DRUG & ALCOHOL TEAM
Cornwall and Isles of Scilly
Reducing Harm | Promoting Recovery

SAFER CORNWALL
Kernow Salwa

Young Persons substance use needs assessment 2026 Refresh

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CORNWALL COUNCIL

wise up to drugs & alcohol

Introduction

In December 2021, the government published their **10-year UK Plan**[1] to combat illegal drugs, backed by additional funding, to start to **reverse the impact of disinvestment** in drug treatment over the previous decade.

The national strategy seeks to deliver the recommendations of Dame Carol Black's landmark **independent review of drugs**,[2] including a new long-term approach, with **changes to oversight and accountability**, delivered by the whole of Government.

The 10-year commitment sets out the expectations of how **Government and public services will work together** and share responsibility for delivery. This includes specific **guidance**[3] for **local partners**.

Every area is required to have a local **Combating Drugs Partnership** to drive effective delivery of the national Drugs Strategy. This partnership must **agree priorities** through a **strategic needs assessment** and develop and deliver a local **drug strategy and action plan**.

In Cornwall, that responsibility is discharged through the **Community Drugs Partnership**. Oversight and governance is provided by the **Safer Cornwall Strategic Board** and the Chair is the Senior Responsible Officer.

Local drug and alcohol strategies continue to be included under the umbrella of the **Safer Cornwall Partnership Plan.**

The strategic needs assessment aims to provide a **shared understanding of local needs and evidence** for drug and alcohol provision. This informs the design of local services and enables individuals, their families and the wider community to have their **needs met more effectively**. A comprehensive strategic needs assessment was published in 2025.

This Needs Assessment partners both the Drugs Needs Assessment and the Alcohol Needs Assessment documents. There are multiple cross-cutting themes and priorities shared throughout.

Local plans responding to these needs assessments consider both drug and alcohol-related harms, and how to meet the complex needs of people who use alcohol as well as other drugs. Alcohol is included alongside drugs in all relevant activity and performance monitoring and reporting.

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[1] From harm to hope: A 10-year drugs plan to cut crime and save lives, UK Government, December 2021
[2] Dame Carol Black's Independent Review of Drugs, Home Office and DHSC
[3] Drugs Strategy Guidance for Local Delivery Partners, Home Office, June 2022

What is a needs assessment?

Needs assessment is the **cornerstone of evidence-informed commissioning**.

NICE (National Institute of Clinical Effectiveness) defines health needs assessment as a "systematic method for reviewing the health issues facing a population, leading to agreed priorities and resource allocation that will improve health and reduce inequalities"[4].

A robust needs assessment provides commissioners with the range of information required to feed into and inform planning and prioritisation.

It is based on:

- **Understanding the needs of the relevant population** from reliable data sources, local intelligence and stakeholder feedback.
- Systematic analysis of **legislation, national policy and guidance**.
- **Understanding what types of interventions work**, based on analysis of impact of local services, research and best practice.

It is a tool for **decision making**, that helps **focus effort and resources** where they are needed most.

Aims and objectives

The purpose of needs assessment is to examine, as systematically as possible, what the **relative needs and harms are within different groups and settings** and make evidence-based and ethical decisions on how needs might be most **effectively met within available resources**.

Through undertaking a rigorous needs assessment, we aim to continue to ensure that **systems and services are recovery focused**, provide **value for money** and **meet the needs** of local communities.

An effective needs assessment for drug interventions, treatment, support, recovery and reintegration involves a process of identification of:

- **What works well, and for whom** in the current system, and what the unmet needs are
- **Where there are gaps for clients** in the wider reintegration and treatment system
- **Where the system is failing** to engage and / or retain people
- Who the **hidden populations** are and their risk profiles
- The **enablers and barriers** to treatment, reintegration and recovery pathways
- The relationship between **treatment engagement and harm** profiles

This provides a **shared understanding of the local need for services**, which then informs treatment planning and resource allocation, enabling residents to

[4] NICE guidance on Health Needs Assessment – www.nice.org.uk

have their needs met more effectively, and ultimately benefiting the communities in which they live.

Such an assessment needs to take full account of the gender, ethnicity and other **diverse needs of the target population and any unmet needs** from this perspective.

We undertake a **full needs assessment every 4 years**, with an annual review and refresh to ensure that our evidence base keeps pace with emerging trends.

This document constitutes a Refresh for 2025 and should be read as an Addendum to the latest Needs Assessment documents for Drugs and Alcohol, which can be found here.

Local context[5]

Along with our **Drugs Needs Assessment papers** the information in this document is set against a backdrop of **escalating risk** across our communities, affecting our most **vulnerable people and places**.

- Many families are experiencing increased hardship as a result and people who were already struggling have been most affected.
- More people are needing extra help and support. As well as practical help to prevent homelessness, get food or other financial support, often more specialist support is needed. This may be help with mental health, drug or alcohol dependency or to recover from trauma or abuse.
- Residents are telling us that they are seeing more anti-social behaviour and crime, which makes them feel less safe in their local area.

There has been a lot of change in central government. We have seen new laws and guidance, with more duties falling on local partnerships to deliver. This affected all areas of community safety, including anti-social behaviour, violence, drugs and domestic abuse.

Key partners have changed how they work and services are being provided differently to both the public and to other partners. This includes the police, health services and probation.

Inclusion health groups

These are groups who are **socially excluded** and likely to have **experienced multiple risk factors for poor health**, such as poverty, violence and complex trauma They experience the most extreme health inequalities- unfair differences in health outcomes

[5] Safer Cornwall Partnership Plan: SC-0042-Partnership-Plan-April-2025-FINAL-v3.pdf

The new **Inclusion health data and intelligence resource**[6] for England includes local data on the health needs and outcomes for these populations, that are not otherwise routinely available.

The tool includes **benchmarking data for local authorities** including prevalence, numbers in treatment and deaths in treatment so that local partnerships can compare outcomes.

As well as bringing together statistics that are already in the public domain, it provides **accompanying narrative and resources to support informed decision-making** and the development of tailored solutions to the challenges faced by inclusion health groups.

People with drug and alcohol dependency **experience extreme health inequalities** and as such are part of the NHS Inclusion Health Groups. **Other vulnerable populations** include people who experience homelessness, people with experience of care, vulnerable migrants, Gypsy, Roma and Traveller communities, sex workers, people in the criminal justice system and victims of modern slavery.

Populations are diverse but can share common experiences such as social disadvantage, poor health and barriers to accessing services.
Health inequalities experienced by belonging to one or more inclusion group can be further exacerbated if **more than one inequality domain** is experienced.

Risk and protective factors

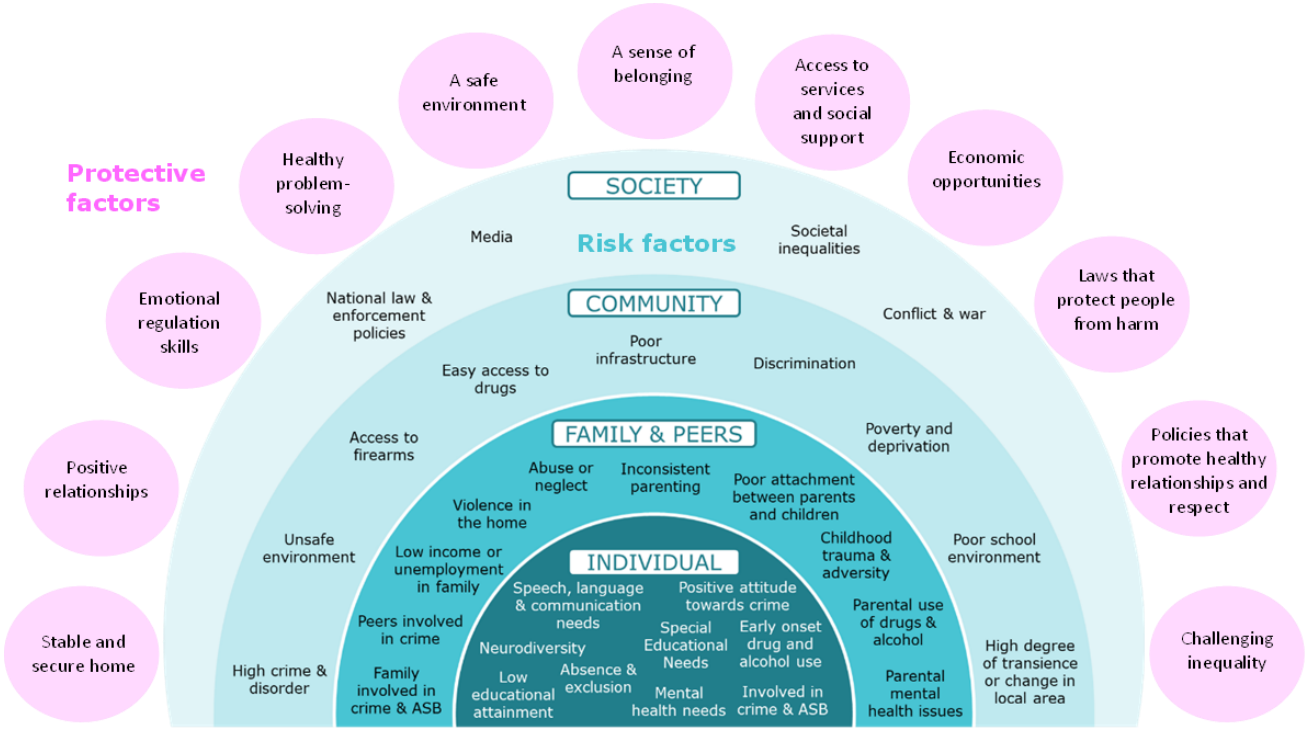
The underlying **risk factors for problem drinking and drug use** and similar to those for violence and abuse, shown in the ecological model below. This shows the **complex interplay of factors** at an individual and family level, and at a wider community and society level.

