03 Dovetail
supporting the youth alcohol and drug sector in Queensland

practice strategies and interventions

youth alcohol and drug good practice guide



Dovetail provides clinical advice and professional support to workers, services and communities across Queensland who engage with young people affected by alcohol and other drug use. Dovetail is delivered by Queensland Health's Metro North Mental Health – Alcohol and Drug Service.

This guide was developed in partnership with the School of Public Health and Social Work at the Queensland University of Technology. Through a participatory methodology, frontline workers and managers from across Queensland nominated, explored and shared insights about their direct knowledge, tools, resources and practice wisdoms to inform the pages of these guides. Aimed at practitioners across clinical and community-based contexts, we trust these guides will further contribute to the growing knowledge and skill-base on how to most effectively work with young people experiencing problematic alcohol and other drug use.

practice strategies and interventions

Written by Phil Crane, Cameron Francis and Jeff Buckley.
Edited by Benjamin Dougherty and Cameron Francis.
Designed by Tony Giacca and Benjamin Dougherty.

About the authors

Phil Crane (PhD) is Senior Lecturer in Youth Services at the School of Public Health and Social Work, Faculty of Health, Queensland University of Technology (QUT).

Cameron Francis is the Social Worker at Dovetail.

Jeff Buckley is the Manager at Dovetail.

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Introduction

Welcome to Dovetail's 3rd Good Practice Guide, *Practice strategies and interventions*. This guide canvasses the main practice approaches utilised by workers who engage with young people experiencing problematic AOD use whilst also exploring the many and varied challenges associated with this type of work.

Practitioners in this field draw upon a wide range of approaches, strategies, tools and interventions. The type they choose depends on a myriad of factors, including the situation of the young person, whether they operate within clinical or non-clinical context, and if their service delivery model is centre-based, home-based, community or outreach oriented. These are some of the factors that can impact upon the types of approaches chosen and the relative effectiveness of one strategy over another in any particular context.

Understandably then, this is a vast terrain, so the contents of this guide should be considered a selective summary rather than a comprehensive stand alone outline. To gain a better understanding of the broader practice framework and legal and ethical underpinnings of this work, we encourage you to read the first two 'good practice guides' in this series:

1. *A framework for youth alcohol and drug practice*
2. *Legal and ethical dimensions of practice*

Working with young people who experience problematic alcohol and drug use can be both a very challenging and rewarding pursuit. We hope that the information in this guide can assist practitioners to better understand the various approaches, tools and interventions available, and encourage them to continually enhance their practice and the outcomes of the young people they work with.

Focus and contents of this guide

The focus is on young people where AOD use is compromising their wellbeing or capacity to develop. As with all of the guides in this series, the goal is to provide practitioners and managers with questions and principles which broadly promote good practice when working with young people.

Section 1

Working with young people

A significant body of theory and practice has been generated about working with young people where their needs and situation are the central focus – this can broadly be considered as 'youth work'.

Youth work has been defined by Bessant, Sercombe and Watts (1998) as "a professional relationship in which:

- *the young person(s) are the primary constituency, the mandate given by them has priority*
- *the young person(s) are understood as social beings whose lives are shaped in negotiation with their social context*
- *the young person is dealt with holistically."*

Source: Bessant, Sercombe and Watts 1998, 104

From this perspective youth work is an orientation to practice rather than a specific employment category or role (even though some workers may have a role called 'Youth Worker').

A wide variety of practitioners may find they need to consider what to do in respect of problematic AOD use by a young person. School-based support staff, youth accommodation workers, community workers, youth justice workers, child protection workers, teachers and police are just some who may regularly need to consider problematic AOD use by young people as needing a response of some kind. For some practitioners, such as those working in specialist youth AOD services, problematic AOD use is the central focus of their work.

Working with people who are highly vulnerable and with limited supports is often experienced as a complex and dynamic process where the practitioner needs to balance a range of considerations. In Queensland, people who work with highly disconnected young people have found that in order to assist a young person to re-engage they need to simultaneously and actively work with young people on their hopes and aspirations (the way they see the world and their place in it), their life context (including the support and constraints arising from families, peers, community, past experiences, problematic AOD use), and the institutional opportunities they have and barriers they face, (locally and systemically). (Crane and Kaighin 2011)

The process of working with highly vulnerable young people is not straightforward. It is often unpredictable, interspersed by various crises, emotionally up and down (for everyone, including workers), in an environment of resource scarcity. Practitioners need to both see the young person as a client in their own right but also consider their particular developmental needs. This requires practitioners to be critically aware, proactive and sometimes assertive. In the absence of sufficient family or community support, many practitioners are required to fulfill a protective role in the lives of their clients. The ethical challenges involved in working in this space and maintaining professional standards are substantial.

Trying to fully capture this craft in a guide is futile. Following are some thoughts from a mix of sources, including practitioners from Queensland, on what principles are key to working with young people in complex situations. This contributes to what can be termed a 'youth friendly' approach.

Table 1: Key principles for good practice with young people

GOOD PRACTICE WITH YOUNG PEOPLE IS …	EXAMPLE
Voluntary	In voluntary contexts, respect the young person as being the client. In involuntary contexts, limit the constraints placed on the young person to the minimum necessary for legal and ethical practice. Many AOD interventions are designed to be used in voluntary populations. However, a young person may have a legal or a social mandate to engage with a service. Social mandates (e.g. parents insisting that a young person access treatment) can be difficult to identify. The young person should be given as much control over the situation as possible, for example, deciding on the length or frequency of sessions and the range of topics covered.
Person-centred	Start where the young person is at practically, developmentally and culturally. Every young person has their own story. Even though they may be part of a group with broad characteristics we should not make assumptions about their individual circumstances and the nature of their difficulties.
Engaging, responsive and flexible	Good youth AOD workers should be able to flexibly engage and respond to the young person's specific situation in a way that the young person finds useful. Many agencies employ a range of engagement strategies including outreach, activity-based approaches and drop-in, rather than purely appointment based work. Responses can include a mix of experiential and verbal, structured and unstructured, and individual and group strategies. When a young person's circumstances change, practitioners require flexibility, drawing on a 'toolbox' of possible responses, for example, switching from counselling to the provision of material support.
Relational	Young people want clear practical support from someone they can trust and feel respected by. Trust is a critical element underpinning effective, ethical and culturally secure practice. Many vulnerable young people have experienced multiple workers in their lives. Providing consistency can enhance the development of a trusting relationship. When specialist expertise is needed, referral 'in' rather than referral 'out' should be considered where possible. Referral 'out' should be assertively supported.
Developmentally responsive	Young people differ across a range of developmental pathways. Young people's sense of, and evaluation of, risk develops over time, as does the bank of experience they have to assist them in making decisions. This has significant implications for how practitioners work with young people.

GOOD PRACTICE WITH YOUNG PEOPLE IS …	EXAMPLE
Goal oriented	Clearly articulated goal oriented practice provides purpose and direction for both worker and young person. Young people can present with a myriad of goals, some contradictory. An important task for the worker is understanding these and forging an agreed pathway with the young person. Furthermore, interventions need to produce outcomes rapidly – every young person needs to walk away with something of value.
Exploratory	Rather than make assumptions, workers should take a curious, inquisitive approach. This can take time and is facilitated by good engagement, developing trust and a supportive professional relationship.
Multi-faceted	Young people engaged in problematic substance use often experience problems in other areas of their lives such as schooling, employment, socially etc. Likewise, problems in other areas of life can sometimes make young people more vulnerable to problematic substance use, meaning that workers often need to focus on more than just AOD use itself.
Multi-role	Practitioners can undertake a variety of roles depending on the context of the young person and the mandate of the practitioner (guide, advocate, case manager). In one day a worker may advocate with welfare providers, discuss housing options, mediate relationship issues and talk about future goals – all with the one young person.
Critical	Practice with young people needs to be undertaken with a critical awareness of the social, political and systemic contexts in which it takes place.
Ethically mindful	Practitioners need to recognise a complex array of considerations which are ethical in nature. What are the limits to informed consent? How are risks managed? What are appropriate practice methods to employ in a particular context?
Well articulated between service elements and agencies	When a young person is being supported by multiple workers and/or agencies, or is transitioning between services, there needs to be a clear articulation of the various roles and responsibilities of all players.

1.1 The importance of the worker - young person relationship

Central to most youth work practice approaches is the importance of the relationship between workers and young people. In health service delivery contexts this is often referred to as the 'therapeutic alliance' and in youth services, more generally as a 'purposeful relationship'.

Therapeutic alliance is an umbrella term for a variety of therapist–client interactional and relational factors operating in the delivery of treatment. It has in the past been seen as a pivotal factor in therapeutic change; usually in the context of psychotherapy

Source: Green 2006, 426

There are two major components of this alliance, the personal component and the task oriented component as stated in the following comment by Green (2009).

The personal relationship is contributed to by therapist qualities such as likeableness, trustworthiness and commitment, but also by patient characteristics. The task alliance reflects the way that the focus, method and goals of treatment are explicit and mutually agreed. Do the patient's goals for the treatment mesh with therapist's assumptions?

Source: (Green 2009, 299)

This emphasis on the primacy of the relationship has been identified as critical within a range of therapeutic interventions. For example, an analysis of research on case management approaches in respect of homelessness by Gronda (2009) found that:

... a relationship which includes elements of emotional bonding and task consensus has a beneficial impact on the person being assisted. However, the beneficial effect will be constrained by the person's capacity for relationship and level of insight... The evidence confirms that time is required for the relationship to become effective, and that case management outcomes can only be assessed once this relationship has been established.

Source: (Gronda 2009, 52)

The following model adapted from Green (2006) and Hougaard (1994) indicates key characteristics of the working relationship between workers and young people.

Attending to both task and relational orientations is important if practice is to be both purposeful and effective. In simple terms the task orientation includes having goals and enabling strategies, including a responsiveness to practical and often quite immediate needs the young person may have. The relational orientation involves establishing effective communication, building trust, and mutually understood boundaries.

The practitioner and young person both influence how well their practice alliance will work.

As depicted in the upper left quadrant of the model below, the practitioner contributes to the purposefulness (task orientation) of the work by clarifying roles, working to increase motivation, and having authenticity in the context (being seen as being a relevant and appropriate person to engage with). The young person also contributes to the purposefulness with their knowledge and skills, resources and capabilities, and previous positive experiences they have had.

The relational orientation is influenced by the warmth and empathy of the practitioner and the young person's level of confidence in the service and the worker, their receptiveness to empathy, and their own sociability.

These various features and qualities interact in a specific practice context to provide both a climate and the basis for workers and young people to effectively engage and work together.

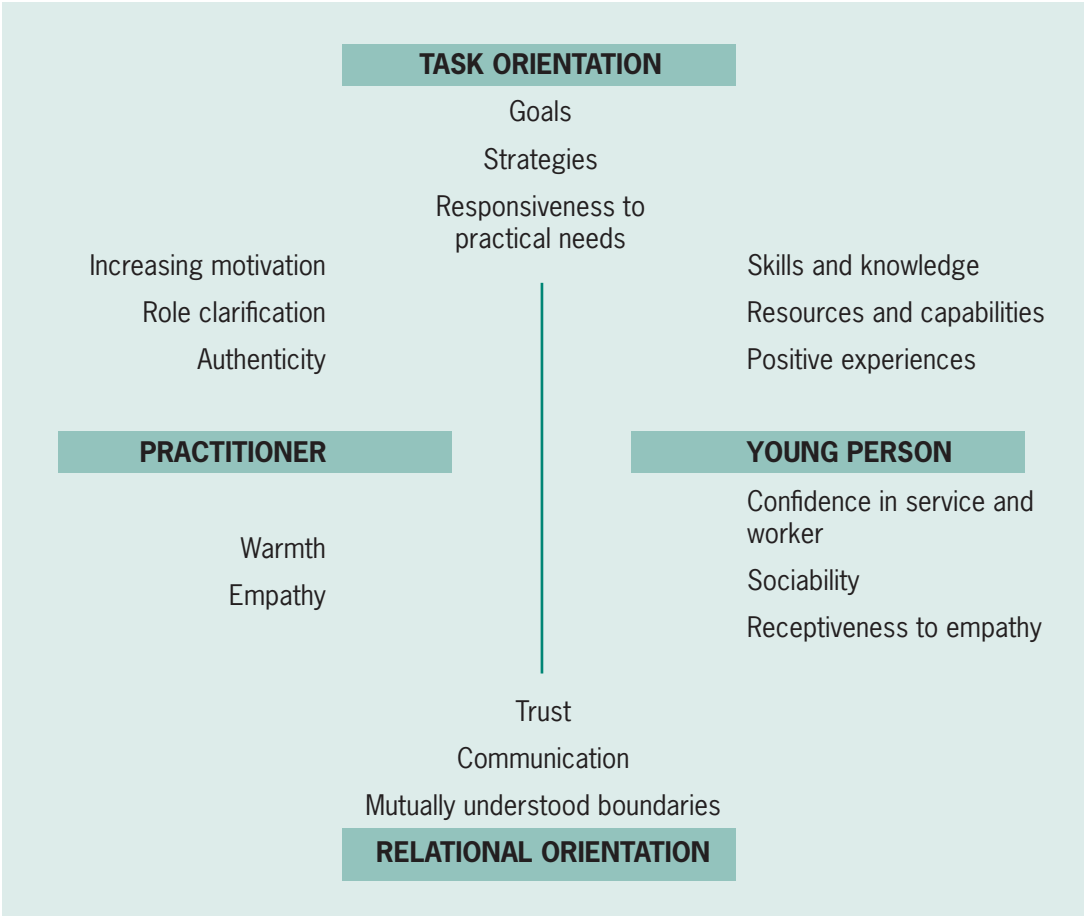


Figure 1. The therapeutic alliance with young people

Section 2

Engagement

Engagement is best understood as the process of building a relationship for the purpose of achieving a goal or outcome. Many approaches to practice processes present engagement as an initial challenge necessary before intervention proper can commence. Yet engagement is more usefully thought of as part of the intervention process. Similarly, engagement is more than simply attendance. It suggests a young person's interest has been sparked, initial trust has been established and a commitment to working on agreed goals has emerged.

Engagement has instrumental (practical) and affective (emotional and relational) aspects. Engagement needs to be established in both practical and relational senses, then sustained and re-visited as young people work with different practitioners, parts of a service or agencies.

More broadly, the term 'engagement' has also been used to refer to a young person's level of participation in decision making and to their level of connection with key social institutions of family, school, the labour market and community.

2.1 Characteristics of effective engagement

Good engagement can be challenging, particularly if young people are disinterested in support, sceptical of services, focused elsewhere or disconnected.

"My time was made memorable at [the service] as I was made to feel that my counsellor was not only my psychologist but someone who would be there to listen and give advice. I never feared that anything I disclosed would be made public or that I would be judged, which I believe is the hardest thing for a young person to get over because in this day and age you are made to feel that everyone is casting judgement on you."

Young person

A number of characteristics of effective engagement with young people who have problematic AOD use can be drawn from practice research and practice wisdom. These involve the service and practitioner:

- being proactive
- being respectful, 'trust building' and relational
- having a good reputation, especially for confidentiality
- providing practical support
- providing a 'safe space'
- being flexible, using a mix of approaches.

2.1.1 Proactive

Many young people do not understand the conventions of 'help seeking', or that particular services exist to help them. As a result many 'youth friendly' services adopt assertive approaches to identifying and engaging the young people they target. Common examples include assertive outreach (sometimes known as 'case finding'), co-location with existing points of contact, or providing free activities which appeal to the target group. These provide opportunities for relationships to be built between workers and young people, often in informal, non-threatening settings.

Most services have access and equity policies; however, challenges can arise in the implementation of these policies, particularly with highly marginalised groups. A proactive approach to access requires a service to critically and reflectively ask itself: "Who are we NOT seeing at our service and why?"

2.1.2 Respectful, trust building and relational

The formation of positive and trusting relationships is a key feature of engagement with young people. It is essential to treat young people with respect and engage them in a process that allows their participation in determining goals and plans.

Young people may be distrusting of helping services and bureaucracies, and often "speak of stigmatizing and discriminatory experiences when interacting with health professionals. This can increase difficulties associated with engaging clients and developing relationships" (Osher and Kofoed, 1989, cited in Dyads report #2: Literature review for model development, 2004, 10).

A key engagement strategy in conveying that you care about a young person is to spend time with them – negotiate regular planned contacts and be reliable in keeping these times. Even where a young person is inaccessible at these times (for example, because their whereabouts just now are unknown or they have had a change of commitments) convey your commitment to the relationship – state that you were available and/or be flexible in accommodating changes in time and place (Queensland Department of Child Safety, 2008).

"It's important to remember that many young people have only known abuse, exploitation, control, and that building relationships is very difficult but essential."

Front line youth AOD worker

2.1.3 Having a good reputation, especially for confidentiality

The reputation of a service amongst young people has a significant impact on its capacity to engage. Just like in other areas of life, we often seek, and highly value, the opinions of our peers when determining what services we might try ourselves. This is particularly the case in rural and regional areas, where service options are limited and word spreads fast. Having a positive relationship with one young person can lead to additional contacts with their peer group.

Confidentiality can be a major concern for some young people. Many do not understand the extent and limits of confidentially and may make incorrect assumptions about how their personal information is handled. It is important that confidentiality is discussed early on in the engagement process. *Guide 2: Legal and ethical dimensions of practice* discusses confidentiality in more detail.

2.1.4 Providing practical support

Providing practical support can be an effective strategy in engaging young people, for it enables them to see a tangible outcome quickly. It is important however, to be cautionary about young people becoming service dependent. Young people should always be supported to find their own solutions and options wherever possible.

2.1.5 Flexible, using a mix of approaches

Effective engagement requires a responsive, adaptable and flexible approach which is mindful of the circumstances surrounding a young person's substance use. Flexibility may need to be in respect of **place** (going to where young people are at through outreach), **time** (hours of the day or night), **type of strategy** (through activities and mediums that young people want to participate in and engage through), **form of communication** (verbal, experiential, expressive, social media), or **social context** (individual, peer, family and community).

Services often have a number of strategies so that young people can engage through various pathways. For example, some youth AOD services see involvement in Youth Justice Conferences as an engagement strategy. For others, a drop-in space may act as a 'soft entry point' (Crane and Brannock 1996) for young people who have not yet engaged with a service.

2.1.6 Providing a 'safe space'

Some young people experiencing problematic AOD use have encountered violence and abuse in their family of origin, or continue to experience violence, abuse and exploitation, particularly if they are homeless. A goal of many services is to provide a 'safe space'. This sense of safety includes physical safety but also a space to explore emotions and problematic behaviours.

A number of services also recognise the need for young people to have a safe space to rest and recover from the effects of intoxication. However, providing a safe space for all young people can present challenges when some behaviour puts other people at risk.

2.2 Youth friendly spaces

Numerous studies have found that many young people do not access services which target them. What do young people themselves value in services to them?

… young people also stated that they felt most comfortable in an environment that was relaxed and welcoming, where they could witness other young people in attendance and where they could access appropriate information about a range of issues that they found of interest.

(Szirom, King and Desmond 2004, 4-5)

A service environment does not have to be youth specific to be youth friendly, but it does need to be carefully tuned to be experienced as friendly by young people. Some services explicitly aim to be both youth and family friendly.

Katina Dimoulias (2009) examined what makes youth centres work (be youth friendly) in terms of their spatial characteristics.

There is substantial research and evidence that shows that the physical or built environment has a significant impact on the development of children and young people, their experiences of places and their well-being. The physical component of youth centres plays an important and vital role not only in relation to young people, but also for staff, behaviour, and service delivery. A well designed youth centre can facilitate and support service delivery, assist with managing behaviour and contribute to positive youth experiences.
(Dimoulias 2009, 16)

When designing 'youth friendly' spaces there can be a tendency to overgeneralise characteristics of young people. Appreciating diversity across and between young people is important and may mean different approaches are required to ensure spaces are tailored to the specific needs of the client group.

"A local youth homelessness service I worked with re-designed their drop-in space. A lot of the young people who accessed the service identified with hip hop and graffiti culture so we spray painted the walls with hip hop motifs. However over time we realised that this design did not represent all of the young people who we were coming into contact with. For example, some young people who listened to heavy metal music thought the design was uninviting."

Frontline Youth AOD Worker

The way a space is designed and set up can have enormous impacts on how it is experienced and what is possible.

Table 2: Spatial considerations when designing or modifying youth centres (drawing on Dimoulias 2009 and Crane 2010)

Involve young people and staff	In the design, setting up and management of the space, consider strategies like having a workshop where young people and staff create layouts and colour schemes together. This can increase engagement and also how well the space meets needs.
Develop robust spaces and rooms	Spaces can be adapted to be used for a variety of purposes. 'Designing-in' smaller 'hang out' spaces so different groups of young people can be there simultaneously is important, as is having a range of spaces that allow for quiet and noisy uses, separate spaces for private interactions, quiet activities, computers for young people, and areas for staff. Large open spaces can be divided using low partitions, hanging cloth or furniture arrangements to create rooms.
A range of facilities and equipment	Consider a range of active and passive options. Examples include kitchen facilities, art supplies, computing and AV options with music/recording/band/dance/performance capacity.
Consider permeability	Spaces which allow easy movement between them are generally experienced as more flexible and 'friendly'. Indoor to outdoor permeability can be important in fostering a sense of flexible options. Low permeability can assist in making a space more amenable to supervision.
Use furniture to promote sociability	Consider a range of formal and informal seating options, lighting and furniture type and placement according to usage patterns, cultural preferences and weather.
Promote personalisation	Artwork, murals, photos, galleries etc. developed by young people can help create a space that is appealing, welcoming, and culturally responsive.
Consider aesthetics and colour	Create an environment that is homely, bright and colourful, inviting and welcoming to young people.
Utilise outdoor areas	Outdoor areas are often underutilised. Create conversation areas, a garden, a basketball area, consider active and passive options.
Create tailored spaces	Your space should be tailored to reflect the service delivery model, the objectives of the service and the interests and needs of young people and staff.

Youth friendly service

Creating a youth friendly service involves more than providing a youth friendly facility. Dovetail have developed a checklist which covers a wide range of factors that may influence how youth friendly your service is. Find the checklist in Drilling Down 2 on page 108 of this guide.

2.3 What young people say about engagement

Here is what some young people consulted for this guide had to say about what they liked and didn't like about services and workers.

Stuff that's cool

- "After hours support with people who know you and can follow up, instead of having to tell your story to someone who doesn't know you or doesn't care."
- "Being able to trust that it's confidential."
- "Not having to wait. With appointments, there's less loitering and fighting, especially when balanced with a chill out space."
- "Being told straight up about our rights and given information about confidentiality. This helps us know that it's safe to speak up."
- "Love the 'vibe'. This service is in a house, there is graffiti outside, artwork and funny stuff."
- "Being in a happy environment makes you want to work more and come back."
- "The workers being young at heart. They can be 'not serious' as well as being professional and knowledgeable."
- "They take me seriously and offer tea and coffee."

