Drug Prevention among *vulnerable* young people

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Introduction

1.1 This briefing focuses on recent [2002-2004] government sponsored research on drug prevention among vulnerable groups of young people, and considers how this relates to current government policy and guidance. This forms part of a complete review of all recent evidence derived from government sponsored drug prevention work to be published by the National Collaborating Centre for Drug Prevention at the end of 2005.

1.2 Different government departments and bodies have published distinct research on these populations, and it is the aim of this review to synthesise these findings in order to provide evidence based recommendations and to highlight gaps in research which require attention. The review process has proceeded in accordance with established National Institute for Health and Clinical Excellence [NICE] protocols.

1.3 A full methodology, which has undergone peer review by NICE research specialists, is available on request from the corresponding author.

1.4 The findings here must all be considered within the context of relevant policy. Drug prevention among young people is a key element of the Updated Drug Strategy [*Home Office, 2002*] and the need to target particularly vulnerable groups is emphasised. In particular, the 2004 Spending Review Public Service Agreement [PSA] states that by 2008 there should be a reduction of use of all Class A drugs and the frequency of use of any illicit drugs among all young people under the age of 25, especially by the most vulnerable young people. £65 million has been allocated for local delivery of the young people aim of the National Drug Strategy under the Young People Substance Misuse Partnership Grant [2004]. One of the key foci of expenditure is early intervention and prevention for vulnerable groups.

1.5 The Every Child Matters Change for Children programme aims to reform children's services to enable them to reach their full potential, tackling not only substance use but also the risk factors that may lead to substance misuse. This work is closely linked to the Updated Drug Strategy and will contribute to the target above. The Every Child Matters Change for Children: Young People and Drugs strategic guidance outlines national expectations for local delivery of young people's substance misuse services [see http://www.drugs.gov.uk/Reportsand Publications/YoungPeople/1111061244/ECM_YPD.pdf].

1.6 'Choose not use Illegal Drugs' is part of the 'Be Healthy' objective. The Choosing Health agenda, while not specifically focussing on drug use, aims to reduce health inequalities and improve the provision of information and advice to vulnerable groups of young people.

1.7 In this report, approaches targeting the larger population of vulnerable young people will be considered and then those targeting more specific groups will be reviewed in turn.

1.8 It must be acknowledged that these groupings may be considered artificial and group membership does not imply homogeneity of need. Young people may move between these groups, belong to more than one group at a time and/or may not identify themselves by these labels. For example, drug misuse and homelessness may be just two of many problems faced, and may not cause the greatest difficulty to that person. However, this approach can be useful in targeting interventions and ensuring that particular needs are being met.

1.9 The report is divided into nine sections focusing on different populations. Each section contains a summary box and sub-sections considering: Population description and drug use; Approaches; Gaps and inconsistencies; and Policy implications and recommendations.

1.10 A summary is provided considering implications for drug prevention work across these groups.

Vulnerable young people

Population:	Vulnerable young people
Description of drug use:	High levels of drug use compared to general population and wider youth population
Specific policy and guidance:	Assessing Local Need: Planning Services for Young People [*2002*], First Steps in Identifying Young People's Substance Related Needs [*2003*]
Targeted professionals:	Drug [and Alcohol] Action Teams [D[A]ATs], professionals providing services to children and young people in statutory or voluntary health, social care, education and the criminal justice agencies/organisations
Key research areas:	Impact of the Positive Futures programme [*MORI, 2004a; MORI, 2004b; Humphreys et al., 2003*]; Use of communications to reduce drug use [*Stead et al., 2002*]; Impact of Health Action Zone pump priming initiative on young people's service provision [*Bauld et al., 2004*]
Research gaps:	Longitudinal research is needed to assess the impact of Positive Futures on drug use and healthy lifestyle choices of young people; co-morbidity between childhood psychiatric problems and initiation of substance misuse

POPULATION DESCRIPTION AND DRUG USE

2.1 The population described are young people considered to be at increased risk of involvement in drug use, and in particular, patterns of use having detrimental effects on life. Whilst problems related to experimentation with illicit drugs should not be underestimated, many consider this a normal part of adolescent behaviour [*HAS, 2001*]. However the likelihood of drug use and developing drug use problems is not uniformly distributed among young people and initiation into drug dependence is through experimental drug use. Key risk factors have been identified [see table 1], which are strongly interconnected and seldom found in isolation.

2.2 From the identification of risk factors and their inter-relationship, groups of young people that may be particularly vulnerable to drug use and misuse have been identified for targeted prevention work. It is important to note that although this approach may be a useful tool in service delivery, inclusion within one or more of the indicated groups is not seen as a pre-cursor to problematic drug use. These groupings are not exclusive, many young people will be part of multiple groups or transfer between groups and there may be particularly vulnerable sub-sets of young people within these groups.

2.3 Several studies have sought to identify 'at risk' groups. Despite variations, some strong common themes are present. The Health Development Agency [now NICE] review of drug use prevention among young people [*2004*] identified the following key groups:

- Children whose parents misuse drugs
- Young offenders
- Looked-after children
- Young homeless
- School excludees/truants
- Sex workers

2.4 The groups of young people indicated in this report are based on those identified above. However, young people from Black and Minority Ethnic [BME] communities are also considered as the literature suggests increased levels of vulnerability among this population, particularly in relation to access to and availability of appropriate services.

2.5 Little data are available concerning drug use among vulnerable young people as a population and indeed the value of such data may be limited by the heterogeneity of the population. However some general findings are worth noting:

2.6 Data from the Youth Lifestyle Survey 1998/99 indicated that in this population drug use was more prevalent, drugs were more accessible and monthly use of Class A drugs was higher among young people who would be considered as 'vulnerable' than among the general youth population [*Goulden & Sondhi, 2001*]. Whilst level of drug use could not be directly associated with problematic use, it may exacerbate other problems. Heavy use and early initiation are both considered to be risk factors for future problematic use.

2.7 Some studies suggest that young people between the ages of 11 and 14, are particularly vulnerable, especially in relation to progressive disengagement from school, less supervision at home and drug experimentation [*Hammersley et al., 2003; Drugscope & Department of Health, 2000*].

2.8 Young women, as a sub-set within these defined vulnerable groups, have been found to have particularly complex and serious drug use problems [*Melrose & Brodie, 2000; Hammersley et al., 2003*]. As they are often in the minority, these young women may lack access to appropriate services.

2.9 The environment in which young people live can be linked to drug use behaviours. Data from the Psychiatric Morbidity Survey, [quoted in *ACMD, 1998*], suggested that lifetime use of any drug among young people living in institutions was twice as high as in the household survey. Among homeless people this was six times as high. Drug use is also found to be significantly associated with living in an "unstable" environment [*Hamilton et al., 2000*].

2.10 Primary studies of drug use among disadvantaged young people found that their drug use behaviour was characterised by polydrug use [*e.g. Wincup et al., 2003; Hammersley et al., 2003*]. Despite this, stigma was still attached to injecting [*Melrose, 2004*]. Patterns of drug use among this group were fluid and there was evidence to suggest that vulnerable young people are as capable of adapting their own drug use over time as their less vulnerable peers [*ibid.*].

2.11 MacDonald and Marsh [*2002*] highlighted the complexities of the relationship between vulnerability and drug use based on a qualitative study of young people living in a severely socially excluded and deprived area. More simplistic notions of normalisation were questioned as drug abstinence was found to co-exist with recreational and problematic drug use, although it was suggested that the distinction between the latter two categories was becoming increasingly blurred. It was suggested that drug careers are shaped by the interaction of individual factors [e.g. family background] with structural opportunities [e.g. access to decent employment] at different points in time. The importance of considering young people's biographies within the broader context [e.g. socio-economic climate, drugs markets] was stressed.

2.12 Home Office Research on drug use amongst vulnerable groups, using Crime and Justice Survey 2003 data, is due for publication at the end of March 2005, and so is not included in this summary. Information on performance against the SR 2004 PSA targets on action against illegal drugs will be available in the Home Office's Departmental Annual Reports due at the end of April and interim reports published in the Autumn of each year.

APPROACHES

2.13 Approaches targeting a wide range of young people considered to be 'at risk' of problematic drug use have included: the Positive Futures programme; the use of communications strategies; the short term 'pump-priming' funding of drug prevention projects and the assessment and identification of those most at risk.

Positive Futures

2.14 Positive Futures is a national sport based social inclusion programme for vulnerable young people aged 10-19. The programme uses sport and other activities to engage with marginalised young people, develop self-esteem and offer informal education around drugs issues.

2.15 Evidence from a participatory multimedia project with young people supported this approach. Drugs were highlighted as a major stressor and young people cited alternative activities as a key intervention to divert them from participating in risky behaviours [*Humphreys et al., 2003*].

2.16 Much of the research evidence generated to date in relation to Positive Futures has focused on output data. However, the Key Elements monitoring programme highlighted evidence of young people demonstrating improved social relations, better performance at school and securing employment. These data must be treated with caution however as no detail was given about how these were assessed and the role of Positive Futures in these achievements has not been analysed [*MORI, 2004b*].

2.17 Crabbe & Slaughter [*2004*] examined the mechanisms through which estate based social inclusion interventions, including Positive Futures funded projects, are developed, participants engaged and results achieved. The report recommends a flexible approach within a non-hierarchical organisational structure. The importance of the ability of project staff to develop relationships with the participants through their intimate awareness of local culture and their skill as sporting coaches was emphasised.

2.18 No data have been reported regarding the success of drug prevention interventions within the projects.

Communications

2.19 Communications can be used to challenge young people's drug norms and their perceptions of specific drugs; heroin and cocaine in particular. The government funded FRANK campaign seeks to do this. There is also a role for communications in raising awareness of sources of information and support within drugs education [*Stead et al., 2002*].

2.20 School based drugs education may be better received by young people if the information provided is balanced and non-didactic and delivered through experiential methods [*Stead et al., 2002*].

2.21 Young people were likely to reject imagery of drug use as deviant, as they were likely to be more accepting of use [*Stead et al., 2002*].

2.22 The most appropriate roles for communications campaigns were raising awareness of messages and interventions, and encouraging attitudinal change. Television could be a useful medium through which to communicate with vulnerable young people, as disadvantaged youths are heavy media consumers, particularly of mainstream television shows [*Stead et al., 2002*]. However, research from the USA, where mass media campaigns are long established have shown mixed results, and whilst parents received them favourably, they have no distinguishable effects on youth [drug-related] behaviour.

