WHO Report on Services for Young People with Severe Substance Misuse in Latvia

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This report was produced at the request of the Latvian Ministry of Health and was organized in partnership with the WHO Country Office, Latvia.

The mission Terms of Reference:

> **What changes to the Addiction Services are recommended to improve care and support for adolescents with severe substance misuse problems in Latvia?**

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Abbreviations

ADHD: Attention Deficit Hyperactivity Disorder

CARC: Child and Adolescent Resource Center

CBT: Cognitive Behavioural Therapy

CCUH: Children's Clinical University Hospital

NHS: National Health Service (National Health Insurance)

SUD: Substance Use Disorder

Context

The Ministry of Health in Latvia is concerned about incidents and its consequences related to severe substance misuse among young people aged 11-18 years old, although mainly concentrated in adolescents aged 15-18 years old.

Alcohol consumption in Latvia is very high. According to OECD, Latvia has the highest alcohol population in the world (11.9 liter per year per person) . Eurostat reports that 11.5% of the population are drunk monthly . Information from the Ministry of Health indicates a high use of alcohol use and a growing problem of drug use is experienced: 17% of Latvian teenagers aged 15-16 have tried any drugs, and 40% of pupils admit that they have started drinking at the age of 13 or earlier, and during the last 12 months, 60% of Latvian teenagers aged 15-16 have consumed alcoholic beverages at least once (ESPAD, 2024). A recent ESPAD data suggests that there has been some decline in use of psychoactive drugs and alcohol use, although 30% of school children still reported to have been drunk at least one. It also has to be borne in mind that self-reporting is likely to be an underestimate considering the self-stigma associated with substance misuse.

This report will focus on the need of services and propose models of treatment and care for adolescents with severe challenges of addiction, requiring interventions and follow up. It will also address issues related to prevention, early intervention and rehabilitation.

This report was developed while the Ministry of Health was drafting its own plan for youth addiction services, which has since been approved (Ministry of Health, 2025), though without full dedicated funding. As the context evolved, WHO experts shifted their focus to broader systemic issues. Some recommendations overlap with the national plan, while others—such as increasing inpatient bed capacity before establishing outpatient services and care pathways—are not endorsed by WHO experts.

More detailed recommendations for designing effective services—developed by the Trimbos Institute—are included in the Annex to support future development efforts.

This report complements an earlier report of the WHO mission to Latvia submitted in November 2023 (WHO, 2023) with its terms of reference as 'What changes to the Mental Health System are recommended to improve the transition from child and adolescent to adult mental health care', since many of the system challenges are similar.

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1. Present situation

Data

Data on the numbers and pathways of adolescents entering the health system with substance use disorders (SUD), especially alcohol or drug addiction, are not systematically collected or comprehensive. Most are probably sent by families, or schools, or by requests from staff in youth social care centres.

Prevalence of requests for services and profiles of people assessed by services such as multiple substance use or co-morbidities such as ADHD, depression or conduct disorders and associated criminality is not known, but all can be predicted to be high.

An indication about the scale of severe use can be gleamed from the use of inpatient addiction treatment in public limited liability company "Hospital Ģintermuiža". According to the Ministry of Health, in 2023 inpatient services were provided for 59 children (from 12 to 17 years old),

According to data from the Children's Clinical University Hospital (received on 04.12.2024), in 2023, the hospital admitted 98 children under the influence of drug substances, of whom 10 required hospitalizations. In the first 10 months of 2024, the number increased to 104 cases, with 28 hospitalized. For alcohol intoxication, 164 children were admitted in 2023 (12 hospitalized), while in the first 10 months of 2024, 167 children were treated (4 hospitalized). This indicates that the focus is on medical care, not psychological or social support for addiction. It is important to highlight that hospital data reflects only the tip of the iceberg, as hospitals are typically the last resort, dealing primarily with emergencies and 'putting out fires.'

Services

Currently there is no unified approach for addiction treatment for adolescents. Responsibility for prevention, identification, treatment, rehabilitation and support are fragmented, with responsibility across Ministries of Health, Welfare, Education and Justice. Services are unevenly available across the country, and some innovative, evidence-based prevention programs—such as the *Unplugged*—rely on temporary EU funding. While these programmes have been piloted, they were not continued due to a lack of initiative from the municipalities responsible for implementing such initiatives in schools.

1. *Child and Youth Mental Health Centre of the Children's Clinical University Hospital (CCUH)*

If emergencies present such as an overdose or a suicide attempt, the young person will be seen at Accident and Emergency Unitof the CCUH in Riga. Here they are assessed by a paediatrician or child psychiatrist from the CCUH (mostly by a trainee due to the very low availability of senior child psychiatrists). Rarely, if required, they are admitted to an inpatient unit.

Involvement of CCUH in the care of young people with addictions is minimal following the assessment in the emergency unit. It does not have a service for children with only addiction problems and no mental health disorder. However, due to the absence of outpatient care addiction services, the Child and Youth Mental Health Care Centre occasionally provides support to young people with addictions and mental health issues, by this ensuring they receive at least some level of care.

The CCUH outpatient multidisciplinary teams are unable to manage substance use problems due to lack of capacity and training and can only treat young people with co-occurring mental health problems. The CCUH only offers advice to children and adolescents and refers them to suitable services. The CCUH often refers young with minor or moderate substance use problems to the CARC (described below; 441 times in 2024), with a nonattendance rate of 20-30%. Continuation of care is the responsibility of the families themselves.

2. *Outpatient clinics*

According to data from the National Health Service (NHS), addiction specialist (narcologist) consultations for children are available in 21 healthcare institutions across the country. However, it is important to note that the same specialists often work across multiple institutions and are not employed on a full-time basis. There is a severe shortage of narcologists that work with youth. For example, only 2 part-time youth psychiatrists offer such a service at CCUH, obviously with very low capacity. The narcologists that work with youth are without special training in youth mental health. They can provide pharmacological interventions, advice to parents or the young people, and in exceptional cases refer to inpatient care program at Ģintermuiža. In the outpatient clinics there are no dedicated therapists offering evidence-informed interventions such as motivational interviewing or cognitive behavioural therapy (CBT) to young people with SUD. There is no system of early intervention or follow up provided by outpatient clinics.

The services lack access to multidisciplinary teams, which are essential for delivering evidence-based, non-pharmacological interventions for children with substance use disorders. These settings are not specifically tailored to the complex needs of children and adolescents with SUD, and therefore often lack the age-appropriate environment, specialized training, and integrated care structures required to ensure effective and developmentally sensitive treatment. This further limit the availability of comprehensive, evidence-based care for young people with addiction-related problems.

3. *Child and Adolescent Resource Center (CARC)*

Important and a unique part within the system of care for young people with SUD is the CARC. The Centre is currently registered as a healthcare institution, although it remains a non-governmental organization. Since the start in 2018 in Riga, the program has grown quickly. Currently there are centres in 9 cities throughout Latvia. It has been difficult to find (sufficiently qualified) personnel to staff these new centers. Each centre has a team of 7 or 9 professionals (total of 117 people across the 9 centers: psychologists, CBT therapists, social workers, child psychiatrists, etc.).

