

# Vulnerable young people and drugs

Opportunities to  
tackle inequalities

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DrugScope has been created through the merger of the UK's foremost drug information and policy organisations: the Institute for the Study of Drug Dependence (ISDD) and the Standing Conference on Drug Abuse (SCODA) – two charities with a total of sixty years in the national and international drugs field.

DrugScope is the UK's leading centre of expertise on drugs. Our aim is to inform policy development and reduce drug-related risk. We provide quality drug information, promote effective responses to drug taking, undertake research at local, national and international levels, advise on policy-making, encourage informed debate and speak for our member organisations working on the ground.

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# Introduction

The Government's ten-year anti-drugs strategy "Tackling Drugs to Build a Better Britain" was published in 1998. It requires services and information to be made available to all young people, including those who may need more targeted information because they are particularly at risk of drug misuse and social exclusion.

In early 1999 the Department of Health funded a rapid programme of research and development that ended March 2000. The programme intended to deliver research based evidence which will underpin the development of high quality and effective interventions with groups of young people thought to be vulnerable to developing drug misuse problems. The focus of the work is to inform primary and secondary drug prevention strategies and other opportunities to intervene.

The projects funded under this initiative were:

- 1 University of Central England – Young Homeless People with Drug Misuse Problems.
- 2 University of Luton – Multi-Site Study of Drug Problems in Three Vulnerable Groups.
- 3 Wolverhampton Health Care – Trends in Drug Taking Among Young Offenders.
- 4 Victoria University of Manchester – New Young Heroin Users.
- 5 University of Essex – Drug Taking Among 'Looked After' Young People.
- 6 Kent Drug Action Team – Assessment Processes in Young People's Services.

The projects were coordinated by DrugScope (formerly the Institute for the Study of Drug

Dependence (ISDD) and the Standing Conference on Drug Abuse (SCODA)). DrugScope brought the projects together, and set some common baselines to ensure consistency across the projects, in relation to:

- terminology, including definitions of use and misuse (see box overleaf);
- age definitions and groupings; and
- principles of 'good practice', as laid out in national guidance (HAS 1996, SCODA/CLC 1999).

This report presents the executive summaries from each of these projects' reports.

## Vulnerability

There are a number of "risk" factors that may make children and young people vulnerable to drug misuse. Children who are, or are likely to start, misusing drugs are also very likely to have other health and social problems, and problems at home or school (Lerner and Vicary, 1984; Shedler and Block, 1990; Hawkins et al, 1992). Conduct disorder in children and young people is also a strong predictor of adolescent drug misuse (Synder and Ooms, 1992).

There are a range of factors which research has identified as being associated with problematic drug use (misuse) during adolescence, and/or as playing a role in the later development of drug problems. The Health Advisory Service report into young people and substance misuse (HAS 1996) detailed these factors as:

Physiological factors:

- physical disabilities.

Family factors:

- belonging to families who condone substance misuse;

- where there is parental substance use;
- where there is poor and inconsistent family management; and
- where there is family conflict.

Psychological and behavioural factors:

- mental health problems;
- alienation;
- early peer rejection;
- early persistent behaviour problems;
- academic problems;
- low commitment to school;
- association with drug using peers;
- attitudes favourable to drug use; and
- early onset of drug or alcohol use.

Economic factors:

- neighbourhood deprivation and disintegration.

This association between youth disaffection and multiple health and social problems is widely recognised. Our challenge is to develop holistic approaches to drug interventions which integrate access to drug education, prevention and treatment into the wide range of other service responses to vulnerable young people. In other words, making sure these young people do not 'fall through the net'.

There are some identifiable groups or categories of young people who are more likely than others to experience 'multiple' risk factors. These groups include:

- young offenders;
- looked after children;
- young homeless;
- children whose parents misuse drugs;
- young people who truant or are excluded from school; and
- young people involved in prostitution.

While it must be remembered that not all young people in these groups do or will use drugs, these groupings can provide a valuable mechanism for targeting preventive and helpful interventions for some of the most vulnerable young people.

This programme of research and development into the needs of some of these vulnerable young people, and the extent to which services have been able to identify and respond to them, is part of a concerted effort to further understanding and to inform service and practice development.

### Definitions for drug taking, use and misuse

Under the Misuse of Drugs Act 1971, the use of all illegal drugs classified in the Act is defined as misuse. However, not all drugs taken by young people are covered by this Act – for example, unprepared magic mushrooms and new derivatives of MDMA (commonly referred to as ecstasy) – and new substances are continually becoming available. Therefore, in this document, we refer to the consumption of any of these drugs (legal or illegal) as *drug taking*.

The Health Advisory Service (HAS) report (1996) states '*one-off and experimental use of drugs and alcohol cannot in itself be seen as indicative of having caused actual harm or being related to any personal disorder*'. In other words, the fact that a young person has taken a drug should not lead to the automatic conclusion that there is a problem or condition to be treated. However, it is essential to recognise that all drug taking by young people carries potential harm.

For the purposes of this document it is necessary to distinguish between the conditions in which different interventions are most appropriate to address drug taking by a young person. Distinctions may only be drawn in each individual case following an assessment of the young person's drug taking. Such assessments should take place whenever a young person's drug taking is identified.

#### *Drug misuse*

Drug taking which harms health or social functioning is described as 'drug misuse'. Drug misuse may be dependency (physical or psychological) or drug taking that is part of a wider spectrum of problematic or harmful behaviour (HAS, 1996). Drug misuse (as defined here) will require drug treatment.

#### *Drug use*

Drug use is drug taking which requires a lower level intervention than treatment. Harm may still occur through drug use, whether through intoxication, illegality or health problems, even though it may not be immediately apparent. Drug use will require the appropriate provision of interventions such as education, advice and information, and prevention work to reduce the potential for harm.

*Definitions taken from 'Young People and Drugs: Policy guidance for drug interventions' (1999) SCODA and Children's Legal Centre*

### Key findings and learning points

While each executive summary in the report presents its own findings, there are some common and important messages, which indicate opportunities for attention and intervention. In particular there are a number of opportunities that will yield best results.

#### Initiation into drug taking and vulnerable ages

If vulnerable young people do use drugs, they start on average at earlier ages than young people generally do. Young drug users across these studies had generally tried an illegal drug by the age of thirteen if not before, and were likely to smoke cigarettes and drink alcohol with some degree of regularity.

