Treatment for substance use problems among young offenders: Difficulties and dilemmas for implementation and evaluation in the UK

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Abstract
Youth offending is assumed in part to be caused by substance use problems, consequently policy and practice in youth justice emphasise their treatment. We review four types of difficulty for substance use treatment of the under-18s and of youth offending team clients, then consider what might work. (1) Working with children raises systemic and ethical issues that complicate intervention and evaluation. (2) Assessing or diagnosing substance use problems in this age group is inherently problematic and often neglects the systemic aspects of pathways to treatment. Ineffective treatment may seem effective because change has occurred naturally with time. (3) Defining realistic and acceptable long-term outcomes for substance use in this age group is problematic. In the early 21st century it is developmentally normative for substance use to increase between ages 10 and 20, so interventions should strictly aim for a reduced rate of increase, rather than decrease or abstinence. Separating drugs from alcohol and tobacco in policy, over-problematising youthful drug use and assuming that drugs simply cause crime have hindered the setting of realistic objectives. (4) Operating, auditing and evaluating a substance problems service for children requires flexibility and sensitivity of practice that can work against evaluation; firm recommendations about the effectiveness of specific treatment packages are as yet inappropriate. Systemic and cognitive-behavioural therapies have most evidence of efficacy, while humanistic advocacy counselling is widely used, but interventions developed for adults cannot be applied unmodified to younger clients.

With rising prevalence, there is increasing need to treat young people’s substance use problems. In 1999 the Youth Justice Board committed £3.8 million from its Development Fund to support projects to enable young offenders to access appropriate intervention programmes. The national evaluation of this provided a candid snapshot of the state of substance services for young people in England and Wales at the turn of the century (Hammersley et al., 2004; Minkes et al., 2005). Four key difficulties in evaluating and defining substance treatment services for young offenders are discussed here; they also apply to substance treatment services for young people in general. It will be suggested that the medico-scientific model of service delivery and service evaluation fits poorly with the broadly humanistic approach of many services. There are reasons to be cautious about simplistic or generic packaged interventions in treating children, and to date evaluations of treatment have been technically or conceptually inadequate.

Difficulties to be reviewed are:
1. Working with children (the under-16s) raises systemic and ethical issues that complicate both intervention and evaluation.
2. Assessing or diagnosing substance use problems in the under-18s is problematic and often neglects the systemic aspects of pathways to treatment.
3. Defining realistic and acceptable long-term outcomes for substance use in this age group is problematic.
4. Consequently, operating, auditing and evaluating a substance problems service for children requires flexibility and sensitivity of practice that can work against evaluation. Firm recommendations about effectiveness are as yet inappropriate.

A number of comprehensive reviews of evaluations of substance use treatments for young people exist (Dakof et al., 2001; Deas & Thomas, 2001; Elliott et al., 2003; Henggeler et al., 1995; Lowman, 2004; Titus et al., 2001; Williams & Chang, 2003), a number of large multi-site trials are currently underway (Dennis et al., 2002; Tims et al., 2002) and there have been calls for improvements in young people’s services (Gilvarry, 2001). All reviews comment that the majority of evaluations in this area are lacking in at least one of (1) consistent diagnosis and assessment; (2) adequate control group; (3) outcome measures that are not just self-report; (4) long-term outcome measures. None the less, there is some evidence for the efficacy and effectiveness of family/systemic therapy and of cognitive-behavioural therapy. Minnesota model and 12-step treatment have been evaluated less, but do no worse when evaluated (see Myers & Brown, 2000). Other approaches lack adequate evaluation, rather than having been shown to be non-efficacious. Notably, neither group work, nor humanistic or client-centred counselling has been evaluated for dealing with young people’s substance use problems. In concert with the national evaluation, these reviews also address, less systematically, the four problem domains that will be used to structure this review.