Stuff that's uncool

- "Betraying trust."
- "It's good to use humour, but not too much."
- "Workers not being themselves, they don't need to act like us."
- "Bad advice."
- "Breaking a promise, not following through gives a false sense of security."
- "Don't talk down to us, we want you to respect our opinion."
- "If you are going to challenge us, do it respectfully."
- "Don't ask too many questions or be too pushy. Give me space to talk when ready and don't expect the whole life story straight up."

From young people at a Hot House workshop, November 2011.

2.4 Challenges of engaging young people with problematic AOD use

The reasons young people use AOD are complex and varied. An effective response has to be holistic and as complex and varied as the needs it addresses (Milne et al. 2007). Engaging with young people with problematic AOD use is compounded by multidimensional and intersecting issues, which can include one or more of the following:

- It can be difficult to communicate or engage young people who are spending large amounts of time intoxicated. This is particularly problematic for young people who are substance dependent and lack the ability to control their use.
- Some young people who are experiencing problematic AOD use may not believe that their substance use is causing them any harm.
- Unstable living arrangements and chaotic daily routines can make contact with services sporadic or purely crisis driven.
- Many young people are fearful of legal ramifications related to their drug use or related criminal activity.
- Some young people referred to AOD services are involuntary and may have been legally or socially mandated to attend.
- Cultural differences between workers and young people can present unique challenges.
- Co-occurring mental health issues present particular challenges for effective engagement in youth AOD services. The symptoms of some mental health issues can impact upon an individual's help seeking ability. Furthermore, health services have in the past dealt with co-occurring mental health and substance use issues separately. This has resulted in young people 'falling through the gaps' between the two service systems. Further information on this topic is provided later on in this guide.

In order to sustain engagement, availability and consistency are vital. Consistency in approach is critical, but also consistency in workers. Young people who have had long involvement with services systems often experience a turnover in workers, creating a need to engage and re-engage as each new worker takes on their case. Young people can become frustrated with the need to tell and retell their story.

2.5 Access and first contact

Engagement is dependent upon having access to the service and to you as a worker. A person's ease or difficulty in accessing the service or worker can significantly impact on the engagement process.

Some of the characteristics that can influence access include:

- geographic location, including accessibility by public transport and privacy considerations
- hours of operation
- entry criteria (for example, requiring photo ID)
- worker characteristics (for example, gender, ethnicity, professional background)
- access for people with special needs (for example, mobility or sensory impairment)
- cultural appropriateness
- the overall level of service appeal or 'look and feel'.

'Low threshold' services are those which can be accessed with the greatest ease, whereas 'high threshold' services are those which require some actions to be undertaken before access is provided. An example of a 'low threshold' service would be a drop-in centre, where no appointments are required, young people do not need to produce a Medicare card or any identification – they simply present and are able to access services. An example of a 'high threshold' service would be a specialist medical appointment – which first requires a referral from a GP, who in turn requires the young person to arrange an appointment, provide a Medicare Card etc.

The first contact with a young person can occur in a variety of ways, often reflecting characteristics of the client group and the accessibility of the service.

Young people may initiate contact with a service or practitioner through various mediums:

- a telephone call
- in person at the service
- a website, email or social media contact
- through detached or `street' contact.

Others may initiate contact:

- a young person's own network (e.g. parents, carers and significant others)
- referral from another agency or service
- referral from another section of the agency or service.

Referrals may be with or without the young person's consent and/or the result of the use of coercive power as in being legally mandated (e.g. through courts) or socially mandated (e.g. as a result of threats by parents or schools in respect of AOD use).

2.6 Engagement at intake

Most agencies utilise an 'intake' process for both case planning and reporting purposes. Usually, initial contact information is taken with a view to establishing the suitability of the young person to the service. In some cases a specific worker is employed for this task, whilst other agencies will rotate the intake role throughout the organisation. Some agencies which use a drop-in model may establish policies around how to conduct an 'intake' in the casual environment of the drop-in. It might be the case that the agency policy stipulates that formal intake processes must be undertaken within a specific time-frame (for example, on the third contact). These types of policies allow for casual contact, without young people being bombarded with questions and paperwork on their first contact with an agency.

However it may be structured, the role of the intake worker is a complex one. It requires a broad knowledge of the local service system in order to facilitate appropriate referrals. Also it requires that rapport is developed quickly between the worker and young person, as it is important to get to the nexus of the issue in order to direct the young person to the appropriate worker or agency. Agencies should not underestimate the specific knowledge and skill set required for this work.

The table on the following page contains a number of suggestions to assist engagement during initial stages of contact.

Table 3: Interviewing for engagement

Interviewing for engagement
• Introduce yourself to the young person first. • Ask the young person to introduce you to others who may be present. This gives the young person a clear message that you are interested in him/her. • Don't begin the interview by asking, "Why are you here?" • Chat with the young person about lighter, non-threatening topics. • Provide an outline of what's going to happen, including an idea of the range of questions. • Prepare them for the sensitive nature of some of the questions. • Let the young person know they can choose not to answer any questions. • Create an empathetic stance by acknowledging they may feel uncomfortable at times. • Build rapport so that the young person feels their concerns have been heard. • The young person should come away feeling that someone cares and that it might be useful to return. • Ask open-ended questions so that there is opportunity for rapport building and engagement. • Remember that the goal isn't just to elicit information about what might be 'wrong' with the young person. • Spend time during the interview asking for feedback. • Check that you understand the young person's main concerns and difficulties. • Clarify the young person's goal in coming to the assessment. • Before concluding, ask if they have any questions or anything more to add. • Parents, family members, or other adults should not be present during the interview unless the young person specifically gives permission, or requests it.
Wrapping up the interview
• Give the young person an opportunity to express any concerns you have not covered. • Ask the young person who they can trust and confide in and why they trust that person. • For young people who demonstrate significant risk factors, relate your concerns. • A youth focus will ensure their active participation in deciding on what to work on and how. • If the young person's life is going well, say so. Source: www.headspace.org.au/what-works/resources; Parker, A. G. et al. (2010)

2.7 Working with involuntary clients

Involuntary clients are those young people who may be "required or mandated to seek and make use of professional help" (Sheafor and Horejsi 2006, 222). For example, contact with a service may be legally mandated. It is critical the worker understands the nature of court ordered requirements and mandates and the impact this may have on the young person's willingness to engage. Some young people may experience feelings of anger and hostility toward the worker and the system, given the coercive nature of mandated intervention.

Young people can also be socially mandated to come to a service through pressure from others, often parents or other services. For example, a parent may insist that their child attend AOD counselling as punishment for being found using drugs. These types of social mandates may not always be obvious on initial presentation and may take some time to tease out.

Attention needs to be drawn to the potential consequences of the involuntary engagement. For instance, a worker may accept the referral source's interpretation of the nature of the problem (and by extension assume a path of action), which may be in conflict with the client's understanding of the problem.

The use of good practice process is essential in working with involuntary clients. A clear focus and direction is required, particularly during the engagement phase.

The following list includes a number of suggestions for working with legally mandated clients.

- Maintaining an appropriate use of power and authority. That is, defining your role, where authority begins and ends, what decisions you have to make and what areas the young person has control over.
- Ensuring that the basis of an authoritative position is considerate, consistent and fair. It is critical to avoid threatening behaviours and attitudes.
- Acknowledge and address any negative responses and conflict as they arise and minimise the potential for further trauma by remaining sensitive to the issues that may emerge for the young person.
- Clarify roles, functions, boundaries and expectations to the young person.
- Obtain relevant background information and only deal with facts.
- Prepare for the initial meeting by exploring potential problematic areas and possible solutions.
- Draw on the strengths of the young person within the context of the intervention to develop a common approach and goal.
- Discuss and outline potential regulatory-based consequences of non-cooperation.
- Provide the young person with choice within the context of legal constraints.
- Develop strategies to manage resistance and threatening behaviours.
- Be aware of the possibility of client manipulation and levels of self-disclosure.

Source: Schaefor and Horejsi (2006); Trotter (1999)

Engagement may take place when young people are already involved with some part of the justice system. Youth justice conferences, detention and court referral are some examples.

"For us, youth justice conferencing is an engagement tool for young people who are likely to be referred to us anyway, because their charges are drug or alcohol related. It allows them to meet us at the actual conference, rather than just being told to make an appointment and show up, and they don't know who we are or what we do."

Front line youth AOD worker

2.8 Information and communications technologies (ICT) for enhancing engagement

Digital communication technologies play an integral role in the social inclusion of young people in our society. For many people 'Google' represents a first port of call for information on multiple and varied topics. Most services have developed websites with information and resources relevant to their target group. These websites can be an important source of information and a useful tool for engagement, as it is clear that many young people will be assessing the suitability of a service based on the information provided on the service's website.

However, the issue of access remains critical. The term used to define unequal access is the 'digital divide', referring to the gap separating those individuals who have access to, and are able to use new forms of technology from those who do not (Gunkel cited in Wyn and Cuervo 2005).

The lack of access to a computer and the internet reproduces and widens the digital divide, but it also can generate further health, educational and employment disadvantages for some young people (Wyn and Cuervo 2005, 35).

Compounding this, is emerging evidence of what is being described as the 'digital disconnect' (Blanchard et al 2012). This describes the disconnect between the ICT use of young people, and the ability of workers and services to keep up. Many workers have a poor understanding of the possibilities for ICT and may be reluctant to engage with these emerging tools. The following comes from a research project which focused on workers from the Australian youth mental health sector. The researchers found:

1. *Poor awareness in the youth health workforce of evidence-based approaches to using technologies to improve young people's mental health and wellbeing. This limits their capacity to use these services and demonstrates that education to address this knowledge gap is much needed;*
2. *A lack of policies and procedures within individual organisations and the service system that support the safe and health-promoting use of technologies; and*
3. *The absence of appropriate technological infrastructure within individual organisations and the service system.*

Source: Blanchard et al 2012

The following table contains a list of websites which may be of use to young people accessing your service.

Table 4: Websites for young people

Kids Help Line: free, private and confidential, online counselling service specifically for young people aged between 5 and 25	www.kidshelp.com.au
headspace: eheadpsace provides online and telephone support to young people aged 12-25 years	www.eheadspace.org.au
Reachout: provides young people with the information, help, support, advice and connections they need to manage mental health difficulties	http://au.reachout.com
Inspire Foundation: an Internet-based foundation that works to inspire young people to help themselves, get involved and get online	www.inspire.org.au
Somazone: free, confidential advice and information for young people about drugs, sex, mental health, body image and relationships	www.somazone.com.au
Itsallright: diaries of four fictional teenagers touched by mental illness and factsheets, helpline, and information on mental illness	www.itsallright.org
Tune in not out: provides a pod-casting service, where young people can learn about healthy decision making around alcohol and other drug use	www.tuneinnotout.com
On Track: a free online tool designed to assist people who want to reduce or control their alcohol use	www.ontrack.org.au
My Smoking: a campaign website developed by Queensland Health to reduce the rates of cigarette smoking amongst young people	www.mysmoking.qld.gov.au
Smiling Mind: free web and app based mindfulness program for children and young people	http://smilingmind.com.au
Hello Sunday Morning: a movement to change the world's relationship with alcohol - one Sunday at a time	www.hellosundaymorning.com.au

Further information on Information and communications technologies (ICT) for enhancing engagement

Young and Well: *Using technologies safely and effectively to promote young people's wellbeing*	www.youngandwellcrc.org.au

2.8.1 Social media for enhancing communication with and between young people

Social media or social networking services (SNS) represent an important tool for information and connection for young people. A Nielsen poll (cited in Third et al. 2011, 9) found that almost all young Australians are online with 90% of 16 – 29 years olds using the internet daily. Use of SNS is quickly becoming the number one online activity, with 83% of young people reporting they use SNS on a regular basis. This survey found that young people are also accessing SNS on the move; with 39% of SNS users surveyed accessing these services via mobile devices.

The benefits identified by young people associated with SNS use include:

- developing social skills
- exploring and trying on different identities: "you can be someone you can't offline"
- keeping in touch with friends and family, especially with those who are geographically distant
- addressing feelings of social isolation - especially for those without a mobile phone
- accessing hard copies of their inter-personal interactions, for example, if being bullied via social networking, unlike face-to-face bullying, young people can access concrete evidence of bullying in the form of screen grabs and transcripts
- creating a personalised space that expresses their identity and over which they have control and ownership
- supporting their friends in a range of ways such as helping them work out personal issues or assisting one another with study.

Source: Third et al. 2011, 20

The speed of change in digital technologies means that by the time you read this there will be new and emerging options.

"I'm talking about eCounselling, eCBT, use of social media. Use all of that stuff to connect with a client. They're on their phones, they're on Facebook, they're on Twitter. And that actually means we can link with them faster than we ever could before."

Frontline Youth AOD Outreach Worker

Developing a social media policy for your organisation

Many organisations struggle with social media by either being unaware of its utility or by being highly concerned about client, worker and agency confidentiality, safety and what is deemed as appropriate usage. This is understandable given the rapid rise and proliferation of a whole range of diverse social networking services (SNS) and the continual updates or changes to settings, permissions and options.

As a result, many organisations have attempted to develop social media policies to govern the set-up, access, usage, content and review of their chosen platforms. The Youth Action and Policy Association (YAPA) in New South Wales has developed a policy guide that organisations can use to assist them in this process. This guide provides a framework for agencies to incorporate social media in a way that is safe (for the organisation, workers and clients), ethical, and effective in supporting service delivery.

In the guide, YAPA propose a set of key questions for staff and managers to consider.

- Why do we want to 'connect' with young people online?
- What risks are there in this engagement that are similar to our offline practice?
- What risks are there in this engagement that are different to our offline practice?
- Given these risks, what are reasonable ways to manage these?

In response to these (and other) questions, YAPA's policy document maps the use of social media against the core ethical principles identified by youth workers, and examines how potential problems and dilemmas can be resolved. The guide also contains a sample policy that can be used as a basis for your own agency.

Interestingly, YAPA propose that youth services may actually have an ethical imperative to be online. The rationale being that young people (as the primary client) should be engaged in the ways and spaces that suit them. If online engagement is simply seen as another space with which to engage with young people, then the same principles that apply to offline engagement should be easily applied.

To access a copy of the YAPA Social Media Policy Guide, visit www.yapa.org.au

Section 3

Outreach

Outreach is most simply defined as a proactive engagement approach targeting young people. Petroulias et al (2006) indicate:

Outreach is mostly undertaken to engage those who are least likely to access services but who are in the most need. This is done by going to service user-preferred spaces and targeting those needs currently considered most important by the client. Outreach is conducted in "out of office settings, including streets, homes and parks, rural and remote settings, within other organisations or agencies".

The Young People's Health Service Clinical Street Outreach Report (Eade 2009) argues that outreach is particularly useful for addressing the needs of high-risk populations. Evidence cited in the literature found that increased frequency of contact with outreach workers showed increased likelihood of taking up referrals and that injecting drug users with four or more contacts with street outreach workers during the preceding six months were more likely to report acting on referrals (Eade 2009, 15).

3.1 Aims of outreach

The aims of youth AOD outreach include the following:

- *minimise the harm caused by alcohol and other drug use*
- *provide assessment, support, and referral and case management on an outreach basis to young people in their own environment in an accessible, 'open door' capacity*
- *encourage entry into treatment*
- *maximise flexibility in treatment and support services so that, where possible and appropriate, young people can maintain their current environment with minimal disruption to themselves or others*
- *provide support, information and resources to generalist agencies that work with young people*
- *develop inter-service networks and linkages to ensure appropriate and coordinated ongoing case coordination and referral processes*
- *provide appropriate services for carers and families of those affected by alcohol and drug use*
- *initiate activities aimed at prevention as well as risk and harm reduction to promote young people's general health and wellbeing*
- *identify and contact young people and prevent further marginalisation*
- *refer young people to existing care services and encourage social integration*
- *advocate on behalf of young people with families, schools, youth specific drug and alcohol services, and generalist services*
- *ensure organisation and the broader community are supported to promote change and better outcomes for young people with drug use problems and/or young people who choose not to access office based AOD services.*

Source: Bruun, 2001, Korf et al., 1999; Pead et al., 1999, (cited in Petroulias et al. 2006, 6)

3.2 Practice principles underpinning good youth AOD outreach

The practice principles underpinning good youth AOD outreach are the same as for other forms of youth AOD practice. The following checklist contains a list of questions you can use to assess the effectiveness of your outreach strategy. It is reproduced from *Youth alcohol and drug outreach: clinical treatment guidelines for alcohol and drug clinicians*, (Petroulias et al. 2006).

Do the youth AOD outreach strategies:

- apply a harm and risk reduction approach?
- focus on engaging and building constructive working relationships with young people?
- apply a developmentally relevant and youth friendly approach?
- apply an empowering approach?
- work with where young people are at with regard to their drug use?
- use an accessible and inclusive, responsive, opportunistic, and flexible approach?
- apply a collaborative approach?
- apply a holistic approach?
- apply effective risk assessment and management practices?
- understand young people's rights and legal entitlements?
- engage families in service plans?
- use an ethical approach?
- work within a supportive and effective organisational structure?

Source: (Petroulias et al. 2006, 7)

"It's important to remember that just because young people are congregating in public space does not mean they need an intervention. Young people commonly socialise in public space because they don't have anywhere else to hang out."

Outreach manager

Case study from Youth Support and Advocacy Service (YSAS) – Leroy, aged 16

Alcohol, cannabis and amphetamine use

We commenced working with Leroy when our staff delivered an AOD harm reduction workshop at a community school. It was evident at the workshop that Leroy, a young man aged 16, was disclosing substance use at a far riskier level than age norms, and additionally, a staff member who had a street outreach role recognised Leroy as a member of a group of six to eight young people who drink to intoxication every weekend at an inner city high rise public housing estate.

Leroy readily consented to a comprehensive psychosocial AOD assessment, as he also recognised the workers from the street based outreach setting, and had already learnt something about YSAS's harm reduction approach and relationship based model. As part of the assessment process YSAS arranged to speak with the school welfare staff, school principal, and Leroy's family in that same week.

We gathered the following information:

- Leroy was frequently truanting from school, attending only two days a week on average.
- He reported frequent offending behaviour including shop thefts, motor vehicle thefts and public drunkenness. Leroy had a number of matters appearing before the Children's Court in the month following the assessment.
- There was a low level of parental involvement at home, and evidence of alcohol misuse by both parents.
- A Victoria Police Youth Resource Officer had reported to the YSAS assertive outreach team that the group of young people Leroy associates with had been involved in a number of violent altercations with security staff.
- Leroy was assessed as having dependent cannabis use patterns, smoking up to 3 grams a day, binge drinking at high risk levels (consuming in excess of 20 standard drinks every weekend), and experimentally using undetermined amounts of amphetamine type stimulants (ATS) twice a month.

Over the next six months, we provided court support, linking Leroy to Victoria Legal Aid, and facilitated his attendance to Youth Justice appointments. Leroy lost his mobile phone over this period, and on several occasions, Leroy was at risk of breaching his legal orders due to non attendance. On these occasions, we were able to alert Leroy to his legal obligations through after hours contact with our street outreach team. With Leroy's consent, Youth Justice and YSAS developed an integrated case management plan. His YSAS case manager worked with the school welfare officers to develop an individualised school attendance plan, and mental health service referral for his father who was suffering from depression. A residential withdrawal stay was arranged at a location distant from his peers (at his request) and Leroy attended for five days. During the residential stay, Leroy received intensive AOD consults with his YSAS case manager, and post discharge, maintained a reduction of cannabis use to 1 gram a day, and one binge drinking event per fortnight. Leroy ceased all ATS use.

Additionally, we delivered a training workshop to the private security company on the high rise housing estate where Leroy and his friends were drinking, which focused on improving management of intoxicated young people. We also increased after hours street outreach patrols to these locations, engaging a number of Leroy's peers into services.

Source: contribution from Youth Support and Advocacy Service (YSAS) www.ysas.org.au

3.3 Models of outreach

Any one, or a combination of any model of outreach, can be undertaken within one service. A major source of information for this section is drawn from the Turning Point *Clinical treatment guidelines for youth alcohol and drug outreach* (Petroulias et al. 2006) along with reports and case examples from YSAS and other frontline practitioners. The five models of outreach in the table below are drawn from Petroulias et al. (2006, 7).

"Outreach is a powerful connecting activity. A simple 'hi' and a sit and a yarn can see your greatest referral pathway develop, enabling young people to refer their friends, in a safe and informal way."

Outreach manager

Table 5: Models of outreach

Streetwork	engages young people in their own environment, often in public places such as cafes, shopping centres, parks, sporting groups, skating ramps, amusement parlours, street sex work locations and the streets.
Detached and mobile outreach	is delivered on an 'as needed' flexible basis to a variety of community locations, including homes, school and public places, to assess and intervene with young people referred to them. In this model, the service is based in a central location such as a community health centre, alcohol and drug service, youth service or hospital.
Satellite outreach	is used in youth friendly settings such as youth centres, youth justice programs, and accommodation centres. This type of outreach work may add value to other frontline services being used by young people (Berends et al, 2004, cited in Petroulias et al. 2006). Referral can come from services such as generalist youth services, general practitioners, schools and government services.
Assertive community outreach	is conducted in the young person's own environment or by primary care and specialist services. It engages with young people who have a range of complex and multiple issues, and who may not be engaged with other services. It is often supported by specialist services through co-location or location in the same auspice agency.
Clinical outreach	involves health care professionals delivering individualised treatment in the community. In a youth AOD context this is often at community based youth services where young people who have problematic AOD use are more likely to feel comfortable accessing assistance. As its name suggests, clinical street outreach engages with young people in a variety of settings including public spaces frequented by the target group.

3.4 Engagement driven service delivery approaches

Engagement and outreach strategies have sometimes been purposefully combined with various treatment approaches to create a service model able to work with young people who are marginalised and unlikely to access location specific services. The service example below brings together many of the characteristics and strategies referred to in this guide.

Barwon Youth's Youth Engagement Program (YEP)

YEP was created in August 2007 with the aim of significantly reducing AOD-related harm through the delivery of accessible, inclusive and opportunistic holistic services, including assertive outreach, as well as through education for early or preventative intervention. The YEP model is designed to provide young people, particularly those who are difficult to reach, with access to services within the community. Young people seen by YEP often present with a range of complex co-morbidities, including mental health issues and acquired brain injury (ABI), and other factors that may be associated with a position of disadvantage, including Aboriginal and Torres Strait Islander (ATSI) heritage, pregnancy, being a young parent and forensic issues.

The YEP program is conducted in out-of-office settings (streets, homes, parks etc.) and is a less formalised engagement process than those used in comparable programs. The YEP service delivery model is based on a social model of health, and does not provide one single treatment method, rather it encompasses a number of approaches that are relationship-based, holistic, narrative, client centred and solution focused. This flexible approach is based on client context, with specific attention given to the client's view of issues and goals. The YEP outreach model is dependent on voluntary engagement creating a window of opportunity for engaging and building opportunities.

The purpose of these programs is to actively reduce AOD-related harm in service users by developing a rapport between them and their caseworker to enhance their ongoing coping skills and independence. This process includes fostering optimism and building interdependence, resilience and community connectedness. Consistent worker–client contact is maintained by achieving a consistency of presence and flexibility in meeting with young people in their own environments and in a range of youth-friendly settings.

