Dovetail
supporting the youth alcohol and drug sector in Queensland

a framework for youth alcohol and other drug practice

youth alcohol and drug good practice guide

Dovetail provides free professional support to any worker or service in Queensland who engages with young people affected by alcohol and drug use. Funded by Queensland Health and delivered by a Consortium of 14 government and non-government agencies, Dovetail seeks to identify a youth alcohol and drug sector, connect its services and workers together, and equip them with evidence-informed knowledge, skills and resources to enhance their practice.

This booklet is one of six Dovetail Good Practice Guides 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. With a dash of help from our friends at YSAS in Victoria, this collective wisdom - grounded in the reality of direct practice with young people - comprises a new evidence-base for the sector. Aimed at practitioners across clinical and community-based contexts, we trust this guide 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.

a framework for youth alcohol and other drug practice

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Introduction

A framework for youth alcohol and other drug (AOD) practice is developed in this first Guide as a way of promoting a coherent and 'joined up' approach to AOD issues faced by young people across Queensland.

Dovetail's vision, developed after consultation with key workers and services across Queensland *(Dovetail service delivery framework 2009),* refers to a sector that is youth centred, and based on principles of:

- youth engagement and participation,
- social justice,
- partnerships and collaboration, and
- inclusion, or the 'no wrong door' approach

Dovetail's vision also emphasises:

- the important role of families and significant others
- the equitable access to flexible services to address the diverse needs of 12-25 year olds, and
- valuing and supporting workers to provide a range of culturally, gender and age appropriate services to meet the diverse needs of young people *(Dovetail service delivery framework 2009).*

The range of approaches required to minimise harm from youth AOD use include:

- supply reduction
- demand reduction, and
- harm reduction.

Focus and contents of this Guide

This Guide outlines a framework for working with young people whose AOD use creates significant vulnerability to current or future harm. A clear message from practitioners and research is that in order to respond to a young person's vulnerability, a broad rather than narrow approach is needed. A broad approach sees various factors and pathways into and out of problematic AOD use by young people.

How can practitioners best respond to young people whose AOD use renders them vulnerable to harm? What considerations, questions and good practices can assist practitioners who find themselves undertaking youth AOD related practice? This Guide is intended as a brief summary, a prompt, and a pathway to what is a complex and dynamic area of practice.

The target audience is practitioners who work with young people who have problematic AOD use and the managers of these practitioners. Areas of content include the elements of a framework for youth AOD practice, an appreciation of the developmental, social and institutional location of young people, key concepts and understandings regarding good youth centred context responsive practice, and key policy constructs and directions.

This Guide draws on a mix of sources: research, practice literature, Dovetail resources and services, practice experience from Queensland youth AOD practitioners, and analysis by the authors.

Section 1

What's in a youth AOD practice framework?

1.1 About frameworks

Why do you need a framework? You're trying to negotiate a complex set of relationships, which means you need to have values, principles and guidelines to inform how you work. This is particularly true in youth work where you often have to be in a reactive mode, responding to crisis. Unless you have a framework, you can just be buffeted around and lose track of where you are going.

- Youth Service Manager

A 'framework' is a way of highlighting key elements of something that is complicated or complex. Another way to understand a framework for practice is to think about what you would explain to a visiting alien if they asked you "what is good youth AOD practice?"

Frameworks make explicit the logic of practice. They need to make the link between the broad contexts of people's lives, a set of needs, and how these should be responded to in practice. They need to be specific and clear enough to provide a foundation and scaffold for practice in a particular type of setting, yet be broad enough to have relevance across the diversity of situations encountered. Frameworks can be held individually by a practitioner, by an agency, and by a sector or field of practice. Frameworks also need to be dynamic, able to develop and change in the light of various forms of evidence and experience over time.

Keep in mind that frameworks are inherently 'reductionist'. That is, they try to make things more simple than they really are. They are a conceptual tool for practice rather than a comprehensive statement of reality.

In Dovetail consultations, youth AOD practitioners indicated they wanted a framework for practice that would provide a common language across a range of settings, from community based youth services to specialist youth AOD services. They also wanted a framework that would support the further development of the sector in Queensland.

1.2 Elements of a youth AOD practice framework

Dovetail identifies 4 essential elements in a framework for working with young people around AOD issues, these being:

- **Appreciating the context / environment** in which interaction with a young person takes place (economic, social, legal, locational, cultural, institutional, organisational, relational). This context, typified by complexity, has broad, situational, and individual aspects to it. How do we understand the context?
- The **conceptualisation of young people** we employ. How do we understand young people and their relationship to family, significant others, education, community and service systems?
- A conceptualisation of **youth AOD practice approaches** including useful practice goals, practice models and elements, and how these are understood to improve the situation of young people. In other words, how do we understand youth AOD practice?
- The **personal perspectives, values and beliefs** about young people and AOD use that each individual practitioner brings to the practice setting. How do we understand ourselves?

These elements are represented in Figure 1 and provide a structure for the rest of this Guide.

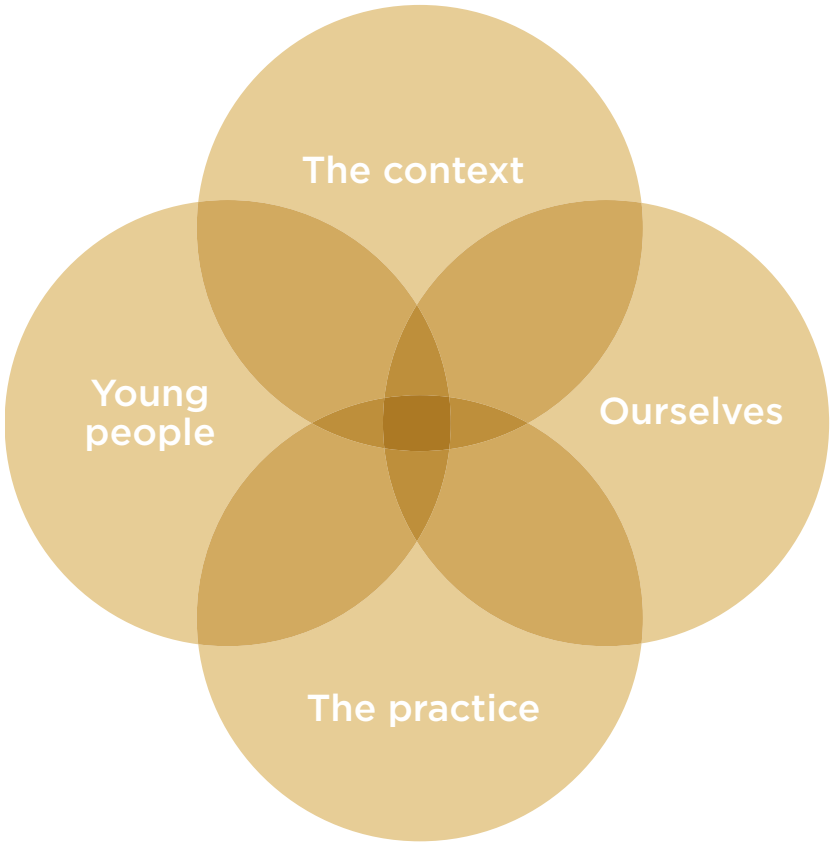

Figure 1: Essential ingredients in a youth AOD practice framework

As this series of Guides was being developed the **overarching theme of appreciating and responding to complexity** became more and more apparent. Problematic AOD use by young people may be a presenting or an accompanying issue but is rarely the only target for intervention. Both research and practitioner experience supports the view that there is usually a constellation of factors contributing to a young person's AOD use. So good practice involves appreciating and responding to this complexity.

Complexity can be found at a number of interacting levels:

- Young people are a heterogeneous population (age, gender and gender identity, ethnicity, race, geographic location etc);
- The complexity of a young person's experience or behaviour, including how the quickly the character of their AOD use may shift and change;
- The multiple and inter-related factors which are associated with AOD use by young people, and whether these cause or are a consequence of their use. For example, AOD use can contribute to a young person becoming homeless, or become an issue as a result of homelessness;
- The complexity of the environment in which a young person lives;
- The complexity of the service system and thus access to relevant and timely support; and
- The complexity within AOD issue construction, policy and practice.

These can all have an impact. Remember something being complex is different from something being complicated! If something is just complicated we can eventually work out how all the components fit together. If something is complex we can never reduce it to a known set of components, so we have to acknowledge and work with the complexity.

1.3 A checklist of questions for practitioners to ask in developing or clarifying their framework for working with young people around AOD issues

The following questions can be used by new or existing practitioners to explain or explore their framework for practice. This can be done as an individual activity, as part of a group process, or as part of a worker's orientation or supervision. The subsequent sections of this Guide will assist you to answer these questions.

Table 1: A checklist of framework questions for practitioners

FRAMEWORK ELEMENT	QUESTIONS
The contexts of youth AOD use	What type or pattern of AOD use is the focus of my practice context? Why do I think young people use AOD? What is the function of AOD use by young people? How do I express 'the problem'? What is my organisation's perspective? What is the perspective of the funding guidelines?
Conceptualisation of young people	What constructions of young people do I generally favour? What "needs" do I think young people have? How would I describe the young people I work with in terms of age, cultural connection, gender and sexual identity, connection to family / education / work? How involved do I think young people should be in deciding what interventions to use?
Practice approaches	What are my goals for practice with young people around AOD use? What do I think 'works'? What discourses do my preferences reflect? What terminology for practice do I prefer and what are the strengths and limitations of this? How does my approach incorporate identified key characteristics of good practice? How pre-determined is my response to young people? (open ... pre-set) Why?

FRAMEWORK ELEMENT	QUESTIONS
Personal values and preferences	How do I feel about people who use AOD? Am I afraid of working with people who use AOD? What am I afraid of? Have I had an AOD problem or habit myself? How has AOD impacted on my life? What values and beliefs do I have about: - legal drugs? - illicit drugs? - people who use particular drugs? What would I do if one of my children had problematic AOD use? How do I link the personal and professional in this area of practice? What do I say if a young person asks me if I have used illicit drugs? What aspects of AOD practice am I comfortable with? Uncomfortable with? e.g., work with families, peers, outreach etc.
Problem solving and keeping my framework fresh	Who can I contact when I feel tentative or want to check something out? What strategies can I use to revisit and refresh my framework for youth AOD practice? What can we do as a service? How can I contribute to the sector?

See 'Drilling Down 1' at the end of this guide for a list of resources that can assist practitioners to develop their youth AOD practice framework. Section 6 also contains a worksheet that can be photocopied and used in this process.

Section 2

Appreciating the context

A youth AOD practice framework requires an understanding of the **context** in which interaction with a young person takes place. This context can be economic, social, legal, locational, cultural, institutional, organisational and relational. It can also include the way problematic AOD use by young people is understood in law, policy and practice and as such has both macro (broad) and micro (situational) aspects to it.

This Guide does not take a moral stance on AOD use itself. Rather than condoning or condemning, it takes a pragmatic and practical approach based on the needs of practitioners faced with responding to problematic AOD use in well founded ways.

2.1 Alcohol and other drug (AOD) use

...in pharmacology [the term "drug" refers] to any chemical agent that alters the biochemical physiological processes of tissues or organisms.

Source: World Health Organization, *Lexicon of alcohol and drug terms*, 1994

Drug use occurs in all societies. Particular forms of drug use are sanctioned, marketed and subsumed into mainstream national identities and everyday cultural practices. Drugs can be legal or illegal (illicit). Drugs can be therapeutic or injurious for us to consume. Negative impacts from a particular drug can result from a single use or build up over a long period of time. It is often the specific nature and form of the drug combined with the context in which it is used that makes its use on any one occasion problematic.

'Drugs' is an evocative term and generally carries a negative set of connotations. Even in generalised uses the term evokes fear and images of 'wasted' individuals and criminality. The moral panic about drug use can and does overlay on the moral panic about young people's successful transition to 'adulthood' … a powerful combination. Myths and misinformation are everywhere, amongst both young people and those who work with them.

Drug types and patterns of use change, sometimes rapidly. This means that the drug related information relied on by practitioners needs to be up to date, and include both valid medical information about drug types and effects, and local information relating to characteristics and patterns of use.

Patterns of AOD use in Australia are part of global trends of licit and illicit trade and consumption, and responses to what is here termed 'problematic' AOD use by young people are heavily influenced by a variety of broad dynamics.

2.2 The 'really broad' context

How social problems are understood and responded to have changed significantly over past decades. In Australia, as in many other countries, ideas and practices broadly described as 'neo-liberal' have underpinned a reconstruction of economic and social relations. For example, many citizenship rights have been reconstructed as consumer rights, welfare support made reciprocal (such as 'work for the dole' schemes) and often linked to education and workforce participation, and 'risky' populations have been engaged in increasingly controlling forms of case management (McDonald 2006).

The question of social change has resonated particularly in the field of youth health and wellbeing because social relations affect the nature and possibilities of personhood - of who we can be - and in this respect changing social relations have a direct impact on young people's subjectivities and on how youth is defined. … Shifts in key social processes (e. g., in the dominant ideas determining the nation's economic management, global processes and market forces) also have a fundamental impact on how health and wellbeing are defined by professionals and managed by governments.

Source: Wyn 2009, 3.

2.2.1 The individualisation of risk

In recent years we have seen a shift in who takes responsibility when 'bad things happen'. Previously we took a collective, society wide approach to difficulties such as unemployment and poor health. Nowadays we are increasingly expected to take individual responsibility for our wellbeing (Furlong and Cartmel 2007), making health choices from a 'marketplace' of options. Citizenship is increasingly accessed through our role as active consumers, rather than as people who have rights (entitlements) to services and benefits. This said, the Australian health system continues to have a mix of universal, targeted, and purchased services.

In respect of AOD use by young people this individualisation of risk can translate into unsympathetic 'blame the person' attitudes and coercive responses. Society commonly views problematic AOD use as a failing of the 'individual'. For example, a young person who uses AOD is often characterised as lazy or lacking in motivation or discipline, needing to constantly escape reality or suffering from some kind of pathology. However this understanding or labelling ignores the broad range of systemic or structural causes that often lead a young person, or indeed groups of young people, to use AOD in problematic ways.

2.2.2 The application of market principles and processes to social programs

Market principles are being applied to the delivery of health and social programs to a much greater extent than they have previously. For example, there is increasing separation of purchasers of services (often government in the AOD area) from providers of services (a mix of government and non-government) through the development of 'quasi-markets'. The use of competitive tendering and contracts has expanded, and the location of responsibility with individual consumers through their exercise of 'choice' is now a prominent feature of how health and human services are delivered. In Australia this has been termed 'new public management' or 'managerialism'. In the public sector this focus on management is evident in an increased attention to 'risk management', output and outcomes based funding models, standards, accountability and 'quality assurance'.

2.2.3 Disadvantage, culture and structural determinants of health

Against a background of ongoing change there are strong continuities in the structural factors that condition young people's life chances, including class, gender, race and geographical location (Wyn 2009).For example, Aboriginal and Torres Strait Islander people generally continue to have poorer health outcomes, and homeless young people experience higher levels of problematic AOD use, both prior to and following homelessness.

The Australian National Council of Drugs (ANCD) asserts that youth drug use must not be seen as an isolated health risk or behaviour type, but instead it is one of a number of risk behaviours that are affected by macro-environmental factors, including socioeconomic gaps, unemployment, social capital, the physical environment and social values and beliefs [and that] the family is a significant mediator of these influences (Spooner, Hall and Lynskey 2001, 26).

