

Sharing the Learning

The Drug and Alcohol Transitions Project
for Young Adults Derby City

2009-12



Acknowledgements

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A number of Addaction staff, service users and staff from partner organisations were interviewed to provide information about how the project operated. We are extremely grateful for their input. Quotes are attributed to the individuals' posts. Where job roles changed during the lifetime of the project, as was the case for several of the Addaction staff, the role chosen for a quote is the one that was relevant to the work described. The names of the young adults that were interviewed have been changed to preserve anonymity.

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Designed by Sheran Forbes

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Introduction

The aim of this report is to tell the story of the Addaction Drug and Alcohol Transitions Project for Young Adults in Derby City. This project carried out successful, innovative work, helping young adults aged 17-24 to end, or substantially reduce, their substance misuse. The approach was highly cost effective and makes a powerful case for age-appropriate services for young adults.

This report is designed for a diverse audience. It will enable practitioners, commissioners and policy-makers working in the substance misuse field to learn the lessons from the project's work and will also be valuable for all agencies concerned about how best to meet the needs of vulnerable young adults.¹

The report has been written by external consultants who interviewed the project staff and some of the young adult clients. Information has also been drawn from the project's records. It covers:

- **an overview of the project**
- **a timeline of the project's activities**
- **the community outreach work and individual treatment in detail**
- **what the focus on young adults meant in practice**
- **finance and value for money**
- **The main messages from the project's work.**

There are also several appendices which cover the project's clients, information about the changing nature of young adulthood, and national data on the use of drugs and alcohol by young adults.

The interview material provides the kind of detail that is necessary to bring the work alive. It shows what the staff actually did and contains their reflections on what worked and what was less successful. The young people also tell about what made a difference to them at a crucial stage in their lives.

This report is not a formal evaluation of the outcomes of the project's work; however, it paints a picture of a very effective project that broke new ground in work with young adults.

We hope this resource will benefit you in your work.

¹The definition of the term 'young adult' varies greatly, with organisations, individuals and researchers often using different parameters in different circumstances. The lower limit tends to vary from 16-18 years and the upper limit from 21-29 years. In the report we often use 18-24 years to reflect the sources we are quoting. The Derby Transitions Project deliberately set the age of 17 years as its lower limit in order to bridge the gap between the young people's service and the Transitions project. Appendix 5 explores this issue in detail.

Executive Summary

Service Users

- Young Addaction Derby's Transitions Project (2009-2012) developed an innovative alcohol and drug project for 17 to 24 year olds by focusing on two tiers of the National Treatment Agency's (NTA) four tier model of service provision for alcohol and drug misuse: community outreach work (Tier 2) and treatment work for individuals (Tier 3).
- The Transitions Project carried out treatment sessions (Tier 3) with 230 young adults and delivered community interventions (Tier 2) to 749 people. An average of 95% of clients completed their Tier 3 treatment successfully (data from years two and three).
- The project reached slightly more women than men in the outreach work, but many more men (70%) than women took up individual treatment. The majority of the project's clients (Tiers 2 & 3 combined) were White British (62%). 38.5% of clients were from BME groups and Pakistani young adults (5.7%) were the largest single minority ethnic group.

Cost benefit

- The project offered excellent value for money, with the cost of successful individual treatment estimated at around £940 per person. This compares very favourably with £3,000 per head identified as by the National Audit Office (NAO) as the 'cost of funding for every adult in effective treatment' (NAO, 2010: Fig 5, p.24).
- The significance of the cost of individual treatment is best appreciated given that the NAO has also noted that the quality of evidence for the effectiveness of drug treatment was 'robust' and that it has been calculated that such treatment saves the taxpayer £2.50 for every £1 invested, mostly by cutting crime (NAO, 2010: p.28).
- The estimated cost of the Tier 2 community interventions also represented value for money at under £140 per head, given that the majority of the 749 young adults would probably not have accessed treatment in the conventional sense.

Treatment

- The treatment offered was in line with NICE clinical guidelines (NICE, 2007) and depending on the type of drug problem included: abstinence; self-help approaches; referrals to AA) where appropriate; harm/risk reduction; opioid detoxification; cognitive behavioural therapy (CBT); psychosocial interventions; referral to a residential rehabilitation centre (referral); and relapse prevention.
- The project was developed following a young person's drug misuse needs assessment in 2007 by Derby Community Safety Partnership (DCSP) which found that young people aged 18-24 in Derby City were generally not accessing adult treatment services and that they were also less likely to be retained in treatment for the recommended 12 weeks.

Target group

- The project also aimed to attract new groups of drug and alcohol users into treatment, including young adults who were reluctant to regard themselves as needing any treatment intervention as defined by the NTA.
- Key target groups were young adults leaving young people's services who were not emotionally appropriate for adult services; young adults not using class A drugs; and young adults whose needs were not being met in an adult service and who were at risk of or had dropped out of treatment.

Principal aims

- The Service Level Agreement (SLA) between DCSP and Addaction contained the following outcomes:
 - to Improve the engagement of 18-24 year-olds, specifically those aged 18- 21 years
 - to Improve the proportion of 18-24 year-olds, specifically those aged 18-21 years successfully exiting treatment
 - to ensure the seamless transition of the small cohort of individuals transferred into adult drug and alcohol treatment services.
- The project met the targets of the SLA. In the project's second and third years, all the young adults assessed as requiring specialist substance misuse treatment began their treatment within 15 working days and 94 per cent (two-year average) of this group had a care plan which specifically related to their substance misuse needs within two weeks of starting treatment. In year two, 92 per cent of the young adults discharged completed their treatment as planned and in the third year this figure increased to 98 per cent.

Why young adults?

- The project targeted young adults because, although drug prevalence is greater amongst younger adults than in the adult population as a whole, treatment services are not attuned to the needs of the younger group. Adult treatment services are more geared towards opiate users, whilst young adults who misuse drugs tend to use alcohol, cannabis, cocaine and ecstasy – the 'ACCE group'.
- The project recognised that the transition to adulthood has changed. Young people now take longer to achieve independence, and this is becoming even harder during a period of recession. Also, modern neurological research now shows that the parts of the brain that affect decision-making and impulse control are not fully developed until a person is in their mid-twenties. Services need to recognise these issues and adapt accordingly.
- Some young people from disadvantaged backgrounds still take a fast track to adulthood and can struggle, especially if they have limited family support. This group is overrepresented in the criminal justice system and are also more likely to misuse drugs.

Referral and outreach

- The project's referral sources remained fairly static over the lifetime of the project with Further Education settings and Crime Prevention services being the highest referrers.
- The project's staff were aware of the life stage and substance misuse patterns of this group. Imaginative community outreach work, coupled with a holistic approach delivered results. The project was successful because staff listened to what the young adults told them about the work, and used the information to develop what was on offer. Above all, they brought commitment, creativity and stamina to what they did.

Approach

- The staff worked in a person-centred way. A holistic approach works best with young adults because it is not effective to focus on drug and alcohol use in isolation. The approach built the young adults self-esteem and confidence. It strengthened family relationships and improved physical and mental health, fitness and general wellbeing and was tailored to the individual's circumstances.
- Flexibility was the key. The young adults appreciated down-to-earth staff who connected with them. Keeping in touch by texting was popular and staff also supported their clients at meetings, making productive use of informal contact such as car journeys.

Supporting activities

- The holistic approach also included complementary therapies such as acupuncture and Reiki and a fully equipped gym was a great asset, helping to attract and retain clients.
- The gym acted as a hub for wider health work which covered the physical impact of substance misuse, nutrition, healthy eating, and cooking.
- The Transitions Project was run along the same lines as a young people's service with smaller caseloads than are typical in adult services.
- The project increasingly included the young adults' families in their work – crucial given the clients' stage of life. 'Significant others' can play a vital role in supporting young adults through the treatment process.
- Although work with individuals varied depending on need, a typical period of treatment was 5-8 months which included use of the gym as part of the discharge and aftercare programme. Clients were not discharged until they were ready.

Community outreach and partnerships

- Community outreach work was also central – enabling the project to contact young adults who were unlikely to approach the project themselves. Building strong links with the local college and university was the key to reaching the target age group. Attending events such as fresher's' fairs, running drop-ins and creating a peer mentors group raised the project's profile and built its capacity.
- Working with community organisations that were supporting disadvantaged young adults such as hostels and education and employment projects was the way to reach young people with a range of problems. A specialist post within the Youth Offending Team helped the project reach young people in the criminal justice system.
- Running mini taster/interventions on topics such as boxing for fitness and acupuncture promoted the project's accessible approach and showcased its complementary therapies.
- Achieving a 'young adults' focus within an overall young people's service meant the project had to address dilemmas such as how best to set aside time slots for separate age groups to avoid potentially inappropriate contact between the young adults and the younger children. It also had to recognise the different range of needs within the 18-24 age group itself.

The national picture

- With the growing awareness that the transition to adulthood has changed, pioneering organisations have begun to target this group specifically in the services that they are providing and the Barrow Cadbury Trust (BCT) has been at the vanguard of this approach. Several research studies have identified the key elements of promising practice in this field and the findings from this study are consistent with this emerging body of work (Burnett et al, 2010; Devitt & Lowe, 2010; Sturrock, 2012).
- Other specialist alcohol and drugs projects with similar aims to that of the Derby Transitions Project exist; for example, Young Addaction's project in Liverpool (Addaction, 2012); Mosaic in Stockport (Mosaic, 2012) and Norcas in East Anglia (Norcas, 2012). But the learning from these projects has not been widely disseminated and other similar projects may well be operating. A comprehensive survey of alcohol and drugs projects that are targeting young adults would be a real asset.

Conclusion

Addaction's Transitions Project in Derby City has shown that a flexible substance misuse service that targets young adults, aged 17-24, can achieve impressive results when staff have the skills and creativity to work in ways that are attuned to the life stage and substance misuse patterns of this group. Imaginative community outreach work, coupled with a person-centred holistic treatment approach, is an effective model for those aiming to support this age group.



Section One: Overview

Young Addaction Derby's Transitions Project began in December 2009 and closed at the end of March 2012, when elements of the service were incorporated into Breakout, a Young People's Substance Misuse Service for Derby City run by the NHS.

From the start, the project staff set out to meet the overall aim of setting up and delivering a substance misuse service for 17 to 24 year olds by focusing on two key strands: community outreach work and treatment work for individuals. These strands fit within the National Treatment Agency's four tier model of service provision for alcohol and drug misuse (NTA, 2002 & 2006):

1. Community outreach (Tier 2 work) – getting into contact with young adults who are unlikely to approach the project themselves by going to a variety of community settings and providing input about the risks of substance misuse and what the project had to offer. This approach would in effect deliver 'brief interventions' to a large number of young adults.
2. Delivering one-to-one treatment sessions (Tier 3 work) – this strand involved in-depth work with individuals and, as the project developed, with partners and family members using a range of flexible methods attuned to the needs the age group.

Over the project's three years it carried out treatment sessions (Tier 3) with 230 young adults and delivered community interventions (Tier 2) to 749 people, 56% of whom were female and 44% were male. Men accounted for a higher proportion of those in treatment – 70%. The majority of the project's clients were White British (62%), with Pakistani young adults (5.7%) the largest minority ethnic group. Appendix 2 provides more information on the gender and ethnicity of the clients. Around 60% of clients were aged 17-19 when they became involved with the project, and the bulk of the remainder were aged 22-23.

Why the project began

Four main factors led to project being set up:

- An understanding of the patterns of alcohol and drug use amongst young adults (17-24)
- Weaknesses in service provision
- Evidence of need locally
- Funding opportunities.

Young adults, substance misuse and service provision

Drug prevalence is greater amongst younger adults than the adult population as a whole, with around one in five young people aged 16 to 24 using one or more illicit drugs in the past year compared with less than 10% of the adult population (aged 16-59). This pattern has been well documented in research since the mid 1990s (Smith & Flatley, 2011). See Appendix 6 and 7 for national statistics and detail on patterns of drug usage amongst young adults.

Young adults who misuse drugs tend to use multiple substances, the most popular combination being alcohol, cannabis, cocaine and ecstasy (Smith & Flatley, 2011) – the ‘ACCE group’. Older adults generally use a single drug and the main drug for which adults receive treatment is heroin, which accounted for 49% of all adult treatments. An additional 32% of treatments are for those who have taken opiates and crack (NHS, 2011).

Speaking at the UK National Drug Treatment Conference in 2008, Professor Howard Parker highlighted why the different patterns of drug use have implications for services:

ACCE users perceive current adult provision as not for them... Community Drug Teams are primarily geared to heroin-crack users and Community Alcohol Teams are already overstretched with middle-aged problem drinkers... vulnerable and previously looked-after young people need special attention during transitional years as previous statutory support ebbs away. (Parker, 2008)

Research from John Moores University, which explored the needs and perceptions of drug users aged 18-25 in Liverpool, confirmed Parker’s conclusions. Around half of the young people reported negative experiences of treatment, with three main barriers identified: interacting with crack/heroin users; having to leave the young people’s service at 18; and the stigma associated with attending adult drug services. The young people questioned wanted their own young adults’ service, where they would be listened to, treated with respect and offered wide-ranging, long-term support (Wareing et al, 2007).

Evidence of need in Derby City

Staff at Addaction and colleagues in alcohol and drug services across Derby City had become aware for some time that a group of young people were slipping through the net. In 2007, Derby Community Safety Partnership completed a needs assessment of drug service users within Derby City. The assessment found that young people transferring to adult services were generally not being assessed within 12 weeks, and as a result, many were failing to engage, and those in treatment were less likely than other users to be retained for 12 weeks (DCSP, 2007).

An Addaction Team Manager at the time the project was conceived remembered:

Young people of that age, that transitions period, were not really accessing treatment. They weren’t in Adult Services and they weren’t in Young Person’s Services. So where were they? (Addaction Team Manager)

Addaction thought it vital to find out what kind of services might connect better with this group and in July 2008 consulted with 150 young service users on the key aspects of ‘young people friendly’ services. The young people said they wanted convenient opening times in accessible locations; a ‘warm, welcoming and friendly’ environment; and more direct involvement in the way the service was planned, developed and promoted (Stephenson, 2008).

Addaction had already run some encouraging young adult pilot projects in Liverpool and South Lancashire and saw the opportunity to build on this learning with a project in Derby City, with the ultimate aim of setting up a network of young adult services around the country.

Funding opportunities

Addaction was able to secure funding for the project, with the following two sources providing roughly equal amounts per year:

- **Derby Community Safety Partnership (DCSP)**
- **The Barrow Cadbury Trust (BCT).**

Derby Community Safety Partnership (DCSP) was formed in 2003, through a merger with the Youth Offending Service; Drug and Alcohol Action Team; Crime and Disorder Reduction Partnership; Domestic Violence Partnership and Anti-Social Behaviour Team.

DCSP works as part of a wider partnership with the services above to promote community safety and build stronger and safer communities. It is a focal point for steering services within Derby City to address local priorities and concerns. DCSP provides funding through government resources to develop and deliver the government's Drug and Alcohol Strategy by investing in services offering treatment for Drug and Alcohol use.

The Barrow Cadbury Trust (BCT) is an independent charitable foundation with a longstanding interest in criminal justice issues. BCT funded the project as part of its Transition to Adulthood initiative, which campaigns 'to produce a better response to offenders in the young adult range' (T2A, 2009: p.7). BCT convenes an alliance of organisations and commissions pilot projects, research and other initiatives. Central to its approach was the view that the transition to adulthood has changed in recent decades and was poorly understood. The first recommendation of the Alliance's 2009 Young Adult Manifesto was:

We recommend that all of the agencies that comprise the criminal justice system recognise young adults (aged 18-24) as a distinct group on account of their developmental stage, as well as social, economic and structural factors that specifically impact on them. (T2A, 2009: p.8)

This view was informed by research which has shown that since the 1980s the traditional markers of adulthood such as entering the labour market, becoming financially independent and starting families have tended to happen later for most young people (see Devitt et al, 2009). But at the same time, vulnerable young people including those from disadvantaged backgrounds often have to tackle the responsibilities of adulthood at an earlier age than their counterparts, with fewer resources and often limited family support (ODPM, 2005) – see Appendix 5.

