

Assessing young people for substance misuse



National Treatment Agency for Substance Misuse

February 2007

The National Treatment Agency for Substance Misuse

The National Treatment Agency for Substance Misuse (NTA) is a special health authority within the NHS, established by Government in 2001, to improve the availability, capacity and effectiveness of treatment for drug misuse in England.

Treatment can reduce the harm caused by drug misuse to individuals' well-being, to public health and to community safety. The Home Office estimates that there are approximately 250,000–300,000 problematic drug misusers in England who require treatment.

The overall purpose of the NTA is to:

- Double the number of people in effective, well-managed treatment between 1998 and 2008
- Increase the percentage of those successfully completing or appropriately continuing treatment year-on-year.

Reader information

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1 Introduction

This document has been developed for service managers and practitioners delivering specialist substance misuse services to young people under the age of 18. It describes a framework for specialist substance misuse assessment, how specialist substance misuse assessment dovetails with the Common Assessment Framework (CAF) for children and young people (DfES, 2006a) and outlines the context of undertaking an assessment of young people and care planning arrangements. It is not an assessment tool but covers the essential elements of specialist substance misuse assessment and other factors that need to be considered.

1.1 Policy context

The Government wishes to see all young people achieve the five Every Child Matters: Change for Children (DfES, 2004) outcomes, with children’s trusts at the centre of the commissioning process. The Common Assessment Framework has been developed to help practitioners working with young people to determine if there are needs that would hinder achieving these outcomes. The relationship between this assessment process and undertaking a specialist substance misuse assessment is explored in this document.

Further to these expectations, the Government has recognised that young people may need special consideration and services more tailored to meet their needs as opposed to those for younger children. Youth Matters: Next Steps (DfES, 2006) sets out a vision for young people. It is expected that:

- Information, advice and guidance services for young people will be more flexible and accessible
- For young people experiencing difficulties there will be better targeted support, co-ordinated by a lead professional.

This document is written for specialists in the substance misuse treatment sector working with children and young people. It is likely that most people using these services will be young people rather than young children. Services should ensure they are aware of changes in relation to children’s and young people’s policy initiatives, and local and national services. However, in this document we will mainly refer to young people, meaning anybody under 18-years-old.

1.2 Purpose of assessment

The aim of specialist substance misuse assessment is to determine the needs of young people and to formulate interventions to meet them. To achieve this, a thorough grasp of young people’s lives must be gained, by understanding how they conduct their lives, what activities they are engaged in, who has an influence on them, how they perceive their lives and what

aspirations they have. There are many influences, which include use of substances, mental and physical health, educational achievements, and relationships with parents. The gathering of information for an assessment can be broken down into components – however, the essence is understanding young people’s lives, how these aspects relate to each other at different points in time and an understanding of what needs young people have as a result of this.

When undertaking any assessment with young people, it is crucial to remember that their parents and carers also have a significant role to play. Ensuring that young people and their parents are part of the process of assessment, rather than feeling it is happening to them, will ensure that their views are incorporated, that they engage with the service and that their care plans are relevant and meaningful to them. Assessment is a cyclical process where the changing needs of people are identified, responded to and reviewed (see figure 1). The key principles of the assessment process are:

- Assessment is part of the care
- Assessment is an ongoing process
- Young people and their parents or carers should participate
- The goals and process of assessment must be clear.

1.3 Relationship with other assessments

There has been much work on developing assessment processes for young people in recent years. We intend this document to complement and build on these processes, not repeat them. The following assessment processes are described below:

- The Common Assessment Framework for young people
- The Asset (used by youth offending teams)
- Substance misuse identification processes and tools.

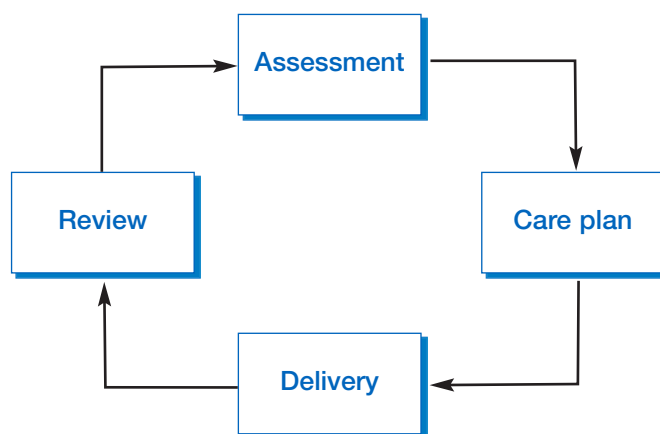


Figure 1: The cycle of assessment

With appropriate consent, needs and information identified from these assessments can be shared with substance misuse specialists, resulting in less duplication.

In other cases where information from another assessment is not available, either because it has not been conducted or because there are restrictions on the access to the information, practitioners should widen the scope of their assessment. A decision should also be made as to whether a CAF should be undertaken and the pre-assessment checklist can help to decide this (see section 1.3.1).

1.3.1 The Common Assessment Framework for young people

The Common Assessment Framework (CAF) for young people has been designed by DfES (2006a) to help deliver frontline services that are integrated and focused around the needs of young people.

The CAF is intended to promote early and more effective identification of needs, particularly in universal services. It is intended to provide a simple process for a holistic assessment of young people's needs and strengths, taking account of the roles of parents, carers and environmental factors on their development. However, it is not intended that all young people are assessed with this tool; rather it can help practitioners assess young people with a range of needs that prevent them reaching their potential in terms of the Government's five outcomes.

The CAF is a shared assessment tool used across agencies in England. It consists of:

- A pre-assessment checklist that practitioners may use to help decide who would benefit from a common assessment
- A common process to enable practitioners to undertake a common assessment and act on the result
- A standard form to help practitioners record and, where appropriate, share assessments, plans and recommendations for support.

Substance misuse, along with many other specific behavioural and medical conditions, is not specifically mentioned in the tool. It is, however, expected that any issues young people may have will be discussed, as the tool leads the practitioner through aspects of their lives. Where explicit issues have been identified through the CAF (such as a mental health or substance misuse problems) it is expected that a specialist assessment will take place.

Some young people will have needs that require them to be safeguarded or protected from harm. These young people will require a more detailed assessment as outlined in Framework for Assessment for Children in Need and Their Families (Department of Health, Department for Education and Skills, Home Office, 2000). Further details about the roles of substance misuse services in relation to safeguarding children are described in section five.

1.3.2 The Asset

The Asset (Youth Justice Board, 2006a) is used by youth offending teams (YOTs) across England and Wales. It aims to identify risks associated with offending and develop sentence plans based on reducing these risks, with substance misuse as one element of this tool. Where substance misuse has been identified as a risk on the Asset, a further assessment of substance misuse takes place – generally this will happen within the YOT and will be undertaken by people with knowledge and skills in this area. Where levels of need are identified that cannot be met within the team, external specialist agencies will be contacted. Information will have already been gathered by the YOT and a sentence plan developed. Specialist substance misuse practitioners should work with the YOT and share information, with consent, and review sentence plans and care plans jointly. This will prevent further unnecessary assessment of the young person and ensure everyone works towards the same goals.

Some young people in contact with YOTs will be sentenced to some time in custody. This could be in a young offenders' institution, a secure training centre or a local authority secure children's home. All secure establishments provide access to substance misuse interventions and there has been considerable work in recent years to improve this provision. The young person's YOT will share the content of the Asset and the sentence plan with these establishments; closer relationships between partner agencies in the community can help ensure better continuity of care in secure establishments. Custodial establishments are required to develop a youth resettlement plan with the young person and their YOT worker prior to their release, which should include substance misuse where relevant.

Secure establishments and specialist substance misuse services should work together to improve continuity of care between custody and the community. Information from specialist assessments, care plans and resettlement plans should be shared, with consent, to reduce the need for repeat assessments and improve the young person's journey through the system. In some cases the YOT will act as a main conduit for this information; in other complex cases, the specialist substance misuse service may require direct contact with the secure establishment.

Further information about how CAF and Asset relate to each other can be found in the Common Assessment Framework, Asset, Onset (Youth Justice Board, 2006b).