Inconsistent and unclear definitions of key concepts beset the topics of substance use problems among young people in general and young offenders in particular. ‘Young’ and ‘youth’ are rarely tied to a clear age range and hardly ever defined according to objective developmental criteria. This will be discussed further below. Collective nouns covering psychoactive substances are used inconsistently and it is sometimes unclear which substances are excluded and included in ‘drugs’ or ‘substances’. Most commonly ‘drugs’ includes cannabis/marijuana and a range of other illegal drugs, although often only a sample of the drugs that are being or might be abused. ‘Substances’ usually also includes tobacco, alcohol and volatile inhalants, but sometimes studies of ‘substances’ are actually studies only of alcohol, tobacco and marijuana, written up as if their findings could definitely be generalised to other substances such as heroin or cocaine. Here, ‘drugs’ refer to illegal drugs and ‘substances’ to all drugs and also tobacco, alcohol and volatile inhalants (although the latter are rare in most studies). A final difficulty is the inconsistent use of drug ‘use’, ‘misuse’, ‘abuse’ and ‘dependence’ (see Newcomb, 1995). Here, ‘use’ will refer to use without making a value judgement and it will be assumed that substance ‘use’ without problems is possible for some people under some conditions. ‘Misuse’ refers to use that is somehow inappropriate, although not necessarily comprising a diagnosable psychiatric disorder. Some authors use ‘misuse’ as a synonym for ‘use’ among young people, on the logic that all ‘use’ is inappropriate or illegal; for example, substance use in school would be a misnomer. This may be true for some substances at some ages, but we avoid the term misuse except when reporting other authors because it can easily produce a wrangle over legal terminology. ‘Abuse’ and ‘dependence’ will be used according to their DSM-IV diagnostic criteria (Diagnostic and statistical manual of mental disorders, American Psychiatric Association, 2000). The wider concept of ‘substance use problems’ will also be introduced (Newcomb, 1995).

In the international context, it is also important to be clear about contemporary drug use by young offenders in England and Wales. Hammersley et al. (2003) surveyed young offenders in England and Wales and found that use of alcohol, tobacco and cannabis was very common, and that these substances were often used at high frequency, but that use of other drugs was rarer. Few young offenders were regular users of
heroin, cocaine or other drugs widely discussed as causes of crime. Thus, the typical form of substance use problem was drinking and smoking (tobacco and cannabis) too much with some secondary, less frequent, polydrug use. Discussions with service providers have since confirmed that alcohol, tobacco and cannabis remain the predominant form of problem among young offenders, although a few become dependent on heroin, cocaine or other combinations of drugs. A similar generational move away from heroin and cocaine has been documented in New York (Golub & Johnson, 1999).

Children and young people
Neither studies of treatment nor services always consider client age. ‘Young people’ aged 9 or younger or 25 or older are not homogenous. Sociological writers have long commented on the construction of ‘young people’ as ‘the other’ (e.g. Pearson, 1983) and this is particularly germane for threatening topics such as drugs.

The definition of a child
Legislation covering the changes between child and adult vary internationally but generally include the following age transitions: that at which children can consent to treatment without parental consent; cease to require special responsibilities of care; are considered responsible for their actions in law (which may be a staged transition); will be dealt with by the adult criminal justice system; can legally purchase alcohol and tobacco. Transitions do not necessarily occur simultaneously, or at the same age in different countries. For most purposes, legally a child in the UK is under 16; after that age people can consent to treatment without parental consent (Department of Health, 2003) and there is no longer a legal requirement for parents to compel their children to attend school. There are related ethical and legal issues in treating children. Particularly important is how to proceed when discovering during therapy that children pose a risk to themselves or to others (Children Act, 1989). Studies of substance use often use the terms ‘young people’, ‘children’ and ‘adolescents’ without defining clear age referents. Age 18 is also of importance because if there is criminal justice involvement then this is the age when a child transfers into the adult system. In consequence 16–17-year-olds can be legally independent of their parents but still juvenile. This paper will refer to the under-16s as ‘children’.

The over-16s may more resemble adults, but transitions to adulthood are more complex than they were fifty years ago (Parker et al., 1998) so aspects of ‘adolescence’, such as continuing education and lack of full financial autonomy from parents, can remain into the mid- and late 20s. ‘Youth’ covers an even wider age band that may extend above age 30.