Source: (Droste et al. 2011)

Kidz Youth Community (KYC)

"KYC is a Caboolture based program that provides a range of services to young people including a volatile substance misuse response and public space outreach.

We use outreach to engage, build rapport, monitor safety and provide services. But we also use it for a whole range of special situations and circumstances. For example, some time ago tension broke out between a group of young Indigenous people and a group of Pacific Islander young people, following the violent death of a local young person. There was a lot of alcohol and other substance use and fights were breaking out between the two groups. In response, KYC began conducting extra outreach sweeps of the parks in conjunction with the police to monitor safety and diffuse violence, which included separating and moving the groups apart. We did this over the course of a number of weeks and also provided support at a community rally/mourning gathering to ensure that young people's safety was maintained.

Effectively we were able to prevent racial and rival group violence through our coordinated outreach strategy by transporting young people away from potentially violent circumstances and using this time to follow up and diffuse the levels of anger."

Executive Director, Kidz Youth Community

3.5 Things to consider when planning outreach

When conducting outreach, workers do not have the usual range of systems and equipment available, nor do they have full control over their environment. As a result, workers and agencies must develop appropriate policies and procedures to ensure safety and to maximise client outcomes. The following table contains some key considerations. These considerations vary depending on the context in which the outreach occurs.

Table 6: Things to consider when planning outreach

Resources	vehicle/transport identifiable clothing/staff name badge personal protective equipment (e.g. gloves) first aid kits torches mobile phones water/food maps laptop/tablet/smartphone with mobile internet access information/referral resources health and hygiene materials harm reduction supplies sharps disposal kit
Policy and procedures	minimum staffing levels personal safety procedures crisis response protocols documenting/recording outreach activities client transport policies confidentiality procedures (e.g. transporting confidential client information, managing visible contact with young people in public space to avoid compromising client privacy) referral procedures agreements with relevant agencies (e.g. police, ambulance, local council etc.) end of shift 'check-in' procedures

Can you think of other resources or policies and procedures required to conduct outreach in your service context?

A Day in the Life of a Youth AOD Worker

8.30am - I drove to see a client living in crisis accommodation. I spent an hour counselling, enhancing motivation to change, giving harm reduction information, relaxation techniques and mindfulness approaches for coping with cravings and then we made the next appointment.

Access to transport for this particular client is quite limited. Without outreach many young people would not be able to access treatment. Motivational interviewing, harm reduction, relaxation training and mindfulness are all evidence based techniques for working with people who use substances. Scheduling the next appointment while with the client enhances engagement.

10.00 - I met up with a new potential client at a school, referred by the school guidance officer. I completed an assessment with the student with particular emphasis on engagement through motivational interviewing techniques and gave harm reduction information as appropriate. I then made another appointment.

Outreach and motivational interviewing are both excellent engagement tools. This particular school is rural and there would be no means for the client to get to my office. Outreach is the only way the young person would get treatment. Outreach to referrers is also a means of engagement with other services and provides a more seamless, 'wrap-around' service to clients.

12.00 - I arrived back at the office and spent an hour counselling a client experiencing co-morbid alcohol misuse and bulimia nervosa. Motivational interviewing was used to bolster motivation to continue current changes, relapse prevention strategies were used to enhance coping and CBT was used to challenge faulty thinking. We then made another appointment.

By having a 'no wrong door' policy and having workers trained in mental health AND AOD, clients are less likely to fall through the cracks or disengage as they are sent from one service to another. Dual diagnosis is common to both alcohol and other drug and mental health services, so having the capacity to address this is important in terms of best possible outcomes for clients. Motivational interviewing has a good evidence base for positive treatment outcomes for substance users, relapse prevention is a tool for maintaining new behaviours and CBT is a therapy used to challenge unhelpful thinking.

1.00 – I drove to a park to meet a new Indigenous client referred by Youth Justice. I spent 40 minutes with the client and used motivational interviewing techniques to assess the client and maximise engagement. I also gave a lot of harm reduction information and then made another appointment.

Outreach appointments where the client feels the most comfortable encourages engagement, although safety must be a priority and the home environment is not always suitable. It is better to cut the session short rather than go on too long and overwhelm the client as they are less likely to stay engaged. I felt 40 minutes was long enough for this client. I am not sure if I will see her again so I made sure she received as much harm reduction information as possible to stay safe.

3.00 – I arrived back at the office and made a call to a client's GP and requested a review of their current medication.

Having a good relationship with others involved in the care of clients ensures the best possible treatment and outcomes for our clients. Having knowledge of mental illness AND alcohol and other drug treatment equips a worker to communicate with other disciplines and services. As a counsellor I am often the person spending the most time with clients and am therefore sometimes the most appropriate person to advocate on their behalf. There is also a need for workers to know their professional and personal boundaries in terms of what they can offer and what they are trained and equipped to deal with, so consulting other workers ensures the best treatment outcomes and safety for clients.

3.10 - I entered all client contacts into our database.

Entering all contact information as soon after the contact as possible ensures nothing is forgotten and it is as accurate as possible.

3.30 - I had an appointment with a client and their mother. I used motivational interviewing techniques to engage the client and enhance motivation for change and used conflict resolution strategies to address their relationship breakdown. I then made a contract between the client and parent to try to maintain the relationship as the client is currently at risk of becoming homeless. I then made another appointment.

Loss of accommodation is an indicator of poor treatment outcomes as is family breakdown, so a session dedicated to stopping this happening will increase the likelihood of positive treatment outcomes.

4.30 - I completed all data entry from the day, checked and replied to emails, and then made sure my appointment calendar was up to date.

Keeping my appointment calendar up to date ensures others in my organisation know where I am. This ensures my safety whilst doing outreach.

"It is better to cut the session short... I felt 40 minutes was long enough for this client... I am not sure if I will see her again so I made sure she received as much harm reduction information as possible to stay safe."

Further information on Outreach

Turning Point Alcohol and Drug Centre: *Youth alcohol and drug outreach: Clinical treatment guidelines for alcohol and drug clinicians*	www.turningpoint.org.au

Section 4

Assessment

Assessment is the process of gaining an understanding of the circumstances of a client to inform the necessary actions a worker should take. It can be a formal or informal process which often occurs early in the engagement. When working with young people it is important that workers balance the investigative nature of assessment with the necessity to build rapport and form a positive relationship.

4.1 Assessing a young person's AOD use

Assessment is usually seen as a 'point in time event'. A key insight from practitioners is that it is better thought of as involving observations and conversations that take place over time. Practitioners consulted for this guide indicated that young people's levels of AOD use can change dramatically from one engagement to another. Therefore, the key practice challenge is to build up a picture of the pattern of AOD use over time.

Depending on the context in which a practitioner is engaging with a young person, assessment can look very different. All young people require a comprehensive assessment that looks at a broad array of life issues, of which AOD use is but one. This should elucidate where AOD use sits in terms of the rest of the young person's life. In the development of this guide, experienced practitioners indicated caution should be used to make sure the practitioner or service is not over-generalising from one specific AOD related incident, but instead focus on understanding a broader constellation of risk, protective and contextual factors.

Practitioners should bring a critical eye to the way assessment is understood and undertaken in a particular context. The following caution from Weber (2006, 139) should be kept in mind.

> *As Senden (1999) points out, situations in which people find themselves invariably are more complicated than manuals might imply. Milner and O'Byrne (2002) alert us to the dangers of shaping information to fit favoured theories, concentrating on risks rather than needs and guarding against assessment taking on the status of 'truth'. In an era replete with guidelines and proformas, the critical practitioner needs to remain flexible and take a holistic approach to the task of assessment*
>
> Source: (Weber 2006, 139)

It is important to note that 'screening' is not the same as 'assessment'. Screening refers to a universally applied set of questions asked to all people accessing a service, designed to indicate whether further intervention is required. For example, many services screen all young people for mental health conditions. This could involve a basic set of questions designed to ascertain whether or not further detailed assessment is required.

4.2 Elements of an initial AOD assessment for young people

Specialist AOD assessment often takes place when a young person's AOD use has already been identified as particularly problematic.

An alcohol and drug assessment usually gathers the following types of information:

- Is the person currently intoxicated or in withdrawal?
- Does the person have other physical health problems and are they using any prescribed medications?
- Does the person have any mental health problems, and if so what treatment (if any) have they received?
- What is the person's alcohol and drug use history?
- At what age did the person commence using substances?
- What is the current pattern of alcohol and other drug use e.g. amount, frequency of use, route of administration?
- Has the person had past periods of abstinence, and what was their experience of this?
- Has the person been in AOD treatment before? What type of treatment and what was their experience of this?
- What is the person's family background, including family AOD use and mental health history?
- Are there any factors which are currently precipitating problematic AOD use, e.g. recent relationship breakdown, grief, etc?
- Are there any factors which are likely to maintain substance use or hinder efforts at change, e.g. unsupportive friendship group?
- Does the person have any current legal issues including upcoming court dates, court orders, child protection orders, or family court matters?
- What are the person's strengths?
- What does the person want to achieve, e.g. Abstinence? Moderation?
- Are there any high risk issues which require immediate attention?

Commonly used AOD assessment tools, measures and instruments

Below is a list of free, commonly used assessment tools and measures. You can find these resources in full at the back of this guide (beginning on page 116).

- The Severity of Dependence Scale has been developed to assess the degree of dependence to various drugs. It is not considered reliable in young people aged under 16. (p. 116)
- DSM-IV Dependence Scale: *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition defines dependence as a maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by three (or more) of the listed symptoms, occurring any time in the same 12-month period. (p. 118)
- SACS (Substances and Choices Scale) is an assessment and outcome measure designed to be used for young people aged 13 -18. (p. 120)
- HEADSS (Home, Education, Activities, Drugs, Sexuality, Suicide) is a psychosocial assessment tool designed for adolescents. (p. 124)
- K-10 The Kessler-10 (K-10) is a screening tool designed to identify non-specific psychological distress. It is valid for use in young people aged over 16. (p. 126)
- DASS-21 (Depression, Anxiety, Stress Scale) is a popular assessment tool, which can be used in people aged over 16. (p. 128)
- The Mental State Examination (MSE) is a standardised assessment tool used primarily in the mental health field. (p. 132)
- AUDIT (Alcohol Use Disorders Identification Test) is designed to measure the nature and extent of alcohol related problems. It is designed to be used in people aged over 18. (p. 134)
- The Alcohol and Drug Use History form is designed to assist in recording the client's history of AOD use. (p. 138)

Taking an AOD History

Accurately quantifying the current level of a young person's substance use can be difficult. Below are a number of questions designed to assist workers in this process.

- "How much cannabis did you smoke yesterday? Was this a usual day, or was that more or less than normal? What about the day before that? And the day before that?"
- "How much do you usually spend on amphetamines each day/week? Has this amount changed over time?"
- "What's the longest amount of time you've been without a drink? Why was this? What was it like? What led to you drinking again?"
- "Tell me about yesterday. You got out of bed and then what did you do? Take me through your day."
- "Tell me about how long you have been drinking daily? How long have you been in this current pattern?"

See page 138 for an example of an AOD Use History Template

4.3 Assessing high risk issues

When conducting an assessment, high risk issues must be considered. Agencies should have policies and procedures around risks identified in assessment and appropriate responses. It is important to accurately document any risks, as well as the decision making process and actions taken to respond to identified risks.

Below is a list of possible risks which may require immediate investigation and a response. Please note, this list is not exhaustive and should also be considered alongside potential protective factors or behaviours which may mediate risk.

- overdose
- sharing injecting equipment
- using alone
- unsafe injecting technique
- blackouts
- threat of violence towards others
- risk of being a victim of violence (e.g. domestic violence)
- unsafe sex
- polydrug use
- risk of accident or injury
- driving whilst intoxicated
- suicide/self-harm
- child abuse or neglect
- misuse of prescribed medication
- recent period of abstinence followed by recommencing AOD use (change in tolerance can lead to increased risk of overdose)

Can you think of any other immediate risks?

4.4 Assessing the use of emerging psychoactive substances (EPS)

In recent years, there has been an increase in the number of new substances available for consumption. Many of these substances are structurally similar to existing drugs; however, manufacturers may be attempting to side-step legal controls by subtly changing their chemical make-up. For this reason, many of these substances are marketed as 'legal highs' and sold either online or through shops which specialise in drug paraphernalia. The legal status of these substances is constantly changing as legislators try to keep up with the pace of new substances. Some of these products are sold as 'Not for Human Consumption' and might be disguised as otherwise innocuous household products such as bath salts or incense. This presents a range of difficulties for service providers, who may encounter young people using substances that the worker may have never heard of.

Workers encountering such substances should attempt to ascertain a subjective account of the drug effects (e.g. Did the young person feel stimulated or sedated? How long did the substance last for? Did the substance produce effects similar to another more well known substance?) and seek further information from reputable sources, often online, as this information will usually be the most current.

Tips for assessing the use of emerging psychoactive substances

- As well as asking your clients about the traditional drugs people use, you might want to add an extra question like "Do you use any herbal supplements, or herbal highs? Party Pills? Legal highs?"
- Get the brand name (you can google it later on).
- Ask what it was sold to them as, e.g. "legal pot" or "just like ecstasy".
- Ask for a description of the subjective effects, e.g. Stimulant? Depressant? Hallucinogen?
- Ask if it was like any other substance they've used.
- Ask if they experienced any negative health effects.
- Advise of the risks involved in using unknown substances.

Further information on Emerging Drugs

European Monitoring Centre for Drugs and Drug Addiction	www.emcdda.europa.eu
Erowid	www.erowid.org
ReDNet	www.rednetproject.eu

4.5 Assessing a young person's stage of change

One of the most common theories underpinning youth alcohol and other drug work, is the concept of 'Stages of Change' as outlined in the Transtheoretical Model (Prochaska and DiClemente 1984). This model allows us to understand where a young person may be in the change process and allows us to direct interventions appropriate to their presenting 'stage'. A common criticism of this model is that young people can change rapidly – often not in a sequential manner. Despite these criticisms, considering the young person's stage of change can be useful in directing future services and deciding on the appropriate approach to take.

4.5.1 Stages of change

The 'Stages of Change' model developed by Prochaska and DiClemente (1986) is commonly used as a tool for guiding psycho-social AOD intervention. Stages of Change (adapted) are conceptualised as:

- pre-contemplation
- contemplation
- preparation
- action
- maintenance (lapse – relapse).

Rather than being a simple linear progression, the analogy of a spiral has been used to describe how people actually move through these stages, with relapse being common rather than unusual.

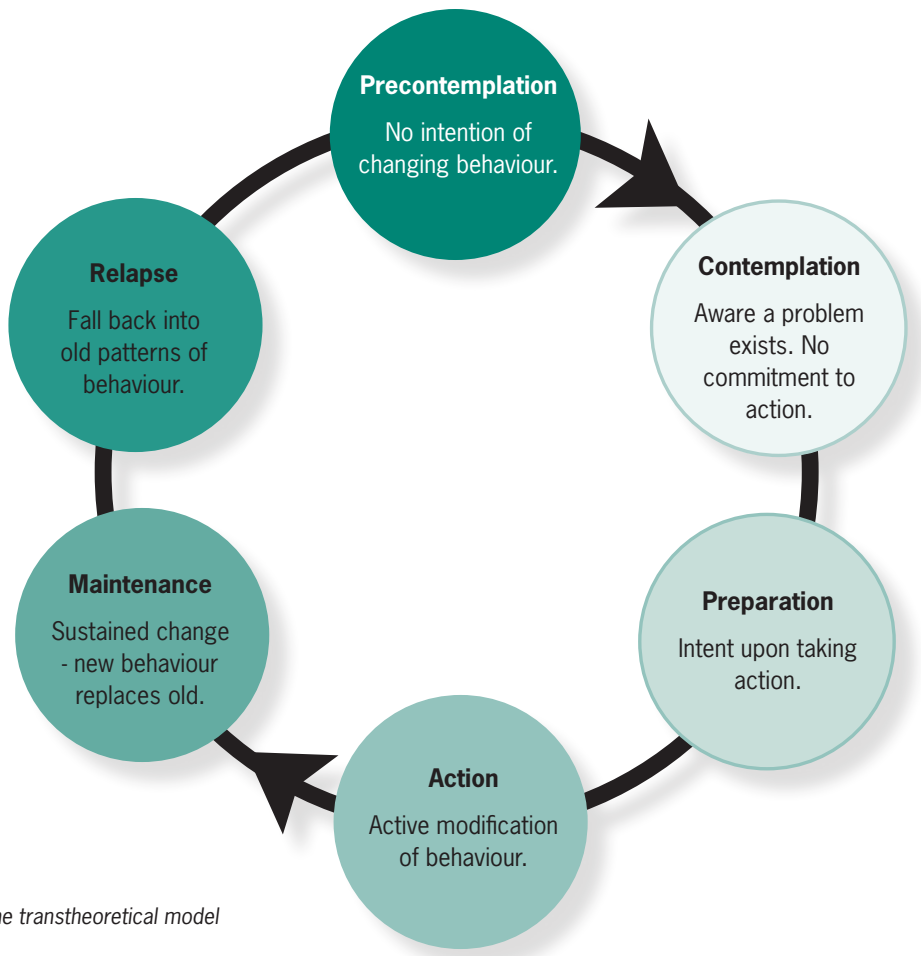


Figure 2: The transtheoretical model

In this spiral pattern, people can progress from contemplation to preparation to action to maintenance, but most individuals will relapse. During relapse, individuals regress to an earlier stage. Some relapsers feel like failures— embarrassed, ashamed, and guilty. These individuals become demoralized and resist thinking about behaviour change. As a result, they return to the precontemplation stage and can remain there for various periods of time. (Prochaska, DiClemente and Norcross 1992, 1104-5)

A variation of the Stages of Change model is depicted below. This was developed from the Living With Alcohol Program in the Northern Territory and has been found useful in practice with Aboriginal people.

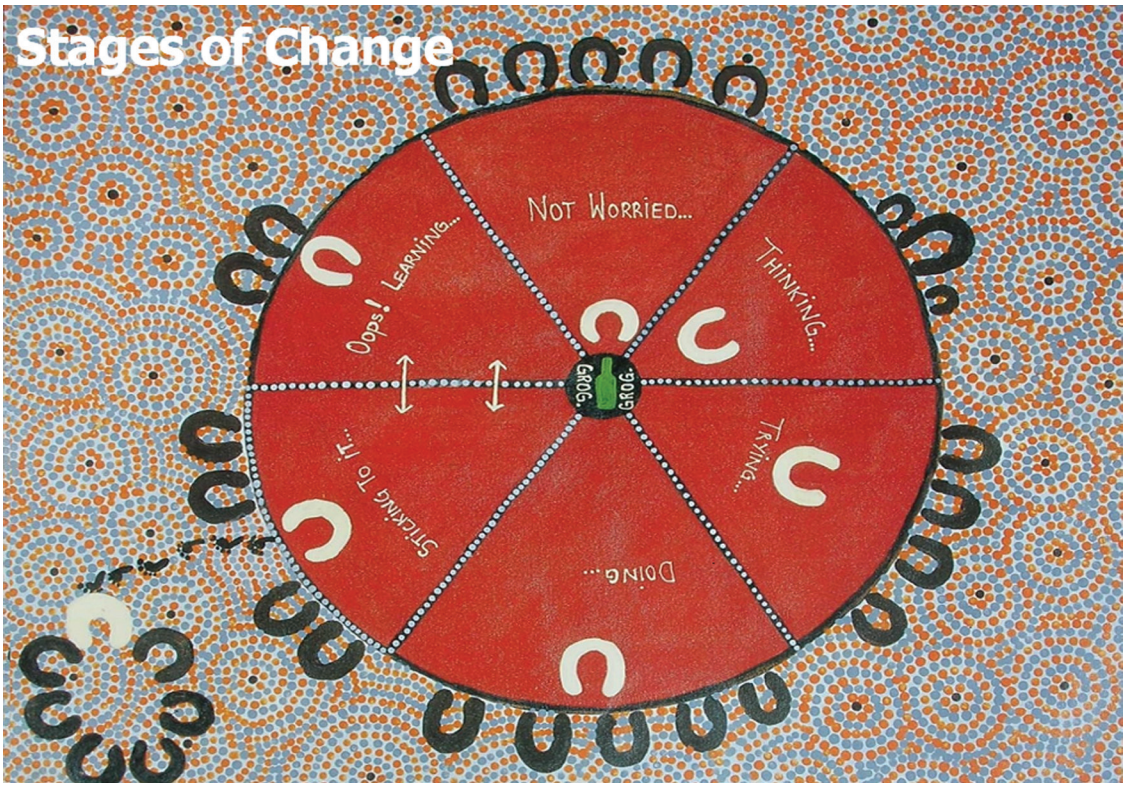


Figure 3: Cycle of Behaviour Change

Not Worried (Pre-contemplation)
Drinking has become a problem for the person in the centre of the circle. He or she is too close to the drinking. The drinker isn't worried about his or her drinking. Family members (at the edge of the circle) are worried and want the drinker to change but the drinker 'can't listen'.

Thinking (Contemplation)
Something has happened to start the drinker thinking that there is a problem and that not everything about drinking is good. He or she has started to listen to what family is saying but still is not ready to change.

Trying (Determination)
The drinker is halfway between grog and the family. The drinker wants to change and starts making plans to cut down or stop drinking. The person starts trying different things like light beer or not drinking on certain days.

Doing (Action)
The drinker has made up his/her mind to change. He/she has now cut down or stopped drinking and has moved closer to family. It is still early days but changes have been made.

Sticking to it (Maintenance)
The person no longer has a problem with drinking. He/she is sticking to the plan that was made. The problem drinking circle has been left and the person has moved back to family.

Oops! Learning (Relapse)
The person has stopped drinking but has not learnt how to 'say no' or has found ways to be strong with other drinkers. He/she may start drinking too much again. The person is learning new ways to stay strong. The family is helping the person.

Source: Graphic and text copied from the Cycle Of Behaviour Change, Living With Alcohol Program; Northern Territory Government (2000) adapting Prochaska, J. O. and C. C. DiClemente (1986).

4.5.2 Processes of change

According to Prochaska, DiClemente and Norcross (1992), there are ten processes that can assist young people to move through the stages of change, some more suited to a particular stage than others. The table on the following page draws on both their descriptions and those of Bruun and Mitchell (2012). To be effective these processes need to match the young person's stage of change. Experiential processes, showing empathy, and being non-confrontational seem to be most effective in the pre-contemplation and contemplation stages, and behavioural strategies are more effective in the preparation, action and maintenance stages (Bruun and Mitchell 2012). Strategies which enhance the material and supportive nature of a person's environment (e.g. helping relationships and social liberation) have value across all stages of change.

Section 5

Intervention strategies

An intervention is any purposeful activity or response implemented by a worker or service, designed to promote wellbeing. There are a broad range of intervention approaches available to workers, but how do we select the most appropriate intervention to use with our clients?

5.1 Matching change processes and interventions to an individual's stage of change

The Transtheoretical Model indicates the need to assess the stage of a client's readiness for change and to tailor interventions accordingly (Prochaska, DiClemente and Norcross 1992, 1110). How has this model been applied to youth AOD practice?

