SCOTTISH EXECUTIVE

Making it work together

Drug treatment services for young people

A research review

research

Effective Interventions Unit

Scottish Executive
Effective Interventions Unit

Remit

The Unit was set up in June 2000 to:

• Identify what is effective – and cost effective – practice in prevention, treatment, rehabilitation and availability and in addressing the needs of both the individual and the community.

• Disseminate effective practice based on sound evidence and evaluation to policy makers, DATs and practitioners.

• Support DATs and agencies to deliver effective practice by developing good practice guidlines, evaluation tools, criteria for funding, models of service; and by contributing to the implementation of effective practice through the DAT corporate planning cycle.

Effective Interventions Unit

Drug treatment services for young people:
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Stephen Burniston

Michael Dodd

Lawrie Elliott

Linda Orr

Lynsay Watson

Scottish Executive

Drug Misuse Research Programme

ACKNOWLEDGEMENTS

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EXECUTIVE SUMMARY

In August 2001 York Consulting Limited (YCL) and the School of Nursing and Midwifery, Dundee University (SNMDU) were commissioned by the Effective Interventions Unit (EIU) to undertake a study of treatment and care services in Scotland for children and young people with developing or established problems with drug misuse. The study combined a survey of Drug Action Teams (DATs), and service providers, case study work including interviews with young service users, and literature reviews.

Aims

The aim was to review current provision and to identify issues for delivery and future development of these services. The study focused on services for under-16s but also considered services and issues relating to 16-18 year olds. Services focusing primarily on prevention, education or the recreational use of drugs were not covered. Links to alcohol were considered but services focusing on alcohol related problems were not included.

Service user characteristics

The children and young people accessing the case study services typically faced a range of issues, not all of which would be related to drug misuse. The severity of drug misuse in itself can vary widely between services and individual cases. In the cases encountered or discussed with key workers, there was a spectrum of misuse ranging from regular use of cannabis, often combined with alcohol, to smoking or injecting heroin on a daily basis. Poly-drug use could start from the age of 11 or 12 in some cases. The findings were broadly consistent with data from prevalence studies based on surveys of 12-15 year olds in Scottish schools.

Children using services often felt that they lacked support and were disapproved of, and distrusted some agencies and staff. They often lacked knowledge of the consequences of their actions and of potential sources of help, and had difficulty in committing to positive action to help themselves. Most children interviewed were not well equipped to articulate their needs or the priorities for meeting them.

Current provision in Scotland

Key findings from the mapping survey were:

- there is a **limited but significant base of existing provision**; 42 relevant services were identified;

- provision is **distributed unevenly across Scotland**; the 42 services were based in twelve of the 22 DAT areas, with another ten DATs being unaware of any relevant services;

- in **large areas of Scotland (predominantly rural) there is no drug related treatment and care available** with any degree of specialisation for children and young people;

- services coverage is often confined to the immediate locality or specific groups; **coverage is usually incomplete even in DAT areas with relevant services**;

- services display varying **degrees of specialisation** in terms of their targeting of and capacity to deal with children and young people;

- there is **great variety in terms of the aims and methods** involved, with **little overall consistency of approach** across Scotland;

- DAT plans include the introduction or expansion of relevant services; many current services have been in operation for one or two years only; this is **a rapidly developing area of provision**;

- the survey indicated that over **400 children and over 800 young people (16-18)** accessed services in the twelve months to autumn 2001.

- **current services exist to a great extent in isolation from each other**; DAT officers may not be familiar with the details of services, and services within a DAT area or across DAT boundaries may have only limited contact with each other;

- there has so far been **limited opportunity to exchange ideas and disseminate effective practice** between services.

Counselling and the provision of advice are common to almost all the services, with other services such as needle exchange and access to legal support. Detoxification treatment is available, but prescribing of methadone to under-16s is very rare.

There are many gaps in service availability in specific areas. There is no specialist residential rehabilitation available in Scotland, although some services have used residential services in England. Practitioners' views on the need for such services in Scotland differed. There is no evidence of services targeted by gender or ethnic group.

Respondents felt there was a need for further guidance to service teams on issues such as confidentiality, joint assessment, and linkages to family and general social work services.

International evidence on effectiveness

In international research literature, effective interventions in terms of drug use reduction are identified as:

- behaviour therapy;
- culturally sensitive counselling;
- family therapy;
- the Minnesota 12-Step Programme;
- therapeutic community and residential care.

The mapping findings suggest that, of the five most effective interventions identified via the literature review, only counselling is widely delivered by relevant children's services in Scotland. While there are instances of the other four, they are limited in scale and distribution.

Factors contributing to the success of interventions were:

- low pre-treatment substance abuse and reduced psychopathology;
- peer and parental support;
- self motivation and completion and having better coping/relapse skills;
- better school attendance and performance;
- comprehensive interventions including non-drugs related issues;

- longer term, well funded programmes;
- school facilities for low risk groups and to target high risk groups;
- experienced, stable staff teams;
- multi-agency working.

Although comparisons between the international findings and those for Scotland should not be made simplistically, there were some key similarities and contrasts worth noting:

- The review emphasis on comprehensive, multi-agency interventions complements the finding that children are faced by a range of needs, not all drug-related;

- The importance of addressing lower and higher risk groups via specific targeted interventions supports the findings relating to a spectrum of misuse among children and young people using services;

- Counselling is a key component of treatment in both contexts, although the exact significance of the term may vary. The review findings on 'culturally sensitive' counselling contrast with an apparent lack of ethnic or gender targeted services in Scotland;

- The lack of evidence for other effective treatment types in Scotland (behaviour and family therapy, 12-Step programmes, therapeutic community and residential care) may partly reflect the low numbers of children involved in individual services and the pressure on professional time;

- There is some limited evidence of the involvement of families, but these do not amount to structured family therapy programmes in the sense discussed in the review (which involve all relevant family members on a group or individual basis, focusing on family structures and/or interactions). In Scotland, DAT plans and recently established projects embody an increased awareness of the family dimension.

Review of the legal framework

The key legislation is the Children (Scotland) Act 1995. The review identified problems in implementing the statutory framework as regards:

- upholding children's rights to health and health care;
- upholding children's rights to participate in decisions;
- upholding children's rights to consent to medical treatment;
- sharing of information.

Problems included practitioners' lack of experience and confidence with the legal and ethical issues, the illegal status of drug taking as a deterrent to seeking help, and conflicts which can arise between the rights of children and those of parents.

Issues and effectiveness in current provision

The findings from the literature reviews were reflected in case study work which gave examples of practical issues in relation to:

- planning a complete, integrated service;
- applying appropriate interventions;
- fostering awareness and motivation in target groups;
- involving schools;
- involving families and carers;

- upholding children's rights;
- reconciling the rights of parents/carers;
- implementing comprehensive, multi-agency interventions;
- developing service capacity;
- assessing and improving service effectiveness.

DATs and practitioners, faced as they are with many existing demands, will need to continue to work in a number of areas to develop and implement effective services:

- to establish a better understanding of the scale and nature of need;

- to fill existing service gaps;

- to promote awareness of rights and responsibilities and overcome legal or associated practical difficulties;

- to plan and implement effective multi-agency working;

- to support effective delivery.

This implies continued prioritisation of this area of policy in Scotland.

CHAPTER 1 INTRODUCTION

This report gives an account of treatment services in Scotland for children and young people who have problems with drug misuse. The research was carried out for the Effective Interventions Unit (EIU) of the Scottish Executive, by a partnership comprising York Consulting Limited (YCL) and The School of Nursing and Midwifery, Dundee University (SNMDU).

The aim of the project was to review existing knowledge about, and current service provision for, the treatment and care of young people with developing or established problems with drugs misuse.

The focus of the review is on children under 16, but it includes consideration of services for 16 to 18 year olds, as there are issues and transition routes which link the two age groups.

Definitions and terminology

'Current service provision' includes all treatment and care services designed to reduce problematic use of drugs, and/or to reduce or alleviate harm as a result of such use. Services designed to educate or advise, to prevent use, or to address the recreational use of drugs, are not covered by this review, unless they also include elements that meet the inclusion criteria. Linked issues and services relating to alcohol are included, but services and themes relevant to alcohol only are not covered.

The descriptions used to refer to children in the study are important both for clarity and in terms of the attitudes or cultural implications they may contain. In common with most practitioners in this area we use the description 'children or young people with drugs misuse problems' to express the fact that drug use is more than merely recreational, and that there are specific problems arising from or associated with it. The term 'misuse' refers to this problematic dimension of use and is not intended to be pejorative.

For clarity, we use 'service' or 'agency' to refer to the organisation delivering treatment or care, and 'intervention' or 'treatment type' to refer to specific types of work undertaken with service users or their families. The exception is where 'intervention' is used in its wider sense to describe early interventions whereby services identify and engage with children at a relatively early stage of misuse.

Project method

This report is based on the results of a mapping survey and subsequent case study fieldwork with selected treatment services, and integrates the results from literature reviews. The various stages of the overall methodology are described briefly below.

Literature reviews

The literature reviews aimed to:

- identify, assess, critically appraise and synthesise the existing evidence from the international research literature concerning the effectiveness of treatment and care services for drug using young people under 16;
- outline the current statutory framework that affects the provision or take up of drug services for young people in Scotland under the age of 16 years.

Mapping survey

A mapping survey took place between September 2001 and the end of January 2002. The aim of this stage was 'to review existing services in Scotland, identifying significant gaps and specific examples of promising and innovative practice'. The focus was on review and analytical description, rather than assessment and evaluation, although one of the aims was to identify cases that offer useful lessons or models for future practice.

The survey collected information on existing (and planned) services, from Drugs Action Teams (DATs) in Scotland and from other sources. This collection involved:

- a review of information contained in DAT plans and similar sources;

- a survey of DAT co-ordinators and other potential sources of information on services;

- where necessary, more detailed telephone or face to face consultations with these and similar contacts, to collect or clarify details of services.

Case Studies

The second phase of the mapping exercise was a more in-depth look at eight selected cases (or a group of services in one case). In choosing these, the aim was to provide, as far as possible, a selection which represented the variety of services available in Scotland, but which also provided useful illustrations of key themes or issues arising from the earlier mapping work.

Chapter 6 describes in more detail the shortlist and the subsequent selection process by which the final eight case studies were agreed. The case studies were conducted with the following:

- services in Aberdeen City;
- Bannockburn's Community Alcohol and Drugs Service;
- Dundee Youth Drug & Alcohol Service;
- Fife Youth Drug Team (YDT);
- Glasgow Council's Looked After and Accommodated Children's Team;
- the Hype Project in Edinburgh;
- Polmont Young Offender's Institution;
- the Rushes project, North Lanarkshire.

Most of the case studies focused on one specific service, while exploring their links to others in the area and their place within overall DAT strategies. The Aberdeen study attempted to expand on this by including interviews with both voluntary sector and NHS services and examining how these worked within the overall framework of services in the city.

Treatment Pathways

In the next stage of the research, qualitative, face to face interviews and group discussions were conducted with service managers, operational and delivery staff, and children and young people being treated. These interviews with service users were conducted in five of the eight cases.

Report Structure

The structure of the remainder of the report is as follows:

- **Chapter 2** describes the characteristics and predicaments of children and young people with problematic drug misuse; this is informed by the case study and treatment pathway work, and integrates some findings from other studies of drug use and related issues.

- **Chapter 3** presents the results of the mapping survey and draws out conclusions on the incidence and nature of relevant services in Scotland.

- **Chapter 4** discusses the evidence available in international literature on the effectiveness of interventions involving children and young people misusing drugs. This evidence is then discussed in the context of the scenario in Scotland identified by the mapping survey;

- **Chapter 5** outlines the legal framework within which provision in Scotland is set and some issues associated with this.

- **Chapter 6** reviews the issues arising from the mapping and the literature and legal review, with other issues encountered during the case study work, as they apply to services in Scotland.

- **Chapter 7** looks at the implications in terms of areas for future development, and poses some questions that might usefully be addressed in further research.

A range of supporting materials, including research instruments and more detailed methodological notes, is provided in separate appendices available on request from the EIU.

CHAPTER 2 CHILDREN AND YOUNG PEOPLE MISUSING DRUGS

This chapter sets out our findings on the characteristics and predicaments of children and young people with problems including significant substance misuse, *as they present to the services covered in the case study work*. It does *not* aim to be a general account of the prevalence of misuse or need in Scotland. It is an account drawn from our qualitative findings – the perceptions of those working with children and young people, and the accounts of some service users from these groups.

The research involved only service users. It did not directly involve children or young people who may have treatment or care needs associated with substance misuse, but who for some reason have not accessed services. Insofar as we can make any comments regarding these non-engaged individuals, they are based on the perceptions of service users and workers. Service users, however, generally report that they live among individuals with similar needs who have not accessed services.

The discussion incorporates some information on the prevalence of drug use amongst children. This provides a context for the description of the characteristics of young service users in the current study. The intention is to describe the characteristics and needs of service users in the examples studied. The services described in subsequent chapters can thus be understood as responses to these needs. The characteristics of the children and young people discussed here are likely to differ in important ways from those of the wider group described in prevalence studies.

Following this brief review of data for Scotland, the chapter looks at three aspects affecting the target group:

- the range and interrelated nature of individual issues and needs;
- the spectrum of substance misuse;
- predicaments faced by children and young people.

The Prevalence of Drug Use in Scotland

In order to locate the more qualitative discussion of need that follows, it is useful to look briefly at what is currently known about the prevalence of drug use by children in Scotland.

Information on drug taking among secondary school children aged 12 to 15 was collected via a survey of over 4,700 pupils in 150 schools, in autumn 2000. The *Smoking, drinking and drug use among young people in Scotland in 2000* survey was commissioned by the Department of Health and the Scottish Executive. This was the latest in a series of national surveys of secondary school children in this age group; questions on the prevalence of drug use were first included in 1998.

Ten per cent of children reported taking drugs within the past month – this proportion remained at the same level between 1998 and 2000. The proportion reporting that they had taken drugs in the last year was 14%, and the proportion who had ever taken drugs was 17%. These figures were both down by one percentage point from 1998 levels, although neither of the changes was statistically significant.

Reported drug use in this group varied markedly by age. Only 1% of 12 year olds had used drugs in the last month, but 22% of 15 year olds had done so.   There was a decrease between 1998 and 2000 in 15-year-olds reporting drug use within the last year (from 35% down to 30%).

Boys were a little more likely than girls to have used drugs in the last month (11% compared with 8%) and were also likely to have used drugs in the last year or to have ever used drugs.

Many more pupils had been offered drugs than had tried them. More than one third (39%) had been offered one or more drugs, and boys were more likely to have been offered them than girls (41% compared with 36%). As with the use of drugs, the likelihood of ever having been offered them increased sharply with age.

The drugs reported as having been **offered** were (in order of prevalence):

- cannabis (32% having been offered this);
- glue or gas (15% offered);
- ecstasy (10%);
- heroin or methadone (7%);
- amphetamines (7%);
- cocaine (6%).

In terms of drugs used in the last year, the order of prevalence was similar:

- cannabis (13% having used it);
- stimulants (including ecstasy, cocaine, crack, amphetamines and poppers) (3%);
- heroin or methadone (1%).

