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POLICY: THE PRINCIPLES OF SERVICE ORGANIZATION AND PRACTICE

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International policies
The UN Secretary-General, Kofi Annan, has remarked that “The proliferation of drugs over the past 30 years is an example of the previously unimaginable becoming reality very quickly” (UN General Assembly 1998a). This “tragic reality” has been attributed to many factors and disproportionately affects the already disadvantaged, the street children of developing countries and the marginalized youth of the developed world (Harris 2000).

A special session of the UN General Assembly (1998b,c) devoted to drug abuse called upon “our communities, especially families, and their political, religious, educational, cultural, sports, business and union leadership, non-governmental organizations and the media worldwide to actively promote a society free of drug abuse, especially by emphasizing and facilitating healthy, productive and fulfilling alternatives to the consumption of illicit drugs, which must not become accepted as a way of life”. They proposed a balanced approach between demand and supply reduction (largely through law enforcement). Drug demand reduction should involve not only prevention but also “treatment and rehabilitation . . . to enable social reintegration”. There should be “comprehensive, multifaceted, coordinated and integrated . . . multisectoral collaboration” to “improve health and well-being”, paying “special attention to youth”. This collaboration was perceived to include an array of groups and organizations including parents, teachers and health professionals.

Expanding on the UN principles, the current EU Drugs Action Plan (Council of the European Union 2005) proposes that demand reduction should incorporate: “the development and improvement of an effective and integrated comprehensive knowledge-based demand reduction system including prevention, early intervention, treatment, harm reduction, rehabilitation and social reintegration measures” and ensuring “the availability of and access to targeted and diversified treatment and rehabilitation programmes” including “psychosocial and pharmacological approaches” in the context of “social reintegration programmes”.

Interestingly, the EU argues that there has been a decline in drug-related harm within the EU despite no fall in drug consumption and implies that this may be attributed to increased treatment availability.

The European Alcohol Action Plan (WHO 2000) is an expert document that advocates a “combined approach” to psychoactive substances. It notes “anecdotal evidence . . . from all over the Region” that drinking by young people is moving toward “drinking more on more frequent occasions”, that “alcohol related social problems” are common, and that alcohol products “are estimated to be responsible for 9% of the total disease burden within the Region”.

It promotes a range of preventative measures including fiscal measures to prevent harmful use, and advises EU member countries to “provide children and young people with effective skills to make healthy choices” via “skill-based learning through an integrated, holistic health education programme”.

Policy in the UK

How this is worked out nationally can be illustrated by the development of UK policy. This has also emphasized the twin tracks of demand and supply reduction. The ‘Updated Drug Strategy 2002’ (Home Office 2002) and the subsequent ‘Tackling Drugs. Changing Lives’ initiative (Home Office 2004) focus on ‘Class A’ drugs, specifically crack, cocaine, heroin and ecstasy, and on demand reduction through treatment and rehabilitation.

An innovative aspect of the strategy is the close links it envisages between law enforcement and treatment: all youth prisons will employ drugs workers; and community-based ‘Youth Offending Teams’ (to whom all young people who transgress are referred) are obliged to refer young substance misusers for treatment. Indeed, treatment can be a mandatory part of a community sentence passed down by a court.

The search for integrated solutions for the problems of young people gained official momentum from the death at the hands of carers of Victoria Climbié, in the face of poor coordination and communication between and within agencies (Lord Laming 2003). The UK government initiative ‘Every Child Matters’ (http://www.everychildmatters.gov.uk) and the Children Act 2004 have now more formally placed a duty on local authorities to promote cooperation between agencies, in order to improve children’s well-being. According to the Act, this includes physical and mental health, protection, education and training, as well as social and economic well-being. One potentially key lever is the introduction of comprehensive assessment, even at the level of tier 1 or universal services (DfES 2006). This covers general health as well as physical, speech, language and communications development; emotional, social and behavioural development; self-esteem, self-image and identity; and family and social relationships, including how far the child or young person is loved, in a stable environment, and in contact with those who are important to him/her. If such an assessment were to become standard for all substance misusing young people in touch with services, it would represent a major advance in the quality of information and communication, providing a common language between services and enhanced potential for research.

