

1:1 Interventions for Young People: Analysis of Monitoring Data

Report for Kent DAAT

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Executive summary

The data

We analysed monitoring data for 205 young people who entered treatment in the year 1st June 2003 to 31st May 2004, and were recorded on a KMEMP young people's form as being in 1:1 counselling at some stage during that year.

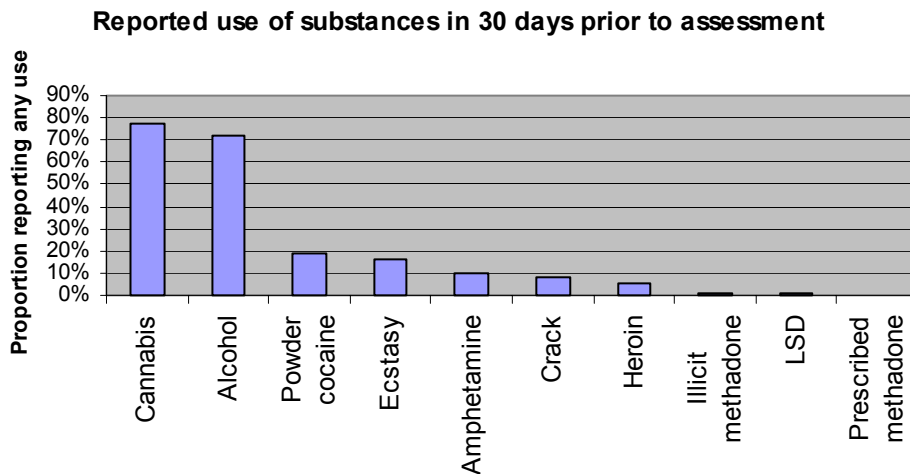
Of those assessed, 33% had a DNA form and 37% had an exit form. Exit from the service was not recorded for 30% of those who were assessed.

It seems that there is serious under-reporting of the person's progress at exit from the service.

1. Characteristics at assessment

The average age of those who were assessed was 16. Nearly half of them (44%) were female; a much higher proportion than is typically seen in adult drug services. Of those whose ethnicity was recorded, 87% were white.

The most commonly reported substances used were cannabis and alcohol. Reported use of class A drugs was relatively rare, especially when compared to adult treatment populations.

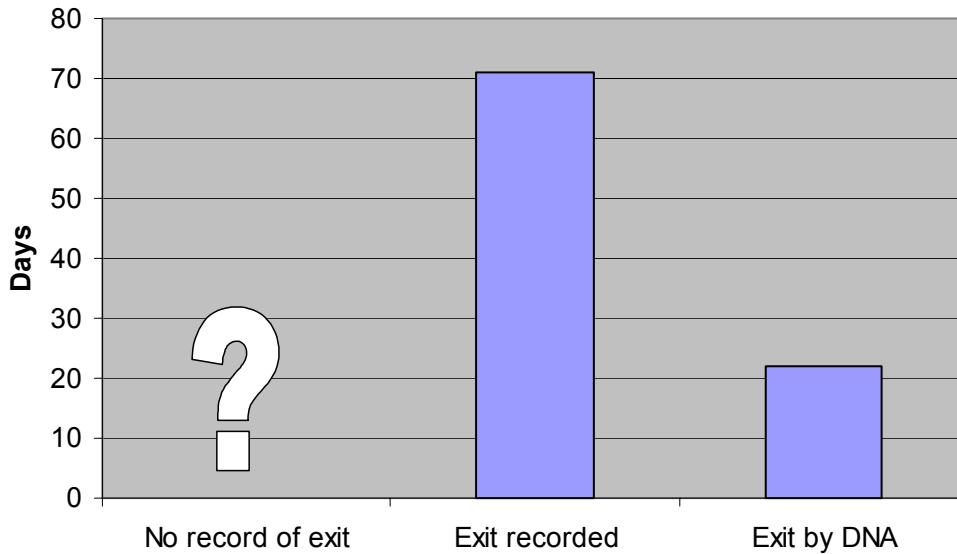


2. Retention

People who have a recorded exit stay longer than those who leave by not turning up, but it is not known how this compares to people who do not have a recorded exit from the service.

