

Warrington

Joint Strategic Needs Assessment (JSNA)

Children and Young People Substance Misuse Chapter 2014/15

March 2015

Version control

Version	Description of amendments	Date of amendment
1.0	Draft version (updates CYP substance misuse chapter produced for JSNA 2011)	01/12/14
2.0	Amendments from proof reading actioned	19/01/2015
3.0	Final amendments made and PDF created	17/03/2015

The Joint Strategic Needs Assessment (JSNA) considers a wide range of factors that affect the health and wellbeing of the people of Warrington. The objective of the JSNA is to involve partner organisations, such as the local NHS, local authorities, Police, Fire and third sector organisations in order to provide a top level, holistic view of current and future need within the borough. The JSNA is used to agree key priorities to improve the health and wellbeing of all our communities at the same time as reducing health inequalities

EXECUTIVE SUMMARY

Introduction and Overview

This chapter provides an update to the 2011 JSNA chapter which examined substance misuse amongst children and young people. The 2010 Government Drug Strategy (HM Government, 2010), defines substance misuse as including the use of drugs, alcohol and volatile substances (such as glue, gas and solvents). This chapter also considers tobacco use amongst children and young people. The definition of children and young people depends on the subject matter and varies between different organisations. The National Treatment Agency (NTA) for Substance Misuse now under the remit of Public Health England separates analysis of data for persons aged 18 years and under, from that of those aged over 18 years (NTA, 2010). The National Institute for Health and Clinical Excellence (NICE) have produced guidance to reduce substance misuse among vulnerable and disadvantaged children and young people aged under 25 years (NICE, 2007a). For the purposes of this chapter, where possible local analysis will include data for those aged up to the age of 24.

National evidence shows that for young people in England, alcohol and cannabis are the key substances of use (British Crime Survey, 2011).

Key Issues, Gaps and progress since the last JSNA Chapter

There is an on-going issue regarding hospital admissions for young people and current work is exploring new referral pathways from hospital to services to ensure that young people receive appropriate provision once they leave hospital. The recent review suggests that the local school nursing service should be advised, via GP Practices, regarding the admission. Historically the local Young People's Substance Misuse Service was unaware of any young person who had been in hospital and released into the community setting but a new referral pathway was developed in late 2014 to ensure that all young people who access A+E are referred to the local Young People's Service for ongoing support around their substance misuse

On-going work since the last JSNA has been looking at how the prevention agenda for young people's substance misuse ensures that age appropriate messages are given, ensuring consistency of information. A range of partners do go into schools to give appropriate advice including Cheshire Police, Warrington Borough Councils (WBC) Public Protection Unit. The Youth Service has been commissioned to deliver a Risky Behaviours programme in all high schools in Warrington. Working in partnership with the School Health Service they are offering classroom sessions and outreach to students after school. There is a better understanding now of how many young people are engaging in services from a range of cohorts, such as young offenders and children in care. The main sources of referrals to the Young People's Drug and Alcohol Service remain the hospital and education (schools).

There has been a great deal of progress regarding parental substance misuse and its connection with the hidden harm agenda. The adult drug and alcohol treatment provider CRI

(Crime Reduction Initiatives, known locally in Warrington as Pathways to Recovery) now collect parental status, number on child protection plans and other appropriate data so that clearer monitoring can occur. The Recovery Hub which supports those service users in recovery have offered parenting courses and CRI have linked in with the NSPCC's range of parental substance misuse support courses, referring service users for additional parental support.

The new links with the Complex Families agenda, too, has ensured that those parents who are identified as requiring support for their substance misuse are referred to services as appropriate.

Since the last JSNA, there has been great progress on information sharing between the drug and alcohol service and key partners to ensure that those adults needing support are referred and also those children at risk are highlighted.

Based on the data available for young people's specialist service provision in Warrington (PhaZe and Youth Offending Team), there is a real presence of Class A¹ substance misuse among the young people who received specialist intervention in 2012-2013, although alcohol and cannabis remain the most prevalent substances.

Out of 103 young people receiving a specialist service, 23 reported using a Class A substance as their main drug, the types of drugs listed were cocaine, ecstasy and opiates. 3 reported using a Class A drug as their secondary drug, the secondary Class A drugs listed were cocaine and ecstasy. 9 reported Class A drugs as their third drug. This development of increased understanding of Class A drug misuse has enabled more robust clinical governance support to be offered to these services by the adult drug treatment provider: Crime Reduction Initiatives. No young people in Warrington have presented to Tier 3 services with problematic use of 'legal highs'.² Compared with National figures where 2,056 young people are using Class A Drugs, proportionally Warrington have a higher percentage of young people using Cocaine (18%) compare to 7% nationally. A similar proportion is using Ecstasy for both Warrington (4%) and England (5%). For Opiates and Crack Cocaine both Warrington and national figures report 1%.

During 2012/13 there were less than five young people who had been identified as having had a history of injecting. This figure has not been made more specific to ensure confidentiality.

Recommendations for Commissioning

Since the last JSNA, there has been the following progress on the recommendations for commissioning:

Development and investment in the Risky Behaviours programme to offer broader prevention agenda in schools settings to ensure young people receive appropriate messages and information.

¹ *Class A drugs have the most harmful effects. This classification includes heroin, cocaine, ecstasy and LSD (Directgov, 2011).*

² Figures taken from Quarter 3 young people Quarterly Agency Local Assurance Report 2012/13

A review of the Young People's Substance Misuse Treatment Provision in conjunction with the youth service review has ensured that more staff are available to offer young people appropriate interventions around substance misuse.

Data collection systems used by the DAAT include a wide range of data sources and are now in line with national guidance. The data collection systems identify young people most at risk and ensure that specialist services offered are most appropriate for their needs.

For those young people affected by parental hidden harm, a provision is now in place within the Family Support service and the local NSPCC services. Within adult services, parental substance misuse effects are addressed within people's recovery by way of courses on parenting for the service user and better linkages with Children's Social Care.

There are now a range of services currently in place which identify and support families where parental substance misuse is identified. For example: - CRI, NSPCC, Young Carers, Complex Families and CAF. There is on-going review and performance monitoring of these services to ensure identification of such young people remain a priority. Learning from Serious Case Reviews and other national key developments around child safeguarding and parental substance misuse are highlighted and reviewed within commissioned services.

Hepatitis screening and interventions are offered and now in place. The numbers of young people that inject drugs are very low but all are offered hepatitis screening.

Pathways are now in place for:

- Pathways from hospital to community for young people
- Community detox options being delivered by CRI for those young people for whom an alcohol detox is required

Development of protocols to include:

Transition framework for young people to adult treatment provision has been developed but requires formal sign off.

The following recommendation is outstanding from the previous JSNA chapter; appropriate protocols, with support from the DAAT, with local pharmacies regarding needle exchange provision and support for young people accessing needle exchange. New guidance has been produced nationally and a report will need to be presented to the Warrington Safeguarding Children's Board (WSCB).

1) WHO'S AT RISK AND WHY?

There is a range of cohorts of young people who are deemed at risk for substance misuse. All young people need to have appropriate information, education and advice to ensure that they can make fully informed decisions. One of the key challenges over recent years has been the wealth of information that young people can access on the internet and on social media websites which often give mixed messages around the use of drugs and alcohol. Evidence shows that certain cohorts, such as young offenders, those not in education, employment or training (NEET), those who are excluded from school, those who truant, and Children in Care (CiC), are more at risk of entering long term substance misuse as adults (NICE, 2007a).

Children of alcohol or substance misusing parents are also deemed at risk. This includes children whose parents are currently engaged in drug/alcohol treatment or, more particularly, those whose parents are not engaged in a service but are drinking or using drugs within the home. Issues such as child welfare and attendance at school, as well as broader issues, such as drug-related debt, need to be addressed as part of the package of support for children and young people. Estimates on the potential extent of hidden harm amongst children and young people due to parental alcohol issues are included in section 2

Historically substance misuse was considered more of an issue in more deprived areas. Whilst the prevalence of heroin and crack cocaine use may still be more concentrated in the more deprived Lower Super Output Areas (LSOAs³), recent changes in the use of powder cocaine and the use of alcohol has meant that substance misuse and alcohol abuse is now an issue across all socio-economic groups.,

1.1) National Drug Misuse Among Children (11 to 15 years): A report by Fuller (2012) for the NHS Information Centre looked at smoking, drinking and drug use amongst secondary school pupils aged 11 to 15 years. Information was obtained from 7,589 pupils in 254 schools across England in the autumn term of 2012. The report found that prevalence of drug use has declined since 2001. In 2012, 17% of pupils said they had ever used drugs, 12% had taken any drugs in the last year and 6% had taken drugs in the last month. In 2001, the corresponding proportions were 29%, 20% and 12%. Pupils were most likely to have taken cannabis (7.5% in 2012, compared to 13.4% in 2001) and 3.6% of pupils had sniffed glue, gas or other volatile substances in the last year. For all other types of drug, the proportion of pupils who reported any use in the last year was below 1%.

