NHS

National Treatment Agency for Substance Misuse

Young people's specialist substance misuse treatment

The role of CAMHS and addiction psychiatry in adolescent substance misuse services

Preface

In January 2007, ministers from the Department of Health, Home Office and Department for Education and Skills (DfES) asked the NTA and DfES to carry out a quick but intensive review of the young person's drug treatment system.

This review was presented to ministers in February 2007 and identified the following key findings:

- Treatment systems across the country varied enormously. Definitions of treatment need also varied and this influenced treatment thresholds
- Child and adolescent mental health service (CAMHS) support for treatment systems was patchy but key to good support and governance, and fundamental to appropriate prescribing services
- Performance management systems needed to be improved.

Several recommendations were accepted by ministers. Key among these was the need for substance misuse commissioners and providers to engage with CAMHS. This became even more important when the National Institute for Health and Clinical Excellence published two guidance documents on public health (NICE, 2007a) and psychosocial interventions (NICE, 2007b).

These documents highlighted the need for young drug and alcohol users to be able to access competent family-focused workers. Again, the importance of the substance misuse treatment system being able to work with and benefit from the experience and competency of CAMHS practitioners was highlighted.

This document highlights the intricate and complex relationships between adolescent mental health and adolescent substance use, demonstrates the need for all CAMHS staff to ask questions about substance misuse and shows a range of different models to illustrate how some CAMHS services have developed useful partnerships with substance misuse services. In some areas of the UK it is addiction services that have reached out to CAMHS to develop adolescent substance misuse services. The diversity demonstrated here highlights not only that there is more than one way this can be done, but also illustrates that services need to be developed to meet local need with local resources.

I hope and expect these models will encourage substance misuse and CAMHS commissioners to enter into dialogue with practitioners to identify better ways for the two services to work together.

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Young People's Substance Misuse Psychiatrists Working Group

Introduction

The purpose of this document is to highlight the unrealised potential for recovery and rehabilitation of a large group of substance-misusing and dependent young people. This is achievable by better assessment of the most severely affected young people, delivery of more systematic, practical interventions and a much greater synergy between mental health services and those working currently in the substance misuse field. We believe that psychiatrists and their mental health colleagues can unlock a great deal of this unrealised added value. We intend to illustrate this by describing the contribution of a small number of psychiatrists who have blended knowledge of child and adolescent mental health and addiction, skills and treatments, and who have facilitated and developed distinctive services. These are models that future services can emulate, adapt and improve upon. This may require redirection of investment, encouragement of professionals including psychiatrists currently on the periphery, and crucially the interest and commitment of NHS and other commissioners.

The scale of the problem

Substance misuse is a major public health problem with substantial levels of morbidity and mortality, and the potential to impair the development of young people. Per capita alcohol consumption has doubled over the last 50 years and is still rising (Cabinet Office, 2004). Young drinkers aged 11 to 15 in England doubled their average weekly consumption of alcohol during the 1990s – from 5.3 units in 1990 to 10.4 in 2004. It has since stabilised for boys but continues to increase for girls. The greatest increase has been among girls aged 14, from 3.8 units in 1992 to 9.7 in 2004. In each year, among those who drank, boys consumed more alcohol than girls in every age group. The proportion of children who drank increased with age, from four per cent of 11-year-olds to 45 per cent of 15-year-olds in 2004. Among both boys and girls, 23 per cent of those aged 11 to 15 drank alcohol in the previous week (ONS, 2004; Home Office, 2007).

Experimentation with drugs and alcohol is sometimes considered to be a rite of passage in adolescence. Estimates from the UK suggest that nearly half of those aged 16 to 24 have used illicit drugs at some point in their life, with up to 20 per cent having used drugs in the last month. Young people report that they take drugs for a variety of reasons: to gain pleasure, to conform to the attitudes and values of their peer groups, to block out traumatic and painful memories and to relieve sadness and worries associated with their everyday lives. For some young people, use of drugs and alcohol may become a problem in itself. The New Zealand Christchurch Health and Development Study (Fergusson, 2007) estimated that ten per cent of cannabis users ultimately become dependent or addicted and that at 18 years-of-age, about six per cent are dependent on drugs or alcohol. Once they become regular users, a substantial group of young people have problems that continue into adult life. In an epidemiological study of Munich cannabis users – who used at least once a month – approximately 40 per cent developed dependence within the five year follow-up (Nocon *et al.,* 2006). No similar studies have been conducted in the UK, which constitutes a major gap in knowledge. Hence, many young people may simply experiment but a significant minority will have difficulties related to their misuse and dependence on a variety of substances.

Dependence syndrome (DSM, ICD-10)

Substance abuse (DSM) and harmful use (ICD-10)

1. Failure to fulfil major role obligations as work school or home
2. Use in situations in which it is physically hazardous
3. Persistent or recurrent use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance
4. Persistent or recurrent use despite substance-related legal problems

Substance misuse by young people is linked with substantial levels of psychiatric and other morbidities and, according to National Statistics data, levels of mortality in this age group that vie with cancer. Serial UK and international school survey data indicate consistently high rates of overall substance (alcohol and drug) use in the UK and penetration of substance use into the youngest age groups surveyed (11-year-olds). However, school surveys do not directly measure the most potentially harmful types of use and there are some indications that due to the availability of more potent agents these may be increasing (Compton *et al.* 2004). These phenomena are also linked with levels of drug-related crime that do not seem to be in decline (Nicholas *et al.* 2007).

It is also a common observation that many of the adolescents presenting to child and adolescent mental health services show significant substance-related problems. The presence of co-existing substance misuse complicates the clinical course, treatment compliance and prognosis for these young people and is the single most important factor for increasing the risk of suicide in young people with psychosis or depression (Mirza, 2002). The converse is also true: substances exacerbate and maintain psychiatric disorders. Nevertheless, child and adolescent psychiatrists, especially those who have been recently trained, have acquired considerable knowledge of substances. However, as a group, psychiatrists and their commissioners have not yet grasped that substance misuse should be a key focus of treatment. Of course, this is even more pertinent for A&E and paediatric staff who also encounter these young people, often in crisis.

Indeed, despite the growing evidence base for effective interventions in adolescent substance use and significant expansion of specialist treatment services in the UK over the past decade, many substance-abusing youngsters do not receive adequate treatment, even the brief interventions that are relatively easily delivered in medical settings. In many instances, it is likely that young people and families would have welcomed appropriate professional help but local services were simply not available, accessible, or well-publicised. There is also wide geographical variation in the range and depth of services provided, especially in terms of child and adolescent mental health (CAMHS) or addiction services. Since many of these youths exhibit complex emotional and psychiatric disturbances, this is a significant deficit.

Why should mental health services be involved?

Substance use and misuse does not occur in a vacuum. Many children and young people who misuse drugs and alcohol have multiple antecedent and co-occurring mental health problems and disorders, unrecognised learning disabilities, and deeply entrenched social problems. There are also striking similarities between the risk and protective factors of mental disorders and substance misuse, in the neurobiological basis of addictions and mental illness, and in response to treatment.

Risks and protective factors

Factors that mediate and modulate development of conduct disorder and substance misuse are strikingly similar and include neurobiological, family and social factors. The role of risk and protective factors in mediating and modulating substance misuse is rather complex but a number of high-risk groups have been identified:

- Young offenders
- Truants and children excluded from school
- Children of drug-misusing parents
- Looked after young people
- Young homeless people
- Teenage mothers
- Young people leaving care
- Young people with mental health problems
- Regular attendees of A&E services
- Abused children
- Family disintegration (outside of issues around substance-misusing parents).

Clinical experience suggests a considerable overlap in these factors in the individual case. Professionals working in CAMHS have an unrivalled opportunity to intervene in the developmental trajectory of these children at risk and play a significant role in the early identification and treatment of substance misuse.

Many shared genetic factors are linked with the emergence of mental disorders and substance misuse in childhood and adolescence. Chronic neglect and maltreatment can also impair brain development, particularly involving areas of brain concerned with memory, learning, anxiety and impulse control. There is a higher risk of development of substance use in children exposed to neglect and maltreatment in childhood (De Bellis, 2005). Similarly, untreated ADHD has been shown to be a significant risk factor for

development of substance misuse in adolescence and adulthood (Biederman, 1999; Wilens, *et al.*, 2003). Inner-city adolescent girls with post-traumatic stress disorder, a common sequel to misuse, are at high risk of developing substance-use disorders (Lipschitz, *et al.*, 2003). Understanding the genesis, assessing the impact and offering evidence-based treatment for these disorders are core tasks of mental health agencies and psychiatrists who are clinical leads.

By bringing to bear the requisite psychological and pharmacological skills, and the capability to mobilise tailored community resources (through skilful advocacy), mental health services can powerfully enhance the efforts of drugs workers and other services in rehabilitating affected youth. Based on a deep understanding of young people, this is in part achieved by linking with statutory and voluntary agencies that give access to health (medical, dental and nursing) and social (education, training and employment, and housing) services. These informal networks built over years have proved essential for the treatment of young people with mental disorders and they can be adapted to great advantage in the interests of those for whom this document is written.

The co-operation and involvement of addiction psychiatrists has been vital, even though they have not always been commissioned to work with young people. Addiction psychiatrists also work in multidisciplinary teams comprising medical, nursing, social work and psychological professionals. Since they have the expertise, depth and duration of training to do so, addiction psychiatrists manage directly the clinical care of the most complex cases. Crucially, they are happy to share their core skills in detoxification, reduction, maintenance and relapse prevention, in addition to the delivery of the range of evidence-based psychosocial interventions.

Child and adolescent psychiatrists and addiction psychiatrists are trained to translate research into practice, crucial in the light of continuing developments in the field. Through supervision and liaison they support and enhance the competence of practitioners inexperienced in addiction and the work of many frontline professionals, acting as a source of calm advice. Keeping alert to the risks, controversies and the evidence is invaluable for all those involved in treating this group of patients. In an inter-agency setting, psychiatrists have no line management function in relation to many of the workers and offer a clinical governance presence. However, this is an area that clearly needs development in order to construct a collective understanding of what clinical governance requires.

Conclusion

Service descriptions compiled by child and adolescent psychiatrists and addiction psychiatrists are presented here. They provide a whistle-stop tour of attempts to develop substance misuse services for young people, which sometimes feels as if it is against the odds. We endeavoured to obtain information about services across the UK through formal and informal links and our own psychiatrists group, facilitated by the National Treatment Agency. However, the summary document of service delivery models will not provide an exhaustive account of all treatment services in the UK and it is highly likely that we may have made some important omissions.

A reading of the service models shows striking similarities between them:

1. All the young people they serve exhibit multiple complex needs, risks and very disadvantaged circumstances in addition to substance misuse and dependence
2. Comprehensive and appropriate assessment is required of development, education, key relationships, mental health (such as depression, anxiety, PTSD, ADHD and psychosis), physical health, and risks of aggression, hostility and self-harm
3. This intervention may require orchestrated collaboration between a range of professionals and agencies, including education, paediatrics, early intervention in psychosis teams, child and adolescent mental health services, child protection services, Connexions and others
4. The involvement of so many raises the question of who takes responsibility. It is critical that this is appropriately shouldered, often by or at the urging of the mental health team with its strong professional ethos
5. The development of these services arose often from the energetic commitment of psychiatrists (child and adolescent psychiatrists and addiction psychiatrists) and others who have often acted as advocates for young people and their families to establish effective interventions. We believe that the proactive commitment of such senior professionals on the provider side is required to make these systems work responsively
6. Taken together, the descriptions included here provide a new vision of the potential course of service development for the most vulnerable of young people in our midst
7. These services require evaluation and audit. They also offer great opportunities for research.

The Young People's Drug and Alcohol Service, Newcastle upon Tyne

Dr Eilish Gilvarry and Dr Paul McArdle

The Young People's Drug and Alcohol Service (YPDAS) was first considered in the mid-1990s in response to referrals of young people to an adult service. It was based on informal collaboration between the adult addiction services and a voluntary sector generic youth counselling service. Funding became available in 1998 from the former district health authority, allowing the appointment of a full-time nurse with a background in adolescent mental health and addictions in addition to two sessions of consultant psychiatrist time.

The current NHS component includes:

- Two nurses with addiction and adolescent mental health training
- One half day of a consultant addiction psychiatrist
- One half day of a consultant child and adolescent psychiatrist.

This modest level of consultant psychiatrist involvement has facilitated diagnosis, pharmacotherapy, including detoxification, stabilisation and the management of dual diagnosis, but is clearly limited. Discussions are in place to expand the time but are hampered by current pressure on budgets.

The service is designed to see young people with problems related to substance misuse up to eighteen years and covers Newcastle upon Tyne and North Tyneside, a combined population of 451,195 (ONS, 2003). It is also used for aspects of service in Northumberland.

The YPDAS has been hosted by the adult addiction service, which has offered considerable support beyond its contractual obligations. A further advantage of the link is the capacity for seamless transfer to adult services at eighteen years for those with continuing problems. Currently there are discussions about an alternative base. The service is now managed through child and adolescent mental health services (CAMHS) within a mental health trust.

Networks

There are also good links with local youth offending teams (YOTs), schools, educational projects, Connexions, the voluntary sector (hostels, bed and breakfast), children's homes and mental health services. There are important links with obstetric services (for pregnant users), adult psychiatry (for mentally ill young people approaching eighteen years), forensic adolescent psychiatry and CAMHS. Indeed, these links have led to increased referrals and awareness of substance use issues throughout CAMHS. Furthermore, the YPDAS has recently begun integration with a Tier 2 and Tier 3 young person's substance misuse team, which is an amalgam of voluntary sector, local authority, and youth offending team staff. This will effectively expand the manpower, access and flexibility of the service.

Referred young people

Many of the attendees are polysubstance users, referred through primary care, schools, social services and increasingly CAMHS. Recently, young adolescents with problems of heavy drinking (often cheap wine) have been referred more frequently. Occasionally these children can show early signs of physical dependence and withdrawal symptoms. These young people and those who are opiate dependent require safe detoxification. This usually takes place on a day basis, sometimes with a small number of young people detoxified together, with the collaboration of parents.

In other cases, the quality of attachment between the young people referred and their families is often poor. This may be due to suspected, but not necessarily proven, abuse or high levels of conflict with a single parent, in the absence of other meaningful relationships. Many referred young people do not have available fathers.

School failure is common among referred boys and often precedes, or becomes apparent in parallel, with substance misuse. It is very common for older referred adolescents to have missed the last two years of school. Often these troublesome young people had not received vigorous follow-up from education authorities. In keeping with this,

some younger adolescents with difficulties at school return only following considerable support, advocacy and discussion between education and YPDAS staff and the negotiation of arrangements that are likely to work. Although YPDAS does not have the resources to make full assessments, many of these young people appear to have literacy problems that prevent access to the national curriculum. Consequently, they might be better served with a more vocational programme that it is sometimes possible to negotiate with non-school educational projects.

