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EVIDENCE TO PRACTICE PART 1

INTEGRATING TREATMENT FOR YOUNG PEOPLE WITH CO-OCCURRING SUBSTANCE USE AND MENTAL HEALTH ISSUES

Orygen has developed a suite of three resources for clinicians working with young people who have co-occurring mental health and alcohol and other drug (AOD) problems.

Part 1 (this resource) focuses on:

- the context for adopting an integrated intervention approach, which is distinguished from parallel and sequential models of care; and
- the evidence for integrated interventions.

Part 2 focuses on:

- the evidence for substance use screening and assessment; and
- the currently available evidence-based interventions for young people with AOD issues.

Part 3 provides:

- practical tips for working with young people who have co-occurring mental health and AOD problems (hereafter termed co-occurring problems).

For the purpose of these documents the term 'young people' refers to individuals aged 12–25 years. The integration of screening, assessment and treatment of substance use issues into primary mental health care should be considered from a funding, organisational, service delivery and a clinical level. These resources focus on addressing integration at the clinical level and are written from the perspective of general practitioners and mental health service providers working in primary care settings, rather than a specialised AOD treatment service provider. Therefore, interventions discussed are designed generally for young people with mild to moderate co-occurring problems and are primarily psychological rather than pharmacological interventions.

WHY ARE INTEGRATED INTERVENTIONS RECOMMENDED AND WHAT IS THE EVIDENCE?

BACKGROUND

Experimenting with alcohol and other drugs during adolescence and early adulthood is considered a normal part of life for many young people.(1) In 2019, the most popular substances used by young Australians were alcohol, cannabis and tobacco – in order of prevalence.(2) Substance use patterns differed depending on age. Risky alcohol use – more than four standard drinks on one occasion at least once a month – over 12 months was more common in young adults aged 18–24 years than adolescents aged 14–17years (41 per cent versus nine per cent).(2) Similarly, 30 per cent of young adults compared to nine per cent of adolescents reported using cannabis within the previous 12 months.(2) The reasons young people continue to use AODs after first use are similar to those reported by adults: primarily for enjoyment and wanting to have fun.(2) Young people are particularly vulnerable when using AODs, given they are in a life stage that is characterised by increased risk-taking and sensation-seeking behaviours. Young adults have a 34 per cent chance of being a victim of any alcohol-related incident, such as physical/verbal abuse or being put in a state of fear.(2) Young adults who engage in risky alcohol use have a 41 per cent chance of injury from a single occasion of drinking.(2) These percentages are higher than for any other age group.(2)

Young people most often seek help from treatment services for problematic cannabis, alcohol and amphetamine use; seeking help for amphetamine use is more common in young adults than adolescents.(2) However, many young people aged 16-25 years do not perceive substance use as necessarily harmful; 74 per cent believe it can be a 'pleasant activity' and 67 per cent believe there are 'many things that are much more risky' than trying substances.(1) More than two thirds of young people do not seek help

from mental health services when it is needed, especially if their problem is AOD use.(3, 4) Therefore, problematic AOD use can often go undetected and untreated. In some instances AOD problems may be perceived by young people as normal experiences, not issues worthy of seeking help for, especially if their peers experience the same or similar AOD problems. Substance use of any kind among young people warrants concern, given that it can cause harm and interfere with the physical, social, emotional and neurodevelopmental changes that take place during the transition from adolescence to adulthood.(5-7)

> "Young people with mental health issues use AODs more frequently, and more often use multiple substances compared to young people who do not have a mental health problem."

