Effective Interventions Unit

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Partnership Drugs Initiative
Lloyds TSB Foundation for Scotland

SERVICES FOR YOUNG PEOPLE WITH PROBLEMATIC DRUG MISUSE: A GUIDE TO PRINCIPLES AND PRACTICE

WHAT IS IN THIS GUIDE?

- Definitions of the target client group and their needs
- Key principles underpinning effective services
- Key issues to address in delivering services

WHAT IS THE AIM?

To provide information and evidence to support the development of services for young people experiencing problems due to their own problematic drugs and/or substance misuse. The guide focuses on the needs of DATs in their role as commissioners of services as well as the direct delivery of services.

WHO SHOULD USE IT?

Anyone involved in developing, designing, implementing or evaluating services for young people with developed substance misuse problems. Those developing wider services aimed at vulnerable children and young people may find the information useful.

WHO WROTE THIS GUIDE?

This guide is a collaborative piece of work between the **Effective Interventions Unit** and Nicola Richards, Programme Manager for the **Partnership Drugs Initiative, Lloyds TSB Foundation for Scotland**.

Contents

Introduction

There is a growing interest in developing services which address the needs of children and young people under the age of 16 who are experiencing problems due to their own substance misuse. Most children and young people do not take illegal drugs. A number of young people will at some point experiment with drugs but most are able to move on with their lives without experiencing lasting problems. However, **for some young people the misuse of drugs will cause very significant difficulties**. It may cause or contribute to family disputes and breakdown, criminal behaviour, disrupted education and psychological and physical harm. In addition, for these young people, drug use is often only one of a number of problems and is frequently part of a range of risk-taking behaviours.

The Effective Interventions Unit and Lloyds TSB Foundation for Scotland Partnership Drugs Initiative have collaborated to produce this Guide to inform and support the design and delivery of services for children and young people under 16 who have problems with drugs and/or substance misuse. It follows from the Research Review on Young People's Treatment Services published by EIU in June 2002 and also draws on a seminar with managers and practitioners from a range of services in June 2002.

The Guide aims to support Drug Action Teams as they work towards the national standard '***to ensure that drug misusers aged under 16 have access to drug treatment and care services which are in line with national guidance, by 2004***'. The Guide is primarily concerned with issues relating to the misuse of illegal drugs. The Research Review published by the EIU in June 2002 looked at links to alcohol but did not explicitly include alcohol services. However, for most services working with young people problems with drugs and alcohol are inter-related. While it is beyond the scope of this Guide to provide detailed information on working with alcohol misuse, we envisage that much of the information will be relevant to both the drugs and alcohol field. In some sections which describe the behaviour of young people, we use the term 'substance misuse' because the information is drawn from that wider context. It is also important to note that this Guide does not cover primary drug prevention and education programmes aimed at all young people.

Developing appropriate interventions for this group of young people will be a challenge. It was clear from the Research Review, from our subsequent seminar and consultations with a range of practitioners that the majority of young people who need support are likely to face a range of problems, not all of which will be related to their substance misuse. There is compelling evidence that, if support for young people is to be effective, there needs to be an integrated approach. There was also a very strong message from our seminar that provision for **young people in this age group should not be about fitting young people into 'cut down' adult drug services. It should offer support that is appropriate and meaningful to the young person and the people that are significant to them.**

The Guide covers a range of issues that need to be addressed when planning how to meet the needs of young people with problematic drug use. For DATS and partner agencies, these include assessing the needs of young people in their area and considering how far existing, generic services can be enhanced to meet those needs and to what extent more specialised treatment services may be required. For service providers, they include thinking about how services can be made accessible to young people, understanding the rights of children and young people and developing an appropriate assessment process.

We see this Guide as part of an ongoing process rather than as a final product. Many of the areas covered in this document are still developing and changing. We have not been able to provide definitive answers on some topics. In this kind of work definitive answers may not be appropriate. However, a large number of new interventions and service developments are underway. Over time, evaluation activities and practice sharing should help us to learn more about what works for these young people.

Partnership Drugs Initiative
Lloyds TSB Foundation for Scotland

Effective Interventions Unit
Scottish Executive

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THANK YOU

The EIU and the Partnership Drugs Initiative would like to thank all those who have helped with this research, by participating in interviews, consultation workshops, providing references and commenting on drafts. This report covers a range of interests and while we have attempted to check the accuracy of all parts of the text, we apologise in advance for any errors or misrepresentation that may remain.

Methods

This Guide builds upon a range of other work and attempts to draw material together in a way that is accessible to commissioners and practitioners. We use methods adopted in a number of EIU reviews and studies, which bring together primary research, literature reviews and views gathered during consultation events. In addition, this Guide includes examples drawn from current practice in Scotland.

The Guide is informed by:

- **A research study and literature review** of treatment and care services for young people with developing or established problems with drug misuse commissioned by the Effective Interventions Unit (EIU). The study was undertaken by York Consulting Limited (YCL) and the School of Nursing and Midwifery, Dundee University (SNMDU) between August 2001 and March 2002. The results, published in June 2002, provide more in depth information and provide crucial context and background to this guide.[1]

- **A Reference Group** with experience of a range of services for young people met between September 2001 and September 2002. **Appendix 1** details the membership of the Reference Group. The expertise of the Group and the practical examples which they were able to provide were particularly useful.

- **A targeted consultation seminar** held in June 2002 drew evidence from a wide range of service commissioners and providers from both the statutory and voluntary sector. There was general consensus on the key issues and principles of delivering services for young people. **Appendix 2** list participants in the Consultation Seminar.

- **The experience of Partnership Drugs Initiative (PDI) projects** currently working with this client group. The PDI aims to promote voluntary work with children and young people affected by drug misuse and is funded by the Lloyds TSB Foundation for Scotland and the Scottish Executive. The Effective Interventions Unit has commissioned an external evaluation to learn from the experience of projects funded by the Initiative. The examples used in this document aim to give an insight into current practice in Scotland. Most of the interventions are still in a developmental phase and so we tend not to be able to draw on evidence from formal evaluations.

This Guide also draws on a number of other publications that address the various needs of young people, in addition to the national drug strategy and the Plan for Action on Alcohol. These include:

- *For Scotland's Children: Better integrated children's services* (October 2001)
- *Scotland's Action Programme to Reduce Youth Crime* (January 2002)
- *Protecting Patient Confidentiality* (April 2002)
- *It's Everyone's Job to Make Sure I am Alright* Child Protection review (November 2002)
- *Supporting Families and Carers of Drug Users: A Review* (EIU November 2002)

This Guide also draws on the work that underpins the recent EIU publication **Integrated Care for Drug Users - Principles and Practice** (October 2002). **Integrated Care** sets out an approach to providing services for adults but many of the underlying principles are relevant.

[1] The reports are available from the EIU or from: http://www.drugmisuse.isdscotland.org/eiu/eiu.htm

Chapter 1: Who are we talking about?

To provide effective services for young people experiencing problems because of their own substance misuse we need a clearer understanding of the main characteristics of this group. There are factors that can increase a young person's vulnerability to developing problems and identifying these can help services to target resources and interventions more effectively. However, the way individuals react to and cope with risk factors will differ from person to person. Young people may experience particular periods of difficulty in their lives and as a result move in and out of drug use. **Services will always need to treat each client as an individual and respond to their specific needs**.

A number of questions will need to be answered before decisions can be made about the nature of appropriate services. These include:

- defining the **age range** of those in need
- **identifying** the young people most likely to require services
- **assessing** the scale and pattern of **need**

Age range

The age group of the target population needs careful consideration. Although young people with drug misuse problems are most likely to come to the attention of services around 15 years old, by this point problems may be well entrenched. In this Guide, we concentrate on the needs of children and young people up to the age of 16. However, much of the information will also be applicable to services for 16 to 18 year olds because many issues and service pathways are relevant to both age groups. **Services will need to be able to offer some flexibility because young people mature at different rates.** A carefully managed transition between young people's and adult services can have an influence on treatment outcomes. Legal age cut off may not be the most appropriate time to transfer to adult services. **The maturity and needs of the young person and the availability of appropriate services should be taken into account when deciding the timing of this transfer.**

The evidence that we have about drug use demonstrates that it varies markedly according to age, with **use of illegal drugs increasing substantially around age 15**. The research review found that interventions were more effective the fewer pre-intervention problems there were for the drug user. **This indicates that, the sooner a person comes into treatment services, the better the outcome.**

Participants at the consultation event emphasised the need for a broad age range for services - '**hard and fast age limits cause problems**'. Young adults who developed significant drug problems in early adolescence often have '**huge gaps in social and life skills**' because they '**miss out big parts of growing up**' and need an opportunity to '**catch up**'.

The age of the young person will also inform judgements about the **level of risk**. For example, an 11-year-old who is a regular smoker and binge drinker may be more vulnerable to problematic drug use and in greater need of services than a 16-year-old who has experimented with ecstasy. These are not simple decisions but age will need to be considered alongside a range of risk factors. A crucial period for establishing vulnerability to drug misuse is in the period of change from primary to secondary school (children aged between 11 and 13 years). A number of studies of young people who are vulnerable to drug misuse (DrugScope 2000) show that children may become disinterested in school during this period even if they are not formally excluded.

Identifying appropriate interventions with younger children at higher risk of developing substance misuse problems may be an effective way of preventing later problems. **These interventions may not be specifically 'drug' related but aimed at providing wide-ranging support to vulnerable children and young people**, such as via generic health-related drop-in services, young carers initiatives, educational special needs services or support linked to looked after and accommodated children and young people.

Risk and protective factors

There is no single 'profile' of a young person who is likely to need services. They may come from a variety of backgrounds and environments and these circumstances may change over time. However, there is evidence that some young people are more likely to be at risk of developing problems with drugs. These include young people:

- who are getting involved with **crime**
- who are **homeless** or insecurely housed
- who have been **excluded** from school or persistently truant
- who are, or were, **accommodated or looked after** by local authorities
- involved in **prostitution** or **sexual exploitation**
- who are exposed to drug misuse in their **family**

'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.'

