

# SUBSTANCE USE AND YOUNG PEOPLE FRAMEWORK



Health

**NSW MINISTRY OF HEALTH**

73 Miller Street

NORTH SYDNEY NSW 2060

Tel. (02) 9391 9000

Fax. (02) 9391 9101

TTY. (02) 9391 9900

**[www.health.nsw.gov.au](http://www.health.nsw.gov.au)**

**SPECIAL THANKS TO:**

Dr Catherine Spooner, Siggins Miller. Consultant and initial author of this Framework

Members of the Substance Use and Young People Framework Working Group (see Appendix B), who were primarily responsible for the development of this Framework.

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## List of Acronyms

ACSQHC	Australian Commission on Safety and Quality in Health Care
ASSIST	Alcohol, Smoking and Substance Involvement Screening Test
AUDIT	Alcohol Use Disorders Identification Test
CALD	Culturally and/or Linguistically Diverse
CBT	Cognitive Behavioural Therapy
CIDI	Composite International Diagnostic Interview
CRAFFT	A behavioural health screening tool for adolescents
CWU	Child Wellbeing Unit
DAST	Drug Abuse Screening Test
HEEADSSS	Psychosocial interview strategy, importing: Home, Education/Employment, peer group Activities, Drugs, Sexuality and Suicide/Depression
LGBTI	People identifying as: Lesbian, Gay, Bisexual, Transgender, or Intersex
MAST	Michigan Alcohol Screening Test
MBSR	Mindfulness Based Stress Reduction
NAAH	New South Wales Association for Adolescent Health
NADA	Network of Alcohol and Other Drugs Agencies
NCRC	National Criminal Record Check
NRT	Nicotine Replacement Therapy
POSIT	Problem Oriented Screening Instrument for Teenagers
MI	Motivational Interviewing
SCID	Structured Clinical Interview for DSM
WHO	World Health Organization
WWCC	Working with Children Checks
YSAS	Youth Support and Advocacy Service

# Executive Summary

## Executive Summary and checklist of service readiness

The purpose of this Framework is to provide clear principles to drug and alcohol services, and more broadly, health services, on working with young people with substance use concerns. The primary focus is young people aged 14 to 18 years. While the Framework has relevance for younger and older clients, there are some considerations that are age specific, for example, those relating to child protection.

It is anticipated that this Framework will assist drug and alcohol services to:

- identify their roles and responsibilities in assessment, referral and treatment of young people
- develop clinical governance structures, policies and workforce development to provide a youth friendly service that acknowledges the difference between young people and adults.

If drug and alcohol services are better equipped to attract and provide an appropriate service to young people, then young people with a substance use problem might enter an appropriate treatment earlier than is currently the case. Collaboration and partnerships with other services is critical to drug and alcohol services being able to accomplish this.

The Framework has been developed by reviewing existing policies, guidelines and literature on service provision for young people with an alcohol or other drug problem. Resources and website hyperlinks are provided in the appendices for further information.

Section 1 provides information on young people and the policy context. This background information provides the basis for the principles of this Framework, which incorporate:

- harm minimisation
- human rights
- respect
- safety
- non-discrimination

- developmental appropriateness
- holistic view of health and wellbeing
- strength-based
- social justice
- accessibility
- youth participation
- collaboration and partnerships
- professional development
- evaluation
- evidence-based approaches
- sustainability.

Section 2 presents statistics around substance use and young people, and addresses risk and protective factors. Section 3 provides information to help organisations to provide an appropriate and effective service to young people. Topics include:

- governance
- facilitation of access
- evidence-based approach
- youth participation
- collaboration and partnerships
- professional development
- sustainability
- evaluation and research.

These topics are consistent with NSW Health's Youth Health Policy Checklist, which is contained in NSW Health's Policy Directive: Youth Health Policy 2011-2016: *Healthy Bodies, Healthy Minds, Vibrant Futures* (see Appendix 8).

Section 4 provides information about responding to young people when they enter your service, with an emphasis on what is different for young people compared to adult clients. It includes information on developmentally appropriate service provision, engagement, screening, assessment, motivational interviewing, brief interventions, referral, managing withdrawal, treatment and family inclusive practice.

Table 1 presents key questions for services to establish their readiness to provide services for young people, with the relevant page number for each question.

**Table 1. Questions on service readiness to provide services for young people**

Topic	Key questions for service readiness	Page
Governance structures	Has the service identified which services for young people are within, and outside its scope of practice? Have all staff members been trained to understand obligations and procedures relating to: <ul style="list-style-type: none"> <li>■ child protection?</li> <li>■ privacy and sharing of information in relation to minors?</li> </ul>	13
Access facilitation	Is the service flexible, affordable, relevant and responsive to the needs of all young people regardless of age, sex, race, cultural background, religion, socio-economic status or any other factor?	16
Professional development	Have all staff had access to appropriate ongoing professional development activities in relation to service provision for young people?	17
Collaboration and partnerships	<ul style="list-style-type: none"> <li>■ Have good collaborative partners and gaps been identified?</li> <li>■ Have the roles and resources of different partners been identified?</li> <li>■ Have protocols been developed to maintain the partnerships?</li> </ul>	18
Evidence-based approaches	Is the evidence used to plan the service regularly updated about: <ul style="list-style-type: none"> <li>■ changing or emerging needs of young people?</li> <li>■ effective interventions for young people?</li> </ul>	19
Sustainability	Are there mechanisms for ensuring the service's ability to provide services for young people are sustained?	19
Developmentally appropriate	Do staff understand the term 'developmentally appropriate' and what it means for service provision?	19
Youth participation	Does the service have policy, protocols and procedures in place for appropriate youth participation and consultation?	19
Treatment	Has your service reviewed its treatment program to identify whether modifications are necessary and possible for young people?	23
Safety	Have safety issues for young people been considered? In particular, how would you assess if an adolescent is safe with the current mix of clients? If not, how would you ensure the adolescent received a service?	24
Engagement	Have all staff who might work directly with a young person had sufficient professional development to be able to communicate effectively with young people? Are policies and training in place for understanding how adolescent developmental issues can impact upon behaviour and for dealing with difficult behaviour (other than exclusionary policies)?	24
Screening and assessment	Where applicable, have appropriate staff members been trained to conduct effective screening and assessment with young people?	25
Motivational interviewing, and other approaches	Have staff had sufficient professional development to be able to use developmentally appropriate motivational interviewing techniques, and other approaches?	28
Brief interventions	Where applicable, have appropriate staff members been trained to deliver brief interventions?	29
Managing withdrawal	If you provide withdrawal services, are there appropriate liaison staff for young people who understand young people's needs and issues?	31
Transition planning	Has the service considered transition planning for young people, to support continuity of care?	32
Family inclusive practice	Has the service considered ways to engage, include and provide therapeutic interventions for the young person's family?	32
Referral	Have clear referral guidelines been developed in collaboration with relevant agencies?	33
Evaluation and research	Has the service reviewed its: <ul style="list-style-type: none"> <li>■ capacity to provide services to young people?</li> <li>■ effectiveness in providing services to young people?</li> <li>■ ability to conduct research?</li> </ul>	20

**Who is this Framework for?** Any drug and alcohol service, in which young people present.

**What is it for?** To help drug and alcohol services identify their roles in assessment, referral and treatment of young people, and to develop clinical governance structures, policies and workforce development to provide a youth friendly service that acknowledges difference between young people and adults. It is intended to encourage workers to make the most of every opportunity to open up conversations with young people about substance use.

**How can it be used?** This Framework is designed to guide a response for the treatment of young people across the spectrum of drug and alcohol use.

**Framework vision** Young people have a right to access services and there is no wrong door. However, if a young person presents to a service identified as unsuitable for their age, staff should be able to assess and refer on appropriately.

## SECTION 1

# Introduction

### Key points: Section 1

#### ■ Principles of this Framework:

- harm minimisation
- human rights
- respect
- safety
- non-discrimination
- developmental appropriateness
- strength-based
- holistic view of health and wellbeing
- social justice
- accessibility
- youth participation
- collaboration and partnerships
- professional development
- evaluation and research
- evidence-based approaches
- sustainability.

■ Young people are a diverse group, and substance use amongst young people exists across a broad spectrum of use.

■ Some young people do experience problems in the short term relating to their substance use, or are at significant risk of substance related harm in the future.

■ Numerous NSW and other policies exist to guide services in appropriate and effective service provision to young people. These include the UN Convention on the Rights of the Child, which stipulates the right of every young person to receive a health service.

The purpose of this Framework is to provide Drug and Alcohol services, and more broadly, health services, with clear principles on working with young people with substance use concerns. The Framework has been prepared with the assistance of a Working Group (Appendix 2), and through consultation with various stakeholders in the public and NGO sectors.

The Framework provides practical information and suggestions for Drug and Alcohol services to facilitate and improve access for young people to appropriate support and treatment services. It does not include discussion of issues that are applicable to all clients (for example, facilitating access in a rural area, providing services for culturally and linguistically diverse populations). Rather, it is focused on providing information about what might be different for young people.

Many existing policies and resources were used to develop this Framework, most of which are freely available online.

This Framework is intended to help services to:

- identify their roles in assessment, referral and treatment of young people

- develop clinical governance structures, policies and workforce development to provide a youth friendly service that acknowledges difference between young people and adults.

If services are better equipped to attract and provide an appropriate service to young people, then young people with substance use problems might enter appropriate treatment earlier. This is an important outcome given the benefits of earlier interventions for substance use and related problems.<sup>1</sup>

The primary focus is young people aged 14 to 18 years. While the Framework has relevance for younger and older clients, there are some age specific considerations (e.g. child protection).

This document begins with information about young people that can have an impact upon service provision. Existing policies that guide the content and recommendations of this Framework are summarised and this information has been used in the development of guiding principles for service provision to young people. The Framework is then focused on organisational development (before a young person walks in the door) and then provision (after a young person enters a service).

## Young people and prevalence of drug and alcohol use and disorder

Young people are a diverse group with many roles and responsibilities. They might have a history of mental health problems in addition to their problem with substance use<sup>2</sup> or could have a history of offending.<sup>3</sup> This (and the following) section includes general information about developmental issues and substance use issues for young people – decisions about a specific young person will need to be made upon an understanding of their own history.

Issues relating to providing services to specific groups such as young people with CALD backgrounds,<sup>4</sup> young people with a dual diagnosis,<sup>2</sup> young offenders,<sup>5</sup> Aboriginal and Torres Strait Islander youth,<sup>6</sup> LGBTI<sup>i</sup> youth and those in regional and rural locations are not comprehensively provided here, but service policy should include the specific issues concerning these groups.