The project's aims and objectives

The overall aim of the project was to improve the health and wellbeing of young adults who are at risk of developing long-term problems associated with drug and alcohol misuse by establishing a bespoke, age-specific service in Derby City.

The specific aims were:

1. To reduce or stop young adults' drug and alcohol use by addressing underlying problems and increasing their knowledge and awareness of drug and alcohol issues
2. To improve young adults' engagement with positive activities by increasing their confidence to participate, identifying barriers and addressing them
3. To achieve policy and practice change at local and national level for this group of young adults.

In order to achieve these aims, the project identified the following key objectives:

- To deliver tailored messages through appropriate channels that build awareness with the target audience and encourage attendance at the young adults' service
- To develop formal care pathways and links with relevant organisations and services
- To provide one-to-one counselling and support on alcohol, drugs and related issues
- To provide group workshops, information and advice on drugs, alcohol and related issues
- To facilitate life skills development workshops such as budgeting, health, nutrition, self-esteem, confidence, education and employment
- To facilitate diversionary activities such as sports to divert young adults away from harmful behaviours
- To promote the benefits of a young adults' service to local and national policymakers and commissioners through reports and information-sharing events.

The Service Level Agreement (SLA) between DCSP and Addaction included the following outcomes:

- to Improve the engagement of 18-24 year olds, specifically those aged 18- 21 years
- to Improve the proportion of 18-24 year olds, specifically those aged 18-21 years successfully exiting treatment
- to ensure the seamless transition of the small cohort of individuals transferred into adult drug and alcohol treatment services.

At the end of 2011, Addaction entered a tendering process to retain the contract to continue to deliver commissioned drug and alcohol treatment services to young people in Derby. However its bid was unsuccessful and Breakout, a Young People's Substance Misuse Service for Derby City run by the NHS was set up in April 2012.

Addaction's Transitions project influenced the shape of the new project in a crucial way as the new service will work with young adults up to the age of 21 which is an improvement on the previous practice of moving them into adult treatment at the age of 17 or 18. There is now general agreement that adult services are an unsuitable environment for vulnerable teenagers.

The new service will maintain the combination of Tier 2 work (providing education and screening) and Tier 3 work (delivering one-to-one treatment). This means there will still be an outreach element to the team's work, and staff will be able to continue to provide a presence at drop-in centres, fresher's events, parades and other public events targeting young adults. Unfortunately, the gym, an innovative aspect of the Transitions Project will not continue.

Section Two: Timeline

This section provides a timeline of the project's activities over the three years. Sections Three and Four consider the work in more detail and Appendix 2 has information about the client's gender and ethnicity.

Year One (Dec 2009 – June 2010)

In the project's early months, the work concentrated on team building and wider development work including making contact with potential referring agencies and publicising the new project. Nevertheless, the project was also working directly with clients quickly because not only did it pick up referrals from these contacts; it was also able to work with young adults moving on from Addaction's young people's service. By about six months, the two strands were firmly in place.

The project carried out treatment sessions (Tier 3) with 62 young adults and delivered community interventions (Tier 2) to 318 people. 71% of those in treatment were males. The majority of the project's clients were White British (73%), with Black Caribbean (10%) and Pakistani young adults (8%) the largest minority ethnic groups.

Tier 2 work included drop-in sessions in community settings at a range of venues, including Derby YMCA, Derby College, Derby University and The Space (a young person's advice and information centre in the city centre). Tier 2 works also included information giving about the risks of substance misuse.

The Tier 3 work was carried out in ways that were more flexible than traditional adult drug treatment services. For example, the young adults responded positively to the opportunity to meet in evening sessions and preferred the convenience of home visits and meetings at neutral, community venues. Also, because Young Addaction Derby is a young person's service, the staff felt that for safeguarding reasons, it was not appropriate for young adults over the age of 18 to be on the premises at the same time as the under 18s.

Partnerships with other organisations were crucial including that with the Derby Drug and Alcohol Action Team (the project's co-funder) along with Derby City Pub Watch, Phoenix Futures (Adult Drug and Alcohol Services), the Probation Service and Derby Community Safety Partnership.

Key achievements included developing new facilities and activities to attract and retain young adults, the most notable being the opening of the project's gym at the end of March 2010. This enabled each Tier 3 client to have a personalised health programme, which was integrated into their overall care plan. The gym became an important element in the project's work in the subsequent two years.

YEAR 2 (June 2010 – May 2011)

Consolidation and expansion were the features of the project's second year. The Tier 2 work reached 328 young adults and the Tier 3 treatment, 82 clients. The proportion of clients from minority ethnic groups was now 44%, a 17% increase on the previous year. Pakistani young adults were the largest single minority ethnic group (18%). Females were now in the majority at 52%, but a higher proportion of males were in treatment (65%). Nearly half (44%) of the 410 young people that the project had reached were aged 18 or 19.

Referrals from criminal justice agencies increased during the second year as did referrals from Derby YMCA and homelessness agencies.

The project's Tier 2 work included providing individual advice or information on drugs or alcohol and by delivering brief interventions. The project was able to reach greater numbers of young adults by raising awareness of the risks of substance misuse at public events such as fresher's' fairs and community events.

Derby University

Work on campus at Derby University was significant and included health road shows; one-to-one work following referrals from student health services; participation in evening patrols on campus with the university's other health services and establishing a team of peer counsellors. Twenty undergraduates were trained to enable them to provide advice, information and signposting to other young adults.

Derby College

The project also cemented its presence at Derby College by attending the fresher's' fair plus a separate health and wellbeing fair which was attended by a range of health agencies. Positive links with key staff resulted in regular referrals of young adults for individual treatment.

Other community venues

Regular drop-ins took place at Derby YMCA, which enabled the project to reach single homeless people, many of whom had a history of problematic drinking and drug taking. Drop-ins at The Space youth centre provided the team with a presence in Derby city centre.

Schools

Peer education work at Landau Forte School in 2010 gave a group of 6th formers training in issues such as drugs, alcohol, risky behaviour and treatment options, as well as support to deliver brief interventions to fellow-students. In 2011 this group took part in PSHE lessons and contributed to training sessions for parents and teachers.

Transitions Health Road-show

The development of a Transitions Health Road show enabled the project to reach many more young adults. Staff attended student or community events to provide information and advice on drugs, alcohol, sexual health, complementary therapies such as acupuncture and Reiki, demonstrations of the box-fit programme and access to general health education. By this time, the road show had attended all 15 sixth form schools in the city as part of an education programme called Control ALT ESC.

Criminal Justice

Perhaps the biggest change during the second year was the increased focus on criminal justice clients, which led to a growth in referrals in this area. The number of referrals from the local youth criminal justice agencies (probation and the youth offending service) increased to 75 – or nearly 20% of clients. To support this focus, a specific Transitions Project Worker was designated to work exclusively with criminal justice clients, which enabled her to maintain close partnerships with other criminal justice agencies and build specialist skills in this area. This post also improved the team's engagement with prison leavers.

In year two the project continued the flexible, personalised and intensive approach to treatment (Tier 3 work) pioneered in young people's service and 82 young adults received one-to-one treatment.

Typically, the one-to-one work began with an individual assessment which resulted in an agreed action plan with the client. The treatment sessions were flexible and took place in the community. Clients were able to request additional meetings at moments of crisis or relapse.

Diversory activities and complementary therapies included the Box-fit programme which uses boxing training as a means of exploring and explaining the physical and emotional effects of substance misuse. This programme was also made available at Foston Hall women's prison to work with prisoners prior to their release. A healthy eating and nutrition programme was also developed, and clients were also able to access individual or group education sessions on nutrition, the basics of cooking and how to eat well on a limited budget.

Year Three (June 2011 – March 2012)

The project worked with 189 clients in its final year. The community Tier 2 work reached 103 young adults, and 86 clients benefited from individual treatment work. 64% of clients were White British with Pakistani young adults the largest minority ethnic group (13%). In terms of gender, the project reached a higher proportion of males in this year (59%) and as with previous years, males were the larger group in treatment (74%).

Following cuts to other services, the Transitions team in Derby had become one of the only young people's services in Derby City that was operating on an outreach basis. As a result, the work expanded to include collaborations with Derby licensing officers, the Police Service and other youth charities such as Safe & Sound Derby.

Highlights of the Tier 2 education work included ongoing work with Derby University, Derby College, Derby YMCA, and adult education colleges, and providing awareness sessions to their staff on the impact of substance misuse and how to support a young adult into treatment. In addition, the project provided drop-in sessions at these centres for students who wanted to talk informally about drug and alcohol problems.

The project also created a five week training programme for young women on alcohol and drug use and sexual exploitation. This was delivered within the Youth Offending Service (YOS) in partnership with Safe & Sound Derby, a charity supporting vulnerable young people in Derby at risk of sexual exploitation.

In this period, the Peer Mentoring programme at Derby University was successful in recruiting and training 12 more peer mentors, who were able to offer advice to students at risk of developing problematic substance use and also information on how to access treatment.

Tier 3 work expanded its scope by developing a parent/carer intervention tool designed to provide support, advice and guidance for parents/carers of young adults in treatment. The aim of this initiative is to ensure that the young adult and their family work together and support each other to achieve the best possible outcomes from treatment.

The project also developed an Open College Network (OCN) accredited programme of learning designed to support young adults in treatment who were not in education, employment or training (NEET) and help them enter the job market.

The project was also extended to offer a relapse prevention package to support young adults who were leaving treatment.

At the end of 2011, Addaction entered a tendering process to retain the contract to deliver commissioned drug and alcohol treatment services to young people in Derby. Unfortunately it was unsuccessful and the project was incorporated into a new Derby NHS team on 1st April 2012.

Section Three:

Community Outreach Work

Community outreach (Tier 2) work was a major strand of the project's activities and the project reached 749 young adults in this way over the three years. This section examines that work in more detail.

Reaching young adults

The aim of the Tier 2 work was to reach young adults who are unlikely to approach the project directly. In doing so, the project would provide information in an engaging way about the risks of substance misuse, deliver 'brief' one-off interventions, and in some cases provide a bridge to Tier 3 treatment work.

This work required building links with a number of community organisations and trying out a range of different strategies, some of which were more successful than others.

The obvious practical dilemma facing the project workers was how to reach young adults who typically do not approach services. The project tried several options, all rooted in the principle of outreach – going to where the young people are.

Colleges and universities

Making links with Derby College, one of the largest Further Education Colleges in the UK and with Derby University provided ready access to a significant part of the project's target age group.

Derby University

There were several productive connections with Derby University which included (at different times): input at freshers' fairs; referrals from the GPs at the student health service; participation in evening patrols on campus with the university's other health services and drop-ins.

The project staff felt that initially, the GPs were perhaps a bit wary of what they were offering, but as professional relationships strengthened the link became successful. The project's staff then met individual students at a place of their choosing – on campus, at a café or other community venue.

At first, transitions workers took part in evening patrols on campus with the university's other health services, but reinstated drop-ins when the university later ended the patrols because of a cut in funds.

Peer mentors

A peer mentoring group was set up in order to build the university's capacity to provide basic advice about drugs and alcohol, to reach the young people effectively and to create a route for referrals to the project.

The initiative took some time to get started because it became a little embroiled in bureaucracy as well as being hindered by staff changes at the university but eventually proved a great success. The project recruited around 20 students via existing links with the students' union, through promotion at fresher's fairs and through leafleting.

The prospective volunteers were interviewed individually to ensure that they had the right motivation and enthusiasm. The mentors received training about alcohol and drugs, particularly cannabis and cocaine. The training also covered legal highs. The input promoted a harm minimisation approach and also covered topics such as brief interventions, the cycle of change, and motivational interviewing. The aim was to build the mentors' knowledge and confidence, not to equip them to act as counsellors.

The training sessions took place at the university and at Addaction's office, with around six students per course. The students that came forward tended to be studying relevant subjects such as health and social care, nursing, criminology, or youth work. Some were looking to work in a field where the peer mentoring experience would be valuable.

Following the training, the mentors made direct contact with Addaction staff if they wanted to check out something. The regular contact the project staff had with the mentors convinced them of the value of this approach, both in terms of its effectiveness in delivering ongoing Level 2 interventions via the mentors, but also in providing a channel through to treatment for individual students from the university.

Derby College

The project also invested significant time in its links with Derby College which again provided an excellent way of reaching large numbers of young people. The input included running 16 separate group sessions (20 students per group) on alcohol and drugs for specific groups of students such as those on the motor vehicle courses. The project also ran awareness sessions for college staff on the impact of substance misuse and how to support a young adult into treatment. Project staff also made themselves available to students in the foyer/reception area over a lunch period for informal drop-in sessions, so they could be approached discretely.

Developing a profile for the project at the college made it easier for students that needed individual treatment to access the service. A Derby College staff member in a pastoral role commented:

Since the sessions, when I've been attending disciplinary reviews (around drugs) and I've said to young people, 'Would you be interested in accessing Addaction?' they go, 'Oh yes, they're the group that came in and saw us'. (Derby College Support Worker)

And the team are young. They are funky. They are not, you know, old fuddy-duddies that come along and just say, 'Drugs are bad' ... They are real people, so my impression is the young people find that really useful. It makes them approachable. (Derby College Support Worker)

The Derby College Support Worker would also get feedback from students that had accessed individual treatment from the project such as an 18 year old Asian young man who had been using marijuana on a regular basis. Drug use by motor vehicle students was treated very seriously at the college because of the risk of accidents it could cause.

And he came to me at the end of the year and said, 'That really changed my life. You know, really turned things around.' Even though he didn't conform ... didn't turn out as a model citizen, but yes, he changed. He got to the end of the year and passed. (Derby College Support Worker)

The project also provided input to the college's Health and Wellbeing Day which catered for about 2000 students.

Project staff saw involvement at the Derby University and Derby College fresher's' fairs as one of the highlights of the Tier 2 work.

Fresher's' Fair is mayhem ... we just have a stand. We take the 'beer goggles' down, the drug box, play a little game. But we get a lot of interest that way.

(Project Worker)

... We'd get them to shoot a mini basket-ball into hoops wearing beer goggles ... At one event we were placed opposite a stand giving away free (alcohol) shots!

(Project Worker)

... Young people come and see you at the end of the day. It is nerve-wracking to come to a drugs and alcohol service when you are at college or university. 'Cos why would you really? There's a whole stigma thing about it. The norm at college is to go and have a good time, so what you normally see is people come to you at the end of the sessions, or first thing the next day. They come to you early and talk to you about something. It's good. Really good. (Project Worker)

Health road-show

To reach young adults in a wide range of settings, the project ran an ongoing road show that went to the university and college as well as a wide range of events including Derby Gay Pride.

In other settings such as hostels for homeless young adults, the road show would take a different format, a mixture of drop-in and group work. For example a session for a group of 5-8 would be scheduled from 7:30 to 9:00 and would begin with a 30-40 minute talk on alcohol or whatever the organisation saw as the most prevalent problem. It would then continue with mini tasters/interventions on topics such as boxing for fitness and acupuncture. The young adults would not necessarily attend all the inputs, but rather drop in and out as suited them. Sessions became more popular as other young adults got to hear about them, and they provided a route into treatment for those that wanted it:

Once we'd done it a couple of times we had a lot more people coming in. Sometimes they'd just come in for boxing. But that was a great opportunity to have a discussion with them outside of a treatment perspective. Generally what you would find is that months, or even weeks, later they would come and have a drop-in and come to your service that way. (Project Worker)

But running health road shows at hostels also requires excellent communication with key hostel staff to avoid arriving for an evening session and finding that the staff on duty did not expect you, or that there were insufficient staff to assist if some residents were disruptive or threatening.