The Substance of Young Needs, Health Advisory Service 2001

McKeganey and Beaton's research (2001) into 96 young people resident in children's units found that 45.8% had used an illegal drug in the preceding month. The research also identified a **close association between illegal drug use and involvement in other anti-social and risk taking behaviours**: nearly 70% of the drug using young people had ridden in a stolen car compared to a third of the non-drug users. Research undertaken in 2000 (Melrose and Brodie 2000) found that young people who were offenders, excluded from school and 'looked after' were more likely to use drugs compared with those who only had one 'vulnerability'.

Recent research from Glasgow University highlights the impact of drug misuse in the family (McKeganey, McIntosh & MacDonald, forthcoming 2003). 10-12 year olds who reported having someone in their family using illegal drugs were five times more likely than their peers to have initiated some form of illegal drug use. There is evidence that **parental drug use** (Cadoret 1992, Mirin et al 1986, Barnard 1999), **marital discord, low supervision of children** and **family break up** are all associated with an increased likelihood of young people initiating some form of illegal drug use (Needle, Su and Doherty 1990, Miller 1997, Nurco et al 1996). Frequent changes in parenting arrangements - which can be a feature of some drug misusing households – can also have a negative impact on children (Keller *et al* 2002). However, research has shown that the family may exert a **strong protective influence** against illegal drug use. McHardle and colleagues, for example, have recently reported that a **close and positive relationship with a mother can act as an important barrier to the development of drug using behaviours** on the part of young people (McHardle et al 2002).

When making decisions about services for young people DATs need to consider drug misuse in a **wider context**. Often young people who are vulnerable to substance misuse are also vulnerable in other ways. There is a danger that these young people fall between services unless efforts are made to provide an integrated approach and there is a follow up or support arrangements to help the young person move between agencies. Services need to consider how they will reach those young people that are most at risk and ensure that they are equipped to deal with the complex needs of particular client groups.

The particularly vulnerable young people highlighted above may not be taking larger quantities of drugs than their peers but the lack of '**protective factors**' can mean that they are more likely to make the transition from experimentation to problematic use. Nonetheless, no young people are immune to developing problems with drugs and services need to be flexible in their responses. Although services may need to **target** young people most likely to be at risk, they need to ensure that this does not serve to **stigmatise** further.

National picture

It is difficult to identify one source of accurate information about the number of young people involved in problematic drug misuse. However, it cannot be assumed that because no reliable figures are available there is no problem or that the issue is trivial. While the numbers involved may be low in comparison to the wider under-16 population or the numbers of adult drug misusers, the long-term implications of failing to provide effective interventions are highly significant.

> *For Scotland's Children* (2001) 'found little evidence that children were presenting to agencies with difficulties relating to drug use. Such drug use was, however, frequently found among those children coming to attention of agencies for other reasons. Professionals working with children have little doubt that, for many children, problems associated with drug use were gestating and, for a proportion of children, would lead to serious problems in adult life.' [p. 97].

Scottish Children's Reporter Administration reported that 1,272 young people were referred under Section 52(2)j of the Children (Scotland) Act for misusing alcohol or drugs in 2001. However, these figures are likely to under-report the level of drug and alcohol related problems because substance misuse is often a contributory factor to a referral on different grounds, such as being outwith parental control. Similarly, the figures for **exclusions from school** due to substance misuse (currently 443) are likely to indicate only a portion of the problem.

The **Drug Misuse Information Team at ISD** primarily collect information on adult drug users although increasing numbers of services working with young people are now returning SMR 24 forms about their clients. From their current statistics, ISD are able to identify 778 under 18s currently in contact with services. **34% of clients reported being 16 or under when their drug use became a problem.** ISD recognise that returns to the Drug Misuse database only provide a partial picture of drug misuse amongst young people. They only have information from those services that return SMR 24 data, only 'new contacts' are recorded and they do not include statistics from any penal institutions.

National data can only provide an indication of the numbers of young people who might require some form of treatment, care and support. Given the range of services that could potentially work with young people with drug problems, a comprehensive national picture is likely to be difficult to establish. This points to the importance of assessing needs locally.

Assessing local need

To plan effective services at a local level **specific needs assessment work** will be crucial. The Drug Action Team has the responsibility for planning and overseeing the local strategy for tackling drugs misuse and should be well placed to co-ordinate the planning and delivery of services for young people with substance misuse problems. The first step should be to work with partner agencies to conduct a **needs assessment exercise** to inform decisions about the nature of the services required. The following Checklist provides an outline of the kinds of information that a needs assessment should attempt to gather.

It is important for DATs to recognise that there will be local variations in trends and patterns of drug use within local communities. **It is vital to conduct a full assessment of local need before planning services.** Some of the most useful sources of information will be:

- the outcomes of the **assessments** of individual young people (see EIU Evaluation Guide 7 on *Using Assessment Data for Evaluation*)
- the results of individual **service evaluations**
- routine **information about trends** available from services working directly with young people

West Lothian Youth Action Project is a young people's streetwork project operating out of Livingston, West Lothian. Through their work in particular localities, they are able to provide in-depth information about trends and patterns of risk taking behaviour amongst young people in specific areas. Over 6 months in 2002 they have had contact with 1773 young people and identified a range of risk factors.

DATs will need to identify the services already available and the gaps in the existing provision. To focus attention on existing routes into services and potential gaps, it may help to start with a question such as:

'Where would a 14 year old developing drug misuse problems go for help?'

To fully understand the factors that will shape the answer to this question, the needs assessment will want to involve and consult young people in the process. The **'Walk the Talk'** resource pack provides ideas and guidance on involving young people and its advice on **consulting young people** is reproduced in Appendix 3.

NEEDS ASSESSMENT CHECKLIST

The needs assessment should attempt to establish:

The profile of the local under 18 population. This should give information about the percentage of the local population that are under 18 and the distribution of this population across the area.

Geographical factors. Given the links between problematic drug use and social deprivation, it may be helpful to map local areas of disadvantage. For example, those areas that have:

- high numbers of children growing up in households claiming income support;
- high numbers of families registered homeless or insecurely housed;
- high levels of children on the Child Protection Register; and
- high youth unemployment.

However, even in localities where there would appear to be few problems there may be local 'hotspots' that can be identified through consultation with local agencies, such as schools, streetwork and outreach services.

Specific needs. Any needs assessment exercise should take account of the accessibility of existing services to all members of the target population. Some ethnic groups may appear to have access to services but in practice they may not be accessible because the services fail to meet the specific cultural needs of particular groups. Similar issues might arise because of gender differences with young women unwilling to access a service used predominantly by young men, and vice versa.

The pattern of existing local services for young people: such as educational and careers services (including any facilities for excluded pupils), medical services (such as Child and Adolescent Mental Health teams, sexual health clinics), social work services (including youth justice and services for looked after and accommodated young people), existing substance misuse services for young people, voluntary sector services (including 'drop in' facilities, information and advice services) and leisure facilities.

The prevalence and patterns of drug and alcohol use amongst this population. Some national survey information, such as the Schools Survey, may provide data that can inform local decisions about the level of need. There will also be local information sources to draw upon such as:

- data from Social Work and agencies working with vulnerable young people
- referrals to the Children's Reporter for alcohol and drug use
- school exclusions due to alcohol and drug use and reports from Guidance Teachers and Joint Assessment Teams
- information from local streetwork projects, housing officers, community safety partnerships and Social Inclusion Partnerships
- local youth crime statistics
- information from Child and Adolescent Mental Health Services
- acute admissions to local hospitals due to alcohol or drug intoxication

Chapter 2: Young people's needs and rights

The Effective Interventions Unit's **Integrated Care for Drug Users: Principles and Practice** highlighted the importance of addressing **the needs of the whole person**. Similarly, effective support for young people who are developing serious problems with drugs cannot address the 'drug use' in isolation. Both the research reviews and the consultation with service providers reported that drug misuse problems are rarely the only problem experienced by a young person and they are often not the problem that provokes the involvement of services.

Participants at the consultation event highlighted that young people are not **mini-adults**, they have a **variety of needs** and are **sensitive to stigma**.

As highlighted above, problematic drug use may be associated with homelessness, prostitution, criminal behaviour or poor attendance and under achievement at school. The Health Advisory Service report (2001) also highlights that many of those young people engaged in the heaviest substance use are likely to experience significant behavioural disorders. These may have hampered their development since early childhood and can take the form of anxiety or depression.

When planning provision for young people with substance misuse problems, DATs and partner agencies will need to consider the spectrum of needs (as identified in the needs assessment) and the type and range of provision appropriate to meet those needs

How do the needs of young people differ from those of adults?

In many respects, the needs of young people are the same as those of adults. Both young people and adults require flexible services that respond to their needs and for both the impact of drug misuse will reach into many areas of their psychological, social and economic lives. However, there are also **important differences** that will have an impact on the services required. These include:

- **Social impact**: The consequences of missing or under-performing at school can have a negative impact on later life chances that may be, or appear to be, irreversible. A chaotic lifestyle may seem acceptable and normal to a young person because they have fewer immediate responsibilities such as childcare, or maintaining housing or employment. However, involvement as a juvenile with a negative and anti-social peer group, particularly where this leads to offending, has been found to be a strong predictor of adult behaviour.

- **Vulnerability**: Young people involved in problematic drug misuse are highly vulnerable. In addition to the risks to their future prospects and the likelihood of later involvement in crime, they are at increased risk of victimisation and exploitation by others, particularly sexual exploitation.

> **'Young people have needs that are distinct from adults**. …Not only are young people vulnerable to exploitation, or misjudgement, adults have a responsibility of care that they may not have to the same extent for adult clients or patients.'
> *The Substance of Young Needs*, Health Advisory Service 2001

- **Physical impact**: Most young people will have been using drugs for a shorter period than adults who present to drug agencies. This tends to mean that the negative health effects of an abusive lifestyle – such as injecting related injuries or blood borne viruses – are less likely to be evident amongst either themselves or their peer group. However, the wider **health needs** of this group – particularly around mental wellbeing – should not be under-estimated.

- **Methods of use**: The ways in which young people take drugs may differ from adults. There is likely to be a higher degree of poly-drug use, with the young person taking whatever is available - including solvents, prescribed or illegal drugs - rather than pursuing one specific drug of choice. Drug use may change from week to week. Binge use of alcohol and other drugs often features with little understanding or awareness of the consequences.

