Local Authority – Harrow Council

Children and Young People's Substance Misuse Needs Assessment – 2021

By: Dr Azza Elnaiem, Public Health Medicine ST1 Registrar

Contents

Acknowledgements

Many thanks to the following individuals for their valued support and contributions with this Health Needs Assessment.

- Bridget O'Dwyer - Commissioner in Public Health, Local Authority (Harrow Council)

- Laurence Gibson - Public Health Consultant in Public Health, Local Authority (Harrow Council)

- Danielle Regev - previously Specialist Substance Misuse Service Team Leader at Compass

- Sonia Rayit - Specialist Substance Misuse Service Manager at Compass

- Anca Ferencz - Specialist Substance Misuse Practitioner at Compass

- Federica Marzullo - Specialist Substance Misuse Practitioner at Compass

All other respondents involved in the stakeholder consultation process who spoke with me anonymously regarding their views on the topic of this HNA, including those in the following teams:

- Children's Services, Local Authority (Harrow Council)

- Early Help, Local Authority (Harrow Council)

- Youth Offending Team, Local Authority (Harrow Council)

- Community Safety, Local Authority (Harrow Council)

- Strategy and Business Intelligence, Local Authority (Harrow Council)

- Healthcare sector (across primary and secondary care)

- Education sector

- Voluntary sector

Executive Summary

Children and young people with substance misuse needs in Harrow are supported by a tiered system of interventions, ranging from evidence-based universal support for prevention (for example, in schools) to targeted interventions for at-risk vulnerable groups, and to specialist substance misuse management in community and outpatient settings. The in-community specialist substance misuse service in Harrow for children and young people is Compass, tackling mainly drugs and alcohol, as well as nicotine when it is being used as an adjunct substance. Compass has been operating in the borough for several years and has received positive feedback from both service users and stakeholders alike for its flexible, outreach-style approach and supportive and responsive staff.

Since 2013, the number of in-treatment young people at Compass has declined and the prevalence of smoking, drinking alcohol, and taking drugs (including 'legal highs') remains lower in Harrow in comparison to the wider region of London and the national averages of England seen in prevalence surveys from 2014 onwards. However, some key concerns regarding the met and unmet needs of children and young people, identified by Compass and other stakeholders, are highlighted in this Health Needs Assessment.

Firstly, although 'one-off' experimentation is not unusual within these cohorts and there have been long-term declines in usage, the acceptance of substance misuse appears to be rising in children and young people (with increasing acceptance with age). This is reported by both stakeholders and in national prevalence surveys. In particular, this includes new psychoactive substances, 'legal highs', cannabis, certain tobacco products and some Class A drugs. In addition to this acceptance, the rapidly changing nature of substance misuse culture has also outpaced the skills of non-specialist frontline staff in their ability to stay up to date for the purposes of recognition, assessment, management and referral. Whilst Compass continues to deliver training to non-specialist frontline staff frequently (in fact, above and beyond its contractual targets across a wider range of settings), the wider network of stakeholders is reportedly still under-skilled in this regard and may struggle to be upskilled successfully due to their own competing priorities of heavy caseload management and underfunding.

Secondly, gaps in tackling the needs of vulnerable groups (for example, dual diagnosis children and young people, Looked After Children, young offenders,

and excluded students) and those affected by trauma who are at risk of taking up substance misuse remain unaddressed in primary prevention strategies. This is compounded not only operational capacity issues at Compass (for example, a shortage of staff or its recent staff turnover) but in its close counterparts in Child and Adolescent Mental Health services who have limited time, capacity and funding to engage in 'low-level' mental health concerns or the broader material environments responsible for mental ill-health. This Health Needs Assessment identifies the need for public health commissioning to focus heavily on the 'pair of ACEs' – adverse childhood experiences and adverse community environments – in future strategy work to ensure primary prevention is embedded in not only substance misuse prevention but all health promotion. In particular, it identifies local socio-economic factors that are important for contextually safeguarding children and young people in Harrow as part of primary prevention, such as disclosures by children and young people of feeling 'unsafe' in certain areas of Harrow, being offered or supplied substances by older adults and other young people, and living with individuals who deal with substance misuse themselves. Examples of 'ACE-aware' and trauma-informed programmes have been given in the document.

Lastly, this Health Needs Assessment emphasises calls from both professional and civil societies towards a non-prohibition-based approach to substance misuse; one that recognises that legality does not always accurately reflect harms (for example, despite being legal, alcohol remains the leading risk factor the leading risk factor for ill-health, early mortality and disability according to PHE), and that penalisation does not necessarily have a successful deterrent effect and in fact, can drive negative health and community outcomes associated with criminality and stigmatisation. Opportunities for harm minimisation are limited by these approaches and so examples of programmes that move away from penalisation, for example diversion programmes from the criminal justice system, are given and discussed as part of the wider conversations needed for policy work.

Part 1

Part 1a: Introduction

Aims & Objectives

The last Health Needs Assessment on the Substance Misuse needs of Children & Young People in Harrow was completed in 2014 by an independent consultant on behalf of the Public Health team in Local Authority.[25] Since then, the landscape of substance misuse, mental health, and children and young people's services has significantly changed both locally and nationally. In addition to this, the physical, mental and socio-economic impacts of the coronavirus pandemic (March 2020-) have substantially impacted the health needs of this cohort directly, the ability of commissioned services to reach them and the timing/format of this piece of work. Therefore, this Health Needs Assessment aims to 'catch up' – not only on the recommendations of the 2014 Health Needs Assessment and on substance misuse trends that may have changed over several years, but also on those needs that have been exacerbated or impeded by the competing priorities of the last two years.

This Health Needs Assessment aims to identify and discuss six core aspects of the Substance Misuse needs of Children and Young People (CYP) within Harrow. These are:

- The national policy background with regards to agenda-setting approaches to substance misuse in CYP in England overall
- The prevalence and incidence of substance misuse issues in CYP locally in Harrow,
- The structure of services tackling CYP substance misuse within Harrow (with reference to national recommendations, local priorities and the evidence base)
- A review of the performance and operations of Compass (the Public Health-commissioned specialist service in Harrow dealing with substance misuse in CYP)
- The map of local stakeholders involved in supporting CYP on substance misuse and their opinions on met and unmet CYP substance misuse needs, the structure of services, the nature of partnerships working on this topic, and their capacity to support this group
- And lastly, a discussion of the cross-cutting themes identified in local CYP substance misuse needs from relevant stakeholder consultations, that will require Public Health strategic focus moving forward. These include prioritisation of work on inequalities, primary prevention, contextual safeguarding, and the social determinants of health.

Following this Introduction, key definitions are listed for reference to throughout the document. This is of particular importance as the term 'children & young people' may have different meanings across organisations (affecting the denominators used in their data sources and analysis) and the phrase 'substance misuse' may not fully encompass the range of recreational drugs available to CYP (e.g. new psychoactive substances) or it may not align with definitions of what is perceived as 'acceptable' and/or 'problematic' by children and young people themselves.

The document is then split into six other parts discussing the core aspects listed above. Finally, a Conclusion section with Recommendations for Commissioners closes this piece of work. A Reference List and Appendix is also available for clarification of sources and documents used throughout.

Part 1b: Methodology

The production of this Health Needs Assessment took place between July and September 2021 and was completed by the Public Health Medicine ST2 (Specialty Training) registrar based in Local Authority. During this time, available prevalence and incidence data was identified, collected and analysed using local, regional and national sources to quantify the 'size' of the substance misuse issue in CYP in Harrow. The structure of services and the mapping of stakeholders was drawn up with reference to national recommendations, the mandatory legal obligations of providers and their partners, discussions with the Compass team and the Commissioner for Substance Misuse services within the Public Health team, and primary consultation of stakeholders regarding their own views of the networks they work within and their capacity to work optimally. These same stakeholders were also consulted regarding their opinions on the met and unmet needs of CYP with substance misuse concerns in Harrow; in particular their opinions were sought on cross-cutting themes previously identified from the previous HNA and early stakeholder consultations elsewhere (e.g. inequalities including missed vulnerable groups, the social determinants of health and primary prevention).

The range of stakeholders were consulted through two ways:

- Firstly, a 30-minute structured survey/questionnaire produced using reference to the old Health Needs Assessment and key policy guidance documents (see Appendix 1). This was emailed out to stakeholders in mid-July 2021 with a proposed 1-month return window.
- Secondly, guided semi-structured interviews with stakeholders held online throughout July-September 2021. These interviews could function in two ways – the first was for completion of the survey alongside the ST1 registrar; the second was for elaboration on answers already given by those who had already completed the survey and wished to be contacted further.

Stakeholders from the following organisations were contacted following purposive sampling from a sampling frame generated through previous HNA work and discussions with the relevant Public Health commissioner:

- Compass (the specialist substance misuse service for CYP with substance misuse concerns in Harrow)
- Local Authority services (Children's Services, Safeguarding, Early Support Teams, Youth Offending Teams, the Violence Vulnerability Exploitation working group, Strategy & Partnerships, Education),
- Acute and Community healthcare partners (CCG Commissioning Leads, Safeguarding Leads across partners, Children & Adolescent Mental Health teams),
- Education Sector organisations/partners including schools and Pupil Referral Units (Headteachers, Safeguarding Leads, Wellbeing Staff)
- Voluntary Sector organisations/partners involved in supporting CYP mental health and/or wellbeing and/or education/training/career opportunities, as well as those focusing on vulnerable CYP groups

Due to COVID-19 virtual working/social distancing requirements, and a change in Compass' staff management affecting feasibility of planned outreach, users of the specialist service were unable to be consulted directly for this Health Needs Assessment. Consequently, secondary data sources already held by Compass were used to feedback their experience. As this group represents the most important stakeholder of all, this Health Needs Assessment remains greatly limited in this regard and should therefore be considered incomplete until this feedback can be collected and appropriately analysed.

Furthermore, due to the competing priorities of other organisations in the COVID-19 pandemic, the limited time allocated to produce this work, the number of partially-filled surveys returned and the methodological differences between the survey and semi-structured interview format, caution is advised regarding the interpretation of this work as either fully comprehensive or precise. The most frequently identified themes in the consultation phase have been summarised and analysed to form the basis of actionable recommendations for public health strategists and commissioners moving forward on this topic. However, the total number of data gaps involved mean that key areas of interest may have been overlooked or over-emphasised; further discussion on the limitations of this Health Needs Assessment are addressed more closely through a breakdown of stakeholder response by sector and the differences identified by the interviewer of the content given through surveys and that given through interviews in Parts 5 and 6 of this Health Needs Assessment. This document therefore represents the starting point for strategic planning by Public Health commissioning and other senior Local Authority groups, such as the Violence Vulnerability Exploitation working group, the CYP Mental Health and Emotional Wellbeing Boards and Harrow's Strategic Safeguarding Partnership.

Part 1c: Key Definitions & Concepts

What is a 'substance'?

- The term 'substance' in the phrase 'substance misuse' traditionally refers to what is known as 'drugs and alcohol'. It is important to expand on the definition of 'drugs' (and consequently, 'substance'), however, as this represents a broad and varied range of chemicals to the public, health and social care professionals and the criminal justice system.

- The dictionary definition of a drug is 'a medicine or other substance which has a physiological effect when ingested or otherwise introduced into the body'[53] – under such a definition, alcohol itself is considered a drug, as can tobacco or other nicotine-containing products. Additionally, this definition would include medicinal compounds found both over-the counter and those prescribed by licensed professionals.

- Historically for the public, the term 'drugs' implicitly refers to illegal drugs used (e.g. methamphetamine, crack cocaine), rather than its traditional dictionary definition. Nevertheless, it is important to not use legality as a distinction for what makes a substance worthy of comment or concern regarding misuse for this Health Needs Assessment. Alcohol, nicotine, and prescribed medication (such as anti-depressants and sleeping pills) can all be misused – yet all are completely legal. Alternative 'legal highs' such as solvents and 'poppers' can also be misused and therefore also form part of this Health Needs Assessment's definition of a 'substance'.

- The phrase 'New Psychoactive Substances' (NPS) is also used in this Health Needs Assessment. The term 'psychoactive' refers to any drug affecting mental processes and as a result can encompass the legal (alcohol, tobacco) and the illegal. Psychoactive substances tend to fall into three sub-types relating to their physiological properties: stimulants (which elevate mood and alertness), depressants (which inhibit alertness or normal brain function, provide pain relief or euphoria), and hallucinogens/psychedelics (which alter perceptions of reality).[69] A fourth sub-type known as dissociative anaesthetics also exist.[20] Although uncommon, a single drug may have multiple properties from each group.

- However, the term 'New Psychoactive Substance' (NPS) in the law represents those drugs which were designed to replicate the effects of illegal substances such as cannabis, cocaine and ecstasy, but with different molecular structures. A large proportion of these NPS drugs – such as 'Spice' and 'Black Mamba' - were once 'legal highs' themselves but following the advent of the Psychoactive Substances Act 2016, their use, supply, production and import/export have been criminalised.[42] The only exceptions from the offences listed under this Act are 'legitimate' psychoactive substances such as food, alcohol, tobacco, nicotine, caffeine, medical products; as well as 'poppers' and 'controlled drugs' (which are regulated elsewhere by statutes such as the Medicines Act of 1978 and the misuse of Drugs Act 1971).[39] When 'NPS' is used in this Health Needs Assessment, it therefore refers to those illegal drugs included under the Psychoactive Substances Act 2016.

- Lastly, the type of drugs included as 'substances' in this Health Needs Assessment is not static and will always lag behind those available or trending in the real world. The range of drugs used by children and young people will continue to grow as novel synthetic chemicals are engineered, discoveries of new natural psychoactive compounds are made and

commercialisation of old or hybrid drugs is scaled up. The ability of public health professionals to 'keep up' with the range of substances available requires strong engagement with frontline services, integration with other sectors (such as Education) and de-stigmatised open channels of communication with children and young people themselves within a wider harm-reduction focussed public health approach to drugs.[69] Our definition of 'substance' will constantly need to be updated in successive Health Needs Assessments and other pieces of work.

What is 'Misuse'?

- In 1994, the phrase 'misuse' of drugs and alcohol was defined by the World Health Organisation as any use of the above that was "not consistent with medical or legal guidelines".[38] As such, the use of any illegal drug is considered misuse, as would be the unlawful use of medicines (over-the-counter or prescribed), 'legal highs' and other 'controlled' substances outside of the scope of laws which regulate them.

- The term 'misuse' is frequently used interchangeably with 'abuse' with regards to substances such as drugs and alcohol. However, the use of the 'abuse' has been discouraged over the years due to its judgmental tone in past usage and associations with clinical contexts.[38]

- Traditionally, public conversations regarding 'substance misuse' have been framed around the serious harm posed by addiction. However, 'misuse' is not just addiction, nor is it merely usage outside of prescribed legal or medical limits. 'Misuse' represents a spectrum of physiological (physical, mental and cognitive) and socio-economic harm to the individual and to the community linked with using a substance.[69]

- In this Health Needs Assessment, 'misuse' may be defined along three criteria. This includes any substance use that is marked by:
    - Inappropriate quantities of use, frequencies of use, patterns of use, and routes of administration. This includes legal substances - for example, 'binge drinking' is considered misuse of alcohol.
    - Negative impact on health, resulting in the presence of physical, mental, and cognitive health problems following personal 'harmful' use. For example, seizures, infection with blood-borne viruses linked to injecting drugs, abscesses, overdoses, liver disease and psychiatric drug-specific disorders. Importantly, the latter includes symptoms of dependence and addiction disorders.
    - Negative impact on the socio-economic life of the individual using drugs and those around them due to 'harmful' use. For example, significantly hampering or harming one's relationship with family, friends, partners, and colleagues; causing financial, legal and employment difficulties; or even causing or sustaining criminal offences to help fund or acquire drugs.

- 'Harmful' use is described further, and clustered into subgroups of 'drug harm' types to the user and to others using sixteen harm criteria, by the Advisory Council on the Misuse of Drugs. A table listing these types of drug harm is linked in the Appendix.

- A 'dependence' syndrome refers to both the physical and psychological elements of 'wanting' to take a substance and 'needing' to take the substance to function or survive. This includes experiences of impaired control such as craving, salience and compulsion, in addition to physical symptoms such as tolerance and withdrawal. Traditionally in biology-focussed discussions, dependence refers to only the physical aspect but in this HNA, it refers to the cluster of physiological, behavioural and cognitive features that characterize the syndrome in line with the diagnostic guidelines of the ICD-10 Classification of Mental & Behavioural Disorders.[33] The term 'addiction' with regards to substance misuse will be avoided except in relation to addiction psychiatry, and the use of 'dependence' syndrome will be preferred as per Clinical Guidelines produced by the Department of Health in 2017.[20]

- It is important to note that a substance may not be perceived as a 'problem' (or its usage considered 'misuse') to the using individual themselves - even if it meets clinical definitions of harms to health - until it meets a certain individually held belief or threshold of concern.[69] Perceptions of 'misuse' may be linked to knowledge, attitudes, and beliefs about a substance's harms, its legal status, personal and social customs (amongst other things). For example, it is known that a minority of under-18 year olds will 'experiment' with or use illegal drugs occasionally (usually in the form of short-term cannabis use); although only few of this group will use it regularly, dependently or in a way that has a harmful impact on their lives[20], this experimentation is still considered 'misuse' under the WHO definition. However, not all of these under 18-year old users, would consider their experimentation as a 'problem' worth discussing or exploring by professionals until it activates their own thresholds of concern.

- Similarly, the clinical threshold of concern, and professional concepts of 'misuse', will also vary in the eyes of the practitioners depending on the age of the using individual. What is considered 'problematic' for children and young people by professionals is different to that of adults because each group's physiological needs, range of vulnerabilities and decision-making capacities are dramatically different. According to national clinical guidance the definition of 'problematic' usage for children and young people depends the following: 'age, the child protection context, the nature of parental involvement and responsibility, and on developmental issues'.[20] Subsequently, the professional processes for screening, referral and management of 'misuse' in this cohort require special attention – these are explored further in Part 3-5 of this Health Needs Assessment.

<u>The Definition of a 'Child' according to the Law</u>

- In England, a 'child' is defined as anyone who has not yet reached their 18th birthday.[15] With regards to child protection guidance, the legal definition of children in England still encompasses those children aged 16 years old who live independently, are in further education, are a member of the armed forces, are in hospital or are in the custody in the secure estate.[83]

- This ‘under 18 years old’ definition is matched in Wales, Northern Ireland and Scotland. However, there are provisions in Scottish law that allow discretion by agencies in deciding which legislation/guidance is appropriate to follow when concerns are raised for at-risk 16- and 17- year olds.[15]

- Furthermore, there are some contexts where the definition of a child is defined in a more precise and specialised way. For example, in the context of child support, a child is defined as a person under 16 years of age under section 55 of the Child Support Act 1991 and in the context of employment, any person who is not over the compulsory school age is considered legally a ‘child’ for the purpose of regulating/prohibiting child labour under section 558 of the Education Act 1996.[75]

    - Compulsory School Age refers to a child who is 16 years old by the last Friday in June of the relevant academic year in which they turned 16, or reaching 16 years old after that Friday but prior to the start of subsequent new school year.[75]

- More broadly, the United Nations Convention on the Rights of the Child (UNCRC) defines a child as anyone under 18 years old unless “under the law applicable to the child, majority is attained earlier”.[17] The age of majority refers to the age in which an individual is no longer considered a ‘minor’ and has achieved the threshold of adulthood in the eyes of the law, with the consequent assumption of legal responsibility over their own person, actions and decisions. This ‘age of majority’ confers certain rights and obligations of legal adulthood that may differ between countries (for example, the right to inherit, the right to vote) but it should not be confused with other legal concepts of age thresholds such as driving age, voting age, age of sexual consent, marriageable age and age of criminal responsibility (*inter alia)* which all may be independent to the age of majority and set at different ages.

- For this Health Needs Assessment, the term ‘child’ will refer to anyone under the age of 18 years old. Where statistics using different definitions of ‘child’ have been used, the relevant definition used by the source will be written in parentheses after the data set.

<u>The Definition of ‘Young People’ according to the Law</u>

- The term ‘Young People’, however, is slightly more nebulous. The concept of youth can encompass many things; it may refer to a time of one’s life that can straddle one’s teenage years and young adulthood (beyond the age of majority), the achievement of certain physical health milestones, increased independence from family/guardianship systems, the participation in socio-cultural rites of passage of a community, or a combination of these factors. However, the legal definitions of ‘young people’ are only precise and specialised to the sector or sphere of society which a particular law regulates.

- The term ‘Young People’ refers to people aged 10 to 18 years old, as well as people aged up to 25 years old who have a special educational need or disability under the Children and Families Act 2014 for certain commissioning functions. For England and Wales, the term ‘young person’ is also defined in section 579 of the Education Act 1996 and Regulation 1 of the Working Time Regulations 1998 (SI 1998/1833) as someone under the age of 18 years

old but over the compulsory school age.[75] Elsewhere, in the context of child support, a 'young person' is defined as anyone aged between 16 and 20 who is receiving full-time education (which is not advanced education) as defined by section 55 of the Child Support Act.[75]

- Elsewhere, the United Nations defines 'youth' as young people between the ages of 15 and 24 years old, with all UN statistics subsequently using this definition for their work.[86] It is worth noting that this definition of 'youth' is inconsistently based on the old UN definition of a 'child' as anyone under the age of 14 years old - the UN no longer uses this definition of 'child', having updated its definition to refer to anyone under the age of 18 years old as per the 1979 UN Convention on the Rights of Child (previously listed above).[17] There is an explicit recognition at the international level that member states of the UN may use differing age groups to encompass 'youth' (e.g. 18-30 years old), and UN entities themselves with 'Youth' in their title may also differ (e.g. Youth Habitat 15-32)

- Due to the differing definitions of 'young people', the term 'young person' in this Health Needs Assessment will refer to anyone above the compulsory school age (approximately 16 years old) up to and inclusive of the age of 24 years old. This means that there is a two-year overlap of ages 16- and 17- years old within our 'child' and 'young person' definition; this is in keeping with legal and professional standards where discretion can be made in the assessment of capacity, vulnerability and situational context of decision-making when dealing with this age group (in particular, where there is a legal presumption of ability of those aged 16 years and older of making decisions with regards to their own medical care).[1] Where statistics using different definitions of 'young people' have been used, the relevant definition used by the source will be written in parentheses after the data set.

Part 2

Part 2: National Policy Background

Key legal frameworks

It is important to recognise the laws around smoking, drinking and use of drugs ('substances') by the defined groups of 'children' and 'young people' listed above. Not only do these govern how freely available and accessible a substance may be to these groups via communities or commercial purchase, but they also govern how a society may respond culturally towards substance misuse (in particular, the acceptability of 'legal' and 'illegal' drugs) and how professionals are expected to respond within a legal framework.

Smoking

- It is a legal offence for vendors to sell tobacco products to someone they know is under 18 years old (the legal definition of a 'child' across the UK). Other laws around smoking, however, are not age restricted; it is illegal to sell single cigarettes to anyone - adult or child – and it has been illegal to smoke in public places in the UK, regardless of age, since 1st July 2007.[36]

Alcohol

- Importantly, the distinction between the age of majority, other legal age thresholds and the definition of a 'child' is of particular relevance to this Health Needs Assessment as the drinking age in England does not match all three definitions; 16- and 17- year olds in England, Wales and Scotland may consume wine, beer or cider on licensed premises when ordered alongside a meal and if they are accompanied by an adult, but they are not allowed to be directly sold, served or offered alcohol by vendors. Across the UK, it is prohibited to sell, serve or offer alcohol beverages to anyone under the age of 18 (although in some nations, individuals over the age of 17 are entitled to a duty-free allowance for alcoholic beverages)

- Many alcohol-serving providers have further restrictions on sales, such as participating in voluntary commercial schemes such as the 'Challenge 21' and 'Challenge 25' schemes which ask retailers to request ID from customers attempting to buy age-restricted alcohol if they look under 21 or 25 years old to the employee serving them.[8] Although these schemes target 'young people' more broadly, they are not limited to them and more importantly, these schemes are not bound by the law.

- There are further restrictions regarding public and private drinking by minors. The law allows those under 18 years old to be stopped, fined, or arrested by police if they are under 18 and caught drinking alcohol in public in all four nations. In Northern Ireland, the law also penalises those under 14 years old on their private drinking whereas there is no age limit for this in England, Wales and Scotland. However, it is illegal in all four nations for someone to give alcohol to children under 5 years old.[8]

Drugs

- The law regarding drug use by a 'child' is more complex and relates to whether the drug is regulated or controlled by various statutes and Acts.

- 'Legal' drugs such as solvents (e.g. aerosols, glues) are not illegal to possess, use or buy at any age but they may still be subject to restrictions on their sale. For example, it is illegal for vendors in England and Wales to sell solvents to anyone under 18 years old if they know it will be used for intoxicating purposes. In some cases, regardless of intent, it is illegal for vendors in England and Wales to sell lighter fuel (butane) to under 18-year olds.[82]

- Other drugs may fall under the Medicines Act 1968, which governs the manufacture and supply of medicines through requirements on doctor-only prescription, pharmacist-only sales, or advertising, labelling and production restrictions. Drugs such as 'poppers' (liquid gold, amyl or butyl nitrate) fall under this Act and are not illegal to possess or buy at any age but must be sold by licensed outlets (chemists only) which may have their own age restrictions on sales.[82]

- Similarly, the Misuse of Drugs Regulations 2001 supplements the Misuse of Drugs Act 1971 and authorises certain individuals to supply and possess controlled substances through a system of five 'medicinal schedules', from those with no accepted use (e.g. Schedule 1), through to prescription-only drugs, to low-strength medicines that require minimal controls (e.g. Schedule 5). For example, doctors can prescribe these controlled substances for medical reasons but unauthorised production, supply, import or possession of them otherwise is an offence. There is overlap of these Schedules with the legal Class system of the Misuse of Drugs Act 1971 and illegal drugs belong to both a legal Class and a medicine Schedule at the same time.[69]

- Acts such as the Misuse of Drugs Act 1971 and the Psychoactive Substances Act 2016 are intended to prevent the non-medical use of certain drugs (including those in the Medicines Act and those not included in it). These Acts can prohibit the unlawful possession, production, import/export, and supply (and intent to supply) of controlled substances regardless of age.[82]

- The legality of drug possession and use is complex; broadly, the legality of possession is linked to the category of controlled drug (Class A, B or C) and its prescribing exceptions by licensed medical professionals. However, the *consequences* for unlawful possession, supply and intent to supply, import/export and production of these controlled substances under these Acts relate to the age of criminal responsibility in each home nation of the UK. The different criminal consequences proposed under the Misuse of Drugs Act 1971 will vary in manifestation depending on the age of the offender and therefore have an impact on the needs of the cohort analysed in this Health Needs Assessment. This encompasses the nature and frequency of contact with the criminal justice system, the type of intervention offered, and the likelihood of conviction or a prison sentence.

Criminal Responsibility

- Of note, the age of criminal responsibility in England and Wales is 10 years old, meaning those under the age of 10 years old cannot be arrested or charged with a crime. In

Scotland, the age of criminal responsibility is 8 years old although the age of criminal prosecution is 12 years old.[6]

- In England and Wales, children between 10 and 17 years old can be arrested and taken to court if they commit a crime, where they are treated differently from adults and are dealt by specific youth courts, given different sentences and sent to special detention centres for 'young' people (not adult prisons).[6]

- In Scotland, only children aged 12 years and older can go to a criminal court (those between 8-11 years old may go to a Children's Hearing). Those between 12-16 years old in Scotland will usually only go to court for serious crimes and will have early intervention for non-serious crimes, whilst 16-17 year olds may go to a criminal court at the discretion of the prosecutor/procurator fiscal of the case.[34]

- Young people in England, Wales and Scotland aged 18 years old and over are considered an 'adult' by the law and will be sent to prison if convicted of a relevant crime, although these can be specific prisons for 18-25 years old (not 'full adult prisons').[6] This is important to note as contact with the criminal justice system often worsens other individual and public health problems linked to illegal drug use, such as social inequality, violence and infection.[69] For professionals working with young offenders linked to substance misuse, emphasis on mitigating the negative consequences of contact with the criminal justice is being done and underpins work done across the country.

Key Statutory Duties for Professionals

- Certain professionals are legally obligated to safeguard, promote, and protect the health of communities with regards to drugs and alcohol, in several ways.

- The duty to safeguard and generally promote the welfare of children in need is embedded in the Children's Act 1989 and 2004 and this remains a statutory duty for professionals across sectors including health and social care, education, and the criminal justice system.[14] The welfare of children is also safeguarded regarding tobacco, nicotine products and smoking under the Children and Families Act 2014 where obligations on local authority enforcement apply. Depending on the role of the professional, duties may include reporting welfare and safety concerns to the appropriate service (for example, for emergency medicine doctors worried about a child, they must escalate this and report to a senior or designated Safeguarding Lead in their department) or appropriately responding to raised concerns through proportionate and ethical interventions including removing a child from harm's way if necessary. Sector-specific safeguarding legislation and professional codes of conduct (e.g. Good Medical Practice by the General Medical Practice) also apply and can supplement the duties listed in the Children's Act 1989.[1]

- For public health professionals, the Health and Social Care Act 2012 requires commissioning of effective services delivering better health and wellbeing outcomes for residents by Local Authorities.[29] Although substance misuse services are not a statutory function of these Local Authority-based public health teams in the Act, much of the funding for drug and alcohol services was transferred to the remit of the Directors of Public Health after the Act's introduction; subsequently, they now frequently commission these services

for adults, young people, and children with a view to fulfilling their wider mandated health and wellbeing duties.[71] [73]

- Furthermore, public health professionals working in health protection are also bound by legislation on controlling communicable diseases, for example outbreaks of Hepatitis C. This is relevant to those who substance misuse as there can be specific infectious diseases linked to the use of certain drugs (e.g. risk of bloodborne viruses in those injecting drugs), as well as the increased susceptibility of this cohort to infection due to biological and environmental factors (e.g. immunosuppression), that these professionals must be aware of and manage.

- For professionals in the education sector (for example, governing bodies, principals, headteachers, teachers), there is also a duty to educate, not just safeguard children and young people at risk of or using substances. It became a statutory duty to deliver drugs and alcohol education to children and young people in the compulsory September 2020 Personal, Social, Health and Economic (PSHE) curricula.[56] This required them to ensure that children and young people in their remits know the facts about legal and illegal harmful substances and associated risks including smoking, alcohol use and drug-taking, by the end of their primary school education. By the end of secondary school, it also requires these professions to ensure that children and young people know how the use of alcohol and drugs can lead to risky sexual behaviour, the link between drug use and serious mental health conditions, the law relating to the supply and possession of illegal substances, the physical and psychological risks associated with alcohol consumption and the consequences of dependency and addiction, what constitutes 'low-risk' alcohol consumption in adulthood, the dangers of prescribed drugs which could still present serious health risks, the harms of smoking tobacco, the benefits of quitting smoking, how to access support for quitting and information about effective interventions for smoking, drug and alcohol concerns.[56]

- For young people in employment, there are additional legal obligations on their employers regarding drugs and alcohol. Employers are legally obligated to stop from working any employee they know to be under the influence of alcohol or drugs under the Health & Safety at Work 1974 and could be liable to charges if they knowingly allow them to continue. Employees themselves could be liable to charges if their alcohol consumption or drug taking puts workplace safety at risk. Similarly, it is illegal for any operators of road vehicles and the transport system to work if they are under the influence of alcohol or drugs while driving or working under the Road Traffic Act 1988 and the Transport and Works Act 1992, and employers could be charged if they have not exercised all due diligence to prevent these offences. It is also illegal for controlled substances to be produced, supplied or used on an employer's premises under the Misuse of Drugs Act 1971.[9]

- Under the Criminal Justice Act 2003, community treatment orders for drug and alcohol misuse related to offending are a potential sentencing option for the courts. As a result, local substance misuse providers must also abide by this law and deliver these orders to the best of their ability when requested to do so.[66]

Key policies and national strategy documents

Smoking

- Despite increased awareness of its significant harm to users, legal drugs such as cigarettes and alcohol have been tricky to tackle due to their relative social acceptability, ease of availability and accessibility, and vested commercial interests. Concerted efforts to reduce smoking through national and international policy have been on the public health agenda for decades, with some great successes as well as some significant political and commercial obstruction. Public health legislation therefore has been one of the key strategic focuses of national policy choices to reduce smoking rates (alongside investment in smoking cessations services) and as a result, there have been significant declines in smoking rates and a 'denormalisation' cultural shift regarding smoking over the last decade.[59]

- As young people's health behaviour is driven by their environments, interventions to reduce smoking prevalence in adults and restrict access to cigarettes by young people have been part of the wider strategy of preventing young people from taking up smoking. These target young people's exposure to smoking role models, and the availability and accessibility of cheap tobacco.[84]

- In recent years, key tobacco control policies that have been successful for adults and children have included the introduction of 'smokefree' legislation in Scotland (2006), England, Wales and Northern Ireland (2007) in what became known as the public 'smoking ban', as well as the increase in the legal age of purchase of tobacco from 16 years to 18 years old for England, Scotland and Wales (2007) and Northern Ireland (2008). Other national legislation has included a ban on smoking in cars with children, a ban on displaying tobacco in small shops and the introduction of standardised packaged regulations in 2015; and continuation of the 'tax escalator on cigarettes at 2% above inflation from 2014 onwards (and commitments to continue this).[36]

- Evidence to suggest these measures work for children and young people (in addition to the whole population) is demonstrated by the reductions in the number of children and young people who try smoking or become regular smokers. For example, this has been seen in academic research evaluating the impact of smokefree legislation and increased legal age of purchase to 18 years old[10], and the sustained drop in self-reported rates in NHS Digital's 'Smoking, Drinking and Drug Use Among Young People in England' biennial survey of secondary school pupils in England in years 7 to 11 from 2016 to 2018.[61]

- In 2017, the Department of Health Social Care published the policy paper 'Smoke-free generation: tobacco control plan for England' with the aim of reducing the number of 15 year olds who regularly smoke from 8% to ≤3%, reducing smoking among adults in England from 15.5% to ≤12%, reducing the inequality gap in smoking prevalence between professions (i.e. those in routine and manual occupations, and the general population) and reducing the prevalence of smoking in pregnancy from 10.7% to ≤6% - all by the end of 2022.[58]

- In 2019, the Department of Health and Social Care also published their Green Paper consultation 'Advancing our health: prevention in the 2020s' that included a commitment to make England 'smokefree' by 2030 and a commitment to consider a 'polluter pays' approach to funding tobacco control measures, alongside other control policies.[3]

- More recently, e-cigarettes have become popular as smoking cessation aids amongst adults and subsequently, experimentation by young people with e-cigarettes has also occurred (although regular e-cigarette use appears to be rare amongst young people and largely confined to 'regular' smokers). However, in 2014, it became an offence to sell e-cigarettes to children under 18 in England and the Medicines and Healthcare Regulatory Authority (MHRA) announced the upcoming regulation of e-Cigarettes in 2013 (making them available for sale as over-the-counter medicines once licensed). There has been no evidence to suggest that e-cigarettes are a 'gateway' into smoking for young people. Public Health England published a report in 2018 reaffirming that vaping is at least 95% less harmful than smoking and in the same year, the House of Commons Science and Technology Select Committee published a reported advising e-cigarettes not be treated in the same way as conventional cigarettes and were being overlooked as a smoking cessation aid.[36]

Alcohol

- Like smoking, alcohol reduction consumption is challenging due to its legal status, its social acceptability and the ease of availability and access to it, despite its known health harms. Although there has been evidence to suggest declining rates over the last two decades, national policy choices around alcohol have not mirrored those of anti-smoking legislation in their comprehensiveness, stringency or innovation.