The centers aim to provide evidence-based and multi-disciplinary support to adolescents with a variety of mental health risks and difficulties. The programs are government funded so they are free of charge for the patients. Its main focus is young people with mental health problems. One of the three programs is aimed at Addiction Risk Reduction (funded by the Ministry of Welfare). However, this addiction risk mitigation program is unsuitable for adolescents who have already developed problematic use or an addiction. It is better suited for adolescents who struggle mentally and are at risk of developing problems with substance use because of this. This program offers a short-term intervention (three months) with an offer of six months of aftercare, with a total program duration of up to 180 days. If this period is not sufficient, the program managers may decide to extend the duration. This is a low-intensity support service, which is the only existing program specifically targeting children and adolescents with SUD in Latvia. Within the program, adolescents receive regular psychosocial support through collaboration with youth mentors, and, when needed, additional professionals are involved. These may include addiction specialists (narcologists), child psychiatrists, nutritionists, creative arts therapists, CBT specialists, and others—forming a multidisciplinary team aimed at delivering the most effective support possible to both the adolescent and their family. Importantly, adolescents or their family members can self-refer to the program, which significantly enhances accessibility and early engagement.

4. *Hospital beds for addiction treatment: Hospital "Ģintermuiža"*

Provision of treatment for the most severe cases, the main subject of this report, are provided by Ģintermuiža, the only institution in Latvia providing inpatient addiction treatment services. It is a unit in a separate building, placed in the mental and addiction health care hospital, about 40km from Riga. The service offers 6 places at any time, with a standard treatment duration of 4 weeks. Demand is high with a waiting list of 3-4 months. The only way to enter the program at the moment is through a referral from a narcologist. Referrals are typically made after requests by parents, Orphan's and Custody Court (which is not an actual court but a municipally-run guardianship and custody institution that intervenes in family conflict situations), or a detoxification hospital unit advising the family or caregivers. Compulsory addiction treatment for children can be imposed on the authority of the court. In 2023 inpatient services were provided for 59 children (from 12 to 17 years old), of which 43 were inpatient drug rehabilitation for children, 16 were mandatory drug assistance for children (with decision of the orphan's court). The total capacity would be appr. 6 beds x12 monthly admission duration=72 places, suggesting an occupancy rate of 82%, which seems to be a realistic maximum considering transition time and gender sensitive placement challenges without excessive pressure. However, it also means on average 1 bed is empty, resulting in a significant loss of income.

Staffing level for 6 residents is good, about a 2-1 staff patient ratio, offering diverse and relevant competencies:

0.5 Narcologist, Program Manager

0.5 Art Therapist (specializing in visual-plastic arts)

1 Clinical and Health Psychologist

1 Health Promotion Coordinator

2.25 Addiction Prevention Specialist

4.8 Social Mentor

0.25 Sports and Physical Activity Group Educator

The most common substance that is misused is alcohol (75% of the presenting cases), however 90% adolescents admitted to the program use a combination of alcohol and other substances (cannabis, amphetamines, very rarely opiates). The program consists of working on motivation for change, coping skills, emotional regulation, commitment to recovery and commitment to goals. It is stated that the aim of the program is not to treat as a priority addiction or abuse of substances, but to provide motivational support to encourage change and to improve mental and emotional well-being.

For the 4 weeks admission, patients enter the program at different times, so new patients enter while others are already in the middle or at the end of the program. Admission is nominally voluntary. One bed is reserved for involuntary treatment. Although 'voluntary', the unit team experiences that most adolescents do not want to be there. Most residents do not consider their alcohol-and drug use as a problem that requires intervention. There is an impression that adolescents are sometimes sent to the program without knowing where and why they are going, even as a form of punishment because more discipline is required. Although little information is available, it can be expected that this group of young people highly selected on severity will present with a variety of co-morbidities such as aggression, neurodiversity (autism spectrum disorder and ADHD), depression, conduct disorder and eating disorder, all requiring different and complex treatment for which staff are probably not well prepared. None of these factors are predictors of positive therapeutic outcomes.

After the inpatient period, children and adolescents return home or to the institution where they live. Follow-up by a narcologist or by the CARC if mental health problems are present is possible, but families or carers must arrange this themselves. Follow-up of this high-risk group seems to be very ad-hoc and limited in scope.

Unfortunately, no outcome data are available. Considering the small number of young people receiving treatment, it should be quite feasible to find data on measures such as attendances in emergency clinics or health appointments, contact with involvement with the justice system , school performance and with some more active research quality of life and functioning. Qualitative interviews with a sample of former residents would also be very helpful. Such data are crucial to guide any further and targeted investments.

5. Municipalities

By law, and within the framework of social welfare, municipalities have a duty to offer rehabilitation and support. There is no agreed structure, so provision is sparse and diverse. Some municipalities employ mentors, who often have a social care background. Some have a history of addiction so can provide peer support. Other municipalities employ psychologists or people with other backgrounds.

Plans are to amend the Social Services and Social Assistance Law to require municipalities to assess the needs of minors who have received treatment or rehabilitation due to behaviour and addiction problems and ensure continued support. This is a good and ambitious initiative requiring considerable investment by municipalities. A concern is the potentially large funding requirement imposed on municipalities without allocated additional funding. Based on experiences elsewhere, this might result in minimal provisions if national standards and quality control are not provided.

An important source of referrals to addiction services as well as mental health services are the youth municipal care centres. A report of the visit in one of them in Riga is given in Annex 4.

Fragmentation, Funding issues, no community-based services

The overall observation is that there are examples of some good national and local initiatives, but a lack of integration. In a system marked by high levels of need and demand but limited resources, this leads to inefficient use of those resources. This is recognized by the Ministry of Health as proposed plans for addiction services aim to remedy this.

Health services are strictly regulated by the NHS and health legislation, which is rigorously applied. While this ensures compliance, it also leads to certain unintended consequences. For example, psychologists are not reimbursed for working in outpatient clinics unless they are part of a multidisciplinary team. Moreover, non-healthcare professionals—such as social workers and peer support workers (individuals with lived experience of addiction)—are not eligible for NHS reimbursement. This creates a critical gap: these roles are essential for effectively supporting adolescents with SUD, yet they cannot be employed within the health system.

Lastly, there should be highlighted that in other countries usually addiction treatment relies heavily on a withdrawal and abstinence combined with peer support, supervised by a coordinator with expertise in the field. Techniques used are very similar, such as Alcoholics Anonymous, the 12 steps program or the Minnesota Program. In severe cases, abstinence is achieved by admissions to units like Ģintermuiža where such abstinence programs are initiated. These units are closely connected to community activities that sustain abstinence by a combination of supervision and peer support aiming to maintain motivation. No such activities seem yet to be established in Latvia but are planned in an ambitious way in the freshly approved (but not funded) plan. The CARC would indeed be a good place to initiate

such activities on a pilot basis considering their national infrastructure and since they already run an addiction program.