Engaging young people

Relating therapeutically to often disturbed and sometimes potentially violent young people requires thoughtful risk assessment, and considerable skill and experience. Young people are seen in a range of settings – home, school, voluntary organisations, YOTs and other situations. Young people may forget appointments and will often be reminded by mobile phone. Sometimes they are transported to appointments by a YOT worker or are seen jointly with YOT; at other times they are seen in youth custody. This type of collaborative practical outreach is often crucial to engaging a young person.

Working with families

Engaging families to help a young person attend appointments with YPDAS staff, with social, educational or YOT workers, can provide a new forum for dialogue and a purposeful structure for family relationships, although short of formal family therapy. Pregnant young people generate considerable liaison, including parents, grandparents, obstetric units and midwives and social services. This ensures safety and good care (including management of withdrawal) of the infant co-ordinated with that of the mother.

Young people themselves are engaged in a supportive, empathic and constructively directive relationship. Their difficulties are assessed then discussed and intervention plans formulated in team meetings. We educate them and their families about substances, with a significant emphasis on improved mental health and harm reduction, including hepatitis B vaccination, reduced intake or abstinence, rehabilitation to training or education. We manage mental health problems (including attention deficit hyperactivity disorder, post-traumatic stress disorder, schizophrenia, cannabis-induced psychosis and major depression), and support them often over many months through key transitions (such as school to training or work, home to parenting), in the direction of normal maturation.

Current plans

We hope to solve the deficit of medical time and to facilitate seamless collaboration of agencies and services, which we see as linked issues.

Lambeth's "virtual integrated team" for young people with substance misuse

Dr KAH Mirza and Ian Moyse

Introduction and history

The "virtual integrated team" of adolescent substance misuse practitioners was conceived following the case of a 16-year-old girl who presented with severe complex difficulties. Maria was a vulnerable young girl with an angelic face, who endured the most horrid forms of neglect and abuse from her caregivers. She struggled at school, started using alcohol, cannabis and various other drugs from a young age, and became a virtual prisoner in a Lambeth crack house. Concerns about Maria were further heightened by the emergence of unusual experiences of hearing voices and believing that people were out to kill her. The spectre of a frail young girl wandering through the dark alleys of inner-city London, high on crack cocaine, screaming at passers-by caused many sleepless nights for the practitioners trying to engage her in treatment. Practitioners from health, social services, a number of voluntary services and the police worked together for a long period to provide a comprehensive network of safety and care to this girl. The virtual integrated team was born. One could argue that, even though Lambeth DAT played a lead role in developing a young people's service in 2001 by commissioning a needs assessment, the major champions for developing the service were practitioners from various voluntary and statutory agencies.

In May 2001, the practitioners decided to meet on a fortnightly basis to discuss cases, engage in peer support and supervision, and help develop a specialist service for young people in Lambeth. We created a database of all agencies working in Lambeth – both in the statutory and voluntary sectors – including people from housing services and youth clubs. Lambeth DAT supported the process by appointing a staff member from a consultant agency to co-ordinate the efforts. South London and Maudsley NHS trust supported the consultant psychiatrist from CAMHS by providing him with four sessions to develop the services and help develop a culture of research within the field of adolescent substance use. After a series of meetings spread over a period of nine months, the practitioner's group agreed on the model of a virtual integrated team – a closely knit network of services by streamlining the existing resources and by identifying funding for new staff members through multiple streams of funding including DAT funding and CAMHS grants.

The basic principles underpinning the service were:

- Substance misuse is often just one of the problems and the service should aim to address the needs of the young person in a holistic way by working with partner agencies.
- The services should be accessible to young people irrespective of whether their first point of contact is a voluntary or statutory agency
- A clear framework would be established to do comprehensive, multi-agency assessment of the unique needs of all young people and a case management structure to ensure a seamless service and accountability
- The services would develop and deliver a tailored package of systemic interventions, taking into account local issues, especially issues of equality and diversity
- An assertive outreach model of service delivery should be followed wherever possible to maximise the rates of engagement in services
- The intervention should be evidence based with clear outcomes and easy to evaluate.

Engaging young people and families in services

A human resource strategy would be developed that engenders a culture of personal development, lifelong learning and retention of staff. The strategy would endeavour to discover competencies and skills of individual clinicians, to help them acquire and maintain a range of new skills and competencies and to maximise their

potential for service delivery through a process of appreciation, support and encouragement

To achieve the aims, two structures – The Lambeth Young Practitioners Group and the support and development group (for peer reflective supervision) – were set up. The groups each meet once in a month each, with a lot of consultation in between by telephone and email.

There were many obstacles during the rather long journey, including learning to trust each other, inter-agency conflicts, ideological differences and personality clashes. However, identification of common goals and a shared vision, emphasis on flexibility, joint academic sessions, case discussions, celebration of different theoretical models, self-reflexivity and spirited leadership, and facilitation by the young people's DAT commissioner helped iron out the differences.

Staffing and base

As a virtual team, staff members of the substance misuse team operate from the respective bases of their own agencies. However, most of the clinical activities are based on a model of assertive outreach and the clients are seen in a number of different settings including clients' homes, schools, youth clubs, GP surgeries and mental health clinics.

Our Tier 3 and 4 substance misuse services

The integrated CAMHS substance misuse and youth offending service consists of:

- A consultant psychiatrist (0.4 WTE)
- A clinical manager (clinical nurse specialist 1.0 WTE)
- A clinical nurse specialist (1.0 WTE)
- A CAMHS practitioner (occupational therapist 1.0 WTE)
- A psychotherapist (1.0 WTE)
- A CAMHS practitioner (counselling psychologist 1.0 WTE).

The rest of the DAT commissioned and CYPS commissioned service consists of:

- Two drug workers based in schools (the On It project)
- One social worker (CYPS)
- One drug worker (based in and commissioned by the youth offending service)
- One drug worker working with the Portuguese community
- One drug worker working with gay and lesbian young people (High Nergy, part of the Terence Higgins Trust).
- Four drug workers working with ACAPS and Turning Point, working with black and ethnic minority young people
- One clinical psychologist who works across the young people's service and adult addiction services, to facilitate smooth transition to adult addiction services

Our Tier 2 substance misuse services

Apart from the treatment services (Tiers 3 and 4), Lambeth DAT has funded a close-knit drug education service, which is closely linked to the Tier 3 and 4 service network through the practitioner group meetings.

Catchment area and populations

The service covers the London borough of Lambeth, one of the most deprived boroughs in England with a total population of 268,120 and child and adolescent population (0-19) of approximately 58,499. Lambeth is well known for its great cultural diversity, with 38 per cent of the population belonging to an ethnic minority.

One in five 16-18 year olds are not in education, employment or training and there are high rates of poverty, unemployment, teenage pregnancy, children on at risk registers or looked after by the local authority (HASCAS, 2005).

Strategic planning and the role of the practitioners on the front line

All of our services work toward an overall strategy plan that is updated every year, the Young People's Substance Misuse Plan (YPSM). The plan sets out the action we need to take to meet the local need and our national targets in relation to young people and drugs. It is informed strategically by the young peoples DAT subgroup and the children and families, which is made up of our substance misuse service leads and key representative from the Children and Young People's Service. A key feature of our strategic planning is the way it is tightly linked to practice and development through the young peoples' practitioner group and the support and development group. Practitioners working on the front line are given ample opportunities to inform and influence the YPSM plan, by regular updates of the needs of the local population and audit of what works for whom. This bottom-up approach to service design and delivery has complemented the top-down process of achieving the local and national targets.

The Lambeth Young People's Practitioners Group

Lambeth CAMHS staff worked with other young people's practitioners within Lambeth to develop and implement policies and protocols regarding joint working, (such as confidentiality, sharing of information and risk management). Membership of the group is open and we have visitors from other services such as housing, police and youth clubs. Anyone interested in working with young people is invited to the forum to help us gain a greater understanding of the needs of young people in the borough. Academic seminars and other teaching sessions are conducted on a regular basis to learn from each other. The YPPG has served as a forum for discussion regarding the development and delivery of the Young People's Substance Misuse Plan.

The support and development group

A peer-reflective supervision group was set up for practitioners who worked directly with clients. The support and development group is vital to facilitating a joined-up approach to the care of a young people within our services. It provides an active focal point to draw together the skills and experience of our services and underwrites the model of substance misuse service provision as a virtual integrated team. This group acted as a referral forum to discuss the individual needs of clients and develop a care plan based on the skill mix and expertise of the staff. The forum provided an opportunity for sharing of information regarding our clients and sharing the skills of individual practitioners. The group provides supervision and emotional support to the staff members to deal with the emotional impact of working with a population of young people who are exposed to multiple risks.

Senior members of the team, including the consultant psychiatrist, have played a major part in ensuring that staff members with different levels of expertise receive regular supervision support and nurturing. The benefits of such a system are obvious, providing a holistic model of care for young people with input from a wide range of professionals, and support and professional development for individual team members.

Role of the young people's DAT commissioner

The DAT commissioner has played a key role in ensuring that staff members from the different agencies attend meetings by both formal and informal measures. The commissioner encourages regular attendance by chairing the meetings and making it part of the job descriptions and service level agreements of individual clinicians and agencies. In fact, the strong and inspirational leadership provided by the commissioner was the key factor in ensuring that the virtual team formed of staff members from disparate disciplines stayed together as a close-knit entity and survived endless staff changes.

Role of CAMHS staff

CAMHS staff are involved in the assessment and treatment of young people and their families who present with multiple complex needs, including mental health and substance-related difficulties. We provide the services through direct therapeutic input, joint working with other agencies, or by providing consultation and support to colleagues from other agencies. The main roles can be summarised as follows:

- We specialise in providing assertive outreach to young people who present with chaotic lifestyles and are using heroin or other class A drugs, using a CPA framework
- We undertake assessment and treatment of co-morbid mental health problems such as depression, ADHD, PTSD and psychosis
- We work with families, providing family and systemic interventions when the young person or family shows features of substance misuse
- We provide consultation and training to other staff members in the network and outside
- We are engaged in development of innovative, evidence-based intervention and research
- We have been involved in providing regular teaching to staff members from a variety of backgrounds and contribute to teaching at national and international forums.

Referral processes

Referrals may be accepted from young people, their families, schools, GPs, social services, YOTs and voluntary agencies. Young people and their families can be referred through any statutory or voluntary agencies. Team members from the respective agencies log the referrals onto their agencies' databases and bring it to the interagency referral meeting. The needs of young people and the families are explored in detail by the multidisciplinary, multi-agency team and an intervention strategy agreed. We tend to follow a case management approach and use the enhanced CPA framework if necessary.

Problems and drugs

Substance misuse in these young people usually occurs in the context of multiple chronic stressors. Many of these young people usually come from a very chaotic and disrupted early life with significant levels of bereavement, loss, neglect, abuse and being in care to social services. Many have failed at school, sometimes through unrecognised learning disabilities and many of the boys and some girls lack basic literacy skills. Many young men are involved with crime and are looked after by the local authority. Some young substance-abusing or dependent young women are sexually exploited. We have a few pregnant and young mothers in this service and close liaison with maternity services and subsequent aftercare is essential. We work within a systemic framework and involve families and other carers in treatment.

The most common drugs used are alcohol, tobacco, cannabis and combinations of the three. Some young people have used ecstasy occasionally as well. A small proportion of our client group – about 15-20 per cent – show class A drug abuse, mostly heroin and cocaine. We have had a few young people using solvents. Although there is some overlap, the difficulties faced by young people seem to fall into a number of discreet patterns.

A significant proportion of young people, as high as 30 per cent, referred to the CAMHS for emotional and behaviour problems admit to using drugs and alcohol on detailed inquiry. However, they do not meet criteria for substance misuse or harmful use according to the criteria laid out by international classifications.

A large group of young people, particularly young men, engage in binge drinking and regular heavy use of cannabis, and may get into trouble with the law, have difficulties with school attendance and family relationships and may be involved with gangs.

We have a small but significant subgroup of young people who present with psychosis, severe depression or post-traumatic stress disorder in the context of regular substance misuse. Those with psychosis often require inpatient treatment for a drug-related psychotic episode.

The number of young people presenting to our services with features of full-blown addiction (substance dependence) is relatively small. For example, about four or five young people present to our services with features of opiate dependence every year. However, this group often present with extremely chaotic life situations and require inpatient detoxification and short-term substitute prescribing, usually methadone or buprenorphine. Inpatient units for detoxification or rehabilitation of young people are few and far between and extremely expensive.

We have been successful in eliciting the help of the local adolescent inpatient psychiatric unit to deal with a rather rare but complex situation. A young man aged 17 presented with alcohol dependence, polysubstance misuse and psychotic symptoms, which lasted for two months after detoxification. He had little social support and was at high risk of relapse once he was discharged to the community. Lambeth DAT's commissioner for young people championed his cause and persuaded the PCT and social services to share the costs of a tripartite funding for rehabilitation placement. Three months later, the young man is on the road to recovery and is not showing any psychotic symptoms.

Theoretical frameworks and types of interventions

The team has been developing a model of working that allows a variety of approaches and techniques tailored to meet the needs of young people at any particular point in their lives. Even though abstinence is seen as a final goal, we see harm reduction strategies as entirely appropriate, especially when there are difficulties in engaging youngsters in treatment. Theoretical frameworks that underpin our services include a systemic view of young people's difficulties, risk and protective factors, developmental perspective on substance misuse, and an awareness of the natural history of adolescent substance misuse. We are informed by humanistic and narrative approaches to working with clients, including principles from Maslow's (1968; 1976) hierarchy of needs and Carl Roger's (1980) client-centred therapy. Other theoretical influences include Prochaska and DiClemente's Stages of Change Model (1992) and discourses on power imbalances in therapeutic relationships by Michael Foucault (1980) and Michael White (2001).

The key elements of our treatment plans include engaging young people and enhancing motivation, involving of family and or carers, improving problem-solving skills, relapse prevention, treatment of co-morbid psychiatric disorders with medication or psychological treatments, enhancement of prosocial peer relationships, drug-free leisure activities, and close liaison with schools and youth offending services to address academic functioning and offending behaviour respectively. Assertive outreach models of service delivery, in partnership with other agencies, help ensure retention of young people in treatment as long as possible.

We use a number of assessment techniques and a wide range of tools for assessing young people's drug use. We are currently involved in testing the psychometric properties of two screening tools: DUST (Drug Use Screening Tool, a screening tool filled by professionals, developed by university of Kent) and MASQ (Maudsley Adolescent Substance Misuse Screening Questionnaire, a self-rating screening tool developed by Mirza and Professor Robert Goodman from the Institute of Psychiatry (Mirza and Goodman, in preparation)). We use a number of intervention strategies such as motivational interviewing, solution focused therapy, cognitive behaviour therapy, group treatment, systemic and narrative therapies, pharmacotherapy and a CAMHS version of multi-systemic family therapy.

