



Practice standards for young people with substance misuse problems

Contents

These standards are linked to the Quality Network for Community CAMHS (QNCC). See www.rcpsych.ac.uk/quality/quality,accreditationaudit/communitycamhs.aspx

For best practice standards on 'information, consent and confidentiality' and 'rights and safeguards' relevant to young people please refer to the QNCC standards. (These standards will apply to most young people accessing support and care from a range of services not just CAMHS.)

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Forewords

We are delighted to introduce this set of practice standards for young people with substance misuse problems and other co-existing difficulties.

The standards were written to support the response these young people receive from a wide range of practitioners, workers, professionals and services. The standards bring together guidance based on the available evidence and emphasise the need for a sensitive, non-judgemental and collaborative approach to identifying risk, assessing all needs, and offering help and support. The importance of developing trusting relationships, involving young people's family or carers, and working with practitioners who are already engaged with the young person is promoted and highlighted throughout.

The standards were developed in consultation with stakeholders across health, education, social and voluntary sectors. They were also informed by our consultations with the young advisors for the CAMHS standards developed at the Royal College of Psychiatrists College for Quality Improvement (CCQI). We would like to thank all those who contributed to developing the standards. We hope that the response these young people receive and the care they are offered will improve as a result of providing clear guidance on agreed best practice.



Professor Sue Bailey
President of the
Royal College of Psychiatrists

DrugScope welcomes the publication of these practice standards for young people.

As the national membership organisation for substance misuse services, with a particular role in supporting and representing the voluntary and community sector (VCS), we work with many organisations who support young people affected by drug or alcohol problems. We know that these services are effective in protecting often highly vulnerable young people from harm and turning lives around, with enormous benefits for families and communities too. A recent survey for the Department for Education by Frontier Economics concluded that every £1 invested in young people's treatment saves £5 to £8 in picking up the pieces later on.

If we are to build on the strides forward that have been made in recent years to engage with young people affected by drug and alcohol problems, then it is vital that our practice is informed by the emerging evidence base, the knowledge and experience of people working on the frontline and the voices of young service users themselves (and where appropriate their families and carers). These practice standards have a critical part to play in promoting evidence based approaches in this challenging and rewarding area for health and social interventions. I am particularly pleased to see the strong focus on multi-agency approaches that recognise that 'complexity is common' and stress the importance of working across professional silos and cultures.

DrugScope is currently working on behalf of its members to highlight both the opportunities and risks that are presented by some fundamental policy changes that will impact on services and interventions for young people affected by drug and alcohol problems in the next few years.

Responsibility for commissioning services will transfer to local authorities during a period of austerity when there is considerable pressure on local budgets. DrugScope members are already reporting cuts in young people's services in some local areas of as much as 50%. At the same time, the transition of responsibility for services to public health could create real opportunities to make links to other issues affecting young people, such as sexual health, promotion of community safety and local initiatives to tackle social exclusion.

Whatever the outcome of these changes, it is fair to say that it has never been more important to ensure that public money invested in young people's services is well spent and that we are able to demonstrate that they are delivering the outcomes sought by local commissioners, communities and elected politicians. These practice standards have a vital role to play in supporting the development of procedures, interventions and services that are both efficient and effective. I do hope that they will become a key reference resource for everyone working with young people affected by substance misuse problems, and will be used to inform workforce development, strategic planning and development and delivery of treatment and care.



Martin Barnes
Chief Executive
DrugScope

Introduction

By **Dr Paul McArdle** from the Royal College of Psychiatrists and **Dr Marcus Roberts** from DrugScope

Most young people do not use illicit drugs or binge drink, and among those who do only a minority will develop serious problems. For some, however, substance misuse may be damaging to the developing brain, interfere in the normal challenges of development, exacerbate other life and developmental problems, and further impoverish the life chances of already vulnerable groups of young people. This is a major problem for the UK, which 'has amongst the highest rates of young people's cannabis use and binge drinking in Europe' with 'some 13,000 hospital admissions linked to young people's drinking each year' (Home Office, *Drug Strategy*, 2010).

The association of substance misuse (particularly alcohol) with crime and anti-social behaviour is often highlighted. The indirect impact on violence, accidents and suicides is responsible for considerable injury and occasionally death among an otherwise conventionally health group. The impact on mental health and well-being and social functioning and integration is also significant.

In attempting to understand and attend to the needs of these young people, the Drug Strategy (2010) stresses the '... range of vulnerabilities which must be addressed, by collaborative work across local health, social care, family services, housing, youth justice, education and employment services', including 'transitional arrangements to adult services' (Home Office, *Drug Strategy*, 2010).

In a report on UK child health services, Kennedy (2010) endorses such a 'whole systems' perspective. He observes that

'providing high-quality services for children and young people requires the NHS to work collaboratively with many other public sector agencies...' Kennedy (2010) aims for 'personalised care that reflects individuals' health and care needs, supports carers and encourages strong joint arrangements and local partnerships'. Clearly, all of this requires a properly formulated and shared understanding of each young person's needs (Mirza & Mirza, 2008), as well as a properly coordinated and sustained intervention thereafter.

These issues are addressed by these practice standards.

Drug and alcohol use among young people: types and trends

Annual schools survey

The NHS Information Centre conducts an annual survey to monitor smoking, drinking and drug use among secondary school pupils aged 11-15 (www.ic.nhs.uk/pubs/sdd10fullreport). The 2010 survey reported 18% of pupils to have ever used drugs, 12% in the last year and 7% in the last month; the corresponding proportions for 2001 were 29%, 20% and 12%. Cannabis was the most commonly used drug at 8.3% for the last year (down from 13.4% in 2001). Use of volatile substances is the second most common at 3.8%.

There has been a decline in the proportion of pupils who say it is 'OK' for someone of their age to drink alcohol once a week, from 46% in 2003 to 32% in 2010, and the proportion who thought it was 'OK' to get drunk fell in this period from 20% to 11%. Nevertheless, almost half (45%) had drunk alcohol and 13% in the last week. The percentage increases with age, from 10% of 11 year olds to 77% of 15 year olds. Last week use has fallen from a peak of 26% in 2001 to 18% in 2009 and 2010. The mean amount of alcohol

consumed by pupils who drank in the last week was 12.9 units, but the skewed data showed a long 'tail' of heavier drinkers.

British Crime Survey

The British Crime Survey (BCS) is an annual self-report study that provides perhaps the best insight into trends and patterns of drug use in Britain among those aged 16 and above. The BCS 2010-11 reports that one in five 16 to 24 year olds used any illicit drug in the past year. By far the most commonly used illicit drug in this age group was cannabis (17.1%), followed by powder cocaine (4.4%) and ecstasy (3.8%). Use of opiates was below 1% for the 16 to 24 year old age group, with use of heroin at 0.1% (although still about 5,400 young people), and use of crack cocaine at 0.3%. However, although drug use overall may be declining, 16 to 19 year olds had the highest use of 'any drug' for any age group in 2010-11, with last year use at 23%, compared to 18.4% for 20 to 24 year olds.

Two further issues include the salience of 'poly-drug use' (EMCDDA, 2009) and the emergence of new synthetic drugs (including so-called 'legal highs') about which there is limited knowledge or research in rapidly adapting and evolving drug markets. For example, the National Treatment Agency's 'Substance Misuse among Young People: 2010-11' reported a sharp increase in the number of young people presenting for specialist treatment primarily for amphetamine use between 2009-10 and 2010-11 (from 256 to 639), but concludes that this is 'probably because it now includes mephedrone'. While mephedrone was included in the latest BCS survey, new psycho-active substances (NPS) are not necessarily included in survey questions and comparatively little is known about their harms.

Introduction (continued)

Treatment for young people in specialist drug and alcohol services

The number of under-18s accessing specialist services for drug and alcohol misuse in 2010-11 was 21,955, rising from 17,001 in 2005-06 to 23,905 in 2007-08 and 24,053 in 2008-09 and now falling. This excludes young substance users attending other services such as child and adolescent mental health services (CAMHS) for which there are no data. It is not clear what accounts for trends in treatment participation, which will also be affected by availability and the behaviour of key referral agencies.

Nature of problems

The NTA report 'Substance misuse among young people 2010-11' states that 'alcohol and cannabis remain by far the main substances...' in specialist drug and alcohol services for young people, accounting for 90% of the treatment population, compared to 4% being treated primarily for Class A drugs.

The notion of 'problematic' drug or alcohol use is different for young people than adults. This is partly because they are younger – what might seem to be 'normal' adolescent experimentation in a 17 year old could be grounds for intervention in a 12 year old. Crucially, drug and alcohol use among young people is often problematic because of its relationships with other problems in the young person's life. Indeed, the NTA's 'Substance Misuse among Young People 2010-11' explains that drug and alcohol misuse among teenagers 'is usually a symptom rather than a cause of their vulnerability', and compounds other problems in their lives such as 'family breakdown, inadequate housing, offending, truancy, anti-social behaviour, poor educational attainment and mental health concerns such as self-harm'.

Mental health data reflect this; in a large US treatment trial, 60% had been abused, 41% had attention deficit hyperactivity disorder, 20% had depression, and 14% post-traumatic stress disorder (Dennis *et al*, 2004). Especially among the youngest, such co-occurring disorders, or co-morbidity, contribute to or tend to drive relapse (Liddle *et al*, 2004) so that much of the psychosocial harm attributed to drug use among young people reflects the impact of co-morbid conditions; drug use is often a 'marker' that should draw attention to the underlying conditions and circumstances (Macleod, 2004).

What interventions – for whom

Given the heterogeneity of drug and alcohol use in young people, it is not easy to decide what constitutes problematic use. Not all young people who experiment with substances develop problem substance misuse. It goes without saying that all young people should receive universal prevention (drug education etc). However it is difficult to define who should receive targeted interventions or more comprehensive, multi-agency interventions. Children are not small adults and the adult definitions of substance misuse are inadequate in capturing the developmental aspects of substance misuse in young people. (See table 1 in [appendix 1](#) for a detailed discussion).

What works and what is delivered

The NTA's 'Exploring the evidence' (2009) highlights the importance of ensuring that services and interventions are designed to engage and retain young people and respond to their needs. For example, 'treatment providers should aim to make their services interesting and responsive to young people's needs; gaining the confidence of the young person by being respectful, trustworthy and emotionally warm', taking into account the young

person's views and encouraging them to allow parents and carers to participate in the development of treatment and care plans. It is inconclusive, however, with regard to recommending one type of intervention above another.

In part, this is because of the findings of the Cannabis Youth Treatment study (CYT), the largest intervention trial to date (Dennis *et al*, 2004). All the interventions evaluated in the CYT were associated with improvement although only 20% of the young people treated were abstinent at 12 months. In a more recent Dutch trial (Hendriks, van der Schee, & Blanken, 2011) treating a more heavily using population of young people, approximately 50% showed a response (defined as 30% less use than at baseline).

Nevertheless, supplementary analysis indicated that the two CYT interventions with family treatment, multidimensional family therapy (MDFT) and the adolescent community reinforcement approach (ACRA), resulted in further improvements post-intervention (www.chestnut.org/li/downloads/Dennis_et_al_CYT_MF_appendix.pdf). In addition, compared to interventions without a family component, two studies have now shown that those that engage with families (both MDFT) are more effective with more severe cases (Henderson, Dakof, Greenbaum, & Liddle, 2010; Hendriks, van der Schee, & Blanken, 2011), possibly in part because they achieve considerably greater treatment attendance (Hendriks, van der Schee, & Blanken, 2011). Both of these studies evaluated MDFT versus cognitive behavioural therapy. When two different brands of family therapy have been compared (Slesnick & Prestopnick, 2009), no significant differences emerged and there were no differences between ACRA and MDFT in the CYT. A cautious interpretation is that no specific brand of family work demonstrates clear superiority, but family work, not currently standard

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practice in the UK substance misuse field (National Treatment Agency for Substance Misuse, 2010), adds value to intervention. In their supplementary analysis of the CYT, Dennis *et al* (2004) also detected 'a generic dosage effect'; irrespective of treatment modality, more treatment was associated with improved outcome.

Trials evaluating more complex interventions targeting adolescent co-morbidity are few (Thurstone, 2010). However, a study of depressed adolescent users showed that drug use reduced only among those whose depression was successfully treated, and this was more likely with a combination treatment of antidepressant medication and therapy (Riggs, 2007). Further, studies of the treatment of substance misusing adults have shown that retention in treatment (Pinto *et al*, 2011) and the addition of further intervention following relapse (Scott & Dennis, 2009), predict better outcomes. A follow-up study of a large sample of clinic attendees, most of whom began their drug careers in late adolescence (Scott, 2011), showed that prevention of death required 'adequate initial treatment, on-going monitoring... and better linkage to recovery support services and mutual aid groups that help sustain recovery...'. This is analogous to systematic review findings supporting the efficacy of intensive case management among the adult mentally ill (Dieterich, 2010).

Indeed, reflecting on the limitations of the adolescent evidence base, Winters and Kaminer (2011) suggested viewing treatment, 'as a process that requires... management and monitoring ... flexible and tailored to the needs of the patient...' (Kaminer, 2011). Such a chronic disease perspective also implies care plans, teamwork, utilisation of the full range of potential evidence-based interventions

(for the co-morbid conditions, depression, PTSD and so on) including active follow-up to detect and treat relapse or exacerbations (Wagner, 2000; Allotey, 2011; Eaton, 2011). It also implies that the co-morbidity is identified in the first place.

Strikingly absent from all this evidence is the potent impact of schools, colleges, training facilities, hostels, youth justice and some of the wider support activities within the voluntary sector. It is clear that the evidence base provides a guide but not a comprehensive one. However, experience would say that when these agencies work harmoniously together quite powerful alterations in life style and well-being are possible.

Young people and young adults

Young people's treatment services are for under-18s, and the term 'young people' generally refers to this age group (as does relevant legislation and guidance). This raises issues about the care and treatment of young people moving into adulthood, particularly as the needs of those in their late teens and early 20s are often closer to under-18s than to adults with alcohol or drug problems, and more services are working with people across this age bracket.