Stigma

In Latvia concern is often raised about stigma related to substance use, and in particular addiction. Children and young people who have problems with substances are often seen as 'bad kids', and their parents are sometimes seen as part of the problem. This attitude hinders help seeking and means that achieving change and recovery is seen as the responsibility of the adolescent and the parents/carers.

Self-stigmatization is also important, since it leads to guilt and feelings of worthlessness. However, equally important to stigmatization of the disorder is the stigmatization of the treatment, and in Latvia young people with SUD will understandably be reluctant to access services considering the fragmented and inconsistent interventions on available. A main action point to reduce stigma and encourage access will be to offer care that is perceived as easily accessible and supportive, rather than punitive.

Planned Services

1. *Pilot: Intensive Integrated Treatment Team*

The Ministry of Health is preparing a pilot initiative to improve access to care for minors using addictive substances in Riga. The program promotes an integrated approach that links existing services, aiming to reduce fragmentation and lower access thresholds. As the initiative has already been approved and funding secured, it aligns well with the recommendations outlined in this report.

Justice Reforms: Progressive Approaches for Youth with SUD

The Ministry of Justice is developing a "Secure Home" model for adolescents aged 11 and older who have committed criminal offenses and present significant risks to themselves or others. While primarily an institutional response to behavioural challenges, the model also offers potential for addressing co-occurring substance use disorders. It proposes a structured, trauma-informed environment combining security with rehabilitation, including individual and group therapy, medical care, continued education, structured recreational activities, and social skills training.

By targeting adolescents with complex behavioural and mental health needs, this model offers a constructive alternative to punitive correctional practices. In parallel, a Ministry of Justice working group is examining broader alternatives to current coercive measures in the early stages of criminal proceedings—signaling institutional commitment to more nuanced, rehabilitative youth justice responses.

This is a promising and progressive direction, particularly as it originates within the justice sector. However, the initiative remains at a conceptual stage, and funding for its development and implementation has not yet been secured.

2. *Social care services*

During the mission, the Ministry of Welfare presented several planned support services that align with evidence-informed approach and the recommendations outlined in this report.

While the proposed services appear thoughtfully designed, at present stage they are being conceptually developed as stand-alone interventions. This approach risks overlooking a key systemic challenge: the absence of a coordinated continuum of care for youth with SUD. Without stronger integration across sectors, these services may struggle to effectively meet the complex and evolving needs of this population.

The creation, implementation, and provision of social care services fall directly within the responsibilities of municipalities in Latvia. If municipalities do not assume their role in ensuring availability and provision of these services, there is a clear risk that the plans will remain aspirational documents rather than tangible support for young people.

2. Challenges

The above description of the services for young people with addiction raises several challenges:

1. The present service model is upside-down, with most resources spent on a small number of severe young people with addiction. A large proportion of funding for adolescent addiction services is allocated to Gintermuiža, a small unit with 6 beds, staffed by a high-quality team. However, there is currently little capacity in the system for early intervention in out-patient settings or follow -up and rehabilitation in municipality or outpatient clinics to sustain abstinence. The proposed new plans for addiction services address some of these challenges and it is hoped that sufficient investment will be forthcoming to make them a reality.
2. Young people with addictions are admitted to Gintermuiža for diverse reasons, including behaviour challenges and even for punishment. Some are admitted on a compulsory basis. Many are unmotivated. It does not offer detox, which is provided in the hospital. It only has one mode of treatment, a 30 days' program that is unlikely to suit every individual. This questions what the aims of this unit are, behavioural change or withdrawal and abstinence.
3. Most of the young people in Gintermuiža will suffer from mental health disorders such as conduct disorder, depression, autism spectrum disorder or ADHD. It is unclear whether appropriate screening by a psychiatrist is performed, and some may well require admission to a mental health unit. The separation from youth mental health services and the absence of sufficient mental health specialists on the unit will pose challenges both during the stay, but also for aftercare.
4. No outcome evaluation of at time of discharge and even more importantly after a period of time following return to the community has taken place, so the benefits of this unit are unknown.
5. There are few effective options for early intervention or for follow-up to sustain abstinence in outpatient settings. Attendance at out-patient clinics is haphazard, mostly people are seen a single time without follow up, and interventions are of an advisory nature, rather than therapeutic.
6. Evidence based effective interventions are not made available due to funding challenges. Some young people with addictions could benefit from a course of CBT, but psychologists are not funded as stand-alone specialists in out-patient settings. However, they would be funded if referred by a general practitioner. This is paradoxical, and some adjustments need to be made.
7. The system is fragmented both within the health system and across different sectors. Within the health system there is little linkage between Gintermuiža, the young people's mental health unit and out-patient clinics. Follow up is the responsibility of both the health system and municipalities with little interaction, but many young people are lost to the system.

8. Staffing levels in Latvia are low, and there are no psychiatrists trained yet in young people addiction. Numbers of psychologists and social workers with expertise in this field are inadequate.
9. Funding for mental health services and addiction services is low in Latvia. Ambitious expansion of services will require additional services if it is not accepted that expansion of one service will lead to failure in another.
10. Currently legislation is hindering the functioning of comprehensive and integrated care by not enabling staff to work across health and social care boundaries.
11. Different professional views on addiction: There is a lack of vision, shared language and coherency of addiction services for minors. This is reflected in different national and local policies, but also within the professional services, where there seem to be different views on the causes and effects of addiction, what addiction treatment should entail, and to what extent recovery from addiction is possible and what this should look like. During one of our visits, for example, hospital staff only talked about the 'impact of addiction' when presenting their program and not about underlying problems which may lead to excessive substance use. This suggests a one directional view with substance use as the cause of problems and not as symptom of other issues. Some parties see addiction as a problem which needs to be treated in a short hospital admission (representing a medicalized view, focusing on substance use and motivation), but others ask for more emphasis on rehabilitation and after care (long term and on multiple life domains). Established international concepts like mental health recovery and positive healthcare still mostly absent within the addiction field in Latvia. The Ministries of Health, Welfare, Education and Justice are all involved in organizing and financing a part of addiction care for young people. This is not unusual as different life domains often fall under the umbrella of different ministries; however, a shared vision is lacking.
12. Lack of early detection and prevention in schools: school prevention programs such as education about risks are not standard, and teachers not trained in identifying children at risk. In many other countries school referrals to addiction clinics is the most prevalent pathway together with parental involvement.

    In Latvia in 2021-2022 twenty schools adopted and piloted the *Unplugged* prevention program (with the help of EU Structural funds). The evidence-based program provides 12 educational sessions for 12–14-year-olds, once a week during the school year. It isn't clear how many schools still offer this curriculum. However, ensuring the continuation and wider adoption of the successfully piloted *Unplugged* program remains essential. There are signals that schools are already struggling to meet the demands concerning the basic curriculum and that their attitude towards taking up a greater role in health education is quite reserved. Schools are also hesitant to contact social services

when there is a problem with alcohol or drug use among students out of fear of damaging the reputation of the school.