Substance use in young people exists on a spectrum of levels of use, and the 2010 National Drug Strategy Household Survey identified frequent levels of alcohol use among some young people (Tables 2 & 3). Use of pharmaceuticals for non medical reasons by young people was lower, with 2.3 per cent of 14-17 year olds and one in twenty young people in the older age groups reporting usage in the previous year (Table 5).<sup>7</sup> In relation to tobacco smoking, 3.8 per cent of teenagers (12-17 year-olds) reported smoking tobacco and 2.5 per cent smoked daily (Table 6). Those in higher age groups reported smoking at much higher rates.

While daily use was rare, about a fifth to a quarter of young people drank in a manner that was categorised as ‘single-occasion risky use’ at least once a month. That is, more than four standard drinks in a row.

About one-fifth to a quarter of young people had used an illicit drug (usually cannabis) in the previous year (Table 4).<sup>7</sup> Use was generally more common among males than females.

**Table 2. Alcohol use pattern in past 12 months by age (per cent of age group)<sup>7</sup>**

Age	Recent drinker <sup>a</sup>	Drink Daily	Drink weekly	Drink less than weekly
12-17	38.4	0.1	5.1	33.2
18-19	86.3	1.2	38.6	46.5
20-29	85.3	2.1	43.9	39.2

<sup>a</sup> Consumed at least a full serve of alcohol in the previous 12 months.

**Table 3. Risky alcohol use based upon NHMRC recommendations (per cent of age group)<sup>7</sup>**

Age	Lifetime risk <sup>a</sup>	Single-occasion risk at least monthly <sup>b</sup>
12-15	1.0	4.3
16-17	9.9	19.4
18-19	31.7	25.7
20-29	26.9	20.4

<sup>a</sup> On average, had more than 2 standard drinks per day.

<sup>b</sup> Had more than 4 standard drinks at least once a month but not as often as weekly.

**Table 4. Use of illicit drugs in previous 12 months by age (per cent of age group)<sup>7</sup>**

Age	Any illicit	Cannabis	Meth/amphetamines	Injectable drugs
14-17	14.5	12.8	0.3	
18-19	25.1	21.3	4.0	
14-19	18.2	15.7	1.6	0.3
20-29	27.5	21.3	5.9	0.9

<sup>i</sup> Lesbian, Gay, Bisexual, Transgendered, or Intersex

**Table 5. Non-medical use of pharmaceuticals within last 12 months, by age (per cent of age group)<sup>7</sup>**

Age	Non-medical pharmaceutical
14-17	2.3
18-19	5.0
20-29	5.6

**Table 6. Tobacco smoking status, by age (per cent of age group)<sup>7</sup>**

Age	Smoke less than weekly	Smoke weekly	Smoke daily
12-17	0.5	0.8	2.5
18-19	1.1	2.2	13.0
20-29	2.8	2.9	18.0

Some groups of young people have been found to consume more substances and have more substance related problems. These include young offenders, particularly Aboriginal young people. For example, in the 2009 survey of young people in custody in NSW, 61 per cent of participants identified that their alcohol consumption had caused them problems in the past year; significantly more Aboriginal participants reported this than non-Aboriginal participants (71 versus 52 per cent).<sup>5</sup> Similarly, 65% of the participants reported they had used illicit drugs at least weekly in the year prior to custody, with significantly more

Aboriginal young people reporting weekly drug use than non-Aboriginal people (72 versus 58 per cent), predominantly cannabis.

### Policy context

Relevant policies have been reviewed to ensure this framework is consistent with state, national and international policies. Excerpts from the relevant policies are presented in Appendix 6 and the key policy principles that guide this Framework are summarised in Table 7.

**Table 7. Relevant policies for this Framework**

Policy name	Policy features to which NSW Health is committed
National Drug Strategy 2010-2015. A framework for action on alcohol, tobacco and other drugs <sup>31</sup>	The overarching approach is harm minimisation and the three 'pillars' of demand reduction, supply reduction and harm reduction need to be balanced and sensitive to age and stage of life. It is underpinned by the development of a qualified workforce, maintaining and improving the evidence base, monitoring performance and enhancing governance.
NSW Drug and Alcohol Plan (2006-2010) <sup>32</sup>	Equity of service delivery to young people with emerging drug problems
NSW Youth Health Policy 2011-2016 <sup>33</sup>	Goals: To encourage and support young people to achieve optimal health and wellbeing, to ensure young people experience the health system as positive, respectful, supportive and empowering, and to achieve positive outcomes for young people that are organisationally effective and early intervention and are delivered efficiently and effectively.  The Policy was underpinned by values relating to a holistic health, strength-based approaches, social justice and innovation.  Implementation principles are accessibility, youth participation, collaboration and partnerships, professional development, evaluation, evidence-based approaches and sustainability.
State Plan Keep Them Safe: A Shared Approach to Child Wellbeing 2009-2014 <sup>34</sup>	Goal: To improve the safety and wellbeing of children and young people.  Strategies: Enhanced early intervention and community-based services to support children and families in the community and prevent children from entering the child protection system and a streamlined statutory child protection system focusing on children at greatest risk.
Child Wellbeing and Child Protection Policies and Procedures for NSW Health <sup>52</sup>	The policy guides Local Health Districts and Specialty Health Networks to implement the responsibilities of NSW Health under the NSW Children and Young Persons (Care and Protection) Act 1998 and the Child Wellbeing and Child Protection – NSW Interagency Guidelines.

Policy name	Policy features to which NSW Health is committed
Clinical Guidelines for the Care of Persons with comorbid mental illness and Substance Use Disorders in Acute Care Settings <sup>35</sup>	The guidelines aim to provide practitioners working with clients who have comorbid mental health and substance use disorders with information to guide care. Young people are highlighted as a specific population for consideration, with emphasis given to early intervention, secondary prevention, psycho-education.
NSW Community Mental Health Strategy 2007-2012 <sup>36</sup>	This youth component of this document emphasises early intervention and comprehensive, accessible and appropriate services. The Youth Mental Health Services Model, described in the NSW Community Mental Health Strategy, was developed to meet the needs of young people aged 14 to 24 years. The model aims to increase early access to mental health services by young people. Young people want services that are non-stigmatising, flexible, holistic, confidential and comprehensive. Services need to have multidisciplinary teams which address multiple and complex problems, including drug and alcohol issues.
NSW Aboriginal Mental Health and Well Being Policy 2006-2010 <sup>37</sup>	The Policy aims to improve the coordination of care for Aboriginal people in NSW by ensuring: <ul style="list-style-type: none"> <li>■ partnerships are formed between relevant organisations</li> <li>■ accessible and responsive mental health services cater for all ages</li> <li>■ a supported and skilled workforce in Aboriginal mental health and wellbeing.</li> </ul>
United Nations Conventions on the Rights of the Child <sup>38</sup>	The four core principles of the Convention are: <ul style="list-style-type: none"> <li>■ non-discrimination</li> <li>■ devotion to the best interests of the child</li> <li>■ the right to life, survival and development</li> <li>■ respect for the views of the child.</li> </ul>

## Principles of this framework

The following principles for this Framework were identified by the *Working Group – Substance Use and Young People*:

- harm minimisation
- human rights
- respect
- safety
- non discrimination
- developmental appropriateness
- holistic view of health and wellbeing
- strength-based
- social justice
- accessibility
- youth participation
- collaboration and partnerships
- professional development
- evaluation and research
- evidence-based approaches
- sustainability.

## SECTION 2

# Adolescent Substance Use, Risk and Protective Factors

### Key points: Section 2

- Decisions about a specific young person will need to be made in conjunction with them, and based upon an understanding of their history and neuro-developmental stages.
- Substance use among young people can often be experimental, and is not of itself indicative of a substance use problem.
- Provision of appropriate and effective services for young people requires an understanding of adolescent developmental processes. Risk taking may take place during adolescence, and professional judgement is required to determine the difference between risk taking as part of a process of development and that which indicates problematic substance use.
- Young people's substance use behaviours can relate to a range of issues, so an appropriate response requires comprehensive assessment.
- Problem behaviours among young people are generally the net result of a series of risk and protective factors over time and can need a range of responses over time.
- Young people tend to not seek help for substance use or other health problems with health professionals in the first instance. Strategies are required to increase youth access

### Young people and substance use problems

Substance use by young people is not necessarily harmful, but it can be so:

Experimentation, including with drugs and alcohol, forms a relatively normal part of adolescence. Indeed, for some adolescents, this experimentation and experience with trial and error processes may be their way of developing a fully formed, healthy personality. While many young people do not use drugs and alcohol at dangerously high levels, there are known harms associated with all levels of misuse. It is also recognised that some young people will develop chronic patterns of drug use and engage in frequent harmful bingeing. As with adult clients, when drug and alcohol use becomes habitual and/or normal functioning is affected, it is cause for concern.<sup>9</sup>

Young people are at risk of later harms from substance use, particularly with greater levels of use and earlier onset of use.<sup>10, 11</sup> For example, longitudinal research has identified a strong

association between age of onset of cannabis use and subsequent educational achievement<sup>12</sup> high levels of cannabis use in late adolescence and poorer educational outcomes, lower income, greater welfare dependence and unemployment and lower relationship and life satisfaction in later life; and between alcohol abuse or dependence among adolescents and later depression.<sup>13</sup> Given that the age of first use of substance use has decreased over the past half century,<sup>14</sup> problems relating to early onset of use might be on the increase.

Substance use can have short-term consequences, including injury due to impaired decision making,<sup>15</sup> and harmful effects on brain development during a critical period of brain maturation.<sup>16</sup>

Young people can also suffer negative consequences from their parents' substance use, from drug use during pregnancy<sup>17</sup> and the increased risk of adverse parenting by substance-dependent parents.<sup>18-21</sup> Substance-dependent people are not necessarily poor parents, however, children of such parents are more likely to be at risk than other children.<sup>22</sup>

## Adolescent development

The main developmental issues, concerns and capabilities across early to late adolescence, are presented in Table 8.<sup>4</sup> Age is a guide, but not necessarily a predictor of developmental stage. To achieve developmental tasks, young people must take risks and learn through experience, with support and guidance from others.<sup>23</sup>

Risk taking may take place during adolescence and adolescents view it differently to adults.<sup>4, 23-26</sup> The risk taking component of adolescent development, includes developing an identity, building competence, and gaining acceptance from peers.