Specialist services and expertise are generally concentrated in cities resulting in poorer access for those in regional and remote locations. Furthermore, even these services are not necessarily experienced as friendly by young people or those from diverse cultural backgrounds. The illicit nature and visibility of some people's drug use brings people from disadvantaged backgrounds more readily into contact with criminal justice systems. AOD use by young people is a ground for ejection from the key institution for future life chances, namely education. Intergenerational processes of disadvantage and AOD use can also compound vulnerability for certain young people.

2.2.4 The challenge of responding more effectively to complex social problems

The theme of appreciating and responding to complexity from client through to systemic levels runs through these Guides.

Whilst policy and service systems have generally focused on one or perhaps two issues (as in co-occurring AOD and mental health), people's lived experience of 'problems' is not segmented in the same way. This is particularly true for young people whose AOD use has become problematic.

There is widespread agreement in the Australian and international literature that, more often than not, young people with support needs in one area present with a number of other needs that are multi-layered, interrelated and complex.

Source: Beadle 2009, 22 citing Sawyer 2002; Taylor, Stuttaford and Vostanis 2007; Worral-Davies et al. 2004.

Policy and program structures have been criticised for creating 'silos' which do not adequately respond to the various and interrelated causes of complex problems. 'Wicked' (that is enduring and complex) social problems such as child abuse, homelessness and problematic AOD use, require an integrated, coordinated, and yet context responsive policy and service delivery approach. This is evident across a range of fields in Australia and Queensland. How to achieve this is the subject of ongoing efforts, including the adoption of a 'no wrong door' philosophy in the youth AOD and other fields.

2.3 The policy context

2.3.1 The international context

A social approach to health and health promotion is endorsed internationally, encapsulated in the Ottawa Charter for Health Promotion (World Health Organization 1986).

Health promotion is the process of enabling people to increase control over, and to improve, their health. To reach a state of complete physical, mental and social well-being, an individual or group must be able to identify and to realize aspirations, to satisfy needs, and to change or cope with the environment. Health is, therefore, seen as a resource for everyday life, not the objective of living. Health is a positive concept emphasizing social and personal resources, as well as physical capacities. Therefore, health promotion is not just the responsibility of the health sector, but goes beyond healthy life-styles to well-being.

Source: World Health Organization, 1986.

Broadly there has been a shift away from the notion of addiction to that of drug dependency as the importance of social and cultural factors have been better recognised. There is however concern that individual factors (emphasised in addiction approaches) may still be overemphasised in dependence theory (Keys, Mallett and Rosenthal 2006, 66).

Importantly there is no single agreed clinical definition of when substance dependence is considered to be **severe** (Queensland Parliamentary Health and Disabilities Committee Information Paper December 20, 2011).

The International Statistical Classification of Diseases and Related Health Problems 10th Edition (ICD-10) (World Health Organization 1992) defines substance dependence based on the following criteria:

A definite diagnosis of dependence should usually be made only if three or more of the following have been present together at some time during the previous year:

- *A strong desire or sense of compulsion to take the substance;*
- *Difficulties in controlling substance-taking behaviour in terms of its onset, termination, or levels of use;*
- *A physiological withdrawal state when substance use has ceased or have been reduced, as evidenced by: the characteristic withdrawal syndrome for the substance; or use of the same (or closely related) substance with the intention of relieving or avoiding withdrawal symptoms;*
- *Evidence of tolerance, such that increased doses of the psychoactive substance are required in order to achieve effects originally produced by lower doses (clear examples of this are found in alcohol- and opiate-dependent individuals who may take daily doses sufficient to incapacitate or kill non-tolerant users);*
- *Progressive neglect of alternative pleasures or interests because of psychoactive substance use, increased amount of time necessary to obtain or take the substance or to recover from its effects;*
- *Persisting with substance use despite clear evidence of overtly harmful consequences, such as harm to the liver through excessive drinking, depressive mood states consequent to periods of heavy substance use, or drug-related impairment of cognitive functioning; efforts should be made to determine that the user was actually, or could be expected to be, aware of the nature and extent of the harm.*

Source: World Health Organization, 1992.

The clinically accepted definition of substance dependence in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) (American Psychiatric Association, 2000) is reproduced below.

A maladaptive pattern of substance use, leading to significant impairment or distress, as manifested by three or more of the following in a period of 12 months:

- *tolerance — the need for larger amounts of the substance to achieve the same effect, or markedly diminished effect with continued use of the same amount of the substance*
- *withdrawal — characteristic syndrome present upon cessation of the substance, or the substance is taken to relieve withdrawal symptoms*
- *the substance is taken in larger amounts or over a longer period than was intended*
- *persistent desire or unsuccessful efforts to cut down or control substance use*
- *a great deal of time is spent in activities necessary to obtain or use the substance, or recover from its effects*
- *important social, occupational or recreational activities are given up or reduced because of substance use*
- *continuation of substance use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance.*

Source: American Psychiatric Association, 2000.

It is expected the revised DSM manual (DSM-V) will be released in May 2013 and that this will endorse significant changes regarding the diagnosis of AOD disorders. See www.dsm5.org for updates. It is expected that there will be critical debate in Australia about the application and relevance of the DSM-V in terms of understanding and responding to AOD use.

2.3.2 The national context

A number of policy domains are relevant in the national context. Firstly the most central policy focus regarding young people in Australia and Queensland is their future contribution to national economic productivity. Participation in education, vocational training and work, or 'learning and earning', has become a core goal not only of education and employment policies but in a wide range of other areas. A dependence on families of origin until economic self sufficiency is reached is the preferred policy outcome. Practitioners and services working with young people will often find that social programs and government funding seek participation in, connection to and re-connection with school, employment and/or family as key intervention goals.

Secondly, policies around AOD use are relevant. Australia's first drug strategy, the *National Campaign Against Drug Abuse,* introduced the concept of harm minimisation in 1985 (Single and Rohl 1997). At the time, HIV was emerging as a significant threat to public health and innovative approaches were required to arrest the spread of the virus. The harm minimisation approach allowed for the introduction of needle and syringe programs, peer education programs targeting injecting drug users, and opiate replacement programs like methadone maintenance. These early responses to the threat of HIV were highly successful in containing the spread of the virus; however a narrow definition of harm minimisation excluded a number of otherwise worthwhile programs from the definition. This included prevention programs, abstinence orientated treatment programs, and efforts to reduce the supply of illicit drugs – all of which were within the scope of the existing *National Campaign Against Drug Abuse,* and all of which had the potential to minimise overall harm.

Throughout much of the 1990s, the term **harm minimisation** was contested and a consensus based definition proved elusive. Single and Rohl (1997) addressed the issue in their 1997 review of the *National Drug Strategy 1993-1997,* where they sought to clarify the harm minimisation concept. The authors devised a set of principles that lay the foundation for what became the standard definition of harm minimisation in Australian AOD policy.

Based on their review, the *National Drug Strategic Framework 1998-99 to 2002-03* contained the following definition of **harm minimisation**, which remains in use today:

> *Harm minimisation aims to improve health, social, and economic outcomes for both the community and the individual and encompasses a wide range of integrated approaches including:*
>
> - **Supply Reduction** *strategies designed to disrupt the production and supply of illicit drugs;*
> - **Demand Reduction** *strategies designed to prevent the uptake of harmful drug use, including abstinence orientated strategies to reduce use;*
> - **Harm Reduction** *strategies designed to reduce drug-related harm for particular individuals and communities.*
>
> Source: Ministerial Council on Drug Strategy (1998)

Today, there is rarely debate over the semantics of harm minimisation. Whilst there are still occasional controversies about particular programs (for example supervised injecting centres) the policy of harm minimisation is accepted by the majority of Australians, with recent research indicating 68.5% of the population support needle and syringe programs *(2010 National drug strategy household survey report. 2011).* Harm minimisation remains as the foundation of all Australian state and territory AOD strategy documents, including those from Queensland.

The current *National Drug Strategy 2010-2015* (Ministerial Council on Drug Strategy, 2011) focuses on minimising the harm caused by drugs in Australia. There have been a series of National Drug Action Plans which specify priorities, actions and performance indicators to reduce the harm arising from the use of both licit and illicit drugs. Roles of the Australian government in addressing AOD misuse include:

- National policy, research and development
- Funding of Indigenous AOD treatment services
- Funding the states and territories to provide specific AOD services in line with national objectives.

Overall, the AOD service delivery system is moving from one traditionally embedded in moral and legal frameworks, associated with shame and guilt *(No shame, no blame! A worker's guide 2007; Davis 2003)*, to a more comprehensive and integrated system that has the goal of being welcoming, recovery-oriented, trauma-informed and culturally competent (Minkoff and Cline 2006).

2.3.3 The Queensland policy and service context

The national principles and trends mentioned above are reflected in the Queensland Government's *2011-2012 Queensland Drug Action Plan (*Queensland Government 2011). The Queensland Strategy contains a focus on five key areas:

- alcohol-related violence and injury
- smoking and heavy drinking
- reducing harms for families
- tobacco, alcohol and cannabis use among Aboriginal and Torres Strait Islander people
- pharmaceutical and illicit drugs.

The *2011-2012 Queensland Drug Action Plan* can be found at www.health.qld.gov.au/atod

Queensland also has a specific policy statement for service delivery with people who have co-occurring mental health and AOD issues, and this is also available on the Queensland Health website at www.health.qld.gov.au/atod/documents/dual_diagnosis.pdf

Historically, policies and frameworks in the field have not specifically addressed service provision for young people. However, attention has enhanced in recent times leading to increased funding for youth specific AOD services. The main types of services currently involved in youth AOD practice in Queensland are:

- Casework and counselling with an AOD focus.
- Drop in spaces with attached AOD case work
- Group programs, often activity based
- Intensive residential support and withdrawal (detox)
- Residential rehabilitation
- Supported accommodation
- Outreach
- Rest and recovery services for intoxicated young people.

A range of specific treatment and diversion programs are delivered by Queensland Health in partnership with other government agencies, non-government organisations and the private sector, including:

- Alcohol, Tobacco and Other Drug Service (ATODS)
- The Youth Substance Misuse Treatment Program (funded through the *Ice-Breaker Strategy*)
- Dovetail (an element of the Ice-Breaker Strategy)
- Queensland Drug Court Program
- Police Diversion Program
- Illicit Drugs Court Diversion Program
- Queensland Magistrates Early Referral into Treatment Program
- Queensland Indigenous Alcohol Diversion Program
- Dual Diagnosis
- Opioid Treatment Program.

Source: www.health.qld.gov.au/atod/

A range of other services in Queensland play a key role in supporting young people, some of whom experience problematic AOD use. These include other youth health services, Youth Support Coordinators, specialist youth housing and homelessness services, school based youth health nurses, youth services which aim to reconnect young people with education, training and employment, youth legal services, youth justice services, and youth corrections.

Dovetail has developed a model (see Figure 2 below) representing how the youth AOD sector is composed in Queensland. Importantly this model includes both specialist AOD services and a range of other services which play a significant role in the lives of young people who may have problematic AOD use.

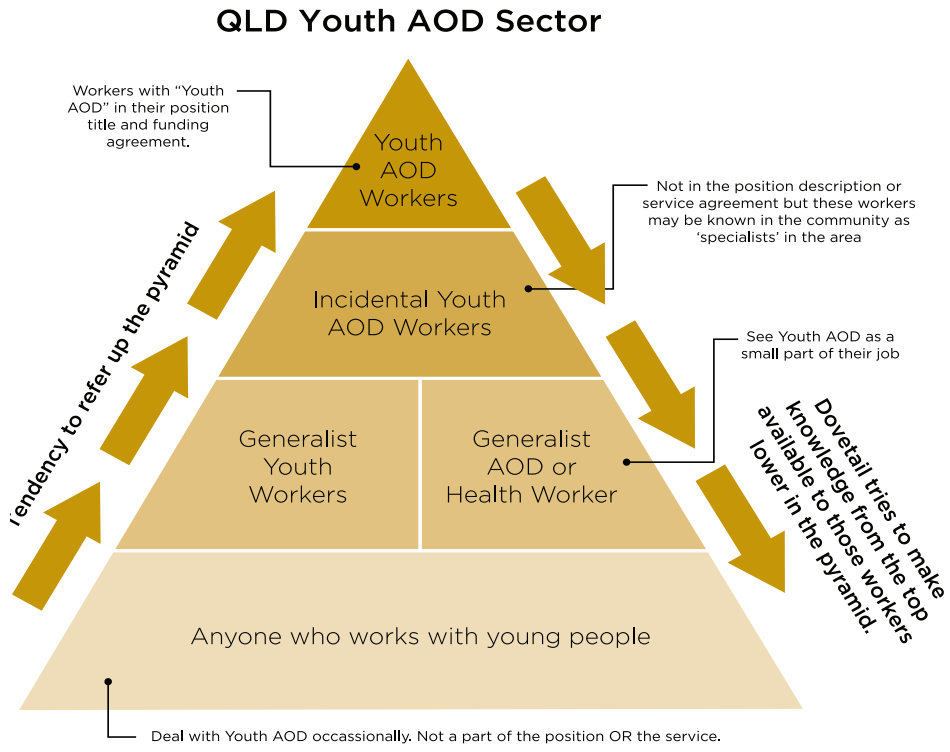

Figure 2: The Queensland youth AOD sector

2.4 Organisational context

Organisations receiving funding have their own policies and procedures which provide an important context for AOD practice. How practice is undertaken in an organisation is influenced by the interplay of the following:

- stated mission, goals and values
- goals and values embedded in how things are actually done
- organisational culture
- location within government, the community sector or private sector
- size of the organisation
- level of influence an AOD service has on resource allocation
- governance structure
- quality assurance, accreditation and accountability requirements
- standing with other agencies and the community it operates in
- professional affiliation of staff
- internal structure
- approach to professional development.

Organisations can have very different goals in terms of youth AOD practice (for example, various interpretations of harm minimisation or abstinence) and very different endorsed practice models (for example residential AOD treatment, non AOD specific case work). This said, the similarities across organisations and their policies are substantial given their obligation to conform to funding program guidelines, externally generated practice standards and quality assurance requirements.

Youth AOD practitioners and managers cite a range of challenges and issues arising from their organisational context which are further explored in the 'Improving Services and Service Systems' Guide in this series.

2.5 Professional, legal and ethical contexts

A framework for good youth AOD practice also needs to promote consideration of legal, ethical and professional requirements and expectations. For example, many of the characteristics of good practice referred to in this Guide have their foundation in these as well as in research. The 'Legal and Ethical Dimensions of Practice' Guide examines these in some detail.

Conceptualisation of young people

A key element of a youth AOD practice framework concerns how young people are defined and understood. This is important because the way we conceptualise young people embodies particular assumptions about what their needs are, and therefore what approaches are most likely to be effective when working with them.

3.1 Chronological age

Governments and administrators have used the simple device of chronological age as a way of defining social, economic and political arrangements across the life span.

Young people are broadly defined as being from 12 to 25 years of age, though particular policies and programs may nominate other age ranges. Whilst convenient for administrative targeting and legal purposes, this approach to age has no inherent coherence in terms of other characteristics of a person. For example, young people of a similar chronological age can be in very different places developmentally and there is no necessary link between the needs of a 12 year old and a 25 year old. Social context, competency, maturity and 'developmental appropriateness' are often more important to practitioners than chronological age.

3.2 Terminology for being 'young'

A range of terms have been used to refer to 'young people'. 'Adolescence' and 'Youth' have often been conceptualised as a 'stage' involving a transition from dependence to independence. However the reality is that people experience many transitions and interdependencies throughout their lives. A life course rather than life stages approach is most appropriate.

