

Family Therapy Within An Adolescent Addiction Treatment Service “In Search of Solutions”

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ABSTRACT

Issues and trends in relation to substance misuse normally develop in the transitional phase of adolescence, as young people begin looking towards their peers for direction and are less subject to parental authority. In relation to substance misuse it is observed that risk and protection factors exist in equal measure within different contexts, including within the individual, family, peer group, school and community settings. In response to problems relating to illicit drug use in Ireland the first adult treatment service was established in Dublin in 1969. As an approach to meeting the complex needs of an adolescent drug using population two designated out-patient treatment adolescent services were established in Dublin during the mid-1990s. Working closely with families, carers and significant others improves communication and mobilises resources in ways that enhances protection for young people especially in circumstances where there are a number of family members engaging in substance misuse.

INTRODUCTION

This paper identifies some of the factors influencing the onset of adolescent substance misuse and factors prompting its continuance in certain circumstances. A summary of the history of the emergence of adolescent drug misuse within an Irish context is provided, identifying trends and approaches to intervention at a statutory level. In particular, trends within one agency are set out for the period 1998-2014. Finally, approaches to intervention from a Family/Systemic Therapy methodology and eclectic framework are presented.

Adolescent substance misuse

It is reported that substance use during adolescence, especially before age 15 years old can lead to continuance in later life (Goldberg, 2012). According to Barry (2010, p.178), 10% of Irish adult males and approximately 5% of Irish adult female drinkers will develop serious problems in relation to alcohol. While many young people experiment with illicit substances such as cannabis, ecstasy, amphetamines, cocaine and heroin, it is reported that very few actually become addicted and that alcohol continues to represent the primary and most dangerous substance of abuse (World Health Organisation, 2007). A study examining the nature of the association between early onset alcohol use and adult misuse revealed that those who engage in regular drinking before age 21 years old had a greater rate of alcohol dependence (Guttanova, *et al.* 2011). Cannabis is reported as the most frequently used illegal substance in Ireland (Long & Horgan, 2012) and cannabis use among adolescents' is becoming as socially acceptable as tobacco and alcohol (Godeau, *et al.* 2007). Research indicates that adolescence is regarded as a time when young people assert increasing independence and autonomy and in the process are

more likely to engage in risky behaviours (Hemphill, *et al.* 2011; Arteaga, *et al.* 2010). In relation to substance misuse it is observed that risk and protection factors exist in equal measure within different context including within the individual, family, peer group, school and community settings.

Individual factors

Young people with conditions such as attention deficit hyperactivity disorder (ADHD), conduct disorder, bi-polar disorder or impulsivity are understood to be at increased risk of developing problems in relation to substance misuse (Kilgus & Pumariega, 2009; Herman-Stahl, *et al.* 2006). Additionally, it is thought that impulsivity may play a part in determining the difference between experimental or recreational drug use and dependence (Moeller, *et al.* 2002, p.8). Personality characteristics associated with youth substance misuse include low self-confidence or esteem, un-assertiveness, problems with inter-personal relationships, sexual promiscuity and poor decision making skills (Pumariega, *et al.* 2004). The co-morbidity of substance use and other mental health disorders is highlighted by Kirby, *et al.* (2008) indicating strong correlation between substance use, suicide, depression, antisocial behaviour.

Parenting and family factors

It is generally understood that young people are offered some protection from substance abuse and other risks when parents communicate openly, are emotionally supportive and monitor their children's activity (NACD, 2011b; Pumariega, *et al.* 2004; Mendes, *et al.* 2001). There is also a strong body of evidence supporting the benefits of parental modelling and disapproval of substance misuse by setting specific rules in addition to restricting access (Mars, *et al.* 2012; Ryan, *et al.* 2010; Pokhrel, *et al.* 2008). Parents who have authoritative and trusting approaches to their children are more successful at encouraging abstinence or harm minimisation than parents whose approaches are either authoritarian or laze-faire (DeHann & Boljevac, 2010; Mendes, *et al.* 2001). Also, it is reported that parents' overestimate the influence of peer pressure and fail to take into account the culture of acceptance for substance use within society especially in relation to alcohol (Peterson, 2010). Moreover, the study revealed that adolescents' want their parents and other adults to set boundaries, monitor their behaviour and to be active role models, expressing the 'desire for "parents to be parents" rather than trying to be their friends' (ibid, pp.61-62).