Other findings from the Fuller (2012) report show that:

- Boys were more likely than girls to have taken drugs
- 2% of pupils reported that they usually took drugs at least once a month (the survey definition of frequent drug use). This is lower than in previous years.
- In 2012, 28% of pupils reported that they had ever been offered drugs, a decrease from 42% in 2001.
- The proportion of pupils who were reported to have taken drugs increased with age.

1.2) National Drug Misuse Among Young Adults (16 to 24 years): Figures from the British Crime Survey (BCS, 2012/13) showed that:

- 16.3% of young people aged 16 to 24 years had used one or more illicit drugs in the last year (an estimated 1.18 million young people).
- Use of any illicit drugs amongst young people has fallen since the 1996 British Crime Survey (29.7%), mainly due to a decline in the use of cannabis. 4.8% of young people aged 16 to 24 (around 379,000 young people) had used a Class A drug in the last year.
- The proportion of young adults aged 16 to 24 using cocaine in the last year increased from 1.4% in 1996 to a peak of 6.6% in 2008/09 and has since fallen substantially to 3.1% in 2012/13).

³ LSOAs are small geographical areas, which, in Warrington, 'nest' within electoral wards.

- The use of ecstasy and hallucinogens has reduced over the longer term. Ecstasy use in the 1996 survey was estimated at 6.6% and has fallen to 2.9% in the 2012/13 survey, and the figures for hallucinogens have fallen from 5.3% to 0.8%.

Chart 1: Proportion of Adults Reporting Use of the Most Prevalent Drugs in the Last Year, By Age, 2012/13 BCS

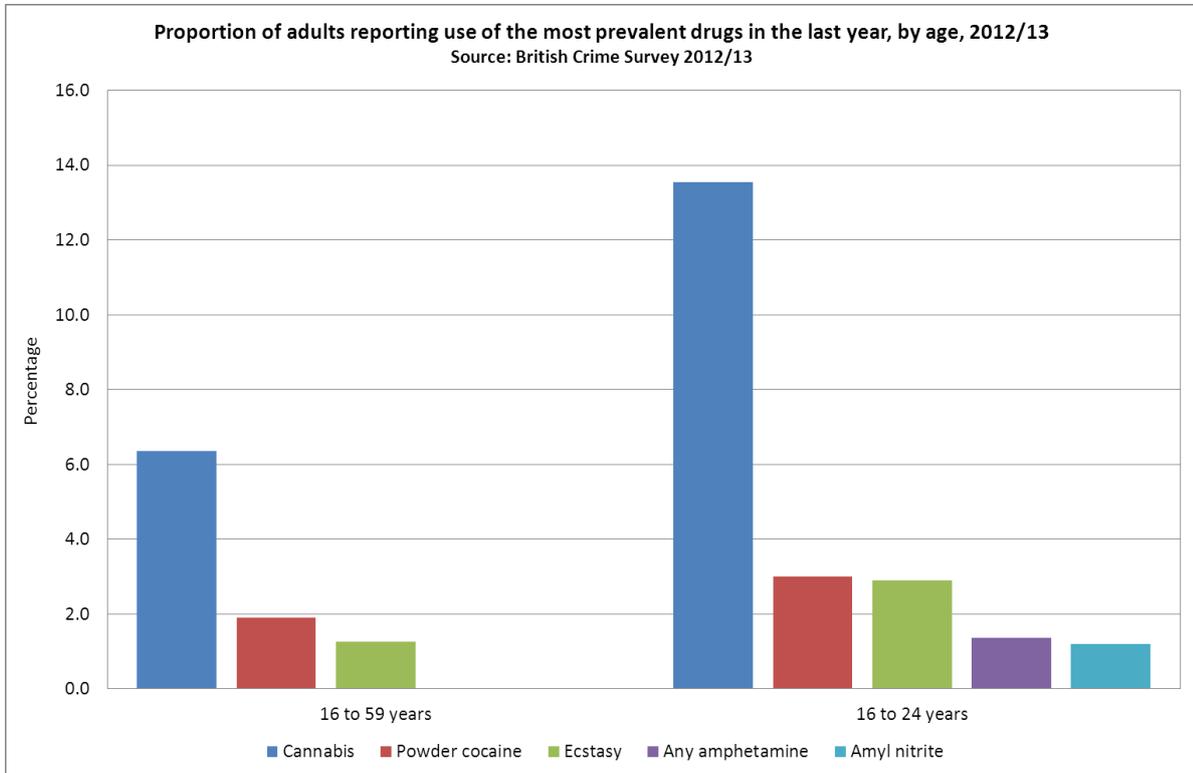
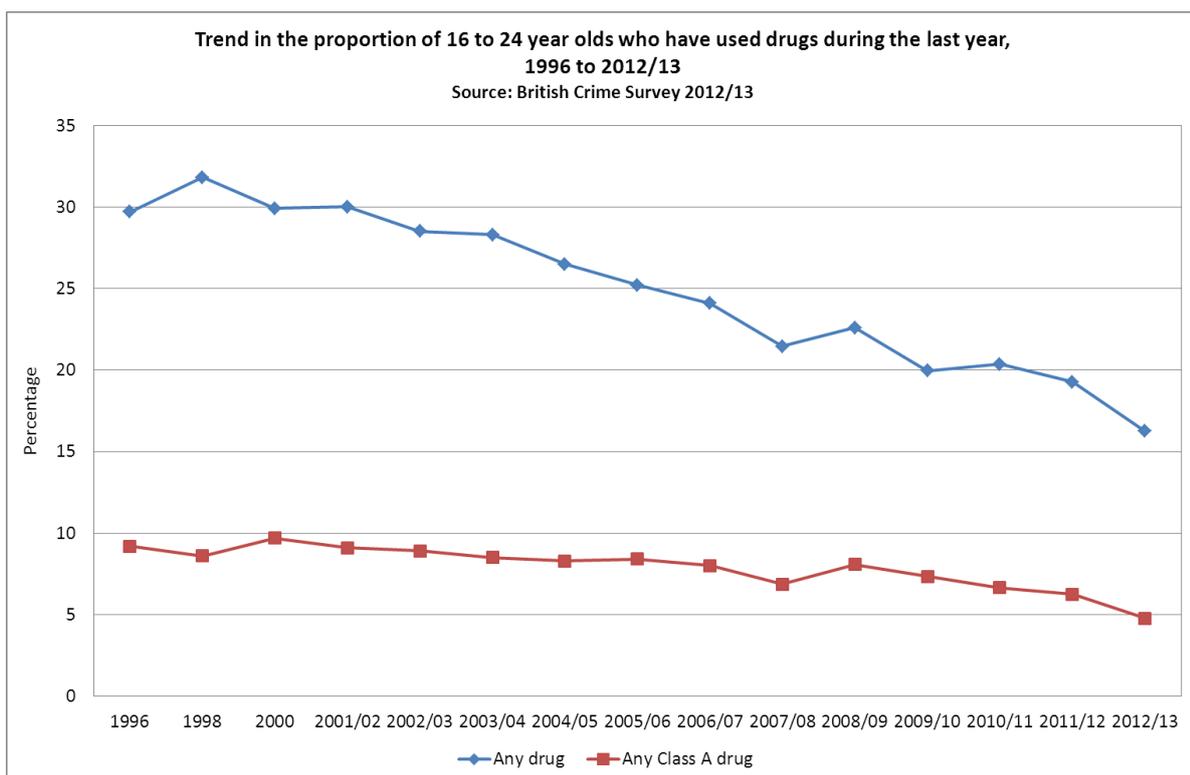


