Brighter Futures

Thurrock Young Person's Substance Misuse

Needs Assessment 2018

Author

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Contents

1. Executive Summary

This assessment examines the needs of young people aged less than 18 years residing in Thurrock and who access or may need to access the specialist substance misuse service. This report incorporates a literature review, an analysis of the local epidemiology and the National Drug Treatment Monitoring System (NDTMS) data, service user engagement and a review of previous benchmarking to determine cost-effectiveness.

This work will help to inform a refresh of the service specification for the young person's substance misuse service which is being retendered in 2018/19 ready for a new contract to commence on 1st April 2019.

The literature review examines the current evidence base and new interventions including best practice. The service offer can be enhanced through the recommendations in this report, informing the new service specification. This report includes a brief evaluation of the current service with key areas highlighted for continuation in the new service specification.

Additionally, the views of service users and their families are incorporated into this document and will serve to co-produce the revised service specification. Other relevant stakeholders such as the current adult and young person's substance misuse treatment providers and the Children's Services team at Thurrock Council have been contacted as part of the service specification refresh and their views and advice will help in shaping the new specification as it undergoes redesign.

This document is also used to inform and make recommendations to commissioners of children's services and to update Brighter Futures partners as to the current evidence base and data explaining drug and alcohol use in children and young people with some guidance about approaches that can be employed to tackle this.

The epidemiology section in this document tells us that we can expect to see a significant increase in the young person's population in Thurrock over the next decade, and by 30% in those aged 10-17 years old. With young person's substance misuse prevalence estimates being unreliable, it is hard to determine what the demand might be on the treatment service from this population increase. Moreover, coordinated preventative interventions under the Brighter Futures umbrella of services should see many young people diverted from becoming problematic substance misusers. This will be an area of close monitoring over the coming years.

The evidence base tells us we should continue to offer coordinated packages of care that address the wider determinants of heath, such as referrals to sexual health and stop smoking support services and partnership working with mental health and youth offending services (YOS) to safeguard our young people. We must remain vigilant of the local dugs market and associated gang activity.

The benefits of preventative and educational interventions outweigh the risks of increasing awareness leading to increased usage of substances and that such programmes should continue. Where practicable, peer mentors should support these initiatives since it has a greater impact on young people than when delivered by school staff alone.

Effective multi-agency working is a strong theme in the literature review and current practice of the existing service, resulting in a high performing, safe service. The new service should therefore continue to integrate as part of Brighter Futures to strengthen multi-agency working and further improve outcomes for children, young people and their families. The size and structure of the current service is meeting the current needs of the local treatment population. The ethnicity of those in treatment is reflective of the local population, whereas the gender split sees more girls aged under 13 accessing support for Hidden Harm (support where their parents have a substance misuse need) whereas boys dominate the 13-17 age categories where we find them in treatment for their own substance misuse needs, irrespective of whether their parents have a substance misuse need too.

Referrals to the service come from a wide variety of partner agencies, which demonstrates effective multi-agency working, although referrals from health and mental health services could be improved as the figure is 4% locally against 11% nationally and we will work to better understand the reason for this.

The vast majority of young people in treatment are in mainstream education, 73% against a national average of 57%. This demonstrates that the local service is better at engaging and accessing young people in our schools and colleges and preventing the escalation of risk that often leads to persistent absenteeism and exclusion. The service does still work with those pupils in alternative education provision such as the pupil referral unit (PRU).

Most young people in treatment, 88%, live at home with their parents or relatives and this figure is in line with the national average of 84%. The remainder are either in the care system or in supported or independent accommodation. With a third of young people in treatment having several wider vulnerabilities such as offending behaviour, Hidden Harm, safeguarding concerns or mental health problems this tells us that many young people in treatment have complex needs; these young people will generally spend longer in treatment and require more regular interventions.

Cannabis and alcohol remain by far the drugs of choice in Thurrock, at 86% and 57% respectively, with ecstasy and cocaine making up just 15% and 10% of cited substances respectively. Poly drug use is common across the treatment population; using more than one substance problematically. An anomaly in the Thurrock data is nicotine, which is actually the second most prevalent substance recorded at 67%; however, this is because the local service is adept at screening for tobacco use and referring to stop smoking services.

The waiting times are now generally good, with planned exit rates being higher than the national average and unplanned exit rates being lower than the national average. Last year the re-presentation rate was unblemished with nobody re-presenting for treatment within 6-months of treatment exit. This reflects the quality of interventions administered and/or the client's positive engagement in treatment. Furthermore, exit questionnaires have shown that clients are happy with the service, meaning they are more likely to re-present if they relapse. Young people tend to spend less time in treatment compared to the national average, meaning the service can identify and effectively treat its clients, then identify new clients, thus having a positive impact on the prevalence of substance misuse across our young person's population.

Psychosocial and motivational interventions are the most popular ones used in Thurrock, with much stronger multi-agency working compared to the national average. Interestingly, our use of harm reduction interventions is far lower than the national average and we need to understand why. We also need to increase the take-up of sexual health screening by those clients that are eligible. We work well with criminal justice clients from the Youth Offending Service (YOS) and we should continue to co-locate a member of staff there at least once a week. This will ensure that we continue to meet the needs of the one in five substance misuse clients that report offending behaviour as a wider vulnerability. According to the YOS, substance misuse was the 4th lowest risk factor out of 12, yet it should be noted that the YOS caseload is higher than the substance misuse service and many of these young people will be clients in both services.

With regards to clients that require a prescribed treatment modality such as opiate substitute therapy (OST), more commonly known as methadone, there is a contractual agreement in place between the adults and young person's service and this should continue in future. This exceptional clause has not been required for the duration of the expiring 5-year contract.

This document asks two key questions of commissioners, firstly whether the population in treatment demonstrate the expected characteristics based on the national literature review evidence and the data on high risk groups. We are confident that the answer is yes. Secondly, has the current provider targeted and 'found' the highest risk groups of children and young people? Based on the evidence of those children and young people in treatment with multiple specific and/or wider vulnerabilities the answer also has to be yes.

Key Lines of Enquiry

- Does the population in treatment demonstrate the expected characteristics based on the national literature review evidence and the data on high-risk groups?
- Has the current provider targeted and 'found' the highest risk groups of children and young people (CYP)?

2. Introduction

2.1 Background/Context

Substance misuse is often a symptom rather than a cause of vulnerability among young people. Many have broader difficulties in their lives that are compounded by drugs and alcohol and which need addressing at the same time. Viewing young people holistically as whole beings and tackling the root causes of substance misuse is more likely to reduce the number of young people who

experience long term negative impacts on their physical and mental health and go on to misuse substances into adulthood potentially as a form of 'self-medication'[1].

Young person's substance misuse treatment services engage vulnerable young people and intervene early to avoid or limit escalating risk and harm from substance misuse. The objective of such services is to support sustained recovery by supporting young people through the entire treatment process; from entrance into treatment to the point of re-integration back into the wider community[2].

Evidence shows that young people's lives can improve when they have access to substance misuse services alongside support to address their wider health and wellbeing needs. This means that the commissioning and delivery of specialist drug and alcohol interventions should take place within wider service structures that meet a range of needs. There is growing recognition that drug and alcohol services should be designed to address the wider determinants of health and that more effective joined up support should be available to tackle the complex needs experienced by many service users. For example, Inclusion (Thurrock's adult drug and alcohol treatment provider) offers support around issues such as intimate partner violence[3].

A Department for Education cost-benefit analysis found that every £1 invested in specialist substance misuse interventions delivered up to £8 in long-term savings and around £2.50 within two years, meaning that this can be a cost-effective way of reducing future demand on health and social care services[4]. A life course approach to drug prevention that covers early years, family support, universal drug education, and targeted and specialist support for young people is one of the key aims of the Government's 2017 Drug Strategy.

Parental drug use can compromise children's health and development, as well as impact on parenting capacity. Research cited in the Government's Hidden Harm report 2011[5] estimated that there were between 200,000 and 300,000 children in England and Wales where one or both parents had serious drug problems – representing 2-3% of children under 16. Children of parental drinkers are also at risk of Foetal Alcohol Syndrome (FAS) or Foetal Alcohol Spectrum Disorder (FASD[6]) – which is a series of preventable birth defects caused entirely by a woman drinking alcohol at any

[1] Public Health England. (2015). The International Evidence on the Prevention of Drug and Alcohol use: Summary and examples of implementation in England. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/669654/Preventing_drug_and_alcohol_misuse__international_evidence_and_implementation_examples.pdf (Accessed June 2018).

[2] Drugscope. (2013). Issues in Recovery: A Changing Landscape for Commissioning. http://www.drugwise.org.uk/wp-content/uploads/Regional-briefing-Changing-landscape-for-commissioning.pdf (Accessed June 2018)

[3] Drugscope. (2013). Issues in Recovery: A Changing Landscape for Commissioning. http://www.drugwise.org.uk/wp-content/uploads/Regional-briefing-Changing-landscape-for-commissioning.pdf (Accessed June 2018).

[4] Gov.UK, Public Health Matters. https://publichealthmatters.blog.gov.uk/2016/07/25/tools-for-assessing-value-for-money-for-alcohol-and-drug-treatment/ (Accessed July 2018).

[5] Gov.UK. (2018). https://www.gov.uk/government/publications/amcd-inquiry-hidden-harm-report-on-children-of-drug-users (Accessed July 2018).

[6] The Parliamentary Office of Science and Technology. Post Note number 570. (February 2018). http://researchbriefings.files.parliament.uk/documents/POST-PN-0570/POST-PN-0570.pdf (Accessed July 2018).

time during her pregnancy, often even before she knows that she is pregnant. Estimates by Alcohol Concern suggest that there were 7,317 children born in England in 2012 with FASD. The lifetime cost to the economy for a child born with FAS was estimated at £1,500,000, and the adverse consequences experienced by children can include: weakened immune systems; a wide range of emotional, cognitive, behavioural and other psychological problems; early substance misuse and offending behaviour; as well as poor educational attainment.

Caveats and limitations of the data

First there can be limited interrogation of the data extracts provided as it was not possible to develop an enhanced analytical approach (e.g. using multivariate statistical techniques) that could determine whether any correlations or associations between factors are statistically significant. The National Drug Treatment Monitoring System (NDTMS) datasets used in this report refer to small numbers of people in treatment and, unlike adult treatment data, do not come with prevalence estimates and penetration rates to compare against.

Current Service Provision

Thurrock's young person's substance misuse treatment service is currently provided by CGL (Change, Grow, Live) Wize Up. Over the life of the contract the service has been developed by recruiting an apprentice, a student social worker, a harm-reduction worker and peer mentors. This service development led to the team recently moving to slightly larger premises, still within a few minutes' walk of the adult treatment service that is now delivered by Inclusion Visions Thurrock (Midland Partnership Foundation Trust (MPFT)). Wize Up works with individual young people as well as families, if appropriate. This supports much of the research that illustrates the strength of working with the entire family unit to reduce risk of harm relating to substance misuse or to support recovery. It is important to note that substance misuse can and often does affect the family and community more widely and not just the person who is misusing substances or alcohol[7].

The local context is of a service which has a strong reputation across schools and partner agencies. The vast majority of interventions are provided via outreach, either in schools or other settings around the borough and occasionally even in the client's home. Only on rare exceptions would a client need to be seen at the provider's office.

Schools are very welcoming of the service and the support it provides to young people. Arrangements are made to ensure the keyworkers and students can meet at mutually agreeable times and venues which have the least impact upon learning e.g. at school and where possible during free periods.

Besides casework, the service also delivers prevention and awareness raising sessions across assemblies and suitable lessons, e.g. Physical, Social, Health, Economic (PSHE) lessons, to ensure a wider audience are aware of the risks associated with substance misuse, how to reduce the harm if they are to take the risks, and where to go for help should that be required.

[7] Drugscope. (2013). Issues in Recovery: A Changing Landscape for Commissioning. http://www.drugwise.org.uk/wp-content/uploads/Regional-briefing-Changing-landscape-for-commissioning.pdf (Accessed June 2018).

Drug use observed in Children and Young People in Thurrock

The drugs of choice used by young people in Thurrock have for a long time been cannabis and alcohol, which is reflected in the treatment population as the two main substances cited by young people in treatment. The main concern with cannabis is the increasing strength caused by hybridising the plants, upping the tetrahydrocannabinol (THC) levels and reducing the cannabidiol (CBD) levels. THC is the principal psychoactive constituent of cannabis and CBD, which has no psychoactive effect, is used in pharmaceutical medications[8]. Anecdotal evidence set out in the following three paragraphs has come by way of either the adult or young person's substance misuse services or from partner organisations and agencies that attend the Community Safety Partnership.

Novel Psychoactive substances (NPS), also known as legal highs or club drugs have seen an emergence in Thurrock in recent years, although not across the treatment population. For example, we know from street littler and local intelligence that the use of nitrous oxide (laughing gas) is a growing trend not in children and young people but in young adults who regularly discard their metal canisters in public car parks of an evening, but who are not presenting to treatment for support. This group of young adults are treatment naïve; they do not recognise the risks to themselves or the impact on others and do not regard themselves as requiring support with their risky behaviour. The misuse of nitrous oxide is not an entirely new phenomenon – the Victorians used to have laughing gas parties!

Synthetic cannabinoids, commonly referred to as Spice, are not an NPS that we see in the young person's treatment population. Anecdotal evidence from the adult treatment service suggests usage even amongst adults is rare and tends to be found in the criminal justice client group when serving custodial sentences.

Further anecdotal evidence suggests some young people in Thurrock are misusing Xanax, although they are not presenting for treatment. Xanax is a benzodiazepine, also known as Alprazolam, which has an immediate onset of action. It was introduced as a treatment for anxiety and panic attacks in the US in 1981 and became a popular recreational drug[9]. In the UK the recreational use of benzodiazepines has typically involved those prescribed by the NHS, in particular diazepam diverted from regulated supplies. A number of benzodiazepines have emerged on the NPS market in the last decade although the emergence of Alprazolam appears to be far more recent[10] and the size and scale of the market is still largely unknown.

Children and Young people in treatment

Thurrock had 94 clients in treatment (rolling 12 months April-March 2017/18), split across structured treatment for substance misuse and early intervention and prevention at a ratio of approximately 1:2 clients. Of those clients, 67 were new presentations to treatment[11]. The proportionately large

[8] Medical Marijuana Inc. News. (2017). https://news.medicalmarijuanainc.com/differences-cbd-thc/ (Accessed July 2018).
[9] National Survey on Drug Use and Health. (NSDUH-2016). https://www.datafiles.samhsa.gov/study/national-survey-drug-use-and-health-nsduh-2016-nid17184 (Accessed June 2018).
[10] DrugWatch Information Sheet: Alprazolam (Xanax). (2018). http://michaellinnell.org.uk/resources/downloads/Alprazolam%20(Xanax)%20briefing%201.0%209_2_18.pdf (Accessed June 2018).
[11] 2017-18 NDTMS CYP DAAT data

number of new clients was due to both an expansion of the Thurrock service and because the time spent in treatment in Thurrock is lower than the national average.

The majority of referrals to the service come from schools and social care, followed by youth criminal justice agencies (such as the Youth Offending Service - YOS). Most clients are in full time education, with a smaller percentage not in employment, education or training (NEET) and the smallest groups are those in apprenticeships or employment.

Many clients reported starting to misuse substances before the age of 16. In accordance with findings from Young Addaction[12] the majority of young people first use drugs when they are 13-14 years old. However, the age at which young people begin to use specific drugs seems to vary; a minority of young people begin their drug use with cannabis and alcohol prior to starting secondary school with the use of cocaine often beginning at a later age. This research suggests that the early teen years offer a key opportunity for early intervention and prevention. Additionally, substance misuse is often coupled with vulnerabilities including being involved in offending behaviour, being excluded from school, care leavers and looked after children. Young people who misuse substance are also more likely to engage in other risk taking behaviours – such as unsafe sexual behaviours, criminal activity and domestic abuse[13].

The numbers accessing the service are relatively small but nevertheless illustrate effective partnership working across Thurrock and demonstrate the young person's substance misuse service's ability to engage and work with some of the most complex cases that involve support from a range of agencies.

In the context of substance misuse, and as noted above, Hidden Harm refers to those young people who have parents or carers that misuse substances. Some of these young people are primary school pupils aged 11-years or younger. Others are older and may have a substance misuse need of their own alongside their hidden harm vulnerabilities.

Nationally, best practice standards apply to service providers to ensure they identify, assess, treat and exit or transfer clients consistently across the sector[14]. Public Health England, which subsumed the National Treatment Agency in 2013, also lays out a set of commissioning standards for specialist substance misuse services for young people, which was published in January 2017[15]. This was a rapid mixed methods evidence review of current provision and highlighted the main principles for commissioning. It ostensibly provides a framework of 4 key principles to ensure that: young people and their needs are at the centre of service provision; quality governance is in place for all services;

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[12] Young Addaction. (2015). Young People and Substance Abuse. http://www.youngpeopleshealth.org.uk/wp-content/uploads/2016/06/Young-People-and-Substance-Misuse-Report.pdf (Accessed June 2018).
[13] Young Addaction. (2015). Young People and Substance Abuse. http://www.youngpeopleshealth.org.uk/wp-contents/uploads/216/06/Young People and Substance-Misuse-Report.pdf. (Accessed June 2018).
[14] College Centre for Quality Improvement. (2012). Practice Standards for young people with substance misuse problems.
https://www.rcpsych.ac.uk/pdf/Practice%20standards%20for%20young%20people%20with%20substance%20misuse%20problems.pdf (Accesses June 2018).
[15] Public Health England. (2017). Specialist substance misuse services for young people: Main principles for commissioning.
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/583218/Specialist_substance_misuse_services_for_young_people.pdf (Accessed June 2018).

multiple vulnerabilities and complex needs are addressed and that appropriate transitional arrangements exist for young people becoming young adults.

2.2 Objectives

The aim of this needs assessment is to examine the needs of young people aged less than 18 years residing in Thurrock and who access or may need to access the specialist substance misuse service. It also reviews the existing service offer and seeks to provide recommendations on where and how to enhance this offer. The report looks to identify gaps or barriers in service provision and provides recommendations to overcome these. Fundamentally, it seeks to discover whether the population in treatment demonstrate the expected characteristics based on the national literature review evidence and the data on high-risk groups set out in this document. It also seeks to determine whether the current provider has targeted and 'found' the highest risk groups of children and young people and Thurrock and supported them through treatment.