- Like the drivers of smoking in children and young people, it is generally thought that social influences from parents, family members, friends and peers' impact on the attitudes, choices and behaviours of children and young people with regards to drinking alcohol. Increasing attention has also been given in research to the impact of commercial advertising, social networking, pricing, labelling and content of alcohol in compelling drinking behaviour amongst this cohort.[84]

- In 2009, the Chief Medical Officer advised that children should not drink alcohol until at least the age of 15 years old and that an alcohol-free childhood was the 'healthiest and best option'. Young people between 15 to 17 years old were advised to only consume alcohol in a 'supervised' environment, doing so infrequently, no more than one day a week and not exceeding the recommended daily limits for adults. The importance of communicating the health hazards that drinking alcohol poses was emphasised to parents and young people. Additionally, there was a recognition of the importance of parental influences on the alcohol use of children and the need for support services for those with alcohol-related problems.[24] This guidance was based on the well-known evidence that drinking at a young age - particularly heavy or regular drinking - could cause physical, cognitive, and mental health harms to a child or young person. The evidence also reflects the increased risk of alcohol-related accident and injury associated with drinking alcohol, and was broadly associated with risky sexual behaviours, violent or antisocial behaviours, and poor school behaviours such as falling behind or missing school.[24 77] For young people aged 16-24, alcohol was responsible for a quarter of all deaths amongst men in that age group in 2014.[69]

- In 2016, the UK Chief Medical Officers issued Low Risk Drinking Guidelines to help people make informed choices regarding their alcohol consumption but these guidelines focused only on adults. Although there was no comment made about children and young people,

the guidelines were still relevant with regards to reducing overall drinking in the population, reducing those drinking in pregnancy (and the consequent effects on babies due to foetal alcohol syndrome), and promoting good role-modelling.[77]

- In 2012, the government's Alcohol Strategy aimed to target 'binge' and 'problem drinking' as well as achieving a sustained reduction in the numbers of those aged 11-15 years old drinking alcohol and the amount of alcohol consumed. A commitment to considering Minimum Unit Pricing in England was made in this 2012 strategy but there has been no legislation on this in England since.[68]

- A more recent Alcohol Strategy at national level has yet to materialise, although one was promised by the government in 2018. Debates on alcohol harm have been proposed by the Backbench Business Committee (BBC) in 2019[68] but there has been little traction, likely hampered by competing political priorities and the coronavirus pandemic.

- Elsewhere, alcohol policy from the individual devolved nations has been developed, for example Scotland's Alcohol Framework 2018 and the Welsh Government's Substance Misuse Delivery Plan 2019-2022 – both these nations have seen the successful introduction of Minimum Unit Pricing of alcohol in the last few years.[68]

- Extensive policy advice has been also given by Public Health England. For example, in its 2016 'The Public Health Burden of Alcohol and the Effectiveness and Cost-Effectiveness of Alcohol Control Policies: An Evidence Review', PHE identified the vast extent of alcohol-related harms, the substantial economic burden of alcohol and the disproportionate impacts on poorer communities across the UK. Amongst those aged 15-49 years olds (inclusive of 'young people'), alcohol is *'the leading risk factor for ill-health, early mortality and disability'*. The local and national policies proposed to tackle alcohol harm by PHE in this report affected three key influences of alcohol consumption – affordability (e.g. controls on the prices of alcohol), availability (e.g. ease of purchase) and acceptability (the social norms around its consumption, including marketing restrictions).[72]

- In October 2019 Public Health England also announced that it would be working with the four home nation governments to produce UK-wide clinical guidelines for alcohol treatment to provide support for alcohol treatment practice. This would mirror the well-known 'orange book' of standardised UK drug misuse treatment guidelines and best practice, produced in 2017 and recommended by the National Institute of Excellence. The new alcohol treatment clinical guidelines were due for publication in 2020 but unfortunately, have also been delayed due to the impact of the coronavirus pandemic on government and public health resources.[76]

- In 2018, the Faculty of Public Health (FPH) also produced 'Priorities for Action on Alcohol for the 2018 Strategy' that hoped to advise the government on the yet-delivered 2018 Alcohol Strategy across alcohol advertising, marketing, sales, licensing and treatment strategy. Alongside key evidence from the scientific literature to support them, FPH echoed those policies previously identified and advised by PHE in its 2016 evidence review, and distilled their advice to 7 specific priority actions.[58] These were:

  - Review of government policy on alcohol marketing including independent market regulation as a replacement for the current industry self-regulatory system,
  - Implement bans or restrictions on price promotions for alcohol
  - Reduce alcohol consumption through price with a combination of taxation and minimum unit pricing,
  - Review the role of licensing in protecting children and young people from exposure to alcohol environments and consider restrictions on where children and young people may be seated in licensed premises, times when they may be present and the supervision of children and young people in licensed premises as measures that reduce harm and promote wellbeing.
  - Explore measures within the current licensing set-up that might better address the recent compelling evidence around the strong social gradient in both alcohol harms and alcohol availability. Consider the introduction of a 5th licensing objective to protect public health
  - Address missed opportunities for identification and brief intervention or treatment through increased screening and Identification and Brief Advice (IBA) training in healthcare professionals
  - Increasing access to cost-effective treatment for higher risk and dependent drinkers through increases in investment in specialist services and the expansion of the relevant workforce, such as specialist alcohol care teams and addiction psychiatry. This included suggestions on how this could be funded by increasing tax on alcohol by 1% and ring-fencing that amount for treatment services.[58]

- The most recent efforts by the government to help people moderate their drinking have been by 'working with industry to deliver a significant increase in the availability of alcohol-free and low-alcohol products by 2025', as outlined in the 2019 Green Paper **'**Advancing Our Health: prevention in the 2020s**'**.[3] Additionally, the government hoped to establish Alcohol Care Teams as part of the NHS Long Term Plan to help tackle alcohol-related admissions, and has made £6 billion of funding available to support children who live with an alcohol-dependent parent.[68] Although these measures are steps towards reducing the availability of alcohol and providing material support to services helping those affected by alcohol dependence or alcohol-related presentations, progress with the more substantial policy recommendations of PHE and FPH remains limited.

Drugs

- According to Public Health England - as with alcohol – any drug use that 'affects, impairs, interrupts or hinders young people in their physical, emotional, social or academic development' is considered harmful.[84] There have been particular concerns about the relationship with drug use and mental health problems amongst young people, with evidence to suggest that young users of recreational drugs run a risk of damaging their mental health including the risk of suicide, depression, psychosis and disruptive behaviour disorders.[54] Clinical guidelines on how to support young people with a drug problem are outlined in the 2017 Clinical Guidelines on Drug Misuse and Dependence, published by the

Department of Health and recommended by the National Institute of Excellence (also known as the 'orange book').[20]

- However, policy regarding drugs in the UK is largely driven by the Home Office - rather than the Department for Health and Social Care and public health bodies like Public Health England. The key objectives of UK drug strategy have been around 3 core objectives: reduce demand, restrict supply and build recovery, as described in the 2017 Drug Strategy (and its older version, the 2010 Drug Strategy published by the Conservative-Liberal Democrat coalition government at the time)[22]. A fourth objective, 'global action' was added in the 2017 Drug Strategy regarding taking a leading role in driving international action and 'spearheading new initiatives'.[2]

- With regards to young people and drugs, the most recent 2017 Drug Strategy has focused on building resilience and confidence among young people to prevent a range of risks, preventing the escalation of use and harms, further development of dedicated drug and alcohol resources for prevention-oriented stakeholders, targeting emerging threats such as New Psychoactive Substances and lastly, collaborative work across sectors and families to address a range of vulnerabilities in young people with substance misuse issues (e.g. gang exploitation, Looked After children, young people not in education, employment or training).[2]

- Although the overall direction of policy is set by the UK Government, the devolved nations each have their own delivery strategies for drugs (and alcohol) and have produced updated policy papers and guidance since, such as the Welsh Government's Substance Misuse Delivery Plan 2019-2022.

- Whilst the Drug Strategies proposed by the government in recent years have focused on some elements of prevention and treatment, policy remains underpinned by two key pieces of prohibition-focused legislation that established drug offences in the UK – the previously mentioned Misuse of Drugs Act 1971 and the Psychoactive Substance Act 2016 (alongside other 'minor' legislation such as the Misuse of Drugs Regulations 2001 and the Drug Act 2005) listed in Part 2.1 of this HNA.[78]

- These Acts have brought the UK largely in line with UN Drug Control Conventions, consolidated drug laws of the past, and have attempted to combat the rise of new synthetic drugs and 'legal highs' that began to rapidly increase in the 2000s in the UK such as the synthetic cannabinoid 'spice'.

- Broadly speaking, these Acts criminalise supply/intent to supply, produce, import/export and - in the case of the Misuse of Drugs Act 1971 - the possession of controlled drugs. The latter offence has key exceptions for those controlled drugs of legitimate therapeutic use listed through the medicinal schedules classification of the Misuse of Drugs Regulation 2001. The Misuse of Drugs 1971 Act also sets out powers for the police to 'stop and search' individuals if they suspect illegal drug possession.[78 82]

- The list of 'controlled' drugs under the Misuse of Drug Acts are classified Class A to C based on an assessment of their relative harms (A being the most harmful, C being the least). An independent expert panel known as the Advisory Council on the Misuse of Drugs (ACDM)

contributes to the assessment of evidence on drug-related harms, subsequently advising the government on whether to amend drug classifications or add new drugs to the Misuse of Drugs Act 1971 list or Misuse of Drugs Regulations 2001. For example, ketamine was moved up to Class B in 2014 under the Misuse of Drugs Act 1971, and medicinal cannabis was moved from Schedule 1 (i.e. of no medicinal value) to Schedule 2 (i.e. doctors are allowed to prescribe under certain circumstances) in November 2018 following formal advice by the ACDM and a rapid evidence review commissioned by the Home Secretary for the Chief Medical Officer.[5 12 78] However, the ACMD have not always been listened to – for example, despite downgrading cannabis to a Class C from a Class B drug on ACMD recommendations in 2004, cannabis was re-classified as Class B in 2009 by the government contrary to the previous recommendation.[12]

- The Class A-C classification system also allows drugs to be coupled to a 'hierarchy of sanctions', with Class A drug offences receiving harsher fines and prison sentences than Class C drugs. This coupling system emphasises a penalisation and prohibition-based approach to drugs that has been at the forefront of national policy in the last few decades.[78]

- Furthermore, the 'stop and search' power outlined by the 1971 Misuse of Drugs Act has been a controversial practice that has had disproportionate impact on targeting minority ethnic groups, in particular Black boys and men, and has exacerbated racial inequalities.[65] Changes to police approach, such as warnings and on-the-spot penalties instead of prosecutions, have been applied in some places, but there have been increasing calls from civil society to wholly dismantle stop and search police powers altogether.

- Background socio-economic policy also represents a key component of tackling the 'drug problem'. It is well-known that exposure to drugs is linked to historical, social and economic forces, and law enforcement behaviours. Poverty, unemployment, social deprivation and pre-existing mental health conditions are also more likely to contribute to riskier patterns of substance use, and harms associated with substance misuse are amplified for those in contact with the criminal justice system.[69] Although recent government drug strategy has recognised these socio-economic vulnerabilities in its Drug Strategy 2017, material improvements in people's day-to-day social and economic lives through other policies have been lacking and inequalities have widened in the last decade.

- Trends in drug use prevalence have also suggested that current drug policy has been limited in effectiveness in deterring the use of drugs deemed 'most harmful' by the 1971 Misuse of Drugs Act's classification system.[78]

- Historically, levels of drug use in the UK showed a rapid increase from the 1960s to the early 1990s and then fell in the early 2000s and 2010s. However, the overall trends in drug use have been mixed over the last decade - for example a reduction in cannabis use (Class B/C) between 2002/03 to 2014/15 was offset by a slight increase in Class A drug use from 1996 to 2008/9, and there was an increase in harms from drug use (such as drug misuse-related deaths linked to Class A drugs) in roughly the same period of time.

- Analysis from research has suggested there is almost no correlation between the class of a drug (including legal drugs in the UK) and their overall associated harm. Unsurprisingly,

there has also been public misconceptions and confusion regarding which drugs are **'**more harmful**'** than others and a mistaken belief that legal drugs are 'less harmful' than illegal ones (despite evidence to the contrary).[69]

- There has also been research to suggest poor correlation with maximum penalties and the level of harm associated with illegal drugs or even their ability to deter use. A review of international drug policies commissioned by the Home Office itself determined that there was no evidence that deterrence was aided by tougher sanctions.[69]

- As a result, the national policy landscape around drugs has been complex, confusing and at times, directly contradictory to reducing drug-related harms. Parts of the system have described by the House of Commons Science and Technology Committee as 'not fit for purpose' and there is now increasing pressure for reform at a political level.[69]

- The approach that is increasingly advocated for by public health professionals, however, is one that moves away from penalisation and criminalisation, to one of harm minimisation, rehabilitation and supportive recovering strategies for drug users. These sentiments are echoed by advocacy groups and international organisation such as the World Health Organisation who emphasise moving away from enforcement practices that propagate human rights violations, contribute to violence and criminal networks, deny individuals access to health-improving interventions and further discrimination.[69]

- The public health approach to drugs was outlined for UK policy makers and civil society in documents such as 2016**'**s **'**Taking a New Line on Drugs**'** by the Royal Society of Public Health (RSPH), supported by the Faculty of Public Health. This document identifies the '5 key pillars of the public health approach to drugs'.[69] These are:

    - Closely aligned, health-led strategies. This includes the transfer of responsibility of the illegal drugs strategy to the Department of Health with a ring-fenced budget, where it could sit with the interlinked risks factors of alcohol and tobacco, destigmatising illegal drug users (and 'denormalising' alcohol misuse) and appropriately target resources as per their relative harm. This approach has already been adopted in Wales.
    - Prevention through universal education. This includes the reform of the current legal classification system into a comprehensible system that young people can be educated upon to make informed choices, through an evidence-based and interactive education that is focused on developing resilience, life skills and self-efficacy.
        - At the time of writing the 2016 RSPH document, drugs and alcohol education was not a mandatory component of the Personal, Social, Health and Economic (PSHE) curriculum in schools and the Royal Society of Public Health recommended it become so. It has since become a statutory requirement in the September 2020-curriculum, with schemes of work for key stages 1-4 developed by Public Health England.[19] [56]

- Evidence-based drug harm profiles. This advised a clearer evidence-based ranking and comparative harm profile for legal and illegal drugs (no longer Class A-C), that would inform not only relevant enforcement strategy but inform clearer public health messaging. The latter would help to dispel misconceptions and myths on the links between drug classification and the true harm and risks posed to health by a drug.
    - For example, using the multi-criteria decision analysis system provided by the Independent Scientific Committee on Drugs which is set against the Advisory Council on the Misuse of Drug's 16 type of harms, alcohol could be communicated as more high-risk than it is currently perceived by society (given its impact on families, physical health, economic cost, injury to others and crimes); the additional harm due to crime from heroin could be highlighted to emphasise how current enforcement strategies and stigmatisation help fuel illicit trade and violence and where harm reduction strategies could help reduce harm to users through accidental overdoses; and how 'legal highs' currently considered safe actually stack up to illegal hard drugs in terms of evidence-based harms.
- Decriminalising drug users for personal possession and use of illegal substances, and diverting them to the health system when helpful. This would be help reduce key health-related harms of drugs by removing harms caused or exacerbated by criminalisation. For example, the loss of training, employment, housing, finance and education; the severing of ties with family and community; and the exposure to trauma and gang violence before, during and after imprisonment; the disproportionate impact on certain ethnic and socio-economically disadvantaged groups (such as Black people), and the stigma associated with seeking healthcare for an illegal drug. This would mirror approaches seen elsewhere in Europe, for example Portugal's 2001 decision to decriminalise the personal possession and use of all illegal drugs, after which dramatically improved health and social outcomes were seen.
    - The Royal Society of Public Health also highlights the body of international evidence growing on the potential benefits and harms removal of organised crime through established legal, regulated markets and the need for the UK government to keep such evidence on review.
- Supporting individuals to reduce and recover from drug harm. This includes the removal of barriers to treatment for many users, such as social stigma, mental health problems and attitudes to treatment by users and providers. It also includes exploiting the potential of the wider public health workforce to support and direct drug users into treatment services despite the ongoing cuts to Local Authority public health budgets.[69]

Part 3

Part 3: Prevalence & Incidence of Substance Misuse in CYP

It is important to understand prevalence and incidence data for substance misuse in children and young people for three key reasons[35]:

- To help plan and allocate resources for the prevention, management and treatment of substance misuse and its sequelae. Resources needed may include funding, additional workforce, novel therapies or services, or communication tools.
- To help monitor key targets of local and national substance policy, for example the number of substance misuse service users relative to geography and population or the number of re-presentations to a service
- To help interpret key harms associated with substance use, for example the burden of drug-related morbidity and mortality linked to other risk factors and behaviours of 'problem' users, as well as the total prevalence of users. For example, the burden of blood-borne disease is linked to the prevalence and popularity of injected drugs, the sharing of needles (or other unsafe injection practices) and the number of intravenous drug users in an area.

Quantifying the size of the substance misuse issue in children and young people can represent a key challenge given the stigmatised and illegal behaviour attempting to be captured, and our ability to access this cohort in the first place. Due to varying levels of social acceptability and legal consequences, some substance misuse behaviours may be more easily captured than others, for example smoking versus the use of Class A drugs. Furthermore, recall of substance taking behaviours can be inaccurate itself due to a substance's psychoactive effects, quantities used may not be standardised for appropriate comparisons (e.g. young people drinking in informal settings vs. being served a limited amount with a meal under adult supervision), and children and young people may not be knowledgeable about the 'strength' of different drinks or the ingredients in an unlabelled pill that may be 'cut' with other substances. This presents issues regarding establishing 'misuse' patterns associated with frequency, strength, administration and levels of consumption.

Data sources for substance misuse can be quantitative or qualitative in nature, collected from a primary source for this specific purpose (for example, direct surveys sent out by myself) or from secondary data sources collected by others for another purpose (for example, vital statistics or disease registers). With registries and databases, however, there is only partial observation of the true number of substance misusers as they cannot cover the whole target population. A direct method of estimating prevalence would be broad general population surveys, but although this is the 'gold-standard' of estimating prevalence of substance misuse[27 31], it is impractical and not feasible to do this as primary data collection for this HNA. Similarly, indirect methods of estimating prevalence (such as multiplier calculations, multiple indicator methods or capture-recapture) are not necessarily reliable, and may have hard to verify assumptions, a lack of robustness and a lack of standardisation underpinning them. The use of multiple methods, therefore, is preferred to get a 'plausible' common estimate through concordance and convergence of others.[35]

This HNA will try and combine data from the following sources, to build up a picture of the prevalence of substance misuse, and trends, amongst children and young people in Harrow and England.

Data specifically regarding the performance of our substance misuse services Compass (for example, the number of referrals and their sources, the number of presentations to the service, demographic

breakdowns, the number and nature of interventions delivered, and the number of successful discharges) and comparison to national performance data from the National Drug Treatment and Monitoring System (NDTMS) will be detailed in Part 4 of this HNA.

Sources of Information on National Prevalence of Substance Misuse in Children and Young People

- Smoking, Drinking & Drug Use among Young People in England in 2018 (SDD18) Survey[61] - produced by NHS Digital, a biennial survey of secondary school pupils in England in years 7 to 11 (most aged 11 to 15 years old) covering substance use prevalence, habits, attitudes and more recently, wellbeing. It has been produced since 1982, and has included a core set of questions on smoking, drinking and drug use (to varying extent) since 1998. The 2018 survey questioned 13, 664 years 7 to 11 pupils from 193 schools across England between September 2018 – February 2019. In a school-based setting. An updated 2020 version of the SDD18 survey has been delayed to the coronavirus pandemic.

- Statistics on Alcohol, England 2020 (SA20)[63] – a report produced by NHS Digital, providing a range of information relating to alcohol use and misuse drawn from a variety of sources for England (unless otherwise stated) such as alcohol-related hospital admissions, alcohol-specific deaths, prescriptions for drugs used to treat alcohol dependence, drinking behaviours among adults and children, road casualties involving illegal alcohol levels and affordability of alcohol. Relevant CYP age cohorts listed in this are categorised as under 16 or between 16-24 years old.

- Statistics on Drug Misuse, England 2020 (SDM20)[64] – a report produced NHS Digital, this presents newly published information on hospital admissions (inpatient settings only) attributable to drug-related mental health and behavioural disorders, and on hospital admissions attributable to poisoning by illicit drugs. It covers both adults and children, linking to information from the National Drug Treatment Monitoring System, Office for National Statistics and the Crime Survey for England and Wales (CSEW) below. An in-built interactive data visualisation tool linked on the report's NHS Digital page allows for breakdown of these figures by Local Authority (to allow for regional and national comparison), as well as by broad age categories 0 of relevance, the age brackets of under 16 years old and 16 -24 years old are useful for this HNA.

- Drug misuse statistics from the Crime Survey for England and Wales (CSEW) for the year ending March 2020[21] - produced by the Office of National Statistics, the CSEW looks broadly at experiences of crime (including illicit drugs) and covers the population living in households in England and Wales. This survey is not inclusive of homeless populations, group residences such as student halls, care homes or other institutions such as prisons, and covers an age range between the ages 16 to 74

years. Drug use statistics within the CSEW were previously produced by the Home Office but have been produced by the ONS from 2020 onwards (although older reports on drug misuse statistics can still be found through the Home Office publications of the government website). The publication for the year ending in March 2020 was largely unaffected by the coronavirus pandemic as it mainly relates to the period prior to lockdown. A telephone CSEW (TCSEW) was launched in May 2020 but had a reduced roster of questions that did not include drug use (due to interview lengths and question sensitivities). The TCSEW therefore will not be comparable with the old face-to-face CSEW findings (such as the one produced for the year ending in March 2020) even when the drug questions will be re-introduced for the TCSEW from September 2021.

Sources of Information on Local Prevalence of Substance Misuse

- How Are You (HAY) Survey (2021)[28] - a local population survey that was conducted by Public Health in Local Authority, with an area sampling frame of children and young people studying in School and Further Educations settings within the Harrow. It had 6000+ respondents across key stages 1-4 and colleges/further education, with an overall return rate that was representative of 25% of all young people aged 9-18 studying in Harrow. The HAY survey did cover schools with pupils who had 'special or additional needs' but did not cover children and young people in Pupil Referral Units or those Not in Education, Employment or Training (NEET).

- **'**This is Harrow**'** Needs Analysis (2018)[74] – a survey conducted by the Young Harrow Foundation, in partnership with Harrow Council, Harrow Youth Parliament and the local voluntary sector, as part of a needs analysis into what young people in Harrow were feeling in 2018. The survey had results for 4358 respondents and highlighted five key areas for unmet need in Harrow: mental health, youth violence, employment, physical health and inequalities.

- What About Youth (WAY) Survey (2014)[81] - a survey conducted by the Department of Health (with Ipsos Mori) that sampled 300,000 15 year-olds on a variety of their health behaviours (including drug use, alcohol consumption, smoking and e-cigarettes) after randomly selecting these students from the Department for Education's National Pupil Database. The survey had a total of 120,000 respondents, of which 780 respondents were from Harrow-based education addresses (although the response rate per question for Harrow pupils varied between 734-780 pupils per each health behaviour question)

- Local Alcohol Profiles for England (LAPE)[40] **–** this Local Authority profile produced by PHE for the Fingertips dashboard (breakdown by Counties & Upper Authorities) which relate the number of admission episodes for alcohol-specific conditions of under 18s between 2017/18 to 2019/20.

- Child and Maternal Health Profiles[13] – this Local Authority profile is produced by PHE for the Fingertips dashboard (breakdown by Counties & Upper Authorities). These broad profiles describe various indicators such as hospital admissions due to substance misuse of those aged 15-24 years, admission episodes for alcohol-specific conditions – under 18s, and the health behaviours of 15-year olds from the What About Youth Survey 2015. Duplication with other PHE Fingertips Profiles is noted.

- NHS Digital Health Episode Statistics – these are collated by NHS Digital and relate to alcohol- and substance-related presentations, admissions, diagnoses, referrals, discharges and safeguarding concerns to local Accident & Emergency Services for North West London. These have been accessed either where HES data has been retrieved in an NHS Digital report (e.g. Statistics on Drug Misuse 2020's Local Authority interactive tool), Public Health England Fingertips tool or via the Emergency Care Data Set (ECDS) using relevant clinical coding.

- SafeStats[57] – this database, which has been managed and hosted by the Greater London Authority Intelligence Unit since 2006, holds a variety of crime and community safety datasets from key organisations in London including the London Ambulance Service, the Metropolitan Police, Emergency Departments and even PHE National Drug Treatment & Monitoring Service (NDTMS) data. Of relevance to this HNA, it holds data on London Ambulance Service callouts related to alcohol and substances.
    - For example, all LAS call-outs for the 0-25 year old cohort from 2017 onwards which have been coded under a relevant substance or alcohol SafeStats Themes or Crime Category, or as reported by the patient on the 999 call as Chief Complaint (or otherwise), or as recorded by the ambulance crew as the Illness or Incident type. Data retrieved for calendar year 2021 is until the end of May 2021. Please see the query protocol listed in the Appendix for further details on how the SafeStats data was retrieved.

Unfortunately, data from Primary Care, Mental Health Trusts and Community Services, and Children's Social Care (regarding drug- and alcohol- related presentations, admissions, diagnoses, referrals, discharges and safeguarding concerns) was not accessible due to information governance issues and delays in access before the publication of this HNA.

Access to primary care data via the Whole System Integrated Care (WSIC) portals will be a key step in gathering more information regarding children and young people presenting to their General Practitioners, as this subset of presentations may not be those who are in immediate crisis receiving A&E or London Ambulance Service-related care. Therefore, data from community mental health services and primary care may give us an indicator of the more stable 'baseline' or chronic rates of substance misuse-related help-seeking behaviours. Similarly, data from voluntary sector organisations for example, the number of calls related to substance misuse received by mental

health charities and crisis lines is also worth exploring in future HNAs. All these health and social care figures, however, measure help-seeking behaviour rather than the actual act of substance misuse itself, and therefore must be taken in consideration with broader household- and school- population surveys of general prevalence.

Sources of Information on National Prevalence of Substance Misuse in Children and Young People

Smoking, Drinking & Drug Use among Young People in England in 2018 (SDD18) Survey[61] – produced by: NHS Digital, relevant age range covered: mostly 11 -15-year olds in secondary school years 7 to 11

Smoking

- 16% of pupils had ever smoked cigarettes (down from 19% in 2016, and 49% in 1996). This is the lowest level ever recorded by this survey, showing a steady decline since 1996.
- 5% of pupils were current smokers (down from 22% in 1996 but largely similar to 6% in 2014 and 2016). Current smokers include regular smokers of at least one cigarette a week (2%) and occasional smokers of less than one cigarette a week (3%).
- London overall had the lowest 'current smokers' prevalence. Current smoking prevalence was highest amongst white pupils (6%). More than half of current smokers were aged 15 years old (55%).
- The proportion of regular smokers has declined over time since 1996 but is not statistically different to the 2016 survey. The proportion of regular smokers increased with age but was the same for boys and girls. Almost half of regular smokers (45%) said they had smoked more than 20 cigarettes in the last week.
- Regular smokers tended to see themselves as 'dependent' on the habit, with 61% reporting they would find it very or fairly difficult to not smoke for a week and more reporting the same sentiments towards giving up altogether. Longer-term smokers (more than one year) were more likely to find it harder to not smoke for a week or give up altogether. 21% of regular smokers were committed to giving up, having tried in the past and would like to try again. However, 34% were unconcerned about their 'dependence' and had never tried to give up nor did they want to.
- For those who had tried to give up smoking, the most common approach of ex-smokers was not to spend time with friend who smoked (45%) and the use of e-cigarettes (44%). For current smokers, 66% had tried using e-cigarettes to give up. Less than 5% had used an NHS or Primary Care service (e.g. smoking cessation clinics, helplines or GPs) to help give up smoking.
- Parents (76%) and teachers (69%) were the most likely to be cited as people who could provide helpful information about smoking, although sources like friends, the Internet and social media were also reported as helpful for some and became more common as pupils got older.
- Survey modelling suggested the following factors identifying pupils with an increased likelihood of being smokers: in descending order of the strength of the association – uses e-cigarettes, takes drugs, have friends who smoke, family don't discourage smoking, smokers at home, drinks alcohol, plays truant, pupils aged 15
- Almost all regular and occasional smokers had a friend who smoked (vs. less than half of non-smokers) and regular smokers were also more likely to have family members who smoked, compared with non-smokers. Pupils were more likely to smoke

themselves if they lived in a household with other smokers, with increasing proportions smoking pupils as the number of smokers in the household increased.

- 60% of pupils reported exposure to second-hand smoke in homes (theirs or other people's) and cars, but this is down from 2014 figures. Smokers were more likely to be exposed to second-hand smoke.
- 49% of pupils that current smoke were 'secret' smokers (family unaware of smoking habit), with occasional smoker more likely to be secret smokers than regular smokers.
- 75% of pupils reported that their family do/would try to stop them smoking, with a further 16% reporting their family do/would try and persuade them to stop (similar levels to recent years). Smokers are less likely to have a family that do/would try to stop them or persuade them to stop.
- Although there has been a general decline positive attitudes towards smoking prior to 2016, the 2018 survey reports similar attitudes to the 2016 survey regarding the number of pupils thinking it was 'OK' to try a cigarette to 'see what it was like' (24%) and the number of pupils reporting that it was 'OK' to smoke once a week (9%). Younger people were less likely to think it was OK to try smoking to see what it was like.
- Common beliefs about why people their own age smoke included: to look cool in front of their friends (79%), addicted to cigarettes (71%) and friends pressuring them into it (68%). 42% of 15 year old pupils had an exaggerated perception of how many people their own age smoked believing it was half to most/all of them, whilst 54% of 15 year old pupils had a more accurate perception of it being 'only a few' people of their own age which is consistent with the current smoking prevalence for 15 year olds was 11% in 2018.
- The proportion buying cigarettes from shops declined from 46% in 2014 to 2013% in 2018 (NB: displaying tobacco products in shops has been prohibited since 2015). 17% of pupils reported not having seen cigarettes on display at any shop in the last year, up from 14% in 2016 and 5% in 2012. Of those who did see them, 60% reported seeing them in newsagents/tobacconists/sweet shops.
- With regards to e-cigarettes, 90% of pupils reported being aware of them, 23-26% reported that that had use them (similar to rates in 2016) with current and regular prevalence at 6% and 2% respectively. Boys were more likely than girls to be current e-cigarettes users, and current use increased with age. 36% of pupils thought it 'OK' for people of other own age to try an e-cigarette to 'see what it's like', with 24% thinking once a week usage was 'ok'. Positive attitude towards e-cigarettes increased with age.
- Pupils who had ever smoked were more likely to have every use an e-cigarette than non-smokers, and most regular smokers (92%) reported having used e-cigarettes in the past with regular smokers also being more likely to be regular e-cigarette users. Regular users were also most commonly given e-cigarettes by a friend (38%), not paying for them. The other most common sources to buy e-cigarettes from were from buying friends or relatives (29%), buying them from the internet (29%), from someone else (26%) or from an e-cigarette shop (despite the law banning sale of these to under 18 year olds since 2018). 5% of pupils have asked others to buy them e-cigarettes or refills from a shop in the last year of which 72% of these peoples were successful; for current users of e-cigarettes, 40% asked others to do this of which 82% of that proportion were successful. The proportion buying from any kind of shop fell from

37% in 2016 to 29% in 2018 but those buying from the internet increased from 23 to 29% in that time period.

- 40% of recent smokers reported low life satisfaction nowadays, compared to 18% across all pupils. 50% of smokers reported a low level of happiness felt yesterday compared to 25% for all pupils, 42% of recent smokers reported a low feeling that the things they do in life are worthwhile compared to 18% for all pupils. 38% of recent smokers reported a high level of anxiety felt yesterday, compared to 27% of all pupils.

Alcohol

- Between 2003 and 2015 there was a decline in the proportion of pupils who had ever had alcoholic drink. But in 2018, the number of pupils saying this (41-46%) was the same as that of 2016. Data prior to 2016 is not comparable due to a change in this initial opening survey question, and the subsequent effects this may have had on further questions.
- 17% of pupils said they usually drank alcohol at least once a month, of which 6% said they usually drink alcohol at least once per week. The proportion usually drinking once a week increased with age. 10% of pupils said they had drink alcohol in the last week (similar to 2016), varying from 2% of 11-year olds, 3% of 12-year olds to 23% of 15-year olds. The majority of drinking done in the last week was done on a weekend (Saturday – 67%, Friday – 38%, Sunday – 30%, other weekdays - ≤10%), with the proportion of drinking on Saturday increasing with age but little age-related variation for other days.
- London had the lowest prevalence of having had a drink in the last week than any other region. White pupils were most likely to had have an alcoholic drink in the last week (13%), followed by Mixed ethnicity pupils (7%), Other ethnicity pupils (4%), Black pupils (3%) and lastly, Asian pupils (1%).
- Survey modelling suggested the following factors identifying pupils with an increased likelihood of having drunk alcohol in the last week: in descending order of the strength of the association – parents don't discourage drinking, older pupils, recent drug use, drinkers at home, smoking, White ethnicity, playing truant.
- Of those drinking the last week, an average of 10.3 units of alcohol was consumed (estimate, with margin of error roughly between 9.1 to 11.6). 21% of pupils drinking in the last week were estimated to have drunk more than 15 units, with younger pupils drinking in the last week more likely to be drinking fewer units than older pupils. The types of alcohol being drunk included beer, lager and cider (more boys than girls drinking these, also contributing more total units to those consumed by boys), and spirits, alcopops, wine, martinis and sherry (more girls than boys drinking these, also contributing more total units to those consumed by girls).
- 9% of pupils said they had been drunk in the last four weeks, of which the proportion increased with age (22% of 15-year olds reported having been drunk in the last four weeks vs. 1% of 11 and 12-year olds). Girls were more likely to have been drunk than boys in the last four weeks. 6% of all pupils had been drunk once or twice, and 2% more often, in the last four weeks. Of the 9% of pupils who said they had been drunk in the last 4 weeks, the most common adverse consequences of being drunk was feeling ill or sick (40%), vomiting (23%), having an argument (18%), damaging clothes or other items (17%) or losing money or other items (17%). Roughly 5% had a fight, under 5% had trouble with the police, and roughly 2% were taken to hospital.

