

**Report to Health Services Executive Regional Drug
Coordinating Office (Waterford) on recommendations
for developing adolescent substance misuse treatment
services in the region**

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ADDICTION RESEARCH CENTRE, TRINITY COLLEGE DUBLIN

The aim of the Addiction Research Centre, which was established in 2000, is to provide a source for independent debate and critical research into the prevention and treatment of drug and alcohol related problems in Ireland. The Centre is sponsored by the School of Social Work and Social Policy, which has been centrally involved in drug and alcohol issues through the Diploma in Addiction Studies, a one-year multi-disciplinary course that has run annually since 1984 and the M.Sc. in Drug and Alcohol Policy, a post-graduate course specifically aimed at policy makers and administrators that was established in 1998. The Centre has three specific objectives as follows:

1. **Academic research:** To undertake and support academic research aimed at contributing to society's knowledge of drug, alcohol and addiction problems.
2. **Policy and practice evaluation:** To undertake commissioned evaluation of drug and alcohol prevention, treatment, and rehabilitation services and policies.
3. **Research and policy interface:** To organise an annual conference, bringing together practice, research and policy personnel from universities and other bodies to engage in public debate on drug, alcohol and addiction issues.

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EXECUTIVE SUMMARY

This report was prepared by the Addiction Research Centre for the Health Services Executive Regional Drug Coordinating Office, Waterford, and is part of a wider study of substance misuse problems and policy implementation in the region. The report is concerned with developing a treatment framework for responding to adolescent alcohol and drug problems in the four local areas in the HSE southeast (Carlow / Kilkenny, South Tipperary, Waterford and Wexford). In each of these areas there is a substance misuse team consisting of a substance misuse coordinator, an education and training officer and addiction counselor or counselors. There are also a number of community-based drug initiatives funded through *Youth Facilities and Services Fund*. Each area also has alcohol and drug counselors as part of mental health teams.

The report builds on the *Report of the Working Group on Treatment of Under 18 year olds presenting to Treatment Services with Serious Drug Problems* (referred to as the *Under 18s Report*), which advocated a 4-tier model of service delivery, corresponding to primary prevention, secondary prevention, specialist treatment and extra specialist (residential) treatment. Specifically the southeast report addresses issues and recommendations in the implementation of the four-tier framework within the southeast. One issue of overriding concern is preserving a regional policy and strategic commitment to integrating alcohol and drugs within a single intervention framework .

Alcohol, and to a lesser extent cannabis use are regarded as the most pressing substance misuse problems in the region. In supporting this report the Regional Drug Coordinating Office wished to ensure that as well as providing a methadone treatment protocol for the small number of adolescents in the area who present with opiate problems, a treatment framework should also include adequate provision for responding to the broader needs of adolescents with alcohol and non-opiate drug problems, and to map out how such provision could be developed through its area teams and community-based projects.

There are two key components to the southeast report: (1) a review of relevant literature on adolescent needs, substance misuse pathways and intervention outcomes, and (2) a summary of the main issues arising from area-based consultations involving personnel working in relevant HSE and community services. The report also includes three main and two secondary recommendations on the service development, namely (1) a dedicated tier-2 adolescent area-based service; (2) a tier 2-3 family intervention programme; (3) a tier 3-4 specialist, day centre service; (4) an expansion of tier-1 community based drug initiatives; and (5) extensive all-tiers in-service training.

A preliminary presentation of the main findings of this report were outlined at a regional seminar held in Kilkenny in early July, 2006. The findings and the report have now been updated taking account of these seminar discussions.

The report's main findings are as follows:

- Alcohol, and to a lesser extent drug use, play an important role in adolescent development and identity formation and there is a normal adolescent alcohol and drug use pathway. Most young people who consume alcohol and drugs, even in large quantities, mature out of this behaviour, without external assistance. This has important implications for both the work of community and youth support personnel and the role of specialist treatment agencies.
- Normal pathways of adolescent alcohol and drug use present short, medium and long-term risks and harms for young people. The most effective strategies for minimizing these risks are population-based policies aimed at reducing the overall consumption of and access to alcohol and drugs in society, and at enforcing regulation where these apply. Community organizations and treatment agencies can play a mobilizing role in supporting general population measures aimed at reducing supply and consumption, but measures aimed exclusively at sub-group behaviours such as adolescent binge-drinking – in the absence of more broadly-based measures - could be perceived as blaming and be counter-productive.

- There is relative satisfaction with the investment in tier-1 measures supporting such mobilization in the southeast, but there are concerns around the need for more community services, particularly in rural areas and also that the knowledge base of persons in community and primary care services needs further development and improvement.
- Pathways to problematic alcohol and drug use are complex; there are multiple risk factors and various risk combinations can result in problems thus making it difficult to predict their onset, and also making it difficult for community agencies to assess their seriousness and to evaluate the impact of and outcomes from their intervention efforts. This suggests the need for improved assessment and screening specifically aimed at identifying adolescents who are using alcohol and / or drugs as a coping mechanism for dealing with life stresses and anxieties. It also suggests the need to put more effort into adapting and utilising interventions that have a demonstrable evidence-base.
- Early intervention strategies need to focus on mobilising family, school and relevant proximal neighbourhood supports in order to help re-affirm family and social attachments, improve personal, social and school functioning and divert from alcohol and drug use in order to bring about a return to normal functioning.
- An escalation in problematic alcohol or drug use towards the development of dependency or serious impairment of health or social functioning suggests the need for more specialist service, especially where this is co-related with other problems involving education, justice or child care systems.
- There is a very robust literature supporting the efficacy and effectiveness of substance misuse interventions; a cluster of interventions utilising behavioural therapies, motivational counselling, systemic and family therapies are well referenced and supported. However, standard interventions particularly 12 steps programmes in US and also in Ireland, do not reflect this evidence base; this issue is widely commented on by reviewers in the field.
- Standard models of specialist adult substance misuse treatment show little evidence of efficacy or effectiveness when adapted to adolescents who are often

- reluctant to participate in programmes they perceive as labeling, or as reinforcing addict-identities and as not reflecting their developmental needs and situations.
- There is quite a lot of frustration in relation to tier 2-4 services in the southeast; there is a general sense that tier 2-3 services lack investment and that it is hard to access services that exist, albeit nominally, at this level. Tier 4 residential service is perceived as not suitable for those adolescents who are seen as most in need of intensive interventions.
 - Adolescent-specific interventions are clearly indicated. These should emphasise motivation - supporting the adolescent to take control of their behaviour. The idea of a dedicated adolescent service is suggested and this would include personnel who are familiar with adolescent developmental needs and are able to work in an engaging, friendly manner with young people while maintaining focus on therapeutic tasks and structures. Such personnel could also potentially operate as keyworkers, supporting the young person through other interventions and programmes as appropriate, and also coordinating interventions across the different tiers.
 - Family-based interventions, as an alternative to adult, addict-identity specialist models have a strong evidence base supporting the use of systemic and family therapies in focusing on family dynamics – rather than addiction, alcohol or drugs – in bringing about sustainable change.
 - A specialist day-centre programme as an alternative to residential placement is suggested. The centre should have multiple social, educational as well as therapeutic components and should also have options for once-off and short-term (2-3 days) residential work to assist time-out or respite.
 - It is suggested that a comprehensive programme of in-service training across the range of community and specialist providers be developed. Such training could focus on updating personnel on research and practice innovations in adolescent substance misuse and also to develop skills in screening, assessment and brief interventions.

1. INTRODUCTION

This report was prepared for the Health Services Executive (HSE) Regional Drug Coordinating Office (RDCO), Waterford, to assist it in developing a treatment framework for responding to adolescent alcohol and drug problems in the HSE – southeast area (HSESEA). Problems relating to alcohol and drug consumption are not peculiar to adolescents but are prevalent in all age groups and sections of the community. Although public discourse can oftentimes focus almost exclusively on young people’s alcohol and drug use such as binge drinking and related problems such as drug crime, social disorder and car accidents, it is important to emphasize that these issues and problems require wider societal responses, and that strategies dealing with young people’s substance misuse need to be reflected in, and be consistent with broader alcohol and drug policies.

Notwithstanding the need for wider societal responses, an adolescent-specific response to substance misuse is also indicated. Initiation into both alcohol and drug use happens primarily during youthful years and the use of illicitly-obtained drugs is primarily a youth phenomenon. Furthermore, problems arising from the misuse of drugs can have adolescent-specific effects, and may, in particular, jeopardize the achievement of important developmental tasks, thereby contributing to social, inter-personal, family and addiction problems in young adulthood and later¹. For these reasons, it is important that young people’s problematic use of alcohol and drugs be considered an important challenge for all agencies and services concerned with young people and their development and that more specific responses to these problems be given separate attention in a substance misuse treatment framework.

1 Newcomb, M. D., Bentler, P. M. (1988) “The impact of adolescent drug-use and social support on problems of young adults – A longitudinal study” *Journal of Abnormal Psychology*, 97 ((1), 64-75.

Under 18s Report

This Report was undertaken following the publication of the *Report of the Working Group on Treatment of Under 18 year olds presenting to Treatment Services with Serious Drug Problems*² (referred to below as the *Under 18s Report*), which advocated a 4-tier model of service delivery, corresponding to primary prevention, secondary prevention, specialist treatment and extra specialist (residential) treatment. The 4 tier model may be summarised as follows:

Tier 1: *Universal – generic and primary care services*: provision of primary information/education, general medical screening and screening across lifestyle issues and related risk behaviours, identification of risk, referral and generalised family support and advice.

Tier 2: *Youth-oriented services offered by practitioners with some drug and alcohol experience and youth specialist knowledge*: targeted groupwork and activity programmes for at-risk persons, counselling on lifestyle issues (harm reduction), parenting programmes and risk assessment.

Tier 3: *Services provided by specialist teams*: specialist assessment leading to a planned package of care and treatment that would augment other services already provided or available at Tiers 1 and 2.

Tier 4: *Very specialised services*: Short-period of residential care during crisis; inpatient / day psychiatric or secure unit to assist detoxification if required. Continued multi-agency involvement across Tiers, 1, 2, and 3.

In addition to this tier outline the *Under 18s Report* also draws together key service principles for working with children and young people, highlighting the intrinsic differences between children and adults and the need for services to be designed and operated within a child developmental model. In this sense substance misuse services for children and adolescents should not be simply an extension of existing adult services. It was envisaged that an adolescent framework would contribute to greater integration with other child and adolescent services who would share knowledge and an appreciation of the ethical and legal issues that are underlined in child welfare and child protection legislation. An understanding of issues concerning consent, confidentiality and the application of protocols for communicating with other agencies and for maintaining case records are all considered important. Service principles concerning comprehensiveness,

2 Report of the Working Group on Treatment of Under 18 Year Olds Presenting to Treatment Services with Serious Drug Problems (2005), Dublin: Department of Health and Children

integration, competence and accessibility are also highlighted; a more detailed outline is available in the *Substance of Young Needs*³, the 2001 UK report that developed the 4 tier model. This latter report also suggests that the 4-tier model needs to be dynamic and flexible and coordinated in order that services and interventions are able to adapt to the variable and changing needs of young people and their families. Consequently the tier outline does not define specific disciplines or agencies needed at any particular level, but rather emphasizes the functions at these levels, and promotes integration across different health and social care sectors, agencies and disciplines, thus promoting comprehensiveness in assessment.

Concerns about alcohol and cannabis use

The *Under 18s Report* arose from Action 49 of the *National Drug Strategy, 2001-2008*, (NDS)⁴ which underlined the need for a treatment protocol for young persons with serious opiate problems presenting to methadone services, a need that arose primarily in Dublin and surroundings, as opiate problems generally, and methadone services, are concentrated there. In the south east region however, alcohol, and to a lesser extent cannabis use are regarded as the most pressing substance misuse problems⁵, and the region's experience of dealing with these problem reflect an emerging political concern about an escalation in adolescent alcohol⁶ and cannabis⁷ use in Irish society As reported by *European Schools Project on Alcohol and other Drugs (ESPAD) (2003)*⁸ Ireland leads

3 Gilvarry, E. (2001) (lead ed.) Review 2001: The Substance of Young Needs, London: Health Advisory Service (available [ww.dpas.gov.uk](http://www.dpas.gov.uk))

4 Department of Tourism, Sport & Recreation (2001) Building on Experience: National Drugs Strategy, 2001-2008, Dublin: Stationery Office.

