



AIM HIGH

MORE AND BETTER YOUTH AOD TREATMENT FOR YOUNG NEW ZEALANDERS

Grant Christie – CADS Altered High Youth Service

A range of AOD interventions

- Individual interventions
 - Psychoeducation
 - Harm minimisation
 - Brief Interventions
 - Motivational interviewing
 - Cognitive behaviour therapy
 - Relapse prevention
 - Therapy for comorbid mental health problems

A range of AOD interventions

- Detoxification
 - Supported accomodation, home detoxification
- Medication
 - Substitution tx - Methadone, Buprenorphine
 - Supporting withdrawal
 - Anti-craving medication - Naltrexone
 - Tx of related comorbid psychiatric conditions
 - SSRI's for anxiety, depression
 - Mood stabilisers for BPAD
 - ADHD tx

A range of AOD interventions

■ Family

- Significant other counselling
- Family involvement (in individual therapy)
- Couple therapy
- Family therapy
 - Functional
 - MutidimensionalFT

■ Systemic

- Multisystemic Therapy
- Multidimensional Foster Care
- Social behaviour network therapy (SBNT)
- Community programmes

A range of AOD interventions

- Group therapy
 - 12 step approaches, AA, NA, Al-Anon
 - Day programs
 - Outpatient groups (psychoeducation, support)
- Residential / Rehabilitation
 - Therapeutic communities (Odyssey House)

Cannabis Youth Treatment Trial

(Dennis et al 2004)

- Ind. Motivational Enhancement/Group CBT
- Family support (education, home visits)
- Community reinforcement (skills and systems approach)
- Multi Dimensional Family Therapy (individual, parent and whole family sessions)
- All equally effective
- Ind. and group more cost effective than family approaches
- Short = long term

RAND trial

(Morral et al 2006)

- Long term residential facilities (6-12 months)
- Short term residential facilities (30–50 days)
- Community programmes (1 to 12 hours of contact per week in individual and groups)
- 12 month follow up, case mix analysis carried out
- All effective and not too much in way of differences even after considering case-mix

Evidence for treatment interventions

- Treatment is effective in reducing substance misuse in the short to medium term (6 – 12 months)
- In addition interventions also
 - reduce problem behaviour
 - increase involvement in positive activities
 - increase confidence and self esteem
 - improve academic attainment
 - reduce criminal activity
 - improve mental health
 - improve family relationships
 - improve attendance at school

Evidence for treatment interventions

- Treatment effectiveness has been shown in variety of settings from residential to outpatient
- Treatment effectiveness has been shown using a variety of techniques
- Comparative trials show little difference in effectiveness between treatments
- Sticking to an intervention model increases retention
- There is little evidence that examines which treatments suit who

Motivational interviewing +/- BI's

- Shown to be effective
 - In reducing alcohol use
 - In A&E's to reduce use and increase attendance at specialist programmes
 - To increase engagement in custodial settings
 - In college settings to reduce use
- Essential skill
 - In variety of non-AOD services to decrease alcohol use, minimise harm and ↑ engagement
 - In AOD services to ↑ engagement

Cognitive Behavioural Therapy

- CBT can be effective in YP though needs to be tailored to developmental stage
- NB (c.f. adults where recommendations for CBT are guarded)
- More likely to be effective in older adolescents and when combined with social and coping skills
- Group CBT can be effective as individual CBT – components of group work beneficial

Family Therapies

- Involving parents improves treatment for YP's (better information and meet needs better) and improves parent's support of children
- Support, information and parenting advice improves parent's ability to cope (with distress and children's behaviour) and reduces substance misuse (in parents and children)
- Good parental supervision improves outcomes
- Engagement in treatment improves if parents are understanding and have firm expectations
- 'Functional' and 'Multi-dimensional' Family therapies have best evidence of effectiveness

Multi-systemic therapies


- Multi systemic therapy (MST) and Multidimensional Foster Care
- Shown to produce good outcomes in young offenders with
 - both low level and more serious substance use
 - both short and long offending histories
 - conduct disorder and other mental health problems
- Decreases criminal activity
- Improves family cohesion
- Use with contingency management/reward systems may improve effectiveness

Pharmacological treatment

- Evidence base for effectiveness is in adults not young people
- Use of meds may assist with
 - controlling withdrawal symptoms
 - substitution therapy
 - reducing cravings
- Be aware of misuse of medication
- Gain informed consent and involve family if possible
- When treating both mental health problems and substance misuse you need professionals with competence in both areas or MDT