Achievements so far

We set up an integrated YOS and substance misuse service, which is an integral part of the core adolescent CAMHS team and in keeping with the substance misuse guidance (HAS, 2001). There were significant advantages to this strategy, which included greater participation of the CAMHS staff in adolescent substance misuse, alleviation of stigma and prejudices against substance-misusing young people, and greater coherence in service delivery to young people with complex needs.

Young people in Lambeth have been provided with easy accessibility to a range of services without stigma by the creation of a virtual integrated network of services across the interagency boundaries. Young people substance misuse services made meaningful contact with over 6,000 young people in 2005/06 and over 1,900 people (including 117 young people) in Lambeth received treatment for substance misuse in 2005/06.

We developed a number of guidance and best practice: documents such as Stand and Deliver (Lambeth young people DAAT, 2006) – drug education, Working with substance using parents, their children and young people's directory of services. We conducted an International conference on systemic therapy in substance use in 2006 and undertook a pilot study to explore the efficacy of recreational therapies in socially isolated young people who are currently using drugs. We have conducted a pilot study of parent groups using narrative and systemic ideas.

We have completed data collection for a pragmatic trial of motivational interviewing for drug workers, especially focusing on feasibility, costs and treatment adherence. Our team is taking a lead in implementing NICE guidelines for public health intervention and psychosocial interventions across the four London boroughs of Lewisham, Lambeth, Southwark and Croydon. It goes without saying that the CAMHS substance misuse team has felt supported throughout the process by colleagues from a variety of voluntary and statutory agencies and the learning opportunities created by the collaboration was priceless.

Future directions

We are planning to develop a specialist service based at local A&E departments to provide easy access to young people who present after a period of intoxication, self-harm or both.

Our first priority regarding research and evaluation is to develop descriptive studies to map the stage of substance misuse and co-occurring psychiatric disorders using standardised assessment tools such as DAWBA (Goodman, 2000). Careful description of the range of interventions and resources required for the same would help us plan research and service development on a firmer footing.

We are keen to embark on intervention trails by securing research funding from local and national agencies. We are in the process of developing a pragmatic trial of systemic motivational therapy – a systemic/family therapy intervention, combining elements of motivational interviewing, and systemic therapy, in collaboration with Prof. Peter Steinglass from Ackerman Institute of Family Therapy, USA and Ivan Eisler from the Institute of Psychiatry, London. We are keen to develop a systemic/family therapy model that can be delivered within the UK context, taking in to account the socio-cultural and economic issues. We are waiting for the outcome for a grant application to NIHR, to secure funding to launch a pilot study of the model.

We are also involved in an epidemiological study of ADHD and substance misuse in young people attending youth offending services in collaboration with colleagues from seven European countries, under the auspices of the international collaboration of research into ADHD and substance misuse (ICASA). The study has been submitted for funding from European grant making bodies.

We are holding an international two-day conference on adolescent substance misuse in November 2007 and it is hoped that our team will continue to play a major role in training of colleagues at local, national and international levels

The Lock young people's substance misuse service

Prof Ilana Crome, Dr Roger Bloor and Jane Christian

Summary of The Lock's approach

- A holistic approach is a necessity for each young person
- The severe nature of the medical, psychological, psychiatric, social and substance misuse problems with which very young people are presenting make the need for trained medical and other professional staff a prerequisite
- It is not just a matter of prescribing – although the approach must be undertaken by trained and experienced staff, the context of many other medical and social problems has to be an integral part of the treatment package and programme
- Good internal multidisciplinary team working is a fundamental, as well as good inter-agency working practice
- Outreach, in-reach and home visits are necessary to ensure that the most vulnerable young people do not drop out of the service
- Further development of the components of a day programme is proposed in recognition that it is valued by those patients who do use it
- Availability and accessibility of accommodation linked in with The Lock is paramount
- Resolution of difficulties in accessing inpatient statutory services, which is one part of the range of inter-professional relationships
- Family involvement when possible and, at the very least, an understanding of the role of family attachment factors in formulating the case and providing treatment
- Disengagement poses considerable dilemmas in this exceedingly vulnerable group who often will not access any other service than The Lock
- Success is sometimes slow and very subtle, and may also mean that there is no further deterioration.

Current provision

The Lock is a young people's substance misuse service. It is a multidisciplinary multi-agency service for young people up to the age of 19 years in Stoke-on-Trent, under the clinical leadership of Ilana Crome, consultant addiction psychiatrist and professor in addiction psychiatry. We provide a Tier 3 and 4 day facility, working as a partnership between North Staffordshire Combined Healthcare NHS Trust and Turning Point (the UK's leading social care organisation and largest third-sector provider of drugs services), with supported accommodation from a local provider (ARCH housing association) to provide a holistic model of care.

History of innovation

Professor Ilana Crome and Jane Christian (locality manager, Turning Point) became involved in young people's services in Stoke-on-Trent over ten years ago. This was the first designated young people's service in the UK and is still the most comprehensive.

The service was first established in recognition of the cumulative experience in frontline clinical provision that the numbers of teenagers accessing services were growing. It was set up in acknowledgement of the rapidly escalating need to provide a specialist service, defined in its own right, for the rising population of young users. This was substantiated by epidemiological evidence over the previous decade, which indicated that young people were increasingly using illicit substances and that the age of initiation was decreasing. Furthermore, it was clear that while some of these young people had a very brief excursion into the drug world, for others it was associated with considerable family, social, psychiatric and medical difficulties. Indeed, their drug misuse might not be their most serious problem.

The service has been in existence since 1995. At this point it was part of an adult community drug service, Druglink. Developed in an inner-city building of an adult drug service, the concept for the further expansion of The Lock was formed. Jane Christian, Roger Bloor and Ilana Crome obtained funding via the Department of Health, as well as support from the local drug and alcohol action team. The Lock was one of four pilot projects selected nationally as part of this grants programme. From its inception, it was built on the principles of an up-to-date appreciation of the evidence base, government guidance, clinical

experience, knowledge of the spectrum of service components and an aspiration for an experiment in action. Since 2002 it has expanded, extended and moved to new premises, and is now called The Lock.

Demographic context

Stoke-on-Trent is an industrial area with a population of about 241,000 (ONS, 2003); 52,456 are under 18-years-old. Thirty per cent of the city's population are said to live in areas classified as being in the ten per cent most deprived areas of England. A high proportion of young people are not in education, employment or training. There is a strong sense of history and local identity within the six towns that make up the city of Stoke-on-Trent. Unemployment is now around the national average, household income is more than 20 per cent below the national average and the rate of Income Support beneficiaries is one-and-a-half-times the regional and national averages. Just over one-third of Jobseekers Allowance claimants in the city are aged 16-24 years. There are high levels of social disadvantage in virtually every ward and correlations between high deprivation, crime and substance misuse. Although this is an area of deprivation, not all clients come from materially disadvantaged backgrounds.

Mission statement

To reduce the incidence of drug, alcohol and substance misuse and other associated consequences among young people through the provision of good quality, comprehensive specialist substance misuse services.

Principles and values

The service aims to offer individually tailored programmes of therapeutic and recreational activities in a safe environment. It is firmly committed to involving service users in the planning and development of provision for young people, their carers and their families. Its fundamental values include building invaluable links with other agencies to facilitate joint working and engaging with young people to work in partnership with the service. The priorities are to reach this client group within the city of Stoke-on-Trent and engage and intervene at an early stage in their addictions and stabilise or resolve them. A range of media and other techniques are used in order to meet the individual requirements of this often chaotic and needy population and engagement may entail flexibility, creativity and involvement.

Population served and problems identified

The Lock serves all young people in Stoke-on-Trent with alcohol and drug problems. We offer support to families and carers and to other services within Stoke to address substance misuse and related issues. We are a treatment service responding to the needs of young people when substance misuse has affected their normal pathways of development.

This means that we see patients who are mainly polydrug users but are dependent on at least one substance, with concomitant physical and psychiatric co-morbidity. As a result, there is a high level of self-harm. They are likely to have some of the following characteristics: poor family relationships, including substance misuse and psychiatric illness in their parents and siblings; a low level of educational attainment; homelessness; offending; involvement in prostitution; pregnancy; and leaving prison or the care of social services.

The following vignettes provide a flavour of whom we treat.

Vignette 1

A 15-year-old was referred by his parent as he was injecting heroin, complained of bullying and had lost weight. He was an only child, was not in school and presented as underweight with poor physical appearance. His mother had been known to adult services for some time, although this information was not immediately divulged. The mother seemed genuinely concerned and close to her son, but was very suspicious of services and their involvement. The drugs worker reassured her that the concern was about getting more support for her and her family. We made contact with the GP regarding the boy's health – there was so much concern that on several occasions the drugs worker actively escorted him, with his mother, from the clinic to attend the GP surgery for blood tests. We were flexible with their attendance as they were often late for appointments, which then had to be rearranged. The drugs workers gained good ground in engagement and the immediate risks were minimised as the young person was in treatment and being monitored.

Soon it started to become apparent that the boy's physical appearance was becoming worse, he was accessing needles through others and we finally arranged an assessment with the community paediatrician. There followed a period of disengagement. It was decided at a multidisciplinary review that we should raise the case as a "child in need" to children's services, so that the family received intensive support. The young person has since re-engaged and is back in

treatment. He has been at the service for two years, is on a regular split daily dose of methadone, attends the day programme and is somewhat less dependent on his mother. He is still fearful of attending his GP and dentist despite his illness and the availability of support from ourselves and the relevant services. Accommodation remains a problem because he will not access The Lock's housing support, preferring to live with his mother in inappropriate accommodation. Although his mother had initially questioned the confidentiality policy, she now says that she understands the decision and is more amenable to working with us. The case is still actively open.

Vignette 2

This 17-year-old girl is known to social services, the leaving care team and the youth offending team. She was re-referred this time by a neighbouring substance misuse service during a temporary period of living with her mother in the Newcastle-under-Lyme area, although her original address was in Stoke. She became pregnant and close working was established with all support services. She started a treatment programme and attended the day programme regularly. She wanted help to get away from her partner, who was a negative influence with regard to drugs. While he was in prison, a very positive period occurred, during which she started to produce negative urine samples and became actively interested in her and her baby's wellbeing. Her worker got her involved with maternity services, Sure Start Plus, and parenting classes. This involvement included accompanying her on initial appointments and to drop-in clinics. We were looking to move her across to Staffordshire services as the temporary move to her mother's was becoming more permanent.

On her boyfriend's release from prison, however, she became of no fixed abode, started to miss her script and disengaged, actively involving herself in crime to fund her and her boyfriend's habits. She was staying at one of the addresses that was raided in Newcastle and came to us in crisis on one occasion, but then disengaged again. Social and intensive support workers were equally concerned. Child conferences were occurring with a view to the protection of the unborn child. She was not in treatment and maternity services were alerted. As the due date approached, concerns were heightened, although she maintained contact with prenatal services. She was admitted to hospital due to bleeding and work started to treat her addiction there in liaison with maternity and adult services. Visits occurred by her drugs worker and the medical team and an active working relationship with her mother was established. She regularly wanted to discharge herself, but good joint working supported her to stay, which often meant late visits. Her boyfriend and friends had to be banned from the ward as they were smuggling heroin into hospital and giving it to her through her drip. The baby was born and did well. An interim care order was placed on the baby, who was being cared for by its grandmother. The girl was discharged from hospital into The Lock accommodation, is producing negatives and is maintained on her script. She is accessing support from her drugs worker and the Arch team. She is on an ISSP order and is attending the day programme as part of this. She has supervised access to the baby and is working towards this increasing.

Referral policy

The service operates an open referral policy and accepts self-referrals and referrals from family, carers, friends, professionals (including health, social services and education), and criminal justice agencies. The Lock has an upper age limit of 19 (though this limit is applied flexibly when the young person is considered especially vulnerable, for example as a result of learning difficulties). An initial assessment is offered to any alcohol and drug user, whether this is a primary or secondary problem. The majority of referrals come from clients themselves, followed by their families and friends and the youth offending team. There are approximately 250 referrals each year.

Interventions offered

The service offers a wide variety of interventions, ranging from advice and information to supportive counselling, brief interventions, motivational enhancement therapy and cognitive behavioural therapy. This often depends on the expertise of the keyworker as well as the needs and preferences of the patient. These modalities may be offered individually, in the family or in groups and may be with a keyworker, the medical team or during the course of the day programme. Life skills training, anger management, education about the effects of drugs and how to resist temptation are some of the options available.

Emphasis is placed on activities with young people that may be described as diversionary, such as going to the cinema, canoeing, playing sports and other leisure activities. Our client group may be wary of the traditional educational approach, which has not worked for them. Enhancing their life skills may be best approached indirectly through activities they enjoy, where they cannot 'fail' and which they may never have experienced.

Although the prescription of substitute and other medication is part of the programme, it is only one element of what we offer. When medication is required, the medical team usually prescribes methadone and, less commonly, buprenorphine, which are monitored extremely carefully. Patients come to collect their scripts weekly and all are supervised at least six days a week (and occasionally seven days a week).

Psychiatric co-morbidity is assessed and may be treated within the service. If not, appropriate referral is made and a care plan formulated to outline responsibilities for those teams and agencies involved. Similarly, physical health problems, which occur in about 40 per cent of clients, are referred to and treated by the appropriate professional, service or agency, such as a general practitioner, dentist, community paediatrician, physician or surgeon.

The service has particularly good relationships with the adult substance misuse service (Edward Myers Centre) and adult general psychiatry services, so that admissions can be arranged if patients fall within their age range. There is an especially strong link with the obstetrics and gynaecology service, which facilitates the treatment of pregnant drug users.

On occasion the service works with local agencies in order to organise for patients to access rehabilitation, which, unfortunately, is some distance from the Stoke-on-Trent area.

Leadership, teamwork and professional networks

Staff are selected first and foremost on the basis of interest (almost a passion) in working with this client group. Although competence is important, if applicants demonstrate the potential to enhance their knowledge, skills and competencies, this will be accommodated during their early period with the service. There is a very heavy emphasis on supervision and monitoring work practice. A regular review meeting is held where all clients are discussed. Staff are strongly encouraged to attend to facilitate decisions by consensus where appropriate.

There is a 0.5 WTE consultant addiction psychiatrist whose determination to ensure safe provision for this complex population remains a prominent feature in the continued evolution of the service. The consultant provides up-to-date clinical information for the team to utilise and disseminate for the benefit of the young people. There is also a strong advocacy component to this role, promoting the work, maintaining the profile, and attending professional and organisational reviews so that the extreme vulnerability of individuals is highlighted and acknowledged by commissioners to support the continued existence of The Lock. Practically, the consultant has a high degree of personal knowledge of the clients and their families and the focus is on the strengths that the individuals offer but awareness of the risks that each bring into the consulting room.

Turning Point's locality manager provides overall management for the service. This includes ensuring that team members receive adequate support and training to fulfill their individual roles, making sure the service is delivered in a safe environment and meets (and where possible, exceeds) required quality standards, and developing appropriate policies and procedures to support the service. The role incorporates an emphasis on partnership working by maintaining effective communication and regular liaison between senior staff within all the providers involved in the service and the commissioners.

