EVALUATION OF ACCESS MECHANISMS FOR YOUTHS WITH ADDICTION

JOËL TREMBLAY, UQTR
NATACHA BRUNELLE, UQTR
NADINE BLANCHETTE-MARTIN, CRDQ, CRDCA
MICHEL LANDRY, CDC-IUD
NADIA L'ESPÉRANCE, CRD-DOMRÉMY-MCQ
MYRIAM LAVENTURE, U. SHERBROOKE
FRANCINE FERLAND, CRDQ, CRDCA
STEVE JACOB, U. LAVAL
GENEVIÈVE DEMERS-LESSARD, UQTR
ANNIE-CLAUDE SAVARD, UQTR

Cross-training/ Douglas Mental Health University Institute
April 27, 2016

Introduction

- Name:
  - **MAJT**: Access mechanism for youths with addiction (Mécanisme d'accès jeunesse en toxicomanie)
- Role of the MAJT:
  - Centralized access mechanism
  - Reception, evaluation and orientation
  - Addicted youths already screened by general services (schools, youth centre, CLSC, community organizations, etc.)

Objectives of the research project

- Implemented over 10 years ago
- **Objectives of the project**
  - Favourable and unfavourable conditions for the implementation of the MAJT
  - Efficacy of the MAJT
    - Improve orientation of youths in services
    - Reduce pre-evaluation waiting time
    - Support youths awaiting services and treatment
    - Reinforce continuity of the service trajectory
    - Improve clinician expertise

Methods

Methods

- Qualitative component (2011-2013)
  - 6 CRD, clinical directors, clinicians, parents, youths

Interviews conducted		
	Interviews (n)	**Participants (n)**
Participants (Clinicians/directors)	81	149
Participants (Youths/Parents)	39	39
Total	120	188

- Quantitative component
  - 1510 youths admitted consecutively in 6 CRD (2012)

Results

Detection and intervention process in primary care and orientation toward the MAJT

- Importance of continuing or intensifying the detection process
- DEPA-Ado or similar test: highly recommanded
- All references include test results
- Continuing education of CRD for referral centres (i.e. DEP-ADO)
  - Primacy of clinical judgment (versus cutoffs)
  - Attention to false negatives
  - ≠ group administration

Detection and intervention in general care and orientation toward MAJT

- To improve the probability of youths being detected in schools and youth centres
  - Staff dedicated to addiction problems working in detection environments (employees from schools or community organizations)
  - Stability throughout time (to establish confidence among youths and a better knowledge of addiction services for staff)

Results

- Reference process
  - Schools:
    - Formal protocols with schools (1/4 of CRD)
    - Clinicians present in schools, others have clinicians who are assigned but not necessarily present in the schools (1/3 of CRD)
    - Some schools have specific staff from their school, from a community organization or from a CSSS dedicated to detection and referrals
  - Youth centres:
    - Clinicians from CRD working in CJ (1/4 of CRD)
    - Clinicians dedicated to respond to CJ clinician requests without working in CJ
  - Minimum of 3 references from a school / CJ to authorize a CRD clinician to visit the school (1 CRD)
  - Others: Formal protocols with CSSS (2 CRD)
  - Screening tool: DEP-ADO (14 CRD), *red Light* criteria, sometimes elevated *yellow light*
    - 10 CRD require DEP-ADO
    - 7 do not require it, but wish to receive it

Results

Sources of referrals to the MAJT

Sources	Proportions
Youth centres/courts	35,0
Schools	33,0
Youths/Parents	11,5
CSSS/Hospitals	10,5
Other family members / Friends	3,4
Community organizations	2,9
Others	0,8
Do not know	2,8