The gradual development of the prefrontal cortex, which supports self-control, compared with the more rapidly developing limbic system, which governs appetite and pleasure-seeking, contributes to novelty seeking and risk taking in adolescence. In addition, neuroendocrine changes can affect their moods and focus their attention on sexuality and sensation-seeking. Concurrently, adolescents are faced with an array of social pressures about taking risks from peers, parents, teachers, communities and the media. These can each contribute positively and negatively to adolescent development.<sup>24</sup>

**Table 8 Adolescent development stages<sup>4</sup>**

	Early (10-13 years)	Middle (14- 17 years)	Late (17-21 years)
Central Question	<b>“Am I normal?”</b>	<b>“Who am I?”</b> <b>“Where do I belong?”</b>	<b>“Where am I going?”</b>
Major 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 with family 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 own 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

## Causes of substance use and other health risk behaviours

There is no definitive list or model of risk and protective factors for substance abuse. The aetiological process is complex and our understanding limited. A review has noted:<sup>26</sup>

- While many people use substances, few progress to substance abuse or dependence.
- Risk factors for initiation of use, continued use, and abuse/dependence differ.
- No single risk factor predicts problematic substance use. Rather it is the number of risk factors, or the balance of the number of negative risk factors relative to the number of protective factors that predicts use.
- Risk factors exist in different domains: individual, family, peer, school, local community, or macro environment. These domains interact with each other in a complex web of causation.
- Risk factors can also be situational; for example, features of licensed premises can impact upon levels of violence

- Risk factors vary across the life course and are cumulative across the life course.
- Risk factors vary with historical period.
- Many of the risk factors for substance abuse are shared with other adolescent problem behaviours (Appendix 3).

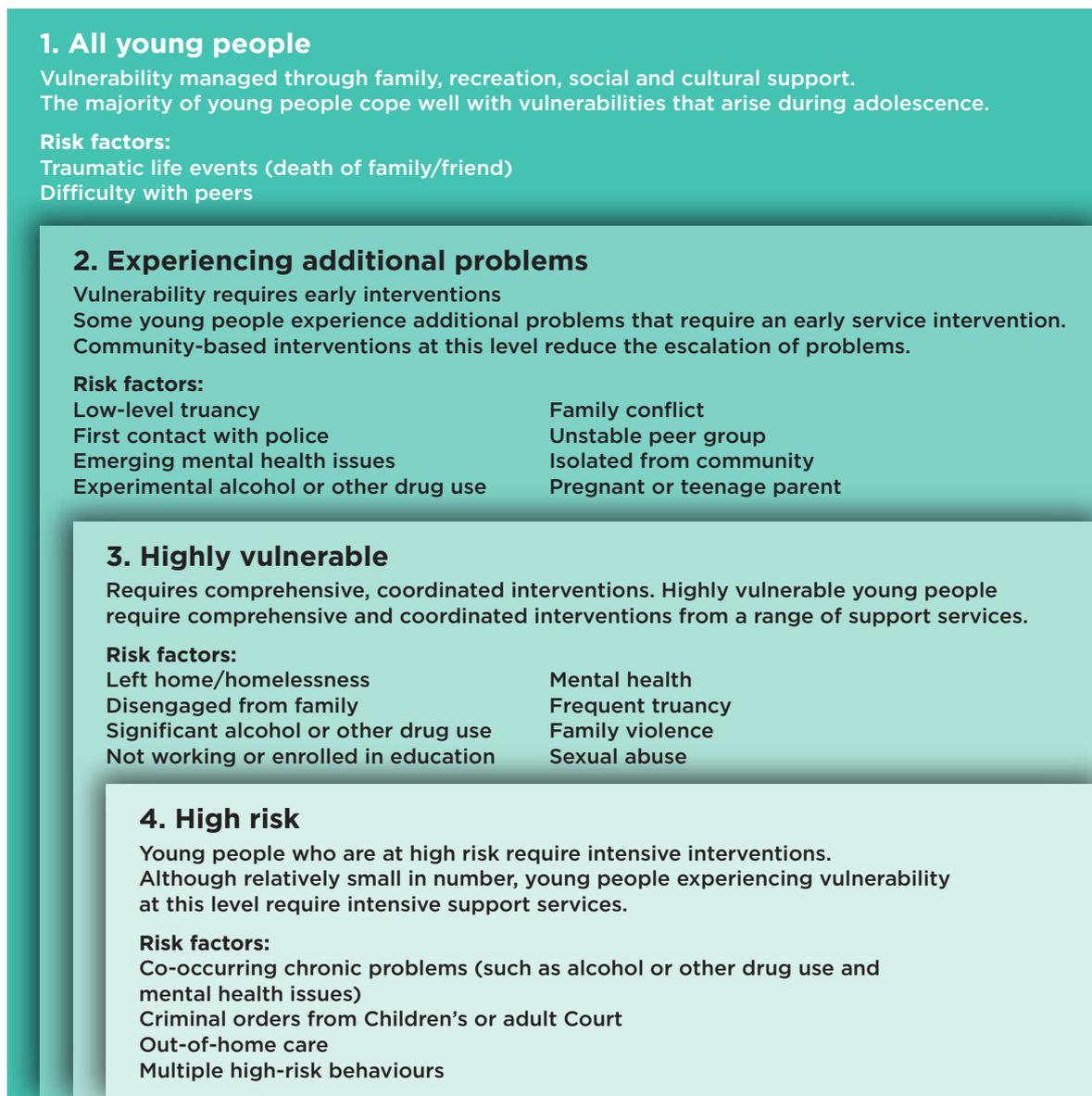
Given these cautionary notes on lists and models, information from the World Health Organization's (WHO) list of risk and protective factors for substance use at the individual and environmental levels and Blum and Blum's model for the development of maladaptive behaviours is presented in Table 9.

Most young people experience some difficulties but do not require professional help with their problems. However, as noted previously, as the number of risk factors and adverse experiences increases, young people becoming increasingly vulnerable to negative outcomes. Services need to aim to prevent transition of young people to more vulnerable levels (Figure 1).

**Table 9. Risk and protective factors for substance use<sup>106, 107</sup>**

Domain	Risk factors	Protective factors
<b>Individual</b>	Genetic disposition Personality disorder Depression and suicidal behaviour	Good coping skills Self-efficacy Risk perception Optimism Health-related behaviour General health behaviour
<b>Family</b>	Family disruption and dependence problems Social deprivation Victim of child abuse	Assistance to attend and maintain treatment Social support Knowledge of individual's history
<b>Friends</b>	Peer culture Cultural norms, attitudes	Ability to resist peer pressure Social integration Positive life events
<b>Education/ employment</b>	Poor performance at school Occupational stressors	Social integration Income
<b>Community/ environmental</b>	Drug availability Poverty Drug policies Discrimination Inequality	Situational control Social capital Social change

Figure 1. Vulnerability model <sup>108</sup>



In summary, like adults:

- adolescent substance use behaviours are complex, so an appropriate response will require comprehensive assessment.
- problem behaviours among young people are generally the net result of a series of risk and protective factors over time and can need a range of responses over time.

### Young people and treatment seeking

Research has repeatedly identified that adolescents tend to not seek help for health concerns (including substance use and mental health problems) from health professionals or services.<sup>3, 27, 28</sup> Factors that have been found to contribute to this include:

- services not catering well for young people with mental and substance use disorders<sup>1, 6, 29, 30</sup>
- fear of confidentiality breaches, lack of trust in the service provider and embarrassment in discussing personal issues<sup>28</sup>
- lack of awareness and knowledge about services and how to access them<sup>28</sup>
- lack of referral to treatment. For example, a study of young offenders servicing community orders with the NSW Department of Juvenile Justice found that despite almost 40 per cent of the sample revealing significant substance abuse problems, only 18 per cent were offered an appointment with drug and alcohol workers.<sup>3</sup>

Consequently, effort is needed to make services accessible, appropriate and attractive for young people as well as to encourage young people to access services via referral.

## SECTION 3

# Organisational Preparation

### Key points: Section 3

- **Scope of practice:** drug and alcohol agencies need to identify which services for young people are within, and which services are not within, their scope of practice.
- **Child protection:** every Health worker coming into contact with a child or young person has a responsibility to protect their safety, welfare and wellbeing. The Child Wellbeing and Child Protection Policies and Procedures for NSW Health (PD2013\_003) presents tools and guidance for workers to meet their legal and policy responsibilities.
- **Working with Children Checks/National Criminal Record Checks:** drug and alcohol agencies need to ensure they comply with the NSW Working with Children legislation and relevant policies regarding criminal record checks.
- **Legal issues:** information on legal issues relating to the following issues is provided in this framework:
  - duty of care
  - confidentiality
  - consent to service provision
  - substance possession and use
  - information sharing across agencies
  - legal situations for young people.
- **Accessibility:** services are more accessible to young people when they are flexible, affordable, relevant and responsive to the needs of all young people.
- **Professional development:** appropriate, adequate and ongoing professional development, support and supervision should be available to health service providers working with young people.
- **Collaboration and partnerships:** collaboration and partnerships with other agencies such as youth-specific services is important for multiple reasons, including ensuring appropriate referrals, allowing for shared care arrangements, and for obtaining professional advice and support on service provision for young people.
- **Evidence-based approach:** services and their programs should be developed according to evidence of need and of better practice from the most reliable and appropriate local, national or international source. Anecdotal evidence alone is generally inadequate.
- **Sustainability:** principles of sustainability need to be applied to the mechanisms identified in this framework for providing services to young people.
- **Developmentally appropriate:** this includes: sensitivity to developmental challenges faced by adolescents; continuous assessment of capacity; appropriate expectations; attention to duty of care and confidentiality; appropriate modes of interaction; awareness of differing developmental trajectories; managing tensions for vulnerable youth; and application to prevention and early intervention.
- **Youth participation:** Participation needs to be proactively enabled, and occurs when young people are actively involved in the development, implementation, review and evaluation of services. It should foster a sense of ownership of, importance to, influence within and/or belonging to that service or program, and a sense of mutual respect. Youth participation also provides for young people being involved in the decisions that directly affect them and their lives.
- **Evaluation and research:** Consideration needs to be given towards evaluating the organisation's capacity to provide services to young people and the organisation's effectiveness in providing services to young people. Services may also conduct research to develop the knowledge-base around substance use and young people.

## Governance structures

### Clinical Governance

This describes a systematic approach to maintaining and improving the quality of care within a health system or service. It is about the ability to produce effective change to achieve high quality care. It requires clinicians and administrators to take joint responsibility for making sure this occurs, and services should consider it as a foundation of their service models.

