

1:1 Interventions for Young People: Overview of Available Evidence

Report for Kent DAAT

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Summary

This report presents an overview of the available evidence on effective practice in interventions for young people who use drugs. It reviews existing publications on good practice and effectiveness, and provides a glossary (at Appendix B) giving brief descriptions of interventions for which there is evidence of effectiveness.

The limited number of robustly designed studies and the fact that much of the evidence is generated within North America constrains what may currently be said about ‘what works’ for young people in the UK. With these limitations in mind, a recent systematic review by the Effective Interventions Unit, Scotland provides an important guide to the evidence at present (Elliott *et al.* 2002). This concludes that there is fairly strong evidence that:

- Behaviour therapy; Culturally sensitive counselling; Family therapy; and, 12-step Minnesota programmes can reduce drug use;
- Family therapy can improve psychological well-being;
- Family therapy; Family teaching; Non-hospital day programmes; Residential care services; and, School life skills interventions can improve family and social relations.

A further examination of publications since the EIU review identified two UK studies that provide useful support for the view that:

- A simple, targeted, lifestyle assessment and information provision appears to offer a relatively simple way of reducing stimulant drug use among young people who do not inject.
- A simple motivational interviewing-based intervention can reduce consumption of tobacco, alcohol and cannabis.

Although questions remain about the exact mechanism by which these interventions work, their brevity and, accordingly, their likely cost-effectiveness means that there should be careful consideration of the ways that brief interventions are commissioned and provided so as to complement more complex and expensive interventions.

Additionally, there is encouraging recent North American evidence that Multi-dimensional Family Therapy is more effective than group therapy or structural, psycho-educational family work for outcomes including school/academic performance and family functioning. Opportunities to implement these cautiously in the UK and evaluate their efficacy and cost-effectiveness should be sought.

Beyond programme types, the EIU review also identifies a number of general programme characteristics that are likely to enhance effectiveness including:

- Comprehensive interventions i.e. not just concentrating on drug use but tackling the wider cultural issues including life skills training, stress and coping;
- Carefully planned interventions with clear aims, objectives and target audience;
- Well-funded interventions; long term with booster sessions;
- Having school facilities for high-risk groups or targeting high risk groups e.g. dropouts;
- Using experienced and well trained staff with low turn over;
- Multi-agency working.

These are largely consistent with other reviews of the evidence and point to important process indicators that deserve the attention of both commissioners and providers of services, within any intervention that is provided.

Similarly, the wider UK literature identifies additional principles and general considerations for working with young people, all of which are likely to enhance the effectiveness of any intervention:

- ‘considering the young person’s view’;
- making the client feel welcome,

- conveying a sense of optimism,
- The accessibility of services in terms of waiting times and the setting within which assessments and interventions occur;
- the quality of assessments and the extent to which these conform with accepted best-practice;
- the use of reminders and follow-up.

At present, the evidence is only of limited use in determining the question of what interventions should be commissioned and provided. As unsatisfactory as that position seems, it reflects our current state of knowledge. It will be important to continue to attend to the question of 'what works' as this evolving literature progressively refines our understanding. Nevertheless, the literature points towards a number of features of good practice that are more concerned with process and clinical quality. These have a bearing for the likely effectiveness of any intervention that is provided and highlight areas where thoughtful commissioning and clinical audit can currently improve the efficacy and cost-effectiveness of services.

1 Introduction

This review is primarily targeted at new practitioners and commissioners whose work concerns young people and drugs. Since the 1990s there has been a rapid expansion in services for young people who use drugs. Typically, these are described within four tiers as follows (The Health Advisory Service 2001):

Tier 1

Interventions	Practitioners / Agencies
<ul style="list-style-type: none"> ● Information/education concerning tobacco, alcohol and drugs within the education curriculum ● Educational assessment and support to maintain in school ● identification of risk issues ● General medical services/routine health screening and advice on health risks/Hep B vaccination / referral / parental support and advice 	Teacher Youth-worker Connexions staff School health

Tier 2

Interventions	Practitioners / Agencies
<ul style="list-style-type: none"> ● Programme of activities and education to address offending ● Family support regarding parenting and general management issues ● Assessment of risk and protection issues ● Counselling / addressing lifestyle issues ● Educational assessment 	YOT / bail support Mentor Social Services Counselling One stop shop service Educational Psychology