1.3.3 Substance misuse identification processes

A number of policy documents (HAS, 1996, 2001; Home Office and DrugScope, 2003) have put expectations on young people's universal and targeted services. They require services to be able to identify a substance misuse need among young people in their care, give an indication of the severity of this need, and make an

appropriate intervention or referral. Early identification of substance misuse is described fully in the Home Office and DrugScope guidance, First Steps.

Some local children's trusts and young people's partnerships have added a "trigger" question related to substance misuse to the CAF. Practitioners completing the CAF are asked questions such as, "Has substance use been mentioned? If so, use a substance misuse screening tool." The trigger question is intended to initiate the use of a substance misuse screening tool, along with relevant referrals and interventions as required.

A substance misuse screening tool and trigger question have been used in tandem with the CAF in Hull for over a year. The process is supported by mandatory substance misuse training for all statutory children's services via the local safeguarding children board (LSCB) and the city has seen a marked increase in the number of children identified with substance misuse needs.

Many DATs have developed local screening tools to help identify substance misuse needs; other tools such as DUST (Drug Use Screening Tool) (DfES, 2005) and SASSI-A (Substance Abuse Subtle Screening Inventory – Adolescent Version) (Miller, 1985) are also in common use. Clear care pathways should be established between these tools and the CAF to support further assessment where a substance misuse issue has been identified. Some of these tools may have not undergone rigorous evaluation on their validity, or may have been used on populations outside the UK.

It is important to remember these tools are only indicators of substance misuse and where needs are identified, a comprehensive specialist assessment should be conducted. It is important to remember that some affected young people may be missed by these screening instruments; if there are concerns about an individual, advice should be sought from a specialist substance misuse practitioner. Training for practitioners should take into account the care pathways between these assessments.

1.4 Co-ordinating care

A lead professional is responsible for co-ordinating the actions identified in the CAF assessment process and is a single point of contact for children with a range of needs being supported by more than one practitioner. Lead professionals will hold multi-agency meetings with all those involved in a young person's care, and develop a multi-agency care plan. Local arrangements will determine which practitioners will undergo training to become designated lead professionals.

Local processes for information sharing are being developed to help practitioners work together more effectively to meet children's needs by sharing information legally and professionally. Electronic systems are due to be implemented by 2008.

1.5 Specialist substance misuse assessment

A specialist substance misuse assessment is not a holistic assessment, but may form part of one. Specialist assessments are defined by Models of Good Practice in Joined-up Assessment: Working for Children with Significant and Complex Needs (DfES, 2006c) as:

- Having a much more specific purpose (for example, assessments under section 17 of the Children Act (1989), where the main purpose is to determine whether children are in need and if they and their families require services; and Asset, where the main purpose is to assess the risk of offending)
- Undertaken by staff from a particular service or sector
- Generally performed only by staff of a particular occupational or professional group
- Done with children with known issues or where there are specific or acute concerns.

Unless a young person contacts a specialist substance misuse service directly, or via a parent, specialist substance misuse assessments should only be undertaken where a substance-related screening has identified needs that cannot be met by the agency conducting the screening. Not every young person with a substance-related need will require referral for a specialist assessment and intervention from a specialist practitioner. Some low-level substance misuse needs can be met by the person undertaking the CAF or other screening or identification processes; for example, advice, information and risk reduction sessions aimed at infrequent, low-risk substance users.

1.6 Assessment is a process

Active participation by the assessor and client is vital in an assessment. The goals and process of assessment must be made clear to young people and their parents. Assessment is a continuing process and should not be attempted at one sitting, although substance-related risks should be assessed at the first interview (see section 3.3). Young people will need time to develop trust in a new relationship with a practitioner and may require help to reflect on aspects of their lives for their needs to be identified.

Open-ended questions should be used rather than closed questions – although closed statements are useful on a form to record information, they are generally unhelpful in gaining information and developing a professional relationship. Other interactive processes, such as a decisional-matrix, timeline, lifeline and family-grams, can be used to facilitate discussions and inform care plans.

Elements of the assessment should be reviewed and reflected upon as part of the care plan review, to determine what changes

have arisen and whether any new information comes to light. This reflection will help young people gain insights into the consequences of their substance misuse and help define new goals and aspirations.

2 Parents and carers

Young people do not live in isolation; while their family circumstances may vary, all will have some relationship with a parent, carer or significant adult. A full assessment of young peoples' needs cannot be undertaken without taking into account the people who support them.

2.1 Contributing to assessment

Parents and carers can offer a new perspective on young people's circumstances. They may help to define patterns of substance misuse that young people may not yet recognise. While some young people will want to be seen in confidence, many will not. Where parents and carers can be involved, this should be encouraged and they should be thought of as active participants in facilitating change, working in partnership with treatment services.

Conducting part of the assessment with the parent or carer is vital. Opportunities should be available for parents and young people to discuss their situations together, to help develop insight into their problems and show that parents and carers are concerned about them. However, young people and parents should also be allowed an opportunity to discuss their concerns and give their perspectives alone with the assessor. It may also be helpful to offer parents a separate worker to support their involvement, understand their own needs and help feed into the assessment process.

In an assessment of a young person's difficulties, assessors should explore the following areas with parents and carers:

- History of presenting problems with details of substance use
- Behaviour associated with substance use
- Onset and progression of co-morbid psychiatric, psychosocial and behavioural problems
- Treatment history
- Developmental history
- Medical history, such as accidents and possible head injuries
- School, interests and hobbies
- Peer relationships
- Family history and relationships, including significant events, such as divorce or bereavement
- Other family members with substance misuse problems.

2.2 Contributing to care planning

The involvement of parents and carers in the care planning process can have a positive impact. Specific ways in which it can help include:

- Ensuring appropriate parental responsibility for the young person
- Parents' and carers' consent may be needed for treatment, which will be reviewed as new care plans are developed
- To give information to the parents and carers on the range of interventions and the specific interventions required for young people in their care
- To improve communication with young people
- To provide information on the progress made by young people
- To put parents', carers' and young people's anxieties into perspective
- To provide sources of support for young people
- To seek help and support for parents and carers with substance use problems or mental health difficulties
- To help seek help and support for families with difficulties
- To increase the informal monitoring of the treatment intervention.

2.3 Parental consent

Parental consent is a legal term that relates only to parents who are the "parental responsibility holders". Legislation clearly defines who this is, whether children are living with natural parents or "looked after" (see section 2.5).

The parental responsibility holder should, wherever possible, consent to the young person's treatment or to information sharing. In some cases, young people may not want parents to know they are seeking assistance for substance misuse and their wishes should be considered – it may be possible for them to maintain confidentiality, and consent to treatment and information sharing. This is explained further in section 2.5.

2.4 Assessing parenting

Young people's specialist substance misuse services have a key role in identifying young people with unmet needs. Practitioners should consider whether poor parenting is having a detrimental effect – if so, the lead professional co-ordinating the multi-agency care plan, where one exists, should be informed. Where a CAF has not been conducted, the service provider should either make a child protection referral, if the young person is believed to be suffering or at risk of suffering significant harm, or arrange for a CAF to be conducted. Action should be taken locally to equip staff with awareness of CAF procedures and demonstrate how to access further support in assessing parenting or meeting a family's needs.

Services working with young people should be aware that some of their service users may be young parents themselves. As such,

their parenting skills should be assessed and the needs of their children (or unborn children) considered.

2.5 Who has parental responsibility?

The Children Act 1989 sets out who has parental responsibility:

- The child's parents if they married to each other at the time of conception or birth
- The child's mother, but not the father if they were not married, unless the father has acquired parental responsibility via a court order, or a parental responsibility agreement or the couple subsequently marry (see section 2.5.1)
- The child's legally appointed guardian – appointed either by a court or by a parent with parental responsibility in the event of their own death
- A person in whose favour a court has made a residence order concerning the child
- A local authority designated in a care order in respect of the child (but not where the child is being looked after under section 20 of the Children Act 1989, also known as being “accommodated” or in “voluntary care”)
- A local authority or other authorised person who holds an emergency protection order in respect of the child
- Foster parents, step-parents and grandparents do not automatically have parental responsibility.