Ethical and systemic issues
The legal status of the child can make treating children and their evaluation (Brody & Waldron, 2000) ethically complex, posing problems for engagement with treatment. There are usually multiple stakeholders, including parents and other family members and various professionals from education, social work and youth justice. Systemic factors affect how a problem is assessed, labelled, dealt with and whether the outcome is judged successful. For example, education may require drug cessation, while the drugs service prioritises engaging the young person with treatment (Minkes et al., 2005). There are related issues of children’s rights, empowerment and autonomy (e.g. Armstrong, 2004). Drugs can be one of the problems that facilitate adult agencies in acting without full regard of these issues, hoping that this is in the child’s best interests. For example, a YOT\(^1\) may refer a young person

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\(^1\)Youth Offending Team, set up by the Crime and Disorder Act 1998. Each area of England and Wales has a YOT, reporting to the Youth Justice Board, which is a quasi-autonomous non-governmental organisation.
to a drugs service on the basis of assessment data, but the drugs service may be reluctant to offer treatment without the young person’s consent and motivation, which can cause problems if drug treatment is part of a legal disposal (Minkes et al., 2005).

Also, during therapy the therapist may discover things that would be judged as ‘risk’ by other adults and may face dilemmas about disclosure to others. For example, whether referred for substance use or not, many young offenders use drugs (Hammersley et al., 2003), which would result in their automatic exclusion from school and can hinder frank discussions about substance use unless the therapist, the school and the client have agreed appropriate boundaries for disclosure and information sharing (Minkes et al., 2005). Incorporating family or systemic work can improve the engagement of young drug users with treatment because systemic issues need to be negotiated (Dakof et al., 2001; Liddle & Dakof, 1995).

A key dilemma for treatment is to decide which stakeholders should know what. This issue is so important that different agencies need to agree procedures in advance (Minkes et al., 2005) and strict client–therapist confidentiality can be unrealistic or counterproductive for substance-using children, whose reintegration may necessitate certain forms of disclosure to YOT, school or family. Very little is known about children’s and families’ views on disclosure. Fear of parents finding out about drug use can be a substantial barrier (Hammersley et al., 2004).

Age-appropriate behaviour
Some behaviour is considered more appropriate, or less problematic, at some ages than at others (Jessor & Jessor, 1977), so the assessment of presenting problems and the resultant formulations can vary with age. Developmental considerations weaken the evidence base for therapeutic effectiveness because study samples tend to be skewed towards older children and young adults. When younger children use drugs – even lightly – this is cause for concern (see Mckeganey et al., 2004), but it is not clear what is effective, or what the appropriate outcomes are. Among younger children the use of age-inappropriate substances is often a sign of other problems (e.g. Elliott et al., 1985; Jessor & Jessor, 1977), but precocious, well-developed children use substances early too (Baumrinid, 1991). These difficulties point towards the need for holistic, individualised approaches to intervention with children, rather than reliance on generic ‘drug treatment’ techniques or packages. Into this complexity is thrown the further problem that contemporary norms for children may involve more substance use than their parents’ generation find acceptable (Hammersley et al., 2003).

Crisis and urgency
Children’s crises can require action because of responsibilities of care for the under-16s, because they can interfere with schooling, or risk attracting potentially damaging youth justice sanctions and because of the sheer weight of concerned stakeholders. There is also a hope that early intervention may make a difference in the long term. There is therefore a tendency to act, rather than reflect or simply wait, which includes a reluctance to delay intervention for the sake of evaluation control or comparison groups.

Among children in crisis who use drugs in problematic ways are (1) children who are already developing substance dependence often with associated criminality (Hammersley, Lavelle & Forsyth, 1992). But there are also (2) children who have multiple life problems of which substance misuse is only...
one component (Elliott et al., 1985). Also, (3) some children temporarily misuse substances as a method of coping or self-medicating for other problems such as bereavement or parental break-up (Hammersley et al., 2003). These three possibilities can overlap and without knowing their relative influence it will be difficult to plan appropriate treatment. The labels ‘addict’ or ‘dependent’ do not fit (2) or (3) well. For all three, an objective of treatment might be to reduce heavy substance use to more normative or acceptable levels. However, most heavy substance users reduce with time (Elliott et al., 1985), so there is a risk of any treatment appearing successful in these simple terms while not necessarily resolving any deeper problems.

Assessment and diagnosis

It can be difficult to diagnose substance dependence or substance abuse among the under-18s (Newcomb, 1995) because not enough time may have elapsed since use began for the diagnostically important features to be clear. In the under-16s, adult concerns about substance use may constitute a socially significant problem with major consequences, even if no other signs of abuse or dependence are present. Despite these differences between adult substance use disorders and children’s substance use problems, until recently treatment for younger people was simply based upon treatment for adults (Muck et al., 2001).