- **Circumstances of use**: The circumstances in which young people misuse drugs may differ from those of adults. Their lack of independence can mean that the drug use takes place in environments that may bring additional risks, such as outdoors or in the company of a much older peer group.

- **Perceptions of risk**: Young people can consider themselves 'immortal' and death or a serious deterioration in their ability to function can seem unimaginably distant. Many young people will not see their drug use as problematic and they may not make connections between the drug use and other issues in their lives. None of the young people involved in the Melrose and Brodie (2000) research felt that the experience of being looked after, excluded or offending were related to their drug use. The positive and enjoyable aspects of drug use may still appear paramount.

What are the rights of children and young people?

DATs need to ensure that services uphold children's rights and that they operate within the sprit and intentions of the law as well as the fact of the existing legal framework.[2] The **Children (Scotland) Act 1995**, the **United Nations Convention on the Rights of the Child 1989** and the **Age of Legal Capacity Act (Scotland) 1991** are the central pieces of legislation in relation to the care and welfare of children in Scotland.

The key themes relevant here are:

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

- Each child who can form a view on matters affecting himself or herself has the right to express those views if he or she so wishes;

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

- 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.

The literature review highlighted potential problems in implementing the framework in four key areas:

- Upholding children's right to health and health care
- Upholding children's right to participate in decisions
- Upholding children's right to consent to medical treatment
- Sharing of information

To overcome these issues, DATs and their partner agencies will need to consider carefully how they ensure that the rights of children are maintained. Information is available from 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.

Involving parents / carers

An intervention with a young person will be more effective if there is support from a parent, family or carer. The building or maintenance of a supportive relationship with a caring adult is important for the young person. As well as a support role the parent may also have a **legal need to consent to treatment**. However, there will be cases where the parents have contributed to the young person's problems and may be unlikely or unwilling to offer any support to the young person. Some young people may need services to support them to mature and develop so they are able to survive independent from their family.

Care must be taken at the time of assessment, and throughout the care process, to establish the possible role of **parents/carers**. The young person's views should inform this process. Support to families and carers is also essential in order to limit the damaging effects that coping with a relative's drug use can have upon others. The EIU review ***Supporting the Families and Carers of Drug Users*** (November 2002) addresses this issue.

> 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)

Sharing of information is a potential source of tension between parents and health and social care professionals. Although agencies share information on a 'need to know' basis, parents may be refused access to this information on the grounds of maintaining a child's confidentiality (Cleland and Sutherland 2001). The **Children (Scotland) Act 1995** gives parent's responsibility for their child's welfare, but not necessarily the legal right to access confidential health information about their child. Only if workers involved in the child's care consider it necessary to inform parents, in order for them to carry out their caring responsibilities, will information be shared against a child's wishes. Furthermore, since complex legal relationships exist within many extended families, ascertaining who can consent and who has the right to information may not be straightforward.

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 person's **physical or mental health** or both are likely to suffer.

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[2] More detailed discussion of the legal framework is provided in Part 2 of the EIU review, 'Drug Treatment Services for Young People: A systematic review of effectiveness and the legal framework' (2002).

- The young person's **best interests** require health professionals to give the young person drug advice or treatment or both without parental consent (Goodsir 1991; Harding-Price 1993).

If practitioners have concerns about issues of confidentiality, **legal advice** should be sought.

NEEDS AND RIGHTS CHECKLIST

When planning future service provision DATs should:

Make **key stakeholders** such as health, education and social care professionals aware of the legislative framework so that they fully recognise and uphold the rights of children and young people.

Realise that **children and young people's** knowledge of the current statutory framework is likely to be limited and that this will undermine their capacity to demand the comprehensive services set out by the law. Services will need to build in capacity to develop this understanding using appropriate methods.

Understand that most **parents and carers** will have limited knowledge of the current statutory framework in which services are provided. This will need to be overcome so that they are able to take valuable opportunities to work with professionals in upholding their children's rights.

Chapter 3: Accessing Services: where, when, who?

Making substance misuse services 'relevant' to young people will be critical, particularly given the stigma attached to drug misuse and the likely vulnerability of the young people needing services. Commissioners and service providers will need to give particular thought to how their interventions will involve and engage young people. The best way to ensure that services are relevant is to **consult young people** before services are established and to find ways to **involve young people** in the management, delivery and review of services.

The resource pack ***Walk the Talk: Developing appropriate and accessible health services for young people*** was published in 2000 following research and consultation with young people. The work identified a clear need to develop appropriate and accessible services for young people. In particular, there was concern about:

- little access to youth focused services
- lack of information designed for young people
- lack of consultation with young people
- general services being "inhospitable"
- fears about patient confidentiality

They suggested the following formula as a 'yardstick' for the development of young people's services:

relevant people + relevant places + relevant times = relevant services

Where and when?

To meet the needs of young people services must be available in the **right places** and at the **right times**. Participants at the consultation seminar suggested that services need to be **informal** and **not appointment led**. This is likely to mean that services have to be accessible outwith school hours - in the evenings and at weekends - and in locations where young people will feel at ease.

A practical example of making a simple change would be to provide reading materials in waiting rooms that were suitable for young people. Another example would be to have an appropriate 'set time' in the week when young people could receive services. A more radical solution would be to have specific 'youth services'. For example, a **youth health facility** involving a network of professionals to deliver a range of treatment and care services specifically designed for young people.

Lanarkshire Alcohol & Drug Action Team's '**Review of Services for Under-18s**' (2002) found that knowledge about services amongst young people was limited. In general, only those young people who had direct experience of services had any knowledge of their role and function, how to access them and their methods of support. Participants distinguished between those services they **could** use and those they **would** use.

Lack of available transport can undermine the accessibility of services so, once a care programme has been agreed with a young person and their carers, it may be necessary to conduct sessions in the young person's home, school or other community setting such as GP surgery, neighbourhood or drop-in centre.

Young people tend to be very affected by issues of **territoriality** and they are often unwilling to access services outside the area in which they feel comfortable. A **city centre** location may help to overcome barriers caused by territorialism and fears about confidentiality, although it may raise other problems such as travel times. Young people, particularly those experiencing deprivation and a range of problems, often have very limited horizons and can find even apparently simple journeys a challenge. Agencies may need to reassess where and when they offer services once they have been in operation for a few months and specific issues about territorialism and travel patterns emerge.

ACCESSIBLE SERVICES CHECKLIST

When deciding **where** to site services and **when** to open, think about:

Can the young person access the service without feeling **stigmatised**? *For example, a generic drop-in service that could be accessed for a wide range of reasons. Even specialist services tend to find that clients and referrers feel more comfortable if the service has a 'neutral' name, e.g. Borders Young Peoples' Drug & Alcohol Project changed its name to the Reiver Project.*

Is there sufficient private space available to safeguard **confidentiality**? *For example, a separate 'consulting' room or area where conversations can not be overheard.*

Are premises available **out of school hours,** at evenings and weekends? *For example, an arrangement with a community centre to use their premises for meeting young clients.*

Are **staff supported to work outside normal office hours**? *For example, through a budget for irregular hours payments and a clear policy for safety and security.*

Is the site already **well known and used by young people**? *For example, a community internet café, sexual health service or youth club.*

Is the environment of the building **welcoming to young people**? *For example, young people have control over decorating and furnishing the space.*

Are services **convenient** for public transport? Would **mobile units** be possible? *For example, a specialist service that offers discreet appointments through the school.*

Will **outreach services** be needed to reach particular populations? *For example, a worker recruited specifically to build trust and develop interventions with local minority ethnic communities.*

Where are the **other programmes** for young people who need additional support? *For example, national training programmes such as 'Getting Ready for Work' who deal with young people with a range of social, emotional and other difficulties and the Beattie Inclusiveness Projects.*

Are a **variety of settings** available to respond to particularly vulnerable groups, such as those involved in prostitution or homeless young people? *For example, a regular clinic based within a night shelter.*

It may be necessary to develop a **multi-modal approach** with a range of **different access points**.

Choosing staff

Supporting young people involves understanding. **The relationship between the worker and the young person will be very important to the effectiveness of the intervention.** The research review found that a factor contributing to the success of interventions for young drug users involved using experienced and well trained staff with low turn over. It is vital that workers and those who have contact with young people at the point of access, assessment and delivery of services are skilled in working and relating to young people.

The Action Team asked children and young people about the kinds of adult they would wish to work with. 'The predominant theme was about the need for adults who listened and did not judge, who cared, who provided protection from harm, who could be funny, who provided safeguards and boundaries, who were never angry and who loved them.'
For Scotland's Children (2001) p.29

Involving young people in the recruitment process can help to identify which adults are likely to be able to establish rapport with young people. Agencies that have taken this approach, such as **Who Cares? Scotland** and **Tayside Council on Alcohol**, report that young people take the role very seriously and that their input has been highly valuable.

In many instances the need to relate well to young people will be of greater significance than specific knowledge about substance misuse. It should be possible to link to specialist services and training resources that can provide this input. **STRADA**, the Scottish Training on Drugs and Alcohol agency, delivers training locally across Scotland to all professionals in health, social, education, police and prison services, pharmacists and non-statutory organisations. No course fee is applicable to those employed in health and social work services as well as non-statutory organisations.

STRADA Young People: Drugs and Alcohol Module

This 1-day course is intended to develop the skills of professional workers who deal with young drug and alcohol misusers or those who work with young people in generic settings. The module covers legislative and assessment issues and aims to improve the specialist skills of the participant to:

- demonstrate a clear understanding and application of the relevant legislation to children, and working with children/young people
- assess the competence of children and young people to commit to treatment modalities
- assess the problem of drug and alcohol misuse and plan effective interventions based upon assessment
- plan and review care to include elements such as parental involvement and involvement of statutory agencies
- integrate knowledge of drug and alcohol trends for this group into practice,
- consider the policy impetus on working with and behalf of children and young people, in the context of the Scottish Executives' National Drug Strategy and the Plan for Action on Alcohol Problems.