The following table has been extracted from a comprehensive youth AOD therapeutic practice framework resource developed by YSAS (Bruun and Mitchell 2012). This table links each stage of change to key focuses of practice, the change processes and a number of psychosocial interventions which have demonstrated relevance to each of these.

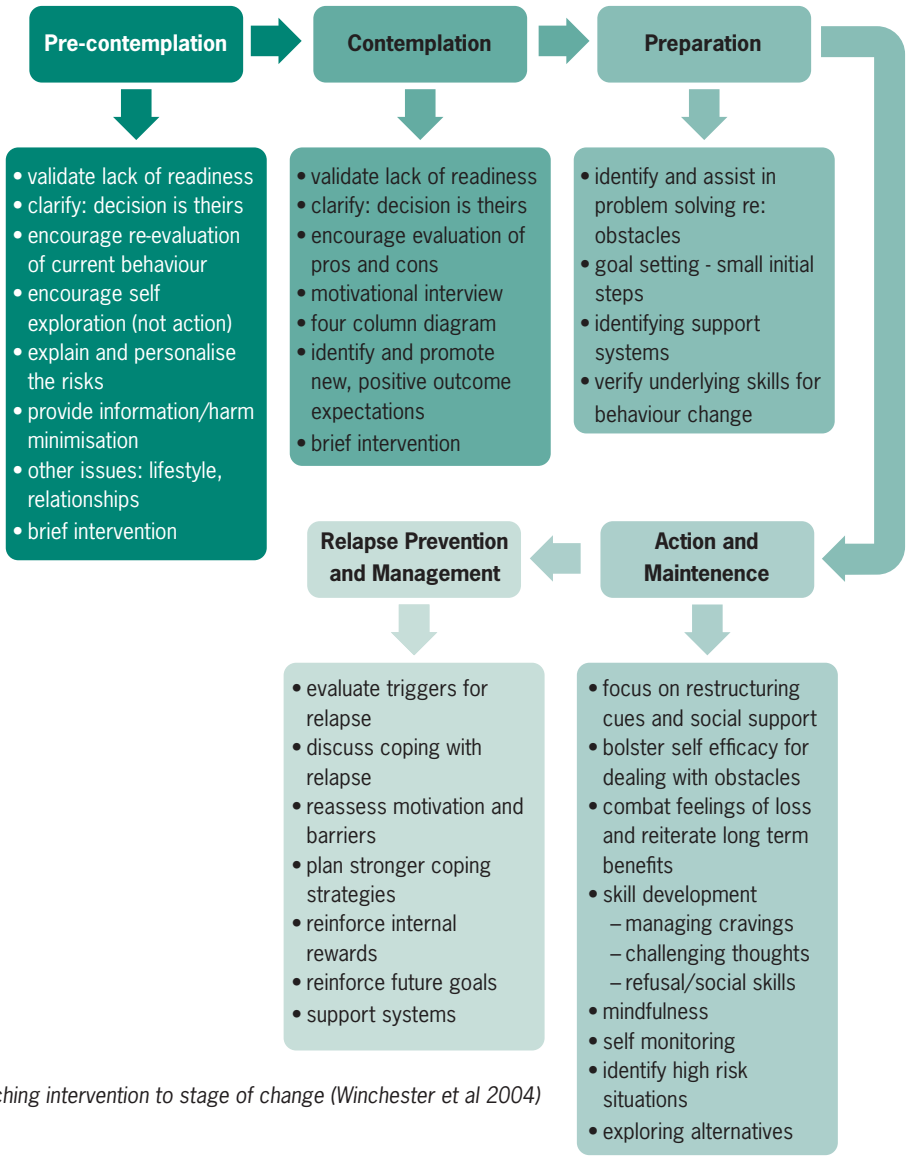


Figure 4: Matching intervention to stage of change (Winchester et al 2004)

Table 7: Matching interventions to an individual's stage of change (Bruun and Mitchell 2012, 132-138)

STAGE OF CHANGE	FOCUS FOR PRACTICE	CHANGE PROCESSES	PSYCHOSOCIAL INTERVENTIONS
Pre-contemplation	Engagement Awareness building Harm reduction Address determinants of problematic AOD use	Consciousness raising Dramatic relief Environmental re-evaluation	Motivational interviewing Client-centred casework
Contemplation	Building a therapeutic relationship Enhancing motivation Modifying cognitions Harm reduction Address determinants of problematic AOD use	Self re-evaluation Environmental re-evaluation	Motivational interviewing Narrative therapy Client-centred casework
Preparation	Goal setting Empowerment and supporting self-efficacy Fostering beliefs that support change Increasing knowledge and understanding Building skills Preparing for relapse prevention Address determinants of problematic AOD use	Self liberation Helping relationships	Narrative therapy Community reinforcement approach Client-centred casework
Action	Goal setting and review Changing environmental contingencies Fostering beliefs that support change Increasing knowledge and understanding Building skills Strengthening or restructuring relationships	Reinforcement management Counter conditioning Stimulus control Helping relationships	Community reinforcement approach Family focused interventions Cognitive behaviour therapy Dialectical behaviour therapy
Maintenance	Maintaining new environmental contingencies Reinforcing beliefs that support change and healthy development Practicing and embedding new skills Strengthening new relationship patterns Relapse prevention	Reinforcement management Counter conditioning Stimulus control Helping relationships	Community reinforcement approach Cognitive behaviour therapy Family focused interventions Dialectical behaviour therapy

Keep in mind that not all intervention is necessarily psychosocial in orientation. Intervention may focus on the provision of material or practical support and/or advocacy to access resources and institutional arrangements critical to the young person's wellbeing. These are all aspects of good social-ecological case work.

5.2 Overview of Key AOD Interventions

5.2.1 Detoxification

Detoxification refers to the process whereby a person experiencing substance dependence ceases use and goes through withdrawal. This could occur in a hospital or institutional setting (often referred to as 'inpatient detoxification'), or in the home (often referred to as 'outpatient detoxification' or 'home detoxification').

Withdrawal symptoms are sometimes managed with pharmaceuticals, referred to as 'medicated withdrawal'. The decision as to which setting or type of detoxification is appropriate is a complex one, and requires consideration of the risks associated with the withdrawal, the suitability of the home environment and the availability of supports.

Detoxification is generally short term, focused just on the removal of a substance from a person's system. For this reason, extensive follow-up care is required in order for detoxification to be successful in treating dependence. Detoxification is, in a sense, not an actual treatment for AOD dependence – it is merely the process of removing a substance from the body.

5.2.2 Residential rehabilitation

In the broader health sector, the word 'rehabilitation' refers to recovery and a return to health following a medical condition. In the alcohol and drug sector, rehabilitation (often shortened to 'rehab') refers to a specific type of inpatient treatment, whereby a person lives in a dedicated service for a period of time (usually between 3 months and 12 months). People entering rehabilitation need to have ceased substance use prior to entry, with many services requesting prospective patients undergo detoxification before entry. Some rehabilitation services offer detoxification services also, but this is not always the case and workers may need to liaise across agencies in order to ensure smooth transition between detoxification and rehabilitation.

Rehabilitation services utilise a variety of approaches to bring about long-term change including Cognitive behaviour therapy (CBT) and faith-based approaches. Many rehabilitation services operate as 'therapeutic communities'. A 'therapeutic community' is a specific therapeutic modality that uses self-help and mutual support in a contained residential environment in order to bring about change. (National Drugs Sector Information Service. 2011)

5.2.3 Brief interventions

A brief intervention is usually limited to a 'one-off' contact which could be as short as five minutes or a full hour session. Some brief interventions are conducted on an ad hoc basis, based on windows of opportunity, for example, while driving a young person to an appointment. Other brief interventions could be part of a structured assessment.

Brief interventions can be used for early intervention or where there is limited mandate or opportunity for a more comprehensive intervention. Health related behaviours which brief interventions have been applied to include smoking, inadequate nutrition, excessive alcohol consumption, inadequate physical activity, use of other drugs etc. (Dunn et al 2001, Moyer et al 2002).

Brief interventions provide an ideal opportunity to undertake psychoeducation with young people. Psychoeducation simply refers to the provision of information to clients about substance use and its related behaviours and consequences (e.g. mental health). The aim is to expand the young person's awareness and understanding of their own AOD use and its physical, medical, behavioural and psychological effects.

Importantly, psychoeducation is not a treatment method of itself: it works best when it is used as part of a broader treatment plan.

Tools for individual psychoeducation can include direct education, where the worker guides the young person through brochures or books, educational videos, websites and other online resources.

5.2.4 Motivational interviewing

Motivational interviewing refers to a cluster of interventions that focus on increasing the person's readiness to change behaviour. It can also be referred to as 'motivational enhancement' and 'motivational counselling'.

Miller and Rollnick (2002) define motivational interviewing as "a client centred, directive method for enhancing intrinsict motivation to change by exploring and resolving ambivalence... motivational interviewing does not focus on teaching new coping skills, reshaping cognitions, or excavating the past. It is quite focused on the person's present interests and concerns." (Miller and Rollnick 2002, p. 25)

There is increasing evidence of the effectiveness of this form of intervention with young people (O'Leary Tevyaw and Monti 2004).

Motivational interviewing, in simple terms, involves assisting a person to explore their relationship with substances to gain better insight into where their use fits in terms of future goals and life values. It achieves this by increasing a person's understanding of the pros and cons of their alcohol and other drug use, while allowing them to consider the potential impacts, often in terms of an idealised future scenario. A discrepancy can emerge between where the person currently is in life, versus where they wish to be. The role of the worker is to assist the person in exploring and clarifying this discrepancy and then assisting the person to ascertain the steps that could be taken to, in a sense, get life back on track and achieve the idealised future scenario that the person has identified. It aims to be non-confrontational and requires workers to develop rapport and trust with their clients.

1. Good things
What are the good things about using?
What do you like about the effects?
What would you miss if you weren't using?
Summarise when the young person is finished

2. Less good things
What are the less good things about using?
What are the things you wouldn't miss if you stopped using?
Do you have any concerns about your substance use?
Summarise the good and less good things

3. How would you like things to be?
How would you like things to be in the future?
If things were different what would you be doing?
Ask the miracle question... If a miracle happened tonight, how would things be in the morning?

4. How are things now?
How would you describe things at the moment?
Are you where you want to be right now?

5. Highlight the discrepancy
How does your substance use fit in with how things are now?
How would things be in a year if you stayed the same?
I'm confused. On one hand you're saying… yet on the other you're saying… How does this fit?

6. Summarise
Where does that leave us now?
What would you like to see happen with your substance use?
What will be your first step?
Identify a small, achievable goal now**,** such as making another appointment or attempting a small behaviour change.
Reference:

Source: Alcohol and Drug Training and Research Unit (ADTRU) (2006) Advanced Motivational Interviewing Training Queensland Health: Brisbane

Below is an example of a motivational interview. NB: The interview assumes that rapport has already been built.

Interviewer: Let's start off by going through all of the things that you like about drinking. Tell me, what are the good things about drinking? What do you enjoy?

Bruce: I suppose I like the social aspect. Hanging out with my mates, watching the football. That kind of thing.

Interviewer: Anything else?

Bruce: It relaxes me. You know after a hard day at work, it's really nice to just sit down, put your feet up and relax with a couple of drinks.

Interviewer: So you enjoy the social part of drinking – with friends. And you also like the way alcohol helps you to relax. Can you think of anything else that you enjoy about drinking?

Bruce: I'm not really sure. I think it's a cultural thing, everyone I know drinks. Drinking is what we do, it's like being a part of the group. Sometimes I suppose it's about fitting in. It'd look a bit weird being at a backyard barbeque and not drinking.

Interviewer: Alright, just to recap – you've talked about enjoying the social aspect – hanging out with mates and drinking. You also say that you like the relaxing effects, especially after work. And you've also said that you enjoy drinking because it's a cultural thing – everyone does it, and it'd feel weird to be a non-drinker amongst other people drinking. Does that sound about right?

Bruce: Sure, that's it.

Interviewer: Now can you tell me about some of the less good things about drinking. What don't you like about drinking – what are the downsides?

Bruce: Well I was busted drink driving – that's a downside! But I think that sometimes I probably spend a bit too much money on alcohol. I'll wake up the morning after a big night and the wallet is totally empty. It leaves me a bit short in the lead up to pay day.

Interviewer: So you've ended up running out of money before you make it to your pay day? What problems has this caused you?

Bruce: Well I've had to borrow money from friends a couple of times, and that doesn't always feel good. I'd rather not have to do that, it's a bit embarrassing, because I earn a decent wage so there's really no excuse.

Interviewer: Ok, so you've been left short of money and had to borrow from friends, which you don't like doing. I can understand that. Are there any other things that you don't like about drinking?

Bruce: Um. I think it's making me get a bit fat too. I've always been pretty skinny, but I think I've been putting on a few kilos over the last few months.

Interviewer: A lot of people we see here say that too. What has been the impact of putting on a bit of extra weight?

Bruce: I can't fit into my usual work clothes so I've had to buy more. But it's not just the alcohol that causes that, I think that I've also probably dropped off exercising on the weekends a bit too.

Interviewer: Why do you think that's been happening? How come you've reduced how much you exercise?

Bruce: Well, I used to play football on the weekends but it got a bit much for me. I was finding that I was always too tired on weekends to go out and play. Probably missed a few games because I was hungover too.

Interviewer: Right, so you're saying that you've put on weight from drinking too much but it's also meant that you've dropped off playing football as well, from too many hangovers on weekends. Maybe we should add that to the list of things you don't like about alcohol too?

Bruce: Yeah, that'd be fair enough.

Interviewer: So you've said that the things you don't like about drinking are things like getting in trouble with the police from drink driving, but also it's meant you're spending too much money, which has meant you've had to borrow off friends. You've also said that it's caused you to put on weight, partly because of the actual alcohol but also because the alcohol has interfered with your regular exercise – your football. Does that sound about right?

Bruce: Yeah, that's about it.

Interviewer: So tell me Bruce. How would you like things to be in the future? Where do you see yourself in, say, a year from now?

Bruce: Well I'd like to put down a deposit on a house. I used to have some decent savings, but that's all been used up. I'd like to save some cash and put down a deposit.

Interviewer: Sounds reasonable. How are things going at the moment? Are you on the right track to achieving that do you think?

Bruce: Ummm. Maybe not, because I haven't been saving any money and so at the rate I'm going, I'll be in exactly the same place I'm in right now – living week to week.

Interviewer: So you're saying that if nothing changes, you'll still be in the same place in one year's time. How does your drinking fit with how things are going at the moment?

Bruce: I'm not really sure. I think it's holding me back in a few areas. Hmmm. I haven't looked at it like that before.

Interviewer: Sounds like you're stuck! Let's just recap. You've said that you enjoy the social part of drinking, you like the relaxing effects of alcohol and sometimes you drink to fit in. But then you've also said that alcohol has had a down side. You don't like being in trouble with the police, you think you're spending too much money, which has left you short a few times and borrowing money off friends. You've also said that you think alcohol has caused you to gain a bit of weight from drinking, but also because you've dropped off playing football on weekends too. You've said that you want to be saving more money so you can put a deposit down on a house, but if you keep spending at the rate you are right now, you'll still be in the same place you are today in one year's time. Where does that leave us now?

Bruce: Well, I suppose I could have a go at reducing how much I drink.

Principles of Motivational Interviewing

- Avoid argumentation. Confrontation is unhelpful to change and is likely to increase resistance.
- Express empathy, warmth and genuineness in order to facilitate engagement and build rapport.
- Support self-efficacy. Build confidence that change is possible.
- Roll with resistance. Arguing, interrupting, negating and ignoring are signs a client is resistant to change.
- Develop discrepancy. Generate inconsistency between how the client sees his/her current situation and how he/she would like it to be. This strategy is based on the notion that discomfort motivates change and internal inconsistency or ambivalence is a cause of human discomfort.

Source: (Mills et al. 2009, 140)

Motivational change is comprised of two elements, building motivation and strengthening commitment. The 'building motivation table' (from Mills et al. 2009, 141) reproduced below, outlines strategies for dealing with particular forms of resistance.

Table 8: Building motivation

Revelling - those who are having too good a time to change	• Stimulate concern about the negative consequences. • Raise doubt about their illusory sense of elevated self-efficacy. • Focus on how their behaviour affects others. • Shift focus from problematic issue.
Reluctant - those who are simply unwilling to consider change	• Build confidence in their ability to change. • Use the support of individuals who have made similar changes.
Resigned - those who feel hopeless and helpless, may have a history of failed attempts	• Provide hope. • Share success stories of similar individuals. • Evaluate prior attempts and suggest different strategies to use.
Rebellious - those who actively resist attempts to encourage change	• Link autonomy and freedom to change. • Shift high-energy levels from rebellion to change. • Make sure they feel in charge of the change at all times. • Offer choices and options for managing their change.
Rationalising - rationalises why the addictive behaviour does not pose a problem	• Continue to make a clear connection between behaviour and consequences. • Do not deride their reasons but try and work them to your advantage. • Build confidence in their potential to change.

Source: Adapted from Clancy and Terry 2007 (cited in Mills et al. 2009, 141)

5.2.5 Case management

Case management and case work are terms often used inter-changeably to describe direct practice with individuals or families. Case management can be distinguished from case work by its focus on management and coordination, evidenced by an emphasis on tasks, guidelines, costs and outcomes. In an environment of increasing service complexity, the role of case management becomes one of service navigation and coordination.

Various forms of case management can be differentiated with one important distinction being between approaches that are client driven, and those driven by funder or management goals. A client driven approach has been preferred in most youth services.

Various approaches to case management are used in youth AOD practice depicted in the following table.

Table 9: Types of case management

TYPE OF CASE MANAGEMENT	FOCUS
Generalist	• generalist assessment, coordination of responses including brokerage and referral
Clinical	• individual therapeutic perspective • sense of self, enhanced relationships and interests • outreach into community
Strengths-based	• individual strengths rather than pathology • the working relationship is central • the client and the community contain assets and resources which can assist in reaching goals
Assertive community treatment	• community based alternative to hospital treatment • comprehensive treatment approach • often multi-disciplinary • assertive engagement (outreach) and follow up
Intensive case management	• when an individual needs long term intensive support • intensive and sustained outreach • flexible and community based

Source: Turning Point Clinical Treatment Guidelines for Alcohol and Drug Clinicians 15: Case management in alcohol and other drug treatment settings, Jenner, Devaney and Lee 2009, 5-7

Gronda (2009) describes case management as most effective when it provides direct assistance with practical and specialist support needs. Effective case management is a time and resource intensive intervention, but overall it is cost effective because it reduces other system expenditure such as hospitalisation.

Case management where there is substantial complexity is increasingly undertaken by teams within agencies or between agencies using coordinated or complex case panels and strategies.

“There are no ‘complex clients’ there is just a complex service system.”

Frontline youth worker

5.2.6 Coordinated case management

Case management where there is substantial complexity is increasingly undertaken by teams across multiple agencies using coordinated case management systems, otherwise known as complex case panels.

These panels aim to provide an integrated cross-agency response to young people with complex needs, including alcohol and drug concerns, mental health issues, legal issues, homelessness or risk of homelessness. They support care coordination by inviting involved agencies to come together as a panel to discuss individual clients who are connected with several agencies.

Some panels are coordinated by either child protection services or youth justice services and have a statutory focus. Other panels maintain a more generalist focus, even though statutory agencies may be involved.

Most coordinated case management panels seek the formal consent of the identified young person before proceeding to discuss their case at meetings. Others waive this stage, particularly when there are duty-of-care concerns. Some even invite the young person to attend the panel, although this is not common.

It is important for coordinated case management panels to establish 'Terms of Reference' that include reference to confidentiality, communication of information to clients and appropriate storage of client information. One issue panels often encounter is when services (and professional groups) have different or conflicting philosophies and service delivery paradigms. These concerns need to be discussed and agreed upon when negotiating the 'Terms of Reference'.

Further information on coordinated case management

Specialist Homelessnes Services Case Management Resource Kit, NSW Department of Family and Community Services	www.housing.nsw.gov.au

Complex Case Panels Explained

The Youth At Risk Alliance (YARA) is a program funded by the Department of Communities and auspiced by Wesley Mission Brisbane. The YARA aims to provide integrated and coordinated services for young people aged 10-17 years with complex needs and their families on the Gold Coast and in Beenleigh and consists of both a service sector development, and a service delivery arm. The service delivery component of the program is supported by its Complex Needs Assessment Panels (CNAP).

The **Complex Needs Assessment Panels (CNAP)** partners government and community representatives to provide a coordinated approach when assessing and planning the needs of clients with complex needs. The CNAP's function is to address identified issues and barriers by planning, implementing and reviewing the strategies and interventions required to support young people at risk and their families. Their function also involves advocating within their organisation, networks and sectors to ensure the effectiveness of collaborative partnerships.

The CNAP has been developed because it recognises that these issues cannot be solved by one organisation alone or by working in isolation. The model does not replace existing service delivery nor place more responsibility on one service. It aims to provide a mechanism for closer working partnerships, improved communication and a system to monitor and evaluate this collaboration, while supporting the participation of the young person and their family in the journey towards improved health and wellbeing.

CNAP Referral Criteria

The criteria for cases to be brought to the panel include:

1. A young person aged between 10 – 17 years old (should a young person reach 18 years of age, panel support can continue for a further 6 months on the condition that the referring agency remains involved; interventions during this period will focus on transitioning to adult care and support);
2. The young person has multiple and complex needs, is at serious risk of harm, and requires intervention from two or more services/ departments;
3. The young person/family/child guardian consents to the process and information being shared; and
4. Evidence that the current service system has been unable to meet the needs of the young person/family and that only a collaborative and multi-agency approach can meet their needs.

CNAP Process

1. CNAP meetings are convened monthly, but more regularly if so required and agreed upon by members.
2. CNAP members discuss the cases brought to the panel by the CNAP Coordinator and participate in discussion, providing honest and frank ideas and expert opinions while taking into consideration the needs and opinions of the client and family.
3. Co-opted members are invited at the discretion of the CNAP Coordinator, panel members and client if other persons, services or organisations are required for individual cases.
4. Minutes of CNAP meetings are taken, which include decisions agreed upon, and distributed within 7 days of the meeting.
5. Decisions on what cases are bought to the panel are made by the CNAP Coordinator and cases are prioritised according to perceived complexity.

Roles and Responsibilities for CNAP Members

Panel members have a responsibility to participate in discussions and case planning, provide resources and time to the agreed case plans. Panel members agree to ensure that their departments and organisations are flexible and willing to assist the panel's decisions in order to achieve the desired goals and outcomes.

All participants are expected to support the mission and principles of the model, especially when making decisions. Members will remain autonomous but will commit to working collaboratively in the best interest of the client and family. Conflicts of interest will be immediately declared. At no time will the process operate contrary to the best interests of a young person or to the detriment of any person or family.

Panel members must attend no less than 70% of meetings a year and/or be available for consultation. Members must stay up to date with the case plans and reviews, and will read minutes and profiles sent to them prior to meetings. All members and their respective organisations/ departments shall adhere to confidentiality protocols. Members agree to report back to the Youth At Risk Alliance Advisory Group on systemic issues and barriers, how the panel operates and the outcomes being achieved.