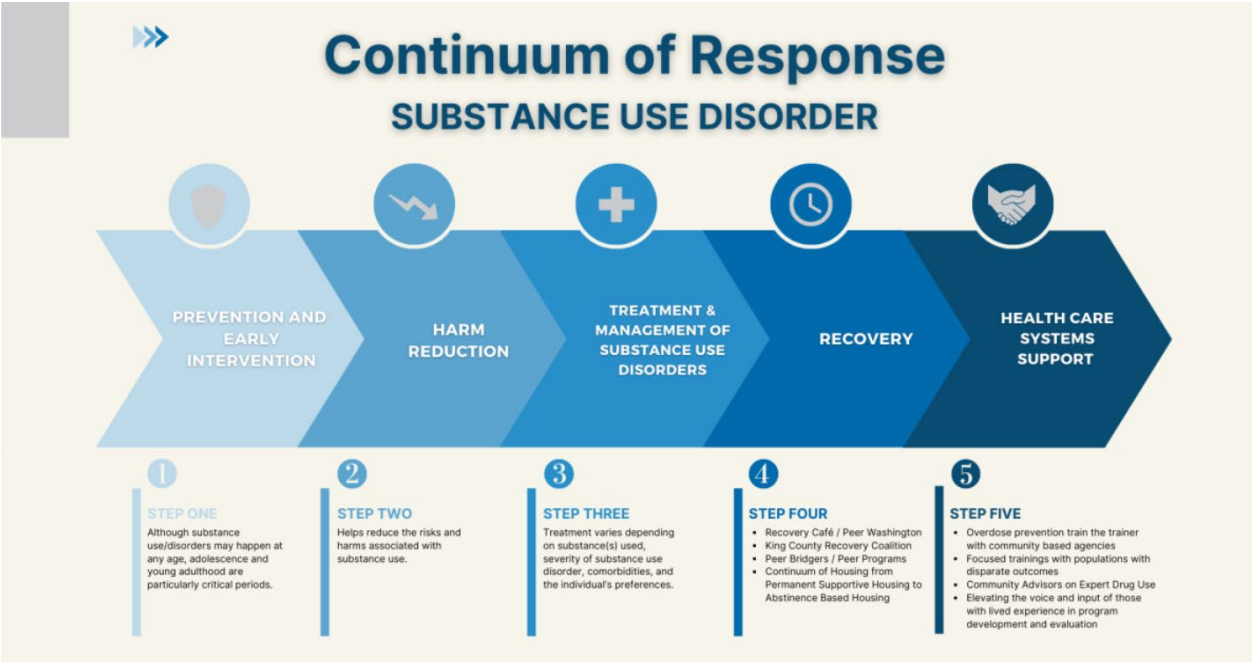
13. Registry*:* Narcologists and child psychiatrists have in many cases stopped officially diagnosing children with substance disorders because this means that they end up in a 'registry' that has consequences for the rest of their lives. The registry can, for instance, be checked when applying for a driver's license or certain lines of work. The Ombudsman also formulated a recommendation to this effect in their report[1]: 'Evaluate in which cases institutions are entitled to request and receive information about a person from the Narcology Patients Register, especially regarding the period when the person was a minor and propose amendments to the regulatory acts'.

[1] There has been a report from the Ombudsman's office in Latvia with concrete recommendations for Ministry of Health, Ministry of Welfare - https://www.tiesibsargs.lv/wp-content/uploads/2024/08/zinojums_par_palidzibas_nodrosinasanu_berniem_kuri_lieto_atkaribu_izraisosas_vielas-1.pdf

3. Recommendations

1. Establishing a model of care addressing the continuum of needs

Addiction services for young people in Latvia are currently constrained by limited treatment and support capacity and their isolated position in a health and social care system that has large gaps and poor coordination. It is understood that high-profile incidents involving youth with severe substance use problems have led to the suggestion to expand the number of inpatient beds in clinical settings. While we acknowledge that such capacity for high-intensity care is indeed limited in Latvia, these severe cases only represent a very small proportion of those with substance use problems. Moreover, inpatient treatment settings pose a great risk of harming a child through trauma and taking them out of their 'normal' setting. On return to their previous residence such as a care home or a dysfunctional family, risks of relapse is very high since the precipitating risk factors have not been addressed in the absence of ongoing rehabilitation services. Besides capacity issues for severe cases, there are large gaps in what should ideally be a continuous structure of evidence-informed addiction services: from prevention to treatment, from treatment to after care and long-term recovery.



Example illustration from King County

2. Shift balance of services

It is recommended to shift the balance service provision of addiction services in Latvia from a clinic centred to a community centred model. Priorities are:

- Create multi-disciplinary teams active in community settings that are easily accessible to young people with addiction problems and their families. Such

services offer information, detox, CBT and family therapy. Home visits and outreach can be available. An example of such a service including staffing and interventions available can be found provided by the Avon and Wiltshire Mental Health Partnership in the UK (www.awp.nhs.uk), but many similar ones are available across the UK and Europe.

- Importantly, the aim of such a service is abstinence and harm reduction, but also rehabilitation and maintaining abstinence. Health and social care services rely on community-based activities often run by peer groups such as Alcoholics Anonymous (AA) or the 12 steps program, with support from a community team that is easily accessible. Although such voluntary sector activities seem to be largely absent in Latvia, small grants by governmental institutions or municipalities and simple provisions such as a room with tea or coffee on a regular basis to ex-addicts or family members, with support from community staff as required, can stimulate their creation.
- Establish good connections with high-risk places such as care homes and places where individuals at risk are identified such as schools and family doctors. Schools can be visited by community addiction staff for prevention purposes. Schools and family doctors need to be confident they can refer to low threshold services.

3. Residential facilities: considering the role of Ģintermuiža

The plans for additional units similar to Ginterrmuiža are of such importance that it requires special consideration. We strongly agree with the broader objectives of greater flexibility of programs and the provision social and educational rehabilitation support, and the availability of coordinated follow-up care. However, implementation will be challenging in regards of objectives, staff resources and community infrastructure.

Modern residential addiction rehabilitation services for adolescents usually are offering detox, a focus on abstinence by interventions encouraging motivation and social reintegration. Family support is an important part of the treatment. Care programmes are individually planned, based on the specific needs of the resident, and can vary in duration form weeks up to many months, and such places can keep connections with the participants who can return at times of crisis. An example is Banbury Lodge in Oxfordshire (https://www.banburylodge.com/. Good research in this field is rare, but the available evidence suggests relapse rates after 90 days of some 50%, heavily reliant on good after care such as described above. Intriguingly, there seems to be little difference in outcomes between voluntary and involuntary placements, possibly partly because very few voluntary placements are truly voluntary, but rather the consequence of family or service provider pressures.