Risk factors often occur in clusters (and interact with each other within the broader social, cultural and economic contexts. These **factors can change over time**, depending on other factors like age.

Addressing risk factors across the various levels of the ecological model may contribute to reduced risk in more than one area. For example, **healthy relationships education** addresses risk factors at an individual, family and community level, with the aim of **preventing domestic abuse** and addressing a key **risk factor for youth violence**, whilst also reducing the risk of both immediate and long-term **mental and physical health-related harms**.

Protective factors act against risk factors and can explain why children who face the same level of risk are affected differently. A combination of protective factors can **prevent the harmful influence of risk factors** that have accumulated over a child's development

[6] Inclusion health data and intelligence resource, Office for Health Improvement and Disparities, January 2026


Protective factors
A safe environment
A sense of belonging
Access to services and social support
Healthy problem-solving
Economic opportunities
SOCIETY
Media
Risk factors
Societal inequalities
Emotional regulation skills
National law & enforcement policies
COMMUNITY
Conflict & war
Laws that protect people from harm
Poor infrastructure
Easy access to drugs
Discrimination
Access to firearms
FAMILY & PEERS
Poverty and deprivation
Positive relationships
Abuse or neglect
Inconsistent parenting
Poor attachment between parents and children
Policies that promote healthy relationships and respect
Violence in the home
Unsafe environment
Low income or unemployment in family
INDIVIDUAL
Childhood trauma & adversity
Poor school environment
Speech, language & communication needs
Positive attitude towards crime
Stable and secure home
Peers involved in crime
Special Educational Needs
Early onset drug and alcohol use
Parental use of drugs & alcohol
Challenging inequality
Neurodiversity
High crime & disorder
Absence & exclusion
High degree of transience or change in local area
Family involved in crime & ASB
Low educational attainment
Mental health needs
Involved in crime & ASB
Parental mental health issues

RISK FACTORS

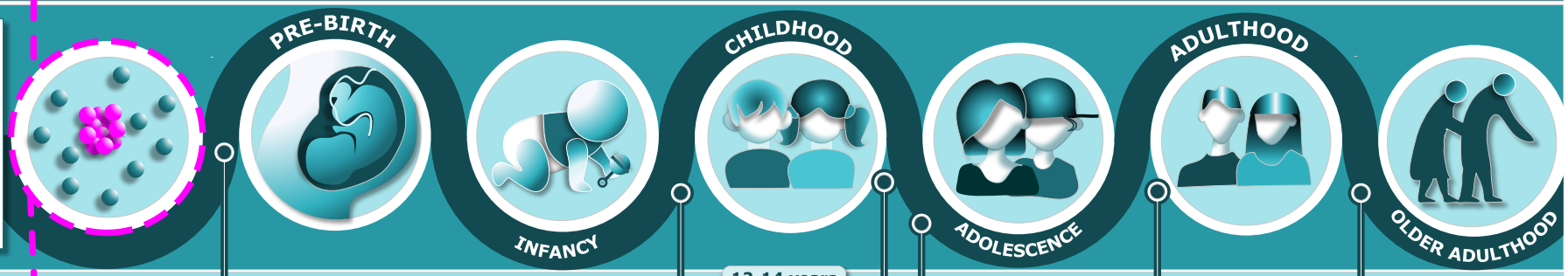
BIOLOGICAL
- Inherited conditions
- Age, Race, Gender, Sexual orientation
- Low birth weight
- Poor physical health
- Disability
- Poor nutrition
- High blood pressure/cholesterol

PSYCHOLOGICAL
- Poor mental health
- Depression
- Stress
- Anxiety
- Experience of trauma
- Experience of loss/ bereavement

SOCIAL
- Low income and debt
- Poor educational attainment and/or exclusion
- Weak social connections, family networks/community cohesion
- Low paid work or unemployed
- Crime – involvement/exposure
- Witnessing family/peer drug use

ENVIRONMENTAL
- Living in a deprived area
- Lack of affordable/appropriate housing
- Poor access to local amenities and core services -primarily healthcare.
- Lack of sufficient public transport

LIFECOURSE



PATHWAYS

We are not **born** with a fixed set of risk factors, but rather a **background set of vulnerability factors**. Just by the chance of our birth there will be risks and the **higher the number** of these the **more probable** it is that a person will initiate **use**. Vulnerability factors cluster together, creating a snowball effect which generates **pathways into drug use.**
The **majority** of young people **age out of drug use** due the presence of **protective factors**. However, risk and protective factors are not equally weighted. Young people who experience **4+ ACEs** are **11-16 times** more likely to become **dependent on heroin** in later life.

10-12 years

Early onset externalised youth
Have poor impulse control disorders, at high risk of abuse, are underprivileged and more likely to be involved in crime.

12-14 years

Mid-onset internalised youth
High rate of mental and emotional difficulties evident in puberty and rooted in trauma experienced.

14-16 years

Late onset normative youth
Separation from parents to peers increases exposure to high-risk situations and exploitation.

19-21 years

Fling users
Largely a student population from a lower economic background who feel alienated and marginalised in a new social setting.

Entrenched drug use
emanating from early onset non-normative consumption can lead to escalating need, exacerbating health risks.
Increased risk of **premature death** linked to chronic **co-occurring health conditions**.
Higher frequency of **suicide** and **drug related deaths**

26-30 yrs

31-60 yrs

The earlier the entry point the harder it is to age out of drug use

OCUs

OCU **numbers are increasing** nationally with the highest proportion concentrated in the 35-64 age bracket, which may reflect an **ageing population** of OCU. Users often have multiple and **complex needs** such as mental health, unemployment, family estrangement, homelessness /rough sleeping and offending histories.

OCUs are at **higher risk** of thrombosis and **respiratory infections**, wound infections, **hepatitis C and HIV**. Use can damage heart, lungs, liver, kidneys and brain. Crack can **evoke psychotic reactions** akin to acute paranoid schizophrenia which can manifest as **aggression or potential violence**. High prevalence of **depression**.

Higher **prevalence of co-occurring health conditions** morbidity and premature mortality, including **suicide and drug overdose** – exacerbated exponentially by the emergence of heroin mixed with **high strength nitazenes**. Protracted use can make **recovery harder.** Multiple treatment attempts and relapses are more likely.

Key messages for 2026

Substance use among young people in Cornwall continues to **shift in complexity** rather than volume. While 142 young people received structured treatment in 2025, and overall numbers have stabilised after a 2024 spike, the cohort is now older and presenting with higher levels of vulnerability. A further 88 young people received harm-reduction support, and 188 were supported as Affected Others due to parental substance use.

Cannabis remains the most common substance (87% of cases), while ketamine use is becoming more common. This is generating some safeguarding concerns, particularly linked to exploitation, and presenting physical health issues such as chronic urinary problems not always recognised by primary care.

Alcohol use persists, with a notable **shift toward high-strength spirits** acquired via shoplifting or social media, contributing to **town-centre anti-social behaviour**. Solvent and aerosol misuse has re-emerged, posing acute risks that cannot be mitigated through harm-reduction.

Vulnerabilities and Complexity

Young people in treatment show **increasing levels of cumulative vulnerability,** often experiencing:

- School exclusion or chronic non-attendance
- Domestic abuse exposure
- Mental health challenges and trauma
- Peer isolation, bullying, and unstable relationships
- Parental substance use and wider family instability

A significant proportion of the caseload present with internalised disorders (e.g., anxiety and depression). Cannabis is often used by these young people to self-medicate, meaning service goals fo**cus on safer use reduction rather than immediate abstinence.** Approximately 80% of young people reported significant peer difficulties, and mental health needs increasingly resemble higher-need social care populations.

Service Delivery and Innovation

YZUP (With You), the commissioned young people's drug and alcohol service, continues to modernise its delivery model. A **virtual practitioner** supported 90 young people whilst reducing waiting times for full-service engagement. Young people who previously avoided face-to-face support engaged well with virtual appointments, demonstrating its value as an **enhancement to the service.**

Schools remain a crucial referral route, but engagement is inconsistent, with some schools not yet utilising YZUP's interventions despite the programme reaching over 4,800 learners across 24 schools. School exclusions related to drug and alcohol use **continue to rise nationally**, reinforcing their role as an early identification setting.

Affected Others and Hidden Harm

Parental substance use is a factor in young people's vulnerability. Over 1,000 local parents in treatment live with children under 18, yet only 5–6% receive parenting support—well below national averages. Estimates suggest 10,990 children in Cornwall live with an adult using substances, including 3,980 with dependency. **Many remain unidentified** in local systems due to hidden harm and multiple co-existing adversities such as domestic abuse and parental mental ill health.