2.5.1 Unmarried fathers

Unmarried fathers do not have automatic parental responsibility. However, the law has changed so that unmarried fathers who registered or re-registered their names on their children's birth certificates after 1 December 2003 will have parental responsibility for their children (Children's Legal Centre, 2006). Therefore:

- If an unmarried father has a child after 1 December 2003 and is registered on the birth certificate, he will have parental responsibility
- If a child was registered before 1 December 2003 and the father was not named on the birth certificate, the child can be re-registered to include the father's name. Once this has been done, the father will have parental responsibility
- If an unmarried father's name is already on the birth certificate and the child was registered before 1 December 2003, the law has not changed this situation so the father will not have parental responsibility (unless obtained by other means).

3 Specialist substance misuse assessment

This section describes a framework for undertaking a specialist substance misuse assessment with a young person. Information can be gained from young people, parents and professionals. Sometimes it is helpful to corroborate information gained from one source with another. The framework described here is not a set of questions; practitioners should use this framework as a guide on what aspects the assessment should cover. Depending on individuals and their substance misuse, different sections will need a greater emphasis or priority.

3.1 Assessment as an intervention

Assessment can be a useful intervention in itself and provides an opportunity for young people to reflect on their circumstances, identify needs and be made aware of their strengths. Earlier in this document we referred to assessment being a process that may take some time to complete. Circumstances may change over time and reassessing and reviewing needs will be required. Assessment should be an active and interactive process. It is reasonable to expect that, as the assessment progresses, some interventions will be delivered as needs are identified, prior to the development of a full care plan. In fact, in order to reduce many substance-related risks, these types of immediate interventions are vital.

Any such interventions delivered should be recorded in the notes and included in the care plan when this is being developed. Where prescribing interventions are prioritised, rapid assessment of other areas and development of a full care plan should not be delayed, and a care plan in relation to prescribing must be developed.

Examples of immediate interventions may include:

- Advice and information on less harmful ways to consume, reduce or stop taking substances
- Brief intervention techniques designed to encourage reflection on substance misuse
- Motivational interviewing techniques to increase engagement in the assessment and subsequent treatment process
- Interventions to involve other agencies in the assessment or care of the young person and their parent or carer
- Concentration on the initiation of a prescribing intervention to reduce substance-related harm and to act as a gateway to other interventions.

3.2 Developing a dialogue

Using a discursive approach where one piece of information can lead to another question, or clarification on how two aspects are

related to each other, will help to determine young people's comprehension of the issues facing them, and their knowledge of substance use and its associated risks and harms, which may not otherwise be uncovered. It allows practitioners an opportunity to gain information on young people's self-esteem, developmental maturity, intellectual capacity, support systems and triggers for substance misuse.

Discussing the issues young people face from their perspective will help to develop a trusting relationship where they will feel listened to. These initial insights can be used to guide the assessment process, highlighting the areas that are of most concern to the young person, and the benefits they see from their continued use, which can be challenged.

This interactive approach allows the assessor the opportunity to pass on information and advice to reduce the harms caused by substances. This approach should be used throughout the assessment and review process, and should encompass all assessment domains.

Important aspects of young people's perspectives on their substance misuse include:

- Level of knowledge of substances and associated risks
- Where, how and with whom young people take substances
- Who else of their friends and family uses drugs
- Whether substances are being used to control thoughts or behaviour
- Expectations of how substance use affects their lives
- Hopes and fears in relation to substance misuse and being drug and alcohol free
- Family views on substance misuse
- Previous experience of being drug and alcohol free
- Young people's goals
- Who can support the young person in changing their substance misuse behaviour.

3.3 Risk assessment

Identifying immediate substance-related risks is vital to ensure young people's wellbeing and ensure that interventions to reduce substance-related risks are prioritised. Information about the high-risk behaviour described in this section will be gathered during the course of the assessment process as the practitioner explores aspects of the young person's life. Practitioners should be aware that these are indicators of risk and should consider what steps are required to reduce the risk as soon as possible. Risk factors also compound each other, so the presence of multiple risk factors means the overall risk to the young person is higher.

Factors indicating substance-related risk include:

- Overdose, deliberate self-harm and attempted suicide
- Substance misuse in risky contexts such as:
 - Taking substances in the presence of older people, including parents, siblings and older partners, especially those with established substance misuse behaviour themselves
 - In association with sexual exploitation or risky sexual behaviour
 - In association with offending behaviour
 - In dangerous physical environments, such as near roads or railway lines, while driving or using alone
- High-risk substance misuse behaviour linked to dose, substance used, route of administration and combinations of substances used together. Examples of this are:
 - Quantities of substance misuse and effects that indicate extreme intoxication that could result in overdose
 - Injecting of substances
 - Direct inhalation of volatile substances, particularly butane
 - Polysubstance use that increases the risk of adverse reactions and overdose
 - Drugs or alcohol being administered to the young person by another person
- The age of the young person, the lower the age the more risky the situation
- Co-existing mental health problems such as psychosis, post-traumatic stress disorder, suicidal thoughts or self-harm
- Co-existing physical health problems such as epilepsy, breathing and heart conditions, pregnancy, and interactions with prescribed medication.

3.4 Demographic and contact details

Demographic and contact details are important for future contact and monitoring a service's accessibility. Some of this data can be gained at the time of referral or initial screening, while other elements are best gathered by talking with the young person. Information should be accurate and regularly reviewed, and practitioners need to consider how the information gained will affect the assessment and treatment process. The following are examples of how demographic and contact details affect assessment:

- Cultural, ethnic and spiritual details – services should be sensitive to these aspects and consider how substance misuse may be viewed by a community, along with the need for interpreters or culturally sensitive interventions

- Age – the younger the person, the more unusual substance misuse behaviour is and the higher the risk of developing substance misuse. Age will also affect maturation and increase the need to work with parents and gain consent from them, rather than young people themselves
- Address and type of residence can yield information on family relationships – whether young people are looked after or live away from parents
- Name and contact details of parental responsibility holder (see section 2.5) – this can be determined by talking to young people about where they live, and is important with regard to involving parents and carers and gaining consent for treatment
- Involvement with other agencies – this is important in determining if other assessments have been completed. It highlights other needs a young person may have and provides opportunities for collaborative work with other services
- Name and contact details of GP – this will be required should a pharmacological intervention be considered, to keep health records up to date.

3.5 Identification of non-substance misuse needs

A holistic assessment will not have been completed for all young people accessing specialist substance misuse services. This may be because they have not accessed any service before, or because previously needs had been within a narrow range that did not justify a holistic assessment. This document is concerned with the specialist assessment of substance misuse among young people, but it is important to explain how it complements and builds on other assessments. The specialist substance misuse assessment complements holistic assessments in four ways:

- If holistic assessment has already been conducted, it is important to attempt to access the information recorded in the assessment and liaise and work with other agencies involved in meeting the young person's needs. This process should be co-ordinated by the lead professional, where one exists
- If holistic assessment has not been conducted, the substance misuse assessor should use the pre-assessment CAF checklist to establish if a CAF is required
- If a pre-assessment CAF checklist identifies needs that cannot be met by the specialist substance misuse service, a CAF should be completed. This process will vary according to local implementation processes and may involve a referral to a CAF assessor, or CAF assessment by the specialist assessor if they are a designated CAF assessor.
- If a pre-assessment checklist does not identify additional needs, continue with the specialist substance misuse assessment ensuring that the context of substance misuse is

explored and reviewed regularly to ensure that if additional needs arise they are responded to.

Section 1.3 contains further details of relationships between assessment processes, which give more information on the CAF, Asset and identification of substance misuse needs. Figure 2 outlines the decision-making process.

Regardless of the pathways described, it is important to remember that the young person is at the service to receive a specialist substance misuse assessment. This will either be later fed into a CAF process and care co-ordination, or be a standalone activity, determined by the indicators described.

3.6 Gaining a history of substance misuse

Understanding the development of substance misuse is an important part of gaining a picture of how substance use is part of a young person's life. There is a need to appreciate:

- Types of substance used
- Age of first use of substances

- Current and past substance use
- Frequency of substance use
- How long specific substances have been used
- Minimum, maximum and usual quantities taken at a time
- Method of use or route of administration
- Substances taken in combination
- Patterns of substance misuse
- History of bingeing, memory loss and overdose
- History of accidents and injuries related to substance misuse
- Previous attempts to change substance misusing behaviour.

