NEEDS ASSESSMENT: YOUNG PEOPLE'S DRUG AND ALCOHOL SERVICES IN EDINBURGH CITY

FINAL REPORT

for Edinburgh Alcohol & Drug Partnership

Julie Dowds, Susie Heywood, Niamh Fitzgerald and Joanne Winterbottom

January, 2012

Create Consultancy Ltd.

www.createconsultancy.com

ACKNOWLEDGEMENTS

The author would like to thank:

The steering group for all their help and support;

The managers and staff who were interviewed for the study or who completed a survey;

The young people who gave their time to be interviewed or who took part in a focus group;

Julie Hale and Lauren Johnston for their support with the literature review and setting up the interviews and focus groups.

CONTENTS

Acknowledgements....2

Overview of Chapters....6

1. Introduction....8

1.1 Aims and Objectives....8

1.2 Policy context....8

1.3 Edinburgh City Demographics....9

2. Methods....11

2.1 Overview....11

2.1.1 Review of evidence and relevant literature....12

2.1.2 Service profile....12

2.1.3 Staff and management interviews....13

2.1.4 Youth engagement....14

2.2 limitations of the study....15

3. Findings: Review of Evidence and Relevant Literature....16

3.1 Defining problematic drug use in young people....16

3.2 Policy and Practice: Models of Delivery....16

3.1.1 Tiered Structure of Services....17

3.1.2 Individual Needs Assessment....20

3.1.3 Working Together....20

3.1.4 Accessible Services Designed for Young People....20

3.1.5 Referral and Care Pathways....21

3.1.6 Awareness Raising of Services....21

3.1.7 Staff Development....21

3.1.8 Monitoring and Evaluation....22

3.1.9 General Issues to Consider....22

3.2 Discussion and Recommendations....23

4. Findings: Identified Needs....27

4.1 Prevalence and patterns of drug and alcohol use among young people in edinburgh City 27

4.1.1 Alcohol use 27

4.1.2 Drug Use 31

4.2 Harm Experienced by Young People 34

4.3 Drugs Used by Young People 36

4.3.1 Cannabis 36

4.3.2 Alcohol 37

4.3.3 Other drugs 38

4.4 Quantifying Problematic Drug use among Young People 40

4.4.1 Data monitoring and Assessment 42

4.5 Discussion and Recommendations 43

5. Findings: Service Provision 46

5.1 Existing Provision 48

5.1.1 What is available 48

5.1.2 Staff and Young person Relationships 49

5.1.3 Holistic Care 51

5.2 Barriers and facilitators to access 51

5.2.1 Self-motivation/timing of support 52

5.2.2 Location 53

5.2.3 Awareness of services 54

5.2.4 Acceptability of service 55

5.2.5 Primary care/adult services 56

5.2.6 Childcare 57

5.2.7 Access by equality groups 57

5.3 Gaps in provision 58

5.3.1 Treatment Options 58

5.3.2 One-to-One support/therapeutic counselling 60

5.3.3 Ongoing Support 61

5.3.4 Services for older young people 62

5.3.5 Staff Training 63

5.3.6 Other gaps 63

5.4 Discussion and Recommendations 65

5.4.1 Service Provision and Gaps 65

5.4.2 Awareness of and Access to Services (Geography, Age and Equality Groups) 68

5.4.3 Staff Development 70

6. Conclusions and Recommendations 71

6.1 DEfinitions, Key Principles and Processes 71

6.2 Service Development 75

6.3 Service Delivery 77

6.4 Workforce Development 78

6.5 Partnership Working 78

Full List of Recommendations 80

References 83

Appendix A: Data on Service Usage 87

Appendix B: Summary of Provision 89

Appendix C: Support Services Provide 91

Appendix D: Referral Pathways 92

Appendix E: Access Routes 93

Appendix F: Waiting Times 95

Appendix G: Barriers to Access 96

OVERVIEW OF CHAPTERS

This is the full report of the Needs Assessment in relation to Young People's Drug and Alcohol Services in Edinburgh City.

Chapter 1 provides an introduction to the Needs Assessment. It aims to inform the implementation of Priority 3 of the Edinburgh Alcohol and Drugs Partnership (EADP) Children, Young People and Families Action Plan. The specific objectives of the needs assessment are as follows:

1. To identify the prevalence of problem alcohol and drug use amongst young people in Edinburgh.
2. To map existing drug and alcohol services in Edinburgh.
3. To explore young people's perceptions of an effective alcohol and drug service.
4. To provide an overview of models of good practice in young people's alcohol and drug services elsewhere in Scotland and the UK.
5. To make recommendations regarding priorities and models for young people's alcohol and drug services in Edinburgh.

Chapter 2 details the mixed method approach adopted including a review of evidence and relevant literature, semi-structured interviews, focus groups and surveys. The approaches were designed to capture, as far as possible, views from a cross-section of stakeholders including strategic leads, managers and staff of services and young people themselves. There were difficulties in engaging young people in the process and this reflects the challenge of working with a client group who are experiencing complex and chaotic lifestyles.

Chapter 3 identifies grey literature and other relevant publications outlining models of good practice in the delivery of young people's alcohol and drug services. This includes discussion of how to define problematic drug use in young people. Initial recommendations are made in relation to this and the process for identifying and responding to individual needs as well as steps that might be taken to reconceptualise services as part of a tiered model.

Chapter 4 outlines the needs identified both from the available literature on prevalence and from the perspective of participants. It also outlines some of the difficulties in quantifying problematic drug use. It is supported by discussion and recommendations in relation to the understanding of the issues for equality groups, development of approaches for working with young people who use cannabis, approaches to identification of needs and assessment and standards for monitoring.

Chapter 5 covers drug and alcohol provision (in Edinburgh City) available to young people, who are experiencing harm or at risk of experiencing harm from drugs and/or alcohol. This includes a suggestion of how the existing models of delivery might be mapped in relation to the Tiers. It also outlines perceived strengths and weaknesses as well as the barriers and

facilitators to access and gaps in provision. It is supported by discussion with recommendations in relation to filling gaps at Tiers 2 and 4, the potential role of specialist youth workers, awareness raising and communications, training, accessible provision (age and geography), services for young people who use cannabis, holistic approaches and cross topic linkages.

Chapter 6 contains combined conclusions and recommendations from all of the above.

1. INTRODUCTION

1.1 AIMS AND OBJECTIVES

The aim of this needs assessment is to inform the implementation of priority 1 and 3 of the Edinburgh Alcohol and Drugs Partnership (EADP) Children, Young People and Families Action Plan (2011) which states:

> 'Fewer children and young people using drugs and children and young people choosing to drink alcohol start later in life and take fewer risks.'
>
> **'**More children and young people receive appropriate and timely support for alcohol and drug use**'**

To do this effectively, the needs assessment set out to fulfil the following aims:

- Provide an understanding of local need in relation to young people and alcohol and drug use in Edinburgh.
- Analyse best practice in alcohol and drug services for young people elsewhere in Scotland and the UK.
- Provide recommendations for future service development.

Objectives:

- To identify the prevalence of problem alcohol and drug use among young people in Edinburgh.
- To map existing drug and alcohol services in Edinburgh.
- To explore young people's perceptions of an effective alcohol and drug service.
- To provide an overview of models of good practice in young people's alcohol and drug services elsewhere in Scotland and the UK.
- To make recommendations regarding priorities and models for young people's alcohol and drug services in Edinburgh.

1.2 POLICY CONTEXT

Edinburgh Alcohol and Drugs Partnership (EADP) are commissioning this needs assessment to support the implementation of the EADP Children, Young People and Families Action Plan (2011).

This follows the launch of the EADP Alcohol and Drug Strategy: A framework for partnership action 2011–2014 (2011). The action plan outlines the vision for the EADP in which Edinburgh 'is a city which promotes a healthy and responsible attitude to alcohol and where recovery from problem alcohol and drug use is a reality' (Feb 2011).

The EADP strategy and vision for Edinburgh is underpinned by three high-level outcomes which are:

- Children, young people and adults' health and wellbeing are not damaged by alcohol and drugs.
- Individuals and communities affected by alcohol and drugs are safer.
- More people achieve a sustained recovery from problem alcohol and drug use.

The EADP strategy has been informed by a number of key national policy approaches, including Changing Scotland's Relationship with Alcohol: A Framework for Action (Scottish Government 2009), and The Road to Recovery: A New Approach to Tackling Scotland's Drug Problem (Scottish Government 2008).

To successfully implement the EADP strategy and enable its vision to become reality, it is important for the EADP to understand the extent of drug and alcohol use among its population, as well as the capability of services to meet this need and support prevention and recovery.

The recent publication, EADP Needs Assessment of Drug and Alcohol Problems in Edinburgh (Figure 8, 2010) goes some way to provide this information. However, this report highlights a gap in knowledge in relation to the use of drugs and alcohol by young people – particularly problematic use – and the capacity of drug and alcohol services for them.

1.3 EDINBURGH CITY DEMOGRAPHICS

In 2010 the population for the City of Edinburgh was 486,120; an increase of 1.8% from 2009 (GROS 2011).

The Scottish Household Study report for Edinburgh city (Scottish Government 2010) provides a breakdown of demographics for the population in 2007/08 as:

- 15% of the total population is in the 0–15 years age group;
- 14% of the total population is in the 16–24 years age group;
- 95% of the population define themselves as White (including "White Scottish", "White British", "White Irish" and "Other White".

Overall, the quality of life within the City of Edinburgh is high. This is reflected in the life expectancy for males and females in Edinburgh being higher than the Scottish average (Edinburgh by Numbers 2011). The 2009 Annual Neighbourhood Survey (City of Edinburgh 2009) – which interviewed over 5,000 residents – reported a 92% satisfaction figure for Edinburgh as a place to live. Key findings from this study include:

- 75% satisfaction figure in the way that antisocial behaviour is dealt with in local neighbourhoods. This ranged from 91% satisfaction in Almond to 55% in Leigh.
- 16% felt their neighbourhood has an issue with alcohol disorder or street drinking (29% in 2008). Residents in Almond were least likely to identify this as problematic and residents in Forth were most likely to identify this as problematic.
- 81% felt safe in their area after dark.

- The number one priority across the city was identified as ‘more activities for children and youths’ – the same as 2008.

Although Edinburgh has been shown to be a positive place to live, it also has 12% of its population living in Scotland’s 15% most deprived areas. This is lower than the national average but indicates that continued effort is required to ensure that everyone living in Edinburgh can share a positive experience and live healthy and fulfilling lives.

2. METHODS

2.1 OVERVIEW

This needs assessment used a mixed method approach that included a review of evidence and relevant literature, semi-structured interviews, focus groups and surveys. The approaches were designed to capture, as far as possible, views from a cross-section of stakeholders including strategic leads, managers and staff of services and young people themselves. The methods used are summarised in the following table:

Table 1: Methods	Details	
Strand one: Context and prevalence	**1a.** Initial meeting with steering group to get background and history of youth drug and alcohol service provision and agree aim and purpose of the needs assessment. **1b.** Review of identified strategic literature. **1c.** Review and analysis of prevalence data on drug and alcohol use among young people in Edinburgh. **1d.** Review of literature and project information on models of good practice in the delivery of young people's alcohol and drug services.	
Strand two: Scope and reach of provision	• Service profile surveys	n=24 surveys
Strand three: Engagement of young people	• Focus groups (n=1) • Interviews (n=9)	n=15 participants
Strand four: Engagement of staff and managers	Interviews (telephone and face-to-face) and focus groups with staff, managers and strategic stakeholders representing the voluntary sector, council services and NHS. Interviews (council) n=9 Focus groups (council) n=1 (8 participants) Interviews NHS n=9 Interviews voluntary sector n=12 Focus groups voluntary sector n=3 (21 participants)	n=59 participants

2.1.1 REVIEW OF EVIDENCE AND RELEVANT LITERATURE

A wide range of literature, policy documents and research were reviewed by the researcher. This included Scottish Government, City of Edinburgh Council and Edinburgh Alcohol and Drug Partnership reports and strategy documents and the recent needs assessment into drug and alcohol problems in Edinburgh city (Figure 8, 2010).

The researcher also examined:

- Published data from the last 10 years into the drug and alcohol use of young people in Edinburgh city.
- Grey literature identified by participants in the interviews.
- Documents published over the last 5 to 10 years that discuss models of delivery and best practice for the delivery of youth drug and alcohol services.
- Projects identified by participants in the interviews that represent good examples of different models of delivery. These were then contacted to see if evaluation reports were available.

A full reference list of all documents used to inform this needs assessment is provided at the end of the report.

2.1.2 SERVICE PROFILE

Young people receive information and advice about alcohol and drugs from many organisations, including schools, as part of their approach to health and wellbeing. In addition, some young people within the ages of 16 to 19 years access support for their drug and alcohol use from adult services.

To remain focused, this needs assessment set out to engage organisations that:

- provide (as their core remit) specialist treatment, rehabilitation and support targeted at young people with problems related to their alcohol and drug use;
- engage young people who are more vulnerable to problem alcohol and/or drug use;
- work within Edinburgh city with young people under 19 years and are statutory or receive funding from the statutory sector.

Organisations which met the criteria were identified through discussion with the steering group and subsequently through interview participants making reference to projects or organisations. A total of 40 potential organisations (or representatives from types of services, that is, schools, GPs, and so on.) were identified and contacted to take part in the survey.

Some organisations responded and indicated that they do not provide drug and alcohol support, others indicated that they could not engage due to pressures and other commitments within their organisation. A total of 25 surveys were included in the analysis.

Two surveys were developed which asked for different levels of information:

- Survey one focused on 'What services can you offer, when and how?' and was sent to organisations with no specific focus on drug or alcohol provision.
- Survey two included all of the questions from Survey one with additional questions on 'To whom and how are you currently providing what services?' This was aimed at services providing specialist treatment, rehabilitation and support targeted at young people under 19 years.

It was hoped that this approach would enable us to gather data on service use to help quantify the numbers of young people experiencing problematic drug or alcohol use and accessing support for this. However, in practice we received limited data monitoring information from organisations that had received Survey two. Therefore, in practice, the information received from both surveys proved to be very similar and were analysed together.

2.1.3 STAFF AND MANAGEMENT INTERVIEWS

Key stakeholders at strategic and service provider level were identified to take part in the interviews through discussion with the steering group. It was anticipated that approximately 30 to 40 individuals would be involved and would represent statutory and voluntary partners within substance misuse, health, social care, housing/homelessness and youth sectors.

The process for engaging stakeholders was:

- Strategic managers from across Edinburgh city were informed of the needs assessment by members of the steering group.
- Individuals identified for interview were sent an initial e-mail informing them about the needs assessment and what their involvement would entail.
- Follow-up phone calls were made to identified individuals to ascertain whether they were able/willing to take part in the needs assessment.
- If able/willing, arrangements were made to carry out an interview (telephone or face-to-face), or if felt to be more appropriate, a focus group with a wider group.
- Discussion questions were sent to all participants in advance.

In many instances the above process involved several follow-up phone calls and re-arranged interviews.

The majority of interviews lasted approximately 30 minutes (ranging from 15 minutes to 1 hour) and all were recorded and fully transcribed.

All data was transferred to N-Vivo where each transcription was read in full and coded according to the emerging themes.

2.1.4 YOUTH ENGAGEMENT

Our intention was to engage young people who access a range of services for their drug or alcohol use (service users), as well as young people from groups known to be vulnerable to substance misuse but not currently accessing specialist services (non-service users). The ideal was to engage young people from four projects – two drug and alcohol specific services and two services working with vulnerable groups. An incentive of £10 per person was provided to encourage engagement.

Young people were identified from four organisations and engaged in the process. However, the total number of young people was fewer than anticipated. This was due to reduced numbers present at pre-arranged visits to organisations due to factors such as illness. It may also reflect the challenges faced by services when attempting to engage with young people with chaotic lives. This challenge was raised in interviews with young people themselves.

The process for engaging young people was:

- Information leaflet sent to organisations and asked to share with young people.
- Where young people identified as willing, suitable times and preferred approach was agreed, that is, face-to-face interview, telephone interview, group interview or focus group.
- Prior to interview or focus group, verbal information was given on the parameters of the needs assessment including all involvement being voluntary, how information would be used and limitations of confidentiality, i.e. child protection, harm to self or others etc.
- Young people were specifically asked if they wanted to take part and whether they were happy with it being recorded. Where possible this was supported by written consent.

Where young people consented to interviews being recorded, this was fully transcribed. Where consent was not given, detailed notes were taken and a summary of their views were read back to them at the end of the interview. These notes were written up on the same day.

All data was transferred to N-Vivo where each transcription/write-up was read in full and coded according to the emerging themes.

2.2 LIMITATIONS OF THE STUDY

The following limitations should be taken into account when reading this report:

- The views of those interviewed and surveyed were taken and reported in good faith and are their own, not necessarily those of Create Consultancy Ltd. or the organisations they represent. It cannot be assumed that the views of the participants in interviews or surveys are representative of all similar stakeholders.
- The majority of interviews were recorded electronically and transcribed; where this was not possible – as participants did not provide consent - detailed notes were taken by the researcher and immediately typed up.
- Organisations that provide services to young people up to the age of 19 years were included in the survey – this meant that adult-facing services were not included. However, it is recognised that these organisations may provide services to young people aged 16 to 19 years.
- Some services found it difficult to complete the surveys – particularly where statistics were asked for. This was generally due to not having specific data for young people experiencing harm from their drug and alcohol use and/or finding it difficult to estimate the numbers of young people their service comes into contact with who may have problematic drug or alcohol use. This linked to wider issues relating to the definition of problematic drug use.
- Where statistics and/or estimations have been provided on problematic drug use, there is no way of knowing whether young people are engaging with more than one service.
- A limited number of young people were engaged as part of this needs assessment. It cannot be assumed that their experiences and views are typical of all young people.

3. FINDINGS: REVIEW OF EVIDENCE AND RELEVANT LITERATURE

3.1 DEFINING PROBLEMATIC DRUG USE IN YOUNG PEOPLE

The Scottish Government (2008) describes problem drug users as those who are "experiencing or causing medical, social, psychological, physical or legal problems because of their use of opiates such as heroin, and benzodiazepines." While this recognises the wider consequences of problem drug use, a definition limited by the specific drug being used is seen by many as unsuitable for application to young drug users, and may have the potential to impact on the support given by drug services to young people who are experiencing the negative effects of wider drug or alcohol use.

No agreed Scottish definition of problematic drug use among young people was found when reviewing the evidence and literature. In the UK wide literature, the most recent useful discussion of how to identify and respond to young people's substance related needs was found in a Home Office document from 2003 (Britton & Noor 2003). This describes a systematic process for identifying and responding to need which generic and other youth services can use to ensure a clear and consistent approach is taken.

3.2 POLICY AND PRACTICE: MODELS OF DELIVERY

A useful starting point for defining models of good practice in the design and delivery of alcohol and drug services for children and young people are the ten key policy principles established by the Standing Conference on Drug Abuse and the Children's Legal Centre (1999). These ten key policy principles, intended to inform substance misuse treatment services for children and young people, are still widely referred to and their importance is highlighted throughout the Department of Health guidance.

Although these principles provide a useful checklist, they provide little insight into the structure or detail of what good practice looks like in operation.

10 Key Policy Principles for Substance Misuse Treatment Services for Children and Young People
1. A young person is not an adult. Approaches to young people need to reflect that there are intrinsic differences between adults and children, and between children of different ages.
2. The overall welfare of the child is paramount.
3. The views of the young person are of central importance, and should always be sought and considered.
4. Services need to respect parental responsibility when working with young people.
5. Services should co-operate with the local authority in carrying out its responsibilities towards young people.
6. A holistic approach should occur at all levels.
7. Services should be child-centred.
8. A comprehensive range of services should be provided.
9. Services should be competent to respond to the needs of young people.
10. Services should aim to operate in all cases according to the principles of good practice.

3.1.1 TIERED STRUCTURE OF SERVICES

It is broadly recommended that a range of interventions should be available in order to meet the needs of individual young people. A Tiered Model based on that used by Child and Adolescent Mental Health Services (as originally outlined by the Health Advisory Service in 1998) is widely advocated with a mixture of services designed to meet identified needs. The model was designed to improve the planning, co-ordination and delivery of substance misuse services for children and young people through early identification of substance misuse needs. Evidence suggests that current practice can be predominantly reactive where as focus should be placed on proactive working through early intervention strategies (Lanarkshire ADAT Young People's Treatment Task Group 2006). There are some variations on the tiers model but it largely appears as follows (Burrell et al 2005, National Treatment Agency for Substance Misuse 2005, Drugscope 2006, Department of Health 2002, Health Advisory Service 2001):

Tier 1 Services

Tier 1 services are mainstream services for young people and should ensure universal access and continuity of care to all young people (National Treatment Centre for Substance Misuse 2005). They are comprehensive and provide a holistic response with opportunity for the establishment of credibility and trust.