Every Child Matters also describes core skills that should be shared by all those working with children and young people, summarized as:

• Effective communication and engagement with children, young people and families
• Child and young person development
• Safeguarding and promoting the welfare of the child
• Supporting transitions
• Multi-agency working
• Sharing information.

National service frameworks (NSFs) are described as long term strategies for improving specific areas of care that set measurable goals within set time frames. In parallel with Every Child Matters, but more focused on the health sector, the Children’s National Service
Framework (DoH 2004) also promotes the health and well-being of all children and young people. It asserts that “children and young people and families [should] receive high quality services [which are] co-ordinated around their individual and family needs and take account of their views”. A second standard urges that “young people have access to age-appropriate services which are responsive to their specific needs as they grow into adulthood.” It sees multi-agency “partnerships” as the vehicle to deliver “services to young people with mental . . . disorders who are misusing drugs and alcohol”. It notes the disadvantages of placing such services in proximity to adult drug and alcohol services. So-called ‘Child and Young Persons Local Strategic Partnerships’ manned by representatives from a range of organizations – but probably dominated in practice by officers geared to respond to central bureaucracies – will commission local services.

The performance of these commissioners is in turn scrutinized by a variety of inspectors including the Audit Commission, an independent public body responsible for ensuring that public money is spent “economically, efficiently, and effectively” (http://www.auditcommission.gov.uk). Their report ‘Drug Misuse 2004’ (Audit Commission 2004) draws attention to the importance of “whole person” assessment and “wrap-around” services including attention to “accommodation, employment and relationships”, which, while oriented to adult predicaments, clearly have counterparts in relation to childhood and youth. This emphasis on comprehensive assessment and on “care planning” is in keeping with what is known about multiple-systems intervention (e.g. Liddle et al. 2001). References to “recovery journeys” appear to accept the necessity for longer-term engagement. Focusing on the common problem of drop out from treatment, it recommends “improving fairly basic administration and customer care [to address] delayed letters, staff who miss appointments [and] distant or dilapidated premises”.

The report acknowledges the local “partnerships” formed around misuse and other youth related difficulty. However, because constituent organizations (e.g. health, social and police services) have different priorities, partnerships contain tensions that may leave substance misuse services in a marginalized position. Some have found a way around this; but within these health and social care partnerships substance misuse may not achieve a high priority and the report notes the marginalization of young people’s services. It also refers to the sometimes “fraught” relations between those who commission services and the health providers involved in treatment. While accepting that commissioning has problems, it implies that tighter performance expectations will draw health services into line, suggesting perhaps that the fault really lies with the providers. Providers might argue that dialogue between providers, commissioners and policy makers is a necessary foundation for rational policy.

Many young substance misusers have grave school-related difficulties so that mechanisms that can help engender an understanding of these and assist in customizing (to a degree) educational provision, can be critical to addressing their needs. UK local authorities are charged with the early reintegration back into mainstream education of pupils (under 16 years) who have been expelled from school. For those for whom reintegration is not feasible, local authorities now have to provide alternative full-time education. In these pupil referral centres, educational programmes can be more tailored to needs. For instance, “for those
whose behaviour problems stem from a lack of basic skills” (DfES 1999) there should be a particular focus on literacy and numeracy in addition to the creative activity and physical education that should be available for all pupils. Also, a drug worker is now routinely attached to these facilities.

However, excluded pupils represent a minority of those not attending school, most of whom are truants. The Department for Education and Skills (DfES) has developed a set of principles in the form of a checklist to enable local authorities to address truancy. This includes setting attendance targets with schools, analysis of local data, liaison with police, support for families in difficulties, and meeting the needs of children with ‘special educational needs’, amounting to the development of local strategic thinking about truancy.

