NHS

National Treatment Agency for Substance Misuse

Young people's substance misuse treatment services – essential elements

June 2005

National Treatment Agency

More treatment, better treatment, fairer treatment

The National Treatment Agency (NTA) is a special health authority, created by the Government in April 2001, with a remit to increase the availability, capacity and effectiveness of treatment for drug misuse in England. The overall purpose of the NTA is to: double the number of people in effective, well-managed treatment from 100,000 in 1998 to 200,000 in 2008; and to increase the proportion of people completing or appropriately continuing treatment, year on year. This is in line with UK drug strategy targets.

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1 Introduction

In March 2005, the Department for Education and Skills and the Home Office published a joint strategy, supported by the Department of Health, linking *Every child matters* and the National Drug Strategy for Young People (DFES 2005).

The joint strategy identifies a joint approach to the development of universal, targeted and specialist services, to prevent drug harm and to ensure that all children and young people are able to reach their potential. The approach has three main objectives:

- Reforming delivery and strengthening accountability. Closer links between the National Drug Strategy and *Every child matters*. Implementing the *Change for Children* programme locally, regionally and nationally
- Ensuring provision is built around the needs of vulnerable children and young people. More focus on prevention and early intervention with those most at risk, with drug misuse considered as part of assessments, care planning and intervention by all agencies providing services for children, including schools
- Building service and workforce capacity. Developing a range of universal, targeted and specialist provision to meet local needs and ensure delivery of workforce training to support it.

Within this approach, specialist drug services will play a vital role where children and young people have developed substance misuse problems.

This document has been developed to facilitate the commissioning and development of substance misuse treatment services for children and young people in line with this joint strategy. In addition to the strategy, this document is part of a range of products being developed to aid the commissioning of young people's substance misuse services:

- the Drug Strategy Directorate has produced a practical electronic commissioning toolkit which will be available on www.drugs.gov.uk
- the Drug Strategy Directorate is also producing guidance on the partnership grant, changes in children's service commissioning and commissioning in relation to the performance management framework
- the NTA is producing models of integrated care pathways that could result in referrals to the young peoples treatment system. This is due in June 2005
- this guidance produced by the NTA concentrates on the types and standards of services that should be available within the young people's substance misuse treatment system.

Audiences
The audiences for this *Essential elements* guide are:

- young people's substance misuse service commissioners, co-ordinators and joint commissioning groups
- drug action team (DAT) co-ordinators
- children and young people's strategic partnerships.

Young people's substance misuse treatment providers may also find it useful.

Why was this guidance developed?
The guidance has been developed in response to a number of factors which will influence the development of young people's substance misuse treatment services. These include:

- the introduction of new key performance indicators

- the implications of both the new joint policy and other DFES publications arising from *Every child matters*
- the NTA's role in:
  - increasing the number of treatment services
  - improving access to treatment services
  - improving the quality of the treatment services
- The young people's substance misuse partnership grant.

The young people's substance misuse partnership grant, which has pooled existing resources, allows more creative development of services that can react to local needs. The context of developing substance misuse treatment services for young people is rich and evolving. It is not an exercise that can be conducted in isolation from other changes in children's services.

Every child matters: the next steps (2004) and the Children Act 2004 set out a range of proposals that will strengthen children's services and improve accountability. The basis of the proposals are the five outcomes which the Government wants to see for children and young people. These are:

- being healthy
- staying safe
- enjoying and achieving
- making a positive contribution
- economic wellbeing.

The main components of the Children Act 2004 are:

- a duty on the local authority to co-operate with key partners, to improve integrated planning, commissioning and delivery of children's services
- clearer accountability for local authority children's services, via a director of children's services and a lead council member
- establishing local safeguarding boards to replace non-statutory area child protection committees.

Interim arrangements for commissioning young people's substance misuse services should include the development of a young people's joint commissioning group. This group should be jointly accountable to the children and young people's strategic partnership and the DAT. However, this will be a transitional process. With the implementation of the Children Act 2004 and the National Service Framework for Children, young people and maternity services and young people's substance misuse commissioning will be firmly located within children's mainstream commissioning arrangements.

The joint strategic guidance presented new key performance indicators in the drug strategy performance management framework. Those relating to the treatment system were:

Young offenders
To ensure that all young people are screened for substance misuse. Of those screened, ensure that those with identified needs receive appropriate assessment within five working days and, following the assessment, access to early intervention and treatment services within ten working days.

Treatment
To increase the participation of young problem drug users (under 18 years of age) in treatment programmes by 50 per cent, between 2004 and 2008. In order to meet these new KPI's, this document will seek to describe:

- a young people's substance misuse treatment system
- the key features for good integrated service delivery
- the minimum range of service delivery available in every area

A glossary of terms used in the document can be found on page 23.

2 Co-ordinated models of service delivery

Children and young people's strategic partnerships and children's trusts aim to provide co-ordinated care and improve delivery and integration across sectors and agencies. It is vital that the planning and organisation of substance misuse services for children and young people fits into the overall planning and commissioning of children's services and ensures that all four elements of the Health Advisory Service (HAS) (2001) tiers are fully integrated to improve outcomes for children and young people.