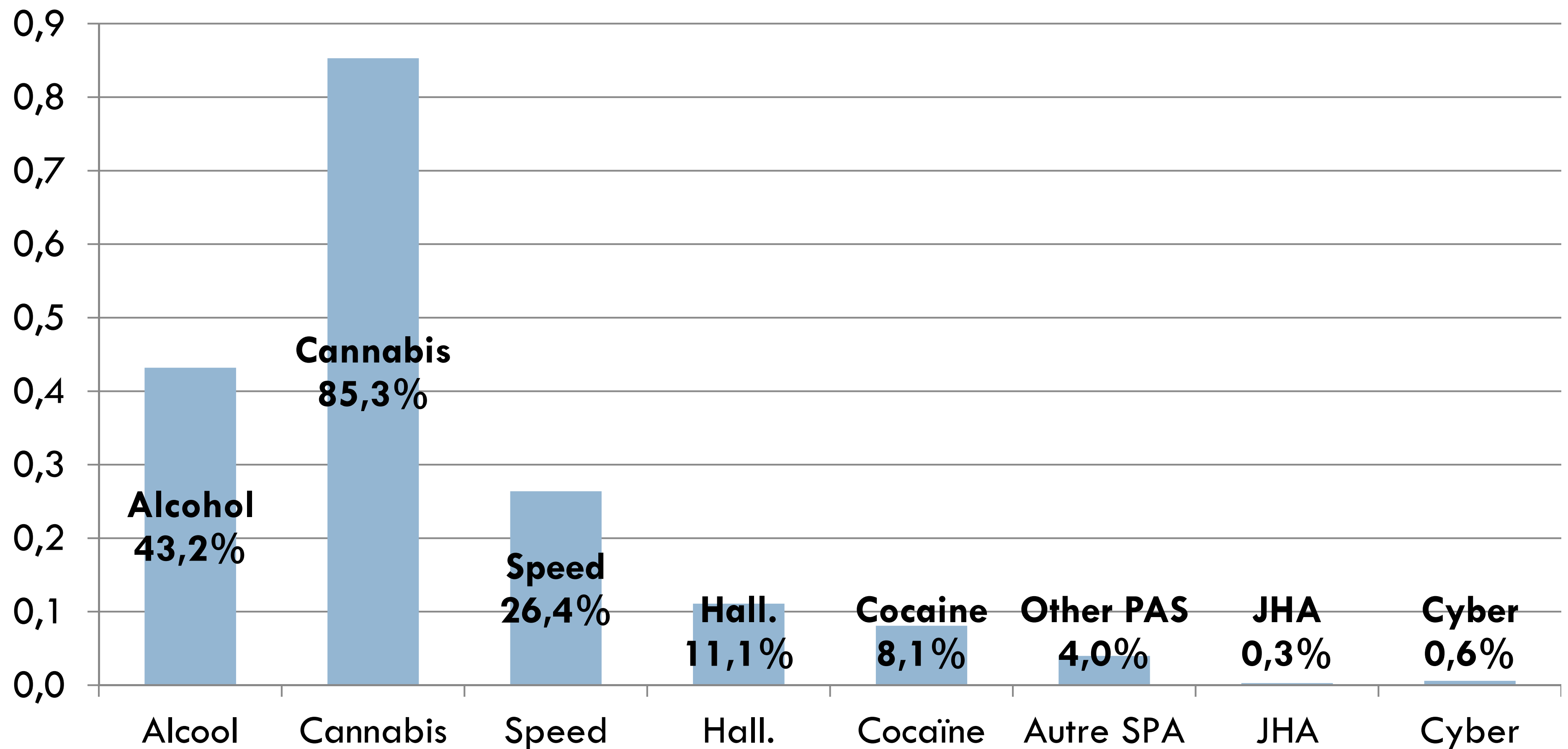
Distribution of youths having made a request for services at the MAJT from January 1 to November 30, 2012, from the CRD, according to the source of the refferal

Regions	Youth centres/ Court (%)	Schools (%)	Youths/ Parents (%)	CSSS / Hospitals (%)	Other family members / Friends (%)	Community organizations (%)	Others (%)	Do not know (%)
Qc	38,8	35,1	1,4	17,6	0,4	5,3	-	1,4
MCQ	27,9	37,8	8,4	8,7	6,9	3,2	3,0	7,0
Estrie	22,4	48,9	16,5	10,6	0,4	0,4	-	0,8
Mtl f	49,5	11,5	16,2	9,7	5,3	4,0	-	3,7
Mtl a	33,2	36,5	20,7	2,6	1,3	1,3	-	4,4
A-T	38,8	33,0	10,7	12,7	1,9	-	-	2,9
Average	35,0	33,0	11,5	10,5	3,4	2,9	0,8	2,8