2.23 Multi-component programmes, incorporating media based interventions with interpersonal and community interventions, are more effective than the use of media alone [*Stead et al., 2002*].

2.24 Media advocacy has been used to influence public health legislation, draw attention to youth access to substances, lobby alcohol and tobacco marketers and stimulate community action, with some success. Within this context, media advocacy should be used to influence drug norms, build support for interventions and policy, redefine drug use as a structural problem and stimulate action among local service providers and the community [*Stead et al., 2002*].

2.25 Involvement of young people in the development of a communication campaign may make the campaigns more credible to the audience and have wider implications associated with young peoples' citizenship [*Jones et al., 2004*].

2.26 It is generally accepted that drug use among Deaf young people [those who use British Sign Language [BSL]] is similar, if not higher, than among the general population. Currently there is limited provision for this group and translation of material into BSL can be complex with no equivalent for some drug misuse terms. These young people could be accessed through text messaging, TV, and deaf pubs and clubs [*COI, 2004*].

Pump-priming of drug prevention projects

2.27 Over £7 million was distributed to Health Action Zones, located in some of the most deprived areas in England with the aim of expanding drug prevention services for vulnerable young people through a short term investment of funding. In total 160 distinct projects or activities were funded [*Bauld et al., 2004*].

2.28 While on a local level the funding initiative provided scope to develop innovative projects and leverage to bring relevant agencies together, on a national level the evaluation identified no significant differences in the service provision between areas that received the HAZ funding and those that did not. This may be attributed to an insufficient level of funding and its short term nature, although results may also have been blurred by changes in the policy context leading to an increased emphasis on drug prevention initiatives in all D[A]AT areas [*Bauld et al., 2004*].

2.29 Sharing of expertise among interagency partnerships increased the effectiveness of interventions. However the short term nature of staff contracts had a negative impact on the development of projects with many staff leaving before the end of their contracts in order to secure further employment [*Bauld et al., 2004*].

2.30 Approaches to drug prevention among young people that involved families, and in particular the parents of drug users, were viewed to be effective, although there was little formal evaluation [*Bauld et al., 2004*].

ASSESSMENT AND IDENTIFICATION

2.31 The introduction of the Young Person's Substance Misuse Plans in 2001 was intended to enable a multi-agency approach to be taken towards targeting drug prevention at vulnerable young people. A standard methodology for needs assessment has been produced for D[A]ATs to assess the local need and gaps in services [*DrugScope et al., 2002*].

2.32 Guidance has also been published highlighting the responsibilities of all professionals providing services to children and young people, [e.g. within statutory or voluntary health, social care, education or criminal justice system] in relation to identifying drug related needs and responding appropriately. A framework for identifying these needs within existing assessment procedures has been provided [*Britton et al., 2003*].

GAPS AND INCONSISTENCIES

2.33 Despite the Positive Futures programme being one of the key national interventions within the National Drug Strategy, little research emphasis has been placed on drug related outcomes.

2.34 Although mainstream TV was highlighted as a useful way of communicating with vulnerable young people, messages that are appropriate for this group may not be suitable for prime time transmission, given the generally more accepting drug norms of this group.

POLICY IMPLICATIONS AND RECOMMENDATIONS

2.35 Further expansion of the Positive Futures projects into non-sport activities could introduce a new audience to the projects and in particular encourage more girls to engage.

2.36 Recruitment and retention of staff within the Positive Futures programme is a key issue particularly as the development of the relationship between the group leader and the young person is seen as fundamental to the success of the programme.

2.37 Drug prevention communications need to be long term and consistent. Messages must be accurate, realistic and non-judgmental.

2.38 Most drug use and misuse issues among Deaf young people should be dealt with by primary care services whilst specialist regional teams are needed to tackle more serious cases of misuse. This would allow linkages to be made with other agencies and organisations that will help support the complex needs of Deaf young people.

2.39 Two years funding is unlikely to be sufficient for developing effective drug prevention interventions and convincing agencies to commit mainstream funding to support their continuation.

2.40 Positioning new staff within existing agencies may help to provide greater job security.

2.41 An exit strategy should be developed early in the lifetime of a project to enhance the likelihood of its continuation, or 'mainstreaming'.

2.42 Identification of drug related needs to be included in all assessments for vulnerable young people [for example those carried out by social services, Criminal Justice Service [CJS], Health services, Pupil Referral Units [PRUs] etc.], this could be achieved through widespread adoption of national assessment guidance.

Table 1 Risk and Protective Factors:

While some factors may be categorical [e.g. early onset of illicit drug use], many are dimensional, with relative levels of risk and protection.

CLASS	RISK FACTORS	PROTECTIVE FACTORS
Environmental/ contextual	High drug availability Low socio-economic status Drug-using peers Delinquent peers	Prosocial adult friends Prosocial peers High socio-economic status
Family	Parental substance abuse and deviance Low parental monitoring Parental rejection Poor disciplinary procedures Family conflict/divorce Familial/environmental predisposition/addicted parents Low parental expectations Family disruption including employment	Absence of early loss or separation Cohesive family unit Parent-child attachment High parental supervision and monitoring
Individual biography	Early onset of deviant behaviour, smoking and drinking Early sexual involvement Early onset of illicit drug use Rapid escalation in substance use Positive expectations and knowledge about substance use History of behaviour problems	Late onset of deviant or substance-using behaviours Negative expectations and cognitions about substance use Religious involvement
Personality	Strain/stress Depression Aggression Impulsivity/hyperactivity Antisocial personality Sensation seeking Mental health problems	High self-esteem Low impulsivity Easy temperament
Educational	Poor school performance Low educational aspirations Poor school commitment Absence, truancy and drop-out Little formal support	Good teacher relations High educational aspirations High parental educational expectations High educational attainment Good formal support in education

Source: Adapted from Canning et al. 2004

Young offenders

Population:	Young offenders
Description of drug use:	High levels of drug use compared to general population, for example: life time prevalence [LTP] among Youth Offending Team [YOT] clients; cannabis 86%, cocaine 25%, crack cocaine 18% and heroin 11%. Fifteen percent were rated as being at risk of drug use problems
Specific policy and guidance:	National Specification for Substance Misuse for Juveniles in Custody [*2004*], Guidance for Adult Arrest Referral; Responding to Children and Young People [*2003*], Key Elements of Effective Practice: Substance Misuse [*2003*]
Targeted professionals:	Heads of YOTs and Youth Offenders Institutes [YOIs], Secure Training Centres and Local Authority Secure Children's Homes; Police, Arrest Referral Scheme providers, D[A]ATs, Community Safety Partnerships, Crime and Disorder Reduction Partnerships [CDRPs]; practitioners, managers and members of strategic partnerships working with young people in the community or secure estate
Key research areas:	Prevalence and patterns of drug use among young offenders and related offending, risk and lifestyle factors [*Hammersley et al., 2003*]; Drug misuse treatment needs of young offenders in prison [*Borrill et al., 2003*]
Research gaps:	Longitudinal studies of relationship between drug use, offending and adolescent risk taking; drug use among young offenders from BME communities; initiation of drug use in young offenders

POPULATION DESCRIPTION AND DRUG USE

3.1 The population descriptor applies to those young people aged 10-17 found guilty of, or cautioned for, an indictable offence [under 20 among the custodial population].

3.2 Of offences committed by young people, and resulting in a disposal of some sort, 84% were committed by those from a White background, 6.2% by those from Black or Black British population and 3.1% Asian/Asian British [*Youth Justice Board, 2004*].

3.3 One quarter of arrestees in England and Wales are under 18 [*Sondhi et al. 2002*]. In one national survey of YOT clients across England and Wales, the most common offences resulting in referral to a YOT were theft [36%], disorder [16%], motoring offences [16%] and assault [15%]. Five percent of referrals were the result of drugs offences. Most respondents admitted to committing six or more different types of offences. One fifth claimed to have committed a range of offences including shoplifting, taking a car without consent and buying and/or selling drugs more than 20 times in the last year [*Hammersley et al., 2003*].

3.4 As with the general population, the most widely used drug among this YOT client sample was cannabis [LTP 86%]. More than forty percent had ever taken ecstasy, and 25% had used cocaine and LSD. Just under one fifth had used crack cocaine and 11% had used heroin, considering the age of the population, these rates are very high, however use of these drugs was infrequent. Few injectors were identified but women were disproportionately represented [*Hammersley et al., 2003*]. This sample may exaggerate the severity of drug use and offending among this population as those with greater involvement with the YOT and longer offending histories were over represented.

3.5 There is a lack of evidence regarding the impact of ethnicity on drug use behaviours of young offenders. A study of drug use among adult male prisoners from ethnic minorities reported patterns of drug use that differed from those based on predominantly White populations. In particular the use of crack cocaine was more prevalent [*Borrill et al., 2003*].

3.6 A study of young men in prison with identified problems related to substance misuse, reported that their drug use behaviours were, like the general population, characterised by a 'pick and mix' approach and differed from the older prison population with an increased use of dance drugs, and greater stigma attached to the use of heroin and injecting, particularly among those from minority ethnic groups [*Borrill et al., 2003*]. One fifth of this sample claimed to have injected drugs at some time; at least half of these reported sharing equipment.

3.7 The relationship between drug use and offending was complex. While drug use may have become socially 'normalised' among the young offender population, their drug use was not necessarily problematic or linked to their offending, and must be considered within the context of the wider problems facing these young people [*Hammersley et al., 2003*].

3.8 The use of more socially acceptable substances [alcohol, tobacco and cannabis] was useful in the prediction of offending compared with the use of other drugs. Hammersley and colleagues [*2003*] also found no evidence to support the progression to heroin/cocaine use and intravenous administration described among delinquents in the 1980s.

3.9 Analysis of data from a small sample of young offenders [aged 12-30] suggested that the prolificacy of offenders is significantly associated with drug use, with serious or persistent offenders having the highest prevalence of drug use and non-offenders the lowest. In particular, prevalence of cocaine use within the last year was twelve times higher among offenders compared to non-offenders and male serious offenders were four times more likely to have used a Class A drug in the last month than female serious offenders [*Goulden & Sondhi, 2001*].

3.10 An analysis of the relationship between drug use, offending and identified risk factors among young offenders suggested that life difficulties or events, disliking and/or being excluded from school, lack of positive coping mechanisms and expectation of getting into trouble again were key factors relating to both behaviours [*Hammersley et al., 2003*].

