London Borough of Tower Hamlets

Child Rights Based Needs Assessment

Young People's Substance Misuse

Clare Skidmore
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Executive Summary and Recommendations

1. Introduction

This document sets out a child-rights based analysis of the needs of children and young people in Tower Hamlets who misuse substances, based on the following principles of the Convention on the Rights of the Child (CRC):

- Participation – the right of all children to be heard and taken seriously;
- Transparency and Accountability – the responsibility of all 'duty bearers' (including government agencies and their service providers, as well as parents and other community organisations) to raise awareness of rights, advocate on behalf of children, and examine all issues affecting children from a child-centred perspective;
- Holistic – a recognition that all human rights are interdependent and inter-related, where the realisation of one right often depends, wholly or in part, on the realisation of others. As a consequence, all service commissioners and providers working with children and young people should take a holistic, child-centred approach, and work together cohesively to support each child (and not just tackle the primary presenting issue).

The primary purpose of this exercise is to inform the re-commissioning of Tier 3 Substance Misuse Services for children and young people in Tower Hamlets. Tier 3 services provide specialist substance misuse treatment for children and young people. However, given the importance of prevention and early intervention, especially from a child rights perspective, a broader view is required. Therefore, this analysis also looks at the role of Tier 1 and 2 services (i.e. universal and targeted substance misuse support), in order to understand how well services in Tower Hamlets are working to support children and young people with substance misuse needs, across the whole system.

2. The Current Picture

Data reviewed to determine the current picture in terms of need in the borough covers a range of risk factors which make a child or young person more vulnerable to becoming involved in substance misuse, and the needs assessment explores the local picture in this respect, mostly based on 2011-12 data. Key risk groups include young offenders, looked after children, those affected by school exclusion or truancy, those at risk of 'hidden harm' (i.e. those affected by parental drug use), and children with mental health needs. The overview also includes national survey data about the views and experiences of children and young people with regard to drug and alcohol issues.

Important findings include:

- Looked after children in Tower Hamlets were less likely to be identified as having substance misuse problems, compared to their peers in comparator boroughs, and in London more widely. Further, even when children were identified as having a substance misuse problem, they were less likely to be referred for treatment.
- 32% of the adult drug treatment population were parents who had their children living with them, while 19% were parents, but did not have their children living with them.
- Local data could not be collected regarding the number and proportion of CAMHS patients identified as being affected by substance misuse. It was not even possible to clarify what data is routinely gathered about this issue. This is a significant gap and it is suggested that efforts should be made to address this gap in knowledge.
- In the period between March 2012 and February 2013, Tower Hamlets recorded the highest rate in London for the number of alcohol related call outs for the 8-17 age group.

According to the most recent data available for alcohol specific hospital admission for young people under the age of 18 (2009 – 2011), Tower Hamlets also recorded the second highest rate in London. Notably, while admission rates had fallen in London and England over the previous 5 years, the Tower Hamlets rate represented nearly a doubling in numbers. It should be noted that not all admissions were of Tower Hamlets residents.

Another principle information source for this needs assessment is local treatment data. Salient findings include:

- **Referrals and Entering Treatment**: Following major improvements in staffing and resources, there has been a significant upturn in the numbers of referrals and those entering treatment in the year to date (2013-14). More than two thirds of clients entering treatment in 2011-12 were male (close to the England average). Referrals data for 2013-14 shows that 81% were male, and 19% were female – i.e. more skewed towards young males than one might expect.
- 60% of young people entering treatment in 2011/12 had an 'Asian / Asian British' ethnicity, while 24% were of a White / White British ethnicity. Referrals data from 2013-14 suggested a slightly greater proportion of Asian / Asian British young people. However, the numbers are relatively small, so should be viewed with caution.
- **Referrals source:** The majority of referrals in 2011-12 came from the Youth Offending Team, or the YOT (48%), the Children and Family Service (34%), and Health and Mental Health services (9%). 80% of YOT referrals were for male clients; two thirds of Children and Family referrals were for male clients; and 100% of referrals from Health and Mental Health were for female clients.
- Since this time, the treatment provider has undertaken an intensive programme of outreach work and marketing to a wide range of key agencies. As a result, the referrals data for 2013-14 (year to date) looks quite different, with a significant increase in the proportion of referrals from schools. However, there have been very few referrals from Looked After Children services, and also few to none from A&E, hospitals, GPs, Youth Services, and Mental Health services.
- **In treatment:** In 2011-12, Tower Hamlets had the 7th highest total number of young people in treatment and the 8th highest rate of young people in treatment by 10,000 population. The comparison has not been made for more recent years.
- **Exiting from treatment:** In 2011-12, Tower Hamlets had a similar rate of drug free completions compared to comparable London boroughs, but a higher rate of unplanned and unknown exists, and a lower number of occasional use completions. However, a significant improvement can be observed in the current financial year (to date). In 2012-13, of those young people who had exited treatment, 73.8% recorded positive outcomes (either completing drug-free, or as occasional users).

3. Key Themes and Issues

This section of the needs assessment was informed by a wide-ranging process of consultation and discussion with stakeholders, largely those working for, or managing, services across the system which supports at risk children and young people.

Participation and Self Expression

Many stakeholders explained that treatment services are a challenging setting within which to create a participative service. However, young people do set their own goals for the outcome of their own treatment – whether to become drug-free, or to reduce their use of drugs, for example – and the service is measured against how outcomes are delivered against young people's own aspirations. It could be argued that this is an inherently participative approach.

When asked about what good participation would look like, the feedback from most stakeholders was that this is not necessarily (or in most cases, at all) about developing focus groups or formalised consultation exercises. Rather, it is about building a culture which is focused on listening to young people, and on recording what they have to say, ensuring that this does inform the way in which the service is developed and improved in the future.

Accountability and Transparency
This section focuses on how the local authorities and service providers have responsibilities as duty bearers to be fully accountable to children and young people. This should include fully informing young people of their rights, and being clear who they should contact, and how, if they are unhappy with a service, or if they feel their rights are not being respected. It is also important to explore the extent to which the Council is responsible for this, as well as the provider.

In terms of Lifeline's own approach to ensuring accountability and transparency, there appears to have been significant progress in this area recently, with a new Assessment Form which sets out clearly what children and young people can expect and what their rights are, and what they should do if they feel that their rights are not being upheld. Lifeline accepts that there is room for reflecting further on, and improving their practice on an ongoing basis, to ensure that young people's rights are respected, promoted and respected.

Holistic
The concept of 'Holistic' encompasses a focus on a child-centred approach, and on considering all the needs of that child or young person, not just those which directly relate to substance misuse. In a child or young person's life, there will be a wide range of needs and issues which are interdependent. These will include many domains which are underpinned by child rights, as enshrined in the CRC Articles. The responsibility of all duty bearers relates not only to how they support young people directly, but also to working holistically with other agencies and partners, in order to support young people with all the needs they may have.

- **The role of Tier 1 and Tier 2 services**

Given the importance of prevention, many stakeholders highlighted the critical role of high quality universal and targeted drug and alcohol support, and of ensuring that everyone who works with children and young people are sufficiently aware of substance misuse issue to be able to talk to young people about these issues, and (with their consent) to make referrals into treatment when needed. In Tower Hamlets, there appears to be a lack of consensus on how these services should be provided.

- **Referring into Treatment Services**

One of the issues identified in the course of this needs assessment has been that several agencies who work with vulnerable children and young people appear to make very few referrals into treatment services. Particular concerns about low referrals relate to the Children and Adolescent Mental Health (CAMHS) team; Looked After Children services; Youth Services – including Targeted Youth Services; and Accident and Emergency and other Health services.

Issues worth highlighting include concern about the suspected lack of access for looked after children placed out of borough to substance misuse services; insufficiently strong relationships between youth services and Lifeline, the treatment provider, in particular; and some stakeholders' concerns about lack of clear referral routes between services.

- **Perceived Collusion, Normalisation and Equalities Concerns**

Alongside the concerns raised above, the manager of the treatment service also highlighted the risks associated with the potential 'collusion' and 'normalisation' of substance misuse among some young people and those who are responsible for them (including both parents and paid

professions). Sometimes, it is alleged, these attitudes arise from misperceptions such as 'all young people are doing this' – or even from misplaced assumptions relating to young people's religion, ethnicity, gender, or sexual orientation. It is suggested that all agencies and workers should be aware that turning a 'blind eye' to substance misuse is effectively collusion.

- **Working Together to Support Children**

Several stakeholders stated that they felt they did work holistically with children and young people, but when probed, it sometimes seemed that they viewed this primarily as an approach which they took within their own organisation, rather than necessarily as part of the wider system which is working to support children and young people.

- **Effective Interventions at Tier 3, and 'Think Family'**

There is robust evidence suggesting the range of interventions which should be provided as part of drug and alcohol treatment services, which are consistent with the current treatment provider's approach. The evidence also suggests that it is important that all staff are caring, committed and flexible in the way they work with young people. The evidence also suggests that it is good practice to consider the needs of the child / young person in the context of their family, support networks and living environment.

- **Transitions - Step Down Support and Transition to Adult Services**

Literature emphasises the importance of step-down support, emphasising that regular contact and monitoring of young people has been shown to reduce the likelihood of their return to substance misuse services. Many stakeholders recognised the importance of this area of practice, but acknowledged that it is currently under-developed in Tower Hamlets.

4. Young People's Substance Misuses Treatment Service - Future Projections

Over the previous 10 years Tower Hamlets was the fastest growing local authority area in England and Wales, with the resident population increasing by 27% from 207,000 to 263,000 (2002 & 2012 ONS MYEs). Over the next 10 years the latest round of GLA SHLAA based projections show Tower Hamlets growing at a slower rate, but still as the 3rd fastest growing borough in London (from 2013 to 2023) after the City of London and Greenwich. The resident population of the borough is projected to increase from 266,144 in 2013 to 320,231 in 2023, representing growth of 20.3% (an additional 54,087 residents).

The projections show that the borough's population will increase across all of the summary age groups. For 0 – 19 the projected percentage growth is 17.1%.

There are also expected to be a significant percentage increase in the number of residents of school age (ages 4 to 15) which are expected to increase by 7,695 residents over the next 10 years (a 21.6% increase in the size of this age group)

In 2011/12 there were 119 young people in treatment this number went down to 115 in 2012/2013. However it is anticipated that in 2013/2014 the number of young people in treatment will be approximately 160.

Mapping population projection growth against numbers in treatment we expect the numbers in treatment to increase to 187 at a minimum.

The calculation 160 + 17.1% (27) = 187

5. Conclusion

This needs assessment identifies the ways in which fulfilling children's rights in this area requires all 'duty bearers' to support young people to participate and express their views; to be fully accountable and transparent with young people about what their rights are and what to do if they feel their rights are not being upheld; and to work in a holistic and collaborative way with all partners, focusing on the needs, wishes and best interests of children.

This latter point is particularly important, considering the complex and multi-faceted issues and barriers which many of the most vulnerable children experience, and also given the diverse and particular needs of every child.

There is evidence that significant progress has been made by the substance misuse treatment provider in generating increased referrals into the service and in achieving improving outcomes for young people.

However, there also appear to be broader systemic difficulties, with widespread confusion in some quarters about the definition of so-called Tier 1, or 'universal' substance misuse services, and Tier 2, or 'targeted' services. It is suggested that this confusion needs to be resolved, and that clear arrangements are required to ensure that Tier 2 services are provided to young people who need them, and that all partners understand exactly how these are accessed and / or provided and their role in this (if any).

It is also suggested that improvements are needed in terms of wider partnership working, in order to strengthen mutual understanding between service areas, identify why some services seem not to be making referrals into substance misuse treatment services, and tackle any issues identified as a consequence.

6. All Recommendations:

Participation and Expression:

Understanding young people's own aspirations:

i. It is already the case that young people's goals are recorded, in respect of their treatment plans – for example, whether they wish to become drug-free, to reduce their drug use or perhaps to continue their drug use, but to manage it more safely. However, it is suggested that in order to gain a broader understanding of young people's aspirations, the wider goals of young people in treatment should also be understood– for example, these could include things like succeeding in education, or getting a job. Given the complex relationship between substance misuse and other risk factors, it is suggested that this information may provide commissioners with a useful broader understanding of young people's own priorities, concerns and motivating factors.

Use of Technology

ii. It is suggested that a wider range of mechanisms should be developed to enable users of treatment services to provide ongoing feedback on their experiences and views, for example through smart use of technology, and through building an increasingly participative approach in young people's day to day interactions with the treatment provider.

Outreach

iii. It is recommended that the service provider continues outreach work into youth clubs, schools, and other service areas, in order to generate greater understanding of young people's own concerns.

Annual Survey

iv. It is recommended that the local Pupil Attitudes Survey should be used as a mechanism for generating information about young people's experiences and perceptions of alcohol and drugs (among many other areas and themes).

Securing Engagement of Young People

v. In order to engage young people and secure their consent for a referral to substance misuse services, workers must win the young person's confidence that service will be interesting and responsive to their needs, developed in the arena of respect, trust and warmth.

Accountability and Transparency:

Accountability of Tower Hamlets Council

i. Tower Hamlets Council (and in particular, children and families services) should explore ways of becoming more accountable to children and young people, for example by making better use of the Council website to be clear with young people about their rights and about how they should complain if they wish to do so.

ii. The Council should also make its position on upholding Child Rights clearer on its website and in other communication channels.

Responsibilities of all duty-bearers

iii. All partners, including Lifeline, should continue to explore ways of improving their practice in this area.

iv. The importance of upholding Child Rights and being accountable to young people should be a key feature of all contracts, SLAs and agreements which the Council makes with its partners, and in staff job descriptions.

Holistic:

Prevention

i. Establish a whole-life approach to drug prevention covering early years, family support, transitions, drugs education and targeted / specialist support for young people. This should be established with the support of the Children and Families Partnership, which works together under the Children and Families Plan to improve outcomes for children, young people and families. The plan encourages the Partnership to adopt a life course approach to ensuring that children and young people are safe and healthy, are achieving their full potential, are active and responsible citizens and are emotionally and economically resilient for the future.

Tier 1 and 2, and 3 Services

ii. All partners to come to a shared view about what Tier 1 and Tier 2 substance misuse services are, and who should provide them. One approach could be for all partners to agree what all mainstream practitioners who work with children should be able to do (regardless of whether those roles are labelled 'Tier 1' or 'Tier 2') and therefore what should be provided by specialist substance misuse services.

iii. It should be made clear to all partners what substance misuse treatment services are, what the referral criteria is for these services, and how to refer.

iv. It is suggested that for all responsible partners, being 'holistic' involves being proactive at identifying the young people who are most at risk, asking the right questions, providing the right information, talking to young people and, where necessary, making referrals to treatment services (having gained consent from the young person).

v. Once the above has been clarified and agreed by all partners, these approaches and commitments should be cemented and formalised in employment and commissioning contracts, SLAs, and policies and procedures.

Training and Support

vi. Ongoing training and support should be provided to: youth workers; foster carers (including those based out of borough); children's centre workers; A&E staff; GP practices; social workers; CAMHS staff; schools staff; and other staff who work with children and young people. These will need to be prioritised and it is possible that training all these staff will not be fundable within the current funding envelope. Part of this programme of training and support should encompass developing the workforce to gain a deeper understanding of child rights, so that all staff working with children and young people, including those working for the substance misuse support provider, should be aware of the Convention of the Rights of the Child and the importance of upholding child rights.

Healthy Lives Team

vii. It is questioned whether the Healthy Lives team should be funded to work on substance misuse and smoking issues in schools, beyond their current remit of alcohol only.

Additional Work with Families and Communities

viii. Health Lives and Lifeline both highlighted the need for additional work to be done with parents, families and communities. The partnership could explore how this additional work could be incorporated into existing service provision.

Rights of Looked After Children

ix. Further consideration should be given to the needs and rights of looked after children and young people who are placed out of borough, and who may need to access substance misuse services. This may involve more focus on building relationships with service providers in the 'host borough' (could we use spot contracts?).

Equalities Concerns

x. All partners working with children and young people should ensure that they address any barriers relating to ethnicity or religion which may be dissuading or preventing young people from accessing a service, and ensure that all referral processes.

xi. Practitioners and services should work closely together to ensure that girls who need support are effectively identified, referred, and supported in treatment in a way which meets their individual needs.

xii. Strenuous efforts should be made to ensure that referral processes and treatment services do not create unwitting barriers which may put off LGBT young people coming forward for help.

'Normalisation' of Drugs and Alcohol

xiii. Further research could be undertaken to understand the extent to which 'collusion' and 'normalisation' is prevalent across the borough, and to explore the interaction with highly sensitive cultural issues of religion and ethnicity. At the very least, all partners should debate whether 'collusion' exists, and if so, what should be done to tackle it. These issues are particularly complex and potentially sensitive, so further research would enable other views and perspectives to surface, which may not have been raised in this report.

Partnership Working

xiv. Agencies must continue to work in partnership to support young people on an ongoing basis, so that, for example, if a young person is simultaneously receiving support from more than one provider or agency, these agencies avoid working in silos within their particular specialism, but instead work together in a child-centred way.

xv. Commissioners could consider whether building the CAF into the treatment provider's assessment process would be beneficial from the point of view of integrated working and contributing to an even more holistic approach.

xvi. The potential role of new targeted youth service based in A&E should be explored and more details provided to enable commissioners to build this into their planning.

xvii. The treatment provider should continue their ongoing outreach and partnership work to raise awareness among key agencies about the role of the substance misuse treatment service. At the same time, the onus should be placed on those partners to engage with the reality of substance misuse among the children and young people they support, work with those young people about the issues arising, and make referrals when needed (with the young people's consent). Where additional complicating issues create barriers to effective referral, all partners should be encouraged to be open and transparent about those issues, and work together to find jointly agreed solutions.

Substance Misuse Treatment - Best Practice

xviii. Where possible, treatment services should engage the family of the young person, recognising that consent from the young person is required before this can happen. However, given the evidence that outcomes are often more effective when the family has been successfully engaged, it seems right that this should be the aspiration for best practice.

xix. It is recommended that other best practice recommendations as noted above, regarding the treatment interventions which are evidenced to be the most effective in terms of resulting in positive outcomes for young people, be noted by commissioners, and reflected in any contracts and specifications which are agreed with treatment providers in the future.

Understanding Treatment Patterns

xx. Treatment data should be studied in more detail, to gain an understanding of more specific patterns within the data; for example, is there a link between young people who exited treatment in an 'unplanned' way and those not-treatment naïve young people who required further treatment at a later stage?

Step-Down Support

xxi. An effective and robust approach to providing after-care / step-down support for young people following treatment should be built into services. This could be a specific role for a particular agency, for example, Targeted Youth Services; or it could be mainstreamed as core to the role of all referring agencies, with contingencies made where there is no referring agency (for example, when a young person self-referred). Whichever is the preferred approach; a protocol should be developed and agreed with all partners, and built into SLAs and contracts wherever possible.

Transition to Adult Services

xxii. Commissioners could examine the current transition arrangements between children's and adults' services, given concerns raised in the national literature about this area, to ensure that there are no unidentified problems affecting transitions between young people's and adults' services in Tower Hamlets. This might relate specifically to

substance misuse services, or services provided by other partners in the borough, to support vulnerable children and young adults.

1. Introduction

This document sets out a child-rights based analysis of the needs of children and young people in Tower Hamlets who misuse substances. The primary purpose of this exercise is to inform the re-commissioning of Tier 3 Substance Misuse Services for children and young people in the borough.

However, in order to fully secure an understanding of the wider context within which these services are required, this needs analysis takes a broader perspective, and does not restrict itself purely to the issues pertaining to Tier 3 services which support this group of young people. In particular, it is important to recognise the key role of prevention and early intervention when working with young people, as well as the systemic nature of the complex needs experienced by many children and young people who misuse substances.

1.1 Child Rights Based Approach in Tower Hamlets

UNICEF's Child Rights Partner programme was established in late 2011 and Tower Hamlets Children and Families Partnership is one of the Child Rights partners in the national working group.

The goal of a Child Rights Based Approach is to promote and secure the full range of a child's social, economic, cultural, civil and political rights. The core tenet is that rights should provide the lens by which all issues impacting on children should be reviewed and resolved.

1.2 Child Rights Based Approach to Needs Assessment

The current Joint Commissioning Framework for children's services in Tower Hamlets identifies the purpose of needs assessment as taking account of all available information, both quantitative and qualitative, in order to build a comprehensive picture of need in Tower Hamlets. This should be set against provision to identify gaps and development priorities.

The child rights based approach should not replace the core focus of a demographic needs assessment, but it should provide added value, by offering a multi-dimensional perspective on the needs, gaps and issues identified.

A child rights based approach differs from a traditional needs assessment in that the focus is not on children and young people as passive recipients of assistance and services, but rather on their status as rights holders, whose ability to enjoy their rights is impeded by structural barriers and systemic challenges which need to be identified and addressed. The views and contexts of children, young people and their families are essential in identifying targeted and effective solutions.

1.3 Convention on the Rights of the Child

The Convention on the Rights of the Child is the first legally binding international instrument to incorporate the full range of human rights —civil, cultural, economic, political and social rights.

The Convention sets out these rights in 54 articles[1] and two Optional Protocols. It sets out the basic human rights that children everywhere have: the right to survival; to develop to the fullest; to protection from harmful influences, abuse and exploitation; and to participate fully in family, cultural and social life. The four core principles of the Convention are non-discrimination;

[1] All the Articles are outlined in Appendix 1

devotion to the best interests of the child; the right to life, survival and development; and respect for the views of the child.

Every right spelled out in the Convention underpins the human dignity and harmonious development of every child. The Convention protects children's rights by setting standards in health care; education; and legal, civil and social services. [2]

Throughout this needs assessment, the issues raised will be discussed in the context of the Convention, and in relation to the particular Articles which are relevant to the matter in question.

In addition, for the purposes of delivering this Child Rights Needs Assessment, a core working group has collaborated with UNICEF to agree three key principles, inspired by the Convention, which will inform the work, as follows:

- Participation
- Transparency and Accountability
- Holistic

These three concepts are explored in more detail below.

1.4 Participation

The right of all children to be heard and taken seriously constitutes one of the fundamental values of the Convention. The Committee on the Rights of the Child has identified Article 12 as one of the four general principles of the Convention, which highlights the fact that this article establishes not only a right in itself, but should also be considered in the interpretation and implementation of all other rights.[3]

Article 12 provides that when adults are making decisions that affect children, children have the right to say what they think should happen and have their opinions taken into account. This is not about giving children authority over adults, but about encouraging adults to listen to the opinions of children and involve them in decision-making. Within this principle, the Convention recognises that the level of a child's participation in decisions must be appropriate to the child's level of maturity.

In order for children and young people to be able to safely and properly exercise their rights, public authorities, parents and other adults working with or for children need to create an environment based on trust, which is open and receptive to the views and feelings of children and young people. Children and young people should be included in decision-making processes, and in planning, implementation, monitoring and evaluating services, in a manner consistent with their evolving capacities. They should also be provided with information about any proposed services and their effects and outcomes, in accessible and interesting formats.

1.5 Transparency and Accountability

This principle recognises the duty that States, government agencies and their providers, as well as parents and other responsible community organisations, all hold, to protect, promote and fulfil children's rights. In this sense, they can all be described as 'moral duty bearers'. As well as providing services, government agencies should also raise awareness of rights, support parents and families in their role as moral duty bearers, advocate on behalf of children and young

[2] http://www.unicef.org/crc/
[3] United Nations (2003): Committee on the Rights of the Child.

people, and examine all issues affecting children, from a child-centred perspective. They should be clear with children and young people about what their rights are, and what they should do if they feel those rights are not being upheld.

