Children and Young People's Alcohol & Drugs Needs Assessment

Southampton – May 2025

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May 2025

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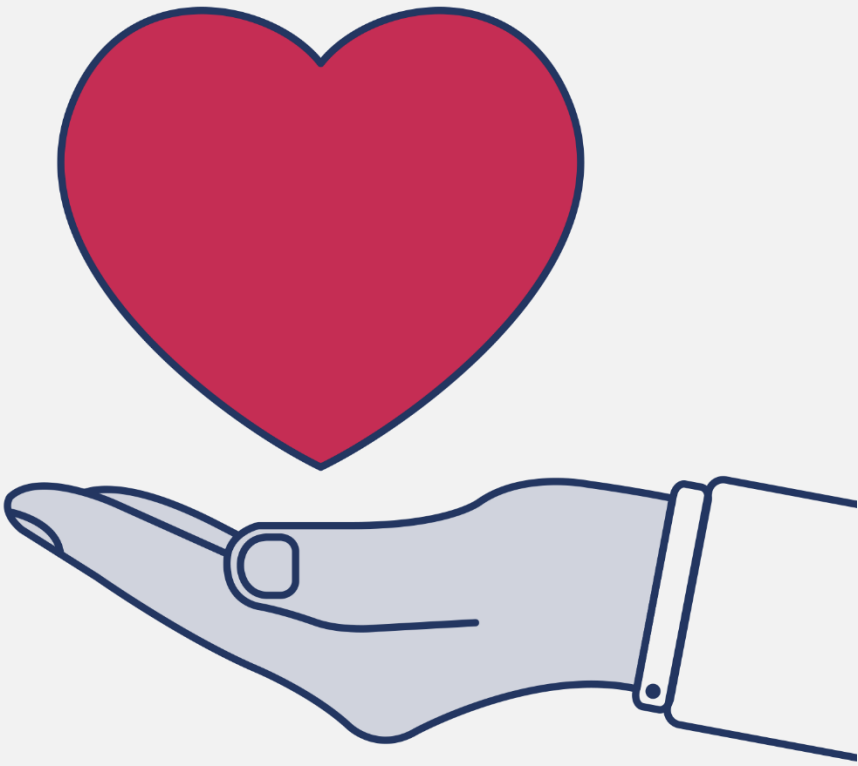


1 Introduction

''If there's something that could be improved, is that some bits of the system don't really understand the impact of domestic abuse on a victim's mental capabilities. People don't understand what it's like. They use the language of trauma informed but the expectation is that I respond like other people. I've had to educate myself , I can't retain information, I can't write emails, I can't do the small things that other people can. Yet the system requires that of me, like writing my own statements. It's exhausting and without my IDVA worker I would be unable to navigate the system. It's not just about organisations collaborating – it is about understanding the real impact of domestic abuse on victims and their families'

Building upon the work we undertook last year in producing Southampton City Council's Adult Drug and Alcohol Needs Assessment - we are delighted to have undertaken this Children's and Young Person's Drug and Alcohol Needs Assessment (CYPDANA). Evaluating the alcohol and drug prevention and treatment system and operating environment in Southampton in relation to children and young people up to the age of 25. We were struck by the level of positive engagement we encountered across the partnership, the level of scrutiny and transparency that all contributors displayed and their collective determination to make the system in Southampton the best it can be.

This needs assessment provides an honest account of the current state and future challenges the city faces in understanding and addressing substance use and related issues in younger people. We have looked at levels of need within the city and the extent to which services currently meet them. Alongside this we have considered the commissioning environment, governance, and strategic leadership as well as the wider partnership and system that sits around the substance use support ecosystem for children and young people.

Southampton is a relatively diverse, young city and home to 37,000 students in higher education. Drug and alcohol use in Southampton is linked to a range of negative impacts for individuals, families, and communities, including early death, increasing prevalence of long-term health conditions, reduced quality of life and economic opportunities, and increased social issues, including homelessness, violence, and exploitation. (1)

However, when addressing substance use among young people, it is vital to recognise that the patterns, drivers, and needs are fundamentally different from those seen in adults. (2) UK evidence and policy consistently support a model rooted in **early intervention, prevention, and holistic support**, rather than replicating the adult-oriented treatment model focused primarily on addiction and recovery. (3) For younger populations, substance use is rarely an isolated problem-

it is almost always a **symptom** of deeper social, emotional, or developmental challenges. (4)

Adolescents are in a critical stage of development-physiologically, neurologically, and socially. The adolescent brain is still forming, especially in areas linked to impulse control, decision-making, and risk assessment. Evidence from neuroscience (5)(6) confirms that our prefrontal cortex—responsible for judgement, impulse control, and decision-making—continues developing well into the mid-20s. It explains why adolescents are more prone to **sensation-seeking, risk-taking** and less able to anticipate long-term consequences. Recognising this alcohol and drug services for young people in Southampton are for those up to the age of 25. Substance use in youth is often exploratory, situational, recreational, or influenced by peers and not indicative of entrenched dependency patterns as typically seen in adult populations. (7) We are also cognisant of some of the commercial drivers for alcohol consumption and targeted marketing campaigns aimed at young people.

Moreover, many young people accessing alcohol or drug services are often dealing with **complex vulnerabilities**: trauma, family dysfunction, school exclusion, poor mental health, or experiences of exploitation. Studies like *The Children's Commissioner's "Keep Kids Safe"* (8) and *The Children's Society's "Counting Lives"* (9) report have shown how substance use among youth is often entangled with wider forms of harm, including **county lines exploitation**, **domestic abuse**, and **neglect**. In such contexts, the drug use itself is rarely the primary concern - it is a coping mechanism or a by-product of being or feeling unsafe

A system based on the idea of "substance misuse treatment" misses this complexity. The need is for **relational services** that can explore identity, trauma, and disconnection. The evidence base shows that what young people need is **meaning, belonging, and purpose**. Substance use often recedes when these are provided - whether through education, mentoring, peer support, or creative/physical activities.

It was in this spirit that we approached the work looking at whether the system around young people centred on **early, compassionate, developmentally appropriate support**, that gives them something to belong to and believe in.

About this report

This assessment of need provides a detailed, up-to-date overview of the causality, prevalence and complexity of alcohol and drug use by younger people (0 to 25) as well as the current strengths and gaps in the wider youth support system in the city. It draws on a wide range of local and national sources, as well as original and comprehensive data analysis to support our inquiries.

In compiling this assessment, and reaching our conclusions, the team interviewed more than 50 system stakeholders and partners, including: Reducing Drug Harm Partnership Board members; key leaders in health and social care, youth justice, education; treatment providers at senior and operational levels; local authority housing and homelessness leads, and partners in the voluntary, community and social enterprise sector (VSCE). A full stakeholder list is appended at the end of this report.

The findings draw on national data sources (where they exist), Office for Health Improvement and Disparities (OHID) data (10)(11)(12)(13) as it relates to Southampton and numerous local sources, including bespoke data requests, service evaluations, contract management records and annual reports - and the comprehensive data analysis and reporting presented on the Southampton Health Observatory.(14) An extensive literature review builds upon primary analysis, and we have sought to identify and present evidence-based areas of good practice where we think they will enhance local provision.

Although some stakeholder input was limited by availability and some data that was requested was not forthcoming, we have highlighted where further work to understand these areas of the system would be helpful going forward.

We would like to thank all of those who contributed their time, insights, and data to enabling this rich assessment to be completed.

About the authors

Mike Pattinson is director of Mike Pattinson Associates. He has over 30 years' experience of senior leadership within complex health, justice, and social care systems. He has worked across statutory and VCSE partnerships at both board and executive level. Since 2020 he has worked as a consultant with a variety of engagements including: service design, research and evaluation, impact analysis.

Kevin Crowley 25 years' experience in leadership and policy roles in complexity, disadvantage, health, and social care. Kevin works as a consultant to the Health and Social care sector. He specialises in organisational and information governance, data, impact, organisational strategy, and quality improvement. He is also an NHS mental health trust Non-Executive Director giving him a window into statutory healthcare services.

Mike and Kevin have collaborated on numerous joint engagements across the health, justice, and social care sectors since 2020.

Mary D'Arcy – Consultant with more than 30 years public service in Criminal Justice and Local Government with a proven track record at Board and Executive

Management level. Former CEO of the Hampshire and Isle of Wight Community Rehabilitation Company and Executive Director of Community, Culture and Homes for Southampton City Council.

Rachel Moran – an experienced social worker, manager, and trainer. Within statutory and voluntary sectors. Extensive safeguarding, family support and children's services experience as well as delivering professional development and learning and development provision within a Local Authority.

2 Executive Summary

This Children and Young People's Drug and Alcohol Needs Assessment (CYPDANA) provides a robust, challenging and intentionally helpful view of both the strengths and weaknesses of the current system.

Services for Children and Young People affected by alcohol and drug use are provided primarily by a local VCSE organisation No Limits through their DASH (Drug and Alcohol Support Hub) service. No Limits provides holistic services to young people up to the age of 26 in Southampton and neighbouring areas. They exist to make positive change possible through the provision of advice, information, and counselling – rooted in youth work values.

There are strong links with the Adult Substance Use Disorder Service (SUDS) provider (Change, Grow, Live) who provide clinical management and interventions to those young people requiring them. This includes jointly held team meetings and use of a shared case management system.

As was shown in the Adult Needs Assessment the Southampton prevention and treatment partnership is one that has many strengths and, on several levels, performs well. This applies equally to the system as applied to children and young people – although we identify several different challenges and opportunities moving forward.

Beneath the headline strengths, however, there are gaps in current provision and challenges for the future. Whilst the system performs relatively well for those who access it, those in treatment present with greater complexity than comparator areas. There is an under-representation in treatment of people from Global Majority communities (although this is improving) and there is a lack of engagement with these communities to properly understand their needs and develop culturally appropriate services.

Other gaps include: the absence of the voices of those with Lived Experience in governance and decision making. There is an underdeveloped relationship with the Universities and Further Education colleges regarding the health needs of the higher education student population and a lack of interface with South Central Ambulance Service NHS Trust. We are though aware that a new service is about to be piloted for those U25 with the ambulance service. All contributing partners identify difficulties in the interface between SUDS and both primary care and mental health services in the city. These concerns are heightened with regards to CAMHS.

Contracts for SUD Services for children and young people were last awarded in 2019 – prior to the Covid-19 pandemic which we know has had a range of severe and enduring impacts upon younger people across the UK that include: increased levels of anxiety, poorer school attendance and other developmental delays.

The National Drug Strategy – From Harm to Hope (15) published in 2022 identified the general deterioration in the provision of alcohol and drug treatment over many years and specifically identified the increased risk of child exploitation. One of the central tenets of the national drug strategy is to achieve a generational shift in the demand for drugs. It was accompanied by renewed investment into the system. This additional investment was in the form of time-limited grant allocations and thus remain a concern for longer term financial stability.

It was clear that the commissioning oversight of Children and Young People's alcohol and drug service provision has to a degree played a secondary role to the adult requirements. We were heartened by the degree to which those in commissioning teams and public health saw this as an opportunity to re-focus on the needs of children and young people in Southampton.

The provision of alcohol and drug services for young people within Southampton (or nationally) cannot be seen in isolation from the impact of prolonged financial constraints that the Local Authority has faced since 2010 and the hollowing out of what was traditionally seen as universal provision.

Targeted and specialist interventions certainly play important roles – many also carrying with them statutory responsibilities. The system in Southampton is particularly good at identifying those at the highest risk and there is evidence of strong partnership approaches to addressing these needs within education, justice, and family safeguarding systems.

But we cannot ignore the voices of most contributors who called for a renewed focus on universal youth provision that builds upon young people's ambitions and opportunities, and which can identify and intervene earlier to prevent things from deteriorating.

As a provider of parent and family support services told us:

“Our families are exhausted by a system that ignores their pleas for help until things reach a crisis point. By that time, it is too late”.

There is a complex pattern of substance use locally, higher than average alcohol consumption amongst young people and much higher rates of hospital admission related to alcohol and drugs than we see in comparable authorities.

The whole system is effective at early identification and engagement with young people. But there remain challenges in translating these contacts into more formal and structured interventions.

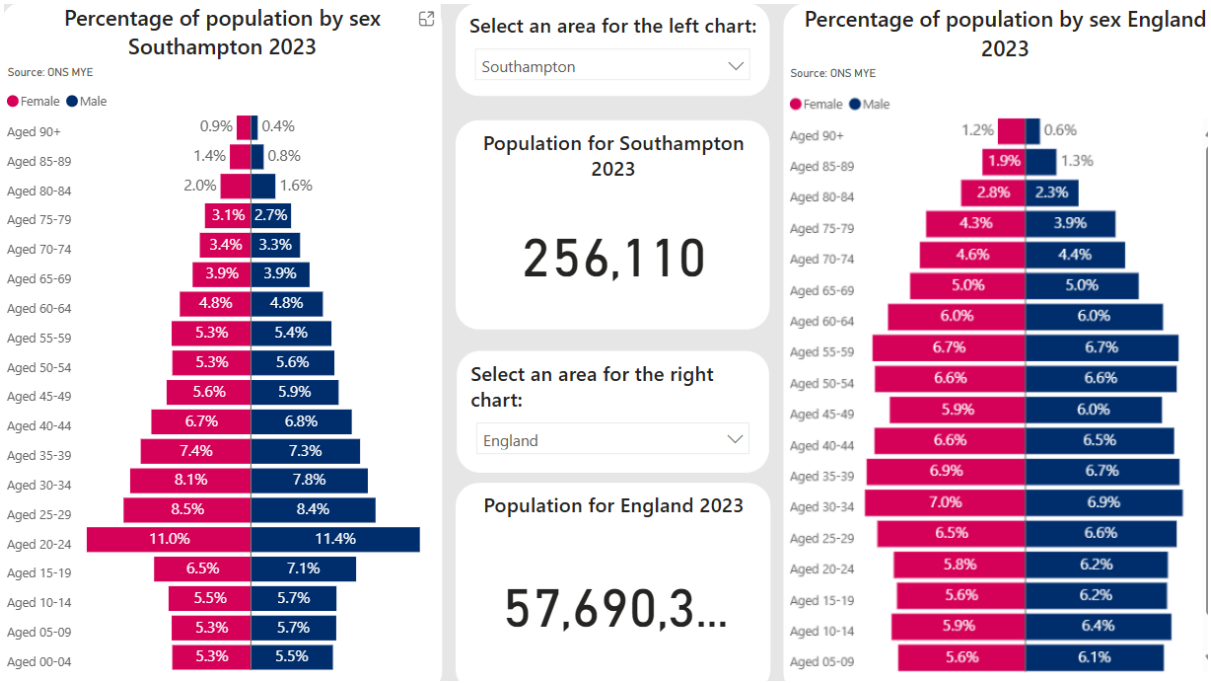
As we look forward, Southampton, which is already a relatively ‘young’ city, is getting relatively younger, and is becoming more ethnically diverse, more quickly than its comparators. Hence the need for leaders and commissioners to consider these changes when planning service development and improvements.

3 Context

This section sets out the current Policy landscape (nationally and locally) and the current and projected demographics and substance use need within the communities of Southampton. Within Southampton the existing Tobacco Alcohol and Drugs strategy contains a children's and young person's component, the Local Authority also has a public Children's Strategy as well as an established Health and Wellbeing Strategy that also contains targeted actions for children and young people. Existing partnership boards and strategic groups oversee all these policy areas.

The Southampton context

The population of Southampton is estimated circa 265,000 (2023) and projected to rise by 7.5% by 2030. Southampton has a younger age profile than England and the South-East, with only 14.5% of the population aged 65 or over, compared to 20% across England. 18.6% of the local population are aged 16-24 compared to 10.6% nationally, heavily influenced by the presence of c37,000 students studying in the city. The 0 – 15 population is roughly the same as England average across each age group.



Source: Southampton Data Observatory (14)

Southampton is a diverse City – with nearly 160 languages being spoken here. 31.9% of the City's usual residents in the 2021 Census considered themselves something other than White British, an increase of around 50% in 10 years. Schools' data shows over 80 minoritised communities and that the 'Non-White British' category is at 45.7%. The city is becoming more diverse, more quickly, than the national picture.