Family instability, conflict, physical/sexual or emotional abuse, parental or sibling substance misuse, harsh parenting, involvement of social services, lack of parental control and absence of parent/s are known risk factors influencing early onset substance use (NACD 2011a; Percy, *et al.* 2008; Stein, *et al.* 1987). A study by Chassin, *et al.* (2004) identified that young people whose family have a history of substance misuse are at greatest risk of developing lifetime trajectories involving substance use. Moreover, such families usually live in communities that have fewer resources and support networks than families in more affluent areas and as a result children living in these situations have poorer outcomes (SAMSHA, 2012; Williams, *et al.* 2009).

Peer influences on young people's substance use

Experimentation with substances is seldom a solitary event and is usually associated with peer group setting (Calfat, *et al.* 2011; Anderson, *et al.* 2009). While there is evidence that initiation to substances often takes place within family contexts, having a network of friends who engage in substance misuse and other risk behaviours increases the likelihood of young people participating in such activity. Additionally, sharing with peers introduces a social dimension to substance use and provides a level of safety in the early stages of experimentation (Heavyrunner-Rioux & Hollist, 2010).

The influence of school in young people's lives

A research study by Truts and Pratschke (2010) comparing Irish school attendees and early school leavers shows higher levels of substance misuse among young people who are out of school or who are in alternative education. These findings are corroborated by Arteaga, *et al.* (2010) who makes links between early school drop-out, parent expectations for children's success, family conflict, instability of accommodation and a young person's dislike of school.

It is proposed that remaining in mainstream education provides a level of protection against substance misuse and that positive relationship with teachers; favourable school experience and good communication between parents and school contribute to school retention (Truts & Pratschke, 2010). Additionally, McCrystal, *et al.* (2006) present research showing that young people in mainstream education have increased levels of home based activity, spend less time hanging out on streets and are least likely to engage in random activity.

Societal Influences

It is generally accepted that environmental factors have a significant influence in determining a young person's initiation and progression in relation to substance misuse (Mayock, 2000). While it is acknowledged that personality characteristics may determine which individuals develop problems in relation to substance use, it is understood that societal attitudes generally determine which substances are tolerated (Kloep, *et al.* 2001; Pearson & Shiner, 2002). However, Stein, *et al.* (1987) following an eight year study of multiple influences on drug use and drug use consequences identified that the proximal influences of personality and prior drug use combined with adult and peer attitudes are stronger predictors of problem drug use than the distal influences of wider community.

