



***National Treatment Agency  
for Substance Misuse***

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Young people's substance misuse treatment  
services - essential elements

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February 2005

## **National Treatment Agency**

### **More treatment, better treatment, fairer treatment**

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

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# 1 Introduction

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This document has been developed to facilitate the commissioning and development of substance misuse treatment services for children and young people. Latest National Drug Treatment Monitoring System (NDTMS) statistics reveal that in 2003/4 8,634 young people (11-18) had contact with treatment services compared to 3,868 young people in 2000/1. The NTA anticipates that this 2001 baseline will be tripled by 2008 but also that the quality of services will demonstrably improve with more consistent geographical coverage.

This document is part of a range of products being developed to aid the commissioning of young people's substance misuse services:

- The Drug Strategy Directorate is producing a practical electronic commissioning toolkit which will be available on [www.drugs.gov.uk](http://www.drugs.gov.uk).
- The Drug Strategy Directorate is also producing guidance on the partnership grant, changes in children's service commissioning and commissioning in relation to the performance management framework.
- This guidance produced by the National Treatment Agency (NTA) concentrates on the type and standard of services that should be available within the young people's substance misuse treatment system.

## **Audiences**

The audiences for this *essential elements* guide are:

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

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

## **Why was this guidance developed?**

The guidance has been developed in response to a number of factors which will influence the development of young people's substance misuse treatment services.

These include:

- the introduction of new key performance indicators
- the implications of *Every child matters: the next steps (2004)* and the proposals in the *Children Act 2004*
- the National Treatment Agency's (NTA) role to:
  - increase the number of treatment services
  - improve access to treatment services
  - improve the quality of the treatment services
- the young people's substance misuse partnership grant.

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

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

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

The main components of the *Children Act 2004* are:

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

Interim arrangements for commissioning young people's substance misuse services may include the development of a young people's joint commissioning group. This group should be jointly accountable to the children and young people's strategic partnership and the drug action team. However, this will be a transitional process. With the implementation of the *Children Act 2004* and the national service framework for children, young people and maternity services, young people's substance misuse commissioning will be firmly located within children's mainstream commissioning arrangements.

This document will seek to describe:

- a young people's substance misuse treatment system
- the key features for good integrated service delivery
- the minimum range of service delivery available in every area
- how the NTA will performance manage the development of young people's substance misuse treatment.

A glossary of terms used in the document can be found in Appendix D.

A series of practice examples illustrate key features for integrated service delivery. The examples are self-evaluated and have **not** been evaluated by the NTA. Neither is any service or system perfect or the only way forward, but it is hoped that examining these examples will help commissioners plan new services and re-design current services to improve their delivery. Each example has been included for their skill in developing one aspect of service delivery, highlighted in the table below.

These examples have been written by project managers. Astute readers will note that although the NTA identify young people as under 18, there were a number of different definitions of young people used before the 2001 and therefore some projects are still commissioned to provide services for under 19's.

**Table 1: Examples of key features for integrated service delivery**

<b>Practice example</b>	<b>Particular skill</b>	<b>Page number</b>
Lambeth DAAT integrated service model	Operational and strategic partnership working	21
Know the score – Rotherham	Integration with child and adolescent mental health services	25
Young people’s tier 4 service at Kenyon House – Manchester	Tier 4 in-patient service	27
The Zone – Dudley	Supervised consumption model	30
r u - ok? – Brighton and Hove	Integrated commissioning	33
Young people’s service – Derby City	Youth offending service	38
Bolton community drug awareness programme	Parent and community participation	41
East Sussex Under 19 substance misuse service	Rural model of service delivery	45

## **2 Co-ordinated models of service delivery**

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Children and young people's strategic partnerships and children's trusts aim to provide co-ordinated care and improve delivery and integration for children and young people, across sectors and agencies. It is vital that the planning and organisation of substance misuse services for children and young people fits into the overall planning and commissioning of children's services; and ensures that all four elements of the Health Advisory Service (HAS) (2001) tiers are fully integrated to improve outcomes for children and young people (see 3.1).

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

### **2.1 Care pathways**

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

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

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

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

### **2.2 Identifying substance misuse need and referral**

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A vital component of young people's substance misuse treatment services is its referral process. In addition to self or parental referral procedures, mainstream children and young people's services are encouraged to develop their competence in identifying substance misuse needs and their ability to make appropriate referrals. Children's practitioners will be supported in this via the development of common core competencies, which will include elements relating to identifying substance misuse

needs. For further information about identification and referral see *First Steps in identifying young people's substance related needs*, Britton and Noor (2003).

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

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

All services working with children and young people will be expected to use this framework in the future. It is expected that substance misuse will be an integral part of this framework.

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

Service level agreements with substance misuse treatment providers should identify the criteria for referral. This is vital not only for establishing what needs require specialist care, but for distinguishing between young people's substance misuse services in areas where there is more than one service. Where children and young people are referred to specialist substance misuse services, the mainstream children's services should remain in contact and in most cases should conduct the care planning and co-ordination function.

## **2.3 Information sharing**

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

## **2.4 Assessment**

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

relationships, understanding of a young person and continuation of inter-personal relationships will strengthen care pathways and tailoring of services to meet a young person's needs.

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

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

## **2.5 Care planning and joint working**

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

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

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

## **2.6 Virtual teams**

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

The good points of virtual teams are:

- access to substance misuse services in a mainstream setting
- opportunities to develop the competency of generic children's practitioners in substance misuse

- access to support and function of the mainstream agency for the child or young person to improve integration and co-ordination
- development of close integrated working between disciplines and agencies which minimises professional rivalry and duplication.

The Lambeth integrated service model is an example of a virtual team, but in this case there are specialist substance misuse services in place as well as virtual team arrangements (see page 19). In other areas multi agency team are developed using different models (see page 31, Brighton and 43 East Sussex).

## **2.7 Transitional arrangements**

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

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

The following points should also be considered:

- The treatment element of the young people's strand of the drug strategy is funded on the basis that early intervention will prevent young people from needing to access adult services.
- All young people in substance misuse treatment should have a transitional care plan devised prior to their 18<sup>th</sup> birthday. This should identify ongoing needs and which organisations are best able to meet these needs.
- To plan transitional arrangements, service providers of adult and young people's substance misuse services should work together.
- Transitional workers could be based in adult services but also hold some sessions in young people's substance misuse services to facilitate transition.
- A care co-ordinator should be identified in the care plan. In many cases a young person of 18 requiring support for their substance misuse may require interventions from mainstream services such as housing, education, and primary care. In these cases the care co-ordinator could be based in a mainstream service.
- Transition to adult services occurs at different age or developmental stages depending on the agency, for example YOTs, CAMHS, and Looked After Teams may have different arrangements. Transitional arrangements will need to ensure that these different arrangements are included in the care plan if relevant.

## 3 Interventions

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### 3.1 The four-tiered framework

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

**Table 2: HAS (2001) four-tiered framework**

#### **Tier 1**

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

#### **Tier 2**

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

#### **Tier 3**

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

#### **Tier 4**

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

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

The establishment of the HAS four tier model is a way of ensuring that services are developed to help meet the substance needs of all young people. Services at tiers one and two already exist as they are mainly statutory children's services. However, interventions in these services will need to be developed and extended to ensure that staff can identify and meet the substance misuse needs of children they are working with. Every effort should be made to meet children's needs in the lowest possible tier.

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

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

### **3.2 Key factors in developing young people's services**

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

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

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

Children's service practitioners from, for example, social services, Connexions or youth services, should remain as key workers even when a child is referred to a tier 3 or 4 substance misuse service. This is imperative as substance misuse will only be one of a whole host of needs a young person may have, and children's services have been

developed to identify and manage the meeting of all these needs. Staff from mainstream children's services should continue to actively contribute, in a planned way, to the overall management of the young person's needs. (See service called 'r u – ok?' in Brighton and Hove for an example of this page 31)

Examples from Addaction in Derby (see page 36) and Know the Score in Rotherham (see page 23) describe the close development of substance misuse services with youth offending services and child and adolescent mental health services (CAMHS) respectively. The examples show the advantages of establishing co-operative and joint working relationships for children and young people with substance misuse problems.

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

- all agencies, including voluntary agencies, have to safeguard and promote the welfare of children

### **3.3 Types of substance misuse treatment services to be provided**

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

- comprehensive assessment of substance misuse needs within five days of referral to a specialist agency
- care planned interventions based on identified needs, including onward referral to tier 3 and 4 services within ten days of assessment
- harm reduction services - interventions provided to meet a young person's need to use substances more safely, including but not exclusively safer injecting advice and interventions provided at tier 3 and 4
- support for family members, with or without the substance misusing young person, within ten days of referral.
- psychosocial interventions, structured interventions involving individual or group work focusing on assessment, defined treatment plans and treatment goals with regular reviews.
- a community based pharmacological intervention within 10 days of referral. This can be provided by a doctor in a community setting, including a competent general practitioner (GP) in or outside of structured shared care arrangements.
- access to specialised in-patient or residential treatment services (this may consist of a range of services or identified provision outside of the local area).

All of these interventions will require consent, given either by the person with parental responsibility for the child or young person, or by the young person themselves provided they are competent. Whilst consent is important for all aspects of treatment, particular caution should be given to the participation of young people in intrusive treatment options. These include prescribing interventions, vaccination, testing for drugs or other conditions, needle exchange, complementary therapies that involve bodily contact and acupuncture, auricular and other forms. For further information about gaining consent

and assessing competence to consent when working with children see *Seeking consent: working with children* Department of Health (2001).

### **3.4 Criminal justice interventions**

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

- all young people in contact with youth offending teams (YOTs) to have their substance misuse needs (if any) identified, those with identified needs receive appropriate specialist assessment within five working days
- following assessment access to early intervention and treatment services is required within 10 working days.

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

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

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

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

Guidance has been developed to support the DIP initiatives.

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

### **3.5 Needle exchange**

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

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

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

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

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

### **3.6 Pharmacological services**

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The evidence base for pharmacological interventions to treat substance misuse in young people is poor. As such the adult evidence base must be used and considered when developing services for young people until further evidence is developed. See the following:

*Drug misuse and dependence – guidelines on clinical management* (Department of Health, 1999)

*Prescribing services for drug misuse* (National Treatment Agency, 2003)

*The substance of young needs: review 2001* (Health Advisory Service, 2001)

However, the adult evidence base also needs to be matched against ensuring the well-being of children. This is not a simple process. Consideration should be given to each young person's individual's situation with regard to the introduction of a detoxification regime or a maintenance regime. It may be considered that due to the short length of dependency in a young person that detoxification is the only option. However, other evidence based factors should be used to aid decision making.

