

Partnership name Suffolk DAAT & Suffolk Children's Trust

Young people's specialist substance misuse treatment plan 2009/10

Part 1

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This strategic summary incorporating the planning grids and funding/expenditure profile have been approved by the Partnership and represent our collective action plan.	
Director of Children's Services	<i>Signature</i>
Chair, Partnership name	<i>Signature</i>
Chair, Young People's Substance Misuse Commissioning Group	<i>Signature</i>

Overall direction and purpose of the strategy for meeting young people's substance related needs and specifically their needs for specialist treatment interventions

The strategy of this Treatment Plan builds on, and integrates with, previous Suffolk DAAT Young People Substance Misuse Treatment Plans, and the arrangements in place for commissioning of children's, young people's and families services. It is informed by the Needs Assessment undertaken throughout October to December of 2008 which has updated the 2007 Desktop Needs Assessment with current data and more extensive sources of information. The process of updating the Needs Assessment has identified several other areas where information would be helpful in informing commissioning and service development and processes to obtain this data will be established during 2009/10.

Responsibility for the development, delivery and monitoring of young people substance misuse services was brought into the Suffolk Children and Young People (CYP) Directorate in 2008, such that the Commissioning Manager for Young People Substance Misuse is employed within the CYP Directorate with aligned responsibility to, and professional support from, the Suffolk DAAT. This joint working arrangement not only grounds commissioning of young people substance misuse services within CYP commissioning processes but also within the structures delivering against the targets within the Public Service Agreements PSA 12, 14, 23, 25 and 40 through the dual reporting mechanisms to the DAAT Board and the Children's Trust Board.

This Treatment Plan fully recognises the key emphasis within the 2008 National Drug Strategy¹ of supporting families, intervening earlier with families at risk, providing targeted youth support for vulnerable young people in all areas, providing effective treatment for those who do develop problems with substance use and mainstreaming prevention.

As such the overall direction is to ensure that specialist treatment interventions are effective, accessible and equitable and reach those young people actually experiencing harm because of their substance use. A clinical governance framework will be used to assess and ensure that services are provided by competent staff and in accordance with national and local policy, such as those for safeguarding and information sharing. In addition specialist treatment will be developed through a care pathway approach across universal, targeted and specialist provision and integrating with developments in CYP services and adult substance misuse services.

The Needs Assessment has highlighted probable capacity issues within specialist treatment provision, identified through analysis of NDTMS data in relation to the treatment journey from referral through to discharge. (See Needs Assessment Sections 6, 7 & 8).

Addressing this issue promptly is a key priority, and within this will be the need to develop family support as a care planned intervention and to ensure accurate data recording, including Treatment Outcome Profile (TOP) monitoring, so that a reliable picture of service effectiveness is obtained.

Specialist treatment for substance misuse is often coexistent with the need for specialist treatment for other problems, such as mental health or offending behaviour. Whilst there is an established pathway for referral between youth offending and specialist substance misuse services, that between CAMHS and substance misuse is less well developed, as is that for emergency services. Work to develop care pathways and joint working in these areas has started in 2008/09 and will continue in the next year.

Future commissioning and service development will be based on an outcomes focus, supported by the introduction of TOP monitoring, involving young people and families in service review and further analysis of care plans and care pathways between agencies supporting young people.

¹ DH (2008) Drugs: Protecting Families and Communities.

Likely demand for specialist substance misuse treatment interventions for young people. Please identify and consider the differential impact on diverse groups and ensure that the overall plan contains actions to address negative impact

Note: Where (NA x.x) is written it refers to the relevant section in the Needs Assessment).

Section 3 of the Needs Assessment looks at estimated prevalence of drug and alcohol use in young people in Suffolk, using information from the Home Office, Crime Surveys, School Surveys, and other sources. However, these can only be very rough estimates and treated with caution, because:

- Descriptors used for frequency of drug use vary from source to source.
- Age ranges vary between sources of information making comparison and extrapolation difficult
- Many sources include 'life time use' or 'ever used drugs/alcohol' as an indicator, which can mean the young person may only have used drugs or alcohol once or twice or, at the other extreme, is using on a daily basis. Clearly, occasional use will not warrant specialist treatment and use at this lower end of the range should not be included when we try to estimate demand for specialist services.

