite quickly.*

No information was available about outcomes for this cohort. Three factors were identified that contributed to their withdrawal from the service:

- sudden events, e.g. imprisonment, that halted contact
- cynicism on the part of these clients, based on previous experience, about helping services
- stringent prescribing criteria. From the young people's perspective, there were hurdles to clear before they could access medication, such as keeping four consecutive appointments. From the agency's point of view, good practice required a full needs assessment, along with construction of a viable care plan acknowledging that a script was not on its own going to provide solutions to a constellation of problem areas.

*Some of the young people we work with left school or were excluded at the age of 14, then only get picked up two years later by the YOT. What happens to these kids between 14 and 16?*

For some, homelessness was a significant difficulty.

*16 and 17 year olds only qualify for housing if they meet the previously in care criteria. When they do get housed, it's generally in poor areas. There's a big lack of supported accommodation.... There's no emergency accommodation, the Ship only accepts 18s and over.*

*In a sense it's 16 and 17 year olds who are the most vulnerable. If they're under 16 foster care would be available, for example through level 3 of the Child Concern Model.*

## **Access to service**

Team members thought there was some way to go before they were in contact with all problematic drug users in the city. The service had been running a little over two years and was not thought to be that well known. In addition, the Harbour adult service had, at the time of interview, closed its waiting lists to all new applicants and there was a suspicion that young people might think this was also the case with their service.

The perception was that the Harbour service had a higher profile in some areas than in others:

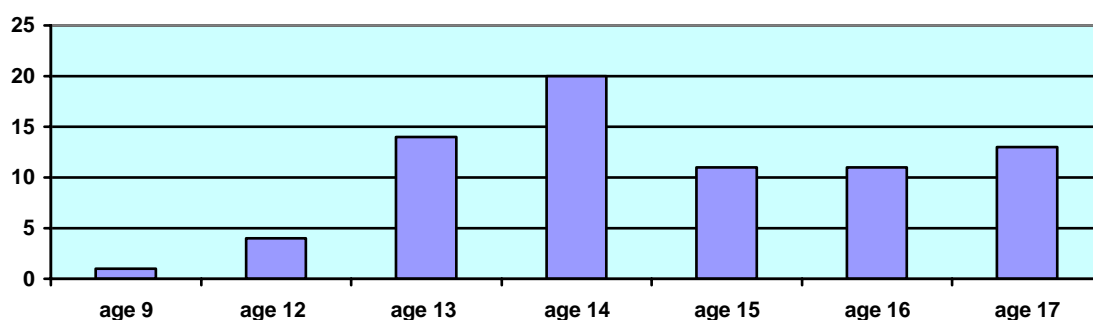
*Currently we've accessed quite a base of heroin users, eg in North Prospect, Efford, and the City Centre. You start by tapping in to one or two, then it gets round by word of mouth. But some locations, like Barn Barton, get spoken of as having a heroin problem and high levels of substance misuse, but we've only seen one person from there. Or Devonport, which has the reputation of high levels of substance misuse, we know people who've moved there, but not people from there.*

#### 4.9 NCH

NCH works with about 180 individual families a year in Plymouth, providing a range of service and support in six week modules. NCH do not currently collect data on substance use, although they are planning this in the future. In the view of the manager, there had been there an increase in young people's drug and alcohol use, especially in the over 14 age group, but it was not possible to quantify it at this time.

#### 4.10 A&E Admissions

There were 74 admissions of young people under 18 to Plymouth A&E services during the year ending 31 December, 2004, diagnosed with accidental poisoning due to alcohol or alcohol intoxication. With three possible exceptions, all were from the Plymouth district. The table below breaks down these admissions by age:



It is not possible from these bald statistics to say how many of those admitted use alcohol problematically, or will go on to do so in the future. Although there is a case to be made that they are doing so already, some of them may be experimenters, ready to learn from their mistakes. Even so, hospital admission is a serious concern, especially at the younger end of the scale.

In the same period there were seven A&E admissions recorded as 'psychiatric – drug abuse'. One of these was age 14, one 15, one 16, and four age 17. It seems that these seven were assessed as needing hospital intervention following overdose in the course of their drug using. This group is distinct from the 73 young people admitted as a result of drugs overdose, linked to intentional self-harm. However, it has not been possible to verify the validity of these distinctions.