A Range of Needs

As noted above, the children and young people we met, or discussed with practitioners during the research, differed from the wider group of drug users described above. They were accessing services, and thus it is reasonable to assume that their drug misuse was associated with problems which are not typical of all young drug users. In general, drug misuse was only one of the factors presenting them with problems. Recognition of this fact is of fundamental importance in understanding the nature of the needs of this group and in service planning and delivery.

Behaviours such as offending, for example, can begin as relatively minor secondary effects of drug misuse or of other issues such as family breakdown, but may develop into key driving factors in the case. The main specific feature of drug misuse when compared to other issues affecting children and young people, is that in some cases it can become a cause of dependence and hence of chaotic behaviour. In these cases it may result in a range of harmful physical and psychological effects which can be very difficult to reverse after a certain point.

The cases of 'Daniel' and 'Philippa', taken from our Treatment Pathways interviews, (Boxes 1 and 2) provide examples of young people with a range of needs closely related to the misuse of drugs. In these cases they include mental and physical health problems, difficult family relationships, and self-harming or suicidal tendencies. Others encountered during the fieldwork included accommodation problems, often as a result of family difficulties, and offending behaviour and problems arising from this.

Cases such as these present a challenge for agencies working together to assess the nature of and relationships between the issues, and to produce a treatment and care plan for the individual which addresses them effectively.

The Spectrum of Substance Misuse – Examples from Case Studies

Individuals accessing case study projects present with a wide range of substance misuse. This range applies to:

- substance (more usually substances) used;
- length of time used (age of first use);
- frequency of use;
- degree of dependence.

Figure 1 gives an example to illustrate this point, using information on children and young people accessing one of the case study services. It shows the incidence of daily and non-daily use of a number of substances for 41 children assessed for entry to one service in a semi-rural area. All of these children had used cannabis, the majority on a daily basis. The next group in terms of prevalence of use included Ecstasy, Valium,

and amphetamines, but few children used these on a daily basis. However the proportions using these drugs more occasionally are much higher in relation to the use of cannabis than for children in general (as evidenced by the survey results cited). For example, the national survey indicates that only 3% had used stimulants in the last year as against 13% using cannabis. In these results, the entire group were using cannabis daily or less frequently, and half of these were also using amphetamines on a non-daily basis. The difference presumably indicates the success of this particular service in targeting children with heavier and more problematic misuse.

Figure 1: Substance Use by 41 Under-16s Assessed for Project Entry
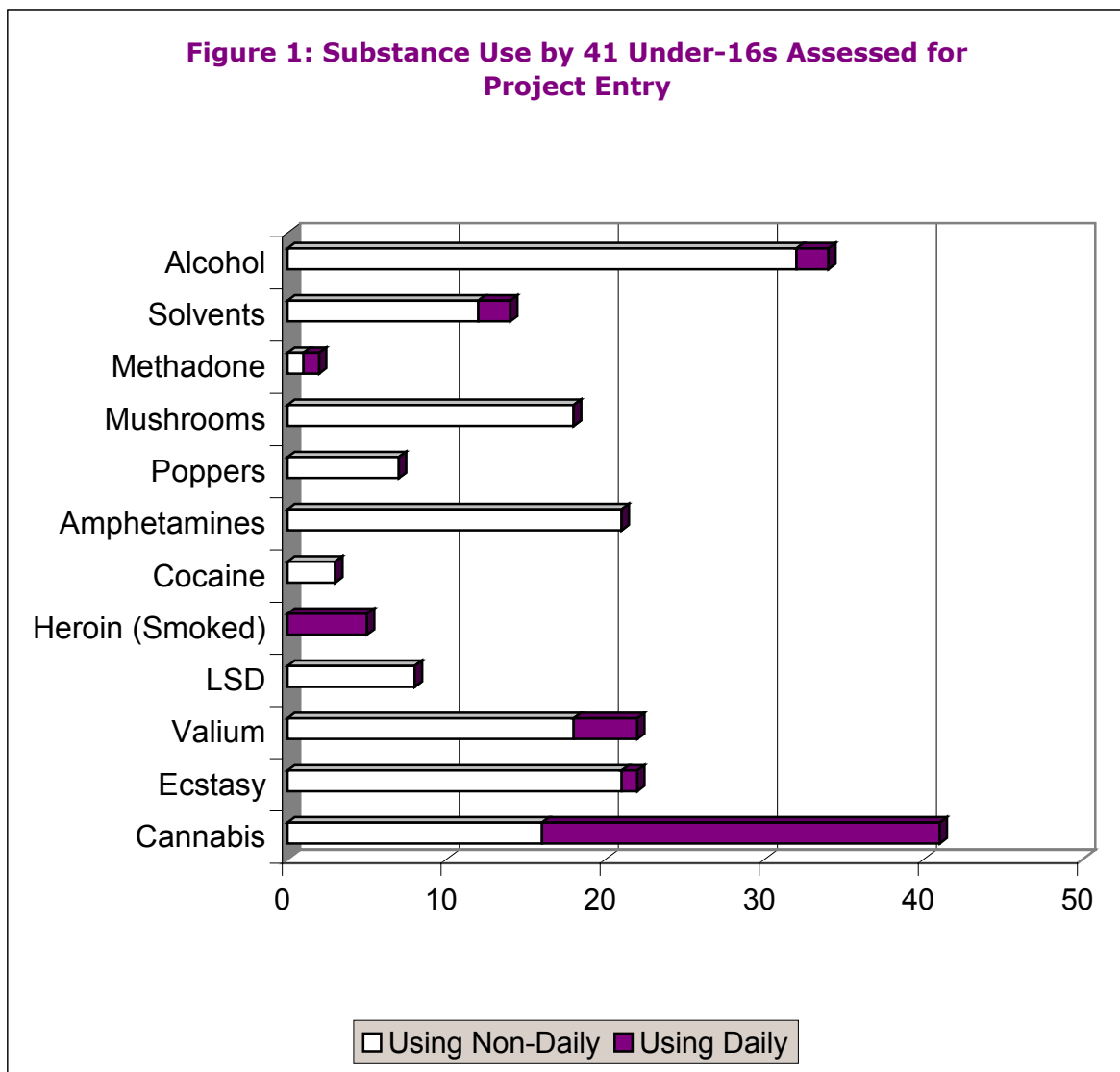
Almost half the children had used mushrooms, (perhaps reflecting the semi-rural nature of the area). A smaller group had used solvents, and a few individuals had used LSD, 'poppers' and cocaine. Small numbers reported having used methadone and heroin, but most of these had been using them on a daily basis, reflecting the

more addictive nature of these opiate drugs. The project had not encountered any heroin injectors in this age group.

Alcohol was reported as widely associated with misuse of these substances in all case studies. In this case, over three-quarters of the children admitted to alcohol use, but very few of these were drinking on a daily basis.

Data on use by gender and first onset indicated that for some of these children cannabis use could start as early as 8 years old and poly-drug use from the age of 11 or 12. There was a tendency towards increased use of 'harder' drugs with age.

Girls in this group were more likely than boys to have used amphetamines or ecstasy, but in general their patterns of use were similar to those of boys. Less than a quarter of those assessed (9 of 41) were girls.

This is a very small and local sample. However, the general picture of initial cannabis use, from a relatively young age, often combined with alcohol use and later with a range of other substances, agrees with our findings in interviews with young people across Scotland.

This early use of cannabis may be recreational and perhaps not particularly problematic in itself. However in our case studies we found that it had often occurred within an overall set of problems. Children were often already in contact with a range of agencies in connection with other issues before their drug use was recognised as a significant factor. At this stage risks, behaviour problems or offences while under the influence of alcohol were also often a trigger for considering drug and/or alcohol specific treatment options.

In this sense one might say that the substance misuse issues faced by these children are not usually the core issues for them, or at least are part of a set of issues from which they cannot sensibly be detached. The design of the service concerned reflected this. It aimed to reduce offending behaviour not by addressing it directly but by focusing on the drugs related aspects of cases. A key criterion for acceptance onto the programme was the willingness of individuals to address their drug misuse issues.

The case of 'Liz' (see Box 3) from another case study provides an example of the more severe end of the misuse spectrum. This involves heroin injecting and fairly advanced dependency. Dependency has become a prime factor and leads to behaviour usually described as 'chaotic'. The service emphasis has been very much on the direct drug-related issues, focusing on the reduction of misuse and dependency.

Liz, 16   **Box 3**

First contact with Liz took place in January 2001. Contact was sporadic and Liz agreed to be referred on to a newly established service in September 2001.

At this time she was spending between £50 and £70 per day on heroin and injecting unsafely. After assessment a co-working approach was taken to address both her drug misuse and offending behaviour.

Liz was quite defensive and the first part of the counselling treatment was spent getting to know her and gaining her trust. Over a period of time, her drug use reduced to approximately £20 per day, (taking heroin twice a day). Liz appeared healthier and better cared for.

At this time Liz was taken to hospital suffering from an infection. Whilst in hospital she was given a 50 ml methadone script while investigations took place. She was prescribed antibiotics and on discharge, the methadone script was stopped.

Liz's drug use stabilised at about £20 per day and her attitude and motivation had improved to an extent where detox was appropriate. Detox using Lofexidine commenced at home where Liz lives with her mother. Unfortunately, Liz used heroin on her second and third day of detox and the regime was abandoned. She claims that her heroin use is still approximately £20 per day but it is suspected that it is somewhat higher.

The detailed characteristics of this 'spectrum of misuse' cannot be understood in full via a small qualitative exercise. But it is important to emphasise that a spectrum exists. Not all substance use by children, even when problematic, is of the same degree of severity or centrality in terms of the overall handling of the case. This has important implications for the ways in which drug agencies and others supporting children co-operate.

For example, assessments need to include consideration of the severity and importance of the drugs misuse problems, along with the possible range of non-drugs issues, and the relationships between them. These findings then need to be shared by a range of relevant agencies as a basis for effective shared treatment or care.

Predicaments of Young Drug Users

The child or young person facing issues such as these is not usually well equipped to articulate his or her needs or the priorities for addressing them. In our study, they usually faced at least some of the following difficulties:

- lack of family and peer support to address their problems;
- lack of awareness of the likely consequences of their actions (particularly of substance misuse);
- lack of knowledge of who to approach for help or how;
- distrust or fear of official agencies and staff, including social workers;
- an assumption that they are disapproved of by most other social groups;

- danger of victimisation or exploitation by others (including dealers and pimps);
- difficulty envisaging and committing to a positive course of action to help themselves.

Some of the problems outlined above were explicitly recognised by young interviewees. Statements made to us included:

> *Some of my friends have got turned away when they looked for help. Because they take drugs, people treat [young drug misusers] differently from people who don't take drugs. But they still need help like other people.*

> *When I was 16 I just wanted to party. When I started coming here it made me more aware of the effects of drugs and I calmed down.*

> *Nobody listened to me before – they just told me what to do.*

Agency workers mentioned other predicaments in relation to specific cases (examples included family difficulties and victimisation) or in relation to their young service users generally.

> *Children can be afraid to approach our workers – they are often from children's homes or from drug using families. If they are involved in the sex industry, for example, they will be aware that under-age sex is illegal, and they may be being pimped, or subjected to family pressures.*

The predicaments faced by individuals will be affected by their position on the 'substance misuse spectrum' and on their particular set of needs. One delivery worker, for example, commented on the sense of separation, and even mutual hostility, between cannabis and heroin users on the programme.

> *The kids that are just using cannabis look down on the heroin users as scum – they have no time for them. We have to be careful how we mix kids from these two groups in our programmes – it takes time for them to settle down and work together.*

Many of the interviewees facing these difficulties were supported by families, carers, or social workers or other agencies, and so might receive support to help them overcome these difficulties. However the children and young people interviewed usually suggested that there were others who did not have access to such support – who were in danger of 'falling through the gaps' in provision. The nature of this study precluded us going beyond this initial identification to assess the likely scale of this problem in Scotland.

CHAPTER 3 CURRENT PROVISION IN SCOTLAND

This chapter sets out the findings from the mapping survey of DATs and practitioners, conducted from September to December 2001. The aim of the survey was to establish the nature and scale of provision for children and young people across Scotland. It also provided an opportunity to start to identify some of the issues associated with provision which were then followed up in the case studies and treatment pathway interviews. The responses were also important in selecting the case studies.

General Features of Provision in Scotland

The key findings concerning provision are as follows:

- There is a **limited but significant base of existing provision**. Details of 42 services which include some provision for children and/or young people were collected;

- This provision is **distributed unevenly across Scotland**. The 42 programmes were based in twelve of the 22 DAT areas, meaning that ten DATs did not provide any details of relevant provision. On further enquiry these ten confirmed that they were not aware of any relevant programmes in their areas;

- There are therefore **large areas of Scotland (predominantly rural) where there is no drug related treatment and care available** with any degree of specialisation for children and young people;

- Where services exist, their coverage is often confined to the immediate locality rather than the entire DAT area, or to specific target groups. **Coverage is usually incomplete even in the DAT areas with relevant services**;

- Existing services display varying **degrees of specialisation** in their targeting of and capacity to deal with children and young people;

- There is also **great variety in terms of the aims and methods** involved. There is much interesting practice but there is **little overall consistency of approach** across Scotland;

- DAT plans include the introduction or expansion of relevant services, and many of the current services have been in operation for one or two years only; this is **a rapidly developing area of provision**;

- The survey indicated that over **400 children and over 800 young people (16-18)** accessed the 42 services during the twelve months to autumn 2001.

Two additional points can be made based on the mapping survey and supporting findings from the case studies:

- **Current services exist to a great extent in isolation from each other**. DAT officers are not necessarily very familiar with the details of services, and services within a DAT area or across DAT boundaries may have only limited contact with each other;

- As a result, there has so far been **limited opportunity to exchange ideas and disseminate effective practice** between services.

Each of these findings is supported with evidence from the survey in the remainder of this chapter. **Gaps in service provision**, and the **need for further guidance**

mentioned by respondents, are also reviewed. More detail on the information collected is set out in separate appendices available from the EIU on request.

A Limited and Uneven Base of Provision

Eighteen DATs identified a total of 45 services. Two of the service providers in question returned blank forms on the grounds that the services provided were not relevant to our survey. This leaves 43 services, two of which (the Adult Care Substance Misuse service and the Cumbernauld and Kilsyth Addiction Services in Lanarkshire) are only mentioned in the response of another service and are thus not available for analysis. There are therefore 41 services of which we have some details. One additional service which was not included in the mapping responses, but was covered as a case study, was the Glasgow Looked After and Accommodated Children's service – this brings the total of relevant services to 42.

The DATs identifying services, and those reporting no relevant provision within their areas, are shown in Table 1. Most of the services operate in mixed urban/rural areas based in local urban centres with the exception of services in inner city Glasgow and Edinburgh, and the Aberdeen City urban services.