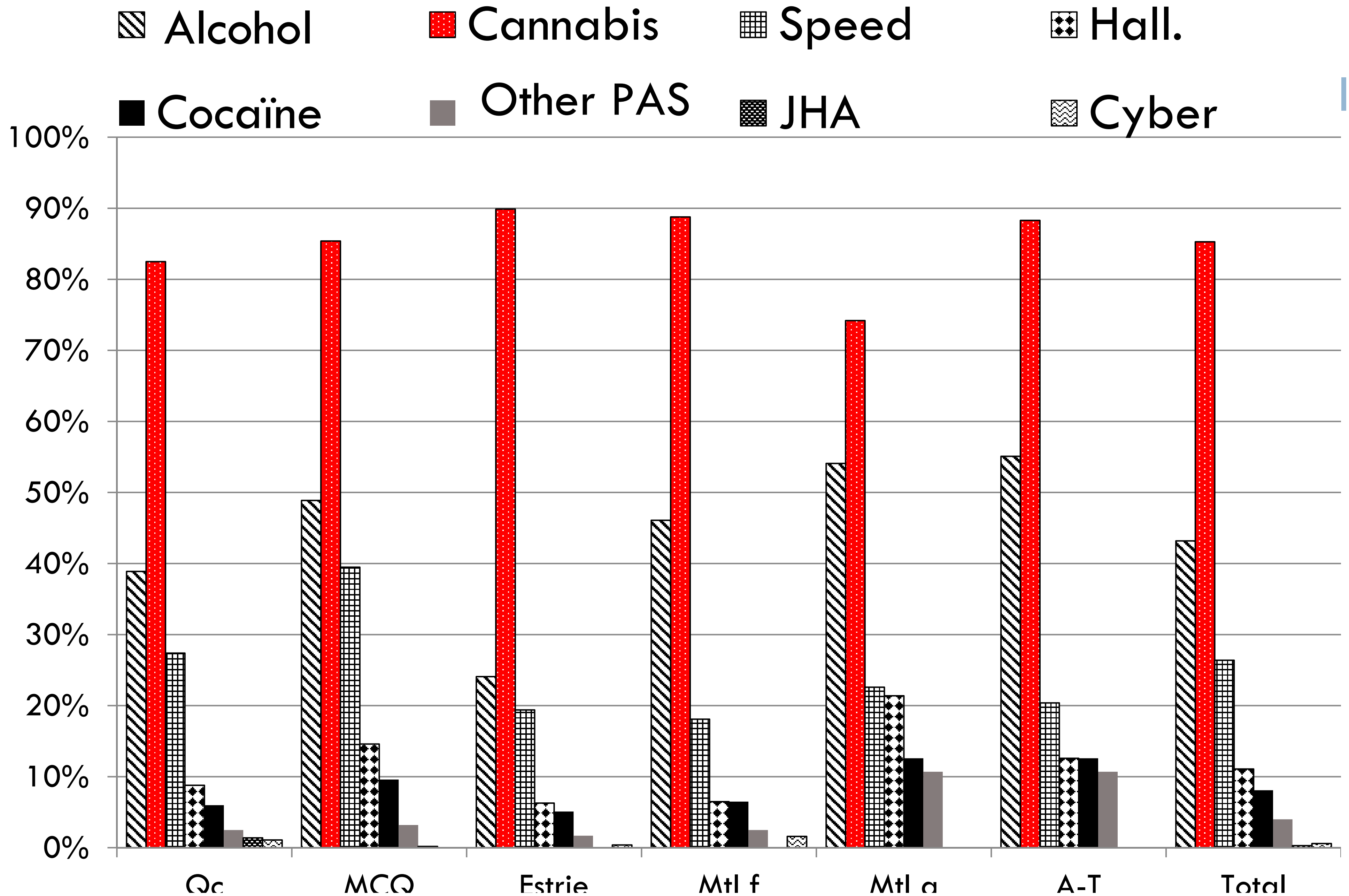
Detection / orientation

- CRD: support referrers to equalize referral sources
  - The ideal is to receive high numbers of referrals from these two sources.
- Particular support for CSSS
  - Capitale Nationale: Frequent contacts with referrers from CLSCs, repeated training / information activities
  - According to CSSS: attributing personnel dedicated to addiction services would help to increase referrals to the CRD
  - “Self-referred” youths to CRD may have had previous interviews at the CSSS

Problematic substances at the source of requests for help : at reception, possibility of more than one per youth

