Drug and alcohol work in child and adolescent mental health

THIS ARTICLE aims to share a way of working with adolescents who have problems with drugs and alcohol. I work in an adolescent mental health team. My role, as a drug and alcohol worker in Child and Adult Mental Health Services (CAMHS), provides a bridge between the two services.

Christian and Gilvarry (1999) have noted the feelings of inadequacy many youth service staff experience when dealing with those with drug problems while, in turn, drug services find it difficult to deal with mental health problems. There is often a lack of integration among these services.

The role of a CAMHS worker is to provide a comprehensive assessment of the young person’s mental health, including his or her physical, psychological and social needs, leading to the provision of care. This may be within CAMHS or through other mental health services.

The drug and alcohol worker’s role is similar, but focuses on drug and alcohol use. The worker provides intervention, advice, information and support for young people and their carers. The role also provides supervision for colleagues in the CAMHS team on substance abuse.

Prioritising care for young people

The Barnes Unit in Sunderland is an adolescent mental health team that provides a community-based treatment service for 16 to 19-year-olds. It follows the Health Advisory Service’s recommendations in Together We Stand (HAS, 1995), which calls for a four-tiered approach to CAMHS, to provide comprehensive services for young people.

■ Tier one: Universal, generic and primary services providing drug education, information, identification and referrals for young drug misusers;
■ Tier two: Services offered by practitioners with drug and alcohol experience, and specialist youth knowledge. Provides all of tier one plus drug-related prevention and targeted education, advice and general counselling;
■ Tier three: Young people’s specialist drug services plus specialist services working with the community for complex cases requiring multidisciplinary team work;
■ Tier four: Highly specialised services for young people with complex care needs; usually an inpatient service.

We provide a tier-three service. To ensure appropriate provision of care, we prioritise four groups of young people: those who self-harm/attempt suicide, those developing symptoms of psychotic illness, those leaving the care system and those concerned about their drug use.

Drug and alcohol work in CAMHS

The role of a drug and alcohol worker within a tier-three CAMHS is ideally suited to:
■ The promotion of service integration;
■ The encouragement of access to services;
■ The promotion of drugs and alcohol as inclusion criteria, allowing young people access to services rather than being excluded because of substance misuse. People who use substances but who do not have a mental health issue can, therefore, receive a comprehensive physical, psychological and social assessment and care package. People with mental health issues can also receive a care package to address drug and alcohol concerns.

Drug and alcohol misuse

An analysis of referrals to the Barnes Unit indicates that 78 per cent of those referred with mental health issues as the primary reason for referral were using psychoactive substances beyond a ‘recreational’ level.

Drug and alcohol misuse is usually an indication of interpersonal, psychological, social, family and peer-related issues that the young person is struggling to deal with. This worsens if the person is homeless and too young to qualify for his or her own tenancy. There is a high prevalence of drug use in this group, and a higher incidence of mental health issues. This suggests a very high level of undiagnosed mental health problems (Adamczuk, 2000). The paradox is that young people who use drugs seem to be excluded from housing/mental health services, when it is they who most need them (Acheson, 1998).

One hypothesis for their exclusion is a lack of understanding about substance use. Health care staff may worry they do not possess the necessary skills, knowledge and experience to deal with people who misuse drugs and alcohol. There is also a fear that such patients will prove difficult, leading to further avoidance and the reinforcement of negative attitudes and stereotyping. Furthermore, a lack of service integration can result in cases being passed on to other agencies.

Assessment

During initial assessment we look for motivation, a desire to change and an identification of who has the problem. If the young person feels he or she does not have a problem then it is possibly the parents, social worker and GP who need support at this stage to assist them in
dealing with their anxieties and frustrations about the young person’s behaviour. A risk assessment is made, especially if the person is under 16. Even if the person is over 16 his or her competence to consent to treatment still needs to be established. The test case that is often quoted is ‘Gillick Competence.’ This is when: ‘As a matter of law the parental right to determine whether or not their minor child below the age of 16 will have medical treatment terminates, if and when the child achieves sufficient understanding and intelligence to enable him to understand fully what is proposed’ (Gillick v West Norfolk and Wisbech Area Health Authority and DHSS, 1986).