Children looked after and care leavers remain at elevated risk due to trauma, instability, peer influence and unmet mental health needs. These vulnerabilities strongly intersect with substance use initiation and escalation.

Prevention Insights

National data shows a decline in drug use among 11–15-year-olds, though vaping is rising—especially among 15-year-old girls. Locally, young people report **higher rates of alcohol experimentation** than national averages. Cornwall's Right On Survey shows nicotine and cannabis use remain significant but not widespread, with ketamine use emerging among a small minority.

Evidence indicates that **effective prevention requires** whole-school approaches, family programmes, early identification, motivational interviewing, and robust pathways between universal, targeted, and specialist support. Conversely, mass-media campaigns, standalone self-esteem programmes, and generic mentoring show **no proven impact** on reducing drug use.

Overall Conclusions

Young people's substance use in Cornwall is becoming less about experimentation and more about **complexity, trauma**, and **co-occurring vulnerabilities**. Services are adapting through integrated safeguarding, school-based prevention, digital innovation, and stronger diversion pathways. However, gaps remain in parental support, school engagement, and identifying hidden populations.

Continued emphasis on early intervention, multi-agency coordination, tailored support for girls and boys, and trauma-informed practice will be **essential to improving outcomes** and reducing future harm.

Young people in Treatment 2025

YZUP as part of With You, are the commissioned providers of community drug and alcohol services to young people across Cornwall. The agency utilises an adolescent development informed treatment model that recognises that young people's risk factors for drug and alcohol involvement cluster, creating identifiable pathways into substance use.

This includes Externalised factors characterised by poor-impulse control, internalised which is characterised by mood disorders and Normative youth, whose involvement in substance use is peer led. Young people can experience both conditions, where Externalised disorders precede Internalised ones. These young people are determined as complex

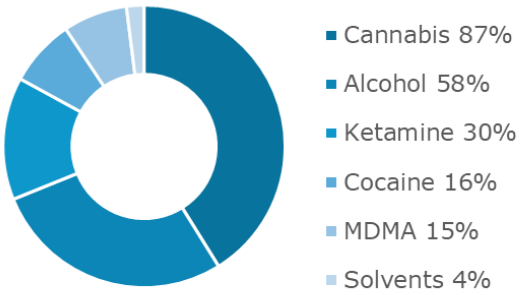
The following information is based on the 2025 calendar year and is compared with the previous year.

Drug and alcohol use

- ▼ **142** young people in treatment in the last year, with a further 88 receiving harm reduction interventions.
- The number of **young people** in treatment has reduced by 9% over the last year, following the spike in 2024. The **rise since the 2022 baseline is 81%**.
- ▲ **188** young people supported as **Affected Others** in a year, **where their parents have an identified drug and alcohol need.**
- **87%** of young people are being supported for **cannabis** use.

We are seeing **increasing multiple vulnerabilities** in young people engaged with treatment services, particularly when there are other people using drugs at home and when they have been excluded from school. Young people are also **starting to use** their substances and cigarettes at a **younger age**.

- **Cannabis is the most used** substance amongst our young people. We do however have increasing numbers of young people **using ketamine** in Cornwall. Although these numbers are smaller, the proportion is increasing compared with last year.



- **Alcohol use is still present** amongst our young people, although we are much more likely to see young people using spirits when compared with previous years. Although Alcohol can be harder to obtain, we are seeing young people now acquire it through shoplifting or social media order. The use of these high strength spirits **can be linked to anti-social behaviour** in our town centres.
- We have seen the **use of solvents and aerosols** re-emerge amongst our young people. Unlike previous years we are seeing these used with other

substances in the community rather than in isolation in the home. There is a **risk of death associated with aerosols** which, unlike other substances, cannot be dealt with through harm reduction interventions.

Focus on Ketamine

The use of ketamine is on the rise and amongst older young people the use of **ketamine and cocaine as a duo is being highlighted**. This is a concern in itself in the fact that ketamine can damage a person's urinary tract, bladder and bowel. There is work that needs to be done with GP's around their knowledge of this. Young people are reporting that they are continually having urinary infections and GP's are treating them **without asking the questions** that could elicit the information about their ketamine use.

- Ketamine is **frequently mentioned in multi-agency panels** and is a common factor in recent referrals to youth services.
- We continue to see a frequent references to ketamine in relation to young people referred for safeguarding interventions[7] for exploitation.
- This increase **reflects a national trend** and is not limited to Cornwall, with widespread concern across the UK. This appears to be an issue in devon as well although less so in Plymouth where Spice is more regularly mentioned.

Health Risks include rapid tolerance development leading to escalated use, which increases the risk of dependency. A pain-use cycle can develop, where users take more ketamine to relieve pain caused by previous use.

Prolonged ketamine use can result in **permanent and irreversible bladder damage** and nasal complications and there have been some cases of young adults affected locally. **Collaboration with a Urologist** at Treliske is underway to develop **clinical advice for GPs** who may not link presenting physical symptoms to drug use.

Organisational Position

The youth issues MoRiLE workshop detailed how Yzup have been receiving a greater number of referrals from a wider range of services.

Over the past year Yzup has **increased their use of breif and extended interventions,** including piloting a virtual 1-1 offer with a practitioner based in Kent[8]. All referrals are triaged (including a risk assessment) and given brief interventions including advice and guidance to the referrer and/or parent/carer. The virtual pilot is currently being evaluated as a **potential strategy to help meet needs more effectively going forward**.

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[7] Missing and Child Exploitation Panel – operational safeguarding response for young people experiencing or at risk of exploitation.
[8] for those pre-structured treatment with support delivered to the young people, referrer and /or parent/ guardian including the option of virtual support for the young person.

Operating three days per week, the practitioner supported a consistent caseload of nine young people through weekly virtual appointments and conducted **triage for over 90 young people to date.** The pilot has demonstrated that virtual delivery is a highly effective supplement to face-to-face provision, offering measurable improvements in engagement, efficiency, and risk management. Key impacts include:

- **90 Young people triaged**, significantly reducing waiting times and improving allocation accuracy.
- **Consistent weekly caseload of 9 young people**, with flexible appointment times, including evenings and weekends.
- **Real-time safeguarding**, with multiple high-risk situations managed swiftly through virtual platforms.
- **Cost and time efficiencies**, including an estimated **85-90 hours saved in travel time and expenses** over the pilot period. (Based on a 20-minute travel time between clients and commute.)
- **Positive young person feedback**, reduced drop-out rates, and improved engagement among young people previously not wanting to engage face to face.

Vulnerabilities of young people

Young people in Cornwall are more likely to have **anti-social behaviour cited as an issue** than the national cohort. There are two factors that contribute to this suggesting we are perhaps better at identifying substance use needs amongst young people involved in ASB:

- Often ASB is **identified by the referring agency** at the start of a young persons intervention.
- YZUP are involved with the **Safer Streets** project of the Serious Violence Prevention Programme and run specific group sessions in schools with young people involved in ASB. A recurring theme of these groups has been the identification of many unmet needs.

Our young people in treatment are more likely to **experience and witness domestic abuse** in the home so it would be safe to suggest that those young people affected by parental substance use would experience the same.

Many young people receiving specialist interventions for substance use have a range of vulnerabilities including: not in education, employment or training (NEET), in contact with the youth justice system, experience of domestic abuse and sexual exploitation.

OHID (Office for Health Improvements and Disparities) recommendations state that universal and targeted services have a role to play in **building resilience** and providing substance use advice and support at the earliest opportunity. Specialist services should be provided to those whose use has escalated and/or is causing them harm. There should be effective pathways between specialist services and children's social care for those young people who are vulnerable,

and age-appropriate care should be available for all young people in specialist services[9].

Substance use services for young people may need to consider sex differences in the treatment population. There are a number of specific issues facing girls, including increased citation of alcohol as a problematic substance, involvement in self-harm, being affected by domestic abuse, and affected by sexual abuse including exploitation[10].

Boys also experience domestic abuse, sexual exploitation and self-harm, and this should be explored by services. It should also be noted that self-harm in boys may present more indirectly, such as picking fights and destruction of their own property.

Services available need to be tailored to the specific needs of girls and boys within these services and ensure that young people with multiple vulnerabilities or a high risk of substance use-related harm get extra support with clear referral pathways and joint working protocols[11].

The following graphics illustrate the wider vulnerabilities of young people who are in treatment as a user or an affected other and the other services they are known to.

Referral Sources

Young people come to specialist services from various routes but are typically referred by schools and colleges, youth justice, children and family services and self, family and friends.

