YOUNG PEOPLE

The Evidence in Policy & Practice

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Introduction

- Drug and alcohol use-significant public health problems

  McArdle, 2002, Krausz 2000

- Epidemiological studies- widespread increase in use and related problems

  Hibell 97, Sutherland et al 2001

- Reviews of treatments and progress in research

  Hawkins et al 1992

  Weinberg et al 1998, Lowman, 2004

Background

- The Substance of Young Needs 2001
- Drug Misuse Strategy 1998-/2002
- National Service Framework – 2003/2004
- Every Child Matters 2004
- Children Act 2004
- Comprehensive CAMHS changes 2004
- Alcohol Strategy England
- Youth Justice – next steps 2004

Outcomes

- Multiple methodological problems
- Sustained abstinence
  - 6 months 38% 12 months 32%
- Reduced substance use
  - 12-13 studies confirmed
- Functioning in other areas
  - ↓ crime, ↑ family / school functioning
- Better outcomes :
  - Lower pre-treatment substance use
  - Better school attendance and functioning
  - Less conduct problems
  - Family support
  - Non-using peer group

Williams and Chang 2000. Hser et al 2001; Grella et al 2001

Treated Adolescents

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Brown et al 2003: 8 year follow up

Abstainers 22% Infrequent users 24%

Worse with time 36% Frequent users 18%

Hser 2001: multi modal interventions

1 year cannabis halved Heavy drinking reduced

Reduction in criminal activity

Increase in psychosocial functioning

Length of interventions positively associated with outcome

Chung et al 2003: All longitundinal studies - approx 50% displayed substantial reduction of alcohol

Outcome

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Hser 2001 – 1167 participants

- 58.4% legal system
- 63% mental disorder
- 33% not attending school
- Settings: inpatient, outpatient, residential

Outcome

Hser 2001

- Weekly/more cannabis 80.4% - 40.3%
- Heavy drinking 33.8% - 20.3%
- Illicit drugs 48 % - 42 %
- Criminal activity 75.6% - 52.8%

Reported improved psychological adjustment

Increased school attendance / ⬆ grades

Cocaine use ⬆

No improvement on hallucinogens (ODF)

Outcomes with SUD and Mental Disorder

- 992 Subject – 23 programmes – 3 modalities
- 64% one co-morbid mental disorder – CD common
- Comorbid: more likely
  - dependent
  - Higher rate of use
  - Greater problem with school, family, legal involvement
  - Initiation earlier

Grella 2001

At 12 months

- Reduction of all drug / alcohol use - although more likely than non-comorbid to:
- Use cannabis weekly
- Use hallucinogens
- More illegal acts
- More arrests
- Positively – more enrolment at school

IMPLICATIONS:

Drug treatment – address all drugs

Integrated treatment protocols

Grella 2001

Treatment

- Care- child protection
- Specific substance treatments
- Comorbidity-physical/psychological
- Education
- Needs of parents/carers
- Specific crises
- Inclusion of child/primary care services

Brief Interventions

- 7of 8 studies positive outcome with reduction in consumption

  Agostinelli et al, 1995, Marlatt et al 1998, Monti et al 1999, Borsari et al, 2000, Dimeff et al 2000, Walters et al, 2000, Larimer et al 200).
- 2 studies –reduction in alcohol-related problems Marlatt et al 1998, Monti et al, 1999
- Motivational interviewing with individualised feedback most effective modality
- Postal feedback also effective

Kaner 2005 (In press)

Brief Interventions

- Evidence mostly adult literature
- Research highly selective groups, mostly white college students motivated to participate
- Most trials 18-21
- Probable large attrition bias
- Self report reliance
- Effect size small to medium

(Natarajan, Kaner 2005, in press)

Specific Therapies

Specific Drug Interventions

- MET — Deas & Thomas 2001
- CBT — CYT 2002, Kaminer 1998
- Behavioural therapy — Azrin 1994, Williams & Chang 2000
- 12 Step — Winters
- Family — Stanton & Shadish 1997, Joanning et al 1992
- Multi-systemic therapy — Henggeler 1997
- Multi-dimensional therapy — Liddle 2000
- Pharmacological