### Scope of practice

Drug and alcohol agencies need to identify which services for young people are within, and outside, their scope of practice. To do this, they will need to consider the scope of practice of their staff. The term *scope of practice* is typically used by licensing boards for specific professions that define actions, and processes that are permitted for the licensed individual. For example, the Australian Commission on Safety and Quality in Health Care (ACSQHC) describe 'defining the scope of clinical practice' as: *describing the extent of an individual doctor's clinical practice within a particular organisation based on the individual's credentials, competence, performance and professional suitability, and the need for the organisation to support this process.*<sup>102</sup> In terms of allied health professionals, Services for Australian Rural and Remote Allied Health (SARRAH) define it as:

... the broad frameworks and context of allied health practice of the individual professions including: (1) the range of roles; (2) functions and responsibilities; and (3) decision making capacity which the professional performs in the context of their practice.

The scope of practice of an individual Allied Health Professional includes (1) education, training and development (in the widest sense); (2) authorisation to undertake scope of practice and (3) competence to perform. An individual's scope of practice is influenced by his/her education, knowledge, experience, currency (recentness of practice) and skills. The scope of practice of an individual may be more specifically defined than the scope of the profession. To practice within the full scope of practice of the profession may require the individual to update or expand their knowledge, skills and competence.<sup>103</sup>

ii The exception to this definition is in Chapter 13 of the Act, which related to children's employment.

Health professionals have responsibility to self-assess, articulate and work within their own competence and scope of practice. SARRAH provide some questions to assist in determining if an activity/task is within an individual's scope of practice:

- Is it in the best interest of the patient?
- Is it within the scope of practice for your profession (legislative, professional association guideline documents)? Is it accepted practice within your profession?
- Is there organisational support (e.g. guidelines, within job description, management approval?)
- Is it within your own scope of practice (do you have education preparation and clinical practice? Are you competent and confident to perform the task safely?)<sup>103</sup>

## Child protection

Under the *Children and Young Persons (Care and Protection) Act 1998 No 157*,<sup>45</sup> 'child' means a person who is under the age of 16 years<sup>ii</sup> – and 'young person' means a person aged 16-17. The person who seeks a service might be a 'child' or 'young person' or might be the parent of a 'child' or 'young person' under the Act.

Since January 2010, reports to the Child Protection Helpline have needed to meet the threshold of 'risk of significant harm' as opposed to 'risk of harm'. This change has been introduced so that children and young people who need the protection of statutory intervention can receive this from Community Services, while children and families who need other forms of support and assistance can receive this from a range of government and community organisations without having to report to Community Services.

The Child Wellbeing and Child Protection Policies and Procedures for NSW Health PD2013\_007 brings together in a single document the tools and guidance for Health workers to meet their legal and policy responsibilities within the NSW Government Child Protection System (see Appendix 7). Information on mandatory reporting is available from the NSW Government Keep Them Safe website (<http://www.KeepThemSafe.nsw.gov.au/home>)<sup>46</sup> and health workers should use the NSW Mandatory Reporter Guide to help determine whether or not to report to the Child Protection Helpline.<sup>47</sup>

## Working with Children Checks/ National Criminal Record Checks

The NSW Health Policy Directive *Employment Checks – Criminal Record Checks and Working with Children Checks* PD2013\_028 sets out the mandatory requirements for National Criminal Record Checks ('NCRCs') and Working with Children Checks ('WWCCs') for persons engaged, or seeking to be engaged, either in a paid or voluntary capacity, in a NSW Health Service.

NGO services should consult their funding agreements for requirements around national criminal record checking of workers and the website of the Office of the Children's Guardian for requirements around the WWCC (<http://www.kidsguardian.nsw.gov.au/>).

'Existing child related workers' are required to obtain a WWCC in accordance with the 'Phase in schedule for existing workers' on the website of the Office of the Children's Guardian. Note that the WWCC legislation defines a child as a person under the age of 18 years.

## Legal issues

The New South Wales Association for Adolescent Health (NAAH) published a resource for health workers in NSW on ethical and legal responsibilities when working with young people.<sup>48</sup> The resource includes information on:

### ■ Duty of care

Once a young person enters a service, a health worker has a duty of care to act with appropriate skill and judgement and take all reasonable steps to ensure that the young person does not suffer harm as a result of their actions or failure to act. A health worker also has a duty of care to others (non-clients) who may be foreseeably affected by the actions of the worker or the client.

### ■ Confidentiality

This is the right of a client to ensure that none of the information relating to their health care is shared with other parties without their permission (*Public Health Act 1991, Health Records and Information Privacy Act 2002, Privacy Act 1988*). There are exceptions to the duty of a health worker to maintain confidentiality with their client. This includes where the young person consents for their information to be disclosed to a third party, such as a parent or caregiver and mandatory reporting of children at risk of significant harm.

### ■ Consent to service provision

Most young people of any age are free to consent to the majority of health services available, provided a health worker can obtain informed consent. If a health worker is not satisfied that the young person seeking medical treatment has the capacity to give informed consent then the additional consent of one parent or guardian is required. See "Consent to Medical Treatment – Patient information" in Appendix 5 for further information.<sup>51</sup>

### ■ Sexual activity

It is illegal for a person of any age to engage in heterosexual or homosexual intercourse with someone aged under 16 years (*Crimes Act 1900* s66C). Where both parties are aged under 16 years, technically they are both committing an offence but would not normally be charged unless one is much older than the other or the sex is non-consensual.

If a young person is aged under 18 years and an individual has 'special care' for them (for example they are a school teacher, step-parent, sports coach or health professional) it is illegal for this individual to have sex with the young person (*Crimes Act 1900* s73).

Use of the Mandatory Reporter Guide will guide a Health worker's decision on whether underage sexual activity, including a case of peer consensual sex, constitutes suspected risk of significant harm requiring a report to the Child Protection Helpline (see Appendix 7 Child Wellbeing and Child Protection Policies and Procedures for NSW Health).

### ■ Alcohol and other drugs

An agency's legal and ethical duty in relation to illegal drugs (e.g. discovering a client in possession of an illegal drug or injecting equipment) are the same as for adults.

Services authorised to distribute injecting equipment should make sterile injecting equipment available to any person, of any age, who is currently involved in injecting drugs.<sup>52</sup> A health worker is not required to report a young person aged under 18 years for possession or consumption of alcohol or tobacco. Nor is a health worker legally required to confiscate the products. It is not an offence for a young person to be in possession of alcohol or tobacco whilst visiting a health service, however, workers should be aware of service policies when it comes to these substances. Some policies may require you to ask the young person to leave or voluntarily give up the substance, if they wish to participate in the activities of the service.

Young people may require legal assistance of their own, for issues that may include: substance use, employment, housing, fines, convictions or other issues. The Shopfront Youth Legal Centre in Sydney has a number of useful factsheets ([www.shopfront.org](http://www.shopfront.org)) (see Appendix 19). Whilst these are advertised as being for youth workers, they are equally useful for workers in drug and alcohol services where young people may present.

## Information sharing across agencies

The following principles from the NSW Health Privacy Manual can be used as an age guide to sharing information:

- Where a client/patient is less than 14 years old, consent should generally be given by the parent or legal guardian.
- Where the client/patient is aged between 14 and 16, efforts should be made to obtain the consent of the parent or legal guardian unless the client/patient indicates a strong objection.
- Where the client/patient is aged 16 years or over, they should generally be capable of deciding on the access issue for themselves.

Further information on information sharing and privacy is provided in Appendix 5.

Further information and guidance on medico-legal issues is provided in the Adolescent Health GP Resource Kit,<sup>4</sup> and has been reproduced in Appendix 14.

## Youth Health Better Practice Framework

The NSW Health Youth Health Policy 2011-2016 contains a *Youth Health Better Practice Framework* checklist (see Appendix 8).<sup>33</sup> This checklist is relevant to organisations reviewing their readiness to work with young people and is expanded upon in this section of the Framework. The checklist provides a guide to check for:

1. Accessibility
2. Evidence-based approach
3. Youth participation
4. Collaboration and partnerships
5. Professional development
6. Sustainability
7. Evaluation.

This section contains information to assist organisations to comply with the checklist, drawing upon research and the *ACCESS Youth Health Better Practice Factsheets*.<sup>28, 98</sup>

The material in this section is also addressed in publications relating to 'youth friendly services'. For example, the World Health Organization (WHO) has said that services can be considered adolescent-friendly if they have the following characteristics:<sup>39</sup>

Equitable	All young people, not just certain groups, are able to obtain the health services they need.
Accessible	Young people are able to obtain the services that are provided.
Acceptable	Health services are provided in ways that meet the expectations of adolescent clients.
Appropriate	The health services that young people need are provided.
Effective	The right health services are provided in the right way and make a positive contribution to the health of young people.

Further information on youth friendly services is provided in the WHO document: *Agenda for Change*.<sup>40</sup>

## Access facilitation

The *ACCESS Youth Health Better Practice Factsheets* identified that services are more accessible to young people when they are flexible, affordable, relevant and responsive to the needs of all young people (regardless of age, sex, race, cultural background, religion, socio-economic status or any other factor).<sup>98</sup> They described indicators of accessibility as per the table opposite:

## Professional development

Professional development should be appropriate, adequate and ongoing. Support and supervision should be available to health service providers working with young people.<sup>98</sup> Indicators are:

- All staff have access to core professional development activities, including orientation, appropriate supervision and training.
- All staff have a mechanism to review and discuss their professional development needs and plan appropriate and accessible training activities around those needs. Services provide an adequate and appropriate budget for professional development.

<b>Awareness</b>	Service has a promotion strategy and the target population is aware of the service and how to access it.
<b>Confidentiality</b>	Confidentiality is defined and explained at every appropriate point of contact between service and target population, including during service promotion. Explanations include clearly describing circumstances where confidentiality may be breached (such as self harm and child protection).
<b>Trust</b>	Young people's self-consciousness, embarrassment and potential cultural sensitivities are acknowledged by service providers at appropriate points of contact and appropriate efforts are made by workers to gain trust.
<b>Cost</b>	Service is provided at no or low cost.
<b>Physical accessibility</b>	Service is located close to public transport or otherwise made physically accessible and is open at appropriate hours for young people.
<b>Flexibility</b>	Service has the capacity to be flexible around appointment/consultation times and staff roles.
<b>Time</b>	Sufficient time is allowed to consult with young people and service removes time/financial pressures for service providers.
<b>Knowledge</b>	Service providers have knowledge about the health and access needs of young people.
<b>Confidence</b>	Service providers are confident in working with young people.
<b>Support</b>	Support is provided for service providers via appropriate training, supervision and peer support, back-up, intra- or inter-service linkages and opportunities to collaborate.