5 Long, J., Jackson, T. Kidd, M., Kelleher, T., Sinclair, H., (2004) Treatment demand for problem alcohol use in the South Eastern and Southern Health Board areas, 2000 to 2002 Occasional Paper No. 10, Dublin: Drug Misuse Research Division (Health Research Board)
Regional Drug Coordination Unit (Health Services Executive) (2006) Overview of Drug Misuse report (2004), Waterford: Author.

6 Joint Committee on Health and Children (2004) Report on Alcohol Misuse by Young People, Dublin: Stationery Office.

7 Joint Committee on Arts, Sport, Tourism, Community, Rural and Gaeltacht Affairs (Ninth Report) (2006) What Everyone should know about Cannabis, Dublin: Stationery Office.

8 Hibell, B., Andersson, B., Bjarnasson, T., Ahlstrom, S., Balakireva, O., Kokkevi, A., Morgan, M. (2003) The ESPAD Report: Alcohol and Other Drug use Among Students in 35 European Countries, Stockholm: The Swedish Council for Information on Alcohol and Other drugs (CAN) and The Pompidou Group at the Council of Europe.

Europe and the US in levels of adolescent binge drinking (32%), levels that increased by 39% between 1995-2003. Over the same period a 11% increase in lifetime cannabis to 39% and a 42% increase in recent cannabis to 17%, is also reported. Figures, which are presented in an Appendix to this report, highlight the following:

- adolescent alcohol use is widespread in Irish society;
- adolescence rather than young adulthood is the significant point of initiation into alcohol use;
- only UK and Ireland in ESPAD and US Monitoring the Future (MTF)⁹ surveys consistently show high levels of *both* alcohol and cannabis use among adolescents; and
- levels and patterns of adolescent cannabis use are similar to US where adolescence rather than young adulthood has become the significant point of initiation.

Joint focus on alcohol and drugs

In the southeast area, the HSESEA has consistently argued the need for a joint focus on both alcohol and drugs through a substance misuse framework¹⁰ a position that has been adopted by other regional groups¹¹ and is also increasingly supported politically¹².

Currently, the RDCO has overall responsibility for substance misuse services in the south-east; this includes four area substance misuse teams (Carlow / Kilkenny, South Tipperary, Waterford, and Wexford) consisting of an area coordinator, education and prevention officer and addiction counselor(s); the RDCO also has responsibility for providing support and funding to local projects (community-based drug initiatives), which are funded under the *Young People's Facilities and Services Fund*, and also to

9 Johnston, L. D., O'Malley, P. M., Bachman, J. G., Schulenberg, J. E. (2004) Monitoring the Future; National Survey Report on Drug Use, 1975-2003, Volume 1: Secondary School Students, NIH Pub. No. 004-5507. Bethesda, MD: National Institute on Drug Abuse.

10 South Eastern Health Board (2001) South Eastern Health Board Regional Treatment and Rehabilitation Working Group Recommendations, Waterford: Author.

11 Walsh, F., Comer, S. (2005) Shared Solutions: First Strategic Plan of the Western Region Drugs Task Force Produced, Castlebar: Western Region Drugs Task Force

12 Joint Committee on Arts, Sport, Tourism, Community, Rural and Gaeltacht Affairs (Ninth Report) (2006) The Inclusion of Alcohol in a National Substance Misuse Strategy, Dublin: Stationery Office.

non-psychiatric residential projects, which are funded through Section 65 grants, as well as through private and other sources. Adult psychiatric services are also involved with substance misuse, providing services primarily, but not exclusively, to persons with co-related psychiatric diagnoses.

Evidence-based psychosocial interventions

It was partly in order to maintain its joint focus on alcohol and drugs with respect to adolescents that the RDCO commissioned this current report. More importantly, the RDCO was concerned to appraise its options in developing interventions for adolescent substance misuse; while it supported the broad thrust of the 4-tier service framework, it wished to ensure that as well as providing a treatment protocol for persons with serious opiate problems that the framework also included adequate provision for responding to the needs of adolescents with alcohol and non-opiate drug problems, and to map out how such provision could be developed through its area teams and community-based projects. A key feature of the report below therefore, is an examination of evidence-based psychosocial interventions with respect to adolescent substance misuse generally, as distinct to under 18s opiate use more specifically.

Adolescent substance misuse pathways

A second feature of this report is that this exploration of psychosocial interventions gives consideration to both normal and problematic substance misuse pathways. Paths to use and misuse of alcohol and drugs are complex; adolescents with similar life and social experiences can and do develop alternative pathways¹³. It may not always be possible

13 Mayock, P. (2000) Choosers and Losers, Dublin: Children's Research Centre, trinity College.

therefore to differentiate normal and problematic pathways¹⁴; associated problems such as dependency do not lend to standard adult diagnostic criteria¹⁵ so the notion therefore that there are set patterns of adolescent alcohol and drug use that provide clear evidence of current or future problems is misleading. This obviously has implications for practitioners, as it may not always be clear as to when, how and with what purpose they intervene to prevent or treat substance misuse problems, or indeed to evaluate whether their interventions have lessened or made worse the supposed problems. On the one hand caution and a sense of intervention restraint may be required; on the other there is a belief that intervention could potentially avert problems that impair the adolescent's development and future life prospects.

Addressing this balance in risk assessment is a key issue for practitioners, particularly those who operate within primary and secondary preventive services. One approach to this difficulty is to consider two general pathways, with alternative responses focused on indirect support and more directive interventions: the first pathway – discussed in section 2 below - associates alcohol and drug use with normal adolescent development although there is the possibility that for some persons use of alcohol and drugs can also cause problems; in the other pathway use of alcohol and drugs is not associated with normal adolescent but rather arises as a way of coping with life or social stresses, thereby contributing further to problems, necessitating treatment interventions. This pathway and associated interventions is discussed in section 3.

Regional consultation

A third feature of the discussion below is that it reports on a consultation held across the southeast region; this consultation included specific discussions with regional and sub-regional (local health area) substance misuse coordinators and also drew from cross-

14 Newcomb, M., Bentler, P. M. (1989) "Substance use and abuse among children and teenagers", *American Psychologist*, 44, 242-248.

15 Martin, C. S., Winters, K. C. (1998) *Diagnosis and Assessment of Alcohol Use Disorders Among Adolescents*, *Alcohol Health Research World*, 1999, 20: 203-224.

discipline, inter-agency, sub-regional focus groups. Participants included personnel from mental health, child psychiatry, psychology service, social work, substance misuse teams and community drug and youth projects; in all 50 persons (approx.) participated. Many of those consulted were very familiar with the 4-tier model, and had little overall criticism. These focus groups were pre-structured to consider the prospective implementation of the 4-tier framework, which was presented as a given, within the context of responding to broad adolescent substance misuse problems. The discussion below therefore draws from this consultation in exploring how the 4-tier framework could be operationalized within the region.

REPORT OUTLINE

In addition to this introduction there are four further sections to this report. First there is a consideration of a normal adolescent alcohol and drug use pathway; this helps to underline the importance of alcohol and to a lesser extent drug use in adolescent development and identity formation and also draws attention to options available to mainstream and tier 1 community and primary care services in preventing an escalation of use and of related harms, within the overall context of broader population measures. The second section focuses on problematic alcohol and drug use, exploring both early intervention and more intensive treatment programmes. The discussion identifies that adolescent-specific interventions are at a relatively early stage of knowledge-development; a review of evidence of treatment outcomes is provided and this gives particular attention to the importance of family based interventions, alongside pragmatic behavioural therapies, in tackling substance misuse problems. Section 4 reports on the consultation held with personnel from HSE and other agencies in the southeast area. As already mentioned this consultation was premised on a broad acceptance of the 4-tier framework and the discussion focused on issues arising in the implementation of this framework within the region. The consultation report therefore follows the 4-tier structure and identifies a number of key issues relating to service development within

each of the four tiers. Finally, there is an outline of recommendations arising from the discussion in this report.

2 ADOLESCENTS AND PATHWAYS TO ALCOHOL AND DRUG USE

Adolescents are persons, between the period of puberty (usually 12-13 years) and adulthood - commonly understood as age 18, the age at which Irish people have an entitlement to vote and also have an entitlement to purchase alcohol and to consume alcohol in licensed premises. The cut-off point of 18 yrs may be somewhat arbitrary, as the coming of age can lack precise definition associated as it is with variable developments such as financial independence, employment and the ability to form medium to long term sexual partnerships¹⁶. Given factors such as increased rates of participation in higher level education and an increased tendency for many young people to delay family formation, the end of adolescence can stretch into the early 20s.

Yet adolescents and young adults, aged between 18 and mid 20s, often have quite similar needs and experiences; more particularly, they experience quite similar patterns of alcohol and drug use and many youth services continue to work with young people until their early to mid twenties. In this particular discussion however, the 18 yrs cut-off point is necessary, because in addition to under 18s being legally prohibited from purchasing alcohol, they are also legally defined as a *Child*, and there are statutory implications arising from this definition that have particular ramifications in the context of treatment interventions, and these are even more complex with respect to medical and / or residential interventions. These issues are closely examined in the *Under 18s Report*.

While it is important to draw a distinction between adolescence and adulthood, differentiating younger and older adolescents is also important; young people's alcohol and drug use show variable patterns across different adolescent years and it is important to acknowledge the progressive nature of these patterns: for example frequency and quantity of drinking or cannabis use tend to increase with age¹⁷, so that levels of use

16 Gullotta, T. P., Adams, G. R., Markstrom, C. A. (2000) *The Adolescent Experience* (4th ed), San Diego, CA: Academic Press.

17 Millman, R. B., Botvin, G. J. (1992) "Substance use, abuse, and dependence", in M. Levine, N. B. Carey, A. C. Crocker, R. T. Gross (eds.), *Developmental-Behavioural Pediatrics* (2nd edd.), New York: W. B. Saunders Company, 451-467

among 17-18 yr olds are likely to be higher than that reported for 15-16 yr olds in the ESPAD report. There is an intra-adolescence developmental distinction between early and later adolescents, with the former still quite dependent on their parents for guidance, direction and the setting of limits, while the latter are more autonomous, trying to work things out for themselves, engaged in the process of making lifestyle decisions and choices, seeking affirmation and acceptance from friends and peers, avoiding rejection; laying a foundation for strong long-term friendships and also developing personal relationships with non-parent adults. Inevitably these distinctions have implications for preventive or treatment interventions, if these are required: a mobilization of family and other proximal influences could have impact on younger adolescent; the older adolescent might be more amenable to interventions that focus on individual motivation and cognitive reasoning.

Adolescence as a period of rapid change

At its most normal adolescence¹⁸ is fundamentally a period of change; it is a period of rapid physical change and readjustment potentially disrupting pre-established sense of image and self-esteem and complicated further by the development of girl-boy relationships, contributing to new stresses and anxieties (particularly in relation to development of peer relationships and vulnerability to peer pressure). A critical issue for the adolescent is the development and consolidation of personal identity (Who am I? Where am I located? What am I going to be? How much am I the same or different to others, particularly in terms of my interests and my taste in music and fashion?), alongside practicing new roles (moving from pretending to be an adult to exercising the choices and decisions of pre-adulthood) and coming of age rituals (first date, first kiss, first nighttime disco, first cigarette, first drink, first time to be served in a pub, first job, first wages, etc.).

18 Hird, S., Khuri, E. T., Dusenbury, L., Millman, R. B. (1997) "Adolescents" in J. Lowinson, P. Ruiz, R. B. Millman, J. G. Langrod, Substance Abuse: A Comprehensive Textbook, London: Williams & Wilkins.