- In 2018, 38% of pupils said they were current drinkers (those drinking alcohol at least a few times a year), with proportions increasing sharply by age (9% of 11-year olds to 66% of 15-year olds).
- Of pupils who obtained alcohol in the last four weeks, they were most likely to have been given it by parents or guardians (71%), then by friends (49%), or take from home with permission (48%). 9% of pupils said they had bought alcohol from a shop or pub in the last four weeks (despite the law against this), with 15-year olds the most likely to have done so. Current drinkers reported buying alcohol from friends or relatives as the most common source (24%), although 19% also reported buying alcohol from retailers and licensed premises with higher rates of this amongst older pupils. 61% of current drinkers said they never buy alcohol, the proportion being higher for younger pupils.
- Those who drank alcohol were more likely to do so in their own home (66%) but other common locations included someone else's home (41%) and parties with friends (40%), followed by on streets, in parks, outside homes, pubs/bars, clubs and discos (all under <15%). Drinking at home was common for pupils of all ages who were current drinkers, but more so for younger pupils, whilst drinking at parties with friends or someone else's home was more common for pupils as they got older.
- Most drinkers said they drank with parents (66%) or friends (58%), and only 3% of pupils said they drank alone. Younger pupils who were current drinkers were most likely to say they drank with their parents, whereas older pupils were more likely to say they usually drank with friends.
- Pupils who lived with people who drank alcohol were more likely to drink alcohol themselves, and only 2% of pupils who lived with only non-drinkers had drunk alcohol in the last week (with 15% having ever had an alcoholic drink). In comparison, those pupils who lived with three or more individuals who drank in their household, 20% of them had drunk alcohol in the last week and 67% of had ever had an alcoholic drink. 49% of pupils said their parents did not, or would not like them to drink alcohol but perceived parental disapproval of their drinking decreased as the age of pupils increased. For those pupils who lived with people who drank alcohol, they were less likely to say their parents do not or would not like them to drink. A reduced perception of parental disapproval was also seen in pupils who drank recently in the last week, those who had been drunk in the last four weeks and those whose families were aware that they drink alcohol.
- Pupils were also more likely to have drunk alcohol (either in the last week or ever) if they had a higher family affluence score.
- Despite a general decline in tolerance of drinking and getting drunk since 2003, the last SDD surveys in 2016 and 2018 indicate a slight relaxing of attitudes in recent years (although tolerance was still lower than 2003 levels). For example, 27% thought it was 'OK' to drink alcohol once a week (24% in 2014, 46% in 2003) and 9% of pupils thought it was 'OK' get drunk once a week (7% in 2014, 20% in 2003). Overall, a greater proportion of 15-year olds thought it was 'OK' to do the above than younger cohorts.
- Common beliefs about why people their own age drink alcohol included: to look cool in front of their friends (74%), friends pressuring them into it (62%), to be more sociable with friends (61%) and because it gave them a rush or a buzz (60%). Other reasons (50% or less) included helping them forget their problems, living with others who drink, making them feel more confident, boredom and helping them relax. 52% of 15 year old pupils thought that most people their own age drank alcohol with 21%

saying about half (a broadly accurate perception given that 66% of 15-year olds were current drinkers in 2018), whilst 18% significant underestimated use amongst their peer groups believing only a few or none did so.

- Parents (77%) and teachers (62%) were the most likely to be cited as people who could provide helpful information about drinking alcohol, although sources like friends, the Internet and social media were also reported as useful media sources and became more common as pupils got older.
- 28% of pupils who had drunk alcohol in the last week reported low life satisfaction nowadays, compared to 18% across all pupils. 40% of recent drinkers reported a low level of happiness felt yesterday compared to 25% for all pupils, 29% of recent drinkers reported a low feeling that the things they do in life are worthwhile compared to 18% for all pupils. 36% of recent drinkers reported a high level of anxiety felt yesterday, compared to 27% of all pupils.

Drugs

- The SDD18 included the following drugs or drug types: amphetamines, cannabis, cocaine, crack, ecstasy, heroin, ketamine, LSD, magic mushrooms, mephedrone, methadone, 'poppers' (e.g. amyl nitrite), tranquilisers, volatile substances such as gas, glue, aerosols and other solvents, new psychoactive substances (NPS), nitrous oxide and 'other' drugs not obtained from a doctor or chemist.
- The definition of drugs was expanded in the 2016 SDD survey to include new psychoactive substances (formerly known as legal highs) and nitrous oxide (laughing gas). Even when accounting for the addition of new psychoactive substances to the prevalence measures in SDD16 2016, a large and unexpected rise in overall drug use prevalence amongst 11- to 15-year olds was noted from 14.6% in 2014 to 23.7% in 2018 (and 24.3% in 2016). It is unclear what has driven the rise of drugs amongst young people, although further investigation suggested contribution to this increased rate from the survey was an increased likelihood of pupils initially not answering questions on whether they had tried individual drugs (although the underlying reasons for that nor how much it contributes to the change is unclear). A genuine increase is evident, but data prior to 2016 is not comparable due to changed definitions with the introduction of the Psychoactive Substances Act 2016 and the expansion of drugs included in this survey.
- The rates of pupils who have even taken drugs in 2018 was 22-25%, having taken drugs in the last year was 16-18%, and having taken drugs in the last month was 9-10% - similar to the rates of 2016. The likelihood of having ever taken drugs, having taken drugs in the last year or having taken drugs in the last month increased with age. There was no statistically significant difference between boys and girls for either having ever taken drugs or taken them in the last year. However, boys were more likely to have taken drugs in the last month.
- London and Yorkshire and the Humber London had the highest prevalence of pupils who had ever had drugs, taken drugs in the last year or last month. Mixed ethnicity pupils were the most likely to have taken drugs in the last year (23%), followed by Black pupils (18%), White pupils (17%), Other ethnicity pupils (17%) and finally Asian pupils (13%).
- 24% of pupils reported that they had ever taken drugs, varying from 9% of 11-year olds to 38% of 15-year olds.

- Survey modelling suggested the following factors identifying pupils with an increased likelihood of having taken drugs in the last month: in descending order of the strength of the association – smoking, drinking, family don't discourage drug use, playing truant, London region, older pupils, low happiness yesterday, school exclusion, male pupils.
- In 2018, 38% of pupils reported that they had been offered at least one of the drugs asked about with older pupils more likely to have ever been offered drugs (with the age differences likely due to accumulated experience over the years and a genuinely increased probability of being approached and offered drugs). The most common drug being offered to pupils was cannabis (22%), followed by volatile substances and nitrous oxide (11-12%). 6% of pupils had been offered a new psychoactive substance and just under 10% had been offered cocaine.
- Cannabis was the drug that pupils were most likely to have taken in the last year, with 8% saying they had done sone in 2018 (similar to 2016, but below the reported 13% figure in 2001). The proportion saying that they had taken volatile substances has been around 3-4% since 2010, and class A drug use around 2-3% across the same period. For nitrous oxide and new psychoactive substances (only included from SDD16 onwards), 4% and 1% of pupils respectively said that they had taken them last year. Of pupils who had reported any drug use in the last year, around two thirds of them (65%) reported taking only one type of drug with 30% saying cannabis only and 18% saying volatile substances only. 35% of pupils who had reported any drug use in the last year were taking two or more type of drug, of which 18% said one of these drugs as a Class A drug.
- Of pupils who had ever taken drugs, 42% said cannabis and 40% said volatile substances were part of their early experience of drug use. 7% said that a class A drug was used at the age of their first drug use. Pupils who tried drugs at an earlier age were more likely to report using volatile substances at the ages, whilst pupils who first took drugs at an older age were more likely to report taking cannabis.
- On the first occasion they tried drugs, 57% said they had gotten the drugs from a friend (mostly of their age group) – for cannabis, 75% of first time use by itself was gotten from a friend. 11% said they got drugs from a dealer on the first occasion of use, but this was 29% when it was a class A drug on the first occasion. 6% said they had gotten drugs from a shop on the first occasion and these mostly involved volatile substances. Drugs taken more recently were most commonly obtained from friends (57%, 40% from their own age group), and from dealers (22%) with boys more likely to get drugs from a dealer than girls. The actual location of obtaining the drugs varied, with 44% of pupils saying they were outdoors (in a street, park etc…) when they last obtained drugs (across all ages), followed by someone else's home and at a party/club. 12% said they had obtained drugs whilst at school, with younger pupils more likely to have obtained drugs at school than older pupils.
- 85% of pupils who had taken drugs in the last year said they were with a friend when they last took drugs, 11% said they were alone, and under and 7% reporting taking with them a relative (including siblings, parents, and step-parents).
- The likelihood of a pupil having taken drugs in the last month or having ever taken drugs was higher for pupils with a higher family affluence score.
- 31% of pupils perceived it to be easy to get illegal drugs, with no significant variation over the last 10 years versus 30% of pupils who perceived it to be different (and 39% who said they did not know how easy it would be). The proportion who thought it

would be easy to get drugs increased with age, with over half of 15-year olds thinking it would be easy to get illegal drugs compared with 8% of 11-year olds.

- Common reasons for why pupil took drugs varied on the first occasion in comparison to the most recent occasions. Pupils who took drugs on the first occasion were most likely to say they took them 'to see what it was like' (50%), whilst on the most recent occasion they were most likely to say 'to get high or feel good' (42%). Both these reasons were the most common reasons for use overall, followed by 'because friends were doing it' and 'to forget my problems' (which also depended on whether it was the first time or most recent occasion of use). Roughly 5% and under said they had done it because it was 'cool' or because 'it was a dare'.
- Pupils taking cannabis, volatile substances or Class A drugs all most commonly gave the 'to see what it was like' reason for their first usage. The reason 'to get high or feel good' was also commonly given by pupils who took cannabis and Class A drugs for the first time, but not commonly for those who had used volatile substances. The reason 'to forget my problems' was more likely to be given by pupils who took Class A drugs. Although never the most common reasons, 'because friends were doing it' did feature in the top four reasons for all the drug types examined on first time use.
- 13% of pupils agreed it was 'OK' for someone their own age to take cannabis to see what it was like, compared to 10% for sniffing glue and 3% for taking cocaine. However, there was a lower tolerance of regular drug use (i.e. taking a drug once a week) with only 7% thinking regular use of cannabis was 'OK, 4% for sniffing glue and 1% for cocaine. Attitudes towards taking drugs 'to see what it is like' or regular use have relaxed, with an increased positive 'OK' responses for all three drug types asked above since 2011 (although these questions were not asked between 2012-2014) despite the overall low acceptance of drug use. The proportion of pupils who thought it was 'OK' for someone their age to try drugs or use it regularly increased with age.
- 73% of 15-year old pupils thought none or only a few people their own age took drugs, despite prevalence of drug use in the last year amongst 15-year olds in this survey was 30%. 10% of 15-year olds, however, significantly overestimated drug by pupils their own age thinking that most or all people their own age took drugs in the last year which is not the case.
- Parents (71%), teachers (66%), other relatives (46%), police in schools (46%) and friends (44%) were the most likely to be cited as people who could provide helpful information about drug use, and sources like the Internet and TV were the most commonly helpful media sources (>50%).
- 33% of pupils who had taken drugs in the last month reported low life satisfaction nowadays, compared to 18% across all pupils. 42% of recent drug users reported a low level of happiness felt yesterday compared to 25% for all pupils, 35% of recent drug users reported a low feeling that the things they do in life are worthwhile compared to 18% for all pupils. 32% of recent drug users reported a high level of anxiety felt yesterday, compared to 27% of all pupils.

Multiple Behaviours

- 56% of pupils said that they had smoked, drunk alcohol or tried drugs on at lease one occasion. The likelihood of pupils having ever smoked, drunk alcohol or taken drugs increased with age from 24% of 11-year olds to 79% of 15-year olds.

- 20% of pupils said that they had recently smoked, drunk alcohol (in the last week) or taken drugs (in the last month), with the likelihood of this increasing with age from 5% of 11-year olds to 39% of 15 year olds.
- 2% of pupils had done all three recently i.e. smoked and drunk alcohol (in the last week) and taken drugs (in the last month). 3% had done a combination of two of these behaviours. 11% had only done one behaviour recently (with drinking being the most common). 84% had not done any of these behaviours recently.
- Pupils were more likely to find **'**one-off**'** experimentation acceptable than doing something frequently as once a week.
- Pupils were much more likely to that drinking alcohol was 'OK' (52% to try, 27% to do every week), than smoking (24% to try and 9% to do ever week). Acceptance of e-cigarette use was higher than that of smoking (36% saying it was OK to try, 24% to saying it was do regularly). Drug use was the least likely activity to be seen as acceptable, with 13% thinking it was 'OK' to tray cannabis and 7% thinking it was OK to do regularly, with even lower approval numbers for sniffing glue and cocaine. Despite long term declines, there have been increased recent acceptance of drinking and drug use in the surveys (but not of smoking).
- The likelihood of pupils reporting a low level of life satisfaction increased with the number of recent behaviours; 15% for no behaviours, compared to 26% for one, and 38% for all three behaviours. The likelihood of pupils reporting a low level of happiness, a low feeling that the things they do in life are worthwhile, or a high level of anxiety increased with the number of recent behaviours.

School Lessons & Guidance

- At the time of the SDD18, drugs and alcohol education were not part of the statutory national curriculum for children and young people (added in the September 2021). They were previously covered in Personal, Social and Health and Economic (PSHE) curricula at schools' discretion.
- More than half of pupils said they had received lessons on smoking, drugs and alcohol during the last year, with a slightly higher proportion for drugs (62%) than smoking (58%) and alcohol (57%). Lessons generally peaked in years 8 and 9 (although lower rates for year 7 in the survey could be due to the timing of the survey's deliver in the Autumn term, quite soon after they had only just started secondary school).
- Most pupils thought that their school gave them enough information about smoking (55%), compared to drinking alcohol (52%) and drug use (51%). The proportions were lowest in Year 7 (with likely contributing factor to the reason listed above).
- Most schools reported pupils had lessons about each topic at least once a year, between 77% of 85% of schools, depending on the school year and topic. The likelihood was highest in year 9 for all topics, and lowest in years 7 and 11. Having lessons at least once a term ranged from 16-24% depending on the school year and topic.
- Teachers contributed to lessons in 86% of the schools (not necessarily PSHE teachers) and most schools also drew on other contributors such as Local Authority drug and alcohol advisors (36%), police (35%), other school staff (32%) an school nurses (23%). Teachers drew on a range of resources to prepare lessons, including the government-funded FRANK website (78%), the PSHE Association (75%), Google and other search engines (69%), the Times Educational Supplement Connect resources (52%) and other teachers (47%).

Statistics on Alcohol, England 2020 (SA20)[63] – produced by NHS Digital, relevant age range covered: 0-24 years old

- Estimates for hospital admissions for diseases, injuries and conditions that can be attributed to alcohol consumption come from Public Health England's Local Alcohol Profiles for England and use data from NHS Digital's Hospital Episode Statistics. Estimates of the number of alcohol-related hospital admissions have been calculated by applying alcohol-attributable fractions (AAFs) to Hospital Episode Statistics. An AAF is the proportion of a condition assessed to have been caused by alcohol.
- Two measures for alcohol-related hospital admissions have been used in the SA20: narrow (where the main reason for admission to hospital was attributable to alcohol) and broad (where the primary reason for hospital admission or secondary diagnosis was linked to alcohol). The narrow measure provides the best indication of trends in alcohol-related admissions whilst the broad measure gives an indication of the full impact of alcohol on the burden placed on the NHS.
- Using the narrow measure, overall, there were 358,000 admissions to hospital in 2018/19 where the main reason was due to drinking alcohol which was 6% higher than 2017/17 and 19% higher than 2008/9. Admissions rose with age (up until ages 55-64-years old) before falling; more men than women were admitted; the majority of admissions were for alcohol-related cancer and unintentional injuries.
- Using the narrow measure, 3440 under 16-year olds and 23,160 16-24-year olds were admitted out of the overall total of 357, 660 individuals admitted in 2018/19, representing roughly under 1% and 6.5% respectively of all admissions in total. More men were admitted in these age groups combined than women. Partially attributable acute conditions such as alcohol-related injuries were particularly common, representing 11,450 admissions in the 16-24-year old group.
- Using the broad measure, 5010 under 16-year olds and 35,420 16-24-year olds were admitted out of the overall total of 1,261,910 individuals admitted in 2018/19, representing roughly under 0.4% and 2.8% respectively of all admissions in total. More men were admitted in these age groups combined than women. Partially attributable acute conditions such as alcohol-related injuries were particularly common, representing 10,650 admissions in the 16-24-year old group, as were wholly attributable conditions such as 'Acute Intoxication' (5630) or 'Toxic Effect of Alcohol' (5840) in the 16-24-year old group.
- The data source for alcohol-specific deaths used for SA20 is the Office for National Statistics 'Alcohol-specific deaths in the UK: registered in 2018'[7], with their definition only including conditions where each death is a direct consequence of alcohol misuse inclusive of chronic conditions associated with prolonged misuse and acute conditions associated with misuse (as opposed to PHE's alcohol-related deaths definition that includes cancers of mouth/oesophagus/liver etc…). More recent bulletins have been produced by the ONS on this topic but for continuity with SA20, the source 2018 bulletin figures are used below.
- From the ONS data for 2018[7], there were 5698 alcohol-specific deaths, 2% lower than 2017 and an increase of 7% on 2008. Males represented twice the rate for females for alcohol-specific deaths, although the rates for males and females stayed broadly similar since 2017. Alcoholic liver disease accounted for 79% of the 5,698 alcohol-specific deaths (although a further 1920 deaths due to unspecified hepatitis, fibrosis and

cirrhosis of the liver were not defined as alcohol-specific deaths due to attribution methodology). A further 10% were from mental and behavioural disorders due to the use of alcohol. Age-standardised death rates were highest in the most deprived areas and lowest in the least deprived areas. They were higher in the North and lower in London and the South.

- There was only a small number of deaths in those under 30 years old in the 2018 alcohol-specific registration data, producing a degree of statistical uncertainty. No alcohol-specific deaths were registered in 2018 for 0-14-year olds. Four alcohol-specific deaths were registered for 15-19-year olds and 17 alcohol-specific deaths were registered for 20-24-year olds.
- Accidental poisoning by and exposure to alcohol accounted for 50% (2 individuals) of alcohol specific-death in those aged 15-19 years, whilst 25% (1 individual) each was due to 'other' alcohol-specific cause and mental/behavioural disorders due to the use of alcohol in the rest of this group.
- Accidental poisoning by and exposure to alcohol accounted for 88% (15 individuals) of alcohol-specific deaths in those aged 20-24 years, whilst the remaining 11% (2 individuals) were due to alcoholic liver disease.
- Alcohol consumption behaviours for the SA20 have been taken from the Health Survey for England (HSE) a survey published by NHS Digital and carious out since 1994 to measure health and health-related behaviours in adults and children in England. The proportion of adults (aged 16 and over) drinking at increased or higher risk of harm levels (>14 units in a week) varied by age and sex. Across all age groups, men were more likely than women to drink at increasing and higher risk levels. 16-24-year olds were the least and third least likely age groups to be at increasing and higher risk of harm in men and women respectively.
- Alcohol consumption behaviour for children (<16 years old) for the SA20 were taken from the SDD18. Please see the previous item to see SDD18 trends.
- There was no age-related data regarding alcohol-related prescriptions on the SA20, although numbers regarding dispensed prescription by primary care and community services is listed by borough. There was also no age-related data regarding road casualties involving illegal alcohol levels, although the source material (the Department for Transport's 'Reported road casualties in Great Britain: Estimates for accidents involving illegal alcohol levels') does break casualties down by age, and the Crime Survey for England and Wales (below) reports self-reported drink driving levels by age as well.
- Data regarding alcohol expenditure for the SA20 is based on publications by the Office for National Statistics, such as 'Focus on Consumer Price Indices' and households' disposable income data published by the ONS in the 'Economic and Labour Market Review'. The only age-related data for children and young people is group with 'under 30 year old' categories, such as the average weekly £11.10 spent by this age group on alcoholic drink, tobacco and narcotics (£6.40 for alcoholic drinks, £4.70 for tobacco and narcotics) for the financial year ending in 2018.

Statistics on Drug Misuse, England 2020 (SDM20)[64] – produced by NHS Digital, relevant age range covered: 0-24 years old

- Three measures for the number of hospital admissions (inpatient settings only) related to drug misuse have been used for the SDM20, calculated using NHS Digital's Hospital Episode Statistics (HES) data. These measures include hospital admissions with a primary diagnosis of drug-related mental and behavioural disorders (admissions for drug-related mental and behavioural disorders = measure 1), hospital admissions with a primary diagnosis of poisoning by drugs that are listed as controlled under the Misuse of Drugs Act 1971 for both intentional and unintentional poisonings (admissions for poisoning by drug misuse = measure 2) and lastly, hospital admissions with a primary or secondary diagnosis of drug-related mental and behavioural disorders (admissions where drug-related mental and behavioural disorders were a factor = measure 3). This latter measure is a broader indicator of drug-related admissions, where a secondary diagnosis was not necessarily a contributor to admission but relevant to the overall episode of patient care. The HES data set relates to 2019/20, covering some pandemic period but this is believed to have a negligible impact on data.
- Admissions for drug-related mental and behavioural disorders, and for poisoning by drug misuse, showed similar age profiles. Levels were highest for younger people between 16-34 years old, peaking between ages 25 and 34 years old. Admissions for drug-related mental and behavioural disorders were lowest for those aged 16-years old and under, and those over 64 years old (the latter representing the lowest figures for measure 1 and measure 2).
- There was a 24.53% increase in admissions for poisoning by drug misuse since 2012/13 for under 16-year olds but a 12.56% decrease in admissions for poisoning by drug misuse for 16-24-year olds since 2012/3 in comparison to the 2019/20 datasets.
- Admissions for drug-related mental and behaviour disorders were a factor (measure 3) were lowest in those aged under 16 years old and those over 75 years. Those aged between 16-24 were in the middle, neither the lowest nor highest proportion for measure 3 admissions.
- Deaths related to poisoning by drug misuse for SDM20 are sourced from the Office of National Statistics' Statistical Bulletin 'Deaths related to drug poisoning in England and Wales'.[18] For a death to be classified as 'drug misuse' by the ONS, it must be a drug poisoning or meeting either one (or both) of the following condition; the underlying cause was drug abuse or drug dependence, or any of the substances controlled under the Misuse of Drugs Act 1971.
- The 2020 Statistical Bulletin **'**Deaths related to drug poisoning in England and Wales**'** highlights that the rate of drug poisonings continues to increase overall, with males accounting for more than two-thirds of registered drug poisonings (consistent with previous years). Two thirds of drug poisonings are because of drug misuse. The highest rate of drug misuse deaths was found in those aged 45-49 years, followed by those aged 40-44 years old ('Generation X'), consistent with previous years and the North East has had the highest rate of drug misuse of any English region for eight consecutive years. Of relevance in this HNA, London has had the lowest rate of drug misuse deaths and the 15-24-year old cohort represents the lowest rate of drug deaths alongside over 65-year olds.
- Almost half of all drug poisonings continue to involve an opiate, cocaine deaths rose for the ninth consecutive year and there was an increase in potentially dangerous drug combinations. Reasons behind the upward trend in drug-related deaths are complex and differ by types of drug involved, with possible explanations linked to an ageing cohort of drug users becoming increasingly susceptible to fatal overdose due to long-

term drug use, new trends in taking certain drugs with opioids/opiates increasing the risk of over-dose, increasing prevalence in cocaine use across Europe, higher availability of cocaine and heroin, and disengagement with opiate substitute therapy. The 2020 bulletin also reflects data during the coronavirus pandemic, for example death registration delays in 2020 were the highest since 1993 and this could have been attributable to the disruption to services caused by COVID-19.

Drug misuse statistics from the Crime Survey for England and Wales (CSEW) for the year ending March 2020[21] – produced by the Office for National Statistics, relevant age range covered: 16-24 years old

- Around one in five adults aged 16-24 years old had taken a drug in the last year (21%, approximately 1.3 million people) which was similar to the previous year (20.3%). Drug use was much more common among younger adults although, again, the proportion of 16 to 24-year olds taking drugs was similar to the previous year. Overall, 1 in 11 adults aged 16059 years had taken a drug in the last year (9.4%, approximately 3.2 million people).
- Around 7.4% of adults aged 16 to 24 years old had taken a Class A drug in the last year (approximately 467,000 people); this was not significantly different from the previous year. Overall, 3.4% of adults aged 16 to 59 years old took a Class A drug in the last year (approximately 1.1 million individuals).
- 4.3% of adults aged 16 to 24 years old were classed as **"**frequent**"** drug users (having taken a drug more than once a month in the least year) which was similar to the previous year's estimates. Overall, 2.1% of adults aged 16 to 59 years old reported "frequent drug use".
- Cannabis continued to be the most common drug used among adults aged 16 to 24 years old (18.7%), and 16 to 59 years old (7.8%), which is much higher than the second most prevalent drug for each age group: nitrous oxide amongst 16 to 24 year olds (8.7%) and powder cocaine amongst 16 to 59 year olds (2.6%).
- Powder cocaine was the third most commonly used drug among young adults aged 16 to 24 years old with 5.3% reporting use, behind cannabis (18.7%) and nitrous oxide (8.7%) listed above.
- Ecstasy use in the last year was reported in 4% among young adults aged 16 to 24 years old, showing no change compared to the previous year but overall lower level of use than in December 1995 (6.5).
- 1.3% of young adults aged 16 to 24 years old reported using new psychoactive substances in the last year (around, 82,000), which has halved from the 2.8% for the year the data was first collected in March 2015 (before the introduction of the Psychoactive Substances Act 2016).
- Young adults account for a disproportionately large proportion of new psychoactive substance users at around 71%, in comparison to proportions for other main drug types: cannabis (45%), powder cocaine (38%) and ecstasy (54%)
- 8.7% of 16 to 24-year olds had used nitrous oxide (around 549,000 individuals), in comparison to 2.4% of adults aged 16 to 59 years old. The level for both age groups has remained the same for the previous four years but had increased compared with the year ending March 2013. Similar to NPS, the use of nitrous oxide is particularly high for young adults and the prevalence rate was more than three times higher than the wider 16 to 59 years old age group.

- Amphetamine use in the last in adults aged 16-59 years old fell by 42% with the previous year (to 109,000 people) continuing the long-term decline since the year ending December 1995.
- Anabolic steroid use among 16-59-year olds in the last year also fell compared with the previous year from approximately 62,000 to 31,000 people, following a period over the last decade where reported use was relatively flat.
- Although there was no change in powder cocaine use among adults aged 16-59 years in the year ending March 2020 compared with the year ending March 2019, the proportion of frequent users fell from 14.4% to 8.7% in that time period.
- Overall, younger people were more likely to have taken a drug in the last year than older people. Other key trends noted in CSEW 2020 were the following:
    - Men were nearly twice as likely as women to have taken any drug.
    - Levels of drug use were higher in those who more frequently visited nightclubs.
    - Drug use was higher in those who consumed alcohol more frequently.
    - Adults living in the lowest income households were more likely to have taken any drug.
    - Those with lower personal wellbeing reported higher drug use.
    - The most common source of drugs among 16-59 years old were from a friend, neighbour or colleague – similar common sources for NPS and nitrous oxide were described, but a considerable proportion was also sourced from shops despite the illegality of most sales of these under the Psychoactive Substances Act 2016.
    - Around two-fifths of adults aged 16 to 59 years claimed that it would be very easy, or fairly easy, for them personally to obtain illegal drugs within 24 hours, although perceived ease varied by age.

Sources of Information on Local Prevalence of Substance Misuse in Children and Young People

HAY Survey 2021[28] – produced by Public Health (Harrow Council), relevant age range covered: 9 -18 years old

- The findings of the HAY survey covered a comprehensive investigation of the health and wellbeing of young people living and studying in Harrow in 2021, including (anonymised) questions on demographics, physical and mental health, coping strategies, home safety concerns such as living with vulnerable adults and food security, schooling and career support, body image, electronic device usage, bullying, fighting, community safety, behaviours related to smoking, drugs and alcohol and overall life satisfaction.
- Of relevance to the HNA are the results directly related to smoking, drugs and alcohol and associated risk factors for their uptake such as living with someone who smokes, influence through media and peers, and adverse community and home environments (including adverse childhood experiences).
- In comparison with previous national data from What About Youth (2015) and the Health Behaviour in School-aged Children (HBSC) study (2020) from the WHO Collaborative Cross National Study, it appeared that less students were drinking, smoking, taking drugs or vaping. Over 90% of respondents answered ‘no’ to whether they smoked, vaped, drank alcohol, took ‘legal highs’ (i.e. new psychoactive substances) or used illegal drugs. Of those who answered yes, the most common substances used were alcohol (6% of young people) and smoking (5% of young people).

- Far more college students smoked than young people in KS3 or KS4-5 and this was statistically significant.
- 2% of young people were current users of legal highs (a further 0.5% said they used to) and 3% were current users of illegal drugs (and a further 1% said they used to).
- About 2% of young people used to smoke, vape, or drink alcohol but had given up.
- Comparing between ethnic groups, fewer (British) Asia and more White young people currently and used to smoke, vape, and drink alcohol than expected.
- Most respondents live in supportive family groups.
- Around 3% of respondents said they lived with some who has problems with substance misuse. This question was not asked of Key Stage 2 children.
- Other data suggested that 20% of respondents lived with someone with a health or mental health condition, and 6% felt unable to get out and exercise because of caring duties of others at home. Just over 10% worried about the family running out of food, with a significant negative link between food insecurity and how respondents felt mentally and physically.
- Around 65% of respondents sometimes or often felt depressed or anxious and older respondents were more likely to rate their life satisfaction and happiness lower. 16% of respondents rated their life satisfaction as below the midpoint score, consistent with findings seen elsewhere during COVID-19. Some particular groups of young people appeared to be really struggling at the time of the survey, such as the 1% who identified as non-binary (a question not asked for KS2) and the 1% who identified at Chinese; reporting negative body image and increased bullying in the first group, and more concerns for safety, finding quiet places to study at home, bullying in the latter group (amongst other issues in both groups).
- Feeling physically well correlated with higher wellbeing scores. Variables such as eating regular meals with family, being active, getting enough sleep, eating breakfast regularly, not worrying about food insecurity, usually brushing teeth and not using electronic devices/the Internet for a long time at weekends did influence the life satisfaction model; smoking, amongst other things, did not.
- Around 7% of respondents across Key Stages 3, 4 and 5 have been offered illegal drugs. There was an increased likelihood of being offered illegal drugs in secondary school Key Stages 4 or 5.
- More broadly, 40% of respondents felt there were areas in Harrow where they felt unsafe (with alleyways and parks noted as unsafe and places such as Harrow-on-the-Hill train station, Wealdstone and Harrow Weald mentioned). 7% of respondents did not feel safe in the area they live in and 2% did not feel safe at home. 3% of respondents across Key Stages 3, 4 and 5 have reported being involved in gang activities but the survey did not define what these were. Males were more likey to say they got into fights, had seen someone else get physically hurt, be involved in gang activities, and be offered illegal drugs.
- When bullying happens (as reported in the survey), it often occurs for perceived ‘differences’ (commonly ethnicity, body size/shape, gender and sexual orientation) , happens at school and sometimes online; for occasions when it happens at school, respondents reporting bullying sometimes feel that nearby adults do not notice it or support them.
- The most common theme related to worries were those about school or college (and the associated workloads of exams etc..), about family/friends (e.g. them getting hurt or drying) and relating to experience personal feelings (e.g. depression, social or anxiety, or fear of failure).

This is Harrow Needs Analysis 2018[74] – produced by This is Harrow, in association with Harrow Youth Parliament, Harrow Council and other voluntary sector organisations, relevant age range covered: 11-20 years old

- When asked their support needs on an 'alcohol issue or problem', 81% of respondents (3134) did not think the issue was applicable to them, 7.5% (290) said enough support was already received, 6% (239) said they knew someone who needed support and 5% (198) said they needed support.
- When asked their support needs on 'substance misuse', 84% of respondents (3239) did not think the issue was applicable to them, 7% (267) said enough support was already received, 4.7% (180) said they knew someone who needed support and 4% (153) said they needed support.
- When asked more specifically about substance misuse with regards to having used Class A drugs in the last 3 months, 87% of respondents (3348) did not think the issue was applicable to them, 5.8% (221) said enough support was already received, 4.1% (158) said they knew someone who needed support and 3.6% (139) said they needed support.
- When asked more specifically about substance misuse with regards to having used Class B drugs in the last 3 months, 84% of respondents (3247) did not think the issue was applicable to them, 7% (271) said enough support was already received, 4.6% (178) said they knew someone who needed support and 4.1% (159) said they needed support.
- When asked their support needs on dealing drugs, 81% of respondents (3158) did not think the issue was applicable to them, 7.7% (297) said enough support was already received, 6.7% (261) said they knew someone who needed support and 4.3% (166) said they needed support.

What About Youth Survey 2014[81] – produced by Department of Health, relevant age range covered: 15 years old

- The smoking prevalence at age 15 in Harrow from the WAY survey is as follows:
    - 'Current smokers' who smoke 'sometimes smoke cigarettes now but don't smoke as many as one a week' and those smoking between 1-6 cigarettes a week or more than 6 cigarettes a week is 4.4%. This is below the region value for London (6.1%) and the England value (8.2%).
    - 'Regular smokers' who smoke between 1-6 cigarettes a week or more than 6 cigarettes per week is 2.2%. This is below the region value for London (3.4%) and England (5.5%).
    - Occasional smokers who smoke 'now but don't smoke as many as one a week' is 2.3%, similar to the region value for London (2.7%) and England (2.7%)
    - The percentage of 15-year olds who have tried e-cigarettes at age 15 was 10.8% in Harrow, better than the regional value for London (11.7%) and England (18.4%). This included those currently using, previously used or merely tried out e-cigarettes.
    - The percentage of 15-year olds who have tried other tobacco products in Harrow is 17.2%, lower than the regional London value of 21.0% but similar to the England value of 15.2%. This includes shisha pipes, hookah, hubble-bubble, waterpipes etc... and those who are currently used, previously used and merely tried out these products.

- The alcohol prevalence at age 15 in Harrow from the WAY survey is as follows:
  - The percentage of those who have ever had an alcoholic drink at age 15 in Harrow was 35.6%, better than the London regional value of 41.2% and England value of 62.4%
  - 'Regular drinkers' who drink at least once a week was 2.1% for Harrow, better than the regional value for London at 3.1% and England at 6.2%.
  - The percentage of those aged 15 who have been drunk in the last four weeks was 7.4% in Harrow, better than the regional value of 8.9% and England value of 14.6%.
- The drugs prevalence at age 15 in Harrow from the WAY survey is as follows:
  - The percentage of those who have ever tried cannabis at age 15 was 8.9% in Harrow, better than the regional London value of 10.9% and England value of 10.7%.
  - The percentage of those who have taken cannabis in the last month at age 15 in Harrow was 5.3%, similar to the regional London value of 5.0% and England value of 4.6%.
  - The percentage who have taken drugs (excluding cannabis) in the last month at age 15 was 0.6% in Harrow, similar to the regional London value of 1.0% and England value of 0.9%.
- The percentage of children with 3 or more risky behaviours at age 15 in the year 2014/2015 was 8.2% in Harrow, compared to a regional value of 10.1% in London and 15.9% in England. These risky behaviours included unhealthy and illegal behaviours, but these were not all exclusively related to substance misuse and included poor diet and physical activity. They included current smokers, those who drank alcohol at least once a month, those who had used cannabis or other drugs in the last month, those who ate less than 5 portions of fruit and vegetables the preceding day and those who had not been active for 1 hour or more on seven days in the preceding week.

