Public Health England

Protecting and improving the nation's health

Young people's substance misuse: JSNA support pack

Good practice prompts for planning comprehensive interventions in 2015-16

About Public Health England

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1.Introduction

Purpose of this support pack

Public Health England (PHE) supports local authorities to improve the public's health by providing data, tools and guidance on evidence-based interventions. The scope of this document is young people's drug, alcohol and tobacco use. The document is structured as a series of commissioning prompts to help local authorities to consider young people's substance misuse as part of their joint strategic needs assessment (JSNA) and to assist with the commissioning of appropriate interventions.

The 2010 drug strategy[1] called for an evidence-based, life-course approach to reducing the demand for alcohol and drugs. Along with tobacco control, preventing harmful substance misuse is central to the public health agenda, which places emphasis on tackling the root causes of problems and on reducing the number of people whose alcohol and drug use has a long-term negative effect on their health, wellbeing and quality of life.

The changing nature of young people's substance use

Patterns of young people's drug and alcohol use often change, so services need to be flexible and respond effectively to changing needs. Cannabis and alcohol are the most common substances that young people say they have a problem with when they present to specialist substance misuse services. However, organisations working with young people should be prepared to deal with all substances, including tobacco and novel psychoactive substances. A small minority will present with class A drug problems (such as heroin and cocaine).

The main prevalence data for trends in alcohol, drug and tobacco use amongst young people is the annual schools survey 'Smoking, drinking and drug use among young people in England'.[2] Although the latest report (for 2013) shows declining trends in substance use overall, it highlights the increased risk of drug use among pupils who truant or who have been excluded from school and whose circumstances or behaviour already make them a focus of concern.

The same survey also indicates that young people at risk of misusing drugs and alcohol are also likely to be smoking and that one of the factors linked to increased initiation of smoking is experimentation with drugs and alcohol.

The majority of smokers start while in their teenage years with very few starting after the age of 20. It is estimated that approximately 207,000 children aged between 11 and 15 start smoking each year in the UK, with 18% of 15-year olds classified as current smokers.[3] Young people's health behaviour is driven by the world they grow up in. Sustained efforts to reduce smoking preveleance among adults, restrict availability and denormalise tobacco use all contribute to lower smoking rates among young people.

A survey, called 'What about youth', has been launched as part of a new government pledge to make improvements to the health of young people. It asks 15-year olds about important subjects including what they eat, what they do in their free time, bullying and whether they smoke, drink alcohol or have taken drugs. Local authority level data will be available from late 2015.

Other statistics are included in the 'Drug misuse: findings from the crime survey for England and Wales'.[4] This is a largely adult survey but includes data on young adults aged 16-24. The latest report (for 2013) found that this age group were more likely to have used drugs in the last year than older adults, with use rising to 18.9% from 16.3% in 2012.

Also worth noting is that related young people's health profiles at home compare poorly to our peers in other western European countries, with evidence of a worsening picture, for example:

- the under-18 conception rate is at its lowest level since 1969, but remains twice that of 16 other European countries[5]
- there has been a threefold increase in the number of teenagers who self-harm in England in the last decade[6]

Despite recent declines, the proportion of children in the UK drinking alcohol remains well above the European average. We continue to rank among the countries with the highest levels of consumption among those who do drink, and British children are more likely to binge drink or get drunk compared to children in most other European countries.[7]

Most recent advice from the chief medical officer in 2009[8] is that an alcohol-free childhood is the healthiest and best option. and that if children do drink alcohol it should not be until at least the age of 15 years.

Key data sources on young people's drinking, drug use and smoking for use in needs assessments and strategic commissioning:

1. 'Smoking, drinking and drug use among young people in England' (as above).
2. 'Crime survey for England and Wales' (described above).
3. Child and Maternal Health Intelligence Network (ChiMat) is part of PHE and provides a wide-range of authoritative data, evidence and practice related to children's, young people's and maternal health.
4. 'Health behaviour of school aged children' HBSC is a cross-national study gaining insight into young people's well-being, health behaviours and their social context. It is a collaboration with the WHO Regional Office for Europe and is conducted every four years in 43 countries and regions across Europe and North America.
5. Schools and student health education unit survey. The SHEU is based at Exeter University and provides lifestyle surveys, research and publishing services for those working with young people.

