Professionals' Understanding of Risk Factors for Substance Misuse by Young People and Approaches to Intervention

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AA:	Alcoholics Anonymous
ACRA:	Adolescent Community Reinforcement Programme
ADHD:	Attention Deficit Hyperactivity Disorder
Benzo's:	Benzodiazepines
CAF:	Common Assessment Framework
CAMHS:	Child & Adolescent Mental Health Service
CBT:	Cognitive Behavioural Therapy
DML:	Dublin Mid-Leinster
EWO:	Education Welfare Officer
Facebook:	Social Networking Website
GIRFEC:	Getting it Right for Every Child
GP:	General Practitioner
Hash:	Cannabis
HIPE:	Hospital In-patient Enquiry
HSE:	Health Service Executive
I:	Interviewee (i.e., I.1=Interviewee number 1)
ISPCC:	Irish Society for Prevention of Cruelty to Children
JLO:	Juvenile Liaison Officer
MDFT:	Multi-dimensional Family Therapy
MI:	Motivational Interviewing
NA:	Narcotics Anonymous
NACD:	National Advisory Committee on Drugs
OECD:	Organisation for Economic Co-operation & Development
Q:	Questionnaire (i.e., Q.3= questionnaire number 3)
QuADS:	Quality standards in Alcohol & Drug Services
SFP:	Strengthening Families Programme
WHO:	World Health Organisation
Yot's:	Youth offending teams

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Abstract

Issues and trends in relation to substance misuse normally develop in the transitional phase of adolescence, as young people begin looking towards their peers for direction and are less subject to parental authority. Risk factors are predictors of the likelihood that an individual or group will be involved in activity leading to adverse consequences. Research indicates that some young people are beginning to initiate alcohol and drug use earlier than many adults suspect. In relation to substance misuse it is observed that risk and protection factors exist in equal measure within different context including within the individual, family, peer group, school and community settings. The enhancement of decision making by young people could delay or inhibit their engagement in harmful activity including substance misuse. If young people experiences substance use as enjoyable and without any negative consequences then it is likely they will not perceive risks relating to such use. Parental disapproval of substance misuse is a strong predictor of delayed initiation, whereas family instability and parental or sibling substance misuse, are identified as significant risk factors placing young people at greater danger of developing lifetime trajectories involving substance misuse. Assessment is central to the identification of needs and forms the basis for the establishment of integrated care plans framed within the context of multi-disciplinary and inter-agency collaboration. Governments and other organisations are required to play an active role in supporting the well-being of individuals, families and communities. As such, the practice of including children within adult categories when referring to "normal" alcohol consumption levels needs to be re-evaluated. Parents' and other adults require information about the risks and harmful effects of early onset substance misuse in order to make informed choices and to be empowered in taking a stance in relation to teenage substance misuse

CHAPTER 1

Introduction

1.1 Introduction

Adolescence is a period of transition involving sensation seeking and experimentation in risky behaviours including substance misuse. The ability of professionals to identify risk factors for young people at an early stage in their risk trajectory is a central tenant of any approach to intervention. In relation to substance misuse and experimentation, risk factors include individual characteristics, family dynamics, peer influences and social/environmental context. This research explores professionals' understanding of risk factors for substance misuse by young people and their approaches to intervention. The study is framed within the context of family support theory and practice.

1.2 Rationale

The rationale underpinning research stems from a review of 36 new referrals to an adolescent addiction treatment service during 2012 which reflected a 39% increase on 2011 and is the highest number of new referrals recorded in any one year since the service was established in 1997. The previous highest was in 1998 when the service had 33 new referrals. In addition to new referrals the service receives re-referrals annually as well as working with people who are in continuing engagement. Some of the significant features and worrying trends echoed within recent referrals relate to poor school attendance and indebtedness, resulting in families being intimidated by drug dealers and an increase in the number of young people absconding from home due to spiralling drug debts. Indebtedness relates primarily to cannabis/weed and to amounts of between €50 and €3600. All of the young people were known to multiple services, yet in most instances none of these services were involved in referral. Consequently, the question arises as to how substance misuse was either not identified or prioritised at an earlier stage? The aim of research is to ascertain some of the reasons why professionals' might not identify or prioritise issues relating to youth substance misuse.

1.3 Hypotheses

The hypotheses to be explored within research include the consideration that some professionals are unaware of the extent to which young people are engaging in substance misuse and are not asking about it in the course of their interaction with them. Secondly, there is a possibility that there is a high level of tolerance for some categories of substance misuse, principally tobacco, alcohol and cannabis among young people by adults including professionals in some communities, particularly those that were severely impacted by heroin abuse in late 1990s and early 2000. Additionally, the third hypothesis is that it can be difficult for professionals to distinguish early stage substance misuse among young people with conduct disorder, attention deficit disorder or impulsivity as behaviours are similar for substance misuse.

1.4 Aims and objectives

The overall aim of this study and the questions posed within research relate to professionals' understanding of the risk factors for substance misuse by young people; exploring the extent to which they discuss issues relating to substance misuse with young people and determining what actions they might take if they had concerns for a young person in relation to substance abuse. The objectives for research were to gather data related to research question through the use of questionnaires and semi-structured interviews and to analyse results in relation to trends in treatment referrals in order to identify what interventions could be developed. It is intended that outcomes from research might inform practice and policy within the treatment service associated with to this study in ways that will encourage professionals in other services to consider early intervention and referral for young people who are engaging in substance misuse. Additionally, outcomes from research may have the potential to inform the practice of professionals in other areas and possibly further research.

1.5 Methodology

The research methods involved the use of anonymous questionnaires and semi-structured interviews. The questionnaires afforded opportunity for individual responses and avoided prestige bias in reply to questions. Semi-structured interviews were carried out with one member of each profession who nominated themselves and were then selected randomly to represent their professional group. The semi-structured format within interviews gave professionals the opportunity to expand on the topic in a way that reflected their practice and experience. The analysis framework applied within this study is inductive which involves constant comparison of data to discover patterns and themes.

1.6 Organisation of Dissertation

This chapter set the scene for research, outlining aims, objectives and methodology. Chapter Two provides an overview of relevant literature related to this study. Chapter Three defines the rationale and objectives of the study and provides information relating to research design and methodology. Chapter Four gives an outline of the agency involved with this study and context within which it is located. Chapter Five, presents findings from research using charts, tables and excerpts from interview transcripts. Chapter Six discusses the findings, reflecting on how the results relate to literature on the topic. In conclusion, Chapter Seven puts forward recommendations based on themes emerging from research, informed by literature review.

CHAPTER 2
Literature Review

2.1 Introduction

Before it is possible to design a research study exploring professional's understanding of the risk and protective factors associated with substance misuse by young people, it is essential that existing literature on the topic is examined in order to identify what is already written on the subject and discover what other people have done that is pertinent to research question. This chapter provides an overview of relevant literature related to this study. The scene is set with a broad definition of family support followed by an exploration of the risk and protection factors relating to substance misuse and attention is then focused on risk assessment and service provision.

2.2 Family Support

Family support is not easy to define and is viewed as an 'umbrella term covering a wide range of interventions which vary along a number of dimensions according to their target group' (McKeown, 2000, p.4). The most practical and workable definition of family support that can be used in different context, is offered in the writings of Dolan, *et al*. (2006) who present a definition of family support that is influenced by social support theory. Within this theory emphasis is placed on an ecological approach, which acknowledges external factors influencing family behaviour and child development (Chaskin, 2008). Also, prominence is placed on building social supports and social capital which is viewed as the relationships, trust, social organisation and productive synergy underpinning community (ibid. p.72). Furthermore, there is emphasis on people's ability to make adjusting and adaptive responses in stressful circumstances, which is termed as resilience (Dolan, 2008). Additionally, there is a focus on attachment theory and the benefits for children in forming secure attachment, as it provides a sense of safety while they begin to explore

the world and develop social bonds. It is understood that insecure attachment in infancy poses a threat to psychological well-being in later life (World Health Organisation 2004). In addition to providing a definition and set of principles informing family support, Dolan, *et al.* (2006) invite practitioners to engage in reflective practice which involves 'checking and changing practice in the light of learning from past experience (reflection-on-action) through improvisation during the course of interventions' (Department of Health and Children, 2007, p. 39).

The definition of family support is broken down into seven components relating to a style of work based on operational and practice principles. These include a wide range of activities and types of services, including integrated programmes combining statutory, voluntary, community and private sector. Informal social networks are positively reinforced and the targeting of hard-to-reach vulnerable populations is prioritised. Within the model early intervention and the promotion and protection of health, well-being and rights of all individuals, families and communities is emphasised. The approach is supported by ten practice principles including collaborative working and partnership approach; matching intervention to need; child well-being; strengthening informal supports and promoting inclusion; accessibility; flexibility and self-advocacy. Specifically, practice principle number four relates to resilience, stating that 'family support services reflect strengths based perspective which is mindful of resilience as a characteristic of many children's and families' lives' (Dolan, *et al.* 2006, p.17). Developing on the work of Dolan, *et al*. (2006) the Family Resource Centre National Forum set out six practice principles for working with families based on: participation; equality; awareness raising; early intervention; strengths based and advocacy (Family Support Agency, 2013).

2.3 Factors Influencing Youth Substance Misuse

2.3.1 Risk and Protective Factors

Risk and protective factors can be viewed as identifiers of individual, family, community or societal health (Naidoo & Wills, 2009). Risk factors are predictors of the likelihood that an individual or group will be involved in activity leading to adverse consequences. On the other hand it is perceived that protective factors lessen the prospect of adverse outcomes. In relation to substance misuse it is observed that risk and protection factors exist in equal measure within different context, including within the individual, family, peer group, community and school settings (Hemphill, *et al*. 2011, pp.312-313).

Issues and trends in relation to substance misuse normally develop in the transitional phase of adolescence, as young people begin looking towards their peers for direction, are less subject to parental authority and more prone to engaging in risky behaviours (Hempill, *et al*. 2011; Arteaga, *et al*. 2010). Research indicates that some young people are beginning to initiate alcohol and drug use earlier than many adults suspect (Peterson, 2010; Fisher, *et al*. 2006). It is reported that substance use during adolescence, especially before age 15 years old can lead to continuance in later life (Goldberg, 2012). It is perceived that 10% of Irish adult males and approximately 5% of Irish adult female drinkers will develop serious problems in relation to alcohol (Barry, 2010, p.178).

Many young people experiment with illicit substances such as cannabis, ecstasy, amphetamines, cocaine and heroin, but it is reported that very few actually become addicted and that alcohol continues to represent the primary and most dangerous substance of abuse contributing to the global disease burden (World Health Organisation, 2007). A study examining the nature of the association between early onset alcohol use and adult misuse revealed that those who engage in regular drinking before age 21years old had a greater rate of alcohol dependence (Guttannova, *et al*. 2011). The consequences of alcohol abuse include increased aggression, physical and psychiatric illness, injuries, un-safe sex and cognitive impairment (World Health Organisation, 2007). Data from Hospital In-Patient Enquiry (HIPE) scheme show that

one quarter of all non-fatal overdoses involved young people age 15-24 (Mongan, 2012). Cannabis is reported as the most frequently used illegal substance in Ireland (Long & Horgan, 2012) and cannabis use among adolescents' is becoming as socially acceptable as tobacco and alcohol (Godeau, *et al*. 2007). It is estimated that approximately 4% of the adult population worldwide use cannabis (Goldberg, 2012). A study evaluating the performance of 104 cannabis users revealed that cannabis use before age 15 years old inhibits brain functioning and may contribute to depression and psychosis (Fontes, *et al*. 2011).

2.3.2 Individual risk and protection factors

Young people with conditions such as attention deficit hyperactivity disorder (ADHD), conduct disorder, bi-polar disorder or impulsivity are understood to be at increased risk of developing problems in relation to substance misuse and other forms of anti-social behaviours (Kilgus & Pumariega, 2009; Herman-Stahl, *et al*. 2006). Also it is perceived that young people with sensitive and vulnerable dispositions are more prone to engaging in alcohol in pre-pubescence (Goldberg, 2012; Coleman, 2011). Additionally, is thought that impulsivity may play a part in determining the difference between experimental or recreational drug use and dependence (Moeller, *et al.* 2002, p.8). A CAMHS report identifies that it can be difficult to distinguish early stage substance misuse from those behaviours that are associated with conduct disorder, attention deficit disorder or impulsivity (HSE, 2011a).

Taking into consideration economic status and age, being a boy, smoking tobacco, drinking alcohol and having been drunk increases the probability of cannabis use (Godeau, *et al*. 2007, p.28s). Furthermore research suggests that young people who engage in regular cannabis use are more likely than recreational users to experiment with other drugs, and as a result lifetime prevalence of drug misuse increases (Mayock, 2000, p.93). If a young person experiences substance use as enjoyable and without any negative consequences it is likely they will not perceive risks relating to such use (Chabrol, *et al.* 2006). A survey by ISPCC (2010) of 9,746 young people revealed that 30% of Irish teenagers reported it is ok to get drunk. Treadway (1989) states that some people can learn to manage their use of substances in a controlled way but highlights that abuse is clearly a precursor to dependency.

Personality characteristics associated with youth substance misuse include, low self-confidence or esteem, un-assertiveness, problems with inter-personal relationships, sexual promiscuity and poor decision making skills (Pumariega, *et al*. 2004). It is perceived that many young people and adults use substances in ways that could be viewed as self-medicating for symptoms of anxiety, shyness, physical and/or emotional pain associated with childhood trauma or sexual abuse (Clinical digest, 2012; Kyle, *et al*. 2011; Kloep, *et al*. 2001; Jarvis, *et al*. 1998). The co-morbidity of substance use and other mental health disorders is highlighted by Kirby, *et al*. (2008) indicating strong correlation between substance use, suicide, depression, antisocial behaviour, school dropout, and poor educational attainment. An Irish report by the National Suicide Research Foundation (2012), highlights the role of alcohol and drugs in relation to suicide and recommends strategies to reduce access and increase awareness especially among pre-adolescents'.

2.3.3 Parenting and family factors

It is generally understood that young people are offered some protection from substance abuse and other risks when parents communicate openly, are emotionally supportive and monitor their children's activity (NACD, 2011b; Pumariega, *et al*. 2004; Mendes, *et al*. 2001). There is also a strong body of evidence supporting the benefits of parental modelling and disapproval of substance misuse by setting specific rules in addition to restricting access (Mars, *et al*. 2012; Ryan, *et al*. 2010; Pokhrel, *et al*. 2008). Further evidence suggests that families who have strong moral, religious or spiritual beliefs help to inhibit or delay young people's engagement with alcohol or drugs in most cultures (Sussman, *et al*. 2006). Parents who have authoritative and trusting approaches to their children are more successful at encouraging abstinence or harm minimisation than parents whose approaches are either authoritarian or laze-faire (DeHann & Boljevac, 2010; Mendes, *et al*. 200). Additionally, Menghrajani, *et al*. (2005) draw attention to a Swiss study on cannabis use and emphasise the importance for parents' in giving consistent messages to young people throughout adolescence. Within the study it was identified that young people expressed opinion for prevention programmes to focus on delaying onset of substance use.

A qualitative comparison of parents and adolescents' views regarding substance use indicate that parents underestimate the influence of negative consequences as young people reported that not wanting to disappoint or lose respect from parents acted as a deterrent (Peterson, 2010). Additionally, it is stated that parents' overestimated the influence of peer pressure and failed to take into account the culture of acceptance for substance use within society especially in relation to alcohol. Moreover, the study revealed that adolescents' want their parents and other adults to set boundaries monitor their behaviour and to be active role models, expressing the 'desire for "parents to be parents" rather than trying to be their friends' (ibid, pp.61-62). Dr Aric Sigman (2013) author of a report by the European Parliament's working group on quality of childhood is reported by Radnedge (2013) as stating 'the fundamental misconception held by many Europeans' that 'early gradual introduction to alcohol will cultivate "responsible drinking"'. Rather, he insisted 'early introduction to an addictive substance leads to greater likelihood of addiction'.

Family instability, conflict, physical/sexual or emotional abuse, parental or sibling substance misuse, harsh parenting, involvement of social services, lack of parental control and absence of parent/s are known risk factors influencing early onset substance use (NACD 2011a; Percy, *et al*. 2008; Stein, *et al.* 1987). A study by Chassin, *et al.* (2004) identified that young people whose family have a history of substance misuse are at greatest risk of developing lifetime trajectories involving substance use. Moreover, such families usually live in communities that have fewer resources and support networks than families in more affluent areas and as a result children living in these situations have poorer outcomes (SAMSHA, 2012; Williams, *et al*. 2009; Pumariega, *et al*. 2004). A survey involving questionnaires, carried out by ISPCC (2010) of 9,746 young people aged 12-18 years old within schools and alternative education centres revealed that 9% of children are affected by parental alcohol abuse. The unhappiness of growing up in such situations may encourage some young people to seek relief in substance misuse as an escape from misery and grinding poverty. The national drug strategy 2009-2016 identifies the need to support families experiencing difficulties with substance misuse in order to break the cycle towards safeguarding children (Department of Community, Rural and Gaeltacht Affairs 2009).

Low, *et al*. (2012), focusing on social processes in sibling relationships, revealed that older siblings' influence on younger siblings substance misuse may function at either direct or indirect levels, through role modelling or through providing access to substances and that collusion between siblings allows for practicing and normalization of deviant behaviour. The role of sibling relationships is perceived to exert greatest influence within single parent or re-constituted families especially in terms of emotional/social adjustment (Feinberg, *et al*. 2012; Becona, *et al*. 2012). The first report from a national longitudinal study of children growing up in Ireland, tracking the lives of 8,500 children revealed that children in single parent families are at greater risk of experiencing drug taking or alcoholism (Williams, *et al.* 2009). In contrast Becona, *et al*, (2012) propose that children in re-constituted families without marriage are at greatest risk in terms of engaging in substance misuse. Regardless of family structure all studies emphasise the need for parental co-operation in monitoring and supervising children as well as having expectations and establishing boundaries.

2.3.4 Peer influences on young people's substance use

Experimentation with substances is seldom a solitary event and is usually associated with peer group setting (Calfat, *et al*. 2011; Anderson, *et al.* 2009; Galaif, *et al*. 2007). As outlined in the previous section there is evidence that initiation to substances often takes place within family contexts, but having a network of friends who engage in substance misuse and other risk behaviours increases the likelihood of young people participating in such activity. Additionally, sharing with peers introduces a social dimension to substance use and provides a level of safety in the early stages of experimentation (Heavyrunner-Rioux & Hollist, 2010; Coleman, 2011). The sharing of tobacco, alcohol or particularly a "joint", cannabis cigarette may be a symbolic expression of shared values and might nurture feelings of belongingness and friendship among young people who are struggling with issues relating to identity. Furthermore, Arteaga, *et al*. (2010) identify that fear of social isolation and peer rejection has a significant influence on drug and alcohol use by young people especially in circumstances where substance misuse is normative within youth culture.

DeHann and Beljevac, (2010) propose that adolescent perceptions of friends' substance use and popularity is linked to increased use. This is something that is reinforced by Graham, *et al.* (2006, p.7) who make reference to reputation enhancement theory (RET) highlighting that young people will engage in risky behaviour if they believe it will enhance their reputation or to avoid social exclusion. Simons-Morton (2007, p.681) propose that 'a better understanding of the dynamic and reciprocal nature of peer influence is important because of the prominence of peer influence as a predictor of adolescent substance use'. In general young people whose peers or friends are participating in mainstream education, sport or other positive forms of recreational activity are less likely to initiate drug use especially at a very young age (Haase & Pratschke, 2010; Mayock, 2000). Furthermore, a study by Chabrol, *et al*. (2006) revealed that if a young person's peer group are opposed to cannabis use this can have a protective influence as it enhances regulation of non-use.