This information will give a perspective on changes in substance misuse and possible difficulties the young person may have in changing substance misusing behaviour. Issues for consideration include:

- Whether there are established patterns of substance misuse for the young person that may be related to psychological or physical dependence

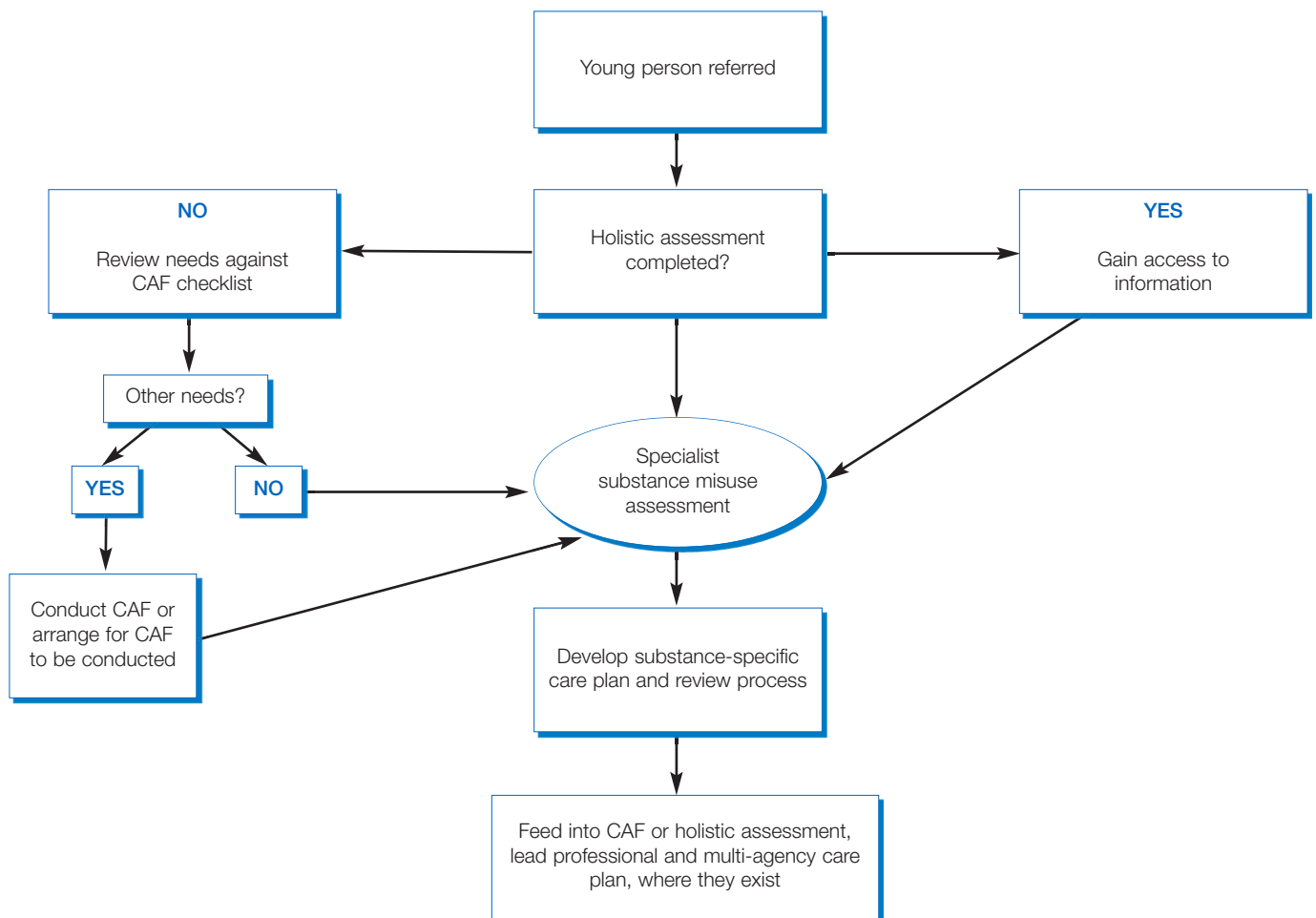


Figure 2: Dovetailing holistic assessment and specialist substance misuse assessment

- Level of substance-related risk related to high-risk substances, high-risk method of use, and occurrences of high levels of intoxication or overdose
- Whether substance misuse is a longstanding activity or a relatively new one
- Increases in substance misuse
- Complexity of substance misuse.

These perspectives should be used to determine the type of interventions required and give some indication of the likely length of treatment.

3.7 Social impact of substance misuse

As well as understanding a young person's typical pattern of substance use, an assessor must understand the context of this use. The context will determine additional risk factors and triggers to substance use, which in turn will determine the targeting of interventions and other needs that other services ought to be addressing. Risky contexts include:

- Criminal behaviour
- Sexual exploitation and disinhibited sexual behaviour
- Parental involvement with substance misuse
- Parental views about a young person's substance misuse. Both positive and negative parental views may increase a young person's risks
- Other family members using substances
- Substance misuse in school or other managed environment that may lead to expulsion from the establishment that will have a detrimental affect on the young person
- High-risk substance misuse alone
- Substance misuse when responsible for another's welfare
- Young people who have lost contact with positive peers and role models
- Accommodation problems
- Substance misuse and its relationship with social, romantic and sexual relationships, including same-sex relationships.

3.8 Health impact of substance misuse

Substance misuse can contribute to and compound physical and mental health problems. Therefore, it is important to take account of a young person's current and past physical and mental health, and be aware of the effects of specific substances upon them. Where any of the issues listed below are a concern, a young person should be referred to a nurse, doctor, psychologist or psychiatrist as appropriate.

Major physical health problems that substance misuse can cause or adversely affect include:

- Breathing problems
- Abscesses and vein damage associated with injecting
- Heart conditions
- Damage to vital organs such as the liver, kidney and brain
- Pregnancy
- Blood-borne viruses and infections.

The risk of sexually transmitted infections should also be assessed and referrals made where appropriate.

Mental health problems that substance misuse can cause or adversely affect include:

- Self-harm
- Suicidal ideation
- Depression
- Anxiety
- Paranoia
- Psychosis.

Substance misuse can adversely affect people with the learning disability attention deficit hyperactivity disorder (ADHD).

Where pharmacological management of substance misuse is being considered a doctor will need to conduct an assessment. Other members of a team can contribute and should consider:

- Signs and symptoms of physical dependence
- Physical withdrawal symptoms
- Tolerance to specific substances
- Other medications taken and compliance with these
- Intolerances or allergies to medication or foods
- Height and weight
- Where appropriate, conducting urine or saliva tests for drugs and a breathalyser test for alcohol use.

3.9 Invasive investigations

An invasive investigation or physical examination cannot be conducted without consent from the young person or parental responsibility holder. Some invasive investigations may be required as part of a comprehensive assessment. These would include:

- Inspection of injection sites, where clothing is removed (for example, to inspect arms) or exposing intimate body parts (for example, to look for groin or breast injecting)
- Drug toxicology prior to and during the prescribing of medication
- Blood tests to investigate health disorders

- Immunisation against health conditions.

Invasive investigations and treatments should only be conducted by practitioners competent to undertake them.

Injection site inspection should include an assessment of any tissue damage and the ability to decide if any treatments are required to remedy any condition found. In addition, practitioners may want to consider having a parent or carer present to act as a witness, or another practitioner of the same sex as the young person.

Drug toxicology and blood tests should be undertaken on a case-by-case basis and not universally applied to all young people. When providing pharmacological interventions, a drug toxicology test is vital to establish current drug use and confirm self-reports of drug use (DH, 1999). Drug toxicology is also used to monitor ongoing treatment. Observed urine collection is strongly discouraged; if there are concerns about sample tampering a thermal collection cup could be used, or oral fluid collected.

Tests for disorders such as hepatitis C and HIV that may have a lifelong impact should only be conducted in conjunction with a pre-test discussion with a suitably informed health practitioner (DH, 2004; Rogstad *et al.*, 2006). All young people who inject substances, share drug using equipment and paraphernalia, or engage in risky sexual behaviour should be considered for counselling and possible testing.

Derricott *et al.* (2001) recommends immunisation against hepatitis B for the following groups:

- Current injecting drug users
- Those who inject occasionally
- Those who may progress to injecting, for example, people who are currently smoking heroin and dependent stimulant users
- Non-injecting drug users currently living with injectors (particularly women living with male injectors)
- Close household contacts (particularly sexual partners) of injecting drug users.