'Adolescence' was originally considered a stage of 'storm and stress' and continuing misconceptions exist that it is typified by emotional upheaval and conflict. There is little empirical support for this. For example, most young people get on well with their parents and see family as an important source of support. The term 'adolescence' continues to be used in health sciences, emphasising psychological and social development commencing with puberty. Call someone an 'adolescent' and they may interpret this as implying that they are in some way deficient.

There is broad agreement that 'youth' is a socially constructed concept (Sercombe et al. 2002). The noun 'youth' generally has a gendered (male) and negative (up to 'no good') connotation (see Bessant and Hil 1997). When used as an adjective, as in 'youth policy' or 'youth AOD practice', the term is more neutral, implying an age related focus. The term 'teenager', whilst used frequently by the media, is rarely (if ever) used in health and human service discourses. In fact, did you know the term 'teenager' is a marketing invention coined in America during the 1940's to refer to the emergence of young people with spending power? (Savage 2007).

For the purposes of a youth AOD framework the term 'young people' has a better fit with a 'strengths' perspective, as well as with the chronological age range approach used in health and community services.

3.3 A relational perspective

Relationships for young people exist at various levels. They have immediate and personal relationships with family, friends and significant others (micro level), relationships with school and various community organisations and processes (mezzo level), and broader institutional relationships with the labour market, the justice system and the political system (macro level).

Ecological systems theory (Brofenbrenner 1979) provides a theory of human development in which these various levels of our environment are seen as interrelated and where a person's development is bounded by context, culture, and history (Darling 2007). Problematic AOD use is best approached from this ecological perspective.

The demarcation between childhood and youth, which brings to an end the assumed innocence and dependence on family of origin, has both physical (puberty) and institutional (primary school to high school) markers. However the demarcation between 'youth' and adulthood is far less clear. This interface into adulthood has something to do with acquiring responsibilities, but these tend to accumulate rather than come all at once. Due to changes in global economics and labour market demands, young people are staying longer in education and training, and in the family of origin home. At the same time a 'new adulthood' has emerged where young people engage earlier in a range of adult practices, for example sexual experiences, student work (Dwyer and Wyn 2001) and unsupervised social communication.

3.4 A developmental perspective

The relationship young people have to their world is not static but dynamic, shifting in part as a consequence of their enlarging base of experience and capacities. Therefore a multi-faceted developmental frame is necessary to assist practitioners in matching the engagement and intervention process with 'where the young person is at'. The point of appreciating developmental aspects of life is not to label young people as necessarily having certain characteristics in common, but to enable **developmentally responsive practice**. That is, a person centred approach responsive to where a young person is at in their life.

In recent years, research on **brain and cognitive development** has suggested a longer period of time over which cognitive development takes place than was previously thought. In developmental terms we know that young people are more likely to engage in experimentation and exploration, including behaviours that involve risk taking (National Health and Medical Research Council 2011) and novelty seeking (Winters and Aria 2011). At the same time they are increasing their capacity to reflect on themselves (Sebastian, Burnett and Blakemore 2008), attend to information, control their behaviour, read social and emotional cues and improve their cognitive processing speed (Yurgelun-Todd 2007). The most dramatic improvements relate to *'the development of executive functions including abstract thought, organisation, decision making and planning, and response inhibition' (Yurgelun-Todd 2007, 251).*

In contrast with the widely held belief that adolescents feel 'invincible', recent research indicates that young people do understand, and indeed sometimes overestimate, risks to themselves (Reyna & Rivers 2008). Adolescents engage in riskier behaviour than adults (such as drug and alcohol use, unsafe sexual activity, dangerous driving and/or delinquent behaviour) despite understanding the risks involved (Boyer 2006; Steinberg 2005). It appears that adolescents not only consider risks cognitively (by weighing up the potential risks and rewards of a particular act), but socially and/or emotionally (Steinberg 2005). The influence of peers can, for example, heavily impact on young people's risk-taking behaviour (Gatti, Tremblay & Vitaro 2009; Hay, Payne & Chadwick 2004; Steinberg 2005). Importantly, these factors also interact with one another.

Source: Richards (2011, 4).

The **cognitive development** of young people can also affect which **learning styles** they prefer. Strategies which engage young people in sensory and socially rich experiences are often preferred. Experiential activities and processes such as camps, arts and activity based programs, group programs, and communication which utilises imagination and visual- kinaesthetic tools are widely used in practice with young people.

Initial interest in **moral development** and adolescence was influenced by assumptions that young people are morally deficient, and the bulk of research has focused on what influences moral thinking and the socialisation process (Hart and Carlo 2005). Other areas explored include the roots of pro-social behaviour, orientations to civic engagement and the appreciation of rights and responsibilities.

The dynamic interplay among beliefs, norms, and perceptions creates a moral atmosphere that is embedded in one's culture. Thus, there are likely multiple cultures of morality in adolescence. At the level of the individual, understanding the multiple contexts (e.g., home, school, neighbourhood, work) that adolescents navigate and the various agents of influence (e.g., biological, family, peers, media) bring us closer to understanding their complexity. All adolescents must learn to navigate through their own moral cultures in their respective communities. These multiple moral cultures may comprise their family demands, their peer demands, and the demands placed on them by the broader society (e.g., school systems). Each of these cultures presents different cultural norms, beliefs, and norms that impact their moral functioning

Source: Hart and Carlo (2005, 231).

Emotional development increases the ability to:

… identify and understand one's feelings, accurately read and comprehend emotional states in others, manage strong emotions and their expression, regulate one's behaviour, develop empathy for others, and establish and sustain relationships

Source: National Scientific Council on the Developing Child (2004, 1).

Over time, research on adolescent development has shifted to the **social context** in which young people live, and in particular on the consequences of this social ecology for their development (Bessant et al. 1998, 32). The notion of **social development** encompasses young people's dynamic relationships over time to parents, changes in family structures (including the shift from family of origin to family of destination), the place of peers, schools, neighbourhoods, communities, and even the role of strangers in their lives.

We know **personal relationships** are extremely important to young people. They generally want to have positive relationships and connection with their family (as long as this is not abusive) as well as with others significant to them. With the rapid development of communication technologies, the methods used by young people to engage and interact with others is undergoing profound change. These changes in how young people communicate have significant implications for how social development and relationships are understood in youth AOD practice (Rice, Milburn and Monro 2011). For example there is increasing use of online and social media by young people to sustain and develop relationships with peers and families.

Young people's **institutional relationships** to education and work have also undergone profound change. Global shifts in production and technology have translated into a casualised, part-time and low waged labour market for young people, together with longer and mandated engagement in education and training. For many young people, individual level wellbeing is now strongly associated with sustained connection to education or vocational training.

The search for meaning, or **spiritual development,** involves locating ourselves in understandings, processes and sometimes rituals that go beyond our everyday life. These may be structured to various degrees in particular religious groups and practices, or be evident in how someone sees the world and their place in it. This notion of spiritual development can become increasingly important for young people as the grow older and their range of experiences increase.

Some implications of being 'young' for youth AOD practice

- *The young person's brain is more susceptible to some of the harms of various drugs, and may identify and process 'risk' differently from adults*
- *'Change' is a key feature of a young person's life*
- *Learned behaviours can be 'unlearned' in young people more easily than adults*
- *The impacts of childhood trauma (for example, various forms of abuse or loss) is sometimes still very fresh*
- *Abuse or grief and loss may still be occurring or experienced as current.*

Source: *Developing a youth AOD framework: engaging young people who use drugs.* 2011. Dovetail Professional Development Training.

There are substantial generalisations embedded in attempts to tie development with chronological age. With this in mind the following table (Table 2) can assist with considering what might be happening developmentally for a young person and what developmentally responsive practice might need to consider. Do not assume these categorisations apply to all young people or across social contexts.

Table 2: Adolescent development

	EARLY APPROX. 10-13	MIDDLE APPROX. 14-17	LATE APPROX. 17-21
Central Question	"Am I normal?"	"Who am I?" "Where do I belong?"	"Where am I going?"
Developmental Issues	• coming to terms with puberty • struggle for autonomy commences • same sex peer relationships all important • mood swings	• new intellectual powers • new sexual drives • experimentation and risk taking • relationships have self centred quality • need for peer group acceptance • emergence of sexual identity	• independence from parents • realistic body image • acceptance of sexual identity • clear educational and vocational goals, own value system • developing mutually caring and responsible relationships
Main concerns	• anxieties about body shape and changes • comparison with peers	• tensions between family and adolescent over independence • balancing demands of family and peers • prone to fad behaviour and risk taking • strong need for privacy • maintaining ethnic identity while striving to fit in with dominant culture	• self-responsibility • achieving economic independence • deciding on career / vocation options • developing intimate relationships
Cognitive development	• still fairly concrete thinkers • less able to understand subtlety • daydreaming common • difficulty identifying how their immediate behaviour impacts on the future	• able to think more rationally • concerned about individual freedom and rights • able to accept more responsibility for consequences of own behaviour • begins to take on greater responsibility within family as part of cultural identity	• longer attention span • ability to think more abstractly • more able to synthesise information and apply it to themselves • able to think into the future and anticipate consequences of their actions

Source: Chown, et al. 2008

3.5 A vulnerability and resilience perspective

There are a wide range of factors that render some young people more vulnerable to problematic AOD use (often referred to as risk factors), and others which can protect or contribute to 'resilience' (often referred to as protective factors). This frame provides guidance in addressing short term vulnerability (harm reduction) and building longer term resilience. Table 3 (below) outlines various **risk and protective factors** that have emerged as significant in problematic youth AOD use, at individual, situational, institutional and structural levels.

Table 3: Risk and protective factors

SOCIAL FACTORS		
LOCATION	PROTECTIVE FACTORS	RISK FACTORS
School	· regular school attendance · positive relationships with teachers, coaches and peers · participation and achievement in school activities · access to personal, interactional and academic support	· academic challenges · truancy · peer rejection · bullying · suspension and exclusion · perceived irrelevance of school · lack of support for learning needs · ascertained learning difficulties
Family	· nurturing, supportive attachments to family and extended kinship networks · parental supervision and interest in child's growth and development · parent access to relevant resources and support	· family conflict and violence · neglect or abuse · parental rejection · lack of consistent nurturing and supervision · family poverty and isolation · parental offending · drug and alcohol dependencies
Peer	· associating with pro-social peers	· associating with offending peers · participating in anti-social behaviour

Table 3: Continued overleaf

Table 3: Risk and protective factors (Cont)

SOCIAL FACTORS		
LOCATION	PROTECTIVE FACTORS	RISK FACTORS
ENVIRONMENTAL FACTORS		
Community	· stable and affordable housing · access to services · participation in community activities, such as sport and recreation · involvement with supportive adults · income security	· lack of support services · socio-economic disadvantage · discrimination · lack of training or employment · non-participation in sport or social/ recreational clubs and activities · lack of income and housing security
Life events	· avoiding, surviving and recovering from the harm caused by loss and trauma	· death and loss · severe trauma · repeated out-of-home-placements · exiting care · early pregnancy · homelessness
INDIVIDUAL FACTORS		
Individual	· pro-social attitudes · competent social skills · regard for self and others · substance avoidance · self confidence · positive sense of identity and belonging · healthy diet, weight, activity, fitness and mental wellbeing · sexual health	· offending history · poor social skills · low self-esteem · self injury · substance misuse/dependency · anti-social attitudes and behaviour · low self-control · disregard for others · poor physical, mental or sexual health

Source: www.communities.qld.gov.au/resources/communityservices/youth/yari-interim-program-guidelines.pdf (reproduced with permission) Adapted from Homel et al. (1999) and Bruun and Mitchell (2012).

The focus of these Guides is on working with young people where there is a significant level of vulnerability contributed to by their AOD use. That is, with young people whose AOD use causes them social and/or psychological harm. The task of youth AOD services is to engage this population of young people and work with them, their families and communities to **reduce this vulnerability** (not focus on drugs per se) and **build resilience.** There is widespread acknowledgement that people's own **strengths, capacities and resources** (protective factors) should be identified, acknowledged, built on and extended so they become more resilient to the impacts of various risk factors.

At its most basic, resilience describes a person's capacity to face, overcome and even be strengthened by life's adversities (Bruun 2012).

The 'Layers of Vulnerability' model below places various risk factors within increasing layers of vulnerability as the cumulative effect of these risks becomes more intense. No particular risk factor correlates with a level of vulnerability. The purpose of this framework is to appreciate how different types of policies and strategies play a complimentary role in supporting young people. Youth AOD practice referred to in this series of Guides responds to young people with higher levels of vulnerability, that is, in the 3rd and 4th layers of vulnerability in this model.

Figure 3: Vulnerable Youth Framework
Source: Development of a policy framework for Victoria's vulnerable young people (Victorian Government 2008, 12).

This vulnerability model needs to be located with a broad appreciation of **disadvantage, human rights and social justice.** Without this, the effect can be to mask the level of influence that systemic, institutional and cultural barriers often play in producing and sustaining AOD problems which manifest in young people's lives.

The Youth Support and Advocacy Service (YSAS) in Victoria have developed an evidenced based framework for youth AOD treatment founded on understandings about vulnerability and resilience (Bruun and Mitchell 2012; Bruun 2012). For a detailed description of this see the **'Resilience-Based Intervention'** paper written for this Guide by Andrew Bruun in 'Drilling Down 2' at the end of this Guide.

3.6 Stereotyping, adultcentrism and ageism

The stereotyping of young people in the Australian media has been well documented (Bessant and Hil 1997), with common representations of young people as problems, threats, victims, ideal, and more recently as 'at risk'. These constructions can significantly impact on the way social problems are defined and responded to. The same young person being abused in their family of origin home (victim) may be viewed very differently when they walk out the front gate and act out in a public space (problem or threat). These are important concepts if we are to distinguish between deficit and strengths based approaches to practice with young people and the associated principle of providing 'youth friendly' services. The following terms are useful to know:

Table 4: Useful terms

TERM	MEANING
Adultcentrism	Refers to the tendency to view the world from an adult perspective rather than appreciate how children and young people perceive and experience things (Petr 1990). *e.g., "We like it calm around here. No boisterous behaviour."*
Ageism	*Involves using beliefs, attitudes, stereotypes, norms or values to justify age based prejudice and discrimination (Kirkpatrick et al. 1987).* *e.g., "Young people don't have enough experience to help others."*
Age discrimination	A legal term for unlawful discrimination on the basis of age in areas such as employment, and access to goods and services*. *e.g., "I don't want school age young people coming into this service / shop." (This could contravene anti-discrimination requirements for access to goods and services, as long as access to this type of service / shop was not legitimately age restricted)* *For more information see the 'Legal and Ethical Dimensions of Practice' Guide.