Adolescence is also associated with an improvement in cognitive abilities: moving from concrete, rational thought to abstract thinking and an ability to deal with complex reasoning and theory and therefore unlikely to accept simplistic explanations of phenomena and more likely to clash with authority figures particularly if the latter continues to seek to deal with adolescents as children (devoid of self-reasoning) – rules previously taken for granted are more likely to be questioned and new lifestyles based on alternative rule systems more likely to be considered or experienced. It is a period of development associated with risk-taking, linked to physical changes, a sense of invulnerability and the increased desire to impress peers. Increase in risk-taking happens despite an undeveloped ability to make informed assessment of risks – too much reliance on own immediate experience: “I’ve done it and it has n’t done me any harm”. Risk assessment based more on here and now than long-term, so for example the immediate negative effects of heroin use are a lot more evident than the long-term effects of alcohol misuse or smoking. Also risk assessments are fundamentally linked in with choices and trade-offs: decisions to participate or not in risk activity are inextricably linked to fears / concerns about rejection, ridicule and the perception of being “not up for it”, “uncool” and immature.

Adolescence and becoming a social drinker / recreational drug user

Overall, adolescence is an important idealistic period during which the person is most consciously engaged in the act of shaping their future, their personal philosophy, their social life and social environment: a period during which they select from a broad menu of choices in terms of lifestyle, health habits and lifetime strategies for personal and social survival. Among these use of alcohol and drugs feature prominently, adolescence is a period during which the person sets out a pathway of becoming a social drinker, like most other adults. A normal adolescent pathway involving the use of alcohol may be associated with¹⁹:

19 Pavis, S., Cunningham-Burley, S., Amos, A. (1997) Alcohol consumption and young people: exploring meaning and social context, Health Education Research Theory & Practice Vol.12 no.3 1997 Pages 311-322

- Peer influences* - for many young people, this constitutes their primary reason for drinking or for using drugs
- Social facilitation* – young people drink or use drugs because it boosts their social experience
- Mood alteration* – drinking or drug use enhances personal relaxation and enjoyment

This normal pathway engages large numbers of young people from variable backgrounds in consuming alcohol in an ongoing predictable manner – among Irish 15-16 yr old schoolgoers 88% have consumed alcohol in last 12 months²⁰. Regular consumption of alcohol, even in circumstances where the alcohol is illegally purchased, could be, and often is, considered conventional, especially if it is paced with gradual increases rather than erratic, binge behaviour, although it is not unusual for many who have binged on alcohol as adolescents not to develop problems in later life. Alcohol use and misuse is extremely common in adolescence and in most instances it can taper off with the onset of adulthood without need for any formal intervention²¹.

This normal pathway has similar, but limited, application to recreational use of illicit drugs; for example the level of lifetime cannabis use among 15-16 yr old schoolgoers in Ireland (39%)²², with the likelihood of this increasing with age, suggests that most adolescents engage with drug use at some stage, and that a normative adolescent pathway involving the experimental use of drugs, particularly cannabis, prevails. While possession of illegal substances is problematic and certainly risky from the perspective of a potential involvement with criminality and legality, it is important nonetheless to acknowledge that most adolescents who use drugs do not develop dependence or other personal problems arising from this use²³; many adolescents who have symptoms of problematic use

20 Hibell et al., (2003)

21 Cole, P. S., Weissberg, R. P. (1995) “Substance use and abuse among urban adolescents” in T. Gullotta, G. Adams, R. Montemayor (eds.) Substance Misuse in Adolescence, London: Sage

22 Ibid.

23 Newcomb MD (1995), Identifying high-risk youth: prevalence and patterns of adolescent drug abuse. In: Adolescent Drug Abuse: Clinical Assessment and Therapeutic Interventions (NIDA Research Monograph 156),

Rahdert E, Czechowicz D, eds. Rockville, MD: US Department of Health and Human Services, pp 7-38; EMCDDA, (2003) “Drug use amongst vulnerable young people”, Drugs in Focus, Sept-Oct.

spontaneously remit as they approach adulthood²⁴ and usually only a small number will continue to have substance misuse problems as they get older²⁵

Population-based prevention

Adolescent alcohol use, and drug use, even if considered normal, nonetheless need to be the concern of policy-makers; as already outlined adolescents go through unique developmental stages, which could, potentially, be impaired as a result of excessive drinking or drug use, and especially if using opiates or cocaine this can lead to problematic pathway as described in section 3 below²⁶; use of alcohol and drugs can also expose the adolescent to potential immediate problems with the law, in school and with family and neighbours, with risky driving and sex behaviour and can also cause direct long-term personal harm²⁷. In this regard various population measures for reducing consumption are warranted; this requires some acknowledgement that general population measures are likely to have greater aggregate impact than specifically targeted programmes²⁸, thus focusing exclusively on sub-group behaviours, e.g. binge-drinkers, could be perceived as blaming young people for societal problems and be counterproductive. Population policy measures are focused on controlling or limiting supply and access and an improvement in the enforcement of laws on under-age drinking and drink-driving; it can also include restrictions on alcohol advertising²⁹

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- 24 Buckstein, O., Kaminer, Y. (1994) "The nosology of adolescent substance abuse" *The American Journal on Addictions*, 3, 1-13.
- 25 Gilvarry, E. (2000) "Substance abuse in young people" *Journal of Child Psychology and Psychiatry*, 41, 55-80.
- 26 Ibid.
- 27 Newcomb & Bentler (1989); Cole & Weissberg (1995)
- 28 Babor, T., Caetano, R., Casswell, S., Edwards, G., Giesbrecht, N., Graham, K., Grube, J., Gruenewald, P., Hill, L., Holder, H., Homel, R., Osterberg, E., Rehm, J., Room, R., Rossow, I. (2003) *Alcohol: No Ordinary Commodity. Research and Public Policy*, Oxford: Oxford Medical Publications.
- 29 Department of Health and Children (2004) *Strategic Task Force on Alcohol (Second Report)*, Dublin: Author.

Role of tier-1 providers

Potentially service providers have a role in assisting broader population measures through providing support to the mobilization of communities³⁰. Such issues are not necessarily the immediate concern of treatment providers, and in general, it is mainstream services – such as schools, primary health care, youth and community services – that carry some responsibility for bringing about reductions in adolescent consumption of alcohol and drugs, where this consumption is linked to the normal pathway, as described above; they may also have a role in other forms of harm reduction and in identifying and / or screening persons whose level of consumption is indicative of current or later problems.

SUMMARY

Adolescence is a period of major and significant change and one during which young people commence the process of becoming social drinkers; in a similar vein experimental use of the illicit drug cannabis is also a common youth experience. Adolescents have numerous opportunities to acquire and use alcohol and drugs in society. Normal pathways into alcohol and drug use are mirrored by normal pathways towards stable levels of alcohol use and non-use of cannabis, as most young people inexorably mature out of risky behaviour, some more quickly than others. In the process however alcohol and drug use can cause damage, and it can also lead to down the road personal and health problems associated with high levels of consumption or dependency. Normal alcohol use, as with experimental use of cannabis, require population-wide prevention measures in order to keep focus on the role of supply, access and opportunity as key variables in ensuring that

30 Grube, J. W. (1997) “Preventing sales of alcohol to minors: Results from a community trial” *Addiction*, 92 (Suppl. 2), 251-260;
Holder, H. (1998) *Alcohol and the Community: A systems approach to prevention*, Cambridge: Cambridge University Press.

normal pathways do not become problematic. Primary and community agencies, alongside treatment practitioners, have a role in supporting population measures at local levels; they can provide assistance to a general community mobilization and also put in place screening and various harm reduction strategies.

3 PROBLEMATIC ADOLESCENT ALCOHOL AND DRUG USE: EARLY INTERVENTIONS AND TREATMENT

Section 2 above gave consideration to a normal pathway to alcohol and drug use. An alternative, potentially problematic adolescent pathway for using alcohol and drugs is as a coping mechanism for dealing with life stresses. This pathway is of particular concern for treatment policy and provision. Mild, moderate or infrequent use is usually considered problematic if use is perceived as directly associated with other once-off problems, such as family arguments, school suspension, or other problem behaviours in the community. Clearly, drugs and alcohol are being used for wrong reasons and a treatment intervention would be deemed appropriate; untreated these problems can escalate and have serious short, medium and long-term impact.

Typical factors associated with problematic alcohol or drug use include:

<i>personal</i>	(childhood emotional stress or anxiety, negative mood states, behavioural problems - such as hyperactivity, aggression and poor impulse control - poor educational performance, lack of attachment or commitment to school, personal alienation from dominant societal values) ³¹ ,
<i>family</i>	(material poverty, lack of family stability, poor parental bonding, family conflicts, crises, neglect / abuse, parental substance misuse) ³²
<i>social and cultural</i>	(drugs availability and affordability, poor social capital, lack of social constraints, identity with and affiliation to using peers, general confusing cultural

31 Norman, E. (1994) "Personal factors related to substance misuse: risk abatement and / or resiliency enhancement" in T. Gullotta, G. Adams, R. Montemayor (eds.) Substance Misuse in Adolescence, London: Sage

32 Turner, S. (1994) "Family variables related to adolescent substance misuse: risk and resiliency factors", in T. Gullotta, G. Adams, R. Montemayor (eds.) Substance Misuse in Adolescence, London: Sage

attitudes in relation to alcohol and drug control and access, legislation and enforcement)³³

Mobilizing family and other proximal influences

Because problematic use of alcohol and drugs is associated with other life problems a mobilization of relevant family, school and community supports would seem appropriate and these would help to affirm family and social attachments, improve, personal, social and school functioning, divert from drug and alcohol use, with an expectation that a return to normal functioning will be achieved. In the normal course of events, it would be expected that such resource mobilisation be achieved with a minimal of disruption or displacement and in a manner that minimizes the relevance of the alcohol and drug behaviours; if a breakdown in family communication is considered a primary causal factor then the focus of intervention would be to concentrate on repairing or rebuilding family communication and avoid too much of a focus on the drug and alcohol behaviour, thereby minimizing the relevance of substance use through focusing on underlying issues³⁴. In circumstances where there are seriously adverse community conditions it may not be possible to effectively mobilize family and proximal and family supports and other measures to increase community capacity and local social capital are also indicated; many of the measures in the *National Drug Strategy* are focused on supporting community development, particularly in areas where opiate problems have been concentrated.

An escalation in drug or alcohol use, in terms of frequency, binge use, use of opiates or cocaine, or poly use and in a manner where health or social functioning is evidently impaired, or where there is a preoccupation with use (daily and more frequently) and the onset of dependency, would be of even more concern to treatment providers. In

33 Duncan, D. F., Petosa, R. (1994) "Social and community factors associated with rug use and abuse among adolescents" in T. Gullotta, G. Adams, R. Montemayor (eds.) *Substance Misuse in Adolescence*, London: Sage

34 Findings (2004) "Doing it together: strengthens families and helps prevent substance use", *Drug and Alcohol Findings*, Issue 10.

particular, where this is co-related with other continuous, serious problems, it is unlikely that a once-off mobilisation of proximal social supports will be sufficient. The likelihood is that problems are so deeply-rooted that proximal supports are exhausted. More intensive interventions are needed and often these require a multi-disciplinary involvement and a long-term engagement with the adolescent and family or carer; a renewed mobilisation of proximal supports could potentially result from a comprehensive family or other systems intervention.

Research on treatment outcomes

Since the 1970s an abundance of research and meta-reviews has addressed issues of efficacy and efficiency in the treatment of substance misuse problems. Taken together these reviews suggest that: low-intensity, brief treatment is better than no treatment; no single treatment stands a cut above all others; and a small number of treatment modalities, with some similar features – specifically their focus on treatment domains other than alcoholic or drug addiction identity – consistently show positive results. Appendix B summarises evidence of best practice in this field from ten separate reviews. A cluster of seven interventions consistently show positive evidence, as follows:

Behavioural therapy: focuses on cognitive processes for developing drink-avoidance techniques, encouraging clients to re-shape their thinking in relation to drink and drugs, developing stress management and also developing a positive outlook towards non-drinking³⁵.