Desired Outcomes

1. To develop a paradigm where integration and collaboration is committed to, understood and practiced by each organisation/department involved.
2. To achieve mutual respect and understanding, common goals and good communication.
3. To identify gaps in service provision, and enable inconsistencies to be addressed.
4. To achieve outcomes for young people and their families in a shorter timeframe than when services work in isolation.
5. To empower clients and families to be part of a process that supports them and allows them access to services that are relevant to their individual needs.
6. To develop the strengths of young people and their family.
7. To support young people and families to achieve stability, health and wellbeing, positive relationships, belonging and connection within their community.

Benefits of This Model

- can draw upon the skill, experience and knowledge of core panel members
- provides a mechanism to address systemic issues and gaps in service delivery
- service provision may be constructively critiqued in a healthy, safe, peer environment
- facilitates outcomes and referral pathways outside of normal service provision
- has 'dual beneficiaries' – the client and the system
- individualised/tailored approach to case planning
- access to flexible brokerage funds to support client

Some of the Challenges

- complexity of the service system and panel model
- organisational and/or legislative constraints around information sharing
- establishing formal mechanisms for reporting and addressing systems gaps and issues
- partnerships take time to establish
- avoiding the creation of another 'layer' in service provision
- when service system gaps are filled, solutions need to be shared

Key Messages (if wanting to establish a panel in your area)

- clearly define the 'target group' and referral criteria
- identify services that would best meet client needs and invest in developing relationships across these
- work collaboratively on establishing shared frameworks of practice
- consider legislative/policy changes that may need to be brought about to facilitate improved ways of working
- consider the need for flexible client brokerage
- focus should be on improving case coordination and the model should adopt a co-case management approach
- evaluation of the model to demonstrate effectiveness and ensure sustainability

5.2.7 Cognitive behaviour therapy

Cognitive behaviour therapy (CBT) is a blend of two therapeutic modalities: behavioural therapy and cognitive therapy. Behavioural therapy emerged from the work of Ivan Pavlov and later B.F. Skinner, who looked at the ways that behaviour is learned and reinforced (Bruun and Mitchell 2012). Contemporary behavioural psychology sees problems as maladaptive patterns of behaviour that have been learned and reinforced over time.

Cognitive therapy differs in that it sees problems emerge due to distortions in thoughts and beliefs. These distorted thoughts and beliefs are often unquestioned and the task of the therapist is to begin to challenge and question the unhelpful beliefs and assumptions that lead people to dysfunction.

Whilst behavioural therapy and cognitive therapy locate the nexus of the problem differently, both operate in the 'here and now' with little reference to historical or contextual factors. Despite significant rivalry between the two disciplines, combined they provide a more rounded approach which sees problems occurring at the intersection of thoughts, feelings and behaviours. CBT sees these as linked, and negative emotional states arise as a negative pattern sets in.

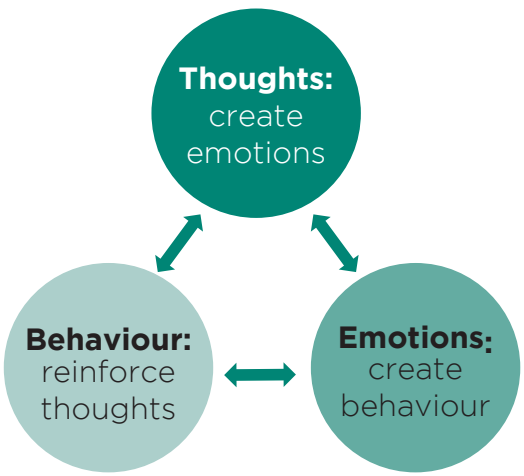


Figure 5: Interplay between thoughts, emotions and behaviour

Cognitive behaviour therapy gained popularity as a distinct therapeutic approach following successful trials of the approach in dealing with panic disorder in the 1980s (Rachman 1997).

From this point on, the body of evidence supporting the use of CBT grew, with a range of disorders being successfully treated with this approach, including panic disorder, phobias, depression, anxiety and substance use disorders (Rachman 1997). There are a number of varieties of CBT available, some placing more or less emphasis on the cognitive component or the behavioural component. Broadly speaking, most cognitive behavioural therapies utilise four techniques, including:

- instruction (including verbal description or explanation and modelling);
- supervised practice (including rehearsal and role play);
- feedback (including reinforcement and reflection on ways to improve), and
- independent practice in the real world.

(Bedell and Lennox 1997 in Bruun and Mitchell 2012, 89)

Bruun and Mitchell (2012) in their analysis of effective youth alcohol and other drug treatment, consider six main types of CBT relevant for addressing commonly associated issues with young people and substance use. These are:

- **assertiveness training:** designed to assist young people in making decisions for themselves, and to resist social pressures to use alcohol or other drugs
- **anger and aggression control training:** designed to assist young people in controlling their emotional responses to situations
- **coping and problem solving skills training:** designed to help young people deal with stressful situations which arise, and to methodically work through complex situations without the need to use alcohol and other drugs
- **motivational enhancement:** to enhance and reinforce desire to change negative behaviours
- **contingency management:** to provide reinforcement of positive behaviours
- **emotion regulation:** to assist young people to manage their emotions, and to express their emotions in a pro-social way.

(Bruun and Mitchell 2012, 88)

The National Drug and Alcohol Research Centre (NDARC) have developed *Guidelines on the management of co-occurring alcohol and other drug and mental health conditions in alcohol and other drug treatment settings*, (Mills et al, 2009) which can be downloaded at http://ndarc.med.unsw.edu.au. The guidelines include the following tools for workers:

- cognitive behavioural techniques
- anxiety management techniques
- good things and not-so-good things worksheet
- cognitive restructuring process
- cognitive restructuring worksheet
- identifying negative thoughts
- structured problem-solving worksheet
- goal setting worksheet
- pleasure and mastery worksheet
- progressive muscle relaxation
- controlled abdominal breathing
- visualisation and imagery.

For more information on CBT

Centre for Clinical Interventions	www.cci.health.wa.gov.au
Psy Check	www.psycheck.org.au
A Brief Cognitive Behavioural Intervention for Regular Amphetamine Users: A Treatment Guide	www.health.gov.au
Mood Gym	www.moodgym.anu.edu.au

5.2.8 Dialectical behaviour therapy

Dialectical behaviour therapy (DBT) was first developed by Marsha Linehan and outlined in her work *Cognitive Behavioral Treatment of Borderline Personality Disorder* (Linehan 1993). As the title of the book suggests, DBT was designed for the treatment of borderline personality disorder (BPD). Dialectical behaviour therapy has much in common with cognitive behaviour therapy, however it differs in that it utilises 'mindfulness' as a way of increasing tolerance of distressing emotional states. DBT sees problematic behaviours (such as substance use, or self harm) as a maladaptive attempt to regulate emotions. The treatment involves learning strategies to monitor and respond to various emotional states. DBT also considers therapeutic alliance to be of central importance and early sessions focus on building this before any other activities are considered. The focus on the therapeutic alliance is significant because most people with borderline personality disorder have come from compromised family backgrounds which Linehan describes as 'invalidating environments' (Linehan 1993).

DBT is a resource intensive treatment involving both individual and group therapy usually conducted over a minimum of twelve months, although modified versions are available for younger people, conducted over twelve weeks (Bruun and Mitchell 2012).

The skills to regulate emotions are broken down into four modules including:

Mindfulness – Developing self-awareness of emotional states, without adding value judgments such as "these thoughts are bad thoughts". This is one of the foundations of DBT.

Distress Tolerance – A further step beyond pure mindfulness, distress tolerance describes the ability to identify distressing emotions and without judgment, accept the situation without becoming overwhelmed by negative emotions.

Emotion Regulation – Involves further skills development in identifying emotions, understanding the barriers to changing emotions, and actively pursuing positive emotional states.

Interpersonal Effectiveness – As many people with borderline personality disorder have problems with interpersonal relations, this technique describes the ability to articulate their needs, setting limits with regards to other people's behaviour, and managing interpersonal conflict.

Source: Linehan 1993, 186

DBT in practice: An overview of the implementation of DBT in a Queensland youth service

History: In September 2009 our service entered into a partnership with a mental health service in order to develop a DBT program. We operate a full DBT program which includes a consult group, individual therapy, a skills group and phone coaching.

Referral: Referrals can be made from a range of service providers, mental health services, school counsellors, GPs, private sector and other youth organisations. The young people do not have to have a diagnosis. Rather, they have to present with traits of borderline personality disorder (BPD). Once a referral is received, we try to make contact within seven days and complete the assessment within two weeks.

Assessment: The assessment can take up to two hours with breaks and is conducted at a site most comfortable for the young person. We inform the young people about the DBT program and what's involved. We look for a minimum of five out of nine of the criteria for BPD and also ensure it is in line with the 'three Ps principle'; problematic, persistent and pervasive. Young people are given an opportunity to discuss how they feel, what they think about DBT and why they might want to attend. Generally if they are unsuitable they are advised at the time of assessment and alternative options are discussed and planned.

Those who fulfill the criteria are presented at the next consult meeting for discussion and allocated a therapist.

Consult: The consult team meets weekly for two hours. The group is structured to discuss business matters and to practice DBT skills training. The consult group practices at least one mindfulness exercise each week. At each meeting new referrals are presented and allocated to a clinician while current clients are discussed. We try to work it so that clients who are higher risk are discussed in depth to assist the therapist. The consult group incorporates peer support, educational learning and a space to debrief. It is an important element of the program to maintain the clinicians input, practice skills and commitment.

Feedback: Following consult, the young person is advised of who their therapist will be and an initial appointment is made. The referrer is also advised of the client's acceptance to the program and details of their clinician are passed on. Within the DBT framework one therapist only is recommended. From referral to starting the program it is estimated that this takes 6 hours per client.

Starting DBT: Once a young person comes onto the program they are required to complete a pre-commitment phase. This can be 2-3 sessions but no more than 8 sessions with their individual therapist. This assists in building rapport, introducing the DBT practices, such as diary cards, chain analysis and phone coaching. It also assists with the preparation for the skills group component.

Young people are expected to see their individual therapist weekly and they are asked to commit to six months initially. This can be extended to 12 months and is recommended to assist the young person in taking on board and practicing the skills

Individual therapy: The individual sessions continue throughout the program and run alongside the skills group. This carries on after completion of the skills group to help support the young person as they transition and move on.

Skills group: The skills group is a 20 week program which is semi-open, meaning that it allows for regular intakes every five weeks. The intake week includes introductions to DBT, mindfulness practices and setting ground rules. While this appears repetitive, young people have found the intake process beneficial in grounding their understanding of the practice.

Graduation: Once a young person has completed the program, they graduate. We conduct a small ceremony to acknowledge this and present them with a certificate of completion. Each graduation presents new fears and some tears but ultimately it is a very promising time for the young person.

Progression: We have had young people move onto university, new jobs or continue with alternate therapy. We have received feedback from families, from young people and other services stating how well a person is doing. We also know that there is a reduction in emergency department (ED) presentations after young people complete the program, and we also see improvements in DASS-21 scores. While there is no cure for BPD, Marsha Linehan (who developed the approach) talks about creating a 'life worth living'. This is how we try to practice DBT with our young people.

For more information on DBT and mindfulness

DBT Self Help website	www.dbtselfhelp.com
Reachout on Mindfulness	http://au.reachout.com/find/articles/mindfulness-wellbeing
Smiling Mind	http://smilingmind.com.au

5.2.9 Narrative therapy

Narrative therapy is an approach which places emphasis on the stories people tell themselves about their lives (Bruun and Mitchell 2012). The approach sees people as experts in understanding their own lives, with a range of skills that can be harnessed to overcome challenges (Morgan 2000). For the narrative therapist, the goal of therapy is to assist the person in 're-authoring' their personal story such that, for example, a story of personal struggle becomes reframed as a story of strength and overcoming. The therapist asks questions designed to assist in re-interpreting experiences to create new meanings. Narrative therapists see stories as being made up of:

- events
- linked in sequence
- across time
- according to a plot.

(Morgan 2000)

Narrative therapy has not undergone the same rigorous evaluation as some other therapeutic approaches. However, it has been noted that ideas from the narrative therapy approach have become pervasive in some practice settings, and the approach does have characteristics of effective service provision for young people (Bruun and Mitchell 2012).

For more information on narrative therapy

Dulwich Centre	www.dulwichcentre.com.au

5.2.10 Experiential approaches

Experiential approaches refer to the delivery of a range of purposeful activities, practical events and structured learning opportunities that are designed to both engage young people and enable relationship-building, critical thinking, creative expression, problem solving and for decision-making in contexts that are personally relevant to them.

Experiential approaches can include a range of techniques not always considered overtly therapeutic, despite often having therapeutic intentions. The provision of fun, free activities has the ability to not only engage difficult to reach young people, but also to provide them with positive life experiences (Bruun and Mitchell 2012, 31: Guide 3, NHMRC 2011). Active participation, learning new skills and providing the space to practice new skills are all considered key elements of effective experiential approaches.

Components of successful activity based programs

- are often developed in collaboration with the young people they are intended for and their communities
- involve meaningful activities that help build skills and the capacity to look after themselves properly – not just recreational activities
- provide a nurturing environment
- achieve a strong rapport between program staff and young people (and often their families too)
- are long-term and sustainable.

NHMRC (2011: 101)

Experiential approaches can include adventure based learning which typically utilise a range of activities and managed adventures such as canoeing, challenge ropes courses, abseiling and rock climbing, as a mechanism for people reflecting on their interactions with others, decision making, behaviour, values and choices. In Queensland, adventure based learning has been used as a mechanism for early intervention for vulnerable young people and has particular value when combined with ongoing support located in a young person's own community, and involves building connection to family and other supports/resources.

A wide range of programs and projects also utilise creative arts based processes as a way of engaging and working with young people. These can have an individual, group and/or community wide focus. Photography, visual arts, performing arts, publishing, computer animation, and fashion are just some of the arts mediums that have been employed, often in combination.

Some experiential approaches can act as diversionary. An example of this might be a night of free activities on school holidays or weekends designed to reduce boredom and engage young people in pro-social, supervised activities. Other experiential activities might form a part of a contingency management approach. For example, achieving a particular treatment milestone might trigger a reward, through the use of an experiential activity.

Experiential approaches have been found to have benefits, particularly for difficult to engage young people such as young people experiencing homelessness, and young people using inhalants.

In recent years a range of experiential approaches to work with young people have been clustered under the concept of 'youth development'. A study undertaken by Griffith University highlighted the following attributes of a youth development framework.

A youth development framework:

- encourages the use of experiential learning across all kinds of learning activities, including those focused on learning about difference
- supports the use of reflection and peer support methods to encourage active engagement, learning and development
- draws out the importance of young people being active in decision making and leadership
- makes a clear distinction between physical, social and psychological safety
- promotes partnerships between and amongst young people, older people and across the community
- encourages inclusivity and accessibility
- recognises that both young and older people engaged in youth organisations have needs that must be met, and promotes the things that program leaders need so they can excel at what they do
- introduces individual learning and development plans as tools for positive learning and development
- encourages the use of succession planning for healthy program growth and skill development
- addresses the need for adopting good practices in volunteering
- promotes the safe and positive use of social media
- requires that effort and achievement across individuals, groups and organisations be recognised
- emphasises the use of ethical and positive promotion strategies.

Source: Seymour (2012: 2-3)

For more information on experiential approaches

Good practice principles for youth development organisations (Seymour 2012)	www.griffith.edu.au

5.2.11 Mentoring approaches

Mentoring approaches have gained significant popularity in recent years. The Australian Youth Mentoring Network describes mentoring in the following way.

Mentoring aims to provide a structured and trusting relationship that brings young people together with caring individuals who offer guidance, support and encouragement aimed at developing the competence and character of the mentee ... (Australian Youth Mentoring Network www.youthmentoring.org.au)

Mentoring involves formally linking at-risk young people with a mentor, in order to provide pro-social influence, skills and experiences. Most mentoring programs involve a formal induction or training component for potential mentors, and then linkages are made based on an assessment of suitability between mentor and mentee.

Peer mentoring programs are those which recruit as mentors, young people of similar background to those they are mentoring. In alcohol and drug, this may involve linking with someone who has experience with AOD problems.

A survey of young people 14-19 years by Wesley Mission (2011) found that in respect of their experience of adult mentoring, four in five young people reported the impact as 'very positive', and over 50% reported that mentoring had assisted them in making decisions about AOD use. The research found that many young people are aware of mentoring and the majority felt that there are benefits from these types of programs.

For more information on mentoring approaches

Australian Youth Mentoring Network	www.youthmentoring.org.au

5.2.12 Peer based strategies

Peer based strategies are those that seek the active involvement of effected communities and individuals in the service response. This includes the development of specific strategies, resources, delivery, feedback and evaluation (Taylor 2008).

Peer programs, peer education, peer mentoring, peer helping, and peer counselling can all be described as peer based strategies employed to empower young people. In the youth AOD context, peer workers are young people who have, or have had, alcohol and other drug problems similar to those accessing services (Alford 2011).

Peer workers can often get information to hard to reach peers and they can convert 'dry information' into useful knowledge because they are able to understand the context in which their peers are best able to use that information. Credible information delivered by peers in a non-threatening and honest way has been found to have a positive effect on young people (United Nations Office on Drugs and Crime, 2003).

AOD peer education has a long history in Australia, particularly with regards to reducing the transmission of blood borne viruses (BBV) such as HIV and Hepatitis C.

"There is often a fear of the 'risks' of peer based strategies, with the result that it is still being adult managed. The strengths of young people need to be more appreciated. We often underestimate the capacities and resources of young people."

Front line youth AOD outreach worker

"AOD peer education involves sharing and providing information about alcohol and other drugs to individuals or groups. It occurs through a messenger who is similar to the target group in terms of characteristics such as age, gender or cultural background, has had similar experiences and has sufficient social standing or status within the group to exert influence."(McDonald et al 2003, 13)

AOD peer education utilises young peoples' natural networks to spread factual information and foster behaviour change in order to reduce harm. Peer education usually involves providing specific training around a particular issue and encouraging the participants to pass on their new knowledge. This type of approach allows health promotion messages to be delivered to the most at-risk populations, and is especially effective for hard to reach groups, such as young people who use illicit drugs.

Research into the effectiveness of peer education is difficult, as the 'intervention' occurs beyond the reach of researchers, making it difficult to measure fidelity. Despite this, a number of reviews have shown positive impacts of peer education. More research is required in order to better understand the factors that contribute to the success or otherwise of peer education programs (Webel et al 2010).

For more information on peer strategies

My Peer Toolkit – resources for effective peer led strategies	http://mypeer.org.au

5.2.13 12 step self-help groups

The most well known 12-step self help groups are Alcoholics Anonymous (AA) and Narcotics Anonymous (NA). The 12-step movement emerged following the publication in 1937 of *Alcoholics Anonymous: The story of how more than one hundred men have recovered from alcoholism*. (Alcoholics Anonymous. 2001) This book remains one of the central texts of the 12-step movement to this day, and the twelve steps remain unchanged. Early members developed what came to be known as the twelve traditions – guidelines describing how the self-help groups should be formed and operated. This led to the development of a non-hierarchical structure, with each group self-organising around the twelve steps and the twelve traditions. Twelve step self help groups remain a common method for people looking to make changes to their alcohol and other drug use. Research into the effectiveness of twelve step groups is mixed, partly because of the difficulty in designing a rigorous research program that eliminates sample bias. Furthermore, the decentralised nature of the groups can result in inconsistencies between groups in different locations.

For more information on 12 step self-help groups

Alcoholics/Narcotics Anonymous	www.aa.org.au

5.2.14 Family focused interventions

A range of family responsive approaches and strategies have been developed. These are canvassed in the guide in this series on *Working with families and significant others*.

5.2.15 Community level approaches

Community level approaches include a variety of strategies that seek to utilise and build community strengths and resources for responding to young people's alcohol and other drug use issues. Examples of community level approaches include formal collaborative systems, community capacity building or public space interventions.

These interventions are premised on the idea that problematic substance use is influenced by a constellation of risk and protective factors, including some which are systemic in nature. This includes community level factors such as access to affordable housing, access to services, income security and a general sense of connectedness to community. For this reason, community level approaches seek to mobilise community agencies to work across multiple domains in order to prevent or reduce problematic substance use. Often these approaches commence with an audit of community strengths and assets which can be mobilised to achieve a particular outcome.

Many communities, for example, establish 'Substance Misuse Action Groups' which regularly meet in order to share information and develop plans for coordinated responses to young people who use substances. These approaches have been found to be particularly effective for addressing complex problems such as inhalant use (D'Abbs and Maclean 2008) where a broad array of stakeholders are required to work together towards a common goal. The advantages of these types of local responses are that they are able to cater to the specific needs of a local community, and they can be adapted over time as circumstances or issues change.

For more information on community level approaches

Community builders NSW	www.communitybuilders.nsw.gov.au
Developing an inhalant misuse community action plan	www.inhalantsinfo.org.au

Case Study - Dovetail Local Inhalant Plans

"We used to make the joke in our training that everyone's looking for that 'one magic powerpoint slide with the answer' – unfortunately no such slide exists." - Dovetail Team Member

Throughout Queensland the most common and complex area of concern for workers and services voiced to us at Dovetail has been around inhalant use. Dovetail has responded by providing a series of information and training sessions across the state around the effects, prevalence and evidence-based responses to the issue. However, the unique nature of this drug's use, its ready supply and its legal status means that training and information on the subject can only go so far. Instead inhalant use requires a whole of community response as no one service or government department holds the answer.

In response, Dovetail undertook a process methodology by which to bring together key stakeholders in the community to devise their own locally-specific actions and strategies, which would eventually be enshrined in a coordinated 'Local Inhalants Plan' (LIP).

The stakeholders invited to these planning sessions include:

- youth workers, support workers
- residential and youth accommodation staff
- police/police liaison officers
- child safety and youth justice officers
- health workers, AOD and mental health practitioners
- ambulance and emergency department staff
- local government stakeholders: community safety/public space managers/youth development officers (YDOs)/Community Development Officers (CDOs)
- schools (including nurses, guidance officers etc.)
- shopping centre managers
- key elders and community leaders
- local political representatives where appropriate.

These Local Inhalant Plans would focus on the following target areas.

- direct users and their immediate (at-risk) peers
- families of users
- public space
- retailers
- media

By the end of 2012, Local Inhalant Plans had been developed in Brisbane, Gladstone, Mt Isa, Cairns and Toowoomba.

Some of the ideas created through these plans include:

- programs of diversionary activities in partnership with local recreation centres, pools and sporting clubs
- teaching first aid and CPR to young users
- establishing youth committees and reference groups
- the development of 'retailer kits' for local businesses and shopkeepers
- a 'name and proclaim campaign' to publicly recognise responsible businesses
- running community information sessions
- building stronger links with family support workers
- conducting sweeps and risk and safety audits of hotspot public spaces.

As well as being a focal point for ongoing networking, planning and collaboration, some of these plans have been instrumental in securing further funding from other sources to build particular responses.

This is a prime example of 'community level approaches' and their ability to draw together the collective resources of various agencies when a common issue requires a response.