While this does not mean that all of them were experiencing problems related to that drug use, early initiation has itself been shown to be associated with the development of drug problems in later adolescence or adulthood. This finding confirms the vulnerability to drug misuse among the groups studied. Early sexual activity appears to start for many around the same age as their drug use, subsequent pregnancy and parenthood is a cause for concern.

This is the period (ages 11–13) following the transition to secondary school, which these studies suggest is a vulnerable time itself. Several reports speak of young people's progressive disengagement from school during this period, even if not excluded, paralleled with poor levels of supervision in the home.

#### *Opportunities to intervene*

These findings indicate that the Connexions service, which will appoint a personal adviser to each child at the age of thirteen, may need a similar supplementary service for some of the most vulnerable who are younger than 13. It will be important to focus on:

- young people who, in primary school, begin to display educational or behavioural problems, or appear to be otherwise disengaging from education. For these young people extra effort and support may be required in the last few years of primary school and the first two years of secondary school, to keep them in, and interested in, education, and to support them through the transition to secondary school;
- aiming significant and explicit primary and secondary prevention at vulnerable 11–13-year-olds, particularly those already excluded from school – adopting a 'joined-up approach' to substance misuse and sexual health;
- research reinforced the national strategy – appropriate drug education early in primary school.

#### Family factors

A lack of appropriate and effective supervision of young people by parents/carers appears to be a major contributory factor to drug taking in children and young people. Reports of substance misuse in the family home, and of family conflict and disruption, are significant in the complex problems experienced by some of the young people.

#### *Opportunities to intervene*

These findings indicate the need to:

- broaden the scope and availability of family support services, including parenting skills support and mediation interventions, to fill the gap between 'doing nothing' and instigating child protection proceedings;
- to ensure that such services recognise and respond to issues of substance use as they affect families, whether child, sibling or parent is using drugs;
- ensure that responses to the needs of children and young people who are showing difficulties of the kind described in the studies take a 'family perspective' to assessing needs and coordinating interventions.

#### Gender

Young women were in the minority in all but one of the groups studied, however most of the findings indicated that these young women often had more complex and more serious problems than many of the young men. Given that women are generally in the minority of the client groups of youth offending teams, drug services, etc, their needs for gender sensitive or specific services can be overlooked.

In contrast, and equally importantly, one study of young homeless people (with an equal male:female ratio) found drug use significantly associated with, and most prevalent among, young men.

#### *Opportunities to intervene*

The findings indicate that it may be important to develop substance misuse prevention programmes and services that look specifically at gender experiences and problems encountered by vulnerable young people, especially in youth offending teams.

#### Black minority ethnic issues

Several teams were unable to access information from black and minority ethnic (BME) communities. Other research reached a higher proportion of BME young people but did not give a full analysis.

#### *Opportunities to intervene*

- longer term research strategies are needed to understand the dynamics of BME groups;

- more research work is needed to identify and access BME drug users. The difficulties in accessing information from these groups should be acknowledged and incorporated into research plans;
- secondary analysis is recommended on research projects with higher numbers of BME sample groups.

### **Mental and emotional health**

Several studies found links between drug taking and poor mental and emotional health. Traumatic events such as family conflict, bereavement and sexual abuse seemed to initiate or increase drug use. Mental health conditions, including eating disorders, anxiety or depression, were identified and reported to have significantly affected some participants' lives.

#### *Opportunities to intervene*

These findings indicate a need:

- to identify and to support young people experiencing trauma, bereavement, etc;
- for services working with vulnerable young people to be aware of potential mental health problems, to identify signals, and refer for mental health assessments;
- for services to be aware of substance misuse among young people in a wider context which includes possible 'dual diagnosis' with mental health problems.

### **Housing and accommodation**

A number of studies found that there was a relationship between the environment in which the young people lived and their drug use. For example one study found that young people who reported feeling unsafe at home were more likely to report drug taking than those who did not. Two others, looking at young homeless people and at young people looked after by local authorities, demonstrated significantly higher prevalence of drug taking across the group than among the general population of young people.

#### *Opportunities to intervene*

- for young people looked after by local authorities  
Quality Protects initiatives provide a vital opportunity to incorporate and improve drug assessments, drug education, prevention and treatment for young people in their care;
- homelessness hostels are well placed to provide drug education and prevention for vulnerable young people, and ensure effective referrals to treatment.

### **Service responses to drug use**

Even where young people's drug use was evidently problematic, it was rarely identified or addressed by services with which they had been in contact. This appears related to:

- increasing detachment from the 'mainstream', and increasing association with drug using peers;
- little evidence of self-motivated help-seeking, or recognition of the connectedness of their drug misuse with the multiple problems they were experiencing; and
- poor assessment processes and skills among professionals involved with the young people.

#### *Opportunities to intervene*

- develop more effective and innovative methods for drug services to 'reach out' into the community, and in particular to connect with young drug using peer groups, and the families of young drug users;
- develop prevention and treatment modalities which allow young drug users to access and receive services as peer groups, as well as individually.

### **Individual assessments for drugs**

Three of the studies looked into the ways vulnerable young people were assessed by professionals:

- assessment systems and approaches rarely looked explicitly or 'proactively' for substance use; and
- there were generally poor levels of training and assessment skills relating to substance misuse among staff in non-drug-specific services that work with and accommodate vulnerable young people.

#### *Opportunities to intervene*

- include substance misuse screening into all assessments of vulnerable young people;
- training in substance misuse assessment and interventions for 'non-drug-specialist' professionals will be crucial to the effectiveness of any attempts to intervene earlier to prevent vulnerable young people from developing substance misuse problems;
- employing a wider range of assessment methodologies – such as those which use youth work exercises and counselling approaches as well as basic 'question and answer' methods – may elicit sensitive information such as drug use.

### **Local needs assessments**

This work shows that prevalence of drug taking among vulnerable young people may be different from other local young people. General population and school-based surveys may not show drug taking or the success or failure of drug interventions with these groups.

- local planners and commissioners may need specific research to discover trends;
- individual substance misuse assessment will benefit local planning mechanisms such as Drug Action Teams and Integrated Children's Services Plans.