The section also includes information from local sources such as the Suffolk Youth Offending Service (YOS) and the 2008 Tell Us3 Survey, which has enabled some comparison of locally derived prevalence figures with estimations of prevalence extrapolated from national data. It is apparent that the estimated prevalence in Suffolk from local data is lower than that expected from using national data.

Based on these somewhat crude estimations the Needs Assessment suggests the prevalence figures given in the table below for young people in Suffolk.

Table 1: Estimated numbers of young people using drugs or alcohol in Suffolk

	11 – 15 years	16 – 19 years
Drugs – likely to be using weekly or more frequently	Estimated numbers	Estimated numbers
Any Drug	1060	562
Class A Drug		130
Alcohol – drinking daily	425 - 1570	

Those given for drug use in 16 – 19 year olds are based on the Home Office's suggestion that a minimum of 7% of young people using any drug in the last year will be taking drugs on a weekly or more frequent basis² and applying that reasoning to the estimated numbers of young people in Suffolk with last year drug usage. (NA 3.1).

Figures for drug use in 11 – 15 year olds are extrapolated from the Estimated Drug Use amongst School Pupils, 2005 (NA 3.2). These estimations do not give a breakdown for Class A use.

The figures for alcohol are gained from extrapolating the findings of a study carried out in 2008 to look at alcohol use in young people in Suffolk aged 11 – 19 years, giving a figure of 1,570 drinking on a daily basis, (NA 3.3.1). It should be noted that the sample group included a Young Offenders Institution and a Pupil Referral Unit, which is likely to result in a higher overall estimation given the

² HORRS 2888. (2001) At The Margins: Drug Use by Vulnerable Young People, in the 1998/99 Youth Lifestyles Survey.

likely higher prevalence within these groups of vulnerable young people. The figure of 425 is extrapolated from a study by the Information Centre³ and using their figures for young people drinking almost every day, (NA 3.3.2).

In addition to this however, estimated numbers of young people drinking more than 14 units a week or always drinking to get drunk are even higher, and it is perhaps this group that are more likely to be involved in offending behaviour or to experience physical harm to themselves. The current pathway between the YOS and treatment services and the development of a pathway between A & E departments and treatment services are important in addressing and meeting this likely demand.

Problematic Drug Use, defined here as use of opiates (heroin) and/or crack cocaine, occupies a relatively very small proportion within drug use by young people in Suffolk. The estimates of prevalence extrapolated from the 2006/07 British Crime Survey⁴ shows less than 5 young people using in the last month for 16 – 19 year olds – see table below. If we apply the 7% of last year drug use numbers indicating those with weekly or more frequent use, we could suggest 5 young people aged 16- 19 years (7% of 70) will be using crack in this way and 82 will be using cocaine (7% of 1,170).

Prevalence rates for PDUs given by the University of Glasgow (2006/07) suggest there are 260 15 - 24 year olds with PDU, (but with 95% confidence interval this could be anywhere between 171 – 512 PDUs), with Suffolk having the lowest prevalence rate in the East of England.

Table 2: Estimated numbers of young people using different drugs.

	Estimated drug use by type for 16 – 19 year olds in Suffolk	
	Use in last year	Use in last month
Amphetamines	860	345
Cannabis	6,995	4,065
Cocaine	1,170	585
Crack	70	-
Heroin	-	-
Methadone	-	-
Any Drug	8,030	4,825
Class A drug	1,860	1,000

Overall it is estimated that 28% of young people fall into one or more vulnerable groups, which include looked after children, truants and excludes, young offenders, young homeless, children whose parents misuse substances and young people at risk of sexual exploitation.

The demand for specialist treatment from vulnerable young people is known to be greater than in

³ Fuller E et al (2006) Drugs, Smoking and Drinking in England in 2005, The Information Centre.

⁴ Drug Misuse Declared: Findings from the British Crime Survey 2006/07 and 2006 Mid Year Population Estimates.

⁵ Becker J and Roe S (2005) Drug Use among vulnerable groups of young people: findings from the 2003 Crime and Justice Survey Home Office Findings 254.