The Social Exclusion Unit report 'Transitions: young adults with complex needs' (2005) had a focus on 16 to 25 year olds with complex needs, and concluded that the transition from childhood to adulthood was increasingly difficult for young people. It concluded in 2005 that '... the ways in which young people ... become adults has become more complicated and diverse but policies have generally failed to keep up with such changes. The age structuring on which many policies are based is often complex, inconsistent and working against the principle of resources following need'.

The policy context – a changing landscape

Significant changes are ahead in the way that services and interventions for young people affected by drug and alcohol problems are developed, commissioned and delivered. Reforms in the Health and Social Care Act (2012) and the 'Healthy Lives, Healthy People' White Paper (Department of Health, 2010) will have a particular impact, but other policy innovations could also be significant, including the introduction of elected Police and Crime Commissioners and the Troubled Families Initiative.

From April 2013, the NTA will be abolished and its functions absorbed into the new public health services, which will have a wide range of responsibilities including obesity, public mental health services, sexual health services, promotion of community safety and local initiatives to tackle social exclusion. This will potentially create opportunities to plan and commission services for young people in a 'joined up' way that effectively addresses inter-related issues. Directors of Public Health employed by local authorities will assume lead responsibility for commissioning drug and alcohol services, working closely with Directors of Children's Services and other local stakeholders. Health and Wellbeing Boards will be established in every upper tier local authority area with a responsibility for conducting a Joint Strategic Needs Assessment (JSNA) and producing a joint Health and Wellbeing Strategy (HWS). The statutory members of the Health and Wellbeing Board comprise local elected councillors, Directors of Public Health, Clinical Commissioning Groups, Directors of Adult Services, Directors of Children's Services and Healthwatch, as well as representation for the NHS Commissioning Board. There is also discretion to include

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other members, such as criminal justice or voluntary and community sector representation.

Children's services will play a critical role, with the Drug Strategy (2010) stating that Directors of Public Health and Directors of Children's Services 'will be empowered to take an integrated and co-ordinated approach to determine how best to use their resources to prevent and tackle drug and alcohol misuse', including flexibility to pool and align budgets through the Public Health Grant and an Early Intervention Grant. Other recent initiatives encourage local commissioners to pool budgets to develop integrated services, including the Troubled Families programme.

It is too early to predict the impact of these policy changes on interventions and services for young people affected by drug and alcohol problems. It is clear, however, that there will be very significant changes in the way services are planned and commissioned in the coming years, during a time when there will be severe budgetary pressures. The commitment to localism may also result in significantly greater divergence in priorities and provision for young people in different local authority areas.

Implications for practice

In keeping with the policy documents and the research to date, and following extensive consultation, this document is proposing a style of intervention that aims at investing in the psychosocial development and well-being of young people to give them the best chance of a normal life through:

- ▲ engagement of the young person, and their family where possible, through outreach if necessary
- ▲ skilled initial analysis of their difficulties, including mental disorders and developmental problems such as learning disability, and life circumstance
- ▲ engaging local systems so that they work together
- ▲ coordinated, well led interventions that mobilise the resources of local communities as required, including safeguarding, education, training, mental health and accommodation
- ▲ active follow-up to detect further episodes of support or intervention
- ▲ prioritising and delivering the training and support of staff

Before you read the standards, please read [appendix 1](#) which:

- ▲ sets out to define problematic substance misuse
- ▲ presents a pragmatic table of the stages of substance use and suggested interventions ([see table 1](#))
- ▲ presents a case vignette to illustrate each stage described in [table 1](#)

How the standards were developed

The Centre for Quality Improvement (CCQI) at the Royal College of Psychiatrists works with child and adolescent mental health service (CAMHS) professionals and young people to develop and implement standards of best practice.

Because of our work in this area, the Department of Health asked us to develop standards to guide and support the screening, assessment and treatment of young people with substance misuse problems and complex needs.

Our aim was to develop practice standards that, if followed, would be likely to result in high quality screening, assessment and treatment for these young people. We also aimed to develop standards that could be used by staff or professionals and services across all the sectors and agencies involved in the care of young people with substance misuse problems.

This first edition of the practice standards and criteria was developed following a review of the literature and a staged process of consultation.

Stage 1 Reviewing the literature

We started by reviewing key documents that might contain material to inform the best practice criteria. These included:

- 1 Guidance from the National Institute of Clinical Excellence (NICE) relevant for young people aged 18 years or under (e.g. Drug Misuse, 2007 and 2008; Alcohol, 2010 and 2011; Self-harm, 2004), and systematic reviews;
- 2 Policy and statutory obligations (e.g. Drug Strategy, 2010; National Treatment Agency (NTA) publications; Kennedy Report, 2010; National Service Framework for Children, Young People and Maternity Services [Children's NSF], 2004);
- 3 Reviews and survey reports of current practices evaluated against NICE guidance, or identifying features of best practice, and what young people and their parents/carers want from services (e.g. Alcohol Concern, 2010; DrugScope, 2010; Addaction and Turning Point, 2005).

The full list of the documents reviewed is listed in the bibliography in [appendix 2](#).

Stage 2 Academic advice and support – Child and Adolescent Substance Misuse (CHASM) Group at the Royal College of Psychiatrists

The CHASM group was consulted throughout the development of these standards. Members of the group formed part of the project team and advisory group, and helped to review the evidence base and developed the clinical standards and guidance notes presented in this first edition.

Stage 3 Project advisory group

An advisory group was established in January 2011 to inform the development of the standards and criteria. The group comprised 20 professionals who represented a range of stakeholder groups, namely: National Treatment Agency (NTA); Alcohol Concern; DrugScope; Turning Point; Addaction – DAT service manager; Commissioner of young people's substance misuse services; Paediatrician from the Royal College of Paediatrics and Child Health; Department of Health; Department of Education; Youth Justice Board; CAMHS psychiatrists; psychologist and nurse from substance misuse services (see acknowledgements in [appendix 3](#) for the list of members). Unfortunately we were not successful in recruiting young people and carers to this group.

The group met for a second time in April 2011 to review the findings from the first workshop consultation (see below) and to agree on amendments to the draft set of standards before further consultation.

How the standards were developed (continued)

Stage 4 Overlap with CAMHS standards for young people

Our initial review of the literature and relevant documents, as well as our discussions on key areas to be covered by the standards, highlighted an overlap with areas covered in the other CAMHS standards developed by the CCQI (see Quality Network for Inpatient CAMHS [QNIC] and Quality Network for Community CAMHS [QNCC]). These are areas that are relevant for all young people, parents or carers and the services they come into contact with irrespective of their specific problems (e.g. standards on information, consent and confidentiality, being fully informed and involved in all decisions made about their care etc). Where this occurred we either referenced the relevant section of the CAMHS standards or adopted, and at times adapted, the CAMHS standards for the purpose of these practice standards. Where relevant the CAMHS standards are integrated with these standards and the accompanying clinical guidance on identifying, assessing and offering care and treatment to young people with substance misuse problems and other complex needs.

It is worth noting that the CAMHS standards have undergone extensive consultation with stakeholders and young advisors, particularly the latest editions published in 2011 (Royal College of Psychiatrists, 2011a and 2011b). Our consultation workshops with young people helped to identify areas that required better coverage in the standards, and helped to rephrase some criteria to enhance their meaning and relevance for young people. Key themes young people wished to emphasise included:

- ▲ being kept informed at every stage – clarity about the purpose of each contact and what is going to happen next (re: referral, assessment, treatment), and how the proposed treatment/s will help;
- ▲ ensuring that no decision is made about them or their care without their full involvement - to be asked what they want and what they feel would help;
- ▲ being offered treatment choices, to receive a copy of their care plan, and that staff ensure the agreed care plan is delivered;
- ▲ ensuring that their rights with regard to consent and confidentiality are respected;
- ▲ the need for continuity with who they see and not having to make contact with a number of different professionals;
- ▲ not having to re-tell their story or repeat themselves to a number of different professionals;
- ▲ being able to access and re-access help when they need it.

These themes were considered throughout the development of these practice standards for young people with substance misuse problems.

Stage 5 Stakeholder consultation

We held two standards development workshops to review the draft standards and the consultation responses in order to reach a consensus on the standards and criteria for this first edition.

Workshop 1 (April, 2011): the workshop was advertised through the email discussion groups and networks established for CAMHS (FOCUS and QNCC) at the CCQI, and the professional networks of the advisory group members and their organisations. A total of 50 professionals expressed an interest in attending, and 36 were selected to ensure representation across the following groups: young people; parents or carers; staff from statutory and voluntary sector substance misuse services for young people; community CAMHS professionals; commissioners; policy and strategy professionals (see full list in [appendix 3](#)).

The standards were then amended in consultation with the Advisory Group in April 2011 and the CHASM academic group. Key points raised related to definitions and the use of appropriate language that would help to engage a wide range of services, staff or professionals, and inform young people and parents or carers about what to expect.

Workshop 2 (October, 2011): the amended standards were reviewed for a second time by delegates attending the 'Master Class in Adolescent Substance Misuse II: Complex problems and innovative solutions' on 11 October 2011. The delegates represented a wide range of stakeholders (policy leads, commissioners, substance misuse treatment service managers and staff, CAMHS psychiatrists and other professionals) and were invited to review the standards and discuss them in a structured workshop. In [appendix 4](#) we summarise the points they raised about how the standards could be improved and their potential use.

How to read these standards

These standards were written for young people with substance misuse problems and other complex needs, their parents or carers, and a wide range of staff or professionals and services whose role it is to respond to their needs.

The standards are organised to follow a young person's care path and increasing intensity of need. This means that not all sections will apply to everybody, but we would advise all readers to refer to the standards and guidance notes that specifically relate to engaging, assessing and offering treatment to young people, and their parents or carers.

The standards are organised within the following sections:

- 1 Identification and brief assessment (including brief advice and intervention for over 15s)
- 2 Comprehensive assessment
- 3 Integrated care planning
- 4 Integrated care and intervention
- 5 Planned completion and transfer of care.

For further guidance on a) information, consent and confidentiality, and b) rights and safeguarding specifically for young people, please refer to our CAMHS standards (see under resources on <http://rcpsych.ac.uk/quality/qualityandaccreditation/childandadolescent.aspx>)

Rating the standards for guidance

The most difficult dilemma in developing any set of standards is the level of expectation they place upon professional practice and the quality of care provided. While we include standards that represent minimum requirements of care, the majority outline good practice that young people and carers should expect to receive from staff, professionals or services.

The standards also include criteria indicating excellent practice that may be outside the control of the staff team, professional or service. While in the current climate of restricted resources these 'excellent practice' criteria may be difficult to achieve, it is important that they are acknowledged so that they can serve as targets for improvement in the future. For this reason, the relative importance of the criteria that support the standards is indicated using the CCQI grading system, which is also used for other CCQI standards for child and adolescent mental health services. Consensus on the grading of the standards was gained from members of the project team and the CHASM group.

Overleaf is an explanation of the grading system and definitions that apply to the standards, and the various terms used throughout this document.

How to read these standards (continued)

Section heading	3.0	Integrated care plans
Standard: This describes the overarching aim or value of a particular group of criteria	3.2	Young people's care plans are regularly updated and shared with relevant parties (QNCC 2.6)
Criterion: a more specific statement explaining what needs to happen. Please note, for a staff member, professional or service to meet a standard they must meet the majority of criteria within it.	3.2.1	2 Care plans are reviewed at regular intervals and include discussions with the young person about whether the treatment is helping (QNCC 2.6.2)
This shaded column shows the grading of each standard and criterion:	3.2.2	2 Depending on severity, risk assessments in relation to substance misuse and co-existing problems are reviewed at regular intervals (e.g. 3 to 6 months)

1 Essential: These are minimum standards and criteria that are critical to care. Failure to meet these standards and criteria would result in a significant threat to patient safety, rights or dignity and/or would breach the law.

2 Expected: These are standards and criteria that a professional and/or team providing a good service would be expected to meet, and that young people and parents and carers should expect to receive.

3 Desirable: Criteria that indicate excellent practice and care. They may not be the direct responsibility of staff, professionals or services.

Please note

- ▲ Where there are notes underneath some criteria, 'Guidance' provides additional guidance on good practice and 'Ref' refers to the source that inspired or closely relates to the criterion.
- ▲ The standards and criteria in this document exist to guide best practice and do not override the individual responsibility of a staff member or professional to make appropriate decisions on a case-by-case basis.

A wide variety of community staff including practitioners, substance misuse workers, single professionals as well as multidisciplinary teams may use these standards. Staff may work in a clinic base or through schools, GP practices, specialist substance misuse treatment services, or other community or voluntary sector settings, or in the young person's home.

Services are different depending on the young people they work with and the level of intervention and support they can offer and provide, including young people with co-occurring chronic or long-term needs (for example, learning disabilities and

autistic spectrum disorders). Therefore, while these standards are designed to be as inclusive as possible, it may be that particular standards are not applicable to some staff, professionals or services that offer help and support for young people with substance misuse problems and health, education, and social care needs. Due to the variety of services it is not feasible to give an exhaustive list of possible exceptions.

If you have any queries about the standards, please contact the project team through Anne O'Herlihy at aoherlihy@cru.rcpsych.ac.uk

Options for implementation

CAMHS: Within CCQI, these practice standards will be integrated into the QNCC quality improvement and accreditation programmes, and will be offered as a component of the QNCC review process (see www.rcpsych.ac.uk/quality/qualityandaccreditation/childandadolescent/communitycamhsqncc/ourstandards.aspx).