The transparency and accountability principle also encompasses the duty to collect data and information about the quality of services provided, including from the point of view of children and young people themselves; and to monitor services' impact and efficacy over time. There is also a clear overlap, here, with the participation principle – because children and young people's views and feedback should be understood as a key and valued source of information to inform the monitoring and evaluation of any service.

1.6 Holistic

This principle recognises that all human rights are interdependent and inter-related. The realisation of one right often depends, wholly or in part, upon the realisation of others. For instance, the realisation of the right to health may depend, in certain circumstances, on the realisation of the right to education or information.

The Convention on the Rights of the Child (CRC) recognises the interdependence and equal importance of all rights that enable children to develop their mental and physical abilities, personalities and talents to the fullest extent possible. Achieving children's rights associated with substance misuse is dependent on the realisation of many other rights outlined in the CRC.

What this means in practice is that in planning or delivering services with and for children and young people, and indeed when working with children and young people in any capacity (not just on substance misuse issues), it is essential for all partners to take a holistic, child-centred approach. This approach would recognise and locate each individual child's unique cultural, social, economic and other needs as part of the context within which the child's substance misuse (or any other) needs have arisen.

This approach should ensure that each agency and service provider understands every child's particular needs as part of a wider systemic framework, and places an expectation on all agencies to work together in a cohesive, holistic way to support each child (and not just to tackle the primary presenting issue, such as substance misuse, for which the child was originally referred).

1.7 Substance Misuse Services: Tiers 1, 2 and 3, and the Importance of a Preventative Approach

In addition to the child rights focus of this needs assessment, it is also important to be clear about the types of services which are commissioned and provided to support children and young people to tackle their substance misuse issues. In the interests of taking a holistic approach, it is beneficial to clarify how these categories align and overlap with those which form the basis of the Family Wellbeing Model, which underpins all children and young people's services in Tower Hamlets.

The National Treatment Agency (NTA)[4] provides a definition of three levels of service which are evident across all health and social care provision:

- Universal services – accessible to all young people, such as schools, family doctors, mainstream youth services, Accident and Emergency services.

[4] Briton, J: '*Exploring the Evidence',* National Treatment Agency, 2009

- Targeted services – accessible by young people who are considered to be vulnerable or who have been identified as having needs that require some low intensity intervention and monitoring – e.g. child in need support services, many targeted voluntary sector and out-patient health services, targeted youth services.
- Specialist services – accessible by young people with identified needs that cannot be met by universal or targeted provision – such as CAMHS (Children and Adolescent Mental Health Services), specialist schools, in-patient health services, child protection services.

In the context of substance misuse services, these levels can be aligned to Tiers 1, 2 and 3, with Tier 1 being the universal level of provision. Tier 2 are targeted services, aimed at young people who are not necessarily seeking help for substance misuse, but who are identified as being at risk on the basis of characteristics they have, of their behaviour, or of the group to whom they belong; and Tier 3 are specialist substance misuse treatment services.

In the case of substance misuse services, the NTA states that young people should have their needs identified and met in universal or targeted services wherever possible. However, specialist substance misuse treatment services should be offered to all young people whose substance misuse is significantly impairing their physical, psychological, and / or social functioning, and who have been assessed as requiring treatment to tackle damaging substance misuse behaviour.

In Tower Hamlets, all children and young people's services are based on the Family Wellbeing Model, which takes the same approach, planned around the concept of Tier 1, 2 and 3, or universal, targeted and specialist services. Inherent in this approach is a focus on prevention and early intervention, where less intense (and costly) types of support earlier on can help prevent needs from escalating, reducing the need for more intensive support later on.

From a child rights perspective, one could cite Article 3, which emphasises that the best interests of children must be the primary concern in making decisions that may affect them. It is clearly in children's best interests for support to be provided when needed, to prevent the risk of greater problems developing at a later stage, with potentially serious consequences for children's health, wellbeing and future life chances.

The primary focus of this needs assessment, as required by commissioners, is Tier 3 / specialist substance misuse treatment services. However, given the importance of the preventative principle, including from a child rights perspective, a broader focus will be taken, in an attempt to consider how well services are working to support children and young people with substance misuse needs, across the whole system.

2. What's the Current Picture?

This section of the document will provide an overview of the current national and local picture in relation to young people's substance use and misuse.

2.1 National Evidence – Children and Young People's Substance use Behaviour and Attitudes

Alcohol

National data (2011-12) about children and young people's substance misuse behaviour is available, based on a survey of school pupils aged 11-15 in England[5]. In summary, the survey

[5] NHS Information Centre, 2011-12.

found that less than half of pupils (43%) had ever drunk alcohol, with boys and girls equally likely to have done so. The proportions of young people who had ever drunk alcohol increased from 12% of 11 year olds to 74% of 15 year olds.

This represents a significant drop in proportions over the previous 15 years; in 1998, 62% of pupils had ever had an alcoholic drink. At the same time, in terms of mean alcohol consumption, despite fluctuation, there does seem to have been an overall increase in the amount of alcohol consumed, by those pupils who were drinking – from a mean of 9.0 units per week in 2007, to 12.5 units per week in 2012, with boys drinking slightly more than girls (figures for alcohol consumption prior to 2007 are not comparable due to a revision in survey methods).

Another major change can be found in a significant increase in the proportions of young people, of those who did drink, who did so at home, or in someone else's home (as opposed to in the street or somewhere else outside, in a bar, or in a club) – from 52% in 1996, to 78% in 2012.

In terms of impact on pupils' drinking behaviour, pupils' perceptions of their family's attitude to their drinking had a significant effect. For those whose parents let them drink as much as they liked, 49% had drunk in the past week, in contrast with those whose parents didn't mind as long as they didn't drink too much, of whom 18% had drunk in the past week. For those whose parents didn't like them to drink at all, only 2% had drunk in the previous week.

Interestingly, there was some divergence between pupils about why they thought people drink, depending on whether they themselves had drunk alcohol in the previous week. When all pupils were asked, the largest proportion thought that other young people did it to look cool in front of their friends (74%). By contrast, when pupils who had drunk alcohol in the past week were asked the same question, far more replied that young people drank in order to be social with friends (89%) or to get a rush and a buzz (81%), with a high proportion also responding that it was to make them feel more confident (75%), to forget their problems (58%), or that they were bored and had nothing to do (59%).

Pupils identified top sources of helpful information about alcohol being parents (75%), teachers (65%), and the internet (53%).

In terms of ethnicity, White and Asian pupils were equally as likely to have drunk alcohol in the past week, with Mixed Race and Black pupils less likely to have done so. With all pupils, the more drinkers there were at home, the more likely they were to have ever had a drink. Peers also had a strong influence.

There was significant variation across the country, with pupils in London far less likely to have ever drunk alcohol, at 31% - compared, for example, to 51% in the North East, 48% in the South East, and 49% in Yorkshire and Humber. They were also far less likely to have had a drink in the past week; and for those who had drunk alcohol in the past week, there was a lower mean consumption of units.

Drugs

Conversely, in London, pupils reported that they were slightly more likely to have ever taken drugs, at 20%, versus 15% in the North West, 16% in the North East, and 19% in the South East, for example. However, they were no more likely to have taken drugs in the last year, or in the last month.

In terms of wider data on drugs, the survey found that as with alcohol, there had been an overall fall in the numbers of pupils who had ever taken drugs, from an England average of 29% in 2001, to an average of 17% in 2012. Again, boys were slightly more likely than girls to have ever taken drugs. In terms of ethnicity, Asian young people were most likely to have ever taken

drugs, followed by Black young people, followed by Mixed Race young people, with White young people the least likely to have ever taken drugs.

In terms of risk factors, if a young person had ever truanted or been excluded, they were far more likely to have ever taken drugs. Pupils with low levels of wellbeing were also more likely to have ever taken drugs.

In terms of sources of helpful information about drugs, pupils outlined the same preferred sources – parents, teachers, the internet, and television. Pupils also expressed an appetite for schools to provide more information about alcohol and drugs.

2.2 Local Evidence - Children and Young People's Substance use Behaviour and Attitudes

Until recently, the main source of local evidence about children and young people's attitudes and self-reported substance use behaviour has been from the central Government–funded Tell Us survey of school pupils, which was decommissioned in 2010.

More recently, the local treatment provider, Lifeline, has conducted their own survey with young people in youth centres, interviewing in total 131 young people over the summer of 2013.

The most recent Tell Us results come from 2009/2010. The detailed results, as set out in the previous Tower Hamlets Young People's Substance Misuse Needs Assessment, published in March 2012, have been reproduced in Appendix 2.

The results are not directly comparable to the national data outlined above, partly because the most recent national data available is for 2011-12 (as opposed to 2009-10); and partly because different questions were asked.

Nevertheless, there were some significant findings iFn the most recent Tell Us survey, which are worth outlining here, in the absence of any more recent local survey results:

- **Frequent Use of Substances**

  Between 2008-9 and 2009-10, there was an increase of 4 percentage points, to 6.7%, in the number of Tower Hamlets young people who reported using substances frequently. This would seem to echo the national findings outlined above, that those young people who were drinking, were doing so more than before. Indeed, although the overall percentage of young people who said that they misused substances remained below the national average of 9.8%, the increase in the proportion of young people who said they used substances regularly was greater than both the London, and the national averages.

- **Use of Alcohol**

  Alcohol was the most common substance in use, with 8.6% of the survey sample in 2009-10 responding that they used alcohol, and 7.1% stating that they used alcohol and no other substance.

  In terms of alcohol alone, the results echoed the points made above about an increase in the intensity of use. There was a significant increase, between 2008-9 and 2009-10, in the percentage of young people who had been drunk at least once in the 4 weeks prior to the survey (from 3% - 8.6%).

  Overall, Tower Hamlets had a lower proportion of young people who reported being drunk (8.6) compared to the national average (15%). However the pattern of use differed

significantly. Nationally, the largest group of respondents (out of those who had been drunk at least once in the previous 4 weeks) were those who had only been drink once during the period covered. In Tower Hamlets, by contrast, the largest group within the sample were those who had been drunk three times or more during that period.

The use of alcohol was strongly associated with age, with older age groups more likely to report having been drunk during the previous 4 weeks.

In terms of ethnicity and gender, White British females were the largest group of alcohol users overall (30.3% of those who reported being drunk). The predominance of White British female drinkers appeared to be apparent across all age groups, although particularly in the Year 8 age group. Indeed, females represented a higher proportion of those who had been drunk in all ethnicity groups, including those of Black or Black British ethnicity, except Asian, where there were no females who reported having been drunk. This gender-related finding would seem to diverge from the National survey results, outlined above.

- **Use of Drugs**

In 2009-10, the proportion of respondents in Tower Hamlets who said that they had used cannabis, the second most used substance after alcohol, was around a third of those who had used alcohol. For other drugs, the proportion was even lower, at less than a quarter.

Once again, the use of other substances (other than alcohol) was strongly correlated with age. 3% of Year 8 pupils said that they had ever tried drugs, compared to 16.2% of those in Year 10.

The survey found that substances other than alcohol were more strongly associated with more frequent use, with cannabis having the highest proportion of more frequent users.

In terms of ethnicity and gender, use of substances other than alcohol was reported almost equally by Asian and White British males, where just over 20% of all substance users were Asian or White British males. Overall, males comprised a larger proportion of users than females, except White British, where use by females almost equalled that of males.

- **Smoking**

Smoking was associated with both alcohol and other substance use; of the entire survey sample, 3.4% of respondents smoked, compared to 37.1% of those who reported substance use. Further, substance users were also more likely to smoke more frequently.

The findings outlined above raise some important questions about whether those young people who were drinking (in 2009-10), were doing so more frequently and at greater levels of intensity than previously; about the substance use risks faced by young women, particularly related to alcohol use; and about the importance of tackling issues of smoking alongside other types of substance use. If these trends have continued (and we have no clear way of knowing whether or not this is the case), these issues may be cause of concern and be worthy of further investigation.

It is hoped that the new local version of the Tell Us Survey, called the Pupil Survey, which is due to be conducted towards the end of 2013, will help to fill some of the recent gaps in the data as outlined above.

Lifeline Survey, Summer 2013

Lifeline interviewed 131 young people during a series of summer clinics held in youth centres during summer 2013. The breakdown of young people who gave feedback was as follows:

	Details	Comments
Age	132 young people aged between 11-18	14 years was the average age.
Ethnicity	Bangladesh: 88% White British: 9% Afro- Caribbean: 1%	
Sex	Males - 98%.	Three of the young people were female and they also gave feedback. Two of whom had reported they had tried drugs.

The headline findings were that:

- Almost 50% of the young people interviewed had ever tried drugs;
- Almost 50% had ever tried alcohol;
- 55% of young people reported that they took drugs because their friends did it;
- 90% of young people claimed they could access drugs, with a third of all the young people reporting that drugs were all around them;
- 43% of young people reported that education would prevent non- use of drugs, closely followed by religion at 25%; and
- 20% of young people report that they did drugs because it made them feel 'less depressed' and 10% to give them 'more confidence'.

2.3 'Legal Highs' and Club Drugs

Significant concern has been voiced nationally over the risk posed to young people by so-called 'legal highs' and club drugs, such as mephedrone, many of which are easy to obtain over the internet. In 2012, the NTA[6] defined 'club drugs' as a 'collective term for a number of different substances typically used by young people in bars and nightclubs, at concerts and parties. These drugs can be harmful and heavy use can develop into a dependency'.

The NTA states that there is evidence of the widespread use of club drugs, but that despite this, 'they are currently causing a treatment problem for relatively few people', although the number of young people who do need treatment is creeping upwards[7]. However, 'those club drug users who need help tend to respond well' – including those aged under 18 – because 'they often have the good personal resources – jobs, relationships, accommodation – that mean they are more likely to make the most of that treatment'.

In relation to under 18 year olds, the total numbers in treatment nationally are relatively very small, with 2,007 in 2011-12, up from 1,534 in 2005-6. Most of this increase came from more people receiving treatment for ketamine and mephedrone.

Anecdotal feedback within the Borough[8] suggests that under 18s very rarely report using these types of substances locally. It appears that they generally prefer buying drugs from dealers,

[6] '*Club Drugs: Emerging Risks and Trends',* NTA, 2012
[7] NTA 2012, see above.
[8] Lifeline, anecdotal reports

face-to-face in their own communities (rather than online, for example). However, some front line staff have reported that they do hear of such drugs being taken; the extent of this is at this stage not possible to verify.

National evidence suggests that the UK adult LGBT community, in particular, are more likely to use drugs in general[9] - and anecdotally, this includes so-called 'club drugs'. However, echoing the point made above, the groups engaged in these activities are thought to be mainly adults aged over 18. The use of these types of drugs is also associated (again, anecdotally) particularly with university students. Both groups are different from the local young people who are the focus in this report, in that they are often older, and are frequently better educated, affluent, more likely to be in employment, and arguably have better prospects. The hard data backing up these statements is not available, and it may be useful for further research to be undertaken, in order to avoid policy and commissioning recommendations being made on the back of anecdotal evidence, and to some extent, speculative conclusions.

2.4 Data Relating to Key Risk Factors

There is significant evidence[10] of a number of key risk factors which make a child or young person much more vulnerable to becoming involved with substance misuse. At risk groups include:

- Young offenders;
- Looked after children;
- Children and young people who are excluded from school, or who truant frequently;
- Young people who are homeless;
- Young people who are not in education, employment or training (NEET);
- Those with parents / other family members who misuse substances;
- Those with behavioural, Mental Health or social problems.

Where data is available, analysis will be provided below to provide a more nuanced overview of the local picture in Tower Hamlets.

2.4.1 Youth Offenders

There is extensive evidence that young offenders are at greater risk of substance misuse than the general population[11]. Research focusing on young offenders describes a complex picture of overlapping risk factors; for example, in one study[12], many of the young people who were the subjects of the research had been excluded or had dropped out from school before age 16, with most leaving school without qualifications; a considerable proportion were in neither education nor employment. Multiple life events and problems were common. Over half of the cohort had experienced at least one of the following: school exclusion, parental divorce/separation, a family member with a criminal record, and / or bereavement. Nearly a quarter had themselves been a victim of crime in the previous two years. Many of these other risk factors will be examined further below.

In terms of young offenders in Tower Hamlets, data is recorded about the number of young people who are supervised by the Youth Offending Team (YOT), and of those, the proportions

[9] '*Part of the Picture'*, The Lesbian and Gay Foundation, 2012
[10]'*Guidance on Substance Misuse in Young People'*, NICE, 2007
[11] For example, '*Substance Use by Young Offenders: The impact of the normalisation of drugs in the early years of the 21st century*'– Home Office Research Study 261, 2003
[12] See above

who are supervised for a substance misuse offence. Of course, as observed above, young offenders as a whole are an at risk group for substance misuse issues, whether or not their original offence relates to substance misuse.

In 2011-12, 275 young people were supervised by the YOT. The numbers are available by age and ethnicity, as outlined below.

Young people supervised by the YOT – Interventions Starting (ethnicity), 2011-12

Ethnicity	Supervised young people	Supervised Young People with Substance Misuse Offences	Proportion (%) of Supervised Young People with Substance Misuse Offences
Asian / Asian British	153	23	15
Chinese or other	2	0	0
Mixed	20	2	10
White / White British	60	7	11.5
Black / Black British	39	5	12.8
Total	**275**	**37**	**13.5**

It can be seen, therefore, that Asian / Asian British young offenders were slightly more at risk of being convicted of a substance misuse-related offence, compared to groups from other ethnicities, with Black / Black British young offenders the second most likely. However, with these figures (as with all the service figures quoted in this report) the data should be viewed with caution, as the numbers are fairly small.

Young people supervised by the YOT – Interventions starting (age), 2011-12

Age	Number of Interventions Starting	Proportion (%) of Interventions Starting	Proportion (%) of all young people with SM offence	Proportion (%) of each age group with SM offence
11	1	0.36	0	0
12	3	1.09	0	0
13	12	4.36	2.7	8.3
14	28	10.18	0	0
15	58	21.09	18.92	12.1
16	83	30.18	43.24	19.3
17	85	30.91	27.03	11.8
18	5	1.82	8.11	60
Total	275	100	100	111.5

It is evident from this data (see above) that young people over the age of 15 were more likely to be at risk of being convicted of a substance misuse offence, with 16 year olds and 18 year olds the most at risk (subject to the same caveats, as raised above, about the relatively small numbers represented here). It is recommended that more up to date data should be examined, in order to ascertain whether these trends have continued up until the present day.

2.4.2 Looked After Children

Evidence suggests that looked after children are more at risk of substance misuse than children who are not looked after by their local authority[13]. In one study,[14] when asked about the health topics on which they would most like to receive information, young people in a mixed residential children's home identified substance use and sexual health. They felt that they did not have an opportunity to raise the issues that concerned them during medical examinations.

Locally, data is collected with regard to the number of looked after children within the year who are identified as having a substance misuse problem, and of those, how many were referred into treatment services.

Looked After Children and Substance Misuse, 2011-12

Borough	No. children looked after at 31-03-12 (for at least 12 months)	No. identified with substance misuse problem	Percentage identified with substance misuse problem	No. receiving intervention for substance misuse problem	Percentage of those identified who received intervention
Tower Hamlets	210	10	4.8%	5	50%
Hackney	195	15	6.7%	10	67%
Islington	225	30	13.7%	30	100%
London	6,980	400	5.7%	260	65%

It would appear, therefore, that looked after children in Tower Hamlets were less likely to be identified as having substance misuse problems, compared to their peers in comparator boroughs, as well as in London more widely. Further, of those who were identified as having a substance misuse problem, they were less likely to be referred for treatment.

The reasons why these patterns might exist should be explored in more detail, and 2011-12 data compared with more recent data from 2012-13, in order to understand whether they are consistent. It is possible that looked after children in Tower Hamlets are indeed less likely to have substance misuse problems than in other boroughs; however, this would be puzzling, given the higher numbers of young people from the borough who are referred into treatment services overall (compared to Hackney and Islington – see below).

2.4.3 School Exclusions and Truancy

There is strong evidence of links between disengagement in school and substance misuse among young people.[15] One study[16] claimed that overall, 12% of pupils who said that they had ever truanted or been excluded said that they usually take drugs once a month, compared with 1% of pupils who had never truanted or been excluded. Similarly, a study in Edinburgh found a strong link between truancy and smoking, alcohol use, drug use, and having sold drugs.[17]

[13] '*Promoting the Health of Looked after Children'*, Thomas Coram Research Unit / University of London / National Children's Bureau, 2009.
[14] Bundle, A. (2002) '*Health information and teenagers in residential care: a qualitative study to identify young people's views*', Adoption and Fostering 26, 4, 19-25
[15] '*Thinking Prevention: Disengaged from School, Engaged with Drugs and Alcohol?*', Mentor, 2013
[16] See above
[17] McAra, L. (2004). '*Truancy, school exclusion and substance misuse'*. The Edinburgh study of youth transitions and crime, No. 4. Centre for Law and Society, University of Edinburgh.

The relationship is complex; in a study[18] which followed young people from ages 14 to 16, it was found that drinking alcohol, especially frequently, was a strong predictor of an increase in truancy the following year. Therefore it is not simply that truancy or exclusion causes substance misuse; indeed, the latter may predate the former. As with all of the risk factors explored here, the issues are often complex and multi-faceted. From a children's rights point of view, there is strong overlap with the need to ensure every child's right to an education, as expressed in Articles 28 and 29.

School Exclusions

Locally, in 2011-12, the Tower Hamlets rate of fixed term exclusions was relatively low, at 1,070.

Rate of Fixed Term Exclusions, 2011-12

	Tower Hamlets	**Hackney**	**Islington**
Rate of fixed term exclusions	2.74%	7.44%	4.31%
Percentage which were drug or alcohol related	2.2% (25 exclusions)	0.5%	1.4%

However, as a percentage of all fixed term exclusions, the Tower Hamlets percentage of those which were drug or alcohol related was higher than that of both comparator boroughs, as can be seen in the table above.

This may simply reflect an effort on the part of schools in Tower Hamlets to avoid excluding pupils on grounds other than those related to drugs and alcohol, resulting in the latter appearing in the figures as a greater proportion of fixed term exclusions overall.

The figures relating to permanent exclusions are so small that it is not possible to reproduce those relating to drug and alcohol-specific exclusions here, for fear of identification.

Once again, more recent data should be analysed to gain an understanding of ongoing trends.

Truancy

Currently we lack local data about truancy and substance misuse. While national research shows a relationship between the two, we have no monitoring data to understand the issue locally.

However, we do know that overall, levels of truancy are relatively low in Tower Hamlets. Service data shows that in 2011-12, provisional secondary school attendance was 95.1% – a new record high for secondary attendance in the Local Authority. A total of 9 schools had attendance above 95.0% and no secondary schools had attendance below 94.0. There was also a trend of gradual improvement in Local Authority secondary attendance (4.6%) during 2011-12. Once again, more recent data would enable us to gain a better understanding of current trends.

In order to understand any association between truancy and substance misuse in Tower Hamlets, it is recommended that an analysis of referrals to the Social Inclusion Panel (SIP) be undertaken, focusing on cases where there are concerns about attendance and substance

[18] Green, R. and Ross, A. (2010) '*Young people's alcohol consumption and its relationship to other outcomes and behaviour'*. Department for Education

misuse. Cases are referred to the SIP where there is cause for concern, and where initial interventions by schools and Attendance Welfare Advisors have not resolved the matter.

2.4.4 Young People Not in Education, Employment and Training ('NEET')

National evidence[19] suggests a link between this group and being at risk of substance misuse, echoing many of the issues of disengagement identified above. Unfortunately, local data has not been sourced to inform an understanding of local trends and issues. It is recommended that this should be done in order to improve understanding of young people's needs and rights in this area.

