

Bristol JSNA Chapter 2016-17

Young People and Substance Misuse

Chapter information	
Chapter title	Young People and Substance Misuse
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Linked JSNA chapters	This needs assessment should be seen as part of a wider commissioning programme of substance misuse services, emphasising prevention work and reducing future needs within the adult population.

Executive summary

Introduction

This JSNA chapter discusses drug and alcohol use by young people aged 11-24. This upper age limit is included in accordance with the World Health Organisation definition. The chapter is underpinned by the national drug and alcohol strategies and the Chief Medical Officer's guidance on young people and alcohol. It shares many aims with local strategies, including The Bristol Health and Wellbeing Strategy.

There are approximately 21,000 young people of secondary school age (11-15) in Bristol (BCC, 2014a) and 70,500 aged 16-24 (BCC, 2016).

Risks related to substance use are particularly relevant for young people. Nationally the incidence of drug use rises with age until 24 and then decreases. Those who use drugs and alcohol at a younger age are more likely to develop unhealthy patterns that continue into adulthood, and are increasingly likely to experience poor health outcomes, including liver disease, cancer and mental ill health.

The Bristol population contains a high proportion of the groups who are more likely to use drugs and alcohol, including young people and those who are vulnerable to poor health outcomes. Substance use among young people in England has been falling since about 2003, but drug use among 15 year olds in Bristol is amongst the highest in England. There are an estimated 4,400 15 year olds in Bristol (ONS, 2015) and HSCIC (2015c) estimates that 17.7% (approximately 780) of this group have tried cannabis, compared to 10.7% of those in England. The level of alcohol use among 15 year olds in Bristol is also above the national average, with 66.7% (approximately 2,900) saying they have ever had an alcoholic drink, compared to 62.4% in England.

Variations between wards highlight inequalities across the city, with some areas in the south and east central experiencing significantly higher rates of drug and alcohol related hospital admissions among young people than other areas in the city.

Opportunities for prevention exist in all education and youth settings, in agencies targeting vulnerable young people and families and in a range of health settings.

Key issues and gaps (summary of section 8)

There are gaps in knowledge among workers within universal services and those who work with vulnerable groups about what constitutes good quality drug and alcohol education and about referral pathways into substance misuse services. There are also gaps in the consistency of delivery of drug and alcohol education in schools. These gaps have an impact on prevention and early intervention among young people, especially among those who are most vulnerable. This is likely to have a negative effect on health outcomes.

Commissioned substance misuse services for young people in Bristol deliver high quality provision and are valued by those who use them, but it appears that the level of provision does not meet need. In addition, resources for children and young people who are affected by a parent or carer's substance misuse do not meet the level of need.

Treatment numbers for female drug and alcohol users are low in some services. Data quality from treatment services is sometimes poor.

Recommendations (summary of section 10)

To Improve Prevention

1. All agencies working with young people and families should encourage workers to attend 4YP substance misuse training appropriate to their role. Where possible,

- commissioners should make this a condition within service level agreements (SLAs) and measure this in performance management. Attention should be paid particularly to those who work with young people and families who are vulnerable.
2. Schools should deliver drug and alcohol education through an evidence based PSHE curriculum, following good practice guidelines.
 3. Those working with LGBT+ young people should ensure that young men are educated about the additional risks involved in chemsex.

To Strengthen Targeted Interventions

4. Targeted services working with young people in the early stages of substance use should be maintained at their current level.
5. A method of follow up evaluation on outcomes of 4YP training should be developed to assess how well this training is being used by trainees. This should include measuring the use of screening and referrals into substance misuse services, so that referrals can be increased.
6. A citywide drug and alcohol policy should be developed for schools and implemented according to DfES Guidance.
7. Hidden Harm services should be maintained at their current level and possibilities for external additional funding opportunities should be explored and bids supported by BCC and NHS commissioners.

To Strengthen Specialist Treatment

8. Frequent (monthly) referral meetings between targeted services and treatment agencies should take place as a matter of routine to identify young people with higher levels of need. This should include consideration of ANY young person with identified vulnerabilities, to ensure that all young people are receiving the appropriate response to their level of need.
9. Specialist treatment services should be maintained at their current level.
10. Relevant people from each of the treatment agencies should attend NDTMS training and all training updates to ensure that data quality is improved.
11. A needle and syringe policy should be developed or updated, according to NICE guidelines.
12. All services should continue to work to YPF standards. Commissioners should ensure that this is in contracts.
13. The resource for the transition into adult substance misuse services is very small. Commissioners should explore with ROADS commissioners whether funding can be redirected to provide a broader transitions service, appropriate to age.
14. Lines of communication should be set up with adult services, young people's services and commissioners to look at young adults coming into ROADS who are unknown to young people's services, in order to identify and remove gaps in earlier intervention.

To Improve Pathways through all Commissioned Substance Misuse Services

15. There appear to be low numbers in all services of specific vulnerable groups of young people. Pathways need to be developed or updated and promoted to ensure this gap is reduced. As a priority, these should include youth services, alternative education, health, social care, youth justice services, housing and the child sexual exploitation support service.

JSNA chapter report

1) Who is at risk and why?

Levels of drug and alcohol use among young people in England have fallen substantially since about 2003 (HSCIC 2015a, Home Office 2015b). In spite of this, young people in England have a significantly higher level of drug use than the older population, with incidence rising until the age of 24 and then decreasing rapidly. Among 16-24 year olds, those who drink are proportionately more likely to adopt risky drinking behaviour than older age groups (ONS, 2016a).

HSCIC (2015a) estimates that in 2014 15% of secondary school aged pupils (11-15 year olds) had ever taken drugs, 10% had taken drugs in the last year and 6% had taken drugs in the last month. They also estimate that 38% of pupils had drunk alcohol at some time, 8% had drunk alcohol in the last week and 8% of pupils had been drunk in the last four weeks. Among 11-15 year olds girls and boys are equally likely to use drugs and alcohol (HSCIC, 2015a). Drug use begins to decrease among women at about the age of 19 but continues to rise among young men until the age of 24 (Home Office, 2015b). They are also more likely than young women to drink frequently (ONS, 2016). The highest prevalence of drug use according to ethnicity is among young people who are Mixed, followed by those who are White (Home Office 2015b, HSCIC 2015c). All other ethnic groups have low levels of drug use among young people compared to the average levels for England (HSCIC, 2015c).

The highest prevalence of alcohol use among young people according to ethnicity is among those who are White. This is the only ethnic group that significantly exceeds the average proportion for those who are involved in alcohol related risky behaviour. The second highest proportion is among those who are Mixed. Rates of alcohol consumption among all other ethnic groups are low (ONS 2012, HSCIC 2015c).

Rates of substance use are higher among lesbian, gay and bisexual (LGB) groups than in the general population (Abdulrahim et al, 2016). Among 15 year olds, those who identify as LGB and other demonstrate higher levels of risk relating to both drug and alcohol use than those who identify as heterosexual (HSCIC 2015c). There is increasing concern about the level of risk for those who engage in chemsex. The number of young people involved in chemsex is currently unknown, but is likely to be extremely small. However the associated risks are high and include sexually transmitted infections and blood borne viruses such as HIV and hepatitis C.