#### **Consider:**

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

- likelihood to relapse or overdose
- co-morbidity factors.

Specific guidelines in relation to clinical governance (see 4.2) will be published by the National Treatment Agency in 2005, as will new guidance for the prescribing of all medication to treat substance misuse.

Supervised consumption of medication by an appropriate professional is recommended in the *Drug misuse and dependence – guidelines on clinical management* (Department of Health, 1999) for all new patients. In arranging this service to young people additional precautions should be considered. Many young people will be engaging in substance misuse treatment for the first time and as such may not fully understand the risks associated with taking a controlled drug. In addition titration for young people is difficult due to differences in body mass and the development of internal organs. Supervised consumption by a pharmacist may be supported by the involvement of other professionals engaged in prescribing to the young person to enhance safety measures. (See The Zone in Dudley for an example of a supervised consumption model page 30).

### **3.7 Developing tier 4 services**

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

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

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

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

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

(see model for Kenyon House page 27)

## 4 Quality of treatment

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

Currently a number of young people are still inappropriately accessing adult services, but this is slowly changing. The NTA will be monitoring service provision and using the following factors as indicators of the quality of local service provision:

- child focused services
- integrated care pathway
- children and young people's strategic planning and commissioning including substance misuse
- care plans
- referral protocols
- full range of services
  - psycho social interventions
  - harm reduction services
  - work with parents and carers.
  - criminal justice interventions.
  - community prescribing
  - access to tier 4 interventions.

The NTA, in partnership with regional government offices will assess performance based on the performance management framework for young people (see Appendix E).

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

### 4.1 Clinical governance

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

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

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

- role of substance misuse specialist doctors

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

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

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

## **4.2 Monitoring**

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It is the responsibility of the regional government office to co-ordinate the performance management of the partnership grant. The NTA has a responsibility to performance manage the treatment element of the grant, in partnership with other stakeholders. This will be facilitated by the NTA's performance management framework for young people (See Appendix E). This performance management framework will evolve over time and is likely to be incorporated into a tool that takes account of the new children's services joint assessment and review process.

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

- to plan and commission local services
- to inform central government and ministers about substance misuse treatment, which in turn may affect funding available
- to identify and performance manage treatment effectiveness
- to identify long-term trends in drug use.

The NTA is developing specific young people's core data set in relation to young people under 18 in contact with specialist substance misuse services. It is important that young people's substance misuse services complete this data set, when it becomes available. The data set will collect information in relation to the type of service a young person has received:

- psychological interventions
- harm reduction services
- work with parents and carers
- community prescribing
- shared care schemes
- specialist pharmacological interventions
- tier 4 interventions
- residential rehabilitation.

(More information in relation to this draft data set is listed in Appendix B)

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

### **4.3 Sharing information and record keeping:**

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

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

Record keeping procedures should also comply with the Data Protection Act 1998 and from January 2005 agencies should also have a policy relating to the Freedom of Information Act 2004.

All agencies should also have policies on confidentiality and consent to treatment. See below in 4.4 and 4.5.

In addition all staff should receive training to ensure they know the process of information sharing and how to document it.

### **4.4 Confidentiality:**

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

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

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

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

See consent below.

### **4.5 Consent:**

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Services can offer advice and information about drugs to children and young people without the consent of a parent. However in line with the Children Act 1989 it is good practice to involve parents in any interventions that follow a comprehensive assessment. The general rule is that if a young person is deemed to be competent to consent to treatment then they are also competent to agreeing to the confidentiality contract above and to their parents not being informed.

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

- s/he understands the advice and has the maturity to understand what is involved
- the health professional cannot persuade the young person to inform the person who holds parental responsibility nor to allow the health professional to inform that person
- the young person's physical or mental health will suffer if s/he does not have treatment
- it is in the best interests to give such treatment without parental consent
- in the case of contraception or substance misuse, the young person will continue to put her/himself at risk or harm if s/he does not have advice/treatment.

Fraser guidelines ( Mental Health Act 1983 Code of Practice 1999)  
Quoted in SCODA 2000.

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

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

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

- SCODA /Children's Legal Centre. Young People and Drugs Drugscope1999
- SCODA. Assessing young people's drug taking. Drugscope 2000
- Royal College of General practitioners and Brook Advisory Services. Confidentiality and Young people: Improving teenagers uptake of sexual and health advice (2000)
- Department of Health: Seeking Consent Working with Children. DH Website

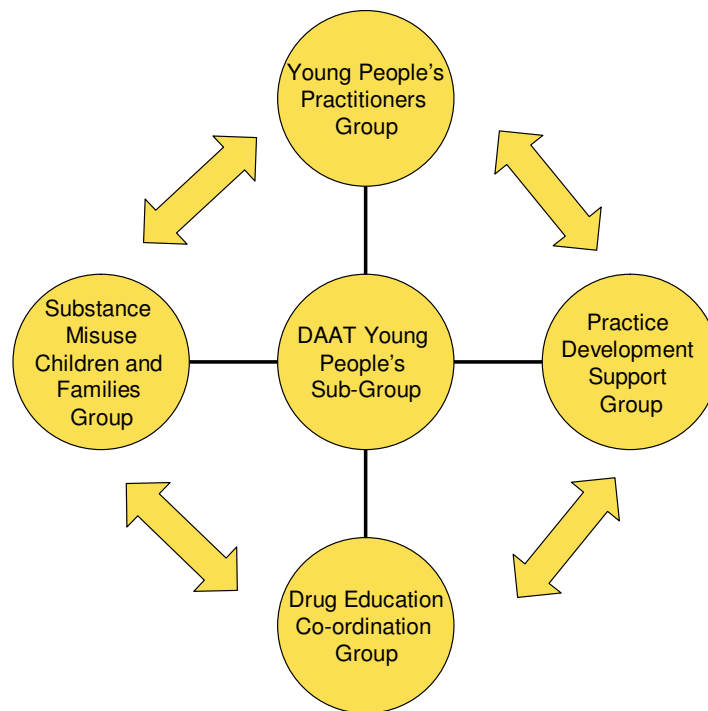
## 5 Practice examples

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### 5.1 Lambeth DAAT integrated service model

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This practice model is not a description of a service, but rather a model of how services can be closely integrated. In Lambeth there are a large number of services, both mainstream and specialist, that offer substance misuse interventions for young people. Unlike many other areas that have a range of service provision, the services are not rivals and consider that trust and collaboration are at the heart of good service delivery. The integration of all services is shown in the diagram below and the role of each group is described in the table.



Young people's practitioners group (service delivery)	Practice development support group (treatment and intensive interventions)	Drug education co-ordination group (education and prevention)	Substance misuse / children and families group (mainstreaming agenda)	DAAT young people's sub-group (strategic group)
Monthly meeting to discuss: <ul style="list-style-type: none"> <li>• the use of resources</li> <li>• delivery of training sessions</li> <li>• plan training opportunities and initiatives</li> <li>• policy development</li> <li>• joint working initiatives</li> <li>• share information on new initiatives</li> <li>• reference group for the DAAT young people's sub-group.</li> </ul>	Monthly peer support meetings focusing on: <ul style="list-style-type: none"> <li>• challenges in individual cases</li> <li>• case discussions</li> <li>• spring board for future referrals</li> <li>• understanding skills and practice of colleagues</li> <li>• developing trust and understanding</li> <li>• giving and getting support.</li> </ul>	Bi-monthly meetings to discuss: <ul style="list-style-type: none"> <li>• links between components of education</li> <li>• planning of training</li> <li>• delivery of initiatives</li> <li>• policy development</li> <li>• links with other tiers of provision</li> <li>• development of out of school provision</li> <li>• reference group for the DAAT young people's sub-group.</li> </ul>	Monthly meetings to discuss: <ul style="list-style-type: none"> <li>• development of services for children of drug using parents</li> <li>• initiatives to help young people who use substances</li> <li>• transitional processes to support young people as they move to adult service provision</li> <li>• reference group for the DAAT young people's sub-group.</li> </ul>	Bi-monthly meetings to: <ul style="list-style-type: none"> <li>• consider the views expressed from the reference groups</li> <li>• develop the young people's substance misuse plan</li> <li>• monitor commissioning and service development</li> <li>• examine the implementation of new initiatives</li> <li>• provide supportive mechanisms for the reference and practitioner groups.</li> </ul>

### 5.1.1 Integration with other services

A local screening tool has been developed. Both statutory and voluntary sector agencies involved with substances and young people have signed up to and are using the screening tool. Training was provided to facilitate this. In addition to using the tool, each agency contributes information to an overarching database to monitor use of the tool and the needs of young people. Alongside the screening tool a referral route-map has been devised to help agencies make decisions about the best service pathways for young people.

Once a referral has been made agencies will consider what their involvement with a young person should be. If a young person is already in contact with a number of services, a joint meeting will be held between them to discuss the referral and the

contribution the new service can make. Often the outcome of this might be that the new substance misuse specialist agency advises and supports one of the key-workers already engaging with the young person, rather than establishing yet another contact point for her/him.

Where a decision is reached that the new service will become directly involved, information from previous assessments and case work with the young person will be shared, with the young person's consent. This facilitates the assessment process, avoids unnecessary re-telling of the young person's story and provides a truly joint working basis.

The case work continues with regular joint working meetings between the professionals, young person and their family to ensure that the care plan is understood and progressing.

Sometimes during the practice development support group it becomes apparent that several agencies are working with the same individual independently, or that a young person could benefit from the services of another agency. At this point the young person will be approached to gauge their opinion on developing joint working arrangements to better meet their needs.

The co-operation and collaboration between agencies at the practice development support group is very strong. This facilitates the building of trust and understanding of other practitioners' specialist skills as well as of other agency/organisational limitations. It is also a very useful point of induction for new professionals to the area.

### **5.1.2 Transitional arrangements**

Transition to adult services is not always easy. To facilitate this, substance misuse-related services try hard to avoid/overcome rigid age boundaries in relation to transfers between services. The practitioners will often continue engagement with a young person who has crossed an official age barrier, and/or help to find and guide a young person to an appropriate adult service. The substance misuse children & families group will try to help in this process where a young person is accessing social care services.

Three new projects are being developed to smooth and improve transitions:

- YOT/Probation cross-over project which includes community safety team and police support.
- young people/adult treatment transition informal arrangements do exist, but these are ad hoc and practitioners have decided to develop more formalised protocols and processes.
- a new cannabis service, which will have both young people and adult elements, is being piloted; expectations are that transfers, if required, will be seamless.