2.4.5 Homelessness

Nationally, according to Crisis, evidence[20] suggests that homeless people are far more likely to die from external factors compared to the general population, and that a high proportion of these deaths are due to drugs and alcohol (comprising over 1/3 of all homeless deaths). Problems with drugs and alcohol are often a contributing factor to someone becoming homeless, and can also develop as a response to becoming homeless – i.e. as a coping mechanism. Many homeless people who abuse alcohol and drugs also have mental health problems. Further, it is extremely difficult for people to address their drug or alcohol problems while lacking stable housing.

The majority of the people discussed in the Crisis report are adults. However, other research shows that homeless young people also record high prevalence for drug use; in Home Office-funded research[21], 95% of young homeless people had used drugs, and had often begun experimenting at a young age, typically 14. Young people often became homeless for the first time at a very young age, and frequently followed episodes of running away from home. Substance misuse was cited by service providers and young people as one of the many barriers to accessing temporary and permanent accommodation.
Further, this and other research by the Joseph Rowntree Foundation[22] found that the relationship between substance misuse and homelessness for young people was complex, with one fifth of young homeless interviewees who reported health problems attributing them solely to substance misuse. Once again, disproportionately high levels of mental health problems were found. 95% of the young people had committed an offence at some point in their lives.

The strongest message emerging from this research was the need for dedicated and appropriate provision for young people, addressing substance misuse within the context of the many other problems they face – and the research found that this message applied equally to substance misuse and homelessness services. The Joseph Rowntree research found that it was very difficult for young homeless people who are dependent on cannabis, to get access to substance misuse treatment services.

In terms of local data, the most recent published information available with regard to people with housing support needs comes from Supporting People monitoring data from 2010-11. In 2010/2011, a total of 2,022 Client Forms were submitted. Services are able to assign a Primary Client Group for each client. This Group should accurately describe the predominant needs or circumstances of the client. Out of the total in Tower Hamlets, 64 cases (3%) were clients with Alcohol misuse problems and 57 cases were clients with Drug misuse (3%) problems. The

[19] Department for Education, '*Understanding Vulnerable Young People: Analysis from the Longitudinal Study of Young People in England'*, 2011
[20] '*Homelessness – A Silent Killer'*, Crisis, 2011.
[21] '*Youth Homelessness and Substance Misuse – Research Study 258'*, Home Office, 2003.
[22] '*Youth Homelessness in the UK – A Decade of Progress?'* Quilgars, Johnsen and Pleace, Joseph Rowntree Foundation, 2008

proportions were similar to the London average of 4% for Alcohol misuse and 3% for Drug misuse.

However, in terms of young people, the figures were very low. Out of the 64 clients with Alcohol misuse problems receiving housing-related support services, 3 cases (5%) were of young people between the ages of 18 and 24. This is slightly higher than the London and East London average of 3% for this age group. Out of the 57 clients with Drug misuse problems, 5 cases (9%) were between the ages of 18-24. This is a similar proportion to the London average of 8% for this age group. No cases were reported for the 16 to 17 age group in Tower Hamlets.

However, this does not mean that one can assume that drugs and alcohol were, and are, not a problem for young homeless people in the borough. The national evidence is so strong in this respect, that it does seem likely that the above figures are an under-representation of the reality. It is suggested that housing providers should be important partners in any whole system approach to supporting young people with substance misuse needs, and that further evidence and information could usefully be sought with regard to the local picture (including anecdotal evidence from service providers and other local experts in this area).

2.4.6 Hidden Harm

The concept of 'Hidden Harm' refers to the negative impacts on children and young people of parental drug use. Nationally, the Advisory Council on the Misuse of Drugs (ACMD) estimated in 2011[23] that there were between 250,000 and 350,000 children of problem drug users in the UK - about 1 child for every problem drug user. The Advisory Council found that parental problem drug use causes serious harm to children at every age from conception to adulthood, and concluded that reducing the harm to children from parental problem drug use should become a main objective of policy and practice. The Report also found that effective treatment of the parent can have major benefits for the child; that by working together, services can take many practical steps to protect and improve the health and well-being of affected children; and that the number of affected children is only likely to decrease when the number of problem drug users decreases.

Locally, Tower Hamlets data (2011-12) showed that 32% of the drug treatment population were, parents who had their children living with them, while 19% were parents, but did not have their children living with them. This means that half of all the adults in drug treatment were parents. More detailed figures than this, including estimates of the numbers of children affected in the borough, may be available, but it has not been possible to source the data for this report.

Concerns about these children[24] [25] would include a whole host of heightened risks to their health and wellbeing, from before birth until adulthood; research suggests that these would include a heightened risk of becoming involved with substance misuse themselves, especially after the age of 15[26].

2.4.7 Children and Adolescent Mental Health

There is strong national evidence[27] to suggest that substance misuse by young people is linked with substantial levels of psychiatric and other morbidities, and that many of the adolescents

[23] '*Hidden Harm'*, Advisory Council on the Misuse of Drugs, 2011
[24] '*Hidden Harm'*, as above
[25] See also '*The Effect of Parental Substance Misuse on Young People'*, Bancroft *et al,* Joseph Rowntree Foundation, 2004
[26] See above; also Ferguson, D M and Lynskey, M T. *Conduct problems in childhood and psychosocial outcomes in adolescence: A prospective study*. Journal of Emotional and Behavioural Disorders, 1998; 6: 6–12.
[27] '*The Role of CAMHS and Addiction Psychiatry in Adolescent Substance Misuse Services'*, NTA, 2008

presenting to child and adolescent mental health services show significant substance related problems. There is evidence that the presence of co-existing substance misuse complicates the clinical course, treatment compliance and prognosis for these young people and is the single most important factor for increasing the risk of suicide in young people with psychosis or depression[28]. Conversely, there is also evidence that substances exacerbate and maintain psychiatric disorders[29].

In 2008, the National Treatment Agency (NTA) recommended that as a result, professionals working in CAMHS should grasp an unrivalled opportunity to intervene in the developmental trajectory of these children at risk, and to play a significant role in the early identification of substance misuse.[30] In 2009, the NTA highlighted that professionals working in substance misuse services and CAMHS should be working closely together.

Unfortunately, it has not been possible to gather together the statistics relating to how many CAMHS patients are identified as being affected by substance misuse, or even to clarify what data, if any, is routinely gathered about this issue. It is suggested that the relevant information should be identified and considered by commissioners, in order to fill this gap. However, there is data about the number of referrals from CAMHS into substance misuse treatment services, and this data will be explored further below.

2.4.8 Accident and Emergency / Hospital Admissions

The data for ambulance call outs shows that in the period between March 2012- February 2013, a total of 108 alcohol related call outs were recorded for the 8-17 age groups in Tower Hamlets, representing around 5% (2,264) of alcohol related call outs in the borough (of course, these may not all be Tower Hamlets residents). This was the highest rate in London, for this age group; the second highest rate was in Westminster, with 91 call outs, and then Croydon, with 77. Notably, the majority of call outs in Tower Hamlets were for females, with 67 call outs, or 62%, compared to 41 call outs for young males.

The number of alcohol-related call outs in Tower Hamlets was stable in 2011 and 2012, after an increase in 2010. However, totals and rates per 1,000 young people were above the rates for 2007 and 2008.

The most recent data available for alcohol specific hospital admission indicates that in Tower Hamlets, between 2008-9 and 2010-11, around 60 young people (under the age of 18) per 100,000 were admitted to hospital in the borough for alcohol specific conditions (as above, these may not all be Tower Hamlets residents). This was the second highest rate in London. The Tower Hamlets rate was above the England average, at 55.8 young people per 100,000, and was also substantially above the London average of 35.7 young people per 100,000.

Notably, over the previous 5 years, while admission rates had fallen in London and England, the Tower Hamlets rate of 60 young people per 100,000 represented nearly a doubling in numbers (from just 33 young people per 100,000 in 2004-5). Once again, it would be useful to source more recent data in order to understand current trends.

2.4.9 Alcohol and Drug Related Crime

In terms of the number of offences committed by young people under the age of 18 in the borough which related to drugs or alcohol, some relevant data has been gathered.

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[28] Mirza KAH, '*Adolescent substance use disorder'* in Text book of Child and Adolescent Psychopharmacology edited by S.Kutcher, Cambridge Monograph series, Cambridge University Press, UK 321-381, 2002.

[29] '*The Role of CAMHS and Addiction Psychiatry in Adolescent Substance Misuse Services'*, NTA, 2008

[30] NTA, as above, 2008.

During the period April 2012 – March 2013, the police flagged 713 incidents in Tower Hamlets as alcohol related (which includes 'suspect has been drinking' / 'victim drinking' / 'alcohol found at crime scene'). The police argue that the flag is highly under-used in the reporting system, based on nearly 30,000 crime incidents each year.

In Tower Hamlets, out of 713 incidents, 25 involved young people aged 17 and below. Again, this is likely to be an under-estimate, based on the police's own reported perspective on the issue.

During the same period, 27,992 drug offences were recorded in the borough. The wards in which the highest numbers of offences were recorded were in Spitalfields and Banglatown, at 2,804, and Weavers, at 2,389. Overall, there were 2803 recorded offences for drug possession, and 176 for drug trafficking. Unfortunately, this data has not been gathered by age, so the numbers of offences which involved suspects under the age of 18 is not available, and has also not been gathered for other Boroughs, so is not available on a comparable basis.

Figures for 'sanction detection rates', or in other words, 'solved crimes', including for drug offences, show that in 2009-10, 97 drug-related crimes were solved in the borough, a slight increase over the previous 4 years. This rate was very slightly above the Met Police Area average for 2009-10, which stood at 92, solved crimes, but did not diverge significantly from neighbouring boroughs (e.g. Hackney stood at 94; Newham at 93; Waltham Forest at 97; and Redbridge at 96). Once again, however, these figures related to all solved drug-related crimes, not just those perpetrated by under 18s.

It would be useful to know how many of these crimes involve those aged under 18, and also the proportion of young people who are arrested in the borough for a drug or alcohol-related offence, are actually residents of the borough, and how many have travelled in from elsewhere.

It is possible that although the author of this needs assessment was unsuccessful in securing much of the data which would be useful here; some of it may still be available.

If so, it is recommended that commissioners should source this data, as it would be informative in giving an indication as to whether young people in Tower Hamlets are more, or less, likely to be involved in drug or alcohol related offences, compared to elsewhere; whether they are more, or less, likely to be convicted of supplying, as well as possessing, drugs, in Tower Hamlets compared to elsewhere; and whether they are more or less likely to be involved in perpetrating other crimes while under the influence of alcohol.

Gaining a better understanding of these trends would inform the development of a more robust understanding of the risks faced by young people in the borough, and the extent to which young people in Tower Hamlets may be more vulnerable to certain risks and outcomes, in comparison to young people elsewhere in London, or nationally.

2.5 Treatment Data

The other key data source for this needs assessment is the treatment data recorded by the NDTMS (now Public Health England, PHE) on the national drug treatment database, and more recent data supplied by the treatment providers themselves. The next section will explore this data in some detail.

2.5.1 Referrals and Entering Treatment

Between April 2011 and March 2012, NDTMS recorded 96 young people entering treatment in Tower Hamlets. This is less than the peaks of 2006/7 and 2007/8, but represented a significant increase from a low of 2008/9, with numbers steadily increasing since that time.

Comparator figures show that the numbers entering treatment in Tower Hamlets in 2011-12 represented, per 10,000 population (aged 12-17), the 7th highest rate in London.

In 2012-2013, Lifeline recorded 85 young people entering treatment in Tower Hamlets. This represented a drop in numbers, but evidence suggests that this related to funding and organisational challenges which were facing the agency at the time. In the year to date (April – August) 2013-14, Lifeline has already recorded 87 young people entering treatment, so a significant upturn can already be seen.

Young People Entering Treatment in Tower Hamlets, by year

	2006-7	2007-8	2008-9	2009-10	2010-11	2011-12	2012-13	2013-14 (April – August)
Entering Treatment	111	108	62	76	88	96	85	87

Gender

The data shows that more than two thirds of clients entering treatment in Tower Hamlets in 2011/12 were male, while 31% were female. This was relatively close to the England average which had a male / female split of 66% and 34%. The table below shows how Tower Hamlets compared with other boroughs and England on this measure.

Young People Entering Treatment by Gender, 2011-12

Gender	LBTH Total	LBTH %	Hackney	Islington	England
Male	66	69%	63%	73%	66%
Female	30	31%	37%	27%	34%

Equivalent data has not been provided for subsequent years, but referrals data for 2013-14 (year to date) is available, which shows that for 94 referrals to Lifeline of young people under the age of 18, 76, or 81%, were male, and 18, or 19%, were female.

The number of referrals do not equate to the numbers entering treatment, because some young people will not progress into treatment for various reasons (for example, they may not have given their consent to be referred, and they may be unwilling to enter treatment). However, this data does seem to indicate a drop in the proportions of young girls / women being referred into treatment, and if, when investigated, this turns out to be the case, it is recommended that the reasons for this drop should be explored, in order to ascertain whether specific outreach work or support needs to be extended to young females who need the support of treatment services.

Ethnicity

The data shows that 60% of young people entering treatment in 2011/12 had an 'Asian/Asian British' ethnicity, while 24% were of a White/White British ethnicity. The table below shows the significant divergence in Tower Hamlets in relation to London comparators as well as to trends across England; it is suggested that this largely reflects the particular demographic profile of the borough.

Young People Entering Treatment by Ethnicity, 2011-12

Ethnic	Tower	Hackney %	Islington %	England %

Group	Hamlets %			
White	24%	26%	55%	84%
Asian or Asian British	60%	8%	8%	4%
Black or Black British	7%	34%	18%	5%
Mixed	8%	13%	15%	5%
Other Ethnicity	0%	13%	0%	1%

As the table below shows, however, despite the demographics of the Borough, there still seemed (in 2011-12) to be a slight over-representation of White/White British, and Mixed ethnicity young people, and a slight under-representation of Asian/Asian British and Black/Black British young people, in the 'Entering Treatment' data. It is difficult to say whether this is a symptom of White/White British young people in the borough being slightly more at risk of substance misuse in the first place, or whether, for some reason, White young people were more likely to be referred into treatment.

Young People Entering Treatment / Proportion of Age Group in the Borough, by Ethnicity, 2011-12

Ethnicity	Young People Entering Treatment (aged 13-17)		Census 2011 by ethnicity – Ages 10-17
White	23	24%	17.8%
Asian or Asian British	58	60%	65.5%
Black or Black British	7	7%	9.4%
Mixed	8	8%	5.5%
Other	0	0%	1.8%
Total	96		

Given the relatively small numbers involved overall, and the significantly increased numbers of young people entering treatment according to the most recent reported figures, strong conclusions cannot be drawn based on one year's worth of data. Detailed 'entering treatment' data (i.e. by ethnicity, age and gender) has not been sourced for more recent years, as has been observed above, but once again, referrals data is available for the 2013-14 year to date, by ethnicity, provided below, once again compared with Census figures:

Referrals of Young People into Treatment, by Ethnicity, 2013-14 (April – August)

Ethnicity	Referrals of Young People (aged 12-17)		Census 2011 by ethnicity – Ages 10-17
White	14	15.1%	17.8%
Asian or Asian British	64	68.8%	65.5%
Black or Black British	6	6.5%	9.4%
Mixed	5	5.4%	5.5%
Other	2	2.2%	1.8%
Not Stated	2	2.2%	
Total	93	100%	

It would appear that from the point of view of referrals into treatment during this financial year, at least, there seems now to be a slight over-representation of Asian / Asian British young people, and a slight under-representation of White British or White Other young people. Once again, there appears to be a slight under-representation of Black / Black British young people being referred into treatment. However, these apparent changing trends may simply arise from the fact that the numbers are relatively small and so apparent discrepancies, although worthy of consideration, should not necessarily be treated as cause for concern in terms of the representation of each ethnic group.

Age

The data shows that in 2011-12, the age group with the largest number of young people entering treatment was 15 years old. Between the ages of 15-17 years, the numbers of young people entering treatment in 2011-12 remained on a similar level.

Entering Treatment by Age, 2011-12

Age at triage (or start of year)	Total Tower Hamlets	Tower Hamlets %	Islington %	Hackney %	England %
12 and under	0	0%	2%	0%	2%
13	5	5%	3%	3%	6%
14	10	10%	7%	8%	15%
15	29	30%	26%	34%	25%
16	24	25%	30%	24%	24%
17	28	29%	31%	32%	28%

The data also shows a small difference to the trends in comparator boroughs, with young people in Tower Hamlets slightly more likely to enter treatment at a younger age (though not compared to England), and slightly less likely to enter treatment at an older age. However, as above, any interpretations should be made very carefully, as the numbers – particularly those in the 12-14 age group – are very small.

Once again, although comparable data has not been provided for 2013-14, referrals data for this period (April – August) is available, to give some indication of more recent trends.

Referrals of Young People into Treatment, by Age, 2013-14 (April – August)

Age	Tower Hamlets	Tower Hamlets %
12	1	1.1%
13	5	5.4%
14	29	31.2%
15	24	25.8%
16	11	11.8%
17	23	24.7%

Although this data has not been provided in comparable form for other boroughs or England, it is interesting to note that there still appears to be a trend for young people in Tower Hamlets to be referred into treatment at a younger age. Notably, within the 12-17 age group, there are more young people being referred into treatment services at the age of 14, than at any other age. It is to be hoped that this suggests that young people in Tower Hamlets, or their referrers, are seeking help at an earlier stage.

By Substance

In Tower Hamlets, as with other Local Authorities in London and indeed nationwide, the majority of young people enter treatment for either Alcohol and / or Cannabis misuse. Of the 96 young people entering treatment in 2011-12, around 53% were entering for Cannabis and Alcohol misuse. 19% entered treatment for Cannabis only misuse, and 22% for Alcohol only misuse.

Proportions Entering Treatment, by Substance, 2011-12

	LBTH Total	LBTH %	Hackney %	Islington %	England %
Class A (Heroin and Crack)	1	1%	0%	0%	2%
Other Class A (Cocaine, Ecstasy and Amph)	5	5%	8%	10%	19%
Cannabis and Alcohol	51	53%	34%	54%	37%
Cannabis Only	18	19%	39%	16%	27%
Alcohol Only	21	22%	16%	20%	14%
Other Substance	0	0%	0%	0%	2%

Compared to both of the other comparator boroughs, and to England, those entering treatment were less likely to do so because of Class A drug use (although, once again care should be taken with these numbers, since they are very small). Otherwise, entering treatment patterns in Tower Hamlets appear to have been very similar to those in Islington.

More recent data, from 2012-13, shows a continued predominance of cannabis and alcohol – and particularly, Cannabis. Anecdotally, in 2013-14, this remains the case.

Main Drugs Used by Young People Referred, 2012-13 (Lifeline data)

Table of Main Drug Use	
Primary Substance	**Count of Client**
Alcohol unspecified	14
Cannabis herbal (skunk)	12
Cannabis resin	1
Cannabis unspecified	71
Cocaine unspecified	1
Heroin illicit	1
Nicotine	1
Solvents unspecified	1
Spirits	1
Grand Total	**103**

2.5.2 Referrals Source

In 2011-12, Tower Hamlets treatment providers received referrals from a number of agencies across the Borough. The majority of referrals came from the Youth Offending Team (YOT), the Children and Family service, and Health and Mental Health services.

Referrals by Source, Tower Hamlets and Comparator Boroughs, 2011-12

Agency	Tower Hamlets	Tower Hamlets %	Hackney %	Islington %
Children and Family Services	33	34%	29%	21%
Looked After Children	3	3%	13%	1%
Health / Mental Health	9	9%	5%	3%
Accident and Emergency	0	0%	0%	0%
Substance Misuse Services	3	3%	3%	0%
Youth Offending Team (YOT)	46	48%	42%	63%
Self, Family and Friends	2	2%	2%	2%
Other	0	0%	0%	2%

Around 48% of all referrals in Tower Hamlets were made by the YOT. More than 80% of their referrals were for male clients. It is suggested that this is because offenders are more likely to be males. The second largest referral source was Children and Family Services, with 34% of referrals, two thirds of which were for male clients. The third largest referral source was Health and Mental Health, with 9% of referrals.

It is important to note that all of the referrals from Health and Mental Health services were for female clients. This, alongside the ambulance call out figures described above, may support wider national and local anecdotal evidence (explored further below) that while girls are less likely overall to be referred into substance misuse treatment services, those who are referred, are often coping with much more complex problems than many of their male peers (such as mental health issues, risks associated with domestic violence and sexual exploitation, and other problems).

Since 2011-12, Lifeline have embarked on an intensive programme of outreach work and marketing to a wide range of key agencies, and as a result, the referrals by source data to date in 2013-14 looks quite different, as can be seen below.

Referrals by Agency, Tower Hamlets, 2013-14 (April – August)

Agency	Tower Hamlets	Tower Hamlets %
Children and Family Services	8	8.6%
CAMHS	2	2.2%
YOT	18	19.4%
Targeted Youth Support	2	2.2%
Schools	46	49.5%
Pupil Referral Units	1	1.1%
Self / Relative	2	2.2%

Youth Centre / Club	5	5.4%
Supported Housing	1	1.1%
GP / Hospital	3	3.2%
Other	5	5.4%

Most notably, there has been a significant increase in the proportion of referrals from schools, which may reflect the extensive work which Lifeline has been undertaking with them, working alongside the Borough's Healthy Lives team. The Children and Family services figures have not been separated out, but anecdotal reports from the treatment provider suggest that very few of these are from Looked After Children services.

Overall, the continuing low number of referrals from A&E, Hospitals, GPs, Youth Services, Mental Health, and Looked After Children services, is striking, given the evidence quoted above about the extent to which the clients / patients of these services are at risk, and potential issues arising will be explored further below.

2.5.3 Entering Treatment – Naïve / Non-Treatment Naïve

This data focuses on whether or not a young person is already known to services. Treatment naïve clients are defined as those clients who have not presented to treatment before. In the consultation to inform this needs assessment, some stakeholders proposed that the number of young people recorded as treatment naïve should be seen as a measure of treatment quality / success, as this suggests that young people are not repeatedly dropping in and out of the system (one could use a 'revolving door' analogy). Other stakeholders, including Lifeline, strongly suggested that this may be a mistaken assumption, and that the fact that young people are willing to re-enter treatment should be welcomed and viewed as a positive.

Treatment Naïve / Not Treatment Naïve, Tower Hamlets, 2011-12

	Total	**Asian / Asian British**	**White / White British**	**Males**	**Females**
Treatment Naïve	81%	66%	78%	70%	73%
Not Treatment Naïve	29%	34%	22%	30%	27%

In 2011-12, Asian / Asian British young people (the majority of whom were Bangladeshi) were significantly more likely to be not-treatment naïve. It may be worthwhile to try to explore the underlying reasons for this. It would also be useful to compare these figures with more recent data to gain a better understanding of trends (more recent data has not been available to inform this needs assessment).

2.5.4 In-Treatment

The numbers of young people in treatment in any given year are higher than those for young people entering treatment, as they include not only those starting within the year, but also any client who started treatment prior to the beginning of the financial year in question, but were still accessing structured treatment at the start of the year.