3. Epidemiology

Key Points

Population

- Thurrock's population for those aged under 18 is set to steadily increase over the next 10 years by 13%, to 47,476
- For those aged 10-17 the projected increase is 30% over 10 years
- Prevalence estimates for young person's substance misuse are currently notoriously difficult to estimate
- Numbers in treatment have increased to a level three times that of 2014

Treatment Population

- It is not yet possible to determine whether the increase in treatment numbers is due to an increase in local prevalence of substance misuse or whether the increased capacity of the existing service has enabled more young people to access treatment
- We are better than the national average at engaging with young people who require substance misuse interventions that are in mainstream education, thus preventing the escalation of wider vulnerabilities
- Over half of young people in treatment are engaged in poly-drug misuse
- Almost 1 in 5 clients have been assessed as being involved in offending behaviour

Criminal Justice

- Young offenders (or those at risk of offending) are a highly marginalised group and often have greater health needs than the non-offending population, experiencing exposure to inequalities in health that persist into adult life, including a higher incidence of physical and mental ill health, sexually-transmitted disease, injuries, and early pregnancy in females
- Drugs offences were uncommon and substance misuse was the 4th lowest risk factor at assessment, out of 12 risk factors

3.1 Population

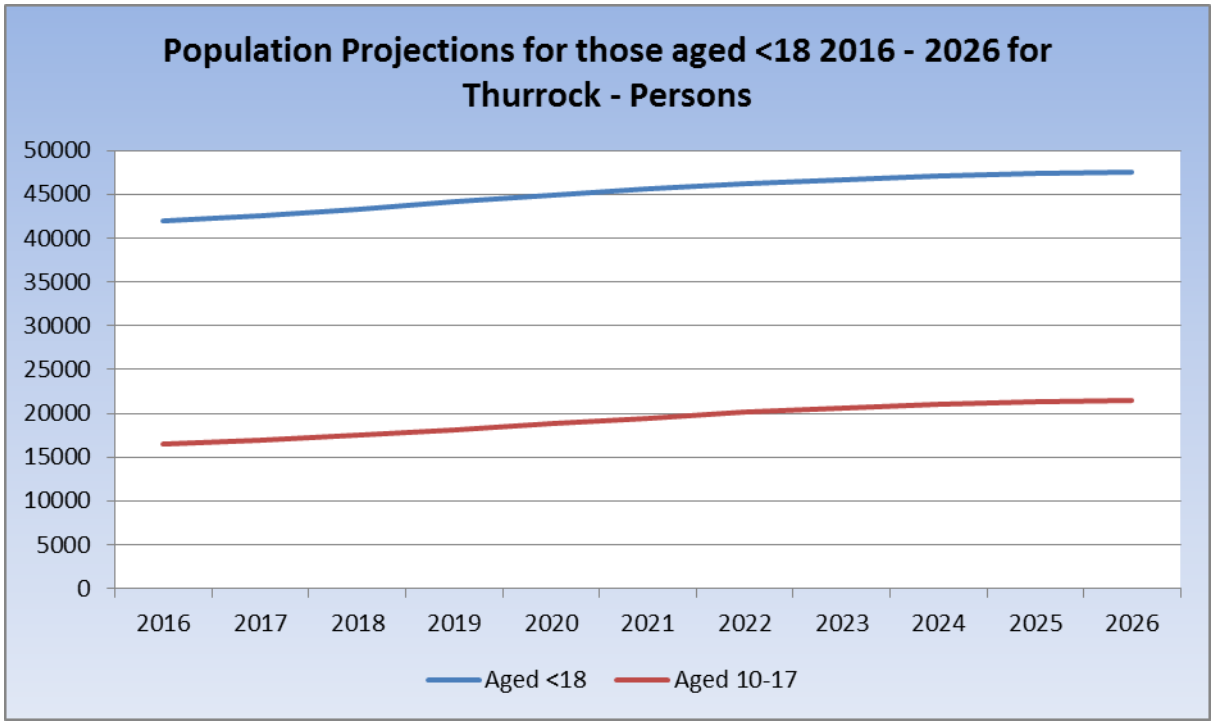
What do we know?

The numbers of young people in treatment misusing substances are generally small, which means using Chartered Institute of Public Finance and Accountancy (CIPFA) comparators is unreliable. The Local Outcome Comparators (LOC) is used for adult services, so for young people it is the norm to compare against national averages.

As of mid-2016 Thurrock had a population estimate of 168,428. Of this, Thurrock's young person's population of under 18's is 42,030 and those aged 10-17 is 16,532. The 10-17 age group is deliberately used since 10 is the age that a child becomes criminally responsible in the eyes of the law and 18 is when young people are deemed to be adults. It is also the age that a client will access the adult treatment service as opposed to the service at the focus of this document.

Thurrock's population for those aged under 18 is set to steadily increase over the next 10 years from 42,030 to 47,476 (from the 2016 baseline), which is an increase of 13%. For those aged 10-17 the projected increase is 30% over 10 years.

Figure 1: Population Projections for those aged < 18 years in Thurrock, 2016-2026



Source: ONS

Against this population increase, the prevalence estimates for young people's substance misuse are notoriously difficult to determine, meaning we cannot say with certainty what the actual level of treatment need is across our young person's population. However, in 2014/15 the What About Youth (WAY) Survey was launched as part of a government pledge to make improvements to the health of young people. The purpose was to collect robust local level data on a range of topics relating to young people, to help drive an improvement in outcomes. Unfortunately the survey has

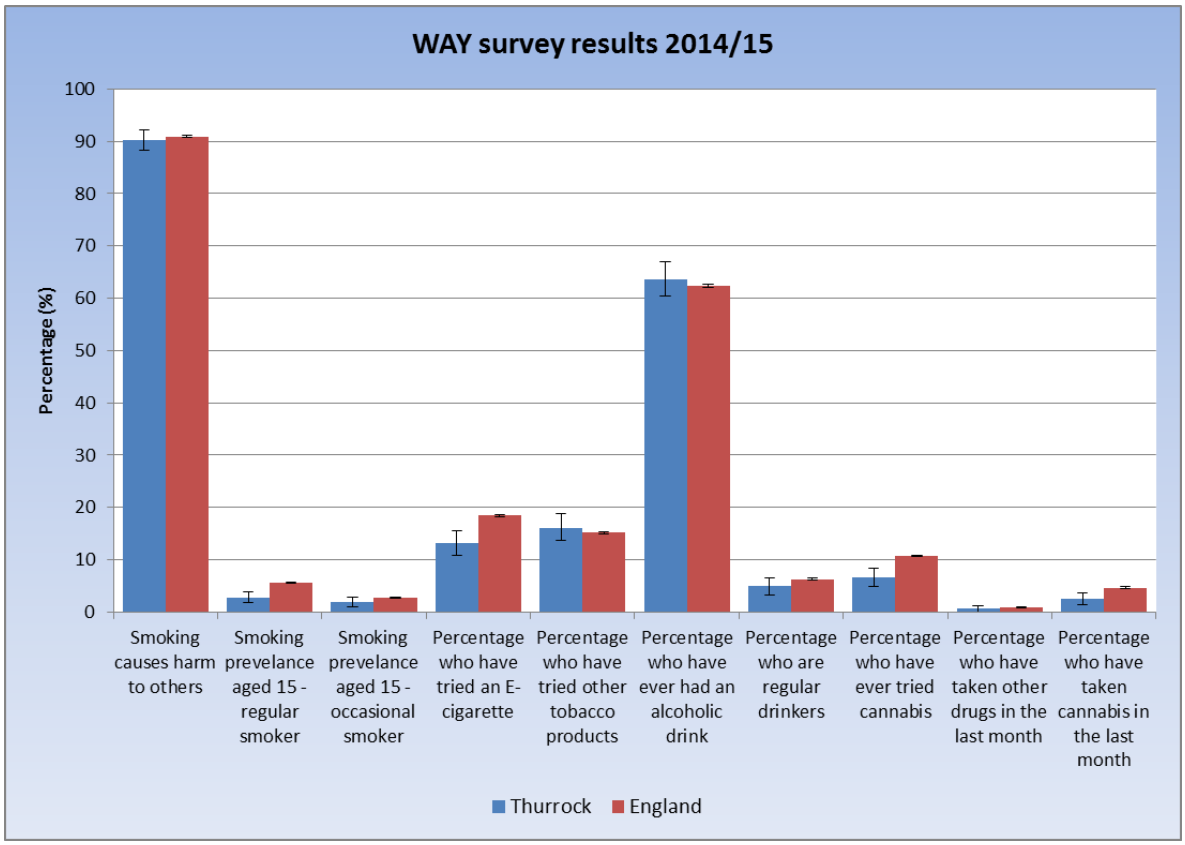
not since been repeated so we cannot compare years or make a trend analysis, although it does provide some useful data on risky behaviours such as tobacco, alcohol and cannabis use.

Around 300,000 15 year olds were randomly selected by the Department of Education and were invited to complete the questionnaire, with around 120,000 completed questionnaires being returned. For Thurrock this equated to 608 questionnaires. Some of the questions asked were regarding substance use and asked for their opinions about this topic.

90% of those who answered the survey in Thurrock felt that smoking caused harm to others, which was a similar percentage to England overall. From the survey 2.3% classed themselves as regular smokers and 1.9% as occasional smokers. Interestingly, the proportion of regular smokers in Thurrock is significantly below the England average. Regarding e-cigarettes, 13.2% of respondents in Thurrock said they had tried one (also significantly below the England average) and 16.1% had tried 'other tobacco products'.

Regarding substance misuse, 63.6% of young people in Thurrock said they had tried an alcoholic drink. Nationally the figure was 62.4%. Almost 5% in Thurrock classed themselves as regular drinkers. Regarding cannabis, 6.6% of young people living in Thurrock said they had tried cannabis with 2.5% having taken it within the last month. This data is summarised in the following figure.

Figure 2: WAY Survey results, Thurrock, 2014/15



Source: Fingertips

The findings from the WAY survey broadly match those from the Smoking, Drinking and Drugs (SDD) surveys. In addition the Brighter Futures survey was commissioned by Thurrock Council to improve local data related to the emotional health and well-being of children and young people. The

intention of this supplementary data source is to improve local knowledge, contribute to local priorities and strategies and improve the provision of needs-led services to children, young people and families. Questions covered a range of risky behaviours and asked approximately 1,000 young people about their level of engagement in them.

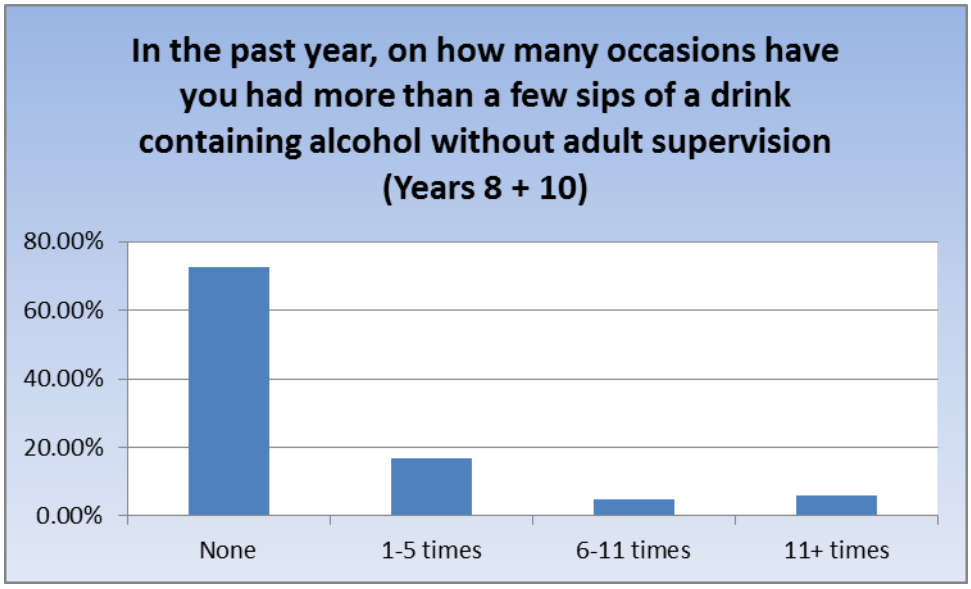
There are limitations to this data. Firstly, the sample size is relatively small and it is based on a single survey, so we recognise that it provides just a snapshot of young people's experiences. The reliability of the responses remains to be proven. Some respondents will have exaggerated their substance misuse, whereas others who were cautious as to the confidentiality of the survey may have minimised or denied any substance misuse. In a sample size of approximately 1,000 pupils we expect this 'noise' within the data to have cancelled itself out. The survey will be repeated annually so the pool of data and our confidence in its accuracy will increase in future years. Until then, the key areas of interest from the inaugural survey are set out below.

Figure 3: Brighter Futures Survey - How many times have you tried alcohol without an adult being around (year 6 in Thurrock)

Source: Brighter Futures survey 2016/17

The figure above illustrates that just over 10% of Year 6 pupils surveyed said they had tried alcohol without an adult being around.

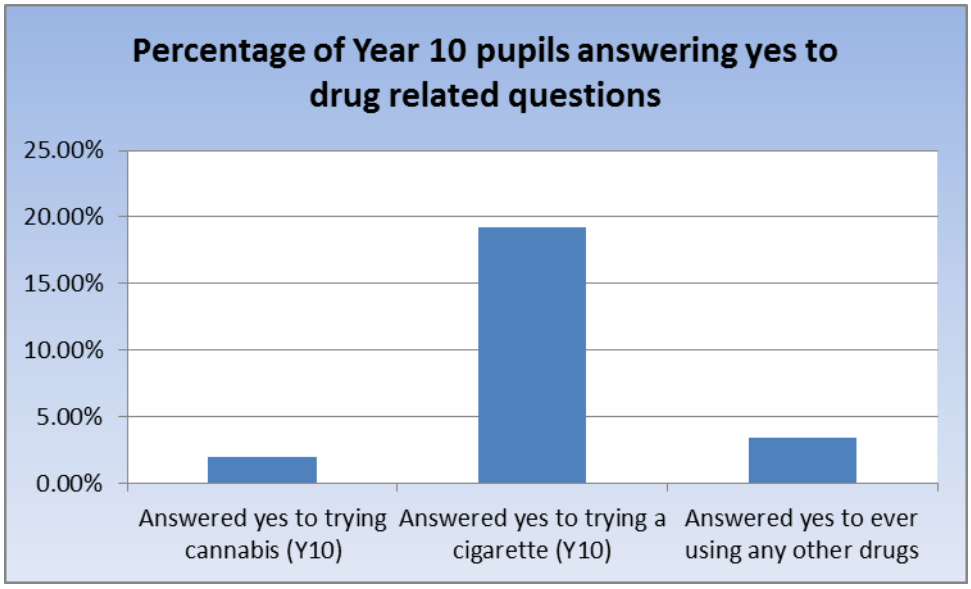
Figure 4: Brighter Futures Survey - In the past year, on how many occasions have you had more than a few sips of a drink containing alcohol without adult supervision (Years 8+10 in Thurrock)



Source: Brighter Futures survey 2016/17

Just over 16% of year 8 and 10 pupils surveyed said they have had 'more than a few sips' of a drink containing alcohol without adult supervision on at least one occasion in the past year, although over 70% had not.

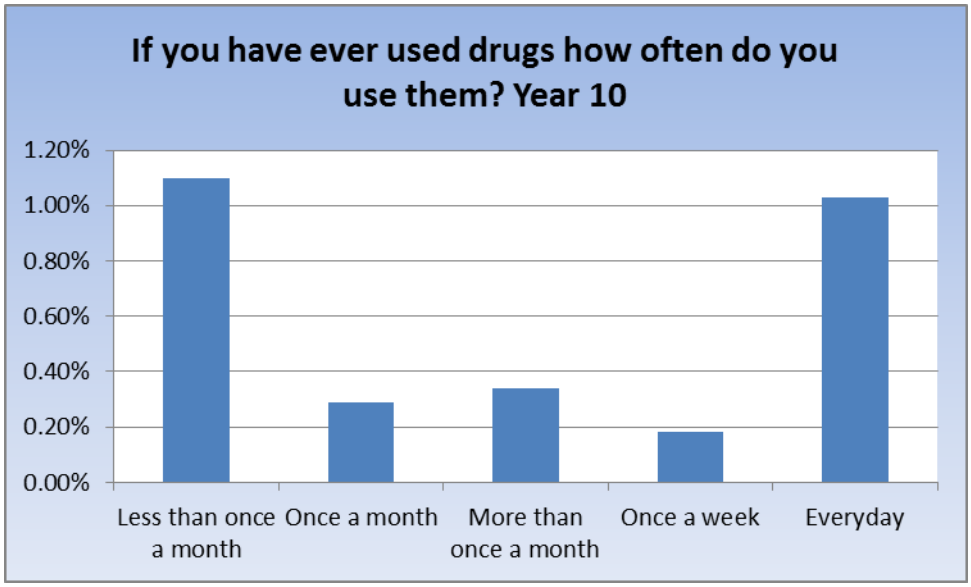
Figure 5: Brighter Futures Survey - percentage of year 10 pupils in Thurrock answering yes to drug related questions - have you tried, cannabis, tobacco or using any other drugs?



Source: Brighter Futures survey 2016/17

Almost 2% of year 10 pupils surveyed answered 'yes' to having tried cannabis, 19.2% had tried a cigarette and 3.38% had tried other types of drugs.

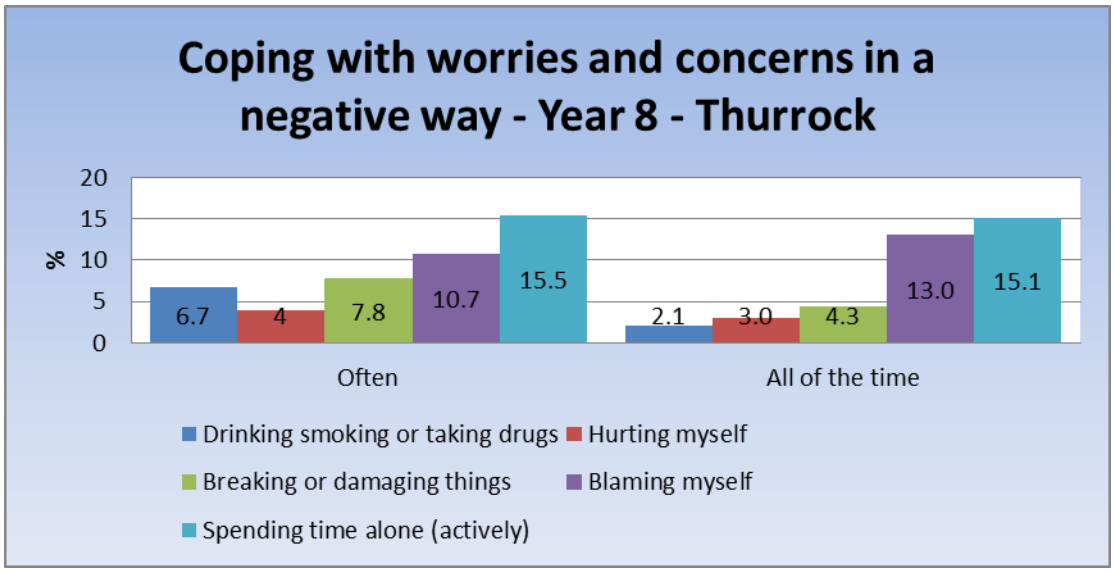
Figure 6: Brighter Futures Survey - If you have ever used drugs, how often do you use them (Year 10), Thurrock



Source: Brighter Futures survey 2016/17

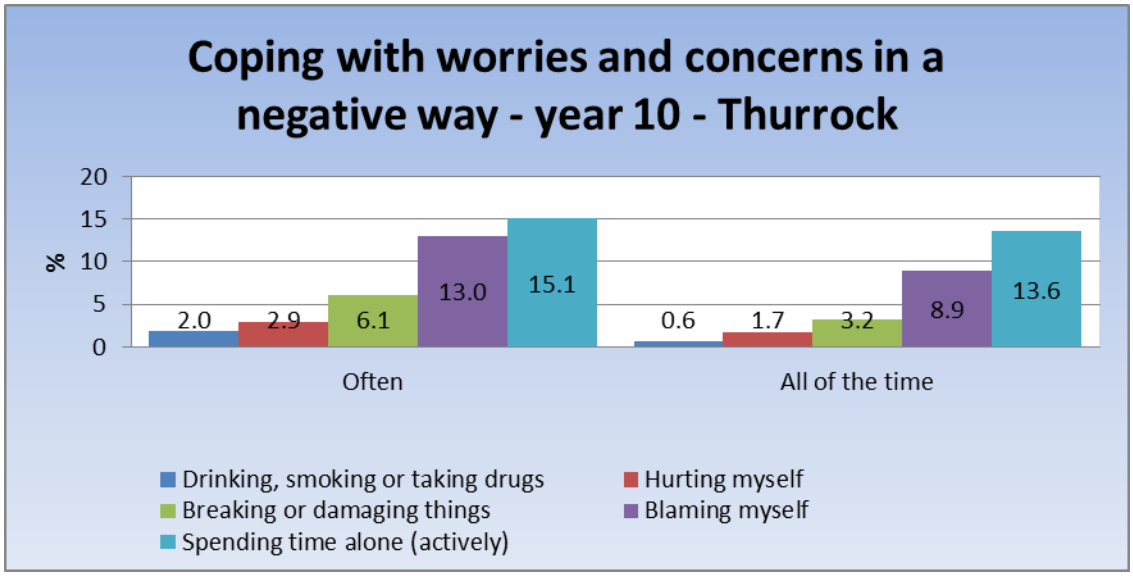
As highlighted in the figure above, just over 1% of year 10 pupils surveyed answered that they used drugs every day.