#### **4.11 Summary**

Those consulted broadly agreed that drugs and alcohol featured in the lives of the young people engaged with their services. The exception was in local education, where there seemed to be only subdued interest in measuring the prevalence of substance use or its impact on school attendance or achievement, despite the burgeoning literature on this subject nationally. Against that background, the general impression received of schools in Plymouth being untroubled by substance issues looks somewhat optimistic.

Most people thought that in the course of a year a small number – somewhere between one and ten, perhaps – of young people struggle to make headway with their substance misuse with the present levels of service.

Most thought that the number struggling could be reduced by improvements in the range and quality of service response, but probably not eliminated. Those that remain are those with most to gain from some form of Tier 4 intervention.

## 5.0 How we work together: what people said

### Background

Almost without exception, those consulted agreed that any attempt to address young people's needs had to be underpinned with cooperation between different helping professionals and across different agencies.

There was wide enthusiasm for more joined up approaches, and recognition that this still presented considerable challenges. This seemed to reflect both an understanding of the core *Every Child Matters* agenda and dedication to the cause of improving children's life chances. There was agreement that those young people with especially complex needs – the target group in this study – stood to gain a great deal from agencies working collaboratively.

In some ways, the role of an agency is analogous to that of a family. Families can devote themselves to the well being of their child, but to meet the full range of developmental needs - health care, education, social affiliations for example – they will rely heavily on external resources.

Thus the questions of how many young people in the city might be best served by Tier 4 levels of intervention, and how those interventions are best managed, are very much to do with how well agencies are working together and how they are planning to do so in the future.

So far, we have established grounds to suppose that a small number of young people, with complex levels of need including substance misuse, will struggle to have their needs met by current levels of service. Further enhancements to service provision, along with improved inter service cooperation, will meet these needs more effectively, thereby reducing the numbers of those who struggle.

This is a lengthy process and in the meantime it would be surprising if the strugglers do not continue drifting towards adult services or, by default, the secure estate. How plausible it is to pre-empt this drift by working with people while they are still young and still within the community is the subject of this and the following chapter.

## 5.1 Working with other agencies

### Current obstacles to working together

*There are some individual practitioners who want to own the young people they're working with. It seems they don't want to share information and make individual needs the focus*

*There's many people talking the talk who actually want to hold on to their territory*

*There's been political shenanigans. For example tensions between voluntary and statutory agencies: we've stayed on the edge of the battlefield*

*One major frustration is we can't currently tell teams to refer to Harbour (ie adult services). This is very significant – it means children whose parents are users enter the child protection domain quite quickly*

*The bit we struggle with is "everybody's child". Other agencies can pass the buck, but we can't*

*We hear about kids attending Hamoaze or Harbour or YES: but who are they? Confidentiality issues abound .... There shouldn't be any kids attending unknown to us – but we can't be sure. We need clear protocols for sharing info between the LEA and voluntary agencies*

*There's a good bit of parochial thinking from agencies with a huge remit but a fixed budget. There's a lot of bureaucracy*

*It's a struggle to get them to screen for drug use, we've been trying for 4 years. There's a tendency to regard it as a minor aberration. All sorts of factors deter children from talking about their drug use, fear of parents, fear of service interventions.*

*There's still a culture of poor info about children's needs - proper epidemiological needs assessments are not happening. We've got good info for under 5s, from health visitors, but for 5 to 18s it's not happening. If we don't know the extent of the problem, we don't know how much to spend*

*At a personal level, people develop their own networks – some are good, some not. Traditionally it's been hard to engage with CAMHS, but there have been changes in the last 2 years*

*If we don't start looking after our young people they're not going to come into adult services anyway*

## **Moving forward**

*The ideal of working together is the easy bit. Funding it, formalising it, putting in protocols – that's the hard bit. So much depends on goodwill*

*Joint training has had a big impact on encouraging collaboration – it takes personal links to move things along*

*As agencies get more proficient, they'll probably need social services involvement less and less. That's our speciality – coordinating packages of care*

*We are part of a whole that could work effectively together*

*This is public money – we don't have the right to block an excellent service where it exists*

## **Developing common understanding**

*The Children Act supplies a common language, a common assessment tool. Voluntary agencies are cock a hoop about this – they've been waiting for years for a document that would explain how agencies actually can work together*