Community reinforcement therapy: focuses on assisting clients to eliminate positive reinforcement for alcohol and drugs and improve positive reinforcement for sobriety, through motivation, planning and goal-setting and involving significant others in the reinforcement process³⁶.

Motivational interviewing: focuses on building motivation to change with therapists adopting a facilitative, non-confrontational role, helping clients clarify their views and attitudes towards drinking and use of

35 Beck, A., Wright, F. D., Newman, C. F., Liese, B. S. (1993) London: Guilford Press.

36 Meyers, R. J., Miller, W. R. (2002) A community reinforcement approach to addiction treatment, Cambridge: Cambridge University Press.

drugs and in developing their own impetus to change, as appropriate³⁷.

Relapse prevention: focuses on assisting clients to identify high-risk situations, such as emotional states, relationship conflicts and social pressure, that can contribute to a return to problematic substance use and to devise plans for avoiding or coping with and managing these risks³⁸.

Social skills training: focuses on teaching clients the skills needed to avoid problematic drinking and drug situations, to develop alternative coping mechanisms, to deal more effectively with relationships and to become more assertive in everyday situations³⁹.

Behavioural family therapies: are interventions where the family, partners or significant others in a client's life, are treated alongside and in conjunction with the client, focusing on re-structuring relationship dynamics in support of drink- or drug-related change⁴⁰.

Brief counselling: consists of a short sequence of scheduled counselling sessions during which the therapist assesses levels and patterns of drinking or drug behaviour and provides advice around potential harms and assists the client to plan reduced or less-harmful drinking and drug use⁴¹.

In general the above seven treatments are consistent with public health, community-based models of intervention, and although they can be provided in either outpatient or residential settings, community settings are less costly and also offer the best prospects of attracting into treatment persons whose problems do not prevent them from full normal functioning, thus it does not become necessary for such persons to cease working or education, or to move away from their families. The research evidence provides encouragement to shifting from intensive, specialist, 12 steps treatment, which are considered the standard model of treatment in the US and also to a certain extent in

37 Miller, W. R., Rollnick, S. (2002) *Motivational Interviewing: Preparing people for change*, (2nd ed.), London: Guilford Press.

38 Marlatt, G. A., Donovan, D. M. (eds.) (2005) *Relapse prevention : maintenance strategies in the treatment of addictive behaviors*, (2nd ed), London: Guilford Press.

39 Jarvis, T., Tebbutt, J., Mattick, R. (1995) *Treatment Approaches for Alcohol and Drug Dependence: An Introductory Guide*, Chichester: Wiley.

40 O'Farrell, T. J. (ed.) (1993) *Treating Alcohol Problems: Marital and Family Interventions*, London: The Guilford Press.

41 Zweben, A., Fleming, M. F. (1999) "Brief interventions for alcohol and drug problems" in J. A. Tucker, D. M. Donovan, G. A. Marlatt (eds.) (1999) *Changing Addictive Behaviour: Bridging Clinical and Public Health Strategies*, London: The Guilford Press.

Ireland, towards a less-intensive, eclectic range of interventions, which may include 12 steps treatment, but also include other interventions with a clearer evidence-base. However, it is important to note that various researchers commenting on substance misuse treatment research have lamented the lack of progress in implementing evidence-based practice, and in making this shift⁴².

Adolescent treatment outcomes research

Few adolescent-specific therapies feature in international meta-reviews of treatment⁴³ primarily because the main treatment response to adolescent substance misuse has been to adapt and apply standard adult intervention models, such as 12 steps and therapeutic community programmes. Standard models of intervention show poorer results with adolescents than adults and are considered to lack efficacy with adolescents⁴⁴ with indications of increased alcohol and drug use, post-treatment⁴⁵. Difficulties associated with the utility of standard adult treatment models centre on:

- restrictions on individual responsibility or on the use of group mediated sanctions as therapeutic tools;
- the need for more directive authority and parenting types of rules;
- variations in adolescents' abilities to develop abstract reasoning, particularly in making the connections between the realities of their levels of substance misuse and the developing consequences;
- the need for programme components to assist educational and intellectual development⁴⁶.

42 Miller, 2005; Lamb, S., Greenlick, M. R., McCarty, D. (eds.) (1998) *Bridging the Gap Between Practiced and Research: Forging partnerships with community-based drug and alcohol treatment*, Washington: National Academy Press.

43 Meyers, R. J., Slesnick, N. (2002) "Establishing and maintaining evidence-based treatment in community programs" in Miller, W., Weisner, C. *Changing Substance Abuse Through Health & Social Systems*, London: Kluwer Academic / Plenum Publishers

44 Brown, S. (1993) "Recovery patterns in adolescent substance abuse" in J. R. Baer, G. A. Marlatt, R. J. McMahan (eds.) *Addictive Behaviours Across the Lifespan: Prevention, treatment and policy issues*, London: Sage.

45 Substance Abuse and Mental Health Services Administration (1998) *Services Research Outcomes Study*, Rockville, MD: Department of Health and Human Services Administration, Office of Applied Studies.

46 Dennis, M. L., Dawud-Doursi, S., Muck, R. D., McDermeit, M. (2003) "The need for developing and evaluating adolescent treatment models" in S. J. Stevens & A. R. Morral (eds.), *Adolescent Substance Abuse Treatment in the United States: Exemplary Models from a National Evaluation Study* (pp.3–34), New York: Haworth Press.

Put simply, standard adult treatment programmes do not take account of the psychosocial differences between young people and adults, nor do they address developmental and other youth specific issues. For example, treatment programmes based on the idea of participants making a lifelong commitment to abstinence are unrealistic as they do not adequately address that few young people are developmentally ready to make such rapid and permanent behavioural change at a time when alcohol is so important to them in terms of pleasure, self-fulfillment, peer acceptance, the development of social relationships and personal identity; they are likely also to resist interventions they perceive as reinforcing negative stereotypes or framed around an adolescent addict-identity⁴⁷. Given their developmental needs they are likely to be more accepting of harm reduction interventions that focus on motivational interviewing or other approaches that encourage them to take personal responsibility and to devise their own plans for change⁴⁸; cognitive behaviour therapy, group therapy, role modelling, self-esteem skills, alcohol education and recreational programmes all have application, particularly at an early stage of problem alcohol or drug use⁴⁹.

Compared to adult alcohol and drug treatment literature, international research on adolescent treatment outcomes has been sparse⁵⁰, although in the last decade there has been a significant expansion in published adolescent research studies with much improved research designs⁵¹. US research funding agencies, such as *National Institute on Drug Abuse (NIDA)*⁵² and *National Institute on Alcohol Abuse and Addictions (NIAAA)*⁵³, have led this expansion, although there are indications of increasing European interest⁵⁴

47 Liddle, H. A. (1999) "Theory development in a family-based therapy for adolescent drug abuse", *Journal of Clinical Child Psychology*, 28, 521-532.

48 Brown, S. (2001) "Facilitating change for adolescent alcohol problems: A multiple options approach", in Wagner, E. F., Waldron, H. B. (eds.) (2001) *Innovations in Adolescent Substance Abuse Treatment*, London: Pergamon

49 Bailey, K.A., Baker, A. L., Webster, R. A., Lewin, T. J. (2004) "Pilot randomized controlled trial of a brief alcohol intervention group for adolescents" *Drug and Alcohol Review*, 23, 157-166.

50 Dennis, M. L., Dawud-Doursi, S., Muck, R. D., McDermeit, M. (2003) "The need for developing and evaluating adolescent treatment models" in S. J. Stevens & A. R. Morral (eds.), *Adolescent Substance Abuse Treatment in the United States: Exemplary Models from a National Evaluation Study* (pp.3–34), New York: Haworth Press.

51 Dennis, M. (2005) www.chestnut.org/LI/Posters/Advances_in_Adol_Tx_APS_11_4_2003.pps – ppt downloaded on May 12, 2006.

52 <http://grants2.nih.gov/grants/guide/rfa-files/RFA-DA-03-003.html>

53 <http://grants2.nih.gov/grants/guide/rfa-files/RFA-AA-98-003.html>

54 EMCDDA, (2003) "Drug use amongst vulnerable young people", *Drugs in Focus*, Sept-Oct.

and a European-based body of research is also emerging⁵⁵; a series of publications specifically dedicated to adolescence has helped maintain a focus on the need for adolescent-specific treatment and related research⁵⁶. This expansion is linked to the increased levels of adolescent drug misuse experienced in the US during the 1990s⁵⁷, an improved understanding of risk and protective factors⁵⁸, and a greater commitment to combining different therapeutic approaches and to cease relying exclusively on standard, single concept models⁵⁹.

The emerging research is highly supportive of ecological and systemic based therapies as providing alternatives to standard addiction-identity models of treatment⁶⁰. Interventions that emphasize a post-treatment involvement with work, school, leisure activities and whose treatment participants develop friendships with nonusers, do relatively better⁶¹; programmes that are accessible and integrated with education, health, and legal service provision are more highly supported⁶²; easy access and low threshold interventions that do not require out-of-home placement are also preferred⁶³. There is considerable research support for programmes that directly intervene with family and proximal neighbourhood

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- 55 Ritger, H. (2003) Action Plan on Cannabis Research, 2003-2006: Belgium, Germany, France, the Netherlands, Switzerland. The Hague: National Drug Monitor/Trimbos Institute.
- 56 Wagner, E. F., Waldron, H. B. (eds.) (2001) Innovations in Adolescent Substance Abuse Treatment, London: Pergamon;
Stevens, S. J., Morral, A. R. (Eds.) (2003) Adolescent Substance Abuse Treatment in the United States: Exemplary Models from a National Evaluation Study, London: The Haworth Press;
Liddle, H. A., Rowe, C. L. (2006) Adolescent Substance Abuse: Research and Clinical Advances, Cambridge: Cambridge University Press.
- 57 Johnston, et al (2004)
- 58 Brook, J. S., Brook, D. W., Pahl, K. (2006) "The developmental context for adolescent substance abuse intervention" in H. A. Liddle, C. L. Rowe (eds.), Adolescent Substance Abuse: Research and Clinical Advances, Cambridge: Cambridge University Press.
- 59 Rowe, C. L., Liddle, H. A. (2006) "Treating adolescent substance abuse: state of the art" in H. A. Liddle, C. L. Rowe (eds.), Adolescent Substance Abuse: Research and Clinical Advances, Cambridge: Cambridge University Press.
- 60 Rowe, C. L., Liddle, H. A. (2003) "Substance abuse", Journal of Marital and Family Therapy, 29, 97-120.
- 61 Catalano, R. F., Hawkins, J. D., Wells, E. A., Miller, J., Brewer, D. (1990/1991) "Evaluation of the effectiveness of adolescent drug abuse treatment, assessment of risks for relapse, and promising approaches for relapse prevention", The International Journal of the Addictions, 25, 1085-1140.
- 62 Williams, R., Chang, S., Addiction Centre Adolescent Research Group (2000) "A comprehensive and comparative review of adolescent substance abuse treatment outcome" Clinical Psychological Science Practice, 7, 138-166.
- 63 Metrick, J., Frissell, K. C., McCarthy (2003) "Strategies for reduction and cessation of alcohol use: What do adolescents prefer?" Alcoholism: Clinical and Experimental Research, 27, 74-80;
D'Amico, E. J., McCarthy, D. M., Metrick, J., Brown, S. (2004) "Alcohol-related services: Prevention, secondary intervention and treatment preferences of adolescents" Journal of Child and Adolescent Substance Abuse, 14, 61-80.

dynamics⁶⁴ and do so in the absence of adolescent-as-addict, or family-addiction or community-addiction labels⁶⁵.