The consultant's personal assistant provides support in the administration and organisation of the consultant's time and is a valuable link with the young people's GPs and other health professionals. She is crucial in establishing and maintaining relationships with the media, non-health professionals and politicians.

The current service manager qualified as a registered mental nurse in 1983. She managed one of the first community-based facilities to support hospital closures, which gained evidence-based practice status for its work with multidisciplinary teams and care planning. In 2000, she became the manager of a hostel for under-19s and accrued the resources and necessary standards for registration as a children's home. In addition, she managed a day centre for the homeless. In her current role, her experience in both the voluntary and statutory sectors is as invaluable as it is effective.

Some staff are linked to other agencies such as Connexions and the youth offending team. A Connexions personal advisor specialises in promoting education and training. He has established himself within drug services and developed a role supporting young people in achievement. He is trained to deliver a needle exchange service and has great rapport with and understanding of young people. The youth offending team link worker has a background in fostering and has acquired expertise in substances and their connection with criminal activity, through study and practice. He provides young people who have come into contact with the criminal justice service with advice and support.

There are several drugs workers, one of whom developed the day programme and three others

who provide health and social care support. Our day programme worker worked in young offenders institutes as a trainer before joining the team. She has developed programmes of training in a variety of subjects that support and educate young people in maintaining safety and knowledge to empower them to make changes. The structured day programme is a unique resource within the UK for young substance misusers. One of the substance misuse workers previously worked in care and social services and is particularly interested in vulnerable women. She works well with other agencies and is successful with the most complex cases due to her honesty and persistence. Another part-time drugs worker also has a background in care and has the skills to support needle exchange and a wide knowledge base with substances through experience in drug services.

There are four supported housing workers (managed by Arch North Staffordshire) who provide supported accommodation for young people who attend The Lock and aim to resolve homelessness within this client group. An administrator and finance support worker maintains the financial and statistical evidence that supports the service.

Until April 2007 we had a systemic family therapist (a 0.5 WTE family therapist) who supported the family and relationship work that is often a primary need for young people. She supported the team in valuable discussions about family dynamics, access to services and pregnant service users. A child and adolescent consultant psychiatrist offered his time as a specialist interest once a week to assess and support young people who need further help with emotional and behavioural problems. These components have been withdrawn as a result of funding constraints and the impact is evident in our inability to offer rapid child and adolescent assessments and support with the range of face-to-face family interventions, as well as training and supervision of drugs workers to undertake comprehensive assessments and do a degree of family work themselves. A healthcare support worker provided valuable nutrition and counselling knowledge to support the physical wellbeing and needs of the young people until 2007.

At any one time there is usually a senior psychiatric or medical trainee or specialist registrar. Since the initiation of the young people's service, fourteen specialist registrars have spent time as a full-time or special interest at The Lock. Addiction psychiatry, child and adolescent psychiatry, and paediatric and general adult psychiatry trainees have availed themselves of the opportunity to observe, participate in and contribute to the service. Almost all have gone on to use this experience directly in their consultant roles.

Level of resources

Our service is housed in a new two-storey purpose-built unit situated on a leisure and commercial park just outside the city centre, with easy access from surrounding towns and villages. It is accessible but secluded. It is in a completely separate location some miles away from the adult services.

We have two day programme rooms, including a living skills kitchen, lounge area and classroom. The lounge provides two electronic keyboards, guitar, piano, mixing decks and two internet connected PCs, which are used for IT skills. There is a relaxation room where clients can access auricular acupuncture and other alternative therapies, a clinic area and one-to-one counselling rooms. The first floor is dedicated to staff teams and medical records. The overall atmosphere has a bright, spacious and contemporary feel, which is well suited to the client group.

Research

The Lock has served as a base for some of the earliest research into young substance misusers in the UK, funded by several government agencies. This research has included risk factors for young substance misusers, teenage pregnant substance users, and the physical health needs of adolescent substance misusers. Current research is focused on client characteristics, referral pathways and outcomes in complex cases, detailed analysis of treatment provision to complex cases, analysis of the prescribing database over 15 years, experiences of staff working in a specialist substance misuse service for adolescents, and older substance misusers (who are often grandparents of younger users).

Training

The Lock is now regarded by policymakers as a model of good practice and as such it is integral to an internationally unique university accredited course, the MSc in Adolescent Addiction Studies at Keele University, which commenced in 2004. This course has already attracted students from as far afield as Cambridge, Edinburgh, London, the Isle of Man and Swansea. We have also been asked to provide short courses based on the MSc around the country, including in Northern Ireland and Scotland.

National conferences (Every Substance Misusing Child Matters and Suicide, Self-Harm and Substance Misuse) were held in April 2006 and April 2007 respectively, to celebrate The Lock and

each graduating group of MSc students. The next conference, Family Are Us, is planned for May 2008.

The Lock has played host to health and other professionals as well as volunteers from as far afield as the United States, some for a half-day visit and others for a four-week placement. We offer regular training slots for medical, nursing, social work and psychology students and have had a steady stream of senior trainees in addiction psychiatry, child and adolescent psychiatry and paediatrics. Medical students at Keele University Medical School have undertaken excellent special project options on the clinical population of The Lock, which have been the basis of published editorials, articles, posters and presentations for staff and at conferences. We provide regular in house training for staff with the objective of enhancing competencies.

Policy

On the basis of their experience at The Lock, Ilana Crome, Jane Christian and Roger Bloor have acted in an advisory capacity to developing services and policy in England, Scotland and Wales. This involved sharing of information about policies and procedures, as well as the experience garnered during the previous ten years.

Ilana Crome has provided specific input to the Advisory Council on the Misuse of Drugs' recent publication Pathways to Problems, and sits on its implementation group. She also provides expert advice to several other government bodies and policy forming groups, including the recently formed UK Drugs Policy Commission and the Royal College of Psychiatrists' Young People's Substance Misuse Working Group. She was chair of the Royal College of Psychiatrists Faculty of Substance Misuse between 1998 and 2002 and chair of the working group, which produced a council report on the roles of doctors working with substance misusers.

What gives us the most satisfaction?

We have the trust of young people, their families and carers. As a result of ongoing clinical training, research, and negotiation with commissioners, we are fortunate to be in a position, as a team, to help substance-misusing youngsters understand, resolve and recover from the most traumatic of experiences. Client satisfaction by independent evaluation, regular in-house client satisfaction assessment and audit has demonstrated that the patients value the service greatly.

What have we learned?

The unit has been and continues to be a great learning experience. We believe a one-stop shop, housed in a modern environment, engages young people and is an appropriate model. A multidisciplinary model is vital and has a great deal to offer the clients and staff, as does the day programme.

We have learned that these complex youngsters have incredibly high levels of need and need long-term support, which involves slow progress – the average length of time in treatment is about two years. We have learned that it would be better all round if there was continuous access to a medical practitioner because of the inevitable crises that require an emergency response by the team. We need primary medical and dental care on the premises and community paediatricians regularly. We need easily accessible and welcoming units where patients can be admitted for assessment, observation, titration, detoxification and rehabilitation. We need to cover the comprehensive needs of the client group, which can range from information for parents to treatment for the suicidal alcohol-dependent pregnant girl.

Transitions between services need to be more seamlessly managed. We have found the partnership arrangement to be very beneficial to clients and staff alike – except when one member has funding difficulties, at which point it destabilises and demoralises the whole team. Thus, the partnership arrangement between the NHS, Turning Point and the housing association, with its inherent potential and actual instability, needs to be sustainable. These collaborations should also be meaningful. Staff should have secure posts to avert shortages in cover due to illness and stress. Most of all, we have learned that immediate cost cutting may be very costly eventually, at a time when, perhaps, we are not in contact with the patient. How do we cost a death, a period in prison, or cognitive damage for a lifetime?

Ten challenges for 2006–2016:

At the culmination of the 2006 Lock Conference, Every Substance Misusing Child Matters, we set ourselves the following challenges:

- A UK-funded research programme
- Better understanding of the factors that influence adolescent substance use and misuse
- Improving the UK evidence base
- Evidence-based prevention measures

- Evidence-based pharmacological and psychological interventions
- Operate within a lifespan addiction service
- Comprehensive services to have mainstream recurrent funding
- Comprehensive services, which cover the transitional ages
- Comprehensive services to bridge primary and secondary care
- Comprehensive services to be multi-agency and integrated.

We are committed to meeting them.

Mental health and young people's services in Bradford

Dr Norman Malcolm

History

Increasing awareness of the needs of young people with substance misuse problems led to a number of initiatives began in 1997. The local child and adolescent mental health services (CAMHS) employed a consultant child and adolescent psychiatrist, half of whose time was to be dedicated to this evolving service and a specialist nurse practitioner with previous substance misuse experience.

Around this time, the Bradford drug action teams appointed a number of assertive outreach workers as under-18s substance misuse workers. Also at that time, a local voluntary sector street agency, The Bridge Project, was successful in bidding for monies to set up a young person's service – "no. 29". It was agreed the three services would accept referrals up to the young person's 19th birthday.

Having worked initially independently of each other, these services gradually came together at no. 29 through a series of initial pilot schemes that were necessary to reconcile different philosophies, including concerning confidentiality, substitute and symptomatic prescribing, complementary therapies, and roles and responsibilities. Over a period, a more seamless multi-agency service has established collaborative outreach, engagement, self referral to a child-centred specific project, assessment of needs (including housing, mental health, drug misuse and relationships) allowing rapid cross-referral and generation of appropriate care and intervention plans.

Over time, we have also formed good links with local housing providers and hostels, physical health nurses with a specific focus on sexually transmitted infections and hepatitis C, substance misuse pregnancy services and links with our colleagues in the adult treatment fields. Latterly the outreach team has expanded through a number of other initiatives now including an arrest referral scheme for young people and an education team involved with the providing of early interventions targeted at at-risk groups (including those in local authority care and pupil referral units).

Catchment area and populations

The services cover the Bradford metropolitan area, which includes Bradford city and a number of large surrounding towns. The population of Bradford is approximately about 467,700 with a wide ethnic mix, a high proportion of young people and significant deprivation in a number of wards.

Staffing and base

As illustrated earlier, the three services started at a similar time. The child and adolescent mental health (CAMHS) component consists of:

- A consultant psychiatrist (four sessions a week)
- A clinical nurse specialist (five sessions a week)
- A CAMHS therapist (full time)

No. 29 (The Bridge Project) houses the young person's service has three full-time young people's substance misuse workers from health, social services and youth service backgrounds. The under-18s substance misuse service (now housed by social services) has a whole time manager, two whole time outreach workers, three education workers and two arrest referral workers.

More recently, CAMHS has extended the consultant child psychiatrist role into providing a service with the local youth offending team (YOT) and has also staffed this service with a half-time community psychiatric nurse with children and a child psychologist. The YOT also makes initial referrals to the education team who may subsequently be seen by any arm of the wider service. However, as with other teams, work also takes place at a number of other venues including children's homes, schools and pupil referral units.

Referrals and types of problems

Young people may enter the services from a wide variety of entry points, have their needs assessed and be quickly directed to an appropriate level of intervention. Although there is some overlap, work tends to fall into a number of discreet patterns. A large group of young people – particularly young men who engage in excessive consumption of alcohol and particularly skunk cannabis – may get

into difficulties with school attendance, family relationships and subsequent criminal activity. A small yet very significant sub-group are people with emerging psychotic disorders who may need treatment and hospitalisation for drug-related psychotic episodes. Some young substance-abusing or dependent young women are sexually exploited. Liaison with social services and child protection agencies is an essential part of this work. Addressing heroin dependence, often in association with crack use, remains a critical component of the work.

These people have usually come from a very chaotic and disrupted early life with significant levels of bereavement, loss, abuse and social services' care. Many have failed at school, sometimes through unrecognised learning disabilities; many of the boys especially are only partly literate. Many are involved with crime or exploitation within the sex industry. Issues arise around their personal safety, stabilising and reducing their substance use through appropriate interventions, close liaison with housing groups and an attempt to make some contact with the family where appropriate. The service regularly sees young people who are pregnant or with young children and close liaison with maternity services and subsequent aftercare is essential. Working with young people with often profound and complex needs is often intensive requiring regular reviews, close liaison with a range of agencies, with families where available, and where indicated, close supervision of substitute prescribing, usually methadone or buprenorphine.

Future directions

We have found we are working with fewer heroin-dependent young people and this has caused a shift in our practice of late. Our street agency base has perhaps in the past been identified by the community as a place associated with heroin and is not as attractive to young people with problematic use of other substances. This has caused us to consider other suitable venues. Working with children of drug-using parents is an often-discussed subject and is an area we feel must be developed further.

We hope that the relationship between the service providers and the children's drug service commissioner continues to grow and will encourage us to come together to form an even more seamless service. Therefore, we are in the process of producing new advertising and a freephone number as a central referral point for young people and carers.

The CAMHS Specialist Substance Misuse Service, London

Dr Ron Alcorn (consultant psychiatrist)
Rosie Winyard (senior nurse)
Dermot Ryall (CAMHS development manager)

East London NHS Foundation Trust

Introduction and history

In 2003, the three boroughs of East London, Hackney, Tower Hamlets and Newham cluster commissioned the CAMHS Specialist Substance Misuse Service (CSSS), previously called ASATS. The project was initially funded for three years and the contract was awarded to the Child and Adolescent Mental Health Services (CAMHS) of the East London and the City Mental Health NHS Trust, who were keen to see a service established. There was little in the way of co-ordinated Tier 2 provision at that stage but, over the next three years, a functioning Tier 2 service was established in each Borough. The cluster commissioned service reported to the commissioners in the three Drug Action Teams and submitted data to the National Drug Treatment Monitoring System.

Following a review in 2006, Hackney, Tower Hamlets and Newham moved to an independent commissioning model for young people's specialist substance misuse services. The level of funding was reduced and this necessitated a change in the design for the CAMHS service and the formation of the current service, CSSS. This specialist service also includes funding for a pilot project in relation to transition in Newham for young people up to the age of 25 years. Other local developments within targeted young people's substance misuse services enabled them to increase their capacity to provide some specialist interventions in addition to CSSS. A system of joint working at both managerial and operational level has been established in line with local commissioning arrangements. CSSS currently operate in conjunction with Lifeline in Tower Hamlets, Sub 19 in Hackney and Create (In-volve) in Newham providing a wide range of treatments, supervision, education and training for young people with substance misuse problems.

Catchment area and populations

The service covers the London boroughs of Hackney, Tower Hamlets, Newham and the City of London. The combined populations are about 650,000 (ONS, 2003). There is a very wide ethnic mix and a high proportion of people under the age of eighteen. The indices of deprivation vary but include some of the highest in the country.

