Substance Misuse Treatment Framework: Integrated Substance Misuse Service Provision for Children and Young People

OGL © Crown copyright 2024, Welsh Government, WG50352, Digital ISBN 978-1-83625-401-0
Mae'r ddogfen hon ar gael yn Gymraeg hefyd / This document is also available in Welsh
Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg / We welcome correspondence and telephone calls in Welsh

Authorship and affiliations at time of writing

Josie Smith, Head of Substance Misuse Programme, Public Health Wales
Michelle Hughes, Project Manager – Substance Misuse and harm reduction, Public Health Wales
Dean Acreman, Project Manager – Trends in Substance Misuse, Public Health Wales
Peter Lowe, Dual Diagnosis Substance Misuse Practitioner, Specialist Child & Adolescent Mental Health Services, Hywel Dda University Health Board
Sarah Burgess, Service Manager, Specialist Child and Adolescent Mental Health Service (S-CAMHS), Hywel Dda
Steve Davis, Service Manager, Pembrokeshire Youth Offending and Prevention Service
Nicky Evans, Flintshire Sorted YPDAT, Flintshire County Council
Charlotte Hopkins, Kinbee Ltd
Lee Richards, Youth Worker, Cardiff Youth Service
Sadie Alexander, Switched on Team, Health Promotion Practitioner, Public Health Wales
Sam Edwards, Barod Young Persons Substance misuse Service- Team Leader
Sandra Smith, Service Manager, Young People's Emotional Wellbeing Service, Change, Grow, live (CGL)
Vicky Jones, North Wales Lead, ACE Aware Wales
Dr Julia Lewis, Consultant Addiction Psychiatrist, Aneurin Bevan Health Board Trust
Sarah James, Barod Young Persons Substance misuse Service Manager
Gareth Morgan, Substance Misuse Commissioner, Cardiff & Vale University Health Board

Table of Contents

1 Summary and key developments 1
2 Background 4
2.1 Purpose and structure 5
2.2 Legislative context 6
2.3 Strategic Policy Context 11
2.4 Methodology 15
2.5 Roles and responsibilities 15
2.6 Definitions 15
2.7 Evidence on harms and assessments associated with substance use amongst children and young people 16
3 Pathway for integrated substance use service provision 23
3.1 Prevention, early engagement and outreach 23
3.2 Effective assessment and integrated care planning 36
3.3 Harm Reduction Approach and Interventions 48
3.4 Psychological interventions and psychosocial support 52
3.5 Pharmacological support and treatment for dependency 58
3.6 Transitional planning to adult services 64
3.7 Planned and unplanned exit from substance use and related treatment services 72
4 Training and workforce development 78
4.1 Background 78
4.2 Workforce development and training across all sectors working with children and young people 79
4.3 Workforce development framework in Youth Justice Services 80
4.4 Workforce development in community substance use and allied services .. 81

1 Summary and key developments

Substance use amongst children and young people may present both as a symptom and an initiating factor in a range of risk behaviours with consequences both in the short and long term. Available data on the health, educational and social harms related to substance use, including alcohol, illicit and licit drugs, would indicate problematic use is limited to a small proportion of the overall population. However, due to the cultural and legislative structures in place, the extent of use, including experimental, occasional, recreational, and problematic use of alcohol and drugs tends to remain hidden. What is clear is that substance use, and particularly the acute and chronic harms related to use, disproportionately affect those most vulnerable in society despite considerable efforts from policy makers and health, social and criminal justice services.

The guidance provided here relies on implementation of three key developments/recommendations across Wales, developed and agreed through the national stakeholder engagement process:

1. **All services for Children and Young People provide an inclusive and adaptive service for all those aged up to 25 years**. It is recognised that many services already operate under this premise, however, not all do with service provision ceasing at aged 16 or 18. For those services where there is a statutory transfer effective transition planning and wrap around support should be in place[1]. Ensuring this <25 model across all services in Wales will facilitate streamlined, person-centred support recognising that physical age does not per se provide a useful measure of need in relation to support for substance use, psychological health and well-being, trauma, social care needs and so on. Providing an adaptive, tailored transitional model across service provision, focussing on early engagement, identification of needs over time, and consistent support promotes greater emphasis on prevention of escalation to more entrenched substance use, related harms and longer-term consequences including intergenerational harm.

2. **Implementation of an electronic unified and modular assessment tool across services in Wales working with children and young people aged up to <25.** At present, each sector of service provision is required to undertake an assessment of circumstance and need for each individual presenting for care and support, leading to duplication, inefficiencies, failure to provide integrated care and potentially re-traumatising the child or young person and thus acting as a barrier to accessing support. Utilising available technological advances including the Welsh Community Care Information

[1] Welsh Government. Managing the transition from children's to adult healthcare services. In consultation phase (from 2020). Available at: [Managing the transition from children's to adults' healthcare services | GOV.WALES]

System (WCCIS), and in line with information governance requirements, implementation of a unified assessment tool, with the record following the individual over geography and time will address these challenges. In addition, implementation would address the current knowledge gap in relation to support requirements and the changing nature of substance use and related harms amongst this population in Wales addressing the limited routine collation and reporting of health and social care needs (including substance use, mental health and wellbeing) for children and young people including those receiving youth justice support.

3. **Development of comprehensive specialised intervention services delivered by creating a single agency, or bringing together separate agencies, to act as a single entity to support those with multiple and/or complex vulnerabilities including substance use, mental health and learning difficulties and/or risk of offending and reoffending aged 15-25 years.** This recommendation is in line with:
    a. Drug misuse and dependence national guidance[2]: 'For those with substantial levels of use or problem use, it is more likely that drug use compounds other problems such as family breakdown, anti-social behaviour, educational issues and mental health concerns – that is, drug use is more of a symptom than a cause of the vulnerability. Evidence indicates that young people with other problems, such as young offenders, young people with mental health problems, those experiencing child sexual exploitation and those excluded from school, are more likely to misuse drugs and alcohol… Treatment services for young people that address substance use problems need to sit within the wider framework and standards for young people. Coordinated, well-led interventions should mobilise resources of local communities, including safeguarding, education, training, mental health and resilience building'.
    b. The Youth Justice Blueprint[3] aim to 'Align preventative services offered to children (including those targeted at reducing the number of looked after children, the prevention of school exclusions and homelessness) with a joint framework model and shared risk or intervention trigger factors to improve outcomes for children.'
    c. The NEST/NYTH Framework developed by the Together for Children and Young People (T4CYP) programme (see figure 1). This Framework provides the Regional Partnership Boards with the planning

---

[2] Clinical Guidelines on Drug Misuse and Dependence Update 2017 Independent Expert Working Group (2017) Drug misuse and dependence: UK guidelines on clinical management. London: Department of Health. Page Drug misuse and dependence (publishing.service.gov.uk)

[3] Welsh Government and Ministry of Justice. Youth Justice Blueprint for Wales. youth-justice-blueprint_0.pdf (gov.wales)

tools required to ensure a ‘whole system’ approach to developing mental health, wellbeing and support services for babies, children, young people, parents, carers and their wider families across Wales.

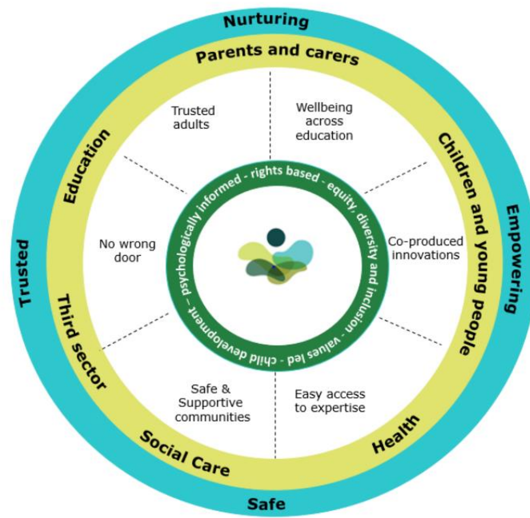


Figure 1: Graphic representation of the whole systems approach of the NEST/NYTH Framework planning tool for Regional Partnership Boards in Wales

2 Background

Substance use amongst children and young people aged up to 25 represents a particular societal focus and challenge in Wales and the wider UK, with many harms remaining hidden from support and treatment services. Harms associated with substance use include, and are not limited to, those impacting on physical health including acute toxicity, infection and premature deaths from poisoning, suicides, accidents or violence and assault; psychological harms, both acute and chronic, particularly amongst those with multiple and complex needs including mental health disorders; and contact with the criminal justice system. Longer term harms include loss of opportunity due to lack of complete education, employment, financial and health inequalities. Children and young people may be at increased vulnerability due to their own or parental substance use and are at a higher risk of physical, emotional and sexual abuse, exploitation and organised crime.[4,5]

Drug markets in terms of availability and potency, as well as the advent of new or novel psychoactive substances including medicines new to misuse, have resulted in substantial changes and distinct challenges in terms of managing harms and adapting services. The changing profile of drug markets and substance use in the community is reflected within populations of children and young people, requiring an adaptive model of care over time. In addition, the emergence of county lines has placed vulnerable children and young people at increased risk of harm and exploitation from gangs and organised crime.[2]

Improved outcomes for children and young people in relation to substance use and misuse can only be achieved through early and credible engagement, integrated assessment and joint working with a harm reduction and needs-based approach. Providing targeted educational interventions, prevention and treatment services for children and young people are key components of safeguarding and improving their health and wellbeing. Providing effective engagement and interventions with integrated and bespoke support in the earlier years and up to the age of 25 will reduce the population of individuals developing life-long substance use issues and the inherent harms associated with entrenched use. The NEST/NYTH[6,7] Framework, established as part of the Together for Children and Young People programme, provides a planning structure and tools aimed at ensuring a whole system approach

---

[4] Windle J, Moyle L, Coomber R. 'Vulnerable' Kids Going Country: Children and Young People's Involvement in County Lines Drug Dealing. *Youth Justice*. 2020;20(1-2):64-78. doi: 10.1177/1473225420902840

[5] Public Health Wales. 2015. Adverse Childhood Experiences and their impact on health-harming behaviours in the Welsh adult population. Available at: Public Health Wales. 2015. Adverse Childhood Experiences and their impact on health-harming behaviours in the Welsh adult population

[6] NHS Wales Health Collaborative. The NEST/NYTH framework. The NEST Framework - NHS Wales Health Collaborative

[7] NHS Wales Health Collaborative. 2015. TOGETHER FOR CHILDREN AND YOUNG PEOPLE' FRAMEWORK FOR ACTION. Available at: Framework For Action.pdf (wales.nhs.uk)

to mental health and well-being and support services for children and young people. Taking a trauma informed approach in line with the principles set out in the Trauma Informed Wales Framework is also critical.

2.1 Purpose and structure

This document is designed to inform and assist health, social care and criminal justice planners and providers to design and deliver high quality, sustainable and equitable prevention and treatment services for those at risk of or experiencing substance use issues. This guidance document forms part of the suite of harm reduction and Substance Misuse Treatment Framework (SMTF) guidance for those working in Wales.[8]

The intended audience for this guidance includes service planners, commissioners, substance use and wider health, criminal justice and social care providers working with those at risk of initiation, or experience of historic or current problematic drug and/or alcohol use. In implementing this SMTF it is therefore expected that children and young people, their families and carers will be involved.

The document provides an overview of the existing situation in Wales and the wider UK and outlines the evidence to inform improvements. Links to relevant strategy and policy documents are provided along with a summary of the evidence relating to required development of services aimed at improving the health and wellbeing of children and young people.

In **Section A**, the pathway, from early engagement to transitional and exit planning is outlined for both alcohol and drugs. As an individual may have both problematic drug and alcohol use, the assessment process and pathway are designed to be flexible and inclusive though to follow-on support and exit planning. **Section B** provides a focus on the required workforce developments including realignment and training. Finally, **Section C** identifies the key indicators to measuring progress, performance and the delivery of an 'excellent, safe and equivalent service' in relation to substance use and related health and social care requirements, and required technological innovation, information governance and information systems covering both community and criminal justice settings.

---

[8] Welsh Government. Suite of Substance Misuse Treatment Framework documents available at: Drug misuse and dependency | Sub-topic | GOV.WALES

2.2 Legislative context

2.2.1 NHS (Wales) Act 2006[9]

The statutory powers and duties of the NHS in Wales are mainly contained within the NHS (Wales) Act 2006. Whilst the NHS Act 2006 applies equivalent legislation to the NHS in England, it also contains some legislation that applies to both England and Wales.

Most of the business of NHS bodies will be conducted in accordance with powers contained in the NHS (Wales) Act 2006 and the arrangements set out within the relevant Constitution, Membership & Procedures Regulations. All NHS bodies must also operate within the wider legislative framework governing all UK organisations. The NHS (Wales) Act 2006 consolidates a range of regulatory requirements relating to the promotion and provision of the health service in Wales. It sets out:

- Welsh Ministers' duty to promote health service
- General power to provide services
- Provision of particular services
- Provision of services otherwise than in Wales
- NHS Contracts
- Provision of services otherwise than by Welsh Ministers

Key sections of this Act include:

- Section 72 places a duty on NHS bodies to co-operate with each other in exercising their functions.
- Section 82 places a duty on NHS bodies and local authorities to co-operate with one another in order to secure and advance the health and welfare of the people of England and Wales.

2.2.2 Well-being of Future Generations (Wales) Act 2015[10]

The Well-being of Future Generations Act was enacted to improve the social, economic, environmental and cultural well-being of Wales. The Act establishes a statutory Future Generations Commissioner for Wales and Public Services Boards (PSBs) for each local authority area in Wales. Each PSB must improve the economic, social, environmental and cultural well-being of its area by working to achieve the well-being goals. Of direct relevance to this document, the seven well-being goals include:

---

[9] National Assembly for Wales (2006). National Health Service (Wales) Act 2006). Available at: National Health Service (Wales) Act 2006 (legislation.gov.uk)

[10] National Assembly for Wales (2015). Well-being of Future Generations (Wales) Act 2015. Well-being of Future Generations (Wales) Act 2015 – The Future Generations Commissioner for Wales

A prosperous Wales - 'A society… which develops a skilled and well-educated population in an economy which generates wealth and provides employment opportunities, allowing people to take advantage of the wealth generated through securing decent work'.
A healthier Wales – 'A society in which people's physical and mental well-being is maximised and in which choices and behaviours that benefit future health are understood'.
A more equal Wales – 'A society that enables people to fulfil their potential no matter what their background or circumstances (including their socio-economic background and circumstances)'.
A Wales of cohesive communities – 'Attractive, viable, safe and well-connected communities'.

2.2.3 The Socio-economic Duty Equality Act 2010[11]

The Socio-economic Duty came into force in Wales on the 31 March 2021 and requires relevant public bodies to give due regard to the need to reduce inequalities experienced as a result of socio-economic disadvantage in our policy making and strategic decisions. The public bodies covered by the Duty are:

- The Welsh Ministers
- County Council or County Borough Councils
- Local Health Boards
- NHS Trusts
- Special Health Authorities (which operate on a Wales only basis)
- Fire and Rescue Authority
- National Park Authority
- The Welsh Revenue Authority

2.2.4 Social Services and Well-being (Wales) Act 2014[12]

The Social Services and Well-being Act imposes duties on local authorities, health boards and Ministers requiring them to work to promote the well-being of those who need care and support, or carers who need support. The term 'well-being' includes safeguarding, specifically the prevention of and protection from abuse, harm and neglect, but it also applies to the physical, mental and emotional well-being of an individual. Within the Act, designed to change to delivery of social services, a series of fundamental principles are specified including:

---

[11] Welsh Government. A More Equal Wales. The Socio-economic Duty Equality Act 2010. Statutory Guidance. Available at: WG42004 A More Equal Wales The Socio-economic Duty Equality Act 2010 (gov.wales)
[12] National Assembly for Wales (2014). Social Services and Well-being (Wales) Act 2014. Social Services and Well-being (Wales) Act 2014 (legislation.gov.uk)

- Putting the individual adult or child, including unpaid carers, at the centre of their care and support. Young people should be allowed control to reach the outcomes that help them achieve well-being across all aspects of their lives.
- Prevention and early intervention: Increasing preventative services within the community.
- Co-production: Encouraging individuals to become more involved in the design and delivery of services that they need.
- Multi agency: Strong partnership working between all agencies and organisations, with integration being the key driver for change.

The Act also introduced the requirement for a National Independent Safeguarding Board and Safeguarding and Protection Boards at local authority level.

2.2.5 The Children Act 1989[13]

The Children Act 1989 is the principal piece of legislation which makes provision about the safeguarding and promotion of the welfare of Children. Part 3 of the Children Act 1989 (local authority support for children and families) no longer applies in Wales and has been replaced by provisions in the Social Services and Well-being (Wales) Act 2014, particularly Parts 3 and 4 (assessing and meeting needs for care and support) and Part 6 (looked after and accommodated children).[14] Section 47(1) of the Children Act 1989 contains duties which require a local authority to make, or cause to be made, such enquiries as it considers necessary to enable it to decide whether it should take any action to safeguard or promote the child's welfare. Such action might result in a child becoming "looked after" by a local authority, either as a result of a local authority providing accommodation for the child (in accordance with section 76 of the Social Services and Well-being (Wales) Act 2014) or following the making of a care order by the court (in accordance with section 31 of the Children Act 1989).

2.2.6 Children Act 2004[3]

The Children Act 2004 builds on and strengthens the framework set out in the Children Act 1989. There are a number of provisions in the 2004 Act, which relate directly or indirectly to agencies' responsibilities to safeguard and promote the welfare of children. Statutory guidance issued by the Welsh Government in 2006[15] states:
"All those who have contact with children and young people, including everybody who works with or has contact with children, parents, and other adults in contact with, or seeking contact with, children, should be able to recognise, and know how to

---

[13] Children Act 1989. Children Act 1989 (legislation.gov.uk)
[14] Children Act 2004. Children Act 2004 (legislation.gov.uk)
[15] Safeguarding Children: Working Together Under the Children Act 2004

act upon, evidence that a child's health or development is or may be being impaired and especially when they are suffering or at risk of suffering significant harm. Practitioners, foster carers, and managers should be mindful always of the welfare and safety of children - including unborn children and older children - in their work."

Since implementation of the Act additional relevant amendments include:

- **Section 25 - Co-operation to improve well-being:** has been amended by the Social Services and Well-being (Wales) Act 2014.
- **Section 26 - Children and Young People's plans:** has been repealed by the Well-being of Future Generations (Wales) Act 2015 and replaced by the duty on public service boards to prepare and publish assessments of local well-being and local well-being plans.
- **Sections 31 to 34 - Local Safeguarding Children Boards:** have been repealed and replaced by the provisions in section 134 to 140 of the Social Services and Well-being (Wales) Act 2014: Safeguarding Boards.

2.2.7 Children and Families (Wales) Measure 2010[16]

The Children and Families (Wales) Measure 2010 provides the legislative framework for tackling child poverty in Wales. It places a duty on Welsh Ministers and named public bodies to publish a Child Poverty Strategy which sets out objectives for tackling child poverty and the actions they will take to achieve the objectives.

The Measure also places a statutory duty on Welsh Ministers to publish a report on progress made towards tackling child poverty every three years.

2.2.8 The United Nations Convention on the Rights of the Child (UNCRC)[17]

The UNCRC is an international agreement that protects the rights of children and provides a child-centred framework for the development of services to children. The UK Government ratified the UNCRC in 1991 and, by doing so, recognises children's rights to expression and receiving information. In Wales, the **Rights of Children's and Young Peoples' Measure (2011)** has the same status as an 'Act' and places a duty on the Welsh Government to have due regard to the United Nations Convention on the Rights of the Child when making policy. Of particular relevance are the following articles:
Article 33: States Parties shall take all appropriate measures, including legislative, administrative, social and educational measures, to protect children from the illicit

[16] Children and Families (Wales) Measure 2010 Children and Families (Wales) Measure 2010v6.qxd (legislation.gov.uk)

[17] UNICEF (1990). The United Nations Convention on the Rights of the Child. UN Convention on the Rights of the Child - UNICEF UK

use of narcotic drugs and psychotropic substances as defined in the relevant international treaties, and to prevent the use of children in the illicit production and trafficking of such substances.

Article 24: States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services.

2.2.9 The Equality Act 2010[18]

The Equality Act 2010 puts a responsibility on public authorities to have due regard to the need to eliminate discrimination and promote equality of opportunity. This applies to the process of identification of need and risk faced by the individual child and the process of assessment. No child or group of children must be treated any less favourably than others in being able to access effective services which meet their particular needs.

2.2.10 Mental Capacity

The Mental Capacity Act 2005[19] is legislation that is enabling and supportive of people who lack capacity, not restricting or controlling of their lives. It aims to protect people who lack capacity to make particular decisions, but also to maximise their ability to make decisions, or to participate in decision-making, as far as they are able to do so.

The Mental Health (Wales) Measure 2010[20] is law that was passed by the National Assembly for Wales and, as such, has the same legal status in Wales as other Mental Health Acts. However, whilst the 1983 and 2007 Mental Health Acts are largely about compulsory powers, and admission to, or discharge from hospital, the 2010 Measure is all about the support that should be available for people with mental health problems in Wales wherever they may be living.

The Welsh Language (Wales) Measure 2011[21] makes Welsh language and official in Wales, and it must be treated no less favourably than English. The Measure modernised the existing legal framework regarding the use of the Welsh language in the delivery of public services.

---

[18] UK Government (2010). The Equality Act 2010. Equality Act 2010: guidance - GOV.UK (www.gov.uk)

[19] UK Government (2005). Mental Capacity Act 2005. Mental Capacity Act 2005 (legislation.gov.uk)

[20] National Assembly for Wales (2010). Mental Health (Wales) Measure 2010. Mental Health (Wales) Measure 2010 (legislation.gov.uk)

[21] National Assembly for Wales (2011). Welsh Language (Wales) Measure 2011 (legislation.gov.uk)

2.2.11 UK Drug Laws[22]

There are three main statutes regulating the availability of drugs in the UK:

- **The Misuse of Drugs Act (1971)**[23] - This act is intended to prevent the non-medical use of certain drugs. For this reason, it controls not just medicinal drugs (which will also be in the Medicines Act) but also drugs with no current medical use. Drugs subject to this Act are known as 'controlled' drugs. The law defines a series of offences including unlawful supply; intent to supply, import or export and unlawful production.
- **The Medicines Act (1968)**[24] - this law governs the manufacture and supply of medicine.
- **The Psychoactive Substances Act (2016)**[25] - makes it an offence to produce, supply, offer to supply, possess with intent to supply, possess on custodial premises, import or export psychoactive substances; that is, any substance intended for human consumption that is capable of producing a psychoactive effect. It enables police and local authorities to adopt a graded response to the supply of psychoactive substances in appropriate cases, including powers to stop and search to seize and destroy psychoactive substances.