However, as the focus of this document is on young people's substance misuse treatment, it is mainly concerned with Tiers 3 and 4, within the integrated system. The following sections describe elements that will be required to develop an integrated care pathway for young people's substance misuse care.

2.1 Care pathways

An integrated care pathway describes the nature and anticipated course of the interventions a young person may need. In many areas of health and social care, an integrated care pathway approach is increasingly used as the preferred methodology to apply packages of care in a co-ordinated and integrated way (NTA, 2002).

Establishing effective care pathways for children and young people, to meet their substance misuse needs, is crucial to effective service delivery. The Health Advisory Service reports (1996, 2001) described this integrated care in four tiers. Building the components of each of these tiers locally is vital. Services or tiers must not operate independently, as the basis of the model is integration. A clear pathway should be formed to help care co-ordinators negotiate intervention paths for children and young people with substance misuse needs.

The HAS (2001) four tier infrastructure and proposals in this document apply to all substances, namely illicit drugs, alcohol and volatile substances. In addition, the NTA is developing an integrated care pathway for young people with primary alcohol problems, which will include children and young people under 18-years-old. Alcohol continues to be the most prevalent substance used by young people aged under 18 (The ESPAD Report 2003).

As such it is important that opportunities are developed for brief interventions in mainstream children's services.

2.2 Identifying substance misuse need and referral

A vital component of young people's substance misuse treatment services is their referral process. In addition to self or parental referral procedures, mainstream children and young people's services are encouraged to develop their competence in identifying substance misuse needs and their ability to make appropriate referrals. Children's practitioners will be supported in this via the development of the *Every child matters* children's workforce strategy and the development of common core competencies, which will include elements relating to identifying substance misuse needs. For further information identification and referral, see *First Steps in identifying young people's substance related needs*, Britton and Noor (2003).

We know that historically, children and young people have been let down by poor co-ordination of service provision and isolated interventions being provided to children who are highly vulnerable with complex needs. The forthcoming common assessment framework seeks to rectify this situation. It will:

- identify needs early
- avoid duplication among agencies
- refer young people to appropriate help
- establish a lead professional who is accountable for service delivery.

All services working with children and young people will be expected to use this framework in the future. In line with the joint guidance, it is expected that substance misuse will be an integral part of this framework.

Developing competence in mainstream services to identify substance misuse needs should ensure that information is passed at referral stage to facilitate basic decision-making. This may include severity of risk in relation to substance misuse, numbers of additional risk factors and identification of protective factors. This information can be used to make informed decisions in relation to urgency and type of service provision required. A sophisticated referral process facilitates efficient use of resources and planning of new services.

Service level agreements with substance misuse treatment providers should identify the criteria for referral. This is vital not only for establishing which needs require specialist care, but for distinguishing between young people's substance misuse services in areas where there is more than one service. Where children and young people are referred to specialist substance misuse services, the mainstream children's services should remain in contact with and – in most cases, in line with *Every child matters* – should co-ordinate care management and act as lead professional.

All local authority/DAT areas should have a common substance misuse assessment tool for the use of staff in universal and targeted services. This tool should be supported by multi-agency and multidisciplinary training, focusing on the use of the training tool and the identification of appropriate referral pathways.

2.3 Information sharing

Many areas will have begun to look at information sharing systems, which will affect service provision, procedures and policies. Important changes are likely in relation to co-operation and information sharing between services, to ensure a child or young person's wellbeing. Substance misuse treatment services and commissioners should be aware of these local initiatives and ensure that substance misuse is included in strategic planning in this area.

2.4 Assessment

Following referral it is essential that the referring agency continues to support the young person. We know that having a consistent adult who cares about a young person is a strong protective factor for reducing vulnerability in young people. The referral agency may be a mainstream children's service or a primary healthcare service, which has built up a detailed picture of the child or young person over a period of time and will continue to be involved following a substance misuse intervention. Capitalising on existing relationships, understanding the young person and continuing interpersonal relationships will strengthen care pathways and tailoring of services to meet a young person's needs.

When a child or young person has been identified with a substance-related need, it is important that a comprehensive assessment of those (and their other) needs takes place:

- holistic assessment should be based on the common assessment framework, currently in development
- joint assessment and a joint care plan will be needed when more than one professional or agency is involved to meet the child or young person's identified needs
- *Assessing a young person's drug taking: guidance for drug services* (SCODA, 2000), provides more information about conducting detailed substance misuse-specific assessments.

2.5 Care planning and joint working

Developing joint assessment processes, joint case meetings and multi-agency partnership working can not only help a child or young person adapt to a new professional, but can ensure that all the young person's needs are being considered and met.

Regular meetings to discuss specific cases or challenges facilitate peer support and understanding of another agency's skills and services. In any one area there is a range of statutory and voluntary services, concerned with meeting the needs of children and young people. Substance misuse services can be isolated, as traditionally their commissioning and planning has taken place outside of children's service planning. Together with better strategic co-ordination between young people's substance misuse commissioners and children and young people's strategic partnerships, managers and practitioners need to develop systems that facilitate collaborative working practices.