AOD USE BY YOUNG PEOPLE WITH MENTAL HEALTH PROBLEMS

Over the past two decades AOD use by young people has decreased in the general population, yet it remains high in those with mental ill-health. Young people with mental health issues use AODs more frequently,(8, 9) and more often use multiple substances(10) compared to young people who do not have a mental health problem. For example, in adolescents with major depressive disorder, prevalence of cannabis use is at least three times and alcohol use is almost two times higher than same-age peers in the general population.(8) To have co-occurring problems, difficulties do not need to be at the level of meeting diagnostic criteria for a mental health/substance use disorder; co-occurring problems may be sub-threshold. Approximately one third of help-seeking young people attending headspace have some degree of problematic alcohol or cannabis use.(11) Around 23 per cent have problems with past/current multi-substance use, including alcohol, cannabis and/or cigarettes plus use of other substances such as amphetamines, ecstasy or cocaine.(12) Help-seeking younger adolescents tend to use a single substance, mainly alcohol, while older adolescents - young adults tend to use more substances.(10, 12) Notably, young people are less likely to seek help for AOD issues than adults.(13, 14) Because people are more willing to seek help for mental health rather than AOD issues,(13) youth mental health services are a key avenue for early detection and treatment of AOD problems.

Having both a substance use disorder and mental health problem in adulthood is associated with greater risk of suicidality and self-harm, more conflicts with family/friends, poorer physical health, poorer social and occupational functioning and increased homelessness.(15, 16) Young people with co-occurring AOD and depression/anxiety disorders, similarly tend to have increased suicidality, more severe AOD use, poorer social skills and decreased academic performance relative to young people who meet criteria for a single disorder.(15) Help-seeking young people with co-occurring problems have been shown to have worse symptoms and poorer functioning at six months follow-up when compared to help-seeking young people without a co-occurring AOD problem.(17)

TAKE HOME MESSAGES

1. Although AOD use has recently decreased amongst young Australians, it remains relatively common, particularly amongst 18-25 year olds. Despite possibly harmful developmental impacts, young people may not recognise AOD use as a problem, with many unwilling to seek AOD-specific care.
2. AOD use remains disproportionately high in vulnerable groups of young people, including those with mental ill-health. Many help-seeking young people attending mental health services will have problematic use of substances like alcohol and cannabis, with a sizeable minority (10-20 per cent) reporting clinically significant patterns of multi-substance use either currently or in the past.
3. Co-occurring problems is an important marker for poor outcomes, including in young people.

Early intervention during the critical maturational stage of adolescence-early adulthood, where substance use issues are less entrenched, is an essential strategy for preventing and minimising both long-term and immediate harms linked to co-occurring problems.(18-20)

> "Early intervention is an essential strategy for preventing and minimising both long-term and immediate harms linked to co-occurring problems."

TREATMENT APPROACHES TO CO-OCCURRING AOD ISSUES AND MENTAL ILL-HEALTH

Historically, sequential and parallel treatment approaches have dominated both research and clinical practice when it comes to co-occurring problems. Sequential treatment typically involves a person first receiving treatment for only one issue (often AOD problems), before receiving treatment for the other issue. Parallel treatment typically involves a person receiving independent simultaneous treatment for both their AOD and mental health issues via different services.(15) These approaches often lead to people 'falling through the gaps' and never receiving treatment for the problem that is perceived to be secondary or less severe.(15, 21) Receiving treatment for one issue but not the other reduces the likelihood of treatment benefits being sustained.(22) Both sequential and parallel approaches fail to address the inherent interconnectedness of mental health and substance use issues, and promote involvement of multiple services and clinicians, placing greater burden on the individual, and their family and friends. Additionally, the young person may not perceive their co-occurring problems as separate issues, which can influence their level of engagement in sequential and parallel treatments.

Integrated models – also termed coordinated or shared care – involve a person receiving treatment for both co-occurring problems simultaneously from a single service. An integrated treatment typically involves a single provider delivering treatment for both issues. In this resource the term 'integrated interventions' will be used to refer to both integrated models and integrated treatments. Integrated interventions allow the exploration of the interconnectedness between the individual's AOD and mental health problems.(15) Common core components of an integrated model of care for people of any age with co-occurring problems can include:(23)

- a multidisciplinary care team;
- shared decision making and treatment planning that considers the individual's readiness for change;
- motivational enhancement interventions;
- self-help groups;
- physical health promotion;
- involvement of family and friends in treatment; and
- assertive outreach and long-term service provision.

