Young people’s drug, alcohol and tobacco use: joint strategic needs assessment (JSNA) support pack

Good practice prompts for planning comprehensive interventions in 2016-17
About Public Health England

Public Health England exists to protect and improve the nation’s health and wellbeing, and reduce health inequalities. It does this through world-class science, knowledge and intelligence, advocacy, partnerships and the delivery of specialist public health services. PHE is an operationally autonomous executive agency of the Department of Health.

Public Health England
133-155 Waterloo Road
Wellington House
London SE1 8UG
Tel: 020 7654 8000
www.gov.uk/phe
Twitter: @PHE_uk
Facebook: www.facebook.com/PublicHealthEngland

For queries relating to this document, contact your local PHE centre alcohol and drugs lead.

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Introduction

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

Prevalence data for trends in alcohol, drug and tobacco use among young people from the ‘Smoking, drinking and drug use among young people in England’ survey shows a whole population decrease in the prevalence of drug, alcohol and tobacco use among school pupils aged 11-15. The survey also finds that young people who truant or have been excluded from school are much more likely to have experimented with substances including tobacco. Local authority level data from the ‘What about YOUth 2014’ survey will be published in December 2014 (see link in annex A).

Estimates suggest that approximately 207,000 children aged 11-15 start smoking each year in the UK, with 18% of 15-year olds classified as current smokers. Young people’s health behaviour is driven by the world they grow up in. Sustained efforts to reduce smoking prevalence among adults, restrict availability and denormalise tobacco use all contribute to lower smoking rates among young people.

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

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

The Association for Young People’s Health, with support from Public Health England (PHE), has published ‘Key data on adolescence 2015’, a compendium of important data on young people’s health.

This document outlines four key principles and some helpful prompts that local areas might consider when commissioning universal and targeted drug, alcohol and tobacco prevention interventions, and specialist interventions for young people already experiencing harm.
Commissioning principles for preventing drug, alcohol and tobacco use in young people and interventions for those already experiencing harm

1. Effective evidence-based interventions are being commissioned universally and in a targeted way to prevent young people’s use of drugs, alcohol and tobacco

Evidence suggests that a number of risk factors (or vulnerabilities) increase the likelihood of young people using drugs, alcohol or tobacco.

Prevention approaches for young people are usually not drug, alcohol or tobacco specific but are focused more on reducing risks and increasing resilience. The more risk factors young people have, the more likely they are to misuse substances. Risk factors include experiencing abuse and neglect, truanting from school, offending, early sexual activity, antisocial behaviour and being exposed to parental substance misuse. The strongest single predictor of the severity of young people’s substance misuse problems is the age at which they start using substances.

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

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

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

- scare tactics and images
- knowledge-only approaches
- ex-users and the police as drug educators where their input is not part of a wider prevention programme
- peer mentoring schemes that are not evidence-based

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

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

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

Evidence shows that school-based interventions are effective in reducing smoking uptake and NICE have published a series of recommendations that set out clear guidelines for commissioners. However, the impact of these interventions are considered more effective when also delivered as a package of cross-cutting tobacco control measures aimed at adults in the community.

Over recent years, e-cigarettes have become the most popular stop smoking aid among adults in England. As e-cigarette use among adults has increased, so too has experimentation among young people, with around one in ten having tried them. However, regular e-cigarettes use among young people is rare, with around 2% using them at least monthly and 0.5% weekly. It is also almost entirely confined to those who have already smoked. Among young people who have never smoked, regular use (at least monthly) is 0.3% or less. Smoking rates among young people have continued to decline and there is no evidence so far that e-cigarettes are acting as a route into smoking for young people.

From 1 October 2015, the sale of e-cigarette products to under-18s in England and Wales will be prohibited. It will also be illegal for an adult to purchase e-cigarettes for someone under the age of 18.
What will you see locally if an evidence-based approach to prevention is followed?

- Resilient young people who make healthier life-choices and develop skills to make informed decisions.
- Services that help prevent escalating harm and that provide evidence-based interventions to young people who are at risk of developing substance misuse problems.

What questions should you ask to check you are following the evidence and best practice?