2. Intervening early to preventing young people's substance misuse problems

Evidence suggests that a number of risk factors (or vulnerabilities) increase the likelihood of young people using drugs, alcohol or tobacco. Therefore, prevention approaches for young people are usually not drug, alcohol or tobacco specific. The more of these risk factors young people have, the more likely they are to misuse substances, to be harmed by them and to misuse drugs and alcohol as adults. These risk factors include experiencing abuse and neglect, truanting from school, offending, early sexual activity, anti-social behaviour and being exposed to parental substance misuse.[9]

Often the strongest single predictor of the severity of young people's substance misuse problems is the age at which they start using substances. But there are also factors that can make young people resilient and the more of these factors they have, the more likely they are to have good outcomes despite bad life experiences.

Preventive approaches are often classified as universal, targeted and specialist. Universal interventions range from drug and alcohol education in schools to environmental or fiscal policies, including action to address alcohol marketing and licensing. Targeted interventions include programmes aimed at building resilience in individuals or groups with risk factors that have been shown to increase the likelihood of harmful outcomes. Specialist services are commissioned for young people who are currently experiencing harm as a result of their substance misuse.

It is vital that all services work together to strengthen factors that promote resilience to substance misuse, such as educational achievement, training and employment, good health, positive relationships and meaningful activities.

With responsibility for commissioning young people's substance misuse services sitting with local authorities, there is a greater opportunity for integration with those other services that have an interest in helping young people achieve positive outcomes: schools, colleges and universities, youth offending teams, youth and community services, public health and specialist services.

Evidence[10] shows that physical and mental wellbeing, and good social relationships and support are all protective factors. Important predictors of wellbeing are positive family relationships, a sense of belonging at school and in local communities. Other factors include good relationships with adults outside the home, and positive activities and hobbies.

Evidence suggests generic approaches that build resilience and ensure informed decision making seem to be most effective.[11] Approaches that the evidence base suggests are least effective include:[12][13]

- scare tactics
- information-only approaches
- involving ex-users and the police as drug educators in schools, without adopting a 'whole school' approach
- mass media campaigns in isolation from other approaches
- mentoring and recreational or diversionary activities that do not have an evidence base of building resilience

Evidence suggests that schools should look at adopting a 'whole school approach' to prevention,[14] where the formal personal and social health education (PSHE) and sex and relationship education (SRE) curriculum is complemented by other actions including promoting a positive ethos and environment, and engagement with parents and carers.

There is some evidence that multi-component prevention programmes for the prevention of substance misuse in young people can be effective.[15] These are approaches that deliver interventions in multiple settings, eg, in school and family settings, typically combining the school curriculum with a parenting intervention.

There are many risk factors associated with increased likelihood of youth smoking including whether a parent, carer or sibling smokes. Lower socio economic status, higher levels of truancy and substance misuse are all associated with higher rates of youth smoking. Smoking prevention is therfore not achieved by youth targeted interventions alone.

There is evidence that school based interventions are effective in reducing uptake and NICE have published a series of reccomendations[16,17] which set out clear guidelines for commissioners. However, the impact of these interventions are considered more effective when delivered as a package of cross cutting tobacco control meausres in the community aimed at adults and away from school grounds.

The use of nicotine vapourisers (electronic cigarettes) has increased greatly in recent years.[18] Evidence suggests that both awareness and experimentation among young people has also increased. Regular use is seen mostly among young people who have already started to smoke although experimentation among youth who have never smoked has been observed.[19] The safety of these products is not known although they are likely to be much less harmful than smoking.[20,21,22] Legislation has been passed to prohibit the sale of nicotine vapourisers to children and to purchasing nicotine vapourisers on their behalf. The European Tobacco Products Directive will prohibit press and broadcast advertising and introduce product regulation. Local authorities can maximise compliance with regulation, so preventing uptake and some businesses, restaurants and public buildings are applying the same restrictions to use of electronic cigarettes as smoking. Given the clear harm caused by smoking, interventions with young people who use both tobacco and nicotine vapourisers should focus on discouraging tobacco smoking.

What will you see locally if you are meeting the principle?

Resilient young people who make healthier life-choices across a number of health areas and develop skills to make healthy, informed decisions.

Services that work together effectively to help build resilience in young people and help them make informed choices not to misuse substances.