Chart 2: Proportion of Adults Aged 16 to 24 years Reporting Use of Any Drug in the Last Year, 1996 to 2012/13



1.3) National Alcohol Use Among Children (11 to 15 years): The report by Fuller (2012) found that:

- In recent years, there has been a steady decrease in the proportion of pupils who drink alcohol.
- The proportion of pupils who had never drunk alcohol rose from 39% in 2003 to 57% in 2012. Less than half (43%) of pupils aged between 11 and 15 said that they had drunk alcohol at least once in their lifetimes.
- The proportion of pupils reporting that they have drunk alcohol at least once increased with age, from 12% of 11 year olds to 77% of 15 year olds.
- The proportion of pupils who had drunk alcohol in the last week fell from a peak of 26% in 2001 to 10% in 2012.
- As in past surveys, similar proportions of boys and girls had drunk alcohol in the last seven days, and older pupils were more likely to have done so than younger pupils (from 3% of 11 year olds to 25% of 15 year olds).
- In 2012, the median amount of alcohol consumed by pupils who had drunk in the last week was 8.0 units (Fuller, 2012). Pupils are more likely to be given alcohol than to buy it, most commonly by family or friends.
- 44% of pupils who have ever drunk also said they buy alcohol, despite being well below the age to do so legally (18 years old).
- In 2012, pupils who drank alcohol were most likely to buy it from friends or relatives (23%), someone else (15%), an off-licence (14%) or a shop or supermarket (11%)

1.4) Tobacco and Young People: Children become aware of cigarettes at an early age. 3 out of 4 children are aware of cigarettes before they reach the age of 5 (ONS, 2007). Parental smoking and approval/disapproval of the habit are critical factors in the uptake of smoking (Royal College of Physicians, 1992). Young smokers are likely to grow up in environments where smoking is a social norm and where adults and peers smoke. Children who live with parents or siblings who smoke are around three times more likely to become smokers themselves, compared to children of non-smoking households (ASH, 2014). Young people are naïve to addiction, however, once they have started smoking, young people quickly become addicted. Symptoms of nicotine dependence can develop soon after the first cigarette (Gervais et al., 2006). A London study suggests that smoking a single cigarette is a risk indicator for children to become regular smokers up to three years later (Fidler et al., 2006).

The proportion of pupils reporting that they have ever smoked has decreased substantially since 1996 when 49% said they had ever smoked. By 2012 this had dropped to 23%, 4% of pupils were categorised as regular smokers; that is, they reported smoking at least once a week. Unlike in previous years where girls were more likely to be regular smokers, both boys and girls were just as likely to be regular smokers (both 4%). The prevalence of regular smoking has declined from a peak of 13% in 1996 (Fuller, 2012).

In England, very few pupils are smokers when they start secondary school, with less than 0.5% of 11 year olds smoking. This increases with age, so that by 15 years of age, 10% of pupils are regular smokers, (Fuller, 2012). Very few people start smoking for the first time after the age of 25.

As peer influence increases over familial influence, peer pressure encourages many young people to initiate smoking. Illicit and cheap tobacco also makes it possible for many young people to smoke and to smoke more heavily. Boredom and the influence of alcohol can also lead to the initiation of smoking (Local Government Group, 2011).

2) THE LEVEL OF NEED IN THE POPULATION

2.1) Drug-Related Hospital Admissions: Analysis conducted by the Child and Maternal Health Observatory (ChiMat, 2014) has shown that, between 2010/11 and 2012/13, within Warrington the rate of hospital admissions amongst young people (aged 15 to 24) due to substance misuse was significantly higher than England.

Between 2008/09 and 2012/13 there were 164 emergency hospital admissions resulting from to substance misuse amongst young people aged less than 24 years (83 males and 81 females).

Young people at the age of 23 years had the highest rate of emergency hospital admissions (184 per 100,000). This rate was higher (but not significantly) than the overall (ages 15 to 24 years) rate for Warrington (134 per 100,000).

Chart 3: Trend in the Crude Rate of Emergency Hospital Admissions Due to Substance Misuse, by Financial Year, Warrington, 2008/09 to 2012/13

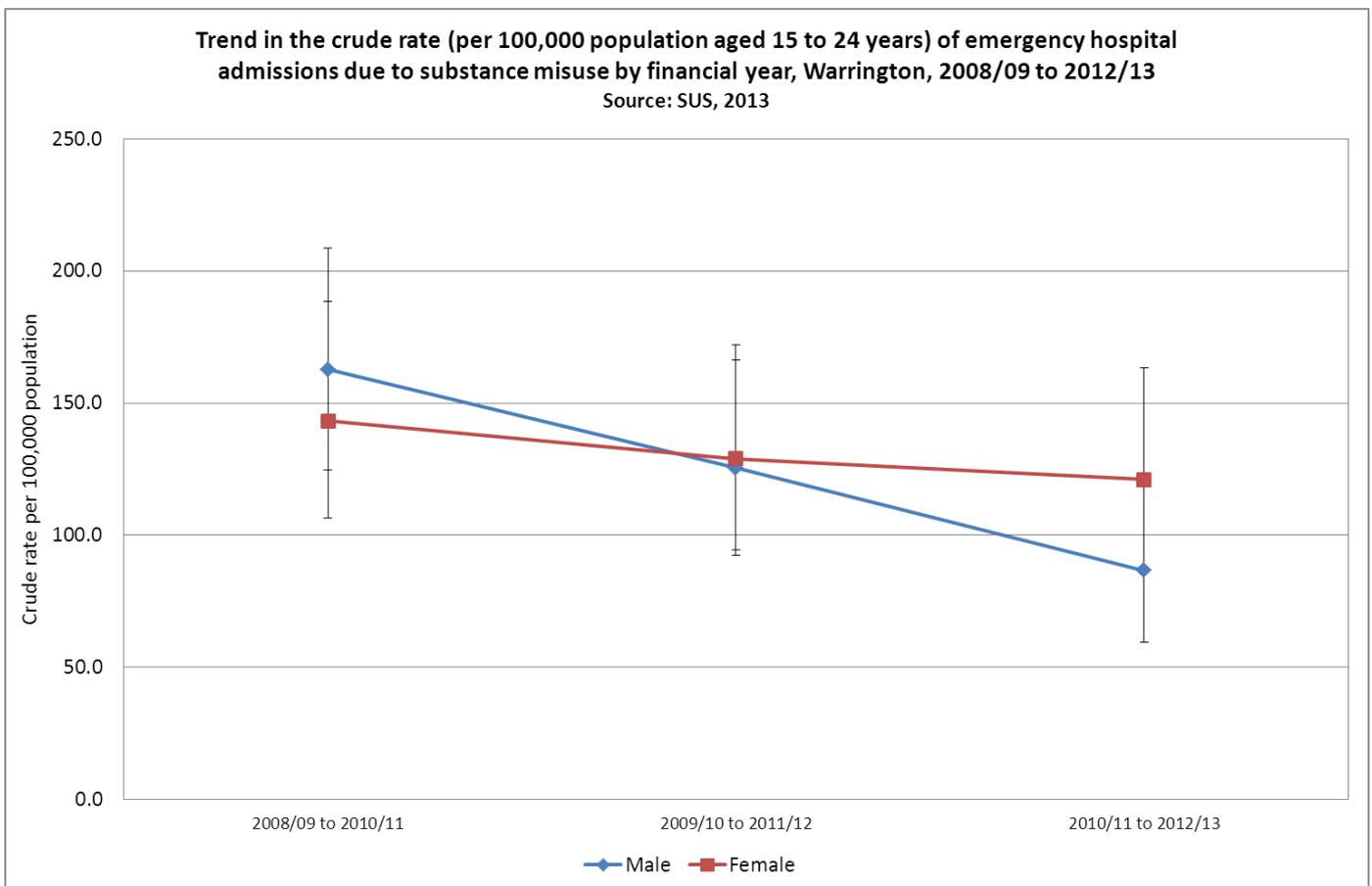
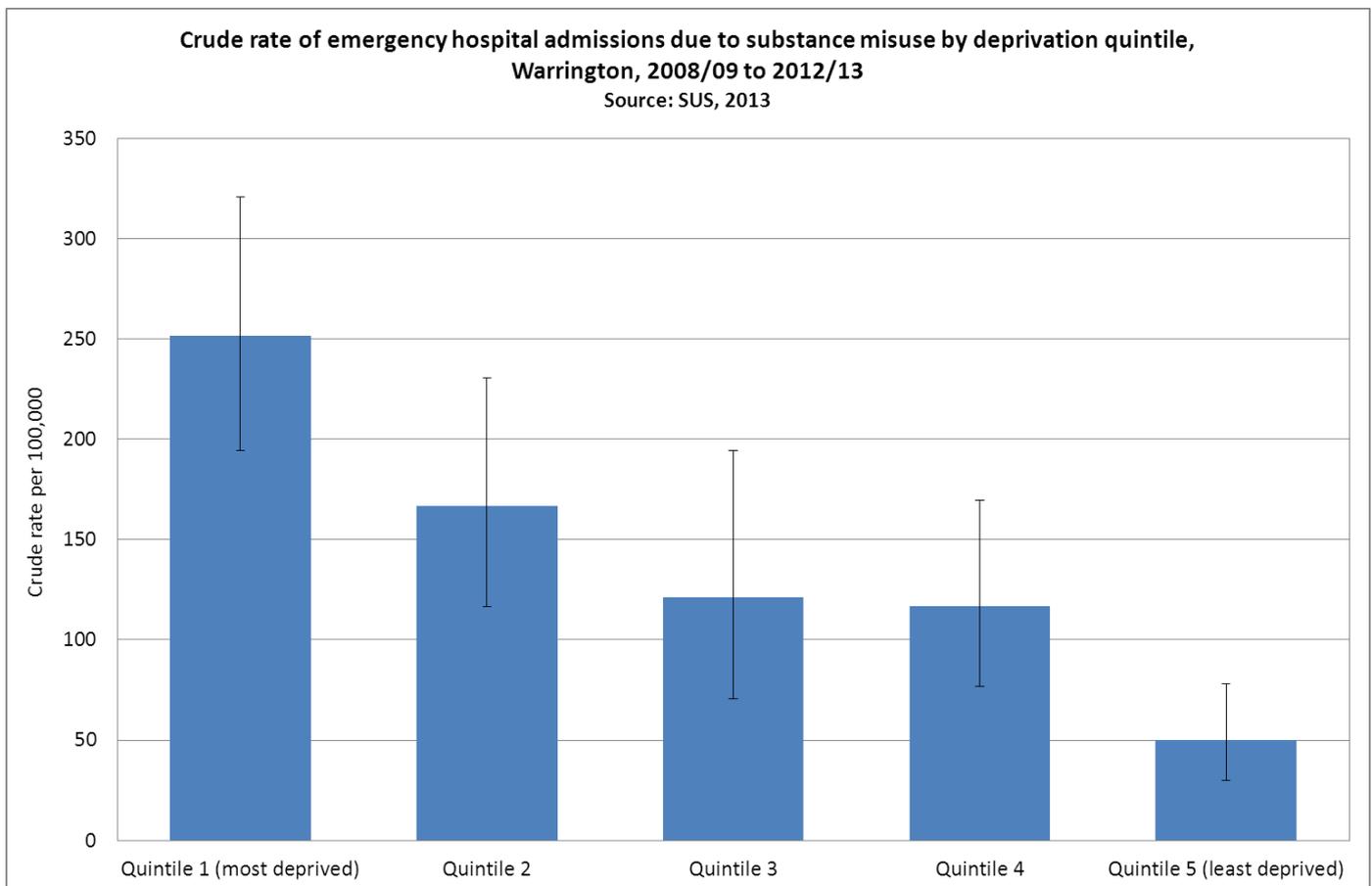


