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Our mission is to improve the outcomes of services for their users, with a particular emphasis on the most disadvantaged.
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1. Executive Summary

1.1 Background
Sefton Council are currently undertaking a review of the current provision of support to children, young people and families affected by substance misuse. Previous intelligence on local substance misuse issues was gathered in a health needs assessment published in 2014. This report highlighted issues around the substance misuse needs of young people and the need to better understand the nature of the issue and the extent to which provision meets the needs of young people.

Sefton Council commissioned this health needs assessment to help understand the needs of the borough’s children, young people and families around substance misuse.

The report looks at substance misuse need from both a preventative and treatment perspective and also looks at issues around children and young people who are affected by substance misuse of a family member or carer.

The HNA will be used to inform policy, strategy and the development of activities for young people in the borough.

1.2 Context
Sefton has two specialist services that support children, young people and families around substance misuse.

**SMASH** – a Council run service (commissioned by Public Health), specifically designed to meet the substance misuse needs of the young people (aged 10 - 18) of Sefton. They are a multi-disciplinary team who support and educate young people with substance misuse and other issues affecting their wellbeing.

**Breaking the Cycle** – a service provided by Addaction (and commissioned by the Council children’s service). This service supports and empowers whole families where parents or carers experience substance misuse and have responsibility for children under the age of 18 years.

There are also obvious links to other services – most notably the 0-19 Healthy Child Programme which is being run by North West Boroughs Healthcare NHS Foundation Trust from April, and also the Ambition Sefton adult substance misuse services run by Merseycare.
1.3 Methodology
This health needs assessment is informed by both quantitative and qualitative data.

A broad range of professional stakeholders were consulted during face to face interviews to determine their views on local drug and alcohol treatment and youth services.

A series of focus groups with young people were undertaken via a range of youth services in Sefton, using a range of engagement methods.

Data analysis was undertaken which allowed a picture of likely levels of drug/alcohol use among young people to be developed by creating a synthetic estimate using a range of data sources for Sefton (in particular the most recent Joint Strategic Needs Assessment). In addition to local data, national lifestyle surveys regarding drug/alcohol consumption among young people were modelled to develop an understanding of what the results would look like when applied locally.

For the purposes of better understanding the situation in Sefton and for benchmarking purposes, data for two of Sefton’s statistical neighbours were used. The comparators chosen were Stockport and Wirral.

1.4 Literature review
Public Health England has set out the framework for the commissioning of young people’s substance misuse services in Good practice in planning young people’s specialist substance misuse interventions. The guidance notes that, “Most young people can have their needs met in universal or targeted services. However, access to specialist substance misuse treatment services is required for all young people whose functioning is greatly impaired by substance misuse, and who have been assessed as requiring specialist substance misuse treatment to meet their needs.”

The literature regarding young people and substance misuse indicates a clear link between certain issues in the lives of young people and the likelihood of drug and alcohol use. These issues include: mental health, sexual exploitation, being NEET, being excluded from school and having a family or

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carer where drugs are used. Furthermore the literature notes that, “The more risk factors young people have, the more likely they are to misuse substances.”

In terms of prevention work, the evidence shows that information and education programmes alone do not reduce drug and alcohol-related harm. The evidence-base suggests that the most effective interventions are those that combine social competence (that aim to improve personal and interpersonal skills) and social influences (reducing the influence of society by addressing norms for instance).

In terms of young people’s substance misuse treatment the literature suggests that motivational interviewing and cognitive behavioural therapy have a positive impact. There is also a growing body of literature on family-based interventions which highlights the importance of engaging parents and carers in the treatment process and that family therapy (along with CBT) show the most consistent reductions in substance misuse.

### 1.5 Profile of young people in substance misuse treatment

Treatment data for Sefton shows that the number of young people in specialist treatment in SMASH has steadily declined from a peak of 269 in 2008/09. In 2014/15 there were 116 young people and 97 in 2015/16. As of January 2017 there were 112 young people who had been referred to SMASH in the financial year.

Sefton specialist support sees very few under 13 year olds and the majority (59%) of those in treatment are aged 15 or 16 years.

Cannabis use is cited in 91% of clients and alcohol in 27%. Cocaine is cited in 28% of treatment cases the second. (Note the figures add up to more than 100% as individuals can cite more than one problematic substance). 31% of young people in treatment had a dual diagnosis – that is co-morbid mental health and substance misuse needs.

Breaking the Cycle received 67 referrals in the period April to December 2016 with an average of 7 referrals per month. If levels of referrals remain constant and are taken onto the caseload it is likely that 88 referrals will be received over the full year period.

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2 Young People – substance misuse JSNA support pack. p.5.
In Sefton in 2015-16 the proportion of young people reporting being affected by others’ substance misuse was 47% - an increase from 39% in 2014-15.

**Dip sample**

A dip sample was taken of case files of young people engaged in support by SMASH. In total a total of 30 files were reviewed. The review identified the following characteristics among the sample population:

- 8 of the young children were designated as Children in Need
- 5 had a Child Protection Plan
- 6 of the young people were ‘looked after’ living in residential care or foster placements
- 11 had been involved in more than two incidents of criminal activity
- 19 young people had been identified as having emotional and mental health needs; the majority of which were anxiety and depression
- 11 of the young people had witnessed or experienced domestic violence
- 7 of the young people had experienced sexual or physical abuse
- 10 of the young people were, or had been known to Child and Adolescent Mental Health Services

**1.6 Links between substance misuse, risks and vulnerabilities**

National statistics show that the majority of young people in specialist substance use services have a range of problems or vulnerabilities related to their substance use. Specialist services therefore need to be able to work with a range of other agencies to ensure that all a young person’s needs are met. The presence of a number of these issues in the wider Sefton population is set out below.

**Young people’s population**

Based on the young people’s population for Sefton and applying national prevalence data:

- 879 11-15 year olds in Sefton could potentially require a specialist (or structured) drug misuse intervention (s) in a young people’s treatment service setting and
- 1,172 a specialist alcohol intervention.

Note that this is substantially more than the total number (97) in structured treatment using SMASH services in 2015-16.
Exposure to child maltreatment and abuse
Alcohol and/or drug misuse featured in 1,079 of 2978 children’s assessments between April 2016 and February 2017 in Sefton. A child can be assessed on more than one occasion throughout the year. Given the way the data is compiled (as assessments) data is not available on the individual number of children assessed. The data indicates that drug or alcohol misuse were a factor in over a third (36%) of assessments in Sefton.

Youth crime
In relation to youth related incidents in Sefton, alcohol related incidents account for 2% and drug related incidents 7% of the total. The data does not however indicate whether drugs and/or alcohol were a contributory factor to the other incidents.

Looked after children
Data indicates that in Sefton there 465 young people looked after by the local authority. Of this group, 360 young people were looked after and had been continuously for 12 months. Of the 360 young people 230 were aged 10 years or older.

1.7 Stakeholder consultation
A number of cross-cutting themes were identified during the consultation. The key themes identified were:

- The normalisation of cannabis use locally in recent years was flagged by a majority of interviewees
- The perceived wide use of ketamine which appears to be more accessible and affordable
- The continuing damage that parental/carer substance misuse has on generations of Sefton children and young people is a concern – both the direct impact, for example in terms of a young person’s health and also indirect impacts on local communities
- Stakeholders stressed the importance of understanding substance misuse provision and future commissioning in the context of the ‘toxic trio’ issues that permeate the lives of many of the most vulnerable families – namely mental health, domestic abuse and drug and alcohol harm.
- The need for a wrap-around family approach was repeated by many interviewees. Whole family working, rather than splitting issues into adult and children and young people provision was on most people’s list of future improvements
The need for greater awareness and communication between young people’s service providers across Sefton was identified as important.

1.8 Young people’s consultation

20 young people aged between 10 and 23 years participated were consulted as part of the health needs assessment. Consultation took place across six sites. The consultation included a mix of those young people receiving treatment (SMASH clients) and wider young people (i.e. those not requiring treatment).

The majority of the young people, including the youngest participants, had drunk alcohol, although some said that they only drank at family gatherings or occasionally on special occasions. A minority of the weekend drinkers said that they drank considerable amounts of alcohol alongside other drug use. A further minority said they drank every day.

All of the young people said they thought that cannabis was the most prevalently used substance along with alcohol. There was considerable variation in how much ‘weed’ young people said they used. The majority of those aged 14 and 15 said that it was occasional and when they had the money. A few of these young people and a number of the older ones, said that they always smoked joints in the evenings and at weekends.

A number of the young people aged 14 and upwards spoke about using ketamine. This corroborates the views of adult stakeholders who noted that ketamine was becoming more prevalent.

A lot of the young people spoke about the drinking and drug use of members of their families. Only one young person said that neither of his parents drank alcohol. Six of the young people referred to the fact that their parents had used drugs (mostly cannabis or amphetamine) in the past. Three had experience of living with parents who were using illegal drugs in the home.
1.9 Conclusions

Whilst there has been a decline in the Sefton young people’s treatment population, it does not logically follow that this is indicative of lower levels of demand. Rather it may be indicative of changing levels of need and different types of drug consumption. Furthermore, the data can be read as indicating that, while demand continues to exist, this is not being matched by supply. Stakeholders who were interviewed commented on lack of knowledge about referral pathways into treatment, lack of awareness about the service (particularly following a reconfiguration) and what it provides and perceptions about the type of young people it works with. All these factors may well have had a negative impact on referral levels into the service in an environment where demand has been constant (or even increasing). The effect of how services are provided is crucial in understanding the data and may well be why numbers of young people in treatment in Stockport are rising whilst numbers in Sefton are decreasing.

Following on from the point above, given that it cannot be concluded that levels of demand are decreasing it is not safe to conclude that the expectation should be that numbers continue to decline in the future. It is quite possible that, should current services be re-structured or awareness of the service increased then the numbers into treatment may start to rise again. Again, the key point to conclude is that the demand for services and the numbers in services may not correspond and that the numbers in treatment are a function of how services are offered rather than the need for services.

The data regarding those in treatment clearly indicates multiple and complex needs. Given the complexity of young people in treatment, the findings endorse the position of PHE and others that indicate that substance misuse treatment for this population cannot be delivered in isolation and that any work must tackle multiple vulnerabilities, adopting a child-centred holistic approach in which substance misuse is understood as a risk-taking behaviour (often alongside other risk-taking behaviours).

There are a range of vulnerability factors that are known to increase risk of substance misuse among young people. The data for Sefton clearly demonstrates the presence of all these risk factors in the local population. The existence of these factors are indicative of cohorts of young people who live in Sefton who may turn to substance misuse as one form of risk-taking behaviour. Given this, it can reasonably be concluded that there will be a need for specialist young people’s substance misuse services for the foreseeable future as a range of socio, economic and cultural factors create future generations of drug and alcohol users.
**1.10 Recommendations**

Based on the data in this report and the conclusions set out above a number of recommendations have been made which are set out below.

1. Consideration should be given to ensure that specialist young people’s provision in Sefton is delivered at appropriate capacity and delivers a comprehensive service in line with PHE and best practice guidelines.

2. Consideration should be given to how to create a joined up model that:
   a. Provides support to all young people where parental substance misuse is an issue
   b. Provides a family-based interventions to young people who require substance misuse treatment

3. Delivery of future substance misuse services should be informed by consultation and co-production with young people.

4. There should be an improved training offer to front-line staff across a range of settings to enable practitioners who come into contact with young people to provide brief interventions and brief advice and to help them assess where an onward referral to specialist services are required.

5. There should be a greater emphasis on prevention work, for example working with schools to tackle risk-taking behaviours (as opposed to stand-alone drug and alcohol awareness modules) among young people. Consideration should be given to adopting one of the evidence based standardised models that have been developed (such as The Good Behaviour Game, PreVenture, Strengthening Families).

6. Consideration should be given to a local education programmes aimed at young people on the dangers associated with any newly emerging substance and how to access substance misuse treatment services.

7. There should be greater awareness of referral pathways and joint working between services to ensure complex needs of young people are met.

8. The service should specifically record numbers of young people entering treatment and capture drug use and emerging drug use patterns, for example ketamine use.
2. Background and local context

2.1 Background

Sefton Council (hereafter Sefton) are currently undertaking a review of the current provision of support to children, young people and families affected by substance misuse. Previous intelligence on local substance misuse issues was gathered in a health needs assessment (hereafter HNA) published in 2014. This report highlighted issues around the substance misuse needs of young people and the need to better understand the nature of the issue and the extent to which provision meets the needs of young people. The HNA made a number of recommendations including:

“There is the need for a comprehensive young person’s needs analysis which takes into account wider data sources and direct consultation with young people to ascertain whether the service data is a reflection of use and at what levels.”

Sefton Council commissioned this HNA to help understand the needs of the borough’s children, young people and families around substance misuse.

The HNA looks at substance misuse need from both a preventative and treatment perspective and also looks at issues around children and young people who are affected by substance misuse of a family member or carer. Specifically the HNA addresses:

- The current context in Sefton
- Estimated prevalence by drug type in Sefton
- Estimated age when children and young people first use alcohol or drugs
- Location and deprivation and the effects they have on drug and alcohol use
- Numbers engaged with services
- Children and young people affected by parental or carer substance use
- Hospital admissions related to children and young people’s substance use

The HNA will be used to inform policy, strategy and the development of activities for young people in the borough.
2.2 Local context

2.2.1 Overview of need
Sefton SMASH provides substance use support for young people. Activity of this service is reported in the National Drug Treatment Monitoring System (NDTMS).

NDTMS data for Sefton shows that the number of young people in specialist treatment has steadily declined from a peak of 269 in 2008/09. In 2014/15 there were 116 young people and 97 in 2015/16.

Similar to the national picture Sefton annual data shows there are around twice as many males to females in the young person’s specialist treatment. The 2015/16 breakdown was 63% males and 37% females. Sefton specialist support sees very few under 13 year olds. In 2015/16 the breakdown of attendance by age was 13 to 14 year olds - 18%, 15 year olds – 25%, 16 year olds – 29%, 18 year olds – 2% and 19 year olds 1%.

The majority of referrals in 2015/16 were from children and family services (32%), education (25%), youth justice services (22%) and self (13%). Other less frequent referrals sources included GP, primary care, adult treatment provider, relative or hospital.

Many young people use more than one substance. Since 2005/06 cannabis has been cited by the majority of young people in specialist support, followed by alcohol and then cocaine. The 2015/16 breakdown was 88% of young people cited use of cannabis, 29% use of alcohol and 22% use of cocaine.

Many of the young people in Sefton’s service have wider vulnerabilities. This includes domestic abuse, self-harm, anti-social behaviour, mental health and being affected by others substance misuse.

2.2.2 Current specialist provision
Sefton has two specialist services that support children, young people and families around substance misuse.

SMASH – a Council run service (commissioned by Public Health), specifically designed to meet the substance misuse needs of the young people (aged 10 - 18) of Sefton. They are a multi-disciplinary team who support and educate young people with substance misuse and other issues affecting their wellbeing. The SMASH service work in close partnership with young people with substance misuse needs, to enable them to support and access:
● drug education
● drug treatments (brief interventions)
● mental health support
● harm reduction strategies
● complementary therapies
● health care

**Breaking the Cycle (BtC)** – a service provided by Addaction (and commissioned by the Council children’s service). This service supports and empowers whole families where parents or carers experience substance misuse and have responsibility for children under the age of 18 years. Families engage voluntarily with BtC to focus on:

● Reducing harmful behaviours
● Prioritising children’s healthy development to ensure they are able to thrive
● Building family resilience

There are also obvious links to other services – most notably the 0-19 Healthy Child Programme which is being run by North West Boroughs Healthcare NHS Foundation Trust from April, and also the Ambition Sefton adult substance misuse services run by Merseycare since October 2016. In regard to the former, their reviews include:

● Reviews (from pre-birth through to pre-school) of mother’s and partners’ alcohol consumption; including advice on parental or sibling alcohol and substance misuse, as part of the universal service element of their service – with one measure being ‘Numbers of new mothers with alcohol or drug misuse’.
● Year 9, Year 11 and ‘transition into adulthood’ reviews of alcohol and substance misuse.

In terms of overarching numbers engaging with services, the expected amount of specialist activity has been set as:

● **SMASH**: between September 2016 and September 2017 “minimum activity level of 175 clients in treatment for 2016/17. There is a ceiling of £253,200 on the annual cost of the contract”.
● **Breaking the Cycle**: “will provide support to a maximum of 90 families per year. Agreed annual funding will be £144,000 for 12 month pro-rata from the 1st January 2016 to 31st October 2017”.
2.2.2 SMASH monitoring statistics

The section of this report presenting NDTMS statistics provides a partial picture of activity for the SMASH programme of work – with the caveat that NDTMS does not record all of the benefits and impacts of a service.

To supplement the NDTMS statistics monitoring returns were requested as part of this project. A limited amount of statistical reporting has been supplied by commissioners of both SMASH and Breaking the Cycle, which is replicated in the remainder of this section, to complement the analysis of NDTMS (see Section 5):

**January 2017 monitoring statistics**, supplied to commissioner by SMASH (17/1/17):

Total number of referrals received by SMASH (a need for intervention identified) (1/4/16 – 31/12/16) **112**

- Q1: 34
- Q2: 27
- Q3: 51

Figure 1 below sets out referral routes into SMASH.
Figure 2 sets out the primary substance used by those young people supported by SMASH. The data is for number of referrals received (new presentations) in Q3 who have undertaken a full assessment and undertaken a SMASH intervention: 24 young people. Note the significant predominance of cannabis misuse.
In addition the SMASH commissioner provided historical data prepared by the SMASH team, to help gauge the number of referrals that do not lead to intervention. These figures are presented below at Figure 3.

**Figure 3: SMASH referrals and interventions (three years, to March 2016)**

<table>
<thead>
<tr>
<th></th>
<th>01/04/2013 - 31/03/14</th>
<th>%</th>
<th>01/04/14 - 31/03/15</th>
<th>%</th>
<th>1/04/15 - mid March 16</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full Intervention</td>
<td>123</td>
<td>70%</td>
<td>126</td>
<td>82%</td>
<td>56</td>
<td>35%</td>
</tr>
<tr>
<td>North of Sefton</td>
<td>44</td>
<td>36%</td>
<td>36</td>
<td>29%</td>
<td>20</td>
<td>30%</td>
</tr>
<tr>
<td>South of Sefton</td>
<td>78</td>
<td>63%</td>
<td>83</td>
<td>60%</td>
<td>34</td>
<td>61%</td>
</tr>
<tr>
<td>N/S not recorded</td>
<td>1</td>
<td>1%</td>
<td>7</td>
<td>5%</td>
<td>2</td>
<td>1%</td>
</tr>
<tr>
<td>Female</td>
<td>18</td>
<td>31%</td>
<td>31</td>
<td>22%</td>
<td>22</td>
<td>39%</td>
</tr>
<tr>
<td>Male</td>
<td>55</td>
<td>69%</td>
<td>95</td>
<td>75%</td>
<td>34</td>
<td>61%</td>
</tr>
<tr>
<td>Re Presentations</td>
<td>24 of 123</td>
<td></td>
<td>22 of 126</td>
<td></td>
<td>12 of 56</td>
<td></td>
</tr>
<tr>
<td>Inappropriate referral</td>
<td>additional to full intervention number eg refusal / low tier</td>
<td>28</td>
<td>28</td>
<td>28%</td>
<td>46</td>
<td>45%</td>
</tr>
<tr>
<td>Total number of referrals for period</td>
<td>101</td>
<td>154</td>
<td>107</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>
From the data at Figure 3 note the shortfall between actual numbers of clients (102) and the number expected by commissioners (175) a variance of some 73 young people.

Notable in the 2015/16 statistics is the percentage of ‘inappropriate referrals’ (45%) – which have doubled as a percentage of all referrals compared to the previous two years (albeit with the caveat that the number of referrals has fallen dramatically). The reason for the fall in numbers of both referrals and interventions was given by SMASH workers as:

- The team had two members off long term sick and one on maternity leave so the team, for the majority of 15/16 was down to two substance misuse workers and an admin worker. As such the decision was made to only take complex cases. This may be a key factor in explaining the shortfall between actual numbers of clients and anticipated numbers.
- There was less capacity for the promoting of SMASH to partner agencies meaning other agencies may not have been aware of the changed referral criteria.
- The team were in a period of transition - moved out to other teams and line managed by other services including YOT, LAC, CAS and MASH.
- They used some of their resources to support targeted services to deliver prevention work that may have become referrals if they had capacity.
2.2.3 Breaking the Cycle monitoring statistics

Monitoring data was provided by BtC and is set out below in this section.