All staff working with young people will need to be trained and skilled in **Child Protection** issues and have access to a designated person within their service who can make decisions related to Child Protection.

Staff will also need to undergo regular checks by Scottish Criminal Records Office / **Disclosure Scotland** to safeguard the young people in their care. 'Enhanced Disclosures' may be necessary if the individual's work regularly involves caring for, training, supervising or being in sole charge of those aged under 18 or vulnerable adults.

Chapter 4: Assessing Needs

Assessment processes and principles

An effective assessment process is necessary to establish as complete a picture as possible of the young person's needs. The assessment will need to cover problems with substance misuse but also the other factors and circumstances in their lives that have an impact on this. The assessment will give a sense of 'where someone is' and help to identify the changes that need to be made to achieve the best possible outcome.

The purpose of assessment is to identify the range of needs and aspirations of the individual in order to inform decisions about treatment, care and support.

The report of the Beattie Committee, ***Implementing Inclusiveness: Realising Potential*** (Scottish Executive 1999), set out a number of principles and key issues to be addressed in developing an assessment process appropriate to young people with social and emotional problems. While the Beattie Committee's remit was to review education and training provision for young people aged 16 -24, it took into account the needs of 14-15 year olds (or younger) who were experiencing difficulties. The report highlighted that young people may be unwilling to participate, or to participate fully; they may have difficulty in communicating their views about problem areas in their lives; and there may be little or no previous information to draw on. In addition their aspirations and ambitions may be unrealistic. The **principles** of assessment set out in the Beattie report are:

It must be open.

It must be fair and accurate.

It must be focused on the individual and not designed to accommodate the organisational structures or administrative practices of an agency.

It must respect confidentiality.

It must encourage full participation and ownership by the individual.

It must aid progression.

It should also:

Be continuous but not repetitive

Be given adequate time and care

Be carried out by competent and well-trained staff

Be designed to allow the transfer of accurate, relevant and up-to-date information

The key issues of **ownership and confidentiality** are crucial in an assessment process designed to engage with young people under 16. As set out above, young people in this age group are considered to have the right to participate in decisions about their treatment and care but tensions may arise in relation to the legal framework. Both the Beattie Committee report and the recent document on ***Integrated Care for Drug Users: Principles and Practice*** (EIU 2002) identify key elements of the assessment process which promote and encourage participation.

These are:

The assessment process should not be a one-off event. It should be a **way of working and part of the overall care** of the young person. It may in itself constitute a therapeutic process.

Openness about the nature and purpose of the assessment. The level of **participation** may be constrained by circumstances but a sensitive and open approach by practitioners may, over time, encourage the young person to speak more freely. The young person should know who is involved at every stage, what issues are being discussed and should be able to participate if they wish.

The assessment process should be given **time** to encourage a more in-depth assessment of the range of the young person's needs. But there may be a need for more immediate choices of treatment, care or support arising from the initial assessment discussion. There may be a case for **different levels of assessment** as set out in Integrated Care for Drug Users.

The **expertise** of staff, particularly their capacity to engage successfully with young people, will be crucial. The relationship of trust built during the assessment process is likely to have a significant impact on the outcomes achieved. The literature review found that having 'experienced and well trained staff with low turnover' contributed to the success of interventions.

There may be benefits in **involving family and friends** in the assessment process because they can provide additional, valuable insights. However, this may not always be the case and staff will have to exercise judgement about when, or if, it would be appropriate.

There should be agreed arrangements between agencies and service providers for **information flow**. Lack of information can lead to inadequate or incomplete assessment and referral to inappropriate provision. This can lead to poor outcomes and cause the young person to be become disillusioned and drop out.

If the assessment process is working effectively, the young person should be **a full participant and understand and agree the goals of treatment and care.**

SERVICE EXAMPLE

The Web Project, Angus develops an individual '**Plan for Change**' following a formal assessment of the young person. The assessment process takes about 6 sessions (usually 2-4 weeks) and can be 'fast-tracked' depending on the level of intervention required. The assessment includes the following stages:

Initial contact (within 48 hours of referral) involves:

- introductions / explanations of the process and what happens next
- expectations of both the worker and the young person
- boundaries of confidentiality
- information from the young person's perspective on social situation, decision makers in their life, peer group, substance use, health, criminality

Meeting 2:

Aims to build trust and put young person at their ease, to gain increased understanding of the young person's issues, to set their drug / alcohol use in the context of their life and to begin to identify nature of drug / alcohol use. The session focuses on encouraging the young person to describe / draw their 'Life Map'.

Meeting 3:

Aims to assess and provide more detail on drug / alcohol use within the previous month, including how, where and when it is used. The level of knowledge about the effects is explored. Activities and friends that are not involved with the drug / alcohol use are identified.

Meeting 4 (5/6):

Aim to identify where the young person is in the cycle of change (denial / pre-contemplation / contemplation / preparation / action / maintenance / lapse) and to identify what changes they would like to make in their life and their short, medium and long term goals. The initial framework and content of the '**Plan for Change**' are agreed with the young person.

Each session is followed by the worker's reflection on compliance and the development of the working relationship.

The worker and the young person review the Plan for Change on a monthly basis.

Assessment tools

There is considerable interest in the use of **assessment tools** to guide and structure the dialogue between practitioner and client and aid the process of assessment. *The Study of Assessment Tools* (Rome 2002), included in ***Integrated Care for Drug Users*** (EIU 2002) sets out key findings about the purpose and use of assessment tools. One of the key findings is that tools must be **tried and tested, fit for purpose, designed to identify the main issues that need to be addressed and to elicit all the information** required to identify individual need. There is relatively little information about specific tools suitable for use with young people although some have been reviewed and developed in related fields, such as youth justice.

SERVICE EXAMPLES

Tools currently in use in Scotland to guide the process of screening and assessment include:

- **EuroADAD** – a structured interview that gives a multidimensional profile of adolescents. This tool is in use in various parts of Europe and training is available in Scotland. It is a development and adaptation of the Addiction Severity Index. The information can be used for clinical, research and organisational purposes.
  Used by: ***Connect Project*** *in Perth and Kinross operated by Tayside Council on Alcohol and* ***Choices Project*** *in Dundee.*

- **POSIT –** the Problem Orientated Screening Instrument for Teenagers can be used as the first step in determining potentially problematic areas that require a more intensive diagnostic assessment. Developed in the USA, the POSIT can be used to collect baseline data to comprehensively describe adolescent subject populations. An abbreviated POSIT can be used as a change measure.
  Used by: ***Reiver Project****, operated by Borders Council on Alcohol.*

A range of other guided interviews and informal tools are used by services working with young people affected by drug/alcohol misuse. For example, the **Barnardo's New Directions Youth Drug Initiative** in **Peterhead** has developed a matrix that plots levels of risk across a range of substance misuse, social and health issues across 4 categories – chaos, regularisation, stabilisation and socialisation.

EIU will undertake a review of tools as part of a wider exercise on effective assessment for young people in 2003. However, it is important to stress that the tools are only part of the assessment process and not a substitute for engaging in a dialogue with the young person using a range of skills and expertise.

Chapter 5: The Importance of Evaluation

Why evaluate?

As set out in the **Methods** section, this Guide builds on a range of activities and types of evidence, including a systematic review of international published research. The Guide aims to draw on the available research and wider experience to identify key principles to underpin service development and delivery. Following these principles should lead to improvements in service provision and help in the development of evidence-influenced practice.

However, this Guide should only be part of an ongoing process. **More evidence and understanding is required and this needs to be built through structured evaluation activities.** The research papers that met the search criteria for the literature review were primarily North American and a large number of questions, particularly about the practical detail of designing and delivering effective interventions, inevitably remain unanswered. **It is imperative that evaluations are routinely conducted to build our understanding of what works with this client group at a national, local and service level.**

Careful monitoring and regular evaluation of services is essential to ensure that services are genuinely meeting the needs of young people.

What is evaluation?

An evaluation is a **systematic assessment** of whether the stated aims and objectives of an intervention have been met. Evaluations commonly address questions about effectiveness, efficiency and acceptability. An evaluation involves the collection and analysis of reliable, relevant and valid data. It should

- consider the **context** and **process** of implementation
- consider the **outcomes** achieved
- allow better and more informed **decisions** to be made about the future of an intervention: for example, when to use a particular treatment type, how to improve a service, or whether to expand, reduce or discontinue a particular approach or activity.

What is monitoring?

An evaluation is likely to draw heavily on the information collected as part of the **routine monitoring** of a service. **Monitoring is an ongoing process** involving the continuous or regular collection of key information about an intervention's inputs, outputs and outcomes: for example, the routine collection of information about the numbers of clients accessing a service. The main aim of monitoring is to assess whether an intervention is going as planned, and whether any change in focus and/or activity is necessary. Having a comprehensive monitoring system in place helps to ensure that evaluations are robust and cost effective.

The Effective Interventions Unit has produced a series of short evaluation guides that cover a range of topics from definitions through to reporting and dissemination. These are available at: http://www.drugmisuse.isdscotland.org/goodpractice/effectiveunit.htm

Planning an evaluation

When **planning** a service level evaluation of an intervention with young people with substance misuse problems a range of questions will need to answered.

Questions	*Fictitious example*
Does the intervention have clear and measurable objectives?	*To deliver a programme of cognitive behavioural therapy to 40 young people to decrease substance misuse and to improve school attendance.*
What exactly does the intervention involve?	*A staff team involving two qualified behavioural therapists and a project manager deliver a one to one, 24 session programme in a range of settings appropriate to the young people, particularly drawing on links with a service for young people excluded from school.*
How and why can the intervention be expected to achieve its aims and objectives?	• *There is research evidence that cognitive behavioural therapy is effective in reducing drug use and some evidence that that it can have a positive impact on school work and school attendance.* • *The intervention aims to maximise its success rates by using well-trained and experienced staff and working closely with a range of local agencies to tackle issues beyond the young person's drug use.* • *Experience of similar projects suggests that the caseloads are viable.*
Who is the evaluation for? Is it feasible and appropriate?	• *The project team are keen to involve all stakeholders in the evaluation, particularly clients and partner agencies.* • *Funding for evaluation was included within the original project application and it is supported by the DAT.* • *Following consultation, an external evaluation was deemed feasible and desirable because there is significant interest in the programme and the DAT needs to decide whether to roll it out to other areas.*
What questions do you want to answer through the evaluation?	• *Has the project recruited the numbers and profile of young people expected?* • *Has the caseload been appropriate?* • *Do clients drop out of the programme? And if so, why?* • *Does dropout have an impact on outcomes?* • *Are clients reducing their drug use?* • *Are clients improving their attendance at school?* • *Do clients find the programme acceptable? What improvements would they suggest?*

Using assessment data in an evaluation

The **primary purpose** of assessment is to **collect information that will help care to be planned** according to a young person's individual needs. Using data collected as part of an assessment in a service or project evaluation is (and should be) **secondary** to this purpose. However, the process of assessment often generates **a wealth of information** that could potentially be used for evaluation.