Services within Tier 1 should identify and screen those with vulnerability to substance misuse and identify those experiencing difficulties in relation to substances. Main concerns will relate to educational attainment and improvement, maintenance of health and identification of risks or child protection issues. Advice and information concerning substances will be embedded within a general health improvement agenda.

Tier 1: Youth oriented universal (non-specific) generic and primary services

- Services offered by all mainstream providers including education, health and child protection.
- Purpose is to ensure universal access and continuity of advice and care for all young people.
- Provide information and advice about substances as part of a general health improvement agenda and screen those who are vulnerable or who have problems with respect to substances.

E.g.: Information/education concerning tobacco, alcohol and drugs within the education curriculum, educational assessment and support to remain in school, identification of risk issues, general medical services/routine health screening

Delivered by: Teacher, generic youth worker, Careers Advisor, school health services, benefits agency, housing services etc.

All interventions should be co-ordinated and managed within the Tier 1 setting. For young people who are not connected with Tier 1, any other services involved should seek to ensure re-integration and provision of services at Tier 1 (Health Advisory Service 2001).

Youth Work

Youth work settings are significant providers of Tier 1 services. Youth work offers an important contribution through provision of diversionary activities and issue based programmes. In addition, youth workers are seen to be approachable and credible sources of information (Furlong et al 1997). They are also in a good position to respond to individual's "whole life" situation (Ward and Rhodes 2001). Young people are likely to have multiple issues and possibly be using a combination of substances. This requires a holistic approach (as outlined in the ten principles) and the youth service is well placed to respond in this respect, with a long tradition of supporting young people with a range of health and social issues including drugs (Drugscope 2006). However, it is essential that youth workers have clear limits and boundaries and are able to make appropriate and effective referrals on to more specialist services.

It is important to understand here that while generic youth workers are included at Tier 1, youth workers with some level of specialist training in alcohol or drugs (e.g. in young people's substance use patterns and risks and in motivational techniques), even if still based within a generic service, would be considered to be operating at the level of Tier 2. Unless such specialist training exists, a generic youth service would not normally be considered to be appropriate for provision of Tier 2 services

Tier 2 Services

Tier 2 services are youth orientated and offered by practitioners with some drug and alcohol experience and youth specialist knowledge (National Treatment Agency for Substance Misuse, 2005). The focus is on reduction of risks and vulnerabilities and reintegration and maintenance of young people in mainstream services. Tier 2 services should be open access (Department of Health, 2002) and provide specialist advice and information on drugs and drug treatment and also harm reduction services.

Tier 2: Youth oriented services offered by practitioners with some drug and alcohol experience and youth specialist knowledge

- Provided by youth service providers with some experience of substance misuse issues and specialist working with young people.
- Aim to reduce the risks of vulnerable young people and to reintegrate and maintain young people in mainstream services.

E.g.: advice and information, activities/education to address offending, family support, assessment of risk/protection issues, counseling re lifestyle issues, educational assessment.

Delivered by: Youth Offending Team/bail support, specialist youth worker, mentor, social services, counselling, one stop shop/drop-in service, educational psychology, GPs, Brief Intervention in Primary Care.

Tier 3 Services

Tier 3 services include specialist drug services and other specialised services, which work with complex cases requiring multidisciplinary team-based work (National Treatment Agency for Substance Misuse, 2005). They should deal with complex and often multiple needs of the child or young person and not just with the particular substance problems. There should also be a focus on reintegrating and including the child in their family, community, school or place of work. Tier 3 services might include structured counselling (with clearly defined assessment, approaches, plans, goals and review), structured day programmes (defined activities with fixed length and required attendance) and substitute prescribing (Department of Health 2002).

Tier 3: Youth oriented services provided by specialist teams

- Provided by specialist drug services and other specialist teams working with complex cases, working as multi-agency teams.
- Aim is to identify and deal with the complex needs of children and young people, not just their substance misuse needs.
- Services work towards reintegrating children and young people with family, community, school or workplace and mainstream services.

E.g.: specialist assessment leading to a planned package of care and treatment augmenting that already provided by Tiers 1 and 2 and integrated with them. Specialist substance specific interventions including mental health issues, family assessment and involvement, interagency planning and communication.

Delivered by: specialist youth drug and alcohol services integrated with Child Adolescent Mental Health Services (CAMHS), Community Drug/Addiction Teams, Drug Dependency Units, Community Rehabilitation, Day Treatment.

It is important to note that there is specific guidance in relation to providing a needle exchange service for young people aged under 18 years (Drugscope 2005).

Tier 4 Services

Tier 4 services provide very specialist forms of intervention for young drug misusers with complex care needs (National Treatment Agency for Substance Misuse 2005). This might include detoxification and staying away from home, possibly in residential units, enhanced fostering and supported hostels (Department of Health 2002).

Tier 4: Youth oriented highly specialised services

- Specialist medical interventions for those young people with complex care needs.
- For a small number of young people, intense intervention could include prescribing substitutes, detoxification and treatment or residential respite.

E.g.: short period of accommodation if in crisis, inpatient/day psychiatric or secure unit to access detoxification if required, continued Tier 3 and multi-agency involvement alongside Tier 1 and Tier 2, specialist inpatient, partial hospitalisation, medical/psychology outpatients, co-morbidity provision, residential rehab.

Delivered by: forensic child and adolescent psychiatry, social services, continued involvement from young people's substance misuse services, substantial support for education.

Ideally, a child's needs should be met in the lowest possible tier. Children and young people may need a range of services from a number of tiers at

different times, but should never have Tier 3 or 4 services without the involvement of Tier 1 and 2 (Health Advisory Service 2001) as continuity of care from health and education services in particular is crucial.

3.1.2 INDIVIDUAL NEEDS ASSESSMENT

A standard and integrated approach to individual needs assessment is recommended (Burniston et al 2002). A consistent effective individual assessment process at Tiers 1 and 2 levels should ensure more appropriate referrals and also enable better collation of data across services (Lanarkshire ADAT Young People's Treatment Task Group 2006).

3.1.3 WORKING TOGETHER

Partnership working is widely advocated (Burniston et al 2002) but this should be formalised by putting in place processes and protocols (Effective Interventions Unit 2003). This should include formal information sharing agreements (Lanarkshire ADAT Young People's Treatment Task Group 2006, Drugscope 2005). The Effective Interventions Unit (Burniston et al, 2002) highlighted planning and implementing multi-agency working as an area for further development work. Where distinct services are commissioned, care is required to ensure full co-operation with colleagues from other agencies and disciplines to ensure all the young person's needs are met (National Treatment Agency for Substance Misuse 2005). Multi-agency working is seen as essential for ensuring that a young person's needs are met. At the most, integrated, co-ordinated multidisciplinary teams with joint training on effective interventions are recommended (NTA 2005). In addition, a network of professionals or practitioner forum is suggested as a useful way to underpin partnership working (Effective Interventions Unit 2003).

3.1.4 ACCESSIBLE SERVICES DESIGNED FOR YOUNG PEOPLE

Services should be specifically designed for young people and be accessible to them. The needs of all groups of young people, including their wider personal, social and cultural background should be taken into account: this includes a young person's individual needs, lifestyle, gender, ethnicity, sexuality, culture and beliefs (National Treatment Agency 2002). In order to address this, service design will need to consider location, accommodation and opening hours. One way of ensuring this is achieved is by involving young people involved in service planning (Effective Intervention Unit 2003).

Depending on anticipated numbers of service users, there is merit to providing more specialist services for specific groups: for example, young women or young people who also have issues relating to mental health, criminal justice, homelessness or are looked after or accommodated (Drugscope 2009). However, if more specialist services cannot be justified, generic services can be modified (Pleace 2008).

3.1.5 REFERRAL AND CARE PATHWAYS

Consistent and appropriate referrals are essential if young people are to take up services (Lanarkshire ADAT Young People's Treatment Task Group 2006, Health Advisory Service 2001). An integrated care pathway describes the nature and anticipated course of the interventions a young person may need (National Treatment Agency 2005). Care pathways are crucial to ensure that care is co-ordinated through the tiers to meet young people's needs. Services should be co-ordinated to provide an integrated and comprehensive care plan for the child or young person and his/her family, rather than fitting the child into the model (National Treatment Agency 2005). In addition, arrangements should be made for transition to adult services for the 16–25 year age group (Burrell et al 2005, Drugscope 2010, Burniston et al 2002).

3.1.6 AWARENESS RAISING OF SERVICES

Where there is low awareness of services, or when services have been redesigned, it is suggested that targeted marketing is put into place aimed at those who might refer in to services at each tier (Health Advisory Service 2001, Lanarkshire ADAT Young People's Treatment Task Group 2006, Burniston et al 2002).

3.1.7 STAFF DEVELOPMENT

The Effective Interventions Unit (Burniston et al 2002) emphasised the value of targeted, well resourced, and sustainable interventions, with clear aims and objectives supported by well trained staff. Standardised training provision is recommended to help to ensure that Tier 2 workers undertaking screening or assessment work possess sufficient knowledge of drugs to be able to identify risky practices among young people (Burrell et al 2005). The National Treatment Agency (2002) recommend that as an operational requirement, staff working with under-18 year olds should know and be able to demonstrate the following skills:

- communication and engagement with young people, especially those who may be 'hard to engage'
- awareness of local children's specialist services and when / how to refer
- understanding of when to inform parents and/or the local authority
- knowledge of the law relating to the principles of confidentiality and the need to disclose information in certain circumstances
- ability to contribute to the development of young people's drug services
- in-depth knowledge of child and adolescent development; the implications of major events such as abuse, bereavement and other traumatic incidents
- ability to conduct assessments
- understanding of the issues of confidentiality and consent to treatment that involve the rights of children and the responsibilities of parents and professionals

- ability to assess the severity and risks of substance misuse, complexity of a planned intervention and the competence of a young person to consent to treatment
- ability to manage and work within child protection guidelines and to understand the relationship between substance misuse and the vulnerability of children and young people.

Given the NTA's remit, this list is designed to apply to staff working in young people's drug and alcohol treatment services (Tier 3). We were unable to find a similar description of the skills needed for Tier 1 or Tier 2 workers in any national guidance however some work has previously been done on competencies for generic staff in adult health and social care services by NHS Greater Glasgow and Clyde in 2003 (Joint Addiction Training Board 2003).

It was beyond the remit of this needs assessment to conduct a training needs analysis of all staff working within services for young people in need of substance use interventions in Edinburgh however no such previous training needs analysis was found.

3.1.8 MONITORING AND EVALUATION

National guidance recommends that services should be outcome focused (Pleace 2008) and therefore evaluation plans and approaches need to reflect this (Lanarkshire ADAT Young People's Treatment Task Group 2006, Effective Interventions Unit 2003, Burrell et al 2005). Monitoring and evaluation should be built in to services and where possible data collection and monitoring/evaluation systems should be standardised to allow a better understanding of prevalence. This is particularly important in relation to monitoring of equality data. There are specific challenges for services which do not work with young people in a formal practitioner-client one to one relationship in gathering meaningful monitoring and evaluation data. This is discussed further in the next Chapter.

3.1.9 GENERAL ISSUES TO CONSIDER

There are a number of other issues highlighted by the literature for consideration in planning services specifically for young people (Britton and Noor 2003). The full range of services across the four tiers needs to be accessible across the entire geographical area. Integrated local child protection policies and protocols need to be in place. Ideally service provision should be integrated with Child and Adolescent Mental Health Services, social services and the youth offending sector.

3.2 DISCUSSION AND RECOMMENDATIONS

The lack of agreed definition or even description of problematic drug use among young people leaves the identification of young people who might benefit from or require a specific service or intervention open to interpretation depending on how individual workers and organisations view their substance use. Currently, deciding what levels of use are problematic and what responses are appropriate is the responsibility of organisations, drug workers or young people themselves, using any number of criteria which could include frequency of use, type of drugs used, addiction or dependence, reasons for substance use and wider effects.

Among young people, as will be discussed in more detail in the next chapter, alcohol and cannabis are by far the most commonly used substances, far outweighing all other drug use which in the traditional sense would be considered problematic (SALSUS, 2011a). The current national definition of problematic drug use does not make any reference to alcohol use despite awareness of increased mortality and morbidity related to alcohol use among adults, nor does it recognise that cannabis use is potentially problematic. It is clearly therefore not an adequate definition to use when judging how to respond to the needs of young people (or adults one could argue) who may be experiencing problems from a whole range of substances, rather than just from opiates or benzodiazepines.

Indeed the potential multiple support needs of young people involved in various levels of drug use, which includes issues around mental health, education and employment and involvement with criminal justice (Roberts 2010) suggest that a widening of the traditional adult definition may be required. In this wider definition, young people all along the spectrum of drug use, from experimentation to dependency, or from occasional alcohol and cannabis use to heavy opiate use, could be considered problematic drug users in need of intervention or support depending on a range of factors.

The point here is not to try to find a definition that can be used to 'label' young people, but to enable clear data to be collected which can support service planning. At frontline service level, it may be that a definition will be less relevant and certainly less important than clear guidance on how to respond to different situations and types of substance use. This was particularly lacking for Tier 1 and 2 workers in the current review (see also next Chapter). This may result in some young people being referred into services when such a response is not required, or when they are not ready to access such services. Conversely, others may not get suitable support for their current situation, depending on what services they are engaged with and if, when and how that service identifies and views their substance use. Without suitable support, their use of substances can then have an increasingly negative impact on their life, potentially leading them to seek support but when their problems are much worse.

The range of ways in which young people use drugs and the very individual nature of how it relates to other aspects of their lives also supports the idea of having clear processes for identifying and responding to a range of substance related needs, rather than 'screening' to decide if a young person's use is 'problematic' or not. Due to this it is felt that what would be useful is greater clarity and guidance on this issue and as a minimum a common method for deciding [or assessing] what support and services are needed in response to young people's use of drugs or alcohol. Clearly this process (assessment) would need to take into account factors such as:

- Age, maturity, insight of the young person.
- Wider vulnerabilities in young person's life
- Current support available to young person (inc. services/information being accessed, family support etc)
- Young person's wishes and motivation, knowledge etc.
- When, where, how and history of substance use, rather than just the substance itself and the quantity.

Recommendation: At ADP level, agree/develop a range of quantitative indicators of how many young people are in need of support with substance use issues to support service planning.

This is vital for future needs assessments and service planning. It may include an all-encompassing definition of problematic substance use in young people and/or a range of indicators of different kinds of problematic substance use defined in different ways e.g. those in need of treatment for dependence; those in need of treatment for use of specific drugs e.g. cannabis etc; those in need of motivational interventions at Tier 2 level; those in need of counselling and so on.

In developing these indicators, there will be a need to take into account, if and how any data relating to the indicators can reasonably be expected to be gathered by services and if so, by which services.

Recommendation: Tier 1 and 2 services should use a consistent, clear and detailed process or set of criteria for identifying and responding to young people's many and varying substance-related needs.

This will require a facilitated partnership approach to define and agree what this process and criteria should look like. It is anticipated that it may not be possible to develop consensus on what should be used across all services but the ADP should at least seek to set and implement minimum standards across ADP funded services. Any such process should be in keeping with wider child protection procedures and GIRFEC principles. We would recommend that the First Steps guide from the Home Office (Britton & Noor 2003) be used as a basis for consultation to take forward this issue.

The majority of documents available on youth drug and alcohol services describe service provision using the tiered model approach however most originate from authors or organisations with a treatment perspective. There is therefore a wide range of documents from the Home Office, the Effective Interventions Unit and the National Treatment Agency that provide guidance on how to organise and manage specialist drug treatment services for young people, which we have referenced above.

Although the important role of Tier 1 and Tier 2 services in supporting young people is recognised in these documents, they provide little or no guidance for generic youth services or even Tier 2 services on how they should be responding to the drug or alcohol needs of the young people with whom they work. In short, we could find few models of good practice documented at these levels though it is possible that such guidance is hidden within generic documents providing guidance to youth workers or social care staff on wider issues. We are aware of some useful training materials on this topic (Fitzgerald 2011, TACADE 1995) and while training is an important aspect of ensuring minimum standards of practice, it is not a substitute for formal guidance to ensure consistency across services.

Finally, it is also interesting to note that although the tiered model is used within the literature this needs assessment has highlighted that this isn't the mindset or the vocabulary used by the majority of people working at Tier 1 or Tier 2 e.g. few services describe themselves or the support they provide in terms of Tiers. This is discussed more fully in Chapter 5 where service provision identified through the needs assessment is outlined along with participant views on models of delivery – in this discussion almost no reference is made by participants to tiered provision.

Recommendation: Young people's services need support and guidance to conceptualise what they are or should be providing to young people to meet their substance related needs; the scope and limits of the competence of staff and current service provision; and how that all fits within a spectrum of provision across the Tiers.

As a starting point, it would be valuable to consider a set of core principles for *the provision of support to individual young people on substance related issues*. How such services are described is important as many of the services providing such support are not substance use services or treatment services and would not identify with these terms but it is clearly a different level of provision from universal drug and alcohol education. From principles, it may be possible to look at defining different types of service more clearly, potentially relating it directly to the Tiered model or developing a new model for conceptualising these kinds of services.

Services also need support in relation to what data they collect and how relating to young people's substance use – this is discussed further in the next Chapter – however minimum requirements for data collection to ensure consistency across all/most agencies would undoubtedly be beneficial.

Finally, another aspect of this guidance will need to be around training, setting some minimum standards for workers at different Tiers/providing different services and making reference to national occupational standards where possible. This is discussed further in Chapter 5.

Clearly the facilitation of a consultative, partnership approach to taking forward this guidance will be key to successful development, acceptance and implementation by relevant organisations and services.

4. FINDINGS: IDENTIFIED NEEDS

The aim of this needs assessment was to identify the needs of young people in Edinburgh city who are experiencing harm or are at risk of experiencing harm from their own drug or alcohol use. This section outlines the needs identified both from the available literature and from the perspective of participants. As outlined in the methodology, participants included service providers from a large number of relevant organisations and well as young people themselves. This section also outlines some of the difficulties in quantifying problematic drug use. It is supported by discussion and recommendations.

4.1 PREVALENCE AND PATTERNS OF DRUG AND ALCOHOL USE AMONG YOUNG PEOPLE IN EDINBURGH CITY

4.1.1 ALCOHOL USE

In Edinburgh city, figures from the Scottish Adolescent Lifestyle and Substance Use Survey (SALSUS) report show that in 2010, 41% of 13 year olds and 78% of 15 year olds had an alcoholic drink (SALSUS 2011b).

In 2010 Health Behaviour in School-aged Children (HBSC) reported that one in ten Scottish 13 year olds and more than a quarter of 15 year olds were drinking alcohol on a weekly basis (Currie et al 2011). This was considerably higher than figures outlined in SALSUS that showed that among young people in Edinburgh city, 5% of 13 year olds and 18% of 15 year olds reported that they usually drink at least once a week (SALSUS 2011b). Both studies agree however that age is a key predictor for frequency of alcohol consumption.

The amount of alcohol consumed among adolescents is also dependent upon age. In Edinburgh city, among those who had ever had a drink, 27% of 13 year olds had consumed 5 or more drinks on the same occasion, this rising to 47% of 15 year olds (SALSUS 2011b).

The SALSUS figures have shown a steady decline in alcohol consumption among 13 year olds and to a lesser degree, 15 year olds (SALSUS 2011b).

In Edinburgh city in 2010, the frequently reported locations for drinking alcohol were: at a party with friends (50%); at someone else's home (44%); and at the pupil's own home (40%) (SALSUS 2011b).

<u>Gender</u>

McVie and Bradshaw (2005) report that boys are significantly more likely to start drinking alcohol at a younger age than girls in Edinburgh city. However, they found no gender difference in the frequency of alcohol consumption between girls and boys at age 13 or 14 years, and some gender difference at age 15, with girls reporting a higher frequency of alcohol consumption in 2005.

The most recent SALSUS report (SALSUS 2011a) indicates an equalisation between boys and girls, at age 13 years, in terms of whether they drink alcohol at all, and their frequency of drinking.

In terms of the amount of alcohol consumed, there is some indication that boys consume slightly more units of alcohol compared to girls. In 2006, SALSUS reported that boys consumed 18 units of alcohol and girls consumed 15 units (SALSUS 2006). The most recent SALSUS report has changed how it reports amount of alcohol consumed (does not provide total units but summary by drinks), making it more difficult to say whether boys continue to consume more than girls.

The type of alcohol drunk by adolescents is gender related. SALSUS (2011a) and HBSC (Currie et al 2011) report that beer is the alcoholic drink most commonly consumed by boys and among girls, spirits and alcopops/liquers are the most commonly consumed.

There is also some evidence of a gender difference in the effects of alcohol. Table 2 outlines how frequently pupils who had an alcohol drink had experienced negative effects. In 5 out of 8 of these effects, girls were more likely to have experienced them than boys, with boys only more likely to report the experience of a fight than girls.