Formal arrangements should be put in place for the management of partnership arrangements and joint working. Relying on close personal relationships is not sufficient and can collapse if personnel changes are made.

2.6 Virtual teams

In some areas, the development of a virtual team is used to provide integrated services to young people. These vary in structure but usually involve the secondment from, or specific funding of posts to non-substance misuse specific adolescent services, in order to build a multi-disciplinary substance misuse team providing services across an area. This can be useful provided that adequate resources, management and joint protocols are put in place. The good points of virtual teams are:

- access to substance misuse services in a mainstream setting
- opportunities to develop the competency of generic children's practitioners in substance misuse
- access to support and function of the mainstream agency for the child or young person to improve integration and co-ordination
- development of close integrated working between disciplines and agencies, which minimises professional rivalry and duplication.

Virtual teams can only exist effectively if:

- there are numerous accessible entry points to the team
- there is a weekly multidisciplinary referral meeting
- a team exists with quick access to medical and other clinical interventions.

2.7 Transitional arrangements

There is a guiding principle for how substance misuse commissioners and providers should consider this issue: services should be provided on the basis of need not on the criterion of age.

Therefore, if a person aged 18 or over has needs that can best be met by a young person's service, then this would be the most appropriate placement, as long as this is not detrimental to the service being offered to other clients. The same would be the case for young people under 18 requiring a service best provided by an adult service. Commissioners should therefore allow flexibility when considering transitional arrangements.

The following points should also be considered:

- The treatment element of the young people's strand of the drug strategy is funded on the basis that early intervention will prevent young people from needing to access adult services

- All young people in substance misuse treatment should have a transitional care plan devised prior to their eighteenth birthday. This should identify ongoing needs and which organisations are best able to meet these needs
- In order to plan transitional arrangements, service providers of adult and young people's substance misuse services should work together
- Transitional workers could be based in adult services, but also hold some sessions in young people's substance misuse services to facilitate transition
- A care co-ordinator should be identified in the care plan. In many cases, a young person of 18 requiring support for their substance misuse may require interventions from mainstream services, such as housing, education and primary care. In these cases, the care co-ordinator could be based in a mainstream service
- Transition to adult services occurs at different age or developmental stages depending on the agency, for example YOTs, Child and Adolescent Mental Health Services (CAMHS), and Looked After Children teams may have different arrangements. Transitional arrangements will need to ensure that these different arrangements are included in the care plan if relevant.

3 Interventions

3.1 The four-tiered framework

The four-tiered model of drug and alcohol interventions outlined in the *Substance of young needs* (HAS, 1996 and 2001) provides a framework to conceptualise the service components of an integrated and comprehensive child-based service. The model should be viewed as a flexible and dynamic strategic approach to commissioning and service provision of substance misuse interventions for children and young people. The following table is a brief description of the four tiers. However, commissioners are advised to familiarise themselves with the original document.

Table 1: HAS (2001) four-tiered framework

Tier 1

The purpose of generic and primary services within this structure is to ensure universal access and continuity of care to all young people. In addition, it aims to identify and screen those with vulnerability to substance misuse and identify those with difficulties in relation to substances. It will be concerned with education improvement, maintenance of health, educational attainment and identification of risks or child protection issues. It will also engage in embedding advice and information concerning substances, within a general health improvement agenda. These should be seen as mainstream services for young people.

Tier 2

Youth orientated services, offered by practitioners with some drug and alcohol experience and youth specialist knowledge, should be working at this level. The aim and purpose of this tier is to be concerned with reduction of risks and vulnerabilities, reintegration and maintenance of young people in mainstream services.

Tier 3

Young people's specialist drug services and other specialised services, which work with complex cases requiring multidisciplinary team-based work, should be working at this level. The aim of Tier 3 services is to deal with complex and often multiple needs of the child or young person and not just with the particular substance problems. Tier 3 services also work towards reintegrating and including the child in their family, community, school or place of work.

Tier 4

Tier 4 services provide very specialist forms of intervention for young drug misusers with complex care needs. It is recognised that, for a very small number of people, there is a need for intensive interventions, which could include short-term substitute prescribing, detoxification and places away from home. Such respite care away from home might be offered in a number of different ways, such as residential units, enhanced fostering, and supported hostels. All professionals working with young people are involved within the tiered model. All have a contribution to make in order to meet the requirements of the National Drug Strategy and key performance indicators set by Government.

Services should be co-ordinated to provide an integrated and comprehensive care plan for the child or young person and his/her family, rather than fitting the child into the model. Tiers 1 and 2 should maintain continuity of care throughout the care planned interventions. The HAS model is intended to support an integrated service system, not a series of compartments. All substance misuse services and interventions for children and young people should also comply with the SCODA/CLC (1999) "ten key policy principles" outlined in the Appendix.

The establishment of the HAS four-tier model is a way of ensuring that services are developed to help meet the substance needs of all young people. Services at Tiers 1 and 2 already exist as they are mainly statutory children's services. However, interventions in these services will need to be developed and extended, to ensure that staff can identify and meet the substance misuse needs of

children they are working with. Every effort should be made to meet children's needs in the lowest possible tier.