Tier 3

Interventions	Practitioners / Agencies
<ul style="list-style-type: none"> ● Specialist assessment leading to a planned package of care and treatment augmenting that already provided by Tiers 1 and 2 and integrated with them ● Specialist substance specific interventions including mental health issues ● Family assessment and involvement ● Interagency planning and communication 	Specialist YP drug and alcohol services integrated with CAMHS or 'one stop shops' combined with child mental health, educational assessment and support, Statement of Special Educational Needs

Tier 4

Interventions	Practitioners / Agencies
<ul style="list-style-type: none"> ● Short period of accommodation if crises ● Inpatient / day psychiatric or secure unit to assist detoxification if required ● Continued Tier 3 and multi-agency involvement alongside Tier 1 and Tier 2 	Forensic child and adolescent psychiatry Social services Continued involvement from YP substance misuse services Substantial support for education

This expansion has led to a considerable increase in specialist face-to-face work with young people in services across tiers 3-4. With the rapid development of any field of work it is important to base practice on the best available evidence of what works. This review attempts to summarise the main points from our current learning about practices and processes that are may improve the effectiveness of work with young drug users. Here, “young drug users” is taken to mean people aged under 18.

Developmentally and socially, young people are different from adults and it is not safe to assume that findings from the adult literature will apply to young people. As a result, this review focuses only on the evidence as it relates to young people. Definitions of ‘young’ are somewhat fluid and where it has seemed relevant, work relating to 18-25 year olds has also been drawn upon. As will be seen, in comparison with the literature on interventions with adults the literature on substance use interventions with young people is relatively thin.

This review does not address ‘primary’ drug prevention work i.e. work that aims to prevent young people from using drugs and typically delivered within schools; nor does it examine the use of pharmacological interventions, notably the use of opioid substitution therapies. Its focus is primarily on the various interpersonal interventions that are encountered in services within tiers 3 to 4 (i.e. one-to-one work and family interventions). A glossary of interventions is provided (see appendix B).

Any assessment of what works needs to begin with some understanding of what services are trying to do. Treatment aims have been characterised as:

- Reducing drug use.
 - Reducing the physical harms associated with drug use.
 - Improving the psychological well being of young drug users
 - Improving family and social relations of young drug users.
 - Improving the uptake of other health and social services among young drug users.
- Elliott *et al.* (2002)

Where the evidence points to the effectiveness of different interventions across these outcomes this is discussed. However, for the reasons identified above, in practice the literature is limited in what it says. Instead the literature generally has a focus on good practice principles that are generally thought to have a bearing on outcomes. Where robust evidence is unavailable these provide the most useful interim framework for assessing how services should be delivered and the most meaningful benchmarks for determining service quality.

In line with the brief provided, a number of publications were examined for content relating to the effectiveness of interventions as part of this review. Some provided national context but lacked content relating to effectiveness:

- Every Child Matters green paper (2003) The Stationery Office
- National Service Framework for Children, Young People and Maternity Services (2004) Executive Summary. London: Department of Health
- National Service Framework for Children, Young People and Maternity Services (2004) The mental health and psychological well-being of children and young people. London: Department of Health
- National Service Framework for Children, Young People and Maternity Services (2004) Core Standards. London: Department of Health
- Audit Commission (2002) Changing Habits: The Commissioning and Management of Community Drug Treatment Services for Adults, Audit Commission.

Some summarised principles and standards for service delivery and training but did not include any explicit, critical appraisal of the evidence:

- QuADS
- DANOS
- SCODA/Children's Legal Centre (1999) Young people and drugs: policy guidance for drug interventions.
- Hayes G (2003) Getting it right for young people: a vision for young people's social care. London: Turning Point.
- Youth Justice Board (2003) Substance misuse: key elements of effective practice. London: Youth Justice Boards for England and Wales.

Two were forthcoming publications that are not yet available:

- NTA guidance on young person's interventions (currently at draft stage and not available for dissemination)
- An Addaction review (currently at draft stage and not available for dissemination)

Only one included a commentary on the evidence base for interventions:

- The Health Advisory Service (2001) The substance of young needs: review. London: Health Advisory Service.

Several additional key resources were consulted as part of this review:

National policy and practice organisations

- The National Treatment Agency for England's website and Tom Aldridge (NTA Young Persons Programme Manager) <http://www.nta.nhs.uk/>
- The resources directory on the website of the Effective Interventions Unit, Scotland <http://www.drugmisuse.isdscotland.org/eiu/eiu.htm>

Selected journals

- Drug and Alcohol Findings – a UK journal that appraises new evidence from across the drug and alcohol field <http://www.drugandalcoholfindings.org.uk/> (volumes from 2001-2004)
- The journal *Drugs: Education, Prevention and Policy*, which has a particular focus on youth substance use, was hand-searched for relevant articles (volumes from 2001-2004).