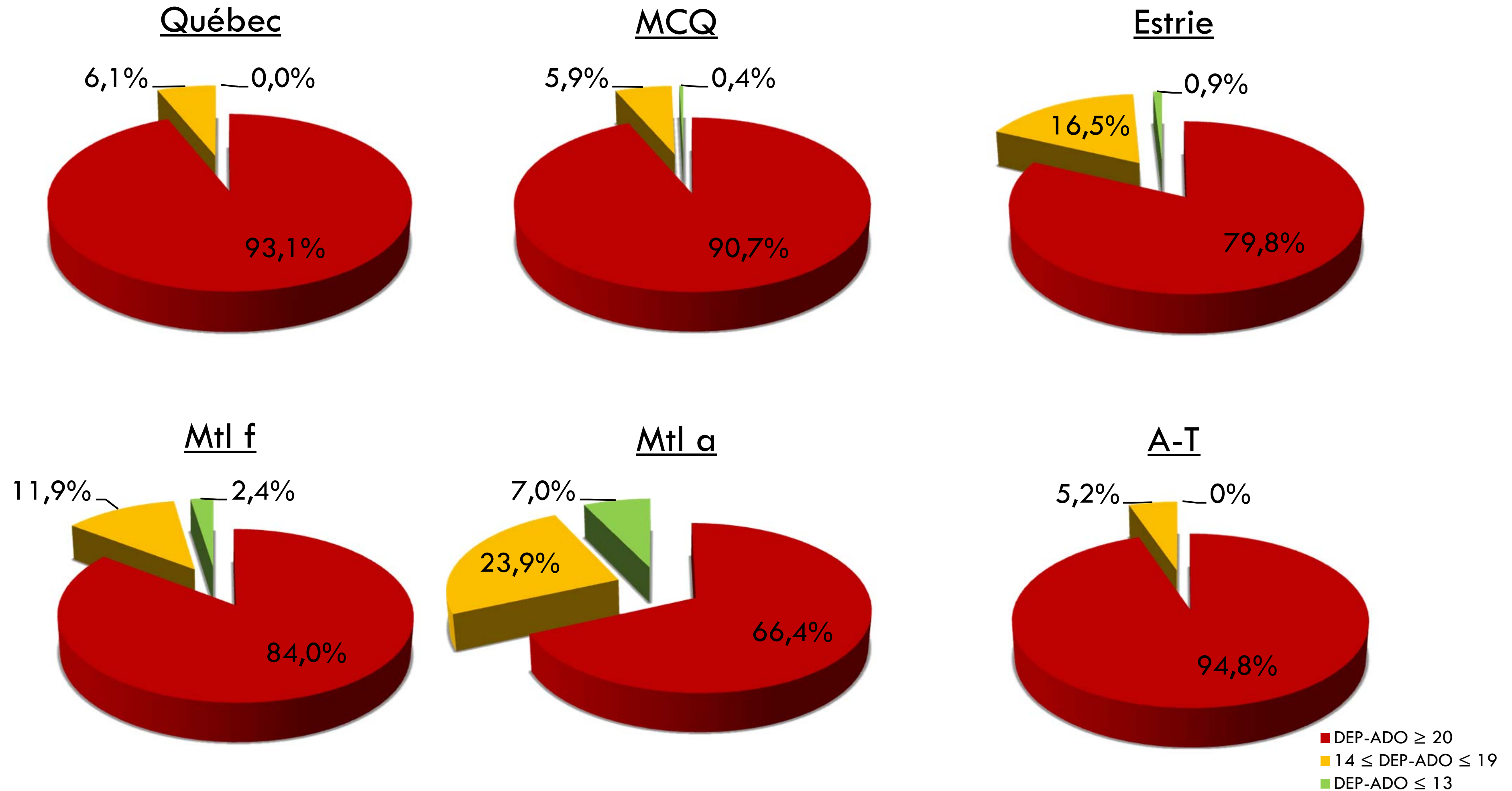


Results - Problematic substances



Results - overviews

When there is a DEP-ADO, do youths have an appropriate severity rating?