3.10 Assessing injecting behaviour

If a young person has ever injected it is important that this behaviour is assessed and that vital information is explained to them. This would include:

- Assessing injecting sites and wound care (see section 3.9 for issues around invasive investigation)
- Alternatives to injecting
- Reducing the frequency of injecting
- Substances that should never be injected

- Safer injecting techniques, including advising against sharing equipment
- Overdose prevention information
- The law and injecting, including the injecting of minors
- Blood-borne viruses
- Testing, vaccination and treatment of blood-borne viruses and infections
- Establishing who is injecting the young person (for possible child protection consequences see section 5.2).

Those under 18 should be strongly encouraged to stop injecting and enter a treatment programme. In some cases this situation cannot be achieved immediately, in which case it will be necessary to supply injecting equipment to reduce substance-related harm. Injecting equipment and advice should only be supplied to a young person where there is evidence that withholding it would a greater risk than continued or increased injecting drug misuse.

Under such circumstances, fewer needles and syringes should be given to a young person than an adult would receive, to increase contact with the practitioner so the situation can be frequently monitored and efforts made to change behaviour. The provision of injecting equipment should form part of a treatment intervention and not be an alternative to it. All young people receiving injecting equipment should have a written care plan.

Young people should not be encouraged to access injecting equipment from adult needle exchange facilities as these services operate in a low-threshold environment that is inappropriate for young people. Adult needle exchanges operate without a full assessment of needs and an assessment should be conducted and an initial care plan in place before supplying advice, information and equipment to young people.

4 Building on assessment

Assessment is not a standalone activity; it is merely a means of identifying needs so that problems can be overcome. During assessment, needs are identified and in order to meet these needs, goals are set and interventions are planned. A care plan is a way of formalising this process. Without a care plan it may not be clear to young people or their parents what the goals of treatment are, especially when a series of goals is used to aim for a long-term goal. In addition to goals being unclear, opportunities for celebrating achievements and reviewing goals may be missed. Young People's Substance Misuse Treatment Services – Essential Elements (NTA, 2005) identifies a range of substance treatment interventions that should be delivered within a care planning framework: harm reduction services, family support, psychosocial interventions, pharmacological interventions and inpatient and residential services.

4.1 Care planning

A care plan provides clarity on goals a client wishes to achieve, what will be done to work towards the goals and when the goals will be reviewed. The care plan should be developed by the practitioners delivering interventions, the young person and the parents or carers. There are likely to be tasks for all three parties and everyone should have a copy of the care plan to keep and use as a resource.

The care planning process can be summarised as:

- Assessment process identifies needs
- Needs are translated into goals
- Interventions are designed to achieve goals
- Individuals responsible for delivering the intervention (including young people and their parents or carers) are identified
- Review dates are scheduled.

Care planning for young people's specialist substance misuse treatment should be across five domains:

- Drug and alcohol use
- Physical and psychological functioning
- Social functioning
- Criminal involvement
- Safeguarding children.

Some of the domains may be met by other services where there are needs in addition to substance misuse – in line with CAF and the lead professional role.

It is not the role of the substance misuse treatment service to meet all needs and a multi-agency approach is strongly recommended.

4.2 Setting goals

Goals within a care plan should be clearly defined and reflect incremental change. All goals should be SMART:

- **Specific**, define precisely the outcome to be achieved
- **Measurable**, define objectively how you will know when you have attained it
- **Action-oriented**, use action words to describe the steps required
- **Realistic**, make sure the goal is possible
- **Timely**, set a deadline for reaching the goal and reviewing the plan.

It is important that there are not too many initial goals – too many will be overwhelming and unachievable. New goals can be added later when others have been attained. It is important to develop care plans with young people and their parents, where they are involved. The care plan should be simple and easy for everyone to understand what is to be done, why and who is responsible for doing it. It should be written down in clear language and translated when written English is not understood by the young person or parent.

Since 1988, the UK has recognised that the use of a hierarchy of goals in drug treatment is useful (Advisory Council on the Misuse of Drugs, 1988, 1989; Department of Health, 1996). These are:

- Reducing health, social and other problems directly related to drug misuse
- Reducing harmful or risky behaviours associated with the misuse of drugs (such as sharing injecting equipment)
- Reducing health, social or other problems not directly attributable to drug misuse
- Attaining controlled, non-dependent or non-problematic drug use
- Abstaining from main problem drugs
- Abstaining from all drugs.

The principle of a hierarchy of goals is useful in helping young people and their parents look at treatment objectives in a systematic manner. The hierarchy helps to set goals that are attainable from the position of the child or young person's current circumstances, rather than expecting complete change from the outset. As each goal is achieved in the hierarchy, a new one can be introduced.

4.3 Inter-agency care planning

All services providing interventions should be involved in an overall care planning process, co-ordinated by the lead professional in line with Every Child Matters: Change for Children (DfES, 2004) and Youth Matters (DfES, 2006).

Individual agencies, working alone or as part of the multi-agency team, may wish to develop their own more detailed care plans. Multi-agency care plans are likely to be reviewed at regular intervals of about three months, unless there is an emergency. Individual agency care plans can be reviewed more frequently, as there is no need to convene a multi-agency meeting, and they can be fed into the multi-agency plan.

The two case study examples below illustrate components of the specialist substance misuse service and the multi-agency care plans.

4.4 Review

Care plans for young people need to be regularly reviewed – at least every three months. Some goals may be reviewed more frequently and there should be opportunities to review goals opportunistically – for example if a goal will not be met or is achieved well ahead of schedule. The young person, parent and practitioner should be able to set up an opportunistic review.

Review should be seen as an opportunity to review needs as well as the care plan, so that new goals can be developed. Therefore, assessment is always ongoing and not something that only happens when contact with a service begins.

Example 1: An injecting heroin user

Jane Smith is a keyworker, co-ordinating work at a young people’s substance misuse service and linking it to the multi-agency care plan. Dr Brown works in an adult substance misuse service that has specialist prescribing facilities and provides clinic sessions and consultancy for the young people’s specialist substance misuse service. Jane Smith initially sees the young person every day; meeting with Dr Brown at clinic sessions where they discuss the service user’s needs and care.

The same overall goal of stabilising drug use is described in each care plan to the same time frame (eight weeks). However the substance misuse service care plan breaks this simple goal into manageable components that can be reviewed at one, two, three and eight weeks so that progress can be tracked more closely. This helps to make sure the plan is on track, aides positive feedback, provides opportunities to reframe the plan should it not being achieved and explains in full the steps to be taken along the way to achieving the goal. New short term goals may be added to the specialist substance misuse service plan to help achieve the overall goal described in the multi-agency care plan.

Goal	Action	Achieve goal	Alarmed if goal not achieved	Person responsible	Review date
Stabilise drug use	Transfer from heroin use to buphrenorphine	In 3 weeks	In 8 weeks	Jane Smith – substance misuse service	2 months

Table 1: Multi-agency plan (substance misuse component)

Goal	Action	Person responsible	Indicator of behaviour change	Review date
Reduce risks of injecting	Provide information and equipment to facilitate safer injecting	Jane Smith	Collects injecting equipment every day	1 week
Introduce buphrenorphine	Start prescribing and titrate according to need	Dr Brown	Supervised consumption of medication from the pharmacy every day	2 weeks
Stop injecting	Service user to stop injecting as prescription is introduced	Service user	Reduced need for injecting equipment	3 weeks
Stabilise buphrenorphine	Maintain dose of buphrenorphine once correct titration reached	Dr Brown	Supervised consumption of medication from the pharmacy every day	8 weeks
Reduce heroin use	Twice weekly key working sessions to talk about how to reduce heroin use	Jane Smith	Stop associating with heroin using peers. Spend more time with parents	4 weeks

Table 2: Specialist substance misuse service plan

High-risk behaviour should be prioritised and addressed with an immediate care plan; again this should be reviewed and embedded into a holistic care plan. During a review and other interactions, new risks may be identified or old ones given prominence again. High-risk behaviour should not be ignored and new goals and interventions should be developed and incorporated into the care plan without delay.