Chapters on young people and substance use

- Crome I *et al.* (2004) Treatment. In (Eds.) Crome *et al.* Young People and Substance Misuse. London: Gaskell.
- Keeling P, Kibblewhite K and Smith Z (2004) Evidence-Based Practice in Young People's Substance Misuse. In (Ed.) Smith D. Social Work and Evidence-Based Practice. London: Jessica Kingsley.

Perhaps reflecting the novel nature of young person's services, much of the recent UK literature on young person's services has primarily addressed the fundamental principles governing provision and how they should be differentiated from adult services. Similarly, there has been considerable emphasis on getting the right people into the right services at the right time through systems for screening and assessment. Although these issues are not the main concern of this report they are integral to the provision of treatment: key points are therefore summarised in sections 4 and 5.

Among the publications identified, a recent review by the Effective Interventions Unit (EIU) in Scotland (Elliott *et al.* 2002) had a very similar brief to this review. Consequently, this is used as a point of departure for an appraisal of the evidence in Section 6 with a commentary on the review. Finally, section 7 provides an appraisal of subsequent primary research identified since EIU review along with two further specialist texts from UK authors that also assess the evidence base for young person's treatment services (Crome *et al.* 2004; Keeling, Kibblewhite K & Smith 2004).

2 Key Principles for Working with Young People

Within the UK there is general consensus that interventions with young people should be provided in line with ten principles that were originally developed by SCODA and the Children's Legal Centre (Standing Conference on Drug Abuse (SCODA)/The Children's Legal Centre, 1999)¹. These state that:

1. A child or young person is not an adult.
2. The overall welfare of the individual child or young person is of paramount importance.
3. The views of the young person are of central importance and should always be sought and considered.
4. Services need to respect parental responsibility when working with a young person.
5. Services should recognise and co-operate with the local authority in carrying out its responsibilities towards children and young people.
6. A holistic approach is vital at all levels, as young people's problems tend to cross professional boundaries.
7. Services must be child-centred.
8. A comprehensive range of services needs to be provided.
9. Services must be competent to respond to the needs of the young person.
10. Services should aim to operate, in all cases, according to the principles of good practice.

Although these principles are not prescriptive about what interventions are provided they do establish some standards concerning the way that any interventions are delivered and the context in which this happens. Whilst some of these embody quite general 'soft' standards, others are more specific and could be audited: for example, Principle 3 suggests that care-planning systems should include evidence that the young person's views have been considered for any interventions that are delivered.

Conclusion

Widely accepted principles for working with young people such as 'considering the young person's view' point towards features of good practice that should apply within any intervention.

¹ Hayes (2003) proposes an overlapping but briefer set of principles within Turning Point's vision statement for young people's social care.

3 Screening, assessing and engaging young people

Within young person's services it is common to distinguish *screening* and *assessment*. *Screening* is a process that identifies young people who may have substance use problems and require more comprehensive *assessment*. Within specialist services, assessment is therefore the process on which interventions will be directly based: as such good assessment is an integral part of good intervention. The Health Advisory Service (2001 pages 33-38) sets out a series of principles for good assessment, which should address: the child's developmental needs; parenting capacity; and, family and environmental factors.

Once the young person reaches a service, for young persons' services to work at all, the young people has to engage with them. Although this seems something of a truism, because of the differences between young people and adults and the implications for the organisation of services, guidance to date has very much focused on what is necessary for young people to engage with services effectively.

Engagement is influenced both by a) the ethos and organisation of a service and, b) the systems that exist to ensure that people's needs are properly identified and assessed in ways that enable suitable interventions to be offered. If people's needs do not correspond well with the interventions offered then no matter how well the intervention is delivered or, how well it may work for other populations, it is unlikely to be effective and a good use of resources.

SCODA and the Children's Legal centre (1999) discuss four principles for engaging young people who take drugs. Which contribute to the ethos within which services are provided:

Appropriate interventions

Young people require appropriate interventions to match their circumstances, age and maturity. Interventions should be planned and not reactive.

Rapid access to interventions

Whenever young people's drug-related needs are identified, responses should be planned and implemented without delay. Young people's needs and problems may develop and change rapidly. Delaying or failing to deliver interventions may result in young people distancing themselves from service providers.