2.3 Strategic Policy Context

2.3.1 Welsh Government Substance Misuse Delivery Plan 2019-22[26]

Welsh Government's Substance Delivery Plan 2019–22 provides the national agenda on tackling and reducing the harms associated with substance use in Wales. The delivery plan is underpinned by five key aims:

- Preventing harm
- Support for individuals – to improve their health and aid and maintain recovery
- Supporting and protecting families
- Tackling availability and protecting individuals and communities
- Stronger partnerships, workforce development and Young Person Involvement

---

[22] Drug Wise. What are the UK Drug Laws? What are the UK drug laws? – DrugWise

[23] UK Government (1971). Misuse of Drugs Act 1971. Misuse of Drugs Act 1971 (legislation.gov.uk)

[24] UK Government (1968). Medicines Act 1968. Medicines Act 1968 (legislation.gov.uk)

[25] UK Government (2016). Psychoactive Substances Act 2016. Psychoactive Substances Act 2016 (legislation.gov.uk)

[26] Welsh Government (2019). Substance misuse delivery plan: 2019 to 2022. Substance misuse delivery plan: 2019 to 2022 | GOV.WALES

The Plan emphasises the importance 'of early identification and intervention, and of measures or programmes to divert individuals from substance use' for all children and young people who begin to misuse substances.

2.3.2 Youth Justice Strategy for Wales: Children and Young People First 2014[27]

This joint strategy brings together the Welsh Government and Youth Justice Board's (YJB) vision and commitment to improve services for children and young people from Wales at risk of becoming involved in, or who are in, the youth justice system. It provides the Welsh Government, the YJB and those delivering youth justice services with a coherent framework through which the prevention of offending and reoffending by children and young people can be achieved. It builds on the approach and achievements delivered under the All Wales Youth Offending Strategy 2004 (AWYOS) and its subsequent Delivery Plan 2009.[28]

2.3.3 Standards for Children in the Youth Justice System 2019[29]

These standards define the minimum expectation for all agencies that provide statutory services to ensure good outcomes for children in the youth justice system. They aim to:

- Provide a framework for youth justice practice and ensure that quality is maintained.
- Encourage and support innovation and good practice to improve outcomes for Children who commit crime.
- Ensure that every child lives a safe and crime-free life and makes a positive contribution to society.
- Align with the YJB's child first principle.
- Assist the YJB and inspectorates when they assess whether youth justice services are meeting their statutory requirements.

These standards are set by the Secretary of State for Justice on the advice of the YJB.

---

27 Welsh Government/Youth Justice Board joint strategy to improve services for young people from Wales at risk of becoming involved in, or in, the youth justice system. 2014. Available at: [Withdrawn] Youth justice strategy for Wales: children and young people first - GOV.UK (www.gov.uk)

28 National Assembly for Wales (2009). All Wales Youth Offending Strategy: Delivery Plan 2009-11. All Wales Youth Offending Strategy: Delivery Plan 2009-11 (ioe.ac.uk)

29 Youth Justice Board for England and Wales (2019). Standards for Children in the Youth Justice System 2019. Standards for children in the youth justice system - GOV.UK (www.gov.uk)

2.3.4 Youth Justice Blueprint for Wales[30]

The Youth Justice Blueprint for Wales builds on the statutory aim of the youth justice system to prevent offending by children and young people, the United Nations Convention on the Rights of the Child, and the Social Services and Well-being (Wales) Act 2014 and the Well-being of Future Generations (Wales) Act 2015 requirement to ensure local services are in place to prevent children from offending and promote their future welfare. The blueprint outlines a 'whole-system' approach for a rights-based and trauma informed system of support services. The approach focuses on targeted prevention, diversion and community-based interventions.

2.3.5 Welsh Government 'Together for Mental Health: A Strategy for Mental Health and Wellbeing in Wales' 2012[31] and Delivery Plan 2019-22[32]

Welsh Government's strategy for mental health and wellbeing in Wales outlines clear actions including development of 'consistent mental health, mental well-being and learning disability services across communities that are tailored to local needs through an agreed set of standards and indicators for community mental health services'. The National Assembly for Wales report 'Mind over Matter'[33] provided a further focus on emotional well-being, resilience and early intervention, with clear recommendations to support prevention, early identification and engagement. The Mental Health Delivery Plan was revised and updated in October 2020 to include new cross-Government commitments to support those most affected by the pandemic.[34] Work is now underway to develop the success to the Together for Mental Health Strategy.

2.3.6 Welsh Language Strategy – Cymraeg 2050[35]

Cymraeg: belongs to us all. It is important that we that we recognise the concept of language need. Receiving services in Welsh, especially when we people are at their most vulnerable should be an integral component of person-centred care. More than just words[36] is the Welsh Government's strategic framework to strengthen Welsh

---

[30] Welsh Government and Ministry of Justice. Youth Justice Blueprint for Wales. Welsh Government and Ministry of Justice. Youth Justice Blueprint for Wales.
[31] Welsh Government (2012). Together for Mental Health A Strategy for Mental Health and Wellbeing in Wales. Together for mental health: our mental health strategy | GOV.WALES
[32] Welsh Government (2019). Together for Mental Health Delivery Plan 2019-2022. Available at: review-of-the-together-for-mental-health-delivery-plan-20192022-in-response-to-covid-19_0.pdf (gov.wales)
[33] National Assembly for Wales, Children, Young People and Education Committee. 2018. Mind over matter: A report on the step change needed in emotional and mental health support for children and young people in Wales. Available at: The Emotional and Mental Health of Children and Young People in Wales (senedd.wales)
[34] Welsh Government (October 2020): Mental health delivery plan 2019 to 2022 | GOV.WALES
[35] Welsh Government Cymraeg 2050: Welsh language strategy | GOV.WALES
[36] Welsh Government More than just words (gov.wales)

language provision in health and social care. Its aim is to support Welsh-speakers to receive services in their first language.

In addition, the Workforce Strategy for Health and Social Care[37] refers to Welsh language and includes actions for improving the Welsh language skills of the workforce.

2.3.7 Children's Commissioner for Wales Annual Reports[38]

The Children's Commissioner for Wales is an independent children's rights institution established in 2001.The Commissioner's principal aim is to safeguard and promote the rights and welfare of children and young people under the United Nations Convention on the Rights of the Child. The Children's Commissioner for Wales publishes an annual report which, in 2020-21 outlined a series of recommendations directly relevant to this document, including:

- Strengthen Wales' corporate parenting role through legislation and guidance, to ensure Wales' care system is rights based and enables children to thrive in care.
- Oversee and monitor the widespread roll out of the Protocol to Reduce the Unnecessary Criminalisation of Looked After Children, supported by resources and training to strengthen existing practice.
- Progress to further enact the Youth Justice Blueprint, particularly the secure accommodation elements.
- Welsh Government should work with stakeholders, schools and children and young people themselves to ensure the ambition of the whole school approach to emotional and mental well-being is matched by resource, capacity and a whole system support network across relevant services which meets the particular needs of each school.
- Welsh Government must continue to work with the Regional Partnership Boards to support the implementation of a No Wrong Door approach, and the NEST/NYTH whole-system model, including the specific work within these models for improving support for neuro-diverse children. This will be further enhanced by the appointment of the NEST/NYTH Implementation Lead, providing a dedicated resource to the RBPs in the development of their Implementation Plans.

---

[37] Social Care Wales and NHS Wales. A Healthier Wales: Workforce Strategy for Health and Social Care (nhs.wales)

[38] Home - Children's Commissioner for Wales (childcomwales.org.uk)

2.4 Methodology

To oversee development of this SMTF for children and young people, a steering group was established in 2018. National stakeholder groups were invited to attend two engagement days to agree amendment and final recommendations of the SMTF. The evidence within this document is drawn from a range of sources including bibliographic databases, personal communication with leading academics, stakeholder and evidence gathering events and key informant interviews. The databases and website sources included MEDLINE, MEDLINE Daily Update, AMED, BNI and EMBASE. Websites included NICE, Health Protection Agency, Welsh Government, Department of Health and Social Care.

2.5 Roles and responsibilities

Welsh Government, Health Boards, Substance Use Area Planning Boards (APBs), criminal justice, local authorities and third sector organisations will be responsible for ensuring delivery of this SMTF for children and young people.

2.6 Definitions

Substance use and dependence - Substance use and dependence, previously referred to as substance misuse, 'refers to the harmful or hazardous use of psychoactive substances, including alcohol, licit and illicit drugs. Psychoactive substance use can lead to dependence syndrome - a cluster of behavioural, cognitive, and physiological phenomena that develop after repeated substance use and that typically include a strong desire to take the drug, difficulties in controlling its use, persisting in its use despite harmful consequences, a higher priority given to drug use than to other activities and obligations, increased tolerance, and sometimes a physical withdrawal state'[39]. In addition to psychoactive substances, this guidance includes the use of image and performance enhancing drugs (IPEDs).
Children and Young People - According to the Social Services and Well-being (Wales) Act 2014, Section 3, a Child is defined as a person who is aged under 18. A Young Person is defined as any person under the age of 25 years. As such, this term encompasses those legally defined as Children.
Children leaving care - In all nations of the UK, Children leaving care at 18 are entitled to support from their local authority until they are at least 21. England, Scotland and Wales are governed by the Children (Leaving Care) Act 2000.
Age of criminal responsibility - The age of criminal responsibility in England, Wales and Northern Ireland is 10 years old. As such, a child is considered capable of committing a crime and old enough to stand trial for a criminal offence. Their case

---

[39] World Health Organisation (2018). Substance abuse. Alcohol, Drugs and Addictive Behaviours (who.int)

will be dealt with by a youth court and if they are convicted, their sentence will take their age into account.

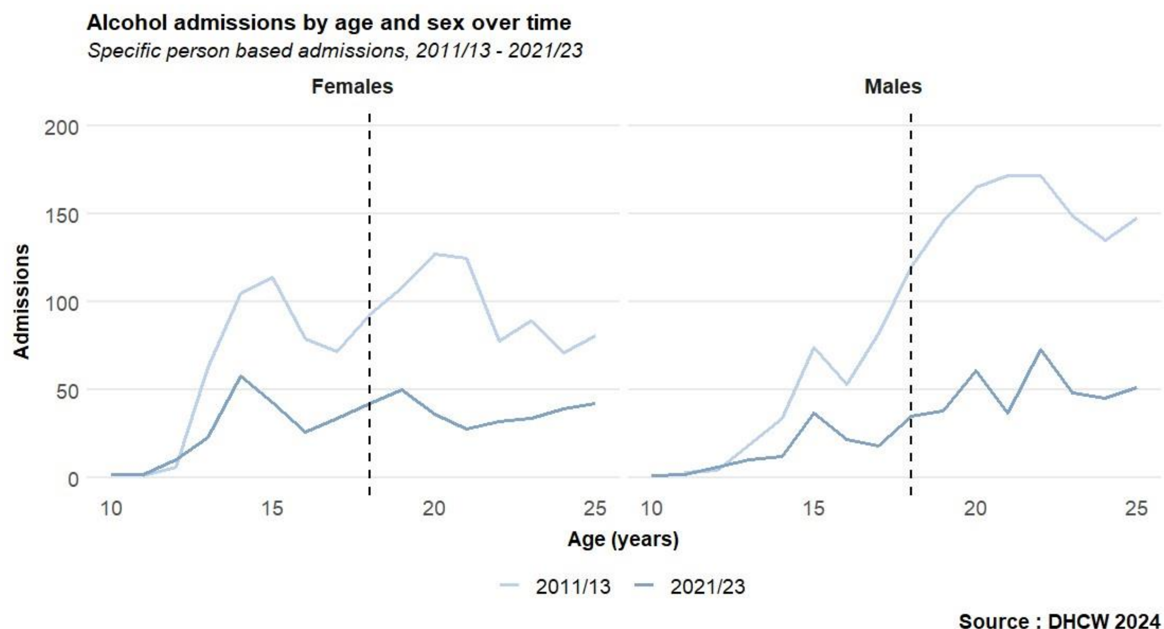
New Psychoactive Substances (NPS) – According to the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA)[40], NPS 'include both non-controlled and recently controlled new psychoactive substances, in particular (but not exclusively) synthetic cannabinoids, synthetic cathinones, new synthetic opioids and new benzodiazepines'.

2.7 Evidence on harms and assessments associated with substance use amongst children and young people

2.7.1 Alcohol admissions in children and young people

The number of alcohol-specific hospital admissions for individuals aged between 10 and 17 years (inclusive) have fallen in the last 10 years. There were 324 alcohol specific admissions for this age group in 2012/13 compared to 137 admissions in 2022/23. This reduction has been observed in both males and females, across all ages. There are more admissions relating to females in this age group then males, a consistent trend over the last 10 years.

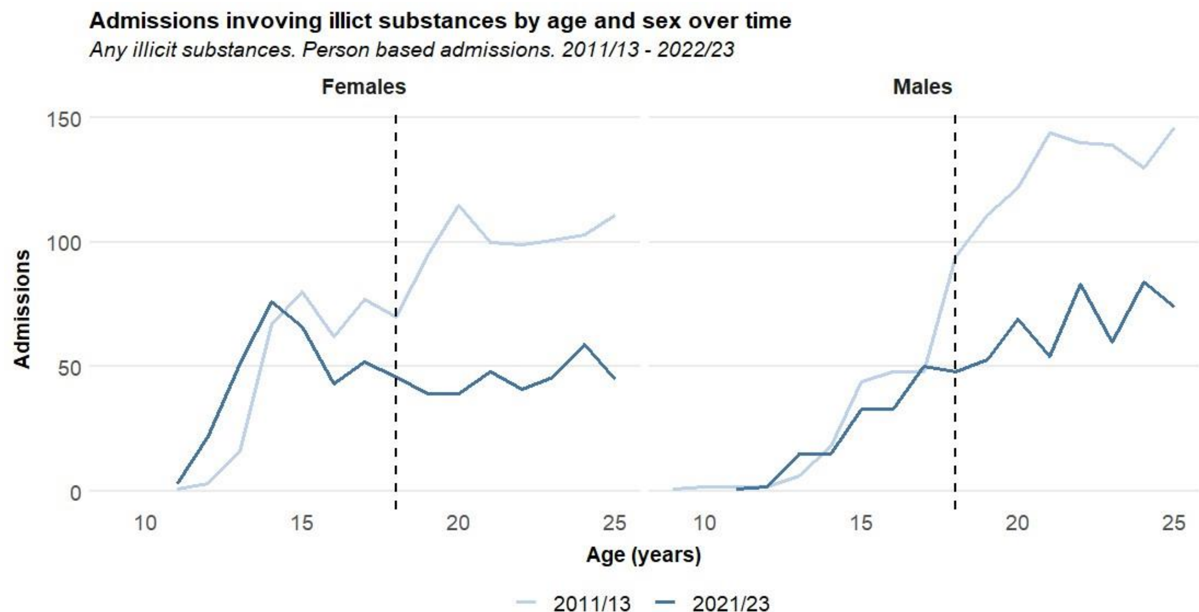
The number of individuals admitted to hospital rises, particularly in males, for those aged between 18 and 24 compared to the younger age cohort. However, admissions in this older age group have also decreased compared to 10 years ago (802 admissions in 2012/13 down to 228 in 2022/23).



[40] European Monitoring Centre for Drug and Drug Addiction (2018). RAPID COMMUNICATION - New psychoactive substances in prison. Results from an EMCDDA trendspotter study June 2018. Available at: [New psychoactive substances in prison (europa.eu)]

2.7.2 Illicit substance admissions in children and young people

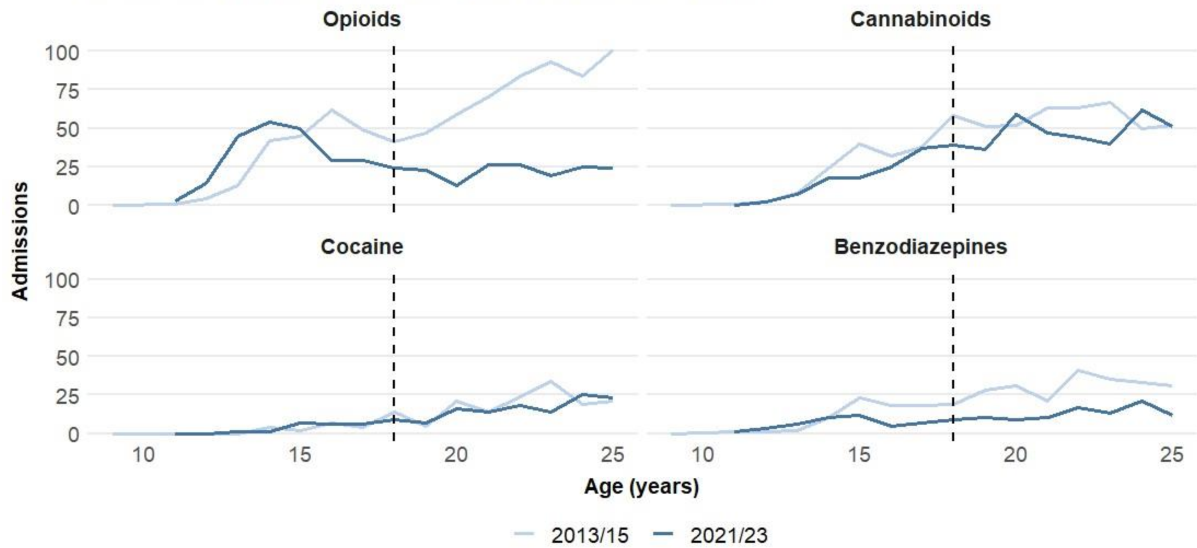
There were 321 admissions relating to illicit substances for individuals aged between 10 and 17 years in 2013/14 compared to 223 in 2022/23. The number of admissions for illicit substances in this age group have been higher than admissions for alcohol since 2013/14. As with admissions involving alcohol, there were a higher number of admissions for females than for males in this age group.



The most common substance group involved in admissions for children and young people (aged 10-17) were opioids (which includes common prescription only painkillers such as Codeine as well as Heroin) with 97 individuals admitted in 2022/23. Other common substance groups include cannabinoids[41] (55 individuals), benzodiazepines and cocaine.

As with alcohol, the number of admissions relating to illicit substances increases in the 18-24 age group compared to those under 18. There are also more males admitted than females in the age group (60 percent).

[41] No distinction can be made between cannabinoids and synthetic cannabinoid receptor agonists (SCRAs) a.k.a Spice, within the PEDW/hospital admissions data due to lack of specific ICD10 codes.



2.7.3 Substance use treatment assessments for children and young people.

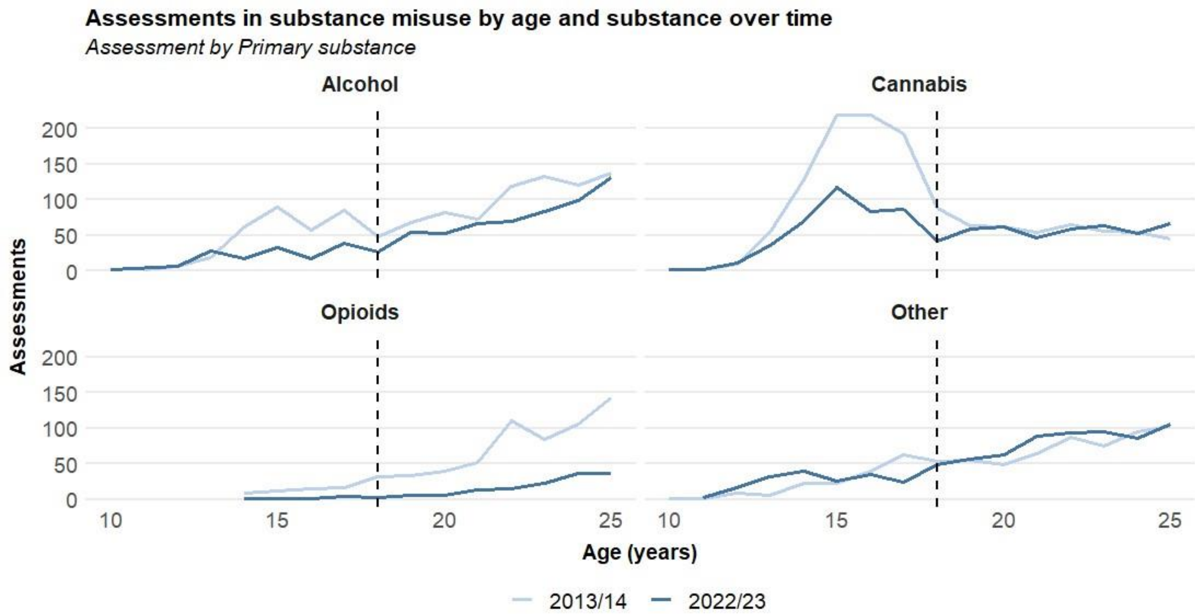
There were 1,013 assessments in substance use service for individuals under the age of 18 in 2013-15, and 727 assessments in 2022-23. There were more assessments involving males (59 percent, n = 601) than females[42]. Over the last 10 years, assessments have reduced by 47 percent, although the impact of the COVID-19 pandemic over the years 2020-22 on treatment service access should be recognised. The reduction is more pronounced in males (60 percent) compared with females (19 percent). There were 1,465 assessments in those aged 18-24 in 2022-23.