Services that help prevent escalating harm and that provide evidence-based interventions to young people who are at risk of developing substance misuse problems.

Prompts to put this into practice

2.1 Integrated commissioning

2.1.1 Has local provision been assessed and set out in terms of universal, targeted and specialist approaches?

2.1.2 Is there a focus locally on the life course, including early interventions; particularly generic pre-school programmes that focus on improving literacy and numeracy and that have a long term effect of strengthening resilience in young people?

2.1.3 Has a protocol with children's services been agreed by the local safeguarding children's board (LSCB) that covers identifying and responding to safeguarding concerns in relation to young people's substance misuse?

2.1.4 Are there policies and protocols in place in relation to information sharing with parents and carers and with other agencies including children's services?

2.1.5 Do local clinical and safeguarding leads review and support the design and delivery of specialist substance misuse services?

2.1.6 Is substance misuse represented across the wider children's agenda: at the LSCB, youth offending team (YOT) management boards, at serious case reviews, within child and adolescent mental health services and across children's services more widely?

2.1.7 How do you use existing local networks for finding and sharing information with partners about new psychoactive substances?

2.2 Universal prevention

2.2.1 Do young people locally have universal access to accurate, relevant and timely information about the health harms of alcohol, drugs and tobacco? (While there is little to no evidence that information alone changes behaviour, it can reduce harm and inform choice.)

2.2.2   Have commissioners built good links with local schools?

2.2.3   Are schools implementing intelligence-led, targeted sessions at all stages within the school environment, adopting a 'whole school approach' to prevention?

2.2.4   Have schools considered using the Mentor ADEPIS resources?

2.2.5   Do prevention programmes use the European drug prevention quality standards (EDPQS)?

2.2.6   Do schools have a tobacco policy which is understood and implemented?

2.2.7   Do schools include tobacco education as part of the curriculum?

2.2.8   Are national resources that provide information (FRANK) and build resilience (Rise Above, to be launched by PHE in November 2014) considered as part of the local approach to prevention?

2.2.9   Are sufficient resources available to prevent under-age sales, sales to people who are intoxicated, proxy sales (that is, illegal purchases for someone who is under-age or intoxicated), non-compliance with any other alcohol licence condition and illegal imports of alcohol?[23]

2.2.10 Are the appropriate authorities working in partnership to identify and take action against premises that regularly sell alcohol to people who are under-age, intoxicated or making illegal purchases for others?[24]

2.2.11 Does the local authority undertake test purchases (using 'mystery' shoppers) to ensure compliance with the law on under-age sales? Is test purchasing also used to identify and take action against premises where sales are made to people who are intoxicated or to those illegally purchasing alcohol for others?[25]

2.2.12 Are sanctions fully applied to businesses that break the law on under-age sales, sales to intoxicated people, and proxy purchases? This includes fixed penalty and closure notices (the latter should be applied to premises that persistently sell alcohol to children and young people).[26]

2.2.13 Do you have plans to ensure compliance with e-cigarettes regulations on advertising and age of sale?

2.2.14 Do young people locally have universal access to accurate and relevant information about the health harms of new psychoactive substances?

2.3   Targeted prevention

2.3.1   Is there an underlying principle of targeting young people at increased risk of harm, with the aim of strengthening their resilience?

2.3.2   Are alcohol, drugs and tobacco prevention approaches aligned with services (such as sexual health) that also focus on building resilience in the same 'at risk' groups?

2.3.3   Have multi-component programmes been considered, involving a combination of schools and parenting interventions, with support for individuals and for families? These may require joined up commissioning and planning locally and may be universal or targeted.

2.3.4   Does the JSNA include a section on the needs of vulnerable young people that reflects the links between substance misuse and a range of other risk factors, such as offending and sexual health and the need for integrated commissioning?

2.3.5   Are commissioners in the public health team working with the NHS England local area team that is responsible for offender health commissioning, to agree a joint approach for substance misuse services in the young people's secure estate?

2.3.6   Are commissioners working with police and crime commissioners to discuss plans for investing in preventing substance-misuse related youth crime and commissioning early interventions that can prevent risk and harm from escalating?