Control ALT ESC

This initiative raised awareness via a short intervention and in a fun, creative way that would aim to challenge what young adults expected of a drug or alcohol treatment service. For example a hostel might identify a particular substance that was causing concern such as M-cat (a street term for mephedrone and also methcathinone) and the project session would focus on the relevant drug(s) providing harm minimisation, advice and information together with a flavour of what the service offered including acupuncture and box-fit. This type of informal intervention also provided staff with the opportunity to ask young adults what they want from a treatment service and to make improvements based on the feedback.

Drop-ins

The project initially ran drop-ins at various locations including at the university, but staff concluded that it was not necessarily a good use of time as very few clients came forward in those settings. Also, if project staff became recognisable to the young adults, it compromised confidentiality if a young person was then seen in town with one of them.

Educational materials

The project created a five week training programme for young women on alcohol and drug use and sexual exploitation. This was delivered within the Youth Offending Service (YOS) in partnership with Safe & Sound Derby, a charity supporting vulnerable young people in Derby at risk of sexual exploitation. The programme has been well received by the YOS.

Bars and pubs

Research confirms the commonsense assumption that there is a clear relationship between nightclub and pub visits and illicit drug use (Smith & Flatley, 2011) – see Appendix 7. Consequently, project workers initially sought to engage young adults in these settings. Project staff had mixed views of the value of that time-consuming work. One worker felt that it had been valuable and that the people they spoke with were open and engaging and that it resulted in a lot of referrals, whilst a colleague had a counter view:

I'm not sure how effective going into nightclubs is. If they are drunk they can't remember. I suppose getting out there and getting your name known is good, but can they remember?

And we asked young people, and they said, 'No we don't want you to do that. We don't want you to be in nightclubs when we are having our free time'. Why would you? I go out for a drink and I wouldn't want to be harassed by somebody coming up with a leaflet. (Project Manager)

The Service Manager summarised the achievement of the Tier 2 work as having been able to influence how young people saw as 'normal' behaviour, especially around alcohol and that such work challenged narrow views about what constitutes treatment:

We see Tier 2 as a non-structured form of intervention. But for me, Tier 2 is treatment because if you're having a conversation with somebody about the ill-health effects of excess alcohol use then that is a form of treatment. It's just not necessarily defined (formally) that way. (Service Manager)

Section Four:

Individual Treatment Work

The project provided individual treatment for 230 young adults over its three years. Appendix 3 includes case studies that illustrate the work and the benefits to the young adults. In this section we explore the approach of the treatment work and also discuss record-keeping and measuring outcomes. We begin with the accounts of some young adults.

The young adults' experiences

Lauren, aged 23 had been referred to the project when she was drinking and using heroin. Sexual abuse and bullying were at the root of her low self-esteem. She was receiving support locally from mental health services and had been referred to adult treatment services for her substance misuse problems, but she did not relate well to what was offered:

I felt that they demoralised me. The bloke was nice to begin with, but he took the moral high ground ... they put me in a box. (Lauren)

Ten months after her discharge from the Transitions Project, Lauren looked back at her time with the project and remembered that at the start her 'big problems' were 'alcohol, heroin, mental health and low self-esteem', but now, only low self-esteem remained as a big problem:

I don't know what I would've done without them. Would've been dead by now. I did overdose on heroin once. It was so easy to do another packet, do another ball. I wouldn't be here without them. That's the credit to the service themselves. (Lauren)

Amit, aged 19 was smoking cannabis a lot when he was referred to the project by Probation, and this was linked to other behavioural problems. He was in treatment for about a year:

I used to be loud and bubbly, but the cannabis just made me tired and lazy. Using the gym at Addaction has made me confident and energized again.

I have the occasional smoke, but not all the time anymore ... sometimes only once a week. I used to spend £20 a day, and not like £10 every few days, sometimes a week... I've saved a lot of money, controlled the smoke. It's a lot lower and a lot more controlled. (Amit)

Ryan, aged 17 was drinking alcohol daily when he was referred to the project as well as suffering high levels of stress and insomnia. He described the project as 'advice heaven' and rated the project as 'eight out of ten' in terms of the difference it had made to his life, helping him control his drinking and make more of his life:

The service helped me to accept other people's help. I wouldn't let people at school help me before... I want to get better qualifications, get the grades I am capable of, so I'm not a waste of space when I am older. (Ryan)

Jasmine, aged 18 had been stealing money from her mother to buy drugs. She said that the project gave her the support she needed to stop.

If it wasn't for Transitions I would still be a complete druggie. They helped me have more of a realistic view of life. You can't go through life like taking drugs every morning. (Jasmine)

Treatment

The project's one-to-one work is the core of its individual treatment. But as the project developed, it expanded to include family work. The wide range of methods on offer suited the client group well and was in line with NICE clinic guidelines (NICE, 2007) and depending on the individual's drug problem included:

- abstinence
- self-help including referrals to AA where appropriate
- harm/risk reduction
- opiod detoxification
- cognitive behavioural therapy (CBT)
- psychosocial interventions
- referral to residential rehabilitation centre
- relapse prevention.

This section describes the treatment work in detail.

Referral and assessment

Following referral from an external organisation, a project worker would see the young adult within five working days. Initial contact was geared to the individual's preferences:

I call them, write them a letter, or text them, whatever they said was their preferred method. Normally its text or phone calls. They will either come here (Addaction's base) or I'll pick them up – however the assessment is arranged.

(Project Worker)

An individual assessment which included a risk assessment and assessment of competency to consent (DH, 1999) resulted in an agreed action plan that includes aims, SMART targets, interventions and referrals to other organisations. The plans varied depending on the client's specific situation:

If (a young adult) is at uni doing a degree – they've got a supportive family, and so have a variety of factors that mean that they have developed a strong resilience to issues they might face in their lives – but perhaps had begun to develop issues with alcohol or started using cocaine and it was getting out of hand. They might need to talk to someone about the triggers for alcohol and cocaine use and ways of controlling or stopping their use. So, that's what we would do for that young person. But say for someone who had just come out of care – poly-substance user, got learning difficulties – the worker would work with them in a very different way. It's based on their individual needs. (Project Manager)

Once the project had established the gym as part of its offer (see below), it proved a key asset:

And nine times out of ten they want to use the gym which is fine. They'll see me and the Health Adviser each once or twice a week. But the Health Adviser gets information that I might not necessarily know because they are working out. So he'll go through sexual health, nutrition, eating and wellbeing. Naturally if you are with somebody for an hour you are going to say and explore more.

The client does not see the health adviser as a project worker, they see him more as a personal trainer, which is fine because under any name you can give advice.

(Project Worker)

Following the assessment, each one-hour session would involve looking at what progress had been made towards the individual's SMART goals, with the initial 15-20 minutes concentrating on what had happened in the previous week. The project workers used a range of techniques including motivational interviewing and approaches drawn from cognitive behavioural therapy (CBT). The project workers focus on practical and emotional

issues and are able to refer clients with more in-depth problems to the project's counsellor.

Given the project's focus, inevitably the main goals are to help clients reduce the amount of alcohol or drugs they are using, or to stop completely.

Because they get to the that point in their life where they've either been doing it (alcohol/drug) for so long, since early teens, and it's started to become a major issue. Or they started at Uni/college and they don't want to be going out every single night, they'd rather just be going out at the weekend and have some money left for doing something. (Project Worker)

Jasmine described the process:

It's just talking – asks how you have been – setting goals, where you are at the moment and where you could be next week – achievable, manageable goals. For example, goals to reduce intake. Three grams of coke a week down to one gram every two weeks. Cut down gently. (Jasmine)

Ryan, had been struck by the fact that he was not simply told what he had to do, but asked about what he wanted to achieve:

They asked me if I wanted to cut it down. It was good to be given a choice. (Ryan)

The environment and approach

The project's clients also commented on the project's overall approach and how these were welcoming, often in contrast to their experiences elsewhere:

She (project worker) was very bubbly. Within minutes she made me laugh. I had this vision she would be in a suit and she was in jeans and Docs (boots), and she was normal. She looked normal, that was important ... suits can be quite scary. (Lauren)

I came here thinking it was a punishment, going to be talked down to, but it's been totally different, a really good experience ... I'm learning (through the gym) as well as enjoying myself and then you can talk about your addiction. (Amit)

Ryan was especially positive about the project's physical surroundings:

It's got more space. They have bigger rooms than with the counsellors at other places. That was a big factor for me. Did my head in – small places. I felt claustrophobic. (Ryan)

And Jasmine summed up the atmosphere created by the combination of the staff and the facilities:

It's really diverse, there's so much that you can do here ... I used to be really wary, but they're all so cool. They can properly talk to you. (Jasmine)

The project's flexible approach, and the fact that project workers were prepared to support young adults when they attended meetings with other professionals, meant that there were often opportunities to have productive conversations during car journeys.

A project worker explained that she had taken a client regularly to a hospital for appointments and had had sessions with her in the car during the journey, but had begun to feel like she was being used as a taxi. But on later talking with the young women about her experience of the project, the young women explained the value of the car journeys to her:

She said, 'Talking with you in the car meant I wasn't thinking about my X-ray or my operation. It calmed me down quite a bit.' This came out later when I had noticed that she was quite closed and would not look at me when we started having sessions in the office.

The car is a great place to talk to clients because they open up personally more to you because you're not looking at them and they don't have to look at you.

(Project Worker)

Although work with individuals varied depending on need, 3-4 months was a typical period in treatment. After the gym was set up it became part of the discharge and aftercare programme, which prolonged typical contact to 5-8 months.

Communicating with clients

As well as the face to face meetings, workers also kept in touch with clients in other ways. Texting was an approach that was valued by many of the young adults. Ryan said, 'I love the texting. It really suits me.' Jasmine was equally positive, saying, 'Texts work best for me. I can't always be arsed to speak on the phone.' Matt, aged 23 also valued this flexibility:

My key worker was great. I had her mobile number, she had mine. It was a case of whenever I have a problem I could just text her and say, 'I need to talk', and she'd ring me up. I thought that was quite unique. I found it massively supportive. And a year later, I'm feeling fantastic. (Matt)

The project also had a Facebook page where clients could post questions.

Complementary therapies

The project's holistic approach included offering complementary therapies that reinforced the one-to-one meetings, notably acupuncture, Reiki and gym-based fitness programmes.

Both acupuncture and Reiki have soothing and relaxing effects that can help people deal better with the stresses and powerful emotions related to making a new life away from alcohol or drugs. Acupuncture and Reiki are used in drug and alcohol treatment by organisations in many countries.

The gym

Setting up a special gym was an important step for the project. The idea for it was generated by one of the project's workers and was strongly supported by young adults:

We started with a punchbag. We started with a few sparring mits and then it escalated – getting some funding for additional equipment and that led to actually having a fully installed gym with a shower room. It all progressed from there, and since its opening the numbers coming through the doors are wonderful. And the retention rate, the individuals coming back, has never been that high. (Project Health Adviser)

The gym became very popular amongst clients and was also used in wider work with families. The Health Adviser developed individual plans for clients and combined this work with education about health, substance misuse, nutrition and healthy eating. Clients were able to sign up for individual or group education sessions including the basics of cooking and how to eat well on a limited budget.

Amit valued the information he got from the Health Adviser about the impact of drug and alcohol misuse during his gym sessions:

He explains scientifically... it does get scary at times, but he does explain to you what happens. (Amit)

Ryan spoke very positively about his work with the Health Adviser, explaining that whilst he had found it difficult to talk with other professionals, he was able to discuss everything with him:

I chat forever whilst I am there... He pushes me. I like it. It's the only thing I have never given up on. I don't like being pushed usually, but I'm motivated here. (Ryan)

Although not everyone used the gym, take-up was very high, with no gender bias. Males tended to use the facilities for muscle development and fitness, whilst women were often attracted to the Box-fit programme including its self-defence element.

The Box-fit programme uses boxing training as a means of exploring and explaining the physical and emotional effects of substance misuse. For many, it also provided a release from deep-seated problems and an opportunity to open up about the reasons behind their addictive behaviour. This programme was also made available at Foston women's prison to work with prisoners prior to their release.

A project manager noted how young women valued health information that registered with their own priorities and could be shocked to realise the impact of alcohol on their weight and skin:

You know what it does to your skin and how it can age you. And the women are always looking at their figure, yet go out and have six pints. They don't know that's equivalent to eating McDonalds three times over... So then it's good to see their realisation – 'OH MY GOD'. (Project Manager)

The Health Adviser gave an example of work with a young man who had become motivated to change:

He wanted to go into the army but had let himself go, smoking crack cocaine as well as eating cannabis. We had about a three-month timescale before his assessment for the army so basically we worked on the fundamentals, the ergonomics of his muscles, what his muscles would allow him to do within safe limits. We'd look at heart intensity rate. I'd give him a heart/blood pressure monitor to record each morning. We'd look at diet and nutrition and we'd see that he got the right kind of carbohydrates and proteins, nutrients. We'd see what we could work towards. Of the 16 sessions, he attended 14. And yes, he got in. So he's away. (Health Adviser)

The support worker at Derby College explained how the gym benefitted one of the young adults she worked with:

He told me how this place was changing his life... He was accessing the gym every few days and what he found was that it was taking up his time so he wasn't able to go out and get stoned all the time. (Derby College, Support Worker)

Family work

Given the organisation's roots in work with young people, the project staff were aware of the importance of family members, and also of the complexities involved in incorporating them into their work with clients, given that the young adults were no longer children. Consequently, the project also developed a parent/carer/partner intervention tool designed to provide support, advice and guidance for parents/carers of young adults in treatment. The principle behind this initiative was that provided family members receive help and information, and the young adults personal confidentiality is respected, 'significant others' can play a vital role in supporting them through the treatment process.

The tool is used at a group session involving the young adult and members of their family. The transitions worker offers information about the treatment regime and the services available, as well as advice on understanding the pressures young adults are facing and the signs of relapse. The project offers joint appointments enabling clients and families to try out therapies such as acupuncture and keep-fit. The aim of this initiative is to ensure that the young adult and their family work together and support each other to achieve the best possible outcomes from treatment:

We invite the parent along and they have a section on confidentiality, the work that we do and why we do it, and the ins and outs of everything. ... We are always encouraging that family unit. Any questions that they've got, they can phone and ask. (Team Manager)

Accredited learning programme

The project developed an OCN accredited programme of learning designed to support young adults in treatment who were not in education, employment or training (NEET) and help them enter the job market. Young people with a history of substance misuse face additional barriers to finding work. The course combines practical advice on interviewing and CV writing, as well as building resilience, self-confidence and self-esteem.

Relapse prevention

The project was also extended to offer a relapse prevention package to support young adults who are leaving treatment. The young person is able to book three aftercare appointments up to three months after their discharge date if he or she is in danger of relapse or wants advice and support.

Discharge

Clients would not be discharged by the project until they were ready, and when clients discharged themselves early, project staff worked vigorously to try and re-engage them:

There is a lot of chasing up, ringing the referrer, ringing guardians – people they put down as emergency contacts. There is a lot of knocking on doors and that kind of thing. (Project Worker)

Lauren described a time when she moved away, but still retained contact with the project:

You weren't just put to the back of a file. You weren't just a number on their client list. You felt bothered about ... I went away to get clean, but we spoke every day, even though it was only by phone it crossed the distance, and that was desperately needed. (Lauren)

The project also worked hard, continuing to care for their clients until they were fully embedded within a suitable follow-on service such as Connexions, the GU clinic, football centres, and a rock climbing organisation or a music project.