Although HAS Tier 3 and 4 services are highly specialised, they can sometimes be developed alongside or as part of existing specialist services for children and young people. That is not to say that distinct services cannot be commissioned but, where this is the case, great care will be required to ensure full co-operation with colleagues from other agencies and disciplines to ensure all the young person's needs are met.

For example, a number of treatment services combine Tiers 2 and 3. This can often be a useful way to build up the infrastructure and ensure the treatment service receives referrals, as well as meeting the young person's substance needs. However, this can sometimes lead to an exclusivity that does not lead to integration with other children's services.

3.2 Key factors in developing young people's services

The previous chapter emphasised that all Tier 1 and 2 services should have clear referral pathways and links with Tiers 3 and 4, including formal arrangements for working together. These processes should be flexible and increase communication and collaboration between different services. Essentially, Tier 3 services should be accessible and appealing to young people with multiple access points, linked with the voluntary sector, outreach teams, youth offending teams, child and adolescent mental health services, health providers, Connexions and education and social services.

In some DAT areas there may be a single service. It is important that young people and professionals can access this through a variety of referral points.

In some cases, Tier 3 substance misuse practitioners may be based for periods of time in Tier 2 settings. These staff should be integrated into the children's service, helping to embed and integrate the assessment and management of substance misuse problems, rather than attempting to identify and address all substance related need.

Children's service practitioners from, for example, social services, Connexions or youth services, should remain as key workers even when a child is referred to a Tier 3 or 4 substance misuse service. This is imperative as substance misuse will only be one of a whole host of needs a young person may have, and children's services have been developed to identify and manage the meeting of all these needs. Staff from mainstream children's services should continue to actively contribute, in a planned way, to the overall management of the young person's needs.

The Children Act 2004 requires each local authority to establish a statutory local safeguarding children board, the purpose of which is to co-ordinate and ensure the effectiveness of local arrangements and services to safeguard children, including services provided by individual agencies. This means that all agencies, including voluntary agencies, have to safeguard and promote the welfare of children.

3.3 Types of substance misuse treatment services to be provided

By 2006, every young person with a substance misuse problem in all areas of the country should be able to access a range of specialist substance misuse treatment services as listed below:

- comprehensive assessment of substance misuse needs within five days, of referral to a specialist agency
- care-planned interventions based on identified needs, including onward referral to Tier 3 and 4 services, within ten days of assessment
- harm reduction services – interventions provided to meet a young person's need to use substances more safely, including but not exclusively safer injecting advice and interventions provided at Tier 3 and 4

- support for family members, with or without the substance misusing young person, within ten days of referral
- psychosocial interventions, structured interventions involving individual or group work focusing on assessment, defined treatment plans and treatment goals with regular reviews
- a community-based pharmacological intervention within ten days of referral. This can be provided by a doctor in a community setting, including a competent general practitioner (GP) in or outside of structured shared care arrangements
- access to specialised inpatient or residential treatment services (this may consist of a range of services or identified provision outside of the local area).

All of these interventions will require consent, either from the person with parental responsibility for the child or young person, or by the young person themselves, provided they are competent. While consent is important for all aspects of treatment, particular caution should be given to the participation of young people in intrusive treatment options. These include prescribing interventions, vaccination, testing for drugs or other conditions, needle exchange, complementary therapies that involve bodily contact and acupuncture (auricular and other forms). For further information on gaining consent and assessing competence to consent when working with children, see *Seeking consent: working with children* (Department of Health, 2001).

3.4 Criminal justice interventions

The NTA and the Youth Justice Board have a joint target, which should be met in all areas:

- all young people in contact with youth offending teams (YOTs) to have their substance misuse needs (if any) identified and those with identified needs should receive appropriate specialist assessment within five working days
- following assessment, access to early intervention and treatment services is required within ten working days.

Within YOTs, the named drug worker should be providing the majority of Tier 3 interventions for young people with identified substance misuse needs. The named drug worker should not, however, be the sole person responsible for Tier 3 interventions. Tier 3 interventions may require a multi-disciplinary approach to meet the needs of the young person, so in this respect the named worker may sometimes take the role of the substance misuse care co-ordinator, as the young person receives a set of interventions to meet a complex range of substance misuse needs.

As the YOT named drug worker role becomes more specialised, the substance misuse competence of all YOT workers will be developed by initiatives from the Youth Justice Board, including new guidance and training programmes. This will result in generic YOT workers being competent to:

- undertake substance misuse assessment as part of the generic assessment process
- provide Tier 1 and 2 interventions
- undertake the care co-ordination role even when there is a substance misuse problem.

In a small number of areas, Drug Intervention Programmes (DIP, formerly known as CJIP) for young people, aged 14 years or over, are being piloted. This will involve the development of arrest referral services for young people or youth support, as it is often called. In some areas, it will also include drug testing on charge and initiatives to promote drug treatment requirements attached to action plans or supervision orders imposed by courts. These initiatives are being piloted and will be evaluated in 2006. The integration of DIP with other local services and the impact DIP may have, on increased demand for substance misuse treatment for young people, will be evaluated. At present, the main increase in demand is expected for social services. Areas not currently included in DIP pilots for young people should monitor developments in this initiative, so that informed planning and service design can be developed if DIP for young people is rolled out nationally.