In England and Wales the 1996 Education Act regulates how the needs of children with a learning difficulty or disability are met. Skilled identification of those who enter these categories can be useful in negotiating a more favourable educational environment for an affected ‘child’ (i.e. any person under the age of 19 and who is on a school role); therefore it is important that services working with vulnerable youth have the capacity to identify learning difficulty or disability (although this is unfortunately not a core skill according to Every Child Matters). If a parent considers that measures within the school are not meeting the child’s needs, they can request a ‘statutory assessment’ of needs, usually coordinated by an educational psychologist. This will incorporate advice from other services such as health and social services and may lead to a ‘Statement’ of special educational needs. This formal document (against which parents have a right of appeal) potentially acts to reframe a child’s difficulties, e.g. from ‘bad’ to ‘in need’, and so offers a measure of protection and understanding. It may also facilitate release of significant funds and additional support or sometimes special schooling. This mechanism may be crucial in rehabilitating younger users and may be even more important in protecting children at risk of substance abuse from linking with deviant peers who are not at school.

It is important to note that these systems do not always work automatically; educational difficulties are not always recognized by schools. Hence, it is fundamental that services for young drug users can recognize school-related problems in order to activate these preventative and rehabilitative mechanisms. Equally, organizations that work with such young people must be competent to recognize school-related difficulties and to advocate for the most appropriate response from local resources.

The Health Advisory Service (HAS) is a semi-autonomous body designed to formulate strategic advice on selected health-related matters. The HAS addressed the issue of youth substance abuse as part of two reports on child and adolescent mental health services (CAMHS) (Williams et al. 1995) and substance abuse (Williams et al. 1996). A more recent report also concerned substance abuse (Gilvarry et al. 2001).

The distinguishing feature of these three reports was their introduction of a strategic framework in which to conceptualize the relationships between clinicians, disciplines and agencies that can appear competitive, overlapping and complex. Williams et al. (1995) proposed a four-tier strategic framework, later adapted by Gilvarry et al. (2001). The tiered concept aims to emphasize functions rather than professions and to promote integration between sectors, agencies and disciplines. It has enabled clinicians to formulate integrated,
multidisciplinary and multi-agency, comprehensive assessment and intervention plans for the child and family, and has helped interested parties (‘stakeholders’) in general to think strategically about services, and has fostered a sense of common enterprise across professions and agencies.

The tiers are: Tier 1 – universal primary-level services; Tier 2 – youth-oriented services, also referred to as ‘targeted’ services; Tier 3 – services provided by teams that specialize in treating young people who misuse substances; and Tier 4 – very specialized and highly intensive services for young people who misuse substances.

TIER 1
This is the front line of service delivery to which all young people and their families should have direct access and which generally provides the first response. These universal services involve those who may have specialized skills but not necessarily skills in addressing specifically substance abuse. These include, for instance, teachers, primary care physicians and nurses, police, some workers within the criminal justice system, and many social workers. The essence of this tier is to provide universal access, to screen for vulnerability, and to embed identification, accurate information and advice into mainstream services. It may be that the common assessment framework (CAF) could be used at this level. All tier 1 and primary care workers should acquire and have access to training which has been made available in local districts in basic skills in recognition and provision of initial interventions such as support, accurate information and advice concerning substance abuse.

TIER 2
Tier 2 practitioners, the front line of specialist services, have expertise in the developmental needs of young people, understand the links between substance abuse and normal and abnormal development and environment, and have an ability to discern good and lawful practice in even complex circumstances. They include child and adolescent psychiatrists and clinical psychologists based in CAMHS, specialized voluntary youth services (e.g. counselling services), paediatric and psychology staff, some specialist primary care and social workers, and some staff working in the youth justice system. They will also include providers of universal young people’s services who also have specific specialist skills, e.g. special needs teachers, some primary care physicians with a special interest, and school or other community nurses with mental health training. Tier 2 is characterized by individual practitioners networking around the needs of individual young people. Although they may well construct “virtual teams” (http://www.everychildmatters.gov.uk/deliveringservices/multi-agencyworking/teamtoolkit/buildingtheteam/location/), they do not typically work in teams. Tier 2 is designed for all young people but in particular those with more problematic use (Zoccolillo et al. 1999), often combined with other vulnerabilities.