The highest prevalence of substance use occurs among vulnerable groups who are more likely than other young people to adopt high risk behaviours and to experience poor health and social outcomes as a result. Public Health England (PHE) has identified these groups as looked after children, children in need and those with a child protection plan; those who experience domestic abuse, including as a witness; those with mental ill health; those who experience or are at risk of child sexual exploitation; those who self-harm; those who are not in education, employment or training (NEET); those who have housing problems; those whose parents and carers misuse drugs and alcohol; and those involved in antisocial behaviour and criminal activity. These groups face complex problems and recurrent studies highlight that they experience much higher levels of substance misuse linked to other risky behaviour than those in the general population (Bellis et al 2015, Meltzer et al 2002; Ward et al 2003; Berelowitz et al, 2012; Green et al, 2005).

Drug and alcohol use is also falling among some of these groups, but at a much slower rate than for the general population and in many cases the gap is still very wide. For example children who have truanted or have been excluded from school are estimated to be 6 times more likely to use drugs at

least once a month and 8 times more likely to have used Class A drugs in the previous 12 months than other young people (HSCIC, 2015a).

Importantly, most of these young people experience multiple vulnerabilities and those who belong to more than one vulnerable group have significantly higher levels of substance use than those who belong to just one group (Becker and Roe 2005, Bellis et al 2015)).

Deaths among those aged 24 and under that are specifically caused by alcohol or are attributable in part to alcohol are very unusual. However, drinking behaviour at this age contributes to cumulative harm and therefore impacts directly on outcomes for older groups. In 2014 8,697 alcohol-related deaths were registered in the UK, equating to 14.3 deaths per 100,000 within the population (ONS, 2016).

Alcohol use also contributes to high levels of morbidity. In 2013/14 the number of hospital admissions in England for alcohol specific illness was 1,059,210 (HSCIC, 2015d). Of these 5,670 were under 16 and 39,620 were aged 16-24. Alcohol use among young people under 18 is known to contribute to problematic patterns in adulthood (DoH, 2009). It also has strong associations with mental ill health and is linked to other risk behaviours including smoking, accidents, violent behaviour and risky sexual behaviour. Alcohol can also have a negative impact on young people's relationships and on their engagement with education, employment and training.

Most deaths that are related to the use of other drugs occur among opiate users. Opiate use is very unusual among young people (ONS 2015b, Home Office 2015b) and therefore those under 20 have the lowest rate of drug related deaths in England, at 2.4 per million (ONS, 2016). The rate for those aged 20-24 is not available but for those aged 20-29 it is significantly higher at 40.5 per million. The highest rate is among those aged 40-49 and is 88.4 per million.

The use of other drugs is also known to contribute to ill health. Cannabis is the most popular illegal substance used by young people. 6.7% of 11-15 year olds and 16.3% of 16-24 year olds say they have used cannabis in the previous 12 months (HSCIC, 2015a, Home Office 2015b). This substance is known to cause smoking related diseases and accidents. Heavy users are at risk of developing dependence (Home Office, 2008). Cannabis is also known to present significant risks to mental health, including psychosis. Younger users and those who are already vulnerable to mental ill health are at particular risk (RCP, 2014).

Other substances that are popular among 16-24 year olds are MDMA/ ecstasy, powder cocaine and nitrous oxide.

The Home Office (2015b) records that in 2014/15 5.4% of 16-24 year olds said that they had used MDMA/ecstasy in the previous 12 months. There has been a significant rise in the proportion of young men who say they have used MDMA/ecstasy during the previous 12 months, increasing from 3.7% in 2012/13 to 7.8% in 2014/15 (Home Office 2015b). Deaths related to MDMA/ecstasy are very rare but these have also risen in recent years. In 2010 only 8 deaths in which MDMA/ecstasy appeared on the death certificate were recorded in England and Wales whereas in 2014 this number rose to 50 (ONS, 2015b). Approximately 50% ecstasy related deaths occur among those aged 15-24, (Ghodse et al, 2014).

There has also been a statistically significant rise in the proportion of young men aged 16-24 who have used powder cocaine during the previous 12 months. (Home Office 2015b). This has increased from 3.6% in 2012/13 to 7% in 2014/15. Cocaine is associated with damage to the cardio vascular system and most deaths and illnesses that are related to cocaine use are due to cardiac problems (ACMD, 2015a). ACMD also identify some of the risks to health associated with pharmaceutical adulterants that are added to cocaine, which have been known to cause overdose and organ

damage.

Nationally, the proportion of 16-24 year olds who say they have used nitrous oxide in the previous 12 months has risen from 6.1% in 2012/13 to 7.6% in 2013/14 (Home Office 2014). The percentage of young people of secondary school age who have tried nitrous oxide is much smaller, at about 2.9%. (HSCIC, 2015a). While there are definite risks involved in nitrous oxide use, most young people who use it do so according to harm minimisation advice and therefore the impact on mortality and morbidity is very low.

There is also a concern about the use of new psychoactive substances (NPS) by young people. In May 2016, production and supply of these substances became illegal in UK under the Psychoactive Substances Act. Between 2011 and 2014 the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) recorded a small rise from 8% to 10% in the proportion of 15-24 year olds in UK who said had ever used NPS (EMCDDA, 2016). 5% of 15 year olds said that they had used NPS in the last year (HSCIC, 2015a). Between 2007 and 2014 the number of deaths in England and Wales where NPS appeared on the death certificate rose from 9 to 67 (ONS 2015b). The Royal College of Psychiatrists (RCP, 2014) reports that use of NPS can seriously affect both physical and mental health, including the development of longer-term physical and psychological dependence. It is too early to tell what impact the new law will have on morbidity and mortality related to NPS.

2) What is the size of the issue in Bristol?

There are approximately 21,000 young people aged 11-15 in Bristol (BCC, 2014a) and 70,500 aged 16-24 (BCC, 2016). The estimated numbers of young people in Bristol who use drugs and alcohol, based on HSCIC (2015a) and Home Office (2015b) data, are shown in Table 1.

Table 1

Estimated number of young people in Bristol who have used drugs and alcohol.

	11-15 (HSCIC, 2015a)	16-24 (Home Office 2015b)
Ever used drugs	3,150	25,730
Used drugs within the last year	2,100	13,680
Used drugs within the last month	1,260	7,191
Ever drunk alcohol	7,980	N/A
Drank alcohol last week	1,680	N/A
Has been drunk during the last 4 weeks	1,680	N/A

Those who used drugs during the last month and those who have been drunk in the last four weeks can be identified as those with more risky patterns. This provides an approximate number who should be targeted for support by substance misuse services. However they are not two distinct groups, as poly drug use is common and therefore there will be crossover.

The figures in Table 1 assume that levels of substance use among young people in Bristol are similar to those for England. However, HSCIC (2015c) estimates that 15 year olds in Bristol have a slightly higher level of alcohol use than those in England and a significantly higher level of use of other drugs (HSCIC, 2015c). The ONS mid-year estimated population of 15 year olds resident in Bristol for 2015 is 4,400. HSCIC (2015c) estimates that 66.7% of this group (approximately 2900) have had an alcoholic drink at some time, compared to 62.4% in England. The percentage of regular (at least once a week)

drinkers among 15 year olds in Bristol is 6.1% (approximately 270) which is very close to the national percentage of 6.2%. However 16.6% of 15 year olds in Bristol (approximately 730) are estimated to have been drunk in the last 4 weeks, compared to 14.6% in England. This suggests that when young people in Bristol do drink alcohol, they are more likely to drink excessive amounts. The estimate within the WAY survey (HSCIC, 2015c) that Bristol has a higher proportion of 15 year olds in Bristol who use drugs compared to the rest of England may suggest that the estimated levels of need in Bristol as calculated in this JSNA chapter are quite conservative.