Table 1 Incidence of Services by DAT Area	
DATs reporting services (N = number of services detailed)	*DATs reporting no relevant services*
Aberdeen City (5)	Aberdeenshire (access Aberdeen services)
Ayrshire and Arran (8)	Angus
Borders (2)	Argyll and Clyde
Dumfries and Galloway (3)	East Lothian
Dundee City (1)	Highlands
Edinburgh City (8)	Midlothian
Fife (3)	Moray
Forth Valley (2)	Orkney
Greater Glasgow (6)	Perth and Kinross
Lanarkshire (2)	Western Isles
Shetland (1)	
West Lothian (1)	
Total Services: 42	**DATs reporting no relevant services: 10**

Source: Mapping Survey

There are examples of services in most semi-urban and city areas, although the number and range of services varies widely. The relevance and coverage of these is likely to be very patchy. It should be remembered that many areas, especially in large cities, will possess many other drugs related services, but these were not seen as being relevant to our study of services for children and young people.

There are some examples of services in predominantly rural areas where there are smallish towns. However, there are many similar towns where there is no indication of any relevant service.

Services in very rural areas are rare. This often reflects rare and small scale demands for drugs misuse services (as opposed to alcohol related services) in these areas.

Some services which centre on alcohol abuse rather than on illegal substances would be available to children and young people. However, there are also likely to be out of area arrangements which enable services in these rural areas to refer to specialist provision elsewhere.

Incomplete Coverage within DAT Areas

Services frequently targeted specific client groups rather than making the service generally available to children or young people. This means that others outside the target group may not have access to services. For example, the Fife Youth Drug Team selects from referrals on the basis of likely benefit. Referrals are all individuals with an offending record as the focus of the service is on reducing offending behaviour.

In some areas, services are available only for looked after and accommodated children, with few or no corresponding services for children not under council care. There are plans to extend service availability in many of these areas. In other cases, a service may be open access but only available in a relatively small part of the overall DAT area.

Degrees of Specialisation

Very few projects are targeted exclusively at our core group of children with drug misuse problems. Our questionnaire asked projects to classify themselves by degree of specialisation on children or young people. The results are shown in Table 2 below.

Table 2 Service Classification	
Service Type	**No.**
Specialist services for under-16s	4
Generic adult services with special facilities for under 16s/16-18	11
Generic services dealing with under-16s and/or 16-18 year olds'	25
Alcohol related services but with drugs misuse and under 18 links	2
Total	**42**

Nineteen services report that they apply specific criteria in determining client eligibility. These vary quite widely, examples include: 'young people who have been looked after by the social work service on or after their sixteenth birthday' and '12 to 18 year [olds] known to have problems with drugs/alcohol'.

Variety of Approaches

Figure 2 shows the number of organisations offering each type of intervention. Almost all services offer advice and counselling, (although these are distinct forms of support they were rarely distinguished in responses) although this appears to vary somewhat in nature and scope. CADS at Bannockburn offers 'a full range of drug related counselling interventions' including 'harm reduction …motivational interviewing...and child sexual abuse work'. In other cases the exact nature of the service is less clear but the general intent is evident; 'coping mechanisms, general support for families, friends and addicts'.

Many respondents also cite 'other services' which are in fact often variants of counselling and advice, or references to referrals to some of the other treatment interventions listed. There are however some treatment services in this category such as 'group work' and 'diversionary activities' which illustrate activities particularly

relevant for younger clients or specific groups of clients, and which are worthy of further exploration in the case studies.

Figure 2 Interventions Available
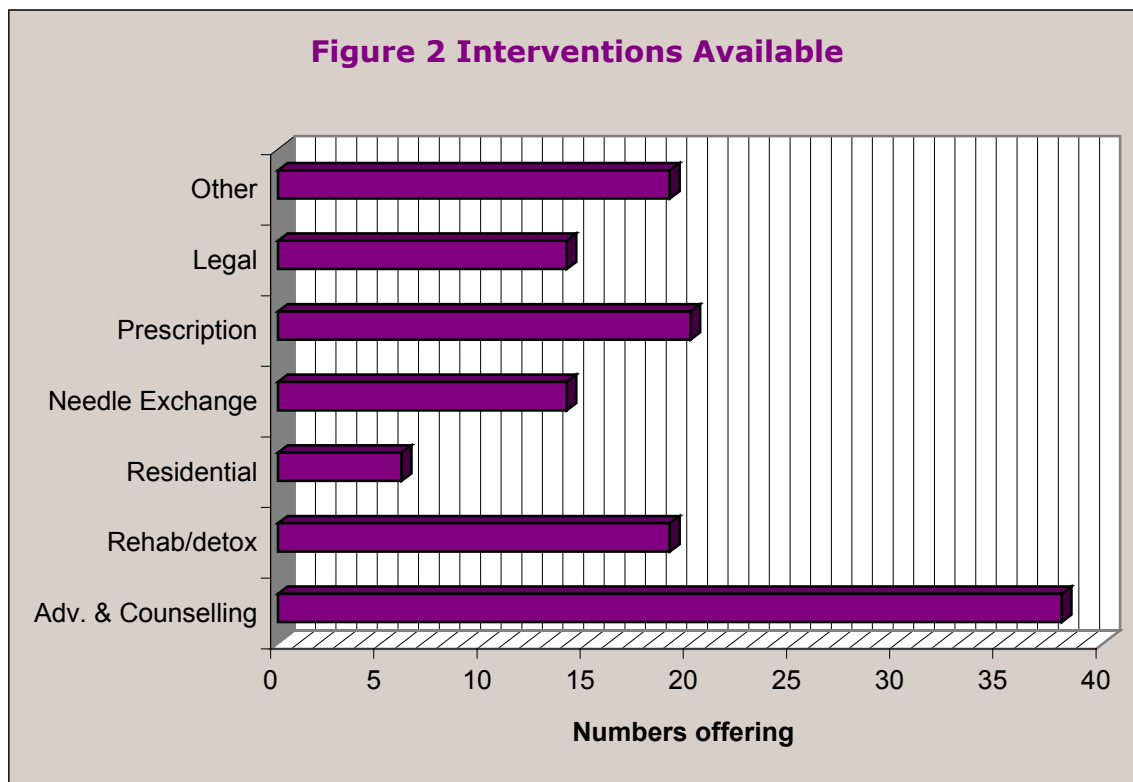
At first sight many services also appear to offer prescription services (almost always methadone based). However this disguises the fact that very few are likely to open these services to children under 16. This can also apply to other services. One service, for example, provides six month and nine month methadone reduction and detoxification, and needle exchange services but for over-16s only.

The least prevalent treatment intervention is residential treatment and/or care. Like other agencies, the Childcare Fieldwork Service in Aberdeen has some access to residential facilities; 'work with this client group may well involve child protection, statutory involvement with the Children's Hearing system, our own residential units, and outreach service'. However the residential units referred to here are generic rather than specifically to address drugs problems. Residential facilities for children, focused specifically on misuse issues, were not found in Scotland; however; the Royal Cornhill Hospital in Aberdeen notes that 'two known *Aberdeenshire* cases have used Middlegate Lodge in Lincolnshire'. Another (voluntary sector) service in a different part of Scotland comments that residential services are 'difficult to access due to funding sources'.

The survey data shows the types of intervention available within services, but does not indicate how many service users are actually accessing each intervention type. The figures indicate that the most prevalent intervention in services accessed by under 16s is counselling, followed by a range of other forms of support, access to legal

advice or assistance, and detox and rehabilitation. For young people over 16, treatments based on prescription are more prevalent features of services accessed, as one might expect.

A Rapidly Developing Service Picture

Most current services are likely to be expanded in the near future, in terms of area, remit, or capacity. Other new or related services will be coming on-line during the next financial year. The overall prospect for these services is one of continued development and ongoing embedding and integration, in response to the likely continued development of need among children and young people.

Some examples of service development plans are given in the boxes setting out practical responses to delivery issues in Chapter 6.

The Scale of Provision

In discussing the scale of provision it is important to note that survey responses were not necessarily based on any routinely maintained records showing the age of young people accessing services. Some services interviewed made the point that in some situations it was difficult to obtain reliable information on age, and that estimates might have to be made. Therefore the status of this information is not the same as that provided, for example, via the Scottish Drug Misuse Database (SDMS) which is based on returns from services using a consistent data collection format.

The questionnaire asked for the numbers of under 16s and 16-18 year olds being treated, both in terms of average caseloads, and in terms of annual totals. For many respondents this was a difficult question to answer, indicating that record keeping in this area is very variable. However, 27 respondents were able, or attempted, to answer these questions in whole or in part.

Fifteen respondents gave numbers for the average caseload under 16. However, three of these gave a figure of zero, so there were twelve remaining cases, most of which reported an average caseload of ten or under. The two exceptions had average caseloads of 55 and 70, and bring the mean number for the under-16 caseload up to 16 per service.

Perhaps surprisingly, the mean figure for the average 16-18 caseload was slightly lower, at 15; sixteen services gave figures in this category, ranging from 1 to 50.

Seventeen services gave figures for the *annual total* of under-16s treated, and the mean for these was 24. In other words, in these seventeen cases, an estimated total of around 405 children under 16 were involved with a treatment service for drugs misuse in the preceding twelve months. There may also be additional children accessing services which have been unable to give numbers.

Figures from the SDMS for 2000/2001 show that 176 under-16s were reported as *new* contacts by Scottish services ('new' means that this was their first ever attendance at the service, or that there has been a gap of at least six months since their previous attendance). This was 1.7% of all new contacts reported by Scottish services in the year.

Given that they describe different things, and the very different methods by which they were generated, the figures from the SDMS neither contradict nor directly

support those from the survey. It is, however, reasonable to assume that the annual total of children in treatment is by some way higher than the number of new contacts.

Neither figure can be taken as an indicator of the scale of *need* across the country, since they only show service users. These may be outnumbered by those who for various reasons are not accessing available services, or who do not have services available to them due to the area in which they live or the fact that they belong to a non 'targeted' group.

The survey figure for the total of 16-18 year olds accessing services during the preceding twelve months is 831 – an average of 33 young people per annum in 25 services.

Of the new contacts with services notified to the Scottish Drug Misuse Database in 2000/2001, 16% reported they were under 15 years of age when their drug use first became a problem, with 44% aged 15-19 ('Drugs Misuse Statistics Scotland 2001', ISD Scotland, 2002).

Isolation of Services

From survey responses it was not evident that services enjoyed regular or close contact with other agencies outside their DAT area. The difficulty experienced by DATs in providing details of some services suggests that even within some DAT areas, communication between services is limited beyond the operational level.

Service Gaps Identified in Survey Responses

DAT contacts were asked to comment on any services for which there is an identified need but which are not currently available. Those that had conducted needs assessments were usually able to make some suggestions:

> *Residential services, particularly detoxification, but also rehabilitation therapy etc. Particularly difficult to find services of this kind for under-16s. [The] identified need is small – perhaps only 2-3 under 16s per year and potentially 10-12 16-18 year olds. Housing for 16-18 year old substance misusers is very problematic. Provision of education/employment training for this group is also problematic.* (Dumfries and Galloway).

> *The needs of young people are currently anecdotal, hence the commissioning of the research [audit and gap analysis of current services for under-16s]. In general terms alcohol, chaotic use of various substances and generally difficult behaviour cause services working with young people some anxiety. Areas for further development could include further development of stable accommodation and alternatives to custody/diversion schemes.* (Lanarkshire).

This theme of anxiety or uncertainty about what might be involved in working with young misusers is echoed elsewhere. 'Some practitioners get over cautious when dealing with young people and tend to over-react. While child protection remains paramount, there can be a tendency to take issues to extremes'.

It is worth noting that no services targeted at young ethnic minority users, and none specialising in working with children of either gender, were reported. Subsequent case

study work in Aberdeen did confirm the existence of specialist facilities for pregnant girls or women, and outreach to sex industry workers (see Chapter 6).

Need for Further Guidance

A number of respondents believe there is a need for further guidance:

> *[Guidance should cover] young people with established substance misuse; young people leaving care with substance misuse issues; how young people's substance misuse impacts on families and generic social work services;*

> *Confidentiality; joint assessment; young people's needs alongside issues of substance misuse;*

> *How to do it!*

These comments suggest that there is considerable interest in the treatment of drug misuse problems in children and young people, and that some research and thought is already taking place to address this. However, there appear to be uncertainties about the issues involved, which may relate to doubts about the policy and statutory framework. These are issues which were explored further via the legal framework review (Chapter 5) and in the case study and treatment pathways work (Chapter 6).

Other Service Characteristics

In addition to the key findings outlined above, the survey provides information on other service characteristics, as follows:

- *Lead organisation*: nine of the services are local authority run; eleven are NHS run, and two are described as a local authority/NHS partnership. Sixteen projects are run by voluntary organisations, and three categorise themselves as 'non-statutory services';

- *Time established*: the length of time for which services have been established varies between 20 years and six months (some services responded only 'many years'; this has been interpreted to mean ten years). Six had actually been operating for less than a year. The mean age of services, subject to the above assumption, was 6.7 years;

- *Budgets*: the total annual spend by the 28 services responding to this question is at least £6,535,000, an average of £233,000 per service per annum. But only a very small fraction of this sum is likely to be directly applied to work with drugs misusers under 16. Services specifically for this group tend to be working with much smaller budgets – for example one such service has a projected first year spend of only £50,000;

- *Security of funding:* twenty-five services enjoyed relatively secure funding; in some of these cases, secure 'core' funding was supplemented by additional project-based funds on a shorter term basis. As one would expect, most local authority and NHS run services received secure core funding, while voluntary sector services were more likely to be dependent on shorter term funds. However there were cases of voluntary sector projects which were long established with secure funding;

- *Staffing*: there were 499 staff (FTE) in total across the projects, with an average complement of 14 staff each. However numbers vary widely, and are likely to be misleading. It is probable that only a very small minority of these staff have regular or even occasional contact with children under 16 who have drugs misuse problems.

- *Research and needs assessments undertaken:* some DATs or DAT partners have undertaken needs assessments or other research exercises relevant to the study. These exercises are a reflection of the recent increase in policy and project funding focus on young misusers, and are associated with service development plans for young people, as evidenced in the corporate plans of most Scottish DATs.

CHAPTER 4 EVIDENCE FOR EFFECTIVE INTERVENTIONS

This chapter presents the findings of the first of two literature reviews which inform the overall study of treatment services in Scotland. More detailed analyses and methodological details are presented in a separate EIU report of the literature reviews.

After the introduction we present our conclusions and discuss the key issues contributing to the success of the interventions that appear to be effective. We then provide more detailed information about each type of intervention and its relative effectiveness and present some limitations of the literature review. Finally, we discuss whether the interventions identified through the literature review are transferable from their place of origin to a Scottish setting.

Introduction

Outlined below are the main findings of a systematic review of published research into the effectiveness of treatment and care services for drug using young people up to the age of 16 years in the following five key areas:

- reducing drug use;
- reducing the physical harms associated with drug use;
- improving the psychological well being of young drug users;
- improving the family and social relations of young drug users;
- encouraging the up-take of other health and social services.