Religious beliefs – 43% of residents describe themselves as having no religion (compared to 36% nationally) whilst 40% of the population describe themselves as Christian, a fall of 18.1% since the 2011 Census. Muslim is the second most prevalent religious identity locally at 5.6%, followed by Sikh 1.7% and Hindu 1.3%.

Economic Disadvantage - There are strong links between poverty, deprivation, adverse childhood experiences, trauma, inequalities, and substance use. Poverty and disadvantage increase the risk of problems associated with substance use – which, in turn, can lead to increased disadvantage. These inequalities can also present barriers in accessing services and poorer health outcomes. (16)

The population of Southampton

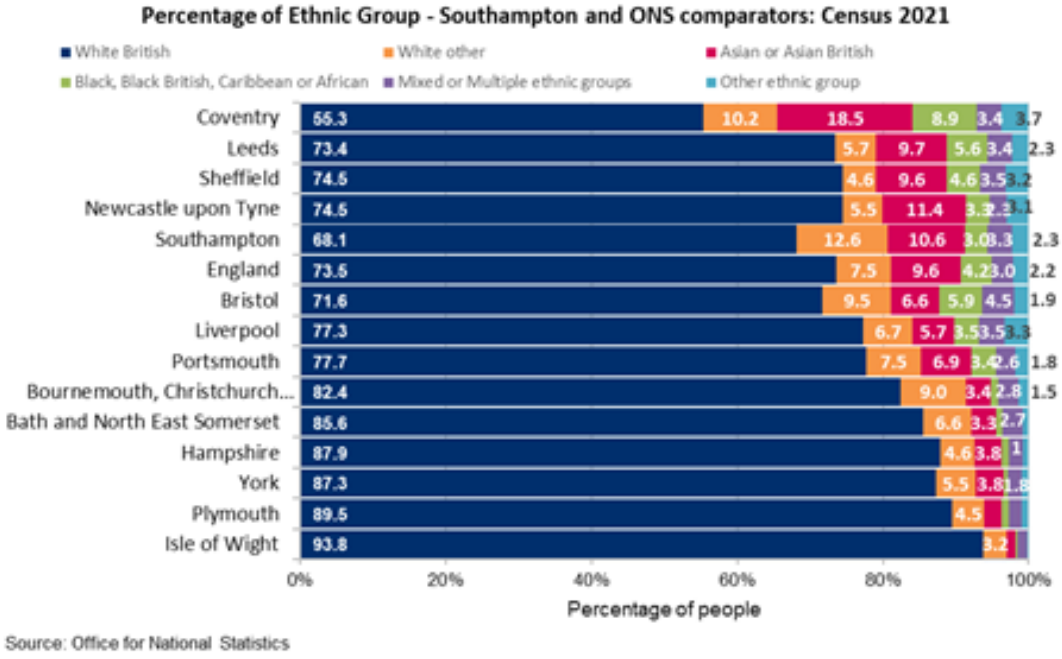
The Index of Multiple Deprivation (IMD 2019) (17) illustrates how Southampton continues to be a relatively deprived city. Based on average deprivation rank of its neighbourhoods (LSOAs), Southampton is now ranked 55th (where 1 is the most deprived) out of 317 local authorities: more deprived than the comparator cities of

Bristol (82nd), Leeds (92nd) and Sheffield (93rd). Southampton has 19 LSOAs within the 10% most deprived in England and one in the 10% least deprived. These disparities are, unsurprisingly given the younger age profile, replicated for Children and Young People as the map on page 12 illustrates.

As of November 2024, 4.5% (7,630 individuals) of the working-age population in Southampton were recipients of Job Seekers Allowance (JSA) comparable to the JSA claimant rate for England, which stands at 4.3%. In 2023, the median weekly gross earnings for a full-time employee, resident in Southampton was estimated to be £652, which is below the England average of £683. In addition, those working in the city earn more than those resident in city (£52 per week gap for full time workers), suggesting the best paid workers in Southampton are commuting into the city. (11)

Deprivation and inequalities between residents and neighbourhoods in Southampton, although not as great as similar cities, are significant and continue to be a driver for poorer health and social outcomes in Southampton.

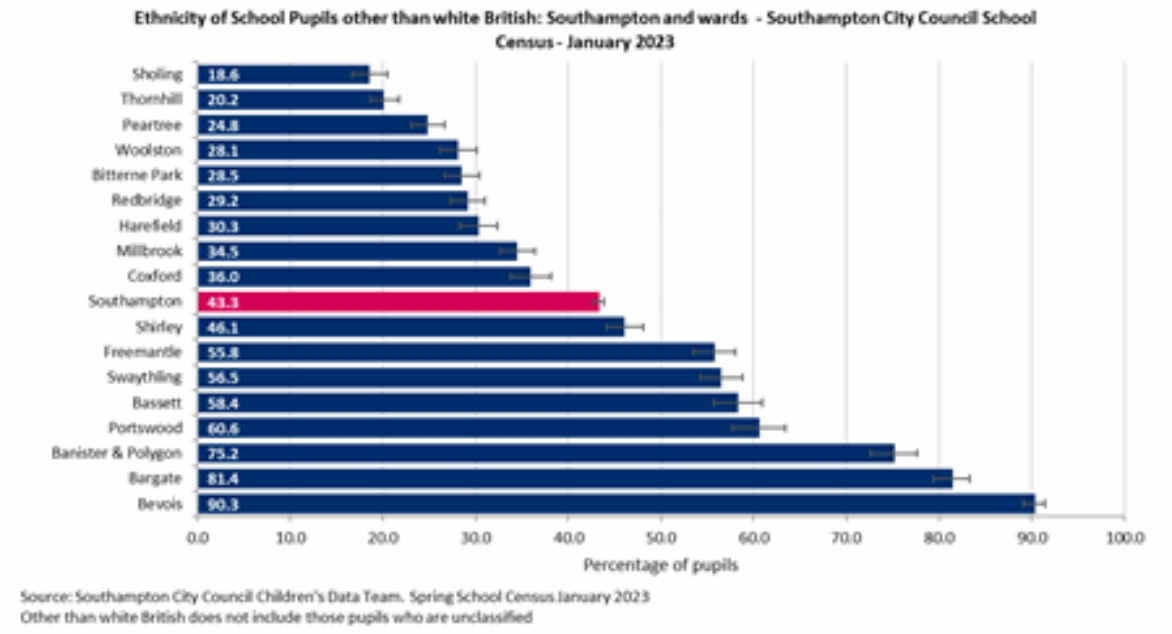
Ethnicity



Source: Southampton Data Observatory (14)

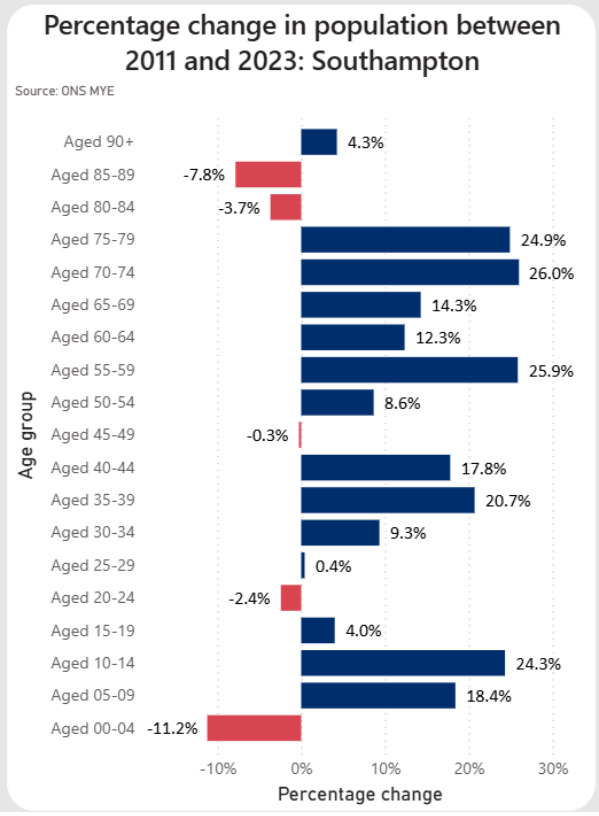
Understanding the demographics of communities is important as residents from global majority communities are known to face different barriers to services. (8) Results from the 2021 Census showed 68.1% of usual residents are white British, a decrease of -7.9% since Census 2011. Compared with a decrease of -1.7% in England. Meaning that the population of Southampton is getting more culturally diverse.

Significant minority ethnic communities in Southampton include: 4.0% of residents are Polish, 3.7% are Indian or British Indian and 1.7% are Chinese.



Source: Southampton Data Observatory (14)

A younger and more diverse population?



Population for Southampton 2023

Source: ONS MYE

Sex	Female		Male		Total	
Age	Population	% Pop	Population	% Pop	**Population**	**% Pop**
Age 10	1,425	1.11%	1,434	1.12%	**2,859**	**1.12%**
Age 11	1,385	1.08%	1,519	1.19%	**2,904**	**1.13%**
Age 12	1,458	1.14%	1,541	1.20%	**2,999**	**1.17%**
Age 13	1,401	1.09%	1,396	1.09%	**2,797**	**1.09%**
Age 14	1,395	1.09%	1,443	1.13%	**2,838**	**1.11%**
Age 15	1,362	1.06%	1,467	1.15%	**2,829**	**1.10%**
Age 16	1,280	1.00%	1,311	1.02%	**2,591**	**1.01%**
Age 17	1,309	1.02%	1,363	1.06%	**2,672**	**1.04%**
Age 18	1,532	1.20%	1,728	1.35%	**3,260**	**1.27%**
Age 19	2,833	2.21%	3,161	2.47%	**5,994**	**2.34%**
Age 20	3,239	2.53%	3,592	2.81%	**6,831**	**2.67%**
Age 21	2,797	2.18%	3,147	2.46%	**5,944**	**2.32%**
Age 22	2,651	2.07%	2,661	2.08%	**5,312**	**2.07%**
Age 23	2,784	2.17%	2,567	2.01%	**5,351**	**2.09%**
Age 24	2,665	2.08%	2,563	2.00%	**5,228**	**2.04%**
Total	**29,516**	**23.04%**	**30,893**	**24.14%**	60,409	**23.59%**

Source: Southampton Data Observatory (14)

- In 2023, the resident population of Southampton was estimated to be 264,957, of which 129,721 (49.0%) were female and 135,236 (51.0%) were male
- Children between the ages 0 to 5 make up 6.3% (16,808) of the population, which is similar to the England average of 6.5% (MYE 2022)
- 18.6% (49,155) of Southampton's resident population is aged between 16 and 24 years compared to 10.6% in England. This is in part due to Southampton being a university city and home to approximately 37,000 students
- The overall resident population is projected to increase by 7.5% between 2023 and 2030 from 264,957 in 2023 to 284,924 in 2030

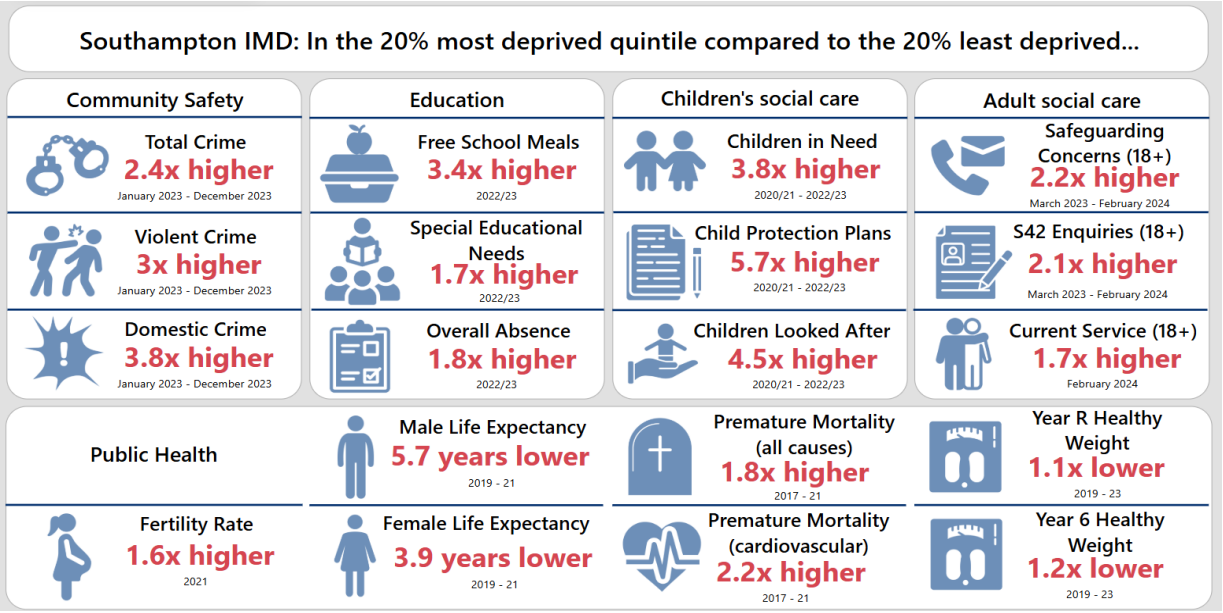
In the spring 2023 school census of pupils, 42.9% of pupils were from an ethnic group other than white British. This has increased from 33.5% in 2015, a 9.4 percentage point increase. (14)

Ethnic groups in Southampton schools (spring 2023), top 20 ethnic groups: Southampton

Source: Southampton City Council

Ethnicity	Number of pupils	Rank	Percentage of pupils
White - British	17,694	1	54.27%
Any other white background	3,993	2	12.25%
Indian	1,625	3	4.98%
Any other Asian background	1,522	4	4.67%
Black - African	1,333	5	4.09%
Pakistani	1,059	6	3.25%
White and Asian	709	7	2.17%
Any other ethnic group	625	8	1.92%
White - English	599	9	1.84%
Any other mixed background	548	10	1.68%
White and Black Caribbean	525	11	1.61%
White and Black African	486	12	1.49%
Bangladeshi	433	13	1.33%
Chinese	240	14	0.74%
White European	127	15	0.39%
Information not yet obtained	119	16	0.37%
White Eastern European	89	17	0.27%
Black Caribbean	77	18	0.24%
Any other black background	76	19	0.23%
Gypsy/Roma	76	19	0.23%
White other	76	19	0.23%

Communities under pressure.