Excluding alcohol, the most common substance reported in assessments in 2022-23 was cannabinoids, reported in 49 percent of assessments among children and young people. Assessments involving alcohol have dropped by 38 percent in the last 10 years. Data from the Healthy Behaviour in School Age Children WHO collaborative study 2017/18[43] indicates that amongst 15 year olds in Wales, 35 per cent of girls and 31 per cent of boys reported having been drunk at least twice in their lifetime, second only to Denmark in prevalence on this measure.

---

[42] There were 3 individuals with an unknown gender

[43] Inchley J, Currie D, Budisavljevic S, Torsheim T, Jåstad A, Cosma A et al., editors. Spotlight on adolescent health and well-being. Findings from the 2017/2018 Health Behaviour in School-aged Children (HBSC) survey in Europe and Canada. International report. Volume 1. Key findings. Copenhagen: WHO Regional Office for Europe; 2020. Licence: CC BY-NC-SA 3.0 IGO. World Health Organisation: Spotlight on adolescent health and well-being



2.7.4 Drug and Alcohol deaths in children and young people.

In the 10-year period, from 2012 to 2022, there have been a total of 39 drug use deaths involving individuals aged under 18. These deaths have involved a range of drugs including heroin/morphine, other opioids including methadone, and Ecstasy. There have been a further 289 in those aged 18 to 24 years, involving a range of substances including heroin/morphine, Cocaine, Benzodiazepines and Ecstasy.

In the same period, there has been a total of three registered alcohol related deaths in children and young people aged up to 18, with a further 37 alcohol related deaths amongst those aged 18 to 24 years.

2.7.5 Crime survey for England and Wales

The Crime Survey for England and Wales (CSEW) publishes yearly the estimated prevalence of substance use in individuals aged between 16-24 years. It is noted that the data is not Wales specific therefore an element of caution is advised. Furthermore, due to the methods used in data collection, the survey may not be effective at capturing problematic use.

The proportion of young people (16-24 years) self-reporting use of illicit drugs in the last year has remained relatively stable over the past decade, with an average of 19% reporting any drug use and 7% reporting ‘Any class A’ drug use. Reported use of opioids in this population remains low. The CSEW[44] consistently reports younger people are significantly more likely to take drugs than older adults.

---

44 Office for National Statistics (2023) Drug misuse in England and Wales: year ending March 2023. Available at: Crime in England and Wales - Office for National Statistics (ons.gov.uk)

2.7.6 Impact of substance use on Children and Young People

Among young people, early initiation into alcohol use has been shown to be linked to later binge drinking, heavy drinking and alcohol-related problems[45] in prospective longitudinal studies. [46,47, 48]

Meta-analyses show that regular cannabis use in adolescence approximately doubles the risks of early school-leaving and of cognitive impairment and detrimental impact on cognition and educational outcomes[49]. In addition, regular cannabis use in adolescence is strongly associated with the use of other illicit drugs. There is a consensus that interventions should primarily aim to reduce or delay first use or prevent the transition from experimental use to dependence.

In relation to psychoactive substances, young people are considered to be at high risk, not necessarily because they are at greater risk from acute harms but because use in this stage of development may establish future drug behaviours, may lead to more years of ill health, and they may not have developed the resources to 'self-manage' their drug use.[50]

2.7.7 Diverse drug use and markets

As evidenced from the samples submitted by individuals of age 25 and under to WEDINOS (Welsh Emerging Drugs and Identification Novel Substances) harm reduction and analytical service, the range of substances consumed by this age group is very diverse including amphetamine, cannabinoids, cocaine, heroin and MDMA, as well as hallucinogens. NPS from the depressant, stimulant and hallucinogenic substances categories were also identified; as were synthetic cannabinoid receptor agonists, prescription-only medications, and IPEDs.

---

45 Kandel D and Kandel E. The Gateway Hypothesis of substance abuse: developmental, biological and societal perspectives. Acta Paediactrica. 2015. 104 (2); 130-137.
46 Moss HB, Cheng CM & Yi H. Early adolescent patterns of alcohol, cigarettes, and marijuana polysubstance use and young adult substance use outcomes in a nationally representative sample. Drug and Alcohol Dependence. 2014. Vol 136: 51-62. https://doi.org/10.1016/j.drugalcdep.2013.12.011
47 Trenz RC, Scherer M, Harrell P, Zur J, Sinhar A, Latimer W. Early onset of drug and polysubstance use as predictors of injection drug use among adult drug users. Addictive Behaviours 2012. Vol 37 (4); 367-372. https://doi.org/10.1016/j.addbeh.2011.11.011
48 Winters KC & Lee CS. Likelihood of developing an alcohol and cannabis use disorder during youth: Association with recent use and age. Drug and Alcohol Dependence. 2008. Vol 92 (1–3); 239-247. https://doi.org/10.1016/j.drugalcdep.2007.08.005
49 Hall W. What has research over the past two decades revealed about the adverse health effects of recreational cannabis use? Addiction. 2014. Vol 110(1); 19-35. https://doi.org/10.1111/add.12703|
50 European Monitoring Centre for Drugs and Drug Addiction, *Health responses to new psychoactive substances,* Publications Office of the European Union, Luxembourg (2016)

2.7.8 Young People and Offending

Young people risk contact with criminal justice services, specifically the Youth Justice System, due to use of illegal substances, through acquisitive crime to fund substance use and/or through behaviours whilst under the influence of substances. This contact may result in a permanent criminal record, with implications for future employment and economic opportunities as well as potential restrictions on travel. Children and young people are also at increased risk of involvement in serious crime and exploitation, including violence, through the emergence of county lines.

In 2022-23, approximately 13,700 children and young people were cautioned or sentenced following committing an offence in England and Wales.[51] Over the last 10 years the number of children and young people formally entering the Youth Justice System has fallen by 72 percent, with increasing numbers of individuals being diverted into community restorative disposals, or 'prevention' work facilitated by the Youth Offending Service (YOS). Due to the non-statutory nature of such disposals, currently no formal or central data system exists to indicate the volume of children and young people receiving such support and the nature of support provided.

A similar trend is also observed in the number of children and young people entering youth custody, where the average monthly population observed in year ending 2023 was 440 individuals, compared to 860 held in custody each month in 2019. Amongst the 34,300 proven offences that were committed by children and young people in 2022-23, with decreases recorded in drugs offences in the last year.

Routine reporting and publication of health and social care needs (including substance use and mental health) is limited for those children and young people receiving youth justice support. This highlights a knowledge gap in relation to support requirements and the changing nature of substance use and related harms amongst this population. Past prevalence estimates have indicated high levels of substance use amongst children and young people attending Youth Offending Team (YOT) services across England and Wales[52] stating;

- 91% ever used alcohol.
- 86% ever used cannabis.
- 44% ever taken ecstasy.
- 25% ever used cocaine.
- 11% ever used heroin.

---

51 Ministry of Justice (2024). Youth justice statistics: 2022 to 2023. Available at: Youth Justice Statistics: 2022 to 2023

52 Home Office (2003). Substance Use by Young Offenders. Available at: Substance use by young offenders: the impact of the normalisation of drug use in the early years of the 21st century (drugsandalcohol.ie)

Furthermore, smaller studies have highlighted both high and complex health and social care needs amongst cohorts of children and young people with higher rates of recidivism, indicating as many as 95 percent demonstrate ongoing substance use issues[53], along with high prevalence rates of abuse/neglect, experience of trauma, witnessing family violence, and requiring social services support.

53 Youth Justice Board Cymru (2012). Profiling Young People with prolific offending histories

3 Pathway for integrated substance use service provision

3.1 Prevention, early engagement and outreach

3.1.1 Prevention – population level approaches

Universal prevention approaches aim to identify and address risk factors and prevent exposure and onset of use,[54] through the provision of population-level interventions and, for Young People, through universal prevention education within school settings and the Whole School Approach.[55] Whilst, the evidence for effective, acceptable, and cost effective universal drug use prevention interventions aimed at Young People is limited,[56,57] and approaches using fear, scare-mongering, and information provision alone ('drug education') do not produce beneficial outcomes, certain components including life skills and exploring normative beliefs appear effective.[58,59]

There is clear evidence to indicate that prevention approaches relying on stand-alone mass media and education campaigns are ineffective.[60] Mass media campaigns should, therefore, only be delivered as part of multi-component programmes to support school-based prevention. Clear definitions and common language are essential to ensure consistent and equitable approach to prevention and early engagement strategies.

3.1.2 Targeted Programmes

Targeted programmes aim to address the needs of Young People whose risk and protective factors impact on their vulnerability of using substances and moving from use to misuse, or problematic use resulting in acute or chronic harms. Evidence supports the need and validity of targeted, drug-specific prevention interventions for

---

[54] Toumbourou JW, Stockwell T, Neighbors C, Marlatt GA, Sturge J, Rehm J. Interventions to reduce harm associated with adolescent substance use. The Lancet. 2007;369(9570):1391-401

[55] Welsh Government and Education Wales. 2021. Framework on embedding a whole-school approach to emotional and mental well-being. WG42005 (gov.wales)

[56] NICE (2017). Drug misuse prevention: targeted interventions Drug misuse prevention: targeted interventions (nice.org.uk)

[57] Welsh Government (2018). Review of Working Together to Reduce Harm Review of Working Together to Reduce Harm (stir.ac.uk)

[58] Sneddon, H. (2015). LifeSkills substance misuse prevention programme: Evaluation of implementation and outcomes in the UK. Belfast: Barnardo's.

[59] European Monitoring Centre for Drugs and Drug Addiction (2017), Health and social responses to drug problems: a European guide, Publications Office of the European Union, Luxembourg. Available at: TI_PUBPDF_TD0117699ENN_PDFWEB_20171009153649.pdf (europa.eu)

[60] Brotherhood AB, Atkinson A, Bates G, Sumnall HR (2013) Adolescents as customers of addiction. ALICE RAP Deliverable 16.1, Work Package 16. Background report 2: Review of reviews. Liverpool: Centre for Public Health

those individuals considered to be at high risk of harm.[61] [62] Targeted approaches incorporate prevention strategies that focus on skill development and social interactions including with peers as well as selective interventions that draw on social and demographic indicators. These aim to identify potential additional risk and indicated prevention approaches which support dealing and coping with individual personality traits and psychopathology.[63] The United Nations Office on Drugs and Crime has undertaken a major systematic review of prevention,[64] as shown in figure 2, addressing the range of life-course stages and settings that should be incorporated along with a set of standards for drug use prevention.[65] In terms of 'what works', emphasis is placed on interventions aimed at development of broader resilience as these have been shown to be effective in relation to a wider range of risk factors and behaviours including truancy, sexual health, offending as well as substance use.

---

[61] Advisory Council on the Misuse of Drugs (2015). Prevention of drug and alcohol dependence. Briefing by the Recovery Committee

[62] NICE (2017). Drug misuse prevention: targeted interventions [Drug misuse prevention: targeted interventions (nice.org.uk)]

[63] Institute of Medicine (US) Committee on Prevention of Mental Disorders, Mrazek PJ, Haggerty RJ, eds. Reducing Risks for Mental Disorders: Frontiers for Preventive Intervention Research. Washington (DC): National Academies Press (US); 1994.

[64] United National Office on Drugs and Crime. Summary table of evidence-based strategies identified in the UNODC/ WHO International Standards on Drug Use Prevention – Second Updated Edition, PREPUBLICATION. VERSION: United Nations Office on Drugs and Crime, 2019. License: CC BY-NC-SA 3.0 IGO.

[65] UNODC/WHO International Standards on Drug Use Prevention. Second updated edition. Available at: International Standards on Drug Use Prevention

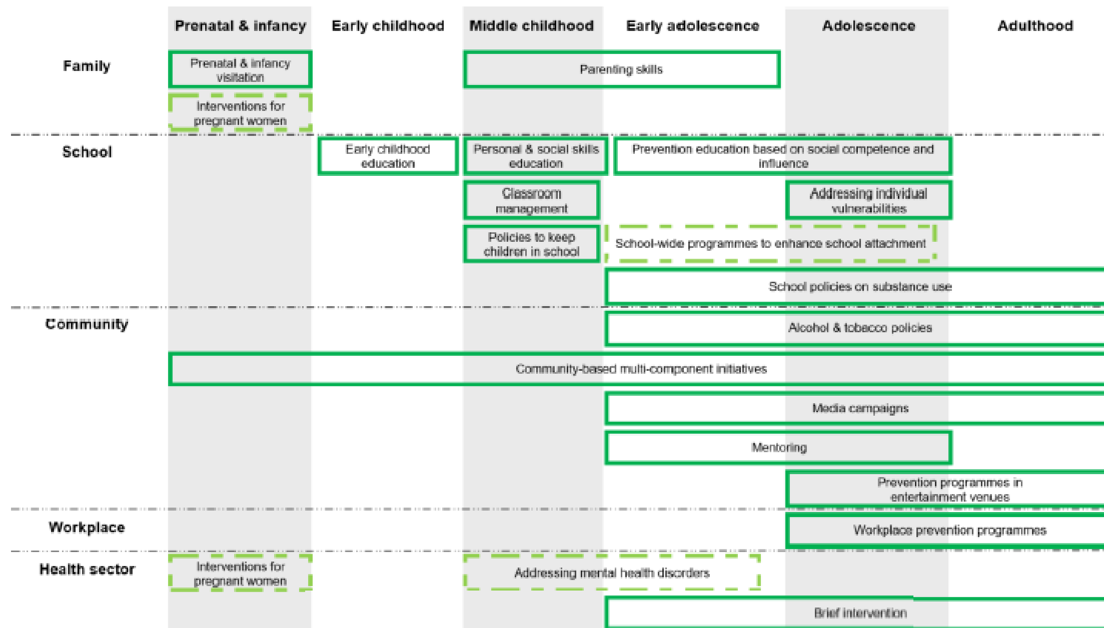


Figure 2 - Summary table of evidence-based strategies on drug use prevention, UNODC

There are two broad types of targeted programmes:
Firstly, targeted programmes focus on **mitigating multi-factorial risk factors and enhancing protective factors,** through addressing the holistic needs of the Young Person and comorbid biopsychosocial concerns.

Clear risk factors for future drug use have been identified as:

- Childhood maltreatment,
- Substance using peers
- Younger age at first cannabis [66]

Protective factor against future drug use:

- Positive attitude towards school[67]
- Positive and strong attachments, skills and resources (internal and environmental)[68]

---

[66] Public Health Wales (2020) What are the risk and protective factors for drug misuse? Full report and systematic review. Internal document.
[67] Public Health Wales (2020) What are the risk and protective factors for drug misuse? Full report and systematic review. Internal document
[68] European Monitoring Centre for Drugs and Drug Addiction (2009), Preventing later substance use disorders in at-risk children and adolescents: a review of the theory and evidence base of indicated prevention.

Risk and protective factors will vary between individuals, are complex, interdependent and cannot be considered in isolation. There should be sensitivity to this when devising and delivering targeted programmes.

The second type of targeted programmes are those focussing specifically on substances, use and associated harms including harm reduction approaches (see Section 3.3).

3.1.3 Early engagement services

The focus of services offering early engagement programmes is to delay or reduce the likelihood of young people moving from using to misusing substances, limiting the harms associated with use, and avoiding progression to dependency. Interventions provided by early engagement services are typically aimed at younger people who are at-risk of initiating or have used substances but to a low level of severity. Younger people whose needs have escalated beyond these levels usually require the specialist services of substance use treatment agencies.

Early engagement services should approach the provision of drug and alcohol programmes in accordance with the two broad types of targeted programmes. Services may include social inclusion programmes that offer a range of health and wellbeing services, for example, sexual health and relationship advice, psycho-social support services, skills and resilience training, sports and other diversionary activities. The goal of these programmes should be to provide a positive, adaptive and non-judgemental environment or service with evidence-informed interventions to meet the needs of young people. These services should support young people to remain positively engaged with their families/carers, education and the community.

To achieve this, early engagement services require the resources, capacity and capability to access a wide range of community services. Young people should have ready access to health (including mental health), education, housing and family support services. In addition, if the young person’s needs are identified as complex and require the input of specialist services, clear pathways and support should be in place to ensure timely and smooth transition into specialist services including those aimed at addressing mental health and wellbeing and substance use.

Thematic papers. Office for Official Publications of the European Communities, Luxembourg (available at: [Preventing later substance use disorders in at-risk children and adolescents | www.emcdda.europa.eu]).

3.1.4 Standards for prevention and early engagement interventions

European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) early drug prevention quality standards[69] [70] highlight the following core principles that should underpin all prevention and early engagement activities:

- Participants' rights and autonomy are respected.
- Provide real benefits for participants (i.e. ensuring that the programme is relevant and useful for participants).
- Intervention causes no harm or substantial disadvantages for participants
- Participants' consent is obtained before participation.
- Participation is voluntary.
- Interventions are tailored to participants' needs.
- Participants are involved as partners in the development, implementation, and evaluation of the programme.

Prevention and early engagement programmes should support the development of values, attitudes and skills that enable young people to make informed decisions regarding use of substances. In addition, effective prevention and early engagement approaches have been identified as:

- Factual and accurate.
- Non-judgmental.
- Interactive and participatory - motivating and confidence building
- Correcting of incorrect beliefs.
- Able to provide alternative discursive opportunities to challenge peer beliefs while giving value to Young Peoples' opinions.
- Relevant to Young Peoples' social realities.
- Innovative through employing a range of learning styles.

Policy makers, commissioners and service planners should ensure that prevention and early engagement programmes are delivered and structured around clear aims, goals and objectives.

Services / organisations should make a critical evaluation of materials to ensure that they are developed in collaboration with young people, do not contradict Young People's personal experiences or appear to be based on 'adults' exaggerations'.[71]

---

69 EMCDDA (2011). European drug prevention quality standards. European drug prevention quality standards (EDPQS) | www.emcdda.europa.eu
70 EMCDDA (2013). European drug prevention quality standards: a quick guide European drug prevention quality standards: a quick guide | www.emcdda.europa.eu
71 Jenkins et al. Developing harm reduction in the context of youth substance use: insights from a multi-site qualitative analysis of young people's harm minimization strategies. Harm Reduction Journal, 2017; 14:53

3.1.5 Digital technologies and online generation

According to European-wide data on sources of information of illicit drugs and drug use, the internet is the most-mentioned source of information reported by 59 percent of young people, followed by friends (36 percent), doctors, nurses or health professionals (31 percent), parents or relatives (25 percent), or specialised drugs counsellors or centres (21 percent). Relatively few respondents would turn to the police (13 percent), the media (10 percent), someone at school or work (9 percent), social or youth workers (7 percent), or a telephone helpline (4 percent).[72] Use of digital technologies and social media can allow prevention and early engagement interventions to be offered to a broad range of young people, including those who are either unable or choose not to access services, and can offer anonymity.[73] However, the evidence surrounding both the effectiveness and cost-effectiveness in reducing drug use amongst children and young people using such means is still limited.

3.1.6 Multi-disciplinary and multi-agency service provision

Health harming and risk behaviours in young people such as drug and/or alcohol use, smoking and risky sexual behaviour may co-occur and multiple risk behaviours are associated with adverse outcomes, poorer emotional wellbeing and fatal and non-fatal injury. [74, 75] There is a strong and growing evidence base indicating that interventions for multiple health behaviours are effective and cost-effective[76] [77] suggesting a more efficient means of preventing or reducing risk behaviours in young people may be achieved than from single risk factor approaches (i.e. drugs only). Best practice examples of engagement services in Wales have demonstrated effective integrated multi-disciplinary and multi-agency approaches with a wide range of existing statutory, voluntary and private services, including:[78]

- Schools, youth organisations, and not in employment, education or training (NEET) services.

---

[72] Flash Eurobarometer 401, Young People and Drugs, European Commission, Brussels, 2014
[73] NICE (2017). Drug misuse prevention: targeted interventions Drug misuse prevention: targeted interventions (nice.org.uk)
[74] Hale DR, Viner RM (2012) Policy responses to multiple risk behaviours in adolescents. Journal of Public Health 34 (S1): 11-19
[75] Khadr SN, Jones KG, Mann S, et al. Investigating the relationship between substance use and sexual behaviour in young people in Britain: findings from a national probability survey. BMJ Open, 2016; 6:e011961. doi:10.1136/bmjopen-2016-011961
[76] Prochaska JJ, Spring B, Nigg CR (2008). Multiple health behaviour change research: an introduction and overview. Prev Med 2008;46:181-8
[77] Werch CE, Moore MJ, Bian H, DiClemente CC, Huang I-C, Ames SC, Thombs D, Weiler RM, Pokorny SB (2010). Are effects from a brief multiple behaviour intervention for college students sustained over time? Preventive Medicine, 50, 30-34
[78] Substance Misuse Treatment Framework: Integrated substance misuse service provision for children and young people - Stakeholder Day (March 2019)

- Health services, such as primary care, community-based health services, mental health, sexual and reproductive health, drug and alcohol, and school nursing and health visiting services.
- Specialist services for people in high-risk groups (e.g. looked after children / care leavers, young carers, asylum seekers, those who are, or are at risk, of homelessness).
- Community-based criminal justice services, including adult, Youth Offender Service, and family justice services.
- Acute health settings e.g. accident and emergency services.

A multi-disciplinary and multi-agency approach requires additional training and support for the workforce across the services on how to deliver education about substances and the dissemination of consistent harm reduction messaging (see *Section B Training and workforce development*).

Multi-disciplinary and multi-agency early engagement activities should not be confined to fixed base/offices or educational facilities. They should also be available at sites and venues that young people using substances or at risk of using substances frequent as well as street-based outreach.[79] Settings should include, but are not limited to:

- Nightclubs, festivals and organised events.
- Wider health services, such as sexual and reproductive health services or primary care.
- Parks and recreational areas.
- Supported accommodation or hostels for people without permanent accommodation.
- Gyms, to target young people who are taking, or considering taking, IPEDs and other substances.

Delivery of prevention and early engagement activities from a broad range of sites and venues increases accessibility and provides an opportunity to engage the hard-to-reach young people who are most at risk, such as those who are not in employment education or training, looked after or on the edge of care.