The small number of papers included in the review (7 reviews and 11 primary papers) indicates that there is a lack of good quality studies on the effectiveness of drug interventions for young people up to the age of 16 years. Nevertheless, they provide useful insights into the types of interventions that have been evaluated using moderately strong research designs. As such the review provides the best available evidence for the effectiveness of these interventions for young drug users. The interventions range from in-patient treatments to school-based programmes and are aimed at reducing drug use and the problems associated with drug use. The review focuses on secondary prevention rather than primary prevention. Practically all of the studies are conducted in North America or Canada.

All 18 publications make specific mention of the design of the interventions. Journal articles restrict the amount of space available to authors, particularly published reviews. So not every article provides similar details about the crucial elements of the service design including, the content of the intervention, who delivered it and the setting in which it was provided. Even when more space is provided, such as in primary papers, the level of detail varies according to the author's preference. The intervention details that appear in this report are based on papers that allow some description but are likely to provide only partial coverage.

More complete analysis would require careful assessment of the relevant primary papers cited in published reviews and, where primary papers fail to provide sufficient detail, direct contact would have to be established with the original author. This is outwith the scope of the current review.

Key Findings

The review clearly demonstrates that some interventions are effective in reducing drug use and the problems associated with drug use whilst others are either weakly

effective or have no impact on these outcomes. The interventions and their associated effect are summarised in Table 3.

In the fairly/strong effect/reducing drug use quadrant, the main drug(s) used by participants have been identified in brackets. The absence of other named drugs means that there is no current evidence that the specific intervention is effective in reducing other types of drug use. It is interesting to note that family therapy is seen to be effective in reducing drug use, psychological problems and social problems.

Table 3: Effectiveness of Interventions			
	Reducing Drug Use	**Reducing Psychological Problems**	**Reducing Social Problems**
Fairly/ Strong Effect	Behaviour therapy (cannabis & cocaine) Culturally sensitive counselling (cannabis, alcohol & tobacco) Family therapy (cannabis, opiates & cocaine) Minnesota 12-step (cannabis & alcohol) Therapeutic communities and residential care[1] (cannabis & alcohol)	Family therapy	Family therapy Family teaching Non-hospital day programmes Therapeutic community and residential care Life skills (some) School programmes (some)
Weak/No Effect	Health education counselling General drug treatment School based programmes	Behaviour therapy Family problem solving School based skills programmes Therapeutic communities and residential care	Behaviour therapy Family therapy (in relation to drug arrests and school grades) Family problem solving School based programmes (majority)

Apart from the evidence presented in Table 3, there is also weak evidence that therapeutic and residential treatments may lead to an increase in the use of medical services by young people and their parents. There is also weak evidence that family therapy reduces the length of stay in prison or residential treatment.

A small number of interventions may have a potentially harmful effect. These are mainly school based life skills programmes that demonstrate an increase in cannabis

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[1] This is a treatment setting rather than a treatment type. The review evidence for its effectiveness suggests that both the setting and the types of treatment applied within it are important. Some detail on the treatment types is given on page 30.

use and drug acceptance attitudes among those exposed to the intervention. This may be related to the influence of drug using peers or family support for drug use.

The review found no studies that demonstrated interventions effective in reducing the physical harms related to drug use. Two possible explanations for this are that good quality research studies have yet to be conducted in this area or that young drug users do not exhibit the same level of physical morbidity as demonstrated by adult drug users. There were also no studies that demonstrated the effects of substitute prescribing for young drug users, such as methadone. This may be due to the reluctance of medical practitioners to prescribe potentially addictive substances to young people or legal restrictions on the licensing of these drugs.

The review provides the best available evidence for the effectiveness of some interventions for young drug users and in addition the factors associated with their success. These factors are best regarded as broad indicators of the types of elements that might be included in successful interventions for young drug users (Table 4).

Table 4: Factors Contributing to the Success of Interventions

Factor	Source
Low pre-treatment substance abuse.	(Williams and Chang 2000; Maisto, Pollock et al. 2001)
Reduced psychopathology.	(Botvin 1997; Williams and Chang 2000)
Peer and parental support (including peer-led support).	(Tobler 1992; Azrin, McMahon et al. 1994; LoSciuto, Freeman et al. 1997; Stanton and Shadish 1997; Weir 1998; Lister-Sharp, Chapman et al. 1999; Williams and Chang 2000)
Self-motivation and completing the programme.	(Williams and Chang 2000; Winters, Stinchfield et al. 2000)
Having better coping and relapse skills.	(Lister-Sharp, Chapman et al. 1999; Nicholas and Broadstock 1999; Williams and Chang 2000; Maisto, Pollock et al. 2001)
Better school attendance and school performance.	(Williams and Chang 2000).
Comprehensive interventions i.e. not just concentrating on drug use but tackling wider cultural issues including life skills training, stress and coping.	(Tobler 1992; White and Pitts 1997; Lister-Sharp, Chapman et al. 1999; Nicholas and Broadstock 1999; Williams and Chang 2000; Maisto, Pollock et al. 2001)
Carefully planned interventions with clear aims, objectives and target audience.	(Nicholas and Broadstock 1999)
Well-funded, long-term interventions with booster sessions.	(White and Pitts 1997; Weir 1998; Nicholas and Broadstock 1999; Williams and Chang 2000)
Having school facilities for low-risk groups or targeting high risk groups e.g. dropouts.	(Tobler 1992; White and Pitts 1997; Weir 1998)
Using experienced and well trained staff with low turn over.	(Tobler 1992; Weir 1998; Morehouse and Tobler 2000)
Multi-agency working.	(Nicholas and Broadstock 1999)

One of the success factors concerns providing separate services for 'low risk' and 'high risk' groups. The potential characteristics of these groups are shown in Table 5.

Table 5: Characteristics of Low and High Risk Groups	
Low Risk	**High Risk**
Low pre-treatment levels of substance abuse	Drop out of school
Reduced psychopathology	Greater levels of substance abuse
Better coping and relapse skills	High level of psychopathology
Well motivated	Reduced coping and relapse skills
Experimenting and still in contact with school	

Involving parents and peers may enhance an intervention and this is why family therapy is particularly effective. However some caution should be shown when involving families, especially where there is negative family or peer pressure. The use of experienced well-trained staff is also important and multi-agency working in some instances is successful e.g., using mental health professionals in schools programmes and linking family therapy with school interventions.

The Effectiveness of Specific Interventions

Each type of intervention assessed in the literature is described below. This is followed in each case by a summary of the assessment findings for that intervention.

Behaviour therapy

Williams and Chang (2000) describe behaviour therapy as outpatient programs including group therapy of no set length. Azrin et al (1994) provide more detail: 'a typical format of therapist modelling, behaviour rehearsal, specific therapy assignments, self-recording between sessions, review of self-recordings and assignment records, and extensive praise for progress'. The major foci in this study are stimulus control, urge control and social control. Therapy is delivered on a one-to-one basis by a therapist.

Findings

There is fairly strong evidence that behaviour therapy is more effective in reducing drug use than non-behavioural support (Azrin, McMahon et al. 1994) and that behaviour therapy and cognitive behaviour therapy are more effective than counselling in reducing drug use (Williams and Chang 2000). In one study young people exposed to behaviour therapy for 12 months achieved 8.9 drug free months compared with 0.6 in the non-intervention group (Azrin, McMahon et al. 1994). Young people also respond more positively to behaviour therapy compared with adults (Azrin, McMahon et al. 1994). Another study reported by Williams and Chang (2000) demonstrates that 73% of those exposed to behaviour therapy achieved drug abstinence at discharge compared with 9% receiving counselling.

There is weak evidence that behaviour therapy (Williams and Chang 2000) improves the psychological well being of young drug users. Behaviour therapy also has a weak effect in improving schoolwork, school attendance, and family relations (Azrin, McMahon et al. 1994; Williams and Chang 2000).

Counselling

Counselling is extremely varied. It encourages the expression of feelings, the initiation of comments, reactions to comments, self-described drug use, discussion of drug use experiences, praise, and abstinence desires (Azrin, McMahon et al. 1994). It may be delivered on a one-to-one basis or in groups (Williams and Chang 2000; Morehouse and Tobler 2000). In one study highly trained counsellors delivered culturally sensitive counselling consisting of drug prevention, wellness and drug freedom sessions to high-risk youths (Morehouse and Tobler 2000). It included the discussion and role-play of drug experiences, family problems, and stress, and aimed to change attitudes, culture and norms. Small interactive health education groups may also involve counselling. In Magura et als' study, for example, emphasis is placed on problem solving around HIV/AIDS, the factors leading to the initiation and continuation of drug use, and problems associated with drug use (Magura, Kang et al. 1994). Interestingly motivational counselling was not evaluated in any of the studies included in the review.

Findings

Culturally sensitive counselling is more effective than non-intervention controls in reducing drug use, and that up to 36% of those exposed to this counselling will reduce their drug use (Morehouse and Tobler 2000). Less intense health education counselling, however, is ineffective in reducing drug use (Magura, Kang et al 1994).

Family Therapy and Other Family Interventions

Family therapy is diverse. Stanton and Shadish (1997) distinguish it from other family interventions in that it involves all relevant family members in a group (co-joint) or individual basis and includes any of the following elements:

- structural therapy which aims to alter family structure (Stanton and Shadish 1997);
- strategic approaches which focus on family interactions out with therapy sessions (Stanton and Shadish 1997);
- multi-systematic interventions which incorporate external systems such as courts and schools (Stanton and Shadish 1997; Schoenwald, Ward et al. 1996);
- contextual approaches which are described as 'psycho-dynamical-oriented and multigenerational'. (Stanton and Shadish 1997);
- Bowden Systems Therapy which is an intergenerational approach using family and individual sessions (Stanton and Shadish 1997);
- functional approach which combines strategic therapy with behavioural tasks (Stanton and Shadish 1997);
- behavioural approach which emphasises social learning principles (Stanton and Shadish 1997).

Other family or peer interventions that do not include family therapy are:

- individual counselling (Stanton and Shadish 1997);
- family counselling which encourages the discussion of health problems, family relations and problem solving (Harrington, Kerfoot et al. 1998);

- peer group therapy involving non-family members (Stanton and Shadish 1997);

- family psychoeducation which usually involves education on drugs and family dynamics (Stanton and Shadish 1997; Weir 1998);

- parenting groups which aim to improve parenting skills (Stanton and Shadish 1997);

- other interventions such as probation officer visits, court orders (Stanton and Shadish 1997).

Findings

There is fairly strong evidence that family therapy is effective in reducing drug use. The upper limit of reduction is approximately 54% of those exposed (Stanton and Shadish 1997; Williams and Chang 2000). Family therapy is also equally effective as parenting groups in reducing drug use (Stanton and Shadish 1997). There is lack of evidence to establish which type of family therapy is most effective. An important factor is the involvement of parents or family in the therapeutic process (Stanton and Shadish 1997). There is fairly strong evidence that family therapy is more effective in reducing drug use than other family interventions such as probation officer visits, drug education and peer education, teacher based therapy, individual counselling, and adolescent group therapy (Stanton and Shadish 1997; Williams and Chang 2000).

There is also fairly strong evidence that family therapy reduces psychological problems, including suicide ideation in young drug users (Williams and Chang 2000). This includes non-hospital-based family therapy and the effect can last up to 14.6 months. Twelve family therapy sessions are equally effective as family therapy combined with other inputs (e.g. school) in improving psychiatric conditions. Co-joint family therapy, that involves the family and client in the same therapy session, is more effective in improving psychological status and psychiatric functioning compared with family therapy that is targeted at individuals. This includes reducing distress and impulse control problems (Stanton and Shadish 1997; Williams and Chang 2000).

Family therapy is also fairly effective in reducing family and social problems compared with parent support groups although family teaching in the community can also reduce anti-social behaviour (Weir 1998). Co-joint family therapy is equally effective as one-to-one family therapy in improving family functioning (Williams and Chang 2000). Linking co-joint family therapy with schools is also effective in improving family functioning (Stanton and Shadish 1997).

There are other areas in which family therapy and non-family therapies are effective but the effects are generally weaker. Family problem solving marginally improves psychological well being for young people with low levels of depression who deliberately self-harm or overdose (Harrington, Kerfoot et al. 1998). Family therapy has a weak effect in reducing drug arrests and improving school grades (Stanton and Shadish 1997). There is weak evidence that community-based family psycho-education improves school grades and decreases absenteeism (Weir 1998). There is weak evidence that multi-systematic family therapy (MST) reduces the length of stay in prison or residential treatment services (Schoenwald, Ward et al. 1996). There is no effect on the use of medical services, including mental health services, which were used by approximately 33% of the treatment and control groups (Schoenwald, Ward et al. 1996).

Family interventions can at times be ineffective. Family problem solving sessions for young people who have deliberately harmed themselves or overdosed has no effect on family functioning or suicide ideation (Harrington, Kerfoot et al. 1998).

General drug treatment facilities

Some authors refer to general drug treatment facilities (Maisto, Pollock et al. 2001) or out patient facilities (Williams and Chang 2000), but offer little else by way of description. Maisto et al suggest that this form of treatment should improve coping skills, and decrease stress. In their study, participants were recruited from psychiatric hospitals, a free standing chemical dependence programme, and an outpatient substance abuse programme. Williams describes the outpatient programmes as consisting of counselling, and occasionally family therapy (Williams and Chang 2000). Treatment tends to be longer in duration (1-2 sessions per week), but may vary from one session to 6 months.

Findings

There is fairly strong evidence that non-hospital day programmes reduce arrests and violence compared with a community integration interventions (Williams and Chang 2000). Hospital in patient intervention does not improve anti-social behaviour (Williams and Chang 2000).

There is weak evidence that general drug treatment programmes are effective in reducing drug use (Maisto, Pollock et al. 2001). General drug treatment services are weakly effective in improving the psychological well being of young drug users (Maisto, Pollock et al. 2001).

Minnesota 12-step programmes

Minnesota 12-step interventions are described by Williams and Chang (1997) as 'a short 4-6 week hospital inpatient programs typically offering a comprehensive range of treatment consisting of individual counselling, group therapy, medication for co-morbid conditions, family therapy, schooling and recreational programming. It often has an Alcoholic Anonymous/Narcotics Anonymous 12-step orientation and is followed-up with out patient treatment'.

Chemical dependency is treated as a disease and abstinence is advocated (Winters, Stinchfield et al. 2000). Winters et als' clients were treated on an inpatient bases for 4 weeks and an outpatient bases for 6 weeks. Treatment components included group therapy, individual counselling, family therapy, lectures, reading and writing assignments, schooling and occupational and recreational therapy. It focused on five elements of recovery 1) admitting the problem, 2) believing in hope for change, 3) learning from others, 4) taking stock of life, 5) discussing problems with peers. Families were encouraged to attend. A six-month programme was advocated with meetings 2/3 times per week.

Findings

Williams and Chang (2000) present fairly strong evidence that the Minnesota 12 step programme is effective in reducing drug use among young people. This is also supported by Winters et al who suggest that 53% of those receiving this intervention

report reduced or no drug use at 12 months compared with 28% of controls (Winters, Stinchfield et al. 2000).