Source: Southampton Data Observatory (14)

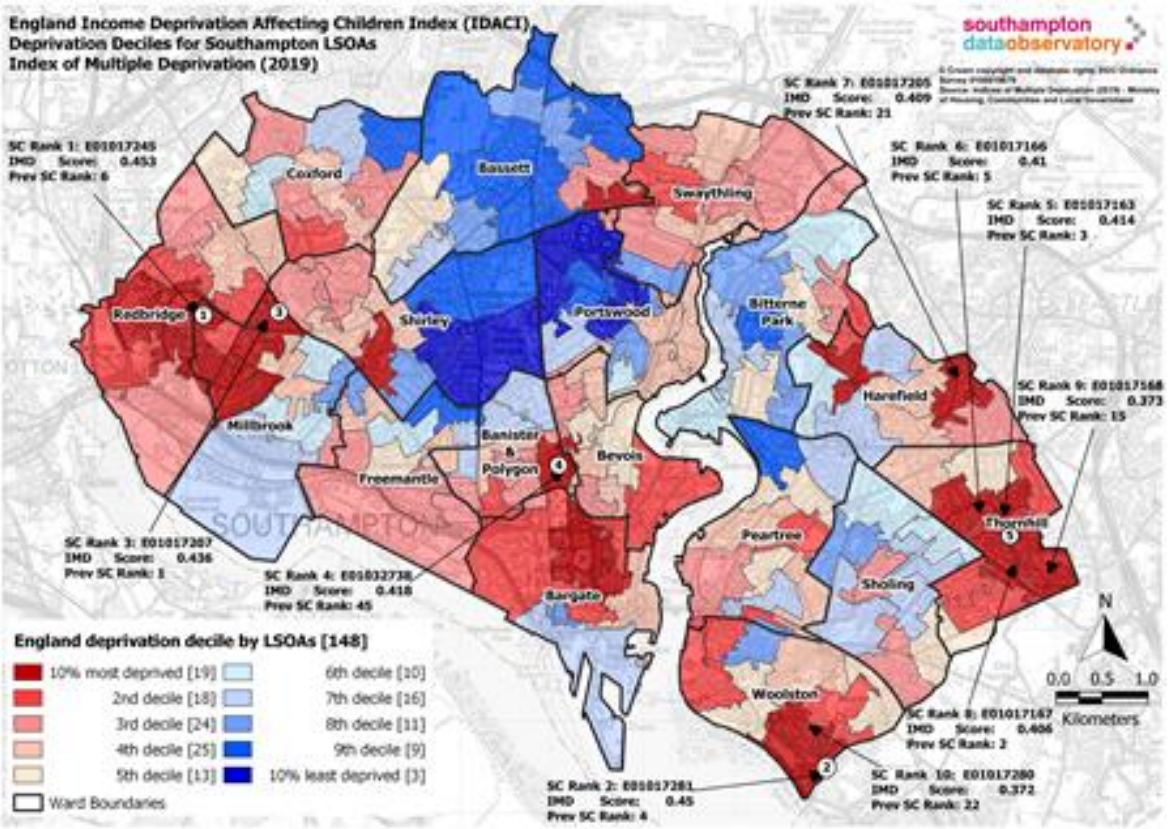
Deprivation and inequalities between residents and neighbourhoods in Southampton are significant and continue to be a driver for health and wider social inequalities in Southampton. Key outcomes for children and young people in Southampton continue to be poorer than the national average, with outcomes significantly poorer (and starting earlier in life) for those residents living in the most deprived areas of the city compared to those living in the least deprived areas.

The Marmot Review (2010) and its 10 year review (18) suggests that childhood poverty leads to premature mortality and poor health outcomes for adults. There is good evidence to show, that children who live in poverty are exposed to a range of risks that can have a serious impact on their mental health and increased problematic substance use. Reducing the numbers of children who experience poverty will have direct impact on adult substance use and increase healthy life expectancy. (19)

The Department for Work and Pensions, (20) suggest that there are 3.3 million (23%) children under 16 in the UK living in absolute poverty (after housing costs). Applying this percentage to Southampton, it is estimated that there could be 10,000 children living in absolute poverty in the city. (14) Figures produced by the Department for Work and Pensions show that in 2021/22, 25% of children in Southampton aged under 16 were living in relative low-income families - higher than the national average (23.8%).

The IMD (2019) includes a supplementary index of Income Deprivation Affecting Children (IDACI). This shows that there is significant variation across the city, with the proportion of children who are income deprived ranging from less than 5% (LSOAs in Portswood, Shirley and Bassett) to over 45% (LSOAs in Redbridge and

Woolston). A map of income deprivation affecting children at neighbourhood level can be seen below.



Source: Southampton Data Observatory (14)

Children living in poverty and deprivation are more likely to have poorer outcomes in adulthood, particularly those relating to health, education, employment, and crime. It has also been found that children and families from the poorest 20% of household incomes are three times more likely to have common mental health problems and substance use issues than those in the richest 20%. (21)

The latest data on those pupils who are eligible for free school meals from Department for Education (DfE) school census (2022/23), (22) shows that 34% of all pupils, in state funded schools in Southampton, were eligible for free school meals, which is significantly higher than the national average (23.8%). The below table illustrates that Southampton also scores highest in the Southeast on the Income Deprivation Affecting Children Index (IDACI)

Area	Recent Trend	Count	Value
England	–	1,777,642	17.1
South East region (statistical)	–	-	-
Southampton	–	9,088	20.5
Portsmouth	–	7,939	20.2
Medway	–	10,599	18.9
Isle of Wight	–	3,984	18.0
East Sussex	–	14,993	16.1
Reading	–	5,300	16.0
Kent	–	46,148	15.8
Brighton and Hove	–	6,968	15.3
Milton Keynes	–	9,010	15.0
Slough	–	5,448	14.7
West Sussex	–	16,639	11.0
Hampshire	–	25,250	10.1
Oxfordshire	–	12,719	10.1
Bracknell Forest	–	2,212	8.9
West Berkshire	–	2,739	8.7
Buckinghamshire UA	–	9,161	8.5
Surrey	–	18,917	8.3
Windsor and Maidenhead	–	2,007	6.7
Wokingham	–	1,877	5.6

Source: Ministry of Housing, Communities and Local Government

Source: Southampton Data Observatory (14)

Wider impacts of deprivation

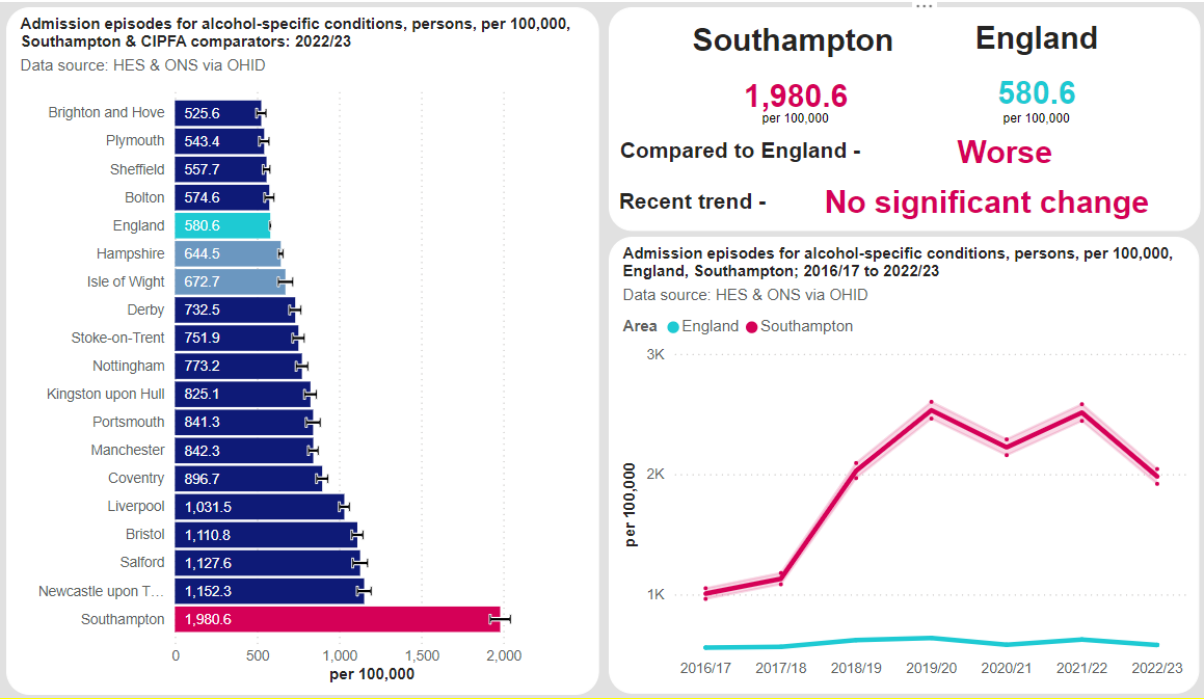
Mental Health. The closest equivalent to substance use issues in terms of predictive validity is mental ill health. In Southampton, the prevalence of mental illness is significantly higher in the most deprived areas of the city compared to the least deprived areas, i.e. Depression (1.78 times higher), severe mental illnesses such as schizophrenia (2.77 times higher) and bipolar disorder (2.77 times higher) and the emergency admission rate to hospital for self-harm is 3.49 times higher.

Substance use prevalence and issues for young people in Southampton

Alcohol-specific hospital admissions in general are 1.94 times higher in the most deprived areas of the city compared to the least in 2020/21 to 2022/23. Hospital admissions for under 18s are significantly higher than both regional and comparator averages and among the worst in the UK. (23)

Admission episodes for alcohol-specific conditions (under 18 years) (Persons)	2021/22 - 23/24	–	92	61.5	24.5*	22.6	61.7		3.8
Admission episodes for alcohol-specific conditions (under 18 years) (Male)	2021/22 - 23/24	–	34	44.4	15.7*	15.4	48.9		2.2
Admission episodes for alcohol-specific conditions (under 18 years) (Female)	2021/22 - 23/24	–	58	79.4	33.6*	30.0	98.5		4.8

Source: PHE (24)

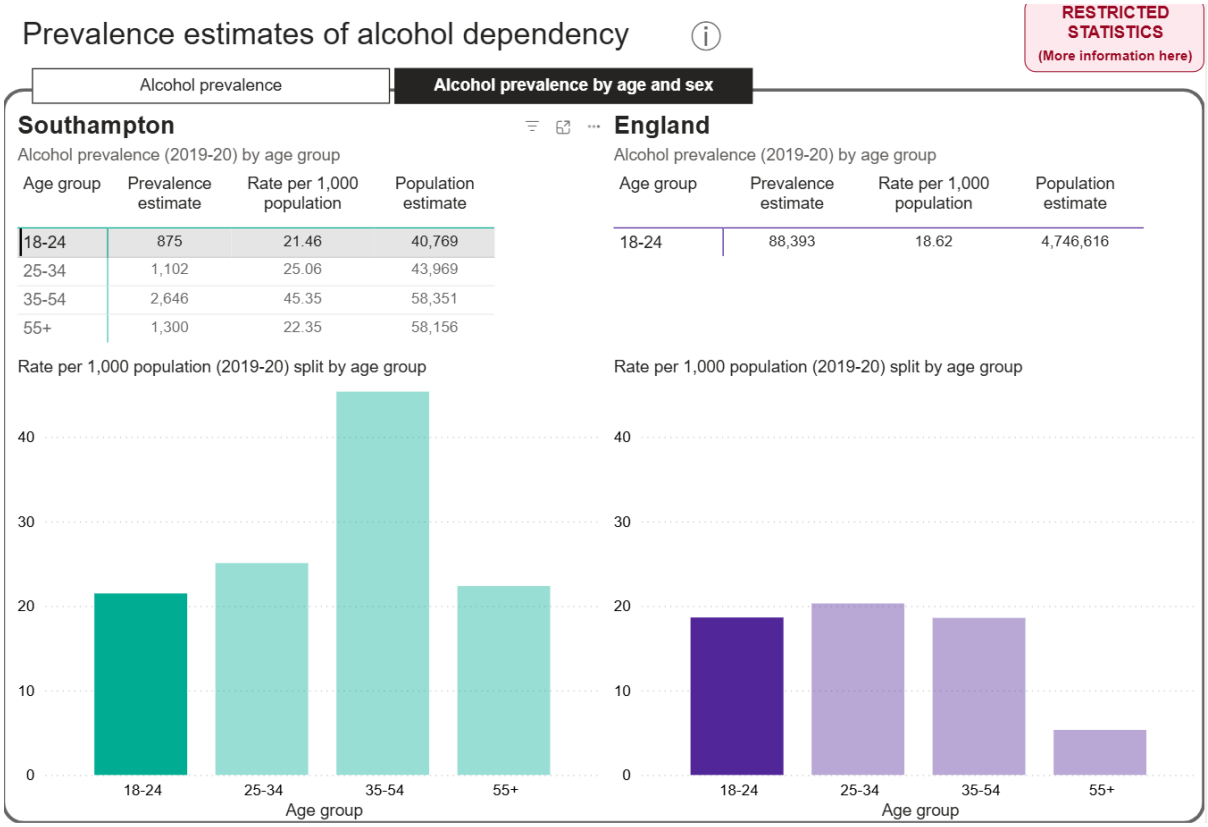


Source: Southampton Data Observatory (14)

National data indicates that alcohol use increases with age (in terms of volume and % who have drunk alcohol in the past 30 days.) Alcohol use amongst 16–24-year-olds has declined with 41% reporting consuming alcohol in the past week in 2019, compared to 58% in 2009. Young men are more than 11 times more likely to consume more than 50 units of alcohol per week (high risk level) compared to women (6.8% vs 0.6%). (11)

OHID (24) estimates that the rate of alcohol dependency is higher in Southampton (21.46 per 1,000 population) than nationally (18.62 per 1,000 population). There were 875 young people aged 18-24 years old estimated to be dependent on alcohol in Southampton in 2019-20 – higher than England average.

In Southampton Child alcohol use is flagged in 2.3% of section 17 assessments undertaken by social workers to identify whether a child is 'in need' and the nature of their needs – a likely underestimate.



Source: NDTMS (11) – accessed May 2025

The impact of harmful drinking and alcohol dependence is much greater for those in the lowest income bracket and those experiencing the highest levels of deprivation. However, people on a low income do not tend to consume more alcohol than people from higher socioeconomic groups. This is known as the 'alcohol harm paradox'. The increased risk is likely to relate to the combination of multiple risk factors which affect those in lower socioeconomic groups. (25)

Estimations made by NDTMS suggest there are between 33 and 57 people under the age of 25 who use opiates, and between 42 and 78 who use crack cocaine in Southampton.

Child drug use is flagged in 5.4% of section 17 assessments in Southampton. The office of the Children's Commissioner and NDTMS provide data on the prevalence of parent/carer drug or alcohol dependency. According to these estimates, Southampton is likely to have higher rates than the nearest statistical neighbours or nationally.

Data from drug and alcohol services in Southampton indicate that **17%** (166/961) adults receiving structured treatment (in November 2023) were parents. Of the adults in structured treatment for drugs or alcohol use:

- **42%** (69) live with children
- **28%** (47) have children under the age of 5

- **11%** (19) have a child who is known as a **child looked after**

The Children's Commissioner data team (26) estimates there are 2,700 children in Southampton living with an adult with alcohol or drug dependency (54.6 per 1,000). Treatment data reveals only 350 children known to live with an adult who entered alcohol treatment and 243 with those who entered drug treatment. However, national evidence shows that roughly half of drug and alcohol service admissions are parents.

	Southampton	Nearest Neighbours[3]	England	Estimated Number in Southampton
Children's Commissioner Estimate[1]:				
Children living in a household where adult has drug or alcohol dependency (2019)	5.5%	4.4%	4.0%	2,780
NDTMS Estimates[2]:				
Children living in a household where adult has alcohol dependency (2018/19)	3.2-3.4%	2.2-2.4%	1.6-1.7%	1,660-1,752
Children living in a household where adult has opiate dependency (2014/15)	*	*	*	593
Alcohol dependent adults living with children (2018/19)	0.5%	0.4%	0.3%	1,004
Opiate dependent adults living with children (2014/15)	0.2%	0.3%	0.2%	285

Source: The Children's Commissioner (26)

4 Children, Young People and Substance Use prevention, and treatment in Southampton

Southampton has a younger age profile than England and the South-East, with only 14.5% of the population aged 65 or over, compared to 20% across England. 18.6% of the local population are aged 16-24 compared to 10.6% nationally - influenced by the presence of 37,000 students living and studying in the city.

The national drug strategy published in 2022 (15) strives to achieve a generational shift in the demand for drugs. In the foreword to this strategy is states:
"We will also ensure that there is early intervention for young people and families at the greatest risk and make sure all children are provided with high quality education on health and relationships to help prevent the use of drugs."

The strategy further contends that:
"Addressing the increase in overall drug use requires a generational and attitudinal shift so that in 10 years fewer people take drugs or feel drawn towards taking them. Investing in the education and resilience of children and young people will help us to level up the whole country, particularly for those families at higher risk of drug use or harm, so that no matter where someone is born or lives, they can excel and prosper in those places".

The strategy proposed a radical reform of accountability, leadership, funding, and commissioning in the sector, creating new standards and setting a refreshed outcomes framework that provide structure and oversight, to drive high-quality services. This section describes the current system of children and young people's drug and alcohol provision seen in the context of these national drivers.