---

[79] Substance Misuse Treatment Framework: Integrated substance misuse service provision for children and young people - Stakeholder Day (March 2019)

3.1.7 Considerations for engagement with specific groups

3.1.7.1 Considerations when engaging young people from Black, Asian and Minority Ethnic Communities

Black, Asian and Minority Ethnic communities is a term used to describe people who are from a non-white British background, however, it must be acknowledged that this term does not capture the diverse cultural differences that exist within these communicates including differences between generations, genders and religions.[80] Cultural differences may influence the substances used and their acceptability, for example, Khat use amongst some Somali and Yemeni communities has been used socially, as a way to pass time and a concentration aid. Furthermore, cultural differences may also influence an individual's willingness to come forward and seek support or treatment. For example, in some South Asian and Chinese communities, the stigma attached to drug use is not just directed towards the user, but also their whole family, leading potentially to concealment and denial of use.[81]

With this in mind, substance use treatment services should endeavour to develop working relationships with specialist ethnic minority services, or in areas where there is a very high ethnic minority populations, specialist ethnic minority services should be commissioned. This integrated working should ensure cultural sensitivity and access to multi-lingual services (relevant to the local community needs), while possibly addressing some of the barriers to accessing services.[82]

Multi-lingual and culturally competent services should provide harm reduction messages and substance education in a variety of formats from oral, written to visual media to make them as accessible as possible. [83, 84] In addition, public information should be available to ensure local knowledge and awareness of the range and value of substance use services that are available. Many ethnic minority community members may source information from their GPs, family and friends, religious or community leaders and community organisations. Professionals within substance

---

[80] Issues in treatment recovery, Treatment and recovery: Black and Minority Ethnic Communities; Adfam; 2015; http://www.recovery-partnership.org/uploads/5/1/8/2/51822429/regional_roundtable_treatment_and_recovery_in_bme_communities.pdf [accessed 7th August 2020]

[81] The Impact Of Drugs on Different Minority Groups: A Review Of The UK Literature, Part 1: Ethnic groups; UK Drug Policy Commission; July 2010; Evidence review - The impact of drugs on different minority groups_ ethnic groups.pdf (ukdpc.org.uk) [accessed 7th August 2020]

[82] Working together: Helping to support and transform the lives of people affected by drug and alcohol problems; Local Government Association; 22 29 Substance Misuse Case Studies_05WEB.pdf (local.gov.uk) [accessed 7th August 2020]

[83] Drugs and Diversity: Ethnic minority groups, Learning from the evidence; UK Drug Policy Commission; Policy report - Drugs and diversity_ ethnic minority groups (policy briefing).pdf (ukdpc.org.uk) [accessed 7th August 2020]

[84] Welsh Government. Health and wellbeing of refugees and asylum seekers: guidance for health boards. Health and wellbeing of refugees and asylum seekers: guidance for health boards | GOV.WALES

misuse services should therefore endeavour to link in with members of the range of relevant groups and peers to support awareness and engagement.[80]

Evidence indicates that members of the ethnic minority community find treatment services less accessible than other members of the population[85] should they decide to seek them out, given the culturally accepted drug use or stigma. Members of ethnic minority communities suggest that services should be delivered at a wide variety of venues including:

- schools and community centres.
- youth clubs, colleges and universities.
- gender-specific venues may be important for some groups.[86]

This is supported by service providers, who recommend proactively reaching out to community organisations and providing outreach services, in order to increase visibility and access. Visible services should provide information to community leaders, relating to the substance use support available, thus ensuring that they are able to direct those experiencing drug and/or alcohol and related issues to the appropriate services.

3.1.7.2 Engagement and service provision for children and young people who identify as LGBTQ+

LGBTQ+ is an inclusive term used to describe people who identify as lesbian, gay, bisexual, transgender, questioning and plus which allows representation of other sexual identities including pansexual and asexual. Evidence indicates that LGBTQ+ young people are at greater risk of substance use and dependence, and almost twice as likely to use drugs and alcohol compared to heterosexual peers.[87] Increased vulnerability and risk is associated with drug use are compounded by experiences of bullying and harassment, negative and adverse disclosure reactions, barriers to access support and stigma.[70]

Substance use services should be inclusive of, and culturally sensitive to, people who identify as LGBTQ+ and service provision should be equitable for those who identify as LGBTQ+. Staff should be provided with appropriate training to increase confidence, awareness and capacity to ensure care provision is responsive and tailored to individual needs. Furthermore, referral pathways to appropriate Gender

---

[85] Substance Misuse Treatment Framework Health and Wellbeing Compendium; Welsh Government; substance-misuse-treatment-framework-health-and-wellbeing-compendium.pdf (gov.wales) [accessed 7th August 2020]

[86] Advisory Council on the Misuse of Drugs (2015). Prevention of drug and alcohol dependence. Briefing by the Recovery Committee.

[87] Marshal MP, Friedman MS, Stall R, King KM, Miles J and Gold MA, Bukstein OG, Morse JQ (2008). Sexual orientation and adolescent substance use: a meta-analysis and methodological review. Addiction, 103, 546-56

Services should be in place to meet identified needs and facilitate holistic care provision.

3.1.7.3 Engagement and service provision for Children and Young People on the edge of care

Own or parental substance misuse, mental health issues, domestic abuse, involvement in gangs or a combination of these are the primary factors for a young person being placed into care. Taking a young person into care can have a significant impact on them, their family and their community. The primary aim of services is to keep Young People safely with their families and within their own community.[88]

Edge of care services are designed to offer support and interventions at a time of family crisis or breakdown, to both young people and the wider family; with the aims of managing risk, improving parenting and working towards keeping families together where it is safe to do so.[89] Edge of care services not only provide early interventions for young people, but should be available for the whole family. Successful edge of care service provision is supported by key factors such as:

- Multi-agency working.
- Clear referral pathways.
- Individual Young Person and family centred approach.
- Building Young Person and family resilience.
- Robust assessment of risk and protective factors.
- Comprehensive care and exit planning.[90]

Reviews of the evidence base for family intervention programmes and troubled families programmes highlight the need for:

- A dedicated care worker per family.
- High quality skilled staff.
- A proactive approach.
- Staying involved with the family for as long is necessary.[91]

---

[88] On the edge of care: Keeping vulnerable young people safely in the community; Local Government Association; September 2018; On the edge of care: Keeping vulnerable young people safely in the community | Local Government Association [accessed 11th August 2020]

[89] | Worcestershire County Council [accessed 11th August 2020]

[90] Edging away from care – how services successfully prevent young people entering care; OFSTED; October 2011; Microsoft Word - Edging away from care - how services successfully prevent young people entering care.doc (publishing.service.gov.uk) [accessed 12th August 2020]

[91] Supporting Adolescents on the Edge of Care. The role of short term stays in residential care. An Evidence Scope; Dixon, J et al; May 2015; Supporting Adolescents on the Edge of Care : The role of short term stays in residential care: an evidence scope (whiterose.ac.uk) [accessed 13/08/2020]

3.1.7.4 Young people at risk of involvement in county lines

The UK Government defines county lines as:

> *"County lines is a term used to describe gangs and organised criminal networks involved in exporting illegal drugs into one or more importing areas within the UK, using dedicated mobile phone lines or other form of "deal line". They are likely to exploit children and vulnerable adults to move and store the drugs and money and they will often use coercion, intimidation, violence (including sexual violence) and weapons."*[92]

County lines can affect any child, male or female, under the age of 18, or any vulnerable adult over the age of 18.[93] The UK Government's primary objective in relation to youth justice is to recognise and promote the safeguarding of children; seeing a child first and offender second. All work undertaken by a professional should be child-focused and child-centred.

County lines cases are extremely varied and need to be handled on a case-by-case basis. A child or young person involved in county lines may be an exploited victim rather than a perpetrator and as such are entitled to the same safeguarding and protection as any other child. Child Criminal Exploitation is a term that is becoming increasingly used to describe children involved in county lines, although it is far broader than that. Although there is no legal definition the UK Government describes Child Criminal Exploitation as:

> *"Child Criminal Exploitation is common in county lines and occurs where an individual or group takes advantage of an imbalance of power to coerce, control, manipulate or deceive a child or young person under the age of 18. The victim may have been criminally exploited even if the activity appears consensual. Child Criminal Exploitation does not always involve physical contact; it can also occur through the use of technology."*[94]

Professionals should also be aware of the prevalence of Child Sexual Exploitation of both boys and girls within the context of county lines. The Department for Education, Child Sexual Exploitation: Definition and a guide for practitioners, local leaders and decision makers working to protect children from child sexual exploitation definition is:

> *"Child sexual exploitation is a form of child sexual abuse. It occurs where an individual or group takes advantage of an imbalance of power to coerce, manipulate or deceive a child or young person under the age of 18 into sexual*

---

[92] County Lines Exploitation, Practice guidance for YOTs and frontline practitioners (page 4); Ministry of Justice; October 2019

[93] Criminal Exploitation of children and vulnerable adults: County Lines guidance; Home Office, September 2018

[94] County Lines Exploitation, Practice guidance for YOTs and frontline practitioners (page 5 and 6); Ministry of Justice; October 2019

activity (a) in exchange for something the victim needs or wants, and/or (b) for the financial advantage or increased status of the perpetrator or facilitator. The victim may have been sexually exploited even if the sexual activity appears consensual. Child sexual exploitation does not always involve physical contact; it can also occur through the use of technology."

The Ministry of Justice's County Lines Exploitation, Practice Guidance for Youth Offending Teams and frontline practitioners outlines several indicators that a child may be being exploited through county lines that professionals should be aware of. These may include:

- Persistently going missing from school or home and/or being found out-of-area;
- Unexplained acquisition of money, clothes, or mobile phones; and
- Excessive receipt of texts or phone calls and/or having multiple handsets.

Any professional working with a young person who they think may be at risk of county lines exploitation should follow their local safeguarding guidance. This information should be shared with local authority social services. If a young person in believed to be in immediate risk of harm, the police should be contacted. If services or professionals believe that a young person has come from another area, this information should be shared within any referral to enable liaison with the relevant safeguarding agencies, as the home area retains responsibility for the Young Person, wherever they are found. [95]

3.1.7.5 Children and young people at risk of homelessness

Young people at risk of homelessness, vulnerably or unstably housed are also at risk of a range of other risk factors including exclusion from school and exploitation by older people. There is clear evidence that the majority of young people who have been homeless will have had traumatic experiences with adults early in their lives and lack supportive and trustworthy adults, teachers and other significant mentors to support healthy relationship building, decision-making and emotional skills.[96] International studies have found low rates of school completion in young people experiencing homelessness due to a combination of undiagnosed learning difficulties, mental health conditions, trauma or harmful substance use issues.[97] Substance use and allied services should ensure clarification and verification of

---

[95] Ministry of Justice. County Lines Exploitation – Practice guidance for YOTs and frontline practitioners. 2019. Available at: [A Guide to Coroner Services for Bereaved People (publishing.service.gov.uk)]

[96] Keats, H. Maguire, N. Johnson, R. and Cockersell, P. (2012) Psychologically informed services for homeless people Good Practice Guide. London: Communities and Local Government.

[97] Valdebenito, S. Eisner, M. Farrington, D. P. et al. (2019) What can we do to reduce disciplinary school exclusion? A systematic review and meta-analysis. J Exp Criminol 15, 253–287. Accessed at: https://doi.org/10.1007/s11292-018-09351-0

secure housing status and safety where possible, with clear processes to regularly monitor and address the potential for vulnerable or insecure housing, including reliance on ‘sofa-surfing’ and staying with friends longer term. Ensuring stability of housing improves social functioning and promotes engagement and retention in substance use, mental health, criminal justice and allied services.[98]

3.1.8 Referrals and sharing of information

3.1.8.1 Referrals to specialist services

All services working with children and young people should be made aware and trained in the appropriate local referral processes and pathways for specialist services aimed at providing treatment and support for substance use and mental health needs. Referrals should be made in line with the child and young person’s capacity to consent, and parental consent where required.

3.1.8.2 Child protection and safeguarding

At an early stage, professionals working with children and young people engaged in risk behaviour should determine whether they need to involve additional services and support e.g. Social Services. All individuals working with children and young people should have received training to assist them to identify indicators that a child may be ‘in need’, where there are child protection concerns or carer responsibilities, and how to refer appropriately.[99]

Local authority Children’s social services, along with other agencies, have responsibilities towards all children whose health or development may be impaired without the provision of services, or who are disabled (defined in section 17 of the Children Act 1989 as Children ‘in need’). All agencies with such a responsibility should:

- Agree with Local Safeguarding Children Board partners criteria with local services and professionals as to when it is appropriate to make a referral to local authority Children’s social services in respect of a child in need;
- Have an agreed format for making a referral and sharing the information recorded.

Where services believe that a child may be suffering, or may be at risk of suffering significant harm, such concerns should be raised as soon as possible to the local authority Children’s social services. Professionals should seek to discuss any concerns with the child’s parent or caregiver with the view to obtain consent to

---

[98] Clinical Guidelines on Drug Misuse and Dependence Update 2017 Independent Expert Working Group (2017) Drug misuse and dependence: UK guidelines on clinical management. London: Department of Health

[99] National Assembly for Wales (2014). Social Services and Well-being (Wales) Act 2014. Social Services and Well-being (Wales) Act 2014 (legislation.gov.uk)

making a referral. However, this should only be done where, in professional judgement, such discussion will not place a child at increased risk of significant harm.

Appropriate sharing of information about cases of concern will enable organisations to consider jointly how to proceed in the best interests of the child and to safeguard children more generally. Further guidance on inter-agency information sharing is given in Safeguarding Children: Working together under the Children Act 2004. [95,100]

3.2 Effective assessment and integrated care planning

3.2.1 Background

Assessment and provision of specialist drug treatment for young people differs to treatment provision for adults. Differences are attributable to age, maturity and developmental factors, differing patterns of substance use, safeguarding and the requirements of legal frameworks.

The aim of specialist substance use assessment is to determine the needs of young people and to formulate a package of care and interventions to meet them, adapting as need changes over time. To achieve this, a comprehensive understanding of young people's lives must be achieved, including how they conduct their lives, what activities they are engaged in, who has an influence on them, how they perceive their lives and what aspirations they have. There are many influences, including and not limited to the use of substances, mental and physical health, educational achievements, and interpersonal relationships. Assessment and subsequent treatment and care for children and young people should be delivered in line with the Wales NHS Health and Care Standards.[101]

Implementation of an electronic unified and modular assessment tool across services in Wales working with children and young people aged up to <25 is required. At present, each sector of service provision is required to undertake an assessment of circumstance and need for each individual presenting for care and support, leading to duplication, inefficiencies, failure to provide integrated care and potentially re-traumatising the child or young person and thus acting as a barrier to accessing support. Utilising available technological advances including WCCIS, and in line with information governance requirements, implementation of a unified assessment tool, with the record following the individual over geography and time will address these challenges.

---

[100] National Assembly for Wales (2006). Safeguarding Children: Working Together Under the Children Act 2004. basw_14350-5_0.pdf

[101] Welsh Government. 2015. Health and Care Standards. Available at Health standards framework english (wales.nhs.uk)

In addition, implementation of a unified national system would address the current knowledge gap in relation to support requirements and the changing nature of substance use and related harms amongst this population in Wales addressing the limited routine collation and reporting of health and social care needs (including substance use, mental health and wellbeing) for children and young people including those receiving youth justice support.

3.2.2 Approach

Comprehensive substance use and dependency assessment should be coordinated, comprehensive, timely and collaborative, with the individual fully involved. Involvement of parents and carers should be facilitated where possible and appropriate. The assessment should address substance use and behaviour, developmental needs, physical and mental health, risks and safeguarding, family functioning, educational attainment and any difficulties, vulnerabilities, resilience, resources and risks.

Assessments should be undertaken in a suitable, safe and private environment. In undertaking a young person's substance use assessment, a discursive, interactive approach should be used to understand the issues from the young person's perspective, whilst allowing the assessor to pass on information and advice. Important aspects of the process should include:

- Level of knowledge of substances and associated risks.
- Where, how and with whom they use substances.
- Methods of use and drug of choice.
- Whether substances are being used to control thoughts or behaviour.
- Understanding and expectations of how substance use affects their lives.
- Hopes and fears in relation to substance use and being drug and alcohol free.
- Goals in relation to their life, including their substance use.
- Is support available to help change their substance use behaviour?

It is important that services recognise the concept of language need and services should be aware of the 'Active Offer', a core principle of the Welsh Government's 'More than just words' strategy, which places a responsibility on health and social care providers to offer services in Welsh (rather than on the patient or service user to have to request them).

The substance use assessment process will often present opportunities for immediate intervention prior to the completion of the assessment process and the agreement of a substance use intervention plan. In many cases immediate intervention is vital to the prevention of substance related harm. Examples of immediate intervention can include:

- Involving other agencies in the assessment or intervention of the young person and their parent or carer.

- Providing harm reduction advice and information on less harmful ways to consume, reduce or stop taking substances.
- Focusing on the initiation of a prescribing intervention to reduce substance-related harm and to act as a gateway to other interventions.
- Using brief intervention techniques designed to encourage reflection on substance use.
- Using motivational interviewing techniques to increase engagement in the assessment and subsequent treatment process.
- Rapid referral to mental health assessment and services[102]

Improved assessment and treatment outcomes for young people will be achieved through collaborative and integrated service provision. Partnership working between organisations should be guided by the Children's and Young People's Plans (CYPP) as required by the Children's Act (2004).[103] The CYPP sets the strategic vision, priorities and targets that guide how services work collaboratively to improve the wellbeing of young people. It is fundamentally important that provision of substance use services, education, prevention and treatment, for young people is not seen as a distinct and separate activity from safeguarding and promoting a young person's welfare. Strengthening partnership and collaborative working with children services to safeguard and promote the welfare of young people is of paramount importance and in accordance with the Children's Act (2004).[104], [105]

3.2.3 Process of screening and comprehensive assessment

Assessment is the key process that initiates intervention and is a determinant of whether younger people and their families continue to access the services they are offered. In order to determine the needs of young people with substance use problems and formulate appropriate interventions a comprehensive picture of the young person's life is needed.

The screening and assessment process and definition of 'problematic' use of substances are different for young people. What constitutes 'problematic' can depend crucially upon the age of the child, the child protection context, the nature of parental involvement and responsibility and on developmental issues.[106] As such effective assessment processes should adopt a 'whole person' approach to take in to account all factors influencing and influenced by substance use and dependency. Factors indicating substance-related risk may include:

---

[102] Mental Health (Wales) Measure 2010. Mental Health (Wales) Measure 2010 (legislation.gov.uk)
[103] Safeguarding Children - Working Together Under the Children Act 2004
[104] Safeguarding Children - Working Together Under the Children Act 2004
[105] National Assembly for Wales (2014). Social Services and Well-being (Wales) Act 2014. Social Services and Well-being (Wales) Act 2014 (legislation.gov.uk)
[106] Department of Health (2017) Drug misuse and dependence UK Guidelines on Clinical management (7) p. 242-243).

- Previous overdose.
- Deliberate self-harm and suicidal ideation or history of attempted suicide.
- Childhood exploitation (e.g. sexual and/or criminal exploitation, county lines).
- Emerging or co-existing mental health conditions including psychosis, traumatic stress disorders.
- Neurodevelopmental disorders including autistic spectrum disorders, hyperactivity and attention deficit disorders.
- Learning disabilities.
- Co-existing physical health problems, both acute and chronic.

Assessment should include use of all substances including illicit psychoactive drugs and IPEDs, licit drugs including prescribed medications, Prescription Only Medications (POMs) not prescribed to the individual, Over-the-Counter medications (OTCs), and alcohol. Effective assessment facilitates effective short and long-term Integrated Care Planning (ICP) for the individual and all those involved in their care.

Where multiple agencies are involved, Children's Services should co-ordinate the case if the child is under their care. If this is not the case, a lead agency should be identified, ideally the one with greatest level of contact and positive relationship with the young person, and this decision clearly documented in order to ensure clarity for clients and families and carers. Involvement of families and carers are not only essential for good practice but are indicators of positive outcomes for the young person. Exceptions are when it is believed that a child may be suffering or be at risk of suffering harm where such discussion and agreement-seeking in respects of referring to social services might place the child or young person at risk of increased harm.

Currently no commonly agreed substance use assessment tool for young people exists in Wales, but a new tool is currently in development by Welsh Government.[107] Several appropriate and validated tools that can help in assessment are described in the Royal College of Psychiatrist practice standards.[108] For all young people aged under 18, initial screening can simply be sensitive, brief questioning about substance use (how often, what was used and in what context) or may be a more specific tool but above all any assessment and any interventions provided should be age appropriate with consideration for safeguarding issues, the competence of the child and the context. All individuals over 15 years of age should be offered extended brief

[107] Substance Misuse Treatment Framework: Integrated substance misuse service provision for children and young people - Stakeholder Day (March 2019)
[108] Royal College of Psychiatrists (2012) Practice standards for young people with substance misuse problems. London: Royal College of Psychiatrists

interventions,[109] and where dependence is identified then comprehensive assessment will be required also.[110]

The use of assessment tools such as Alcohol Use Disorders Identification Test (AUDIT) or Treatment Outcome Measures (TOPS) may provide prompts for further discussion of psychosocial issues.

A conventional checklist may not be the most effectual way to capturing strengths, risk or engaging young people in the care planning process. “Mapping” (including Node link Mapping) is a simple technique for presenting verbal information diagrammatically that has been shown to have positive benefits for counselling interventions, irrespective of the counselling style used. Creation of a visual map summarises the therapeutic issues and removes the focus on the young person. This can enable the development of the therapeutic relationship and enhance collaboration with the young person.[111]

Where substance dependency is established then the processes outlined in 3.4 *Pharmacological support and treatment for dependency* should be followed in conjunction with NICE Clinical Guidelines and Drug Misuse and Dependence UK Guidelines on Clinical management.[112]

3.2.4 Risk and support assessment

As part of the risk management and risk reduction framework, substance related risks need to be identified and links to other health practitioners be made for those requiring support with general health matters or Children and Adolescent Mental Health Services (CAMHS) specialist interventions.
Factors indicating substance related risk may include:

- History of overdose, deliberate self-harm and attempted suicide.
- Substance use in risky contexts, for example in the presence of older people (e.g. parents, siblings, older partners), in association with sexual exploitation or risky sexual behaviour, in association with offending behaviour, in dangerous physical environments.
- Issues around dose, method of administration, or combinations of substances. For example, amounts and effects that indicate extreme intoxication, injecting,

---

[109] NICE (2007a) Drug misuse in over 16s: psychosocial Interventions. NICE clinical guideline 51. London: National Institute for Health and Care Excellence

[110] Department of Health (2017) Drug misuse and dependence UK Guidelines on Clinical management p. 242-243

[111] Department of Health (2017) Drug misuse and dependence UK Guidelines on Clinical management p.61-62

[112] Department of Health (2017) Drug misuse and dependence UK Guidelines on Clinical management p.245-247

direct inhalation of volatile substances (especially butane), poly-substance use, administration by another person.
- Co-existing mental health problems.
- Co-existing physical health problems (epilepsy, respiratory and heart conditions, pregnancy, interactions with prescribed medication).