2.3.7   Does the JSNA take into account of the needs of young people who suffer from domestic abuse, sexual assault and sexual exploitation, who are more likely to be vulnerable to substance misuse? Does the JSNA look at this group by gender?[27]

2.3.8   Have additional funding streams to the public health grant been identified for early identification and interventions to provide targeted support for specific groups of young people deemed to be more at risk than others of developing substance misuse problems? (This may be from the police and crime commissioners to support the targeted substance misuse interventions provided by the youth offending teams, or from the local authority business rates retention funding which absorbed the previous early intervention grant.)

2.3.9   Are there policies and protocols in place in relation to information sharing with parents and carers and with other agencies including children's services?

2.3.10 Do local clinical and safeguarding leads review and support the design and delivery of specialist substance misuse services?

2.3.11 Is there engagement with the local troubled families team?

2.3.12 Is tobacco prevention work in schools evidence-based and linked to NICE PH23?[28]

2.3.13 Do interventions with young people who use tobacco and nicotine vapourisers focus on discouraging tobacco smoking?

Benefits of investing in prevention

School-based prevention interventions, including those delivered as part of the curriculum, derive cost-benefits for society. Interventions to tackle emotional learning, for example, are cost saving in the first year through reductions in social services, the NHS and criminal justice system costs and have recouped £50 for every £1 spent.[29]

Further resources

- http://mentor-adepis.org/
- EMCDDA best practice portal
- Society for Prevention Research
- Forthcoming PHE document mapping UNODC international standards on drug use prevention to provision in England
- PSHE Association
- European drug prevention quality standards
- PHE young people's health and wellbeing framework (forthcoming, autumn 2014)
- Education Select Committee Inquiry into PSHE and SRE in schools: written evidence submitted by PHE
- School-based interventions to prevent smoking. NICE public health guidance 23.
- Preventing the uptake of smoking by children and young people. NICE public health guidance 14

3. Specialist substance misuse interventions are commissioned for young people experiencing harm as a result of their substance misuse

Specialist substance misuse interventions should be individual packages of care-planned support, which can include medical, psychosocial or specialist harm-reduction interventions that build young people's resilience and reduce the harm caused by substance misuse.

Specialist substance misuse services should help young people to stop using drugs and alcohol, to reduce the harm they cause themselves and others, to develop their resilience, and to manage the risks they face to ensure that when they leave services they can sustain their progress. This might include giving support to parents and carers to help the young people with healthy decision making.

Young people who smoke should be offered very brief advice by all front line workers. If a young person expresses motivation to quit, they should be referred to the local stop smoking service. The period between expressed motivation to quit and access to cessation services should be minimal. Nicotine replacement therapy is licensed for use for young people aged 12 and over.

There is strong evidence that a combination of pharmacotherapy (nicotine replacement therapy) and behavioural support increases the chance of a successful smoking quit attempt four-fold.[30] Smoking cessation services, commissioned by local authorities offer proven methods of cessation treatment as recommended by NICE.

There are a number of specific issues facing girls including increased risk of alcohol problems. A recent report[31] highlights that responses to adversity, including abuse, tend to be differentiated by gender, with boys more likely to externalise problems (and to act out anger and distress through anti-social behaviour) and girls to internalise their responses in the form of depression and self-harming behaviours. Substance misuse services for young people may therefore need to consider the particular needs of girls.

What will you see locally if you are meeting the principle?

Reductions in smoking, drinking and drug use, related offending, drug or alcohol-related deaths and hospital admissions and risk-taking behaviours more widely.

Young people with improved confidence, self-esteem, school attendance and involvement in positive activities. Longer term, there are likely to be improvements in education and employment outcomes, wellbeing, mental health and family relationships.

Prompts to put this into practice

3.1 Ensuring delivery of high-quality evidence-based interventions

3.1.1 Is the full range of evidence-based treatment available to young people in need?

3.1.2 Is there a governance framework in place that sets out expectations for:

- appropriate specialist interventions
- quality standards
- risk management
- staff competence
- case load management
- clinical supervision in line with local safeguarding policies
- compliance with legal requirements, which require services to be child-centred and appropriate to the young person's age and maturity
- development of the young person, to take account of individual vulnerabilities

3.1.3 Do young people receive a range of interventions that vary in intensity and duration according to changing needs? Does this reflect changes in their risk and resilience factors?

3.1.4 Are the interventions in line with relevant NICE guidance (eg, PH4 Interventions to reduce substance misuse among vulnerable young people,[32] CG115 Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence[33])?