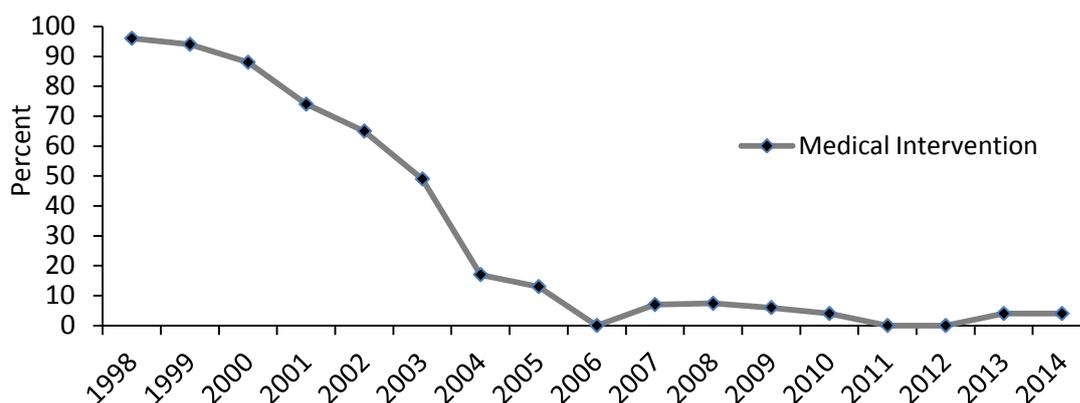
AGENCY CONTEXT

In Ireland the problem of drug abuse among adolescents' emerged in the mid-1960s when there were raids on community and Health Authority pharmacies. In the same period there was a report that sixteen people were admitted to hospital due to amphetamine abuse. In response to an Interim Report from a working party on drug abuse the Jervis Street Hospital, Drug Advisory and Treatment Centre was established in 1969. Records from 1997 indicate that there was an increase in drug consumption within the eastern part of the country, especially Dublin city (O'Brien & Moran, 1998). The main drugs of misuse during this period were opiates (65%) with heroin users generally age 15-19 year old (Keenan, 1999). Throughout the 1990s treatment services available for young people were primarily for management of heroin misuse and were based on adult models (*ibid*). As an approach to meeting the complex needs of an adolescent drug using population two designated out-patient treatment services were established in Dublin during the mid-1990s. A community based programme was set up in North Inner City and a service was developed in the western suburbs of Dublin City which is the project associated with this article. These services offered differentiated treatment plans involving medical treatment and family therapy combined with group activity and emphasis on social re-integration (Vitale & Smyth, 2004). Additionally, a number of beds were designated for adolescents' within an inpatient detoxification facility operated by the HSE. In the late 1990s a designated adolescent residential aftercare facility was opened in the midlands to provide a service nationally and in early 2000 the Department of Health established a Young Persons Treatment Programme within the National Drug Treatment Centre (Vitale & Smyth, 2004). Over the years there has been an increase in the number and type of services available to young people within communities. For example most Local Drug Task Force areas have Community Drug Teams and provide therapeutic support, and education/training, employment access and family support including child care in addition to adult education and community awareness programmes (Department of Community, Rural and Gaeltacht Affairs 2009).

In 2005, a working group set up to address the treatment needs of under 18 year olds, proposed a four tier model of intervention, centred on a framework established by the Health Advisory Service in the United Kingdom (Department of Health and Children, 2005, p. 45). The tiered method to treatment is based on a multidisciplinary approach and co-ordination and collaboration between agencies. Within the framework it is determined that tier 1 services be accessible to all young people and are not required to have specialist expertise in substance misuse. Professionals' operating at this level includes primary care workers, teachers, Garda, youth workers, probation officers and community and family support agencies. At the next level, tier 2 services are expected to have proficiency in adolescent mental health and/or addiction. Professionals involved in these services include General Practitioners (GPs), drugs task force projects, home school liaison officers, outreach youth drugs workers, alternative education projects and youth homeless services. In general young people availing of these services are abusing alcohol and/or drugs and experiencing problems as a result. Tier 3 services are targeted towards young people who are experiencing substantial problems due to alcohol and drugs misuse and who may also have co-occurring psychiatric illness. Work with young people and their families at this level require a multi-disciplinary and inter-agency approach in order to address multiple risk factors. Services are required to have expertise in both adolescent mental health and addiction. At the more specialised level, tier 4 services have all of the above expertise but also have the capacity for intensive treatment within a day hospital or in-patient facility.