The practice development support group and the close working relationships within it, is helping ensure that transition from specialist services to mainstream provision (and vice-versa) is seamless, since mainstream services are involved from the outset.

### **5.1.3 Child protection**

The young people's practitioners group has identified and facilitated the planning of confidentiality, child protection and substance misuse training across all agencies. This training is co-funded by the area child protection committee; the aim is for a common understanding and action in relation to these issues. In addition the management and training consultant affiliated to the DAAT is developing joint working policies for all agencies to use in relation to child protection regarding parental or the young person's own substance misuse.

All associated agencies across Lambeth are happy to participate in child protection conferences, ensuring that a child or young person's welfare is of utmost importance at all times.

#### **5.1.4 Commissioning structure**

The Lambeth young people's practitioners group and Drug education co-ordination group regularly discuss the needs of young people, how these needs are being met, what gaps there are in provision, and develop ideas and priorities for action. The Lambeth DAAT young people's substance misuse co-ordinator attends these and all local young people's substance misuse groups, and contributes to and appreciates the local situation analysis.

The reflections and recommendations of the group are fed into the DAAT young people's sub-group. This is a strategic planning group (chaired by a voluntary sector provider, vice-chaired by the YP police inspector), whose members also include managers from the youth offending team, social services, police, and the DAAT joint commissioning manager (based in the local Primary Care Trust). This group shares with the young people's substance misuse co-ordinator responsibility for developing the strategic plan for Lambeth DAAT in relation to young people. During the development of the plan, drafts pass between the groups to ensure collaboration, active contributions and ownership.

Following the joint production of a final agreed plan, the young people's joint commissioning group (a sub-group of the DAAT adult joint commissioning group) scrutinises the plan and ratifies the commissioning decisions, before passing it to the DAAT/CDRP for final approval and signing off.

Young people themselves do not have a direct role in commissioning; however they are involved in the overall process. Lambeth young people's substance misuse co-ordinator encourages services and workers to:

- act as advocates for the young people and represent their views at the Lambeth young people's practitioner group and drug education co-ordination group
- have mechanisms for young people's involvement in service delivery and planning within their own organisations.

#### **Contact details**

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## **5.2 Know the score - Rotherham**

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This service was established in 1997 as a tier 2/3 service offering interventions such as needle exchange, one to one work and prescribing interventions. The service is now developing its tier 2 role due to a shift in the patterns of local drug use. This is due mainly to two factors: the stabilisation of the number of young heroin users in the area, and the better retention of service users in adult service provision locally. This has taken pressure off the service to work with young adults (aged 19-21). Additional tier 2 service provisions include two vulnerable young people's outreach workers, combined with more work occurring at satellite venues in children's services, rather than children and young people always coming to the service. The role of these workers is to make contact with young people identified as vulnerable by Know the score or other services such as the YOT, social services, accommodation support workers or sexual exploitation team. Once contact has been made substance misuse education and prevention work can begin and ultimately work to link the young person into mainstream children's provision and/or substance misuse services as appropriate.

### **5.2.1 CAMHS connections**

Prescribing provision is obtained from a session from a consultant child and adolescent psychiatrist from the CAMHS team. Any young person in contact with Know the score can be seen by the psychiatrist if there is a concern that they may have mental health needs. The psychiatrist will assess the young person and if he identifies a need will refer the young person directly into CAMHS ensuring a faster service than a GP referral would yield.

Similarly if CAMHS pick up a substance misuse issue from a young person attending or referred to their service, a referral to Know the score can be easily facilitated.

### **5.2.2 Child protection**

Know the score has a resident children and families social worker. This worker can conduct statutory child protection assessments in line with the assessment framework for children in need and their families, as well as conducting or working with a colleague on substance misuse assessments. This worker will also provide on going or joint work on child protection issues including the writing of reports and attendance at child protection conferences. This worker is employed by the local authority.

### **5.2.3 Clinical governance**

All of the substance misuse services are currently led by Doncaster and South Humber NHS Trust. As such clinical governance is managed via this route. This has meant that in the past many of the policies and procedures were based on adult service provision, partly as a result of also working with adults up to age 21. However, with the re-configuration of service delivery back to under 19 the service will be more closely aligned to CAMHS and as such will develop policies and procedures based on those operating in CAMHS.

### **5.2.4 Commissioning structure**

The service manager has worked closely with the commissioner to develop the service over time. The local DAT merged with the Crime and Disorder Reduction Partnership, Safer Rotherham. However, there is still a specialist lead commissioner for young people's substance misuse treatment. The service manager meets with colleagues at the bi-monthly young people's substance misuse planning group, which reports to the

young people's joint commissioning team for substance misuse. This in turn links to the joint commissioning team for children and families.

The manager feels that the proposals set out in the new *Children Act 2004* combined with the partnership grant for substance misuse will help clarify the situation.

Until recently the different aspects of the service were commissioned separately from specific funding streams. This led to a situation where funding streams and associated positions would come under pressure and face disinvestment; this would happen at different times for different aspects of the service. However, an overarching service level agreement has now been developed. This ensures better security for the service, continuity for service users and local services and enhances staff retention.

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### **5.3 Young people's tier 4 service at Kenyon House – Greater Manchester**

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The young people's tier 4 service at Kenyon House offers services to young people aged 13 – 19 years old with substance misuse problems. Kenyon House consists of a six bed short stay (up to four weeks) specialist in-patient substance misuse centre. The in-patient unit not only works with young people who are dependent on drugs or alcohol who want to become drug free but also provides care to help stabilise young people. Young people's substance misuse patterns do not always follow those of adults. Often young people may not be dependent on one particular substance but may use a wide range of substances in a frequent and random manner that affects their ability to function. Such young people benefit from the opportunity to break from the chaos of their lives and put plans in place. The in-patient unit provides a safe place to do this.

Assessment of the young person at Kenyon House is multi-disciplinary to ensure a holistic approach. It includes a physical examination, a mental health assessment, and the information provided by the tier 3 service. The multi-disciplinary team has access to a consultant psychiatrist from CAMHS, a consultant psychiatrist from substance misuse services, and nurses with backgrounds in mental health, substance misuse and CAMHS. In addition the young person is encouraged to attend appointments with a dentist, optician, and a general practitioner.

Referrals were initially only taken from young people's tier 3 substance misuse services. However, direct referrals have now been opened up to CAMHS, youth offender teams, and social services.

#### **5.3.1 Integration**

Kenyon House works in tandem with community-based advocacy workers based in young people's substance misuse services in each of the ten Greater Manchester drug action teams. The service is being extended to Lancashire and other North West areas. The advocacy workers are linked to local tier 3 substance misuse services. The advocacy workers are able to quickly make contact with young people considered to have substance misuse problems, assess their situation and develop a care plan to meet their needs. Those in need can be referred to Kenyon House without cumbersome funding arrangements holding up the process. The advocacy worker keeps in contact with the young person throughout their in-patient stay and continues to work to co-ordinate other services' responses. As local tier 3 services have developed any of the young people's workers in tier 3 services can fulfil this function.

Integrated services for young people are co-ordinated by the advocacy workers, or equivalent, encouraging the involvement of social services, youth justice and housing.

If child protection issues are raised either the staff at Kenyon House or the community tier 3 service can initiate an investigation, depending on where the issue arose. With regard to attending a child protection conference, more often than not the community based workers would be best placed to attend as they have a long-term relationship with the child or young person. Staff from Kenyon House would attend only if the unit's role was pertinent to the case, for example if an incident had occurred on the unit that led to the child being at risk.

Meeting the education needs of young people at Kenyon House differs depending on the access to education the young person had prior to their stay. Those who are

participating in education would have arrangements put in place to ensure that work was set during their stay. The advocacy workers, or equivalent, would assist those out of education to link with local education services so that aftercare arrangements could be put in place. As the average length of stay in Kenyon House is 17 days it is not felt appropriate to provide teachers on site. However, the unit can access support and advice from teaching staff on longer in-patient children's units on the same hospital site.

### **5.3.2 Care planning**

On admission to the unit a care plan is worked out with the young person and may include stabilisation, prescribing, detoxification, titration and blind titration. The unit provides group programmes and individual sessions for clients around three core areas; drug awareness, health education (safe sex, blood borne viruses), social skills (anger management). They offer sessions around self-harming, encourage hepatitis B vaccinations and encourage testing for blood borne viruses. A range of crafts, cooking, complimentary therapies, physical activities in a gym, and time management skills are offered.

### **5.3.3 Sharing of information**

Information is shared between the advocacy staff and in-patient staff, and vice versa, to ensure services are offered that meet the young person's needs.

It is the role of the advocacy worker to ensure a holistic care package is developed for the young person.

### **5.3.4 Transition to community based services**

The arrangements for community services in each DAT vary. Although there is an advocacy worker to continue contact with the young person the provision of tier 3 services varies widely. Only a minority of the ten DATs can currently offer community prescribing.

The in-patient unit offers a 24 hour telephone helpline for clients once they have left the service, and clients can return to the service after discharge with their advocacy worker. However, visits are usually advised against for a few weeks to allow a period of disengagement from the service.

In relation to the post-discharge care plan the tier 4 services manager and the senior nurse at the in-patient unit have noted that as clients move around the Manchester area they are retained in their care plans. It is felt that this is because the advocacy workers meet regularly and have formed a close network.

### **5.3.5 Clinical governance**

As part of the clinical governance requirements, issues related to service delivery of the in-patient unit are taken to the substance misuse directorate clinical governance group.

### **5.3.6 Service development**

There is a high incidence of young people participating in the in-patient programme that have mental health problems and deliberately harm themselves. While staff are competent in working with these conditions, there is concern that the young people are only in contact with this service for a short time. Advocacy workers will try to access mental health services for their clients. The 17 – 19 year old age group often need to access adult mental health services, especially if they haven't had any previous

experience with CAMHS. In addition the in-patient unit can refer young people whose first onset of mental illness was detected at the unit to the Early detection intervention team (EDIT). However, the young people may benefit from closer relationships with CAMHS community services across the region.

The service manager gave the following recommendations for providers setting up tier 4 services for young people:

- ensure that the budget and time frame is adequate to set up a tier 4 service, and that funding arrangements are long-term (at least three years).
- establish local tier 3 services for young people prior to setting up a tier 4 service
- establish a tier 4 service using a partnership approach supported by commissioners and agencies, this will provide support and be less vulnerable.
- ensure that activities are taken into account in the budget for in-patient services for young people, as they require more than would be anticipated in an equivalent adult unit.
- access to accommodation on discharge is a serious problem and can result in a young person not being referred for in-patient care, as there is no aftercare or contingency accommodation set-up. Commissioners need to work closely with their colleagues in housing departments to rectify this.