- Wherever appropriate, young people are involved in training.
- Services provide feedback mechanisms for staff to share newly acquired knowledge.
- Services collaborate around training to maximise resources and share expertise.
- Where appropriate, staff are rotated through, or exposed to, different roles to gain a broader knowledge and skill base.
- Evaluation of quality and outcomes of training is planned. For some disciplines and some activities, this is pre-built into the training activity (e.g. general practitioner continuing education programs).

Clinical supervision plays an important part in the ongoing development of workers. Its purpose is to ensure: delivery of high quality patient care and treatment through accountable decision making and clinical practice; facilitation of learning and professional development; and promotion of staff wellbeing by provision of support<sup>104</sup> (see Appendix 13: Training Resources).

## Collaboration and partnerships

Collaboration and partnerships with other agencies is important for ensuring appropriate referrals, allowing for shared care arrangements, and for obtaining professional advice and support on service provision for young people. Collaboration and partnerships also acknowledge that young people often present with complex and comorbid needs

that require a linked-up, shared and collaborative care plan involving a multiple agency response.

Collaborative, multidisciplinary healthcare has been increasingly seen as 'best practice'.<sup>42</sup> For services that do not specifically cater for young people, the referral to other services can be necessary. This might be the end of the matter for the referring organisation, or the beginning of a shared care arrangement.

Collaborative or share care can include enhanced communication, sharing of clinical care, joint education, joint program and system planning. It involves a degree of systemic co-operation (how systems agree to work together) and local co-operation between different groups of clinicians (p. 5).<sup>43</sup>

A literature review on care pathways as structured models for service delivery to young people who misuse substances and require specialist services recommended that:

A model of care be developed as a prelude to building each care pathway for each identified client group. Thus, care pathways should be determined by agreed models of care, and describe the ways in which those models of care are implemented, used and monitored.<sup>44</sup>

The principles of collaboration are defined as: service providers (within a service, as well as

different services within and across sectors) who share common service goals and target groups network, communicate and/or work together to plan, deliver, review and evaluate their service provision to young people.<sup>98</sup> Indicators are:

- Collaboration within and between services is articulated in service's strategic plan.
- Potential collaborative partners are identified within service's strategic and/or business plans.
- The plan(s) identify the purpose and potential benefits of collaboration and the roles and resources of different partners.
- Protocols are formed to develop and maintain the collaboration and review process, including communication channels, referral pathways and feedback mechanisms.
- Young people are informed about collaborative practices and involved as equal partners where appropriate.

Refer to the Adolescent Health GP Resource Kit<sup>4</sup> for further information, available from [http://www.caah.chw.edu.au/resources/gpkit/17\\_Section\\_4.pdf](http://www.caah.chw.edu.au/resources/gpkit/17_Section_4.pdf).

General guidance on developing partnerships is provided in Appendix 11.

Information about useful organisations and services that could assist or provide collaboration opportunities can be found in Appendix 1.

Collaboration with primary health care services, including GPs can ensure young people's physical and mental health needs are met. In this regard, workers should be aware of Medicare item numbers associated with young people with complex care needs or mental health issues. Refer to [www.health.gov.au](http://www.health.gov.au) for further details.

## Evidence-based approach

This principle is when services and their programs are developed according to evidence of need and of better practice from the most reliable and appropriate local, national or international sources.<sup>98</sup> Indicators include:

- Evidence is provided for the establishment of a service / program.
- Evidence is regularly updated about changing or emerging needs of target population(s), personnel and other stakeholders.

As this is not a youth-specific principle, no more will be presented here, other than to reinforce the assertion that the evidence upon which a service is planned needs to be consistent with local needs, and anecdotal evidence alone is generally inadequate.

## Sustainability

Service sustainability includes developing and implementing strategies that help them last longer.<sup>28</sup> Indicators are:

- Service has, and reviews, strategic and business plans with sustainability strategies, such as income generation, development of partnerships and collaboration, and evaluation processes to measure the effectiveness of its programs.
- Programs and services are integrated with existing mainstream programs and services wherever appropriate.
- Programs are designed to be replicable in other settings and/or contexts.
- Programs that measurably improve young people's or services' outcomes are favoured.
- The program has a 'champion' (advocate) who has connections with boards or funding bodies.

## The meaning of 'developmentally appropriate'

Developmentally appropriate service provision includes:

- sensitivity to the developmental challenges and changes faced by all adolescents
- continuous assessment of client capacity
- developmentally appropriate expectations, and methods of communication
- attention to duty of care and confidentiality
- awareness of differing developmental paths
- managing the tensions for working with vulnerable youth (e.g. balancing self-determination with duty of care or protection).

A discussion of these characteristics, including the application to prevention and early intervention is provided in Appendix 16.

## Youth participation

Youth participation has been defined as being when young people are actively involved in the development, implementation, review and evaluation of services and programs (in ways that create for each young person a sense of ownership of, importance to, influence within and/or belonging to that service or program, and a sense of mutual respect).<sup>98</sup> Indicators are:

- Service has policy, protocols and procedures in place for appropriate youth participation and consultation.
- Service has mechanism to regularly review the effectiveness of its youth participation strategies.
- Young people's input is sought about how they can participate.
- Young people are given appropriate knowledge and skills about how to participate (e.g. how to have a voice in meetings, how to facilitate meetings, how to consult with their peers in ways that bring useful information back to service providers).
- Young people are given credit for their participation and appropriately remunerated for their expertise, in monetary terms where possible, or in kind.
- Service has mechanism to ensure that youth participation is sufficiently representative so that the needs and views of the whole target group and/or different target groups are canvassed.

Participation by youth is affirmed in the United Nations' Convention on the Rights of the Child and barriers to youth participation include:

- cultural norms that favour hierarchical relationships between young and old
- economic circumstance of young people
- lack of access to information
- adults'/youths' mindsets fixed on 'ageism'
- judgemental attitudes between generations based on age
- conflicts that arise from differences in learning and working styles, time-management, communication patterns and means of involvement.

The NSW Commission for Children and Young People provides web-based resources for creating child safe organisations, which includes facilitating youth participation.<sup>41</sup>

## Evaluation and research

Evaluation involves services regularly examining the quality, relevance and results of their programs using appropriate evaluation methods, which include measuring the outcomes of the service for young people and service providers against their program goals.<sup>28</sup> Indicators of achievement of this principle are:

- Service has clear aims and objectives, linked to evidence.
- Service evaluates against aims and objectives.
- Service incorporates evaluation into its operations (via business, operational, project or other appropriate plan).
- Service allows sufficient resources (financial, human, time) to conduct evaluation at timely and appropriate intervals.
- Service identifies appropriate type of evaluation (e.g. process, impact or outcome) and develops strategies for conducting the evaluation.
- Service incorporates evaluation findings as new evidence.

Evaluation links to the principle of youth participation. That is, youth should be involved in all aspects of evaluation – not just as research subjects, but helping to inform the questions, the interpretation of results and decisions on the incorporation of findings. Further, consideration needs to be given towards evaluating the organisation's capacity to provide services to young people and the organisation's effectiveness in providing services to young people.

In line with the evidence-based approach mentioned earlier, services can conduct research to develop the knowledge-base around substance use and young people. Such research may help services to develop their awareness of issues relating to young people, in the context of their service. Conducting research can also increase the capacity of services to engage with complex clients, contribute to professional development, and introduce services to new approaches to data collection and analysis.

## SECTION 4

# Service Provision

### Key points: Section 4

- Guidelines for treatment are presented, including the involvement of family and dealing with difficult behaviours in a residential setting. Effective engagement with adolescents requires:
  - understanding of adolescent developmental issues
  - effective communication skills
  - knowledge of medico-legal issues e.g. being alone with children and confidentiality.
  - strategies for working with adolescents and their families
  - understanding the young person's cultural background and how they see themselves within it.
  - young people have requirements that are distinct from adults, and they can be vulnerable to exploitation or misjudgement. Services have a duty of care to ensure their safety, including consideration of vulnerability, circumstances of use, and association with adults in the service.
- Screening instruments need to be able to identify problematic alcohol use, including binge drinking.
- A comprehensive holistic assessment is the critical first step in the treatment of adolescent substance use. This is not a one-off event, should be staged over time and should ideally be conducted in a youth-friendly environment.
- The 'HEEADSSS' psychosocial screen can be used as a broad assessment tool with young people. It incorporates: **H**ome, **E**ducation and **E**mployment, **E**ating, **A**ctivities, **D**epression, **D**rugs, **S**pirituality, **S**afety and **S**exuality.
- Motivational interviewing (MI) is an interview style for encouraging motivation for change, and can be incorporated within other treatments, e.g. brief interventions. It involves expressing empathy, developing discrepancy, rolling with client resistance, and supporting their self-efficacy.
- Other psychosocial approaches, which can be used with young people (and can incorporate the spirit of MI) include cognitive behavioural therapy (CBT), Dialectical Behavioural Therapy (DBT) and Mindfulness Base Stress Reduction (MBSR), among others.
- The *NSW Clinical guidelines for methadone and buprenorphine treatment of opioid dependence* (GL2006\_019) include some guidance around the use of pharmacotherapies with young people. Young tobacco smokers should be encouraged to quit through the use of nicotine replacement therapy, where needed.
- Pharmacotherapies are occasionally used for young people, particularly those with dependence on opioids or nicotine.
- The management of withdrawal should be guided by an assessment of need. Medically supervised or hospital-based detoxification is rarely required for young people.
- The complex problems of young people require a range of services to work effectively together. Collaborations and partnerships are needed to facilitate referrals and shared care.
- Family inclusive practice is an approach recognising that individuals influence other members in their environment, and vice versa. Therapeutic interventions with families are an important consideration.
- Referral requires a number of processes to ensure the young person can provide informed consent to the referral and is supported to proceed with the referral.

The scenario below illustrates some of the complex needs that a service might need to address to provide an adequate service to a young person who presents with a substance use problem. It also illustrates how services need to work with other services to do this. This section provides information about how to respond when young people approach a service, with an emphasis on what is different for young people relative to adult clients.