APPROACHES

3.11 Young offenders are identified as a vulnerable group within the Updated Drug Strategy [*Home Office, 2002*]. Interventions specifically targeted at this group are; the inclusion of prevention programmes at Pupil Referral Units [PRUs]; increased powers for drug testing and treatment for young offenders; named drugs workers in each YOT; and drugs interventions as part of sentencing for young offenders with drug misuse problems.

3.12 In a study of drug use among young offenders in contact with YOTs, one quarter of respondents had been referred to a drug/alcohol project during their current order; this included only half of those deemed at high risk of drug misuse problems [using Assessment of Substance Misuse in Adolescents [ASMA]]. Only those using heroin, opiates or crack cocaine were likely to have had more than one contact with the service. Few of those that had accessed services felt that the help had been useful. This population also had a history of accessing help from the GP, social services and A & E. However two fifths regarded this provision as only 'better than nothing' or 'no use at all'. This suggests a gap between current service provision and the needs of this group [*Hammersley et al., 2003*].

3.13 Among those in secure facilities there was some limited evidence of support, from staff and young offenders, for the drug rehabilitation unit, rehabilitation and relapse prevention programmes. In particular, it was suggested that self-policing within the rehabilitation unit was a contributory factor to the rarity of drug use there. However, waiting times were seen as prohibitive [*Borrill et al., 2003*].

3.14 The National Specification for Substance Misuse for Juveniles in Custody [*YJB, 2004a*] requires that the assessment and identification of drug use needs are an integral part of reception into a facility, that a range of education and prevention programmes that cover all drugs and include harm reduction messages are to be provided and that support programmes acknowledge the full range of needs of the young people. Small group work, peer led interventions and counselling are highlighted as potentially useful interventions.

3.15 Arrest referral was initially established for use with adults, offering arrestees the opportunity to access drug treatment services. Guidance for adult schemes wanting to extend their services to include young people includes a strong emphasis on a long term, partnership approach. Pilot arrest referral schemes for young people were established in 10 D[A]AT areas in 2003 and are subject to evaluation. This work has not yet been published.

GAPS AND INCONSISTENCIES

3.16 The impact of gender and ethnicity on the experiences and behaviours of young offenders should be explored.

3.17 Drug use among these young people varies dramatically according to the data source, and is expected to either over represent [i.e. YOI or YOT data] or under represent [i.e. Youth Lifestyle Survey data] the problem].

3.18 There is a need to examine initiation of drug use in young offenders, and its relationship to establishment of institution based peer groups and social networks.

IMPLICATIONS AND RECOMMENDATIONS

3.19 Interventions need to be age appropriate and consider the wide range of substances used by this group.

3.20 Drug and alcohol education and prevention should be targeted at young people between the ages of 11 and 14 years old, and those becoming disengaged with school.

3.21 Teaching positive coping mechanisms may be valuable.

3.22 Harm minimisation messages need to be delivered, particularly in relation to the sharing of injecting equipment and polydrug use. Existing negative attitudes towards heroin and injecting should be promoted.

3.23 Improved access to rehabilitation units and rehabilitation and relapse prevention programmes in YOIs.

3.24 The use of peer educators within Young Offenders Institutes may merit wider extension.

Cared for children

Population:	Cared for children
Description of drug use:	High levels of drug use compared to general population, [e.g. LTP Cannabis 73%, 34% daily smokers; LTP heroin or crack cocaine = 15%]. No gender differences, but with respect to ethnicity, drug use in Black children < White < Mixed ethnicity. Up to 30% of the population have been described as existing problematic users, or potentially problematic users
Specific policy and guidance:	Promoting the Health of Looked After Children [*2002*]; Children's Act [*2004*]; Every Child Matters: Change for Children in Social Care [*2004*]
Targeted professionals:	Directors of Children's Services; joint service commissioners; adult drug services; social workers, social care workers, leaving care teams
Key research areas:	Transitions from care to independent living [*Ward et al., 2003*]; Drug Prevention training for project workers and carers [*Bauld et al., 2004*]
Research gaps:	Relationship between parental and child drug use; transition out of care requires as much consideration as experiences of care itself

POPULATION DESCRIPTION AND DRUG USE

4.1 This population descriptor refers to young people accommodated in state-sponsored residential and foster care. Often facing early and accelerated social independence, up to 75% have not completed formal education, and 50% are unemployed at the time of leaving care [compared with approximately 14% and 11% respectively in the equivalent general population; *DfES, 2004c; Labour Market Trends, February 2005*].

4.2 Key features of the Government's integrated strategies for promoting health, safety, achievement, economic stability and engagement for cared for young people include the Common Assessment Framework, promotion of interagency governance, and multi agency working.

4.3 As with other populations of vulnerable young people, Home Office Research Findings on drug use amongst this group are not available. The DfES recommends that screening for drug misuse should be a core part of care planning and data collected on the number of all children looked after for at least 12 months who were identified as having a substance misuse problem during the year; the number of these children who received an intervention for their substance misuse problem during the year; and the number of these children who refused an offered intervention.

4.4 Screening should take place in the context of a holistic assessment of needs and may result in one of three possible options: no need is identified; need is identified and a care plan agreed, substance use being one area of action, but not the major focus; substance misuse is identified and requires specialist intervention focusing on a substance misuse based care plan.

4.5 Primary investigations indicated that this population reported higher levels of all illicit drug use than the general population [including approximately 10% reporting heroin and/or crack cocaine], used drugs more frequently, and were initiated into drug use at an earlier age [*Newburn & Pearson, 2002; Ward 1998; Ward et al., 2003*]. It has been reported through twin studies that early initiates of cannabis, for example, have a risk of other drug use, alcohol dependence, and drug abuse/dependence 2.1 to 5.2 times higher than those of their co-twin [*Lynskey et al., 2003*]. These findings remained after controlling for other known risk factors such early-onset alcohol or tobacco use, parental conflict/separation, childhood sexual abuse, conduct disorder, major depression, and social anxiety.

4.6 Compared to other events in their lives, many young people perceived drug use as a relatively minor challenge [*Ward et al., 2003*].

4.7 Important issues impacting upon drug use included parental/carer use, challenging life events [including bereavement, rejection, early independence and responsibility, and sex work], and transition from care [*Ward et al., 2003*].

4.8 Upon leaving care, the majority of drug users in one sample had reduced the frequency of drug intake [*Ward et al., 2003*]. The most commonly cited reasons were maturation and social responsibility; becoming a parent; and awareness of dependence and health consequences. This corresponds well to reasons identified in general population studies where individuals have reported stopping using drugs when they reached their mid twenties, coinciding with dedication to career and family, or if they no longer desired the effects that drugs produce [*Chen & Kandel, 1998*].

4.9 Some members of these populations had grown up in homes where parental problematic drug use was evident. In a study of the social and behavioural characteristics of drugs treatment seeking individuals, parents with children in care or living elsewhere showed high prevalence of a number of indicators, including more regular drug use and more adverse social circumstances [*Meier et al., 2004*]. This profile of drug use and adverse social circumstance may promote normalisation, and act as a barrier to some young people returning to the care of their parents.

APPROACHES

4.10 There has been no work investigating the impact of specialised interventions on problematic drug use in looked after young people. Existing work has reported drug use patterns and behaviours, and the drug misuse training experiences of care workers.

4.11 Some care workers perceived drug use to be normalised in the young people they worked with, although there was little focus on the effects of volatile substance abuse [VSA] [*Bauld et al., 2004*]. Many report that they had insufficient standardised drug-related training in order to respond to presented needs.

4.12 There were differences between the approaches towards drugs of staff who had been on an evaluated dedicated training course and those who had not; the former preferred harm reduction approaches, whilst the latter abstinence [*Bauld et al., 2004*].

4.13 Informal harm reduction was seen as a viable approach, although drug use on premises is generally not tolerated [*Bauld et al., 2004*]. Care workers needed support in identifying appropriate target agencies for individuals with more problematic drug using behaviours.

4.14 Staff frequently reported a need for training on effective communication skills, as there were already many recognised sources of drugs information. Additionally, many young people felt that staff were only concerned about personal drug use if it impacted upon the professional workings of the establishment [e.g. legal liability [Section 8 of the MDA 1971], disciplinary procedures etc.].

GAPS AND INCONSISTENCIES

4.15 A training disparity exists for staff; there is a need for focus on transferable skills.

4.16 Cared for children are a marginalised group. It is important to explore how drug use, which is linked to anti-social behaviours, is perceived as a further stigmatising factor in this population and how this may prevent seeking help for any arising problems. However, young people themselves may perceive their drug use as a positive and socially cohesive part of their lives.

IMPLICATIONS AND RECOMMENDATIONS

4.17 Standardised drug education [including VSA] needs to be available to those caring for young people in residential units.

4.18 Staff training should not be limited to information delivery, and there is a need to differentiate between universal and secondary approaches. It is not considered appropriate for care workers to provide individual counselling unless they have received adequate training.

4.19 Introduction of screening questions during 2005/06 will help to identify those young people with drug misuse related needs.

4.20 Not all residential units have formal drug use policy and practice guidelines. There is a great problem with staff turnover, resulting in lack of consistency in institutional drugs policy and a loss of skills.

4.21 Provision should be developed for marginalised groups within the care system [e.g. young people of BME origin, sex workers, those with behavioural problems].

Young homeless people

Population:	Young homeless people
Description of drug use:	Use of all types of drugs is greater than corresponding general population samples
Specific policy and guidance:	Achieving Positive Shared Outcomes in Health and Homelessness [*2004*]; Drug Services for Homeless People: a Good Practice Handbook [*2002*]
Targeted professionals:	Drug services; D[A]ATs; local authorities; homelessness agencies
Key research areas:	Population and drug use description [*Wincup et al., 2003*]; access and barriers to existing national information service [FRANK] [*Frontline, 2004*]
Research gaps:	No targeted evidence based drug interventions in the UK

POPULATION DESCRIPTION AND DRUG USE

5.1 It has been estimated that up to 52,000 young people under the age of 19 were homeless in 2003 [*Pleace & Fitzpatrick, 2004*]. Often misperceived as being forced to the streets by their own actions, such generalisations fail to take into account dysfunctional homes and adverse environments [*Ginzler et al., 2003*].