There is no Bristol specific data about patterns of alcohol use among those aged 16-24 but regionally the South West has the highest proportion of people aged 16-59 who drank alcohol in the previous week and high percentages of other alcohol related risk behaviours (ONS, 2013).

Hospital admissions for alcohol specific conditions among those under 18 in Bristol are 35.7 per 100,000, (HES, 2016), similar to the benchmark for England which is 36.6. However, variations across the city for alcohol related hospital admissions highlight inequalities, indicating a significantly higher level of need in some wards.

Table 2 shows the rates of alcohol related hospital admissions in Bristol by ward, with data provided by the Southwest Commissioning Support Unit (CSU) and aggregated between 2011/12 and 2015/16. It shows hospital admissions for alcohol specific conditions, where alcohol is causally implicated in all cases of the condition, and alcohol attributable admissions, where alcohol contributes to but is not the sole cause of a condition. The latter is calculated according to the proportion of the condition that is caused by alcohol (PHE, 2015). Filwood and Easton have the highest rates, particularly among 16-24 year olds. Westbury-on-Trym and Henleaze has the lowest rate.

Table 2 Admissions to hospital with alcohol-specific and alcohol attributable conditions: crude rates per 10,000 population, persons under 25 years old in Bristol 2011/12 to 2015/16

Ward	Admissions to hospital with alcohol-specific conditions: crude rates per 10,000 population, persons under 25 years old			Admissions to hospital with alcohol-attributable conditions: crude rates per 10,000 population, persons under 25 years old		
	Under 16	16 - 24	Under 25s	Under 16	16 - 24	Under 25s
Ashley	1.2	51.1	25.5	4.4	47.7	25.5
Avonmouth & Lawrence Weston	6.0	67.0	27.3	4.9	66.3	26.3
Bedminster	1.2	38.0	16.8	3.1	29.0	14.0
Bishopston & Ashley Down	2.7	59.5	30.4	4.1	50.5	26.7
Bishopsworth	3.9	34.7	15.2	3.5	39.2	16.6
Brislington East	0.0	32.4	10.7	3.3	37.8	14.7
Brislington West	2.0	39.5	14.9	5.0	48.5	20.0
Central	0.0	27.9	24.1	4.8	25.7	22.8
Clifton	1.7	21.5	16.5	4.2	19.8	15.9
Clifton Down	0.0	25.9	20.9	5.1	22.6	19.2
Cotham	1.9	13.5	11.0	5.2	17.0	14.5
Easton	0.7	101.3	34.1	4.2	79.0	29.1
Eastville	0.0	71.7	29.1	3.7	62.8	27.6
Filwood	4.6	105.4	36.7	6.7	82.2	30.8

Frome Vale	1.9	20.8	11.7		3.2	28.2	16.2
Hartcliffe & Withywood	0.9	37.0	13.3		4.5	52.2	20.9
Henbury & Brentry	0.8	76.7	26.8		2.9	69.0	25.5
Hengrove & Whitchurch Park	1.9	87.3	33.7		4.7	65.6	27.3
Hillfields	2.1	41.1	15.4		4.3	53.9	21.3
Horfield	0.9	26.2	13.3		3.1	36.8	19.7
Hotwells & Harbourside	0.0	23.9	19.3		3.6	21.8	18.2
Knowle	1.4	47.5	16.1		4.7	47.8	18.5
Lawrence Hill	0.4	52.1	19.7		3.8	46.3	19.7
Lockleaze	2.9	47.0	19.7		4.2	52.6	22.7
Redland	2.3	20.4	10.3		2.2	30.2	14.6
St George Central	0.0	35.6	12.7		2.8	41.2	16.5
St George Troopers Hill	3.8	51.0	20.8		5.5	56.2	23.7
St George West	0.0	53.9	17.8		4.2	45.8	18.0
Southmead	1.3	68.9	22.9		2.8	66.1	23.0
Southville	0.0	69.7	31.6		4.2	69.7	33.9
Stockwood	5.7	33.0	16.0		5.0	38.5	17.6
Stoke Bishop	2.2	45.0	27.7		2.7	32.1	20.2
Westbury-on-Trym & Henleaze	0.0	26.8	7.3		1.5	39.0	11.7
Windmill Hill	0.9	52.9	20.1		5.8	48.9	21.7
Bristol total	1.7	43.4	20.6		4.0	42.1	21.3
Bristol total numbers	71	1461	1532		163	1,418	1,582

Levels of drug use among young people in Bristol are estimated to be among the highest in England. HSCIC (2015c) suggests that 17.7% of 15 year olds (approximately 780 people) have tried cannabis, compared to a national benchmark of 10.7%. 8.9% of 15 year olds in Bristol (approximately 390 people) are estimated to have used cannabis in the previous month. This is the second highest recording by local authority in the country and compares to a national benchmark of 4.6%. 2.5% of 15 year olds in Bristol (approximately 110 people) had also taken drugs other than cannabis during the previous month. This is the third highest recording in the country at local authority level and compares to a national benchmark of 0.9%.

The level of drug use among 16-24 olds in Bristol has not been measured but drug use in the South West region is very high among those aged 16-59, with a higher prevalence than the national benchmark for all substances recorded and the highest prevalence in England and Wales for cannabis use in the last year (Home Office 2015b).

HES (2016) estimates that the aggregated rate of substance use related hospital admissions among those aged 15-24 in Bristol between 2012/13 and 2014/15 was 82.1 per 100,000. This is similar to the national benchmark of 88.8 per 100,000, but variations across the city for drug related hospital admissions again highlight inequalities. Data from the South West CSU shows very high rates of admission among 16-24 year olds in Hartcliffe and Withywood and Filwood. The lowest rates are in Clifton.

Table 3 Admissions to hospital with one of the diagnosis of mental and behavioural disorders due to use of drugs and noxious substances: crude rates per 10,000 among people under 25 years old, Bristol, 2011/12 to 2015/16.

Aggregated 2011/12 to 2015/16	Crude Rate per 10,000 population		
	Under 16	16 - 24	Under 25s
Ward			
Ashley	5.4	203.9	102.1
Avonmouth & Lawrence Weston	6.4	353.9	127.7
Bedminster	5.8	228.0	99.9
Bishopston & Ashley Down	0.9	151.2	74.3
Bishopsworth	4.8	358.1	135.1
Brislington East	3.5	253.7	86.1
Brislington West	7.9	310.5	111.9
Central	2.0	98.9	85.8
Clifton	5.0	47.9	37.2
Clifton Down	0.0	54.1	43.6
Cotham	3.7	63.4	50.9
Easton	5.2	257.9	89.2
Eastville	2.1	219.4	90.2
Filwood	8.0	643.1	210.7
Frome Vale	6.8	151.9	82.0
Hartcliffe & Withywood	7.9	809.2	283.1
Henbury & Brentry	5.9	318.2	112.6
Hengrove & Whitchurch Park	11.0	259.8	103.5
Hillfields	4.8	290.7	102.4
Horfield	7.5	187.0	95.5
Hotwells & Harbourside	0.0	118.1	95.1
Knowle	3.5	308.6	101.1
Lawrence Hill	3.9	302.9	115.3
Lockleaze	3.6	285.5	111.3