Process of detection, intervention in primary care and orientation toward the MAJT

- Develop protocols
  - Intra-institutional
    - Intervention (When, How, Who?)
  - Inter-institutional
    - Clarify moments and roles
    - Communication: What, When, How and by whom?
- In the event of a gap in services: return to the protocol
- Useful if a key member of the personnel is not there
- Must be known by all

Process of detection, primary care intervention and orientation toward the MAJT

- Frequently mentioned: Lack of expertise in addiction within primary care services (++ mentioned in schools)
- Training offered by CRD ++ appreciated
  - Continuing education/ rotation of staff

Detection / Orientation

- Preparation activities for youths when referred to specialized services
  - CJ: prepare youth to go to internal services by helping him/her to better control anger or by promoting a better follow-up of mental health problems
  - Good explanation of specialized services by the referring clinician
  - Staff from specialized services meets youth at school to prepare him/her when arriving in services
  - Referrent accompanies youth to a first meeting in specialized treatment center (increases probability of treatment adherence)

Detection / Orientation

- Lack of intermediate outpatient services between external 1x/week and residential
- Laurentides region (DéClic, Intermède)
  - Program developed by the school with the CRD and community organizations
  - Red light youths++ / refusal to go to the CRD
  - Day centre-type services
  - 4 weeks in a community organization
  - AM catching up on school material, PM psychoeducational activities
  - Support to prevent substance use during the day
  - Better prepared for residential services
  - Impact: Less youths in need of residential services?

Detection / Orientation

- North shore
  - Group program in CJ, offered by the CRD
  - Red Lights and in residential services at the CJ
  - 6 weeks
  - Impact: Less youths referred toward residential addiction services

Detection / Orientation

Regions	Penetration rates - Boys (%)[1]	Penetration rates - Girls (%) [1]	Penetration rates - Total[1]	Penetration rates - Active files
Qc/CN	18,4	11,5	15,4	31,8
MCQ	30,6	21,7	26,8	33,1
Estrie	29,2	14,7	22,9	29,0
Mtl a/f	11,7	6,9	9,6	14,7
A.-T.	21,4	16,0	19,2	22,5
Total	**18,0**	**11,2**	**15,1**	**22,4**

[1] Penetration rates were calculated from *red* light rates reported by the Institut de la Statistique du Québec within the Enquête québécoise sur la santé des jeunes du secondaire (2010): boys, 5,5%; girls, 4,8%; total, 5,1%.

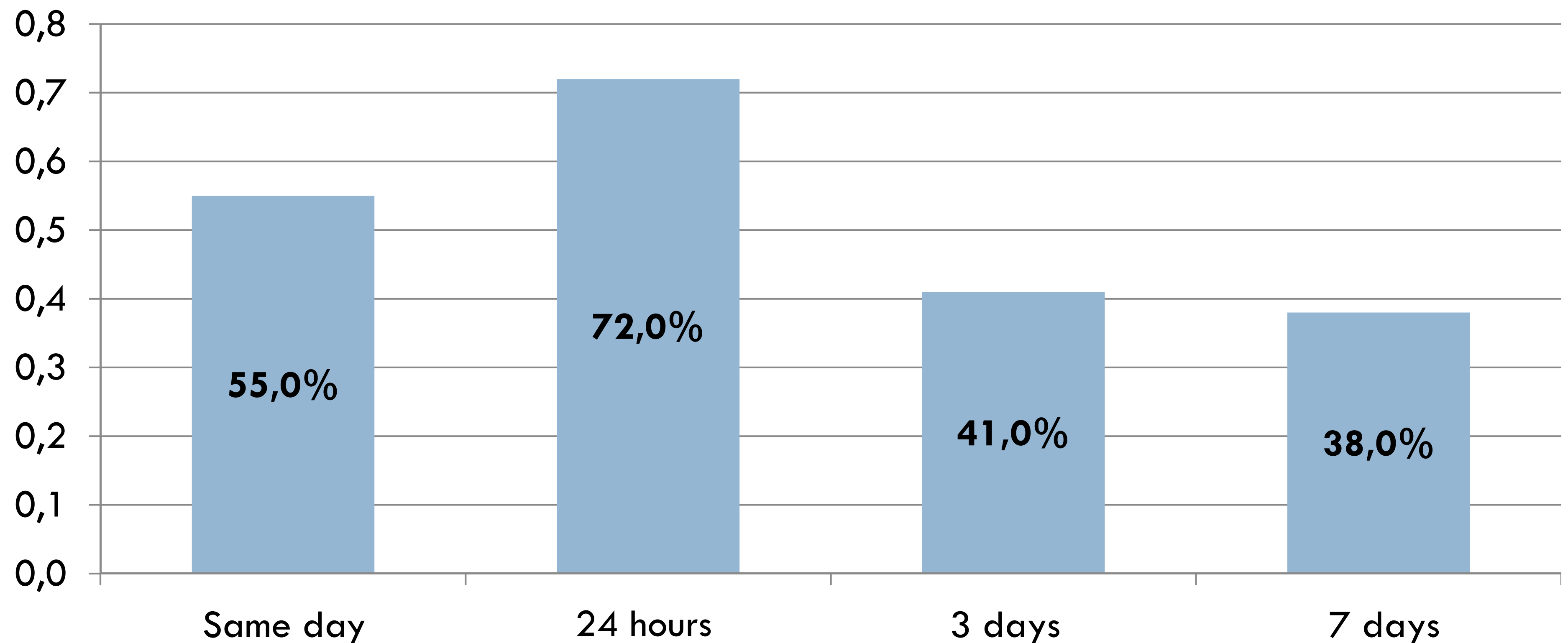
[*] The number of service requests includes a small percentage of *yellow lights*