55% have no recorded appointments. Excluding these people, the median number of appointments was 4.

Median Duration of Service (assessment to exit)



3. Outcomes

There was no record of outcome for 62% of the people. Reported drug use, health and crime at exit from the service were available for 77 people.

- 71% reported reduced use of alcohol.
- 62% reported reduced use of cannabis.
- There was also a significant reduction in the reported use of class A drugs.
- 48% reported less physical health problems.
- 66% reported less mental health problems.

There was no significant change in reported crime between assessment and exit.

Conclusion

Lack of data hampers efforts to evaluate the process and outcomes of services for young people in Kent. In 1:1 counselling, a third of people who were assessed had no further record. Another third had no record of substance use, crime or health at exit.

For those whose exit was recorded, there were significant reductions in substance use and significant improvements in physical and mental health.

This gives an encouraging indication of positive effects of the service provided. However, due to the large amount of missing data, it is impossible to say if the service produced these positive outcomes. It may be that the people for whom there is a record of exit were those people who would have improved, even without the service.

The full report gives more details of the analysis and identifies areas for further examination of the process and outcomes of 1:1 interventions.

Full report

Introduction

EISS was commissioned by Kent DAAT to carry out analysis of monitoring data relating to 1:1 interventions for young people with substance use problems. The aim of this analysis was to examine:

1. The characteristics of people who enter the service
2. Retention in the service. How long do these people stay in treatment?
3. Does monitoring data tell us anything about outcomes of the service?

This report describes the analysis that we have carried out in pursuit of these aims. It starts with a description of the data that we used, before giving information on each of the three aims.

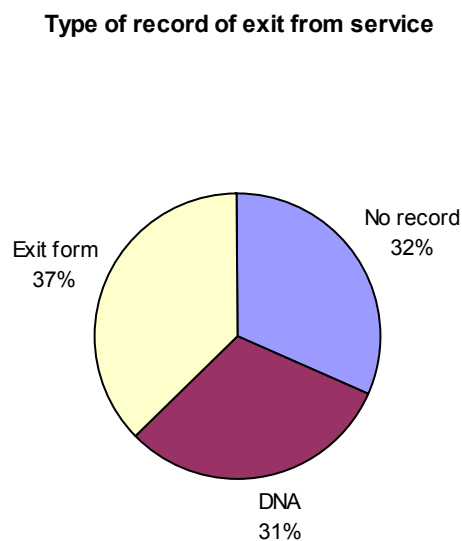
The data

For this analysis, we used data held in the KMEMP system on 205 people who were recorded on a KMEMP young peoples form as entering treatment in the year 1st June 2003 to 31st May 2004, and who were recorded as being in 1:1 counselling at some stage during that year. This was the most recent 12-month period for which records were available.

In this monitoring data there were:

- 185 initial assessments
- 41 three-month updates
- 14 six-month updates
- 77 exit forms
- 65 DNA forms.

The pie chart below shows the proportions of clients who had different types of record of exit.



Only a minority of clients had a full record of exit. Further examination is needed of why this is. For 65 people (32% of the sample) there was no record of exit from treatment. This indicates that there is a serious problem of under-reporting of progression through the service.

The table below shows where the recorded assessments were carried out. As expected, the two services that recorded the largest number of assessments were KCA Young People's Service in Canterbury, and Elm House.