Family interventions

There is an important emerging literature dedicated to family-based, adolescent-specific interventions⁶⁶. Systemic family therapies have been incorporated as key components of exemplar services in the US⁶⁷; previously many such services operated according to traditional adult treatment models. While many family interventions have been developed in the US there is evidence that they have been successfully modified for other societies⁶⁸. Such family-based interventions have broader application with respect to young people with emotional and behavioural problems and reflect a growing reorientation of helping systems towards working with children and their families in the context of their homes

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- 64 Weinberg, G., Naimah, Z., Rahdert, E., Collier, J. D., Glantz, M.D. (1998) *American Academy of Child and Adolescent Psychiatry* Volume 37(3), March 1998, pp 252-261.
- 65 Rowe & Liddle (2006)
- 66 Anonymous, (2004/2005) "Interventions for alcohol use and alcohol use disorders in youth", *Alcohol Research and Health*, 28 (3) 163-174.
- Austin AM, MacGowan MJ, Wagner EF (2005) "Effective family-based interventions for adolescents with substance use problems: A systematic review" *Research on Social Work Practice*, 15 (2): 67-83 Mar;
- Dembo, R., Schmeidler, J. (2002) *Family Empowerment Intervention: An Innovative Service for High-Risk Youths and their Families*, Binghamton, NY: Haworth Press.
- Henggeler, S. W., Clingempeel, W. G. (2002) "Four year follow-up of multisystemic therapy with substance-abusing and substance-dependent juvenile offenders", *Journal of American Academy of Child and Adolescent Psychiatry*, 41, 7.
- Kumpfer, K., Alvarado, R., Whiteside, H. (2003) "Family-Based Interventions for Substance Use and Misuse Prevention", *Substance Use and Misuse*, Vol. 38, Nos. 11-13, 1759-1787.
- Latimer, W. W., Winters, K. C., D'Zurilla, T., Nichols, M. (2003) "Integrated family and cognitive-behavioural therapy for adolescent substance abusers: A stage 1 efficacy study", *Drug and Alcohol Dependence*, 71, 303-317.
- Liddle, H. (2004) "Family-based therapies for adolescent alcohol and drug use: research contributions and future research needs", *Addiction*, Vol 99 (suppl. 2), 76-92
- Schoenwald, S., Rowland, M. (2002) *Multisystemic Therapy*, in B. Burns, & K. Hoagwood (eds.) *Community Treatment for Youth*, Oxford: Oxford University Press
- 67 Kumpfer, K. (1999) *Strengthening America's Families: Exemplary Parenting and Family Strategies For Delinquency Prevention*, Washington: U.S. Department of Justice Office of Justice Programs Office of Juvenile Justice and Delinquency Prevention
- 68 Jefford, T., Squire, B. (2004) *Model Practice: Tom Jefford and Brigitte Squire describe the impact multi-systemic therapy has had on their work with young offenders in Cambridgeshire*, *YoungMinds Magazine*, 71
- Anonymous (2003) *Pilot aimed at reducing youth offending*, *Judges' Update*, May.
- Cunningham, A. (2002) *Lessons Learned from a Randomized Study of Multisystemic Therapy in Canada*, London, Ontario: Research from the Centre for Children & Families in the Justice System

and environments as an alternative to providing interventions in counselling offices or residential centres⁶⁹.

Typically family interventions are provided on the premise that the adolescent lives with the family and through highly individualized interventions, specific treatment goals are negotiated in conjunction with adolescents, their parents and, where appropriate, local systems (school, youth club, etc). Family / community strengths are used as levers for bringing about change and for dealing with future difficulties. Interventions of this type might be organized in stages to allow:

- developing a therapeutic alliance with family and its members;
- assessing family strengths / capacities to be supportive / authoritative with youth members;
- developing a change strategy for increasing family competence (problem-focused and direction-oriented); and
- implementing change strategies and reinforcing through parental guidance and coaching.

This focus on in-home family interventions constitutes an important shift in the prospective orientation of adolescent substance misuse services, going forward. In this regard it is important to reference that virtually all adolescent treatment programmes, including those that have been developed out of traditional adult models of treatment, tend to reference family involvement; typically a family dimension in modified adult programmes would consist of family meetings during which adolescents-in-treatment describe their pathways through addiction and they and their addiction become the central focus of therapy. In contrast, the focus of treatment in systemic family therapies is the family system-as-lacking-functionality, with problematic substance use represented as symptomatic of underlying family problems: marital, parenting, relational or management. In this latter sense the family intervention is therapeutically focused and differentiated from non-directive support or psychoeducational groups⁷⁰. The growing

69 Duchnowski, A., Kutash, K., Friedman, R. (2002) "Community-based interventions in a system of care and outcomes framework" in B. Burns, & K. Hoagwood (eds.) *Community Treatment for Youth*, Oxford: Oxford University Press.

70 Stanton MD, Shadish WR (1997), Outcome, attrition and family/couples treatment for drug abuse: a meta-analysis and review of the controlled, comparative studies. *Psychol Bull* 122:170-191.

support for family interventions highly suggests that practitioners give more attention to these approaches

Fundamentally, this shift signals a further move away from *addiction* as the key *specialism* in adolescent substance misuse towards a better understanding of pragmatic and systemic therapies with similar application across a range of problem domains – behavioural, emotional and educational problems. The Table in Appendix C is highly suggestive that practitioners focus on behavioural, family and other systemic interventions, “particularly in light of alternative interventions more strongly supported by available empirical evidence”⁷¹. Clearly, this has important implications in developing an adolescent substance misuse framework; a focus on family interventions and other pragmatic interventions, would suggest that addiction counselling, day programmes and residential treatment may need to function as back-up resources to evidence-based family and other proximal social interventions, and not as self-contained or core treatments in their own right.

Keyworkers / case coordinators

Alongside family intervention programmes, the idea of dedicated adolescent keyworkers is also highly supported ⁷²; such keyworkers should be able to understand the needs of young people and their stages of development and be able to engage them through informal activities and conversation, as well as proposing and maintaining boundaries and limits appropriate to a formal intervention. Many adolescents with substance misuse problems tend also to experience other psychosocial problems and some are linked with justice, child care or mental health systems⁷³; this suggests the need for a case coordinator or case manager, whereby a keyworker could ensure coordination of agreed individual

71 Vaughn M.G., Howard M.O. ((2004) Adolescent substance abuse treatment: A synthesis of controlled evaluations, *Research on Social Work Practice*,14 (5): 329.

72 Gilvarry et al 2001

73 Kraft, K., Schubert, K., Pond, A., Aguirre-Molina, M. (2006) “Adolescent treatment services: the context of care” in H. A. Liddle, C. L. Rowe (eds.), *Adolescent Substance Abuse: Research and Clinical Advances*, Cambridge: Cambridge University Press

plans across agencies, ensuring continuity of care and retention in services, and regular review⁷⁴. Such a role could be performed by an addiction-trained worker, or alternatively by a social worker, probation worker or youth intervention worker. As already mentioned an understanding of youth needs and an ability to engage with young people are key attributes, more so than addiction skills *per se*.

SUMMARY

The above discussion focuses on the problematic alcohol and drug use pathway, identifying that it usually arises when alcohol or drugs are used as a mechanism for coping with life stresses. As already mentioned in section 2, a normal pathway can, through excessive consumption also lead to a problematic alcohol and drug pathway. It is suggested that early intervention can have significant impact; the focus needs to be on mobilizing family and other proximal supports in order to identify and work with the causes of stress and anxiety and to assist the young person in re-engaging with normal, primary support systems. An escalation of alcohol or drug use and / or an exacerbation of associated problems give rise to more intensive interventions. Research on substance misuse treatment suggests there is a cluster of well-tested interventions that have strong efficacy and effectiveness and that generally these include behavioural, motivational and systemic-based therapies. Adapted standard 12 step and other intensive adult intervention programmes have relatively poor results with adolescents. Consequently, there has been an expansion in adolescent-specific interventions; the research literature on such interventions is promising and highly suggestive that family-based interventions can have significant impact across a range of adolescent problem areas: substance misuse and other emotional and behavioural problems. Because many of these problems are co-related and

74 Hser, Y., Grella, C., Hubbard, R. Hsieh, S. C., Fletcher, B. W., Brown, B. S., and Anglin, M. D (2001) "An evaluation of drug treatment for adolescents in four US cities", Archives of General psychiatry, 58, 689-695.

inevitably involve education, welfare and justice agencies the need for keyworkers / case coordinators is also suggested.

4 REGIONAL CONSULTATION

This section of the report draws from a consultation exercise held involving practitioner personnel within the southeast area. The consultation involved discussions with regional and area substance misuse coordinators as well as area-based focus groups. In general the discussions addressed regional service practitioners' views on the implementation of the 4-tier framework, with which they were, in general, very familiar. The discussion below has three parts corresponding to prevention (tier-1), early intervention (tier-2) and treatment (tiers 3-4). Discussion of tiers 2-4 is more detailed; this should not be surprising as the consultation's primary focus was on developing a treatment framework. However, the discussion inevitably included reference to tier-1 services, to progress, achievements, existing gaps and the need for new developments. However, the main recommendations in this report arise from the discussion of tier 2-4 services.

A Preventive responses – tier 1

In the consultation for this report there was considerable reference to targeted, focused programmes of prevention intervention, including the provision of harm reduction information at the level where young people have already engaged in drug and alcohol use, to complement broad, universal messages that are made available through schools, media and various public fora. However it was emphasized that the different meanings of prevention within the context of community responses need to reflect differential forms of drug and alcohol use and experimentation and local context, which obviously differ from situation to situation. It was emphasized that: it was important to remain rational within the context of local, community responses; experimental alcohol and drug use is, for all intents and purposes, normal adolescent behaviour, and for most might best be considered as a rite of passage; while personal and social harm with once off substance use is possible, the fact that a young person has taken a drug should not lead to the

automatic conclusion that there is a problem that needs to be treated; referral to higher tiers may not be indicated. Indeed, it suggested that a reduction in the numbers of adolescent clients referred to substance misuse services during 2004 and 2005, following an increase during 2000-2003, may be attributed to the investment in outreach education and prevention programmes through community-based drug initiatives funded under the *Young People's Facilities and Services Fund*.

It was suggested that often what is most needed is that youth and community projects remain engaged with young people and familiar with their patterns of substance use and misuse, that they ensure young people are fully aware of harm messages and that these messages are adjusted taking account of changes in alcohol and drug-use patterns. Of particular importance is that community personnel are able to track patterns of experimental and post-experimental use so that they have insight into young people's pathways into both deeper, more involved use and alternatively into forms of reduced, leveling off use, and the impact of age, study, work and relationships on these variable patterns; different pathways are indicative of different harm-reduction messages and it was considered important that community personnel not restrict themselves to any single prevention approach, but that they remain open to and cognizant of changing patterns of substance use and misuse and of the need for variable interventions.

Within the consultation there was a strong sense that through funds allocated under the NDS it has been possible to develop localized and targeted programmes to augment broader health messages with respect to alcohol and drugs. In the main these have taken place as community and youth initiatives and there has also been an involvement of schools and parents' groups – programmes aimed at developing whole-school policies toward substance misuse are particularly noteworthy. It was pointed out that communities have played an important role in identifying adolescent substance misuse problems, in taking initiatives and in maintaining an overview of changes and developments with respect to availability, accessibility and use of alcohol and drugs. Although there has been an expansion of services and facilities at the level of community projects, some neighbourhoods - particularly rural based communities - continue to lack basic

community and youth services. Some community personnel were concerned that a lot of energies were devoted to responding to crisis issues and there was not enough effort at prevention or in trying to mobilise communities to define their own problems or to process new ways of engaging – at tier 1 – young people who lived in dispersed rural areas.

B Early intervention – Tier 2

Much of the discussion concerning adolescent treatment interventions in this consultation was focused on Tier 2, which is considered pivotal within the helping system: it is the point where formal assessment and intervention is being envisaged and planned and as it is the first line of specialist services it is the tier in which personnel (keyworkers) could potentially facilitate and coordinate, in a general sense, relationships between different elements across the four tiers. The consultation focused on cross-tier relationships; the role of community organizations in tier 2; the limitations of existing tier 2 responses and the need for these to be enhanced and developed; and the need for an adolescent-specific service.