3.1.5 Are the interventions appropriate to the age and development of young people?

3.1.6 Do services and commissioners regularly review the range and type of interventions available, who receives them, and which service is best placed to deliver them depending on risk and harm levels?

3.1.7 Do young people with multiple vulnerabilities or a high risk of substance misuse-related harm get extra support? (This includes young people affected by parental substance misuse, experiencing domestic violence, early problematic misuse, class A users, looked-after children, those not in education, employment or training, and involved in crime.)

3.1.8 Are services tailored to the needs of vulnerable girls (eg, are girls offered the option of a female keyworker)?

3.1.9 Are young people who smoke offered very brief advice by frontline workers in school and youth settings?

3.1.10 Is there easy access to an evidence based stop smoking service for everyone who smokes or uses tobacco in any other form?

3.1.11 Is the stop smoking service accessible for young people?

3.1.12 Do local agencies have a good understanding of young people's new psychoactive substance use in their area, and use this knowledge to develop local responses to NPS?

3.2   Psychosocial interventions

3.2.2 Do interventions include evidence-based psychological, psychotherapeutic, or counselling-based techniques to help young people change their behaviour and lifestyles, and to improve their coping skills?

3.2.3 Do these also include evidence-based interventions such as motivational interventions, cognitive behavioural interventions, relapse prevention and structured family interventions?

3.2.4 Do appropriately competent staff deliver these interventions?

3.3 Harm-reduction

3.3.3 Are all needle and syringe programmes, including those provided in pharmacies, operating in line with NICE PH52 guidance on needle and syringe programmes?[34]

3.3.4 Are there policies on providing needle and syringe programmes and related services to meet the needs of different age groups that have been agreed by the local safeguarding children's board?

3.3.5 Are professionals skilled and competent to deliver needle and syringe programmes to under 18s and able to assess safeguarding issues in relation to injecting drug use and the young person's competence to consent

3.3.6 Do all young people receive age-appropriate advice and information on:

- the spread of blood-borne viruses

- sexual health and contraception

- overdose

- health harms and reducing risky behaviour?

3.3.7 Are there care pathways in place for young people to access age-appropriate sexual health services and testing and treatment for blood-borne viruses?

3.3.8 Does harm reduction advice include new psychoactive substances?

3.4 Pharmacological interventions

3.4.1 Do these include prescribing for detoxification, stabilisation and symptomatic relief of substance misuse as well as medication to prevent relapse?

3.4.2 Is pharmacological management delivered alongside specific psychosocial interventions?

3.4.3 Is pharmacological management delivered in an age-appropriate manner and in the context of a clear clinical governance framework which sets out how prescribing should happen?

3.4.4 Are age-appropriate pharmacological interventions provided in line with the Department of Health's 'Guidance for the pharmacological management of substance misuse among young people' and 'Guidance for the pharmacological management of substance misuse among young people in secure environments'?

3.4.5 Are there mechanisms in place to support the parent or carer's involvement in the assessment, care planning and delivery of clinical interventions as appropriate?

3.5 High-intensity support for the most vulnerable young people

3.5.1 Do vulnerable young people with complex needs receive multi-agency care packages that are provided locally?

3.5.2 Do these packages include substance misuse treatment and detoxification, along with support for housing (potentially via short term fostering arrangements) and education if these are appropriate?

3.5.3 Is multi-agency funding available through complex care panel arrangements? Is this underpinned by funding protocols for young people requiring high-intensity multiagency provision?

3.5.4 Do complex care systems support the needs of 16 and 17-year olds whose substance misuse has become problematic (they are still 'children in need' and eligible for local authority assistance)?

3.5.5 Are joint working protocols with child and adolescent mental health services (CAMHS) in place, and do they include young people with complex needs?

3.5.6 Do professionals consider local solutions for complex cases before looking for non-local residential placements (placements closer to home help young people maintain links with their families and other sources of support)?

3.5.7 Are there arrangements to provide residential interventions away from home for the few young people it is appropriate, such as fostering arrangements, secure units or child and adolescent mental health inpatient units?

3.5.8   Do commissioners promote a joined-up response across children's services using care and referral pathways for children who have been sexually exploited?