Staffing and base

The CAMHS service commenced operations in mid 2003 with two clinical nurse specialists (CNS). In mid 2004 a consultant psychiatrist joined the team along with a third CNS. Since 2007, CSSS staffing includes:

- A senior nurse/service manager (1 wte)
- A consultant psychiatrist 3 sessions per week)
- Three CNS (3 wte), one assigned to each borough
- One substance misuse practitioner (1 WTE) for transition in Newham

CSSS had an administrative and team base in the first three years of operations but the work and work bases of the CNSs and practitioner are now fully devolved to the three boroughs where they have become members of both local CAMHS and voluntary sector teams providing treatments for young people with substance misuse problems. Young people are seen at a site suitable for them including youth offending teams, schools, homes, young people's projects, CAMHS premises, courts and hospitals.

Service model and links

CSSS sees young people up to the age of 19 (25 in Newham) and their families or carers referred by partner agencies. The service has established good links with CAMHS (especially the adolescent mental health and paediatric liaison teams), youth offending teams, social services departments (especially the looked after children and leaving care teams), schools (especially the pupil referral units), universal and targeted young people's substance misuse agencies and voluntary sector projects. It has strong links with the GP shared care networks. In addition to direct client work,

CSSS offers 1:1 and group case management supervision, consultancy, teaching and training. There are partnership agreements covering management and operational issues with a number of linked agencies for this combination of functions. CSSS regularly attends youth offending teams, adolescent mental health teams and targeted agencies helping to screen, triage and consult on young people with significant alcohol and drug problems. A flexible, assertive approach to engagement and working with young people is employed. The emphasis is on comprehensive assessment (including risk assessment), a care plan agreed with the young person and skilful joint working with other agencies. Transitions to adult services after the age of 19 are flexibly and carefully arranged. The pilot post in Newham is for one year and information from this project may also usefully inform work in other boroughs.

Referrals and types of problems

CSSS received approximately 150 referrals in 2005/6. CSSS works with young people with significant drug and alcohol problems and people with complex needs. This includes people with substance dependence, co-morbid conditions, child protection issues, physical health problems and forensic concerns. The aim is to enable service users to move between different services in a seamless way to provide the most effective and acceptable treatments for young people and their families. The majority of referrals are for heavy cannabis (skunk), alcohol and poly drug problems, although there have been a significant number of referrals for class A drug use (cocaine, crack and opiates). There have also been a small number of very problematic volatile substance users. A number of agencies and young people themselves are concerned about cannabis dependence and there has been a steady number of referrals for first onset psychosis where cannabis use may have played a role. Other very complex cases have included homeless young people, those who are exploited and involved in sex work, and young abusers and young sex offenders. Many young people have fractured family lives and very poor educational achievement. There is a high incidence of substance misuse problems in the immediate family and in the networks/peers of young people referred. A number of young people have been involved in drug dealing and have witnessed, or been victims of a great deal of trauma and violence.

Types of interventions

The emphasis is on engaging young people and their families in as creative and flexible a manner as possible, often over a long period of time. CSSS clarifies, and make links with, the network of agencies working with (or having had experience of working with) young people in line with commissioning arrangements within each Borough. A comprehensive needs assessment, care plan and risk assessment is provided with an emphasis on helping young people back into some sort of education or training. Engaging service users in health, sexual health and psychiatric services is also a priority and can involve accompanying them to appointments and advocating for them.

Drug and alcohol-related goals are negotiated with an emphasis on motivational enhancement and education. Harm reduction, moderation and abstinence goals are all supported. Most of the work is in one-to-one sessions with a key worker. Treatment may include prescribing medication (for associated mental health problems, detoxification or substitute maintenance), blood-borne virus screening and immunisation. Pharmacological interventions are provided both by the senior nurse and consultant in conjunction with NTA guidance on non medical prescribing. CSSS assesses, arranges and supports rehabilitation placements and provides aftercare.

The service also supports and takes referrals from youth criminal justice programmes including arrest referral, Drug Treatment (and Testing) Requirements and Resettlement and Aftercare programmes. This is a growing proportion of the work and set to increase as these programmes are extended. The length of a treatment episode may vary from brief interventions (two to three sessions) to longer-term engagement (including maintenance prescribing).

Outcomes

Outcomes with young people are difficult to capture and measure, although this may improve as the service is currently using the TOPS indicators for young people over 16 within NDTMS recording. CSSS also reports quarterly for borough monitoring meetings to include referral and retention rates, response times, completion of agreed care plans, changes in drug and alcohol use (frequency, patterns and amounts), repeat measures using validated scales (such as severity of dependence scale) and user satisfaction questionnaires.

Future challenges

These include retaining funding for the project, working with the commissioners to agree appropriate service targets (not merely aping adult targets and models of care), attracting/ retaining staff to work in this challenging field and

developing meaningful outcome measures for young people. Perhaps one of the biggest challenges is coming from working with young people themselves in identifying the kinds of specialist services they would find most helpful and making this appropriate and accessible for them in a multicultural context. In addition, there is a particular problem for substance misuse services to keep pace with the rapidly changing pattern of substances misused by young people and provide appropriate quality treatments in a cost effective manner.

Adolescent Drug and Alcohol Service, Hertfordshire

Dr Clare Casey[1] and the current A-DASH team

Introduction and history

A-DASH, originally known as the Young Person's Substance Misuse Service (YPSMS) was established in CAMHS in April 2003 when the young person's specialist workers who were previously based and managed in adult treatment services were transferred to CAMHS. The staff had a variety of health and social care backgrounds.

Catchment area and population

Hertfordshire has a population of just over one million (ONS, 2003) and is also the least deprived area in Eastern England. Initially, there were three drug and alcohol workers in post (with one vacant post), two sessions of a dedicated CAMHS consultant with recent substance misuse experience in Hertfordshire and a 0.5 WTE project manager. This group was responsible for all referrals of 11–18 year olds. Just prior to the transfer to CAMHS, the service benefited from further investment from youth offending teams and joint commissioning with the establishment of the service becoming four quadrant workers, a full-time administrator and manager of the team (who had been the project manager) and funding for a full-time consultant. At the time of the transfer, prescribing was provided in shared care arrangements with the adult CDATS and medical issues were dealt with on a consultative and liaison basis and continued goodwill of the local CDATS.

The service is now commissioned by the joint commissioning group for young people's substance misuse and contributors to the delivery of the YPSM strategy in Hertfordshire. In March 2004, a full-time consultant child and adolescent psychiatrist was appointed. Currently there is a 0.5 WTE consultant in post (with a 0.3 WTE about to commence), an administrator, team manager (substance misuse specialist nurse by background), and four drug and alcohol quadrant workers. The generic quadrant workers are from probation work, psychology and counselling backgrounds.

[1] Dr Clare Casey has now left the service but works at the Priory Hospital North London

A-DASH, the specialist Tier 3 service (for the more complex and entrenched drug and alcohol problems) is supported by four dedicated quadrant drug workers who provide the named drug worker role for YOT and a targeted intervention to young people who are referred by children, schools and families services. This targeted service is commissioned by the joint commissioning group and located in the youth justice service with line management provided by the local YOT assistant manager in the quadrant that the worker is based. The targeted service sees the less-entrenched and less-complex drug and alcohol clients, such as those who are commencing binge drinking and regularly using cannabis with less-complex consequences, and thus provides an early targeted intervention.

Networks

The specialist Tier 3 service continues to provide the specialist treatment interventions with the local YOT and provides regular formal advice, support and consultancy to the dedicated service workers as well as treatment to a small number of YOT clients. A-DASH also provides this on a case-by-case informal basis to other professionals in the county. The service comes under the administrative and managerial umbrella of the local child and adolescent mental health services (CAMHS) and as such has excellent co-ordination with the four quadrant CAMHS services, Forest House residential unit as well as the adolescent outreach team (which also shares the same administrative base).

This means that people with pre-existing mental health problems receive help from A-DASH and the appropriate mental health team. As the service has grown and developed, the importance of these links has become paramount; it is helpful to address drug and alcohol abuse in conjunction with co-occurring or underlying mental health problems such as depression (often associated with self-harm), conduct disorders, autistic spectrum disorders, obsessive compulsive disorders and ADHD.

There are improving links with children, schools and families (CSF). The managerial structure works in partnership with the managerial structure of

CSF, and in some cases the service will refer to children's services for assessment that may include investigation for child protection. In many cases there is emotional abuse or neglect or exploitation by others involved, but no sign of overt current physical or sexual abuse. Neglect and emotional abuse can often be the root cause of many of the problems that the service sees in the younger clients and can be difficult for other services to clearly identify issues, so it is crucial that the service works closely with CSF to safeguard and protect children and young people. The service also has links with Connexions, children's and young people's health services, various non-statutory services such as the Prince's Trust and adult drug services.

The service has piloted the use of specialist foster care placements for young people to stabilise them on prescribed medication and slowly withdraw them with the support from A-DASH, foster carers, CSF, Connexions, youth offending teams and other partnership agencies. In these cases it has been crucial to move the young person out of the family home before any stabilisation or detoxification could be effective. This has been a preferred option rather than using detox beds in an adult focused agency. These specialist foster carers received training and support in the supervision and administration of Subutex® (buprenorphine). The service successfully detoxified two adolescents in this way, who remained in these specialist foster placements for three and nine months respectively. A-DASH works closely with the looked after children services including residential homes and leaving care services, and the early intervention in psychosis teams.

Referrals and substances

There are just over one hundred referrals annually mostly from CAMHS, YOTs, Connexions, parents, carers and to a lesser extent self-referrals and GPs. Less than six per cent of referrals involve entrenched heroin addiction patterns. A-DASH can provide community detoxification with daily visits and support to parents and carers. However, only a small percentage of our clients require a prescribing intervention and the majority of specialist treatment being based upon psychosocial interventions and the support and advice of the keyworker. Cannabis is clearly the primary drug of choice with just 50 per cent of the referrals having this as the prime drug; next is alcohol with 30 per cent of young people referred having alcohol as a primary drug (predominately females aged 15–17), with a small number who are presenting with adult-like pictures of alcohol dependence. The service has had a small number of inpatient detoxifications that have taken place in independent sector psychiatry beds through joint commissioning managements and funded from the pooled treatment budget for young people's substance misuse. The majority of young people who are using cannabis are using skunk, which seems to produce varying symptoms in the adolescent population. For example, some young men are seen with paranoid and aggressive symptoms; while many young people seem to suffer from a low-grade (depression-like) mood disorder and lack of motivation. A-DASH also receives referrals of young people who are misusing cocaine and ecstasy. More than half are polydrug users although a significant minority, probably ten to fifteen per cent, have a more adult-like picture of narrowing down their substance misuse to one substance (such as heroin or alcohol).

Complex problems

A number of referred young people come from emotionally abusive or neglectful backgrounds. A smaller proportion suffer from child sexual abuse and their drug and alcohol misuse may be a way of self-medicating to avoid the complex emotional issues and flashbacks. A significant proportion of the clients live in areas of Hertfordshire where alcohol and a variety of drugs are available. A proportion of the young people will have attended CAMHS clinics perhaps two or three years earlier but have been lost to follow-up, often dropping out of the engagement process. A number of young men seen have a history of attention deficit hyperactivity disorder (ADHD); many have been prescribed Ritalin® but have taken it on an irregular basis.

Often these children come from chaotic family backgrounds without boundaries. Poor school attendance and exclusion is common; often the pupils' poor attendance and behaviour has finally been topped off with drug and alcohol misuse, which the schools see as the final straw and the children are excluded. At this point their drug and alcohol misuse may spiral completely out of control. One fourteen-year old-girl, who had previously been functioning well at school, was found in possession of cannabis and subsequently excluded. She received no proper educational support for over a year and a half. During this time, while her parents were out at work, she started mixing with older drug dealers and her cannabis usage escalated to cocaine and to alcohol dependence. She entered into an informal agreement where sex was exchanged for drugs. Eventually she needed to have an inpatient detox because her alcohol dependency was so entrenched.

Some of the young people of school age that are referred are in exclusion units or are at home with limited educational input. With the development of the lead professional and Connexions workers becoming budgets holders there is emerging flexibility in obtaining education and training for clients of the service.

Engagement

The engagement process is facilitated by outreach service to young people's own homes, one-stop shops, mainstream children services, schools, GP surgeries, and sometimes in public places such as cafes. The service has to be prepared to deal with a chaotic and sometimes homeless population and is often dependent on telephone contact. A-DASH offers a proactive, assertive engagement process, unlike adult addiction services and mainstream CAMHS.

Intervention

A-DASH offers a variety of treatment packages based upon a holistic, empathetic, individually tailored package of care. Key to the work is multi-agency liaison including child protection work. The service offers a specialist prescribing service, either as an outpatient or an inpatient, as well as providing a variety of talking therapies including motivational interviewing techniques, solution focused therapy, informal family work, and individual supportive work as well as cognitive behavioural work. An interim care plan based upon harm reduction and risk minimisation to all the young people we meet is implemented.

A-DASH attempts to work with families where at all possible. Some young people refuse to give consent to contact their carers and involve them in the treatment plan. If the services assesses them as competent, then this choice will be respected. The worker involved will continue to encourage them to involve their parents and it is not infrequent that once the young person develops some trust in the worker and service, that they allow contact with their family. Each case is reviewed frequently on a case-by-case basis.

Some families are too chaotic to do any significant work with and the service has difficulties in engaging the support of parents in treatment plans. These parents may have drug and alcohol abuse problems themselves, have mental disorders, or have maybe subjected the young person to forms of emotional abuse or neglect, some of which in the past may have led to child protection concerns. Some of the children or young people are infamous and their behaviour, including drug taking, is almost expected of them on the street, which makes treatment engagement difficult and challenging. In these cases it is necessary to get all parties to agree to the young people moving out to specialist foster placements, hopefully out of their own localities. This is rare and has only occurred twice through the service, although some of the children or young people have ended up in looked after services of CSF due to other concerns.

There are agreed statutory and non-statutory transition policies with adult drug services to provide a smooth transition and continuity of care.

The Young People's Drug Treatment Service, Bristol

Dr Deborah Judge

The Young People's Drug Treatment Service (YPDTS) was set up in March 2000. This was in response to the HAS 1996 and the level of substance misuse identified in the area in the under-18 population. Avon Health Authority reviewed its funding and recognised the need for a specialist service, separate from adult services and closely aligned to CAMHS.

Once the decision was made to develop the service, funding was identified, with an understanding that there would be access to the children's hospital for beds (this was never realised for a variety for reasons).

A CAMHS consultant interested in the field was identified and drugs workers with a young people focus were employed. A holistic approach was agreed with emphasis on working closely with other agencies.

Staffing and base

The YPDTS is currently based at 38 Southwell Street. It is a standalone unit for young people's drug treatment. The service is situated within child and adolescent mental health services within the women's and children's department of United Bristol Healthcare Trust. The service delivers a mixture of office-based sessions and outreach sessions. Young people can be seen in their places of education, GP surgeries, and local agencies offices as well as at home, once a risk assessment has taken place. The service consists of:

- A consultant psychiatrist – six sessions
- A consultant psychologist – two sessions
- A service manager – full time
- A clinical nurse specialist – 1.75 WTE
- A specialist drugs workers – 2.0 WTE
- A social worker – one WTE
- An administrator.