Residential Treatments

- Shown to be as effective as community based therapies
 - outcomes are similar
 - more expensive
 - need to be reserved for those unsuitable for community txs
- Therapeutic community models with strong hierarchies and punitive models are not recommended
- Effectiveness more likely if
 - small units
 - close to the youth's community
 - phased and supported reintegration planning
 - family involvement



Factors associated with engagement and retention in treatment

- Service responsiveness
- Realistic goal setting
- Therapeutic alliance
- Family involvement
- Practical support and semi-formal contact
- Group work
- Aftercare and transitions

Service responsiveness

- Interesting
- Responsive and confidential
- Respectful, trustworthy, warm, flexible
- Caring, committed and optimistic staff

Realistic goal setting

- Goals need to be
 - Achievable
 - Negotiated between young person, parents, practitioner
- Initial motivation isn't related to outcome (nor self efficacy)
 - Support YP to understand reasons to change
 - Build motivation and awareness
 - Treatment builds confidence and self efficacy

Therapeutic alliance

- Effective and collaborative bond between therapist and patient
 - Addresses questions and anxieties
 - Respects their wishes
- Aided by
 - Orienting yp's to services
 - Making treatment voluntary
 - Confidentiality
- Poor alliance leads to quick treatment drop out

Family involvement

- Alliance with family important
- Secures early changes in substance use and behaviour
- Can assist with enhancing engagement in tx later

Practical support and semi-formal contact

- Aimed at eliminating barriers to tx
- Increases engagement and retention
- Advocacy, transportation, housing/social support, coordinating other interventions (in a location that suits yp)

Group work

- Past reports of negative consequences of groups overstated
- Can incorporate wider health/social issues training

Aftercare

- Return to substance use is common however usually at lower levels than before treatment
- Regular contact and monitoring can reduce relapse rates and maintain treatment benefits