Alcohol and Drug Treatment in Southampton:

The Substance Use Disorder Services (SUDS) in Southampton cover all adults and young people and are commissioned against national guidance, standards, and evidence. Services were last commissioned in 2019 prior to the publication of the 2022 national drug strategy, before the global Covid-19 pandemic and in advance of additional investment to enable local authorities tackle drug related deaths and associated harm in their communities. Locally the system has maintained a 'harm reduction first' focus and has actively sought to reduce the stigma that is often associated with alcohol and drug use. Creative approaches to both diversionary activities and to personalising care and support have been implemented and maintained. It is also clear that the importance of substance use interventions are widely recognised and this is reflected in associated strategies.

SUDS within Southampton are divided into two main cohorts namely:

- **Adult** provision – for those aged 25+. Provided through a single contract and delivered currently by a national VCSE organisation (Change Grow Live).
- **Young People's** Provision – for those under 25. Provided by a local specialist young people's service No Limits through their DASH service.

Both providers work in close collaboration and share a case management system. The adult service provides clinical input (where needed) into the young people's service.

- **Parent and Carer Support** work is subcontracted to a local provider (PSL) from within the main adult contract and there are established multi-agency pathways agreed with mental health, primary care, and homeless services.

No Limits are a well-established local provider and the primary provider of specialist young people's services in Southampton. They take a youth work approach to delivery and their mission is 'to enable change through the provision of advice and information'. Their DASH (Drug and Alcohol Support for Health) service is the primary commissioned service for supporting young people under the age of 25 in Southampton who are experiencing issues related to drug and alcohol use. The service is designed to be accessible and youth-friendly, offering harm reduction, psychosocial interventions, and support across a spectrum of need and age.

Alcohol and drug prevention for children and young people:
The role of **schools** is seen as a critical driver of provision under the national drug strategy which committed to delivering school-based prevention and early intervention – delivering and evaluating mandatory relationships, sex and health education to improve quality and consistency, including a clear expectation that all pupils will learn about the risks of drugs and alcohol during their time at school. Local School leaders reported noteworthy progress as having been made ensuring that all staff worked in a 'trauma informed' way.

We know through direct engagement with schools' representatives as part of this Needs Assessment that their main concerns currently are around the availability of Vapes that are thought to be 'laced with drugs'. At the time of writing these concerns tend to be emergent and anecdotal rather than evidenced through 'number of reports' but are certainly felt too real and growing within a schools setting.

For older young people there are 3 colleges of further education, two sixth form colleges and two universities. We were unable to speak to representatives from

any of these establishments during this Needs Assessment. We do know from our previous work around the adult treatment system that the strategic links with the university sector was identified as needing attention.

We heard that policies around alcohol and drugs were individual responsibilities of each school and that they therefore varied considerably – from taking a 'zero tolerance' approach often resulting in either temporary or permanent school exclusion to taking a more inclusive approach to maintaining attendance. There was appetite expressed from those we spoke to for a more collaborative and consistent approach across the city.

Drug and alcohol treatment

Structured treatment

Nationally, "structured treatment" refers to specialist drug and/or alcohol treatment where people have a comprehensive assessment, a recovery care plan and care from more than one professional discipline. It is a comprehensive package of concurrent or sequential specialist drug- and alcohol-focused interventions. It addresses multiple or more complex needs that would not be expected to respond to less intensive or non-specialist interventions alone. "Non -structured treatment" is defined as specialist work that falls short of this care-planned approach. For example, informal psychoeducational approaches, open access sessions and harm reduction interventions.

Young People who may require support from these services are referred via many routes mental health, education, primary health care, the criminal justice system, friends and family, and self-referral.

The No Limits 'Advice Hub' is a well-used central base and the primary means of engagement is via their drop-in services and targeted outreach. The benefits of the drop-in approach are seen as important as they open opportunities for young people to access the full range of services provided by No Limits, reducing stigma and in many cases is seen as more appropriate than labelling the intervention as a 'drug session' or the young people attending as 'substance misusers' - labels which they don't often identify with. For most young people alcohol and drug use is non-dependent and can be a symptom of trauma, adverse childhood experiences or just experimentation.

For those young people, whose use of alcohol and drugs may be more complex (requiring clinical interventions) then there are joint working protocols in place with Change Grow Live who provide these. This approach is particularly effective for those young people using physically dependency forming drugs like opiates or alcohol. In the case of young people using drugs dependently, joint case reviews are held, and the prescribing regime is overseen by CGL's Consultant Psychiatrist.

The young person continues to receive their primary support and case management through No Limits.

Providers try to ensure that these interventions are delivered through the No Limits premises. The number of young adults receiving substitute prescribing interventions is relatively low (n=4) and it is acknowledged that at times there is insufficient clinical expertise within the DASH team to confidently work with young people on a clinical pathway.

It is similarly acknowledged that the primary presenting drugs of concern for young people are rarely those that require a substitute prescribing regime and that the system needs to be able to provide a wide range of psychosocial interventions to support those young people presenting for other substances including cannabis and ketamine.

There are relatively few young people transitioning from young peoples to adult treatment services. This is an area we think requires further consideration given the complex profile of adults engaged in the local alcohol and drug treatment system.

For young people using alcohol problematically (and Southampton has a very high alcohol consumption rate for younger people in treatment – see below) access to clinical health screening, assessments and review is through the CGL Nurse Lead team based within their adult service. No Limits staff endeavour to accompany young people to these appointments where possible.

What stakeholders told us.

DASH - the young person's substance use service at No Limits - has developed a strong and responsive model grounded in a young person centred, relational outreach. The service is visible and accessible in community spaces, including schools, youth hubs, and, through detached outreach to areas identified as hotspots for high-risk behaviour. Stakeholders highlighted the role of outreach workers in engaging young people informally - building trust over time, offering safe spaces for conversation, and enabling early identification of risk. This visible, proactive approach was consistently praised by partners as approachable, youth-friendly, and stigma-free.

Stakeholders reported that the service is effective at working in partnership with statutory agencies, particularly with safeguarding, education, and youth justice. The service is well embedded in multi-agency forums, including child exploitation panels and early help hubs, and is regularly cited as a trusted contributor in case planning around issues such as the youth justice decision making group. There is

evidence of joint working with children's social care, CAMHS, schools, and the Youth Offending Service, with DASH providing substance use expertise and flexibility that complements more formal interventions. However, as we will see below referrals from some relevant settings - including GPs, adult mental health, housing teams, and adult social care - remain lower than we would expect. This may reflect wider systems issues and limited awareness of the service's role and remit.

DASH offers a comprehensive advice and information function that is both preventative and responsive. It delivers tailored workshops in schools and through its advice and interventions centres, provides accessible online content, and responds to emerging substance use trends with up-to-date harm reduction materials. We were told that content is co-produced with young people and adapted to different community contexts, with a focus on empowering informed decision-making rather than instilling fear or shame and this tone is evident from their website and social media presence.

A consistently reported strength of the DASH service is its youth work offer, which stakeholders identified as positive and effective. It provides regular drop-in sessions, small group programmes, and creative or physical activities through which practitioners can engage young people in low-pressure settings. These informal approaches were described by DASH management as key to relationship-building and uncovering hidden risks. However, the service has challenges in converting initial engagement into more structured treatment activity. While the ethos of voluntary participation is valued, it is of concern that attrition rates between referral and engagement in treatment from several priority groups appear very high.

Where structured support is delivered, the service appears to draw on a range of evidence-based approaches including motivational interviewing, CBT-informed techniques, and work with the wider system around young people. These are tailored to the complexity and readiness of the young person, and often delivered in flexible, youth-led formats. Nevertheless, the service has acknowledged difficulties in **differentiating substance use needs from other presenting needs** such as trauma, poor mental health, or family breakdown within assessment and reporting processes. While this reflects the complex reality of young people's lives, it can make it harder to demonstrate impact or identify specific patterns of substance use behaviour across Southampton.

Finally, while the service is working proactively to build trust within diverse communities and while No Limits has achieved strong initial engagement with some minoritised groups, there remain **challenges in converting this engagement into**

active substance use interventions. This may also be a definitional issue or might highlight the need for more culturally responsive pathways, language support, and co-designed practice tailored to the concerns and contexts of different communities.

Service Provision: The Role and Reach of DASH

As of the latest data, 86% of people accessing services through DASH (11) are aged 18 or over, indicating a significant gap in engagement with under-18s. This skew raises concerns about the visibility and accessibility of provision for younger adolescents, particularly those who may not meet safeguarding thresholds but who would benefit from early support. The underrepresentation of this group suggests that the service model - and the wider system around it - is not currently configured to reach and retain those at an earlier stage of need.

Gender representation in the DASH caseload deviates from national trends. While young males typically outnumber females in substance use disorder services nationally, in Southampton, 51% of service users are female (138 out of 272), compared with 47% male (128). This pattern is consistent across structured treatment episodes for both alcohol (53 females vs. 44 males) and cannabis (54 females vs. 44 males). Whilst 'not stated' rates remain low we know that this figure may include young people who are non-binary or simply choosing not to state their gender. This may reflect strengths in DASH's approach to working with young women and warrants further exploration to identify transferable learning that could improve younger male engagement.

In terms of ethnicity, most people accessing services (76.1%) identify as White British, a proportion notably higher than the demographic profile of Southampton's 18–24 population, of which only 60.2% are White British. This suggests potential under-engagement of young people from global majority backgrounds. While DASH adopts an inclusive approach, the data points to the need for a more proactive engagement strategy with underrepresented communities - including co-designed outreach and culturally responsive service adaptations.

Referral routes into DASH reflect a service that is responsive and accessible. Of the 733 referrals received between 2023/24 and 2024/25, the largest single source (158 referrals) was self-referral followed by internal referral from the No Limits advice centre (91). That over a third of referrals come directly to the organisation is a positive sign of service visibility among some segments of young people. However, referrals from statutory partners are comparatively low. Southampton City Council services contributed 19% of referrals split between children and families (71), youth offending (36), Adult Social Care (11) and housing (31). Health

services, mental health, schools, and targeted youth support played a more minor role, raising questions about the consistency and strength of inter-agency identification and referral mechanisms.

It is clear from our review of service user feedback and surveys that DASH is widely viewed positively by young people who use the service. Its harm reduction approach and focus on building trust are recognised strengths. However, the broader question remains whether the service's reach and configuration align with population-level need. While many of those who do engage are well supported, the data suggests that cohorts of young people - especially under-18s and young people from global majority communities - are either not being reached or are not staying engaged. Addressing these gaps is a priority for future commissioning and partnership development.

Despite these issues, the service is regarded by professionals and young people as a vital resource that provides not only support but also advocacy, compassion, practical support and belonging. With focused investment in data, cross-sector training, and community partnerships, the service is well placed to build on its strengths and extend its reach.

At a glance: What's happening in children's and young person's substance use services?

- DASH self-report that over 2500 young people and young adults received alcohol or drug brief intervention and over 1,500 young people received a substance education session in 2024/25.
- 844 young people were contacted through targeted outreach of whom 650 engaged in conversations around their needs.
- There were a total of 733 referrals for structured treatment received between 2023/24 and 2024/25.
- The largest single source (158 referrals) was self-referral followed by internal referral from the No Limits advice centre (91).
- Southampton City Council services contributed 19% of referrals split between children and families (71), youth offending (36), Adult Social Care (11) and housing (31).
- 39.2% of those referrals made it to structured treatment meaning that 447 young people did not.
- According to NDTMS During 2024/25 there were 141 18–24-year-olds in treatment with 101 new starters. This represents 8% of the adult caseload which is above national average.
- During 2024/25, a below average 27 under 18s engaged in treatment.
- A further 65 young people (11–24-year-olds) received more informal interventions.
- The treatment profile is 53% female vs 47% male – inverting the national rate of 38% vs 62%.
- The treatment profile is 85% white British and 11% Black/Asian vs Southampton profile of 72% and 19%.
- New presentations follow the same pattern with 88% White British so this is not changing.
- 27% of the YP caseload has been in treatment for over a year compared to 11% nationally
- Successful treatment completion rates (50%) are comparable to national average (52%) with fewer young people dropping out (33% vs 34%)
- Substances used follow the national trend but with significantly higher crack and poly drug use. Under 18s have higher ketamine and alcohol use than average
- Just over half (52%) of all clients entering treatment were receiving mental health treatment for reasons other than substance use – higher than average. However, fewer than average received specialist help from the mental health trust (13.4% vs 17.5%), with most of those in need receiving help from GPs (55.8%).
- The number of clients with untreated mental health issues was much higher than national average 36.2% vs 27.4%: that is, 260 individuals without help.

Type of drugs used

Drug and alcohol use by those on the structured treatment caseload appears to follow national trends with Cannabis, Alcohol, Cocaine and Ketamine the most used drugs. However, poly drug use, crack use and very high alcohol use are above national average with recorded Ketamine use (whilst still being relatively low) showing a 50% rise over the past 2 years. This concurs with later findings that the treatment needs in Southampton appear to be more complex than its neighbours.

Southampton vs England

Substance use group	Total	Proportion
Cannabis	84	52.8%
Alcohol	78	49.1%
Cocaine (excluding Crack)	46	28.9%
Ketamine	19	11.9%
Crack	13	8.2%
Heroin	8	5.0%
Ecstasy	7	4.4%
Codeine	3	1.9%
Amphetamines (excluding Ecstasy)	2	1.3%
Other Opiates	2	1.3%
Benzodiazepines	1	0.6%
Gaba Drugs	1	0.6%
GHB/GBL	1	0.6%
Hallucinogens	1	0.6%
Methamphetamine	1	0.6%
Prescription Drugs	1	0.6%
PS Cannabis	1	0.6%

Substance use group	Total	Proportion
Cannabis	10,279	49.6%
Alcohol	9,739	47.0%
Cocaine (excluding Crack)	6,138	29.6%
Ketamine	3,235	15.6%
Crack	1,386	6.7%
Heroin	1,126	5.4%
Benzodiazepines	948	4.6%
Ecstasy	632	3.1%
Other Opiates	495	2.4%
Codeine	367	1.8%
Gaba Drugs	306	1.5%
Nitrous Oxide	222	1.1%
Amphetamines (excluding Ecstasy)	161	0.8%
Hallucinogens	140	0.7%
Other Drugs	131	0.6%
Methamphetamine	115	0.6%
PS Cannabis	95	0.5%
Methadone	47	0.2%

Source: NDTMS (11) – accessed May 2025

Southampton

Alcohol consumption

2023/24

	Number	Proportion
0 units	95	36%
1 to 199 units	99	37%
200 to 399 units	35	13%
400 to 599 units	16	6%
600 to 799 units	5	2%
800 to 999 units	4	2%
1000 and over units	12	5%
Total	**266**	

England

Alcohol consumption

2023/24

	Number	Proportion
0 units	15,497	42%
1 to 199 units	11,348	30%
200 to 399 units	4,223	11%
400 to 599 units	2,692	7%
600 to 799 units	1,214	3%
800 to 999 units	836	2%
1000 and over units	1,495	4%
Total	**37,305**	

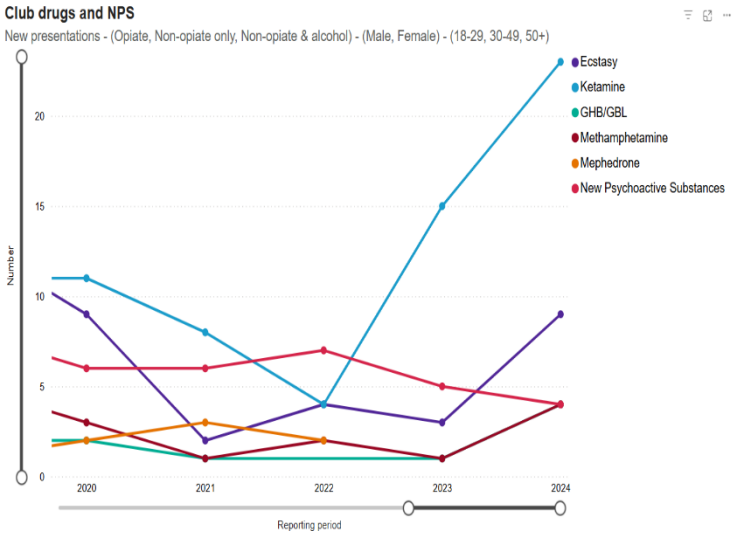
Source: NDTMS (11) – accessed May 2025

Meanwhile, stakeholder feedback that Ketamine use is on the rise among young people, is validated by the ‘Club Drug’ data for people new to treatment. These numbers are small when compared with the major drug groups above but specialist treatment presentations for club drug issues are traditionally much lower than other drugs and sometimes indicative of future trends.