Newcomb (1995) recommends simply describing ‘drug problems’ or ‘substance use problems’ instead of abuse or dependence. This inclusive definition risks treating substance use ‘problems’ that require no treatment but simply represent use which is normative for the peer group (Parker et al., 1998). From this perspective, it may be ‘difficult’ to diagnose substance dependence or substance abuse because many child substance users do not suffer from any psychological disorder, but are simply behaving within norms for their age. ‘Difficult’ becomes ‘impossible’ when relevant peer norms are unknown.

The absence of clear diagnostic criteria, coupled with the systemic sensitivity of ‘drug use’ for the young person, means that assessment usually has to rely upon self-report, in spite of the fact that young offenders are often motivated to under-report drug use, if only to conceal it from their parents. Even when the assessor is confident of the quality of the information there are problems of interpretation. For example, at the turn of the century young offenders who used heroin or cocaine were more likely to be treated than those who used only alcohol and cannabis (Hammersley et al., 2003), although heavy use of the latter two drugs
was an increasingly common form of problem. This suggests a simplistic focus on ‘drugs of addiction’ in referral.

Young substance users referred to treatment have high rates of comorbidity. In the USA, more than half such referrals have criminal justice involvement and other psychological difficulties (Farabee et al., 2001; Tims et al., 2002). Furthermore, of 600 adolescents currently in outpatient treatment for cannabis problems, only 4 per cent met DSM-IV diagnostic criteria for neither abuse (50 per cent did) nor dependence (46 per cent did) (Tims et al., 2002). There is evidence that substance use tends to worsen other problems (Newcomb, 1995), and concerned adults are not blind or naïve to the difference between normative, if undesirable, substance use and the makings of serious problems. None the less, comorbidity may be a cause of referral, rather than being evidence that substance use is causing problems. That is, adult judgements about the severity and impact of substance use depend upon the child’s other problems, related to or caused by substance use or not.

Children are often referred for behavioural problems, most commonly at home or at school, which may concern adults more than it concerns them. While in many cases assessment leads to a clear diagnosis, in some cases a clear diagnosis is not possible. Substance use problems are often comorbid with other problems and disorders, including depression, anxiety, poor school performance, personality or conduct disorders (including attention deficit and hyperactivity disorder) and family problems (Grella et al., 2001; Parker & Roy, 2001). In different circumstances, a drug problem may be regarded as the central cause of the child’s other problems or as a secondary symptom that does not require priority treatment. Further confusion about cause, effect and outcome is facilitated by the fact that drug use can be viewed both criminologically and as a mental health problem. It can be deserving of both punishment and treatment and be both explanation and symptom.

In the context of a seriously disrupted life course, substance use and even abuse may be one of the more positive aspects of a young person’s life. It can provide escape from atrocious family circumstances, major bereavements and other life problems (Hammersley et al., 2003; Ward et al., 2003). Drugs can also provide an alternative social network that provides support and esteem for young people who are excluded from school and other conventional institutions (Golub et al., 2005). Also, involvement in drug selling can provide social status and disposable income (Golub et al., 2005). If and when a young person’s life circumstances change, that person may reduce substance use, which ceases to serve a useful function (Carpenter et al., 1988; Ward et al., 2003). All these complications make it difficult to diagnose substance use problems or to recommend outcomes for everyone.

Outcomes for young offenders who use substances
Is treatment to lead to lifetime abstinence, to normal substance use as an adult (and, if so, defined as normal by whom and relative to what standards?), or simply to a reduction or delay in the regrettably normal increase in substance use as children become adults? Alternatively, is substance use treatment for children largely preventive? That is, is it primarily intended to stop or reduce later problems? Or, as the Youth Justice Board expected, should effectiveness be measured as reduced reoffending? The most useful interventions and outcome measures may vary substantially for different objectives and the more rigorous the outcome, the less probable that treatment will seem effective (see Hammersley et al., 2004, for reoffending).