Redland	3.9	92.5	43.0
St George Central	1.6	300.2	108.0
St George Troopers Hill	3.8	268.6	99.0
St George West	8.3	354.0	122.4
Southmead	8.8	387.5	129.8
Southville	2.5	247.6	113.5
Stockwood	5.7	271.8	105.9
Stoke Bishop	4.4	87.8	54.1
Westbury-on-Trym & Henleaze	0.0	114.0	31.0
Windmill Hill	3.5	232.7	88.1
Bristol	5.0	222.8	103.7

The picture of alcohol and drug use in Bristol may reflect the fact that the population includes high proportions of those who demonstrate the greatest levels of drug and alcohol use nationally. This includes those aged 16-24, especially young men, and those whose ethnicity is defined as White or Mixed (BCC 2016c). Bristol also has a higher proportion of groups who are identified as vulnerable. Calculating the number of young people in Bristol who are vulnerable to substance misuse according to the PHE definitions is very difficult, partly because not all of this information is recorded and partly because multiple vulnerabilities mean that young people do not fall into individual groups, which could result in double counting. However, the Children's and Young People's Mental Health and Wellbeing profile records high proportions of these young people in Bristol, compared to the national average. This includes Looked After Children; those with risk factors for poor mental health and wellbeing; hospital admissions as a result of self-harm; those who are not in education, employment or training (NEET); those who have been excluded from school; those who are in contact with the criminal justice services for the first time; those whose parents are in drug treatment. The estimated number of children under 16 living in Bristol with parents who are in drug and alcohol treatment, based on adult data held by BCC is 1301.

Department for Communities and Local Government (2016) figures on homelessness shows that Bristol also has high levels of homelessness among those aged 16-24

Other vulnerable groups in Bristol who are difficult to measure include young people are known to be at risk of child sexual exploitation (CSE). From the data that is available, Skidmore and Chapman (2016) estimated that there were 439 children and young people previously victimised or at risk of CSE collectively in Bristol in 2015-16.

Bristol Drugs Project carried out a survey with LGBT+ people at the 2016 Bristol Pride Festival to identify the need relating to chemsex. Raw data shows that among 104 respondents who completed the survey, <5 young people under 16 and 29 people aged 16-24 who identified as LGBT+ also reported using substances that are strongly associated with chemsex. Respondents within all age groups also reported injecting methamphetamine and/or mephedrone. It is not known whether any of these people were Bristol residents but this identifies a need relating to appropriately targeted education and an awareness of sexual exploitation.

3) What are the relevant national outcome frameworks indicators and how do we perform?

The success of reducing the harm caused by drug and alcohol use among young can be measured using a variety of PHE profiles. The most specific data about levels of substance use are taken from the Health Behaviours in Young People: What About YOUth? (WAY) Survey (HSCIC, 2015c). Table 4 shows the data compared to regional and national benchmarks with RAG (red, amber, green) status showing how well Bristol performs.

Table 4

WAY data for Bristol, England and South West region with RAG rating showing performance (HSCIC, 2015c)

	Bristol	England	South west region
Percentage who have ever had an alcoholic drink.	66.7	62.4	71.8
Percentage of regular drinkers	6.1	6.2	7.4
Percentage who have been drunk in the last 4 weeks.	16.6	14.6	17.5
Percentage who have ever tried cannabis	17.7	10.7	13.3
Percentage who have taken cannabis in the last month	8.9	4.6	5.9
Percentage who have used drugs excluding cannabis in the last month.	2.5	0.9	1.4

Local Alcohol Profiles for England show a broad range of alcohol indicators at local authority level. They measure mortality; hospital admissions, including by gender and age group; alcohol related conditions; other impacts and treatment outcomes. Some of these indicators are included as key indicators for the Public Health Outcomes Framework.

Other public health profiles measure outcomes that are linked to substance misuse include the liver disease profiles, co-existing substance misuse and mental health issues profiles and the children and young people's mental health and wellbeing tool. Improvements in these areas will also indicate the success of drug and alcohol prevention interventions with young people.

Data about young people in drug and alcohol treatment services is also collected by Public Health England through the National Drugs Treatment Monitoring System (NDTMS) and locally by Bristol City Council using the data monitoring system, Theseus.

4) What is the evidence of what works (including cost effectiveness)?

1. Evidence of what works in prevention and early intervention is provided by The National Institute on Health and Care Excellence (NICE), Department for Education (and Skills) and PHE and includes:

PH4, Interventions to reduce substance misuse among vulnerable young people (2007).

<https://www.nice.org.uk/guidance/ph4>

This guidance is aimed at all agencies involved in reducing substance misuse, including those working in the NHS, local authority, education, voluntary or community sector, social care, youth services and criminal justice services. It recommends targeting vulnerable and disadvantaged young people and their families, developing a strategy, the use of screening tools to identify young people at risk of substance use, referral into specialist services, such as drug and alcohol treatment, housing support etc, and using evidence based approaches like motivational interviewing.

PH7, School based interventions on alcohol (2007)

<https://www.nice.org.uk/guidance/ph7>

This guidance is aimed at teachers, school governors and practitioners with health and wellbeing as part of their remit working in education, local authorities, the NHS and the wider public, voluntary and community sectors.

PH24 Alcohol-use disorders: preventing harmful drinking (2010)

<https://www.nice.org.uk/guidance/ph24?unlid=5675043132016218111122>

This guidance is aimed at all those whose actions affect the population's attitude to, and use of, alcohol. It includes the whole population, not just young people, encouraging screening and brief interventions.

Department for Education and Skills. Drugs: Guidance for Schools (2004)

<http://webarchive.nationalarchives.gov.uk/20130401151715/http://www.education.gov.uk/publications/eOrderingDownload/DfES%200112%20200MIG619.pdf>

This document was issued in 2004 by the New Labour government, but is still the main guidance document for drug and alcohol education. It is very similar to NICE Guidance PH7 (see above), but is broader in its scope. It covers all school relevant issues relating to drugs. It is divided into four sections:

Section 1- Developing, implementing and reviewing a comprehensive and effective drug education programme for all pupils

Section 2- Managing drug incidents in the school community

Section 3- Supporting the personal, social and health needs of all pupils with regard to drugs

Section 4- Developing, implementing and reviewing a school drug policy

DfE and ACPO drug advice for schools: Advice for local authorities, head teachers, school staff and governing bodies (DfE and ACPO September 2012)

<https://www.gov.uk/government/publications/drugs-advice-for-schools>.

This advice was issued by the coalition government and supports the previous document with the exception of drug and alcohol education, which is excluded from this document.

PHE have also produced guidance on evidence based and needs led approaches to prevention.

<http://www.nta.nhs.uk/uploads/unodc-prevention-guide.pdf>

2. Evidence of what works in treatment has been produced by NICE and DoH and includes:

PH 43 Hepatitis B and C: ways to promote and offer testing to people at increased risk of infection (2012)

<https://www.nice.org.uk/guidance/ph43>

This includes Hep B and C testing in drug treatment services.