⁶ NTA (October 2008) Interim Guidance on Commissioning Young People's Specialist Substance Misuse Treatment Services.

the general population⁵, and applying national estimations of prevalence to local figures for 2007/08 would give figures of 25 Looked After Children needing specialist treatment and 21 care leavers potentially using cannabis daily, 6 using alcohol daily and as many as 49 using some drug at some time, (NA section 4.2 & 4.3). The likely demand from young offenders is estimated at 21% with regular and frequent drug use, which equates to a figure of 184 needing treatment services, using the 2007/08 YOS caseload numbers as a baseline (NA 4.5).

The likely demand from other vulnerable groups has been more difficult to estimate from the information available, although it is clearly evident that there are at least 1000 children and young people at risk of harm because of parental substance misuse in Suffolk who would benefit from targeted prevention, if not specialist treatment.

The work with young offenders will continue through the partnership with Suffolk Youth Offending Service and it is expected that there will be an increase in demand for specialist treatment from other vulnerable young people as a result of raising awareness with CYP staff and developing the care pathway between universal, targeted and specialist services.

Likely demand for interventions by modality:

Specialist treatment provision in Suffolk includes pharmacological, specialist harm reduction and psychosocial interventions, with access to residential treatment and rehabilitation if needed but no facility for care planned interventions for family support.

Pharmacological interventions are most commonly associated with opiate use, so given the low estimation of PDU in young people the likely demand for pharmacological interventions will be correspondingly low.

The need for specialist harm reduction, as defined in the NTA Commissioning Guidance⁶, is also likely to be low, as only a minimum number of young people will require needle exchange services or counselling and testing for hepatitis C, for example, at the end of Q3 2008/09 only 5 young people in treatment had been identified as currently or previously injecting. A higher number of young people will benefit from information and guidance in relation to prevention of Hepatitis B, overdose and accidental injury as it could be argued that this applies to heavy drinking as much as to class A drug use.

Residential treatment and/or rehabilitation is most likely to be associated with Class A drug use or co-morbidity of other illness such as severe mental illness. There is only 1 – 2% annually of young people in treatment with a dual diagnosis of mental health problems, although poor identification and recording may be masking actual prevalence. This together with the low prevalence of class A drug use suggests a low demand for residential treatment rehabilitation and there has been no need identified in young people with substance misuse in the last two years.

If the need for residential care should arise there is a process in place for an application to be made to the County Panel for funding of complex care needs for children and young people and the DAAT Rehabilitation Funding Panel, for joint funding. A more robust procedure for gaining funding for this need will be developed, in line with the established process in Suffolk for any child or young person requiring residential treatment and care for complex need.

Prevalence and treatment data show that the majority of substance misuse within young people is in alcohol and/or cannabis use, (42% and 46% respectively of numbers in treatment in 2008). It is therefore reasonable to suggest that the demand for psychosocial interventions and general harm reduction - but including key guidance on maintaining safety - will be the highest. A range of psychosocial interventions are offered by the specialist provider, including motivational interviewing, and interventions to stop or reduce substance misuse.

From the current knowledge of the type of substance misuse within vulnerable groups it is not expected that an increase in referrals from these groups will change the profile of substance misuse of those in treatment. However, an increase in numbers in treatment from vulnerable groups, or indeed young people in the general population, will most likely mean that demand for psychosocial interventions will increase more than pharmacological or specialist harm reduction.

Currently, care planned interventions to support the family of a young person in treatment are not offered within specialist treatment in Suffolk – although the specialist treatment provider responds to a number of calls requesting advice and guidance from parents. The likely demand for family support has not been ascertained within the Needs Assessment but it is recognised as a priority for service development and will be particularly important given that social and family relationships may well be more complex within vulnerable groups.

Likely demand and differential impact on diverse groups:

Initial findings from the transition work project (NA 7.6), have shown that young people aged between 18 and 24 years admit to using drugs or alcohol at a younger age but are only experiencing or perceiving detrimental effects as they become young adults. As such they would not be picked up by young people specialist substance misuse services, but may also find it difficult to access adult services. The number of young people moving from young people to adult substance misuse services has been difficult to ascertain from data analysis but it is apparent that numbers are minimal. This factor highlights the need for targeted work at this early stage of use, when young people would not necessarily present or accept specialist treatment. It also indicates a need to develop specialist treatment services for this group to encourage access and prevent development of further problematic drug use. The project will continue through 2009/10 in collaboration with the Adult Treatment Plan for substance misuse.