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0161 772 3816 (for the unit)

## **5.4 The Zone - Dudley**

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The Zone provides a range of holistic interventions on substance misuse for young people. The purpose of this section however, is to describe their supervised consumption model. A young person may engage in a prescribing programme, only in conjunction with a contracted care plan to meet all their needs.

The first stage of engagement is to undertake a full assessment, including gaining urine samples. All urine samples must show positive results to indicate that the young person is dependent on a substance. Treatment provided will usually be buprenorphine as this is considered to be safer than methadone, due to the reduced overdose risk. Methadone prescribing is available but only in extreme circumstances in this service.

### **5.4.1 Referral**

The majority of referrals come either from a parent or another agency. Self referrals tend to be generated on the spot with young people attending with a friend. Parental referrals invariably result in a joint parent/child initial assessment held by a family worker and young person's key worker. Although, sometimes only the young person is seen, this is dependent on age and family circumstances. Occasionally agency referrers attend initial assessments too, to facilitate involvement.

### **5.4.2 Integrated working**

Along with many other young peoples treatment services the Zone works closely with Social Services, YOTS, Education, Connexions and the adult substance misuse services. Joint working with CAMHS is very strong. A reciprocal arrangement has been made to facilitate better access to CAMHS and clinical development. A joint protocol is in place to establish this.

A joint working agreement with social services has developed the Zone's responsibilities in relation to assisting social services meet its child protection obligations. The Zone will undertake assessments for substance misuse as well as meeting the criteria laid out in the national assessment framework for children in need and their families. The Zone can also call strategy meetings with social services and case conferences (but not child protection case conferences) to assist in planning a child's care. In practice the Zone will take on much of the care management role for social services unless it is a complex case, and the child is on the child protection register. The Zone has an agreed established process with social services for identifying if a child or young person needs residential care and access to social services funding.

Clear information-sharing arrangements have been agreed between the Zone and the YOT.

### **5.4.3 Methadone prescriptions**

Initially, there will be a stabilisation period of two to three weeks. This will allow the young person time to adjust to the methadone and to examine craving patterns and high-risk situations. The prescription is issued to the young person on a weekly basis, but the methadone is dispensed daily, under the supervised consumption regime.

Methadone will be prescribed on a reduction programme only. No maintenance programmes are offered unless there are specific mental health issues. Longer term prescribing would be done by the adult service who are more experienced with this client group. There is a clear transitional policy with a joint care plan which will manage the young person's needs holistically with frequent reviews by staff from both services. The young person's general practitioner and pharmacist are notified about the prescription regime.

#### **5.4.4 Buprenorphine prescriptions**

Buprenorphine is prescribed by daily, supervised consumption. Parents/guardians are generally contracted to supervise the weekend doses. However, some pharmacies do offer weekend supervision for clients who may not have enough family support.

The stabilisation period will be negotiated in the client's treatment plan, between the young person and their key-worker. This will allow the young person time to adjust to buprenorphine and actively engage in relapse prevention work. The young person's general practitioner and pharmacist are notified about the prescription regime.

The programme will be reviewed weekly with the young person by their key-worker. Urine samples will be taken at least once a week for the first six weeks, thereafter every one to three weeks according to clinical needs. This is to ensure that the young person is using their prescription properly and is not using illicit substances on top of their prescription, or selling or giving away their prescribed substances.

Buprenorphine prescribing is initiated, stabilised and reduced according to a strict protocol. However the length of stabilisation, and stabilisation dose required, is determined according to individual needs. Following five to seven days of being drug free the opiate blocker naloxone is prescribed.

#### **5.4.5 Supervised consumption regime**

The young person is expected to attend the pharmacy at specific times, to behave appropriately whilst at the pharmacy and to abstain from any illicit drug use whilst receiving a prescription for substance misuse treatment. Failure to do so may result in the prescription being stopped.

The Zone has access to seven pharmacies who participate in the shared care monitoring group. There is a specific room allocated to supervised consumption at the pharmacy. On the first two occasions the young person is met at the pharmacy at an allotted time by the young person's substance misuse key-worker. The medication is administered by the pharmacist in the presence of the substance misuse worker, provided that there are no signs of intoxication. Following administration of the medication, the young person is expected to remain in the room, and demonstrate that the medication has completely dissolved before leaving the pharmacy. For the initial dose the client will be asked to wait for one hour to ensure there are no adverse effects. This is to reduce the chances of overdose and passing of medication to another person. It also helps to monitor if the correct dose is being prescribed and gives support and security to vulnerable young people.

On the third day an appointment at the Zone must be kept to ensure that all is going well. If there are any difficulties an appointment can be made to see the doctor on the fourth or fifth day of initiation of prescribing.

#### **5.4.6 Clinical governance**

The Zone is a voluntary sector organisation. Clinical services are led by the consultant psychiatrist in substance misuse from the local NHS trust. This ensures that there is a formal route to clinical governance. The Zone has established its own operation child specific policies that have been passed by the clinical governance group.

The consultant psychiatrist provides leadership to the other doctors working at the Zone. These consist of a specialist GP and a child and adolescent psychiatrist. A clinical development meeting is held every six weeks to look at the development of the service, including monitoring arrangements, evaluation of delivery and range of treatment modalities used.

#### **5.4.7. Transitional arrangements**

There are different procedures and protocols in use at the young person's service compared with the adult service. As such it is important to make the young person aware of this and help them to adapt to different service provisions as they reach maturity.

Young people attending the service are prepared for transition to adult provision in a staged process with long lead-in periods. The service's agreement with the young person changes at around 17½ years as boundaries are made stricter in relation to prescribing and service attendance. It is felt that by this age the young person should be more aware of their own responsibilities and taking account of their own actions, than those of a younger child.

At 18½ years the service will begin to look at transfer needs. If the care plan suggests that the treatment period will need to be continued beyond the 19<sup>th</sup> birthday, work is begun to transfer the young person to the adult service. Two key workers meet and build their relationship and the young person is introduced gradually to the new service's mechanisms and personnel until they are ready for transfer.

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## 5.5 r u - ok? – Brighton and Hove

r u – ok? is a specialist substance misuse service, meeting the tier 2 – 4 needs of young people aged 10 – 18 years and their families. The service was commissioned as a multi-agency service bringing together health, local authority and the voluntary sector. This example focuses on these commissioning arrangements and the co-operation of a range of service providers.

The service provides a range of interventions including:

- family work
- group work
- individual counselling
- key working
- prescribing.

The service is managed by the local authority. The service manager is a core member of the children, families and schools operational management group, ensuring the service is kept closely in touch with children’s strategic developments, and the scope and nature of the services offered are well publicised and understood by all social care managers.

Many of the practitioners are placed in the team by parent agencies rather than being employed by the local authority.

Team member	Parent organisation
Service manager	Local authority
Consultant child and adolescent psychiatrist (two sessions)	CAMHS
Associate specialist in child psychiatry (two sessions)	CAMHS
Young person’s substance misuse worker	Hove YMCA
Connexions personal advisor	Hove YMCA
Education support worker	Local education authority
Young person’s substance misuse worker	Local authority
Senior social worker	Local authority
YOT young persons substance misuse worker *	Youth offending team
Female specialist worker *	Oasis women’s project

\* = a worker who is based in their parent organisation rather than r u – ok? and who has a link with the service.

### Integration with other services

The service accepts referrals from other professions, parents/carers, and from young people themselves. Its aim is to work very closely with mainstream children’s services and is the philosophy behind the multi-agency team. This ensures that as children’s substance misuse needs diminish, their transfer back into mainstream agencies is

simplified. In addition, management by the local authority ensures that social care and particularly child protection issues are addressed.

The establishment of a local screening tool to identify immediate substance misuse needs is helping mainstream services to come on board with the substance misuse agenda. There is also a commitment that substance misuse should form part of the general assessment processes of mainstream children's services.

There is improving co-operation between children's services due to the multi-agency delivery model. If an assessment has been undertaken by a partner agency then the substance misuse service will have full access to the information, including contact with the young person's file and case notes. This arrangement has been agreed with the youth offending team, Connexions, social services, Hove YMCA and Oasis (voluntary sector drugs agency).

In addition to information sharing to inform the assessment process, on occasions there are joint assessments undertaken by r u - ok? and the referring partner agency. This is consolidated by further joint working sessions as required and by involving parents and young people fully in the process.

r u - ok? rarely acts as a care co-ordinator for young people, as the majority of the young people are currently receiving services from statutory mainstream children's services.

Transitional arrangements for returning children and young people to mainstream children's services following a substance misuse intervention are part of the main agenda of r u - ok?. The multi-agency nature and care co-ordination by children's services makes this process both co-ordinated and seamless.

Transition to adult services for continued work on substance misuse is more complex. An agreement has been made with the adult service that cases will be dealt with on a case-by-case basis considering the complexity of the case and the likely length of substance misuse intervention. When a young person is reaching maturity or is referred after their 18<sup>th</sup> birthday a decision will be made as to where the individual can best have their needs met. If it seems likely that long-term care will be required the case could be taken on by the adult substance misuse team. However, conversely, if a young person aged over 18 is referred to the adult service but short-term work will be required, r u - ok? may take on the case. In the case of a referral to adult services of a young person over 18 years of age who has either a short substance-using history or is a new presenter to 'treatment services', r u -ok? may assess the person. For young women the issue is potentially simpler. Oasis is a female specific service and so a seamless service can be provided.

### **5.5.1 Child protection**

A senior social worker has recently been recruited. The service manager has ensured that all staff are competent in relation to identifying and responding to child protection concerns. If there is a concern about a child or young person the manager will be contacted and a decision will be reached as to whether the concern warrants reporting to the duty assessment team at social services. The duty assessment team will then decide if action needs to be taken. A joint assessment may be undertaken between social services and r u -ok?. The senior social worker will be able to make independent

decisions and assessments to determine if a child protection investigation is to take place.

The senior social work post is to be supervised by a manager from the duty assessment team, and therefore there will be structural links to the duty assessment team, which is the directorate's main child protection response service.

The service's child protection, information sharing, lone working and confidentiality policies are all area child protection committee approved.