School based programmes

These are diverse and include combinations of the following:

- Classroom teaching and skills development sessions. Teaching includes drug, risk and well-being awareness classes. Skills training includes developing, drugs resistance skills; social skills; listening skills; decision making skills; reducing hazardous behaviours such as drink driving; peer leadership and influence skills;

- Stress management; and managing human relations (Nicholas and Broadstock 1999; Tobler 1992; White and Pitts 1997; Lister-sharp, Chapman et al 1999; LoSciuto, Freeman et al 1997; Botvin 1997). Other affect based programmes involve building self-esteem, self awareness, expressing feelings and value clarification (Tobler 1992; White and Pitts 1997);

- School-based health centres or consultations with a doctor or nurse (Nicholas and Broadstock 1999);

- Academic support including basic reading skills and job skills (Nicholas and Broadstock 1999; Tobler 1992);

- Cognitive or behavioural and other counselling approaches (Nicholas and Broadstock 1999);

- Combining school sessions with after-school facilities e.g., community youth centres, drama workshops, psychosocial education (Nicholas and Broadstock 1999; Tobler 1992 LoSciuto, Freeman et al 1997; Stead, MacKintosh A et al. 2001);

- Involving parents (Nicholas and Broadstock 1999; White and Pitts 1997; Lister-Sharp, Chapman et al 1999; LoSciuto, Freeman et al 1997; Stead, MacKintosh A et al. 2001);

- Involving peers (Nicholas and Broadstock 1999; Tobler 1992; LoSciuto, Freeman et al 1997; Stead, MacKintosh A et al. 2001);

- Involving professional mental health counsellors (Tobler 1992; White and Pitts 1997);

- Involving teachers (Tobler 1992; White and Pitts 1997; Botvin 1997; Stead, MacKintosh A et al. 2001).

Findings

There is fairly strong evidence that school life skills interventions improve school grades and school attendance (Tobler 1992).

There is weak evidence that school based programmes reduce drug use (Nicholas and Broadstock 1999; Tobler 1992; White and Pitts 1997; Lister-sharp, Chapman et al 1999; LoSciuto, Freeman et al 1997; Botvin 1997). It is also clear from these studies that certain aspects of these programmes are more beneficial. These include skills development, self-esteem and confidence building, targeting high risk groups, using health professionals and peers, booster sessions, and involving parents (Nicholas and

Broadstock 1999; Tobler 1992; Lister-sharp, Chapman et al 1999; LoSciuto, Freeman et al 1997; Botvin 1997; White and Pitts 1997).

School-based interventions are also weakly effective in improving psychological wellbeing. These include, joint school and community skills development interventions (Nicholas and Broadstock 1999); teen-leader compared with teacher led resistance interventions; and self-efficacy and life skills programmes (Botvin 1997; White and Pitts 1997; Lister-Sharp, Chapman et al. 1999).

School life skills interventions can improve interpersonal and communication skills (White and Pitts 1997; Lister-Sharp, Chapman et al. 1999). School drug resistance skills improve general social skills (Lister-Sharp, Chapman et al. 1999). There is weak evidence that school interventions improve family and social relations. School based counselling, mentoring and academic support increases school involvement (Nicholas and Broadstock 1999). Joint school and community skills interventions are successful in reducing delinquency among young people defined as at risk of drug use (Nicholas and Broadstock 1999).

Counter to the findings of research cited above, many school-based programmes were found to be ineffective in improving the psychological well-being of young people. This included joint community support (Nicholas and Broadstock 1999), programmes that focus solely on psychological problems (Tobler 1992), and some skills programmes (Botvin 1997; LoSciuto, Freeman et al. 1997).

The school counselling and support intervention described by Nicholas et al, was not effective in reducing depression or suicide ideation. School interventions that focus solely on psychological problems do not have an effect on the psychological factors that place young people at risk of drug use (Tobler 1992). The multi-component intervention described by LoSciuto et al and designed to improve life skills and self-esteem failed to do so. This may have been due to negative peer or family pressure. The intervention described by Botvin et al, based on life skills and self-esteem, failed to improve decision-making skills. This may have been due to the lower baseline level of intentional drug use among the experimental group.

Studies also demonstrate that school interventions have no effect on young peoples' social well being including racist thoughts (LoSciuto, Freeman et al. 1997) and communication skills (Botvin 1997). This may be due to negative peer or family pressure (LoSciuto, Freeman et al. 1997) or improved baseline skills of the experimental group (Botvin 1997). School counselling, mentoring and academic support classes also have no effect on social coping (Nicholas and Broadstock 1999). The authors offer little explanation as to why this outcome was demonstrated, especially since the same intervention was successful in increasing school involvement and reducing delinquency (Nicholas and Broadstock 1999). Purely education programmes are generally ineffective in reducing drug use. These include general multifaceted school programmes that include drama, class support and drug awareness classes for parents (Stead, MacKintosh et al. 2001).

Some studies have discovered potentially harmful effects of school interventions. There was an increase in drug use (cannabis) among those exposed to a life skills programme and a teacher based support programme in the USA, particularly among boys (Nicholas and Broadstock 1999; Lister-Sharp, Chapman et al 1999). This is thought to be related to their experience of drug use or social support for drug use from friends or family. Older school children exposed to a life skills intervention in the USA demonstrated more unhealthy attitudes (acceptance) towards drugs. This was

thought to be related to either their experience of drugs or the influence of other drug users and peers (LoSciuto, Freeman et al. 1997).

There is also insufficient evidence to demonstrate that school-based health centres have an effect on drug use (Nicholas and Broadstock 1999).

Therapeutic community and residential care

This has been described as a specialist treatment facility consisting of between 6 months to 2 years stay (Williams and Chang 2000). These interventions tend to be highly regimented residential settings with treatment facilitated by paraprofessionals and often run by residents (Freeborn, Polen et al. 1995). Older traditional therapeutic communities for young people are rare. Some offer day programmes where recovering patients live at home with their parents (Freeborn, Polen et al. 1995; Weir 1998). Therapeutic communities can offer assistance in enhancing coping skills, refusal skills, problem solving, personal responsibility and social network development, and many offer counselling (White and Pitts 1997; Weir 1998). Community based group-homes for offenders are also included in this category (Weir 1998).

Findings

Williams and Change (2000) suggest that residential treatment and out patient treatments are strongly effective in reducing drug use. They present fairly strong evidence that residential care also reduces school disturbance and anti-social behaviour compared with probation.

Nevertheless, therapeutic communities that offer coping and problem solving are weakly beneficial in reducing drug use and improving the psychological well being of young drug users (White and Pitts 1997). There is also weak evidence that those attending a specialist drug treatment service that offers counselling and residential care use more medical services during a 1.5 year follow-up compared with the comparison group (Freeborn, Polen et al. 1995). There is evidence that their parents also increase their contact with medical services. The authors conclude that service use may be determined by familiarity with health services and past positive experience of services

Review Limitations

Gaps & research design constraints

There are some limitations to the review. The first is that there may be interventions that are not yet the subject of research. Motivational counselling is an example. The second limitation is that the review contains studies that are moderately strong in design and as a result research using weaker designs is excluded. These studies may contain valuable information about the context or limitations of some interventions and the findings may be missed. Third, it was evident in reading some reviews that the original studies may have measured outcomes that are of relevance to the present review, but these were not reported (Tobler 1992). Finally, almost all of the studies included in the review were conducted in the USA or Canada. This means that the results may not automatically transfer to Scotland. For example, US drugs policy is based predominantly on abstinence rather than tackling problems associated with drug use. In addition, many of the interventions studied were targeted at high risk

populations, many of which include culturally diverse groups not found in the UK, e.g. African, Asian and Latino Americans.

Heterogeneity

There was some degree of variation in the findings. This was particularly evident among studies that investigated the effects of school interventions. For example, some studies indicate that school interventions are fairly effective in reducing social problems (Tobler 1992), whilst others suggest only a weak effect (Nicolas and Broadstock 1999) or no effect at all (LoSciuto, Freeman et al 1997).

This may be explained by a number of factors such as the impact of peer influences, study design (Botvin 1997) and type of intervention (Stead, MacKintosh et al 2001). Peers or significant others, such as family members, may have a potentially negative effect on young people (Botvin 1997). Study design is important in that although only well designed studies were included in the review these ranged in quality from quasi-experimental studies to controlled observational studies.

The following types of school intervention are thought to be generally more effective than purely educational interventions:

- skills development
- self-esteem and confidence building
- targeting high risk groups
- using health professionals and peers
- booster sessions
- and involving parents

(Nicholas and Broadstock 1999; Tobler 1992; Lister-sharp, Chapman et al 1999; LoSciuto, Freeman et al 1997; Botvin 1997; White and Pitts 1997).

Need and Provision in Scotland in the Light of the Literature Review

The literature review helps place the situation in Scotland in an international perspective. As remarked above, the findings display some variation and they may not necessarily be transferable from the cultures in which the interventions took place. So one should not attempt to draw conclusions for Scotland from the international studies in an overly simplistic way. Nevertheless, some of the key review findings provide support for the mapping and case study fieldwork. There are also some important similarities and differences between the interventions studied in the USA and Canada, and those mapped or researched in Scotland, worth highlighting.

Similarities with the Scottish Context

There is, for example, an interesting correspondence between the research findings on the needs of young misusers in Scotland, and the types of approach found effective elsewhere. The concept of a 'complex set of needs' (Chapter 2), many of which are not directly misuse related, corresponds well with the review finding that effective approaches are characterised by comprehensive interventions (Table 4). In the same table, multi-agency approaches are also noted as a factor supporting effectiveness, and this implies a similar need to deal with a complex of issues.

Similarly, the findings in chapter 2 on the broad spectrum of drug misuse echo the review finding that interventions need to be well targeted, especially in terms of

dealing differently with high and low-'risk' groups, ie groups with differing degrees of misuse and related problems.

The review finds that well funded, longer term interventions using experienced and well trained staff, are more likely to be effective. In Scotland, there is great diversity in terms of:

- the length of time projects have been established;

- the duration and continuity of their contacts with service users;

- the training and experience of the staff;

- the adequacy of funding and staff resources, and

- the degree of strategic thinking and planning as opposed to 'ad-hoc' service development in response to local factors or funding opportunities.

The review findings suggest that there is a need to achieve more consistency in these areas in order to increase the overall effectiveness of provision in Scotland.

In comparing findings relating to specific interventions, there are some difficulties caused by the incomplete descriptions of interventions studied in the literature. The same difficulty is inherent in the mapping of Scottish provision, where (for example) it can be difficult to be sure that the term 'counselling' means the same thing in descriptions of two separate services. This reflects a wider problem, namely the lack of a nationally or internationally established and common set of terms and definitions when discussing interventions of this type.

While this means that some caution is needed in comparing interventions, one can identify a number of correspondences and contrasts between the review findings and the Scottish situation.

The review finds that *behaviour or cognitive therapies* are likely to be effective in reducing drug misuse. From the mapping survey, it is not clear that these therapies are widely used with children and young people in Scotland, except in a few services. For example there are instances in Dundee (Youth Drug and Alcohol Service, using cognitive behaviour therapy, and in Polmont, where a 'cognitive behavioural approach' is used in group work). Most of these tend to deal with low numbers of children and young people. This may reflect pressure on professionally qualified therapist time, and/or a lack of recognition of the effectiveness of this approach amongst referrers and other practitioners.

Counselling is found by the review to be effective in a number of senses, and this is one of the most common terms used by services in Scotland when describing their delivery methods. The intervention in Scotland appears similar to that defined in the literature, as described in some survey returns or via case study work. That is 'it encourages the expression of feelings, the initiation of comments, reactions to comments, self-described drug use, discussion of drug use experiences, praise, and abstinence desires'.

The review studies stress the need for counselling to be 'culturally sensitive', which reflects the North American links between ethnicity and misuse, but which is also likely to be relevant in Scotland when dealing with children from ethnic minority

communities. It is notable that the mapping and case study work found no examples of services targeted at children in these communities, although some workers acknowledged a probable need in this area (see Chapter 3).

Contrasts and Gaps

The review identifies *family therapies* as a key component of effective approaches. Here there is a clear contrast between North American and Scottish interventions. The mapping survey provides little evidence that family based interventions are currently in place. The case studies provide some limited instances of work with parents or families, but there are no explicitly family focused drug treatment or care services.

Instances of services citing family involvement or parental support services include the Rushes in Lanarkshire, the Hype project in Edinburgh, and the CADS service in Bannockburn. The extent and impacts of this work are currently unclear. Having said this, there are plans in many DAT areas to develop such services, and the Lloyds TSB projects are stimulating work in this area. The literature review supports the importance of this approach.

Similarly, there are no examples from the case studies of very structured programmes like the *Minnesota 12-step*. (An exception may be the 21 hour group programme running at Polmont, which provides a programme for up to eight users, over 21 hours of contact time, aimed at raising awareness, changing behaviour, and harm reduction).

There may be differences between British and North American cultures which partly explain this contrast (e.g. more explicitly confessional and inspirational programmes involving group work may be less readily embraced by individuals on this side of the Atlantic). However it may simply be that lack of experience with and information on these methods are preventing their use as an effective component of programmes.

Therapeutic communities and residential care programmes for children, which focus specifically on drug misuse, are not readily available in Scotland. Small numbers of children or young people are referred to services in England. Drug treatment and care programmes are provided, where a need is identified, for children and young people in secure and residential facilities. However this is not the main focus of the service user's experience in these settings.

This comparison suggests that, of the five most effective interventions identified via the literature review, only counselling is widely delivered by relevant services in Scotland. Instances of the other four are limited in scale and distribution.

Other interventions discussed by the review (as more weakly effective) are found in the Scottish context. Services often include (usually as activities under the heading 'counselling and advice') group work involving peers, and life skills development. There are also some examples of school links examined via the case studies (for example the Rushes in North Lanarkshire, and the Fife Youth Drug Team – see Chapter 6). There may be other such links, but for clarity of definition school prevention and education services were excluded from the survey scope. There are likely to be 'grey areas' where school based services of this type shade into true treatment and care services, which have been missed in the mapping for this reason. The review findings are particularly heterogeneous in this area and suggest that further study of these approaches would be useful.

The review found no studies of physical harm reduction or substitution prescribing services. Mapping and fieldwork findings for Scotland suggest that such services, while available in some areas, are likely to be limited in their applicability to children. While some children may access them, this can be difficult to identify. For example, it can be difficult to establish the age of young people using needle exchanges and practitioners are generally reluctant to prescribe substitute drugs to young people, and do not 'advertise' the few cases where this is done (see Chapter 6).

CHAPTER 5 THE LEGAL FRAMEWORK IN SCOTLAND

This chapter summarises the findings of a literature review of the current statutory framework that might affect the provision or take up of drug treatment services for young people under the age of 16 years in Scotland. The full results are available in a separate EIU report on the two literature reviews. Firstly we outline the current statutory framework and discuss some inherent difficulties in implementing it. The review results are then presented in more detail.