Outcomes: Adolescent Outpatients

Cognitive behavioural therapy alone or with motivational work

Kaminer 2001 & 2002, Waldron 2001

Family education / therapy approaches

Azrin 2001, Henggeller 1991 & 2002, Lewis 1990, Liddle 2001

Group psycho-educational approaches

Kaminer 2002, Liddle 2001

Individual behavioural approaches

Azrin 1994 & 2001, Godley 2002

Engagement approaches

Szapocznik 1995, Dakof 2001

12 Step approach

Winters 2000

Family-based Treatments

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SEVERAL APPROACHES

- Multi-systemic therapy (Henggeler 1999)
- Brief strategic family therapy (Szapocznik 1986)
- Integrative cognitive behaviour therapy and family therapy model (Waldron 2001)
- Family empowerment intervention (Dembo, et al 1998)
- Multidimensional family therapy (Liddle et al, 2002)

Family-based Treatments

- Engagement in treatment- increased
  Liddle & Dakof, 2002, Donohue et al 1998
- Retention (Henggeler, 1996, Waldron, 2001)
- Reductions in drug use
  Ozechowski & Liddle 2000
- changes -behavioural problems,
  -co-morbidity
  -School attendance
  -family functioning

Cannabis Youth Trial

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Trial I: MET / CBT5
MET / CBT 12
FSN (Family Support Network)

Trial II: MET / CBT
ACRA (Adolescent Community Reinforcement Approach)
MDFT (Multi-dimensional Family Therapy)

Stepped Care

- Intuitively appealing
- Optimal implementation involves the existence of full continuum of care, coordination of care delivery, consistent monitoring of outcome and empirically derived decision making rules on determining level of care and change of level.
- Systematic studies rare

  Sobell & Sobell 1999, & 2000, Breslin 1999
- Research mostly adult

Cannabis Youth Trial

- Days of abstinence:

  52 (of 90) prior to treatment to 65 (of 90) across four follow up periods.

  Overall – stable across follow up

- Percentage in recovery:

  3% intake to 24% across follow up periods.

  Individuals moved in/out of recovery.

Cannabis Youth Trial

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Trial I Total days of abstinence NOT significantly different

In recovery:	MET/CBT5	27%
At end:	FSN	22%
	MET/CBT12	17%

Trial II Total days of abstinence NOT significantly different

In recovery:	ACRA	34%
At end:	MET / CBT5	22%
	MDFT	19%

Cost Effectiveness

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Cost per day of abstinence (CPDA)
Cost per person in recovery

Trial I:	MET / CBT5	£4.91	£3,958
	MET / CBT 12	£6.15	£7,377
	FSN	£15	£15,116
Trial II:	ACRA	Variation across sites (CPDA)	
	MET / CBT5		
	MDFT		

although ACRA economically dominated MET / CBT5 and MDFT

Cannabis Youth Trial

- Treatment differed
- Costs differed (French 2002)
- Treatments acceptable
- Many showed improvements during treatment/ following completion
- Amount / duration of improvement similar across treatments and sites
- Cost effectiveness differences

Implications

- No effects with increased intensity
- No iatrogenic effects for group work
- All interventions: developmentally appropriate, approved, implemented to high quality
- Outcomes - ? General factors
- Relapse common
  - 2/3 using at 12 month period
  - chronicity – monitoring,
    - re-intervention
    - continuing care.

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PHARMACOTHERAPY

- Emergency
- Detoxification
- Stabilisation / Maintenance
- Relapse prevention
- Treatment of consequences eg. HIV / Hep C
- Treatment of comorbidity eg. ADHD
- Treatment of co-existing physical care
  eg. DM
- Drug interactions

Settings, Interventions

- No single intervention or setting
- Identification and sensitive intervention

  Programmes to encourage retention, compliance and maximise motivation
- Stepped approach
- Multi modal treatments
- Interagency liaison

Recommendations

- Safe and effective settings
- Family therapy as component
- Maximise retention/completion
- Post care treatment
- Peer support-non use
- 12 step as adjunct
- Comprehensive

(AACAP)

CONCLUSIONS

- Comprehensiveness
- Integration with child services
- Evidence base- much development in young people
- Stepped care continuum
- Research agenda-treatment evaluation

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