5.2.14 Culturally specific interventions

A range of culturally specific interventions have been developed, particularly targeting Aboriginal and Torres Strait Islander young people. Perhaps the most well known of these, are programs designed to reconnect Aboriginal and Torres Strait Islander young people with their traditional cultural heritage. These types of cultural reconnection programs are premised on the idea that loss of culture is a precipitating factor for the problematic behaviour. Cultural reconnection programs have been found to be effective at addressing inhalant use in certain Aboriginal communities, such as the Mt Theo Outstation in Yuendumu, Central Australia (d'Abbs and MacLean 2008).

Case Study: Mt Theo Outstation

The Mt Theo Outstation started in 1994, taking in young people who have been engaging (or at risk of) engaging in petrol sniffing. The area around Mt Theo is recognised by the traditional owners of the land as a healing place. It is a considerable distance from the main community making it difficult for young people to leave without permission. While at Mt Theo, the young people learn traditional bush craft skills including hunting, using traditional bush foods, and learning about traditional culture. The initial program lasts for one month, and on completion young people may return to their communities of origin. In the case of a relapse to petrol sniffing, the young person is sent back to Mount Theo. After successfully completing the program, a range of after-care programs and activities are available in the young person's community of origin, designed to maintain the changes they have enacted at Mt Theo. On evaluation, Mt Theo has been found to have successfully reduced VSM in the Yuendumu region (d'Abbs and MacLean 2008), however, it was mostly effective for young people whose families are traditional owners of the area.

Source: d'Abbs and MacLean 2008

Section 6

Practice in specific situations

6.1 Responding to intoxication and overdose

Some practice settings involve working in environments where there are high levels of alcohol and other drug consumption. Examples include entertainment precincts, music festivals, 'schoolies week' and other similar events, as well as some 'drop-in' and 'rest and recovery' services.

Whilst most young people do not consume alcohol or other drugs to the point of becoming significantly imparied, a small proportion may drink or take drugs to levels that cause them to become vulnerable to harm.

AOD services, health clinics, emergency departments and tertiary homelessness services must also be willing and able to respond to young people who are significantly intoxicated as part of their day-to-day business.

There are a number of signs that may suggest that an individual may require assistance. These include:

- overpowering smell of alcohol or chemical fumes
- excessive sweating
- grinding of teeth and jaws
- excessively dilated and/or constricted pupils
- inability to focus
- slurred speech
- impaired short-term memory, or tendency to repeat one's self over and over
- rapid behaviour swings (e.g. from crying to laughter, or introversion to extroversion)
- high levels of distress or anxiety
- excessive swaying or inability to walk properly
- disorientation, including not knowing one's location, who they are with (if they are with anyone at all), where they are going etc.
- unconsciousness (can not be roused)
- not aware of one's own injury (e.g. bleeding).

Detailed guidance on responding to intoxication and overdose is available from the Facilitators Guide for the Working with Intoxicated Young People module of the NSW Training Frontline Workers, Young People, Alcohol and Other Drugs Project (2004) available for download from www.health.gov.au

Note: Just because someone is displaying one or more of these behaviours, does not automatically mean that they require assistance. However, they are a signal that you should assess their level of vulnerability further to see if they require help.

For more information on responding to intoxication

Guide for the Working with Intoxicated Young People module of the NSW Training Frontline Workers, Young People, Alcohol and Other Drugs Project (2004)	www.health.gov.au

Note: Some young people may refuse assistance or prefer assistance from someone else, or not at all. Respect their choices, unless you believe this places them at significant risk, in which case you may wish to consider calling your supervisor for assistance or the police for intervention.

If a young person is upset …

- offer them the chance to go to somewhere safe to sit and receive support if necessary.
- offer to locate or contact friends or family for support.

If a young person is injured …

- if qualified, offer them First Aid or assist them to access medical assistance of their choosing, including calling an ambulance if required.

If a young person is not responsive …

- place them in the recovery position and call for immediate assistance, and stay with them.

If a young person has been sexually assaulted …

- offer them choices for assistance. This may include Police, Ambulance (if injured), family members for support— but it should be the young person's choice.
- be conscious of your response. Try not to over-escalate the situation, nor underestimate the seriousness of the claim.
- provide reassurance and a sense of safety.
- do not ask for too many details of what has happened. This may not be personally helpful nor legally advisable. Rather, focus on what the young person wants to happen right now.

Remember!

- Entertainment precincts and youth events can generate a great deal of public and media interest. If the media is interested in a young person you are assisting, help to protect their privacy and maintain their dignity without engaging the media in discussion.
- Most people who work in these places and events do so as part of a team. Draw on the strengths and diversity of your colleagues and report any issues or inappropriate behaviour to your manager.
- Individuals who are intoxicated can often be easily influenced, either by you or by others around them. Be conscious of your power to influence and do not assume that someone cannot make good decisions simply because they are intoxicated. Conversely, if you assess someone as being clearly unable to make decisions that preserve their safety, then you may have a professional responsibility to intervene, which may include negotiating and/or managing other people (such as friends or other professionals) whose intentions may not actually be in the best interests of the intoxicated young person (e.g. forcing a drunk person to eat or consume excess water, encouraging someone to move/leave or refuse assistance if injured etc). This requires good negotiation and communication skills, an ability to de-escalate or calm a situation, and more often than not the support of colleagues and/or a supervisor.
- If your agency/role regularly involves working with intoxicated young people, consider a policy of mandatory First Aid training. In this case it may also be advisable to develop policies and procedures specific to situations involving intoxicated young people.

A young person may not remember what you said or did, but will always remember how you made them feel. Always treat young people with respect. Make sure that everything you do helps to maintain the young person's dignity as much as possible.

The following is taken from a guide dealing specifically with methamphetamine presentations, however the information is relevant to working with anyone who may become irritated or aggressive.

Strategies for managing challenging behaviour from methamphetamine or amphetamine-type stimulant (ATS) users who become irritable or aggressive.

- Speak to them in a steady quiet manner.
- Listen to them carefully and ask for clarification if you need it.
- Avoid humour and jokes.
- Explain what you are doing, and why, in short simple statements.
- Avoid rapid movements or sudden moves towards the person.
- Take nothing personally.
- Don't expect to be able to engage the person in an assessment or counselling.
- Where a suitable place is available keep people in low stimulus environment.
- Make sure that you can leave the environment quickly.
- Advise colleagues of potential risks.
- Consider the use of sedative and or psychotic medication if you have access to a doctor.
- If not in a secure environment contact the police if the situation escalates.

Source: Matua Raki (2010, 9) Interventions and treatment for Problematic Use of Methamphetamine or Amphetamine-Type Stimulants (ATS). Wellington: Ministry of Health, New Zealand.

6.2 Inhalant use

Inhalant use is also referred to as volatile substance use (VSU), and occassionally as volatile substance misuse (VSM). These terms are interchangeable. The key document for practice regarding inhalant use is the *Consensus-Based Clinical Practice Guideline for the Management of Volatile Substance Use in Australia* (NHMRC 2011). A broad range of stakeholders had input into these guidelines. There is also a short, reference guide for front-line workers to assist them in decision making around how to best support people affected by inhalants.

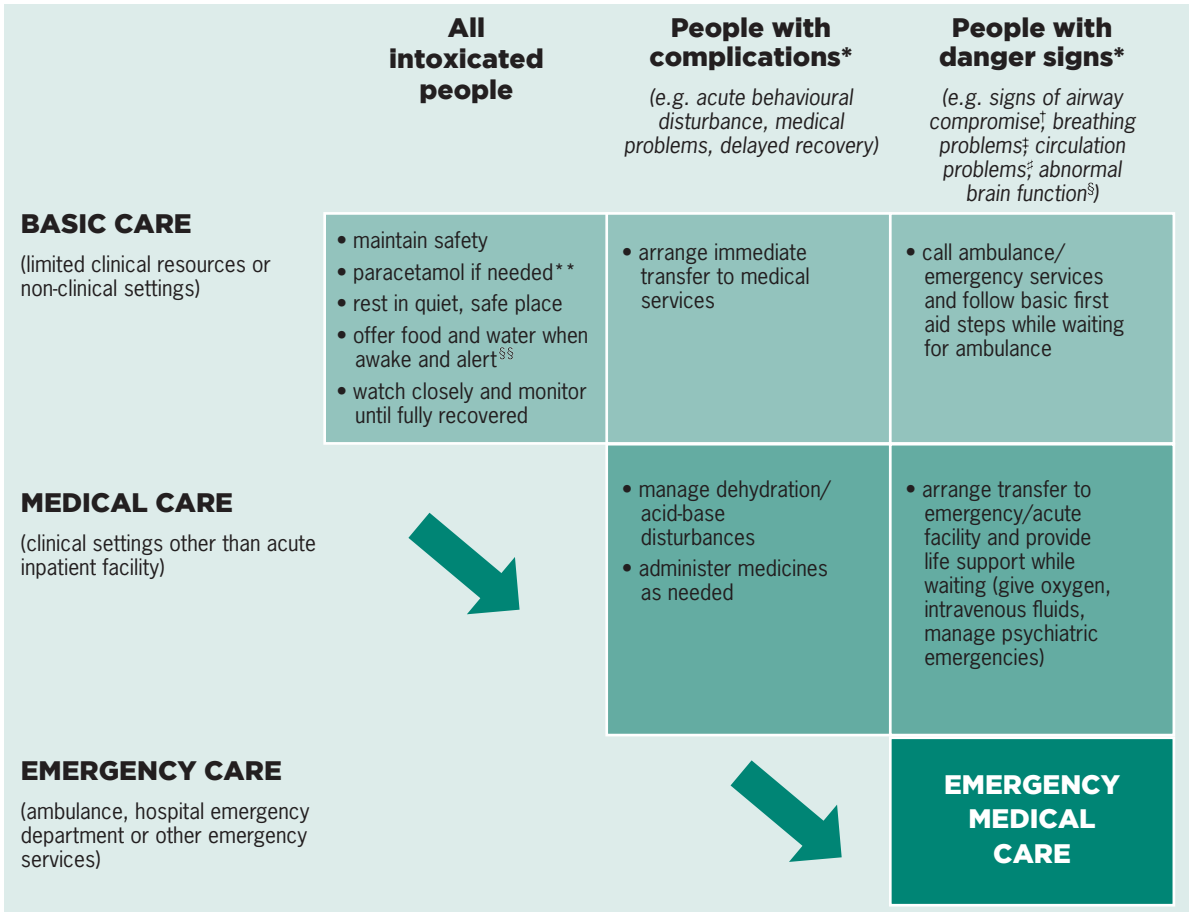


Figure 6: Responding to VSM use: Consensus based clinical practice

* or if staff not confident to manage situation
† gurgling airway noises or evidence of bloackage
‡ noisy, laboured, or shallow breathing
♯ cold skin, sweaty skin, pallor, blue lips
§ poor concentration, becoming more agitated, losing consciousness, unresponsive to pain, seizures

** Use paracetemol with caution; some volatile substances are toxic to the liver. Consider other cautions that apply to the individual (refer to TGA-approved product information).
§§ Offer sips of water first. If person can swallow safely, offer water and food.

Source: NHMRC, 2011

Strategies for responding to inhalant use include:

- systemic responses (e.g. family systems responses which may involve getting young people out of home or back to home; responses which understand and work with peer networks; and community level approaches)
- medical interventions
- psychosocial therapies
- activity and youth development programs, including diversionary strategies.

It is very important for services working with young people who use inhalants to be well connected and collaborative.

For more information on inhalant use

National Inhalants Information Service:	www.inhalantsinfo.org.au
National Health and Medical Research Council - Consensus-based clinical practice guidelines for the management of volatile substance use in Australia	www.nhmrc.gov.au

6.3 Co-occurring AOD and mental health conditions (dual diagnosis)

Dual diagnosis is a commonly used term to describe the co-occurrence of AOD and mental health issues. This is also sometimes referred to as 'co-morbidity', although co-morbidities can exist between a range of different diagnoses (or experiences) such as homelessness, disability or chronic disease. However, the term 'dual diagnosis' is most commonly used to describe the experience of AOD and mental health issues together.

The interactions between mental illnesses and alcohol and other drug problems is complex. AOD use can induce mental health problems. Alternatively, people experiencing mental health problems may attempt to self-medicate by using AOD. There can also be indirect links between AOD use and mental health problems. For example, AOD problems can lead to loss of employment, which can itself be a risk factor for developing a mental health problem. Likewise, having a mental illness may make it difficult to maintain employment, which then leads to increased use of alcohol and other drugs. Finally, the common pathway hypothesis suggests that the same factors which lead to AOD use may also lead to the development of mental health problems.

Regardless, a dual diagnosis should not necessarily change or rule-out the types of treatment or interventions one might offer a young person. Most importantly, workers should understand how their local AOD and mental health services operate so that both treatments can be coordinated and delivered together.

The key principle for effective work with young people experiencing co-occurring AOD and mental health conditions is that neither condition should preclude access to one service or another. The 'no wrong door' approach involves ensuring that regardless of where a young person enters the service system; they will not be turned away. It may be the case that the worker's role is to ascertain the most effective service for the condition; however no young person experiencing co-occurring mental health and substance use disorder should be denied access to treatment based on the presence of one or the other condition.

In Queensland, formal guidelines (*Dual diagnosis clinical guidelines, co-occurring mental health and alcohol and other drug problems* 2010) have been published which describe the way collaborative service delivery between Mental Health Services and Alcohol, Tobacco and Other Drugs Services should occur. These guidelines utilise Ken Minkoff's 'Quadrant Model' (2009) as reproduced in Figure 7, which can assist workers in understanding the nature and scope of their role with regards to the treatment of co-occurring disorders.

A copy of the above mentioned guidelines is available for download at www.dovetail.org.au

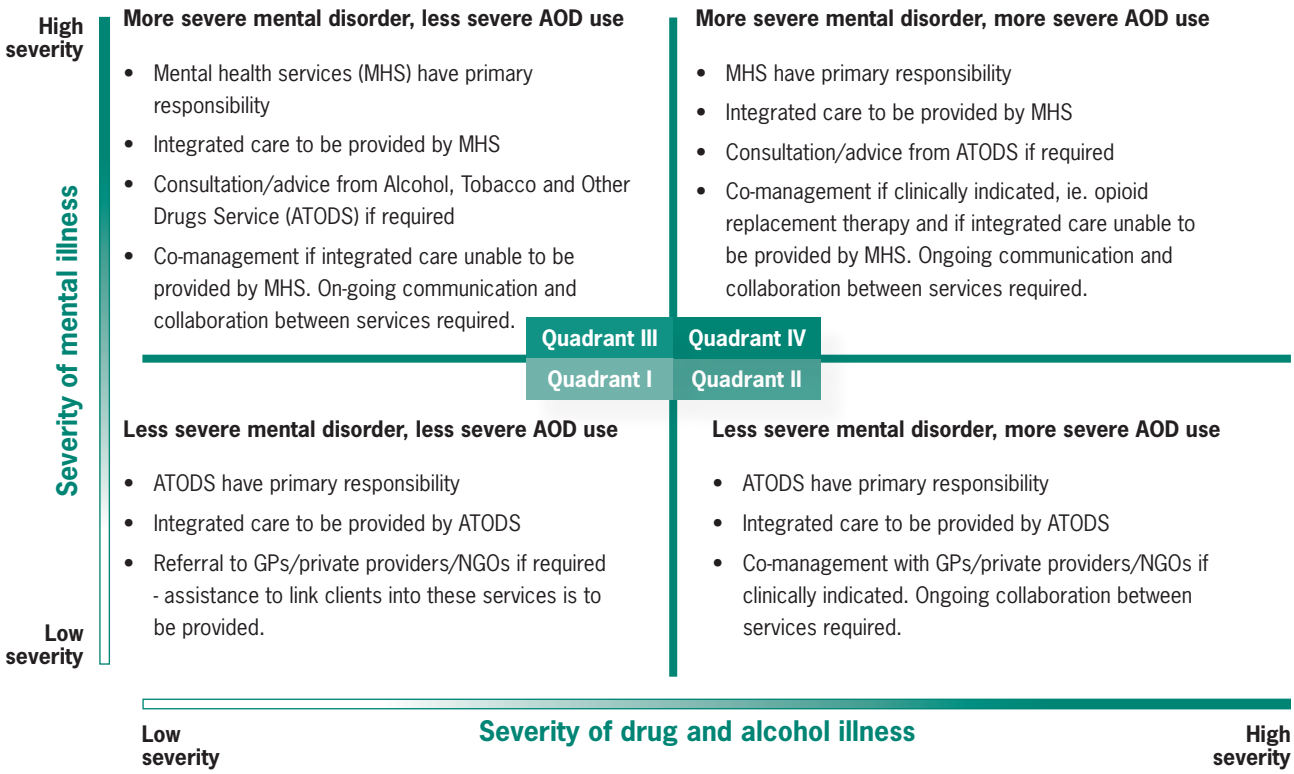


Figure 7: The quadrant model for understanding co-occurring mental health and alcohol and other drug use disorders
Source: Dual diagnosis clinical guidelines: Co-occuring mental health and alcohol and other drug problems. QLD Health 2010.

Quadrant I

Less severe mental disorder, less severe alcohol and other drug use

This domain is consistent with the needs of people whose problems are generally not severe enough to fulfil the eligibility criteria for public health sector services provided by Mental Health Service (MHS) and Alcohol, Tobacco and Other Drug Service (ATODS). This group may also include people at risk of harm and/or developing more severe alcohol and drug or mental health disorders. This group may include children and young people.

Individuals falling into this domain are most appropriately serviced by the primary health care system, the non-government sector and in some cases local alcohol and other drug services. Individuals presenting to public health care services with this profile should be assisted to access an appropriate primary health care provider. A brief intervention prior to referral and linkage to the appropriate services is to be provided to all individuals and follow-up care should be provided until effective engagement with the identified service is achieved.

Quadrant II

Less severe mental disorder, more severe alcohol and other drug use

People whose needs are consistent with this quadrant include those with a more severe alcohol and drug use and a less severe mental health problem. This includes people who may be unstable and actively using substances. These individuals are most appropriately cared for in the alcohol and drug treatment sector.

Less severe mental health problems can be managed under an integrated treatment framework with the alcohol and drug service providing treatment for their mental health symptoms. Alternatively, if mental health expertise is not available in the alcohol and drug service, collaboration, consultation and support by the local MHS or by the non-government, primary care or private health sector can assist in the management of this client group. The alcohol and drug sector will hold primary responsibility for the care of these clients and is required to coordinate ongoing treatment across both services. The alcohol and drug sector will take responsibility for inter-service consultation, and care planning and review, until the new service provider and consumer (and primary carers if appropriate) agrees that the new service will provide more specialised mental health or alcohol and other drug interventions and coordinate care according to need.

Quadrant III

More severe mental disorder, less severe alcohol and other drug use

Individuals whose needs meet the profile of this domain include those with more severe mental health problems and less severe alcohol and drug problems. People falling into this domain may include those not currently misusing alcohol or drugs or those using infrequently, with minimal to moderate impact upon their mental health. MHS are generally the most appropriate service to be managing individuals described in this domain.

MHS must screen and assess all individuals presenting to their service for alcohol and drug problems and provide treatment appropriately matched to their client's needs. In this situation, MHS should provide brief interventions, harm minimisation, motivational interviewing, cognitive behavioural therapy (and/or other evidence-based psychosocial interventions) and relapse prevention to their clients. Consultation with ATODS to inform care and, if necessary, specialist input from ATODS can be accessed if integrated treatment by MHS is unable to be provided. Specialist consultation may include: joint assessments, joint case conferencing, supervision, joint training, and consultation and liaison.

Specialist consultation from a MH Dual Diagnosis Coodinator (DDC) is available to many Queensland Health districts and can enhance the capability to respond holistically to the needs of MHS clients. MHS will hold primary responsibility for the care of these clients. The MHS is required to coordinate ongoing treatment across both services (if relevant) and take responsibility for inter-service consultation, care planning and review.

Quadrant IV

More severe mental disorder, more severe alcohol and other drug use

This domain includes people with more severe mental health disorders and more severe alcohol and drug problems. This domain will reflect those individuals with severe and persistent mental health problems. Those individuals described by this domain may include individuals with drug induced psychoses, severe personality disorders, severe mood disorders or psychotic disorders and concurrent alcohol and drug problems and/or dependence. These individuals may present to either MHS or ATODS.

The best practice recommendation for the treatment of this client group is for MHS to take primary responsibility and provide integrated treatment to this client group. Specialist input from ATODS may be required for specific issues such as opiate substitution programs, withdrawal management programs, specialist consultation, specialist assessments and co-management of particularly complex clients. MHS are to retain primary responsibility for this client group and to coordinate treatment planning, management and review, and specialist consultation across both services.

Special considerations

One of the challenges in applying this framework is the movement of clients across services, as is commonly found in traditional models of service. Services must consider the implications of fluctuations in severity of symptoms that influence a client's profile within a particular domain and the importance of continuity of service provision. Individuals who initially present with severe symptoms that settle with a clinical intervention, may be best served by remaining within this treatment sector to reduce future presentations and the provision of ineffective care.

This is particularly the case for individuals presenting with a personality disorder who are frequent presenters at services and who may settle following the provision of crisis intervention. MHS may best meet the needs of these individuals by providing brief interventions or retaining continuity of care in pursuit of the long-term goal of reducing mental health presentations and fluctuations in severity of mental health symptomatology.

In addition, individuals presenting with drug induced psychoses may also experience a reduction in severity of symptoms but re-present frequently if not adequately cared for by MHS. In these cases, it is the MHS that should adopt the primary responsibility for service provision. In rural and remote areas where limited service capacity exists or limited tertiary services are available, these issues need to be reflected in the local district health service protocols. In the absence of alcohol and drug treatment services, the service sector with greater resource capacity may end up managing individuals representing all four domains described in the Quadrant Model. District health services need to identify intersectoral support and processes for referral and ongoing collaboration between general practitioners, local non-government providers, ATODS and MHS.

Source: Queensland Health (2010, pp15-17)

6.4 Trauma informed practice

In recent years, there has been a growing recognition of the impacts of past trauma on later alcohol and other drug problems (Jacobsen et al 2001).

There are two types of trauma which can be seen in young people presenting to services: post traumatic stress disorder, and complex trauma. Post traumatic stress disorder (PTSD) is classed as an anxiety disorder which occurs following exposure to a one-off traumatic event such as a car accident or a one-off violent assault. PTSD leaves the person with a range of symptoms such as re-experiencing the trauma (through flashbacks or dreams), avoiding things which remind them of the trauma, and increased arousal (for example difficulty sleeping, unexplained anger or being hypervigilant).

Complex trauma differs in that it is the result of cumulative exposure to trauma over a period of time, and often committed by someone close – for example a parent or care giver. The symptoms of complex trauma are varied but include: affect dysregulation, dissociation, impaired self-development and disorganised attachment. (Kezelman & Stavropoulos 2012:3)

While there are some similarities between the two disorders, there are many differences and increasing recognition that some of the treatment approaches for PTSD may in fact increase distress in those with complex trauma (Kezelman & Stavropoulos 2012, 2). In fact, many people who present with symptoms of complex trauma may be re-traumatised by their negative experience of help seeking.