Figure 4: BtC referrals by month (1 April – 31 December 2016)

<table>
<thead>
<tr>
<th>Month</th>
<th>Referrals</th>
</tr>
</thead>
<tbody>
<tr>
<td>April</td>
<td>8</td>
</tr>
<tr>
<td>May</td>
<td>5</td>
</tr>
<tr>
<td>June</td>
<td>12</td>
</tr>
<tr>
<td>July</td>
<td>5</td>
</tr>
<tr>
<td>August</td>
<td>4</td>
</tr>
<tr>
<td>September</td>
<td>12</td>
</tr>
<tr>
<td>October</td>
<td>8</td>
</tr>
<tr>
<td>November</td>
<td>9</td>
</tr>
<tr>
<td>December</td>
<td>4</td>
</tr>
<tr>
<td>Average</td>
<td>7.4</td>
</tr>
<tr>
<td>TOTAL</td>
<td>67</td>
</tr>
</tbody>
</table>

As indicated at Figure 4, on average 7 referrals were made per month to BtC by other agencies with a total number of 67 over the April to December period (note therefore that the figures are not therefore for a full year).

If levels of referrals remain constant and are taken onto the caseload (7 per month) it is likely that BtC will receive 88 referrals over a full year period. This puts it almost exactly in line with the expected caseload per annum (90) as set out by commissioners.

Figure 5 sets out the source of referrals.
Figure 5: BtC referrals by source (1 April – 31 December 2016)

<table>
<thead>
<tr>
<th>Source</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child Protection Officer</td>
<td>1</td>
<td>1.5%</td>
</tr>
<tr>
<td>Children and Family Services (Social Care)</td>
<td>4</td>
<td>6%</td>
</tr>
<tr>
<td>Community Alcohol Team</td>
<td>1</td>
<td>1.5%</td>
</tr>
<tr>
<td>Drug Service (Statutory)</td>
<td>1</td>
<td>1.5%</td>
</tr>
<tr>
<td>Education Service</td>
<td>1</td>
<td>1.5%</td>
</tr>
<tr>
<td>Generic Children's Services</td>
<td>1</td>
<td>1.5%</td>
</tr>
<tr>
<td>Primary Care</td>
<td>1</td>
<td>1.5%</td>
</tr>
<tr>
<td>Self</td>
<td>1</td>
<td>1.5%</td>
</tr>
<tr>
<td>Adult Social Care</td>
<td>55</td>
<td>82%</td>
</tr>
<tr>
<td>Specialist Counselling Service</td>
<td>1</td>
<td>1.5%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>67</td>
<td>100%</td>
</tr>
</tbody>
</table>

Note that the overwhelming majority of referrals were from Social Care accounting for more than four in five referrals made.

Figure 6: Referrals by month into BtC service (1 April – 31 December 2016)

<table>
<thead>
<tr>
<th>Month</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>April</td>
<td>1</td>
</tr>
<tr>
<td>May</td>
<td>3</td>
</tr>
<tr>
<td>June</td>
<td>2</td>
</tr>
<tr>
<td>July</td>
<td>0</td>
</tr>
<tr>
<td>August</td>
<td>2</td>
</tr>
<tr>
<td>September</td>
<td>2</td>
</tr>
<tr>
<td>October</td>
<td>2</td>
</tr>
<tr>
<td>November</td>
<td>3</td>
</tr>
<tr>
<td>December</td>
<td>3</td>
</tr>
<tr>
<td>TOTAL</td>
<td>18</td>
</tr>
</tbody>
</table>

Figure 6 sets out the monthly number of referrals into BtC (not actual caseload) so gives an indication of the volume of clients engaging in any given month. Note that the numbers are low but are relatively constant.
Figure 7 shows data relating to attendance at BtC appointments by clients. Note that nearly a fifth of clients failed to attend their first appointment with the service. Figure 8 (below) indicates however that the proportion of clients not attending their appointment drops significantly following the first (down to 4%).

**Figure 7: First appointment records (from 18 who started a treatment modality) (1 April – 31 December 2016)**

<table>
<thead>
<tr>
<th>Attended</th>
<th>14</th>
<th>78%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did Not Attend</td>
<td>3</td>
<td>17%</td>
</tr>
<tr>
<td>Client Cancelled</td>
<td>1</td>
<td>5%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>18</td>
<td>100%</td>
</tr>
</tbody>
</table>

**Figure 8: Follow up appointment records (from 18 who started a treatment modality) (1 April – 31 December 2016)**

<table>
<thead>
<tr>
<th>Attended</th>
<th>191</th>
<th>86%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did Not Attend</td>
<td>8</td>
<td>4%</td>
</tr>
<tr>
<td>Client Cancelled</td>
<td>13</td>
<td>6%</td>
</tr>
<tr>
<td>Service Cancelled</td>
<td>1</td>
<td>0%</td>
</tr>
<tr>
<td>Drop-In / Unscheduled Visit</td>
<td>8</td>
<td>4%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>221</td>
<td>100%</td>
</tr>
</tbody>
</table>

**Figure 9: DNA rate (1 April – 31 December 2016)**

<table>
<thead>
<tr>
<th>Overall</th>
<th>239</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did Not Attend</td>
<td>11</td>
</tr>
<tr>
<td>DNA RATE</td>
<td>5%</td>
</tr>
</tbody>
</table>
Figure 10 sets out data relating to reason for discharge from BtC.

**Figure 10: Discharges (1 April – 31 December 2016)**

<table>
<thead>
<tr>
<th>Reason</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client Unable to Engage</td>
<td>10</td>
<td>17%</td>
</tr>
<tr>
<td>Inappropriate Referral</td>
<td>6</td>
<td>10%</td>
</tr>
<tr>
<td>Incomplete (Client Died)</td>
<td>1</td>
<td>2%</td>
</tr>
<tr>
<td>Incomplete (Dropped Out)</td>
<td>7</td>
<td>12%</td>
</tr>
<tr>
<td>Incomplete (Commencement Declined by Client)</td>
<td>5</td>
<td>8%</td>
</tr>
<tr>
<td>Never Attended / Not Contactable</td>
<td>8</td>
<td>14%</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>37</td>
<td>64%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Treatment Type</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Completed Treatment (Alcohol-Free)</td>
<td>12</td>
<td>21%</td>
</tr>
<tr>
<td>Completed Treatment (Drug-Free)</td>
<td>1</td>
<td>2%</td>
</tr>
<tr>
<td>Completed Treatment Occasional User (Not Heroin or Crack)</td>
<td>8</td>
<td>14%</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>21</td>
<td>36%</td>
</tr>
</tbody>
</table>

**WEEKS IN TREATMENT (AVERAGE)**

<table>
<thead>
<tr>
<th></th>
<th>Average</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>TOTAL</strong></td>
<td>43</td>
</tr>
</tbody>
</table>

The data set out above indicates that a little over a third of clients successfully completed treatment with BtC. Other data from BtC indicates that:

- From the 21 clients who completed treatment (discharges shown above), the average number of sessions per family is 3
- Only 11 of 21 had a Family Session. For these, the average goes up to 5
- Average waiting time from point of referral to attendance at first appointment is 8.5 days (rounded up to 9)
3. Methodology

This health needs assessment is informed by both quantitative and qualitative data.

A broad range of professional stakeholders were consulted during face to face interviews to determine their views on local drug and alcohol treatment and youth services. A list of professional stakeholders consulted and a list of questions that were asked during the interviews can be found in Appendices 1 and 2.

A series of focus groups with young people were undertaken via a range of youth services in Sefton, using a range of engagement methods. The list of organisations that we worked with, along with a list of questions can be found in Appendix 3.

Data analysis allowed a picture of likely levels of drug/alcohol use among young people to be developed by creating a synthetic estimate using a range of data sources for Sefton (in particular the most recent Joint Strategic Needs Assessment). In addition to local data, national lifestyle surveys regarding drug/alcohol consumption among young people were modelled to develop an understanding of what the results would look like when applied locally.

For the purposes of better understanding the situation in Sefton and for benchmarking purposes, data for two of Sefton’s statistical neighbours were used to refine the modelling. Two comparator areas were chosen from a long list of 10 local authorities. The areas chosen were:

- Stockport
- Wirral

The statistical neighbours were derived from a Department of Education report statistical benchmarking tool which is explicitly designed for the purposes of enabling the comparison of young people’s population between different local authorities. As such, the statistical neighbours selected were wholly suited to the purposes of this HNA.

Primary data analysis enabled a more in-depth picture of young people’s substance misuse and to estimate numbers in treatment versus likely local demand. Bi-variate analysis was carried out to understand the profile of young people’s substance misuse in relation to:

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• Deprivation
• Geographical location
• Demographic characteristics

A range of locally held data sets were used in the analysis including data from:

• Treatment services
• A&E/hospital
• Mental health services (CAMHS)
• Early Intervention services
• “Troubled families”
4. Literature review
This section sets out an overview of guidance relating to children and young people’s substance misuse provision as well as a review of the literature relating to best practice in the field.

4.1 Policy and guidance

4.1.1 National policy
The Government’s 2010 Drug Strategy sets the context for the provision of young people’s drug and alcohol services in England. The Strategy notes that “The majority of young people do not use drugs and most of those that do, are not dependent.” As such the Strategy notes that the substance misuse needs of young people are distinct from those of the adult population (where dependency is the norm). Given this, the Strategy notes that: “specialist substance misuse interventions should be delivered according to a young person’s age, their level of vulnerability and the severity of their substance misuse problem, and should help young people become drug and alcohol free.”

4.1.2 Commissioning guidance
Public Health England has set out the framework for the commissioning of young people’s substance misuse services in *Good practice in planning young people’s specialist substance misuse interventions*. The guidance notes that, “Most young people can have their needs met in universal or targeted services. However, access to specialist substance misuse treatment services is required for all young people whose functioning is greatly impaired by substance misuse, and who have been assessed as requiring specialist substance misuse treatment to meet their needs.”

More recently, in 2016, Public Health England has issued good practice guidance for young people’s substance misuse services. The guidance sets out a number of principles that commissioners should consider when commissioning services. The principles are:

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

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5 Ibid

2. A full range of specialist drug, alcohol and tobacco interventions are available to young people in need.
3. Commissioning is integrated across prevention and specialist interventions and the wider children’s agenda.
4. A skilled workforce is in place to provide effective interventions.\(^7\)

## 4.2 Influences on young people’s substance misuse

### 4.2.1 Vulnerability factors
The literature regarding young people and substance misuse indicates a clear understanding of links between certain factors and issues in the lives of young people and the likelihood of drug and alcohol use. NICE identify key risk factors for young people as:

- with mental health problems
- who are being sexually exploited
- those who are engaged in commercial sex work
- who are lesbian, gay, bisexual or transgender
- who are NEET
- who are excluded from school or who truant regularly
- whose families or carers use drugs
- who are looked after or who are care leavers
- who are in contact with youth offending services\(^8\)

PHE notes that risk factors also include early sexual activity, antisocial behaviour and – as per NICE – exposure to parental substance misuse.

Furthermore the literature notes that, “The more risk factors young people have, the more likely they are to misuse substances.”\(^9\) NICE note those that are particularly vulnerable include:

- who are in multiple groups of need

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\(^8\) Drug misuse prevention: targeted prevention. NICE Guideline NG64 (2014).

\(^9\) Young People – substance misuse JSNA support pack. p.5.
• whose personal circumstances put them at risk
• those who use drugs on an occasional basis
• those who are already excessively using another substance such as alcohol

The literature also notes that girls face a number of specific issues and are more likely to internalise problems in the form of depression and self-harm. It is therefore considered appropriate for provision to be differentiated by gender to allow the needs of girls to be met more effectively.

4.2.2 Protective factors
Conversely there is an evidence base for those factors which have a protective effect. PHE note that “physical and mental wellbeing, and good social relationships and support are all protective factors.”

PHE goes on to note that key predictors of wellbeing are:

• Positive family relationships
• A sense of belonging – at school and in communities
• Good relationships with adults outside the home
• Positive activities and hobbies

PHE note that potentially the most significant protective factor is the age at which young people start using drugs and alcohol with severity of substance misuse problems strongly correlated to early onset.

4.3 What works

4.3.1 Young people focussed
The literature stresses the importance of building provision around young people, stressing the importance of understanding young people as a distinct cohort: “Children are not small adults and the adult definitions of substance misuse are inadequate in capturing the developmental aspects of substance misuse in young people.”

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10 NICE Guideline, p.12.
11 Ibid, p.5
12 Ibid, p.6
13 Ibid., p.5
14 Practice Standards for Young People with Substance Misuse Problems, Royal College of Psychiatrists (2012). p.5
Given this PHE note the need for services to adopt an approach that recognise the strengths and assets of young people, which treat them with respect and as agents of change and which help to build:

- Resilience
- Life skills
- Ability to make better choices and to deal with difficulties

PHE therefore indicate that treatment services should be compliant with the Department of Health’s quality criteria for young people’s services, “You’re Welcome”.

### 4.3.2 Education programmes

In terms of prevention work, evidence shows that information and education programmes alone do not reduce drug and alcohol-related harm; nevertheless, they have a role in

- Providing information
- Reframing drug and alcohol-related problems, and
- Increasing attention to alcohol on the political and public agendas.

School-based education can be important, but the literature indicates a number of important caveats to education programmes. A recent review of the literature by the Scottish Government noted that the evidence is not strong for school-based prevention work and that the effect sizes are small. The paper notes that data demonstrates the most effective interventions are those that combine social competence (that aim to improve personal and interpersonal skills) and social influences (reducing the influence of society by addressing norms for instance). The elements of effective education programmes were identified as:

- Interactive programmes with high levels of participation
- Multi-component programmes that include other elements, and
- Age appropriateness, with the optimal time being at the transition from primary to secondary education.

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17 WHO (2009). Evidence of the effectiveness and cost-effectiveness of interventions to reduce alcohol-related harm. WHO Regional Office for Europe: Denmark
A number of named programmes that have been standardised and subjected to robust research were identified as being beneficial and cost-effective. These programmes were:

- The Good Behaviour Game
- PreVenture
- Strengthening Families
- Unplugged, and
- Life Skills Training.

The paper notes a number of educational programmes that have been demonstrated to have been ineffective. These include:

- Stand-alone school-based activities designed to increase knowledge of drugs
- Diversionary activities (such as theatre- and drama-based education)
- Fear arousal approaches
- Mentoring programmes, and
- Mass media campaigns.

The authors therefore conclude that the most effective responses are those that are linked to wider strategies that promote general health and wellbeing.

The evidence from the paper makes clear that, whilst education programmes can be valuable, their use must be carefully considered and the type of programme must be carefully selected and designed.

4.3.3 Treatment

Evidence on the effectiveness of treatment interventions for young people is limited. There is both a relative scarcity of high quality published evidence and, where this evidence exists, much does not relate to the UK context (with a tendency to report on treatment in the US). Given this, the conclusions that are reached must necessarily be somewhat tentative.

Whilst evidence is limited, what evidence does exist suggests that current recognised treatment approaches have some signs of effectiveness.

Standard pharmacological approaches which are normative practice in the treatment of adults were not identified in the literature as of significant relevance to young people. Partly it is noted that by far the majority of young people will not have a need that requires a pharmacological approach and
additionally, due to the fact that research into pharmacological treatment of young people is sparse in terms of safety and effectiveness. Ahuja et al note that, "Pharmacotherapy should only be initiated with extreme caution after thorough assessment."\(^{18}\)

The literature suggests that **motivational interviewing** and **cognitive behavioural therapy** (CBT) have a positive impact on young people. An Australian study of young people who received CBT alongside motivational interviewing noted significant improvements in depression and reductions in drug use compared to a group receiving standard treatment interventions.\(^ {19}\)

There is a growing body of literature on **family-based interventions** which highlights the importance of engaging parents and carers in the treatment process and that family therapy (along with CBT) show the most consistent reductions in substance misuse.\(^ {20}\) The review emphasises the need for holistic assessments that explore wider issues in the life of the young person (i.e. looking beyond their substance misuse) and which then build support around the child dependent on the range of needs identified. Other studies endorse family-based approaches. A meta-review by Baldwin et al of family therapies notes that these approaches indicate better outcomes compared to non-family based approaches.\(^ {21}\) The study therefore suggests that family therapies are an important approach to treating young people’s substance misuse. An evaluation of Family Intervention Projects found reductions in drug and alcohol problems from 32% at the outset of engagement to 17% at treatment exit.

### 4.3.4 Integrated approach

Recognising that substance misuse is often related to multiple vulnerabilities (see section 4.2.1) PHE recommend that services understand and tackle multiple vulnerabilities as part of their approach.

Given this, PHE guidance indicates that treatment approaches offer “integrated services that deliver targeted interventions to young people at risk of developing problems with substance misuse alongside specialist services, particularly with identified vulnerable groups with specific risk factors.”\(^ {22}\) As such,

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\(^ {19}\) Does the addition of integrated cognitive behavioural therapy and motivational interviewing improve the outcomes of standard care for young people with comorbid depression and substance misuse, Hides et al, Medical Journal of Australia, (2011), 195

\(^ {20}\) Ibid., 337.


PHE stress the need for multi-agency responses with robust joint working arrangements. In particular it notes the need to engage with and provide seamless transition to services including:

- Child and Adolescent Mental Health Services (CAMHS)
- Child Sexual Exploitation and abuse support services
- Youth offending teams
- Sexual health services
5. Profile of young people in substance misuse treatment

This section sets out a profile of those children and young people who are engaged in substance misuse treatment in Sefton. Data for Sefton is compared against the national picture as well as with two comparator areas – Stockport and Wirral. For the most part, the data for this section is derived from NDTMS.

5.1 Prevalence of alcohol misuse

NDTMS structured treatment data for 2015-16 (year-to-date - or YTD - March 2016) details the numbers in specialist substance misuse community services for young people. Substances cited are from any episode for the young person in the year (i.e. any citation in drug 1, 2 or 3). Individuals may have cited more than one problematic substance so percentages can sum to more than 100%.

Alcohol is cited in 27% of episodes in Sefton which is slightly lower than in the 2014-15 YTD data (29%).

Alcohol is cited in 76% of episodes in Stockport which is higher than in 2014-15; prevalence of 71% in Wirral is lower (39% in 2015-16 and 47% in 2014-15) than in Stockport but exceeds the Sefton structured treatment prevalence. Data is not available to indicate why there is such a pronounced difference in alcohol clients between Sefton and the comparator areas.

The discrepancy between Sefton and the comparator areas is unlikely to be due to much lower levels of alcohol consumption in Sefton and is most likely linked to how services are structured in Stockport and Wirral – potentially there is a greater/specific focus on alcohol clients in these areas. Necessarily however this conclusion is tentative in the absence of supporting data. It is also worth noting that the consultation with young people – see section 8.3 – indicated very high levels of drinking among young people and that alcohol consumption was part of normative behaviour. This would tend to indicate that alcohol treatment numbers do not necessarily closely correlate with actual levels of alcohol consumption among young people.
5.2 Prevalence of drug misuse

With reference to substances other than alcohol, cannabis is cited in 91% of episodes in Sefton in 2015-16, which compares to 88% in 2014-15.

Cocaine is also a feature in Sefton (28%) followed by ecstasy (14%) and Novel Psychoactive Substances (hereafter NPS) (5%).

These proportions have all increased since 2014-15, when they were respectively 22%, 8% and 2%.

Amphetamines were cited in 3% of episodes in 2014-15 with solvents at 2% and opiates and crack at 1% each. Only one of these four substances (opiates) was cited in 2015-16 when it was also 1%.

In 2015-16 in Stockport the main citations included cannabis (82%), ecstasy (24%), cocaine (14%) and NPS (14%). In 2015-16 in Wirral the main citations included cannabis (86%), cocaine (30%) and ecstasy (24%).

5.3 Prevalence of dual diagnosis

The NDTMS Quarterly Activity Report provides data on whether a young person (in treatment) answers ‘yes’ for having an identified mental health problem at the first episode in the latest treatment journey. It is also possible to identify referral sources via either ‘Child Mental Health Services’ or ‘Non-Child Mental Health Services’. Mental health problems are reported under ‘wider vulnerabilities’ in the Activity Report.

The proportion of young people with a dual diagnosis in Sefton was 31% in 2015-16 and 28% in 2014-15 and slightly higher than the comparator areas.

The proportions reporting identified mental health problems in Stockport were 29% (2015-16) and 22% (2014-15) which is lower than Sefton.

The picture in Sefton becomes more similar to Wirral over time where 29% of clients reported dual diagnosis in 2015-16 compared to 26% in 2014-15.