Guidance has been developed to support the DIP initiatives:

- *Drug testing on charge information for professionals working with young people*
- Home Office (2004) *Drug testing requirements in action plan orders and supervision orders* (Home Office 2004).

Further guidance on the role of the YOT substance misuse worker is being developed in May by the Youth Justice Board and the NTA.

3.5 Needle exchange

All DATs should ensure that harm reduction services are available for young people. Some DATs have found a need to provide needle or syringe exchanges for under-16s.

In such cases services must ensure that staff are competent to consider the following issues:

- the child's welfare is paramount in every activity
- consent is gained for the intervention
- parents' and carers' involvement
- ensuring needle or syringe supply is part of a care planned activity
- the young person's awareness of the risks of injecting and their ability to understand these risks
- the young person's, family's or carer's awareness of confidentiality issues and the service's duty in relation to child protection
- child protection procedures to enable easy access to safeguarding young people when necessary.

These issues are explained in *Making harm reduction work: needle exchange for young people under 18 years old*, which is available from DrugScope.

In addition, services should ensure that needle exchange protocols are accepted by the local area child protection committee (ACPC) and local children safeguarding boards when established. A number of ACPCs have sanctioned needle exchange policies and these can be obtained from the NTA.

3.6 Family support services

Many interventions relating to a young person's service are likely to focus on the caring or family system. This focus can consider how such a system is related to problematic use or how the system has the potential to provide either a solution or support for the young people. Many services now provide staff skilled in working with families, to focus on support for the young person, family members or both. However there are a limited number of substance misuse practitioners able to competently perform this function. Some commissioners have identified local CAMHS services able to support this function.

3.7 Pharmacological services

The evidence base for pharmacological interventions, to treat substance misuse in young people, is poor. As such, the adult evidence base must be used and considered when developing services for young people until further evidence is developed. For more details, refer to *Drug misuse and dependence – guidelines on clinical management* (Department of Health, 1999), *Prescribing services for drug misuse* (NTA, 2003) and *The substance of young needs: review 2001* (Health Advisory Service, 2001).

However, the adult evidence base also needs to be matched against ensuring the wellbeing of children. This is not a simple process. Consideration should be given to each young person's individual's situation, with regard to the introduction of a detoxification regime or a maintenance regime. It may be considered that, due to the short length of dependency in a young person, that

detoxification is the only option. However, other evidence-based factors should be used to aid decision making. Factors to consider are:

- the level and type of social support an individual can access
- an individual's engagement with substance misuse services
- level of dependency and polydrug use
- previous attempts to become drug-free
- likelihood of use of alcohol or illicit drugs
- likelihood to relapse or overdose
- co-morbidity factors.

Specific guidelines in relation to clinical governance will be published by the NTA in 2005, as will new guidance for the prescribing of all medication to treat substance misuse.

Supervised consumption of medication by an appropriate professional is recommended in *Drug misuse and dependence – guidelines on clinical management* (Department of Health, 1999) for all new patients. In arranging this service for young people, additional precautions should be considered. Many young people will be engaging in substance misuse treatment for the first time and as such may not fully understand the risks associated with taking a controlled drug. In addition, titration for young people is difficult due to differences in body mass and the development of internal organs. Supervised consumption by a pharmacist may be supported by the involvement of other professionals engaged in prescribing to the young person to enhance safety measures.

3.8 Developing Tier 4 services

Tier 4 young people's substance misuse treatment services are:

- not solely about rehabilitation or dependency
- frequently about safety, security and respite
- flexible services that are commissioned or purchased around the needs of young people.

The NTA is working with local authority and voluntary sector children's homes to establish which services are able to support a young person with substance misuse problems, in tandem with Tier 3 specialist services. This work will culminate in the publication of a new directory of residential care that can help provide the safety and security that some young people require, during or following intensive substance misuse treatment.

The NTA is currently considering new initiatives in relation to commissioning residential and inpatient services for adults (*Models of care* – Tier 4). One of the options is regional commissioning structures. If this proves successful, young people's substance misuse commissioners should consider how these new adult commissioning models may be adapted to meet young people's needs.

Commissioners should consider accessing mainstream support for the delivery of Tier 4 services, by applying Tier 3 provisions in a mainstream residential setting. This may include placing a child in supported housing, temporary foster care, or using paediatric inpatient services to bring some stability to a young person's life, while an intense piece of work is conducted to prepare a young person for community based Tier 3 services. Partnership funding between mainstream funding streams and substance misuse monies may help facilitate this. This work will require imagination and commitment from all parties, the establishment of integrated children's service provision may provide opportunities for this.

4 Performance management

4.1 Regional teams

The 2005 joint DFES/HO guidance identifies joint teams based in Government offices. These teams will bring together staff from Government office drug and crime teams – DFES, YJB, NTA, and public health and other regional bodies.

The teams will identify the problems and challenges that local areas experience, provide performance management and intervention where needed and negotiate local targets between DATS and children's trusts or children and young people's strategic partnerships.