Table 2 Negative Effects of Alcohol Use	Total %
Been sick	29%
Had argument	28%
Been in trouble with police	15%
Had fight	12%
Tried any drug	11%
Stayed off school	7%
Seen by a doctor	3%
Been admitted to hospital	2%
Source: SALSUS 2011b	

A&E Admissions

Between 1st January to 31st December 2010, 244 young people were drunk/treated for drink related issues in NHS Lothian A&E departments. The age breakdown of these young people is outlined below:

Table 3: A&E attendees under 18 presenting with alcohol related issues (yr ending 31/12/10)	
Age	Number
1 to 5	<5
6 to 10	<5
11	0
12	<5
13	15
14	58
15	57
16	58
17	51
Total	254
Source: NHS Lothian, 2011	

Ethnicity

There is a lack of information on the prevalence of alcohol consumption among ethnic minority groups in general, as well as among young people of such groups within Scotland. However, the Institute of Alcohol Studies (IAS) report shows that within the UK, ethnic minority teenagers are less likely to drink alcohol. One in 20 non-white, 12 to 17 year olds are frequent drinkers compared with one in four whites in the UK (Institute of Alcohol Studies 2010). This suggests that youth alcohol consumption is more common in white children.

A study conducted by Bradby and Williams (2006) in Glasgow reported that young Asians consume less alcohol and fewer cigarettes than non-Asians. Young Scottish Asian males between 14 and 15 years old were abstinent from alcohol due to their religious affiliations.

Findings from the 2010 Glasgow City Secondary Schools Health and Wellbeing survey (Traci Leven Research 2012) suggested that consumption was lower among ethnic minority groups. Those from Asian, Black and 'other' groups were more likely than those from a White British or 'other White' group to report abstinence from alcohol.

Young offenders

The IAS report (2010) shows that a higher proportion of offenders aged 12–17 years old are frequent drinkers (36%) than non-offenders in the UK (20%).

A research project conducted for the Scottish Prison Service (2009) states that alcohol consumption among young offenders has increased between 1996 (74%) and 2007 (90.6%). Many of the young offenders stated that their alcohol consumption contributed to their previous offending.

In 2009, the Scottish Prison Service reported that young offenders are more likely to report being drunk at the time of their offence compared to adult prisoners.

Furthermore, 27% of young offenders stated they were worried that alcohol would be a problem for them upon release.

Looked after and accommodated children

Scott and Hill (2006) identified high levels of underage and problem drinking among a Scottish sample of looked after and accommodated children. This finding is consistent with earlier studies conducted by Triseliotis et al. (1995).

Similarly, in 2004, Meltzer et al. concluded that looked after and accommodated children in Scotland aged 11 to 17 years old were twice as likely to drink alcohol as their English counterparts.

Young mothers/carers

The Social Care Institute for Excellence (2005) recognises that there is little research available with a specific focus on young mothers and carers in general with regards to alcohol use. The research that is available has tended to focus principally on substance misusing mothers rather than fathers, and drugs rather than alcohol.

Childline report that alcohol plays a significant contributing factor towards teenage pregnancy (Childline 2006).

Homeless

The latest available data shows over 20,500 young people aged under 25 years presented to local authorities across Scotland as homeless (Scottish Council for Single Homeless 2007).

People aged 16–24 years make up 36% of all recorded homeless people, even though people aged 16–24 years account for only 14% of the adult (16+) population in Scotland.

There is little data on young homeless individuals. This is because most young people will be taken into care and classed as looked after or accommodated children rather than homeless. However, a study in Glasgow showed more than half were classified as having a hazardous pattern of drinking (Scottish Council for Single Homeless 2007), suggesting problematic alcohol use within this group.

Wider factors

As part of The Edinburgh Study of Youth Transitions and Crime (ESYTC), McAra (2004) supported that truancy has an impact on children engaging in risk behaviours, such as underage drinking. McAra highlighted that children who truant often are more likely to engage in underage drinking. Out of those respondents who reported truancy within the study, drinking alcohol on a weekly basis increased in prevalence with increasing age.

Parental use of alcohol has a strong impact on the drinking behaviours of young children. Living without two birth parents and/or parental separation or divorce emerged as significant predictors for drinking in children aged 12–17 years old. Conclusions from the ESYTC study suggest that family structures and stability are important aspects in preventing problematic behaviours, such as underage drinking (McVie and Holmes 2005).

As part of the ESYTC, Bradshaw (2003) reported that there is a significant relationship between alcohol and delinquency. In particular, purchasing alcohol has been shown to be a stronger predictor of involvement in delinquent behaviour than drinking alcohol.

4.1.2 DRUG USE

While illicit drug use is less common than drinking alcohol or smoking, some evidence suggests that the prevalence of drug use in Scotland is increasing, especially among young people (McVie and Bradshaw 2005). However, since 2002, SALSUS report that there has been a steady decline in drug use in 13 year olds. In the most recent SALSUS report there has also been a notable decrease in the proportion of 15 year olds who have ever used or taken drugs.

Kirby et al. (2008), cited by HBSC (Currie et al 2011), report that cannabis is the most commonly used drug among Scottish youths and the drug which is offered most often (Currie et al 2011). This finding is supported by SALSUS, which reports that 18% of 15 year olds and 3% of 13 year olds had used cannabis in the last year (SALSUS 2011): it is further supported by local needs assessment (Riches and Bray, 2008). Very few (<2%) pupils reported having used any other drug in the previous year.

Similar to alcohol consumption, age is a key predictor of frequency of drug use. The average age of initiation into drug use in 2010 was 14 years old. Within Edinburgh city, 6% of 13 year olds and 21% of 15 year olds had used or taken one or more drug. Drug use was more common among boys. (SALSUS 2011b)

The frequency of drug use differs between age groups; in Edinburgh city, no 13 year olds reporting taking drugs at least once a week and 2% of 15 year olds. The most frequently reported locations for taking drugs were: out on the street; in a park or other outdoor area (41%); at someone else's home (29%); and at a party (24%) (SALSUS 2011b).

The most commonly reported source of drugs was a friend of their own age (49%) or an older friend (26%) (SALSUS 2011b).

Gender

In Edinburgh city, boys were slightly more likely to report taking drugs at the age of 12 years in 2005 (McVie and Bradshaw 2005). This trend continued in 2010 with boys again more likely than girls to indicate that they have used or taken any drug. (SALSUS 2011b).

McVie and Bradshaw support that there are slight gender differences in the type of drugs used and this is supported by HBSC and SALSUS who report that boys are more likely to have used cannabis than girls (Currie et al 2011, SALSUS 2011b).

In Edinburgh city, girls were more likely to report using volatile substances than boys up to age 12 years and at age 15 years (McVie and Bradshaw 2005). This finding isn't supported by SALSUS, where boys are more likely or equally as likely to report using any drug compared with girls, including volatile substances (SALSUS 2011b).

McVie and Bradshaw report slight gender differences in the frequency of drug use in Edinburgh city. At age 12 years, boys were more likely than girls to report using more than one type of drug (1.7 and 1.3, respectively) and to use drugs on more than one occasion (3.3 compared with 2.3, respectively).

Ethnicity

There are some variations between ethnic groups: among 13 and 15 year olds, white and mixed ethnicity boys and girls are, at present, more likely than others to report hazardous drug use (Institute of Alcohol Studies 2010).

There has been a slight increase in Scottish Asian girls taking illicit drugs between ages 14–15 years and 16–18 years (Bradby and Williams 2006).

The age of initiation of drug use in Asian boys (16.5 years) is higher than non-Asian boys (15.4 years) (Bradby and Williams 2006).

When substance use was analysed by religion, Christians or 'others' in Glasgow were the most likely to report having experimented with or used alcohol, tobacco and illegal drugs (Bradby and Williams 2006).

Bradby and Williams (2006) report that Asian men and women typically state religious reasons for their abstention from drugs.

Young offenders

In 2009, 80% of young offenders reported that they had used drugs in the 12 months prior to coming into prison compared to 65% of adult offenders (Scottish Prison Service 2009).

Furthermore, 51% of young offenders in 2009 reported that they were under the influence of drugs at the time of committing their offence; 8% committed their offence to get money to buy drugs.

Although young offenders typically attribute offending to their alcohol consumption, Forsyth and Lightowler (2009) report that young offenders rarely attribute their offending, especially violence, to illegal drugs.

Looked after and accommodated children (LAAC)

Griesbach and Currie (2001) found a significant uptake of drugs by young people who had experienced care, compared to other teenagers.

Scott and Hill (2006) support that: around 31% of looked after and accommodated children first tried drugs while in care, but just over two-thirds had taken drugs before coming into care.

Looked after and accommodated children in Scotland aged 11 to 17 years were twice as likely to take drugs as their English counterparts (Scott and Hill 2006).

Homeless

The National Advisory Committee on Drugs, cited by Rome et al. (2010), state that homeless problematic drug users were significantly more likely to be younger in age.

Among the general homeless population the recent needs assessment in Edinburgh city estimates that 28% of homeless people in Edinburgh have a drug problem (Figure 8, 2010).

Wider Factors

As part of the Edinburgh Study of Youth Transitions and Crimes, McVie and Norris (2006) report that higher cannabis use has been associated with factors such as high levels of neighbourhood instability and economic deprivation.

McKeganey et al., (2004) cited by HBSC (Currie et al 2011), report that higher cannabis use is associated with low parental supervision.

In Edinburgh city, McAra (2004) reported that truants have a significantly higher incidence of illegal drug use.

Pupils in Edinburgh city who have been excluded from school report a significantly higher incidence of illegal drug use (McAra 2004).

Although the numbers are extremely small, truants are significantly more likely to have sold drugs than non-truants (McAra 2004).

Children's Reporter

In 2010/11, 1,981 children in the city of Edinburgh were reported to the Children's Reporter. Approximately 55% were male and 45% female. The majority of these referrals (82%) came from the police. Of these referrals 17 were specifically due to drug use - 'misused alcohol or any drug, whether or not a controlled drug' – all of these young people were between the ages of 13 to 17 years. The grounds of referral in the children's hearing system are varied and for many alcohol or drug use could be a factor in their lives even when not the principle ground for referral. In particular, the considerably higher numbers of young people that were referred due to:

1. Being beyond the control of any relevant person (n=250);
2. Falling into bad associations or being exposed to moral danger (n=180);
3. Failing to attend school regularly without reasonable excuse (n=101);
4. Having committed an offence (n=355).

4.2 HARM EXPERIENCED BY YOUNG PEOPLE

Participants indicated that the harm experienced by young people ranged significantly and was linked to factors such as drug used and frequency of use, age of user, setting of drug use and wider vulnerabilities, such as family background – particularly parental drug and alcohol use – experience of the care system, being a young carer, physical, emotional or sexual abuse, experience of poverty, and so on. Many participants found it unhelpful to consider drug and alcohol issues in isolation. Instead, they framed drug and alcohol use in terms of wider factors experienced in the life of the young person:

> 'For the young people that we are most concerned about it's not the issue of a single drug or a single type of behaviour. It tends to go with a pattern of chaotic behaviour that we are responding to where there are other issues in their lives.' **Participant, Statutory Service**

Specific harms raised by participants as experienced by young people as a result of drug and alcohol use

- Accidents and incidents related to binge drinking.
- Offending behaviour – often related to binge drinking, opiate use or poly drug use.
- Sexual exploitation.
- Mental health issues related to all drug use but specifically increased levels of paranoia, anxiety and, to a lesser extent, psychosis due to cannabis use.
- School exclusion – linked to all drug use.
- Homelessness – linked to all drug use.
- Fractured relationships – linked to all drug use.

> 'We see and work with the young person as a whole person rather than just saying the drug or the alcohol. It is all interlinked so to separate it out is quite difficult to do.' **Participant, Third Sector**

Participants specifically discussed drug and alcohol use in terms of broader risk-taking behaviour and the interconnections between drug and alcohol use, and issues such as sexual risk taking and offending behaviour among others:

> 'I'm normally finding we're looking at people who started playing with drugs from say the age of 13, 14. Starting to get into a bit of trouble, starting to miss school, mental health issues etc.' **Participant, Third Sector**

> 'Often alcohol and drug use – linked to sexual risk-taking behaviour – is a considerable factor. Many of the young women have complex issues that are linked to self-esteem. They are at high risk of sexual exploitation.' **Participant, Statutory Service**

The negative impact that can come from the experience of having a parent/carer who themselves have a drug or alcohol addiction was acknowledged. In particular, how vulnerable this can make young people to the use of drugs and alcohol themselves:

> 'I suppose young people who are in families where drug and alcohol use is normalised and that quite often might be families that are chaotic anyway or young people in households where there's experience of domestic abuse for example.' **Participant, Statutory Service**

> 'These are children of parents who are substance users, a generation of them. It may be the culture of communities that they are living in and the prevalence of drug use which is in these communities.' **Participant, Statutory Service**

> 'The other big one we see is where parents have recovered or are in recovery but the work is needing done for the damage they have done to the kid. They seem to fall through the net. If their parent is still a drug misuser then they fit a bit more neatly into the support service.' **Participant, Third Sector**

4.3 DRUGS USED BY YOUNG PEOPLE

The two most common drugs identified by all participants as being used by young people were cannabis and alcohol. There was general consensus that the largest proportion of young people used these in a 'recreational' or 'experimental' way.

Other drugs that participants had experience of young people taking were valium, cocaine and heroin, and to a lesser extent, stimulants (ecstasy, speed) and legal highs.

4.3.1 CANNABIS

The use of cannabis by young people was felt to be considerably more common than any other drug. This was supported by young participants who also identified cannabis use as being very common among young people:

> 'Generally young people don't think about taking cannabis or alcohol. Don't care at the time; it's not a big deal.' **Participant – young person**

> 'Mostly start about 14 or 15 cause all your friends are trying it….feel good when take it [cannabis] so doesn't matter that it is illegal…know the risks but don't really care.' **Participant – young person**

'I started smoking cannabis when I was 13 and really quickly moved onto trying pretty much everything apart from heroin. I smoked cannabis like other people smoke cigarettes, and it got to a point where I wasn't eating and wasn't communicating with anyone except my dealer. I was so paranoid I couldn't leave the house for more than 30 minutes without collapsing. I knew I needed help.

I went to see my doctor who gave me medication and referred me on to a specialist service for young people. I'd used a service when I was a bit younger, but I'd felt that some of the questions they'd asked were too deep for someone my age and I had trouble communicating, so I was not optimistic about this latest referral. After a couple of hours talking with them I felt different. I think it was the personal touches. I didn't just feel like a patient and it was great to have someone neutral who I could talk to without feeling like I was being judged. Even though I had to travel quite far to get there, my overall experience of the service was absolutely brilliant. I've not smoked cannabis for over 2 months now.' **Young Participant**

The use of cannabis was felt to range from 'recreational' or 'experimental' to significant numbers of young people who use it on a daily basis and are experiencing some problems due to their cannabis use. This included lack of motivation to issues such as paranoia and anxiety:

> 'Cannabis is very much a natural state for them, like having a cigarette.' **Participant, Statutory Service**

> 'My problem is that cannabis, particularly the skunk, is getting more and more powerful and I'm observing that people are hitting mental health problems and anxieties and paranoia much, much quicker than they used to in the past.' **Participant, Third Sector**

> 'A lot of them have got habits. They are dependent upon it, and this is from as young as 14. They've certainly come out with comments such as they can't function without it, they can't sleep without it, they don't feel normal unless they're on it.' **Participant, Third Sector**

The general view was that young people start to use cannabis on a more regular basis from the age of 14 or 15 years, with the frequency of use increasing with age.

4.3.2 ALCOHOL

Alcohol use by young people was largely viewed as weekend/evening use with friends. It was raised that although some of these young people may experience problems when under the influence or as a result of their alcohol use – largely linked to issues associated with binge drinking, that is, getting into fights, arguments, accidents, trouble at school, and so on – few of the young people (or significant others) would consider their use to be 'problematic' and fewer again would identify the need for treatment or any ongoing intervention:

> 'The level of alcohol that they are drinking is phenomenal ... Part of me thinks I don't know how you can manage to drink that much but there's still that kind of "it's a rite of passage" kind of way of thinking among quite a lot of adults.' **Participant, Third Sector**

> 'They are 14, 15, 16 year olds who would consider themselves to be experimenting, but actually some of that alcohol use is pretty heavy but even their families might not consider it to be particularly problematic because they will see it within the continuum of adolescent behaviour.' **Participant, Statutory Service**

This view was supported within the youth interviews and focus group, where it was raised that alcohol was 'not viewed as a drug' by young people as it is seen as a 'rite of passage' by young people and adults alike:

> 'Alcohol is a Friday night thing, the start of the weekend.'
> **Participant – young person**

A very small number of participants indicated that they work with young people with dependency issues around alcohol. In the majority of instances, these young people were in their upper teens/early twenties. However, a minority indicated that they have experience of young people with dependency issues who are aged 14 and 15 years old.

> 'Yes, binge drinking. Getting themselves into fights, or you know, getting drunk and getting into arguments with their parents or arguments with their girlfriends and that's leading them to get thrown out of their home.' **Participant, Third Sector**

Among those young people who use alcohol more frequently and are experiencing harm or significant problems related to their alcohol use, it was felt that this is linked to wider vulnerabilities within their life. It was felt the reasons these young people drink are different from the wider group who drink for fun. Participants had specific concerns about these young people due to worries that they are more likely to go on to use other drugs and develop more entrenched and problematic drug use as they get older:

> 'Alcohol can be common. Again it's because of the background from these kids have come from. So alcohol might be a norm within their own family.' **Participant, Statutory Service**

> 'Rich people are less likely to experience problems and if you come from a poor background [you are] more likely to experience problems….also if family use alcohol. My mum's an alchie.' **Participant – young person**

> 'I had a lower frame of mind when I had first drink. Everything seemed better.' **Participant – young person**

4.3.3 OTHER DRUGS

- Legal highs
- Valium
- 'hard drugs', i.e. cocaine or heroin.

Legal highs were mainly discussed by organisations with drop-in provision. They indicated that there had been an increase in the numbers of young people attending and asking for information on legal highs. No organisations gave estimations on the proportion of young people using legal highs or the frequency of use:

> 'A lot about new emerging trends, legal highs ... Certainly from what we've experienced in the drop-in, that's quite high. A lot of stuff around methadrone.' **Participant, Third Sector**

Valium use by young people was discussed in relation to poly drug use – most often alongside alcohol or cannabis. It was also discussed more frequently by organisations that work with very vulnerable young people. It was felt that in many situations young people who use valium were getting it from parents or other family members who use drugs:

> 'Getting drunk then using valium and it would not agree with them and they would do things that maybe they wouldn't normally do. It

> makes them feel invincible and stuff and that's not something you hear about on the news. You know, it's not widely known about, that valium is such a big thing for young people to use.' **Participant, Third Sector**

> 'We later found out that her mum had been giving her valium for some time. That was to calm her down because she was very hyperactive.' **Participant, Statutory Service**

The majority of participants who engaged in this needs assessment indicated that they rarely work with young people under the age of 19 years who use heroin or cocaine. Those who were working with young people using heroin or cocaine indicated that they were most commonly over 16, generally in their upper teens or early twenties.

Overall, if young people were using opiates or cocaine, this was considered to be 'harder drug use' and automatically viewed as problematic.

> 'I tried heroin for the first time when I was 11, though it was mainly cannabis and valium I was using until I was about 12 or 13 when I got heavy into smack. When I was about 15 I managed to get a script, but it's really hard to get one if you are under 16. I'd had some support before but I wasn't that interested, I just wanted a script [prescription, probably for methadone] and they told me I was too young for it. After I got my script, I'd go into the service, get drugs tested and have a wee chat, but really it was mainly about getting my script. The service is good though, they are really flexible which is good. I think it's important that services for young people are in a different bit from the adults, as it can be a wee bit intimidating going in to a room full of people older than you with habits. It's a hard was to stay clean if you're going in and there's maybe 20 people and only 5 of them want what you want. I think they underestimate the number of young people that need services.' **Young Participant**

Most frequently, these young people were described as coming from chaotic family backgrounds and were known to 'the system', having had social work involvement throughout their lives. The potential exception to this was felt to be cocaine users (and potentially other psycho-stimulant users) who engage with services in their upper teens/early twenties and have no previous experience of services.

Throughout all the discussions with participants who work with young people using drugs such as heroin, they discussed this in relation to wider vulnerabilities, such as parental drug use, abuse and sexual exploitation:

> 'We do get the very high-end kids who are maybe addicted to heroin or have a real problem but it is hard to work out cart and horse ... It is always related to some other issue.' **Participant, Statutory Service**

> 'We are aware of cocaine and heroin users: 17, 18 and 19 year olds, but they tend to stay more in their houses.' **Participant, Third Sector**

> 'Sometimes their experience of drugs and alcohol in the family have turned them against it [drug and alcohol use] when they are younger. But even those young people tend to drift towards it later on.' **Participant, Statutory Service**

4.4 QUANTIFYING PROBLEMATIC DRUG USE AMONG YOUNG PEOPLE

Trying to quantify the number of young people under the age of 19 years that live in Edinburgh City and are experiencing harm (or at significant risk of experiencing harm) from their own drug and alcohol use has proved to be very difficult.