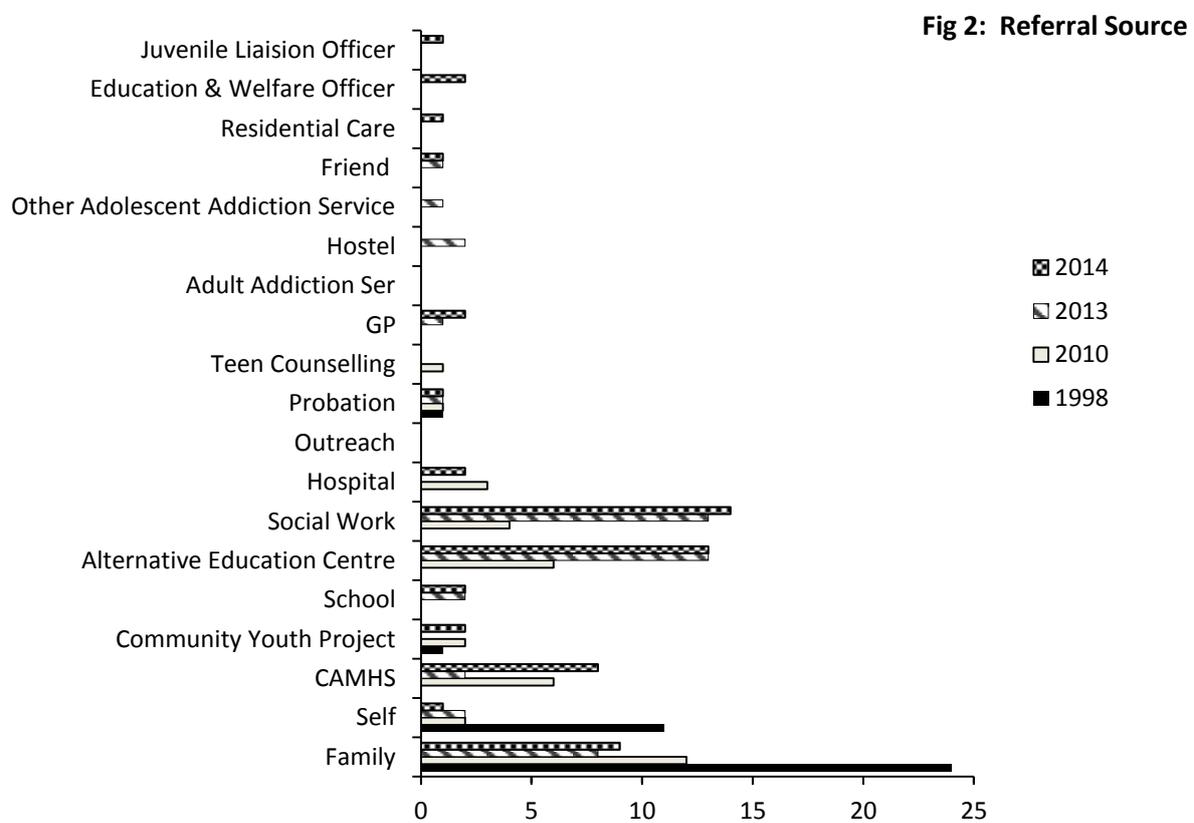
The agency associated with this article is a statutory service operating at tier 3. It was set up initially within a clinic setting where methadone (opiate substitute) was prescribed. The clinical team working in the programme during the first six years of operation comprised general practitioner (GP) part-time; pharmacist part-time; nurse part-time; three general assistants part-time; family therapist full-time and administrative support. With exception of the family therapist, all other members of the team worked primarily within adult addiction service. In 2003 a point was reached when the service was treating 50% of clients outside of structured programme and without medication. The medical and therapeutic components of programme were separated in 2004 due to the fact that decreasing numbers of young people were presenting with problems in relation to heroin use/abuse or at a point where they required medical intervention (see fig.1). Additionally, parents' reported feeling uncomfortable about attending a clinic where methadone was dispensed (Murray, 2011). Also, in 2003 a Consultant Child and Adolescent Psychiatrist was employed to head up the service and to establish treatment services for young people within other communities. Currently, referrals are made to the family therapist initially and other members of the team are involved when necessary if medical intervention or psychiatric assessment is required. To coincide with the re-configuration of services the criteria for access was expanded to include treatment of young people experiencing problems with alcohol and other drugs.

Fig 1: Trends in relation to medical intervention 1998 - 2014



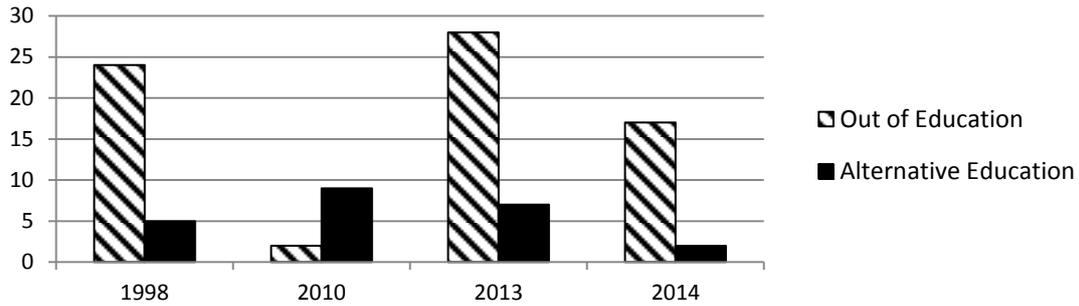
Trends

In 2014 the Adolescent Addiction Service worked with 59 young people and their families with a mean age of 15 years (range 13–19 years), comprising new referrals, re-referrals and continuances. The majority (69%) were male. Referrals were received from a broad range of services with the majority from social work, education settings, Child & Adolescent Mental Health Service (CAMHS) and family. Significantly, referrals have not been received from Adult Addiction Service or Outreach despite the fact that on average 24% of attendees have parents or siblings linked to Adult Addiction Services and that professionals working with adults who abuse substances ought to prioritise the needs of children in such circumstances (Shannon & Gibbons, 2012). See Fig. 2 for a comparison with previous years. Of note are statistics for 1998 when the majority of referrals were from family members and young people themselves. This was due to the fact that no service had existed previously and was established in response to the needs of young heroin users. In addition to direct work with young people and families the service engaged in consultations with other professionals and services about young people for whom there were concerns in relation to substance misuse, including consultations relating to young people who live outside of catchment area.