*We need to stick to tiers as descriptions of service, not need. We must empower different workers in different agencies to discuss levels of need*

*I think there was mutual surprise attending a meeting with Harbour staff to find the way we think about young people, and the agenda of working with them, is actually similar. As is the way we conceive of our work as a joined up agenda. In other words my pre-suppositions were not borne out when meeting people face to face*

*What really impressed me about the Harbour Team was their willingness to maintain low levels of engagement with service users. In the morass of psych and environmental problems members of the Harbour Team have become significant figures*

*Referrals from CAMHS started only this summer. Previously I think they rather looked down on the substance misuse service. Now we have fortnightly meetings I think we're heading for more collaborative approaches*

## **Multi resourced teams**

*I'd dearly love a CPN presence in this service, but I'm not willing to pay for it. It's not just salary, there's clinical supervision needs, and that's not what I'm legislated to provide*

*CAMHS would be the vital component in understanding the mental health needs and drugs combination. It's chicken and egg – do we deal with substance misuse first, or, will you come in and help us?*

*We need a CPN on the team, not to work with the client group, but to work with their families*

## **5. 2 Concerns about sending people away to a residential service**

*I'm sceptical about warehousing children into residential units where basic needs are met, but a range of service is not provided. My concern is that once you have a 24/7 service, people give up on meeting needs in the community*

*People sometimes fight over this age group – when people are really busy it's tempting to get rid of the ones with the problems. They easily feel deskilled, it's hard to get experience and training on substance misuse*

*Sending kids away if they're not willing to go is the same as prison. They'll come back with a higher risk of overdosing. Even when they come out with a sensible approach, there's the risk their drug use will go back up, so support in the community is vital*

*If there was one [ie, a unit] of superb quality you'd have to consider it. But then if it's further away, how would you monitor it?*

*My impression is that substance misuse develops with age – it would be accompanied by other major problems – how would it be possible to manage the experience of being in rehab?*

*I have big concerns about children leaving the community. Where to? Who with? What then?*

*My concern about residential treatment is that belief based services just replace one dependency with another*

*The trouble with private sector resources, there's a danger of their being quick fix solutions. Once children are there, providers start asking for extensions. The more you spend out of the community, the less there is to spend in it*

*It's this great big beast again that needs all this feeding – soaking up money that could be used locally*

### **5.3 Virtues of Tier 4 provision out of the community**

*What provides best outcomes should be the driver. Away from home provision is a minefield - but for one in a 1000 you need that specialist placement*

*It's pointless putting kids through an adult programme in a different location. Every point in a short or fairly short programme should be giving individuals an experience of themselves as interesting, useful, in relationship with others – letting them see there are other things to do apart from take drugs*

*Try and get them out and about. Experiencing hope is the first point in the therapeutic journey*

*A residential unit can be a really good platform from which young people can begin to use services better, once they've had a taste of hope*

*We've got an 18 year old at the moment who contracted HIV from his mum. Problems don't suddenly occur age 18 – it may be more that you suddenly get funding*

*When you take the drugs out of the equation, that's when problems begin. Some people may not respond to medication, perhaps when there's a strong negative influence from family or social groups. There's a very small number of people for whom you may consider something away from the community*

### **5.4 Virtues of Tier 4 in the community**

*There's room for a day care service, including things like a drop in, activities, programmes to build self esteem. Just seeing a key worker twice a week is an adult model. Clients might work really hard here, and have no base to go back to – some might be sleeping on drug users' floors*

*We do need a service offering more intensive support, a crisis intervention, an out of hours service, and should be able to spend significant amounts of time with that person. I'd like to see specialist fostering locally*

*Sending people out of the community should not be a default option – you need a Tier 4 service for when Tier 3 fails*

*Relationships, doing something useful that they want to do, accommodation – that's the three most important aspects of young people's lives*

*Substance misuse intervention – it's only going to work in context. We need a holistic, not stand alone approach. If someone's going to stop using substances, they need to change other factors too, like the peer group*

*Foster carers would need 24/7 phone support. And an out of hours service – say up to 11pm, available weekends and bank holidays too*

*A Tier 4 service can't exist on its own, it must be locked in to partnerships – either multi skilled teams or embedded in partner agencies*

## **5.5 Concerns about Tier 4 in the community**

*The city is yet to get to grips with how we hold overall responsibility, whatever organisation it is that takes on provision. Organisations have not felt able to take that level of risk – meanwhile young people are left in risky situations, with enhanced vulnerabilities*