Staff and working philosophies

Personal commitment and dogged persistence are key features of successful work with so-called 'hard-to-reach' clients. A project worker explained a big challenge:

For me it's the nitty gritty stuff – getting in touch with somebody, having the right phone numbers – they change their numbers on a weekly basis. (Project Worker)

She also explained more about the overall working approach that was needed:

You've got to be innovative and you've got to be creative. You can't have a kind of, 'You missed three session so you're discharged' attitude. You've got to be flexible and you've got to give them time to trust you and engage in the process, and also trust the treatment process itself. (Project Worker)

Young adults themselves highlighted the positive way staff had treated them:

I talk to (Health Adviser) about everything while I'm working out at the gym, I can talk to him about anything. (Ryan)

Down to earth ... I used to be really wary, but they're all so cool. They can properly talk to you. (Jasmine)

Senior managers in the project highlighted the mix of skills within the staff team, and the credibility the workers had with young adults, emphasising the need to make imaginative choices when appointing staff rather than just picking the person with the most obvious experience. For example, one staff member had been in the fire service and had been selected ahead of a nurse with excellent drugs knowledge because wider expertise and risk management perspectives added something extra.

The senior managers also recognised the contributions the project workers made to the direction of the project and this had been actively encouraged:

We have been very mindful of the fact that they (project workers) are working on the project. They need to love it, so in order for them to love it they need some kind of ownership over the direction of where it goes. (Service Manager)

Client feedback and participation in shaping the project's direction flowed from the open relationships that were cultivated during the direct work, and young adults contributed to major initiatives like going ahead with setting up the gym as well as more routine activities like updating display material.

Recordkeeping and measuring outcomes

The project used the Nebula online data system, designed specifically for substance misuse services to record data of the individual work with clients. Orion, the software company that developed the system provides this description of how it operates on its website:

The heart of the Nebula system is the Event Manager and Nebula is described as an event-driven system for substance misuse services. This means that the software reflects the processes that the client undergoes during his association with the service. Events may be one-to-one sessions with a key worker, or they may be group sessions. They may be unattended paperwork opportunities for key worker administration or perhaps a family session – and multiple events are possible, so the user can quickly select all those that are relevant to any appointment. (Orion, 2012)

The project also used the Treatment Outcomes Profile (TOP) (NTA, 2007) to record care plans, reviews and discharge information. The tool was developed by the National Treatment Agency and is used throughout the drug treatment system in England. It has three aims:

- To provide a tool that is clinically useful, that can add value to the important work that is done between the client and the key worker.
- To enable the NTA to monitor and assess the effectiveness of the national drug treatment

system.

- To support commissioners and treatment providers in making improvements, where necessary, in the local treatment system.

The TOP is a 20 item measure that focuses on four treatment domains: substance use; injecting risk behaviour; crime; health & social functioning. The TOP is completed with the client at the start of treatment, periodically throughout treatment and at the end of treatment.

TOP information is submitted to the National Drug Treatment Monitoring System (NDTMS) where quality assurance and analysis are undertaken. The information is fed back to the local treatment system to inform the development of services.

The following table provides NDTMS data on the project's performance against targets in the Service Level Agreement (SLA) with Derby Community Safety Partnership (DCSP) for years two and three. Data for the first year is not available because the performance forms for the project were not separated from the overall young people's service during that period. Above all, it shows that over the two years an average of 95% of clients successfully completed their treatment programmes.

Performance against Targets for Year Two and Year Three

Targets	Year Two	Year Three
Proportion of new referrals that were re-referrals	8%	22%
Proportion of young people assessed as requiring specialist substance misuse treatment who commenced treatment within 15 working days	100%	100%
Proportion of young people in specialist substance misuse treatment who have a care plan within 2 weeks of treatment start date specifically related to their substance misuse needs	93%	95%
Proportion of discharges that were planned completions	92%	98%

Unfortunately, as yet, the TOP system does not provide individual agencies such as Addaction with other aggregated data about its clients such as whether they then move on to treatment in adult services, which would be useful in terms of measuring outcomes and assessing the longevity of treatment benefits. The Service Manager acknowledged this weakness noting that there are plans for the system to ultimately provide such information. However she had knowledge about the number of clients that had then gone on to use adult services and commented:

We know that there has only been one young adult that has gone from our service into adult treatment out of the whole entire time the project's been established which is really successful. But at the same time we don't get information about what the young adult's accessed adult treatment for ... so they may have come here for alcohol use, and may go there for something entirely different. And it's something we've always been really curious about. (Service Manager)

The project's other records show that referral sources remained fairly static over the lifetime of the project with further educational settings and crime prevention being the highest referrers.

All clients at tier 3 received a full comprehensive assessment which included a risk assessment and assessment of competency to consent (DH, 1999). All clients received a full individually tailored care plan with SMART goals.

The treatment offered was in line with NICE clinical guidelines (NICE, 2007). The range of approaches treatment offered depended on the type of drug problem but included:

- abstinence
- self help approach (referrals to AA) where appropriate
- harm/risk reduction
- opioid detoxification
- cognitive behavioural therapy (CBT):
- psychosocial interventions
- residential rehabilitation centre (referral)
- relapse prevention.

Project staff were able to reflect upon the effectiveness of individual care plans and interventions through reviews with clients every six to eight weeks. Also the Service Manager requested that staff also write reflective accounts of individual cases to enable them to step back and assess what they are providing for the young adults and from their own perspective, how successful it had been. This practice development tool can help an individual worker to assess what they have been doing and where necessary make changes. The Service Manager explained how one project worker responded:

The reflective account should make you think about the work differently, and develop an approach that's different. She (the worker) did that, and it did. She was like, 'You know what I'm doing? I'm feeding into all that negativity, so we're not actually moving along in treatment. We are staying there.'... And she (the worker) then did a really good piece of work with that client that made her think differently ... and she (the client) was able to continue her studies and she got a degree in the end.

Appendix 3 includes examples of reflective accounts.



Section Five: Partnerships and Promoting the Project

Developing and sustaining relationships with other organisations was central to the project's success. These links enabled the project to reach young adults and also to open up further support for them.

Although the project started with the advantage of being part of an established young people's service, which meant that some clients would move on to the new service when they became too old for the young people's service, it also presented challenges as the project did not necessarily have the links with adults' organisations at the beginning:

18-24 year olds were a completely different market, so it was about approaching services that we didn't really speak to before because we were a young people's service, and encouraging them to refer to us, and seeing the benefit for them.

(Project Worker)

Project staff put in a lot of time building on these contacts and, as has been described in sections two and three, created excellent relationships with community organisations such as Derby College, Derby University, Probation, the Youth Offending Service, YMCA, Skill Build, Probation and others.

A probation officer explained why she referred her client to the project and how it also benefited what she was trying to achieve:

He was aged 21. It was a more appropriate place for him. The drugs' testing was still done at Adult Services, but the Transitions Project was a more specialised service. It reduces association with adults with more entrenched drug problems... At his age there's usually more scope for change.

He was still attending the Transitions Project when he was not complying with probation. It was good that he had someone to talk to and could access positive activities. His transitions worker persuaded him to come and see me and she came in with him. (Probation Officer)

A Personal Development Tutor from Skill Build, a local charity which delivers Foundation Learning for young people aged 16-19 also felt that the specialised nature of the project's services was its selling point:

Some of our students are still very vulnerable at age 19. They are not ready for adult treatment services. (Skill Build, Personal Development Tutor)

Both the probation officer and the personal development tutor recognised the specialist nature of the Transitions Project and also the particular needs of the young adult group, a theme that is explored in more detail in Section Six.

Although the Transitions Project was set up to fill a gap in services, inevitably a new initiative can be treated with wariness by some organisations that see it as potentially overlapping their remit, especially at a time of harsh economic conditions, when services need to meet target numbers to stand a chance of securing ongoing funding. Project staff commented on this issue in relation to adult substance misuse services:

I would have liked more input from adult drug services even though we did get referrals from them. There must be more clients who aren't using Class A substances. (Project Manager)

The Service Manager expanded on this point:

I think the relationship with Adult Services could have been stronger. As Service Managers we could have been more forceful to make that relationship better in order for them to think about transferring clients over to us. (Service Manager)

Yet, the probation officer saw what was on offer as complementary because, although probation had its own drugs service, the Transitions Project was better matched to the needs of some of her clients:

Our aim is to reduce reoffending and help long-term rehabilitation, so I'll take whatever resources are available, especially those that are more specialised. (Probation Officer)



Section Six:

The Focus on Young Adults

Running the Transitions Project for young adults along the same lines as a young people's service and the smaller caseloads of the staff provided greater flexibility in the times and setting for meetings with clients. Above all, workers were able to deal with the substances used by young adults which are primarily alcohol and herbal cannabis rather than the opiates that are the focus of adult drug services. Also, the Transitions team did not treat the problem of substance misuse as an isolated problem, but within the wider context of the client's life – academic, social, emotional or financial. For example, advice on health and nutrition complemented clinical treatment and supported recovery. The project staff believed that this approach resulted in a more equal relationship between client and case worker based upon mutual trust.

Young adults commented on the issues related to their age and the appropriateness of services:

Adult Services was good, but it felt more like for older people. Like, I was sitting in the waiting room and everyone in there was like thirty, and total drug addicts ... (Jasmine, 18)

You can get it in your head that there's no-one there for you, as someone in their mid-20s. It is a nice feeling to know that I'm not the only one of my age out there feeling like this. It definitely made me not feel alone. (Matt, 23)

Ryan, aged 17, thought it was essential that the service was a targeted one. He said, 'We've got a completely different attitude and mental image to adults.' (Ryan)

One of the project managers involved at the early stages of the Transitions Project explained:

A needs analysis for Derby City found the age group were not accessing services. They weren't in treatment here... so what was happening to them? Are none of them using drugs, or are they slipping through the net?

Adult services are traditionally opiate based. They do have stimulant groups, but this age group don't really fit in. It's not what they necessarily want. (Project Manager)

Another project manager felt that young adults needed similar approaches to young people and that it was also important to see different age bands as part of a continuum:

We look at the whole age scale because typically you are not going to be 20-24 and straight away use cocaine. You would have started on something else, and definitely had alcohol. So we look at the whole background. (Project Manager)

Young adults' lifestyles meant that treatment methods that were effective with older teenagers also suited this age group:

Because the 'typical' 18-24 year old client is quite chaotic at the beginning, you might see them two to three times at first and there might be a lot of brief appointments because you are gaining their trust. You might feel like you are being used a little bit because they might ring you to take them to appointments and things like that, but that's OK because you have to gain their trust somehow. And they would not just see one of the key workers, they would see other members of the team like the health adviser. (Project Manager)

The Support Worker at Derby College noted that young people mature at varying rates and also explained how it was necessary to relate to older young people in a different way than to their younger counterparts:

You can have some 18 year olds that are like 16 year olds and vice versa. I think the approach has got to be more on the learner's level and being a real person. Pre-16s expect professionals to be 'professional', whereas post-16 want to be a bit more like you, to be treated slightly differently. So that's a massive difference. (Derby College, Support Worker)

Staff at Addaction felt that the organisation's experience meant it had been well placed to set up a project aimed at young adults:

I think that being a young person's organisation enables us to offer a service to young adults because we understand young people, if that makes sense, as opposed to being an adult service that understands adults. We have always recognised that a lot of the young people that we have seen are at quite a precarious stage in their lives, they are maybe moving to a new city. They're away from their homes and familiar surroundings. (Service Manager)

Age bands and service development

But, setting up a project for young adults had raised questions of principle and practice for the project given that Young Addaction had catered exclusively for young people. Should they simply extend the aged band for young people or create something new?

The Service Manager noted some of the dilemmas:

You have got practical things to consider like the mix of age ranges. You obviously don't want a group of 13 year olds accessing a service with a bunch of 23 year olds because that's just not right. So we specifically had to identify some days and some evenings where we would be open to Transitions clients and then some, obviously, for young people. So although we share a building, we tried to develop two different services and make them quite distinct. (Service Manager)

A team manager also noted the significance of being aged 18 in society, and how this influences young people. This reinforced the idea of separating the Transitions Service from existing services:

18-year olds, even though they might not be ready for adult treatment services see themselves as very different to being 17. As soon as you have your 18th birthday, you see yourself as an adult. You might not be one. You might not be mature enough to be one. But you definitely see yourself differently, so I think there has to be a clear line in the service to say, 'This is 18 and this is because I am 17.' There might not be anything different in your working practice. (Project Manager)

But maintaining the age boundaries could also be problematic, especially when running drop-ins at the university where some students were much older than the project's upper limit.

Ah you're 45 ... But you (the Transitions Service) still provide interventions. You could not turn them away. (Project Worker)

Shaping a project for young adults aged 17-24 also raised questions about how best to meet the varying needs of all young people within that age range, given that six years at this stage of life can be significant in terms of development and experience.

One staff member thought that the project's methodology was as much attuned to particular kinds of drug use, as it was to age, but that the specific drug use and age group did go hand in hand. She felt that the project's success was that it targeted the recreational drug user, the ACCE group (see Smith and Flatley, 2011), the young person that more traditional drug and alcohol services did not reach:

I don't want to stereotype but the younger people that we've had in before who are opiate users tend to have already been mixing with the adult opiate users. There's almost a lifestyle that they have, and they're already entrenched in the adult kind of world. And this doesn't fit for them... I've never seen an opiate user be interested in the gym. (Service Manager)

It is also important not to see young adults as a homogenous group. Research (Smith and Flatley, 2011 and see Appendix 6 and 7) confirms the significance of gender, deprivation and ethnicity, with males from poorer backgrounds more likely to use drugs; and within the offender population, the highest rates of drug use amongst males from mixed ethnic groups.

Criminal Justice

The project's part-funding from the Barrow Cadbury Trust meant that an important aim was to reach young adults from vulnerable groups, particularly those that had become involved in the criminal justice system. The project took significant steps in its second year to reach this group and organised networking events to talk to key figures in the probation, police and prison services, and raise awareness of the Transitions Project. To support this focus, the project appointed a specific Transitions Project Worker who was then based at the Youth Offending Team and worked exclusively with criminal justice clients. This enabled her to maintain close partnerships with other criminal justice agencies and build specialist skills in this area.

This approach proved successful and referrals increased from the local youth justice agencies (probation and the youth offending service) and ultimately accounting for 20% of the clients in treatment in the project's second year.

The dedicated Criminal Justice post was also able to improve the team's engagement with prison leavers – visiting young adult clients in prison (Stoke Heath) prior to their release and ensuring they received appropriate support once released into the community. The Service Manager commented on the value of this approach:

Having a leaflet about a service is brilliant you know, it gives you advice, information on what the service offers. But actually sitting down and meeting somebody face-to-face is completely different. And we have been really good at that bit I think. (Service Manager)

The project was also able to reach a diverse group of young people across all its activities with 38% coming from minority ethnic groups. Pakistani young adults were the largest minority group (5.7%), with a higher proportion in treatment in years two and three (12%). The project's gender split was also interesting with the Tier 2 work reaching more females (56%) than males (44%), although the situation reversed in the Tier 3 work where more males (70%) were in treatment than females (30%). The latter figure reflects the national picture in relation to gender and substance misuse (see Appendix 6)

Conclusion

Addaction's Transitions Project in Derby City has shown that a flexible substance misuse service that targets young adults, aged 17-24, can achieve impressive results when staff have the skills and creativity to work in ways that are attuned to the life stage and substance misuse patterns of this group. Imaginative community outreach work, coupled with a person-centred holistic treatment approach, is an effective model for those aiming to support this age group.