Figure 7: Brighter Futures Survey - Coping with worries and concerns in a negative way (Year 8), Thurrock



Source: Brighter Futures survey 2016/17

Figure 8: Brighter Futures Survey - Coping with worries and concerns in a negative way (Year 10), Thurrock

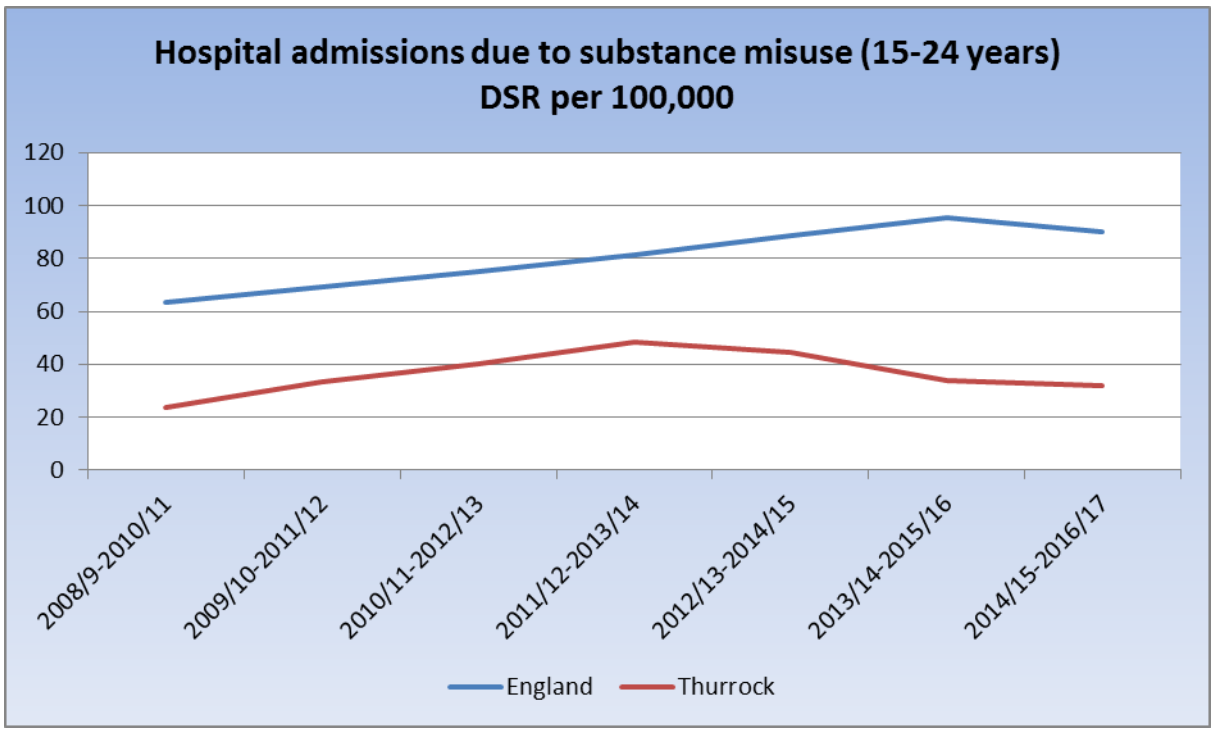


Source: Brighter Futures survey 2016/17

The survey recorded that 6.7% of Year 8 pupils surveyed coped with worries and concerns by drinking, smoking or taking drugs often and that 2.1% did it all the time. For year 10 this was 2.0% and 0.6% respectively, which is a downward trend but could be confounded by the lower rate of survey completion in year 10 compared with year 8 pupils. Moreover, a slightly higher percentage of year 10's said they drank, smoked or took drugs none of the time (89%), rarely (5%) or some of the time (4%) compared to year 8's that were 88%, 3% and 3% across the same questions. This shows that more year 10's never drink, smoke or take drugs, or if they do they are more likely to do it rarely or some of the time.

With regards to A&E/hospital attendances due to substance misuse, overall Thurrock has lower levels of admissions than England. The rate was increasing between 2008/9-2010/11 and 2011/12-2013/14 but has been reducing over the more recent few years. However, the level in 2014/15-2016/17 is still higher than that of 2008/09-2010/11. A recording issue at the nearest A&E department was attributed to the drop in the Thurrock rate from 2011/12-2013/14. Once rectified we saw the rate of decline reduce. Quite why the Thurrock rate is so far below the national average remains to be fully understood. The data largely refers to alcohol misuse and the nearest A&E departments are out of borough. There is a possibility that due to accessibility Thurrock young people simply do not present to A&E for alcohol related illness or injury compared to their national counterparts, that the local ambulance service and nearest A&E departments provide effective treatment that prevents hospital admissions in this group or that it is simply not accurately recognised that alcohol/drugs is the main cause for the hospital admission.

Figure 9: Hospital Admissions due to Substance Misuse (15-24 years), DSR per 100,000 Thurrock 2008-2017

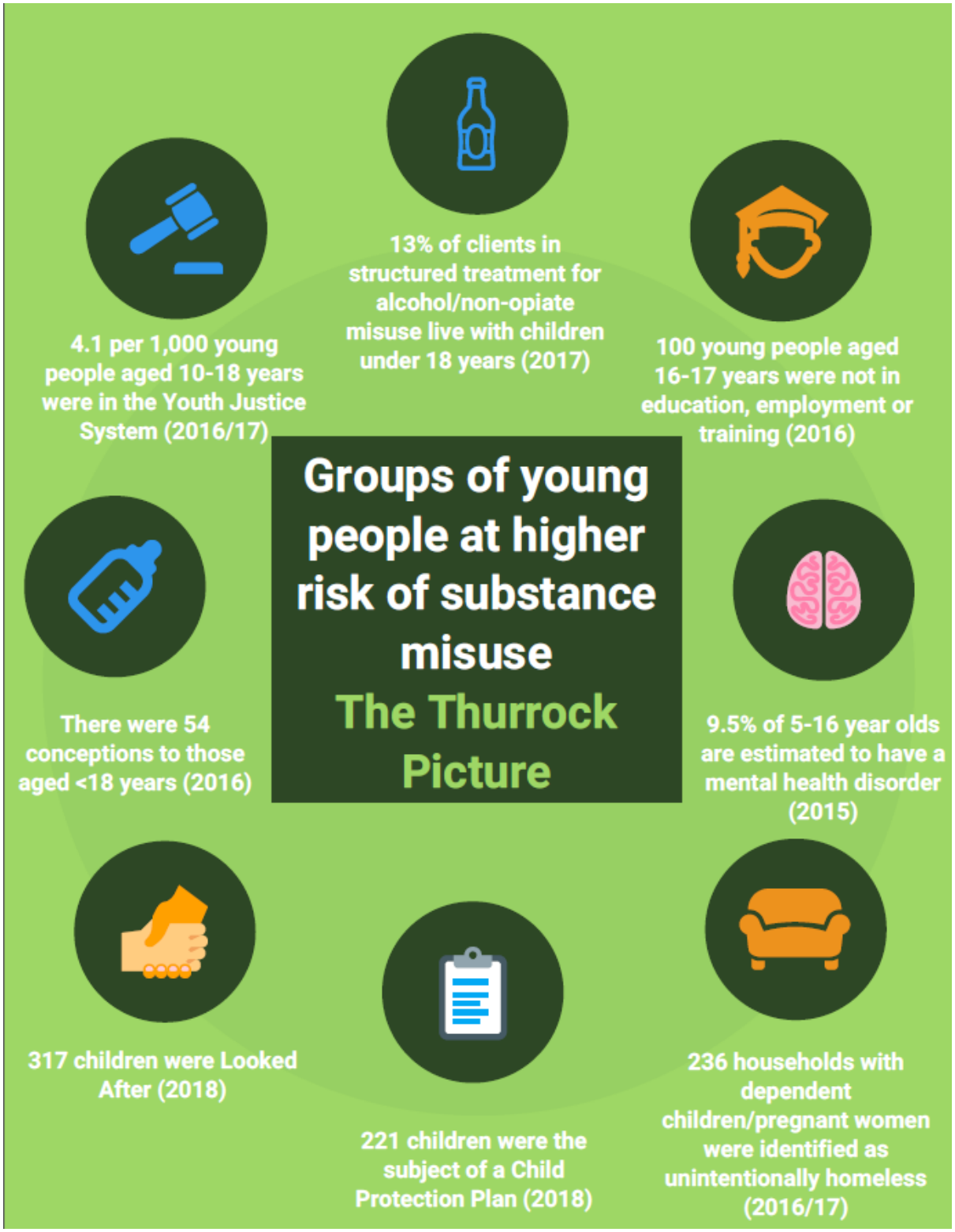


Source: Fingertips

3.2 Description of the treatment population

The following infographic provides a picture of the groups of Thurrock young people at higher risk of substance misuse.

Figure 10: Groups of Young People at Higher Risk of Substance Abuse: The Thurrock Picture



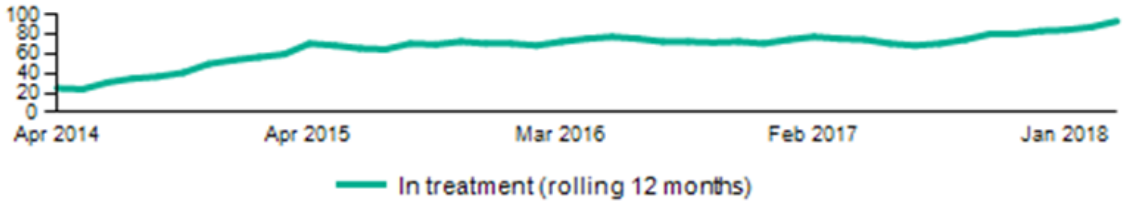
Source: NDTMS 2017/18, PHE Fingertips

What do we know?

Entering Treatment

As of March 2018 the young person's substance misuse service had 94 people in treatment. This is rolling data and the below graph illustrates the steady rise in treatment numbers across the last 5 years, which matches the lifetime of the expiring contract.

Figure 11: Number of young people accessing treatment in Thurrock, 2014-2018



Source: NDTMS

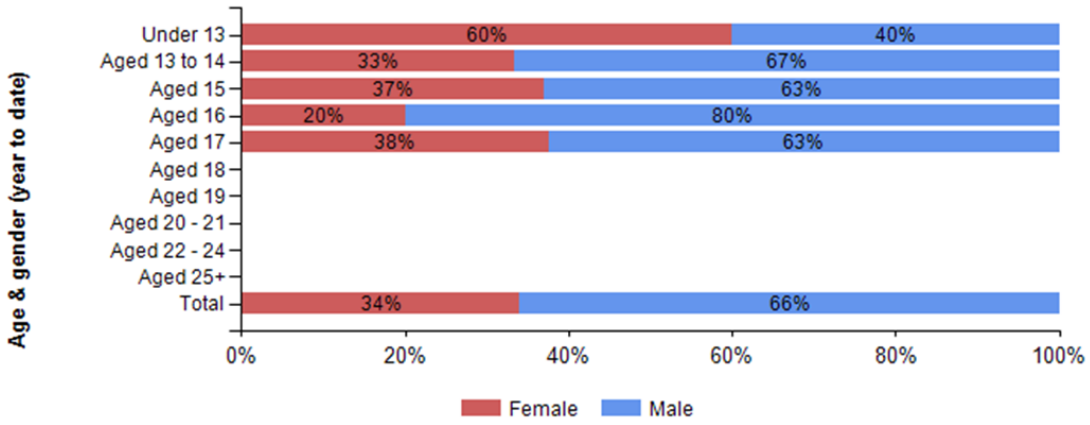
The numbers in treatment were unusually low in April 2014 due to the transfer of cases from the outgoing provider, particularly as the client group are naturally sensitive to change. Added to this is the requirement for clients to be closed to the outgoing provider and opened as new clients to the incoming provider and we find some clients disengaged from treatment for a while until reassurance spread across the treatment community.

The service works with those young people aged up to 18 years of age. Some similar services elsewhere also work with vulnerable adults up to the age of 25. For Thurrock, the adult and young person contracts have agreements built in to allow for transfer of such clients by exception.

In Thurrock, there were 94 new entrants to treatment services in 2017/18 and the below graph illustrates the gender split of those in treatment. The very young clients tend to be majority female, accessing hidden harm support. As age increases we see a sudden shift towards males being the majority group in treatment. Age of initiation is often the strongest predictor of the length and severity of substance misuse problems – the younger the age that young people start to use, the greater the likelihood of them becoming adult problematic drug users. (It is noted that this does not necessarily indicate the age of initiation). This underpins the findings from Young Addaction[16], as noted in the Introduction in this report.

[16] Young Addaction. (2015). Young People and Substance Abuse. http://www.youngpeopleshealth.org.uk/wp-content/uploads/2016/06/Young-People-and-Substance-Misuse-Report.pdf (Accessed June 2018).

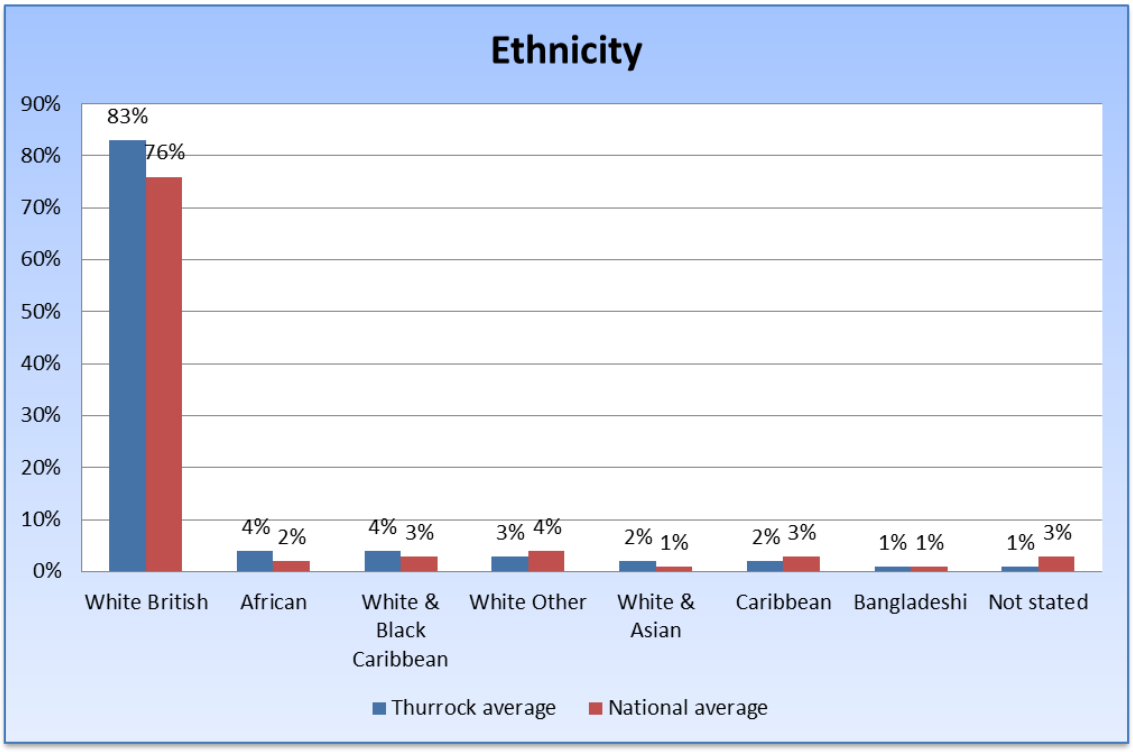
Figure 12: The age of young people entering treatment services in Thurrock in 2017/18



Source: NDTMS

In terms of ethnicity, those in treatment were predominantly White British, with six ethnic minority groups making up the remaining client groups. This was not dissimilar to the national average, where the unaccounted 7% was split equally across 7 other ethnic minority groups. The service receives referrals from numerous agencies and partners, including self-referral. The percentages here are unlikely to be a reflection of the true substance misuse levels within these ethnic groups and accurately determining the prevalence estimates across these groups is not currently possible. What we can see is that the service works with twice as many African and 25% more White & Black Caribbean young people than the national average.

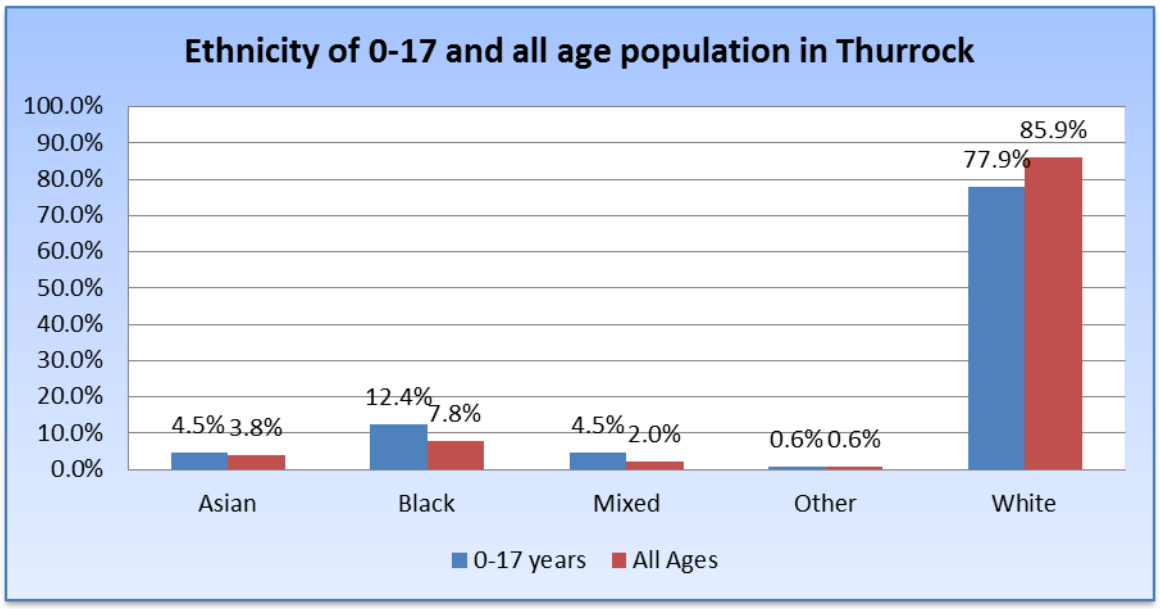
Figure 13: Ethnicity of young people accessing treatment in Thurrock, 2017/18



Source: NDTMS

Our child population in Thurrock is more ethnically diverse than the all age population. The figure below compares the ethnicity of the local population aged 0-17 years with the ethnicity of the total Thurrock population. From this, it can be seen that there is a lower proportion of White residents in the 0-17 population and a higher proportion of Asian, Black and Mixed ethnic groups, which tells us that the local service is identifying and working proportionately across these ethnic groups.