Building relationships

Skills in forming and building relationships with young people are imperative if an ongoing intervention is to be provided. Young people will not appreciate or respond to being talked at or not listened to.

Confidentiality

As a general rule, confidentiality should be maintained if a young person approaches a service for simple advice, information or an onward referral. Children and young people are entitled to seek such information without the consent of a parent and services are under no legal obligation to inform parents or social services that a young person has sought advice. This is the same for low threshold interventions. However, young people should be made aware that if, whilst seeking simple advice and information, they indicate that they are 'suffering, or at risk of suffering, significant harm', this is likely to be disclosed to social services.

Whatever intervention is offered, it is more likely to be effective if it is available quickly. This suggests that waiting times are an important benchmark and that expectations for young person's services may need to exceed those within adult treatment.

Turning Point's principles also emphasise another aspect of accessibility – location, saying that services should “be based in settings where they feel most at ease and welcome, particularly given the distrust that many young people have for public services and the stigma attached to mental health, substance use and problems with schooling and families” (Hayes

2003 page 8). Variations in the extent to which services work with young people in their own space or neutral locations away from specialist service centres may be useful to monitor and consider when comparing the effectiveness of different services.

Conclusions

Within any monitoring of the effectiveness of interventions, the quality of assessments and the extent to which these conform with accepted best-practice are useful indicators of potential effectiveness.

The accessibility of services in terms of waiting times and the setting within which assessments and interventions are offered are likely to influence effectiveness.

4 Findings from the Scottish Effective Interventions Unit Review of the effectiveness of treatment for young people

In 2002, the Effective Intervention Unit (EIU) in Scotland commissioned a review of the effectiveness of treatment for drug-using young people (Elliott *et al.* 2002). The criteria for the review were not identical to those of this report but were very similar. The review was extensive in its search strategy and considered abstracts from 5,874 papers published between 1990 and 2001, of which 18 met the criteria for inclusion. As such, the EIU report comprises the most rigorous and contemporary review of the literature identified while preparing this report and merits detailed consideration as a point of departure for an examination of the subsequent and additional literature.

There are two differences within the scope and emphasis of the EIU review:

- a) The intended age group was young people aged 16 years or under, as opposed to people aged under 18. Technically, this suggests that 17 year olds might be omitted from the EIU review. However, in practice the review had to include some studies with age groups that spanned up to age 19 and so the influence of this difference is probably modest.
- b) The review includes some additional secondary prevention programmes that are outside the scope of this report e.g. school-based life skills programmes targeting high-risk groups. Nevertheless, those interventions that are the focus of this review were all within the scope of the EIU report.

With these differences in mind, what follows is an extract from the summary taken from the EIU review. This is followed by a commentary on the review's conclusions with reference to the present report.

EIU summary of findings - the effectiveness of treatment and care services for drug using young people

The small number of papers included in the review (7 reviews and 11 primary papers) indicates that there is a lack of good quality studies on the effectiveness of drug interventions for young people up to the age of 16 years. Nevertheless, they provide useful insights into the types of interventions that have been evaluated using moderately strong research designs. As such the review provides the best available evidence for the effectiveness of these interventions for this population. The interventions range from in-patient treatments to school-based programmes and are aimed at reducing drug use and the problems associated with drug use. The review focuses on secondary prevention rather than primary prevention. Practically all of the studies are conducted in North America or Canada.

How effective are drug services in reducing drug use among young drug users?

There is fairly strong evidence that the following interventions reduce drug use:

- Behaviour therapy;
- Culturally sensitive counselling;
- Family therapy;
- 12-step Minnesota programmes.

Interventions also effective in reducing drug use, although less successful are:

- General drug treatment programmes;
- Therapeutic community and residential care;
- School based programmes that use life skills development and are targeted at high-risk groups.

Purely educational programmes are generally ineffective in reducing drug use and there is an indication that some life skills interventions for school children might increase drug use among males.

How effective are drug services in reducing the physical harms associated with drug use among young drug users?

There were no studies identified that assessed the effectiveness of interventions in reducing the physical harms associated with drug use among young people.

How effective are drug services in improving the psychological wellbeing of young drug users?

There is fairly strong evidence that family therapy is effective in reducing psychological problems of young drug users.

Other interventions although successful have a weaker effect and include:

- Behaviour therapy;
- General drug treatment services;
- Family problem solving for young people with low levels of depression who have harmed themselves or overdosed;
- Therapeutic community offering coping and skills development;
- School based interventions that provide life skill development.