5.2 Studies conducted on behalf of the Department of Health, Home Office, and the charity Crisis have indicated that whilst drug choices in young homeless populations mirrored that of the general population, levels of use [e.g. prevalence and frequency] exceeded general population reporting [*Adamczuk, 2000; Fountain & Howes, 2002; Wincup et al., 2003*]. For example, up to 95% had used an illegal drug. In relation to heroin and crack cocaine use, combined last year prevalences of 16% and 13% respectively, were significantly greater than the estimated 0.2 and 0.5% [16-24 year olds] reported in the 2002/03 analysis of the British Crime Survey [*Condon & Smith, 2003*].

5.3 Primary evidence from the USA suggested that homeless young people follow different patterns of use than other population groups [*Maclean et al., 1999*]. Although there was a steep rate of initiation shortly after leaving home, being homeless per se was not been shown to be a trigger for using drugs, as complex aetiological factors had often been established before becoming homeless. However, in many cases change in housing status exacerbated escalation, and becoming homeless often reduced the opportunities to reduce drug use.

5.4 Drug use was the second most common explanation for homelessness in one sample but this was not always perceived or treated as problematic use [*Wincup et al., 2003*]. Often this led to being asked to leave the family home.

5.5 Homeless youth that did not report a supportive social network were found to be significantly more likely to report current illicit drug use, despite the existence of drug users within network groups in those with support [*Ennett et al., 1999*].

5.6 There may be a high level of undiagnosed psychopathological disorder [directly or indirectly related to drug use], and a high level of school exclusion among homeless young people. Subsequently, many of the target group may have missed out on any formal drugs education due to being absent from school. Those that had received drugs education felt that its impact was limited by the fact that drugs filled a need and were part of their culture [*Frontline, 2004*]. Most drug knowledge came from personal experience [experiential learning], followed by literature, friends and school [observational and database learning].

5.7 Drug and alcohol education and prevention should be targeted at young people between the ages of 11 and 14 years old, and those becoming disengaged with school.

APPROACHES

5.8 Little work has been described and evaluated in the UK.

5.9 FRANK was widely recognised by one sample of homeless young people, but they preferred one-to-one contact to internet or phone based support [*Frontline, 2004*]. Support workers working with young homeless people felt that helping the young people with their drug problem was part of their role although little interactive and counseling work was done. Often information provision and informal discussion was the only prevention work received [*Wincup et al., 2003*].

5.10 Accommodation, employment, and financial matters were cited as the most pressing need for young people [*Wincup et al., 2003*]. Twenty three percent reported needing assistance for self-reported drugs problems.

5.11 Appropriate referral seemed to be the most common response to drug use by homelessness service staff, although the service often provided a wide ranging point of access to other interventions [*Wincup et al., 2003*].

GAPS AND INCONSISTENCIES

5.12 Whilst homelessness may exacerbate drug problems or escalate initiation, UK based preventative measures have not been developed or explored.

5.13 There is a disparity between FRANK awareness and utility. No evidence has been presented of the effectiveness of current FRANK drug prevention resources. Most of the published UK work seems to be focused on homelessness and how the young people became homeless.

IMPLICATIONS AND RECOMMENDATIONS

5.14 Resources must not stereotype young homeless people, and should be targeted at providing information at an early stage before the young person becomes homeless. Harm reduction and risk reduction programmes need to be tailored to facilitate engagement based upon clients' life circumstances, availability, motivation, and environmental protective factors such as community support and mentoring [*Baer et al., 2004; Taylor-Seehafer et al., 2004*].

5.15 The importance of partnership working to tackle the complex needs of this group is strongly emphasised as drug use is just one of many issues experienced. Specific types of prevention work are needed with young people including early intervention, highlighting dangers of polydrug use, associated health risks including safer injecting practices and promoting skills to cope with accidental overdoses, one to one work and formal prevention activities. GP surgeries might provide appropriate interventions.

5.16 Service access might be improved by advertising availability, more funding for expansion and improvements, provisions to be open/available during the daytime, more outreach work.

5.17 Investigation into the protective effects of supportive social networks and how this can be fostered through care projects for young homeless people.

5.18 Barriers to intervention include dislike or fear of other service users, lack of awareness of what is available, insufficient bed spaces, and restrictive admissions criteria. The most positive experiences are with drop-in and counselling services, although total service access has been reported to be low [0-30% of the population accessing a service in last month].

5.19 Training should be provided to all homelessness service providers around drugs issues and HO guidance to implement Section 8 of Misuse of Drugs Act 1971.

School excludees

Population:	School excludees
Description of drug use:	Higher prevalence and perceived 'easiness' of availability of all drugs compared with school attendees; relationship between Class A drug use and participation in other criminal activity
Specific policy and guidance:	Drugs: Guidance for schools [*DfES, 2004*]
Targeted professionals:	Teachers [mainstream and pupil referral unit]; Youth workers; Local Education Authority [LEA] school exclusion officers
Key research areas:	Population descriptions [*MORI, 2004c*]
Research gaps:	Effectiveness of early intervention; content and effectiveness of PRU drug curriculum

POPULATION DESCRIPTION AND DRUG USE

6.1 It is estimated that everyday around 50,000 children miss school through truancy [*DfES, National Truancy Sweeps*], and in 2002/03 there were 9290 [12 in 10,000] permanent exclusions in England [*DfES, 2004d*]. Only a minority of permanently excluded pupils return to full time education. For many young people, exclusion from school represents the initial stages of more problematic behaviour and further social exclusion. There is an association between lack of involvement with the education system and elevated levels of criminality and illicit drug use [*MORI, 2004c; Powis et al., 1998*].

6.2 There is strong evidence linking school attendance with [protection against] problematic drug use. Furthermore, individual students are more likely to initiate drug use in schools where truancy is high and student commitment to school is low. According to the 2004 MORI Youth Survey, conducted on behalf of the Youth Justice Board of England and Wales [*MORI, 2004c*], 19% of excluded young people reported Class A drug use [generally Ecstasy [15%], and cocaine 10%] compared with 4% of school attendees. Over half [56%] of excludees reported Class B use [which included cannabis at the time of sampling], compared with 15% of those in mainstream education. Drug use was also associated with truancy; 23% of young people in school who had truanted on more than five occasions reported Class A drug use, compared with 1% who had not. Similarly, from interviews conducted with school excludees attending PRUs in an inner-city area of London it was reported that 78% had used an illegal drug, and 38% had used drugs other than cannabis [*Powis et al., 1998*]. Nine percent reported a lifetime use of cocaine, and 5% crack cocaine, whereas only 1% reported heroin. Drug use was largely experimental as use in the last month was relatively low, although cannabis was reported by 58%. The majority lived in single parent households, and two thirds had no adult wage earner. Furthermore, the majority of referrals were male, and in this particular sample, over half the subjects were from BME backgrounds, but there was no association between these two variables and drug use. In contrast, the 1998/99 Youth Lifestyles Survey reported that among a small sample of truants and excludees, females had higher lifetime and last year prevalence rates than males for most drugs [*Goulden & Sondhi, 2001*].

APPROACHES

6.3 Although resources such as DEPIS[1] and EDDRA[2] catalogue interventions targeted towards this population there is a lack of properly evaluated UK based projects.

6.4 The Government encourages early intervention and prevention of exclusion through a range of measures, including Key Stage 3 [KS3] and Primary Behaviour Strategy, Learning Support Units, police in schools, and through the Behaviour Improvement Project [BIP]. The BIP is part of the National Behaviour and Attendance Strategy, and aims to provide full time, supervised education for all excluded pupils; offers key workers for all pupils at risk of exclusion, truancy and criminal behaviour and ultimately to lead to a reduction in the levels of truancy and an improvement in attendance levels. By promoting school attendance these approaches should indirectly impact upon drug use. PRUs' small size, rapidly changing role and the type of pupils they teach mean they are not subject to all the legislative requirements that apply to mainstream schools. The curriculum offered is designed to introduce flexibility and enable tailoring to individual learning needs. PRUs are in a position to describe and modulate drug using behaviours, based upon key personal relationships.

6.5 In Drugs: Guidance for Schools [*DfES, 2004a*], teachers are advised to pay special attention to the drugs education needs of pupils at risk from exclusion and those that have been excluded. It is recommended that they:

- focus on harm reduction
- involve a range of external contributors as part of the planned programme to add value by providing additional perspectives and approaches
- link with tier 2 and 3 services such as young people's drugs services, which can provide targeted education, advice and support
- provide a range of highly engaging activities including media, film, music and ICT which focus on life skills
- arrange access to diversionary activities that focus on life skills and develop pupils' self-esteem and self-worth, and basic skills such as literacy and numeracy
- help pupils to access further information and support.

[1] Drug Education and Prevention Services [DEPIS] http://199.228.212.132/doh/depisusers.nsf/Main?readForm

[2] Exchange on Drug Demand Reduction Action [EDDRA] http://eddra.emcdda.eu.int/

6.6 Assessment of projects conducted in the USA showed that intensive home support for vulnerable families in the preschool period resulted in prolonged educational and social benefits [*American Academy of Pediatrics, 1998*].

GAPS AND INCONSISTENCIES

6.7 Drugs education for school excludees had been reported to be "inadequate, unsuitable, or unavailable", and "hampered by lack of resources or awareness of available services" [*Draper et al., 2002*]. In response, effective education was highlighted as a priority in DfES Drugs Guidance for Schools [*2004a*]. As yet there has been no evaluation of the successes of this commitment in addressing prevention gaps for school excludees.

6.8 Drug use may be one of the reasons why pupils were initially excluded from school; therefore drugs prevention needs to establish what interventions are needed to target this group [*Goulden & Sondhi, 2001*].

6.9 Short drugs prevention programmes cannot be expected to deal with all the problems faced by young people who are excluded from school. Successful programmes with this group need a wider focus than just dealing with educational problems. As well as earlier education, help to develop employment skills is likely to be at least as important in producing positive changes in outcome [*Powis & Griffiths, 2001*].

6.10 There are suggestions that provision is often dependent upon an individual professional's motivation, and relationships developed through participation in steering groups rather than formal structure and inter agency co-operation [*DrugScope & Department of Health, 2000*].

IMPLICATIONS AND RECOMMENDATIONS

6.11 Locally developed and evaluated interventions for young people who have been excluded from education, or are at risk of exclusion, should be specifically encouraged. Subsequently, this work should be shared between LEAs.

6.12 Drug education should be considered an integral part of educational reintegration programmes. LEA drug specialists and exclusion officers should work with PSHE co-ordinators to develop monitored work plans tailored to the individual needs of the pupil.

6.13 This population may benefit from early interventions prior to the onset of problematic behaviour such as private counselling, private space at school and drop-in centres.