The proposed pilot project for Latvia aims to provide for the enhancement of the motivation programme developed and currently practiced at VSIA "Ģintermuiža Hospital" – by extending it to 2 months. They aim to treat a total of 18 patients in closed facilities, concentrating on adolescents entering under compulsion. Some challenges will need to be considered:

- These adolescents, the large majority of whom will be male, will present with a high level of psychiatric co-morbidities including ADHD, mild intellectual disabilities and behaviour challenges. It can be presumed that motivation will be absent and resistance high, requiring intensive and skilled treatment and care. Although abstinence will be achieved in closed units, it can be predicted that adherence to follow up will be low for a proportion of residents and after discharge many will be lost to the system, resume substance misuse and putting themselves at risk in the absence of strong community infrastructure. The planned aftercare rehabilitation services are excellent, but have yet to be established, and will be costly. If rehabilitation services are not in place, relapse rates are likely to be high—posing risks to the health and wellbeing of young people, while also resulting in inefficient use of already limited resources.
- A standard length of stay and treatment is inadvisable. Adolescents with addiction will present with different needs, challenges and backgrounds, and individual assessments and care plans will be required for treatment to be effective.
- These facilities will require very high staffing levels at a high cost, particularly if separate small units are planned due to inefficiencies. There will also be initially a lack of experienced staff. Fragmentation of such a specialist service in a country with a small population and therefore a relatively small need is inadvisable. It is therefore advisable to consolidate expertise by concentrating such residential capacity in one place, possibly slightly extending the number of beds at Ģintermuiža.
- Considering the high prevalence of co-morbidities, the unit needs to be in close proximity to a young people's hospital.
- It is essential to create community aftercare services in advance of new investment in residential services, since without such services residential service are likely to be ineffective.
- Unless additional funding is secured beyond the initial Norwegian grant—identified as a planned source in the Ministry's newly developed plan—this service will either be unsustainable or will divert resources from an already overburdened youth mental health system. It is recommended, before progressing, to evaluate the effectiveness of current services run at Ģintermuiža. A retrospective evaluation, identifying and tracing the post-admission careers of past residents and interviewing present patients will offer valuable insights, and could be completed within a few months.

4. Develop a vision and legal framework for compulsory and forensic treatment

A comprehensive vision and legal framework for compulsory treatment of youth should be developed, establishing clear and ethically grounded criteria for intervention. This framework must define the specific circumstances under which

compulsory treatment is justified—such as significant self-endangerment, risk to others, severe substance use, or failure of voluntary care—while prioritising a rights-based approach and patient agency. It should specify requirements for treatment settings, including architectural and environmental standards that balance safety and therapeutic effectiveness, alongside mechanisms for ethical oversight. Independent monitoring, quality control, and strong safeguards are essential to ensure that compulsory treatment is used only as a last resort and remains focused on rehabilitation and well-being. A separate legal and therapeutic framework should also be created for forensic treatment of youth, addressing the intersection of substance use, mental health, and criminal justice.

5. Develop a shared vision on addiction, treatment, and recovery

A comprehensive, science-based, and widely supported understanding of addiction should be established as a starting point. This vision must be co-created with professionals from the mental health and addiction fields. To facilitate this, a multidisciplinary workgroup should be initiated and tasked with producing a national vision document or white paper within a defined timeframe, drawing on relevant international examples. This process should guide a gradual shift in mindset—both in terminology and in understanding the nature of addiction, treatment, and recovery—ensuring the resulting document becomes a living framework for change rather than a static report.

It is essential that participants have access to up-to-date scientific knowledge and that individuals with lived experience, including patients, families, and caregivers, are actively involved in the process. The vision document should address key questions such as: What is addiction? How does it develop? What are the risk factors? How is drug use perceived? What are effective prevention strategies? What forms of support are most helpful in treatment and recovery?

Beyond creating a formal policy document, this process offers an opportunity to engage stakeholders, build broad support for systemic change, and promote a shared language across sectors involved in addiction and recovery.

6. Prevention

Often simple information can be effective, provided it is easily available. A national website that provides information about types of substances involved, signs and symptoms of addiction and evidence-based treatments, where such services are available and how to contact them can be very helpful and reassuring to young people with addiction and their families. This can also be supported by a help line and links to self-help websites offering interventions such as CBT. Good examples can be found on the English NHS website or on the websites of many national or local European service providers.

Schools play a central role in prevention, as they provide a unique environment where health education can consistently reach adolescents. It is therefore recommended to ensure the continuation and scaling up of structured, evidence-based programs such as *Unplugged*.

4. Conclusions

Strategic direction, prioritisation, and dedicated funding

Rather than offering an additional list of recommendations, we endorse the overall direction and core principles of the proposed national plan for the development of youth addiction services. The plan reflects a high level of expertise and local insight and addresses many of the systemic challenges outlined in this report.

Our primary observation concerns the scale of the plan's ambition, which may prove difficult to fully implement given Latvia's current resource constraints. In this context, it is important to remain mindful that the perfect can become the enemy of the good. Strategic prioritisation is essential balancing what is most urgently needed with what is realistically achievable.

We recommend focusing initial investments on three essential components, that can already be found in the Ministry's newly developed plan, with dedicated funding, rather than expanding residential care at this stage:

- A mobile psychiatric service.
- A multi-disciplinary outpatient addiction service.
- A municipality-led motivational rehabilitation service.

All three should be supported by enabling legislation and clear implementation frameworks. If well executed, these components are likely to reduce the overall need for inpatient care, thereby lowering reliance on the costliest part of the system.

A final and noteworthy observation concerns a paradox within the Latvian context: although human resources in the sector are limited, the calibre of professionals—at both strategic and operational levels—is exceptionally high. If the Ministry of Health can ensure a well-planned, system-wide intervention design and apply high-level project management—leveraging modern approaches such as design thinking, intersectoral think tanks, and effective cross-sectoral leadership and communication—Latvia has the potential to maximise existing national expertise. With targeted support from international organisations and peer countries, the knowledge and capacity required for implementation are largely present within the system.

Annex 1: Evidence-informed inpatient treatment programme for adolescents with substance use disorders

In collaboration with Latvian experts, this section presents additional and more detailed elements of an evidence-informed inpatient treatment programme for adolescents with substance use disorders (SUD).At the request of the Ministry of Health, the recommendations are structured around three core themes: **(A) Conditions surrounding admission, (B) Structure of inpatient treatment, and (C) Post-programme service pathways.** These proposals are intended to support the development of specialised care that is targeted, proportionate, and integrated within the broader system of youth support services.

A. Conditions Surrounding Admission

• **Age range:** The suggested age group for admission is 11 to 18 years. Children under 11 with SUD should be assessed separately and potentially admitted elsewhere. It is recommended to subdivide this population into smaller age cohorts, such as 11–14 and 15–18 years, as mixing younger and older adolescents may pose risks.

• **Location:** In the current system in Latvia, inpatient centres should be based near psychiatric hospitals, as this would be in line with existing service structures. Potential sites include Ģintermuiža and Ainažu PNS. Future options could include Daugavpils PNS, Strenču PNS (as a potential replacement for Ainaži), and Piejūras slimnīca in Liepāja. Longer term, centres co-located with general hospitals may also be considered.

• **Voluntary vs. compulsory admissions**: Group composition should be determined by a needs assessment and the severity of substance use disorder—not solely by patient motivation. The current capacity to admit one compulsory patient reflects the team's ability to provide adequate care.

• **Criteria for compulsory treatment:** This option should be limited to cases involving an acute risk of severe self-harm or death, such as repeated opioid overdoses.