Club drugs and NPS

2023/24

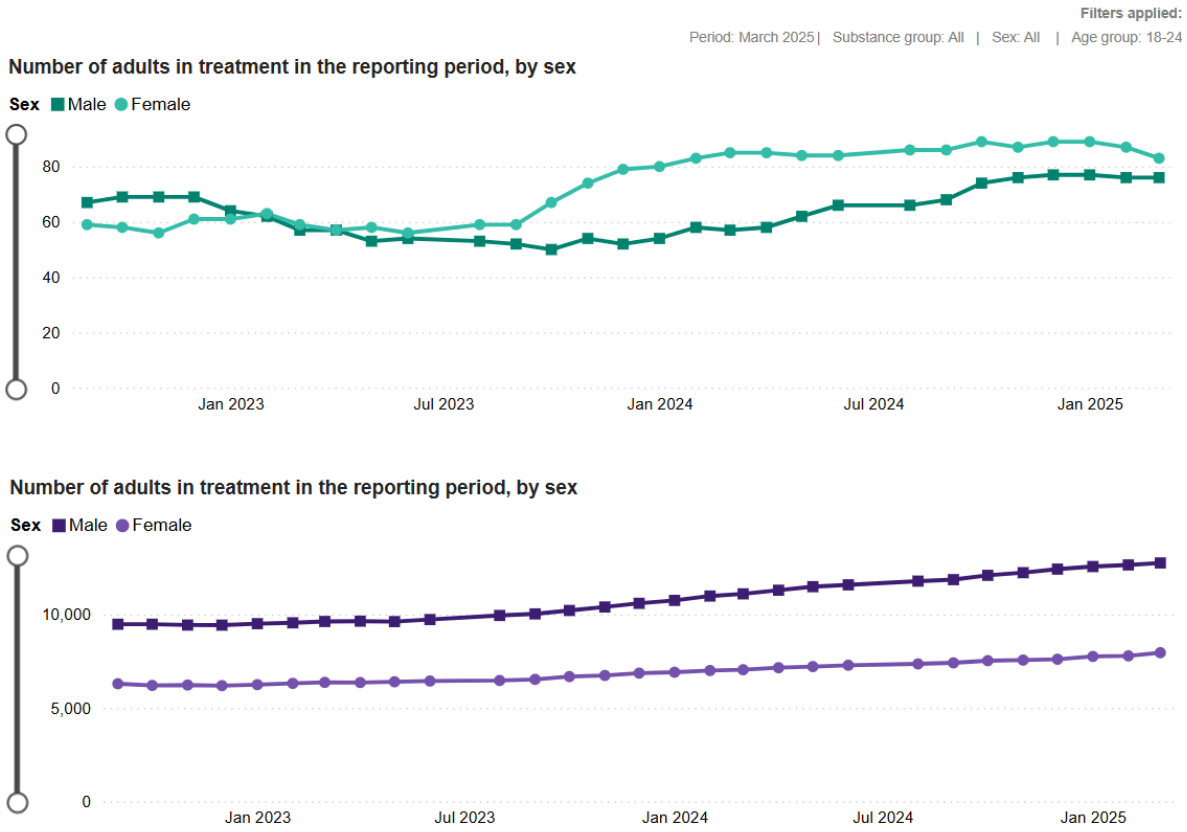
	Number	Proportion
Ecstasy	13	1%
Ketamine	30	2%
GHB/GBL	4	0%
Methamphetamine	5	0%
New Psychoactive Substances	9	0%
Total	**61**	**3%**



Source: NDTMS – accessed May 2025

Demographics of people in drug treatment

In 2024/25, there were 147 young people (12 – 24) in drug treatment in Southampton. Of these, 47% were male (much lower than the national figure of 62%) and 53% female (higher than the England average of 38%). This trend is continuing as shown by the new starters data. Transgender data is not captured by NDTMS but were a total of 3 people who described themselves as either non-binary or ‘other’ on the caseload.



Source: NDTMS (11) – accessed May 2025

Ethnicity

NDTMS for 2024/25 shows that only 10% of new treatment starts came from Global Majority communities, compared with a city population where 19.3% of 18–24-year-olds belong to those communities. Figures representing the proportion of people 'in treatment' caseload is slightly more representative at 13%. This underrepresentation is especially noticeable among Black and Asian young people. For the under 18's this pattern continues with only 1 Black or Asian young person out of 22 new entrants this year. The service's offer may be broadly inclusive in intention and delivery - but this is not necessarily reflected in who accesses structured support.

Age

In Southampton, by far the largest age group in drug treatment was the 18–24 group (86%) vs 14% under 18's. Compared to England average it has a slightly higher age profile with higher proportions of those aged 18-24 and at 8% of the whole adult treatment group is slightly higher than the rest of England - but it must be remembered that a much higher % of the general population are in this age group in Southampton (16% vs 10% nationally).

Southampton ‘all in treatment’ profile vs England ‘all in treatment’ profile

Age (detailed breakdown)

2023/24

	Number	Proportion
18-24	105	8%
25-29	107	8%
30-34	213	16%
35-39	237	17%
40-44	246	18%
45-49	203	15%
50-54	144	11%
55-59	61	4%
60 or above	49	4%
Total	**1,365**	**100%**

Age (detailed breakdown)

2023/24

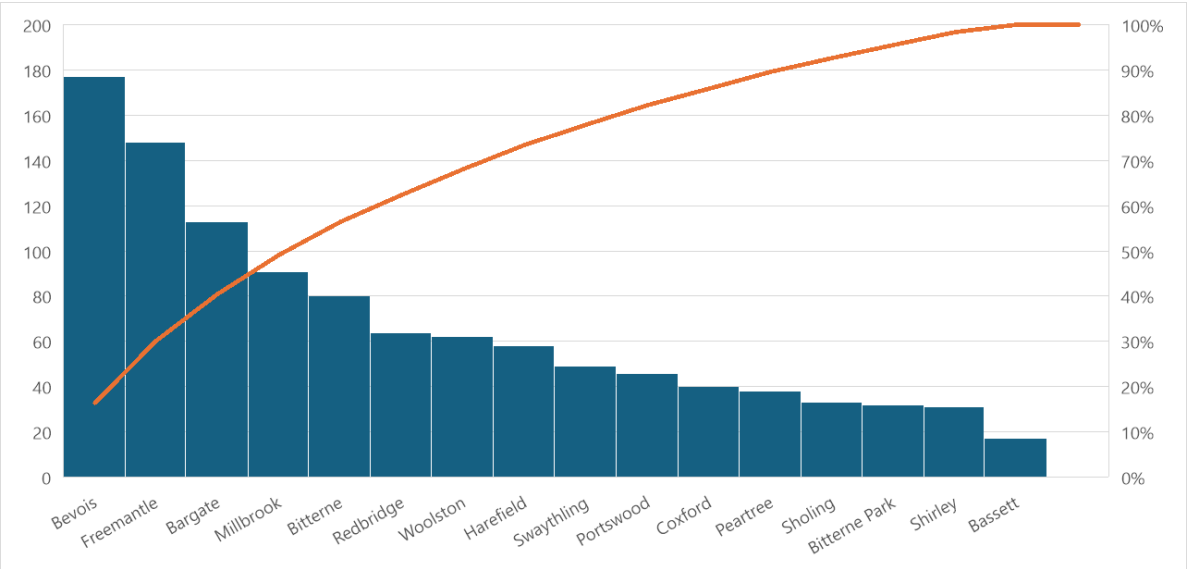
	Number	Proportion
18-24	15,329	7%
25-29	17,685	8%
30-34	26,922	12%
35-39	34,400	16%
40-44	40,125	19%
45-49	32,898	15%
50-54	25,117	12%
55-59	14,826	7%
60 or above	9,388	4%
Total	**216,690**	**100%**

Source: NDTMS (11) – accessed May 2025

District of residence

There is a strong correlation between the home addresses of the in-treatment drug population and the areas of the city with the highest levels of deprivation. Our analysis of the treatment caseload at Middle Super Output Area (MSOA) sub-ward) level in drug treatment shows that the bulk of those in treatment live in areas with higher deprivation which is a positive sign of engagement with at risk communities.

Southampton 0 - 24 drug treatment caseload by Ward



Source: Provider Supplied data

Outcomes for young people in treatment

Systemic Outcomes

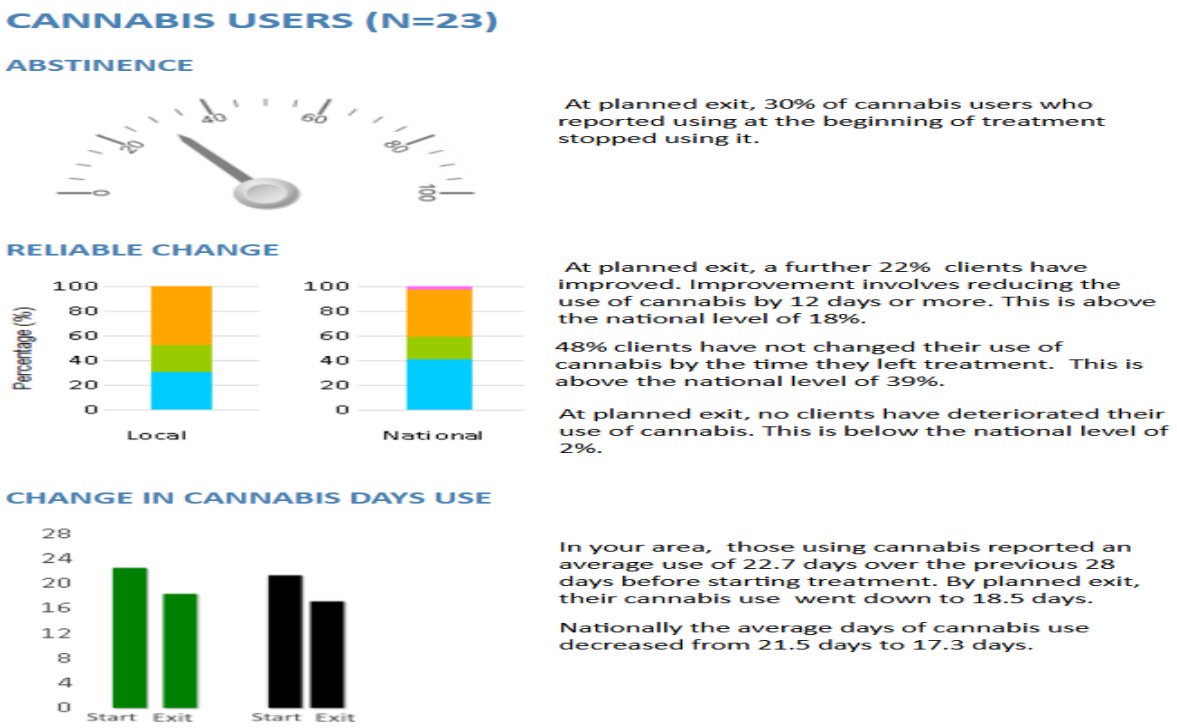
As stated earlier the model for young person's 'treatment' in Southampton is different in focus to the adult system. Taking a holistic and relational approach to engagement and support for young people rooted within youth work values. It is however still required to provide treatment, within national guidelines to young people using alcohol and drugs - so we need to understand how it performs against both treatment and wider outcomes. This also allows greater comparisons to be made with neighbouring authorities and at a national level. The number of new entrants to the system in 2024/5 was 85 which, although a comparatively healthy number, represents a lower % of the whole young person's caseload than average. 27% of the YP caseload has been in treatment for over a year compared to 11% nationally. Both of these facts taken together indicate a slower 'churn' of people in treatment reflecting the service ethos of longer-term engagement with young people.

Successful treatment completion rates (50%) are comparable to national average (52%) with comparable rates of young people dropping out (33% vs 34%) of treatment. This indicates that the service is good at engaging with and retaining young people until their goals are met.

Progress in treatment

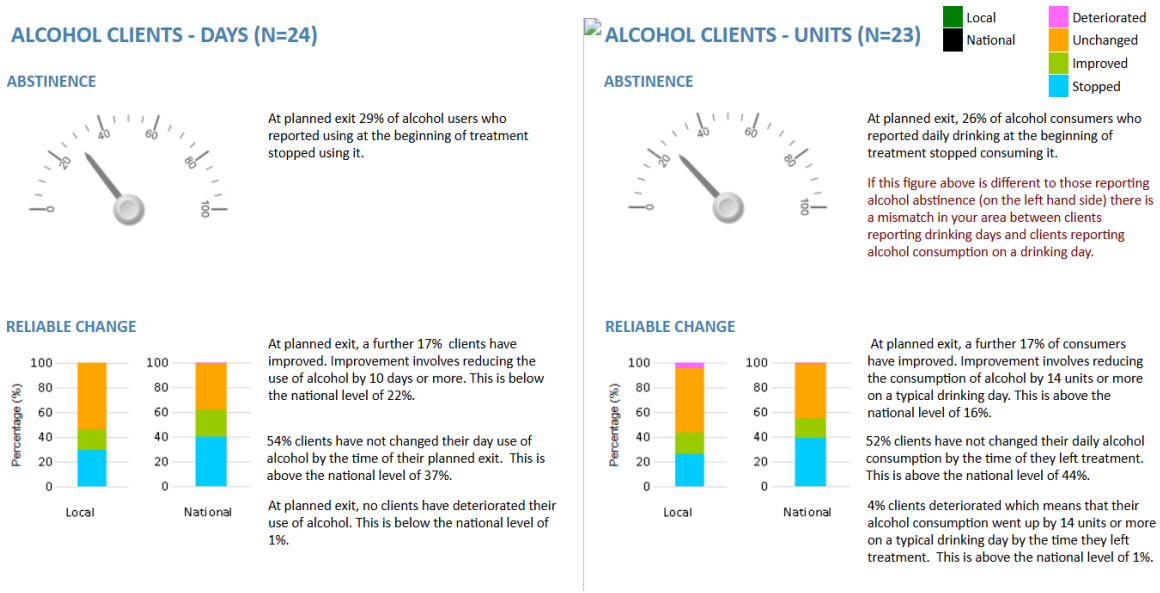
Beneath the successful completion headline there are some anomalies that have not been fully explained by stakeholders. Young person's successful treatment completions are, by definition, less strict than adults when it comes to using substances and that on the core measure of substance use the service does not make as much progress as would be expected. Cannabis, Alcohol, and 'Other drug' use does reduce over the course of treatment but far less than England average.

For cannabis, only 30% of those who presented with this as a problematic substance had stopped using and a further 22% had reduced. This means that 48% had not changed their use which is higher than the national average of 39%.