The numbers of young people attending the service of school going age and who were out of education/training at time of referral remained high at 29%. See Fig 3 for comparison with other years. Also the number of young people who had previous/current contact with CAMHS was similar to previous years at 72%, which is consistent with research highlighting that young people with pre-existing mental health or behavioural difficulties are at greater risk of engaging in substance misuse and other risk behaviours. All attendees were known to a number of agencies. On average the service worked with two other agencies on behalf of young people (range=1-5) in addition to other concerned persons.

Fig 3 : Number of young people out of education or in alternative education at time of referral



The catchment area covered by the service comprises five communities and the greatest numbers of referrals were from Community No 1 (42%), followed by Community No 2 (26%), Community No 3 (23%), Community No 4 (7%) and Community No 5 (2%). See Fig 3 for comparison with previous years. Significantly, communities 1, 2 and 5 are designated areas of disadvantage. Community No 3 is the second fastest growing community in Ireland with a mix of public and private housing and an emerging young population. Community No 4 is a well-established community with mainly private housing. While community No 5 is showing the greatest drop off in referrals this is partly due to Urban Renewal and the demolition of Apartments Complex which had been the feature of many social problems in that area during 1980s and 1990s. The extent to which substance misuse featured within families was lower in 2014 at 45%, representing a drop of 23% from 2013. The number of young people who had parent/sibling linked to Adult Addiction services remained high at 24%. The incidence of parental separation was also high at 72%.

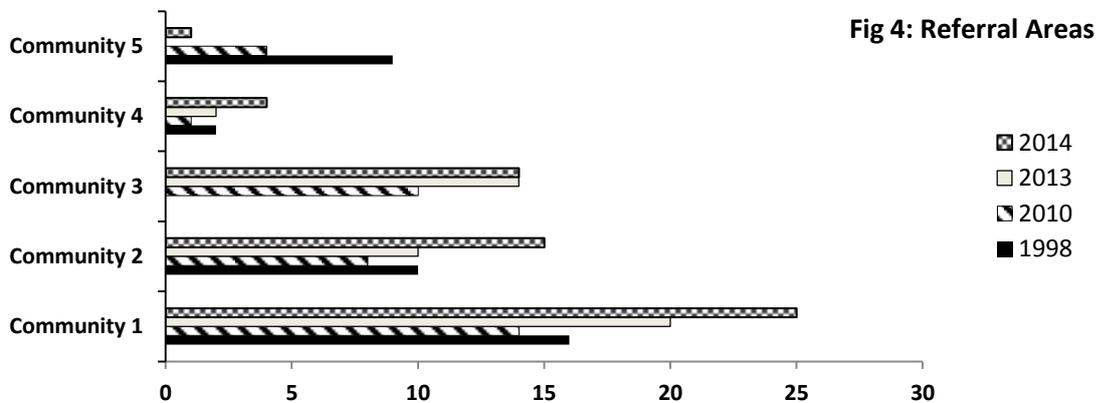
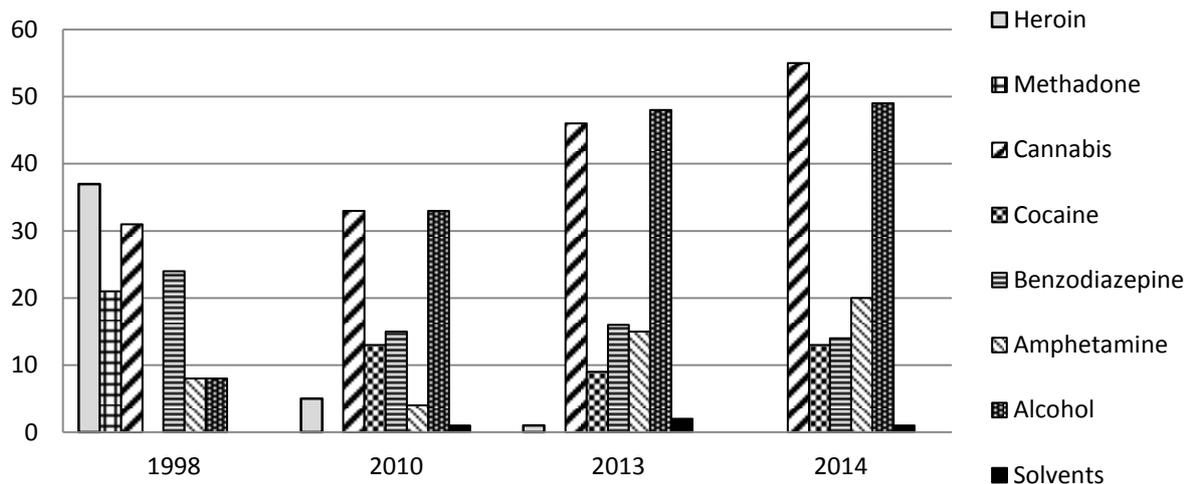