Detection / Orientation

- Inter-regional gaps could be explained by service organization
- Clinicians from CRD present in schools / CJ help to improve services access
  - Physical and temporal proximity
  - Familiarity between clinicians from CRD and Schools/CJ
  - Services offered to youths without the obligation to inform parents

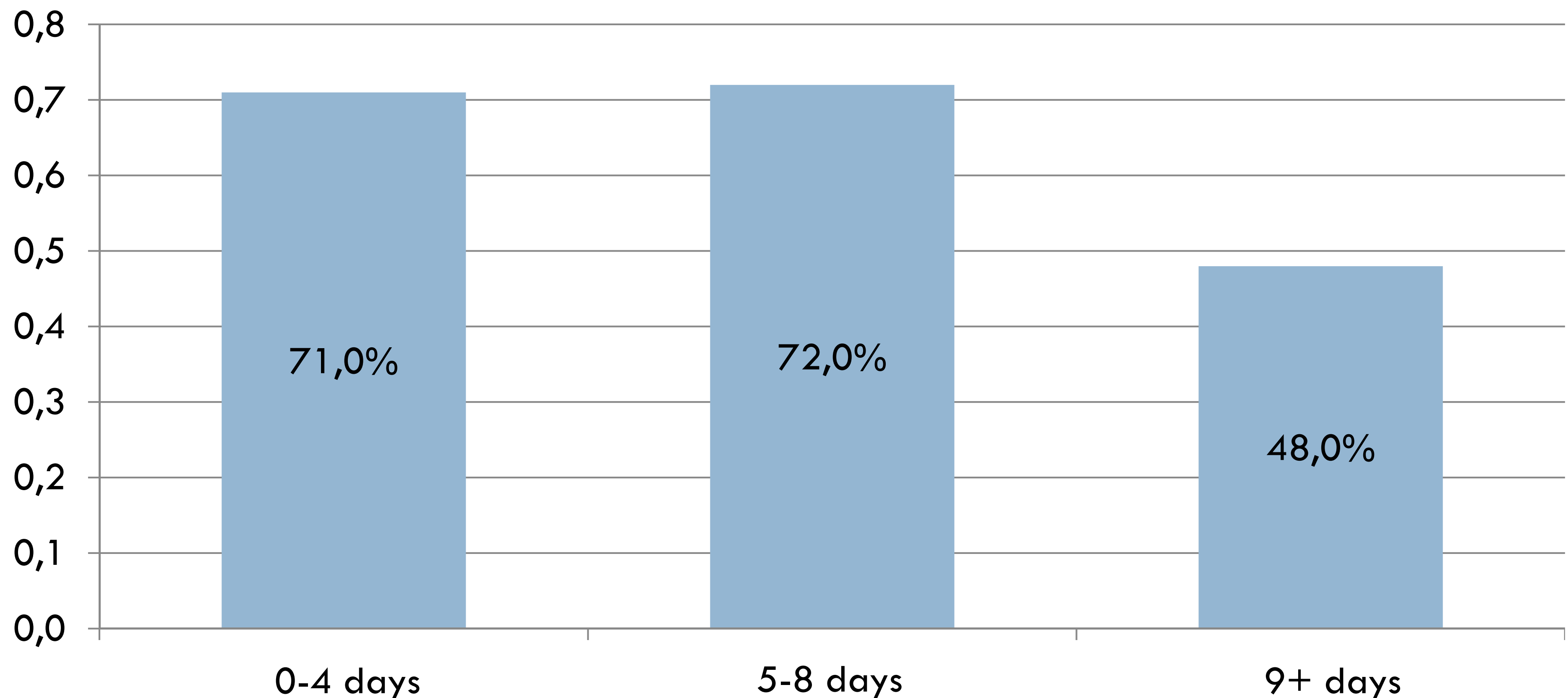
Pre-evaluation waiting time: 116 cocaine users radomized between 4 delays