In relation to child protection conferences it is usual for the caseworker involved to attend. Information is then passed to the manager via supervision. The service manager is line managed in turn by the assistant director of social services who is also responsible for the duty assessment team and so is well versed in child protection issues and practice.

### **5.5.2 Clinical governance**

ru – ok ? has its prescribing needs met by two psychiatrists from CAMHS. The psychiatrists have established close links with the substance misuse psychiatrist in the adult service. This has meant that hands-on experience has been gained by shadowing the adult psychiatrist and that monthly supervision arrangements are in place between the child and substance misuse specialists. Policies and procedures of clinical governance are routed via the medical committee of the local NHS trust.

### **5.5.3 Commissioning structure**

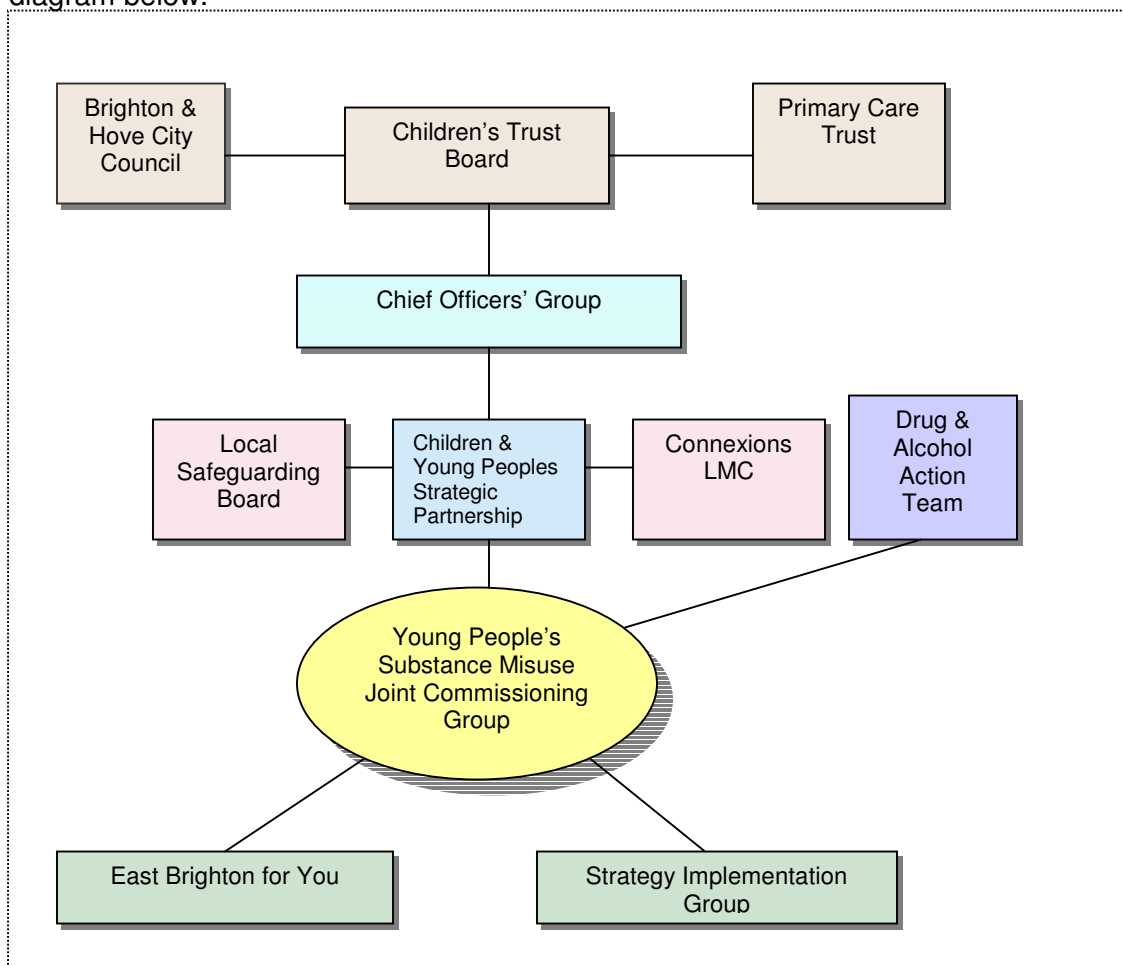
The concept for the service was first discussed in 1998. A needs assessment conducted in 1999 and a working party established following this. The crucial element for ensuring that the service was established was a number of local children's service champions. These included the medical director of CAMHS, the group manager for child protection within the local authority and the chief executive of the YMCA.

The working party established a development project and employed a development officer to take the work forward, including developing the philosophy and the model of delivery. Consultation with a small sample of young people (20), parents / carers and providers occurred. Information gained was fed back into the commissioning process. From this consultation the structure, philosophy and location of the service was developed.

A young people's substance misuse joint commissioning group was established in 2001 and now consists of the following members:

- primary care trust joint commissioning manager
- children's trust commissioner
- drug and alcohol action team co-ordinator
- youth offending team manager
- head of social inclusion (chair)
- Connexions manager
- Sure Start manager
- Children's fund manager

The integrated arrangements for governance and commissioning are described in the diagram below.



The diagram identifies Brighton and Hove as being a children's trust pilot. As this pilot gets underway the relationship between the YPSMJCG and the children's trust will develop. Presently the group reports to the DAAT and the children and young people's strategic partnership.

East Brighton for You (eb4u) is a project set up with regeneration funds from New Deal in the Communities money. The aim of the group is to address issues of social exclusion in East Brighton.

The strategy implementation group consists of local substance misuse service providers, which, like the young people's substance misuse joint commissioning group, meets quarterly.

This arrangement ensures that initiatives from different groups are fed into and considered by other groups to ensure that work is integrated and, therefore, not sitting outside the commissioning framework.

The DAAT (drug and alcohol action team) co-ordinator develops the DAAT plan for young people's substance misuse, with specific input from those at the strategy

implementation group. The plan will then go formally to the commissioning group and then to be ratified by the DAAT.

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## **5.6 Addaction young people's service – Derby City**

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The Addaction young people's service in Derby City is a peripatetic service for young people aged under 18 years. Due to the peripatetic nature of the service all young people are seen off premises, as only administration is managed on site. This involves working in community settings, other agencies and conducting home visits. A range of services are offered including support and information, one to one work, and access to drug awareness training for staff of other agencies. In addition, support is given to other professionals and parents in relation to substances. This means that support and work with young people, or their children, can continue without Addaction needing to be directly involved with the young person themselves. This supports the model of maintaining children in mainstream services and with their families.

A specific service has been developed to work with young people involved in the criminal justice system. A member of the Addaction team is funded via the YOT named drug worker programme to work full-time at the youth offending service (YOS). It is this work that this example will focus on.

### **5.6.1 Referral procedures**

Following the YOS worker conducting an assessment of the young person based on ASSET, referrals are made to the named drug worker where a substance misuse need has been identified. Young people with tier 2- 4 needs may be referred in this way. Though sometimes tier 2 work is conducted by the mainstream YOS worker, this is dependent on the individual competency of the worker in relation to substance misuse. All YOS workers have access to a two day substance awareness training programme.

### **5.6.2 Integration with other services**

The named drug worker has access to the full assessment information and information is shared within the team as required. Young people understand that as they are seeing the named drug worker as part of a sentence plan that information may be disclosed to the team and not kept confidential to the named drug worker.

In some cases a young person may have been working with Addaction prior to involvement with the YOS. In this case continuity with the existing, or previous, Addaction staff is encouraged. There is also support available from another member of Addaction staff not based at the YOS. Addaction staff will help the young person to understand what changes may be necessary due to the involvement with the YOS, including any changes in confidentiality and information sharing. Arrangements will differ depending on the sentence that the young person has been given.

### **5.6.3 Integrated working**

The named drug worker is integrated with the YOS and Addaction team, attending multi-disciplinary team meetings and having fast track access to other substance misuse services that Addaction can provide, for example access to the medical team.

Line management is provided by both Addaction and the YOS service manager, with joint meetings being held periodically.

### **5.6.4 Transitional arrangements**

Transition from accessing the named drugs worker to accessing voluntary substance misuse services is a seamless process. A flexible arrangement is in place that allows the named drugs worker to continue to see some young people following the end of their sentence if they wish. In other cases another Addaction worker may hold the case during YOS involvement due to an existing relationship with the young person.

If the young offender is transferred to adult probation services and their substance misuse need is either likely to be short term or due to slow emotional or cognitive development the young person's worker will continue to remain involved. For longer term cases the adult treatment service would become responsible for the substance misuse work.

#### **5.6.5 Child protection**

The named drugs worker would represent any substance misuse issues at a child protection conference for a young person involved with the YOS. This is in addition to the YOS workers attendance for other issues.

If the named drug worker was concerned that a child may be at risk, discussions would be held with both the line manager at Addaction and the YOS. Jointly a decision would be reached on the next course of action.

#### **5.6.6 Commissioning structure**

The young people's service is commissioned via the drug action team as a whole service provision, including the work undertaken at the YOS. The YOT pool their budget for a named drug worker with other young people's substance misuse monies and as such do not have a direct contract with Addaction.

The service manager attends the young person's reference group of the DAT and the joint commissioning group, when required. There is full and open dialogue between the commissioners and the service provider.

#### **5.6.7 Monitoring arrangements**

The named drug worker collects information to inform the Nation Drug Treatment Monitoring System, provides quarterly information to the drug action team and also meet YOS monitoring requirements.

Locally an identification referral and tracking system (IRT) is being explored. Addaction has been closely involved throughout the process and has ensured that substance misuse is represented in the discussions and decisions. Addaction is committed to engaging and participating with IRT when it is implemented.

#### **5.6.8 Service development**

In addition to the work undertaken with the YOS, Addaction has developed a working relationship with the police. This has resulted in the police making and encouraging young people to take up referrals to Addaction services when they identify substance related needs at arrest. One of the outcomes of this is the development of a fortnightly alcohol clinic.

Addaction would like capital spend for their service to enable young people to access their service at a specific base. This would allow complementary therapies to be

provided, encourage social inclusion and provide access in less formal hierarchical settings.

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## **5.7 Bolton community drug awareness programme**

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This community drug awareness programme aims to develop the capacity of the local community to participate in commissioning and delivery of services for parents of drug users and drug services for young people. The programme was initially developed and managed by Manchester Metropolitan University.

The community drug awareness programme comprises of a number of elements of awareness-raising events and accredited training programmes. To develop local people's knowledge and skills to support parents and communicate their perceptions and needs to drug action teams to inform the planning and commissioning process.