1.1 Universal prevention

- Do young people locally have universal access to accurate, relevant and timely information about the health harms of alcohol, drugs and tobacco?
- Do young people locally have universal access to accurate and relevant information about the health harms of NPS?
- Are schools implementing intelligence-led, targeted sessions at all stages within the school environment, adopting a ‘whole school approach’ to prevention?
- Have schools considered using the Mentor ADEPIS resources?
- Do prevention programmes use the European drug prevention quality standards (EDPQS)?
- Have commissioners built good links with local schools?
- Do schools have a drugs, alcohol and tobacco policy that is understood and implemented?
- Do schools include drugs, alcohol and tobacco education as part of the curriculum?
- Is tobacco prevention work in schools evidence-based and linked to NICE PH23?
- Are national resources that provide information (FRANK) and build resilience (Rise Above) considered as part of the local approach to prevention?
- Are sufficient resources available to prevent under-age sales, sales to people who are intoxicated, proxy sales (that is, illegal purchases for someone who is under-age or intoxicated), non-compliance with any other alcohol licence condition and illegal imports of alcohol?¹⁶
- Are the appropriate authorities working in partnership to identify and take action against premises that regularly sell alcohol to people who are under-age, intoxicated or making illegal purchases for others?¹⁷
- Does the local authority undertake test purchases (using ‘mystery’ shoppers) to ensure compliance with the law on under-age sales for
alcohol, tobacco and electronic cigarettes? Is test purchasing also used to identify and take action against premises where sales are made to people who are intoxicated or to those illegally purchasing alcohol for others?\(^{18}\)

- Are sanctions fully applied to businesses that break the law on under-age sales, sales to intoxicated people, and proxy purchases? This includes fixed penalty and closure notices (the latter should be applied to premises that persistently sell alcohol to children and young people).\(^{19}\)

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

### 1.2 Targeted prevention

- Are young people at increased risk of harm being targeted, with the aim of strengthening their resilience?

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

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

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

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

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

- Does the JSNA take into account the needs of young people who suffer from domestic abuse, sexual assault and sexual exploitation, who are more likely to be vulnerable to substance misuse? Does the JSNA look at this group by gender?\(^{20}\)

- Have additional funding streams been identified for early identification and interventions to provide targeted support for specific groups of young people deemed to be more at risk than others of developing substance misuse problems? (This may be from the police and crime commissioners
to support the targeted substance misuse interventions provided by the youth offending teams or from wider local authority funding).

- Are hospital care pathways in place for young people presenting to A&E with alcohol-related problems?
- Do local clinical and safeguarding leads review and support the design and delivery of specialist substance misuse services?
- Is there engagement with the local troubled families’ team?
- Do interventions with young people who use tobacco and nicotine vapourisers focus on discouraging tobacco smoking?

Benefits of investing in prevention

School-based prevention interventions, including those delivered as part of the curriculum, derive cost-benefits for society. For example, interventions to tackle emotional learning save money in the first year by reducing costs for social services, the NHS and criminal justice system, and have recouped £50 for every £1 spent.\(^\text{21}\)

Further resources

- mentor-adepis.org/
- EMCDDA best practice portal
- Society for Prevention Research
- PHE document mapping UNODC international standards on drug use prevention to provision in England
- PSHE Association
- Alcohol Education Trust resources for schools and parents
- European drug prevention quality standards
- Young people’s health and wellbeing framework (PHE 2015)
- Promoting children and young people’s emotional health and wellbeing: a whole school and college approach (PHE 2015)
- The link between pupil health and wellbeing and attainment: a briefing for head teachers, governors and staff in education settings (PHE 2014)
- Education Select Committee Inquiry into PSHE and SRE in schools: written evidence submitted by PHE
- School-based interventions to prevent smoking. NICE public health guidance 23.
- Preventing the uptake of smoking by children and young people. NICE public health guidance 14
- Young people’s hospital alcohol pathways (PHE 2014)
2. A full range of specialist drug alcohol and tobacco interventions are available to young people in need

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

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

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

Young people’s substance misuse services also need to have the knowledge to understand, identify and respond to child sexual exploitation and abuse, because of the links to the use of alcohol and drugs.

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

Strong evidence shows that a combination of pharmacotherapy (nicotine replacement therapy) and behavioural support increases the chance of a successful smoking quit attempt four-fold. Smoking cessation services offer proven methods of cessation treatment as recommended by NICE.

What will you see locally if you are commissioning effective specialist substance misuse interventions?

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

- Young people with improved confidence, self-esteem, school attendance and involvement in positive activities. Longer term, there are likely to be improvements in education and employment outcomes, wellbeing, mental health and family relationships.
What questions should you ask to check you are following the evidence and best practice that supports the principle?