Changes in universal and targeted young people's services may affect screening, referrals and demand for specialist interventions. There should be clear pathways between targeted and specialist young people's services, **supported by joint working protocols and good communication.**

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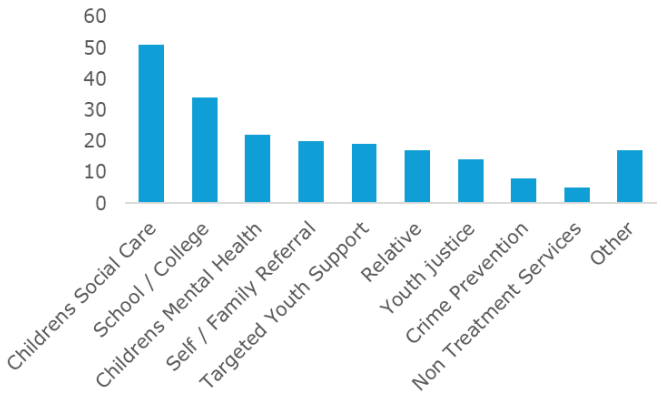
[9] Jackson, C., Sweeting, H., & Haw, S. (2012) Clustering of substance use and sexual risk behaviour in adolescence: analysis of two cohort studies. BMJ Open, 2(1), pp.1-10

10 Public Health England (2017) Child Sexual Exploitation: how Public Health can support Prevention and Intervention. Available at: https://www.gov.uk/government/publications/child-sexual-exploitation-prevention-and-intervention

11 Jackson, C., Sweeting, H., & Haw, S. (2012) Clustering of substance use and sexual risk behaviour in adolescence: analysis of two cohort studies. BMJ Open, 2(1), pp.1-10

- We have **greater proportions of education referrals** which is likely to be the result of YZUPs presence in schools and the delivery of the schools programme;
- The greater proportions of self and family referrals that we previously saw has **reduced back down to normal levels** when compared with previous years.



Outcomes[12]

YZUP is now working with a larger, older, and more complex client group than ever before. Despite this, the organisation has delivered its strongest set of clinical outcomes in seven years. An outcomes report is produced annually based on the results of clinical real-time feedback tools and a strengths and difficulties questionnaire that establishes whether a young person is presenting as externalised, internalised, normative or complex. Externalised and Complex trajectories respond particularly well to intervention, while Internalised and Affected Others need renewed strategic focus to improve engagement and outcomes.

The 2024–25 reporting period shows a major rise in demand for YZUP services and a significant shift in the complexity of young people presenting for support.

A total of 339 presentations were recorded, and a changing client profile has been identified in the evaluation.

- The internalised cohort (anxiety/depression) remains the largest group, making up 45.5% of the caseload.
- Complex cases have increased substantially and now exceed Externalised-only cases.
- Normative (peer-led) substance use cases are now very few highlighting the change of complexity for the cohort.

Just over 50% of young people are female which is above the national average for young people's treatment services. The average age of first presentation has risen to 15, which is higher than previous years.

The average age for affected others is slightly younger at 14, suggesting stable family-related risk factors.

Peer relationships

[12] Phil Harris, YZUP Outcomes Report 2024-25

One of the key findings was regarding peer relationships with 4 out of 5 of young people known to YZUP saying they had issues with their peers leading to social isolation. This includes:

- Bullying or being bullied
- Social withdrawal
- Exclusion or marginalisation
- Difficulty maintaining stable friendships

Mental Health

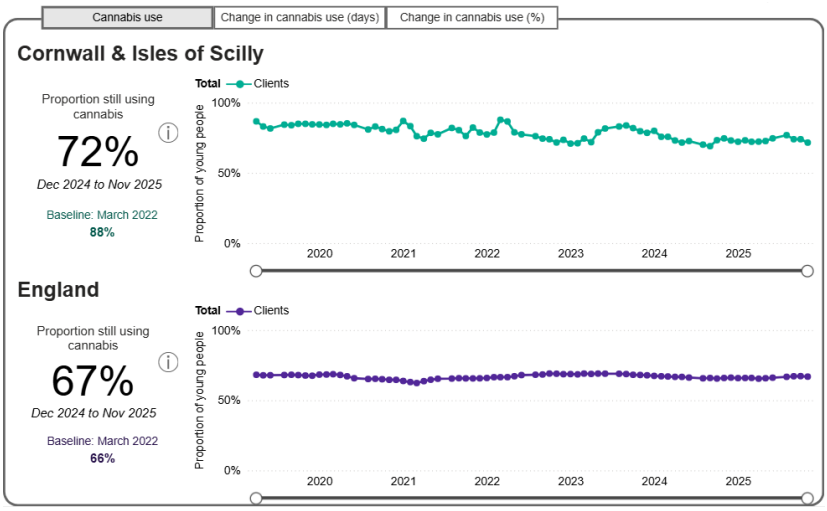
The outcomes report also shows that YZUP's clients now have mental health needs that are more in line with higher-need mental health and social care populations rather than a community substance-use cohort. This is due to:

- Higher rates of trauma exposure
- More severe mood disorders
- Increased social isolation
- More entrenched and complex behavioural patterns
- Later age of presentation (average now 15.6), meaning difficulties are more established at entry

Treatment exits

When looking at cannabis use at treatment exit we can see that young people are more likely to be using cannabis when compared with the national cohort.

- Even though we are reporting higher than national rates we can see an improvement compared with the March 22 baseline.



The Outcomes report indicates a notable shift in the young people accessing the service with normative young people now being largely absent from the data. This is significant, as they would typically be more likely to complete treatment without continuing to use cannabis.

The current cohort is far more complex than previous ones. Seventy percent of young people in treatment fall within the top 5% for complexity, up from 50% in earlier samples. Additionally, 81% score within the highest ranges for internalised disorders. These internalised young people often experience diagnosed or undiagnosed mental health challenges or may be managing neurodiversity. Because many are using cannabis to self-medicate, their

treatment goals tend to focus on reducing and managing use, rather than achieving full abstinence immediately. More complete abstinence often becomes realistic only once they develop alternative coping strategies or progress further in their adolescent development with better tools and resilience.

The team has spent considerable time reflecting on how to work more effectively with internalised young people, recognising that they can be the hardest to engage and that changes often occur slowly. This can affect both staff morale and outcome data. Outcomes and learning will continue to be explored as the team grows more confident in supporting this group.

There's also an acknowledgment that working with young people who use cannabis can be challenging. Small, meaningful progress—such as avoiding use before school, staying engaged in education, or limiting use to weekends—often represents important therapeutic wins.

Schools

In England, there were 10,885 permanent exclusions and 954,952 suspensions from state-funded schools in the 2023-24 academic year, including 742 drug and alcohol related permanent exclusions and 24,554 drug and alcohol related suspensions[13].
Schools are an **important part of any young people's drug strategy**, for building resilience, for early prevention, to identify substance use and refer into specialist substance use services. Being excluded or suspended from school can have a negative effect on young people and increase their vulnerability to problematic substance use.

There has been a shift in ethos by some pastoral staff in some secondary schools where there is an understanding that a young person's **substance use may be in response to lived experience.**

The YZUP school programme has met over **4,848[14] children from 24 different schools.** An additional 4,000 students at Truro College were shown a bespoke video about the YZUP service, before the Christmas holidays. As a result, tutors at the college have booked in follow up sessions.

YZUP offer each school in Cornwall small group sessions for students who are **identified by the school** as needing interventions around drug and alcohol use to reduce harm and stay safe. There are however **some schools that fail to engage** and respond to YZUP's requests to deliver these sessions and this is currently being worked on by the service.

[13] Suspensions and permanent exclusions in England, Academic year 2023/24 - Explore education statistics - GOV.UK
[14] As of Q3 2025/26

Youth justice

Most children in Cornwall and the Isles of Scilly do not offend. We know that children coming to the attention of Youth Justice Services **present with high levels of need** relating to neurodiversity, education, mental health and wellbeing. It is now widely recognised that adverse childhood experiences are highly prevalent amongst this population.

There has been a shift in the national approach to Youth Justice which **recognises that children who offend are often vulnerable** and in need of support rather than punishment. As a result, the Youth Justice partnership in Cornwall and Isles of Scilly aims to provide holistic and trauma-informed interventions that address the underlying causes of offending behaviour and help children to achieve positive outcomes.

It is recognised that this is **best achieved through early intervention, prevention and interventions to divert children** away from the formal criminal justice system whenever possible, and to use restorative practices that promote accountability and empathy. The Out of Court Decision Multi Agency Panel effectively does this, and we are seeing **increasing numbers of young people being diverted away** from the criminal justice system via **Outcome 22**[15].

Workshop update

Youth Justice Service:

- 232 children in the year, 12% linked to 571 offences
- 30% (174) of offences are related to violence of which 17 (10%) can be categorised as serious *(includes possession of firearms, threats to kill, serious assaults and wounding)*
- 43 sexual offences (+22 crimes), The majority of which are classified as serious *(includes rape, sexual assault and indecent photographs)*
- Theft offences reduced by 19% (16 crimes).

Key Statistics

Children in Cornwall tend to be charged with less serious violence, usually offences of common assault or assault with injury (ABH) making up 89% of all violence offences in the past year. 10% related to serious violence, made up of Grievous Bodily Harm, possession of weapons as well threats to kill and kidnapping.

There are inherent risks in carrying weapons / drugs which could lead to criminalisation / custody and will impact on future employment and other

[15] Outcome 22 is used as an alternative by the police to offences where no further action would have been recorded. The investigation has taken place and action has been taken to prevent further offending. This might include attending a victim awareness course or engagement with drug and alcohol services. It could also include some form of restorative justice intervention with the victim.

outcomes. The volume of incidents is consistent when compared with last year. Previously there has been little evidence of endemic issues with knife crime and serious violence in Cornwall, and recorded incidents were isolated.
In relation to offence types, a third of offences related to violence with 16% of offences relating to both criminal damage and drug offences also. We have seen increases in sexual offences and burglary offences when compared with the previous year.