This was due to a number of factors including:

- The large number of youth facing organisations that provide a range of services that may come into contact with young people who are experiencing harm or at risk of due to own drug and alcohol use. ,
- Difficulties around the subjective nature of how 'problematic' or 'harmful' drug or alcohol use among the youth population is defined.
- A lack of consistent assessment to identify problems due to drug or alcohol use.
- A lack of monitoring information. The majority of organisations that have a primary purpose other than drug and alcohol support often do not collate centralised data about drug and alcohol use. This included the majority of social work services and a number of youth organisations.

Due to these limitations it is not possible to provide definitive statistics or accurate estimations on the number of young people experiencing problematic drug or alcohol use. However, as part of this needs assessment some services were able to provide data on the number of young people accessing their service due to drug or alcohol issues. Other services – mainly youth providers – were able to give estimations on the proportion of young people they work with whom they have concerns about due to drug or alcohol use. A summary of the information is as follows:

- The following services outlined that young people aged under 19 years accessed 1-2-1 support for their drug or alcohol use:
    - 56 young people: Adolescent Substance Use Service (Nov – Nov 2011)
    - 14 young people: Castle project (2010/2011)
    - 15 young people: Crew drug counselling service
    - 6 young people: HYPE (Nov 2010 – Nov 2011)
    - 17 young people (1-1) and 12 young people (counselling): The Junction (Jan 2011 – Nov 2011)

- In 2010 OF 84 young people accessing support from the Children and Families Integrated Community Support Service
    - 18% routinely used drugs
    - 15.5% had been hospitalised due to drugs or alcohol
    - 14.2% excessively used alcohol
    - 8.3% routinely used drugs at school
    - 5% regularly drank alcohol at school
    - 3.5% had active involvement from a substance misuse service

- As previously reported in 2010/11 1,981 children and young people were reported to the Children's Reporter 17 young people were specifically referred as they had 'misused alcohol or any drug, whether or not a controlled drug' – all of these young people were between the ages of 13 to 17 years. Numbers referred for factors known to be linked to substance use were:
    - Being beyond the control of any relevant person (n=250)
    - Falling into bad associations or being exposed to moral danger (n=180)
    - Failing to attend school regularly without reasonable excuse (n=101)
    - Having committed an offence (n=355)

- 1st Jan to 31st Dec 2010 244 young people aged 12 to 17 years were drunk/treated for drink related issues in NHS Lothian A&E departments. The majority were aged 14 years (n=58), 15 (n=57), 16 (n=58) or 17 (n=51)

- A youth project working in North Edinburgh estimated that of 400 young people they engaged with in previous year approximately 50% regularly smoked cannabis and they had concerns about approximately 15% due to excessive cannabis use and 10% due to 'worrying' levels of alcohol use.

- Another youth project working in North Edinburgh estimated that of 2000 young people engaged through street work approximately 90% were using alcohol, 50% using drugs and alcohol and that 10-20% had problematic usage.

- Within social work services (including residential care, Through care and After care, youth offending teams and children and families) all staff interviewed were aware of young people being supported by staff with concerning drug and/or alcohol use; none were able to provide an estimate of how many young people overall have concerning drug or alcohol use.

See Appendix A for full data on service usage.

4.4.1 DATA MONITORING AND ASSESSMENT

As outlined above, there were significant difficulties in gathering accurate data on young people who are experiencing harm from their own drug or alcohol use.

All of the organisations involved in the needs assessment worked with vulnerable groups of young people and at times support young people with problematic drug or alcohol use. However, there was no consistency in how this was recorded or monitored and a lack of guidance available to organisations on what information they could (or should) be recording.

Due to the nature of many services, they don't see it as their role to gather specific data on drug and alcohol use; particularly where drug and alcohol support is not their primary function. This was most pronounced within statutory services such as social work and A&E. For these services, although drug and alcohol use by young people would be explored – within social work as part of a wider care pathway and plan – there was no system in place for this information to be recorded and collated centrally:

> 'There isn't really an awful lot of scope for us to get a clear idea of things. We're slightly limited from that point of view. I know some departments do a rapid assessment, or use rapid assessment tools for alcohol dependence or drug abuse, but we are not able to provide that with the pressures that we are under.' **Participant, Statutory Service**

Among 3rd sector organisations there were considerable variations in how information about young people's drug and alcohol use was collated and how this translated into statistics. Although all organisations had systems in place to record use and engagement with their service, often this would not include specific information on young people's use of drugs and alcohol, or the level or frequency of that use.

Different models of engagement also posed specific challenges around data monitoring. This was demonstrated by outreach services. Key questions raised here included, what is the best way to implement a consistent way of recording the young people outreach services engage with without it becoming overly onerous or intrusive? How can workers gauge or assess levels of intoxication/drug use without using approaches that run contrary to good youth work principles and an informal approach? In many instances it was felt that it was not possible to record this data in a meaningful way:

> 'We're not able to record – legally or practically. We're not able to record a young person that comes to our provision who, for example, has been arrested. Youth work relies on trust, so if they think we're tracking them, but also practically we don't have the capacity to do it. There are legal, moral and practical difficulties to

any kind of system that records individuals on that basis.'

Participant, Statutory Service

The majority of services engaged as part of this needs assessment indicated that they do not use any formal assessment tool to identify levels of drug and alcohol use among young people (3 indicated that they did). The issue of assessment was linked to wider discussion on defining problematic drug use and the subjective nature of this due to a lack of clear guidance.

Some participants indicated that they would not be comfortable using a formal assessment tool as it would not work with their informal approach to youth work, or because they carried out a more holistic assessment of need in a formal or informal way.

When discussing data monitoring and assessment, it raised a number of questions about what the expectations should be of youth-facing services that obtain funding from the ADP. How important is it that services can accurately identify the needs of young people and their level of drug and alcohol use? Is there a requirement for some consistency of response to the identified needs of young people across Edinburgh city?

It was felt that currently there are no clear answers to the above questions and that further debate and discussion on this issue is required.

4.5 DISCUSSION AND RECOMMENDATIONS

The prevalence data identified as part of this needs assessment is useful in providing an overall picture of drug and alcohol use among young people. It also provides useful indicators in patterns of drug use in relation to age and gender; with increased age being strongly associated with use of drugs and frequency of that use.

This needs assessment indicates that more serious harm and entrenched drug using behaviour experienced by young people is closely linked to age; in that significant problems that are part of a pattern of behaviour (rather than one off incidents) start to manifest in later teens and early twenties. This is significant as the ability to engage with young people after the age of 16 years reduces dramatically. This is linked to the finding discussed in the following chapter about there being no consistency in the age of young people that services can work with.

Prevalence data also indicates that there has been equalisation between genders in terms of whether they drink and frequency of drinking and the potential that girls may experience more negative outcomes from their use of drugs or alcohol. This again has some potential implications for services.

Where the prevalence data has significant gaps is in the information available on the use of drugs and alcohol by young people from equality groups; in particular young people from

different ethnic backgrounds and from different deprivation category (dep-cat) zones. Through the interviews there was a sense that deprivation does impact on young people's use and experience of drugs and alcohol – potentially due to the complex relationship between deprivation and known vulnerabilities to substance use such as family breakdown etc. However, participants did not provide much insight into the use of drugs and alcohol by different ethnic groups. Although previous research has indicated that being from a black or minority ethnic background may be a protective factor for substance use there is no information available on young people from areas of recent migration such as Eastern Europe.

Recommendation: Specific research is required into the use of drugs and alcohol and the impact of that use on young people from different equality groups; particularly those from areas of recent migration such as Eastern Europe.

The prevalence data, supported by the experience of participants, provides strong evidence that cannabis is the most common drug of choice for young people – perhaps becoming more common though not as common as alcohol use. The engagement of young people who are accessing drug and alcohol services provides useful insight into the harm that can come from cannabis use as well as other drugs. This adds further weight to the recommendations in the previous chapter that it is important that any move towards developing a definition or description of problematic drug use among young people is not restricted to type of drugs used i.e. opiates etc.

The use of cannabis also raises a broader issue about how best to tackle the culture of cannabis use and effectively challenge the view that it is 'normal' to use it. This is reminiscent of the challenges that have surrounded (and continue to surround) alcohol which have led the Scottish Government to take a number of measures to change Scotland's relationship with alcohol.

Recommendation: **Greater recognition of the harm that can come from cannabis use and further discussion on the best way to tackle increased use of cannabis among young people.**

The individual nature of young people's use of drugs and the multiple factors that impact on substance use would suggest that there is significant scope in developing a risk behaviour model to help tackle the harm experienced by them. The views of the participants within this needs assessment would suggest that this approach is one that would be broadly welcomed – more discussion on this is provided within the next chapter.

The findings within this chapter highlight the difficulties around quantifying problematic drug use. This is evidence in the lack of indicative measures within the prevalence data and also the difficulties organisations had in providing this data in relation to young people their own service engages. This makes it very difficult to plan service provision as the level of potential unmet need is largely unknown. It was interesting that many participants were

reluctant to use the word 'assessment' with some indicating strongly that this is not something they would want to do.

As highlighted in the previous chapter the use of the term 'assessment' is not about labeling young people or the desire to develop very formal procedures that would be inappropriate for many youth facing services. Instead it is used as an overarching term that describes the process for determining what support a young person requires and importantly the process surrounding how this information is recorded and collated.

The lack of quality data monitoring was clearly evident through the process of conducting this needs assessment. It has raised the need for more consistency on what projects should be collecting to help fill the information gaps that currently exists. It is felt that organisations need guidance on what information they should gather and how this information should be recorded for information sharing purposes and centralised data collection.

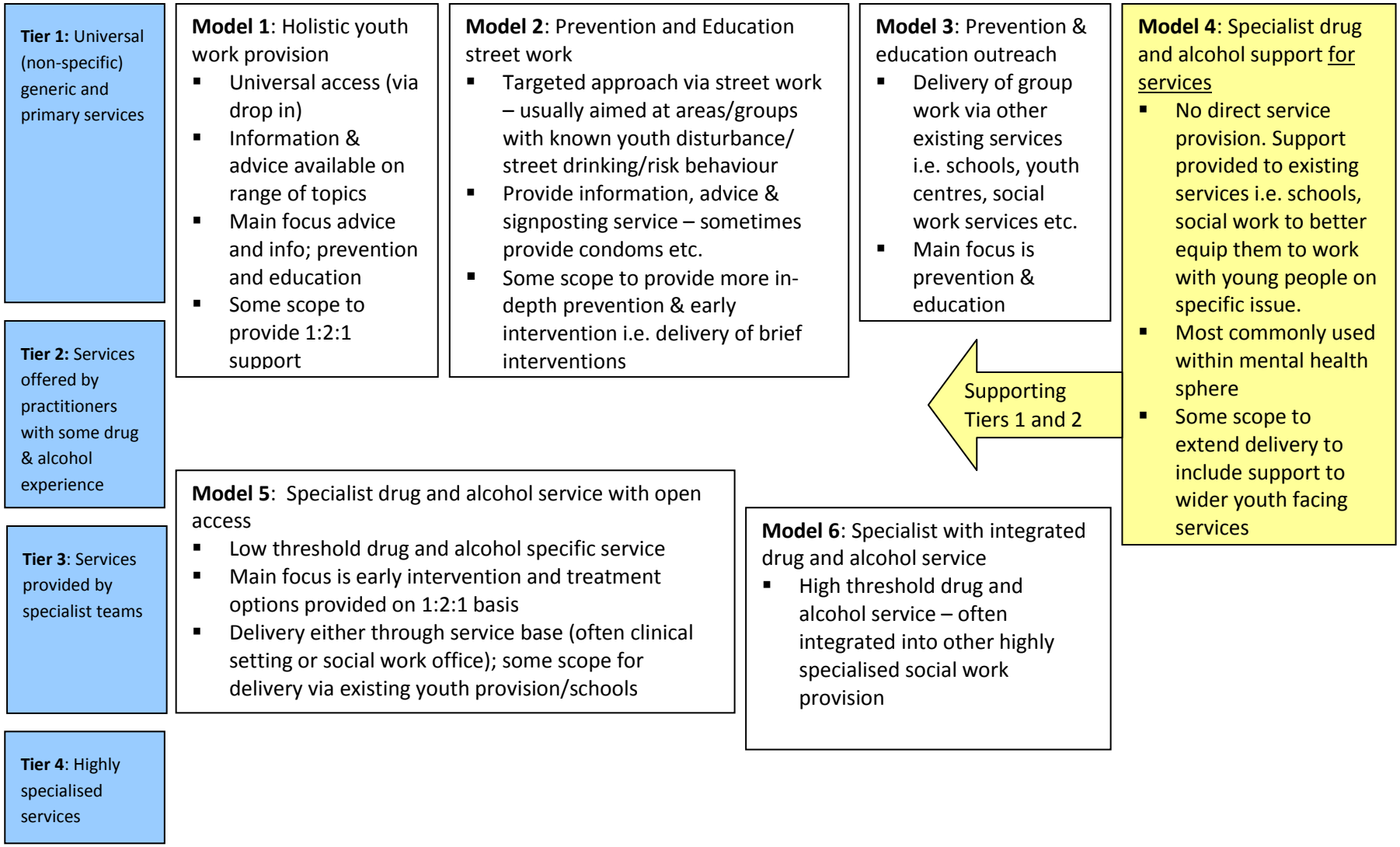
Recommendation: At ADP level a process is required that engages partners with the purpose of agreeing minimum monitoring requirements - at least for ADP funded projects.

It is felt that if minimum standards for monitoring can be agreed this can then be advocated to other services who do not receive funding from the ADP but work with young people at risk of problematic drug or alcohol use.

5. FINDINGS: SERVICE PROVISION

This section outlines drug and alcohol provision available to young people – including models of delivery - in Edinburgh city who are experiencing harm or at risk of experiencing harm from drugs and/or alcohol. It also outlines the barriers and facilitators to access and gaps in provision. It is supported by discussion with recommendations.

Models of Delivery: The figure below provides a suggestion for how the models of drug and alcohol service provision currently available to young people might be mapped in relation to the Tiers as discussed in chapter 3.



5.1 EXISTING PROVISION

5.1.1 WHAT IS AVAILABLE

Key information, collated from the 25 surveys received, on what, where and who they provide services to can be found in the appendices. Key points from this data include:

- All services indicated that they work with vulnerable groups of young people. This included youth organisations located within areas of deprivation and services that specifically support young homeless, looked after and accommodated young people, young people at risk of secure care, sexually exploited young people, young offenders, young carers and young people from chaotic homes (including drug using parents or carers), among others.

Strengths of current provision as identified by participants

- Breadth of youth provision available.
- Links between youth organisations and schools (where established).
- Partnership working and information networks.
- Easy access services offering different levels of support.
- Use of peer-led approaches.
- Improved approach to drug users by services.
- Improving access to prescribing service by GPs.

- The age range that services worked with varied considerably from statutory services that worked up to the age of 16 or 18 years (21 if LAAC) and 3rd sector providers who worked with age ranges from 8 to 21 years; 16 to 30 years; and 11 to 24 years, among others.

- Few services specifically supported young people with drug and alcohol issues as their primary role, instead classifying their role as 'other'. This incorporated youth services, diversionary activities, homelessness support, family support and child protection services.

Weaknesses of current provision as identified by participants

- Lack of universal education programme on drugs and alcohol.
- Media representation of drug users.
- Lack of feedback from specialist services given to referral organisations.
- Young people being required to access adult drug and alcohol treatment services.
- Lack of long-term funding and organisations competing for funding streams.
- Communication about provision across local area and within organisations, i.e. managers informing wider staff about new services.

- The majority of services indicated that they provide advice and information and prevention and early intervention to young people, with few providing specialist interventions. The breakdown of was as follows:
    - Advice and information n=25
    - Prevention and early intervention n=17
    - Outreach n=15

- Family support n=5
- Drug and alcohol treatment n=3
- Rehabilitation (community) n=3
- Needle exchange n=1
- Rehabilitation (residential) n=0

- Services identified a range of access routes. The most common were:
  - Via service base n=13
  - Via schools n=11

- 10 services indicated that appointments were required, with others having open access to all young people via drop-in or outreach services or restricted access to specific groups of young people, i.e. LAAC, young offenders, young people at risk of secure care etc.

In addition to services identified as part of this needs assessment, participants made reference to support being provided to young people through:

- Drug and alcohol education provided as part of the school curriculum;
- Adult drug and alcohol treatment services that engage some young people aged 16 to 19 years.

Specific details on services can be found in the following appendices: Appendix B – Summary of Provision; Appendix C – Support Services Provide; Appendix D – Referral Pathways; Appendix E - Access Routes; Appendix F – Waiting Times.

5.1.2 STAFF AND YOUNG PERSON RELATIONSHIPS

Participants held mixed views about who should deliver drug and alcohol services to young people. This debate focused on whether it should be specialists in drugs and alcohol or non-drug and alcohol specialists, that is, social workers, youth workers, and so on.

All participants recognised the importance young people place on trust and strong relationships. Due to this, some participants felt that it was more appropriate to build on existing relationships and use staff who already work with young people to support drug and alcohol use:

> 'I think that too often when the young person and family is in crisis, our response to that is putting lots of strangers around them because they have a specialism … Often from the young person's view point it doesn't actually make sense. What they would say is: well, the way I can be helped is through the people I have a relationship with and some trust with.' **Participant, Statutory Service**

It was suggested that staff could develop their knowledge and expertise through support from existing specialists (see Model 4). As part of this discussion participants made specific reference to Edinburgh Connect and felt that this model of delivery was potentially a useful approach for services to better support young people about their drug and alcohol use This model of delivery was felt to be particularly helpful for incidences of lower-end drug and alcohol use and/or in situations where young people were coming to terms with identifying their own problematic drug and alcohol use and reluctant to access specific services on this issue.

Other participants felt that in order to deliver a full range of services to young people – particularly where gaps were identified at Tiers 3 and 4 – a high level of expertise was required, and that this could only be provided by specialist drug and alcohol staff (see model 5 and model 6):

> 'Very chaotic and risk-taking young people need more than youth projects can provide. Youth projects can't work at this level as you need a level of knowledge and expertise that they won't have.' **Participant, Statutory Service**

It was felt that within this model, strong relationships could be developed – particularly if specialist staff provided an initial outreach service where young people were met in familiar settings, such as a school or youth club. It was felt that all support could be provided in this way, or it would bridge the gap for young people to eventually start attending a service base where highly specialised provision could be available:

> 'Getting specialist folk to work alongside youth workers or to come to places where young people are currently accessing would probably be a higher chance of success.' **Participant, Third Sector**

Linked to the above was discussion on the different type of relationship that young people have with staff and whether this makes some staff more or less appropriate to support and treat drug and alcohol use. An example given was that a residential care worker has a 'parental' relationship with young people. This means there is a power imbalance as they may need to take punitive action if drug or alcohol use is identified. They may also not be seen as credible sources of information on drugs and alcohol in the eyes of young people:

> 'The kids see us as substitute parents and that we nag and we don't know anything … so possibly they get better engagement and listen better because they've got the materials and the fun things to do with them.' **Participant, Statutory Service**

Another example of relationships that may be less appropriate to support drug and alcohol use was teachers. This was linked to the requirements of teaching staff around confidentiality and child protection as well as pragmatic issues, such as the time they have available.

Examples of staff felt to be more appropriate to support drug and alcohol use were youth workers, social workers, youth offending team workers, and so on, who have good relationships with young people and often have more time to spend with them. Where non-drug and alcohol specialists were used to support young people it was recognised that a crucial factor was the provision of high quality training:

> 'We could go on more specialist training, it does give you more confidence to address these issues. Also more support to deliver stuff yourself.' **Participant, Statutory Service**

5.1.3 HOLISTIC CARE

An important consideration when developing services for young people was felt to be having clarity on what need the service is trying to meet. This was felt to shape the type of service provided. For example, was it all drug and alcohol use? Or specific types of drugs? Was it risk taking behaviours more generally? Was it meeting holistic needs?

All participants stressed that taking a holistic approach to young people's drug and alcohol use was important because of the interconnections between substance use and other behaviours and life experiences.

When discussing a holistic approach to supporting young people, it was felt to be important to consider whose needs were being met and how this would impact on how services were delivered and the expertise required by staff. It was felt that a holistic model which is primarily meeting the information and prevention needs of young people may want to be part of more generic provision that can provide information and advice on any health and wellbeing topic (see model 1 and model 3), whereas a holistic model which is primarily meeting the treatment needs of young people who have identified problematic drug or alcohol use may use a risk-taking model (see model 2 and model 6).

The approach of developing a service that is based around supporting risk behaviour was raised by a number of participants (see model 2 and model 6). This was due to the known links between substance use and other risk behaviours, such as sexual risk taking, offending, and so on. Specific reference was made to the policy document that was out for consultation from the children and families department on this approach. Among those that made reference to this policy, this approach was warmly welcomed.

5.2 BARRIERS AND FACILITATORS TO ACCESS

Table 10 provides information on services' own perspectives on the barriers that prevent young people from accessing their service. The most common barriers identified were:

- Lack of awareness (n=10)
- Lack of motivation (n=8)

- Referral criteria (n=6)
- Capacity (n=6)
- Location (n=6).