Number of assessment forms from treatment units	
KCA Canterbury	1
KCA Canterbury Young People's Service	118
Cornerstone Maidstone	8
Cornerstone Tunbridge Wells	5
WKSMS Medway	1
WKSMS Bridge House	1
Elm House Young People's Service	51
Total	185

1. The people who enter the service

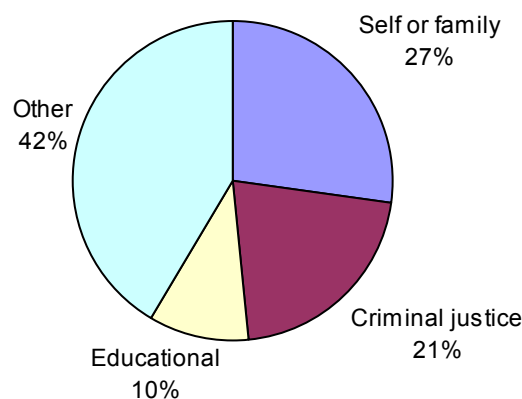
In this section we will describe patterns of referral, demographics, substance use, mental and physical health and crime in order to show what the monitoring data tells us about the young people who use the 1:1 counselling service.

Referral

KMEMP records have 15 categories for sources of referral to the service. In order to make sense of these categories, we combined them into 4 groups: self or family; school or college (educational); YOT, probation or police (criminal justice); and other.

The pie chart below shows the proportions of assessed clients who were referred from each of these four sources.

Proportions referred from each type of source



The other sources of referral included other agencies, including social services and voluntary agencies.

Demographics

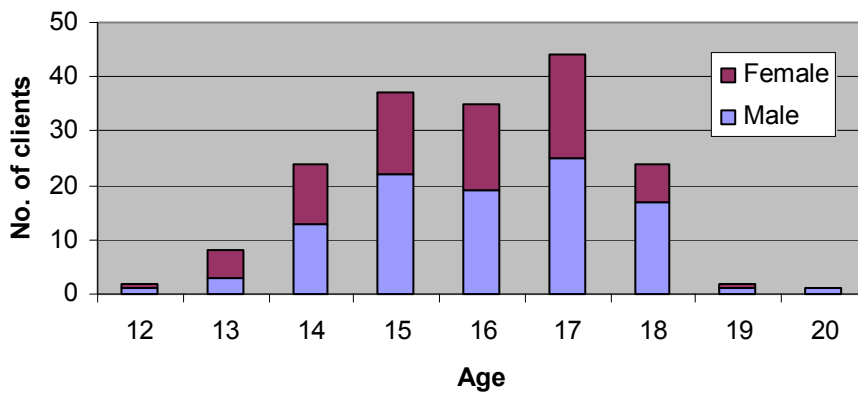
The people who were recorded as being assessed for treatment had the following demographic characteristics

Demographics	
Average age	16
Gender	56% male
Ethnicity	87% white

For 67 people (36% of the sample), ethnicity was not recorded, which harms the reliability of the information. Of those whose ethnicity was recorded, 103 (87%) were recorded as white UK, 6 as mixed ethnicity, 3 black Caribbean and 2 black other.

The age and gender profile of assessed clients is shown in the graph below. The proportion of young women in this group was much higher than is typically seen in drug treatment for adults. There are two potential explanations for this. One is that the average age of adults in drug treatment is typically around 30, by which time most women may have matured out of substance abuse. The other is that young people’s services may be more accessible to women than adult services.

Age and gender of assessed clients



Substance use

At assessment, clients are asked questions from the KMEMP form about their use of a variety of substances over the last 30 days. In many cases, these cells in the monitoring data were blank. This indicated that the person did not report any use of that substance. This may have been because they said that they had not used the substance, but it also may have been that they were not asked if they had. In this analysis, we have assumed the former, and replaced blank cells with 0. However, this may mean that substance is under-recorded in the monitoring data and in this analysis.

The table below summarises responses on substance use. The first column shows the proportion who reported any use of the substance. The second shows the median days of reported use and the third shows the mean. The median is the number below which half the sample reported their days of use. For highly skewed numbers (with a lot of people

reporting no use and a few reporting high use) the median gives a better idea of the general pattern of use than the mean.