# Drug misuse, cigarette smoking and alcohol use among young homeless people

Henryk Adamczuk (Universities of Central England and Newcastle upon Tyne)

## Background

High levels of drug use have been recorded in surveys of vulnerably housed people across age bands from 16–21 and above. Between 43,000 and 80,000 adults under 19 become homeless every year in the UK (estimate derived from Smith, 1996). There are no previous estimates for the extent of drug use and misuse among such young vulnerable homeless people. This research project within the setting of city hostels was designed to contribute in an incisive way to the knowledge base for policy makers and agencies across the health and housing spectrum.

## Aims

The study programme specifically addressed drug misuse among young homeless people aged 16 to 18. The narrow age permitted an evaluation of the experiences of large numbers of young people in the transition to adulthood coinciding with the absence of a settled home. The first aim was to measure accurately the raw prevalence rate and so generate evidence and improve on previous estimates. The second aim was an exploration of wider experiences of the social life of young people to identify patterns of risk.

## Methods

Birmingham and Newcastle were suitable for a large sample survey to give a measure of representation of homelessness in two English regions, the midlands

and the north east. Birmingham is the second largest metropolitan area in England with a population of 935,000 as well as a large homeless problem. The area has 120 hostels with 3,000 bedspaces. Newcastle has a population of 240,000, with a smaller level of general homelessness. There were less than 30 projects with accommodation for the homeless population.

The methodology developed in the research could provide agencies working with the young homeless with reliable base-line data across a spectrum of “risky” behaviours, including drinking alcohol, cigarette smoking and sexual behaviour.

The primary research instrument was a general lifestyle questionnaire, administered anonymously. The questionnaire contained sections inter alia on substance use, social and psychological background, sexual behaviour and attitudinal questions. The substance use section was piloted carefully to cover common and street names and to ensure consistency with recent Home Office reports. The adoption of the past year prevalence for the use of illicit and licit drugs was one important element in the reliability of the measurement tool. Supplementary qualitative data was gained from 50 screened interviews, mainly of drug users linked to the main sample.

The sampling strategy involved the capture of a representative profile of those staying at hostels which offered accommodation to homeless young people. Over 70% of qualifying residents in each project completed the schedule of questions.

Table 1 Use of specific illicit drugs in the past year by city

<i>Drug</i>	<b>Newcastle</b> <b>n = 63</b>		<b>Birmingham</b> <b>n = 93</b>		<b>Both cities</b> <b>n = 156</b>	
	<i>n</i>	<i>%</i>	<i>n</i>	<i>%</i>	<i>n</i>	<i>%</i>
Amphetamine	39	62	20	22	59	35
Barbiturate	12	19	9	10	21	13
Cannabis	50	79	39	42	89	54
Ecstasy	26	41	20	22	46	28
Cocaine powder	17	27	7	8	24	15
Crack cocaine	11	17	10	11	21	13
Magic mushroom	21	33	11	12	32	19
LSD	19	30	11	12	30	18
Heroin	6	10	20	22	26	16
Illicit Methadone	2	3	8	9	10	6
Solvents	13	21	4	4	17	10
Illicit Tranx	9	14	4	4	13	8
No drug	11	17	35	38	46	34
One or more drug	52	83	58	62	110	66

### Sample characteristics

A total of 156 questionnaires were completed, split equally between males and females. Ninety-three of the participants were from Birmingham and 63 were from Newcastle. The study had hoped to get 100 participants from each city but the samples are still reliable because a high percentage of the relevant hostel population was covered. Additionally, the samples replicated the selected population characteristics.

The social characteristics of the samples reflected the wider ethnic and gender make up of young people; 38 per cent of the Birmingham sample and 6 per cent of the Newcastle sample were from an ethnic minority background. The mean age across both samples was 17.1.

Respondents had varied experiences of single parenting, fostering, adoption and care; sometimes a combination of these experiences within their childhood. The average age at which they had their first episode of homelessness was 16. The average age of their first episode of drug use was 13, and 12 for starting cigarette smoking.

### Findings

A wide range of licit and illicit substances were, or had been, used by young residents of homeless projects, exceeding levels found in the general population. Across both samples, two thirds had used at least one illicit drug – predominantly cannabis resin- in the previous twelve months.

Some geographical differences in prevalence and patterns of use were reported. These may reflect differences in availability and regional trends, and do not automatically reflect on the nature or degree of vulnerability of the young people themselves.

In Newcastle, the 'order of preference' in terms of past year prevalence rates were cannabis resin (79%), amphetamine (62%), ecstasy (41%), cannabis leaf (40%), magic mushrooms (33%), LSD (30%), cocaine powder (27%) and solvents (21%). One in ten had used heroin at least once in the last year.

More young people in Birmingham reported no drug use in the last year, and among those who did report use (62%), the patterns were also somewhat different. Cannabis resin use was significantly lower than Newcastle (42%), while one in five (22%) reported

Table 2 **Age of initial use of each substance**

	Newcastle	Birmingham
Smoked first cigarette	12.2	13.0
First illicit drug	12.7	14.1

heroin use in the last year.

In relation to heroin use, both Birmingham's 22% and Newcastle's 10% are significantly higher than the 1% past year prevalence rate for heroin use in the general population among 16–19 year olds in Britain (Ramsay and Partridge 1999).

The effect of gender was pronounced. Nine out of ten (91%) young men in Newcastle and 80% in Birmingham reported using at least one illicit drug in the previous year. Young women reported a lower prevalence: 73% in Newcastle and 46% in Birmingham. The gender effect is statistically significant and demonstrates that male substance use is a predominant feature within these samples.

There were far higher reported rates of cigarette smoking among homeless young people than among young people in the general population. Respondents in Newcastle (79%) were more likely than in Birmingham (65%) to describe themselves as smokers. In the Birmingham hostels more young

females than young males smoked cigarettes. In Newcastle a higher percentage of women (73%) than men (61%) consumed alcohol in the previous week. Birmingham young hostel residents reported lower levels of drinking than in Newcastle. Although there were a number of instances of binge drinking and negative behaviour following the use of alcohol, there were few reported cases exceeding recommended safety limits. One respondent described himself as an alcoholic.

Homeless young people using alcohol and illicit drugs typically tried their first drink aged 13 or 14; the average age of initiation for smoking was earlier at 12 or 13 years of age.