*It would be good to have Tier 4 level of support in the community. To do that professionals must agree about that child's needs – so we need more specialists. But who is available with that level of expertise?*

*The City Council seems to have a limited view of what a wraparound 24/7 service entails. They haven't looked at the US evidence, I don't think it's been thought through*

*Think of Maslow's hierarchy of needs. You've got to start at the most basic level, at home ... is there food in the cupboard, is the electricity connected? A wraparound service needs a total change of culture, not just buying in bits from services*

*Could a Tier 4 service work in the community? If it's about keeping away from substances, how would that be possible? Unless you watch them 24/7*

*Tier 4 provision in the community could work if we could persuade CAMHS to work 7 days a week instead of 5. There's lots of pros, the cons are that it's difficult, or impossible, to manage a drug free environment*

*We have use of a 4 bed unit in adult psych ward and we've put in support, ie drug specialists to back up the existing service. But we still get psych patients blaming the drug users and v/v.*

*One issue is the peer group and the area they're living in. In Barne Barton for example, or North Prospect, it could be hard to get away from drugs, the milieu can be reinforcing what people are trying to change. How does a young person break those links?*

## **5.6 Funding young people with complex needs**

*There's no children's lead on the commissioning side, to represent the needs of kids rather than the needs of services*

*There was a young chap we had down for Middlegate. The presenting issue was drugs. He just wasn't someone we could work with in the community – there were too many loose ends. There had to be boundaries. There was a tripartite panel to fund independent placements, with reps from social*

*services, health and education, who said the monies for Tier 4 had gone to the DAAT – but the DAAT said there was no money in the pot*

*Everyone in these teams has done the appropriate training. This needs to happen a minimum of once a year. It's good to have time out from the office to reflect on your work*

*Every care leaver has to have a Pathway Plan – but in terms of health, it's difficult to identify who are the funders. For example a 17 and a half year old - CAMHS wont take the referral*

*There's a gaping big hole in terms of residential provision outside YOIs – sometimes we might need a residential resource. You have to jump hoops to get funding. It's very rare we need that service, but it may be very rare because it's not an option*

*Sixty children looked after out of the community accounted for one third of the child and families budget in 2002/3*

*Tier 4 candidates in an extreme mess from alcohol or drugs – where do we get their financial support from? Supposing someone's not getting a Tier 4 level of support in the community, how do we provide it? Not necessarily in the middle of Wales*

*The NTA specified 7% of the pooled treatment budget was to go to young people's services but actually we've put in 13%. If we don't start looking after our young people they're not going to come into adult services anyway. We need to work really hard on how we perceive drug use among young people.*

## 6.0 Options for service development and expansion

The majority of those consulted expressed a definite preference for meeting young people's needs within the community, wherever possible. This position had usually been thought through, and seemed consistent with the overarching vision of Every Child Matters.

There was a general distrust, often backed with specific concerns or events, about uprooting young people from their communities and placing them in residential settings. There were occasions, however, where it had not been possible to contain and cater for individual young people's needs in Plymouth, and people had noted benefits arising from some away from home placements. In general, however, there was a feeling that these benefits would only rarely outweigh the very considerable costs.

The following options, therefore, build on the opinion held in common by most of those consulted, that every possible attention should be given to maximising the effectiveness of interventions within the city. In effect, this means enhancing Tier 3 levels of service, with additional components and layers of structure and intensity for those at most risk or in most need.

These options are outlined in four sections:

- expanding current Tier 3 provision
- achievable, cost effective options for an enhanced, or Tier 3 plus service
- Tier 4 services now available
- options to support closer collaboration between agencies.

### 6.1 Options for developing existing Tier 3 service

- **Devise and develop outreach strategies.**

As discussed above, the evidence shows problematic use takes time to develop; at least for young people in touch with services, this is much more likely to occur at 15 or 16 than earlier. It is probable that there are young problematic users in Plymouth who have not engaged with services, perhaps concentrated in a relatively small number of neighbourhoods with pockets of drug using cultures and higher drug availability. This was supported by anecdotal evidence. Those with established relationships and experience over time in particular localities, such as youth workers, may be the best people to work with to develop strategies. There is evidence that the best way to reach out to some young people is "on their terms and in their place" (Duff and McNab, 2004).