3.5.9   Are professionals supported to respond appropriately to victims of child sexual exploitation?[35]

3.6   Transition to other services

3.6.1   Is there a transition policy in place that sets out roles and responsibilities between different services? Does it set out expected outcomes and standards for effective transfers?

3.6.2   Are there reviews involving the service, the young person and the service they're moving to (adult or other young people's service) to ensure an effective handover and continuity of care?

3.6.3   Are young people who have reached the upper age limit of the service, but don't need to move to adult services, informed about how to access adult services later if they need to?

3.6.4   Do universal and targeted services support young people discharged from substance misuse specialist services, to address their wider health and social needs?

3.6.5   Do children's social care services assess young people before they turn 18, if there is significant benefit in doing so, and if it is likely they will need adult care and support after turning 18?[36]

3.7   Access and engagement

3.7.1   Are young people's specialist substance misuse services open at accessible times, in appropriate settings and locations?

3.7.2   Do services assertively engage with young people who miss appointments or stop attending?

3.7.3   Does the service evaluate why young people engage or fail to engage with the service and respond to the findings by adapting its services?

3.7.4   Do services enhance their response to young people who come back, and particularly to those whose needs have increased?

3.7.5   Do services ensure young people are not retained in specialist interventions any longer than necessary?

3.7.6   Do services make appropriate use of technology (eg, texting, social media) to engage, maintain contact and follow-up young people?

3.8 Young people's secure estate

3.8.1 Are there arrangements to support continuity of care for those entering, transferring within or leaving the young people's secure estate? Do they include a referral to a specialist service nearest the young person's home and pre-release contact with a professional to encourage the young person to engage with the service after release?

3.8.2 Is this underpinned by a formal agreement that sets out the roles and responsibilities of each agency and clarifies who is responsible for coordinating care?

3.8.3 Are arrangements in place to monitor NDTMS reporting across the secure estate to track outcome improvements in continuing care?

The benefits of specialist substance misuse interventions

Specialist interventions for young people's substance misuse are effective and provide value for money. A Department for Education cost-benefit analysis found that every £1 invested saved £1.93 within two years and up to £8.38 in the long term.[37] Specialist services engage young people quickly, the majority of whom leave in a planned way and do not return to treatment services.

Further resources

- 'Young people's specialist substance misuse treatment: exploring the evidence' (NTA, 2009)
- 'Practice standards for young people with substance misuse problems' (CCQI, 2012).
- Quality criteria for young people friendly health services (Department of Health, 2011)
- 'Working together to safeguard children' (HM Government, 2013)
- 'Healthcare standards for children and young people in secure settings' (Royal College of Paediatrics and Child Health, 2013)
- 'Healthcare standards for children and young people in secure settings' (Royal College of Paediatrics and Child Health, 2013)
- 'Supporting information for the development of joint local protocols between drug and alcohol partnerships, children and family services' (NTA, 2011)
- 'Guidance for the pharmacological management of substance misuse among young people in secure environments' (Department of Health, 2009)
- 'Substance misuse interventions within the young people's secure estate: guiding principles for transferring commissioning responsibility from the YJB to local partnership areas' (NTA, 2012)
- 'Interventions to reduce substance misuse among vulnerable young people: NICE public health guidance 4' (NICE, 2007)
- 'Needle and syringe programmes: NICE public health guidance 52' (NICE, 2014)

- 'Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence' NICE CG115
- 'Quality standard for the health and wellbeing of looked-after children and young people' NICE quality standards [QS31]
- 'Smoking cessation services: NICE public health guidance 10' (NICE, 2008)
- 'Tobacco harm reduction: NICE public health guidance 45' (NICE, 2013)
- 'Smoking cessation – acute, maternity and mental health services: NICE public health guidance 48' (NICE, 2013)
- 'Brief interventions and referral for smoking cessation: NICE public health guidance 1' (NICE, 2006)
- 'When to share information: best practice guidance for everyone working in the youth justice system' (2008)
- 'Practice standards for young people with substance misuse problems' (CCQI 2012)
- Quality Network for Community CAMHS

4. A skilled workforce is in place to provide effective interventions

The government's 2010 drug strategy recognises that good quality service delivery depends on skilled staff.

Developing an understanding of the range of skills and knowledge required for working with children and young people is important for anyone coming into contact with under 18s, in particular those working with more vulnerable groups. This is relevant to staff who work with children and young people all the time, as well as those who work with children and young people as only part of their job, whether as paid workers or volunteers.