4.5 Transition to adult specialist substance misuse services

Where a young person is making the transition to an adult specialist substance misuse treatment service, a plan should be made with the adult service. The transition should be a stepped approach including:

- Acknowledgment of the move from a young people's service to an adult service
- Sharing information with the adult team about current circumstances, with consent
- Introducing the young person to the adult keyworker and attending several joint appointments
- Introducing young people's parents or carers to the new adult service and discussing their role in their child's care, where a young person agrees to this
- Developing a new care plan in tandem with the adult service provider
- Ensuring that wider needs are addressed within the care plan
- Ensuring a review date is set that the young person, the specialist young person's worker and the new adult services worker will attend.

Example 2: Frequent alcohol use combined with amphetamine use

A young person is using amphetamines on Friday and Saturday evenings, alongside binge drinking. The alcohol use is continued during Wednesday, Thursday and Sunday evenings. This has affected school attendance and attainment, and an educational welfare officer is involved and acting as the lead professional. Abdul Miah is a counsellor at a young people's specialist substance misuse service.

This care plan notes that all three parties – the substance misuse worker, the service user and the user's parents – have a role to play in delivering the care plan. Again, the overall goal and methods of achieving it are summarised in the multi-agency care plan.

Goal	Action	Achieve goal	Alarmed if goal not achieved	Person responsible	Review date
Reduce alcohol and stop amphetamine use	Weekly counselling sessions, support for parents	Stop using amphetamines; reduce alcohol use to weekends only	In 3 months	Substance misuse service counsellor	2 months

Table 3: Multi-agency plan (substance misuse component)

Goal	Action	Person responsible	Indicator of behaviour change	Review date
Stop drinking alcohol during weekdays and reduce during weekend	Write an alcohol and drug use diary	Service user	Bring to key work session each week	4 weeks
Stop amphetamine use	Find alternative weekend pastimes	Service user and parents	Stop associating with amphetamine using peers	4 weeks
Reduce or stop amphetamine and alcohol use	Weekly counselling sessions	Abdul Miah and service user	Drug and alcohol diary indicates lower use	8 weeks
Help parents support their child in changing substance misuse behaviour	Three sessions of parental support and information	Abdul Miah and parents	Parents support their child to find alternative coping strategies and pastimes	6 weeks

Table 4: Specialist substance misuse service plan

4.6 Discharge and aftercare

When a young person has stopped using substances or reduced use to a non-problematic level, their contact with the specialist substance misuse service should cease. The young person may still be receiving services from other members of the multi-agency team, so the care plan must be updated and the lead professional made aware of what is happening.

A discharge time should be considered at the start of the treatment intervention and reviewed regularly. The timeframe will depend on the likely length of treatment, but will be at least every three months. This is to ensure that the young person does not come to rely too heavily on the service, that they can see a future goal of not being in treatment and to put in place an aftercare plan. The specialist substance misuse service should facilitate access to support services providing aftercare.

Substance misuse aftercare should be planned by the specialist substance misuse service and fed into the multi-agency plan, where this exists. Substance misuse aftercare may include:

- A contact in a mainstream or targeted service who will respond if there is a substance-related incident
- Emergency contact numbers and the number of the specialist substance misuse service
- A pack or information sheet reinforcing positive goals that have been achieved and how to stay on track
- Relapse prevention advice
- Additional support services for education, training, employment and leisure.

Where a young person is being discharged to a custodial establishment, specialist substance misuse services should actively make contact with the YOT, substance misuse service or worker within the custodial establishment to enable continuity of care for the young person (see section 1.3.2). In 2007, the National Treatment Agency and Youth Justice Board will issue guidance on continuity, throughcare and aftercare arrangements for young people entering and leaving the secure estate.

5 Responsibilities to young people

Specialist substance misuse assessment fits into a wider context of safeguarding young people from harm and working to ensure that the rights of children, young people and their parents are respected.

5.1 Safeguarding young people

The Children Act 2004 places a duty on all agencies to make arrangements to safeguard and promote the welfare of children. In order to ensure that children are protected from harm and their welfare promoted there must be a commitment by senior managers and clear lines of accountability.

Any professional working with young people needs to be aware that there may be safeguarding needs in relation to abuse or neglect. Specialist substance misuse practitioners are not exempt from this and should act on any concerns that they have, in line with local safeguarding children boards (DfES, 2006b).

The Department for Education and Skills (DfES, 2006b) states that LSCBs have a role in setting thresholds for referrals to social care and setting processes for multi-agency assessments of young people who may be “in need” (section 17 of the Children Act 1989). They also have a role to agree inter-agency procedures and protocols for children “suffering or at risk of suffering significant harm” (section 47 of the Children Act 1989), including those children where substance abuse is the issue.

For those children who are suffering, or at risk of suffering significant harm, joint working is essential to safeguard and promote welfare of children and, where necessary, to help bring to justice the perpetrators of crimes against children. All agencies and professionals should:

- Be alert to potential indicators of abuse or neglect
- Be alert to the risks which individual abusers, or potential abusers, may pose to children
- Share and help to analyse information so that an assessment can be made of the child’s needs and circumstances
- Contribute to whatever actions are needed to safeguard and promote the child’s welfare
- Take part in regularly reviewing the outcomes for the child against specific plans
- Work co-operatively with parents unless this is inconsistent with ensuring the child’s safety.

Detailed guidance about inter-agency collaboration and statutory duties on safeguarding children and promoting their welfare can be found and should be read by all managers and practitioners in Working Together to Safeguard Children (DfES, 2006).

5.2 Substance misuse as a safeguarding issue

Specialist substance misuse practitioners should consider whether children or young people are at risk from their own substance misuse. Where this is the case practitioners should act on any concerns that they have, in line with local safeguarding children boards.

Examples of substance misuse impacting on safeguarding issues:

- A young person caring for another child while under the influence of substances
- Substance misuse problem among young people’s parents or carers
- Sexual or physical abuse related to substance misuse
- Self-harm or suicidal behaviour related to substance misuse
- High-risk substance misuse behaviour
- Injection by a third party.

The four parameters were developed by the Standing Conference On Drug Abuse (SCODA) and The Children’s Legal Centre (CLC) (1999) to help determine whether confidential information about substance use, given by a young person, should be disclosed to a parent or child protection agency on the grounds that there may be a safeguarding issue (see Appendix 1). Decisions about making a child protection referral and about breaching confidentiality should be made in consultation with a line manager and should not be the sole responsibility of one practitioner.

In addition to arrangements with LSCBs in relation to safeguarding young people, young people’s specialist substance misuse providers should establish relationships with children’s social care services, including duty teams. These relationships can then be used to informally discuss cases in confidence where there is indecision as to whether a child protection referral is required. Reciprocal training should also be explored to ensure specialist substance misuse staff receive regular updated child protection training and other staff within children’s services receive training on young people’s substance misuse.

5.3 Confidentiality

Young people should be consulted and their perspectives taken into account in reaching decisions about their future. They can expect to enter into confidential relationships with practitioners concerning their health. The boundaries of confidentiality should be explained, in terms of the limits with regard to balancing confidentiality and the agencies’ duty to safeguard their, and others’ wellbeing. Ensuring that confidentiality is not breached unnecessarily means gaining consent to information being shared from the young person or the parental responsibility holder, whenever it is possible to do so.

For children or young people to enter into a confidential relationship or treatment intervention they will have to demonstrate that they are competent to consent to do so, as this right is not automatic before reaching full majority age (18). The Department of Health has published guidance on these issues for practitioners and leaflets aimed at parents and young people (DH, 2007).

5.4 Informed consent

Before any treatment intervention can be delivered, informed consent to that intervention must be gained. Informed consent means that the person giving the consent must understand the reason for the treatment, what is likely to happen without it, the range of possible treatments, and the benefits, composition and any possible negative consequences. As such, it should not be assumed that any or every treatment offered will be taken up – young people, like other service users, have a choice.

Young people aged 16 or 17-years-old can usually consent to their own treatment, unless they have severely diminished ability to understand the treatment, in which case the parental responsibility holder would be required to consent to their treatment until they reach 18. As some treatments for substance misuse can carry their own risks, practitioners should take active steps to ensure that even 16 or 17-year-olds are competent to consent to their own treatment (see section 5.5). In any case active participation of parents and carers should be encouraged.

Young people under 16 can only consent to their own treatment if they are assessed as being competent to consent under the Gillick and Fraser guidelines (see section 5.5.1).

Informed consent is required for any intervention that only a specialist practitioner can deliver, but not interventions that any ordinary individual or parent could provide.