2.3.5 The influence of school in young people's lives

Information relating to substance misuse trends among young people within a schools context is largely derived from countries taking part in European School Surveys Project on Alcohol and Other Drugs (ESPAD) or Health Behaviour in School-Going Children (HBSC). These surveys are carried out every four years since 1995 and 1998 respectively, among students age 15-16-years-old. The first ESPAD survey revealed high levels of substance misuse among Irish school going pupils compared to twenty five other European countries (Hibell, *et al.* 1997). But, the most recent HSBC report for 2010 points to an overall decrease in tobacco, alcohol and cannabis use among Irish youth compared to previous surveys (Kelly, *et al.* 2012). However, McCrystal, *et al*, (2005) point to the fact that much of the evidence on drug use behaviours of young people excludes those no longer attending school. The National Drug Strategy 2009-2016 outlines plans to reduce the number of early school leavers by targeting those most at risk and ensuring that substance misuse policies in schools are implemented and youth services, alternative education projects and juvenile diversion programmes are funded to support young people who are most at risk (Department of Community, Rural and Gaeltacht Affairs 2009).

A research study by Truts and Pratschke (2010) comparing Irish school attendees and early school leavers shows higher levels of substance misuse among young people who are out of school or who are in alternative education. These findings are corroborated by Arteaga, *et al.* (2010) who makes links between early school drop-out, parent expectations for children's success, family conflict, instability of accommodation and a young person's dislike of school. It is proposed that remaining in mainstream education provides a level of protection against substance misuse and that positive relationship with teachers; favourable school experience and good communication between parents and school contribute to school retention (Truts & Pratschke, 2010). A review of responses from 7642 9^{th}-11^{th} grade students who participated in Californian Healthy Kids Survey revealed that school support has a significant influence in reducing male substance misuse and highlights the need for focus on strong interaction between schools, families and peer groups (Shekhtmeyster, *et al.* 2011). Moreover, McCrystal, *et al.* (2006) present research showing that young people in mainstream education have increased levels of home based activity, spend less time hanging out on streets and are least likely to engage in random activity.

Amonini and Donovan (2006) carried out research related to moral perceptions of tobacco, alcohol and cannabis use among 611 young Australians aged 14-17 years old, revealing that most viewed substance use as a moral issue. Results also showed greater tolerance for alcohol (80%) than tobacco or cannabis (50%), indicating a level of tolerance and social acceptance for alcohol within Australian society mirrored by increased levels of alcohol consumption among adolescents' (Graham, *et al.* 2006). A high level of tolerance for alcohol also exist in Ireland as reflected in ESPAD survey 2012, indicating that Irish teenagers have a greater propensity for binge drinking (Hibell, *et al.* 2012). It is proposed that education and awareness programmes ought to focus on morality as well as on health issues as it is understood that moral discernments are learned and as such can be swayed, suggesting that interventions start at a younger age as 'moral development accelerates in primary school stage (5-12 years) and is almost complete by 15 years' (Amonini & Donovan, 2006. p. 284). In the process of encouraging young people's moral development it is important that they experience justice and fairness within society. Ultimately, the enhancement of decision making by young people could delay or inhibit their engagement in harmful activity including substance misuse.

2.3.6 Societal Influences

It is generally accepted that environmental factors have a significant influence in determining a young person's initiation and progression in relation to substance misuse (Mayock, 2000; Stein, *et al.* 1987). Drug use prevalence studies highlight 'that the more prevalent is the use of a substance in any country or region, the less will young people tend to perceive a risk of great harm in using it' (Anderson, *et al.* 2009, p.194). In times of recession, and high unemployment, social deprivation and disorganisation can result in young people feeling disconnected from society where continuance in education offers little hope for the future (McCrystal, *et al.* 2006). Also, community adversity, poverty and unemployment are considered the most substantial contextual factors associated with substance misuse (Hempill, *et al.* 2011; Arteaga, *et al.* 2010). However, Stein, *et al.*(1987, pp.1100-1101) following an eight year study of multiple influences on drug use and drug use consequences identified that the proximal influences of personality and prior drug use combined with adult and peer attitudes are stronger predictors of problem drug use than the distal influences of wider community.

Research indicates that young people's experience and perceptions of community supportiveness and the way in which laws regulating substance misuse are enforced boosts compliance (DeHann & Boljevac, 2010; Amonini & Donovan, 2006). It is acknowledged that personality characteristics may determine which individuals develop problems in relation to substance use, but it is understood that societal attitudes generally determine which substances are tolerated (Kloep, *et al.* 2001; Pearson & Shiner, 2002; Stein, *et al.* 1987). Alcohol Policy Youth Network (2012) an organisation established to facilitate the coming together of youth clubs and organisations across Europe in order to increase levels of youth participation around issues relating to alcohol, highlight evidence demonstrating that alcohol pricing, marketing and availability is having a significant influence on consumption levels. Concern for binge drinking among Irish youth is also expressed by Alcohol Action Ireland (2013) highlighting that alcohol can be purchased at pocket money prices. According to Radnedge (2013) a European Parliament working group report states that imposing a minimum age of 18 years in relation to alcohol would send an unambiguous message to young people and society.

The Royal College of Physicians of Ireland (2013) report that the rate of discharges for alcoholic liver disease increased by 247% for 15-34 year olds between 1995 and 2007. The fact that such a startling increase in liver disease is occurring at the same time as it is reported that alcohol consumption levels are decreasing seems to confirm Irish people's propensity for binge drinking. Exposure to advertising and promotion of alcohol is viewed as a predictor of early onset drinking and of increased levels of drinking (Department of Health, 2012). Moreover, it is confusing when research gives the impression that there is a normal level of alcohol that can be consumed by young people age 13-18 years old (Dooley & Fitzgerald, 2012, p.30) and when 15year olds are included within adult category in national and international statistics relating to alcohol consumption (Department of Health, 2012; OECD, 2011). Realistically, the age within which adulthood begins is shifting and the period between ages 18-25 year old is increasingly defined as emerging adulthood, when individuals begin to discover their identity and are more prone to engaging in risk behaviours (Nelson & McNamara Barry 2005; Arnett, 2000).

2.4 ASSESSMENT

2.4.1 Assessment Processes

Assessment is viewed as the avenue that leads to effective intervention, and approaches to assessment usually take into consideration family and social context, child development and parenting capacity (Buckley, *et al.* 2007; McAuley, *et al.* 2006). Moreover, Rose, *et al.* (2006, p.286) assert that the effectiveness of interventions 'is intimately bound up with assessment'. A report by Shannon & Gibbons (2012) on the deaths of 196 children and young people in state care, after-care or known to child protection services in Ireland for the years 2000-2010 revealed that 112 deaths were due to non-natural causes. It was found that 27% were directly related to drugs and that 25% involved suicide while a further 15% were due to road traffic accidents which may also have involved substance misuse. Additionally, it is reported that many of the children had lived in circumstances where drug/alcohol abuse was a problem. Therefore, it is proposed that assessment ought to be central to the identification of needs and form the basis of an integrated care plan (HSE, 2010).

The U.K National Treatment Agency for Substance Misuse, propose that 'assessment can be a useful intervention in itself and provides an opportunity for young people to reflect on their circumstances (NHS, 2007, p.10). Identifying those who may be at risk of developing serious problems can help to reduce their vulnerability to risk and may provide some level of prevention in terms of the number of adults who develop substance misuse problems (NHS, 2007). It is advocated by Percy, *et al.* (2008) that all agencies have a role to play in the identification of substance misuse and that all assessments take into consideration contextual issues. Mars, *et al*. (2012, p.803) advocate that practitioners need to be aware of the potential contribution parents can make in guiding young people's behaviour by setting specific rules. In circumstances where familial substance abuse exists, it is recommended that drug and alcohol services be actively integrated into the child protection system, and that professionals working with adults who abuse substances prioritise the needs of children and alert social workers of risks in such circumstances (NACD, 2011b; Shannon & Gibbons, 2012; Butler, 2002).

The Effective Interventions Unit, Substance Misuse Division Scottish Executive (2004, p.3), identify assessment as 'core of delivering effective treatment, care and support to individuals'. Moreover, it is stressed that assessment is a process not an event, and is viewed as a way of making sense of young people's lives in order to inform actions and decisions to help them achieve their potential. The Scottish Government (2011) propose that 'work with children and young people who offend must embrace the principles of "Getting it right for every child" (GIRFEC)'. This approach is based on research, and best practice to make sure all parents, carers and professionals' work well together to give children and young people the best chance in life. The Hidden Harm Action Plan established in Northern Ireland, identifies that not all families who encounter substance misuse will experience problems but emphasises that routine assessment will help to identify those who do (Public Health Agency, Health and Social Care Board 2009). The plan describes actions that can be taken to ensure children and young people who experience compromised parenting receive the support they need. Within an Irish context the National Drug Strategy 2009-2016 identifies the need to target measures focusing on the welfare of children whose parents are engaging in drug/alcohol abuse (Department of Community, Rural and Gaeltacht Affairs 2009).

There are different approaches to assessment and it is generally acknowledged that the method applied with young people will take a different format than with children as it is appreciated they experience the world differently (Guddemi, & Chase, 2004). Within the confines of this research it is not practical to cover all assessment models; therefore emphasis is placed on three standard approaches that are primarily used with young people in Ireland, including assessments carried out by CAMHS, the Common Assessment Framework (CAF) and the Asset assessment tool.

2.4.2 Child and Adolescent Mental Health Services

In Ireland, CAMHS work with young people under age 18 years old who present with mental health, behavioural and developmental problems. CAMHS services operate within a multidisciplinary team approach, employing a range of professionals. Within a report for 2009-2010 it is acknowledged that multi-disciplinary perspectives are required in order to offer complete assessment and care planning (HSE, 2011a). Additionally, the report highlights that on average 1 in 10 children and adolescents' experience mental health disorders and that for the most part the majority of adults with mental health disorders experienced onset before age 18 years old. The primary reasons why young people are referred to CAMHS as indicated by initial assessment relates to the following conditions; hyperkinetic disorder/problems (33.1%); autistic spectrum (10.7%); depressive disorders (8.8%); conduct disorders (8.6%) (HSE, 2011a, section: 4.10). According to Drugscope (2010, p.35) a lot of young people who engage in substance abuse have complex needs and diverse histories combined with co-occurring mental health problems and unrecognised learning disabilities in addition to deep-rooted social problems. It is for this reason that it can be difficult to identify substance misuse when a young person presents to CAMHS as the behaviours associated with ADHD, conduct disorder, depression and substance misuse are similar (Subotsky, 2003).

2.4.3 Common Assessment Framework

The Common Assessment Framework (CAF) was designed as a shared assessment tool for use within children's services to help frontline workers in England and Wales have a focus on assessing the needs of young people up to age 18 years old in circumstances where it has been identified that interventions and supports may be required (Drugscope, 2010). However, the CAF is not for use with children who are considered to be at risk or harm. In such circumstances workers are required to adhere to child protection procedures (North Yorkshire Council, 2012). The expectation within CAF is to promote early identification of needs within a holistic framework. An assessment procedure requires parent/guardian consent and participation and is designed to capture basic information including relationship with parents/carer's as well as community resources. Upon completion of assessment it is expected that strengths and challenges will be identified and actions to be taken, if any. In relation to substance misuse it is anticipated that a referral would be made to specialist agency within the framework of multi-agency and inter-disciplinary team working.

2.4.4 Asset assessment tool

The Asset is a well thought-out assessment tool which is used with all young offenders by Youth Offending Teams (Yots) in England and Wales (Justice, 2012). In addition to addressing a young person's offending behaviour and gathering information for court reports, the Asset explores young people's attitudes and beliefs and seeks to identify influences and circumstances contributing to behaviour including substance misuse and mental health concerns. The assessment process involves multiple questions that are intended to give a comprehensive picture of a young person's life and which can enlighten court reports so that appropriate interventions can be put in place (NHS, 2007). The Irish Probation Service in its Strategic Statement 2008-2010 outlines the establishment of a young person's probation service 'by implementing relevant sections of Children's Act 2001 in conjunction with the Irish Youth Justice Service and the Office of the Minister for Children' (The Probation Service 2008, p.12). Additionally, the plan identifies the need to put in place systems for the assessment and management of risks posed by all offenders within a life cycle framework.

2.5 Treatment Interventions

2.5.1 Approaches to intervention

Interventions that are proven to work with young people who are experiencing problems with substance misuse include pharmacotherapy, motivational interviewing (MI), cognitive behavioural therapy (CBT), family therapy and family/systemic education and training programmes. All of these interventions can be applied within community or residential settings. However, Drugscope (2010, p.38) highlight that 'the evidence-base on residential treatment for substance misuse for young people is not encouraging' but it is acknowledged that young people with a dual diagnosis may realize better outcomes in residential settings, especially those who are substance-dependant and who are motivated to change but who would not have sufficient support within their family or community. It is argued that young people for whom residential treatment is not suitable other forms of out of home care or respite might be appropriate (ibid, p.38).

Reports from programmes in United Kingdom and United States of America indicate that working closely with families, carers and significant others improve communication and mobilises resources in ways that enhances protection for young people (SAMSHA, 2012; Scottish Government, 2011). Importantly, Duncan and Miller (2000) as cited in Larner (2004) highlight that therapeutic intervention accounts for approximately 15% of success regardless of approach and that individual's resourcefulness and chance events accounts for 40% of the change process combined with expectations and hope for change which is estimated at 15%. The remaining 30% of the variance influencing outcomes is believed to exist in the relationship between therapists and client. Furthermore, Larner (2004, p.23) emphasises 'what works in therapy is not technique alone but its application in the context of human relationships'. The Family Support Agency (2013, p. 37) acknowledge that some families may need support over an extended period of time and emphasise the value of therapeutic relationships that are 'emotionally warm, attentive, responsive, sensitive, attuned, consistent and interested'.

2.5.2 Psychopharmacology of Adolescent Addiction.

Substance misuse by young people can fall on a continuum from nicotine at low risk end to heroin and cocaine at the more high risk, involving a range of other substances in-between such as alcohol, aerosols, cannabis, sedatives, hallucinogens and other synthetic products. In some circumstances there are pharmacological treatments available, for example opiate substitution to treat people experiencing problems as a result of heroin abuse. But, there is no pharmacological substitution treatment for cannabis. In relation to alcohol an agonist may be prescribed that would cause a person to have an adverse reaction if alcohol is consumed and benzodiazepines may be prescribed on occasion to treat symptoms of withdrawal (Byrne 2006, p.8). Drugscope (2010, p.29) indicate that little is known about the usefulness of pharmacological interventions for drug dependence and withdrawal in young people. Therefore, to compliment medical interventions or as alternatives, the evidence suggests that motivational interviewing, cognitive behavioural therapy and family therapy are among the treatment models that have proven superiority (Becker & Curry, 2008).

2.5.3 Cognitive Behavioural Therapy

Cognitive Behavioural Therapy (CBT) places emphasis on shared observation and the importance of monitoring and modifying automatic thoughts, assumptions, and beliefs. The goal is to influence maladaptive behaviours by reinforcing desired behaviour while reducing emotional reactiveness to stressful events or erroneous thinking (Becks, *et al.* 1991). The approach with adolescents' emphasises the use of concrete examples with a focus on trust, cognitive distortions and the acquisition of problem-solving and social skills. The treatment programme is usually delivered in 12 to 16 weekly sessions. With adolescents' CBT is applied through the use of motivational interviewing, problem solving, self-monitoring, contingency management and establishing approaches to relapse prevention (Carr, 2010, p.85). It is acknowledged that CBT is an effective intervention that has application with a wide range of problems, however it does not compare as favourably to systems based approaches with young people who present with complex needs (Hendriks, *et al.* 2011; Carr, 2010; Henderson, *et al.* 2010)

2.5.4 Motivational Interviewing

Motivational interviewing (MI) is a goal-directed, client-centred counselling style to help people explore and resolve ambivalence. It is accepted that motivational interviewing with young people who are in the initiation stage of drug use may help them to reflect on the consequences of their behaviour (Miller & Rollnick, 1991). The examination and resolution of ambivalence is a key goal of this model. The approach involves establishing rapport, listening reflectively and asking open-ended questions to explore individual's motivations for change while addressing resistance without confrontation and encouraging self-efficacy (Carr, 2010). Interventions may be most effective in the early stages of substance use through generating awareness of the discrepancy between current behaviour and desired life goals (Barrett, *et al.* 2012; Jensen*, et al*. 2011).

2.5.5 Family Systemic Therapy

The principles that inform family therapy 'transcend simple cause and effect explanations which located deficits within the individual, and to include those aspects of the clients context in the therapy process which will enable them to manage, resolve or better understand their difficulty' (Irish Council for Psychotherapy, 2003, p.32). Family therapy methodologies are grounded in systems theory and are viewed as ecological interventions that do not easily translate into manualised approaches that can be repeatedly applied (Larner, 2004, p.19). From a therapeutic perspective there is less emphasis on deficits and pathology with increased focus on valuing strengths. In the process of actively looking for positive assets, healing and developmental potential is nurtured, that otherwise might go unrecognised (Gilligan, 2000, p.16). The practice of family therapy is subject to different perspectives and treatment models, including; Structural Family Therapy which focuses on family boundaries and the way members organise into subsystems (Minuchin, 1988). The model explores coalitions, triangulations, the degree of enmeshment or disengagement and how individuals are scapegoated through the processes of detouring or deflection. Taking a different approach, Strategic Family Therapy approaches treatment indirectly and is used when direct methods will not work. Symptoms are viewed as 'maladaptive attempts to deal with difficulties, which develop a homeostatic life of their own and continue to

regulate family transactions' (Kaufman, 1988, p.121). The goal of therapy is to join with family/system and devise strategies for solving presenting problems and to addresses strengths, resources and encourage pro-social behaviour, positive parenting capabilities and solutions rather than problems or pathology (O'Hanlon & Davis 1989).

A study comparing Multidimensional Family Therapy (MDFT) with CBT and enhanced service as usual (ESAU) revealed that MDFT produced better outcomes for young people who presented with increased levels of substance use combined with psychiatric co-morbidity (Henderson, *et al*, 2010). These findings are corroborated by randomised controlled trials carried out in the Netherlands comparing MDFT and CBT (Hendriks, *et al,* 2011). MDFT is a family based therapy approach used with adolescents' who are engaging in substance misuse and other behaviours. The approach involves intervening within the major domains of a young person's life, including family, peers, school, leisure and work (Liddle, *et al,* 2005). Within both studies it is identified that young people with more severe problems seem to benefit from family based treatments due to the fact that the approach encompasses a wider range of risk factors and involves parents and other family members in addition to significant other people.

Mapping the effects of a problem across different domains and between various relationships opens up a broad field in which to explore unique alternatives and establish supports (White & Epston, 1990). In the process, opportunities exist to establish a community of support among concerned others (Dulwich Centre, 1990). The goal is to improve interpersonal and family functioning as a protective factor against substance abuse and related problems. The aim of therapy is to improve functioning within family, school performance and achieve these outcomes at a cost savings by reducing the use of out of home placements (Carr, 2010). In circumstances where there are a number of family members engaging in substance misuse it is proposed that intervention encompass a systemic perspective and that working at an individual level may be unproductive (Low, *et al* 2012; Becona, *et al*, 2012; Percy, *et al*. 2008).

2.5.6 Family Education and Training Programmes

In working with families who are experiencing problems in relation to substance misuse there are two education and training programmes that have proven effectiveness; the strengthening families programme (SFP) and the adolescent community reinforcement approach (ACRA). The SFP is designed to increase resilience and reduce risk factors for substance misuse by addressing behavioural, emotional, academic, and social problems in children and young people age 3-16 years old (Kumpfer, 2009). It comprises three life-skills courses delivered in 14 weekly, 2-hour sessions. Parenting skills sessions are designed to help parents learn how to increase desired behaviours in children by using attention and rewards, clear communication, effective discipline, problem solving, and limit setting. Sessions with children focus on life skills and are designed to help them improve communication, problem-solving skills and understanding of feelings. Family sessions focus on life skills, structured activities, therapeutic child play and the value of family meetings in terms of communication and effective discipline.