As part of these regional teams, the NTA will be monitoring specialist service provision. A cross-government working party is currently developing an effective practice model. This model besides identifying models of practice will also identify performance indicators at a local and regional level. This guidance is likely to be published in June 2005, but factors that the regional team will want to focus on, in relation to the specialist or treatment system, are likely to include the following:

- child-focused services
- integrated care pathways
- children and young people's strategic planning and commissioning, including substance misuse
- care plans
- referral protocols
- number of young people being reported to NDTMS
- full range of services
    - psychosocial interventions
    - harm reduction services
    - work with parents and carers
    - criminal justice interventions.
    - community prescribing
    - access to Tier 4 interventions.

It is envisaged that during 2005/06, waiting times targets in line with the YJB/NTA target will be introduced. This target is: "Where necessary a young person will receive a comprehensive assessment within five days of referral and a maximum of ten days before the young person receives a treatment intervention."

Commissioners should also be aware of the proposed joint assessment and review framework. This will ensure all services for children and young people are assessed according to quality inspection criteria, based on the five children's outcomes (see page 5). As this work develops, the NTA will ensure there is consistency between the two approaches.

4.2 Data collection

The NTA has developed a young people's core data set, in relation to young people under 18 in contact with specialist substance misuse services – this can be found on the NTA website, www.nta.nhs.uk.

Substance misuse treatment specialists have a responsibility to report data to the National Drug Treatment Monitoring System (NDTMS). Aggregate information from these returns is used in a number of ways:

- to plan and commission local services
- to inform Government and ministers about substance misuse treatment, which in turn may affect funding available

- to identify and performance manage treatment effectiveness
- to identify long-term trends in drug use.

The young person's core data set will collect information in relation to:

- types of substances and methods used
- referrers
- age, gender, accommodation
- the types of service a young person has received, namely:
  - psychological interventions
  - harm reduction services
  - work with parents and carers
  - community prescribing
  - shared care schemes
  - specialist pharmacological interventions
  - Tier 4 interventions
  - residential rehabilitation.

More information in relation to this data set is listed on the NTA website.

This additional information will help local partnerships and regional teams to determine what services are being taken up by young people and help to develop future planning to meet young people's needs.

5 Quality of treatment

All substance misuse treatment services for children and young people under 18 years old should be built around the needs of children and young people and the poor outcomes that arise from substance misuse. Appendix A describes the ten key principles (Standing Conference on Drug Abuse and Children's Legal Centre, 1999) for underpinning the development of services that ensure that the service is child-focused.

Currently, a number of young people are still inappropriately accessing adult services, but this is slowly changing. There are also a number of other areas that commissioners should be considering.

5.1 Clinical governance

Substance misuse treatment services for young people that are part of the NHS are subject to clinical governance arrangements. This includes voluntary sector services that have access to sessional NHS-funded doctor or nursing care.

"Clinical governance is a framework through which NHS organisations are accountable for continually improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish." (Scally and Donaldson, 1998).

Clinical governance arrangements, in relation to young people's substance misuse treatment, will need to take account of many aspects of care in order to improve the quality of service provision. Some of these aspects will be:

- role of substance misuse specialist doctors
- role of child and adolescent specialist doctors
- policies and procedures specific to meeting the needs of young patients
- safety of children and young people in receipt of care
- needs and wishes of children, young people and their parents
- examination of good practice and new research evidence.

Specific issues that clinical governance commissioners and providers may wish to consider are:

- supervised consumption
- detoxification and stabilisation of medication
- medication unlicensed for use by under 18's.

5.2 Sharing information and record-keeping

Many young drug misusers will have complex needs requiring a multi-disciplinary approach. All services working with young people should have policies and procedures on information sharing. The following areas should be identified: sharing within the service, sharing with parents, sharing with other agencies and sharing with public bodies such as NDTMS.

These policies should be agreed at a strategic level with other agencies such as YOTs, the Area Child Protection Committee and the DAT.

Record-keeping procedures should also comply with the Data Protection Act 1998 and from January 2005, agencies should also have a policy relating to the Freedom of Information Act 2004. All agencies should also have policies on confidentiality and consent to treatment (see sections 4.4 and 4.5). In addition, all staff should receive training to ensure they know the process of information sharing and how to document it.

5.3 Confidentiality

When young people attend services, they should know that their confidences will not automatically be passed on to others without their permission. They should also know that services have a statutory responsibility to inform child protection agencies if there are concerns about a young person's safety.

The issue of when a child is at risk is not a simple one. There are no foolproof frameworks for assessing risk or for identifying when information should be disclosed. *Working together under the Children Act* (DH, 1991), identifies the concept of "significant harm". This is defined in the glossary and would be a starting point for deciding to implement a child protection procedure. In addition, there are a number of professional codes of practice on when to disclose information for child protection purposes.

These should form the basis of any confidentiality training organised in association with the Area Child Protection Committee.

Services should ensure that staff understand the nature of confidentiality and that their confidentiality policy is explained and presented to young people using the service, in both verbal and written forms. This should form the basis of a confidentiality agreement, identifying details on when outside agencies will be contacted, when parents will be involved and should also identify what information will be reported to NDTMS. Ideally this should happen before assessment begins (see section 5.4).