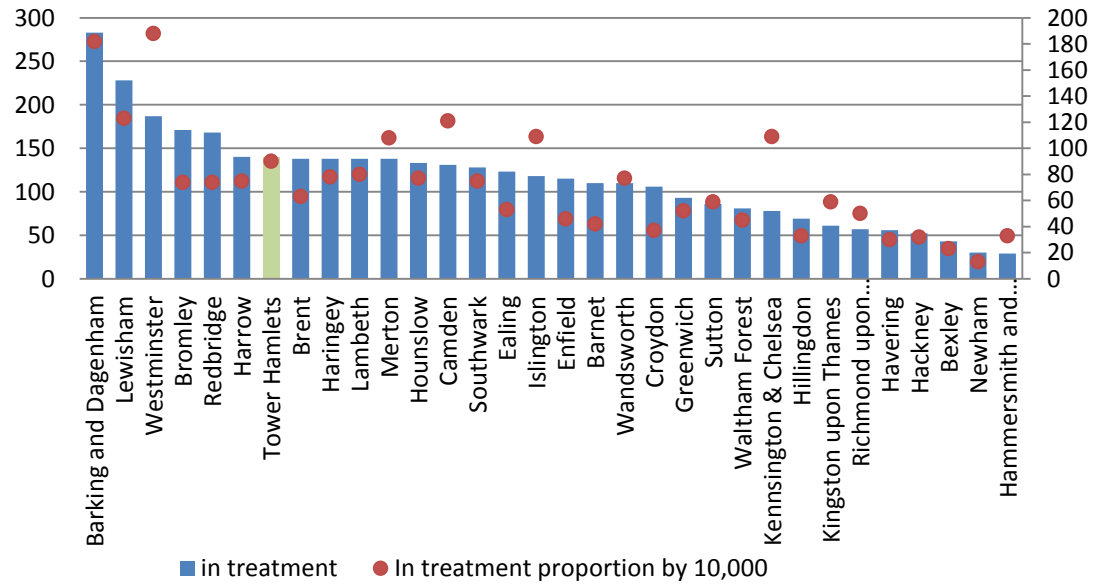
	2006-7	**2007-8**	**2008-9**	**2009-10**	**2010-11**	**2011-12**	**2012-13**	**2013-14 (April to August)**
In Treatment	157	158	137	109	126	136	103	164

A significant increase in the numbers of young people in treatment can be observed in the past year. It is suggested that this is a consequence of the strenuous efforts of the current provider, Lifeline, to recruit a new team, increase outreach activity and encourage more referrals, in recent months. Indeed, not even halfway through the year, Lifeline has already exceeded its annual target for the numbers of young people in treatment (the target is 160).

The graph below shows the number of young people in treatment for each local authority, in 2011-12. In London 3,677 young people were in treatment, with significant differences between boroughs, from low numbers in Hammersmith and Fulham (29) to very high numbers in Barking and Dagenham (283).

In 2011-12, Tower Hamlets had the 7th highest total number of young people in treatment and the 8th highest rate of young people in treatment by 10,000 population (aged 12-17). The highest rate can be observed in Westminster and the lowest in Newham. See chart below.

Chart: Young people in treatment in London (Total & In treatment per 10,000 young people), 2011/12



It would be interesting to explore why Tower Hamlets had such a high rate compared to other Boroughs, and whether this is still proportionately the case, based on the most recent figures.

2.5.5 Exiting from Treatment

It is important to examine the data in order to gain an understanding of how and why young people leave treatment. In 2011-12, a total of 83 young people left treatment; while a further 39 young people were still in treatment at the end of the year. The table below sets out the reasons why young people left treatment during that period.

	Completed drug free	Completed, Occasional Use	Transferred but Not in Custody	Transferred, In Custody	Unplanned and Unknown
Tower Hamlets	19%	46%	5%	5%	25%
Hackney	12%	61%	5%	7%	15%
Islington	23%	67%	0%	4%	6%

National	30%	47%	4%	3%	17%

The data shows that in 2011-12, Tower Hamlets had a similar rate of drug free completions compared to comparable London boroughs, but a higher rate of unplanned and unknown exits, and a lower number of occasional use completions. The 2012-13 and 2013-14 data has been provided slightly differently, but can still serve to provide a picture of trends in this respect.

Discharges from Treatment, Tower Hamlets, 2012-13

Planned Discharges	59
Unplanned Discharges	65
Total number of Discharges	124
Onward Referrals	21
Onward Referrals to CAMHS	2
Onward Referrals to Youth Services	14
Onward Referrals back to original referring agency	55

This data shows that in 2012-13, there were a particularly high number of unplanned and unknown discharges from treatment – 65 in total, or 52%, a significant increase from the previous year. However, the data from the current financial year (again reflecting the period since the new Lifeline staff members have been in post) show an improvement in this respect.

Discharges from Treatment, Tower Hamlets, 2013-14 (April – August)

Planned Discharges	37
Unplanned Discharges	24 (compared to 32 during the same period in 2012-13)
Total number of Discharges	61
Onward Referrals	0
Onward Referrals to CAMHS	0
Onward Referrals to Youth Services	0
Onward Referrals back to original referring agency	0

However, given the importance of the treatment provider working in partnership with other key agencies, especially in the context of the complex needs which many of the young people have (this issue will be explored in greater depth later in the report), it may be seen as surprising that Lifeline are apparently making no onward referrals to other agencies following discharge. The feedback from the treatment provider themselves is that there are a range of reasons for this. For example:

- Some young people are resistant to being referred on for additional support.
- Young people are often referred to other services well before they complete their treatment, and because this is not recorded on the discharge data, it isn't reflected on the official monitoring (PHE) database.
- Many partners, such as the YOT, already have robust support systems around them including, amongst other areas, CAMHS for mental health needs and NEET workers who support clients back into education or work. This work would, in many cases, have been ongoing throughout the young person's drug treatment programme.
- Likewise, young people referred from some services, like supported housing, already have wrap- around- care in place and a keyworker (and a 24 hours staff team) covering on-going support in key work sessions and care plans.

- Equally, Schools and those referred from Social Services etc. generally already have good support systems in place and it is easy for Lifeline to offer additional support when required.
- Some clients require lower levels of support, as their use may be minimal – these young people are less likely to want to be referred on.
- Referrers and clients are assured that Lifeline can reactivate cases when required, and this is recorded, and added to any written communications.

Nevertheless, it might be worth commissioners exploring this issue further with all key partners to discuss any issues at stake, and identify any solutions, if any genuine issues are identified through the course of this discussion. The issue of 'step-down' support is addressed further, later in this paper.

2.5.6 Treatment Outcomes

In 2012-13, of those young people who had exited treatment, 40% (32 young people) completed drug free, and a further 33.8% completed as occasional users. This equates to 73.8% positive outcomes for those who had completed their treatment.

2.6 Impact of substance misuse for young people – harms

In order to understand the current picture relating to substance misuse and young people in the borough, it is important to clarify the ways in which substance misuse can have a negative impact on a child or young person, and the reasons why children should have the right to be protected from substance misuse and its consequences.

Looking at the evidence, the NTA 'Exploring the Evidence' report[31] referenced a New Zealand based study[32] which estimated that 10% of young cannabis users ultimately became dependent or addicted, and that at 18 years of age, about 6% are dependent on drugs or alcohol. Once they become regular users, a substantial group of young people have problems that continue into adult life.

The NTA report asserts that substance misuse by young people is linked to substantial levels of psychiatric and other morbidities, and also, according to National Statistics data, with levels of mortality in this age group that vie with cancer.

The report explains, however, that there are far more deaths due to drug misuse in the 20-29 age group, than in younger age groups. Although this may seem more relevant to questions relating to the commissioning of services for young adults than for children and young people, it does illustrate the importance of preventative work with young people, especially with those who are already using substances before the age of 20, in order to maximise their chances of a positive future and protect them from the risk of an early death.

In particular, Article 24 of the Convention on the Rights of the Child highlights the right of all children to access to good quality health care, which, it is suggested, is the context within which drug treatment should be viewed here. In addition, Article 33 highlights the role of Governments in protecting children from the use of harmful drugs and from being involved in the drugs trade. One could also quote Article 3, with the concept of the 'Best Interests of the Child,' as providing a sound basis on which to assert the rights of children to protection from the harms of

[31] *'Exploring the Evidence'*, NTA, 2007
[32] '*Cannabis Use in Adolescence'*, Fergusson and Boden, New Zealand Christchurch Health and Development Study, University of Otago, 2007

substance misuse, and highlight the duties of the local authority to commission high quality drug treatment services, as well as preventative support, in order to provide this protection.

At the same time, it is clear that the relationship of substance misuse with other issues and harms is far from straightforward[33]. The evidence suggests that drug and alcohol use among young people is often problematic because of its relationships with other problems in the young person's life, and that substance misuse among teenagers is usually a symptom rather than a cause of their vulnerability, compounding other problems in their lives such as family breakdown, inadequate housing, offending, truancy, anti-social behaviour, poor educational attainment and mental health concerns such as self-harm. Drug use is, therefore, often a 'marker' that should draw attention to the underlying conditions and circumstances in a young person's life.

Therefore, the responsibilities of 'duty bearers' (such as the local authority, parents, and service providers) are not just to protect children and young people from substance misuse itself, but from all of the harms outlined above, and more. These relate to a large number of CRC Articles, from those protecting the child's rights to good housing, education, and healthcare, to those relating to family life, protection from sexual exploitation, and persecution.

This highlights the importance of the 'holistic' principle outlined above, because in order to provide protection from such a complex and inter-related set of risks and harms, partners have a responsibility to work together effectively in order to provide holistic, child-centred support across all the key domains of a child's life.

At the same time, it is important to note the feedback from children and young people themselves (below) that many of them do not consider substance use to be a problem for them. It is important that all workers who are supporting children and young people try to understand each young person's own perspectives on their substance use (as emphasised in Article 12 of the CRC, covering respect for the views of the child), and enable them to have access to as much information as possible about the possible implications of substance misuse (echoing Article 17, highlighting the rights of children to have access to information which is important to their health and wellbeing).

2.7 Children's Health Outcomes – Forum Report and DH response

In January 2012, the then Secretary of State for Health established the Children and Young People's Health Outcomes Forum composed of individuals with a wide range of expertise and a shared commitment to improving the health of children and young people. The Forum was asked to:

- Identify the health outcomes that matter most for children and young people;
- Consider how well these are supported by the NHS and Public Health Outcomes Frameworks, and make recommendations; and
- Set out the contribution that each part of the new health system needs to make in order that these health outcomes are achieved.

The Children and Young People's Health Outcomes Forum Report was submitted to the Department of Health in July 2012 following engagement with over 2000 children and young people, their families, those working in health and wider health and social care related settings. The report had two key messages:

[33] *Practice Standards for Young People with Substance Misuse Problems*, College Centre for Quality Improvement, 2012

- Too many health outcomes for children and young people are poor and for many this is related to failures of care; and
- There is substantial and unexplained variation in many aspects of children's healthcare. The UK is worse than many other countries in Europe for many outcomes that could be improved through better healthcare and preventative interventions. There are also wide differences in health outcomes between groups and families with a social gradient, resulting in avoidable health inequalities.

The report advocated a compelling case for system-wide change. The Government's response, published in summer 2013, set out a number of key actions, including better involvement and engagement of children and young people, with a clear role here for Healthwatch; a focus on early intervention, and on reducing health inequalities; the importance of partnership and integrated working; and the critical role of strong evidence and knowledge, to drive service improvement and good commissioning.

These messages are critical to consider in the context of substance misuse services, the success or failure of which has a significant impact on children and young people's health outcomes. Indeed, these themes will be echoed several times in the course of this needs assessment.

3. Key Themes and Issues

This section will explore the key themes and issues raised in the course of completing this needs assessment. It is based on a range of evidence sources, including a literature review, as well as discussions with a wide range of key stakeholders from across the relevant service areas, and will reflect on the implications of some of the issues raised in the data analysis above. It will also include recommendations for commissioners, and highlight further questions or gaps in our knowledge, to inform the future commissioning / planning of services. This section will be organised in relation to the three broad themes identified by the UNICEF Project Board – Participation and Self Expression; Accountability and Transparency; and Holistic.

3.1 Participation and Self Expression

The rights of children and young people to participation, involvement and self-expression are core to the Convention on the Rights of the Child, however, it has proved very difficult to secure direct feedback from children and young people in Tower Hamlets, who are using substance misuse services, about their experiences, views and perceptions, whether of substance misuse itself, or of the services provided. Some of the issues raised, however, are explored below.

Young people's own experiences of drugs and alcohol

Unfortunately, as outlined above, it wasn't possible to get feedback directly from substance misuse treatment service users, but a group of young people were consulted about their general experiences. Lifeline, the treatment provider, also undertook their own consultation with young users of youth services about their own drug use – these results have been provided above.

In the focus group undertaken to inform this needs assessment, some of the young people said that they felt that substances were not a significant problem for many young people, and that they could '*stop just like that'* if they chose. They also believed that cannabis was the most common substance that was used by young people. All of the young people felt that drugs were easy to get hold of and that drug pushers could always be found hanging around the school gates.

While some of the young people felt that drugs and alcohol didn't affect them (for example, their school performance), and therefore that they would use substances at any time, others in the group felt that substances did have an impact on them, so they would only take them after school, if at all.

When at school, some of the young people felt that teachers treated young people who took drugs in negative ways. Some of them felt that many schools' approaches to drugs were based on meting out punishment rather than on offering support, and that there should be more positive services available to support young people who use drugs and alcohol.

When asked why young people took drugs, some of the consultees felt that other young people did so just for fun; others felt that they were influenced by peer pressure; and some expressed the view that taking drugs could be a coping mechanism in response to problems like depression and poverty.

3.1.2 How participative are Substance Misuse Treatment services at present?

Following discussion with a wide range of stakeholders, there was a general consensus that the current treatment services provider, Lifeline, does recognise the importance of gathering feedback from young people and of being more participative. This was echoed in direct discussion with the manager of the Lifeline service, who was also able to set out some of the recent historical context for the service.

The Lifeline service has undergone a series of major organisational challenges in the past year, and with staff capacity increasing to current levels only very recently (April / May 2013), they have already begun to increase referrals by a significant degree, as described in this report (see above). In discussion with the manager of the service, there was a clear recognition that getting feedback from young people should be a daily and ongoing priority and that there needs to be a real focus on this area in the future. Indeed, they are making significant plans in this regard, including designating one worker as the User Involvement lead.

Some stakeholders expressed the view that there may be specific opportunities for substance misuse services to learn lessons from the participative nature of many of the other services working with children and young people in the borough, including Looked after Children services, and youth services. One option would be to explore the use of technology in engaging young people in new and innovative ways. For example, LAC services have imminent plans to begin using the 'Viewpoint' interactive software platform, enabling young people to provide electronic feedback on their views, experiences and concerns.

3.1.3 What are the challenges / barriers, and solutions?

Many stakeholders explained that treatment services are a challenging setting within which to create a participative service. For example, the Lifeline manager explained that many young users of the service are reluctant to provide feedback, when asked. However, young people do set their own goals for the outcome of their own treatment – whether to become drug-free or to reduce their use of drugs, for example - and the service is measured against how outcomes are delivered against young people's own aspirations. It could be argued that this is an inherently participative approach.

One key aspect of substance misuse treatment is that services are voluntary, and therefore young people have to give their consent in order to be referred. Many stakeholders described the challenges of working with, often, highly 'resistant' young people, who may feel that they do not need help from services, or that additional support is unwelcome. In this context, securing consent for a referral can be difficult.

In response to this challenge, the manager from Lifeline recommended that the solution lies in how practitioners 'sell' the service, in the questions they ask, and the approach they take, to persuade young people to engage – arguing that this is all part of the skillset of being any professional working with (often resistant) children and young people (whether in youth services, children and families services, in school, health services, or in the youth offending team).

It is evident that many of the young people referred from the Youth Offending Team present particular challenges, since attending treatment may be part of their sentencing requirement, with the result that the voluntary aspect of the service may be less evident to the young person. Nevertheless, Lifeline state that they can often still do positive work with such young people and that it remains important to take a participative approach as much as possible.

When asked about best practice, or what good participation would look like, the feedback from most stakeholders was that this is not necessarily (or in many cases, at all) about developing focus groups for formalised consultation processes. Rather, it is about building a culture which is focused on listening to young people, and on recording what they have to say, ensuring that their ongoing feedback does inform the way in which the service is developed and improved in the future.

3.1.4 Persuading Young People to Engage

Many stakeholders, when asked, highlighted the challenges posed in persuading often resistant children and young people to engage, and to agree to be referred to Lifeline for additional support.

Lifeline emphasised, as described above, that the key is to ask the right questions and to approach the young person in a non-intimidating way, using all the skills which are required from professionals in working with harder to reach young people.

The NTA evidence[34] report echoes these messages, highlighting the importance of understanding young people's own perspectives of substance misuse treatment. Some may not feel they need any help; others may have little / no concept of what substance misuse treatment might be like. Young people may think it will be boring, or strictly run, or even prison-like. It is important to win the young person's confidence that service will be interesting and responsive to their needs, developed in the arena of respect, trust and warmth.

Participation and Expression – Summary of Recommendations:

Understanding young people's own aspirations:

vi. It is already the case that young people's goals are recorded, in respect of their treatment plans – for example, whether they wish to become drug-free, to reduce their drug use or perhaps to continue their drug use, but to manage it more safely. However, it is suggested that in order to gain a broader understanding of young people's aspirations, it would be enlightening if the wider goals of young people in treatment could also be understood (on a purely anonymised basis) – for example, these could include things like succeeding in education, or getting a job. Given the complex relationship between substance misuse and other risk factors, it is suggested that this information may provide commissioners with a useful broader understanding of young people's own priorities, concerns and motivating factors.

Use of Technology

[34] *'Exploring the Evidence',* NTA, 2009

vii. It is suggested that a wider range of mechanisms should be developed to enable users of treatment services to provide ongoing feedback on their experiences and views, for example through smart use of technology, and through building an increasingly participative approach in young people's day to day interactions with the treatment provider.

Outreach

viii. It is recommended that Lifeline be encouraged to continue outreach work into youth clubs, schools, and other service areas, in order to generate greater understanding of young people's own concerns.

Annual Survey

ix. It is recommended that the local Pupil Attitudes Survey should continue to be supported, as one mechanism for generating at least some information about young people's experiences and perceptions of alcohol and drugs (among many other areas and themes).

Securing Engagement of Young People

x. In order to engage young people and secure their consent for a referral to substance misuse services, workers must to win the young person's confidence that service will be interesting and responsive to their needs, developed in the arena of respect, trust and warmth.

3.2 Accountability and Transparency

The focus of this section is on how the local authority, and the providers who offer services on the local authority's behalf, have responsibilities as duty bearers to be fully accountable to children and young people.

This should include fully informing young people of their rights, and making it clear to young people who they should contact, and how, if they are unhappy with an aspect of a service, or if they feel their rights are not being respected.

It is also important to explore the extent to which the Council is responsible for this, as well as the provider. In particular, it should be clear to young people who they should contact at the Council if they are unhappy with an aspect of the service they have received, for example if they are uncomfortable with contacting the provider direct, for any reason, or if they have already complained to the provider but are unhappy with the response received.

Children, Schools and Families (now part of Education, Social Care and Wellbeing) do have a complaints number and email address provided on the Council website, with additional help offered to children in care or care leavers; but it is not clear on the website whether or not this route is just for people who are unhappy with a service which the Council has provided directly, or whether users of services which have been contracted out can also use this complaints route.

It is also not easy to find out from the Council website what the Council's position is on Child Rights. There are references to children's rights across many pages within the site, but no clear overall policy statement or commitment to respecting children's rights.

In terms of Lifeline's own approach to ensuring accountability and transparency, there appears to have been significant progress in this area in recent months. The new Assessment Form sets out clearly what children and young people can expect and what their rights are, and what they

should do if they feel that their rights are not being upheld. The information included within the new form informs clients of:

- Their Rights
- What to do if they believe their rights aren't being respected - this is in the form of a feedback form at the end of each key work session
- Expectations about what to expect from the service. These are explained in the Care plan, the Confidentiality and Consent Form and the Feedback form.

Lifeline accepts that there is definitely room for reflecting further on their practice on an on-going basis, to both improve their service to clients and make client feedback more accessible, and to ensure young people's rights are respected, promoted and protected.

It is to be noted that complaints from young people about the service is minimal, but this mirrors feedback from substance misuse services in England as a whole. Therefore the provider confirms that they are constantly looking at ways to improve the service and that they have started to formulate a plan in order to do this.

Accountability and Transparency: Recommendations

Accountability of Tower Hamlets Council

v. Tower Hamlets Council (and in particular, children and families services) should explore ways of becoming more accountable to children and young people, for example by making better use of the Council website to be clear with young people about their rights and about how they should complain if they wish to do so.
vi. The Council should also make its position on upholding Child Rights clearer on its website and in other communication channels.

Responsibilities of all duty-bearers

vii. All partners, including Lifeline, should continue to explore ways of improving their practice in this area.
viii. The importance of upholding Child Rights and being accountable to young people should be a key feature of all contracts, SLAs and agreements which the Council makes with its partners, and in staff job descriptions.

3.3 Holistic

The concept of 'holistic' is central to this needs assessment. It encompasses a focus on a child-centred approach, and on considering all the needs of that child or young person, not just those which directly relate to substance misuse. From the point of view of child rights, it is important to emphasise that all rights are indivisible, and dependent on one another. Likewise, in a child or young person's life, there will be a wide range of (often complex) needs and issues which are interdependent. These will include many key domains which are underpinned by child rights, as enshrined in the CRC Articles, such those covering the right to protection from harm, the right to a family life, the right to an education and access to good health care, and the right to non-discrimination.

The responsibility relates to supporting young people with substance misuse needs directly, but also to working holistically with other agencies, as well as with other duty bearers such as community organisations, parents and families, for example – in order to support children and young people across all the needs and issues they may have. The responsibility is not always straightforward; for example, the Youth Offending Team has an enforcement function and as well as safeguarding the wellbeing of young people, its focus is therefore also on protecting the

wider community from crime, and on preventing young people from perpetrating crime. Nevertheless, this is a balance which has to be struck, because being convicted of a crime should not result in children and young people being deprived of their rights.

3.3.1 Ensuring Tier 2 (and Tier 1) services are meeting needs, and clarifying thresholds

It is clear from the literature that service commissioners, planners and managers should be clear about the role of prevention in any drug and alcohol system. Indeed, evidence-based prevention is a key element of drug strategies in the UK[35] - and establishing a whole-life approach to drug prevention covering early years, family support, drug education and targeted, specialist support for young people is a key aim of the UK Drug Strategy[36]. Given the importance of prevention, all stakeholders highlighted the critical role of high quality Tier 1 and 2-level services (i.e. universal and targeted drug and alcohol support), alongside ensuring that all the main professional groups who work with children and young people are sufficiently aware of drug and alcohol issues to be able to have the right discussions with young people, and (with their consent) to make referrals to Tier 3 (i.e. to treatment services), and to feel confident about doing this.

To provide some context to this discussion, for the past two years it has been official policy that Tier 2 substance misuse services for children and young people should be provided in-house by the Targeted Youth Services team. All partners who provided views and perspectives to inform this needs assessment agreed that for a variety of reasons, this has not been happening. The suggested reasons for this are explored below.

In discussion, some stakeholders – particularly from Looked After Children and Targeted Youth Services – stated that they felt unclear about the thresholds for Tier 2 and Tier 3 services, and they even expressed uncertainty about what Tier 2 services were and how they differed from Tier 3 services. This is of particular concern, since Targeted Youth Services have been expected to actually deliver Tier 2 services, and it is hard to see how this could ever have been possible if they were not themselves sure about what Tier 2 services were.

By contrast, the representatives from both the treatment provider, Lifeline, and the Youth Offending Service, expressed the view that the thresholds were in fact very clear. In fact, the Lifeline manager suggested that all staff who work with children and young people should be able to provide basic Tier 1 and Tier 2 substance misuse services, which he defined as essentially general information and advice (Tier 1), and targeted 'brief interventions', talking to young people about their substance misuse where specific issues or risks are identified – but not providing 'treatment' (Tier 2). Treatment is provided at the Tier 3 level of service. He suggested that agencies should make it clear in staff contracts that it is their responsibility to talk to young people about substance misuse, when concerns arise, and then with the young person's consent, to refer on to substance misuse treatment services when there is a need.