Sexually exploited young people and sex workers

Population:	Sexually exploited young people and sex workers
Description of drug use:	High levels of drug use compared to general population, limited reliable data as a hidden population. Last month use of any drug among 16-19 year olds involved in sex work was 88%, 92% among 20-24 year olds. Last month use of heroin 44% and 33% respectively; crack cocaine; 56% and 33% [*Cusick et al., 2003*]
Specific policy and guidance:	Solutions and Strategies: Drug Problems and Street Sex Markets [*2004*]
Targeted professionals:	CDRPs, D(A)ATs, Local Authorities [LAs], Police, practitioners, and commissioners
Key research areas:	Relationship between drug use and sex work [*Cusick et al., 2003*]; lessons from the Tackling Prostitution initiative [*Hester & Westmarland, 2004*]
Research gaps:	Involvement of BME populations in sex work and drug use, drug use among young men involved in sex work; drug use differences between work environments; influences of managed zones on drug use

POPULATION DESCRIPTION AND DRUG USE

7.1 The population descriptor relates to young people under the age of 18 who are victims of sexual exploitation and abuse through sex work [*Department of Health et al., 1999*] and those up to the age of 25 involved in sex work. The balance of research focuses on those that define themselves as sex workers and particularly those involved in street sex work. While Working Together to Safeguard Children requires that people under the age of 18 are treated as victims of abuse rather than offenders [*Department of Health et al., 1999*], victims of child abuse per se are not considered here.

7.2 Estimations of the size of this population must be treated with caution. A study based on Police data [*Bluett et al., 2000*], estimated that there were approximately 2000 young people involved in sex work in any year, with one third of these expected to be under 16. This is likely to be a considerable under representation. Research conducted with adult sex workers report that initiation into sex work often occurs before young people reach the age of consent [*Cusick et al., 2003*]. Data from Home Office funded interventions suggest three quarters of young sex workers enter sex work before the age of 21 [*Hester & Westmarland, 2004*].

7.3 Studies have suggested that more young women become involved in sex work than young men, at a ratio of 4:1 [*Barrett, 1998*]. Far less has been documented about sex work among young men but evidence suggests that boys tend to enter and exit sex work at a younger age [*Palmer, 2001*]. As male sex work tends to be more hidden, due to the additional perceived stigma of homosexuality, this population may be less visible [*Palmer, 2001*].

7.4 A range of vulnerabilities are likely to be experienced by these vulnerable young people prior to and during their involvement in sex work; many of these are similar to the identified risk factors for drug use. The inter relationship of these risk factors is complex. Evidence suggests particularly strong links between experience of residential care and involvement in sex work [for example: *DrugScope and Department of Health, 2000; Crosby and Barrett, 1999*].

7.5 Little reliable data on prevalence and patterns of drug use is available for this population, particularly as those with more problematic use are likely to be under represented. Problematic drug use is particularly associated with street sex work that often involves the younger more vulnerable women [*Crosby, 1999*]. In one study 84% of those working in outdoor or independent drift sex work admitted to having a current drug problem, compared to 13% of those working in indoors [*Cusick et al., 2003*]. Street work has particularly been linked to use of cocaine and crack cocaine with some overlap demonstrated of personnel and premises involved in both activities [*Parker & Bottomley, 1996*].

7.6 The relationship between drug use and sex work is complex and the sequence of initiation into these behaviours is varied. In one analysis of this relationship, 56% participants reported starting 'hard drug' use before they started sex work [*Cusick et al., 2003*]. Twenty one percent initiated 'hard drug use' after starting sex work, and 23% reported starting 'hard drug' use and sex work in the same year. However it should be noted that these results might not reflect the experiences of more problematic users.

7.7 Sex work and drug use may be mutually reinforcing. This is more likely to be the case if 'trapping factors' are present, these have been described as:

- involvement in prostitution and/or 'hard drug' use before age 18;
- sex working 'outdoors' or as an 'independent drifter';
- experience of at least one additional vulnerability indicator such as being 'looked after' in local authority care or being homeless [*Cusick et al., 2003*].

APPROACHES

7.8 There has been no work examining interventions specifically targeted at drug misuse prevention among young people involved in sex work. Available work has examined the relationship between drug use and sex work and lessons from the Home Office 'Tackling Prostitution' initiative.

7.9 Cusick and colleagues [*2003*] reported that "outdoor and independent drift sex work sectors are so characterised by experience of vulnerability that they may serve as a site for linking and reinforcing these vulnerabilities". It is suggested that the introduction of licensed sex work premises may provide a way of geographically separating drug use and sex work and preventing those under 18 getting involved in prostitution. License retention would be reliant on the absence of drugs and underage workers [*Cusick et al., 2003*].

7.10 Multi-agency working, including information sharing protocols and multi-agency strategies, are of central importance to work with young people.

7.11 Although no specific evidence has been presented in relation to young people, outreach and drop-in services were generally found to be effective in engaging women in drug programmes [*Hester & Westmarland, 2004*]. Arrest referral was found to be less effective [*ibid.*].

7.12 Within the framework of Working Together to Safeguard Children [*Department of Health et al., 1999*], local authorities are expected to develop multi agency protocols to tackle child prostitution, developing support and exit strategies tailored to the specific needs of young people.

GAPS AND INCONSISTENCIES

7.13 Young men who are sexually exploited or involved in sex work are under represented in the research.

7.14 There is a lack of research on the use of drugs in sexual abuse of young people [e.g. drug facilitated sexual assault].

IMPLICATIONS AND RECOMMENDATIONS

7.15 Future research should explore the impact of the licensing of sex work premises by local authorities. In particular the potential for separating the environment for sex work and drug use and preventing young people being exploited through prostitution should be investigated [*Cusick et al., 2003*].

7.16 Specific services should be developed for young people, as they are less likely to engage in adult services.

7.17 Harm reduction services should focus on establishing and maintaining contact with those young people involved in sex work and developing problematic drug use, offering advice and support on health, safety and social issues. Referrals should be made where appropriate.

7.18 Information on drug misuse could be made available to these vulnerable young people via outreach workers, GPs, Police and drop-in centres.

7.19 All sex work programmes should have fast track drugs programmes that can respond to crack cocaine as well as heroin.

Young people from Black & Minority Ethnic communities

Population:	Young people from Black & Minority Ethnic communities
Description of drug use:	Generally lower levels of drug use than the general population, although drug use varies significantly between ethnic groups. Highest levels are seen in young people of mixed ethnicity
Specific policy and guidance:	None identified
Targeted professionals:	N/A
Key research areas:	A case study of an information and outreach project for an Asian community [*Bauld et al., 2004*]; results of community needs assessments on drug issues [*Bashford et al., 2003*]; a review of drug use and service provision for BME communities [*Fountain et al., 2003*]; knowledge and attitudes towards drugs and drug treatment among Asian families [*Turnstone, 2003*]; an overview of drug use among asylum seekers and refugees [*Cragg Ross Dawson, 2003*]; review of education materials for travellers [*DrugScope, 2004*]
Research gaps:	Drug use, prevention and treatment issues in relation to Black African and Black Caribbean populations, reasons for high prevalence of drug use among people of mixed ethnicity

POPULATION DESCRIPTION AND DRUG USE

8.1 Within the UK, BME communities make up 7.9% of the population [largest populations: Indian [1.8%], Pakistani [1.3%], Black Caribbean [1.0%] and Black African [0.8%]] [*ONS, 2004a*]. This proportion varies geographically and by age group; for example, 12% of children in the UK are from minority ethnic groups [*ONS, 2004*].

8.2 In 2001/02 people from BME backgrounds had higher rates of unemployment and lower levels of household income [*ONS, 2002*]. Black pupils were more likely to be excluded from school than young people from other ethnic groups. Chinese and Indian children were least likely to be excluded and performed better in GCSE exams [*ONS, 2004b*].

8.3 Despite survey data indicating drug use as being generally lower among BME communities, this group is considered as vulnerable. Under reporting is expected within these data due to stigmatisation of drug use within these communities and under representation of BME populations in general surveys. There were indications of increased drug use among some communities [*Fountain et al., 2003*] and barriers to engagement with services [discussed later]. Social exclusion and deprivation were high amongst many BME communities and were risk factors for problematic drug use [*Fountain et al., 2003*].

8.4 Last month drug use among secondary school children was higher among young people of mixed ethnicity [15% boys and girls] and White populations [13% boys, 10% girls], than among Asian pupils [8% boys and girls]. Prevalence among Black students was not statistically different from other groups [*Department of Health, 2003*]. British Crime Survey data concurred that drug use was significantly more common among young people of mixed and White backgrounds [33% and 32% last year use, respectively]. The consistently higher prevalence of drug use among people of mixed ethnicity could be related to a higher level of deprivation within this population [*Aust & Smith, 2003*]. These data are, however, unlikely to reflect more problematic drug use, particularly among vulnerable young people who may be under represented in these samples.

8.5 The proportion of women reporting drug use is lower than that of men. However there are some suggestion that this may be changing [*Fountain et al., 2003*]. Within some BME communities there is less tolerance of drug taking by women, particularly in relation to South Asian populations. Women may therefore be reluctant to declare their use or openly contact services [*Bauld et al., 2004*].

8.6 Community drug misuse needs assessments suggest distinct patterns of drug use exist between ethnic groups [*Bashford et al., 2003*]. Drug use by South Asians was more characterised by the use of heroin than crack, and also the use of a wide range of drugs including ecstasy and LSD. Black Africans reported drug use was characterised by the use of both heroin and crack, while Black Caribbean use was more characterised by crack, amphetamine and ecstasy. Middle Eastern respondents reported no use of ecstasy, crack or heroin. As with the wider population, cannabis was the most widely reported drug used among all ethnic groups. Most of the drugs used within these communities were similar to those used by the wider population. One significant exception is the use of khat, particularly by the Somali population. The majority of respondents reporting drug use were under the age of 22 [65%], with 75% of South Asians reporting use under 21. Sixty nine percent stated that age of first use was under 18, with one third under the age of 15.

8.7 Significant stigma is attached to drug use among some BME communities but it is particularly pronounced in research on Asian populations. Among the Pakistani community it may be considered shameful and a reflection of moral failing, creating a culture of denial, and acting as a barrier to accessing services [*Turnstone, 2003*]. It should be noted, however, that this stigmatisation may not exist, or even be reversed among the younger population with involvement in drug use perceived as adding to their reputation [*Bashford et al., 2003*].