Local Alcohol Profiles for England (LAPE) 2017-2020[40] – produced by Public Health England, relevant age range covered: under 18 years old.

- Admission episodes for alcohol-specific conditions for under 18s for 2017/18 to 2019/2020 in Harrow were 20, with a value of 11.4 per 100,000. This is a lower value than the regional value for London (15.4) and England value (30.7).
- These new indicators were added to LAPE in 2017 and the PHE definition of 'alcohol-specific' to include those conditions where alcohol is causally implicated in all cases of the condition e.g. alcohol-induced behavioural disorders and alcohol-related liver cirrhosis (meaning the alcohol attributable fraction, AAF, is 1.0 because all cases are 100% caused by alcohol).

Child and Maternal Health Profiles (2017-2020)[13] – produced by Public Health England and inclusive of other data sources such as the WAY 2015 Survey, relevant age range covered: indicator dependent (e.g. <18 years old, 16 -24 years old)

- This Child and Maternal Health Profile duplicates data in the WAY 2014 Survey and Local Alcohol Profile England. However, under its Young People filter for this profile, it does also list hospital admissions of those aged 15-24 years old by Local Authority.
- In Harrow, there were 40 individuals aged 15-24 years admitted to hospital due to substance misuse between 2017/18 to 2019/20, with a value of 52.2 per 100,000, lower in comparison to the London region value of 55.6 and England value of 84.7.

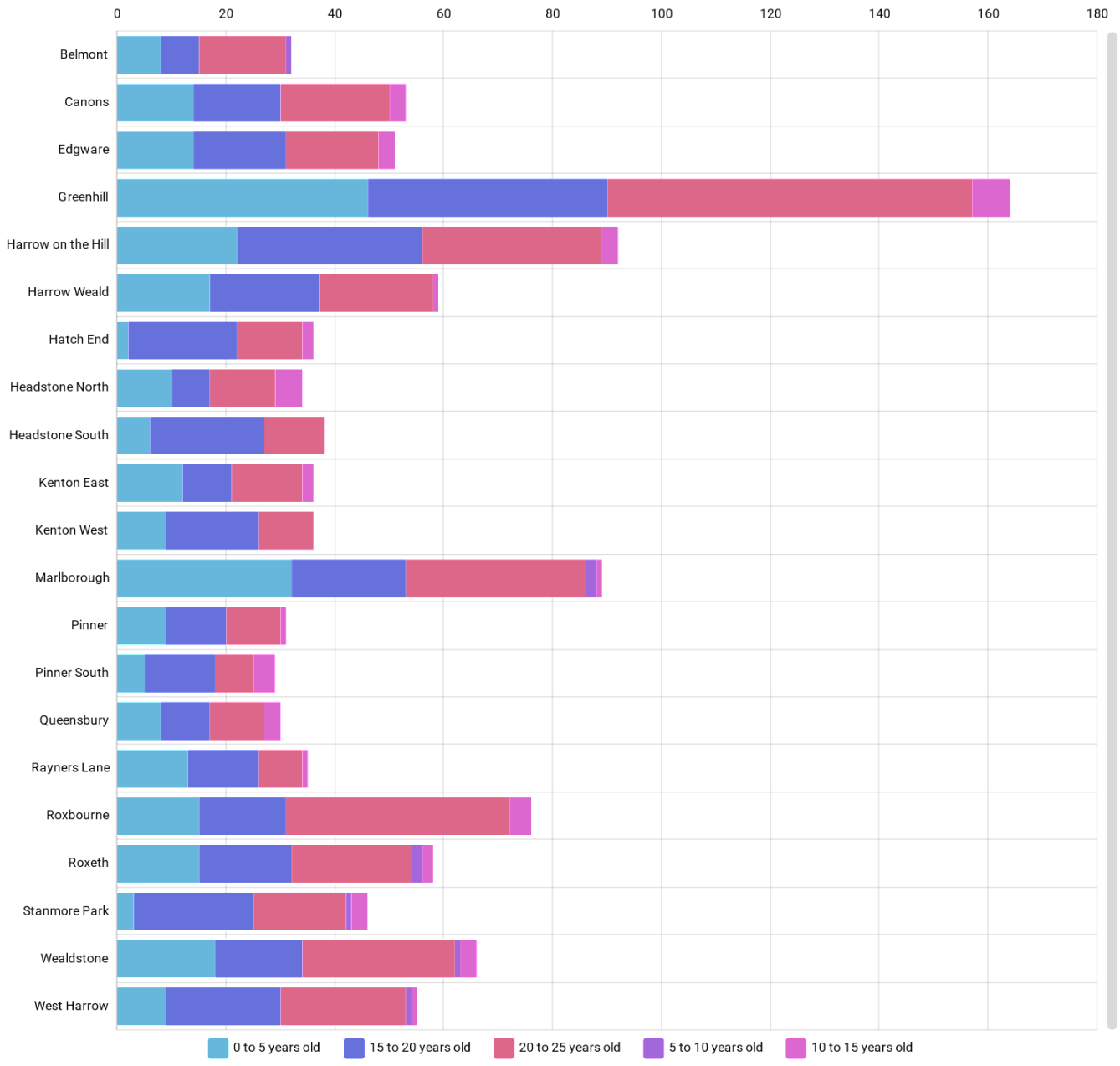
Health Episode Statistics – produced by NHS Digital and aggregated via their Emergency Care Data Set, age range covered: 0-25 years old

- There was no longer access to the 'Statistics on Drug Misuse, England 2020' interactive tool to allow for the breakdown of drug-related admissions by Local Authority over time due to a broken link on the webpage. The interactive data visualisation tool is still linked on the page and may be updated in future.

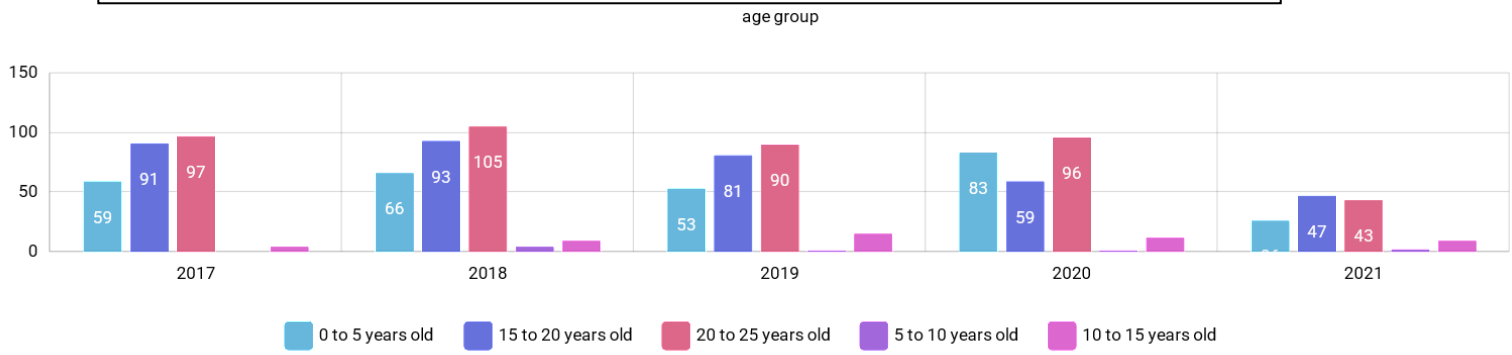
SafeStats[57] – hosted by the GLA Intelligence Unit aggregating data produced by London Ambulance Service, age range covered: 0-25 years old

- Between 2017-2020, there were roughly 980 first dispatch ambulance callouts per year for alcohol- or substance- related concerns in Harrow for the 0-25 years old age group. These relate to codes derived from either the caller's chief complaint, the Advanced Medical Dispatch Priority System (AMDPS) or the ambulance paramedics' entry regarding the nature of the Illness on attending the scene. The full query used for interrogating the SafeStats database is listed in the Appendix.
- Notably, callouts for 0-5 years old may not reflect intentional 'substance misuse' (for example, they may indicate accidental ingestion of a substance) and the callers phoning emergency services on behalf of these age group (and slightly older children) may not accurately reflect what truly happened with regards to the drugs and alcohol for a variety of reasons.
- The electoral wards with the most callouts over that time-period were Greenhill, Marlborough, Harrow-on-the-Hill and Roxbourne (in descending order). Of these boroughs, the greatest proportion of call-outs was in the 20-25 year old age group, followed by 0-5 years old and 15-20 year olds (except for Harrow-on-the-Hill where the 15-20 year old proportion was second and 0-5 year old proportion was third).
- These age groups trend across all boroughs in Harrow have roughly followed the same pattern since 2017 (20-25 years old > 15-20 years old > 0-5 years old), with the exception of 2020 where the second and third most common age groups were swapped.
- There were more callouts for Alcohol-related concerns than there were for Substance-related concerns (Class A or related to Solvents).
- There were 20 callouts for which a Class A related concern was coded, either from the caller or through triggering the AMPDS with the words 'cocaine' and/or 'heroin'. Six of these incidents involved the 0-5 years old age group – although it is unclear if the Class A coding relates to the patient or those around them (e.g. the caller themselves).
- Other data held on the SafeStats database include data from the Metropolitan Police (MPS) and British Transport Police (BTP) coded under 'Substance-related' or 'Alcohol-related' Themes. These refer to incidents coded as Offence = 'Drugs'(MPS)/Crime Group was 'Drugs' (BTP) or if the Cause of the incident was 'Disturbance, Alcohol-related' (MPS) or Offence contains 'alcohol'/'drunk' respectively (BTP). Although this data was not broken down by age, there were 3492 incidents with these codes for the MPS for data between 2016-2021 and 82 incidents with these codes for BTP recorded in the database for 2014-2021. This data is relevant to the wider picture of prevalence, as community use impacts children and young people, and represents opportunities for intervention through diversionary schemes.

- Figure 1. Horizontal bar chart showing the age-group breakdown of callouts in different wards of the London Borough of Harrow between 2017-2020



- Figure 2. Vertical bar chart showing the age-group breakdown of callouts overall in the London Borough of Harrow between 2017-2021



National Drug Treatment & Monitoring System (NDTMS)[41] – produced by Public Health England from information reported and shared (with service user consent) by local substance misuse services including Compass, age range covered: 0 – 18 years old. See Part 5 for Performance Data, with regional and national comparison.

Part 4

Part 4: The structure of services tackling CYP substance misuse within Harrow

The current structure of CYP substance misuse within Harrow follows that recommended in national guidance for a tier-based system of interventions, scaling up from the needs of the general population (universal intervention), at-risk vulnerable groups (targeted interventions) and those requiring professional management of their substance misuse (specialist interventions). These 3 levels of intervention overlap with a four-tiered framework that identifies the level and setting for different types of drug and alcohol treatment[67]:

Tier 1: Universal provision i.e. the police, housing, primary care and education. These services work with a wide range of clients.

This tier covers 'Universal Interventions'.

Tier 2: Low threshold substance misuse specialist interventions i.e. drop-in centres, harm reduction programme (e.g. needle and syringe/injecting equipment exchange programmes), specific advice and information services, assertive outreach programmes and triage referrals. These provide accessible drug and alcohol specialist services for a wide range of substance misusers.

This tier covers 'Targeted Interventions' and 'Specialist Interventions'.

Tier 3: Care planned interventions including substitute prescribing, psychodynamic interventions and recovery support. These are aimed solely for drug and alcohol misusers in structured care programmes.

This tier covers 'Specialist Interventions'.

Tier 4: Inpatient treatment including detoxification, stabilisation and recovery programmes, and residential rehabilitation or crisis intervention. These are aimed at individuals with a high level of presenting need.

This tier covers 'Specialist Interventions'.

- *Universal interventions (Tier 1)*
  These interventions reflect prevention approaches for children and young people as a broad population regardless of whether they misuse substances or not. It is also used to reflect the services which can be universally accessed by any CYP without the need for a referral from a professional (for example, GP or IAPT where services can be accessed by self-referral) and also includes legislation and policy that would universally affect these groups (for example, the enforcement of laws preventing under-age sales and proxy sales of alcohol, tobacco products and e-cigarettes). Importantly, it encompasses school-based prevention approaches for smoking, alcohol and drugs.

  Different strategies for prevention of misuse of different substances are utilised.
  - Smoking prevention in schools does have an evidence base (NICE Guidance PH23: Smoking prevention in schools, 2010[48]) but the impacts of this intervention are more effective alongside a package of cross-cutting tobacco control measures to reduces smoking prevalence in adults in the community as well.

- 'Whole-school approaches' to alcohol are perceived as most effective by NICE (NICE Guidance NG135: Alcohol interventions in secondary and further education, 2019[47]) where a package of pastoral care, strong PSHE and RSE education, positive environments and parent/carer engagement is sustained for wider wellbeing in students.
- Drug prevention approaches that focus more on reducing risk and increasing resilience (for example, promoting positive health, wellbeing and meaningful activities) are also more effective than topic specific programmes and interventions and are therefore recommended by PHE to support these strategies. Approaches that are least effective for drug use prevention include those centred on scare tactics/images, knowledge-only approaches, non-evidence based peer mentoring schemes, and programmes that use ex-drug users and the police as drug educators without integrating this education with other prevention approaches.

Since 2020, drugs and alcohol education has been on the mandatory PSHE curriculum for schools, with the depth of education needed dependent on the age, learning ability and Key Stage of pupils. National resources that support this work include Mentor's Alcohol and Drug Education and Prevention Information Service (ADEPIS), government-funded FRANK services (providing information), quality assured resources by the PSHE association and qualified local specialist substance misuse providers. Additionally, all drug prevention programmes are advised to use the European drug prevention quality standards (EDPQS).[2] The fundamental principles behind universal prevention are that all young people should have access to accurate, relevant and timely information about the health harms of alcohol, drugs and tobacco, prevention programmes are evidence based and integrated by authorities, and parents and carers are enabled to support children to stay safe from harm.[84]

- *Targeted interventions (Tier 2)*

  Targeted interventions refer to prevention approaches that support 'at risk' groups who are at an increased risk of harm from substance misuse, either due to their individual health needs, adverse home circumstances or negative community environments. Examples of these 'at risk' groups include homeless CYP, young offenders, excluded and truanting CYP, CYP suffering from domestic abuse, sexual assault and sexual exploitation, Looked After Children/Children in Need, those with behavioural/mental health/social problems, and those living with parents who substance misuse.

  The purpose of targeted prevention is to strengthen resilience of these young people and prevent risk and harm from escalating through commissioned early interventions. Commissioners in public health therefore work alongside NHS England, CCGs, primary care, schools and other providers to ensure provision of targeted support in the relevant contexts, for example the young people's secure estate, emergency departments or children under review by the local Troubled Families teams. The range of services where these activities may occur include statutory, voluntary or private services.

  Targeted prevention strategies for smoking require smoking cessation/stop smoking services tailor their wider communications towards low income and minority ethnic groups to address inequalities in smoking cessation rates for these groups, as seen in 2018 NICE Guidelines NG92: Stop smoking interventions and services.[46] Specific groups who are at high

risk of tobacco-related harm listed in that guideline include those who have mental heal problems, those who misuse substances, those with health conditions caused or made worse by smoking (for example, chronic obstructive pulmonary disease), those with a smoking-related illness, those with a high prevalence of smoking-related morbidity or a particularly high susceptibility to harm, those whose communities or groups have particularly high smoking prevalence (such as manual workers, travellers, and LGBT people), those in custodial settings, those living in disadvantaged circumstances and pregnant women who smoke. However, there is no explicit targeted prevention strategies for children and young people beyond universal strategies of prevention (including school-based education, public legislation, and commercial policy), unless they fall into categories of the above.

With regards to targeted interventions for alcohol misuse, NICE guidance (PH24: Alcohol-use disorders: prevention, 2010[49]) offers different recommendations dependent on the age of the CYP 'at risk' of drinking harmfully or becoming dependent on alcohol. For example, special considerations for persons aged 10-15 years old requires the use of professional judgement to routinely assess the ability of these CYP to consent to alcohol-related interventions (and may require guardian consent) and requires the use of professional judgement on the appropriate course of action (which in some cases, may be 'sufficient' to empathise and advise on the significance of impact by their drinking and in others, may require more intensive counselling and support inclusive of onward referral to CAMHS, Social Care or specialist interventions). However, a screening process for 16-17-year olds 'at risk' differs from the above by requiring not only routine assessment and sensitive discussion, but by asking practitioners to complete (or ask CYP to self-complete) a validated alcohol screening questionnaire. For those 'at-risk' 16-17-year olds who have been identified via screening as drinking hazardously or harmfully, an extended brief intervention and referral for appropriate treatment and care (if desired) is recommended. Key groups identified at increased risk of alcohol-related harm in the under 18-year old age groups include those who have had an accident or minor injury, those who regularly attend genitourinary medicine (GUM) clinics or repeatedly seek emergency contraception, those who are involved in crime or other anti-social behaviour, those who truant on a regular basis, those who are at risk of self-harm, those who are looked after and those involved with child safeguarding agencies.

The pathway for adults 'at risk' of harmful and hazardous drinking follows a similar pathway to young people aged 16-17-years old, necessitating the completion of a validated alcohol questionnaire and sensitive discussion, followed by either: brief advice; extended brief intervention (for those not responding to brief advice or who would benefit from extended brief intervention); or referral to specialist treatment (for those who show signs of moderate or severe alcohol dependence, those who show signs of severe alcohol-related impairment and those who have not benefited from structured brief advice or extended brief intervention). Groups at an increased risk of harm from alcohol/those with an alcohol related condition which NHS professionals can screen include people with relevant physical conditions (such as hypertension and liver disorders), relevant mental health problems (such as anxiety, depression or other mood disorders), those who have been assaulted, those at risk of self-harm, those who regularly experience accidents or minor traumas and those who regularly attend GUM clinics or repeatedly seek emergency contraception. Groups at an increased risk of harm from alcohol/those with an alcohol related condition which non-NHS

professionals can screen include people at risk of self-harm, those involved in crime or other antisocial behaviour, those who have been assaulted, those at risk of domestic abuse, those whose children are involved with child safeguarding agencies and those with drug problems.[49]

The recommendations for targeted interventions regarding drug misuse found in NICE guidance (NG64: Drug misuse prevention: targeted interventions, 2017[45]) centre on assessment of risk at both routine appointments and opportunistic contacts; using consistent respectful, non-judgemental and proportionate approaches to assessment; considering skills training of CYP and their families (e.g. regarding social and personal skills such as conflict resolution, identifying and managing stress, dealing with feelings of exclusion etc...); offering information on the effects of drugs and advice on how to get support (across settings where there is a risk of using drugs, printed and online); and ensuring consistency between universal intervention strategies. Groups at risk of drug misuse identified in the guidance include people who have mental health problems, those who are being sexually exploited or sexually assaulted, those involved in commercial sex work, those who are LGBT, those not in employment/education/training (including children and young people who are excluded from school or who truant regularly), those who are considered homeless, those who attend nightclubs and festivals, those who are known to use drugs occasionally and recreationally and, for CYP – those whose carers or families use drugs, those who are Looked After or care leaves and those who are in contact with young offender teams but are not in secure environments (such as prisons and young offender institutions).[45]

- *Specialist interventions (Tiers 2, 3 and 4)*
  Specialist interventions refer to individual packages of care-planned support that can include medical, psychosocial or specialist harm reduction interventions that build resilience, help people stop using drugs and alcohol, reduce the harm caused by substance misuse to themselves and others, and to manage the risks people face so progress is sustained upon discharge. The provision of specialist intervention itself covers a range of outreach and community-based educational interventions, psychosocial interventions, harm reduction interventions (for example, needle and syringe programmes), prescribed pharmacological interventions in community and lastly in-patient services (for example, admission for rehabilitation and detoxification).[84]

  Psychosocial interventions include evidence-based psychological, psychotherapeutic or counselling-based techniques to help young people change their behaviour and improve their coping skills. It includes evidence-based interventions such as motivational interviewing, cognitive behavioural therapies (CBT), relapse prevention and structured family interventions. Harm reduction programmes include needle and syringe programmes as well as age-appropriate advice and information on overdoses, health harms and reducing risky behaviour, the spread of blood-borne viruses, and sexual and reproductive health (including sexually transmitted infection screening, condom provision, early pregnancy testing and unbiased pregnancy options advice). Care pathways should be in place to help support CYP in accessing age-appropriate sexual health services, as well as blood-borne virus testing and treatment. Pharmacological interventions include prescribing for detoxification, stabilisation and symptomatic relieved of substance misuse and medications that prevent relapse. Specialist interventions covering smoking, drugs and alcohol are covered in a variety

of clinical guidance produced by NICE including NG92: Stop smoking interventions and services (2018)[46], CG115: Alcohol-use disorders: diagnosis, assessment and management of harmful drinking (high-risk drinking) and alcohol dependence (2011)[44], PH52: Needle and syringe programmes (2014)[50] and the 2017 Clinical Guidelines on Drug Misuse and Dependence, published by the Department of Health and recommended by the National Institute of Excellence (also known as the 'orange book').[20] The evidence base for these interventions has identified not only their effectiveness at reducing substance misuse but also improving other health and wellbeing outcomes, such as reduced problem behaviour, increased involvement in positive activities, increased confidence and self-esteem, increased academic attainment, reduced criminal activity, improved mental health, improved familial relationships and improved attendance at school.[23]

Usually, separate service providers are commissioned for specialist substance misuse for CYP and adults with a borough. In Harrow, the specialist drug misuse service for CYP is Compass, whilst the adult service is run by the Westminster Drug Project (WDP). Given the complex relationships between mental health and substance misuse, particularly in adolescents, joint working arrangements between specialist substance misuse services and child and adolescent mental health services (CAMHS) also exists and are recommended in PHE commissioning principles for these services.[84] Furthermore, multi-agency care packages exist for vulnerable young people with complex needs, for example support for housing and education if appropriate, necessitating a complex care panel review of the need for high-intensity multi-agency provision.[84]

In Harrow, nicotine used as an adjunctive substance alongside an alternative 'primary' substance misused by CYP is covered by Compass as part of the specialist substance misuse service. However, the general smoking cessation service (i.e. for a singular or primary tobacco or nicotine problem with a view to quitting smoking) for over 18-year olds does not sit with substance misuse services and is instead also run by WDP.[60] This would cover 'young people' between the ages of 18-25 years old who are interested in quitting smoking. For young people aged 12-17 years old who would like to stop smoking but are not accepted by WDP (for example, on a case-by-case basis), these individuals may be managed by primary care with age-appropriate measures. This includes practical advice, harm reduction advice, prescriptions for nicotine replacement therapy (but not varenicline or buproprion for this age group), follow up monitoring of carbon monoxide levels and referral to the free NHS Smokefree helpline as per NICE guidance on smoking cessation in this group.[43] All frontline workers in all substance misuse services are expected to ask young people if they smoke (including under-18-year olds) and advise that the most effective form of quitting is with a combination of behavioural support and stop smoking medications, with timely referral to the local stop smoking service if a CYP expresses motivation to quit (even if they are experiencing other health issues such as poor mental health).[43]

All interventions provided by any of these providers are expected to be delivered by qualified and competent staff; to be appropriate to the age and development of the young person; to take into account individual vulnerabilities; and to use a high-quality, evidence-based non-judgemental and inclusive approach. They are also expected to be cohesive with universal and targeted intervention strategies, and integrated with wider services regarding early help, safeguarding, and information-sharing policies and protocols. Four core commissioning protocols for CYP specialist substance misuse services identified in 2017 by

PHE were that young people and their needs must be at the centre of services, that quality governance is in place for all services, that multiple vulnerabilities and complex needs are addressed and lastly, that appropriate transitional arrangements for young people becoming young adults are in place.[62]

Part 5

Part 5: A review of the performance and operations of Compass

Description of service and interventions offered

The children and young people's specialist service for drugs and alcohol in Harrow is run by the organisation Compass. It operates a free, confidential service which can be accessed through self-referral or referral from a professional through:

- an online referral form (alternatively, a paper form can be completed and then emailed to the service),
- a weekday telephone hotline number (Mon-Thurs 9am-5pm, Fri 9am-4:30pm),
- a physical Hub based near Harrow on the Hill station (a major Underground tube station in the borough with access to National Rail from central London to Aylesbury).[26]

The service is not currently operating a wait list and referrals are allocated to practitioners on the first or next working day of its receipt. Service users can then be seen at the Hub itself and can be offered 'outreach' arrangements, including telephone calls and interventions at schools, cafés, parks or other appropriate public spaces of their choosing. Prior to the pandemic, an additional base for staff was available at the Civic Centre as one of the service's 'satellite' sites for outreach.

The service operates locally with a single Team Leader (with recent staff turnover into this role from September 2021) and currently three other Substance Misuse practitioners. Of these three practitioners, one practitioner additionally works as the link worker for the Youth Offending Team (within Local Authority) and one practitioner is also funded to undertake Eastern European Youth Outreach (funded by a one year grant from the Controlling Migration fund from national government). These practitioners may also undertake administrative roles. A Service Manager (overseeing services for two boroughs, Tower Hamlets and Harrow) and a Clinical Lead for the service are also supplied by the provider for purposes of operational management and clinical governance respectively.

The service is co-located with other providers of CYP health and wellbeing services with whom it may have joint working arrangements, such as those supporting issues of mental health, domestic violence, sexual health (for example, HIV testing and free condom provision), youth offending, and careers and employment opportunities. The service aims to build and maintain partnerships with key agencies (for example, Children's Services, Local Children's Safeguarding Board, the Youth Offending Team, local schools) to build awareness, offer training to frontline staff, encourage referrals (particularly for 'at risk' vulnerable groups), deliver aligned interventions and support advocacy/policy development for substance misuse prevention. Other than the Controlling Migration fund, the service is commissioned and funded entirely by Public Health at Local Authority.

The service generally covers a service user population from ages of 11 to 18 years old. There are exceptions to this age range, including young people up to the age of 25 years old being managed by Compass if they have particular vulnerabilities (for example, SEND needs) or if they are perceived to be unsuitable for adult services (at the Westminster Drug Project) following a case-by-case discussion.

The service provides targeted and specialist interventions for children and young people who are affected by their own or another's substance misuse across Tiers 2 and 3 (see Part 4). The service does not do Tier 4 inpatient specialist interventions. It does support Tier 1 services through its training and advocacy/policy development work.

The services available for young people include the following:

- Non-structured interventions (for example, brief interventions that centre largely on education and signposting, rather than counselling, behavioural therapies and/or pharmacological therapies) *Tier 2*
- Specialist substance misuse Hidden Harm work *Tier 2*
- Specialist substance misuse Harm Reduction support *Tier 3*
- Specialist substance misuse care-planned psychosocial interventions *Tier 3*
- Specialist substance misuse care-planned pharmacological interventions *Tier 3*
- Engagement work *Tier 1*
- Multi-agency working solutions *Across tiers*

Most interventions are provided on a 1:1 basis, although some element of group work may be appropriate (e.g. in engagement work). Whilst the service does not provide family therapy, it does encourage children and young people to invite their parent's involvement and it may refer to other services that can provide a whole-family approach (with consent).

All practitioners currently working at Compass are equipped to do Hidden Harm work with service users. All practitioners undertake an element of engagement work, such as training, advocacy and policy development work with schools or through the LCSB. As previously mentioned, one practitioner also currently acts as the main link worker for the Youth Offending Team (based within Local Authority) to work with young people under 18 years old who have come into contact with criminal justice system and who are identified as having drug and alcohol as a risk factor related to their offending by the YOT team on assessment. This includes individuals who have gotten in trouble with the police, have been arrested, charge with a crime, convicted of a crime and/or sentenced. The Triage team at Youth Services can also identify 'at risk' offenders with related substance misuse concerns and can divert them away from the criminal justice system with a referral to Compass to the appropriate link worker. As previously mentioned, another practitioner also currently as an Eastern European Outreach worker with additional funding provided to engage with this community on matters of drugs and alcohol within Harrow.

<u>Performance of Compass – data from the NDTMS until 2019/2020</u>

Performance data for Compass' drug and alcohol treatment is collected for the National Drug Treatment and Monitoring System (NDTMS) which covers information for young people's services (<18 years old, from Compass), in addition to those derived from adult services (>18 years old, from WDP).[41] Data is held for key indicators number of individuals in treatment, young people's characteristics at treatment start, substance use profile, access to services and treatment outcomes.

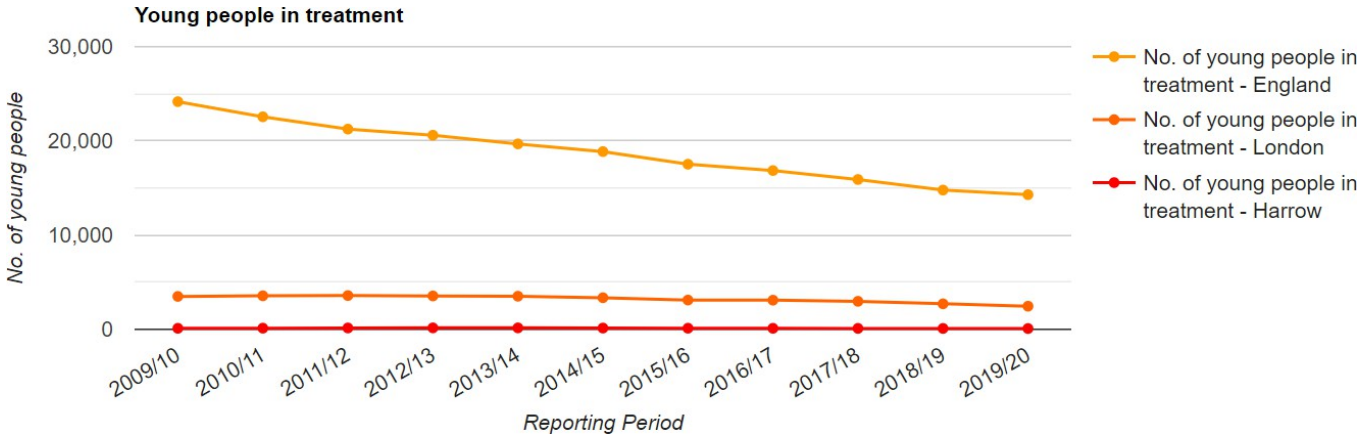
Although this HNA is designed to cover the period since the last HNA (2014), the following charts and graphs below will extend back to earliest data available on the NTDMS from 2009/10 to be able to see the broader trends and to compare against regional and national levels. The data covered extends to 2019/20, the latest data available for Local Authority on NDTMS.

National Drug Treatment & Monitoring System (NDTMS)[41]– produced by Public Health England from information reported and shared (with service user consent) by local substance misuse services including Compass, age range covered: 0 – 18 years old.

In Treatment data

Young people in treatment: Harrow, London (regional) and England (national) comparisons

The number of young people in treatment in Harrow has shown a downward trend since 2014, and remains under 1% of the total proportion of young people in treatment in England and roughly 3% of the total proportion of young people in treatment in England.