Fig 4: Referral Areas

Cannabis/weed is currently the primary substance of use (94%) which represents a 7% increase on 2013. Other substances used included Alcohol (83%); Amphetamines (34%); Benzodiazepines (24%); Cocaine (22%); Solvents (2%); and LSD (2%). See Fig.5 to view comparison with previous years. The biggest shift concerning secondary drug use related to increased Amphetamine and Cocaine usage. As a consequence 34% had issues relating to indebtedness. Other issues related to absconding (22%); self-harm (14%); care placement (10%); child protection (10%) and child to parent violence (3%). Additionally, young people's capacity to purchase alcohol or to have alcohol purchased for them continues to be an issue. The majority of young people 88% (N=52) were seen by Family Therapist only while 12% (N=7) had Psychiatric Assessment with 4% (N=2) receiving medication for treatment of ADHD and Benzodiazepine detoxification. In most cases young people had established patterns of substance misuse for over two years prior to referral (range 1mth to 4 years) and as a consequence many struggle to maintain drug free status but most achieve stability and several remain abstinent.

Fig. 5: Drug use trends 1998 -2014



PRACTICE ISSUES

Engagement with clients

Currently, young people attending the service are less concerned about their engagement in substance misuse following the decline of heroin use particularly in Dublin where the problem peaked in the late 1990s. Substances such as alcohol, cannabis/weed, ecstasy and cocaine tend to be viewed more as recreational by young people. In recent years referrals to the service have come from parents or non-parental adults such as professionals rather than from young people themselves. In contrast to an adult substance using population, young people are at an early stage in the substance misuse and may not have experienced any negative consequences to cause them to be concerned. The situation is compounded in conditions where substance misuse features within a family and wider community context. In the circumstances motivation for change is not very high and parents often report feeling overwhelmed, disempowered and frustrated at their inability to cope especially in situations where a young person is out of school and may be indebted. The position is further complicated if parental relationship is strained or if parents are separated. Additionally, children's rights are complicated by the fact that the appropriate distance among family members and the nature of boundaries between parents and children change as a young person matures (O'Neill, 1991). Ethical considerations come into play as one attempts to balance legitimate values of the rights of children to appropriate autonomy within the family system while taking into consideration the variables that thwart the evaluation of information if different members of the family/system have different perspectives or priorities involving a web of overlapping rights and responsibilities. In such situations one encounters ethical issues to which there are no simple or unquestionably right solutions (Family Therapy Association of Ireland, 2005). In the circumstances it has been my experience that families may have to spend more time resolving internal conflicts or in some situations it is appropriate to suspend consultations in order to encourage parents, young people and professionals to engage in relational processes allowing for the possibility of re-contracting with services. In taking time out no member of the family/system is alienated.

As an approach to establishing relationship with clients as short a period of time between referral and initial meeting is found to enhance potential for engagement as well as making contact by phone, where possible to set up initial appointment rather than posting out appointment that may not fit with family schedule or circumstances. For example families on low income may not have bus fare until allowance payment day or parents with child care needs will have to make specific arrangements especially in circumstances where they can not avail of

extended family network or informal social supports. It is acknowledged that parents' ability to carry out their parenting role is enhanced by the extent of their social networks and level of social support (Chaskin 2008; Dolan *et al.* 2006; Heenan 2004). In exploring family circumstances at point of responding to referral it is possible to get an understanding of resourcefulness/flexibility within client system. Also, as highlighted by Grimes & McElwain (2008) flexible working is essential as parents/carers who work long or irregular hours may find it difficult to attend a service that has restricted appointment times. This approach is intended to show an understanding of individual circumstances and willingness to be accommodating and supportive which can be conducive in the building of relationship. As identified by Miller *et al.*, (1997, p.183) what works in therapy is not technique alone but its application in the context of human relationships (30%) with other factors such as extra therapeutic influences (40%), placebo factors (15%) and the remaining 15% left to therapeutic model or technique.