(Festinger et al., 2002)



Festinger, D. S., Lamb, R. J., Marlowe, D. B., & Kirby, K. C. (2002). From telephone to office: Intake attendance as a function of appointment delay. *Addictive Behaviors, 27*(1), 131-137. doi: 10.1016/S0306-4603(01)00172-1

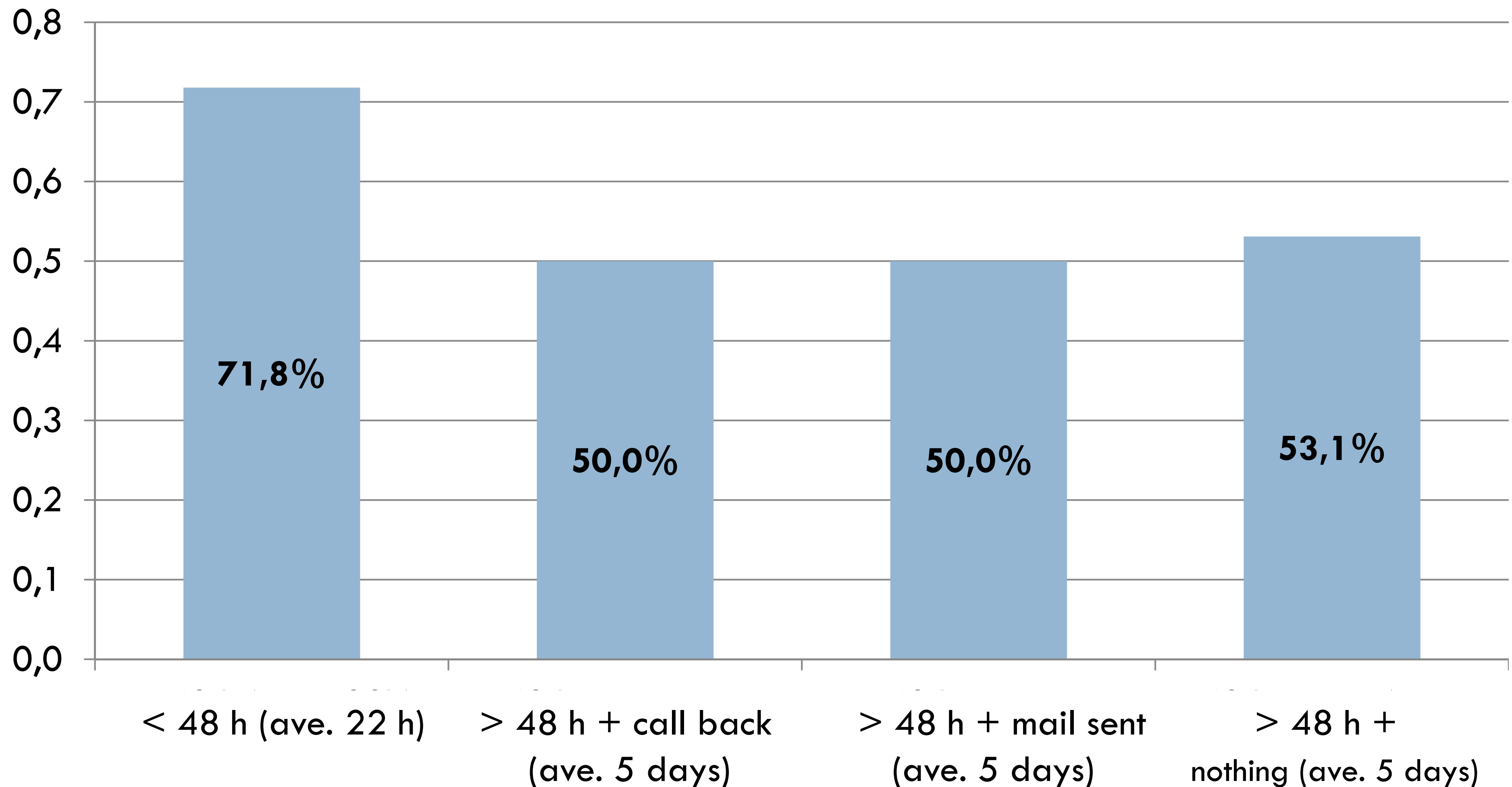
Pre-evaluation waiting time: n=267 alcoholic adults - naturalistic distribution (Wanberg & Jones, 1973)