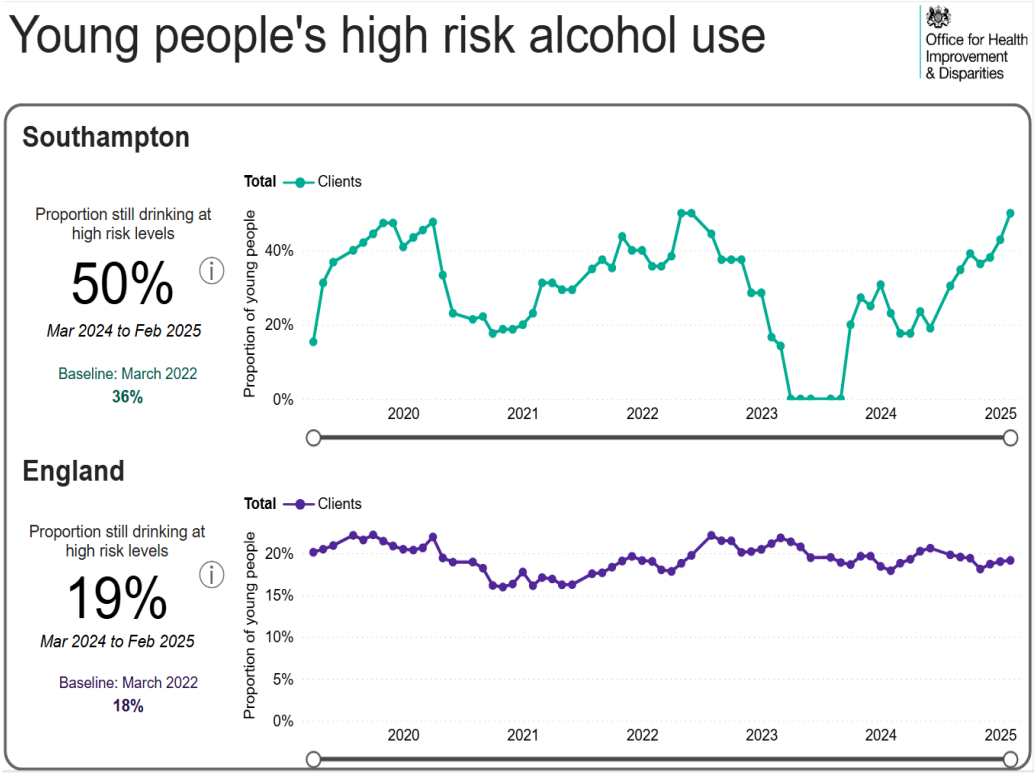
Source: DOMES - accessed May 2025

It is a similar picture for young people presenting with problematic alcohol use (defined as drinking above low risk guidelines of 14 units per week). Only 26% of those who presented with this as a problematic substance had stopped using and a further 17% had reduced. This means that 57% had not changed their use or increased which is higher than the national average of 45%.



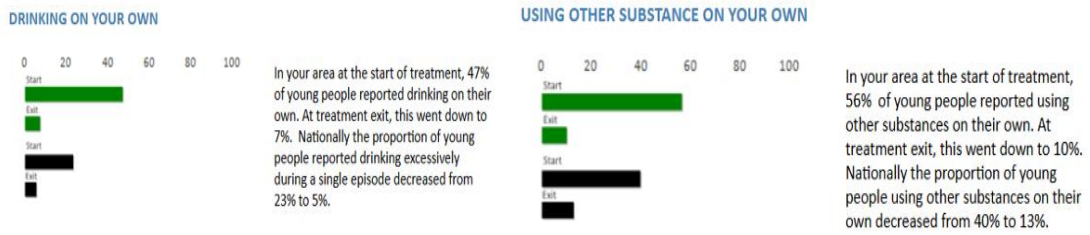
Source: DOMES - accessed May 2025

Although the numbers are small, it is a concern that 50% of those who report high risk drinking at treatment start also report this at exit (compared to a national figure of 19%)



Source: DOMES - accessed May 2025

On other important consumption measures the service does markedly better. The number and frequency of younger people drinking or using substances alone (a higher risk activity) shows a much greater improvement than national average. This reflects well on the commissioned intention of reducing the harms experienced by young people.



Source: DOMES - accessed May 2025

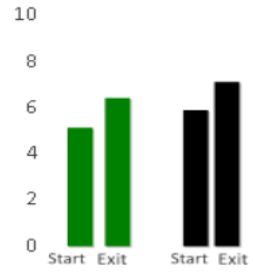
The Southampton treatment system has been designed to keep young people who use substances safe - and to reduce the harm experienced by them. On many measures of harm reduction, it does this particularly well. However, any treatment

system is also intended to produce outcomes around substance use itself so further enquiry about progress in this domain seems important.

Other measures of progress.

Outside of substance use, the system does make progress with younger people. On core life satisfaction and mental health scores it makes better than average progress. As referenced below, the DASH service has made good progress with engaging young people with mental health services while in treatment. However, in keeping with our other findings about complexity, it should be noted that young people in Southampton (while numbers are low) leave with worse mental health scores than most of England starts with.

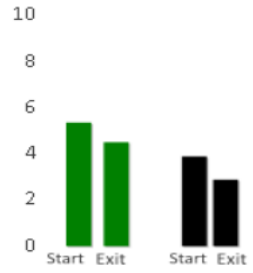
Source: HEALTH AND WELLBEING — CHANGE IN LIFE SATISFACTION SCORE — **DOMES - accessed May 2025**



In your area, 28 young people reported how satisfied with life they were at the start of treatment and at exit.

By the time of treatment exit, young people's satisfaction score improved from 5.1 to 6.4. Nationally young people's happiness score improved from 5.9 to 7.1.

CHANGE IN ANXIETY SCORE



In your area, 27 young people reported how anxious they felt at the start of treatment and at exit.

By the time of treatment exit, young people reported feeling less anxious (from 5.4 to 4.5). Nationally young people reported feeling less anxious (from 3.9 to 2.9).

5 The System – a wider partnership around alcohol and drugs

Partnership work is **essential for young persons' treatment and care. Problems relating to alcohol or drug use often coexist with mental health challenges, unstable housing, or homelessness, which can prevent younger people accessing support or impede their progress when they do. Integrated support ensures that these interconnected needs are addressed simultaneously, enabling individuals to build stable, healthy lives. A collaborative, young person-centred approach across sectors not only improves outcomes for individuals but also enhances the efficiency and impact of the broader system.**

The Southampton Reducing Drug Harm Partnership oversees the delivery of the City's Tobacco, Alcohol and Drug strategy via an annual delivery plan and is chaired by the Director of Public Health. It draws together senior representatives from strategic partner organisations, elected representatives, as well as delivery partners. Unsurprisingly the agendas for these meetings and programmes of work that sit underneath the strategy can look and feel both busy and adult oriented despite there being space on each agenda to discuss CYP issues. It was commented that securing representation from children's services at RDHP has been challenging. There appears to be scope to better understand the relationship between RDHP for example and other strategic partnerships around children and young people in the city.

Feedback from many stakeholders indicated that the commissioning of SUDS services for children and young people needed strengthening and that there was a desire to see greater strategic leadership at a partnership level for children and young people. It was commented consistently that current systems were good at identifying those young people most at risk – but that this was often at the expense of an ability to support, engage and nurture young people on their own terms.

One stakeholder stated, "I would love to see us develop a strategy and a partnership that has young people, their hopes and aspirations at the centre – rather than seeing them as problems to be managed".

Young people within the criminal justice system

Criminal justice performance

Young people's intersection with the criminal justice system presents both a sign of vulnerability and a key opportunity for intervention - one that is not yet being fully realised.

Probation

Stakeholders report a positive relationship between probation and the young person's treatment service with good communication, information sharing and agreed joint working protocols.

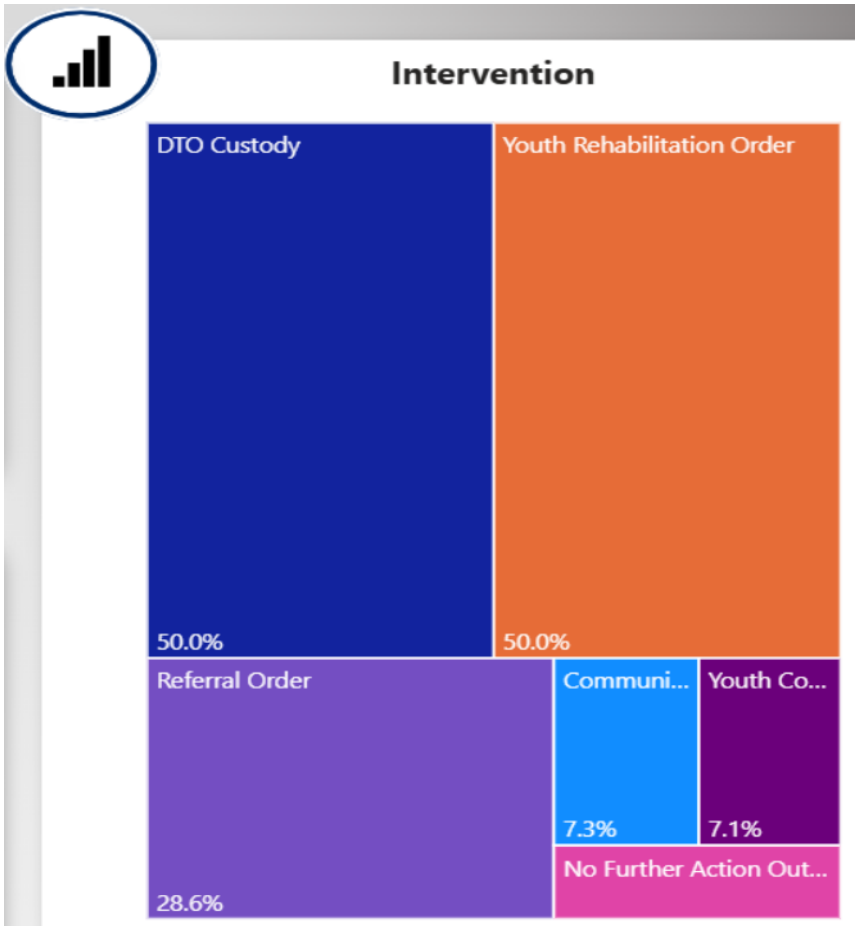
Probation caseload data (2024/25) shows that 21 (24%) young people (aged 18 to 25) were identified with Binge Drinking / Excessive Alcohol in last 6 Months and 13 (15%) have alcohol problems. A further 24 (27%) have drug use categorised as a 'major activity'. It is unclear how serious the substance use issues are, but DASH provider data shows that only 24 young people have been referred by probation to treatment over the past two years - and of those 70% disengaged before starting structured support.

The use of court-imposed levers, such as Drug Rehabilitation Requirements (DRRs) and Alcohol Treatment Requirements (ATRs) for younger people (18 to 25) is extremely low - with just three requirements recorded across two years. Both probation and DASH management are aware of this issue and have committed to examine and address it as part of this review.

The Youth Offending Service (YOS) also presents a mixed picture. Of 160 young people screened, only 31 were flagged with concerns around alcohol or drug use. From the perspective of local treatment providers, referral volumes (36 over two years) seem proportionate, but with 50% attrition, many young people are not making the journey into structured support. This is surprising given the presence of embedded alcohol and drug workers within the YOS, suggesting a potential disconnect between screening, referral, and ongoing engagement.

On the positive side the HELP (Health Education and Learning Pathway) seems to be particularly effective for young people who either have substance use issues or are being exploited within organised criminal networks. DASH are contributors to the joint decision-making group and all stakeholders were complementary about their expertise and contribution to criminal justice decisions about young people.

It is not clear which young people benefit from the group however and the data from YOS indicates that the more serious offences tend to get considered for substance use interventions.



Source: YOS data

An additional concern voiced by stakeholder is that the **Turnaround Project**, (which previously offered a more holistic preventative offer) due to funding restrictions no longer accepts substance use cases - representing a loss of one of the community-facing routes into early intervention. As an aside there appear to be disparities in community engagement on this project with 50% of referred White young people accessing support, compared with 20% of those from other ethnic backgrounds.

Police

Unlike the over 25's adult picture, which is overwhelmingly positive, engagement with the treatment system for young people appears more limited. Although under 18s are not eligible for drug test on arrest, Hampshire constabulary data shows that there were 137 U18s arrested for 'trigger offences' in 2023/24. For the 18 – 25-year-olds we have not been able to get specific data, but it appears as if the majority who tested positive were referred to the RESET programme or CGL. DASH data shows that over the past two years, only 11 referrals were made by police services - but with a very low attrition rate for those few who were referred. This indicates that when young people are identified and referred early, engagement can work - but frontline detection and referral is inconsistent. Increasing the capacity and confidence to identify issues and make appropriate referrals could make a significant difference at a critical touchpoint.

On the other hand, the partnership work with youth justice decision making appears to be a strength with No Limits a key contributor to the joint decision-making board. The picture across the criminal justice system shows opportunities **for earlier, more coordinated interventions**, more consistent data collection, better integration between services, and a stronger shared understanding of roles and responsibilities are needed.

Primary Care and Mental Health: Strengthening the Frontline Response

Primary care settings are often the first point of contact for young people experiencing health concerns, including those related to substance use and mental wellbeing. In Southampton, most young people entering the drug and alcohol treatment system (88%) are registered with a GP at the point of assessment, rising to 95% once treatment begins. This high level of registration presents a strong foundation for integrated care. Despite this positive baseline, DASH data shows that **only nine referrals** to treatment were recorded from general practice over a two-year period (2023-2025).

This potential underutilisation of GP referral pathways is particularly notable given that 75% of all mental health interventions for this cohort are delivered through primary care. GPs are clearly playing a central role in managing young people's emotional and psychological wellbeing - but substance use may be going unrecognised or inadequately addressed within these consultations. There is an opportunity to enhance GP awareness and confidence around substance use, and to reinforce referral pathways through joint training, shared care protocols, and proactive liaison from treatment providers. There are opportunities to enhance confidence in identifying early concerns as well awareness of the provision of local support services and Quitline for young people using tobacco and vapes.

A specialist team of **Family Nurse Practitioners** operates in Southampton providing support to young parents from the time of conception until a child's second birthday. Funding constraints have reduced the size of this team to 5 practitioners and thus restricted to the age range of those young parents supported to being under 18. The focus of this team is on providing practical and emotional support to young parents, building their resilience and ability to provide safe and stable homelife for their child(ren). Since the target age range was narrowed to focus on those parents under the age of 18, they report little exposure to alcohol or drugs although are aware of how to access DASH / No Limits if required. We also heard positive feedback about the Bright Beginnings programme being run as a partnership between the FNP and No Limits for new parents.

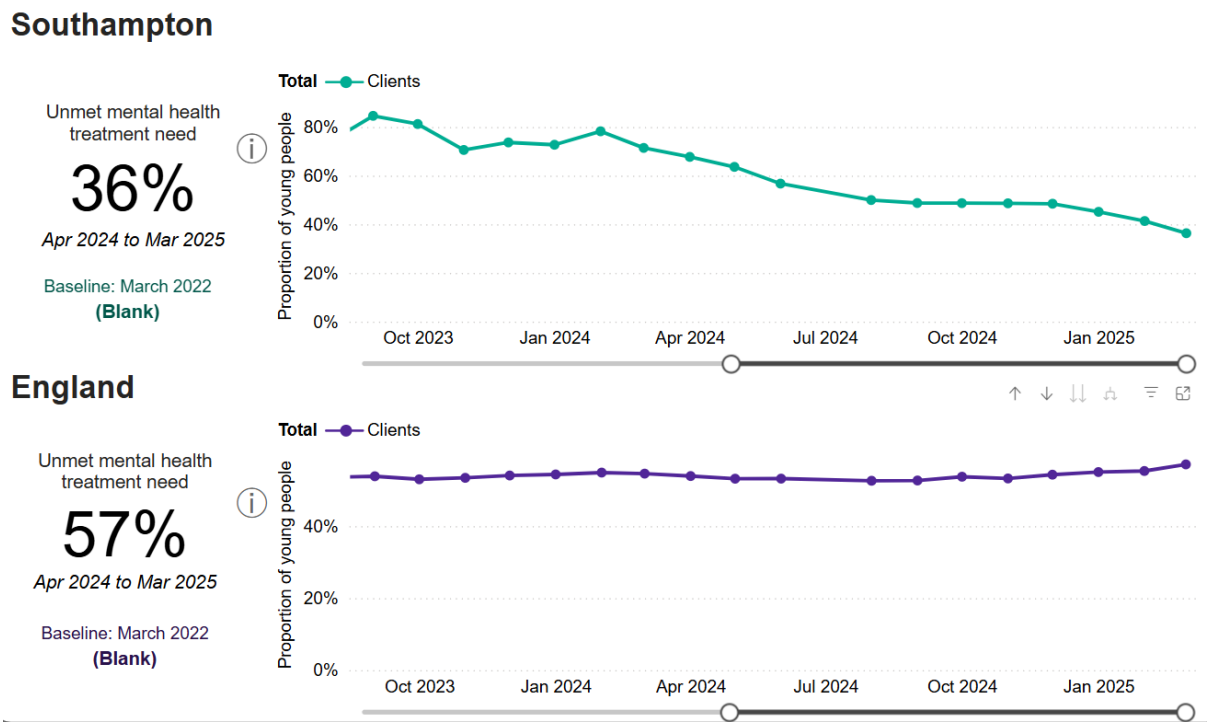
Mental Health

The intersection and collaboration between specialist mental health services and young person's provision are critical for addressing the complex needs of young people. Public Health England (25) estimates that around 70% of people in community drug and alcohol treatment services have co-occurring mental health problems. These dual challenges exacerbate one another, create barriers to progress, increase the risk of harm, and strain current health and social care systems. Joint working is therefore essential to provide holistic, person-centred care that addresses the full spectrum of needs.