Full details of barriers to access for services can be found in Appendix G: Barriers to access.

Overall, service providers indicated within the survey that there were few barriers to accessing their services – with some indicating none. This provides an initial impression that there are limited barriers experienced by young people. However, within the interviews, all participants could identify a range of barriers and indicated that overcoming these was a substantial and ongoing challenge for service providers. The following provides insight into participant views on what can prevent and inhibit or encourage and support young people to access services.

5.2.1 SELF-MOTIVATION/TIMING OF SUPPORT

Participants felt that young people lacking motivation, drive or confidence to engage with a service was the greatest barrier to accessing support for their drug or alcohol use.

It was recognised that it can be a sensitive and protracted process for young people to identify that their use of drugs or alcohol is becoming problematic, and that this does not happen after a set time or in relation to a clear pattern in terms of amount, type or frequency of use. It was felt often that this realisation doesn't happen until young people are in their late teens or twenties:

> 'When I talk to clients about their childhood, they weren't that ready to look at their issues. They were having a bit of fun in some respects.' **Participant, Third Sector**

> 'It's not until these kids are maybe 17, 18, 19, 20 that they realise the damage that they've done, by which time it's a different ball game because they are in adult services.' **Participant, Statutory Service**

For many young people it is a gradual realisation that they are no longer drinking or taking drugs in a fun or experimental way. This was reflected in the experience of one of the young people interviewed. 'John' – who is now accessing support for alcohol addiction – indicated that on reflection he had always had some awareness that he drank in a 'different' way to his friends. That is, that when he drank, he did so in reaction to a negative feeling or situation. However, at the time he didn't think about this and drank with his friends and thought it was fun.

For others the realisation may be due to a specific event/sequence of events and for others it may be due to the influence of a significant other in their lives. This could be a family member or friend or, in some instances, a teacher or other professional (either due to concern or an incident that has triggered a referral).

The latter point raised discussion about the role of others in identifying alcohol or drug use as 'problematic', even when the young person themself doesn't. Some practitioners felt that they had a role in working with the young person to identify consequences – using motivational interviewing and brief intervention techniques – whilst others felt that if a young person has not identified their drug or alcohol use as being problematic then it is unlikely that they will engage in any meaningful way with a service:

> 'You end up with a young person who is accessing some sort of treatment but doesn't really want to be there. The likelihood of any shift in attitudes or their drug use is none, or will very rarely happen.' **Participant, Statutory Service**

Wider issues that related to self-motivation were situations where young people do recognise their use as being problematic but lack the confidence to access a service. A key facilitator to access was felt to be having the appropriate support available at the point of young people recognising that they need some help. If not, then the window of opportunity may be lost:

> 'Our young people have got such low confidence and especially if they've got quite heavy drug use that's bigger than normal.' **Participant, Third Sector**

> 'It can be a bit scary in terms of their experience and how they'll manage, about fear of failing, about not coming up to the standard, about not being able to read or write very well.' **Participant, Statutory Service**

> 'The thing we've learned about young people is they're quite spontaneous. They don't want an appointment two weeks on Friday. They want: I'm going to wake up today and go and see somebody. So we need that accessible service where people can pop in on the spur of the moment because by the next day it's all gone and they've changed their mind.' **Participant, Third Sector**

5.2.2 LOCATION

The location of services was also recognised as being both a barrier and a facilitator to access. There was some debate over whether it is best to have services located centrally in the city centre of Edinburgh or within local areas. No clear consensus was reached as part of the interviews – practitioner or young person – instead participants could identify pros and cons in both approaches:

> 'You need to have neutral venues. You need to have them in the city centre, but if you have them in communities they need to have a choice.' **Participant, Statutory Service**

Ultimately, it was felt that having a mixture of services located in different places was required. Other favoured approaches were having outreach services that can engage young people in a range of different locations, from schools to cafes if necessary. This approach was felt to be particularly useful when working with vulnerable groups of young people who may lack the motivation, drive or confidence to walk into a service base on their own:

> 'I find that the expectation that they must come to us is a wrong expectation because a lot of them are not ready to go; they need people to come to them.' **Participant, Third Sector**

Linked to the discussion on location were practical issues, such as the cost of attending a service if young people are required to travel, and the importance of services being located on a bus route. These were seen as important considerations if young people were accessing any longer term support:

> 'It's cost as well and they're young and maybe if you're not working to pay the bus journey in and out it can be quite a lot. So when you have ongoing support that becomes an issue. Where young people go in a couple of times every so often, that's different.' **Participant, Third Sector**

> 'Make the service more accessible; being as frequent as every time you see a post office! If you had one place that you went, but you had people in a few schools that would bring young people to it.' **Participant – Young people**

5.2.3 AWARENESS OF SERVICES

It was recognised that ongoing issues around awareness and knowledge of services continues to be a barrier for young people. This was staff knowledge as well as awareness among young people themselves.

> 'I think young people in Edinburgh don't know where to go to get help. They might not feel comfortable talking to their family doctor, and if like me they were housebound because of their drug use that would be a big barrier. I think there needs to be more publicity so that people know the different types of services there are. I also think that location is important, not just in terms of travel, but also having services based within adult services could be quite frightening for some young people.' **Young participant**

It was acknowledged that ensuring staff knowledge is up to date can be difficult – particularly if drugs and alcohol are a small part of their work that only occasionally arises. Lack of knowledge was also due to services – particularly in the 3rd sector – getting funded for short periods of time, leading to the perception that services get closed or change frequently:

> 'We get so bombarded with so many offers of services that we don't remember them all until we need them and then we have to go and look for them again.' **Participant, Statutory Service**

Many staff interviewed indicated that the internet was a useful tool for identifying services available. It was also observed that many staff who engaged in this needs assessment indicated that they would call Crew or Fast Forward to get advice on support services if a drug or alcohol issue was identified.

5.2.4 ACCEPTABILITY OF SERVICE

Participants raised a number of issues about how young people view services. This related to perceptions about what to expect from services, whether services were confidential, how they would be treated by services and the reputation and potential stigma associated with a service:

> 'I just think going into town and going into an organisation that they know nothing about or don't know anybody who goes there, it's just huge and they're just not able.' **Participant, Third Sector**

Specific issues that related to this was the lack of diversity among workers potentially putting off young people from BME communities or young people being concerned about the inclusiveness of a service:

> 'That trust issue there. Will this person make a judgment about me? Will they connect that to alcohol ... that it's because I'm gay, I'm drinking or something.' **Participant, Third Sector**

It was also felt that young people are very sensitive to the reputation of a service and how they might be viewed if they attend. This latter point was raised specifically in relation to young people attending adult services, or services well known for a specific topic such as drugs or sexual health:

> 'I went with them to an AA meeting ... they sustained it for a short time afterwards but then didn't kind of pursue it long-term. I think that was not so much to do with the quality of the AA as a structure, but that many of the people who attend the meeting were much older.' **Participant, Third Sector**

> 'It was getting him to go and engage. Whether that was with social work or what at the time was X, but his view was, "I'm not going there, that's for smack heads.' **Participant, Statutory Service**

Developing a positive image was felt to lie with staff building relationships with young people and their approach to young people generally. The terms frequently used were flexibility and trust:

> 'Unless the relationship is there, unless we're building relationships up with young people, how on earth can you have these conversations that you really desperately need to have with a young

person because they're not getting them at home?' **Participant, Third Sector**

This was helped when staff were able to meet young people in an environment they felt secure in, that is, school, residential unit, and so on. Examples of this were services going into schools or youth organisations to deliver inputs and enabling young people to meet staff and see how they work. In addition, having drop-in facilities so that young people can see what the service is like. These approaches were felt to help build relationships and make it easier for young people to attend a specific location or base for 1-2-1 support:

'We run a drop-in so they can just come in when they need it and then also the street work access and that can feed into a referral as well.' **Participant, Third Sector**

'We need to send workers out to young people in different settings or maybe home visits. I think with young people you have to have a more flexible approach. If you expect them to turn up for appointments all the time, you're going to be disappointed.' **Participant, Statutory Service**

5.2.5 PRIMARY CARE/ADULT SERVICES

A smaller number of participants discussed specific barriers that prevent or inhibit young people from attending their GP or services that are adult facing about a drug or alcohol issue. This was primarily due to the systems in place within these services:

'Often the NHS provides a very rigid service that has policies, such as 3 missed appointments and you no longer have support.' **Participant, Statutory Service**

Although, within the youth focus group a potential benefit of attending a GP was felt to be that you could be attending for any issue; it was also felt that it would be difficult to discuss drugs or alcohol within the short appointment times:

'If your doctor asks you what drugs you're taking you say none.' **Participant – young people**

The expectations of some services were felt to be problematic. It was raised that many young people will need to use adult services because it will be in their late teens or early twenties when they want to access support. However, although in age they would be adults, it was felt that in many instances, due to lack of schooling and other vulnerabilities, they would lack the emotional and social maturity required to fully engage with an adult service:

'They have to show willing ... if they miss an appointment they get struck off and lose their script. They will do that because they are chaotic.' **Participant, Third Sector**

5.2.6 CHILDCARE

This barrier was raised by one participant who indicated that due to a large number of clients being parents, lack of childcare facilities was a significant barrier:

> 'Basically it's like being in a wheelchair and being told sorry you can only come in here if you can climb up steps ... we're losing a lot of opportunities not having funding for childcare facilities.'
> **Participant, Third Sector**

5.2.7 ACCESS BY EQUALITY GROUPS

The majority of participants were unable to identify any drug and alcohol services within Edinburgh city that work specifically with young people from equality groups such as BME communities, young carers, young people with disabilities, LGBT young people, and so on. Instead, participants were aware of organisations that worked with these groups generally, but not specifically, around drugs and alcohol, that is, LGBT Scotland, Edinburgh youth carers, ELREC, and so on:

> 'I think the whole Asian community, the ethnic community, are definitely being missed.' **Participant, Third Sector**

The only exception to this was Fast Forward who was identified as having a worker that is working specifically on drugs and alcohol and targeting BME communities.

Participants felt that young people from equality groups experienced a number of additional barriers to accessing services – particularly around drug and alcohol issues – with some groups being particularly vulnerable:

> 'Some young asylum seekers are here, very young, and are quite often living on their own: some about 16 and 17 in their own tenancies. They've led fairly sheltered lives back at home and they've come here and drugs are readily available.' **Participant, Third Sector**

> 'There are shame issues that people won't discuss ... parents wanting to meet with you individually because they are affected by their partners drug abuse or their child and they don't know how to overcome that situation, where to go to seek help.' **Participant, Third Sector**

Specific barriers raised by participants included:

- Cultural factors, including communities where there is particular stigma attached to drug and alcohol use;
- Lack of BME staff working within services;

- Lack of provision in different languages – with specific reference to Polish and eastern European communities;
- Concerns about the inclusiveness of services – with specific reference to LGBT young people;
- Practical barriers, such as locations having wheelchair access etc.

There was some debate around whether there was a need for specific drug and alcohol services targeting these groups, or whether all services should be accessible to any young person. Generally, participants felt that the latter approach was preferable. However, it was recognised that use by young people from equality groups does not happen without services putting in specific effort to engage with these groups and demonstrate that they are inclusive:

> 'I think that all young people should be offered the same services across the board, no matter what their background ... but I think there is a need for services to try to make sure that those least likely to access, can access.' **Participant, Third Sector**

5.3 GAPS IN PROVISION

Data from the surveys indicated that the majority of services that work with young people on drug and alcohol issues work at the Tier 1 or Tier 2 level, that is, prevention and education. This view was supported in the participant interviews where they were asked for their views on existing gaps in provision. The most common gaps in provision identified were:

- Treatment options
- 1-2-1 support/therapeutic counselling
- Ongoing support
- Services for older young people
- Staff training.

Each of these is discussed more fully below.

5.3.1 TREATMENT OPTIONS

The most common gap identified by participants was a lack of treatment options available to vulnerable young people experiencing significant harm through their use of drugs or alcohol – particularly at the Tier 3 and 4 levels.

This view was consistent with the data provided through the surveys which indicated that the majority of youth-facing services offer Tier 0 or Tier 1 provision, that is, information and advice; and prevention and early intervention:

> ‘Getting help for a young person who is obviously struggling, maybe to the point of having mental health problems and all the rest of it ... getting help for them is well on nigh impossible.’ **Participant, Third Sector**

> ‘For my client group, there aren't the services in Edinburgh that there used to be. There are no rehab or detox services in Edinburgh now.’ **Participant, Third Sector**

> ‘Lack of services, they don’t exist, lack of services for opiate use. You’ve got 2 routes: your GP or CBPS. It’s dependent on willing GPs, which there’s a lack of.’ **Participant, Third Sector**

Participants felt that the most common route for young people to access treatment services for alcohol or drug use was through primary care and/or attending adult-facing services. All participants stressed that, in their view, adult-facing drug and alcohol services were not appropriate for younger people. This included those in their early twenties who were felt to be very vulnerable and at risk of being influenced by older, more entrenched drug users:

> ‘The problem is they are not children and they are not adults, so they fall through. There’s not enough creative thinking of how we deal with that. They need to be given opportunities, so sending them to adult services isn’t age appropriate. They end up seeing their demons; adult users that they have grown up with.’ **Participant, Statutory Service**

When discussing available treatment options for young people, many participants made reference to HYPE and the gap that the closure of this service had left behind:

> ‘[Closing] HYPE did create a hole. They were very flexible in their approach, now we’re limited to what we can refer to.’ **Participant, Statutory Service**

> ‘There are always gaps. Since HYPE folded there hasn’t been a service to substitute it.’ **Participant, Statutory Service**

With the exception of HYPE, participants made limited reference to existing services that provide treatment options. This included the Adolescent Substance Use Service which has the capability to provide a range of treatments, including prescribing, to young people.

Where participants did make reference to available services and referenced the ASUS there was confusion about what it could provide, how young people accessed it (referral criteria and location of access) and in some cases an assumption that the staff member must be working to full capacity.

Related to the lack of treatment, was the view held by some participants that it is easier for young people to access support for drug or alcohol use if they get into trouble with the

police and involved in the 'system'. This included referral to adult-facing services and for some young people, at risk of secure care, support from ICCT services (this includes commissioned services provided by 6VT cafe and Cair Scotland):

> 'There is a real lack of services working with the most vulnerable young people. Many of these young people are too much trouble so the solution is seen as securing them. But this leads to a cycle of harm that is constantly feeding itself.' **Participant, Statutory Service**

This was felt to be particularly problematic, partly due to another gap identified by participants; the lack of drug and alcohol programmes for young people in secure care:

> 'If we get a young person admitted into secure for alcohol misuse or it's caused such a behaviour in terms of risk, we need to look at really good interventions to be going on in there and I don't think we've got that. **Participant, Third Sector**

> 'The key issue is that once young people are in secure units, they no longer have the chance to do intensive work as there is a change of focus. It becomes about control and punishment rather than care and recovery.' **Participant, Statutory Service**

The lack of treatment services for young people led participants to believe that young people 'slip through the net' and get picked up again as adults through a range of services – often homelessness organisations:

> 'For the few that present as chaotic, it's difficult to get them to go and seek out any help. Even though they may say they want support. The chaotic ones are the ones that tend to slip through the net.' **Participant, Statutory Service**

This was the experience of two younger people interviewed as part of the needs assessment that had started to access support for drug or alcohol addiction through their involvement with a homeless charity. Both indicated that they had wanted support earlier in their lives but didn't know where to start.

5.3.2 ONE-TO-ONE SUPPORT/THERAPEUTIC COUNSELLING

Through the surveys and participant interviews an identified gap was the availability of 1-2-1 support and counselling services for young people. Although this was seen as an issue for young people who use a range of drugs, it was raised with specific reference to cannabis use and to a lesser extent, alcohol use.

Of the services that identified as providing intensive 1-2-1 support and/or counselling, most had significant waiting lists or indicated that they were working to capacity. This was often due to these services having one worker (or less) to provide this support, or in some

instances – including the case of CREW – the counselling service was predominately being used by people aged 21 years and over.

This issue related to views that there is a lack of drug and alcohol workers within youth-facing services in Edinburgh city. Where there were workers, it was felt that they have limited capacity or restrictions on the geographic areas they could work within. It was felt that the NE and SE of Edinburgh had some provision for young people but that there was a gap in the SE:

> 'Need a city-wide thing rather than another project in the North or the East.' **Participant, Statutory Service**

5.3.3 ONGOING SUPPORT

Participants felt that there was a lack of ongoing support available to young people. This was seen as a critical gap because of the difficult pathway to recovery, particularly when people continue to live in the same environment that contributed to their misuse of drugs and alcohol.

This was felt to be an issue for young people involved in various types of drug use – from cannabis to heroin:

> 'You can stay off heroin for a week then you run into someone who tempts you into using again.' **Participant, Third Sector**

> 'I think cannabis can be quite demotivating. For their needs to be met, we need to look at longer term services ... Where someone might think they're managing, they're maintaining a change, but the service still has to be there if they do lapse or relapse. So not just meeting the needs of treatment, but there's also the after care and that takes a long process.' **Participant, Third Sector**

Linked to this issue was the view that there was also a gap in programmes of work that engage with the whole family. Again this was seen as critical because of the view that the most vulnerable young people have a history of drug or alcohol use in their family. It was felt that in the past the 'hidden harm' agenda has focused on offering support to families with younger children. Although the need for this was recognised, it was also felt that this type of work has to continue in families with teenagers – particularly where teenagers are known to be using drugs and alcohol themselves:

> 'There might be a bit of it that is about professionals working with children, but another bit of it that is about supporting parents: doing some parenting work around care and control and some of these issues.' **Participant, Statutory Service**

> ‘It’s about engaging them in activities and things they can do together so they can feel as though they are a family.’ **Participant, Third Sector**

There was some debate around who should provide ongoing support. This was largely due to the view that many of the most chaotic families have a deep mistrust for statutory services – particularly social work:

> ‘I get self-referrals because people are terrified to approach social work to say, I have a child and I have a substance problem. Because they are terrified the child will be immediately whipped off them.’ **Participant, Third Sector**

5.3.4 SERVICES FOR OLDER YOUNG PEOPLE

Linked to the above 3 gaps was the view that there is a lack of services that work specifically with older young people; that is young people aged 18 to 25 years.

This gap was clearly evident among statutory services – the majority of whom stop working with young people aged 18 years. However, it wasn’t immediately apparent when the age of 3rd sector services were reviewed; as many can engage with young people up to the age of 21 or 25 years. However, when interviewing youth-facing services it became apparent that the majority tend to work with young people in their mid-teens, that is, 13 to 16/17 years:

> ‘Often organisations lose young people after really good work due to their age through them moving into adult services or drifting back into their old life – so homelessness, offending, prostitution becoming real threats.’ **Participant, Statutory Service**

> ‘It's hard to reach young people at 18; they're maybe not engaged in other services. For the young people no longer engaged in the universal services, they are extremely vulnerable ... So concentrating on that group that have just left school and are more vulnerable to becoming entrenched in drug and alcohol [would be good].’ **Participant, Third Sector**

Within the youth focus group and interviews, it was identified that if a service is largely used by younger people it is likely that it won’t be used by those in their late teens or early twenties. Young people interviewed identified that they stopped using youth organisations about the age of 17 or 18 years:

> ‘They stop going to the projects around 14 or 15; if their pals are more interested in getting wasted, they’ll go with them.’ **Participant, young person**

5.3.5 STAFF TRAINING

There was consensus among participants about the need for well trained staff. However, whether there were specific gaps in staff training was an area of debate. Some participants felt that there was training available whilst others felt that it was very limited:

> 'I think probably across the board we're not skilled adequately.' **Participant, Third Sector**

> 'I think there is an interest and an enthusiasm and don't think that there is a difficulty at all as people are really keen to learn. In residential units people are well trained these days because there is a core group of expertise and that can be developed.' **Participant, Statutory Service**

> 'It worries me that people with very good intentions don't have the right training. Really need training so that we don't have just a bunch of do gooders doing their best.' **Participant, Statutory Service**

Participants did agree however that it can be increasingly difficult to get staff released for training – particularly at this time when there is less funding available for training and staff cover:

> 'I can imagine for us when it comes to training and things that take people out of their work. So if you're not doing your work, taking someone out for a day, that could be three groups that are affected by that. And you've got to weigh all these things up.' **Participant, Third Sector**

Whether training was sufficient was linked to participant views on models of delivery: in particular, whether young people's drug and alcohol use can be sufficiently supported by non-drug and alcohol specialists. Factors that were discussed included the level of drug and alcohol use, that is, are they dependant? And the importance of staff who have established relationships working with young people.