2.1 Ensuring delivery of high-quality evidence-based interventions

- Is the full range of evidence-based treatment available to young people in need?
- Is there a governance framework in place that sets out expectations for:
  - appropriate specialist interventions
  - quality standards
  - risk management
  - staff competence
  - case load management
  - clinical supervision
  - compliance with local safeguarding policies
  - compliance with legal requirements, which require services to be child-centred and appropriate to the young person’s age and maturity
  - development of the young person, to take account of individual vulnerabilities
- Do young people receive a range of interventions that vary in intensity and duration according to changing needs? Does this reflect changes in their risk and resilience factors?
- Are the interventions in line with relevant NICE guidance (e.g., PH4 Interventions to reduce substance misuse among vulnerable young people,\textsuperscript{24} CG115 Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence)?\textsuperscript{25}
- Are the interventions appropriate to the age and development of young people?
- Do services and commissioners regularly review the range and type of interventions available, who receives them, and which service is best placed to deliver them depending on risk and harm levels?
- Do young people with multiple vulnerabilities or a high risk of substance misuse-related harm get extra support? (This includes young people affected by child sexual exploitation and abuse, parental substance misuse, experiencing domestic violence, early problematic misuse, class A users, looked-after children, those not in education, employment or training, and involved in crime.)
- Are services tailored to the needs of vulnerable girls (e.g., are girls offered the option of a female keyworker)?
- Are young people who smoke offered very brief advice by frontline workers in school and youth settings?
• Is there easy access to an evidence-based stop smoking service for everyone who smokes or uses tobacco in any other form?
• Is the stop smoking service accessible for young people?
• Do local agencies have a good understanding of young people’s NPS use in their area, and use this knowledge to develop local responses to NPS?

2.2 Psychosocial interventions
• Do interventions include evidence-based psychological, psychotherapeutic or counselling-based techniques to help young people change their behaviour and lifestyles, and to improve their coping skills?
• Do these also include evidence-based interventions such as motivational interventions, cognitive behavioural interventions, relapse prevention and structured family interventions?
• Do appropriately competent staff deliver these interventions?

2.3 Harm-reduction
• Are all needle and syringe programmes, including those provided in pharmacies, operating in line with NICE PH52 guidance on needle and syringe programmes and working to policies that have been agreed by the local safeguarding children’s board?26
• Do all young people receive age-appropriate advice and information on:
  o the spread of blood-borne viruses
  o sexual health and contraception
  o overdose
  o health harms and reducing risky behaviour
• Are care pathways in place for young people to access age-appropriate sexual health services and testing and treatment for blood-borne viruses?
• Does harm reduction advice include new psychoactive substances?

2.4 Pharmacological interventions
• Do these include prescribing for detoxification, stabilisation and symptomatic relief of substance misuse as well as medication to prevent relapse?
• Are pharmacological interventions delivered alongside and appropriately integrated with specific psychosocial interventions?
• Are pharmacological interventions delivered in an age-appropriate manner and in the context of a clear clinical governance framework which sets out how prescribing should happen?
• Are age-appropriate pharmacological interventions provided in line with the Department of Health’s ‘Guidance for the pharmacological management of substance misuse among young people’ and ‘Guidance for the pharmacological management of substance misuse among young people in secure environments’?

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

2.5 High-intensity support for the most vulnerable young people

• Do vulnerable young people with complex needs receive multi-agency care packages?

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

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

• Do complex care systems support the needs of 16 and 17-year olds whose substance misuse has become problematic?

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

• To help young people maintain links with their families and other sources of support, do professionals consider local solutions for complex cases before looking for non-local residential placements?

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

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

• Are professionals supported and competent to identify and respond appropriately to victims of child sexual exploitation?27

2.6 Access and engagement

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

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

• Does the service evaluate why young people engage or fail to engage, and does it respond to the findings by adapting services?
Young people’s substance misuse

- Do services enhance their response to young people who are returning for treatment and whose needs have increased?
- Do services ensure young people are not retained in specialist interventions any longer than necessary?
- Do services make appropriate use of technology (e.g., texting, social media) to engage, maintain contact and follow-up young people?

2.7 Young people’s secure estate

- Are there arrangements to support continuity of care for those entering, transferring within or leaving the young people’s secure estate? Do they include a referral to a specialist service nearest the young person’s home and a pre-release contact with a professional to encourage the young person to engage with the service after release?
- Is this underpinned by a formal agreement that sets out the roles and responsibilities of each agency and clarifies who is responsible for coordinating care?
- Are arrangements in place to monitor NDTMS reporting across the secure estate to track outcome improvements in continuing care?