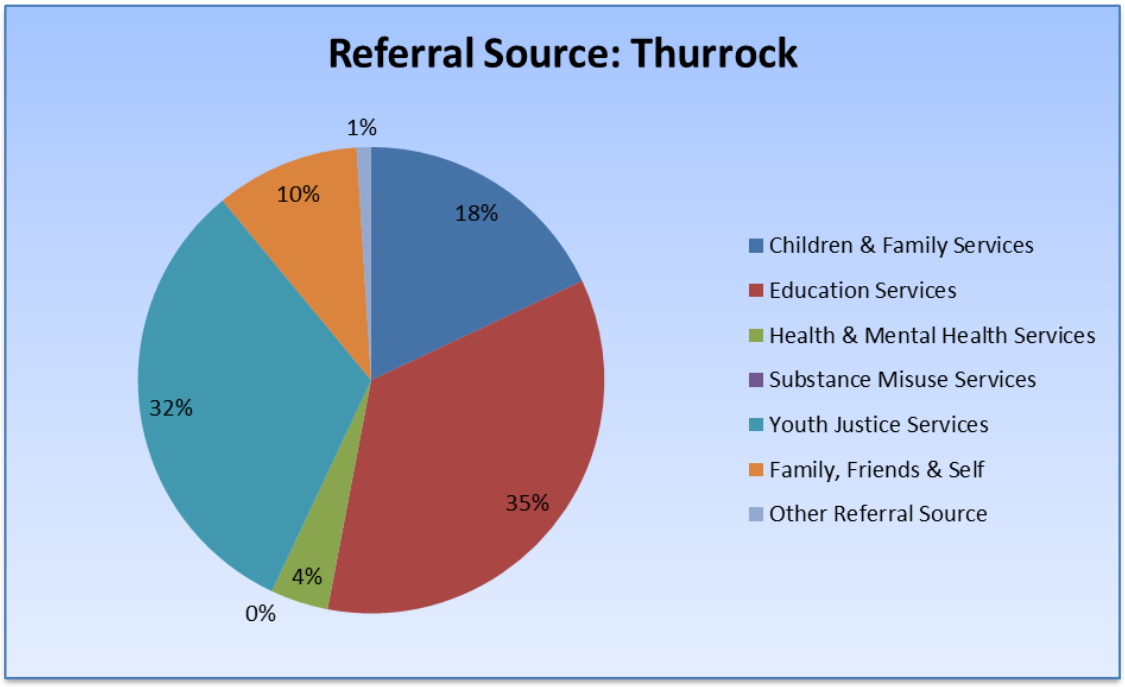
Figure 14: Ethnicity of 0-17 year and all age population in Thurrock



Source: Child and Maternal Health Intelligence Network

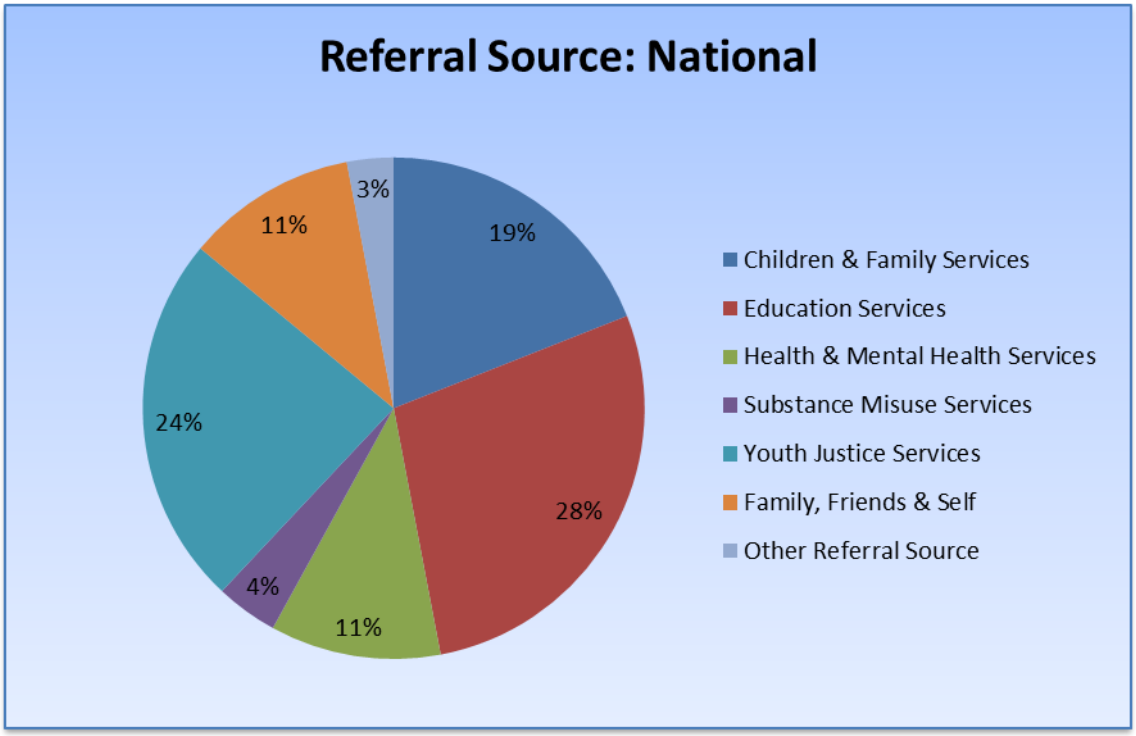
Referrals to the service come from a range of sources, illustrated by the below pie chart. The vast majority have come from Education and Youth Justice Services, demonstrating effective referral pathways and partnership working. Thurrock is above the national average against these two referral sources, considerably so with regards to Youth Justice Services. Children's Services is also a popular referral source, followed by Friends, Family or Self-referral, both of which are in line with the national averages. Just 4% of Thurrock referrals came from Health & Mental Health Services compared to 11% nationally and should be an area of future focus.

Figure 15: Referral Source for young people accessing treatment in Thurrock, 2017/18



Source: NDTMS

Figure 16: Referral Source for young people accessing services, nationally, 2017/18

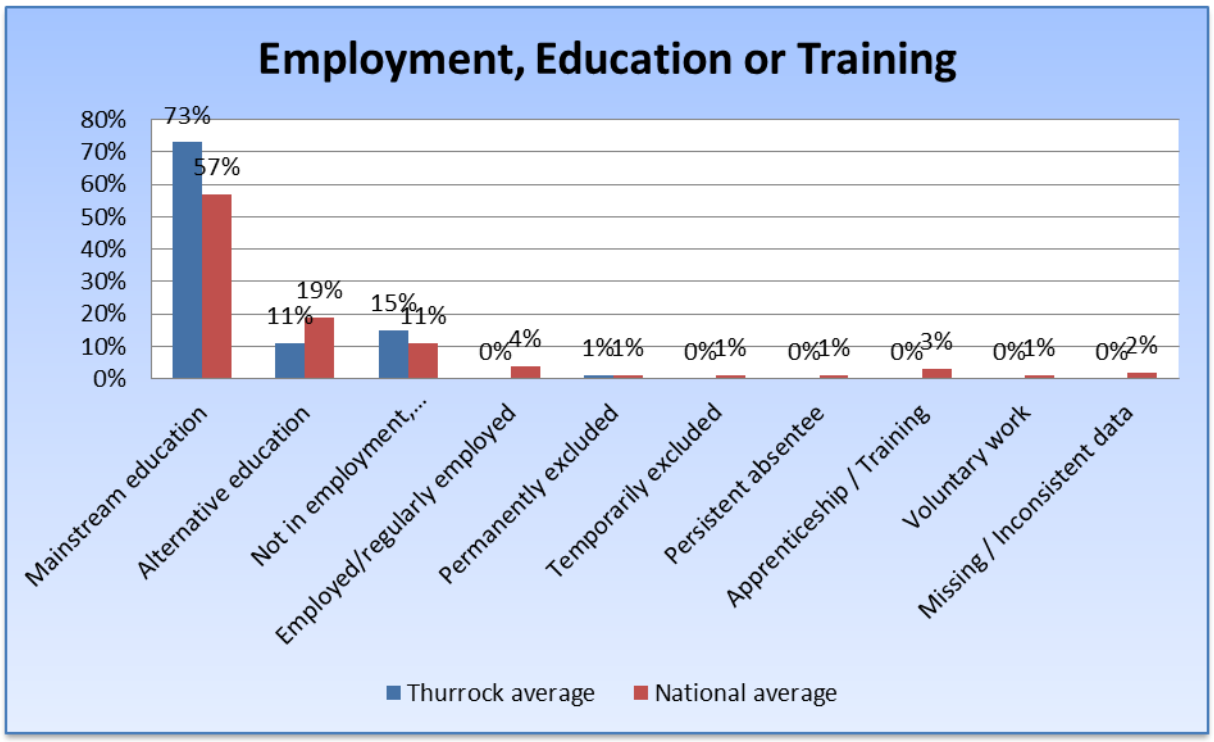


Source: NDTMS

In terms of education, employment or training, the majority of young people in treatment were in mainstream education, a figure that was above the national average. The next largest group for Thurrock were those not in employment, education or training (NEET), closely followed by those in

an alternative education programme such as the Pupil Referral Unit (PRU). These figures were similar to the national average. The remaining group was formed of individuals who were permanently excluded. No young people were recorded as being in full time or regular employment; the national average being 4%. Nationally, the unaccounted 8% was shared across the bottom 5 groups in the below graph.

Figure 17: Young People who are in treatment who remain in employment, education or training in Thurrock, 2017/18

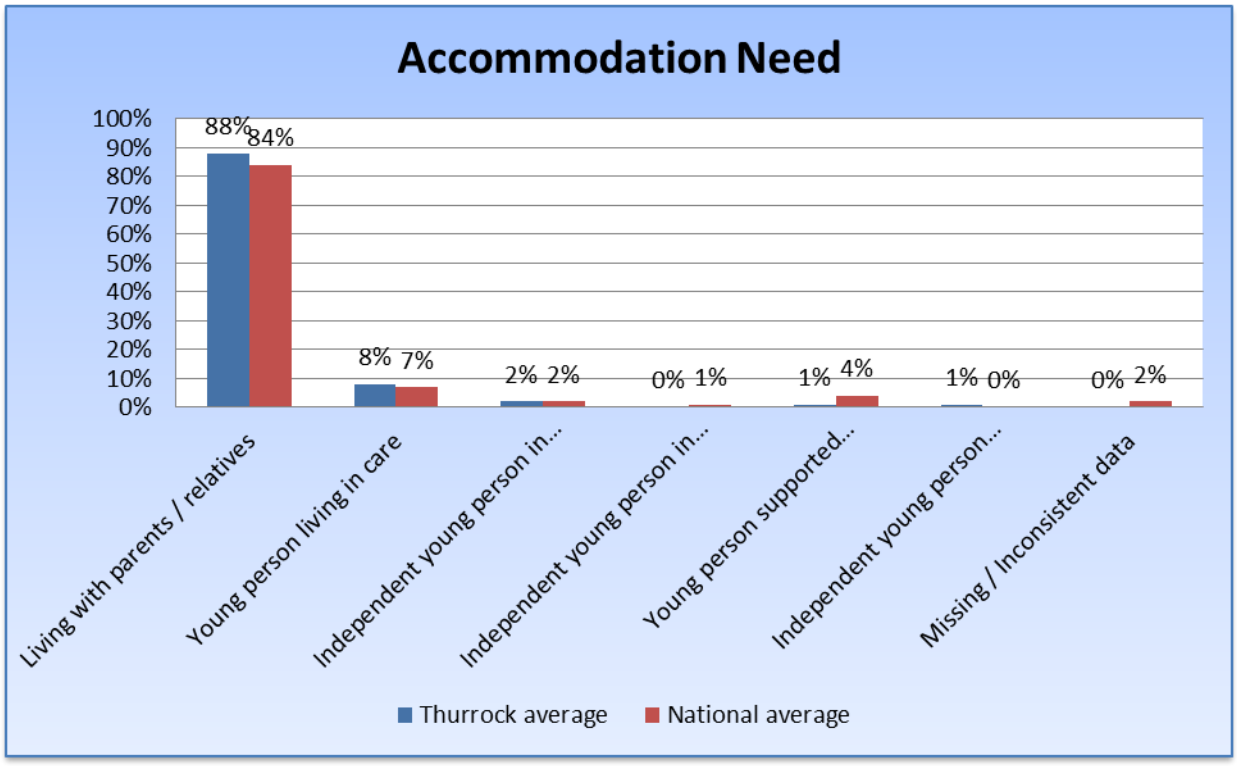


Source: NDTMS

We can see from the above graph that in Thurrock we are better than the national average at engaging with young people who require substance misuse interventions that are in mainstream education, thus preventing the escalation of wider vulnerabilities that are set out below.

The vast majority of young people in treatment in Thurrock live with their parents or relatives, with the remainder split across living in care, independent accommodation or supported housing. This broadly matches the national averages for such a client group. The no fixed abode category refers to those clients who 'sofa surf' and rotate usually between a core group of friends' addresses as opposed to being street homeless.

Figure 18: Accommodation need of young people accessing treatment in Thurrock 2017/18



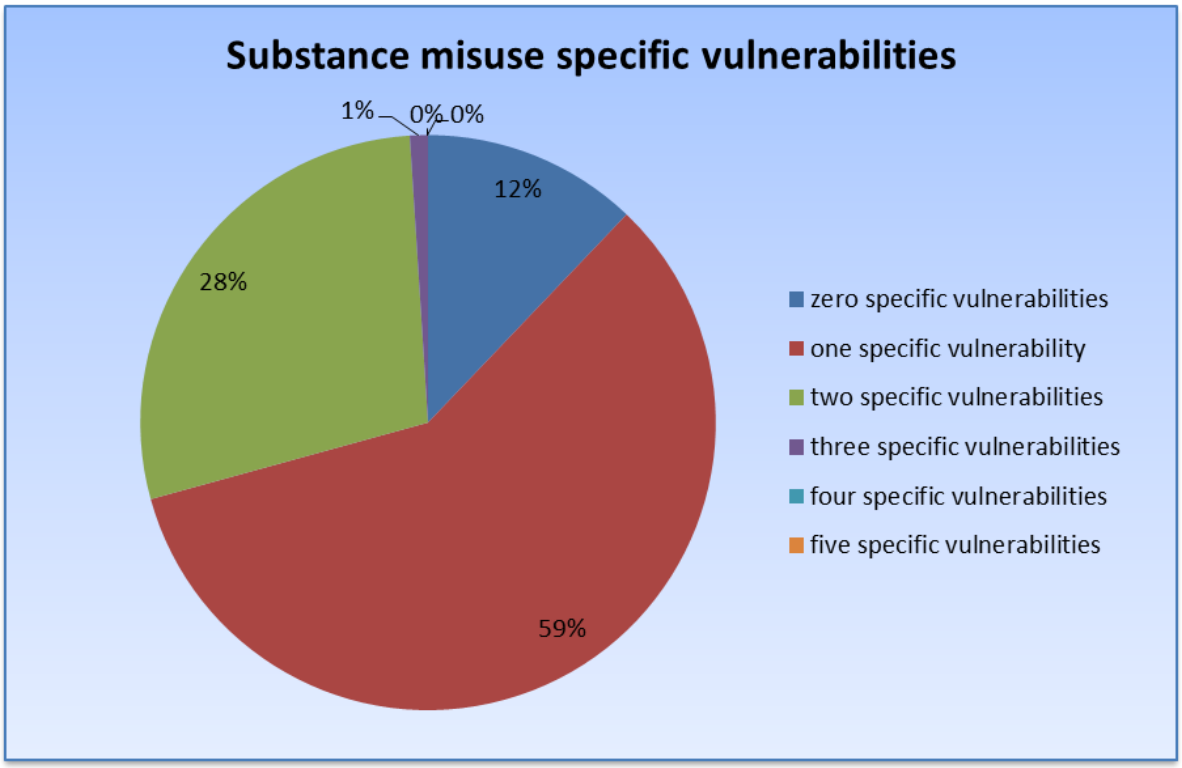
Source: NDTMS

Substance misuse specific vulnerabilities are categorised in 5 groups:

1. Early onset of usage (young age when misuse begins)
2. Poly-drug user (more than one problematic substance misused)
3. High risk alcohol user
4. Opiate or crack user
5. Injecting

The following pie chart illustrates these groups; it should be noted that Thurrock has no opiate or crack users or injecting young people in treatment (groups 4 and 5). Therefore the segments in the following pie chart refer to clients who have either no specific vulnerabilities or have up to three specific vulnerabilities from groups 1-3 above.

Figure 19: Number of substance misuse specific vulnerabilities experienced by young people in Thurrock, 2017/18



Source: NDTMS

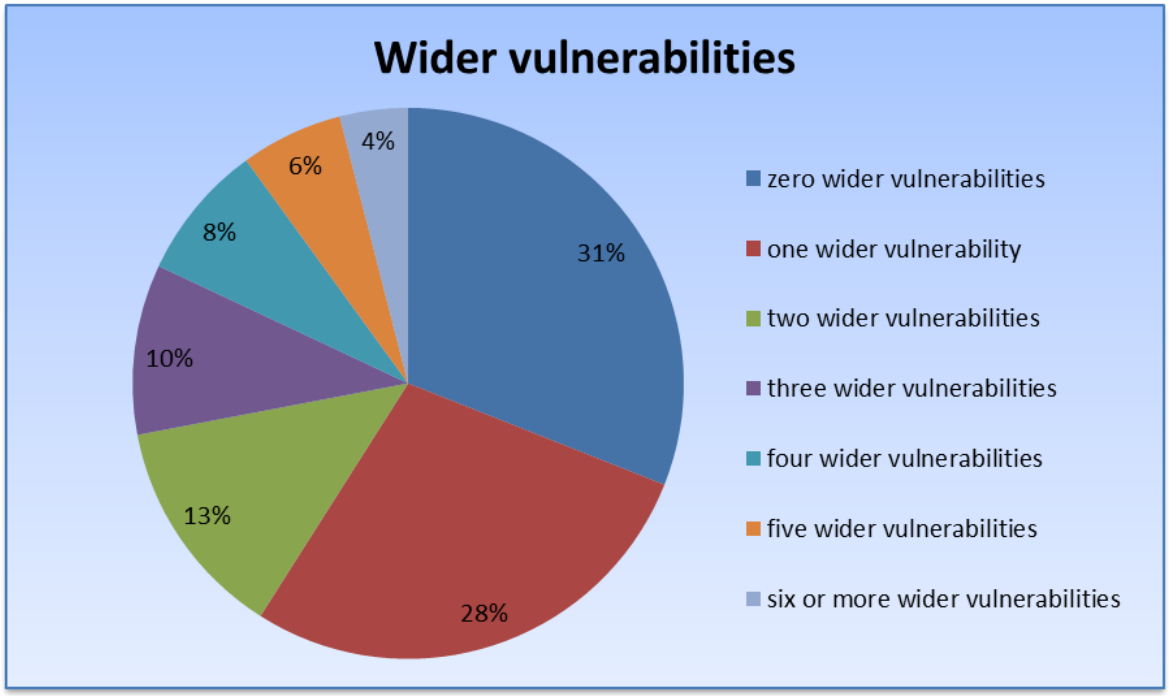
Wider vulnerabilities form a larger list of twelve categories:

1. Looked After Child
2. Child In Need
3. Domestic Abuse
4. Mental Health problem
5. Sexual exploitation
6. Self-harm
7. Not in Employment, Education or Training (NEET)
8. Housing problems
9. Parental status / pregnant
10. Child Protection Plan
11. Anti-social behaviour / criminal act
12. Affected by others' substance misuse.

The following pie chart illustrates the complexities of the client group in Thurrock, with roughly a third of clients having no wider vulnerabilities from the above list, a third having one or two wider vulnerabilities and the remaining third of clients having three to six or more vulnerabilities. By definition, those clients scoring three or more wider vulnerabilities will be very complex cases with multi-agency action plans; high users of services. These clients are more likely to demonstrate offending behaviour, poor school attendance or attainment and suffer socio-economic disadvantages, which might include living in a deprived part of the borough or have parents/carers who are unemployed and who may have a substance misuse need of their own. They are likely to

utilise more keyworker time and spend longer in treatment compared to clients with fewer wider vulnerabilities.

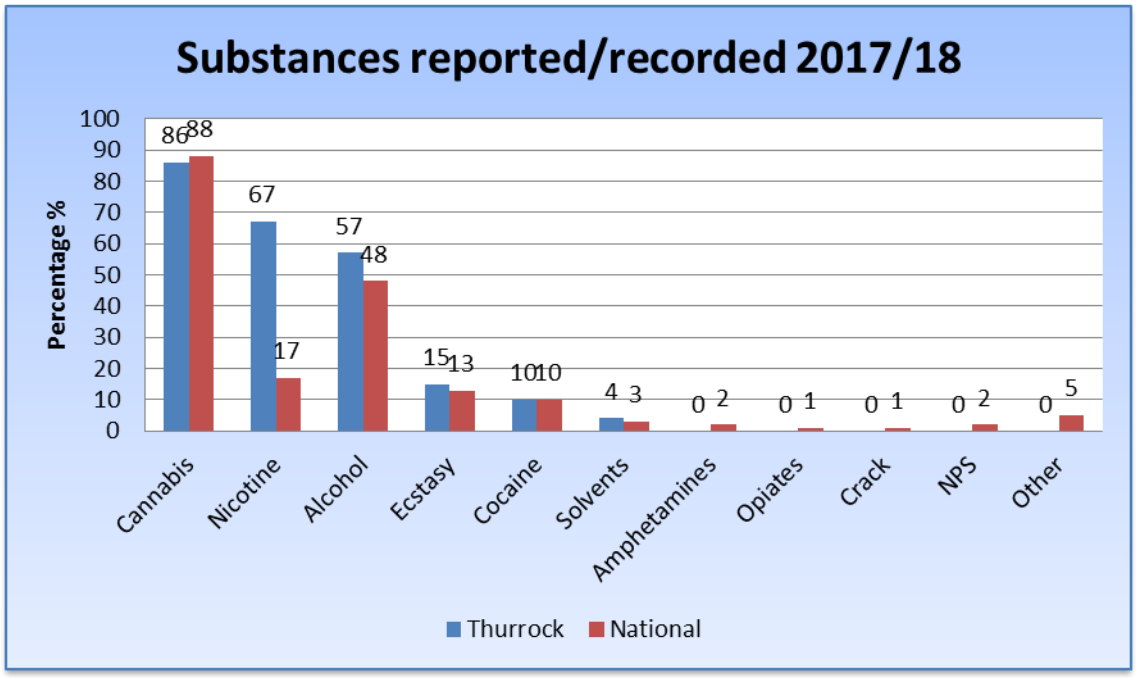
Figure 20: Number of wider vulnerabilities experienced by young people accessing treatment in Thurrock, 2017/18



Source: NDTMS

The main type of substance misuse service offered in Thurrock in 2017/18 was for cannabis, followed by alcohol. When compared to the national average, Thurrock was broadly in line with the national data, although it can be noted that no young people were in treatment for opiate or crack misuse. The main anomaly is the data for nicotine. Thurrock's data has stood out in the national figures for the last 5 years when we implemented stop smoking referrals into the treatment offer; by definition cannabis misuse will almost always involve some level of tobacco smoking. Cocaine and ecstasy are not common drugs cited by young people in treatment, and the level of misuse in Thurrock is in line with the national picture.