Different levels of assessment will provide **different types of data** for the purposes of evaluation. For example, data from **first level assessments** may provide useful profile information on the population contacting a project or service (e.g. number of attenders, age and gender mix, area of residence).

Data from the **second and third level assessment** will probably provide a **mix of process and outcome** measures. For the outcome measures to be useful, it will probably be important to repeat the use of an assessment tool at structured intervals. For example, comparing the level of drug use amongst clients at entry and at 3 month follow-up. The main problem with this approach is the **drop-out** (or 'attrition') rates. Some clients may leave the service or project before the second assessment. It may be possible to address some of these issues by using tools such as the Christo Inventory for Substance-misuse Services (CISS).

It is also important to note that **assessments may not provide all the information you need** to undertake an evaluation. For example, assessment tools rarely collect **qualitative information** on young people's experiences of the service and they tend to **focus only on the clients** - not on their families or the staff at the service. The evaluation may need to hear their views as well.

Assessment tools (particularly those designed for specific use by a service) often include **'open questions'**. This means that there are no pre-defined answers to choose from, the questions are answered in text. This information may be very valuable and it is still possible to use it in an evaluation. Completed forms would need to be collected and analysed so that the key themes and common answers can be identified. These themes would then be used to 'code' the data.

Service providers and evaluators will need to give careful thought to:

- **Computerising the data** – For the data from assessments to be useful for evaluation, they will need to be computerised. Most data can be stored in databases such as Access or Excel. However, this can be time consuming. Someone within the organisation / agency may need to take responsibility for entering data regularly.

- **Analysing and interpreting the data –** You will need to organise the data and make sense of what the information is telling you. This can require specialist skills. It is sensible to identify someone in your organisation or agency who has these skills, or you may need to purchase specialist skills periodically to undertake analysis.

- **Data protection –** The Data Protection Act 1998 gives individuals the right to gain access to information on themselves, held on computer or paper. It also imposes on data users a number of obligations including the eight Data Protection Principles that say that data must be:

  fairly and lawfully processed;

  processed for limited purposes;

  adequate, relevant and not excessive;

  accurate;

  not kept longer than necessary;

  processed in accordance with the data subject's rights;

  secure;

  not transferred to countries without adequate protection

Information generated by an assessment is likely to fall into the category of 'sensitive personal data'. This includes data that relates to the physical or mental health of data subjects. To lawfully process sensitive data particular conditions have to be met, such as obtaining the explicit consent of the data subject. This can be done relatively simply by explaining the typical flows of information and likely uses of data at the outset. If information is used for additional purposes it will need to be explained to the specific individuals at the appropriate time and when they are able to make sense of it. Consent may not be required if the information is **anonymised** and used at a service level rather than to make judgements about individual cases.

To ensure that the processing of information conforms to standards of 'fairness', the service can notify the client by providing a standard information leaflet or letter or informing face to face in the course of a consultation. The effort involved in providing this information may be minimised by integrating the process with existing procedures. For example, new clients should be given information about the uses and disclosures of personal data and could be advised that their records may be made available to researchers who may wish to contact them in the future.

Organisations must notify the Data Protection Register about any data held on computer. It should be recorded that data may be used for research purposes. Forms can be completed online at: http://www.dpr.gov.uk/

Chapter 6: Planning Services

From the evidence that we have gathered, we have identified the following **key principles** that should underpin the design and planning of services for young people under the age of 16 years:

- An intervention should take account of the unique development needs of young people.
- Services should be dedicated to children and young people.
- The views of the young person are of central importance and need to be taken into account at all stages.
- Services should promote Children's Rights and Welfare

The planning process: generic and specialist services

It is not straightforward to identify a singular 'drug treatment service' for young people. Effective services for young people are unlikely to be housed in one building or delivered by one profession. The word 'treatment' can itself be misleading because it can imply a relatively simple and ordered process of treating an individual until they have recovered. Given the likely range of needs and the number of potential outcomes, the process of intervening with a vulnerable young person is likely to require the involvement of a network of professionals across a range of agencies and service providers.

Participants in the consultation event preferred the term '**intervention**' to 'treatment' because it can incorporate a range of responses. There was concern that services for young people were not '**over medicalised**'.

Once they have completed their **needs assessment**, the key issues for DATs and partner agencies will be:

To what extent is it appropriate and relevant for generic services to enhance their provision to address drug problems amongst their existing client group? And to what extent should specialist services be developed?

The debate is likely to focus on how far generic services can – and should – attempt to address the problems of drug use among their clients, particularly when these problems are having a direct impact on other aspects of their lives. To resolve these issues the Drug Action Team will need to ensure that **key agencies working with young people - such as Health services, Children and Families Social Work, Education (including Community Education), Youth Justice services and the voluntary sector - are well represented within, and full contributors to, the DAT partnership**. These agencies may contribute as full members of the DAT or as part of a Sub Group dedicated to children and young people. The commissioning of services needs to be **integrated and cross-referenced** with all other **universal, thematic and more focused plans for children and young people**. To ensure that services are focused on the needs of young people, the planning and commissioning process should involve, at all stages, those services that routinely work with and understand the needs of young people.

The **Corporate Action Plan** returns to the Scottish Executive indicate that 14 of the 22 Drug Action Teams currently have sub-groups that focus on the needs of children and young people (either as 'Young People' sub groups or as 'Prevention and Education' sub groups). All DATs indicate that they have some links to the local Children's Services Plans.

The planning and commissioning process will need to consider how best to develop services from within mainstream resources and how to make the most appropriate use of specialist resources. There may be a case for developing a **staged or tiered intervention model**. This approach has been used in a number of areas including special educational needs, mental health and substance misuse and it can help planners to identify potential gaps in provision. Lanarkshire is currently considering a staged approach to young people's health services (see **Appendix 4**).

It may be useful to situate the development and planning of services in the context of developments related to the Scottish Executive's report ***For Scotland's Children: Better Integrated Children's Services*** (October 2001). This suggests that each children's service planning area should establish a model for staged intervention (tiered intervention) which sets out the responsibilities of universal and specialist/targeted services; identifies characteristics which indicate the potential requirement for higher stage service; and establishes information-sharing and assessment arrangements. A standard element of such a model is a single shared assessment format which should be established within each children's service planning area and agreed for use by all agencies.

For Scotland's Children states that 'the majority of children can have their needs met by their families and the universal services - health and education' by having 'a **named individual who can function as the main point of information / reference for the child**'. The document recognises that some situations may require more than a 'named individual', such as when **long term, intense or complex needs** have been identified. This is likely to be the case for young people who have developed problematic substance misuse.

The Health Advisory Service report, **The Substance of Young Needs** (2001) uses a four tier model to define the range of functions required, moving from generic (Tier 1) to highly specialised services (Tier 4). In particular, the report highlights that 'where possible the intervention should be co-ordinated and managed within the Tier 1 setting. This will tend to minimise the stigmatisation and 'normalise' the situation for the child and family'.

In these circumstances, as part of the staged/tiered approach, a **care co-ordinator** should be identified. This might be the 'named individual' already identified - such as a secondary school guidance teacher - but more often it will be a worker from another setting who will function as the care co-ordinator. This may be a social worker, educational psychologist, child and adolescent psychiatrist, paediatrician or other professional. Where a young person's drug misuse problems are causing the primary concern, it may be appropriate to assign a specialist worker with expertise in young people's substance misuse. As children's services consider the training, experience and skills required of a care co-ordinator it will be important to ensure that the individual is equipped with knowledge of substance misuse issues and knows how to access specialist support.

"Young people don't make good referral parcels"
Member of Young People's Treatment Reference Group

When considering how best to address the needs of young people with drug misuse problems, DATs will need to work closely with children's services across Health, Social Work, Education and other key agencies. It will be important to consider how specialist substance misuse services will work in conjunction with wider support structures for vulnerable young people. Needs assessment work may show that there are some young people whose problems with drugs are so serious that they require very specialised treatment, such as in-patient detoxification or residential rehabilitation. Our current understanding of the prevalence among young people suggests that this number is likely to be small. It was suggested at our consultation seminar that in such circumstances there may be a case for neighbouring DATs to collaborate in developing a more specialised service – **as a consortium**.

PLANNING SERVICES CHECKLIST

In particular, DATs and their constituent agencies will need to understand:

What **care co-ordination arrangements** are already in place, or are under development, in your area.

Whether an '**administrator**' has been established by children's services (as suggested in ***For Scotland's Children***) to work with all the relevant agencies to identify children requiring a care co-ordinator, identify the care co-ordinator for each child, arrange for service reviews and ensure the proper distribution of information.

What services for young people are available and how **substance misuse expertise** can be most effectively linked into generic services.

If it would be a better use of resources to develop and co-ordinate a '**network of existing professionals**' who are trained and supported rather than to appoint single issue staff that can get subsumed into existing service frameworks.

How far **universal services** are **accessible** to vulnerable young people. For example, are basic health services such as primary care routinely accessible to young people with substance misuse and other problems?

Which existing services are **most accessible and acceptable to young people**. For example, are there existing young people's 'drop in' facilities that have contact with a range of young people which could provide a non-stigmatising entry point into more specialised services?

What **screening** processes do universal services use to identify those young people that might require more specialist support. What mechanisms exist to manage onward referrals?