Substance	% reporting any use in last 30 days	Median days use in last 30	Mean days use in the last 30
Cannabis	77%	15	14.8
Alcohol	72%	5	8.9
Powder cocaine	19%	0	1.8
Ecstasy	16 %	0	0.7
Amphetamine	10%	0	0.9
Crack	8%	0	0.4
Heroin	5%	0	0.8
Illicit methadone	1%	0	0.03
LSD	1%	0	0.03
Prescribed methadone	0	0	0

The table shows that cannabis and alcohol were by far the most commonly reported substances used by these young people. Use of class A drugs was relatively rare, with only small minorities of the sample reporting use of cocaine, ecstasy and heroin.

This finding fits with the annual survey of drug use by school pupils, which found that cannabis was the most commonly used drug and that only 4% reported use of class A drugs (National Centre for Social Research & the National Foundation for Educational Research for the Department of Health, 2004). Even for people who develop problematic drug use, use of class A drugs is relatively rare in the teenage years. We are currently carrying out research (in the QCT Europe project) with 87 adult problematic drug users in treatment in Kent. In this group, the average age of first use of heroin was 22.

In this sample of young people, there was, as expected, a moderate correlation between age and drug use. The older people in the sample tended to report using substances more frequently¹.

There were no significant differences between genders in the proportion who reported use, nor in mean days of total substance use.

Health

The KMEMP form asks people to describe how often they experience 10 types of poor physical health and 10 types of poor mental health (never, rarely, sometimes, often or always). The proportions who said that they experienced the symptoms often or always are shown in the table below.

Percentages reporting "often" or "always" feeling symptoms of poor health			
<i>Physical health</i>		<i>Mental health</i>	
Tiredness/fatigue	37	Feeling tense	30
Poor appetite	17	Feeling no interest in things	22
Stomach pains	11	Feeling hopeless about the future	20
Tremors	10	Nervousness or shakiness inside	17
Nausea	6	Feelings of worthlessness	15
Numbness/tingling	6	Feeling lonely	15
Difficulty breathing	4	Feeling fearful	11
Muscle pain	4	Suddenly scared for no reason	7
Chest pains	3	Thoughts of ending your life	6
Joint/bone pain	3	Spells of terror or panic	5

¹ Pearson's $r = .352, p < .001$

The table shows that the clients reported symptoms of poor mental health more frequently than those of poor physical health.

For analysis, and following the protocol of the Maudsley Addiction Profile from which these sections of the KMEMP form are taken, we created scores by totaling indicators of poor mental and physical health (0 for never, 1 for rarely, 2 for sometimes, 3 for often and 4 for always). The possible scores for poor physical and mental health therefore range from 0 to 40.

For poor physical health, the mean score was 8.6. Young women reported significantly higher scores for poor physical health than the young men (7.4 for men, 10.2 for women)². There was a moderate correlation³ between poor physical health score and total days of substance use reported at assessment. Those people who reported more frequent substance use were also more likely to report poorer physical health.

As suggested in the table above, problems were reported more frequently for mental health than physical health. The mean score for mental health problems was 11.7. Females had significantly higher scores for poor mental health than males (9.6 for young men, 14.9 for young women)⁴. There was again a moderate correlation⁵ between poor mental health score and more frequent substance use at assessment.

Crime

The KMEMP form also asks people whether they have committed a crime in the last 30 days. In our QCT Europe project, our comparison with KMEMP monitoring data showed that people were much less likely to report crime when being assessed than when being interviewed by an independent researcher. This suggests that there is serious under-reporting of crime in KMEMP, although it is conceivable that young people are less reluctant than adults to disclose crime to their drug worker.

So the figures presented here on crime should be taken with a pinch of salt. There was no response to the crime question recorded for 14% of the people who were assessed. Of those for whom there was a response recorded, 21% reported that they had committed a crime in the last 30 days.

