Appendix D: Case Studies

Case study 1.

YM is 16 and is a looked after child (LAC). YM was referred into service following a routine appointment with a LAC nurse.

After gaining consent from YM, the DUST was completed (the referrer had recently listened to a service presentation delivered by Addaction staff at their team meeting, so she had a good understanding of the support Addaction offers and how to complete a DUST form).

The referrer stated that YM had experienced turbulent relationships with his birth family which was impacting their substance use. The referrer reported that the highest risk to the young person was their use of alcohol which was causing YM to have “no control”. The referrer noted however, that although YM had already made some changes to alcohol use, there was no reason for them to abstain at this point.

Key issues identified from assessment.

Outline the key areas which needed to be addressed (what was found in assessment)

Substance misuse: From the initial assessment it was identified that YM had a history of cannabis and alcohol use. At assessment YM reported that they had used alcohol, cannabis and tobacco since the age of 11. YM disclosed that they had also historically dealt substances, YM has however never been involved with the police, no cautions or convictions for this. At the time of assessment, YM reported that they had not used cannabis in the last 25 days, however, continued to use alcohol. YM stated that substances allow them to forget the past and stop thinking/reliving this for a little while. While YM had managed 25 days without cannabis and noticed that tobacco and alcohol use increased in this time. With support from the Addaction worker, YM set a goal of maintaining abstinence from cannabis and reduce alcohol to only on special occasions. Explored these special occasions with YM and stated that they wanted to be able to use alcohol socially rather than alone and in excess. At assessment YM did not want to make changes to their tobacco use.

Mental Health: YM reported self-harming behaviour, cutting to the wrists with a razor blade, in the past few months (last self-harm July) and was in a consistently low mood. There were no suicidal thoughts at time of assessment. YM stated that they had accessed support through their GP around consistent low mood and self-harm. YM not meet CAMHs threshold for support and due to age, the GP did not prescribe medication. YM spoke frequently about their past experiences (particularly in relation to parental substance misuse and neglect) and how these impacts on everyday life.

Positive aspects that came from assessment: YM had good daily structure with a part time job and attended college three days a week. YM also had hobbies that were a good distraction and was in a good relationship with foster carer and other supportive relationships with adults. YM is very motivated to make changes and already not used cannabis for 25 days without any support and presented as willing to engage with services.

Key areas of support and plan.

What was put in place to help the service user? (care plan) (multi-agency meetings/involvement)

From the assessment the key areas of support identified for YM:

1) Substance education and harm reduction in full.
2) Relapse prevention work around cannabis.
3) Healthy and unhealthy coping mechanisms to be explored.
4) Alcohol reduction techniques.
5) Referral to Addaction's Mind and Body (MAB) programme (community) in relation to self-harm.
6) ACE questionnaire to be completed.
7) Referral for CBT sessions once substance use work has been completed
8) A need for multi professional working.

Outcomes.

What was achieved in terms of progress and benefits, what changed, how did support make a difference? If possible, if the service user could identify one significant factor which made the difference to them, what would this be? Please link outcomes to Key Performance Indicators where appropriate.

YM has now finished their treatment sessions with Addaction Kent and maintained no cannabis use throughout and continues to be cannabis free. A significant reduction was made to their alcohol use, at closure session YM reported to have used alcohol on three occasions over the past 28 days with an average of 15 units on each occasion. Our teen outcomes assessment shows an improvement from when YM first entered treatment compared to exit, YM went from 3 to 5. However, YP continues to use tobacco. YM met all of their goals which is positive. (Outcome of 1,2,3 and 4 in support plan.)

Onward referrals: A referral to MAB was made and assessment was completed. YM however declined their offer of group support; YM wanted one to one support ideally. YM does know where to access support around self-harming behaviours in the future if needed.
While the assessment was being completed by MAB, sexual abuse was disclosed, this was the first time YM disclosed this information. MAB shared this information with Addaction after gaining YM's consent to do so. MAB also contacted social services to share this information, YM at that time, had no allocated social worker (allocated worker had left and had not been replaced) so social services team manager was made aware so it could be passed onto new worker when allocated, at the time of closure YM was still without an allocated social worker. One week after closure YM was allocated a new social worker which was positive. Addaction also referred YM to the East Kent Rape Crisis Team for them to access specialised support around this disclosure (with consent). YM completed the assessment with this service, was on a short waiting list but has now started session which is positive. (Outcome of 5 in support plan.)

The ACE questionnaire was completed during treatment sessions. YM did not wish to answer all questions on the questionnaire. However, YM disclosed recently to his CBT worker that completing the questionnaire made them think about some events that they had experienced and never disclosed. YM went on to disclose sexual abuse at the MAB assessment. (Outcome of 6 in support plan.)

A referral for CBT sessions was made and YM has been attending which is positive. This CBT support is being undertaken by an Addaction staff member completing the CYP IAPT CBT course. Due to CBT being time bound they are due to finish soon. However, the CBT worker will be making an onward referral to CAMHs for trauma work to be completed. It is noted by workers that YM really wants to make changes, but trauma can cause barriers. (Outcome of 7 in support plan.)