Risk assessment is a dynamic process that requires review over agreed time frames or in response to change in circumstances. Furthermore, risk assessment should be holistic and incorporate assessment of strengths and protective factors.[113,114]

The young person's support needs, other than those related to substance use, should also be explored. If the young person is in contact with other agencies, the substance use assessment should be incorporated into the unified and modular assessment tool as part of a wider IPC. Within specialist services, young people should receive other health related advice including smoking cessation. If needle and syringe provision is required, a careful assessment of age and capacity, with frequent review, is advised to prevent escalation of risk.[115]

3.2.5 Cultural needs assessment

Wide ranging cultural needs should be determined at the earliest opportunity in order to facilitate effective communication and engagement with the individual. Services should also consider the 'Active Offer' of Welsh. An Active Offer simply means providing a service in Welsh without someone having to ask for it. It means creating a culture that places the responsibility on health and social care providers to provide a proactive language offer so that people can access care, as equal partners, through the medium of Welsh. Identification through the assessment process of a young person with specific cultural and complex social needs is particularly important as evidence indicates that failure to do so may result in early disengagement from treatment and support if these needs are not met.[111] Specific cultural needs may include differing perceptions to health and illness, language, experience of trauma, cultural identity, gender and sexuality and societal norms, values, beliefs and attitudes.[116,117]

---

[113] Department of Health (2017) Drug misuse and dependence UK Guidelines on Clinical management

[114] Public Health Wales (2020) What are the risk and protective factors for drug misuse? Full report and systematic review.

[115] Clinical Guidelines on Drug Misuse and Dependence Update 2017 Independent Expert Working Group (2017) Drug misuse and dependence: UK guidelines on clinical management. London: Department of Health. p244

[116] Welsh Government. Health and wellbeing provision for refugees and asylum seekers. health-and-wellbeing-provision-for-refugees-and-asylum-seekers_0.pdf (gov.wales)

[117] Welsh Government. 2015. Travelling to Better Health- Policy Implementation Guidance for Healthcare Practitioners on working effectively with Gypsies and Travellers travelling-to-better-health.pdf (gov.wales)

3.2.6 Assessment of comorbidities, including mental health, and learning disabilities

Substance use, especially persistent and dependant use can all cause or exacerbate existing mental health problems and impact on treatment of such problems[118]. Spotting the signs of a mental health problem and providing help as soon as possible is important. It is therefore important that all young people with drug and alcohol problems are offered and receive a comprehensive assessment of their mental health by a competent health professional. These may include but are not restricted to, issues of self-harm, neurodevelopmental concerns such as autistic spectrum disorders, hyperactivity and attention deficit disorders, learning difficulties, emerging personality issues, or cognitive impairment.

NICE Guidelines[119] require that healthcare professionals in all settings, including primary care, CAMHS and accident and emergency departments, and those in prisons and criminal justice mental health liaison schemes, should routinely ask adults and young people with known or suspected psychosis about their use of alcohol and/or prescribed and non-prescribed (including illicit) drugs. If the person has used substances, ask them about all the following:

- Particular substance(s) used.
- Quantity, frequency and pattern of use.
- Route of administration.
- Duration of current level of use.

The Department of Health and Social Care[120] outlines further “The mainstay of the treatment for comorbidity is addressing the range of a Young Person’s identified personal, family, health and social care needs within which the substance use is occurring and maintaining carefully coordinated care. The treatments for comorbid mental disorders will vary but are mainly psychological, e.g. Cognitive Behavioural Therapy for depression”.

Generally, psychosocial interventions should, as for adults, involve motivational and engagement techniques, including building a therapeutic alliance, to work collaboratively with the young person and their family. The range of specific psychosocial interventions that are used for adults may be relevant for some young

[118] Clinical Guidelines on Drug Misuse and Dependence Update 2017 Independent Expert Working Group (2017) Drug misuse and dependence: UK guidelines on clinical management. London: Department of Health
[119] National Institute for Health and Clinical Excellence (2011) Nice Guidelines Recognition of psychosis with coexisting substance misuse state
[120] Clinical Guidelines on Drug Misuse and Dependence Update 2017 Independent Expert Working Group (2017) Drug misuse and dependence: UK guidelines on clinical management. London: Department of Health p.247

people. Individual Cognitive Behavioural Therapy should be available for those with certain comorbidities in line with the established evidence base.[121,122]
It is recognised that some young people may also require pharmacological treatments such as for Attention Deficit Hyperactive Disorder or major psychotic disorders. Where mental health treatment occurs, this will often involve paediatric services and CAMHS. Active communication and coordination with those providing interventions in young people's substance use services is therefore essential in supporting both the Young Person and those delivering psychological support.

3.2.7 Trauma informed assessment and care planning

The assessment and care planning process should be sensitive to an individual's potential exposure to trauma, in line with the recently published Trauma Informed Wales Framework. The all-society Framework has been developed by Public Health Wales and Traumatic Stress Wales to support a coherent, consistent approach to developing and implementing trauma-informed practice across Wales, providing the best possible support to those who need it most. Traumatic experiences are events or an event that an individual experienced as causing emotional or physical harm. Trauma can have a pervasive and detrimental impact on a young person's cognitive, emotional and social functioning and developmental progress.[123] These symptoms may impact on the ability of a young person to engage with services and treatment outcomes.[124] Appropriate process should be in place to ensure access to and timely provision of specialist intervention if needed.[125]

Trauma-informed approaches training should be provided to staff across services to ensure development of necessary competencies. Enabling staff to recognise and work effectively with trauma symptoms and behaviours, to promote inclusion and facilitate positive change within the young person. Appropriate supervision and support should be provided with an awareness and sensitivity to symptoms of secondary traumatic stress (see workforce development).[126]

---

[121] National Institute for Health and Care Excellence (2011a) Diagnosis, assessment and management of harmful drinking and alcohol dependence. NICE clinical guideline 115
[122] Clinical Guidelines on Drug Misuse and Dependence Update 2017 Independent Expert Working Group (2017) Drug misuse and dependence: UK guidelines on clinical management. London: Department of Health p.244
[123] Marusak, HA, Martin, KR, Etkin, A et al. (2015). Childhood trauma exposure disrupts the automatic regulation of emotional processing'. Neuropsychopharmacology, 1250-58.
[124] Department of Health (2017) Drug misuse and dependence UK Guidelines on Clinical management p.41
[125] National Institute for Health and Care Excellence (NICE). NG116. Post-traumatic stress disorder.
[126] Department of Health (2017) Drug misuse and dependence UK Guidelines on Clinical management p.42

3.2.8 Assessment within Youth Justice Services

3.2.8.1 Young people referred under 'Youth Caution' or higher statutory intervention order

All Welsh YOTs employ the YJB-approved ASSET Plus assessment tool for young people who have offended where they meet the threshold for a Youth Caution or higher statutory intervention. In practice this means any child or young person who receives a Youth Caution, Youth Conditional Caution or any form of Court Order.

ASSET Plus takes a holistic approach and takes account of risk as well as desistance factors; assessment will involve identifying risk and protective factors in a young person's life, alongside how each factor interacts with each other at different points in time.[127] [128][129] For example, there will be interactions between a young person's personal situation, their attitudes and their social setting.[130]
As part of the ASSET Plus framework a comprehensive substance use assessment has been established as part of a broader holistic assessment framework, enabling the assessor to develop a Comprehensive Intervention Plan. All required substance use work should integrate with the Intervention Plan but will typically be delivered by a specialist worker employed by (or working in conjunction) the YOS.

3.2.8.2 Young people referred for Community Restorative Disposal or 'Prevention' work

For young people referred to the Youth Offending System as part of less formal interventions such as a Community Restorative Disposal or 'Prevention' referrals there is no requirement from YJB for an ASSET Plus assessment to be completed. In such instances, contact with the Youth Offending System may be brief and timescales not practical for full completion of ASSET Plus. Due to an absence of a commonly agreed substance use assessment tool for children and young people in Wales[131] YOTs across Wales have developed a range of substance use assessment tools to meet their own service delivery needs. However, YOS should ensure screening and assessment conducted using such tools is delivered in line with the approach, screening and assessment, risk assessment, and ICP processes outlined previously in this section.

---

[127] Youth Justice Board (2008) Assessment, Intervention Planning and Supervision
[128] Case S. (2007) 'Questioning the "evidence" of risk that underpins evidence-led youth justice interventions', Youth Justice, 7; 91-105.
[129] Baker K, Kelly G, Wilkinson B. (2011). Assessment in Youth Justice, Bristol: The Policy Press.
[130] Youth Justice Board (2014) Asset Plus Rational, Revised 2014 p4. Available: Formal document (publishing.service.gov.uk)
[131] Welsh Government (2019). Substance Misuse Treatment Framework: Integrated substance misuse service provision for children and Young People - Stakeholder Day (March 2019)

3.2.8.3 Young adults (18-21 years) within youth offender services

The assessment processes for young people aged 18-25 years incarcerated in prison is currently outlined within *Substance Misuse Treatment Framework – Clinical pathway for the management of Substance Misuse in Prisons in Wales*[132]. Such processes should be undertaken in line with Welsh Government Substance Misuse Core Standards[133], where all services should complete substance use assessment using the WIISMAT tool which includes the NHS clinical alcohol assessment tool AUDIT. In line with the UK guidelines on clinical management of Drug misuse and Dependence[134], assessment should be undertaken across four domains: drug and alcohol use and dependence, physical and mental health, social functioning and forensic history, leading to the development of a person centred ICP.

3.2.8.4 Young People in contact with YOS with co-occurring needs

Effective care pathways should be in place at a local level to ensure that Young People in the YOS have access to the whole range of services, which includes those outside of the YOS, for which they have an assessed need. Young People's substance use services and Youth Offender Services should ensure that service provision is complementary. Furthermore, substance use services and YOS should develop and maintain effective working relationships with local services to ensure Young People's individual needs are met.

Youth justice services and CAMHS should ensure there are effective links with police and other appropriate criminal justice agencies to make sure those who have become disengaged from mainstream services can be identified and given the relevant care and support to enable them to lead crime free lives.

For YOTs to support young people in accessing treatment and services for identified mental health problems, co-occurring conditions and emotional and behavioural issues, a Health Board Mental Health Advisor role is needed. This role will support each YOT, aligned with Forensic CAMHS team, and strong links between CAMHS and YOTs to enable access to relevant help and support for young people identified at risk of offending and antisocial behaviour.

---

[132] Welsh Government (TBC – out to consultation). Substance Misuse Treatment Framework – Clinical pathway for the management of Substance Misuse in Prisons in Wales. See also New Standards for Mental Health Services in Prisons in Wales (also out to consultation).

[133] Welsh Government. Substance Misuse Service and System Improvement: National Core Standards for Substance Misuse Services in Wales. 2010. national-core-standards-for-substance-misuse-services-in-wales.pdf (gov.wales)

[134] Clinical Guidelines on Drug Misuse and Dependence: Independent Expert Working Group (2017). Drug misuse and dependence: UK guidelines on clinical management. London: Department of Health. Drug misuse and dependence (publishing.service.gov.uk)

3.2.9 Consent

3.2.9.1 Parental consent

Parental consent is a legal term that relates only to parents who are the "parental responsibility holders". Legislation clearly defines who this is, whether children are living with natural parents or "looked after". The parental responsibility holder should, wherever possible, consent to the young person's treatment or to information sharing. In some cases, young people may not want parents to know they are seeking assistance for substance use and their wishes should be considered – it may be possible for them to maintain confidentiality, and consent to treatment and information sharing.

3.2.9.2 Young People under 16 years of age

Children under the age of 16 can give their own consent to receive or decline health care, even in opposition to the views of their parent, if they can be demonstrated to be Gillick competent. Gillick competence refers to the legal right of a child aged under 16 years to consent to advice, medical examination and treatment if they are assessed by the health professional to have sufficient maturity and intelligence to understand the nature and implications of the treatment.[135] Any assessment of Gillick competence should be documented in the health care record.[136]

3.2.9.3 Young People aged 16 years of age or above

Young people aged 16 can give their consent to health care. At 16 years they must be engaged directly in decisions about their health care, and especially involved in the decision about which service they should enter, if there is a choice of Children or Adult Services.

The Mental Capacity Act (MCA) applies in most respects to young people from the age of 16. Any young person who is felt to be lacking capacity to make a specific decision once they are aged 16 should be assessed under the MCA to determine their best interests and the appropriate course of action. Where care and treatment arrangements amount to a deprivation of liberty of the young person, the relevant Deprivation of Liberty Standards or Liberty Protection Standards (DOLS/LPS) or other procedures should be followed to lawfully safeguard their wellbeing whilst giving due regard to their human rights.

---

[135] Gillick -v- West Norfolk And Wisbech Area Health Authority and Department of Health and Social Security [1985] 3 WLR 830 [HL]

[136] NHS Wales. Governance e-manual. [Governance e-Manual - NHS Wales Shared Services Partnership]

3.2.9.4 Mental Capacity

MCA (2005) facilitates the assessment of the individual's capacity to make decisions and is based on the five principles of:

- Presumption of capacity.
- Individuals to be supported to make their own decisions.
- A person is entitled to make an unwise decision.
- Best interest principles.
- Using least restrictive options.

When assessing capacity under the MCA, the assessment of capacity has to be done by the decision maker, where the decision maker is the person deciding whether to take action in connection with the care or treatment of an adult who lacks capacity or who is contemplating making a decision on their behalf. Where the decision involves medical treatment – the doctor proposing the treatment is the decision maker.

3.2.10 Integrated care planning (ICP)

ICP provides a mechanism to facilitate and monitor delivery of equitable, seamless and high-quality health and social care. This may be achieved at the micro or personalised level through individualised care plans; the meso-level, providing care and support for groups of children and young people with a similar conditions, for example those identified substance use and dependence; through to the macro-level, providing integrated care for the whole population with appropriate stratification of need across settings.[137] Ensuring clear mechanisms for reporting and monitoring relevant indicators of need at the micro and meso-levels evidences and enables effective and cost-effective assessment and planning at the macro-level (see Section C – Monitoring, Evaluation and Key Performance Indicators).

ICP allows for the development of care pathways and monitoring of progress for treatment, care and support, in partnership with the individual, covering the four main domains outlined in the assessment process, specifically drug and alcohol use and dependence, physical health, mental health and social functioning including involvement with criminal justice.[138] The ICP provides a single reference point for any and all of the providers involved in the care of the child or young person. Following assessment of need, the lead co-ordinator / keyworker should develop the

---

[137] Curry N, Ham C. Clinical and service integration. The route to improved outcomes. The King's Fund; 2010. Available at: Clinical and service integration: the route to improved outcomes, The King's Fund, 22 November 2010 (kingsfund.org.uk)

[138] Clinical Guidelines on Drug Misuse and Dependence Update 2017 Independent Expert Working Group (2017) Drug misuse and dependence: UK guidelines on clinical management. London: Department of Health. Available at: Drug misuse and dependence (publishing.service.gov.uk)

ICP, negotiate and co-ordinate the delivery of multidisciplinary health and social care and support, with the authority to ensure successful delivery of the ICP.[139] The identified keyworker or case co-ordinator, alongside discussions and agreement with the child or young person, is responsible for updating the ICP.

An ICP should address the full range of needs, be effectively coordinated with all agencies and family/caregivers where possible, be regularly updated and monitored and where appropriate should have coordinated transition arrangements to adult services, over time with clear engagement.[140] The ICP should be regularly updated, on at least a monthly basis or sooner in the event of significant change in circumstances, for example, changes in substance use or risk, and incarceration.

The ICP should include goals related to substance use and dependence including those related to treatment such as the provision of and engagement with structured harm reduction (e.g. needle and syringe provision, supply of take home naloxone) and psychosocial interventions, and prescribing for dependence. It is important to ensure that agreed goals and actions, both short and longer term, are consistent and coherent across and between interventions, particularly in the event of a multi-agency response[141]. All health and other professionals involved in a child and young person's treatment and support should be named on the ICP. To ensure effective communication and clear adherence to information governance requirements, the informed consent statement must be included in the ICP.

3.3 Harm Reduction Approach and Interventions

3.3.1 Background

Harm reduction interventions were established in the UK in the late 1980s in response to the Human Immunodeficiency Virus (HIV) Acquired Immune Deficiency Syndrome (AIDS) epidemic. This resulted in the first Needle and Syringe Programme (NSP, previously Needle Exchange Programmes) opening in 1986, and the onward evolution of policies, services and actions that work to reduce the health, social and economic harms to individuals, communities and societies that are associated with the use of drugs, alcohol and tobacco[142]. The harm reduction approach to substance

---

[139] World Health Organisation, Regional Office for Europe. 2016. Integrated models of care – an overview. Available at: [Integrated care models: an overview (who.int)]
[140] Clinical Guidelines on Drug Misuse and Dependence Update 2017 Independent Expert Working Group (2017) Drug misuse and dependence: UK guidelines on clinical management. London: Department of Health. Available at: [Drug misuse and dependence (publishing.service.gov.uk)]
[141] Clinical Guidelines on Drug Misuse and Dependence Update 2017 Independent Expert Working Group (2017) Drug misuse and dependence: UK guidelines on clinical management. London: Department of Health. Available at: [Drug misuse and dependence (publishing.service.gov.uk)]
[142] Newcombe, R. (1992) *The reduction of drug related harm: a conceptual framework for theory, practice and research.* In, O'Hare et al (Eds.) The reduction of drug related harm. London Routledge.

use is based on a strong commitment to public health and the following core principles:

- is pragmatic.
- prioritises goals
- is based on humanist values.
- focuses on risks and harms.
- does not focus primarily on abstinence but does incorporate recovery as part of a range of goals and outcomes over time.
- seeks to maximise the range of intervention options available.
- is facilitative rather than coercive and grounded in the needs of individuals.

The specific aims and objectives of harm reduction policy and interventions can often be arranged in a hierarchy with the more feasible options for the individual at one end (e.g. measures to keep people healthy) and less feasible but desirable options at the other. Keeping people who use drugs and alcohol alive and preventing irreparable damage should always be regarded as the most urgent priority. It is often considered that abstinence is a longer-term goal, as such models of harm reduction should work in parallel with a range of strategies aimed at addressing substance issues within a community such as abstinence and recovery-based interventions.

Harm reduction interventions are evidence based and cost effective when delivered in a targeted way at reducing the harms and risks to an individual and the community in which they live. The approach is designed to be relevant to all psychoactive drugs, including controlled and licit drugs, alcohol, tobacco and pharmaceutical drugs, and as such, should not be solely targeted towards injecting drug use.

3.3.2 Harm reduction in the context of Children and Young People

Direct substance use related harms amongst children and young people are often related to acute intoxication and/or excessive consumption, for example following use of NPS, which carry risks because of toxicity and the use of combined and untested ingredients. At the time of writing, the evidence base surrounding misuse of OTC or prescription drugs amongst young people in the UK is limited.[143] However, anecdotal service and experiential reports have highlighted this as an area of growing concern.

In the provision of harm reduction services to young people, a balance is required between safeguarding a young person's welfare and deterring them from seeking help. As such reducing drug and alcohol related harms and promoting public health activities including preventing communicable and non-communicable diseases,

---

[143] Department of Health and Social Care. Drug misuse and dependence: UK guidelines on clinical management. 2017 [Drug misuse and dependence: UK guidelines on clinical management - GOV.UK (www.gov.uk)]

premature mortality and morbidity, in addition to social harms and exploitation, must be considered when planning for and providing services for young people.

3.3.3 Harm reduction and abstinence goal orientated interventions

In 2015 a briefing by the Advisory Council on the Misuse of Drugs (ACMD) concluded that that evidence concerning best practice approaches in relation to drug prevention interventions for young people was limited. Contemporary evidence and reviews continue to highlight the limited impact and cost-effectiveness of strategies aimed at young people that are primarily abstinence goal centred. This can often be attributed to a one-size-fits-all approach employed by many strategies which fail to acknowledge young peoples' perceived motivational factors surrounding substance use along with the social context in which they are used.[144]

In contrast, contextually relevant and responsive harm reduction approaches can demonstrate effective outcomes in improving behavioural effects and reducing harms associated with the use of drug and alcohol amongst children and young people.[145] [146] As such, practitioners and commissioner should remain mindful that the prevention of adverse long-term health and social outcomes may still be achieved even in the absence of drug abstention.[147]

3.3.4 Specialist Harm Reduction Interventions

Specialist harm reduction interventions are targeted programmes designed to reduce harms and improve public health associated with specific risk behaviour. This may include, but is not limited to:

- Needle and Syringe Programmes (NSP)
- Opiate Substitution Therapy (OST)
- Take Home Naloxone (THN)
- Blood Borne Virus (BBV) screening, vaccination and treatment
- Sexually Transmitted Infection (STI) screening and treatment
- Provision of contraception
- Psychoactive substance testing and profiling services (e.g. WEDINOS)

---

[144] Jenkins *et al*. Developing harm reduction in the context of youth substance use: insights from a multi-site qualitative analysis of young people's harm minimization strategies. *Harm Reduction Journal,* 2017; 14:53

[145] Jenkins *et al*. Developing harm reduction in the context of youth substance use: insights from a multi-site qualitative analysis of young people's harm minimization strategies. *Harm Reduction Journal,* 2017; 14:53

[146] McKay M, Agus A, Cole J, et al. Steps Towards Alcohol Misuse Prevention Programme (STAMPP): a school-based and community based cluster randomised controlled trial. BMJ Open 2018;8:e019722. doi:10.1136/ bmjopen-2017-019722

[147] Advisory Council on the Misuse of Drugs (ACMD). Prevention of drug and alcohol dependence. (2015)

- Targeted health screening services (e.g. Image and Performance Enhancing Drugs)

In Wales, provision of specialist harm reduction and public health interventions such as NSPs, THN and BBV screening are recorded and monitored via the Harm Reduction Database (HRD) Wales.[148,149,150] Commissioning teams, service planners and providers are required to ensure careful consideration is made to current guidelines and treatment frameworks when developing local policy for specialist harm reduction interventions.[151,152,153,154]The provisions of specialist harm reduction interventions should always form part of a range of relevant interventions relating to the young person's ICP.