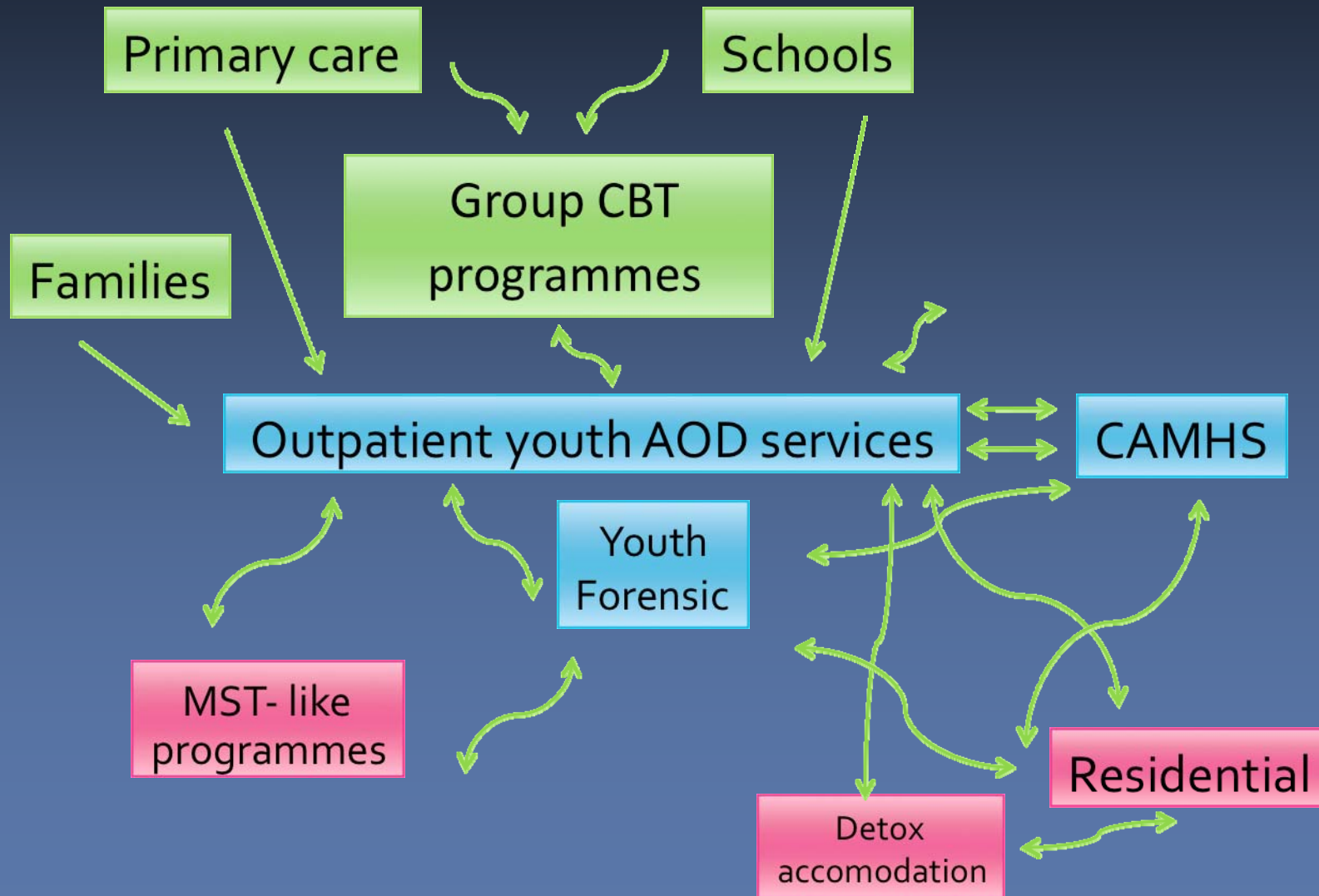
All services need to have

- Flexibility
- Accessibility
 - too many hoops will discourage those most needing treatment
- Nimble and responsive systems
 - waiting lists or periods between assessment and entry into services need to be avoided
- Emphasis on relationship building in early stages of entry into services
 - Assessment and engagement and brief interventions before treatment planning
 - Motivation changes and is likely to be enhanced if attention is paid to developing therapeutic relationship
 - If therapeutic alliance with YP difficult, may need to be a goal achieved through developing alliance with parents first

Implications for NZ service development

- One type of service or service delivery styles isn't likely to be better than another
- Range of services advantageous and meet variable needs of population better
- Established services need strengthening and encouragement to provide evidence based treatment robustly
- New development of services need to complement those already established
- Balance of
 - School based group CBT interventions
 - Outpatient – individual and family based interventions
 - MST or other multi-systemic interventions
 - Residential

A tiered service system



A tiered service system

- Group CBT programmes
 - School, primary care and cultural health services
 - Integrated health, mental health and AOD related skills training
 - For identified at risk young people (not part of curriculum)
 - Mainstream and Alternative Education
 - Referral to more specialist services if required
 - Advice, liaison and consultation from outpatient AOD services

A tiered service system

- Outpatient Youth AOD services
 - Individual interventions (including family involvement if possible)
 - Family interventions
 - Balance of Individual to Family interventions increases as adolescent gets older and more independent
 - Group interventions
 - Detoxification expertise
 - Management of mild to moderate co-existing disorder and risk
 - Close liaison with CAMHS
 - Dual diagnosis consultation, support and co-working
 - Mental health support for more severe mental health and risk presentations
 - Flexible entry criteria
 - Accept self, family, school, primary care, CAMHS, ED sig other referrals
 - Aftercare

A tiered service system

- Residential

- Expensive thus need to be used efficiently
- Some access from community but most via Youth AOD, CAMHS and Youth Forensic Services
- Flexible programmes 3 – 6 months with extension to 1 year if required (for older young people)
- Family involvement
- Aftercare and reintegration

- MST

- Conduct disorder and young offenders
- Complex care and protection/mental health

AOD service system in smaller areas

- AOD teams within CAMHS – may need separate identity
 - At least 2-3 AOD clinicians (i.e. 1 DD and 2 AOD – incl. nurse with detoxification experience)
 - Supervision/oversight and involvement from senior team clinician
 - Close links with other CAMHS workers especially
 - EPI team members
 - Family therapists
 - Psychiatrist
 - Together working together should be able to provide a range of outpatient therapies required for most AOD difficulties
- NGO's provide
 - school/primary care based group work
 - detox/residential accommodation/rehab

Conclusions

- Lack of difference in treatment efficacy means that decisions about treatment need to hinge on
 - Cost effectiveness
 - Flexibility and accessibility of services
 - Complexity
 - Individual client issues
- A variety of treatments (to meet varying needs) is good
 - However more expensive treatments should be accessed via outpatient tx (cheapest) and following comprehensive assessment and preparatory work
 - We need to see better liaison and working together between different treatment services
 - More shorter term residential treatments
 - Access to brief respite accommodation for adolescent detox

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