3.7 Connecting constructions about young people to policy and service delivery

Continuing a long interest in the connection between the way young people are 'constructed' and the way policy and programs respond, Wyn (2009) suggests 3 clustered conceptions of 'youth'. These conceptions or argued to have a profound effect on the way professionals define problems and what they see as solutions (paraphrased below):

Table 5: Conceptions of young people and responses (amended from Wyn 2009, 12-13*).*

CONCEPTION OF YOUNG PEOPLE	ASSUMPTIONS FOR POLICIES, PROGRAMS AND RESEARCH THAT COME WITH THESE CONCEPTIONS
Phase of bio-psycho-social development **Defined by chronological age** **A deficit state**	• Frame of 'futurity', that is, young people primarily seen and valued in terms of what they will become. That is, they are incomplete at the moment. • Failure to go through developmental stages ('adolescence') will mean failure to transition to adulthood - meaning young people are inherently 'at risk' of engaging in problematic AOD use (some more vulnerable than others). • Professional interventions are aimed to assist young people 'at risk' to become normal / mainstream. This provides rationale for adult defined interventions. • Research tends to focus on constraints that make young people vulnerable, for example brain development.
A socially and culturally constructed phase which is historically and socially specific **A social process defined by social relations**	• The period of 'youth' is shaped by interaction between social context and individual action, so its meaning changes over time and across cultures. • Is a transitional stage, for example that some experimental AOD use is to be expected by young people. • 'Youth' represents both threat to society and hope for future. AOD use by young people often presses this button. • Research explores young people's diverse experiences, and the way institutional practices and professional discourses construct 'youth'.
An outcome of both bio-psycho-social development within individuals and the impact of social conditions and processes on them	• AOD use by young people is seen in a multi-dimensional way where various factors interact in an often complex way. • Young people are seen as having an active role in decision making about their lives and in contributing to society more generally. • Young people have both interpersonal and institutional relationships. • Cross-sectoral collaboration brings benefits to meeting young people's various needs. • Research and practice draw on different disciplines and recognise the complexity in young people's lives.

The third category in Table 5 reflects an emerging consensus that our conception of young people should be informed by different disciplines, and by young people themselves. This is based on an assumption that developmental, social and broad contextual frames are necessary to adequately appreciate the complexity of young people's lives.

Implications for practice to emerge from this conceptualisation of young people include:

- Policies and programs are largely predicated on preparing young people for future economic and social contribution, through an assumed engagement or re-engagement in mainstream processes (family of origin economic and social support, education and work).
- A young person's situation is more usefully assumed to be 'complex' rather than typified by 'risk'. This can help shift the focus from one primarily on deficits and risks, to one which actively appreciates individual and situational strengths and capacities.
- The situations of young people can only be understood by using a combination of individual, relational and systemic lenses.
- Young people are people now, not simply being prepared for the future, and should be respected as having legitimate views, preferences and relationships.

3.8 Challenges for practitioners

Being aware of the various constructions of young people can be important for responsive practice. Cultural constructions can be more oriented to seeing young people as part of a collective group or identity, or as needing to learn from others (such as elders). Understanding how young people, their significant others and programs and services construct identity and roles, is an important part of practice. This topic is explored in further detail in the 'Working with Families and Significant Others' Guide.

A respectful and multi-faceted frame for conceptualising young people can tension against some specific professional categorisations and practice assumptions, particularly those which do not serve a young person's best interests.

Young people and AOD use

Young people understand that not all substances are lethal ..... (Bonomo and Bowes 2001, 8)

4.1 Why do young people use AOD?

The following text is an extract from the Youth Action and Policy Association's (YAPA) self-paced learning package: Working with young people with alcohol or other drug issues. Well worth a look! This resource can be accessed on the YAPA web site at www.yapa.org.au

Often people see or fear dysfunctional outcomes that occur for some and forget, or do not see, the functional nature of substance use by most young people. That is, young people use substances for many reasons and most do not develop adverse consequences. Like adults, young people do not use substances to feel bad or because they are illegal! The reasons that young people use substances are many and varied and may include, but are not limited to:

- For excitement
- To stay awake / alert
- To get to sleep / dream
- To reduce pain (physical and emotional)
- To hallucinate
- To socialise
- To increase sexual experiences
- To forget
- For FUN

Just think, if we were to interview a number of young people outside a nightclub and ask them why they were using substances such as ecstasy or alcohol, what do you think their responses might be?

The responses at the club would most likely be about using substances to increase the pleasure of the night, to make the music sound better, or to make it easier to socialise. The responses would not generally be that they are using because they were molested or raped, or abused as children. But often these are the reasons proposed for adolescents' substance use. We do not usually make these suppositions about adult substance use.

Why do you think this might be?

Could it be because we do not believe that young people are able to make responsible decisions? That we do not understand that they can and often do enjoy themselves by using their substances of choice in a non-problematic way?

The heightened concern about AOD use by young people poses a challenge for service providers. A recognition of any positive aspects of AOD use can be interpreted by some as tacit encouragement to use, and services and practitioners can feel quite constrained in their capacity to acknowledge the full range of reasons why young people use.

Source: www.yapa.org.au/youthwork/aod/drugsyoungpeople.php (Reproduced with permission)

4.2 Statistics and trends in AOD use by young people

There are various sources of statistics regarding AOD use generally and by young people in particular. The National Drug Sector Information Service (NDSIS) provides links to all major AOD statistics in Australia at www.ndsis.adca.org.au

Interesting isn't it?

Some statistics and trends drawn from the 2010 National Drug Strategy Household Survey

- The proportion of teenagers aged 12–17 years abstaining from alcohol increased in 2010.
- There was a **shift away from pre-mixed spirits.**
- Recent **illicit drug use** (use in the previous 12 months) **rose** from 13.4% of the population aged 14 and over in 2007 to 14.7% in 2010. This was still below the 1995 peak of 16.7%.
- The rise was mainly due to **an increase in cannabis use** (from 9.1% to 10.3%), pharmaceuticals for non-medical purposes (3.7% to 4.2%), cocaine (1.6% to 2.1%) and hallucinogens (0.6% to 1.4%). These drugs were also perceived as being more easily available or accessible in 2010 than in 2007.
- Between 2007 and 2010, recent **ecstasy use declined** from 3.5% to 3.0%. There was no change in the use of meth/amphetamines, heroin (used by 0.2%in the last 12 months), ketamine, GHB (gamma hydroxybutyrate), and inhalants.
- Recent **illicit drug use** was highest in the **20–29 year age group** for both males and females (30.5% and 24.3%, respectively).
- 12–15-year olds and 16–17-year-olds had their **first drug experience** with inhalants at an average age of initiation of 9.7 years and 13.1 years respectively. In comparison, 12–15 year olds and 16–17-year-olds did not start **smoking and drinking**, on average, until they were 13.1 and about 14.6, respectively (p.31);
- or 18–19-year-olds, the **earliest drug experience** was with painkillers/analgesics (14.5 years on average), a year before they started smoking and drinking (p.31).
- **cannabis was the drug most often used in addition to other illicit drugs,** with proportions ranging from 31.5% of pharmaceuticals users to 90.0% of hallucinogen users also reporting using cannabis in the previous 12 months
- **users of pharmaceuticals and cannabis were the least likely to be using other illicit drugs** in the same 12-month period; the drugs most likely to be used concurrently by these groups were ecstasy and cocaine for cannabis users (21.6% and 14.9%, respectively), and cannabis and ecstasy for pharmaceuticals users (31.5%and 16.3%, respectively)
- for both males and females, **the proportion of the population who had recently used any illicit drug fell** over the period 1998 to 2007 and slightly rose again in 2010 (p.117)
- for most age groups, **males were more likely than females to have recently used an illicit drug, except among 14–17-year-olds** (15.7% for females compared with 13.3% for males) (p.117).

Source: *2010 National Drug Strategy Household Survey* accessed at ndsis.adca.org.au/drug_statistics.php

4.3 Patterns of AOD use

Various patterns of AOD use have been identified. The following table summarises these.

Table 6: Types of drug use

TYPE OF DRUG USE	CHARACTER
Controlled	Level of use avoids intoxication or dangerous use.
Experimental	Single or short term use where there is curiosity to experience something new.
Social / Recreational	Controlled use that takes place in specific social situations by people who have knowledge about what drug suits them and in what circumstances.
Circumstantial / Situational	Drug use occurs for a purpose such as when a specific task is undertaken and particular attributes are sought such as alertness, calm, endurance or pain relief.
Intensive	Similar to circumstantial / situational use but typified by regular, usually daily use, often related to gaining relief or achieving high performance.
Dependent	Persistent and frequent high doses where the user cannot stop without experiencing significant distress. Can be psychological and/or physical.

Source: Addy, Ritter, Lang, Swan and Engelander (2000, 8).

Young people may move to more or less intensive AOD use for a range of reasons (Addy et al. 2000). Not all these types of drug use are problematic as defined earlier, yet any type of use can have problematic aspects for a particular young person. In terms of becoming involved in treatment, intensive and/or dependent use is usually involved.

4.4 So what is fact and what is fiction?

The following information is sourced from the Australian Drug Foundation (2011) "The facts about young people and drugs" accessed at www.druginfo.adf.org.au/information-for/the-facts-about-young-people-and-drugs#myths

Table 7: Myths and realities about young people and drugs

MYTH	REALITY
Most young people use illegal drugs.	The opposite is true. Most young people have never even tried illegal drugs, let alone use them on a regular basis.
You can become addicted to some drugs after taking them once.	No drug is instantly addictive. However, over time people can become dependent on (addicted to) drugs.
All drug use by young people will lead to problems later as an adult.	While there are very real risks associated with drug use, most young people who experiment with drugs will not go on to develop major problems in adulthood.
Drinking alcohol is a rite of passage and is safer than taking other drugs.	Although widely perceived as safe and acceptable, drinking alcohol is a risky activity that leads to many more deaths and hospital admissions than illegal drugs.
You can sober up after drinking alcohol by exercising, taking a cold shower, eating mints, drinking coffee or milk, or vomiting.	A person will only sober up when the alcohol has been naturally processed and removed from the body. It takes about one hour to remove just under one standard drink from the body. There are no tricks that will speed up the process.
Prescription drugs are safe.	All drugs, even prescribed and over-the-counter medicines, have side effects that can affect a person's health if they are not used correctly. It is important to always follow the instructions of your doctor or pharmacist.
Cannabis is much stronger today than it was in the 1970s.	Although the cannabis that is used today may be slightly more potent than what was used 30 years ago, there is no evidence to suggest that cannabis potency has increased markedly, as has been suggested by some commentators.
Inhalant use is only a problem in Aboriginal communities.	This perception is possibly due to media attention given to petrol sniffing in isolated Aboriginal communities. In reality, inhalants are used by a wide range of people.
Ecstasy will kill you.	Deaths from ecstasy are relatively rare; however, there are no checks on the ingredients and no "safe" levels of consumption.
LSD can come as a temporary tattoo or transfer that is placed on the skin.	This is not true. People may be confused because the cartoon characters and images found on blotting paper look like transfers. Absorbing LSD through the skin has very little effect on a person.
Marijuana is healthier than cigarettes because it's natural.	Marijuana smoke contains tars and carcinogens just like tobacco smoke.

4.5 What is problematic AOD use?

Patterns of AOD use by young people are varied and do not necessarily lead to significant problems. This said, occasionally there can be substantial harm arising from a single episode of AOD use. There are also multiple pathways out of problematic AOD use other than via treatment and professional assistance (Keys, Mallett and Rosenthal 2006, 67 citing a range of studies).

An Australian study by Keys, Mallett and Rosenthal (2006, 73) found that problematic drug use was identified by young homeless people as involving one or more of the following:

- a need for a drug in order to get through the day (dependence)
- drug use dominating daily life at the expense of other activities (drug use dominating)
- unpleasant physical and psychological effects (negative effects).

There are numerous factors associated with problematic drug use among young people, as summarised by the Australian Institute of Health and Welfare report (AIHW 2011) *Young Australians: Their health and wellbeing* in the box below.

Some of these occur before they reach adolescence, such as maternal drug use during pregnancy, early behavioural and emotional problems, and early exposure to drugs (NHMRC 2001). Other factors include peer antisocial behaviour, poor parental control and supervision, drug use among family members, low self-esteem, academic failure, leaving school early, poor connection with family, school and community, and legal and financial problems (Spooner & Hetherington 2005). Substance use can also be associated with a range of mental illnesses, such as depression, anxiety, personality disorders and schizophrenia, with evidence suggesting that people with mental illness are up to 4.5 times as likely to have a substance use disorder than the general population.

Source: Australian Institute of Health and Welfare (AIHW 2011, 100).

Clearly there are various factors associated with problematic AOD use by young people, many of these being a contributor, a response, or both.

4.6 What do young people say about AOD?

In their own words, young people's wellbeing is about having the ability to make decisions and have control over their lives, about being safe and having a positive sense of self. And young people value feeling valued and needed (Wyn, 2009, 103).

4.6.1 Young people generally

Alcohol and drugs are a key concern of Australian young people aged 12-24 along with school and study problems, coping with stress, and body image. The 2011 Mission Australia survey of 45,961 young people aged 11 to 24 years found that:

Nationally, the top three issues of [personal] concern were school or study problems (37.3% of respondents, up from last year's figure of 25.5%), coping with stress (35.4% compared with 27.3% in 2010), and body image (33.1% compared with 31.1% last year). Respondents aged 20 to 24 were more likely to be concerned about coping with stress, body image and depression than the younger respondents. Concerns about family conflict, bullying/emotional abuse, personal safety, drugs, alcohol and suicide decreased with age. Female participants were more likely than males to be concerned about coping with stress and body image, while males were more likely to be concerned about drugs and alcohol than females.

Source: National survey of young Australians, 2011.4.

Table 8 (below) indicates the range of issues of personal concern to young people from Queensland according to age cluster.

Table 8: Issues of personal concern to young people, by age.
Note: Data are aggregated and include items ranked one, two or three by respondents

	11-14 yrs%	15-19 yrs%	20-24 yrs%
School or study problems	34.7	42.8	17.9
Body Image	34.0	35.6	48.6
Coping with stress	26.6	41.1	57.1
Family conflict	30.2	29.9	15.7
Bullying / emotional issues	27.7	17.9	13.6
Personal safety	21.3	15.7	12.1
Depression	14.8	19.9	39.3
The environment	18.2	15.1	13.6
Drugs	18.8	13.1	8.6
Alcohol	14.0	14.2	9.3

	11-14 yrs%	15-19 yrs%	20-24 yrs%
Suicide	10.6	8.2	7.9
Physical / sexual abuse	9.9	7.4	6.4
Discrimination	6.7	9.0	14.3
Sexuality	6.3	8.0	7.1
Self harm	6.8	6.4	5.7

Source: *National survey of young Australians 2011*, Queensland report 2012, 77.

Aboriginal young people, particularly those 15-19 years, were more likely to be concerned about AOD than non-Aboriginal young people (*National survey of young Australians 2011 report [Aboriginal*]).

When asked whether or not they had somewhere to go for advice and support about their number one issue of concern, one in five young people indicated that they did not have anywhere to go. **Friends, parents and relatives / family friends** are the three main sources of advice or support for young people across various issues of concern, including AOD issues.

Table 9: Where young people turn for advice and support when their main issue of concern is alcohol or drugs (Australia wide)

Where young people turn for advice and support on their main issue of concern	Alcohol	Drugs
Community Agencies	13.1	8.9
Friend/s	78.1	76.2
Internet	17.4	16.4
Magazines	6.3	3.9
Parent/s	70.8	75.3
Relative/Family Friend	47.4	49.8
School counsellor	15.7	19.9
Someone else in your community	8.7	9.3
Teacher	14.7	16.3
Telephone Helpline	4.3	4.9

Source: Table 14 of the *National survey of young Australians 2011*, Executive Summary 2012, 15.

For support around alcohol, Aboriginal young people mostly turned to friend/s' (73%), parent/s (62%), relatives / family friends (48%), community agencies (20%) and school counsellors (18%) (Mission Australia 2012b). Across all young people in Queensland, AOD was the second most commonly listed issue for young people at 31% (National survey of young Australians, 2011. Report (Aboriginal). 2012, 79).