- **Consider how young people's access can be improved.**

Basing appointments within the young person friendly setting of the Youth Enquiry was chosen to reduce possibly stigmatising effects and promote

engagement; it is possible this principle could be extended. Some young people may benefit from the opportunity to meet practitioners in school; although previous experience found, with one pupil at least, this added an unhelpful political dimension. Improved understandings with particular schools could help to iron this out. Flexibility with time as well as with place could also be considered as a means of making the service more available. An out of hours telephone contact and support service could be piloted at low cost to gauge possible take up.

- **Develop a young person oriented website.**

There is some evidence that web based resources provide an easy, non threatening way to reach young people with clear information, and lay the ground for a later engagement with services. Young people are sensitive and discerning: distinctions between a website that encourages and attracts and one that effectively puts people off may be fine. For this reason young people need to be consulted and involved in such a project, or perhaps manage it if the right skills or training can be made available. Examples are Stoner Lemmings, based in Devon, targeting young substance users [[http://www.stonerlemmings.com/help\\_national.html](http://www.stonerlemmings.com/help_national.html)]; and the Manchester based 42<sup>nd</sup> Street project which takes a broader, mental health approach [<http://www.fortysecondstreet.org.uk/index.htm>].

- **Continue building referral pathways into the service.**

Some relationships with inward referrers work very effectively, the presence of a YOT funded team member, for example, materially assisting the inward referral of young offenders. The Tier 2 training modules have raised the profile of the agency with other agencies and contributed to improved referral mechanisms. However, some potential referrers still seem relatively unaware of the service. A&E, for example, is believed not to have made a single direct referral, although substantial numbers of young people are seen annually who have had serious problems in connection with drugs and alcohol, including intentional overdoses and self harm.

- **Continue to revise and develop prescribing strategies.**

Clearly there are serious implications to consider when prescribing prohibited substances, particularly to under 18s. However, there is an unfolding debate around how this can be best managed and whether there is room for more flexibility in accommodating individual young people's preferences. Certainly there is room to question what happened to the young heroin users who had brief contact when the service opened and then went off the radar.

- **Develop family work as a core strategy.**

Family therapy is one of the very few interventions in working with young substance users whose effectiveness is supported by a solid evidence base (see, for example, Crome, 2004). As a local repository of experience and expertise in family therapy, CAMHS could play a vital role in Tier 3 work with young drug misusers. Thought should be given to further development of this core element, through access to training and clinical supervision.

- **Continue building links with CAMHS**

The seeds of a working relationship between Harbour YPS and CAMHS, referred to earlier, were regarded as extremely positive beginnings on both sides. There are unresolved difficulties. Demand for CAMH resources outstrips demand, with a typical six month waiting list for service. Quite how the time and expertise of a paediatric consultant could be funded or timetabled is yet unclear -- would this be preferred on a spot or regular basis? Nonetheless, untangling the relationship between substance use and mental health disorders in some, more problematic, clients was regarded as a challenge where CAMHS involvement would be invaluable.

- **Encourage sharing of local resources.**

The independent agencies, especially Hamoaze and YES, were able to provide a number of resources that seemed outside the usual scope of their mainstream colleagues, including outdoor activities, excursions, fitness training and music. Surprisingly, there were accounts of these resources being made offered to other services, but not being taken up. Young people often take drugs in pursuit of a good time but, by the time drug use has reached a problematic stage, find themselves enjoying life less than their non using contemporaries. Opportunities to enlarge the service repertoire with access to activities that are fun and enjoyable should be seized.

- **Keep young people's views at the heart of service design.**

Harbour develops good working relationships with its clientele and is willing to maintain low level contact over long periods to prepare for later intervention or simply maintain support. The more young people are encouraged to contribute their views to how services are designed and managed, the greater their sense of ownership and the more likely they are to be influenced by programmes of change. Although service users are consulted individually, there may be additional benefits from involving them as a group in planning aspects of service.

## 6.2 Options for development of a Tier 3 Plus service

- **Consider development of a day programme.**

Much of the concern about children missing from school centres around their having a great deal of time on their hands, and the opportunities for affiliating with drug using or offending related peer groups. While the two appointments a week model may be just the right amount for some young people, there will be others, with more complex needs, perhaps, or less support at home, for whom this level of input is easily swamped by what is happening to them in the rest of the week. However, if young people are going to be working together as a group, then issues of age and sex need to be thought through carefully.