The Lifeline manager suggested that one solution to some agencies' apparent confusion with regard to what level of support they should be able to offer, and when they should refer on to specialist services, would be to strengthen relationships between partners in order to improve communication and joint working. Lifeline staff members have been undertaking an extensive programme of outreach work and liaison with a wide range of partners including schools, youth services, GPs, housing providers and others, in order to support improvements in awareness and understanding.

[35] '*United Kingdom Drug Situation – UK Focal Point on Drugs'*, Department of Health, 2012 Edition.
[36] '*Drug Strategy'*, HM Government, 2010.

One of the concerns expressed by the stakeholder from Targeted Youth Services was that he was unconvinced that his staff could offer Tier 2 services, in part due to the fact that they were not trained to deliver group-work sessions.

However, the Lifeline manager expressed the view that in fact group-work is rarely a suitable delivery method when working with young people on substance misuse issues, because of the wide range of levels of engagement which individual young people may have with drugs and alcohol. For example, a young person with only an intermittent use of cannabis may find that encountering much more intensive users in a group-work situation could create peer pressures which might influence them to increase their own use of drugs.

This difference in perspective on basic issues would again appear to demonstrate a lack of consensus on how these services should be provided.

3.3.2 Extent to which other services (including Targeted Youth Services) should be providing Tier 1 and even Tier 2 services

The question of whether all agencies who work with children and young people should in fact be able to provide Tier 1 and Tier 2 services (in relation to substance misuse) was discussed with stakeholders. Most partners (Looked after Children, Children and Families, youth services, and Healthy Lives from the perspective of the role of schools), were of the view that all workers should be able to talk to young people about their drug and alcohol issues, and offer general information and advice (such as providing a leaflet).

However, they were all very cautious about stating that they could offer any more specialist advice. For example, the targeted youth services manager expressed caution about this suggestion.

By contrast, as outlined above, the Lifeline manager characterised Tier 2 services as being something any 'targeted' service working with at risk young people should be able to provide.

Therefore, it does not in fact seem that there is a consensus across all partners about how specialist Tier 2 services are, and who should be able to provide them. It seems that what is needed is a straightforward shared understanding of what any worker with vulnerable young people should be able to do with respect to advice and support on drug and alcohol issues, and when they should refer on to specialist or treatment services.

In terms of how Tier 2, 'Targeted' support should be provided, some partners may feel that it should indeed be 'everyone's business'. In other words, perhaps all agencies which work with vulnerable children and young people should be able to offer targeted substance misuse support (but not treatment), without having to refer onto any other agency.

Indeed, one could argue that 'mainstream' targeted service providers (including Targeted Youth Services, but also other agencies, such as Looked After Children, and the Youth Offending Team) should be well placed to offer Tier 2 services, given that they are already familiar with the individual young people themselves, and should therefore be in a good position to have the relevant one to one discussions with them, as concerns about substance misuse arise. It may be that, informally, this is already happening in some cases, but not being recorded or widely communicated.

On the other hand, it may be that on consideration of the issues, commissioners would conclude that Tier 2 services are in fact more specialist than many mainstream workers would be expected to provide, and may wish to consider commissioning these as a separate service – for example, either from the current Tier 3 provider, or else by refreshing the efforts to support Targeted Youth Services to provide this service.

However, Targeted Youth Services themselves state that they are not in a position to offer Tier 2 services at the present moment, and the Lifeline manager was clearly of the view that the expectation that Targeted Youth Services would offer Tier 2 substance misuse services has never been fulfilled.

One disadvantage of commissioning a separate Tier 2 service could be the creation of multiple referral arrangements between agencies depending on whether Tier 2 or Tier 3 services are needed (echoing a concern expressed by the manager of the Targeted Youth Service about the potential for confused referral arrangements).

Once a shared consensus is achieved, the treatment provider was of the view that training, awareness raising and up-skilling will be needed with agencies across the board.

3.3.3 Role of Tier 3 service provider in promoting referrals, and delivering / coordinating / providing training for Tier 2 services

As outlined above, Lifeline are currently undertaking an intensive programme of outreach work to a wide range of agencies and partners. Raising awareness about the role of these agencies in working with young people on substance misuse issues is part of this work, and so, critically, is encouraging referrals into substance misuse treatment. As demonstrated in the recent monitoring data (provided above), this has led to a recent increase in referrals. However, the Lifeline manager explained that this aspect of their work will remain an on-going requirement, reflecting the fact that partner organisations will all experience staff changes, and that even for those staff who have been in post for some time, regular reminders are often useful.

Lifeline staff have, also provided training to Targeted Youth Services in the provision of Tier 1 and 2 services. In discussion, it became clear that neither Lifeline, nor Targeted Youth Services, were persuaded of the benefit of repeating this exercise – it would appear that it hasn't led (in the course of 2 years) either to Targeted Youth Services feeling more able to deliver Tier 2 services, nor to more referrals being made into substance misuse services. Indeed, the Lifeline manager expressed his concerns that with too much training, some workers may feel that they need to become 'experts' on substance misuse before they can talk to young people in a targeted way about drugs and alcohol, or before they can feel confident about referring to treatment services.

For his part, the manager from Targeted Youth services also expressed his doubts about the benefits of repeating the training. This is because the feedback from youth service staff was that they felt the training for Tier 1 services was very similar to that for Tier 2, leading to greater confusion about which was which.

Based on discussions with a range of partners, it is suggested that whether or not these activities are labelled as 'Tier 1' or 'Tier 2', all staff who work with at risk groups should certainly be able to offer generalised (age-appropriate) information and advice to all children and young people about drugs and alcohol, and that to some degree at least, they should also be able to work with young people on a one-to-one basis on drug and alcohol issues (just as they would on any other issues in their life).

Where needed, they should also be proactive about seeking young people's consent to be referred to substance misuse treatment, if they feel that the young person's drug and alcohol use is becoming problematic or beyond their own level of expertise.

3.3.4 Referring Into Treatment Services

As indicated above, one of the issues identified both in analysing the referrals data, and in discussions with a range of stakeholders, was that several agencies who work with vulnerable children and young people appear to make very few referrals into treatment services. One of the reasons given by some stakeholders was that some staff do not feel confident about making an appropriate referral, or about securing young people's consent for a referral to be made. Others felt that few of the children and young people they worked with really needed the service.

In response to these concerns, the Lifeline manager expressed the view that all staff who work with vulnerable children and young people should be able to make a judgement about whether a referral to substance misuse treatment is needed; they should be skilled in having the right type of conversation with the young person about the referral in order to gain their consent; and they should be confident about referring, when needed. Many other stakeholders emphasised the challenges inherent in working with often resistant young people, especially when attempting to secure consent for a referral; however, in the Lifeline manager's view (to quote): '*It's about how you sell the service… working with resistant young people should be our bread and butter'.*

In terms of those stakeholders who felt that few of the vulnerable young people with whom they worked would really benefit from substance misuse treatment services, this does seem surprising, given the evidence presented in this report about the groups of children and young people who are likely to be at most risk of becoming involved with substance misuse.

The next section of this report will explore some of the specific issues identified in relation to particular services who work with children and young people.

3.3.4.1 Schools

Until very recently, there have been extremely low rates of referrals into treatment services from schools, although has been demonstrated above, there has been a significant increase this year, at least in part due to increased marketing of the service by Lifeline staff themselves.

In terms of barriers to referral, the Lifeline manager expressed the view that some schools underestimate the extent of substance misuse among their pupils, or think that covering it in a few lessons or assemblies is enough. In contrast, the Lifeline manager's experience is that in fact many of the most at risk young people are living in a home environment or mixing with peers for whom substance misuse is '*completely normalised'*, or where parents and others '*turn a blind eye'*.

The Tower Hamlets Healthy Lives team works closely with Lifeline and with schools, focusing on working with children and young people on alcohol issues. The representative from the Health Lives team testified to a significant recent increase in demand from schools, especially secondary schools, for the Healthy Lives team to run sessions in assemblies.

However, it appears that the Healthy Lives team are only funded to provide education on alcohol issues, and are not funded to cover drugs or smoking as part of their work. This could be viewed as a missed opportunity.

In terms of one of the most effective aspects of their work, both the representatives from the Healthy Lives team and from Lifeline emphasised the importance of working with parents in schools.

When asked about barriers to referrals in schools, the Healthy Lives team representative explained that in some cases, referrals into treatment services have to be approved by one of the schools' child protection coordinators. If the coordinators' time is very stretched, then this

can lead to bottle necks and delays in referrals. However, she also expressed the view that many schools have improved their systems – and indeed this would appear to be borne out in the referrals figures quoted earlier in this report.

Finally, the representative from the Healthy Lives team suggested that some teachers could benefit from training and support in how to talk to pupils about substance misuse and the benefits of the treatment service, and therefore to feel more confident about making referrals.

3.3.4.2 Children and Adolescent Mental Health Services

Unfortunately, it was not possible to source CAMHS data. It would have been particularly enlightening to view CAMHS records with respect to the percentage of their patients who are identified as having a substance misuse need. Despite some efforts, it was also not possible to interview any representatives of Tower Hamlets CAMHS.

There is evidence, as highlighted elsewhere in this needs assessment, that a significant proportion of CAMHS referrals into substance misuse treatment services are of girls – echoing the issue highlighted above about the increased vulnerability of many girls. This latter point was also affirmed anecdotally by the Lifeline manager. More widely, evidence[37] suggests that the relationship between CAMHS and substance misuse services is key, because of the intricate and complex relationship between adolescent mental health and substance misuse.

However, the Lifeline manager stated that very few referrals in Tower Hamlets come from CAMHS, and this is confirmed by the referrals data referenced above, although the reasons why are not clear. The Lifeline service is working to build relationships and improve performance in this area. In the other direction, however, when Lifeline make referrals of young people on to CAMHS, Lifeline state that the two agencies work very effectively together.

In discussion, the Lifeline manager was not persuaded of the benefit of having a specialist CAMHS worker working within the treatment service, or indeed a specialist Lifeline worker based in CAMHS (as recommended by the NTA report referenced above), because of the risk that mental health (or substance misuse) becomes the specialism for that one worker, rather than being seen as 'everybody's business' (as long as each worker knows when and how to refer on and collaborate for more specialist support). On the other hand, it is clear that in some other geographical areas, a common model of provision is for the substance misuse service to be actually located within the CAMHS team. It is clear, therefore, that there are a variety of models of service provision in this respect, with Tower Hamlets being managed very differently to some neighbouring boroughs.

3.3.4.3 Looked After Children Services

The Lifeline manager expressed the view that substance misuse is very common among young people who are looked after by the local authority – whether in foster care or in children's homes. Indeed, the literature review undertaken to inform this needs assessment would seem to bear this view out. As a result, it seems possible that the official data quoted above regarding the percentage of children and young people who are looked after, and who have an identified substance misuse problem, could be an underestimate of the real numbers.

Overall, monitoring data suggests that referrals do come from Children and Families services, but very few from Looked after Children (LAC). The LAC manager interviewed to inform this needs assessment highlighted that many foster carers and workers in children's homes find working with young people on substance misuse issues to be very difficult, partly because of

[37] '*The role of CAMHS and addiction psychiatry in adolescent substance misuse services'*, Aldridge *et al*, NTA, 2008

anxieties about the criminal aspect of drug use, feeling responsible for drugs being used on the premises, and whether misuse should therefore be reported to the police.

LAC Policies highlight that the service has a zero tolerance policy on substance misuse, but that 'zero tolerance' does not necessarily mean involving the police immediately. The Children's Residential procedure document recommends that '*a good starting point would be to collectively subscribe to the value that substance use is essentially a health issue rather than a moral one*' and that a helpful approach might be *'to ask the question, "How would a good parent respond?"*. In answer to this question, the policy suggests that '*most parents would not generally choose to criminalise their young people by automatically informing the Police, but they probably would want to look at what was going on, and the issue to be addressed.*'[38]

The Fostering Procedure states that foster carers should be able to understand and have the ability to discuss a wide range of issues with young people, including substance misuse, and that when concerned; they *'should seek advice and information, and enlist the help of the child's social worker, their supervising worker and other outside organisations'.*[39]

From the perspective of the treatment provider, the manager of the service expressed his view that many children's homes workers are resistant to referring young people into treatment services. He felt that policies should be reviewed to ensure that foster carers and children's home workers are encouraged to discuss substance misuse issues with the young people they care for, and to refer to treatment services when needed. He also proposed that there should be a training programme offered to all foster carers and children's home workers and that the need to engage with young people on substance misuse issues should be covered in workers' contracts.

Several stakeholders, when interviewed, including the LAC and Lifeline managers, explained that looked after children's access to services was complicated by the fact that many children and young people are placed in homes outside of the borough. This may provide part of the explanation for why there may be relatively few referrals of looked after children into the borough's treatment services. Indeed, the view was expressed by the LAC manager that it can be difficult to enable these out of borough young people to access their local drugs services if needed, because in many cases the relationships with local commissioners and providers in the 'host' boroughs are not in place.

On the other hand, the Lifeline manager made the point that these young people should have the same rights as any others to substance misuse treatment, and that LBTH foster carers who live in in other boroughs should be offered the same training as those in the borough. Also, he suggested that efforts should be made to ensure that young people can access their local drugs and alcohol service, wherever they are placed. This would appear, on the face of it, to be inarguable, especially when considered from a child rights perspective.

3.3.4.4 Youth Offending Team

Stakeholder discussion made it clear that, after a long period of restructures and cuts in funding to the substance misuse service; the Youth Offending Team and Lifeline now work together very closely and effectively. Indeed, treatment data shows that links have remained strong, at least at the level of making referrals, throughout this period of uncertainty; nearly 50% of referrals in 2011-12 came to Lifeline via the Youth Offending Team. More recent figures show that the proportion has fallen (as can be seen in the referrals data provided above), but that this is in part due to a significant rise in referrals from other partners, especially schools.

[38] '*Children's Residential Procedures'*, Howe and Best, London Borough of Tower Hamlets, June 2010
[39] London Borough of Tower Hamlets Fostering Procedures, April 2013.

The Youth Offending Team representative, when interviewed, expressed the view that the old model of having a substance misuse treatment worker based permanently in the Youth Offending Team was particularly effective, but that because relationships between the two agencies are so robust, partnership working is currently working very well despite not having this model in place.

3.3.4.5 Youth Services

Feedback from representatives both of Targeted Youth Services and from Lifeline suggested that while the relationships between the two agencies ought to be very strong, there is currently significant room for improvement in this area. The Lifeline manager recounted his view that youth services in general could be more responsive to joint working, e.g. to requests for outreach sessions in youth clubs and other recent attempts at communication and partnership working, including answering and responding to phone calls. It was not possible to put these specific points to representatives of youth services.

However, it is clear from the referrals data provided above that there are very few referrals into treatment services from the youth service, and the Lifeline manager was not clear why this might be.

One hypothesis made by some stakeholders, in relation both to the youth service and to many of the other agencies which make few referrals into treatment services, is that there may be a degree of cultural normalisation of substance misuse among some workers – a sense, perhaps, that most 'at risk' young people are involved with substance misuse to some degree, and that in many cases they are facing other problems which are perceived to be more serious, so that the substance misuse itself is not viewed as a priority for intervention. However, this hypothesis is based purely on anecdotal feedback from some stakeholders in the field, and would need further investigation to identify whether or not it is a fair reflection of reality.

In terms of how partnership working could be improved between the substance misuse service and youth services, some of the challenges and barriers have already been outlined above, such as the confusion in the youth service about what Tier 2 and Tier 3 substance misuse services are, and what youth services should be offering young people. Indeed, the Targeted Youth Services manager expressed the view that few of the young people with whom his service works actually need Tier 3 treatment services at all (perhaps one of the reasons for the low number of referrals), but that they would benefit from Tier 2 level services, which in his view should also be provided by the substance misuse treatment provider.

The same interviewee also expressed his view that referral routes into treatment services are not currently clear, perhaps echoing some of the confusion described above. As already mentioned above, he was concerned about the impact on young people of being referred between agencies for different services – i.e. that the experience could be unsettling and off-putting, creating another barrier in terms of providing effective, seamless, holistic support.

Finally, the latter explained that his service is currently undergoing a restructure, and that as a result it will be difficult for them to commit to new arrangements until this process is resolved.

3.3.4.6 Accident and Emergency and other Health agencies

Surprisingly, despite the high numbers of young people being taken to Accident and Emergency departments, and admitted to hospital, for alcohol related issues (as outlined above), there seem to have been no referrals into substance misuse treatment from these sources. This would seem to be a priority area for proactive outreach and action.

In the course of gathering evidence for this needs assessment, some information was provided about future plans for a youth worker to be stationed in Accident and Emergency to pick up and

refer on to specialist support any young people who come in with particular issues, which could include substance misuse, but could also include sexual exploitation, domestic violence or sexual health issues. However, unfortunately very few details were forthcoming about these plans and objectives, beyond the information which is provided here.

In terms of other potential health referrers, there are also very low rates of referrals from GPs; again, it would seem, a missed opportunity. In an attempt to improve performance in this area, Lifeline staff have, all been allocated GP practices with whom to build relationships and improve partnership working, and are embarking on an awareness raising exercise with GPs for this purpose.

3.3.5 Collusion and normalisation – wider cultural challenges

In discussion to inform this needs assessment, the substance misuse treatment service manager highlighted a complex set of concerns about 'collusion' and 'normalisation' of substance misuse amongst young people - whereby authority figures in young people's lives, including parents, at best turn a 'blind eye', and at worst, fund the young person's substance misuse behaviour.

The view was expressed that in some cases, the agencies who are supposed to protect children and young people and promote their best interests, in effect collude with these attitudes, as a result of (mis)perceptions such as 'all young people are doing this' or 'these are such resistant young people, of course they are going to misuse substances, and there is nothing much we can do' – or even, 'they have much worse problems to contend with than smoking cannabis'.

The Lifeline manager expressed the view that this culture creates 'a fast track to addiction' – exacerbating the other challenges which young people may have to cope with in their lives, and potentially leading to much more serious addiction problems in adulthood.

3.3.6 Equalities Issues

In addition to the concerns raised above, the same stakeholder also outlined anecdotal perspectives based on his own experience in the field, with regard to the way in which these issues can interact with particular challenges faced by young people in the Bangladeshi community in the borough.

The manager described some parts of this community as being '*in many ways a monoculture*' or '*a bubble'*, in which there is limited mobility, and in which social relationships can be very close and interlinked. In his view, while such a community can have many strengths in terms of cohesion and robust social networks, such a culture can also make it hard for young people to feel that they can escape particular challenges or lifestyles, or indeed to talk about particular worries they may have, if they are perceived to include 'taboo' topics.

The Lifeline manager also expressed the view that some professional partners tend to stereotype the Bangladeshi community as being immune to drug or alcohol issues, because of perceptions about the role of religion in regulating behaviour, a stereotype which the manager states confidently from his experience to be untrue for many young people, a view which would appear to be confirmed by the ethnicity profile of the treatment figures quoted above.

However, it clearly would be of concern if some agencies were unwilling to address substance misuse issues among some young people, or indeed to ask young people's consent regarding a referral into treatment, because of assumptions about a young person's religion, culture or ethnicity, or indeed other characteristics such as gender. It is difficult to know whether or not such attitudes are prevalent, based on the evidence we have.

However, as a matter of good equalities practice, it is suggested that all partners working with children and young people should ensure that they identify and address any barriers relating to ethnicity or religion which may be dissuading or preventing young people from accessing a service, and ensure that all referral processes, and services are reviewed from an equalities perspective to ensure that they are tailored around the needs of the individual child.

The same issues should be considered with a view to other equalities groups, for example, gender. The tendency of girls who are referred to the service to have a greater range of complex needs and vulnerabilities should be noted; and it should also be noted that far fewer girls are referred into substance misuse services overall. Therefore, practitioners and services should work closely together to ensure that girls who do need support are effectively identified, referred, and supported in treatment in a way which meets their individual needs, and that they are not being missed because of assumptions about their gender. In some cases, assumptions and stereotypes about gender, ethnicity and religion may have a multiplying effect, so this in particular should be guarded against.

The specific needs of Lesbian, Gay, Bisexual and Transgender (LGBT) young people should also be carefully considered. The treatment provider expressed the view that many LGBT young people in the borough may be afraid to reveal their sexual orientation or may feel confused about this. Strenuous efforts should be made to ensure that referral processes and treatment services do not create unwitting barriers which may put off LGBT young people coming forward for help.

From a child rights perspective, it should be noted that these latter points all echo Article 2 of the CRC, i.e. the non-discrimination principle; Article 8, the preservation of identity; Article 14, the right to freedom of thought, association and religion; and Article 30, the rights of children of minority groups.

In terms of the reported issue of ‘collusion’ in the community more widely, the Lifeline manager suggested that more work with parents and community organisations should be funded, and that people should be made aware that the outcomes for young people in treatment are, overall, very good.

He also suggested that all agencies and workers should be made aware that turning a ‘blind eye’ to substance misuse is effectively collusion, and that as highlighted above, all workers should be able to discuss concerns with young people and refer if necessary. This should be embedded into all policies, SLAs, and contracts.

Finally, it is suggested that from a child rights perspective, in terms of the best interests of the child, and promoting the child’s rights to health care, a positive living environment, as well as to education (and all the other domains which are impacted by substance misuse), it should be seen as the responsibility of all ‘duty bearers’ to take a proactive approach to supporting young people with substance misuse issues, regardless of ethnicity, gender, religion, or sexual orientation.

3.3.7 Working Together to Support Children

In terms of their responsibilities as duty bearers, and the ‘holistic’ theme, it is important to examine how well all agencies do work together to support young people with complex needs – i.e. the most at risk groups - holistically. From the point of view of substance misuse, this includes being proactive in identifying the young people who are most at risk, asking the right questions, providing the right information, talking to young people and, where necessary, making referrals to treatment services (having gained consent from the young person); these requirements have been addressed in some detail above.

However, it is suggested that it is equally important for agencies to continue to work in partnership to support young people on an ongoing basis, so that, for example, if a young person is simultaneously receiving support from more than one provider or agency, these agencies avoid working in silos within their particular specialism, but instead work together in a child-centred way (bearing in mind issues of confidentiality of course).

When interviewed, several stakeholders stated that they felt that they did work holistically with children and young people, but when probed, it sometimes seemed that they viewed this primarily as an approach which they took within their own agency or organisation, rather than necessarily as part of the wider system of all the public, voluntary sector and community organisations working to support children and young people.

Illustrating the importance of working holistically, given the interdependence between complex issues, a study of depressed adolescent substance users[40] showed that drug use reduced only among those whose depression was successfully treated – this was more likely through a combination of treatment, and anti-depressant medication and therapy.

Another NTA report[41] observed that many of the adolescents presenting to child and adolescent mental health services showed significant substance misuse problems. The presence of co-existing substance misuse complicates the clinical course, treatment compliance and prognoses for these young people and is the single most important factor for increasing the risk of suicide in young people with psychosis or depression. The converse is also true – substances exacerbate and maintain psychiatric disorders.

3.3.8 Child Assessment Framework

In order to improve holistic working, one proposal could be for Lifeline to begin to use the CAF (Child Assessment Framework), which, in Tower Hamlets and nationally, is a key part of delivering frontline services that are integrated and focused around the needs of children and young people. It is a standardised approach used by practitioners to assess children's additional needs and decide how these should be met.