Stakeholders noted that autistic spectrum disorders are not captured on NDTMS and therefore a range of neuro-developmental conditions will not be captured in the data. This indicates that there are likely to be more mental health issues present in the treatment population than are indicated by the data.
5.4 Prevalence of substance/alcohol misuse by a parent/carer

‘Wider Vulnerabilities’ data also reveals if clients are affected by others’ substance misuse\(^{23}\)

This data will not distinguish if the household/family member is a parent or carer but it is still an extremely useful measure of the context within which the young person lives and their exposure to substance misuse among significant adults in their lives.

In Sefton in 2015-16 the proportion of young people reporting being affected by others’ substance misuse was 47%; an increase from 39% in 2014-15.

The proportion in Stockport was lower at 28% (2015-16) and 21% (2014-15) whereas the corresponding values in Wirral were 37% in 2015-16 and 31% in 2014-15.

5.5 Comparator data – national

5.5.1 Numbers in treatment and profile

Figure 11 shows the downward trend of total numbers in treatment in England to 17,077 in 2015-16 from a peak of 24,053 in 2008-09.

The data can be broken down into those aged under 12 as well as single year age bands from 12-13 through to 17-18. Throughout the period, those aged under 12 have never exceeded 1% of the total.

Young people aged 15-16, 16-17, 17-18 each represent, respectively, around one-quarter of the structured treatment population. The next largest single age-band (14-15) has traditionally represented around 14% to 15% of the YP treatment population.

64.9% of the national treatment population were male and 35.1% were female in 2015-16. Girls in treatment were younger, with 25.9% younger than 15 years old compared to 20.2% of boys.

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\(^{23}\) I.e. if they answer ‘yes’ to the question, ‘Does the young person feel affected by substance misuse in your close family/members of your household’ at the first episode in the latest treatment journey.
Figure 11: Number of young people in structured treatment (England)

5.5.2 Substances used

Figure 12 highlights primary substance and adjunctive.\(^{24}\)

Cannabis represents the largest proportion, followed by alcohol. 87% of young people in treatment in England cite cannabis in either problem substance 1, 2 or 3.

For comparative purposes the figure for alcohol is 48% and for NPS it is 6%.

**Figure 12: Substance use of all young people in treatment 2015-16 (England)**

<table>
<thead>
<tr>
<th>Substance</th>
<th>Primary</th>
<th>Adjunctive</th>
<th>Total</th>
<th>Primary</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>%</td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td>Cannabis</td>
<td>12,863</td>
<td>75</td>
<td>2,005</td>
<td>12</td>
</tr>
<tr>
<td>Alcohol</td>
<td>2,556</td>
<td>15</td>
<td>5,682</td>
<td>33</td>
</tr>
<tr>
<td>Ecstasy</td>
<td>261</td>
<td>2</td>
<td>1,344</td>
<td>8</td>
</tr>
<tr>
<td>Cocaine</td>
<td>251</td>
<td>1</td>
<td>1,226</td>
<td>7</td>
</tr>
<tr>
<td>Amphetamines</td>
<td>317</td>
<td>2</td>
<td>835</td>
<td>5</td>
</tr>
<tr>
<td>NPS</td>
<td>420</td>
<td>2</td>
<td>636</td>
<td>4</td>
</tr>
<tr>
<td>Solvents</td>
<td>121</td>
<td>1</td>
<td>320</td>
<td>2</td>
</tr>
<tr>
<td>Heroin</td>
<td>77</td>
<td>0</td>
<td>24</td>
<td>0</td>
</tr>
<tr>
<td>Other opiates</td>
<td>35</td>
<td>0</td>
<td>70</td>
<td>0</td>
</tr>
<tr>
<td>Nicotine (adjunctive use only)</td>
<td>-</td>
<td>-</td>
<td>2,443</td>
<td>14</td>
</tr>
<tr>
<td>Crack</td>
<td>21</td>
<td>0</td>
<td>74</td>
<td>0</td>
</tr>
<tr>
<td>Other</td>
<td>148</td>
<td>1</td>
<td>572</td>
<td>3</td>
</tr>
<tr>
<td>Total</td>
<td>17,070</td>
<td>100</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Missing, misuse free or inconsistent data</td>
<td>7</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total including missing</td>
<td>17,077</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Figure 13 highlights the main routes into treatment episodes in 2015-16 for young people across England. Between them, Education (28%), Youth / Criminal Justice (26%) and Social Care (14%) account for almost 70% of total referral sources. See Figure 14.

\(^{24}\) I.e. also present in problem substance no.2 or no.3; hence total is not 100%.
Figure 13: Source of referral of all treatment episodes 2015-16 (England)

<table>
<thead>
<tr>
<th>Referral source</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mainstream education</td>
<td>3,878</td>
<td>21</td>
</tr>
<tr>
<td>Alternative education</td>
<td>698</td>
<td>4</td>
</tr>
<tr>
<td>Education service</td>
<td>617</td>
<td>3</td>
</tr>
<tr>
<td>Other</td>
<td>25</td>
<td>0</td>
</tr>
<tr>
<td><strong>Education total</strong></td>
<td>5,218</td>
<td>28</td>
</tr>
<tr>
<td>YOT</td>
<td>4,265</td>
<td>28</td>
</tr>
<tr>
<td>YP secure estate</td>
<td>145</td>
<td>1</td>
</tr>
<tr>
<td>Other</td>
<td>454</td>
<td>2</td>
</tr>
<tr>
<td><strong>Youth/criminal justice total</strong></td>
<td>4,864</td>
<td>26</td>
</tr>
<tr>
<td>Children and family services</td>
<td>1,893</td>
<td>10</td>
</tr>
<tr>
<td>Looked after child services</td>
<td>148</td>
<td>2</td>
</tr>
<tr>
<td>Social services</td>
<td>255</td>
<td>1</td>
</tr>
<tr>
<td><strong>Social care total</strong></td>
<td>2,455</td>
<td>14</td>
</tr>
<tr>
<td>Self</td>
<td>1,216</td>
<td>7</td>
</tr>
<tr>
<td>Relative, family, friend, concerned other</td>
<td>945</td>
<td>5</td>
</tr>
<tr>
<td><strong>Self, family &amp; friends total</strong></td>
<td>2,161</td>
<td>12</td>
</tr>
<tr>
<td><strong>Substance misuse total</strong></td>
<td>1,546</td>
<td>8</td>
</tr>
<tr>
<td>GP</td>
<td>192</td>
<td>1</td>
</tr>
<tr>
<td>A&amp;E</td>
<td>229</td>
<td>1</td>
</tr>
<tr>
<td>School nurse</td>
<td>246</td>
<td>4</td>
</tr>
<tr>
<td>CAMHS</td>
<td>689</td>
<td>4</td>
</tr>
<tr>
<td>Hospital</td>
<td>138</td>
<td>1</td>
</tr>
<tr>
<td>Other</td>
<td>87</td>
<td>0</td>
</tr>
<tr>
<td><strong>Health total</strong></td>
<td>1,581</td>
<td>8</td>
</tr>
<tr>
<td>YP housing</td>
<td>344</td>
<td>2</td>
</tr>
<tr>
<td>Other</td>
<td>323</td>
<td>2</td>
</tr>
<tr>
<td><strong>Total (episodes)</strong></td>
<td>18,603</td>
<td>100</td>
</tr>
<tr>
<td>Missing or inconsistent data</td>
<td>33</td>
<td></td>
</tr>
<tr>
<td><strong>Total (episodes)</strong></td>
<td>18,636</td>
<td></td>
</tr>
</tbody>
</table>
The majority of young people in specialist substance use services have a range of problems or vulnerabilities related to their substance use, such as poly drug use. Wider factors can further impact their substance use such as:

- self-harming (17% in 2015-16),
- anti-social behaviour (32%; and more likely for males to report),
- domestic abuse (21%, but more likely that females report), and
- sexual exploitation (6%).

**Figure 14:** Individual vulnerabilities identified among all young people starting treatment in 2015-16 (England)

<table>
<thead>
<tr>
<th>Vulnerability</th>
<th>Female</th>
<th>Male</th>
<th>Persons</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early onset of substance misuse</td>
<td>12,3917</td>
<td>7,325</td>
<td>11,242</td>
</tr>
<tr>
<td>Poly drug user</td>
<td>2,752</td>
<td>4,581</td>
<td>7,333</td>
</tr>
<tr>
<td>Antisocial behaviour</td>
<td>815</td>
<td>3,074</td>
<td>3,889</td>
</tr>
<tr>
<td>Affected by others’ substance misuse</td>
<td>1,188</td>
<td>1,559</td>
<td>2,747</td>
</tr>
<tr>
<td>Affected by domestic abuse</td>
<td>1,162</td>
<td>1,439</td>
<td>2,601</td>
</tr>
<tr>
<td>Mental health problem</td>
<td>1,043</td>
<td>1,233</td>
<td>2,276</td>
</tr>
<tr>
<td>Self-harm</td>
<td>1,407</td>
<td>704</td>
<td>2,111</td>
</tr>
<tr>
<td>NEET</td>
<td>546</td>
<td>1,474</td>
<td>2,020</td>
</tr>
<tr>
<td>Looked after child</td>
<td>587</td>
<td>843</td>
<td>1,430</td>
</tr>
<tr>
<td>Child Protection Plan</td>
<td>463</td>
<td>429</td>
<td>892</td>
</tr>
<tr>
<td>Child in need</td>
<td>406</td>
<td>384</td>
<td>790</td>
</tr>
<tr>
<td>Sexual exploitation</td>
<td>598</td>
<td>106</td>
<td>704</td>
</tr>
<tr>
<td>High risk alcohol user</td>
<td>319</td>
<td>202</td>
<td>521</td>
</tr>
<tr>
<td>Pregnant and/or parent</td>
<td>102</td>
<td>125</td>
<td>227</td>
</tr>
<tr>
<td>Opiate and/or crack use</td>
<td>93</td>
<td>113</td>
<td>206</td>
</tr>
<tr>
<td>Housing problem</td>
<td>70</td>
<td>115</td>
<td>185</td>
</tr>
<tr>
<td>Injecting</td>
<td>56</td>
<td>57</td>
<td>113</td>
</tr>
<tr>
<td>Total new presentations</td>
<td>4,215</td>
<td>7,976</td>
<td>12,191</td>
</tr>
</tbody>
</table>
17% of all young people starting treatment in England in 2015-16 were NEET (not in employment, education or training). However almost three-quarters were in some form of education - 54% were in mainstream education and 20% were in alternative education.

5.6 Comparator data – local comparator areas

5.6.1. Numbers in treatment

Figure 15 shows the downward trend of total numbers in treatment in Sefton to 97 in 2015-16 from a peak of 269 in 2008-09.

Although the numbers are much smaller, this pattern echoes the trend for England in the same period (see Figure 11 above).

Numbers in Wirral have also followed a generally downward trend since a peak of 256 in 2006-07. Comparable data for Stockport indicates more fluctuation since a peak of 202 in 2005-06; treatment numbers here have picked up since 2012-13 and stood at 160 by March 2016.
Similar to the national breakdown, those aged 15, 16 and 17 each represent the largest proportions of the treatment population in Sefton and Wirral. Percentages for those aged 18-24 are much smaller in these two areas but are zero in Stockport which hints at different commissioning arrangements here.

The male/female split in both Sefton and Wirral is close to 70/30 but in Stockport it is 43% male, 57% female.

**5.6.2. Substances used**

Figure 16 shows young people in specialist substance misuse community services, year to date.

Substances cited are from any episode for the young person in the year (i.e. any citation in drug 1, 2 or 3). Individuals may have cited more than one problematic substance so percentages may sum to more than 100%.
The substances used are in similar proportion to those seen nationally with cannabis being highest; Sefton has 91% and Stockport 82%.

Alcohol is the next most commonly used although Sefton has a lower proportion (27%) compared to the other areas and nationally. The 2014-15 value for Sefton was 29%.

Cocaine is a feature in Sefton (28%) although Wirral was slightly higher at 30%.

NPS in Sefton is slightly lower than the national figure of 6% but in Stockport it is 14% (9% in 2014-15). These percentages are informative although it should be noted that the actual numbers of clients citing NPS are smaller (for instance only 1,250 citations nationally, compared to 9,944 for alcohol). Full details are given at Figure 17 below.

**Figure 16: Substances cited from any episode**
5.6.3 Source of referral

There is variation in sources of referral between the local partnerships under consideration.

Children and Family Services is the largest proportion (32%) of all sources in Sefton although Wirral is much higher at 49%.

Education Service referrals are very high in Stockport (49%) but at 25%, Sefton is on a par with the national level.

Youth Justice Services account for only 5% of referrals in Stockport in 2015-16 although the proportion was 13% in 2014-15.
**5.6.4 Wider vulnerabilities**

There is considerable variation in wider vulnerabilities between Sefton, Stockport and Wirral, as demonstrated in Figure 18.

Domestic Abuse and Affected by Others’ Substance Misuse features strongly in Sefton at 45% and 47% respectively.

Sexual Exploitation is 3% (it was 5% in 2014-15) in Sefton, but 17% in Stockport; up from 9% in 2014-15.

Full information is set out at Figure 18.
In terms of the vulnerability data, children in need are included under the data for LAC for Sefton.

5.7 Hospital Admissions related to children and young people’s substance use

Public Health England (hereafter PHE) profiles are a rich source of indicators across a range of health and wellbeing themes that have been designed to support commissioning to improve health and wellbeing, and reduce inequalities. They enable the user to browse indicators at different geographical levels, benchmark against the regional or England average.

The Child and Mental Health profiles are particularly useful in an exercise such as this HNA, as they bring together a range of publicly available data, information, tools and resources on child and maternal health into one easily accessible hub. One of the most obvious drawbacks, however, to the statistics in
these profiles is the fact that they can often be fairly dated. Therefore efforts to obtain more recent locally sourced statistics and data is included in other sections of this report.

The following graphics present benchmarking statistics relating to substance use (alcohol and drugs) for Sefton and England using the PHE profiles.

5.7.1 Alcohol hospital admissions
The data presented in this section of the report relates to persons under 18 admitted to hospital for alcohol-specific conditions. The statistics have been calculated by PHE: Knowledge and Intelligence Team (North West) using data from the Health and Social Care Information Centre - Hospital Episode Statistics (HES) and Office for National Statistics (ONS) - Mid Year Population Estimates.

As can be seen in Figure 20 that follows, Sefton’s rate of persons under 18 admitted to hospital due to alcohol-specific conditions has fallen substantially since 2006/07 however remains above the national average.
5.7.2 **Drug admissions**

The data presented in this section of the report relates to hospital admissions due to substance misuse (15-24 years).

As can be seen in the Figure 20, the rate of hospital admissions due to substance misuse (15-24 years) is in line with the national average, and has been for the last five data-points.

---

25 Source: Hospital Episode Statistics (HES) Copyright © 2017, Re-used with the permission of NHS Digital. All rights reserved.
5.8 Dip sample

In addition to the review of NDTMS data, a dip sample was taken of case files of young people engaged in support by SMASH. The purpose of the dip sample was to gather additional insight into the range and depth of vulnerabilities of young people in drug and alcohol treatment.

In total a total of 30 files were reviewed. The files were a selection of current clients and closed cases all relating to the period 2016 to 2017.

5.8.1 The profile of the subjects

In the dip sample there were 25 young men and 5 young women. Of these 28 were White British, one was Black British and one was Black/White British mixed race.

---

Source: Hospital Episode Statistics (HES) Copyright © 2017, Re-used with the permission of NHS Digital. All rights reserved.
There were:

- 3 young people aged 13,
- 4 young people aged 14,
- 6 young people aged 15,
- 7 young people aged 16,
- 8 young people aged 17, and
- 2 young people aged 18.

Eight of the young children were designated as Children in Need and five had a Child Protection Plan.

Six of the young people were 'looked after' living in residential care or foster placements.

### 5.8.2 Risk taking behaviours
The following risk taking behaviours were recorded in the files of the young people in the sample:

- 11 had been involved in more than two incidents of criminal activity
- All of the young people had used an illegal substance
- 11 of the young people were known to Youth Justice Services

### 5.8.3 Emotional and mental health
The following emotional and mental health needs were recorded in the files of the young people in the sample:

- 19 young people had been identified as having emotional and mental health needs; the majority of which were anxiety and depression
- 4 young people had experienced significant childhood trauma
- 11 of the young people had witnessed or experienced domestic violence
- 7 of the young people had experienced sexual or physical abuse
- 1 young person was known to have been the victim of sexual exploitation
- 10 of the young people were, or had been known to Child and Adolescent Mental Health Services
- 1 young person was recorded as being referred to the Early Intervention in Psychosis Team
5.8.4 Physical and mental illness/disabilities
The following physical health needs and mental illnesses were recorded in the case files of the young people in the sample:

- 1 young person had a physical disability
- 3 young people had a learning disability including dyslexia
- 7 young people had a diagnosis of ADHD or autism or both

5.8.5 Familial factors
The following family factors were recorded in the case files:

- 19 of the young people had been assessed as lacking stable family relationships
- 14 had been assessed as living in chaotic families
- poor parental supervision was identified in 17 cases
- 16 of the young people had at least one parent or close family member misusing substances.
- 7 of the young people had been victims of bullying by family members
- One of the young people had a parent who was in prison.
- 7 of the young people had experienced a recent family breakdown and were now living with a single parent
- 7 of the young people had experienced bereavement, loss or abandonment by a key family member

5.8.6 Education and Training
The following educational factors were identified in the case files:

- 10 of the young people were recorded as having poor school attendance
- 9 of the young people were recorded as having low levels of attainment
- 5 of the young people had been victims of bullying by peers
- 15 of the young people had been excluded from school at least once and had received alternative education.
- 9 of the young people over the school leaving age were not in education, employment or training
5.8.7 Environmental factors

The following environmental factors were recorded:

- 6 of the young people were recorded as living in material poverty, for example disconnected services or squalid housing conditions
- 9 young people had associations with gang members
- 14 young people lived in neighbourhoods where gangs sell drugs
- 3 young people had experienced periods of homelessness
- 3 young people were living in insecure accommodation

It is no surprise that most of the known vulnerability factors figured largely within this analysis of the case files. However, it is perhaps interesting how many young people had been identified as having serious emotional and mental health needs which appeared directly related to their family circumstances and parenting practice. In particular, the incidence of parental substance misuse, domestic violence and abuse are notable.
6. Links between substance misuse, risks and vulnerabilities

The previous section of the report focussed upon the treatment population, using NDTMS to identify key characteristics of those using the SMASH service – to enable us to begin to tease out some of the risk factors and wider vulnerabilities affecting children and young people using alcohol and drugs.

This section of the report delves deeper into several of those vulnerabilities and indicators of risk with reference to young people who are not in treatment. This section therefore explores those factors that increase a young person’s vulnerability and therefore the possibility that they engage in substance misuse at a later point in their life.

National statistics show that the majority of young people in specialist substance use services have a range of problems or vulnerabilities related to their substance use (such as poly drug use and drinking alcohol daily) or wider factors that can impact on their substance use (such as self-harming, offending or domestic abuse). Therefore, specialist services need to be able to work with a range of other agencies to ensure that all a young person’s needs are met.

As well as developing sound operational links to other agencies across Sefton to ensure that a child and family focussed system of care is maintained, information sharing and reporting needs to link across sectors and organisations to ensure intelligence regarding the substance misuse and vulnerabilities of the service user (and potential service users) is fully understood. For this project data and statistics were requested from across a range of agencies to build as comprehensive picture as possible about the associations between substance misuse, harmful behaviours and wider vulnerabilities.

Wherever possible the link back to substance misuse is made in presenting multi-agency statistics, though the exact cause or driver of behaviour is often hard to ascertain from the statistics.

Among 10 to 15 year olds, an increased likelihood of drug use is associated with a range of adverse experiences and behaviour, including:

- truancy,
- exclusion from school,
- homelessness,
- time in care, and
- serious or frequent offending.
All of which has damaging effects on individuals, families, the community and organisations providing services. Likewise, alcohol consumption is a contributing factor to hospital admissions and deaths from a diverse range of conditions, and impacts on many services.

The remainder of this section of the report seeks to explore some of the causes and/or associations of substance use, and explore the associations between substance use and other risk factors and vulnerabilities. It is structured using the following sub-sections:

6.1 Demographics,
6.2 Deprivation,
6.3 Exposure to child maltreatment and abuse,
6.4 Youth crime, ASB and young offending,
6.5 Domestic abuse
6.6 Child sexual exploitation,
6.7 Looked after children.