Some additional health investment in 2023 was intended to provide an additional treatment capacity within CAMHS services nationally. It is unclear what difference this has made locally.

UK evidence highlights the benefits of integrated and collaborative approaches. Shared care models, where mental health and SUD services work together to develop coordinated care plans, have demonstrated significant improvements in both engagement and outcomes.

Mental health issues among young people in the treatment system are significantly higher than the national average however, access to treatment appears to be challenging. Among new entrants to the treatment system, 37% have unmet mental health needs, compared with a national average of 27%. Of those who have mental health needs, 36% do not get any mental health treatment while in substance use services and this rises to 100% for the two under 18's who completed treatment. However, as can be seen in the below graph there has been significant progress with mental health treatment over the past 2 years and, while 36% untreated is a worrying figure, it is better than the England average of 57%.



Source: DOMES - accessed May 2025

The treatment gap suggests that not only is need greater in Southampton, but that current pathways are not fully responding. DASH Referral data underscores this concern: over two years, only six referrals were made to DASH from CAMHS and ten from Community Mental Health Teams (CMHT), pointing to under-engagement between specialist mental health services and the substance use treatment system.

Furthermore, only 13.4% of younger adults in treatment received support from specialist mental health services, compared with a national average of 17.5%. This highlights a critical system gap. The current configuration leaves many young people with overlapping needs without access. There are clear opportunities to strengthen joint working - including the development of co-located services, shared assessments, and integrated care pathways - to ensure that young people experiencing both substance use, and mental health difficulties receive timely and coordinated care. Strengthening the interface between these two sectors should be a priority for commissioners and strategic partners alike

In the Southampton system, as elsewhere, there is a challenge with securing mental health services for younger people. Almost all contributors to this needs assessment had concerns about access to and capacity within mental health services to meet the needs of the local population. Long waiting times for assessment and additional waits for interventions characterise people's experiences of the CAMHS and CMHT services. It was also noted by different contributors that where specialist Mental Health posts have been created in multi-

agency teams to support initiatives like Family Safeguarding Teams that they have been unable to recruit to the vacancies. HIOW foundation trust (who also provide the CAMHS service) was unable to provide a stakeholder in time to contribute to this report so we cannot accurately capture their response or plans to rectify things.

Children's Social Care, parenting, and safeguarding.

The intersection between drug and alcohol use and children's social care is vital in addressing the complex challenges faced by families affected by substance use. Parental drug and alcohol use is a significant factor in children's social care (CSC) cases, which can contribute to neglect, abuse, and family breakdown. According to the Children's Commissioner, nationally around one in three children referred to Children's services live in households where problematic drug or alcohol use is present. (25) Research shows that problematic alcohol and drug use can reduce parenting capacity and is a major factor in cases of child maltreatment. In 2019/20, the Department for Education found that parents using drugs was a factor in around 17% of 'child in need' cases, with parental alcohol use a factor in 16%. (26)

Early Help and family support is provided through the Children's Resources Service (CRS) that operates from family hubs. The vision for this service was described as one where the service could respond to those presenting for help appropriately without the need for onward referrals to specialist workers. The service lead described a distant relationship with the young people's SUDS service provider and would welcome greater resource being available within the service to be able to support earlier interventions with families.

UK evidence demonstrates the effectiveness of integrated approaches in improving outcomes for families affected by substance use. Programmes like **Family Drug and Alcohol Courts (FDACs)** have shown how multi-agency collaboration can provide tailored, intensive support that keeps families together, while safeguarding children. The FDAC in Southampton has operated for over 10 years and is felt by contributors to be performing well. Numbers of active cases have reduced since peaking in the years following the Covid-19 pandemic. Impressively 63% of families worked with under the FDAC model stay intact.

A new approach to **Family Safeguarding Teams** has been implemented in CSC in Southampton in 2024, with SUD workers embedded within the teams. This is taking time to gain momentum as the service sought to recruit appropriately qualified and experienced staff into roles. This service when fully operational will include embedded alcohol and drug practitioners, mental health support workers and domestic abuse staff. The team is set up to work with those families subject to formal child protection processes as well as those assessed as having high needs as children in need.

Representatives from several VCSE organisations expressed the view that embedding family support and early help provision under Children's Social Care served to deter some people from seeking help through fear (real or imagined) that they would be drawn into child protection processes.

DASH has seconded workers into the CSC via the young people's hub at the Civic Centre. There is significant joint working and clear benefit from this arrangement with 15 young people aged 11-17 per quarter receiving joint support from DASH and the Young People's Hub, 84 team round the family meetings attended and over 100 alcohol and drug support interventions provided on site ensuring sessions are delivered within environments where the young people are already engaged to minimise drop-out rates.

Co-location of DASH workers with Children's Services	Number of young people aged 11-17 receiving joint support from DASH & Young People's Hub	15	17	12	14
	Number of referrals received from co-location work	8	10	13	15
	Number of contacts made due to co-location work	35	28	32	33
	Number of interventions provided from co-location work	24	17	27	21
	Number of consultations with Youth Hub staff	34	43	52	37
	Number of Team Around the Family meetings attended	34	36	4	10

Source: Provider data

Children's Social Care in common with both England and Statistical Neighbours appears to be good at identifying "children in need" with drug issues (with 171 or 6.1% of all concerns identified in 2024) but less so with alcohol issues (only 49 or 1.8%). There also appears to be an ongoing (if improving) issue with identifying need with looked after children where only 13 out of 389 (3.3%) % of children are identified with concerns around alcohol or drug use.

	% of episodes with Alcohol Misuse child	% of episodes with Drug Misuse child
England	2.1%	5.0%
Stat Neighbour Average	1.8%	4.9%
Southampton	1.8%	6.1%
Portsmouth	0.8%	2.6%
Sheffield	1.6%	4.3%
Peterborough	2.0%	3.9%
Plymouth	2.1%	6.9%
Derby	0.8%	2.9%
Bristol, City of	2.5%	6.8%
Coventry	2.6%	5.8%
Stoke-on-Trent	2.8%	5.7%
Kingston upon Hull, City of	1.7%	4.2%
Salford	1.3%	5.9%

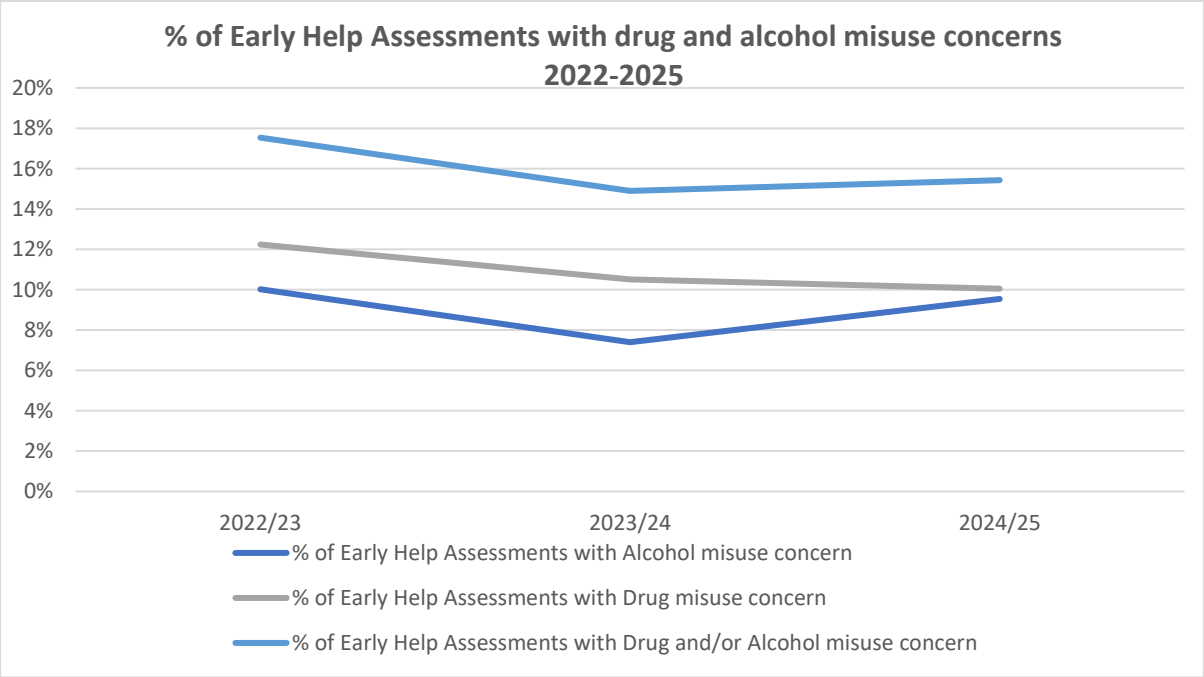
Source: CSC Data

However, when it comes to what children identified with substance use related needs receive in terms of service it appears as if over the past 5 years fewer children get CSC provision and there has been a significant drop off in Early Help provision (from 29% to 2%).

% of Assessments with Drug and/or Alcohol misuse concern that was followed by Early Help Assessment	22%	29%	18%	13%	7%	3%
% of Assessments with Drug and/or Alcohol misuse concern that was followed by CIN Plan	51%	52%	54%	68%	60%	51%
% of Assessments with Drug and/or Alcohol misuse concern that was followed by CP Plan	29%	32%	36%	29%	24%	25%

Source: CSC Data

Within Early Help assessments, 10% of cases have an alcohol concern and another 10% a drug concern which represents a largely steady state over the last 3 years.



Source: CSC Data

This activity seems to result in both **High Referrals & High Attrition into treatment.** According to DASH data CSC referrals into the young people's treatment system are comparatively high (n=71), but 55% do not progress to structured treatment (n=39 lost). This represents one of the largest single sources of dropout in the system and may reflect both practice challenges and young people's ambivalence or readiness.

Schools

Schools have an integral role in providing age-appropriate alcohol and drug education as part of their PHSE curriculum. There is no collective view on the content, rather each school can take their own approach. This also applies when looking at exclusion / inclusion policies and how they respond to alcohol and drug use when it becomes apparent.

DASH are contracted to deliver specialist training to staff in schools, but this activity fell away in 2024 and is only now back up and running. The provider reported that many schools have shown little interest or want much shorter pieces of training which was felt to be counterproductive if the aim of the training is to encourage schools to take a whole school approach. There is a renewed effort to arrange more training in the next academic year.

15 schools per annum offered specialist staff training	100%	100%	100%	100%	100%
Percentage of schools receiving specialist staff training	50%	0%	0%	7%	14%
15 schools per annum offered targeted student groups	100%	6.5%	13%	20%	20%
10 targeted student groups delivered per annum	100%	0%	0%	10%	0%

Source: Provider Data

The number of young people that DASH worked with in schools is starting to increase after a hiatus.

Schools Work this quarter	Number of students engaged through schools work	0	0	28	6
	Number of conversations with students through schools work	0	0	168	11
	Number of conversations with staff through schools work	0	0	12	41
	Number of students on School Worker caseload(s)	0	0	N/A	N/A

Source: Provider Data

In addition to the PHSE delivery, specialist alcohol and drug education is available through a contract with DASH/No Limits, and this is further supported by their counselling and health and wellbeing practitioners that operate in local schools. In terms of outcomes, we know that some 67 pupils have been referred into the treatment system from local schools in the last 2 years with 20 turning up in treatment representing a 65% attrition rate.

Housing and Homelessness

Partnership work between local authority (LA) housing departments, registered social landlords (RSLs), and both statutory and voluntary, community, and social enterprise (VCSE) homelessness services is critical in supporting individuals with problems relating to the alcohol or drug use.

Despite a steep decline, Southampton has significantly more social housing than the national average (23% vs 16%). Of the 108,518 dwellings in Southampton, 16,381 (15.1%) dwellings were owned by the Local Authority (Local Authority Housing Statistics, 2021/22). A further 7,901 (7.3%) dwellings were owned by housing associations in Southampton.

According to the 2023 Homelessness assessment of need (27) among those assessed as homeless or threatened with homelessness, Southampton had one of the highest percentages of households with additional support needs (1,229, 76.6%) (out of those households for which a duty of prevention or relief of homelessness was accepted) in 2021/22 highlighting the complexity of Southampton's homeless cohort.

The top five support needs were a history of mental health problems (21.4% of needs), a history of repeat homelessness (12.5% of needs), drug dependency needs (11.8%), having a history of offending (11.1%) and having physically ill health or a disability (9.5%).

Similarly housing need on the drug and alcohol treatment caseload is high (19% vs 14% National Average) and particularly high for younger people (29%.) However, housing need on completion is exceptionally low, indicating that the treatment system acts to stabilise housing needs. (3%)

Housing & Homelessness Pathways

- **Housing Need and Treatment Interface:**
  Housing need is high among young people in treatment with DASH – In 2024/25 29% of under-25s report housing instability at entry, compared to 14% nationally. However, by the time of treatment exit, only 3% still report housing need, suggesting strong in-treatment housing support. Referrals to treatment from supported housing providers into treatment are reasonably strong (n=28), with 50% attrition.

- **Social Housing Landscape:**
  The prevalence of substance use within tenants of social housing, the private rented sector (PRS), or housing-related support services (HRS) is not fully understood. This presents a data gap that, if addressed, could improve early identification and engagement.

- **Homelessness Pathways:**
  Pathways between homelessness services and treatment appear to function well. There is dedicated outreach, health input, and accommodation available. Rates of "no fixed abode" status decrease once individuals enter treatment. However, consistent homelessness data across the under-25 cohort is not currently available and should be prioritised.

Contributors talked positively of the success of housing related interventions for children in the city. Reporting that there were no incidents of under 18-year-olds being found statutorily homeless in the last two years and as a result YMCA acceptance criteria now being amended accordingly so that they no longer accept under-18-year-olds.

Conversely, we heard from providers of services to people experiencing homelessness who described what they felt were disproportionate numbers of young adults being accommodated within their hostel provision because of eviction from their previous lodgings. It was felt that closer communication between accommodation providers and floating support could help reduce this.

Adult Social Care

Adult social care plays a vital role in addressing vulnerabilities that contribute to and are worsened by substance use, supporting individuals across a wide range of needs in the UK. Many younger people engaging with adult social care are at greater risk of isolation, financial instability, and safeguarding concerns, increasing their susceptibility to substance use.

The complexity of needs among those younger adults (18-24) supported by adult social care highlights the importance of coordinated and trauma-informed approaches. For instance, younger adults experiencing homelessness often require access to housing, substance use treatment, and social care to address overlapping issues.

In Southampton, the relationship between adult social care (ASC) and drug and alcohol treatment services is still evolving, with notable strengths and areas for growth. Positively, initiatives such as the Family Drug and Alcohol Court (FDAC) have demonstrated a proactive approach to addressing substance use within family contexts, offering structured and therapeutic interventions that can help prevent family breakdown. ASC staff are reported to have a good level of awareness of substance use issues, facilitating referrals and contributing to a growing understanding of how these needs intersect with safeguarding and care responsibilities.

However, challenges remain that impact the potential of this partnership for younger people. Referral rates between ASC and treatment services are low in both directions, suggesting missed opportunities for earlier intervention and holistic care planning. We were unable to secure information about substance use from ASC but there were only 11 referrals from ASC to DASH in 2023/24 & 2024/25 and only 3 of these started treatment – a 73% attrition rate.