*Jimmy: "Wow! Did my life get messed up. Started using weed with my brother and his friends when I was about 11. Loved it, felt great, felt grown up. Lot of shit was happening at home – parents fighting, mum left, came back, dad left..... then at school kept getting into fights, got suspended... boring! Weed helped heaps, so started smoking more cones each day. Don't like booze much, but tried some ice and liked it a bit too much – but sometimes it was a bit too fast for me."*

*"Last year, after I turned 16, I started to use more and more dope... used to smoke myself to sleep – couldn't sleep without being stoned... during the day was stoned most of the time, busy scoring, mulling up, rorting to get money... Then it got really weird. I didn't notice at first, then me mates started to say 'hey, what's up, you're freaking us out bro!' I was getting sooo paranoid, and even started to hear voices yelling at me, dumping on me. Freaked me out too. Didn't know what to do."*

*"Lucky I had some OK mates who made me go and see a counsellor, who got me to see a really cool doctor who sorted me out. Had to go to a program for a while, and he gave me some medication to help with the paranoia and voices. Talking to the counsellor is OK, sorting out stuff with family, and I want to get back into education – I want to do a good trade course – AND get my head sorted so I don't freak out any more, and freak me mates. I am still taking the medication, and getting my life back now. It takes a lot of work, but it's worth it."*

**Jimmy needed:** support; referral; competent assessment of his mental health; continued support with his treatment plan; regular review of his medication and mental health; assistance with education, training and employment; psychoeducation; support with withdrawal management and support for his family. He may also be in need of legal advocacy.

## Treatment for young people

### Core elements of effective treatment for young people

A literature review has proposed that treatment programs should be designed specifically for young people, because adolescent and adult drug problems are often manifested differently. "Adolescents present higher rates of binge use, lower problem recognition, and higher rates of comorbid psychiatric problems as compared with adults. In addition, adolescents are more likely to be more susceptible to peer influence and are more highly focused on immediate concerns." <sup>77</sup> (p. 417)

Core elements identified as associated with effective drug treatment for adolescents include:

1. Screening and comprehensive assessment to ensure understanding of the full range of issues the young person and their family are experiencing.
2. Comprehensive services to address the young person's substance abuse problem as well as any medical, mental health, familial, or education problems.
3. Family involvement. Parents' involvement in their adolescent's treatment and recovery increases the likelihood of a successful treatment experience.

4. Developmentally appropriate services and therapies offered address the different needs and capabilities of adolescents.
5. Strategies to engage and keep adolescents in treatment, to help adolescents recognise the value of getting help for their problems.
6. Qualified staff: staff should have knowledge of and experience working with adolescents/young adults with substance abuse problems and their families.
7. Cultural and gender differences: programs should consider and address cultural and gender differences within their population.
8. Aftercare support: effective programs plan for care after the formal treatment program is completed to ensure support and successful recovery.
9. Data gathering to measure outcomes and success of the program.

The Youth Support and Advocacy Service (YSAS) have developed a resource for the purpose of enabling youth drug and alcohol services to develop and/or strengthen their therapeutic practice frameworks.<sup>23</sup> It contains characteristics of effective youth services, which may also be useful for adult services where young people may present.

## Safety of young people in services

Young people have requirements that are distinct from adults. They can be vulnerable to exploitation or misjudgement,<sup>94</sup> and service providers have a duty of care to ensure the safety of young people in their care that may be greater than for adult clients or patients.

The following factors should be considered as part of service provision to young people:

**Vulnerability:** Young people involved in substance misuse are highly vulnerable. In addition to the risks to their future prospects and the likelihood of later involvement in crime, they are at increased risk of victimisation and exploitation by others.<sup>95</sup>

**Circumstances of use:** The circumstances in which young people misuse drugs may differ from those of adults. Their lack of independence can mean that the drug use takes place in environments that may bring additional risks, such as outdoors or in the company of a much older peer group.<sup>95</sup>

**Association with adults in the service:** dependency in young people is likely to be less entrenched than for adults.<sup>96</sup> Consideration should therefore be made as to the mix of clients, and the potential positive and negative impacts this may have on young people, and levels of supervision that can be provided by staff. As a result, a service may conclude that a young person's care is better provided in another setting, and it is the responsibility of this service to assist the young person to access that care.

## Engagement

The Adolescent Health GP Resource Kit provides strategies and practical steps for engaging and communicating effectively with adolescent patients, and is relevant more broadly for other health professionals.<sup>4</sup> The Kit discusses how effective engagement with adolescents requires:

- understanding of adolescent developmental issues, including the physical, cognitive, emotional and psychosocial changes for the young person effective communication skills
- knowledge of medico-legal issues, e.g. being alone with the child, and confidentiality
- strategies for working with adolescents and their families
- making attempts to understand the young person's cultural background and how they see themselves within it.<sup>4</sup>

Effective consultation with young people includes:

- the establishment of a supportive and trusting relationship, through spending time to engage and build rapport
- identify their developmental stage in order to tailor communication, questions and instructions appropriately
- always explain confidentiality and its limits at the initial consultation
- where possible, see the person on his or her own, even if briefly
- be sensitive to their cultural background, values and norms
- communicate interactively – involve them in decision-making, encourage questions and foster their participation in the consultation process.<sup>4</sup>

See Appendix 15 for guidance on conducting a youth-friendly consultation.

## Screening and Assessment

Screening instruments need to be able to identify potentially harmful substance use. A review of the literature has found:

The best (indicators) of adolescent alcohol misuse are repeated episodes of binge-drinking, loss of control, psychological craving and academic and interpersonal problems resulting from alcohol use. Generally, adolescents tend not to meet diagnostic criteria for abuse or dependence, but rather engage in problematic use that increases their risk of developing an alcohol problem. Therefore, the best measure for this age group is one that assesses low-level hazardous and harmful alcohol use.<sup>64</sup>

There are multiple tools for screening of substance use and related problems for adults that are appropriate for young people, and others designed specifically for young people.<sup>60-64</sup> Substance misuse screening tools that are appropriate for adolescents include the MAST, the AUDIT, the DAST, the POSIT, the CRAFFT and the ASSIST (links to these tools are available at <https://www.oasas.ny.gov/admed/sbirt/index.cfm>).<sup>65</sup>

The ASSIST screens for all levels of problem or risky substance use in adults, and Drug and Alcohol Services South Australia (DASSA) has developed draft versions of the test for young people (see <http://www.dassa.sa.gov.au/site/page.cfm?u=477>).

There are some general principles in conducting a youth friendly assessment.

A comprehensive assessment is the critical first step in the treatment of adolescent substance use. A well-conducted assessment can increase engagement in treatment and be a therapeutic intervention in and of itself.<sup>66</sup>

- Spend time engaging the young person
- Negotiate to see the young person alone
- Discuss confidentiality
- Use communication appropriate to the developmental stage of the young person. Avoid medical jargon.
- Be sensitive to and respect the cultural norms when seeing young CALD people
- Adopt a non-judgemental and collaborative approach
- Consult with the young person on the development of their management plan
- Decide with the young person the issues to be discussed with their parent/guardian.
- Address the parental concerns and involve them where possible.<sup>4</sup>

There are a number of key areas that should be covered in any assessment with a young person:

- **Chief complaint/issue** – find out his or her understanding of what has brought him or her to the point of assessment. If the chief issue is not a substance use problem, then assess the history of the chief issue, i.e. duration, impact upon the young person's life, steps taken to resolve the issue and the results of these steps. Then appropriate referral would follow. If the chief issue is primarily substance use related, then move to the areas described below.
- **HEEADSSS ASSESSMENT:** The HEEADSSS psychosocial screen provides a broad assessment for young people (see box). See Appendix 20 and the following resources for guidance on this tool:
  - **The Adolescent Health GP Resource Kit 4** (Chapter 2) [http://www.caah.chw.edu.au/resources/gpkit/Complete\\_GP\\_Resource\\_Kit.pdf](http://www.caah.chw.edu.au/resources/gpkit/Complete_GP_Resource_Kit.pdf)
  - **HEEADSSS 3.0 The psychosocial interview for adolescents updated for a new century fuelled by media** [http://contemporarypediatrics.modernmedicine.com/sites/default/files/images/ContemporaryPediatrics/cntped0114\\_Feature%201%20Hi-Res.pdf](http://contemporarypediatrics.modernmedicine.com/sites/default/files/images/ContemporaryPediatrics/cntped0114_Feature%201%20Hi-Res.pdf)

## HEEADSSS Assessment

This assessment includes the following domains:

**Home**  
**Education**  
**Eating**  
**Drugs**  
**Depression**  
**Suicide**  
**Safety**  
**Sexuality**

## Drug Use History

A drug history should begin with the more common substances such as tobacco, alcohol and cannabis, then go on to include amphetamines, hallucinogens, ecstasy, benzodiazepines, inhalants and opiates.

For each drug, include age at first and last use, reasons for continued use, method of administration (including any changes), sharing of injection equipment, where they use (e.g. street, home, dealer's place) and whether they use alone or in a group, impact of drug use on functioning, periods of non-drug use, attempts to control/stop use, withdrawal symptoms and the young person's goals in relation to his or her drug use.

- **Severity of the problem** – use of standardised measures to assess the severity of the problem is recommended; e.g. Severity of Dependence Scale, Diagnostic and Statistical Manual of Mental Disorders (DSM5), or the International Classification of Mental and Behavioural Disorders.
- **Previous treatment** – include perceived usefulness of such treatments and reasons for cessation/continuation of treatment.
- **Physical and mental health** – include examination of past medical history, allergies, psychiatric history (individual and family), current medications and medical compliance.
- **Developmental history** – include birth history and early development.

Upon completion of assessment, a more comprehensive assessment could be undertaken in any of the aforementioned areas, by a more specialised medical practitioner, if required.

- **Offending history** – include the number and types of offences, and links with substance use, number of times incarcerated (and length of time), current legal status and any upcoming legal appearances.
- **Trauma history** – explore abuse, violence, torture and experience of armed conflict and natural disasters (e.g. fire, flood and famine).  
Reassessment and monitoring will need to occur over time.