Cross-tier relationships

There was discussion on the relationship between community prevention interventions, which would normally involve youth activity programmes, health education, personal development groups and so on, *and* more intensive, one-to-one early interventions. There was concern about continuities between the two different approaches, about knowing when it is appropriate to continue with an informal, flexible approach (tier 1), when a more formal intervention (tier 2) is required and what are the most appropriate methods for screening. It was evident that some community-youth services already provide forms of psychosocial counselling to young people, who seemed willing to access such services; there were concerns however that there was no consistent triage system to differentiate those adolescents who needed more specialist interventions, that in some areas there was often a considerable time lag between identifying the need for more specialist services

and being able to access these, and that when community personnel managed to make referrals up through the system, there was a lack of communication back about progress and a sense therefore that the community worker is now outside the loop, in terms of information-sharing and ongoing discussions.

In one regional city a contact worker, who is managed by a multi-agency steering group, acts as a liaison between, on the one hand, various youth and community projects, school completion programmes, and diversion projects and, on the other, the more specialized substance misuse services and this was considered particularly vital in maintaining the continuity between tiers 1 and 2. The contact worker undertook outreach work in people's homes and also contributed to a workers' forum, which met periodically to share ideas and information on substance misuse problems and issues. In this way the outreach worker is able to maintain familiarity with what is going on in the community and remains updated in relation to any single young person's engagement with alcohol and drugs in a manner that might be considered beyond experimentation and not normal. Formal supervision for the contact person and accountability is provided through the youth service. This approach could be considered as akin to that of a keyworker, which is advocated in *The Substance of Young Needs* and could also potentially serve as a model in other sub-regional areas.

Role of community organizations in tier 2

During the consultation it was commonly understood that community and youth projects should not be expected to provide the full range of interventions that would be necessary at tier 2, although it was highlighted that the absence of service options at tiers 2 and 3, meant that community and youth work personnel at tier 1 were drawn into responding to adolescents who needed to be dealt with elsewhere. The lack of refer-on options meant that community and youth work personnel continued to work with these adolescents at tier 1.

Some contributors to this consultation were of the view that in situations where more specialist (tier 2-4) interventions for young people were indicated, the role of community

projects and personnel should be minimized, as they were not normally party to protocols and procedures for guiding inter-agency referrals and joint working relationships, and it was not normal for community and youth projects to work in a counselling or one-to-one manner. There is a sense that formal interventions with adolescents at this level need to operate within systems of structured supervision and accountability, systems that are not always apparent in community projects, which have more flexibility for working with young people in an informal manner or through groupwork or activity programmes. There is a view that community projects need to concentrate on this latter form of provision, to play to their strengths in making good use of social networking and social education but that they also need the back-up of other personnel who operate within the parameters of a professional, direct helping system. It was emphasized that community projects are particularly good at working at this level with young people, and to draw them too much into more formal relationships with statutory agencies in relation to some adolescents, could potentially jeopardize this work.

However, it was also highlighted that for two specific reasons community and youth projects should continue to have an important role and influence at tier 2. First, because other services and interventions lack presence and visibility at this level, community and youth services are drawn further into tier 2 in order to devise ways of filling service gaps that they have identified through needs assessment and local demand, and in this regard they have played a vital role in service development, and one that could not have been played without them having a direct involvement at service provision. It was emphasized that if community personnel did not respond there would be an escalation in unmet needs.

Second, community projects and personnel can have an important impact on the way in which more specialist services at tier 2 are devised and delivered. For example, community and youth services are critical of an approach to interventions with adolescents that consist solely of scheduled, office appointments for one-to-one counselling. It is suggested that young people don't easily respond to this type of service and that the youth services have struggled for years to develop models of engagement with young people that are outside counselling offices, and that build on the informal

engagement that can take place in youth and community centres, through outreach contacts and in young people's homes. While formal, one-to-one counselling – as provided through existing substance misuse services - is considered part of the overall package of services that need to be offered, it is stressed that it requires other, more practical components also; there was a strong sense that adolescent substance misuse services need to be driven by an understanding of adolescence, and through giving attention to the uniqueness of their needs and situations and that community organizations can have a role in assisting other helping services to maintain a focus on these dimensions.

Limitations and potential at tier 2

Currently, some community addiction counsellors across the HSE south east area function as tier 2 practitioners, and take in referrals from social work, probation JLOs and various other sources. The basic idea here is that adolescents can get easy access to a specialist substance misuse service without the necessity of going through a medical or clinical referral, although this too often happens. Essentially this becomes the first point of contact for specialist substance misuse services. The response is primarily counselling-based, assessment and 2-3 sessions of harm reduction. A mixed response is reported, some adolescents making it clear they don't want to come, others coming but sometimes out of duress because of probation orders and discontinuing after 2-3 sessions. There is a sense that, in most instances, the response is modeled on an adult service and more careful consideration of an appropriate tier 2 adolescent service is required, perhaps with a clearer focus on harm reduction and deeper consideration of the co-related issues that surround and contribute to the substance misuse. Part of the difficulty seemed to be a perceived expectation that court-based referrers, such as probation officers and JLOs for legal reasons operate out of an adult addiction model that allow them to report *yes* or *no* as to whether those referred are “dealing with their addiction” perhaps because “addiction” was being proposed as a mitigating factor in court proceedings. In reality there was very little for counsellors to report, or predict, often for the reason that the adolescents concerned were too immature to deal with addiction, if indeed this was their basic problem.

There was a very strong sense that new ideas and new models of intervention with adolescents were needed at tier 2 and also that in-service training on substance misuse responses – akin to that already available in suicide prevention - was needed across a whole range of tier 2 personnel. It appeared that many personnel working at this level, were missing out on some basic knowledge and skills that would enable them to make some focused interventions themselves and also help them clarify their expectations of onward referrals. There was a need to appraise personnel of the different types and variety of interventions and that there was a general lack of clarity as to what interventions could work with adolescents. It was suggested that substance misuse problems provided good leverage for getting adolescents involved in interventions, provided the aim and focus of the intervention was clear; so for example, as an alternative to the traditional adult model of 3-4 addiction counselling sessions, personnel in one area are focusing on the idea of a 4-session, intensive education programme, undertaken in small groups and in which there is less focus on the individual and more on the learning process and on how participants could use this in their own self-development.

The role of social workers and other statutory tier 2 service personnel, such as probation officers, and junior liaison offices, was discussed during the consultation. An overriding issue with respect to most personnel functioning at this level was, arising from agency priorities, their seeming inability to be involved in cases without statutory sanction: thus social workers are only involved in cases of child protection or social or educational risk; probation officers only get involved through the courts; and JLOs get involved only in legal cautioning. There was some discussion as to whether such personnel at this level were willing or able to engage in brief interventions with their clients or to become designated keyworkers at tier 2. The situation is quite variable across the region: some suggestions that personnel will do brief counselling but others prefer to refer to substance misuse services and at times there are inappropriate referrals.

Two contrasting perspectives emerged with respect to the utility of the involvement of social workers, probation workers and other similar personnel in adolescent substance

misuse. On the one hand, there was a view that services follow services, so that persons who get into the statutory system can attract a lot of additional services, while other adolescents just find it difficult to get into the system; thus, many non-statutory personnel seem to devote a lot of energies into getting young people into the statutory system. An alternative perspective is that keeping adolescents outside of the statutory system is itself an important objective, as the over-involvement of the statutory system can itself contribute further to their risk; while this approach may often be considered as an excuse for rationalization, there appeared to be sound reasons for keeping a distance between young people and the statutory system.

Need for adolescent-specific service

The consultation process for this report drew into focus the need to distinguish adolescent services from child care; there was a lot of concern with this issue and with the need to identify adolescent needs, in such manner that they be clearly distinguished from the needs and situation of younger children. The consultation included many references to the manner in which adolescents get caught between adult and children's services. It was suggested, for example, that it was totally inappropriate to expect that a social worker, who was focused on child protection risk assessments for young infants, to use the same knowledge and skills base to assess the needs and capacities of adolescents. It was furthermore highlighted that adolescents do not have the requisite lifetime insights as potentially do adults, to respond to the structures and formality of counselling.

There was a need therefore to be more creative with respect to adolescents, to structure services around their needs, to make these services adolescent-friendly and to bring adolescent expertise to the overall response. Such concerns about the shape and structure of interventions for adolescents are consistent with the shift towards adolescent-specific models of treatment taking place within a systemic, ecological framework, as discussed earlier in this report. In one area it was suggested that a way forward was to try and shift the community-based drug initiatives up a higher level so they are able to build on their knowledge of community context and informal ways of working with young people, but

that such a move would need to be within clear, professional structures and boundaries and should not happen at the expense of more informal approaches.

Indeed, there was widespread support across all areas towards the idea of a separate adolescent service, that would be dedicated to developing specific adolescent interventions, particularly in the area of substance misuses – as this was seen as useful leverage for getting adolescents into the service – but also with respect to other co-related personal, emotional and behavioural problems. It was highlighted that typical difficulties arising in work with adolescents concerned issues of consent, the fact that they are not adults and cannot therefore give consent, the fact that they are being monitored through children's services more used to dealing with under 12s, the fact that they also expected to present to adult services for counselling and they are simply not comfortable dealing with this adult environment.

The consultation emphasized that work with adolescents required a unique set of communication and other skills that were distinctly different to those more often associated with either adult or child services; it was believed that a dedicated adolescent team could develop expertise in this specific area, through team structures, supervisory arrangements, team discussions, through sharing information on different approaches, cross-checking file notes and records and so forth. In this way a dedicated team could build capacity and competency but it was hard to see how this could happen if team members also had to switch to risk assessment for babies-at-risk, as currently happens with social workers who are assigned adolescent cases. It was also indicated that a dedicated adolescent service needed to become more available outside, normal 9-5 working hours; both adolescents and their families tend to be more available after tea-time and there was little point in trying to engage them at other times.

There was a view that the overall HSE model for responding to adolescent problems was framed within a consideration of the needs of young children and that the specific needs of adolescents have tended to get lost, and have not been prioritized; there was therefore, a strong sense that an appropriate response to adolescent substance misuse needed to be

framed within a separately funded adolescent service. It was suggested that members of a dedicated adolescent team could function as keyworkers (discussed earlier); these could have basic training in a variety of disciplines and also training in alcohol and drugs; they could be assigned at tier 2 to work in parallel with other services and personnel, helping to embed and integrate services' assessment and treatment of drug and alcohol problems, and to facilitate and coordinate, in a general sense, relationships between different elements across the four tiers; such keyworkers could form a network of professionals across adjacent areas using joint training and case discussions to develop practice and also using their numbers to develop a critical mass of competence within the overall system.

C Treatment interventions - Tiers 3-4

During the consultation there was a strong sense of frustration in discussing Tier 3 and 4 services, which are focused on drug / alcohol problems where there are other serious co-related problems; at these tiers it is envisaged that highly developed skills and knowledge in child and adolescent mental health, child development, paediatrics and drugs and alcohol, be mobilised into structured programmes of intervention. Much of the frustration concerned: the absence of pathways to formal tier 3 services such as child guidance and psychology; the absence of a coherent, coordinated response to a small group of young people whose drug-using and anti-social behaviour in the community were perceived as particularly challenging; and a perception that existing residential provision was not appropriate for those considered to be most in need of extra-intensive services. On the positive side the consultation was enthusiastic in its discussion of family interventions, which were perceived as a key component to prospective service development.

Pathways to existing tier 3, specialist services

During the consultation, concern was expressed that personnel working in community initiatives have little access to pathways into formal adolescent interventions, such as through child psychology or child psychiatry, although it was clear that all forms of access to these services were varied across the region. The main access to such specialized services was through GP referral although some psychology services operated regular drop-in facilities for parents and also made other efforts in outreach. These drop-in services were considered to be very successful, primarily because parents can access it without having to see a GP or other professional. It is also a good screening tool. It is suggested that the demand is such that drop-in could be organized everyday, if the resources permitted.