PH52, Needle and syringe programmes (2014)

<https://www.nice.org.uk/guidance/ph52>

This guidance gives recommendations on developing and implementing a policy on providing needle

and syringe programmes. It includes additional advice relating to the specific needs of young people who inject drugs and the importance of balancing treatment needs with safeguarding responsibilities. It recommends developing a policy for young people who inject drugs. While there are agreements in Bristol based on good practice about working with young people who inject drugs, this specific policy does not exist and needs to be developed.

CG 51- Drug misuse: psychosocial interventions (2007)

<https://www.nice.org.uk/guidance/cg51>

This guidance makes recommendations for the use of psychosocial interventions in the treatment of people who misuse opioids, stimulants and cannabis in the healthcare and criminal justice systems.

CG 52- Drug misuse: opioid detoxification (2007).

<https://www.nice.org.uk/guidance/cg52>

Opiate use is highly unusual but not absolutely unknown among young people and therefore guidelines for dealing with this extremely risky behaviour are important. These guidelines also cover how families and carers may be able to help and support a person with a drug problem and get help for themselves.

CG120, Psychosis with coexisting substance misuse (2011):

<https://www.nice.org.uk/guidance/cg120>

This guideline covers the assessment and management of adults and young people (aged 14 years and older) who have a clinical diagnosis of psychosis with coexisting substance misuse.

Drug misuse and dependence: UK guidelines on clinical management (Department of Health (England), the Scottish Government, Welsh Assembly Government and Northern Ireland Executive, 2007)

<http://www.dldocs.stir.ac.uk/documents/orangeguidelines2007.pdf>

This document provides evidence based guidance on what works in drug treatment and clinical practice. It operates in line with other guidance produced by NICE (see above). The short section on young people highlights the importance of separate services for adults and young people and points to differences in patterns of use between these two groups. It emphasises that drug treatment goals for young people should be to reduce immediate harms from substance misuse, stabilise the young person and enable them to move to abstinence from illegal drug misuse, though it also points out that because of the stage of adolescent development for this group, some drug use may still occur. Importantly, it also suggests that because young people will inevitably have been using substances for a shorter period of time and because of their continuing development and maturation, improvements can be often be made very quickly.

3. Evidence on cost effectiveness and return on investment

A cost benefit analysis of specialist drug and alcohol treatment services for young people carried out by The Department for Education (DfE, 2011) concluded that the immediate and long-term benefits of having these services in place are likely to significantly outweigh the cost. The benefits they identified included a reduced risk of being involved in criminal behaviour, improved health outcomes and an increased likelihood of employment. Using figures from 2008/09 they estimated that the annual cost of crime committed by young people in UK who misuse drugs and alcohol was just under £100m and the annual cost for health care was around £4.3m per year. In contrast to this, the total amount spent on treatment services for young people was £62.2m per year. They estimated a benefit of £4.66-£8.38 for every £1 spent on young people's drug and alcohol treatment. They also point out that many of their estimates were based on conservative estimates and therefore the benefit of drug and alcohol treatment for young people may be even larger than stated.

5) What services / assets do we have to prevent and meet this need?

Young people's substance misuse work in Bristol is delivered within a framework of prevention, early intervention and treatment, in line with the national drug strategy, the Government's Alcohol Strategy and NICE guidance.

1. Prevention

Prevention is promoted in Bristol through workforce development, targeted campaigns and the school curriculum.

a) Workforce Development

4YP Training is a programme of workforce development provided by Public Health and offered to all professionals working with children, young people and families. It includes a wide range of courses, aimed at promoting and improving health among young people by building skills and knowledge among workers. In 2015/16 the programme included 5 substance misuse courses, which were designed to ensure that professionals across Bristol were able to contribute to the aims of the national drug and alcohol strategies, specifically reducing demand and improving treatment outcomes through a range of interventions. These courses are compliant with NICE guidance PH4, PH7 and PH24.

The level 1 course, which promotes drug and alcohol awareness, screening and knowledge of referral pathways, was delivered six times in 2015/16 and 117 people attended. Impact evaluations were very good but data about wider outcomes such as an increase in referrals into substance misuse services from wider young people's agencies show that only 4 referrals were made. Other training was not well attended, with only 72 trainees attending these courses in total.

This raises concerns about equipping the wider children and young people's workforce with the appropriate skills and knowledge to contribute to the aims of the national drug and alcohol strategies and improve health among young people in Bristol.

b) Drug and alcohol prevention and education in schools

The Children and Young People's Public Health team in Bristol City Council supports staff in schools to establish a whole school approach to delivering evidence based drug and alcohol education, in compliance with DfES (2004), (DfE and ACPO, 2012) and with NICE guidance PH4, PH7 and PH24. Drug and alcohol education is delivered in schools through science and PSHE. The PSHE framework outlines age appropriate learning that should be covered at each key stage. PSHE is currently a non-statutory subject but over 75% of schools in Bristol are delivering drug and alcohol education in line with best practice guidelines. However, the majority of these are primary schools, identifying a gap in prevention for secondary school age pupils.

There is currently no citywide drug and alcohol policy for schools in Bristol, meaning that some responses to drug related incidents, such as exclusion of pupils without also referring them into support services, are not compliant with DfE (2004) or NICE guidance and may potentially increase vulnerability for the young people involved.

c) Public Health campaigns

The national drug strategy highlights the role of Public Health in developing specific campaigns to reduce the demand for drugs. The most recent of these was launched in Bristol in March 2016 and was designed for parents as part of the prevention strand of the Bristol Alcohol Strategy. It has been developed in compliance with the CMO's advice on young people and alcohol (DoH, 2009). This online resource gives parents information and advice on the importance of talking to their children about the positive and negative impact of alcohol. It includes activities that parents can complete on their own or with their young people.

<https://www.4ypbristol.co.uk/for-parents/for-parents/alcohol/>

2. Early Intervention

Bristol Youth Links (BYL) Substance Misuse Service

The targeted early intervention service works with young people in Bristol aged 9-19 who are in the early stages of substance use. It also offers support to those who are affected by a parent or carer's substance use, where there is no social worker. It is compliant with NICE guidance PH4, PH7 and PH24, as well as DfE (2004). The service offers screening followed by up to six sessions of 1:1 support, using evidence based skills such as motivational interviewing. It also provides some group work as a way of engaging young people and encouraging referrals.

This service is commissioned by the Strategic Commissioning Team in Bristol City Council and provided by Bristol Drugs Project (BDP). It is funded from the youth service budget within Bristol City Council. It is mainly delivered in Bristol secondary schools and post 16 colleges and this is where most of their referrals come from. Young people who are offered support because of parental substance misuse may attend primary schools. Those who do not attend Bristol schools can access the service through out of school referrals, but the number of referrals from non-school based services is very low. The BYL BDP service sees high numbers of young people, but is still below the numbers identified as risky drug and alcohol users in section 2 of this needs assessment. In 2014/15 880 young people were seen in this service, whereas section 2 identifies 1260 drug users and 1680 alcohol users.

Data on the substances used shows that 82% of young people in this service use cannabis and 62% use alcohol. 10% had also used NPS. Estimates of risky drug and alcohol use among young people in Bristol (HSCIC, 2015c) show that a much higher proportion of young people are involved in risky alcohol use (approx 16.6%) than higher risk use of any other substance (approx 8.9%). This suggests that young people who use alcohol are underrepresented in this service.

The data on gender shows that 53% were male and 41% were female, 1% described themselves as 'other' and 5% preferred not to say. This may suggest that better targeting of females is needed.