Indeed, the NTA[42] highlights that multiple professionals and services may be required to meet a young person's needs which are often complex and extend beyond the remit of substance misuse services, and does recommend that care should be co-ordinated across services by an identified lead professional and in line with the CAF.

However, at the moment, Lifeline use, their own assessment process, which seems highly holistic in its focus. However, it might be useful for commissioners to consider whether building the CAF into Lifeline's assessment process would be beneficial from the point of view of integrated working and contributing to an even more holistic approach.

3.3.9 Effective Interventions at Tier 3

The evidence[43] suggests that a range of interventions should be provided at Tier 3 level, consistent with Lifeline's current approach. These include brief interventions, motivational interviewing, and other largely psychosocial approaches. In the same report, the NTA sets out the key features of success (in young people's substance misuse treatment services) according to one study, many of which echo the approach in Tower Hamlets as described by the main provider, Lifeline:

- Allowing young people to visit services before they commit to treatment.

[40] NTA – 'Exploring the Evidence' 2009
[41] NTA Report on CAMHS and SM Services for YP – 2007

[42] NTA – Exploring the Evidence, 2009
[43] NTA – Exploring the Evidence, 2009

- Ensuring that the young person understands that referrals to treatment were not compulsory.
- Developing positive relationships with young people.
- Not overwhelming YP with long term plans.
- When working with families, creating an alliance between professionals and parents.
- Providing practical support to help young people access the more formal aspects of treatment. Examples include physically helping young people attend treatment; checking on treatment progress; advocacy; helping access to wider support e.g. housing; providing transport.

The NTA also quotes evidence that it is important for young people that staff are caring and committed, and that they are flexible to their needs. Setting treatment goals in a way that fully includes the young person offers the opportunity to demonstrate flexibility and commitment to that young person, and is a way of respecting the child or young person's rights.

The NTA sets out a proposal for a style of intervention which aims at investing in the psychosocial development and wellbeing of young people to give them the best chance, through:

- Engagement of young people, and the family if necessary (this is explored further below)
- Skilled initial analysis of their difficulties, including MH and life circumstances
- Engaging local systems so that they work together
- Coordinated, well led interventions that mobilise the resources of local communities as required, including safeguarding, training, mental health and accommodation.
- Active follow-up to detect further episodes of support or intervention (this aspect is explored further below)
- Prioritising or delivering the training and support of staff.

It is recommended that these best practice recommendations be noted by commissioners, and reflected in any contracts and specifications which are agreed with treatment providers in the future.

3.3.10 'Think Family'

A key aspect of being holistic is to consider the needs of the child and young person in the context of their family, support networks and living environment. The literature is quite clear about the importance of this. For example, evidence[44] suggests that including family members in treatment can produce positive outcomes and more likelihood of sustainable change for both substance misusers and members of their family. 'Family' could mean parents, foster carers, or extended family members.

The NTA[45] highlights two studies which show that compared to interventions without a family component, those which engage with families are more effective, both gaining greater information about the young person's needs, and providing opportunities to mobilise the parents' support, as well as to discuss parents' behaviour which may be contributing to the child's difficulties. However, the NTA observe that such an approach is not standard practice with young people in the UK substance misuse field at the moment.

Clearly, there are many challenges to achieving this, and indeed, the treatment provider does report that many young people refuse their consent for their family to be engaged. As a voluntary service, this is their choice.

[44] Breaking the Cycle of Substance Misuse among Families 2009 - Addaction Family
[45] NTA – Exploring the Evidence, 2009

The NTA[46] references one study which found that young people mostly wanted to lower (but not cease entirely) their levels of substance consumption, but felt that their parents wouldn't accept this as a goal, because of their wish for their child to become abstinent. If families are to be involved successfully, therefore, it would be important to discuss realistic goals with them, and ensure that the young person's point of view is respected (with constructive challenge where helpful or appropriate).

Once again, it is recommended that the best practice in this area be reflected in any contracts and service specifications which commissioners agree with providers in the future.

3.3.11 Perceived 'revolving door' issue

There is evidence in the data (from 2011-12) that around 30% of young people entering treatment are already known to treatment services – known as 'not-treatment naïve'. One point of view is that this could be seen as a measure of the quality of treatment services – i.e., the more treatment-naïve young people coming into treatment the better, if one assumes that if a young person has already been treated effectively, he or she should not relapse, and therefore should not require treatment again.

On the other hand, if young people are returning to treatment, one could argue that this demonstrates their trust in the service, enabling the treatment provider to continue positive work with young people, recognising that when working with children and young people with complex needs, a quick fix is rarely, if ever, available.

One proposal would be that the treatment data should be studied in more detail, in order to gain an understanding of more specific patterns within the data; for example, is there a link between the proportion of young people who exited treatment in an 'unplanned' way (25% in 2011-12) and the 30% not-treatment naïve young people who required further treatment at a later stage?

In 2011-12, the numbers exiting treatment in an unplanned way was higher than in Hackney (15%), Islington (6%) and the England average (17%), although outcomes have improved since that time. It is recommended that further investigation (including examination of more recent figures) should be undertaken to understand these patterns.

3.3.12 Step Down Support

The NTA[47] highlights the importance of after-care, or step-down support, emphasising that regular contact and monitoring of young people has been shown to reduce their return to substance misuse services. One study referenced in the report shows that this is particularly true of those aged over 15 years. After care interventions also offer opportunities to bolster and reinforce messages from treatment.

The NTA report also suggests that the transition between services and discharge planning should be started well in advance of the transition / discharge date.

In discussion with all the stakeholders prior to the writing of this report, many recognised the importance of post-treatment support, but acknowledged that this area of practice is undeveloped in Tower Hamlets.

Targeted Youth Services expressed the view that they should be the natural providers of this type of step-down support, and that they would welcome the opportunity to work with the treatment provider to plan this transition, well in advance of the young person's completion of their treatment plan.

[46] NTA – Exploring the Evidence, 2009
[47] '*Exploring the Evidence'*, NTA, 2009

The treatment provider expressed the view that while this might be a positive approach, further work on building relationships and protocols would need to be undertaken between the two partners before it was possible. Indeed, if Targeted Youth Services are to imminently undergo a further restructure as stated, this may be additionally challenging to achieve.

The treatment provider suggested that all the original referring agencies should be prepared to offer effective post-treatment support, and to be able to work closely with the treatment provider to plan this transition.

3.3.13 Transition to Adult Services

In the national literature[48], there is much discussion about the way in which transitions between young people's and adult health and social care services are planned and implemented, with significant questions raised about how effectively this transition currently meets young adults' needs, including for those young people with substance misuse needs[49]. In particular, concern has been identified regarding young people who are living in out-of-borough placements and where there are other complex issues, such as for young people with mental health needs. Difficulties identified included health services having little if any input at the point of transition, and differences in threshold criteria which could leave some young people without a service and therefore particularly vulnerable[50]. However, despite attempts to explore this issue locally, very few stakeholders expressed concern about how transitions are managed locally.

In terms of substance misuse services, Lifeline currently holds the contract for the provision of substance misuse services for the 18-25 year old age group; although this is a much harder group to work with (in part because the young adults are no longer in full time education and so are more difficult to access), the view of several stakeholders was that this arrangement should enable Lifeline to ensure a seamless transition between young people's and adults' services. However, this doesn't address the wider question of how well transitions are managed across all children's and adults' services, in terms of how that transition point affects young people with substance misuse needs.

It may be worth commissioners exploring this issue further, given concerns raised in the national literature, to ensure that there are no unidentified problems affecting the transitions between young people's and adults' services. In particular, it might be valuable to consider the experiences of looked after children placed out of borough, especially. Unfortunately, it was not possible to secure an interview with a representative from the Leaving Care Team in order to inform the content of this needs assessment.

It is also suggested that this is one particular area where direct feedback from the young people who are affected by the issues would be likely to add extra value to the debate.

4. Young People's Substance Misuses Treatment Service - Future Projections

Over the previous 10 years Tower Hamlets was the fastest growing local authority area in England & Wales, with the resident population increasing by 27% from 207,000 to 263,000 (2002 & 2012 ONS MYEs).Over the next 10 years the latest round of
GLA SHLAA based projections show Tower Hamlets growing at a slower rate, but still as the 3rd fastest growing borough in London (from 2013 to 2023) after the City of London and

[48] '*Young people's drug and alcohol treatment at the crossroads'*, DrugScope, 2010.
[49] See also '*Transitions: Young adults with complex needs',* Social Exclusion Unit, 2005
Unit final report
[50] '*Promoting the Health of Looked After Children'*, University of London / National Children's Bureau, DCSF, 2009

Greenwich. The resident population of the borough is projected to increase from 266,144 in 2013 to 320,231 in 2023, representing growth of 20.3% (an additional 54,087 residents).

The projections show that the borough's population will increase across all of the summary age groups. For 0 – 19 the projected percentage growth is 17.1%.

There are also expected to be a significant percentage increase in the number of residents of school age (ages 4 to 15) which are expected to increase by 7,695 residents over the next 10 years (a 21.6% increase in the size of this age group)

In 2011/12 there were 119 young people in treatment this number went down to 115 in 2012/2013. However it is anticipated that in 2013/2014 the number of young people in treatment will be approximately 160.

Mapping population projection growth against numbers in treatment we expect the numbers in treatment to increase to 187 at a minimum.

The calculation 160 + 17.1% (27) = 187

5. Conclusion

Following detailed examination of a wide range of data, evidence sources and feedback from service managers working in the borough, it is evident that substance misuse is an issue which impacts on many children and young people locally, particularly those who are affected by a number of additional risk factors and vulnerabilities. From a child rights perspective, there are a number of principles and articles of the Convention on the Rights of the Child which provide a clear drive for the creation and maintenance of high quality substance misuse services for children and young people, including those which encapsulate the child's right to good healthcare, education, cultural identity, and survival, and protection from harm.

This needs assessment has identified the ways in which fulfilling children's rights in this area requires all partners and 'duty bearers' to support young people to participate and express their views; to be fully accountable and transparent with young people about what their rights are and what to do if they feel their rights are not being upheld; and to work in a holistic and collaborative way with all partners, focusing on the needs, wishes and best interests of children, from a fully child-centred perspective.

This latter point is particularly important, considering the complex and multi-faceted issues and barriers which many of the most vulnerable children experience, and also given the diverse and particular needs of every child, especially in Tower Hamlets, with its rich ethnic, cultural and religious diversity.

This needs assessment has demonstrated that significant progress has been made by Lifeline, the substance misuse treatment provider, in generating increased referrals into the service and in achieving improving outcomes for the young people being supported. This is a considerable achievement given the period of change and uncertainty which the service has experienced until very recently.

However, there is also evidence of broader systemic difficulties, particularly in relation to widespread confusion in some quarters about the definition (and expectations of staff in relation to the delivery) of so-called Tier 1, or 'universal' substance misuse services, and Tier 2, or 'targeted' substance misuse services. It is suggested that this confusion needs to be tackled and resolved, and that clear arrangements need to be put in place to ensure that Tier 2 services

are provided to children and young people who need them, and that all partners understand exactly how these are accessed and / or provided and their role in this (if any).

It is also suggested that improvements are needed in terms of wider partnership working, in order to strengthen relationships and mutual understanding between service areas, identify why some services seem not to be making referrals into substance misuse treatment services, and tackle any issues which are identified as a consequence.

Clare Skidmore, Corporate Research Unit, September 2013

Data and / or content also contributed by Matthias Schneppel and Juanita Haynes, Corporate Research Unit; Wesley Hedger, formerly of Children's SPP; George Gallagher, Lifeline; and Anthony Walters, ESCW.

With thanks to the following individuals who generously gave their time to contribute their views and experience to inform this needs assessment: Bola Akinfolarin; Anthony Walters; Wesley Hedger; Sheila Begum; George Gallagher; Kevin Jones; Abzal Ali; Phil Long; Hilary Bull; Jade Clark; and Jane Cooke.

Appendix 1

The United Nations Convention on the Rights of the Child

Convention on the Rights of the Child

Adopted and opened for signature, ratification and accession by General Assembly Resolution 44/25 of 20 November 1989

entry into force 2 September 1990, in accordance with Article 49

Preamble

The States Parties to the present Convention,

Considering that, in accordance with the principles proclaimed in the Charter of the United Nations, recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world,

Bearing in mind that the peoples of the United Nations have, in the Charter, reaffirmed their faith in fundamental human rights and in the dignity and worth of the human person, and have determined to promote social progress and better standards of life in larger freedom,

Recognizing that the United Nations has, in the Universal Declaration of Human Rights and in the International Covenants on Human Rights, proclaimed and agreed that everyone is entitled to all the rights and freedoms set forth therein, without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status,

Recalling that, in the Universal Declaration of Human Rights, the United Nations has proclaimed that childhood is entitled to special care and assistance,

Convinced that the family, as the fundamental group of society and the natural environment for the growth and well-being of all its members and particularly children, should be afforded the necessary protection and assistance so that it can fully assume its responsibilities within the community,

Recognizing that the child, for the full and harmonious development of his or her personality, should grow up in a family environment, in an atmosphere of happiness, love and understanding,

Considering that the child should be fully prepared to live an individual life in society, and brought up in the spirit of the ideals proclaimed in the Charter of the United Nations, and in particular in the spirit of peace, dignity, tolerance, freedom, equality and solidarity,

Bearing in mind that the need to extend particular care to the child has been stated in the Geneva Declaration of the Rights of the Child of 1924 and in the Declaration of the Rights of the Child adopted by the General Assembly on 20 November 1959 and recognized in the Universal Declaration of Human Rights, in the International Covenant on Civil and Political Rights (in particular in Articles 23 and 24), in the International Covenant on Economic, Social and Cultural Rights (in particular in Article 10) and in the statutes and relevant instruments of specialized agencies and international organizations concerned with the welfare of children,

Bearing in mind that, as indicated in the Declaration of the Rights of the Child, "the child, by reason of his physical and mental immaturity, needs special safeguards and care, including appropriate legal protection, before as well as after birth",

Recalling the provisions of the Declaration on Social and Legal Principles relating to the Protection and Welfare of Children, with Special Reference to Foster Placement and Adoption Nationally and Internationally; the United Nations Standard Minimum Rules for the Administration of Juvenile Justice (The Beijing Rules) ; and the Declaration on the Protection of Women and Children in Emergency and Armed Conflict, Recognizing that, in all countries in the world, there are children living in exceptionally difficult conditions, and that such children need special consideration,

Taking due account of the importance of the traditions and cultural values of each people for the protection and harmonious development of the child, Recognizing the importance of international cooperation for improving the living conditions of children in every country, in particular in the developing countries,

Have agreed as follows:

PART I

Article 1
For the purposes of the present Convention, a child means every human being below the age of 18 years unless under the law applicable to the child, majority is attained earlier.

Article 2
1. States Parties shall respect and ensure the rights set forth in the present Convention to each child within their jurisdiction without discrimination of any kind, irrespective of the child's or his or her parent's or legal guardian's race, colour, sex, language, religion, political or other opinion, national, ethnic or social origin, property, disability, birth or other status.

2. States Parties shall take all appropriate measures to ensure that the child is protected against all forms of discrimination or punishment on the basis of the status, activities, expressed opinions, or beliefs of the child's parents, legal guardians, or family members.

Article 3
1. In all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration.

2. States Parties undertake to ensure the child such protection and care as is necessary for his or her well-being, taking into account the rights and duties of his or her parents, legal guardians, or other individuals legally responsible for him or her, and, to this end, shall take all appropriate legislative and administrative measures.

3. States Parties shall ensure that the institutions, services and facilities responsible for the care or protection of children shall conform with the standards established by competent authorities, particularly in the areas of safety, health, in the number and suitability of their staff, as well as competent supervision.

Article 4
States Parties shall undertake all appropriate legislative, administrative, and other measures for the implementation of the rights recognized in the present Convention. With regard to economic, social and cultural rights, States Parties shall undertake such measures to the maximum extent of their available resources and, where needed, within the framework of international co-operation.

Article 5
States Parties shall respect the responsibilities, rights and duties of parents or, where applicable, the members of the extended family or community as provided for by local custom, legal guardians or other persons legally responsible for the child, to provide, in a manner consistent with the evolving capacities of the child, appropriate direction and guidance in the exercise by the child of the rights recognized in the present Convention.

Article 6
1. States Parties recognize that every child has the inherent right to life.

2. States Parties shall ensure to the maximum extent possible the survival and development of the child.

Article 7
1. The child shall be registered immediately after birth and shall have the right from birth to a name, the right to acquire a nationality and. as far as possible, the right to know and be cared for by his or her parents.

2. States Parties shall ensure the implementation of these rights in accordance with their national law and their obligations under the relevant international instruments in this field, in particular where the child would otherwise be stateless.

Article 8
1. States Parties undertake to respect the right of the child to preserve his or her identity, including nationality, name and family relations as recognized by law without unlawful interference.

2. Where a child is illegally deprived of some or all of the elements of his or her identity, States Parties shall provide appropriate assistance and protection, with a view to re-establishing speedily his or her identity.

Article 9

1. States Parties shall ensure that a child shall not be separated from his or her parents against their will, except when competent authorities subject to judicial review determine, in accordance with applicable law and procedures, that such separation is necessary for the best interests of the child. Such determination may be necessary in a particular case such as one involving abuse or neglect of the child by the parents, or one where the parents are living separately and a decision must be made as to the child's place of residence.

2. In any proceedings pursuant to paragraph 1 of the present article, all interested parties shall be given an opportunity to participate in the proceedings and make their views known.

3. States Parties shall respect the right of the child who is separated from one or both parents to maintain personal relations and direct contact with both parents on a regular basis, except if it is contrary to the child's best interests.

4. Where such separation results from any action initiated by a State Party, such as the detention, imprisonment, exile, deportation or death (including death arising from any cause while the person is in the custody of the State) of one or both parents or of the child, that State Party shall, upon request, provide the parents, the child or, if appropriate, another member of the family with the essential information concerning the whereabouts of the absent member(s) of the family unless the provision of the information would be detrimental to the well-being of the child. States Parties shall further ensure that the submission of such a request shall of itself entail no adverse consequences for the person(s) concerned.

Article 10

1. In accordance with the obligation of States Parties under Article 9, paragraph 1, applications by a child or his or her parents to enter or leave a State Party for the purpose of family reunification shall be dealt with by States Parties in a positive, humane and expeditious manner. States Parties shall further ensure that the submission of such a request shall entail no adverse consequences for the applicants and for the members of their family.

2. A child whose parents reside in different States shall have the right to maintain on a regular basis, save in exceptional circumstances personal relations and direct contacts with both parents. Towards that end and in accordance with the obligation of States Parties under Article 9, paragraph 1, States Parties shall respect the right of the child and his or her parents to leave any country, including their own, and to enter their own country. The right to leave any country shall be subject only to such restrictions as are prescribed by law and which are necessary to protect the national security, public order (*ordre public*), public health or morals or the rights and freedoms of others and are consistent with the other rights recognized in the present Convention.

Article 11

1. States Parties shall take measures to combat the illicit transfer and non-return of children abroad.

2. To this end, States Parties shall promote the conclusion of bilateral or multilateral agreements or accession to existing agreements.

Article 12

1. States Parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child.

2. For this purpose, the child shall in particular be provided the opportunity to be heard in any judicial and administrative proceedings affecting the child, either directly, or through a representative or an appropriate body, in a manner consistent with the procedural rules of national law.

Article 13

1. The child shall have the right to freedom of expression; this right shall include freedom to seek, receive and impart information and ideas of all kinds, regardless of frontiers, either orally, in writing or in print, in the form of art, or through any other media of the child's choice.

2. The exercise of this right may be subject to certain restrictions, but these shall only be such as are provided by law and are necessary:
(a) For respect of the rights or reputations of others; or

(b) For the protection of national security or of public order (*ordre public*), or of public health or morals.

Article 14
1. States Parties shall respect the right of the child to freedom of thought, conscience and religion.

2. States Parties shall respect the rights and duties of the parents and, when applicable, legal guardians, to provide direction to the child in the exercise of his or her right in a manner consistent with the evolving capacities of the child.

3. Freedom to manifest one's religion or beliefs may be subject only to such limitations as are prescribed by law and are necessary to protect public safety, order, health or morals, or the fundamental rights and freedoms of others.

Article 15
1. States Parties recognize the rights of the child to freedom of association and to freedom of peaceful assembly.

2. No restrictions may be placed on the exercise of these rights other than those imposed in conformity with the law and which are necessary in a democratic society in the interests of national security or public safety, public order (*ordre public*), the protection of public health or morals or the protection of the rights and freedoms of others.

Article 16
1. No child shall be subjected to arbitrary or unlawful interference with his or her privacy, family, home or correspondence, nor to unlawful attacks on his or her honour and reputation.

2. The child has the right to the protection of the law against such interference or attacks.

Article 17
States Parties recognize the important function performed by the mass media and shall ensure that the child has access to information and material from a diversity of national and international sources, especially those aimed at the promotion of his or her social, spiritual and moral well-being and physical and mental health.

To this end, States Parties shall:
(a) Encourage the mass media to disseminate information and material of social and cultural benefit to the child and in accordance with the spirit of Article 29;

(b) Encourage international co-operation in the production, exchange and dissemination of such information and material from a diversity of cultural, national and international sources;

(c) Encourage the production and dissemination of children's books;

(d) Encourage the mass media to have particular regard to the linguistic needs of the child who belongs to a minority group or who is indigenous;

(e) Encourage the development of appropriate guidelines for the protection of the child from information and material injurious to his or her well-being, bearing in mind the provisions of Articles 13 and 18.

Article 18
1. States Parties shall use their best efforts to ensure recognition of the principle that both parents have common responsibilities for the upbringing and development of the child. Parents or, as the case may be, legal guardians, have the primary responsibility for the upbringing and development of the child. The best interests of the child will be their basic concern.

2. For the purpose of guaranteeing and promoting the rights set forth in the present Convention, States Parties shall render appropriate assistance to parents and legal guardians in the performance of their child-rearing responsibilities and shall ensure the development of institutions, facilities and services for the care of children.

3. States Parties shall take all appropriate measures to ensure that children of working parents have the right to benefit from child-care services and facilities for which they are eligible.

Article 19

1. States Parties shall take all appropriate legislative, administrative, social and educational measures to protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse, while in the care of parent(s), legal guardian(s) or any other person who has the care of the child.

2. Such protective measures should, as appropriate, include effective procedures for the establishment of social programmes to provide necessary support for the child and for those who have the care of the child, as well as for other forms of prevention and for identification, reporting, referral, investigation, treatment and follow-up of instances of child maltreatment described heretofore, and, as appropriate, for judicial involvement.

Article 20

1. A child temporarily or permanently deprived of his or her family environment, or in whose own best interests cannot be allowed to remain in that environment, shall be entitled to special protection and assistance provided by the State.

2. States Parties shall in accordance with their national laws ensure alternative care for such a child.

3. Such care could include, inter alia, foster placement, *kafalah* of Islamic law, adoption or if necessary placement in suitable institutions for the care of children. When considering solutions, due regard shall be paid to the desirability of continuity in a child's upbringing and to the child's ethnic, religious, cultural and linguistic background.

Article 21

States Parties that recognize and/or permit the system of adoption shall ensure that the best interests of the child shall be the paramount consideration and they shall:

(a) Ensure that the adoption of a child is authorized only by competent authorities who determine, in accordance with applicable law and procedures and on the basis of all pertinent and reliable information, that the adoption is permissible in view of the child's status concerning parents, relatives and legal guardians and that, if required, the persons concerned have given their informed consent to the adoption on the basis of such counselling as may be necessary;

(b) Recognize that inter-country adoption may be considered as an alternative means of child's care, if the child cannot be placed in a foster or an adoptive family or cannot in any suitable manner be cared for in the child's country of origin;

(c) Ensure that the child concerned by inter-country adoption enjoys safeguards and standards equivalent to those existing in the case of national adoption;

(d) Take all appropriate measures to ensure that, in inter-country adoption, the placement does not result in improper financial gain for those involved in it;

(e) Promote, where appropriate, the objectives of the present article by concluding bilateral or multilateral arrangements or agreements, and endeavour, within this framework, to ensure that the placement of the child in another country is carried out by competent authorities or organs.