Crime trends across Cornwall

There has been an 7% increase in the total number of recorded crimes, with two thirds of the rise accounted for by **continued growth in stalking and harassment offences** (32% or 1371 offences). Other types of crime that are up on last year include public order offences and criminal damage as well as violence without injury and other theft.

Improvements in Police 101 call handling has resulted in increased reporting of low level, low vulnerability crimes such as public order and criminal damage offences and low-level violence.

We know that there are **crime 'hotspots' in our larger town centres**, however, and police and partners are working together to **address local concerns and provide public reassurance.**

The rise in **reported levels of shoplifting has plateaued** but remains high in most of our main towns. Recent trends indicate that we have seen reductions in Truro and St Austell, whereas we have seen notable rises in both Falmouth, Bodmin, Camborne and Saltash.

Offences where the victim is aged under 18

- Over the last 12 months we have seen that offences where the victim is aged under 18 have increased by 3% (125 offences) when compared with the previous year.

- The majority of the rise can be accounted for by an increase in stalking and harassment offences which has risen by 24% or 106 offences.

- There has been a 26% increase in theft offences. This is mainly related to opportunistic theft offences where young people are recorded as the victim.

Turnaround Programme

Turnaround is a funding program available to Youth Offending Teams (YOTs) across England and Wales in order to intervene earlier and improve outcomes for children on the cusp of entering the youth justice system. This additional funding allows YOTs to consistently support a cohort of children not currently on their statutory caseload. Across England and Wales it was estimated that up to 17,000 would be eligible. The overall aims are to:

- Achieve positive outcomes for children with the ultimate aim of preventing them going on to offend.
- Build on work already done to ensure all children on the cusp of the youth justice system are consistently offered a needs assessment and the opportunity for support.
- Improve the socio-emotional, mental health and wellbeing of children; and
- Improve the integration and partnership working between YOTs and other statutory services to support children.

The Local Youth Justice partnership is committed to diverting children from the youth justice system. Over the last 3 years the Turnaround program has seen 122 children engaged in targeted interventions. We have continued to support local community projects to work with our targeted group to promote inclusion and belonging and ensure that children continue to have opportunities to engage in support at the end of their Turnaround intervention.

Tevyans[16]

In 2024/25, a new VCSE-led mentoring programme was successfully commissioned to support children at risk of offending. Launched July 2024, the Tevyans Mentoring Project, delivered through a collaboration between the Youth Justice Service (via Turnaround) and a local VCSE partner.

The pilot had a significant positive impact, with eight young people completing the programme and benefiting from a range of learning and development opportunities. Although the pilot period has ended, its learning has been embedded within the organisation, and its success has enabled further funding to be secured to continue developing mentoring support for children at risk.

Re-Frame

Re-Frame is a pre-arrest diversion scheme for young people aged 10-17 who are found in possession of a Class B or C drug. It is delivered through YZUP in conjunction with the Police. It involves brief interventions with sessions that broadly focus on harm reduction and restorative intervention, encouraging consequential thinking such as what happened at the time of the offence and what its impact was. They also cover the law and general drugs education.

In 2025 we had 20 referrals to Re-Frame in Cornwall and all but one fully engaged. Alongside Sefton, Kent and Wigan, Cornwall have been part of the evaluation by the University of Kent with the publication due in the next year. Work is already underway to consider how the delivery of this successful intervention can be continued at the end of the pilot.

- 4 additional members of staff have been trained in order to deliver interventions to both the police and Youth Justice Service as a diversionary project.

[16] Youth Justice Plan 2024-27

Affected Others

A significant proportion of the young people who have sought specialist help are **affected by parental alcohol and other drug use** (as well as parental mental health problems and domestic abuse in the family).

Due to the **hidden nature** of young people who are **affected others** we believe that there are still many more young people in need. Our system data indicates that there are **over 1000 substance-using parents** in treatment who are living with a child under the age of 18 years.

Parental problem substance use is the **third most common reason** (after domestic abuse and parental mental ill health) children are **referred to children's social care**. The experiences of children living with problem substance using parents are **complex and risk factors are multiple**. The challenges experienced are compounded by the decade-long impact of austerity measures, which have reduced early intervention services, resulting in practitioners prioritising the needs of younger children to the detriment of older children. The research has highlighted the impact of parental problem substance use on older children with their **increased risk of significant harm due to criminal exploitation and/or child sexual exploitation.**[17]

52% of the 2,387 people in adult drug treatment were **recorded as being a parent**. The NDTMS local outcomes framework reports that **only 5% of parents have received parental support**, compared with 17% nationally. We have identified a recording issue with this measure which we aim to resolve in the near future. We do see **some differences based on age and gender** with those most likely to receive parental support.

- The proportion of **younger parents** (aged 18-29) accessing parental programs are **more in line with the national average** at 15% compared with 17%. This reduces to 10% and 7% for the 30-49 and 50+ age groups respectively.

Children looked after

Children looked after are a vulnerable group who are at higher risk of substance use. Nationally, 40% of children looked after with an identified substance use problem received an intervention. Nationally, 8% of young people in community structured substance use treatment are children looked after.

Children in care face a variety of challenges, including an increased risk of using alcohol or other substances. These challenges include:

- **Trauma and Neglect**- Many children in care have experienced significant trauma, including neglect, abuse, or household dysfunction. These experiences can lead to emotional distress, which may increase the

[17] Todman H, McLaughlin H, (2024) Understanding the Needs of Children Living with Parental Substance Misuse: Perspectives from Children and Practitioners. The British Journal of Social Work, Volume 54, Issue 7. May 2024

likelihood of substance abuse as a coping mechanism. The NSPCC[18] have identified that households where domestic abuse and parental drug use is common is more likely to lead to young peoples drug use.

- **Instability**- Children in care often experience unstable living conditions, frequent moves between foster homes, or separation from siblings. This instability can create a sense of insecurity, leading some to turn to drugs or alcohol to manage stress and anxiety.
- **Lack of Emotional Support**- Without a consistent and supportive family environment, children in care may lack emotional guidance or feel isolated. This can make it harder to deal with feelings of abandonment, loneliness, or low self-esteem, increasing the risk of drug use.
- **Peer Influence and Environment**- Children in care are sometimes placed in environments or foster homes where they are exposed to drug use either directly or through peers. Peer pressure can further exacerbate the risk of substance use.
- **Barriers to Mental Health Services**: Though many children in care need mental health support, they may face difficulties accessing these services. Without proper intervention, they become more likely to self-medicate with drugs.

[18] What professionals know, think, and do to prevent child abuse – and how we can support them

Prevention and Prevalence

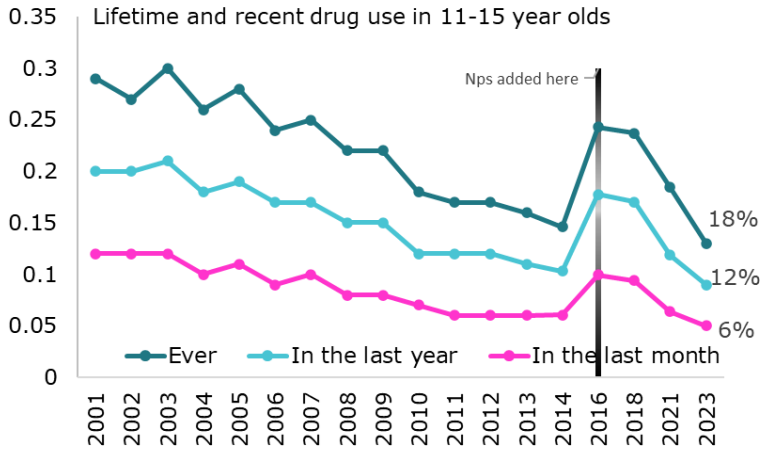
The government's current approach to prevention mirrors the international standards on drug use prevention[19] – "to avoid or delay the initiation of psychoactive substances, or, if they have already initiated use, to avert the development of substance use disorders (harmful substance use or dependence).[20]. This approach to prevention covers drug use amongst adults but also provides the tools for children and young families to help avoid initial drug use.

Drug use amongst young people

"Preventing drug misuse is more cost effective and socially desirable than dealing with the consequences of use… Local authorities should identify, and provide additional support to, those young people most at risk of being drawn into using illicit substances or involvement in supply." Dame Carol Black Review Part 2

The **NHS Smoking, Drinking and Drug Use (SDD) among Young People** report provides the results of the biennial survey of secondary school pupils in England, mostly aged 11 to 15, focusing on smoking, drinking, drug use and vaping. It covers a range of topics including prevalence, habits, attitudes, and wellbeing.

The 2023 SDD[21] found that there had been a continued **decrease in the prevalence of lifetime and recent illicit drug** use amongst young people.



The 2023 survey introduced additional questions relating to pupils wellbeing. These included how often the pupil felt lonely, felt left out and that they had no-one to talk to.