If young people want treatment, we get them to complete a ‘pay off matrix’, a list of the positive and negative aspects of their substance use. From this we gain an understanding of their concerns regarding their substance use and can also explore the benefits of their drug use. These ‘benefits’ include increased confidence, reduced levels of anxiety, greater happiness and a reduction in unpleasant withdrawal symptoms.

Asking about the benefits provides the opportunity for a different conversation to occur, one where the young person does not feel defensive or chastised, but feels safe and accepted. You can then, by negotiation and collaborative work with other services, begin to develop strategies to replace these ‘positives’ with more socially acceptable and helpful activities.

We also try to work collaboratively with young people and negotiate the work that is going to occur, be it information, advice, treatment or counselling (Standing Conference on Drug Abuse, 2000a; 2000b). We establish an overall aim, as abstinence might be our goal but not the young person’s. If they want to continue taking drugs, try to have drinks with the lowest percentage of alcohol to reduce the total number of units.

We support this with education about their substance of choice, so that if they continue to misuse they are making informed decisions. A behavioural approach using drink/drug diaries is also a useful strategy in working with young people as it gives them responsibility for self-monitoring on a daily basis and provides a baseline of their behaviour and weekly usage. Consideration should be given to the young person’s literacy levels and helping them find creative ways of recording the information, for example using pictures instead of words.

By reflecting together on the diaries we begin to identify patterns of use. This forms a template for the best way to work together to cut down or stop their behaviour.

Supervision and education
I am allocated referrals specifically for drugs and alcohol, with supervision provided to me for issues relating to development potential and child protection from my colleagues. The local addiction service supervises my drug and alcohol work to encourage reflection on my practice and ensure young people receive appropriate interventions.

If a referral is primarily for mental health, but the assessment indicates drug and alcohol issues, then the original key worker in the team maintains his or her involvement but will receive supervision and education relating to the drug and alcohol work. Through this process and discussion we can begin to look at drug and alcohol use from a different angle.

Collaborative working
Young people’s problems do not respect professional boundaries (Department of Health, 2002). To try to provide a holistic service and explore beyond the issues of drug and alcohol dependency, we liaise with community resources such as the YMCA, careers service, education authorities and local housing schemes.

This collaborative working also provides an opportunity to engage young people with services that may help their re-inclusion into society and help them make informed lifestyle choices – as opposed to reactive choices based on crisis.

Dependence
Physical dependence on opioid-based drugs is of particular concern. Substitute prescribing of methadone for de-toxification from opioids, especially for young people, is a contentious issue as it is only licensed for adult use.

The Barnes Unit does not provide a prescribing service, though any young person presenting with physical dependence on opioids will, where appropriate and with his or her permission, be referred to the opioid clinic of the local community addiction team (CAT). There they will receive a comprehensive assessment and, if appropriate, a reducing prescription of methadone to be dispensed daily under the supervision of a local chemist.

During this period I remain the key worker and maintain contact with the young person via regular appointments, working in parallel with the CAT, to ensure continuity of care and minimise the potential for lapse/relapse. Following the reducing regime of methadone there is also the opportunity for the prescription of naltrexone, an opioid antagonist, which blocks the effect of opioids and reduces the potential for relapse.

Other difficult areas to address are psychological and social dependence. Lifestyle changes need to occur. Young people need to review their peer group, find alternative activities to replace the void left when they stop using and discover alternative ways to increase self-esteem and confidence. This can help them deal with the psychological/physical cravings they may experience and minimise the chance of relapse.

Conclusion
The Barnes Unit strives to offer any style of treatment that might fit the young person’s needs. However, the core components of working with young people who misuse drugs and alcohol are the same as those of working with any young person: that is to treat them with respect, listen to what they have to say and work in a climate of collaboration and negotiation.

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REFERENCES


Gillick v West Norfolk and Wisbech Area Health Authority and DHSS (1986) AC 112. www.fnt.org.uk/gillick.htm


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