The breakdown according to ethnicity shows that 84% of the young people seen by BDP were White and 8% were Mixed. 3% of their clients were Asian and 5% were Black. This fits with the Bristol population of young people and knowledge about substance use according to ethnicity.

Data on vulnerability is currently not collected by the commissioners of this service. Confidential data presented to BCC shows that there are high numbers of young people in this service who are from vulnerable groups. This may indicate that more onward referrals into treatment services are needed.

This service is currently going through a recommissioning process, with new services in place for 2017/18.

3. Treatment Services:

The young people's substance misuse treatment services support young people in Bristol with more complex needs. These services work with young people until their 18th birthday. They are commissioned and funded through a range of organisations and funding streams and are compliant with all relevant NICE guidance, with the exception of PH52, Needle and syringe programmes (2014), which needs updating.

The young people's treatment services in Bristol are delivered by three specialist agencies, aiming to target and provide appropriate treatment interventions for the most vulnerable. They work in close partnership to ensure that young people receive the most appropriate response to their needs.

a) Young People's Substance Misuse Treatment Service (YPSMTS)

This service is commissioned as part of the Children's Community Health Partnership contract, and is funded and performance managed by Public Health Bristol. It is delivered by a specialist team within Children and Adolescent Mental Health Services (CAMHS). This is a consultant led service and works with those who have complex health and welfare needs linked to their drug and alcohol use. It is the only young people's substance misuse provider that is commissioned to provide pharmacological interventions. It also provides evidence based psychosocial interventions and harm reduction.

NDTMS performance data for Bristol shows that 95 young people were in this service in the year to date 2015/16, of which 55 were new presentations. Most referrals came from other substance misuse services with 42% coming from the BDP targeted services and 11% from other young people's treatment services, showing a good level of partnership working. Referrals from other key partners, such as health, housing support services and CSE services are very low.

b) Drugs and Young People Project (DYPP)

This service is co-commissioned by Public Health Bristol and the Substance Misuse Team in BCC and is a specialist safeguarding team within Children and Family Services in BCC. It works with young people who have a social worker. It provides evidence based psychosocial interventions and harm reduction. This agency includes an At Risk Service, supporting young people who use drugs and alcohol themselves, and a Hidden Harm Service, supporting people who are affected by a parent or carer's substance misuse.

NDTMS data shows that 29 young people were seen in the At Risk service in the year to date March 2016, of which 16 were new presentations. In addition, data presented to BCC shows that 50 were seen in the Hidden Harm Service. All referrals to DYPP come from Children and Family Services, which is in line with their service level agreement.

An evaluation of the Hidden Harm part of this service (BCC, 2014), was very positive, showing statistically significant improvements in resilience for young people. There is always a waiting list for the Hidden Harm service. At the end of 2015/16 the waiting time between referral and first appointment was approximately 4 weeks.

c) Youth Offending Team (YOT) Drug and Alcohol Treatment Service

This service is funded by the Police and Crime Commissioner. It provides support for young people who use drugs and alcohol and are involved in the criminal justice system. Like the other treatment services it provides evidence based psychosocial interventions and harm reduction.

NDTMS data shows that 41 young people were seen in this service in the year to date April 2016, of which 9 were new presentations. All referral sources into the YOT treatment service are recorded on NDTMS as self-referrals, which is inaccurate as they must all come through youth justice sources.

The 2015/16 NDTMS data for the specialist treatment services shows that 95% of the young people in treatment in Bristol recorded cannabis use, compared to 85% nationally. This fits with the picture of high prevalence in Bristol. 58% in Bristol treatment services were using alcohol, compared to 49% nationally, supporting the WAY figures (HSCIC, 2015c) which suggest that although prevalence is very close to the national average, risk behaviour is more prevalent. However, the target figures from section 2 of this needs assessment suggest that alcohol figures should represent the highest number of young people, with an estimated 1680 young people involved in risky alcohol use in Bristol, compared to 1260 involved in risky drug use.

All other substances are recorded by a much smaller proportion of those in treatment. Fewer than 5 young people were recorded as using opiates, adding evidence to the intelligence that these drugs are currently not popular with young people. However, this data appeared not to be recorded under the appropriate treatment service and therefore may have been recorded inaccurately.

67% of new presentations were poly drug users, slightly higher than the national proportion of 61%. Data on vulnerabilities have been recorded for the 80 young people who were new presentations during 2015/16. This shows good targeting of vulnerable groups compared to national data, reflecting the high level of vulnerable young people in the city. YOT and DYPP have particularly high proportions of clients with complex and vulnerable profiles, although care should be taken with percentages as both services have small client groups.

The highest level of substance misuse specific vulnerability is recorded against early onset, with 96% of young people in treatment having begun their substance use under the age of 15. The only substance misuse related vulnerability that affected a smaller proportion in Bristol treatment

services than the national figure was high risk alcohol use, which is recorded for only 2.5% of treatment clients in Bristol, compared to 4% nationally. This may be because the definition is extremely complicated and is based on adult patterns of use.

Among wider vulnerabilities, Bristol showed significantly higher proportions of young people recorded against all categories when compared to national proportions, with the exception of looked after children, which was equal to the national figure.

It should also be noted that although proportions are higher than national figures, these are percentages of only 80 young people and therefore some of the actual numbers are low, especially when compared to the numerical size of these groups in Bristol. In addition, few referrals come from key agencies working with these at risk groups, suggesting that some vulnerable young people who would benefit from substance misuse treatment are not referred. This may mean that more targeting of these groups is required.

In 2015/16 57% of young people seen in Bristol treatment services were male compared to 65% nationally. 43% were female compared 35% nationally. Only DYPP saw more girls than boys. While the Bristol figures show a more balanced picture than the national data, they are still seeing a higher proportion of males, suggesting that better targeting of girls is needed.

In Bristol 80% of clients were White and 11% were Mixed. Nationally 79% were White and 7% were Mixed, reflecting a higher level of Mixed young people in Bristol. 6% were Black, compared to 5% nationally. YOT had no clients in treatment who were recorded as Mixed. This may have reflected the YOT population more generally, or alternatively, it may identify poor access to treatment among some ethnic groups, specifically those who are Mixed.

Bristol clients are close to the national proportion for the age of young people in substance misuse treatment services, with only 1% under 13. The highest proportions enter treatment at age 15, 16 or 17 (68%). In spite of the fact that 96% of clients were registered as having early onset of substance use, 53% of clients enter treatment services at 16 or 17. This means that referrals may not be being made at the earliest opportunity, missing out on the chance for early intervention and increasing the risk of poor health outcomes.

Planned and unplanned exits from treatment are one indication of successful outcomes. According to NDTMS data, only 37% of young people who exited from treatment in Bristol in 2015/16 had a planned exit from treatment. This is likely to be inaccurate because aggregated data for the previous three years shows that 71% of young people who were discharged had successful planned exits. In addition, the majority who were discharged in quarters 1, 2 and 3 of 2015/16 had planned exits so the data for quarter 4 was probably inaccurate, making outcomes look worse for the whole year than was actually the case.

Transfers from young people's services into adult services is recorded for <5. Again, this is likely to be inaccurate as the number recorded by the transition service for 2015/16 was 23.

NDTMS data differs from performance reports submitted directly to BCC, suggesting that data quality continues to be an area for improvement, with NDTMS data showing lower numbers than the BCC data. Some of these problems may arise from late entry of data.