### **5.7.1 Needs assessment**

Initially local voluntary, community-based, and parent/carer projects and groups are identified and contacted in order to conduct a parent and community group needs assessment. Commonly needs identified would include:

- information about effects of drugs
- information about young people and drug taking
- information about local and national plans for addressing drug use
- information about local service delivery and how to access help for a young person
- knowledge and skills in how to support parents and community groups.

Following the needs assessment the community drug awareness programme would be run to meet the needs identified.

### **5.7.2 Elements of the programme**

#### **Identify local people interested in training**

A small group of individuals, a maximum of 15, were identified by questionnaire to established community groups and voluntary organisations in the DAT area. These individuals were chosen because they have an interest in local substance-related issues, expressed an interest in developing their own training skills, and were willing to assist in the delivery of introductory community-based training sessions within their area.

Targeted voluntary organisations, community projects and groups would be likely to include:

- locally based voluntary organisations that work with children and young people
- community groups and projects that work with children and young people and their parents
- community associations
- tenant and resident groups
- cultural groups and organisations
- parent/family support groups
- school based parent groups
- carers and foster carers.

#### **Three-day drug awareness/training programme for local people**

A three-day drug awareness programme would be adapted taking into account local issues, including local drug taking trends, local service delivery and identified substance misuse training needs of the participants. This course would be delivered to the ten people identified in stage one. This course consists of drug awareness and training skills elements. It is delivered by qualified and experienced drug trainers.

#### **Design and delivery of drug awareness ‘taster’ sessions**

Very short 2½ hour drug awareness ‘taster’ sessions were developed ensuring that they reflected local issues and services. The key aims were to recruit individuals to the two-day course and to identify additional local issues. Twenty ‘taster’ sessions took place in different regions in Bolton.

This short course was rolled out widely to local community groups and at open events (all the ‘taster’ sessions were open events). The sessions were delivered by two people, one qualified trainer and one local person (a trainee) who had participated in the three day programme, described above.

The ‘taster’ sessions also served as a recruitment opportunity for the longer drug awareness training programmes offered in the next stage of the programme.

#### **Two day community drugs awareness training course.**

Individuals who attended a ‘taster’ session were invited to participate in two-day community drugs awareness training courses.

The two-day session involved more in-depth drug awareness (day 1). It included an exploration of identified drug-related issues in the local community, identification of potential needs and the role of community projects and groups in local drug prevention and support (day 2). It was delivered by two people, a trainer and one local person (a trainee) who had participated in the three-day programme, described above.

#### **Accredited five-day community-drug training course including a parallel parent/carer support training course**

Individuals who completed the two-day community drug awareness training course, including all the trainees, were invited to apply for a level three accredited 30-hour community-drug training course and a parallel accredited parent/carer support training course. A two-day ‘training the trainers’ course was also included (see below).

The community drugs training course is accredited through the Open College. The parent/carer support training course is the Parents against drug abuse (PADA) training course, which is also accredited through the Open College. Two trainers would deliver these courses.

The PADA course is specifically designed to develop parent skills with a view to participants developing new parent/family support networks within their areas.

#### **Accredited ‘training the trainers’ course**

Participants on both accredited training courses were offered a further optional ‘Training the Trainers’ five-day course. The level three courses would be delivered by trainers.

### **The formation of a virtual community training team**

The aim of the accredited courses described above is to create trained community members who can provide local training on drug awareness, develop local support groups and develop channels through which community issues can be fed back to the drug action team to influence the local drug strategy.

Individuals who completed one of the accredited training courses and the 'Training the trainers' day, became members of a new virtual community training team. The team members are not new employees of any organisation but continue their previous role; however they are available as a local resource. The role of the virtual team is to deliver and support local community based training throughout the local area.

To ensure that the team is kept informed of current trends and developments it is vital that links are established with local community based drug services and the drug action team. Additional support to the virtual team was provided to ensure that they can establish their role and provide further local community training programmes.

### **5.7.3 Outcomes**

The community drug awareness programme was well received in Bolton and met the needs of local parents in relation to drug awareness and understanding local service delivery. It has facilitated the development of a number of new parent/carer support groups.

The participants of the programme came from a wide range of groups and projects including:

- parents of adolescents and primary school children
- members of community groups not related to drugs, such as religious groups
- professionals working in a role where they have regular contact with young people or parents.

Members of Bolton virtual community training team include:

- school governors
- members of a mosque
- community police officers
- practitioners from a domestic violence project
- practitioners from Connexions.

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## **East Sussex under 19 substance misuse service**

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The service is a county wide, multi-disciplinary, young person's substance misuse service offering interventions to meet tier 2-4 needs. It has a local authority social services lead, which works collaboratively with partner agencies from health, youth offending, voluntary sector, education and Connexions. Whilst some staff are employed directly by social services, others are seconded to the service to provide a multi-disciplinary team, for example the GP specialist is employed by East Sussex County NHS Trust.

*This service is particularly interesting because it serves both rural and urban communities.* As the geographical area covered by the service is predominately rural the service operates on a core and cluster model. This involves the establishment of a 'core' administrative centre, with practitioners being co-located in a number of other vulnerable children's services that are locality contact points for young people. These include services for young homeless people, leaving care teams, information shops and the youth offending team. Practitioners may be based in these agencies full or part-time depending on the level of need in any particular setting. Decisions about where to locate the practitioners, is based on information from local needs assessments and from referral information, ensuring that the 'clusters' are situated in places of greatest need. The service currently operates in two urban towns, and five rural localities. Out of hours services are available between 3-7 pm or 4-8 pm in each locality, at least once per week.

There are multiple benefits of operating this core and cluster model:

- Agencies invest in the service by seconding their employees which increases cohesiveness between the mainstream and substance misuse services.
- Substance misuse services have invested in the rental of office accommodation from partner agencies by assisting with the refurbishment cost of existing premises to make them suitable for substance misuse interventions. This in turn improves the overall environment of the agency and allows other services to make use of the premises. For example by developing clinical assessment rooms at a Connexions information shop the substance misuse GP can conduct clinical assessments and the sexual health service could also offer interventions at the Connexions information shop.
- Utilising existing premises for young people reduces accommodation costs and enables the development of a one stop shop style holistic adolescent services.
- Using existing locality bases for young people allows greater access to young people that are traditionally hard to reach such as young homeless people.
- Offering services in multiple settings on a sessional basis extends services into rural areas rather than expecting young people to travel to big towns.

### **Integration with other services**

As the substance misuse service utilises seconded practitioners from a variety of statutory agencies and front line workers are co-located within vulnerable children's teams, the service is highly integrated. Indeed other local adolescent services use the 'core and cluster' model too which increases services integrating further.

All practitioners working with vulnerable young people, across statutory and voluntary services, are committed to attending a two day, level 2, training course in working with young people about substances. The training covers topics such as:

- how to screen and refer to specialist services
- highlights the potential crossover between substance misuse and other difficulties such as mental health and offending
- demonstrates how to deliver low threshold interventions and provides participants with a practise resource pack and service literature.

This training is delivered by local substance misuse service practitioners and thereby enables a face to face introduction to the various service personnel. Practitioners within the youth offending team and social services looked after children's teams and foster carers/lodgings providers who work with adolescents, Connexions "intensive" personal advisors, school nurses and the young

homeless sector have participated on the training and are now able to meet the tier 2 needs of young people and work jointly with substance misuse specialists when required.

There is a locally developed screening and referral tool in use which children's services are expected to implement as part of the referral process. However, youth offending team practitioners will implement ASSET as the screening mechanism and those young people who receive a score of 2 and above, receive an initial assessment at dedicated YOT assessment clinic times. In addition, the substance misuse practitioner is expected to look at other holistic needs and how substance misuse impacts upon the young person's health and social welfare. The initial assessment could result in a comprehensive substance misuse assessment conducted by a specialist based in the agency, or by the delivery of a tier 2 intervention.

The delivery of tier 3 interventions often forms part of an integrated care plan. For example the substance misuse practitioner seconded to the YOT will undertake elements of a supervision order which are focussed upon addressing the young person's substance misuse, or they can conduct specialist assessments for pre-sentence reports or bail support applications.

### **Sharing of information**

East Sussex was part of the government's identification, referral and tracking (IRT) trailblazers, later renamed information, sharing and assessment trailblazers (ISA). Much of the trailblazer's role is to properly explore a wide variety options in developing effective information sharing practices and systems. Substance misuse elements were incorporated into local ISA procedures.

All substance misuse practitioners have access to the ISA database alongside their colleagues in children and young people's statutory services. Only information regarding whether young people are receiving a substance misuse service is entered onto the database along with a contact name. Substance misuse practitioners can also identify from the database if another service is working with a young person, which gives a point of contact to integrate service planning and delivery.

In addition to the database information, local agencies are also signed up to an information sharing protocol. The protocol works by allowing practitioners from participating agencies to access previous assessments undertaken and care plans, provided that the young person consents to this sharing across agencies.

As a multi agency service the East Sussex substance misuse service has computerized access to the following systems:

- YOT, youth offending information system
- social services, Care First
- Connexions

This system speeds up access to comprehensive information about a young person and removes the necessity for repeated assessments being undertaken by each agency involved in the young person's care.

### **Integrated working**

Holistic care is often dependent on good integrated working. For integration to work well allocation is an important factor. Allocating a young person to a practitioner who can offer the most support for the highest priority need is essential. This practitioner can then ensure that as the care plan is developed it dovetails into existing planning and review mechanisms and thereby reduce duplication. Specific responsibilities will be allocated to specific practitioners, but most planning and review will occur in multidisciplinary meetings ensuring that all practitioners know the care plan and who is responsible for each aspect.

In most cases the case management function will be undertaken by a practitioner from a statutory agency that has existing relationship or a statutory duty to the young person, such as a YOT worker or a social worker. However, where substance misuse is the most significant problem or where a young person has little involvement with statutory services the substance misuse practitioner can become the lead professional.

Supervision arrangements also help to ensure an integrated service. All staff employed to work within the service receive day to day operational management from within the substance misuse service. In addition professional accountability is the responsibility of the individual's employing agency. This ensures that the practitioner does not lose touch with developments in their parent organisation and that relationships between colleagues are maintained.

For example it is important that the education officer is a senior teacher. This status ensures that the post holder is kept aware of all secondary school age, substance related exclusions and can attempt to retain pupils in education by advocating for interventions prior to permanent exclusions. Furthermore, she is appropriately skilled to participate in pastoral planning for client's of the service and can keep in contact with other senior staff within schools. For Connexions personal advisors seconded to the service, mentoring undertaken by a career officer ensures that the advisor is always up to date with developments in local career and training opportunities.