Community Engagement

Engaging with local communities in their entirety is critical for young person's services and commissioners to ensure that services are accessible, culturally appropriate, and reflective of local needs. Communities directly experience the effects of alcohol and drug use, and their insights can help shape responsive and

effective services. Local communities and voluntary, community, and social enterprise (VCSE) groups often have unique insights into the barriers faced by individuals struggling with substance use, including stigma, lack of awareness, and systemic inequities. Research by Public Health England (28) highlights that community involvement improves service design and uptake by fostering trust and enhancing awareness of available support. Engaging communities can also help address health inequalities by ensuring that marginalised or underserved groups are included in service

Community Engagement and Representation: A System with Contradictions

Southampton's young people's substance use service operates within a broader organisation No Limits that is widely recognised for its **strong community engagement credentials**. No Limits has well-established links across a wide range of neighbourhoods, cultural communities, and grassroots groups. It is often described as a trusted local partner, particularly by those working in areas of youth work, safeguarding, and housing. This organisational ethos of inclusivity and visibility sets a strong platform for engaging young people in need of substance use support.

DASH itself takes this commitment seriously. It undertakes regular **detached outreach**, is visible in schools and youth hubs, and works closely with the city's **contextual safeguarding team** to identify and support young people who may be at risk due to their environments, peers, or exploitation. There is strong anecdotal evidence of good-quality engagement work with individuals and families, including those who are not already in the statutory system. Stakeholders consistently report that the team is **welcoming, approachable, and inclusive** in its practice. The staff team in DASH also appears to be more reflective of the communities in Southampton.

However, despite these strengths in outreach and ethos, the treatment system does not appear to **translate its community-facing activity into a representative caseload in terms of race or ethnicity**. Data for 2024/25 shows that only 10% of new treatment starts came from Global Majority communities, compared with a city population where 19.3% of 18–24-year-olds belong to those communities. This underrepresentation is especially noticeable among Black and Asian young people. The service's offer may be broadly inclusive in intention and delivery - but this is not yet reflected in who accesses structured support.

There are several explanations for this gap. One may be that **community engagement and treatment access are being handled by different parts of the organisation**, with too little crossover or referral. Another possibility is that there is a **disconnect between early relationship-building and actual entry into structured treatment**.

Another significant factor may be the system's current orientation toward **community safety, rather than community development**. Stakeholder feedback suggests that local approaches to young people's substance use often default to risk management, compliance, and enforcement, rather than seeing communities as partners in prevention, education, and support. This framing may alienate young people from some backgrounds who already experience over-surveillance or feel mistrustful of formal systems.

The challenge going forward is not only to improve representation numerically, but to create a **more culturally intelligent and community-embedded system** where trust leads to access, and access leads to sustained support. This may involve building peer-led referral networks, investing in culturally responsive outreach roles, or shifting some provision into neighbourhood settings. The building blocks are clearly there - but further work is needed to close the gap between engagement activity and actual inclusion in structured treatment.

NDTMS – 2024/25 YP in treatment by ethnicity

Ethnicity	In treatment
White British	129
White Irish	1
Other White	7
White and Black Caribbean	2
White and Black African	1
White and Asian	3
Other mixed	5
Indian	1
Pakistani	1
Bangladeshi	0
Other Asian	1
Caribbean	1
African	2
Other Black	2
Chinese	0
Other ethnicity	1
White Gypsy or Roma or Traveller or Irish Traveller	0
Unknown ethnicity	1
White (Inconsistent)	0

Opportunities for Improvement - Despite these disparities, treatment outcomes for individuals who do engage with services are positive, suggesting the potential for the system to deliver equitable care, if engagement and co-design is embraced and strengthened. Stakeholders we engaged with had a deep understanding of some of the barriers for certain communities, which will require investment, tenacity, and creativity to overcome.

To address these gaps, there is a need for a more strategic and inclusive approach to community engagement that prioritises representation and cultural competency. Strengthening partnerships with VCSE groups, particularly those embedded within underrepresented communities, could help improve outreach and

build trust. Additionally, the local authority engagement should broaden their focus beyond community safety to include community development, ensuring that all voices are reflected in service design and delivery.

7 Conclusions

A good system in need of revitalisation

The young people's substance use system in Southampton has many strong foundations on which to build. Services are well embedded in key parts of the youth landscape and are viewed positively by both young people and professionals. It is supported by an experienced and well-regarded parent organisation with community ties, a relational ethos, and a history of effective partnership working. The city benefits from a dedicated workforce that brings a clear commitment to harm reduction, youth work values, and the safety and wellbeing of young people.

There are also areas of measurable success. Treatment numbers for young adults are good, retention rates are strong, waiting times are low, and harm reduction outcomes - such as reductions in using substances alone - suggest that the interventions offered are making a meaningful difference. The service performs particularly well in engaging young adult females, who are often underrepresented nationally. Partnership links with teams such as youth offending, contextual safeguarding, CAMHS, supported housing, and some parts of children's services show that multi-agency working is happening and has the potential to be deepened and expanded.

Perhaps most importantly, there is a clear appetite across the system for learning, adaptation, and improvement. Stakeholders express a shared understanding of the complexity of young people's needs and the importance of a flexible, inclusive, and community-connected response. There is no shortage of commitment or care - rather, the task ahead is to ensure that these strengths are harnessed more systematically, so that every young person in Southampton who needs support with drugs or alcohol can access the right help, in the right way, at the right time.

An Over-Reliance on High-Risk Identification Pathways

There is no doubt that the city is effective at identifying young people already at high levels of risk. Systems such as Multi-Agency Safeguarding Hubs (MASH), the Youth Justice (YJS) are working hard to respond to serious harm, often in difficult circumstances. However, these pathways are designed for those who pose either a risk to others or are already deeply vulnerable.

It was also observed by several contributors that the system as currently configured does not meet the needs of those with the most complex and compounding needs. Office based drop-in activity and outreach provision was seen as insufficient for this cohort of young people who needed a much more focused relational intervention and a genuine coordinated multi-agency approach to their engagement and support.

There is **limited infrastructure to support those young people who do not yet meet high risk or safeguarding thresholds**, but who may be showing escalating indicators of substance use, disengagement, or emotional distress.

Missing CYP in treatment This group-the "missing middle"-is critically underserved. They may be absent from school, exposed to family breakdown, or experiencing hidden harm. However, they are not currently triggering statutory responses and therefore fall outside the radar of local authority children's services, which have increasingly narrowed their focus to only those meeting statutory thresholds for intervention.

Systemic attrition in the referral processes

One of the most visible challenges in Southampton's young people's substance use system is the **high level of attrition between referral and treatment start**. Over the past two years, 733 young people were referred into the service, but only 287 went on to start structured treatment - a drop-off rate of nearly 61%. This represents a sizeable number of potentially disengaged or unsupported young people and raises important questions about system function. Attrition rates vary depending on the referring agency, with particularly high losses from social care and criminal justice referrals, despite many of these young people being identified as having clear substance-related needs.

The scale and consistency of this attrition suggests that the issue is not isolated to one service or group but rather points to **system-wide barriers** in communication, identification, and perceived relevance of the treatment offer. It is unclear whether young people are choosing not to engage, not being followed up adequately, or simply not understanding what is being offered, or that the services provided are not perceived as meeting their needs. In some cases, the threshold for structured treatment may not align with the young person's level of need or readiness to engage. In others, the referral process may lack clarity or continuity, resulting in drop-off before contact is even made. These patterns suggest a need for more relational, flexible, and responsive early engagement - and for greater shared system across agencies for ensuring that referral leads to support. (see below on YP screening tools). Including processes that are accessible to those young people who may be neuro atypical or who may have low literacy levels.

A System Struggling with Prevention

This review has found that disinvestment in universal and preventative services for young people has weakened the city's capacity to intervene early in the lives of those at risk of substance use and associated harms. Over the past decade, the erosion of youth services, targeted educational support, and community-based provision has created a gap between need and response. Once a source of trusted relationships, informal safeguarding, and positive alternatives to risk-taking behaviour, these universal services have been hollowed out by successive rounds of budget constraints and policy redirection. As a result, the system has become more **reactive than preventative**, catching young people only once risk has escalated. As one VCSE chief executive said, "I long for a day when the needs and hopes of children and young people become central to our planning".

A System Not Led by Young People's Needs

What emerges from this review is that the current system is not organised around the needs of young people themselves. Rather, it reflects the legacy of service eligibility criteria, fragmented commissioning, and risk-driven thresholds. There is **no clearly mapped local offer for early support for young people with emerging needs**, nor a citywide framework to ensure that every child can access developmentally appropriate, culturally relevant, and timely substance use support. While there is evidence of strong intent and committed practice in some parts of the system, the architecture to support a **needs-led, equitable response** is lacking. It was commented by one senior contributor to this report that "it is clear that no-one really has overall responsibility for our young people in their entirety" which has contributed to a fragmented approach to commissioning and provision.

Challenges with Community Engagement and Cultural Relevance

One of the most striking findings is the lack of consistent engagement with the city's diverse communities. There is a **significant knowledge gap** about how substance use manifests across different ethnic, faith, and cultural groups, and very few mechanisms exist to understand lived experiences from within those communities. Language barriers, distrust of statutory services, and lack of culturally competent provision may have contributed to this gap.

In turn, this has resulted in the **under-representation of Black, Asian, and other minority ethnic young people in support services** relative to known vulnerabilities. Community leaders report that families often do not know where to turn, or fear judgement or repercussions if they seek help. Without a concerted, long-term approach to building trust and co-producing solutions with communities, this pattern will continue.

Under-Leveraged Role of the VCSE Sector

The Voluntary, Community and Social Enterprise (VCSE) sector remains a **critical but underutilised asset** in this landscape. Many VCSE organisations-particularly those rooted in minoritised or hard-to-reach communities-hold relationships, trust, and local knowledge that statutory services cannot replicate. However, their role in the current system is often marginal. They are rarely involved in service design, receive limited and insecure funding, and are not sufficiently represented in strategic decision-making forums.

Repositioning the VCSE sector and Young Southampton (an established coalition of providers working with young people in the city) as a **core delivery partner** will be essential to any future system change. This includes not only investing in

community-led services, but also equipping and resourcing organisations to deliver early help, facilitate engagement, and contribute to workforce development.

A lack of commissioning capacity has left an impact

As in many areas the attention of commissioning and public health teams has been focused upon the adult population when it has come to drug and alcohol treatment. This tends to be where the volume of activity is undertaken, investment made and where the significant levels of substance related harm and death reside.

Several of the grants and funding streams are often distributed to a Local Authority level with grants and conditions attached that reflect a focus on adult provision and drug related harms.

The system has sometimes had a narrow focus on young people in terms of risk of exploitation through county lines or as perpetrators of anti-social behaviour.

Different contributors when describing local approaches to commissioning of SUDS services for young people described a 'lack of grip' and losing sight 'of what outcomes we should and could expect' alongside a belief that insufficient investment is made in young(er) people's treatment activity. We note however that approximately 25% of the treatment allocations within Southampton are directed at those under the age of 25 which seems proportionate.

It is also the case that there have been several changes within the commissioning team overseeing all SUDS delivery which may in part account for some of this drift.

Responsiveness to change.

The city as we have shown is relatively young and diverse. The profile of residents is changing – and changing more quickly than comparable areas. The system therefore needs to remain alert and agile in responding to these changes and emerging patterns of substance use. Funding for treatment provision and therefore many of the services provided have traditionally been targeted at opiate use and its associated harms. More creative and appropriate responses are needed for those young people using ketamine, vapes or alcohol at high risk levels for example. It is welcome that DASH staff have been trained to deliver brief smoking cessation interventions for young people.

Lastly

Meeting the needs of young people affected by drug and alcohol use is not the job of a single service - it is a collective responsibility that sits across the whole system. The partnership in Southampton has the people, the relationships, and the foundations to deliver something genuinely impactful. The challenge now is for partners to close the gaps, align efforts, and reimagine what support can look like

- not just when crisis hits, but earlier, smarter, and more equitably. By working together with openness, ambition, and trust, partners can work collaboratively to create a system that young people recognise, access, and value - one that not only responds to potential harm but creates the conditions for thriving.

Appendix 1.

Screening and Assessment of Young People's Substance Use

Screening and assessment are essential first steps in understanding and responding to young people's substance use. Unlike adult users, adolescents are often in the early stages of risky experimentation, and their substance use is frequently linked to wider vulnerabilities such as trauma, exclusion, or exploitation. As such, tools must be developmentally appropriate, trauma-informed, and usable in non-clinical environments. Evidence supports the use of brief screening instruments such as the **CRAFFT tool**, which is widely used internationally and has been successfully piloted in youth work settings in the UK [1]. NICE recommends that screening should be embedded in universal and targeted youth services and that it must be followed by a psychosocial assessment if risk is identified [2].

While tools like **AUDIT-C** and **ASSIST** have been adapted for use with adolescents, they are more commonly used in healthcare settings and may not capture the relational and contextual drivers of youth substance use [3]. In contrast, comprehensive tools like the **Drug Use Screening Inventory (DUSI-R)** and **SASSI-A2** offer more in-depth assessment but are typically reserved for specialist services due to their length and complexity. Generic assessments like the Early Help Framework (formerly CAF) can provide contextual information but are not validated for substance-specific identification [4] so we should not rely solely on these general frameworks when trying to detect substance-related risk.

The most effective systems use **a layered approach**-starting with validated brief screening in trusted environments (schools, youth clubs, outreach), followed by holistic assessments when indicated. Importantly, the quality of engagement and the skill of the practitioner are as vital as the tool itself. National and international guidance stresses that assessments should not be a "tick-box" exercise but a **conversational gateway** into understanding the young person's wider needs [5]. Frontline staff should be confident in using validated tools,

trained in youth-friendly communication, and supported to make appropriate referrals based on screening outcomes.

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Appendix 3 – List of stakeholders

Nicola Herod	Consultant Psychiatrist	Change Grow Live
Donna Martin	Registered Services Manager	Change Grow Live
Rhona Hawkins	CEO & Service Manager	Parent Support Link
Tim Nelson	Head of Young People's Services	Southampton City Council
Paul White	Data and Digital Lead	Southampton City Council
Rebecca Holdsworth	Safeguarding Partnership Team Manager SSCP & SSAB	Southampton City Council
Matthew Andrews	Lead Commissioner	Southampton City Council
Neil Poulton	Young Peoples Practitioner.	Southampton City Council
Anna Harbridge	Head of YJS	Youth Justice Service
Jemma Thomas	YJS data lead	Youth Justice Service

Jacqui Markie	Head of Southampton Eastleigh and New Forest Probation Delivery Unit	Probation
Dan Rogers	Project Manager	DASH/No Limits
Alan Haysom	Data and Digital Lead	DASH/No Limits
James McCombe	Service Manager	DASH/No Limits
Kate Anderson	Strategic Data Analyst - Public Health	Southampton City Council
Andrea Thwaites	Family Nurse supervisor	Family Nurse Partnerships
BennJoseph Vaugan	National Domestic Abuse lead	Change Grow Live
Colin McAllister	Senior Public Health Practitioner	Southampton City Council
Francesca Prior	Community Cohesion and Engagement Manager	Southampton city Council
Robert Henderson	Executive Director Community Wellbeing, Children and Learning	Southampton City Council

Clodagh Freeston	Head of Education Services	Southampton City Council
Matt Jenkins	Head of Family Safeguarding	Southampton City Council
Gary Spencer-Humphrey	Service Manager Mental Health, Forensics and AMHP Lead	Southampton City Council
Dan Clark	Service Manager - Family Safeguarding Central and Specialist Services	Southampton City Council
Kasia Tylmanowska	Regional Data Business Partner	Change Grow Live
Natalie Bates-Siney	Southampton data manager	Change Grow Live
Debbie Chase	Director of Public Health	Southampton City Council
Kristy Dixon	CRS Manager, Children's Resource Service, Children's Social Care	Southampton City Council
Dan Buckle	Head of Family Help, Children's Social Care	Southampton City Council

Natlie Webb	CEO	No Limits
Chris Douglas	Detective Chief Inspector	Hampshire Constabulary
Paula Johnstone	Head of Service (Adult Social Care)	Southampton City Council
Hannah Balzaretti	Head of Service (Learning disability/neurodiversity/provider services)	Southampton City Council