Young people's levels of anxiety and depression were measured using Hospital Anxiety Depression (HAD) schedule. (HAD is used to 'screen' for the probable existence of these disorders and is not a diagnostic tool itself). The higher the score denotes the intensity of any indicators of anxiety or depression. When totalled, scores are assessed as follows:

Table 3 **School exclusion and qualifications on leaving school**

	Newcastle n = 63	Birmingham n = 91
Excluded	46.0%	29.6%
Not excluded	49.2%	40.6%
No response	4.8%	29.8%
No qualifications	44.4%	36.2%
CSE	12.6%	15.3%
5GCSE (grade A–G)	23.8%	20.8%
2A levels	1.5%	2.1%
No response	17.4%	15.3%

Below 8 = no case of anxiety or depression  
8–10 = possible clinical prevalence  
11 + = probable diagnosis for anxiety or depression

Forty two percent of the participants from Birmingham scored above 10 for anxiety and 18% had depression. In Newcastle 49% scored above 10 for anxiety and 19% for depression. The study showed high levels particularly for anxiety. Almost half of the Newcastle sample scored in the upper portion of the scale, which suggests a likely diagnosis of the disorder.

About half the Newcastle cohort reported school exclusion, while 30% reported exclusion in Birmingham. Over one third in each cohort had no qualifications. Great variations in past educational experiences were reported overall. For some school was a positive time and they were now able to build on qualifications gained at 16. For a minority however, instances of interrupted secondary education featured. There was a considerable group in each city with a period of exclusion from school.

### Key issues

The experiences within the 10–14 age band appear critical for shaping later behaviour among homeless drug users:

- homeless service reviews regarding opportunities to intervene;
- hostels intervene in prevention more effectively.

Conclusions were drawn that certain risk factors, carer/parenting circumstances, educational experience including exclusion and experience of rough sleeping impacted disproportionately on homeless people. Using the Hospital Anxiety and Depression scale as a screening device, 42% of the Birmingham cohort and 49% of the Newcastle cohort were categorised as suffering from an anxiety condition. This suggests a very high level of undiagnosed mental health problems and replicates previous findings of research on the mental health of young homeless people.

# Vulnerable young people and their vulnerability to drug misuse

Margaret Melrose and Isabelle Brodie (University of Luton)

## Background

### Aim

The aim of this particular piece of work was to investigate drug taking among three of these vulnerable groups of young people aged 13–18 (HAS 1996, SCODA 1997) :

- those who have offended;
- those who have been excluded from or not attending school; and
- those who have been looked after in the local authority care system.

As a result of the complexities of the overlaps between these experiences the project identified 7 groups :

- those who have offended;
- those who have been excluded from or not attending school;
- those who have been looked after in the local authority care system;
- those who have offended *and* been excluded/not attended school;
- those who have offended *and* been looked after in the local authority care system;
- those who have been looked after in the local authority care system *and* been excluded/not attended school; and
- those who have offended, been looked after in the local authority care system and been excluded/not attended school.

The project aimed to understand from the point of view of the young people concerned, their motivations for initiating drug use and the types of interventions that such young people might find beneficial in allowing them to cease their involvement with drugs and/or which might have prevented them from becoming involved in drug taking in the first place.

### Sample

There were 59 participants. Forty-nine were aged 13–18 and 10 were aged 19–25.

Two-thirds were male, and one third female.

Over two thirds of the sample were white.

### 13–18 age group

	<i>African – Caribbean</i>	<i>Mixed race</i>	<i>White</i>
Female	1	4	10
Male	5	2	27

The project's failure to access Asian young people was seen as a disappointment for the research team, as drug use amongst young Asians in the local community is a matter of serious concern. It is felt that some of the difficulties in recruiting young Asian people to the project were because young Asians have lower rates of participating in offending than either whites or African-Caribbean groups (Graham and Bowling 1995). Although those of Pakistani origin represented 20% of fixed term exclusions from school in the Luton area in the period 1997/1998 (Tyler and Marlow 1998) these young people will not be coming to the attention of educational support services because of the fixed term nature of their exclusions. In relation to Asians who are problematic drug users but are not accessing drug services, research suggests this is may be for cultural and/or religious reasons, (Pratt and Paylor 1999) and the fear of the stigmatising effects of admitting to drug problems to 'white' institutions.

### Method

The fieldwork was completed during a five-month period and all participants in the study were accessed through negotiation with voluntary and statutory agencies providing services for vulnerable young people, for example youth offending teams, educational support services and youth services, in two main local authority areas in the south-east.

Table 4 **Drugs ever used and drugs used in past month by sex**

	<i>None</i>	<i>Cannabis only</i>	<i>Cannabis &amp; others</i>	<i>Cannabis, other &amp; volatile substances</i>	<i>Other*</i>
<b>Drug use ever</b>					
Male (n = 34)	4	8	12	8	2
Female (n = 15)	1	0	5	8	1
<b>Drug use in the past month</b>					
Male (n = 34)	9	20	5	0	0
Female (n = 15)	2	3	6	3	1

\*Refers to those participants who had taken cannabis and volatile substances.

In depth face-to-face semi structured interviews were used with a small sample (n=59) of young people over a five month period. The interviews were flexible enough for them to allow the exploration of issues that arose in the course of them.

**Findings**

Nine out of ten of the young people reported having ever used a drug. The age at which they had first used a drug ranged from 8 to 16 years old, with an average age of initiation of 13.1 years. This is a higher proportion than that found in studies of drug use among the general population of young people.

Eighty-nine percent of the 13–18 age group and 100% of the 19–25 age group had used drugs. Of the 89% who had ever used drugs, three-quarters had used drugs other than cannabis. This lifetime prevalence of use is also considerably higher than that found generally in studies of young people and drug use.

Most of these young people began using drugs with friends and found drugs easy to access. Peer group associations are important in initiating young people into drug use but motivations for beginning to use drugs varied.

Forty eight participants had tried alcohol and, at the time of the interview, 43 used alcohol. A quarter of the sample had first used alcohol before they were 12 and the average age for first use of alcohol across the sample was 12.4 years. All had tried tobacco and, at the time of the interview, 45 participants were regular smokers. Half had started smoking before they were 12 and the average age for first use of tobacco across the sample was 11.6 years.