Role of the team

The team is involved in the assessment and treatment of young people and their families who present with multiple complex needs, including mental health and substance misuse difficulties. This can be done through direct therapeutic input, consultation or around joint working with other agencies.

- We specialise in providing assertive outreach to young people who present with complex presentations, using a variety of drugs and alcohol, by using a care plan approach framework
- We undertake assessment and treatment of co morbid mental health problems such as depression, anxiety, ADHD, PTSD and psychosis
- We work with families where the young person is misusing substances
- We provide liaison, consultation and training to other staff members in the network
- We are engaged in the development of innovative, evidence based intervention and research

Catchment area

The service covers Bath and North East Somerset, North Somerset, Bristol and South Gloucestershire. The total population for this area is 814,820 (ONS, 2003).

Once a month YPDTS hosts a clinic to the peripheral (Bath, North Somerset & South Gloucestershire) areas, which provides:

- Consultation and liaison
- New assessments
- Specialist assessment – referral to clinical psychology for further assessment, advice and evidence-based psychological therapies such as cognitive behaviour therapy (based on NICE guidelines), and emergent personality difficulties related to forensic issues and risk assessments.
- The service also provides clinical supervision to a number of workers within the peripheral area.
- Access to services

Referrals are through Tier 3 teams in the peripheral areas and Tier 2 services in Bristol, early intervention services, GPs, children and young people's services and YOTs. The referral is discussed in detail at the team meeting and

further history may be gained. They are then allocated to an appropriate team member for assessment, often with the referrer in order to ensure attendance.

Presentations to service

The most common presentations are a combination of cannabis, alcohol and co-morbid problems. Some of the young people present using different pills and a small proportion use solvents. We are seeing very small numbers of heroin users and some cocaine users.

The pattern of presentation tends to be proportion of young people who have chaotic use, offending behaviour, difficult family backgrounds and some co-morbid features – ADHD, learning needs and PTSD. They often have multi-agency involvement through YOT, children and young people's services, housing and education. Some will require prescribing for their heroin use – these will be mainly male with an average age of 17. Many come form backgrounds of neglect and abuse and often have been in care. Some of the girls have been in involved in sexual exploitation and have much older boyfriends who are injecting drug users.

The second group we see is 14–16 years old and using large amounts of cannabis and alcohol that is causing disruption to school and home life. They often have difficult family relations and problems with making plans for the future.

Working with these groups of young people requires intensive reviews, close liaison with a range of agencies, with families if available and close supervision of substitute prescribing usually, methadone, buprenorphine or naltrexone.

Types of interventions

The model of service delivery used with the client group allows for a variety of approaches and techniques tailored to suit them at the particular time they come to the service and progresses through their treatment plan. Theoretical frameworks that underpin our approach to service delivery include a systemic view of young people's lives, taking into account a developmental perspective and Maslow's hierarchy of needs (1968, 1976). Intervention strategies include motivational interviewing, harm minimisation, brief solution-focused therapy, relapse prevention and multi-systemic family therapy.

Future directions

Within Bristol, the strategic plan is to align the young people's substance misuse services with every child matters arrangements thereby creating a multi-agency "virtual team".

Currently within Bristol there are three teams that provide substance misuse treatment to under-18s:

- YPDTS
- Drugs and young people's service
- Project Max – a youth offending team.

The alignment of these services will be on the principles of Every Child Matters arrangements:

- Integrated services for children
- Universal and targeted provision
- Information sharing
- Strong leadership and accountability
- Common assessment process
- Multi-disciplinary teams
- Stronger workforce.

The aim of this virtual team will be to provide a best practice model for young people in terms of access, identification, assessment, referral and lead professional case co-ordination.

This will in turn provide closer organisational working between the drugs strategy team and children's trusts in terms of strategy, commissioning, information sharing, capacity, workforce development and improving outcomes for young people.

Dr Deborah Judge[2]

Introduction and history

This service was first commissioned in 2002 and a service co-ordinator appointed. He had a desk in a shared office and two drug and alcohol workers to work with – one based within the YOT in Melksham (North Wiltshire) and one based in Salisbury. There was no joint working protocol for the roles and responsibilities of these workers, who were employed by the county council. In August 2003, a part-time consultant child and adolescent psychiatrist was appointed (four sessions of generic CAMHS and two sessions of young people's substance misuse) to work alongside the co-ordinator to develop the service. The remit was to develop a Tier 3 treatment service for young people across Wiltshire.

Catchment area and population

The population of Wiltshire is about 433,000 (ONS, 2003). People live around the main towns – Salisbury, Trowbridge, Devizes and Chippenham – but a significant proportion live in rural areas.

Wiltshire young people's substance misuse service (flux)

Staffing and base

During 2003 we were housed temporarily with the adult treatment service in Trowbridge. The young people's service now has an office base within that building since January 2004 and was equipped with telephones and computers in September 2004. A half-time office administrator was appointed in July 2005 and 1.5 WTE additional drugs workers. Staff contracts were moved into the mental health NHS trust in June 2005. The service is now a specialist CAMHS service under the CAMHS management structure.

Networks

The working agreement with the YOT has developed into a formal agreement for those drug and alcohol workers. We are looking towards making a similar agreement regarding the community psychiatric nurses currently based in the two YOTs, so that they too would come into CAMHS. The two recently appointed young people's workers have a remit to liaise closely and develop links with education (around excluded young people) and looked after children and young people. We work closely with the adult service and there are regular local meetings for prescribing doctors to discuss clinical issues. In Trowbridge the consultant offers informal support.

Referrals and substances

The service launched in November 2005 and was fully operational from October 2005. The launch described the referrals process and is open access and includes self referrals. The majority of treatment work is around polysubstance use, heavy binge drinking and regular heavy use of cannabis. The service is beginning to see young people with physical signs of alcohol dependence. There is no inpatient or day patient hospital base to provide detoxification.

The service is currently treating two 17-year-old girls for opiate dependence with substitute methadone prescribing. Both were involved in sexual exploitation, but have stabilised through treatment. However, obtaining support from social services for such older adolescents who have no previous history with social services can be difficult and can result in significant problems, for instance, in securing appropriate housing. In other cases there are productive and regular network meetings leading to multi-agency support for such a vulnerable young person engaged in crucial transitions. Often a substance misuse service can effectively champion the cause of such young people with statutory and voluntary agencies.

Complex problems

In light of our experience that many referred young people have complex social, family, mental health, educational and health issues overlapping, interlinking and tangled up together, the service is building a broad view of treatment. However, this holistic approach does not always survive the transition to adult services, even though the young person, while eighteen years of age, remains immature in crucial areas. Sometimes indeed, under-18's previously known to our service are being admitted to general adult wards without any contact with our service in relation to care planning (this came to light in an audit). This is an area of liaison where more negotiation is required.

Engagement

The model of engagement is community-based outreach. The workers will meet young clients anywhere suitable in the community and are able to transport young people to appointments (this is often functionally crucial but also affords the opportunity to demonstrate practical care and to relate to the young person). We try to arrange clinic appointments off-site when we can, to avoid young people coming to the adult service building. This is partly due to the possibility of clients of the adult service hanging around outside the building, perhaps deterring families and young people. It is recognised that this is an inappropriate environment for young people. The service is implementing in-house training to develop skills in engaging families and engaging adult team members interested in this area.

[2] Dr Deborah Judge has now left the service but works at YPDTS in Bristol

Future developments

The service is setting up a pilot study with the equine department at a local agricultural college to provide equine-assisted psychotherapy sessions for young people and families. We are collaborating with CAMHS specialists and the adult service to set up a mother-infant intervention study with drug and alcohol using mothers.

Interventions

Having recently employed new staff we are beginning to profile the team's skills and areas of clinical experience. This will help us to allocate cases and identify gaps in experience and training needs. The team provides a range of individual interventions – motivational work, CBT and alternative therapies (such as auricular acupuncture) – and can offer family sessions (although it does not yet offer formal therapy). The service provides a comprehensive assessment and a treatment plan that reflects the complex interaction of social, educational, developmental and mental health issues. The treatment plan may indicate further joint assessment and joint work with the other local teams such as the psychosis team (based with the young people's service in Bath – a specialist Tier 3 and 4 adolescent service) or generic CAMHS teams.

Birmingham's young people's substance misuse service

Dr Sangeeta Ambegaokar

The Birmingham service is a partnership between the young person's substance misuse service, Birmingham HIAH (Holistic Innovative Approaches to Health), and Birmingham Children's Hospital Child and Adolescent Mental Health Service. The CAMHS substance misuse team works across both of these services and provides specialist substance misuse input into CAMHS; both psychiatric and specialist substance misuse input into HIAH. The HIAH and the CAMHS substance misuse team see young people up to their nineteenth birthdays.

History

Birmingham HIAH is commissioned by Birmingham drug action team and also funded through social care, health and the Youth Justice Board. The service, which is run by the voluntary sector organisation In-volve, was first commissioned in 2000 as a pilot for the city and has since grown from a staff of five to a multidisciplinary team of over 35. HIAH is a young person's drug and alcohol treatment service that sees young people up to the age of 19 in the city of Birmingham.

HIAH initially employed a standalone community psychiatric nurse who was responsible for managing young people with co-morbid substance misuse and mental health problems. There were however considerable difficulties in accessing mental health services for these young people, particularly the over-16s, as Birmingham CAMHS only covers young people up to their 16th birthdays. There was also difficulty in accessing CAMHS as one of the exclusion criteria was young people with primary drug and alcohol issues.

The HIAH community psychiatric nurse identified the need for increased mental health input into the service following an audit from April to June 2004, which showed that 50 per cent of young people referred to HIAH had either currently or previously had CAMHS input, had been referred to adult mental health services or had presented at assessment reporting mental health difficulties.

Following this identification of a gap in service provision, the HIAH community psychiatric nurse set up a DAT and CAMHS working group involving relevant personnel including HIAH, Birmingham DAT, CAMHS, looked after children services and education. A model was then developed for two nursing posts to work across primarily CAMHS and HIAH to be based at HIAH with outreach to CAMHS teams. The broad aims were to provide a service for young people in Birmingham with dual diagnosis and to develop an innovative model of intervention for this group. This would involve providing mental health input to HIAH, providing drug and alcohol input to CAMHS services, providing training for both agencies and providing consultation and liaison for young people under-19 with co-morbid substance and mental health issues. Funding was also applied for a consultant psychiatrist and an associate specialist but this bid failed.

The two nurses started with the service in September 2004. The difficulties exposed the lack of medical input into the service and medical support for the nurses led to another proposal for the development of a dedicated consultant child psychiatrist post. This time the proposal was taken more seriously as the GP providing the prescribing service, who also had considerable CAMHS experience, was due to retire, potentially leaving the young people's service with no medical input at all. The psychiatrist post came into existence due to the efforts of the HIAH community psychiatric nurse, the person interested in taking up the post and an interested and committed DAT commissioner.

The post was designed to provide assessment and treatment of young substance misusers where a co-morbid psychiatric disorder is suspected and substitute prescribing of methadone or buprenorphine to those young people with a diagnosis of opiate dependence. In addition, the consultant would also provide clinical supervision to the two nurses. Funding was initially agreed by the Birmingham drug action team for 12 months on the proviso that the three primary care trusts would pick up 40 per cent of the funding from the following year.

Catchment area and population

The service covers the city of Birmingham, a large city of approximately 1.1 million inhabitants with a wide ethnic mix and areas of significant deprivation. The under-19 population is approximately 283,000 (NSTS, 2007).

Staffing and base

The CAMHS substance misuse team comprises one full-time child and adolescent psychiatrist, two clinical nurse specialists and a full time medical secretary (Grade A&C 4). The team is based within HIAH's premises in Birmingham city centre.

HIAH has a very well-established multidisciplinary team, managed by the head of operations who is accountable to the CEO at In-volve's head office in London. The team currently consists of five streams – treatment, social care, outreach, youth offending, and training and volunteering.

The treatment team consists of two counsellors and two complementary therapists and the social care team consists of two social workers and two generic drug workers. The HIAH criminal justice team is made up of five named drugs workers and five Drug Interventions Programme support workers, who are based across the city's five youth offending teams. The staffing is likely to change slightly in the near future as HIAH moves from being a city centre-based service to providing more local services.

Networks

There are good networks between the CAMHS substance misuse team, Tier 3 and Tier 4 CAMHS, youth offending teams and the adult addiction psychiatrists. The clinical nurse specialists attend the Tier 3 referral meetings regularly and meet with the youth offending CAMHS clinical nurse specialists on a monthly basis. In addition, every two months the substance misuse team meet with the youth offending CAMHS clinical nurse specialists, the adolescent psychiatrist from the 16-18 transitional service and the forensic adolescent psychiatrist to discuss cases and good practice. The CAMHS substance misuse psychiatrist meets with the adult addiction psychiatrist on a monthly basis at their PDP meetings. there has however been some difficulty in forming good links with the looked after children's CAMHS service for the city.

Clinical governance

The CAMHS substance misuse team takes clinical responsibility for any patient they see and for advice given to members of the multidisciplinary team. Consultations with HIAH staff and other agencies are all recorded and filed. With assistance from the CAMHS Substance Misuse team, HIAH now have an updated prescribing procedure and improved guidelines and procedures on the management of risk in young substance misusers.

In-volve have recently appointed a clinical lead who has been specifically tasked with addressing clinical governance issues at HIAH.

Clinical problems

HIAH receive about 500 annual referrals and the CAMHS substance misuse team receives approximately 100 referrals each year, including referrals from both CAMHS and HIAH. These include young people with substance dependence and those with co-morbid psychiatric disorders. The cases are often highly complex with issues including homelessness, sexual exploitation and educational failure. Many young people have had some experience of being in the looked after children system and are often estranged from family members. Most of the CAMHS referrals use cannabis and alcohol. Referrals from HIAH include both class A users, and cannabis and alcohol users with co-morbid psychiatric disorders including depression, anxiety disorders, attention deficit hyperactivity disorder and psychosis. Psychiatric disorders are managed within the team and referred on to appropriate services including primary care, adult mental health services and the early psychosis teams as and when necessary. We have also managed a number of pregnant opiate users.

Examples of cases include a 17-year-old girl with Asperger's syndrome and attention deficit hyperactivity disorder with a history of depression. Her mother has Huntingdon's disease but the young person had not been tested for this. She presented to the service with heroin dependence and concurrent crack use and has now been stabilised on methadone. Two young men with previously good educational records presented with heavy cannabis use, failure at college and family difficulties, and were assessed and diagnosed with depressive disorders. Following treatment with antidepressants alongside their keywork sessions they both made extremely good recoveries in a matter of weeks and stopped using substances altogether.