² p<0.01

³ Pearson's r = .441, p<.001

⁴ p<0.001

⁵ Pearson's r = .440, p<.001

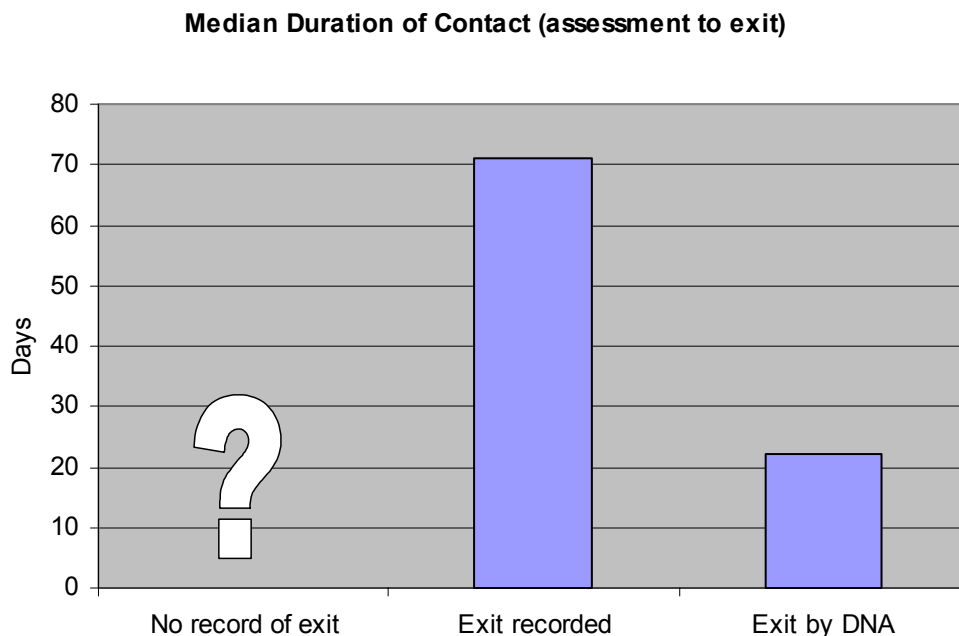
2. Retention - how long do they stay in treatment?

It has been a common finding in evaluations of drug treatment services that retention is associated with better outcomes, in terms of reduced drug use and crime and improved health. We looked at the monitoring data to see what it tells us about retention.

Obviously, for the third of the sample for whom there is no record of exit, it is not possible to tell for how long they were retained in the service. An educated guess would be that they were less likely to be people who formed effective therapeutic relationships and were more likely to leave early, but this is just a guess.

Duration of contact

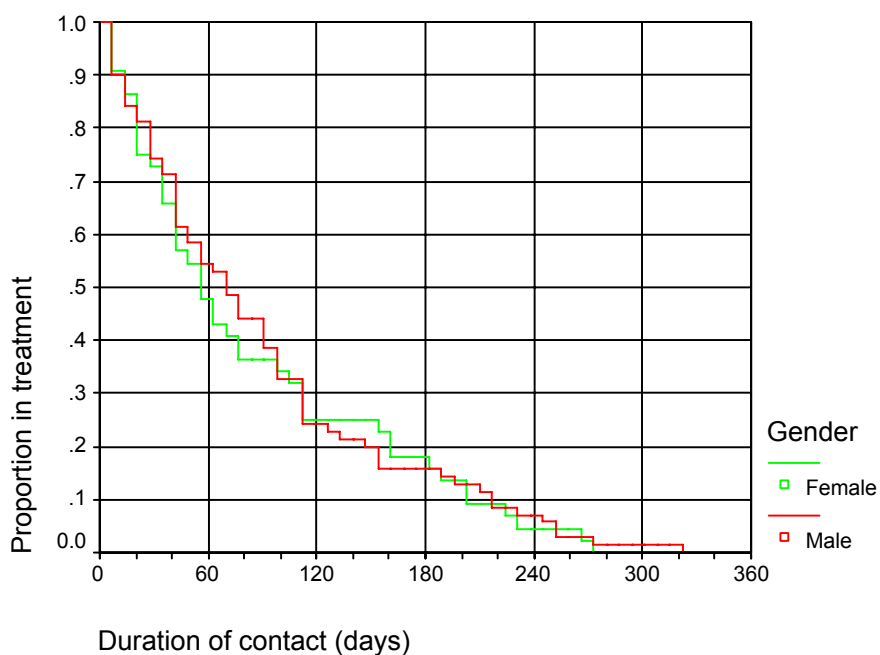
For those who did have a record of exit, we calculated the number of days between their assessment and their last recorded contact with the service. The median figures are shown in the graph below.