Assessment instruments can be useful tools in screening for and determining the frequency, quantity and severity of substance use in young people. Furthermore, structured interviews such as the Structured Clinical Interview for DSM-IV (SCID) and the Composite International Diagnostic Interview (CIDI) may be useful in determining whether young people meet DSM-5 or ICD-10 criteria for abuse or dependence, potentially requiring more intensive intervention. However, most assessment tools are not youth specific, or they require adaptation for Australian populations. (pp. 142-144)

Australian reviews of screening and assessment instruments for alcohol and other drug use and other psychiatric disorders (not specific to young people, but applicability to adolescents is noted) are available from:

- the Department of Health and Aging:<sup>64</sup>  
[http://www.health.gov.au/internet/main/publishing.nsf/Content/0F0A76CDCA7CD3EBCA256F19000448CF/\\$File/mono48.pdf](http://www.health.gov.au/internet/main/publishing.nsf/Content/0F0A76CDCA7CD3EBCA256F19000448CF/$File/mono48.pdf)
- the Network of Alcohol and other Drug Agencies<sup>63</sup>  
[http://www.nada.org.au/media/7678/review\\_of\\_measures\\_09.pdf](http://www.nada.org.au/media/7678/review_of_measures_09.pdf)

## Motivational interviewing

Motivational interviewing (MI) is an interview style for encouraging the motivation of clients to change. It is a method of communication rather than a specific strategy, so it can be incorporated within other treatments, e.g. brief interventions.<sup>68</sup>

Guiding principles of motivational interviewing are:

- express empathy
- develop discrepancy
- roll with resistance
- support self-efficacy.<sup>58</sup>

There is reasonable evidence for the effectiveness of MI with young people in increasing engagement with and attendance at services and reducing cannabis abuse/dependence, when combined with Cognitive Behavioural Therapy (CBT). MI is not effective as a stand-alone treatment for substance use problems in young people, particularly those who have complex presentations such as homelessness.<sup>59</sup> Further, it has been reported that the effects of MI do not appear to last as long for young people as they do in older adults.<sup>59</sup> Naar-King provides information on how to implement MI with adolescents, given the sorts of developmental processes that can impact upon MI, highlighting the importance of making a special effort to avoid pressuring for change or premature problem solving.<sup>99</sup> An example interaction which emphasises choice is:

“You have a choice to discuss the rules with your parents and see if there is room to compromise, or you can decide to break the rules and deal with your parents’ reaction.”  
(p. 652).

MI has the aim of promoting engagement, minimising resistance and defensiveness and encouraging behaviour change. Three main features of motivational interviewing are:

- discussion about the good and less good things about problematic substance use
- assessing the young person’s concerns about current levels of use
- assessing the young person’s confidence in making changes to their use.<sup>100, 101</sup>
- the young person shows greater preference for the good things about their problematic substance use, the following strategies could be used:
  - summarising, with an emphasis on the less good things of greatest concern to the person
  - highlighting and creating discrepancies in the young person’s assessment of their use (e.g. looking to the future, exploring past goals and expectations, and contrasting the self with the substance user).<sup>100, 58</sup>

A comparison of adolescent developmental processes and their implications for motivational interviewing is provided at Table 10.

**Table 10. Summary of adolescent developmental processes and implications for motivational interviewing**

Developmental process	Implication for motivational interviewing
<b>Cognitive</b>	
Formal operations	Affects discussions of long-term goals and abstract values
Information processing	May relate to misinterpretations of consequences of behaviours and promote active seeking of disconfirming evidence
<b>Social and emotional</b>	
Identity formation	Allow exploration of self-concept, empathise with ambivalence, and be tolerant of shifts in perspective
Autonomy	Opposition to authority is a normal developmental process
Family	Help family members to reframe adolescent rebellion as normal process of identity formation
Peers	Explore values and stresses associated with peers as possible pros and cons of behaviour change
Emotional lability	Caution when making plans for change during period of intense emotion

### Brief interventions

These are clinical interventions, including screening and assessment, as well as information and advice that is designed to achieve a reduction in risky substance use. They are typically used with individuals who are using substances at risky levels before they develop into abuse or dependence disorders. Any health care professional or treatment provider can deliver brief interventions, with appropriate training.<sup>68</sup>

Brief interventions have been demonstrated to be effective with adults in a range of contexts, and show promising outcomes with young people.<sup>69-71</sup> The Royal College of Psychiatrists (RCP) provide guidance on delivering brief interventions to young people, noting that workers should have the competencies to:

- identify those at risk
- know when a more detailed assessment is required
- be able to either conduct the assessment (using motivational interviewing for engaging with the young person, and their parent or carer if applicable) or quickly access an appropriately skilled professional to take the next steps.<sup>72</sup>

The RCP suggests a different approach according to age:

- For all young people aged 18 or under: Identification should simply involve brief questioning about substance misuse (e.g. what was taken, how often, and in what context.)

- For young people under 15 years: If any concerns are identified (positive screen), young people are offered a comprehensive assessment to assess for health, education and social care needs (including substance misuse, mental health problems, physical health, family and other complexities).
- For young people aged 15 years or over: If concerns are identified, the young person's use is explored with more detailed questions (a brief assessment) and if appropriate they are offered advice and/or an extended brief intervention. If they screen positive for a substance use disorder and complex needs, a comprehensive assessment is offered and arranged.

When conducting the brief intervention:

- Understand risk and the risk thresholds that indicate when further action is required
- Take into account their age, emotional maturity, level of understanding, their culture, faith and beliefs
- Encourage them to consider involving their parents or carers (where possible) or other responsible adults
- Provide information on how the young person and their parents or carers can access help or advice whenever they require it
- Prior to an interview, explain to the young person and their parent or carer (if appropriate) about the purpose of the questions, and what will be offered if a problem is identified.

## Other therapies and approaches

Other intensive psychosocial approaches used to support people with substance use issues include: psychodynamic and interpersonal approaches, Dialectic Behavioural Therapy (DBT) and Mindfulness Based Stress Reduction (MBSR), among others. Refer to the Drug and Alcohol Psychosocial Interventions Professional Practice Guidelines for further details:

[http://www0.health.nsw.gov.au/policies/gl/2008/pdf/GL2008\\_009.pdf](http://www0.health.nsw.gov.au/policies/gl/2008/pdf/GL2008_009.pdf)

## Pharmacotherapies

There is very little research on the use of pharmacotherapies with adolescents.<sup>53</sup> With regard to opioid replacement therapy, the *NSW Clinical guidelines for methadone and buprenorphine treatment of opioid dependence* (GL2006\_019) include some guidance for treatment of young people. These guidelines (Appendix 5) advise:

When a young person clearly has serious and dangerous drug use problems, but may never have been neuroadapted to opioids, the best course of management is a difficult decision and a second opinion is essential before considering opioid treatment. (p. 77)<sup>55</sup>

Nicotine Replacement Therapy (NRT) involves the delivery of a dose of nicotine into the bloodstream which replaces the nicotine that is lost when a person stops smoking. The goal is to assist smoking cessation through reduction of nicotine withdrawal symptoms and cravings. NRT should always be accompanied by behavioural strategies to increase the likelihood of quitting. When added to behavioural strategies, NRT has been shown to double the chance of quitting.<sup>105</sup> Young people should be supported to access NRT, when required.

## Residential drug and alcohol programs for young people

There are some day programs and short term residential programs for young people under 16 years of age with drug and alcohol problems (e.g Dunlea day program, Ted Noffs Drug and Alcohol program and Triple Care Farm). They provide a holistic approach to care for the young person focusing on educational needs, social concerns as well as mental health and drug and alcohol issues.

## Behavioural strategies

The behaviour of young people presenting to drug and alcohol services may be difficult. This can be due to a range of reasons, including:

- a history of exposure to anti-social influences
- substance withdrawal
- anger, fear, frustration around issues relating to the service individual issues such as: learning disabilities, intellectual disability, hyperactivity, or mental health issues
- developmental issues – not having learned to deal with frustration.

The Australian Government's training resource for frontline workers to work with young people<sup>56</sup> describes the Rogers model of managing behaviours. This model aims to assist workers to help young people to own and manage their behaviours.<sup>57</sup> The model includes four interactive phases relating to preventing problems, encouraging and correcting negative behaviours, consequences, and repairing and rebuilding relationships. This model can be used in a one-off interaction or, most usually, as part of an ongoing process. It is described in Appendix 12.

The Rogers Model provides a framework, to be supported by policies and training in behaviour management developed by the service. For example, contracting can be used to reinforce an agreed plan of action between workers and young people. Contracting involves:

- significant input needed from the young person
- specifying the behaviour
- realistic, achievable options
- signatures by both parties (if written)
- review date.

Defusion strategies may be required, including:

- active listening
- calm, pacifying language
- statements beginning with 'I', to show your concern about the potential for someone getting hurt, and your need to prevent that
- using their name, model calmness in your voice and movements (e.g. deep breathe if you are becoming anxious)
- avoid excessive questioning
- don't smile, which can signify nervousness or amusement, or touch them
- don't talk down to or patronise them. Treat them as equals who have a reason for being angry or upset

- staff training and documented policies for managing aggressive behaviour and other critical incidents are essential.

## Managing withdrawal

General principles in managing withdrawals are as relevant for young people as they are for adults. This includes <sup>74</sup>

- match the person with the treatment intervention that maximises patient safety and provides the most effective and most economical options for withdrawal management.
- consider ambulatory withdrawal management (patient at home, supported by visits to the clinic or visits from the clinician and by telephone) as the first option
- guide the intervention by a thorough assessment
- Provide a supportive environment
- Monitor mental health complaints such as mood, anxiety, risk of psychosis

While some young people with severe addiction require specialist detoxification services, most adolescents will require mainly psychosocial support.

Guidelines for the management of cannabis withdrawal are available from the National Cannabis Prevention and Information Centre's website.<sup>76</sup>

## Transition planning

Transition planning is a key issue when providing a service to young people, to ensure that once a young person is engaged, there is a process in place to facilitate continuity of care between services. Three types of continuity of care are:

1. *Informational continuity* – the use of information on past events and personal circumstances to make current care appropriate for each person
2. *Management continuity* – a consistent and coherent approach to the management of a health condition that is responsive to a person's changing needs
3. *Relational continuity* – an ongoing therapeutic relationship between a person and one or more services.<sup>97</sup>

## Collaborative care

The complex problems encountered by young people require a range of services to work effectively together. This is to meet the young person's needs stemming from the coexistence of mental disorders and health, education, family and social problems.

Many young people with substance use problem are clients of the juvenile justice system, are engaged with the mental health system, and/or students in the school system. It is important to know who is already engaged with them.

Section discussed the need to establish collaborations and partnerships before the young person enters the service, to facilitate referrals and shared care.

In relation to specific clients, collaboration with other agencies can be facilitated by:

- Including a section within care plans that identifies practitioners in other organisations that are providing relevant treatment/care for the client and describing ways in which you will liaise, coordinate or collaborate with these providers
- Involving collaborating practitioners from other agencies in case reviews (if you are the lead service)
- attending case reviews at the agencies of other services (if you are involved in the shared care of a client, but not the lead service).

## Working with families of young people

The following information has been adapted from a document on working with families and carers of drug and alcohol clients that was published by the Network of Alcohol & other Drug Agencies (NADA).<sup>78</sup>

Family inclusive practice is an approach recognising that individuals influence other members in their environment, especially family, and that family members in turn have an impact on these individuals. Therapeutic interventions with the families of young people are an important component of any program designed to assist young people deal with any substance abuse issues they may be struggling with. This becomes even more important if the young person has a mental health condition as well as a substance abuse concern.