Approaches to intervention

Working closely with parents/carers and significant others improves communication and mobilises resources in ways that enhances protection for young people especially in situations where they may be less motivated to attend and or to address concerns relating to their substance use and associated behaviour. In circumstances where young people have dropped out of school and are detached from other services they may be more difficult to engage. As such my approach to intervention is eclectic, integrating Structural Therapy (Minuchin, 1988); Strategic Therapy (Barker, 1986) and Solution Focused Therapy as espoused by O'Hanlon & Davis (1989) who propose that there is no one right theory of Psychotherapy and that many different techniques/approaches produce positive results and change. This perspective is supported by Lerner (2003, p.212) who acknowledges that an integrative philosophy of practice offers an ethic of hospitality towards all therapeutic discourses and approaches. In the process I also incorporate Narrative practices (White & Epston, 1990) within a Justice Therapy framework (Dulwich Centre, 1990). It is important also that I emphasise the value of creativity, humour, imagination, flexibility and ability to laugh at ourselves when working with young people in addition to instilling expectation and hope for change as espoused by Miller, *et al.* (1997). Additionally, Victor Frankl (2004) highlights that in the face of adversity humans have the capacity to be their own self healers and illustrate how optimism and humour can protect against despair. Also, Goleman (1996, p.88) indicates that 'optimism, like hope, means having a strong expectation that, in general, things will turn out all right in life, despite setbacks and frustrations'. It is within this framework that interventions are viewed from a first order change and second order change process (Keeney 1983).

Operating within a structural/strategic approach I gather information relating to family history and focus on strengths and resources including social supports while exploring family relationships and boundaries as well as the way members organise into subsystems. In the process of actively looking for positive assets, healing and developmental potential is nurtured, that otherwise might go unrecognised (Gilligan, 2000 p.16). The involvement of different professionals in addition to family members and concerned other people is viewed as central to the identification of child protection concerns and better outcomes for children (Devaney, 2008). From a therapeutic perspective there is less emphasis on deficits and pathology with increased focus on valuing strengths. The aim of therapy is to improve functioning within family and social context and achieve these outcomes to eliminate the need for out of home placements except in circumstances where it is indicated or residential treatment is required (Carr 2010). While, the preferred outcome for most parents and other professionals may be for young person to achieve abstinence from substance misuse/abuse, deterring progression from less to more severe levels of drug use is viewed a worthwhile goal within a continuum of care. But when a young person achieves abstinence they are presented with a Certificate of Achievement in recognition of their efforts and to strengthen their resolve. Although, it is acknowledged that other interventions have proven effectiveness, such as Cognitive Behavioural Therapy (CBT),

Motivational Interviewing (MI) and pharmacotherapy, especially where a young person has an established substance dependency it is proposed that in circumstances where there are a number of family members engaging in substance misuse interventions ought to encompass a systemic perspective and that working at an individual level may be unproductive (Low, *et al* 2012; Becona, *et al*, 2012; Percy, *et al*. 2008).

The safety, security and welfare of young person for whom concern is being expressed is my primary focus initially as well as the safety and welfare of all other children/family members. In circumstances where medical intervention is indicated appointment is arranged. My approach involves intervening within the major domains of a young person's life, including family, school and other services such as Child & Adolescent Mental Health Services (CAMHS), Education & Welfare Officer, Social Work, Juvenile Liaison Officer, Probation Officer, Alternative Education/Training and Community Projects where appropriate with consent from young person and parent/s or guardians as advocated by Liddle, *et al*, (2005). Fundamentally, good communication and relationships are central to effective intervention at all levels in addition to multidisciplinary approach and co-ordination and collaboration between all agencies involved in young person's life. Within the family the goal is to improve interpersonal relationships, family functioning and parental supervision as a protective factor against substance abuse and related problems. In addition to engaging with external services I sometimes provide reading material or links to information/resources on websites and send out mail shots during High Risk periods such as Halloween, New Year and St Patrick's Day advising of the need to be safe and plan for fun activity without use of alcohol or drugs.