The ACRA is a comprehensive behavioural programme for treating substance-abuse problems based on the belief that environmental factors play a role in encouraging or discouraging substance misuse (Meyers, *et al*. 1999). The approach makes use of social, vocational, recreational and family interactions to support protective and preventative interventions. The goals within this approach include; improved communications and the encouragement of lifestyles that are more rewarding than substance misuse. Similar to SFP the approach involves three types of sessions; adolescents' alone, parents/caregivers alone, and adolescents' and parents/caregivers together. Within both programmes concerns exist with regard to their cultural transferability. It is recommended that culture-relevant language is used and that approaches integrate culturally accepted norms for behaviour (Allen, *et al*. 2007). Ultimately, giving time to development of social and emotional skills is of value to children and particularly to parents who may struggle with their own issues and might not have had opportunity to develop appropriate coping skills (SAMSHA, 2012).

2.6 Chapter Summary

Research indicates that adolescence is regarded as a time when young people assert increasing independence and autonomy and in the process are more likely to engage in risky behaviours including substance misuse. Among those most at risk of developing problems relating to substance misuse are young people who have pre-existing mental health issues which may be influenced and exacerbated by family and community disorganisation. In circumstances where a young person does not have a strong attachment to school or other pro-social activities there is the potential for affiliation with peers who also engage in high risk behaviours. The level of risk increases if parents/siblings also abuse substances or are permissive of substance misuse. However, risks for young people can be ameliorated if protective interventions are introduced. Approaches to intervention require assessment, taking into consideration contextual issues, and is viewed as a way of making sense of young people's lives in order to inform actions to help them achieve their potential.

In keeping with family support principles it is proposed that interventions need to target a broad population of young people in pre-adolescence when it is anticipated that programmes can have the greatest influence on later behaviour. For young people within high risk category, early identification of risk factors is optimal towards establishing protective and preventative interventions. Working closely with families, carers and significant others improve communication and mobilises resources in ways that enhances protection for young people especially in circumstances where there are a number of family members engaging in substance misuse. Other interventions that have proven effectiveness include CBT, MI and pharmacotherapy especially where a young person has an established substance dependency. In certain circumstances residential treatment or out of home care may be required. Fundamentally, good communication and relationship is central to effective intervention at all levels in addition to multidisciplinary approach and co-ordination and collaboration between agencies.

CHAPTER 3

Methodology

3.1 Introduction

This chapter defines the rationale and objectives of the study and provides information relating to research design and methodology. The approach to sampling, consent and access are outlined in addition to ethical issues. The methods applied in data analysis are discussed and issues relating to validity and reliability of study are addressed together with strengths and limitations.

3.2 Rationale and Objectives

The understanding and response of professionals' to substance misuse by young people may determine or influence whether an individual or group maintain involvement in such activity. As identified in literature review it is observed that risk and protection factors exist in equal measure within different context (Hemphill, *et al*. 2011). According to Wei, *et al*, (2011, p. 278) it is suggested 'that as adolescent's improve their coping skills and social supports, their motivation to reduce their use of substances also increases'. It is intended that this research will inform practice among professionals working with young people who engage in substance misuse, through highlighting risk factors and protective interventions. It is hoped that the risks for some young people in developing problems in relation to substance misuse or becoming substance dependant may be reduced especially within communities covered by this study.

According to Gilligan (2000, p.13) child protection and family support is about rallying all the supports possible for children's normal development within the context in which they live their lives. This includes the influences of wider society in addition to family when considering the scope for intervention (Chaskin, 2006). The rationale underpinning this research project stems from a review of new referrals to an

adolescent addiction treatment service during 2012, accounting for 36 treatment referrals and reflecting a 39% increase on 2011 when the service had 26 new referrals. It is the highest number of new referrals recorded since the service was established in 1997. The previous highest was in 1998 when 33 new referrals were received.

In general referrals come about following a crisis event, for example, a young person age 14 years old was referred following hospital admission after they were discovered unconscious in a public place. In another situation, a family presented having vacated their home where they had lived for eighteen years because they were being threatened to pay drug debts owed by their 15year old son. The circumstances of another case relate to a 14 year old with a three year history of cannabis use, referred due to absconding which was linked to indebtedness. This young person was introduced to cannabis by a parent who was connected with adult addiction treatment services. A number of other services were linked with this young person and their family, yet none of these services were involved in referral. A further two young people had to be re-accommodated out of community within extended family due to indebtedness and intimidation.

Overall, the issue of drug indebtedness was a significant feature of referrals during 2012, with some young people accumulating debts between €50 and €3600. Parents' report that they are borrowing from money lenders at high interest rates to pay children's drug debts. In relation to school attendance only 22% (n=8) of new referrals were attending school as would be expected with 50% (n=18) either expelled or having dropped out of school. Consequently, the question arises as to how substance use/abuse was either not identified or not prioritised at an earlier stage? The aim of research is to ascertain some of the reasons why professionals' might not identify or prioritise issues relating to youth substance misuse at an earlier stage and determine what they could do differently in order to recognise issues in relation to substance misuse by young people at an earlier stage.

The main objectives of research are:

1. Ascertain professionals' understanding of the nature and extent of substance misuse by young and the risk factors associated with early onset substance misuse.

2. Determine the extent to which professionals' discuss issues relating to substance misuse with young people and what actions they might take if they had concerns for a young person in relation to substance abuse.

3. Analyse results in relation to trends in treatment referrals.

4. Identify what protective and preventative interventions can be developed in order to reduce young people's vulnerability to risk or harm in relation to substance misuse or dependency.

5. Inform practice and policy within adolescent substance misuse treatment services in ways that will encourage professionals in other services to consider early intervention and referral to treatment for young people who are engaging in substance misuse.

6. Inform agency policy and further research.

The hypotheses explored within research included the consideration that some professionals' are unaware of the extent to which young people are engaging in substance misuse especially at an early age. Secondly, there is a possibility that there is a high level of tolerance for some categories of substance misuse, principally, alcohol and cannabis among young people by adults including professionals in some communities, particularly those that were severely impacted by heroin abuse in late 1990s and early 2000. Additionally, the third hypothesis is that it can be difficult for professionals to distinguish early stage substance misuse among young people who have pre-existing diagnosis of conduct disorder, attention deficit disorder or impulsivity, as behaviours are similar for substance misuse.

3.3 Research Design

The target population for research included professionals' working in voluntary, community and statutory organizations within a specific catchment area of the south-western suburbs Dublin City. Fifty four organisations and professional groups were identified and contacted. Professional groups included; teachers, home school liaison officers, education and welfare officers, social workers, youth workers, outreach workers, social care workers, alternative education/training instructors, nurses, outreach workers, addiction/generic counsellors, youth counsellors, psychiatrists, psychologists, family support workers, juvenile liaison officers, and probation officers. These professions were chosen as their work brings them into regular contact with young people and families.

The approach to data collection involved mixed methods through the use of questionnaires and semi-structured interviews which were carried out concurrently. These methods were applied because it is understood that not all studies fit neatly into one methodology and that a combined approach can offset the weaknesses in each approach (Hewitt Taylor, 2011; Robson, 2011; Thomas, 2011). It is appreciated that a pragmatic approach to research focuses on "what works" and the importance of the questions asked rather than the methods (Creswell & Plano Clark, 2007, p. 23). The questionnaire was designed to gather quantitative information relating to the research question and interviews allowed for the voice of participants to be heard. The merging and analysis of both sets of data allowed for a triangulated design based on the complementarity between the approaches as interviews enhanced findings from survey in their description of the issues related to research topic (Creswell & Plano Clark, 2007, p.62-64).

Out of the 54 organisations and professional groups contacted, responses were received from 48 (89%). A total of 136 questionnaires were posted together with stamped addressed envelopes, interview request forms and information leaflets. Returns from questionnaires totalled 87 (64%) and 53 people (39%) consented to interview out of which twelve were selected randomly (see Appendix: A).

3.4 Research Methods

The research methods involved anonymous questionnaires (Appendix: B) and an invitation to participate in semi-structured interviews with one professional from among each professional group. It was planned that anonymous questionnaires would afford opportunity for individual responses and avoid prestige bias in reply to questions. The questionnaire was reviewed by colleagues and fellow students to ascertain if the format addressed the research questions and to determine readability and ease of understanding. In the process questions were adapted to achieve clarity of wording and direction in relation to approaches in answering questions. All tick box questions were grouped together and a similar approach was applied to scaling and ranking questions. An interview schedule was designed to complement questionnaire and to guide interviews (Appendix: C). It was intended that semi-structured interviews would provide focus within interview and give professionals opportunity to expand on the research topic.

3.5 Sampling

The research was conducted among professionals working in different settings within the catchment area covered by the study (see Table 1). This was to allow for representation from among the broadest range of professionals who are working with young people or who would have a duty of care for young people in the course of their work with an adult population. Organisations were contacted by telephone initially with the researcher establishing a link with one key person in all organisations. The purpose of the research was explained to this person and the aims/objectives were outlined while requesting permission to post questionnaires, information leaflet (Appendix: D) interview consent forms (Appendix: E) for distribution among their colleagues. Upon securing engagement from a key person within each agency, all documents were posted. Questionnaires were given a reference number identifying agencies and to assist with the monitoring of returns.

Table 1 The types of agencies and services contacted

Service	Number	Participation
Alternative Education Projects	4	3
Child & Adolescent Mental Health (CAMHS)	3	3
Community Drugs Services	3	3
Community Centre	1	1
Community Project	1	1
Counselling (Adult & Youth)	2	2
Counselling (Youth)	1	1
Education & Welfare Services	1	1
Family Support Services	6	5
HSE Adult Addiction Counselling Service	1	1
HSE Outreach Service	1	0
Juvenile Liaison Services	1	1
Practice Nurses Group	1	1
Probation Service	1	1
Psychological Service	1	1
Schools	13	10
Social Work Service	1	1
Youth-reach Projects	3	3
Youth Services	9	9
Total	54	48 (89%)

3.6 Access

Access to participants was gained through their work settings following initial contact with a key person in each setting. In some circumstances formal requests were required by schools Boards of Management or alternative education projects, and the probation service have a standard application which is required by their Ethics Board. The time involved in awaiting approval within these organisations meant that research extended for two weeks beyond original closing date. A personalised letter (Appendix: F) based on standard format was sent to all key people together with 2-3 copies of all questionnaires, consent forms and supporting documentation. The fact that the researcher involved with this study works for an agency within the catchment area covered by research generated some concerns in relation to the potential challenges posed in gaining access to participants. It is acknowledged that "insider" researchers are often faced with the politics of institutions and the concerns that colleagues may have around sharing information and issues relating to confidentiality (Robson, 2011,

pp. 403-404). Also, it is appreciated that concerns may arise for potential participants in relation to researchers' ability to maintain objectivity and the preservation of working relationships. It was respected by this researcher that professional's might feel uncomfortable talking to another professional who also works with young people and families from the same catchment area. However, the fact that people consented to interviews was viewed as an indication that they had overcome any issues or concerns that might have arisen for them.

Candidates for interview were self-selected through the process of returning consent to interview forms. At the time of interview they were asked to sign a separate consent form (Appendix: G). Participation in the study was completely voluntary. The researcher focused on selecting interview candidates among professional's that have contact with young people who may be engaging in substance misuse. In keeping with random selection process the first person to return consent form among each profession was selected for interview with exception of psychologist where the second person was chosen as the first return related to someone who worked within adult services. Interviews took place at a location and time of interviewees choosing and all interviews lasted approximately 30 minutes. Interviews were voice recorded and subsequently transcribed.

3.7 Ethical Issues

Ethical considerations included protecting identity of respondents to questionnaires and the people who participated in interview as well as the population of young people whose statistics form part of the comparison information. All participants were informed of the nature and purpose of research and an anonymous method for receiving confirmation that they understood the process was used. Participants were informed of the nature and purpose of research by an information sheet attached to questionnaires and interview consent forms. This information sheet also clarified the consent process and that individuals were free to withdraw from process at any stage and it contained contact details for researcher and supervisor. The fact that one key person within each organisation and professional group took responsibility for distribution of documentation within their service/group meant that

respondents to questionnaires had someone to contact if they had issues in relation to questionnaire. The identity of respondents to questionnaire was protected due to the fact that researcher had no knowledge of process relating to their distribution. By completing questionnaire respondents indicated their understanding of information contained in information leaflet and their consent.

Professionals who took part in interviews were asked to sign a consent form which is stored securely until such time that all documents relating to research are destroyed. All recordings from interviews were coded to protect identity of interviewees. Only the researcher and research supervisor know the identity of interviewees in accordance with good practice (Bowling, 2009; Cryer, 2006). In the process none of the interviewees had any issues with interview process or questions. All interview questions were discussed with interviewees in advance of recording. If an interviewee had been affected by questions the interview would have been stopped and support provided to interviewee. The research was ethically approved within University following a comprehensive assessment process (Appendix: H) and at an organisational level the research was discussed and approved by a link person within researcher's place of employment (Appendix: I) this person did not have any involvement in research. No reward was offered to participants and the independence of researcher was emphasised as research was undertaken as part fulfilment of a Master's programme and was not directly associated with researchers' employer. The interest of researcher in the particular area of research was declared and the aims and objectives of research were clarified.

3.8 Analysis

The analysis framework applied within this study involved inductive and deductive thinking in keeping with the overall pragmatic approach advanced in mixed methods studies (Robson, 2011; Creswell & Plano Clark, 2007). The basic analytic approach involved constant comparison of data to identify emerging themes and to reveal the interconnectedness between qualitative and quantitative aspects (Thomas, 2011). Within this approach findings emerge out of data as a result of researchers' interaction with the material. The approach included coding and classification of data

with a focus on examining themes and the existence of relationships and differences between and among them. Not all questionnaires could be used in their entirety as some had spoiled sections where respondents marked all boxes instead of ranking by numbers while others declared an absence of knowledge in relation to specific questions.

3.9 Validity & Reliability

The validity of research was maximised by ensuring the anonymity of all respondents to questionnaires. In this way the phenomenon of 'social desirability' or 'prestige bias' was reduced as confidentiality was protected. Additionally the use of standardised questionnaires increased credibility as all respondents were asked the same questions. Interviewees were randomly selected following self-nomination. Data triangulation was achieved through the use of mixed methods and the fact that research and analysis was carried out by the same person alleviated potential for breakdown in communication.

3.10 Strengths & Limitations of Study

The study is confined to a specific catchment area located within suburbs of Dublin city and to a relatively small number of professionals with diverse backgrounds and training. As such the findings are not generalizable. However, that being said, insights and findings from research may have application within other communities. The fact that primary schools were not included in the study could be viewed as a limitation given that young people are reported to be experimenting with substances at a much younger age. Additionally, the fact that General Practitioners (GPs) were not included could also be viewed as a limitation given their potential to identify risks for young people at an early stage. However, within the confines of this research the researcher made a choice to restrict study to professionals that are most likely to come into regular contact with young people who are deemed to be most at risk in terms of initiating substance misuse. The researcher formed the opinion based on experience over twenty seven years of working with young people who engage in substance misuse that the transition period from primary school to secondary is a time

when young people are most at risk. It is for this reason that a decision was made to focus on secondary schools. In relation to GPs it was decided that individuals are most likely to present to their GPs once a problem exists in relation to the physical or psychological consequences of substance misuse. In the circumstances it was appreciated by researcher that GPs would treat and/or refer to other services as appropriate. The inclusion of practice nurses went some towards establishing link to GP services.

Overall the strengths of the study relate to the fact that it targeted a broad population of professionals who have regular contact with young people within diverse settings. In combining questionnaires and semi-structured interviews the study allowed for a more comprehensive response than could have been achieved by either approach separately. The fact that researcher made direct contact with one key person within each organisation or professional group may have contributed to 64% (n=87) response to questionnaires which is very favourable considering that according to de-Leeuw & Collins (1997) quoted in DeVaus (2002, p.127) general response rates to postal questionnaires is 61%.

3.11 Chapter Summary

This chapter outlined the methodology and design of a research study involving a survey and interviews undertaken within a specific catchment area among a broad range of participants. The validity of research was maximised through the use of anonymous questionnaires and by maintaining confidentiality and anonymity of interview participants. Although generalisation of results is not possible due to restriction of data collection to five communities within a specific catchment area, there is the possibility for insights or learning to be gained by professionals within other communities. Additionally, the research might act as a catalyst for a more comprehensive study.

CHAPTER 4
Agency Context

4.1 Introduction

This chapter provides a summary of the history in relation to youth drug culture within Irish society and identifies approaches to intervention. An outline is presented of the agency involved with this study and context within which it is located including policy context. Issues and trends are highlighted from work undertaken with young people and their families during 2012.

4.2 Treatment Service

4.2.1 Historical Dimension

In Ireland the problem of drug abuse among adolescents' emerged in the mid-1960s when there were raids on community and Health Authority pharmacies (Kelly & Sammon, 1975). In the same period there was a report that sixteen people were admitted to hospital due to amphetamine abuse (Walsh, 1966). In response to an Interim Report from a working party on drug abuse the Jervis Street Hospital, Drug Advisory and Treatment Centre was established in 1969. Records from 1997 indicate that there was an increase in drug consumption within the eastern part of the country, especially Dublin city (O'Brien & Moran, 1998). The main drugs of misuse during this period were opiates (65%) with heroin users generally age 15-19 year old (Keenan, 1999). Additionally, a study by Smyth, *et al.* (1998) of 733 new attendees to the Drug Treatment Centre Board 1992-1997, revealed Hepatitis C antibodies (61.8%) and HIV (1.2%) which was associated with an increase in intra-venous drug use. Throughout the 1990s treatment services available for young people were primarily for management of heroin misuse and were based on adult models (Keenan, 1999).

4.2.2 Harm Reduction

It was with the emergence of intra-venous drug use that harm reduction practices were introduced on public health grounds (Butler & Mayock, 2005). The emphasis within harm reduction is primarily on the establishment of opiate substitution programmes, outreach services and needle exchange facilities (HSE, 2011b; NACD 2004b). Currently, it is reported that the trend in relation to intra-venous drug use within western European countries relates more to performance enhancing drugs such as anabolic steroids than to opiates (European Harm Reduction Network, 2011). It is understood that preventative interventions are more successful in containing the spread of blood-borne viruses (Harm Reduction International, 2012). In acknowledgement of the fact that women who work in prostitution are a vulnerable group, the Women's Health Project was founded in 1991 (HSE, 2013a). The Gay Men's Health Project was established 1992 (HSE, 2013b) as it is stated that men who have sex with men experience disproportionate levels of ill health compared to the general population due to the fact that they are reported to use a broader range of drugs (European Harm Reduction Network, 2011, p.148).

Over the years many other non-statutory drugs services such as Anna Liffey Drugs Project (2007) and Merchants Quay Ireland (2013) pioneered harm reduction approaches and local drugs projects and youth services embraced a harm reduction philosophy. In response to changing trends in drug use, the emphasis within harm reduction has broadened to address issues relating to the use of substances such cannabis/weed, steroids, cocaine and "legal highs" intoxicating drugs that are not controlled under the misuse of drugs act 1977 (Ballyfermot Drugs Task Force 2010; Chrysalis CDP, 2009). Additionally, organisations such as the Gaelic Athletic Association (GAA) established an alcohol and substance misuse prevention programme to advance health promotion (GAA/Cumann Luthchleas Gael, 2012). Butler and Mayock (2005) propose that the absence of debate around harm reduction in Ireland has not facilitated more tolerant and respectful attitudes to drug users and may have delayed the introduction of a wider range of harm reduction practices. A study carried out by Youth Work Ireland, Cork (2011) highlights that problem drug use is a consequence of social inequality and proposes that social interventions rather than a medical or legal approach offer the best outcomes.