Examples of interventions that do not need informed consent:

- Advice and information such as that contained within widely available leaflets and other public information sources on substance misuse
- Encouragement to attend appointments and progress with the assessment and treatment plan
- Advice on risks and harms of substance misuse that allow young people to reflect on their substance misuse.

Examples of interventions that do need informed consent:

- Advice and information about safe injecting techniques and access to injecting equipment
- The use of counselling, regardless of the technique, conducted over a series of planned sessions
- Any invasive procedure that could be, without informed consent, described as actual bodily harm. Examples include prescribing of medicines, massage methods, acupuncture and removal of clothes to inspect injecting sites.

5.5 Assessing competence to consent

Young people under 16 can only consent to their own treatment if they are assessed as being competent to consent under the Gillick or Fraser guidelines (see section 5.5.1). These guidelines can also be useful when working with 16 and 17-year-olds, especially when the intervention is potentially harmful (for example injecting equipment and access to medication controlled under the Misuse of Drugs Act 1971).

If young people under 18-years-old are not competent to consent to their own treatment, consent should be sought from a person with “parental responsibility”. Legally, consent is needed from one person with parental responsibility, although it is good practice to involve all those close to the young person in the decision making process (see section 2.2).

5.5.1 Gillick and Fraser guidelines¹

Young people under 16 have a right to confidential medical advice and treatment if the provider assesses that the young person:

- Understands the advice and has the maturity to understand what is involved
- Their physical/mental health will suffer if they do not have treatment
- It is in their best interest to give such advice and treatment without parental consent
- Will continue to put themselves at risk of harm if they do not have advice and treatment
- Cannot be persuaded by the doctor or health professional to inform parental responsibility holders, nor allow the doctor to inform them.

5.6 Information sharing

Every Child Matters and its subsequent guidance emphasises the need for multi-agency working. Systems are being developed in local children’s services to enable professionals to come together to meet the needs of children and families, and jointly agree action plans to meet identified needs. Practitioners conducting specialist assessments are encouraged to participate in this process, facilitated by the lead professional co-ordinating care.

Multi-agency working should not be compromised by fear of sharing information and breaching confidentiality. Information sharing needs to take place within the boundaries of the law, particularly the Data Protection Act. This means that information can be shared but only with the consent of the person the information is collected from. In working with young people, this

1. These guidelines are interchangeably referred to as “Gillick” or “Fraser” but actually reflect different parties within the same case law. The Stationery Office uses the term “Fraser” (Fraser Guidelines, 1983).

consent should be received either from them or, if they are not competent to consent to this information sharing, from the parental responsibility holder. Part of the assessment process should be establishing with young people how information relating to them may be shared and for what purpose. This should be revisited as part of the care planning process.

Local agencies should be aware of how to make referrals to other agencies and which agencies can meet the specific needs of young people and their families. Local protocols should be used and reviewed annually to ensure that they still meet referral criteria. All services should have clear policies on confidentiality, consent and information sharing which are agreed with the local safeguarding children board and partner agencies. Referral processes should attempt to improve accessibility to services to ensure:

- Young people understand why they are being referred and what they can expect from another agency. However, they should not promise services on behalf of other agencies
- Information is shared on a need to know basis and with appropriate consent
- Involvement is continued by the referring agency, by means of joint working where appropriate.

Some services have a form which identifies other agencies the young person is in contact with and permission from the young person to engage in information sharing.

6 Workforce support

Working with young people with substance misuse problems can be complex and the workforce is growing and evolving. It is important that there are proper systems in place to ensure that practitioners receive the support they need and ensure formal lines of accountability.

6.1 Child specific skills and knowledge

The Department for Education and Skills is reforming the workforce to ensure everyone working with children (including volunteers) have basic skills and knowledge. This will enable multi-disciplinary teams to work together more effectively in the interests of the child. The common core of skills and knowledge for the children's workforce is:

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

In addition to these core competencies, children's practitioners require competencies related to the practitioner's sector, such as youth justice or education. For the social care sector, the competencies are currently listed in Health and Social Care National Occupational Standards (TOPSS, 2005) and include such elements as:

- Contributing to the assessment of young people's needs, wishes and preferences
- Supporting the development and implementation of care plans.

From the end of 2007, the Sector Skills Agreement for the adult social care and the children and young people's services workforce will map out the skills needed by the workforce and how these skills will be developed. These developments will be described by the Children's Workforce Development Council (see www.cwdcouncil.org.uk).

6.1.1 Common Assessment Framework competencies

As part of the Children's Workforce Strategy, the Department of Health is undertaking workforce reform to ensure all practitioners working with children and families:

- Understand the outcomes we want for all children, for example by using the CAF checklist to identify children who need extra support to fulfil their potential

- Know about the CAF, and when and how to have a common assessment completed, or know how to complete one themselves. For more information about the CAF and workforce initiatives go to www.everychildmatters.gov.uk (see section eight). Gaining these skills in understanding and using the CAF should enable a practitioner to view a young person's needs holistically and take action to ensure that these needs are properly assessed and met.

6.2 Substance misuse skills and knowledge

Anyone working with young people and substance misuse will require:

- Children's workforce core competencies
- Sector specific competencies
- Drug and Alcohol National Occupational Standards (DANOS) competencies

The skills and knowledge required to undertake a specialist substance misuse assessment are described in DANOS. As DANOS considers the specific skills and knowledge to carry out a specific task, it encompasses all professional backgrounds. DANOS is used to develop curricula and training for all sectors, job descriptions and person specifications.

Assessment is not a standalone activity and other DANOS competencies will be required in order to approach the assessment appropriately and to analyse and act on information appropriately.

There are many other competencies described in DANOS that will relate to work in the substance misuse sector. Practitioners, managers and supervisors should ensure they have the necessary competencies for the work they are undertaking. Further information about the Government's plans for workforce development can be read on the workforce development page on the Home Office's Drug Strategy website at www.drugs.gov.uk (see section eight).

6.3 Development awards for the drug and alcohol sector

Sector skills councils and a number of Government departments are working together to help build a framework of qualifications at different levels to achieve the following aims:

- Attracting and retaining new recruits to the drug and alcohol workforce
- Helping drug and alcohol practitioners to progress their career development
- Encouraging staff mobility across the related health, social care, criminal justice mental health and drug and alcohol sectors

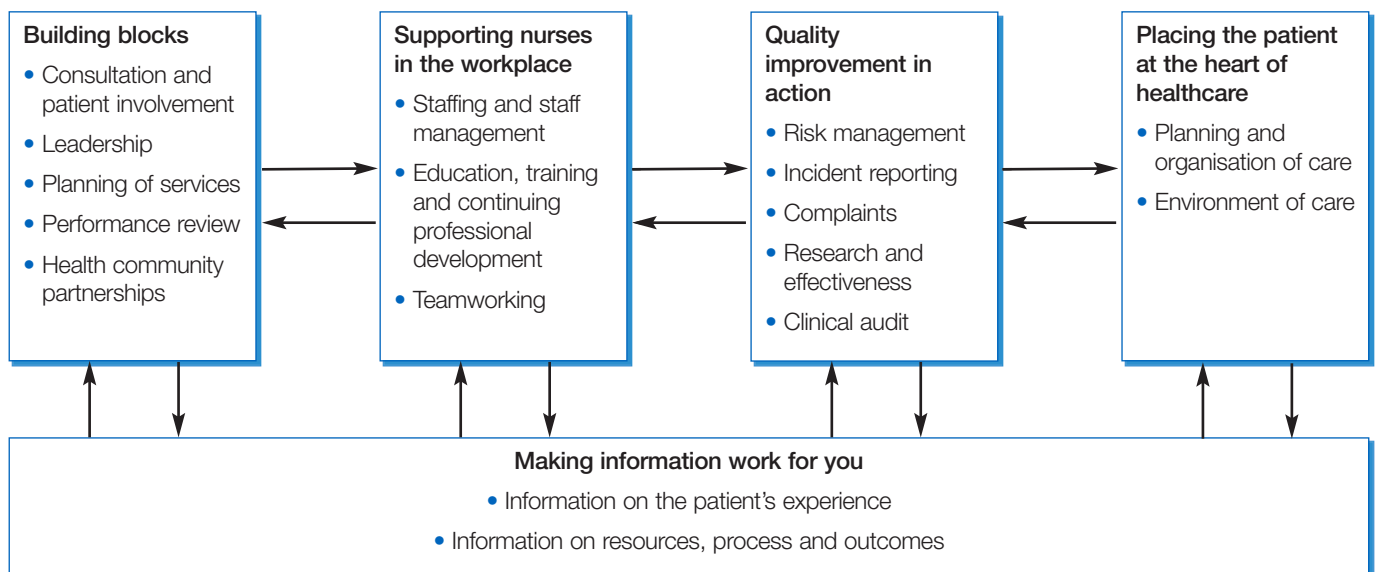


Figure 3: Key themes of clinical governance (from *Clinical Governance: An RCN Resource Guide* (Royal College of Nursing, 2003))

- Enabling those who are already qualified in a related sector, and who therefore already have generic skills, to add the specific knowledge and understanding they need to work in the drug and alcohol sector.