6.1 Demographics

6.1.1 Overview of Sefton young people’s population

A snapshot of statistics on children and young people provided in the ‘LSCB Integrated Early Help Strategy (2016-2018)’ states that:

- “The number of children and young people estimated to be living in Sefton in 2015 (0-25 year olds) is currently considered to be 77,355 (Public Health figures) which is a 9% decrease compared with 2005 when it was 85,306.
- 20% of our children in the borough grow up in poverty;
- On the whole our children and young people achieve in school. However, there are still some that do not reach their full potential which impacts on their ability to go into further education, training and to get a job;
- The health of children and young people is generally improving and they have access to a wide range of physical activity opportunities;
- The number of hospital admissions related to alcohol use in under 18’s is also higher (though declining) than the England average and childhood smoking rates are average
55

Sefton Council Substance Misuse Needs Assessment for Children and Young People

- There are fewer teenage mothers in the borough than in previous years.  

Some of Sefton’s young people will have issues that cause harm to themselves, their families, relatives or the community at large. These issues might for example include (in some cases) being pressured into being in a gang, suffering from sexual exploitation, having problems with drugs and alcohol, having poor mental health, experiencing violence, or running away from home. For those who have problems with substance misuse (or have parents/carers with a problem) there are a range of support services to help. Of most relevance to this report are the services SMASH and BtC – each of these services is briefly described at section 2.2.

6.1.2 Young people’s population

To gauge more accurately the target population for local services trying to support children and young people to overcome problems with substance misuse, it is possible to use demographic statistics and apportion from surveys, to generate synthetic estimates. This is explored in the remainder of this section, together with comparison with Wirral and Stockport (the two statistical neighbours chosen for the purposes of benchmarking data for Sefton).

The latest population estimates (2015, Nomis) show that Sefton’s total population is 273,705 (Figure 21). This is the lowest total population compared to the comparator areas of Wirral (320,900) and Stockport (288,735).

In all three areas there are more females than males. However, the reverse is true when looking at the total 13-17 age group – with males outnumbering females in these age bands. The Sefton 13-17 total is the lowest population (15,050) compared to both Wirral (18,590) and Stockport (16,375).

In all three comparison areas the proportion of those aged 13-17 (total, male or female) does not account for more than 6% of the total population.

---

Figure 21: 2015 Population estimates – All ages and aged 13-17 (under 12 not included because of very low proportions in treatment)

<table>
<thead>
<tr>
<th>Age</th>
<th>SEFTON Total</th>
<th>Male</th>
<th>Female</th>
<th>STOCKPORT Total</th>
<th>Male</th>
<th>Female</th>
<th>WIRRAL Total</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age 13</td>
<td>2,850</td>
<td>1,470</td>
<td>1,380</td>
<td>3,120</td>
<td>1,645</td>
<td>1,475</td>
<td>3,505</td>
<td>1,765</td>
<td>1,745</td>
</tr>
<tr>
<td>Age 14</td>
<td>2,925</td>
<td>1,460</td>
<td>1,465</td>
<td>3,190</td>
<td>1,630</td>
<td>1,565</td>
<td>3,580</td>
<td>1,815</td>
<td>1,765</td>
</tr>
<tr>
<td>Age 15</td>
<td>2,985</td>
<td>1,510</td>
<td>1,470</td>
<td>3,385</td>
<td>1,700</td>
<td>1,685</td>
<td>3,775</td>
<td>1,890</td>
<td>1,885</td>
</tr>
<tr>
<td>Age 16</td>
<td>3,115</td>
<td>1,575</td>
<td>1,535</td>
<td>3,290</td>
<td>1,635</td>
<td>1,655</td>
<td>3,815</td>
<td>1,965</td>
<td>1,850</td>
</tr>
<tr>
<td>Age 17</td>
<td>3,175</td>
<td>1,605</td>
<td>1,570</td>
<td>3,390</td>
<td>1,750</td>
<td>1,640</td>
<td>3,915</td>
<td>2,000</td>
<td>1,915</td>
</tr>
<tr>
<td>Total 13-17</td>
<td>15,050</td>
<td>7,620</td>
<td>7,420</td>
<td>16,375</td>
<td>8,360</td>
<td>8,020</td>
<td>18,590</td>
<td>9,435</td>
<td>9,160</td>
</tr>
<tr>
<td>% 13-17</td>
<td>5</td>
<td>6</td>
<td>5</td>
<td>6</td>
<td>6</td>
<td>5</td>
<td>6</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>All Ages</td>
<td>273,705</td>
<td>131,505</td>
<td>142,205</td>
<td>288,735</td>
<td>141,370</td>
<td>147,360</td>
<td>320,900</td>
<td>154,780</td>
<td>166,120</td>
</tr>
</tbody>
</table>

### 6.1.3 Levels of drug and alcohol consumption among young people in Sefton

‘Smoking, Drinking and Drug Use among Young People in England’ is a survey of secondary school pupils in England in Years 7 to 11 (mostly aged 11 to 15). 6,173 pupils in 210 schools completed questionnaires in the autumn term of 2014 (the latest date for which data is available).

Table 9.1 from this survey, titled ‘Ever smoked, drunk alcohol, taken drugs: 2005-2014’ suggests that trends have travelled in a downwards direction between 2005 and 2014. Conversely, the proportion of pupils who have ‘never done any of these’ has increased nationally, from 34% to 54% in the same period.

The outputs from the survey (national and regional subsets) are useful to help synthesise estimates for young people populations (aged 11-15) who might be eligible for / require universal, targeted and even specialist treatment interventions. In each case, the England figures are lower than the North West, so if the England data is used it should represent a minimum figure for Sefton, Stockport and Wirral in the following analysis.

Based on population estimates the 11-15 age group in Sefton, Stockport and Wirral make up between 5% and 6% of the total population in each locality. Figure 23 below shows the total (male and female) 11-15 age group numbers and therefore the potential cohort for ‘universal’ interventions in each of the three localities.

---

Naturally, drinking alcohol or trying drugs does not imply that each young person has a ‘problem’ with these substances. However, if that use is recent it might suggest that those young people have a greater potential to either have a problem or develop a problem if use is sustained.

Based on this approach, Figure 22 reveals that:

- 879 11-15 year olds in Sefton could potentially require a specialist (or structured) drug misuse intervention (s) in a young people’s treatment service setting and
- 1,172 a specialist alcohol intervention.

Note that this is substantially more than the total number (97) in structured treatment using SMASH services in 2015-16 - which also relates to a wider age range (i.e. all YP in structured treatment in Sefton, with 46 aged under 13 to 15 in 2015/16).

**Figure 22: Potential Universal / Targeted / Specialist groupings**

<table>
<thead>
<tr>
<th></th>
<th>Sefton</th>
<th>Stockport</th>
<th>Wirral</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total aged 11-15 - ‘Universal’ intervention group</td>
<td>14,650</td>
<td>15,960</td>
<td>18,125</td>
</tr>
<tr>
<td>Ever drunk alcohol – potential ‘Targeted’ intervention subset</td>
<td>5,567</td>
<td>6,065</td>
<td>6,888</td>
</tr>
<tr>
<td>Ever taken any drugs – potential ‘Targeted’ intervention subset</td>
<td>2,198</td>
<td>2,394</td>
<td>2,719</td>
</tr>
<tr>
<td>Drunk alcohol in last week – potential ‘Specialist’ intervention subset</td>
<td>1,172</td>
<td>1,277</td>
<td>1,450</td>
</tr>
<tr>
<td>Taken any drugs in last month – potential ‘Specialist’ intervention subset</td>
<td>879</td>
<td>958</td>
<td>1,088</td>
</tr>
<tr>
<td>Took drugs in last year – potential ‘Targeted/Specialist’ intervention</td>
<td>1,465</td>
<td>1,596</td>
<td>1,813</td>
</tr>
</tbody>
</table>

Figure 23 shows the respective England and North West region percentages for each category of the Smoking, Drinking and Drug Use Survey.

**Figure 23: Potential national and regional ‘Targeted’ groupings**

<table>
<thead>
<tr>
<th></th>
<th>England %</th>
<th>NW %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ever drunk alcohol – potential ‘Targeted’ intervention subset</td>
<td>38</td>
<td>43</td>
</tr>
<tr>
<td>Ever taken any drugs – potential ‘Targeted’ intervention subset</td>
<td>15</td>
<td>19</td>
</tr>
<tr>
<td>Drunk alcohol in last week – potential ‘Specialist’ intervention subset</td>
<td>8</td>
<td>9</td>
</tr>
<tr>
<td>Taken any drugs in last month – potential ‘Specialist’ intervention subset</td>
<td>6</td>
<td>9</td>
</tr>
<tr>
<td>Took drugs in last year – potential ‘Targeted/Specialist’ intervention</td>
<td>10</td>
<td>15</td>
</tr>
</tbody>
</table>
6.2 Deprivation

There is a strong association between poverty, social exclusion and substance abuse. It is therefore important to understand the geographical distribution and types of deprivation that exist across Sefton.

The Index of Deprivation 2015 (ID2015) ranks all 326 local authorities in England according to an overall Index of Multiple Deprivation from 1 (most deprived) to 326 (least deprived). Ranks and scores are also produced for the seven domains of:

- Income,
- Employment,
- Education-Skills-Training,
- Health & Disability,
- Crime,
- Barriers to Housing and Services, and
- Living Environment

Supplementary indices of income deprivation among children (IDACI) and older people (IDAOPI) are also incorporated.

ID2015 is also published at Lower Super Output Area (LSOA) level - a smaller subdivision within each local authority containing an average of 1,500 people. There are more than 32,000 LSOAs in England.

It is possible to explore the ID2015 in many ways including by averaging all of the LSOA ranks in each larger area, after taking account of the population (population weighting) for example. The nature of this measure means that a highly polarised larger area (i.e. with pockets of both very high and very low deprivation) would not tend to score highly, because extremely deprived and less deprived LSOAs will ‘average out’. Conversely, a larger area that is more uniformly deprived will tend to score highly on this measure. Similarly the proportion of LSOAs in the most deprived 10% nationally means that larger areas with no LSOAs in the most deprived 10 per cent of all such areas in England have a score of zero for this summary measure.

Figure 24 confirms that despite pockets of high deprivation within each of the comparator areas used in this study, none of the overall local authority areas are either the most, nor the least, deprived local authorities in England. However, based on rank of average rank Sefton (102) is relatively more deprived than both Wirral (106), and Stockport (178). In terms of the IDACI (Children) Wirral is relatively more
deprived than Sefton across all measures shown - with ranks / scores of 98, 0.1796 and 42 compared to 115, 0.1429 and 60 respectively.

**Figure 24: Index of Deprivation 2015**

<table>
<thead>
<tr>
<th></th>
<th>Rank of average rank</th>
<th>IMD - Rank of proportion of LSOAs in most deprived 10% nationally</th>
<th>IMD - Rank of proportion of LSOAs in most deprived 10% nationally</th>
<th>Income Deprivation Affecting Children Index (IDACI) - Rank of average rank</th>
<th>IDACI - Rank of proportion of LSOAs in most deprived 10% nationally</th>
<th>IDACI - Rank of proportion of LSOAs in most deprived 10% nationally</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sefton</td>
<td>102</td>
<td>41</td>
<td>0.2011</td>
<td>115</td>
<td>0.1429</td>
<td>60</td>
</tr>
<tr>
<td>Stockport</td>
<td>178</td>
<td>93</td>
<td>0.0895</td>
<td>193</td>
<td>0.0579</td>
<td>138</td>
</tr>
<tr>
<td>Wirral</td>
<td>106</td>
<td>36</td>
<td>0.2136</td>
<td>98</td>
<td>0.1796</td>
<td>42</td>
</tr>
</tbody>
</table>

Maps were supplied by the Business Intelligence and Performance Team at Sefton Council for this project – including the deprivation mapping that follow:
Figure 25: IMD 2015 – LSOA Analysis

Figure 26: IDACI 2015 – LSOA Analysis

6.3 Exposure to Child Maltreatment and Abuse

A growing body of research is revealing the long-term impacts that experiences and events during childhood have on individuals’ life chances. Adverse Childhood Experiences (ACE) such as abuse, neglect and dysfunctional home environments have been shown to be associated with the development of a wide range of harmful behaviours including:

- smoking,
- harmful alcohol use,
- drug use,
- risky sexual behaviour,
- violence, and
- crime.

6.3.1 Parental substance misuse

Substance misuse by parents is a well-recognised risk factor for child maltreatment and neglect, and Cafcass\(^{29}\) (and others) continue to push for more integrated strategic development for effective child protection that takes account of the scale and impact of parental/carer substance misuse. This is important because successful interventions can reduce the need for children to enter care, reduces costs to society, promotes drug recovery, reduces alcohol-related hospital admissions and improves family outcomes.

Parental/carer substance misuse is characterised by the use of drugs (both illicit and legal) and/or alcohol to a degree where the physical, emotional, psychological or behavioural well-being and care-taking capacity of a parent is compromised. It should be remembered that not all substance misusing parents/carers mistreat their children - nevertheless this issue features highly in child protection. The remainder of this section of the report present some of the statistics sourced on this issue.

Alcohol and/or Drug Misuse featured in 1,079 of 2978 children’s assessments between April 2016 and February 2017 in Sefton. A child can be assessed on more than one occasion throughout the year. Given the way the data is compiled (as assessments) data is not available on the individual number of children assessed.

\(^{29}\) Cafcass are the body who represent children in family court cases to ensure that the voice of children are heard and that decisions taken are in their best interest.
Note from the results at Figure 27 that drug or alcohol misuse were a factor in over a third (36%) of assessments in Sefton.

6.3.2 Households where alcohol misuse is a factor

Figure 28 sets out data relating to children living in households in Sefton where alcohol misuse is a factor.

<table>
<thead>
<tr>
<th>Children Living in Households where Alcohol Misuse is a Factor</th>
<th>Alcohol Misuse identified as key factors of concern</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number of children in the year where an assessment includes Alcohol Misuse</td>
<td>554</td>
</tr>
<tr>
<td>Concerns about misuse by child</td>
<td>40</td>
</tr>
<tr>
<td>Concerns about misuse by Parent/Carer</td>
<td>442</td>
</tr>
<tr>
<td>Concerns about misuse by another person in family / household</td>
<td>72</td>
</tr>
</tbody>
</table>

NOTE: The three concerns will not add up to the total number of individual children known for Alcohol Misuse factors because they are not mutually exclusive i.e. More than one concern can be recorded per case e.g. the child and the Parent/Carer may have been identified as both Misusing Alcohol within the same case.
Figure 29: Alcohol and other factors in assessments April’16 – Feb’17

<table>
<thead>
<tr>
<th>Children Living in Households where Alcohol Misuse is a Factor</th>
<th>Alcohol Misuse identified as key factors of concern</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number of children in the year where an assessment includes Alcohol Misuse</td>
<td>554</td>
</tr>
<tr>
<td>Factors of Alcohol and Drug Misuse</td>
<td>119</td>
</tr>
<tr>
<td>Factors of Alcohol Misuse and Domestic Violence</td>
<td>321</td>
</tr>
<tr>
<td>Factors of Alcohol Misuse and Mental Health</td>
<td>261</td>
</tr>
<tr>
<td>Factors of Alcohol Misuse and Learning Disability</td>
<td>123</td>
</tr>
<tr>
<td>Factors of Alcohol Misuse and Physical Disability</td>
<td>74</td>
</tr>
<tr>
<td>Factors of Alcohol Misuse and Abuse &amp; Neglect</td>
<td>1016</td>
</tr>
</tbody>
</table>

*The five factors are based on assessments that relate to only the child and not those inclusive of Parent/Carer or Household.*

Figure 30: Alcohol and concerns about parent, April’16 – Feb’17

<table>
<thead>
<tr>
<th>Alcohol Misuse: Concerns about Parent/Carer</th>
<th>Alcohol Misuse identified as key factors of concern</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number of children in the year where an assessment includes Alcohol Misuse</td>
<td>442</td>
</tr>
<tr>
<td>Factors of Alcohol and Drug Misuse</td>
<td>814</td>
</tr>
<tr>
<td>Factors of Alcohol Misuse and Domestic Violence</td>
<td>1252</td>
</tr>
<tr>
<td>Factors of Alcohol Misuse and Mental Health</td>
<td>1008</td>
</tr>
<tr>
<td>Factors of Alcohol Misuse and Learning Disability</td>
<td>476</td>
</tr>
<tr>
<td>Factors of Alcohol Misuse and Physical Disability</td>
<td>515</td>
</tr>
<tr>
<td>Factors of Alcohol Misuse and Abuse &amp; Neglect</td>
<td>1489</td>
</tr>
</tbody>
</table>

The five factors will not add up to the total number of individual children known for Alcohol Misuse factors because they are not mutually exclusive i.e. More than one factor can be recorded per case e.g. The Alcohol Misuse may be coupled with both Domestic Violence and Mental Health.

Factors of Alcohol Misuse and Abuse and Neglect incorporate:

- Neglect
- Emotional Abuse
- Physical Abuse
- Sexual Abuse
6.3.3 Households where drug misuse is a factor

Figure 32 sets out data relating to children living in households in Sefton where drug misuse is a factor.

<table>
<thead>
<tr>
<th>Children Living in Households where Drugs Misuse is a Factor</th>
<th>Drug Misuse identified as key factors of concern</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number of children in the year where an assessment includes Drug Misuse</td>
<td>525</td>
</tr>
<tr>
<td>Concerns about misuse by child</td>
<td>79</td>
</tr>
<tr>
<td>Concerns about misuse by Parent/Carer</td>
<td>373</td>
</tr>
<tr>
<td>Concerns about misuse by another person in family / household</td>
<td>73</td>
</tr>
</tbody>
</table>
Figure 33: Drug misuse as a factor with other factors, April’16 – Feb’17

<table>
<thead>
<tr>
<th>Children Living in Households where Drugs Misuse is a Factor</th>
<th>Drug Misuse identified as key factors of concern</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number of children in the year where an assessment includes Drug Misuse</td>
<td>525</td>
</tr>
<tr>
<td>Factors of Drug and Alcohol Misuse</td>
<td>119</td>
</tr>
<tr>
<td>Factors of Drug Misuse and Domestic Violence</td>
<td>360</td>
</tr>
<tr>
<td>Factors of Drug Misuse and Mental Health</td>
<td>300</td>
</tr>
<tr>
<td>Factors of Drug Misuse and Learning Disability</td>
<td>162</td>
</tr>
<tr>
<td>Factors of Drug Misuse and Physical Disability</td>
<td>113</td>
</tr>
<tr>
<td>Factors of Drug Misuse and Abuse &amp; Neglect</td>
<td>1055</td>
</tr>
</tbody>
</table>

*The five factors are based on assessments that relate to only the child and not those inclusive of Parent/Carer or Household.*

Figure 34: Drug misuse – concern about parent/carer, April’16 – Feb’17

<table>
<thead>
<tr>
<th>Drug Misuse : Concerns about Parent/Carer Only</th>
<th>Drug Misuse identified as key factors of concern</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number of children in the year where an assessment includes Drug Misuse</td>
<td>373</td>
</tr>
<tr>
<td>Factors of Drug and Alcohol Misuse</td>
<td>815</td>
</tr>
<tr>
<td>Factors of Drug Misuse and Domestic Violence</td>
<td>1183</td>
</tr>
<tr>
<td>Factors of Drug Misuse and Mental Health</td>
<td>939</td>
</tr>
<tr>
<td>Factors of Drug Misuse and Learning Disability</td>
<td>407</td>
</tr>
<tr>
<td>Factors of Drug Misuse and Physical Disability</td>
<td>446</td>
</tr>
<tr>
<td>Factors of Drug Misuse and Abuse &amp; Neglect</td>
<td>1349</td>
</tr>
</tbody>
</table>
Figure 35: Drug misuse and concerns about household member, April’16 – Feb’17

<table>
<thead>
<tr>
<th>Drug Misuse: Concerns about Household member</th>
<th>Drug Misuse identified as key factors of concern</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number of children in the year where an assessment includes Drug Misuse</td>
<td>73</td>
</tr>
<tr>
<td>Factors of Drug and Alcohol Misuse</td>
<td>145</td>
</tr>
<tr>
<td>Factors of Drug Misuse and Domestic Violence</td>
<td>193</td>
</tr>
<tr>
<td>Factors of Drug Misuse and Mental Health</td>
<td>158</td>
</tr>
<tr>
<td>Factors of Drug Misuse and Learning Disability</td>
<td>95</td>
</tr>
<tr>
<td>Factors of Drug Misuse and Physical Disability</td>
<td>95</td>
</tr>
<tr>
<td>Factors of Drug Misuse and Abuse &amp; Neglect</td>
<td>1049</td>
</tr>
</tbody>
</table>

6.4 Youth crime, ASB and young offending

This section explores local data relating to youth crime and offending, recognising the significant cross-over between this issue and young people’s substance misuse.