Depending on the role and function of the organisation and the type of contact, some staff groups will require a higher level of competence than others. However, all staff should have at least a basic level of substance awareness, some knowledge of local resources, thresholds for interventions and an ability to engage children and young people in conversations about substance use and its consequences. This will help staff identify young people's vulnerabilities and to refer them on for further assessment and into targeted or specialist substance misuse interventions as appropriate.

Staff who deliver specialist interventions such as motivational interviewing, cogitative behavioural therapy (CBT) and multi systemic therapy need to be qualified and competent.

The Department for Education's common core skills[38] describes the skills and knowledge that everyone who works with children and young people is expected to have. The six areas offer a single framework to support multiagency and integrated working, professional standards, training and qualifications across the children and young people's workforce. These are:

- effective communication and engagement with children, young people and families
- child and young person development
- safeguarding and promoting the welfare of the child or young person
- supporting transitions
- multi-agency and integrated working
- information sharing

The therapeutic relationship young people have with their keyworkers is vital and positive outcomes depend on a positive and trusting relationship between them. Research suggests that young people's feelings about the quality of their relationships

with key adults and peer mentors contribute significantly to their wellbeing and positive outcomes.

What will you see locally if you are meeting the principle?

Commissioners and services working together to develop and support a workforce that is competent to work with young people and their families and delivering improved outcomes for them.

Prompts to put this into practice

4.1   Are young people's substance misuse services commissioned to ensure that all staff have the core skills and knowledge necessary for working with children and young people?

4.2   Are staff qualified and competent to deliver the interventions they provide?

4.3   Are these skills regularly assessed and updated?

4.4   Are staff skilled in building therapeutic alliances with young people?

4.5   Are commissioning mechanisms are in place to ensure services are delivered by a competent workforce?

4.6   Are these in line with national occupational standards and relevant professional standards?

4.7   Are mechanisms in place to encourage a culture of learning via peer reviews, team meetings, appraisals and supervision?

4.8   Are workers in children and family services competent to screen young people for substance misuse and refer as appropriate to specialist substance misuse care?

4.9   Are there reciprocal arrangements, such as joint working protocols, mentoring arrangements, attachments and secondments, to enable children and family workers and specialist substance misuse staff to support each other in screening and referring young people, and in responding to their wider health and social care needs?

4.10   Are staff delivering specialist interventions able to access regular clinical supervision with appropriately skilled clinicians?

4.11   Are frontline workers in schools and youth settings trained to discuss smoking with young people?

Further resources

- The Royal College of Paediatrics and Child Health e-learning tools for the substance misuse workforce

- A competence framework for child and adolescent mental health services. Skills for Health is reviewing the children's services suite of national occupational standards (NOS) and their applicability to those working in children and adolescent mental health services (CAMHS) and substance use services for children and young people. Published in December 2014
- The alcohol and drugs competency assessment framework (ADCAF) is a tool for individuals, managers and commissioners to access information on how to assess and enhance competence in the field of substance misuse
- Substance Misuse Skills Consortium

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[1] The 2010 drug strategy, 'Reducing demand, restricting supply, building recovery: supporting people to live a drug-free life'. Home Office 2010

[2] Smoking, Drinking and Drug Use Among Young People in England Health & Social Care Information Centre, 2014

[3] Child uptake of smoking by area across the UK (Thorax 2013)

[4] Drug misuse: findings from the 2013 to 2014 Crime Survey for England and Wales. Home Office 2014

[5] Public Health England's written response to the Health Education Select Committee inquiry into PSHE (July 2014)

[6] The Health Behaviour of School-Aged Children Survey (2013/14)

[7] Hibell B, Guttormson U, Ahlstrom S, et al (2012) The 2011 ESPAD report: substance use among students in 36 European countries

[8] Guidance on the Consumption of Alcohol By Children and Young People (DH, 2009)

[9] UNODC International Standards on Drug Use Prevention

[10] UNODC International Standards on Drug Use Prevention

[11] UNODC International Standards on Drug Use Prevention

[12] UNODC International Standards on Drug Use Prevention

[13] European drug prevention quality standards

[14] School-based interventions on alcohol NICE public health guidance 7

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