- **More investment in supporting, training and resourcing families.**

A study commissioned by the NSPCC found that

Parents are crying out for sensible advice on how to maintain discipline among children. They say this parenting task, more than any other, is useful to know about. In particular, they want to know how to deal with their children's challenging behaviour and their own stress without resorting to harmful punishments (Cawson et al, 2002).

Parents are likely to face still more challenges when substance use fans the normal tensions and conflicts of adolescence. Opportunities for parents in need to learn more effective strategies, and meet others facing the same challenges, can help families to be more confident in supporting young drug misusers through programmes of change. There is a sound evidence base to inform such approaches; see for example Ghate and Hazel (2002).

- **More investment in recruiting, supporting, and resourcing carers.**

Plymouth Social Services are already developing a programme of support to families and carers aimed at improving the life chances of young people in need or at risk. The emphasis will be on "rapidly deployed, flexible support services that are available at the time of need – whenever that may be".

Difficulties have been identified, however, in the recruitment and retention of suitable carers. Some of those consulted here, for example, thought that few foster carers feel qualified to look after children with a cluster of difficulties including substance misuse.

This is a complex area, beyond the scope of this paper, but one of the central issues appears to turn on whether carers are paid on the basis of

reward for skill or compensation for demands (Fostering Network, 2004). Adequate levels of payment, in addition to specific support and resources appears to be the key. A pool of carers is required if there is to be a reasonable chance of good matching, particularly as young people's needs can develop into crisis very rapidly. This challenge – having the right carers available *at the right time* – was highlighted by the Tier 3/4 team in Derby 18 months into their pilot Foster Plus initiative to work with young drug misusers.

- **Maintain or increase investment in training staff.**

The present uncertainty over funding for Tier 2 staff training, despite its good record, is a matter of concern. In principle, the benefits of high quality, focussed training greatly outweigh its costs. Empowering and resourcing operational staff to respond with confidence to their clients' issues with drugs and alcohol assists earlier recognition of need, prompter service response and, where required, more appropriate referral. The risk of progression to more serious levels of need is reduced, as is the likelihood of expensive specialist intervention further down the line.

- **Consider combining these training components in one strategy.**

The substance related training needs of parents, carers and practitioners are specialities yet occupy similar territory. An overarching strategy should consider the potential benefits of a single agency bringing together specialised training skills under one roof.

- **Consult with Supporting People to provide access to housing.**

Supporting People is the only provider of young people's housing in the city, apart from private landlords. SP funds the Foyer project, which also provides access to ETE and life skills support, and the Alma Road project for young people with more complex needs. Former substance misusers would meet the criteria for young people at risk, one of the categories eligible for SP funding. Using substances, on the other hand, would disqualify them from SP funded accommodation.

SP in Plymouth are well aware of the gap in provision for 16 and 17 year olds who are struggling with their substance use. Apart from their own families, carers, or friends, the only option for this group at present is private rented accommodation or bed and breakfast. As we have seen, this is likely to be of poor standard for young people who are already disadvantaged and may struggle to sustain tenancies.

How to respond effectively to these needs remains problematic. One possibility is that housing associations with protocols on working with young people may be able to hold a tenancy in equity on a young person's behalf. Floating support, while it does not include substance misuse in its remit, should assist young people's life chances once they are accommodated. SP has undertaken a young persons' housing needs analysis to inform service planning discussions, in which the needs of young drug users are represented.

In certain circumstances, with care leavers for example, it has been possible to arrange 24/7 floating support. This is an option for keeping strugglers in the community, though at a minimum cost of £1,500 pw it might not be sustainable for long. Assessing whether this would represent better value than a time limited, substance specific, out of the community intervention, could be a fine judgement to call.

Another possibility raised by the care leavers team, for young people with complex needs, would be to distinguish the costs of rent and floating support from the costs of therapeutic input. On that basis, a housing association such as Stoneham would seek around £75 pw rent and another £125-150 to cover support costs, such as access to ETE and a keyworker. The cost to CAMHS or the PCT of clinical provision for a range of needs is unclear at this point.

- **Further expand ETE access, for example with Foyer Project and Connexions, and work with PRUs to identify and support pupils whose engagement is compromised by substance use.**

Employment, training and education access is acknowledged in UK and USA studies as a core component in effective working with young people, besides reflecting the priorities of *Every Child Matters*.