Section Seven:

Finance and Value for Money

The table below summarises the project's budget over the project's three years. Appendix 4 provides a detailed breakdown for each year.

EXPENDITURE	Years 1-3
Staff	£255,770
Premises	£ 3,480
Direct project	£ 15,253
Capital equipment	£ 32,690
Management and support	£ 1,000
Total	£308,193
INCOME	Years 1-3
Derby Community Safety Partnership (DCSP)	£153,000
Barrow Cadbury Trust (BCT)	£150,000
	£303,000
Net (Deficit) surplus	£ (5,193)

Staff costs accounted for 83 per cent of overall costs with management and support costs at 11 per cent. Direct project costs and capital equipment costs accounted for 5 per cent of expenditure with premises costs at one per cent.

The project's income came from two separate grants. The Derby Community Safety Partnership's (DCSP) grant was £153,000 over three years and the Barrow Cadbury Trust (BCT) matched this with £150,000.

The project benefited from having an experienced full time manager, team leader and 3 full time project workers, throughout the lifetime of the project.

It also benefited from organisational economies of scale and utilised at no additional cost:

- experienced area managers for young people and adults
- the communications and marketing team
- the performance monitoring officer
- existing premises.

Value for money

Although it is hard to be precise about the division of staff time between Tier 2 (Community Outreach) and Tier 3 (Individual Treatment) activities, a reasonable assumption is that around two thirds of the project's costs covered individual treatment, and if this cost is divided equally between the 219 clients that successfully completed treatment, it would mean that the cost of treatment per person was just £938. This compares very favourably with the £3,000 that the National Audit Office (NAO) has identified as the 'cost of funding for every adult in effective treatment' (NAO, 2010: Fig 5, p.24). The NAO has also noted that the quality of evidence for the effectiveness of drug treatment was 'robust' and that drug treatment saves the taxpayer £2.50 for every £1 invested, mostly by cutting crime (NAO, 2010: p.28).

Given that an average of 95% of the project's clients successfully completed their treatment in the project's second and third years (the period for which the most reliable data is available) it seems reasonable to conclude that the project offered excellent value for money.

Using the same split in overall project costs as above would mean that the cost of reaching each young adult at Tier Two (749 people) was £137 per head. Given that the majority of these young adults would probably not have accessed treatment in the conventional sense, these important activities also represent value for money.



Section Eight:

The National Picture

This section puts the Transitions Project's work into the national context of developing work with vulnerable young adults.

With the growing awareness that the transition to adulthood has changed, pioneering organisations have begun to target this group specifically in the services that they are providing (Devitt & Lowe, 2010). Beginning with its commission on young adults in the criminal justice system, the Barrow Cadbury Trust (BCT) has been at the vanguard of this approach, and through its work with the organisations in the Transition to Adulthood Alliance (T2A) has campaigned for more effective approaches to offenders in the young adult group (T2A, 2009 & 2012).

As well as part-funding the Derby City Transitions Project, BCT also funded three small pilot projects that focused exclusively on young adult offenders. The aim was to put the 'T2A approach' into practice. The pilots are run by three different organisations in separate locations in England (London, Birmingham and West Mercia). There have been three independent evaluations of their work:

- A formative evaluation conducted by Oxford Centre for Criminology (Burnett et al, 2010), which investigated the pilots work from an early stage
- A break-even analysis by Matrix Evidence (Matrix, 2011), which examined the levels of reduction in reoffending required at each site in order to 'break-even'
- A summative evaluation carried out by Catch 22 (Sturrock, 2012), which tracked outcomes for young people over a six month period.

The findings from these studies are relevant to wider work with young adults including drugs and alcohol services, so are set out in more detail below.

The Oxford study examined the pilots' work as it developed and described a model that is 'goal-based' and rooted in a 'person-centred' approach. It concludes that the work was underpinned by seven key precepts (Burnett et al, 2010):

1. The formation of a working alliance based on mutual respect and agreed goals, which increases self-worth of service users and motivates them to remain engaged
2. The use of strengths-based principles, emphasising what a service user can achieve rather than focusing on weaknesses or mistakes, motivating engagement and readiness to change
3. An action plan determined by the client encourages co-operation because what is required of them is what they want anyway, respecting and promoting the agency of the service user in making changes
4. The development of a respectful, empathetic relationship so there is a readiness to work together
5. A client-led model of work giving the service user a taste for being in control and thereby building up self-efficacy
6. Service users are connected to material resources and opportunities, which promotes changes in self-concept and identity

7. Through referring and connecting the service users to the material resources and social opportunities that they need to 'get on' in life, their sense of self-efficacy and agency is sustained.

The formative evaluation recognised that these features had been marshalled into a casework approach with young adults that are 'highly attuned to the transitional needs of young adults' (Burnett et al, 2010: p.94):

Each of the T2A projects has applied a model of working with young adults which provides holistic support, rather than being focused on offending, and which is geared to their immaturity and need for guidance through crossroads of experience which are new to them. (Burnett et al, 2010: p.27)

The break-even analysis found that the work of all three pilots work was offering 'good value for money' (Matrix; 2011: p.8) and the summative evaluation which looked at the outcomes for the young people over a six month period once the projects had become more established concluded:

... this evaluation has provided good indicators that the T2A model provides effective support for young adults, helping them to desist from crime, improving the quality of life of service users and enhancing their emotional wellbeing and self-belief... (Sturrock, 2012: p.8).

This summative evaluation also confirmed that the seven key precepts identified in the Oxford team's earlier evaluation remained at the heart of the T2A approach.

The detailed description in this report of the work of the Transition Project in Derby City shows an approach that mirrors those of the T2A pilots. Although the project's focus was obviously on drugs and alcohol, it took a holistic, goal based approach that was person-centred. Other specialist drugs and alcohol charities have noted the significance of this way of working. For example, in reviewing drug and alcohol treatment for young people, Drugscope recommended that the government produce a policy framework for 16-25 year olds, 'with a focus on transitional processes and arrangements' and concluded:

A lot of the work by specialist drug and alcohol services is not 'treatment' in the narrow medical sense... Almost all (young people aged 16-24), however, need support on other issues in their lives. Young people's treatment needs to be holistic. (Roberts, 2010: p.5)

Other specialist alcohol and drugs projects with similar aims to that of the Derby Transitions Project certainly exist; for example, Young Addaction's project in Liverpool (Addaction, 2012); Mosaic in Stockport (Mosaic, 2012) and Norcas in East Anglia (Norcas, 2012). But the learning from these projects has not been widely disseminated and other similar projects may well be operating. A comprehensive survey of alcohol and drugs projects that are targeting young adults would be a real asset.

Section Nine:

Summary and Conclusion

Young Addaction Derby's Transitions Project (December 2009-March 2011) provided an innovative substance misuse service for 17-24 year olds by focusing on two tiers of the National Treatment Agency's four tier model of service provision for alcohol and drug misuse: community outreach work (Tier 2) and treatment work for individuals (Tier 3).

Achievements

The Transitions Project carried out treatment sessions (Tier 3) with 230 young adults and delivered community interventions (Tier 2) to 749 people, 56% of whom were female and 44% were male. An average of 95% of the Tier 3 clients in the project's second and third years completed their treatment successfully.

Men accounted for a higher proportion of those in treatment – 70%. The majority of the project's clients (Tiers 2 & 3 combined) were White British (62%) and 38.5% were from Black and Minority groups (BME), with Pakistani young adults (5.7%) the largest single minority ethnic group.

The project offered excellent value for money, with the cost of successful individual treatment estimated at around £940 per person. This compares very favourably with £3,000 per head that the National Audit Office (NAO) has identified as the 'cost of funding for every adult in effective treatment' (NAO, 2010: p.24). Effective drug treatment saves the taxpayer £2.50 for every £1 invested, mostly by reducing crime (NAO, 2010).

The estimated cost of the Tier 2 community interventions also represented value for money at under £140 per head, given that the majority of the 749 young adults would probably not have accessed treatment in the conventional sense.

The overall aim

The project addressed local need; the patterns of alcohol and drug use amongst young adults (17-24); and the weaknesses in service provision for this group.

- 1. Local need:** In 2007, a needs assessment of drug service users within Derby City conducted by Derby Community Safety Partnership (DCSP, 2007) found that young people transferring to adult services tended to fail to engage, or dropped out of treatment early.
- 2. Young adults and substance misuse:** Drug prevalence is greater amongst younger adults than the adult population as a whole, with around one in five young people aged 16 to 24 using one or more illicit drugs in the past year compared with less than 10% of the adult population (aged 16-59). Young adults who misuse drugs tend to use multiple substances, the most popular combination being alcohol, cannabis, cocaine and ecstasy (Smith & Flatley, 2011) – the 'ACCE group'. Older adults generally use a single drug with treatment most often focusing on heroin (NHS, 2011).
- 3. Weaknesses in service provision:** Research has shown that ACCE users do not see current adult provision as for them. Young people identify three main barriers: interacting with crack/heroin users; having to leave the young people's service at 18; and the stigma associated with attending adult drug services (Parker, 2008; Wareing et al, 2007).

The Service Level Agreement between DCSP and Addaction contained the following outcomes which included an emphasis on reaching the younger members of the 18-24 age band:

- to Improve the engagement of 18-24 year olds, specifically those aged 18-21 years
- to Improve the proportion of 18-24 year olds, specifically those aged 18-21 years successfully exiting treatment
- to ensure the seamless transition of the small cohort of individuals transferred into adult drug and alcohol treatment services.

Recognising the changing transition to adulthood

The project's approach was influenced by the latest research on young adults which shows that the transition to adulthood is taking longer in modern society (see Devitt et al, 2009) and also that young adults' brains continue developing into their mid twenties which challenges long held assumptions about maturity (Johnson et al, 2009: p.216).

Young adults are now increasingly dependent on family support, and those in higher education (around 40%) take a 'slow track' to adulthood. However, those who attempt to take the 'fast track' to adulthood by trying to find jobs and/or starting families can struggle, especially if they come from disadvantaged backgrounds and have limited family support. Young adults from this group are overrepresented in the criminal justice system and also more likely to misuse drugs.

The Barrow Cadbury Trust (BCT) has convened the Transition to Adulthood Alliance (T2A) to help produce a better response to offenders in the young adult age range and part-funded the Transitions Project to support that aim.

How the Transition Project works

Individual treatment (Tier 3): The project had a holistic approach. All clients received a full comprehensive assessment which included a risk assessment and assessment of competency to consent. The project workers created a treatment/care plan with each individual with SMART goals that was designed to help them tackle their substance misuse problem. However, the plan also explored other relevant issues. The project workers provided information about drugs and alcohol, but also worked on building self-esteem, confidence, family relationships, physical and mental health, fitness and general wellbeing. They tailored the approach to the individual's circumstances. All of the young people assessed as requiring specialist substance misuse treatment began their treatment within 15 working days and the plan was in place for 93% of this group within two weeks of the start of their treatment in year two and for 95% in year three.

Individual treatment work was attuned to young adulthood and the workers' accessible styles won the confidence of clients who had sometimes had negative experiences of other services.

The project workers used a range of techniques in line with NICE clinical guidelines (NICE, 2007) including motivational interviewing and approaches drawn from cognitive behavioural therapy (CBT). The work focused on practical and emotional issues and clients with more in-depth problems were able to meet with the project's counsellor. The workers' flexible approach included keeping in touch by texting, which was popular amongst many clients. Also, taking clients to meetings with other professionals gave staff the opportunity to maximise opportunities to talk during car journeys.

The holistic approach included an accredited learning programme designed to help clients return to the job market plus complementary therapies that reinforced the one-to-one meetings, notably acupuncture and Reiki. The project also set up a fully equipped gym at the end of the first year and this proved to be an essential asset, helping to attract and retain clients. The gym acted as a hub for wider health work with clients (and their families) which covered the physical impact of substance misuse, nutrition, healthy eating, and

cooking. The Box-fit programme used boxing training as a means of exploring the physical and emotional effects of substance misuse.

As the project developed, it increasingly included the young adults' families in their work – an approach especially attuned to the client's stage of life and different from work with older adults. The project staff recognised that 'significant others' can play a vital role in supporting young adults through the treatment process.

Although work with individuals varied depending on need, a typical period of treatment was 5-8 months which included use of the gym as part of the discharge and aftercare programme.

Clients were not discharged until they were ready, ensuring that they were fully linked in with an appropriate follow-on service. Ninety-two per cent of discharges were planned in year two and this figure reached 98% in year three. When young adults discharged themselves early, staff worked vigorously to try and re-engage them. The project used the nebular data system to record its individual work and the Treatment Outcomes Profile (TOP) to record care plans, reviews and discharge information (NTA, 2007). Only one of the young adults that had been in treatment with the project subsequently went into treatment with the adult service.

Community outreach work (Tier 2): The work to reach young adults who are unlikely to approach the project themselves was particularly successful. Building links with community organisations proved to be the key, and Derby College and Derby University were particularly important because they provided access to large numbers of the project's target age group. The project's initiatives included: input at fresher's' fairs and special events such as Derby College's Wellbeing Day; drop-ins; and creating a peer mentors group of 20 young adults at the university. All these activities, including outreach work in pubs and clubs, enabled the project to provide information about the risks of substance misuse in engaging ways and to deliver 'brief' one-off interventions. Winning the confidence of health and wellbeing professionals at the college and university, coupled with the various profile raising activities opened the door to individual treatment (Tier 3) for many individuals.

The project also worked with community organisations that were supporting disadvantaged young adults such as hostels and education and employment projects. Mini taster/ interventions on topics such as boxing for fitness and acupuncture promoted the project's accessible approach and showcased its complementary therapies. A specialist post within the Youth Offending Team developed excellent links with youth justice organisations, developed a training programme on alcohol and drug use and sexual exploitation, and contributed to a significant increase in referrals for treatment from this sector.

The focus on young adults

The Transitions Project proved effective in its work with young adults because, being run along the same lines as a young people's project with smaller caseloads than are typical in adult services, the staff were able to operate in a 'person-centred' way that has been shown to be successful in work with vulnerable young adults (Burnett et al, 2010; Sturrock, 2012). This approach also included listening carefully to the feedback from clients and learning from them about what works. Above all, workers were able to deal with the substances used by young adults which are primarily alcohol and herbal cannabis rather than the opiates that are the focus of adult drug services.