Other services: While we currently do not have an established implementation programme for other services that identify, assess and offer care and interventions for these young people, we would like to explore implementation options if sufficient interest is expressed. If you work in one of these services and would like to discuss how you could use these standards in your own service please contact the QNCC team on 020 977 6681 or Peter Thompson at pthompson@cru.rcpsych.ac.uk

Key terms and definitions employed

Staff: The term 'staff' is employed throughout and refers to all practitioners, workers and professionals who work with young people and are in a position to: identify risk and access or offer help, support and treatment for substance misuse problems and other complexities. A number of standards specify 'professional' and 'senior professional' and these are defined as:

Professionals: In this context they have a formal qualification at postgraduate or doctoral level that will include supervised face-to-face contact with clinical casework – for instance a clinical psychologist, nurse, general practitioner, paediatrician, occupational therapist, psychotherapist, family therapist, doctor, and others.

Senior professionals are those that have clinical responsibility for face-to-face clinical work, but also supervisory responsibility for practitioners and junior professionals under their clinical supervision. Such individuals are expected to have additional training and work experience in their field, and are responsible for the quality of clinical work and the personal development of the staff. They are likely to be capable of being respected and listened to by key systems such as education and social care.

Young people: This term is used to describe all age groups up to and including 18 years.

Drawing a distinction between what should be offered to young people aged 15 or over and those under 15 years: This is based on the NICE guidance on alcohol prevention and screening ([see website](#)) and consensus among the clinicians and professionals who contributed to these standards.

Other complex needs: Throughout the document we refer to young people with substance misuse problems and other complex needs. This term is used to represent all complexities that relate to health, education and social care needs (for example, safeguarding concerns and risks, substance misuse, mental health, physical health, educational difficulties or not being in school or on training schemes, family difficulties, and all other complexities).

Parent or carer is used to identify and acknowledge those who hold parental responsibility but who may not be the biological parent.

In terms of the pathways these young people may follow, universal, targeted and specialist services are defined as follows:

Universal services and programmes:

Available to all children and young people who *'do not seek help, and no one within the population is singled out for the intervention'* (Offord, 1994).

Young people in any given geographical area can access help through their contact with staff in universal services (e.g. school staff and teachers, youth

centre workers, social care staff, GPs, emergency services - A&E, paediatrics, police). In this context these services may include universal prevention and drug education programmes (formal and informal) or school-based (or youth/ Scout groups), PHSE (personal, health, social and education) programmes, basic drug information and signposting to services.

Targeted services and programmes:

For young people who are not necessarily seeking help but are identified as being at *'risk on the basis of characteristics they themselves have, or on the basis of the group to which they belong'* (Offord, 1994). Targeted early interventions are offered by staff working in non-specialist services such as young people's counselling services, services working with Improving Access to Psychological Therapies (IAPT) for young people, youth offending teams, targeted youth support programmes (for example for those not in education, employment or training, or teenage pregnancy services). These may include:

- ▲ drop-in sessions with young people in hostel accommodation or children's homes;
- ▲ group sessions or psycho-education with groups identified by schools as being at risk or vulnerable – for instance when young people in a school have developed a specific local culture of heavy or dangerous drug use;
- ▲ drug education sessions with groups in youth offending services;
- ▲ drop-in sessions in the above settings;

Key terms and definitions employed (continued)

▲ brief interventions (e.g. assessment, feedback, planning and information-giving delivered by health care staff in emergency A&E departments are delivered to young people brought in with drug or alcohol related problems). Such interventions may be supervised by specialist drug and alcohol workers.

Specialist services and programmes:

Young people identified as likely to have complex, sometimes profound, and persistent needs are offered a comprehensive assessment and evidence-based interventions by professionals qualified to undertake the assessment and provide the intervention/s offered. These coordinate *help across health, education, social care and youth offending, and work with children and young people with the highest level of need* (www.dh.gov.uk/en/Healthcare/Mentalhealth/CAMHS/index.htm). In this context professional staff are likely to be based in specialist substance misuse treatment services specifically designated for young people, or child and adolescent mental health services (CAMHS) based specialist substance misuse services - these may have a range of configurations but tend to include staff from CAMHS, adult addiction services, statutory agencies such as social services, GP practices with specialist skills and the voluntary sector.

There is broad consensus and official guidance that supports the value of close collaboration and a systemic framework across these agencies to support the quality of care provided to treat the whole range of substance related problems (Mirza *et al*, 2007). Coordinated by specialist substance misuse treatment

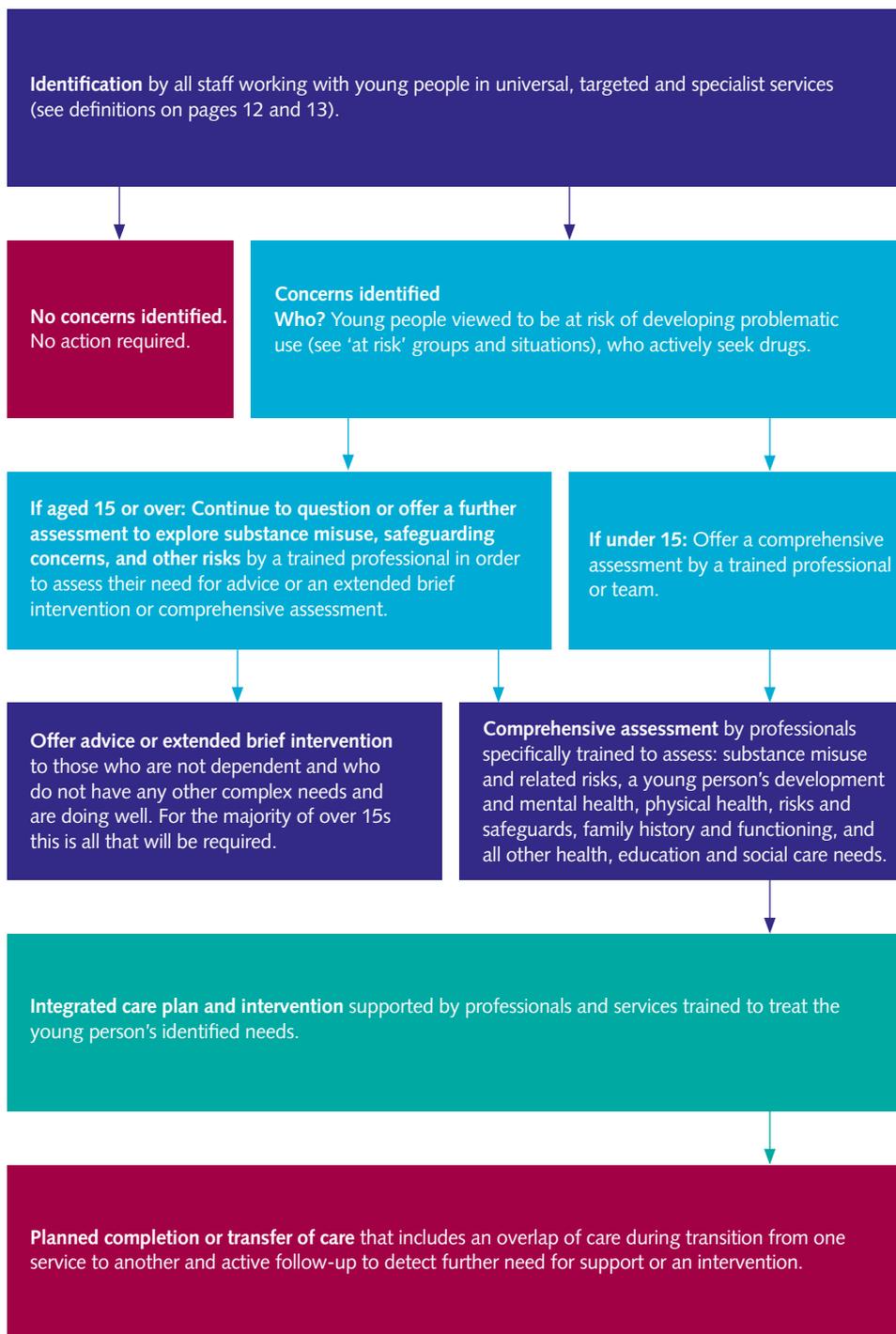
services for young people, which have a specialist assessment framework, the goal is to skilfully deliver a range of interventions from brief motivational interviewing through to complex multi-modal packages.

Note the NTA defines specialist substance misuse treatment services as a *'care planned medical, psychological or specialist harm reduction intervention aimed at alleviating current harm caused by a young person's substance misuse'* (NTA, 2008, page 45).

A full glossary can be found in [appendix 5](#).

Figure 1 overleaf outlines the potential care paths young people at risk of substance misuse problems may follow according to the risks identified.

Figure 1 Care pathways young people may follow



At risk groups

- ▲ Looked after
- ▲ Excluded from school, or who truant on a regular basis
- ▲ Involved with the youth justice system
- ▲ Involved with safeguarding agencies
- ▲ Has a learning disability or developmental disorder (e.g. ADHD) or any other mental disorder
- ▲ Family member known to misuse substances

At risk situations

- ▲ Being homeless
- ▲ Involved in anti-social behaviours or crime
- ▲ Involved in an accident or who repeatedly presents with a minor injury
- ▲ Under the influence of a substance at school or other settings
- ▲ When their behaviour raises concerns about risk
- ▲ Regular attendance at a genito-urinary medicine clinic or repeatedly seeks emergency contraception

Practice standards

1.0 Identification and brief assessment,
including advice and brief intervention for over 15s

CG1 Substance misuse screen or assessment instruments

CG2 Interviewing young people – clinical guidance

2.0 Comprehensive assessment

3.0 Integrated care planning

4.0 Integrated care and interventions

CG3 Individual therapies – summary of the evidence base

CG4 Treating co-morbidity – summary of the evidence base

5.0 Planned completion and transfer of care

1.0

Identification and brief assessment, including advice and brief intervention for over 15s

Target audience: All staff in contact with young people aged 18 or under (in universal, targeted, and specialist services) across health, social care, education, youth justice system, and the voluntary and community sector (NICE Alcohol, 2010; Alcohol Concern, 2010).

This section aims to support the identification of young people not seeking treatment but who may be at risk of substance misuse problems (Adapted from NICE PH Alcohol, 2010, page 8). Staff or professionals working with children and young people should have the competences to:

- ▲ identify those at risk
- ▲ know when a more detailed assessment is required
- ▲ be able to either conduct the assessment
- ▲ quickly access an appropriately skilled professional to take the next steps.

For all young people aged 18 or under: Identification should simply involve brief questioning about substance misuse (e.g. what was taken, how often, and in what context - see NICE *Drug Misuse: Psychosocial Interventions*, 2008).

For young people under 15 years: If any concerns are identified (positive screen), young people are offered a comprehensive assessment to assess for health, education and social care needs (including substance misuse, mental health problems, physical health, family and other complexities).

For young people aged 15 years or over: If concerns are identified, the young person's use is explored with more detailed questions (a brief assessment) and if appropriate they are offered advice and / or an extended brief intervention. If they screen positive for a substance use disorder and complex needs a comprehensive assessment is offered and arranged.

1.1	Young people thought to be at risk are identified and briefly questioned or assessed for substance misuse and other related risks	
1.1.1	2	Commissioners of children's services (including commissioners for substance misuse services for young people) work with providers to:
1.1.1a	2	<ul style="list-style-type: none">• produce a written strategy to identify young people at risk of substance misuse problems and other concerns (e.g. safeguarding issues, school non-attendance or failure, mental health problems) through an integrated system
1.1.1b	2	<ul style="list-style-type: none">• ensure universal and targeted services are commissioned and resourced to provide an integrated system of identification, with access to support from specialist services <p>Guidance: See Alcohol Concern (2010) for examples.</p>
1.1.1c	2	<ul style="list-style-type: none">• ensure systems of identification are an integral part of the Local Safeguarding Children Board (LSCB) training so that a broad range of staff have the skills to identify use and other risks, and know when to refer on

Identification and brief assessment,
including advice and brief intervention for over 15s (continued)

1.1	<i>Continued</i>	
1.1.2	2	Local agencies and service providers ensure staff use a locally agreed brief and valid questionnaire to routinely identify young people who may be at risk (such as the CRAFFT recommended by NICE, 2010-see instruments listed under CG 1).
1.1.3	2	The agreed questionnaire and supplementary questions enable staff to enquire about: <ul style="list-style-type: none"> • whether a young person has used substances • the type used and how it was taken (in what context) • how frequently taken (incl. first and most recent time) • presence of any other risks or concerns (e.g. mental health concerns safeguarding, use within family, sexual vulnerability) • young person's view of use and impact on their lives (problems at home, school, with relationships) • their willingness to access a further assessment or help
1.1.4	2	Staff working with young people in universal and targeted services receive guidance and training from specialist services to ensure they know
1.1.4a	2	<ul style="list-style-type: none"> • the indicators of substance use (at risk groups and situations-see figure 1) <p>Guidance: <Click this link: Fig 1> See table 1 (Mirza and Mirza, 2008) in appendix 1</p>
1.1.4b	2	<ul style="list-style-type: none"> • to approach questioning with sensitivity as for 1.2.1c in a non-judgemental manner (linked to QNCC 1.3.1c)
1.1.4c	2	<ul style="list-style-type: none"> • how to use the locally agreed brief questionnaire accurately and in a valid manner
1.1.4d		<ul style="list-style-type: none"> • how to respond to identified needs through defined care pathways
1.1.5	2	Staff have access to a guide/flow-chart/information with contact details for specialist advice or to arrange a further assessment.
For clinical guidance on interviewing young people – <Click this link: CG 2>		

1.0

Identification and brief assessment, including advice and brief intervention for over 15s (continued)

1.2	Appropriately trained staff evaluate the needs of, and consider the next steps for, young people aged 15+ who are judged to be at risk	
1.2.1	2	Staff who question young people at risk are trained and supported by specialist services to:
1.2.1a	1	<ul style="list-style-type: none"> understand risk and the risk thresholds that indicate when further action is required
1.2.1b	2	<ul style="list-style-type: none"> access advice and support from specialist services
1.2.1c	1	<ul style="list-style-type: none"> approach the assessment with sensitivity, taking account of the young person's age, emotional maturity, level of understanding, their culture, faith and beliefs <p>Guidance: See CG 2 for clinical guidance on interviewing young people. The way 'professionals engage with and question the young person at identification/screening has the potential to help the young person reflect on their use and their other problems and to access further help and a more detailed assessment'.</p> <p>Ref: You're Welcome (2011; 5.1 & 5.2)</p>
1.2.1d	2	<ul style="list-style-type: none"> encourage the young person to consider involving their parents or carers (where possible) or other responsible adults
1.2.1e	2	<ul style="list-style-type: none"> provide information on how the young person and their parents or carers can access help or advice whenever they require it
1.2.1f	1	<ul style="list-style-type: none"> understand and follow national guidelines and protocols for requesting a young person's consent <p>Guidance: See NHMDU (2009); DH guidance (www.dh.gov.uk/consent); Code of Practice to the Mental Health Act (chapter 36).</p>
1.2.1g	1	<ul style="list-style-type: none"> understand and follow national guidelines and protocols for respecting a young person's rights to, and the limits of, confidentiality <p>Guidance: See NTA (2003); You're Welcome Quality Criteria (2011; 3.1-3.4); see QNCC standards on 'information, consent and confidentiality' and 'rights and safeguards'.</p>
1.2.2	2	<p>The questionnaire/s used are referenced next to questions about substance use in the 'Common Assessment Framework-CAF', 'Care Programme Approach-CPA', or other assessment procedures employed by local sectors and agencies.</p> <p>Guidance: NTA (2011b)-Drug treatment plan: section 2-Local CAF processes are supported to ensure substance misuse interventions are identified and referred on as required (also see NTA, 2007)</p>
1.2.3	2	Prior to an interview, the young person and their parent or carer (if appropriate) are informed about the purpose of the questions, and what will be offered if a problem is identified.
1.3	The questions used to identify and/or briefly assess risk are fit for purpose, appropriate to the setting, and acceptable to young people, parents or carers, and staff	
1.3.1	2	The questions asked are acceptable and accessible to young people and their parents or carers.
1.3.2	2	Staff report that the process of identification and further questioning is quick and practical to use within their practice and setting.