What 'tier' are services working within? I.e. what **level of intervention** is the service aiming to provide and how does this fit with other local services?

How will **review** and **evaluation** be built into the development of services?

Working Together

An integrated or multi agency approach is necessary to achieve a successful intervention. ***For Scotland's Children*** states:

'Arrangements should in future avoid the accident of the entry point determining the service provided. The development of a multi-disciplinary, multi-agency model of staged/tiered intervention will enable more rational consideration of the optimum response to the child/family from within the service network. It will be important for all agencies to have a good understanding of the remits, responsibilities and services provided by other agencies within the service network.'

Angus is developing a multi-agency response to children and young people's substance misuse. This work builds upon the Angus **Drug Action Plan**, **Youth Justice Strategy** and the **Review of Angus Children's Services Plan**. The multi-agency working builds on four strands:

1. Community based counselling and support services.
2. Specialist drug service for children and young people where drug use is a contributory factor in their involvement in persistent offending.
3. Family support, direct work with families with children affected by parental drug use.
4. Resource service for professional staff.

The approach will work Angus-wide through three local **multi-agency resource teams**, involving a core group of agencies that are both committed to the partnership and able to commit resources. The local leads include the Web project (local voluntary organisation), Social Work and Tayside Police. Groups will meet monthly to discuss cases and allocate services and the lead agencies will have responsibility for chairing sessions and reporting on case progress. The purpose of the teams is to achieve:

joint decision making
early screening and support
localised integrated response
the promotion of alternatives
collation of information

The multi-agency approach is underpinned by a **referral system** involving shared referral and monitoring forms and clear referral routes and procedures. The target client group is children and young people up to 18 years old with substance misuse problems (either their own or parental), offending issues and school or community problems. The teams will allow **review and evaluation processes** to operate more effectively across services and provide a focus for data collection and trend analysis. The partnership will operate to common aims and standards to ensure that there is a high quality integrated service. A key outcome should be a package of support without disengagement or **passing the buck**.

The EIU publication - ***Integrated Care for Drug Users - Principles and Practice*** - sets out how an integrated care service for adults can be implemented. Similar principles apply to integrated services for young people. The following agencies and service providers will need to be involved in planning and delivering services to young people with drug problems:

- Education including schools, colleges, community education and careers services. Specific links may need to be made with Joint Assessment Teams, Guidance Teachers and services for school excludees.
- Social services including Children and Families Teams, Youth Justice services and services for looked after and accommodated young people.
- Health services including primary care, Child and Adolescent Mental Health Teams and Accident and Emergency services
- Specialist drug misuse services
- Police
- Child Protection Committees
- Children's Reporters and Panels
- Community based services including leisure, arts and diversionary activities

This network should aim to include both statutory and voluntary sector providers. Voluntary sector services may find it easier to engage and build trusting relationships with young people who may have negative views and experiences of 'authority'. These services may also be better equipped to adapt quickly and flexibly to suit the changing needs of young people. However, it is vital that voluntary sector provision is well integrated into the decision-making processes of statutory services, in particular they need to be part of care planning.

The Action Team met with children and young people to get their views of services. 'Those services which they identified they would recommend to other young people were predominantly those provided by the **voluntary sector**.' ***For Scotland's Children*** (2001) p.29

The **roles** of the various agencies and services will range from **initial recognition and screening** of a problem – for example through Schools, GPs, Police, information and advice services and Accident and Emergency admissions – to **care co-ordination and planning** – for example through social work or specialist professionals. When working out the relative roles and responsibilities of local services it is useful to go back to the questions posed during the needs assessment exercise:

'Where would a 14 year old developing drug misuse problems go for help?'

PARTNERSHIP WORKING CHECKLIST

Effective partnerships depend upon clear organisational arrangements. In particular, agencies will need to negotiate and agree:

Intra- and inter-agency **protocols and procedures** will need to be set up **before** conflicts arise. Guidance on information sharing is provided in Chapter 6 of EIU's *Integrated Care for Drug Users – Principles and Practice*.

How to recognise and **screen** for problems. DrugScope are currently developing a *Common screening framework for substance use among young people*.

Assessment processes: what **core data** can be shared to avoid duplication? EIU will address the issues of core data sets as part of their work on assessment for young people in 2003.

Structures and other processes for **referral**, **planning and provision** of services: identify who can make decisions about resources and ensure that the client knows what to expect from referrals.

Recording and **management information systems**: how will trends and gaps in services be identified?

Training and staff development opportunities for professional staff, carers and others including administrative staff.

Inter-agency training programmes: joint training breaks down barriers between agencies and improves communication and understanding.

Quality control / quality assurance systems: having some core standards, for example on time between referral and first appointment, can help improve services.

Family / carers involvement and feedback on the assessment and care processes.

Joint review and evaluation processes that consider the operation of partnership working and its impact on service delivery.

Chapter 7: Which Interventions?

Given the wide range of young people's needs and the involvement of a wide range of services, a number of different approaches and interventions will need to be available. In this **Chapter** we set out some approaches to providing specialist substance misuse interventions for young people and indicate the availability of evidence for effectiveness. As set out above, **these services should complement a range of accessible but more generic services, such as education, health, social care and leisure services.**

• No single treatment is appropriate for all individuals.

• Effective treatment attends to multiple needs of the individual, not just his/her drug use.

'Principles of Effective Treatment', USA National Institute on Drug Abuse, http://www.nida.nih.gov

Interventions work in different ways for different people at different times.

In specifying particular interventions and approaches there is a danger that the **method** becomes more significant than the **outcome**. When planning services and deciding the most appropriate approach the first consideration should always be '**what are we trying to achieve?**'. Once the desired outcomes are clear it is then possible to decide which **approaches** are likely to be the most effective.

The literature review (EIU, June 2002) commissioned by the Effective Interventions Unit assessed the evidence for effective treatment and care services for drug using young people up to the age of 16 years in the following five key **outcome** 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) demonstrated the 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. Practically all of the studies were conducted in North America or Canada. More detailed information about the studies can be found in the full reports (EIU, June 2002). In this Chapter we draw on the available evidence and other information to set out possible intervention options and key issues to address.

Diversionary and preventative approaches

This Guide and the research commissioned to inform it have focused primarily on intensive support, treatment and care services for young people who have already developed problems with substance misuse. Prevention, education and diversionary approaches were not specifically included within the review. However, it has become clear that it is difficult and perhaps undesirable to establish rigid boundaries between prevention and more intensive treatment and care work, particularly with those young people most vulnerable to developing problems. Findings from the literature review (EIU, June 2002) highlighted the importance of early intervention because improved outcomes were associated with:

Participants at the consultation event were concerned that young people have to reach a **crisis** point before services become available.

- low pre-treatment substance abuse
- reduced psychopathology and
- better school attendance and school performance

It is clear that intervening before problems become critical and entrenched, particular with those young people most at risk, is likely to enhance the effectiveness of the intervention. These early interventions will need to be carefully targeted and delivered in a flexible way that is able to build upon the positive events and protective factors present in a young person's life.

Mechanisms for **natural change and recovery**, particularly as part of the maturing process, may be encouraged by changes in peer group, success at school, structured activities, and support from the family. Substantial numbers of young people will attempt to reduce their drug use themselves, for example by drawing support from friends or family (HAS, 2001). **A skilled therapeutic intervention may be able to harness these existing mechanisms to encourage and support the young person to change without the need for a formal 'treatment' programme**.[3] It may be possible to support the young person to change through providing meaningful and attractive **options** and **diversions** that help to develop capacity for change and resilience rather than concentrating on negative factors and vulnerabilities. This approach should form part of a spectrum of services. It may also form a useful part of more intensive interventions that aim to both address issues and promote alternatives.

Risk reduction services

A small number of young people under 16 may be exposing themselves to very serious risk through **intravenous drug use**. In Scotland adult drug users continue to inject and to share their injecting equipment. In 2000/01 over one third of current injectors in contact with services reported that they had shared injecting equipment in the previous month (EIU April 2002). This exposes individuals to a range of risks, particularly HIV/AIDS and hepatitis. Needle and syringe exchange schemes are seen as an essential part of strategies to prevent the transmission of bloodborne viruses and under 16s may need to access these services. Health Department Letter (HDL (2002) 90) has recently revised guidance on the number of sets that can be given at any one visit to a needle exchange. The HDL acknowledges that some needle exchange clients may be under 16 and it suggests that workers should give due consideration to the particular needs of these clients. The revised Lord Advocate's Guidance states:

> The supply of needles and syringes to be used for injecting controlled drugs is not a criminal offence under statute. However, the existence of common law crimes in Scotland – and in particular the crime of reckless conduct – makes it impossible to say that such supply could never amount to the commission of a criminal offence here. That does not mean that such supply would generally or normally be a criminal offence. The Lord Advocate's view is that the crime of reckless conduct would only arise very exceptionally as regards the supply of needles and syringes by doctors and pharmacists. But to ensure that even the remote possibility of the commission of an offence does not have any inhibiting effect on the special schemes the Lord Advocate has stated that he will not authorise the prosecution of any participating registered medical practitioner (or staff under the supervision of such a practitioner for this purpose and properly authorised by him) in respect of controlled supply in accordance with approved schemes.

The full text of the Health Department Letter and the Lord Advocate's revised guidance is available at http://www.show.scot.nhs.uk/sehd/hdl.asp

[3] Orford suggests that research should be focused on understanding 'basic change processes' rather than concentrating on 'named therapies and therapeutic techniques'. (Orford, 2001)

'Counselling' and behavioural approaches

The design and delivery of counselling services varies significantly. Broadly, counselling encourages the young person to talk about themselves, their feelings, their wider circumstances and their substance misuse. It is primarily delivered on a one to one basis. The intervention requires the young person to be participative and to be able to articulate their feelings. The literature review (EIU, June 2002) found that intensive counselling delivered in a culturally sensitive way was effective in reducing drug use. From the review, less intense health education counselling was not found to be effective in reducing drug use.

Lanarkshire ADAT's '**Review of Services for Under 18s**' (2002) found that the most commonly cited form of treatment and support offered by responding services was **counselling**.