Many participants felt that nothing would have prevented them from taking drugs when they did as

they wouldn't have listened to anyone at the time. Also many felt that they would not need the help of outside agencies to stop taking drugs if they should decide to do so – they felt that their drug taking wasn't a problem and that they could stop when and if they wanted to.

A major theme for the vulnerable groups was that the interviewees did not consider their experiences of being looked after, offending or excluded from school to be related to their own drug misuse. None were excluded because of drug use, none were looked after because of drug use but some had drug related convictions.

The 'offended, excluded and looked after group' had the highest prevalence of drug use and were the most likely of all the groups to be users of volatile substances. The 'excluded' group had used volatile substances at the earliest ages compared with other groups. It is clear that the combined experiences of being looked after, excluded and offending do indeed leave some young people more vulnerable than others to drug misuse (HAS 1996, SCODA 1997).

**Young women**

Women were also not represented proportionately in the sample, which may, to an extent reflect the general ratio of male: female offending. Although the sample of women was smaller than that of the men, a range of interesting findings were shown:

- young women had the most problematic and frequent drug use;
- none of the females were from 'traditional' nuclear families;
- one third were from single parent households;

- two thirds experienced conflict or abuse at home, compared to half of the males;
- over a quarter of the women reported having been sexually abused compared to one male;
- young women initiated drug use, alcohol and tobacco at younger ages than men and tended more frequently to use drugs other than cannabis; and
- more young women than men had used drugs intravenously.

These gender differences are a reversal of patterns found in general studies of young people and drug use. In conclusion these female participants came from situations that made them more vulnerable to drug misuse than appeared to be the case for the men. (HAS 1996, SCODA 1997).

#### **Key issues**

The most problematic patterns of drug use reported in this sample are those of the young women. They most frequently reported disorganised home backgrounds compared to young men.

The identified patterns of drug use among young women in the sample suggest that rather than the gender gap in the use of licit and illicit substances diminishing it has actually reversed in these vulnerable groups. The findings suggest that vulnerable young women have overtaken young men in their consumption of both licit and illicit substances, both in how early they start, the ranges of drugs used, and the degree of problematic use.

The age at which young vulnerable people initiated use of drugs, alcohol, tobacco and volatile substances appeared to be between one and two years younger than the general population of young people. As might be expected as a result of earlier initiation, lifetime prevalence rates for the whole range of substances also appear to be higher amongst these young people than their 'non-vulnerable' peers.

The study recommends that more services be developed specifically to target young people who are using drugs. These should take a holistic view of the child or young person and be sensitive to gender and ethnic differences as well as to other problems and difficulties that the young person may be facing in their life – for example, problems with family relationships, unemployment, housing and so on.

# Determining drug use and evaluating effective assessment methods in a Youth Offending Team

Carol Green, Rob Willoughby, Andrea Smith, Pamela Harris and Illana Crome  
(Wolverhampton Health Care)

## Background

The project set out to examine drug use amongst young people referred to the Youth Offending Team (YOT) between August 1999 and March 2000, and to understand their drug use in the wider context of their lives, including other emotional and physical health issues, their home environment and their educational history and ability.

Of the 327 young people who were referred to the YOT during the period, just over half (n=186) participated in the research. The ratio of males to females was 3:1, and the average age at interview was 15 amongst the males, 14.6 for the young women.

In addition, the project piloted three different assessment styles to compare their effectiveness in eliciting sensitive personal information, such as drug use. Each young person was allocated, at random, to one of the following three assessment styles:

### A – Questionnaire style

In this method, the assessor sat down with the young person and asked them questions as they were laid out on a pro-forma questionnaire, and filled in the answers as they were given. Coop charts adapted from 'Measuring Health' (Bowling 1997) were used in relation to specific questions. This approach (without the Coop charts), was seen to be the closest in method to a medical approach to assessment, and

was also similar to the way in which ASSET assessments were being undertaken.

### B – Counselling style

In this method the assessor engaged the young person conversationally, remembering the areas that needed to be covered and the answers given, filling out the questionnaire after the session.

### C – Youth work style

This method employed an exercise, in which young people were invited to construct a life-line and discuss significant events in their lives. This exercise was followed with a similar exercise of constructing a family tree, during which the young person was invited to discuss their family members and relationships. Information gathered through this method was also transferred to the questionnaire after the session.

Both the assessors were trained and randomly allocated to carry out all three assessment styles, so that variations in the effectiveness of any method could not be significantly to do with the personal style of the assessor.

## Findings

### Substance use

Over half of the group described themselves as current smokers of tobacco (59%), and current drinkers of alcohol (55%). Nearly three quarters of the

Table 5 Reports of drug taking by assessment method

	Assessment method		
	A (n = 69)	B (n = 71)	C (n = 77)
Percentage of each group who reported having tried at least one drug	26%	45%	50%

smokers started smoking before the age of 13, and half of the drinkers had also started by this age.

Nearly half the young people (47%) reported having ever tried an illegal drug – almost half of them (49%) had first done so at or before the age of 13.

#### *Cannabis*

The most commonly used drug was cannabis, with 65% of those who reported any use saying that had only ever used cannabis. Half of the ‘cannabis only’ users said that they were current users, with nearly a third (31%) of them using cannabis between 3 and 7 days a week.

#### *Those who have tried more than one drug (described here as poly drug use)*

Nearly one in six (15%) of all the young people had tried more than one drug. All had used cannabis, with the most common other drugs they reported having tried being amphetamines (46% of the poly drug users), crack, heroin and solvents (32% for each). The average age at which the poly drug users had first tried a drug was 12.8 years.

Nearly three quarters of the poly drug users (71%) described themselves as current cannabis users, while very few (n=1–3) were current users of any other drug.

#### *Drug offending*

Nearly a quarter (23%) of the young people had committed drug offences, mainly final warnings for cannabis possession. Two young people were on charges of possession with intent to supply, and one for supply.

The most common offences committed by the young people interviewed were theft of less than £300 and common assault.