Family problem solving for young people with high levels of depression who have harmed themselves, or taken an overdose, is ineffective in reducing suicide ideation. Similarly school based counselling and support is not effective in reducing depression or suicide ideation. There is also an indication that older school children exposed to life skills training are more receptive to the idea of using drugs.

How effective are drugs services in improving the family and social relations of young drug users?

There is fairly strong evidence that the following interventions are effective in improving family or social relations:

- Family therapy;
- Family teaching;
- Non-hospital day programmes;
- Residential care services;
- School life skills interventions.

Interventions also effective in improving family and social relations, although less successful are:

- Behaviour therapy;
- Community based psycho-education;
- Family therapy in relation to drug arrests and improving school grades;
- School-based interventions such as counselling, academic support and life skills.

Interventions shown to be ineffective in improving family or social relations are:

- Hospital in-patient programmes;
- Family problem solving for young people who have deliberately harmed themselves or taken an overdose;
- Some school based programmes that did not take account of negative peer or family pressure.

How effective are drugs services in encouraging the up-take of other health and social services?

Only two primary studies address this question. One study indicates that family therapy reduces the length of stay in prison or residential treatment. However there was no effect on the use of medical services, which were contacted by approximately 33% those exposed to the intervention. The second study demonstrated that parents and young people exposed to a specialist drug treatment service that offers counselling and residential care actually increased their use of medical services.

The factors contributing to the success of interventions for young drug users and might enhance future service development are:

- Low pre-treatment substance abuse;
- Reduced psychopathology;
- Peer and parental support (including peer-led support);
- Self-motivation and completing the programme;
- Having better coping and relapse skills;
- Better school attendance and school performance;
- Comprehensive interventions i.e. not just concentrating on drug use but tackling the wider cultural issues including life skills training, stress and coping;
- Carefully planned interventions with clear aims, objectives and target audience;
- Well-funded interventions; long term with booster sessions;
- Having school facilities for high-risk groups or targeting high risk groups e.g. dropouts;
- Using experienced and well trained staff with low turn over;
- Multi-agency working.

Commentary on the EIU review

The review has been conducted in a way that is consistent with the usual conventions for 'critical appraisals'. Strict standards are applied within a transparent process to show how studies were identified, assessed and whether they are included.

Conclusions derived from such critical appraisal represent the most robust evidence concerning what works. This does not imply that other research should be disregarded.

However, it means that greater weight should generally be attributed to the conclusions of such a review than to individual studies that lack controls or for which there is a lack of detailed description of matters such as the sample composition, intervention or the analysis that was conducted.

As the authors note, the review identified very few studies that were eligible for inclusion – seven primary papers and eleven systematic reviews. In itself, this implies that caution is necessary in evaluating the conclusions of the review. Although this provides the best guidance as to what works at present, this does not mean that other approaches don't work. Where interventions have not been subject to high quality evaluation we are in a position of equipoise - we don't know if they are effective or not - and the proper response is to proceed with these cautiously and support any opportunities to evaluate them properly.

It should be noted that the intervention categories are relatively broad so, for example: 'family therapy' is discussed as a uniform modality whereas practitioners might consider that differences between structural or systemic approaches were important; and, 'general drug treatment' is included as a category that includes the structured provision of counselling and family therapy, even though practitioners may believe that the type of counselling is related to effectiveness. As unsatisfactory as such a position may be for anyone seeking definitive guidance about exactly what works, this is indicative of our present state of knowledge. Other studies with weaker designs might be indicative of what may be happening when particular interventions are used but do not allow definitive or even provisional assessments of whether, say, structural or systemic family therapy should be preferred.

One limitation that the authors mention deserves particular attention. The studies are almost universally from North America and it is uncertain how social and cultural differences between North America and England might affect their relevance. Of special note here is the finding that Minnesota 12-step programmes reduce drug use. This may also hold true for young people in England; however, differences in a) the level of religiosity/secularism within society b) the extent to which 12-step ideology is infused within the two different societies through the mass media and lay understanding c) the number and nature of 12-step support groups in each location, may all be important factors that alter effectiveness.

Finally, it is of note that the reviewers conclude with some consideration of wider factors that may influence effectiveness across interventions. These comprise a mixture of **client** and **service** characteristics. Other than through the assessment process, it is beyond services to alter the characteristics of the clients who present to them. And even though factors such as better school attendance might enhance the chances of success it would plainly be wrong to exclude young people from treatment on the basis of such factors.