In 2011 The Western Australian Commissioner for Children and Young People surveyed nearly 300 young people aged 14 to 17 years from metropolitan and regional Western Australia to find out their views on what influences their decisions around drinking alcohol and what they believe would be effective strategies in reducing the harms associated with alcohol consumption. Key themes to emerge from these consultations were:

- There is a strong perception among the young people consulted that a culture of excessive alcohol consumption is pervasive in the Australian community. Many young people perceive that the majority of adults drink alcohol and that most would consume more than is considered an acceptable amount even if they don't appear to 'get drunk'.
- Not all young people drink alcohol and those who don't drink want greater recognition from the media, the broader community and other young people.
- Among a significant number of young people there is a culture of drinking with the sole purpose of becoming drunk.
- Many young people themselves are concerned about the impact of alcohol on their lives, particularly when it affects their family life, their enjoyment of social and recreational activities and their feeling of safety in the community.
- Most young people were able to describe a comprehensive list of potential long-term and short-term harms caused by alcohol use including physical, social, financial and legal problems. Of principal concern to young people were harms relating to:
    - violence – mainly, but not exclusively, from strangers
    - damage to their reputation – including the dissemination of gossip and images via social media
    - the impact of drink driving.
- Young people were also very concerned about looking after their friends who were intoxicated, often feeling scared about seeking help due to the prospect of getting in trouble with parents or authorities.
- Family conflict and violence were of serious concern to some young people across all demographic groups.
- A wide range of factors influence young people's decisions about alcohol consumption:
    - Parents were considered a significant influence (both positively and negatively) by more than half the young people who participated in the online survey.
    - Friends were also a significant influence, particularly among 16 to 17 year-olds.

Source: Speaking out about reducing alcohol-related harm on children and young people: The views of Western Australian children and young people (2011) Commissioner for Children and Young People [ccyp.wa.gov.au]

4.6.2 Young people who use AOD services

Understanding the perceptions of young people who use AOD services is an important part of any practice framework. Of particular relevance is the study *"Social Contexts of Substance Use for Vulnerable 13-15 year olds in Melbourne"* (McLean et al. 2009), which investigated the views of young people engaged in AOD treatment services in Victoria. This client perspectives study provides insight into the meaning to young people of their substance use and the context in which it occurs. AOD use was only one of many interlinked problems, including significant substance use within their family of origin. The following summary statements from the study are particularly useful in considering how marginalised young people understand and perceive AOD use and how practitioners might therefore respond.

Young people involved in the 'Vulnerable 13-15 year olds' study ....

.... greatly enjoyed physical sensations associated with substance use. Young people spoke about the sense of calmness or ability to manage anger that came with using cannabis; and the energy, gregariousness and confidence associated with use of alcohol, ecstasy and methamphetamines. Alcohol was strongly linked with having fun. Many used drugs to feel normal, to enhance their personalities and social interactions and to help them get the most out of life (McLean et al. 2009, 54).

While using substances frequently, many young people argued that substance use was not particularly important to them and that their use was neither dependent nor a response to hardship, but rather that they chose to use substances because they enjoyed it. A smaller proportion felt that one or more substances were very important to them (often cannabis, which helped them sleep, feel calm or manage anger) (McLean et al. 2009, 60).

Young people had a variety of views about short and longer term negative impacts

Immediate effects of substance use such as coughing or vomiting concerned participants. Young people also disliked feeling out of control; they regretted, for example, outbursts of anger or violence. Violence was most often a problem identified by young men and related specifically to heavy alcohol use. As with other substance-using cohorts, young people distinguished between drug users and out-of-control 'junkies'. Some resented their reputations being (they believed unjustly) tarnished as drug abusers with limited control over their behaviour. Others found it hard to identify any negative consequences of their substance use. Young people viewed cannabis as particularly functional and unproblematic (McLean et al. 2009, 58).

Young people wanted to be recognised as competent and in control of their lives

Many young people strongly believed they were in control of their own substance use. They saw learning to manage drug use as part of growing up, and control over intoxication as a way to demonstrate maturity. Participants argued strongly that managing alcohol and drug use is an individual responsibility that no-one could or should help them with (McLean et al. 2009, 63) .

Which drugs?

Young people chose different drugs depending on availability, their perceptions of associated harms and how they wanted to feel. Cannabis and alcohol were usually seen as 'everyday' drugs and methamphetamines, ecstasy or speed were identified (by those who used them) as drugs for weekend use or special events (McLean et al. 2009, 65) .

Ambivalent attitudes to intoxication

Attitudes to intoxication were ambivalent. While young people were generally critical of people who failed to use in a controlled way, many also enjoyed telling stories which equated intensive substance use with pleasurable experience. Young people frequently did not see episodic intensive substance use as undermining their sense of self as responsible and in control. They attributed social status to the ability and capacity to drink high volumes of alcohol without getting sick (McLean et al. 2009, 66).

There are numerous implications for practice arising from how young people understand their use of alcohol and other drugs. Appreciating the perspectives of young people is a key element of a youth AOD practice framework.

Section 5

Practice Approaches

This section is relevant for those undertaking specialist youth AOD practice roles right through to practitioners who undertake generalist or other issue focused practice (e.g., youth homelessness) and who wish to develop their literacy in youth AOD practice.

There are various types of responses to problematic AOD use by young people at the population, community and individual levels. Reflecting the earlier outline of AOD policy in Australia and Queensland, a comprehensive approach requires a wide range of harm minimisation strategies, including health promotion and prevention responses. An evidence based analysis of literature identified the following broad categories of intervention as being effective in particular contexts.

Table 10: Broad types of AOD intervention

Regulatory interventions	Law, policies and enforcement to reduce supply and demand (universal)
Developmental prevention interventions	Improving conditions for healthy child and adolescent development (targeted and universal)
Early screening and brief interventions	Brief motivational interventions to reduce high-risk use (targeted)
Treatment	Tertiary prevention of substance use disorders (targeted)
Harm reduction	Reducing harms but not necessarily levels of use (targeted and universal)

Source: Toumbourou, Stockwell, Neighbours, Marlatt, Sturge and Rehm (2007, 1394).

The focus of this Guide is on **direct practice** with young people who have problematic AOD use. Early screening and brief interventions, treatment and harm reduction interventions are all relevant to this focus.

As indicated previously, AOD use by a young person may not be problematic, and when it is, the young people themselves may not necessarily see it as being an issue. The implication of this is that direct practice around problematic AOD use can **range from being a bi-product to an intervention about another issue** (eg homelessness, family conflict, youth justice involvement) **to being the main and explicit focus** (eg AOD counselling, detox). In our consultations, practitioners across Queensland also spoke of the importance of **early intervention** with young people who were pre-contemplators as a pathway to being able to provide assistance.

5.1 The Queensland youth AOD sector's vision

The Queensland youth AOD sector's vision was developed by Dovetail following consultation with approximately 70 key informants across a range of frontline services. This vision comprises ten values and principles considered core to good youth AOD practice.

Young person centred
A holistic approach which is centred on the needs of the young person is fundamental to effective AOD service delivery.

Youth participation
Young people's meaningful participation in the services and systems that affect their lives is essential.

Social Justice
The rights of young people are paramount. Activities that reduce barriers and expand choice for all people are prioritised, with particular regard for the most high-risk, vulnerable and disadvantaged young people in Queensland.

Partnerships and collaboration
Strengthening and supporting existing service delivery and partnerships is essential in meeting the current and future needs of young people.

Relationships
The role and involvement of family and significant others is considered and supported in working with young people.

Flexibility
Service policies are flexible and are not overridden by selective or prescriptive criteria which potentially restrict young people's access to a diverse range of service responses.

Access to Services
A range of culturally, gender and age appropriate alcohol and drug services are available to meet the particular and diverse needs of young people aged 12-25 in Queensland.

Inclusion (No wrong door)
Service systems should be inclusive and not discriminate on the basis of gender, sexual identity, race, culture, or ability.

Harm Minimisation
A range of approaches are required to reduce the harm from alcohol and drug use, including supply reduction, demand reduction and harm reduction strategies.

Valued & Supported
Workers are valued and supported in all areas of their practice.

5.2 Practice frameworks

Developing a robust practice framework requires workers and services to not only have a way of explaining their goals, practice values and intervention approaches, but a capacity to critically engage and communicate about these with clients, other workers and other service sectors.

Four characteristics central to this capacity to identify and discuss AOD practice are:

- Having an outcomes orientation
- Appreciating how different discourses view AOD use and responses
- Appreciating various terminologies for practice
- Seeking well founded practice (informed by relevant evidence and understandings).

5.2.1 Having an outcomes orientation

There is increasing recognition that a focus on client outcomes and goals should underpin the clinical process, rather than a focus on delivering a particular type of intervention (Miller, Duncan and Hubble 2004). Miller et al. conclude that identification, organisation and systemisation of specific therapeutic strategies and processes have not led to improved outcomes for clients (ibid. p.4). They talk of the need for an eclecticism which results from paying attention, within a therapeutic alliance, to the diverse preferences and needs of clients, utilisation of whatever means are at their disposal, guided by a focus on the outcomes that clients seek, rather than the techniques, processes and modes of treatment. The strong regard for an informed eclecticism where young people inform the intervention process, underpinned by a trans-theoretical approach, is consistent with this orientation.

Having an outcomes focus is one thing, but which outcomes and whose outcomes are prioritised? As previously mentioned, minimising harm is central to both Australian and Queensland AOD policy. At a deeper level however, it is important for practitioners to distinguish between the different types and priority of goals for the young person, their parents, referring agencies, other workers and their service overall. Sometimes the degree of alignment or tension between the goals various parties have is not stated or obvious.

It is also important to appreciate that there is increasing evidence that reduction in AOD use by young people who have high levels of vulnerability, such as homeless young people, is often associated with **improvements in their relationships** with family and / or with supportive partners and **improvements in both relationships and the stability of accommodation** (Keys et al. 2006, 90). **Where relevant and possible these should be incorporated into the goals of intervention.**

How goals and outcomes are understood by young people, practitioners and others involved in the practice context is important to establish and revisit. Different people and agencies might have quite different (or even opposing) views of these! The following scenario provides an example.

A referring agency phones a youth AOD service to follow up about a client. They ask, "How is Johnny going?" The worker asks themselves, "What does this question mean? Do they want to know …"

- Is he turning up?
- Is he actively engaging in the counselling process?
- Is he feeling happier in himself?
- Is he reducing his AOD use?
- Have risks of harm been reduced?
- Have protective factors relevant to his wellbeing and AOD use been enhanced?
- Is he complying with our expectations?
- Has he got stable housing yet?

The worker knows that Johnny has not stopped using. In fact his level of use has not changed. However he now has stable accommodation, regularly attends the needle and syringe program, and uses more safely.

As this example illustrates, the goals of youth AOD practice can be variously understood as:

- Enabling young people to cease or reduce their substance use (LEVEL OF USE)
- Reducing the harm associated with substance use (SHORT AND LONG TERM IMPACT)
- Longer term behaviour change that reduces a young person's vulnerability (LEVEL OF VULNERABILITY)
- Improved wellbeing / resilience (SUSTAINABILITY)
- Increasing the choices and options young people have in their lives (CHOICE)
- Increasing young people's own sense of wellbeing and happiness (SUBJECTIVE WELLBEING)

The priority of these practice goals is invariably linked to both the functional reasons why a young person might use certain substances on one side, and the knowledge, skill and value base of the practitioner on the other.

The following table (Table 11) canvasses some of the ways that young people might express their goals.

Table 11: How young people might express their goals

WHAT IS THE GOAL OF THE YOUNG PERSON IN SEEKING TREATMENT OR SUPPORT FROM A WORKER OR SERVICE?	YES / NO / A BIT
I want to cut down.	
I've been using for a bit and have started to notice some negative effects, so I want some help and support.	
My life is going off-track because of my AOD use. I need some help.	
Every time I have a fight with my parents / partner / at work, I just spin out of control.	
I've started using alcohol and/or drugs, I don't know much about them or their effects and I want to learn more.	
My friends / parents / carers / others have said that I should go and see someone about my AOD use, so I'm going to give it a try just in case.	
Unless I see someone, I'm going to get into big trouble with my parents / my girlfriend / my boyfriend / my teachers / my school / my worker / my employer etc.	
I want to keep using alcohol and/or drugs but I also want to make sure I don't get a problem.	
I want to be happier. I don't want to feel like ...	
Or, in the young person's own words, "I want to .... "	

Conversely, the goal/s of the worker may range from supporting the young person very generally around a wide range of issues, to goals that focus very specifically around AOD use only. Furthermore the worker's goals will reflect their own values, beliefs and personal experiences of AOD use generally, and their view of the young person's use, in the particular context. These goals can also be significantly influenced by the model of service, the organisational purpose / mission, available resources and the worker's overall practice framework.

Table 12: How workers might express their goals

WHAT IS THE GOAL OF YOU, THE WORKER, IN PROVIDING TREATMENT OR SUPPORT TO A YOUNG PERSON?	YES / NO / A BIT
It is my job to establish a safe, trusting relationship and space with a young person for them to talk about or do whatever it is that is important to them.	
My goal is to increase the amount of options and choices for this young person's life generally.	
My goal is to help a young person establish goals for themselves, and then we work together to achieve them.	
My goal is to help this young person take control of their AOD use.	
My goal is to reduce the risks of harm associated with AOD use.	
My goal is to help this young person reduce their AOD use.	
My goal is for this young person to stop their AOD use altogether.	
My goal is to purely to increase the knowledge and skill of the young person in relation to AOD use.	

5.2.2 Appreciating how different discourses view AOD use and responses

Health and social welfare are shaped by various discourses. An appreciation of these can help workers identify and discuss how they conceptualise the needs of young people, the goals of practice, and what interventions are preferred.

Discourses are the particular ways of seeing the world and prioritising what is important.

They are evident in the knowledge, arguments, language, values and practices that we use to understand and explain things. A number of broad and service delivery oriented discourses condition the youth AOD programs operate (drawing on Healy 2005 and Ife 1998). Some of these are:

- Biomedical
- Neoclassical economic
- Legal
- Managerial
- Professional
- Psychological sciences
- Sociological
- Consumer rights
- Religious and spiritual.

Within a particular discourse there are often competing perspectives. Frameworks for practice inevitably include ideas and assumptions drawn from a number of these. Even choosing what we research (and how we go about it) is underpinned by ideas and assumptions drawn from particular ways of viewing the world. Being able to identify the different discourses evident in a particular setting or framework can **help services and practitioners critically discuss and develop their frameworks.** Some points of focus evident in various discourses are depicted in the following figure (Figure 4).

Figure 4: Discourses present in youth health policy and practice

Frameworks for youth AOD practice necessarily draw on various discourses and perspectives within them, with particular services and practitioners mixing these somewhat differently depending on their professional training and identity, accepted norms in a particular practice field, client characteristics, agency setting, community setting and personal world views.

When people talk about 'holistic' practice they usually mean combining various elements drawn from more than one discourse. For example, bio-psychosocial approaches in youth AOD practice represent a combination of elements drawn from biomedical, psychological and social ways of seeing the world.

What discourses are most evident in your specific field, service, or personal understandings of practice

5.2.3 Appreciating various terminologies for practice

There are various terms used across agencies, disciplines and practitioners to describe aspects of practice. Often these differences in terms reflect different discourses. Sometimes they just reflect the preferences of a particular practice location. The following table (not be taken too seriously) gives some tentative examples. Keep in mind the same term can be interpreted differently across these. The cultural context can also influence the language used to describe practice. For example the term 'yarning' is commonly used to describe community discussion, collaboration and consultation in Aboriginal communities. To build capacity across agencies and practitioners involved in youth AOD work it is important to understand and appreciate these various terminologies and consider how we communicate with young people.