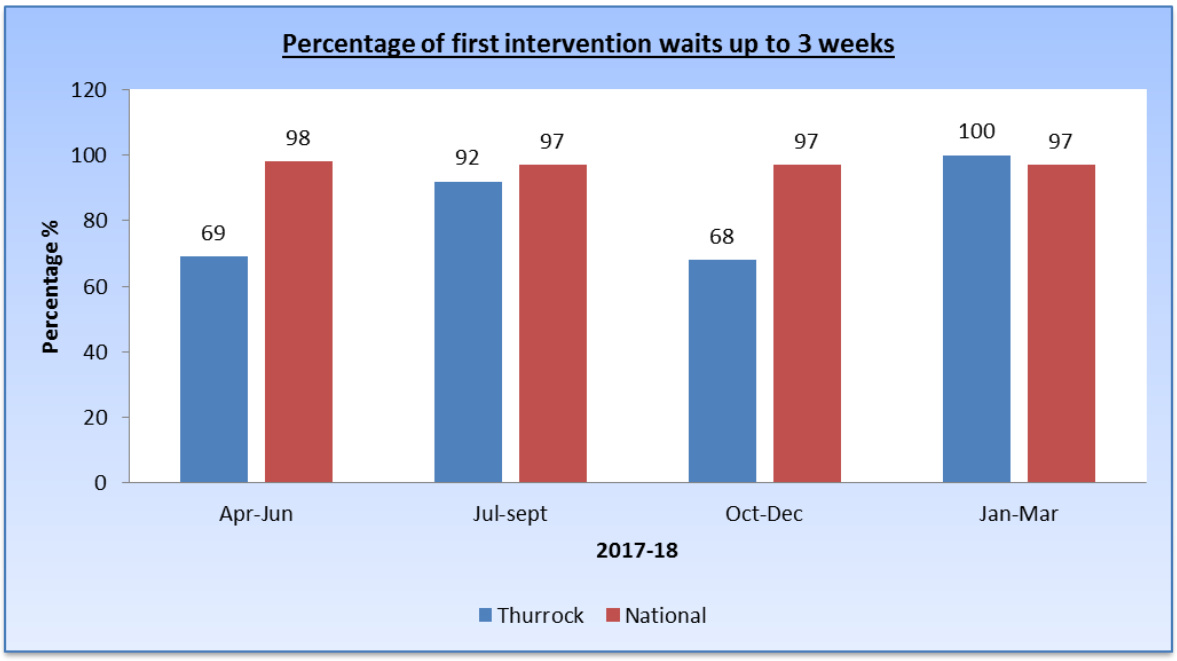
Figure 21: Young people entering treatment services in 2017/18 in Thurrock and England by substance type



Source: NDTMS. Technical Notes: Figures are of YP in specialist substance misuse community services 2017/18. Substances cited are from any episode for the young person in the year (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%

Waiting times

Figure 22: Percentage of first intervention waits of up to 3 weeks, 2017/18 (Thurrock and nationally)



Source: NDTMS

The graph above shows that the waiting time for Children and Young people in Thurrock to be seen by the service is worse than the national average for the first 9 months of 2017-18 but slightly better

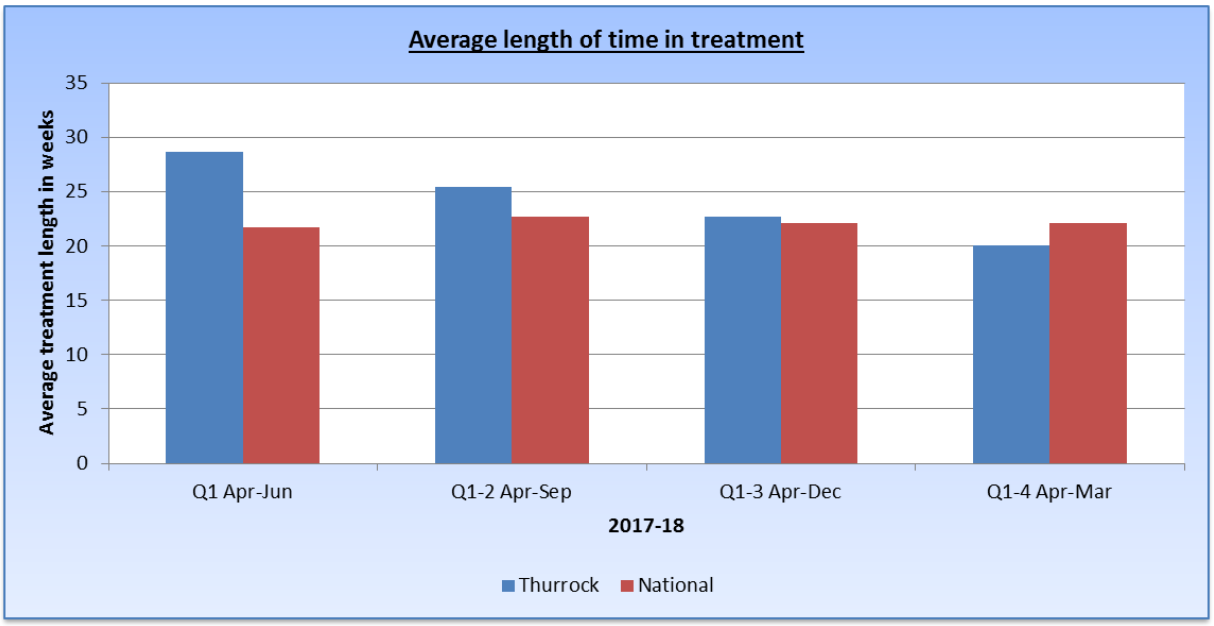
for quarter 4, with 100% being seen within 3 weeks; demonstrating that young people no longer have to wait lengthy periods between assessment and the start of their treatment. It also signifies that the longer waiting times observed at the start of 2017/18 has been reduced. Consequently it is proposed that this should continue to be monitored by the new for Thurrock.

In Treatment

The graph below outlines the average length of time that young people were in treatment services in Thurrock in 2017/18. Young people generally spend less time in specialist interventions than adults because their substance misuse is not entrenched; however those with complex care needs often require support for longer.

The data below shows that the average length of time in treatment for Thurrock young people is slightly less than the national average when looking at the Q1-4 Apr-Mar columns. This tells us that more clients are in treatment for shorter periods of time, and fewer clients are in treatment for lengthy periods, suggesting good engagement by young people or effective treatment delivery by the provider.

Figure 23: Average length of time in treatment, 2017/18 (Thurrock and nationally)

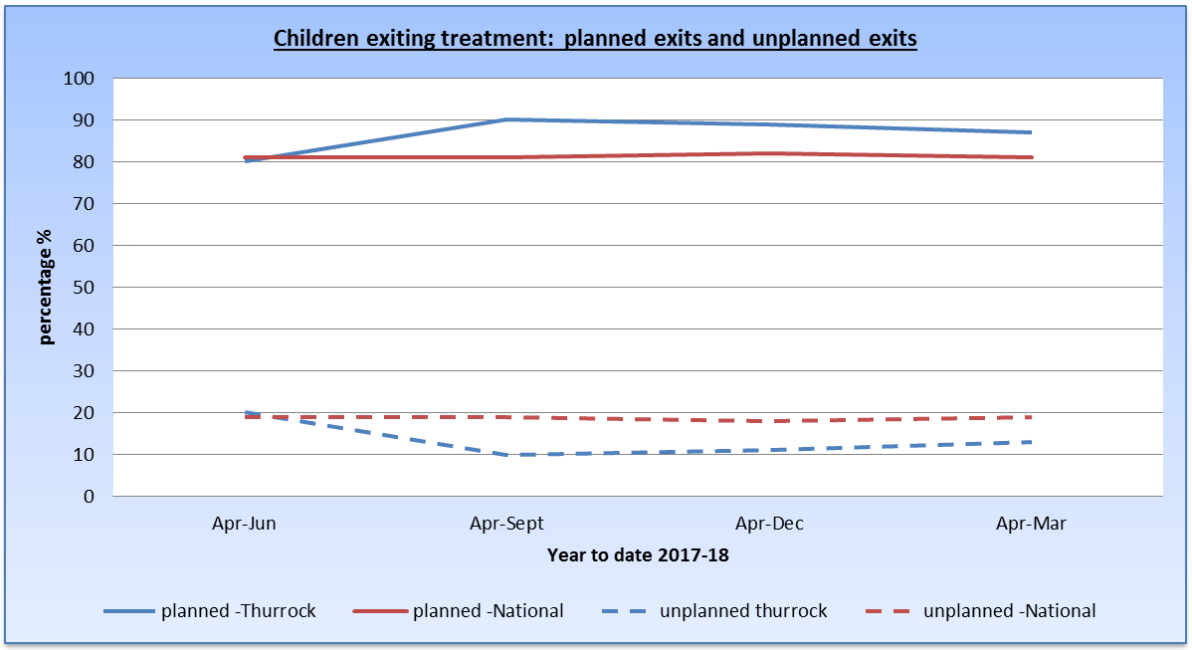


Source: NDTMS

The graph below shows that there are a higher percentage of planned exits in Thurrock young people comparing with nationally and less unplanned exits than national data shows. This suggests that although children are staying in treatment on average slightly longer, they are doing so appropriately and in a planned way. The fact that there have been no re-presentations to the service from last year (at the time of writing this document) supports this interpretation and reflects the quality of interventions delivered. Re-presentations are clients who re-present for treatment within 6-monthsd of treatment exit. Given the high satisfaction with the service based on both the annual service reviews which include analysis of feedback questionnaires and the service user engagement for this report, we can expect clients to want to re-present if the need were to arise,

whereas poor service user satisfaction would logically cause clients to not re-present, thus artificially inflating the re-presentation rate performance.

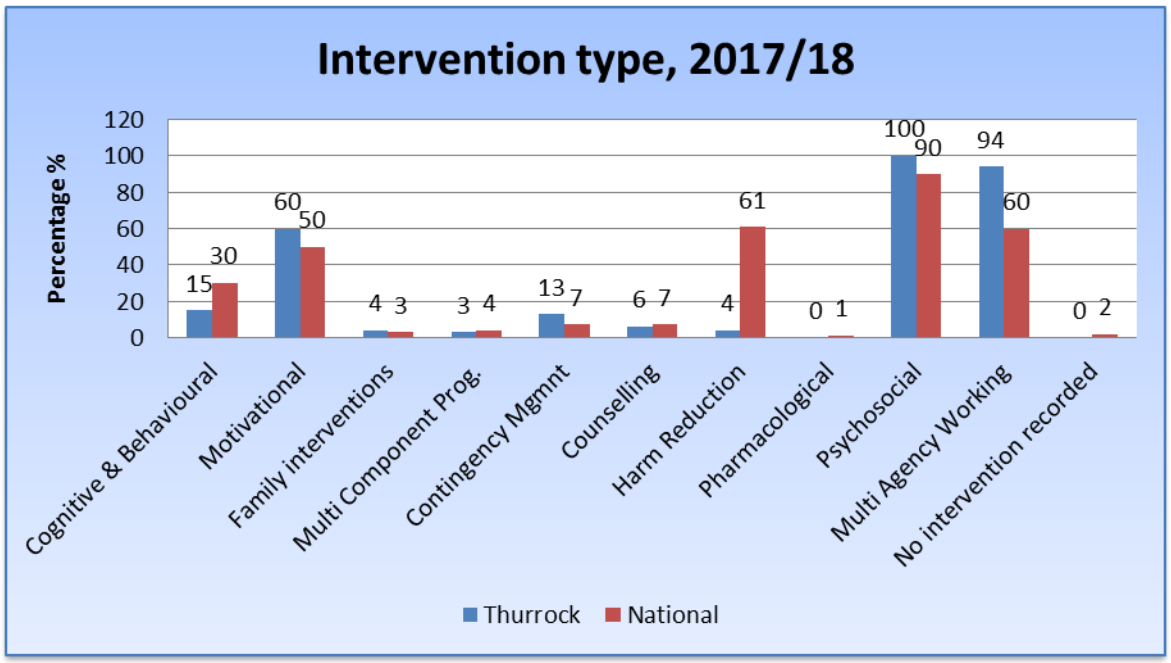
Figure 24: Children exiting treatment, planned exits and unplanned exits, 2017/18 (Thurrock and nationally)



Source: NDTMS

Young people have better outcomes when they receive a range of interventions as part of their personalised package of care. The figure below outlines the percentage of young people accessing different types of interventions in Thurrock and England. The majority of young people in Thurrock access psychosocial interventions followed by motivational interventions, whereas nationally more young people accessed harm reduction interventions as the second most common intervention. For Thurrock, cognitive and behavioural interventions were half the national level. However, almost all intervention types for Thurrock included multi-agency working, a level far higher than the national average and which demonstrates both the complexities of the local caseload and our excellent partnership working – something we expect the new service to incorporate and continue.

Figure 25: Types of substance misuse interventions accessed by young people in Thurrock and England, 2017/18



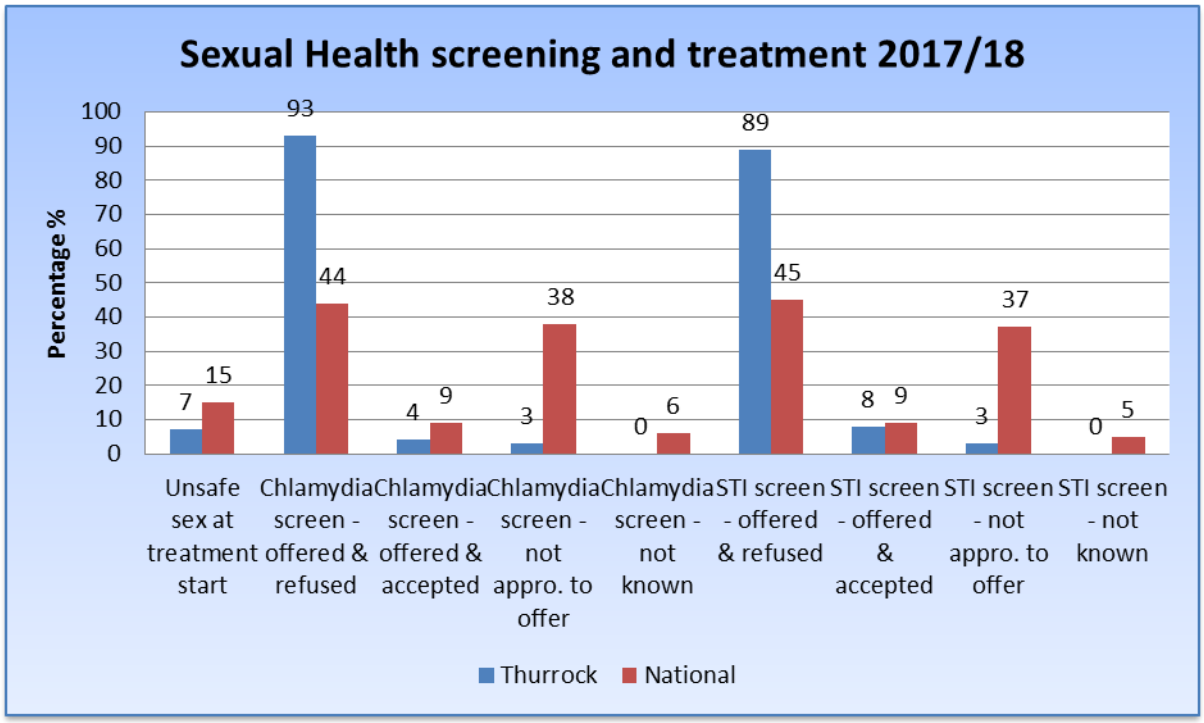
Source: NDTMS. Technical Notes: Overview of intervention figures are out of YP accessing specialist substance misuse services in the year to date period. Each individual is only reported once against each intervention type. † An individual may have received more than one intervention type so percentages may sum to more than 100%. Multi Agency Working figures are out of all young people receiving structured specialist treatment only.

The vast majority of interventions are delivered in the community (99%) which typically refers to schools or colleges. The remaining 1% of interventions are delivered in the home. This broadly reflects the national picture, which is 97% and 3% respectively.

Young people in treatment are, where appropriate, screened and referred for treatment for chlamydia and sexually transmitted infections (STIs). Thurrock young people report half the level of unsafe sex at treatment start compared to the national average. What we can see from the below figure is that the offered and refused percentage for chlamydia and STIs is twice that of the national average and we should better understand why the level of acceptance of sexual health treatment is so low. Against this, we can see that in over a third of cases it is not appropriate to offer chlamydia or STI treatment, which is significantly higher than the national average of just 3%. We know that in Thurrock much of the hidden harm casework is with children under the age of 13, hence why it is recorded in this way; unless a disclosure is made by the young person it would not be appropriate to offer such a young client a sexual health screening.

Offering free and open access to sexual health advice and treatment will help young people make healthy choices regarding their own sexual health. Thurrock's Integrated Sexual Health Service currently offers young people sexual health advice and treatment when needed, which in turn can help to prevent unplanned teenage conceptions.

Figure 26: Sexual Health screening and treatment in 2017/18 (Thurrock and nationally)



Source: NDTMS

3.3 Criminal Justice

The 2016 Children and Young People's Joint Strategic Needs Assessment (JSNA) tells us that young offenders (or those at risk of offending) are a highly marginalised group and often have greater health needs than the non-offending population, experiencing exposure to inequalities in health that persist into adult life, including a higher incidence of physical and mental ill health, sexually-transmitted disease, injuries, and early pregnancy in females.

Youth Offending Teams (YOT)/Services (YOS) consist of professionals from Social Care, Probation, the police as well as Health & Education. They work with young people aged 10-17 who have been either convicted in the Courts or have been made subject to a pre-Court outcome. Interventions can take place in the community or in the secure estate and are designed and implemented to address the risk factors that each young person presents. They also work with the victims of Youth Crime and manage restorative justice processes.

YOS prevention work focuses upon young people aged 8 to 17 years before they enter the criminal justice system but at a time where they are presenting offending or anti-social behaviour.

What do we know?

There were 207 offences committed in Thurrock in 2013/14 that were known to the Youth Offending Team – 174 were committed by males and 33 by females. This is in line with national and adult data. The most common type of offence committed was Violence against a person, with 53 of the 207

offences falling into this category. Drugs Offence accounted for 18 offences. Again, this is in line with national and adult data.

The assessed generic risk factors for young people offending and re-offending in Thurrock indicate that the most common risk factor is thinking & behaviour, followed by family and personal relationships, emotional and mental health, education, training and employment and attitudes to offending. The least common is physical health. An increase has been observed in young people presenting Emotional & Mental Health issues linked to their offending. However, this may be due to the increase of increasingly robust services within the YOS which is ensuring that issues are identified and managed. There also may be a link to the increase of young people being supervised who have been involved in serious youth violence and the emotional issues it can instigate. Perhaps surprisingly, substance misuse was the 4th lowest risk factor at assessment, out of 12 risk factors.

Due to high migration from the London Boroughs, the Thurrock YOS is supervising a number of young people who have links to serious youth violence and gangs. We remain vigilant to the strong association between this gang activity and its links to emerging drugs markets, particularly regarding county lines and cuckooing[17]. County lines refers to city-based gangs operating phone lines and transactions for drug dealing that permeate into surrounding areas such as from London and into Thurrock and the Home Counties. Cuckooing refers to gang members taking over the properties of vulnerable people in order to use the premises as a base to operate their drug dealing.