The median duration of contact for all those with a record of exit was 56 days (nearly two months). It was over two months for those who had an exit form completed for them, compared to under one month for those whose exit was recorded with a DNA form.

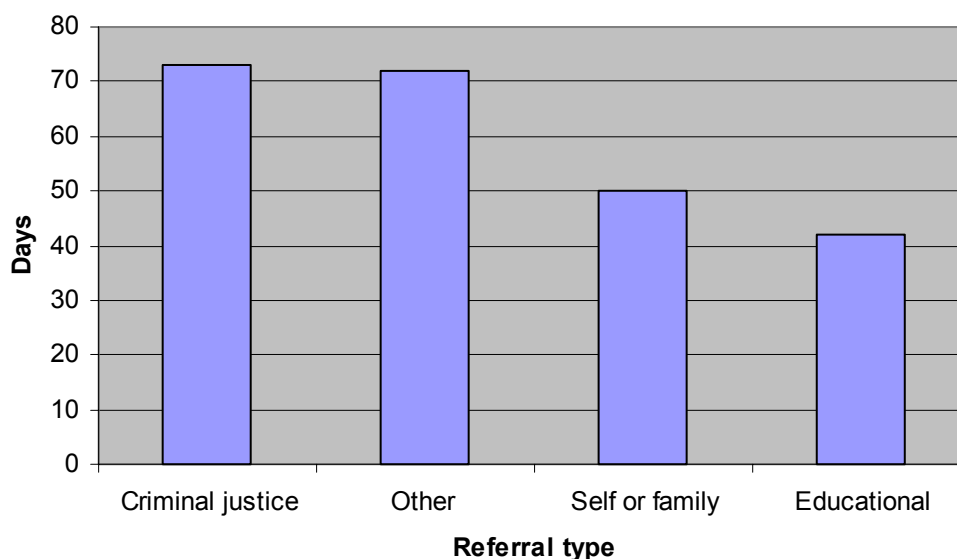
The survival graph over the page shows the proportions of young men and women who were recorded as still being in treatment at increasing numbers of days after assessment. It shows the similar patterns of retention and drop-out for young men and women. The survival curve is typical of those for retention in treatment, with a steep drop-off in the first few weeks followed by lower rates of drop-out in later weeks. There were no significant differences between genders, and no association between age of client and duration of contact. Nor was substance use at assessment associated with duration of contact. Recorded duration did tend to be slightly longer for those whose ethnic origin was recorded as other than White UK, but not significantly so.

Survival in treatment



There were significant differences between the duration of contact for people who had different types of referral, as shown in the graph below.

Median duration of contact for each type of referral



Number of appointments

The KMEMP forms also have a space to enter the number of appointments since the previous form was filled in. For the majority of clients (113, or 55%) there were no recorded appointments. This includes 52 (86%) of those who finished with a DNA report, but also 13 (17%) of those with an exit form (the total number of appointments for those with no record of exit is obviously not available). This suggests that many of the young people who are assessed for treatment in 1:1 counselling never actually receive any service beyond that initial assessment. Again, this suggestion needs to be checked in more detail.

Excluding those with no recorded appointments, the average number of appointments is 6.25 (median 4), in an average duration of 111 days (median 84), making the average spacing between appointments 18 days. There was, as expected, a significant correlation⁶ between longer duration of treatment and more appointments.