Wanberg, K. W., & Jones, E. (1973). Initial contact and admission of persons requesting treatment for alcohol problems. *Br J Addict Alcohol Other Drugs, 68*(4), 281-285

Pre-evaluation waiting time: 128 alcoholic adults – randomized distribution within 4 groups

(Stasiewicz & Stalker, 1999)



Pre-evaluation waiting time

- Earliest is best
- 48 hours or less if possible
- No results regarding youths with addiction

Orientation following specialized evaluation

- <u>Orientation toward inpatient or outpatient services?</u>

Orientation following specialized evaluation

	Qc/CN (n=285)	MCQ (n=405)	Estrie (n=237)	Mtl f (n=321)	Mtl a (n=159)	A-T (n=103)	Total (n=1510)
CRD external	70,9% (n=202)	96,0% (n=389)	76,8% (n=182)	54,5% (n=175)	69,8% (n=111)	94,2% (n=97)	76,6% (n=1156)
Inpatient services[b]	35,8% (n=102)	20,0% (n=81)	5,5% (n=13)	28,7% (n=92)	10,1% (n=16)	-	20,1% (n=304)
CRD internal	-	-	4,6% (n=11)	1,6% (n=5)	-	-	1,1% (n=16)
Grand-Chemin interal	27,0% (n=77)	19,5% (n=79)	-	12,5% (n=40)	-	-	13,0% (n=196)
Portage internal	8,8 % (n=25)	0,3% (n=1)	0,5% (n=1)	1,2% (n=4)	10,1% (n=16)	-	3,1% (n=47)
Pavillon du Nouveau Point de Vue internal	-	0,3% (n=1)	0,4% (n=1)	13,4% (n=43)	-	-	3,0% (n=45)
Other external services[c]	2,8% (n=8)	3,5% (n=14)	-	5,3% (n=17)	-	-	2,6% (n=39)

[a] A youth can have more than one orientation retained, the percentage can therefore surpass 100% and it can be less than 100% because not all youths received an orientation toward specialized services.
[b] The line “inpatient services” is the total of all orientations to internal services, regardless of the type. Following this is the detailed orientation, by resource.
[c] Grand-Chemin external, Portage external, Pavillon du Nouveau Point-de-Vue external
Note: All percentages are calculated taking into account the total number of requests for each column.

Orientation following specialized evaluation

- Inpatient VS Outpatient
  - Improve access to internal / intensive services
    - Intermediate intensive outpatient service?
  - Remote areas?
  - Standardize orientation criteria?

Orientation following specialized evaluation

- Difficulties with inpatient orientation
  - **94%** of youths oriented to outpatient services begin treatment
  - **Half** of youths oriented to inpatient services, **refuse** it
  - **35%** of youths oriented to inpatient services actually begin them
  - Pick-up Theory

Orientation following specialized evaluation

- Motivational Interviewing
- Accompany youth to inpatient resource
- Visits from inpatient clinicians

Support activities during waiting period

- ++ important
- Who is responsible?
- Not pertinent if the same clinician conducts the evaluation and treatment
- No uniform model
  - Group
  - Support by CRD clinician to school/CJ clinicians
  - Support must be active
  - Hierarchy for support needs while on the waiting list
    - I.e. on-call staff for emergency cases

Continuity of services

- Clinical and administrative regional comittees: include many institutions
- Positive MAJT impact on inter-institutional communication
- ++ Important communication from CRD / résidential services to referrents regarding treatment
  - Schools VS Intake team: ++ insatisfaction
  - 1st line services: they refer and continue follow-up post-specialized treatment

For Montréal

- Need for an action plan aiming to:
  - Reach more youths having difficulties with PAS and who could benefit from specialized services;
  - Keep them in specialized services.
- Challenges
  - Large number of partner organizations
  - Large territory that is densely populated

Conclusion: key ideas

- Quick access
- Simplicity of procedures
- Geographic proximity of services offered, for example by the physical presence of staff in the living space of youths
- Personalized contact between staff of the CRD and referrers