Through multi professional workings within Addaction we have manged to offer support to this young person in three different areas which he requires support for. Disclosures have been dealt with following correct safeguarding procedures. We have worked with other services, made referrals and shared information to ensure YM receives specialised support. YM did not consent to Addaction contacting thier foster carer this was however encouraged throughout treatment, Addaction shared relevant directly to social services rather than foster carer because of the lack of consent. (Outcome of 8.)

The future.

Any future support planned, how did the support given affect the service user's life looking forward?

From the support put in place YM will hopefully continue to not use illegal substances to cope with daily life or manage their feelings using the healthy coping strategies explored throughout treatment.
I hope YM will access further support from substance misuse services if required in the future because of the good experience with Addaction.
YM will receive specialist support from other services to address trauma which will impact on their quality of life in the future.

I will undertake an aftercare review with YM six weeks after his final appointment to ensure that the relevant support remains in place.

Case study 2

FG (20 years)

FG is an international student studying International Law at the University of Kent. FG struggles with attendance and has already had to retake a year due to issues with substances and not meeting the required standards to complete the year. FG was referred

to Addaction service by the wellbeing advisor at the University. After an initial meeting with the wellbeing team to discuss FG education provision and counselling options, FG advised that they felt benefit from support relating to escalating substance use would be useful.

FG acknowledges that their substance use has been impacting upon studies at university and financially it is affecting their ability to live and fulfil their studies.

KEY ISSUES

Outline the key areas which needed to be addressed (what was found in assessment)

A Young Person Worker from Young Addaction has been supporting FG since November 2018. From the initial assessment it was identified that FG had had a history of using substances. FG advised he had been alcohol and heroin dependent in the past. The alcohol dependence continued when he came to study at UKC, and this was one of the reasons he had to re-take a year.

Mental Health - FG was diagnosed with depression and continues to take medication to manage this and has been prescribed this by the GP in the UK. Depression continues to be present and is one of the catalysts to FG's continued substance use.

Substance use - At the initial assessment FG was using cannabis daily (1g), drinking alcohol 2 – 4 times per week (10 – 15 units per session), using MDMA 1 – 2 days per week (3 – 6 pills), and tobacco. FG's use at the beginning of treatment fluctuated and FG managed a period of 10 days without any substances. This correlated with a spike in motivation to change and increase in undertaking additional activities to include going to the gym and playing futsal most days. FG advised that they felt great and that their health and mood elevated.

In December 2018 FG travelled to see their family over the Christmas period. Since returning to the UK, their substance use has escalated. FG reported that whilst home they injected heroin daily and consumed alcohol most days. FG reports sharing equipment with friends whilst injecting. Since returning to the UK no heroin has been used. However, they are drinking alcohol and smoking cannabis daily and using MDMA 3 – 4 times per week. FG has used ketamine once in this period. FG advised that they would use heroin but the reason they have not is because they do not know how or where to get this directly.

The key areas of support identified for FG by an Addaction worker was to: provide harm reduction advice around the substances being used, a focus on alternative coping strategies, refer to his GP for BBV screening, liaison and joint meetings with the referrer and wellbeing team at the University, referral to Think Action (mental health support), liaison with Forward Trust adult provider, and taking FG to a GP appointment to discuss a review of their prescribed medication for mental health.

SUPPORT PLAN

What was put in place to help the service user? (care plan) (multi-agency meetings/involvement)

1. FG has had a BBV screening and is currently awaiting the outcome of this test.
2. FG has been to see their GP with the Addaction worker and had a medication reviewed their mental health. They have been given a new prescription and the dosage continues to be the same.
3. FG has had an initial appointment with Think Action, and they are discussing his treatment options.
4. FG has attended a drop in session with Forward Trust and they have discussed their treatment options. The Addaction worker has referred FG to them as they felt that they would benefit from a 4-week alcohol programme. FG is keen to engage with this support.
5. The Addaction worker has met with the wellbeing team at the University in which FG attended the meeting and all parties discussed the support options.
6. Addaction worker is researching AA/NA meetings to direct FG to an additional layer of support.

OUTCOMES

What was achieved in terms of progress and benefits, what changed, how did support make a difference? If possible, if the service user could identify one significant factor which made the difference to them, what would this be? Please link outcomes to Key Performance Indicators where appropriate.

There has been one period of success in terms of FG's use. As mentioned, FG managed a 10 day period of non-use which resulted in an improved mood and motivation to be more active. This was near to the start of his engagement with Addaction.

FG is consistent in terms of his attendance to sessions and communicates regularly with the worker.

FG motivation to reduce their use is sporadic and one of the reasons for limited sustained change.

THE FUTURE

Any future support planned, how did the support given affect the service user's life looking forward?

The Addaction worker is investigating the options to attend an NA/AA meeting with FG to highlight the support options. FG is open to trying any source of support and feels this might be helpful.