Figure 37 below sets out data for youth related incidents in Sefton broken down by the type of incident.

As demonstrated in Figure 36, alcohol related incidents account for 2% and drug related incidents 7% of the total. The data does not however indicate whether drugs and/or alcohol were a contributory factor to the other incidents.
Figure 36: Youth related incidents (2015/16) – rowdy inconsiderate behaviour

- Abusive / Aggressive / Threatening: 19%
- Alcohol: 14%
- Climbing: 2%
- Criminal Damage: 4%
- Drugs: 5%
- Fighting: 2%
- Fire: 7%
- Firework: 4%
- Gathering: 4%
- General Nuisance: 1%
- Football Nuisance: 2%
- Other: 3%
- Refusing to Leave: 2%
- Throwing Missiles: 6%

Source: Sefton’s Strategic Intelligence Assessment for SSCP SSNA, June 2016
Figure 37: Organised Crime Groups and Youth at Risk Meetings

![Bar chart showing the age distribution of young people involved in organised crime](chart.jpg)

Source: Sefton’s Strategic Intelligence Assessment for SSCP SSNA, June 2016

Figure 37 shows numbers of young people engaged in organised crime who were discussed at risk meetings. The data indicates 42 young people involved in organised crime and therefore at heightened risk. Data is not available to determine whether any of these young people were known to treatment services.
Figure 38 sets out an overview of young people known to the Sefton Youth Offending Team.

Figure 38: Youth related incidents (2015/16) – rowdy inconsiderate behaviour

Note that 62 young people were engaged in youth offending specifically relating to drug offences. The data does not indicate whether the other young people had a substance misuse need or whether their behaviour was motivated or influenced by drug and alcohol consumption.
6.5 Domestic abuse

Exposure to domestic abuse is another factor that is known to correlate to substance misuse. Figure 39 sets out data for domestic abuse for Sefton.

Figure 39: Children Living in Households Where Domestic Abuse is a Factor (2015/16)

<table>
<thead>
<tr>
<th>Domestic Violence identified as key factors of concern</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number of children in the year where an assessment includes Domestic Violence</td>
<td>929</td>
</tr>
<tr>
<td>Concerns about the child being subjected to DV</td>
<td>332</td>
</tr>
<tr>
<td>Concerns about the child's parent/carer being subjected to DV</td>
<td>838</td>
</tr>
<tr>
<td>Concerns about another person in the family/household being subjected to DV</td>
<td>81</td>
</tr>
</tbody>
</table>

The three concerns will not add up to the total number of individual children known for Domestic Violence factors because they are not mutually exclusive i.e. More than one concern can be recorded per case e.g. the child and the Parent/Carer may have been identified as both subject to Domestic Violence within the same case.

A child can be assessed on more than one occasion throughout the year.

<table>
<thead>
<tr>
<th>Domestic Violence identified as key factors of concern</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number of children in the year where an assessment includes Domestic Violence</td>
<td>929</td>
</tr>
<tr>
<td>Factors of Domestic Violence and Alcohol Misuse</td>
<td>267</td>
</tr>
<tr>
<td>Factors of Domestic Violence and Drugs Misuse</td>
<td>264</td>
</tr>
<tr>
<td>Factors of Domestic Violence and Mental Health</td>
<td>356</td>
</tr>
<tr>
<td>Factors of Domestic Violence and Learning Disability</td>
<td>56</td>
</tr>
<tr>
<td>Factors of Domestic Violence and Physical Disability</td>
<td>46</td>
</tr>
<tr>
<td>Factors of Domestic Violence and Abuse &amp; Neglect</td>
<td>311</td>
</tr>
</tbody>
</table>

The five factors will not add up to the total number of individual children known for Domestic Violence factors because they are not mutually exclusive i.e. More than one factor can be recorded per case e.g. the Domestic Violence may be coupled with both Drugs Misuse and Mental Health.

Source: Sefton’s Strategic Intelligence Assessment for SSCP SSNA, June 2016
The data at Figure 39 indicates that, of the 929 children assessed where domestic violence was known to be a factor in the family, in 267 cases (28.7%) alcohol misuse was present and in 264 cases (28.4%) drug misuse was present. The data therefore indicates a considerable overlap between domestic abuse and drug and alcohol misuse.

### 6.6 Child sexual exploitation

Sexual exploitation of children and young people under 18 involves exploitative situations, contexts and relationships where young people (or a third person or persons) receive something in exchange for them performing, and/or another or others performing on them, sexual activities. These things may include:

- Food
- Accommodation
- Drugs
- Alcohol
- Cigarettes
- Affection
- Gifts
- Money

The link to drugs and alcohol is often complex – sometimes substances are used as a ‘hook’ and/or reward to keep people returning to exploitative activities or events, sometimes acting as a reward and sometimes interchangeably linked to other exploitative activities, such as criminal exploitation whereby young people might act as a ‘mule’, delivering on behalf of a dealer and then causing another person to get involved in CSE.

The number of Multi Agency Safeguarding Hub (MASH) referrals relating to CSE was supplied for this HNA, together with drug and/or alcohol concerns noted for CSE referrals. As can be seen from the analysis that follows for the last two financial years, there has been a fall in the number of CSE referrals made, however an increase in the number of children dealt with, revealing a reduction in repeat referrals.
Figure 40: CSE referrals

<table>
<thead>
<tr>
<th>April 2015 - March 2016:</th>
<th>April 2016 – 21st March 2017:</th>
</tr>
</thead>
<tbody>
<tr>
<td>During 2015-16 310 CSE referrals, regarding 182 children, were received by the MASH.</td>
<td>During April 2016 – 21st March 2017 243 CSE referrals, regarding 210 children, were received by the MASH.</td>
</tr>
</tbody>
</table>

The graphics that follows reveal the drug and/or alcohol concerns noted for CSE referrals for the last two years (note that the 2016/17 Quarter 4 statistics only go to 21st March 2017, due to the timing of this request in the year).

Figure 41: Young People’s drug and/or alcohol use - Number of CSE Referrals (not number of young people) with a breakdown of Child/young person’s drug and/or alcohol use during previous 4 quarters:
Figures 41 and 42 indicate that, of those young people referred on the basis of CSE, a significant proportion reported drug or alcohol use or combined drug and alcohol use.

### 6.7 Looked after children

Data indicates that in Sefton there 465 young people looked after by the local authority. Of this group, 360 young people were looked after and had been continuously for 12 months. Of the 360 young people 230 were aged 10 years or older.

Of the young people looked after 10 were identified as having a substance misuse problem (some 2% of the total).

In Stockport there were 295 young people who had been looked after for 12 months and 9% were know to have a substance misuse problem. In Wirral there were 670 young people and 4% were identified as having a substance misuse need. The data therefore indicates that Sefton has a lower number of young people looked after than Wirral.

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30 As of 31st March 2016.
Data was available to indicate the location of looked after children (and those on a child protection plan) across Sefton. The data is set out at Figure 43. The data indicates a pronounced clustering of this client group in the southern end of the local authority area.

**Figure 43: Children Looked After and Child Protection Plan distribution – LSOA Analysis**

*Source: Performance & Intelligence Service ‘Framework for Change Supporting Data’ 11/10/2016.*
7 Consultation with professionals and wider stakeholders

7.1 Approach to consultation with professionals and wider stakeholders

As noted in the methodology, a key requirement set out in the client’s brief for this HNA was for ‘wider stakeholder’ consultation, including education, community and health providers and commissioners.

An introductory email was sent in the inception week to a list of 26 named contacts, on behalf of the Director of Public Health – forewarning of the timescale for this work and the need to involve relevant staff and commissioners. This list of consultees was supplied by the steering group, encompassing a wide range of stakeholders - and was built upon mid-way to include more voluntary, community and faith (VCF) contacts

Appendix 1 sets out the stakeholders who were interviewed, either in one-to-one telephone calls or meetings, or else in group meetings. Stakeholder participants included: staff, commissioners, members of the VCF sector and service providers.

The semi-structured questionnaire pro forma that was developed for this exercise is included in Appendix 2, and is structured around three main thematic areas of questioning:

- What are seen as the main health/wellbeing needs of young people and families around drugs and alcohol? (are there particularly vulnerable groups?; emerging misuse trends?; etc)
- What people think of local service provision? (what gaps are there?; what do you think of prevention / early intervention / treatment services?; etc)
- What should future provision look like? (what are the barriers/challenges? What are the opportunities? etc).

The Every Child Matters (ECM) Forum meeting held on 29th March enabled the authors to present back findings to date and crucially enable the VCF sector to communicate: gaps in services locally, priorities for service development, and how they wanted to be involved in the development of future service co-design and co-production.

31 The ECM Forum homepage: https://seftoncvs.org.uk/networks-forums/ecm/
This section sets out cross-cutting themes that emerged from the wider stakeholder consultation - identifying some of the key themes that appeared in conversations with a variety of commissioners, service managers and operational staff during February and March 2017. Detail around these common themes is added in the section that follows. Note that the qualitative data is the subjective assessment of those interviewed and therefore may not correspond with the quantitative data and will be subject to perceptual bias.

This section also sets out further observations on need, services and future provision - that came from each of the main elements of questioning

7.2 Cross-cutting themes

A number of cross-cutting themes were identified during the consultation. The key themes identified were:

- The **normalisation of cannabis** use locally in recent years was flagged by a majority of interviewees (note that this is corroborated by the NDTMS data set out earlier in the report regarding prevalence in the treatment population).
- The perceived wide use of **ketamine** which appears to be more accessible and affordable - and has links to the local party scene and in turn child exploitation.
- The continuing damage that **parental/carer substance misuse** has on generations of Sefton children and young people is a concern – both the direct impact, for example in terms of a young person’s health and also indirect impacts on local communities (for example, the impact dysfunctional families and their children have on class attendance, disruption and the achievements of the pupil community in schools).
- Stakeholders stressed the importance of understanding substance misuse provision and future commissioning in the context of the ‘**toxic trio**’ issues that permeate the lives of many of the most vulnerable families – namely mental health, domestic abuse and drug and alcohol harm.
- Linked to an integrated understanding and response to the toxic trio elements above, the need for a **wrap-around family approach** (rather than silo services dealing with specific issues) was repeated by many interviewees. Whole family working, rather than splitting issues into adult and children and young people provision for example, was on most people’s list of future improvements - applying lessons, for example, from initiatives like the Turnaround Programme (Troubled Families).
• The need for **greater awareness and communication** between young people’s service providers across Sefton was identified as important. Most interviewees highlighted that treatment services need to work closer with a wide range of other children and young people’s health and social care services, to ensure that vulnerable young people have all their needs supported.

• Several professionals noted that awareness of the SMASH service offer was poor and better promotion of support services was needed. It was also noted that communication needed to be ‘smarter’ and reflect the needs of professionals and the families/children and young people being supported.

• Workforce capacity and training issues emerged in almost all conversations including:
  
  • some questioning whether SMASH had the capacity to deal with referrals
  • several commenting on whether there could be a re-focus of the SMASH service more towards preventative work and less specialist provision
  • the need to up-skill and increase the expertise across the entire Sefton workforce was a common demand – so people can better triage, deal with ‘low level’ issues themselves and know when to bring in specialist assistance rather than press the referral option immediately.

• Opportunities are emerging locally to **better integrate services**, outcomes and operational working on the ground – although several commented on services appearing to evolve in a fairly piecemeal way, with changes occurring in line with contracts ending and new ones starting, which were not synchronised. The newly commissioned 0-19 (North West Borough Healthcare NHS Foundation Trust) service that begins in April 2017 and the bedding-in of the relatively new Merseycare Ambition adult substance misuse service provided obvious opportunities to link outcome frameworks and clarify pathways.

• **Public sector reform** projects focussed on early intervention and prevention are seen as opportunities to better integrate services across Sefton, and the benefits of linking expertise and localities via hubs is seen, on the whole, as a positive step.

7.3 **Observations on needs of young people and families**

Answers given in each of the three main elements of interviewee questioning are explored in this section of the report.
When asked about who are most vulnerable to substance misuse and if any emerging trends have been noticeable regarding drug and alcohol misuse, the wide range of interviewee perspectives meant the focus for conversations would be quite diverse – often dependent on a person’s area of work and service user groups (which would range from early years help to adolescent and adult services). However common threads in interviews include:

- When asked about trends in drug and alcohol use, and vulnerable groups, the normalisation of cannabis use locally in recent years was mentioned in almost all interviews.
- The perceived emergence of ketamine use was a constant theme. Ketamine appears to be more accessible and affordable, and has links to the ‘party scene’ locally and in some cases child sexual exploitation (CSE). As one SMASH worker noted “… there’s been a sharp rise in the use of ketamine, and that affects the very vulnerable. The party model around CSE is a worry – and they’re [the victims] are presenting more and more at the front door. There has been in the last couple of months a big increase in ketamine availability, and ketamine parties”. The ‘ket parties’ are a worry across the board, with the school health team explaining how there isn’t a perception of danger for young people because people aren’t necessarily being hospitalised by using ketamine, which can lull them into risk taking behaviour and environments – and the school health teams are “seeing a lot more anxiety from come downs”.
- Some professionals expressed anxiety about recent trends in which young people are sniffing cocaine and ketamine together (“snowballing”). It was felt that this was indicative of a concerning level of sophistication in which young people were seeking to balance “highs” and “downers”.
- SMASH staff noted the increase in young people presenting with emerging emotional and mental health problems – from those who are regularly feeling low and mildly depressed at one end of the spectrum, to those who self-harm and have suicidal tendencies. “There are strong links between cannabis use and low moods…… SM worker knows if someone is self medicating, and the worker gets to the core issues”.
- Professionals consulted were keen to highlight in terms of trends is the increasing number of young people experiencing family breakdown and increasingly dysfunctional relationships with carers.
- When asked about local drug and alcohol trends, the prevalence of cannabis as drug of choice was repeated in most conversations (and mirrored the treatment statistics presented in earlier sections of this report). However what is less evident from statistics is the use of drugs associated with the party scene locally.
- Staff working with young people in treatment noted how "legal highs come and go. And some CYP are using lots of drugs, but they're a minority”. Previously termed ‘legal highs’ (psychoactive substances\textsuperscript{32}) like nitrous oxide and spice are an issue to many stakeholders, and a particular concern to VCF service providers working with adolescents. Nitrous oxide canisters were considered particularly visible at the moment, and “this could be due to availability/cost, and also maybe because they’re still seen as 'legal'”? In tandem “the other concern is the high publicity that 'spice' is getting even though as far as we are aware it was removed from sale in a legal way some time ago”.

- Those working in schools noted how many of the local vulnerable groups they see in drop-in sessions and group work (including young women with low self-esteem) combine cannabis with high levels of alcohol intake.

- Young people who are engaged or on periphery of organised crime groups (OCG) has increased, and drug use is one of risk factors - either CYP using drugs or being criminally exploited as part of OCG and sometimes forced to act as ‘mules’ for dealers.

- Concerns about an increasing number of girls being exploited came to the fore, with drugs and alcohol used in CSE (in parties etc) by young people and adults.

- The continuing damage that parental/carer substance misuse has on generations of Sefton children and young people and families is a cross-cutting concern:

- The issue of parental substance misuse can be seen in terms of direct impact (for example via the effects on a young person’s health and wellbeing, particularly when living in families where the ‘toxic trio’ of mental health, domestic abuse and substance misuse are prevalent), and also indirectly through the impacts on local communities (for example, the impact dysfunctional families and their children have on class attendance, disruption and the achievements of the pupil community in schools). “Some experiment as they see parents doing it, and think that’s how to do things in life”.

Those working in educational settings highlight how “it’s just tragic, and it doesn’t get better – it goes on for years and years, and we’ve got intergenerational abuse now. We see drug addicted mums with babies,

\textsuperscript{32} Banned in May 2016, as new laws came into effect via the Psychoactive Substances Act 2016, a psychoactive substance is a substance that “produces a psychoactive effect in a person if, by stimulating or depressing the person’s central nervous system, it affects the person’s mental functioning or emotional state” (Home Office).
people going into and out of care... the social care system is very slow, with people focused on attachment and people given as many chances as they can”.

7.4 What do people think of local service provision?

7.4.1 Multiple vulnerabilities
When asking about gaps in service there was consistency in the way people tended to bring their answer around to the lack of a concerted family approach to substance misuse and the associated ‘toxic trio’ of key issues affecting many vulnerable families, namely:

- Domestic abuse
- Mental health
- Drug/alcohol misuse

The importance of understanding substance misuse (prevalence, needs, service provision and future commissioning) in the context of the ‘toxic trio’ came to the fore in many conversations with commissioners and staff with mental health, domestic abuse and drug and alcohol harm themes that seem to permeate the lives of many of the most vulnerable families.

One stakeholder focussed their response onto parental/carer substance misuse and the wider family service offer: “We have the toxic trio in many families (MH, DV, SM)...which causes or triggers which we don’t know and I don’t think families know after a while. But our joint ability to tackle that in a significant way, rather than one service dealing with each, is the big issue”.

Managers in services ‘on the ground’ flagged a fragmented approach to dealing with problems as an issue that often added complexity for the service user. For example one of the SMASH team remarked how: “It is kind of segmented – if you have a specific issues you go to this team; if another go another team. There are barriers that aren’t helpful. It isn’t always a family approach – need a lot of services in to deal with them, and that’s confusing.”

The need for a wrap-around family approach, rather than silo services dealing with specific issues, was repeated by many interviewees. ‘Whole family working’, rather than splitting issues into adult and CYP provision for example, was on most people’s list of future improvements, as well as applying lessons from initiatives like the Turnaround Programme (Troubled Families).
7.4.2 SMASH

In terms of the SMASH service, many had complimentary examples of their work. However a perceived scarcity of staff was raised by several, as was a lack of understanding of what the SMASH team did (and didn’t do) and therefore when to refer. There are many examples of good practice from those who have worked alongside SMASH, however staff have seen problems recently in how the service is perceived externally: “over the last few years we’ve hit a barrier. Referrals have reduced dramatically as there’s a perception that it’s only a specialist service. So now we’re having to do bigger piece of work to raise people’s awareness - to say can access SMASH and make people use the service again”.

Themes that emerged relating to SMASH included:

- The need for greater awareness and communication between young people’s service providers across Sefton. Most interviewees highlighted that treatment services need to work closer with a wide range of other children and young people’s health and social care services, to ensure that vulnerable young people have all their needs supported.

- Several professionals noted that awareness of the SMASH service offer was poor and better promotion of support services was needed. As one children’s social care representative remarked: “I’m not sure what SMASH do and what preventative work they do with younger kids”.

- For families experiencing substance misuse, several noted that more could be done to raise awareness of services – for example, in reference to the Addaction Breaking the Cycle programme one support service worker noted that “their profile and communication needs to be raised”.

- It was noted that communication needed to be ‘smarter’ and reflect the needs of professionals and the families/CYP being supported with greater application of new mobile technologies and ‘apps’, together with a review of the “clunky, user un-friendly” Sefton directory pages suggested.

- Workforce capacity and training issues emerged in almost all conversations. In relation to the SMASH service offer some questioned whether SMASH had the capacity or presence to deal with referrals or other service demands. In recent years the service has adopted a ‘virtual’ model of delivery that entails practitioners moving to key interfaces, such as the multi agency safeguarding hub (MASH), to attempt to stem the fall in referrals and link through more directly to the vulnerable CYP - but had not promoted the change in delivery model particularly well in the eyes of some.

Both service managers and commissioners commented on whether there could be a re-focus of the SMASH service more towards preventative work and less specialist provision. The need to up-skill and increase the expertise across the entire Sefton workforce was seen as an important priority – so people
can better triage, deal with ‘low level’ issues themselves and know when to bring in specialist assistance. Broadening out the knowledge, understanding and ability for ‘universal’ stakeholders to respond was a theme in many conversations.

In relation to parental substance misuse, for example, a stakeholder mentioned a case of a couple expecting their first baby, who went to their GP and started attending midwifery appointments. In journey planning workshops, the professionals who came into contact with the couple explained the frustration that “people knew one [of the parents] was misusing alcohol, but no-one challenged it at that point. So we had really good triggers for change (like the birth of new baby) but professionals weren’t taking those… and didn’t link them directly into services, to establish team around the family, to keep the baby safe”.

It is worth noting that SMASH are rolling out training via the LSCB, though there are questions from some as to how to integrate the ‘up stream’ development of skills and knowledge, and who is best placed to lead. Conversation with the training lead at the LSCB revealed that the imminent roll out of the SMASH training programme will lead to three sessions being held in 2017/18, with potentially 25 to 30 agencies attending each session. The immediate training benefits include expected improvements in attendee confidence in handling substance misuse concerns, improved understanding and knowledge – and also benefits to SMASH in reducing the number of inappropriate referrals.