As evidence continues to emerge, specific treatments are being developed. While these specific treatments require extensive specialist training, all workers can become trauma-informed in their practice.

The following is from *Practice Guidelines for Treatment of Complex Trauma and Trauma Informed Care and Service Delivery* (Kezelman & Stavropoulos 2012), where the authors state:

A trauma-informed service is one which:

- commits to and acts upon the core organising principles of safety, trustworthiness, choice, collaboration and empowerment
- has reconsidered and evaluated all components of the system `in the light of a basic understanding of the role that violence plays in the lives of people seeking mental health and addictions services'
- applies this understanding `to design service systems that accommodate the vulnerabilities of trauma survivors and allows services to be delivered in a way that will avoid inadvertent retraumatization and… facilitate consumer participation in treatment'
- requires (`to the extent possible') close collaborative relationships with other public sector service systems serving these clients and the local network of private practitioners with particular clinical experience in `traumatology'.

Adapted from: Fallot, R. & Harris, M. (2009) `Creating Cultures of Trauma-Informed Care (CCTIC): A Self-Assessment and Planning Protocol'. Washington, DC: Community Connections.

Further information on trauma informed practice

How children and young people react to traumatic events	www.earlytraumagrief.anu.edu.au/trauma

6.5 Homeless and/or transient young people

Homelessness research has found that:

- *Drug use can act as a precursor to homelessness, where an individual's drug use results in financial difficulties or relationship problems which then contribute to becoming homeless.*
- *Drug use can begin as a way of coping with homelessness (for example, self- medication).*
- *Homelessness can exacerbate drug use and associated problems (and vice versa) via its impact on an individual's ability to access health and welfare services.*
- *Homelessness can exacerbate problems associated with drug use as it makes drug users more vulnerable to problematic drug use and chaotic and dangerous drug-using practices.*
  (Bessant et al. 2003, 15)

The *Project i* research (Mallett et al.) cautions against tightly linking youth homelessness and problematic drug use, with only one in five young people in the study indicating their own AOD use was integral to their pathway into homelessness.

This said, a minority of homeless young people do have persistent AOD problems.

Although our findings suggest that most young people significantly reduce or cease their drug and alcohol abuse over a two-year period, a minority, especially those living in highly unstable if not street-based accommodation, have persistent drug and alcohol problems. Compounding these problems is young people's exclusion from education, employment and training due to either their unstable living circumstances or lack of support from school (ibid, 6).

Research by the Australian Housing and Urban Research Institute (AHURI) suggests that housing quality can impact upon a number of risk factors for 'drug abuse', including educational achievement, employment, and participation in recreational activities, stress, social supports, self-identity and psychological health (Phillips, Milligan and Jones 2009).

However, little research has concentrated on housing as an aetiological risk factor for problematic drug use. Housing does appear to be important however for the health and welfare of people who use drugs, providing a safe and stable environment in what can be an otherwise chaotic life.

The importance of housing has been recognised in the Australian Government's National Partnership Agreement on Homelessness agreed to by all states (Australian Government 2009). This policy framework has clear significance for young people with problematic AOD use given their overrepresentation in homeless and 'at risk of homelessness' populations.

Gaining stable sustainable housing is an AOD intervention in itself. The importance of good housing is highlighted in *The road home: A national approach to reducing homelessness*. 2008, where it is suggested that good housing:

- is associated with a range of general health benefits (including better nutrition, adequate sleep and improved personal hygiene) and mental health benefits (homelessness was associated with feeling depressed, 'having no future' and low self-esteem);
- minimises the potential for drug- and injecting-related harm;
- provides people with greater control in their lives and reduces high risk injecting practices;
- allows them to establish sustainable relationships with mainstream as well as specialist service providers;
- makes a significant contribution to alleviating social disadvantage by enhancing an individual's capacity to take advantage of education, employment and other opportunities.

Affordable, safe and secure housing and accommodation is a substantial issue for many young people with problematic AOD use and where this does not exist, securing it should be seen as a matter of the highest priority. Specialist youth homelessness services are important to link with for this purpose.

Good practice insights drawn from the youth homelessness field relevant to youth AOD practice include the *Good practice principles for early intervention into youth homelessness* developed through the Australian Government's Reconnect program. A copy of the *Housing assistance and homelessness prevention: Reconnect operational guidelines* 2011 is available for download at www.facs.gov.au and the good practice principles are listed in the table below.

Table 10: Reconnect good practice principles

GOOD PRACTICE PRINCIPLE	ELEMENTS
Accessibility of services	Maximising accessibility to parents, other family members and young people is an important element of good practice. Key features of accessibility include effective promotion, immediacy of response and outreach.
Client driven service delivery	Flexible services that can adapt to the needs of both young people and families are important and can be achieved by: • recognising the different stages families and young people may go through after seeking assistance, e.g. families may want more active, practical assistance in the short-term before being moved to explore underlying issues; • using different models of intervention; and • linking participants with a range of supports and ensuring they are referred to appropriate services. Brokerage funds, incorporated in the budget, may enable a service to respond creatively by purchasing specific services.
Holistic approaches to service delivery	Services need to work from an understanding that problems are not isolated from other aspects of a Participant's life. This means: • viewing a person's situation in the context of employment, education, family and community participation; • working with families rather than just individuals; and • experienced case managers with a 'tool box' of interventions such as counselling, group work, mediation, family meetings and practical assistance.

GOOD PRACTICE PRINCIPLE	ELEMENTS
Working collaboratively	This involves working with a range of core services in the early intervention network including: • schools, community agencies, (such as family support agencies and generalist and specialist youth services), income support agencies, and state/territory community service departments; and • specialist services such as cultural-specific and Aboriginal and Torres Strait Islander organisations, drug, alcohol and health services including community and mental health. Four key features of good practice in engaging other agencies in collaborative early intervention work have been identified. • A clearly defined task or issue that needs to be addressed • mutual benefit to be gained • organisational commitment to working together • good relationships with individuals in other agencies.
Culturally and contextually appropriate service delivery	Flexibility in responding to the different needs of different communities is good practice. Promoting a service, assessing needs and issues and providing support, require a sensitive approach to cultural and contextual differences. Contextual considerations may include: • geographical location (urban, rural or regional) • distances to be travelled • key issues affecting families in the community being served. Cultural considerations may include: • the effects of migration on families • the different values within diverse cultural groups and in particular, the difference in the culture of the country of origin and the new culture (conflict between parent and young person) • differences in Aboriginal and Torres Strait Islander groups and between generations • language issues (potentially requiring bilingual staff, translation and interpreters).

GOOD PRACTICE PRINCIPLE	ELEMENTS
Review and evaluation	Ongoing review and evaluation is important in ensuring that early intervention services are effective and responsive to the needs of participants. Evaluation methods such as Participatory Action Research assist service providers to provide flexible services. Building-in regular feedback from participants and other agencies should enable adjustments to service delivery.
Sustainability	Building sustainability is an important principle of good practice because it recognises the importance of ensuring continuity of support for individuals and families, e.g. by identifying gaps and barriers in services over the medium to long term. It also means working in a way that empowers individuals and communities by developing their knowledge and skills so they can sustain their own change processes.

Source: Australian Government Department of Families, Housing, Community Services and Indigenous Affairs (March 2011) Housing assistance and homelessness prevention Reconnect operational guidelines.

For more information on youth homelessness services

Queensland Youth Housing Coalition	www.qyhc.org.au
National Homelessness Clearinghouse	http://homelessnessclearinghouse.govspace.gov.au
Reconnect	www.fahcsia.gov.au
The road home: A national approach to reducing homelessness	www.fahcsia.gov.au

Section 7

AOD practice with particular groups or populations

This section provides some basic guidance on working with Aboriginal and Torres Strait Islander young people, culturally and linguistically diverse (CALD) young people and lesbian, gay, bisexual and transgender (LGBT) young people.

7.1 Aboriginal and Torres Strait Islander young people

Substance use must always be understood within its social and cultural context. This is particularly relevant for Aboriginal and Torres Strait Islander peoples, who tend to be underemployed and marginalised within Australian society—both highly significant predictors of vulnerability to alcohol and other drug use (Spooner and Hetherington, 2005). The cultural stress, grief, trauma, separation, disadvantage, and physical illness that are disproportionately experienced by Aboriginal and Torres Strait Islander peoples also contribute to their high prevalence of substance use problems (Szirom, King and Desmond 2004, 2). Alcohol and other drug use problems among Aboriginal and Torres Strait Islander peoples are the result of a long history of social problems, which cannot be fixed by a simple intervention. Recommendations for addressing the existing situation include:

- *build strength/resilience (feelings of hope, family strength, and community capital) in addition to addressing specific problems such as drug use, suicide, crime, unemployment and domestic violence;*
- *publicise and promote successes/strengths of Aboriginal and Torres Strait Islander peoples rather than focus on problems to raise sense of hope among Aboriginal and Torres Strait Islander peoples as well as in the broader community;*
- *facilitate self-help and self-determination, without expecting communities to do it alone;*
- *be realistic because change will take time.*

(Spooner 2009, xiii)

The following suggestions for practitioners was developed by workers from an agency who deal predominately with Aboriginal and Torres Strait Islander young people.

Some suggestions for practitioners working with Aboriginal and Torres Strait Islander young people

1. Silence is fine.
2. Always ask where young people are from. If you know people in that community, you could say you've met them.
3. Cultural vouching is important, i.e. if they have heard good things about your agency.
4. Be aware of the impact of the Stolen Generations on young people.
5. Be aware of systemic discrimination in relation to policing, justice, and child protection.
6. Don't be patronising and don't make assumptions, treat people as individuals.
7. Understand that Indigenous young people usually have an extended network of family members (aunties, uncles) even if they don't get along okay with their parents.
8. Be aware that there is a great degree of diversity in Aboriginal and Torres Strait Islander culture and peoples. Cultural practices and protocol will vary between different peoples across Queensland.

Source: Workshop from a regional Queensland youth service

The following reflection by a youth AOD worker in regional Queensland incorporates a range of important engagement principles and strategies for youth AOD work as they engage across services and across cultures.

"I found through my work with Indigenous people that you need to integrate yourself into the agency. You need to go there, you need to work on the ground with the other people providing services there, and build relationships slowly with the young people, to develop that trust and to know that you're a familiar face, and someone that you can talk to. It's important to get to know the elders in the local community. That has been far more successful for me. I might present there for outreach and they may have no-one, but it could be more about: 'What are you guys doing? Do you need any help?' It can be about being on the same level and working together.

We need to make sure that we're not being ignorant or pretending that we do know the cultural customs. I think the biggest thing is if you don't know, then ask. I found that successful because people appreciate that you are interested and you want to learn more. I don't know what it's like to be an Indigenous person, I'm not going to pretend that I do. They're the experts, so going to them to get that knowledge base I think is far more appropriate. And I think even for individual practitioners it's good to know who are the traditional owners of the land that you're working on, all that sort of stuff, so you've got a little bit of information, and an idea as to who the key players are, and what's important to the Indigenous community locally."

Front line AOD youth worker

For more information on working with Aboriginal and Torres Strait Islander communities

Australian Indigenous Health*InfoNet*	www.healthinfonet.ecu.edu.au
Handbook for Aboriginal Alcohol and Drug Work	http://ses.library.usyd.edu.au

7.2 Culturally and linguistically diverse (CALD) young people

We all have 'culture' and practitioners may come from a wide variety of cultural and ethnic backgrounds. Good practice with young people from CALD backgrounds should start with our awareness of our own cultural location, history, preferences and views.

The term culturally and linguistically diverse (CALD) young people can generally refer to those born overseas in a non-English speaking country as well as those born in Australia, but with one or both parents or grandparents born overseas in a non-English speaking country.

This group includes voluntary migrants, people who have been drawn to Australia for their own personal reasons, and involuntary migrants, refugees and asylum seekers, who have felt 'pushed' out of their country of origin (Howell et al. 2008, 5).

Forced and voluntary migration poses significant risk of problematic AOD use among young people. These include:

- family issues such as parent–child conflict or prolonged separation from family members
- low socioeconomic status
- unemployment or lack of meaningful work
- difficulties at school
- a desire to gain acceptance
- little knowledge about problematic AOD use.

(Browne and Renzaho 2010, 5)

For refugee and migrant young people key barriers to service providers have been identified as:

- language
- availability of public transport
- understanding systems and processes, financial barriers
- trusting in confidentiality
- respectfulness of services.

(Francis and Cornfoot 2007, 9)

The following is an extract from *Making treatment services and prevention programs accessible for culturally and linguistically diverse clients* (2007) from The DrugInfo Clearing House and was prepared by the Drug and Alcohol Multicultural Education Centre (DAMEC).

STRATEGIES TO IMPROVE ACCESSIBILITY

Build partnerships between AOD services and multicultural/ethno-specific agencies

- Develop relationships at both the clinician and management levels.
- Formalise these relationships if necessary, for example, through Memoranda Of Understanding (MOU).

AOD services (both treatment and prevention) can:

- Identify the main CLD groups, relevant ethno-specific welfare agencies and ethnic community and religious associations in the geographic area.
- Identify local migrant and multicultural services.
- Promote their services to these groups.
- Provide AOD information in relevant community languages.
- Consult with these CLD groups to identify their concerns in relation to AOD, as well as their informational and treatment needs.
- Develop recruitment procedures which encourage bilingual/bicultural workers to apply (particularly those with local community language skills).
- Advocate for designated bilingual/bicultural positions where these would be valuable.

Treatment services can:

- Use interpreter services when required. Workers should inform clients of their right to an interpreter. If a client declines an interpreter but the worker is finding communication difficult, the worker may choose to explore the reasons for the client's choice and negotiate the use of an interpreter.
- Ensure that, at a minimum, a comprehensive assessment is conducted (with an interpreter if necessary) and treatment plan formulated.
- Provide written information in a range of languages.
- Provide information in alternative formats (e.g. CD, DVD).
- Manage expectations by explaining the processes of intake, assessment, detoxification, and aftercare, and checking with clients to ensure they have understood.
- Remember that bilingual welfare workers may not have extensive knowledge of AOD issues. If referring a client to a bilingual worker, the AOD service should offer ongoing support.
- Remember that multicultural and ethno-specific agencies can provide support regarding cultural and linguistic issues.

Source: (Making treatment services and prevention programs accessible for culturally and linguistically diverse clients. 2010) www.druginfo.adf.org.au

For more information on working with people from CALD communities

The Drug Info site contains fact sheets in various languages	www.druginfo.adf.org.au
Ethnic Communities Council Queensland	www.eccq.com.au
Centre for Multicultural Youth	www.cmy.net.au

7.3 Lesbian, gay, bisexual and transgender (LGBT) young people

Lesbian, gay, bisexual and transgender (LGBT) populations are known to experience higher rates of AOD use than the general population. A recent survey of LGBT people indicated that almost 25% of LGBT people in the sample had used cannabis in the previous twelve months, compared with the National Household Survey which found approximately 10% of the mostly heterosexual sample had used cannabis in the previous twelve months (Leonard et al 2012). Similarly, rates of other drug use are also substantially higher in the LGBT population than in general population samples. For instance, around 12% of LGBT people recently sampled indicated that they had used Ecstasy in the previous twelve months, compared with 3% of the general population (Leonard et al 2012).

The LGBT community also experience higher rates of mental health problems. A recent study used the K-10, a scale designed to measure non-specific psychological distress to ascertain population rates of distress. This study found an average K-10 score of 19.59, which compares to the Australian average of 14.5 (Leonard et al 2012).

A number of different theories have been espoused to explain this, with most agreeing that stresses related to being in a minority population and experiencing homophobia is the likely cause. Likewise, the LGBT community tends to socialise in a limited number of public spaces – most of which are bars or nightclubs, which can bring with them alcohol and other drug use. Additionally, the experience of 'coming out' can be a traumatic one for many young LGBT people, with the experience of family rejection leaving some LGBT young people socially isolated and lacking in the usual supports.

For more information on youth LGBT issues

Healthy Communities	www.qahc.org.au
ACON	www.acon.org.au
Open Doors	www.opendoors.net.au

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Questions for reflective youth AOD practice

The following table outlines a number of key areas and questions to consider when working with young people around AOD. This is not an exhaustive list and you are encouraged to both re-express the questions in ways which best fit in your context, and add others as you reflect on what is important.

	KEY QUESTIONS
	Initial context
Service engagement	What is necessary for initial engagement and ongoing engagement of young people in your practice setting?
Clienthood	Who is the client in this instance? An individual young person? A peer group? Siblings? Family members? Young people at a particular place? A community? What considerations, processes and permissions are needed to clarify the nature and limitations of clienthood in this instance?
Significant others	Who else does the young person have social relations with relevant to their AOD use? Who else could or should be involved, according to the young person, the practitioner? What considerations, processes and permissions are needed to engage appropriately with significant others?
Your framework for practice in this type of context	How would you complete the sentences: 'What young people need is …?' and 'What young people with problematic AOD use need is …?'

Practitioner role and orientation	What is the possible and appropriate agency role? What is the possible and appropriate scope and limitations of your role as a practitioner? Are you the right person in this instance? Individually or as part of a team? How does the young person understand you and your role? What do you see as a good outcome for a young person? What is your personal-professional orientation to/ values about AOD use?
The working relationship	How can you build a trusting purposeful relationship with the young person and significant others?
	Assessment
The situation	How would you summarise the situation?
Presenting issues	What are the presenting issues?
Urgency	What is important immediately, in the short term, medium term, long term? Is there a need for safety issues to be addressed? How?
AOD component	How does AOD use fit with the situation? i.e. Is the AOD use a cause or a symptom of the situation? How might this affect your practice response?
Assessment approach	What approach to assessment should you take? A generalist approach? Apply a specific AOD assessment model/tool?
Assessment process	How do we undertake assessment in this context? What role do young people's views and perspectives have in the assessment? Who else is important or potentially worthwhile to include in the process?

Identification of broader context of AOD use	What constellation of risk and protective factors are important here? What strengths and capacities does the young person and their context bring? What other needs/issues does the young person see as important? What other needs/issues does the practitioner see as important? What role for family and significant others in the assessment process?
	Intervention
AOD readiness to change	What 'stage of change' is the young person at?
Goals	What goals? Short, medium, long term? Whose goals? About what? How will the value/outcomes/purpose of intervention be mutually understood/measured?
Intervention approach	Where to start? What should happen first? What approach or mix of practice methods/elements should be used in this instance? Who else should be involved? Supervisor? Other team members? Other agencies?
Intervention process	What role do young people's views and perspectives have in the ongoing intervention process? How will the goals and methods of intervention be revisited, reviewed and updated? Who else is important or potentially worthwhile to include in these processes? How should this case be closed?
Good practice elements	How are recognised elements of good practice present in the intervention approach?

	Improving practice
	What can be learnt from this? What will you do with these insights? What are the implications for your future practice? What are the implications for your agency? For the sector?

Checklist of youth friendly AOD service characteristics

Environment			
Does the service look and feel youth friendly? (e.g. art, music, magazines, colour, furniture?)	Yes	No	Unsure
Location			
Is the service easily accessible by public transport?	Yes	No	Unsure
Could young people be scared to be seen walking through the doors? (discreet entry)	Yes	No	Unsure
Do young people know where you are located?	Yes	No	Unsure
Confidentiality			
Do you have a clear confidentiality policy which is explained to all young people in simple, easy-to-understand terms?	Yes	No	Unsure
Do staff clearly understand the importance of confidentiality for young people?	Yes	No	Unsure

Training			
Do staff have access to ongoing training and professional development around effective work with young people?	Yes	No	Unsure
Feedback			
Are there effective feedback mechanisms to ensure young people's opinions are taken on board (not just a complaints policy)?	Yes	No	Unsure
Intake procedure			
Are there barriers such as requiring a Medicare card or photo ID?	Yes	No	Unsure
Do you require all new clients to fill in forms? And if you do fill in forms, do you check first to see if the young person can read and write?	Yes	No	Unsure
Appointments			
Is the service entirely appointment based? Or is it possible for young people to just drop in?	Yes	No	Unsure
Do you offer SMS, email or Facebook appointment reminders?	Yes	No	Unsure

Do you have appointments available outside of school hours, or on weekends?	Yes	No	Unsure
Outreach/Access			
Are there other locations (e.g. a local youth service, school, Youth Justice Office etc.) that would be more suitable for an appointment with a young person?	Yes	No	Unsure
Are there barriers to accessing the service for people with disabilities?	Yes	No	Unsure
Are there barriers to accessing the service for young people from Aboriginal and Torres Strait Islander backgrounds?	Yes	No	Unsure
Are there barriers to accessing the service for young people from culturally and linguistically diverse backgrounds?	Yes	No	Unsure
Are there barriers to accessing the service for young people who identify as lesbian, gay, bisexual, transgender?	Yes	No	
Do you have information available in different languages? Can you access an interpreter if required?	Yes	No	Unsure

Is there a complex intake procedure? Or can a young person walk through the door and speak with someone immediately?	Yes	No	Unsure
Do you have a massive waiting list?	Yes	No	Unsure
Does your service support professional development opportunities to enhance accessibility for people from different social or cultural backgrounds?	Yes	No	Unsure
Promotion			
Do you promote the service to other youth agencies?	Yes	No	Unsure
Is there a regular youth network or interagency meeting that you could attend?	Yes	No	Unsure

National and state level resources

NAME	WEBLINK
Alcohol and other Drugs Council of Australia (ADCA) (Home of: *Tips and Tricks for New Players: A guide to becoming familiar with the alcohol and other drug sector*)	www.adca.org.au
Association for Prevention and Harm Reduction Programs Australia (ANEX)	www.anex.org.au
Australian Council of Social Service (ACOSS)	www.acoss.org.au
Australian Drug Information Network (ADIN)	www.adin.com.au
Australian Indigenous Health Info Net	www.healthinfonet.ecu.edu.au
Australian Institute of Health and Welfare (AIHW)	www.aihw.gov.au
Australian National Council on Drugs (ANCD)	www.ancd.org.au
Australian Youth Affairs Coalition	www.ayac.org.au
Drug and Alcohol Nurses of Australasia (DANA)	www.danaonline.org
DrugInfo provided by the Australian Drug Foundation (DrugInfo)	www.druginfo.adf.org.au
National Centre for Education and Training on Addiction (NCETA)	www.nceta.flinders.edu.au
National Drug and Alcohol Research Centre (NDARC)	www.ndarc.med.unsw.edu.au
National Drug Research Institute (NDRI)	www.ndri.curtin.edu.au
National Drug Strategy (NDS)	www.nationaldrugstrategy.gov.au
National Health and Medical Research Council (NHMRC)	www.nhmrc.gov.au
National Indigenous Drug and Alcohol Committee (NIDAC)	www.nidac.org.au

NAME	WEBLINK
Queensland Alcohol and Drug Research and Education Centre	www.uq.edu.au/qadrec
Turning Point Alcohol and Drug Centre, Victoria (Turning Point)	www.turningpoint.org.au
Youth Affairs Network of Queensland	www.yanq.org.au

Print resources

NAME OF PROVIDER	RESOURCES	AVAILABLE FROM
Alcohol and Drug Information Service (ADIS)	Stock a wide range of print resources.	Phone 1800 177 833 to request their latest order form.
Australian Drug Foundation Book Shop	Publish and supply a range of alcohol and other drug print resources, DVDs, posters and books.	http://bookshop.adf.org.au
National Cannabis Prevention and Information Centre (NCPIC)	Have developed a number of print resources around cannabis use.	http://ncpic.org.au/
National Drug and Alcohol Research Centre (NDARC)	Have developed a number of print resources which can be provided to clients.	http://ndarc.med.unsw.edu.au/resources
Orygen Youth Health	Resources dealing with youth mental health issues.	http://oyh.org.au
Queensland Government Bookshop	Stock all Queensland Government print resources.	www.bookshop.qld.gov.au
Turning Point	Publish a range of print resources for purchase, including information for clients, as well as treatment manuals.	http://www.turningpoint.org.au/Media-Centre/TP-Catalogue.aspx

Severity of Depdence Scale

OVER THE LAST 3 MONTHS:

1. Did you ever think your use of the substance was out of control?

Never or almost never	0
Sometimes	1
Often	2
Always or nearly always	3

2. Did the prospect of missing using make you very anxious or worried?

Never or almost never	0
Sometimes	1
Often	2
Always or nearly always	3

3. Did you worry about your use?

Not at all	0
A little	1
Quite a lot	2
A great deal	3

4. Did you wish you could stop?

Never or almost never	0
Sometimes	1
Often	2
Always or nearly always	3

5. How difficult would you find it to stop or go without?

Not difficult	0
Quite difficult	1
Very difficult	2
Impossible	3

"The Severity of Dependence Scale (SDS) is designed to be administered by either the worker or the client. Each item is scored from 0-3 and is focused on the client's experience of the past three months. Add up the scores of the five items to get a total. The higher the score, the higher the level of dependence."

sds score /15

Please note: there are two cut-off scores: one for adults; SDS score of 3. And the other for adolescents; SDS score of 4.