Key Findings

Current Statutory Framework

The current statutory framework in which services for young people in Scotland are delivered is derived from key legislation, essentially the Children (Scotland) Act 1995 and the United Nations Convention on the Rights of the Child 1989, and related professional and organisational policy documents. This is the overarching framework in which drug treatment services for young people should be provided and the management of risk in relation to service provision should be reduced. Although the current statutory framework is intended to facilitate care decisions, at times legislation and professional guidance may appear to conflict. Legally the welfare of the child should be given paramount consideration but in reality professional guidelines may trigger responses that are not in keeping with a young person's wishes or immediate needs. As such, potential difficulties arise in implementing the framework.

Difficulties in implementing the statutory framework

Expert commentaries suggest difficulties in implementing this statutory framework in four key areas:

- upholding children's rights to health and health care;
- upholding children's rights to participate in decisions;
- upholding children's rights to consent to medical treatment;
- sharing of information.

Whilst provision of a comprehensive range of drug treatment services for young people may be advocated, in practical terms it may be difficult for young people to exercise their rights to these services. Children's knowledge of the current statutory framework is likely to be limited. Organisations such as the Scottish Child Law Centre, which provides independent, free legal advice to children, and Who Cares? (Scotland), which provides independent advocacy for children cared for by local authorities, offer potentially useful resources.   However, it is unclear how best to inform the majority of Scottish children of their rights, including young drug users.

Key stakeholders such as health and social care professionals may also be unaware of children's rights and as a result may not fully recognise or uphold these rights (Home Office Drugs Prevention Initiative 1998). In addition many parents will have limited understanding of the current statutory framework in which services are provided and may miss valuable opportunities to work with professionals in upholding their children's rights (Drakeford 1996; Etchegoyen and Adams 1998). It is important to address these gaps when planning future service provision.

Some authors also report a degree of professional reluctance to become involved in upholding children's rights to health and health care (Seivewright and Greenwood

1996; Drugs Prevention Advisory Service, Newburn et al. 1999; Parker 2001). This may be due to lack of professional knowledge and experience, or uncertainty of the legal boundaries within which services should be provided. Medical reluctance to prescribe substitute drugs for young drug users under the age of 16 years may highlight professional fear of litigation. Since drug safety and efficacy in adults can rarely be extrapolated to children, it is understandable that prescribing raises concerns about liability litigation. Although professional guidelines may offer some reassurance, substantive research evidence from studies involving young people is required to establish its efficacy among young drug users (Vitiello and Jensen 1997).

Upholding a child's right to participate in decisions about their treatment also raises some difficulties, particularly in relation to parental involvement and deciding what is in a young person's best interests. For example, when parent's views about care decisions differ from those of the young person, professionals face the dilemma of deciding whose wishes have precedence. The current statutory framework provides guidance but the practicalities are such that it is extremely difficult to provide a clear ruling.

Dealing with the practicalities of real-life situations may also challenge professionals' ability to uphold children's rights to medical treatment. If, for example, a young person is prescribed methadone, it may be advisable to inform their parents of the possible side effects. Clearly, in this instance, it is important to establish the ground rules in which therapeutic relationships are managed and give clear guidance to all young people about the circumstances in which confidentiality may be breached (Scottish Drugs Forum 1999). However, this may deter young people from taking up drug treatment and as such inadvertently restrict their right to that treatment.

The sharing of patient information between agencies is also important. Although the circumstances in which information should be shared within and between agencies may be fully explained to young people, it may not be until a young person is more fully involved with a service that the reality of this requirement becomes clear. Then professionals may face the dilemma of deciding whether to disclose information against the wishes of a young person. Whilst guidance documents can ensure that procedures are followed appropriately, therapeutic relationships between young people and service providers may be threatened.

Review Results

Children (Scotland) Act 1995

The literature clearly establishes the Children (Scotland) Act 1995 as the key legislation in relation to the care and welfare of Scottish children, which in turn is supported by articles of the United Nations Convention on the Rights of the Child 1989. The essential principles of the Act are that:

- each child has the right to be treated as an individual;
- each child who can form a view on matters affecting him or her has the right to express those views if he or she so wishes;
- parents should normally be responsible for the upbringing of their children and should share that responsibility;

- each child has the right to protection from all forms of abuse, neglect or exploitation;

- so far is consistent with safeguarding and promoting the child's welfare, the public authority should promote the upbringing of children by their families;

- any intervention by a public authority in the life of a child must be properly justified and should be supported by services from all relevant agencies working in collaboration.

Three main themes are evident in the Children (Scotland) Act 1995 in support of these principles:

- the welfare of the child is the paramount consideration when his or her needs are considered by courts and children's hearings;

- no court should make an order relating to a child and no children's hearing should make a supervision requirement unless the court or hearing considers that to do so would be better for the child than making no order or supervision requirement;

- the child's views should be taken into account where major decisions are to be made about his or her future.

The remaining results are presented under three broad headings: a) official government publications, b) drug organisation publications and b) expert commentaries. Expert commentators suggest potential difficulties in implementing the statutory framework in the four key areas already outlined above (5.3).   The possible impact on drug service provision and uptake in Scotland is discussed.

The review uncovered 11 publications that referred to the legal framework affecting drug services for young people.   Four of these publications are issued by the Government and contain guidance relating to the provision of drug services, two of which relate specifically to Scotland.   Three publications are issued by drug organisations and contain guidance relating to drug treatment services for young people, one of which relates specifically to Scotland. The remaining four publications offer expert comment in relation to legislation and provision of drug services to young people.

Government Publications

Getting Our Priorities Right: Policy and Practice Guidelines for Working With Children and Families Affected by Problem Drug Use (2001), is underpinned by the key principles of the Children (Scotland) Act 1995 (Scottish Executive 2001). Guidance is aimed at workers involved in providing support to families affected by problem drug use, including Drug Action Teams and local Child Protection Committees. The main legal considerations relate to sharing information, confidentiality, ascertaining when to intervene and improving inter-agency working.   This document comments on perceived inconsistencies between legislation and professional guidance, and directs workers to other guidance documents issued by the Government relating to the care of children in general (The Scottish Office 1997 (a); The Scottish Office 1998).   It should be noted that this is currently a consultation document and has therefore not been published in its final form.

Drug Misuse and Dependence – Guidelines on Clinical Management (1999) offers guidance to medical practitioners throughout the United Kingdom, particularly those working in general practice (Department of Health, Scottish Office Department of

Health et al. 1999). The key principle underlying these guidelines is that services provided by medical practitioners should meet both general health needs and drug-related problems. Specific guidance in relation to young people and drugs is included, and covers issues such as consent, prescribing medication, and data collection and monitoring. Principles of good practice in caring for young drug users are outlined:

- all interventions should be undertaken in accordance with the guiding principle of the Children Act 1989 (or the Children (Scotland) Act 1995), that the welfare of the child is paramount;

- the practitioner should adhere to local policies and procedures that are agreed with the relevant local Child Protection Committee;

- the practitioner should involve other children's and young people's services and substance misuse services;

- family involvement should be seen as good practice;

- interventions should follow a comprehensive assessment of need, developmental maturity, family factors and the risk of substance-related harm;

- the provision of advice and treatment services separate to those from adults – that are both appropriate to and sensitive to the specific needs of children and young people in an environment appropriate to their age;

- if practitioners have concerns about issues of confidentiality, legal advice should be sought.

These guidelines have no defined legal position. However, in providing a consensus view of good clinical practice, they provide a significant reference point for the General Medical Council and are therefore relevant where allegations of poor service provision are made (Department of Health, Scottish Office Department of Health et al. 1999).

The document makes specific recommendations in relation to prescribing for young drug users. That is, since a young person under 16 is unlikely to fully understand the implications of being prescribed controlled drugs, this treatment option is not recommended unless parental consent is obtained. Even with parental consent, it is recommended that controlled drugs should only be prescribed to a young person following a full assessment and with specialist supervision. The need for more comprehensive data collection and monitoring in relation to the young person, compared to that required for an adult, is also noted (Department of Health, Scottish Office Department of Health et al. 1999).

Two other Government publications offer guidance in relation to drug treatment services and although more directly applicable to England and Wales are clearly relevant to Scotland.

Drugs and Young Offenders – Guidance for Drug Action Teams and Youth Offending Teams (1999) aims to raise awareness of the co-existence of drug misuse and offending behaviour and outlines opportunities to intervene through multi-agency approaches. Evidently providing services for young offenders raises many of the same legal challenges as providing services for non-offenders in relation to access to treatment, inter-agency collaboration, consent, and confidentiality and sharing

information (Drugs Prevention Advisory Service and Standing Conference on Drug Abuse 1999).

The Substance of Young Needs (2001) presents a review of the changes in policy and practice in relation to the misuse of drugs by young people up to the age of 19 years. The Children Act 1989 and the United Nations Convention on the Rights of the Child 1989 are acknowledged as the underpinning legal framework. One of the key issues identified in this document is that provision of services should 'operate within the fact of the law but also within the spirit and the intentions of the law' (Health Advisory Service 2001). The publication gives guidance in relation to training staff for working with young substance users and highlights areas in which staff must acquire competence to work within the law:

- knowledge of The Children Act (Scotland) 1995, education act, relevant law regarding race relations, gender, disability, equality and mental health and other relevant law commensurate with the interventions that are to be adopted;
- young person's ability to give or refuse consent to treatment to health and social care;
- confidentiality and communication with other agencies and parents;
- all guidance and procedures to be agreed with local Child Protection Committee;
- guidance on recruitment, checking and appointing staff;
- availability of complaints procedure;
- training on maintenance of adequate case records (Health Advisory Service 2001).

Publications from Drug-related Organisations

The Scottish Drugs Forum offers comprehensive guidance on the legal framework for young drug users. The aim of *Working with Young Drug Users: Guidelines to Developing Policy (1999)* is 'to meet the need of agencies and individuals working in the drugs field for clarification on legal and professional boundaries in respect of working with young drug users.' The document effectively brings together relevant policies, key legislation and professional frameworks to inform service provision. The Children (Scotland) Act 1995, United Nations Convention on the Rights of the Child 1989 and Age of Legal Capacity (Scotland) Act 1991 are identified as key legislation (Scottish Drugs Forum 1999).

The document identifies sections of Children (Scotland) Act 1995 that are particularly relevant to those working with young drug users and also highlights Articles of United Nations Convention on the Rights of the Child 1989 that are important in developing policies for working with young drug users.

In terms of the statutory framework, the authors highlight the breadth of knowledge required by those working with young drug users and comment that at times existing legislation appears to be inconsistent with professional guidelines. There is a specific focus on the young person's competence to consent to treatment, and the issues of disclosure, confidentiality and privacy. However, the authors do not provide definitive answers and are careful to stress the need for agencies, owing to diversity in roles and responsibilities, to address their own specific policy needs. The Scottish Drugs Forum suggests that current legislation presents opportunities for proactive service development - in that, it respects the 'privacy and dignity of young people, their right

to make certain decisions for themselves and the right to a say in who should and should not be involved in their care'. (Scottish Drugs Forum 1999).

A further two publications commenting on legislation relating to drug treatment services are issued by drug-related organisations in England. Whilst not wholly applicable to Scotland, the information offered is of interest to those working with young people in Scotland.

Making Harm Reduction Work (2000) offers specific guidance in relation to the provision of needle exchange services to young people and highlights measures to maximise professional protection from litigation. That is, by involving parents whenever possible, by adopting a holistic approach to assessment and by giving due consideration to child protection issues (Drugscope and Department of Health 2000).

Expert Commentaries

The review identified four publications that comment on legislation and provision of drug services to young people.

Upholding Children's Right to Health and Health Care

The rights of young drug users to access a comprehensive range of drug treatment services should be encompassed in their right to health and health care. However, in reality fulfilling this right presents difficulties for service providers and young people.

Many professionals lack experience and confidence in dealing with young drug users. Difficult decisions are often made using information and a rationale applicable to adult drug users. Professionals may also feel vulnerable and inadequate when intervening in more severe cases of drug misuse:

> *We enter territory where the legal and ethical ice is thin indeed, such as prescribing dangerous drugs to children, enabling them to do risky thing such as injecting rather more safely, and taking a degree of responsibility as an adult for the life of a young person clearly at risk of losing it. Fear of failure and the instinct to cover your back may be as strong and understandable as the urge to help* (Marlow and Pearson 1999)*.*

Goodsir (1991) advises health professionals to adopt a consensus approach to drug treatment services and thereby minimise the risks of legal action being taken against them.

The illegal status of drugs and fear of reprisal may in itself prevent young people seeking treatment services. Established adult responses to drug use, such as exclusion from school and informing authority figures (parents, school or police), may seem wholly appropriate. However, such responses have the potentially harmful effect of adding to a young person's problems, and may ultimately deter other young people from seeking help. An alternative approach in which the positive as well as the negative aspects of drug use are acknowledged by drug treatment services may be more easily accepted by young people (Marlow and Pearson 1999).

Upholding Children's Right to Participate in Decisions

Harding-Price (1993) describes the dilemma faced by nurses when parents have expectations that they will be informed and involved in treatment decisions about their child. The author stresses that it is incumbent upon health professionals to check with a child, on an ongoing basis, whether sharing information with their parents is an option (Harding-Price 1993). Those working in this field face professional dilemmas on a regular basis: *'Legally playing safe may not be the same as ensuring the young person's safety'* (Marlow and Pearson 1999).

Although drug use and potential for harm is widespread among young people, those at greatest risk of harm are concentrated in certain groups. For example, young offenders, young people in-care or those who are homeless, those whose parents who are using drugs and those who have troubled family backgrounds (Health Advisory Service 2001). The multiplicity of problems facing these young people complicates the legal framework in which services must be provided, and necessitates a pragmatic approach to ensure that their rights to participate in decisions are upheld.

These vulnerable young people do not access services readily and when they do they are often only prepared to co-operate on their own terms. This may be at odds with the legal context in which services are provided, when professional guidance highlights the need to adhere to principles of good practice, such as maintaining contact and monitoring change. This creates a tension between professional protection and upholding children's rights to participate in treatment decisions (Marlow and Pearson 1999).

Upholding Children's Right to Consent to Medical Treatment

Several commentaries refer to an extremely influential piece of English case law in 1986 known as the 'Gillick Case'. Although not strictly applicable to Scottish law, further explanation is appropriate. According to the outcome of this case, a child is deemed legally capable, having acquired sufficient intellectual and emotional maturity, of consenting to medical treatment without parental consent. This case represented a huge turning point in legislative history and was quickly followed by legislative changes to incorporate these principles, which in Scotland is provided for in the Age of Legal Capacity Act 1991 (Section 2(4)) and Children (Scotland) Act 1995. Subsequently a series of cases presented in court have challenged and overruled Gillick based decisions, with the welfare principle being given priority over children's rights.

It is suggested that under the principles applied to the 'Gillick Case', treatment without parental consent might be justified where health professionals are satisfied that:

- the young person, although under 16 years of age, will understand the advice;
- the young person cannot be persuaded to inform parents or to allow someone else to inform their parents that the young person is seeking drugs advice;
- the young person is likely to begin or continue using drugs with or without drugs treatment;
- unless the young person receives drugs advice or treatment the young persons physical or mental health or both are likely to suffer;
- the young persons best interests require health professionals to give the young person drug advice or treatment or both without parental consent (Goodsir 1991; Harding-Price 1993).