- **Mentoring.**

Numerous accredited substance misuse programmes in the USA regard mentoring as a helpful component in young people's re-integration into the community, particularly when relationships with caring adults in the family are missing or problematic. A recent UK study found that, with the right match, young people valued the presence of a mentor highly. They concluded that while mentoring cannot remedy all the ills facing vulnerable young people, it played an important part in the range of interventions (Philip et al, 2004).

- **Capitalize on natural resources.**

The *enjoying and achieving* component in the *Every Child Matters* vision is all too easily neglected in approaches to working with young substance misusers. In concentrating on the various problem domains that young people bring to services, one can forget that many have a daily diet of cares and anxieties, from which of course substances offer a measure of relief. There is abundant evidence, especially from the USA, that outdoor activities substantially impact on young people's abilities to build trusting relationships, form positive peer groups, develop self-reliance and self-esteem, and perhaps above all gain first hand experience that having fun does not mean they have to take drugs. Geographically, Plymouth could hardly be situated more favourably for access to natural resources.

- **Support direct access hostel for 16-17 year olds.**

The Youth Enquiry Service is considering a feasibility study to inform a proposed 12 bed unit for young people in crisis. YES catches many young people who would otherwise be at risk of falling through gaps between services and there is enough evidence to suppose that this proposal merits serious investigation. The Local Authority seems concerned that this is a risky enterprise for an organisation to take on; this view should be balanced by an appreciation of the grave risks currently borne by some young people in its absence.

Such a project would very helpfully untangle some of the conflicting needs that young people bring when interventions are being considered. The emphasis in a Tier 4 referral, according to HAS 2001, should be on a planned contribution to the overall package of care – if this is on a residential basis, or in-patient detox, both entry and exit plans need to be carefully prepared in advance. These boundaries are easily blurred if the process is rushed because, for example, of a precipitating crisis. To be effective, crisis intervention and Tier 4 intervention need to be kept separate rather than conflated.

### 6.3 Tier 4 options in and out of Plymouth

The range of Tier 4 programmes of change, rather than just detox, for young people with substance issues remains very limited. The NTA lead claimed there were just five in January 2005, although one has opened since. They comprise

- Promis, Kent, an independent company. The young people's unit and adult service are in the same grounds; the brochure suggests the two programmes are also closely related in spirit. Addiction seems to be the preferred description of needs. Fees are £3,800 pw for 2004-05; the programme is a nominal 12 weeks.
- Ticehurst, Kent, part of the Priory Hospital Group. This 6 bed in-patient unit has been running since January 2005, developing from the child and adolescent mental health service which was set up in about 1994. Fees are £572 per day till December 2005, with a slight discount for NHS referrals.
- Godden Green, Kent, part of Cygnet Health Care. This service was launched in February, 2005, complementing existing adolescent psychiatric services available in the hospital. Fees are approximately £550 per day.
- Middlegate Lodge, Lincolnshire, an independent company. This is the longest running service for young people with serious substance issues, and appears to take a genuinely holistic approach with input from education and social services as well as health. Plymouth has referred young people there in the past. Fees are currently £3,400 per week.
- Companions, West Midlands. It is not clear whether this 3 bed unit has opened yet. A holistic, family style approach for very vulnerable children with substance issues is intended. Fees in the region of £3,500 per week.
- Prestwich, Manchester. This eight bed unit in the grounds of a hospital. takes a holistic approach, with a strong health care component including detox. Although set up with the needs of four local DAAT areas in mind, referral from other areas are accepted. Fees are in the region of £1,600 per week.

It has to be said that none of these services, at least in their present format, meets the expressed preferences of those consulted in this survey. Both cost and distance are likely to be prominent in any discussion of individual referrals, though that is not to dismiss out of hand the possibility that a young person in certain circumstances could benefit from one of these programmes.

Two other services are important to mention:

- Longreach, Plymouth. It seems remarkable that Longreach has attracted so little interest from City based referrers of young people, despite its excellent reputation for working effectively and sensitively with the most vulnerable and disadvantaged young women. In the last two years there was a single referral from Plymouth of a female aged 16 or 17, but this petered out despite a successful assessment for a place. In the meantime Longreach has worked with 21 referrals of this age group from other areas.