3.3.5 General and specialist Harm Reduction Information and Advice

Evidence-based generic information and advice should be available aimed at enabling individuals to make informed choices and reduce harms associated with specific behaviours, e.g., poly-drug use / mixing substances, thinking ahead, personal and environmental awareness and safety. Targeted information and advice aimed at enabling individuals to make informed choices and reduce harms associated with specific behaviours, e.g. safer methods of administration, route transition, overdose prevention and tolerance, sexual health and contraception advice.

3.3.6 Considerations on delivering harm reduction interventions to Children and Young People

In line with the principles of harm reduction, interventions should be tailored to the individual. Consideration should be given to the young persons age, developmental need and educational ability. The Young Person should not be overloaded with information, rather and where possible, information should be provided in written /graphic form as well as verbal information. Provision of the range of harm reduction services to all those requiring them should be consistent across areas whilst addressing local needs and specific trends in substance use.

---

[148] Public Health Wales. Harm Reduction Database: Needle and Syringe Programmes 2017-18. 2018
[149] Public Health Wales. Harm Reduction Database: Take Home Naloxone 2017-18. 2018
[150] Public Health Wales. Harm Reduction Database: Blood Borne Virus Testing and treatment in community settings 2017-18. 2018
[151] Welsh Government. Substance Misuse Treatment Framework: Service Framework for Needle and Syringe Programmes in Wales. 2011
[152] Welsh Government. Substance Misuse Treatment Framework: Health and Wellbeing Compendium. 2013
[153] National Institute for Health and Care Excellence (NICE). PH52 - Needle and Syringe Programmes. 2014
[154] Medicines & Healthcare products Regulatory Agency. Widening the availability of naloxone. 2017 Widening the availability of naloxone - GOV.UK (www.gov.uk)

Services should ensure that the range of harm reduction interventions and approaches cover the following key themes:

- Physical wellbeing
- Psychological wellbeing
- Infectious diseases, treatment and care
- Overdose prevention
- Family and community wellbeing
- Sexual wellbeing and relationships

Safer sex advice and information along with low threshold screening, referral and signposting to specialist sexual health clinics should be standard practice in all substance use services and in other young person's and health-related settings. Information regarding the risks of unprotected oral sex and sexually transmitted infection should be included.[155]

Young people may not identify with more adult-orientated models of treatment and should be involved in designing new services to meet their specific developmental needs. For example, case studies have highlighted how it is possible to use participatory and peer-led methods to engage people who inject drugs (PWID) to inform more appropriate youth-led and youth-friendly services.[156] Services aimed at providing harm reduction advice and interventions should ensure careful consideration is made to a wide range of substances types including alcohol, tobacco, illicit psychoactive drugs, IPEDs, licit drugs including prescribed medications, and over-the-counter drugs. Changes in drug markets and NSPs since the late 2000's highlight the importance of proactive outreach and development of interventions accessible to those who are not in contact with mainstream services.

3.3.7 Co-occurring risk, harms, and vulnerable groups

Evidence indicates that young people are more likely to misuse drugs and alcohol if they are engaged in offending behaviour, have comorbid mental health concerns, are excluded from school or experiencing child sexual exploitation[157]. There is an association between early substance use problems and crime and antisocial behaviour, an indirect impact on suicide and accidents, and impacts on mental health and general functioning. For those with substantial levels of use or

---

[155] Welsh Government (2013). Substance Misuse Treatment Framework: Health and Wellbeing Compendium.

[156] International HIV/AIDS Alliance, Harm Reduction International & Youth RISE. Step by step: Preparing for work with children and young people who inject drugs

[157] Clinical Guidelines on Drug Misuse and Dependence Update 2017 Independent Expert Working Group (2017) Drug misuse and dependence: UK guidelines on clinical management. London: Department of Health. P.241 [Drug misuse and dependence (publishing.service.gov.uk)]

problematic use, it is more likely that drug use compounds other problems, such as family breakdown, anti-social behaviour, educational issues and mental health concerns – that is, drug use is more of a symptom than a cause of the vulnerability.[155]

Consideration needs to be given to gender differences, with young girls and women more likely to have mental health problems and be vulnerable in specific ways, such as exposure to sexual exploitation and abuse.[158] Furthermore, nationally representative studies have indicated substance use was strongly associated with sexual risk and adverse sexual health outcomes among young people. Wider qualitative or event-level research is needed to examine the context and motivations behind these associations in order to inform joined-up interventions and address these inter-related behaviours.[159]

Social policies and interventions which address the broader 'risk environment' may have the greatest impact on reducing drug related harms at a population level, for example, by addressing poverty, trauma, homelessness and social exclusion. This is also in line with a Children's rights-based approach. Harm reduction in this context is about keeping at-risk youth alive and safe, while also addressing the causes of their vulnerability.[160] Zero tolerance approaches may result in drug use not being addressed. Research suggests that in this situation peer influences may lead to more harmful forms of drinking and drug use in hostel and foyer settings.[161] As such, accommodation providers caring for vulnerable children and young people should be considerate in adopting zero tolerance policies to drug and alcohol use (and intoxication) as this may preclude them from providing harm reduction advice and interventions. Induction into hostel or foyer accommodation should include drug education information.

---

[158] Royal College of Psychiatrists (2012) Practice standards for Young People with substance misuse problems. London: Royal College of Psychiatrists

[159] Khadr SN, Jones KG, Mann S, et al. Investigating the relationship between substance use and sexual behaviour in young people in Britain: findings from a national probability survey. *BMJ Open,* 2016; 6:e011961.doi:10.1136/bmjopen-2016-011961

[160] International HIV/AIDS Alliance, Harm Reduction International & Youth RISE. Step by step: Preparing for work with children and young people who inject drugs

[161] Welsh Government (2013). Substance Misuse Treatment Framework: Health and Wellbeing Compendium.

3.4 Psychological interventions and psychosocial support

Psychosocial interventions are defined as therapeutic and structured processes, which address the psychological and social aspects of behaviour. The interventions can vary in intensity depending on the needs of individuals.[162]

Substance use in young people is a significant concern as it can have long term effects on all aspects of their lives. Effective treatment must be individualised and young person-focused, with assessment and treatment of co-morbidities having an important role in the substance use treatment journey. Therefore, the ICP must be multi-disciplinary, include community and family participation and involvement, while ensuring that the needs of the young person remain at the core to facilitate engagement, leading to developing the young person's skills and resilience to reduce harms. Harm reduction education and relapse prevention strategies should be provided throughout the whole journey.[163]

Effective treatment for all substance use problems includes psychosocial interventions.[164,165]

In the United Kingdom, there is a broad evidence base alongside national guidance for the use of psychosocial interventions for the treatment and management of substance use problems. These include the Drug misuse and dependence: UK guidelines on clinical management and Drug Misuse: Psychosocial Interventions.[166]

Effective psychosocial interventions should include the following key elements:

- Therapeutic alliance, sometimes called the therapeutic relationship, this is the relationship between a healthcare practitioner and their client. The quality of this relationship can be a reliable predictor of positive treatment outcomes.[167]

---

[162] Substance Misuse Treatment Framework (SMTF) Guidance for Evidence Based Psychosocial Interventions in the Treatment of Substance Misuse; Welsh Government; 2011; page 3; substance-misuse-treatment-framework-guidance-for-evidence-based-psychosocial-interventions-in-the-treatment-of-substance-misuse.pdf (gov.wales) [accessed 25th August 2020]

[163] Jayarajan D, Jacob P. Psychosocial interventions among children and adolescents. Indian J Psychiatry. 2018;60 (Suppl 4):S546-S552. doi:10.4103/psychiatry.IndianJPsychiatry_22_18

[164] Clinical Guidelines on Drug Misuse and Dependence Update 2017 Independent Expert Working Group (2017) Drug misuse and dependence: UK guidelines on clinical management. London: Department of Health

[165] Abdulrahim D, Bowden-Jones O, on behalf of the NEPTUNE Expert Group. Guidance on the Management of Acute and Chronic Harms of Club Drugs and Novel Psychoactive Substances. Novel Psychoactive Treatment UK Network (NEPTUNE). London, 2015.

[166] National Institute for Health and Clinical Excellence. Drug Misuse: Psychosocial Interventions (Clinical Guideline 51). 2007.

[167] Ardito, RB, and Rabellino, D. "Therapeutic alliance and outcome of psychotherapy: historical excursus, measurements, and prospects for research." Frontiers in psychology vol. 2 270. 18 Oct. 2011, doi:10.3389/fpsyg.2011.00270

- Use of evidenced based interventions.
- Adequate staff competencies and supervision (See work force development). This will ensure a balanced implementation of interventions and assure their quality.
- Monitoring and review system of agreed treatment goals and outcomes. This will allow for focus and re-focusing of the structure of interventions delivered and goals. Agreed goal directed work is associated with positive client engagement and better outcomes.

Although there are many interventions for the treatment of substance use issues, practitioners should tailor their interventions to the individual needs and circumstances of the young person and the nature and context of their substance use; selecting the most appropriate evidence-based intervention or mix of interventions. Goals should be agreed between the practitioner and Young Person, helping to build the therapeutic alliance, and allow discussion of any feelings of coercion or external pressure that the young person might have. As with selecting and tailoring goals the care plan should be bespoke to individual young person's needs, a "one-size fits all" approach is unlikely to have successful outcomes. There is evidence that routine review and feedback can lead to positive treatment outcomes. When outcomes are not met it is important to utilise this information to identify any barriers to change and to continue to build a positive therapeutic alliance through empathetic listening.

3.4.1 Low and high intensity psychosocial interventions

Low intensity interventions are particularly effective at engaging young people with treatment services, for facilitating changes to their substance use and delivering harm reduction messages, as well as measuring levels of motivation. These can usually be delivered by suitably skilled keyworkers in a single session, within a wide variety of settings.[168,169]

High intensity interventions are generally better suited to individuals who require a more structured and formal treatment plan and should be undertaken only by individuals with the appropriate skills and qualifications to deliver them. High intensity

---

[168] Substance Misuse Treatment Framework (SMTF) Guidance for Evidence Based Psychosocial Interventions in the Treatment of Substance Misuse; Welsh Government; 2011; substance-misuse-treatment-framework-guidance-for-evidence-based-community-prescribing-in-the-treatment-of-substance-misuse.pdf (gov.wales) [accessed 25th August 2020]

[169] Pilling S, Hesketh K, Mitcheson L; Routes to recovery: Psychosocial interventions for drug misuse. A framework and toolkit for implementing NICE-recommended treatment interventions; National Treatment Agency NHS, London, 2010

interventions should be used to address the reasons for substance use and help to reduce harms and consumption.[170]

3.4.2 Treatment pathway

Treatment for problematic substance use and dependence can be conceptualised as a "treatment pathway" characterised by four phases:

- Assessment.
- Engagement.
- Behaviour change.
- Early recovery as defined by progress towards achieving voluntarily sustained control over substance use which maximises health and wellbeing.[171]

A different balance of psychosocial interventions tends to be needed in each phase.[172]

A period of assessment, engagement and collaborative working is usually required to develop an agreed ICP and to prepare with a young person for longer term behavioural changes. This may incorporate interventions such as harm reduction and development of coping strategies and building resilience to help maintain any changes. At the assessment stage, services should endeavour to provide rapid access to treatment, a simple assessment process and an ability to deal with any immediate presenting concerns, such as a specific health concern. A robust assessment stage is essential not only to the start of care, but throughout the continued treatment, engagement and behavioural change of a client.

This early stage of engagement, assessment and treatment may focus more around managing risks to an individual than introducing behaviour change or building resilience. It may also be more intensive than other phases of the treatment pathway. With the potential for numerous risks at this stage, the care plan may require focussed work by the healthcare workers on those issues providing oversight of risk.

---

[170] Pilling S, Hesketh K, Mitcheson L; Routes to recovery: Psychosocial interventions for drug misuse. A framework and toolkit for implementing NICE-recommended treatment interventions; National Treatment Agency NHS, London, 2010
[171] UK Drug Policy Commission Recovery Consensus Group. Policy Report 2008. A vision of Recovery. Available at: Microsoft Word - A Vision of Recovery v2.doc (ukdpc.org.uk)
[172] Clinical Guidelines on Drug Misuse and Dependence Update 2017 Independent Expert Working Group (2017) Drug misuse and dependence: UK guidelines on clinical management. London: Department of Health p.48

Assessing risks is an important part of the assessment process and can help determine the type, focus and priority of psychosocial interventions allowing an action plan to reduce or eliminate risk.

As an individual moves through the assessment and engagement phases there will likely be a shift of focus to developing a young person's own strengths and resilience, whilst providing them with greater control of their care plan.[173]

The assessment stage needs to be carefully managed and may take place over several meetings as a therapeutic alliance is developed and there is a balance between obtaining comprehensive client information whilst also being engaging. This may be achieved through the management of short terms goals and discussions around longer term aspirations. For some young people with complex needs a multi-disciplinary, multi-agency approach may be required during the assessment stage. These young people should be identified early on in the assessment process as they may be at particular risk of early disengagement if their needs are not addressed.

The psychosocial interventions and approaches used should be strength based, focusing on a young persons personal strengths and resources. These strengths can be described in a "recovery capital model" and are split into four types:[174]

- Human capital – e.g. skills, employment, mental and physical health.
- Physical capital – e.g. tangible resources, housing, money.
- Cultural capital – e.g. values, beliefs.
- Social capital – e.g. relationships with others.

If a young person has reduced resources within a type of capital, more intensive interventions and support may be required to improve the likelihood of a positive outcome. Indicators for more intensive interventions include, but are not limited to: longer problem duration, injecting drug use, or multiple co-occurring problems. An additional consideration is that a young person may have substantial substance use problems, but at the present time are only ready to engage with less intensive interventions (e.g. NSP).

Whilst supporting the young person to develop their resources, resilience and coping skills, attention should also be paid to an individual's social network. This can have a significant influence on the prospects of positive outcomes. Building positive and healthy relationships with friends, family and community should be aimed for and supported throughout an individual's treatment journey. However, it has also now

---

[173] Reference Department of Health (2017) Drug misuse and dependence UK Guidelines on Clinical management p.60
[174] HM Government. The Drug Strategy: 'Reducing Demand, Restricting Supply, Building Recovery: Supporting People to Live a Drug Free Life'. 2010.

been recognised that supporting the needs of those who form part of a young person's social network is also an essential part of service provision.

Following the assessment phase there should be a clear plan for a young person's treatment based on their current issues, aims and goals for treatment, strengths and risks. This should also form the basis for review of treatment progression into the future. The frequency of attendance and participation within sessions are both markers of engagement. Motivation is associated with likelihood of participation in treatment in the first few months, and those young people achieving higher participation are then twice as likely to develop a favourable therapeutic relationship with their healthcare worker.[175]

The engagement phase can therefore vary enormously and can be determined by a number of factors including motivation, nature and degree of substance use, therapeutic alliance and the availability and accessibility of the service. Motivation and the therapeutic alliance can be enhanced through interventions such as motivational interviewing techniques, and availability and accessibility to services can be improved through the arrangement of a drop-in service or assertive outreach.

Within the behaviour change phases of the treatment pathway, the focus is on implementing and continuing changes in substance using behaviour and other areas of a young person's life, such as physical and mental health, social networks or steps into education, training or employment. During this phase, interventions should support maintenance of change whilst further developing coping skills and developing an individual's resilience to achieve their treatment goals. However, as a young person may move through cycle of changes and fluctuations in motivation, including potentially episodes of relapse to problematic use, harm reduction interventions should continue to be available and provided where needed.

Difficulty in maintaining change or lapses / relapses can be identified through a young person's participation within sessions or during a collaborative ICP review and development with the Young Person. An individualised care plan with an emphasis on personalised SMART (Specific, Measurable, Agreed, Realistic, Time limited) goals is associated to more positive and better treatment outcomes. If done well, goal setting can provide for both a reward for achieving them, and also can identify specific or additional needs, acting as part of the monitoring and review process.

Whilst addressing behaviour change it may be necessary to adapt psychosocial interventions for specific substances. Therefore, healthcare workers should have comprehensive knowledge around substances and their specific effects, relevant risk

---

[175] Clinical Guidelines on Drug Misuse and Dependence Update 2017 Independent Expert Working Group (2017) Drug misuse and dependence: UK guidelines on clinical management. London: Department of Health

management and harm reduction advice. In situations where a young person engages in poly-substance use, each substance must be addressed, although the primary focus can be adapted relative to the complexity and severity of use and current problems.

3.4.3 Evidence based psychosocial interventions for substance use

***Motivational interviewing* (MI)** (low intensity) is a client centred approach that can help a Young Person resolve the ambivalence associated with treatment and enhance their motivation to change. It has also been shown to enhance engagement and reduce harms relating to substance use and associated risks[176]. MI can be delivered in a variety of settings outside of a substance use service, including outreach.

***Contingency management* (low intensity)** utilises the principles of social learning theory, behavioural modification and positive reinforcement. Here a desired behaviour or change of behaviour is rewarded with a pre-agreed reward. This could be vouchers or access to diversionary activities (which can be an intervention in their own right). This may be used alongside motivational interviewing.

***Cognitive Behavioural Therapy* (High Intensity)** has been shown to be an effective intervention for substance misusing children and young people, both on an individual basis and in a group setting[177]. The intervention is designed to take into consideration the young person's substance use history, attitudes towards substances and their use as a dysfunctional coping mechanism. This process enables the Young Person to gain insight and understanding into their use, develop alternative coping strategies and resilience to support relapse prevention.

Family based interventions can be multi-functional, and are utilised to promote engagement into treatment services, involving a young person's family in their treatment or responding to the needs of the family. The aims of this type of intervention may not only be the reduction or cessation of use, but may include improving general quality of life, relationships and/or family functioning[178].

---

[176] Substance Misuse Treatment Framework (SMTF) Guidance for Evidence Based Psychosocial Interventions in the Treatment of Substance Misuse; Welsh Government; 2011; page 3; substance-misuse-treatment-framework-guidance-for-evidence-based-psychosocial-interventions-in-the-treatment-of-substance-misuse.pdf (gov.wales) [accessed 25th August 2020]

[177] Jayarajan D, Jacob P. Psychosocial interventions among children and adolescents. Indian J Psychiatry. 2018;60 (Suppl 4):S546-S552. doi:10.4103/psychiatry.IndianJPsychiatry_22_18

[178] Akram, Y., Copello, A. & Moore, D. Family-based interventions for substance misuse: a systematic review of systematic reviews—protocol. Syst Rev 3, 90 (2014). https://doi.org/10.1186/2046-4053-3-90

3.5 Pharmacological support and treatment for dependency

3.5.1 Treatment as part of a comprehensive, holistic care plan

Although the need for pharmacological management of substance use arises less frequently in children and young people compared to adults, when it does so it often forms just one component of a spectrum of difficulties, including family disruption, antisocial behaviour, disengagement with education and mental health problems. It is therefore essential that pharmacological treatment should only ever be initiated as part of a comprehensive, holistic management plan, following evidence-based guidelines and managed by treatment providers with the appropriate level of expertise. Age-appropriate pharmacological interventions will need to involve specialist substance use services, paediatricians, primary care, CAMHS staff and addiction psychiatrists.[179]

Development of a holistic management plan requires a comprehensive assessment. If prescribing is being considered, then it is important to include the following points in an assessment:

- Treatment of emergency situations.
- Nature of substance use (including route of use).
- Inspection of injecting sites.
- Urine/oral drug screens.
- Identification of any objective signs of withdrawal.
- In the case of transfers from other agencies, corroboration of current prescribed medication.
- Identifying urgent physical health problems.
- Identifying risk of suicide, self-harm and mental health difficulties.
- Identifying pregnancy (all young women should be offered a pregnancy test with a clear explanation of why).
- Conducting any necessary invasive investigations such as blood tests.

Pharmacological treatment can be used to:

- Manage withdrawal symptoms.
- Support abstinence.
- Prevent complications.
- Treat comorbid disorders.

[179] Gilvarry and Britten, Guidance for the pharmacological management of substance misuse among young people. London. Department of Health. 2009

Prescribing in adolescents should be initiated and monitored by specialist services. For those over 16 this can include services primarily designed for adults but for those under 16, more specialist skills are required.[180]

Young people metabolise medication differently to adults and their response to medication may also be different. Prescribing in young people, therefore, must be undertaken with caution by suitably qualified prescribers and take into consideration their age, weight and developmental stage.[181]

3.5.2 Licensing of medication in Young People

The use of medication in an “off label” or “unlicensed” way is often unavoidable in children if they are to have access to effective treatment. Prescription of medication in this way is allowed in legislation, as long as it is prescribed by a registered doctor working within their area of competence. The Medicines Act 1968 covers such use as long as the doctor is able to justify the prescription in accordance with a body of medical opinion (including guidelines). In any organisation where medication will be used in this way, there must be local safety standards and arrangements in place to monitor the use of unlicensed and off label medicines.

Clinicians prescribing for substance use in young people must be aware of their additional responsibilities in this regard and the relevant precautions that need to be taken.