TIER 3
Tier 3 comprises multidisciplinary teams of professionals able to demonstrate a threshold of aggregate expertise and competence, capable of comprehensive assessment and formulation of care plans for those young people with substance abuse/dependence and multiple complex
problems. Like all the tiers it is concerned with outcomes across all domains of functioning, not substance abuse alone. The team includes professionals with specialist knowledge of addictions, child and adolescent mental health practitioners, specialist teachers, psychologists, social workers and other therapists. Although in small centres, practitioners in this team may also work at tier 2; the aggregation of specialists forming tier 3 leads to enhanced skills and capacities: the cornerstone of such a team is likely to be a permanent collaboration between those with skills in addictions and those with skills in child health and mental health or in both.

**Tier 4**

Tier 4 is the most resource-intensive and so should be an option of last resort, adjunctive to tier 3. In the health context, it might consist of inpatient adolescent psychiatric or forensic services, medicine or obstetric (e.g. for young pregnant users) units complemented by specialist young people’s addiction services for complicated detoxifications, specialized crisis placements, highly intensive interventions with a residential component or perhaps unusually intensive outpatient therapies.

The current UK reality is that tier 4 services explicitly designed for youth drug abuse are few. However, residential facilities for other purposes such as specialist children’s homes may provide in effect the same function, albeit appropriately focused on underlying difficulties rather than substance abuse itself. Also, the HAS report (Williams et al. 1995) recommended there should not be an explicitly substance abuse focused tier 4 service unless the other tiers are in place. Otherwise, existing resources are not effectively mobilized, too few will receive intervention, and those who do may not receive an intervention geared to their needs. Hence, consideration should be given to augmenting already available units such as local authority children’s homes, inpatient and outpatient adolescent and forensic psychiatric services.

**Links Between Tiers**

Although described separately, the tiers of service should be closely linked. For instance, a social worker or nurse who initially recognizes a set of problems at tier 1 might follow their client or patient through the tiers: perhaps temporarily participating as a ‘virtual team’ member in relation to a particular young person. In this way their initial engagement and knowledge of the young person is not lost to other tiers; there is continuity of care and sharing of skills (by this means it is also possible to avoid the potentially corrosive notion of an explicit hierarchy). Indeed, young people should never be referred from service to service with the case closed behind them. As often the point of first contact, and in cooperation with other tiers, tier 1 may be in some cases the key to the outreach capabilities that specialists may lack, particularly for hard to reach young people. Clearly, this process would be facilitated by use of the CAF and indeed by the core skills noted above.

**Conclusion**

International policy envisages tackling a worldwide problem through reduction of demand and supply. The former should involve treatment. However, the key point emerging from
the national and international documents is that treatment is not envisaged as an intervention carried out solely in an outpatient clinic. It should involve a more radical mobilization of a community’s resources based on multisectoral or multi-agency collaboration built upon common detailed assessment and common core skills. Formally or informally acquired psychotherapeutic skills are likely to be crucial to successful professional work. However, the inclusion of ‘multiagency working’ as a core skill underlines the realization that intervention for young people with complex problems often requires interagency problem solving and not just a modality of psychotherapy.

In the UK, it remains to be seen whether official-led local ‘partnerships’ can be made to work, whether they will produce effective professional services, or whether the tensions noted by the Audit Commission will prove fatal. To some extent this will depend upon the capabilities and determination of large numbers of individual practitioners but it will also depend upon giving due prominence to substance misuse and to consulting with, appropriately, misusers, parents and carers and with the professionals who offer the services.

REFERENCES