Identification and brief assessment,
including advice and brief intervention for over 15s (continued)

1.4	Services that identify risk and offer a brief assessment record and monitor their activity and response to young people in need	
1.4.1	2	<p>Services record and monitor the:</p> <ul style="list-style-type: none"> • consistent use of agreed risk thresholds for when further action is required • number identified to be at risk and offered a brief assessment • number of brief interventions offered and delivered • number offered a comprehensive assessment and treatment intervention
<p>Advice and extended brief interventions for over 15s</p>		
<p>Target audience: Young people aged 15+</p>		
<ul style="list-style-type: none"> ▲ who screen positive for substance use but not disorder or ▲ where there are concerns about use but who are not dependent or ▲ who present without complex or multiple needs (e.g. doing well at school, no major issues at home or with relationships, good level of functioning in most areas of life) 		
<p>are offered an extended brief intervention for hazardous or harmful alcohol or drug use (NICE Alcohol, 2011). In addition, all the staff and professionals who are trained to respond to the young person's needs.</p>		
<p>NICE Alcohol (2010) recommendation 6 is cautious about the use of advice or extended brief interventions with younger children. There is no evidence for the use of extended brief interventions for those under 15 years. (Also see Alcohol Concern, 2010: pages 13 - 16; Kaminer <i>et al</i>, 2008).</p>		
<p>A comprehensive assessment (see section 2) should be offered to those</p>		
<ul style="list-style-type: none"> ▲ under 15 years who screen positive for substance use or ▲ those over 15 who screen positive for a substance use disorder or ▲ who have complex needs 		
1.5	Young people aged 15+ who are <i>not</i> dependent but are judged to be at risk are offered age-appropriate advice and/or an extended brief intervention to discourage further use	
1.5.1	2	<p>Young people are offered advice or a brief intervention by staff who are trained to use age-appropriate interventions that aim to increase motivation to change behaviour through reflective and non-judgemental feedback.</p> <p>Ref: NICE, <i>Drug Misuse: Psychosocial Interventions</i>, (2008, page 12).</p>
Stem	Staff that offer advice or brief interventions receive regular training on:	
1.5.2	2	<ul style="list-style-type: none"> • clinical techniques such as motivational interviewing for engaging with the young person, and their parent or carer (where possible), as part of the delivery of a brief intervention (See McCambridge <i>et al</i>, 2008)
1.5.3	2	<ul style="list-style-type: none"> • age-appropriate advice and self-help guidance <p>Guidance: 'The precise components of a successful brief intervention with young people are unknown, but findings show that even taking a substance history and discussing briefly its findings may be helpful, opening to a wide range of clinicians the possibility of intervening' (McArdle <i>et al</i>, 2011). See also Walton <i>et al</i> (2010) and Alcohol Concern (2010).</p>

Alcohol

- ▲ **AUDIT-C-Alcohol Use Disorders Identification Test** - Knight *et al* (2003) is used among 14 to 18 year olds but not in primary care settings; recommended by NICE for 16 and 17 year olds (NICE Alcohol, 2010, page 16) www.cqaimh.org/pdf/tool_auditc.pdf
- ▲ **SASQ-Single Alcohol Screening Questionnaire** – see www.swpho.nhs.uk/resource/view.aspx?RID=46136

Drug and alcohol

- ▲ **CRAFFT** (Knight *et al*, 1999) Screens for alcohol and drugs and is developmentally appropriate for adolescents; it has proven validity and reliability-see page 68 of Knight *et al* (2003). The use of CRAFFT is recommended by NICE (2010) and is an acronym of the first letters of key words in the six screening questions. *The questions should be asked exactly as written* - see www.ceasar-boston.org/CRAFFT/index.php
 - C Have you ever ridden in a CAR driven by someone (including yourself) who was 'high' or had been using alcohol or drugs?
 - R Do you ever use alcohol or drugs to RELAX, feel better about yourself, or fit in?
 - A Do you ever use alcohol or drugs while you are by yourself, ALONE?
 - F Do you ever FORGET things you did while using alcohol or drugs?
 - F Do your family or FRIENDS ever tell you that you should cut down in your drinking or drug use
 - T Have you gotten into TROUBLE while you were using alcohol or drugs?
- ▲ **SQIFA** employed by YOTs (www.yjb.gov.uk/engb/professionals/Health/MentalHealth/) is a short Mental Health Screening Questionnaire Interview for Adolescents that includes questions on substance misuse. It can be completed by all YOT staff, and if positive for risk a more detailed screening interview can be undertaken by health YOT staff.
- ▲ **MASQ-Maudsley Adolescent Substance Misuse Tool** has face validity but reliability and construct validity is being tested at present and is being validated against the CRAFFT (personal communication with Dr KAH Mirza and Dr Paul McArdle in 2012). It is a self-rated scale that takes five minutes to complete and contains 5 questions each on drugs and alcohol, and 3 on cigarettes. It also assesses whether the young person seeks help or not.

Any instruments used to further supplement information gained from initial questioning should have proven validity and reliability. Otherwise there may be a risk of too many false positive or negative assessments and of identifying the wrong people. For a review of assessment instruments see Perepletchikova *et al* (2008).

NICE emphasise that ‘any professional with a safeguarding responsibility for children and young people and who regularly comes into contact with this age group’ should be capable of this sort of conversation - see NICE guidance for 10-15 year olds. In all conversations with young people always consider their culture, faith and beliefs and that of their family. Guidance by Dr Paul McArdle

Assessments should be undertaken by staff competent in talking to young people (e.g. those who are trained to work with young people such as a youth worker, teacher, paediatrician or nurse) and their parents or carers. The purpose is not just to estimate substance use but to generate some indication of whether the young person is more generally in need. Where possible, it should be complemented by the views of parents or carers. The use of appropriate, valid and reliable questionnaires can usefully supplement information gained in an assessment (see instruments listed under CG 1. [<Click this link: CG1>](#))

Begin with non-intrusive, rapport-building questions, such as:

- ▲ Where they go to school, perhaps whether it is a good or bad school? (This sort of question ‘permits’ the young person to speak their mind, is likely to reflect her/his own scholarly aptitude, and is not attempting to rate the school)
- ▲ What team they support or music they like? (It is useful to have some knowledge of contemporary trends)
- ▲ Who they live with?

Continuing to use age appropriate language, here geared to younger adolescents, elicit more detail on:

- ▲ Whether they attend school?
- ▲ Do they like reading? Do they ever read the paper, magazines, and instructions for computer games, text or use Facebook or Twitter?
- ▲ Are they a happy person or a not happy person? Especially if ‘not happy’, do they ever think of doing harm to themselves? Is whoever they live with nice to them; if the mother is present, are they nice to their mother?

This sort of questioning offers the possibility of gauging the cognitive development and the affective and interactional quality of key relationships. In order to include young people with poor language skills, it uses simple language that can be upgraded.

Proceed to open ended questions concerning substances:

- ▲ Do you drink alcohol? What do you like to drink – keeping it light – ‘what does that taste like?’
- ▲ Do you drink alone or with friends; how long have you known them, are they nice or ever nasty to you?
- ▲ How much do you drink? If ‘a couple of cans’, sometimes it is useful to use permission giving prompts e.g. ‘twenty cans’? Mildly entertained by this, the young person may feel able to admit a realistic estimate. A similar style can be used to estimate cannabis misuse ‘twenty bongs/buckets/pipes a day’ but the answer might be ‘ten’

Include questions about what young people are good at, what skills they have, and what hopes they have for the future. An assessment should also be about exploring the strengths and resources of the young person and their hopes and dreams for their future (see McAdam and Mirza, 2009). Throughout, the interviewer is observing the general demeanour and well-being of the young person.

2.0

Comprehensive assessment

The Drug Strategy (2010, page 12) explicitly states that ‘*Substance misuse services, youth offending, mental health and children’s services must all work together to ensure (specialist support that tackles drug and alcohol misuse) is in place.*’ Equally, DrugScope (2010, page 22) emphasised the need for a multi-agency (where appropriate) and holistic approach to ensure young people have all their needs considered and addressed. Specialist substance misuse treatment assessments may form part of a holistic assessment of all needs (NTA, 2007).

Target audience: Specialist services or professionals with the competences to assess and treat young people at risk.

For an assessment to be comprehensive it needs to be undertaken by a team of professionals (e.g. specialist substance misuse professionals, social workers, CAMHS with other engaged agencies) or a senior professional (e.g. consultant community paediatrician with the involvement of the GP and parents or carers) that has the competences to assess the wider developmental and mental health needs of the young person and inform a comprehensive care and intervention plan.

For those with multiple and complex needs (including concerns about mental health) a comprehensive assessment should be offered and undertaken jointly with specialist substance misuse teams and CAMHS or other relevant agencies (e.g. YOT or social services) to determine all the needs of the young person (and if appropriate their parent or carer). This should inform a comprehensive care and intervention plan that tackles not only the substance misuse problems but all areas impacting on the young person’s ability to function.

If possible a comprehensive assessment should be undertaken close to, or following on from, when the young person’s problems are first identified.

Access		
2.1		Young people, and parents or carers, access an appropriate, coordinated comprehensive assessment through a wide range of universal or targeted services (linked to QNCC 1.1)
2.1.1	2	Commissioners for children’s services and providers have agreements in place to ensure young people receive a comprehensive assessment for substance misuse and co-existing problems that is coordinated with other relevant disciplines and agencies.
2.1.2	2	Services and professionals that offer a comprehensive assessment agree on locally defined referral pathways and criteria (including guidance for self-referrals), and this is communicated to all services in contact with young people. For example (note this is not an all inclusive list): primary care professionals; youth justice system – including for those on community sentences and returning from secure estate; accident and emergency departments; paediatrics; CAMHS; sexual health clinics; schools/colleges; integrated and targeted youth support; police; social services (including LA residential care homes); voluntary third sector providers (e.g. youth counselling organisations).
2.1.3	2	Staff who identify a risk have access to guidance and referral criteria for when a comprehensive assessment is required, with details of who to contact. Guidance: Many services employ a flow-chart that provides contact details of who to contact according to the risk factors identified.