4.2.3 Establishment of Adolescent Services'

As an approach to meeting the complex needs of an adolescent drug using population two designated out-patient treatment services were established in Dublin during the mid-1990s. A community based programme was set up in North Inner City and a service was developed in the suburbs of Dublin City which is the project associated with this study. These services offered differentiated treatment plans involving medical treatment and family therapy combined with group activity and emphasis on social re-integration (Vitale & Smyth, 2004). Additionally, a number of beds were designated for adolescents' within an inpatient detoxification facility operated by the HSE. In the late 1990s a designated adolescent residential aftercare facility was opened in the midlands to provide a service nationally and in early 2000 the Department of Health established a Young Persons Treatment Programme within the National Drug Treatment Centre (Vitale & Smyth, 2004). Over the years there has been an increase in the number and type of services available to young people within communities (Department of Health and Children, 2005). For example most Local Drug Task Force areas have Community Drug Teams and provide therapeutic support, and education/training, employment access and family support including child care in addition to adult education and community awareness programmes (Department of Community, Rural and Gaeltacht Affairs 2009). The HSE, in partnership with voluntary/community sector, hosts www.drugs.ie, the national drug and alcohol information and support website (Department of Health, 2012).

In 2005, a working group set up to address the treatment needs of under 18 year olds, proposed a four tier model of intervention, centred on a framework established by the Health Advisory Service in the United Kingdom (Department of Health and Children, 2005, p. 45). This approach is endorsed by the current national drug strategy (Department of Community, Rural and Gaeltacht Affairs 2009). The tiered method to treatment is based on multidisciplinary approach and co-ordination and collaboration between agencies. Within the framework it is determined that tier 1 services be accessible to all young people and are not required to have specialist expertise in substance misuse. Professionals' operating at this level includes primary care workers, teachers, Garda, youth workers, probation officers and community and family support agencies. At the next level, tier 2 services are expected to have

proficiency in adolescent mental health and/or addiction. Professionals involved in these services include General Practitioners (GPs); drugs task force projects; home school liaison officers; outreach youth drugs workers; alternative education projects and youth homeless services. In general young people availing of these services are abusing alcohol and/or drugs and experiencing problems as a result. Tier 3 services are targeted towards young people who are experiencing substantial problems due to alcohol and drugs misuse and who may also have co-occurring psychiatric illness. Work with young people and their families at this level require a multi-disciplinary and inter-agency approach in order to address multiple risk factors. Services are required to have expertise in both adolescent mental health and addiction.

At the more specialised level, tier 4 services have all of the above expertise but also have the capacity for intensive treatment within a day hospital or in-patient facility. Young people requiring these services would be experiencing drug or alcohol dependence and will require medical intervention in addition to individual, group and family involvements. Currently there is one designated residential adolescent facility in Ireland, the Aislinn Adolescent Addiction Treatment Centre, Ballyragget, Co Kilkenny. This Centre offers medically supervised detoxification to 15-21 year olds since 2011 and a residential drug free rehabilitation programme since 1999 (Hartnett, 2012).

4.3 Agency

4.3.1 Establishment of Service

The agency associated with this study is a statutory service operating at tier 3. It operated initially out of a clinic setting where methadone (opiate substitute) was prescribed. In the first year of operation programmes involved structured ten week detoxification in conjunction with individual/family therapy and group work, followed by two weeks aftercare support. Although, a number of young people managed to complete these programmes they quickly relapsed (Keenan, 1999). In reality there were no structures in place for aftercare or rehabilitation within communities which is essential when dealing with young people as the issue is often not one of rehabilitation

but addressing deficits relating to knowledge and skills especially given that most of the young people attending were coming from socially disadvantaged communities (Murray, 2011). In 1998 a more flexible approach to treatment was introduced, focused on individual care plans privileging young people's voices and family concerns (Keenan, 1999). Work was undertaken to build relationships with other statutory and community services towards developing a community of interest in support of young people's integration within their community as espoused by the work of White and Epston (1990) and the Justice Therapy Group (Dulwich, Centre Newsletter, 1990). It is reported by Keenan (1999), that as a result of these developments there were improved retention rates among those receiving treatment and better outcomes for young people and their families in terms of overall stability.

4.3.2 Target population

The service is available to young people under age 18years old from five communities that form the catchment area. It was initially intended that the service would be limited to young people from one community only, however despite the extent of the drug problem among the adult population in the area during the mid-1990s there was not sufficient numbers of young people presenting to sustain a programme and thus the catchment area was extended to include adjacent communities within community care area (Keenan, 1999).

4.3.3 Staffing and team structure

The clinical team working within the programme during the first six years of operation comprised general practitioner (GP) part-time; pharmacist part-time; nurse part-time; three general assistants (GAs) part-time; family therapist full-time and administrative support. With exception of the family therapist, all other members of the team worked primarily within adult addiction service. In 2003 a consultant child and adolescent psychiatrist was employed to head up the service and to establish treatment services for young people within other communities. Currently, referrals are made to the family therapist initially and other members of the team are involved when necessary if medical intervention or psychiatric assessment is required.

4.3.4 Policy context

The service operates under Children's First Guidelines (2011), Child Care Act 1991 (2001) and HSE Addiction Service, Policies/Procedures (2006). In 2003 a point was reached when the service was treating 50% of clients outside of structured programme and without medication. The medical and therapeutic components of programme were separated in 2004 due to the fact that decreasing numbers of young people were presenting with problems in relation to heroin abuse or at a point where they required medical intervention. Also, parents' reported feeling uncomfortable about attending a clinic where methadone was dispensed (Murray, 2011). To coincide with the re-configuration of services the criteria for access was expanded to include treatment of young people experiencing problems with alcohol and other drugs. As identified within literature review the approach to working with young people experiencing problems with alcohol, cannabis/weed and some other drugs primarily involves psychosocial interventions.

4.4 Trends

During 2012, the service worked with 48 adolescents' 75% (n=36) were new referrals with a mean age 15.5 years (range 13-19 years). Most 77% (n=37) were male. Referrals were received from a broad range of sources with family (27%), school/training centre (19%), CAMHS (13%) and social work (10%) being the most common. Consistent with research identifying social risk factors the communities most represented are those with the highest levels of unemployment and where there are low levels of expectation in terms of educational achievement. Cannabis/weed is currently the main problem substance (80%) while alcohol was the main substance for the remaining 20%. However, poly-substance use was the norm, with only 19% of clients presenting with a single problem substance. Other drugs to feature as part of the pattern of poly-substance misuse were benzodiazepines (15%), amphetamines (8%), cocaine (10%) and heroin (4%). No young person required pharmacological treatment.

The most recent statistics, available from National Drug Treatment Reporting System (2013) in relation to under 18 year olds are for 2010 and indicate that cannabis accounted for almost 50% of treatment presentations nationally followed by alcohol at (32%), benzodiazepines (3%), Cocaine (1.5%) opiate (3%) and inhalants (2.5%) with poly-substance misuse accounting for the remainder. Statistics available for the same period relating to county Dublin indicate that among under 18 year olds presenting for treatment, totalling 179 adolescents', cannabis accounted for 57.5% of cases followed by alcohol (21%), cocaine (3.4%) benzodiazepines (2.8%) and other or poly-substance misuse accounting for the remainder.

The European School Survey Project on Alcohol and Drugs (ESPAD), for 2010-2011, carried out among 15-16 year olds revealed that 9% of girls and 13% of boys in Ireland had their first drink before age of 13 years and that the European average for drunkenness in the last 30 days within the age cohort is 17% whereas in Ireland it is 23% (Hibell, *et al.* 2012). This suggests that Irish people have a greater propensity for binge drinking. Results from the Irish Health Behaviour in School-age Children (HBSC) survey for 2010 indicate an overall decrease in alcohol consumption among 10-17 year olds in Ireland at 46% compared to 2006 when 53% stated having consumed alcohol (Kelly, *et al*. 2012, p.23). In relation to cannabis 5% of children stated they used cannabis within the previous month which is a decrease from 2006 when 7% reported using cannabis (ibid, p.28).

Among current attendees at the service associated with this study 65% (n=31) had past or current contact with CAMHS. Consistent with this, it was found at assessment within the service that 30% (n=14) had a history of past or current deliberate self-harm or suicidal ideation/behaviour, while 50% (n=24) were not engaged in any form of education or training, despite their young age. Of those in education, 25% (n=6) had poor attendance. Most had contact with youth services 84% (n=40) and 54% (n=26) had some contact with the criminal justice system, primarily Juvenile Liaison Officers, while 34% (n=16) had contact with family support services and 18% (n=9) with social work. A major trend in 2012 was the frequency of indebtedness 52% (n=25) linked primarily to cannabis/weed. A survey by the Family Support Network of Ireland highlights that intimidation and threats of violence are increasing among families where members have drug related debts (Connolly, 2010).

4.5 Chapter Summary

This chapter provided a summary in relation to youth drug culture within Irish society and identifies approaches to intervention. In response to problems relating to illicit drug use the first treatment service was established in Dublin in 1969. As an approach to meeting the complex needs of an adolescent drug using population two designated out-patient treatment services were established in Dublin during the mid-1990s. Additionally, a number of beds were designated for adolescents' within an inpatient detoxification facility. In the late 1990s an adolescent residential aftercare facility was opened in the midlands and in early 2000 the Department of Health established a Young Persons Treatment Programme within the National Drug Treatment Centre. In 2005, a working group set up to address the treatment needs of under 18 year olds, proposed a four tier model of intervention, centred on a framework established in the United Kingdom. Currently, trends in relation to drug use are changing as the abuse of heroin is on the decline particularly in Dublin. The changing profile of drug use presents challenges to services in terms of establishing a broad range of treatment responses and greater emphasis on inter-agency working.

CHAPTER 5

Findings

5.1 Introduction

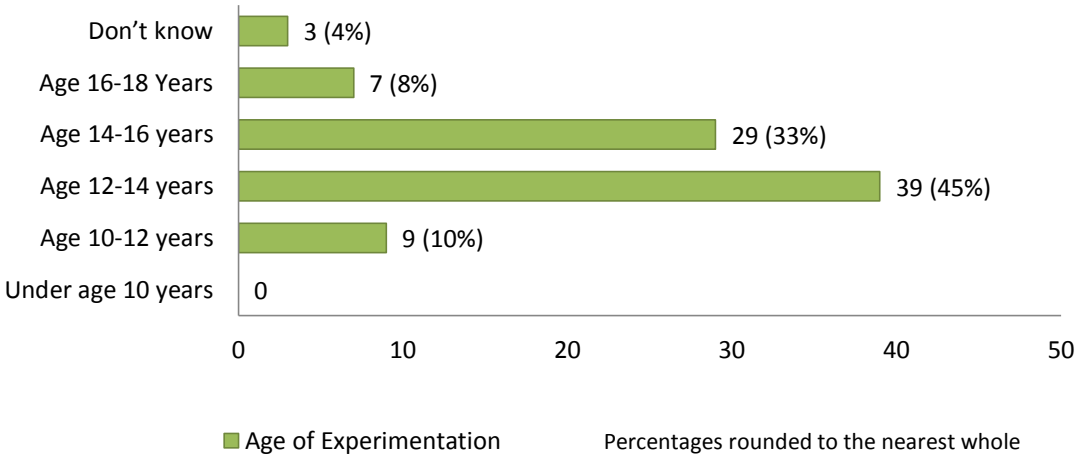
This chapter presents the main findings from research relating to professionals' understanding of the nature and extent of substance misuse by young people with whom they have contact and their understanding of the risk factors associated with early onset substance misuse. Additionally, the actions that might be taken by professionals' where concerns exist for a young person in relation to substance misuse are identified. Data from questionnaires is presented figuratively or in tabular format complimented by quotes from interviewees. Finally the chapter closes with a list of additional comments and recommendations made by respondents to questionnaires.

5.2 Professionals' understanding of the nature and extent of substance misuse by young people

5.2.1 Professionals' perception of the age at which young people begin to experiment with substances.

This research found that 10% (n=9) of respondents to questionnaires are of the opinion that young people begin to experiment with substances between the ages 10-12 years old and that 45% (n=39) of are of the opinion that young people initiate experimentation between ages 12-14 years old (see Figure 1). A further 33% (n=29) of respondents identified young people's experimentation with substances as beginning between ages 14-16 years old, and 8% (n=7) indicated that young people's experimentation with substances between ages 16-18 years old and 4% (n=3) reported not knowing what age young people begin experimenting with substances.

Figure 1: Professionals perception of the age at which young people begin to experiment with substances.



Within interviews a similar pattern was reflected as highlighted in the following extracts when an outreach youth drugs worker identified;

> *"I am seeing them at eleven, ten or eleven drinking alcohol, eleven, twelve, thirteen sampling cannabis"* **I.1**

A family support worker stated;

> *"I think thirteen and fourteen and that would be alcohol and hash"* **I.2**

A clinical nurse specialist who reported;

> *"I certainly have seen children as young as ten or eleven……smoking hash in particular"* **I.3**

A Juvenile Liaison Officer stated;

> *"I suppose you always have exceptions……I would say around fourteen"* **I.5**

A child and adolescent psychiatrist indicated;

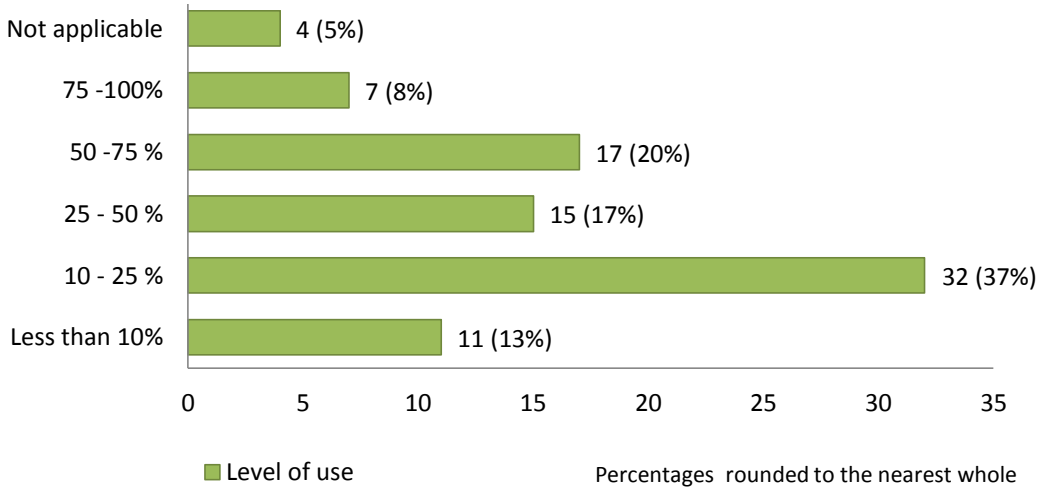
> *"I think the people that we would see…are using substances twelve to thirteen"* **I.8**

A clinical psychologist stated *"I would say around age sixteen"* **I.9**

5.2.2 Professionals perceptions of the extent to which young people attending their service are engaging in substance misuse

When asked about their estimation of the extent to which young people attending their service engaged in substance misuse? The results show that 13% (n=11) of respondents to questionnaires estimate that less than 10% of young people are engaging in substance misuse, while 37% (n=32) give estimation at 10%-25%. A further 17% (n=15) point toward 25%-50% while 20% (n=17) indicated that between 50%-75% are using substances and 8% (n=7) gave an estimation of over 75% (see Figure 2).

Figure 2: Professionals perception of the extent to which young people are engaging in substance misuse



Professionals' who gave a high estimation for substance misuse among young people within interviews included a probation officer who reported;

> *"I very rarely come across a young person who has not engaged in some form of substance misuse",* **I.12**

An outreach youth drugs worker stated;

> *"99% of all young people who come into our centre using alcohol…..75% using cannabis…40% who would maybe have another substance involved"* **I.1**

A home school liaison co-ordinator reported;

> *"I would say 90% of them engage in alcohol….Oh we could be missing 20% of our students on a Monday morning……now the notes won't say that...one parent said to me Facebook will!"* **I.4**

In relation to cannabis/weed a teacher reported;

> "*probably about 90% of young people in this centre"* **I.6**

Professionals who reported experiences of youth substance misuse at the lower end of the scale included a juvenile liaison officer who reported in relation to cannabis;

> *"20% would be either using it or have tried it"* **I.5**

A family support worker stated;

> *"I would say 20%-25% and I don't mean hard drugs, but I mean kind of alcohol and hash"* **I.2**

5.2.3 Professionals perceptions of the types of substances used by young people

Data from this research indicates that alcohol is viewed as the primary substance of misuse by young people according to 66% (n=42) respondents and that cannabis/weed was rated as primary by 34% (n=22) respondents. However, as a secondary drug of misuse cannabis/weed was rated highest at 61% (n=36) followed by alcohol (34%, n=22); solvents (3%, n=2); and cocaine (2%, n=1). Within a third category of substance misuse ecstasy, benzodiazepines, cocaine and solvents featured most prominently. Other drugs mentioned within 4th and 5th categories included amphetamines, LSD and Ketamine (see Figure 3).