Gossop M, Darke S, Griffiths P, Hando J., Powis B., Hall W, Strang J (1995). The Severity of Dependence Scale (SDS): psychometric properties of the SDS in English and Australian samples of heroin, cocaine and amphetamine users. Addiction, 90(5):607-14.

Martin, G., Copeland, J., Gates, P., Gilmour, S. (2006) "The Severity of Dependence Scale (SDS) in an adolescent population of cannabis users: reliability, validity and diagnostic cut-off" in Drug and Alcohol Dependence, Jun 9; 83(1) pp90-93

DSM-IV Dependence

The Diagnostic and Statistical Manual of Mental Disorders, 4th Edition, describes substance dependence as "A maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by three (or more) of the following, occurring at any time in the same 12-month period:"

Tolerance

In terms of your recent drug use, do you find that now you need to use much larger amounts of the drug than you used to, to get intoxicated or to get the effects you want?

Withdrawal syndrome

In the past 12 months, have you experienced withdrawal symptoms when you do not use or take less of the drug?

Drugs used in larger amount or for longer periods than was intended

Have you used the drug in larger amounts, or for a longer time than you had intended?

Persistent desire or unsuccessful attempts to reduce or control drug use

In the past 12 months, have you had a sustained desire to cut down or control your drug use?

Great deal of time spent obtaining, using and recovering from the use of drugs

In the last 12 months, have you spent a lot of your time on activities necessary to get the drug, using the drug or recovering from the effects of the drug?

Important social, occupational or recreational activities are reduced because of drug use

In the past 12 months, have you had to give up or reduce important social, work or leisure activities because of your drug use?

Drug use is continued despite knowledge that it causes or exacerbates physical or psychological problems

In the past 12 months, have you continued using the drug even though you knew that you had an ongoing physical or psychological problem that's likely to have been caused or made worse by your drug use?

Total Score

Queensland Government (2005) AOD Clinical Assessment Version 2, Brisbane: Queensland Health

American Psychiatric Association (2000) Diagnostic and Statistical Manual of Mental Disorders, 4th ed., Text Revision (DSM-IV-TR). Washington, DC: American Psychiatric Association, 2000.

Substances and Choices Scale

Name .....

Date of birth .....

The SACS is only to be used by health professionals working with young people who are engaged in a treatment agency.

The questions in part A) and B) are about your use of alcohol and drugs over the last month. This does not include tobacco or prescribed medicine. Please answer every question as best you can, even if you are not certain. Tick only one box on each row.

Date completed..... Clinician .....

Notes .....

.....

.....

.....

A) How often did you use each of the following in the last month?	Didn't Use	Once a week or less	More than once a week	Most days or more
1. Alcoholic drinks (e.g. beer, wine, spirits, premixes)				
2. Cannabis (e.g. weed, marijuana)				
3. Ecstasy and other party pills (e.g. 'E', mephedrone, BZP)				
4. Hallucinogens (e.g. LSD, acid, mushrooms, ketamine)				
5. Inhalants (e.g. glue, petrol, solvents, paint, nitrous)				
6. Amphetamines (e.g. speed, crystal, ice, base)				
7. Sedatives (e.g. sleeping pills, benzos, downers, valium)				
8. Synthetic cannabinoids (smokable 'herbal highs')				

A) How often did you use each of the following in the last month?	Didn't Use	Once a week or less	More than once a week	Most days or more
9. Opiates (e.g. heroin, morphine, methadone, codeine)				
10. Cocaine (e.g. coke, crack, blow)				
11. Other drug:				
12. Other drug:				
B) Mark one box (on each row), on the basis of how things have been for you over the last month.		Not true	Somewhat true	Certainly true
1. I took alcohol or drugs when I was alone.				
2. I've thought I might be hooked or addicted to alcohol or drugs.				
3. Most of my free time has been spent getting hold of, taking, or recovering from alcohol or drugs.				
4. I've wanted to cut down on the amount of alcohol and drugs that I am using.				
5. My alcohol and drug use has stopped me getting important things done.				
6. My alcohol or drug use has led to arguments with the people I live with (family, flatmates or caregivers etc.).				
7. I've had unsafe sex or an unwanted sexual experience when taking alcohol or drugs.				

B) Mark one box (on each row), on the basis of how things have been for you over the last month.		Not true	Somewhat true	Certainly true
8. My performance or attendance at school (or at work) has been affected by my alcohol or drug use.				
9. I did things that could have got me into serious trouble (stealing, vandalism, violence etc.) when using alcohol or drugs.				
10. I've driven a car while under the influence of alcohol or drugs (or have been driven by someone under the influence).				
TOTAL				
C) Finally, how often have you used tobacco (e.g. cigarettes, cigars) in the last month?	Never	Once a week or less	More than once a week	Most days or more

Date Completed ..... Clinician .....

Notes .....

.....

.....

Christie, G., Marsh, R., Sheridan, J., Wheeler, A., Suaalii-Sauni, T., Black, S., Butler, R. (2007) "The Substances and Choices Scale (SACS) - the development and testing of a new alcohol and other drug screening and outcome measurement instrument for young people." Addiction, Vol 102, Number 9, September 2007, pp1390 - 1389

The Substances and Choices Scale (SACS) is a screening and outcome measurement tool specifically designed to be used with young people aged 13 - 18. For detailed information on scoring and administering SACS go to www.sacsinfo.com

HEEADSSS

Bold = Essential questions

Roman = As time permits

Italics = Optional or when situation requires

Please note: This assessment tool was developed in North America. Many Australian services adapt the language used in this tool in order to ensure it is appropriate for their clients. We encourage anyone using this tool to do the same.

HOME

Who lives with you? Where do you live? Do you have your own room? What are relationships like at home? To whom are you closest at home? To whom can you talk at home? Is there anyone new at home? Has someone left recently? Have you moved recently? Have you ever had to live away from home? (Why?)

Have you ever run away? (Why?) Is there any physical violence at home?

EDUCATION AND EMPLOYMENT

What are your favourite subjects at school? Your least favorite subjects? How are your grades? Any recent changes? Any dramatic changes in the past? Have you changed schools in the past few years? What are your future education/employment plans/goals? Are you working? Where? How much?

Tell me about your friends at school. Is your school a safe place? (Why?) Have you ever had to repeat a class? Have you ever had to repeat a grade? Have you ever been suspended? Expelled? Have you ever considered dropping out? How well do you get along with the people at school? Work? Have your responsibilities at work increased?

Do you feel connected to your school? Do you feel as if you belong? Are there adults at school you feel you could talk to about something important? (Who?)

EATING

What do you like and not like about your body? Have there been any recent changes in your weight? Have you dieted in the last year? How? How often? Have you done anything else to try to manage your weight? How much exercise do you get in an average day? Week? What do you think would be a healthy diet? How does that compare to your current eating patterns?

Do you worry about your weight? How often? Do you eat in front of the TV? Computer? Does it ever seem as though your eating is out of control? Have you ever made yourself throw up on purpose to control your weight? Have you ever taken diet pills?

What would it be like if you gained (lost) 10 pounds?

ACTIVITIES

What do you and your friends do for fun? (With whom, where, and when?) What do you and your family do for fun? (With whom, where, and when?) Do you participate in any sports or other activities? Do you regularly attend a church group, club, or other organized activity?

Do you have any hobbies? Do you read for fun? (What?) How much TV do you watch in a week? How about video games? What music do you like to listen to?

DRUGS

Do any of your friends use tobacco? Alcohol? Other drugs? Does anyone in your family use tobacco? Alcohol? Other drugs? Do you use tobacco? Alcohol? Other drugs? Is there any history of alcohol or drug problems in your family? Does anyone at home use tobacco?

Do you ever drink or use drugs when you're alone? (Assess frequency, intensity, patterns of use or abuse, and how youth obtains or pays for drugs, alcohol, or tobacco)

SEXUALITY

Have you ever been in a romantic relationship? Tell me about the people that you've dated. OR Tell me about your sex life. Have any of your relationships ever been sexual relationships? Are your sexual activities enjoyable? What does the term "safer sex" mean to you?

Are you interested in boys? Girls? Both? Have you ever been forced or pressured into doing something sexual that you didn't want to do? Have you ever been touched sexually in a way that you didn't want?

Have you ever been raped, on a date or any other time? How many sexual partners have you had altogether? Have you ever been pregnant or worried that you may be pregnant? (females) Have you ever gotten someone pregnant or worried that that might have happened? (males) What are you using for birth control? Are you satisfied with your method? Do you use condoms every time you have intercourse? Does anything ever get in the way of always using a condom? Have you ever had a sexually transmitted disease (STD) or worried that you had an STD?

SUICIDE AND DEPRESSION

Do you feel sad or down more than usual? Do you find yourself crying more than usual? Are you "bored" all the time? Are you having trouble getting to sleep? Have you thought a lot about hurting yourself or someone else?

Does it seem that you've lost interest in things that you used to really enjoy? Do you find yourself spending less and less time with friends? Would you rather just be by yourself most of the time? Have you ever tried to kill yourself? Have you ever had to hurt yourself (by cutting yourself, for example) to calm down or feel better? Have you started using alcohol or drugs to help you relax, calm down, or feel better?

SAFETY (SAVAGERY)

Have you ever been seriously injured? (How?) How about anyone else you know? Do you always wear a seatbelt in the car? Have you ever ridden with a driver who was drunk or high? When? How often? Do you use safety equipment for sports and or other physical activities (for example, helmets for biking or skateboarding)? Is there any violence in your home? Does the violence ever get physical? Is there a lot of violence at your school? In your neighborhood? Among your friends? Have you ever been physically or sexually abused? Have you ever been raped, on a date or at any other time? (If not asked previously)

Have you ever been in a car or motorcycle accident? (What happened?) Have you ever been picked on or bullied? Is that still a problem? Have you gotten into physical fights in school or your neighborhood? Are you still getting into fights? Have you ever felt that you had to carry a knife, gun, or other weapon to protect yourself? Do you still feel that way?

Goldenring, J., Rosen, D. (2004) "Getting into adolescent heads: An essential Contemporary Pediatrics January 2004;21:64

Kessler Psychological Distress Scale (K10)

Name .....

Date .....

For all questions, please circle the answer most commonly related to you. Questions 3 and 6 automatically receive a score of one if the proceeding question was "None of the time".

In the past four weeks	None of the time	A little of the time	Some of the time	Most of the time	All of the time
1. About how often did you feel tired out for no good reason?	1	2	3	4	5
2. About how often did you feel nervous?	1	2	3	4	5
3. About how often did you feel so nervous that nothing could calm you down?	1	2	3	4	5
4. About how often did you feel hopeless?	1	2	3	4	5
5. About how often did you feel restless or fidgety?	1	2	3	4	5
6. About how often did you feel so restless you could not sit still?	1	2	3	4	5
7. About how often did you feel depressed?	1	2	3	4	5
8. About how often did you feel that everything is an effort?	1	2	3	4	5
9. About how often did you feel so sad that nothing could cheer you up?	1	2	3	4	5
10. About how often did you feel worthless?	1	2	3	4	5
TOTAL					

Test: Kessler, R.C. (1996). Kessler's 10 Psychological Distress Scale. Harvard Medical School: Boston, MA.

K10 Score	Level of Psychological Distress
10 – 15	Low
16 – 21	Moderate
22 – 29	High
30 - 50	Very High

For detailed information on administering and scoring the K-10 go to: www.abs.gov.au/ausstats/abs@.nsf/mf/4817.0.55.001

DASS21

Name .....

Date .....

Please read each statement and circle a number 0, 1, 2 or 3 which indicates how much the statement applied to you **over the past week**. There are no right or wrong answers. Do not spend too much time on any statement.

The rating scale is as follows:

0 Did not apply to me at all

1 Applied to me to some degree, or some of the time

2 Applied to me to a considerable degree, or a good part of time

3 Applied to me very much, or most of the time

1	I found it hard to wind down	0	1	2	3
2	I was aware of dryness of my mouth	0	1	2	3
3	I couldn't seem to experience any positive feeling at all	0	1	2	3
4	I experienced breathing difficulty (e.g. excessively rapid breathing, breathlessness in the absence of physical exertion)	0	1	2	3
5	I found it difficult to work up the initiative to do things	0	1	2	3
6	I tended to over-react to situations	0	1	2	3
7	I experienced trembling (e.g. in the hands)	0	1	2	3
8	I felt that I was using a lot of nervous energy	0	1	2	3
9	I was worried about situations in which I might panic and make a fool of myself	0	1	2	3
10	I felt that I had nothing to look forward to	0	1	2	3
11	I found myself getting agitated	0	1	2	3
12	I found it difficult to relax	0	1	2	3
13	I felt down-hearted and blue	0	1	2	3

14	I was intolerant of anything that kept me from getting on with what I was doing	0	1	2	3
15	I felt I was close to panic	0	1	2	3
16	I was unable to become enthusiastic about anything	0	1	2	3
17	I felt I wasn't worth much as a person	0	1	2	3
18	I felt that I was rather touchy	0	1	2	3
19	I was aware of the action of my heart in the absence of physical exertion (e.g. sense of heart rate increase, heart missing a beat)	0	1	2	3
20	I felt scared without any good reason	0	1	2	3
21	I felt that life was meaningless	0	1	2	3

www.psy.unsw.edu.au/dass

Please turn over for DASS21 scoring instructions.

DASS21 – SCORING INSTRUCTIONS

PLEASE NOTE: The DASS21 should NOT be used to replace a face to face clinical interview. If you are experiencing significant emotional difficulties you should contact your GP for a referral to a qualified professional.

Depression, Anxiety and Stress Scale - 21 Items (DASS21)

The Depression, Anxiety and Stress Scale - 21 Items (DASS21) is a set of three self-report scales designed to measure the negative emotional states of depression, anxiety and stress.

Each of the three DASS21 scales contains 7 items, divided into subscales with similar content. The Depression Scale assesses dysphoria, hopelessness, devaluation of life, self-deprecation, lack of interest/involvement, anhedonia, and inertia. The Anxiety Scale assesses autonomic arousal, skeletal muscle effects, situational anxiety, and subjective experience of anxious affect. The Stress Scale is sensitive to levels of chronic non-specific arousal. It assesses difficulty relaxing, nervous arousal, and being easily upset/agitated, irritable/over-reactive and impatient. Scores for Depression, Anxiety and Stress are calculated by summing the scores for the relevant items.

The DASS21 is based on a dimensional rather than a categorical conception of psychological disorder. The assumption on which the DASS21 development was based (and which was confirmed by the research data) is that the differences between the depression, the anxiety, and the stress experienced by normal subjects and the clinically disturbed, are essentially differences of degree. The DASS21 therefore has no direct implications for the allocation of patients to discrete diagnostic categories postulated in classificatory systems such as the DSM and ICD.

Recommended cut-off scores for conventional severity labels (normal, moderate, severe) are as follows:

NOTE: Scores obtained on the DASS 21 will need to be multiplied by 2 to calculate the final score.

	Depression	Anxiety	Stress
Normal	0-9	0-7	0-14
Mild	10-13	8-9	15-18
Moderate	14-20	10-14	19-25
Severe	21-27	15-19	26-33
Extremely Severe	28+	20+	37+

Reference: Lovibond, S.H. & Lovibond, P.F. (1995). Manual for the Depression Anxiety Stress Scales. (2nd. Ed.) Sydney: Psychology Foundation.

Where possible avoid jargon and document client's own words.

Appearance

How does the client look?

(Accurately and non-judgementally describe physical appearance. Record age, gender, race/ethnicity, build, hair style and colour, grooming, posture, hygiene, dress, general health and signs of AOD use.)

Behaviour

How does the client behave?

(General behaviour, facial expression, eye contact, body movements and gestures)

How is the client reacting to being in the session?

(Co-operative, angry, hostile, withdrawn, inappropriate, afraid, suspicious, evasive)

Avoid making assumptions so signs of illness can be separated from culturally appropriate behaviours.

Speech and language

How is the client speaking?

What is the rate, volume, tone, quality and quantity?

(Rapid, pressured, slow, loud, whispered, quiet, monotone, stutter, slurring)

How does the client express himself/herself?

(Disorganised, absent, irrelevant or incomplete replies)

Mood and affect (feelings)

Exploring mood can indicate potential risk to self or others.

How does the client describe his/her mood?

(Down, depressed, sad, anxious, angry, irritable, happy, ok, fearful)

What do you observe about the person's emotional state (affect)?

(Flat, restricted, tearful, blunted, agitated, distressed, fearful, irritable, hostile, defensive, elevated)

A person's mood and affect should be consistent and appropriate.

Thought content (thinking)

What is the person thinking about?

(Delusions, suicidality, paranoia, homicidality, sad, anxious)

Does speech flow easily or is it slow and hesitant?

Is the ability to think limited?

Does the conversation stay on track and flow logically?

Is there repetition?

Perception

Is the client experiencing hallucinations or other perceptual disturbances?

Are they likely to act on these perceptions?

Do you observe the client responding to these perceptions?

- Hallucinations are false perceptions in the absence of stimulus.
- Auditory hallucinations 'hearing voices' are the most common form of perceptual disturbance and they seem real to the person experiencing them.

They can be experienced in any of the five senses:

- Sight (visual)
- Smell (olfactory)
- Hearing (auditory)
- Touch (tactile)
- Taste (gustatory).

Explore command hallucinations, where the voices tell the person to act in a particular way.

Cognition

Cognition can be observed during the course of the appointment process. Explore these areas by asking simple direct questions.

Level of consciousness

Is the client alert and oriented to time and place?

Can the client stay focussed during the appointment?

Can the client concentrate on a simple mental task, such as counting backwards or adding numbers?

Does the client present as confused?

Memory

Can the client remember:

- Why he/she is with you? (immediate)
- What he/she did yesterday/last week? (recent)
- What he/she was doing this time last year? (remote)

Orientation

Can the client tell you:

- The day of the week, the date, the month, the year?
- Where he/she is?
- Why he/she is with you now?

Insight and judgement

Insight refers to the client's capacity to recognise his/her own problems and symptoms. Judgement refers to the client's capacity to make sound, reasoned and responsible decisions.

How does the client perceive the 'problem'? What does the client think the solution should be?

Sources of information

Mills, K. L., Deady, M., Proudfoot, H., Sannibale, C., Teesson, M., Mattick, R., Burns, L. *Guidelines on the management of co-occurring alcohol and other drug and mental health conditions in alcohol and other drug treatment settings*. National Drug and Alcohol Research Centre, University of NSW. Australian Government, Department of Health and Ageing.

Developed by the Perth Co-occurring Disorders Capacity Building project, funded by the Australian Government, Department of Health and Ageing through the Improved Services Initiative.

Perth Co-occurring Disorders Capacity Building Project. (Non-Residential) Understanding the Mental State Examination (MSE): a basic training guide. Palmerston Association Inc. 2011.

The Alcohol Use Disorders Identification Test (AUDIT)

AUDIT: Self-Report Version

PATIENT: Because alcohol use can affect your health and can interfere with certain medications and treatments, it is important that we ask some questions about your use of alcohol. Your answers will remain confidential so please be honest. Place an X in one box that best describes your answer to each question.

QUESTIONS	0	1	2	3	4	SCORE
1. How often do you have a drink containing alcohol?	Never	Monthly or less	2 - 4 times a month	2 - 3 times a week	4 or more times a week	
2. How many standard drinks containing alcohol do you have on a typical day when you are drinking?	1 - 2	3 - 4	5 - 6	7 - 9	10 +	
3. How often do you have six or more standard drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	

QUESTIONS	0	1	2	3	4	SCORE
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
8. How often during the last year have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
9. Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, during the last year	
					TOTAL	

Scoring instructions for the AUDIT on following page

Scoring for AUDIT

Questions 1 through 8 are scored 0, 1, 2, 3 or 4.

Questions 9 and 10 are scored 0, 2 or 4 only.

The AUDIT elicits a score of between 0 and 40.

Although a score of 8 or more (some studies suggest a score of 7 for women) indicates hazardous or harmful alcohol consumption, 13 suggests further investigation (clinical examination) is required to assess for possibility of dependence.

It is not a diagnostic, but rather an interpretive and indicative tool. Although the global score itself is useful, also consider the three main areas of questioning to elicit specific information about patterns of use and potential for dependence.

The three main areas assessed are:

Questions 1–3: Quantity and frequency of use

Questions 4–6: Possible dependence on alcohol

Questions 7–10: Alcohol-related problems

A guide to interpretation and intervention

Abstainer	Low risk alcohol use	Risky or harmful alcohol use	Alcohol dependence likely
0 No further intervention necessary	<8 Reinforce safe drinking behaviour	8+ Provide evidence on the consequences of continued risky or harmful alcohol consumption	13+ Provide advice and prescribe pharmacotherapy

Developed and validated by World Health Organization (WHO) 1989

Alcohol and Drug Use History

Substance (List primary drug of concern first)					
Age of first use					
Date last used					
Method of use (IV, smoked, snorted, swallowed)					
Amount used on an average day (Cost? Weights? Standard Drinks?)					
Pattern of use in the past 7 days (frequency, fluctuations, precipitators)					
Pattern of use in past 28 days (frequency, fluctuations, precipitators)					
Duration of use (How long in the current pattern?)					
Longest abstinence? (Any compications? Why resumed?)					
High risk AOD use? (e.g. overdose, poly-drug use, dangerous contexts)					
Family history of use					



Queensland University of Technology

Dovetail

supporting the youth alcohol and drug sector in Queensland