The total number of young people seen in both early intervention and treatment services in Bristol in 2015/16 was 1,045. This is smaller than the identified 1680 young people with risky patterns of alcohol use and 1260 with risky use of other drugs. Provision in Bristol is therefore not currently meeting need.

Treatment for young people aged 18 and over

Transitions Service

The Recovery Orientated Alcohol and Drug Service (ROADS), which is the commissioned multiagency substance misuse service for adults in Bristol, includes one transitions post. Commissioning a transitions service which is a separate, distinct part of ROADS enables it to be delivered in line with the Chief Medical Officer's advice (DoH, 2013), recognising that the development into adulthood is

not complete until the age of 25 and that young people's needs are different from those of adults. This service takes referrals of young adults who have reached their 18th birthday, most frequently from the young people's treatment services. This post is funded by Bristol Public Health and commissioned by the Substance Misuse Team in BCC as part of the wider adult provision. It is delivered by Bristol Specialist Drug and Alcohol Service (BSDAS).

Data for this service is not recorded separately from other adult data but confidential data presented to BCC showed that 23 young people were seen in this service in 2015/16. 13 were male and 10 were female. 91% were White and 9% were Mixed. 78% had early onset of substance use and >5 were recording as injecting drugs. 7 had high risk alcohol use and 5 were using opiates or crack cocaine. 19 were poly drug users. All of these young people also experienced high levels of wider vulnerability.

Other ROADS Services

BCC confidential data shows that since 2013, when ROADS was launched, a total of 245 people aged 18-24 have been seen in the adult service outside of the transitions post. 109 of these young people have recorded that they started to use their problem substance before the age of 18.

Confidential data held by BCC records that in 2015/16 38 young people aged 18-24 in Bristol treatment services were using opiates. 25 of these young people were also using crack cocaine. Three young people were using crack cocaine only. There is also a possibility that some additional young people use these substances and are not in contact with services. All of these young people recorded onset of drug use before the age of 16. Anecdotally only some of these people were previously known to young people's services and therefore more work needs to be done to ensure that systems are in place to find out why some young people with the most risky patterns of drug use are not being identified and offered early intervention and earlier treatment in order to improve health outcomes.

In addition, 70 young adults were recorded as injecting drugs. Seven of these young people were using heroin and the others were injecting steroids. These substances are not common within young people's services, identifying a gap in education and early intervention. It would also be useful to explore how many of these young people would benefit from a transitions service, rather than going straight into an adult model.

Other assets

DHI (Developing Health and Independence)

DHI is commissioned within the adult ROADS provision to support adults who are affected by another person's use of drugs and alcohol. It is a valuable resource for parents and carers who are worried about their children's substance use.

Think Family

Think Family engages with and supports families who have additional or multiple needs and aims to achieve improved outcomes by offering intensive family support. Think Family has links into substance misuse services but referrals into both adult and young peoples' services are reported to be low.

BDP mentoring and M32 group

These BDP services are funded from a variety of external sources, including charitable funding. The services support young people whose parents are in drug and alcohol treatment. Mentoring involves weekly 1:1 activities with a trained mentor for a period of a year and the M32 group offers positive group activities. Both help develop life skills and build resilience. The resource for this provision is small compared to the need identified by Theseus and the Public Health profiles and BDP report constant long waiting lists for this support. During 2014/15 10 young people were mentored weekly for 12 months and 24 young people were supported in the M32 group.

Hawkspring

Hawkspring is a voluntary sector agency, funded through charitable or private funding. It offers a non-treatment based whole family approach in South Bristol to those who are affected by drug and alcohol use. This includes support for young people who are affected by a parent or carer's drug use.

Avon and Somerset Police pilot on diverting young people from the criminal justice services.

In 2016, Avon and Somerset Police began piloting a new intervention in partnership with BYL, to try and steer young people away from criminal justice services. This applies to anyone who is caught for a first offence of possession of any illegal drugs for personal use. These young people are now referred into the BYL service at BDP, where they receive an approved one off intervention. Having made this contact, it is hoped that they will engage for a longer intervention. This brings young people's enforcement in line with adults' and safeguards some young people by ensuring that their vulnerability is not increased by engagement with criminal justice services. The evaluation of this pilot will be available in 2017.

6) What is on the horizon?

The new national drug strategy will be launched during 2017. It is not expected that this will introduce a major change in direction, but it is thought that it will place even greater emphasis on supporting vulnerable families, Child Sexual exploitation and use of NPS. Training and service provision will need to be able to support these issues.

Future changes that may have a positive effect on levels of substance use among young people include a strong emphasis on supporting vulnerable families within Bristol City Council e.g. through Think Family and Early Help. This will contribute to reducing the intergenerational cycle of substance misuse and the effects of hidden harm. Strengthening families may also reduce substance use among young people through positive role modelling by parents.

Challenges arise from the prediction by Bristol City Council of a significant rise in population by 2037, based on recent trends (BCC, 2015a). This includes a significant rise among the age groups who show the highest levels of substance use. The 0-15 population is expected to rise from the current level of 86,700 to 98,100, representing an increase of 21.6%. Among the 16-24 age group there is a projected rise from the current level of 70,500 to 79,100, representing an increase of 12%. It is important that policies of early intervention and effective education are maintained, in order to prevent an increase in substance use and an expensive escalation in need for treatment services in line with population growth.

Confidential Theseus data on adult services shows extremely high levels of need for support associated with alcohol use within the adult Bristol population, putting additional pressure on the capacity of these services. In an environment of reducing budgets this makes prevention work, underpinned by good quality education and early intervention, a priority.

Changes in patterns of drug use among young people, especially any increases in NPS use, will need to be carefully monitored. This is not suggested by current evidence but there is anxiety that this may change, especially for those using cannabinoids, collectively known as 'spice'. Within ROADS, BSDAS is developing a treatment programme that includes a managed withdrawal from cannabinoids using benzodiazepines. Some of this treatment has been delivered in an in-patient setting. Future cases will need to be closely evaluated to provide evidence of effective treatment for people using these substances and the need for this treatment may increase, depending on the results.

In-patient beds for young people in Bristol have not been identified as a need for several years due to different patterns of drug use from adults. However, if patterns of NPS use show a significant rise and in-patient managed withdrawal is shown to be effective, there may be a small number of young people for whom this is appropriate.

7) Local views

Views from Communities in Bristol

Community health assessments in both Avonmouth and Southmead identify concerns among residents about levels of drug use among young people in their neighbourhoods. Southmead has the 4th highest rate in the city of hospital admissions among young people under 25 for mental and behavioural disorders due to use of drugs and Avonmouth and Lawrence Weston has the 5th highest rate. There is no other data to provide evidence on levels of drug use in these areas, making these concerns difficult to respond to. However, school health data from the Pupil Voice Survey is about to be published in Bristol and may provide an opportunity to estimate drug and alcohol use by young people in identified neighbourhoods. Southmead holds a drugs forum, led by Public Health, where drug and alcohol issues are discussed. These communities have not expressed concerns about alcohol use.

Feedback from trainees who attended 4YP substance misuse training

189 trainees attended the 4YP substance misuse training courses in 2015/16. Impact evaluation is carried out at the end of each session. On a scale of 1-5 trainees assessed their change in knowledge with an average increase of 1.6 points.