5.3.6 OTHER GAPS

In addition to the gaps outlined above which were raised by a larger number of participants, there were some gaps raised by specific organisations or a minority of participants. These were:

- Support to young people after A&E admission

It was raised that there is currently no system in place for the ongoing referral of young people after they have had an A&E admission due to alcohol or drug use:

> 'If there is someone who is identified as being vulnerable, obviously taking a chronically large amount of alcohol, we actually don't have a very straightforward process in terms of referring or getting follow-up with community services or alcohol or drug dependency. That's something that we find quite difficult.' **Participant, Statutory Service**

However, it was also raised that it was unclear how useful it would be to invest any significant levels of time or financial resource to this issue because of the wider debate as to how beneficial or otherwise it is to deliver an intervention when a person is intoxicated, and the potential low levels of take-up if referred to another service:

> 'It is also unclear as to how beneficial that might be, especially in this group of patients. They are often not particularly amenable to straightforward interventions with a sort of decent return on that investment if you like.' **Participant, Statutory Service**

- School nurse

This was raised by one participant who felt that the diminishing role of the school nurse was having a negative impact on the ability of universal services to pick up and respond to the health needs of young people – including substance use:

> 'Obviously some of these kids are either excluded from school and then it might fall into the domain more of the youth workers etc., but if you say a lot of our kids do go to school in this age then I think the role of the school nurse is just considerably diminished.' **Participant, Statutory Service**

- Generic youth work

Two participants raised concerns about investment in generic youth work being reduced, thus diminishing the ability of this sector to appropriately respond to the needs of young people:

> 'Access to generic youth work by young people has dropped ... There's much less concentration of CLD programmes in the community because budgets have been cut and there's a concentration much more on issues like adult learning, literacy and employability – so generic young people's work that used to be fairly well supported around substance misuse issues has dropped off.' **Participant, Third Sector**

5.4 DISCUSSION AND RECOMMENDATIONS

5.4.1 SERVICE PROVISION AND GAPS

Although the tiered model of service delivery is widely advocated in the literature, the models of service provision available do not fit neatly into the tiers. There are 3 models of service operating largely at tier 2 and partially at tier 2 (models 1, 2 and 3). In addition model 4 provides support for services to address the needs of young people in relation to drug and alcohol use. Models 5 and 6 appear to be operating largely at tier 3 but there is some question as to whether these services have the capacity. Therefore the main gaps appear to be around tier 2 and tier 3-4 (especially in relation to secure care).
Within services working at tier 2 there is limited evidence of 'specialist youth workers'. A very small number of services made reference to them and in all cases these were alcohol workers within services with specific geographic remits. This means that building capacity for generic staff who are trained to have an additional focus or specialism (i.e. a youth worker with a special interest/skill in drugs/alcohol, but not a drug and alcohol worker) is a key area for development for addressing the needs of the mid-teens who are drinking at 'worrying' levels or who are dependent on cannabis. These young people are not, from the evidence available, currently well served. This is due to the gap in one-to-one counselling, and the lack of training available to staff to help develop this specialism. These young people are probably at risk of moving onto more serious problematic use, but it feels like there is an acceptance that they're not ready to change thus there is a wait until the problem escalates and is picked up at a later time.

There is some evidence base to support this approach, particularly in relation to alcohol. Brief interventions are usually one off encounters and usually take 5-10 minutes. However, most of the evidence for efficacy is from a Primary Care setting (Kaner et al 2009) and the evaluation of impact of brief interventions in youth work and other settings is still an emerging field.

Monti et al., (2001) suggest that "brief interventions can be effective in a variety of contexts, particularly when delivered at a teachable moment". As adolescents do not typically identify themselves as problem drinkers, it seems that this proactive approach to screening and intervention might be suitable for non-school environments as a more effective way of including a wider segment of the population (Monti et al. 2001). It is possible that where teens have already experienced some discomfort as a result of their actions, the "teachable moment" or "window of opportunity" may well be reinforced (Monti et al 2001). Both Monti et al. (2001) and Baer and Peterson (2002) have shown brief interventions and motivational interviewing to be effective at reducing alcohol related risk in 18 to 19 year olds but less successful in those aged 13 to 17. Cambridge and Strang's (2004) multi-site cluster randomised trial in Further Education colleges has found that a single session of motivational interviewing is effective in reducing multiple drug use

(cigarettes, alcohol and cannabis) amongst young people, when compared to a non-intervention control. The techniques may be a useful approach for outreach or initial engagement the brief format is appropriate for use in informal settings (Baer and Peterson 2002). This makes it ideal for detached work and drop-in youth centres.

There is a considerable amount of guidance under development in relation to this (e.g. from the National Institute of Alcohol Abuse and Alcoholism) and further evaluations of impact will be forthcoming as models are rolled out. This is a promising area for development and should be considered as a way of making best use of known and trusted workers in accessible locations. It is important to note that this would not fill the gap in relation to on-to-one counselling. It may be that across a team, different workers might be able to develop different topic specialisms.

Recommendation: Development of more specialist youth work posts to provide interventions across a range of different drug use topics incorporating health behaviour change, motivational interviewing and brief intervention approaches. (See also recommendations under "staff development" and "holistic approach"

Gaps were identified at tier 2 in relation to re one-to one counselling and ongoing support. Existing counselling services often have significant waiting lists and some tended to be more widely used by people aged over 21. Geographical coverage was also raised as an issue.

Recommendation: Increased availability of treatment options (at Tier 2) available specifically for young people who are experiencing increasing levels of harm from their drug or alcohol use. This level of support should be provided away from adult treatment services and should include one-to-one counselling and ongoing support available across the whole city of Edinburgh (although potentially centrally located operating on a peripatetic basis).

Another gap identified was in relation to programmes of work that engage with the whole family. It is perceived that the priority for family work is often families with younger children. However, there is a need for support for families with teenagers who are using alcohol and drugs themselves. It is suggested that a two-pronged approach is taken to addressing this. Rather than setting up a separate service to work on family interventions or to support parents, it is suggested that the core principles of work (see above) should encourage all services to work with young people in the context of their families. In addition, there is potential for the type of organisation identified as Model 4 to build capacity and provide support for services to do this effectively.

Recommendation: Investigation of the potential for Model 4 type organisations to build capacity and provide support for services to respond to the needs of young people in the context of their families and to support parents where appropriate. This would include development of a model for family support in line with the principles suggested above.

The most common gap identified was lack of treatment options available to vulnerable young people experiencing significant harm, particularly at Tier 3 and 4. Frequently young

people seem to access adult services, which were not seen to be appropriate for younger people. Although there was some awareness of the Adolescent Substance Use Service, there was some confusion about what the service provided. Particular gaps were highlighted for young people in secure care. Although part of this problem could be resolved by greater awareness of existing services there was still seen to be a limited capacity to meet demand.

Recommendation: Increase availability of treatment options (at Tiers 3 and 4) available to young people who are experiencing significant harm from their drug or alcohol use, especially in secure care. This level of support should be provided away from adult treatment services but could be delivered through expansion or reconfiguration of existing services.

The variety of approaches across tiers 1 and 2 indicates that, without a common consistent approach to identifying and responding to need, the services offered to young people across the city may vary hugely depending on who picks up on the problem

Recommendation: Develop, for Tier 1 and 2 services, a consistent, clear and detailed process (or set of criteria) for identifying and responding to young people's many and varying substance-related needs. This should include clear pathways for referral to another service where this is deemed to be more appropriate.

Considerable support was noted for addressing a young person's alcohol and drug use as part of a more holistic approach to addressing risk taking behaviour. However, within that, it is clear that the main substances being used by young people are alcohol and cannabis with the latter having potential for significant impact on a young person's mental health. Identified barriers to access to services are not insurmountable. There is potential to learn from extensive work in other topic areas related to young people's health, including the work surrounding 'Walk the Talk' (NHS Health Scotland) initiative and in the area of sexual health. It may be possible to make links with more established services that have developed in youth friendly way. This would fit well with a risk behaviour approach. Overall a holistic approach is advocated but with development to address specific gaps in relation to interventions for cannabis use.

Recommendation: Greater links across topics to learn from other areas of health improvement – in particular youth health service provision, tobacco interventions and sexual health service provision.

Recommendation: Greater recognition of the harm that can come from cannabis use and further discussion on the best way to tackle increased use of cannabis among young people/ services that can support cannabis use across range of need

5.4.2 AWARENESS OF AND ACCESS TO SERVICES (GEOGRAPHY, AGE AND EQUALITY GROUPS)

In general, access to services was highlighted as a strength in the assessment. However, there are inconsistencies in relation to what services are available across different parts of the city. In particular the need for citywide access to counselling services was highlighted. However, citywide access does not necessarily mean service bases should be located across the city but there is scope to explore the extent to which services could be provided from a range of locations citywide. The opening times and acceptability of some services to young people can be a barrier and therefore services such as counselling should ideally be offered in locations that young people can travel to easily and feel comfortable using, at a time that takes into account their often complex lifestyles. At Tiers 3 and 4 it may be more practical for services to be centrally located but measures should be put in place to address identified barriers to access and use.

Recommendation: Development of services across the city to address geographical gaps in relation to the lower Tiers (particularly Tier 2). This may be resolved through increased partnership working and offering services such as counselling from a variety of community bases through partnership arrangements. Measures to address barriers to use for centrally located services in tiers 3 and 4.

There is a lack of consistency in the age range of young people that services work with. In many instances there seems to be a frustration that good work is undone because contact has to stop when the young person reaches a certain age. This needs assessment indicates that many young people want to access support in their upper teens but there a lack of youth appropriate services available to them. Therefore many end up using adult provision and the literature and this needs assessment would concur that adult provision is not suitable for them.

Recommendation: Agreement regarding greater consistency in age that youth facing services work with ideally across all organisations (statutory and Third Sector). This may have implications in relation to funding criteria for externally funded services so this potentially may only apply ADP funded projects

There are very limited specialist alcohol and drug services that are designed to target specific equality groups. However, development of specialist services is not seen to be the solution to this. Efforts should be made to ensure that mainstream services are adapted to meet the needs of people included in the protected characteristics of the Equality Act 2010. The most robust way to achieve this would be by carrying out thorough Equality Impact Assessments of existing and proposed services in line with the interim guidance for Scottish Public Authorities provided by the Equality and Human Rights Commission (2011).

Recommendation: Equality Impact Assessments to be completed and where possible, recommendations enacted across all services across all Tiers. Support and guidance may need to be provided for this to be a meaningful exercise that achieves the intended outcome of more accessible services for equality groups.

Key gap is services that are addressing the needs of the mid-teens who are drinking at 'worrying' levels or who are dependent on cannabis. Essentially it would seem that there are specific gaps for providing support to non-opiate users who are showing some indications of existing problematic use or use that could escalate. This includes young people who have well established patterns of cannabis use but differing wider needs i.e. everyday smokers but otherwise have relatively stable lives i.e. attend school etc; young people who use cannabis and have other multiple needs – chaotic family life, are in care etc. This raises significant questions about where these young people should go? How can they access services without requiring to escalate drug use, get into trouble with police? be very proactive themselves?

Recommendation: services that can support cannabis use across range of need.

Current gap in specialist staff for young people so that their needs can be met within generic services without need for external referral (at tier 2). At moment no evidence that the needs of young people across Edinburgh City who have emerging issues with drugs or alcohol are being met – particularly within tier 2 services. However this could also be a reflection of poor monitoring data and useful information on capacity which makes it difficult to give definitive answers to number of young people with unmet need and service availability.

Recommendation: increased availability of treatment options available to young people who are experiencing significant harm from their drug or alcohol use. This level of support should be provided away from adult treatment services

There appeared to be a lack of awareness of the few services that can provide treatment options to young people.

Recommendation: Improved approach to awareness raising to promote what provision is available to young people. This should include marketing targeting staff within services and young people themselves.

5.4.3 STAFF DEVELOPMENT

There was consensus across participant views that there is a need for well trained staff, however some participants felt that adequate training is available but others felt that opportunities were limited. No recent comprehensive training needs analysis across the sector was found. It was highlighted that is often difficult to release staff for training due to the pressures if service delivery.

Recommendation: Specific training to support development of specialist youth work posts interventions across a range of different drug use topics incorporating health behaviour change, motivational interviewing and brief intervention approaches

One of the main areas where training would be required to build capacity at Tier 2 among youth services would be to support the development of more specialist youth worker roles in generic settings.

Recommendation: Carry out training needs analysis across tiers for staff working in the sector to highlight areas where development is needed and prioritise these to develop workforce development programme.

6. CONCLUSIONS AND RECOMMENDATIONS

This chapter draws together the main themes from each chapter and clarifies and combines all of the recommendations with some additional recommendations based on reflection of the overall findings. It concludes with a full list of all the recommendations

6.1 DEFINITIONS, KEY PRINCIPLES AND PROCESSES

There is no commonly agreed definition of problematic drug use amongst young people. This means that decisions about service delivery are left to subjective interpretation of young people's circumstances. The purpose of providing a definition is not to label young people but to support the process of identifying an individual's needs and respond appropriately. Therefore, it is suggested that as a starting point across the ADP a common understanding should be reached in relation to what constitutes problematic use for young people. Only then will it be possible to quantify the number of young people in need of support with substance use issues to support service planning.

In addition, the literature review highlights key policy principles for the delivery of young people's substance misuse treatment services. These could be expanded and adapted to provide a useful a starting point for an agreed way forward locally. Although these wouldn't provide specific guidance for actual service delivery they would clarify expectations around minimum standards and frame the services delivered in a local context. The principles could make explicit reference to Getting it Right for Every Child (GIRFEC), child protection guidance and frameworks with young people in a context of a family. This would support an integrated approach to working with families across the tiers (see recommendation 5 below). The principles could be quite generic to allow for the number of services that do not provide an alcohol and drug specific service but may still want to sign up to the principles.

Recommendation 1: At ADP level, facilitate collaborative development and agreement of the following:

- **Common definitions (or a range of indicators) of different kinds of problematic drug use.**
- **Tailored set of key principles for service delivery taking into account local priorities.**

Once this definition is agreed, it will be easier to establish prevalence. Particular gaps were identified in the prevalence data in relation to the needs of young people from particular equality groups, in particular ethnicity.

Recommendation 2: Specific research is required into the use of drugs and alcohol and the impact of that use on young people from different equality groups; particularly those from areas of recent migration such as Eastern Europe.

The tiered model of services is widely recognised and recommended in the literature. However, the tiered model was not within the mindset or vocabulary of the majority of people working at Tiers 1 and 2. The tiered approach is summarised in table 1 overleaf.

The tiered approach has clear advantages in providing a recognised framework for conceptualising services and making it simpler to demonstrate the links between them and other fields such as mental health, social work and youth offending. This is demonstrated in Figure 1, which offers a suggestion for linking the Tiers Model to the GIRFEC Children's Services Delivery Model for Edinburgh. This could be expanded and made more practical by producing tailored documents outlining referral pathways. This would assist with referrals in from A&E and school nurses, both mentioned in the assessment. In addition, one of the weaknesses highlighted was the feedback provided to referring organisations from specialists. A greater understanding of the tiered model could assist services to work together more effectively.

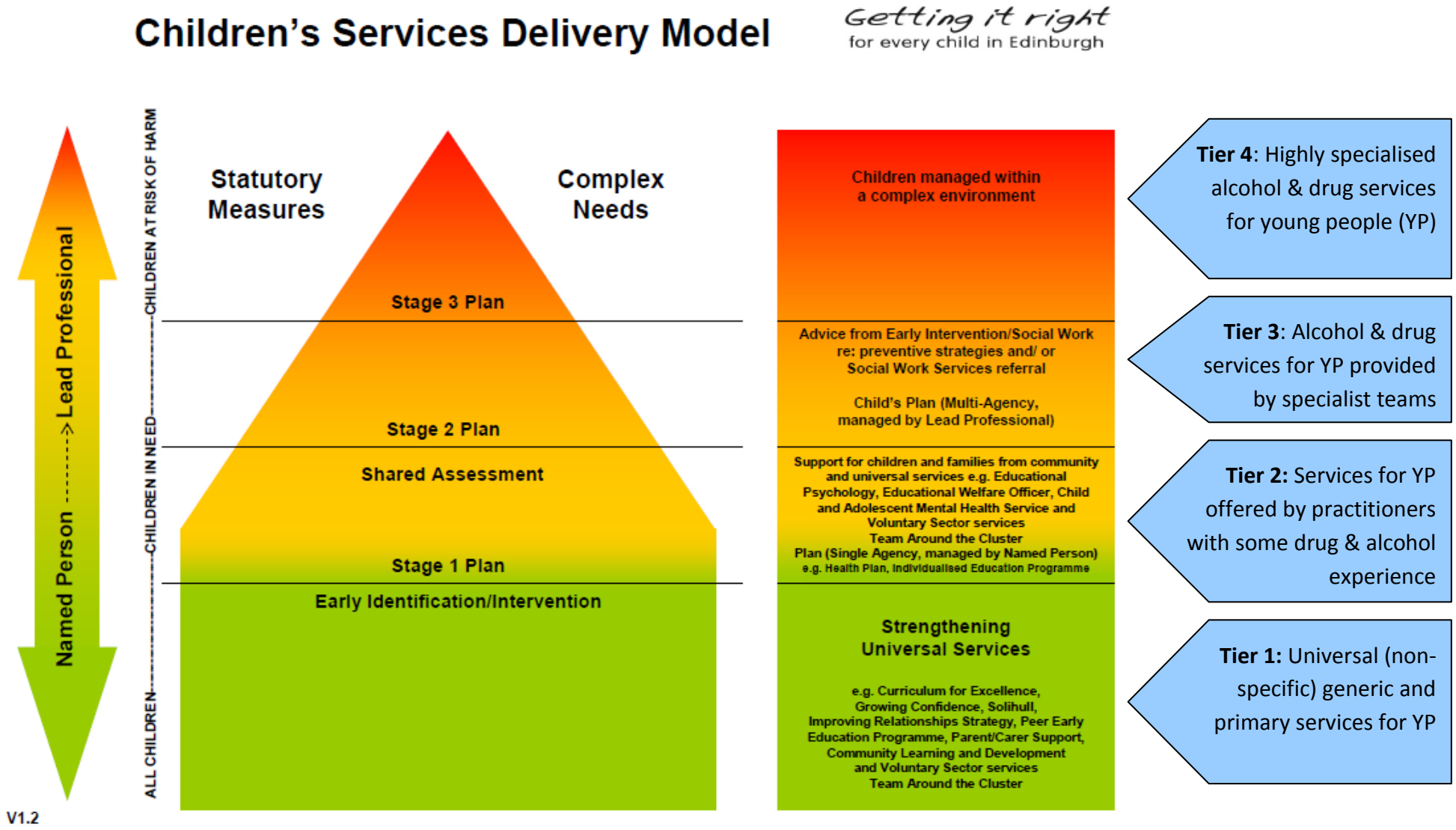
Furthermore, the literature highlights the need for a clear means of assessment of the level of substance misuse issues a young person has. There is no consistent approach to this or to the levels of support a young person may receive in relation to their need. Many staff expressed that they would not be comfortable using a formal tool and were uncomfortable with the term "assessment" as a whole. It may be more helpful to this as an approach to "identifying needs" to take account of the generic nature of services operating at Tiers 1 and 2. However, a more standardised approach to identifying needs and clarifying the services to offered/delivered dependent on these would be beneficial in line with the "First Steps" guidance (Britton & Noor 2003). This should ensure that young people across the city are able to access a consistent level of service.

Finally, there are inconsistencies in the way that service data is monitored. This provides a challenge for data aggregation and establishing an overall picture. This is partly a reflection of the fact that many of the services included in the assessment are not primarily drug and alcohol focussed. However, a more standardised approach would be beneficial, at a minimum for services funded by the ADP. Analysis of monitoring data has an important role in improving practice and therefore any proposed system should outcome focussed where possible and include elements deemed to be a priority for delivery (i.e. equality data, appropriate referrals as opposed to just signposting)

Table 1: Tiered Model of Alcohol and Drug Services for Young People

Tier	Examples:	Delivered by:
Tier 1: Universal (non-specific) generic and primary services for YP • Services offered by all mainstream providers including education, health and child protection. • Purpose is to ensure universal access and continuity of advice and care for all young people. • Provide information & advice about substances as part of a general health improvement agenda & screen those who are vulnerable or who have problems	Information/education concerning tobacco, alcohol and drugs within the education curriculum, educational assessment and support to remain in school, identification of risk issues, general medical services/routine health screening	Teacher, generic youth worker, Careers Advisor, school health services, benefits agency, housing services etc.
Tier 2: Services for YP offered by practitioners with some drug & alcohol experience • Provided by youth service providers with some experience of substance misuse issues and specialist working with young people. • Aim to reduce the risks of vulnerable young people and to reintegrate and maintain young people in mainstream services.	Advice and information, activities/education to address offending, family support, assessment of risk/protection issues, counselling re lifestyle issues, educational assessment.	Youth Offending Team/bail support, specialist youth worker, mentor, social services, counselling, one stop shop/drop-in service, educational psychology, GPs, Brief Intervention in Primary Care.
Tier 3: **Alcohol & drug services for YP provided by specialist teams** • Provided by specialist drug services and other specialist teams working with complex cases, working as multi-agency teams. • Aim is to identify and deal with the complex needs of children and young people, not just their substance misuse needs. • Services work towards reintegrating children and young people with family, community, school or workplace and mainstream services.	Specialist assessment leading to a planned package of care and treatment augmenting that already provided by Tiers 1 and 2 and integrated with them. Specialist substance specific interventions including mental health issues, family assessment and involvement, interagency planning and communication.	Specialist youth drug and alcohol services integrated with Child Adolescent Mental Health Services (CAMHS), Community Drug/Addiction Teams, Drug Dependency Units, Community Rehabilitation, Day Treatment.
Tier 4: Highly specialised alcohol & drug services for YP • Specialist medical interventions for those young people with complex care needs. • For a small number of young people, intense intervention could include prescribing substitutes, detoxification and treatment or residential respite care.	Short period of accommodation if in crisis, inpatient/day psychiatric or secure unit to access detoxification if required, continued Tier 3 and multi-agency involvement alongside Tier 1 and Tier 2, specialist inpatient, partial hospitalisation, medical/psychology outpatients, co-morbidity provision, residential rehab.	Forensic child and adolescent psychiatry, social services, continued involvement from young people's substance misuse services, substantial support for education.