Table 13: Bridging the language divide

PRACTICE FOCUS	HEALTH TERMINOLOGY	HUMAN SERVICES TERMINOLOGY	TO A YOUNG PERSON
Worker - client	Therapeutic alliance: 'quality treatment relationship based on mutual respect' (Qld Health 2008)	Casework relationship. Purposeful relationship typified by trust	Is this a service and worker I am comfortable to work with?
Understanding the situation of an individual	Diagnosis / Assessment	Assessment Understanding	What problem/s? What issue/s? What is going on?
Planning	Treatment plan Case plan	Case plan	What might help? What will we try? Where to from here?
Practitioner role	Therapist Clinician Professional role (e.g., psychologist, social worker)	Support worker Youth worker Case manager	Someone in a role that can help. The terminology is not as important as what they can do.
Practice response/s	Treatment Therapy Clinical	Intervention Case work 'Working with'	What approach/es are we taking? What am I doing?

What language is used in your service context and what are the strengths and limitations of this?

Where broadly is your practice located? What about your agency's practice?

5.2.4 Seeking well founded practice

Practice in complex contexts needs to be well founded. This means being informed by multiple sources and types of theory and evidence. In recent years there has been increased pressure on health and social policies, funding programs and services to indicate the evidence base underpinning their practice.

Terms you might hear for evidence include:

- empirically based treatment or practice
- evidence based practice
- evidence informed practice
- practice based research
- knowledge based practice
- practice wisdom

This Guide takes a broad rather than narrow approach to what constitutes evidence. The term **'well founded'** has been chosen to capture the variety of forms of evidence and understanding that a front line worker will need to draw on in responding to client and system complexity.

Evidence-based treatment and **empirically supported treatment** refer to the use of standardised treatment protocols or discrete practices that have been demonstrated to be clinically effective in randomised trials (Mitchell 2011 citing Garland et al. 2009). These are important sources of knowledge. However if we inform practice only from externally derived scientific research then we will be limited to only that which we have evidence for. Furthermore, theories that are tested in another context can achieve an assumed legitimacy when they may have only partial relevance or be based on assumptions which do not fit with another practice context. Importantly there is clear evidence that the intervention technique used contributes only a small amount to successful AOD intervention outcomes compared to other characteristics of the intervention process (Miller, Duncan and Hubble 2004, 2). Section 5.2.1 of this Guide talks of how a focus on outcomes within a therapeutic alliance has been found to be more influential than use of specific therapeutic techniques.

Evidence-based practice (EBP) considers how the best available research findings relate to the individual practice situation (Gambrill 2003). The *National Drug Strategy 2010–2015* defines evidence-based practice as using approaches which have proven to be effective. Much of the research focus to date in the AOD field has been on the content and techniques of interventions. A broader approach to EBP which values the contribution of practice wisdom and client expectations and values alongside science is now gaining support (Bruun and Mitchell 2012).

The term **evidence-informed practice** is also used *to refer to integrating existing evidence with professional expertise to develop optimal approaches, including new or innovative approaches in a given situation* (Ministerial Council on Drug Strategy 2011, 34).

Practice-based research involves practitioners and agencies studying their own practices and clients, inquiring into issues and questions seen as important (Petr 2009). Action research is often used as a methodology for practice based research, and in Australia has received national recognition as being able to make a contribution to policy and program development (Australian Government 2008).

Knowledge-based practice sees various forms of knowledge as explicitly sought and applied to practice. For example, policy knowledge, organisational knowledge, practitioner knowledge, user knowledge and research knowledge (Coren and Fisher 2006 cited in Petr 2009).

Practice wisdom is *'knowledge that has emerged and evolved primarily on the basis of practical experience'* (Mitchell 2011, 208). The focus of this is often on the 'how' or character of practice, and can be found expressed in a range of places, including qualitative studies of practice and practitioners, client consultations, service evaluations and other accounts of practice from a particular setting.

Recently a **'meta-analysis' approach** has been used to identify key characteristics and elements of effective practice drawing on a wide range of studies and literature sources. This series of Guides draws on a number of these 'meta-analyses' as an evidence base (Mitchell 2011, Gronda 2009, Miller, Duncan and Hubble 2004, Bruun and Mitchell 2012).

The Consensus-Based Clinical Practice Guideline for the Management of Volatile Substance Use in Australia published by the National Health and Research Council (2011) is an example of how the use of various types of evidence, including practice wisdom validated through consensus, can be combined to inform practice (NHMRC 2011, 29).

There is a role for all of these sources and types of evidence in the development of sector, service and practitioner frameworks, an approach that has been termed **intentional eclecticism** (Bruun and Mitchell

2012). A word of caution however. There is a problem with eclecticism when it adds up to no more than a list of poorly connected concepts and strategies! This said, increased efforts to undertake and include a variety of practice based research and context sensitive evaluation is essential given the highly variable and complex contexts in which AOD practice needs to occur.

Regardless of how well a framework for practice is articulated it is essential that **ongoing inquiry** is embedded into the culture and everyday practices of services. At the casework level this manifests as reflective inquiry with the young person or client group. At a service and interagency level it involves ongoing collaborative inquiry (including action research) into effective practice.

5.3 Characteristics of effective youth AOD service delivery

There is widespread support for comprehensive, multi-faceted prevention and treatment approaches which acknowledge complexity (Rickwood et al. 2008). The key characteristics of good youth AOD practice cited below have drawn on various sources, particularly Bruun and Mitchell (2012), Berends, Deveney, Norman, Ritter, Swan, Clemens and Gardiner (2004), and the resources gathered by Dovetail and specialist youth AOD services in Queensland through the process of developing these Guides.

Good youth AOD service delivery is:

- Well founded
- Client centered / socio-culturally relevant
- Holistic
- Focused on improvement and outcomes.

To achieve this, good youth AOD practice is:

- Relationship based
- Situationally responsive
- Developmentally responsive
- Of sufficient duration and intensity
- Well connected to services, supports and resources
- Inquiry oriented.

Good youth AOD service delivery uses **well founded client centred, holistic responses** that are **focused on improving the situation (or outcomes) of the young person**. Practice is not defined or focused simply on the AOD problem, or limited to a specific intervention technique. Rather services engage and start working with the young person to assist with whatever will make a positive difference (which in a particular situation may be relationships, housing, income security and/or something else). Intervention does not have to be AOD focused, but is focused on outcomes that are meaningful to the young person, and which reduce their vulnerability and enhance their resilience to problematic AOD use. Numerous strategies, supports and resources over a period of time are typically involved in this process, and interventions can be at policy, workforce, community, group, family, peer and individual levels.

Within this comprehensive range of intervention options, therapeutic approaches play an important contributing role.

5.4 A framework for therapeutic youth AOD practice

In Australia the most comprehensive work undertaken to develop an integrated framework for therapeutic youth AOD practice has been by the Youth Support and Advocacy Service (YSAS), located in Victoria. YSAS are a participating service in the Dovetail initiative, and have made a unique and substantial contribution through the provision of training and access to resources.

This Guide acknowledges the place of both clinical therapeutic youth AOD practice and practice undertaken in other settings that do not identify as clinical (often community-based). Even though the transtheoretical model and YSAS framework outlined below utilise 'therapeutic' terminology these approaches have utility across a wide range of practice contexts.

5.5 The Transtheoretical Model

The Transtheoretical Model (Prochaska and DiClemente 1984; Prochaska and Velicer 1997) is an individual health behaviour change model which *describes how people either modify problem behaviours or adopt more healthy behaviours* (Bruun and Mitchell 2012, 126).

Change is viewed as a process that unfolds over time rather than an event, and the focus is on the decision making of each individual. The Transtheoretical Model enables practitioners to assess each young person's motivation and readiness to change and informs the formulation of more meaningful and efficacious interventions that can be employed to facilitate change (Bruun and Mitchell 2012, 126).

The Transtheoretical Model consists of various individual components which can be divided into main categories. Drawing on Bruun and Michell (2012) and Prochaska, Redding, Harlow, Rossi, and Velicer (1994), the model is presented here as comprising three major elements:

- a **Stages of Change model** which comprises five stages that people move through during a change process
- **Processes of Change** which are cognitive and behavioural activities that facilitate change
- **Levels of Change** that influence, and are influenced by the practice process. At times these are targets for change, and at other times they are necessary for sustaining change.

5.5.1 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.

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)

Whilst practitioners and AOD services across Queensland clearly support the stages of change model, some researchers have suggested that the five stages are more simply understood as two phases: a motivational phase which culminates in the formation of a behavioural intention, and a second phase which translates motivation into action (Armitage 2009, Gollwitzer 1993, Heckhausen 1991). A variation of the five (5) Stages of Change model is depicted below. This was developed from the Cycle Of Behaviour Change, Living With Alcohol Program in the Northern Territory and has been found useful in practice with Aboriginal young people.

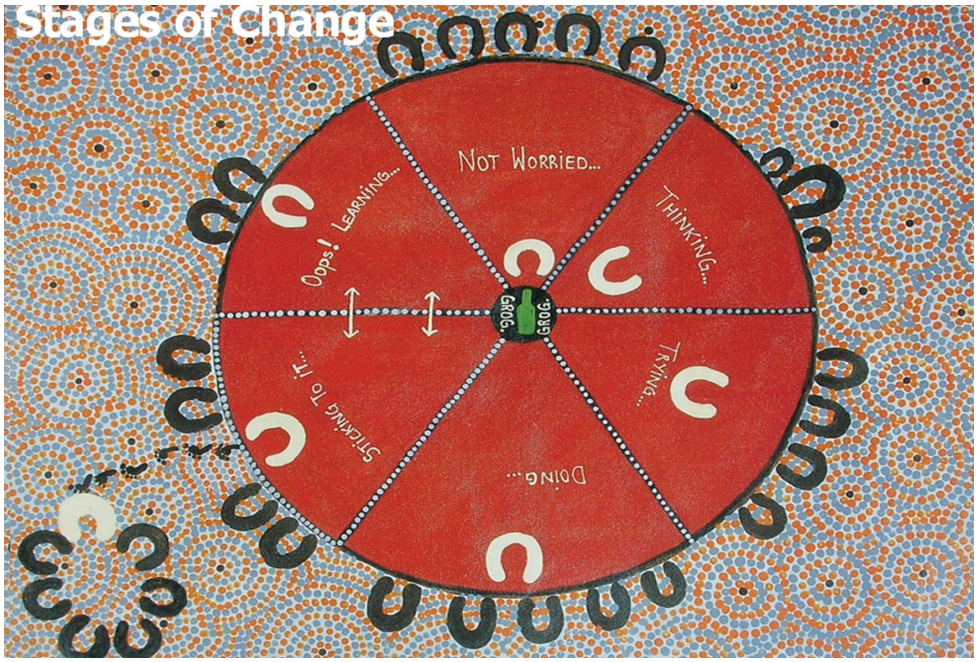

Figure 5: Indigenous Stages of Change model developed from the Cycle of Behaviour Change, Living With Alcohol Program (2000) Artists: Terry Simmons and Sophia Conway from Titjikala Community [www.health.nt.gov.au]

Indigenous stages of change story

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 member (at the edge of the circle) are worried and wants 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). Toward a comprehensive model of change. in *Addictive Behaviours: Processes of Change*. W.R. Miller and N. Heather (Eds.), New York, Plenum Press

Table 14: Matching change processes to deal with problematic AOD use

EXPERIENTIAL PROCESSES	FOCUS	DESCRIPTION
Consciousness raising	Increasing awareness	Increasing awareness about self and a problem: the causes, consequences and potential ways to deal with it
Dramatic relief	Experiencing and expressing feelings about problems and solutions	Involves people being moved emotionally and / or exploring the impact of AOD use in their lives (e.g., through grieving, role playing)
Environmental re-evaluation	Assessing how a problem affects the person's environment	Combines affective and cognitive assessments of AOD impacts on their lives
Social liberation	Increasing opportunities, resources and alternatives when people are disadvantaged or oppressed	Seeking social change through advocacy, empowerment, policy interventions (e.g., accessing stable accommodation / housing / return to education after suspension)
Self re-evaluation	How the person feels and thinks about themselves with respect of a problem	Combines affective and cognitive assessments of how substance use shapes self image and the way others see the person
BEHAVIOURAL PROCESSES	FOCUS	DESCRIPTION
Stimulus control	Removing, avoiding or countering stimuli that elicit problem behaviours	Restructuring the environment by reducing negative cues and/or increasing prompts for healthier alternatives. Creates conditions that support change and reduces risks for relapse
Helping relationships	Supportive relationships	Provide / maximise relational support for behaviour change (e.g., trust, acceptance, validation). Includes positive case work relationships, family and social supports, self-help groups
Counter conditioning	Behaviour substitution	Substituting problematic AOD use with healthy behaviours
Reinforcement management	Rewarding particular steps / behaviours	The person rewarding themselves (or being rewarded by others) for making changes. Helping young people to understand how this can happen naturally by better appreciating the logical consequences of decisions / actions
Self liberation	Commitment	Committing to an act on the basis of a belief about change being possible. Arises from enhanced self-efficacy and perception that the environment is conducive to change

Source: Prochaska, DiClemente and Norcross (1992) and Bruun and Mitchell (2012).

5.5.2 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 opposite draws on both their descriptions and those of Bruun and Mitchell (2012, 130).

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, 130). 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.

5.5.3 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? Below are two examples.

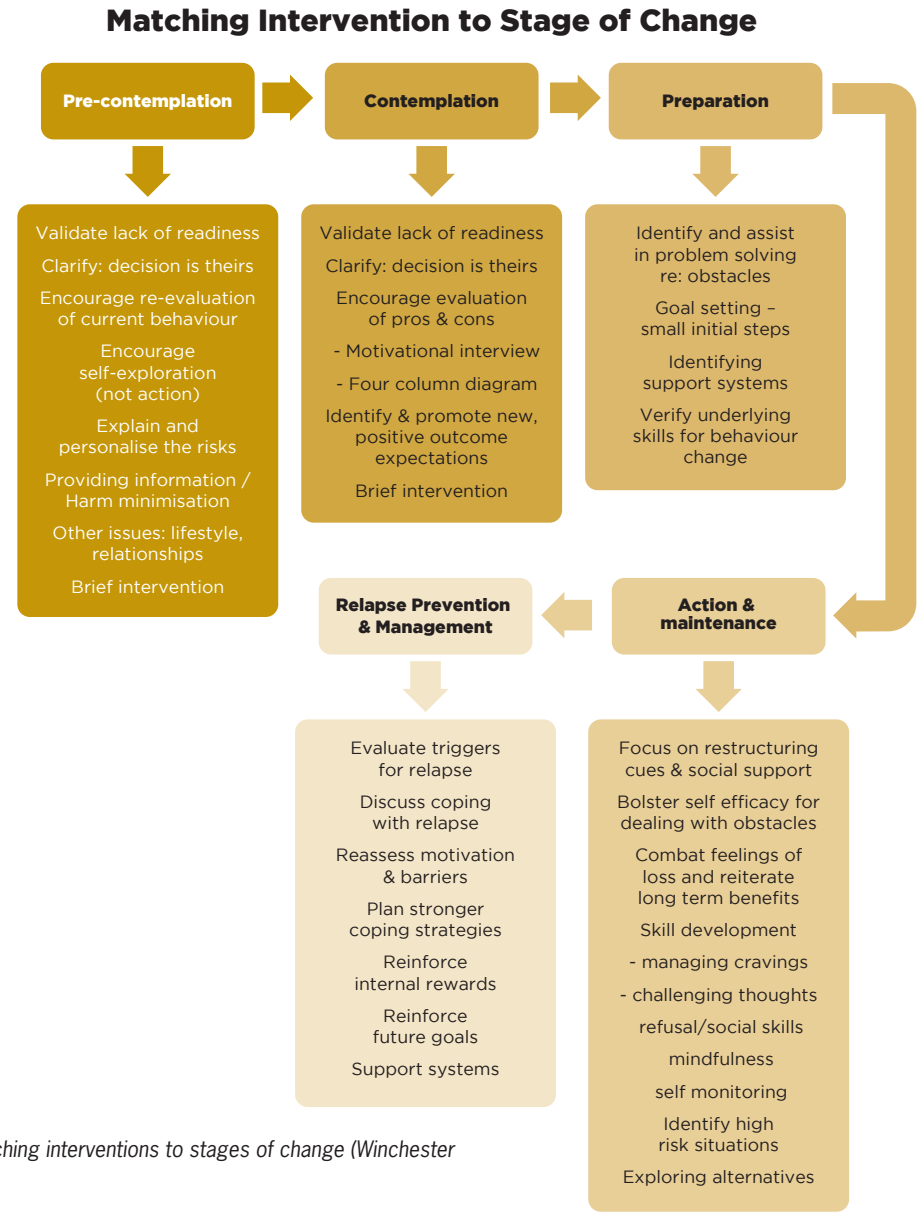

Figure 6: Matching interventions to stages of change (Winchester et al. 2004)

The following table has been extracted from the 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.