#### **Associated factors**

The range of personal, social and environmental factors of the young people interviewed broadly supported the picture of ‘increased vulnerability’

among young offenders that was described in the Health Advisory Service Report (1996). Some of the most notable findings were:

- over half were not in school, training or employment – only a third (36%) were attending school regularly. Teachers’ ratings were that 35% were below average performers at school – 15% of the young people rated themselves as having difficulties with concentration, reading and writing skills;
- nearly a third (30%) were not living with either of their natural parents, and 12% reported that they did not feel safe where they were currently living;
- nearly one in five (18%) were living in families where drugs were used regularly, and one in 6 (15%) were living in households where violent behaviour was exhibited on occasions;
- nearly one in five (19%) of the young people had a history of sexual and/or physical abuse prior to their involvement with the YOT;
- over half of the young people (55%) reported that they had experienced bereavement of somebody with whom they were close – 10% of those had lost one or both of their parents, 11% had experienced the death of a friend;
- one in ten (11%) of all the young people interviewed had either been pregnant or, in the case of young men, had been responsible for a pregnancy. Over a third of all the young women (34%) had been pregnant at least once;
- five percent of the young people were parents themselves, with 2 of them each having three children at the time of interview.

Living in an “unstable” environment was significantly associated with drug taking, and those young people attending school for less than one or two days a week were more likely to be using substances than those attending more frequently.

Strong associations were found between physical abuse and poly drug taking; and between sexual abuse and poly drug taking.

#### **Professional practice**

There was a statistically significant relationship

between the levels of drug taking reported by young people and the assessment approach employed. Assessment style A, the questionnaire approach, was shown to have elicited significantly lower reports of drug taking, feelings about themselves and the safety of where they were living, than styles B and C. Both these latter approaches (counselling and youth work) showed similar results, and were thought to be equally effective in eliciting sensitive information.

The variables which may have been influential in this finding included:

- style A took the shortest time to complete, usually only one session, although up to three sessions were permitted for completing any assessment;
- styles B&C did not immediately notate answers within view of the young person; and
- styles B&C allowed the young person to take some control/have some influence in the process and pace of the assessment.

The assessors reported that style A (questionnaire) was the most 'practical' for them, enabling them to ensure that all relevant questions were asked, and it was the least time-consuming. They reported, however, that young people responded more enthusiastically to the other two styles in practice, and showed a particular preference for style C (youth work), with many asking if they could keep the exercises they had undertaken after the session.

### **Key issues**

- The combination of high rates of lifetime prevalence, the early onset of all reported substance use (commonly taking place at or before the age of thirteen), and the evidence of educational difficulties and school non-attendance amongst this group, raise the importance of targeting drug and alcohol education and prevention at young people who start to disengage or show behavioural or educational difficulties at primary school.
- High rates of risky sexual activity, and particularly of pregnancy and parenthood raise the importance of ensuring that multi-facet programmes (for example Final Warning Schemes) and supervision plans for young offenders address sexual health, contraception and parenting skills as well as substance misuse.
- Training and practice in assessment should look more flexibly at a range of methods for eliciting sensitive information from young people, even where it is to be recorded on existing data gathering tools (eg ASSET).

# Hidden heroin users

Roy Eggington and Howard Parker (Victoria University of Manchester)

## Background

There are numerous indications that heroin is being used by a small minority of adolescents found, for the first time, in the youth populations of small cities and towns in several English regions. Thus, along with much of Scotland, the northern and east side English regions, parts of the Midlands and south west England all have towns hosting 'outbreaks' which begin in the 1994–7 period.

Heroin is still a drug with a dreadful reputation and stigma carried with its local presence and use. Hence its uptake by adolescents in these areas remains largely hidden. Local officials are reluctant to assess and discuss the scale of their problem for fear of the media negatively labelling their particular town or area and young users and their families are often too insecure and fearful to seek meaningful help. The end result is an inadequate and uncoordinated response exacerbated by a reluctance to develop early interventions within central government. This means several years elapse before users present for treatment or are netted in the criminal justice system, by which time they are 'excluded', dependent, poly drug users.

## Sample

This report profiles 86 young heroin users who began to take heroin when they were 15. The fieldwork took place in three different English regions involving towns and cities at different stages of their heroin problem. The interviewees ranged from 15–20 years with a mean age of 18 years. Sixty nine of the 86 were males, nearly all were white.

## Key findings

A detailed assessment of the interviewees' childhoods found that whilst these were far from ideal only a minority could be described as developmentally damaging. Where significant difficulties did occur was in early adolescence. The sample were routinely out and about unsupervised from around thirteen. Their parents did not know where they were. They were early smokers and drinkers and moved into a phase of florid drugs experimentation. At fifteen they initiated on heroin two years younger than in the 1980's heroin epidemic.

Most of the interviewees' educational performance deteriorated during secondary school years. They truanted regularly and many became disruptive at school whereby they were repeatedly temporarily or permanently excluded. A few did obtain some educational qualifications but most remain underqualified. Few have been successfully employed. Most are receiving state benefits and increasingly sickness benefit.

Heroin initiation was usually with drug using peers and involved smoking/'tooting'. Re-trying followed rapidly and most moved to weekly and then daily use. Experimental injecting was widespread and nearly half are injectors. With more regular heroin use a poly-drugs repertoire becomes common involving cannabis, tranquillisers, methadone and crack cocaine.

The dire consequences of heroin 'careers' were fully observable in this teenage sample. They had gradually become stigmatised as 'smackheads' and become dislocated from parts of their family, 'straighter' friends and conventional activities. They gravitated into poly drug using networks and cohabitations which provided support.

Ill health is settling in with this group and most also show clear signs of physical and psychological dependency on heroin and other drugs. This dependency and associated anxiety increases with length of use and the switch to injecting.

These interviewees were poly drug users. Most worryingly three quarters had tried crack cocaine and a quarter used it in the past week.

Average drugs bills were over £160 a week, about £8,000 a year. Most interviewees utilised benefits, acquisitive crime and especially shoplifting to pay for drugs with drug dealing and, to a lesser extent, begging and prostitution also being utilised. Most are becoming heavily convicted but not yet incarcerated. Around half had delinquent careers prior to heroin use but their drugs habit amplified offending. For most others heroin use led to offending.

These heroin users were initially very naïve and ill informed about heroin. They did not understand its subtle potency and addictiveness and had little idea where a heroin career might take them. As habits grow, injecting becomes routine, health and self esteem suffer and poly drug use looms, users increasingly claim to regret having ever taken heroin. Currently their drugs knowledge is sourced by their own experiences and those in the local heroin networks far more than from public health or drugs educational sources. They are a group falling between almost all local advice and service interventions. They are basically too insecure and immature to visualise the benefits of 'presenting' and simultaneously distrust adult authority which has little time for them.