The rights of young drug users to consent to medical treatments may be blocked by professional guidance, backed by legal imperatives, in relation to service provision. For example, since low threshold clinics and outreach services are not conducive to full assessment of competency to consent, needle exchange services should not be provided to those under 16 years of age (Marlow and Pearson 1999).

The Sharing of Information

Although misuse of drugs is grounds for referral to the Children's Hearing system, Harding-Price (1993) emphasises the need for service providers to consider the full consequences of whatever actions are being taken (Harding-Price 1993). Referral to a hearing may not be necessary in every case of drug use by a young person. Early supportive measures to minimise risk may obviate the need for action within the hearing system.

This view is supported within the principles of the Children (Scotland) Act 1995, which states that the welfare of the child is paramount and that any intervention should be made in the child's best interest. Parker (2001) asserts that most adolescent drug use is recreational and that many otherwise law-abiding young people become stigmatised for drugs offences unnecessarily. In this respect the sharing of information between agencies merits careful consideration (Parker 2001).

Links to Case Studies and Treatment Pathways

The themes derived from the literature review are strongly supported by some survey responses (see Chapter 3, 'Needs for Further Guidance') and by the qualitative field research. The latter provides a number of instances of the existence and effects of legal framework issues, and practical solutions adopted. These will be discussed as part of a review of issues and their effects for service users, in the next two chapters.

CHAPTER 6 EXAMPLES FROM CURRENT PROVISION

In this chapter we review issues raised earlier in the report. The themes emerging from Chapters 2-5 provide a framework for discussion of the issues faced by DATs and practitioners in this area. The themes overlap or are closely related to each other, but can be summarised as follows:

- planning a complete and integrated service;
- applying an appropriate range of interventions;
- fostering awareness and motivation in target groups;
- involving schools;
- involving families and carers;
- upholding children's rights;
- reconciling the rights of parents/carers;
- implementing comprehensive, multi-agency interventions;
- developing service capacity;
- assessing and improving service effectiveness.

Case Study Selection

This account of issues 'on the ground' is based mainly on the case study work undertaken with eight services or service 'clusters' in Scotland. The characteristics of the case studies are summarised in Table 6.

These eight cases provide a good spread geographically and in terms of rural/urban/inner city coverage; they include local authority, voluntary sector and NHS services, and one case focusing on the operation of a range of services in a single city. There are new services just completing their first year of operation, and some which have been operating for ten years and more. The number of under-16s seen varies from a very few to sixty per annum, and there are varying degrees of specialisation for this and the 16-18 year old group. The eight include some non-statutory services, and all the main types of service delivery are represented in one or more cases.

Table 6: Case Study Summary

Name	Area	Specialism	Services	Years Est.	Under-16s per year
Aberdeen Inter-Agency Operation	Aberdeen City	Mixed	All, from various partners	various	Small numbers
CADS Community Alcohol and Drugs Service	Forth Valley	Generic- priority for under 18	All	5	10
Dundee Youth Drugs & Alcohol Service	Dundee	Looked after & accommodated	Counselling, one-to-one & group work, diversionary	<1	16
Fife Youth Drug Team	Fife	Under 16	Counselling, one to one & group work, diversionary	1	50
Looked After and Accommodated Children Service	Glasgow	Generic with some specialist services for young people.	Counselling, detox and rehab referral, 4 methadone clinics, GP links, legal liaison, group work	14	Not specified. 140 16-18s
The Hype Project	Edinburgh	Under 18	Counselling and group work	<1	10
Polmont YOI	Forth Valley	16 - 18	All	various	N/A
The Rushes Project	Bellshill, North Lanarkshire	12 - 18	One-to-one support, groups and family support work	6	103

Planning a Complete and Integrated Service

The mapping survey established that services are incompletely available both across Scotland and within specific DAT areas. Some DATs are moving forward quickly in terms of planning to make provision accessible to all children in all areas. For example the Glasgow City Implementation Group on Alcohol and Drugs has reviewed the current situation, in which there has been patchy coverage of services, mainly focusing on looked after and accommodated children. Current capacity restrictions, the existence of wider needs, and the need to integrate planned service extensions with other developments, have all been recognised and addressed in new service specifications.

The literature review points to the importance of adequate funding and long term planning and delivery for service effectiveness (Table 4). Some of the services studied have begun life as ad-hoc solutions to problems in local areas. Some have piloted responses to particular issues with specific target groups. In many cases, limitations of targeting and funding have constrained the capacity of the programmes to be flexible in meeting the needs of individuals from outside their catchment areas.

The literature review also notes the importance of experienced and well trained staff (Table 4), and this should be seen as linked to the theme of longer term funding.

Annually renewed funding can create uncertainty and restrict the ability of some services to retain and develop staff. Some commissioned services rely on many separate funding streams. However this can soak up senior worker and administrative time and divert resources from the effective management and implementation of services.

Finally, the case study work suggests the importance of ensuring that strategies for child treatment and care are firmly integrated within the overall strategy for service development, and within the strategies of all partner agencies. This can be complex given the range of development strategies currently being taken forward, but failure to make these links can result in confusion or contradictions in strategy and hence in delivery work.

Applying an Appropriate Range of Interventions

The mapping survey shows that a range of interventions is available for children in Scotland, with counselling forming the common basis for almost all services. It is seen as critically important to build a relationship and gain the trust of the young person, and this is a common core function of counselling throughout the projects studied.

However some of the interventions identified as effective in the international literature, especially behaviour therapy, family therapy, and more structured 'step' programmes, do not appear to be widely available.

The literature review also suggests that the *duration* of programmes, and the availability of 'booster sessions' where needed, are factors supporting effectiveness. The experience of 'Neville' (Box 4) illustrates this point and also how the Rushes service provides support beyond 18 for those who need this.

Neville, 20 **Box 4**

Neville has been involved with the Rushes since he was 16. His 'probation officer' suggested 'at court' that it would be helpful if he attended, but the actual decision was mainly his '- it was partly voluntary'.

At the Rushes he talked about his home life, what he wanted to do, and about drugs and alcohol. He found it 'helped to talk through it a bit'. But he then ceased to work with the project, although he 'never really lost contact completely', as he would telephone his key worker from time to time, until that person left the team.

Neville was initially a heavy drinker, but when he started on heroin around his 19th birthday he 'returned' to the project. He was introduced to his current key worker and has been working with him for around 15 months. Neville has also been introduced to a key worker in the Community Addictions Team (the adult service) and has obtained a methadone prescription. In future Neville expects to stay in touch with the Rushes (although in time the team will move him into the adult service).

The literature review points to the need to provide *early* interventions (for low risk groups) to take advantage of the increased chances of success when dealing with children with lower misuse and psychopathology and higher school achievement and motivation (Table 4). Early interventions to access children before misuse and associated problems become established appeared rare. An exception is the Early Interventions service in Glasgow. This is a small team set up, originally as the Arrest

and Referral service, to work with local police to identify and intervene in cases where children and young people are coming into contact with officers and where drugs issues appear to be involved.

There is a range of *residential accommodation* for children and young people in Scotland (essentially residential schools, secure units for under-16s, and Young Offenders' Institutions for 16-21 year olds).   These will generally include some provision to support children and young people with misuse problems. However this is a relatively new development.

There are no residential rehabilitation units specifically for children and young people with drug misuse issues in Scotland.   There are a few such units in England; an example of where referral to this residential treatment was considered is the case of Philippa (Box 5).

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Philippa, 18   **Box 5**

After undertaking what Drugs Action described as a '*de facto* detox' at the Child and Adolescent Mental Health Service (CAMHS), it was felt that Philippa needed 'twenty four hour residential support' with supporting therapeutic care. However there are 'no rehabilitation services and no formal NHS funded detox services in Aberdeen'.   There was discussion of using one of the England based services (Middlegate Lodge, which accepts under–18 year olds). However, at this point there was a problem as the girl was now 17 and 'it was difficult to get a social worker involved'.   This affected the funding options for this referral.

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We asked case study interviewees if they felt that the lack of such a facility in Scotland caused problems. Opinions varied: some felt that this would be a useful addition to services, since children or young people had to be sent a great distance from parents or carers for the duration of the residence. Others felt that the number of cases requiring such a service was very small, and that the service was inherently expensive; as such, it might not be the best application of scarce resource. In some cases it was actually beneficial to ensure that the individual was removed to some distance, due to security factors.

Physical separation from adult services is widely regarded as important, to avoid children coming into contact with adult users, and possibly dealers. The avoidance of stigma is also key. In general children attend on an appointment basis, do not spend long periods of time in delivery locations, and mix with others primarily during group work or diversionary activities, when they are well supervised. A slightly different approach to separation was seen in one case where the children's service has its own entrance which is off-street and unobtrusive, but the same building also houses an adult addictions unit, for which the same manager is responsible. There is an internal connection used by staff only. The manager feels that this arrangement is effective in maintaining the required separation between child and adult users, while easing the transition of individuals to the adult service. At this transition, they can work with some of the same staff, the adult team will be familiar with their case, and they will be visiting a familiar location.

Fostering Awareness and Motivation in Target Groups

Findings from the mapping and literature review indicate the importance of first engaging children with services, and then building individual motivation to change. These two separate points were illustrated in the case studies and service user interviews.

Obtaining individual consent and commitment to the drugs programme is one of the key issues facing the Polmont service. Despite induction sessions and repeated opportunities to join the programme, 35% of referrals in the period January to October 2001 refused the help being offered. The case of 'Jez' is an example, (Box 6) which (albeit in an untypical setting) illustrates the fact that many children and young users will resist attempts to define drug use as a problem. The second case (Box 7) illustrates how one service attempts to overcome the problem of engaging young people.

Jez, 16	**Box 6**

Jez considered that his drug use, which predominantly involves smoking marijuana, was under control. He did not think that he required any clinical or counselling support. He was aware that he will automatically be referred again in 28 days' time and thought that he would sign off again. Additionally Jez did not perceive that he would need any support concerning drug misuse once he is released from Polmont.

Fostering Awareness and Motivation in Target Groups	**Box 7**

Aberdeen Drugs Action (ADA) is an open access service which faces problems in engaging children and young people in the city. This is due to their mistrust of the authorities and reluctance to discuss drug taking with adults, or to their failure to recognise the associated risks and harms. ADA obtains many self referrals via its needle exchange, outreach facilities, counselling service and family support group, a telephone helpline, and 'drop in' to its city centre premises. Other referrals come from GPs, prisons (for adults), council care or secure units (children and young people), schools, and Social Work.

A range of outreach services which target young people are available. This includes outreach work at dance events, in community settings, and street work with women involved in prostitution. Key workers will also signpost girls and women to a special pregnancy clinic for drugs users unable/unwilling to access mainstream services. The aim is to stabilise/reduce use in pregnancy and provide morphine withdrawal for babies if needed.

Involving Schools

The literature review, although identifying some contradictory indications of the effectiveness of school based work, underlines the potential importance of school links. We did not identify strong links between most services and their local schools. This may be due to the emphasis on treatment and care rather than on education and prevention work. There were some exceptions (see Box 8), but this area appears to be one where there is considerable potential for further development. If early

interventions are indeed more likely to be effective then liaison with schools is an important avenue to explore.

One should bear in mind that the literature review also raises the possibility of negative effects, if work in schools is negated by peer pressures, or if it leads to a wider acceptance of drug taking as a normal recreational activity (Chapter 4). This suggests the need for careful design of such activities.

Involving Schools   **Box 8**

Fife Youth Drug Team wished to identify and engage young people who were offending in terms of drug use and disruptive or criminal behaviour. To do this they needed to work with schools to help the referrals process and to obtain access to the children in question.

The Fife team have spent considerable time working with schools to establish relationships. Schools are now the main source of referrals (46%), and this is helped by the fact that participants are normally collected from, and may be returned to, school as part of their programmes. This required that schools were satisfied that the programme contributed to the school's own educational and pastoral objectives for these children.

Involving Families and Carers

The literature review also identified the importance of family-based work. This was seen as involving all family members in co-joint or individual programmes, aimed at improving family interactions and functioning. As previously noted, no well-developed examples of programmes of this type were identified in Scotland. In two cases where figures for referrals from parents were available, the numbers and percentages of referrals overall were low (Glasgow, ten referrals, 11% of the total; Fife Youth Drug Team, 3 referrals, 7% of the total). This suggests that one benefit of more work with families might be to encourage referrals via this route, which might also facilitate earlier intervention.

However, the importance of involving family members is a common theme in guidelines and advice to practitioners (see the legal framework review, Chapter 5), and many practitioners have recognised the need to engage parents or families, with a variety of approaches being adopted (Box 9).   The future plans of many DATs or partners include the further development of family oriented services.   Examples include provision of a drug education service for parents and carers and others involved with young users or those at risk of misusing drugs (Dundee DAAT), and new Family Support posts linked to local addiction services to support vulnerable families (Greater Glasgow DAT).

Involving Families and Carers   **Box 9**

Many services take measures to involve parents and carers in the treatment and care process; these are seen as contributing to the overall effectiveness of treatment and care for the children and young people concerned.

The Rushes team works closely with other Social Work departments to provide support at Children's Hearings or in the development of care plans. They also help to co-ordinate work with families. The Rushes itself has a Parents Group which helps to support parents (mostly mothers) struggling with drugs misuse and related behavioural problems of their children such as running away from home or offending. There is also a Family Support Group to assist families where there is chaotic misuse. The service feels that the existence of these groups, as well as being important in supporting families, is key in understanding 'all sides of the picture' in individual cases.

Upholding Children's Rights: Awareness, Consent and Prescription

The legal framework review (Chapter 5) identifies key rights of children (to access to treatment, participate in decisions, and to give consent) and a number of difficulties in relation to these. Clearly, where appropriate specialist provision is not available, as it is not in large areas of Scotland, rights to access are limited in reality.

In general we found that practitioners were very much aware of the principle that the welfare of the child should be the primary consideration in the final analysis. Staff in relevant services were also well aware of the principles underlying interventions made through the Children's Hearing system (the 'no order principle' that action should only be taken in response to an identified need). The rights of children to access treatment were perhaps less to the fore, although this probably reflected not so much unawareness of the principle, as recognition of the difficulty of upholding this where appropriate services were difficult to access.

We were unable to assess parental awareness of rights and the statutory framework, although the low proportions of parental referrals, noted earlier, may reflect a lack of knowledge or confidence in referring amongst parents and carers. Children interviewed were not aware of general rights to treatment, beyond the availability of specific local services; their awareness of these was generally incomplete.

In the cases studied, it was made explicit to children that their participation in treatment was on a voluntary basis. Confidentiality policies and situations in which disclosure might be made were also explained. This indicates practitioner awareness of the child's right to participate in treatment decisions and consent to treatment. For some practitioners, considerations of the child's welfare may at times obscure these rights, especially in crisis situations, or where the child appears at risk of harm. Nevertheless this is counterbalanced by the fact that participation in programmes is generally voluntary (or perhaps semi-voluntary where it results from a recommendation in a Hearing). Practitioners agree that trust, empathy and motivation are key components of successful treatment.