Interventions

The teams provide a number of interventions including individual work based around motivational interviewing and cognitive behavioural therapy. The service is also able to offer an extensive range of complementary therapies such as auricular acupuncture, reflexology, massage, aromatherapy and reiki,

which are popular with young people and can act as extremely good engagement tools. Families are encouraged to engage in the young person's treatment and this is facilitated by HIAH's family counsellor, who is also being funded by the organisation to train in systemic therapy. Treatment may also include prescribing medication such as opiate substitution therapy or medication for co-morbid psychiatric disorders.

Young people are comprehensively assessed and care plans and interventions are individualised to reflect the particular needs of the young person.

Achievements

The Birmingham service model has hugely improved transition for young people between CAMHS, HIAH and adult mental health services. Mental health services for young substance misusers are more accessible with a timely response and crisis intervention as appropriate. The CAMHS substance misuse team run a two-day training programme in substance misuse for CAMHS staff covering topics including basic drug awareness and treatment of psychiatric co-morbidity in substance misusers. The training is run three times a year and is popular and well attended by all disciplines including inpatient CAMHS nurses, community CAMHS nurses, YOT and CAMHS nurses, consultant child psychiatrists, junior doctors and CAMHS social workers. This in turn has led to improved substance screening and intervention by CAMHS professionals.

A case discussion group is run by the CAMHS substance misuse team on a fortnightly basis to give an opportunity for HIAH staff to discuss complex and challenging young people and share experiences and information. A number of mental health issues in young people have been highlighted in this forum, leading to an increased understanding of the importance of identifying psychiatric co-morbidity in young substance misusers. In addition, all young people assessed by HIAH complete the Strengths and Difficulties Questionnaire, a validated mental health screening tool, in order to assist in the identification of mental health problems.

Permanent funding has now been agreed for the consultant child and adolescent psychiatry post in the CAMHS substance misuse team.

Challenges

There have been some challenges for the CAMHS substance misuse team in establishing themselves as part of the Birmingham CAMHS service. The team has worked hard to establish itself as a CAMHS team in its own right and to keep substance misuse on the agenda in CAMHS as a whole.

There have been some difficulties in the working relationship between HIAH and CAMHS at a management level but these have been resolved to a large extent following open discussions between the relevant personnel. There continue to be difficulties making links with the looked after children's CAMHS service.

Young person's substance misuse services in Waltham Forest, London

Dr Annie McCloud and Carol White

History

In 2006, the London Borough of Waltham Forest began its initial work with young people by commissioning the local authority to provide a young person's substance use service – a one-stop shop. This focused on reaching out to and engaging young people in the service, to explore their substance use and offer psychosocial interventions. At that time, evidence from the adult treatment providers demonstrated that many adult drug users acknowledged problematic use of substances from a young age. There had also been a small population of young people who presented to the adult services with complex substance use needs. As a result, the local DAAT partnership commissioned the North East London Mental Health Trust (NELMHT) to provide a service for those young people with more complex needs. The commissioning of Tier 3 services for young people would provide integrated care to those whose substance misuse required more structured treatment interventions and care management. The service opened with the appointment by NELMHT with a senior full-time addictions consultant in December 2006, who also had a strategic development role for addiction psychiatry across NELMHT. She has two sessions a week for young persons addictions work and is supported by a full-time substance misuse nurse in young persons substance misuse services. However it proved difficult to recruit to this post and it remained vacant until May 2007.

Waltham Forest DAAT and NELMHT have been strong supporters of addiction services in recent years. NELMHT regards addiction services as "core business" and was recently successful in a capital bid to build an adult detoxification facility (due to open 2009). The DAAT was committed to funding a senior addiction consultant post with a strategic managerial role.

While competition for funding has remained keen, concerns about drug and gang-related violence involving young people keep young persons addiction services high on the agenda.

Catchment area and population

Waltham Forest is an outer London borough and contains the areas of Leytonstone, Leyton, Walthamstow and Chingford. It has a population of about 218,000 (ONS, 2003). The ethnic make-up is very diverse and there is a high percentage of young people. The east and south of the borough have many inner city characteristics and border on Hackney and Tower Hamlets. The north of the borough is more affluent but with pockets of marked deprivation, and alcohol-related harm is common.

Staffing and base

The service is based in Leytonstone in an anonymous shop-fronted building. It is named "722" after its address at 722 High Road, Leytonstone. It is separate therefore from other young person's or addiction services but serves as the main hub for both Tier 2 and Tier 3 services. The Tier 2 service, in Waltham Forest consists of a manager, a receptionist, and three drugs workers. There is a separate YOT substance misuse worker who is encouraged to attend team meetings.

The Tier 3 SMN employed by NELMHT is also based at 722 to ensure an integrated approach to care. The adult addictions consultant is allocated two sessions a week for young people's substance misuse services. She is based about a mile away in the adult community drug and alcohol team (CDAT), but attends a joint clinical meeting fortnightly and will see young people either at 722 or at CDAT as the need arises, or at other locations including homes if necessary.

Networks and relationships with other agencies

There are good working relationships between the two partnership agencies, although confusion can arise in terms of differing policies and procedures followed by Waltham Forest and NELMHT health staff. The substance misuse nurse (SMN) attends, in addition to meetings at 722, clinical meetings held by the trust's EIP (early intervention for psychosis) service and CAMHS meetings. The CNS

is fairly new in post and it is intended to develop his role in working with pregnant young females.

The 722 staff have in-reach into and extensive relationships with other young persons services, including counselling and education services, social services and youth offending as well as the adult CDAT, if a young person presents there without complex needs but requires psychosocial interventions. Staff work tirelessly to engage hard-to-reach young people and provide much outreach and consultation to generic young person's services.

The consultant and SMN have done considerable work to engage CAMHS clinicians who can be wary of the new services. The SMN and consultant work with young people who require prescribing at the adult CDAT, mostly 17–18-year-olds. They might also provide input for young Waltham Forest residents who are admitted to the inpatient adolescent service at Goodmayes Hospital in Redbridge, but to date have not received any requests for this.

The consultant holds a strategic development role across NELMHT as well as being the Waltham Forest addictions consultant and liaises with the clinical director for CAMHS and specialist services, and other young persons services provided in the other three boroughs making up the NELMHT area. Along with the CAMHS clinical director she has organised an away day in October 2007, designed to bring together clinicians and commissioners from CAMHS and young people's substance misuse services across the four boroughs.

Clinical governance

The part of the service operated by NELMHT is accountable to the Waltham Forest substance misuse service manager and clinically to the consultant to the associate medical director for Waltham Forest. Informally, there are links with the CAMHS clinical director.

The service falls under the trust's clinical governance arrangements. Great attention has been given to policy and practice for needle exchange and prescribing interventions, including the assessment of capacity in young people's services, and recording informed consent both for treatment and for information sharing.

There is an expectation that staff within the service – which would include NELMHT and Waltham Forest – would work within the policies of their own employment but also within where appropriate those of the other agency. Differing policies and practices between the trust and local authority can be an issue where, as is often the case, workers from both providers are involved with young people or their families. These issues are resolved through regular liaison through the service's clinical team meeting and communication through clinicians and managers. Managerial responsibility for the Waltham Forest service has been moved between different arms of the local authorities children's services and there have been several changes of manager.

Clinical problems, referral pathways, and co-morbidity

A steady trickle of older adolescents present to the adult CDAT, sometimes with older adult service users, for prescribing interventions. No under-16s have been prescribed for opioid use yet and injecting drug use appears to be rare. A significant proportion of young people refer themselves to the service or are referred by youth offending agencies with extremely complex needs including mental health concerns, homelessness, sexual exploitation, family breakdown and absent parents.

Few clients are referred by CAMHS or parents and few referrals can be genuinely regarded as requiring only psychosocial interventions in terms of brief advice or interventions for non-chaotic substance misuse.

A considerable number of clients present with possible psychotic symptoms related to heavy skunk cannabis use leading to a close working relationship with the early intervention in psychosis team (EIP). The lack of a clear evidence base around interventions for cannabis-using youth with or at risk of psychosis has generated much discussion.

CAMHS are responsive to substance-abusing young people presenting with acute mental health concerns, but are less certain about making effective referrals from CAMHS to the young people's service. This partly due to lack of skills and knowledge about how to screen for or ask about young people's substance misuse, and possibly because young people in CAMHS may be less motivated to attend the service than users who refer themselves.

Both services struggle with the housing and social care needs of young people with complex substance misuse-related needs and care pathways need to be developed. The non-substance misuse parts of social services are perceived as sometimes reluctant to work with older adolescents who are homeless; some have not had stable housing for many years and it can be difficult to identify the responsible local authority or get the service user to attend services in the "correct" borough. The inpatient adolescent facility is wary about accepting young people with primary substance

misuse issues, yet no is there a clear commitment to fund other Tier 4 young person's placements.

The consultant sits on the Waltham Forest young people's substance misuse service steering group and CAMHS has also been invited to join.

Interventions

Waltham Forest has detailed policies for prescribing, harm minimisation and related interventions for under-18s with primary opioid use. We attempt to deliver interventions for cannabis dependence along evidence-based lines, and with close liaison with the early intervention for psychosis service (or CAMHS) where necessary.

There has been considerable discussion about providing shorter-term advice and support (1-4 sessions) for parents affected by their children's substance misuse or the children of substance misusing parents. It is hoped that further work with CAMHS will increase the effectiveness and scope of such interventions.

Achievements

- Appointment of key staff to NELMHT posts
- Comprehensive assessment and treatment policies in place
- Links made with other agencies, both within Waltham Forest, across NELMHT area and neighbouring agencies such as ASATS in Tower Hamlets
- Retention of a number of clients with severe and complex needs
- Services are well publicised and have high profiles given short period in existence.
- Challenges and future directions.
- Fully equipping the 722 team to provide a full range of harm minimisation interventions, toxicological testing and generation of prescriptions for opioid-dependent clients.
- Recruitment of specialist manager and substantive team by Waltham Forest
- To integrate more effectively with CAMHS, especially to provide the most effective care for parents affected by their children's drug use, and children affected by their drug use (especially in the 9–15 age group who may best benefit from early interventions and long term monitoring).
- To better meet the needs of young people with the most complex needs, at the Tier 3 and 4 interface, for example by developing a multi-systems approach including specialist residential, fostering and housing options. This may include use of the adolescent inpatient mental health unit and private Tier 4 providers, but not solely these, but a range of options to meet the varying needs of young people.
- To better engage hidden groups such as pregnant teenagers who may be using substances.

Discussion

In the past ten years the state has invested substantially in services for young people engaged in substance misuse and these are widely used. However, these services have often minimal involvement with psychiatric and mental health services in general. Yet among their clients, when assessed using psychiatric techniques, it becomes clear that there is a substantial group that suffers serious psychiatric disturbance, in addition to high-risks of dependence. This is commonly central to their overall marked dysfunction but is also treatable. Concern for this group has prompted the involvement of child and adolescent and addiction psychiatrists. Most of the young people seen in the services described here present with complex problems suggesting that others have been filtered out previously. In other words the thirteen services described here function as what the Health Advisory Service described as Tier 3, with aspects of Tier 4 services. In keeping with their shared functions, while written independently, the service descriptions show considerable similarities.

Organisational challenges

It is clear that the young people seen by the services described face difficulties that far transcend education, social needs, health or crime. However, they will often not attend conventional services, may not be aware of them, or, since they cannot articulate or have not divulged their difficulties to their GP or others, there is no one who will refer them. All too often, even if they are referred there is no one to ensure they attend. In addition, as a result of their difficult backgrounds, affected young people are sometimes suspicious and superficially hostile, and can be difficult to engage. Adults can sometimes unknowingly mirror this demeanour, in a sense maintaining the rejection that originally contributed to their predicament. As a result of their readily apparent multiple problems, many practitioners quite plausibly regard the young person as some other service's responsibility. This response may be driven not by indifference but by a sense of despair about what to do, where to go and who to ask. Their experience of services may be far from integrated, reflecting their own inner fragmentation.

Integrating services

The services described usually emerged from an initiative led by a concerned individual practitioner who negotiated a way into a service and clarified referral pathways, links and teamworking with other frontline practitioners who come from a range of backgrounds and organisations (such as substance misuse, local authority, criminal justice, education, health and voluntary sector). In this way they knitted together a coherent community response across the widest spectrum of statutory and voluntary agencies, with the support of service commissioners driven by the presentations and predicaments of individual patients and their families.

These practitioners have worked with key allies to reconcile apparently intractable differences in philosophy, working practices, funding problems and mutual suspicions. Ultimately, because everyone wishes to obtain the best results for the young people for whom they feel responsible, these seemingly insurmountable obstacles are often overcome. The psychiatrists and the teams who have taken on the role enjoy the challenge of encountering, understanding and negotiating and mobilising holistic care for these youths. These collaborations have increased, through the recognition that this complex group of patients required specialist help but, it has to be said, require painstaking local building of infrastructure to support the delivery. All this is fully in keeping with the HAS advisory paper (Gilvarry, 2001) that proposed a vision of embedding substance misuse services within children's services.

However, we still have miles to go to achieve the aspiration of developing comprehensive substance misuse services across the whole of UK. Many CAMHS services provide little input to young people with substance-related problems. Inpatient facilities for young people with substance dependence are few in number; apart from a small number of adolescent psychiatry beds that are widely scattered and decidedly rare, none are available in the public sector.

Further service developments

The blueprints for models of service delivery are not meant to be followed rigidly. Instead, the service delivery models are intended as a stimulus to promote informed discussion between all parties involved in commissioning and providing substance misuse services. Accordingly, the way forward is not to impose one promising solution on everyone. We need instead to generate a range of promising solutions, taking in to account the local aspirations, needs and resources. We will then be in a position to compare these alternatives using the same assessment and outcome measures. Only this will enable us to see how

different models work out in practice and subsequently allow us to retain the best from each model.

Evaluation and audit

"There is no such thing as a perfect service – only better and worse approximations to that ideal" (Goodman, 1997, p.49). An inbuilt mechanism to evaluate what works is essential to ensure that the service we developed shall go on improving. We stand the risk of losing vital information on how to improve the services if we do not routinely monitor the outcome of every young person we see.

Research

There is a strong need to harness the research potential of every substance misuse service throughout the country. Each service needs to modify its practice in the light of feedback and new research findings – one of the first tasks of the substance misuse working group of the Royal College of Psychiatrists would be to launch a descriptive study to map the stage of substance misuse and co-occurring psychiatric disorders using standardised assessment tools. We are keen to apply for research funding to the Medical Research Council, Wellcome Trust, Health Technology Assessment, and other funding bodies, which recognise the need to understand, treat and examine outcomes in this vulnerable young population.

Roles of other professionals

General practitioners are often appointed to support drug services as prescribers – this is a key service for the minority of patients who are opiate dependent. However, few claim to have skills working with adolescents and do not work in the multidisciplinary context that psychiatrists do. Paediatricians, including those interested in adolescent medicine, could adapt their considerable knowledge and capabilities but do not yet see this population as "theirs". Many remain hospital bound and often have difficulties in admitting this group even when it is required for medical supervision of detoxification for example. However, paediatrics has much to offer and the future involvement of paediatricians should be a further major stage of engagement and development.