Chart 3 shows that the trend in the rate of admissions (using three year rolling averages) has decreased for both males and females. The chart also shows that the rate of admission for males has reduced at a faster pace than for females resulting in a lower rate of admissions for males during the time period 2010/11 to 2012/13.

The electoral ward of Bewsey and Whitecross had a significantly higher admission rate when compared to the overall admission rate for Warrington. Bewsey and Whitecross had a rate of 325 per 100,000, and Warrington had an overall rate of 134 per 100,000. No wards had an admission rate that was significantly lower than the Warrington rate of admission.

The rate of emergency hospital admission due to substance misuse was significantly higher in the 20% most deprived areas of Warrington (deprivation quintile 1), when compared to the Warrington average (using Index of Multiple Deprivation (IMD), 2010), as shown in chart 4.

Chart 4: Crude Rate of Emergency Hospital Admissions Due to Substance Misuse, by Deprivation Quintile, Warrington, 2008/09 to 2012/13



Cause of admission: For both males and females, *poisoning by narcotics and psychodysleptics (hallucinogens)* was the most common cause of admission. This includes substances such as opium, heroin, codeine, morphine, methadone, pethidine, cocaine, cannabis, lysergide (LSD) and other unspecified narcotics and psychodysleptics.

2.2) Hospital Admissions due to alcohol: Between 2010/11 and 2012/13, Warrington had a slightly higher rate of *alcohol-specific*⁴ hospital admissions in persons aged 18 years and under (52.3 per 100,000 population) when compared to England (44.9 per 100,000 population) (LAPE, 2014).

Between 2010/11 and 2012/13 there were 69 alcohol-specific admissions. Over this time period, the trend in the rate of alcohol-specific admissions decreased steadily in Warrington. During 2012/13 Warrington had an admission rate that was similar to England and significantly lower than the North West.

Chart 5: Trend in the Rate of Hospital Admissions for Alcohol-Specific Harm, per 100,000 Population, ages 0 to 17 years, between 2006/07 to 2008/09 and 2010/11 to 2012/13



As explained in further detail within the alcohol JSNA chapter, there have been changes to the definition of alcohol specific conditions, based new evidence and research of health conditions that are wholly associated with the consumption of alcohol, a revised list of health conditions has been developed. The data presented above is based on the new definition, whilst the following data is based on the pre 2014 definition. It has not been possible to update the following analysis due to restrictions in access to hospital admissions data. Therefore, the following analysis should not be compared to the data presented above.

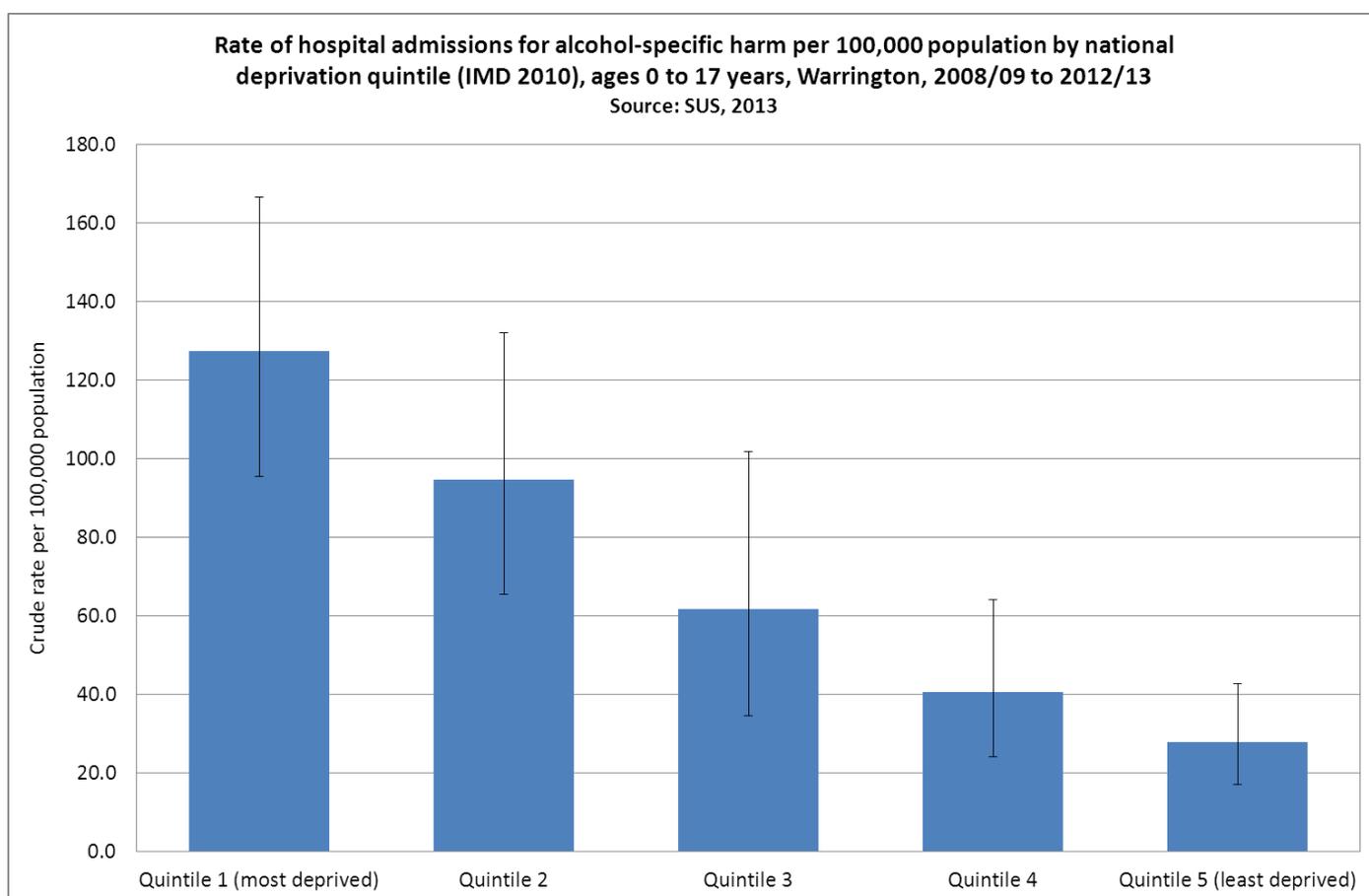
⁴ Alcohol specific relates to admissions where the reason for admission is wholly due to alcohol