Specialist treatment is delivered on an outreach basis, recognising that much of Suffolk is rural and as a consequence many young people may find difficulty in accessing centre based services. Young people in treatment are mostly from within, or close to, the main urban centres (NA 8.7) but feedback from CYP practitioners suggests that there is need in the rural areas in the west of the county that is not being met. Geographical equity of access will be considered when addressing the capacity of the service, alongside the need for flexibility in providing appointment times outside of general hours in order to accommodate young people in education, training or employment, but also those with chaotic lifestyles or who find it difficult to engage with services.

The ethnic profile of young people in treatment is broadly that of the county as a whole (94% white British). Very limited information is currently available as to the likely demand from ethnic minority populations, migrant populations or asylum seekers within Suffolk, so it is not possible to say whether there is unmet need in these groups over and above that within the general population. Further information gathering, including engagement with diverse groups is required to fully understand the needs of diverse groups and ensure services are accessible and appropriate. This will be addressed by the involvement working group, and will include consideration of diverse groups other than just ethnic origin, such as young people with a disability. (NA sections 5 and 10.1.3).

Links will also be made with the forums and practitioners that work with these groups to ensure that they are able to identify need and facilitate contact with treatment services for young people when needed. There is an established procedure for treatment providers to access interpretation/translation services should the need arise and the location, time and format of appointments with service users can be adapted to the needs of individual clients, because of the outreach nature of the service.

In summary, it is evident from the estimations of prevalence, the rural nature of the county and the likely increase in demand resulting from work with vulnerable young people and raising awareness and identification of substance misuse with CYP services that demand on specialist treatment will increase in the next year.

Key findings of current needs assessment and a brief summary of the prevalence of problematic substance misuse by young people in the local area, changing trends, treatment mapping, characteristics of met and unmet need, attrition rates and treatment outcomes

The current Needs Assessment has highlighted a number of factors within universal and targeted CYP and health services that are likely to be contributing to the difficulty within specialist provision to attain some of the performance targets. These factors include: (NA sections 4.3, 4.7, 5,7 and 9)

- Lack of awareness of specialist treatment services
- Low use of the Drug Use Screening Tool (DUST) to raise the subject of substance use with young people and screen for misuse such that early identification and subsequent targeted support or referral for treatment is missed.
- Low capacity, knowledge or confidence within services working with children, young people and families to undertake targeted support of young people identified with substance use but not requiring specialist treatment.

This strategy therefore includes development of the wider workforce in order to achieve a care pathway between universal, targeted and specialist services for substance misuse for young people and for families where substance misuse is identified and causing harm. An essential element of this will be the development of staff and promotion of services able to offer targeted support of young people, such as the Youth and Connexions Service.

Joint care pathways between specialist substance misuse services and other specialist services such as CAMHS will also be developed.

Specialist Provision

The Needs Assessment draws on NDTMS data for 2007/08 and that available for 2008/09 in order to understand the treatment pathway and relationship with other service providers (NA section 5). Appendix 1 gives the Treatment Map for young people in Suffolk in 2007/08.

There is one treatment provider in Suffolk which has two distinct responsibilities:

- Outreach specialist treatment for young people and
- Substance misuse workers hosted within the Youth Offending Service.

Prevalence and unmet need:

The previous section gives estimation of prevalence within the general population of young people in Suffolk. Tables 3 and 4 show the comparison between these estimates and the actual numbers in treatment.

The column titled 'percentage of estimated prevalence' gives an indication of the percentage of young people likely to be using drugs/alcohol that have received specialist treatment. It would appear from this that there is a high level of unmet need, but this must be viewed with caution. A proportion of those young people not in treatment will be from choice - many young people will be using substances but not perceiving that it is a problem – as shown by the transition project and also the early findings from a project in Ipswich offering follow up to young people attending A & E with an alcohol related injury, in which 7 out of 10 young people agreed to follow up with a youth worker to discuss their alcohol use, but subsequently declined contact (NA 6.2).