Inclusion criteria must be clear and consistently applied, as inpatient care may risk doing more harm than good if misapplied. Criteria should be developed in consultation with local experts. Proposed inclusion guidelines include:

- Diagnosis of severe substance use disorder with clear indicators of harmful use[2].
- Co-occurring medical, social, or behavioural issues are not sufficient grounds for admission unless accompanied by SUD. If there are other problems - including medical problems, severe social problems and problems in functioning (e.g. not attending school, small crimes) – these are not sufficient for admission. This may only be considered if the patient is also suffering from

[2] According to the DSM V or other diagnostic manual. Persons with mild to moderate levels of addiction should be treated in outpatient settings.

SUD.
Patient has already received a comprehensive diagnostic and needs assessment either in outpatient or another inpatient setting.

- Withdrawal symptoms should be medically managed or a least have already been initiated before entry.
- Previous motivational and treatment outpatient or inpatient interventions should have been attempted and shown no or limited success. The referrer must indicate what has already been tried before. An inpatient treatment should preferably not be the first attempt at care.
- Some degree of motivation to reduce or stop use is preferred. Involuntary admissions should involve informed consent unless legally mandated.
- Co-morbid mental health disorders do not exclude eligibility, as these often overlap with SUD.

General exclusion criteria include:

- Absence of severe SUD (e.g., cases with only behavioural or social issues).
- High risk of aggression or harm to others.
- Diagnosed antisocial personality disorder or serious criminal behaviour, which may warrant treatment in secure forensic settings.

B. Structure of Inpatient Treatment

In collaboration with Latvian experts, the following elements were identified as essential for the structure and functioning of an inpatient treatment programme. These cover treatment goals, team composition, interventions, and discharge planning.

• Treatment goals: Full recovery is not a realistic goal within the limited timeframe of inpatient care. Instead, the programme should aim to achieve a period of abstinence and stabilization. Following goals would help on achieving it:

- Build motivation for change;

Identify and engage the patient's support network;
– Initiate a rehabilitation pathway;
– Begin therapeutic work (e.g., trauma-focused therapy) to be continued in outpatient care;
– Conduct psychiatric assessments for patients without a prior evaluation.

• Involving the network: Patients eligible for admission typically present with complex needs. As such, professionals from the community as well as parents or carers should be actively involved in the treatment process. The programme should facilitate network engagement from the beginning to the end of treatment, linking and coordinating all relevant parties.

• Core responsibilities of the treatment team include:
– Reviewing prior treatment efforts and outcomes;
– Mapping the client's professional network;
– Holding admission and discharge meetings with the network;

– Coordinating post-discharge support and referrals;
– Conducting SUD and mental health assessments;
– Initiating evidence-based psychotherapy and pharmacological treatments, including ADHD medication where applicable.

• **Recommended programme components:**
– Structured leisure activities and exploration of meaningful use of time;
– Group-based interventions and peer support activities;
– Physical activity or psychomotor therapy;
– Promotion of healthy eating habits;
– Cognitive Behavioural Therapy (CBT) for anxiety and depression;
– CRAFT/A-CRA approaches[3];
– Trauma-informed therapy;
– Family-based and behaviour-oriented interventions.

• **Activities specifically for parents and carers:**
– Psychoeducation on addiction (offered online when necessary);
– Motivational support and practical guidance for reintegration following the child's return home.

• **Discharge planning and connection with outpatient services:**
– Discharge preparation should begin at the point of admission, with outpatient services involved early in the process;
– Patients who request early discharge should be encouraged to remain unless there are clinical reasons to end treatment;
– Options include transitioning to compulsory treatment or discharging only once an alternative voluntary support plan is in place and accepted by the patient;
– Discharge documentation should include an updated needs assessment, summary of treatments received, and clear recommendations for continued care.

C. Post-Programme Service Pathway

In addition to inpatient services, the development of day and part-time treatment centres is essential. These centres should be embedded in local communities, enabling children and adolescents to remain in their usual environments and continue participating in school, sports, and social activities. This proximity facilitates stronger involvement of families and carers and helps build practical coping skills, such as resisting peer pressure.

To support recovery beyond inpatient care, a network of accessible, low-threshold centres is recommended. These centres should provide a broad mix of support services, tailored to individual needs and not bound by fixed treatment durations. In

[3] This is based on the Community Reinforcement Approach (CRA), a comprehensive behavioral program for treating substance-abuse problems. It is based on the belief that environmental contingencies can play a powerful role in encouraging or discouraging drinking or drug use. Consequently, it utilizes social, recreational, familial, and vocational reinforcers to assist consumers in the recovery process. Its goal is to make a sober lifestyle more rewarding than the use of substances.

many countries, such services are classified as treatment and typically financed through health insurance systems.

Overview: Role and Function of Outpatient Services

• Flexibility of support: Centres should offer flexible, needs-based treatment without a fixed duration, recognising that recovery timelines vary across individuals.

• Step-down support: Once substance use is stabilised, care can be transitioned to regional PRC teams, family doctors, or school counsellors. In the initial two-month transition period, inpatient centres should remain available for consultation and support.

• Specialisation: Over time, centres may develop specific areas of expertise (e.g. dual diagnosis, younger age groups, complex cases). Cross-referrals should be encouraged to make use of these specialisations.

• Role of mentors and case managers: These professionals provide long-term engagement and trust-building. Their primary value lies in relational consistency rather than formal qualifications.

• Multidisciplinary teams: While addiction care remains the central focus, teams should prioritise behavioural, systemic, and recovery-oriented approaches. Suggested roles include psychologists, psychiatric nurses, vocational specialists, social workers, case managers, and mentors.

• Risk identification: Special attention should be given to identifying vulnerabilities, such as children with parents who have addiction or mental health conditions. Targeted group interventions (e.g. KOPP/KOV groups in Netherland[4]) may be offered through these centres or in collaboration with PRC teams.

• 'Time-out' options: Once established, centres may also consider offering temporary relief placements (e.g. guest families or respite beds) to help defuse acute tensions and reduce reliance on inpatient admissions. These are used to give a young person and the people around him or her a break when tensions within a family or instruction are running high and it can help to prevent admission to an inpatient setting.

• Youth and family involvement: Children, adolescents, and their families should be actively involved in the design and evaluation of services. Their insights and lived experiences are essential. Facilities are encouraged to collect feedback during development and establish client councils to guide future improvements. WHO can support Latvia in establishing this participatory approach.[5]

Services and Activities Provided by Outpatient Centres

a. Outpatient Follow-Up and Counselling: Aims to maintain therapeutic support during reintegration into daily life. Includes individual and group psychotherapy,

[4] Kinderen van ouders met psychische of verslavingsproblemen (KOPP/KOV) - Trimbos-instituut
[5] youth-engaged-for-mental-health-eng.pdf

relapse prevention, family or systemic therapy, and treatment for co-occurring mental health conditions.

b. Case Management and Assertive Outreach: Ensures coordinated care across systems. Services include individualised care planning, regular contact between mentors and providers, and coordination with housing, education, justice, and employment sectors.

c. Supported Housing and Independent Living: Promotes stable, substance-free living through sober housing options, halfway homes, and access to mentoring and life skills training.

d. Education and Vocational Reintegration: Supports youth in building long-term independence by facilitating return to education, vocational training, apprenticeships, and job placement support.

e. Peer Support and Youth Networks: Aims to reduce isolation and reinforce positive behaviours through peer mentoring, youth recovery groups, sober leisure activities, and culturally relevant community programmes. For this peer mentoring and buddy systems are needed, in combination with youth recovery groups and sober leisure activities. Also important are: community-based and cultural programs offereing arts, sports, or cultural engagement as therapy, volunteering and civic programs, culturally specific or faith-based support.

f. Family Involvement and Support: Emphasises strengthening the family system. Services include family therapy, coaching for parents and carers, caregiver support groups, and psychoeducation on addiction and recovery.