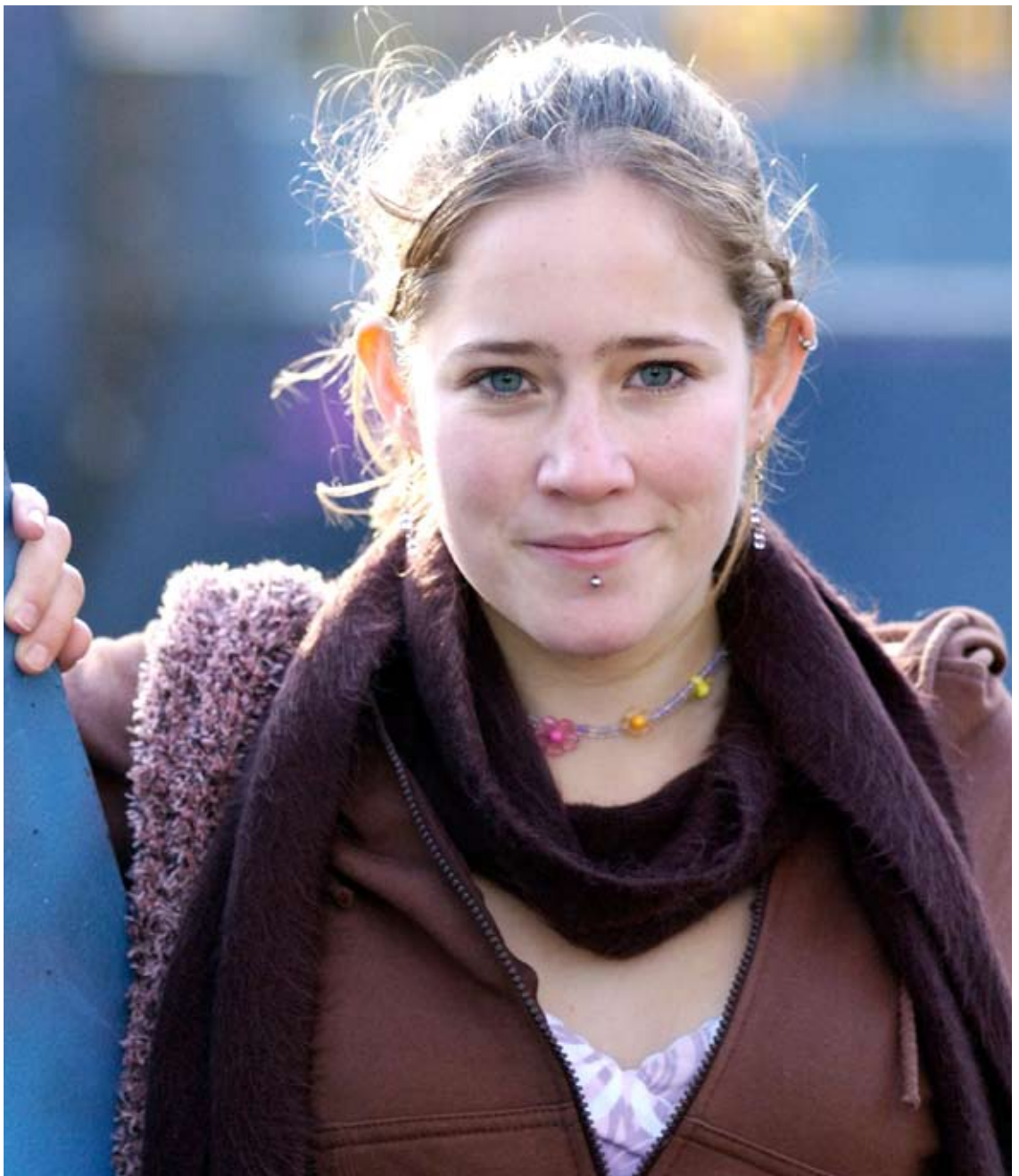
Achieving a 'young adults' focus within a young people's project meant that the project had to address a variety of dilemmas. For example, how best to set aside time slots for separate age groups to avoid potentially inappropriate contact between the young adults and the younger children as well as what to do when older adults accessed services such as drop-ins in the community. It also had to recognise the different range of needs within the 17-24 age group itself, and in practice the focus was more towards the younger end of the age span with the majority of the projects clients aged 17-19 (60%) with most of the remainder

were aged 22-23. As noted above, the project's SLA included a particular emphasis on the 18-21 age group.

The project was joint funded by the Derby Community Safety Partnership (DCSP) and the Barrow Cadbury Trust (BCT). When the funding ended its approach influenced the creation of a new drugs and alcohol service for young people in Derby City run by the NHS, particularly the decision to set its upper age limit at 21 rather than at 18.

Conclusion

Addaction's Transitions Project in Derby City has shown that a flexible substance misuse project that targets young adults, aged 17-24, can achieve impressive results when staff have the skills and creativity to work in ways that are attuned to the life stage and substance misuse patterns of this group. Imaginative community outreach work, coupled with a person-centred holistic treatment approach, is an effective model for those aiming to support this age group.



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APPENDICES

1. Addaction Transitions Project Model
2. Client Data
3. Reflective Case Studies
4. Financial Information
5. Young Adulthood
6. Young Adults, Alcohol and Drug Misuse: Key Data
7. Drug Misuse Amongst Young Adults (16-24 year olds): Patterns of Use

Appendix 1: The Addaction Transitions Project Model

The following description of the project's model is provided as a succinct outline for projects that might choose to replicate the project.

The purpose of the project is to create a stand-alone project for 17-24s. The project's target groups are:

- Young adults leaving the young people's project who are not emotionally appropriate for adult drug and alcohol services
- Young adults whose drug and alcohol needs are not being met because their patterns of misuse do not match the user profile offered by adult services
- Young adults with growing drug and alcohol problems who view current treatment as irrelevant or inappropriate, and who are not currently accessing services.

Referrals and screening

The project will take referrals from local agencies, using a screening tool that employs identifying criteria such as age, drug use, lifestyle issues and vulnerability. The indicators for 'vulnerability' include: learning difficulties; mental health issues; exclusion from school; leaving care; young parents; young carers; parental substance misuse; and involvement in the criminal justice system.

The Young Adults' project will also be promoted to attract self-referrals from young people whose misuse problems are growing but are reluctant to define themselves as needing treatment. A key to reaching them will be effective promotion in colleges, clubs and businesses.

Approach and treatment methods

The project's ethos is to create a project that is friendly, inclusive, holistic and welcoming, employing the kind of methods already proven to be effective in young people's services such as flexible opening hours and a willingness to meet in informal settings.

In one-to-one sessions, a dedicated key worker will use techniques such as: motivational interviewing; cognitive behavioural therapy; relapse prevention; harm reduction; health screening (BBV and sexual health); group work; and complementary therapies. There will be a strong commitment to user involvement in the form of user meetings, feedback questionnaires, celebration events and representation on steering groups and recruitment boards.

The project also intends to equip users with the social and communication skills, and where appropriate, accredited training and work experience, to give them the best chance of employment and independence to reduce the likelihood of relapse. Diversionary activities such as sports and social trips will help fill the void left by withdrawal from a lifestyle dominated by drink and drugs.

Local partnerships

The project will work to develop partnerships with a range of local organisations – both to receive referrals and to signpost service users into specialist services. Formal care pathways will be developed with partners including: young people’s mental health services; training and employment services; information and counselling services; the Youth Service; family support groups; services for young people at risk of sexual exploitation; the local university, colleges and schools; children’s centres and services for young parents.

Appendix 2: Client Data

Chart 2.1: Totals and breakdown by ethnicity and gender by project year

YEAR ONE: JUNE 2009-MAY 2010					
Tier	Nos	Ethnicity		Gender	
Tier 2	318	N/K – no data recorded		N/K - no data recorded	
Tier 3	62	Black Caribbean	6	Male 44	Female 18
		Irish	1		
		Not Stated	1		
		Other Mixed	1		
		Pakistani	5		
		White British	45		
		White Other	3		
TOT	380				

YEAR TWO: JUNE 2010-MAY 2011					
Tier	Nos	Ethnicity		Gender	
Tier 2	328	Chinese	11	Male 143	Female 185
		Black Caribbean	15		
		Black Other	10		
		Eastern European	2		
		Indian	23		
		Not Stated	5		
		Other Asian	10		
		Other Mixed	14		
		Pakistani	15		
		Welsh	1		
		White Asian	10		
		White British (E)	189		
		White Other	23		
Tier 3	82	Black Caribbean	4	Male 53	Female 29
		Other Asian	5		
		Pakistani	13		
		White British (E)	53		
		White Other	7		
TOT	410			196	214

YEAR THREE: JUNE 2011- MARCH 2012

Tier	Nos	Ethnicity		Gender	
Tier 2	103	Black Caribbean	9	Male 47	Female 56
		Chinese	2		
		Mixed Race	5		
		Other Asian	10		
		Pakistani	15		
		White British	62		
Tier 3	86	Black Caribbean	3	Male 64	Female 22
		Chinese	1		
		Mixed race	6		
		Not stated	1		
		Other Asian	4		
		Other	2		
		Pakistani	10		
		White British	59		
TOT	189			111	78

Chart 2.2: Combined three year totals for ethnicity and gender

Tier	Nos	Ethnicity		Gender	
Tier 2	749	Black Caribbean	24	Male	Female
		Chinese	13	Yr 1 – no data	Yr 1 – no data
		Black Other	10		
		Eastern European	2		
		Indian	23	Y2+Yr3	Yr2+Yr3
		Mixed Race	5	190	241
		Not Stated	5		
		Not Collected (Yr 1)	318		
		Other Asian	20		
		Other Mixed	14		
		Pakistani	30		
		Welsh	1		
		White Asian	10		
		White British	62		
		White British (E)	189		
White Other	23				
Tier 3	230	Black Caribbean	13	Male	Female
		Chinese	1	162	69
		Irish	1		
		Mixed Race	6		
		Not Stated	2		
		Other	2		
		Other Asian	9		
		Other Mixed	1		
		Pakistani	28		
		White British	104		
		White British (E)	53		
		White Other	10		
GRAND TOTAL	979			[318 – NK] [351 – M]	[310 – F]

Notes

- 1) Slightly different categories were used to record clients' ethnicity over the project's lifetime. All categories are listed above and some appear to overlap.
- 2) No data on ethnicity, gender and disability was recorded for the Tier 2 work in the project's first year, although the number of clients for that period was recorded (318).
- 3) The Tier 2 work reached more females than males – 56% compared with 44% who were male. In the Tier 3 work males accounted for the majority – 70% compared with 30% female.
- 4) In the periods where ethnic data was recorded, 62% of the project's clients (Tier 2 & 3 activities) were White British and 38.5% were from Black and Minority Ethnic (BME) groups. The largest minority ethnic group was Pakistani (5.7% overall and 12% of those in treatment in years two and three).

Appendix 3: Reflective Case Studies

These case studies are real-life examples recorded by project workers to enable themselves to consider current dilemmas in casework with colleagues and with their supervisor.

Reflective Practice: Case Study A [Four sessions already completed]	
<p>Background Information <i>[Give brief details of referral information, clients age, drug use and type of environment in which the activity/ies took place]</i></p> <p>Female, 19. Primary alcohol, dependency – drinking every day, withdrawal symptom, Cannabis and heroin (smoking) use recreationally</p> <p>Full-time student with part-time jobs</p> <p>Initial presentation was pre-contemplation towards contemplation</p> <p>Initial appt in café, followed by several appts at xx clinic</p> <p>Lives with Mum and brother</p> <p>Presented with a variety of ‘problems’ but lack of desire to change of address currently problems</p> <p>Prev CAMHS involvement, current self-harm and depression.</p>	<p>Intended outcome(s) <i>[Describe the objective(s) behind the practice outlined here]</i></p> <ul style="list-style-type: none"> - to reduce harm - to increase motivation to change and by exploring change talk and cognitive dissonance <p>Get A to address drinking and drug use rather than listing it as one her ‘faults’</p> <ul style="list-style-type: none"> - improve positive thinking, self-esteem and self-believe through drawing out strengths and social support systems already existing - reach the point of a care plan and setting realistic actions to achieve end goals
<p>Key points for effective practice <i>[Briefly identify the most important points in the case study for other practitioners – these may include risks as well as benefits]</i></p> <ul style="list-style-type: none"> - Initially client presented very negatively, sessions were longer than planned and lacked focus or action planned. Risk of worker left feeling drained. - Planned and prepared better for sessions to make them more guided, and drew client back into discussing alcohol and drug use - Discussed session at supervision for support with 1:1 techniques 	
<p>Description of Interventions</p> <ul style="list-style-type: none"> - BSFT tried out new care plan, highlighted what’s important, strengths, goals, important people - CBT exploring drinking levels and awareness of safety towards reduction actions 	
<p>Conclusions and recommendations <i>[A summary of how and why the practice outlined here has been effective/ineffective]</i></p> <ul style="list-style-type: none"> - Ineffective practice was taking place when the client was solely leading the session and presenting with a large amount of problems. Worker is at risk of feeling pressure to problem solve - Effective by indentifying this direction of the sessions and seeking support through supervision - Effective by using new 1:1 techniques and guiding sessions towards BSFT rather than general counselling - Recently client cancelled a weekly appt due to celebrating end of exams – on return for next appt, Mum had found alcohol bottles and client had been away with mum for a ‘detox’ and ‘break from it all’ - Alcohol used had reduced greatly, after initially following with actions planned 	

Reflective Practice: Case Study B

Background Information [Give brief details of referral information, clients age, drug use and type of environment in which the activity/ies took place]

Referral from parent

Age: 17

In Full time education – 6th form

Home visits – after school hours

Mephedrone use with recreational alcohol use

Previous Ketamine, cocaine, cannabis and ecstasy use

Intended outcome(s) [Describe the objective(s) behind the practice outlined here]

Reduce the harm

Abstain from Mephedrone use

Increase motivation to change

Increase self-esteem

Key points for effective practice [Briefly identify the most important points in the case study for other practitioners – these may include risks as well as benefits]

Client presented with low mood, sleep problems and not eating regular meals – Referred on to xx for health assessment, Chlamydia testing and BBV screening

Joint sessions with family were key to his reduction in use – although at times family presence during sessions were stressful having individual client, parent and then family conversations proved more successful.

Description of Interventions

Acupuncture, BSFT (around care plan), MI particularly when client spoke about mephedrone use, 1:1 sessions, joint acupuncture and joint parent sessions.

Sessions were based either within the office or going on walks with the client and myself.

The use of ITEP maps proved useful in mapping out not only client's substance misuse but feelings around his family relationships.

Conclusions and recommendations [A summary of how and why the practice outlined here has been effective/ineffective]

Joint parent sessions kept JD more focused and allowed the family a neutral space for conversations to occur about drug use and the impact that it was having on the family as a whole.

Reflective Practice: Case Study C [Two sessions already completed]

Background Information [Give brief details of referral information, clients age, drug use and type of environment in which the activity/ies took place]

Male, 17, Currently living in xx (country). Been staying in England with sister for several weeks – travelling back next week.

Primary cannabis, daily use

Working and attending college in xx

Initial presentation in need of some help with cannabis use having become problematic. Concerns by B and parents that there are no similar services available in xx.

Intended outcome(s) [Describe the objective(s) behind the practice outlined here]

- to reduce harm
- to pass on information, tools and techniques that would benefit the client after the interventions
- to increase awareness of cannabis and own drug use
- to achieve client lead goals in a short space of time

Key points for effective practice [Briefly identify the most important points in the case study for other practitioners – these may include risks as well as benefits]

- Ensuring interventions were brief and qualitative. Making sure everything the client wanted to know and wanted help with was covered within a max of three sessions.
- Planning the sessions was important, and being reactive to the client's needs of what was important first. My goal may have been to complete a full assessment and get all paperwork signed, whilst the client's goal was to gain as much information and help as possible in three sessions.
- Reflected upon this work in supervision. Time constraints meant the brief and concise interventions were necessary, resulting in more qualitative sessions.

Description of Interventions

- Ear acupuncture, followed by ear seeds and breathing techniques
- MI exploration of change, individual drug use, and setting SMART goals
- CBT exploration of triggers and patterns of own drug use, and changing these

Conclusions and recommendations [A summary of how and why the practice outlined here has been effective/ineffective]

- Successful intervention was completed. The time constraint meant that a more qualitative intervention was completed, with the aim of meeting the immediate needs of the client and supporting contingency management.