Conclusions

Young people with substance-related problems are a heterogeneous population with multiple problems and disadvantages. The service descriptions included in this document offer a mechanism to serve them better. Psychiatry and mental health have a considerable role to play in their treatment. There is an urgent need to launch audit and research in to evidence based interventions in the UK context. Setting up the Adolescent Substance Misuse Working Group at the Royal College of Psychiatrists has created a rare opportunity to share the unique skills of CAMHS psychiatrists and addiction psychiatrists and engage in pioneering research in to adolescent substance misuse.

Everything that is done to help troubled and distressed children should be informed by a sense of history, a reflective awareness of current value systems, economic and social factors and by a mature and balanced judgment of what is or is not possible. Unfortunately, one of the enduring myths about substance misuse is that treatment is generally ineffective. Well-led, integrative, multi-agency treatments addressing a range of crucial aetiological factors have the potential to dispel the myths, helplessness and stigma, engender a culture of therapeutic optimism and salvage some young lives.

Appendix 1: Other services

Young people's substance misuse services in County Durham

Dr Hla Htin

Development, level of service and staffing

The development of the team began in April 2004 and provides Tier 3 services with Tier 2 support. It covers the whole of County Durham except Darlington (an independent borough council). It is the lead agency for social care and health and aims to be eventually integrated under County Durham children's services. The services originally consisted of:

- One team manager (social work)
- Three band 6 nurses (seconded from the local mental health trust)
- Three social workers
- Three support workers (seconded from DISC) – Tier 2 workers

Services originally operated from three separate bases – east (Peterlee), north (Chester-le-street) and south (Newton Aycliffe). Each base had a nurse, social worker and support worker. The team manager has always been based within the south team. From mid-2006, it operated from two bases (north and south) as the East area had the lowest numbers of clients and staff had to be redistributed to the other two busier areas. Accessed medical input from an adult addiction psychiatrist as required until late 2005.

Since this time, there are now three sessions a week of dedicated time from an associate specialist who completed two years' training in adolescent addiction at Keele University. In the last three months the agency:

- Recruited a band 7 nurse as deputy team manager, to take on the nursing lead role and provide a clinical governance structure for the nurses
- Budget reductions meant only two band 6 nurses are employed, following the departure of the third.

The Head2Head team, Nottingham Healthcare NHS Trust

Dr Ann Taylor

Background

The Head2Head team is a Tier 3 service providing assertive assessment and follow-up to children and adolescents presenting with substance misuse and dual diagnosis. The team provides a service to those young people (18 years and under) requiring specific interventions such as opiate detoxification and cases presenting with both substance use and significant mental health difficulties in the city of Nottingham. The team offers a county-wide service for dual diagnosis.

The team aim is to offer assessment and follow-up in appropriate, community, low-stigma settings to improve the engagement and retention of patients within treatment. Young people are seen in a variety of community settings, including home, schools, and youth offending team bases. The team aims to retain contact with those patients serving custodial sentences and review them promptly following release in order to identify and address any relapse into substance use and associated mental health problems. The team also offers assessment, and support for patients who have substance misuse problems and are pregnant, and is able to offer rapid assessment with no waiting lists. The team is also able to provide some out-of-hours support for patients presenting in crisis.

In addition to direct clinical work, the team also offers regular consultation and training to professionals in partner agencies, for example Tier 2 drug services and youth offending teams.

The team acquired self-directed status in 2004 and has a dedicated service team leader. The team has two administrative main bases, in Nottingham and Mansfield. There is a Tier 4 adolescent inpatient service (a 12- bedded unit) on the Thorneywood Campus in Nottingham. Young people with dual diagnosis needs can be admitted but at present there are no specific facilities for inpatient detoxification.

Team structure

- Service team leader (1 WTE; includes 0.2 WTE clinical sessions in dual diagnosis)
- Consultant child and adolescent psychiatrist 0.5 WTE
- County posts

  - 0.4 WTE administrator
  - One WTE dual diagnosis nurse
  - 0.3 Dual diagnosis nurse
  - 0.3 Dual diagnosis nurse
- City posts
  - 0.3 WTE administrator
  - One WTE treatment nurse
  - 0.6 WTE treatment nurse
  - 0.6 WTE treatment nurse

IMPACT – drug and alcohol treatment for young people in Norfolk

Dr Daphne Rumball

IMPACT is a countywide multi-agency and multidisciplinary specialist treatment service specifically for young people (19 and under) who need help and support with their drug, alcohol or related problems. Specialist young people's workers provide a flexible and responsive service to ensure that young people's treatment needs are met throughout Norfolk. We have offices in Norwich, Great Yarmouth and Kings Lynn but we are very flexible about where we meet young people and see most young people in the community or where they live.

The service is provided by a team of specialist nurses, social workers, youth workers and other professionals and is supported by specialist doctors. All Impact workers have a wide range of experience in working with young people with drug and alcohol issues. We aim to provide a single point of access for drug and alcohol and associated needs in order to help young people address their problems associated with drug and alcohol use.

We have a harm reduction and harm minimisation philosophy and aim to help young people make informed choices about their drug and alcohol use and believe that young substance users are young people first and foremost.

We also work closely with other agencies and services to provide the widest possible range of support with issues such as housing, education, training, employment and benefits.

The team

- Full-time posts:
  - Manager and deputy, social work
  - Three nurses
  - Three young people's drug workers
- Consultant addiction psychiatrist
- Administrator and secretary

Assessments are undertaken based on Models of Care and a database is used that enables multi-professional, consecutive record keeping.

Activity is linked to geographical areas with highly flexible boundaries to ensure appropriate service delivery according to need. There are clinical bases for staff activity and client attendance in Norwich, Kings Lynn and Great Yarmouth. Most service users are seen at home or in non-clinical settings. Each service user has a keyworker.

Services offered

- Advice and information: positive and active engagement of young people. Advice on harm reduction and minimisation as well as other issues
- Advocacy – help with accessing other services
- Assessment and treatments for all drugs including alcohol
- Blood-borne virus screening and vaccination. Hepatitis B vaccination and hepatitis B and C testing
- Care needs incorporated into comprehensive care plans, process shared with service user and significant others
- Detoxification in community or residential settings
- Health assessment and advice
- Family work – work with service user and family if appropriate
- Personal development – social skills and personal development opportunities to help build confidence and self-esteem
- Liaison with and referral to other services
- Medical assessment and referral for associated health problems
- Prescribing – medical treatment for treatment of dependence or to facilitate withdrawal and abstinence
- Psychiatric assessment and referral by psychiatric nurses and consultant
- Rehabilitation, access to residential rehabilitation services

SUBS – Wolverhampton's young people's drug and alcohol team

Jo Flanagan

The service aims to deliver the provision in line with the current NTA definition of a young person's service which is as follows:

"Young people's specialist substance misuse treatment is a care planned medical, psychosocial or harm reduction intervention aimed at alleviating current harm caused by a young person's substance misuse."

Young people are can be referred to the service by a self referral, a parental or professional referral, or through the YOT system.

The young person will then be offered an initial screening within five working days, and then an appropriate intervention will be offered within ten working days from this initial screening.

The young person can be offered a range of interventions including:

- Motivational interviewing
- Harm reduction
- Specialist pharmacological interventions
- Hepatitis immunisation programs
- GU support
- Specialist midwife support
- Groupwork programs
- Work with parents and carers (including brief family therapy)
- Criminal justice interventions (including a resettlement scheme)
- Diversionary activities
- Support with education, training and housing
- Advocacy
- Outreach
- Auricular acupuncture.

This menu is not exhaustive and will depend on need. All young people will be involved in their care plan. Reviews are undertaken three-monthly or as required.

The staff team is made up of eight people:

- Team manager
- Service administrator
- Youth engagement and support worker
- Two young people's substance treatment workers paediatric nurse or youthworker
- YOT substance worker
- Resettlement aftercare provision (RAP)
- Co-ordinator
- RAP support worker.

Staffs all have ongoing access to training including RGCert in substance misuse, advanced motivational interviewing and criminal justice awards.

The service continues to develop and this year has supported and endorsed a city-wide screening tool (DUST), training program for social workers, youth workers education and connexions. This is a city wide achievement to support consistency in referrals and early identification. We currently negotiating new premises so as to enhance service provision with a main priority being on-site hepatitis, health screenings and needle exchange.

The service has an exemplary record at engaging with some of the most high-risk young people in the city, particularly looked after children and young sexually exploited girls. We have a positive partnership with the vice team and a developing relationship with residential units.

The service has experienced challenges in creating a clear joint working protocol with CAMHS and this is currently under discussion to ensure progress with this vital component of the service. We continue to integrate with other city-wide strategies ensuring young people and substances are a priority.

An associate specialist does three clinics a month for SUBS during which most of the prescribing for the service is undertaken while the consultant addiction psychiatrist conducts one clinic a month. (SUBS is the name chosen by the patients for Wolverhampton adolescent addiction service.)

Appendix 2: The working group

Young People's Substance Misuse Psychiatrists Working Group, The Royal College of Psychiatrists, UK

The child and adolescent substance misuse working group is a national forum of child and adolescent psychiatrists and addiction psychiatrists, which was set up about nine months previously under the auspices of the Faculty of Child and Adolescent Psychiatry, of the Royal College of Psychiatrists. The aim of the group is to improve the understanding of adolescent substance misuse by enhancing academic debate and research in to adolescent substance misuse. The forum offers the opportunity to share expertise and skills in managing these complex cases and developing services for treatment and prevention of substance misuse in young people. We organise training events including international conferences, lectures and workshops. Members of the group are involved in training colleagues from a wide variety of disciplines.

The group plays an active role in the development of treatment guidelines and undertakes audit and research. We are currently collecting systematic data regarding psychopharmacological treatment of young people with substance misuse. Other research interests of the group include family/systemic interventions in adolescent substance misuse, interface between ADHD and substance misuse and systematic evaluation of service delivery for young people with substance misuse and co-morbid mental health problems.

Plans are underway to run regular academic sessions and to hold regular forum for case discussion. Membership is open. We work closely with the National Treatment Agency (NTA), and senior members of the NTA attend our business meetings. The group meets four times a year at the Royal College of Psychiatrists, London. Anyone who is interested in joining the group may contact Dr Norman Malcolm, at caroline.kula@bdct.nhs.uk.

Chair: Dr Paul McArdle, Newcastle, UK
Secretary: Dr Norman Malcolm, Bradford, UK

Current members include:

Dr Andrew Weiner, sessional child and adolescent psychiatrist
Dr Annie McCloud, consultant addictions psychiatrist
Dr Chin Chee, consultant child and adolescent psychiatrist
Dr Claire Casey, consultant child and adolescent psychiatrist
Dr Deborah Judge, consultant child and adolescent psychiatrist
Dr Eilish Gilvarry, consultant psychiatrist in addictions
Dr Fiona Grant, consultant child and adolescent psychiatrist
Dr Hannah Bateman, specialist registrar in child and adolescent psychiatry
Dr Hla Htin, consultant child and adolescent psychiatrist
Dr Joy Owens, consultant child and adolescent psychiatrist
Dr K.A. Mirza, consultant psychiatrist and hon. senior lecturer
Prof. Ilana Crome, lead consultant in adolescent addiction psychiatry
Dr Norman Malcolm, consultant child and adolescent psychiatrist
Dr Paul McArdle, consultant child and adolescent psychiatrist
Dr Arif Rahman, specialist registrar addiction psychiatry
Dr Raj Sekaran, consultant child and adolescent psychiatrist
Dr Ron Alcorn, consultant psychiatrist specialising in substance misuse
Dr Sangeeta Ambegaokar, consultant psychiatrist in child and adolescent substance misuse
Dr Seth Bhunnoo, consultant psychiatrist
Tom Aldridge, young person's manager, National Treatment Agency
Jill Britton, independent consultant to NTA and Youth Justice Board

Appendix 3: Authors

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Dr Deborah Judge, consultant child and adolescent psychiatrist, Dr Deborah Judge, FLUX, Wiltshire Young Person's Substance Use Service, Court Mills House, Court Street, Trowbridge, Wiltshire, BA14 8BR.

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Appendix 4: Addresses of services

The Young People's Drug and Alcohol Service (YPDAS) in Newcastle, Newcastle and North Tyneside Addictions Service, Plummer Court, Carliol Place, Newcastle NE1 6UR

The Lambeth "Virtual Integrated Team" for Young People with Substance Misuse, Integrated CAMHS YOS/Substance Misuse Service, South London and Maudsley NHS Trust, 35 Black Prince Road, Kennington, London SE11 6JJ, Tel: 020 3228 7370, Fax: 020 3228 7402, email: ian.moyse@slam.nhs.uk

The Lock, Young People's Substance Misuse Service, Stoke on Trent, 3 Canal Arm, Festival Park, Hanley, Stoke on Trent, ST Tel. 01782202077, marion.riley@northstaffs.nhs.uk

Child and Adolescence Mental Health Service (CAMHS) and 'No 29' (The Bridge Project, Young People's Service), 29 Salem Street, Bradford, BD1 4QH, Tel: 01274745636

CAMHS Specialist Substance Misuse Service – CSSS (formerly ASATS), 409 High St, Stratford, London E15 4QZ

Adolescent Drug and Alcohol Service (A-DASH), Forest House Annex, Forest Lane Harperbury, Harper Lane, Shenley, Nr. Radlett, Hertfordshire, WD7 9HQ, Tel: 01923 427288

Young People's Drug Treatment Service (YPSDTS), 38 Southwell Street, Bristol, BS2 8EJ, Tel. 0117 9285370

Wiltshire Young People's Substance Misuse Service ('flux'), Court Mills House, Court Street, Trowbridge, Wiltshire, 01225 759944

Birmingham CAMHS Substance Misuse Team, c/o Birmingham HIAH, 3 Bath Court, Bath Row, Edgbaston, Birmingham, tel. 0121 622 7780

Young Persons Substance Misuse Services (YP SMS) in Waltham Forest, 722 High Road, Leytonston, London E11, tel: 020 8496 5020

XS Substance Misuse Service, Copelaw Education, Aycliffe, Young People's Centre, Copelaw, Newton Aycliffe, County Durham DL5 6UT. Tel: 0132 537 5703

The Head2Head team, CAMHS, The Lodge, Thorneywood. Porchester Road, Nottingham NG3 6LF. Tel: 0115 844050

IMPACT – Specialist Drug and Alcohol Treatment Service for Young People in Norfolk, Web: www.impactnorfolk.org, Telephone: 01603 877480, Fax: 01603 877488, Email:richmondhouse@norfolk.gov.uk

SUBS – Wolverhampton's Young People's Drug and Alcohol Service, Castle House, Wheelers Fold, Wolverhampton WV1 1ST, Tel: 01902 572041

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DUST screening tool:
http://www.dfes.gov.uk/datastats1/guidelines/children/pdf/DUST-DFES.pdf