Annex 2: Case management with examples

Outpatient teams are typically formed with case managers as key members.[6]. In general terms case management (for addiction) can be described as a coordinated, individualized approach that links patients with appropriate services to address their specific needs and help them achieve their stated goals. Case management for patients with substance use disorders (SUDs) has been found to be effective because it helps them stay in treatment and recovery. Also, by concurrently addressing other needs, it allows patients to focus on SUD treatment. (SAMSHA)

The reason why case management is needed is fragmentation of care and available services.

Effective case management systems for treating and rehabilitating minors with substance use issues typically integrate medical, psychological, educational, legal, and family-based services. See attachment 1 for examples of effective models and systems that are considered successful or best-practice in this area.

Common Components of Effective Case Management Systems for Youth[7]:

Component	Description
Multidisciplinary Teams	Professionals from mental health, education, law enforcement, and social services.
Individualized Plans	Based on comprehensive needs assessments.
Family Involvement	Active participation in treatment and planning.
Continuity of Care	Support throughout detox, treatment, and aftercare.
Youth Empowerment	Encouraging autonomy and goal-setting.
Cultural Competence	Sensitivity to cultural background and context.

An effective case management system for minors dealing with substance use should involve a multidisciplinary team of professionals who can **collaboratively** address the wide-ranging needs—medical, psychological, educational, legal, and social—of the youth. Below is a breakdown of essential roles and specialists, their responsibilities:

[6] A good description of the principles of case management can be found here: The Role of Case Management in Effective Substance Abuse Treatment and 1 Substance Abuse and Case Management: An Introduction - Comprehensive Case Management for Substance Abuse Treatment - NCBI Bookshelf

[7] Sources: Growth-Focused-Youth-Justice-Case-Management-Guidebook-Jul2024.pdf;
Schuetz, N., Mendenhall, A.N. & Grube, W. Strengths Model for Youth Case Management: Impact on the Provider and Agency. *Child Adolesc Soc Work J* **38**, 43–55 (2021)

Core Roles in a Youth Drug Use Case Management Team

1. Case Manager / Care Coordinator

- **Role:** Central coordinator who ensures that all services are integrated and aligned with the youth's treatment goals.
- **Key Tasks:**
    - Conduct intake and assessments.
    - Develop and update individual care plans.
    - Coordinate communication among team members.
    - Monitor progress and ensure follow-up.

2. Substance Use Counselor / Therapist

- **Role:** Provides individual and group therapy targeting substance use behaviors.
- **Key Tasks:**
    - Conduct therapy (CBT, MI, A-CRA, etc.).
    - Address triggers, coping skills, and relapse prevention.
    - Educate on substance effects and harm reduction.

3. Family Therapist

- **Role:** Works with the family to strengthen dynamics and support recovery.
- **Key Tasks:**
    - Resolve conflicts, improve communication.
    - Educate families about addiction.
    - Provide family-specific treatment strategies (e.g., MDFT).

4. Psychiatrist or Child & Adolescent Psychiatrist

- **Role:** Assesses and treats co-occurring mental health disorders (ADHD, depression, anxiety, trauma).
- **Key Tasks:**
    - Medication management.
    - Psychological evaluations.
    - Coordinate with therapists and case manager.

5. School Counselor or Educational Liaison

- **Role:** Ensures academic continuity and supports re-engagement with school.
- **Key Tasks:**

- Develop individualized education plans.
- Coordinate tutoring or alternative schooling.
- Advocate within the school system.

6. Social Worker

- **Role:** Addresses broader social and welfare issues.
- **Key Tasks:**
  - Assess family environment and risks.
  - Connect families with housing, food, financial assistance.
  - Monitor child safety and coordinate with child protection if needed.

7. Peer Support Specialist / Youth Mentor

- **Role:** Offers lived experience and relatable guidance to the youth.
- **Key Tasks:**
  - Provide emotional support and accountability.
  - Model recovery behavior.
  - Encourage engagement with healthy peer activities.

8. Probation Officer or Legal Advocate (if justice-involved)

- **Role:** Ensures the youth complies with legal requirements while supporting rehabilitation.
- **Key Tasks:**
  - Monitor conditions of probation.
  - Collaborate on treatment plans instead of punitive measures.
  - Advocate for diversion or drug court options.

Examples of effective casemanagement models and systems

1. Wraparound Model (USA) National Wraparound Initiative (NWI) Overview:

- A highly individualized care coordination approach for youth with complex needs, including substance use.
- Involves building a team around the child (case manager, therapist, school counselor, probation officer, family, etc.).

Key Features:

- Youth- and family-driven care.
- Emphasis on community-based services.

- Ongoing team meetings and case planning.
- Outcome-based goals.

Success Example:

- Used in states like Oregon, Florida, and Illinois.
- Shows reduced substance use, improved school performance, and decreased juvenile justice involvement.

2. Multidimensional Family Therapy (MDFT) – USA/EU https://www.mdft.org

Overview:

- An evidence-based, family-centered therapy approach that integrates case management.

Key Features:

- Targets multiple areas: youth, parents, family functioning, school, and peers.
- Case managers coordinate between therapists, schools, probation, and medical care.

Success Example:

- Used in the US, Netherlands, France.
- Proven to reduce drug use and improve family cohesion in adolescents.

3. Adolescent Community Reinforcement Approach (A-CRA) – USA

The Adolescent Community Reinforcement Approach

Overview:

- Behavioral therapy model that includes case management to reinforce sober activities.

Key Features:

- Individualized treatment plans.
- Case managers ensure linkages to services like school reintegration and job training.
- Family involvement encouraged.

Success Example:

- Promoted by SAMHSA (Substance Abuse and Mental Health Services Administration).
- Implemented in the Netherlands

- Shows high retention rates and improved youth outcomes.

4. National Drug and Alcohol Treatment Service (NDATS) – Australia

NATIONAL FRAMEWORK FOR ALCOHOL, TOBACCO AND OTHER DRUG TREATMENT 2019–2029

Overview:

- Government-funded services offering integrated treatment and case management for young people.

Key Features:

- Holistic, youth-focused care plans.
- Cultural adaptation for Aboriginal and Torres Strait Islander youth.
- Emphasizes early intervention and outreach.