Comprehensive assessment (continued)

2.1		Continued
Stem		Professionals offering a comprehensive assessment:
2.1.4	2	<ul style="list-style-type: none"> work to locally agreed protocols for arranging the assessment, and if necessary involve other disciplines to assess all presenting needs <p>Guidance: DrugScope (2010) report that effective integration was achieved when a CAMHS worker was embedded in a substance misuse treatment service and youth offending team; with young people reporting positive experiences of care. In some areas a weekly joint MDT forum helps to ensure an appropriate and comprehensive response to referrals.</p>
2.1.5	2	<ul style="list-style-type: none"> share a locally agreed list of common terms and definitions regarding substance misuse, health, education, and social care needs, mental health and learning disabilities (adapted QNCC 1.1.3)
2.1.6	2	<ul style="list-style-type: none"> are available for consultation for the staff and services that first identify risk and/or offer advice or brief interventions
2.1.7	2	<p>Services offering a comprehensive assessment identify where access difficulties exist for particular groups, and implement and monitor strategies to address these difficulties (QNCC 1.3.4).</p> <p>Guidance: Depending on the locality this may include strategies to address the needs of black and minority ethnic and newly arrived groups; young people on the autistic spectrum, learning disabilities and/or with multiple mental health problems; school non-attenders; young people in transition such as asylum seekers, travellers, and those without secure accommodation.</p> <p>Ref: CQC 16A and You're Welcome (2011; 1.7 & 1.8).</p>
2.2		Young people and parents or carers (where appropriate) are offered a timely assessment of need and are informed about what to expect (adapted QNCC 1.2)
2.2.1	2	<p>Young people in need are offered a comprehensive assessment from appropriately trained professionals close to the time of identification.</p> <p>Ref: Addaction (2009); NTA (2011b); DrugScope (2010); Alcohol Concern (2010).</p>
2.2.2	2	<p>Prior to the assessment, the assessing professional or service inform young people, and their parent or carer (where possible), about the purpose of the assessment, what it will involve, and who they will see and why.</p> <p>Ref: You're Welcome (2011; 1.1).</p>
2.2.3	2	<p>Services contact young people, and parents or carers (if appropriate), to agree times and locations of appointments or contacts that are convenient to them (linked to 4.5.5).</p> <p>Ref: You're Welcome (2011; 1.2).</p>
2.2.4	3	<p>Commissioners and providers resource assessing professionals to offer out-of-hours and home assessments for those in education, college or employment and those unable or reluctant to attend the service.</p>

Comprehensive assessment		
2.3		Young people and their parents or carers experience a collaborative assessment and are fully informed and involved in all decisions about their care (QNCC 2.4).
2.3.1	2	Before the assessment begins, the assessing professional checks with the young person, and their parent or carers, that they know who the assessor is, the reasons for the assessment and what it will involve, and how it will help (linked to 2.2.2).
2.3.2	2	Where it is not appropriate or possible for a young person's parent or carer to attend, they are asked whether they would like another family member, friend or advocate to accompany them during an assessment. Ref: NICE (2012, <i>Patient experience</i> , 1.5.16).
2.3.3	2	With regard to age and ability, the lead assessor ensures the young person's views, wishes and feelings are actively sought and recorded in the case notes by the assessing professionals to ensure that no decision is made about them without their full involvement. Ref: DH (2011, ' <i>No decision about me without me</i> ').
2.3.4	2	Young people, their parents or carers, and/or referrers are provided with feedback on the outcome of the assessment, including an explanation of the nature of the problem and proposed intervention or next steps. Guidance: Verbal feedback is given in the session and written feedback, where relevant, is sent within 48 hours.
2.4		Comprehensive assessments are effectively co-ordinated to support the young person's continuity of care and existing relationships with other professionals
		'Continuity and consistency of care and establishing trusting, empathetic and reliable relationships with competent and insightful ... professionals is key to patients receiving effective, appropriate care. Relevant information should be shared between professionals and across ...[service] boundaries to support high-quality care' (NICE, 2012, <i>Patient experience</i> , 1.4).
2.4.1		In line with national and local policy and guidance on confidentiality, professionals offering a comprehensive assessment establish whether the young person: Guidance: The assessment process should be coordinated across agencies, where necessary, to avoid repetition where possible. Ref: CQC 4L 6B
2.4.1a	2	• is being supported by any other care services (e.g. YJS, social care, or substance misuse services)
2.4.1b	2	• has completed other assessments such as the CAF, ASSET, CPA or other assessments
2.4.1c	2	• has a named care co-ordinator under the CAF or lead professional under CPA
2.4.1d	2	• is already engaged with a named key worker and service
2.4.2	2	As appropriate and with the young person's consent, agencies access and share information gathered during previous assessments in order to remove repetition and support continuity of care. Ref: CQC 4L; Children's NSF (std 3), 2004; DH, <i>No Health without Mental Health</i> -'only ask once' principle (2011d, page 32); DH CPA (2008, page 30).

Comprehensive assessment (continued)

2.4	<i>Continued</i>	
2.4.3	2	Young people report that the plans for assessment were collaborative and involved professionals they are already engaged with.
2.4.4	2	If additional information or liaison with other professionals is required (beyond those immediately involved), the lead assessor ensures that consent is first sought from the young person or their parents or carers (if appropriate). Guidance: Adapted from QNCC 2.2.3 and 4.2.1-see CQC 1A 6G and the Code of Practice to the Mental Health Act paragraphs 36.27 to 36.34; NMHDU Legal Guide, pages 19-23.
2.5	Professionals have the necessary competences and resources to conduct a comprehensive assessment and arrange a care and treatment plan (QNCC 2.3)	
2.5.1	3	Young people receive a comprehensive assessment that is overseen by a senior professional to ensure all needs are considered (linked to 3.1.2). Ref: Munro Report (2011).
2.5.2	2	Young people, and where possible their parent or carer, are assessed by staff who have the competences and are trained to establish rapport and engage with (linked to 4.2.3): <ul style="list-style-type: none"> • young people (e.g. employing motivational interviewing techniques) • parents or carers, partners and wider family networks to support the young person's recovery (e.g. family based engagement processes) • other professionals as required to meet the range of presenting needs Guidance: Staff should employ an explicit framework and model for approaching such interactions; ideally these would be drawn from an evidence-base approach such as (motivational interviewing, appreciative enquiry, or mentalization-based practice). However, the authors recognise that evidence for any single approach for this age group is weak. Ref: NTA (2007); Bukstein <i>et al</i> (1997, page 152s); Mirza and Mirza (2008, page 359); Winter and Kaminer (2011); Spirito <i>et al</i> (2009); Hogue <i>et al</i> (2009).
2.6	Assessments are comprehensive and according to need (QNCC 2.5)	
2.6.1	2	With the young person's agreement, assessments involve other professionals involved with the young person. Guidance: For example, GPs, staff from school, social services, youth justice system, or other relevant agencies.
2.6.2	2	Staff actively support the involvement of parents or carers in the assessment, and their views are recorded in the case notes (linked to 3.1.7). Ref: NTA (2007 and 2009).
2.6.3	1	Young people are assessed by professionals who are qualified and have the skills and competences required to undertake their role in the comprehensive assessment. Guidance: Employ a flexible emphatic and non-judgemental approach, with an initial focus on a young person's leisure activities or interests and short and long-term goals, before exploring the nature and extent of use context, and impact on their functioning and achieving their goals (Mirza and Mirza, 2008, page 359; Winter and Kaminer, 2011).

2.6		Continued
Stem		A young person's comprehensive assessment includes: Ref: NTA (2007 and 2009); Bukstein <i>et al</i> (1997).
2.6.4a	1	<ul style="list-style-type: none"> • <i>substance misuse behaviours and related risks</i>, including time-lines, supported by age-appropriate, valid and reliable rating scales or structured interviews Ref: Perepletchikova <i>et al</i> (2008); NTA (2009, page 26).
2.6.4b	1	<ul style="list-style-type: none"> • <i>developmental, including education, and mental health</i> - pre-morbid and / or co-morbid psychiatric or behaviour disorders Ref: NTA (2009, page 26).
2.6.4c	1	<ul style="list-style-type: none"> • <i>physical health</i> which includes consideration of direct (e.g. abscess, hepatitis, bronchitis) and indirect impact on health (e.g. sexual health)
2.6.4d	1	<ul style="list-style-type: none"> • <i>risks and safeguarding concerns</i> – in addition to current and past risks in each of the above areas, it includes an assessment of risks at home or in the local community, the presence of parent or carers that use substances, and child protection issues that need to be dealt with urgently according to local policy and procedure
2.6.4e	2	<ul style="list-style-type: none"> • identification of (or helping to identify and encourage) the aspirations and goals of the young person, and their parents or carers Guidance: DH CPA (2008, page 18)
2.6.4f	2	<ul style="list-style-type: none"> • <i>family history and functioning</i>, both past and current with respect to the young person's relationships
2.6.4g	1	<ul style="list-style-type: none"> • <i>factors contributing to vulnerabilities</i>, including how the young person is getting on at home, in school, general social functioning, involvement in criminal behaviour
2.6.4h	1	<ul style="list-style-type: none"> • <i>factors contributing to resilience</i>, including the above areas (2.6.4) and identifying factors that support resilience to substance misuse Ref (2.6.4.g&h): NTA (2007; 2009, page 27); ACMD (2006); DH CPA (2008, page 18); Children's NSF (2004, page 40).
2.6.5		Where possible, parents or carers are interviewed by professional/s with the competences to assess:
2.6.5a	2	<ul style="list-style-type: none"> • their family functioning past and present, presence of stressors and support, history of substance misuse and other psychiatric disorders Guidance: For example, assessments consider the needs and the impact of substance misuse and related problems on parents and siblings and vice versa.
2.6.5b	2	<ul style="list-style-type: none"> • assess community resources and risks Guidance: If specific community-based risks are identified, staff should follow clear protocols (within agreed terms of confidentiality and its limits) for teams to contact relevant agencies (most likely Police or Social Services). For instance, if there is evidence that a local dealer has started to target minors, or if there is emerging evidence of groups of sexually exploitative adults supplying minors with drink or drugs.
2.6.5c	2	<ul style="list-style-type: none"> • assess the parents or carers' ability and willingness to engage with, and support their child's treatment intervention and recovery

3.0

Integrated care planning

'The care plan should address an individual's full range of needs, taking into account their health, personal, social, economic, educational, mental health, ethnic and cultural background and circumstances'. [www.dh.gov.uk/en/Healthcare/Longtermconditions/DH_093359]. This should be a succinct and readable account of the young person's predicament and how it should be addressed. It is essential that consideration is given to the young person and their family's culture, faith and beliefs in all aspects of how the care plan is to be delivered.

Note: the term 'care plan' refers to both the overall care planned and specific plans for medical and therapeutic interventions.

3.1	Young people have care plans that are comprehensive, and are effectively co-ordinated to meet their needs (linked to QNCC 2.7)	
3.1.1	1	Young people have a written care plan for intervention (QNCC 2.6.1). Guidance: For examples of 'young people friendly' care plans for different parts of the therapeutic journey - see CASUS care plans on http://ambit-casus.tiddlyspace.com
3.1.2	2	This is overseen by a senior professional who has the skills to ensure the needs identified in the assessment are addressed through a holistic approach (linked to 2.4.1). Ref: Munro Report (2011).
Stem		The care plan:
3.1.3	2	<ul style="list-style-type: none"> is developed in collaboration with the young person and includes whether and how they would like their parent, carer or other family member to be involved in decisions about their care Ref: NICE (Patient experience, 1.3.10)
3.1.4		<ul style="list-style-type: none"> records the young person's agreed goals and desired outcomes
3.1.5	2	<ul style="list-style-type: none"> covers the whole period of care including aftercare or plans for transfer of care, and close liaison with family, education and other appropriate agencies
3.1.6	2	<ul style="list-style-type: none"> is drawn up in line with the principles outlined in the NTA (2008b) '<i>Commissioning young people's substance misuse treatment services</i>' Ref: NTA (2011b, page 7)
3.1.7	2	<ul style="list-style-type: none"> supports the involvement of parents or carers in its development and review (linked to 2.5.2) Ref: NTA (2008a)
3.1.8	2	<ul style="list-style-type: none"> outlines the arrangements agreed with other services or agencies to ensure the young person's educational, employment, debt, housing, and social care needs are met Ref: DrugScope (2010); NICE guidance relevant to young people.
3.1.9	2	<ul style="list-style-type: none"> addresses all the areas listed under 2.6.4 and 2.6.5 and the capacity and willingness of other agencies to support the planned interventions Guidance: For example staff may need to talk to schools, voluntary services, social services to establish their ability to support the intervention.
3.1.10	2	Young people's case notes record the range of professional disciplines and agencies that jointly agreed action plans to meet their identified needs.
3.1.11	2	Young people have a named key worker/professional who is responsible for ensuring their care is co-ordinated across services and agencies if required, and whose responsibilities are known to the young person and all those involved.

3.2 Young people's care plans are regularly updated and shared with relevant parties (QNCC 2.6)		
3.2.1	2	Care plans are reviewed at regular intervals and include discussions with the young person about whether the treatment is helping (QNCC 2.6.2).
3.2.2	2	Depending on severity, risk assessments in relation to substance misuse and co-existing problems are reviewed at regular intervals (e.g. 3 to 6 months).
3.2.3	2	The agreed goals of the young person and their parents or carers in the care plan are monitored at regular intervals (QNCC 3.5.3). Guidance: DH CPA (2008, page 20); CQC 16A.
3.2.4	2	Written copies of the reviewed plans are offered to the young person, their parents or carers and relevant others, such as the young person's GP and other partner agencies supporting the plan.
3.2.5	2	For young people approaching the upper age-limit of the service, plans for transfer are jointly agreed with adult services and include a six-month overlap in the delivery of care. Ref: CQC 4.4L; CQC 12.12B.
3.2.6	2	Wherever an element of an intervention detailed in the care plan does not take place, reasons for this are recorded in the case notes and communicated to the young person and their parent or carer (QNCC 2.7.3).

4.0

Integrated care and interventions

Recommended service delivery model - Assertive Outreach Model in partnership with other agencies (NTA, 2008a).

'Children and young people accessing specialist services for alcohol [and drug] use are offered individual cognitive behavioural therapy, or if they have significant co-morbidities or limited social support, a multi-component programme of care including family or systems therapy' (NICE Quality Standards. *Alcohol Dependence 'Specialist interventions for children and young people'*).

Note: CBT is recommended partly because it is the most evaluated form of therapy. Other models may be as effective. The main point is that a recognised form of structured therapy is offered by a competent person.

A meta-analysis suggests that good interpersonal skills as measured by warmth, empathy and genuineness, and provision of an acceptable rationale for the intended intervention are important (see Karver *et al*, 2006). Also, preparedness to engage in outreach, such as visiting young people where they are, rather than rely exclusively on clinic visits, and to offer reminders of meetings are likely to aid engagement.

Young people should experience care as seamless - where possible, and should have regular contact with the same worker/therapist who, with the support of others as required, is responsible for engaging the trust of the young person; this is a fundamental quality of a helping relationship.

www.nice.org.uk/guidance/qualitystandards/service-user-experience-in-adult-mental-health/ContinuityOfCare.jsp

See **CG 3 and 4** for further guidance and a summary of the evidence base for individual therapies and treating co-morbidity

4.1	Young people, and where appropriate their parents or carers, are offered a range of evidence based interventions to improve overall functioning and life chances	
4.1.1	2	Commissioners for children's services and providers have explicit agreements to ensure that the full range of evidence-based treatments for substance misuse and co-morbidity (according to NICE guidance and the best available evidence) are available for young people in need. Ref: NICE guidance (2007; 2008; 2011); Bevington, D (chapter on substance misuse in 'what works for whom' due to be published 2012); Perepletchikova <i>et al</i> (2008); Bukstein <i>et al</i> (1997); Drug Strategy (2010); CQC 4.4A; DH CPA (2008).
4.1.2	2	Agreements include partnerships for joint working that ensure young people with a co-occurring disability or long-term condition (such as a learning disability, an autism spectrum disorder or a sensory impairment) receive interventions that are provided by professionals with appropriate understanding and skills related to that disability or condition.