Among interviewees a similar trend was reflected with a probation officer reporting;

> *"There is quite high potent cannabis available out there and that's clearly having an effect on my clients. Also, tablet based use, un-prescribed medication"* **I.12**

An outreach youth drugs worker reported;

"I am seeing 80%-90% alcohol, 50%-60% cannabis" **I.1**

A clinical nurse specialist stated;

"Mainly alcohol and cannabis….would be the big problems" **I.3**

A social worker reported;

"alcohol and then you have weed/hash ….and various pills". **I.11**

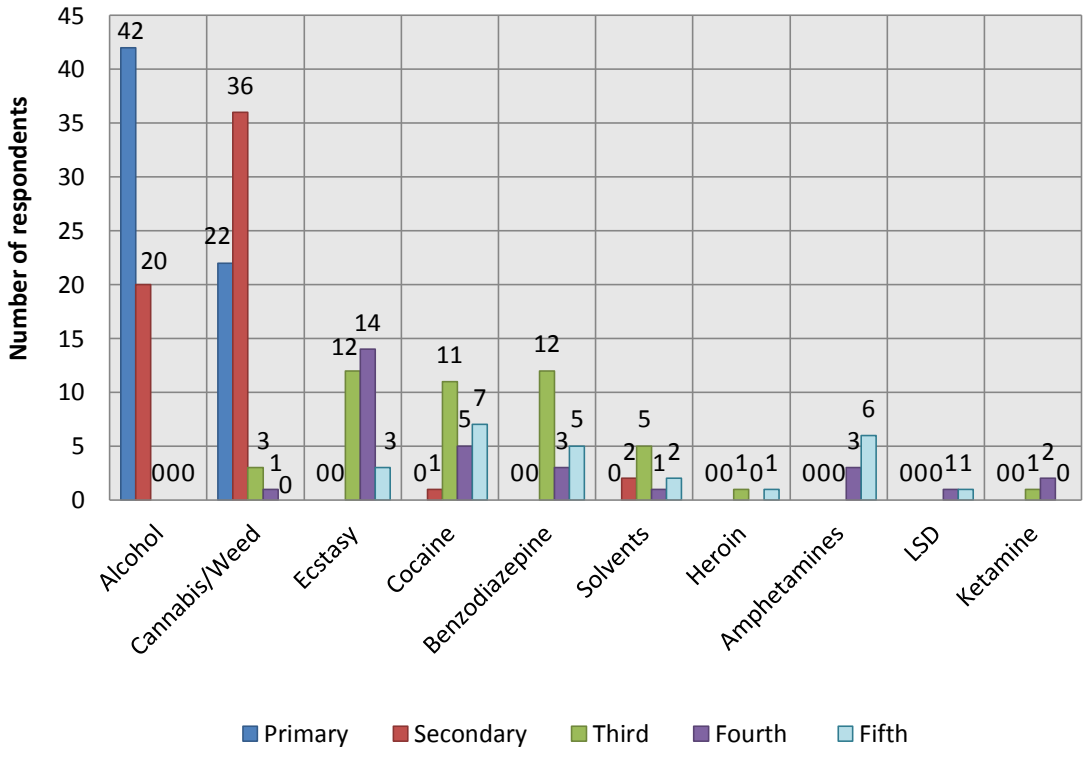
A child and adolescent psychiatrist stated;

"cannabis….Benzo's……and the other thing like Head Shop stuff" **I.8**

An education and welfare officer reported;

"*I think hash is more freely available than alcohol…….I have suspicions of maybe "E" being used"* **I.7**

Figure 3: Professionals perceptions of the types of substances used by young people



5.2.4 The extent to which professionals' ask young people about issues relating to substance misuse

This research data indicates that 17% (n=15) of respondents specified that they always ask young people attending their service about issues concerning substance misuse. A further 44% (n=38) of respondents showed that they would discuss issues relating to substance misuse with young people frequently, while 31% (n=27) indicated that they occasionally ask young people about substance misuse, and 3% (n=3) indicated they never ask, while 5% (n=4) specified that the question was not relevant as they do not work with young people under age 18 years old (see Figure 4). The professionals who reported in interviews that they would always ask young people about substance misuse included a teacher within an alternative education project who stated;

> *"Yes, because we are under pressure to get the young people their FETAC level four"* **I.6**

A clinical nurse specialist stated;

> *"Yes most definitely in terms of risk taking behaviour"* **I.3**

An outreach youth drugs worker indicated

> *"Yes they would be raised by me. Again, they would be raised to me in the course of my work"* **I.1**

A probation officer confirmed that a probation assessment and report details

> *"drug and substance misuse issues*" **I.12**

A juvenile liaison office described

> *"Yes…in kind of building a profile of the child"* **I.5**

A child and adolescent psychiatrist reported;

> *"Yes we would raise all of the time….some people if you ask will tell you the truth…some people are afraid…because of the setting here that we'll tell their mum and dad….the other thing is that we don't do any drug screens here"* **I.8**

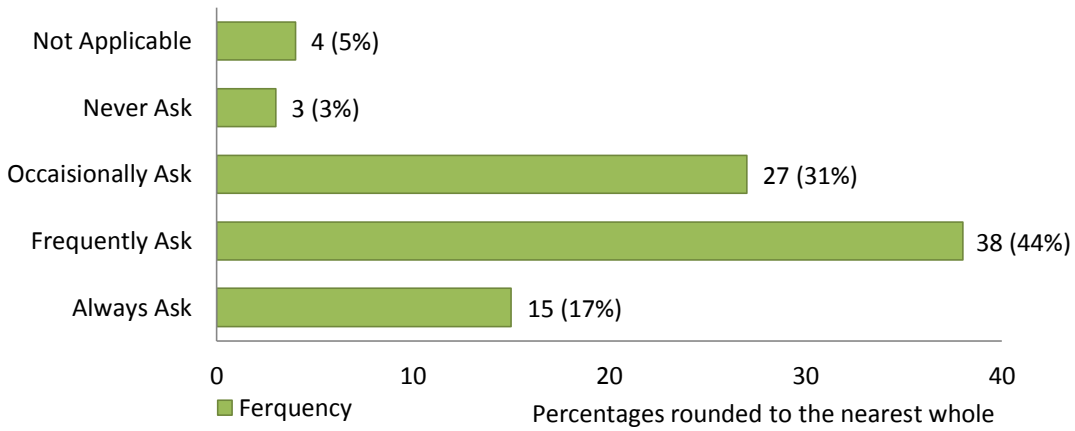
Professionals who reported in interview that they would occasionally or never ask young people about issues relating to substance misuse included a youth worker within a school setting stated;

> *"If there is an issue of a young person that we suspect or has disclosed that they are abusing or misusing substances, it would be dealt with by the project worker"* **I.10**

A social worker indicated that the service would take a different approach with children who are in long term care compared to young people who are referred in their teenage years;

> *"in some cases, not top of their agenda when children are in care..... ....community by definition when they are teenagers are much more problematic……so most if not all would have issues with some form of substance misuse"* **I.11**

Figure 4: The extent to which professionals' ask young people about issues relating to substance misuse



5.3 Professionals' understanding of the risk factors associated with early onset substance misuse.

5.3.1 Professionals perceptions of the circumstances that cause young people to initiate substance misuse

The results from this research show that 65% (n=56) of respondents perceive young peoples' peers as having the greatest influence over whether they initiate substance use. Family circumstances were ranked second at 23% (n=20) and lack of parental support or guidance ranked third at 17% (n=15). Curiosity and environmental factors ranked joint fourth at 16% (n=14) while parental/sibling substance misuse was ranked fifth at 15% (n=13) followed by boredom 12% (n=10); normalised within society 12% (n=10) and experimentation/fun12% (n=10). Personal circumstances were identified as contributing factors by 10% (n=9) of respondents and low self-esteem by 9% (n=8) followed by family breakdown and self-medicating at 6% (n=5). Various other factors were also identified as influencing young people's decisions in relation to early stage substance misuse (see Table 2). Even, if all of the family factors are added together the total is 61% (n=53) which is 4% less than that indicated for peer influences. In interviews a family support worker offered the following insight;

> *"Families will always put it down to peer pressure, but I actually think the main influence is within the family. It comes down to parental authority……I find it worrying the number of children that are now self-medicating*" **I.2**

The following insights were shared by a Juvenile Liaison Officer;

> *"Number one if there is problems at home and especially if there is drug problems at home. Number two is the environment……where it is freely available and if there is dealing…….Number three is if they leave school early and number four and probably the most important one is peers"* **I.5**

The following reflection was given by consultant child and adolescent psychiatrist;

> *"Well a lot of the time there is problems at home, like they are not being supervised very well……..maybe they are sort of nearly taking drugs to get away from how they are feeling"* **I.8**

A youth worker within a school setting shared the following insight;

> "*I suppose the family circumstances……..if there is a family member whether it's an older sibling or a parent that missuses substances and it's seen as kind of the norm…..I think the environment…..availability….If friends are doing it……it's an escape"* **I.10**

A clinical nurse specialist stated;

> *"acceptance, that it's a teenage experimentation that happens in this area. Parent's come along, yes well they were smoking a bit of hash……they wouldn't necessarily always feel that it was something they might need to tell you"* **I.3**

An outreach youth drugs worker stated;

> "family behaviour…..I have a client where a father and son would be playing the play-station, they are having a joint together" **I.1**

A probation officer gave the following reflections in relation to early onset substance misuse;

> "*peer association…parent's that are also using, that's really a contributory factor, we find that again and again, and being out of school"* **I.12**

An education and welfare officer stated;

> *"the main influence is within the family, it comes down to parental authority……I find it worrying the amount of children that are now self-medicating"* **I.7**

A home school liaison co-ordinator recounted;

> *"A non-drinking adult is unusual for a lot of these children…the other big thing we would see is dependency on parent's medication"* **I.4**

Table 2: Professionals perceptions of circumstances influencing substance misuse by young people

Perceptions of circumstances influencing substance misuse	Frequency of mention
Peer Influences	56 (65%)
Family Circumstances	20 (23%)
Lack of parental support/guidance	15 (17%)
Curiosity	14 (16%)
Environmental Factors	14 (16%)
Parental/sibling substance abuse	13 (15%)
Boredom	10 (12%)
Normalised within society	10 (12%)
Experimentation & Fun	10 (12%)
Personal circumstances	9 (10%)
Low self esteem	8 (9%)
Family breakdown	5 (6%)
Self-medicating	5 (6%)
Belongingness	4 (5%)
School difficulties	3 (3%)
Incorrect information about effects of substances	3 (3%)
Stress	3 (3%)
Sexual abuse	2 (2%)
Physical abuse	2 (2%)
Psychological abuse	2 (2%)
Acting out behaviour	2 (2%)
Mental Health	2 (2%)
Lack of Love or Neglect	2 (2%)
Lack of discipline	1 (1%)
Depression	1 (1%)
Early childhood trauma	1 (1%)
Disengagement	1 (1%)
Poverty	1 (1%)
Dissatisfaction with life prospects	1 (1%)
Adolescent transition	1 (1%)

Percentages rounded to the nearest whole

5.3.2 Professionals perceptions in relation to substance misuse by adolescents'

This research found that in relation to alcohol use and experimentation by young people, 3% (n=3) of respondents strongly agreed and 45% (n=39) partially agreed with question 7 on questionnaire asking them to express their opinion on adolescent experimentation with alcohol. In relation to young peoples' experimentation with drugs the data indicates that none of the respondents agreed to the statement in question 8 on questionnaire asking them to express their opinion in relation to adolescent's experimentation with drugs and 30% (n=26) partially agreed,

6% (n=5) indicated they were not sure (see Figure 5). In interviews respondents reflected on the fact that there seems to be a high level of tolerance within communities and among parents for alcohol in particular and to a lesser extent for cannabis. In some instances it was indicated that parents give children tablets that are not prescribed for them. This culture is encapsulated in the following quote from an outreach youth drugs worker who reported;

> *"I have actually known parent's to give their children benzodiazepines to help them ... Now the alcohol bit, you know again when speaking to parent's who would say to me, you know what, they are not on heroin….It's positive….'oh sure he's only having a drink and I know where he is"* **I.1**

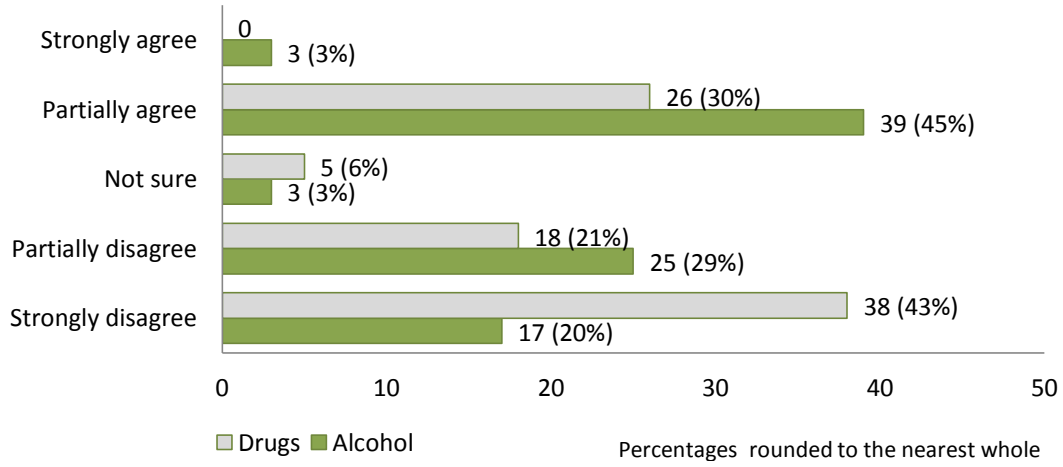
A home school liaison co-ordinator reported;

> *"I would have parent's buying alcohol for their children as young as thirteen"* **I.4**

And the same person stated that a mother said;

> *"I remember a mother once saying, I'm the parent who is the baddie for not supplying alcohol to my fourteen years old and she said she was isolated by a group of parents who felt she was being condescending and judgemental"* **I.4**

Figure 5: Professionals perceptions of adolescent substance misuse



5.3.3 Professionals perceptions of the risks associated with early onset substance misuse

Question 9 on questionnaire asked respondent's opinion in relation to the following;

> "Young people who engage in substance misuse before age 16 years old are at greater risk of having problems in relation to substance abuse throughout their life"

Almost half 49% (n=43) of respondents agreed with this statement, a further 36% (n=31) partially agreed, 8% (n=7) were not sure and 6% (n=5) partially disagreed (see Figure 6).

In interview a teacher working in an alternative education project stated;

> *"I have seen people that I worked with twenty one years ago, and they are on the main road selling drugs, strung out totally"* **I.6**

A home school liaison Co-ordinator said;

> *"I think it will always have far reaching consequences for the child in terms of their mental health"* **I.4**

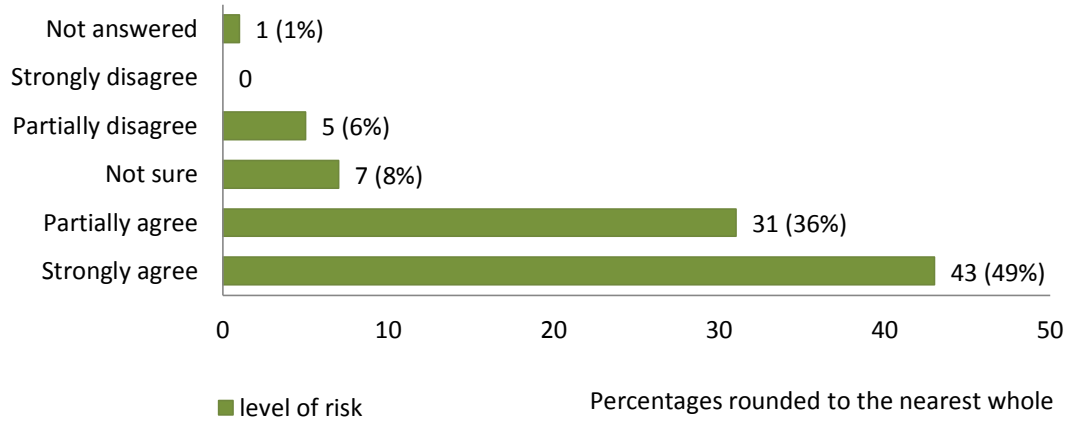
A probation officer gave the following reflection;

> "*it can be an aggravating feature in their offending*" **I.12**

A juvenile liaison officer stated;

> *"the arrogance is…….I can control it. But as you know yourself you can't……it takes you over…..So it's that kind of stepping stone of alcohol, cannabis, tablets, coke, crack or whatever"* **I.5**

Figure 6: Professionals perceptions of the risks associated with early onset substance misuse



5.3.4 Professionals reflections on why substance misuse by some young people goes un-noticed until a crisis occurs

The following explanations were given in interview as to why substance misuse might go un-noticed.

A juvenile liaison officer stated;

> *"If parent's have their eye off the ball it can go un-noticed"* **I.5**

A teacher made a similar statement;

> *"they don't have anyone who has their finger on the pulse with them"* **I.6**

A probation officer recounted;

> *"lack of communication or marital issues"* **I.12**

A family support worker reflected;

> *"people live with drugs; I don't think they actually know the early signs"* **I.2**

An outreach youth drugs worker shared;

> *"I think the first thing that has to be answered is very poor inter-agency work, poor communication across all agencies around the young person's needs…….inter-agency work is atrocious, it's like they are my clients….you have a youth service and they have a characteristic form which they use for screening the young people that they engage with….their active characteristics substance misuse, problems living at home, trouble with Garda….yet they would not dreamt of referring"* **I.1**

A youth worker within a school setting gave the following reflection;

> *"If somebody is experimenting or taking drugs, but actually they are still managing to get up and go to school, they are not having massive physical rows at home, they may kind of get away with it….if that family is taking drugs it's kind of part of the norm, so they don't even do anything about it"* **I.10**

A psychologist gave the following account;

> *"I think they would tend to hide that they self-medicate"* **I.9**

A child and adolescent psychiatrist stated;

> *"Parent's they don't know what to be looking out for"* **I.8**

A social worker gave the following account;

> *"Well of course if it's hidden it's because adults haven't been aware of the signs….So key adults are not paying attention……working class culture there is much greater tolerance of hash/weed…..great tolerance of alcohol. We have foster parent's taking weed and we have to deal with that"* **I.11**

5.4 Actions that might be taken by professionals if they had concerns for a young person in relation to substance abuse.

5.4.1 Action that might be taken by professionals if they became aware that substance misuse was a problem for a young person

Results from this research show that the majority 70% (n=57) of respondents would talk with a young person in the first instance if they had concerns about them in relation to substance misuse, and 11% (n=9) stated that they would consult with a colleague initially while 10% (n=8) designated that they would discuss with parent's at the outset and 3% (n=2) reported that they would support the young person within their organisation, with a further 3% (n=2) specifying that they would consult with addiction service in the first instance and the remaining respondents indicated that they would either refer to addiction service 1% (n=1), social work service 1% (n=1) or CAMHS 1% (n=1) in the first instance (see Table 3). Within a ten point ranking system 94% (n=76) overall indicated that they would discuss the issue with the young person at some stage, with 67% (n=55) stating that they would encourage young person to get help, and 77% (n=63) reported they might discuss with young person's parents; 80% reported that they would refer to addiction service at some stage with 62% (n=50) reporting that they would continue to support the young person within their organisation overall. Referral to social work at some stage was rated as an option by 36% (n=29) and referral to CAMHS at any stage was chosen by 33% (n=27) of respondents. A number of respondents 16% (n=13) indicated that at some level they would ignore the issue in the hope that the young person might cop-on and stop.

Table 3: **Actions that might be taken by professionals if they had concerns for a young person in relation to substance misuse (Percentages rounded to nearest whole)**

Action	1st	2nd	3rd	4th	5th	6th	7th	8th	9th	10th	Not chosen
Discuss with young person	57 (70%)	12 (15%)	1 (1%)	3 (4%)	2 (3%)	1 (1%)	0	0	0	0	5 (6%)
Consult with colleague	9 (11%)	8 (10%)	10 (12%)	4 (5%)	2 (3%)	5 (6%)	0	0	1 (1%)	1 (1%)	41 (51%)
Discuss with parent	8 (10%)	24 (30%)	12 (15%)	8 (10%)	5 (6%)	2 (2%)	2 (2%)	2 (2%)	0	0	18 (23%)
Support within organisation	2 (3%)	6 (7%)	12 (15%)	15 (19%)	7 (9%)	2 (2%)	4 (5%)	2 (2%)	0	0	31 (38%)
Consult Addiction Service	2 (3%)	2 (3%)	10 (12%)	11 (14%)	10 (12%)	12 (15%)	4 (5%)	0	0	0	30 (36%)
Refer to Addiction Service	1 (1%)	2 (3%)	16 (20%)	13 (16%)	7 (9%)	10 (12%)	13 (16%)	2 (2%)	0	1 (1%)	16 (20%)
Encourage young person to get help	1 (1%)	21 (26%)	12 (15%)	9 (11%)	8 (10%)	2 (2%)	2 (2%)	0	0	0	26 (33%)
Refer to Social Work	1 (1%)	3 (4%)	1 (1%)	2 (3%)	5 (6%)	1 (1%)	2 (3%)	11 (14%)	3 (4%)	0	52 (64%)
Refer to CAMHS	0	2 (3%)	2 (3%)	4 (5%)	2 (3%)	2 (3%)	2 (3%)	6 (7%)	6 (7%)	1 (1%)	54 (67%)
Ignore as they may stop	0	0	0	0	0	0	0	0	5 (6%)	8 (10%)	68 (84%)

In interviews participants gave the following accounts of what they might do if they had concerns for a young person in relation to substance misuse.