### Recommendations

This time lag between these young people taking heroin and engaging with community drugs services is often several years by which time their successful treatment is far more problematic. Early interventions need to be developed. They must include providing accurate targeted information about dependency – how it develops and its consequences; how to avoid or respond to accidents and overdosing, the dangers of injecting and sharing equipment, the additional 'price' of taking crack cocaine and the knowledge and skills required to self detox/come off heroin.

As young person's drugs services slowly develop they must pay full attention to understanding and

monitoring their local drugs situation, reaching out to hidden adolescents developing problematic drug use and providing user friendly, flexible services. Currently the myriad of professionals (e.g. police, teachers, youth and community workers) who come into contact with these hidden heroin users have little knowledge about drugs issues or experience of how to intervene and advocate help. It is important that local professionals and the new personal advisors/mentors located in secondary schools are recruited to help identify young problem drug users and refer them appropriately.

Whilst problem drug use remains correlated with socio-economic deprivation and difficult family life, there are signs that new waves of young heroin users will also contain young people from more conventional, 'adequate' family backgrounds. The current policy focus on vulnerable, 'at risk' young people may need broadening slightly.

### Conclusion

This study offers further evidence that a gradual deterioration in the heavy end drugs scene is underway. In the current absence of effective routine monitoring systems more immediate efforts should be made to better define what is happening in heavy end drugs scenes across the UK. In particular the epidemiological forecasting models suggest that heroin and cocaine/crack cocaine can combine and interact for the worse. There are worrying signs that this is already occurring in the English regions.

# Drug interventions for looked after young people

**An exploration of opportunities to intervene with regard to assessment of drug use and misuse amongst young people looked after by Essex Social Services**

Carolyn Hamilton, Sue Sherwood, Nigel South and David Teeman (University of Essex)

## Background

The aim of the project was to explore the opportunities to intervene, particularly with regard to assessment of drug use and misuse among young people looked after by Essex Social Services. The objectives were:

- to examine Local Authority processes for looked after children in Essex;
- to examine the extent to which drug misuse issues are explored within those processes and how responses are dovetailed into health assessments, placement and case management for different age groups; and
- to identify how the Local Authority might integrate good practice in drug interventions into their procedures and placements for looked after children.

## Methodology

Relevant documents, guidance, pro-forma assessments and policies employed in the management, assessment and placement of young people looked after by Essex social services department (SSD) were reviewed in relation to the research objectives.

A survey of residential staff, foster carers and social workers was carried out, focussing closely on:

- issues relating to substance use/misuse among young people;
- the respondent's levels of knowledge in relation to substance misuse;
- awareness of opportunities to assess and intervene; and

- the extent to which they were trained and felt able to do so.

A total of 77 completed survey questionnaires were returned.

Seventeen subsequent semi-structured interviews were carried out with a selection of residential workers, foster carers staff and doctors.

Thirty case file reviews were carried out. This meant studying all the recorded information in the files relating to young people who were, or had been, looked after by Essex SSD. This review process looked for information relevant to the research objectives of the project, eg. to examine whether substance misuse had been identified or assessed within health assessments, and whether substance misuse was considered within placement decision-making.

## Findings

### Awareness of use among young people

There was considerable variation between foster carers on the one hand and care home staff and social workers on the other, in respect of their views about the extent of substance use among young people they were working with. Foster carers were the most likely to strongly believe that no young people were using drugs at all. On the other hand, one in eight care staff believed strongly that all young people were using drugs (although the majority of all professionals disagreed with this statement).

Table 6 **Professionals' views of extent of drug use among young people**  
(Care staff: *n* = 25; Foster carers: *n* = 41; social workers: *n* = 11)

	Strongly agree	Agree	Not sure	Disagree	Strongly disagree
	%	%	%	%	%
<b>'No young people are using drugs'</b>					
Care Staff	4	17	8	21	50
Foster carers	67	17	3	11	3
Social workers	18	–	9	36	36
<b>'Some young people are using drugs'</b>					
Care staff	25	46	12	8	8
Foster carers	3	9	6	18	64
Social workers	9	45	18	–	27
<b>'Most young people are using drugs'</b>					
Care staff	8	17	17	42	17
Foster carers	–	3	9	12	76
Social Workers	9	–	18	36	36
<b>'All young people are using drugs'</b>					
Care staff	12	–	4	42	42
Foster carers	3	–	6	9	82
Social workers	9	–	9	9	73

### Professionals' knowledge in relation to substance use and misuse

Those who had undertaken training, across all professional groups, felt better informed than those who had not. For example, when asked whether they felt 'informed on effects of drugs' two thirds of those who had received some training felt very well or well informed, compared with less than one third (30%) of those who had received no training.

Some form of training had been received by a majority of staff, however this was received from a variety of sources, with varying content and length and, for many, had taken place some time ago. In general, there was found to be a lack of any shared 'baseline' knowledge across all those responsible for the care of looked after young people, which limited opportunities for assessment and intervention and, particularly, limited the opportunities for them to initiate and/or to participate in multi-agency responses to the young people's needs in relation to substance use.

### Assessment processes

Both the general assessments and specific health assessments which were being carried out with the young people provided little or no opportunity to elicit or to record information on substance use/misuse.

These assessments therefore could not provide a basis for planning interventions in response to identified substance use, or for integrating such interventions within care plans.

### Interventions

The research found no evidence of a coordinated intervention strategy, and few examples of implemented interventions. Those interventions that were identified tended to be reactive to a localised problem and reliant on one or two informed and motivated individuals.

### Strategy

There was awareness within Essex SSD of the shortcomings of current assessment procedures, staff skill levels, and the lack of intervention services available locally. This was being responded to with multi-agency development and planning, which included plans for training, and service development.

This was matched by a willingness on the part of professionals to learn and adapt their practices, if they were given opportunities to do so.

# Towards better assessment

## An investigation of the opportunities and obstacles for the development of integrated, multi-agency assessment of young people's drug taking across Kent and Medway

Neil Hunt, Gary Stilwell, John Jolly and Judy Doherty (Kent Drug Action Team)

### Background

The research was undertaken on behalf of Kent and Medway Drug Action Team, as part of their 10 year strategy to improve substance use services for under 18s in the area. The main aims of the study were to:

- review the procedures currently employed by some of the key generic and specialist agencies in Kent and Medway to screen and assess for substance use related need among under 18 year-olds;
- examine the attendant procedures for screening and assessment used by the agencies eg. Onward referral arrangements and confidentiality procedures; and
- identify discrepancies between current and best practice, and make recommendations to develop existing service provision beyond this standard.