However, the **service** factors point to areas where effectiveness may be enhanced through good management and commissioning and are reiterated here:

- Comprehensive interventions i.e. not just concentrating on drug use but tackling the wider cultural issues including life skills training, stress and coping;
- Carefully planned interventions with clear aims, objectives and target audience;
- Well-funded interventions; long term with booster sessions;
- Having school facilities for high-risk groups or targeting high risk groups e.g. dropouts;
- Using experienced and well trained staff with low turn over;
- Multi-agency working.

Again, although these may seem akin to truisms they draw attention to aspects of process that warrant careful attention within any services that are delivered and resonate with a recent review of the way services are delivered as opposed to what they aim to do (Ashton and Witton 2004). This summarises the evidence that factors such as rapid treatment intake,

making the client feel welcome, conveying a sense of optimism, the use of reminders and, follow-up are all likely to increase effectiveness.

Conclusions

The limited number of robustly designed studies and the fact that much of the evidence is generated within North America constrains what may currently be said about 'what works' for young people in the UK. With these limitations in mind, the EIU review concludes that there is fairly strong evidence that:

- *Behaviour therapy; Culturally sensitive counselling; Family therapy; and, 12-step Minnesota programmes can reduce drug use*
- *Family therapy can improve psychological well-being*
- *Family therapy; Family teaching; Non-hospital day programmes; Residential care services; and, School life skills interventions can improve family and social relations*

Additionally, a number of general programme characteristics are also identified as being likely to enhance effectiveness and deserve the attention of both commissioners and providers of services including:

- *Comprehensive interventions i.e. not just concentrating on drug use but tackling the wider cultural issues including life skills training, stress and coping;*
- *Carefully planned interventions with clear aims, objectives and target audience;*
- *Well-funded interventions; long term with booster sessions;*
- *Having school facilities for high-risk groups or targeting high risk groups e.g. dropouts;*
- *Using experienced and well trained staff with low turn over;*
- *Multi-agency working.*

5 Evidence beyond the EIU review

This section augments the conclusions from within the EIU review and discusses additional research published since its completion. This is prefaced by an overview of the evidence discussed in the Health Advisory Service (HAS) review (2001), which is arguably the closest thing we have to a National Service Framework for young person's drug services. The main conclusions from two, more recent UK reviews of the evidence on young person's treatment are also summarised (Crome *et al.* 2004; Keeling, Kibblewhite K & Smith 2004).

HAS Review

The HAS review distinguishes different modalities for young people under the following categories (with sub-groups where shown by indented headers):

- Information and advice
- Psychological therapies
 - Counselling
 - Brief interventions
 - Individual Psychological Therapies
- Pharmacological Therapies
- Family Therapies
 - Multi-systemic Therapy
- Group Therapy
- 12 Step Approach
- Residential settings
- Aftercare and follow up

Those that are within the scope of this review are underlined. Of these, the sections on 'counselling', 'brief interventions' and 'psychological therapies' contain commentary without any direct reference to the evidence on which it was based.

The section on 'family therapies' refers to 'functional family therapy' commenting that this "is currently recommended for children and young people with behaviour problems of the type likely to co-occur with substance use problems". There is further comment that treats family therapies as a homogenous group of interventions and, specific discussion of 'multi-systemic therapy'.

Group therapy is only considered with reference to school-based prevention approaches. The brief commentary on 12-step approaches identifies the same study considered within the EIU review (Winters *et al.* 2000.) but is sceptical about abstinence-based approaches even though the study found that 53% of participants reported reduced or no drug use at 12 month follow up compared to 28% of the waiting list control.

Other commentaries on the evidence

Two recent UK commentaries on the evidence-base for young person's services were also identified (Crome *et al.* 2004; Keeling, Kibblewhite K & Smith 2004). Although these do not have the rigour of a systematic review, their UK focus and recent publication means that they merit comment.

The chapter on 'Young People and Substance Misuse' by Keeling *et al.* (2004) largely focuses on principles of provision and issues concerning the organisation of services, notably the tiered approach. Regarding 'Types and Effectiveness of Interventions', the authors draw on the EIU review (Elliott *et al.* 2002) and the Health Advisory Service (2001), but do not

include any references dated after 2002. Several contrasting case studies of service organisation are provided. Their conclusion identifies the need to further develop and disseminate the evidence base for services, reflecting its current, under-developed state.