8.8 Young Asian people can be reluctant to discuss drugs issues with their parents, as they perceive them to have limited knowledge on the subject and through issues of respect. This latter reason is particularly evident between young Pakistani males and their fathers.

8.9 Barriers to engagement with services identified by community needs assessments include: ethnicity of staff, cultural and linguistic understanding, concerns related to confidentiality, lack of awareness of services, waiting times and perceptions of inferiority of services available to ethnic minority groups.

8.10 Issues preventing established BME populations from accessing services may be even more acute for asylum seeker and refugee communities. Small studies on drug use in these groups concluded that while drug use varied according to specific populations it was rare. However, once in the UK they were considered to be vulnerable to developing drug related problems, particularly in relation to high levels of deprivation and despair [*Cragg Ross Dawson, 2003*].

8.11 Little is known about drug use among the UK traveller population [approximately 300,000 people], but there is evidence of poor general health and access to services, and presence of risk factors for drug and alcohol misuse. Attendance at school and attainment of targets were generally low among this population, 12,000 [17%] of these children were not registered at schools. Gypsy children were also disproportionately represented among those excluded from school. As a result, school based drugs education was often missed. Limited engagement with other services and low literacy levels indicated that these young people relied on advice and information from the family network, whose knowledge was generally considered to be poor [*DrugScope et al., 2004*].

APPROACHES

8.12 Whole community approaches in the delivery of information and outreach work to Asian communities could be more effective than an exclusively youth focus. Advantage may be taken of the strong family networks existing in Asian society, who with improved knowledge may provide vital support to young people with drug misuse problems [*Bauld et al., 2004*].

8.13 The positioning of projects within community centres makes the staff highly visible, enabling them to build relationships with a variety of community members and allowing clients to access the service discreetly. It has been acknowledged, however, that more innovative methods would be required to engage the most at risk groups of young people [*Bauld et al., 2004*].

8.14 Delivery of interventions to an Asian community by Asian workers, from a similar country of origin, can increase the capacity to identify and communicate with the target audiences through their understanding of community languages, cultural and religious issues. However, the shortage of experienced Asian drugs workers can pose problems for recruitment [*Bauld et al., 2004*].

8.15 School based drugs education is credible and well received when delivered using interactive methods by project workers with specialist knowledge and an ability to develop a rapport with the young people. However schools may be unwilling to use external agencies for the delivery of drugs education for fear that it signifies a problem within the school [*Bauld et al., 2004*].

8.16 The use of community researchers to complete drug misuse needs assessments within their own communities may allow unique access to these communities. In addition to the production of needs assessment reports, providing a valuable insight into these communities, this approach also builds capacity and knowledge at an individual and community level. Localised employment of more people from BME communities in the health and social care field and community group representation on some D[A]AT sub groups were also attributed to this approach [*Winters et al., 2003*].

GAPS AND INCONSISTENCIES

8.17 There is a lack of focus specifically on young people who, although influenced by, may not share their parents' value systems.

8.18 GPs were identified by some groups as a primary information source regarding drug use, others, including young people, stated that they would not approach the GP through concerns over confidentiality and family reputation.

8.19 Most of the work identified comes from pilot or scoping projects. Therefore, there is still a lack of robust data collection and analysis in this area.

8.20 Black African and Black Caribbean populations are under represented in the body of research.

8.21 Religion features prominently in the work but views of its role are mixed.

IMPLICATIONS AND RECOMMENDATIONS

8.22 National Drug Strategy needs to take into consideration the diversity between, and within, ethnic minority groups. Responses may need to be tailored to particular communities.

8.23 Increased representation of BME communities is needed in D[A]ATs.

8.24 Accurate and robust monitoring systems are needed that are sensitive to the full diversity of the local communities.

8.25 Capacity building is needed within communities alongside the development of local partnerships.

8.26 Some subjects prefer to access services from outside their community [either geographic/ethnic], for reasons including confidentiality and family reputation. Therefore generic services are needed as well as specialist provision.

8.27 Drugs services should be sited sensitively to allow discreet access, particularly if targeting Asian women.

8.28 There is a need for more qualified drugs workers, of both genders, from Asian and other minority ethnic backgrounds are needed.

8.29 School based information provision should be seen as an important intervention particularly in relation the young Asian population.

8.30 The general lack of knowledge and awareness amongst parents needs addressing.

8.31 There is a need for translators trained in drug related issues.

8.32 Developing materials for ethnic minority groups is more than just translation, particularly in relation to high levels of illiteracy and cultures of oral communication.

8.33 Non-school based drug education resources are needed for use with young people from the travelling community but efforts should also be concentrated on trying to engage the young people with the school provision. The importance of story telling and low levels of literacy among this community should be considered when developing resources.

8.34 Use of khat among some populations, in particular Somali groups, requires training of professionals in harm reduction and treatment methods in relation to the drug.

8.35 The vulnerability of refugees and asylum seekers may be reduced through improved support, especially in relation to housing and health, and drug prevention work for the children.

Carers of drug users

Population:	Carers of drug users
Description of drug use:	Unknown how many carers are affected by drug use, but many of these are ill prepared if behaviour becomes problematic
Specific policy and guidance:	None identified
Targeted professionals:	D[A]ATs; YOTs; Tier 2 drug services
Key research areas:	Information provision [*Research Works Ltd, 2003*]; Parental support [*Bauld et al., 2004*]
Research gaps:	Influence of parenting skills courses on the primary and secondary prevention of drug use in the UK; Role of GPs and other primary care practitioners in offering advice and referrals

POPULATION DESCRIPTION AND DRUG USE

9.1 It is not known how many carers or family members are affected by drug use in young people, although it is estimated that 18% of 11-15 year olds used illicit drugs in 2004 [*Department of Health, 2005*].

9.2 In one study of parental awareness of adolescent drug use, 39% of parents were aware that their child used tobacco, 34% were aware of alcohol use, but only 11% were aware of illicit drug use [*Williams et al., 2003*]. There were no factors that differentiated 'aware' from 'unaware' parents for all drugs. High adolescent ratings of family communication combined with low parental ratings of family communication were associated with greater parental awareness of alcohol and tobacco use. Better school performance predicted greater awareness of alcohol and illicit drug use. Single parents and blended families were more aware of tobacco and illicit drug use. Many families of drug users have limited knowledge about drugs.

APPROACHES

9.3 The information available to family members supporting drug users is uniform, but as the nature of relationships and the range of drug related experiences is wide, there will be differences in the type and scope of information needed. Factors influencing tailoring include specific relationship needs [information provided should be targeted], and the length and type of drug use problem. Drugs problem are likely to be dynamic and change over time; this will be reflected in the support needed. Furthermore, many carers and family members felt excluded from drug services, which tended towards the needs of users [*Sims, 2002*].

9.4 Carers can be helped in identifying the early stages of drug use and recognising transition into more problematic patterns of use [*Research Works, 2003*]. This should be followed up with description of effective and informed coping and response strategies [including interpersonal relationships and conflicting emotions within the care group/family], and the range of help available locally. Carers can also be supported in learning about the nature of drug dependence and the role that they can play in treatment options [e.g. family/carer therapy]. Proactive contacting of carers and home visits by support workers are an effective means of engagement, and help to develop knowledge about family dynamics [individual caseloads need to be maintained]. The school and community networks that universal campaigns are based upon may be used as means to recruit carers, although more marginalised populations may be excluded. In contrast, support groups for more problematic drug use are often not well attended due to their public nature. Where run, these should be done in small groups with a focus on informal teaching and learning methods [*ibid.*].

9.5 Providing a portfolio of information may be advantageous in some circumstances, [e.g. universal prevention], but more problematic behaviours are unlikely to be addressed through a generic approach, particularly with respect to different types of relationship, circumstance, and issues faced. Telephone helplines may be preferable when supporting responses to experimental drug use or as a first contact [*Research Works, 2003*].

9.6 Suitably targeted approaches can reduce carers' feelings of isolation and increase their ability to cope with difficult situations. An improvement in knowledge and communication skills may lead to an increase in communication and support within the relationship [*Research Works, 2003*].

9.7 Carers may be more likely to take part in schemes that address wider issues than just drugs [*Bauld et al., 2004*].

9.8 There is almost a complete absence of work done in this field in the UK, but research from the USA suggested that engagement and retention rates for family-based universal programmes and specialised treatment approaches were superior to standard treatment engagement/retention methods [*e.g. Guyll et al., 2004; Kumpfer & Bluth, 2004; Riddle 2004*]. In the majority of trials in which they were compared with alternative interventions, family-based treatments produced superior and stable outcomes with significant decreases on targeted indicators of drug use, and related problems such as delinquency, school and family problems, and affiliation with drug using peers. Mechanisms of change studies supported the theory basis of family-based treatments. For instance, improvements in family interaction patterns coincided with decreases in core target alcohol and drug misuse symptoms.

9.9 Successful family based approaches to primary prevention include components that aim to increase knowledge, confidence in communication, ability to influence behaviour, and understanding of realistic aims of prevention. Parenting skills courses with drugs components could achieve many of these aims. Respite opportunities and advocacy may assist family members and carers in this process [*Effective Interventions Unit, 2002; Velleman et al., 2000*].

9.10 Successful outcomes for families and carers may include improvements to physical and psychological health; improved family relationships; improved social life; and cross family engagement [*Effective Interventions Unit, 2002*].

GAPS AND INCONSISTENCIES

9.11 Primary care practitioners often do not have tools and skills for effective responses.

9.12 Most often it is the mothers of young drug users who seek assistance; there is often little targeting of, or engagement with other family members, and partners.

9.13 Emphasis on drug awareness skills and resources may mean that carers with unique needs are less well served.

IMPLICATIONS AND RECOMMENDATIONS

9.14 Research and clinical advances of family-based approaches have implications for non-family-based interventions for adolescent drug misuse, such as developing partnerships between differently tiered services.

9.15 There is great importance for GPs in particular to be able to respond to the needs of carers, particularly in signposting other services. Research needs to be conducted into the effectiveness of this approach.