7.4.3 Breaking the Cycle

Whilst fewer of the professional mentioned BtC than SMASH, those who did have experience with the BtC team were complimentary on how they provide an essential component of how substance misuse is dealt with locally, given the scale of parental/carer substance misuse.

An early help manager in the council noted: “Some programmes in place work really well – certainly Breaking the Cycle works with some families”. However BtC and SMASH could both improve how they communicate across sectors and with professionals, according to many of those interviewed. As one of the school based stakeholders remarked “as a professional I find they’re [SM services] very thin on ground, never seen and constantly change name… staff are confused as to who to refer what to. So don’t work together at all…. Only time work together is when all sit round a conference table”.
7.4.4 Wider stakeholder perspective

A consultation session was held at the Sefton Every Child Matters Forum (facilitated by Sefton Council for Voluntary Services) at which a wide range of practitioners were asked to offer their views. Attendees were asked to comment on gaps in current provision. Their responses are set out in Box 1 below.

Box 1: Every Child Matters Forum consultation response

Round 1 Question: From your perspective, what is missing in terms of support services for children and young people who are directly or indirectly affected by substance misuse?

Discussion prompts included: whether they thought they had enough knowledge of where to look for advice – particularly relevant for those who didn’t have direct knowledge of the area, but might have children and/or relatives who could be potential service users in future.

Here is a note of the flip chart answers from each of the four tables (ordered crudely according to number of groups giving similar answers), relating to perceptions of gaps:

- Lack of whole family work [x 3 groups].
- Wouldn’t know where to go to find support. Lack of knowledge of the services. [x 3 groups].
- Better understanding of needs of CYP.
- Support for parents.
- Communication – no referrals from Breaking the Cycle to SMASH.
- Capacity of services to reach all of CYP that need help.
- A bridging service – sometimes dual diagnosis (mental health and alcohol) complicates access.
- Transition to adults – still difficult due to lack of two way communication.
- No drop-in service.
- Young person not having a consistent person / support; Child telling story time and time again.
- Co-location missing.
- Earlier intervention for parents / carers needed (eg mental health support)
- Primary school engagement – including drug awareness for parents. Where children have ADHD and self-medICating, find parents unaware what to do.
- Inconsistent education for CYP and parents.
- Links with A&E Alder Hey, so there are gaps in referrals (e.g ADHD referrals).
A recurrent theme among those consulted was the need to better integrate services, align outcomes and integrate operational delivery and commissioning.

Whilst this was seen as a significant benefit a number of challenges were identified that would need to be overcome to enable integration to take place.

In terms of parental/care substance misuse and the need to take an holistic family approach, being able to break the downward spiral was mentioned several times as a long term problem faced by a myriad of agencies, and some focussed in on the need to focus the system around the person and family more - “it’s getting to families at the exact point when they’re willing to hear and to change, which is extremely tricky. When they do engage at right time it does work! But whether we’ve got enough of it [services], probably not. And whether we’ve got the right mechanisms to identify when people are at that point of change, and able to provide a quick link in to the right place, I’m not sure...”.

Several stakeholders commented on the historical legacy of services appearing to evolve in a fairly piecemeal way, with changes occurring in line with contracts ending and new ones starting, which were often out of sync. The newly commissioned 0-19 (Five Borough Partnership) Service that begins in April 2017 and the bedding-in of the relatively new Merseycare Ambition Sefton adult substance misuse service provide obvious opportunities to link outcome frameworks and clarify pathways and were felt to have provided opportunities whereby more systematic change could have been adopted wholesale.

There is an onus, in the short term, to at the very least improve two-way communication and awareness raising between relatively newly commissioned services in 2017. As one of the school health team remarked “it would be brilliant if people could come out from SMASH to a team meeting every quarter, to tell us about trends and close the loop on referrals, for example...but we need to network with them better also”.

As detailed in the last section of this report, training and up-skilling a wide range of the Sefton workforce is a key issue for many, to improve who gets involved at which point in a young person’s and families life. As a children’s social care manager noted: “having sufficient skills and knowledge about dealing with emerging substance misuse issues is important. We do need a specialist service for those with entrenched and problematic difficulties, but where it’s low level there’s a gap”.

Public sector reform projects focused on early intervention and prevention are seen as opportunities to better integrate services across Sefton and the benefits of linking expertise and localities via hubs is
seen, on the whole, as a positive step. The caveat some stakeholders noted is that multi-agency hubs need to be well planned, and the right level of people, expertise and resource committed.

Other areas to focus change and improvement planning include:

- More work is needed to build on the commissioning strategy linking across health and the local authority – as one council commissioner noted “we’re at an early stage in that, and we know we need to do more work”.
- As one of those closely involved with early help commissioning noted, in future: “there’s something about what we establish, how we explain (unpack) that and then how people get to it at right time - which we haven’t quite got right. So we have some things in the mix that are good, but some of the linkages are less so”.
- Having more examples of pooled budgets or pooled funding is seen as important to commissioners. "It tends to be when we bring those services together under one organisation...That’s what’s been done in the past. But we might want to have a think about pooled budgets, and what difference that can have to our commissioning plan”.
- Co-design and co-production with beneficiaries was flagged as an improvement area. "How we co-produce delivery strategies and delivery models, with people who are going to benefit, isn’t something we’re great at. We’re good at consulting, and relatively good at incorporating people’s views into a needs assessment and potentially a new method of delivery....but getting users in at the beginning, when they can really shape things, so people feel part of the creation – we’re immature at that”.

Austerity remains the main challenge to provision of services for most of those we spoke to. Wide ranging cuts to cross-sector budgets has reduced services in many areas, whilst there is extra demand on some services that can be the critical safety net for the most vulnerable cohorts in the Sefton population. VCF sector support services to young vulnerable people communicated the financial hardship that they face going forward. As one VCF youth worker noted: “everybody’s feeling the pinch – not just organisations but individuals. The squeeze creates things that thrive, including the bookies and places that sell alcohol. Youngsters are feeling the pressure. And diversionary activities have dropped year-on-year. It’s noticeable that gaps are appearing”. Another VCF family worker, whose organisation targets services to vulnerable children, young people and families, highlighted how they’d “taken a 7% cut from the CCGs across the service; we’ve taken a 50% cut last year for our youth centre – and although funding is going to remain the same this year, the provision is needed more than ever. People are saying the family
have drug and alcohol problems, but we don’t know where to refer people who come to us, given our waiting lists – and we know all the other voluntary sector [services] have waiting lists”.

Identifying, evaluating and then investing in effective activities during young people’s formative years is an important area to invest dwindling funds. The importance of work in schools is mentioned time and again. As one VCF stakeholder remarked: “Whether more can be done in the school environment to make them aware of risks I’m not sure. How to make people change is hard. It needs peers and those who have suffered - those who’ve had drugs and alcohol balls-up lives, to go round schools”. And several noted how the age of those being targeted needs to become younger, to reflect the perceived earlier use of drug: as one VCF family worker explained, “work needs to go on in schools before they become teenagers – years 6 and 7. They start young, and they see their older siblings doing it and its just become the norm – to smoke cannabis, and legal highs, they just think it’s ok”.

There are many challenges as well as opportunities that emerged from these stakeholder conversations. One key challenge that has been voiced several times is how to effectively evidence the return on investment from prevention focused models while preserving the quality and availability of specialist treatment for both young people and young adults.

Attendees at the Every Child Matters Forum were asked to comment on priorities for commissioners. Their responses are set out below at Box 2.
Box 2: Every Child Matters Forum consultation response

a. **Round 2 Question:** From your perspective, what should the priorities be for commissioners to improve the support that is available for children and young people who are directly or indirectly affected by substance misuse?

Discussion prompts included: asking people to remember that many budgets are limited and public sector cuts continuing, therefore to consider priorities in terms of what would have most ‘bang for the buck’.

Here is a note of the flip chart answers from each of the four tables (ordered crudely according to number of groups giving similar answers), relating to **priorities**:

- **Whole family approach. [x 3 Groups]**: Family focussed work as part of offer; focus on the parents, especially young parents.
- **Increasing joint/multi-issue approach [x2 Groups]** – via multi-agency working, and making sure the whole picture is captured so that support can be effective and joined up; real joined up partnership approach.
- **Link with adult services [x 2 groups]** – so CYP really do go from 0-15 rather than 0-19; Robust links to CYP an adult services – so prevention not fire fighting.
- **Increasing capacity of SMASH.**
- **Drop-in service**
- **Offer training to range of services / families to raise awareness, skills and understanding.**
- **Empowering families and CYP to ‘own’ the process and chose their own paths.**
- **Joining up specifications – integrated commissioning**
- **Co-location of prevention services, and also co-location of health/social services.**
- **More data sharing in specifications (of services).**
- **More early help and interventions, especially in Primary Schools.**
- **Reconsider pathways message – from preventative to specialism.**
- **Parallel programmes for parents, CYP.**
Attendees at the Forum were also asked to comment on the range of stakeholders who should be involved in the design of substance misuse services. Their responses are set out below.

Box 3: Every Child Matters Forum consultation response

**Round 3 Question:** Who needs to be involved in the design and co-production of services for children and young people who are directly or indirectly affected by substance misuse?

Discussion prompts included asking people to extend the question beyond the ‘who’ should be involved, to explore how involvement should take place.

- **Service users.**
- **Non-service users**
- **Families**
- **Schools, education establishments** (e.g. schools/colleges involved in design of SMASH leaflet a few year ago).
- **Wider health services – L&D; CAMHS; GPs; School nurses; Health visitors; etc**
- **Youth service.**
- **Community organisations / CVS.**
- **Need both youth voice and parental voice** (e.g. Parenting 2000).
- **Adult service users**
- **Private sector** – where often zero tolerance in workplace. Need to move away from waving the stick to more of a message of understanding.

How involve?

- **Through schools** – ‘Big Brother’ diary room idea, for anonymised feedback; Use Board of Governors if can’t access Head Teachers; barriers to access some CYP e.g. Academy Schools.
- **Via positive role models** – feeding back about ‘I had a choice’ moment.
- **Integrated team approach** – for example, ‘toxic trio’ training rolled out using multi-agency approach.
- **Regular consultation with adult service users as well as CYP.**
- **Continuous process involving CYP.**
8 Young people’s consultation

8.1 Approach to consultation with children and young people
A crucial element of the HNA was engagement with children and young people to understand their perspective on issues around drug and alcohol use among their peers.

Altogether 20 young people aged between 10 and 23 years participated in consultation across six sites. These sites were:

- Netherton Park Neighbourhood Centre
- Youth 8 at Christ Church Bootle.
- SMASH South group at Cambridge Road Adult Education Centre
- SMASH North group at Southport Town Hall
- Venus Centre at ‘Our Place’ Waterloo
- Sefton Care Leavers at ‘Our Place’ Waterloo

Note the consultation included a mix of those young people receiving treatment (SMASH clients) and wider young people (i.e. those not requiring treatment).

The names and identifying details of the young people have been changed in this report. Where there were useful quotes illustrating the young people views and feelings, these have been reproduced as closely as possible. The case studies at the end have also been anonymised.

8.2 Profile of the young people interviewed
Those consulted ranged in age from 10 years to 23 years. The average age was 16. There were 8 young men and 12 young women

In terms of ethnicity there were 19 White British young people and 1 Black British young man.

In relation to the neighbourhoods within Sefton where they lived, young people came from:

- Netherton,
- Litherland,
- Seaforth,
- Fernhill,
- Bootle,
• Waterloo,
• Crosby, and
• Maghull.

All the young people had had some contact with children and young people’s services and a number had had contact with SMASH young people’s service.

8.3 Substances used
The young people were asked what they knew about the drugs that were available in their neighbourhoods. In nearly all cases, the young people volunteered information about this, but also told the interviewer whether they had used any of these substances or not. They also volunteered information about use by members of their family and friends.

8.3.1 Alcohol
The majority of the young people, including the youngest participants, had drunk alcohol, although some said that they only drank at family gatherings or occasionally on special occasions. Several said that they didn’t really enjoy it. This included those who were very young but also some aged sixteen and over. Others said they only drank at weekends and usually at parties. Some said they didn’t drink during the week but described bingeing at the weekends, especially at parties.

Those who said they didn’t drink alcohol during the week cited the reason as being that they couldn’t drink on a school / work night as they wouldn’t have been able to get up the following morning.

A minority of the weekend drinkers said that they drank considerable amounts of alcohol alongside other drug use. A further minority said they drank every day. It was apparent that many of those who were heavy cannabis users were less likely to consume large amounts of alcohol. Drinking was considered a social activity and only two of the older young men said they drank when they were on their own.

The young men said that they usually drank beer or when they could afford it spirits like Jack Daniels. The young women said they usually drank vodka or wine (cheap sparkling wine was very popular) or cider. In terms of quantities, the older young women described regularly drinking a bottle of wine, or sharing a bottle of vodka between several friends.
Several younger people spoke about ‘getting pissed’ or ‘getting off’ as a sort of badge of honour. The older young people also spoke about being ‘hammered’ but emphasised that they stayed in control – and this appeared to be their badge of honour.

**8.3.2 Cannabis**

Perhaps not surprisingly, all of the young people said they thought that cannabis (‘weed’ as they referred to it as) was the most prevalently used substance along with alcohol. Of note, this substantiates quantitative data elsewhere in this report.

Young people referred mostly to ‘weed’ but also ‘bud’ which is a kind of herbal cannabis and which a number of them thought must be ‘healthier’ because it was natural.

With the exception of one young person, those who smoked cannabis had all started smoking cigarettes at a young age (often 10, 11 or 12) and generally one or two years before using ‘weed’ for the first time thereby indicating tobacco is a potential “gateway” to cannabis use.

None of the younger participants said that they smoked cannabis on a regular basis. Two had tried smoking it – those who also smoked cigarettes. They said that there were local dealers and didn’t think most young people bought on-line.

In the other groups, nearly all the young people had used weed, although a 17 year old young man who was not in education, employment or training (NEET) said that he had now stopped using it as he felt that it was getting in the way of doing anything constructive with his life.

There was considerable variation in how much ‘weed’ young people said they used. The majority of those aged 14 and 15 said that it was occasional and when they had the money. However, a few of these young people and a number of the older ones, said that they always smoked joints in the evenings and at weekends. A smaller number, notably those who were not in regular education, employment or training were smoking throughout every day and evening. This also applied to those who had had contact with youth offending services and it is possible to surmise that their offending may have had something to do with funding their use, although only two young people were explicit about this.

Those who used ‘weed’ every day said that they needed it indicating some dependency.
Those who smoked on an occasional or only in a social context said that they smoked weed because it was fun and because their friends also smoked. These young people said that they rarely or never smoked when they were alone. Those who were heavier users and used on a daily basis variously described ‘needing’ it to:

- control anger,
- help to calm them down,
- reduce anxiety and/or depression,
- alleviate boredom, and
- help them sleep.

The preferred herbal cannabis was approximately £35 per quarter ounce. The interviewer was told that cannabis resin was cheaper at about £30 per quarter ounce, but that the quality of this was sometimes ‘rubbish.’ Cannabis purchases would last some young people several weeks and was often bought jointly by two or more friends.

8.3.3. Nitrous Oxide Balloons

Approximately half of the young people interviewed talked about having used balloons filled with nitrous gas. All of them knew other young people who used them, including some of the youngest participants. They said that it was possible to buy ready filled balloons for £2 or less. One young woman told the interviewer you could buy ‘three for a fiver.’ Some of the older young people said that it was better to buy the canisters of gas yourself as they cost as little as £1.49 for eight via online vendors.

While inhaling or ‘huffing’ balloons was thought to be low risk by most of the young people, a few were clearly concerned that the practice was dangerous and stated that, like inhaling other substances such as nail polish remover, deodorant or glue they freeze your throat and could be potentially fatal. One young man responded to other members of the group who were saying how much fun balloons were, by saying: ‘Yeah its funny ‘til someone dies cos they freeze up your insides.’ This was generally dismissed by the others.

There was little evidence of any widespread use of other kinds of solvent misuse. Only one young man said he had used butane gas on a regular basis a few years ago and one young woman referred to a

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33 The canisters are used legally in the catering trade for preserving whipped cream and the discarded cans are known locally as ‘whip its’. They are not illegal to use, although supplying them for recreational purposes is illegal.
younger friend who sniffed a piece of cloth soaked in solvent. The other young people in these groups expressed disapproval of this practice.

8.3.4 Ecstasy
The most common drug slang for ecstasy in Sefton is ‘Gary’. Most of the young people used this slang phrase but also referred to ‘mandy’, ‘brownies’ and quite simply pills.

Ecstasy was fairly widely used by the young people and was considered affordable at £5 a pill. The young people said that the most popular ‘Gary’ was a pill that looks like a ‘gold bar.’ These were bought from local dealers and not on-line.

The interviewer met a very shy 12-year old girl who had been reported to SMASH by her parents who discovered that she and another girl had used ecstasy. She said that she had never previously used any other drugs, did not smoke and did not drink alcohol. She told the interviewer: ‘I won’t be doing it again. I only took half of one and then got scared and told my mum who took me to hospital to check I was alright and then afterwards to the police station and they suggested that I came to SMASH.’

8.3.5 Magic
After ‘weed’, ‘Gary’ and ‘balloons’ the most frequently used drug cited by the young people was ‘magic.’ In many areas of the UK, ‘magic’ refers to magic mushrooms. However, in Merseyside, including Sefton, ‘magic’ is a slang/street term used to describe the drug M.D.M.A –in a crystalline, powder form instead of a tablet - and usually costs about £40 per gram but sold in much smaller bags.

This appeared to be very easily purchased and was very popular giving what one young man said was a ‘serious high.’ As with ‘weed’, ‘magic’ was purchased by the young people from local dealers, rather than on-line.

8.3.6 Cocaine
Cocaine was variously referred to as ‘lemmo’ or ‘sherbert’ and one young person called it ‘beak’. It appeared to be quite widely used by young people aged 15 years and over and a number of young ones had tried it on one or more occasions.

34 The term - apparently - originally comes from the name of a former Everton and Liverpool defender Gary Ablett - tablet.
The main issue preventing younger children using cocaine was the cost involved (generally £35-40 per gram). It was clear that cocaine was usually used as part of a cocktail of party drugs and often alongside alcohol.

8.3.7 Ketamine
A number of the young people aged 14 and upwards spoke about using ketamine (‘ket’). This corroborates the views of adult stakeholders (see previous section) who noted that ketamine was becoming more prevalent.

Only two of the young people interviewed seemed to be fully aware of the dangers associated with the use of this drug. One young man told the interviewer: ‘I heard it’s what vets use to give as anaesthetics to horses and so I wouldn’t use it’ and another young woman said: ‘you can lose the use of your arms and legs - so no I wouldn’t touch it.’ However it was also described as quite affordable at £20-£30 per gram. No reference was made in this small sample to ketamine parties to which the adult stakeholder had referred.

8.3.8 New psychoactive substances (NPS)
Several boys referred to ‘Space Trips’ and ‘Neuroblaster’ which are legal highs, but neither had used them. The only two NPS regularly referred to by the young people were Spice and Mephedrone (meow meow).

Just two of the older young men had tried Spice and both said that they were unlikely to use it again. One young man told the interviewer: ‘I just didn’t like the effects at all.’ He suggested that younger people could be attracted to it because it was easy to get hold of in ‘town’ (Liverpool) and only cost £10 for a one gram packet. However, there was no evidence of this amongst the younger participants interviewed.

While Spice and other NPS are most commonly bought and sold online, the two young people who had used it insisted that they could still be bought in ‘Head Shops’ in Liverpool, despite the fact that Spice has been made illegal and recent legislation has stamped down on Head Shops.

The only young man to have used ‘meow meow’ was an established poly drug user and said very little about it other than the fact that he had used it a couple of times.
**8.3.9 Amphetamine**

None of the young people had used amphetamine but all knew that ‘speed’ was available and that older friends used it. It was suggested that a lot of ‘older women’ who lived on the Dodge Estate used it. However, the young people seemed to be talking about on-line legal high equivalents rather than the traditional form of amphetamine sold on the streets.

One young man was open about the fact that his mother had been heavily dependent on amphetamine. He said it had been very hard because she had ‘really let herself go’ and he had been embarrassed by her in front of his friends. His friends in the group were very supportive telling him that they liked his mother and that she was ‘funny and kind.’ This visibly helped the young man who said that she was very much better since she had stopped using and now was taking pride in her appearance again. He said: ‘She looks so much better – she’s even had her teeth fixed!’ He also said that he knew he hadn’t helped her at the time: ‘I feel bad because I know I was a pain at the time and just took it out on her.’