5.4 Consent

Services can offer advice and information about drugs to children and young people without the consent of a parent. However, in line with the Children Act 1989, it is good practice to involve parents in any interventions that follow a comprehensive assessment.

The general rule is that if a young person is deemed to be competent to consent to treatment, then they are also competent to agreeing to the confidentiality contract above and to their parents not being informed.

Usually, young people over 16 should be able to consent to treatment and confidentiality. The Fraser guidelines (1999) identify that young people under the age of 16 can consent to confidential medical advice and treatment, provided that:

- they understand the advice and have the maturity to understand what is involved
- the health professional cannot persuade them to inform the person who holds parental responsibility or allow the health professional to inform that person
- their physical or mental health will suffer if they do not have treatment
- it is in the best interests to give such treatment without parental consent
- in the case of contraception or substance misuse, young people will continue to put themselves at risk or harm if they do not have advice or treatment (Fraser guidelines (Mental Health Act 1983 Code of Practice 1999) quoted in SCODA 2000).

All services should have guidelines identifying competencies for staff who are required to assess a young person's ability to consent to treatment or a confidentiality agreement.

The guidelines should also agree the process for a multidisciplinary case discussion, for circumstances where an under-16 is deemed to be able to consent to their own treatment or not involving people with parental responsibility.

Consent and confidentiality issues are discussed in more detail in the following documents:

- SCODA /Children's Legal Centre. *Young People and Drugs,* Drugscope1999

- SCODA. *Assessing young people's drug taking*. Drugscope 2000
- Royal College of General Practitioners and Brook Advisory Services. *Confidentiality and young people: improving teenagers uptake of sexual and health advice* (2000)
- Department of Health: *Seeking consent working with children*. DH Website.

Appendix: Ten key policy principles

The quotes in this section are taken from *Young people and drugs: policy guidance for drug interventions*, *standing conference on drug abuse and children's legal centre* (1999) available from DrugScope. They are based on the Children's Act and the United Nations Convention on the Rights of the Child.

Providers should note that, in addition to their responsibilities for children, they also have a responsibility to protect the community which in rare cases may override the rights of the child.

1. "A child or young person is not an adult. Approaches to young people need to reflect that there are intrinsic differences between adults and children and between children of different ages."
Drug services should have guidelines and competent staff on the assessment of the following:

- differences in legal competence
- age appropriateness
- parental responsibility
- confidentiality
- "risk" and "significant harm".

2. "The overall welfare of the child is paramount."
This should be reflected in assessment guidelines and referral procedures between young people's services and child protection agencies in accordance with the Children Act 1989 and the UN Convention on the Rights of the Child.

3. "The views of the young person are of central importance and should always be sought and considered."
Drug services will be able to demonstrate how care planning reflects a dialogue between the young person, assessor and carer, where appropriate, in line with the *National assessment framework for young people in need and their families* (Department of Health, 1999) and the forthcoming *Common assessment framework*. In addition, drug services will provide young people with an opportunity to contribute to operational and strategic planning.

4. "Services need to respect parental responsibility when working with a young person"
The education, involvement and support of parents or carers may be beneficial to successful work with young people. All young people should be encouraged to discuss their substance use with a parent or carer.

5. "Services should co-operate with the local authority in carrying out its responsibilities towards children and young people."
Protocols for liaison and joint working between the young person's drug service and child protection and children in need services should be established. The passing of the Children Act 2004 establishes a statutory duty on all services, both voluntary and statutory, to safeguard and promote children's wellbeing.

6. "A holistic approach will occur at all levels."
In addition to holistic strategic planning, multi-disciplinary training, protocols and practice forums will include staff from among youth offending teams, Connexions, CAMHS, education, youth services, social services, voluntary sector children services and drug services.

7. "Services must be child-centred."
Services should be accessible and attractive to young people. Services should be in safe areas and separate from adult services. Available literature will need to reflect the age, culture, gender and ethnicity of the client group. Consideration must be given to the accessibility of services to

young people, particularly opening times, location and age appropriate publicity. All staff must have received Criminal Records Bureau clearance.

8. "A comprehensive range of services should be provided."
DATs will need to ensure that service providers will be able to offer a range of services reflecting different patterns of alcohol and drug use by young people. The range of interventions should include drug education, targeted prevention programmes, advice, counselling, prescription and detoxification, rehabilitation and needle exchange services, as well as information, advice and support for parents.

9. "Services must be competent to respond to the needs of young people."
Staff should be competent to work with children, adolescents and families in line with social care and DANOS occupational competencies. Managers and supervisors will also need to be competent in considering the needs of young people.

10. "Services should aim to operate in all cases according to the principles of good practice."
Services will operate within the current legal framework, respecting the underlying philosophy of the Children Act 1989 and the UN Convention on the Rights of the Child. They should also reflect evidence-based effectiveness.

Glossary

Children and young people
The term "children" refers to all those individuals who are under the age of 18, in accordance with the UN Convention on the Rights of the Child (1989). The term "young people" is also used in this document as many services for teenagers, and teenagers themselves, prefer the term "young people" to "children" – however we are still referring to those under the age of 18.