The chart shows the timeseries for lifetime and recent drug use in 11-15 year olds. Psychoactive substances (NPS) were included from 2016 and so data before then is not comparable. In 2016, even when accounting for the addition of NPS, there was a **large and unexpected rise in overall drug use** prevalence, with increased use of stimulants, volatile substances and psychedelics – a reversal of the previous long-term reducing trend.

[19] Joint Combatting Drugs Unit
[20] UNDOC – International Standards on Drug Use Prevention
[21] NHS Smoking, Drinking and Drug Use among Young People 2023, NHS Digital (2024)

- In 2023, **13% of pupils reported they had ever taken drugs** (18% in 2021 and 24% in 2018), 9% had taken drugs in the last year (12% in 2021 and 17% in 2018), and 5% in the last month (6% in and 9% in 2018). These results are below the averages seen over the five years pre-2016.

There has been a decrease in the prevalence of smoking cigarettes but **an increase in vaping**.

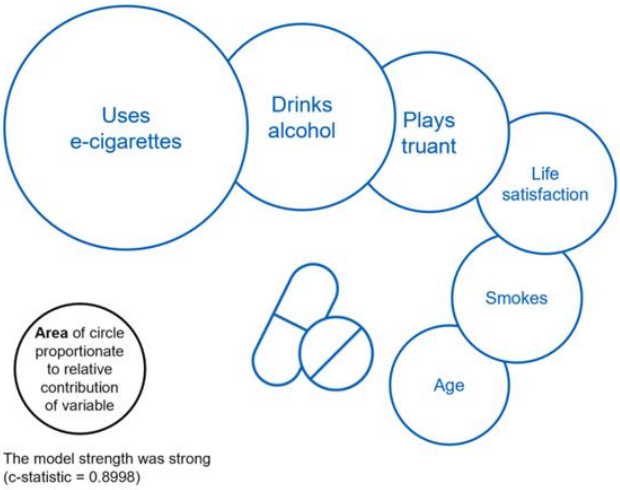
- Current e-cigarette use (vaping) has increased to 9%, up from 6% in 2018. Around 1 in 5 (21%) 15-year-old girls were classified as current e-cigarette user.
- Of pupils who have ever tried vaping, 89% have never regularly smoked tobacco cigarettes.
- A further 6% reported starting vaping before smoking cigarettes, only 5% of pupils reported smoking cigarettes before using vapes.

Low wellbeing was more likely amongst pupils who recently smoked, drank and/or have taken drugs. 39% of pupils who had taken drugs in the last month, and 38% of pupils who smoked in the last week reported low life satisfaction nowadays, compared to 19% for all pupils.

28% of pupils who smoked in the last week, 23% of pupils who had taken drugs in the last month, and 15% of pupils who had drunk alcohol in the last week reported often or always feeling lonely, compared to 10% for all pupils.

The 6 factors (explanatory variables) shown below had a significant association with having taken any drugs in the last month. The size of the circles represents an estimate of the relative contribution to the model.

It was estimated that using e-cigarettes had the strongest association, followed by drinking alcohol, and then playing truant.



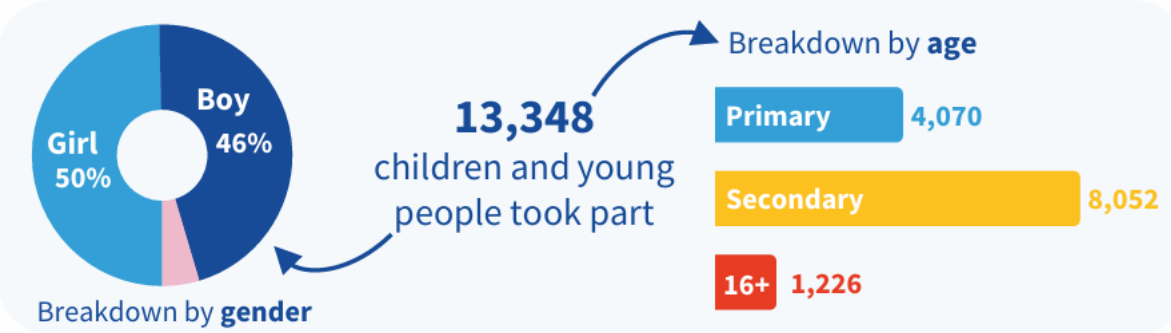
Cornwall's Right On Survey 2025

The Right On Survey is an extensive **biennial consultation with children and young people** in Cornwall and the Isles of Scilly.

The survey invited children and young people to let us know their thoughts on a wide range of issues that impact their lives. This survey forms part of wider engagement and participation work to ensure we are connected with the children and young people of Cornwall.

Cornwall Council has formally adopted the United Nations Convention on the Rights of the Child (UNCRC), a global agreement that sets out the basic rights every child should have. These rights ensure children are protected, treated fairly, listened to, and supported to grow and thrive. The UNCRC helps guide how services, schools, and decision makers in Cornwall consider and act on children's rights —making sure young people's best interests.

By using the UNCRC alongside the Right On Survey, we can better understand children's experiences and make decisions that respect and uphold their rights to improve their daily lives.



The following findings for drugs and alcohol are based on the secondary and post 16 participants which amounts to just over 9,200 responses.

- **Smoking:** Smoking rates increase with age, as expected. National data for secondary-aged pupils is broadly in line with local rates. "Coping with stress and worry" is frequently cited as a key reason for smoking, highlighting a need for improved stress-management and emotional-regulation strategies.
- **Vaping and Nicotine Pouches:** More pupils across all age groups have tried vaping—or currently vape—than have ever smoked. This may indicate that vaping is a more accessible entry point to nicotine use, raising questions about whether it acts as a potential gateway to cigarette smoking. Use of nicotine **pouches remains low.**
- **Alcohol:** National survey data shows that a much higher proportion of young people report never having consumed alcohol (68%) compared with local secondary respondents (27%). This suggests alcohol is **more commonly experimented with locally**, even though overall drug-use rates remain low.

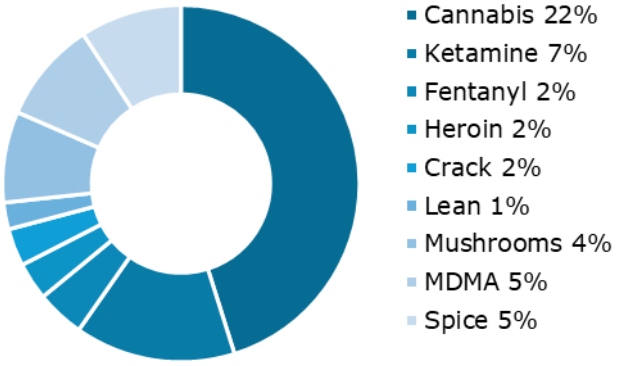
- **Drugs:** The proportion of pupils reporting that they have been offered or have taken drugs is lower than levels seen in national surveys.

When we look specifically at drugs, young people were asked what substance they have used.

- The majority (78% of Secondary and 60% of 16+) of pupils report they have never taken drugs.
- Conversely, 8% of Secondary and 18% of 16+ pupils report they have taken drugs. Whilst there are no national data available for those aged 16+, the local rate of taking drugs is lower than the average for England (13%) (survey as above).

Whilst some of the free text answers were bogus or junk, some were valid and included below. In total there were 420 responses to the question that asked specifically about types of substance.

- Most responses to this question reinforced the students' views that they don't use illicit drugs. Paracetamol, ibuprofen, Calpol and prescribed medicines were most often cited as the drugs that young people are using.
- 22% of secondary/ post 16 respondents said they used cannabis.
- Heroin, Fentanyl and Crack were mentioned in 2% of responses although they were often cited together.
- Ketamine often appeared on its own and was mentioned in 7% of responses as ever being used. This equates to 30 young people

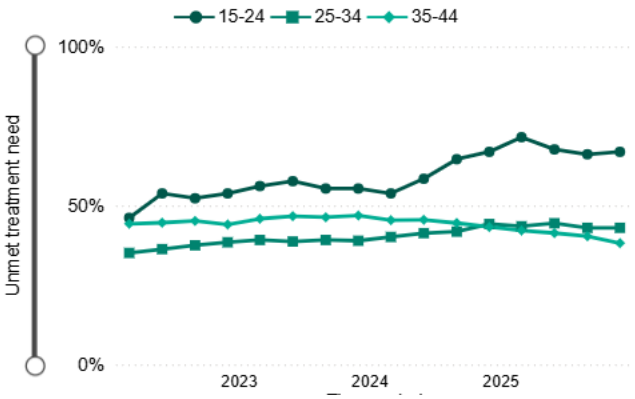


- MDMA and Spice were also both mentioned and were present in 5% of responses.
- Lean (also known as purple drank and dirty Sprite) was mentioned in a handful of responses. This relates to the mixing of counter prescribed liquid medicine mixed with sugary fizzy drinks.

Unmet treatment need amongst younger people

As noted previously, 67% of OCUs aged 15-24 are not in treatment services compared with 30% of 35-64 year olds.