The review mentions 'professional reluctance to become involved in upholding children's rights to health and health care' (Chapter 5). We did not interview GPs, but this point arose in two interviews suggesting difficulties in obtaining support from GPs.

This is clearly insufficient evidence to support any general conclusions, but if there are difficulties they may relate to doubts or perceived lack of consensus about treatment options, or about the legal issues involved in treatment. GPs do not generally figure as a significant source of referrals, where breakdowns are available.

Other difficulties can include apparent conflicts between the welfare and the rights of the child (see Box 10). These issues are presumably not restricted to the drugs treatment field.

Upholding Children's Rights   **Box 10**

Needle exchange facilities in one service are provided at a number of outreach venues to all, including children. It is recognised that this may cause some difficulties in relation to upholding children's' rights. this will arise where children access the service and do not become involved in any other way. This means there is no opportunity to assess whether their involvement is in their best interests, to discuss provision of the service with them, to check the possibility of informing parents, or to ensure that they consent to receive the service. This presents a dilemma to the service, as identified in the literature on this subject. (see under 'Upholding Children's Right to Consent to Medical Treatment', Chapter 5).

The service concerned has decided to continue offering the service, given the following considerations:

- Staff will make efforts to engage users of the needle exchange as a matter of course;

- The service is provided in locations that reach sections of the user population which would not normally access services. This aim would be compromised by attempts to impose age limits or investigation of the age or circumstances of service users;

- The service is an important source of self-referrals. It is one of the few ways in which children under 16 can become aware of and have access to the full range of services that are available.

Prescription Principles and Practice

Prescription is an area where the issues around children's rights and appropriate practice are particularly prominent. Practitioners report that they meet with very few children who might benefit from prescription of opiate substitutes. The guidelines emphasise that for children 'drug misuse, even with some significant dependence, is not in itself an indication to prescribe substitute medication' (Annex 6, 'Drug Misuse and Dependence – Guidelines on Clinical Management', 1999). In the one case we did become aware of where methadone prescription had been used, the service user herself was sceptical about the ultimate value of the approach, as she felt it had led to substitute dependence.

Other, non-substitute drugs may be prescribed to children as aids to detoxification or to treat psychological or physical difficulties associated with misuse. Opiate antagonists, which block the effect of heroin, may also be used. An example where

Buprenorphine hydrochloride (Subutex) was used for this purpose on a trial basis is shown below (Box 11).

Philip, 17   **Box 11**

Philip has been involved in detox on two occasions. The second of these involved Subutex, a drug which has been used quite widely with young people in France and is being piloted with young people in Scotland. Philip was able to contrast the new detox method compared to the traditional method. He said that detox by Subutex was far easier in that his general sense of well-being was better; he was able to sleep and took the edge off the cravings he felt.

On release, Philip is due to be prescribed Naltrexone, an opiate blocker to help prevent relapse. Philip is aware that taking illicit drugs would be "money down the drain" as it would have no effect. Philip will also have one-to-one counselling to support him through the process.

Reconciling The Rights Of Parents/Carers

In the literature review it was noted that, although family therapy can be an effective intervention, care must be taken to ensure that this is not neutralised by negative family pressure (Chapter 4). The evaluation of the parent-child relationship and the prospects for positive engagement of the family are at the heart of the issues facing practitioners when deciding how far to uphold parental rights:

- existing family difficulties may underly drug misuse and associated problems, and these may be exacerbated by upholding parental rights;

- in more serious cases, child protection issues and associated orders may restrict parental rights on a statutory basis;

- parental collusion or pressure may exist in relation to the drug use of the child; this may be known to practitioners through their contacts in the field, but not be provable in any sense which would provide 'cover' for restriction of parental rights;

- information on family conditions may not be fully available to the drugs practitioner due to maintenance of client confidentiality by other agencies involved in the case.

Despite these difficulties, the services we studied subscribed to the guideline view, that in principle informing and involving parents or carers was desirable and should be encouraged wherever possible.

Implementing Comprehensive, Multi-Agency Interventions

The literature review and case study work both indicate the importance of making comprehensive interventions, where problems including non-drugs related issues can be dealt with in a coherent fashion. This implies the need for multi-agency co-operation, which is also identified as a factor supporting effectiveness in the literature (Table 4). The following note some difficulties experienced in multi-agency working.

Establishing Consistent and Shared Assessment

In order to have an agreed and consistent view of service user needs and the treatment plan, it is important that initial assessments are made which meet, as far as practical, the needs of all partners and which can be shared between them. If this is not done:

> *Children can end up having to tell their story three or four times to different agencies. They can find this upsetting, and they don't understand why the people involved can't just talk to each other and share the original information. It doesn't give [the children] confidence that they are being helped in the best way.* (Practitioner interview)

Ensuring Consistency of Treatment and 'Routing'

One obvious assessment issue is whether the case is defined as primarily a 'drugs' case, or as some other kind of case with a drugs facet. This may determine the main agency responsibility, with implications for the resources and partners accessed.

> *I have concerns about consistency in dealing with cases. For example if we first become aware of a child when they self refer, or are referred by a parent, to the [non-statutory] community drugs service, we are likely to view that as a "drugs case" and deal with it as part of the Addictions Service caseload. If the same case came to us via a Hearing or from a school referral to Social Work, it would be on the Social Work caseload and the drugs issue might not be recognised for some time.* (Addiction Service Interviewee)

Sharing Information

There can be a possibility that sharing of information with statutory agencies may trigger responses which, while they reflect the responsibilities of that agency, may have a detrimental effect on the therapeutic relationship established with the service user:

> *If we have someone who has self referred to us, we may want to provide the information on that child to Social Work. However once they are aware of the circumstances they may have a statutory obligation to take action of some kind. Even if the action is helpful, the trust between our worker and the child will be broken and that may have consequences which are more harmful in the long run.* (Practitioner interview)

Some voluntary sector interviewees perceived other reasons why statutory services might be reluctant to pass information to them;

> *I think, as well as the worries about confidentiality and data protection, there are sometimes some tendencies to distrust non-statutory sector workers or to see them as less professional in some way. There can even be an element of competition between services. All these things can hinder information sharing.* (Practitioner interview)

Where more than one agency is involved in a case, it can be problematic to establish who is the key worker. Normally the key worker will be a social worker, but this could be unclear in practice.

> *Because of the way we need to work, we will build up a very close and supportive relationship with the client. For the social worker this is much more difficult because they get involved in decisions and enforcements that the child may resent.   So you can get a 'good cop-bad cop' situation where the child thinks of the drugs worker as the most important person for them, and this may lead to them taking on a wider role than they originally planned.*
> (Practitioner interview)

In many areas, social work resources are stretched, and this can contribute to a blurring of responsibilities.

> *When social workers are very heavily loaded, they might go along with the tendency to regard the drugs worker as the key person in the case, and we end up doing things that we think they should really be doing.*
> (Addictions Service interviewee)

Onward Transition at 16 and 18

There can be difficulties in multi-agency working at the points at which service users make the transition out of childhood, and beyond 18.   At these points, the statutory responsibilities of the relevant agencies change, and as the transitions approach this may affect the handling of the case. However it was not clear how widespread these issues were. Both the overcoming resource issue and onward transition at 16 and 18 issue is illustrated in the case of Philippa (Box 12).   In Chapter 2 we described the range of needs that Philippa has, and earlier in this Chapter we highlighted that residential treatment was thought to be an appropriate treatment option, but there was a difficulty as Philippa was now 17.

Philippa, 18   **Box 12**

After Philippa reached 17 'it was now difficult to get a social worker involved'. The factors as perceived by the treatment service were:

- that the girl would soon be old enough to access the adult service, so there would be two sets of work involved to appoint a key worker and then to transfer her between the services;

- that there were doubts about the motivation of the girl to change her behaviour;

- that there might be reservations about the capability of the voluntary sector service to identify the need for social worker involvement.

If a care manager is not appointed in the case, this restricts the ability to fund treatment and care options. This case was viewed by the service as an example of the way in which current case handling could be 'designed around organisations and funding – not the needs of the young person'.

Developing Service Capacity

Partly because many services are new, there appears to be limited sharing of information on interventions or effective practice between providers, particularly outside DAT areas. Many DATs have provider fora which are intended to facilitate this communication, but perceptions of the effectiveness of these arrangements vary.

> *There were some problems with the provider forum. There were some differences between service leaders and practitioners, and the forum seemed to feel that the DAT didn't take it seriously. The DAT people felt that the providers tended to bring complaints rather than firm, constructive proposals to the table. There has been a review of the forum which is nearly complete and will lead to changes which should improve relationships between DAT and providers.*
> (DAT interview)

Effective communication can help meet the need for wider agreement: for example, on the legal framework, particularly consent and confidentiality issues; treatment concepts and effectiveness; and on co-ordinated capacity development.

Assessing and Improving Service Effectiveness

Services in this field can face particular problems in monitoring and assessing the effectiveness of approaches. The aims and objectives of services may be broad and may not lend themselves to straightforward outcome measurement. Some services have developed targets and measures which can be used to aid planning and service review (see Box 13). This is easier for more tightly focused interventions. In other cases it may be difficult to demonstrate that the most appropriate action has been taken in individual cases, due to the conflicts of rights and practicalities discussed earlier. There may be cases in the future when the accountability of such services is tested.

Assessing And Improving Service Effectiveness   **Box 13**

The Fife Youth Drug Team is focused on reducing offending behaviour by addressing drug use and associated issues. After leaving, the participant's progress in terms of reduced offending is measured using two sources. The Scottish Crime Records Office keeps records of offences, which are checked. The Fife Constabulary's Police Criminal Intelligence system is the other source. Police in the participant's local area are also asked whether they have been in contact with the individual. A post-programme offending profile can thus be built for comparison with the pre-programme situation.

CHAPTER 7 FURTHER DEVELOPMENT AND RESEARCH

This study has presented an overview of drug misuse treatment and care services for children and young people in Scotland and the planning and operational issues they face. It has not aimed to produce direct recommendations for the further development and implementation of these services. An informed and detailed set of key issues for the implementation of services is presented in 'Review 2001: The Substance of Young Needs (Health Advisory Service, 2001), though this is set mainly in the English context. We do not aim to duplicate or directly complement that review here.

This section briefly summarises the implications of the study findings for further development work, and makes some recommendations for future research themes.

Areas for Further Development Work

The findings point to a number of areas where further work will be required in order to meet the policy aim of providing access to treatment and care services for children and young people. In summary these are:

- Establishing the scale of need: there are indications from the qualitative research that some children and young people are in need of services, but are not accessing them either because of lack of availability, lack of awareness, or lack of a stimulus to seek help with misuse issues. It may be that the potential scale of such services is significantly larger than their current size. Much work is in hand to meet this need for information.

- Filling service gaps: these may relate to service access, in rural areas; or there may be a need to give additional groups access to services; or there may be limited availability of specific treatment or intervention types (such as specialist residential rehabilitation facilities). There may also be a need to consider the mix of earlier interventions for lower risk groups, and services for higher risk groups.

- Promoting awareness and understanding of rights and responsibilities: in particular, overcoming delays or problems in service implementation associated with the legal and practical issues involved.

- Planning and implementing multi-agency working: this includes providing consistent delivery to service users irrespective of their entry point to the system; providing for effective shared assessment and information exchange; establishing clear roles and responsibilities; and organising effective transitions at 16 and beyond.

- Supporting effectiveness in service delivery: the study findings emphasise the value of targeted, well resourced, and sustainable interventions, with clear aims and objectives and appropriate monitoring and assessment methods, supported by well trained staff.

DAT partners are researching and developing strategies for provision for under-16s, and many have implemented or are about to implement services in this area. However DATs are facing a range of strategic demands and opportunities, including those relating to the development of employability initiatives and of work with families affected by drug misuse. With their very limited resources, they can be hard pressed to co-ordinate and progress work on all these fronts. Although we have shown that much good practice is being developed and implemented at local level, DATs and DAT partners will continue to face time and resource issues in attempting to deal with these. The policy task is to prioritise and facilitate this work within the overall strategy for drugs service development in Scotland.

Further Research

Areas where further research would be helpful include the following:

- Further assessments of need and potential demand – local results could be drawn together, where available. In general these will be unpublished and not accessible via literature reviews – some have been collected for this study, and later studies may be available on further investigation. Further research could be undertaken nationally and/or in areas where less information is available. This work should complement existing studies such as the Scottish Crime Survey and more specific surveys of children and young people. Lessons should be derived from the methodological approaches adopted to date and the issues encountered;

- Prevalence/needs studies of this type should be repeated at appropriate intervals so that trends can be identified;

- The Scottish Drugs Misuse Database collects information about those presenting to drugs treatment and care services, based on birth date rather than by age band. This presents an opportunity to undertake analyses focusing on children and those under 18, and to track numbers in treatment in these groups over time;

- The provision of records to the SDMD from all those delivering drugs services to these groups is important to facilitate this. Liaison between services should be undertaken to avoid duplicating individual records;

- The attitudes of GPs and their practice in relation to young drugs users presenting within primary care settings might usefully be explored further. Although we saw relatively little referral from GPs, one might feel that they would be well placed to identify issues and, at least, signpost and encourage young people towards suitable provision;

- At present it is difficult to be specific about the nature and extent of successful outcomes from treatment, partly because there is little opportunity to track the progress of individuals as they move through agencies and into adulthood. A longitudinal study, looking at treatment pathways beyond 18 where relevant, and at a range of outcomes, from relapse to cessation of use and/or employment, would be of benefit in assessing the value and effectiveness of treatment and care services for under-16s and 16-18s;

- International experience suggests that it would be worthwhile to establish a better understanding of the nature and potential role of family therapies, links with schools, and other interventions which appear to have been effective in other countries. Evaluation of the work being done with families as part of the Changing Children's Services Fund and Lloyds TSB Foundation Partnership Drugs Initiative projects may be able to make a valuable contribution.

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Scottish Executive Effective Interventions Unit Dissemination Policy

1. We will aim to disseminate the right material, to the right audience, in the right format, at the right time.

2. The unit will have an active dissemination style. It will be outward looking and interactive. Documents published or sent out by the unit will be easily accessible and written in plain language.

3. All materials produced by the unit will be free of charge.

4. Material to be disseminated includes:

- Research and its findings
- Reports
- Project descriptions and evaluations
- Models of services
- Evaluation tools and frameworks for practitioners, managers and commissioners.

5. Dissemination methods will be varied, and will be selected to reflect the required message, and the needs of the target audience.

These methods are:

- Web-based – using the ISD website 'Drug misuse in Scotland' which can be found at: http://www.drugmisuse.isdscotland.org/eiu/eiu.htm

- Published documents – which will be written in plain language, and designed to turn policy into practice.

- Drug Action Team channels – recognising the central role of Drug Action Teams in developing effective practice.

- Events – recognising that face-to-face communication can help develop effective practice.

- Indirect dissemination – recognising that the Unit may not always be best placed to communicate directly with some sections of its audience.

6. This initial policy statement will be evaluated at six-monthly intervals to ensure that the Unit is reaching its key audiences and that its output continues to be relevant and to add value to the work of those in the field.

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