Article 22

1. States Parties shall take appropriate measures to ensure that a child who is seeking refugee status or who is considered a refugee in accordance with applicable international or domestic law and procedures shall, whether unaccompanied or accompanied by his or her parents or by any other person, receive appropriate protection and humanitarian assistance in the enjoyment of applicable rights set forth in the present Convention and in other international human rights or humanitarian instruments to which the said States are Parties.

2. For this purpose, States Parties shall provide, as they consider appropriate, co-operation in any efforts by the United Nations and other competent intergovernmental organisations or nongovernmental organisations co-operating with the United Nations to protect and assist such a child and to trace the parents or other members of the family of any refugee child in order to obtain information necessary for reunification with his or her family. In cases where no parents or other members of the family can be found, the child shall be accorded the same protection as any other child permanently or temporarily deprived of his or her family environment for any reason, as set forth in the present Convention.

Article 23

1. States Parties recognize that a mentally or physically disabled child should enjoy a full and decent life, in conditions which ensure dignity, promote self-reliance and facilitate the child's active participation in the community.

2. States Parties recognize the right of the disabled child to special care and shall encourage and ensure the extension, subject to available resources, to the eligible child and those responsible for his or her care, of assistance for which application is made and which is appropriate to the child's condition and to the circumstances of the parents or others caring for the child.

3. Recognizing the special needs of a disabled child, assistance extended in accordance with paragraph 2 of the present article shall be provided free of charge, whenever possible, taking into account the financial resources of the parents or others caring for the child, and shall be designed to ensure that the disabled child has effective access to and receives education, training, health care services,rehabilitation services, preparation for employment and recreation opportunities in a manner conducive to the child's achieving the fullest possible social integration and individual development, including his or her cultural and spiritual development.

4. States Parties shall promote, in the spirit of international cooperation, the exchange of appropriate information in the field of preventive health care and of medical, psychological and functional treatment of disabled children, including dissemination of and access to information concerning methods of rehabilitation, education and vocational services, with the aim of enabling States Parties to improve their capabilities and skills and to widen their experience in these areas. In this regard,particular account shall be taken of the needs of developing countries.

Article 24

1. States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services.

2. States Parties shall pursue full implementation of this right and, in particular, shall take appropriate measures:
(a) To diminish infant and child mortality;

(b) To ensure the provision of necessary medical assistance and health care to all children with emphasis on the development of primary health care;

(c) To combat disease and malnutrition, including within the framework of primary health care, through, *inter alia*, the application of readily available technology and through the provision of adequate nutritious foods and clean drinking-water, taking into consideration the dangers and risks of environmental pollution;

(d) To ensure appropriate pre-natal and post-natal health care for mothers;

(e) To ensure that all segments of society, in particular parents and children, are informed, have access to education and are supported in the use of basic knowledge of child health and nutrition, the advantages of breastfeeding, hygiene and environmental sanitation and the prevention of accidents;

(f) To develop preventive health care, guidance for parents and family planning education and services.

3. States Parties shall take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children.

4. States Parties undertake to promote and encourage international co-operation with a view to achieving progressively the full realization of the right recognized in the present article. In this regard, particular account shall be taken of the needs of developing countries.

Article 25

States Parties recognize the right of a child who has been placed by the competent authorities for the purposes of care, protection or treatment of his or her physical or mental health, to a periodic review of the treatment provided to the child and all other circumstances relevant to his or her placement.

Article 26

1. States Parties shall recognize for every child the right to benefit from social security, including social insurance, and shall take the necessary measures to achieve the full realization of this right in accordance with their national law.

2. The benefits should, where appropriate, be granted, taking into account the resources and the circumstances of the child and persons having responsibility for the maintenance of the child, as well as any other consideration relevant to an application for benefits made by or on behalf of the child.

Article 27

1. States Parties recognize the right of every child to a standard of living adequate for the child's physical, mental, spiritual, moral and social development.

2. The parent(s) or others responsible for the child have the primary responsibility to secure, within their abilities and financial capacities, the conditions of living necessary for the child's development.

3. States Parties, in accordance with national conditions and within their means, shall take appropriate measures to assist parents and others responsible for the child to implement this right and shall in case of need provide material assistance and support programmes, particularly with regard to nutrition, clothing and housing.

4. States Parties shall take all appropriate measures to secure the recovery of maintenance for the child from the parents or other persons having financial responsibility for the child, both within the State Party and from abroad. In particular, where the person having financial responsibility for the child lives in a State different from that of the child, States Parties shall promote the accession to international agreements or the conclusion of such agreements, as well as the making of other appropriate arrangements.

Article 28

1. States Parties recognize the right of the child to education, and with a view to achieving this right progressively and on the basis of equal opportunity, they shall, in particular:
(a) Make primary education compulsory and available free to all;

(b) Encourage the development of different forms of secondary education, including general and vocational education, make them available and accessible to every child, and take appropriate measures such as the introduction of free education and offering financial assistance in case of need;

(c) Make higher education accessible to all on the basis of capacity by every appropriate means;

(d) Make educational and vocational information and guidance available and accessible to all children;

(e) Take measures to encourage regular attendance at schools and the reduction of drop-out rates.

2. States Parties shall take all appropriate measures to ensure that school discipline is administered in a manner consistent with the child's human dignity and in conformity with the present Convention.

3. States Parties shall promote and encourage international cooperation in matters relating to education, in particular with a view to contributing to the elimination of ignorance and illiteracy throughout the world and facilitating access to scientific and technical knowledge and modern teaching methods. In this regard, particular account shall be taken of the needs of developing countries.

Article 29

1. States Parties agree that the education of the child shall be directed to:
(a) The development of the child's personality, talents and mental and physical abilities to their fullest potential;

(b) The development of respect for human rights and fundamental freedoms, and for the principles enshrined in the Charter of the United Nations;

(c) The development of respect for the child's parents, his or her own cultural identity, language and values, for the national values of the country in which the child is living, the country from which he or she may originate, and for civilizations different from his or her own;

(d) The preparation of the child for responsible life in a free society, in the spirit of understanding, peace, tolerance, equality of sexes, and friendship among all peoples, ethnic, national and religious groups and persons of indigenous origin;

(e) The development of respect for the natural environment.

2. No part of the present article or Article 28 shall be construed so as to interfere with the liberty of individuals and bodies to establish and direct educational institutions, subject always to the observance of the principle set forth in paragraph 1 of the present article and to the requirements that the education given

in such institutions shall conform to such minimum standards as may be laid down by the State.

Article 30

In those States in which ethnic, religious or linguistic minorities or persons of indigenous origin exist, a child belonging to such a minority or who is indigenous shall not be denied the right, in community with other members of his or her group, to enjoy his or her own culture, to profess and practise his or her own religion, or to use his or her own language.

Article 31

1. States Parties recognize the right of the child to rest and leisure, to engage in play and recreational activities appropriate to the age of the child and to participate freely in cultural life and the arts.

2. States Parties shall respect and promote the right of the child to participate fully in cultural and artistic life and shall encourage the provision of appropriate and equal opportunities for cultural, artistic, recreational and leisure activity.

Article 32

1. States Parties recognize the right of the child to be protected from economic exploitation and from performing any work that is likely to be hazardous or to interfere with the child's education, or to be harmful to the child's health or physical, mental, spiritual, moral or social development.

2. States Parties shall take legislative, administrative, social and educational measures to ensure the implementation of the present article. To this end, and having regard to the relevant provisions of other international instruments, States Parties shall in particular:
(a) Provide for a minimum age or minimum ages for admission to employment;

(b) Provide for appropriate regulation of the hours and conditions of employment;

(c) Provide for appropriate penalties or other sanctions to ensure the effective enforcement of the present article.

Article 33

States Parties shall take all appropriate measures, including legislative, administrative, social and educational measures, to protect children from the illicit use of narcotic drugs and psychotropic substances as defined in the relevant international treaties, and to prevent the use of children in the illicit production and trafficking of such substances.

Article 34

States Parties undertake to protect the child from all forms of sexual exploitation and sexual abuse. For these purposes, States Parties shall in particular take all appropriate national, bilateral and multilateral measures to prevent:
(a) The inducement or coercion of a child to engage in any unlawful sexual activity;

(b) The exploitative use of children in prostitution or other unlawful sexual practices;

(c) The exploitative use of children in pornographic performances and materials.

Article 35

States Parties shall take all appropriate national, bilateral and multilateral measures to prevent the abduction of, the sale of or traffic in children for any purpose or in any form.

Article 36

States Parties shall protect the child against all other forms of exploitation prejudicial to any aspects of the child's welfare.

Article 37

States Parties shall ensure that:
(a) No child shall be subjected to torture or other cruel, inhuman or degrading treatment or punishment. Neither capital punishment nor life imprisonment without possibility of release shall be imposed for offences committed by persons below eighteen years of age;

(b) No child shall be deprived of his or her liberty unlawfully or arbitrarily. The arrest, detention or imprisonment of a child shall be in conformity with the law and shall be used only as a measure of last resort and for the shortest appropriate period of time;

(c) Every child deprived of liberty shall be treated with humanity and respect for the inherent dignity of the human person, and in a manner which takes into account the needs of persons of his or her age.

In particular, every child deprived of liberty shall be separated from adults unless it is considered in the child's best interest not to do so and shall have the right to maintain contact with his or her family through correspondence and visits, save in exceptional circumstances;

(d) Every child deprived of his or her liberty shall have the right to prompt access to legal and other appropriate assistance, as well as the right to challenge the legality of the deprivation of his or her liberty before a court or other competent, independent and impartial authority, and to a prompt decision on any such action.

Article 38

1. States Parties undertake to respect and to ensure respect for rules of international humanitarian law applicable to them in armed conflicts which are relevant to the child.

2. States Parties shall take all feasible measures to ensure that persons who have not attained the age of 15 years do not take a direct part in hostilities.

3. States Parties shall refrain from recruiting any person who has not attained the age of 15 years into their armed forces. In recruiting among those persons who have attained the age of 15 years but who have not attained the age of eighteen years, States Parties shall endeavour to give priority to those who are oldest.

4. In accordance with their obligations under international humanitarian law to protect the civilian population in armed conflicts, States Parties shall take all feasible measures to ensure protection and care of children who are affected by an armed conflict.

Article 39

States Parties shall take all appropriate measures to promote physical and psychological recovery and social reintegration of a child victim of: any form of neglect, exploitation, or abuse; torture or any other form of cruel, inhuman or degrading treatment or punishment; or armed conflicts. Such recovery and reintegration shall take place in an environment which fosters the health, self-respect and dignity of the child.

Article 40

1. States Parties recognize the right of every child alleged as, accused of, or recognized as having infringed the penal law to be treated in a manner consistent with the promotion of the child's sense of dignity and worth, which reinforces the child's respect for the human rights and fundamental freedoms of others and which takes into account the child's age and the desirability of promoting the child's reintegration and the child's assuming a constructive role in society.

2. To this end, and having regard to the relevant provisions of international instruments, States Parties shall, in particular, ensure that:
(a) No child shall be alleged as, be accused of, or recognized as having infringed the penal law by reason of acts or omissions that were not prohibited by national or international law at the time they were committed;

(b) Every child alleged as or accused of having infringed the penal law has at least the following guarantees:
(i) To be presumed innocent until proven guilty according to law;

(ii) To be informed promptly and directly of the charges against him or her, and, if appropriate, through his or her parents or legal guardians, and to have legal or other appropriate assistance in the preparation and presentation of his or her defence;

(iii) To have the matter determined without delay by a competent, independent and impartial authority or judicial body in a fair hearing according to law, in the presence of legal or other appropriate assistance and, unless it is considered not to be in the best interest of the child, in particular, taking into account his or her age or situation, his or her parents or legal guardians;

(iv) Not to be compelled to give testimony or to confess guilt; to examine or have examined adverse witnesses and to obtain the participation and examination of witnesses on his or her behalf under conditions of equality;

(v) If considered to have infringed the penal law, to have this decision and any measures imposed in consequence thereof reviewed by a higher competent, independent and impartial authority or judicial body according to law;

(vi) To have the free assistance of an interpreter if the child cannot understand or speak the language used;

(vii) To have his or her privacy fully respected at all stages of the proceedings.

3. States Parties shall seek to promote the establishment of laws, procedures, authorities and institutions specifically applicable to children alleged as, accused of, or recognized as having infringed the penal law, and, in particular:
(a) The establishment of a minimum age below which children shall be presumed not to have the capacity to infringe the penal law;

(b) Whenever appropriate and desirable, measures for dealing with such children without resorting to judicial proceedings, providing that human rights and legal safeguards are fully respected.

4. A variety of dispositions, such as care, guidance and supervision orders; counselling; probation; foster care; education and vocational training programmes and other alternatives to institutional care shall be available to ensure that children are dealt with in a manner appropriate to their well-being and proportionate both to their circumstances and the offence.

Article 41
Nothing in the present Convention shall affect any provisions which are more conducive to the realization of the rights of the child and which may be contained in:
(a) The law of a State party; or

(b) International law in force for that State.

PART II

Article 42
States Parties undertake to make the principles and provisions of the Convention widely known, by appropriate and active means, to adults and children alike.

Article 43
1. For the purpose of examining the progress made by States Parties in achieving the realization of the obligations undertaken in the present Convention, there shall be established a Committee on the Rights of the Child, which shall carry out the functions hereinafter provided.

2. The Committee shall consist of ten experts of high moral standing and recognized competence in the field covered by this Convention. The members of the Committee shall be elected by States Parties from among their nationals and shall serve in their personal capacity, consideration being given to equitable geographical distribution, as well as to the principal legal systems.

3. The members of the Committee shall be elected by secret ballot from a list of persons nominated by States Parties. Each State Party may nominate one person from among its own nationals.

4. The initial election to the Committee shall be held no later than six months after the date of the entry into force of the present Convention and thereafter every second year. At least four months before the date of each election, the Secretary-General of the United Nations shall address a letter to States Parties inviting them to submit their nominations within two months. The Secretary-General shall subsequently prepare a list in alphabetical order of all persons thus nominated, indicating States Parties which have nominated them, and shall submit it to the States Parties to the present Convention.

5. The elections shall be held at meetings of States Parties convened by the Secretary-General at United Nations Headquarters. At those meetings, for which two thirds of States Parties shall constitute a quorum, the persons elected to the Committee shall be those who obtain the largest number of votes and an absolute majority of the votes of the representatives of States Parties present and voting.

6. The members of the Committee shall be elected for a term of four years. They shall be eligible for re-election if renominated. The term of five of the members elected at the first election shall expire at the end of two years; immediately after the first election, the names of these five members shall be chosen by lot by the Chairman of the meeting.

7. If a member of the Committee dies or resigns or declares that for any other cause he or she can no longer perform the duties of the Committee, the State Party which nominated the member shall appoint another expert from among its nationals to serve for the remainder of the term, subject to the approval of the Committee.

8. The Committee shall establish its own rules of procedure.

9. The Committee shall elect its officers for a period of two years.

10. The meetings of the Committee shall normally be held at United Nations Headquarters or at any other convenient place as determined by the Committee. The Committee shall normally meet annually. The duration of the meetings of the Committee shall be determined, and reviewed, if necessary, by a meeting of the States Parties to the present Convention, subject to the approval of the General Assembly.

11. The Secretary-General of the United Nations shall provide the necessary staff and facilities for the effective performance of the functions of the Committee under the present Convention.

12. With the approval of the General Assembly, the members of the Committee established under the present Convention shall receive emoluments from United Nations resources on such terms and conditions as the Assembly may decide.

Article 44

1. States Parties undertake to submit to the Committee, through the Secretary-General of the United Nations, reports on the measures they have adopted which give effect to the rights recognized herein and on the progress made on the enjoyment of those rights
(a) Within two years of the entry into force of the Convention for the State Party concerned;

(b) Thereafter every five years.

2. Reports made under the present article shall indicate factors and difficulties, if any, affecting the degree of fulfilment of the obligations under the present Convention. Reports shall also contain sufficient information to provide the Committee with a comprehensive understanding of the implementation of the Convention in the country concerned.

3. A State Party which has submitted a comprehensive initial report to the Committee need not, in its subsequent reports submitted in accordance with paragraph 1 (b) of the present article, repeat basic information previously provided.

4. The Committee may request from States Parties further information relevant to the implementation of the Convention.

5. The Committee shall submit to the General Assembly, through the Economic and Social Council, every two years, reports on its activities.

6. States Parties shall make their reports widely available to the public in their own countries.

Article 45

In order to foster the effective implementation of the Convention and to encourage international cooperation in the field covered by the Convention:
(a) The specialized agencies, the United Nations Children's Fund, and other United Nations organs shall be entitled to be represented at the consideration of the implementation of such provisions of the present Convention as fall within the scope of their mandate. The Committee may invite the specialized agencies, the United Nations Children's Fund and other competent bodies as it may consider appropriate to provide expert advice on the implementation of the Convention in areas falling within the scope of their respective mandates. The Committee may invite the specialized agencies, the United Nations Children's Fund, and other United Nations organs to submit reports on the implementation of the Convention in areas falling within the scope of their activities;

(b) The Committee shall transmit, as it may consider appropriate, to the specialized agencies, the United Nations Children's Fund and other competent bodies, any reports from States Parties that contain a request, or indicate a need, for technical advice or assistance, along with the Committee's observations and suggestions, if any, on these requests or indications;

(c) The Committee may recommend to the General Assembly to request the Secretary-General to undertake on its behalf studies on specific issues relating to the rights of the child;

(d) The Committee may make suggestions and general recommendations based on information received pursuant to Articles 44 and 45 of the present Convention. Such suggestions and general recommendations shall be transmitted to any State Party concerned and reported to the General Assembly, together with comments, if any, from States Parties.

PART III

Article 46
The present Convention shall be open for signature by all States.

Article 47
The present Convention is subject to ratification. Instruments of ratification shall be deposited with the Secretary-General of the United Nations.

Article 48
The present Convention shall remain open for accession by any State. The instruments of accession shall be deposited with the Secretary-General of the United Nations.

Article 49
1. The present Convention shall enter into force on the thirtieth day following the date of deposit with the Secretary-General of the United Nations of the twentieth instrument of ratification or accession.

2. For each State ratifying or acceding to the Convention after the deposit of the twentieth instrument of ratification or accession, the Convention shall enter into force on the thirtieth day after the deposit by such State of its instrument of ratification or accession.

Article 50
1. Any State Party may propose an amendment and file it with the Secretary-General of the United Nations. The Secretary-General shall thereupon communicate the proposed amendment to States Parties, with a request that they indicate whether they favour a conference of States Parties for the purpose of considering and voting upon the proposals. In the event that, within four months from the date of such communication, at least one third of the States Parties favour such a conference, the Secretary-General shall convene the conference under the auspices of the United Nations. Any amendment adopted by a majority of States Parties present and voting at the conference shall be submitted to the General Assembly for approval.

2. An amendment adopted in accordance with paragraph 1 of the present article shall enter into force when it has been approved by the General Assembly of the United Nations and accepted by a two-thirds majority of States Parties.

3. When an amendment enters into force, it shall be binding on those States Parties which have accepted it, other States Parties still being bound by the provisions of the present Convention and any earlier amendments which they have accepted.

Article 51
1. The Secretary-General of the United Nations shall receive and circulate to all States the text of reservations made by States at the time of ratification or accession.

2. A reservation incompatible with the object and purpose of the present Convention shall not be permitted.

3. Reservations may be withdrawn at any time by notification to that effect addressed to the Secretary-General of the United Nations, who shall then inform all States. Such notification shall take effect on the date on which it is received by the Secretary-General

Article 52
A State Party may denounce the present Convention by written notification to the Secretary-General of the United Nations. Denunciation becomes effective one year after the date of receipt of the notification by the Secretary-General.

Article 53
The Secretary-General of the United Nations is designated as the depositary of the present Convention.

Article 54
The original of the present Convention, of which the Arabic, Chinese, English, French, Russian and Spanish texts are equally authentic, shall be deposited with the Secretary-General of the United Nations.
IN WITNESS THEREOF the undersigned plenipotentiaries, being duly authorized thereto by their respective governments, have signed the present Convention.

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UNICEF UK
30a Great Sutton Street
London EC1V 0DU

www.unicef.org.uk

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Appendix 2

TELLUS 4 Local Authority Results

TELLUS 4 Questionnaire Results for Tower Hamlets

	Your LA	National
Number of pupils responding		
Primary	829	96,020
Secondary	300	157,735
Number of schools responding	27	3,699

All figures presented in the following tables are percentages:

1. Are you:	Your LA	National	Statistical Neighbours	Contextually adjusted figures
Male	52	51	50	59
Female	48	49	50	41

2a. How old are you?	Your LA	National	Statistical Neighbours	Contextually adjusted figures
8	0	0	0	0
9	0	0	0	0
10	27	26	27	26
11	8	7	7	9
12	24	26	25	19
13	9	7	8	8
14	23	27	25	24
15	10	7	7	14
16	0	0	0	0

3. Which one of these best describes you?	Your LA	National	Statistical Neighbours	Contextually adjusted figures
White - British	15	73	33	68
White - Irish	2	1	1	2
White - Traveller of Irish heritage	0	0	0	0
White - Romany or Gypsy	0	0	0	0
White - any other white background	3	2	5	3
Mixed - White and Black Caribbean	4	2	4	3
Mixed - White and Black African	1	1	2	1
Mixed - White and Asian	1	1	1	1
Mixed - any other mixed race	2	1	2	2
Asian or Asian British - Indian	1	3	4	0
Asian or Asian British - Pakistani	1	3	7	0
Asian or Asian British - Bangladeshi	45	2	7	7
Asian or Asian British - any other Asian background	3	1	3	0
Black or Black British - Caribbean	4	2	6	3
Black or Black British - African	10	3	16	5
Black or Black British - Other	2	1	2	1
Chinese	1	1	1	0
Any other ethnic background	3	1	3	2
Don't know / Prefer not to say	4	2	3	3

TELLUS 4 Local Authority Results

TELLUS 4 Questionnaire Results for Tower Hamlets

4a. Do you get extra help at school from a person like a Teaching Assistant?	Your LA	National	Statistical Neighbours	Contextually adjusted figures
Yes, I often get extra help with school work and learning	25	19	22	18
Yes, I often get extra help with getting about	3	2	3	2
Yes, I often get extra help with communicating	2	2	2	1
Yes, I often get extra help to stay calm	3	3	4	3
Yes, I often get extra help with taking my medicine	1	1	1	0
No, I do not get any extra help	65	73	69	70
Don't know / Don't want to say	8	6	7	10

4b. Do you have a disability?	Your LA	National	Statistical Neighbours	Contextually adjusted figures
Yes	3	6	5	7
No	89	87	89	84
Don't know	7	7	6	9

5. Do you have free school meals?	Your LA	National	Statistical Neighbours	Contextually adjusted figures
Yes	50	17	39	25
No	45	81	58	72
Don't know	4	2	3	3

6. What is your postcode? *(not reported)*

7. What do you think of the parks and play areas in your area?	Your LA	National	Statistical Neighbours	Contextually adjusted figures
Very good	23	15	19	19
Fairly good	34	39	37	35
Neither good nor poor	16	18	19	15
Fairly poor	9	11	9	9
Very poor	14	12	11	20
Don't know	4	4	4	3

TELLUS 4 Local Authority Results

TELLUS 4 Questionnaire Results for Tower Hamlets

8. How safe do you feel …	Your LA	National	Statistical Neighbours	Contextually adjusted figures
In the area where you live?				
Very safe	37	37	31	33
Quite safe	35	44	42	34
A bit unsafe	20	14	20	24
Very unsafe	6	4	6	7
Don't know	2	1	2	2
Going to and from school?				
Very safe	44	44	42	46
Quite safe	41	44	44	42
A bit unsafe	10	9	10	9
Very unsafe	3	2	3	2
Don't know	2	1	2	1
In school?				
Very safe	58	58	59	57
Quite safe	30	33	30	32
A bit unsafe	5	6	6	6
Very unsafe	5	2	3	4
Don't know	2	1	2	2

9a. Do you use local public transport (such as buses, trams, trains, the underground)?	Your LA	National	Statistical Neighbours	Contextually adjusted figures
Yes	45	31	49	44
Sometimes	37	42	37	38
No	18	27	14	18

9b. How safe do you feel when you travel on local public transport (such as buses, trams, trains, the underground)?	Your LA	National	Statistical Neighbours	Contextually adjusted figures
Very safe	18	15	16	22
Quite safe	49	57	53	47
A bit unsafe	25	23	25	24
Very unsafe	6	3	4	6
Don't know	2	2	3	1

Percentages based only on pupils who use public transport.