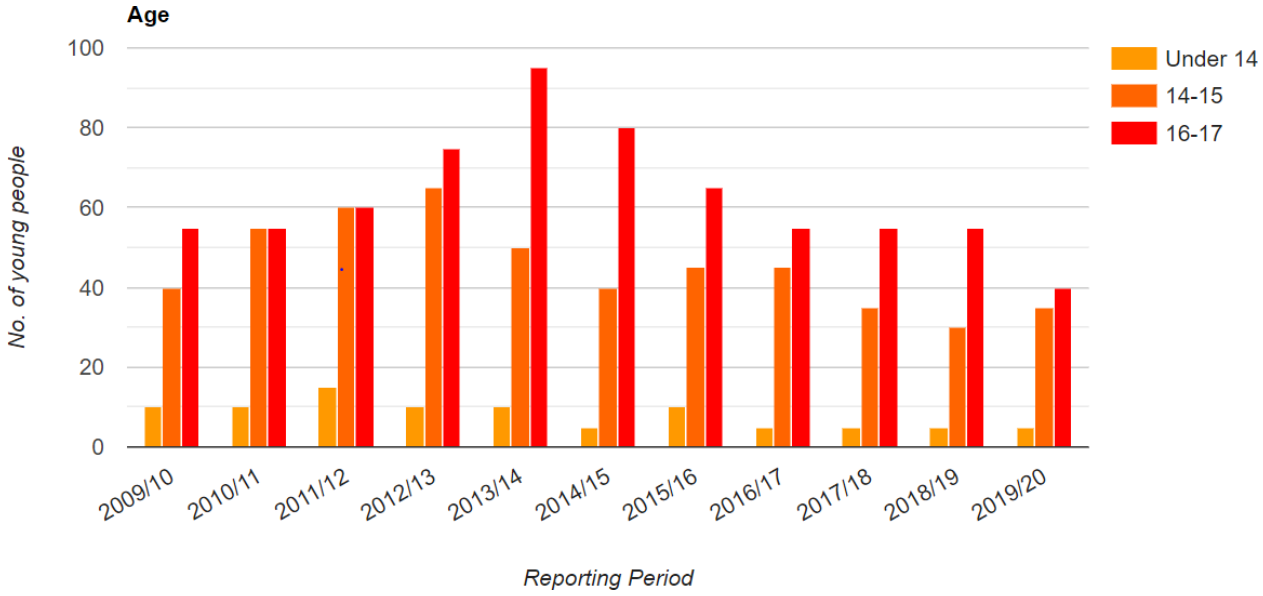


No. of young people in treatment	Area	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
No. of young people in treatment	England	24165	22555	21249	20601	19682	18865	17523	16849	15902	14777	14291
No. of young people in treatment	London	3490	3555	3580	3540	3510	3350	3105	3090	2970	2705	2450
No. of young people in treatment	Harrow	105	120	140	150	150	130	115	105	95	90	80

Young people's characteristics at the start of treatment data

Age: Harrow

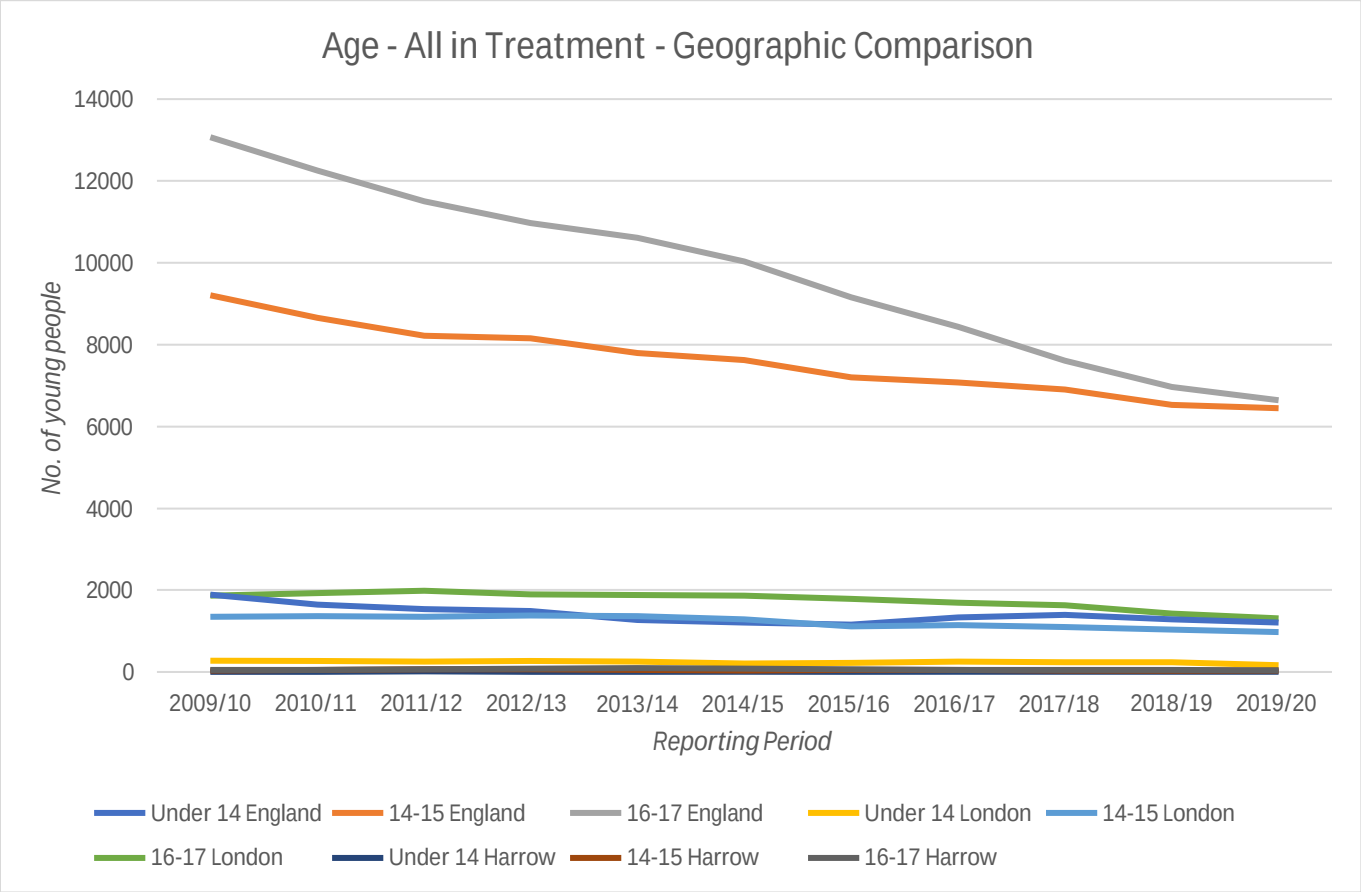
The age distribution of young people in treatment in Harrow remains largely centred in those above the age of 14 years old, with slightly more 16-17-year olds in the service than 14-15 year olds. The proportion of those under 14 years old remains very small. This pattern of distribution has been consistent since 2009, although the gap between the number of 14-15 and 16-17 year olds is decreasing over time as less 16-17 year olds enter treatment.



Age (young people)	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
Under 14	10	10	15	10	10	5	10	5	5	5	5
14-15	40	55	60	65	50	40	45	45	35	30	35
16-17	55	55	60	75	95	80	65	55	55	55	40

Ages: all under 18s, regional and national comparison

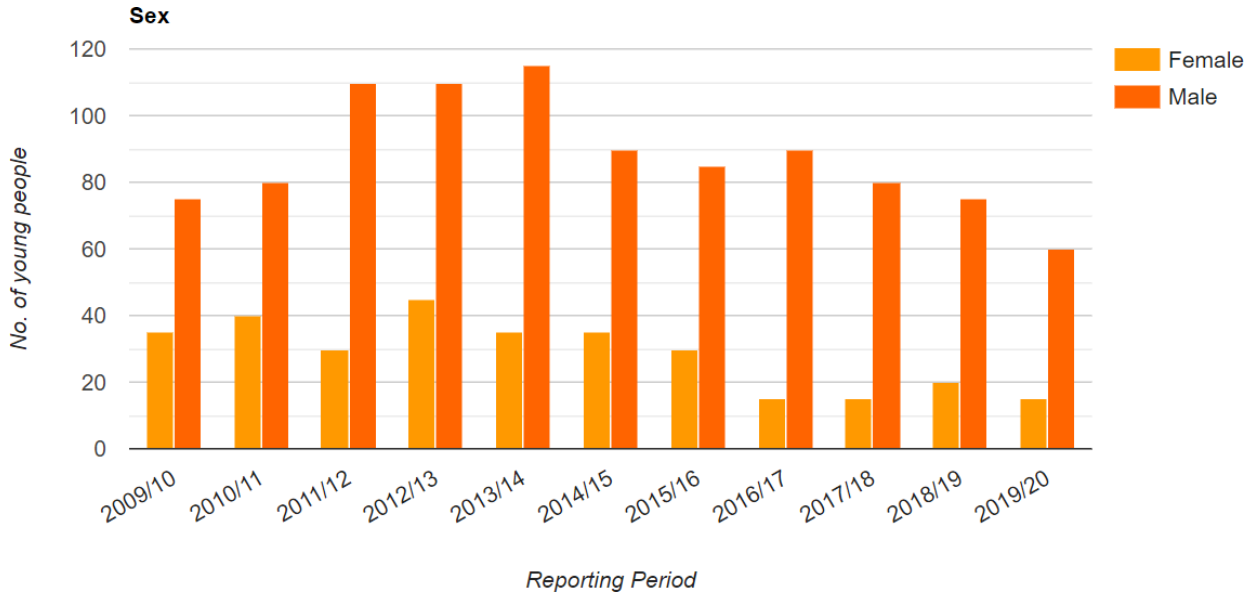
The age distribution of young people in treatment in Harrow (largely 14 years old and older) is mirrored in the age distributions seen for London and England over the years. The downward trend in the number of 16-17 year olds using the service across the years is also seen at regional and national level, although this age band still remain the greatest proportion of service users.



Age (young people)	Area	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
Under 14	England	1890	1643	1533	1487	1275	1211	1157	1337	1402	1289	1204
14-15	England	9206	8651	8219	8151	7801	7628	7205	7076	6899	6529	6446
16-17	England	13069	12261	11497	10963	10606	10026	9161	8436	7601	6959	6641
Under 14	London	275	265	250	265	260	205	215	250	240	235	165
14-15	London	1355	1365	1350	1380	1370	1280	1110	1140	1105	1040	975
16-17	London	1860	1925	1985	1895	1885	1865	1780	1700	1625	1430	1310

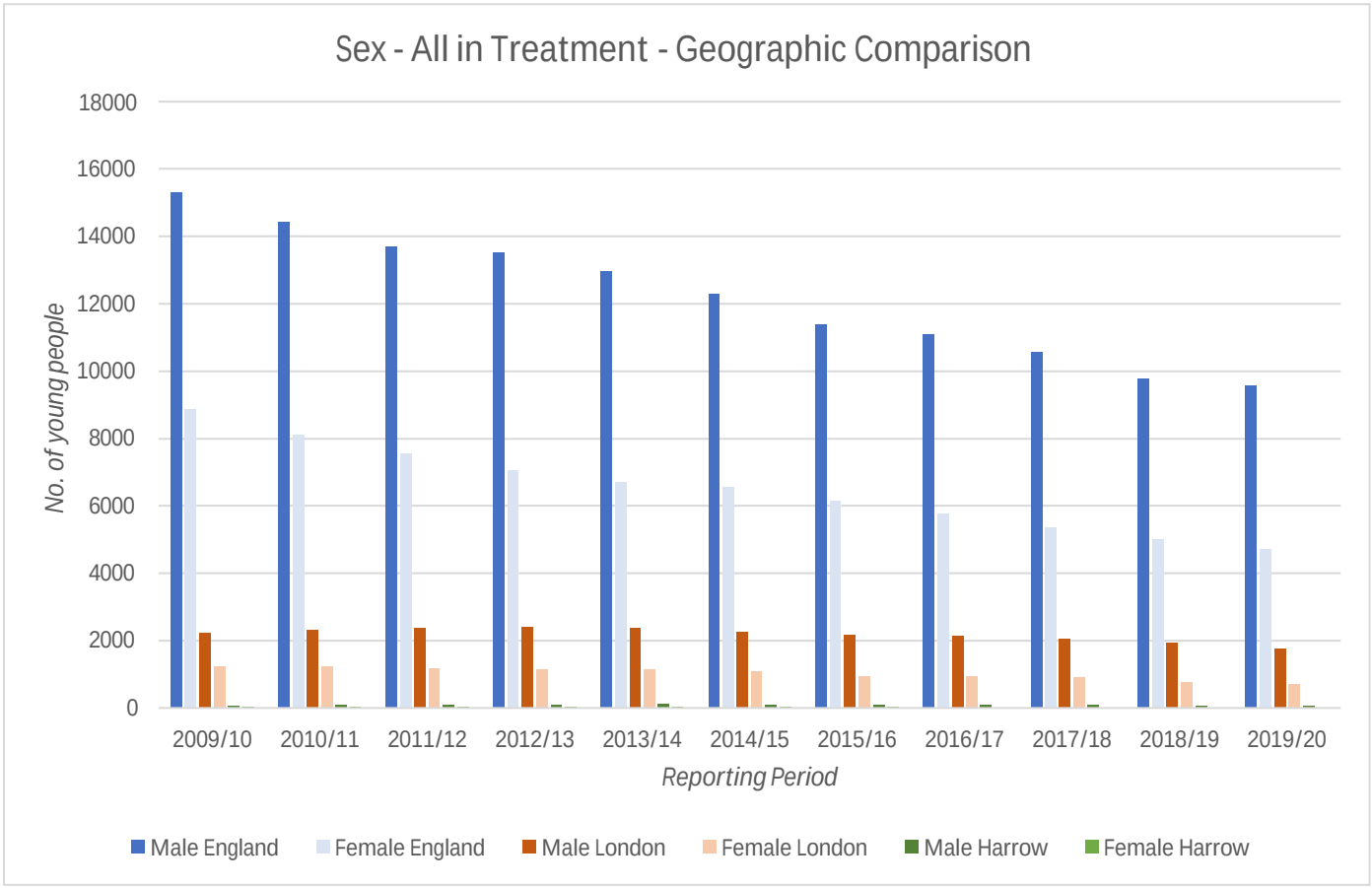
Sex: Harrow

The majority of service users of CYP substance misuse services in Harrow are male, consistently representing over 60% of service users from 2009 onwards, and over 70% from 2011 onwards. This is broadly similar to the patterns seen regionally and nationally, where most service users are male.



Sex (young people)	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
Female	35	40	30	45	35	35	30	15	15	20	15
Male	75	80	110	110	115	90	85	90	80	75	60

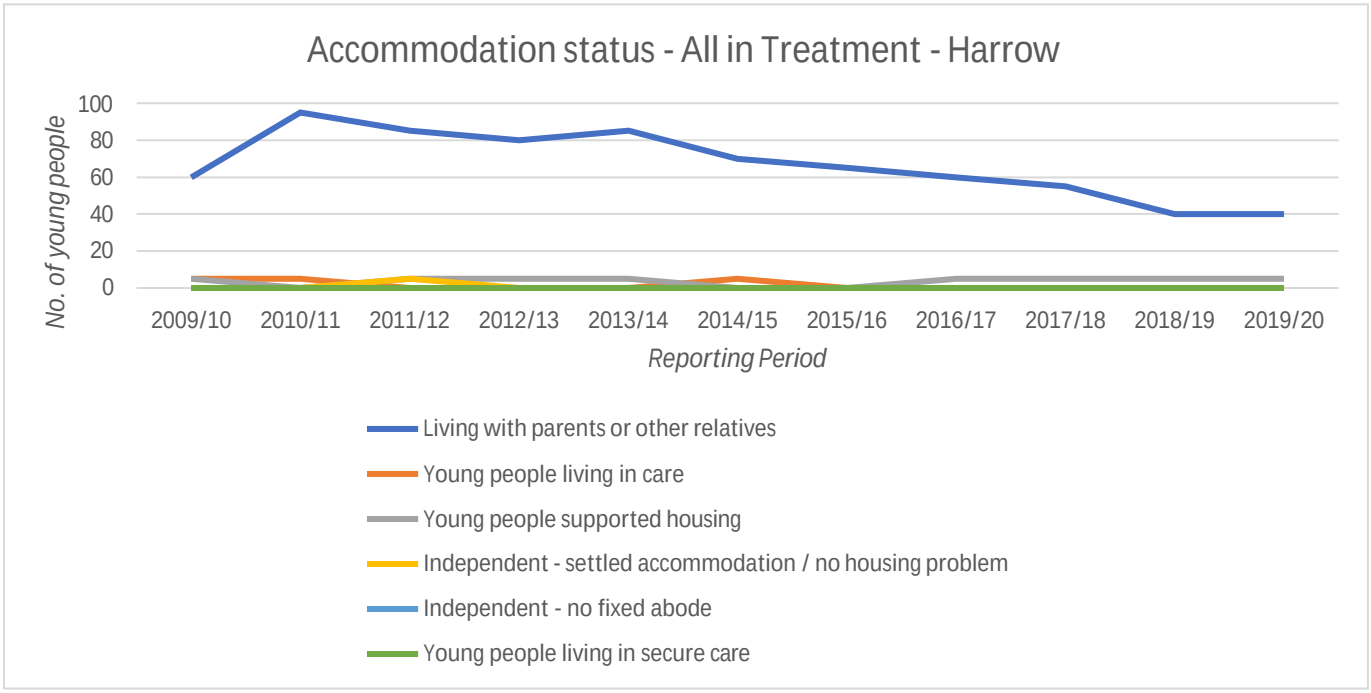
Sex: regional and national comparison



Sex (young people)	Area	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
Male	England	15297	14440	13704	13541	12964	12291	11393	11074	10561	9766	9559
Female	England	8868	8115	7545	7060	6718	6574	6130	5775	5341	5011	4732
Male	London	2250	2320	2390	2400	2375	2255	2175	2150	2055	1940	1745
Female	London	1240	1235	1190	1140	1135	1095	930	940	910	765	705

Accommodation Status: Harrow

The majority of CYP service users in Harrow lived parents or other relatives at the time of their service use, with none living in secure care, or with no fixed abode, or living in 'unsettled' accommodation as an independent individual between 2009-2020. Only a handful (5) lived in either care, supported housing or settled accommodation (as an independent individual) during the period of 2009 to 2020. It is not clear whether these 5 individuals for each type of accommodation are the same as those in the subsequent years or in different types of accommodation, for example as a result of having remained in treatment for over a year and thus counted in consecutive years or having transitioned from one accommodation to another. A more granular look at the data for these individuals could help clarify this but this is not possible due to confidentiality purposes, to protect against the risk of identifying these service users.



Accommodation status	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
Living with parents or other relatives	60	95	85	80	85	70	65	60	55	40	40
Young people living in care	5	5	0	0	0	5	0	0	0	0	0
Young people supported housing	5	0	5	5	5	0	0	5	5	5	5
Independent - settled accommodation / no housing problem	0	0	5	0	0	0	0	0	0	0	0
Independent - unsettled acccommodation / housing problem	0	0	0	0	0	0	0	0	0	0	0
Independent - no fixed abode	0	0	0	0	0	0	0	0	0	0	0
Young people living in secure care	0	0	0	0	0	0	0	0	0	0	0

Accommodation Status: regional and national comparison

Regional and national comparisons of accommodation status of CYP substance misuse service users shows that although across London and England, most services users remain living with parents or relatives, there are greater proportions of other insecure accommodation statuses seen in London and England (for example, 'Independent - unsettled accommodation/housing problem' or 'no fixed abode').

There was no data generated for 'Young people living in secure care' for London or England from which to draw regional and national comparisons against Harrow (where 0 CYP service users were identified as having that accommodation status over the years).

Accommodation status	Area	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
Living with parents or other relatives	London	1765	1915	2020	2050	2145	1950	1805	1795	1770	1665	1450
Young people living in care	London	160	200	120	95	100	140	125	150	130	110	110
Young people supported housing	London	80	115	160	190	145	115	80	70	55	65	50
Independent - settled accommodation / no housing problem	London	130	80	90	70	80	80	75	70	55	50	35
Independent - unsettled accommodation / housing problem	London	90	55	45	25	30	15	30	15	15	5	15
Independent - no fixed abode	London	25	20	15	10	10	10	5	5	5	0	5

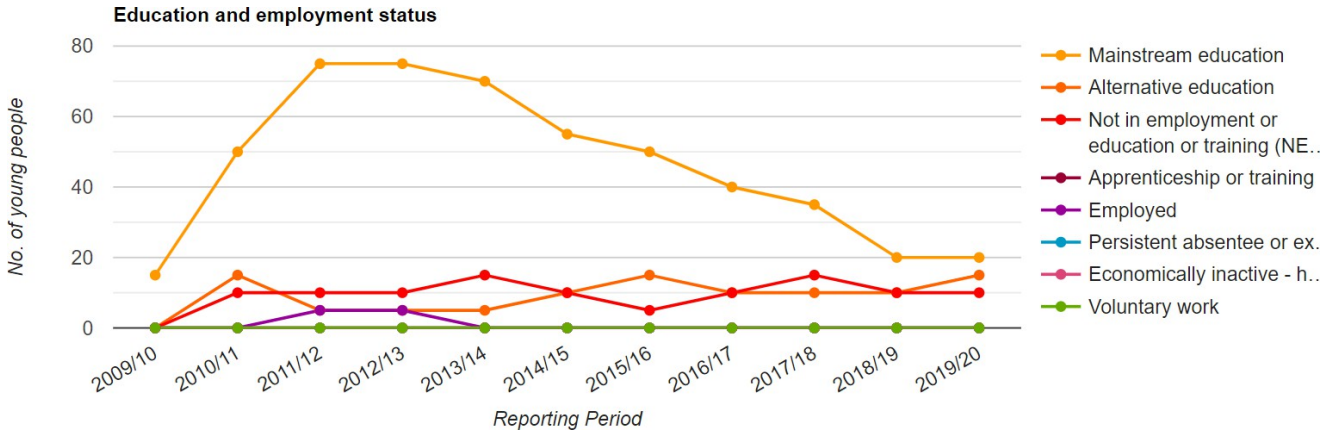
Accommodation status	Area	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
Living with parents or other relatives	England	12578	12056	11471	11169	10796	10321	9754	9481	9157	8746	8458
Young people living in care	England	1229	1322	678	546	679	945	967	974	809	664	644
Young people supported housing	England	523	658	1004	1027	939	730	596	505	416	418	386
Independent - settled accommodation / no housing problem	England	920	637	668	641	516	409	347	351	270	226	247
Independent - unsettled accommodation / housing problem	England	641	458	374	294	246	193	135	118	95	83	73
Independent - no fixed abode	England	193	158	117	85	91	63	43	41	37	32	17

Education and Employment Status: Harrow

Most CYP substance misuse service users in Harrow were still enrolled and attending mainstream education at the time of initiating treatment, although this number has decreased over the years from roughly 75 in in 2011-2013 to 20 in 2018-2020. There have been no service users who were permanent absent or excluded in these time periods.

Another 5 to 15 individuals were in alternative education or not in employment/education/training (NEET) over the years, figures that have remained roughly static within that range from 2010 onwards.

For a brief period between 2011-2013, 5 individuals were employed at the time of their CYP substance service misuse. This has not been the case for the most recent last 8 years where no other service users have been in full-time/part-time employment, nor have they been apprenticeships, voluntary work or described themselves as 'economically inactive'.



Education and employment status	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
Mainstream education	15	50	75	75	70	55	50	40	35	20	20
Alternative education	0	15	5	5	5	10	15	10	10	10	15
Not in employment or education or training (NEET)	0	10	10	10	15	10	5	10	15	10	10
Apprenticeship or training	0	0	0	0	0	0	0	0	0	0	0
Employed	0	0	5	5	0	0	0	0	0	0	0
Persistent absentee or excluded	0	0	0	0	0	0	0	0	0	0	0
Economically inactive - health issue or caring role	0	0	0	0	0	0	0	0	0	0	0
Voluntary work	0	0	0	0	0	0	0	0	0	0	0

Education and Employment Status: regional and national comparison

The regional and national figures represent similar trends regarding the number of CYP substance misuse services users being mostly in mainstream education (with an overall decreasing trend since 2013). However, slightly higher proportions of those in alternative education, employed or NEET are reflected in the London and England figures. Furthermore, education and employment statuses which were not present in the Harrow data are seen at London and England levels, including

Education and employment status	Area	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
Mainstream education	England	6425	7112	6925	7010	6916	6670	6353	6374	6099	5876	5714
Alternative education	England	3022	2711	2671	2672	2600	2433	2315	2182	2055	1949	1847
Not in employment or education or training (NEET)	England	227	2813	2801	2631	2488	2165	1976	1800	1705	1491	1437
Apprenticeship or training	England	35	767	835	755	783	680	538	438	421	370	345
Employed	England	28	363	307	294	312	310	320	329	292	258	245
Persistent absentee or excluded	England	1272	615	433	384	259	252	211	224	214	188	151
Economically inactive - health issue or caring role	England	9	54	36	21	24	17	24	16	18	13	13
Voluntary work	England	0	0	0	0	1	11	6	13	10	14	7
Mainstream education	London	890	1130	1250	1375	1430	1285	1135	1210	1195	1130	955
Alternative education	London	290	425	405	440	445	405	410	400	335	355	280
Not in employment or education or training (NEET)	London	25	405	490	440	460	415	400	355	365	310	310
Apprenticeship or training	London	0	75	120	75	95	85	80	50	60	45	50
Employed	London	0	55	35	35	45	55	55	50	50	35	35
Persistent absentee or excluded	London	170	95	45	35	40	30	20	10	30	25	15
Economically inactive - health issue or caring role	London	10	10	5	5	15	15	5	5	5	25	10
Voluntary work	London	0	0	0	0	0	0	0	5	0	0	0

apprenticeships/training, exclusion/permanent absenteeism, economically inactive (for health or caregiving roles) or voluntary work.

Substance use profile data

NB: more than one substance can be listed on a single individual's profiles, and data from the NDTMS reflects 'any citation' in the substance misuse service record, not the primary substance of concern or presentation.

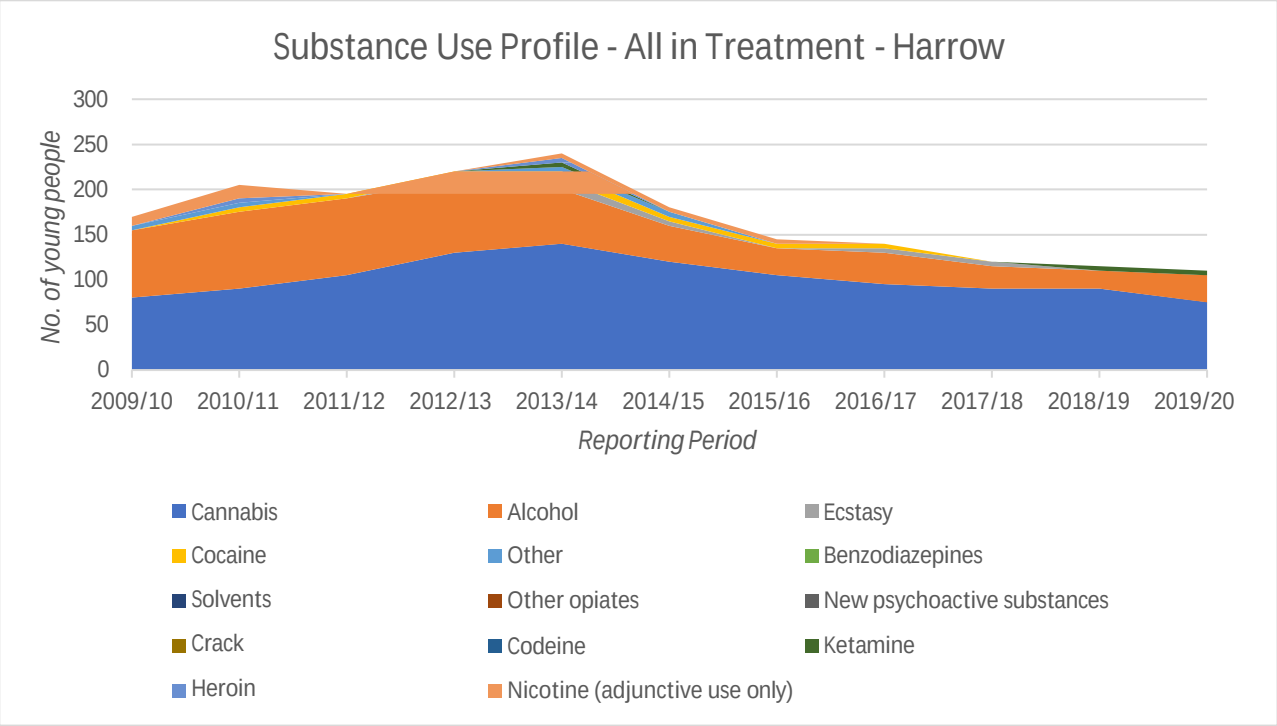
Substance Use Profile: Harrow

The use of cannabis in the substance profile of CYP attending substance misuses service in Harrow predominates throughout the years, with a notable peak in absolute numbers in 2013/14. TThere has been a downward trend in absolute numbers of reported usage (now currently at half of the 2013/2014 peak) although he most recent figure listed of 75 in absolute terms, however, represents just under 70% of total substances noted on the substance misuse profiles for that year. The next most reported substance is alcohol, which has dramatically decreased in frequency in absolute terms of reporting since 2009-2010 where use reporting by service users was equivalent to that of cannabis. The current absolute figure for reported alcohol use is half of that noted in 2009/10 and also represents a much lower share of the total reported substances, dropping from 44% to under 30% over the years, with the lowest proportion seen in 2018/19 (roughly 17%).

Historically, there has been some Class A drug use reported by service users in absolute terms – notably, a period of 2012-2018 where ecstasy was reported almost yearly, a period between 2010-2016 where cocaine was reported yearly, and two separate non-consecutive years of 2010 and 2013 where heroin was reportedly used. These figures were very low, usually reported in 5 individual profiles only, with the exception of the year 2013/2014 where 10 profiles listed both cocaine and ecstasy use. These figures represented between 2-5% of the total reported substance misuses.

Class B drug use such as ketamine was reported in 2013/24 and between 2018-2020, more recently representing just under 5% of total reported substances. Nicotine, as an adjunctive substance use only, was reported for 2009-2011 and 2013-2016. Most notably, as an adjunctive substance, it was listed in under 10% of the total drugs listed in 2010/11 but it has not been used like this or in as large a proportion of the total drugs listed since then. No use of new psychoactive substances, solvents, amphetamines, benzodiazepines, codeine, crack or other opiates have been listed. At least 5 substance profiles reported 'Other' in 2009-2011 and 2013-15, although it is unclear what these are. Given that the 'other' listings predate the Psychoactive Substances Act 2016, it could be plausible that these 'Other' substances may since be reclassified, although this is unlikely as collection of NPS

data started in the year 2013/14 and has shown no profile reports since then to indicate changes to coding that could explain why 'Other' no longer occurs.



Substance Use	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
Cannabis	80	90	105	130	140	120	105	95	90	90	75
Alcohol	75	85	85	80	60	40	30	35	25	20	30
Ecstasy	0	0	0	5	10	5	0	5	5	0	0
Cocaine	0	5	5	5	10	5	5	5	0	0	0
Other	5	5	0	0	5	5	0	0	0	0	0
Benzodiazepines	0	0	0	0	0	0	0	0	0	0	0
Solvents	0	0	0	0	0	0	0	0	0	0	0
Other opiates	0	0	0	0	0	0	0	0	0	0	0
New psychoactive substances	-	-	-	-	0	0	0	0	0	0	0
Crack	0	0	0	0	0	0	0	0	0	0	0
Codeine	0	0	0	0	0	0	0	0	0	0	0
Ketamine	0	0	0	0	5	0	0	0	0	5	5
Heroin	0	5	0	0	5	0	0	0	0	0	0
Nicotine (adjunctive use only)	10	15	0	0	5	5	5	0	0	0	0

Substance Use Profile: regional and national comparison

The regional and national profiles for substance misuse follow roughly similar patterns to that of Harrow, with some notable exceptions. Cannabis and alcohol both remain the most largely reported substances, with cannabis leading both regionally and nationally. In both absolute terms and the proportion of the total drugs listed that they represent. Rates for both cannabis and alcohol have declined over the years in absolute usage. Cannabis, however, continues to represent just over 50% of total drugs listed in London and between 44-49% in England overall. Reported cannabis use has

also declined at a slower rate than the much faster decline in alcohol use in reported service users from at least 2010 (mirrored in the Harrow data). Alcohol currently represents just over 20% of total drugs listed in London and Harrow.

The reported use of Class A drugs such as heroin, cocaine, and crack are seen at London and England level in service users, although all of these reported rates have declined over time in both absolute terms and relative proportions to total number of substances cited. In both London and England, heroin and crack use is reported for under 1% of CYP substance misuse service users. However, where ecstasy and cocaine are now under 2% of total substances reported for London, they represent a higher total proportion of 7 and 5% at the national level in England. Ecstasy, in particular, has increased at the national level in absolute terms since 2013/2014 (although its most recent absolute figure shows a slight downtrend) but it has otherwise declined since that time in London (although its most recent absolute figures remain largely static).

The use of Class B drugs such as ketamine, codeine and benzodiazepines, legal highs such as solvents, and other opiate substances is also seen in increasing absolute numbers and generally more consistently year-on-year, at London and England levels. They also represent increasing proportions of the total number of drugs cited, although these proportions remain largely under 1% with the exception of ketamine use (just under 2% in England, just under 1.5% in London) for the most recent figures. The use of new psychoactive substances, cited from 2013/2014, and amphetamines have declined in absolute numbers and the proportion of total cited substances for since 2015 and the early 20101s respectively, for both London and England.

Similarly, nicotine where used as an adjunctive substance has been reported more regularly by service users at London and England levels; the overall trend shows an increasing share of total citations since 2009 (currently 7% for England and 10% for London overall) although changes in absolute numbers have been more variable.

These overall differences in substance misuse profiles between Harrow, London and England are underpinned by a variety of factors including regional patterns in supply (including availability, accessibility and affordability) and demand (including socio-economic factors) across the country.

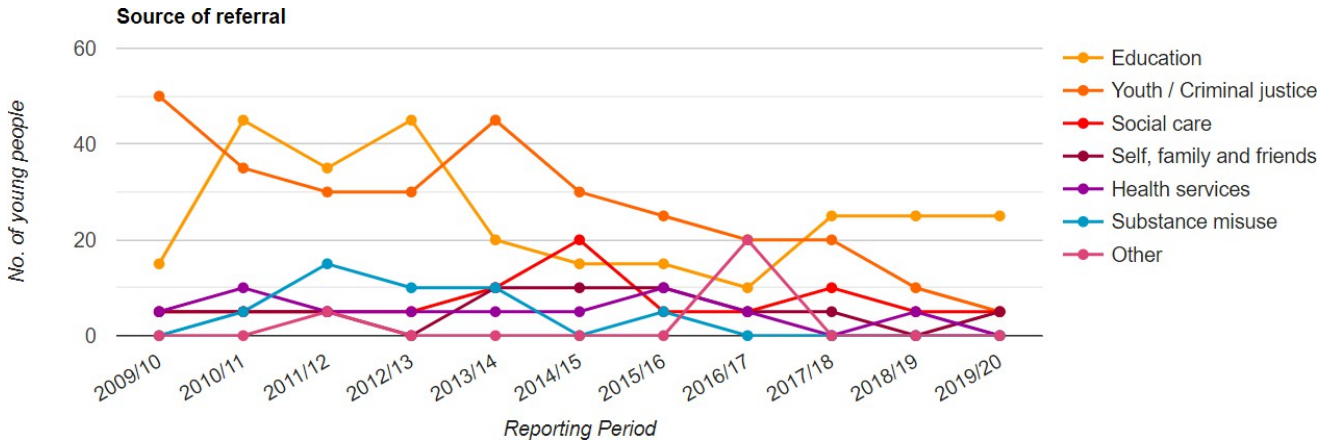
Substance	Area	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
Cannabis	London	2045	2130	2130	2080	2210	2090	1885	1830	1760	1695	1530
Alcohol	London	1310	1475	1485	1280	1240	1095	990	960	885	735	560
Ecstasy	London	60	55	85	115	135	125	80	90	90	80	80
Cocaine	London	130	135	135	100	110	115	75	75	75	65	55
Other	London	50	35	25	30	40	60	50	30	50	45	35
Benzodiazepines	London	5	0	5	0	5	5	5	20	55	55	30
Solvents	London	25	20	10	15	25	60	95	90	85	85	105
Amphetamines	London	25	45	35	30	40	30	20	10	10	10	5
Other opiates	London	15	5	5	10	0	0	0	5	10	10	5
New psychoactive substances	London	-	-	-	-	5	15	30	20	15	5	10
Crack	London	50	15	20	20	10	15	10	10	10	5	5
Codeine	London	0	0	0	0	0	0	10	5	15	20	45
Ketamine	London	15	25	30	25	45	15	10	15	45	35	45
Heroin	London	40	30	20	15	10	10	5	10	10	5	5
Nicotine (adjunctive use only)	London	220	335	265	270	395	385	405	395	390	330	260

Substance	Area	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
Cannabis	England	13139	12527	12214	12053	11705	11200	10521	10208	9601	8994	8937
Alcohol	England	11610	10659	9702	8193	7478	6523	5874	5767	4940	4576	4191
Ecstasy	England	797	483	571	790	752	1046	1152	1334	1502	1351	1208
Cocaine	England	1610	1349	1142	1027	1085	1046	1081	1091	1082	986	961
Other	England	621	402	311	420	478	380	323	235	270	272	290
Benzodiazepines	England	209	165	139	119	92	128	93	129	257	349	233
Solvents	England	429	346	312	234	223	282	339	292	258	284	328
Amphetamines	England	811	1648	1346	1755	1325	1230	703	282	166	134	119
Other opiates	England	127	81	79	85	68	61	44	33	44	57	39
New psychoactive substances	England	-	-	-	-	320	708	743	317	149	80	85
Crack	England	214	123	106	81	83	73	66	66	69	65	79
Codeine	England	19	19	13	13	18	21	42	26	54	64	111
Ketamine	England	260	325	261	264	297	99	98	160	249	338	388
Heroin	England	330	200	146	123	102	93	63	66	40	38	33
Nicotine (adjunctive use only)	England	1148	1214	1160	1079	1350	1681	1894	1996	1753	1855	1365

Access to services data

Source of referral: Harrow

The majority of referrals to the CYP substance misuse service have consistently come from the Education sector (for example, referrals from schools or Pupil Referral Units) and from the Youth/Criminal Justice system (although more recently, these numbers have declined in absolute figures). Other referrals source with variable levels of referral include Social Care, health services (for example, A&E or General Practice), adult Substance Misuse services and through self-, family or friend-referrals. Of note, in 2015/16 20 referrals came from 'Other' services which can include a



Source of Referral	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
Education	15	45	35	45	20	15	15	10	25	25	25
Youth / Criminal justice	50	35	30	30	45	30	25	20	20	10	5
Social care	5	5	5	5	10	20	5	5	10	5	5
Self, family and friends	5	5	5	0	10	10	10	5	5	0	5
Health services	5	10	5	5	5	5	10	5	0	5	0
Substance misuse	0	5	15	10	10	0	5	0	0	0	0
Other	0	0	5	0	0	0	0	20	0	0	0

broad range of voluntary sector services, charities and other forms of community and social support networks.