The development award for the drug and alcohol workforce will incorporate both DANOS units and other national occupational standards from related sectors.

The Development Award for Young People and Substance Misuse is being developed by Skills for Justice. Further details can be found on Skills for Justice website at www.skillsforjustice.com (see section eight)

6.4 Clinical governance

All aspects of clinical care for a young person with a substance misuse problem should be provided in accordance with evidence-based practice and within the context of a clinical governance framework. While working to this framework is mandatory for NHS organisations, voluntary organisations can establish their own clinical governance arrangements to ensure their practice is evidence based and safe.

Clinical governance is described as a framework through which NHS organisations are accountable for continually improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish.

Clinical governance requires changes at three levels: individual healthcare professionals, teams and organisations.

- Individual healthcare professionals need to embrace change, adopting reflective practice that places patients at the centre of their thinking
- Teams need to become true multidisciplinary groups where understanding about roles, information sharing and knowledge, and support for each other become part of everyday practice.
- Organisations need to put in place systems and local arrangements to support such teams and assure the quality of care provided. Commitment and leadership from the board and throughout organisations is clearly crucial.

The Royal College of Nurses describes the key themes of clinical governance in figure 3.

Clinical governance applies to all healthcare professionals, not only nurses. Figure 3 demonstrates that all aspects of service planning, monitoring and delivery will be subject to clinical governance scrutiny. Specialist substance misuse assessment arrangements will be an essential element in considering the needs of young people with substance misuse problems, as will policies and procedures for all other aspects of care and service management.

6.5 Clinical supervision and consultation

One aspect of clinical governance arrangements will be to ensure that suitable clinical supervision arrangements are in place. Clinical supervision allows practitioners an opportunity to reflect on their practice and discuss complex cases with a senior practitioner, to ensure that the best standard of care is being provided and their needs for training and support are discussed. All practitioners

who have therapeutic face-to-face time with service users should receive and participate in clinical supervision.

Specialist substance misuse assessment may raise needs that the substance misuse practitioner is less familiar with. It is important in these cases to ensure that consultation takes place with another practitioner familiar with this area of work. This can provide support in terms of meeting a young person's needs and precipitate referrals to other specialist practitioners in some cases. An example of this may be that specialist substance misuse practitioners feel able to support a young person with low mood when assisted by a mental health specialist, but that a referral would be taken should the situation seriously deteriorate.

6.6 Equality

The Equality Act 2006, with effect from April 2007, brings together existing legislation on sex, race and disability discrimination with new legislation on the discrimination of age, sexuality and religion or belief. This work will be overseen by a new Commission for Equality and Human Rights. Managers should ensure their services comply with this legislation in relation to workforce development and recruitment, and the provision of services.

Managers should work towards embedding equality issues in its policies and practices. This should include:

- Ensuring that relevant information about services reaches all communities
- Ensuring that account is taken of the needs and culture of families, including minority ethnic families, in providing information, undertaking assessments and arranging services
- Working towards a more diverse and ethnically and culturally sensitive children's workforce to ensure that frontline practice more effectively meets the needs of children.

7 Glossary

Asset

The structured assessment tool used by YOTs with all young offenders who come into contact with the criminal justice system.

Child

In this document, as in the Children Acts of 1989 and 2004, a child is anyone who has not reached their 18th birthday.

CAMHS

Child and adolescent mental health service

Child protection

This is part of safeguarding and promoting welfare and refers to activity that is undertaken to protect specific children who are suffering, or at risk of suffering, significant harm.

CAF

Common Assessment Framework for Children and Young People (DfES, 2006)

CLC

Children's Legal Centre

DANOS

Drug and Alcohol National Occupational Standards

DfES

Department for Education and Skills

DH

Department of Health

Keyworker

The person responsible for co-ordinating care in relation to substance misuse, who liaises with other professionals.

Lead professional

The person responsible for co-ordinating the actions identified in the CAF assessment process and the single point of contact for children with a range of needs, who is supported by more than one practitioner.

LSCB

Local safeguarding children boards are the key statutory mechanism for agreeing how the relevant organisations in each local area will co-operate to safeguard and promote the welfare of children in that locality, and for ensuring the effectiveness of what they do.

NTA

National Treatment Agency for Substance Misuse

Onset

A referral and assessment framework for children and young people at risk of committing crime or anti-social behaviour.

Parental responsibility holder

The person or authority designated by law who can make decisions on behalf of a child (see section 2.5)

Safeguarding children

A term used to describe safeguarding and promoting the welfare of children, which include:

- Protecting children from maltreatment
- Preventing impairment of children's health or development
- Ensuring that children are growing up in circumstances consistent with the provision of safe and effective care
- Undertaking a safeguarding role to enable children to have optimum life chances and to enter adulthood successfully.

For further details of safeguarding children and child protection, readers are directed to *Working Together to Safeguard Children*, Department for Education and Skills (2006).

SCODA

Standing Conference On Drug Abuse

Substance

A term used to describe all illicit and illegal drugs, alcohol and solvents (or volatile substances) but not tobacco

Treatment

An intervention intended to remedy an identified problem or condition in relation to an individual's physical, behavioural, psychological and psychiatric wellbeing. Treating a young person for substance misuse will start with a full assessment and the treatment will be delivered within a care plan according to agreed procedures for case management.

YOT

Youth offending team

Young person

There is no specific age at which a child under 18 becomes a young person. In this document, any reference to young people or children denotes someone under 18 years of age.

Universal services

Services that all children and young people are expected to come into contact with, for example schools and primary healthcare.

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Appendix 1: The four parameters

The four parameters of decision making (SCODA & CLC, 1999) are:

1. The age and maturity of the child or young person

As a general rule the younger the child, the more problematic it is to maintain confidentiality. There is no age limit in law below which a child cannot enter into a confidential relationship, but given the problems of establishing competence, and therefore capacity to consent, it is difficult to envisage children being offered confidential treatment for substance misuse, without parental consent, or parental involvement, much under the age of 13. Indeed it is possible that a failure to inform parents that a young child is misusing substances could lead to a possible negligence action if the substance misuse service failed to take sufficient action to protect the child from harm as a result of that substance misuse.

2. The degree of seriousness of substance misuse

The more serious the substance misuse, the more likely it is that disclosure of confidential information to parents or other agencies (NSPCC, social services, police) will have to be considered. In deciding whether to disclose, the substance misuse service must take into account patterns and levels of substance misuse, the risks of morbidity (other health problems) and mortality, and other risks such as involvement in crime and other behaviour linked with the substance misuse. The supply source of the young person's substances may also be important, particularly if the young person is at risk of exploitation or coercion.

3. Whether harm or risk is continuing or increasing

Harm from drug taking needs to be assessed with consideration of past, present and potential future behaviour. If there is a clear risk to the child or young person arising from present behaviour or evidence of an escalation of risk to an unacceptable level, it is important that the service takes steps to ensure the future safety of the child or young person.

4. General context in which substance misuse is set

Where the child or young person has multiple problems, it is likely that other agencies or professionals will need to be involved to resolve these problems or reduce the vulnerability and risk to the child or young person. For instance, the child or young person needs to be encouraged to involve other agencies if abuse is revealed within their home or accommodation, if family relationships have collapsed and they are homeless, if the child has absconded from care or unable to obtain any legitimate income. The substance misuse service will need to assess the child or young person's circumstances and determine whether to disclose confidential information against the child's wishes, if they cannot be persuaded to consent to the information being shared.

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