48% of trainees evaluated the courses they attended as excellent and 48% evaluated them as good. 4% evaluated the course as satisfactory and no course was evaluated as poor.

There is currently no method of longer term outcome evaluation. This needs to be planned and implemented.

Young People's feedback about Commissioned Services

All commissioned services evaluate their interventions with service users. Young people are almost always very positive about their experience. Feedback during 2014-15 reflected satisfaction with the services and improvements in a broader range of outcomes, including substance use, involvement of families and self-assessed mental health.

Feedback from staff within commissioned substance misuse services

Workers within commissioned services identified gaps in current provision, highlighting difficult access into treatment for vulnerable young people.

They also highlighted the need for effective drug and alcohol education and the need for strong service user involvement.

Finally they identified a shortage in the resource for responding to young people's needs, particularly in relation to Hidden Harm.

Feedback from other professionals about commissioned services

DYPP is the only commissioned substance misuse service that formally involves other professionals in evaluating their work with young people. This feedback is from social workers who look at the contribution the service makes to overall improvements in resilience and risk among young people. It is clear from their comments that they value this service highly and they identified positive outcomes for the young people and good partnership working.

There was also a strong feeling identified within some of the social workers' comments that DYPP provided a very specialist service for children in care and those with a child protection plan that others did not have the resource to provide.

Feedback from parents and carers about treatment services

DYPP also collect evaluative feedback from the parents and carers of their young people. Again the feedback is invariably positive.

When asked about gaps in services, parents and carers usually responded that there were none, but those who did answer, identified a lack of funding to engage the young people in additional positive activities.

8) Key issues and gaps

The Bristol population includes a greater proportion than the national average of those identified as using higher levels of drugs and alcohol. These include young people and young adults, men aged 16-24, White and Mixed ethnic groups and those belonging to identified vulnerable groups. Prevalence of drug use is therefore comparatively high in the city and levels of alcohol use, especially alcohol related risk behaviour, are also above the national average. Prevention, early intervention and treatment interventions are therefore all essential in order to reduce demand for drugs and alcohol among young people in Bristol

Key issues and gaps in prevention:

1. Drug and alcohol training is poorly attended by those who work with young people and families in Bristol. This means that there are gaps in the knowledge and skills needed to deliver evidence based education outside of schools and to understand which factors contribute to prevention.
2. There is a gap in the delivery of drug and alcohol education in schools, with many secondary schools choosing to deliver PSHE outside of recommended good practice guidelines.

Key issues and gaps in early interventions

Data shows that that Bristol Youth Links at BDP delivers a young people friendly service that supports high numbers of young people. Most of these referrals come from the schools and colleges in which the service is delivered, showing that it is well placed in Bristol Secondary Schools.

However, the following gaps still exist:

3. The number of young people in the service is lower than the estimated need
4. There are very few referrals from sources outside of education
5. There is no citywide drug and alcohol policy for schools in Bristol, meaning that responses to drug related incidents are inconsistent and miss the opportunity for early intervention. Some may potentially increase levels of vulnerability among the young people involved.
6. The number of females accessing targeted services is low
7. Alcohol referrals are low compared to identified need
8. Hidden Harm resources do not match the level of need in the city.

Key issues and gaps in specialist treatment

Specialist substance misuse treatment services in Bristol respond to high numbers of young people with complex needs. Feedback from service users and other professionals shows that these services are highly valued and effective. However, the following gaps still exist:

9. The number of young people in the service is lower than the estimated need
10. Data recording by the Bristol substance misuse treatment services is poor in some areas.
11. Many young people who are categorised as vulnerable according to PHE definitions, are in targeted rather than treatment services, suggesting that they are engaged at too low a level of support to meet their needs.
12. The needle and syringe policy for young people in Bristol is old and needs updating.
13. The resource for the transition for young people into the adult ROADS service is very small, and some young adults are not benefitting from this approach.

14. Many young adults coming into ROADS record early onset of substance use but are unknown to young people's services, and there is currently no mechanism for identifying and removing gaps in earlier intervention.
15. Referrals into treatment come from a narrow set of agencies and some key referral sources are missing, suggesting that some young people who are highly vulnerable to substance misuse and other poor health outcomes are not able to access treatment.
16. The number of young females in treatment is low.
17. The number of young people who are of Mixed ethnicity is low in some parts of the treatment services

9) Knowledge gaps

There is a gap in knowledge about substance use in neighbourhoods in Bristol. Some communities have expressed concern about drug use among young people but data is collected by the targeted service according to school attended, rather than home address, making interventions on a community level difficult to plan.

Information about some of the young adults presenting to adult services recording early onset of substance use is difficult to break down. More information on which services they were in contact during their early use may be useful to identify gaps in referral pathways.

Different commissioning processes mean that different data are collected, especially between targeted and treatment services. Information between different levels of services is therefore not always comparable.

More information is needed about young adults going into the adult ROADS services. It would be useful to see if outcomes would be better in a young person model of delivery.

10) Recommendations for consideration

To Improve Prevention

1. All agencies working with young people and families should encourage workers to attend 4YP substance misuse training appropriate to their role. Where possible, commissioners should make this a condition within service level agreements (SLAs) and measure this in performance management. Attention should be paid particularly to those who work with young people and families who are vulnerable.
2. Schools should deliver drug and alcohol education through an evidence based PSHE curriculum, following good practice guidelines.
3. Those working with LGBT+ young people should ensure that young men are educated about the additional risks involved in chemsex.

To Strengthen Targeted Interventions

4. Targeted services working with young people in the early stages of substance use should be maintained at their current level.
5. A method of follow up evaluation on outcomes of 4YP training should be developed to assess how well this training is being used by trainees. This should include measuring the use of screening and referrals into substance misuse services, so that referrals can be increased.
6. A citywide drug and alcohol policy should be developed for schools and implemented according to DfES Guidance.
7. Hidden Harm services should be maintained at their current level and possibilities for external additional funding opportunities should be explored and bids supported by BCC and NHS commissioners.

To Strengthen Specialist Treatment

8. Frequent (monthly) referral meetings between targeted services and treatment agencies should take place as a matter of routine to identify young people with higher levels of need. This should include consideration of ANY young person with identified vulnerabilities, to ensure that all young people are receiving the appropriate response to their level of need.
9. Specialist treatment services should be maintained at their current level.
10. Relevant people from each of the treatment agencies should attend NDTMS training and all training updates to ensure that data quality is improved.
11. A needle and syringe policy should be developed or updated, according to NICE guidelines.
12. All services should continue to work to YPF standards. Commissioners should ensure that this is in contracts.
13. The resource for the transition into adult substance misuse services is very small. Commissioners should explore with ROADS commissioners whether funding can be redirected to provide a broader transitions service, appropriate to age.
14. Lines of communication should be set up with adult services, young people's services and commissioners to look at young adults coming into ROADS who are unknown to young people's services, in order to identify and remove gaps in earlier intervention.

To Improve Pathways through all Commissioned Substance Misuse Services

15. There appear to be low numbers in all services of specific vulnerable groups of young people. Pathways need to be developed or updated and promoted to ensure this gap is reduced. As a priority, these should include youth services, alternative education, health, social care, youth justice services, housing and the child sexual exploitation support service.

11) Key contacts

This chapter is owned by the Joint Commissioning Group for Substance Misuse
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