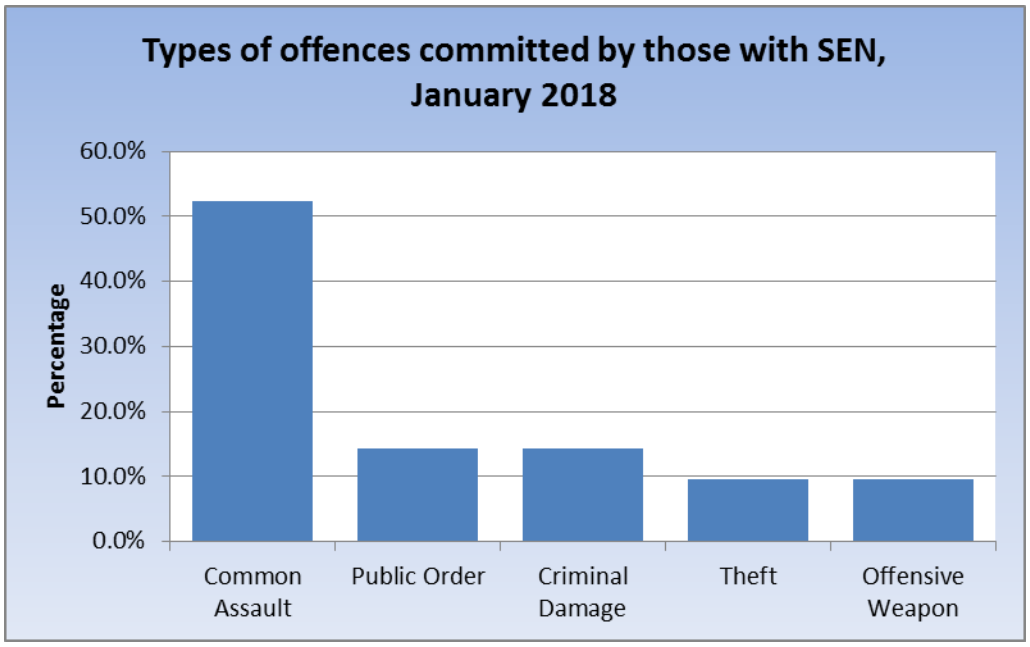
At the point of analysis (July 2018), 11 of the 54 cases on the YOS caseload (not including young people subject to prevention interventions or out of court disposals) had Special Educational Needs (SEN) recorded in their initial ASSET plus assessment (20%). Of these 11 cases, seven had Education, Care and Health plans (ECHP), two had Statements of special Educational Needs (SEN) and two had special needs identified but where not currently subject to an ECHP or SEN statement.

One key outcome measured by the YOS is the rate of reoffending 1 year post-conviction. Looking at all young people who offended in a six month period who are then tracked for a year, it was ascertained that 33% of them were identified as having special educational needs, which is proportionally higher than would be expected.

When considering the types of crimes committed by this cohort, it can be seen that the most prolific offence committed by young people with Special Educational Needs is common assault, followed by criminal damage and Public Order offences. The rate of common assaults committed by young people with special educational needs is higher than that of the general population, (52% as opposed to 39%) and the comparison is similar in respect of criminal damage and public offender order offences. It should be noted that these offences are often reactionary and directly linked to behaviour management, perhaps related to anxiety, frustration and communication problems.

[17] Vice. How Drug Dealing Gangs Are Taking Over the Countryside. (2018) https://www.vice.com/en_uk/article/zm84bx/how-londons-drug-dealing-gangs-are-taking-over-the-countryside (Accessed July 2018).

Figure 27 Types of offences committed by children with SEN, January 2018



Source: Thurrock Council Youth Offending Service, January 2018

What are we doing in Thurrock?

The YOS historically employed a full time substance misuse worker, but in recent years they referred clients to treatment and interventions facilitated by Thurrock's young person's substance misuse service. In 2013-14 over 8% of convictions were in relation to possession or possession with intent to supply of illegal substances but the use amongst our client base is far bigger. However, whilst this can increase other risk factors it is rarely the sole reason for their offending. The use of class A drugs is rare in young people in Thurrock, but there were a number of convictions of young people dealing crack & heroin in 13-14.

2017/18 NDTMS data tells us that 18% of young people in treatment had offending recorded as a sub-intervention for their multi-agency support package, meaning that almost 1 in 5 clients have been assessed as being involved in offending behaviour. In 2017/18 the young person's substance misuse service co-located a member of staff in the YOS one-day a week. It should be noted that many of these clients will also be those noted in the YOS data.

Recommendations

Population

- The expected 30% increase in the 10-17 year old population over the next ten years and the uncertainty of what impact this will have on treatment numbers means we need to continually assess and be responsive to potential increases in service demand
- The major issues and future risk factors for Thurrock are the continued increase in migration from the London boroughs, especially in relation to the management of young people who have been involved in serious youth violence

Recommendations - continued

Population

- The increasingly diverse population and consequent increase in the BME population will result in changing risk factors and a change in interventions and supervision will be needed to meet these
- The increase of young people involved in gangs brings with it the increased risk of sexual exploitation and increases in vulnerability and safeguarding which has been evident over the preceding years. The strategy to manage this risk is more partnership working both locally and with the London boroughs which are the sources of the migration
- Additionally, although it is not yet presenting itself, there may be an increase in substance misuse issues specifically related to Class A addiction in young people and the provider must be responsive to this
- Provider to continue to be accommodating of complex cases with multiple wider vulnerabilities
- Commissioners to deepen their understanding of the A&E hospital admissions data
- Brighter futures partners to recognise that some young people state they are using drink or drugs to cope with worries/anxiety and to be responsive to this via targeted support or universal prevention and education interventions

Treatment population

- Provider to increase the acceptance of sexual health screening, where deemed appropriate/eligible and to explore why our referrals are lower and how to strengthen links to sexual health services
- Regularly review the use of Novel Psychoactive Substances ((NPS), also referred to as Legal Highs or Club Drugs) and adapt the treatment offer accordingly
- Reaching treatment naive parents who require treatment for substance misuse, due to children experiencing hidden harm, is a challenge for treatment services and something they must maintain a focus on
- Continue to ensure that appropriate links are being made locally between Brighter Futures partners and particularly between services for domestic and sexual violence, young people and substance misuse to address and support the specific and wider vulnerabilities set out in Figures 10, 19 & 20 and ensure strong multi-agency working remains a priority of the new service
- Commissioners to review the referral pathways from children and young person's health and mental health services to better understand the low referral rate compared to the national average
- Our use of harm reduction interventions is far lower than the national average and commissioners need to understand why this is the case and what the implications are
- Provider to continue to offer referrals for stop smoking support
- Commissioner to match the new service specification to the existing age eligibility of up to 18 years old, with exception for up to 25 years old if SEND/disabled and appropriate
- Provider to explore why fewer referrals come from those young people in apprenticeships or employment, compared to national average

Recommendations – continued

Criminal Justice

- Provider and commissioner to remain vigilant to the strong association between gang activity and its links to emerging drugs markets, particularly regarding county lines and cuckooing
- Continue to co-locate a young person's substance misuse service worker in the YOS at least once a week and recommend this in the updated service specification
- Brighter Futures partners to be vigilant of SEND children being disproportionately represented in YOS data and cater for their additional needs

4. Literature review summary

A comprehensive literature view has been conducted by commissioners, largely based on a review of articles and publications that resulted from a literature search conducted by the Aubrey Keep Library.

Key Points

Prevention & Education

- Prevention and education programmes carry a risk of increasing use of substances, but overall, the benefits outweigh these risks if even from a harm reduction perspective.
- Prevention and education work in schools is a key focus of the current young person's substance misuse service

Treatment

- The trends and high risk groups set out in the infographic in Figure 10 are explored in the below summary
- Family therapy is emerging as an area of best practice
- Multi-agency working is key to ensuring that the whole child is supported holistically
- Hidden Harm work with children of substance misusing parents/carers continues to have a strong evidence base
- Our Stop Smoking Service has long since forged effective partnership working with our substance misuse service and the latest evidence shows that this can be a mutually beneficial investment
- Coproduction should feature in programme development to prevent the focus being on what adults perceive the issues to be

Mental Health

- Rates of Common Mental Health Disorders (CMHDs) such as depression and anxiety have recently increased in the children and young people population
- Substance misuse can be linked to suicidal ideation
- Review partnership working with Mental Health services to ensure service delivery is not fragmented

4.1 Prevention & Education

How far we can go to prevent substance misuse is a topic of contention, since it is a fact that drug and alcohol problems persist in our society and generations of young people continue to use drugs and alcohol, whether that be experimentally, recreationally or to hazardous and harmful levels despite increasing awareness of the potential for harm.

Programmes designed to prevent substance misuse in young people have almost invariably been designed by adults, based on their concerns regarding drug and alcohol use rather than young people's experiences. It is important to note that there are intrinsic difference between adults and children of different ages. Furthermore, the experiences of this generation of young people likely differs greatly from the childhood experiences of the current generation of adults, particularly with the more recent boom in technology and the development of numerous social media platforms[18]. Evaluations of these programmes have also tended to be undertaken over a relatively short time frame and more longitudinal studies are needed to determine whether prevention and education is truly effective. According to Phil Harris', *Youthoria*[19], this has led to the implementation of poor prevention programmes, which have resulted in poor outcomes and thus provide justification for disinvestment, with such strategies being branded as education rather than prevention.

However, there is a benefit to these overarching education-style programmes. Getting universal prevention messages across to large groups of young people can ensure that they take informed risks. The counter argument is that this heightens young people's awareness of the opportunities that exist, some of whom might seek out these opportunities. Education programmes, therefore, tend to focus on harm reduction messages, rather than the zero tolerance scare mongering messages that were favoured in the 1980s and 1990s; evidence shows us that young people take risks, it's their nature to do so, and as such minimising the risk should be the focus.

However, there is a case to argue for targeted or selective prevention. For example, we know that young people with key vulnerabilities as outlined above are much more likely to participate in such risk taking behaviour. We know that these young people tend to have poor school attendance or attainment, might live in a 'troubled family' unit, could be known to mental health services, be an open case with children's social care or even be in the care system. They are more likely to be engaged in offending behaviour and could already be in the criminal justice system, perhaps already on the caseload of the youth offending service (YOS). A limitation of this approach is that it's a generalisation and not all young people in these cohorts will be engaged in substance misuse. Moreover, there is a risk of stigmatisation and the feeling of being 'singled out' on top of other vulnerabilities young people may be facing. Indicated prevention is a method that targets those young people known to be engaged in risky behaviours and substance misuse. Interventions can help prevent normalisation or escalation of the behaviours and begins to cross over into the realms of treatment, often referred to as early intervention or early help.

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[18] Public Health England. (2015). The International Evidence on the Prevention of Drug and Alcohol use: Summary and examples of implementation in England. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/669654/Preventing_drug_and_alcohol_misuse__international_evidence_and_implementation_examples.pdf (Accessed June 2017).

[19] Harris, P (2013) Can Substance Misuse Be Prevented in Young People? *Youthoria*. 128-131.

The success of any targeted prevention intervention will be reliant on the skill of the facilitator/keyworker and honesty of the young person. Since a number of agencies might be working with that child or family a multi-agency approach with effective information sharing will be important to enable building up a more accurate picture of the true situation, particularly where young people attempt to play agencies off against one another. Reasons for doing so might include wanting to resist change, particularly where the behaviour or activity is seen by the young person as enjoyable and interventions are being enforced by statutory agencies, or where the young person fears dramatic intervention such as removal from a family unit.

The outcomes of specific prevention and education programmes across alcohol, tobacco and cannabis suggest that the initial short-term impact was similar for tobacco and alcohol. However, the longer-term impact on smoking reduction was three times higher than the reductions in alcohol use and that alcohol programmes were more likely to have no effect or a harmful effect in that they could increase drinking post-intervention. A larger scale study also found similar results; most effective in reducing tobacco consumption, then 'all drugs' then alcohol and finally 'soft drugs'[20].

The question of who delivers these programmes is important. Young people tend to respond poorly to teachers delivering drug and alcohol prevention messages in PSHE lessons; teachers are not supposed to be viewed as fallible but instead as pillars of the community with reputations to uphold. Having core subject matter teachers suddenly delivering messages about reducing the risks of substance misuse, or even delivering zero-tolerance messages can blur the lines between the teacher-pupil relationship. Measuring the learning is difficult, since many young people are likely to consider teachers as not coming from a position of experience. Those teachers that might share experiential messages further risk the teacher-pupil relationship, with the exception being those pupils that admire the risks their teacher may have taken, which then risks normalising the substance misuse.

However, having guest speakers from local substance misuse services overcomes this issue. The evidence suggests that if the messages come from one's peers the impact is even greater than teacher-led programmes, and that health professionals appear to be more effective delivery agents than peers[21].

It is likely that a suite of coordinated and well-presented universal and targeted interventions will have the largest impact on reducing substance misuse, or risk of harm for young people living in the borough[22].

As outlined above Hidden Harm is a term used in drug and alcohol treatment to refer specifically to young people whose parents/carers misuse substances. These parents/carers may be in treatment themselves and the young people might also have a substance misuse need of their own. It is a complex area of work, much of which sits within the realms of prevention and education since there

[20] Harris, P (2013) Can Substance Misuse Be Prevented in Young People? *Youthoria*. 154-155.
[21] Harris, P (2013) Can Substance Misuse Be Prevented in Young People? *Youthoria*. 161.
[22] Public Health England. (2017). Young People's Statistics from the National Drugs Treatment Monitoring System (NDTMS) 1st April 2016 to 31st March 2017. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/664945/Young-people-statistics-report-from-the-national-drug-treatment-monitoring-system-2016-2017.pdf (Accessed June 2017).

is a need to help young people understand their situation and divert them from falling into the intergenerational cycle of substance misuse. Furthermore, great care is required when working with this cohort because once the gravity of their situation has been unpacked before them they are almost always unable to change their circumstances by themselves. This topic will be explored further under 'Treatment'.

4.2 Treatment

Measuring the efficacy of treatment modalities for young people is a challenge. A young person's age is deemed to be a poor measure of maturity so it is not easy to determine which interventions suit a certain age group, particularly if the young people in question have experienced some degree of developmental delay.

With the exception of young children receiving support under the Hidden Harm agenda, young people in treatment are generally at a transitional phase whereby the safety of parental influences (however limited these may or may not be) fall into decline and give way to peer influences. Add to this an increase in emotionality and life stresses, particularly via relationships and exam or employment pressures and hormonal changes during puberty, and one can see how some young people might turn to substance misuse as a form of distraction, 'self-medication' or, a source of enjoyment. For this reason, the notion of abstinence-based recovery can seem a paradox. Instead, the focus is often to ensure that repeated exposure to substances does not lead to physical dependence in adulthood and that young people can be provided with the tools to avoid addiction and instead develop their resilience, increase will power and be directed towards meaningful activities such as hobbies, recreational activities or voluntary work that are all strong attributes to attaining life skills and achieving recovery[23]. This is somewhat of a challenge considering that as children move into adulthood their opportunities to earn a wage and have disposable income both increase dramatically, therefore, enabling them to afford a lifestyle that might have negative connotations, could involve committing criminal offences if misusing banned substances and ultimately be harmful to their physical and mental health. On the other hand, employment is one of the most protective factors for health and well-being and as such may begin to reduce some of the fears or vulnerabilities that young people were facing during adolescence[24].

Treatment methods to address these risks and issues lie along a continuum with harm reduction at one end and abstinence-based recovery at the other. In between are a myriad of psychosocial interventions that include cognitive behavioural therapy (CBT), motivational interviewing (MI), counselling, 12-step programmes, multi-agency input, peer support, group work and 1:1 sessions all designed to lead the young person towards aftercare and recovery. For some young people enforcement (especially if known to criminal justice agencies) will come into play and treatment providers will be obliged to inform youth justice agencies whether or not a young person at the centre of a multi-agency action plan is complying with the terms of their court order. This in itself can have an effect on the client-keyworker relationship and thus impact on the success of the interventions.

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[23] Harris, P (2013) Can Substance Misuse Be Prevented in Young People? *Youthoria*. 169 & 175.

[24] Waddell, G. & Burton, A.K for Department of Work and Pensions (2006). Is Work Good for your Health and Wellbeing? https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/214326/hwwb-is-work-good-for-you.pdf (Accessed June 2018).

MI has been found to be effective with adolescent substance misusers in a number of studies. The brief intervention recognises that motivation for change occurs in stages and reflective listening is important in guiding the young person towards change. Reflective listening is an advanced technique that reflects back the deeper messages in the young person's statement.

The Thurrock service does not provide counselling in-house, but by working with existing Services such as the Emotional Wellbeing and Mental Health Service (EWMHS) it enables service providers to ensure continuity of care for children and young people and that the 'whole person' is being treated. Brighter Futures provides a structure for working in partnership with other services to improve this for CYP in Thurrock.

CBT is the most common treatment delivered in community settings for young people with substance misuse problems and is a generic name given that covers a wide range of cognitive and behavioural approaches. It assumes that human behaviours are governed by an individuals' self-efficacy belief; our expectation that we can perform a task to a given standard. It is based less on ability than ones' perception of their ability, something referred to as reciprocal determinism. Therefore, belief, performance and response are inter-linked. Where clients lack self-efficacy belief and turn to substance misuse as a coping strategy, CBT can be effective in assessing a young person's triggers in high-risk situations and then teaching them a range of coping skills to overcome the triggers without resorting to use.

The Twelve Step approach was developed in the 1930's for adults and has been adapted for young people. It is faith-based and a well-known version is Alcoholics Anonymous. These programmes are prevalent across the globe and have developed into Narcotics Anonymous and Cocaine Anonymous. Ostensibly a set of twelve therapeutic exercises, the programmes have become difficult to evaluate such is the extreme diversity of the organisation and its members.

Randomised Control Trials in young person's substance misuse treatment have shown that when comparing structured treatment approaches head-to-head at gold standard, there is no one treatment model that demonstrates superiority over another. This is referred to as the 'dodo-bird effect'[25]. It is taken from *Alice in Wonderland* where the Queen announces that everyone is a winner and that there are prizes for all. Numerous studies including those of meta-analysis have shown that treatment outcomes are driven more by the relationship between the client and the therapist or keyworker than by the quality of the intervention delivered. Lambert's (1992) studies support this theory, where 15% of outcomes were based on therapeutic approach, 15% were a placebo response, 40% were attributed to extra-therapeutic responses such as gaining employment, entering a new relationship, etc., and 30% were driven by the client-practitioner relationship[26]. This suggests that some focus in designing specialist substance misuse services relies on recruiting the 'right' people who will be able to develop rapport with young people and build that ever important client-practitioner relationship. This does not come without its challenges. However, evaluation and research of effective services could focus on characteristics and skill-sets of practitioners as a means of beginning to un-pick this complex issue.

[25] Luborsky, l., Rosenthal, R. and Diguer, L. (2002) The Dodo Bird Verdict is Alive and Well – Mostly. *Clinical Psychology Science and Practice.* 9, 3-12.
[26] Lambert, M.J. (1992) Implications of Outcome Research for Psychotherapy Integration. In Norcross, J.C. and Goldfrieds, M.R. (Eds.) *Handbook of Psychotherapy Integration*. Basic Books.

Many young people enter treatment independent of their parents or carers knowledge. There is sometimes good reason for this, especially where the young person might experience an increase in risk or safeguarding issues. Having said this, there is a growing body of evidence that tells us that where parents/carers can be engaged in the young person's treatment the outcomes can be improved[27]. Currently this is not commonplace in the existing service. Systemic and behavioural family therapies and family case conferencing are examples of interventions that can be used to good effect. The impact could be far greater if completed in conjunction with family members who are in treatment with the adult drug and alcohol treatment service, since it would deepen the understanding of both the parents and the children and help them identify ways to further build on the progress they are making and to work together as an effective a family unit. This could also aid in supporting young people to overcome some of their vulnerabilities by building closer relationships with their family.

Effective multi-agency working and information sharing is key to success with this client group, whether the staff are co-located in one multi-agency service or operate as a virtual team but remain based in their parent organisation. The Thurrock service operates a blend of the two models, with one staff member being co-located at YOS one day a week. This increases the opportunity to facilitate casework with criminal justice clients, particularly where transport is a barrier due to the two services currently being based in separate towns within the borough. The current service is exploring further integration with the Brighter Futures work as this develops and this should continue in order to further increase effective partnership working.