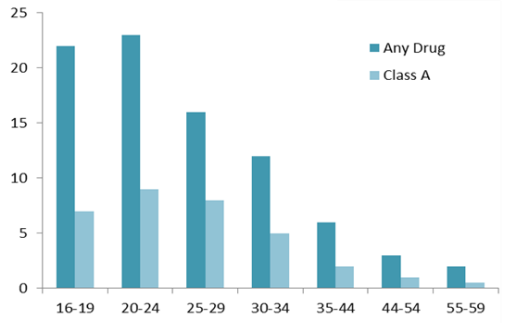
The chart (right) tracks the level of unmet treatment need broken down by age group as a proportion of resident population each quarter. As you can see the level of **unmet need reduces as people get older**.



One of the main reasons for this is that the prevalence of drug use reduces as we get older, meaning that the proportion of unmet need reduces. Remission rates for different types of drugs shows this with approximately 24% of people who have ever used heroin, and 17% who use cocaine, going on to develop dependence.

Research demonstrates that the majority of young people who experiment with drugs and alcohol **age out of involvement**, often without professional help. However, it also identifies a sub-population that cannot do this. This suggests that it is not merely exposure to a substance that matters, but that there are **certain vulnerabilities in some young people that elevates their risk** of experiencing long term difficulties.

Prevalence of Drug Use



Proportion of 16-59 years olds reporting use of any or class A drug use in the last year by age group (BCS 2008/9)

Children and families

Families are key to recovery, but family are not always included in the recovery process/journey.

46% of people in treatment in locally are parents[22] and this represents a **greater proportion** of our local treatment population than the national average (35%).

People in treatment for **opiates are more likely** to be parents, whereas people in treatment for **alcohol**, particularly alcohol only, are **least likely** (38%). Those in treatment for alcohol tend to be older therefore are more likely to have adult children.

The Local Outcomes Framework provides a measure of **parental support provided** which looks at the percentage of parents receiving any parenting or family support interventions at any point in their treatment journey.

Reported **rates of parental support are comparatively low** at only 6% of the parent population. There are some **substantial variations by sex and age**.

- 12% of women in treatment receiving parental support and only 2% of men (compared with 18% and 12% nationally).
- The proportion of **younger parents** (aged 18-29) accessing parental support are **in line with the national average** at 11%. This reduces to 6% and 4% for the 30-49 and 50+ age groups respectively.

	Cornwall and Isles of Scilly			England	
Drug group	**Parents in treatment**	**% by drug group**	**Parental support**	**% parents by drug group**	**% parental support**
Opiates only	553	50%	7%	42%	23%
Crack (no opiates)	93	50%	4%	31%	8%
Opiates and crack	130	54%	9%	32%	20%
Alcohol only	506	38%	6%	31%	9%
Non-opiates and alcohol (no crack)	389	49%	5%	36%	9%
Non-opiates only (no crack)	179	47%	5%	38%	9%
Total parents in treatment	**1,850**	**46%**	**6%**	**35%**	**14%**

Parental Drug Use and Affected Others

It is estimated that there were between **200,000 and 300,000 children in England and Wales where parents or carers are dependent on drugs**.

This can compromise **children's health and development** from conception onwards, though the risks of **harm may be reduced through treatment**. Support for the affected adult as well as the presence of at least one other

22 Determined by those with parental responsibility (living with children or not), based on the PARENT, PRNTSTAT, CIRPARENT, and CIRPRTST fields at any point in their treatment journey.

consistent parent or carer, a stable home with adequate finances, maintenance of family routines and activities, and regular attendance at a supportive school.[23] Parental substance use is the **third most common reason** (after domestic abuse and parental mental ill health) children are **referred to children's social care**. The experiences of children living with substance using parents are **complex and risk factors are multiple**. [24]

The challenges experienced are compounded by the **decade-long impact of austerity measures**, which have reduced early intervention services, resulting in practitioners prioritising the needs of younger children to the detriment of older children.

The research has highlighted the impact of parental substance use on older children with their **increased risk of significant harm due to criminal exploitation and/or child sexual exploitation.**[25]

Based on a national study,[26] 10,990 children in Cornwall (10.3% of the population aged 0-17 years) are projected to be living in a household where an adult reports any substance use (broad estimate).
An estimated **3,980 children** live in a household where an **adult has reported an alcohol or drug dependency** (narrow measure).

Of the 10,990, around **14% (940 children)** are predicted to be in a household with **all three vulnerabilities** – domestic abuse in the last year, an adult reporting drug and/or alcohol dependency and an adult with severe symptoms of mental or psychiatric disorders.

We explored this in detail in the 2022/23 needs assessment and estimated that **around 75% were not identified in local datasets**. Drug and alcohol use **commonly occurs with other vulnerabilities**, such as domestic abuse and mental health issues.

Adverse Childhood Experiences

When individuals have **secure foundations from early childhood** there is a real opportunity for growth. Many will experience problems throughout their life which will cause instability in one or more areas but **most will recover** because they have a strong support network, particularly family and friends.

Conversely when children are subject to multiple **Adverse Childhood Experiences** (ACEs) growth is suspended and the trajectory of their life is influenced by the trauma they have experienced.

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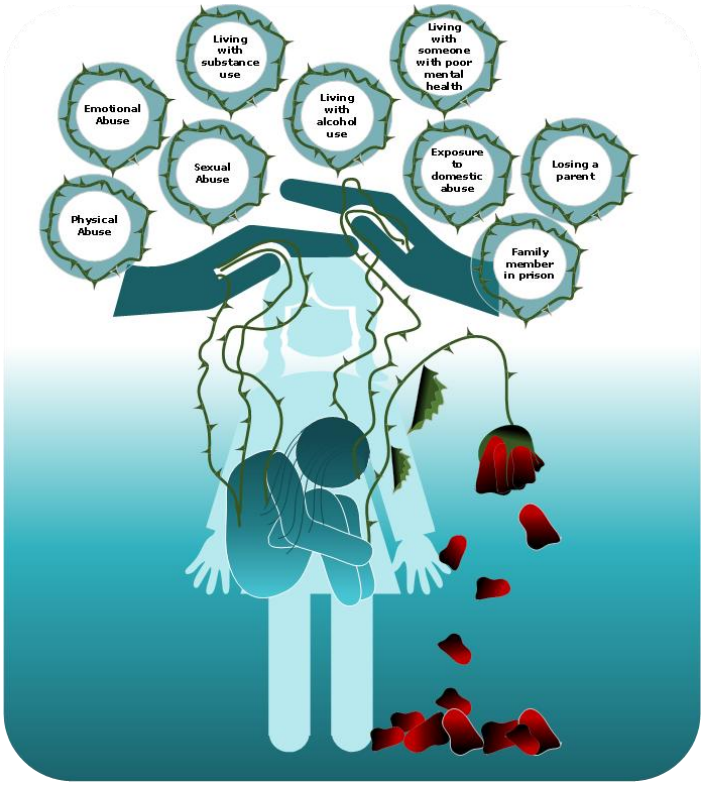
[23] Advisory Council on the Misuse of Drugs (ACMD) (2003) Hidden Harm - responding to the needs of children of problem drug users.
[24] Todman H, McLaughlin H, (2024) Understanding the Needs of Children Living with Parental Substance Misuse: Perspectives from Children and Practitioners. The British Journal of Social Work, Volume 54, Issue 7. May 2024
[25] Todman H, McLaughlin H, (2024) Understanding the Needs of Children Living with Parental Substance Misuse: Perspectives from Children and Practitioners. The British Journal of Social Work, Volume 54, Issue 7. May 2024
[26] Estimating the prevalence of the 'toxic trio', Children's Commissioner's Office (Chowdry, 2018)

'Adverse childhood experiences (ACEs) are traditionally understood as a set of **10 traumatic events** or circumstances **occurring before the age of 18** that have been shown through research **to increase the risk** of **adult mental health problems and debilitating diseases.**

Five ACE categories are forms of **child abuse and neglect**, which are known to harm children and are punishable by law, and five represent forms of **family dysfunction** that increase children's exposure to trauma'.[27]

The 10 ACEs are:

- Physical abuse
- Sexual abuse
- Psychological abuse
- Physical neglect
- Psychological neglect
- Witnessing domestic abuse
- Having a close family member who used drugs or alcohol
- Having a close family member with mental health problems
- Having a close family member who served time in prison
- Parental separation or divorce



To understand how **early trauma** experienced in childhood **impacts the course** of someone's **life** we undertook a series of journey maps across a broad and diverse range of people.

Some key areas that emerged were:

Family

- Journey mapping has shown the prevalence of Adverse Childhood Experiences for people with complex needs. The **lack of a secure base and absence of positive parental modelling** (often as a result of parents being subject to childhood trauma themselves) has a detrimental and far-reaching effect on self-worth.
- This in turn leads to **poor relationship choices** and poses challenges for raising children, particularly in the absence of a supportive wider family network. The **intergenerational play out of trauma** is evident in the journeys that we looked at, and a reliance on alcohol/drugs to self-soothe.

[27] Adverse childhood experiences: What we know, what we don't know, and what should happen next | Early Intervention Foundation

Education

- **Poor school engagement** is a common thread running through the stories documented. People with complex needs talk of bullying, being singled out or marginalised due to 'acting up' and eventually dropping out.

Friendships and social networks

- **School and activities** provide a pivotal role in developing positive and healthy friendships. When these avenues are closed to young people there is a real chance that the connections that they make will be with people who have also experienced trauma can lead to criminality and possible exploitation.