Some substance misuse services had access to adult psychiatry for adolescents over 16 years. In such situations adult psychiatry was perceived as a better option than child psychiatry for the reason it had an historical relationship with substance misuse services. In general it was felt that adolescent substance misuse has low priority in child psychiatry and that even in situations where referrals are taken it can take 9-12 months for a person to be seen. It was suggested that external pressures and demands can cause specialized services to prioritise around problem areas where there is a lot of public concern. The issue of teenage suicide prevention was referenced in this regard and it was suggested that referral for suicide risk can therefore become a quicker way into the system.

It was emphasized that while psychology and child psychiatry services are already seeing some adolescents with substance misuse problems, in general these tend to be secondary to other serious problems. It would seem clear that an agreed, common referral / protocol between substance misuse services and psychology and psychiatry services would greatly improve access to these services. Taking account that many adults with serious substance misuse problems will have tended to have other emotional or psychological problems preceding the onset of substance misuse, the consultation considered it particularly

important that a more comprehensive, psychology service for adolescents was needed and this needed to be provided as part of a tier 3 response.

In general the absence of tier 3 services for adolescent substance misusers attracted broad comment. There was a lot of discussion as to how such services could be developed, particularly in the context of rural communities, where easy access to services – if they were available - was not always possible. Some of this discussion focused on the idea of a virtual tier 3 service, consisting of personnel who could work both individually and jointly with individuals in a very coordinated, casework manner – this arrangement was already partly in place in one of the sub-regional areas. While this approach was considered positive and potentially a pragmatic way of overcoming problems of geography, it was also suggested that quite often a tier 3 system requires that there be a place to which the young person goes, on a daily or regular basis, and where the young persons is seen – either individually or in groups – and can also participate in an activity or event with a therapeutic focus. The logistical issue of transport was identified as requiring a lot of resources if a proper tier 3 service, whatever its design, was to be developed.

Adolescents with challenging behaviour

The issue of adolescents with difficult, challenging behaviour caused particular concerns in the consultation. It was for instance suggested that some, but very few, young people were causing violence and disorder in the home and in the community, arising from their substance misuse. The frontline services were constantly facing demands that these young people be contained, that there needed to be some facilities within which they could be held, short of them coming before the law, which had limited capacity to contain them anyway. There was a strong sense of frustration in the consultation with respect to this issue and in general an openness to consider any measures that promised to come up with options for dealing with this matter.

For example, the idea that these young people could respond to counselling or brief interventions was discounted on the basis that many young people at this age are simply

“having a great time” and rarely have reason to slow down or take stock; so, on occasions when these young people do show some sense of enthusiasm to make a change in their lives, this was the time when more intensive interventions could be made. They could, at this stage, be brought into a residential facility, if only for a few days, and even if it was only to provide the parents with the space to take breath, and to become re-energised and reflective in connecting back with the problems.

There was some discussion on the need for a mandate with some of these young people: not a probation order mandate and not a child protection mandate, but generally one that allowed a keyworker to legally make demands of the young person in terms of where they could reside, and where they socialized, etc. It was indicated that a mandate in the form of a supervision order might be appropriate in some circumstances.

There was a sense at the consultation that residential services could be better utilised in making an appropriate response with this particular group, for instance in order to provide weekend, or occasional breakouts or as a form of family respite. Overall, there was a very strong sense that these adolescents, even when small in number, can make huge demands on community services and personnel, but they are the most difficult group to plan for in terms of providing service options at both community and more intensive levels.

One key issue that arose in the consultation with respect to this group was that no one seemed to be leading the response. For a variety of reasons, including public pressure on respective key agencies, there is a sense of everybody knowing the young person, of everybody been involved, but no single agency or practitioner in charge, no single agency ensuring there is communication across all the services / practitioners that are involved. Indeed, it was claimed that it would be difficult to identify adolescents with serious, multiple needs who were not well known across most of the key agencies, but who were not necessarily getting picked up by the right agency at the right time. The problem was that often no single agency was taking the lead role – the idea of a keyworker as discussed earlier in relation to tier 2 could have application here in terms of coordinating

a response across the different tiers and in terms of managing the relationships between these tiers. In some situations there were already good inter-agency communication; one town had an inter-agency network consisting of core statutory and voluntary organizations, bringing together all the respective practitioners working with different families and facilitated effective planning; the contact person model referred to in previous discussion of tier 2 is an example where inter-agency practice principles could be further developed. Protocols for confidentiality and information-sharing are issues that would need to be dealt with, in such networks.

Specialist, residential services

During the consultation there was some reference to the need for detoxification facilities for young people but in general persons who worked in substance misuse services tended to be more skeptical of the need for such services, especially on an in-patient basis. Although there was reference to the need for in-patient facilities for the rather small number of young opiate users there was a general sense that limited provision of out-patient facilities would be sufficient and that greater attention needed to be given to developing psycho-social interventions. There was some concern during the consultation that existing access to such facilities was likely to be restricted in the future.

Overall community-based substance misuse personnel tended to be critical of a perception, seen as common among the public and some other community practitioners, that all adolescents with substance misuse problems need intensive treatment, with detoxification, residential and after-care components; it was suggested that this perceived need is linked to an increased monitoring of adolescents who were seen as having exceptional risks and could potentially be referred to in-patient adult psychiatric services when there was little else available for them on an out-patient basis. It was considered that a great deal of re-education needed to take place and that substance misuse services needed to put more effort into explaining to other practitioners both the potential and limits of specialist services as well as highlighting the progress that could be made through generic services. Reference, in the previous discussions of tier 2 has already been

made to the issue of in-service training and it seems clear that there is a general need for greater in-service training across the whole intervention system.

Discussion of tier-4 services as provided through the specialist residential service was rather muted in most areas. In part this may be attributed to a decreasing level of referral to tier 4 and a sense in which personnel tended to be more pre-occupied with the need for services at tiers 2 and 3. Indeed, throughout the consultation it was clear that the main gaps in service provision existed at tiers 2 and 3, although references were also made to the need for a different type of service at tier 4. During one sub-regional consultation it was commonly agreed that there were considerable shortcomings with current tier 4 provision; it is important to reference these criticisms because in part they can point to a prospective better utilization of resources at tier 4, perhaps with a better integration with tier 3 provision.

The tier 4 service was perceived as having the following weaknesses: (a) it operates as a stand-alone service and although there is now a standard procedure for facilitating public admissions, the service does not have in-built systems of continuity; (b) it does not facilitate admission for persons who are currently in chaos and therefore does not function as a stabilization service for persons who must first undergo a detoxification elsewhere and stabilize before tier 4 entry; (c) it offers one model of treatment only, 12 Steps Facilitation Therapy, and this is perceived as unnecessarily conferring an adult, addiction identity; (d) the model focuses primarily on the young person's use of alcohol and drugs irrespective of the family and environmental circumstances, and although there is a family programme its primary focus is a family addiction model (e) young people leaving tier 4 are discharged back into the same environmental conditions that gave rise to their problems in the first place and they are ill-equipped for dealing with these conditions. Some contributors to the consultation emphasized that whereas they had previously used the tier-4 service in the past they were currently less likely to use it for the reason that they do not believe that the outcomes through non-referral are any less better.

Some questions were raised in relation to the cost and funding of tier 4 services. However, it was generally considered that the overall issue of cost should not predominate as there were very strong arguments in favour of operating a residential component to substance misuse treatment and that once this is agreed there can be little argument about the costs as these tend to be fixed. It was emphasized that there are some, albeit usually only a few, young people who require the facility of a residential centre during their treatment. Rather than getting caught up in a discussion about the relative costs of providing such facilities it was considered a lot more beneficial to get into detail as to the potential, variable uses of such a centre and indeed how the type of services provided at tier 4 can only really change when there is improved provision at tiers 2 and 3.

Family interventions

There was a lot of discussion in the consultation about the merits and prospects of a family intervention service, specifically focused on adolescents. Indeed there was virtual unanimity about the value of family interventions and it was indicated that a lot had been achieved through family support services for child-related issues and of family support meetings around substance misuse issues. However, it was clear there was an absence of family therapy services in the region or of family intervention services dealing specifically with adolescent substance misuse. Many parents were finding it increasingly difficult to manage early adolescence, particularly males, and they were also finding it difficult to acknowledge these difficulties in fora such as parents groups or parenting courses and there was a need for more directive interventions taking place within the home.

The need for family interventions was particularly highlighted with respect to out-of-control adolescents and the difficulties for parents in trying to get a focus on dealing with the adolescent's substance misuse in the midst of the adolescent's out-of-control and sometimes violent behaviour. The need for a back-up, intensive, residential service was indicated with respect to family interventions. The consultation generated a lot of discussion on how to organize and locate family intervention services. There was a

general sense that the HSE needed to be involved and that the service needed to be linked to HSE structures, and there was a need for social work involvement. However, there were strong views that it needed to be separate from social work so that it did not become too pre-occupied with child protection issues and further there was a need to develop family interventions within an adolescent-specific model of intervention.

In general discussions about family models of intervention reference was made to new family conference projects in two of the sub-regional areas. Both of these were operated by the voluntary organisation Barnardo's, with HSE funding. One was already in operation and the second was about to be set up. The project aim was to involve extended family members in coming together to resolving family difficulties in order to avoid court proceedings or out-of-home placement for children. The approach is described as a slow process of building family esteem and confidence and it was perceived as being successful. There was certainly a positive air about these initiatives and one that practitioners felt could be built on in developing other projects and interventions.

While the need for family interventions was hardly disputed, the need to assist adolescents to move away from, and become independent of, their families was also indicated. The youth service in one area highlighted that parental substance misuse was so severe in some families, and with parents refusing to access or engage with services, it became necessary for youth workers to support young people in searching for alternative care and accommodation arrangements.

SUMMARY

Overall the consultation highlighted that a lot had been achieved at a primary prevention level through the involvement of local communities, non-governmental agencies, schools and parent groups, particularly in urban areas; however, a deeper reach into rural neighbourhoods is required. It is also suggested that further knowledge development is

required in relation to problem identification and screening at local levels so that agencies and personnel are able to differentiate more clearly normal and more problematic substance misuse.

The consultation identified considerable frustration at tiers 2-4; in general there is an absence of investment at tiers 2-3 and various community-based practitioners experience difficulty in accessing intensive psychology and child psychiatric services. An overriding difficulty is the absence of effective coordination between different service providers; no specific discipline or agency is perceived as taking a leading, directive role. It is suggested that a dedicated adolescent service would help move things forward.

The consultation was generally very positive about systemic family-based interventions, which were perceived as offering some basic, pragmatic solutions. It was suggested that proposals on initiating such interventions should be brought forward. Overall discussion of tier-4 service was quite muted; there was a sense that practitioners are making fewer referrals to tier 4, which is perceived as being unable to effectively respond to the needs of those adolescents who are in most need of intensive interventions. It was suggested that a hybrid of tier-3 (day-centre) / tier-4 (residential) be developed in order to have a day facility that can both attract the most challenging adolescents, provide some basis for engaging their families and also utilise once-off residential components when these are necessary.

Across all tiers the discussion continuously referenced in-service training and further knowledge development, highlighting the need to develop a greater appreciation of evidence-based practice and of an understanding of the potential role of various pragmatic and systemic interventions in responding to adolescent substance misuse. It was believed that training needed to be developed across the whole health and social care system, so that various professionals could acquire a better understanding of both their potential and limitations in contributing to the service response to this particular vulnerable group.

5 RECOMMENDATIONS

The primary focus of this report and consultation is the implementation of the 4-tier framework with particular reference to tiers 2-4. In preparing to undertake this report it was evident that recent years have witnessed a significant investment at tier-1; in this regard therefore the consultation was considerably more focused in bringing forward recommendations in relation to tiers 2-4. However, in the course of the consultation it became quite clear that the tier-4 framework is premised on an integrated approach; it simply does not make sense to proceed with a discussion of tiers 2-4 without reference to tier 1 also. The report therefore adopted a structure that allowed consideration of primary prevention through tier-1, in reviewing normal alcohol and drug use pathways and in identifying evident gaps in current provision. Two specific gaps were evident, one relating to the need to bolster primary services within rural areas, and the second concerned the need for information about screening, assessment and brief interventions across the whole primary and community sector. The knowledge gap was also apparent across the whole discussion and in general there was support for more in-service training and development relating to adolescent substance misuse.