Source of referral: regional and national comparisons

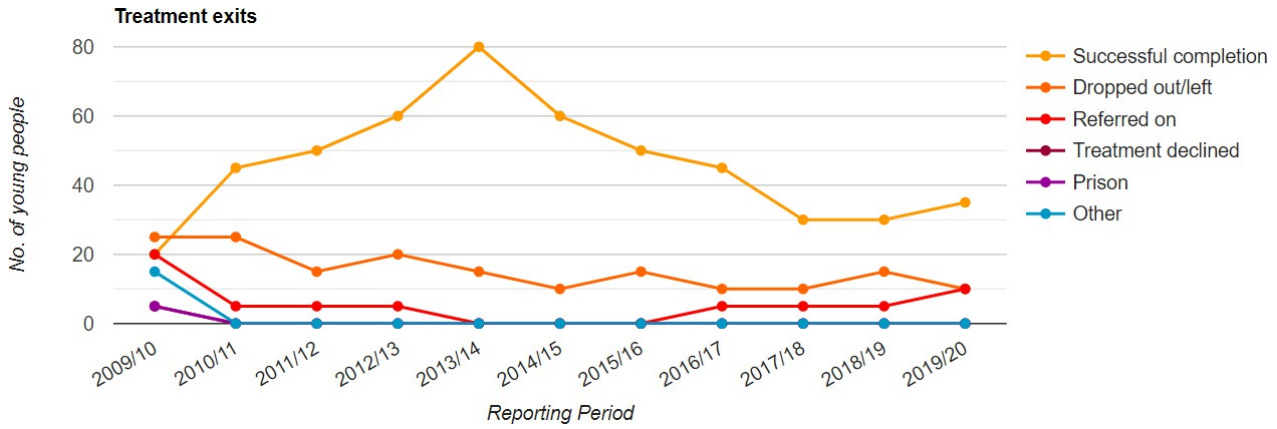
The sources of referral into CYP substance misuse services at regional and national level remain quite similar to that of Harrow, reflecting a majority of referrals from Education and the Youth/Criminal Justice services. Education remains consistently the highest referral source nationally, although Youth/Criminal Justice services are the highest referral sources in London. The next most common source after Education and Youth/Criminal Justice, for both England and London is Social Care services. This is then followed by Health Services in London and self-/family/friend referrals in England overall. These patterns have largely stayed consistent for all the aforementioned sources of referral, with the exception of Social Care overtaking self-/family/friend referrals as the third most common source in England in 2015/16.

Source of Referral	Area	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
Education	England	3098	3203	3176	3409	3457	3445	3298	3383	3340	3342	3196
Youth / Criminal justice	England	7073	6433	5793	4968	4458	3931	3274	2982	2578	2173	2157
Social care	England	1570	1559	1414	1517	1476	1564	1750	1825	1797	1751	1748
Self, family and friends	England	1939	1771	1721	1649	1557	1480	1414	1277	1263	1235	1256
Health services	England	1233	1225	1296	1262	1150	1096	1043	1173	1129	1005	980
Substance misuse	England	1737	1319	1139	1187	1208	954	882	697	653	661	461
Other	England	367	465	506	450	520	499	462	361	185	159	171
Education	London	545	620	645	695	740	635	590	620	630	645	455
Youth / Criminal justice	London	1090	1030	1100	985	1010	1000	890	795	795	685	645
Social care	London	230	240	175	180	185	200	180	210	205	200	260
Self, family and friends	London	175	175	175	130	145	150	155	135	120	125	105
Health services	London	160	230	195	215	230	185	200	215	210	165	125
Substance misuse	London	205	180	175	200	195	115	100	95	75	75	55
Other	London	55	70	70	95	90	80	60	75	20	35	25

Treatment outcomes

Treatment exits: Harrow

Treatment outcomes have seen a positive shift in Harrow, with no recent declines in treatment or treatment exits into prisons in recent years. Over 60% of treatment exits follow successful completion of the recommended service provided by the substance misuse service. The most recent figures show that just under 20% dropped out/left the service, although this proportion has been variable between 10-30% over the years (e.g. in 2018/2019, 30% of total service users dropped out/left). The last five years have seen increasing onwards referrals to other services.



Treatment Exits	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
Successful completion	20	45	50	60	80	60	50	45	30	30	35
Dropped out/left	25	25	15	20	15	10	15	10	10	15	10
Referred on	20	5	5	5	0	0	0	5	5	5	10
Treatment declined	5	0	0	0	0	0	0	0	0	0	0
Prison	5	0	0	0	0	0	0	0	0	0	0
Other	15	0	0	0	0	0	0	0	0	0	0

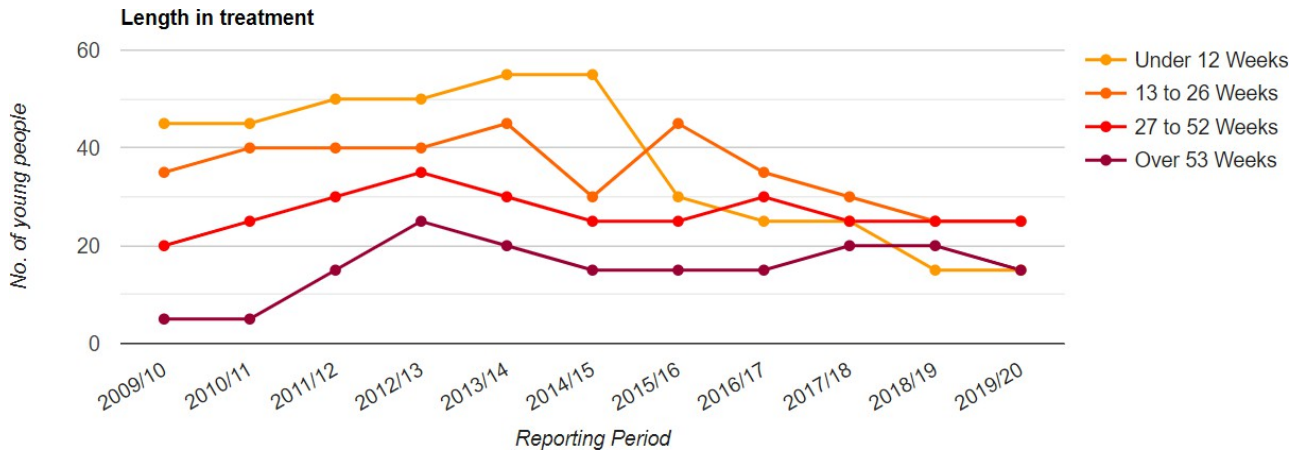
Treatment exits: regional and national comparisons

Treatment exit patterns in Harrow are largely mirrored at the regional and national levels, although a greater proportion of successful completion and a smaller proportion of dropping out/leaving is seen in London and England overall in comparison. A smaller proportion of treatment decliners is noted over the years. Absolute numbers of onwards referrals and 'Other' exits are declining, in line with an absolute reduction in overall treatment exits. Furthermore, given the larger sample size for London and England, more exits to prisons are seen although these numbers have also dropped in absolute terms over the years as well.

Treatment Exits	Area	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
Successful completion	England	10460	10848	10436	10567	10165	9917	9172	9099	8719	7988	7960
Dropped out/left	England	2565	1968	1683	1580	1474	1396	1276	1211	1241	1275	1208
Referred on	England	840	825	904	772	784	760	681	493	500	394	347
Treatment declined	England	542	461	328	283	250	238	250	198	197	177	145
Prison	England	182	139	102	66	67	53	32	43	25	22	24
Other	England	371	199	179	105	66	60	64	111	43	60	47
Successful completion	London	1435	1415	1580	1845	1905	1705	1545	1560	1600	1420	1285
Dropped out/left	London	300	320	265	235	230	180	165	215	215	225	225
Referred on	London	130	150	230	165	160	135	175	125	150	120	110
Treatment declined	London	125	125	75	55	65	40	35	25	35	30	20
Prison	London	25	25	15	25	20	10	15	15	5	5	5
Other	London	90	40	40	20	25	25	30	65	15	25	25

Length in treatment: Harrow

There is good degree in variation in the length in treatment for CYP substance misuse service users in Harrow, with a relatively even spread in recent years of those who have short-term service use under 12 weeks up to those with more long-term service use over 53 weeks. This is a trend that began to emerge after 2015 – prior to that, the majority of service users were short-term (under 12 weeks) and following that, between 13-26 weeks.



Length in treatment	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
Under 12 Weeks	45	45	50	50	55	55	30	25	25	15	15
13 to 26 Weeks	35	40	40	40	45	30	45	35	30	25	25
27 to 52 Weeks	20	25	30	35	30	25	25	30	25	25	25
Over 53 Weeks	5	5	15	25	20	15	15	15	20	20	15

Length in treatment: regional and national comparisons

Unlike the figures for Harrow, the majority of CYP substance misuse service users stayed under 12 weeks for treatment across London and England overall and consistently across the years. Frequency and length in treatment follows a roughly inverse pattern in both London and England, with fewer individuals using services as length in treatment increases (proportionately, fewer people overall stayed with the service over 53 weeks).

Accommodation status	Area	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
Under 12 Weeks	England	10617	9799	9110	8600	8222	7741	7087	7000	6661	6310	6073
13 to 26 Weeks	England	6857	6524	6421	6367	6009	5951	5525	5198	5071	4701	4554
27 to 52 Weeks	England	3982	4062	3828	3860	3782	3516	3447	3271	2940	2686	2736
Over 53 Weeks	England	2709	2170	1890	1774	1669	1657	1464	1380	1230	1080	928
Under 12 Weeks	London	1545	1605	1620	1665	1685	1425	1270	1285	1250	1240	1050
13 to 26 Weeks	London	1030	1000	1010	970	995	985	940	905	965	825	745
27 to 52 Weeks	London	545	520	595	595	610	635	630	605	515	475	525
Over 53 Weeks	London	365	435	370	315	235	300	270	285	230	145	150

<u>Recent trends in Activity and Performance – in-depth look at 2020/21</u>

Looking at more recent data for the year 2020/21 allows for a closer interrogation of Compass's operations. This data is taken from the most recent contract monitoring undertaken for 2020/21 and covers some data from the year prior 2019/20. Overall, this information is not yet available publicly on the NDTMS, and so has been broadly summarised to maintain confidentiality.

The numbers in treatment for the 2020/21 year by Quarter 4 were 73 (40 in Tier 2, 33 in Tier 3), with a 100% conversion rate of referrals into treatment episode starts. 13 of these 'in-treatment' figures were through the Eastern European outreach worker, also with a 100% conversion rate. The number of CYP having been referred via Hidden Harm (through WDP) at that time was 11.

Most treatment modalities have centred around psychosocial and harm reduction interventions, as well as multi-agency working, followed by brief or non-structured interventions. There has been no pharmacological intervention given in the year 2020/21, like previous years (the last availably documented record of a pharmacological intervention occurred in 2015/16. This pattern was anecdotally confirmed by the then Team Leader at Compass, although monitoring data for 2016/17 and 2017/18 is missing currently). No client was undergoing Tier 4 intervention such as community/inpatient detox or residential rehabilitation, like previous years. Only 1 service user waited more than 3 weeks for a treatment modality to start and this was reportedly due to poor engagement. The most common length of treatment episodes was either less than 3 months or 3-6 months, with reducing frequency as duration increased, like previous years. Those spending over a year in treatment amounted to single figures. Harm minimisation interventions for the year were only related to signposting to other services, such as sexual health and smoking cessation. No interventions requiring blood-borne virus screening, vaccination or treatment referral was undertaken this year. No client was excluded from the service this year.

The total discharges for 2020/21 Quarter 4 were 25, roughly similar to the 2 prior quarters but almost half the first quarter of that year. Within Quarter 4, 8 out of the 18 Tier 2 discharges and 2 out of the 7 Tier 3 discharges were unplanned. Of note, 7 of these discharges were considered incomplete as treatment commencement was declined by the client and 1 was considered incomplete because the client dropped out. Other discharges were either due to completed treatment, completed Hidden Harm support work, transfer out of the service or ongoing occasional drug use.

Inward referrals for the year thus far have been 105 in total, with most referrals coming from the Youth Offending Team (31), Children & Families' social care (31) and Universal Education (14). Other referrers this year have included Alternative Education, hospital/A&E, CAMHS, Housing, Self-Referral, Relatives, Young People's Structured Treatment, Adult Mental Health, Police and Other. Outwards referral has been to a broad range of services, from the voluntary sector, social care (e.g. Family Support Services, MASH, Youth Services), primary care, other community services and programmes. Outward referrals totalled 72 referrals so far, the majority going to Prospects (an employment, training and careers service) or another careers support provider, Youth Services in Local Authority, sexual health services and back to the referrer themselves.

Joint working arrangements remained in place with Youth Offending Team and CAMHS with regular meetings as appropriate, based on clinical need and governance issues. Attendance at a variety of other Professional meetings was undertaken this year: depending on the group, attendance was undertaken at regular frequency of 2-3x per quarter for the Local Safeguarding Children's Board (LSCB), Core Group, Review Child Protection Conferences, Multi-Agency Sexual Exploitation (MASE), Multi-Agency Safeguarding Hub (MASH) and its Steering Group meetings, (with some exceptions due to COVID-19 limitations). Other input was given via weekly responses to email, for example to e the

Multi-Agency Risk Assessment Conference (MARAC). Specialist advice and joint working with other agencies (e.g. WDP, Romanian and Eastern European Network, Harrow Carers) also took place.

The target of 6 training sessions per year delivered to other agencies was exceeded, with 10 alone delivered in Quarter 4 of 2020/21. Most of these were to the Metropolitan police and to social workers with WDP. Due to COVID-19, physical promotion of the service within the borough via community events and groups was limited in the first two quarters of the year (due to lockdown and social distancing requirements) but these took off again following the easing of restrictions in the summer and included physical and virtual presentations and alerts. Compass continued to maintain up-to-date information about its services with regular updates about changes to its physical presence during the pandemic (such as closure of its outreach satellite sites in the Civic Centre across Q2-3) and promotion of its referral pathways during 2020/21.

The profile of those CYP attending Compass within the 2020/21 year was largely similar to that of previous years. Of note, the following key vulnerabilities were recorded. Most of them were not a parent, although in Quarter 4 one individual did have children living with them. The percentage of clients with a mental health treatment need was 21% in Quarter 4, although only 18% of clients had engaged in mental health treatment at that same time period; these figures were roughly the same average for the year. 8% of clients had a recorded disability within Quarter 4 of that year, roughly the average of that year. Across Tiers 2 and 3, by Quarter 4 of 2020/21, 7 and 10 clients reported ever being affected by abuse respectively across Tiers although none were currently victims or perpetrators. These numbers were just below the yearly average of 5 and 11 respectively. 4 Young Carers were known to the service by the end of 2020/21 year Quarter 4, having been identified through Hidden Harm work who did not misuse substances themselves. Comparison with other vulnerability data held the year prior, and with national figures, is demonstrated in the second figure below.

This additional performance data is collected by the Compass team and submitted to PHE, to help support commissioning of services. Examples of this include continuity of care data (for example, the number of under 18 years old referred to treatment at Compass in a partnership on their release from the secure estate), as well as data on wider vulnerabilities of 'at risk' or vulnerable groups for whom targeted services may be particularly relevant. Below is the 2019/20 data used to support the latest commissioning support pack produced by PHE for local authority commissioners; up-to-date comprehensive data for 2020/21 was not available at the time of writing this HNA although some figures in the previous paragraph are directly comparable to those below.

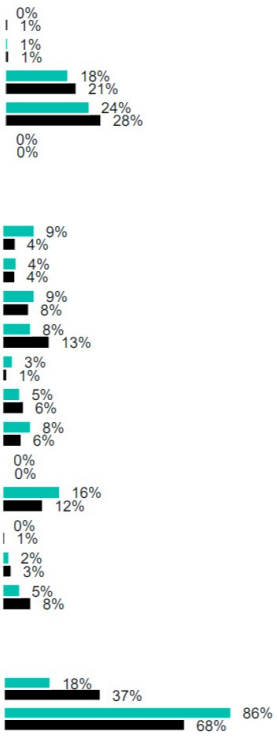
Continuity of Care data

	Local	National
Number of young people referred to treatment in this partnership on release from the secure estate	2	209
Number of young people picked up by a community service within three weeks of release	0	8
Proportion of young people picked up by a community service within three weeks of release	0%	4%

Vulnerabilities profile data[85]

Number of young people with each risk/ vulnerability item	Local n	Local %	National %
Substance specific vulnerabilities			
Opiate and/or crack user	0	0%	1%
High risk alcohol users*	1	1%	1%
Using two or more substances (incl. alcohol)	18	18%	21%
Began using main problem substance under 15	24	24%	28%
Current or previous injector	0	0%	0%
Wider vulnerabilities			
Looked after child	9	9%	4%
Child in need	4	4%	4%
Affected by domestic abuse	9	9%	8%
Identified as having a mental health treatment need	8	8%	13%
Affected by sexual exploitation	3	3%	1%
Involved in self-harm	5	5%	6%
Not in education, employment or training (NEET)	8	8%	6%
NFA/unsettled housing	0	0%	0%
Involved in offending/antisocial behaviour	16	16%	12%
Pregnant and/or parent	0	0%	1%
Subject to a child protection plan	2	2%	3%
Affected by others' substance misuse	5	5%	8%
Co-occurring substance misuse and mental health issues			
Identified as having a mental health treatment need	14	18%	37%
Receiving treatment for their mental health need(s)	12	86%	68%

Proportions are of all young people entering services for specialist substance misuse interventions in the year and may sum to more than 100% as an individual may have more than one recorded vulnerability



Service User Feedback

Service users were not directly consulted for this HNA regarding their opinions on Compass (i.e. they were not sent the written survey or undergo guided semi-structured interviews listed in Part 6 of this HNA) for several reasons: firstly, the survey was written for professionals and not appropriate for the full age range seen by Compass, and secondly, an adapted survey for use of a focus group was not feasible due to COVID-19 restrictions on meeting with young people for non-essential purposes. Consequently, service user feedback from Compass staff and from Case Studies for contractual monitoring have been used as secondary data sources of service user experience below. An independent Service Users' Experience Survey is contractually requested every 6 months by the specialist service's contract to help identify if young people are being appropriately catered to and centred in the service (as recommended by PHE commissioning principles), and to help develop remedial action where appropriate. Key compliments and complaints provided by the service for the year 2020/21 will be listed below.

However, it is extremely important that further engagement with service users regarding this HNA is the most crucial action to take forward by commissioners to maintain best practice and keep the service focussed. Whilst secondary data is useful in terms of accessibility and convenience, it may have issues of validity, precision, relevance and incompleteness regarding its scope and coverage. These must be accounted for a with subsequent primary data collection with the true cohort that matters in this HNA – the service users themselves, and will necessitate solicited feedback either through observation, questionnaires, interviews, focus groups or case studies. This is in keeping with

climbing up the 'ladder of engagement' proposed by NHS England, based on the work of Sherry Arnstein, to centre public and patient voice at the heart of all healthcare activities.[39]

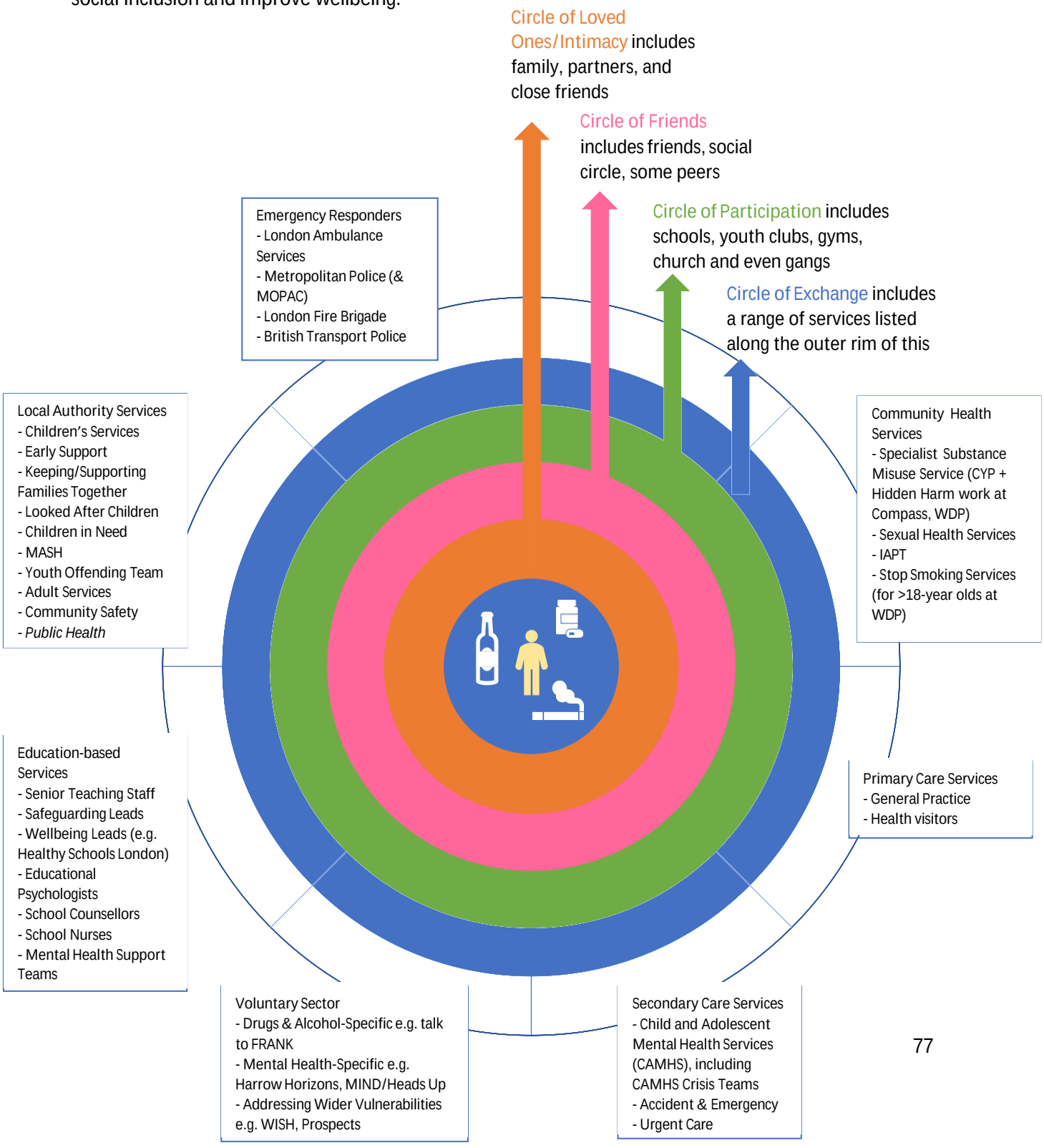
There were 17 compliments given during the 2020/21 year. No complaints were given. Examples of positive feedback from service user include thanks to the service being given for having 'someone to talk to', 'having my [client's] back and looking after me [client] for such a long time', 'listening' and for helping the clients feel 'supported'. Additionally, two compliments included praise for the educational role Compass had had in helping them learn more about cannabis, for example its long-term effects, and other relevant information. Two compliments also mentioned thanks for skills-based improvement, feeling 'much more confident', 'feel so much better and stronger in myself' and 'looking at things from a different perspective now'. One also mentioned a positive career outcome following engagement with Compass, having been 'encouraged..to follow my [client's] dreams'. Other compliments included general enjoyment of the service by clients.

The service was also praised for its professionalism, including a key worker who 'was always on time' and 'always treated me with respect', practitioners who did 'hard work' and a Team Leader who was 'very customer friendly' by service users (and other stakeholders feeding back regarding educational or liaison work).

Part 6

Part 6a: The map of other local stakeholders involved in supporting CYP with Substance Misuse issues and their capacity to do so

A range of stakeholders are involved in supporting Compass, and children and young people with substance misuse concerns, within Harrow. Below is a diagram showing the general landscape of support services for children and young people dealing with substance misuse concerns, representing those who can immediately provide support (or can disrupt it), as identified throughout the course of this HNA. The concept of Circles of Support is based off the work of Snow, Pearpoint and Forest , where the concept was originally designed to help enable those with disabilities to live full lives as part of their community, with success in harnessing community resources to promote social inclusion and improve wellbeing.[16]



Part 6b: Stakeholder Consultation Methodology

As previously mentioned in Part 1b: Methodology, stakeholders were consulted through either a structured survey or a guided semi-structured interview (and where possible, both). The survey was designed using reference to needs identified in the old HNA (2014) as well as key policy documents and is attached in the Appendix for review. A short Purpose and Information Governance page was attached. The survey had a total of 30 optional questions, split into seven sections addressing the following subjects:

- Section 1: General questions regarding role of respondent
- Section 2: Views regarding which CYP substance misuse needs are being met
- Section 3: Views regarding which CYP substance misuse needs are NOT being met
- Section 4: Views regarding the current structure of CYP Substance Misuse specialist services
- Section 5: Views regarding the current network of stakeholders involved in addressing CYP Substance misuse needs
- Section 6: Views regarding your current capacity to practically support CYP substance misuse needs
- Section 7: Closing comments

There was an additional question regarding whether respondents wished to be contacted further. Respondents had the option of answering anonymously or not. The predicted completion time for the survey was roughly 20-30 minutes.

For individuals who did not return a survey but agreed to be interviewed online through MS Teams or Zoom software, the survey was introduced to the stakeholder at time, and then used to guide the one-hour meeting. It was filled contemporaneously by the author with the interviewee's consent. For those wishing to review what was written (including to confirm notes were written without reference to personal details), a copy of the notes was emailed for review with an expected return of the same day. Only two interviewed individuals requested this, with two amendments made by the same individual to clarify a personal opinion, and to add a missing item on the question regarding unmet needs of vulnerable groups (Section 3 of the above).

Only one individual (the then-Team Leader of the Substance Misuse Service) returned both the survey and was interviewed.

Respondents

In total, 23 consultations were undertaken. 15 other stakeholders/stakeholder groups were contacted directly for comment for this HNA but did not respond either with a survey or to arrange a meeting in time for the HNA to be written. Contact was attempted with two telephone conversations, an email and where necessary, escalation to senior members of staff.

The respondents in the survey (anonymised) belonged broadly to the following organisations:

- Compass (4)
- Local Authority (10)
    - Early Support (2)
    - Youth Offending Team (4)
    - Safeguarding (1)
    - Strategy (1)

    - Community Safety (1)
    - Public Health (1)
- Healthcare Partners (2)
    - Acute Care Providers - Safeguarding (1)
    - CCG (1)
- Education Sector (1)
    - Pupil Referral Units (1)
    - Educational Psychologists (1)
- Voluntary Sector (5)
    - Mental health support (1)
    - Addressing wider vulnerabilities – Careers, Employment and Training (4)

Six of these respondents were not in front-line roles working with CYP directly but were aware of their Safeguarding roles and responsibilities accordingly.

The following organisations (or roles) were contacted but did not respond to requests:

- Local Authority (5)
    - Children's Service - Heads of Service for Early Support and YOT, Referral and Assessment Team
    - MASH
    - MARAC and Domestic Violence Policy Leads
- Education Sector (2) – *although please note that at the time of production of this HNA, the summer holidays were underway for schools/colleges/further education.*
    - Headteachers
    - Safeguarding Leads at Pupil Referral Units
- Healthcare Sector (2)
    - Child and Adolescent Mental Health Services, including Crisis Hub
- Voluntary Sector (4)
    - Mental health support (Mind, Kooth)
    - Drugs and alcohol-specific services (Ignite)
    - Addressing wider vulnerabilities – Self Harm, Sexual Abuse and Exploitation (WISH)

The input of Early Support Practitioners, Compass staff and some of the Voluntary Sector (e.g. Careers Advisers) are potentially over-represented in this sample. Most notably elsewhere, the input of key stakeholders from CAMHS and Schools is under-represented as it is missing either entirely or significantly for the respective services, therefore represents a key obstacle to addressing the full needs of CYP with regards to Substance Misuse. The likely reasons for their absence include competing demands and staff turnover at CAMHS (which was expecting a new Service Manager at the time), and the summer holiday period for schools overlapping at the time of the HNA being produced. Unfortunately, as evidenced below in the discussion of the key findings from the stakeholder consultations, CAMHS was most frequently highlighted as a stakeholder that needs to improve its availability and attend shared conferences more frequently – regrettably, but understandably, this represents another key missed opportunity to interrogate obstacles from CAMHS' perspectives as to why this is but should remain an important action for commissioners to take forward.

Service users were not sent the written survey and did not undergo guided semi-structured interviews for several reasons: firstly, the survey was written for professionals and not appropriate for the full age range seen by Compass, and secondly, an adapted survey for use of a focus group was not feasible due to COVID-19 restrictions on meeting with young people for non-essential

purposes. Consequently, service user feedback from Compass staff and from Case Studies for contractual monitoring have been used as secondary data sources of service user experience. As with CAMHS and Schools, further engagement with service users regarding this HNA should be the most crucial action to take forward by commissioners.

Methodological Differences between Written Survey and Guided Semi-Structured Interviews

As the survey had optional questions (including some not relevant to all stakeholders, for example non-frontline staff working in Safeguarding) and the majority of respondents did not want to be contacted further, multiple surveys were only 'partially'-filled but could not be followed up for clarification. For surveys filled by the author during the online interviews, guided by the surveys, the content produced through natural discussion was much more rich and fruitful than the (majority) of those received only by email with no online interview to supplement them. This was likely due to having an advantageous longer period of time to think about and discuss the questions, space to clarify and elaborate on ideas, and potentially any differences in those respondents who committed to spending time out of their workday to arrange and meet with the author as opposed to those who completed it in their own time (for example, potentially being more passionate about the issue).

Furthermore, although some questions were directly asked 'as written' to online interviewees, some topics in Section 2-6 of the Survey were covered without prompting or naturally evolved from the conversation. Record of what was discussed was contemporaneous, with an attempt to fill out the survey in as structured a fashion as possible. However, given the above methodological differences between the two methods of survey completion, caution is advised regarding the interpretation of this work as either fully comprehensive or precise.

Lastly, a group interview was undertaken on two separate occasions; firstly, with three consenting Compass staff (two Drugs and Alcohol practitioners and one Service Manager) and a combined interview with those interviewed in Community Safety and Strategy. These group interviews acted as small focus groups, of relatively homogenous colleagues with the same employers and similar professional affiliations (as well as some demographic similarity, broadly age and sex). However, as a result of combining their interviews due to scheduling/convenience, the group dynamic and relationship between colleagues may have impacted how open, transparent or transgressive participants could be for fear of, social or professional repercussions, such as embarrassment or reproach. None of these stakeholders completed the written survey beforehand (or after the interview) so it is unclear whether issues raised in the mini focus groups are truly reflective of their own opinions, distinct from the group's effect. Broadly speaking, the comments elicited during these sessions were very similar within the group as well as when the content was compared to other stakeholders, and the overall interviews proceeded without any particular concern regarding a sense of restraint or awkwardness. However, the effect of a group dynamic cannot totally be discounted as part of a conscious or unconscious palatable process towards consensus or appeasement, or potential impacts on cognitive biases such as groupthink.

Part 6c: Key Findings from Stakeholder Consultations

The following are Key Findings from the Stakeholder Consultations, broken down into the Sections 2 – 7 of the survey where appropriate.

Section 2: Views regarding which CYP substance misuse needs are being met

Meeting children and young people where they are, in a flexible and non-judgmental approach, was a need that was well-met by Compass according to most stakeholders.

With regards to substances, stakeholders who identified substances explicitly in the survey felt that Compass managed alcohol and drugs such as cannabis very well (for example, smoking cannabis and cannabis edibles).

One respondent noted that the needs of CYP with more **'**obvious**'** substance misuse issues, such as attending to A&E with an overdose, were also being met, as these were more likely to be picked up for Safeguarding and Referral than those not meeting clinical thresholds for concern. Additionally, the 'priority access' that Compass has to sexual health services meant that one respondent in Public Health felt that harm minimisation for risky sexual behaviours in Compass service users was also adequately being met. Overall, the management of cases of those referred in was perceived to be done well, promptly and with appropriate scrutiny.

The needs of some cultural groups were being met, for example through the Eastern European Outreach Worker (who is also one of the CYP Drugs & Alcohol Practitioners) at Compass who has engaged with Romanian churches in Harrow on drugs and alcohol issues. However, this was the only named cultural/ethnic group out of a few others named (for example, young men of Black ethnicity or heritage) where needs were being met according to stakeholders who answered the relevant question. Among wider vulnerabilities, substance misuse needs linked to offending were also identified as being met from respondents in the Youth Offending Team, Community Safety and Compass due to the present of a YOT link worker (who is also one of the CYP Drugs & Alcohol Practitioners) although concerns about this population's general risk and holistic wellbeing still existed.

There were also conflicting views regarding whether children with substance misusing parents were being adequately provided for, with two respondents in the Voluntary Sector and in Safeguarding believing that this was the case and that the need was well-met (supported by evidence that over half of children on Child Protection Plans currently have parents with known substance misuse, indicating adequate recognition and response). Furthermore, Compass practitioners reported feeling comfortable delivering Hidden Harm work and (alongside some YOT practitioners) were aware of the needs being met by the Hidden Harm worker based in Adult Substance Misuse Services /Westminster Drug Project. However, three respondents across YOT, Early Support and Safeguarding believed more needed to be done for children whose parents and/or siblings were substance misusing.

Section 3: Views regarding which CYP substance misuse needs are NOT being met

Missed substances included the use of khat by the Somali community, 'party drugs', Class A drugs like cocaine, new psychoactive substances, and those more visible but sometimes unfamiliar to frontline staff such as still 'legal highs' (e.g. nitrous oxide, poppers, balloons) and any related activities to them such as 'chemsex'. Although smoking was not mentioned by any stakeholders (see Section 7 of this Part), vaping was identified as a substance increasing in trend and potentially causing issues in educational settings due to a perceived social acceptability and the ease of access in obtaining it. Certain professions were viewed as less likely to meet these 'missed substance' needs according to stakeholders; this included non-frontline staff or policy-makers who were removed from CYP, healthcare professionals (such as doctors and nurses) working within more

'traditional' understanding of drug harms, and the police (who were perceived to view drugs through a criminal binary lens.)