The study used two main data-collection methods:

- a detailed, semi-structured questionnaire, completed by one respondent from each participating agency; and
- interviews with key persons, which elaborated on questionnaire answers, and explored their perceptions of the obstacles and opportunities to develop good practice.

Questionnaires were returned from 36 agencies, and all were followed up with an interview. In some cases one agency was reporting on the activities of more than one specific service or project. Between them the 36 agencies were managing 87 services/projects based in the Kent and/or Medway areas. These services included substance misuse specialist services, youth offending teams, youth services, and a wide range of other health, and education services.

### Findings

#### Knowledge of prevalence of substance use amongst young clients

Services rarely had a clear idea about the extent of drug and alcohol use among their clients. Two in five of the agencies could not provide any estimate of the percentage of their young clients who were using or misusing substances. Of these 15 agencies, 12 were generic agencies and the other three were criminal justice agencies. Of the remaining 21 agencies, five were able to provide an estimate for drug use and alcohol use combined, but were not able to be any more substance specific. A further seven agencies could only provide very rough 'guesstimates', ie rounded to the nearest 10%.

#### Screening and assessment

The study distinguished screening and assessment. Screening was defined as '*any process used to identify whether or not someone is using drugs*'. Assessment was defined as '*a process that informs intervention planning by ascertaining the severity and pattern of use, and how the drug use affects the young person concerned*'.

Many agencies did not recognise the screening role (i.e. identification of drug-related needs) that they undertook. Many reported 'reactive' screening following an incident or other reason for a worker to look into the substance use of a young person. Only a minority used a combination of proactive and reactive screening assessments.

Most services saw assessment as a process, taking place over a number of contacts. The nature of the work of some services eg. casualty departments, restricted them to making assessments during a single contact.

Table 7 **Methods of screening/assessment used by agencies**

<b>Method of gathering information</b>	<b>Number of agencies</b>
Assessment undertaken by referring agency	4
Interview	36
Observation	33
Questionnaire or checklist	4
Assessment by diagnostic instrument	1
Reviewing previous reports	18
Urine testing	3

(multiple answers)

Few agencies reported having protocols describing how to screen for, or assess, drug and alcohol use, or what questions should be included. All agencies reported that questions about the type, amount and frequency of drug and alcohol use would 'most likely' be asked. Particularly among the more generic agencies, practice was fragmented regarding questions such as route of administration, pattern of use or future intentions regarding drug use – questions that would be regarded as essential to informing decisions about action and intervention. Although most services considered that screening/assessment was important to their work only about a third of all services regarded their practice as either 'very good' or 'good'.

#### **Multi-agency working**

Just under half of all the agencies had not participated in multi-agency assessment or work involving drug or alcohol use by a young person. Only four agencies had written protocols to guide their participation in multi-agency assessments. The majority of agencies that had participated in such work rated the process as 'adequate' at best.

#### **Informed consent and referral procedures**

Guidance on good practice suggests the use of written consent to referral for under 16 year olds, however the agencies surveyed mainly relied on verbal consent for such referrals. A few agencies never made any direct referrals but encouraged clients to self-refer. Although most agencies would directly refer young people taking drugs to other services at times, there were rarely written protocols to guide practitioners. The participants generally estimated the quality of their own service's referral practice with regard to informed consent in this area to be only adequate or poor.

#### **Confidentiality and the sharing of information**

Most agencies (n=21) reported that the criteria they applied to confidentiality and information sharing were those established within local Area Child Protection Procedures, i.e. confidentiality may need to be breached if the young person is thought to be 'suffering, or at risk of suffering, significant harm' (Department of Health 1999). Ten agencies also specified that it would be made clear that any information given by a young person would be confidential 'within the team' rather than to the specific worker who received it. The five criminal justice agencies reported that the child protection criteria informed their agreements, with the addition that disclosure of offending behaviour could not remain confidential. A minority of agencies had a written protocol clarifying how confidentiality agreements with clients should be established, requiring signed confidentiality agreements with the young person, and, where appropriate, with their parents or carers.

#### **Data collection and storage**

Most of the participating agencies primarily store information about their clients within paper-based systems that make data retrieval for monitoring purposes difficult. It was nevertheless evident that this is likely to change in the short to medium term for many services. Six agencies reported that they were about to install new computer-based systems. However, it was not clear that consideration had been given to the need for systems to 'talk to each other' through the use of standardised fields of information or compatible file formats. Even among those agencies where assessment and screening procedures were thought to be important, only a few agencies reported having data management systems that they judged to be better than adequate.

### Training

The majority of agencies reported that some training for their staff about drug taking was available. This was often cascaded down from one worker to another and of uncertain quality. Agencies nevertheless considered that the training that was provided was generally of a good standard. The scope of the available training was largely limited to general awareness training rather than any specific skills-based programmes. Almost five out of every six agencies reported that training for screening was unavailable. The use of 'dedicated' training programmes around young people's drug taking was rarely reported by the participating agencies.

### Parent and carer involvement

The majority of agencies (22) took the position that, where possible and appropriate, parents or carers should be involved as early as possible. Seven of these agencies said contact would not be automatic but that a judgement would be made about what was best for the young person. Five agencies reported that they would always contact parents or, failing that, inform a third party with pastoral responsibility, such as a school. Few agencies had written protocols governing the involvement of parents, but most had established 'common practice' for them in relation to contacting and/or working with parents.

In relation to drugs specifically, some agencies had absolute expectations that the parents/carers of an under 16 year-old would always be involved whenever drug taking was identified.

### Key issues

- While many agencies recognised the need for, and the benefit of, screening and assessing young people's substance use, many lacked any protocol or process to ensure that they did so proactively.
- As such procedures are developed, they will need to be incorporated into training for the professionals who are asked to screen and assess substance use.
- Current developments in information gathering and monitoring tools across all agencies involved with young people need to consider the collection of substance misuse data, and the need for comparability of the data to inform local and national strategies.

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