**8.3.10 Poppers**

The young people had all heard of poppers, and referred to them as ‘Rush’, Rock’ and ‘Gold’ stating that these were the ones most commonly used. Only a few had actually tried them.

One young man of 17 years who was involved in sexually exploitative activities with gay men described their use in enhancing sexual pleasure.

**8.3.11 Prescription drugs**

Although none of the young people misused prescription drugs on a regular basis, several referred to taking the ‘odd tab’ from the medicine cabinet at home. One young woman said she had experimented mixing pain killing tablets with alcohol. A young man told the interviewer that his mother had been addicted to tranquilisers but that she was now getting help to stop using them.
8.4 Acquiring drugs and alcohol

8.4.1 Obtaining alcohol
The young people stated that they frequently pooled pocket money to buy cheap alcohol. It was also common practice for older siblings to buy alcohol for younger ones in the family.

In some cases young people stole alcohol from home and several admitted to shop lifting bottles or cans from supermarkets. In a few cases young people said that adults in the family (usually older siblings, aunts or uncles) actively shared their alcohol with the young people, although this was not the norm.

8.4.2 Funding drug use
As indicated above it was clear that some drugs were more affordable than other drugs. The cheapest drugs were ‘weed’, ‘magic’ and ‘balloons’ and not surprisingly these were the most common drugs used by the younger participants who, for the most part, had limited funds.

The younger people who used ‘weed’ said that they paid for this by pooling pocket money or borrowing money, often from older family members. Several young people said that they obtained drugs in exchange for ‘baby-sitting’ for older siblings.

Cocaine was considered to be one of the most expensive drugs referred to despite its relative affordability compared to the past. One of the older young women said that she regularly spent Saturday evenings in her local pub in Fernhill, having ‘taken ‘magic’ before going to the pub and then went back to her flat with friends to relieve the baby sitter and share a few stripes (lines of cocaine).

Some of the young people had obtained money through illegal activities. Shoplifting and stealing money from family members was admitted by a number of young people. Some of those who were in contact with youth offending services may have committed more serious offences, at least in part to fund their substance use. In one case a young man who had been looked after in a series of residential homes and excluded from numerous schools and who said he used a wide range of drugs and alcohol on a regular basis, said that he funded his use through ‘dating’ contacts he made through ‘Grindr’.35

35 The gay dating app and social network
8.5 Situational use
Young people said that they usually used alcohol and drugs in ‘other friend’s houses’. When asked about this they explained that this was usually in someone’s house where the parents or extended family did not object and where boundaries were flexible and supervision was low.

In addition, most of the young people were able to identify local spots in parks, school playing fields, subways or near transport terminals where they could use without detection or interference.

Interestingly, the younger ones said that they usually got away with drinking alcohol at family parties and gatherings where older family members were ‘pissed.’ Two young women described going around emptying the dregs of alcoholic drinks into pop bottles and then getting drunk on strong cocktails of vodka, whisky, wine, beer and cider. Several young people spoke about being able to drink when on family holidays. One young man said ‘It’s great when we go to Spain, because booze is really cheap and my mum gives us money to go out, while they are partying. We can get really ‘pissed’ on cheap vodka and wine and no one seems to notice.’

Two young people described regularly staying out all night ‘at friend’s houses’ or ‘sofa surfing’ for several days and bingeing on both drugs and alcohol. In another case a younger person said he had collapsed after using a mixture of alcohol and Ketamine and had been reported as Missing from Home, but told the interviewer that no action had been taken when he had eventually returned home with the help of his friends.

8.6 Parental attitudes
There was considerable variation in parental attitudes to young people using drugs and alcohol. In some cases the young people spoke about their parents concern and disapproval about drugs and alcohol. In general, those parents appeared to be more concerned about the young people’s use of drugs than alcohol.

Most of the younger ones said that they were only allowed to drink alcohol on ‘special occasions’ and that when they asked if they could have an alcoholic drink, their mum or dad would say ‘Well ok, just one’ or ‘Yes but take it easy.’
In relation to drug use, many of the young people who used ‘weed’ said that their parents had found out about their use either because they had detected the smell in their bedrooms or had been informed by school following incidents where they had used in or near school premises. However, the same young people who often used a wide range of other drugs said that their parents did not know about these although some thought ‘they may have suspicions but don’t really want to know.’

In a few cases, parents (usually dads) had been very punitive when they had discovered the young person’s drug use, for example grounding them or in one case beating the young person. The young people told the interviewer that this hadn’t stopped them using but had created problems in their relationships with their parents. Many of the young people said that they were upset that their mothers were worried. It was interesting that a number of the young people who had had sanctions imposed by their parents, said that these were short term and that they just weathered the restrictions until the time passed, and then they went back to using again.

8.7 Identified vulnerability factors for substance misuse within the sample

8.7.1 Environmental factors

A number of the young people spoke about the neighbourhoods in which they lived and highlighted the availability of drugs in them. For example, the four young people who were interviewed at the Netherton Park Neighbourhood Centre lived on what is known as the ‘Dodge Estate. (The interviewer was told that the area got this name many years ago because it was an estate with one of the highest number of benefits claimants in the area.) It is an area with a large number of families living in material poverty. The area was, and still is associated with some gangster activity related to drugs.

The young people told the interviewer that the estate is the first place that families on the housing list are offered accommodation by the council because no one wants to live there because of its reputation for gangs and drugs. They told the interviewer that the Cabbage pub had been a focal point for this activity for many years, although it has recently had a ‘make-over.’

It seems that in the past there had been some problems with members of local gangs using threatening behaviour towards staff and young people in the Netherton Centre and they were thought to be trying to sell drugs. However, the young people also said that they thought that ‘Dodge’ was better than Pendle. ‘There is only one real gang round here in Dodge now. A bit of ‘beef’ goes on and there are guns,
but people don’t go out tooled up with knives – they only carry them when there is a problem – so on a sort of ‘needs to know’ basis.’

The Youth 8 group and the Smash South young people talked about living in Bootle and suggested that, as with Netherton, there were high levels of poverty, and drugs were readily available often being dealt by gang members. They emphasised that in Bootle (and this was also confirmed to be the case in other areas) different dealers sold different drugs.

Young people living in Fernhill told the interviewer about the notorious Fernhill Gang who it seems had been ‘busted’ several years ago, but who they suggested had now re-formed with younger members, many of whom were from the same families.

Two young people who lived in Seaforth described the local neighbourhood divisions between communities on either side of an area of raised ground. They suggested that each area had its own public house (referred to as ‘Bennos’ and ‘The Doric’) and local drinking and scoring drugs revolved around these. Young people from one side of the area would not cross the imagined boundary to the other side, and the dealers from whom they scored were local to their particular neighbourhoods.

8.7.2 Age of first use

There is considerable evidence to suggest that age of first use of substances can be a predictor of later more problematic use.

As indicated earlier, some of the young people in the sample had started using substances, particularly tobacco, in their very early teens. While learning to smoke is generally a pre-requisite for using cannabis it is not the case that it is always a predictor or a pathway into the use of other substances. However, it is clear that many of those who started smoking cigarettes at a very early age lived in families where smoking and the use of other substances was the norm.

8.7.3 Young people’s experience of education, employment or training

Six of the young people who were interviewed had a history of being excluded from school generally as a result of ‘challenging’ behaviours. All of these young people said that they had used substances during the time they were at school, notably cannabis and alcohol. Two said they had been using a range of drugs at the time they had been excluded. Some of the young people attributed their
substance misuse to the behaviours that led to their exclusion. One young man admitted that he had often been ‘stoned’ in class and totally ignored the teachers when he was in this state.

In two cases the young people had been given the opportunity to re-engage with mainstream school and two others had spent time in alternative education. The two eldest young people who had been excluded were not in education, employment or training although one told the interviewer that he hoped to start a Princes Trust 12-week Personal Development Programme.

8.7.4 Young people with mental health needs and / or learning disabilities

A significant number of the young people in the sample had experienced, or were experiencing signs of anxiety and/or depression. For some this related to particular current circumstances in their lives, for example stress related to school; family relationships or difficulties with friends. For others, it was obvious that the young people had long histories of adversity, abuse, neglect and trauma. A few had self-harmed or discussed previous episodes of suicide ideation. Two disclosed they had had contact with Child and Adolescent Mental Health Services. For many of these young people substance use was evidently a coping mechanism.

Two young people who participated told the interviewer that they had been diagnosed with ADHD. One of these young people also had a diagnosis of autism. The relationship between these conditions and mental health conditions such as anxiety and depression is well documented. Similarly, the relationship between mental health conditions and substance misuse are also well established. Both young people were regular and moderately heavy users of cannabis and alcohol.

A third much younger person, who was ‘looked after’, had a diagnosis of bi-polar disorder. She spoke about using a range of substances, although her mood was clearly elevated and it was not clear how accurate her accounts were.

8.7.5 Being ‘looked after’

Five of the young people who were in the interview sample were, or had been ‘looked after’ and were in contact with Sefton’s Leaving Care Service.

It was evident that these young people were those who had had most experience of using substances. It was also the case that these young people generally had a number of other factors which would be
likely to make them more vulnerable to substance misuse, for example, parental substance misuse, experiences of abuse and neglect, sexual exploitation and being excluded from school.

Most had had several placements in foster homes and residential settings and this had militated against establishing friendship groups and long term relationships.

**8.7.6 Being a ‘young offender’**

Several of the young people in the sample had had ‘brushes’ with the law, but only two disclosed that they had been in contact with youth offending services. However, several described illegal ways of raising money to buy drugs and alcohol including shoplifting and theft.

As stated above, it was also the case that some of the young people had associations with gang members and were engaged in low level dealing.

Two of the young people had been sexually exploited.

**8.8 Parental Substance Misuse**

A lot of the young people spoke about the drinking and drug use of members of their families.

Only one young person said that neither of his parents drank alcohol. Three young people said that their fathers drank alcohol, but their mothers did not. Just under a half described both parents drinking but said this was mostly at weekends in the pub or at special occasions.

Of the remaining young people, the majority said that their parents drank every day and three said that a parent’s alcohol use was causing friction in the family. This was also the case with older siblings living at home.

Four young people talked about a parent or family member whose drinking was, or had been, dependent. Two had relatives who had lost their lives to alcohol-related harm (liver problems and accidental deaths). Of these young people, two said that their parents had been helped to stop drinking by an alcohol service.
Six of the young people referred to the fact that their parents had used drugs (mostly cannabis or amphetamine) in the past. Only three had experience of living with parents who were using illegal drugs in the home. One of these young people described the use of cannabis in the home as being a normal part of their lives as they grew up. Two sisters described trying to get help for their mother who was using amphetamines. One young man told the interviewer about the problems his mother had experienced when she became dependent on prescription drugs, and how proud he was that she had managed to stop using them and had turned her life around.

8.9 Case Studies
The interviewer constructed seven illustrative case studies from the material obtained from participants. As stated at the beginning, names and key features of the young people’s lives have been changed to protect confidentiality.

Case study 1. Mac
Mac is 15 years old and lives in the Southport. He started smoking cigarettes when he was 13 years old and a year later started smoking cannabis. Within the first year of use his cannabis consumption increased from the occasional shared joint with friends at weekends, to smoking two to three spliffs a day during the week and seven or eight at weekends. He funded his use by using pocket and dinner money to buy sweets, which he then sold at school.

Mac says he knows how to buy cannabis and other drugs on-line, but prefers to buy cannabis from the same local dealer. He and his friends usually buy ‘resin’ but prefer ‘bud.’ He knew where to buy cocaine; ‘Gary’ ketamine and MDMA powder, but said he was not interested in using them.

Unusually, he said that although he knew friends who had tried balloons – he didn’t know where to get them and didn’t want to know.

Mac also said he doesn’t drink alcohol, although some of his friends do. He told the interviewer: ‘People get very smashed at parties, especially the girls drinking vodka. I just think it’s embarrassing seeing what people do when they are drunk – I would hate to be like that.’

Mac says that he has several family members who do drugs. He said ‘Neither of my parents drink now, although my mum used to do a lot of drugs including weed, ecstasy and cocaine when she was younger. My
dad used mainly weed but neither of them do anything now, not since my sister and I were born.’ He told the interviewer that he had an uncle who still uses heroin, and an aunt and cousins who use cocaine and drink heavily.

Mac told the interviewer that following an incident where a group of friends were caught by a teacher smoking at the bottom of the school playing field, there was a meeting of the head, pastoral worker and his parents at school. He said that: ‘the head said that he was the so called 'ring leader' of a group of school friends.’ He thought the head had called him this because they found out he was the one who had bought the cannabis which they all shared. Mac said that both of his parents were very angry and grounded him for two weeks. (He admitted that this wasn’t a bad thing as it meant that he had to cut down his smoking.)

At the time of the interview, Mac had attended approximately 10 sessions at SMASH. He said that he hadn’t been keen to go at first, but thought it had been good – especially the art expression sessions. He said that although he wouldn’t stop smoking cannabis altogether, he had decided to smoke less and concentrate more on his forthcoming GCSEs over the next few months. He is committed to gaining good grades. He recognised that he had been lucky not to have been excluded.

Case Study 2: Caitlin

Caitlin is a 17 year old young woman who at the time of the interview was living at home. Both her mother and father have poor health and one of her sisters is autistic.

Caitlin says that as she was growing up she remembered her parents smoking skunk weed in the house: ‘I can remember liking the smell – I thought it was like oranges when I was little’. She also recalled that other close family members used cocaine in the house. She described a childhood characterised by violent arguments and fights between various family members. Caitlin told the interviewer that she was not happy at home and wanted to move out permanently.

Caitlin had a difficult time at school where her challenging behaviour led to her being excluded several times. She says that although she hasn’t been diagnosed with ADHD, her teachers have told her she is hyper-active. She recounted how she would ‘kick off’ in class because she didn’t like being told what to do and then would fall asleep in class. The second time she was excluded it was because she had brought alcohol into school and had been consuming it during lessons. Caitlin says that when she was
threatened with exclusion for a third time in Year 10, the safeguarding teacher intervened and she was put into temporary isolation and put on a special timetable.

Caitlin has a long history of running away from home – usually staying with an older sister of a friend in Liverpool; sleeping on the floor or settees for several days at a time. She says when she ran away she would go on benders. She said that she would baby-sit for a woman’s small child in exchange for ‘bifters’. She has been reported as Missing from Home on numerous occasions and eventually was designated as a Child in Need with a Child Protection Plan.

Caitlin has mental health issues. She has experienced high levels of anxiety for several years and described periods of shaking, compulsive scratching and hair pulling. She says she knows she is hyperactive a lot of the time and sometimes experiences feelings of paranoia. She also has periods of serious depression when she withdraws from other people. She has a history of self-harming and says that ‘it’s better to cut herself or punch walls rather than people’. She has a prescription for anti-depressants. She told the interviewer that she was recently sexually assaulted and subsequently attempted suicide. She says that she has been told that she has symptoms of PTSD. Caitlin was referred to CAMHS when she was 16, but was told she was too old for the service. She now receives help from another service.

Caitlin says she currently smokes 20 cigarettes a day and uses cannabis a few times a week. She started smoking cigarettes at 10 and started using cannabis at 13 years old. She says cannabis eases the pain arising from an accidental injury. She says it also helps to calm her down and helps her to block out things that have happened to her in the past. She buys home grown cannabis from a friend of the family who lives nearby.

Caitlin binge drinks at weekends. She says she prefers to drink cider and likes to use cocaine when she is drinking. Caitlin has also used Magic powder. She says that at first this was ok, but after a while the substance made her anxious, angry and aggressive. Caitlin has a group of friends who are poly drug users and regularly binge on alcohol, cannabis, Gary; magic and ketamine. Caitlin says she thinks she has always used less than her friends. She told the interviewer that since being in contact with SMASH, she thinks she will just smoke weed from now on.
Case Study 3: Kieran
Kieran is 14 years old and lives on a south Sefton estate with his father, mother, older brother and two younger sisters. Kieran’s family have a history of drug misuse.

It is widely known in the neighbourhood that Kieran’s mother was dependent on tranquillisers and pain killers for a number of years. She had originally been prescribed pain killers following an accident. Kieran is aware of this and told the interviewer that she used to spend a lot of time trying to buy strips of drugs from other mothers in his school. He recalls that eventually she couldn’t get any more from her doctor and was very ill. He says it made him very anxious and he was frightened of leaving her and stopped going to school.

Kieran’s maternal grandmother also had a history of drug misuse and his mother grew up in a household where there was domestic violence. Since gradually withdrawing from tranquillisers, Kieran’s mother is hoping to work with other women who have experienced the same difficulties.

Kieran himself is a large, loud, impulsive and excitable young man, and it is thought he probably has ADHD although he has not received a formal diagnosis yet. He has been accused of bullying other children at his school. He attends a local youth club, but is a loner with no close friends. Kieran’s school is aware of his mother’s problems and are concerned about the impact of these on him. He now has a learning mentor who spends a lot of time with him.

Case Study 4: Tracy
Tracy is a 19 year old young woman from Litherland.

When she was 15 years old she became pregnant. She did not tell her mother or step father as she knew they would be extremely angry and would force her to terminate the pregnancy or give the baby up for adoption.

When she reached six months in her pregnancy, her mother confronted her, and as she had expected there was a huge row in which her step father ordered her to leave the house. Tracy spent the rest of her pregnancy in hostels. After the birth of the baby Tracy went to a mother and baby foster placement. She and her four-month old son have just recently moved into her own flat where they live alone.
Tracy says that her parents were heavy drinkers during her childhood, and she had drunk alcohol when she was very young before becoming pregnant. She smoked cannabis when she was pregnant and living in the hostels, and says she still has a very occasional spliff late at night to wind down from the day. She says she will never do alcohol or any other drugs now because of her responsibility to her son.

At the time of the interview, Tracy was living on universal credit and actively looking for a job.

She has no contact with any of her family and says she doesn’t want to ever see them again.

**Case Study 5: Ethan**

Ethan is 14 years of age, is looked after and lives in a residential children’s home. He has been in care since he was six following a violent childhood during which he and his sister were abused by their father and witnessed extreme domestic violence towards their mother. His father was eventually imprisoned but his mother was no longer able to cope and so he was looked after in a foster home. Since then he has lived in five other foster placements and four children’s homes. He explained that with each move he has had to change schools as well.

Ethan has severe anger management problems and his last educational placement was in a special school for children with Emotional and Behavioural Difficulties. He told the interviewer: ‘I know I just kick off really easily and I have been kicked out of so many schools because of this.’

Ethan says that he smokes ‘rollies’ because they are all he can afford, but shares weed when he can and has had ‘Haze’ which is a synthetic kind of cannabis. Ethan says that he prefers drinking to using cannabis and doesn’t think he would do any other kinds of drugs, although he uses balloons whenever they are available. But he told the interviewer he likes to drink vodka and lager and once mixed a lot of vodka with eggnog which made him very sick. He likes experimenting with alcohol.

**Case Study 6: Deana and Daisy**

Deana and Daisy are sisters. Deana is 10 and Daisy is 12. There are a further 7 children in the family – all older than Daisy. Their parents separated because of arguments over their mother’s drug use. However, Deana and Daisy continued to live with their mum and two of their brothers near Crosby.
The girls’ mother had a long history of using amphetamines. They told the interviewer that it was very difficult for them as they were growing up as money was always very tight because all their mother’s money was spent on speed. However, they said that their older siblings who were working, used to make sure they didn’t go without, and ensured that they had Christmas and birthday presents like other children.

Despite support from their older siblings, they described how difficult life had been for them and how upsetting it had been to see their mother so ill. ‘At times when mum was at her worst we went to sleep at our older sister’s house but we didn’t like doing this ‘cos we knew that it upset mum and we were worried about leaving her. Also when we were away, mum used to spend a lot of time with her sister and she was always using drugs too, so we worried about that too.’ Both girls missed a lot of school at this stage. They said that during this difficult period their father came to see them once a week to make sure they were ok and take them out for a meal, but this too often led to arguments between their parents.

The girls described how difficult it was for them at school during this time. ‘Our sister just told the teacher that we were having difficult times and I don’t think they knew about mum. Our friends didn’t know what was going on either. They noticed we were upset and kept asking if we were alright. We just said ‘its family business.’ They also told the interviewer that they couldn’t invite any friends home and were often embarrassed if they met friends in the street when they were out with their mum. It was clear that the two girls relied a lot on each other for support.