4.2		A range of psychosocial interventions is offered and delivered according to need, by competent and qualified professionals
4.2.1	2	For those with limited co-morbidities and good social support, young people are offered individual cognitive behavioural or equivalent therapy or skilled counselling (NICE Alcohol, 2010; 2011).
4.2.2	2	For those with significant co-morbidities and/or limited social support, young people are offered multi-component programmes (such as multidimensional family therapy, brief strategic family therapy, functional family therapy, or multi-systemic therapy) (NICE Alcohol, 2011).
4.2.3	2	Motivational and clinical engagement techniques are used to engage the young person, and work with parents, carers or wider family members, to secure their involvement in the care and intervention plan (linked to 2.5.2). Ref: See O'Leary-Tevyaw and Monti (2004) and Tait and Hulse (2003) for reviews of its use in adolescence.
4.2.4	2	Family therapy techniques are used to engage families and to facilitate positive change in a range of areas in the young person's life. Guidance: There is evidence to support the use of a range of family therapy interventions that focus on engagement with the young person and their family, their interactions and extra-familial domains of functions (Hogue <i>et al</i> , 2009). Ref: Hendriks (2011); Hogue <i>et al</i> (2009); Henderson <i>et al</i> (2009); Austin <i>et al</i> (2005).
4.2.5	2	For young people approaching the upper age-limit of the service, plans for transfer are jointly agreed with adult services and include a six-month overlap in the delivery of care. Ref: CQC 4.4L; CQC 12.12B.
4.2.6	3	Where appropriate, young people are offered peer-support and group therapies including: <ul style="list-style-type: none"> • Group CBT (see Kaminer, 2002; 2008; Dennis <i>et al</i>, 2004). Manuals: CBT-7, (Webb <i>et al</i>, 2002); MET/CBT-5 (Sampl & Kadden, 2001). Also see Dishion <i>et al</i> (1999) 'When interventions harm: Peer groups and problem behavior' • Psycho-educational interventions • 12-Step/Minnesota programme, such as Alcohol Anonymous or Narcotics Anonymous may be considered for older adolescents (16 +) as there is evidence for adult populations, but this is more equivocal for adolescents (Kelly <i>et al</i>, 2000). For older adolescents and young adults (18+) consideration needs to be given to the appropriateness of other members in the group for each young person
See CG3 for a summary of the evidence base for individual therapies		

Integrated care and interventions (continued)

4.3

A range of pharmacological interventions is offered and delivered according to need, by competent and qualified professionals (this will only be for a minority of young people)

Guidance

▲ The pharmacological management of substance misuse may help reduce self-harm and suicidal behaviour and, with the treatment of co-morbid ADHD for example, improve adjustment to school or college. Especially in the context of replacement therapy for those very few young people who develop dependence, the aim is to become drug or alcohol free. This requires structured treatment with the objective of achieving abstinence (*Drug Strategy*, 2010).

It should be:

- only one component of addressing substance-related needs
- tailored to a holistic assessment of the child or young person's needs
- delivered alongside relevant psychosocial and mental health interventions
- in the context of a clear clinical governance framework

For further guidance on pharmacological approaches for the treatment of substance misuse: see all NICE clinical and public health guidance for alcohol and drug misuse (2007–2011) including a technology appraisal of methadone/buprenorphine and of naltrexone for opiate use; DH guidelines on clinical management of drug use.

4.3.1	1	Where medication is used, prescribing protocols and best practice guidance are followed (e.g. NICE guidelines for over 16s) (linked to QNCC 3.1.4).
4.3.2	1	Young people and their parent or carer are given information to enable them to use any medicines correctly and staff check that they understand how to use the medicines as prescribed. <i>Ref: NICE (2012, Patient experience, 1.5.17)</i>
4.3.3	1	Prescribing is closely monitored and regularly reviewed by a competent and qualified professional (linked to QNCC 3.1.4).
4.3.4	3	Where possible (if the symptom severity, home setting and staff experience and resources allow), young people are offered outpatient or home-based detoxification, stabilisation and treatment as an alternative to residential care.

Alcohol (note few are dependent)

4.3.5	2	Young people with alcohol withdrawal symptoms are offered benzodiazepines to support their treatment. <i>Guidance: NICE Alcohol (2010) suggests a symptom triggered approach to detoxification in hospital settings. They recommend admission with full comprehensive assessment of all domains in those under 16 and careful consideration of admission for those 16-18 year olds with dependence.</i>
4.3.6	2	For young people with moderate to severe alcohol dependence, the treating professional considers the use of naltrexone and/or acamprosate. <i>Note: This is likely to be rare in this age group and this is particularly so for those under 16.</i>

4.0

Integrated care and interventions (continued)

4.3	<i>Continued</i>	
Opiates		
4.3.7	1	Young people with dependence on opiates are offered methadone or buprenorphine for detoxification with appropriate consideration of dose in relation to size and age. Ref: NICE Drug Misuse (2008).
4.3.8	2	Buprenorphine or methadone are used for longer term stabilisation treatment plan with frequent review. Guidance: Such drugs should be dispensed (at least until the client is well known and controlled) by pharmacists under a negotiated "Observed Consumption" agreement, by which the pharmacist observes the patient taking the medication and records this.
4.3.9	2	Young people receiving stabilisation for opiate dependence are offered psychosocial interventions to supplement this intervention and support their participation and engagement in treatment with the aim of achieving abstinence.
4.3.10	2	If relapse prevention treatment for opiate use is required by older adolescents (16+), ensure there is good supervision and support from family members when naltrexone is considered. Ref: NICE Technology Appraisal Guidance 115 (2007).
4.3.11	2	Professionals monitor length of substance use and the young person's engagement and adherence to their treatment plan.
Benzodiazepines		
4.3.12	2	For the few young people who are dependent on benzodiazepines, professionals consider short term use of diazepam to support detoxification.
4.4	Psychosocial and pharmacological interventions are offered and delivered by competent and qualified professionals	
Stem		Professionals offering and delivering care and interventions:
4.4.1	1	<ul style="list-style-type: none"> are qualified and have the competences required for the intervention they provide
4.4.2	2	<ul style="list-style-type: none"> receive supervision from qualified and competent senior professionals
4.4.3	2	Psychosocial interventions are offered by professionals competent in generic skills with young people. Guidance: Pilling <i>et al</i> (2011) notes the 'compelling evidence that variation in therapist competence and performance is a significant, and probably the single largest contributor to variance in outcomes in psychosocial interventions... A large number of competences...are generic and the essential building blocks of any psychosocial intervention... [these are] common factors in achieving positive outcomes... Therefore it is important not to stress the technical aspects/competences of particular interventions at the expense of the generic competences such as the importance of relationship building and the management of the therapeutic process'. Also see: www.ucl.ac.uk/clinical-psychology/CORE/child-adolescent.php
See CG4 for clinical guidance on the treatment of co-morbidity at the end of this section		

Integrated care and interventions (continued)

4.5	Young people, and parents or carers (where possible), receive prompt care and an intervention through a flexible appointment system that is responsive to their needs (QNCC 3.7)	
4.5.1	2	Young people receive their planned care and interventions promptly after assessment. Guidance: NTA (2011b; page 8) All young people assessed as requiring specialist treatment commence treatment within 15 working days of referral.
4.5.2	1	Young people and parents or carers are given information about what to do and who to contact for support and help when required, particularly in an emergency 'out of hours' (linked to QNCC 3.2.3). Ref: NICE (2012, <i>Patient experience</i> , 1.4.6).
4.5.3	2	Professionals are resourced to work intensively and flexibly with young people, and parents or carers, as required to meet their needs, and to secure and maintain their engagement. Guidance: DAT recommended averages for contact e.g. 3 to 5 contacts a week (including home-visits, phone and text contact).
4.5.4	2	Continuing treatment and support is offered to those with persistent and complex needs, until the need for the intervention is resolved, rather than time-limited interventions.
4.5.5	2	The times and location of appointments or contacts are agreed and regularly reviewed in consultation with the young person, and their parent or carer (if appropriate) (linked to 2.2.3).
4.6	Professionals prioritise a flexible and assertive approach to engaging young people, and their parents or carers, in the treatment intervention (linked to QNCC 3.8)	
4.6.1	2	Young people are offered care and interventions in their home or other safe informal locations in the community (e.g. specialist substance misuse treatment service/drug and alcohol service, youth centre, GP practices, health centres, YOS) (linked to 2.2.4). Guidance: See DrugScope (2010, page 26) consultation with young people found that many were attracted to engaging with Drug and Alcohol Services through a positive relationship with their key worker, access to computers or musical instrument equipment, access to peer-support and meeting up with others in a safe and stimulating environment.
4.6.2	2	Staff continue with assertive efforts to engage with young people who do not attend planned contacts and disengage from treatment (e.g. texted reminders, follow-up of missed appointments and home/hostel visits). Guidance: '...proactive, assertive engagement, particularly with young people at higher risk (e.g. young people at risk of offending/offenders)' (see DH, 2011, page 32).
4.6.3	2	Staff inform the referrer, and the appropriate bodies if there are risks or safeguarding concerns when a young person does not engage with the assessment or intervention, after all reasonable steps are taken to achieve successful engagement (QNCC 3.8.6).
4.6.4	2	The treatment service monitors successful and/or failed engagement in their intervention programmes and discuss lessons learned (QNCC 3.8.7).

4.0

Integrated care and interventions (continued)

4.7 Professionals provide support and guidance to enable young people and their parents or carers to help themselves (QNCC 3.3)		
4.7.1	2	Young people are supported to pursue plans relating to personal development and learning, and their aspirations and goals.
4.7.2	2	Young people are guided in self-help techniques, coping strategies and receive guidance on how to reduce or abstain from substance misuse and lead a healthy lifestyle. <i>Guidance:</i> These aspects may include sexual health, pregnancy, drugs, smoking, diet, and so on. Direction to relevant services may be required.
4.7.3	2	Where it would support the treatment benefits post-care, young people and their parents or carers are sign-posted to local voluntary organisations and peer and self-help groups, including culturally specific groups and organisations (linked to 3.3.4).
4.8 Young people and parents or carers experience collaborative and consistent care (QNCC 3.4)		
4.8.1	2	Young people and parents or carers have regular discussions with key professionals about the young person's progress and, where relevant, diagnosis (QNCC 3.4.1).
4.8.2	2	Young people and parents or carers are provided with information about the evidence-base, and the risks, benefits and side effects of intervention options and of non-intervention (QNCC 3.4.2). <i>Guidance:</i> For example, staff provide young people and their families with NICE/Cochrane guidelines about the treatment for particular conditions.
4.8.3	2	Young people and parents or carers consistently see the same professional for any given intervention, unless their preference or clinical need demands otherwise (QNCC 3.4.5). <i>Guidance:</i> For example, this may be their key worker or care co-ordinator.
4.9 Outcome measurement is undertaken routinely using validated instruments (QNCC 3.5)		
DH 'No health without Mental Health' (2011d, page 32) 'coordinated interventions [should be] planned around outcomes agreed by the user of the service, tailored to their individual needs, choices and preferences, with a recovery-based focus on building individual strengths and improving quality of life, including improvements in employment, accommodation and social relationships'.		
4.9.1	1	Staff monitor clinical and patient reported outcomes (PROMs) at regular intervals using validated outcome instruments that are specific to the treatment of the substance misuse problem, co-morbidity and other co-existing problems. <i>Guidance:</i> For overall functioning see instruments employed by CORC (CAMHS Outcome Research Consortium- www.corc.uk.net) for example the HoNOSCA (includes an item on substance misuse), SDQ and CGAS.
4.9.2	2	Outcome measurement is completed from the perspective of the young person, the professional providing treatment, and parents/carers at a minimum (QNCC 3.5.4). <i>Guidance:</i> DH CPA (2008; page 20) "an outcomes focus can help to improve the impact of services on the lives of the people who use them; give assurance that treatments and care are producing results; and ensure that outcomes related to treatment, care and support are monitored on an ongoing basis". <i>Ref:</i> Children's NSF (standard 9); Self-assessment 10 (ii).

Integrated care and interventions (continued)

4.9	<i>Continued</i>	
4.9.3	2	Resources are available to support the routine evaluation of outcome (QNCC 3.5.1). Ref: CQC 16A.
4.9.4	2	For young people over 16 years, progress throughout their planned care and intervention is monitored using the treatment outcomes monitoring instrument (Treatment Outcomes Profile-TOP) and is reported through the National Drug Treatment Management System (NDTMS) or NHS database equivalent. Ref: NTA (2011b, page 7)-In April 2012 the NTA reported that they are consulting on TOP for young people under 18 years.
4.9.5	2	Individual outcome measurement data is discussed with the young person as part of their care planning (QNIC 4.7.4).
4.9.6	2	Information from outcome measurement is: <ul style="list-style-type: none"> • fed back to young people, parents or carers, the staff and professionals providing care, and commissioners • is used to inform service evaluation and development (QNCC 3.5.5) Ref: Children's NSF (9) 9.20.
4.10	Young people and parents or carers are encouraged to give feedback on the service and their responses are reported back to them (QNCC 3.6)	
4.10.1	2	Young people and parents or carers are actively encouraged to give feedback on the service and interventions they receive (QNCC 3.6.1). Guidance: For example, this may take the form of suggestions boxes, discharge questionnaires, follow-up letters, satisfaction surveys, focus groups or young people's consultation groups. Ref: CQC 1J; You're Welcome (2011; 7.1 to 7.3).
4.10.2	2	Young people are actively involved in the development of services that respond to the needs of young people with substance misuse and co-existing problems (adapted QNCC 3.6.2). Guidance: This should include substantive participation, for example, in staff training, service policies and information; this may be achieved through a young people's panel or equivalent. Ref: CQC 1J; You're Welcome (2011; 7.1 to 7.3).
4.10.3	2	Feedback from young people and their parents or carers is monitored and used to inform service evaluation and development (QNCC 3.6.3). Ref: CQC 1J, 16A, 16C; You're Welcome (2011; 7.1 to 7.3).
4.10.4	2	Young people's views on their therapeutic relationship with their key worker/main professional are sought throughout their contact with the service (e.g. on a session-by-session basis) to monitor their engagement and experience of treatment and inform their care plan (QNCC 3.6.4). Guidance: The ChASE is an instrument recently validated for use among 8 to 18 year olds accessing CAMHS to assess the quality of their service experience and therapeutic relationships; see (Day <i>et al</i> , 2011).
4.10.5	2	Young people and parents or carers are given information about how to make a complaint and are helped in how to access complaint procedures. Ref: NICE (2012, <i>Patient experience</i> , 1.3.13).