The fact that young people take risks is consistent with adolescent period of development, but it is the way in which adults respond to young people's behaviour that will determine its progress (DeHann & Boljevac, 2010). In relation to substance misuse young people and adults are prone to lapse or relapse, often as a result of environmental cues or as a result of attachment to drug using lifestyle in the absence of human relational attachments. Additionally, distress my result from a loss of joy in life and new awareness of the degradation and pain one has suffered and the degradation one may have caused (Zackon 1988). It is for this reason I place emphasis on the importance of parents and other family members working together even in circumstances where parents are living apart and especially where there is a shared care arrangement in order to create a supportive environment and to avoid splitting or allowing young person playing one parent/person against another. But, I am also cognisant of the fact that some young people report the only time parents talk is when they are in trouble. As such young people often set themselves up in order to give parents a reason to engage. Hellinger (1998, p.93) states 'children are unable to balance out the great disparity of giving and taking in their relationship with their parents...as if love could tolerate no difference', highlighting the bonds of attachment between children and their parents and the sense that being similar will reinforce that bond. From a position of love children often imitate their parents even in suffering as if being different would lead to separation and loss.

Within the family system there may be conflicting narratives with parents and other adult language around retribution and chaos while the young person minimises their activity within a quest narrative that presents their drug use as something that provides release and helps them to feel connected and relaxed. In considering the work of White & Epston (1990) and the metaphor of 'Fifth Provenance' as invoked by Kearney, *et al* (1989) it is possible to externalise the problem and engage in conversations around substance misuse outside of an iatrogenic framework which may have connotations of promiscuity, deviancy or helplessness. In this way opportunities are opened up to rally people against the problem and not the person and to avoid 'ethical trespass' which is viewed by Orlic, 1997, quoted in Weinberg, (2005, P. 331), as 'the harmful effects...that inevitably follow not from our intentions and malevolence but from our participation in social processes'. As a practitioner I position myself in ways that facilitates engagement with clients and avoids shaming them especially in circumstances where one must

straddle the gap between developing and maintaining relationship within the framework of Child Protection Legislation. Adopting a not-knowing stance in therapy is an ethical position that allows for dialogue and open enquiry without erasing a practitioners knowledge and expertise (Larner, 2000). Mapping the effects of a problem across different domains and between various relationships opens up a broad field in which to identify situations of symmetry and to explore alternatives within a framework of complementarity while interweaving external circumstances into therapeutic goals and to inform clients of resources within their community as well as addressing issues relating to physical health and education, training or other opportunities. Equally, accommodation arrangements are discussed as the psychological and physical problems associated with overcrowding can cause conflict which may result in absconding and/or substance misuse as a means of escape. In such situations young people and family are complimented for managing to survive in difficult/challenging circumstances. To avoid such social, political and economic issues can result in self-blame and feelings of incompetence. As highlighted by Dulwich Centre, (1990), therapists cannot separate clinical knowledge from cultural economic social or gender knowledge as to do so could have the effect of silencing the voice of the main victims of inequitable economic policies. In keeping with the philosophy of Hoffman (1998, p. 106), if one can influence a cloud of perceptions so that the persons involved feel more positive about each other, the chances of other things getting ironed out will be better.

CONCLUSION

In this paper I provided a summary of factors influencing substance use by young people. Highlighting that adolescence is a time when young people assert increasing independence and autonomy and in the process are more likely to engage in risky behaviours including substance misuse. Among those most at risk of developing problems relating to substance misuse are young people who have pre-existing mental health issues which may be influenced and exacerbated by family and community disorganisation. In circumstances where a young person does not have a strong attachment to school or other pro-social activities there is the potential for affiliation with peers who engage in high risk behaviours. The level of risk increases if parents/siblings also abuse substances or are permissive of substance misuse. The historical events relating to the development of adolescent specific treatment services in Ireland was outlined and trends within one agency were presented. In addressing practices issues the importance of the building relationships was emphasised and the benefits of working eclectically within a systemic framework towards improving communication and mobilising resources in ways that enhances protection for young people. Additionally, ethical and justice issues were addressed and the value in multidisciplinary approach and co-ordination and collaboration between agencies promoted.

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