### **Commissioning structure**

Within the current DAAT structure, the chair of the young person's performance management group is also the Head of the Local Authority Children's Services, Planning and Commissioning Unit. This consistency of senior personnel will ensure the continued integration of the substance misuse agenda at a time when statutory children's services are working towards the development of a local children's trust.

The commissioning arrangements adopted for substance misuse have mirrored those previously established for the development of the youth offending team. In fact the whole structure mirrors the YOT in many ways. Both substance misuse services and the YOT have a social services lead, work on a core and cluster model and have a number of practical similarities such as staff profile.

The young people's substance misuse commissioning structure in East Sussex was formed in 2001 following a needs assessment that recommended the development of a dedicated young person's, tier 2-4, multi disciplinary service with a local authority lead. The core and cluster options were identified and examined using a business planning model for local commissioners to consider. The model and its implications were accepted and taken forward. A significant implication of the proposal was the necessity to pool moneys (virtually at the time) in order to finance the development of a new multi agency county wide under 19s service.

Members of the young person's commissioning group agreed that they had responsibilities to:

- provide accommodation and office space for the service.
- sign their agencies up to training, described earlier.
- ensure that supervision would be appropriately provided, the substance misuse service provides day to day management supervision, and professional accountability rests with the employing agency.
- ensure that the appropriate lead agency undertook its responsibility with regard to addressing areas such as clinical governance, child protection, accommodation and education needs are all appropriately addressed.

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## APPENDIX A

### Ten key policy principles

Italicised words in this appendix are direct quotes from *Young people and drugs: policy guidance for drug interventions*, Standing Conference on Drug Abuse and Children's Legal Centre (1999) available from DrugScope. They are based on the Children's Act 1989 and the United Nations Convention on the Rights of the Child.

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

***1. A child or young person is not an adult. Approaches to young people need to reflect that there are intrinsic differences between adults and children and between children of different ages.***

Drug services should have guidelines and competent staff on the assessment of the following:

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

***2. The overall welfare of the child is paramount.***

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

***3. The views of the young person are of central importance, and should always be sought and considered.***

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

***4. Services need to respect parental responsibility when working with a young person.***

The education, involvement and support of parents or carers may be beneficial to successful work with young people. All young people should be encouraged to discuss their substance use with a parent or carer.

***5. Services should co-operate with the local authority in carrying out its responsibilities towards children and young people.***

Protocols for liaison and joint working between the young person's drug service and child protection and children in need services should be established. The passing of the Children Act 2004 establishes a statutory duty on all services, both voluntary and statutory, to safeguard and promote children's well-being.

**6. A holistic approach will occur at all levels.**

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

**7. Services must be child centred.**

Services should be accessible and attractive to young people. Services should be in safe areas and separate from adult services. Available literature will need to reflect the age, culture, gender and ethnicity of the client group. Consideration must be given to the accessibility of services to young people, particularly opening times, location and age appropriate publicity.

All staff must have received Criminal Record Bureau clearance.

**8. A comprehensive range of services should be provided.**

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

**9. Services must be competent to respond to the needs of young people.**

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

**10. Services should aim to operate in all cases according to the principles of good practice.**

Services will operate within the current legal framework, respecting the underlying philosophy of the Children Act 1989 and the UN Convention on the Rights of the Child. They should also reflect evidence based effectiveness.

## APPENDIX B

### Guidance for NDTMS recording.

A current version of this document will be available on the NTA website from March 2005.

## 1 Introduction

### 1.1 Purpose of the document

These are the draft guidance notes for the National Drug Treatment Monitoring System core data set for drug treatment interventions with young people. They include: definitions of all modalities; confidentiality and consent issues; definition of a treatment service, definition of a young person a description of how statistics may be collated and comments on new referral sources. Each section contains guidance and examples, and answers to questions for clarification.

This guidance focuses on issues about how to report to NDTMS it does not intend to describe the types of services to be delivered or identify how services should be delivered.

### 1.2 Context

The young People's NDTMS should make completing NDTMS forms easier and more relevant for young people's practitioners. Young People's NDTMS also hopes to capture the wide range of treatment and interventions and work undertaken with those under 18. For this reason, all work covering Young People's tier 2, 3 and 4 work should be recorded if delivered by staff employed by treatment services.

The Young People's data will be reported starting in April 2005. Some Young People's services have reported data to NDTMS in 2004/5 but they have used adult intervention types. From April 2005 they will use Young People's intervention types.

NDTMS will be able to provide data on the following: people receiving interventions under or over 18; people receiving treatment from a young person's service, people receiving treatment from an adult service and data on tier 2 episodes.

## 2 Definitions

### 2.1 Young People

A young person is defined by the NTA as a person under the age of 18.

The definition of a young person and transitional arrangements is fully discussed in Essential Elements (2005) available on the NTA website. It may, however, be appropriate for a young person's service to continue working with a young person past their 18th birthday. In some cases it may be appropriate for an adult service to work with a person under 18. See, Essential Elements for further clarification. In such cases a young person's service will report using the young person's data set and the adult service will report using the adult data set irrespective of data.

### 2.2 Young person's treatment service

A treatment service is defined as any service that has been established as part of the young person's substance misuse planning process to provide tier 3/4 interventions to young people under 18 in line with the HAS review: The substance of Young Needs (2001).

The service will be funded in part or completely from the Local Authority administered partnership grant for substance misuse.

There is a small but dwindling number of staff employed to work with young people but based in adult services. These workers should be functioning differently to their adult focused colleagues and will therefore record young peoples' data for all clients. However if they have a mixed case load in terms of young people and adults, or their methods of working do not differ significantly from their colleagues, they should record data for those aged under 18 as if they were adults.

Most YOT substance misuse workers have close and formal links with the local treatment service. YOT work should be recorded by the treatment service. If the YOT substance misuse worker is not integrated within the treatment service, then the YOT worker will have to report to NDTMS and the YOT will be identified as a treatment service.

A CAMHS practitioner may work solely on substance misuse issues with a young person. There may be no links in some areas between CAMHS and young people's treatment services. Such interventions are likely to be rare and are unlikely to be notified to NDTMS. If they are a regular occurrence, however, then the service should become more involved with substance misuse strategic planning and start notifying interventions to NDTMS.

### 2.3 Young People's Core Data Set

Young Peoples NDTMS core data set conforms to the adult core data set. The only difference is that there is a separate young person specific set of interventions (modalities). An additional set of referral sources has also been defined. In all other aspects of NDTMS reporting guidance to the existing adult based data set is applicable to young people.

## 3 Young People's Treatment Interventions

### 3.1 Definitions

The definition of a structured Tier 3 or 4 or substance misuse treatment intervention is: an intervention that is provided within the context of a care plan that is focused on the young person's substance misuse and is provided by a practitioner from a "specialist treatment service" (definition below).

Care plans should be written down and agreed between the worker and young person and their carer if appropriate. Each care plan should be based on an assessment and should identify: the issues to be addressed; the key worker and/or care co-ordinator, agreed goals and milestones and review periods.

A young person and/or family may receive one, all or a combination of the interventions identified below – as befits the individual's needs. In such circumstances the care plan should explicitly identify the key worker or care co-ordinator responsible for reporting to NDTMS and identifying all interventions being received.

### 3.2 Tier 3 Interventions

#### **Psychosocial interventions:**

Structured interventions involving individual or group work sessions focusing on assessment, meeting needs identified in treatment plans, and reviewing progress to treatment goals on a regular basis.

This is likely to be the most common intervention. In group work all participants should have an individual care plan. The care plan should identify the care coordinator or key worker responsible for reporting to NDTMS.

#### **Harm reduction services:**

Interventions with an aim of reducing harm to the individual such as safer drug use or needle exchange services in the context of planned care. In the case of young people under 16, a written care plan should be produced by the key worker identifying the goals of this intervention. This care plan should also highlight protective factors and concerns. This may be included in a wider care plan.

Needle exchange services for young people are not the same as those for adults 18 or over. Even for those over 16, protective reasons for the exchange or provision of injecting equipment should be identified. Even with young people whose behaviour is chaotic or whose help-seeking is intermittent an assessment (or review) must occur.

**Work with parents or carers:**

Structured interventions (normally individual or group work sessions) focusing on a young person's drug use involving carers or family members with or without the young person attending.

Family members affected by a young person's drug use are included in this category even if the young person is not involved in sessions. If the young person is receiving treatment then this intervention will be identified under the young person's NDTMS identifier.

If the young person is not known then one of the family members' initials will be identified but the young person's drug use, age and other relevant details will be provided to NDTMS.

**Shared care schemes:**

Community-based prescribing services for drug or alcohol misuse in the context of a care planned package of care involving GPs in formal shared care schemes.

Prescribing should be one part of a treatment package that involves a care plan with a treatment agency. The key worker care co-ordinator from the substance misuse treatment agency named in the care plan should notify NDTMS about this intervention.

**Specialist pharmacological interventions:**

Interventions involving specialist services such as paediatricians, young people's clinicians, and CAMHS staff and during transitional processes with clinicians based in adult services. This could include prescribing services for drug or alcohol misuse (ameliorative prescribing, detoxification or longer-term opiate substitute prescribing) in the context of a care planned package of care.

The key worker care co-ordinator from the substance misuse treatment agency named in the care plan should notify NDTMS about this intervention

**Criminal justice interventions:**

Care planned interventions by specialist YOT workers will be included in this category.

**3.3 Tier 4 interventions**

**In-patient interventions:**

These are interventions which take place in residential or secure setting which address a complexity of needs requiring a range of interventions including medical for the young person. Such services could include in-patient pharmacological services, such as paediatric, CAMHS or general medical ward for over 17's.

**Supported generic child care:**

This intervention includes supported foster care and residential child care placements with care planned drug treatment. The key worker care co-ordinator from the substance misuse treatment agency named in the care plan should notify NDTMS about this intervention.

**Residential rehabilitation:**

Specialist residential services with a primary focus of on young people's substance misuse.

The key worker care co-ordinator from the substance misuse treatment agency named in the care plan should notify NDTMS about this intervention.

### **3.4 Tier 2 Interventions**

NDTMS data on Young peoples tier 2 interventions will record activities rather than personal information about young people. To record a tier 2 episode the minimum data required will be a young person's initials, date of birth, presenting drug of use and gender.