Policy assumes that substance use is a risk factor for offending in general and ‘career’ criminality associated with drug dependence in particular (e.g. Drugs Strategy Directorate, 2002; Youth Justice Board, 2001). However, offending is also a risk factor for heavy – expensive – drug use because it is impossible for a young person to afford large
quantities of drugs without a substantial source of income (Hammersley et al., 1989). Drug-using young offenders include a large minority who will still be offending and additionally substance dependent in their early and mid-20s. This is not, however, the normal untreated outcome. Between ages 10 and 20 young people tend to increase their substance use and these days this includes the use of a widening range of substances, including sometimes cocaine and heroin (Parker et al., 2001). Over the same decade, young people tend to increase their offending and then decrease it again. Some YOT clients may be at their peak of offending and simultaneously using substances more heavily than adults consider acceptable without any future grave implications of either. Untreated, their offending would tend to cease and their substance use to increase, but not beyond age norms. It is difficult to identify in advance those who will follow more problematic pathways. Young people with multiple additional life problems may be most at risk (e.g. Elliott et al., 1985; see also Robins & Rutter, 1990). Without going into detail, the implication is that ‘treatment’, whatever its title and objectives, often has to address multiple individual needs and issues. Neither offending behaviour nor substance use problems can be addressed in isolation. Untreated, both types of behaviour tend over time to either stay the same\(^2\) or reduce, with only a minority getting worse (e.g. Elliott et al., 1985).

Specifying outcome simplistically, most young offenders will reduce offending and increase substance use. Interventions that are not genuinely efficacious will therefore seem to work for offending and fail for substance use in terms of hard outcome measures. Young adults are no longer supposed to smoke tobacco and their ‘binge drinking’ is of concern (Prime Minister’s Strategy Unit, 2004) along with their drug use (Drugs Strategy Directorate, 2002). Policy aims at a temperate ideal, rather than behaviour that can easily be achieved in current social norms.

In the absence of clear social norms or policy guidelines about what forms of substance use are acceptable and achievable for young adults, it is not surprising that substance use treatments focus on overall improvement in the child’s well-being and functioning, rather than solely upon substance use, or offending, outcomes. Unfortunately, this can lead to mismatches between policy outcomes, practice in relevant services and outcomes as defined in research and evaluation.

A modest outcome would be to reduce or delay the normal increase in substance use. Unfortunately, measuring a decreased rate of increase requires better data than are often available and some form of comparison data for the untreated. Such data are rarely available and ‘outcomes’ are often assessed solely by self-reports of use, or self-ratings of ‘improvement’ – compared to what?

In this context, interventions that apparently reduce subsequent substance use by children are worthy of close attention, as often these findings will turn out to be due to inadequate evaluation (see Miller & Sanchez-Craig, 1996). Specifically, there is a need to be cautious about findings that report substantially more than one-third of clients improving after treatment. ‘Honest’ improvement rates for substance use treatment tend to be 20–30 per cent (Miller & Sanchez-Craig, 1996). Little is known about the impact of substance treatment on offending. Among adults, treating dependence tends to substantially reduce, but not eliminate, juvenile offending (e.g. Gossop et al., 2003). Whether treating children’s substance problems has any measurable impact on offending is unknown. There will be plenty of claims that it does, but many of these will simply have recorded the general tendency for people to desist as they age and then treated this as the result of whatever

\(^2\)Which for substance use really means continuing to increase into the early 20s.
intervention was being evaluated. While substance use increases with age into the 20s, so other related problems such as offending tend to decrease – unless, that is, the young person has embarked on a career of drug-dependent offending. Longitudinal studies have not been able to differentiate those who become substance dependent from those who resist this despite having a prior profile of heavy substance use and offending (see Robins & Rutter, 1990). Specifying clear outcomes for children’s substance services may fail to appreciate the complexity and unpredictability of their cases.

**Practice in services**

This section will use the services for young people funded by the Youth Justice Board as a case study of how services operate. Further details are elsewhere (Hammersley et al., 2004; Minkes et al., 2005).

**Outline of services**

Of the 27 projects 24 offered an ‘industry standard’ of individual counselling that included some of the following elements: assessment; counselling (which might include any of the following as elements); advice and information; harm reduction and preventative work, such as drugs awareness; motivational interviewing; one-to-one solution-focused work; relapse prevention; various forms of psychological therapy, notably cognitive-behavioural work; anger or anxiety management programmes; befriending, mentoring and advocacy; referral to leisure or educational activity programmes; alternative health therapies; referral to other agencies for treatment. Projects also offered a range of other interventions. Useful ones included drugs education, which was offered by four projects and was well received by young people and staff. It appears particularly appropriate for less intense substance users. Four projects formally provided training for professionals, which was also offered on a more ad hoc basis by others. This appears to be an important component of substance project work. Family support was definitely offered by one project and possibly by another. As discussed above, many interventions with children have family or systemic elements in practice, but formal systemic interventions were not offered.