Table 3: Estimation of unmet need in young people using drugs:

	Estimated drug use	In treatment 2007/08	Percentage of estimated prevalence (Penetration rate)
Taking drugs weekly or more frequently			
11-15 years			
Any Drug	1060	69	6.5%

Class A Drug	-	<5	
16 – 19 years			
Any Drug	562	156	27.7%
Class A Drug	130	39	30%

Table 4: Estimation of unmet need in young people using alcohol:

	Estimated prevalence of alcohol use	In treatment 2007/08	Percentage of estimated prevalence
Drank in the last week			
11 -15 years	425 – 1570	40	36% - 9%
16-19 years		114	

The needs assessment does not give a figure for numbers of young people referred for treatment and then refusing the service, neither does it give a figure for the number of young people receiving appropriate targeted intervention for their substance use, but clearly experience shows that this will be the case for a significant proportion of the estimated prevalence of young people using substances.

The number in treatment in Suffolk for opiates and/or crack cocaine in 2007/08 was 29 (primary or secondary substance), which is considerably lower than the University of Glasgow (2007/07) estimated prevalence in 15 – 24 year olds of 260, although this will largely be accounted for by the age range seen by the treatment provider only going up to 19 years. The number of 19 – 24 year olds in adult treatment for 2007/08 for these substances was 123, so it is likely that there is unmet need in both age groups. This trend is reflected within Class A drug use generally, i.e. low prevalence but with indication of some unmet need.

The average age of referral into treatment is 16 years and over and it is recognised generally that drug and alcohol use increases with age in young people, (NA 8.3). However, given that the estimated prevalence for 11 – 15 year olds is around 1,060 taking some sort of drug on a weekly basis and only 69 received treatment, and only 40 received treatment for alcohol misuse, there is clearly indication of unmet need within the younger age group, certainly for targeted prevention / intervention if not specialist treatment. The transition project has shown that a proportion of young people would have benefited from early specialist intervention, but actual numbers are unknown.

At least 18% of the YOS caseload in Suffolk received treatment for substance misuse in 2007/08 (NA 6.3.1), which compares well with the national estimate of prevalence in young offenders. Extrapolation from national figures compared with local information of prevalence indicates a level of unmet need within looked after children, children leaving care, homeless young people / those in unsettled accommodation and children/young people with parental substance misuse, (NA section 4).

The percentage of looked after children in Suffolk receiving treatment for substance misuse is

below the national figure of 5.1% and regional figure of 3.6%, (NA 4.2). This has been analysed further to suggest two contributory factors, one being a high number of looked after children being placed out of Suffolk and secondly, a high level of competence within staff of children's homes in providing support and targeted intervention, supported by the specialist treatment provider and the DAAT trainer. This does not however negate the need for continued work to ensure those that need specialist intervention are identified and will include those leaving care, who are perhaps even more vulnerable at this time.

Truants, excludees, migrant populations, asylum seekers and those at risk of sexual exploitation are equally at risk, but local prevalence data was not available for these vulnerable groups. It is difficult to determine whether unmet need is more prevalent in the general population or within vulnerable groups from the available data and further analysis will require more information from services working with vulnerable groups and in relation to the level of targeted interventions that take place by CYP services.

Unmet need for family support has already been identified in the previous section. It is also apparent from NDTMS data that there is a low uptake of hepatitis B vaccination and Hepatitis C testing by young people receiving harm reduction interventions which requires further understanding of the reasons why.

Referrals in to specialist treatment:

Referrals come in to the service from many sources and looking at the Treatment Map for 2007/08:

- There were 214 referrals in total (the higher figure for those in treatment reflect that some would already have been in treatment at the start of the year).
- 73% were from the youth offending service.
- 17% were from services to young people, including education
- 8% were self/parent/carer referrals
- 2% were from "other"

The NTA expect that at least 20% of referrals come from services for children, young people and families (CYP services), but over the year this target was not achieved, a situation which has continued into 2008/09. Whilst it could be argued that the high rate of referral from the YOS includes a number of young people who would otherwise have been referred by a different CYP service if they had not been involved with youth offending, there is clear indication that most unmet need is from young people in the general population or other vulnerable groups.