However, the following data is being presented as it is expected that the same patterns of hospital admissions presented below will most likely be currently experienced in Warrington.

Orford and Poplars and Hulme wards had significantly higher rates of alcohol-specific hospital admissions for people aged less than eighteen years, when compared to the overall rate of admissions for Warrington. The most common cause of admission was due to *acute intoxication due to alcohol* (63 admissions).

Alcohol-specific hospital admission rates were significantly higher in the most deprived quintile (20% most deprived areas) when compared to the overall rate for Warrington. The following chart illustrates the significant difference in admission rates by deprivation quintile.

Chart 6: Rate of Hospital Admissions for Alcohol-Specific Harm per 100,000 Population, by National Deprivation Quintile (IMD 2010), ages 0 to 17 years, Warrington, 2008/09 to 2012/13



Trading Standards North West (TSNW) conducted a regional survey to understand teenage relationships with alcohol. The 2013 survey was completed by 683 teenagers aged 14 to 17 years in Warrington. The frequency of drinking alcohol in Warrington was very similar to the regional pattern. 10% responded that they drank alcohol twice or more in one week, compared to 9% in the North West. However, 18% responded that they never drink alcohol, compared to 32% in the North West.

Warrington had a similar percentage of regular binge drinkers⁵ (12%) to the North West (11%). A higher percentage of occasional⁶ binge drinkers were found in Warrington (52%, compared to 43% in the North West). (TSNW, 2013).

In Warrington, 11% of the TSNW (2013) survey respondents reported that they consume alcohol in pubs and/or clubs, this was lower than the North West average (14%). However, 19% of Warrington respondents reported that they drank alcohol outside (14% in the North West). This would indicate that a lower proportion of the young people surveyed were being served alcohol in Warrington, although this has resulted in a higher percentage drinking in public areas.

When comparing the TSNW results between 2009 and 2013, the percentage of teenagers buying alcohol for themselves has reduced, both locally and regionally. In 2009, 17% of respondents stated they had bought alcohol themselves, but this reduced to 13% in 2013.

2.3) Hidden Harm: In addition to the direct impact of alcohol on an individual's health, there is the associated, but often hidden, problem of the harm to children of parents with alcohol-related problems. Dube et al. (2001) have shown that exposure to parental alcohol abuse is highly associated with adverse childhood experiences. Estimates of alcohol-related hidden harm vary. In 2004, the Cabinet Office (Prime Ministers Strategy Unit) report, *Alcohol Harm Reduction Strategy for England*, estimated that between 780,000 and 1.3 million children are affected by parental alcohol problems annually (Cabinet Office, 2004).

More recently, Manning et al. (2009) examined responses from both the *Health Survey for England* (2004) and the *General Household Survey* (2004), which generated consistent estimates. The reports suggest that approximately 30% of children under 16 years (3.3 - 3.5 million) in the UK lived in a household with at least one adult binge drinker, 8% with at least two binge drinkers (typically both parents), and 4% where the only adult in the household was a binge drinker. Manning et al. (2009) also reported that the National Psychiatric Morbidity Survey (NPMS) indicated that in 2000, 22% of children (2.6 million) lived with a hazardous drinker and 6% (705,000) with a dependent drinker.

There are approximately 39,000 children aged under 16 living in Warrington, according to 2012 population estimates. Applying the national estimates to the Warrington population suggests that there are just over **11,700** children in Warrington living with at least 1 binge drinker, and just over **2,340** with a dependant drinker. Table 1 provides further estimated numbers of Warrington children potentially affected by parental alcohol use.

⁵ *Binge Drinker-* Where a person consumes at least twice the daily recommended amount of alcohol (8 units for men and 6 units for women) in a single drinking session. A regular binge drinker was defined as binge drinking one or more times in one week.

⁶ An occasional binge drinker was defined as binge drinking on three or less occasions per month

Table 1: Estimated Numbers of Under-16's in Warrington Affected by Alcohol Use

Estimates of Children (under 16 years)	Estimated Number in Warrington
Living with at least 1 binge drinker	11,700
Living with 2 binge drinkers	3,120
Living with lone, binge drinking adult	1,560
Living with hazardous drinker	8,580
Living with dependant drinker	2,340

(Source: Health Survey for England, General Household Survey and National Psychiatric Morbidity Survey estimates applied to 2012 population estimates for Warrington.)

Alcohol and drugs are a major contributing factor in cases that are discussed at the monthly Multi Agency Risk Assessment Conference (MARAC⁷). Cheshire Police Domestic Abuse data for Warrington 2010/11 states that MARAC related reports note alcohol (28%) and substance misuse (13%) as a significant contributory factor. For more information, please see the JSNA chapter on Domestic Violence.

2.4) Tobacco Harm: In previous years, the pattern of young people's smoking prevalence was higher in Warrington than the national average. However, the latest survey from Trading Standards (2013) has shown a substantial reduction for 14 to 17 year olds in Warrington; prevalence has fallen to 15%, compared to 21% in 2009 and 23% in 2007 (TSNW, 2013). National prevalence suggests 10% of 15 year olds are regular smokers (Health and Social Care Information Centre, 2012) and 17% of 16 year olds (Department of Health, 2011).

The North of England Illicit Tobacco Survey 2011 indicated that there has been a tangible and measurable shift in attitude towards illicit tobacco⁸, with more people feeling uneasy about purchasing these products over the last two years (NEMS, 2011). This data also suggests that the illegal tobacco market across the North West is diminishing, with the number of smokers admitting that they buy illegal tobacco down from 19% in 2009 to 17% in 2011. However, of particular note and focus for attention are the availability of illicit tobacco shops in the North West region and the availability of illicit tobacco to young people through fag houses⁹.

In Warrington, recent research suggests that the previously high level of access to illicit tobacco that 14 to 17 year olds have in some areas is reducing. Only 34% now report

⁷ In a MARAC, local agencies meet to discuss the highest risk victims in their area and consider other family members, including any children. Information about the risks faced by those victims, the actions needed to ensure safety and to manage the behaviour of the perpetrator is shared. Information is also shared to ensure that the resources available locally are used to create a risk management plan that involves all agencies.

⁸ Illicit tobacco can be either smuggled (legitimately manufactured but have evaded payment of tax by being illegally transported and distributed), bootlegged (purchased in a country with a low level of taxation and illegally brought into the UK) or counterfeit (illegally manufactured, often abroad, using inferior materials).

⁹ Private houses selling cigarettes to those too young to buy them in shops.

having bought cigarettes with health warnings in different languages compared with 62% in 2009 (TSNW, 2013).