Last year, the girl’s mother sought help with her drug use and the Venus Centre became involved with the family. The girls said they were delighted and did everything they could to help and support their mum. One of their older sisters came over to stay with Deana and Daisy while her mum did a home detox. They told the interviewer that she stayed for five days and they carried on going to school knowing mum was safe. It was clear that it was really important for them to remain at home even over this difficult time as they now feel that they played a part in helping their mum get better.

Case Study 7: Jayden
Jayden is 18 years of age and has been ‘looked after’ since he was seven. Currently he is living independently in Bootle, an area where he spent his early years. Jayden describes the area where he
lives as ‘very rough’ with gangs of lads around all the time, but says it is the only area he can afford to live in.

Jayden started using cannabis when he was 13 and was smoking high strength skunk weed when he was 14 years. He told the interviewer that he was smoking skunk through the day and evenings. He says was smoking every day usually on his own. He was spending between £20-£30 per day on cannabis and got the money through shop lifting and theft.

Apart from skunk Jayden says he also used solvents when he was younger and in a care home in Lancashire– at one time he claims to have been using six cans a day of deodorant. He says it gave him very severe headaches and so he stopped doing it. He says he also used Spice at this time but says he didn’t like it: ‘It was cheap, but I felt as if my legs were like metal discs rubbing together – so I only did it three times.’

Jayden still uses skunk. When he can afford it he buys 20grms of cocaine which he uses with friends in a night. Apart from using drugs, Jayden also drinks heavily and says that since the break-up of a special relationship he has been drinking every day – usually vodka but also strong lager.

Jayden told the interviewer that since he has funded his drug use through ‘escort work’ with people he meets through the gay online social chat room Grindr. He says he can make £60 a day and has been doing this intermittently since he was sixteen. He says he knows this is sometimes dangerous.
9 Conclusions
A number of conclusions are set out below based on the data contained in this report.

9.1 Young people’s treatment population
The data indicates that there has been a steady drop in the number of young people in treatment in Sefton from a peak of 269 in 2008/09 to 97 in 2015/16. It is important to note that this decline mirrors both national and local trends (whilst not mapping exactly against these parallel trends).

Whilst there is a decline in the treatment population, it does not logically follow that this is indicative of lower levels of demand. Rather it may be indicative of changing levels of need and different types of drug consumption. Furthermore, the data can be read as indicating that, while demand continues to exist, this is not being matched by supply. Stakeholders who were interviewed commented on lack of knowledge about referral pathways into treatment, lack of awareness about the service (particularly following a reconfiguration) and what it provides and perceptions about the type of young people it works with. All these factors may well have had a negative impact on referral levels into the service in an environment where demand has been constant (or even increasing). The effect of how services are provided is crucial in understanding the data and may well be why numbers of young people in treatment in Stockport are rising whilst numbers in Sefton are decreasing.

Following on from the point above, given that it cannot be concluded that levels of demand are decreasing it is not safe to conclude that the expectation should be that numbers continue to decline in the future. It is quite possible that, should current services be re-structured or awareness of the service increased then the numbers into treatment may start to rise again (as would seem to be the case for Stockport). Again, the key point to conclude is that the demand for services and the numbers in services may not correspond and that the numbers in treatment are a function of how services are offered rather than the need for services.

Treatment data indicates that cannabis is by far the most commonly used drug among the treatment population (cited by 91% of those in treatment) followed by alcohol (cited by 27% of young people in treatment). Cocaine and ecstasy use is also a feature of the treatment population.

The qualitative data tends to suggest that young people are engaging in poly-drug use with ketamine appearing to be increasingly prevalent, used alongside cannabis, alcohol and other drugs. Of some concern, ketamine does not appear to be seen as being potentially harmful by young people (perhaps
due to its clinical origins) and there is some sense that young people see it as “safe” or “risk free”. Given apparent levels of ketamine use it is likely that future young people’s treatment presentations will increasingly feature this and other drugs that are relatively new to the treatment system. If levels of ketamine use are as high as the qualitative data would suggest, this may also indicate an increase in demand for young people’s substance misuse over the medium term.

The data is striking insofar as it indicates that the treatment population have complex and co-morbid needs. For instance, 31% of those in treatment have a co-morbid mental health diagnosis, nearly a half are affected by parental substance misuse (47%) or domestic abuse (45%). The data therefore indicates very significant levels of vulnerability.

Given the complexity of young people in treatment, the results endorse the position of PHE and others that indicate that substance misuse treatment for this population cannot be delivered in isolation and that any work must tackle multiple vulnerabilities, adopting a child-centred holistic approach in which substance misuse is understood as a risk-taking behaviour (often alongside other risk-taking behaviours).

9.2 Profile of wider young people’s population
Analysis of population data for Sefton indicates that there is a much larger population of young people who would benefit from some sort of support (ranging from targeted prevention to brief interventions to structured support). Note that:

- 879 young people potentially require structured drug misuse intervention
- 1,172 potentially require specialist alcohol intervention

These figures are substantially more than the total number of young people in structured treatment – currently 97. This reinforces the conclusion (set out above) that there is still a significant demand for treatment services and that the decline in the treatment population is not a function of reducing demand.

The literature on young people and substance misuse makes it clear that there are a range of vulnerability factors that are known to increase risk of substance misuse and vice versa–or rather forms of vulnerability which may manifest in the use of drugs and alcohol. It is worth noting therefore that these forms of vulnerability are present in the population of Sefton and are therefore drivers of future treatment need. These local factors include:
20% of children grow up in poverty – this is more acute in the southern end of Sefton

Alcohol and drug misuse were a factor in 36% of children’s assessment cases

Of 929 children assessed where domestic violence was known to be a factor, in 267 cases alcohol misuse was present and in 264 cases drug misuse was present

210 children were referred as potential victims of CSE

465 young people were looked after by the local authority

While these are by no means the only vulnerability factors that exist in the local area, they are indicative of cohorts of young people who live in Sefton who may turn to substance misuse as one form of risk-taking behaviour. Given this, it can reasonably be concluded that there will be a need for specialist young people’s substance misuse services for the foreseeable future as a range of socio, economic and cultural factors create future generations of drug and alcohol users. Those presenting will continue to have complex needs that should be addressed holistically (as described at 9.1 above).

9.3 Current provision

Local service provision has been adversely affected by staff shortages which have affected the ability of SMASH to deliver the range of services as outlined in the specification for the service. We note that staff have not been back-filled and so there has been a shrinking pool of professionals to deliver a wide range of services (for a long time the service has been operated by two substance misuse workers and an admin worker). A number of stakeholders noted that the logical consequence of this is that the service has focussed on those young people with higher levels of need and that the more preventative elements of the work have not been delivered to the same extent as previously. Furthermore other agencies seem to have “lost sight” of SMASH – that is, they have lost contact or been forgotten about. Again this appears to have been due to a lack of staff who were able to keep in regular contact with other agencies.

It would appear therefore that the drop in client numbers, in addition to being part of a wider local and national trend has been exacerbated locally by a reduction in capacity in the service. As noted above it should not be assumed that reduced numbers in treatment are indicative of reduced levels of demand.

The data indicates that there are significant numbers of young people adversely affected by parental and carer substance misuse – with the data indicating that 36% of children’s assessments involving drug or alcohol misuse. Given this, there is a clear need for not only young people’s substance misuse services, but services that look at the wider context of the family and the impact that this has on young
people. Breaking the Cycle provide a service that caters for this group of vulnerable children and so it is important to note that the issue has been recognised locally. As per young people’s substance misuse services however there appears to be a disjoint between demand and actual levels of service provision (with likely levels of referrals to Breaking this Cycle this year of around 88 clients).

9.4 What works
The evidence base for what works in terms of young people’s substance misuse provision is by no means as developed as the literature for adult’s treatment. The literature does however make clear that treatment for young people is distinct from that for adults and that it requires its own approach.

The literature emphasises that substance misuse sits within a constellation of other vulnerabilities that is manifested in risk-taking behaviours. Substance misuse among young people should not therefore be addressed in isolation.

There is an emerging evidence base that some of the most effective approaches are delivered in the context of the young person’s family – recognising both that parental substance misuse is a key predictive factor and that the family is an important therapeutic environment through which to achieve change. Consideration might be given to adopting this family based therapeutic work in Sefton.
10. Recommendations

Based on the data in this report and the conclusions set out above a number of recommendations have been made which are set out below.

1. Consideration should be given to ensure that specialist young people’s provision in Sefton is delivered at appropriate capacity and delivers a comprehensive service in line with PHE and best practice guidelines.

2. Consideration should be given to how to create a joined up model that:
   a. Provides support to all young people where parental substance misuse is an issue
   b. Provides a family-based interventions to young people who require substance misuse treatment

3. Delivery of future substance misuse services should be informed by consultation and co-production with young people.

4. There should be an improved training offer to front-line staff across a range of settings to enable practitioners who come into contact with young people to provide brief interventions and brief advice and to help them assess where an onward referral to specialist services are required.

5. There should be a greater emphasis on prevention work, for example working with schools to tackle risk-taking behaviours (as opposed to stand-alone drug and alcohol awareness modules) among young people. Consideration should be given to adopting one of the evidence based standardised models that have been developed (such as The Good Behaviour Game, PreVenture, Strengthening Families) that are set out in section 4.3.2.

6. Consideration should be given to a local education programmes aimed at young people on the dangers associated with any newly emerging substance and how to access substance misuse treatment services.

7. There should be greater awareness of referral pathways and joint working between services to ensure complex needs of young people are met.

8. The service should specifically record numbers of young people entering treatment and capture drug use and emerging drug use patterns, for example ketamine use.
Appendix 1 - List of stakeholders consulted

**Interviewees**

<table>
<thead>
<tr>
<th></th>
<th>Name</th>
<th>Organisation</th>
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<tbody>
<tr>
<td>1</td>
<td>Laura Hughes</td>
<td>Breaking the Cycle (BTC) – Addaction</td>
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<tr>
<td>2</td>
<td>Dot Tinsley</td>
<td>Liverpool Community Health NHS Trust (0 - 19 Service)</td>
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<tr>
<td>3</td>
<td>Karen Garside</td>
<td>Halton Clinical Commissioning Group (CCG)</td>
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<td>4</td>
<td>Katie Taylor</td>
<td>Ambition Sefton - Transforming Addiction Services</td>
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<td>5</td>
<td>Kara Haskayne</td>
<td>Sefton Council - Safeguarding Unit</td>
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<td>6</td>
<td>Ian Willman</td>
<td>Sefton Council - Neighbourhoods &amp; Partnerships (N&amp;P)</td>
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<td>7</td>
<td>Julie Barlow</td>
<td>Sefton Council - Family Support</td>
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<td>8</td>
<td>Linda Turner</td>
<td>Sefton Council - Public Health</td>
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<td>9</td>
<td>Jacqui Kerr</td>
<td>Sefton Council - Schools and Families</td>
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<td>10</td>
<td>Tracy McKeating</td>
<td>Sefton Council - Schools and Families</td>
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<td>11</td>
<td>Shareen Turner</td>
<td>SMASH</td>
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<td>12</td>
<td>Mark McCausland</td>
<td>Community Adolescent Service (CAS) service / SMASH</td>
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<tr>
<td>13</td>
<td>Gaynor McGregor</td>
<td>Targeted Youth Prevention (TYP) - previously SMASH</td>
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<td>14</td>
<td>Mike McSorley</td>
<td>Sefton Council - Schools and Families</td>
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<tr>
<td>15</td>
<td>Caroline Watts</td>
<td>Sefton Council - Children's Social Care (Locality Service)</td>
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<tr>
<td>16</td>
<td>Peter Moore</td>
<td>Sefton Council - Commissioning and Business Intelligence</td>
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<tr>
<td>17</td>
<td>Colette Aslanian</td>
<td>Parenting 2000</td>
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<tr>
<td>18</td>
<td>John Oldland</td>
<td>Seaforth Information Network Group</td>
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## Attendees at Every Child Matters Forum

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<thead>
<tr>
<th></th>
<th>Name</th>
<th>Organisation</th>
<th>Additional meeting attendees?</th>
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<tbody>
<tr>
<td>1</td>
<td>Adele Maddocks</td>
<td>Youth Offending Team</td>
<td>Ian Corcoran</td>
</tr>
<tr>
<td>2</td>
<td>Adele Hoskison-Clarke</td>
<td>Sefton Council - SEN and Inclusion Service</td>
<td>Elaine Heague; Karen Thornhill</td>
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<tr>
<td>3</td>
<td>Alex Walker</td>
<td>1st Steps Day Nursery</td>
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<td>4</td>
<td>Alan McGee</td>
<td>Sefton Council - Public Health</td>
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<td>5</td>
<td>Caroline Roberts</td>
<td>Sefton Carers Centre</td>
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<td>6</td>
<td>Chris Jones</td>
<td>Tomorrow's People</td>
<td>Chris White</td>
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<td>7</td>
<td>Chris McBrien</td>
<td>Sefton Council - Public Health</td>
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<td>8</td>
<td>Emma Lambert</td>
<td>Sefton CVS - CWAN Chair</td>
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<td>9</td>
<td>Helen McGreavey</td>
<td>YMCA Sefton</td>
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<td>10</td>
<td>Jane Perry</td>
<td>Liverpool Community Health</td>
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<td>11</td>
<td>Julie Harrison</td>
<td>Mama Bliss</td>
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<td>12</td>
<td>Justine Poland-Angunoby</td>
<td>S MASH</td>
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<tr>
<td>13</td>
<td>Kristen Robinson</td>
<td>Relax Kids</td>
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<td>14</td>
<td>Lorraine Akins</td>
<td>Sefton Council - CLC</td>
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<tr>
<td>15</td>
<td>Liz Barr-Jones</td>
<td>Sefton Council - SEN and Inclusion Service</td>
<td></td>
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<tr>
<td>16</td>
<td>Sarah Dewick</td>
<td>PSS</td>
<td>Sarah Austin; Alison Taylor</td>
</tr>
<tr>
<td>17</td>
<td>Leah McGuinness</td>
<td>SMASH</td>
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<tr>
<td>18</td>
<td>Alexandra Beresford</td>
<td>OSSME</td>
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<tr>
<td>19</td>
<td>Joanne Williams</td>
<td>SMASH</td>
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<tr>
<td>20</td>
<td>Julie Murray</td>
<td>Sefton Council</td>
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<tr>
<td>21</td>
<td>Elizabeth Kay</td>
<td>NHS – Sexual Health</td>
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<tr>
<td>22</td>
<td>Ann-Marie Crosby</td>
<td>Parent</td>
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<tr>
<td>23</td>
<td>Rosaleen Dokie</td>
<td>Our Place</td>
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<tr>
<td>24</td>
<td>Steph Critchley</td>
<td>School Readiness - Litherland CC</td>
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Appendix 2 - Stakeholder consultation pro forma

Sefton children and young people’s (CYP) substance misuse health needs assessment (HNA)

Proforma for semi-structured interviews with:

STAFF/ STAKEHOLDERS IN SERVICES THAT ENGAGE WITH CYP WITH SUBSTANCE MISUSE ISSUES

Interview to be conducted by Michael Lloyd, independent researcher [see end of sheet for contact details]

- Not all questions will be relevant, so we’ll tailor the session to your experiences and role.
- Before the interview begins I’ll run through the introductory letter from the DPH, and provide more information on the format of the session and how the information will be used.
- The answers may require you to consider alcohol and drug misuse separately.

<table>
<thead>
<tr>
<th>Introduction</th>
<th>Feel free to add reminder notes here</th>
</tr>
</thead>
<tbody>
<tr>
<td>• About me and the HNA project [letter of introduction handed out on day]</td>
<td></td>
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<tr>
<td>• About you:</td>
<td></td>
</tr>
<tr>
<td>o Can you confirm your preferred job title(s) / role (s) please?</td>
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<tr>
<td>o How long have you been in this organisation?</td>
<td></td>
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<tr>
<td>o What experience have you working with CYP in Sefton, and in particular those with substance misuse (SM) needs?</td>
<td></td>
</tr>
<tr>
<td>o Who funds your work with CYP – how much?; contract/budgets?</td>
<td></td>
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</tbody>
</table>

1. Sefton substance misuse – your overview of

Feel free to add reminder notes here
CYP & Family needs

1.1 Could you briefly summarise your perspective on CYP drug and alcohol misuse? (ie who do you work with? What level of involvement?)
1.2 Who do you think are most vulnerable to substance misuse? (co-morbidities? Protected characteristics?)
1.3 Have any local issues emerged recently re CYP substance misuse? (for example any new types of drug use? Growing / declining trends?).
1.4 Do you see the impact on CYP of family members/carers who misuse drugs and alcohol – and if so how well are local services set up to deal with the impacts?
1.5 What difference in substance use and health/wellbeing needs exists? (ie across the various age groups – for example under 18s and ‘transition’ 18-24?).
1.6 How do you monitor CYP needs and how you help? (which reports are accessible?)

2. Service provision in Sefton

[A] Overview of CYP substance misuse service provision
2.1 Could you briefly summarise the various substance misuse services used by CYP you deal with? [is there documentation I can take away that summarise?]  
2.2 What major gaps exist locally, if any?

Next we’re going to ask you to think about treatment and preventative/early intervention services separately….

[B] Treatment services
2.3 Do you link into treatment services, and if so how often are these services used by you/your organisation? (ie approx number of referrals; etc)
2.4 What strengths and weaknesses do you think stand out regarding the treatment services you deal with?
2.5 What barriers to engagement exist for CYP?
2.6 Anything else that could be improved?

[C] Early intervention / preventative services
2.7 Do you link into preventative / early intervention services, and if so how often are these services used by you/your organisation? (ie approx number of referrals; number of times asked for advice; etc)
2.8 What strengths and weaknesses do you think stand out regarding the early intervention services you deal with?
2.9 What barriers to engagement exist for CYP?
2.10 Anything else that could be improved?

**[D] Partnership working / integration**
2.11 What examples do you have of good partnership working with local agencies supporting CYP?
2.12 Any examples of partnerships or joint-working not being as effective as it should?

**[E] Service integration**
2.13 Do you think there are opportunities for greater integration of services? If so how and where?
2.14 What are the main barriers to integration?

### 3. Future provision in Sefton

3.1 Are there any initiatives about to start in 2017 that you think will change how CYP substance misuse is dealt with in Sefton?

3.2 What do you think are the main challenges or threats going forward to how you support CYP with substance misuse issues?

3.3 What should future CYP substance misuse service provision look like?

### 4. Other information / comments?

Any other issues you’d like to mention and/or ideas for improvement? Feel free to add reminder notes here
The interviewer will conclude with:

- A recap about any actions that have come from this meeting / interview.
- A check to see if there are any monitoring reports or datasets that the interviewee may be able to supply that hasn’t been mentioned earlier.

Thank-you for your time today!

Interviewer contact details:
Michael Lloyd          Email: michael@researchmlr.co.uk
Appendix 3 – Services through which youth consultation took place

Consultation with young people took place via the following services:

- Christ Church Youth and Community Centre
- Netherton Park Community Centre
- SMASH
- Venus Centre

Appendix 4 – Calculation of admission data

Alcohol

In terms of how the rate is calculated:

The number is:

- Persons aged less than 18 years admitted to hospital where the primary diagnosis or any of the secondary diagnoses are an alcohol-specific condition for three financial years pooled
- In addition individuals admitted are only counted once per financial year

The denominator is:

- ONS mid-year population estimates for 0-17 year olds. Three years are pooled.

The rate presented is thus:

- The number of persons under 18 admitted to hospital due to alcohol-specific conditions divided by the under 18 population of the area and multiplied by 100,000

Drugs

The numerator is compiled from a number of admissions where the primary diagnosis is one of the following:
• Mental and behavioural disorders due to use of opioids
• Mental and behavioural disorders due to the use of cannabinoids
• Mental and behavioural disorders due to use of sedatives or hypnotics
• Mental and behavioural disorders due to use of cocaine
• Mental and behavioural disorders due to use of other stimulants, including caffeine
• Mental and behavioural disorders due to use of hallucinogens
• Mental and behavioural disorders due to use of volatile solvents
• Mental and behavioural disorders due to use of tobacco
• Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances
• Poisoning by narcotics and psychodysleptics (hallucinogens)
• Toxic effect of organic solvents
• Toxic effect of organic solvents
• Toxic effect of other gases, fumes and vapours
• Poisoning by psychotropic drugs, not elsewhere classified — psychostimulants with abuse potential

Or the main cause is one of the following:

• Poisoning by and exposure to narcotics and psychodysleptics not elsewhere classified, undetermined intent.
• Poisoning by and exposure to organic solvents and halogenated hydrocarbons and their vapours, undetermined intent
• Poisoning by and exposure to other and unspecified chemicals and noxious substances, undetermined intent