- **Methadone** - is not licensed for use in children. “Children” is this context is generally taken to apply to those aged 13 and younger although manufacturers do note the lack of evidence for its use in adolescents.
- **Buprenorphine** - is licensed from age 16 years for use in opioid dependence.
- **Injectable Buprenorphine** – is licenced in young people and adults aged 16 years and over for use in opioid dependence.
- **Naltrexone** - is licensed for use as relapse prevention in opioid dependence only in those over 18 years.
- **Lofexidine** - is licensed for use in opioid detoxification only for those age 18 years and above.
- **Acamprosate** - is licensed from 18 years and up for alcohol relapse prevention.
- **Nicotine replacement therapies** - are licensed from 18 years and upwards.

---

[180] Welsh Government, Substance Misuse Treatment Framework: Integrated care for children and young people aged up to 18 years who misuse substances. 2011

[181] Department for education and skills, National Service Framework for Children, Young People and Maternity Services – Medicines for Children and Young People. Department for Education and Skills and Department of Health. 2004

3.5.2.1 Evidence

The evidence for treatment effectiveness in young people is limited due to a paucity of research in this age group. Most of the research originates from outside the UK and includes only a few randomised controlled trials. The Royal College of Psychiatrists has developed a set of practice standards for the management of substance use in young people.[182] In addition, several of the NICE Guidance documents summarise the evidence base for pharmacological management, although these primarily relate to adolescents and adults.[183] [184] [185] [186] [187] [188] [189] As such, recommendations for pharmacological management of substance use in young people are usually arrived at by extrapolation from research in adults.

Very few young people presenting for treatment will display physical signs of dependence and will, therefore, most will not require medically assisted detoxification. A small number, however, will require prescribing such as opiate substitution treatment and will need prompt, safe access to such treatment. In all the research evidence relating to young people it is repeatedly emphasised that the pharmacological management of substance use cannot sit in isolation and must be conducted as part of a holistic package of care aimed at addressing a range of comorbidities and psychosocial needs. In some cases, this may require in-patient care and/or specialist residential treatment.

3.5.3 Alcohol dependence

Alcohol detoxification should be managed using one of the long-acting benzodiazepines, i.e. diazepam or chlordiazepoxide. The dose and duration of treatment will be determined by the severity of dependence and so mechanisms for assessing this should be built into the assessment process. Alcohol detoxification in those aged 10 to 17 years should ideally be managed in a specialist inpatient

---

[182] Gilvarry et al (eds), Practice standards for Young People with substance misuse problems, Royal College of Psychiatrists. 2012
[183] NICE, Drug misuse in over 16s: psychosocial interventions. NICE clinical guideline 51. London. National Institute for Health and Care Excellence. 2007
[184] NICE Drug misuse in over 16s: opioid detoxification. NICE clinical guideline 52. London. National Institute for Health and Care Excellence. 2007
[185] NICE, Naltrexone for the management of opioid dependence. NICE technology appraisal guidance 115. London. National Institute for Health and Care Excellence. 2007.
[186] NICE, Methadone and buprenorphine for the management of opioid dependence. NICE technology appraisal guidance 114. London. National Institute for Health and Care Excellence. 2007.
[187] NICE, Substance misuse interventions for vulnerable under 25s. NICE public health guidance. London. National Institute for Health and Care Excellence. 2007.
[188] NICE, Alcohol use disorders: preventing harmful drinking. NICE public health guidance 24. London. National Institute for Health and Care Excellence. 2010.
[189] NICE, Alcohol use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence. NICE clinical guidelines 115. London. National Institute for Health and Care Excellence. 2011

setting.[190] Relapse prevention medication such as naltrexone and acamprosate may be considered in young people aged 16 and over where other methods of maintaining abstinence have been unsuccessful. [191]

3.5.4 Benzodiazepine dependence

The misuse of benzodiazepines in young people typically occurs in a binge pattern in contrast to the more regular, dependent patterns of use seen in adults. When young people do display signs of physical dependence, a reducing regime of diazepam may be prescribed. It is recommended that the starting daily dose be no higher than 30mg in young people and a time limited withdrawal be prescribed with close monitoring. There is no evidence to support the use of a benzodiazepine maintenance prescription.

3.5.5 Stimulant dependence

There is no evidence to support the use of substitution medication in the management of stimulant dependence. Physical complications of acute intoxication may need to be treated as emergencies (e.g.: cardiovascular complications). Acute psychosis arising from stimulant use resolves within a few days of cessation of use and needs to be managed appropriately, potentially involving mental health services. Lowered mood can occur on cessation of use; the presence of depression needs to be adequately diagnosed and antidepressant treatment may be required.

3.5.6 Cannabis dependence

A small proportion of regular cannabis users can experience sleep problems, agitation and a risk of self-harm on cessation of use. These may require supportive treatment and should be monitored for in those thought to be at risk. Cannabis intoxication is associated with potential psychosis and withdrawal can lead to lowering of mood. It is important to manage these appropriately as with stimulant dependence.

3.5.7 Opioid dependence

Methadone and buprenorphine are the recommended pharmacological approaches to opioid dependence as with adults. They can be prescribed in the form of assisted

---

[190] NICE, Alcohol use disorder: diagnosis and management of physical complications. NICE clinical guideline 100. London. National Institute for Health and Care Excellence. 2015
[191] NICE Alcohol use disorder: diagnosis and management of physical complications. NICE clinical guideline 100. London. National Institute for Health and Care Excellence. 2015

withdrawal over a period of a few months or as longer-term maintenance. All opioid substitute medication in young people should be dispensed under supervision and regularly reviewed. Due to the differences in tolerance in young people compared to adults, pharmacists should inform the responsible prescriber even if a young person misses one day of their opioid substitution medication. Prescribing for young people should always be in line with guidance set out in the Orange Book.[192]

Due to the metabolic differences between young people and adults, it is important to be mindful of tolerance in the early initiation periods. Induction and titration of medication follows a similar process to adults but may require a lower starting dose and should take into account the age and physique of the young person as well reported tolerance and evidence of intoxication or continued withdrawals following medication. However, it is important to remember that using lower doses of medication with too slow an incrementation process could lead to additional heroin use, thus increasing the initial risks.

In the case of young people dependent on prescribed opiates, there is little evidence to guide management. In clinical practice both buprenorphine and reducing doses of the original medication can be used and should be decided on a case-by-case basis. For some young people the use of an initial stabilisation period on substitute medication will allow time for a full assessment of all needs and to develop a comprehensive, holistic care plan. The length of this stabilisation period and then the subsequent detoxification period will depend on factors such as the clinical risk, severity of dependence, other substance use, social functioning, mental health comorbidity, family context and offending behaviour.

Lofexidine can be used in young people where levels of dependence and tolerance are unknown and there is a need for supported detoxification.[193]

Naltrexone as relapse prevention medication following opioid withdrawal can be used in adolescents aged 16 and over where there is good supervision, family engagement and ongoing psychosocial support. [194]

---

[192] Clinical Guidelines on Drug Misuse and Dependence Update 2017 Independent Expert Working Group (2017) Drug misuse and dependence: UK guidelines on clinical management. London: Department of Health

[193] NICE Drug misuse in over 16s: opioid detoxification. NICE clinical guideline 52. London. National Institute for Health and Care Excellence. 2007

[194] NICE, Naltrexone for the management of opioid dependence. NICE technology appraisal guidance 115. London. National Institute for Health and Care Excellence. 2007.

3.5.8 Considerations on delivering pharmacological support and treatment to Children and Young People

Professionals delivering prescribing services to young people with substance use issues must be suitably qualified and competent to work in the field of substance use and competent to work with young people. All professionals should receive supervision from qualified and competent senior professionals. Where medication is used in the management of substance use in young people, prescribing protocols should be in place following best practice guidance and with careful consideration given to the use of "off label" and "off license" medication.

Young people should receive their planned care and medication promptly after an individualised, holistic assessment and as part of a comprehensive treatment plan. Thorough, clearly written records should be kept of all interactions with the young person. As young people who require prescribing generally present with complex needs, support should be offered until the need for the intervention is resolved and young people should not be subject to time limited interventions.
An assertive outreach approach to young people should be taken by staff, with efforts made to reengage young people who start to miss appointments, including use of text reminders, home visits, etc.

Informed consent to treatment should be sought in line with national guidance and aspects of confidentiality should be carefully considered. As part of obtaining informed consent, prescribers should provide young people and their carers with written information in a relevant format, about the medication, its effects and their timing, potential side effects and relevant safety advice. As part of this, information in relation to the licensing of the medication should also be given.

Alcohol - Young people with evidence of alcohol withdrawal are offered alcohol detoxification utilising long-acting benzodiazepines (NICE supports a symptom-triggered approach). Individuals under 16 years should receive their detoxification in hospital with staff qualified and competent to undertake this process. In young people with moderate to severe alcohol dependence, naltrexone and/or acamprosate as relapse prevention medication should be considered.

Opioids - In young people dependent on opioids, offer methadone or buprenorphine for either detoxification or, where appropriate, longer-term stabilisation. Prescribed doses and regimes must take account of size and age of the young person. Young people on stabilisation treatment must have frequent reviews.

If relapse prevention medication is required in a young person over the age of 16, naltrexone may be considered where there is good supervision and support from family/carers. The prescriber should liaise frequently with the pharmacist and all

young people prescribed opioid substitute medication should receive supervised consumption.

Services must have protocols in place relating to the clinical response to missed doses. UK guidelines[195] suggest no more than three days for adults but, due to the lowered tolerance in young people, it is advisable that pharmacists inform the prescriber after even one missed dose.

Benzodiazepines - For the small number of young people with a physical dependence on benzodiazepines, prescribers may consider the short-term use of diazepam to support detoxification. Treatment must be reviewed frequently due to risks and potential diversion.

3.6 Transitional planning to adult services

It is recommended that all services for children and young people provide an inclusive and adaptive service for all those aged up to 25 years, in line with Welsh Government guidance which states: "*Rather than take a strict age bound approach, the system must respond to the child or young person's individual needs. A child's experience of growing older into adulthood is a process, not an event, and may span a wide age range*"[196]. It is recognised that many services already operate under this premise, however, not all do with service provision ceasing at aged 16 or 18 years, which for some services is a statutory point.

The Welsh Government have developed new guidance, following extensive consultation, to improve the care young people, aged 16 to 25, receive during this period – it covers the time before, during and after they move from children's to adult services. It aims to ensure young people and their carers have a better experience of transition by improving the way care is planned and carried out.

Young people should be fully involved in the way transition and the handover of care between children's and adult services is planned, implemented and reviewed. Planning for transition should start when a young person is 13 or 14. It is important care is provided in a developmentally appropriate, patient-centred way without any loss in the quality of services provided, ensuring on-going engagement and good patient experience.

---

[195] Clinical Guidelines on Drug Misuse and Dependence Update 2017 Independent Expert Working Group (2017) Drug misuse and dependence: UK guidelines on clinical management. London: Department of Health

[196] Welsh Government. 2022. Managing the transition from Children's to adults' healthcare services (in draft). Managing the transition from children's to adults' healthcare services | GOV.WALES

Ensuring this <25 support model across all services in Wales will facilitate streamlined, person-centred support recognising that physical age does not, per se, provide a useful measure of need in relation to support for substance use, psychological health and well-being, trauma, social care needs and so on. Providing an adaptive, tailored transitional model across service provision, focussing on early engagement, identification of needs over time, and consistent support promotes greater emphasis on prevention of escalation to more entrenched substance use, related harms and longer-term consequences including intergenerational harm.
All NHS organisations must have a clear accountability and delivery mechanism in place, which includes the identification and designation of a transition and handover senior lead, who will have accountability for ensuring implementation and quality of the transition and handover guidance across all primary, community, secondary and specialist (tertiary) services provided by their organisation.

3.6.1 Background

Transition between young people services and adult services at 18 years coincides with significant neurological, psychological, physiological and social change within the young person. The maturation process of the brain, specifically the prefrontal cortex, is not fully achieved until around the age of 25 years. The prefrontal cortex is involved in abstract thought, cognitive analysis, decision making and moderation of behaviour in social situations, [197] therefore, impacting on a young person's risk-taking behaviour and behavioural maturity.

Developmental changes occurring at a time of significant situational and social transitions increases this cohort's vulnerability to development of comorbid mental health disorders.[198] Evidence indicates that 75 percent of all adult mental health disorders start before the age of 24 years[199] and first onset of psychosis often emerges in late adolescents, early adulthood.[200] Pervasive mental health conditions have a significant detrimental impact on a young adult's life course. Services need to respond to co-occurring mental health problems that are common in substance use.[201]

---

[197] Arain, M., Haque, M., Johal, L., Mathur, P., Nel, W., Rais, A., Sandhu, R., & Sharma, S. (2013). Maturation of the adolescent brain. Neuropsychiatric disease and treatment, 9, 449–461. https://doi.org/10.2147/NDT.S39776
[198] Jones PB. (2013) Adult mental health disorders and their age at onset. The British Journal of Psychiatry , Volume 202 , Issue s54: Youth mental health: appropriate service response to emerging evidence , January 2013 , pp. s5 - s10 DOI: https://doi.org/10.1192/bjp.bp.112.119164
[199] Kessler RC, Berglund P, Demler O, Jin R, Merikangas KR, Walters EE. (2005) Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. Arch Gen Psychiatry. 2005 Jun;62(6):593-602. doi: 10.1001/archpsyc.62.6.593.
[200] World Health Organisation, (2020). Adolescent Mental Health. [Online] Available at: Adolescent mental health (who.int)
[201] Welsh Government , 2019. Substance Misuse Delivery Plan 2019-2022, Cardiff : Welsh Government. Avaliable at: Substance misuse delivery plan: 2019 to 2022 | GOV.WALES

Transition from CAMHS to Adult Mental Health Services (AMHS) for many young people is sub optimal. Many young people experience a difficult transition, fail to sustain or even make the transition and this has been attributed to multifaceted reasons such as the anxiety and fear associated with the transition that is compounded by the timing of the transition and the organisational, cultural and structural differences between CAMHS and AMHS.[202, 203]

Differences between CAMHS and AMHS that impact on the transition process have been identified. For example, CAMHS places a greater emphasis on the support network around young person in the care process, whereas, in AMHS the focus is on the individual and the young person required to take greater responsibility for their care at a time where the young person may find this responsibility difficult due to competing life stressors. CAMHS focuses more on symptoms and supporting young people to cope with problems, in contrast AMHS is led by diagnosis and utilisation of medication. AMHS is characterised by higher thresholds and the management of crisis and more severe complex cases, and although thresholds are rising in CAMHS there is provision of longer-term community work. CAMHS is made up of a small multidisciplinary team, whereas AMHS are large multidisciplinary teams, with more specialists, greater capacity may have longer waiting lists for some specialities.[200, 201]

3.6.2 Process

Transition for young adults who present with multiple vulnerabilities such as poverty and trauma and cumulative adversity such as educational failure, mental health disorders, substance use, unemployment, homelessness, family discord, engagement with the criminal justice system and neurodevelopmental disorders, is particularity challenging. These individuals are at much higher risk of substance use and the development of a mental health disorders. This requires services to provide a developmentally sensitive, holistic and an integrated multi-disciplinary, multi-agency response that is culturally appropriate and centred on the young adults' needs, of which substance use is one. To support this, an integrated commissioning approach between young people and adult services is also required in order to ensure adherence to the principle of resources following need and the life course perspective outlined in the Welsh Government's Together for Mental Health Plan 2019-22. [204]

---

[202] Welsh government. Review of evidence on all-age mental health services. 2020. Available at: [Review of evidence on all-age mental health services | GOV.WALES]

[203] Singh SP, Paul M, Ford T, Kramer T, Weaver T et al.,2010. Process, outcome and experience of transition from child to adult mental healthcare: multiperspective study. British Journal of psychiatry, 197(4):305-12, doi: 10.1192/bjp.bp.109.075135.

[204] Welsh Government, 2020. *Together for Mental Health: delivery plan 2019-2022 in respone to Covid 19.* [Online] Available at: [review-of-the-together-for-mental-health-delivery-plan-20192022-in-response-to-covid-19_0.pdf (gov.wales)]

Adapting existing services to incorporate the <25 years delivery of care model will require greater levels of multi-agency, multi-disciplinary working within a person-centred approach to ensure that in the period prior to an individual transitioning to adult services, every measure is taken to avoid a cessation in service, treatment quality or failure in continuity of care.

- For an individual presenting for support with substance use services aged under 18 years, the assessment and provision of care should be with the Young Persons services.
- For an individual presenting for the first time aged 18 to 24 years, the assessment, identification and provision of care should be with the young persons services to establish circumstances, risk and need profile, existing support structures and vulnerabilities. Following this, and over a period of stabilisation and progress, consideration should be given of the preferences of the individual and, in full consultation and consent of the individual, decision made as to the best setting for provision of ongoing care, be that young persons or transitioning gradually into adult service provision. There is evidence of higher levels of disengagement within the 18-to-24-year age cohort following referral to adult specialist services. This may be influenced by the transition process itself and should be avoided through use of dedicated transition workers and teams to manage continuity of care, with an adaptive and responsive approach.
- An individual who is 23 and 24 years, and who requires ongoing treatment and care for substance use issues, with or without additional risk or complex needs, who be offered and supported to transition to adult service through the multi-agency, multi-disciplinary joint working approach to ensure seamless transition when they reach 25 years if not before. Young adults who 'fall' at the existing transition gap often present to services at time of crisis and when more enduring problems have developed.[205] Therefore, it is critical that multiagency services respond to and prevent associated wider harms across the life course due to disengagement.
- Young adults accessing adult services may need to be appropriately separated from older or more entrenched drug and/or alcohol users in order to mitigate risks including exploitation.

Where successful, service redesign projects to develop high-quality and effective transitional services have incorporated the overarching principles of involvement of young people in the design, development and delivery of the service, ensuring that

---

[205] Signorini, G. Singh SP, Marsanic VB, Dieleman G, Franic T, et al., 2018. The interface between child/adolescent and adult mental health services: results from a European 28- country survey. *European Child and Adolescent and Adolescent psychiatry,* 27(4): 501-511. Available at: The interface between child/adolescent and adult mental health services: results from a European 28-country survey | SpringerLink

provision of multi-disciplinary services meet the broad spectrum of physical and emotional needs of young people in an easily accessible, non-stigmatising, youth friendly location. Psychological and psychosocial interventions are strength focused and there is integrated working with third sector and other agencies.

3.6.3 Considerations and complexity

Young people and vulnerable young adults may have experience of a combination of educational failure, mental health problems, neurodevelopmental disorders, learning disabilities, poverty, trauma, substance use, unemployment, family and housing difficulties and engagement with the criminal justice system. Integrated multi-disciplinary, multi-agency responses are therefore vital to ensure that the wide range of their needs are met, including cultural needs. For the most disadvantaged young people, housing issues are often critical, and can be the trigger for very isolated and disengaged young people to access services. Mental health problems often first surface during the transition to adulthood, due to new pressures and challenges. As such, protocols need to be in place to manage effectively the transition to adult substance use services aligned with mental health services.

NICE guidance[206] highlights the importance of transition in vulnerable groups such as looked after children and young offenders, identifying the need for more research into the most effective ways of supporting transition in these groups and the costs and consequences of a poor transition.

Transitional processes between Young Peoples' Substance Use Services and Adult services currently differ across Wales, often reflective of local geographical and strategic arrangements.

3.6.4 Considerations during the transition planning process between substance use and allied services

The transitional planning process should form part of the young person's ICP and be agreed by the young person and all services providing them with treatment and support. Regular assessment should inform the comprehensive ICP, to assess the optimal process, pathway and timing to transitioning from Young Persons to adult services up to the age of 25. Where possible parents or carers should be involved in the transition process.

---

[206] National Institute of Health and Care Excellence. 2016. Transition from children's to adults' services for young people using health or social care services. Available at: 1 (nice.org.uk)

Where possible, arrange for young person's appointments within adult services to be at quieter periods of the day/ week and ensure Transition Keyworkers[207] are able to attend with the young persons if seen at the adult services.

3.6.5 Transition from care and the context of substance use

Young care leavers are a vulnerable population particularly at risk of substance use and associated harms. Young care leavers are more likely to use substances than non-care leavers [208]

Where alcohol and/or drug use may have become established while in care the period of transition to independent living is a time of significant social, emotional and cultural change that compounds escalation substance use risk. [209]

Existing structures are in place for the provision of ongoing support for young people who are leaving care having been looked after to support transition into independent living up until the age of 25 depending on circumstances.[210] Substance use services should work collaboratively with services and where appropriate establishment of direct referral pathways to specialist services that are responsive to identified multiple and complex needs.

3.6.6 Transition planning processes within Youth Justice Services

Current structure and processes within Youth Justice Services require the young person to transition to adult services / adult secure prison estate from the age of 18 years. Such structures facilitate extended supervision of young people beyond their 18th birthday in line with sentencing and licence requirements as per section 256AA of the Offender Rehabilitation Act 2014.[211] Within the young persons prison estate a young person aged 18 may be transitioned to a dedicated prison or unit dedicated to young adults aged 18-21 years.

---

[207] Welsh Government. 2020 Review of evidence on all age mental health services. Review of Evidence on all-age Mental Health Services (gov.wales)

[208] Alderson H, Brown R, Copello A, Kaner E, Tober G, Lingham R, McGovern. (2019). The key therapeutic factors needed to deliver behavioural change interventions to decrease risky substance use (drug and alcohol) for looked after children and care leavers: a qualitative exploration with young people, carers and front line workers. *BMC Medical Research Methodology* 19,38. Available at: The key therapeutic factors needed to deliver behavioural change interventions to decrease risky substance use (drug and alcohol) for looked after children and care leavers: a qualitative exploration with young people, carers and front line workers | BMC Medical Research Methodology | Full Text (biomedcentral.com)

[209] Ward J, Henderson Z, Geoffrey, P. (2003) One problem among many: drug use among care leavers in transition to independent living. London: Home Office. Research, Development and Statistics Directorate. https://www.drugsandalcohol.ie/5584/

[210] Welsh Government (2014) Social services and Well-being (Wales) Act 2014 Social Services and Well-being (Wales) Act 2014 (legislation.gov.uk)

[211] UK Government (2014). Offender Rehabilitation Act 2014. Offender Rehabilitation Act 2014 (legislation.gov.uk)

3.6.6.1 Young People referred under 'Youth Caution' or higher statutory intervention order

Transitional processes between YOS and Her Majesty's Prison and Probation Services where a young person has been issued a higher statutory intervention are outlined as part of the National Standards[212] and Case Management Guidance developed by YJB. [213] As part of these standards YOT management boards and secure establishments are required to have mechanisms in place which provide them with assurance that:

- local systems and approaches recognise and reflect that moves / transitions for Children in the youth justice system can be frequent.
- local systems are in place that demonstrate flexibility and capacity for continuity in assessment, planning and the delivery of interventions for Children in the youth justice system who make a transition / change.
- planning and leadership at all levels, together with strong governance and clear responsibilities, are required to minimise, as far as is reasonable and practicable, any potential for the negative impact that any transition may have for a child.
- there is a robust approach to holding services and agencies to account in the event of insufficient planning and delivery of the transition and or resettlement plan for a child.