'A great strength of counselling is that it potentially impacts on all relevant aspects of the lifestyle of the young person and not just drug use or misuse.' *The Substance of Young Needs*, Health Advisory Service 2001, p.44.

The EIU research – ***A survey of NHS services for opiate dependents in Scotland*** – found clinicians included a range of interpretations and interventions within the 'counselling' label. These included relapse prevention, cognitive behavioural techniques, motivational interviewing and anxiety management. In general, clinicians hoped that counselling would help clients to define goals, gain an insight into their problems and develop problem solving skills. It was also seen as a way of addressing individual issues, specific personal problems – such as abuse – and enhancing self esteem.

We need greater understanding of the counselling process, and the difference between using broad 'counselling skills' and applying a specific counselling approach. The literature review identified that carefully planned interventions with clear aims, objectives and target audience are more likely to be successful. Clarifying these will be particularly important for counselling interventions if the approach itself is fairly wide-ranging.

The following questions will need to be considered:

- Is the intervention **appropriate, accessible and designed** for young people? For example, are the counsellors trained to work with young people and do they understand the cultural setting in which the young people operate?
- What are the **goals of care**? What is the counselling intervention aiming to achieve with the client? Are these well-understood by the young person?
- Is there **evidence** or reasons to believe that this approach is likely to be effective with this client group? If there is little existing evidence then it is critical that the therapist is involved in designing an appropriate **evaluation** of the intervention.
- What is the optimum **length** for the counselling process? How and when will the end point be agreed and the client supported to move on?
- Is there clear and regular managerial and non-managerial **supervision** available for the counsellor? The close relationships developed during the counselling process will place particular demands on staff and they will need established mechanisms to receive support and guidance.
- **Confidentiality** – and the limits to confidentiality – need to be clearly understood and agreed between the counsellor and the young person.

A number of literature reviews, in both the drugs and alcohol fields, have broadly found psycho-social interventions – including cognitive behavioural therapy, brief interventions,

relapse prevention and '12 step' programmes – to be effective in reducing drug use. However, it can not be assumed that approaches that work for adults will work the same way for young people.

Effectiveness does appear to vary amongst the different approaches. The literature review (EIU, June 2002) found fairly strong evidence that **behaviour therapy** and **cognitive behaviour therapy** were more effective than counselling in reducing drug use. Studies found that young people responded more positively to behaviour therapy than adults. There was also limited evidence that behaviour therapy would also have a positive impact on psychological well-being, school work, school attendance and family relations.

Working with families

The literature review (EIU, June 2002) found good evidence that family therapy and other family interventions are effective in reducing drug use, psychological problems and family and social problems. However, the literature recognised the diversity of family therapy and there is a lack of evidence as to which type is most effective. Nonetheless, there was evidence that **involving parents in the therapeutic process improved outcomes**.

The **Rushes** team helps to coordinate work with families. The Rushes 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. (EIU, June 2002)

Although the literature review identified positive results for 'family therapy', it is clear that this is not being offered systematically in Scotland at present. *For Scotland's Children* identifies the need for specially skilled and trained workers who are able to work with families to effect positive change in the lives of children. It states 'a much more robust and change-orientated approach to working with families is generally seen to be required'.

The 'Substance of young needs' (HAS, 2001) says 'some, often adult orientated services or professionals are reluctant to engage parents because of possible issues of confidentiality and the theoretical possibility of reduced engagement of the young person. However, it is important to assess family functioning and communication with the aim to help and support the family (this may be by another service), allow individuation and maturation of the child, and reframe parents' anxieties'.

Pharmacological therapies

'Pharmacotherapy is directed at a number of specific areas: treatment of overdose in emergencies, detoxification, substitution or maintenance therapy, adjuncts to relapse prevention as well as treatment of co-morbid disorders. It should be used in conjunction with a comprehensive plan incorporating a variety of individual interventions (education, psychotherapies) designed to meet the needs of the young person' (HAS, 2001).

The literature review (EIU, June 2002) did not include any studies that demonstrated the effects of substitute prescribing, such as methadone, for young drug users. The wider research similarly found that prescribing to under 16s was very rare in Scotland. The decision to prescribe substitute medication, such as methadone, to under-16s needs to be taken extremely carefully and with full consideration of the implications for the young person.

Drug Misuse and Dependence – Guidelines on Clinical Management (1999) sets out principles of good practice in caring for young drug users to medical practitioners, particularly those working in general practice. These include some points relevant to prescribing decisions such as:

- The practitioner should involve other children's and young people's services and substance misuse services;
- Interventions should follow a comprehensive assessment of need, developmental maturity, family factors and the risk of substance-related harm;

The document makes specific recommendations in relation to prescribing for young drug users:

- Since a person under 16 is unlikely to fully understand the implications of being prescribed controlled drugs, doctors should avoid doing so unless they have first sought explicit consent from a person with parental responsibility for the young person.
- Even with consent, it is recommended that controlled drugs should only be prescribed to a young person after a full assessment and supervision by a specialist.
- Generalists, including child psychiatrists, should not prescribe substitute drugs without either specific training or formal liaison with a drug misuse treatment specialist.
- Longer-term or 'maintenance' prescribing is not recommended.
- The pharmacist should be informed in writing if a parent or guardian is to supervise the consumption of the drug. This arrangement should be agreed prior to the commencement of the prescription by all parties.
- If possible, where family supervision is not available, daily supervised consumption should be arranged with the community pharmacist, with clear dispensing instructions.

The Guidelines also highlight that:

- Drug misuse, even with some significant dependence, is not in itself an indication to prescribe substitute medication.
- Regular but not daily, non-dependent injecting of opiates is not necessarily an indication for prescribing substitute medication.

The spirit of the Guidelines and other advisory material suggests that prescribing to under-16s should be a highly unusual occurrence that is only undertaken in the most extreme circumstances. It is absolutely vital that any decision to prescribe is taken as part of a multidisciplinary approach that includes a range of psychological, social and medical interventions. Nonetheless, a very small number of young people may benefit from stabilisation on methadone and occasions may arise when this is necessary.

The HAS report (HAS, 2001) suggests that 'the majority of adolescents are not dependent and so do not generally require detoxification'. The report also highlights that the '*pharmacological management of young drug users is faced with considerable difficulty. Many of the medications are not licensed in children. Thus, treatment is based on clinical acumen, and extremely careful monitoring by trained staff in conjunction with parents/carers*'.

Key Action Areas

From our evidence gathering and consultation activities, we have identified the following areas for action:

Needs assessment:

DATs will need a clear understanding of the needs of the young people in their area. This will require the DAT and partner agencies to:

Commission a needs assessment to

- **assess and map** the number and needs of young people involved in drug misuse
- understand the **type of drugs** involved and the pattern of use
- establish which services young people are likely find **most accessible**
- identify **gaps** in services
- **map** potential partner agencies - particularly those specifically targeted at young people

Build routine mechanisms for gathering information about changing trends and need and mapping service to identify changes in accessibility and service delivery

Understanding young people's needs and rights:

Drug misuse problems are rarely the only problem experienced by a young person and they are often not the problem that provokes the involvement of services. Young people may have some specific needs, particularly around the long term social impact of their problems, their vulnerability to harm and their comprehension of risk. DATs, partner agencies and service providers should

create services **specifically designed** for young people rather than 'cut down' adult services.

train staff to **understand and implement the legal rights** of young people themselves, their families and carers.

throughout the care process, **establish the possible role of parents** but make sure that the young person's views inform this process.

consider the circumstances where **treatment without parental consent** might be justified.

Making services accessible:

It will be crucial that young people see services as relevant and available. For DATs, partner agencies and service providers this means

relevant people + relevant places + relevant times = relevant services

involving young people in the planning, management and review of services to make sure that they are young person friendly'

considering carefully when and where services are offered, and taking account of issues such as territoriality, accessibility, confidentiality and the need to avoid stigmatising clients.

finding, keeping and supporting the right staff

An effective assessment process:

Identifying the range of needs and aspirations of the individual young person is essential to inform decisions about treatment, care and support. Agencies and service providers need to

develop an **open, accurate, participative and comprehensive** assessment process to identify the areas for change.

use assessment tools that are **fit for purpose** to structure parts of the process **but** not as a substitute for building a relationship of trust with the young person

Building in structured evaluation:

Evaluation is essential to develop our understanding of what works with this client group at a national, local and service level. DATs, partner agencies and service providers need to

commission and plan evaluations as an **integral part** of service development

put in place **structured evaluation activities**, built on routine monitoring data and accurate baseline information, to inform service development and lead to improved outcomes for clients.

draw upon data gathered as part of individual client assessments and consider how to **store, sort and analyse** this information, taking account of Data Protection

establish **structured processes of monitoring** and regular review within individual services and across partnerships

Planning across a range of needs and services:

Given the likely range of needs and the number of potential outcomes, the process of intervening with a vulnerable young person is likely to require the involvement of a wide range of agencies and service providers. DATS and partner agencies should

ensure that clear mechanisms exist for **involving representatives** from children and young people's services in the planning process.

consider a model which sets out the responsibilities of universal and specialist/targeted services and establishes **care co-ordination, information-sharing and assessment arrangements.**

put in place a range of processes and protocols to underpin **partnership working**.

look across the range of services in the area – education, health, social care, youth justice, leisure - and seek to develop **a network of professionals** that can provide a co-ordinated approach to meeting young people's needs.

Deciding on the range of interventions:

We know that interventions work in different ways for different people at different times. Agencies and service providers should

start with the desired **outcome** and identify interventions that are effective in delivering it.

carefully plan interventions with clear **aims, objectives and target audiences**.

consider **diversionary** programmes to build on and support natural processes of change and recovery, particularly before problems become entrenched.

Needle and syringe exchange schemes are an essential part of strategies to prevent the transmission of bloodborne viruses and under 16s may need to access these services.

develop a greater understanding of the **counselling process**, and the difference between using broad 'counselling skills' and applying a specific approach, such as behaviour therapy.

explore the use of **family therapy** and other family interventions; and the involvement of parents in the therapeutic process.

ensure that decisions about **prescribing substitute medication**, such as methadone, to under-16s are taken as part of a multidisciplinary team, and with full consideration of the implications for the young person.