Furthermore, a lack of support for families was identified as an unmet need – an unmet need that was also identified in 2014. This included more support for children subject to Hidden Harm from parents and other household members (e.g. siblings) as listed above, and more support for the non-using parents of CYP in contact with Compass (who can only be involved in services with consent of the services user but lack a structured individual programme). This unmet need is recognised as one that would be in-keeping with aims to make Local Authority services 'whole-family'-oriented but which have not progressed to reality. These concerns were listed by some in the Early Support, YOT, Community Safety, Compass and the Voluntary sector. The Compass team itself identified unresolved trauma as an unmet need for some of their service users, including trauma from dysfunctional families (including for Looked After Children who have experienced traumas linked to difficult parenting and separation). A focus on dysfunctional families and the need to support them underpinned a broader theme of managing adverse childhood experiences as part of a wider public health approach to substance misuse and mental health, which was also reported by stakeholders such as those in Education Services.

Another key theme highlighted was the need for more targeted support to vulnerable groups including the following: Children In Need, Looked After Children, Children on Child Protection Plans, Non-verbal children, SEND CYP, Young Carers, Asylum Seekers, CYP not in Education, Employment of Training (NEET), excluded CYP, those in contact with gangs, first-time buyers and sellers of small quantities of drugs who come into contact with police services (who could be treated in a less punitive way), other Youth Offenders, Black boys in particular, home-schooled CYP (who may not be visible or regularly monitored by other services) and lastly dual diagnosis service users with both substance misuse and mental health needs. The key respondents in highlighting these vulnerable groups were partners at Compass, in the Youth Offending Teams, Early Support Hub and Healthcare (CCG, Safeguarding). Stakeholders were asked to elaborate on the background socio-economic contexts for why these vulnerable groups remain at risk, or why the need remains unmet, and the following answers were given by Compass, YOT, Early Support, Safeguarding, Community Safety, Strategy, Education Sector, and the Voluntary Sector:

- Ongoing poverty and widening inequalities
- Early childhood trauma and Adverse Childhood Experiences (ACEs)
- The lack of psychological support for addressing trauma in children that does not meet CAMHS thresholds,
- Peer pressures including bullying, the need to **'**fit in**'** as the demographics of Harrow shift, transitions between different stages of schooling, training, or employment
- A prohibitive criminal justice approach to policing, serious violence and drug crime
- Institutional racism
- The impact of inadequate funding on safe community spaces, supervision and access to frontline services (e.g. the closing down of Youth Clubs)

Early prevention of, and support of current substance misuse needs, at school or other education settings*, was also picked up as a variable unmet need by seven responders from Compass, Youth Offending Team, Early Support, the Education Sector, and the Voluntary Sector. The reasons for this varied but included whether schools were receptive towards external support provision on this topic, concerns by senior staff about the perceived 'image' of a school where drugs and alcohol is a talked-about concern, the burden already held by school staff in manging acute and chronic emotional stress of CYP without material support, and lastly, the competing operational demands

during the COVID-19 pandemic and isolated/remote learning set-ups for the previous academic year. Additionally, the transition period between primary and secondary school was highlighted by two respondents as a gap in service provision, for which strong prevention strategies could build on the resilience and wellbeing skills of children prior to entering potentially adverse and turbulent environments in secondary schools where more complex peer relationships, unfamiliar teaching staff and exposure to new 'risky' environments occurs.

The stigma attached with talking about drugs and alcohol was highlighted by two stakeholders as a key obstacle to prevention work in schools, as conversations about **'**low-level**'** use by teens for **'**experimentation**'**, **'**rebellion**'** and **'**coping**'** are overall discouraged when instead, they could be potential opportunities for recognising early problematic drug use and considering harm minimisation. One of these respondents describes that 'not talking about it at all in regular lives' or 'leaving it to the experts only' who attend infrequently mean that young people are not engaged on what is 'normal' experimentation and what is considered a 'problem'. In addition to this, the stigma talking about mental health was reported by one respondent in the Education sector as feeding substance misuse where substance misuse was used as an alternative 'socially accepted' coping mechanisms/comfort aid where counselling (or other formal psychological or cognitive health support) would have been appropriate for the underlying issues. This stakeholder described substance misuse, in some cases, as being a **'**symptom**'** of underlying undiagnosed emotional and behavioural needs, for example the case of a young person who was smoking cannabis to 'help them concentrate' which was a concern that needed further exploring and could instead have benefited from structured psychological, cognitive and physical support.

**It is important to note that at the time of writing this HNA the statutory requirement for schools to teach drugs and alcohol in the Personal, Social, Health and Economic (PSHE) curriculum for Key Stages 1-4 had only come into effect in the last year and therefore impacts of this are unlikely to be reflected in this current HNA.*

Section 4: Views regarding the current structure of CYP Substance Misuse specialist services

Consensus from most stakeholders was that Compass had an adequate range of services, with an appropriate age-range seen, and a flexible and adaptable outreach-based style. As a service, it received positive feedback from both clients and other stakeholders who found them prompt and responsive to work with. One respondent from the Voluntary Sector described service user feedback of Compass as 'overwhelmingly positive'.

Nearly all stakeholders were aware of Compass**'** remit and were aware of how and when to refer into the service, where appropriate. Broadly, there was good awareness of Safeguarding roles and responsibilities by both Compass and other stakeholders.

There was also appreciation for the presence of the YOT link worker, the links with Hidden Harm (including liaison with the Hidden Harm worker based at Westminster Drug Project for Adult Substance Misuse Services) and the connections forged by a former Team Leader with healthcare providers such as A&E (that are being maintained by the current Compass team). The outreach-based approach to prevention and training workshops at youth clubs, schools, other education settings and professional meetings (now online) was also considered a benefit of the current model of services.

However, some concerns regarding the current set-up up of specialist services was the lack of 24/7 availability of the current service, according to five respondents across YOT, Education and the

Voluntary Sector. It is unclear to where these respondents signpost struggling CYP during times when Compass is not available nor the circumstances with which when this occurs as this was not elaborated on further in the survey. Two of these respondents had suggested elsewhere that more preventative and response work could be taken up by Mental Health Support Teams, Educational Support and other School partners but these were not as direct replacements for the specialist needs met by Compass. One of these respondents suggested that Compass needs more specialist practitioners in general.

Additionally, concerns around the sustainability of funding streams for aspects of Compass' targeted interventions agenda were raised by one respondent, for example, the likely renewal of grants or funding for the Controlling Migration fund (for Eastern European outreach) or for the embedded Hidden Harm work (overlapping remits, for Westminster Drug Project). How funding streams are to be maintained when they are not part of a specific commissioning contract, and therefore subject to the shifting landscape of public health policy and government cuts to frontline services, were considered an action for commissioners to reflect on from an inequality and wider vulnerabilities' perspective.

During times where Compass is not available, CYP services users can message the day team through an online message system (to be picked up at the next working day) and are signposted to Voluntary Sector organisations (such as Kooth, Shout, Crisis Line) or emergency healthcare providers (such as A&E) through the public website.

Section 5: Views regarding the current network of stakeholders involved in addressing CYP substance misuse needs

Through direct questioning, some key individuals were personally named in the survey as being very important or key drivers of discussion regarding CYP substance misuse services.

Key individuals* named by respondents included:

- the (former) Team Leader at Compass who was name by 5 respondents,
- 2 of the Compass Drugs & Alcohol CYP practitioners who were named by 2 respondents each, all 4 from different organisations
- the Public Health Commissioner for Drugs and Alcohol who was named by 2 respondents,
- the Safeguarding Lead at a PRU who was named by 1 respondent,
- the Head of Services in Children's Services in the Referral & Assessment Team who was named by 1 respondent
- the Divisional Director in Children's Services who was named by 1 respondent

**All these individuals were consulted successfully for this HNA except for the final two, where meetings were still pending at the time of writing of this HNA.*

Many other organisations were identified and named as collaborators - a list in the survey provided names of organisations based on the expected landscape of services and those noted in the previous HNA, as well as the option to identify 'Other' stakeholders not previously listed.

Stakeholders were also asked to identify their closest collaborators. These have been colour-coded in in terms of broad organisation/sector they belong to, with the number of respondents citing them in parentheses.

- Specialist Substance Misuse Service - Compass (13 respondents)

- Local Authority - Youth Offending Team (13 respondents)
- Local Authority - Children's Services including Early Support (12 respondents)
- Local Authority – Children in Need (6 respondents)
- Local Authority - Safeguarding (6 respondents)
- Local Authority – other Early Intervention teams (5 respondents)
- Local Authority – Adult Social Care (1 respondent)
- Local Authority – Public Health (1 respondent)
- Secondary healthcare partners such as CAMHS (6 respondents), A&E (1 respondent)
- Primary healthcare partners such as General Practice (3 respondents), Health Visitors (2 respondent)
- Community health services such as Sexual Health Services (2 respondents), School Nurses (2 respondents), Speech & Language Therapy (2 respondents), Perinatal Mental Health (1 respondent), Sensory Processing Team (1 respondent)
- Education - Senior Teaching Staff (8 respondents)
- Education - Wellbeing Staff such as Educational Psychologists (5 respondents), Pastoral Care Leads (2 respondents), Mental Health Support Teams (2 respondents, one working cross-borough with Brent), School Counsellors (1 respondent), Learning Mentors (1 respondent), Special Educational Needs Coordinator/Lead (1 respondent), Child Wellbeing Practitioners (1 respondent)
- Voluntary Sector – Harrow Horizons (7 respondents)
- Voluntary Sector – Ignite (4 respondents)
- Voluntary Sector – WISH (3 respondents)
- Voluntary Sector – Other e.g. CAS (2 respondents), Harrow Parent Carer Forums (1 respondent), Citizens Advice (1 respondent)
- Other - Police (7 respondents)

The network of stakeholders was generally perceived to be working well together. A range of multi-agency fora where individual CYP with substance misuse needs are discussed and alternative wider Professionals spaces for Compass to attend (such as Safeguarding Forums for GPs) were noted. Despite the COVID-19 pandemic, some merits to virtual working were described by stakeholders including being able to attend meetings and forums that would otherwise be too logistically difficult to attend (particularly, for those doing outreach work based in schools, public places or Children's Centres).

Opinions on collaborators depended on the nature of the working relationship between the respondent and cited organisation, for example if a collaborator was directly supportive to the respondent's current role, if it was an internal stakeholder (e.g. under the 'Early Help' umbrella of Local Authority) or an external one (e.g. the voluntary sector), if a professional relationship with named persons in the collaborating service existed, if the service was perceived to be responsive to a respondent's needs or requests, and if the respondent had a transactional relationship with the collaborator (e.g. commissions a services). In addition to this, personal opinions regarding broader issues which may affect opinions of services were elicited. For example, opinions regarding the public health approach to policing could determine whether the police as a collaborating partner was perceived to be doing a 'good job'.

Liaison with healthcare services by Compass appeared to be mixed. Referrals from healthcare partners have historically been low but have improved following efforts of Compass to make their service more visible and well-known to staff. Strategies to do this have included emails being written by the (former) Team Leader to A&E doctors regarding 'missed opportunities for referral' in clients they have seen that have been flagged up at the weekly A&E Safeguarding meeting Compass

attends at the Acute Trust. New doctor training does exist for A&E staff, but this can be limited due to high turnover of staff and the demands of the job. Similarly, awareness training for GP is available but limited due to competing demands and is therefore also reliant on how proactive a Team Leader can be at getting into their spaces without a direct invite.

The proactive efforts and personality of the (former) Team Leader are complemented by the frequency of times they were named by other stakeholders as being important to wider delivery. Despite the Team Leader leaving this role with no formal handover process, current Compass staff have not reported changes to the number of referral sources in the last month since this has occurred. Concerns regarding the sustainability of maintaining referrals exists amongst some stakeholders, given the small working capacity at Compass currently, a new Team Leader and the restructure at the Civic Centre where certain CYP services may no longer be present on the same floor all at once(3 respondents).

Elsewhere, more recent service-to-service referrals from Compass directly into CAMHS had reportedly improved the working relationship between the two organisations (according to Compass staff surveyed). However, more generally CAMHS was identified as needing to **'**do more**'** with regards to dual diagnosis substance misusers, their ever-increasing threshold for referral, not attending shared conferences frequently enough/not being available. These latter beliefs came from not just Compass, but most Local Authority and Healthcare partners as well. All stakeholders reporting this were sympathetic to the fact that CAMHS has an increasingly heavy workload with limited capacity and funding, in addition to staff absence and turnover at the time of this HNA. However, they felt that these issues continued to hinder progress with engaging with young people on wellbeing issues, even more so when waiting lists were very long and options for 'interim' support were not always appropriate. Compass providers reported using Education Services such as Educational Psychologists and Voluntary Sector Services such as Harrow Horizons, Ignite and WISH in the interim when they needed to find interim support alternatives to CAMHS. These organisations were similarly named by Youth Offending Team and Early Support respondents. Within these 'interim support services', for example Harrow Horizons, one Education service stakeholder reported a belief that these **'**holding measures**'** (e.g. six sessions of therapy) were no substitute for material changes to the provision of clinical and therapeutic services (e.g. CAMHS) and increased capacity, availability and access to these services by CYP should be the key priority.

Additionally, schools were identified as being key stakeholders with variable engagement depending on how receptive they were to external support or engaged with substance misuse as part of their pastoral programs. Outreach sessions at schools were the most commonly cited form of collaboration between Compass and the Education sector, although concerted efforts at attending School/Education Designated Safeguarding Lead meetings (such as termly meetings) was being made by the previous Team Leader; this is an idea which was also suggested by one Education sector stakeholder as a 'good opportunity' for Compass to update schools of any critical information, that has not been capitalised upon.

Respondents from Community Safety and Strategy believed that other Education based support services such as Educational Psychologists and Mental Health Support Teams (piloting in Harrow last year) could be of help. The former was identified by these respondent as key stakeholders in early recognition of adversity and behavioural issues directly or indirectly linked to substance misuse (and risk factors) for which early intervention could then be prescribed. Stakeholders within the Education sector, however, had mixed views as to how effective this could be. One stakeholder within the Education sector reported concerns that schools were already stretched to their limit, and perhaps even beyond their remit, with regards to the emotional burdens of CYP that its staff

already carry and process (a responsibility and role which had a light shone on it during the pandemic). This was highlighted by the ongoing process of some school staff requiring to be equally supported at work, as are the children and young people, on their exposure and feelings towards dealing with difficult and emotional subjects. Although this stakeholder emphasised a need for early intervention and liaised with school-based partners such as School Counsellors, they were concerned as to how much further frontline school services could do without necessary investment and scale up of its workforce and CAMHS provision. This Education stakeholder did, however, agree with respondents from Community Safety and Strategy that trauma-informed approaches and the 'whole-school' approach ethos of such an approach, would be valuable once embedded into schools to help them cope and respond to trauma as part of early intervention. Models to help support this or learn from were given, for example including professional supervision for school wellbeing staff (such as School Counsellors or Learning Mentors) or pilot programs such as Islington Council, CCG and Whittington Health NHS Trust ' 'Trauma Informed Schools Pilot Project' across school sites in 2019 onwards.

Respondents in the Youth Offending Team also believed that early recognition and signposting by the Early Support Service (for vulnerable individuals) could prevent trajectories into the criminal justice system, and that frontline staff with CYP contact need to upskill regarding their ability to support CYP with substance misuse needs. One YOT respondent also believed that Mental Health Support Teams and Educational Psychologists, as above, are key potential partners that could be exploited further for the public health approach to drugs. Only one respondent (Education) mentioned collaborating with the police directly, suggesting that Compass work alongside other specialist workers in MOPAC do shared outreach for high-risk vulnerable CYP in Pupil Referral Units, whilst four other respondents (Community Safety, Strategy, YOT, Early Support) more broadly advocated reforming police strategy at policy and operational levels to include amongst other things: diversionary schemes for small-scale drug possession, reform of Stop and Search, and potential decriminalisation.

Five respondents across sectors believed that that there was good awareness of available mainstream Children's Services by Adult's Services, but Safeguarding respondents felt that more generally Adult's Services sometimes did a 'better' job at identifying additional CYP needs beyond direct harm than the opposite. This is perhaps linked to the lack of additional support for adults whose children substance misuse and are affected by this and would require separate assessment of the needs of this particular group interfacing with different services in Local Authority, healthcare and elsewhere. Extra support for this group under Early Support Teams was being established but has since stalled for unknown reasons. Whilst this is underway, increased training of first-response teams (e.g. MASH/Children in Need/Looked After Children) and Early Support on prevention work - inclusive of the whole-family approach – can be another action for the specialist substance misuse service to take forward, a strategic need identified by two respondents.

Lastly, the need for overall improved communication and information-sharing (where appropriate) was emphasised by some respondents. Although forums exist to raise concerns for individual CYP and deliver training/awareness sessions, some information is being lost on the way. Although this did not appear to be a significant obstacle for liaison between services, it affected some providers more than others. For example, data gaps in coding for referrals, assessments and interventions in Social Services (still single-item coded) may not prompt a drugs and alcohol concern immediately (although it is routinely asked) and some stakeholder respondents find data missing in the referrals they receive (for example, YOT) or in requested updates about interventions delivered to CYP under their remit.

Section 6: Views regarding your current capacity to practically support CYP substance misuse needs

Compass-delivered training appeared to be the most common drugs and alcohol-training delivered to frontline practitioners (after their own mandatory organisational training). Within Compass, practitioners felt equipped to do their jobs (for example, both practitioners could undertake Hidden Harm work) and they also felt that they had appropriate types of supervision (Clinical, Business, Restorative) which was being supplied by the wider Compass organisation at the time. Elsewhere, the stakeholders most equipped or confident in their drugs and alcohol skills were unsurprisingly, those based in the Youth Offending Team who worked the most closely with Compass staff. Training offered largely covered the prevalence of local CYP substance misuse, harms associated with substance misuse, relevant screening tools, safeguarding roles and responsibilities, and communication tools with young people. Respondents from the YOT team reported that they would particularly like this training to be part of wider upskilling of other parts of Children's Services, such as the Youth Service or Early Support team to form a preventative and risk mitigating safety-net around CYP in contact with Children's Services before they get to YOT.

Where more training was desired by stakeholders for themselves, it was either to be longer, on a more frequent basis or more comprehensive in nature. A focus for future training remained the changing subculture of drugs, particular the rise of new psychoactive substances and increased use of Class A amongst young people, and the associated behaviours, paraphernalia, harms and risks of these. One respondent noted that it is **'**difficult to assess young people due to our own ignorance as professionals sometimes – we can**'**t give advice, can**'**t offer referral and can**'**t offer harm minimisation when we do not know**'**. Additionally, generic training on 'young people lingo' was desired by one respondent in Healthcare. Although respondents did not list whether they wanted such training to be mandatory or not, respondents mentioned it would be useful as part of Induction into new roles to be set up by line managers (especially given high staff turnover), as part of refresher courses offered by the LCSB or other Continuing Professional Development (CPD) programmes.

Other notable restrictions on capacity to deliver services was, unsurprisingly, funding – one respondent in the Voluntary Sector noted that for prevention and early intervention to work well, more funding for Children's Social Care would be required to allow case workers more time to interact with 'lower risk cases' before they are escalated to other services such as YOT or PRUs. Funding concerns were unsurprisingly also highlighted as a concern for CAMHS's capacity. The impacts of coronavirus also affected the ability of many stakeholders to work with CYP due to restrictions on gatherings, the need for mask wearing and limited face-to-face outreach. Although many of these restrictions have since relaxed, lasting operational impacts of the pandemic such as a backlog of cases for Children's Services and Secondary Care CAMHS to work through, sick leave and bereavement of other staff, and changes to working spaces mean delays and organisational friction is to be expected. In the background, several respondents also noted the mounting evidence of widening inequalities and worsening mental health which will likely limit capacity even further.

Section 7: Closing Comments/Other

Notably, no stakeholders mentioned smoking throughout the consultation process. This may partly be explained by the different definitions held by stakeholders as to what a 'substance' is, that Smoking Cessation services are often funded and delivered separately to wider Substance Misuse services (for example, for young people aged 18-24 years old, this would be covered by the

Westminster Drug Project's smoking cessation service and for 12-17 years old, this may be covered by their primary care physicians), and lastly the survey did not explicitly clarify what 'substances' would be covered.

Part 7

Part 7: A discussion on cross-cutting themes for substance misuse prevention

Throughout the stakeholder analysis, feedback regarding Compass as a service was generally positive, with most critique centred on operational capacity issues, rather than negative service experiences – namely, the lack of practitioners available in comparison to the overall demand of the service, the lack of a 24/7 service or concerns regarding the sustainability of funding streams. However, there were major themes raised across the stakeholder analysis from both Compass and non-Compass staff that need exploring and these were centred largely on the overall strategic vision regarding substance misuse control – what approaches in Harrow need to be taken (or to change) to not only reduce the negative impacts of substance misuse on CYP, but to stop them altogether? Of note, three core themes of prevention emerged – primary (preventing substance misuse occurring in the first place), secondary (preventing substance misuse from getting worse) and tertiary (preventing harms linked to substance misuse already occurring) for services to address.

1) Firstly, the need for stronger primary prevention strategies that go beyond **'**education**'** of smoking, drugs, and alcohol harms. Primary prevention aims to prevent substance misuse from occurring in the first place; for some CYP presenting to Compass, the root causes of their substance misuse are sometimes found many years earlier in their past, due to early experiences of adversity at home, at school or in the community. Addressing these experiences of adversity (for example, abuse, neglect, domestic violence, housing insecurity, community violence, discrimination) which are linked to an increased risk of substance misusing, may address the genesis and consequences of health-harming behaviour that emerges later in life.

    a. Addressing Adverse Childhood Experiences
    The first issue to be addressed is 'Adverse Childhood Experiences', which are acute traumatic events or chronic stressors in childhood beyond the control of the child that are linked to a unique experience of adversity and toxic stress, with associated negative outcomes (although these are not the only causative factors of negative outcomes, nor is risk deterministic). As above, examples of these include abuse, neglect and violence at home. Examples of negative 'ACE consequences' include poorer educational outcomes, anxiety, personality disorders, substance misuse, cardiovascular disease and criminal behaviour amongst other things. Multiple studies into these associations, and the strength of associations, have been undertaken into this; from a seminal study in the 1990s covering 15,000 health insured adults in Southern California by the US Centre for Disease Control and Kaiser Permanente, to more recent studies across England and Wales exploring local and national prevalence of ACEs.[4]

    The prevalence of ACEs strongly correlates to income deprivation and density (as seen in the 2019 UCL ACE Index by Lewer et al[37]) and whilst Harrow is not highly ranked nationally or in London as a 'hotspot' of these issues, addressing ACEs presents a clear opportunity to not only address issues such as violence for their own intrinsic immediate harm, but also for their far-reaching effects on an individual and community. The term 'trauma' was mentioned frequently by multiple stakeholders as an issue for CYP that needed 'resolution' or 'addressing' not just at the stage of specialist treatment, but prior to accessing services at all. A majority of

the 'missed' vulnerable groups whom stakeholders believed needed more effort included groups made vulnerable by past and ongoing trauma, including but not limited to Looked After Children, Children in Need, Excluded students (particularly Black boys), Young Offenders, Asylum Seekers and in some instances, SEND CYP (who can be traumatised by their experiences with exploitative individuals and/or stigmatising non-facilitative mainstream services, rather than just experiencing these traumas at home).

The ability to address ACEs requires concerted and coordinated effort across services, operating on a framework for intervention as that described by Oral et al (2016) that addresses factors before they become ACE risks (primordial prevention), preventing adverse experiences from occurring (primary prevention), reducing the impact of exposure to adverse experiences (secondary prevention) and addressing the impact of current or past ACEs on CYP and adults living with the sequelae of trauma (tertiary prevention).[52]

For CYP substance misuse, examples of approaches using Oral et al.'s framework include drugs and alcohol treatment before an individual becomes a parent (primordial prevention), parenting classes that reduce negative parenting behaviours or funding and maintaining a Hidden Harm worker not just for parents but for individuals whose siblings are under 18 years old and live with them (primary prevention), resilience support for vulnerable traumatised groups such as Excluded pupils (secondary support) and creating 'trauma-informed' services (tertiary prevention).

Across London, boroughs have produced multi-agency ACE Working Groups to draft an 'ACE approach' to support the application of such frameworks. Trauma-informed services – that recognise how behaviours of traumatised service users manifests in distress (including aggression and violence), how engagement can risk re-traumatisation and how staff can be traumatised by encounters – has been successfully seen in homelessness services but has also been applied to Children's Services in other London boroughs. For example, in Enfield where local services such as Educational Psychology, Parent Infant Partnership, School Emotional Wellbeing and Behaviour Support were all considered examples of this. Examples of training undertaken by Enfield's teams include Attachment Lead Training by schools, Nurture Group staff training in early or developmental trauma and CPD events for CAMHS and Educational Psychology staff on trauma-informed practice. Another example that addresses primary prevention in schools is Islington Council, CCG and Whittington Health NHS' 'Trauma Informed Schools Pilot Project' training staff in select primary schools and PRUs and all CAMHS staff across multiple school sites (in phase 1) in the Attachment, Regulation and Competency (ARC) Framework).[4]

b. Addressing Adverse Community Environments

Although the traditional model of ACEs considered only those events/stressors in the home, the range of adverse experiences which CYP may be subjected to has been expanded to include adverse community environments outside the home that can also have serious effect – together, the combination of these two factors form

the 'pair of ACEs' that underpin not just substance misuse, but other negative health risk factors and outcomes in their own rights which can have complex relationships that are difficult to detangle where one starts and another finishes (and vice versa). Concerning adverse community environments identified in the literature include community disruptions, poverty, poor housing quality and affordability, the lack of opportunity and economic mobility, housing insecurity or homelessness, discrimination and prejudice, bullying, and violence in the community.[2]

These examples do not just echo concerns listed in the stakeholder survey (when asked what 'broad background contexts need to change to help prevention and early intervention for CYP with unmet substance misuse needs') but are also those listed in the HAY Harrow Survey (2021) where key concerns reported by respondents included food insecurity, bullying and feeling unsafe in some parts of Harrow and some of those also cited in the 2018 'This is Harrow' report that highlighted youth violence, employment, and inequalities as three out of five key areas of unmet need for young people (the others being mental and physical health).[28 74] These Adverse Community Environments also reflect issues that remain deeply relevant to our wider sense of geography and time, as London's widening inequality, housing shortages, pockets of escalating violence, decades of underfunded frontline health services and the economic impacts of coronavirus continue to compound.

'Contextual safeguarding' in extra-familial environments underpins the 'whole-family' approach embodied by Local Authority Children's Services and has recently been employed by the Community Safety Partnership to target the most at-risk young people with proposed and current preventative interventions in Harrow; for example training sessions by the University of Bedfordshire (which has developed a Contextual Safeguarding Approach programme across North West London), employing a Violence Vulnerability and Exploitation worker to deliver a series of parenting programmes on this approach, supporting a full-time gang worker employed by the voluntary sector organisation Ignite and supporting a 'Ripple Effect Intervention' (REI) strategy. However, the HNA's stakeholder consultation highlights that these are ongoing concerns regarding community safety; including the places where CYP are exposed to, are offered/offer others to buy/sell/use drugs and alcohol (for example, schools, parks and parties outside of the familial home), hotspots of gang violence and 'spill-over' from other boroughs, the transitioning environments of children moving from primary schools to secondary schools, and the overall lack of safe spaces for CYP with adequate supervision and role modelling.

Moving forward, a more public health approach to policing serious violence needs to be taken, looking at 'the pair of ACEs' together in a way where not only can public health intelligence combine with information held by partners in Strategy, Community Safety, Housing, Children's Services, healthcare and the police, but serious investment in a partnership for prevention is maintained through an 'ACE Aware' Wellbeing Working Group that addresses wellbeing and resilience of young people as individuals and as they are situated in communities.[4 80]

Furthermore, a combination on environmental strategies to improving the safety of spaces where CYP are exposed to, and use, substances needs to be taken. This would cover a broad range of environments, from schools, parks, house parties and commercial venues. For example, providing safe space chill out rooms/free water at

venues such as clubs or shisha lounges, drug-checking services in premises that serve high risk substances to adults alongside children, providing access to emergency care such as defibrillators to the general public, explicit clean up schemes of remnant drug paraphernalia in green spaces, pro-mental health urban planning, increased street lighting of dark routes, enforcing rules on poor serving/sale practices of legal substances.[80] These strategies should work alongside the dissemination for harm-reduction materials to tackle primary, secondary and tertiary prevention across a spectrum with regards to an creating an informed public population operating in physical environments of safety. Some of these environmental strategies have a strong evidence base[31] (e.g. providing free water at or nearby venues servicing substances, illegal or otherwise) whilst others have limited evidence but are worth pursuing as part of a wider culture iterative research on local needs.[80] Looking at spaces where children and young people are exposed to the 'Hidden Harms' of other intimate loved ones (for example, close friends or intimate partners), not just parents, should be supplemented by the work done by the Safer Harrow partnership regarding the designated Youth Offer Link workers tied to Local Authority Secondary Schools and consider expansion to other key areas where young people congregate. This will also be supplemented by trauma-informed 'whole school' approaches that recognise the role community plays in social and emotional wellbeing of pupils and staff.[4]

c. Addressing **'**low-level**'** poor mental health in all young people by improving support systems for mental wellbeing, inclusive of CAMHS services
A key factor for addressing substance misuse prevention across its spectrum must be addressing mental ill-health. Mental ill-health remains not only a risk factor for substance misuse, but one that can both co-exist with substance misuse ('dual diagnosis') and be exacerbated by substance misuse itself (for example, depression or psychotic symptoms worsened by cannabis use). A chief concern of stakeholders and in local CYP area population surveys (including HAY Harrow 2021 and This Is Harrow 2018) were the number of CYP looking for support for their mental health and wellbeing (as well as support for developing 'resilience' skills such as 'being able to deal with stressful situations') and how these requests for support were being met in a variable fashion; in particular, by an underfunded CAMHS and over-stretched schools.

Protective factors against mental ill-health in adulthood, identified in national literature, for CYP (for example, Public Health Wales' Child and Youth Resilience Measures) include having role models, feeling supported, having a sense of self-efficacy and control, emotional management and self-regulation, attending social activities/sports/clubs and having a sense of identity or community.[4] As the threshold to meet and attend secondary care mental health services is increasingly out-of-reach for those struggling with their mental health, a reliance on digital applications, schools, and families to plug gaps with general wellbeing advice has occurred. At the same time, national strategy has attempted to promote more open conversations on mental health, to destigmatise feelings of distress and struggle and the process of seeking support for them. There is room to exploit already-existing structures and funded projects within public health afforded for these wider purposes, with a view to supporting factors influencing substance misuse too. For

example, embedding 'whole-school' approach practices supported by PHE and promoted by the GLA Healthy Schools London award or learning from trauma-informed services in other London Boroughs of Islington and Enfield, or through utilising Mental Health Support Teams as familiar first ports of call pre-primary care that could refer into specialist substance misuse services. Support for those supporting CYP is also fundamental, with the need for staff to not only be trauma-aware for themselves but supported with professional supervision, adequate resources and material reward.[4]

However, whilst there has been a successful cultural shift towards normalisation and a 'time to talk', there are limits to this specific preventative approach. Firstly, some of the conversations on mental health can sometimes ignore the less 'palatable' and 'extreme' diagnoses of mental ill-health (for example, personality disorders) which are still vitally important to discuss and manage both in their own right and for substance misuse support, but which often require concerted and expensive efforts on which to upskill professionals and to adapt communities to support. Secondly, many of the underlying poor social and home environments that foster mental illness cannot be 'talked away' with good self-care and resilience strategies. Commissioners across public health will be unable to tackle poor mental health in general without substantially offering ways to materially change these social and home environments, and primary prevention strategies against the 'pair of ACEs' alongside political and financial commitments to tackle poverty, inequality, violence and discrimination will ultimately ensure the longevity of promoting good mental health.

Lastly, some vulnerable groups will have poor mental health that will need strengthened secondary care services no matter what. For example, the needs of the CYP population with a 'dual diagnosis' reportedly remain difficult to meet, consistent with evidence suggesting how even integrated care pathways can succumb to capacity and operational pressures on either side of services, may still view support through a '1 problem at a time' lens, and may have inadequate community-based after-care following discharge from services.[51] Although the rates of co-occurring substance misuse and mental health issues reported by the substance misuse service in Harrow is lower than the national figures for the same (18% vs. 37% respectively), no data for the prevalence in secondary mental health services was retrieved for this HNA (due to limited contact with CAMHS) and it is unclear how well the needs of CYP mental health service users are being met with regards to substance misuse. Although studies from the late 2000s suggested a prevalence of 20-37% substance misuse issues in secondary mental health services for all presenters[11], other studies have suggested a potentially much higher figure for prevalence of substance misuse concerns for young people in these settings of between 11-71% (although different methodologies have been used for these studies).[32] Therefore, more exploratory analysis regarding prevention strategies for these groups should be considered, following engagement with the CAMHS service and service users themselves, in the context of a local mental health service pathway review.

2) Secondly, improving the knowledge, attitudes, and skills regarding substance misuse for non-specialist frontline staff to allow for early intervention and secondary prevention.

Unsurprisingly, given their remit, certain professional groups such as the Compass practitioners and the Youth Offending Team felt highly skilled and confident in their ability to manage substance misuse. However, other stakeholders across Children's Services (for example, Early Support), healthcare and the voluntary sector highlighted a need and desire for more training on a wide range of substance misuse concerns – namely, how to open conversations without stigma on first contact with an at-risk CYP (before professional rapport can be established), refresher sessions on new psychoactive substances/legal highs and new 'trends' in drug use behaviour, and how to be 'trauma-informed' as a whole. Early intervention through upskilling staff who have first contact with CYP who may not have overt substance misuse needs (for example, having been referred as part of a whole family support package) was recognised by Compass and YOT as key for secondary prevention.

Training sessions to other agencies are already a mandatory component for the current specialist service contract and although the target number of sessions delivered is frequently, if not always, met (for example, over-exceeded target in 2019-20 but under-achieved in the early months of lockdown in 2020), the appetite for increased training sessions delivered to other agencies is still there despite targets being met. It is likely that competing pressures and other mandatory learning requirements mean that substance misuse is not the topic that is most frequently refreshed, exacerbating learning gaps. This is an important barrier to overcome due to the speed at which these trends change, the risk associated with the hazards and harms of use (particularly synergistic physiological effects of multi-drug use), and the associations between substance misuse and other 'underlying' problems (for example, associated truancy linked to smoking, drug and alcohol use seen in SDD18 survey models). Furthermore, the lack of recognition in stakeholder responses of smoking as being a 'substance' that can be misused by CYP is one that needs addressing due to the intrinsic harms of smoking and the increased likelihood of smokers misusing other substances, being exposed to those using substances (friends and family), and early 'red flag' behaviours such as truancy. Given that vaping is prevalent to some degree in Harrow, conversations regarding its benefits and downsides (for example, as alternatives to cigarettes) also needs to be addressed. Although smoking behaviours may not have been considered or discussed due to the lack of an explicit definition in-survey - as well as broader social acceptance and the artificial distinctions in having separate smoking cessation/advice services – it should also be well-integrated when considering how to make non-specialist frontline staff both 'ACE-aware' and 'substance misuse aware'.