Several of the authors of the 'Treatment' chapter 'Young People and Substance Misuse' Crome *et al.* (2004) are among the lead authors of the Health Advisory Service review (2001). As such this chapter resembles aspects of the discussion of treatment in that review. However, the chapter is slightly more comprehensive in its discussion of the evidence and the authors provide useful descriptions of the treatment modalities they refer to. No references after 2002 are included; nor does the chapter refer to the systematic review by Elliott *et al.*, which was published in the same year. This is probably a guide as to how up-to-date the review is. As would be expected, the chapter emphasises the importance of several general features of treatment systems including: comprehensive assessment; engagement and retention; and, a collaborative, multi-component approach across the professions.

On the basis of: a) selected studies and reviews of interventions addressing young people's substance use; b) reference across to the adult treatment literature; and, c) the broader child and adolescent health literature, the authors conclude quite generally that "cognitive and behavioural approaches, family-based approaches, motivational enhancement and relapse prevention therapies have empirical support from the adult literature and have much in common with cognitive-behavioural therapies for young people with behavioural problems". They also note the impact of staff factors on outcomes that emerged within a review by Catalano *et al.* (1990). This resonates with the review by Ashton and Witton (2004) and reinforces the likely importance of paying attention to quality and process issues within the commissioning and provision of services.

Other identified controlled trials published since the EIU review

An evaluation of a brief intervention model for use with young non-injecting stimulant users (Marsden *et al.* 2003)

This study was conceived within a harm reduction framework and compares a single brief, *motivational intervention* providing personal advice, information, motivation and support with an *information-only* intervention giving information about stimulants and local services. Participants were users of cocaine powder, crack or ecstasy aged 16-22 (n=342).

Both groups improved at follow up on outcomes including: frequency of use; awareness of services; and, applying for and taking up education/training and employment.

Although the motivation approach achieved greater success than information only, overall this was not sufficiently significant to provide a clear indication that MI should be delivered without further development. The improvements from information only were noteworthy and suggest that a simple lifestyle assessment and information alone can achieve positive changes in younger stimulant users. The absence of a control group that received no intervention means that threats to validity including history and maturation effects cannot be evaluated.

The efficacy of single-session motivational interviewing in reducing drug consumption and perceptions of drug related risk and harm among young people: results from a multi-site cluster randomized trial (McCambridge and Strang 2004)

Further Education College students aged 16-20 who used drugs and from 10 colleges across London were randomized to a motivational interviewing or no intervention control (n=200).

The intervention group received a one-hour face-to-face intervention. At three month follow up the intervention group had significantly reduced their use of cigarettes, alcohol and

tobacco whereas consumption had increased among controls. Reductions were greatest among heavier users and were mainly achieved by moderation rather than cessation.

The involvement of the interventionist in the collection of follow-up data for three quarters of the participants may have meant that they were reluctant to disclose that the intervention had been ineffective and led to some social desirability responding.

Multidimensional family therapy for adolescent drug abuse: results of a randomized clinical trial (Liddle et al. 2001)²

Clinically referred marijuana and alcohol abusing adolescents aged 13-18 were randomly assigned to one of three contrasting interventions: multidimensional family therapy (MDFT) – a psychotherapeutically inclined family approach working with one family at a time; adolescent group therapy (AGT) – which works with peer group influences; or, multifamily educational intervention (MEI) – a more structural and psycho-educational family approach that works with several families at once (n=182). Treatments were delivered on an outpatient basis over 16 weekly sessions.

Follow up at 6 and 12 months showed improvements in each group, but with superior results for MDFT across factors including school/academic performance and family functioning.

The absence of a control group that received no intervention means that threats to validity including history and maturation effects cannot be evaluated. However, the fact that inter-group differences were found means that although absolute effects of the intervention cannot be evaluated there is strong evidence that benefits are derived from MDFT among North American youth. How well these results might be reproduced within the UK remains uncertain.

Conclusions

Two recent UK studies provide useful support for the view that:

- *A simple, targeted, lifestyle assessment and information provision appears to offer a relatively simple way of reducing stimulant drug use among young people who do not inject.*
- *A simple motivational interviewing-based intervention can reduce consumption of tobacco, alcohol and cannabis.*

Although questions remain about the exact mechanism by which these interventions work, their brevity and, accordingly, their likely cost-effectiveness means that there should be careful consideration of the ways that brief interventions are commissioned and provided so as to complement more complex and expensive interventions.