Tier 2 interventions include a range of substance misuse-related interventions provided by staff employed by substance misuse treatment services which are not provided in the context of care planned care. In line with the Health Advisory Service review, Substance of Young Needs (2001), these interventions are not confined to a treatment setting.

When NDTMS data is collated, Tier 2 work will only reflect the amount of work done by an agencies' staff, e.g. number of sessions done, number of people seen, etc. Information requirements will be less strict.

#### **One to One interventions:**

This would be one or more non-care planned sessions with a young person using drugs or alcohol, focusing on the provision of harm reduction advice and information.

This definition would include substance misuse assessments of a young person using drugs or alcohol that did not lead on to a substance misuse focused care plan. This would include assessments of: a young person in the alternative education system, a Looked After Child, or a substance misuse assessment by a specialist YOT worker. The assessor or treatment worker will be responsible for notifying NDTMS.

#### **Group Interventions:**

These would be educational or advice groups with vulnerable young people focusing on substance misuse risk behaviours including drug and alcohol misuse.

The reporter to NDTMS will need to separately record each person seen in the group identifying as a minimum: age, date of birth, gender and type of drug use.

This excludes lectures to schools, youth clubs etc. The focus is on vulnerable groups such as looked after children, children in Pupil Referral Unit's, alternative education schemes, YOTs or schemes for the children of parents with drug or alcohol problems.

#### **Outreach work:**

This covers work with groups or individuals provided in unstructured environments in partnership with outreach workers, detached youth workers or community development workers.

The reporter to NDTMS will need to separately record each person seen in the group identifying as a minimum: age, date of birth, gender and type of drug use.

### 3.5 Examples

Most vulnerable young people will have care plans some of which will identify substance misuse as an issue. The difference between a tier 2 and treatment intervention is that in the treatment intervention the care plan focuses primarily on the interventions provided by staff from treatment services.

For a young person who is homeless and drinking heavily the major focus of the care plan could be accommodation and support. If the assessment by the specialist treatment worker on the drinking behaviour results in a care plan on how to change this aspect of the person's life, it is a treatment intervention. If no further action or a brief intervention occurs during the assessment, it is a tier 2 intervention.

A young person receiving a detoxification or ameliorative prescribing programme from a GP should only do so in the context of a care plan and with support from the local substance misuse treatment service. In this example the bulk of the care plan may be delivered by non substance misuse specialist staff (eg youth counsellor) but it should be recorded by the treatment agency as a psycho-social intervention (the care planned support) and a shared care or specialist pharmacological intervention.

## APPENDIX C

### The NTA performance management framework for young people

#### Introduction:

This paper was used as a basis for the performance management of young people's treatment services during the financial year 2004/5. It will be refined in April 2005.

The NTA has a number of specific young people's targets that it is required to performance manage:

- Ensure that by March 2005 90% of DATs can provide access to a comprehensive range of young people's treatment services. (NTA business plan 2004/05).
- With the Youth Justice Board ensure that 100% of YOT referrals for substance misuse treatment are seen within ten days. (NTA business plan 2004/05).
- Ensure adequate young people's treatment services are available to meet demand in YP DIP areas. (NTA business plan 2004/05).
- Partnerships are required to negotiate targets and key milestones against the key performance indicators with the government offices for the regions. GO staff will engage other relevant regional partners including Youth Justice Board regional staff, Connexions leads, National Treatment Agency in this process. In areas where there is evidence of poor performance, GO staff, with regional partners will negotiate with the partnership a plan of targeted support to improve delivery. (Partnership guidance 2004)
- KPI 3. The NTA performance monitoring framework should provide information useful to DSD and RGO staff performance managing KPI 3.

#### A comprehensive range of services:

The NTA has defined six types of interventions that are deemed to be essential for a DAT to be seen to offer a comprehensive range of treatment services based on local need.

These are

- psychosocial interventions
- harm reduction services
- work with parents and carers
- criminal justice interventions
- community prescribing
- access to tier 4 interventions

#### Definitions:

All people receiving the following interventions should have a care plan and a key worker or care co-ordinator. Plans should be written down and agreed between the worker and young person/carer. A young person and/or family may receive one or all of these interventions.

- **psychosocial interventions:** Structured intervention involving individual or group work focusing on assessment, defined treatment plans, treatment goals with regular reviews.
- **harm reduction services:** Non structured intervention based on harm reduction strategies such as safer drug use, needle exchange etc. In the case of young people under 16 a written plan will be produced by the key worker identifying the goals of this intervention. This plan will also highlight protective concerns.
- **work with parents or carers:** Structured interventions focusing on young person's drug use involving carers or family members with or without the young person attending.

- **criminal justice interventions:** Treatment staff based in either YOTs or treatment services that are able to respond and meet referrals from youth offending teams or arrest referral workers.
- **community prescribing:** GP prescribing including GPs in formal shared care schemes and other prescribing services such as paediatricians, YP clinicians, CAMHS staff and in transition clinicians based in adult services.
- **access to tier 4 interventions:** Complex cases requiring a range of interventions including medical and secure accommodation for the young person. Such services could include in-patient pharmacological services, such as paediatric or CAMHS, plus supported foster or residential child care placements. This would also include funding for residential rehabilitation services focusing on young people's dependency or addiction.

### **Purpose:**

In addition to the monitoring of the above targets the NTA expects that this tool should be able to provide a snap shot of local provision and will be useful to DATs, regional partners and DSD, YJB, DH and NTA policy leads. The tool focuses on the treatment system and is likely to be complemented by other frameworks focusing on the other young people's KPIs.

This tool can be used by regional government offices as a self assessment checklist and sent out to DATs or as a guide for the monitoring of performance at regional performance management panels established in line with the partnership guidance. Some of the questions raised in this document are likely to be included in performance management documents produced by DSD or regions. The intention is not to increase DAT workloads so such documents should be coordinated to ensure no repetition of questions.

### **Monitoring tool:**

#### **Data collection:**

- Do all treatment services provide data to NDTMS?
- If not do does the DAT have a service level agreement that insists on this function?

#### **Range of services**

- Does the DAT provide a range of the six services defined above?
- If not what plans do they have to ensure they have services in place by March 2005?
- What other services do they provide including complementary therapies?
- Are services provided for the children of drug-using parents?
- How many YP have received or are receiving treatment in this financial year? (statistics provided by NDTMS)
- Are these figures in line with agreed milestones or investment in the treatment system?

#### **Quality of service provision:**

- Are services being provided in line with SCODA/CLC 10 key principles?
- If yes how has this been evaluated? Has an external or QuADS assessment occurred?
- If the service being provided is not consistent then what steps are being taken and will child focused services be provided?
- What is the waiting time between referral and a care plan being initiated?
- How are parents, carers and young people's views included in care plans?
- Are there separate services for parents and carers?
- How is the DAT meeting the treatment needs of BME communities and other underserved groups?
- Do YP services have links with adult services? Are there transitional arrangements?

**Integrated systems:**

- Does the DAT area provide comprehensive, integrated care packages for young people?
- How is this evidenced?
- Do YOTs Connexions, CAMHS, social services and education have shared protocols?
- If the service offered is a virtual team is there clear management responsibility for all staff from an experienced (young people's) substance misuse manager? How do YP access the service and are there written referral protocols? What are the case referral procedures and are these written down?
- Is this management post full time for YP substance misuse and does it involve a co-ordination function?
- How are CAMHS services involved?

**Protocols and pathways:**

Do services have:

- referral pathways?
- information sharing protocols?
- arrangements for case management?
- policies and procedures agreed by ACPC?
- screening and assessment tools?

**Criminal justice system**

- Will the YJB/NTA target be met?
- If not what steps are being taken to meet the target?
- How many YOT specialist workers are there?
- Are these workers based in the:
  - YOT?
  - treatment service?
  - between both?
- Is the case load of the specialist worker mainly:
  - treatment focused?
  - education and prevention?
  - mainly generic YOT work?

**Commissioning arrangements**

- Does the DAT have a designated young people's commissioner?
- Does the DAT have a separate young people's commissioning group?
- How is the DAT linked to the local preventative strategy/ children and young people's strategic partnerships?
- Is this a formal link or is it based on people or the dual function of job roles, e.g. social services manager sitting on DAT and above groups?
- Do PCTs or social services fund treatment services?
- Are treatment services being funded from time limited resources?
- If yes what are the DAT doing to address this issue?
- What steps are the DAT making to explore the potential for securing investment from partner agencies?
- Has the DAT considered what will happen if demand for services outstrips young people's funding allocations?

## APPENDIX D

### Glossary.

#### Children and young people

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

#### Drugs, alcohol and substances

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

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

- **Substance misuse**

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

#### Drug Interventions Programmes:

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

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

#### Competency:

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

#### Holistic:

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

#### Intervention

We use the term 'intervention' to refer to the taking of any particular planned course of action (with a young person and/or their family) by a professional, a team of professionals, and/or a specific type of service. In this document we have focused attention on young people who have already started to experiment with substances, and more specifically those who have developed problems with, or associated with, their use of substances.

- **Counselling**

'Counselling' is described as the principled use of a relationship to provide someone with the opportunity to work towards living in a more satisfying and resourceful way. The relationship takes

place within boundaries which may specify duration, regularity, availability and confidentiality of counselling. The counsellor's role is to facilitate the client's work in ways which respect the client's values, personal resources and capacity for self-determination. Although counselling skills may be used in a variety of informal settings, in this document the term counselling is defined as a specific structured intervention, as described above, carried out by a person who has a demonstrable competence in counselling.

- **Harm reduction services**

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

- **Treatment**

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

(Adapted from SCODA/CLC, 1999)

### **Key-working**

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

### **Looked After Child:**

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

**Significant harm:** The Children Act 1989 introduced the concept of significant harm as the threshold that justifies compulsory intervention in family life in the best interests of children. There are no absolute criteria on which to rely when judging what constitutes significant harm.

"Consideration of the severity of ill-treatment may include the degree and extent of harm to..... physical or mental health, ..... intellectual, emotional, social or behavioural development, or ill-treatment which includes sexual abuse and forms of ill-treatment which are not physical.

(DH1999c).

### **Youth Offending Teams: (YOTs)**

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

### **Youth Justice Board: (YJB).**

The Youth Justice Board was established under the Crime and Disorder Act 1998. The aim of the YJB is to prevent offending by children and young people. It delivers this by: preventing crime and the fear of crime;

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identifying and dealing with young offenders; reducing re offending. The YJBs key responsibilities are to: advise the Home Secretary; set and monitor standards; set up and oversee 155 Yots; purchase and commission secure accommodation; and disseminate good practice.

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