Figure 1: Suggested Mapping of Young People's Alcohol and Drug Services Tiers Model to Children's Services Delivery Model



Recommendation 3: Engage partners at ADP level in a process to agree guidance and provide support for young people's services in relation their role within the tiers model, referral pathways and standard approaches to identifying needs and monitoring data. This guidance should:

- **Assist services to conceptualise what they are (or should be) providing to young people to meet their substance related needs; the scope and limits of the competence of staff and current service provision; and how that all fits within a spectrum of provision across the Tiers.**
- **Provide, for Tier 1 and 2 services, a consistent, clear and detailed process (or set of criteria) for identifying and responding to young people's many and varying substance-related needs, possibly in line with the First Steps guidance (Britton & Noor 2003)**
- **Outline clear pathways for referral to another service where this is deemed to be more appropriate.**
- **Explain minimum monitoring requirements (at least for ADP funded projects). This should include minimum requirements for monitoring equality information in line with the Equality Act 2010.**

6.2 SERVICE DEVELOPMENT

One of the key strengths highlighted was the breadth of generic youth provision available, although little of this has an alcohol and drugs primary role. It was also suggested that frequently the focus of generic youth provision has shifted towards the employability agenda. Services at this level mainly provided an advice and information role with signposting and some scope to provide one-to-one support or brief interventions. There was no evidence of specialist youth workers operating in generic settings. This is an area that could be developed to broaden the coverage and increase the impact of services at Tier 2, making best use of the good relationships already built up by practitioners working in this sector (except where clear role conflict occurs).

Considerable support was noted for addressing a young person's alcohol and drug use as part of a more holistic approach to addressing risk taking behaviour. However, within that, it is clear that the main substances being used by young people are alcohol and cannabis with the latter having potential for significant impact on a young person's mental health. Overall a holistic approach is advocated but with development to address specific gaps in relation to interventions for cannabis use.

Specific gaps were identified at tier 2 in relation to re one-to one counselling and ongoing support citywide. Existing counselling services often have significant waiting lists and some tended to be more widely used by people aged over 21.

In general, access to services was highlighted as a key strength in the assessment. However, there are inconsistencies in relation to what services are available across different geographical areas of the city. Citywide access does not necessarily mean service bases should be located across the city but there is scope to explore the extent to which services could be provided from a range of locations citywide. The opening times and acceptability of some services to young people can be a barrier and therefore services such as counselling should ideally be offered in locations that young people can travel to easily and feel comfortable using, at a time that takes into account their often complex lifestyles.

The most common gap identified was lack of treatment options available to vulnerable young people experiencing significant harm, particularly at Tier 3 and 4. Frequently young people seem to access adult services, which were not seen to be appropriate for younger people. Although there was some awareness of the Adolescent Substance Use Service, there was an element of confusion about what the service provided. Particular gaps were highlighted for young people in secure care. Although part of this problem could be resolved by greater awareness of existing services there was still seen to be a limited capacity to meet demand.

Recommendation 4: Development of services at Tiers 2, 3 and 4 are suggested as follows:

- **More specialist youth work posts to provide interventions across a range of different drug use topics incorporating health behaviour change, motivational interviewing and brief intervention approaches. (See also recommendations under "workforce development" below)**
- **Greater recognition of the harm that can come from cannabis use and further discussion on the best way to tackle increased use of cannabis among young people/ services that can support cannabis use across range of need.**
- **Increased availability of treatment options (at Tier 2) specifically for young people who are experiencing <u>increasing levels of harm</u> from their drug or alcohol use. This level of support should be provided away from adult treatment services and should include one-to-one counselling and ongoing support available across the whole city of Edinburgh. This may be centrally located operating from a variety of community bases through partnership arrangements**
- **Increased availability of treatment options (at Tiers 3 and 4) available to young people who are experiencing <u>significant harm</u> from their drug or alcohol use, especially in secure care. This level of support should be provided away from adult treatment services but could be delivered through expansion or reconfiguration of existing services.**

Another gap identified was in relation to programmes of work that engage with the whole family. It is perceived that the priority for family work is often families with younger

children. However, there is a need for support for families with teenagers who are using alcohol and drugs themselves. It is suggested that a two-pronged approach is taken to addressing this. Rather than setting up a separate service to work on family interventions or to support parents, it is suggested that the core principles of work (see above) should encourage all services to work with young people in the context of their families. In addition, there is potential for organisations that provide support to services to build capacity and provide support for existing services to work with families effectively.

Recommendation 5: Investigation of the potential for organisations that provide specialist drug and alcohol support <u>for services</u> to build capacity and provide support for existing services to respond to the needs of young people in the context of their families and to support parents where appropriate. This would include development of a model for family support in line with the principles suggested above.

6.3 SERVICE DELIVERY

It was noted in the findings that engaging with young people after the age of 16 can be increasingly difficult, often due to the tendency of young people to opt out of mainstream youth provision after this age. However, there is also the potential for young people to 'fall through the gaps' in the transition to adult services. It was recognised that some problems experienced by young adults could be addressed by earlier access to appropriate services as a young person. It was also noted that young people aged 18 to 25, although in theory eligible for adult services may not find these suitable for their needs. There is a lack of consistency across the services regarding age cut off points and it would be helpful to address this in order to provider a service that best meets the needs of young people in the transition to adulthood, up to 21 or even possibly 25. In addition, limited service provision was identified that addressed specific equality groups

Recommendation 6: Agreement regarding greater consistency in age that youth facing services work with ideally across all organisations (statutory and Third Sector). This may have implications in relation to funding criteria for externally funded services so this potentially may only apply ADP funded projects

Recommendation 7: Robust Equality Impact Assessments of individual services should be completed and where possible recommendations enacted across all services across all Tiers. Support and guidance may need to be provided for this to be a meaningful exercise that achieves the intended outcome of more accessible services for equality groups.

One of the barriers identified in relation to access for young people was lack of awareness of services and potential confusion over what services are offered by whom. This was partially echoed by services themselves. In addition, one of the weaknesses raised in the assessment was the way that young people who use drugs are represented in the media.

Recommendation 8: Improved approach to raising awareness and promotion of provision available to young people (taking into account the needs of different equality groups). This should include:

- **Appropriate marketing and communication targeting staff within services and young people themselves, using electronic and print media where necessary**
- **Guidance for a standard approach to communications with the media and public across the city providing accurate information in context and suggestions regarding suitable language.**

6.4 WORKFORCE DEVELOPMENT

There was consensus across the literature and participant views that there is a need for well trained staff. The literature provides minimum standards for staff working with young people aged under 18. Some participants felt that adequate training is available but others felt that opportunities were limited. However it was recognised that is often difficult to release staff for training due to the pressures if service delivery. There is a balance to be struck in order to maintain service quality. One of the main areas where training would be required to build capacity at Tier 2 among youth services would be to support the development of more specialist youth worker roles in generic settings.

Recommendation 9: Carry out training needs analysis across tiers for staff working in the sector to highlight areas where development is needed and prioritise these to develop workforce development programme.

Recommendation 10: Specific training to support development of specialist youth work posts interventions across a range of different drug use topics incorporating health behaviour change, motivational interviewing and brief intervention approaches

6.5 PARTNERSHIP WORKING

Partnership working was highlighted as one of the main strengths of the current provision. However, it was also noted that this was in the context of decreasing generic youth work services. There is also the additional challenge of operating in competitive and often short-term funding environment Partnership working should be enhanced by many of the recommendations above, in particular, framing services in relation to the Tiers Model and clearer referral pathways will provide greater understanding of how services fit together to best meet the needs of young people. However, partnership working could be greater enhanced in two ways.

Considerable support was noted for addressing a young person's alcohol and drug use as part of a more holistic approach to addressing risk taking behaviour. However, within that,

it is clear that the main substances being used by young people are alcohol and cannabis with the latter having potential for significant impact on a young person's mental health. A holistic approach is advocated and there is potential to learn from and link to services across a range of health improvement topics.

Recommendation 11: Greater links across topics to learn from other areas of health improvement – in particular youth health service provision, tobacco interventions and sexual health service provision.

In addition, partnership working could be enhanced by opportunities for involvement in a future model of service delivery. It was also noted that the level of involvement of young people in the needs assessment was disappointing. However, this reflects the challenge that workers face in engaging with the client group. It is suggested that further development of service models or delivery or implementation of any of the recommendations above should, where possible, involve not only partners and staff but also young people. This should make use of appropriate methods and be in line with recognised standards (such as the National Standards for Community Engagement).

Recommendation 12: Collaborative approach to service development and implementation of recommendations involving, where appropriate, ADP partners, staff and young people using appropriate methods.

FULL LIST OF RECOMMENDATIONS

Recommendation 1: At ADP level, facilitate collaborative development and agreement of the following:

- **Common definitions** (or a range of indicators) of different kinds of problematic drug use.
- Tailored set of **key principles** for service delivery taking into account local priorities.

Recommendation 2: Specific research is required into the use of drugs and alcohol and the impact of that use on young people from different **equality groups**; particularly those from areas of recent migration such as Eastern Europe.

Recommendation 3: Engage partners at ADP level in a process to **develop and agree guidance and provide support** for young people's services in relation their role within the tiers model, referral pathways and standard approaches to identifying needs and monitoring data. This guidance should:

- Assist services to conceptualise what they are (or should be) providing to young people to meet their substance related needs; the scope and limits of the competence of staff and current service provision; and how that all fits within a spectrum of provision across the Tiers.
- Provide, for Tier 1 and 2 services, a consistent, clear and detailed process (or set of criteria) for identifying and responding to young people's many and varying substance-related needs, possibly in line with the First Steps guidance (Britton & Noor 2003)
- Outline clear pathways for referral to another service where this is deemed to be more appropriate.
- Explain minimum monitoring requirements (at least for ADP funded projects). This should include minimum requirements for monitoring equality information in line with the Equality Act 2010.

Recommendation 4: Development of services at Tiers 2, 3 and 4 are suggested as follows:

- More specialist youth work posts to provide interventions across a range of different drug use topics incorporating health behaviour change, motivational interviewing and brief intervention approaches. (See also recommendations under "workforce development" below)
- Greater recognition of the harm that can come from cannabis use and further discussion on the best way to tackle increased use of cannabis among young people/ services that can support cannabis use across range of need.

- Increased availability of treatment options (at Tier 2) specifically for young people who are experiencing increasing levels of harm from their drug or alcohol use. This level of support should be provided away from adult treatment services and should include one-to-one counselling and ongoing support available across the whole city of Edinburgh. This may be centrally located operating from a variety of community bases through partnership arrangements
- Increased availability of treatment options (at Tiers 3 and 4) available to young people who are experiencing significant harm from their drug or alcohol use, especially in secure care. This level of support should be provided away from adult treatment services but could be delivered through expansion or reconfiguration of existing services.

Recommendation 5: Agreement regarding greater **consistency in age range** that youth facing services work with ideally across all organisations (statutory and Third Sector). This may have implications in relation to funding criteria for externally funded services so this potentially may only apply ADP funded projects

Recommendation 6: Robust **Equality Impact Assessments** of individual services should be completed and where possible recommendations enacted across all services across all Tiers. Support and guidance may need to be provided for this to be a meaningful exercise that achieves the intended outcome of more accessible services for equality groups.

Recommendation 7: Investigation of the potential for organisations that provide specialist drug and alcohol support for services to build capacity and provide support for existing services to **respond to the needs of young people in the context of their families** and to support parents where appropriate. This would include development of a model for family support in line with the principles suggested above.

Recommendation 8: Improved approach to **raising awareness and promotion** of provision available to young people (taking into account the needs of different equality groups). This should include:

- Appropriate marketing and communication targeting staff within services and young people themselves, using electronic and print media where necessary
- Guidance for a standard approach to communications with the media and public across the city providing accurate information in context and suggestions regarding suitable language.

Recommendation 9: Carry out **training needs analysis** across tiers for staff working in the sector to highlight areas where development is needed and prioritise these to develop workforce development programme.

Recommendation 10: Specific training to support development of specialist youth work posts interventions across a range of different drug use topics incorporating health behaviour change, motivational interviewing and brief intervention approaches

Recommendation 11: Greater **links across topics** to learn from other areas of health improvement – in particular youth health service provision, tobacco interventions and sexual health service provision.

Recommendation 12: Collaborative approach to service development and implementation of recommendations involving, where appropriate, ADP partners, staff and young people using appropriate methods.

REFERENCES

Baer, J.S. and Peterson, P.L. (2002) 'Motivational Interviewing with Adolescents and Young Adults' in Miller, W.R. and Rollnick, S. (2002) *Motivational Interviewing* (2nd edn.) New York: Guildford Press

Bradby, H. and Williams, R. (2006) Is Religion or Culture the Key Feature In Changes in Substance Use after Leaving School? Young Punjabis and a Comparison Group in Glasgow. Ethnicity and Health. Vol. 11, No. 3, 307 324.

Bradshaw, P. (2003) Underage Drinking and the Illegal Purchase of Alcohol. Scottish Executive Social Research Report.

Britton, J., and Noor, S. (2003) First Steps in Identifying Young People's Substance Related Needs. London: Home Office. Available at: http://www.drugscope.org.uk/resources/goodpractice/treatment/youngpeople

Burniston, S. Dodd, M., Elliott, L., Orr, L. and Watson, L. (2002) Drug treatment services for young people: A research review. Edinburgh. Scottish Executive.

Burrell, K., Jones, L., Sumnall, H., Mcveigh, J and Bellis, M. (2005) Tiered Approach to Drug Prevention and treatment among young people. National Collaborating Centre for Drug Prevention

Cambridge, J. and Strang, J. (2004) 'The efficacy of single session motivational interviewing in reducing drug consumption and perceptions of drug-related risk and harm among young people: results from a multi-site cluster randomised trial' *Addiction*, Vol. 99, pp. 39-52

Childline (2006) Childline Casenotes: Alcohol and Teenage Sexual Activity. http://www.nspcc.org.uk/Inform/publications/casenotes/clcasenotesalcoholandteenagesex_wdf48184.pdf [Accessed 1st November 2011.]

City of Edinburgh Council (2009) Services for Communities Annual Neighbourhood Survey, Customer Information and Research Team

City of Edinburgh Council (2011) Edinburgh by Numbers 2011/12. Economic Development Service

Currie, C., Levin, K., Kirby, J., Currie, D., van der Sluijs, W., and Inchley, J. (2011) Health Behaviour in School-Aged Children: World Health Organization Collaborative Cross-National Study. Findings from the 2010 HBSC Survey in Scotland. Child and Adolescent Health Research Unit; The University of Edinburgh.

Department of Health (2002). Models of Care for Substance Misuse Treatment: Consultation Document, London, Department of Health

Drugscope (2005) Needle Exchange for Young people under 18 years old: a framework for providing needle exchange to young people

Drugscope (2006) Drugs: Guidance for the Youth Service

Drugscope (2009) Young people's specialist substance misuse treatment: Exploring the evidence

Drugscope (2010) Young people's drug and alcohol treatment at the crossroads

Edinburgh Alcohol and Drugs Partnership (2011) Children, Young People and Families Action Plan 2011-2014

Edinburgh Alcohol and Drugs Partnership (2011) Alcohol and Drug Strategy: A framework for partnership action 2011–2014

Effective Interventions Unit (2003) Services for young people with problematic drug misuse: A guide to principles and practice. Substance Misuse Division, Scottish Executive, Edinburgh.

Equality and Human Rights Commission Scotland (2011) Meeting Public Sector Equality Duty in Scotland. Intermin Guidance for Scottish Public Auhtorities: Assessing Impact.

Furlong A, Cartmel F, Poweney J, and Hall S (1997) Evaluating Youth Work with Vulnerable Young People. The Scottish Council for Research in Education.

Figure 8 (2010) Needs Assessment of Drug and Alcohol Problems in Edinburgh. Edinburgh Alcohol and Drugs Partnership.

Fitzgerald, N (2011) Alcohol, Drugs and Youth Work. A training manual for youth workers. Glasgow: NHS Greater Glasgow and Clyde.

Forsyth, A., and Lightowler, C. (2009) Alcohol and Violence among Young Male Offenders in Scotland (1979-2009) (SCCJR Briefing Paper) http://www.sccjr.ac.uk/pubs/Alcohol-and-Violence-among-Young-Male-Offenders-in-Scotland-1979-8208-2009/133 [Accessed 18th November 2011]

General Register Office for Scotland (2011)City of Edinburgh Council Area – Demographic Factsheet. http://www.gro-scotland.gov.uk/files2/stats/council-area-data-sheets/edinburgh-city-factsheet.pdf [Accessed 14 Dec 2011]

Griesbach, D., and Currie, C. (2001) Health Behaviours of Scottish Schoolchildren: Report 7: Control of Adolescent Smoking in Scotland. Child and Adolescent Health Research Unit, University of Edinburgh.

Health Advisory Service (2001) Review 2001: The Substance of Young Needs

Institute of Alcohol Studies (2010) Alcohol and Adolescents : IAS Factsheet. Accessed 31st October. http://www.ias.org.uk/resources/factsheets/adolescents.pdf

Joint Addiction Training Board (2003) Proposed Knowledge, Skills and Approaches to Addressing Alcohol & Drug Issues for Generic Staff in Health and Social Care. Produced by representatives of NHS Greater Glasgow and Glasgow City Council.

Kaner, E.F., Dickinson, H.O., Beyer, F.R., Campbell, F., Schlesinger, C., Heather, N., Saunders, J.B., Burnand, B. and Pienaar, E.D. (2009) Effectiveness of brief alcohol interventions in primary care populations (Review) Cochrane Database of Systematic Reviews 2007, Issue 2. Art. No.: CD004148. DOI: 10.1002/14651858.CD004148.pub3.

Kirby, J., van der Sluijs, W. and Inchley, J. (2008) *Young people and substance use: The influence of personal, social and environmental factors on substance use among adolescents in Scotland*. Edinburgh: NHS Health Scotland.

Lanarkshire ADAT Young People's Treatment Task Group (2006) *Tier 3 & 4 Young People's Substance Misuse Services.* Found at http://www.lanarkshireadp.org/Professionals/Publications/Local/Documents/YPTTG_FinalDraft.pdf

McAra, L. (2004) Truancy, School Exclusion and Substance Misuse. Edinburgh Study of Youth Transitions and Crime Research Digest No. 4. Edinburgh.

McKeganey, N., McIntosh, J., MacDonald, F., Gannon, M., Gilvarry, E., McArdle, P. and McCarthy, S. (2004) Preteen children and illegal drugs. *Drugs: Education, Prevention and Policy,* 11: 315-327.

McKinlay, W, Forsyth, A.J.M. and Khan, F. (2009) Alcohol and Violence among Young Male Offenders in Scotland (1979 - 2009) Scottish Prison Service.

McVie, S. and Bradshaw, P. (2005) Adolescent Smoking, Drinking and Drug Use at Ages 12 to 17, Edinburgh Study of Youth Transitions and Crime Research Digest No.7, Edinburgh

McVie, S. and Holmes, L. (2005) Family Functioning and Substance Use at Ages 12 to 17, Edinburgh Study of Youth Transitions and Crime Research Digest No. 9, Edinburgh

McVie, S. and Norris, P. (2006) Neighbourhood effects on youth delinquency and drug use. Edinburgh Study of Youth Transitions and Crime Digest Report No. 10, Edinburgh.

Meltzer, H., Lader, D., Corbin, T., Goodman, R. and Ford, T. (2004) The mental health of young people looked after by local authorities in Scotland. The Stationery Office. Edinburgh

Miller, W.R. and Rollnick, S. (2002) Motivational Interviewing (2nd edn.) New York: Guildford Press

Monti, P.M., Barnett, N.P., O'Leary, T.A. and Colby, S.M. (2001) 'Motivational Enhancement for Alcohol-Involved Adolescents' in Monti, P.M., Colby, S.M. and O'Leary, T.A. (eds.) (2001) *Adolescents, Alcohol and Substance Abuse: Reaching Teens through Brief Interventions.* New York: Guildford Press

Monti, P.M., Colby, S.M. and O'Leary, T.A. (eds.) (2001) *Adolescents, Alcohol and Substance Abuse: Reaching Teens through Brief Interventions.* New York: Guildford Press

National Institute on Alcohol Abuse and Alcoholism. http://www.niaaa.nih.gov/Pages/default.aspx [Accessed 12 January 2012]

National Treatment Agency (2002) Models of care for the treatment of drug misusers. Department of Health.