The TSNW survey reports other encouraging trends for Warrington:

- In October 2007, the minimum legal age for buying tobacco rose from 16 to 18 years. National data on secondary school pupils aged 11-15 years (Health and Social Care Information Centre, 2011) indicated that the proportion of regular smokers who buy cigarettes from shops, initially decreased to 55% in 2008 following the change in the law. However, since 2008 there has been a slight upwards trend, and the latest figure is 60% (2012). Within Warrington the proportion of young people accessing cigarettes from shops has continued to decrease. (TSNW, 2013).
- Locally, access from other sources, such as street sellers, neighbours, private houses, ice cream vans, and car boots also appears to be decreasing; down from 39% in 2011 to 22% in 2013. (TSNW, 2013).
In Warrington, 22% of young people have bought fake cigarettes (22% regionally). Locally, this is a downward trend from 35% in 2011 (TSNW, 2013).

2.5) Steroids: Evidence gathered in recent years around the numbers of needles being exchanged for injecting purposes showed an increase of needle being utilised for steroid usage and a decline of those being used for heroin injecting.

Year end 2013/14 data from The Inter Agency Drug Misuse Database from Liverpool John Moores University has been provided.

The quarter 4 data highlights that Warrington has a higher prevalence of steroid usage compared with other North West drug service agencies that provide needle exchange. Warrington reports 85% of clients who accessed the Agency Needle Syringe Programme was for steroid use. Other agencies also report Steroids as the highest prevalent drug with 70%¹⁰.

Table 2: Warrington Percentages for Substance Prevalence compared with the Average of all Agencies listed below in the North West Counterpart Breakdown, Quarter 4, 2013/14

	Steroids Unspecified	Heroin Illicit	Growth Hormone	Melanotan	Amphetamine	Methadone	Testosterone & Esters	Cocaine Freebase (Crack)	Cocaine	Cyclizine	Diamorphine	Morphine Sulphate	Temazepam	Other Drug	Not Recorded
Warrington	85%	7%	2%	2%	0%	0%	1%	0%	0%	0%	0%	0%	0%	1%	3%
All SES ¹¹	70%	13%	2%	1%	1%	1%	0%	0%	0%	0%	0%	0%	0%	0%	12%

¹⁰ Data taken from LJMU IAD Quarter 4 2013/14 Report

¹¹ SES refers to Syringe Exchanges

For all individuals by age groups, the breakdown for Warrington identifies that there were no needle exchanges for the under 18 age group, 2% of the exchanges were for the 18 to 19 age group, 22% of the exchanges were for the 20 to 24 age group and 24% for the 25 to 29 group. Compared with the average for the other North West agencies, this shows that although Warrington reports a similar trend to the average for the under 18 and 18 to 19 age groups, other counterparts report 19% aged 20 to 24 and 23% aged 25 to 29 (slightly less presentations in other areas compared with Warrington but not drastically different). (Data taken from IAD Quarter 4 2013/14 Report).

As at March 2014, the Inter Agency Drug Misuse Database from Liverpool John Moores University reported that there were 1,316 individuals (of all ages) who presented to pharmacies for the Needle Syringe Programme across Warrington between April 2013 and March 2014. (Data taken from IAD Quarter 4 2013/14 Report).

A Warrington specific breakdown provided by Liverpool John Moores University for steroid use identifies 5 individuals for the 18 and under age group. For the 19 to 24 age group there were 36 individuals and the 25 to 29 age group accounts for 45 individuals. (Data taken from Warrington Specialist Needle & Syringe Programme Analysis 2013-14 from Liverpool John Moores University)

2.5.1) Needle Exchange:

During 2013/14, there were 272 presentations to the CRI Needle Exchange services made by young people aged less than 25 years (16 to 25 years), the majority were aged 22 to 25 years (189 presentations).

For all age presentations at the Needle Exchange 87.2% of the exchanges were for people using steroids, injecting Class A drugs accounted for 5.8% of the needle exchanges.

The needle exchange service reported that during 2013/14, steroid use was reported in the under 25 population using their service. Steroid use equated to approximately 93% of those presenting to the Needle Exchange aged 25 and under, as was heroin use (approximately 3% of the 25 and under population presenting to the Needle Exchange), melanotan¹² (approximately 2% of the 25 and under population), other stimulants (approximately 2% of under 25 population) and an unknown substance (approximately 2% of the 25 and under population presenting to the Needle Exchange Service). (Data taken from Quarter 4 2013/14 CRI Pathways Drug Treatment Report, Needle Exchange Section and specific Needle Exchange Breakdown Report provided by CRI)

¹² *Melanotan is advertised and sold illegally as an injectable tan. There are two types of Melanotan (Melanotan I and Melanotan II) which increase the levels of melanin (the body's natural protection from the sun), resulting in a suntan. Melanotan has not been tested, so the side effects are unknown.*

3) CURRENT SERVICES IN RELATION TO NEED

The main specialist services for children and young people's substance misuse are the Young People's Drug and Alcohol Team (formerly known as Phaze) and the Youth Offending Service.

3.1) The Young People's Drug and Alcohol Team is a specialist substance misuse service that works with young people who are affected by their own or someone else's alcohol or drug use. The service's main approaches are of prevention and harm minimisation. The service provides support for young people who want to stop using drugs and alcohol and provides information on how to minimise the dangers for those who do. There are currently only two full time members of staff at the Young People's Drug and Alcohol Team.

3.2) The Youth Offending Team (YOT) includes drug misuse professionals who deliver specialist provision for young offenders. By including substance misuse support as part of the youth offending service, the team aims to reduce the impact that drugs and alcohol can have on the young person's life, as well as the impact they can have on society. The YOT Substance Misuse Officer covers all young offenders across Halton and Warrington.

Between October 2012 and March 2013 the Substance Misuse Officer delivered specialist substance misuse interventions to a total of 44 young people across the Halton and Warrington footprint, predominantly for alcohol and cannabis misuse, but also for other substances. The emphasis was on those young people who are 'high risk' of harm either to others or themselves and those young people who form a part of the Integrated Offender Management (IOM) 'Navigate'¹³ cohorts for both the Halton and Warrington schemes (usually around 10 young people on each at any one time).

¹³ The "Navigate scheme" is managed by Cheshire Police and works with a range of partners including Probation services, Housing, local prisons and local drug/alcohol services, amongst others and their work focusses on ensuring that offenders have a range of options in place to reduce their reoffending

3.3) Service User Profile

(Data taken from Quarter 4 2013/14 Young People Executive Summary Report 2013-14 from Public Health England & NDTMS)

Table 3: Age Profile of Service Users (Young People's Substance Misuse Service), 2013-14

Age	Warrington (%)	National (%)
Age 12	0%	1%
Age 13	26%	19%
Age 14		
Age 15	29%	25%
Age 16	26%	27%
Age 17	19%	27%

The largest proportion of service users are aged 15, similar numbers are reported for ages 13 to 14 and 16. A smaller proportion of the treatment population are aged 19. Those aged over 18 would be classed under the adult treatment population and are not listed under the Young People Executive Summary report.

Overall Warrington has a higher proportion presenting under the age group of 13 to 14 and 15. There are more presentations nationally for ages 16 and 17 than those reported for Warrington.

Data based on Quarter 4 2013/14

There were 77 individuals reported to be in service/receiving treatment who are aged 18 years and under for the rolling 12 month period at quarter 4 2013/14, of these 58 were new presentations.

Table 4 presents all Substances reported as being used by clients in service during 2013/14. The figures relate to all substances cited by individuals as being used over the year. Individuals may cite more than one substances, therefore the total of percentages may exceed 100%.

Table 4: Substance Use Reported by Clients in Service, 2013/14

Substance	Warrington (YTD at Quarter 4 2013/14)	National (YTD at Quarter 4 2013/14)
Cannabis	87%	85%
Alcohol	66%	55%
Amphetamines	4%	10%
Cocaine	14%	8%
Ecstasy	5%	6%
Solvents	4%	2%
Opiates	0%	1%
Crack	0%	1%
NPS	6%	2%
Nicotine	0%	9%
Other	8%	6%

Data Source: Quarter 4 2013/14 YP Executive Summary Report 2013/14 from Public Health England & NDTMS

In keeping with the national picture, data suggests that locally more young people seeking treatment are citing cocaine use and alcohol use than across England as a whole.

Cocaine is the most popular Class A drug reported as main drug of choice, followed by ecstasy.