Reflective Practice: Case Study D

Background Information [Give brief details of referral information, clients age, drug use and type of environment in which the activity/ies took place]

Referral from xx

Age: 23

Has a full time job (xx) and sometimes works weekends as well

xx used as primary location although home visits have been offered – usually appointments occur on a Wednesday night due to D's employment

Alcohol use – daily and binge use

Working with (agency) and seeing a private psychologist (specialises in CBT)

Intended outcome(s) [Describe the objective(s) behind the practice outlined here]

Reduce the harm

Reduce drinking to controlled amount

Increase motivation to change

Increase self-esteem and confidence

Key points for effective practice [Briefly identify the most important points in the case study for other practitioners – these may include risks as well as benefits]

Initially client presented with low self esteem and confidence – couldn't look directly at key worker, used negative language about himself, was nervous and couldn't concentrate for long periods of time (session where 20 minutes)

In further sessions that consisted of acupuncture and focused, short and direct work clients self confidence increased, began to participate in session more vocally and negative thought pattern began to change

Sessions need to be focused and direct otherwise client disengages if becomes bored or doesn't understand certain aspects of the care plan maps

Description of Interventions

Acupuncture, BSFT (around care plan), MI particularly when client spoke negatively about himself, 1:1 sessions and joint acupuncture with his mother, drinking levels exercise

Conclusions and recommendations [A summary of how and why the practice outlined here has been effective/ineffective]

After three sessions D became more focused and negative thought patterns began to change. This allowed the focus to remain on decreasing TN substance misuse and his motivation to attend partnership agencies appointments increased

Appendix 4: Financial Information

Project Budget

The table below shows the project's budget for the three years. Staff costs accounted for 83% of overall costs with management and support costs at 11%. Direct project costs and capital equipment costs accounted for 5% of expenditure with the cost of premises at 1%.

The project benefited from having an experienced full time manager, team leader and 3 full time project workers, throughout the lifetime of the project.

It also benefited from organisational economies of scale and utilised at no additional cost:

- experienced area managers for young people and adults
- the communications and marketing team
- the performance monitoring officer
- existing premises.

The project's income came from two separate grants. The Derby Community Safety Partnership's (DCSP) grant was £153,000 over three years and the Barrow Cadbury Trust (BCT) matched this with £150,000.

	Year 1 (£)	Year 2 (£)	Year 3 (£)
EXPENDITURE			
Staff costs (inc NI & pension)	84,126	84,523	87,121
Premises costs	1,160	1,160	1,160
Direct project costs	4,626	4,750	5,877
Management and support costs	10,861	10,861	10,968
Capital equipment costs	1,000	0	0
Total	101,773	101,294	105,126
INCOME			
Funder 1 (Derby Community Safety Partnership)	51,000	51,000	51,000
Funder 2 (Barrow Cadbury Trust)	50,000	50,000	50,000
Total	101,000	101,000	101,000
NET (DEFICIT) SURPLUS	(773)	(294)	(4,126)

Appendix 5: Young Adulthood

Changes in society over the past 30 years or so, that have seen many young people in western countries taking longer to achieve social and economic independence, have led commentators to argue that adolescence as a life stage has extended past the teens into the mid 20s (Chisholm, 1995), or that a new life stage has emerged (Arnett, 2004).

First it is important to recognise that life stages such as childhood, adolescence and adulthood are social constructs rather than fixed by biology. Ideas about human development change over time and, whilst clearly influenced by biological development, are primarily shaped by society.

The concept of adulthood is linked to that of adolescence which only emerged at the start of the 20th century (Hall, 1904). Hall identified a clear stage in life between childhood and adulthood and characterised it a time of 'storm and stress', before a more stable equilibrium is reached in adulthood. And although modern research has rejected this view as something of a stereotype (Adams et al, 1996), the concept remains strong in popular culture.

During the 1940s and 1950s 'adolescence' acquired firmer age boundaries with the rise of the 'teenager' as a marketing phenomenon, and again this notion remains firmly embedded in society. The age 18 tends to be treated as the formal start of adulthood, but in some instances age 16 is the marker, and in others, age 21. And of course, age 10 remains the age of criminal responsibility in England, Wales and Northern Ireland.

Sociologists have tended to understand adulthood in relation to the following transitions: leaving school and having full-time work; leaving the parental home; having a partner; and becoming a parent. And certainly, since the 1970s, these have gradually been happening later, with the period continuing to extend since the 1990s.

Relatively few young people are able to move directly from school to work, a situation that has worsened since the 2008 recession. The great majority are now in some form of training, higher education or are unemployed. Young adults are now increasingly dependent on family support for accommodation, with 58% of males and 39% of females living in the family home aged 20-25. Consequently, the average age of first time parents has also increased. At the start of the 1970s nearly half of all babies were born to mothers under the age of 25. Now that proportion is 25%, with the average age of a first time mother now 28, and that of fathers age 30. (Devitt et al, 2009)

The most persuasive explanation is that worldwide structural changes that became apparent in the later 1970s and early 1980s have transformed the youth labour market with the emergence of high levels of youth unemployment (Côté & Bynner, 2008). In response, governments have expanded the education system, with the 'staying on' rate doubling since 1970, with some 40% of young people currently going to university (Devitt et al, 2009).

Consequently, the delayed entry into the labour market has extended young people's period of dependence, extending 'adolescence' or creating a new life stage of 'emerging adulthood' (Arnett, 2004). Arnett emphasised the young person's input into shaping their own life course at this stage, whilst others have questioned this interpretation given that lack of economic power the young person is experiencing (Côté & Bynner, 2008) and the significance of class, gender and ethnicity to an individual's options (MacDonald et al, 2005).

Nevertheless, the argument for recognising the new challenges facing young people in their late teens, and early to mid-twenties has become powerful and is further emphasised by the great strides that have been made in the understanding of brain development in recent decades through MRI studies (magnetic resonance imaging). A key finding of the neurological research is that the 'higher executive functions' of the brain – functions such as planning, verbal memory and impulse control – are located in the frontal lobes and that these are 'among the last areas of the brain to mature; they may not be fully developed until halfway through the third decade of life' (Johnson et al, 2009: p.216). The new understanding of brain development, coupled with changes in society, strengthens the view that services, including those in the criminal justice system, need to take adults' age and maturity into account (T2A, 2009).

It is also important to include economic and social disadvantage into this debate. Young adults from poorer backgrounds are more likely to enter the labour market at a younger age, and whilst some do well, high unemployment rates are making this much more difficult. Young adults from disadvantaged backgrounds are overrepresented amongst those who experience a range of significant difficulties and are more likely to be involved (or have been involved) in the criminal justice and public care systems. Disadvantaged young adults are also more likely to become parents in their teens or early twenties than their better resourced counterparts, and are also more likely to misuse drugs. In effect, this group experiences a 'fast-track' to adulthood and, often with limited family support, is not well equipped to cope (ODPM, 2005).

Recognising the particular context for young adults face today can help professionals and policy-makers design better, more effective services, especially for those for whom the transition to adulthood is the most challenging.

Appendix 5: References

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Appendix 6:

Young Adults and Alcohol and Drug Misuse: Key Data^a

Key Facts

- Although 'binge drinking' rates are highest amongst young adults aged 16-24, the rates across age groups have evened out over the past five years with big increases amongst older adult females
- Drinking rates are much higher amongst vulnerable groups including male young adult offenders (18-21) for whom rates have quadrupled since 1979
- Drug misuse is highest amongst young adults, but has fallen significantly over the past 15 years
- Young adults in vulnerable groups are more likely to have tried drugs
- Young adult offenders are more likely to have taken drugs than their older counterparts, but they are less likely to be problem drug users, or to use harder drugs

This appendix sets out key facts and figures about alcohol and drug misuse amongst young adults, aged 18-24 and highlights differences between age groups and changes over time.

It also pays specific attention to young adults from vulnerable groups, including offenders. Having a drug or alcohol problem seriously increases the chances of an offender committing further crimes. In 2010, 71% of poly-drug using offenders were reconvicted of an offence within a year of being discharged from custody.

Alcohol Misuse

According to data provided by the National Health Service in 2011, it is estimated that over one third of adults in the UK exceed the recommended daily drinking limit (more than 3-4 units of alcohol for men and 2-3 units for women) on at least one occasion each week. Levels of excess drinking have steadily increased over the past decade with the greatest increases found amongst women aged 35-64.

Chart 5.1 below shows that despite the high profile given to young adults for excessive single-session 'binge-drinking', the drinking pattern amongst different age groups has evened out over the past five years, with levels amongst the 16-24 age group actually reducing. However, data on specific 'high-risk' groups shows a more complex picture, as is explained after the chart below.

^aThis Appendix is an abridged and updated version of Devitt, K. (2011) Young Adults Today: Substance Misuse and Young Adults in the Criminal Justice System Fact File which was published by Young People in Focus (YPF). The material is used with permission.

^bThe term 'vulnerable groups' is used here to include those who have been in the public care system, been homeless, truanted or excluded from school, or offended.

Estimated alcohol consumption on heaviest drinking day in the last week by age, 2000-2010



Alcohol misuse and vulnerable groups

Rates of binge-drinking and alcohol misuse are higher amongst certain groups. A 2003 Home Office report on youth homelessness and substance misuse found that 9% of young people aged 25 experiencing homelessness drank daily and 14% were identified as problem drinkers. Alcohol misuse is also more common in young adults experiencing mental health problems, with a strong association between suicides and suicide attempts and hospital admissions following primary and secondary diagnoses of mental and behavioural disorders.

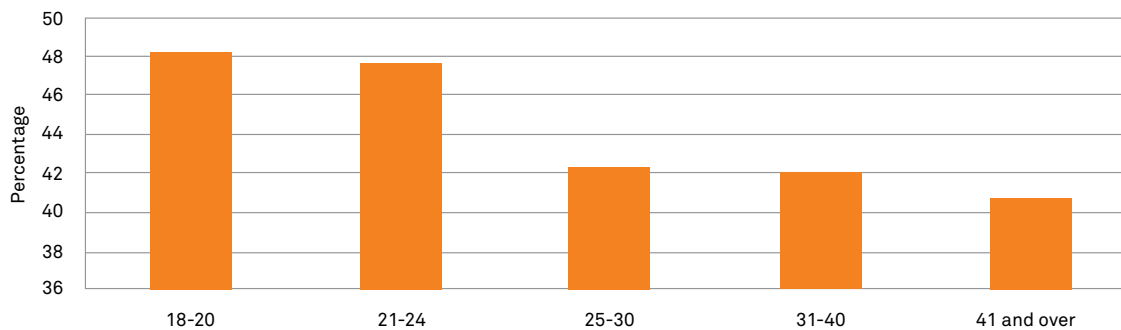
Alcohol misuse and young adult offenders

Young adult offenders are particularly likely to have a problem with alcohol. In 2001, for example, a Home Office report found that 70% (of 80) young adult offenders aged 18-21 reported hazardous or harmful alcohol use in the past year before coming to a Youth Offending Institute (YOI). In addition, 46% said that there had been weeks when they drank every day, and 14% reported drinking every day of the previous year. And more recently, in 2009, OASys data revealed that not only had the criminogenic need relating to alcohol risen to 43.5% , young adult offenders were in the highest risk group – see

Chart 6.2.

Chart 6.2

Offenders exhibiting a criminogenic need relating to alcohol in England and Wales by age, 2008



SOURCE: Ministry of Justice. (2009). A Compendium of Research and Analysis on the Offender Assessment System (OASys), 2006-2009. Ministry of Justice Research Series 16/09.

Whilst it is hard to be accurate when measuring trends over time, it appears that since the 1970s, there has been a dramatic increase in binge-drinking amongst young adult offenders. Nearly four times as many young men in 2007 reported being drunk daily compared to the young men in 1979. And 57% in 1979 reported being drunk less often than once a week, compared with just 10% in 2007 .

Offending, alcohol misuse, ethnicity and gender

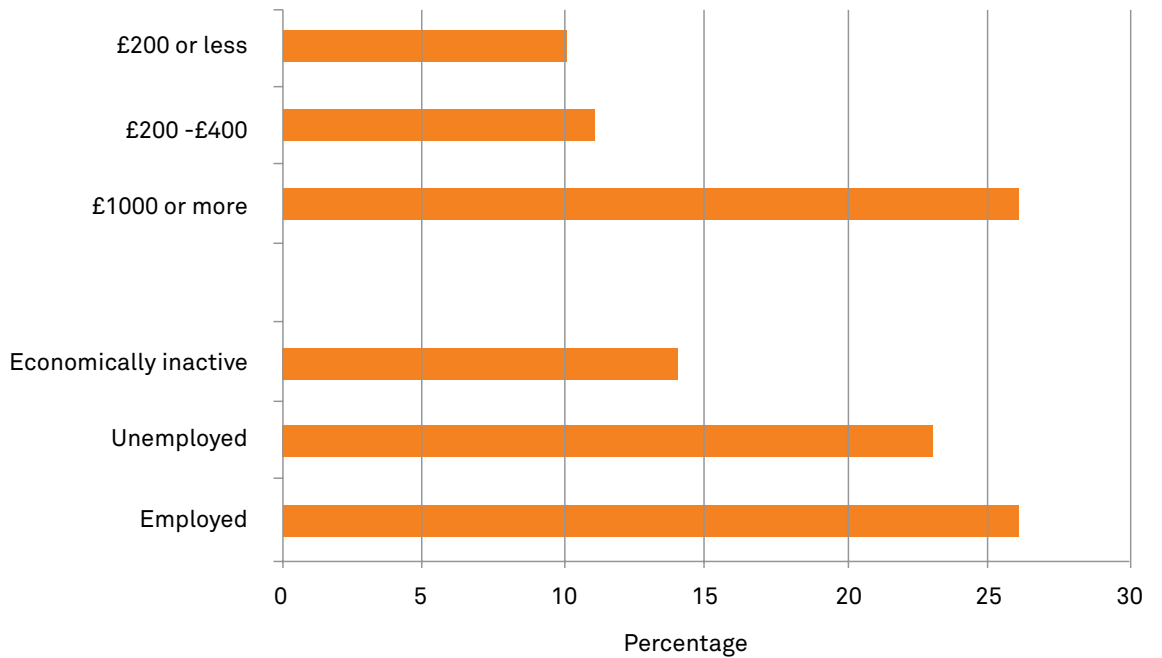
There are also some key trends relating to ethnicity and alcohol misuse amongst offenders. Alcohol misuse is significantly more of a problem for offenders from a White background than for any other ethnic group. Indeed, in 2008, 48.4% of White offenders had a criminogenic need relating to alcohol, compared to 32.6% of offenders from a mixed ethnic background, 22.3% of Asian offenders and just 17.9% of Black offenders . And in 2001, a Home Office report showed that White female offenders had higher rates of harmful drinking (37%) than either Black or mixed race female offenders (29%) .

Offending and alcohol misuse also has a gendered relationship, with research indicating that rates of binge drinking amongst female offenders may be as much as five times higher than those for the general female population .

Finally, there is an interesting relationship between alcohol misuse, social and economic status, and offenders. In the general population, alcohol misuse is considerably more prevalent amongst those who are employed and those who are higher earners – see **Chart 6.3**. However, offenders, who are statistically much more likely to misuse alcohol than their non-offending counterparts, predominantly have histories of disrupted or no employment, and often come from financially disadvantaged backgrounds. This does not seem to fit the pattern found in the wider population.