9.16 Confidentiality waivers may allow certain information to be passed to family members and carers.

9.17 Research is needed into the balance between skills and knowledge based work according to individual circumstance.

Children of drug users

Population:	Children of drug users
Description of drug use:	Approximately 250,000-350,000 children in the UK have a parent who is a problematic drug user
Specific policy and guidance:	Hidden Harm [*2003*]; Children's Act [*2004*]; Children's National Service Framework [*2004*]
Targeted professionals:	Drug treatment providers; advocate groups; social workers, social care workers; children's charities; Connexions; Area child protection committees
Key research areas:	Characteristics of families affected by drug misuse [*Meier et al., 2004*], Programmes targeted towards children of problematic drugs users [*Bauld et al., 2004*]
Research gaps:	National Drug Treatment Monitoring System [NDTMS] data on dependents; differentiation between drug using parents who experience disrupted relationships with their children, and those who do not; drug using fathers and parental roles

POPULATION DESCRIPTION AND DRUG USE

10.1 It has been estimated that there are between 250,000 and 350,000 children of problem drug users in the UK, 2-3% of all under 16 year olds. Problematic users were defined as those exhibiting serious negative everyday consequences resulting from their drug use, and were identified from the regional drug misuse databases [*Advisory Council on the Misuse of Drugs* [*ACMD*], *2003*]. Six percent of men, and 29% of women accessing drug treatment services in England and Wales with children at home, either lived alone or with strangers [*Meier et al., 2004*]. The more severe the drug use disorder, the more likely it was that a parent would be separated from their children.

10.2 Parental drug use can impact upon household stability; child health, safety, and neglect [including access to illicit drugs]; reception into care system; changes in the quality of parent-child relationships [when there is an interaction with socio-economic deprivation]; and increase social stigmatisation [*ACMD, 2003*].

10.3 The timing of any teratogenic insults [production of structural malformations in foetal development] in relation to fetal development is critical in determining the type and extent of damage produced. Women who are dependent upon drugs may not cease use even when they become pregnant. Drug exposed newborns may exhibit reductions in birth weight and head circumference [an indirect measure of brain size], and be at increased risk from structural malformations. Exposure to drugs during pregnancy may lead to long lasting cognitive change in the newborn, who may show abnormalities in learning, and other behavioural changes, including sensory modalities. Offspring of opiate dependent mothers show withdrawal syndromes, although this has not yet been demonstrated with cocaine.

10.4 Additional effects on the child include an increased risk of problematic behaviour; poor school performance; difficulty in developing peer relationships; anxiety about the health and safety of the parent.

10.5 Drug use per se may not be an aetiological factor, but interacts with socio-economic deprivation, environment stressors, and poor mental health.

10.6 Whilst family drug use did not directly lead to an increase in prevalence in younger aged children, it influenced the choice of the child's peer group [*Bahr et al., 1993*]. This in turn influenced the child's drug using behaviours. In contrast, other studies in USA teenagers suggested that parental choice of drugs determines that of their child [*Johnson et al., 1991*].

10.7 Older children may act as carers/guardians for younger siblings, with all attendant problems. In some cases this may lead to resentment [*ACMD, 2003*].

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10.8 Like other types of prevention intervention, few have been subject to rigorous evaluation. There is evidence, however, that it is possible to recruit and retain children and parents over long periods of time.

10.9 Although most programmes have originated in the USA, experiences of residential, home-visiting, non-residential programmes and playgroup-based clinics have led to an outline of issues and dilemmas faced by this population. These include balancing trust and acceptance with intervention when problems are identified, harmonising accessibility and flexibility with the provision of child-focused activities and adult education, finding a location that is both suitable and affordable, appropriately supporting staff, collaborating with other services and securing adequate funding, including for ongoing evaluation and monitoring [*Banwell et al., 2002*].

10.10 Only marginal improvements have been observed in studies of the effects of community health nurse visits, although some mothers are more likely to enter treatment if visited by positive role models [e.g. other mothers experienced in similar life events] [*Black et al., 1994; Ernst et al., 1999*].

10.11 Playgroup based clinics [e.g. based on health, welfare, and advocacy] assist children in developing skills, and allows parents to share information and to play with their children. In existing programmes no demands are usually made regarding drug use, but support is available to those who request it [*Denton et al., 2000*].

10.12 Greater successes at residential schemes for drug using parents have been attributed to low attrition rates, and greater positive intervention perceptions by staff.

GAPS AND INCONSISTENCIES

10.13 Data on dependent children are not included in the NDTMS minimum set.

10.14 Not all parents who have drug problems have childcare difficulties. Stable households may experience disruption during periods of chaotic or escalating drug use.

10.15 Children and extended families are rarely the focus of interventions.

10.16 There is limited research on planned pregnancy and contraception among drug users.

10.17 Reasons underlying maternal drug use during pregnancy are not examined.

10.18 The focus of research is on mothers to the exclusion of fathers.

10.19 The role of grandparents also merits exploration.

10.20 There is little focus on children's role as carers.

IMPLICATIONS AND RECOMMENDATIONS

10.21 Holistic family approaches, including integration of courses on parenting skills may improve the quality of self-esteem and parent-child interactions. Implementing and managing such programmes is likely to be difficult and resource intensive.

10.22 Social expectations/disapproval upon child welfare should be explored.

10.23 An examination of non-pharmacological risk factors for description of impact upon children is needed.

10.24 Safety at home should be discussed with drug using parents, particularly concerning injection equipment and drug storage.

Summary

11.1 Among the varying recommendations three areas in particular are included consistently and have the potential to make an impact across all vulnerable young people.

11.2 Throughout the literature the importance of school as both a protective factor against harmful drug use and as a medium for the delivery of drug education is emphasised. The Updated Drug Strategy [*Home Office, 2002*] highlighted improved school based drug education as a key intervention and Drugs: Guidance for schools [*DfES, 2004a*], acknowledged the role that schools have in reducing the vulnerability of young people as well as emphasising the need to target those at risk of exclusion for specific drug education. School and curricular based programmes are considered to be the most efficacious drug prevention initiatives [*White & Pitts, 1998*], and this is being tested by the UK Government's Blueprint Research Pilot [see http://www.drugs.gov.uk/NationalStrategy/YoungPeople/Blueprint].

11.3 Training in drug use issues is needed for non-drugs specialists [e.g. youth workers, teachers in Pupil Referral Units] working with vulnerable young people, in particular those that may have missed school based drug education. This should include training on appropriate referrals and the use of external contributors. The Every Child Matters green paper called for 'training for all professionals working with children to enable them to identify, assess and respond to young people with substance use problems', this is also detailed in the Children's National Service Framework.

11.4 Finally there is a need for young people to be routinely assessed for drug related needs when they come into contact with [non-drug specialising] agencies. Guidance to implement this approach is provided in 'First steps in identifying young peoples substance misuse needs' which describes a framework to incorporate drug misuse assessment within established practices. Within the secure estate this approach is to be implemented as part of the national specification for drug use for juveniles in custody, but the practicality and usefulness of brief screening tools needs to be investigated in other sectors.

11.5 Specific research gaps have been identified in each section. In general, there is a lack of robust evaluation of drug prevention interventions targeted at this group. Longitudinal evaluation methodologies and the inclusion of long term [post initiative] follow up within evaluations would help to assess impact. Research focusing specifically on the relationship between vulnerabilities and drug misuse is also limited. A longitudinal approach examining the changing nature of vulnerability in young people generally and in particular it's association with drug use over time may be best placed to fill this gap. Identifying specific needs and drug related behaviours could contribute to the tailoring of existing approaches.

Table 2: Recent governmental policy and guidance addressing drug use in vulnerable young people

TITLE	DATE	LEAD AGENCY	AIMS	INTERVENTIONS	WEB ADDRESS
Updated Drug Strategy	2002	Drug Strategy Directorate; Home Office	Sets out the government's strategy to reduce the harm that drugs cause to society. A key priority is to prevent today's young people becoming tomorrow's problematic drug users. Updates the drug strategy published in 1998.	Key target: To reduce the use of class A drugs and the frequent use of all illicit drugs by all young people [<25] and in particular the most vulnerable by 2008. Key interventions: Improving quality of schools drug use education, diversionary schemes including Positive Futures, drug testing and treatment for young offenders, FRANK communications campaign.	www.drugs.gov.uk
Every Child Matters	2003	Department for Education and Skills	The Children's Green Paper outlining whole system reform to the delivery of children services. Aims to help children fulfil their potential by reducing levels of educational failure, ill health, drug misuse, teenage pregnancy, abuse and neglect, crime and anti-social behaviour among children and young people. Childrens Act provides the legal framework for reform.	Interventions include the creation of new posts and statutory bodies, including Local Safeguarding Children Boards. Specific drug misuse interventions include training for all professionals working with children to enable them to identify, assess and respond to young people with drug use problems, funding to tackle drug misuse among most vulnerable and ensuring that the full range of drug use services are embedded in mainstream services. Interventions contribute to Home Office under 25s Class A target.	www.everychildmatters.gov.uk
Every Child Matters: Next steps	2004	Department for Education and Skills	Sets out the purpose of the Children Bill and the next steps for delivering change in children's services.	Interventions highlighted include Parenting Fund, Sure Start, Connexions and the Common Assessment Framework, with an emphasis on partnership working. No specific emphasis on drug misuse.	www.everychildmatters.gov.uk
Every Child Matters: Change for Children [1]	2004	Department for Education and Skills	Explains the requirements of the Children Act 2004 and how it fits with other core elements of Every Child Matters to provide a national framework for local change programmes.	Provides a national framework in which local authority lead change programmes can respond to local needs. A specific report on young people and drugs will explain the relationship between Every Child Matters and the Updated Drug Strategy. Specific documents have been published for those working in social care, the criminal justice system, health services and schools. 'Choose not to take illegal drugs', is part of the 'Be Healthy' objective. Contributes to HO under 25s class A target.	www.everychildmatters.gov.uk
Children Act [2]	2004	Department for Education and Skills	The Act provides legislation for the reforms detailed in Every Child Matters. The overall aim is to encourage integrated planning, commissioning and delivery of services as well as increasing accountability. The legislation is intended to be enabling rather than prescriptive providing local authorities with flexibility in the way they implement its provisions.	The Act includes legislation enabling increased information sharing, establishment of an independent champion for children and young people, an integrated inspection framework.	www.dfes.gov.uk
National Service Framework for Children, Young People and Maternity Services	2004	Department of Health	The framework sets standards for health and social care services for children, young people and pregnant women. It is a ten-year programme intended to stimulate long-term and sustained improvement in children's health. The implementation of the Children's National Service Framework is a major part of the Change for Children programme; Change for Children Health services includes details of how to implement the framework.	11 standards are detailed, drug misuse features in a few of them, standard 4, 'Growing up into Adulthood', is the most relevant. Interventions specified include: provision of school based education covering all substances to be provided to all young people, including those in PRUs; Primary Care Trusts [PCTs] to ensure that information and advice services are provided for young people and their parents; PCTs and Local Authorities [LAs] to ensure information regarding support services is accessible to all young people including those not in school; staff from all agencies able to identify young people at risk of misusing drugs or alcohol, access to a range of local prevention and treatment programmes.	ww.dh.gov.uk