Evidence suggests that treatment intervention times for young people generally should be shorter than for adults, with most young people needing to engage with specialist drug and alcohol interventions for a short period of time, often weeks, before continuing with further support elsewhere, within an integrated young people's care plan (NTA, 2012).

Table 5: Length of Time in Service, Statistical Neighbours for Young Peoples Services

	Average Time in Service (YtD¹⁴) Weeks
Authority	
Warrington	18.04
Bury	28.80
Cheshire East	14.91
Cheshire West & Chester	30.74
Stockport	25.89
East Riding of Yorkshire, North, East & West	28.15
York	23.69
Solihull	30.25
Staffordshire	13.44
Warwickshire	18.81
Central Bedfordshire	26.65
National	22.25

Warrington reports a lower average treatment length than other authorities, with Cheshire West and Chester reporting the highest with 30.74 weeks.

4) PROJECTED SERVICE USE AND OUTCOMES IN 3-5 YEARS AND 5-10 YEARS

4.1) Substance Misuse: Nationally, the proportion of pupils (aged 11 to 15 years) who have ever taken drugs has reduced. In 2001, 29% of pupils had taken drugs, whilst in 2012 this reduced to 17% (Fuller, 2012). When applying this percentage to the number of pupils aged 11 to 15 years in Warrington, approximately 2,078 pupils have tried drugs. If the current national trends were to continue, by 2018 12% of pupils will have tried drugs, and, applying this percentage to the predicted Warrington population aged 11 to 15 years, approximately 1,415 pupils will have tried drugs in Warrington.

¹⁴ YtD refers to all young people who were in service between 1st April 2013 and 31st March 2014

If current trends in the rate of drug-related hospital admissions were to continue in Warrington, it is expected that, in just two years, the rate of admissions will reduce by approximately 33%. However, the current trend in hospital admissions analysis only covers three time periods. Due to this relatively short space of time, these trends, and any projections, should be used with caution.

Alcohol and cannabis use are likely to remain key priorities over the next 5-10 years for the population. The national trend suggests that drugs such as crack cocaine and heroin are now not as prevalent as they have previously been. There has also been a growth in the use of powder cocaine and its perception as a drug that is not addictive needs to be addressed. As stated previously, there is a lack of local data on specific drug use that can be compared to the national data. Whilst it seems unlikely that patterns experienced nationally will differ greatly from the local picture, local intelligence is needed to confirm this, and this data gap needs to be addressed to allow for effective prioritisation of services.

The recent growth of 'legal highs' may lead to longer term health impacts, particularly around mental health issues, for this cohort. "Legal highs" or its professional term "New Psychoactive Substances" contain one or more chemical substances which produce similar effects to illegal drugs (like cocaine, cannabis and ecstasy). These new substances are not yet controlled under the Misuse of Drugs Act 1971 and are often sold as plant food and are not fit for human consumption (info taken from talktofrank.com)

The availability of steroids and Melanotan on the internet, and the local growth in the use of cannabis within the North West, has meant that drugs are now more easily accessible. Without key interventions and prevention work around substance misuse, this could lead to more young people presenting to specialist service provision, and then potentially into adult drug and alcohol treatment.

4.2) Alcohol: The proportion of pupils (aged 11 to 15 years) who have ever had an alcoholic drink has been reducing year on year at a national level. During 2001, 61% of pupils reported having an alcoholic drink, this percentage reduced to 43% in 2012 (Fuller, 2012). If the 2012 percentage is applied to the Warrington pupil population, approximately 5,255 pupils have tried an alcohol drink. If national trends were to continue, by 2018 only 35% of pupils will have tried alcohol. Applying the predicted percentage to projected populations for 2018, it is estimated that 4158 pupils in Warrington will have tried alcohol. Trend analysis highlights that the rate of alcohol-specific hospital admissions in Warrington has reduced. If these trends continue, further reductions in the rate of admissions will be observed. However, the current trend in hospital admissions analysis only covers three time periods. Due to this relatively short space of time, these trends, and any projections, should be used with caution.

4.3) Tobacco: The percentage of pupils aged 11 to 15 years who have reported that they have ever tried smoking has reduced substantially over time. In 1982, 53% reported that they had tried a cigarette. This percentage had reduced to 25% by 2011 (Health and Social Care Information Centre, 2012). There was a sharp reduction in percentage observed from 2007 onwards, which could be a reflection of the increase in the minimum age at which a person can buy tobacco (16 to 18) in this year. Due to the change in law, and the resulting substantial reduction in the percentage of pupils trying smoking, as yet there is insufficient data on which to predict future figures.

5) EVIDENCE OF WHAT WORKS

The National Institute for Health and Care Excellence (NICE) has produced evidence based guidelines on:

- *Community-based interventions to reduce substance misuse among vulnerable and disadvantaged children and young people* (NICE, 2007a), which covers the development of local strategy, use of tools to identify those at risk, multi-partner working, motivational interviewing, behavioural therapy and family based programmes. The pathway was updated in June 2013 (NICE, 2013)
- *Interventions in schools to prevent and reduce alcohol use among children and young people* (NICE, 2007b), which covers methods for encouraging children and young people not to drink, including a whole school approach (policy, staff training, parental and child involvement), one-to-one approaches, and partnership working.
- *Needle and syringe programmes* (NICE, 2014) makes recommendations on needle and syringe programmes, including those provided by pharmacies and drugs services for adults and young people (including those under 16) who inject drugs, including image- and performance-enhancing drugs.
- There are also a number of guidelines for adult substance misuse which can be found in the JSNA Chapter for Substance Misuse (adults).

There are an extensive number of Cochrane systematic reviews on alcohol and/or drug misuse in children and young people. These include:

5.1) Alcohol Misuse Prevention: Foxcroft & Tsertsvadze (2011a; 2011b; 2011c) conducted a number of systematic reviews of the evidence surrounding prevention programmes for alcohol misuse in young people. The first review (Foxcroft & Tsertsvadze, 2011a) considered universal family-based programmes, which included aspects of parenting skills, parental monitoring, social resistance skills and the development of behavioural norms. Most of the studies reported positive effects of family-based universal programmes for the prevention of alcohol misuse in young people. However, two studies, each with a large sample size, reported no effects. The authors concluded that the effects of family-based prevention interventions are small, but generally consistent, and are also persistent into the medium- to longer-term.

The second review (Foxcroft & Tsertsvadze, 2011b) looked at universal multi-component prevention programmes. Multi-component prevention programmes deliver interventions in multiple settings, such as both a school and family setting, combining school curricula with a parenting intervention. Most of the studies reported positive effects of multi-component programmes for the prevention of alcohol misuse in young people, with effects persisting into the medium- and longer-term. However, when the impact of single versus multiple components was assessed, only 1 out of 7 studies clearly showed a benefit of components delivered in more than 1 setting. Overall, there is some evidence that multi-component interventions for alcohol misuse prevention in young people can be effective, but there is

little evidence that interventions with multiple components are more effective than interventions with single components.

The third review (Foxcroft & Tsertsvadze, 2011c) found no difference between programmes that specifically targeted the prevention or reduction of alcohol misuse and generic programmes with a wider focus of prevention (e.g., other drug use/abuse, antisocial behaviour). The most commonly observed positive effects across the programmes were for drunkenness and binge drinking. In conclusion, current evidence suggests that certain generic psychosocial and developmental prevention programmes can be effective. For example, the Life Skills Training Program, the Unplugged Programme, and the Good Behaviour Game.

5.2) Opioids, Opiates and Heroin: Minozzi et al. (2009a; 2009b) conducted reviews of the evidence surrounding detoxification and maintenance treatments for opiate dependent adolescents in the USA. Minozzi et al. identified one study that compared buprenorphine tablets to clonidine patches as a **detoxification** treatment. The trial reported a trend in favour of buprenorphine in reducing the dropout rate, but found no difference between treatments in the duration and severity of withdrawal symptoms. More participants in the buprenorphine group went on to long-term naltrexone treatment. Minozzi et al. also reviewed a study that compared methadone and LAAM¹⁵ as a **maintenance** treatment. The two maintenance treatments gave similar improvements in social functioning.