Chart 6.3

Binge-drinking episode in the previous week by employment status and weekly earnings in England, 2009

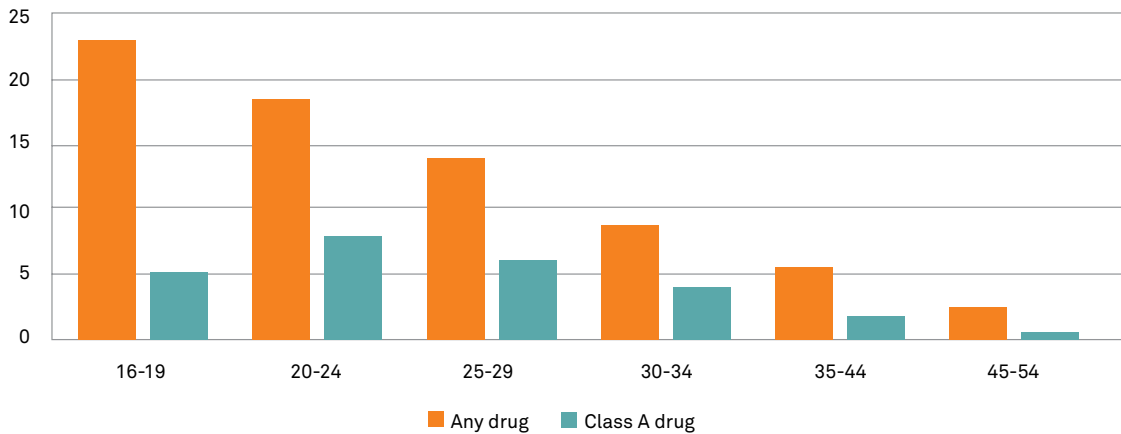


Drug Misuse

Drug misuse in adults and children has fallen over recent years. In 2010/11, 8.8% of adults had used illicit drugs in the past year compared with 12.1% in 1998. Drug misuse generally peaks in the late teens with rates steadily falling after that point – see Chart 6.4.

Chart 6.4

Percentage of adults reporting drug use in the last year in England and Wales by class of drug and age, 2010/2011 BCS



But although the percentage of drug misuse is highest amongst the young adult age-group, usage has significantly decreased over the past 15 years. Indeed, from the 1996 British Crime Survey (BCS) to the 2010/11 BCS, reported use of cannabis fell from 26% to 17.1%; amphetamines from 11.8% to 2.5%; and amyl nitrite from 4.6% to 2.4%.

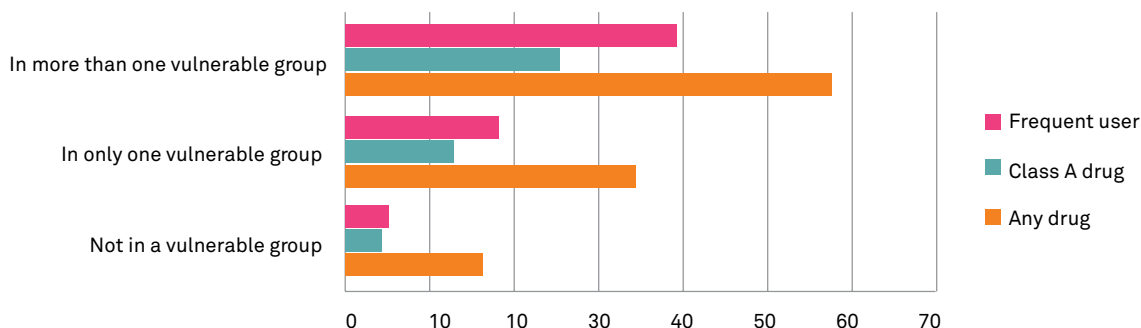
Nevertheless, although falling, Class A drug use remains higher amongst the 20-24 age group than for any other age band (7.8%). Equally there are different trends for individual drugs amongst this age group. Cannabis remains the most popular drug, followed by powder cocaine (4.4%). See Appendix 7 for more information about the classification of drugs and their use within the young adult age group.

Drug misuse and vulnerable young adults

Chart 1.5 shows that young adults who are in one or more vulnerable groups are three and four times more likely to have tried drugs, tried class A drugs, and be a frequent drug user than those who are not in a vulnerable group.

Chart 6.5

Young adults, 16-24, reporting drug use in the last year in England and Wales, by whether part of a vulnerable group, 2003



SOURCE: National Health Service. (2008). Statistics on Drug Misuse: England, 2007.

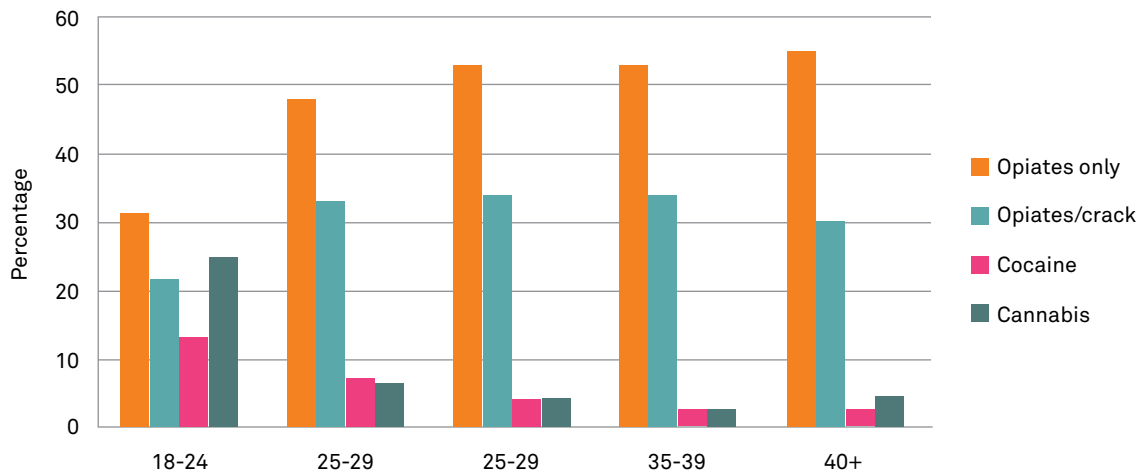
As with young adults as a whole, drug use amongst offenders steadily declines with age. The 2007 Arrestee Survey shows that 69% of newly arrested 17-24 year-olds in 2006 reporting having used drugs in the last year, compared with 67% of newly arrested 25-34 year-olds and 38% of arrestees aged 35 and over. Research also suggests that the link between crime and drug use is less strong amongst young adults than with older offenders.

Although young adult offenders are more likely to take drugs than their older counterparts, the severity of the drug taking often shows a different pattern. According to a 2010 report by the Department of Health looking at people accessing drug treatment services, (a sample comprising over 30% offenders), young adults, 18-24, were found to be the least likely group to be classed as a Problem Drug User (PDU) – 57% compared with 84% of 25-29 year-olds, 89% of 30-34 year-olds and 90% of 35-40 year-olds. The report also indicated that not only were young adults the least problematic in their usage, they were also less likely than older adults to be in treatment for harder drugs such as opiates and/or crack – see Chart 6.6.

In addition, in 2008, results from a national survey looking at the problems and needs of newly sentenced prisoners found that a greater proportion of adult offenders (aged 21 and over) reported using heroin, non-prescribed methadone or tranquilizers, and crack cocaine, whereas offenders aged 18-20 years-old were more likely to report usage of cannabis, cocaine powder and ecstasy.

Chart 6.6

Trends in primary drug usage amongst people receiving treatment for drug misuse in England by age, 2008/09



SOURCE: Department of Health. (2010). Statistics from the National Drug Treatment Monitoring System (NDTMS), 1 April 2009 – 31 March 2010.

The decline in drug use of the past decade or so is also mirrored amongst the young offender population. The 2007 Arrestee Survey indicated that in 2003/04, 74% of young adult offenders, aged 17-24, had taken drugs in the last year and that the figure had gradually declined to 69% in 2005/06.

Ethnicity, gender and substance misuse

There are some differences between ethnic groups in relation to substance misuse. The 2010/11 BCS found that people with a mixed ethnic background were the most likely group to have taken drugs in the previous year (at 19.2%), compared with 9.4% of White people, 4.6% of Black or Black British people and 3.7% of Asian people. This reflects findings from the Ministry of Justice 2008 research into the needs of newly sentenced prisoners which found that 34.5% of mixed ethnic groups have a criminogenic need relating to drugs, compared with 29% of Black people, 28.5% of White people and 21.3% of Asian people.

In terms of gender, men are considerably more likely to misuse drugs than women. Again, the 2010/11 BCS found that 12% of men, compared with 5.7% of women, had used drugs in the past year. And in 2009, data on all deaths due to drug poisoning in England and Wales showed that there were 1,512 deaths from drug abuse amongst males compared with 364 amongst females.

Finally, the relationship between drug misuse and socio-economic status (SES) is in direct contrast to that of alcohol misuse, with drug usage being most common amongst lower earners and those who are unemployed. The findings from the last BCS showed that in 2010/11, 17.7% of unemployed people had used illegal drugs in the past year compared with just 7.7% of employed people. In addition, those in routine/manual occupations were more likely to have taken illegal drugs in the past year than those in professional or managerial positions – 9.5% and 6.2% respectively. Full-time students were the most likely group to have taken drugs overall.

Conclusions

- The information in this appendix shows that alcohol misuse and drug misuse amongst all young adults (16-24) has declined in recent years, although rates are highest amongst this age group when compared with other age bands.
- Alcohol misuse and drug misuse are significantly more common amongst young adults in vulnerable groups, especially offenders.
- Young adults' (16-24) drug use patterns are different from those of older adults. Although, the use of Class A drugs are highest of all within the 20-24 age group.

This means that:

- Tackling substance misuse during young adulthood does not only result in major health benefits for individuals, it also impacts on offending and re-offending.
- Adult substance misuse treatment services need to be attuned to the specific needs of young adults, and their substance misuse patterns, which are different from those of older adults.
- It is also important to recognise that substance misuse patterns change within the broad young adult age band, given that the use of Class A drugs starts to rise for those in their early 20s. Better links between adult and youth substance misuse services are essential as well as clarity over the upper and lower age ranges of each service.
- There are clear associations between lower socio-economic status (SES) and drug misuse. Improving employment prospects will help break the cycle of drug use and offending.
- Services for young offenders with substance misuse problems need to be alert to issues related to gender and ethnicity.

Appendix 6: References

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Appendix 7: Drug Misuse amongst Young Adults (16-24 year olds): Patterns of Use

This appendix expands on the material in Appendix 6 and provides more information about the classification of drugs and the use of different drugs by young adults.

The information here is drawn from the results of the 2010/11 British Crime Survey (BCS) (Smith and Flatley, 2011) including comparisons with the 2009/10 BCS (Hoare and Moon, 2010) and trends since the 1996 BCS. This summary focuses on material relating to 16-24 year olds.

The BCS drug misuse estimates are produced from responses to a self-completion module of the wider survey. Use of drugs in the last year is deemed to be the best indicator to measure trends in recent drug use. The figures in this report are based on interviews conducted between April 2010 and March 2011. This data is generally regarded as the most accurate estimates of the prevalence of substance misuse, although there is always a need to treat the information with some caution, especially given that some respondents may be reluctant to declare illegal drug use (Ghodse, 2004).

The classification of drugs

The Misuse of Drugs Act 1971 classifies controlled drugs into three categories (Classes A, B and C) according to the harm that they are thought to cause. Class A drugs are considered to be the most harmful. The following chart lists the drugs the BCS 2010/11 found to be most frequently used by young adults. The classifications below are those as of May 2012 (when this report was written).

Class A	Class B	Class C	Not classified*
Amphetamines (injected)	Amphetamines (powder)	Anabolic steroids	Amyl nitrite
Crack cocaine	Cannabis (since January 2009; due to reclassification)	Ketamine (since April 2006)	
Ecstasy	Mephedrone	Tranquillisers (e.g. benzodiazepines)	
Heroin	Tranquillisers (e.g. barbiturates)		
LSD			
Magic mushrooms			
Methadone			
Methamphetamine			
Powder cocaine			

*Possession of 'non-classified' substances is not illegal, but it is an offence to supply these substances if it is likely that the product is intended for abuse.

Key findings from the BCS 2010/11

The term Young Adults is used to describe those aged 16-24 unless otherwise stated:

- Drug use is higher amongst young adults than for the adult population as a whole.
- Around two in five (40.1%) of young adults had ever used illicit drugs in their lifetime – approximately 2.7 million young people in England and Wales.
- Around one in five young adults had used illicit drugs in the last year (20.4%) – an estimated 1.4 million people.
- Use of any illicit drugs among young adults has fallen by nearly 10% since 1996 – largely due to the decline in cannabis use.
- The level of Class A drug use among young adults is falling. It was 9.2% in 1996 and was 6.6% in 2010/11, but there are different trends in the use of individual Class A drugs.
- Also, there are different usage patterns within the 16-24 age group. Class A drug use was higher amongst 20-24 year olds (7.8%) than for any other age group.
- Cannabis continues to be the drug most likely to be used by young adults, as it is for all adults. Approximately 1.1 million people used cannabis in the last year (17.1%) – one in six people.
- Powder cocaine is the second most used drug, at 4.4% amongst this age group.
- The proportion of young adults using any cocaine in the last year increased from 1.4% in 1996, peaking at 6.6% in 2008/09 and then falling to its 2010/11 level of 4.5%.
- There have been falls in the use of ecstasy (6.6% to 3.8%) and hallucinogens (5.3% to 1.7%) between 1996 and 2010/11.
- Mephedrone use is at the same level as that for powder cocaine (4.4%).
- Amphetamine (2.5%), amyl nitrite (2.4%), ketamine (2.1%) and magic mushrooms (1.3%) are the other most popular drugs amongst this age group.

The drugs most frequently used by young adults

Cannabis (17.1%)

As with 16-59 year olds, cannabis remains the drug most likely to be used by those aged 16 to 24; the 2010/11 BCS estimates that around one in six young people used cannabis in the last year (17.1%). This represents around 1.1 million young people.

For young people aged 16-24, over the period from the 1996 BCS to the 2010/11 BCS, there was a fall in the level of use of cannabis (from 26.0% to 17.1%).

Cocaine (4.4%)

As in previous years, powder cocaine was the second most commonly used drug among young people with 4.4 per cent reporting its use in the last year, representing 293,000 young people. Amongst young people, use of powder cocaine (and hence, any cocaine) is higher in the 2010/11 BCS (4.4%) than in the 1996 BCS (1.3%). Prevalence of the use of powder cocaine within this age group rose to a peak of 6.6 per cent in the 2008/09 BCS, with most of this increase occurring between the 1996 (1.3%) and 2000 BCS (5.2%).

Ecstasy (3.8%)

After cocaine, ecstasy was the next most prevalent Class A drug among young adults; 3.8% of young people reported taking ecstasy (249,000) according to the 2010/11 BCS – a fall from 6.6% in 1996.

Mephedrone (4.4%)

The 2010/11 BCS estimates relatively high levels of mephedrone use. For adults aged 16-24, the level of mephedrone (4.4%) was similar to powder cocaine (4.4%), the second most taken drug within this age group. When the survey was carried out, mephedrone was not a controlled substance.

Amphetamines (2.5%) and amyl nitrite (2.4%)

As with Cannabis, the level of use of amphetamines also fell from 11.8% to 2.5% between 1996 and 2010/11. The use of amyl nitrite also fell – from 4.6% to 2.4%.

Ketamine (2.1%)

The increase in the use of ketamine in young adults is more pronounced than that seen for adults aged 16-59 as a whole. The 2010/11 BCS estimates that 2.1% of adults aged 16 to 24 had used ketamine in the last year, more than double the estimate in the 2006/07 (0.8%).

Magic Mushrooms (1.7%)

The 2010/11 BCS estimates magic mushroom use amongst young adults at 1.7% – a fall from 5.3% in 1996.

Other drugs

The use of opiates estimated by the 2010/11 BCS is low, although methadone use has increased from 0.1% in 1996 to 0.4%. Heroin, by contrast, has reduced from 0.4% to 0.1%.

Appendix 7: References

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Sharing the Learning

The Drug and Alcohol Transitions Project
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