Money

- The **limiting effect of financial constraints** on choices and mental health is omnipresent in all journeys. In several there was a direct **correlation between lack of money and criminal activity**. It was also identified as a trigger, exacerbating poor mental health and contributing to relapse.

Housing and Environment

- Without a family network or a stable home, **in times of crisis people are left open to homelessness**. The stories demonstrate that individuals are moved frequently because of a significant **lack of appropriate housing** and to places and types of accommodation out of necessity rather than choice.
- **Housing providers are not always able to meet the needs of highly complex individuals** or adjust placement terms and conditions to accommodate them, making them more vulnerable and exacerbating their situation. Lack of a stable base for protracted periods **prevent people from establishing roots** and accessing consistent support.

Health and Wellbeing

- The **sense of isolation and loneliness** was evident in all stories. In most cases the person at the centre had either attempted suicide or were suicidal at points in their journey. All displayed a **high degree of vulnerability** which for some led to significant self-neglect.
- The presence of **multiple socio-economic and family challenges** contributed to their sense of hopelessness which was further exacerbated by drug and/or alcohol use.

Drugs prevention – what works for Young People

Public Health Commissioning Guidance

Invest in provision from schools to treating young people's substance use

There should be effective pathways between specialist services and children's social care

Clear pathways needed between targeted and specialist young people's services, supported by joint working protocols and good communication

Universal and targeted services: help build resilience and provide substance misuse advice and support at earliest opportunity

Specialist services: for those whose use has escalated and/or is causing harm

Specialist services must deliver age-appropriate interventions and promote safeguarding and welfare

Every effort should be made to assess the risk of children and young people interacting with older service users

Services available need to be tailored to the specific needs of girls and boys within these services and ensure that young people with multiple vulnerabilities or a high risk of substance use-related harm get extra support with clear referral pathways and joint working protocols.

Services for Children and Young People

Build resilience and confidence amongst young people to prevent a range of risks including substance use

Outcomes of effective specialist substance misuse interventions include:

- Improved health and wellbeing
- Better educational attainment
- Reduction in NEET numbers
- Reduction in risk taking behaviour

Young people have better outcomes when they receive a range of interventions as part of their package

Young people generally spend less time in specialist interventions than adults. However, those with care needs often require support for longer

If young people re-present to treatment, this is not necessarily a failure and should be rapidly re-assessed

Sources:
Community-based interventions for the reduction of substance misuse among vulnerable and disadvantaged young people, National Collaborating Centre Drug Prevention (2006)
'What Works' in Drug Education and Prevention, Scottish Government (2016)
School-based alcohol and drug education and prevention

Peer educators should be involved, although not necessarily lead drug education but trained teachers and health professionals can be effective

The rationale for this approach is that young people learn from each other and have greater credibility, sensitivity and understanding than adults when discussing health behaviour, and can act as positive role models to reinforce these messages.

Integrated information – children and young people cannot make the healthy, pro-social decisions, without accurate information. But information on its own is insufficient to enable (young) people to make informed decisions

Drug education programmes which are **multi-component** in nature and/or which target young people's environment (e.g. school, community) are possibly more effective than those which are single-component in nature and which primarily target the individual (moderate evidence). Multi-sectoral programmes with multiple components (**including school and community**) are effective in reducing illegal drug use.

Correcting the 'myth-understandings' which need to be **based on local data** including the results of **anonymous in-school questionnaires** and then to be followed up with teaching **practical refusal skills.**

There is evidence from local services to suggest that there are better outcomes when young people can **access mental health/ pastoral support in schools**, both for their own or a family member's use

Interactive drug education programmes are nearly always **more effective than non-interactive programmes** and those which incorporate active learning and pupil-to-pupil interaction, are more likely to reduce drug use. Some **social influence programmes** can produce short-term reductions in cannabis use, particularly in low-risk populations.

Social competence approaches offering information but also allow pupils to model and practice giving feedback and positive reinforcement. These approaches teach personal and social skills such as generic self-management, target-setting, problem-solving and decision-making, as well as cognitive skills to be able to resist media and interpersonal influences. They also increase assertiveness skills and competence and to interact with others.

"There should also be a focus on preventing the risk factors and enhancing the **protective factors**, increasing young people's **resilience capability**, helping with strategies for refusal and hence supporting young people's resilience."

Drug education programmes adopting **life skills, social influences, resistance skills** or normative approaches are more effective.

Drug and alcohol screening and early intervention

To prevent or reduce the harm of drug use in children, young people and adults who are most likely to start using drugs or who are already experimenting or using drugs occasionally, NICE guidance recommends:

- **Skills training for children and young people** who are vulnerable to drug use
- **Information to adults** who are vulnerable to drug use
- Information about drug use **in targeted settings** that people who use drugs or are at risk of using drugs may attend

Quality statements from NICE[28] identify the following standards for screening people for drug use:

- **Looked-after children and young people** having their annual health plan review are assessed for vulnerability to drug use
- **Care leavers having a health assessment** as part of planning to leave care are assessed for vulnerability to drug use
- Children and young people having a **young offender assessment** are assessed for vulnerability to drug use
- **Adults assessed as vulnerable to drug use** are given information about local services and where to find further advice and support.

Other: High risk, vulnerable individuals

NICE guidance highlights **vulnerable and disadvantaged children and young people aged under 25**[29] as at particular risk of using substances including:

> "those who are - or who have been - looked after by local authorities, fostered or homeless, or who move frequently, those whose parents or other family members misuse substances, those from marginalised and disadvantaged communities, including some black and minority ethnic groups, those with behavioural conduct disorders and/or mental health problems, those excluded from school and truants, young offenders (including those who are incarcerated), those involved in commercial sex work, those with other health, education or social problems at home, school and elsewhere and those who are already misusing substances".

There is a case for **maintaining drug-specific prevention interventions for those young people most at risk of harm**, or already misusing drugs.

NICE, as highlighted above, provide guidance on substance use interventions for under 25s and has recently consulted on draft guidelines for this group for 2017. However, the evidence also suggests that young people considered at greater

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[28] Quality statements | Drug misuse prevention | Quality standards | NICE

[29] Community-based interventions for the reduction of substance misuse among vulnerable and disadvantaged young people, National Collaborating Centre Drug Prevention (2006)

risk will also benefit from universal approaches, and so tailored approaches may not always be required (Spoth et al., 2006, in ACMD, 2015).[30]

Other: The following factors are identified as being "likely to be beneficial" or "mixed evidence" of success:

- **Pre-school, family-based programmes** in producing long-term reductions in the prevalence of lifetime or current tobacco use, and lifetime cannabis use.[30]
- **Motivational interviewing** in producing short-term reductions in multiple substance use.[30]
- **Whole school approaches** that aim to change the school environment on use of multiple substances.[30]
- **Parental programmes** for parents designed to reduce use of multiple substances by young people. Where effective, programmes included **active parental involvement**, or aimed to develop skills in social competence, self-regulation, and parenting skills.[30]
- Drug education needs to be **deployed early enough to be preventative** (before young people begin to experiment) but also to be **relevant and age-appropriate**.[31]

[30] 'What Works' in Drug Education and Prevention, Scottish Government (2016)
[31] School-based alcohol and drug education and prevention – what works?, Mentor Adepis (2017)

The use of **'sniffer dogs' in schools**. Policy should not create a climate of fear and mistrust

Programmes relying on **scare tactics** to prevent children and adolescents from engaging in risky behaviours are not only ineffective, but may have damaging effects

Alcohol and drug testing in schools can give high levels of false positives; non-invasive tests are unlikely to be admissible in a court case and testing can only be conducted with explicit and informed parental consent for under 16s.

Targeted support for individuals as part of a broader treatment programme may be considered as a voluntary collaboration to manage risk and support a vulnerable young person to re-enter school as part of a broader treatment programme.

'Health terrorism' (including 'Scared Straight' approaches). Petrosino, Turpin-Petrosino and Finckenauer (2000) found these well-meaning programmes **can have harmful effects**. Scared Straight and other prison or parole programmes which bring together prisoners and students have **resulted in higher rates of re-arrest** and offending behaviour than youths not involved in the intervention.

Mass media programmes targeting illegal drug use

Mentoring programmes have no short or long-term preventative effects on illegal drug use

Focusing only on the **building of self-esteem** and emotional education. Addressing only ethical/moral decision making or values

Interventions which do not take into account the situation and **vulnerability of a target group**. (ACMD 2015)

One-time assemblies, events or testimonials. Former users engaged as visiting speakers are likely to have a **negative impact** on the beliefs, attitudes and behaviour of young people and children **if not used in the context of a broader curriculum** and within a **life skills-based approach** to education.

Standalone school-based curricula **relying solely on facts** about illegal drugs and their dangers, designed only to increase knowledge

Utilising **non-interactive methods**, such as lecturing, as a primary delivery strategy; information-giving alone, particularly fear arousal

A **'zero tolerance' approach** to substance misuse. If young people know school policy includes a punitive approach to disclosure it will prevent the creation of an environment which is conducive to discussion.

Recreational/diversionary activities, and theatre/drama based education to prevent illegal drug use. Experience from local services indicates, however, that this can be beneficial when combined with a programme of reduction and as a way of distraction to experience natural lifting of mood, and new friends with more positive attitudes to free time.

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