TITLE	DATE	LEAD AGENCY	AIMS	INTERVENTIONS	WEB ADDRESS
Choosing Health	2004	Department of Health	White Paper setting out how the Government plans to assist people in taking responsibility for their health by improving information and providing support in making healthy choices. This includes how the health of children and young people will be safeguarded.	Addressing health inequalities among children and young people is identified as a major priority for all local agencies in order to break the cycle of deprivation. Emphasis on information provision, in particular the role of the youth service, young people's development programme and outreach services to provide information and advice for vulnerable young people who may be excluded from services. Drug misuse is not a specific priority; forthcoming youth green paper deals with risk taking behaviours.	ww.dh.gov.uk
First steps in identifying young people's substance related needs	2003	Drug Strategy Directorate; Home Office	Highlights the responsibilities of all professionals working with young people in identifying substance related needs and ensuring these needs are addressed, with the aim of reducing vulnerability to developing substance misuse problems. Contributes to the Updated Drug Strategy young people aim.	Emphasises a holistic approach to needs assessment, with a framework provided for identifying substance related needs within existing assessment procedures. Tier 1 and 2 interventions highlighted include provision of information and advice, support for carers, outreach work, counselling and drug related prevention programmes.	www.drugs.gov.uk
Assessing local need: Planning services for young people	2002	DrugScope & Home Office	To provide a framework for assessing young people's needs for drug programmes. Aims to help D[A]ATs analyse the needs of children and young people, and the current resources that are available. This needs assessment forms part of Young People's Substance Misuse Plans.	Advocates building a profile of the young people in the D[A]AT area, highlighting; areas with particular needs, vulnerable young people, vulnerable young people in contact with children's services and harder to reach young people. Comparison of this data with current provision to identify gaps. There is also a focus on multi-agency working and service co-ordination.	www.drugs.gov.uk
Drugs: Guidance for Schools	2004	Department for Education and Skills	To provide guidance to all schools in England [including PRUs] on issues relating to drug education, schools drugs policy and supporting the drug related needs of young people. This guidance considers drugs in the widest sense. Links to the Updated Drug Strategy through contribution to the aim of 'preventing today's young people becoming tomorrow's problematic drug users' and by highlighting the needs of vulnerable young people.	Proposes that schools have a role in: reducing the vulnerability of young people through providing supportive relationships, encouraging school attendance etc.; and the identification of and response to the drug related needs of vulnerable pupils. Specific recommendations made in relation to the high priority of targeted drugs education for school excludees and those at risk of school exclusion. Determining needs of children of problem drug users is also highlighted as a priority and the possibility that the young person's parent/carer may use drugs to be considered while planning drugs education. Peer education may be particularly useful for vulnerable young people, especially if involved as educator.	www.drugs.gov.uk
Key Elements of Effective Practice: Substance Misuse	2003	Youth Justice Board for England and Wales	To support consistency of delivery across youth justice services. The guidance describes features of effective youth justice services with relevance to practitioners, managers and strategic partnerships. Links with updated drug strategy focus on vulnerable young people. Links with national specification for substance misuse for juveniles in custody and young people's substance misuse plans.	Focus is on working practices and assessment of needs with a table of quality indicators. Indicators of quality include; screening for drug misuse to take place in early stages of a young person's contact with services; interventions must encompass a holistic approach taking account of individual circumstances; drug misuse awareness training to be part of all staff's training and development; young people to have access to a wide range of interventions from brief to intensive; data to be collected on young people with drug misuse needs, to inform planning and co-ordination of local services.	www.youth-justice-board.gov.uk
Guidance for adult arrest referral schemes: Responding to children and young people	2003	Drug Strategy Directorate; Home Office	To provide guidance on how an arrest referral scheme may be adapted to the needs of young people. Clarifies key issues including; how extending arrest referral schemes to the under 18s is compatible with the Updated Drug Strategy 2002, legal issues, and approaches that might be regarded as appropriate/effective practice.	A pathway is proposed, illustrating the series of events involving the young arrestee, from entry into to exit from the custody area, and any subsequent contact with the arrest referral worker. Suggest some minimum standards of service delivery.	www.drugs.gov.uk

TITLE	DATE	LEAD AGENCY	AIMS	INTERVENTIONS	WEB ADDRESS
National Specification for Substance Misuse for Juveniles in Custody	2004	Youth Justice Board for England and Wales	Sets out the requirements of the Youth Justice Board for the delivery of drug misuse interventions to young people in custody. Response to Updated Drug Strategy aim to target action at most vulnerable including young offenders.	Focus is on drug misuse initiatives being considered within the context of other needs young people may have. Each establishment must produce an annual development plan detailing the integrated care pathway. It is concerned with the delivery of the Detention Training Order [DTO] as a whole and, as such, also addresses resettlement to ensure continuity of care in the community. Requirements include; identification and assessment as part of normal reception process; universal education and prevention programmes covering all substances delivered to all young offenders, focusing on increasing knowledge, personal skills and attitudes; Range of treatment to be available to all on priority basis; Throughcare and resettlement planning to include a completed asset profile, continuity of service provision and harm reduction education.	www.youth-justice-board.gov.uk
Achieving positive shared outcomes in health and homelessness	2004	Office for the Deputy Prime Minister	The aim of the guidance is to improve access to health care for the homeless, including improving drug misuse treatment and prevent homelessness through targeted health support. This does not represent statutory guidance. This work would contribute to DH targets.	Suggested interventions for increasing access to treatment for drug use include: developing screening and referral protocols for drug misuse; providing outreach drugs services to day centres or temporary accommodation and providing structured after-care/tenancy support to enable drug users to sustain their accommodation. No interventions targeted specifically at young people are included.	www.odpm.gov.uk
Drug services for homeless people: a good practice handbook	2002	Office for the Deputy Prime Minister	Aims to help D[A]ATs to develop more effective services for homeless users. Links with Updated Drug Strategy 'increasing people in treatment' target.	Interventions discussed include establishing a joint drug and homelessness strategy, close cooperation with accommodation providers and the provision of tier 1-4 services. Specific guidance is to be produced for homeless young people.	www.drugs.gov.uk
Solutions and strategies: Drug problems and street sex markets.	2004	Home Office	To provide good practice advice on addressing drug and sex markets to local agencies and partnerships.	Although the main focus is on adults, there is some consideration of the prevalence of drug use among young people and presentation of good practice examples. Recommendations are made regarding the use of a multi-agency early intervention approach and the need for specialist child centred services for young people, which can deal with their complex needs.	www.drugs.gov.uk
Promoting the Health of Looked After Children	2002	Department of Health	This document sets out a framework for the delivery of services from health agencies and Councils with Social Services Responsibilities [CSSRs]. The aim is to improve the health of looked after children and young people.	Adopts a holistic approach to health. Drug specific recommendations include; young people's drugs services need to be commissioned, planned and delivered across health and social care agencies and staff and carers have a key role to play in providing support and information and need to be aware of local services.	www.publications.doh.gov.uk
Hidden Harm [3]	2003	Advisory Council for the Misuse of Drugs	In depth investigation carried out by the Prevention Working Group of the Advisory Council on the Misuse of Drugs. The aims of the work are to; examine the immediate and long term impact of parental drug use on their children and the number of children affected; consider the current involvement of a range of agencies in this area, identifying best practice; and to make policy and practice recommendations.	48 recommendations are made, intending to provide support for these children from conception to adolescence. It is suggested that this needs to become a central issue in UK drugs policy and that whilst parental drug treatment may be helpful, children need services in their own right. There is an emphasis on the training of staff in frontline agencies and increased monitoring of this group. Specific recommendations are made for relevant agencies.	www.drugs.gov.uk

[1] Every Child Matters: Change for Children. Young People and Drugs' was published March 2005, and is available at www.everychildmatters.gov.uk.

[2] Children bill became Children Act in November 2004 when it received royal assent.

[3] A strategic response to the Hidden Harm report has been published, providing an update of progress against the 48 recommendations and setting out a delivery plan. The majority of the recommendations have been accepted. The full response is available from www.drugs.gov.uk.

NB The Home Office Drugs bill received Royal Assent in April 2005 but this was enacted after the cutoff date for this review and so is not included in the Table above. The bill includes plans to make drug dealing near schools or using children as couriers an aggravating factor in sentencing and to give Police powers to test for class A drugs on arrest

Glossary

CHILDREN

People under the age of 18 years, in accordance with the Children Act [*1989*], and the United Nations Convention on the Rights of the Child [*1989*].

DRUG DEPENDENCY

A compulsion to take a drug on a continuous or periodic basis in order to experience psychic effects and sometimes to avoid discomfort in its absence. Both physical and psychological dependency can occur.

DANCE DRUGS

Drugs associated with use in night clubs and similar venues, including stimulants, entactogens, hallucinogens, alcohol, cannabis, and tobacco.

DRUG MISUSE

Illegal or illicit drug taking which leads a person to experience social, psychological, physical or legal problems related to intoxication or regular excessive consumption and/or dependence. Drug misuse is therefore drug taking that causes harm to the individual, their significant others or the wider community.

DRUG PREVENTION

Interventions that prevent the onset, delay the initiation, promote cessation and reduce the harms associated with drug use. The Institute of Medicine proposed a new framework for classifying prevention, which has three categories, namely, universal, selective and indicated prevention [*Mrazek & Haggerty 1994*]. This system replaces the definitions of prevention in terms of primary, secondary and tertiary preventions. This system is based on weighing up risks of developing drug use in population[s] and the extent of interventions:

- Universal prevention: targeted to the whole population
- Selective prevention: targets subsets of the population that are identified as having a higher than average risk of drug use
- Indicated prevention: targets those that may have already initiated drug use and are considered to be at risk of dependency

POLY DRUG USE

The simultaneous, sequential, or concurrent use of more than one drug, often with the intention of enhancing or countering the effects of another drug, or to substitute for the effects of an unavailable drug.

PROBLEMATIC DRUG USE

As drug misuse.

SUBSTANCE MISUSE

As drug misuse, but including alcohol and tobacco.

YOUNG PEOPLE

People under the age of 25 [in line with the Home Office definition]. Some data sources used however had alternative definitions. This is noted where relevant.

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