There is encouraging North American evidence that Multi-dimensional Family Therapy is more effective than group therapy or structural, psycho-educational family work for outcomes including school/academic performance and family functioning. Opportunities to implement these cautiously in the UK and evaluate their efficacy and cost-effectiveness should be sought.

² A further appraisal of this study can be seen in: Drug and Alcohol Findings (2002) Holistic therapy preferable for troubled teens. Issue 7, page 13.

6 Conclusions

Although a considerable number of studies have examined one to one and family interventions with young people, few of these have been conducted using designs that allow a high degree of confidence in the results. Those that have, largely originate from North America, leaving questions about how well the conclusions might be applicable in the UK.

With these caveats in mind, there is nevertheless fairly strong evidence from the EIU review that behaviour therapy, ‘culturally sensitive counselling’ and family therapy can reduce drug use. Although there is also evidence that 12-step Minnesota programmes may be effective, greater caution is probably advised in assuming that these can transfer readily to young people in the UK. More recent, English evidence suggests that targeted, brief, motivational and information-based approaches can reduce the use of tobacco, alcohol, cannabis, ecstasy, cocaine and crack (Marsden *et al.* 2003; McCambridge and Strang 2004). The relative simplicity and cheapness of such interventions is an important point in their favour when compared to more intensive or complex one to one or family interventions. Family therapy appears to be effective in reducing psychological problems of young people and can also be effective in improving family and social relations of young drug users. There is also evidence identified in the EIU review that ‘family teaching’ can improve family and social relations.

The trial of Multidimensional Family Therapy (Liddle *et al.* 2001) that was published at more or less the same time as the EIU review gives some of the most encouraging support for an intervention effect on school/academic performance and family functioning.

The relative weakness of the existing evidence base for the range of young person’s services that are typically provided, along with our understanding of the influence of process variables and other quality indicators on outcomes (such as waiting times, the use of reminders, and a welcoming approach) means that, at present, these additional factors merit close attention. Our present understanding simply does not allow any straightforward assessment of what works best within young person’s services in England. Nevertheless, ensuring that whatever is done, is done well and, in accordance with widely-accepted principles for the provision of young persons’ services is likely to make a useful and important difference to their effectiveness.

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Appendix A - References Included in the EIU Review

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Appendix B - Interventions glossary

Behaviour therapy - may involve therapist modelling, behaviour rehearsal, specific therapy assignments, self-recording between sessions, review of self-recordings and assignment records, and extensive praise for progress.

Brief interventions - are time limited, structured interventions directed toward specific goals. They follow a specific plan (and in some cases a workbook) and may have timelines for the adoption of specific behaviours.

Cognitive-Behaviour Therapy (CBT) – aims to modify or eliminate thought patterns contributing to problems and help the client change his or her behaviour. The behavioural portion of cognitive-behavioural therapy may involve systematic training in relaxation techniques as well as other methods from *behaviour therapy*. *Motivational Interviewing* and *Relapse Prevention* are sometimes regarded as approaches within CBT.

Counselling – variously defined to embrace a wide variety of approaches. These include non-directive ‘Rogerian’ techniques based upon ‘warmth, empathy, genuineness and unconditional positive regard’ as well as *brief interventions*, *CBT*, solution-focused therapy, problem-solving and psycho-dynamic approaches.

Family therapy – embraces a wide variety of approaches including structural approaches that aims to solve problems and change the underlying systemic structure of the family and, strategic approaches using specific techniques such as ‘paradoxical intervention’ to bring about problem-based behavioural change

Multidimensional family therapy (MDFT) is specifically associated with the work of Liddle *et al.* (2001) and is a psychotherapeutically inclined family approach.

Motivational Interviewing – is widely used across the substance use treatment field. It has been defined as “a client-centred, directive method for enhancing intrinsic motivation to change by exploring and resolving ambivalence” (Miller and Rollnick, 2002) and uses techniques such as ‘rolling with resistance’ and structured feedback that aims to develop awareness of discrepancies between thoughts and actions and increase dissonance to produce change.

Relapse prevention – is widely used across the substance use treatment field. Largely based on the work of Alan Marlatt, relapse prevention works with people to understand triggers to relapse and improve the way that people manage this common feature of the ‘recovery’ process.

12-step Minnesota programmes – have their theoretical origins in the Alcoholics Anonymous self-help movement and are based upon 12 steps to recovery. These include acknowledging powerlessness over use, reliance on a ‘higher power’. The approach is often associated with a disease model of dependence.