We acknowledge that the evidence base for individual programmes of this sort of integrated manualized approach is thin, and those studies that do exist have mostly been carried out in locations geographically (and culturally) remote from the UK. For this reason, and at this point in time, no single “brand” of complex multi-component program is recommended over another, but from the research there does appear to be value in the use of a single coherent approach that is shared across a whole team.

Therapeutic approaches may include:

- ▲ **Cognitive behavioural therapy (CBT)** is considered for young people with substance misuse problems and co-morbid depression and anxiety disorders (NICE, 2007, 1.4.6.1 and 2, page 14). Various combinations of motivational enhancement therapy with CBT have been used – often as control conditions for more expensive and complex treatment packages, and in some cases this is formally manualised and published. In general, combinations of motivational and cognitive behavioural work have been found to perform well in comparisons – especially if economic analysis is included in the evaluations.
- ▲ **Dialectical behaviour therapy (DBT)**: randomized trial data derives from adult studies that include many younger adults. Herved *et al* (2008) demonstrated that in its effect on substance misuse, it was superior to a high quality comparison. Authors attributed this to directly targeting substance use through ‘...self-monitoring, behavioral analyses and problem-solving strategies...’ (Herved *et al*, 2008).
- ▲ **Contingency management programmes** are considered if the offer of incentives will help to promote engagement, behavioural change and adherence to treatment (see NICE, 2008, pages 12 and 13 for brief guidance on delivery; see Bevington, D chapter in ‘what works for whom’ due to be published in 2012).
- ▲ **MST-CM is the contingency management module for multi systemic therapy (MST)**. This is an intensive, home-based intervention that operates according to a broadly eco-systemic and behavioural framework. It should have strong supervisory structures that support adherence to the monitoring of fidelity, in the context of very small caseloads for workers. It is mostly evidenced in young people who have been mandated into treatment, and not in the UK context (where there is a much richer multi-agency environment than the [mainly US] settings where it has been trialled to date). Thus it may be less transferable to mainstream services that must manage all kinds of referrals. It also excludes young people without families around them, and therefore excludes some of the youth at highest risk (those who are functionally homeless or living in low support hostels, etc.).
- **Systemic/family based intervention**: early outcome evaluation from a small pilot study demonstrated effectiveness in young people who present with mental health problems, substance misuse and complex psychosocial problems (Richards, 2011). The innovative treatment model is cost effective and the evidence base is still under development (Mirza *et al*, in press).
- **Multidimensional family therapy (MDFT)** has not been formally trialled in the UK, but has some evidence in the US and Canada. It was one of the treatments in the large Cannabis Youth Treatment trial, and although it performed well, there were few differences in main outcomes between it and much cheaper brief motivational and CBT approaches (it did show particular effectiveness for the most severely affected youth). In common with other complex treatment models, it purposefully works across multiple functional domains, is highly intensive, and is home and community-based.
- **Adolescent mentalization-based integrative therapy (AMBIT)**. AMBIT is an “open source” approach to therapy, and provides a web-based platform for local services to develop adapted and locally-attuned programs that deploy evidence-based practices, rather than prescribing a ‘fixed menu’. Emphasis is placed on engagement and relational aspects to the work, the use of peer-to-peer supervision, and attention to ‘dis-integration’ in the multiagency network. It has a small amount of data from early outcomes evaluation suggesting effectiveness with young people who present with complex co-morbid substance use, mental health, family, educational and offending problems. (This is an innovative treatment model, and the evidence base is still under development; Bateman and Fonagy, 2006; Bevington *et al*, 2011; Bevington *et al*, in press)-see <http://ambit.tiddlyspace.com>
- **Social-ecological interventions**: Anecdotal evidence suggest that large scale, systemic and appreciative inquiry based approaches involving the whole community can produce lasting benefits to young people presenting with substance misuse and complex psychosocial problems involving severe marginalisation (McAdam and Mirza, 2009).

Substance misusing young people, especially those whose difficulties are such that they reach services, commonly experience complex and sometimes intractable co-morbidity, often against a background of privation and adversity. This subgroup should receive an integrated intervention as far as possible involving evidence based treatment (EBT) while acknowledging that crucial interventions such as support at school are largely unevaluated. Interventions offered need to be of sufficient intensity and length to potentially alter the young person's developmental trajectory. It should include elements of assertive community treatment including:

- ▲ rapid access to services
- ▲ a small case load
- ▲ a designated and skilled practitioner
- ▲ assertive engagement (e.g. with multiple attempts)
- ▲ a shared care approach with care co-ordinators working within a multidisciplinary team that meets frequently

Professionals should extrapolate treatment from the evidence base for young people and adults (NTA, 2008b), from shared clinical experience and in the knowledge of available local resources. Intervention should address the developmental needs of young people for safety, care and shelter, education and training as well as specific interventions for their mental health (e.g. depression) and substance use.

While evidence based treatments differ in important aspects, it is likely that they also share important active characteristics. These may include:

- ▲ socially skilled, charismatic therapists (Slesnick *et al*, 2006);
- ▲ a strategic direction generating tailored, focused and purposeful rather than haphazard actions, based on a convincing rationale;
- ▲ a capacity to engage with complexity, to mobilise other services, and to organize lasting support (e.g. through education, social care or other relevant resources) [Winters and Kaminer, 2011; Slesnick *et al*, 2006 and 2009; Burns *et al*, 2007; Karver *et al*, 2006]

We are not advocating that all services should offer EBT as originally designed, but they should have the capacity to offer interventions that operate on similar principles.

Attention deficit hyperactivity disorder and substance misuse commonly co-occur. This presents a challenge. The long-term effects of effective treatment of ADHD and its protective effect against a later substance use disorder (SUD) have been documented (Wilens *et al*, 2008). Existing evidence indicates that treatment of ADHD with medication does not increase the risk of the development of substance misuse in the treated individual. Indeed, pharmacological treatment should not be postponed pending resolution of substance misuse as key opportunities for intervention may be lost.

- ▲ Young substance misusers are at risk of diversion of prescribed drugs. This may apply particularly to short acting methylphenidate and perhaps in the absence of a focus for constructive, prosocial activity (as an alternative to substance misuse)
- ▲ Long acting preparations, which are more difficult to misuse, and less intrinsically rewarding, are preferable
- ▲ Other agents such as Atomoxetine and Bupropion are believed to be also less prone to misuse (Mirza and Bukstein, 2011)
- ▲ A novel pro-drug Lis-dexamphetamine is available in the US and is expected to be licensed for use in the UK in 2013. Early results from the US indicate that the above drug is very difficult to be snorted or injected two common forms of abuse of stimulants.
- ▲ Use medication as part of an overall plan involving, for example, education or training and improving family relations.
- ▲ A reliable person (e.g. a family member or hostel staff) should undertake responsibility for the safe supervision and cooperation with the medication regime, supported by reviews to clarify discrepancies
- ▲ Similar general principals apply to the pharmacological treatment of depression and psychosis. Medications should, if possible, be used purposefully and generally in the context of a plan including supportive therapeutic, family or other relationships, supervision and review

Treatment of other co-morbid psychiatric disorders

Similar general principals apply to the pharmacological treatment of depression and psychosis. Medications should, if possible, be used purposefully and generally in the context of a plan including supportive therapeutic family or other relationships, supervision and review.

5.0

Planned completion and transfer of care

This section aims to provide standards of best practice for young people who are being transferred:

- ▲ from the service after completing their care plan
- ▲ to intensive community or residential treatment
- ▲ to adult drug and alcohol services and mental health services.

Transfer after completing their care plan

5.1	Young people and parents or carers are involved in agreeing arrangements for leaving the service and know how to re-access help if they need it (QNCC 6.1).	
5.1.1	1	Young people are offered a discharge planning meeting before leaving the service.
5.1.2	1	Young people and parents or carers (where possible) are involved in agreeing plans for completing their care and leaving the service, and their views are recorded in the notes. <i>Ref: CQC 4C 16D; Children's NSF, page 138.</i>
5.1.3	2	Agencies and professionals involved in supporting the care plan are invited to attend the discharge planning meeting.
5.1.4	2	Young people reaching the upper age limit of the service, who do not need a referral to an adult specialist substance misuse treatment service or mental health service, are informed about how to access these services later on if needed (QNCC 6.1.3).
5.1.5	2	If young people stop attending appointments before formal arrangements for this are made, there are procedures in place to facilitate their return to the service (QNCC 6.1.4). <i>Guidance: For example, the key worker contacts the young person or parent/carer to discuss reasons for leaving and this is used to inform service evaluation and audit.</i>
5.2	The treatment service makes arrangements to ensure that young people are offered continuity of care when they move on from the service (QNCC 6.2)	
5.2.1	2	When young people are to leave the service the care programme approach is completed where appropriate (QNCC 6.2.1). <i>Guidance: See 'Refocusing the care programme approach' for guidance as to when the CPA should apply; DH (2011, page 32), "co-ordination of care and support - using tools such as the care programme approach".</i>
5.2.2	2	When young people leave the service, their key worker or equivalent takes responsibility for planning this (QNCC 6.2.2). <i>Guidance: This would include the care co-ordinator for services which participate in 'Team Around the Child' processes (Department of Education, 2009).</i>
5.2.3	2	When transfer of care is planned, the roles of the agencies involved in any subsequent care are clarified, agreed and documented beforehand (QNCC 6.2.3). <i>Ref: CQC 6C.</i>
5.2.4	2	For young people who are Looked After, arrangements for their continuing care are planned in conjunction with the relevant social services departments (QNCC 6.2.4).

Planned completion and transfer of care (continued)

5.2	<i>Continued</i>	
5.2.5	2	When young people leave the service, a summary letter outlining recommendations for future care is sent to their GP and any other agencies involved (QNCC 6.2.5).
5.2.6	2	On leaving the service, there are agreements with other agencies for young people to re-access the service if needed, without following the initial referral pathway (QNCC 6.2.6). Guidance: There may be exceptions where young people require a generic assessment and where it may be appropriate to follow the initial referral pathway.
5.2.7	3	Staff and services are resourced to follow-up young people who have left their service to detect any further need of support or an intervention. Ref: Allotey (2011).
Transfer to residential care		
5.3	Young people who require residential care are referred to units that meet their individual needs with effective continuing care (QNCC 6.3)	
5.3.1	2	Young people are offered a referral to a safe and age-appropriate unit that meets their developmental needs, working with their choices and preferences (QNCC 6.3.1). Ref: Children's NSF (2004, standard 9, page 5).
5.3.2	2	Young people are offered a referral to a unit that is as accessible as possible so that contact with home and family is maintained (QNCC 6.3.2). Guidance: 'Outcomes are improved due to less disruption the ability to maintain wider family ties and the ability for supportive services to be provided in an ongoing way' (Children Act 1989; revised regulations and care planning for Looked After Children). Ref: Children's NSF (2004, standard 9, page 19).
5.3.3	1	There are clear procedures for staff to follow in situations when residential beds are required but are not immediately available within the relevant service (QNCC 6.3.4). Guidance: Local authorities and substance misuse partnerships have to give due consideration to these high intensity low demand cases prior to placement being required. It is in these circumstances that integrated services can assist in the delivery of a child centred response to the needs of these complex young people with substance misuse problems. This can be best carried out with complex care panels with a joint agency response and shared case planning.
5.3.4	2	If residential care is required, the key worker or equivalent contacts the service soon after admission and attends review meetings (e.g. CPA meetings) during the inpatient stay (QNCC 6.3.5). Guidance: 'When children and young people are discharged ... into the community and when young people are transferred from child to adult services, their continuity of care is ensured by use of the 'care programme approach'. Ref: Children's NSF (2004, standard 9, recommendation 10, page 5).

5.0

Planned completion and transfer of care (continued)

Transfer to adult specialist substance misuse treatment service		
5.4		Young people and parents or carers are involved in agreeing arrangements for leaving the service and know how to re-access help if they need it (QNCC 6.1).
5.4.1	2	A written transition policy is in force and followed which states the age for referral to adult services (QNCC 6.4.1). Guidance: The national CAMHS review recommends that the transition process starts by age 17.5; You're Welcome (2011, 8.3).
5.4.2	1	Young people aged below the locally agreed cut-off for referral to adult services are not referred unless in exceptional circumstances (QNCC 6.4.2). Guidance: This may occasionally be appropriate if there is good clinical cause which outweighs developmental and/or other needs.
5.4.3	2	Joint reviews of young people's needs are held with adult services (e.g. using the CPA) and the young person to ensure that effective handover of care takes place (QNCC 6.4.3). Ref: CQC 6M; Children's NSF (2004, standard 9, recommendation 10, page 5).
5.4.4	2	Young people with co-morbid autistic spectrum disorders, are directed to other support where the young person does not meet the criteria for adult services (adapted QNCC 6.4.4).
5.4.5	3	Young people's services have a named link person with responsibility for transitions so that professionals and young people know who to approach with queries (QNCC 6.4.5).
5.4.6	3	There is a handover period during which the young person is seen by the young people's service and the adult service jointly (QNCC 6.4.6). Guidance: 6 months is an appropriate period.
5.4.7	3	Where young people reaching the upper age limit of the service are not referred to an adult service, but access adult services at a later date, the young people's service will provide liaison to the adult service, if needed (QNCC 6.4.7).
5.4.8	2	Young people referred to adult services are provided with a transition pack which contains information on: <ul style="list-style-type: none"> • what to expect after transfer to the new service • the roles of the professionals from the adult service (for example general adult psychiatrist, substance misuse worker/specialist, CPN) • who to contact if there is a problem (QNCC 6.4.8) Ref: You're Welcome (2011, 8.5).
5.4.9	3	Young people referred to adult services are allocated a transitions mentor to support the transfer, who should be either an independent advocate or based within the adult services (QNCC 6.4.9).