The reasons for this lack of support are unclear. It may be that potential referrers are keenly aware of the need to separate adult and young people's services, and are fearful of cross fertilisation in this setting. It may be, too, that because the service is well supported by other areas, potential referrers are put off by waiting lists. Certainly there seems to be a lack of awareness of both what the Longreach programme involves, and of how or even if funding is available.

On the other hand its proximity, relatively low cost at around £450 per week, access to a range of services including detox, its compliance with CSCI standards for 16-18 year old young adults, and insistence on individually planned programmes of intervention, argue strongly for its inclusion in discussion of potential Tier 4 resources for young women.

- The Nelson Trust, Gloucestershire. This charitable organization has looked long and hard at the needs of young people in the region who struggle with substance use, and is now moving steadily towards implementation, possibly in 2006, via fund-raising and consultation with stakeholders. Conceived with the South West region very much in mind, the project looks set to embrace the values and priorities of those who work with vulnerable young people, and should be a valuable resource in the medium term.

## **6.4 Options for developing relationships in and between agencies**

In its onward journey to meeting the objectives of *Every Child Matters*, Plymouth has the advantage of being a unitary authority with mostly coterminous services and a strong sense of identity. The goal of every child in the City having the chance to fulfil their potential was something that everyone consulted in this report was eager to support.

The emerging Children and Young People's Strategic Partnership is nurturing a coherent, across the board approach between agencies, building on the foundation of the Child Concern Model. In these relatively early stages, however, tensions between agencies still found their way into this report, as previously mentioned. A few tentative suggestions are offered to improve understanding:

- **Raise profile of voluntary agencies.**

There were shining examples in all the agencies consulted of how to engage with young people and build working relationships. Voluntary agencies particularly viewed relationship building as the bedrock of any helping endeavour. This may partly derive from their greater freedom to set their own agenda, partly from the knowledge that young people would come through the door only if there was a perceived benefit. But there was a view within the sector that, however hard they tried and regardless of what they achieved, it was sometimes a struggle to gain recognition for good practice from their statutory service colleagues. As a result, there were uncertainties about continued funding which sometimes led to staff anxieties and obstructed longer term planning, along with a feeling – sometimes – that their views were taken less into account.

- **Monitoring and evaluation systems.**

A difficulty cited by commissioners was that there was sometimes a lack of outcome related data on which to base a funding decision. While mainstream agencies had mechanisms in place for gathering and processing this information, independent agencies were sometimes unclear about what commissioners wanted from them or would find most helpful. More dialogue between services could help to resolve this by encouraging the collection of data that had meaning and interest outside the host agency.

- **Improved understanding between practitioners and managers.**

Many people from different agencies worked hard to track down data and make it available for this study. This process was sometimes difficult, and a few surveys rumoured to have a close bearing on the remit of this study have still not come to light. One person said that their work effectively came to a halt for a month when the time came around to do the figures. Several people said they knew there were data lurking somewhere in the building, but not where.

These discrepancies suggest room for more dialogue between practitioners and managers about why, indeed if, data are important, and how they might constitute an important tool for improving service delivery and reality based commissioning.

- **Training.**

Tier 2 training in three and five day modules for practitioners and managers has been well attended by over 200 so far, including 40 or 50% of Social Service operational staff. Those consulted in this study found the training helpful and widely appreciated, both in understanding and responding to substance use, and in nurturing better working relationships between different agencies. The training organisers too felt that it had been effective, and fulfilled what they had been asked to do.

However, the present trainer's post is due to end in March 2005 and the future of the project is undecided. The organisers' opinion was that this training could continue in similar format, or take a longer term, more strategic view which would see the training further developed and having a more enduring effect – a better, but more expensive approach. As agencies consider ways to continue funding Tier 2 training, they should consider that even in these early stages of delivery positive impact is already reported on

- practitioners' skills and confidence in dealing with substance related issues
- young people's needs being more promptly and appropriately responded to
- the ability of different agencies' staff to understand each other and work collaboratively.

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## Appendix: list of those consulted

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Andy Sedgwick	Social Services
Jane Hampton	Social Services
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Richenda Broad	Lifelong Learning
Arnet Donkin	Lifelong Learning
Christine Smith	Lifelong Learning
Jane Harris	Lifelong Learning
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*Paul Taylor  
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