An education and welfare officer said;

> *"make sure that the parent is aware and start giving some level of education….get permission for the parent to refer the child to either GP to addiction service….a lot of kids we come across, would be referring them to the children's mental health service"* **I.7**

An outreach youth drugs worker stated;

> *"I engage with parent's first then the young person…We then refer to GP…we would provide a programme that would be youth friendly…If he continues with his drug use we would refer him to addiction counsellor which we can provide in-house, and then if we think that is not working then we will try and put in place like consequences. So he might lose his allowances, he might lose his little project that we are working on…Now in relation to referrals…..we would make a referral to yourself usually at a very late stage and the reason that would be…if I make referral early...you have lost him and I have lost him"* **I.10**

A home school liaison co-ordinator stated;

> *"Well the first thing I would do is talk to them…link with parent's…and you'll find that the parent's had been looking for things…doubting themselves yes definitely. It's amazing how some parent's don't consider it sort of a right to question their child"* **I.4**

A social worker reported;

> *"Our first protocol is really linking with the young person and immediate carers……..Then you would be looking at how best to deal with it….is there a way we could manage it ourselves….What does the young person need to help them….So in a sense you are looking at levels, ideally you want that on the lowest key possible initially"* **I.11**

A consultant child and adolescent psychiatrist stated;

> *"Well usually we would have time for them, have a chat with a young person about it….I suppose we are lucky we have….addiction service nearby"* **I.8**

5.4.2 Professionals perceptions of the types of interventions that are most useful with young people who are experiencing problems in relation to substance misuse

When asked about the types of interventions considered most useful with young people who regularly abuse substances and who may have developed substance dependency, 35% (n=28) of respondents chose individual counselling as their first preference, followed by family therapy 27% (n=21); ACRA 10% (n=8); MI 9% (n=7). While SFP, CBT and residential treatment ranked equally at 5% (n=4) and medical intervention ranked at 4% (n=3), (see Figure 7). Overall, individual counselling ranked highest within an eight point intervention ranking structure with a total non-selection of 3% (n=7) within total non-selections across all intervention types. Family therapy ranked second overall with a total non-selection of 9% (n=25), followed by SFP which had a total non-selection of 10% (n=27) of overall non selected category. The other intervention types ranked on the basis of their total non-selection were CBT 12% (n=33); MI 13% (n=35); ACRA 17% (n=45) with medical intervention and residential treatment ranking equally as both had a total non-selection of 18% (47).

Within interviews respondents expressed the following preferences; a child and adolescent psychiatrist stated;

> *"Motivational Interviewing is good……if the parents are involved it can help…the other thing that is helpful is an Extern worker…one or two have been totally out of control…..ended up going to the special care unit"* **I.8**

A social worker reflected;

> *"Ideally you would want that on the lowest key possible initially....can we deal with it ourselves….and then you are looking at the necessary tasks referral to services like yours or CAMHS…Youth Advocacy"* **I.11**

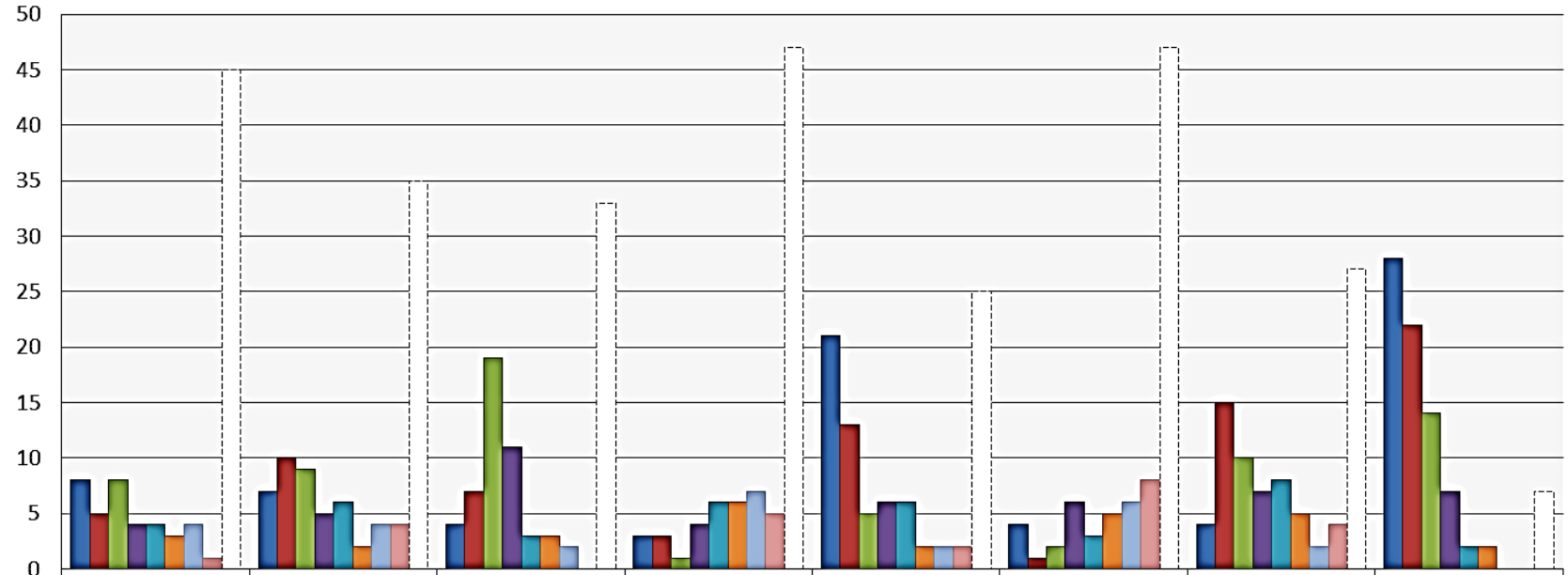
A family support worker stated;

> *"Make sure that the parent is aware….refer the child either to GP to addiction service…parent's….if they are within addiction services themselves…..don't want their child to go"* **I.2**

An outreach youth drugs worker identified;

> *"The number one strategy is motivational interviewing……..the other thing is a carrot, one needs to attract young people…like the Gym pass, or a small allowance or some little activity"* **I.1**

Figure 7: **Professionals' perceptions of intervention types that are viewed as most useful when working with young people who engage in substance misuse**

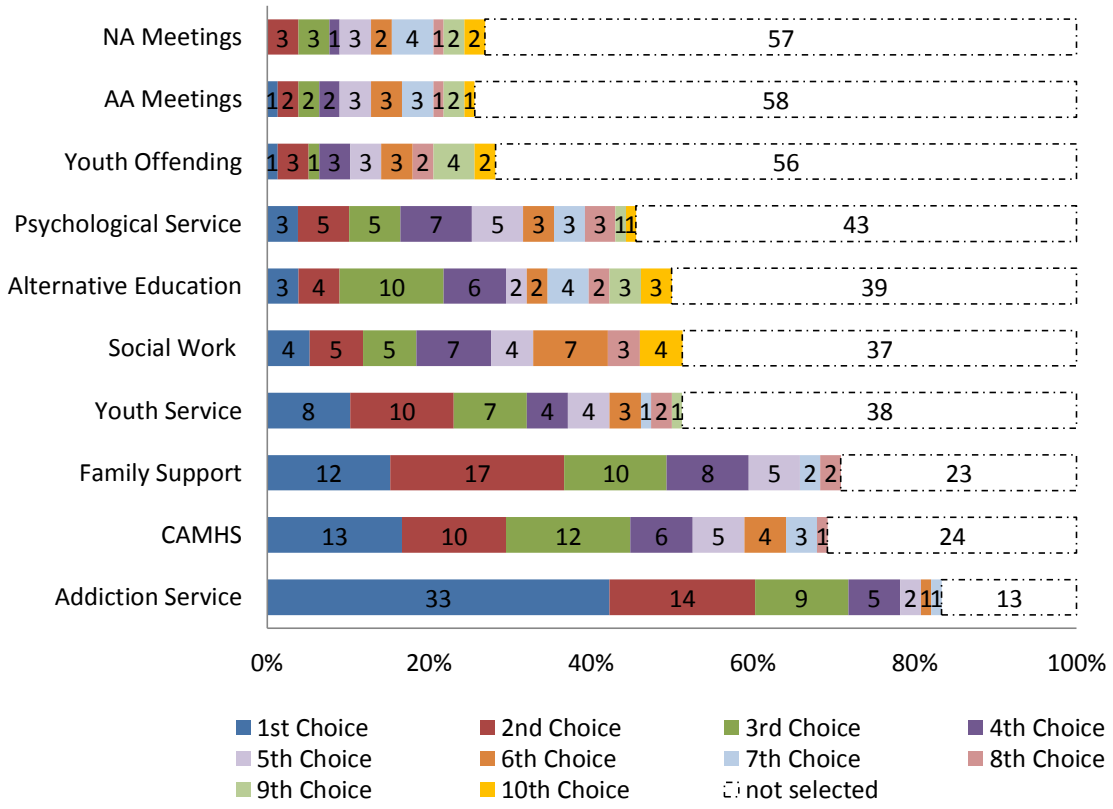


	Adolescent Community Reinforcement Approach	Motivational Interviewing	Cognitive Behavioural Therapy	Medical Intervention	Family Therapy	Residential Treatment	Strengthening Families Programme	Individual Counselling
Intervention 1	8	7	4	3	21	4	4	28
Intervention 2	5	10	7	3	13	1	15	22
Intervention 3	8	9	19	1	5	2	10	14
Intervention 4	4	5	11	4	6	6	7	7
Intervention 5	4	6	3	6	6	3	8	2
Intervention 6	3	2	3	6	2	5	5	2
Intervention 7	4	4	2	7	2	6	2	0
Intervention 8	1	4	0	5	2	8	4	0
Not selected	45	35	33	47	25	47	27	7

5.4.3 *Professionals indications of the types of services they would most likely refer a young person for whom there are concerns in relation to substance misuse*

When provided with a list of the types of services available within the catchment area covered by this study and asked which service they are most likely to refer a young person who is engaging in substance misuse, respondents indicated the following as their first preferences; addiction service 42% (n=33); CAMHS 17% (n=13); family support 16% (n=12); youth service 10% (n=8); social work 5% (n=4); alternative education 4% (n=3); psychological services 4% (n=3); youth offending project 1% (n=1); and AA meetings 1% (n=1). A similar pattern continued throughout respondents second preferences, with family support featuring more prominently at 23% (n=17); addiction service 19% (n=14); CAMHS 14% (n=10); youth service 14% (n=10); social work 7% (n=5); psychological services 7% (n=5); alternative education 5% (n=4); youth offending 4% (n=3); NA meetings 4% (n=3) and AA meetings 3% (n=2). The trend in service selection was constant throughout within a ten point rating system and in the way services were not selected (see Figure 8).

Figure 8: **Services professionals are most likely to refer a young person for whom they have concerns in relation to substance misuse**



Within interviews respondents indicated the following preferences;

A youth drugs worker stated;

> *"GP.....our own in house counselling…refer them into education……if not making progress … we would make a referral to the parent and the young person to attend your service"* **I.1**

A psychologist reported;

> *"A specialised service for young people who also discuss drugs and welcome the families"* **I.9**

A clinical nurse specialist stated;

> *"My initial reaction is the substance abuse service……the most important is the inter-agency piece...I have to make an assessment based on risk……So the only thing is to keep talking……it doesn't mean that every time I see somebody with a joint, I send them off to substance misuse service. My first priority is the child, how it's affecting them and the drug testing go to GP"* **I.3**

A teacher within alternative education service stated;

> *"probably one to one....group.…it's powerful because they are opening up to each other and they are building trust … a lot of young people are over eighteen, so we wouldn't involve parent's.....They start at fifteen.....then we work with the parent.....we would try and encourage them to get some help outside of here"* **I.6**

A family support worker reported;

> *"Well when it starts it has to be individual because I think the relationship has to be built. Group work then yes brilliant.....unless we are working on the family.....I think you are banging your head off a brick wall"* **I.2**

A juvenile liaison officer reported;

> *"Contact the parent's.....trying to form a united front with the parent's … then get them to a treatment agency.....sometimes it is the Courts…consequences .....the national juvenile director can say well right we can authorise a caution, put them under strict conditions that they would have to engage maybe with yourself or with the likes of the youth services.…..obviously counselling is a great thing, but then again some of these kids aren't able for counselling……if the parent's aren't united and aren't giving the same message to the child, the child will split and divide"* **I.5**

A youth worker within a school setting stated;

> *"If it an older child…not an immediate crisis, we probably would discuss at a care team, a parent would be brought in, discuss with the parent and young person…..we would ascertain….can we do some work within the school…..if it's not, referrals would be made to either yourself at HSE or the outreach drugs and substance misuse worker"* **I.10**

A home school liaison co-ordinator reported;

> *"one of the main ones we link with is……any child adolescent mental health service ……we tried intervene with youth clubs and after school clubs and family support and it's like it needs to get through a very serious stage before big interventions happen"* **I.4**

5.5 Additional comments and recommendations made by respondents to questionnaires

The following additional comments and recommendations were made by some respondent's within questionnaires in answer to question 14 which asked "is there anything else you would like to add?" The list comprises the total number of responses. In summary respondents highlighted that in general issues in relation to substance misuse by young people do not arise until a crisis occurs. There is acknowledgement of the roles of parent's, schools, youth services and family support in the lives of young people. Additionally, there is recognition of the need for professionals working with adults who are engaging in substance misuse to expand their knowledge in relation to the impact that parental/sibling substance abuse has on children.

1. Addiction Counsellor

> *"As I do not work directly with young people I am unable to contribute appropriately to this piece of research/dissertation"* **Q.87**

2. Addiction Counsellor

> *"As I do not work directly with young people I am unable to contribute appropriately to this piece of research"* **Q.86**

3. Teacher

   "Young people do not give schools information on their use of drugs/drink etc. It usually comes as out when young person is in deep crisis" **Q.73**

4. Teacher

   "Parent's need to be greater stakeholders and should be supported in applying boundaries" **Q.70**

5. Education & Welfare Officer

   "Guidance counsellors in school, ISPCC teen focus mentoring, Extern mentoring programme. **Q.69**

6. Counsellor

   "As we have a low number of clients with drug misuse we haven't prioritised expanding our knowledge in this area and look forward to an opportunity to learn more" **Q.67**

7. Juvenile Liaison Officer

   "A Family Support Service is very important when dealing with juveniles who abuse substances" **Q.66**

8. Counsellor

   "CAMHS – only if there are mental health issues" **Q.58**

9. Psychologist

   "I am not aware of the details and functions of some of the services listed" **Q.48**

10. Youth Worker

    "Medical Intervention as it establishes the 1st place from which the most appropriate approach can be taken" **Q.44**

11. Youth Worker

"Youth service can work on individual and group supports to change behaviour of the individual and peers. Ours in particular has a dedicated adolescence" **Q.42**

12. Outreach Worker

"Teen Counselling, teen addiction counsellor, outreach worker, youth support" **Q.39**

13. Social Care Worker

"I feel intervention should be got immediately when it is suspected" **Q.34**

14. Outreach Worker

"Would only refer to other services if young person was drug free for some time" **Q.32**

15. Youth Worker

"Circumstances can influence my referral. I would rarely answer these questions the same way for different young people" **Q.13**

16. Probation Officer

"I think there is a major gap in Adolescent Addiction services" **Q.3**

17. Teacher

"I feel that the proper implementation of SPHE programme in school is very important to educate and give students a chance to reflect on substance misuse" **Q.1**

5.6 Chapter Summary

This chapter presented findings from questionnaires and interviews that were carried out to explore research question. These findings will now be discussed in the following chapter.

CHAPTER 6

Discussion

6.1 Introduction

This chapter discusses the findings from research and provides an interoperation of results in order to tease out the objectives of the study with reference to literature review and trends presented in chapter four relating to agency context. In keeping with the objectives of the research the discussion will address professionals understanding of the nature and extent of substance misuse by young people and their understanding of the risk factors associated with early onset substance misuse. Finally the actions that might take by professionals if they had concerns for a young person in relation to substance abuse are reviewed.

6.2 Professionals' understanding of the nature and extent of substance misuse by young people

The respondents to this study confirmed both in interviews and through questionnaires that they have a good knowledge of the types of substances being used by young people currently. In this regard the first hypothesis was partially disproven as professionals are aware but do not ask young people about issues relating to substance misuse as frequently as might be expected given the history of substance misuse with the area. The fact that the agency associated with this study and adolescent substance misuse services nationally are dealing with more referrals in relation to cannabis/weed than alcohol is perhaps an indication of the fact that there is less tolerance for the use of these drugs than there is for alcohol as indicated by respondents perceptions of substance misuse by adolescents' and reports that parents' are buying alcohol for their children. As indicated in chapter four in relation to trends, the ESPAD survey 2010-2011 (Hibell, *et al.* 2012) and HBSC survey for 2010 (Kelly, *et al*. 2012, p.23) identify alcohol as the primary substance of misuse but acknowledge that cannabis is the most frequently used illicit drug.

In relation to the age at which young people begin experimenting with substances, respondents to this research reflected trends as identified within HBSC and ESPAD surveys. But, the levels of experimentation reported in each age category appear to be much greater within this research than is the case in school based surveys. This difference may be explained by the fact that three of the five communities covered by this research are identified as areas of social disadvantage. Furthermore, reports by a home school liaison co-ordinator that 20% of students could be absent from school on Monday's and the assertions by outreach youth drugs worker and teacher within alternative education project that over 90%, of the young people with whom they have contact are engaging in substance misuse confirms reports identifying such young people as falling into high risk category (Haase & Pratschke 2010; McCrystal *et al*. 2005). It is for this reason that there is a need to target resources at those who are most at risk especially in times of recession, as espoused within family support principles and within broader literature relating to risk and protection factors for vulnerable populations (Haase & Pratschke, 2010; Kilgus & Pumariega, 2009; Dolan, *et al.* 2006; Herman-Stahl, *et al*. 2006).

Given the circumstances as outlined above, the extent to which respondents in this study report asking young people about issues relating to substance would seem to be lower than might be expected. The approach to clarifying concerns relating to substance misuse is best encapsulated by a social worker who stated "*in a sense you are looking at levels, ideally you want that on the lowest key possible"*. This approach fits with the four tier model of family support developed by Hardiker (1991) to distinguish between different levels and types of support. Similar to the four tier substance misuse treatment model, at Level 1 there are services that are available to everyone. Level 2 services include support for those who have specific needs. Level 3 services are more likely to be required if there are concerns for a child's welfare. Level 4 services generally involve a child or young person receiving out of home care. Ideally, a service operating from child protection or family support framework will look beyond direct service provision, to identifying protective and preventative interventions within community, towards decreasing risks for children and young people and reducing the need for them to access out of home services. There is similarity and complementarity between the four tier substance misuse intervention model and the Hardiker model as they both involve risk assessment.

Pinkerton (2006, p.185) proposes that interventions 'always aspire to reducing need and/or improving coping capacity so that it can be met at a shallower level in the system'. Among respondents to this research it appears that most professionals take a pragmatic approach to intervention as they try to build/maintain relationship with young people. Furthermore, as clarified by outreach youth drugs worker if they raise the issue of attending a substance misuse service too early in their engagement with a young person they may not see them again. Thus, the challenge for professionals working within tier 1 and tier 2 services is to establish rapport, and to use effective assessment tools in addition to MI as they explore an individual's motivations for change and generate awareness of the discrepancy between current behaviour and desired life goals (Barrett, *et al.* 2012). As identified by Duncan and Miller (2000) relationship is central to any approach towards intervention

However, if a young person's primary motivation in using substances is as a means of escape or self-medication (Kyle, *et al*. 2011) or if they are attracted to the lifestyle that goes with substance misuse, then they may minimise the consequences of their activity (Heavyrunner-Rioux & Hollist, 2010). In such circumstances, it is important that professionals be aware of the multiplicity of risk factors that are associated with an individual's circumstances and to view assessment as a process taking into consideration personal, social and contextual issues. Additionally, assessments ideally involve parents, guardians and significant other people who are part of a young person's life (North Yorkshire Council, 2012). Within the context of assessment, if it is identified that a young person falls within high risk category, then an inter-agency and multi-disciplinary consultation would be indicated in addition to referral to a specialist tier 3 substance misuse service (Department of Health and Children, 2005; Public Health Agency, Health and Social Care Board 2009).