Table 15: Matching change processes and interventions to an individual's stage of change

STAGE OF CHANGE	FOCUS FOR PRACTICE	CHANGE PROCESSES	PSYCHOSOCIAL INTERVENTIONS
Pre-contemplation	Engagement Awareness building Harm reduction Address vulnerability	Consciousness raising Dramatic relief Environmental re-evaluation	Motivational interviewing Social-ecological casework
Contemplation	Building a therapeutic relationship Enhancing motivation Modifying cognitions Harm reduction	Self re-evaluation Environmental re-evaluation	Motivational interviewing Narrative therapy Social-ecological casework
Preparation	Empowerment and supporting self-efficacy Modifying cognitions Increasing knowledge and understanding Building skills Preparing for relapse prevention	Self liberation Helping relationships	Narrative therapy Community reinforcement approach Social-ecological casework
Action	Changing environmental contingencies Modifying cognitions 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 new cognitive schemas Practicing and embedding new skills Strengthening new relationship patterns	Reinforcement management Counter conditioning Stimulus control Helping relationships	Community reinforcement approach Cognitive behaviour therapy Family focused interventions Dialectical behaviour therapy

Source: Extracted from Bruun and Mitchell (2011, pp.132-139).

Keep in mind that not all intervention is necessarily psycho-social 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.

5.5.4 Levels of change

As outlined in Section 3.3 an ecological approach recognises there are various levels of influence which result in and sustain problematic AOD use by young people.

The focus on the client - worker interface does not explicitly capture broader systemic strategies that involve collaboration across services and institutions. 'Social Liberation' (the 'process of change' through advocacy, empowerment and policy interventions) needs to be an ongoing element of both social-ecological case work and advocacy for systemic reform.

5.5.5 Resilience-Based Intervention

The YSAS framework for Resilience-Based Intervention is utilised in this guide.

At its most basic, resilience describes a person's capacity to face, overcome and even be strengthened by life's adversities. Resilience-Based Intervention is focussed on creating the conditions that nurture and support the development of this capacity in young people (Bruun and Mitchell 2012, 144).

Resilience-Based Intervention is particularly relevant for young people who use substances as a coping strategy in response to life stressors or underlying problems. By building a young person's capacity for resilience, the necessity for him or her to rely on substance use as a coping mechanism can be reduced or removed. The intention is to enable young people to gain as much control as possible over their own health and well-being and in particular, their AOD use. By working closely with young people (and their families where appropriate), practitioners strive to establish a range of viable alternatives to AOD use as a way of meeting needs and coping with life's challenges. In this way the agency of each young person is recognised and respected, maximising their likelihood of engagement and minimising their potential for resistance (Bruun 2012).

The Resilience-Based Intervention framework identifies 5 domains of need:

- Protection from harm and the capacity to respond to crisis
- Stability and the capacity to meet basic needs
- Opportunities for participation and constructive activity
- Developmentally conducive connections
- Greater control of health compromising issues and behaviours,

and 3 categories of resources and assets:

- External: Context or social ecology
- Internal: Skills and attributes
- Internal: Beliefs.

Each of these categories is further broken down into particular elements and the entire schema displayed as a matrix. **The paper and Assets and Resources Matrix at the end of this Guide by Andrew Bruun outlines the Resilience-Based Intervention approach in detail.** A range of other resources can be found on the YSAS web site at www.ysas.org.au

5.6 Acknowledging purpose and limitations of any particular framework

Models and frameworks assist in making complex phenomena more understandable by isolating and exploring significant elements, relationships and processes. However it is important we appreciate that models and frameworks are not 'reality'.

A useful framework is one which has application and utility to improve the situations of people in a particular practice context. A complex of local, legal, ethical, institutional, professional, cultural and organisational factors mean that every practice framework will have a unique character. Time pressures, funding constraints and limitations arising from the agency setting (e.g., location, type of premises, facilities etc) also heavily condition how a practice framework can be implemented or sustained in a particular context.

There is a natural tendency to seek 'answers' and direction in frameworks. Whilst frameworks can guide by organising relevant understandings and processes, they are necessarily located at the 'meta' understandings level … a bit like looking down at the ground from the top of a Ferris Wheel. We can see people, towns, roads, rivers and houses but we can't assume much about the lives of the individuals and groups we see. To understand their situation and how we might interface with them requires engagement and a process of inquiry. This is where ongoing strategies for critical reflective and reflexive practice come in.

Section 6

Ourselves

6.1 Personal perspectives, values and beliefs

The final element of a youth AOD practice framework relates to **ourselves**. More specifically, what **personal perspectives, values and beliefs** about young people and AOD use does a practitioner bring to the practice setting? How do we understand the contribution we make to youth AOD practice?

Whilst this Guide has outlined a broad framework for direct practice with young people who have problematic AOD use, it is important for each practitioner to consider where they are located and oriented, and the values their practice is explicitly and implicitly founded on. Each of the Guides raises questions for practitioners to consider about AOD use generally, about young people, about practice values, approaches and boundaries, to mention but a few.

The 'Legal and Ethical Dimensions of Practice' Guide explores how **law and ethics** impact upon youth AOD practice.

The 'Practice Strategies and Interventions' Guide explores in more detail the **values and principles that underpin good youth AOD practice.**

The 'Improving Services and Service Systems' Guide explores the importance of workers **taking an inquiry approach** to practice, often described in terms like **reflective and reflexive practice.** Being willing to reflect deeply in an ongoing way on our values, perspectives and approaches to practice, individually and with colleagues and managers, is vital.

The following activities can assist workers to clarify and explore where they are 'at', either individually or in groups. This Guide then concludes with a checklist of generic questions for practitioners to ask (again individually, or in groups) to develop or clarify their framework for working with young people around AOD issues.

6.2 Activities to clarify and explore values and beliefs

There are a range of activities for training around AOD issues. Here are some you might like to use.

Activity 1: What are drugs?

Break into three groups. Each group is to come up with a definition for one of the following terms: "Drug, Medicine, Poison". Each group presents their definition, with feedback from the other groups. "Drugs, Medicines and Poisons" are slippery terms: a "medicine" can be a poison, and a "drug" could be either a medicine or a poison. It often depends on the context, and groups will discover this as each definition is teased out.

Activity 2: Harm reduction activity

Either in small groups, or as a large group brainstorming activity, list as many different "harm reduction" strategies that we employ in our day-to-day lives.

Examples can include:

"Slip, slop, slap" sun protection

Seat belts

Bike helmets

Designated driver programs

Discuss the merits or qualities of these strategies and then compare them to AOD specific harm reduction strategies.

Activity 3: Discussing practice values

Individually or in groups take one of the following statements and brainstorm how relevant you think it is to youth AOD practice.

"Doctor knows best"

"Families should always be involved in treatment"

"Young people become adults at age 18"

"Drugs take away people's ability to make choices for themselves"

"Substance use is always wrong"

"Substance use is usually a sign of an underlying mental health problem"

"The person must want to change, in order to engage in treatment"

"Young people usually know what's best for themselves"

"Drug use is normal"

"People have the right to decide what they do with their own body"

"Drug use is a moral problem"

"Parents are usually responsible for how their children turn out"

Activity 4: Same, same but different

Either in small groups, or as a large group brainstorming activity, think of as many terms as you can to describe: "Young People", and then "People who use drugs".

Consider how many of these terms are positive, negative or neutral? The consider the context each term tends to be used in (e.g., in the media, in health services and elsewhere)

Activity 5: Exploring norms

Either in small groups, or as a large group brainstorming activity consider what behaviour around AOD use is expected and how this is viewed at each of the following occasions.

ACTIVITY	WHAT AOD BEHAVIOUR DO WE EXPECT?	HOW IS THIS VIEWED?
At the Melbourne Cup		
At Schoolies Week		
On Christmas Day		
On New Year's Eve		
Breakfast at home		
Dinner at a restaurant		
On Monday morning before work		
On Friday afternoon after work		

Activity 6: Exploring frameworks

FRAMEWORK ELEMENT	QUESTIONS	RESPONSES	STRATEGIES TO EXPLORE
The contexts of youth AOD use	What type or pattern of AOD use is the focus of my practice context? Why do I think young people use AOD? What is the function of AOD use by young people? How do I express 'the problem'? What is my organisation's perspective? What is the perspective of the funding guidelines?		
Conceptualisation of young people	What constructions of young people do I generally favour? What "needs" do I think young people have? How would I describe the young people I work with in terms of age, cultural connection, gender and sexual identity, connection to family / education / work? How involved do I think young people should be in deciding what interventions to use?		
Practice approaches	What are my goals for practice with young people around AOD use? What do I think 'works'? What discourses do my preferences reflect? What terminology for practice do I prefer and what are the strengths and limitations of this? How does my approach incorporate identified key characteristics of good practice? How pre-determined is my response to young people? (open … pre-set) Why?		

FRAMEWORK ELEMENT	QUESTIONS	RESPONSES	STRATEGIES TO EXPLORE
Personal values and preferences	How do I feel about people who use AOD? Am I afraid of working with people who use AOD? What am I afraid of? Have I had an AOD problem or habit myself? How has AOD impacted on my life? What values and beliefs do I have about: - legal drugs? - illicit drugs? - people who use particular drugs? What would I do if one of my children had problematic AOD use? How do I link the personal and professional in this area of practice? What do I say if a young person asks me if I have used illicit drugs? What aspects of AOD practice am I comfortable with? Uncomfortable with? e.g., work with families, peers, outreach etc.		
Problem solving and keeping my framework fresh	Who can I contact when I feel tentative or want to check something out? What strategies can I use to revisit and refresh my framework for youth AOD practice? What can we do as a service? How can I contribute to the sector?		

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Drilling Down 1: Useful resources to inform framework development

RESOURCE	FOCUS	WEB ADDRESS
A Resource for Strengthening Therapeutic Practice Frameworks in Youth AOD Services	Written by Andrew Bruun and Penny Mitchell this YSAS resource outlines in detail the framework for therapeutic youth AOD practice referred to in this Guide	www.ysas.org.au
Australian Governments youth AOD training package	Includes a workbook on Frameworks for AOD Work	www.health.gov.au
Australian Drug Information Network	'Youth' link contains a good range of links to international and Australian agencies.	www.adin.com.au
Working with young people with alcohol or other drug issues: A self paced learning package	A package produced by the Youth Action and Policy Association NSW (YAPA) to improve service delivery for young people by increasing the knowledge, skills and organisational capacity of youth workers and youth services on alcohol and other drug issues	www.yapa.org.au
Australian National Council on Drugs	Lots of useful reports and links to data	www.ancd.org.au
The facts about young people and drugs	From the Australian Drug Foundation	www.druginfo.adf.org.au

Drilling Down 2: A framework for "Resilience-Based Intervention"

Written by Andrew Bruun (2012) and reproduced with permission.

Introduction

The framework for resilience based intervention emphasises young people's social and emotional well-being and synthesises lines of evidence from both resilience and developmental health research.

At its most basic, resilience describes a person's capacity to face, overcome and even be strengthened by life's adversities (see Table below). Resilience based intervention concentrates on how to create the conditions that nurture and support the development of this capacity in young people.

Resilience based intervention is particularly relevant for young people using substances as a coping strategy in response to life stressors or underlying problems. By building a young person's capacity for resilience, the necessity for him or her to rely on substance use as a coping mechanism can be reduced or removed. The intention is to enable young people is to gain as much control as possible over their own health and well-being and in particular, their substance using behaviour. By working closely with young people and their families, practitioners strive to establish a range of viable alternatives to substance use as way of meeting needs and coping with life's challenges. In this way the agency of each young person is recognised and respected which maximises the likelihood of engagement and minimises resistance.

A young person's capacity to be resilient can be protected by altering exposure to risk, influencing the experience of risk, averting chain reactions of negative experience and fostering healthy adaptation and growth. This reflects "…a concern with the young person in the present as well as the young person as a future adult" (Hamilton and Redmond 2010; p5). Bruun (2006) suggests that practitioners keep "…one eye on the present and the other on the path" (p.22). The impact of interventions made in the short term to address urgent need should always be considered for their impact on the longer-term developmental pathway of the young person.

The *Framework for Resilience Based Intervention* draws on substantial evidence to identify a range of resources and assets that are demonstrated to foster both resilience and healthy development. Young people can learn how to locate relevant resources and assets and develop the knowledge and skills to apply them in the interests of meeting their needs and achieving their goals. Services should seek to maximise the possibility that relevant resources and assets are available and accessible for young people through understanding their culture and working with families and communities (Masten 2009; Ungar 2011).

Resilience based intervention: core assumptions

- Resilience is not an intrinsic trait but a dynamic process occurring under specific circumstances (Masten, 2001). It is never an across the board phenomenon and no young person is invulnerable.
- All young people can develop their capacity to be resilient given the right conditions (Johnston and Howard, 2007). The same factors that interact to foster and protect healthy development and optimal functioning also support resilience.
- Positive adaptation (through regulated exposure to adversity) involves a developmental progression, such that new vulnerabilities and/or strengths often emerge with changing life circumstances.
- Developmental problems arise when children and young people are not exposed to enough adversity and risk, or so much that it is impossible to overcome (Masten, Obradovi and Burt, 2006, 21).
- There are huge individual differences in young people's exposure to the 'bad' experiences that constitute environmental risks (Harvey and Delfabbro, 2004, 3). The experience of disadvantage and social exclusion means that not all young people have access to useful and necessary resources and assets that most young people might take for granted (Johnston and Howard, 2007).
- Negative social discourses characterising young people with substance use as delinquent, disordered, dangerous or deviant can mask their strengths and efforts to meet their needs. Ungar (2005) calls this hidden resilience.

Domains of need

The framework articulates five domains of need that, if adequately addressed, will contribute to improved health and developmental outcomes as well as the resolution of substance use problems.

The goals of young people (and of those involved in their care) are invariably needs related and can be themed to fit within one or more domain.