Aftercare in young people is critical since their self-efficacy belief in change is generally lower than in adults, meaning a focus on abstinence-based recovery that is popular with adults is often an unrealistic proposition for many young people. The reasons for this include the fact that their exposure to the negative socio-economic aspects of substance misuse and the health impact, particularly regarding developing or accelerating long-term conditions do not begin to crystallise in the teenage years. Young people go through puberty at a stage where their brain is still developing, they often do not fully comprehend the consequences of their behaviour, Moreover, young people in treatment tend to have little or no prior experience to call upon, and as such the temptations and opportunities thrust upon them during the developmental stages of adolescence into adult may mean that they adapt rather than sustain change. This can particularly be the case if they continue to spend time with friends who engage in substance misuse, who may encourage them to resume their past behaviours. Furthermore, because trends in substance misuse develop so quickly, e.g. the rapidly changing NPS market, treatment methods are often lagging behind the realities of what young people are experiencing. Broadly, adults tend to relapse due to unpleasant mood states and conflict, whereas young people tend to relapse due to positive emotional states and social pressure, with alcohol being a common factor even if wasn't when they first presented to treatment[28]. Harm reduction interventions help to reduce these risks when abstinence is not seen as achievable by the client.

Therefore, keeping young people on track with their treatment and ensuring they do not relapse and represent to treatment is a significant challenge with different drivers compared to the more

[27] Harris, P (2013) Can Substance Misuse Be Prevented in Young People? *Youthoria*. 209-2016.
[28] Harris, P (2013) Can Substance Misuse Be Prevented in Young People? *Youthoria*. 217.

established treatment methods seen with the adult population. Young people need to create or strengthen pro-social networks to assist with recovery back into mainstream society. Unlike the challenges of helping adults find meaningful employment, a big advantage with young people is that they will almost always be in some form of education that they can develop their engagement with to strengthen their recovery capital.

Where young people demonstrate a desire to give something back to the service for the treatment they have received, every opportunity should be taken to engage them onto a peer mentor programme, as is common in adult treatment settings. This is largely an emerging area within young people's substance misuse services and something that will underpin the evidence base mentioned earlier that young people are more likely to listen to their peers than their teachers, as in the case of prevention and education programmes. Moreover, those still in treatment can see that recovery is both tangible and achievable.

4.3 Mental Health

The rates of mental health conditions such as depression and anxiety has increased across adolescence, with anxiety disorders being the most common mental health problem in those young people presenting for substance misuse treatment. Children with anxiety disorders often delay the initiation of drug and alcohol use, however, once initiated consumption tends to increase dramatically[29]. There is some evidence to suggest that even after cessation from substance misuse that anxiety disorders can persist.

Numerous studies have identified a prevalence of suicidal ideation in young people, the peak of which tends to occur in early adolescents through overdose or self-harming behaviours for example cutting, but few attempts result in death. The rates are higher in young people who misuse substances and poly-drug using and opiate misuse are the substances most associated with suicide. In Thurrock we currently don't have any opiate or crack using clients in treatment in the young person's service; however, poly-drug misuse is very common, with 52% of those in treatment in 2017/18 reporting using multiple substances. In spite of this, the service has not had a client death in the duration of its expiring 5-year contract.

As noted under 'treatment' above, effective multi-agency working with EWMHS and the Brighter Futures agenda is important to ensure that the whole-child is supported and that treatment is not fragmented between agencies working in silos.

[29] Harris, P (2013) Can Substance Misuse Be Prevented in Young People? *Youthoria*. 202-203.

Recommendations

Prevention & Education

- Preventative interventions should continue to feature in future service delivery
- Service design should involve further development of peer-led programmes to enhance and diversify the offer and overcome the risk of adults designing interventions based on their perception of the risks rather than the actual experiences of young people

Treatment

- Specialist services to deliver DAAT are necessary for CYP although a partnership approach to delivering services to CYP in Thurrock is important. Services should integrate as part of the Brighter Futures group of services to maximise benefits to children and their families whilst giving appropriate support to other professionals involved in their care
- Where practicable, programmes should be co-produced with young people to prevent the focus being based on adults' perceptions of the issues
- Evidence supports family therapy being available, this should be considered as an offer as part of the new service specification but needs to be child led and clearly will not be appropriate in every therapeutic relationship. There is particular benefit if any adults in the family unit who have a substance misuse need are also in treatment
- Future treatment options should include Motivational Interviewing, CBT and Twelve Step programmes at the discretion of the client
- Motivational interventions are utilised more in Thurrock when compared to national trends where Harm Reduction interventions are considerably more prominent. A deeper analysis of this intervention should be conducted by commissioners to understand whether our new service provider should offer more harm reduction interventions to our residents
- Continue to offer Hidden Harm support to children affected by parental substance misuse
- Provider to continue to refer to stop smoking support services
- Continue to work closely with the mental health services (EWMHS) to ensure that if young people complete treatment for substance misuse that they can receive any necessary help for enduring mental health problems such as depression or anxiety disorder

Mental Health

- Continued and further integration as part of Brighter Futures and partnership working with Mental Health services will be beneficial for improving outcomes for children, young people and their families
- Ensure that the service remains vigilant to the heightened risk of suicide across its client base; such is the link between suicidal ideation and substance misuse.

5. Tier 4 treatment provision and prescribed treatment modalities

Key Points

- Tier 4 treatment and prescribing modalities for Thurrock children and young people are incredibly rare
- These treatment modalities have not been activated during the five years of the expiring contract

Tier 4 treatment refers to those clients who require an inpatient or community detoxification or rehabilitation programme. This is a highly specialised area of drug and alcohol treatment more typically seen in the adult treatment population, since such clients have experienced chronic substance misuse and this is not something we tend to see in the under 18 population.

Where clients are in need of a prescribed treatment modality, on the rare exception that it's required, the service is able to provide this in partnership with the adult drug and alcohol treatment service who are commissioned to provide prescribed treatment modalities e.g. opiate substitute therapy (OST) (more commonly known as methadone) or medication to help with medical withdrawal from alcohol. In the lifetime of the expiring 5-year contract the incumbent service provider has never needed to utilise this partnership agreement.

The future needs of Thurrock young people do not indicate a risk of a sudden high demand in Tier 4 or prescribed treatment modalities, but we will remain vigilant to local drug market trends and treatment activity.

Transition into adult service

Currently, if a young person in treatment is approaching the age of 18, a decision is reached between the adult and young person's service as to whether it is appropriate to keep them in the young person's service or transfer them into the adult service for a continuation of their treatment episode. This is decided on a case by case basis, is good practice and should continue in the future.

Recommendations

- The future service specification should retain the current clause regarding partnership working with the adult service to cater for such exceptional cases

6. Return on Investment

Key Points

- The existing service model represents good value for money, with high quality interventions and strong performance
- Waiting times have been an area of focus for improvement, and service growth helped address this

6.1 Benchmarking and cost impact of service

A Department for Education cost-benefit analysis found that every £1 invested in specialist substance misuse interventions delivered up to £8 in long-term savings and almost £2 within two years, meaning that this can be a cost-effective way of reducing future demand on health and social care services. A life course approach to drug prevention that covers early years, family support, universal drug education, and targeted and specialist support for young people is one of the key aims of the Government's 2017 Drug Strategy.

How does our current service compare?

The Thurrock Drug and Alcohol Action Team (DAAT), (part of Public Health) conducted a comprehensive benchmarking exercise back in 2015/16, see appendix 1. This incorporated 3 other CIPFA comparator upper tier local authorities and measured the Thurrock services against performance and cost. In summary, the Thurrock service was seen to have strong performance, with an excellent representation rate demonstrating interventions were of high quality, thus ensuring clients exit treatment and remain in recovery.

The only noted improvements to the service offer were length of waiting times which could have been better. At the time this was attributable to the small staff team that has since seen growth by 50%, plus additional roles for student social workers and an apprentice. A peer mentoring scheme was also launched, which evolved into an accredited offer in 2017/18.

In 2016 the service was the lowest cost across those compared in the benchmarking exercise at almost 5 times cheaper. The budget for the Thurrock young person's service has since increased from £75,000 to £135,000, yet this would still place it at over 2.5 times cheaper than the comparable services. Anecdotally, Thurrock DAAT has spoken with other local commissioners regarding their young person's services and this latest figure still seems to be the case.

Recommendations

- The current service model should be retained in the new service specification

7. Co-production

Key Points

- Service users are happy with the existing treatment offer
- Parents/carers also value the existing treatment offer
- Staffs' friendliness, knowledge and expertise is highly valued
- (A caveat of this section is that the sample size was small)

7.1 Service user and stakeholder engagement

Service users and stakeholders have been invited to engage in the retender of this service. Service users were contacted by the incumbent provider and stakeholders were written to by commissioners asking for any comments or recommendations on the existing service. Commissioners also attended Thurrock's Youth Cabinet and will be devising an electronic survey to send out to its members for cascading across the secondary schools in the borough.

Meantime, commissioners met with a two client groups accessing treatment at the incumbent provider, to seek their views on the current service offer. The questions for the Youth Cabinet and clients are in appendix 2 and the transcript from these sessions with the clients is in appendix 3.

The first session was with a 17 year old female cannabis user who had been in treatment for just over a month. They gave a very positive account of the support they had received and, whilst stating that their parent felt she shouldn't require structured treatment to address her cannabis misuse, the client herself felt this would not have been possible alone. In terms of accessing family sessions, they felt their parent might be awkward if attending a session with them, but could see the value in it. They could not identify any areas to strengthen the service offer, felt the service was accessible and would recommend it to peers.

The second session was with a family unit comprising a mother, grandmother and three of five children, albeit the 3-year-old did not actively participate. The children were accessing the service to receive support for Hidden Harm; the now estranged father/step father had been the misusing adult in a complex multi-agency case. Their involvement with the service was due to end in the coming weeks. All participants heavily valued the support they had received and felt it had enabled them to become closer as a family. The children felt the support they had received had helped them to understand their emotions and they valued their independent time talking with the keyworker. All family members felt the service was accessible and the parent and grandparent valued both the independent and family sessions. Of particular note were the 'unsent letters' that the children wrote and gave to their mum, which deepened mum's understanding of what her children were experiencing and brought them closer together. The family could not identify any areas where the service could be improved and had already recommended the service.

It is important to note that the service provider was the gatekeeper to organising these primary sources of research and an element of bias should be factored into this. Nevertheless, clients were sought based on their availability and willingness to participate, for which commissioners are grateful.

Other relevant stakeholders such as the current adult and young person's substance misuse treatment providers and the Children's Services team at Thurrock Council have been contacted as part of the service specification refresh and ultimately will support in shaping the design of the service as it goes through the re-tendering process.

Recommendations

- To offer more family sessions where assessed as appropriate
- No further areas to strengthen the existing treatment offer were identified by the service users and the parent or grandparent

8. Conclusion

The above document makes a series of recommendations under each section, of which will be cross referenced with the existing service specification and updated where necessary.

The epidemiology section in this document tells us that we can expect to see a significant increase in the young person's population in Thurrock over the next decade, and particularly so in those aged 10-17 years old. Quite how many of these young people will require treatment for substance misuse is hard to determine since the prevalence estimates for substance misuse are virtually impossible to determine, and due to the revised approach to delivering coordinated preventative interventions under the Brighter Futures umbrella of services, many young people may be diverted from becoming problematic substance misusers. This will be an area of close monitoring over the coming years.

It is right that we continue to offer coordinated packages of care that address the wider determinants of heath, such as referrals to sexual health and stop smoking support services and partnership working with mental health and youth offending services (YOS) to safeguard our young people. We must remain vigilant of the local dugs market and associated gang activity.

The literature review confirms that with regards to prevention and education programmes, the benefits of preventing harm outweigh the risks of increasing awareness and usage of substances and that such programmes should continue. Where practicable, peer mentors should support these initiatives since it has a greater impact on young people than when delivered by school staff alone.

The service should continue to integrate as part of Brighter Futures to strengthen multi-agency working and further improve outcomes for children, young people and their families. The current service demonstrates strong performance and balanced caseloads, suggesting the size and structure of the service is meeting the needs of the local treatment population.

So in response to the question of whether the population in treatment demonstrate the expected characteristics based on the national literature review evidence and the data on high risk groups, we are confident that the answer is yes. Has the current provider targeted and 'found' the highest risk groups of children and young people? Based on the above evidence of those children and young people in treatment with multiple specific and/or wider vulnerabilities the answer also has to be yes.

9. Appendices

Appendix 1: DAAT Benchmarking, 2015

Appendix 2: Service User/Parental/Youth Cabinet questions

Appendix 3: Service User & Parental feedback

Appendix 1

Thurrock Council Public Health Benchmarking Review with Comparator Councils

for

DAAT – Adults & Young People

DRAFT 2015 /16

Version: 5.0

Version	Date	Author	Changes
1.0	07/08/2015	Sarah Hurlock	First draft Document created
2.0	08/09/2015	Sarah Hurlock	Demography data added
3.0	21/09/2015	Kev Malone & Sarah Hurlock	Section 4 added
4.0	29/09/2015	Kev Malone	Performance, recommendations, conclusion & executive summary added. Formatting.
5.0	16/10/2015	Sarah Hurlock	Proof read & formatting
		Helen Horrocks	Sign off

CONTENTS PAGE

EXECUTIVE SUMMARY

All sixteen CIPFA comparator sites were contacted and invited to participate in this exercise. Of the three that agreed to participate, the service for each Local Authority was reviewed against the national guidance and best practice principles, as detailed in the current service specifications. Any identified variance which exceeds the recommended guidance was picked out so that innovative practice could be identified.

Each site had also been sent a short pro forma to complete regarding staffing and funding of their provider service. This allowed comparisons of different staffing models and funding of programmes to be determined and where possible cost effectiveness was also calculated.

Performance was taken from restricted data via the National Drug Treatment Monitoring System (NDTMS) and the publically accessible National Public Health Profiles available on Fingertips, such as the Local Alcohol Profiles for England (LAPE). NDTMS are official statistics to which we have privileged access in advance of release. Such access is carefully controlled and is provided for management, quality assurance, and briefing purposes only. Release into the public domain or any public comment on these statistics prior to official publication would undermine the integrity of official statistics. Please prevent inappropriate use by treating this information as restricted, refrain from passing information on to others who have not been given prior access and use it only for the purposes for which it has been provided.

The benchmarking work undertaken in compiling this report has identified two key areas for Thurrock; our residential detox and rehab budget for tier 4 adult treatment is considerably under resourced, and our young person's service is under staffed/resourced. Both areas require urgent funding reviews in order to respond to need and ensure service user health is not placed at risk.

Acknowledgements

The Public Health benchmarking review would not have been possible without the help of our comparator local authorities who participated in the process. We would like to acknowledge colleagues at Medway Council, Trafford Council and Milton Keynes Council who provided service specifications and performance data to inform the findings of this report. We would also like to acknowledge the work of the Thurrock Public Health team.

1 INTRODUCTION

1.1 Responsibility for the majority of Public Health services transferred into Local Authorities on 1 April 2013. In September 2013 the Thurrock Public Health team established a work programme to review all Public Health services in 2014/15. At this time, responsibility for DAAT transferred within the council from Public Protection to Adults, Health & Commissioning and new contracts were awarded for Drug Treatment providers.

1.2 However, it is now necessary to conduct this benchmarking exercise with relevant comparator Local Authorities to attempt to identify and understand the different practices, methods and processes used within each DAAT service across the group of local authorities.

1.3 This report will examine and assess the different performance and costing models using best practice principles

1.4 The aims of the benchmarking exercise are to:-

- **Identify if each LA service specification is following best practice guidelines**
- **Identify how each LA is currently performing against their service specifications**
- **Identify any innovative practice across the five LA sites**
- **Review staffing models for each service**
- **Review the current service for value for money and make recommendations on a future costing model for the service**

1.5 For the purpose of the review we have used 2013/14 as the benchmark year as we needed full year performance data to complete fully.

2. METHOD

2.1 There was a general consensus to use Thurrock CIPFA comparator sites for this process to ensure that benchmarking informed the review and benchmarking with comparator sites was proposed as part of carrying out a full review.

2.2 Contact was made with 16 CIPFA comparator sites in April 2015. Three of the sites confirmed agreement to participate. Regular contact was made with these sites to capture the relevant consistent paperwork, and emails were sent to clarify the information needed.

2.3 A benchmarking template was developed to collate data on various indicators. The following indicators were analysed for each area:

- **Current service model**
- **Staffing model**
- **What KPIs and information is collated as part of performance**
- **Cost of current service**
- **% of Public Health Grant allocated for the service**

Within our benchmarking process we also looked at Public Health profiles (fingertips) for each CIPFA area.

2.4 All relevant guidance eg Public Health England Guidance, NICE Guidance was considered during this benchmarking exercise.

2.5 The final information was received in the summer of 2015 from the three comparator sites, with a first draft of the benchmark exercise produced in August 2015 and the final version shared in October 2015.

3 DEMOGRAPHY

3.1 The table below shows the demographic makeup of the Local Authorities that participated in the benchmarking process. This includes children and adult data, population size for the different age groups, deprivation scores and life expectancy.

Table1.1 Demography of Thurrock and CIPFA sites

Indicator per 100,000	Thurrock	Milton Keynes	Trafford	Medway	ENGLAND
Adult Population (16+)	127,258	200,316	184,618	218,628	
0-15 year old population	24,236	39,730	32,216	38,120	
Male Life Expectancy	79.1	79.1	79.9	78.8	79.4
Female Life Expectancy	82.7	82.6	83.5	82.5	83.1
LA Deprivation Score	13.3	12.9	11.2	15	20.4
% of children in poverty	20.8	19	14.1	21.2	19.2
Hospital stays for alcohol related harm	520	631	646	438	645
Prevalence of opiate and/or crack use	4.8	5.6	5.6	7.3	8.4
Alcohol specific hospital stays (under 18s)	13.7	16.9	39.5	29.9	40.1
Alcohol specific hospital admission (person)	182	323	494	243	374
Admission episodes for alcohol related alcoholic liver disease condition (Broad)(Persons)	54.4	91.9	171.3	87.0	105.3
Number in treatment at specialist alcohol misuse services	193	249	437	273	89265
Successful completion of treatment for alcohol	43	41	36.4	45.8	42.5
Proportion waiting more than 3 weeks for alcohol treatment	25.4	0	2.1	2.9	7.3
Note: Significance is compared to the England average					
Significantly better					
Significantly similar					
Significantly worse					

Source: Health Profiles 2014

As shown above, Trafford has the second lowest adult and young people population, yet has significantly higher male and female life expectancy, as well as alcohol specific hospital admissions and admission episodes for alcohol related alcoholic liver disease condition. By contrast, Medway has the highest population yet is significantly better in all indicators, with the exception of male (78.8%) and female (82.5%) life expectancy and child poverty (21.2%).

Table 1.2 Populations, Contract Values and Cost per Unit for Thurrock and CIPFA sites

The table below gives a summary of the variance in contract values and cost per person for each service in each area. It should be noted that this is a very simplistic overview based on ONS population data and contract values or 2014, where provided. The limited information here made it difficult to draw firm conclusions beyond Thurrock spending less on both adult and young people services per unit than Medway that only provided the adult contract value.

Local Authority	Population (16+)	2014/15 Contract Cost(£)	2014/15 Cost per unit(£)
Thurrock	127,258	1,414,511.00	£11.12
Medway	218,628	2,693,551.00*	£12.32*
Trafford	184,618	Not provided	N/A
Milton Keynes	200,316	Not provided	N/A

*Excluding young person spend as not provided

Table 1.3 Public Health Grant allocated in 2014/15 to each LA and % spend on each programme

The table below compares the overall Public Health Grant allocated to each Local Authority in 2014/15 and the percent allocated to DAAT services.

Local Authority	PHG Total 2014/15 (£)000	% spend on DAAT 2014/15 (£)000
Thurrock	7,417	19.07
Medway	13,170	20.45*
Trafford	10,171	Not provided
Milton Keynes	7,989	Not provided

* Figure does not include young person's services spend as not provided

It is difficult to draw firm conclusions on the above table because so little information was provided by the CIPFA comparators in terms of finance. However, a broad conclusion can be made against the Medway spend; their grant allocation adult spend are roughly twice that of Thurrock's, yet as a percentage the allocation is fairly similar. If the young person % spend were available for Medway it would increase this spend further, meaning we perhaps under resource some of our DAAT allocation.