Apart from raising the number of target training sessions delivered to other agencies, novel approaches at making this training 'stick' should also be considered: for example, simulation training with service users/actors (on screening, brief intervention and referral into treatment) as part of inductions for new staff, creating a pre-prepared CPD package of modules and training events (e.g. e-Learning for Health alongside LCSB sessions) that can be managed in downtime periods, and offering substance-misuse focussed Professional Supervision sessions for professionals about cases that may not require multi-agency conferences, but were relevant or interesting regardless. As drugs and alcohol has also recently been made a compulsory PSHE mandate in school curricula, these professional supervision spaces should also include pastoral and teaching staff who can offer feedback on how this universal approach is being delivered in schools and offer a space to reflect on anonymised experiences of CYP receiving this information there. Funding for professional supervision is on the agenda within other Local Authority services as part of support wider

professions (for example, Public Health and Educational Psychologist Services) and the appetite for this should also be capitalised for substance misuse professionals.

A key issue here will remain regarding overall capacity and funding where Compass itself will need to increase its staff capacity to manage this (for example, a dedicated D&A practitioner Training Lead) as well as the acute and chronic pressures elsewhere on Local Authority and healthcare frontline staff find themselves having greater caseloads and less time for 'low-risk' cases. This means missed opportunities for early recognition and mitigation before an escalation of concerns that can be linked to worsening individual health, the impulsivity of adolescence and deteriorating home and community environments. Short of radical restructure and immense funding, it will be difficult to improve full capacity for these professionals; so, alongside advocating for more financial capital, interventions at improving knowledge, attitudes and skills of these frontline staff must centre on empowering them to use brief but high yield skills (e.g. changes in communication styles) and making the case that early interventions saves time and money down the line – reducing stigma, offering the opportunity to minimise harm, and creating an atmosphere of support for resilience.

3) Thirdly, supporting non-prohibition-based strategies to those misusing substances for secondary and tertiary prevention. Consistent with calls from both civil society and professional organisations such as the Royal Society for Public Health, non-prohibition-based strategies to those misusing substances form part of a public health approach to the secondary and tertiary prevention of substance misuse. Although this primarily concerns 'illegal' substances listed under the Misuse of Drugs Act 1971 and the Psychoactive Substances Act 2016, it also includes approaches for <18 year olds where smoking and alcohol are also illegal (with some exception on being served alcohols at meals with adult supervision). New strategies must acknowledge that deterrence through penalisation is not necessarily effective; that it contributes to the highly competitive lucrative drug markets that worsen community environments and are costly to pursue; that legal 'punishments' including incarceration often exacerbate the harms linked with substance misuse (for example, infection, violence, hidden harms) and that stigmatisation through the law does not allow a pathway from open conversations to treatment.

Examples of successful non-prohibition-based strategies to learn from, which have grounding in trauma-informed approaches as well, include the positive trends already demonstrated by the Triage service in Youth Offending in Harrow that can refer at-risk individuals to Compass, and the DIVERT pilot projects in Brixton, Tower Hamlets and Hackney, which divert young people at the point of police detention into support for training and development with a view to gaining employment. This can be expanded to include diversion schemes for those arrested for drug possession for the first-time or with small quantities of drugs such as that seen in the Thames Valley Police Drug Diversion Scheme. This latter scheme is not age specific and covers any drug; it allows officers to book a 'diversion' to a local drug service (after seizing the drug, checking the Police National Computer services and recording the offence) and engage a person with an outreach service that they can voluntarily attend. This form of 'community resolution' is also invisible on standard DBS check. An 81% engagement rate was seen for CYP and a 30% engagement rate for adults in a 10-month period covered.[70] This scheme, however, still records the possession as a crime, whilst civil societies and professional institutions such as RSPH and FPH have

gone one step further to call for total decriminalisation of drug possession altogether - allowing users to seek treatment without fear of reprisal and allowing clearer communication of drug harm profiles based on physiological risks, not just legal status.[69]

Emphasising harm-minimisation, rather than penalisation and the fear of 'getting caught' misusing substances, should also be adopted in school and home prevention strategies. With the reality being that a small proportion of individuals will always use regardless of prohibitive deterrence strategies and that CYP will continue to 'experiment' with smoking, drugs and alcohol, education strategies must adapt to keeping channels of communication open. They must strike a careful balance of being able to encourage pupils to take part in discussions, help them make informed and safe choices, and avoid unintended consequences (prompting curiosity into trying substances) in interactive formats that do not use scare tactics (which have no evidence to suggest they work). This is in line with NICE Guidance such as education strategies for alcohol and smoking in PH23: Smoking prevention in Schools (2010)[48] and NG135: Alcohol Interventions in Secondary and Further Education (2019)[47], and the focus on skills training for at-risk CYP as part of target prevention in NG64: Drug misuse prevention: targeted interventions (2017)[45]. An inability to talk to young people about use – especially if they are already living with those who substance misuse or are exposed to it in extra-familial environments – mean that concepts about recognising what is a problem and what is not 'normal' (See: definitions of 'misuse' in Part 1), and what grooming looks like, cannot be explored; this may compound a sense of distrust, alienation and hypocrisy if what is being taught at school or at home is not supported by a young person's daily experiences in their own personal lives and communities, and it further limits options of support.

Part 8

Part 8: Conclusions & Key Recommendations for Commissioners & Strategists

- Maintain lessons learned from the current COVID-19 pandemic, including flexible outreach through telephone and attending meetings with other Lead Professionals more easily

- Ensure that vulnerable groups are appropriately supported by CYP substance misuse service. This includes continued outreach to the Eastern European community, but that additional support is also given to the vulnerable groups listed in Parts 6-7 of this HNA.
    - Consider alternative funding streams (similar to the Controlling Migration Fund) for dedicated workers for: Hidden Harm work beyond substance-misusing parents (e.g. siblings, partners), NEET CYP, SEND CYP, CYP in contact with Local Authority and Criminal Justice Team
    - Increase the number of practitioners at Compass as current numbers are at capacity with workload including YOT link working and Eastern European outreach

- Ensure that commissioning of CYP substance misuse services increasingly addresses education/advocacy work at early and key transition points (such as primary schools --> secondary schools) as part of a primary prevention strategy that allows conversations about drug use to be normalised.

- Ensure that commissioned substance misuse services can upskill non-frontline staff on their knowledge, attitudes, and skills regarding substance misuse, particular new trends and new psychoactive substances, to allow for early intervention and secondary prevention

- Develop a wider public health strategy that integrates the prevention and mitigation of adverse childhood experiences and adverse community environments into all public health work
    - Strong examples of trauma-informed approaches to learn from are the 'ACE-aware' approaches of other boroughs such as Enfield and Islington, and the integration of appropriate training in departments such as the Educational Psychology, Behavioural Psychology, the Parent Infant Partnership, teachers and CAMHS staff in trauma-informed schools. These can be supported by other providers delivering primary prevention and universal intervention such as the Mental Health Support Teams and the Healthy Schools London programme.
    - A public health approach to policing should also be embedded across Community Safety contexts, with a variety of environmental strategies and socio-economic risk factor mitigation employed.

- Expand on the input of service users for this HNA, in particular primary consultation with CYP service users (COVID-19 restrictions permitting), Child and Adolescent Mental Health Services and Schools
    - Primary data collection from service users for the purpose of this HNA should be undertaken, be that in observation, questionnaire, interview, focus group or case study formats.
    - The development of service user structured feedback during treatment is underway but should be adopted, monitored, and reviewed before the next HNA
    - Consideration of formal discharge follow-ups (for example, anonymised forms or text messages) should be established to avoid missed relapses and capitalise from previously positive working relationships, and to describe what the service does well by successful completers.
    - Obstacles to CAMHS being more freely available to other stakeholders, managing dual diagnosis patients and attending shared conferences should be explored – ideally in interview and focus group setting to yield rich results as this was a key stakeholder identified by the network as potentially poised to do more (capacity-permitting)

- Develop the CYP Emotional Wellbeing Board with a Schools Co-Lead as a conduit for discussion of broader wellbeing themes, including substance misuse, but not limited to it.
    - For example, the CYP Emotional Wellbeing Board could be tasked with reviewing the findings and recommendations of the current HAY Survey (2021), and developing future iterations of it with reference to other relevant Health Needs Assessments or national documents (e.g. SDD18). They could then tailor resources to the most pressing objective e.g. food insecurity or living with vulnerable adults which may underpin other structural drivers of substance misuse
    - The CYP Emotional Wellbeing forum could also be responsible in addressing concerns regarding 'low-level' mental health that may amplify substance misuse, but also exacerbate other associated risks, by overseeing the future CYP Mental Health strategy.
    - The CYP Emotional Wellbeing forum could also adopt an Advocacy role within public health for the cross-cutting themes identified in Part 7 of this survey, such as supporting non-prohibition-based strategies towards substance misuse/control and educating stakeholders on 'ACE aware' approaches.

- Explore attitudes to smoking and smoking cessation, as well as smoking prevalence, in children and young people, including the use of shisha and hookah in social settings.

References

1. *0-18 years: Guidance for all doctors.* General Medical Council. Last updated 25 May 2018. Last accessed 20/09/21 at: https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/0-18-years/appendix-1#who-are-children-and-young-people

2. *2017 Drug Strategy*. Policy Paper. National government (UK). Published July 2017. Last accessed 20/09/21 at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/628148/Drug_strategy_2017.PDF

3. *Advancing our health: prevention in the 2020s.* Green Paper Consultation Document. Department of Health and Social Care. Published July 2019. Last accessed 20/09/21 at: Advancing our health: prevention in the 2020s – consultation document - GOV.UK (www.gov.uk)

4. *Adverse Childhood Experiences in London. Investigating ways that Adverse Childhood Experiences and related concepts of vulnerability can help us to understand and improve Londoners' health.* Bullock, M. Greater London Authority. Published 2019. Last accessed 20/09/21 at: adverse_childhood_experiences_in_london._final_report_october_2019_with_author._mb.pdf

5. *Advice on scheduling of cannabis-derived medicinal products*. Correspondence. Advisory Council on the Misuse of Drugs. Published 19th July 2018. Last accessed 20/09/21 at: https://www.gov.uk/government/publications/advice-on-scheduling-of-cannabis-based-medicinal-products

6. *Age of criminal responsibility.* National government (UK) Website. Last accessed 20/09/21 at: https://www.gov.uk/age-of-criminal-responsibility

7. *Alcohol-specific deaths in the UK: registered in 2018.* Statistical Bulletin. Office for National Statistics. Published December 2019. Last accessed 20/09/21 at: https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/causesofdeath/bulletins/alcoholrelateddeathsintheunitedkingdom/2018

8. *Alcohol and young people.* National government (UK). Website. Last accessed 20/09/21 at: Alcohol and young people - GOV.UK (www.gov.uk)

9. *Alcohol, drugs and substance abuse.* UNISON. Website. Last accessed 20/09/21 at: https://www.unison.org.uk/get-help/knowledge/health-and-safety/alcohol-drugs-and-substance-abuse/

10. Anyanwu, P. E., Craig, P., Katikireddi, S. V., & Green, M. J. (2020). Impact of UK tobacco control policies on inequalities in youth smoking uptake: a natural experiment study. *Nicotine and Tobacco Research*, *22*(11), 1973-1980.

11. Carrà G, Johnson S. Variations in rates of comorbid substance use in psychosis between mental health settings and geographical areas in the UK. *Social psychiatry and psychiatric epidemiology.* 2009;44:429-47

12. *Cannabis schedule review: part 1.* Independent Report. Department of Health and Social Care. Published 3rd July 2018. Last accessed 20/09/21 at: https://www.gov.uk/government/publications/cannabis-scheduling-review-part-1

13. *Child and Maternal Health profile.* Fingertips Dashboard. Public Health England. Last accessed 20/09/21 at: Child and Maternal Health - Data - PHE

14. *Child protection system in England.* National Society for the Prevention of Cruelty to Children (NSPCC) Learning Training Module. Website. Last updated 28 April 2020. Last accessed 20/09/21 at: Child protection system for England | NSPCC Learning

15. *Children and the Law.* National Society for the Prevention of Cruelty to Children (NSPCC) Learning Training Module. Website. Last updated 13 April 2021. Last accessed 20/09/21 at: https://learning.nspcc.org.uk/child-protection-system/children-the-law#article-top

16. *Circles of Support.* Based on the work of Judith Snow, Jack Pearpoint and Marsha Forest. Last accessed 20/09/21 at: https://independencenw.org/circles/

17. *Convention on the Rights of the Child* (1989) Office of the United Nations High Commissioner for Human Rights (OHCHR) Geneva: OHCHR

18. *Deaths related to drug poisoning in England: 2020 registrations*. Statistical Bulletin. Office for National Statistics. Published August 2021. Last accessed 20/09/21 at: https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsrelatedtodrugpoisoninginenglandandwales/previousReleases

19. *Drug and alcohol education – lesson plans, resources and knowledge organisers.* PSHE Association. Website. Last accessed 20/09/21 at: https://www.pshe-association.org.uk/curriculum-and-resources/resources/drug-and-alcohol-education-%E2%80%94-lesson-plans

20. *Drug misuse and dependency. UK guidelines on clinical management* (2017) Independent Expert Working Group. London: Department of Health. Last accessed 20/09/21 at: Drug misuse and dependence (publishing.service.gov.uk)

21. *Drug misuse in England and Wales: year ending 2020.* Article. Office for National Statistics. Published December 2020. Last accessed 20/09/21 at: https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/drugmisuseinenglandandwales/yearendingmarch2020

22. *Drug Strategy 2010.* Policy Paper. National Government (UK) Published 8th December 2010 under the 2010 to 2015 Conservative and Liberal Democrat Coalition Government. Last accessed 20/09/21: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/98026/drug-strategy-2010.pdf

23. *Exploring the evidence. Young people's specialist substance misuse treatment* (2009). National Treatment Agency for Substance Misuse, NHS. Last accessed 20/09/21 at: http://drugslibrary.wordpress.stir.ac.uk/files/2017/04/yp_exploring_the_evidence_01091.pdf

24. *Guidance on the Consumption of Alcohol by Children and Young People.* From Sir Liam Donaldson. Chief Medical Officer for England. Department of Health. Published December 2009. Last accessed 20/09/21 at: https://www.ias.org.uk/uploads/pdf/News%20stories/doh-report-171209.pdf

25. *Harrow Young People's Substance Misuse Needs Assessment & Specialist Services Review* (2014) Internal Document. For Public Health, Harrow Council. Local Authority. Available upon request.

26. *Harrow Young People's Substance Misuse Service.* Compass. Website. Last accessed 20/09/21 at Harrow Young People's Substance Misuse Service | Compass (compass-uk.org)

27. Hartnoll, R., Frischer, M., Wiessing, L., Bello, P., Kraus, L., Mckeganey, N., D'ippoliti, D., Domingo-Salvany, A., Smit, F., & Hay, G. (1999). Methodological guidelines to estimate the prevalence of problem drug use on the local level.

28. *HAY Harrow Survey Results – the 'How are you Harrow?' health and wellbeing survey for students in Harrow.* Internal Document. Newman, T (Timmus Research Limited) for Public Health, Harrow Council. Produced July 2021, pre-publication.

29. *Health and Social Care Act* (2012). Act of Parliament. National Government (UK). Last accessed 20/09/21 at: Health and Social Care Act 2012 (legislation.gov.uk)

30. *Health and social responses to drug problems. A European Guide.* European Monitoring Centre for Drugs and Drug Addiction. Published 2017. Last accessed 20/09/21 at: TI_PUBPDF_TD0117699ENN_PDFWEB_20171009153649.pdf (europa.eu)

31. Hickman, M., Taylor, C. (2005) Indirect Methods to Estimate Prevalence. pp113-131.*Epidemiology of Drug Abuse*. Springer, Boston. MA. https://doi.org/10.1007/0-387-24416-6_8 Last accessed 20/09/21 at: 113-131.pdf (lsmuni.lt)

32. Hides, L., Elkins, K., Catania, L., Mathias, S., Kay-Lambkin, F., & Lubman, D. (2007). Feasibility and outcomes of an innovative cognitive-behavioural skill training programme for co-occurring disorders in the youth alcohol and other drug (AOD) sector. *Drug and Alcohol Review*, 26, 517–523.

33. *ICD-10 Classification of Mental and Behavioural Disorders: Clinical descriptions and diagnostic guidelines -F10-F19: Mental and behavioural disorders due to psychoactive substance use. The.* (1999) World Health Organisation. Please note ICD-11 will replace ICD-10 from 1st January 2022.

34. *If a young person gets in trouble with the police.* Scottish national government. Website. Last updated June 2020. Last accessed 20/09/21 at: https://www.mygov.scot/young-people-police

35. *In-direct methods for estimating the size of the drug problem. GAP Toolkit Module 3: Prevalence Estimation.* Pre-publication version. UNDCP. Published November 2002. Vienna International Centre. Austria. Last accessed 20/09/21 at: https://www.unodc.org/pdf/gap_toolkit_module3_estimation.pdf

36. *Key dates in tobacco regulation: 1962-2020*. Action on Smoking and Health. Published 2020. ASH –Last accessed 20/09/21 at: Key-Dates.pdf (ash.org.uk)

37. Lewer, Dan., King, Emma., Bramley, Glenn., Fitzpatrick, Suzanne., Treanor, Morag C., Maguire, Nick., Bullock, Miriam., Hayward, Andrew., and Story, Al. The ACE Index: mapping childhood adversity in England. *Journal of Public Health* 42, no. 4 (2020): e487-e495.

38. *Lexicon of alcohol and drug terms.* (1994) Alcohol, Drugs and Addictive Behaviours, World Health Organisation. Last accessed 20/09/21 at: Lexicon of alcohol and drug terms (who.int)

39. *Ladder of engagement. Based off the work of Sherry Arnstein. (*Date Unknown) NHS England. Last accessed 20/09/21 at: NHS England » Ladder of engagement

40. *Local Alcohol Profiles for England.* Fingertips Dashboard. Public Health England. Last accessed 20/09/21 at: Local Alcohol Profiles for England - Data - PHE

41. *National Drug Treatment Monitoring System. ViewIt* Interactive Tool. Website. Last accessed 20/09/21 at: NDTMS - National Drug Treatment Monitoring System

42. *New Psychoactive Substances.* DrugWise. Website. Last updated November 2018. Last accessed 20/09/21 at: https://www.drugwise.org.uk/new-psychoactive-substances/

43. *NICE CKS Smoking Cessation Scenario: 12 -17 years.* Clinical Knowledge Summary. National Institute for Health and Care Excellence (NICE). Last revised in November 2020. Last accessed 20/09/21 at: Scenario: 12-17 years | Management | Smoking cessation | CKS | NICE

44. *NICE Guidance CG115: Alcohol-used disorders: diagnosis, assessment and management of harmful drinking (high-risk drinking) and alcohol dependence.* Clinical guideline. National Institute of Health and Care Excellence (NICE). Published February 2011. Last accessed 20/09/21 at: Overview | Alcohol-use disorders: diagnosis, assessment and management of harmful drinking (high-risk drinking) and alcohol dependence | Guidance | NICE

45. *NICE Guidance NG64: Drug misuse prevention: targeted interventions*. NICE Guideline. National Institute for Health and Care Excellence (NICE). Published February 2017. Last accessed 20/09/21 at: Overview | Drug misuse prevention: targeted interventions | Guidance | NICE

46. *NICE Guidance NG92: Stop smoking interventions and services.* NICE Guideline. National Institute for Health and Care Excellence (NICE). Published March 2018. Last accessed 20/09/21 at: Overview | Stop smoking interventions and services | Guidance | NICE and https://www.nice.org.uk/guidance/ng92/resources/stop-smoking-interventions-and-services-pdf-1837751801029

47. *NICE Guidance NG135: Alcohol interventions in secondary and further education*. NICE Guideline. National Institute for Health and Care Excellence (NICE). Published August 2019. Last accessed 20/09/21 at: Recommendations | Alcohol interventions in secondary and further education | Guidance | NICE

48. *NICE Guidance PH23: Smoking prevention in schools*. Public health guideline. National Institute for Health and Care Excellence (NICE). Published February 2010. Last accessed 20/09/21 at: Overview | Smoking prevention in schools | Guidance | NICE

49. *NICE Guidance PH24: Alcohol-use disorders: prevention.* Public health guideline. National Institute for Health and Care Excellence (NICE). Published June 2010. Last accessed 20/09/21 at: Overview | Alcohol-use disorders: prevention | Guidance | NICE

50. *NICE Guidance PH52: Needle and syringe programmes.* Public health guideline. National Institute for Health and Care Excellence (NICE). Published March 2014. Last accessed 20/09/21 at: Overview | Needle and syringe programmes | Guidance | NICE

51. NICE Guideline Scope: Severe mental illness and substance misuse (dual diagnosis): community health and social care services. National Institute for Health and Care Excellence (NICE). Published ?2016. Last accessed 20/09/21 at: 1 (nice.org.uk)

52. Oral, R., Ramirez, M., Coohey, C. et al. Adverse childhood experiences and trauma informed care: the future of health care. *Pediatr Res* 79, 227–233 (2016). https://doi.org/10.1038/pr.2015.197

53. Oxford Dictionary of English. 3rd Edition. Oxford Languages. Oxford University Press. Last accessed 10/08/2021 via Google's English Dictionary at: www.google.com

54. Pathways to Problems. Corporate report. Advisory Council on the Misuse of Drugs. Last Published 14 September 2006. Last accessed 20/09/21 at:

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/119053/Pathwaystoproblems.pdf

55. *Priorities for Action on Alcohol in the 2018 Strategy.* Walmsley & Mooney. Alcohol Special Interest Group. Faculty of Public Health. Publication date unknown. Last accessed 20/09/21 at https://www.fph.org.uk/media/2324/fph-alcohol-sig-response_final-for-fph.pdf

56. *Relationships Education, Relationships and Sex Education (RSE) and Health Education. Statutory guidance for governing bodies, proprietors, head teachers, principals, senior leadership teams, teacher.* Guidance. Published 25th June 2019. Department for Education. Last accessed 20/09/21 at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/908013/Relationships_Education___Relationships_and_Sex_Education___RSE___and_Health_Education.pdf

57. *SafeStats -Public Safety Data for London.* Database. Greater London Authority Intelligence Unit. Last accessed 06/09/21 at: Safestats (london.gov.uk)

58. *Smoke-free generation: tobacco control plan for England.* Policy Paper. Department of Health and Social Care. Published July 2017. Last accessed 20/09/21 at: Smoke-free generation: tobacco control plan for England - GOV.UK (www.gov.uk)

59. *Smokefree: The First Ten Years – Tackling the smoking epidemic in England: the views of the public. Research Report.* ASH - Action on Smoking and Health. Published July 2017. Last accessed 20/09/21 at: https://ash.org.uk/wp-content/uploads/2017/06/170107-Smokefree-the-first-ten-years-FINAL.pdf

60. *Smoking Cessation.* Westminster Drug Project. Website. Last accessed 20/09/21 at: https://www.wdp.org.uk/smoking-cessation

61. *Smoking, Drinking and Drug Use among Young People in England 2018.* NHS Digital. Published August 2019. Last accessed 20/09/21 at: https://digital.nhs.uk/data-and-information/publications/statistical/smoking-drinking-and-drug-use-among-young-people-in-england/2018

62. *Specialist substance misuse services for young people. A rapid mixed methods evidence review for current provision and main principles for commissioning.* (2017) Public Health England. Last accessed 20/09/21 at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/583218/Specialist_substance_misuse_services_for_young_people.pdf

63. *Statistics on Alcohol, England 2020.* NHS Digital. Published February 2020. Last accessed 20/09/21 at Alcohol-specific deaths in the UK: registered in 2018. Statistical Bulletin. Office for National Statistics. Last accessed at: https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/causesofdeath/bulletins/alcoholrelateddeathsintheunitedkingdom/2018

64. *Statistics on Drug Misuse, England 2020*. NHS Digital. Published January 2021. Last accessed 20/09/21 at: Statistics on Alcohol, England 2020. NHS Digital. Published February 2020. Last accessed 20/09/21 at Alcohol-specific deaths in the UK: registered in 2018. Statistical Bulletin. Office for National Statistics. Last accessed at: https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/causesofdeath/bulletins/alcoholrelateddeathsintheunitedkingdom/2018

65. *Stop and search data and the effects of geographical differences.* Research and analysis. Race Disparity Unit. Published 31st March 2021. Last accessed 20/09/21 at: https://www.gov.uk/government/publications/stop-and-search-data-and-the-effect-of-geographical-differences/stop-and-search-interpreting-and-describing-statistics

66. *Supporting Community Treatment Order Requirements.* Commissioning Group for the National Offender Management Service. Published February 2014. Last accessed 20/09/21 at: Microsoft Word - Commissioning Group for data room v2..doc (publishing.service.gov.uk)

67. *Surrey Drug and Alcohol Treatment.* Surrey County Council. Last accessed 20/09/21 at: item 09 - Annex 2 Tiers of Drug and Alcohol Treatment.pdf (surreycc.gov.uk)

68. *Tackling Alcohol Harm.* Debate Pack Number CDP 2020/0059. Written by Bukky Balogun and Nikki Sutherland. Produced for debate by the Backbench Business Committee on 16th March 2020. House of Commons Library. Last accessed 20/09/21 at: https://researchbriefings.files.parliament.uk/documents/CDP-2020-0059/CDP-2020-0059.pdf

69. *Taking a New Line on Drugs.* (2016) Royal Society for Public Health. Last accessed 20/09/21: https://www.rsph.org.uk/static/uploaded/68d93cdc-292c-4a7b-babfc0a8ee252bc0.pdf

70. *Thames Valley Police Drug Diversion Scheme.* Thames Valley Police - Detective Chief Inspector Jason Kew and Detective Sergeant Wojciech Spyt. Presented 2019. Last accessed 20/09/21 at: jason-kew-10.30am.pdf (leph2019edinburgh.com)

71. *The new public health role of local authorities*. (?2013) Department of Health. Last accessed 20/09/21 at: Public Health in Local Government: Local Government Leading for Public Health (publishing.service.gov.uk)

72. *The Public Health Burden of Alcohol and the Effectiveness and Cost-Effectiveness of Alcohol Control Policies: An Evidence Review.* Public Health England. Published December 2016. Last accessed 20/09/21 at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/733108/alcohol_public_health_burden_evidence_review_update_2018.pdf

73. *The Public Health Reforms: What they mean for drug and alcohol services.* DrugScope briefing for the Recovery Partnership. Published February 2013. Last accessed 20/09/21 at: Public-Health-Reforms-what-they-mean-for-drug-and-alcohol-services.pdf (drugwise.org.uk)

74. *'This is Harrow: Understanding the needs of young people in Harrow' – Harrow Young People's Need Analysis.* (2018) Report and Interactive Data Set. Young Harrow Foundation. Last accessed 20/09/21 at: Young People's Need Analysis (youngharrowfoundation.org)

75. *Thompson Reuters Practical Law UK Glossary (2021) Thomson Reuters.* Last accessed 20/09/21 at: 10b-5 letter | Glossary | Practical Law (thomsonreuters.com)

76. *UK alcohol clinical guidelines development begins.* Public Health England. News Story. Published 18th October 2019. Last accessed 20/09/21: https://www.gov.uk/government/news/uk-alcohol-clinical-guidelines-development-begins

77. *UK Chief Medical Officers' Low Risk Drinking Guidelines.* Department of Health, Welsh Government, Department of Health (Northern Ireland) and the Scottish Government. Published August 2016. Last accessed 20/09/21 at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/545937/UK_CMOs__report.pdf

78. *UK Drug Laws.* Transform – Drug Policy Foundation. Website. Last accessed 20/09/21 at: https://transformdrugs.org/drug-policy/uk-drug-policy

79. Viner R, and Taylor B, (2007) Adult outcomes of binge drinking in adolescence: findings from a UK national birth cohort. *Journal of Epidemiology and Community Health*, 61: 902-907.

80. *Violence in London: what we know and how to respond. A report commissioned by the Mayor of London's Violence Reduction Unit.* Weishmann, H., Davies, M., Sugg, O., Davis, S., and Ruda, S. The Behavioural Insights Team. Published 2020. Last accessed 20/09/21 at: BIT-London-Violence-Reduction.pdf

81. *What About YOUth 2014.* Survey. NHS Digital. Published December 2015. Last accessed at 20/09/21 at: Health and Wellbeing of 15-year-olds in England - Main findings from the What About YOUth? Survey 2014 - NHS Digital

82. *What are the UK Drug Laws.* DrugWise. Website. Last accessed 20/09/21 at: https://www.drugwise.org.uk/what-are-the-uk-drug-laws/

83. *Working together to safeguard children: a guide to inter-agency working to safeguard and promote the welfare of children.* (2018). Department for Education. London. Last accessed 20/09/21 at Working Together to Safeguard Children 2018 (publishing.service.gov.uk)

84. *Young people commissioning support: principles and indicators.* Guidance. Public Health England. Last updated 4th October 2018. Last accessed 20/09/21 at: Young people commissioning support: principles and indicators - GOV.UK (www.gov.uk)

85. *Young people – substance misuse commissioning support pack 2021-22: key data. Planning comprehensive interventions for young people. Harrow.* Guidance. Public Health England. Accessed through the Drugs and Alcohol Commissioner, Public Health Team, Local Authority (Harrow Council)

86. *Youth.* United Nations. Website. Last accessed 20/09/21 at: Youth | United Nations

Appendix

1) Survey example (please see the attached Document)

2) Sub-groups of drug harm, using sixteen harm criteria, as agreed on by the Advisory Council on the Misuse of Drug (ACMD).

The following table is taken from page 9 of *Taking a New Line on Drugs.* (2016) Royal Society for Public Health (Reference number 65). It is cited as "Table 1: types of drug harm. Adapted from Nutt et al. 2010"within the document. It references the following piece of work: 'Nutt, D. J., King, L. A., & Phillips, L. D. (2010). Drug harms in the UK: a multicriteria decision analysis. *The Lancet*, *376*(9752), 1558-1565.

		Types of harm	Examples
To users*	Physical	Drug-specific mortality	Acute alcohol poisoning, heroin overdose
		Drug-related mortality	Fatal road traffic accidents, lung cancers, suicides
		Drug-specific damage	Cirrhosis, seizures, strokes, cardiomyopathy, stomach ulcers
		Drug-related damage	Consequences of unwanted sexual activities, self-harm and blood-borne viruses
	Psychological	Dependence	Alcoholism, heroin addiction
		Drug-specific mental impairment	Ketamine intoxication, drunkenness amphetamine-induced psychosis
		Drug-related mental impairment	Mood disorders, such as depression, related to drug use or lifestyle
	Social	Loss of tangibles	Loss of income, housing, employment; imprisonment
		Loss of relationships	Damaged relations with friends or family
To others	Physical and Psychological	Injury	Domestic violence, road crashes, foetal harm, transmission of blood borne viruses
	Social	Crime	Acquisitive crime
		Environmental damage	Toxic waste from drug production, discarded needles
		Family adversities	Family breakdown, child neglect
		International damage	Deforestation, destabilisation of countries, international crime
		Economic cost	Costs to healthcare, police, prisons, social services; indirect costs e.g. lost productivity
		Community	Decline in social cohesion and community reputation

3) SafeStats Query Protocol.

This query protocol was built using the Query Builder tool on the *SafeStats -Public Safety Data for London* database produced by the Greater London Authority Intelligence Unit and accessed on the following website: Safestats (london.gov.uk). It was last accessed on 06/09/21 and uses the following filters to access London Ambulance call-out data and Metropolitan Police call-out data

Query Number 1 - London Ambulance Service (LAS) data
Filters:
Data Source: LAS
Location: Harrow
Date: Calendar Years, 2014-2021
Ages: 0-25 years old
Grouped By: Electoral Ward + First Dispatch Only
AND
Chief Complaint
- Overdose/Poisoning (either from a caller-derived or from AMDPS determinant source) *OR*

Illness
- Alcohol-related and/or
- Drug Overdose and/or
- Poisoning and/or
- Solvent-related (paramedic derived source) *OR*

LAS Category
- Alcohol-related (paramedic derived from the similarly coded above Illness coding) and/or
- Class A-related (caller derived or AMDPS determined for heroin and cocaine) and/or
- Overdose (if from the similarly coded caller-derived or AMDPS-determined Chief Complaint or from coded paramedic-derived Illness) *OR*

SafeStats Theme 1
- Alcohol (if the above LAS category Alcohol-related is not null, derived from paramedic Illness input) and/or
- Substance (if the above paramedic-derived Illness was Solvent-related and/or the above LAS category for Class A-related is not null, derived from the caller or AMPDS determined coding for heroin or cocaine) *OR*

SafeStats Theme 2
- Alcohol (if the above LAS category Alcohol-related is not null, derived from paramedic Illness input) and/or
- Substance (if the above paramedic-derived Illness was Solvent-related and/or the above LAS category for Class A-related is not null, derived from the caller or AMPDS determined coding for heroin or cocaine) *OR*

SafeStats Crime Category
- Drug-related and/or
- Supply/Production/Trafficking-Related and/or
- Possession/Use-Related and/or

- Null/Other/Combined-Related (drugs)

Query Number 2a - Metropolitan Police Service (MPS) data
Filters:
Data Source: MPS
Location: Harrow
Date: Calendar Years, 2014-2015
AND
SafeStats Theme 1
- Alcohol-related (where the Cause of the incident recorded and coded by the MPS was 'Disturbance, Alcohol-related') and/or
- Substance-related (where the Offence had been recorded and coded as 'Drugs' by the MPS) *OR*
SafeStats Theme 1
- Alcohol-related (where the Cause of the incident recorded and coded by the MPS was 'Disturbance, Alcohol-related') and/or
- Substance-related (where the Offence had been recorded and coded as 'Drugs' by the MPS)
NB: data not available by age and electoral ward breakdown for this source

Query Number 2b - British Transport Police (BTP) data
Filters:
Data Source: BTP
Location: Harrow
Date: Calendar Years, 2014-2015
AND
SafeStats Theme 1
- Alcohol-related (where the Offence contained 'alcohol'/'drunk' recorded and coded by the BTP) and/or
- Substance-related (where the Crime Group was recorded and coded as 'Drugs' by the BTP)
OR
SafeStats Theme 1
- Alcohol-related (where the Offence contained 'alcohol'/'drunk' recorded and coded by the BTP) and/or
- Substance-related (where the Crime Group was recorded and coded as 'Drugs' by the BTP)
NB: data not available by age and electoral ward breakdown for this source