In circumstances where a young person is presenting with difficulties at school or has poor school attendance it is essential that a complete assessment of their needs is undertaken to support their retention prior to any decision being made in relation expulsion or alternative placement. As identified by Truts & Pratschke (2010) it is important that there is good communication between parents and schools. Absences from school could be utilised to encourage young people and parent's to reflect on the circumstances of their lives and to initiate interventions in order to

prevent early school leaving. The essential component to effective interventions for young people is communication with families and between agencies around young people's developmental needs (SAMSHA, 2012; Scottish Government, 2011).

6.3 Professionals' understanding of the risk factors associated with early onset substance misuse.

It is acknowledged within literature that personal circumstances and personality characteristics such as low self-confidence or esteem, un-assertiveness, problems with inter-personal relationships, sexual promiscuity, impulsivity and poor decision making skills may determine which individuals develop problems in relation to substance use, but it is understood that societal attitudes generally determine which substances are tolerated (Kloep, *et al.* 2001; Pearson & Shiner, 2002; Stein, *et al.* 1987). Given the devastation experienced as a result of the heroin epidemic throughout the 1990s into early 2000s by some families within communities covered by this research, it is understandable that expressions of relief are reflected to professionals by parents when it is reported that young people are drinking alcohol or smoking cannabis/weed. In the circumstances the second hypothesis would seem to be supported. The reduced levels of concern in relation to the consumption of alcohol in particular and to a lesser extent cannabis/weed is mirrored by professional's actions when they report that their initial interventions take place primarily at an organisational level and are low key.

It is worrying to hear that some children are missing school on a regular basis due to substance misuse and that some parents are buying alcohol for children age 13 years old while other parents are reported to be providing un-prescribed medication to children. Furthermore, reports that young people are smoking cannabis/weed with parents as highlighted by youth drugs worker substantiates findings that some young people are introduced to substances by adults (Godeau, *et al*. 2007). The fact that professionals are aware that such activity is taking place requires a response that addresses the issue and elevates concerns in order to avoid services engaging in collusive or enabling practices.

In relation to influences on young people's decision to initiate substance use a broad range of factors were identified by a small number of respondents with peer group viewed as having the greatest influence among respondents to questionnaires, but within interviews most participants stated family as the primary influence. It seems surprising to this researcher that only 3% of respondents to questionnaires perceived school difficulties as contributing to early onset substance misuse especially given the evidence indicating a strong correlation between substance misuse antisocial behaviour and school dropout (Arteaga, *et al.* 2010; Truts and Pratschke 2010; Kirby, *et al*. 2008; McCrystal *et al*. 2005). Also, in the current economic climate where the state is in a bailout agreement (Healey, *et al.* 2011) and there are reports of unprecedented numbers of families struggling to pay essential services (St Vincent de Paul, 2013). In the context it seems extraordinary that poverty was only identified by 1% (n=1) of respondents as a factor influencing young people's decision in relation to substance misuse, especially given that it is understood the unhappiness of growing up in poverty is a key social factor influencing some young people decision to initiate substance misuse as a relief from misery (SAMHSA, 2012; Hempill, *et al.* 2011; Arteaga, *et al.* 2011; Stein, *et al*. 1987).

Environmental factors was mentioned more frequently in interviews than recorded in questionnaires but given the history of substance misuse within three of the communities covered by this survey it would appear to this researcher that 16% is a rather low assessment of the impact of environmental influences on young people's engagement with substance misuse within the catchment area covered by this research. Also given that 65% of young people attending the service associated with this research have a history of contact with CAMHS it would seem as if there is an under estimation by a number of respondents of the extent to which some young people self-medicate. Thus the third hypothesis would seem to be supported as it appears it can be difficult for professionals to distinguish early stage substance misuse from other behaviours. Also, as outlined in chapter four trends in 2012 in relation to the service associated with this study revealed that at assessment 32% had a history of past or current deliberate self-harm or suicidal ideation/behaviour.

The respondents to this research showed a good understanding of the consequences that may occur as a result of early onset substance misuse as reflected in reports from probation officer who stated that it can be an aggravating feature in their offending. A report by The Probation Service (2012) reveals that 89% of adult offenders on probation had misused drugs or alcohol. Within this research a home school liaison co-ordinator expressed the opinion that it will always have far reaching consequences for a child in terms of their mental health while a juvenile liaison office identified the progressive nature of substance misuse. Additionally an example given by teacher within alternative education project gives an indication of how an individual's circumstances can progress in a worst case scenario when they reported seeing people that they worked with on the main road selling drugs.

Given the devastation experienced as a result of heroin abuse within communities associated with this research it is not unusual that respondents show a greater tolerance for alcohol and to a lesser extent for cannabis/weed as indicated in figure 5. If substance misuse is viewed from a harm reduction perspective then clearly alcohol and cannabis/weed are at the lower end of the scale compared to heroin or cocaine. It is this perspective that kept alcohol and drug services separated up until recent years with the emergence of Steering Group Report on a National Substance Misuse Strategy (Department of Health 2012). Familiarity with substances and their effects often creates a very relaxed attitude regarding their use. Research suggests that young people who engage in regular alcohol or cannabis use are more likely than recreational users to have a lifetime history involving substance misuse (Sigman, 2013; Guttannova, *et al*, 2011 Chabrol, *et al.* 2006 Mayock, 2000). However, Treadway (1989) states that some people can learn to manage their use of substances in a controlled way but highlights that abuse is clearly a precursor to dependency.

Ultimately, if adults have relaxed attitudes towards substance misuse it may result in them being less vigilant in relation to experimentation by young people and more tolerant of some substances. In such circumstances substance misuse by young people can go un-noticed especially if they are managing to function at some level as reported by social worker and home school liaison co-ordinator. Also, as emphasised by youth drugs worker, if there is not good communication between agencies in relation to young people then it is possible for them to slip through the net.

6.4 Actions that might take by professionals if they had concerns for a young person in relation to substance abuse.

The majority of respondents to questionnaires and those who participated in interviews reported that they would talk with a young person in the first instance if they had concerns for them in relation to substance misuse. Within a ten point scale respondents initial intervention preferences took the following pattern in their 1st to 3rd actions towards intervention with 86% identifying that they would discussed with young person; 55% reported that they would discussed with parent's; 42% state they would encouraged a young person to get help and 33% indicated that they would consulted with a colleague, while 25% reported that they would support a young person in their organisation. It was revealed that between the 3rd and 6th stages of intervention most respondents reported they would begin to look outside of their organisation for consultation or referral. Moreover, it is significant that an outreach worker reported that they would only refer to another organisation if a young person is drug free. In the circumstances this researcher would be interested in knowing more about their approaches to working with young people who are actively engaging in substance misuse.

When respondents were given a list of types of services available in their area most considered a range of options with addiction services featuring prominently followed by CAMHS; family support; youth service; social work; alternative education and psychological services. In interviews four of the twelve interviewees (33%) mentioned that they would encourage parents to seek consultation with their GP initially. This pattern of referral helps to explain how it is that most of the young people attending addiction service associated with this research are known to multiple agencies in addition to schools prior to their referral. It is indicative of a need for closer collaboration between the agency associated with this research and GPs working within catchment area. Also, the fact that the majority of respondents to questionnaires are of the opinion that individual counselling is the most suitable intervention adds clarity to why referrals are received at an advanced stage in a young person's substance misuse trajectory. As highlighted within literature review MI and

CBT combined with family based interventions are viewed as the most effective with young people who are engaging in substance misuse (Hendriks, *et al.* 2011; Henderson, *et al*, 2010; Barrett, *et al.* 2012; Becker & Curry, 2008). In circumstances where there are a number of family members engaging in substance misuse it is proposed that intervention encompass a systemic perspective and that working at an individual level may be unproductive (Low, *et al.* 2012; Becona, *et al.* 2012; Henderson, *et al*. 2010; Percy, *et al*. 2008).

A further explanation as to why referral to addiction service may be considered at a later stage by some professional's might relate to the fact that agencies are funded to support interventions with young people who are at risk (Department of Community, Rural and Gaeltacht Affairs 2009). As indicated by an outreach youth drugs worker, who said they would support a young person within their organisation through activity and monetary incentives along with group work, education and addiction counselling if required. Additionally, a social worker; youth worker; family support worker; clinical nurse specialist and psychiatrist indicated that they would work with young people within their service initially. The challenge for all professionals is to know when a young person's circumstances are at a stage where they require a different level of intervention. It is for this reason that it is important for services operating within the tiered framework to be in regular contact.

In addition to young people who are offered tier 1 and tier 2 interventions there also seems to be a cohort who are managing to function at some level without raising concerns from adults as identified in interviews with home school liaison co-ordinator; juvenile liaison officer; social worker; youth worker; psychiatrist and psychologist. There is a possibility that tolerance for substance use among young people has reached a new threshold especially in relation to alcohol and cannabis/weed as indicated by the number of respondents who partially agree or are not sure about whether such use by adolescents' is acceptable. The fact that 23% of respondents did not view parents as a resource at any level and that a further 22% would only consult parents at a later stage within an intervention framework is worrying. It is an indication that a significant group of professionals either underestimate the extent to which parents can influence young people's behaviour as identified by (Wright, *et al*. 2007; Graham, *et al*. 2006; Kloep, *et al*. 2001) or that they

do not trust in parents' fitness to intervene, perhaps due to the fact that they are aware of substance misuse within a family context. However, even in circumstances where there are a number of family members engaging in substance misuse it is proposed that intervention involve all family members (Low, *et al* 2012; Becona, *et al*, 2012; Percy, *et al*. 2008;). This can be facilitated through direct family support or within a therapeutic context.

The fact that there was a low level of response from counsellors working within HSE adult addiction services covered by this study and that HSE outreach workers did not participate means that the richness of their experience is not captured within research. As outlined in chapter three it is understandable that professionals might feel uncomfortable about taking part in research that is being carried out by someone who works within their organisation. However, it would have been helpful to get an understanding of the challenges faced in working with adults who abuse substances as it is understood that the majority of adults with substance misuse or mental health issues experienced onset before age 18 years old (Guttannova, *et al*, 2011; Hempill, *et al*. 2011; World Health Organisation, 2007). Also as identified by Butler (2002, p.44) addiction specialists have not prioritised child care issues and social workers did not challenge the mystique of addiction treatment, therefore children living in such circumstances rarely had their needs met.

In conditions where a young person's parents have combined drug and alcohol issues as well as mental health problems, there is increased risk of them developing substance misuse difficulties (SAMHSA, 2012; Stein, *et al*. 1987). This is something that was highlighted by Shannon & Gibbons (2012) in a report on the deaths of children and young people known to child protection services in Ireland for the years 2000-2010. In such situations it is recommended that drug and alcohol services be actively integrated into the child protection system, as professionals working with adults who abuse substances are required to have the capacity to alert social workers of risks for children (Shannon & Gibbons, 2012; NCAD, 2011b;) This is something that is further emphasised by the Scottish Government (2011) within the GIRFEC framework and in the Hidden Harm Action Plan (Public Health Agency, Health and Social Care Board 2009).

It is encouraging to see that HSE service plan for 2013 proposes the establishment of a Children's First and Hidden Harm Implementation Guide in combination with the development of a pilot training module in at least one HSE addiction service area, with a commitment to progressing implementation in other areas (HSE, 2013c, p.41). Fundamentally, 2013 marks a significant milestone in terms of child protection in Ireland as children and family services will be disengaged from the HSE into a new agency, the Child and Family Support Agency incorporating education and welfare services and family support services (HSE, 2013c). Additionally, CAMHS are now working with young people up to age 17 years old since the January 2013 and will work with young people up to age 18 years old from January 2014 (HSE, 2012a, p.5). Moreover, the provision of services to children and young people may be further enhanced following the passing of Children's Referendum in 2012 (Shannon, 2013).

HSE addiction treatment services are also undergoing transformation as the nature of drug use is changing and the Drug Treatment Centre Board (DTCB) which operated under the Department of Health is being integrated into HSE Addiction Services (HSE, 2013c). In this regard the unique position of Social Inclusion services within HSE allows for the development of collaborative work practices at an organisational level and between other agencies within statutory, voluntary and community sectors towards progressing protocols in relation to child protection and inter-agency working. Also, with the passing of the Health Service Executive (Governance) Bill 2012 the HSE is undergoing transformation and is becoming more of a commissioning body than a direct provider of health care. However, regardless of the structures, if a similar focus is created on the introduction of protective and preventative measures within addiction services as has been applied within harm reduction programmes the possibility exist to break the cycle of addiction that has affected so many families. Furthermore, the HSE has adopted the Quality Standards in alcohol and drugs services (QuADS) which is quality standards framework that was developed by Drug Scope and Alcohol Concern in the UK in 1999 (drugs.ie, 2013). The aim is to enable addiction services within both statutory and voluntary sector to become more quality compliant (HSE, 2012b).

6.5 Chapter Summary

Respondents to this research revealed a good level of knowledge in relation to the nature and extent of substance misuse by young people. Additionally, the majority indicated awareness of the age range within which young people initiate substance misuse. In this regard the first hypothesis was partially disproven as professionals are aware of current trends but do not ask young people about issues relating to substance misuse as frequently as might be expected given the history of substance misuse within the area. In relation to the second hypothesis considering the possibility that there is an increased level of tolerance for some categories of substance use by young people, it was revealed that there is a high level of tolerance for alcohol and to a lesser extent for cannabis/weed. Moreover, respondents shown a consciousness that some parents tolerate and facilitate their children's substance use.

In relation to factors influencing young people's decision to initiate substance use the greatest number of respondents to this research viewed peer influences as most significant, followed by family factors. The number of respondents who gave consideration to environmental influences was low considering the history of drug use with communities covered by the study. More significantly, poverty or problems at school did not feature prominently among respondents interpretation of factors influencing youth substance misuse. Overall respondents indicated cognizance of the negative consequences of early onset substance misuse and awareness that it can go un-noticed if adults, are not vigilant.

The majority of respondents showed a preference for individual counselling as an intervention over proven models of practice such as CBT, MI and family based approaches. Additionally, respondents primarily reported that efforts would be made to support a young person within their organisation before they would seek consultation externally or consider referral. Also, some respondents indicated lack of appreciation for inclusion or consultation with parent's while a small number indicated poor levels of awareness around issues for young people in relation to substance misuse. The need for improved communication and inter-agency working and was emphasised. The next chapter puts forward recommendations arising from the findings reported in this chapter.

CHAPTER 7
Conclusion and Recommendations

7.1 Conclusion

It is important to acknowledge that a significant amount of good work is being carried out by statutory, voluntary and community organisations in support of young people and families who are seeking to address issues in relation to substance misuse. Within the confines of this research it has not been possible to acknowledge the diversity of services and practices that exist throughout the communities that make up the catchment area covered by this study. As outlined within the previous chapter, 2013 marks a significant period in terms of child protection in Ireland and at the same time addiction treatment services are undergoing transformation with the merging of agencies and the integration of drug and alcohol services. It is in this context that the recommendations put forward below are framed, based entirely on the key themes emerging from this research and informed by literature review. In keeping with the aims of research the researcher and the agency associated with this study has a responsibility to be proactive in progressing recommendations.

7.2 Recommendations

7.2.1 Assessment

Where concerns exist for a young person at any level it is important that a complete assessment of their needs is undertaken. An integrated assessment aims to get a full understanding of the events and situations impacting on young people's lives in order to inform actions and decisions to help them achieve their potential. In circumstances where there are on-going issues involving substance misuse it is essential that referrals are made to a specialist agency within the framework of multi-agency and inter-disciplinary team working. Young people with conditions such as ADHD or impulsivity are understood to be at increased risk of developing problems in relation to substance misuse and other forms of anti-social behaviours. Thus, it is vital that professionals working with such young people are cognisant of the consequences that result when issues involving substance misuse are not addressed.

7.2.2 Family Support

The involvement of parents, caregivers and significant other people in the lives of young people is central to their health, well-being and stability. Therefore, professionals need to be aware of the benefits in supporting families towards strengthening informal supports especially where there is a family history of substance misuse. The provision of family support services in all formats from information giving, direct practical support, parenting support groups or family therapy can contribute to the empowerment of parents and caregivers especially where a young person is engaging in substance misuse. It is appreciated that young people are offered some protection when parents communicate openly, are emotionally supportive and monitor their children's activity. In circumstances where a young person is affected by parent/s substance misuse family support could be viewed as the most appropriate first step towards assessing and addressing the impact of such activity. In the context of the tiered model of family support and with supervision from child protection services such an intervention may eliminate the need for a young person requiring out of home care.

7.2.3 Inter-agency Working

The establishment of protocols between services makes for good practice in the interest of children and families. In this regard there are specific recommendations within Report of the Working Group on Treatment of under 18 year olds (Department of Health and Children, 2005); National Drug Strategy 2009-2016 (Department of Community, Rural and Gaeltacht Affairs, 2009) and Steering Group Report on a National Substance Misuse Strategy (Department of Health, 2012). It is important that these recommendations are progressed and that professionals know how to respond to child protection issues. A multi-agency response is required where children's lives are affected by personal and/or parental substance abuse. It is essential that all professionals and agencies especially GPs have a good understanding of the tiered model of intervention so that appropriate and timely referrals are made where a particular need is identified.

7.2.4 Delaying Onset

Early intervention and efforts to support young people in delaying induction or avoiding substance use in the first instance are likely to have an impact on lifetime trajectories in terms of substance use. The enhancement of decision making by young people could delay or inhibit their engagement in harmful activity including substance misuse. In this regard young people need to be supported in building resilience and the management of delayed gratification within all contexts. Given the prominence of peer influence as a predictor of adolescent substance misuse it is important to support young people in developing interests/activities that may lead to positive peer group associations. Additionally, parents/carers need to be informed and involved where there are concerns for young people in relation to substance misuse.

7.2.5 Elevating Concerns

In situations where professionals are aware of young people engaging in substance misuse it is important that they can identify processes and strategies to elevate concerns for such activity among young people themselves and with their parents, guardians and other adults. Especially in circumstances where parents or significant other people are facilitating substance misuse and where there are signs that a young person's use of substances extends beyond curiosity and experimentation. Failure to act may be viewed as collusive and enabling. Organisations and services that are ideally positioned to assess a young person's circumstances and to elevate concerns include; Courts, JLO service, probation officers, hospitals, schools, training centres, social workers, GPs, practice nurses, adult addiction services, youth services and family support services.

7.2.6 School Retention

The school environment is perhaps the most significant and influential setting in young people's lives where non parental adults can identify risks and trends. Where a young person's participation or attendance at school gives cause for concern it may be indicative of disruption or absence of support in other areas of their life. As such teachers are playing a central role in the identification of issues for young people and in elevating concerns. Hence, it is important at a policy level to ensure that schools are resourced and young people are encouraged and supported to remain within mainstream education in keeping with target set by National Drug Strategy 2009-

2016. It is also important that national statistics do not mask what is happening within local communities. In addition to work with young people there is a need to support good communication and relationship between schools and parents in order to enhance school experiences for children and potentially increase school retention.

7.2.7 Professional Development

Within the context of continuing professional development there is a need to focus on collaborative practices and the sharing of knowledge and skills across disciplines, especially between adult and adolescent addiction services. Having an appreciation for the most effective approaches to working with young people or adults in relation to substance misuse may help to avoid crosscutting interventions and encourage awareness of referral pathways within the tiered intervention framework. In addition to training programmes in CBT and MI there is a need for professionals to have an understanding of interventions that are inclusive of family and wider social/support networks.