4 SUMMARY OF SERVICE

4.1 Service Model Offered

The table below summarizes the service model and programme offered by each LA:

Table 1.4

Local Authority	Name of Service	Approach of Service	Length of Contract
Thurrock Adults	Addaction Visions (nee KCA Visions)	Integrated Adult Drug and Alcohol Treatment Service	3 years + 2 year option
Thurrock Young People	CRI Wize-Up	YP Substance Misuse Service	3 years + 2 year option
Medway	Medway Active Recovery Service (MARS)	Integrated adult substance misuse service	3 years + 1 year option

Trafford	AIM Drug and Alcohol Service	Service Specification not provided	
Milton Keynes Adults	Compass: Adult Drug and Alcohol Support Service	Recovery orientated hub and spoke service.	3 years
Milton Keynes Young People	Compass: Young People's Drug and Alcohol Support Service	Holistic offer, 4 key components: info & advice, engagement, targeted and structured interventions	3 years

Thurrock re-commissioned its adult drug and alcohol service in April 2014, combining the separate Community Drug and Alcohol Service (CADS) and the adult service into one integrated service. These separately located services were also co-located.

Thurrock's young person service remained in its base within the adult service, with the same core staff, but with management operating via the service provider based in a separate local authority.

The Medway service specification was very similar to Thurrock's, even including the 24/7 helpline that not all CIPFA comparators operate. The majority of the programmes offered were again almost identical to Thurrock's offer, demonstrating core service delivery. However, the main difference on the Medway offer here was in regards to the secure estate; having several prisons in their locality means their offer to clients serving custodial sentences or being on licence in the community received much more focus and resource than Thurrock's offer.

The Milton Keynes Adult service, Compass, placed its emphasis on three main tenets of engagement, treatment and recovery, with the principle of recovery underpinning the whole system. This ethos flowed throughout their service model. The service operates between 9am and 5pm Monday to Friday, excluding bank holidays, from a hub and spoke delivery model. While no 24/7 helpline is available, they do offer two late nights per week (to 8pm) and peer mentor support at weekends.

Compass was specifically tasked with investing £100,000 into developing a drug and alcohol care service and pathway within Milton Keynes Hospital for patients of all ages. The team of two nurses and a link worker will be co-located in MK Hospital, with the nurses covering shifts and the link worker covering core hours. The team are tasked with reducing unnecessary drug and alcohol related hospital admissions, preventing re-admittance and reducing the length of stay in hospital. This service is very similar to provision elsewhere, except MK is funding the co-located team.

The Milton Keynes young person's service, also called Compass, operates a 9-5 Mon-Fri service with evening and weekend appointments on request. The service has a very similar approach to that of Thurrock, with effective multi-agency working and a focus on field work with young people, rather than extensively operating from a base.

4.2 Performance

Providers are required to comply with the National Drug Treatment Monitoring System (NDTMS) reporting framework and the authors utilised the latest available restricted data from NDTMS to draw conclusions for this section.

You are reminded that NDTMS are official statistics to which we have privileged access in advance of release. Such access is carefully controlled and is provided for management, quality assurance, and briefing purposes only. Release into the public domain or any public comment on these statistics prior to official publication would undermine the integrity of official statistics. Please prevent inappropriate use by treating this information as restricted, refrain from passing information on to others who have not been given prior access and use it only for the purposes for which it has been provided.

Table 1.5 Source NDTMS June 2015 ADULTS Successful Completions

Local Authority	Opiate	Non-opiate	Alcohol	Alcohol & non-opiate
Thurrock Adults	2.4%	18.8%	29.4%	15.6%
Medway	6.1%	46.7%	35.0%	28.6%
Trafford	4.4%	50.0%	27.3%	25.0%
Milton Keynes Adults	9.8%	0.0%	30.8%	28.6%

Baseline period: Completion period: 01.04.14 – 31.03.15

The Baseline measure was taken for two reasons; firstly this was the contract implementation date for Thurrock's new providers. Secondly, the earlier data, although having reliable representation data did include a reporting period associated with the previous provider. The timeframe selected does of course allow for some clients to still represent in the remaining days of September 2015, but this risk applies to all CIPFA comparator sites and so the timeframe was chosen as a best fit.

Table 1.6 Source NDTMS June 2015 ADULTS Representation Rates

Local Authority	Opiate	Non-opiate	Alcohol	Alcohol & non-opiate
Thurrock Adults	11.1%	7.7%	20.0%	12.5%
Medway	31.6%	0.0%	9.1%	12.5%
Trafford	36.4%	0.0%	17.1%	9.1%
Milton Keynes Adults	20.0%	0.0%	0.0%	0.0%

Latest period: Completion period: 01.07.14 – 31.12.14

This table illustrates a comparatively low opiate representation rate for Thurrock compared to the other comparator sites, yet the quality of our interventions could improve against non-opiate and alcohol clients to ensure lower representations rates. Milton Keynes, in particular, has exceptional performance in these latter 3 indicators.

Table 1.7 Source NDTMS June 2015 ADULTS Waiting Times

Local Authority	Opiate	Non-opiate	Alcohol	Alcohol & non-opiate
Thurrock Adults	0.0%	3.8%	0.0%	6.3%
Medway	0.0%	0.0%	0.0%	0.0%
Trafford	0.0%	0.0%	7.5%	4.0%
Milton Keynes Adults	0.0%	0.0%	0.0%	0.0%

Latest period: 01.04.15 – 30.06.15

Waiting times are a key measure in any NDTMS reports. Medway and Milton Keynes both have 0.0% waiting times for the timeframe selected. The numbers of clients referred to in this data are generally very small. In the case of Thurrock, the two percentages above zero relate to one client for non-opiate and two clients for alcohol and non-opiate that waited for over 3 weeks to start their first intervention. For Trafford, the client numbers are seven and one respectively.

Table 1.8 NDTMS June 2015 YOUNG PEOPLE

Local Authority	Planned exits	Planned exits which represent	Waiting times
Thurrock Young People	75%	0%	88%
Medway	65%	8%	100%
Trafford	22%	16%	100%
Milton Keynes Young People	76%	13%	100%

Reporting period: Quarter 1 15/16.

The reporting period for planned exits and planned exits which represent runs from 1st January 2014 to 31st December 2014 and have represented within 6 months after exit. Since the delivery team for Thurrock's YP service TUPE'd into the new provider, this measure was used here.

All waiting time figures are of young people in specialist substance misuse community services since 1st April 2015.

Numbers in treatment tend to be relatively small so the percentages quoted can be skewed quite significantly by individual clients, more so than even the adult data. For example, for planned exits, the highest number behind the data was 13. For waiting times, Milton Keynes and Medway had in the region of 50 new clients during the quarter. Thurrock performed very well for representations because this number was against 28 clients, demonstrating there was quality built into the intervention.

The Local Alcohol Profiles for England (LAPE) from Fingertips was also compared. Using the England average as the benchmark, the below table illustrates the latest available data from LAPE to compare successful completions of treatment for alcohol against alcohol related mortality rates.

Table 1.9 LAPE

Local Authority	Successful completions of treatment for alcohol	Alcohol related mortality (persons) per 100,000 (2013)
Thurrock	43.0%	44.7
Medway	45.8%	46.9
Trafford	36.4%	55.3
Milton Keynes	41.0%	45.1

From the above table it is possible to conclude that, for alcohol treatment, Thurrock fares well against the CIPFA comparator sites, with only Medway having a higher success rate but also having a higher mortality rate in the general population. Milton Keynes perform slightly lower than Thurrock with a slightly higher mortality rate, and Trafford perform the poorest, having a considerably higher alcohol related mortality rate and considerably lower successful completion of treatment for alcohol.

4.3 Costs

Table 1.10 Costs FY13/14

Local Authority	Core Contract Value (£) for Adults inc. CDAS	Residential Detox/Rehab Budget	Contract Value (£) for Young People
Thurrock	£1,416,907.00	£120,000.00	£75,000.00
Medway	Not provided	Not provided	Not provided
Trafford	£883,000.00	£175,000.00	£352,676.00
Milton Keynes Adults	Not provided	N/A	Not provided
Milton Keynes Young People	Not provided	N/A	Not Provided

Table 1.11 Costs FY14/15

Local Authority	Core Contract Value (£) for Adults inc. CDAS	Residential Detox/Rehab Budget	Contract Value (£) for Young People
Thurrock	£1,259,511.00	£80,000.00	£75,000.00
Medway	£2,693,551.00	Included in Core	Not provided
Trafford	£818,990.00	£165,000.00	£352,680.00
Milton Keynes Adults	Not provided	N/A	Not provided
Milton Keynes Young People	Not provided	N/A	Not Provided

Table 1.12 Costs FY15/16

Local Authority	Core Contract Value (£) for Adults inc. CDAS	Residential Detox/Rehab Budget	Contract Value (£) for Young People
Thurrock	£1,200,946.00	£60,125.00	£75,000.00
Medway	£2,641,900.00	Included in Core	Not provided
Trafford	£178,000.00*	£160,000.00	Not provided
Milton Keynes Adults	Not provided	N/A	Not provided
Milton Keynes Young People	Not provided	N/A	Not Provided

*CDAS only – no Core Contract value provided

4.4 Demography – population covered and any exclusion criteria

Table 1.13

Local Authority	Inclusion Criteria	Exclusion Criteria
Thurrock Adults	All Thurrock adults aged 18 or over, plus those expecting to reside in Thurrock following residential rehabilitation and those detained in police stations in Thurrock but reside out of Thurrock	Service withdrawal from violent or aggressive clients following risk assessment by provider
Thurrock Young People	All Thurrock young people aged under 18. In exceptional cases, those aged 18-25. Must be resident in Thurrock for specialist service delivery. Must reside in Thurrock or attend a Thurrock school for universal/targeted service delivery	None
Medway	All Medway residents aged 18 and above	None
Trafford	Service specification not provided	
Milton Keynes Adults	All Milton Keynes residents aged 18 and above	None
Milton Keynes Young People	All Milton Keynes Young People aged under 18	None

There were no exclusions in the specifications provided. Thurrock's adult service specification does have a set of exclusion criteria for clients that behave in a violent or aggressive manner, resulting in service withdrawal, usually for a fixed period. Such risk assessment or service withdrawal will be in line with the provider's policies and procedures.

4.5 Examples of Innovative Practice

Table 1.14

Local Authority	Innovative Practice
Thurrock Adults	Smoking cessation
Thurrock Young People	Smoking cessation
Medway	Substance Misuse Arrest Referral Scheme Alcohol and Cannabis Diversion Scheme
Trafford	Service specification not provided
Milton Keynes Adults	Delivery of drug and alcohol care service at Milton Keynes Hospital Smoking cessation Payment by Outcomes
Milton Keynes Young People	Smoking cessation

A variety of innovative practices were described in the specifications provided by Medway and Milton Keynes, including smoking cessation for both the adult and young people population in Milton Keynes.

It was also noted that Milton Keynes has introduced Payment by Outcomes in years 2 and 3 of the Adult contract.

Moreover, like Thurrock, Milton Keynes has already developed a smoking cessation treatment pathway. There is a strong national evidence base behind this provision, although not yet mandated by Public Health England, so it is welcoming to see other areas responding early to the opportunities and outcomes such a provision can yield.

It was pleasing to see a Payment by Outcomes element in the Milton Keynes Adult service specification.

4.6 Type of staff required to deliver service

Table 1.15

Local Authority	Adults	Young People
Thurrock	1 x service manager 1 x deputy manager 19 x staff 5 x peer mentors 4 x volunteers	2 x staff and shared management from Southend service
Medway	Sub-contractors may be used	Not provided
Trafford	Not provided	7 x staff to deliver DAAT Young People service
Milton Keynes	Specific staffing numbers not provided	4 x staff to deliver DAAT Young People service

All the specifications provided clearly stated staffing requirements and workforce development. It was noted that Medway encourage their service provider to sub-contract the delivery of services where such an arrangement is likely to lead to better quality intervention for service users and/or more efficient service delivery.

4.7 Recommendations

- For Thurrock to increase investment in its tier 4 treatment budget for detox and rehab.
- For Thurrock to invest in its young person's service to ensure the service can grow to not only better meet the increasing demand, but also better service the needs of the young people of Thurrock.

5 CONCLUSION

The limited number of participant sites in this exercise made it difficult to draw firm conclusions beyond Thurrock spending less on both adult and young people services per unit than Medway, that only provided the adult contract value. The service models across the comparator sites were very similar, with little difference to distinguish between them based on the level of information shared.

For the adults' service, Thurrock appears to be, at worst, a broadly similar value compared to Medway. However, current performance is preventing commissioners drawing conclusions that cost and performance combined demonstrate value for money. The re-tender and subsequent merger of KCA with Addaction have been considered as factors in this. Waiting times need to improve for Thurrock and Trafford compared to MK and Medway, while representation rates for MK are exceptional with the exception of Opiate clients, where Thurrock fared well in comparison. It is worth reminding ourselves that client numbers behind these figures are generally small, meaning 2 or 3 individuals can skew the figures significantly. This characteristic is true for all sites in this report.

For the young person's service it is apparent that Thurrock has an under-resourced service that is performing at the limit of, if not beyond its capabilities, which is not sustainable in the long term without investment in the service to ensure growth. The performance is very good, demonstrating excellent value for money. Only waiting times could have been better, but as with the adult service, the client numbers tend to be low; the difference between 88% and 100% was 2 clients.

Representation rates for Thurrock's young person service were exemplary, indicating quality within the interventions/treatment that ensured no clients represented within the selected reporting timeframe.

The tier 4 treatment budget for Thurrock has diminished significantly to 50% of its value over just 3 years. Other related costs across our comparator sites, where available, are broadly in line with the population size and other related demographics, but our latest detox and rehab budget is significantly undersized following sharp reductions in recent years.

No comparisons could be drawn against the adult service staffing models, but for young people it was apparent that Thurrock's service is under resourced in terms of both funding and staff.

Innovative practice was identified across all service specifications, but not all learning was transferrable to Thurrock. For example, the nearest general hospital is out of borough for Thurrock and while there are established links to an alcohol liaison service at the hospital, many of the patients at the hospital are not Thurrock residents. It was pleasing to see that MK has also implemented

smoking cessation into their service specification. Payment by results and diversion schemes are areas to explore in future service reviews.

Appendix 2

Service User Feedback – CYP Wize Up DAAT service.

17 year old client

1. **Do you feel the service you received has been of benefit and how?**

Yes, it has helped me to understand the risks of continuing to use substances and I feel ready to give it up. I've also learnt about the pros and cons of cannabis.

2. **What did you enjoy/not enjoy about working with the service?**

Friendly faces every week, stability and routine.

3. **How did you hear about the service?**

Mentor put me forward for the service.

4. **Did you find the meeting times and meeting locations convenient?**

Yes they were convenient; outreach was so useful as the worker would meet me at college during free periods. **(sub-question – were college okay with supporting this?)** – yes the college were okay and as they knew what was happening with me they gave me a bit of leeway. **(A further sub-question – do you feel that you could attend appointments within the home?)** – No definitely not suitable at home.

5. **What do you feel are the strengths of this service?**

Give guidelines to help understand the risks and the consequences such as prison sentences for dealing and helps with weighing up pros and cons and more about giving advice rather than telling you what to do, which is completely different.

6. **Do you think your parent/carer would benefit from attending any appointments with you?**

Think it works here and separately, feels parent might be a bit awkward **(sub-question – does your parent/carer know you are accessing service?)** – yes but doesn't agree with it and doesn't agree with client accessing service, feels client should be sorting it for themselves and though does not like client engaging in the behaviours but doesn't condone it**. (sub-question- do you think you would be able to sort it without the support of the service?)** – no I don't think I could.

7. **What areas, if any, do you feel could be changed or improved and why?**

Not really, but it's only early days as I'm only been attending the service for 5 sessions (weeks) so can't give a definitive answer.

8. **What reasons would you give for recommending/not recommending this service?**

Would recommend as gives help and offers support from friendly faces – tried to bring two friends but they said no. **(sub-question – do you think the service length is suitable? For example, if got told could only have 2 more sessions or if you were still in the service after 2 years?)** – would like 30 sessions in total so 25 more, 1 session per week, 2 years too long but 2 more weeks not long enough.

The client had a social work student (who had been on placement) with them for support and who attended the session to support the client despite the placement having recently ended. We asked them whether they found working in the service useful.

Yes it was a good placement, brilliant, lasting 70 days in total, 4 days per week. The client added that their social worker was great!

Family client group – parent and grandparent + 5 children (17, 14, 12, 10 and 3 years of age). 2 children completed this survey, aged 12 and 10.

1. **Do you feel that the service you received has been of benefit and how?**

Both said they found it useful and helpful for emotional support.

2. **What do you enjoy/not enjoy about working with the service?**

10 year old – helps us and gives us sheets to do – have packs indoors where complete 'feelings' sheets.

12 year old – like having conversations that stay between me and the worker.

3. **Did you find the appointment times and meeting locations convenient?**

Both said that they like it when the worker comes to see them at school (10 year old commented that this is the best bit).

10 year old – likes the times at school except during maths, art and music.

Parent commented that the 12 year old had the worker's number.

4. **What do feel are the strengths of the service?**

12 year old commented that likes having space with the worker on own.

5. **Do you think your parent/carer would benefit from attending any appointments with you?**

Worker commented that sometimes they see the whole family at home during joint sessions.

6. **What areas, if any, do you feel could be changed or improved and why?**

12 year old commented all of the writing. Parent added that sometimes felt that 12 year old wasn't sure how best to write down their feelings.

10 year old – liked everything, no changes to the service.

7. **What reasons would you give for recommending/not recommending the service?**

Both said would tell friends about service if they might need it.

Parent and grandparent feedback

1. **Have you found the service of benefit to your child/children and how?**

Yes definitely, especially the unsent letters, and seen changes in children (particularly 12 year old e.g. sharing the letters with them) although heart-breaking was welcome. Children having other people to talk to.

2. Have **you found the service of benefit to yourself/family any why?**

Yes useful for ourselves also. Grandparent added that the family are a lot closer now.

3. **Did you find the appointment times and venues convenient for yourself and your child/children?**

Appointment times worked well and it was good to have someone to talk to.

4. **What have been the strengths of the service?**

The worker, their rapport with the entire family and the fact that they always go the 'extra mile'. The knowledgeability of the entire team – they are knowledgeable and dedicated.

Grandparent added that accessibility of the service was good and helped the children to ask for help and to speak to the worker.

5. **Do you think you would have benefitted from attending any appointments with your child/children?**

Had mix of sessions both on own and with family. Service helped to develop confidence and felt able to ask questions if unclear on anything. Worker relationship more informal

than with other professionals and helped me to help my family and helped me to change the situation so that my children can stay safe within the home.

6. What areas, if any, would you change or improve and why?

It was a happy medium between advice giving and information about what should do. Grandparent added - just continue doing what you're doing. More funding needed to support these types of services.

7. What reasons would you give/not give for recommending the service?

Parent commented that they have already recommended some friends to the service.

Appendix 3

CGL Wize Up retender

Service User feedback forum

Q1. Do you feel the service you received has been of benefit and how?

Q2. What did you enjoy/not enjoy about working with the service?

Q3. Did you find the appointment times and meeting locations convenient?

Q4. What do you feel are the strengths of this service?

Q5. Do you think your parent/carer would benefit from attending any appointments with you?

Q6. What areas, if any, do you feel could be changed or improved and why?

Q7. What reasons would you give for recommending/not recommending this service?

Parent/carer feedback

Q1. Have you found the service of benefit to your child and how?

Q2. Have you found the service of benefit to yourself/family and why?

Q3. Did you find the appointment times and venues convenient for your child?

Q4. What have been the strengths of the service?

Q5. Do you think you would have benefitted from attending any appointment with your child?

Q5. What areas, if any, would you change or improve and why?

Q6. What reasons would you give for recommending/not recommending this service?

Youth Cabinet questionnaire

CGL Wize Up is a young person's substance misuse service, based in Grays. The team delivers treatment and harm reduction interventions to young people who are misusing drugs or alcohol. They also deliver prevention and education messages in schools and colleges across Thurrock.

Q1. Have you heard of the Young Person's Substance Misuse Service?

Q2. Do you know how to access the service?

Q3. Do you know anyone who is or has worked with the service?

Q4. Have you seen any presentations/lessons delivered at your school and did you find them useful?

Q5. Do you think the Council providing this sort of service is a good idea and why?

Q6. Would you recommend this service to someone who you felt needed it and if so, why?