The benefits of specialist substance misuse interventions

Specialist interventions for young people’s substance misuse are effective and provide value for money. A Department for Education cost-benefit analysis found that every £1 invested saved £1.93 within two years and up to £8.38 long term. Specialist services quickly engage young people, the majority of whom leave in a planned way and do not return to treatment services.
3. Commissioning is integrated across prevention and specialist interventions and the wider children’s agenda

What you will see locally if commissioning is effectively integrated

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

What questions should you ask to check that you are following the evidence and best practice?

3.1 Integrated commissioning

- Has local provision been assessed and set out in terms of universal, targeted and specialist approaches?
- Is there a focus locally on the life course, including early interventions; particularly generic pre-school programmes that focus on improving literacy and numeracy and that have a long-term effect of strengthening resilience in young people?
- Has a protocol with children’s services been agreed by the local safeguarding children’s board (LSCB) that covers identifying and responding to safeguarding concerns related to young people’s substance misuse?
- Are policies and protocols in place that cover information sharing with parents and carers and with other agencies, including children’s services?
- Do local clinical and safeguarding leads review and support the design and delivery of specialist substance misuse services?
- Is substance misuse addressed across the wider children’s agenda: at the LSCB, youth offending team (YOT) management boards, at serious case reviews, within child and adolescent mental health services and across children’s services more widely?
- Are existing local networks used for finding and sharing information with partners about new psychoactive substances?

3.1 Transition to other services

- Is a transition policy in place that sets out roles and responsibilities between different services? Does it set out expected outcomes and standards for effective transfers?
- To ensure an effective handover and continuity of care, are there reviews involving the current service, the young person and the service he or she is moving to (adult or other young people’s service)?
- Are young people who have reached the upper age limit of the service, but don’t need to move to adult services, informed how to access adult services later if they need to?
Do universal and targeted services support young people discharged from substance misuse specialist services in order to address their wider health and social needs?

Do children’s social care services assess young people before they turn 18 if there is significant benefit in doing so, and if it is likely those young people will need adult care and support after turning 18?29

Further resources

- ‘Young people’s specialist substance misuse treatment: exploring the evidence’ (NTA, 2009)
- ‘Practice standards for young people with substance misuse problems’ (CCQI, 2012).
- Quality criteria for young people friendly health services (Department of Health, 2011)
- ‘Working together to safeguard children’ (HM Government, 2013)
- University of Bedfordshire publications on responding to child sexual exploitation
- ‘Healthcare standards for children and young people in secure settings’ (Royal College of Paediatrics and Child Health, 2013)
- ‘Healthcare standards for children and young people in secure settings’ (Royal College of Paediatrics and Child Health, 2013)
- ‘Supporting information for the development of joint local protocols between drug and alcohol partnerships, children and family services’ (NTA, 2011)
- ‘Guidance for the pharmacological management of substance misuse among young people in secure environments’ (Department of Health, 2009)
- ‘Substance misuse interventions within the young people’s secure estate: guiding principles for transferring commissioning responsibility from the YJB to local partnership areas’ (NTA, 2012)
- ‘Interventions to reduce substance misuse among vulnerable young people: NICE public health guidance 4’ (NICE, 2007)
- ‘Needle and syringe programmes: NICE public health guidance 52’ (NICE, 2014)
- ‘Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence’ NICE CG115
- ‘Quality standard for the health and wellbeing of looked-after children and young people’ NICE quality standards [QS31]
- ‘Smoking cessation services: NICE public health guidance 10’ (NICE, 2008)
- ‘Tobacco harm reduction: NICE public health guidance 45’ (NICE, 2013)
- ‘Smoking cessation – acute, maternity and mental health services: NICE public health guidance 48’ (NICE, 2013)
- ‘Brief interventions and referral for smoking cessation: NICE public health guidance 1’ (NICE, 2006)
- ‘When to share information: best practice guidance for everyone working in the youth justice system’ (2008)
- ‘Practice standards for young people with substance misuse problems’ (CCQI 2012)
4. A skilled workforce is in place to provide effective interventions

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

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

The therapeutic relationship young people have with their keyworkers is vital. Positive outcomes depend on a positive and trusting relationship between them. Research suggests that young people’s feelings about the quality of their relationships with key adults and peer mentors contribute significantly to their wellbeing and positive outcomes.

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

What will you see locally if a fully competent workforce is in place?

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

What questions should you ask to check you are following the evidence and best practice?

- Are young people’s substance misuse services commissioned to ensure that all staff have the core skills and knowledge necessary for working with children and young people?
Are staff appropriately trained in routinely identifying child sexual exploitation and abuse, and in ensuring that young people have access to appropriate services?