7.2.8 Organisational Change

In order for good outcomes to be achieved for children, young people, families and communities it is essential that models of good practice are supported at an organisational level and that inter-disciplinary and inter-agency co-operation and collaboration is encouraged. In keeping with Ottawa Charter (WHO 1986) a focus on activist and protective/preventative and health promotion measures in addition to harm reduction programmes would allow for the possibility to break the cycle of addiction that has affected so many families. Within the context of integrating alcohol and drug services an opportunity exists for HSE Addiction Services to expand consultation process when considering practice issues and formulating policy. Given the increased emphasis on child protection, family support and inter-agency working the approaches to intervention in relation to substance misuse might achieve different outcomes if viewed through a lens of health promotion and child welfare as opposed to harm reduction and containment. Such a move will require a shift in thinking from primarily medical perspectives to advancing therapeutic approaches that transcend simple cause and effect explanations to include those aspects of an individual's context in the treatment process.

7.2.9 Policy Context

In addition to the work that is being done to address sponsorship and advertising by alcohol and tobacco industries there is a need for national governments and other organisations to review the practice of including children within adult categories when referring to "normal" alcohol consumption levels. Additionally, parents and other adults require information about the risks and harmful effects of early onset substance misuse in order to make informed choices and to be empowered in taking a stance in relation to teenage substance misuse.

7.2.10 Further Research

This research suggests that there may be merit in carrying out a more in-depth study of professional's perceptions in relation to substance misuse by young people, especially given the culture of alcohol abuse within Irish society and the increasing tolerance for cannabis/weed. Also, it might be useful to research the needs of professionals who are working within adult services in terms of identifying their training requirements in order to develop their capacity to assess risks for children where parents and siblings are engaging in substance misuse. Additionally, there is scope for research to be carried out between CAMHS and adolescent addiction services to explore ways of identifying and addressing the particular needs of young people who have co-occurring mental health issues.

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APPENDECIES

Appendix: A

List of professionals who participated in interviews

Clinical Nurse Specialist (CAMHS)

Education & Welfare Officer

Family Support Worker

Home School Liaison Officer

Juvenile Liaison Officer

Outreach Youth Drugs Worker

Probation Officer

Psychiatrist

Psychologist

Social Worker

Teacher

Youth Worker

Appendix: B

Questionnaire

Reference No:

Questionnaire

Date: 23rd January 2013

Dissertation Title: **Professionals' understanding of risk factors for substance misuse by young people within urban communities and approaches to intervention**

1. What age groups does your service work with? (Please tick all relevant age categories)

0-5 year olds ☐ 5-10 year olds ☐ 10-15year olds ☐ 15-18 year olds ☐ Over age 18 years old ☐

2. Which of the following activities most closely reflects your work? (Please tick one box only or specify other category)

Family Support ☐ Social Work ☐ Youth Work ☐ Teacher ☐ Counsellor ☐

Psychiatrist ☐ Trainer ☐ Juvenile Justice ☐ Psychologist ☐ Outreach Worker ☐

Probation Officer ☐ Nurse ☐ Other (please specify) _____

3. In your experience at what age are young people availing of your service beginning to experiment with substances?

Under age 10 years ☐ Age 10-12 ☐ Age 12-14 ☐ Age 14-16 ☐ Age 16-18 ☐

4. In the course of your work with young people are issues concerning substance misuse raised by you? (Please tick one of the boxes below that most closely reflects your agency practice)

Always ☐ Frequently ☐ Occasionally ☐ Never ☐

5. Amongst the young people who attend your service what percentage do you estimate might be engaging in substance misuse?

Less than 10% ☐ 10-25% ☐ 25-50% ☐ 50-75% ☐ 75-100% ☐

6. In your experience what are the circumstances that could cause young people to initiate substance use?

_____

In the following questions you will be asked to express your opinion. Please tick one of the boxes that most reflects your views.

7. "It is natural that young people in early adolescence will be curious about the effects of **alcohol**. It is acceptable that that they would experiment"?

Strongly agree ☐ Partially agree ☐ Not sure ☐ Partially disagree ☐ Strongly disagree ☐

8. "It is natural that young people in early adolescence will be curious about the effects of **drugs**. It is acceptable that that they would experiment"?

Strongly agree ☐ Partially agree ☐ Not sure ☐ Partially disagree ☐ Strongly disagree ☐

9. "Young people who engage in substance misuse before age 16 years old are at greater risk of having problems in relation to substance abuse throughout their life"?

Strongly agree ☐ Partially agree ☐ Not sure ☐ Partially disagree ☐ Strongly disagree ☐

Please Turn Over to Complete Questionnaire

10. In your experience what are the substances most regularly used currently by young people availing of your service? (Please rank in order with No1 being most commonly used)

Ecstasy ☐ Alcohol ☐ Cocaine ☐ Cannabis ☐ Amphetamines ☐ Benzodiazepines ☐

Heroin ☐ LSD ☐ Solvents ☐ Ketamine ☐ Other _____

11. If you became aware that substance misuse was a problem for a young person what might you do and in what order? (Please number relevant boxes with No. 1 been most significant)

Discuss with young person ☐ Support them within organisation ☐ Consult with Colleague ☐

Refer to Addiction Service ☐ Encourage young person to get help ☐ Discuss with Parents ☐

Consult with Addiction Service ☐ Ignore as they may cop-on and stop ☐ Refer to Social Work ☐

Refer to Adolescent Mental Health Service ☐ Other action_____

12. In your experience what are the most useful interventions with young people under age 18 years old who regularly abuse substances and who may have developed substance dependency? (Please rank in order with No. 1 been most useful)

Adolescent Community Reinforcement Approach	
Motivational Interviewing	
Cognitive Behavioural Therapy	
Medical Intervention	
Family/Systemic Therapy	
Residential Drug Treatment	
Strengthening Families Programme	
Individual counselling	

13. The following are a list of types of services in your catchment area. Which of these services are you most likely to refer a young person who is engaging in substance misuse and in what order? (Please number relevant boxes with No. 1 been most significant)

Child and Adolescent Mental Health Service (CAMHS)	
Youth Service	
Youth Offending Project	
Addiction Service	
Social Work Service	
Family Support Service	
Alternative Education/Training Project	
Psychological services	
AA meetings	
NA meetings	

14. Is there anything else you would like to add? _____

_____

Thank you for taking time to complete this questionnaire.

Please return in stamped addressed envelope provided.

Denis Murray, Bridge House, Cherry Orchard Hospital, Dublin 10.

Appendix: C

Interview Schedule

Interview Schedule

1. I am here with Interviewee number_____ in relation to research into Professionals' understanding of risk factors for substance misuse by young people within urban communities and approaches to intervention. You are very welcome and I appreciate that you have agreed to interview

2. For the record, how would you describe the primary function of your work?

3. In your experience what age are young people beginning to experiment with substances?

4. In your experience what are the substances most regularly used by young people currently?

5. In the course of your work with young people are issue concerning substance misuse raised by you?

6. Amongst the young people who attend your service what percentage would you think are engaging in substance misuse?

7. What are your thoughts in relation to early onset substance misuse and experimentation?

8. What in your experience are the circumstances that cause young people to be most at risk in terms of initiating substance use?

9. Why might it be that substance misuse by some young people goes un-noticed until a crisis occurs?

10. If you became aware that substance misuse was a problem for a young person what might you do?

11. In your experience what are the interventions that are considered to be most effective with young people who regularly abuse substances and who may have developed substance dependency?

12. What type of services are you most likely to refer a young person who is engaging in substance misuse?

Appendix: D

Information Sheet

Information Sheet

For Masters in Life-course Studies NUI Galway Research Dissertation

Dissertation Title: **Professionals' understanding of risk factors for substance misuse by young people within urban communities and approaches to intervention**

Name of Researcher: Denis Murray Date: 23rd January 2013

Supervisor: Mr Declan Coogan
Lecturer
Master of Arts in Social Work Programme
School of Political Science and Sociology
National University of Ireland
Aras Moyola
Newcastle Road
Galway

Tel No: 091-495373
Email: declanp.coogan@nuigalway.ie

I am interested in this area of research because it is directly related to my work within an adolescent addiction treatment service. The study will consist of an extensive literature review exploring a variety of themes that surround the topic. The research will be supported through a questionnaire and semi-structured interview with one person from each professional group working with young people within catchment area covered by this study. The intention is to correlate data from fifteen Interviews and all returned questionnaires for the purpose of analysis comparing insights, understandings, ideas, experiences and opinions of different professional's.

Participation in the study is completely voluntary and should you consent to participate your identity will be protected. By completing questionnaire you indicate your understanding of information contained in this leaflet and your consent to completing the questionnaire. If you are willing to participate in semi-structured interview please indicate your willingness by completing consent statement for your name to be put forward for random selection. If selected for interview you will be asked to sign a consent form. However, you are free to withdraw at any stage, without needing to explain decision to withdraw. Interviews will take place at a location and time of your choosing and will last for approximately 30 minutes. All interviews will be voice recorded. Records and data will be anonymised and stored securely for the duration of research and will subsequently be destroyed. The survey results will be made available to you upon request from researcher after research is complete.

The contribution of professionals to research is an essential component of any study and of great value. It is hoped that you will gain some satisfaction from knowing that your experience and knowledge will contribute to informing policy and practice in relation to interventions with young people who are engaging in substance misuse, within your local area and beyond. If you want to know more about this research project, please do not hesitate to contact me at 01-6206493 or denis.murray@hse.ie

Signed: _____

Denis Murray
Student, M A in Lifecourse Studies, NUI Galway

Appendix: E

Consent Statement

Consent Statement

I understand the information contained in letter dated 23rd January, 2013, from Denis Murray relating to research into 'professionals' understanding of risk factors for substance misuse by young people within urban communities and approaches to intervention'.

I am willing to put myself forward as a candidate for random selection to participate in interview.

Profession: _____

Name: _____

Signed: _____

Date: _____

Please return form with questionnaire in stamped addressed envelope provided.

Thank you

Denis Murray

Appendix: F

Format of letters sent

To

Key person in each organisation

Dissertation Title: **Professionals' understanding of risk factors for substance misuse by young people within urban communities and approaches to intervention**

Bridge House
Cherry Orchard Hospital
Dublin 10

23rd January 2013

Dear …….

I am writing following our conversation, when I contacted you to discuss research I am undertaking as part of a Masters in Lifecourse Studies in NUI Galway. I appreciate that you took time to talk with me, that you have agreed to distribute questionnaires among your colleagues and that you or one of your colleagues will consider taking part in a semi-structured interview. Please find enclosed information leaflets questionnaires and consent form relating interview nominations.

The contribution of professionals to research is an essential component of any study and of enormous value. I greatly appreciate and welcome you and your colleague's participation in this research and its associated outcomes. Please return Questionnaire and interview consent statements to me in the stamped addressed envelopes provided. Your answers will be completely confidential. The identification number on the first page is simply for the purpose of checking returns and to avoid contacting you again after you have returned questionnaire.

You can be sure that no-one will ever know how you responded to questions. The survey results will be made available upon request to me once the research is complete.

If you want to know more about this research project, please do not hesitate to contact me at 01-6206493 or denis.murray@hse.ie

Thank you for your assistance.

Sincerely,

Denis Murray

Appendix: G

Interview Consent Form

Interview Consent Form

By signing this form, I agree that:

- I have read and understood the information sheet on the research and I have had the opportunity to ask questions about this study
- I have read this form and understand how I will be participating
- My participation in this study is completely voluntary
- I may withdraw my participation at any stage during the research without my legal rights being affected
- My name and address will be kept confidential

Participant Name Printed: _____

Participant Signature: _____

Date: _____

Researcher Name Printed: _____

Researcher Signature: _____

Date: _____

Appendix: H

Ethics Form

School of Political Science and Sociology
NUI, Galway

MA in Life Course (Family Support) Studies

Research Ethics Form for Proposal for Minor Dissertation

(Extracted from the NUI Galway Research Ethics Committee Application Form)

October 2012

United Nations Educational, Scientific and Cultural Organization

UNESCO Chair in Children, Youth and Civic Engagement Ireland

The following form must be completed in addition to your main research proposal. You need to complete this form and discuss with your supervisor in advance.

1. General Design

Tick as appropriate the methods you intend to use

	yes
Survey/Questionnaire	
Case Study	
Observational	
Action research	
Record based	
Cohort	
Case control	
Other	
(please specify)	

	yes
Interviews	
• individual	
• group	
• person-to-person	yes
• telephone	
• electronic	
Forms of Recording	
• Video	
• Audio	Yes
• Photography	
• Notes	
• Electronic recording	

Size of the study (including controls):

(i) How was the size of the study determined?

The size of group for questionnaire is determined by the number of relevant agencies within catchment area to be covered by survey (49 Agencies).
Interview participants will be selected from among sixteen different professional groups working within catchment area who are relevant to research. But only one member from each profession will be asked to participate in interview. The process of selection will be randomized and will operate on the basis of refusal and acceptance. Therefore once a professional from each category agrees to interview to selection process will be complete

(iii) What method of analysis will be used?

Data gathered from questionnaires and interviews will be examined for the existence of relationships and differences between and among them.

Where[1] will the study take place and in what setting?

Questionnaires will be distributed to agencies within specific catchment area of south western part of Dublin City. Interviews will take place in location of interviewees choice and at a time that is acceptable to them.

[1] Geographical location; laboratory, hospital, general practice, home visits etc.

Who will have overall responsibility for the study?

The researcher will have overall responsibility for study

Who has control of the data generated?

The researcher will have control of data.

2. Recruitment of participants

Who is being studied?

A set group of professionals working within a specific catchment area located within south western area of Dublin City who work with young people.

How will the participants in the study be?

(i) Selected?

Questionnaires will be sent to 49 agencies within catchment area covered by study.
Candidates for interview will be selected randomly

(ii) Recruited? (Please append advertisement materials to application)

Questionnaires will be posted to organizations with a letter explaining research and what is expected of them. Potential interviewees will be sent a letter explaining research, how they were selected and what is expected of them if they agree to participate. Telephone contact will also be used.

What criteria will be used for inclusion and exclusion of participants?

(i) Inclusion criteria:

For questionnaires: Organizations working with young people
For interviewees: Professionals' selected through random process.

(ii) Exclusion criteria:

For questionnaires: Organizations not working with young people.
For interviewees: Professionals' not selected through random process.

How many participants will be recruited and of what age groups?

Questionnaires will be sent to 49 organizations (All Adults).
It is identified that interview group will involve up to 16 professionals' (All Adults).

If applicable, how will the control group in the study be:

(i) Selected?

Not applicable

(ii) Recruited? (Please append advertisement materials to application)

Not applicable

What criteria will be used for inclusion and exclusion of the control group?

(i) Inclusion criteria:

Not applicable

Not applicable

If applicable, how many controls will be recruited and of what age group?

Not applicable

Are the participants/controls included in this study involved in any other research investigation at the present time?

YES: ☐ NO: ☒

If YES, please give details

This information can only be determined upon recruitment and engagement with respondents.

Will participants receive any payment or other incentive to participate?

YES: ☐ NO: ☒

(i) If YES, give details of incentive per participant?

If YES, what is the source of the incentive?

3. Consent

Is written consent for participation in the study to be obtained?

YES: [X] NO: [ ]

If YES, please attach a copy of the consent form to be used *(Guidance on consent is given in the Guidance Notes)*

If NO written consent is to be obtained, please explain why

How long will the participant have to decide whether to take part in the study?
(If less than 24 hours, please justify)

Seven to ten days.

Does the study include participants for whom English is not a first language?

YES: [ ] NO: [X]

If YES, give details of special arrangements made to assist these participants

Please attach a copy of the written participant information sheet
If NO information sheet is to be given to participants, please justify

If you are recruiting from a vulnerable groups (Children under 16 years of age; People with learning difficulties; Unconscious or severely ill participants; Other vulnerable groups e.g. dementia, psychological disorders, etc.), please specify and justify

Not applicable

(i) What special arrangements have been made to deal with the issues of consent and assent for vulnerable participants e.g. is parental or guardian agreement to be obtained, and if so in what form?

Not Applicable
Not Applicable

4 Risks and ethical problems

Are there any potential risks to participants?

YES: ☐ NO: ☒

If YES, explain

Is this study likely to cause any discomfort or distress, either physical or mental?

YES: ☐ NO: ☒ X There are no apparent risks or issues within research that are likely to cause any significant level of discomfort or distress.

If YES, estimate the degree and likelihood of discomfort or distress entailed and the precautions to be taken to minimize them.

If it should occur that an interviewee becomes uncomfortable or distressed then interview will cease and support offered to interviewee. Any material from interview will be destroyed unless interviewee requests otherwise and wishes to proceed with interview. In such circumstances researcher will stay with interviewee and will ask them if they would like to contact someone who if familiar to them for support. Interviewees will not be offered contact details for Helpline or Support Services as it is appreciated that as professionals they will have knowledge of such services, but this issue will be explored with sensitivity. Upon leaving researcher will ask if it would be OK to contact them later that day or the following day.

What particular ethical problems or issues do you consider to be important or difficult with the proposed study?

There is a slight possibility that professionals selected for interview might feel uncomfortable talking to another professional (Researcher) who also works with young people and families from the same catchment area. But the fact that they are willing to participate in interview will be viewed as an indication that they may have resolved any issues or concerns that might have arisen for them.

(i) Will participants be provided with information on follow up referrals if needed? (E.g. counseling services or help lines)

YES: NO: Not applicable: X

(ii) If NO, is this made clear in the participant information sheet?

YES: NO: X

If NO, please give reasons

Interviewees will not be offered contact details for Helpline or Support Services as it is appreciated that as professionals they will have knowledge of such services, but this issue will be explored with sensitivity. Upon leaving researcher will ask if it would be OK to contact them later that day or the following day.

5 Confidentiality

Will the study include the use of any of the following?

Audio/Video recordings	YES: [X]	NO: [ ]
Observation of participants:	YES: [ ]	NO: [X]

If YES to either:

(i) How are confidentiality and anonymity to be ensured?

No names will be used on audio recordings. All material will be coded and codes linking to peoples names will only be known to researcher.

(ii) What arrangements have been made to obtain consent for these procedures?

Letters will be sent to all candidates selected for interview. This letter will explain purpose of research and process involved. Professionals who agree to interview will be asked to sign consent form

(iii) What will happen to the tapes at the end of the study?

The tapes will be destroyed in accordance with University guidelines and procedures.

Will the study data be held on computer?

YES: [X] NO: [ ]

If YES, will the data be held so that participants cannot be identified from computer files (i.e. no name, address, medical chart number or other potential identifier such as GMS or RSI number?

YES: [X] NO: [ ]

If NO, please give reasons

Will records (preferably paper records) linking study participant ID with identifying features be stored confidentially?

YES: [X] NO: [ ]

Please give details of arrangements for confidential storage

The anonymous Questionnaires and anonymised audio tapes will be kept in a locked filing cabinet in a secure location. All information will be coded and therefore only researcher will be able to know the identity of respondents and participants.

For how long will records be retained prior to destruction?

Until such time as deemed appropriate by University once research is complete, but not for longer than five years.

Will any participant records be examined by investigators in the study?

YES: [X] NO: [ ]

If YES, will information relevant **only** to this study be extracted: YES: [X] NO: [ ] Not applicable: [ ]

(i) If extra information is extracted, please justify

(ii) What, if any, additional steps have been taken to safeguard the confidentiality of personal records?

Questionnaires will be totally anonymous and personal interviews will only identifiable by code, for example Interviewee A.1. Only researcher will know code and the names of persons involved.

Name: Denis Murray (Please Print)

Signed: _____

Thank you

Appendix: I

Name of link person within researchers organisation

Dr Bobby Smyth
Consultant Child & Adolescent Psychiatrist
HSE Addiction Services
Dublin Mid-Leinster
Bridge House
Cherry Orchard Hospital
Dublin 10