Success Example:

- Case managers serve as coordinators across detox, outpatient, school, and family services.
- Demonstrated reduction in relapse and improved mental health outcomes.

Annex 3: Role of the Family Doctor

Family doctors play a critical role in the early detection, intervention, and coordination of care for young people with substance use issues. As they are often the first healthcare professionals to encounter individuals with emerging substance-related problems, family doctors are in a unique position to identify early warning signs and initiate timely responses. In addition to providing medical support, they can act as trusted figures for both the young person and their family, offering continuity and a holistic perspective on care. Importantly, the role of a family doctor goes beyond treating a specific disease or condition—they care for the whole person in their social and developmental context.

Below is an overview of the core functions family doctors can fulfil, based on clinical guidelines, Dutch primary care practices, and international sources such as EUDA and the American Academy of Pediatrics (AAP).

Early Recognition

Family doctors can identify early signs of problematic substance use during routine consultations, especially by being alert to common risk indicators such as:

- Sleep disturbances
- Anxiety or mood complaints
- School-related problems
- Changes in social behaviour

To support early identification, they can use **validated screening instruments**, many of which are accessible through resources such as the EUDA online library[8]. Common tools include:

- AUDIT (Alcohol Use Disorders Identification Test)
- AUDIT-C (Short 3-item version of AUDIT)
- DUDIT (Drug Use Disorders Identification Test)
- ASSIST (Alcohol, Smoking and Substance Involvement Screening Test)
- CAGE-AID (Adapted to include drugs)
- CRAFFT (Specifically developed for adolescents)

Brief Interventions

Brief interventions are structured, time-limited conversations (typically 5–15 minutes) that aim to raise awareness, increase motivation for change, and support healthier choices. These interventions can be delivered effectively within primary care by GPs. Key components include:

[8] EUDA Document Library | www.euda.europa.eu

- Providing non-judgmental, neutral information about risks and effects of substance use
- Using motivational interviewing techniques to encourage behaviour change
- Offering normative feedback, e.g., “Most teens your age are not using alcohol regularly”
- Supporting the minor in setting concrete, achievable goals, such as avoiding use at an upcoming party
- Involving parents or carers, when appropriate and with the young person’s consent, in the planning of support and follow-up

Treatment and Counselling

Within their scope, family doctors can also provide or coordinate further treatment options, including:

- Medication support, for example for nicotine addiction or managing alcohol withdrawal symptoms
- Relapse prevention follow-up, to help the young person maintain progress and manage setbacks
- Counselling for parents or family members, offering guidance and emotional support to those in caregiving roles

Annex 4: Site visit to Riga Municipal Child and Youth Centre

One of the places where youth with substance use problems are often found is in municipal housing projects. Therefore, for our assessment, we visited the Riga Municipal Children and Youth Center, which is a social care center that consists of housing units with the aim of providing home, care and education for children and young people who have no caregivers or who are unable to live with them. It is colloquially referred to as the 'orphanage'. Until recently, children and adolescents who lost their parents, or could not stay with their families for other reasons, were placed in large institutions. However, these turned out to not be the best environments to grow up in. In Riga, these have therefore been replaced with houses, in which smaller groups of adolescents live with a small team of carers. The units sometimes house specific groups, such as a 'family support house' for new mothers and their babies. Furthermore, some houses are mixed for boys and girls, and some are just for boys.

Below we describe our site visit to one of the units. We describe this as a case-study example as our experience there highlights many of the challenges that characterize the discussions in Latvia around care for youth with substance use problems.

Site visit

To visit one of the Riga municipal child and youth centers, we drove about 20 minutes to the edge of the city. The house - a detached three-story building surrounded by a garden, a driveway and a small gated wall - was located in a quiet green neighborhood filled with private and lush villas. We were welcomed and guided to a room in the basement by a young friendly woman, who turned out to be the unit manager. We sat down to talk at a table between some fitness equipment and a ping-pong set.

We were told that the house was known as the 'bad boys house' around town. The unit manager found the boys living there pleasant and genuinely cared for them. However, she told us that they have a lot of problems with drug use and all of them are regularly involved with the police. While there are regular occurrences of violence from the boys and some also carry weapons, we were told that the aggression is never aimed at the staff.

The team is made up of social workers, supported by staff (untrained in mental health care). Their relationship with the boys can be characterized as sympathetic and respectful, while also consequently enforcing rules. The rules are quite strict and are generally followed by the boys. There is a curfew, boys are always searched (for drugs and weapons) when coming back from town and there are regular room checks. If the staff finds any drugs or when a boy is noticeably intoxicated, carers call the police. The police then take them to

the police station where they have to perform a drug test and are held for the night[9]. The staff explain that this is their only way to enforce the rules consistently and that it is also done for safety reasons, as they fear aggression from intoxicated boys or health incidents such as overdoses. Boys with a history of overdoses are sometimes given naloxone at the police station and are then discharged back to the house. As later indicated by the Ministry of Interior, child's healthcare is these situations is taken care by medical professionals.

While most boys living there have problems with substance use, there is no treatment or support programs available for them. One of the staff members told us about a boy who regularly uses drugs, including fentanyl. He has a reputation among social workers, health professionals and the police for being a serious case. He has been to the Ģintermuiža program, which consists of 30 days of detox and motivation. However, after the program he came back to the same situation: living among peers and housemates who use drugs and getting into trouble in the 'bad boys house'. There were some aftercare options available after the hospital program, but he has to go there himself. His social worker tried to motivate him to go but soon his motivation waned. Now he continues his risky lifestyle, which is sometimes interrupted by a period in youth prison. These are rare moments when his social worker worries less about him, as he is taken care of in a structured environment. She nevertheless calls him multiple times a week when he is there. When he turns 18, there are more treatment options with Minnesota programs, which also consists of detox, abstinence and motivation to change. The level of his problems, including those with substances, will likely make this an impossible task. Furthermore, he would not be able to stay in the 'bad boys house' for too long as an adult, so his problems may expand to housing problems as well.

Help and treatment for boys like him are hard to find. They have comorbid problems: many struggle with trauma, a history of violence and heavy alcohol and drug use in their family, attachment issues, low self-esteem and no confidence. The team tries to help them with these issues, but they are not equipped or specifically trained to do so. A narcologist is available for consultation, but there is not much that the team can do besides crisis management, building trust and offering a relatively safe place.

It is therefore no surprise that the team feels unsupported and quite alone in caring for these boys. They expressed a need for backup by a multidisciplinary team of specialists, who can act when help is needed and motivation present.

"We are the only ones, but all sorts of things are expected of us. We worry a lot about the boys." (social worker)

[9] As later indicated by the Ministry of Interior, in such situations, the police first ensure that the child receives appropriate medical care. If the child's health is not at risk and hospitalization is not required, then, in line with the Law on the Protection of the Rights of the Child, the following applies: if within four hours it is not possible to confirm the child's identity and return them to their parents, foster family, guardian, the childcare institution they left, or an authorized representative—and if detention is not applied—the child is placed in a foster family, crisis center, or childcare institution. Placement in the State Police Preventive Institution is not considered to be in the best interests of the child and is therefore used only as a measure of last resort.