National Treatment Agency (2005) Young people's substance misuse treatment services – essential elements. Department of Health.

National Treatment Agency (2009) Young people's specialist substance misuse treatment: Exploring the evidence. Department of Health

National Treatment Agency (2009) Guidance for the pharmacological management of substance misuse among young people. Department of Health.

NHS Greater Glasgow & Clyde (2008) Alcohol and Drug Prevention and Education Model 2008-2011.

NHS Health Scotland. Walk The Talk http://www.walk-the-talk.org.uk/index.aspx [accessed 8th February 2012]

NHS Lothian (2011) Under 18's Admitted to Accident and Emergency for Drink Related Issues. FOI Request 15/01/2011.

Pleace, N. (2008) Effective Services for Substance Misuse and Homelessness in Scotland: Evidence from an International Review. Centre for Housing Policy, Scottish Government.

Roberts (2010) Young People's Drug Treatment at the Crossroads: What it's for, where it's at and how to make it even better. Drugscope.

Rome, H, Hanning, K, Mackenzie, M, Elliot, K, Boyle, K (2010) Needs Assessment of Drug and Alcohol Problems in Midlothian/East Lothian and West Lothian: Evidence into Practice. Dundee

ScotPHO (2010) How Much Are People In Scotland Really Drinking: A review of data from Scotland's routine national surveys. Health Scotland

Scott, J. and Hill, M. (2006) The Health of Looked After and Accommodated Children and Young People in Scotland. Social Work Inspection Agency, Edinburgh.

Scottish Council for Single Homeless (2007) Young People and Homelessness. Accessed 31st October. http://www.scsh.co.uk/information/features/homelessness/people_at_risk.htm

Scottish Government (2009) Changing Scotland's Relationship with Alcohol: A Framework for Action.

Scottish Government (2008) The Road to Recovery: A New Approach to Tackling Scotland's Drug Problem.

The Scottish Government (2010) 2009/2010 Scottish Household Survey. Available from: www.scotland.gov.uk/Publications/2011/08/17093111/11 [accessed 12 December 2011]

Scottish Prison Service (2009) Prisoner Survey: Young Offenders, 12TH Survey Bulletin, Offender Case Management. http://www.sps.gov.uk/Publications/Publication77.aspx [Accessed 1st November 2011].

Scottish Schools Adolescent Lifestyle and Substance Use Survey (SALSUS) (2006) Smoking, drinking and drug use among 13 and 15 year olds in Edinburgh City.

Scottish Schools Adolescent Lifestyle and Substance Use Survey (SALSUS) (2011a) National Report 2010.

Scottish Schools Adolescent Lifestyle and Substance Use Survey (SALSUS) (2011b) Smoking, drinking and drug use among 13 and 15 year olds in Edinburgh City - 2010.

Social Care Institute for Excellence (2005) Parenting Capacity and Substance Misuse. http://www.scie.org.uk/publications/briefings/briefing06/ [Accessed 31st October 2011]

TACADE (1995). Lager and Blastaways, youth work with young problem drinkers, an alcohol training programme for youth workers. Out of print.

Traci Leven Research (2012) Glasgow City Schools Health and Wellbeing Survey 2010 Glasgow City Report. NHS Greater Glasgow & Clyde.

Triseliotis, J., Borland, M., Hill, M. and Lambert, L. (1995) *Teenagers and the Social Work Services.* London: The Stationery Office

Ward J. & Rhodes T (2001). Drugs prevention through youth work. Centre for Research on Drugs and Health Behaviour, 2001.

APPENDIX A: DATA ON SERVICE USAGE

TP – time period AS – accessed service FTU – first time users RU – repeat users	G – gender E – ethnicity A – age VG – vulnerable groups

Overview of service usage

Service	TP	AS	FTU	RU	G	E	A	VG
6VT	Oct 2010 – Nov 2011	476						
ASUS	Nov 2010 – Oct 2011	56	77%	23%	M: 59% F: 41%	-	12<: 0% 13: 3.5% 14 3.5% 15: 12.5% 16: 12.5% 17 29% 18: 34% 19: 5.5%	-
CoE: ICSS	Jan 2010 – Dec 2010	>84	-	-	M: 56% F: 44%	-	-	
Castle Project	2010/11	14	12	2	M: 30% F: 70%	Majority white Scottish	12<: 6.25% 13: 6.25% 14 25% 15: 12.5% 16: 12.5% 17 18.75% 18: 0% 19: 6.25%	Risk of homelessness: 12.5% LAAC: 12.5% Young Carers: 25% Young offenders: 6.25% Not attending school: 25% Parental Substance Misuse: 50%
CREW - outreach	April 2010 - March 2011	7525	33%	67%	M: 49.5% F: 35%	- -	13-25: 78%	-
CREW - shop	1st April - 31st March	2372	-	-	M: 70% F: 30%	- -	15: 5% 16: 5% 17:10% 18:10% 19:10% 20-25: 30% 25+: 30%	-

Cyrenians - communities	April 10 - March 11	27 (75 referrals received)	24	3	-	-	-	All at risk of homelessness
Granton Youth Centre	Oct 10 – Oct 11	1422	unknown	60%	M: 60% F:40%	majority white Scottish	0-10: 7.3%; 11-18: 90%; 19-25: 2.7%	-
HOT	Oct 10 – Oct 11	11	-	-	M: 50%; F:50%	-	11-18: 99%; 19-25=1%	-
HYPE	1st Nov 2010 - 1st Nov 2011	6	6	0	M: 4 F:2	Wh B:1 Wh S: 5	15=50% (n=3) 17=16% (n=1) 20-25=16% (n=1) 25+=1	1 y.p not attending/excluded from school
Rock Trust - Crisis Project	1 Oct 2011 – 9 Dec 2011	71	40	31	M: 66% F: 34%	White British - 96% white other - 4%	16: 9.8% 17: 4.2% 18: 4.2% 19: 14% 20-25: 67.8%	all at risk of homelessness young carers: 4.2% young offenders:7%
Streetwork - ESIST	1st April 2010 - 31st March 2011	26 (33 referred)	26	0	M: 60% F:40%	White Scottish: 100%	16: 10% 17: 50% 18: 20% 19:10% 20-25:10%	all at risk of homelessness
Streetwork - RAP	July 2010 - July 2011	9	9	0	M: 78% F: 22%	White Scottish: 100%	12–15:66%; 16+: 33%	Risk of homeless: 1 LAAC: 3 Young carer:1 Not attending or excluded from school: 2
The Junction - ASE	1st July 2010 - 30th June 2011	476	NA	NA	M: 64%; F:36%	not always asked BME - 12%	< 12: 1% 13: 20.5%; 14: 14% 15: 26% 16: 14% 17: 12% 18: 7% 19: 5% 20-25: 0.5%	risk of homelessness: 20% LAAC: 30% young carers: 15% young offenders: 40% not attending school: 40% 80% of those accessing 1-2-1 support have a history of offending and are in temporary accommodation

APPENDIX B: SUMMARY OF PROVISION

Summary of Provision				
Service	**Age range**	**Geographic location**	**Primary role**	**Vulnerable groups?**
6VT	11-24	City centre based	Other	Yes
ASUS	Up until 20th birthday	Edinburgh City; East Lothian	Drugs & Alcohol	Yes
CoE: ICSS	11-16	City of Edinburgh	Other	Yes
CoE: RC	Outreach and respite 10 to 16; y.p centres 12 to 18; secure services 10 to 16; close support units 12 to 18	Edinburgh City	Other	Yes
CoE: TcAc	16-21	Edinburgh City	Other	Yes
CoE: YOT	8-18	Edinburgh City	Other	Yes
Castle Project	12-18	Craigmillar & Portobello	Drugs & Alcohol	Yes
CREW - outreach	Any age	All of country	Drugs	Yes
CREW - shop	13-25	Edinburgh City; All of country	Drugs & Alcohol	Yes
Cyrenians - communities	16-30	CoE pay a block grant for 11 beds of a total of 15 across the two projects.	Other	Yes
Granton Youth Centre	12-19	North Edinburgh: Forth Ward	Alcohol	Yes
HOT	12-25	Craigmillar & Portobello	Alcohol	Yes
HYPE	11-18	Liberton & Gilmerton	Drugs & Alcohol	Yes
L&B– ABI project	All ages	Lothian & Borders	Alcohol	Yes
LGBT youth	13-25	City of Edinburgh; Lothians	Other	Yes
MYDG	8-24	Muirhouse	Other	Yes
Pilton Youth	5-19	North Edinburgh: Forth Ward	Other	Yes
Rock Trust - Crisis Project	16-25	Edinburgh City	Other	Yes
Streetwork - ESIST	14-25	Edinburgh City	Other	Yes
Streetwork - housing support	16 plus	Edinburgh City	Other	Yes
Streetwork - RAP	11-18	Edinburgh City	Other	Yes

Streetwork - Women's project	18 plus	Edinburgh City	Other	Yes
The Junction - ASE	12-21	North Edinburgh	Alcohol	Yes
Young carers	5-18	Edinburgh City	Other	Yes

APPENDIX C: SUPPORT SERVICES PROVIDE

A - Advice and Information	O – Outreach
T- Alcohol or Drug Treatment	PEI – Prevention and Early Intervention
FS- Family Support	R/C – Rehabilitation (community)
NE – Needle Exchange	R/R – Rehabilitation (residential)

Support Services Provide									
Service	**A**	**T**	**FS**	**NE**	**O**	**PEI**	**R/C**	**R/R**	**Other**
6VT	✓	-	✓	-	✓	✓	✓	-	-
ASUS	✓	✓	-	-	-	-	✓	-	✓
CoE: ICSS	✓	✓	✓	-	✓	✓	✓	✓	✓
CoE: RC	✓	-	✓	-	-	-	-	-	-
CoE: TcAc	-	-	-	-	-	-	-	-	✓
CoE: YOT	✓	-	✓	-	-	✓	-	-	-
Castle Project	✓	✓	✓	-	✓	✓	-	-	-
CREW - outreach	✓	-	-	-	✓	✓	-	-	-
CREW – shop	✓	-	-	-	✓	✓	-	-	✓
Cyrenians - communities	✓	-	-	-	-	✓	-	-	✓
Granton Youth Centre	✓	-	-	-	✓	✓	-	-	-
HOT	✓	-	-	-	✓	✓	-	-	✓
HYPE	✓	-	-	-	-	✓	-	-	-
L&B – ABI project	✓	-	-	-	-	✓	-	-	-
LGBT youth	✓	-	-	-	✓	-	-	-	-
MYDG	✓	-	-	-	✓	✓	-	-	-
Pilton Youth	✓	-	-	-	✓	✓	-	-	✓
Rock Trust - Crisis Project	✓	-	-	-	✓	✓	-	-	-
Streetwork - ESIST	✓	-	-	-	✓	-	-	-	-
Streetwork - housing support	✓	-	-	-	-	✓	-	-	-
Streetwork – RAP	✓	-	-	-	✓	✓	-	-	-
Streetwork - Women's project	✓	-	-	✓	✓	✓	-	-	✓
The Junction – ASE	✓	-	-	-	✓	✓	-	-	-
Young carers	✓	-	-	-	✓	-	-	-	✓

APPENDIX D: REFERRAL PATHWAYS

Referral pathways								
Services	**Any agency**	**Self**	**GP**	**H prof**	**SW**	**Court**	**School**	**Other**
6VT	-	✓	-	-	✓	-	-	-
ASUS	✓	✓	✓	✓	✓	✓	✓	Family member; TcAc; CAMHS
CoE: ICCS	-	-	-	-	✓	-	-	Youth offending team; Children's reporter
CoE: RC	-	-	-	-	✓	-	-	-
CoE: TcAc	✓	✓	-	-	✓	-	-	-
CoE: YOT	-	-	-	-	✓	✓	-	Police; Children's reporter
Castle Project	✓	✓	✓	✓	✓	✓	✓	
CREW - outreach	✓	✓	-	-	-	-	-	-
CREW - shop	✓	✓	-	-	-	-	-	-
Cyrenians - communities	-	-	-	✓	✓	-	-	-
Granton Youth Centre	-	✓	-	-	-	-	-	-
HOT	✓	✓	✓	✓	✓	-	✓	-
HYPE	✓	✓	-	-	✓	-	-	-
L&B – ABI project	-	-	-	-	-	-	-	No referrals
LGBT youth	✓	✓	-	-	-	-	-	-
MYDG	-	✓	-	-	✓	-	✓	School drop in, word of mouth; engagement in activities.
Pilton Youth	-	-	-	-	-	-	-	-
Rock Trust - Crisis Project	✓	✓	-	-	-	-	-	-
Streetwork - ESIST	✓	-	-	-	-	-	-	-
Streetwork - housing support	✓	✓	-	✓	✓	-	-	Hostels, council, outreach services
Streetwork – RAP	✓	-	-	-	-	-	-	-
Streetwork - Women's project	✓	✓	✓	✓	✓	-	-	-
The Junction – ASE	✓	✓	✓	✓	✓	-	✓	Parents
Young carers	✓	✓	✓	✓	✓	✓	✓	-

APPENDIX E: ACCESS ROUTES

A – by Appointment	HC – health centre
H- Home visits	Ho – Hospital
S- School	HL – Helpline
SB – Service base	O/St – Outreach (street)
	O/S – Outreach (services)

Table 6: Access routes

Service	Opening Hours	A	H	S	SB	HC	Ho	HL	O/St	O/S	Other
6VT	5 nights 6-10pm; Sat 12 -5pm	-	✓	✓	✓	-	-	-	✓	-	-
ASUS	Mon - Fri 9-5pm; appointments can be arranged outwith	✓	-	✓	✓	✓	✓	-	-	-	✓
CoE: ICSS	24 hours 7 days	-	✓	-	✓	-	-	-	-	-	✓
CoE: RC	24 hours 7 days	-	-	-	-	-	-	-	-	-	-
CoE: TcAc	Mon – Thurs 8.30am - 5pm; Fri 8.30am to 3.50pm	-	✓	-	✓	-	-	-	-	-	-
CoE: YOT	9-5pm Mon to Thurs; 9-3.45pm Fri	✓	✓	✓	✓	-	-	-	-	-	✓
Castle Project	9.00-4.30pm	✓	✓	✓	-	✓	-	-	✓	✓	-
CREW - outreach	as required	-	-	-	-	-	-	-	✓	✓	✓
CREW - shop	Mon/Wed/Fri/Sat - 1-5pm; Thurs 3-7pm; Wed (am) - Dry blood spot testing	-	-	-	✓	-	-	-	-	-	-
Cyrenians - communities	Residential	✓	-	-	✓	-	-	-	-	-	-
Granton Youth Centre	Weekends/evenings	-	-	-	-	-	-	-	✓	-	-
HOT	9-5 and drop ins Thurs 3.45-6pm and Weds 7-9pm	✓	-	✓	✓	-	-	-	✓	-	✓
HYPE	Tues 9.30-4pm; Wed 6.30-9.30; Thurs 9.30-4pm.	✓	-	-	✓	-	-	-	-	✓	-
L&B – ABI project	24 hrs 7 days	-	-	-	✓	-	-	-	-	-	-
LGBT youth	Groups: Tues 7-9pm; Wed 6.30 - 8.30pm; Thurs 7-9pm	✓	-	-	✓	-	-	-	-	✓	-
MYDG		-	-	✓	-	-	-	-	✓	✓	✓
Pilton Youth	Mon - Sat 9.30-8pm	-	-	✓	✓	✓	-	-	-	✓	-
Rock Trust - Crisis Project	9-5 Mon to Fri; Sat and Sun 9 -11	-	-	-	✓	-	-	-	-	✓	-
Streetwork - ESIST	Mon & Tues - 9 to 5pm; Wed to Fri - 9am to 9pm; Saturday - 1pm - 9pm	-	✓	✓	-	-	-	-	✓	-	-
Streetwork - housing support	9-5pm - Mon - Fri	-	-	-	-	-	-	-	-	-	✓

Streetwork – RAP	Mon & Tues 9-5pm; Wed – Fri 9-9pm; Sat - 1- 9pm	-	✓	✓	-	-	-	-	✓	-	-
Streetwork - Women's project	Office: Mon-Fri 9-5pm; Outreach Mon 3-6pm and Fri 4.30-7.30pm; Targetted outreach Thurs and Fri 1pm - 1am; Drop in Tues 1-4pm, Wed 4-7pm, thurs 1-4pm; Drop in for women involved in prostitution - Wed 8-11pm	✓	✓	-	✓	-	-	-	✓	✓	-
The Junction – ASE	open access: Mon 3-5pm, Tues and Thurs 3.30-6pm, Fri 1-4pm; Street work Fri 6-8pm; ROSP outreach - thurs 6-9pm; school outreach - monthly; other work negotiated with y.p/schools/other providers	-	-	✓	✓	-	-	-	✓	✓	-
Young carers	9-5.30pm	-	-	-	-	-	-	-	-	✓	-

APPENDIX F: WAITING TIMES

Waiting times		
Service	**Waiting time?**	**Comments**
6VT	YES	drop in no; 1-2-1 support yes
ASUS	NO	
CoE: ICSS	NO	Operates a no-waiting list policy.
CoE: RC	Not answered	
CoE: TcAc	NO	
CoE: YOT	NO	
Castle Project	NO	
CREW - outreach	NO	
CREW - shop	NO	
Cyrenians - communities	YES	Dependent on speed that SW work team confirm payment for placement - this can take weeks
Granton Youth Centre	NO	
HOT	NO	
HYPE	NO	
L&B – ABI project	NO	
LGBT youth	NO	
MYDG	NO	
Pilton Youth	NO	
Rock Trust - Crisis Project	NO	
Streetwork - ESIST	NO	
Streetwork - housing support	YES	3 months
Streetwork – RAP	NO	
Streetwork - Women's project	YES	Drop-in or outreach – no waiting time; 1-2-1 - approx. 4 weeks
The Junction – ASE	YES	1-2-1 – 2 weeks; Therapeutic counselling- 8 weeks
Young carers	NO	

APPENDIX G: BARRIERS TO ACCESS

OH – Opening hours	PT – Availability of Public Transport
WT – Waiting times	Con – Confidentiality Concerns
RC – Referral/Exclusion criteria	SE – Service Environment
Cap - Capacity	SF – Safety Fears
L – Location of Service	LoM – Lack of Motivation (by young person)
TC – Travel Cost	LoA – Lack of Awareness

Barriers to access													
Service	**OH**	**WT**	**RC**	**CAP**	**L**	**TC**	**PT**	**CON**	**SE**	**SF**	**LM**	**LA**	**Other**
6VT	-	-	-	-	-	✓	-	-	-	-	✓	✓	-
ASUS	✓	-	-	-	✓	✓	-	-	-	-	✓	✓	-
CoE: ICSS	-	-	✓	-	-	-	-	-	-	-	-	-	✓
CoE: RC	Not applicable												
CoE: TcAc	✓	-	✓	✓	-	-	-	-	-	-	✓	✓	-
CoE: YOT	✓	-	-	-	-	-	-	-	-	-	✓	-	-
Castle Project	-	-	-	✓	-	-	-	-	-	-	-	-	-
CREW - outreach	-	-	-	-	✓	-	-	-	-	-	-	✓	-
CREW - shop	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	-
Cyrenians - communities	-	-	✓	-	✓	-	-	-	-	-	-	✓	✓
Granton Youth Centre	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	-
HOT	-	-	-	-	-	-	-	-	-	-	-	-	-
HYPE	-	-	✓	-	-	-	-	-	-	-	-	✓	-
L&B – ABI project	-	-	-	-	-	-	-	-	-	-	-	-	✓
LGBT youth	-	-	-	-	-	✓	-	-	-	-	-	✓	-
MYDG	-	-	-	-	✓	-	-	-	-	-	-	-	-
Pilton Youth	-	-	-	-	-	-	-	-	-	-	-	-	-
Rock Trust - Crisis Project	-	-	-	-	-	-	-	-	-	-	-	-	-
Streetwork - ESIST	-	-	-	-	-	-	-	-	-	-	✓	-	-
Streetwork - housing support	-	-	-	-	-	-	-	-	-	-	-	-	✓
Streetwork - RAP	-	-	-	-	-	-	-	-	-	-	✓	✓	-
Streetwork - Women's project	-	-	-	-	-	-	-	-	-	-	-	-	-
The Junction - ASE	-	✓	-	-	-	-	-	-	-	-	-	-	✓
Young carers	-	-	-	✓	-	-	-	-	-	-	-	-	-