Appendix 1: Reference Group Membership

Reference Group on Treatment Services for Young People

Mike Brown	Social Work Services Inspectorate, Scottish Executive
Dr Stephen Burniston	York Consulting Limited
Iain Cowden (until 08/02)	Social Work Services Inspectorate, Scottish Executive
Gerry Hart (wef 08/02)	Social Work Services Inspectorate, Scottish Executive
Dr Lawrie Elliot	Dundee University
Lis Hill	Tayside Drug and Alcohol Action Teams
Neil Hunter (until 06/02)	Glasgow City Council Addiction Services
Gemma McNeil (wef 06/02)	Glasgow City Council Addiction Services
Gordon Irvine	Scottish Children's Reporter Administration
John McCaig	HM YOI Polmont
Jackie McRae	Women and Children's Unit, Scottish Executive
Mike Baxter	Young People and Looked After Children, Scottish Executive
Dr Nicola Richards	Lloyds TSB Foundation for Scotland
Dr Sarah Sieley	CORA House
Ray de Souza	City of Edinburgh Council
Graham McKinnon	Who Cares? Scotland
Dr Hugh Whyte	Primary Care Division, Scottish Executive
Peter Willman	Children and Family Support, Scottish Executive
Patricia Russell	Effective Interventions Unit, Scottish Executive
Nick Bland	Effective Interventions Unit, Scottish Executive
Isabel McNab	Effective Interventions Unit, Scottish Executive

Appendix 2: Seminar delegates

Young People's Treatment Consultation Seminar Delegates

Derek Aitken	Dundee City Council
George Allan	Aberdeenshire Council
Kathryn Baker	Tayside Council on Alcohol
James Black	Drugs Action, Aberdeen
Nick Bland	Effective Interventions Unit
Dr Stephen Burniston	York Consulting Limited
Helen Burns	Alternatives, West Dunbartonshire
Mike Burns	Dundee Drug and AIDS Project and The WEB, Angus
Mike Cadger	Crew 2000
Ann Marie Campbell	Greater Easterhouse Community Health Project
John Chalmers	Fife Youth Drug Team
Valerie Corbett	Aberlour Child Care Trust
Dennis Ferrier	St Phillips School
Elspeth Findlay	Good Shepherd Centre
Peter Flanagan	Barnardo's Aberdeenshire
Grace Fletcher	St Johns Residential School
Phil Forbes	Bridge Project, Ayr
Kay Geddes	Aberdeen City Council
Lloyd Girling	Perth Connect
Lis Hill	Tayside Drug and Alcohol Action Teams
Rhona Hunter	HYPE, Edinburgh
Neil Hunter	Glasgow City Council Addiction Services
Gordon Irvine	Scottish Children's Reporter Administration (SCRA)
Marion Logan	Forth Valley Health Board
Dr John Loudon	Public Health, Scottish Executive
Iain MacDonald	Highland Mentoring Project, NCH Scotland
John McCaig	HM YOI Polmont
Isabel McNab	Effective Interventions Unit
Graham McPhie	Aberlour Child Care Trust
Janice Munro	Fife Youth Drug Team
Ann Nelson	HM Young Offenders Institution Polmont
Leona Paget	Clackmannanshire Council
Jayne Reed	HYPE, Edinburgh
Dr Nicola Richards	Lloyds TSB Foundation for Scotland
Patricia Russell	Effective Interventions Unit
Eileen Ruthven	CORA St. Mary's Kenmure
Dr Sarah Sieley	CORA House
Iain Sneddon	NCH Scotland
Bruce Thomson	Aberlour Outreach Services
Jennifer Tocher	Dundee City Council
Gillian Turner	Rushes
Eric Watson	Barnardo's
Moira Whyte	Careers Scotland Centre

Appendix 3: Consulting Young People

Extract from *Walk the Talk*, 2000

Ascertaining the views, needs, and concerns of young people is crucial to the delivery of relevant services. However, it can be difficult to know where to start. There are many different methods of consultation, as outlined in Consulting Consumers: A Guide to Good Practice for the NHS in Scotland (1999). Consulting young people can bring particular challenges, and often requires the adoption of a variety of approaches. There is no magic key that unlocks the door to what young people think about services. If you don't succeed by using one approach, try another. At a glance, here are some of the things you should be thinking about:

Method of Consultation	Benefits	Drawbacks	Checklist for Success
Questionnaires - written forms sent to representative sample	• It's quick • Can get both quantitative and qualitative data	• Requires literacy • Low returns • Poor qualitative data	• Forms that are easy to read and fill in • Freepost envelopes • Incentive such as a prize draw • Feedback results to young people
Focus Group - single meeting held with small (up to 10) group of the representative sample	• Elicits good qualitative data • Young people feel involved and listened to	• Time-consuming • Low turnouts • Processing data is more difficult	• Work in partnership with youth agencies • Incentive to attend • Be neutral while interviewing • Guarantee confidentiality • Feedback results to young people
Face to face interviews - verbal questioning with single representative of sample in meeting	• Can get more complete data • Can tackle more sensitive subjects	• Dependant on personality of interviewer • Time-consuming	• Work in partnership with youth agencies • Incentive to attend • Be neutral while interviewing • Guarantee confidentiality • Feedback results to young person • It is worth remembering Child Protection issues when interviewing under 16s
Telephone Interview - verbal questioning of single sample representative over the telephone	• Quick and easy • More complete response than questionnaires	• Not all young people have access to telephones • Difficult to build up rapport • More errors	• Make sure questions are clear • Check that timing is convenient for young person • Feedback results to young person
Young User's Panel - regular meetings with group of representatives from sample	• A useful sounding board for ideas • Can involve young people in design of services in quite a meaningful way	• The group will require support which can be time consuming • Difficulties in recruiting and retaining young people for this group	• Work in partnership with youth agencies • Make provisions for support of group • Consult regularly with group • Regular information updates

Appendix 4: Lanarkshire Staged Intervention Model

The table below describes the development agenda for Youth Health Services at all levels in Lanarkshire, based on the framework set out in *For Scotland's Children*. The approach could be used to plan appropriate integrated interventions in relation to Youth Health priorities (Alcohol/Drugs, Sexual Health and Mental Health) and responds to the need for clinical services to be in **relevant places** at **relevant times** and delivered by **relevant people** (Walk the Talk, 2000). Flexibility is required between level two and three in relation to the location and setting of the service delivery. The plan for the future is to provide clinical 'services' in schools including 'hands on' care for all children and young people who have a need of them. The model requires inter-agency co-operation to ensure effective provision of integrated services. The model is intended to be responsive to the expressed needs of young people to enable early detection, early intervention, and support a holistic, inclusive and integrated approach.

	Level of Intervention	Setting	Agencies / staff	Target group
Level 1	Universal Provision Information, Education, training, consultation	Schools, Health Promotion, Youth services	Schools Nurse, Youth Health Promotion Team, Teachers	Universal Population
Level 2	Access to supports and general health services	Health Centres, Youth Provision – non traditional settings	Specialist services	Vulnerable population
Level 3	Access to specialist services/ Interventions	Health Centres, Youth Provision, Hospitals, relevant places	Health Specialist services – CAMHS, GUM, **Addictions	At risk & socially excluded population
Level 4	Access to hospital services Treatments-residential/ Rehabilitation services	A & E & Other **No services in Lanarkshire	Relevant Acute sector staff	Young people who are on the margins between child & adult health provision

** No such services exist at present for young people (current developments with Lanarkshire ADAT Young Person sub group).

The Staged Intervention model should include the following services / approaches:

- Information, advice and guidance services – web based, one to one and groupwork.
- Drop-in / walk in services, conferences, seminars, training, health promoting social events that engage young people in a creative way.
- Advocacy work by staff to involve young people to increase informed choices and assist communication with other agencies with and on behalf of young people.
- Support and outreach programmes delivered jointly with a range of agencies to assist young people to cope in the community and remain at home with their families.
- Cognitive behavioural programmes to tackle rehabilitation and build links to relevant community based services.
- Well-being groups – Youth Substance Misuse workers working jointly with Health Professionals to take an overall preventive and supportive approach to child protection.
- Harm Reduction programmes – using one to one, groupwork and a range of methods working closely with Community Addiction and Social Work teams.
- Potential to work with single sex groups, focussed age groups, target provision at the most vulnerable or at risk groups and specific client groups.

For more information contact: Kate Bell, Youth Health Services Manager, Lanarkshire Primary Care NHS Trust.

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Policy documents

Scottish Executive publications:

- *It's Everyone's Job to Make Sure I am Alright* Child Protection review (November 2002)
- *Protecting Patient Confidentiality* (April, 2002)
- *Scotland's Action Programme to Reduce Youth Crime* (January 2002)
- *For Scotland's Children: Better integrated children's services* (October 2001)
- *Getting Our Priorities Right: Policy and practice guidelines for working with children and families affected by problem drug use* (consultation document issued September 2001)
- *Implementing Inclusiveness: Realising Potential* (Report of the Beattie Committee, Scottish Executive 1999) The Beattie Committee work on post-school education, training and employment for young people who have social, emotional and behavioural problems included the development of a digest of assessment tools: www.scotland.gov.uk/library3/education/ilsn.pdf.

These publications should all be available on the Scottish Executive website: http://www.scotland.gov.uk/

Effective Interventions Unit publications:

Support for the Families of Drug Users - A Review of The Literature (EIU November 2002)

Supporting Families and Carers of Drug Users: A Review (EIU November 2002)

Integrated Care for Drug Users: Principles and Practice (EIU October 2002)

The effectiveness of treatment for opiate dependent drug users (EIU July 2002)

A Survey of NHS Services for opiate dependents in Scotland (EIU July 2002)

Drug Treatment Services For Young People - A Research Review (EIU June 2002)

Drug Treatment Services For Young People - A Systematic Review of Effectiveness & The Legal Framework (EIU June 2002)

Hepatitis C: Risks and Prevention Strategies in Injecting Drug Users - Research Review (EIU April 2002)

These publications and the series of EIU **Evaluation Guides** are all available on the EIU section of the ISD drug misuse website: http://www.drugmisuse.isdscotland.org/

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