Appendix 1

Defining what constitutes problematic substance use is crucial

By Dr KAH Mirza

Most children in their middle childhood are exposed to various substances including alcohol and tobacco, and only a minority use and continue to use drugs through adolescence and into adulthood. The risk of developing problematic substance use is higher in those with developmental and social risk factors.

How do we make sense of the high frequency of the occasional 'recreational' or 'normative' drug use versus the relative infrequency of substance abuse or dependence?

Let us look at some pieces of evidence:

Evidence from longitudinal studies such as the Christchurch study show that while many young people (nearly 70%) used cannabis at some time, less than 7% showed features of abuse or dependence (Fergusson *et al*, 2000 and 2007). Factors that increase the risk for initiation to substance use are different from the factors that increase the risk for substance abuse or dependence. The other issue is whether there is a gate way effect: for example whether use of one substance leads to poly substance use and problematic substance use? The longitudinal studies from New Zealand show that virtually all (99%) people who used other illicit drugs have used cannabis first, but nearly two thirds of cannabis users did not use other illicit drugs.

We also know that the extent of cannabis use strongly predicted whether they will progress to other illicit drug use. Heavy users of cannabis (those who used more than 50 times in the previous year) were 140 times more at risk than young people who did not use cannabis at all. There may be a number of factors to account for this including the possibility that cannabis use puts young people in contact with substance using peers and drug sellers. But even when these personal and experiential risk factors were

taken in to account, heavy, regular use of cannabis still predicted other illicit drug use later in life (Fergusson, 2000).

Are there different stages of substance use in young people? A developmental approach

It may make intuitive sense to adopt a developmental approach to describe the heterogeneous patterns of substance use in young people. Not all substance use in adolescence is problematic. It is quite likely that young people go through different stages before they develop substance abuse (harmful use) or dependence. We need to define different stages on the pathways and how to give clear information to parents and young people regarding when they should be concerned about their substance use (universal prevention) and who should be assessed more thoroughly for the details of their substance misuse and other risk or protective factors (targeted prevention).

Based on the work of some of our colleagues from different parts of the world, we have tried to come up with a pragmatic way of defining the different stages of substance misuse in young people. This developmentally sensitive and dimensional model tries to classify the stage of substance use in young people - starting with non use at one end, moving through experimental stage, social stage, at risk (prodromal) stage, and stage of harmful use to substance dependence on the other end.

The above model has been found to be very useful in our clinical practice and research studies are currently underway to test its usefulness in a population sample (see table 1 for details).

Based on this model, the experimental stage and social stage are seen as normative stages, albeit with different patterns (mind altering effects of drugs are important in the social stage). But as far as we know when young people **actively seek drugs**,

irrespective of whether their mates are going out with them or not, that should ring warning bells for you. This stage (the at risk stage) is rather difficult to identify and time and effort, and a sensitive approach are essential to help the young person to disclose the impact of substance use on their lives. The last two stages (harmful use and dependence) are perhaps easy to define – when the problems are clearly obvious to all.

I wish to emphasise that the above stages are not water tight compartments and many young people do not go through all stages or move from one to another. The model simply helps us define the stages of substance use at any particular time and decide what interventions they need, if any.

Implications for standards:

Universal prevention: Could we tell all young people to check where they are in terms of their substance use - based on the characteristics described such as whether they actively seek drugs, even when their mates are not keen to go out, do they use on their own, if they think they are on a slippery slope they can pull themselves back or seek help. Parents, teachers and others who come in to contact with children can also help their children, if they suspect that the child has moved beyond the normative (experimental and social) stages.

All who are at the 'at risk' stage would require an assessment to ascertain the impact of substance use in their lives and whether they need a full assessment by a specialist in substance misuse. We need to make sure that those who do the screening or a brief assessment should do it in such a way that it helps the young person to find a way to deal with their problems. We may have only one session with the young person and we should make the best of it, so motivational interview (MI) based approaches may be quite helpful in this regard.

Appendix 1

Table 1 Stages of substance (alcohol and drugs) use and suggested interventions: a pragmatic classification (Mirza and Mirza, 2008, 2011, Gilvarry *et al*, 2001).

Table modified and reproduced with permission from Mirza and Mirza, (2008), Elsevier Publishers, London

Stage	Motive	Setting	Frequency	Emotional impact	Behaviour	Impact on functioning	Suggested Interventions (Gilvarry <i>et al</i> , 2001)
Experimental stage	Curiosity and risk taking	Alone or with peer group	Rarely or very occasionally	Effect of alcohol or drugs is usually very short term	No active alcohol or drug seeking behaviour	Relatively little; may rarely result in dangerous consequences.	Universal prevention (Drug and alcohol education – formal or informal)
Social stage	Social acceptance/ the need to fit in	Usually with peer group	Occasional	Mind altering effects of drugs are clearly recognize	No active alcohol or drug seeking behaviour	Usually no significant problems, - but some can go on to show features of the early at risk stage	Universal prevention (Drug and alcohol education – formal or informal)
Early 'At Risk' stage	Social acceptance / peer pressure / beliefs valuing substance-led experiences, based on pleasurable early experiences	Facilitated by peer group	Frequent, but variable, depending on peer group	Mind altering effects of drugs are clearly recognized and sought	No active alcohol or drug seeking behaviour – but develops a regular pattern of drug / alcohol use	Associated with significant dangers problems associated with acute intoxication (e.g. accidents related to recurrent binge drinking)	*Targeted intervention/ treatment by non-specialist services (e.g. GP, school health worker, young people's counseling services, health care staff working in CAMHS, paediatrics etc)
Late at risk stage (substance use is not dominating mental state)	Cope with negative emotions or enhancing pleasure through wider experimentation	Alone or with an altered/-selected (e.g. drug or alcohol using) peer group	Frequent / regular use	Uses alcohol or drugs to alter mood or behaviour	Active alcohol or drug seeking behavior is a key indicator of this stage	May be impairment in functioning in some areas (e.g. school and family)	Treatment by specialist services (see below) – for both mental health issues and progression of substance use to further serious stages
Stage of harmful use or substance abuse (similar to ICD-10 or DSM-IV)	Alcohol or drug use is the primary means of recreation, coping with stress or both	Alone or with an altered (alcohol or drug using) peer group	Regular use, despite negative consequences	Negative effects on their emotions and ability to function	Active alcohol or drug seeking behavior, despite negative consequences across many areas of life	Impairment in almost all areas of life and or distress within families or close relationships	*Treatment by specialist services (e.g. specialist substance misuse treatment services for young people and specialist substance misuse professionals within CAMHS)
Stage of dependence (Similar to ICD-10 and DSM-IV)-(Only a rare minority of YP progress to this stage)	To deal with withdrawal symptoms, and stop craving.	Alone or with like-minded peer group	Compulsive, regular or often daily use to manage withdrawal symptoms	Emotional impacts of alcohol or drugs are very significant. Withdrawal symptoms prominent	Active alcohol or drug seeking behaviour, often loss of control over use, pre-occupation with alcohol/drug use, craving, and behaviour may involve criminality	Physical and psychological complications, impairment in all areas of life	*Treatment by specialist services including detoxification and for some residential rehabilitation

*For some the involvement of agencies and services, other than substance misuse services, may be required

Appendix 1

Case vignettes to illustrate the stages described in table 1

Experimental stage:

Roy, a 14 year old young student smoked weed with his friends during the lunch break at school. He felt weird, very giggly and talkative, but he was able to go back to the class around 3pm. However one of his friends started crying after smoking weed and became suspicious; accusing others, even strangers of trying to harm him. His friends had to look after him until late in to the night when he calmed down on his own. Roy was very concerned about the above, and is not sure whether he wants to try weed again.

Social stage:

Tom, a 16 year old young student goes out with his mates over the weekend, mostly Friday night only. Drinks 1 or 2 cans of lager, except when there are special occasions. He and friends have a lot of fun with mates, without getting in to any trouble and usually reaches home no later than 11.30pm-12.00. During A level exam time, the group decides to stop going out for a month.

Early at risk stage:

Mike, a 15 year old student goes out with his mates over the weekend, usually Fridays and Saturdays, at times on Sunday nights as well. He drinks on average 4-5 pints of 8% lager in one sitting and ended up in the A&E department in an intoxicated state on a couple of occasions over the last few months. He has smoked weed on a few occasions and ecstasy once, with his friends. However they do not get in to trouble with law and are generally doing well at school. Mike does not go out on his own or drink when his mates are not around. He is keen to cut down for the sake of his mother whom he cares about a lot, but struggles to say no to his mates.

Late at risk stage:

Stacey is a 16 year old young girl who is currently not in education or training. She has been seen in CAMHS following a few overdoses, but failed to attend further appointments. She was prescribed antidepressants by her GP, but she told me that it does not work. She drinks 2-3 times per week on her own or with her friends. She drinks about a half bottle of vodka in one sitting and smokes weed once or twice a week. She usually drinks when she feels low in mood or has flashbacks about past sexual abuse from her stepfather. "I can block things out from my mind when I am plastered. I know it is bad for me, but nothing else has helped me so far".

Harmful use/substance abuse:

Johnny is a 16 year old young man who was recently expelled from school for aggressive behaviour and smoking weed in school. He has been smoking weed, almost every day for more than 1 year and has been hanging out with a group of young people who has been getting in to trouble with police. He drinks heavily, about 4-5 pints of lager and a few spirits per sitting, at least 3-4 times per week. He has got in to fights after a few drinks and was charged with driving while drunk and drunken and disorderly behaviour. He has stolen from home and outside and there are major strains in relationship with family members. He is due to attend his first appointment with the local Youth offending Team.

Substance dependence

Paula is a 17 year old looked after child living in a residential home run by the local authority. Her mother has a history of intravenous drug use and dad is in jail for abusing her older sister. She has been using a number of drugs including cannabis, alcohol, cocaine, ketamine and heroin from the age of 12- 13 years and has been using heroin daily over the past one year. She uses alcohol and ketamine from time to time, but heroin is her favourite drug, though she has never injected it. She has tried to cut down a number of times, but failed to do so in account of severe withdrawal symptoms. She shows features suggestive of PTSD and depression, and has been engaged in self cutting on a regular basis for the past few years. However she failed to engage with CAMHS and the frequent changes to the care placements contributed to the above. She engages in fleeting relationships and has failed to hold down any jobs or educational placements. She feels hopeless.

Appendix 2

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Appendix 3

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How to improve the standards

- Add more guidance on the treatment of co-morbidity
- Remove all jargon so that it is accessible to all
- Focus on an integrated approach
- Outcomes should be targeted and relate to specific goals and the aims of interventions

How could the standards benefit young people and their parents or carers?

- Give young people and carers an idea about what to expect
- It would help to inform a young person's charter
- Provide clarity on the range of options that should be made available to young people
- Encourage collaborative relationships with young people and their parents or carers where possible

How could they help inform practice?

- Encourage a consistent approach across sectors and agencies to how young people at risk are identified, assessed and offered evidence-based care and interventions
- Help to raise awareness for treating substance misuse and co-morbidity issues

How could they support service improvements and the response young people receive?

- Could be used to assess local provision and identify gaps
- Useful benchmark for practice
- Inform training needs and help to promote evidence-based practice

Potential barriers to informing practice and achieving a consistent approach

- Having separate targets and budgets
- Provision of training

ACRA

Adolescent community reinforcement approach

ACMD

Advisory council on the misuse of drugs

A&E

Accident and emergency departments

AMBIT

Adolescent mentalization-based integrative therapy

AUDIT-C

Alcohol use disorders identification test – consumption items

ASSET

Adolescent substance use skills education training

CAF

Common assessment framework – an assessment tool for use across all professionals working with children

CBT

Cognitive behavioural therapy

CAMHS

Child and adolescent mental health services

CPA

Care programme approach – systematic assessment of an individual's health and social care needs, care plan, key worker and regular review of progress

CYT

Cannabis youth treatment study

CORC

CAMHS outcome research consortium

CGAS

Children's global assessment scale

CPN

Community psychiatric nurse

CRAFFT

Is an acronym of the first letters of key words in the six screening questions
[<Click this link>](#)

CQC

Care quality commission

DAT

Drug and alcohol team

DBT

Dialectical behavioural therapy

DNA

Did not attend – when a young person misses a planned appointment

DUST

Drug use screening tool

DH

Department of Health

EBT

Evidence based treatment

GP

General Practitioner

HoNOSCA

Health of the nation outcome scales for children and adolescents

IAPT for YP

Improving access to psychological therapies for young people

MASQ

Maudsley adolescent substance misuse tool

MDFT

Multidimensional family therapy

NDTMS

National drug treatment management system

NHMDU

National mental health development unit

NICE

National institute of clinical excellence

NPS

New psycho-active substances

NSF

National service framework

NTA

National treatment agency

PH

Public health

PHSE

Personal, health, social and education

QNCC

Quality network for community CAMHS

SASQ

Single alcohol screening questionnaire

SDQ

Strengths and difficulties questionnaire

SQIFA

Screening questionnaire interview for adolescents employed by staff working in the youth justice system

TOP

Treatment outcomes profile

YOT

Youth offending team

YJS

Youth justice system

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