There is extensive evidence, primarily from the global movement towards integrating mental health treatment within primary medical health care, that integrated models work for young people.(24-26) Evidence also comes from research into the efficacy of early intervention psychosis services,(27) where young people receive integrated specialised treatment for psychosis/psychosis risk, as well as vocational/educational support, and treatment for co-occurring mental health issues, such as depression and anxiety.(28) Broad principles of integrated community-based care models specifically for young people commonly include:(29)

- rapid access and early intervention;
- engagement of the young person and their family;
- service provision in a youth-friendly setting;
- partnerships and collaboration, for example with academic institutes, support agencies; and
- evidence-based practices.

> "Integrated interventions allow the exploration of the interconnectedness between the individual's AOD and mental health problems."

An integrated model of care for addressing co-occurring mental health and AOD issues is the approach recommended by Australian(30, 31) and international(32, 33) government bodies, and by AOD and youth mental health experts and organisations.(16, 34-41) Globally, there is service-wide acceptance that mental health and AOD support is best integrated across the model of care. However, multiple barriers exist when it comes to implementing an integrated care model and more so integrated treatments. Structurally, there is a need for services to broaden the scope of care provided, and to provide adequate support and training to up-skill the clinical, allied health, and AOD workforce to better detect and treat co-occurring problems. (42) There is also need for increased accessibility and affordability for clients.(42) Other barriers for young people seeking help for co-occurring problems include: stigma and embarrassment; beliefs of health care providers; fears around confidentiality; lack of family/community support; lack of awareness about the interconnectedness of problems; and the direct impact of symptoms of mental health and of AOD problems, on motivation, judgement and insight.(42-44) These barriers are not only real-world obstacles young people face, but they also make it difficult to run randomised controlled studies. This has slowed down the development and evaluation of specifically integrated interventions and ultimately much needed system reform.

INTEGRATED INTERVENTIONS ARE PREFERRED, ALTHOUGH HIGH-QUALITY RESEARCH IN YOUNG PEOPLE IS LACKING

RESEARCH EXCLUSIVELY INVOLVING YOUNG PEOPLE

The majority of previous randomised controlled trials (RCTs; gold standard studies) in mental health focused on two cohorts; children/adolescents aged 12-17 years, and adults (people aged 18 and older). This is largely because mental health systems traditionally divide service provision into child and adult services. The global movement in youth mental health service reform has lead to new models of care that provide specialised treatment to young people aged 12-25 years.(45) However, some researchers and health systems have yet to embrace this shift and are yet to view young people aged 12-25 years as having unique developmental and cultural needs. Therefore, there is currently a lack of high quality research that specifically involves young people aged 12-25 years.

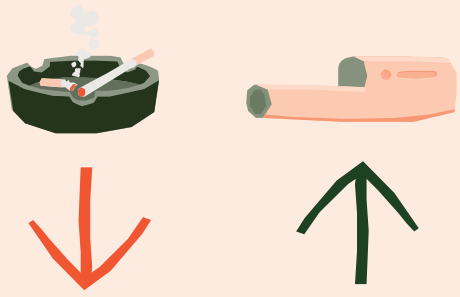
A limited number of RCTs have evaluated the efficacy of integrated interventions – both integrated models and integrated treatments – for young people with co-occurring issues. A review that evaluated RCTs of integrated interventions in adolescents who had both a substance use disorder and (any) mental health disorder, found cognitive problem solving therapy and family behaviour therapy in particular had large effects on reducing substance use and internalising and externalising problems, compared to either treatment as usual or some other active intervention.(46) Cognitive behavioural therapy (CBT) also had moderate-to-large effects on reducing both substance use and internalising problems, compared to interactional group therapy or psychoeducation.(46) A review of integrated treatments for young people with a substance use disorder (excluding tobacco) and depression, found preliminary evidence for the efficacy of CBT, family-focused therapy and motivational enhancement therapy (MET) to reduce both depressive symptoms and symptoms of substance use disorder.(47) A recent narrative review concluded that integrated treatments combining elements of CBT, family-based therapy, motivational interviewing (MI) and/or contingency management, are the most promising for treating adolescents with co-occurring substance use disorders and either internalising or externalising disorders in adolescents.(48) Overall, emerging evidence supports family-based interventions, problem solving therapy, CBT and MET for treating co-occurring problems in young people.