For young offenders the following interventions did not work well: work in groups about drugs, outreach work and arrest referral. A major common reason was the serious logistic problems of getting drug workers together with young drug users in the right place at the right time in a resource-effective manner. The remainder of this section will focus on individual work with clients, which was the mainstay of most successful projects. Some commonplace but under-appreciated features of drugs services will be highlighted.

**Humanistic counselling principles**

Services were client centred, with positive regard for the client. Clients mentioned that their drugs worker was the first adult who had really listened to them. Positive regard included respecting clients’ wishes on matters such as confidentiality, which could otherwise block evaluation data collection. In the youth justice context this could be problematic because of the need for drug services to manage how and what they reported back to YOTs. Generally, it was agreed that the young person’s attendance was reported, at least in sketch form, while the content of the counselling and its outcome would not be reported in detail. Services were very reluctant to either prioritise or report on offending behaviour and although YOTs were often

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3 In the UK youth justice ‘cognitive-behavioural’ (CBW) work can be distinct from cognitive behavioural therapy (CBT). CBT usually involves work with individual clients where the client plays an active role in the specification and conduct of therapy. CBT may instead involve work in groups, using manualised approaches that cover common thought processes related to offending and substance use, having predefined objectives. CBT in youth justice can mean either or both options.
disappointed about this, they usually learned to live with it (see Minkes et al., 2005).

Services felt that rapport with younger people was particularly fragile and needed nurturing. This included ensuring that the young person felt comfortable with the setting of counselling, being aware of the potential gaps between an adult counsellor and a young client, being non-judgemental even about difficult behaviour and ensuring that the young person’s right to privacy and confidentiality was respected. This often involved not only not disclosing to parents, but also emphasising this non-disclosure. It was felt that a common barrier to attendance at a ‘drugs service’ was fear that parents would find out and take drastic action or become very upset without further inquiry. Children feared that there would be extremely damaging consequences, varying from parents ‘going mad’ to forcibly sending their children away, or abroad. It would be extremely difficult to implement some family interventions in this context.

While services were aware of many treatment options and of good practices such as thorough assessment, they none the less put clients first. This meant that if the worker had any concern that a particular procedure would jeopardise the counsellor–client relationship, then generally the procedure was truncated or avoided. The alternative was widely thought to be that clients would not return or, if they could be coerced to return, would not participate sincerely. It is extremely difficult to deliver standardised treatment packages under these conditions. These realistic difficulties contrast markedly with a quasi-medical model of consent that assumes that clients, having agreed to treatment, should comply with the requirements of treatment as specified by the counsellor and service. The quasi-medical model is presumed in most large-scale outcome evaluations.

Assessment and record keeping
Because of concerns about confidentiality and deficiencies of record keeping, it was often difficult for evaluators to work out what had been offered to individual clients. Data about assessment might be recorded, along with some outcome data such as staff-assessed improvements. In between, interventions were not offered according to a manual, but delivered according to what the counsellors saw as clients’ individual needs. Additionally, clients could be offered some of the following:
- befriending, mentoring and advocacy;
- referral to leisure or educational activity programmes;
- alternative health therapies;
- referral to other agencies for treatment.
Records for these were not usually well kept. Even if all such activities were theoretically recorded, in practice they could also take place without there being traceable records for the individual clients involved. Thus, it was impossible to tease apart different interventions within or across projects or routinely to establish what had been provided for individual clients, which made outcome data difficult to interpret. It was not even usually possible to tell how long interventions had taken.

It can be difficult to get the staff of any service to prioritise record keeping, which can to be seen as detracting from work with clients (Holdaway et al., 2001). Here, these difficulties were in part also due to projects being new. Additionally, drug services can be particularly casual about record-keeping, perhaps because they often have histories of being reliant upon client self-referral, with high standards of client confidentiality and without any statutory reporting requirements. Records were better kept where information requirements had been negotiated in advance and when the local project was part of a national organisation, but inadequate record keeping greatly hindered many local evaluations.