3.6.6.2 Young People referred for Community Restorative Disposal or 'Prevention' work

For young people referred to the YOS as part of less formal interventions such as a Community Restorative Disposal or 'Prevention' referrals there is no requirement from YJB for formal transitional processes to be undertaken. As such YOS should ensure transitional planning processes are conducted as party of a multiagency approach in line with community health and social care services and local pathways.

3.6.7 Key principles in transitioning from young person to adult services <25 years

NICE provide guidelines to ensure young adults are appropriately supported in transition from child and young person to adult services.[214] These guidelines should inform service provision and evaluation. The key guiding principles to inform service delivery are:

---

[212] Youth Justice Bard for England and Wales (2014). Standards for children in the youth justice system

[213] Youth Justice Board for England and Wales (2014). Case management guidance

[214] National Institute of Health and care excellence. 2016. Transition from children's to adults' services for young people using health or social care services. Available at: 1 (nice.org.uk)

- Young people and their carers to be involved service design, delivery, and evaluation.
- Service provision across agencies should be integrated and co-ordinated to ensure smooth and gradual transition.
- Care delivery should be developmentally appropriate, strength based and person-centred.
- Allocation of a named worker to lead in co-ordinating care delivery.
- Continuity of support before and after transition to facilitate engagement.
- Carer involvement to be encouraged where appropriate.
- Training should be provided for the workforce to ensure practitioners are competent and confident to provide developmentally appropriate care.
- Gap analysis should inform local planning and commissioning of services. A gap analysis informs understanding of the needs of young adults who have been in receipt of care from child and young people's services who are unable to receive care from adult services.

3.6.8 Case study - Good practice in transitional planning

In April 2017, an integrated service model was commissioned in Gwent that aimed to support the transition of young people with substance use needs into adult services. The model was structured alongside third sector substance use providers, Health Board, and CAMHS, and offered:

- Interventions across tier 2 and 3.
- Training for professionals.
- Family support.
- Prevention and activities.

Core functions of the team include the identification, planning, co-ordination and supporting young people in the transition into adult provision, building on previously established joint working protocol documentation to ensure clear communication and information sharing to the benefit of young person between Services. Each stage of the protocol recognises that joint working, holistic risk assessment and multiagency care planning are best practice and aim to promote improved engagement in treatment and outcomes.

At the point of transition, processes and arrangements should be discussed with the young person as part of a care planning stage. It is at this point further required support is identified. If a young person feels that they need continued support at time of transition the following should take place to ensure a seamless transition:

- Discuss the transfer to adult services well in advance of the transition date

- Signpost and explore additional support services for adults with the young person which could also be accessed to support their need.
- Begin a transition to the adult services buildings / offices by conducting one to one appointments there. This will enable the individual to become familiar with the environment and the workers, reducing anxieties.
- Provide tour of the adult building / offices explaining how adult services differ from young person's services.
- Services to have a 'Transition Worker' within young person's team.
- Introduce the individual to activities and group work that is currently being held at adult services where and when appropriate.
- Introduce the young person to members of staff in Adult Services. In an ideal situation this would ideally be the member of staff who would be taking over the case.
- Liaise with other young persons' services supporting the individual for information sharing on the transition process being undertaken.
- Provide advocacy within adult services for the young person and undertake joint meetings to promote the transition of services.
- Complete feedback with the individual at the end of the transition period, should improvement needs be identified.
- Adult Services to have a young persons Champion to support the under 25s.

3.7 Planned and unplanned exit from substance use and related treatment services

3.7.1 Background

Successful exit planning should provide young people with the confidence in their own personal resilience, and the tools to identify when support may be required again in the future. In order to achieve progress to the stage where mutual planned exit is agreed, engagement and retention in services is essential. The Children and Young Peoples Outcome Monitoring Tool along with ICP should inform decision making around timing of planned exit from services, including completion at exit meeting.

There are a number of approaches that may increase engagement and improve retention in substance use services, and thus reduce unplanned drop out by young people, including:

- Strong and consistent key working practices including offering practical support, advocacy and semi-formal contact sessions focussing on eliminating

issues that may be a barrier to effective treatment engagement e.g. unstable housing, relationship issues, debt, transport.[215]
- Arrangement of meetings and sessions in places that the young person has no difficulty attending, such as their own home or local community resources.[185]
- Semi and informal contact with practitioners, seeing them as 'real people' has been shown to be particularly effective in groups hard to engage including those from ethnic minority communities, young women and those with mental health issues. [185, 216]

As with adults, the importance of engagement and retention in substance use treatment services for young people is clear with evidence of the negative impact of unplanned drop out on levels of substance use, physical and psychological health, family and relationships, housing and social circumstances, and crime and criminal justice services. Self-report data from Wales[217] indicating that following unplanned drop out:

- 61% reported an increase in drug use.
- 25% reported an increase in alcohol use.
- 26% reported losing their housing.
- 34% reported an increase in criminal activity and a further 9% reported imprisonment following unplanned drop out.
- Around 50% reported onset of depression and other negative psychological symptoms.
- Increased risk of drug related overdose and death.
- Decrease in likelihood of returning to service or recommending service to peers.

Negative consequences of unplanned drop out were also reported by service providers in relation to staff motivation and morale and the potential impact of negative messages relating to service users having been 'failed' by the services.

3.7.2 Unplanned Exits:

An unplanned exit is where treatment is withdrawn by the provider,[218] this includes clients who:

- Did not attend or respond to follow up contact.

---

[215] Noel, P.E. (2006). The impact of therapeutic case management on participation in adolescent substance abuse treatment. American Journal of Drug and Alcohol Abuse, 32 (3), 311-327.
[216] Duroy, T.H., Schmidt, S.L. and Perry, P.D. (2003). Adolescents' and young adults' perspectives on a continuum of care in a three year drug treatment program. Journal of Drug Issues, 34 (4), 801-832.
[217] Public Health Wales. (2010) Influencing factors and implications of unplanned drop out from substance misuse services in Wales - Guidance for reducing unplanned drop out from and promoting reengagement with substance misuse services. Available at: Microsoft Word - Influences and implications of unplanned drop out (wales.nhs.uk)
[218] NHS Wales Information Service and Welsh Government. Substance Misuse Data Set Implementation Date: 1st April 2020 Business Definition version 2.4. Available at: Substance Misuse Documentation - Digital Health and Care Wales (nhs.wales)

- Moved from area (if client moved from geographical area but was also referred to another service, the latter should be captured).
- Retained in custody / prison.
- Deceased.
- Declined treatment.

Unplanned exits from services most commonly occur following a young person's disengagement from service or where they have not attended consecutive scheduled appointments or responded to follow-up contact to re-engage. Welsh Government have previously defined such occurrences as when '*The treatment provider has lost contact with client for 8 weeks or more without a planned discharge and attempts to re-engage the client have not been successful.*'[219]

It should not be assumed that any episodes of disengagement are indicative of the young person no longer requiring support. In addition, full consideration should be given of any safeguarding concerns that may arise from the young person disengaging from support. It is important to ensure a comprehensive resolution following disengagement to avoid premature closure of a case and to avoid a young person being reintroduction into the system at a later date with a more entrenched and complex presentation.

Best practice indicates that before a case can be closed as an unplanned exit, reasonable measures of re-engagement, and establishment of reasons surrounding disengagement should be attempted by the keyworker, or re-engagement team. Such reasonable measures are currently dictated at service level and vary throughout Wales, typically these may include:

- Two consecutive Did Not Attend (DNA) appointments with no response to the keyworker's attempts to contact in between
- Subsequent attempts to contact via appropriate method (i.e. phone call / email / text / letter / postcard / third party message where consent allows) utilised after the last DNA, to inform the young person of closure and relay 'Invite to Contact' information.

Where a young person re-engages with a substance use service they should be seen as soon as possible, without penalty, and an assessment of the reasons for disengagement should be made to avoid future occurrences.

During assessment and ongoing formulation of an ICP, discussion with the young person should include action and mitigation in relation to the potential for

---

[219] NHS Wales Information Service and Welsh Government. 2019. Key Performance Indicators for substance misuse treatment services in Wales version 1.5. Available at: Substance Misuse Documentation - Digital Health and Care Wales (nhs.wales)

disengagement including detailing responses to the following questions including alternative options and actions:

- "How will we know when our work together is complete?"
- "If your motivation dipped or your circumstances changed, what could I / we do to help support you to remain in contact and engaged / keep you on track with your stated goals?"
- "What might cause you to drop out of service?"
- "If you were to drop out of service, how would you want me to respond?"
- "what measures can we put in place to reduce the risk of unplanned drop out and promote ongoing engagement?"

Where a young person is marked as an unplanned exit within an eight-week window since last contact and the young person re-establishes contact for on-going support (directly or via third party), the existing treatment episode should be re-opened. Case notes must clearly indicate the content of any discussions held outlining the additional actions required to remain engaged, including amendments to the ICP.

In the event that a young person is retained in custody or prison, and none of the multi-disciplinary, multi-agency service/s provided currently to the individual include support within the youth offender/prison environment, contact should be established with the relevant support staff within the institution and the existing comprehensive assessment and ICP shared with the new keyworker to ensure continuity of care for the young person. Likewise, when the young person is released to the community, transitional arrangements prior to release and reengagement with community services should include updating of assessment and ICP to resume support within the community.

3.7.3 Planned Exits

Welsh Government guidance[220] for selection of the 'Treatment Complete' outcome states, '*The client has reached their treatment goal(s) as agreed at commencement of treatment'.* In order to accurately understand and assess completion of treatment, it is imperative that clear goal setting and discussion takes place from the earliest appropriate contact and throughout the course of support and treatment with all supporting agencies.

The exit planning process should form part of the young person's ICP and be agreed with the young person and all services providing treatment and support. Other services detailed within the ICP and supporting the young person should be made

---

[220] NHS Wales Information Service and Welsh Government. 2019. Key Performance Indicators for substance misuse treatment services in Wales version 1.5. Available at: [Substance Misuse Documentation - Digital Health and Care Wales (nhs.wales)]

aware, with consent from the young person, that support is ending in advance of last formal face-to-face appointment.

Services should provide opportunities for step down support and Keeping in Touch (KiT) periods to ensure withdrawal of service is gradual and a gateway to service re-engagement is available as and when required. Relapse prevention planning and resilience work should be completed before KiT begins. This may include step down periods of scheduled telephone appointments following final face-to-face meeting, providing relapse prevention and motivational interviewing techniques.

Services should ensure each young person leaving service is provided with a support pack linked to the young person's ICP prior to exit – this should include details of who to contact should their situation change, including professionals and family / peers (e.g. safe people /a safety plan similar to those completed by Social Services). This pack should be developed in conjunction with the young person.

The exit or final treatment meeting should include completion of the Exit Children and Young Peoples TOPs, and review of ICP should be scheduled during last formal face-to-face appointment, and/or at end of KiT period. In addition, the young person should be encouraged to complete a service feedback form on exit.

Young people exiting services to have the option of being referred to a diversionary activities worker / services during the KiT period. This would enable the opportunity for diversionary activities and ongoing support where necessary.

3.7.4 Exiting youth justice services

Exit planning processes from YOSs are outlined as part of the National Standards[221] and Case Management Guidance developed by YJB. [222]

3.7.5 Information sharing

Management of planned and unplanned exits from care is grounded in appropriate sharing of personal information that is in compliance with data protection legislation. The Welsh Accord for Sharing of Personal Information (WASPI) is a single framework of agreed principles and standards that guides organisations in the sharing of personal information in Wales. WASPI is a tool supported by the Welsh Government that facilitates consistency and good practice which is crucial as services increasingly move to more integrated and collaborative models.

---

[221] Youth Justice Bard for England and Wales (2014). Standards for children in the youth justice system

[222] Youth Justice Board for England and Wales (2014). Case management guidance

3.7.6 Outcome measures

The statutory, strategic planning guidance for Children and Young People's Plans and Health, Social Care and Well-being Plans are outcome focused, requiring partners to indicate change and improved effectiveness using methods such as Results Based Accountability[223] or Outcomes Based Accountability. Detailed service plans should support an outcome-based focus.

3.7.6.1 The Children and Young Peoples Substance use outcomes monitoring

Services should record and report against the following outcomes in addition to reporting into the Welsh National Database for Substance Misuse:

- Employment.
- Education.
- Training.
- Reducing/stopping substance use behaviour.
- Reducing offending behaviour.
- Re-established links with family.
- Accommodation issues resolved.

Outcomes should be monitored and reported by the Substance Use APB, shared with all key partners and the information used to inform future service planning.

[223] Further information on RBA can be found at Results Accountability | Results-Based Accountability and Outcomes-Based Accountability resources provided by the Fiscal Policy Studies Institute (FPSI) and RBA Implementation Guide (raguide.org)

4 Training and workforce development

4.1 Background

A strategic approach to the development of the sector workforce is essential to better support implementation and delivery of effective and adaptive multi-disciplinary and multi-agency treatment and support for children and young people <25 years. There is a recognition that supporting providers to deliver effective substance use and related service treatment provision requires the development of highly skilled and knowledgeable young people's workers across custody and community settings. This will play an essential role in implementation of the key recommendations and securing the best possible outcomes for young people engaging with services.

The Welsh Government National Core Standards for Substance Misuse are used by Health Inspectorate Wales to review substance use services. Standards 23-25 include core standards that link to appropriate recruitment, training and development for the workforce working within substance use, specifically:

- Organisations have human resource management systems in place that:
    1. Support staff and value the individual contribution; and,
    2. Treat staff with dignity and respect, value, understand and respect diversity.
- Staff responsible for developing and delivering services are appropriately recruited, trained and qualified for the work they undertake in line with extant national guidance.
- All interventions are delivered by appropriately trained and qualified staff that are supervised where appropriate.

Health Inspectorate Wales use these Substance Misuse Core Standards to measure and assess the safety and quality of substance use services in Wales.

Having the right people to construct a competent team is part of an ongoing process which starts *before* recruitment and selection, carries on through employment and on until that individual leaves the service. A robust human resources and performance management structure is integral to service delivery which should include a workforce development lead.

In the current climate, there are increasing numbers of young people who have co-occurring needs that are more diverse and complex. It is crucial that the workforce becomes more highly skilled and knowledgeable so practitioners can engage in a trauma informed and culturally sensitive manner - completing detailed assessments, ICPs and delivering effective interventions and preventative approaches.

In addition, the Welsh Government's Health and Social Care Workforce Strategy details actions for improving the Welsh language skills of the workforce. The strategy builds on the foundations of the Wellbeing of Future Generations Act (2015), and Cymraeg 2050: A million Welsh speakers to create an engaged, healthy, flexible, responsive and sustainable workforce for the future that is reflective of Wales' diverse population, Welsh language and cultural identity.

Evidence of better clinical outcomes, and outcomes for people accessing care and support, highlights the vital importance we place on the delivery of health and social care in the language of Wales. An aim of the Strategy is to plan to meet the Welsh language needs of health and social care students, the workforce and ultimately patients and people in receipt of care and support across Wales.

Traumatic Stress Wales (TSW), a Welsh Government funded initiative, manages and delivers an improvement programme to offer evidence-based resources for professionals dealing with individuals who have experienced trauma. Specialist work-streams are in place for key groups – including offending populations; refugees, asylum seekers and other people seeking sanctuary; survivors of sexual assault; and gender-based violence. As part of the TSW initiative an emotional stabilisation training package is available aimed at staff working in primary care, social services and the third sector – and the TSW team are working with partners to develop a complementary training programme.

4.2 Workforce development and training across all sectors working with children and young people

The workforce within the young people's sector is multi-disciplinary and therefore consideration is needed to ensure the diverse learning and development requirements of the workforce are actively monitored and can evolve to meet the changing needs and trends and deliver within best practice standards.

All services supporting children and young people, within both community and YOS, should include recognising and responding to substance use throughout all workforce development planning, including recruitment, induction, reflective practice, training, exit planning and staff wellbeing support.

The importance of non-specialist workers who work alongside children and young people and their families is acknowledged, particularly as they are well placed to facilitate low-threshold interventions. However, the ability of information and advice services to support people with a substance use problem is partly dictated by the availability of other specialist and non-specialist services.

There is currently no single national co-ordinated workforce development strategy for practitioners who work with young people using substances, however, each APB has a responsibility to provide clear outcomes at a localised level. As such, each APB region should ensure provision of accredited substance use awareness and low-threshold training including intervention skills to help prevent and reduce harmful and problematic substance use. Due to the range of educational, sport and leisure, support and welfare services working with children and young people all staff outside of specialist substance use and youth justice services should have knowledge, skills and understanding about the complex use of drugs and alcohol and associated harms.

4.3 Workforce development framework in Youth Justice Services

The YJB has a comprehensive Workforce Development Strategy[224] with ambitious support functions including a Workforce Development Council, a National Learning and Skills Framework for Youth Justice and a Learning and Skills matrix. There is a Resource Hub that provides support for practitioners to help build a "Centre of Excellence". As a non-devolved function, there were some limitations for these documents with England-based referencing.[225]

YJB has 'Oversight and Support Effective Practice Senior Advisers' in Wales.[226] Key activities include:

- To maintain their knowledge about the latest workforce initiatives (by reference to the National Workforce Lead).
- To assist youth justice services in accessing appropriate learning opportunities.
- To ensure that workforce development is considered in peer review, performance management and service improvement activities.
- To advise services about the availability of relevant professional qualifications including the Effective Practice Certificate.
- To identify and collate training needs and other issues to the National Workforce Development Lead at YJB Cymru and nationally.
- To identify and facilitate the submission of examples of good/effective practice to the central YJB Social Research and Effective Practice team.

The YJB Workforce Development Strategy is governed under the Evidence and Practice Governance Group with the Workforce Development Lead that work alongside The YJB's Executive Management Group (EMG) to give direction to the

---

224 Youth Justice Board. Workforce development hub. Available at: Workforce development - Youth Justice Resource Hub (yjresourcehub.uk)
225 Youth Justice Board (2019) The Youth Justice Skills Matrix Workforce Development Strategy, 2021-2023 - Youth Justice Board (January 2021) - Youth Justice Resource Hub (yjresourcehub.uk)
226 Youth Justice Board (2019) The Youth Justice Skills Matrix Workforce Development Strategy, 2021-2023 - Youth Justice Board (January 2021) - Youth Justice Resource Hub (yjresourcehub.uk)

essential strategic requirements and priorities for Youth Justice Workforce Development.

4.4 Workforce development in community substance use and allied services

A Healthier Wales[227] identifies the need for a motivated and sustainable health and social care workforce, with specific focus on evidence that 'The best new models being developed in Wales share a common characteristic: a broad multidisciplinary team approach where well-trained people work effectively together and all the up-to-date and relevant information...'. In order to achieve this and to support these new models of care, services must strengthen the support, training, development and services available to the workforce with a focus on building skills across a whole career and supporting their health and wellbeing.

A 'National Evidence and Effective Practice Governance' Group should be established for substance use workforce development, building a joint approach across Wales on education, training, and development; sharing best practice and ensuring the quality assurance of training provision across children and young people using substances and linked with the youth justice and criminal justice systems.

There is currently no single co-ordinated workforce development strategy across Wales following the completion of the Substance Misuse Workforce Strategy in 2010. The Parliamentary Review of Health and Social Care in Wales[228] (January 2018) called for One Seamless System Across Wales and work has been done to work towards this but further analysis across the sector itself demonstrates very little focus on substance use itself. The increasing numbers of service users presenting with complex needs, wider than substance use, requires practitioners to effectively engage and understand the challenges and holistic support needs that children and young people have. Being able to holistically assess a young person and provide bespoke appropriate interventions and preventative techniques are crucial competencies to prevent further harm.

The Drug and Alcohol National Occupational Standards[229] describe the different tasks and activities that are relevant to a particular area of work and explain the underpinning knowledge and understanding required to carry these out. In addition, the Trusted Charity Accreditation[230] states there should be a commitment to

---

[227] Welsh Government (2018) Healthier Wales Report A Healthier Wales (gov.wales)
[228] Parliamentary Review of Health and Social Care (2018)Parlimentary Review of Health and Social Care in Wales Final Report (gov.wales)
[229] Skills for Health (2008) Drugs and Alcohol National Occupational Standards (DANOS) Guide DANOS_Guide_2005 for DANOS PB 7 Feb05.doc - NeoOffice Writer (drugsenseuk.co.uk)
[230] WCVA. Quality Assurance in Third Sector Organisations 2019 WCVA Quality Assurance in Third Sector Organisations 2019 - Google Search

organisational learning and continuous improvement – rather than a ‘one off’ process, third sector organisations are required to regularly review progress against defined Trusted Charity (formally PQASSO) indicators.

A national ‘Professional Competencies Framework’ should be agreed for multi-disciplinary professionals supporting Children and Young People up to the age of 25 (and their families) using substances. This framework should include:

- Core competencies such as Safeguarding, GDPR, Confidentiality and Professional Boundaries.
- Basic wellbeing and resilience that recognises and responds appropriately to cultural sensitivities such as LGBTQ+, Ethnic minority, ACEs, homelessness, poverty and trauma informed approaches.
- Specialist learning and development that is specific to working with entrenched drug and alcohol users such as substance use knowledge, Harm Reduction advice and specialist Interventions.