RESEARCH INVOLVING YOUNG PEOPLE AND ADULTS

The lack of good quality evidence in this area also extends to young adult and adult populations. A gold standard review recently examined the efficacy of psychological interventions for over 4,000 participants aged 18-65 years with co-occurring AOD use and serious mental illness.(49) Only four of the RCTs reviewed used integrated models, which were intensive and usually lasted 36 months. When compared to treatment as usual, there were no significant differences in illness outcomes, including reducing substance use, remaining in treatment, improving mental health or global functioning.(49) Overall, it was concluded there was no evidence to support any one particular intervention over and above standard care, and that evidence to date has been of poor quality.(49) The same was concluded in a Cochrane review of psychological therapies for people with co-occurring substance use disorder and depression, where one of seven studies comprised adolescents.(50)

WHAT ABOUT TOBACCO?

Tobacco use is the leading cause of preventable death and disease worldwide.(51) Despite this, research into the efficacy of integrated treatments for young people with co-occurring issues often excludes individuals when their only AOD issue is tobacco use. Around 70 per cent of young people with co-occurring problems are current smokers.(52) A meta-analysis involving at-risk adolescents (defined as having a mental illness, receiving treatment for substance use problems or being pregnant) failed to find CBT, MI, MET, peer support, relapse prevention, nicotine replacement therapy or a combination of these, to be effective for smoking cessation when compared to treatment as usual or a control intervention.(53) Another more recent review of interventions for reducing or ceasing tobacco use in young people with co-occurring depression highlighted the need for more research in this area, as only two (unsuccessful) RCTs were identified.(54) Further, these interventions did not appear to be delivered as integrated treatments.



Cigarette usage E-cigarette usage

E-CIGARETTES

Although tobacco use is at an all-time low in Australia, use of electronic cigarettes (e-cigarettes) is on the rise, with around 10 per cent of adolescents and 26 per cent of young adults having ever smoked e-cigarettes.(2) People with mental illness are twice as likely to be current e-cigarette smokers than people without a mental illness.(55, 56) Evidence suggests that the vapours inhaled from e-cigarettes may overall, be less harmful than smoke inhaled from traditional cigarettes.(57) However, e-cigarettes still contain worrying levels of heavy metals and carcinogens, and most contain the addictive substance nicotine, which has been shown to impact on brain development.(57, 58) The World Health Organisation and the Thoracic Society of Australia and New Zealand regard e-cigarettes as not safe with the long-term effects of e-cigarettes unknown.(59, 60) This further highlights the need for new interventions, including integrated interventions, targeting all forms of cigarette smoking in young people, especially for those with co-occurring mental health issues.

SUMMARY

An integrated approach is the preferred form of care for young people with co-occurring AOD issues and mental ill-health. Overall, there is currently insufficient research into integrated interventions for the treatment of co-occurring problems in young people to inform clinical practice. Nonetheless, CBT, family-based therapies and motivational interventions appear to be the most promising to date. There are several studies currently underway.(61, 62) While integrated interventions continue to be developed and evaluated, preliminary guidance on the screening, assessment and treatment of co-occurring problems can be drawn from empirical research that focuses on the detection and treatment of AOD issues in young people, irrespective of whether or not they have a mental health issue.

See Part 2 of this resource suite for recommendations on screening, assessment and treatment of young people with co-occurring problems.

See Part 3 of this resource suite for practical tips on how to integrate screening, assessment and treatment of AOD issues into clinical practice.

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