The gradual achievement of goals builds the motivation of young people to set more ambitious goals, which if achieved can have a snowballing effect that promotes and sustains healthy development. The scarcity or availability of meaningful and useable resources and assets can either obstruct or nurture the capacity of clients to achieve these goals.

Protection from harm and the capacity to respond to crisis

Safety is fundamental to healthy development (Bickerton, Hense, Benstock, Ward, & Wallace 2007). A young person's capacity to be resilient in the face of adversity also requires a degree of safety.

All young people, particularly those who are minors, have a right to be protected from danger and harm. Crisis situations often manifest when the physical and emotional safety of young people is compromised or threatened and those responsible for their care do not have the capacity to deal with stressors and/or provide adequate protection. Masten (2001) points out that it is most often the young people who contend with the greatest adversities that do not have the protections offered by adequate resources and social 'scaffolding' capable of regulating their exposure to risk. Young people in such circumstances must rely on their own capacity to cope with crisis situations.

Resilience based intervention aims to enable young people to manage and resolve crisis situations and take responsibility for their own safety as well as building the capacity of parents, guardians and significant others to provide adequate support and protection.

Stability and the capacity to meet basic needs

Young people, particularly minors, have a right to expect those involved in their care will provide for them stable conditions in which to develop. The experience of stability creates a sense of coherence (see Giddens, 1991) whereby a young person might come to trust in the reliability of people and the availability of resources and life opportunities. Some degree of stability in life circumstances is a precondition to being able to gain control over the range of health-compromising issues and behaviours that underlie problematic substance use. Rowe (2005) points out that "…often health is not considered a priority in a chaotic life where survival takes precedence" (p.32).

Stability and coherence are undermined when a young person's basic needs are not met. Many young people contending with substance use problems have experienced extended periods of instability during their childhood and adolescence, including periods where basic needs may not have been met.

Naidoo and Wills (2000) explain that only when basic needs are met are people free to pursue their goals and achieve their potential. The capacity to meet basic needs has also been found to be integral to the process of resolving substance use problems (Keys, Mallet and Rosenthal, 2006; Cloud and Grandfield, 2004; Grandfield and Cloud, 2001).

Resilience based intervention involves ensuring that young people have the capacity to meet basic needs and have a stable base on which to develop. This involves working to ensure that young people and those involved in their care have access to sufficient resources and possess the skills and motivation to employ them effectively to maintain stability. Further, young people and their carers can learn how to predict and prevent crisis. Planning and preparation can reduce the number of crises and the degree of harm experienced by clients (Robinson and Miller, 2010).

Participation in constructive activity

Positive functioning and healthy development for young people is strongly associated with engagement in structured, pro-social activities (Bartko and Eccles, (2003).

Constructive activity, be it schooling, work or recreational pursuits, can counteract 'boredom' but can also be a vehicle for the "…development and demonstration of new competencies, problem solving, helpfulness and other positive attributes associated with resilience" (Ungar, Dumond, & MacDonald, 2005).

Engagement in constructive activity over time promotes social inclusion and economic participation. It is a means by which a young person might come to be treated as a person of value; "…a capable person who can contribute in the life of the community" (Ungar 2006, 57).

The adoption of problematic substance use patterns by young people can also be linked with a lack of opportunities for recreation and participation in activity that is socially integrative (Bonomo, (2003). Young people participating in a major Melbourne based study into youth homelessness "… stressed how all other dominating activities fell by the wayside as drug taking or getting money for drugs became their prime activities" (Keys et al., 2006; 74).

Disconnection from social institutions such as schools, workplaces and sporting clubs means missing crucial development experiences and opportunities to develop new social connections and networks. Premature exclusion from school is strongly associated with the development of substance use problems and involvement in the criminal justice system. (Prichard and Payne 2005).

Resilience based intervention involves motivating and enabling young people to either initiate or maintain participation in constructive activity that is both satisfying, rewarding and socially valued. For young people on a pathway of recovery after experiencing substance use related problems, constructive activity is a vehicle for establishing and regaining social connections and facilitating further development.

In most cases, problematic substance use is incompatible with participation in constructive activity. Young people who feel strongly attached to one or more constructive activity have a reason not to let substance use become so problematic if it restricts their involvement.

Developmentally conducive connections

Young people, like all of us, desire to support, to value and be valued by people who know them well and have an ongoing commitment to their well-being. Developmentally conducive relationships offer young people protection and care (including an appropriate level of monitoring and discipline), mutual support, fraternity, modelling and guidance, recognition and understanding as well as the opportunity to envisage a positive future (see Aronowitz, 2005). Further, an appropriate level of guidance and reinforcement has been found to create a stronger motivation to learn, solve problems, and engage successfully in the world (Masten, 2001).

Young people also derive a sense of belonging and meaning in life through connections with places, their cultural heritage and related institutions, faith-based organisations and broader social movements (see social ecological resources and assets below).

Connections can also be a source of harm and limit the healthy development of young people. Poor family cohesion, parental conflict, lack of affection, and low attachment to family are associated with increased substance misuse (Mitchell, et al., 2001). Further, Granfield and Cloud (2001) explain that "…substance use and misuse generally occurs in a larger social context within which individuals are socialised into use, develop the rationales associated with use, and derive meanings from their substance use related experiences" (p.1553).

Beyond helping them to belong, some young people might use substances to attain status among their peers (Paglia and Room 1998). Strong peer group associations of this kind may exacerbate other vulnerabilities in some young people (Seidman and Pederson 2003) and limit their capacity to pursue new opportunities and goals changes (Green, Mitchell & Bruun, in revision). Despite this, it has been demonstrated that interventions aiming to breaking all such contacts will likely be met with resistance and are of questionable utility (Kidd, 2003).

Resilience based intervention involves enabling young people to develop insight into how their connections influence their capacity to meet their needs and achieve their goals. Young people might also need assistance in maximising the helpful influence of their connections and minimising the limiting and sometimes harmful effect. At other times young people might be supported to identify and develop new connections.

Greater control over health-compromising issues and behaviours

Each young person's capacity for resilience and healthy development can be comprised of a range of personal issues and behaviours. Young people have been found to use substances to cope with one or more of the following underlying issues:

- Childhood abuse and neglect
- Past and current sexual assault
- Exposure to violence (domestic and other)
- Family breakdown
- Complicated grief
- Physical health complaints (particularly involving persistent pain).

Substance use can offer young people immediate relief from the distress associated with these issues and experiences while at the same time being a potential source of harm and an impediment to finding more constructive solutions over time. These underlying issues also contribute to the development of mental health problems and behaviours such as offending and self harm.

There are complex interrelationships between each of these issues and behaviours (including substance use) and all have potential to compromise the well-being of young people and their families. When these issues and the problems associated with particular behaviours become overwhelming and intolerable, crisis situations develop that and can undermine young people's stability, the quality of their relationships and their options for constructive participation.

Greater control over one or more of these issues and behaviours enhances a young person's potential to make resilient responses to life's challenges. This can involve:

- Crisis prevention and intervention,
- Knowledge and skill development,
- Building healthy beliefs and encouraging help seeking behaviour,
- Providing vital services and treatments or navigating young people to them and assisting them to be provided in practical and useful ways,
- Enabling young people to co-opt significant others, such as family members, in a concerted effort to gain greater control over these issues and behaviours.

Resources and assets

The *Framework for Resilience Based Intervention* articulates three categories of resources and assets. The first category, 'social ecology', includes all external or contextual resources and assets. The second and third categories, 'knowledge, skills and attributes' and 'systems of belief', both pertain to internal resources and assets that are qualities of the individual.

The framework is designed to enable practitioners and service planners to chart how resources and assets might

be configured to have a strengthening and protective effect for a client within one or more domains of need.

Epidemiological research has shown that young people who experience significant problems with AOD use, particularly in combination with other related outcomes, frequently experience a lack of, or reduced access to, a large proportion of these resources and assets (Spooner, Hall & Lynskey, 2001).

Social ecology (opportunity structure): external resources and assets

Resilience is not a static, internal quality of individuals; it is an ecologically dynamic and mutually dependent process (Ungar, 2005). The capacity of young people and their carers to cope and thrive depends on the availability and accessibility of resources and assets within their social ecology.

The framework described in this section identifies four groups of resources and assets which pertain to one's social ecology. These are:

- Material resources
- Human resources
- Socio-cultural resources
- Health and community services

Knowledge, skills and attributes (ability): internal resources and assets

All young people are striving to become socially competent individuals who have the skills to cope successfully with life (Balk 1995). Knowledge, skills and attributes are internal resources and assets processed by young people that range from "…the ability to identify and understand one's feelings, accurately read and comprehend emotional states in others, manage strong emotions and their expression, regulate one's behaviour, experience and express empathy for others, and establish and sustain relationships. Skills and knowledge in the form of insight and self awareness form the basis for self-regulation, enabling children to withstand impulses, maintain focus and undertake tasks regardless of competing interests" (AIHW 2009,60).

These skills and attributes, together with knowledge, are also instrumental to the ability of young people and their carers to locate other necessary resources and assets, and to negotiate for them to be provided in meaningful and culturally appropriate ways (Ungar, 2011).

Four groups of these resources and assets are identified:

- Living skills
- Self-management skills
- Interpersonal skills
- Attributes (attributes tend to be innate qualities and are less amenable to being learned than knowledge and skills)

Systems of belief (identity and motivation): internal resources and assets

"Belief systems imbue life (and death) with meaning and can sustain adaptive behaviour in the face of great adversity" (Masten, 2009) (p.30). A young person's beliefs are formed through the interpretation of experiences as they occur and are incorporated into the stories they tell about themselves and their world. Stories consist of dominant plots or themes that link events in sequence and across time (Ungar, 2005).

Self-beliefs are formed through subjective appraisals of oneself and one's life circumstances. Young people will hold a range of core self-beliefs that strongly influence the way they interpret and respond to events. Many are below the level of awareness.

Self-esteem and self-efficacy can be understood as closely interconnected self-beliefs that strongly influence one's approach to new opportunities and experiences. For example, self-esteem can dictate the extent to which a young person feels worthy of investing in self-care and personal growth. Likewise, self-efficacy is based on a young person's appraisal of their own skills and effectiveness in relation to specific tasks. Low self-efficacy can mean a young person becomes unwilling to take on new experiences for fear of failure.

Young people's beliefs also influence their outlook and attitudes. A young person might, for example, be aware of several resources and assets in their social ecology that are available and that could be beneficial, but based on past experience might not believe that they are accessible in ways that have meaning and relevance. Young people's interests and commitments, as well as their values, are also crucial in shaping their motivation for self-care and constructive development.

Further, young people's sense of security, purpose, belonging and hope all profoundly influence, and are influenced by, their experience as they develop and consider their future. These influences are grouped as assets under the heading 'meaning making'.

Together, all resources and assets associated with systems of belief strongly influence a young person's identity and motivation.

Conclusion

Clark (2001) contends that "[youth] care workers are in a position to mobilise, channel and focus what the client brings with them, but, ultimately, the powers for change reside within the client him/herself" (p.20). He suggests

that this involves meeting three conditions:

- To convey an attitude of positive possibility (hope) without minimising the problems and pain that accompany the client's situation,
- To turn the focus of treatment towards the present and future instead of the past,
- To instil a sense of empowerment and possibility to counteract feelings of demoralisation and passive resignation.

A distinguished AOD treatment expert, Bill Miller, corroborates Clark's view, stating that "optimal care is likely to happen within the context of an ongoing relationship in which support and care are provided through the normal ups and downs of life" (Miller, 2002 22). Further, Miller (2002) believes that care must be "…attuned to the person's particular social context, network of relationships, and the full spectrum of strengths and problems" (p.22).

Many young people with the right mix of support and opportunity will develop resilience naturally and resolve substance use-related problems without requiring intervention from service providers.

Munford and Sanders (2008) describe the way that chance, choice and opportunity can come together to create 'critical moments' (Thomson, Bell, Holland, Henderson, McGrellis et al., 2002) in which a young person might decide to take a new path and begin addressing their problems with substances. As such, young people who do require professional help are often in crisis. Services providers need to be able to make a timely and useful response to immediate need. Crisis situations are often associated with particular heath-compromising issues and behaviours, which need to be addressed simultaneously with immediate substance-related harm.

This demands that practitioners concentrate their attention on the first two domains of need emphasising safety, harm reduction and stabilisation. The priority is to prevent deterioration of the client's circumstances and to engender an interest in their own self-care. This establishes and/or protects a secure base that supports efforts to develop more constructive ways to cope with life stressors and the issues underlying substance use problems.

A stable and secure base is a prerequisite for being able to pursue positive health and developmental goals. Participation in constructive activity and the availability of developmentally conducive connections (the third and fourth need domains) promote social inclusion and a sense of connectedness. In turn, the sense of achievement and support that young people may experience contributes to a client's ability to increase control over behaviours and issues that drive substance use problems and restrict healthy development.

Alternatively, early intervention with young people who are showing signs that substance use could become a problem is best geared towards strengthening developmentally conducive connections, maintaining participation in constructive activity, and ensuring that health-compromising issues and behaviours are being addressed to avoid crisis and loss of stability.

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Framework for resilience based intervention

		RESOURCES & ASSETS			
		EXTERNAL			
		Social Ecology			
		OPPORTUNITY STRUCTURE (I/WE HAVE)			
		Material resources & assets	**Human resources & assets**	**Socio-cultural resources & assets**	**Health & community services**
		Degree to which young person (& / or their carer/s) has access to: • Income • Housing • Food & clothing • Information technology • Transportation • Safe physical environments	**Degree of access to protection, mutual support & expectation from:** • Family system & networks • Friendship networks & partners • Connections with significant adults (e.g. teachers, employers, coaches etc) • Community networks	**Opportunities to contribute through Participation in:** • Education, employment & training • Sport, recreation & leisure • Broader social movements **Connection with:** • Culture • Spiritual & faith based organisations • Enabling places	**Availability & accessibility of:** • Health care • Dental care • Mental health services • AOD services • Homelessness services • Counseling & support services • Emergency services
DOMAINS OF NEED	Protection from harm & capacity to respond to crisis				
	Stability & capacity to meet basic needs				
	Participation in constructive activity				
	Developmentally conducive connections				
	Greater control of health compromising issues / behaviours				

RESOURCES & ASSETS					
INTERNAL					
Knowledge / Skills & Attributes				**Beliefs**	
ABILITY (I CAN)				**IDENTITY (I AM) & MOTIVATION (I WILL)**	
Living skills	**Selfmanagement skills**	**Interpersonal skills**	**Attributes**	**Selfconcept & world view**	**Meaning making**
• Health literacy • Self care knowledge • Selfcare skills (udgeting, cooking, etc) • Resourcefulness (ability to access & utilise resources) • Numeracy & literacy	• Insight (self awareness) • Regulation of emotion & arousal • Problem solving & decision making skills • Ability to make sense of experiences & put them into context	• Insight (social awareness) • Communication skills • Assertiveness skills • Ability to find a balance between personal needs & the needs of others	• Temperament • Concentration & attention • Intelligence • Physical talents & abilities • Fitness & health • Appearance	• Self esteem • Self efficacy • Gender identity & sexuality • Values & attitudes • Interests & commitments • Core cognitive schemas (re self / world) • Mood & affect	• Sense of security (coherence) • Sense of purpose • Sense of belonging & connectedness (feeling connection to something greater than oneself) • Hope & expectancy

Queensland University of Technology

Dovetail

supporting the youth alcohol and drug sector in Queensland