Very few young people (1 – 2% in treatment) are recorded as having co-occurring mental health problems, although regional and national analysis of dual diagnosis suggests a much higher prevalence. Currently the Young Offenders Institute, Warren Hill, offers substance misuse and CAMHS services to inmates but the threshold criteria for on-going support in the community is different. The work to address this and develop a joint care pathway between mental health and substance misuse services and also with the YOI is being progressed through the CAMHS in Suffolk Service Review and Development.

It is clear from the experience with the YOS that the presence of a procedure within a service to consistently screen young people for substance use and refer for the appropriate intervention is significant in identifying, referring and supporting those in need of specialist treatment. Hence, it is a priority to develop and support universal and targeted services within CYP services and referral pathways between services.

Waiting Times:

Analysis of waiting times shows that the proportion of young people having to wait less than 15 working days between referral and first appointment is below the NTA target of 100%, ranging from 68% to 79% in the first three quarters of 2008/09. This is most likely to be indicative of insufficient capacity within the treatment service to meet demand and is of great concern given that the demand on the service is likely to increase if the planned work to raise awareness within

CYP services is successful in increasing identification and referral of young people with substance misuse.

Further analysis of waiting times reveals that the longest waits are for psychosocial interventions and for young people referred to the outreach service (as oppose to those referred to a substance misuse worker with the YOT). The young people accessing the outreach service are presenting with more complex need, i.e. more are needing psychosocial and specialist pharmacological intervention than those referred through the criminal justice route.

Hence, a key priority for this Treatment Plan is to ensure that there is sufficient capacity within specialist treatment, particularly within the outreach service, to meet current and future demand, without the need for young people to wait for the service.

Length of time in treatment:

During April to December 2008, the average length of time in treatment varied according to the primary substance used by the client (based on all clients discharged):

- 37 weeks for opiates/crack (1 client)
- 30 weeks for other stimulants (2 clients) 24.5 weeks for cannabis (52 clients)
- 48 weeks for alcohol (48 clients)
- 18 weeks for all other substances (6 clients).

The development of a robust referral pathway into CYP services for on-going support during and after treatment may reduce times in treatment for some young people and will ensure that specialist provision is used most effectively and appropriately.

Leaving treatment in an agreed and planned way:

Around two fifths to a half of young people in treatment proceed to a successful planned discharge but this is below the NTA target of 65%. Figures for quarter 2 2007/08 indicate that 53% of young people seen by the Youth Offending Service were discharged from treatment in a planned way, while the proportion for the Outreach Service for the same period was 38%.

There is indication that some of the apparent unplanned discharges are due to a data recording process, whereby an agreed final appointment is made with a young person and recorded as the discharge date, but the young person then fails to attend, suggesting that they have left treatment in an unplanned way although the actual treatment had finished. This will be rectified through follow up telephone contact to confirm planned discharge and referral to appropriate CYP service to ensure that the young person can access on-going support.

Referrals out of specialist treatment:

Six young people in treatment in 2006/07 were referred to CYP services at the end of their care planned intervention, with 5 of those being referred to targeted youth support. This low number of referrals at discharge suggests a lack of on-going support for individual young people during and after leaving treatment, which may compromise their potential for a completely successful outcome. Hence the planned improvements given in the following section.

It will be very important that the treatment provider engages with the NTA Treatment Outcome Monitoring Profile process (TOPS) as this will give a much clearer indication of the effectiveness of a young person's pathway through treatment and highlight areas for development.

Possible trends in substance use:

National data does not suggest an increase in drug or alcohol use in young people – in fact the prevalence of regular drug and alcohol use may actually be in decline⁷

As yet trends in substance use by young people in Suffolk remain consistent, with the majority receiving treatment for alcohol and/or cannabis. Anecdotal evidence from treatment providers and youth workers indicate there may be increasing use of solvents in the older age groups of young people, and use of ketamine – but this is not reflected in the data as yet.

Currently the percentage of those in treatment for cannabis misuse is around 46% and 42% for

alcohol. Interestingly surveys of young people asking about their use of substances indicate a far greater propensity towards using alcohol than cannabis, borne out by the TellUs3 surveys and the YOS Health Needs Assessment (NA 4.5.1). In the latter, 85% of the sample survey of young offenders reported ever using alcohol and 59% reported ever using cannabis. The National Youth Alcohol Action Plan states that rates of young people drinking are dropping but that for those that do drink they are starting at an earlier age and drinking more heavily. This may well have an impact on the numbers needing to access specialist treatment both in numbers and in the age at which they present. It is unclear what the change in classification for cannabis to a Class B drug will mean in terms of numbers of young people accessing treatment.