Drugs, alcohol and substances
The term "drug" is used to refer to any psychotropic substance, including illegal drugs, illicit prescription drugs and volatile substances.

Young people's drug use and misuse is often inextricably linked with alcohol use and misuse, therefore it will be common in this document to refer to drugs and alcohol together as "substances".

Substance misuse
Use of a substance, or combination of substances, that harms health or social functioning – either dependent use (physical or psychological) or use that is part of a wider spectrum of problematic or harmful behaviour.

- The updated strategy target and the *Every child matters* outcome "Be Healthy" aim both use the term "drugs" which refers to controlled drugs within the meaning of the Misuse of Drugs Act 1971. Reducing the use of these drugs by children and young people will often involve broader education, assessment and intervention covering a wide range of substances, including alcohol and volatile substances. All substances that become problematic are legitimate areas of concern for the young people's treatment system.

Drug Interventions Programme
Previously called the Criminal Justice Interventions Programme (CJIP), the Drug Intervention Programme (DIP) is a major part of the measures in the Updated Drug Strategy for reducing drug-related crime.

It aims to take advantage of opportunities within the criminal justice system for accessing drug-misusing offenders – many of whom are difficult to access by other approaches – and moving them into treatment, away from drug use and crime.

Competency
Competency in this document is used in the context of occupational standards. Competency in this context refers to the knowledge, skills and experience a practitioner will require in order to be able to do the job.

Holistic
Holistic in this document refers to a holistic assessment or holistic service. This term developed from the DH guide *Working together to Safeguard Children* (DH, 1999), which identified a range of children's needs through a national assessment framework. This framework suggests that all the child's needs should be considered under the following headings: the child's development needs, family and environmental factors and the capacity of parents help children develop and stay safe.

Intervention
We use the term "intervention" to refer to the taking of any particular planned course of action (with a young person and/or their family) by a professional, a team of professionals, and/or a specific type of service. In this document, we have focused attention on young people who have already started to experiment with substances and more specifically those who have developed problems with, or associated with, their use of substances. A full range of interventions that should be provided in each DAT area is provided in section 3. Other interventions commonly mentioned are:

- **Counselling**

”Counselling” is described as the principled use of a relationship to provide someone with the opportunity to work towards living in a more satisfying and resourceful way. The relationship takes place within boundaries which may specify duration, regularity, availability and confidentiality of counselling. The counsellor’s role is to facilitate the client’s work in ways which respect the client’s values, personal resources and capacity for self-determination. Although counselling skills may be used in a variety of informal settings, in this document the term counselling is defined as a specific structured intervention, as described above, carried out by a person who has a demonstrable competence in counselling.

- **Harm reduction services**

Interventions based on strategies that seek to reduce the harm caused by substance misuse. This may include information and practical advice on safer substance use, as well as the provision of resources, such as needle exchange, and may also include vaccinations and testing to prevent or detect blood-borne viruses. In the case of young people under 16, a written plan must be produced by the key worker identifying the goals of this intervention. This plan will also highlight protective concerns.

- **Treatment**

”Treatment” is defined as an intervention which is intended to remedy an identified problem or condition in relation to an individual’s physical, behavioural, psychological and/or psychiatric wellbeing. Treating a young person for substance misuse will start with a full assessment and the treatment will be delivered within a care plan according to agreed procedures for case management. Treatment options may include a course of counselling (as defined above), a wide variety of interventions offered through the medical and psychiatric professions and alternative and complementary therapies. (Adapted from SCODA/CLC, 1999.)

Key-working

”Key-working” is used to refer to regular and care planned meetings between a young person and an allocated professional. During these meetings, various issues can be addressed including: substance use, family life, emotional problems, the co-ordination and progress of interventions, etc. Key-work should be facilitated by the use of counselling skills.

Looked After Child

Refers to those children where the local authority has parental responsibility. Except for cases defined by The Children Act 1989 s33(3), it is always good practice and usually a duty for the local authority to involve parents in all decisions relating to their children’s welfare.

Significant harm

The Children Act 1989 introduced the concept of significant harm as the threshold that justifies compulsory intervention in family life in the best interests of children. There are no absolute criteria on which to rely when judging what constitutes significant harm. “Consideration of the severity of ill-treatment may include the degree and extent of harm to… physical or mental health… intellectual, emotional, social or behavioural development, or ill-treatment which includes sexual abuse and forms of ill-treatment which are not physical (DH1999c).

Youth Offending Team (YOT)

Youth Offending Teams are multidisciplinary teams working within the youth justice system to prevent offending and reoffending by children and young people.

Youth Justice Board (YJB)

The Youth Justice Board was established under the Crime and Disorder Act 1998. The aim of the YJB is to prevent offending by children and young people. It delivers this by preventing crime and the fear of crime, identifying and dealing with young offenders and reducing re offending. The YJBs’ key responsibilities are to advise the Home Secretary, set and monitor standards, set up and oversee 155 YOTs, purchase and commission secure accommodation and disseminate good practice.

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