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

Are these skills regularly assessed and updated?

Are staff skilled in building therapeutic alliances with young people?

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

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

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

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

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

Are staff who deliver specialist interventions able to access regular clinical supervision with appropriately qualified clinicians?

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

Further resources

- The Royal College of Paediatrics and Child Health e-learning tools for the substance misuse workforce
- Skills for Health national children and young people’s occupational standards for the CAMHS and young people’s substance misuse workforce 2015
- The alcohol and drugs competency assessment framework (ADCAF) is a tool for individuals, managers and commissioners to access information on how to assess and enhance competence in the field of substance misuse
- Brook and the Department of Health, Combating child sexual exploitation: an e-Learning resource for health professionals
- Barnardo’s Spot the Signs for Professionals resource on child sexual exploitation
Young people’s substance misuse

1 Smoking, Drinking and Drug Use Among Young People in England, Health and Social Care Information Centre, 2015
2 Child uptake of smoking by area across the UK (Thorax 2013)
4 Guidance on the Consumption of Alcohol By Children and Young People (DH, 2009)
5 Key Data on Adolescence 2015 (AYPH, 2015)
6 UNODC International Standards on Drug Use Prevention
7 UNODC International Standards on Drug Use Prevention
8 UNODC International Standards on Drug Use Prevention
9 UNODC International Standards on Drug Use Prevention
10 European drug prevention quality standards
11 School-based interventions on alcohol NICE public health guidance 7
12 Interventions to reduce substance misuse among vulnerable young people: NICE public health guidance 4 (NICE, 2007, PH4)
13 School-based interventions to prevent smoking. NICE public health guidance 23.
14 Preventing the uptake of smoking by children and young people. NICE public health guidance 14
16 Alcohol-use disorders: preventing harmful drinking (NICE PH guidance 24)
17 Alcohol-use disorders: preventing harmful drinking (NICE PH guidance 24)
18 Alcohol-use disorders: preventing harmful drinking (NICE PH guidance 24)
19 Alcohol-use disorders: preventing harmful drinking (NICE PH guidance 24)
20 “If only someone had listened” Office of the Children’s Commissioner’s Inquiry into Child Sexual Exploitation in Gangs and Groups Final Report November 2013
22 Women and girls at risk: Evidence across the life-course, Di McNeish and Sara Scott, DMSS Research 2014
23 Smoking cessation services. NICE public health guidance 10.
25 NICE Guidelines CG115 (2011)
26 NICE Guidelines PH52 (2014)
27 Health Working Group Report on Child Sexual Exploitation: An independent group chaired by the Department of Health focusing on: Improving the outcomes for children by promoting effective engagement of health services and staff January 2014
28 Specialist drug and alcohol services for young people: a cost benefit analysis, published by Department for Education, 2011
29 The Care Act 2014
30 Common Core of Skills and Knowledge for the Children’s Workforce, HM Government 2005
ANNEX A. Key data sources on young people’s drinking, drug use and smoking for use in needs assessments and strategic commissioning

1. Child and Maternal Health Intelligence Network (ChiMat) is part of PHE and provides a wide-range of authoritative data, evidence and practice related to children's, young people's and maternal health.

2. NDTMS data including the JSNA data support pack.

3. ‘Smoking, drinking and drug use among young people in England 2014’ survey

4. What about YOUth survey 2014 is a newly-established survey designed to collect robust local authority level data on a range of health behaviours amongst 15 year-olds, including whether they smoke, drink alcohol or have taken drugs. Other topics include general health, diet, use of free time, physical activity, emotional wellbeing, and bullying. The smoking prevalence findings were published in August 2015 in order to meet the public health outcome framework release data requirements and the Health and Social Care Information Centre will be publishing the other key findings from the survey in December 2015. Local authority level tobacco data is available on the local tobacco control profiles website www.tobaccoprofiles.info/

5. ‘Crime survey for England and Wales, Year Ending March 2015’ is a largely adult survey but includes data on young adults aged 16-24. The latest report found that this age group were more likely to have used drugs in the last year than older adults.

6. ‘Health behaviour of school aged children’ survey is a collaboration with the WHO Regional Office for Europe and is conducted every four years in 43 countries and regions across Europe and North America, gaining insight into young people’s wellbeing, health behaviours and their social context.

7. The Schools and Student Health Education Unit is based at Exeter University and provides lifestyle surveys and research reports for those working with young people.