Class A drug use is predominantly in the older age groups and whilst the age of presentation to treatment has remained fairly consistent over the two years 2006 – 2008, males using cocaine has dropped from 18 years to 16.5 years at age of referral. Given the small numbers this may be insignificant, but future trend data will determine whether it is or not. It is hoped that the transition worker will be able to encourage access to services with this group of young people.

There is concern within the Children's Trust that the current economic downturn in Suffolk and nationally will result in an increase of vulnerability and risk taking behaviours in young people. This may be reflected in the anecdotal evidence of young people becoming involved in supply as well as use of drugs, and once again underlines the need for specialist treatment set within a fully integrated framework of prevention and interventions for substance use with all partner agencies. (NA 9.1.1).

In summary, the Needs Assessment indicates there is a level of unmet need and a lack of capacity within the specialist treatment service to meet this need. There are also some areas for improvement in meeting performance targets. Strategies to address these findings will include working with treatment services to increase capacity, with CYP services to provide targeted interventions for young people and clear protocols for joint working with universal and specialist CYP services.

Improvements to be made in relation to the impact of treatment in terms of its outcomes which will deliver improvements in individual young people's health and social functioning

An increased number of young people will develop the confidence and resilience to abstain, or reduce their level of substance misuse, such that they are able to fulfil the five outcomes of Every Child Matters to their full potential, i.e.

- Be healthy – e.g. avoid the physical and emotional harmful effects of substance misuse
- Enjoy and achieve - maintain participation in education or training
- Achieve economic well being – e.g. gain employment, not be pressurised into spending on substances or engaging in offending behaviour because of substance misuse
- Stay Safe - e.g. avoid accidental injury, being a victim of crime as a result of substance misuse
- Make a positive contribution – e.g. participate in activities and supportive networks rather than being marginalised as a result of substance misuse,

To contribute to the achievement of the above overall outcome, the following improvements to the treatment pathway are planned:

Young people will receive the following support during their treatment episode or as part of their discharge referral pathway

- All young people will be seen by the treatment provider within an appropriate timescale.
- All young people engaging with the treatment system will be registered with a GP (to ensure their physical health and well being is addressed).
- All young people will be referred to a named practitioner within services to children, young

people and families, to ensure on-going support as required.

- All young people engaging with substance misuse treatment will be screened for mental health problems and referred as required.
- All young people with co-occurring problems, such as emotional/mental health issues or family difficulties are assessed through the Common Assessment Framework process prior to discharge, to ensure multi disciplinary co-ordination of their care
- All parents/carers of young people in treatment will be able to access structured family support as part of the young person's care plan.
- All young people aged 16 – 24 with problematic substance misuse are able to access treatment appropriate to their needs (level of maturity) through supported transition between young people and adult services.
- All young people will be supported to remain in education, training or employment through referral to the Youth and Connexions service as required.
- All young people with identified accommodation needs (e.g. poor accommodation/no accommodation) will be referred for support from housing support services.
- All young people experiencing difficulty with finances will be supported by referral to the Connexions service.

Key priorities for developing young people's specialist substance misuse treatment interventions to meet local needs during the next financial year

1. Ensure that specialist treatment provision is within an agreed framework of clinical governance, audited on an annual basis.
2. Ensure that there is a clear care pathway for family support within specialist treatment, aligned with interventions available within CYPS.
3. Ensure that there are clear care pathways between specialist services, including for CAMHS and substance misuse and between criminal justice services (YOS and YOI) and substance misuse.
4. Ensure that the treatment system is delivered in line with the improvements outlined in the previous section.
5. Ensure capacity within specialist treatment provision is sufficient to meet the current and likely future demand.
6. Ensure that there is capacity within specialist treatment services to support for targeted interventions provided by mainstream services for children, young people and families.

⁷ NTA-YP (2009) Getting to Grips with Substance Misuse Among Young People.