3. Outcomes

There are two major problems in analyzing outcomes of the 1:1 counselling service for young people. The first is that information drug use, health and crime are only available for the 77 people (37% of the sample) for whom there were exit forms. The second is that the absence of a comparison group makes it impossible to attribute any changes to the service that the people received.

Nevertheless, there were some interesting changes reported by the people who did have an exit form.

Substance use

The table below shows reductions in substance use among those who reported use of a substance at assessment.

Substance	Proportions reporting reduced use*	Mean reduction (days of use)
Alcohol	71%	3.9
Cannabis	62%	5.8
Class A drugs	65%	3.7
All substances	58%	4.2

* of those who reported use of the substance at assessment.

There were statistically significant reductions in days of reported use of cannabis, class A drugs and total days reported drug use.

It should be remembered that these reductions are in the context of the tendency for drug use to increase as young people get older.

There was a moderate correlation⁷ between total days reported substance use and reduction in days reported substance use at exit. Those who were using most heavily at entry had larger reductions on average.

There were no significant gender or ethnic differences in reduced reported days of use of alcohol, cannabis, class A or total substances.

⁶ Pearson's $r = .537$, $p < .001$

⁷ Pearson's $r = .490$, $p < 0.01$

Physical and mental health

Scores for health that were calculated from reports on exit were compared with those calculated from reports at assessment (as above).

	<i>Proportion reporting reduction at exit</i>	<i>Mean reduction</i>
Poor physical health score	48%	1.3
Poor mental health score	66%	2.7

The reductions in reported poor mental and physical health were statistically significant.

For gender, the reduction in reported physical health scores was significantly greater for young men than young women, but it was the other way around for young women, who improved more in their mental health.

Crime

There was apparently no significant reduction in reported offending between assessment and exit. As mentioned above, reports of crime are likely to underestimate actual offending. The lack of change between assessment and exit could reflect increased reporting, due to increased trust of workers, even while offending falls.

Conclusion

Our analysis of this monitoring data suggests that:

- There is serious under-reporting of progress in treatment. For one third of the people who were assessed, there is no record of whether they ever used the service again. For two-thirds, there is no record of the progress they make subsequent to assessment.

Characteristics of those young people who use the service

- Cannabis and alcohol were the most commonly used substances at assessment.
- Use of class A drugs was reported relatively rarely.
- Mental health problems were more common than physical health problems at assessment. A fifth of the sample reported that they often or always felt hopeless about the future, and higher proportions reported that they often or always felt tense or felt no interest in things.
- Young women reported both physical and mental health problems more frequently than young men at assessment.

Retention

- For the two-thirds of the sample for whom there is a record of exit, most of them were in contact with the treatment service for about two months, during which time they typically attended about 4 appointments.
- Duration in treatment, and the number of appointments was significantly higher for those who had an exit form than those who left the service with a DNA form.

Outcome

- For the third of the sample for whom there was an exit record, there were significant reductions in reports of drug use, and in reported physical and mental health problems during treatment.
- This does not mean that these reductions were necessarily produced by the service. However, it is encouraging that, at least for those people who have an exit record (and they are the ones who tend to stay longer in treatment) there are signs of positive changes.

Gender

- The proportion of young women in 1:1 treatment was higher than is typically seen in adult drug treatment services.
- There were remarkably few differences in retention and drug use outcomes for young men and women in the service.

For further examination

- Why do so many people not have a record of how they left the service?
- How would information on these people affect the figures on retention and outcome?
- Does the reported pattern of drug use reflect that of all those young people with drug problems in Kent, or are there groups of young users of class A drugs who are not accessing treatment?
- Is there an explanation for the different outcomes in mental and physical health between girls and boys?
- How do other characteristics of services and clients relate to retention and outcome?
- What elements of services are associated with better retention and outcome?

Reference

National Centre for Social Research & the National Foundation for Educational Research for the Department of Health. (2004). *Drug use, smoking and drinking among young people in England in 2003*. Retrieved 9th March 2005, from <http://www.dh.gov.uk/assetRoot/04/09/89/17/04098917.pdf>