A further trial compared buprenorphine-naloxone **maintenance** and buprenorphine **detoxification**. The maintenance treatment had a lower dropout rate and a higher attendance at the follow up appointment, but that there was no difference in the reduction of opiate use. At a one-year follow up, self-reported opioid use was clearly less in the maintenance group and more adolescents were enrolled in other addiction programmes. Although methadone is the most frequently used drug for the treatment of opioid withdrawal in the US, Minozzi et al. did not find any controlled trials using methadone as a detoxification treatment.

5.3) Poly Drug Use: Gates et al. (2009) reviewed interventions for prevention of drug use by young people delivered in non-school settings, which evaluated four types of intervention: motivational interviewing or brief intervention, education or skills training, family interventions, and multi-component community interventions. Many studies had methodological drawbacks, especially high levels of failure to follow-up and the authors concluded that there were too few studies to form firm conclusions. One study of motivational interviewing suggested that this intervention was beneficial for cannabis use. Three family interventions (Focus on Families, Iowa Strengthening Families Programme, and Preparing for the Drug-Free Years), each evaluated in only 1 study, suggested that they may be beneficial in preventing cannabis use. Multi component community interventions were not found to have any strong effects on drug use outcomes, nor were education and skills training interventions.

5.4) Tobacco Use: There is little published evidence of the effects of interventions that focus on smoking cessation in adolescence. Nationally, only 3% of service users who set a quit date were aged 18 or under. Stop Smoking Support Services for this age group should be

¹⁵ LAAM- Levacetylmethadol (or levo- α -acetylmethadol) is a synthetic opioid with a similar structure to methadone

'young people friendly' and should link in with other programmes to ensure they reach as many children and young people as possible. This should be through healthy school programmes, health services on secondary school sites and other youth settings.

The evidence base for preventive strategies for young people is improving and include peer mentoring initiatives and the wider public health and tobacco control agendas that focus on de-normalising smoking. The latest research in social psychology and behavioural economics suggests that reducing the uptake of smoking is best achieved by influencing the adult world in which young people grow (Department of Health, 2011).

In 2010, a Cochrane Review (Grimshaw et al., 2010) was published that looked at tobacco cessation for young people (those aged under 20). The review found 24 good quality studies (with over 5000 participants) that researched ways of helping teenagers to quit. Programmes that combine a variety of approaches, including taking into account the young person's preparation for quitting, supporting behavioural change and enhancing motivation, show promise. Medications such as nicotine replacement and bupropion have not yet been shown to be successful with adolescents.

Since the publication of the Cochrane review, two further studies have been published. Harris et al.'s (2010) study compared Motivational Interviewing for smoking cessation with a comparison condition. The study found Motivational Interviewing for smoking cessation is effective for increasing cessation attempts and reducing the number of days the client smoked. However, the effects found were only short-term.

The second study (Stein-Seroussi et al., 2009) looked at a trial of an interactive, games-based, tobacco cessation program (ACTION). The program is designed to help adolescents who live in tobacco-growing communities to stop using tobacco. The study found that ACTION participants were more likely than comparison participants to achieve abstinence at 90-day follow-up. However, the generalizability of this particular (USA) intervention is open to question.

6) (TARGET) POPULATION/SERVICE USER VIEWS

As part of the young people's consultation (WBC, Children and Young People's Directorate, 2011), a survey was distributed to years 8 and 10 in four high schools across the borough and was completed by 605 pupils. Although there are some gaps in the evidence collected, 87% responded to the question asking if they had consumed a full alcoholic drink and 62% of these respondents had. Regarding the frequency of their drinking, 55% responded, with 29% saying they had not been drunk in the last 4 weeks, 21% saying they had been drunk once or twice in the last 4 weeks, and 40% saying they had never been drunk. The remaining 5% stated they did not know. The majority of respondents (51%) said they got alcohol from their parents or carers.

A small review of the young people accessing Phaze during 2011 was also completed. The feedback on the referral process, sessions delivered, staff, confidentiality and impact of the interventions were all positive. Clarity on confidentiality was noted, in that some young people did not fully disclose their information for fear of it being passed on. Reflections on location and opening times of the service were also noted, with options of weekend and evening work being preferred options.

Feedback from service users are routinely collected by the Young People's Drug and Alcohol Team. Below are extracts from the evaluation forms completed by service users:

Service user A says: *the service is easy to access. Appointments were made where I felt comfortable.*

Service user B says: *You (the Young People's Drug and Alcohol Team) are doing well as you do not give up on people*

Service user C says: *the service worked for me – fantastic!!*

Service user D says: *it helped me to change my drinking and feel better.*

7) UNMET NEEDS AND SERVICE GAPS

Since the last JSNA, there has been the following progress of the unmet needs and service gaps:

Working in partnership with the wider Children and Young People's agenda to develop, implement actions that focus on de-normalising smoking behaviour is crucial if the recent improvements in reducing Warrington's high smoking rates are to be sustained in this vulnerable group.

An enhanced support programme for schools began in January 2014, with local stop smoking service staff working with teachers and school health. Currently, work is being undertaken to understand the large health inequalities gap for women who smoke at time of delivery. Warrington is now part of the 'Smokefree Play Areas' initiative, and there has been a renewed push on 'Take 7 Steps Out' and smokefree homes messages during 2014.

A dedicated resource should be made available to develop, co-ordinate and promote the 'Take 7 Steps Out' Smokefree Homes scheme.

This is now part of a Health Improvement Practitioners Role.

Resources are needed for proactive/prevention work on illicit tobacco, as well as reducing under age sales.

Illicit tobacco information is part of the Smokefree Schools Award. A new factsheet has been developed to support schools with this.

The following unmet needs and service gaps have been identified:

- As mentioned previously, the key critical elements are the current gaps in service around the prevention agenda within school and other settings. Whilst this will be addressed with the implementation of a framework for supporting delivery of risky behaviours agenda in schools and out of school settings, a key element will be the effectiveness and quality assurance of the information being given by the providers within a young people's setting
- There is also a gap in the potential capacity for the young people's substance misuse treatment provision. The issue of hidden harm remains high and consideration regarding support for young people whose parents use substances needs addressing.

8) RECOMMENDATIONS FOR COMMISSIONING

Since the last JSNA, there has been the following progress on the recommendations for commissioning:

Development and investment in the Risky Behaviours programme to offer broader prevention agenda in schools settings to ensure young people receive appropriate messages and information.

A review of the Young People's Substance Misuse Treatment Provision in conjunction with the youth service review has ensured that more staff are available to offer young people appropriate interventions around substance misuse.

Data collection systems used by the DAAT include a wide range of data sources and are now in line with national guidance. The data collection systems identify young people most at risk and ensure that specialist services offered are most appropriate for their needs.

For those young people affected by parental hidden harm, a provision is now in place within the Family Support service and the local NSPCC services. Within adult services, parental substance misuse effects are addressed within people's recovery by way of courses on parenting for the service user and better linkages with Children's Social Care.

There are now a range of services currently in place which identify and support families where parental substance misuse is identified. For example: - CRI, NSPCC, Young Carers, Complex Families and CAF. There is on-going review and performance monitoring of these services to ensure identification of such young people remain a priority. Learning from

Serious Case Reviews and other national key developments around child safeguarding and parental substance misuse are highlighted and reviewed within commissioned services.

Hepatitis screening and interventions are offered and now in place. The numbers of young people that inject drugs are very low but all are offered hepatitis screening.

Pathways are now in place for:

- Pathways from hospital to community for young people
- Community detox options being delivered by CRI for those young people for whom an alcohol detox is required

Development of protocols to include:

Transition framework for young people to adult treatment provision has been developed but requires formal sign off.

The following recommendation is outstanding from the previous JSNA chapter; appropriate protocols, with support from the DAAT, with local pharmacies regarding needle exchange provision and support for young people accessing needle exchange. New guidance has been produced nationally and a report will need to be presented to the Warrington Safeguarding Children's Board (WSCB).

9) RECOMMENDATIONS FOR NEEDS ASSESSMENT WORK

The evidence base within this JSNA chapter is based on a needs assessment conducted in 2011, (WBC Children and Young People's Directorate). It is suggested that this is performed at regular intervals to predict young people's substance misuse prevalence and need.

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Strategic Groups include:

Children and Young People's Commissioning frameworks

Children and Young People's Partnership

Public Health Governance Board

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ASH see Action on Smoking and Health

ChiMat see Child and Maternal Health Observatory

NICE see National Institute for Health and Care Excellence

NTA see National Treatment Agency for Substance Misuse