9c. Why don't you use public transport?	Your LA	National	Statistical Neighbours	Contextually adjusted figures
I don't need to	86	86	85	82
There isn't any where I live	6	5	3	7
It costs too much	5	6	3	5
I don't feel safe	6	8	7	12
It isn't easy	2	4	3	3
My parents/carers don't want me to	6	9	10	12

Percentages based only on pupils who do not use public transport.

TELLUS 4 Local Authority Results

TELLUS 4 Questionnaire Results for Tower Hamlets

10a. (Years 8 and 10) Have you been asked to give your ideas about things that are important to you in the last year in any of these ways?	Your LA	National	Statistical Neighbours	Contextually adjusted figures
By telephone, text or online	12	9	11	10
Filled in a questionnaire (not including this one)	36	29	30	37
Given your ideas to a school council	23	15	15	15
Given your ideas to a youth council or youth parliament	4	4	4	2
Been to a meeting outside school about making things better in your local area	3	3	4	2
Something else	9	6	7	7
Don't know	25	26	26	27
None of these	9	14	13	11
I haven't given my ideas	17	24	22	20

10b. How much have your ideas about your school been listened to when you have given them to your school council or in other ways?	Your LA	National	Statistical Neighbours	Contextually adjusted figures
A lot	14	10	12	12
A little	25	23	23	19
Not very much	16	18	18	19
Not at all	15	14	15	12
Don't know	14	12	12	21
I haven't given my ideas	15	23	19	17

11. In the last 4 weeks, have you taken part in any group activity led by an adult outside school lessons (such as sports, arts, or a youth group)?	Your LA	National	Statistical Neighbours	Contextually adjusted figures
Yes	52	60	53	54
No	42	35	42	39
Don't know	6	4	5	7

TELLUS 4 Local Authority Results

TELLUS 4 Questionnaire Results for Tower Hamlets

12. Which of these have you been to in your free time in the last 4 weeks? (Please do not count things that were part of school lessons)	Your LA	National	Statistical Neighbours	Contextually adjusted figures
Local park or playground	67	66	68	68
Sports club or class (not in school lessons and only count where you've done sport not just watched it)	43	52	45	48
A youth centre or club to take part in organised activities	34	28	29	32
A youth centre or club with few or no organised activities	19	14	16	18
Religious, faith or community group (not including services)	38	17	30	20
Art, craft, dance, drama, film/video-making group (not in school lessons)	26	27	29	33
Music group or lesson (not in school lessons)	18	20	20	25
Given your time to help a charity, a local voluntary group or done some organised volunteering	32	17	20	35
Something else	56	62	64	58

13. What sort of things stop you from doing any activities you would like to do?	Your LA	National	Statistical Neighbours	Contextually adjusted figures
Nothing stops me	33	38	38	38
Not available in my area	23	23	22	20
Not available when I want to do it	17	15	17	12
Costs too much	16	23	20	12
I can't get there	13	15	13	9
I have no one to go with	17	17	17	15
I don't have the time	19	17	18	12
My parents/carers worry about me	23	12	20	16
I don't know how to find out what's on offer	12	10	10	11
Something else	15	13	14	16

14a. (Years 8 and 10) Do you go out on a Friday or Saturday night to take part in any activities such as sports, arts, media or go to a youth centre or club?	Your LA	National	Statistical Neighbours	Contextually adjusted figures
Yes	16	21	20	18
Sometimes	27	24	27	23
No	53	53	50	55
Don't know	4	2	3	5

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14b. (Years 8 and 10) What do you think about the things to do and places to go on Friday and Saturday nights?	Your LA	National	Statistical Neighbours	Contextually adjusted figures
There are safe places where I can go out to do activities on Friday and Saturday nights				
Agree	32	38	41	32
Don't know	39	41	40	41
Disagree	29	20	19	26
There is a good choice of activities I can go out and do on Friday and Saturday nights				
Agree	27	27	33	23
Don't know	48	42	42	43
Disagree	25	31	25	33
There are enough activities for me to go out and do on Friday and Saturday nights				
Agree	22	26	29	20
Don't know	41	41	42	47
Disagree	37	33	29	33

15. Which of these things do you often worry about?	Your LA	National	Statistical Neighbours	Contextually adjusted figures
Being bullied	24	25	25	23
School work and exams	60	51	55	49
Relationships/ girlfriends/ boyfriends (Years 8 and 10 only)	23	25	23	23
Sex (Years 8 and 10 only)	20	15	16	19
Being healthy	26	26	24	22
Money	24	26	26	26
Friendships	29	31	28	28
What to do after Year 11 (Years 8 and 10 only)	52	43	46	52
My parents or family	40	29	32	32
Being a victim of crime	21	16	21	15
The way I look	23	30	25	22
Something else	15	12	13	12
Don't know	8	6	6	6
Nothing worries me	10	12	12	14

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16. Please read each sentence below and tick the box next to it to show if it is true for you or not true for you.	Your LA	National	Statistical Neighbours	Contextually adjusted figures
I feel happy about life at the moment				
True	63	67	66	68
Neither true nor not true	19	20	19	18
Not true	11	8	9	9
Don't know	7	5	6	5
I have one or more good friends				
True	86	92	90	87
Neither true nor not true	6	3	4	7
Not true	3	3	3	3
Don't know	4	2	2	4
When I'm worried about something I can talk to my mum or dad				
True	59	64	62	68
Neither true nor not true	15	16	16	12
Not true	19	14	16	17
Don't know	7	6	6	4
When I'm worried about something I can talk to my friends				
True	64	66	64	65
Neither true nor not true	16	17	17	14
Not true	14	11	12	15
Don't know	7	6	7	6
When I'm worried about something I can talk to an adult who isn't my mum or dad				
True	41	40	41	43
Neither true nor not true	18	19	18	20
Not true	29	30	30	28
Don't know	12	11	11	9

17. How do you get to and from school on most days?	Your LA	National	Statistical Neighbours	Contextually adjusted figures
Walk	60	54	54	58
By bike	5	8	5	8
On the school bus	9	14	12	9
By public transport (bus, train, tube, tram)	32	15	34	25
By car	16	35	24	19
Other	3	2	2	2

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18. How much do you agree with these things about your school?	Your LA	National	Statistical Neighbours	Contextually adjusted figures
My school is giving me useful skills and knowledge				
Agree	70	76	76	77
Not sure	18	18	18	13
Disagree	11	5	6	10
My school has lots of activities (like sport and drama) to take part in at lunchtime or after school				
Agree	68	74	74	68
Not sure	18	17	17	19
Disagree	14	8	9	12
Most of my teachers make my lessons fun and interesting				
Agree	47	46	46	46
Not sure	25	29	27	25
Disagree	28	25	27	29
Most of my teachers tell me how I am doing with my work				
Agree	61	63	65	61
Not sure	23	25	23	23
Disagree	16	13	12	16
Other pupils often disrupt my lessons				
Agree	55	54	58	47
Not sure	28	30	28	26
Disagree	17	16	15	27
I get enough help at school with learning				
Agree	59	63	61	60
Not sure	25	26	27	22
Disagree	16	11	13	18
We have enough chances to learn somewhere that is not in a classroom (*this can include learning outside, going on visits*)				
Agree	45	46	47	44
Not sure	30	30	28	28
Disagree	25	25	25	28
I get enough help with making choices and decisions				
Agree	49	52	51	47
Not sure	32	34	33	30
Disagree	19	14	15	23

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19a. Have you ever been bullied at school?	Your LA	National	Statistical Neighbours	Contextually adjusted figures
Yes	41	46	39	42
No	59	54	61	58

19b. Have you been bullied at school?	Your LA	National	Statistical Neighbours	Contextually adjusted figures
In the last year	33	26	28	31
In the last six months	10	9	9	7
In the last four weeks	16	18	19	17
I was bullied more than 1 year ago	41	48	44	45

Percentages based only on pupils who have ever been bullied at school.

19c. How often has someone done something to bully you at school? This could be by the same person each time, or different people.	Your LA	National	Statistical Neighbours	Contextually adjusted figures
A few times this year	46	51	53	53
Every month	8	8	7	10
Every week	7	7	6	7
Most days	25	23	22	14
Every day	13	11	12	17

Percentages based only on pupils who have been bullied in the last year at school.

20a. Have you ever been bullied when you are not in school (including on your journey to school)?	Your LA	National	Statistical Neighbours	Contextually adjusted figures
Yes	16	21	17	17
No	84	79	83	83

20b. Have you been bullied when you are not in school (including on your journey to school)?	Your LA	National	Statistical Neighbours	Contextually adjusted figures
In the last year	29	30	30	21
In the last six months	14	15	15	20
In the last four weeks	25	24	24	22
I was bullied more than 1 year ago	33	31	31	36

Percentages based only on pupils who have ever been bullied out of school.

20c. How often has someone done something to bully you when you are not in school? This could be by the same person each time, or different people.	Your LA	National	Statistical Neighbours	Contextually adjusted figures
A few times this year	50	59	59	45
Every month	14	9	7	12
Every week	9	7	5	13
Most days	17	16	19	16
Every day	10	9	9	14

Percentages based only on pupils who have been bullied in the last year out of school.

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21. How well does your school deal with bullying?	Your LA	National	Statistical Neighbours	Contextually adjusted figures
Very well	32	25	26	26
Quite well	27	33	30	24
Not very well	13	15	16	13
Badly	12	11	12	15
Bullying is not a problem in my school	3	4	4	2
Don't know	12	12	12	20

22. (Year 6) What do you think you will do when you finish Year 11?	Your LA	National	Statistical Neighbours	Contextually adjusted figures
Do some more studying at college or sixth form	54	49	53	55
Be an Apprentice	2	2	2	1
Get a job with training	20	21	20	21
Don't know yet	24	28	25	22

22. (Years 8 and 10) What do you want to do when you finish Year 11?	Your LA	National	Statistical Neighbours	Contextually adjusted figures
Do a course in a school sixth form	13	23	19	13
Do a course at college or sixth form college	54	40	46	53
Do an Apprenticeship / Advanced Apprenticeship	3	5	4	4
Get a job with training (full or part-time)	6	11	11	6
Get a full-time job without training	6	2	3	6
Not sure yet	18	19	18	18

23. Do you think that you will go to university / higher education in the future?	Your LA	National	Statistical Neighbours	Contextually adjusted figures
Yes	63	62	68	63
No	7	10	7	12
Don't know	30	28	25	26

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24. (Year 6) How much help have you had to plan what you do when you are older from any of the people below?	Your LA	National	Statistical Neighbours	Contextually adjusted figures
Your family				
A lot	68	58	69	69
A little	19	25	19	20
Not very much	6	7	5	5
None	3	5	4	2
Don't know	4	4	4	3
Your friends				
A lot	26	25	29	20
A little	40	34	36	41
Not very much	16	18	16	19
None	12	18	15	13
Don't know	6	6	4	7
Your teachers				
A lot	41	29	39	41
A little	27	28	27	29
Not very much	14	17	15	15
None	11	18	13	10
Don't know	7	7	6	4
A Connexions Personal Adviser				
A lot	10	8	11	6
A little	10	9	12	7
Not very much	6	7	8	8
None	40	45	41	50
Don't know	34	30	28	28
Teachers at secondary schools or colleges				
A lot	14	13	19	12
A little	8	13	12	9
Not very much	4	7	7	8
None	40	43	39	49
Don't know	32	24	24	22

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24. (Years 8 and 10) How much help have you had to plan what to do after the end of Year 11? Help from:	Your LA	National	Statistical Neighbours	Contextually adjusted figures
A Connexions Personal Adviser				
A lot	12	8	12	13
A little	22	17	17	23
Not very much	12	14	13	6
None	34	42	39	32
Don't know	21	19	19	26
Your family				
A lot	59	47	57	59
A little	22	33	26	21
Not very much	8	8	6	4
None	5	6	5	3
Don't know	7	6	6	12
Your friends				
A lot	37	23	32	35
A little	28	35	34	23
Not very much	14	19	15	21
None	12	17	13	9
Don't know	10	7	7	11
Your teachers				
A lot	30	19	27	18
A little	31	32	30	40
Not very much	12	20	17	8
None	19	21	18	21
Don't know	8	8	8	13
College teachers				
A lot	13	9	14	16
A little	12	10	10	14
Not very much	7	11	10	5
None	47	53	48	45
Don't know	21	17	18	20
Someone telling you about their job				
A lot	30	21	28	35
A little	30	31	30	27
Not very much	8	15	13	5
None	17	23	19	20
Don't know	14	10	10	14
The online prospectus listing all the courses in your area				
A lot	12	10	15	15
A little	18	15	15	12
Not very much	12	14	13	15
None	35	41	36	30
Don't know	23	20	20	28

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25. (Years 8 and 10) Do you feel you have enough information and support to help you plan your future? For example help from a teacher or careers adviser to choose subject options and think about jobs and careers.	Your LA	National	Statistical Neighbours	Contextually adjusted figures
Yes	40	43	46	42
No	26	23	23	25
Don't know what there is	14	16	14	11
Not sure	20	18	18	23

26. (Years 8 and 10) How helpful is the information and advice you get in school on the things listed below?	Your LA	National	Statistical Neighbours	Contextually adjusted figures
Healthy food and lifestyles				
Helpful	59	67	67	48
Not helpful	14	15	15	16
Don't know	16	12	11	21
Haven't received any	11	7	7	15
Alcohol				
Helpful	39	58	50	37
Not helpful	28	20	23	29
Don't know	11	11	11	15
Haven't received any	21	11	16	19
Smoking				
Helpful	39	62	54	38
Not helpful	31	19	22	31
Don't know	11	9	10	12
Haven't received any	19	10	14	18
Drugs				
Helpful	41	62	54	37
Not helpful	28	18	21	27
Don't know	10	9	10	13
Haven't received any	20	11	15	24
Sex and relationships				
Helpful	42	53	49	40
Not helpful	20	19	20	14
Don't know	14	14	15	20
Haven't received any	23	13	16	26
Managing your money				
Helpful	40	40	44	33
Not helpful	19	21	20	20
Don't know	16	15	15	17
Haven't received any	25	23	22	29
Staying safe				
Helpful	62	68	69	47
Not helpful	12	14	13	13
Don't know	14	10	11	20
Haven't received any	12	7	7	20
Handling your feelings				
Helpful	44	45	46	32
Not helpful	20	21	20	21
Don't know	17	16	16	21
Haven't received any	19	18	18	27

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27. How many of the 'five a day' fruit and vegetables did you eat yesterday?	Your LA	National	Statistical Neighbours	Contextually adjusted figures
None	15	9	12	15
1-2	32	29	32	29
3-4	26	35	30	31
5 or more	19	19	19	19
Don't know	9	7	7	6

28. Thinking back to last week, how often did you do something active?	Your LA	National	Statistical Neighbours	Contextually adjusted figures
I did something active before school				
Everyday	25	24	26	31
Most days	20	16	18	14
Some days	26	25	26	23
Never	29	35	31	31
I did something active during lesson time (including PE lessons)				
Everyday	26	21	25	25
Most days	31	34	32	25
Some days	34	40	36	39
Never	10	5	7	11
I did something active during lunchtime/ break times				
Everyday	38	37	40	43
Most days	18	20	20	16
Some days	23	23	21	20
Never	21	20	19	21
I did something active after school				
Everyday	30	36	35	33
Most days	23	27	24	22
Some days	28	25	26	24
Never	19	12	15	21

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29. Did you take part in any organised sport or keep fit activities last weekend?	Your LA	National	Statistical Neighbours	Contextually adjusted figures
Yes	44	46	44	47
No	56	54	56	53

30a. Have you ever had an alcoholic drink - a whole drink not just a sip?	Your LA	National	Statistical Neighbours	Contextually adjusted figures
Yes	21	42	29	41
No	74	51	64	51
I don't want to say	6	7	7	9

30b. In the last four weeks, how many times have you been drunk?	Your LA	National	Statistical Neighbours	Contextually adjusted figures
None/never had an alcoholic drink	80	68	76	60
Once	3	6	4	8
Twice	2	4	3	6
Three or more times	4	5	3	9
Don’t want to say	7	8	8	9
Don’t know / can't remember	1	2	1	2
I have never been drunk	4	6	4	6

31. Read the sentences below carefully and tick the box next to the one that best describes you.	Your LA	National	Statistical Neighbours	Contextually adjusted figures
I have never smoked	73	77	76	69
I have only ever tried smoking once	10	10	11	14
I used to smoke sometimes but I never smoke a cigarette now	4	4	4	3
I sometimes smoke cigarettes now but I don't smoke as many as one a week	2	2	2	2
I usually smoke between one and six cigarettes a week	2	1	1	2
I usually smoke more than six cigarettes a week	2	3	2	4
I don’t want to say	7	4	5	5

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32a. (Years 8 and 10) Have you ever taken drugs?	Your LA	National	Statistical Neighbours	Contextually adjusted figures
Yes	9	9	9	18
No	89	88	88	79
I don't want to say	2	3	3	3

32b. (Years 8 and 10) In the last 4 weeks, how often have you taken any of the following drugs?	Your LA	National	Statistical Neighbours	Contextually adjusted figures
Cannabis or skunk				
Never in the last 4 weeks	92	91	92	81
Once	1	1	1	3
Twice	0	1	1	2
Three or more times	2	2	2	5
Prefer not to say	3	4	4	7
Don't know/can't remember	1	1	1	2
Solvents, glue or gas (to inhale or sniff)				
Never in the last 4 weeks	94	93	94	91
Once	1	1	1	1
Twice	0	0	0	0
Three or more times	1	1	1	1
Prefer not to say	3	4	4	7
Don't know/can't remember	1	1	1	1
Other drugs (like cocaine, LSD, ecstasy, heroin, crack, speed, magic mushrooms etc.)				
Never in the last 4 weeks	94	93	94	91
Once	1	1	1	0
Twice	1	0	0	0
Three or more times	1	1	1	2
Prefer not to say	3	4	4	7
Don't know/can't remember	1	1	1	1

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33. You have told us lots of things about your life. If there are three things that would make your life better, what would they be?	Your LA	National	Statistical Neighbours	Contextually adjusted figures
More help to do better at school	36	23	29	28
More interesting school lessons	35	36	35	32
Less bullying	17	19	19	19
More organised activities and things to do	19	19	20	15
More places where I can go to spend time with my friends	32	42	37	33
More chance to have a say in how things are run at school or in the local area	9	11	11	13
More ways I can volunteer or help people	10	8	8	9
More advice about being healthy	12	11	11	9
More help to plan for my future	32	34	34	30
More help to feel safer at school and in the local area	9	8	11	10
Someone I can always talk to	16	15	14	15
None of these	4	6	5	6
Something else	8	13	11	12
Don't know	10	11	10	6

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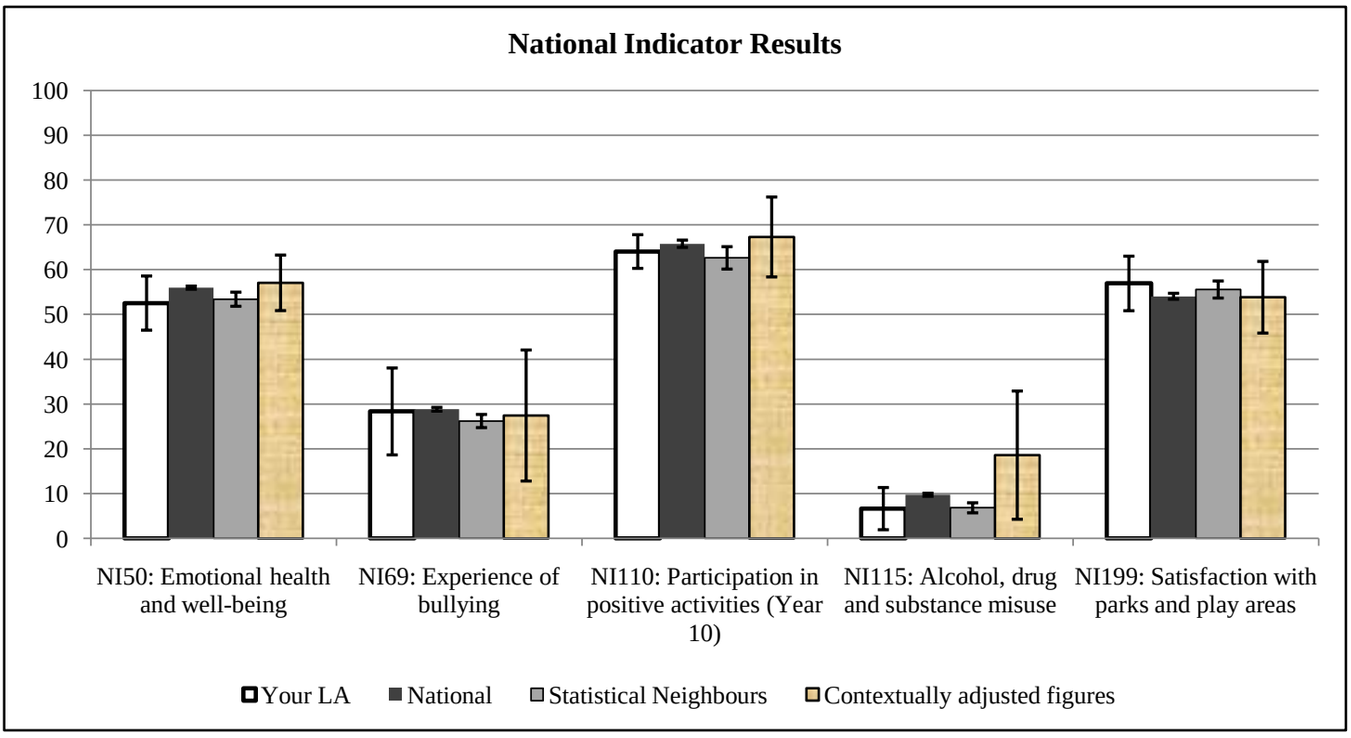
National Indicators	Your LA	National	Statistical Neighbours	Contextually adjusted figures
NI50: Emotional health and well-being	53	56	53	57
NI69: Experience of bullying	28	29	26	27
NI110: Participation in positive activities (Year 10)	64	66	63	67
NI115: Alcohol, drug and substance misuse	7	10	7	19
NI199: Satisfaction with parks and play areas	57	54	56	54



Error bars are used to denote 95% confidence intervals for the given estimates (confidence intervals estimated simply using twice the standard error).