Tensions between practice and evidence-based practice
Few are critical of evidence-based practice (but see Pawson & Tilley, 1997; Tannenbaum,
Yet the common features of young people’s substance services highlight some tensions between doing treatment well and recording and evaluating that treatment well. ‘Doing treatment’ was widely believed to involve great sensitivity to the child’s feelings, needs and situation, usually in a therapeutic dyad, which took priority over ‘manualised’ intervention procedures, documentation and reporting requirements. The processing of clients for evidence-based practice may disrupt the subtle but vital interpersonal processes that cause change. Where the evidence for practice is strong, replicated and considers such issues, then some disruption is worth the overall improvement in outcome. Where evidence is more tenuous, clinical judgement about the use of specific techniques comes into play. When drug counselors are ‘required’ to use specific techniques then clinical judgement is probably still applied by covertly minimising, modifying or subverting the techniques behind closed doors. This is not a scandal or old-fashioned thinking but everyday clinical reality.

**What works?**

The efficacy/effectiveness distinction is vital for treating children’s substance use because there are many barriers to effectiveness that may render the formal efficacy of treatment largely irrelevant to practice. Children need to be engaged with treatment and systemic interventions appear to be particularly helpful in encouraging treatment uptake and retention (see Elliott et al, 2003; Liddle & Dakof, 1995). However, this literature has not discussed the systemic issues of interagency working, particularly in a criminal justice context. Offending may or may not be a useful lever to encourage children to look at their substance use. Systemic working should not occur at the expense of sensitive humanistic interventions. A client-centred approach is widely believed to be essential because failures of rapport result in non-attendance. There does not appear to be a relevant systematic literature on this clinical topic.

Another barrier is deciding upon appropriate outcomes. The therapeutic ideal is that this is negotiated with clients and there is no evidence that this should be different for substance-using children. There is, however, a lot of systemic pressure to define outcomes on children’s behalf. Common sources of pressure include schools, families and youth justice workers. Therapy needs to occur with an understanding of these pressures, communicating these to the child. The broadly humanistic approach of most services often appeared to meet these goals as far as possible. However, services were generally pressed to accomplish success in terms of routine hard outcomes that would persist. This is in part a result of unrealistic and out of date, if not illogical, expectations about the normative outcome of substance use for those under-16. It is also perhaps the result of an under-estimation of the complexities of children’s problems. The subject is beyond the scope of this paper, but should ‘drugs treatment’ really be isolated from treatment of other relevant problems? Drug services are often seeing extremely complex cases with difficult systemic issues, where the children involved have not been helped by mainstream services, often several different services. Some local evaluation reports quoted children and families commending the drugs worker as the first adult who had really listened to the child and lamenting the lack of previous help.

**Conclusions**

Children’s substance use problems do not sit tidily in a box to be addressed in isolation. It is important that evidence-based practice does not lead to boxing things inappropriately in order to file them easily and partially automate interventions. Adolescent substance use problems differ from adult problems. There is a risk of defining ‘problems’ so widely that many young people without definite psychological morbidity are treated, but there is also a risk of defining problems so narrowly that many young people whose drug use seems somehow problematic are
not treated seriously. There are related risks of on the one hand using drugs as the focus for a wide range of psychological problems in young people, but on the other hand neglecting the contribution of substance use to other problems, even if the extent of use is relatively modest by peer norms. Furthermore, most ‘treatments’ of widely defined ‘problems’ will appear effective unless good comparison groups are used, because many of those treated will be able to modify (or pretend to modify) their behaviour as required. Additionally, some very generic treatment or intervention elements, such as the therapist–client relationship, are liable to improve the young person’s psychological or social functioning, in some sense, thereby perhaps also reducing, or not increasing, substance use at least in the short term. Longer-term outcomes are difficult to specify sensibly because there is a wide gap between society’s ideal temperate standards for young people and the intemperate behavioural norms of people in their late teens and early 20s. There is also the problem that offending naturally tends to decrease as children age.

Practitioners and young people’s services are sensitive to these difficulties and tend to take an approach that prioritises the client and does not prioritise record keeping or formal intervention procedures. This is not inappropriate, but is a headache for evaluation and probably underestimates the influence of systemic factors on the recognition, assessment, treatment and outcome of children’s substance use problems. There is a need for further evaluation of substance services for young people, which needs to be sensitive to the complexities of this work. As yet, the razor of efficacy is too sharp to work well here.

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