In relation to tiers 2-4 the report and consultation took guidance from the UK *Substance of Young Needs* report, which initially brought forward 4-tier service proposals. This report adopted the approach that the 4-tier system needed to be flexible and adaptable to existing service systems within any given context, suggesting therefore that new service developments should be grafted on organically to what is already there and that existing providers needed to be drawn together to map out an area approach that was consistent with local needs, structures and possibilities. The consultation for this report could be considered as an initial stage in such exercise; a next stage on could potentially see

existing practitioners and agencies coming together within existing structures in order to make detailed proposals towards the implementation of more broadly defined recommendations, outlined below.

Three key recommendations for moving forward are outlined below, as follows:

- Adolescent service – tier 2
- Family intervention service – tier 2-3
- Specialist service - tier 3-4

In addition, two secondary recommendations concerning prevention and in-service training are also briefly outlined. In outlining these recommendations, there is a need to first give some consideration to the issue of structure. The report adopts the position that new initiatives would be best undertaken through existing local structures, with regional support where feasible; some initiatives would require inter-area collaboration. This report was compiled during a period of organizational change within the operation of health services nationally and locally; the regional levels of coordination and management are in the process of being replaced by strengthened local structures and in the southeast these would correspond to the local health offices at Carlow / Kilkenny, South Tipperary, Waterford and Wexford.

At the national level more attention is to be given to strategic development, to drawing from best evidence and to standardizing, where appropriate, interventions and services across all areas. However, former regional health boards did not all provide for the development of local substance misuse structures; indeed in some instances separate structures exist for alcohol, drugs and methadone services. The existence of local structures in the southeast however, albeit structures that are at an early and delicate stage of development, provide good opportunities for modeling service innovation, and the recommendations in this report are premised on developing the service capacity of existing local substance misuse teams in the four respective areas. It is proposed that three separate structures for service development be explored:

- an expansion of personnel within existing teams through direct recruitment;
- contracting to suitable local service provider or service provider partnership;
- a collaboration across two or more adjacent teams with either of the above.

Recommendation 1: Adolescent service – tier 2

The consultation for this report highlighted a gap in the provision of one-to-one psychosocial services to adolescents, who are caught between adult and children's services. An adolescent-specific service is recommended, and it is suggested that such service provide tier 2 support to adolescents with substance misuse problems and other co-related problems. This tier 2 service should be located within the local substance misuse team, or contracted by it, and it should consist of adolescent support worker(s), who could be persons with a professional background and qualification in social work, youth work or counselling. Specifically the tier 2, adolescent service would have the capacity to provide:

- adolescent brief interventions;
- motivation support through one-to-one counselling and groupwork;
- case management (keyworker) in conjunction with other formal service providers;
- referral to other tier 3-4 services, maintaining contact and ongoing coordination of interventions

It would be important that such an adolescent service not be hospital or medical-based and that it have the facility to work out of buildings / centres that have meaning for young people, are accessible and can draw in persons from dispersed communities. It would be important that an adolescent service can convince adolescents and their families that it will be professional and operate within standard procedures of case management and confidentiality. It should have specific protocols, mediated through area substance misuse coordinator for:

- liaising with, advising (especially in relation to screening) and receiving referrals from youth, community and outreach services;

- developing collaborative work with other tier 2 service providers such as specialist youth services, probation and welfare, juvenile diversion and educational welfare and vocational preparation programmes;
- linking directly with and onward referral to specialist child care, mental health, psychology and other tier 3-4 services.

Recommendation 2: Family intervention service – tier 2-3

The consultation indicated considerable support for family interventions; in the literature review family intervention services are also highly supported in both early and more intensive interventions for adolescent substance misuse and other co-related problems. It is recommended that family intervention services be established possibly through a collaboration of two or more adjacent areas, either through direct provision or contracting out. Two approaches to family intervention are envisaged:

- early intervention family programmes as a way of mobilizing family and proximal supports, through advice, counselling and family group training;
- more intensive family-based interventions in situations where more serious, problematic adolescent substance misuse and / or other co-related problems are indicated.

Family interventions should be undertaken primarily in family homes or alternatively in accessible community facilities where in-home work is not possible. The work should be undertaken in accordance with existing, evidence-based programmes, and in keeping therefore with qualification, training, programme adherence, supervision and monitoring requirements, as appropriate. Intensive family interventions should be undertaken on a short-term (4-8 weeks), family contractual basis, with small caseloads at any one time. Such intensive programmes should have an agreed referral / intake procedure, involving adolescent service (as outline above) and also drawing in other relevant service providers. Discharge procedure should include a consideration as to whether further intensive interventions are required and referral-on, as appropriate.

Recommendation 3: Specialist service – tier 3-4

The consultation highlighted the need for a specialist service (tier 3-4) that would be primarily structured around day centre provision, but would also have facilities for short-term residential provision, if required. This structure would be specifically targeted at young people with particularly difficult challenging behaviour. It should have the capacity to provide:

- Intensive, motivational support, psychosocial services in an intensive setting
- Therapeutic medicines and other clinical procedures, as appropriate
- Facilities for other tier 2-3 adolescent and family intervention services, when required
- Educational / vocational inputs
- Short-term or occasional residential for time-out or respite purposes - with transport to and from day facilities

This service should be provided through a collaboration between two or more adjacent areas, either directly or through contracting out. As this is a proposal for a specialist service it would be important that there be an agreed mechanism for receiving referrals through a structure involving relevant service providers / managers at tier 2-3, and that it would not receive referrals from other sources; it needs to be able to function as a back-up to other tier 2-3 service providers and provide programmes on a customised basis in conjunction with these other providers. The proposal includes provision for a residential component; it would be important that this be used sparingly and as a back up to therapeutics/ psychosocial engagement that is provided primarily in day centre, or elsewhere (e.g. through adolescent service or family intervention service). The residential provision would need to be in accordance with relevant statutory regulations on residential children's services.

Although this report and its preparation was not specifically concerned with prevention or education issues, two specific issues of concern arose in the consultation that suggest the need for further development and investment.

Recommendation 4 – primary prevention tier 1

The consultation highlighted the very valuable preventive work that had been undertaken through community and youth projects; however, it was widely commented that this work needed expansion and there was a need to engage rural communities, particularly those located some distance from cities and larger towns. It is recommended that any future expansion of programmes funded through *Youth Facilities and Services Fund* and supported through the HSESE give particular attention to engaging rural communities.

Recommendation 5 – in-service training

Through the course of this consultation it was commonly referenced that many personnel currently working for HSESE, other statutory agencies such as probation service and juvenile diversion schemes, and community and voluntary agencies were not familiar with the range of possible interventions for responding to adolescent substance misuse and related problems. In particular there was a view that various personnel were not familiar with screening, brief interventions or other non-residential interventions. It is recommended that each area substance misuse education coordinator prioritise the development of in-service training programmes for personnel across this range of agencies and that such training focus on screening, brief interventions, motivational counselling, family interventions etc.

CONCLUSION

Finally, and in conclusion it can be noted that on the basis of both the review of evidence and the consultation undertaken for this report, there is a relatively strong basis for being sanguine about developing an effective service framework for adolescent substance misuse. However, a note of caution also needs to be sounded; some practitioners expressed reluctance to invest energies and time into developing proposals that had little hope of attracting the type of serious funding necessary to both justify their efforts, and to make real impact. There is a sense therefore of resources being needed to drive innovation, that the development of ideas is premised on real prospects of funding becoming available. In moving forward with recommendations therefore, this report has deliberately sketched these within relatively broad parameters. The real work of bringing such proposals forward requires both managerial initiative and practitioner dedication to working out the detail; this latter exercise should preferably also involve some deeper consultation from communities and also involving direct input from young people themselves.

Appendix A

Table 1: Changes in Alcohol and drug use, 1995-2003

		1995	1999	2003	% change		
					95-99	99-03	95-03
Alcohol	<i>Lifetime; 40 times or more</i>	34	40	39	18	-3	15
	<i>Last 30 days; 10 times or more</i>	12	16	16	33	0	33
	<i>Last 30 days; beer 3 times or more</i>	34	35	36	3	3	6
	<i>Last 30 days; wine 3 times or more</i>	4	8	10	100	25	150
	<i>Last 30 days; spirits 3 times or more</i>	20	34	38	70	12	90
	<i>Drunkenness; lifetime; 20 times or more</i>	19	25	30	32	20	58
	<i>Drunkenness; last 30 days; 3 times or more</i>	15	24	26	60	8	73
	<i>Binge drinking</i>	23	31	32	35	3	39
Cannabis	<i>Lifetime</i>	35	33	39	-6	18	11
	<i>Last 30 days</i>	12	15	17	25	13	42

- 90% increase in spirits (3 or more in last 30 days)
- 58% increase in lifetime drunkenness
- 70% increase in recent drunkenness
- 39% increase in binge drinking
- 11% increase in lifetime cannabis
- 42% increase in recent cannabis

Appendix B

Table 2: Summary of evidence of effectiveness based on (n = 10) research reviews

Treatment types	S-EBP ++	EBP +	Total No. of +
Cognitive behaviour treatment	3	3	9
Community reinforcement	3	3	9
Motivational interviewing	1	7	9
Relapse prevention	1	7	9
Social skills training	4	1	9
Behavioural / marital	3	1	7
Brief intervention	2	2	6
Behavioral self-management	1	2	4
Community reinforce + vouchers	1	2	4
Behaviour contracting	1	1	3
Biblio- (self-change + manual)	1	1	3
Methadone + psychosocial	1	1	3
12 steps facilitated		3	3
Aversion therapy		2	2
Covert sensitization		2	2
Individualized drug counselling		2	2
Matrix model		2	2
Stress management training		2	2
Supportive-expressive psycho-therapy		2	2
Behaviour therapy adolescents		1	1
Client-centred counselling		1	1
Cue exposure		1	1
Day treatment, abstin + vouchers		1	1
Group therapy		1	1
Intensive case management		1	1
MDFT – adolescents		1	1
Multi-systemic therapy (MST)		1	1
Therapeutic community		1	1
Voucher reinforcement in MMT		1	1

Table drawn from: Miller, W. R., Zweben, T. J., Johnson, W. R., (2005) Evidence-based treatment: Why, what, where, when, and how? *Journal of Substance Abuse Treatment* 29, 267– 276

S-EBP: Review identified the treatment / intervention as being strongly evidence-based ++

EBP: Review identified the treatment / intervention as being evidence-based +

Total: - total no. of + for each specific treatment based on ten reviews

Treatments are arranged in order of evidence of effectiveness

Appendix C

Table 3: Summary of evidence (n= 15 research studies) for adolescent substance misuse treatment

Evidence	Intervention
<i>A: Evidence of meaningful effect with strong design with 1 yr follow-up or replication</i>	1: Multidimensional family therapy 2: Cognitive-behavioural group treatment
<i>B: Evidence of meaningful effect with relatively strong design with less than 1 yr follow up and no replication</i>	3: Behavioural therapy 4: Combined cognitive behavioural therapy with functional family therapy 5: Family systems therapy 6: Functional family therapy 7: Multi-systemic treatment 8: Combined life-skills and value clarification 9: Psycho-educational therapy
<i>C: Evidence of negligible or undesired effect with less strong designs</i>	10: Supportive group counselling 11: Interactional group treatment 12: Aftercare services 13: Residential treatment with multiple and variable components
<i>D: Evidence of negligible or undesired effect with relatively strong designs</i>	14: Individual counselling 15: Family education 16: Adolescent group treatment 17: Individual cognitive behavioural treatment
<i>E: Evidence of indeterminate effect, mixed or incomplete findings</i>	18: Parent group method 19: Minnesota Model 12 Step Program 20: Coping skills training 21: Brief strategic family therapy 22: General group treatment 23- Purdue brief family therapy 24: Training in parenting skills

Source: Vaughn M.G., Howard M.O. ((2004) “Adolescent substance abuse treatment: A synthesis of controlled evaluations”, *Research on Social Work Practice*, 14 (5): 329.