The family of the young person, which may be either functioning or non-functioning as an effective family unit, is the base from which the young person emerges into the realisation of their real self. The young person who does not have access to the psychological and/or physical resources of their family, even when it is dysfunctional, faces major threats to their emerging developmental needs, mental health needs and substance abuse issues.

The benefits of interventions with families are largely focused around the communication needs, relationship needs and developmental needs of the young person. Added to this are the various needs the family unit itself has in maintaining itself in a healthy or even an unhealthy systemic way. When some of these matters are addressed in family therapeutic sessions, the young person has a greater opportunity to move on from any blocks they may have in these areas.

In addition, when a young person has mental health issues, the family may be the principal resource from which information about the genesis and ongoing nature of the problem can be accessed. This information is important in the development of an ongoing treatment plan to deal with the complex problems surrounding the co-existence of mental health and substance abuse matters.

There are numerous challenges for anyone making any therapeutic intervention with families and young people with mental health and substance abuse issues. They are manifested in a whole range of human behaviours, from aggression and violence on one hand, to love and compassion on the other.

## Referral

Referral might be appropriate if the assessment has identified the need for external services.

When referring, consider the following:<sup>4</sup>

- Referral should be discussed sensitively with the young person and the reasons clearly explained
- Clarify your role with respect to the referral (e.g. shared care arrangement)

- The questions used to identify and/or briefly assess risk should be fit for purpose, appropriate to the setting, and acceptable to young people, parents or carers, and staff
- Services that identify risk and offer a brief assessment should record and monitor their activity and response. Young people aged 15 and above, who are not dependent but are judged to be at risk are offered age-appropriate advice and/or an extended brief intervention to discourage further use
- The brief intervention is provided by staff who are trained to use age-appropriate interventions that aim to increase motivation to change behaviour, through reflective and non-judgemental feedback.
- Obtain their permission to share information with the other referral body
- Plan the referral/appointment in collaboration with the young person
- Support the young person if they are anxious – make the 'handover' as smooth as possible
- If possible, give them the name of a contact person at the other service
- Explore logistics of travelling to and meeting additional costs of referred services
- Explain if you need to provide information to other professionals (reassure confidentiality) and obtain their consent to include their health information in the referral
- Tell them that you are available to see them again if they need help or are unhappy with the new service
- Provide follow-up support and care where needed.<sup>4</sup>

## Agencies and services for workers supporting young clients

### Health Child Wellbeing Units

Child Wellbeing Units (CWUs) operate in NSW Health, the NSW Police Force and the Department of Education and Communities.

CWU functions are to:

- help agency mandatory reporters identify the level of suspected risk to a child or young person, including whether matters require a report to the Community Services Child Protection Helpline
- provide advice to agency mandatory reporters about possible service responses by the agency or other services to assist children, young people, and families, and in some cases initiate direct referrals
- drive better alignment and coordination of agency service systems, to enable better responses to vulnerable children, young people, and families.

Information on the NSW Health CWUs:

<http://www.health.nsw.gov.au/initiatives/kts/cwu.asp>

### Family Referral Services

Health workers may refer vulnerable children, young people and families to a Family Referral Service for information, assessment and referral to a range of support services in their local area.

To contact a Family Referral Service, see Fact Sheet: [http://www.dpc.nsw.gov.au/\\_\\_data/assets/pdf\\_file/0009/83646/06\\_Family\\_Referral\\_Services.pdf](http://www.dpc.nsw.gov.au/__data/assets/pdf_file/0009/83646/06_Family_Referral_Services.pdf) or ask the NSW Health CWU.

### Alcohol Drug Information Service (ADIS)

A telephone service for the public and health workers, operating 24 hours a day, 7 days a week for support, information, advice, crisis counseling and referral to services in NSW.

Tel: 9361 8000 (Sydney)

or free call: 1800 422 599 (For NSW regional and rural callers)

### The Drug and Alcohol Specialist Advisory Service

<http://yourroom.com.au/helplines/the-drug-and-alcohol-specialist-advisory-service-dasas/>

DASAS is a free telephone service for doctors, nurses, and other health professionals to use. DASAS is designed specifically to support staff working in regional and rural areas in NSW but is available to any health professional. DASAS is a 24-hour telephone service to support doctors and health professionals exclusively with any assistance they may need with diagnosis and treatment of patients with alcohol and drug issues. DASAS is staffed by drug and alcohol advisors, who refer issues to on-call senior medical staff specialists if necessary to advise on clinical management of patients.

Tel: 9361 8006 (Sydney)

or free call: 1800 023 687.

## Drug and alcohol services for young people in NSW

Service name	Org.	Description	Suburb / Area	Phone number / website
Bridge Youth and Family Program	Salvation Army	Addresses gambling, alcohol or other drug addictions. Family and significant others are encouraged to participate in the person's recovery.	Wickham	(02) 9212 4000 <a href="http://salvos.org.au/need-help/addiction-services/about-the-bridge-program/">http://salvos.org.au/need-help/addiction-services/about-the-bridge-program/</a>
Bridges	Bridges	Works to connect and strengthen individuals, families and communities, in particular working to prevent and reduce harm related to alcohol and other drug use.	Blacktown	(02) 9622 7511 <a href="http://www.bridges.org.au/page7473/Alcoholdrug-family-counselling.aspx">www.bridges.org.au/page7473/Alcoholdrug-family-counselling.aspx</a>
Centre for Youth Well Being: Junaa Buwa	Mission Australia	Rehabilitation centres for young people who have entered, or are at risk of entering, the juvenile justice system. Offers rehabilitation and treatment, educational and living skills training and aftercare support.	Coffs Harbour	(02) 6651 3418 <a href="http://www.missionaustralia.com.au">www.missionaustralia.com.au</a>
The Crossing	Mission Australia	A mobile, intensive case-management service for young people (18-25 years) with complex support needs. Co-located with Reconnect Inner City (early intervention services for young people aged 12 to 18 who are homeless, or at risk of homelessness, and their families), and Young People Connected (mobile phone service for young people).	Kings Cross	(02) 9357 1144 <a href="http://www.missionaustralia.com.au">www.missionaustralia.com.au</a>
Dunlea Alcohol and other Drug Youth Service	Youth Off The Streets	For young people (13-19 years) with varied levels of substance use and motivation. Includes information and assessment, harm minimisation groups, referral, and case management. Can also provide 1:1 counselling.	Merrylands	(02) 9721 5714 <a href="http://www.youthoffthestreets.com.au/page.aspx?pid=258">http://www.youthoffthestreets.com.au/page.aspx?pid=258</a>
Holyoake Family AOD Program	Catholic Care	Offers group education, therapy and support programs for families impacted by substance dependence	Lewisham, and Tighes Hill (Hunter)	(02) 9509 1255 <a href="http://www.catholiccare.org/community/drugs-alcohol-and-gambling/holyoake">http://www.catholiccare.org/community/drugs-alcohol-and-gambling/holyoake</a>
Mac River Centre	Mission Australia	Provides rehabilitation for young people with drug and alcohol problems (13-18 years). Individualised programs, including therapy, counselling and education are provided.	Dubbo	(02) 6809 9420 <a href="http://www.missionaustralia.com.au">www.missionaustralia.com.au</a>
Manly Drug Education and Counselling Centre (MDECC)	MDECC	Works with young people (12-28 years), their families and the broader community to minimise the harms associated with substance use. They offer health promotion, targeted intervention and counselling and treatment.	Manly	(02) 8966 9333 <a href="http://www.mdecc.org.au/">http://www.mdecc.org.au/</a>
Nepean Youth Drug & Alcohol Service (NYDAS)	Wentworth Centre for Drug & Alcohol Service	Uses a holistic model of care to address a range of issues for young people related to their substance use.	Kingswood, Nepean	(02) 4734 2129 <a href="http://www.somazone.com.au/help-support/nepean-youth-drug-alcohol-service.html">http://www.somazone.com.au/help-support/nepean-youth-drug-alcohol-service.html</a>
Oasis Youth Support Network	Salvation Army	Therapeutic services for young people, (16-25 years) experiencing disadvantage or homelessness. Services include: counselling, therapeutic groups and education programs.	Darlinghurst, Sydney	(02) 9331 2266 <a href="http://salvos.org.au/oasis/">http://salvos.org.au/oasis/</a>
Program for Adolescent Life Management (PALM)	Ted Noffs Foundation	A residential program of up to three months for young people aged 14 to 18 years with serious substance use related difficulties	Randwick, Sydney	(02) 8383 6612 <a href="http://www.noffs.org.au/TED/client/GeneralContent/c_singleDynamicPage.jsp?pageName=Residential+Palm+About">http://www.noffs.org.au/TED/client/GeneralContent/c_singleDynamicPage.jsp?pageName=Residential+Palm+About</a>
Newcastle Youth Service	Wesley Mission	Provides casework, counselling, crisis intervention, information and referrals, advocacy, outreach, community education and early intervention and prevention group work programmes for young people (12-25 years), their families and communities.	Newcastle West	(02) 4962 2188 <a href="https://www.wesleymission.org.au/centres/Youth/Newcastle_Youth_Service.asp">https://www.wesleymission.org.au/centres/Youth/Newcastle_Youth_Service.asp</a>
Resources & Education on Alcohol and Drugs for Youth (READY)	St George Youth Services	Information and support, education and group work around substance use issues for young people and those working with them.	Hurstville	(02) 9556 1769 <a href="http://www.stgeorgeyouth.org/">http://www.stgeorgeyouth.org/</a>

Service name	Org.	Description	Suburb / Area	Phone number / website
South West Youth Services - Drug and Alcohol Awareness Program	Mission Australia	Provides education, employment, life skills and counselling support to marginalised youth (12-24 years).	Campbelltown	(02) 4621 7422 <a href="http://sd.missionaustralia.com.au/274-south-west-youth-services">http://sd.missionaustralia.com.au/274-south-west-youth-services</a>
Triple Care Farm	Mission Australia	A residential, treatment and vocational training program for young people (16-24 years). The service provides intensive support, including counselling, mediation, confidence-building and skills development.	Robertson, Southern Highlands	(02) 4860 7403 <a href="http://www.sdmf.org.au/youth-programs/triple-care-farm">http://www.sdmf.org.au/youth-programs/triple-care-farm</a>
Waverley Action for Youth Services (WAYS)	WAYS	Caters for with young people (9-25 years) to create pathways to the future. Services cover recreation, education and training, case management, counselling, health promotion and clinical services.	Bondi	(02) 9365 2500 <a href="http://ways.org.au/ways_wordpress/">http://ways.org.au/ways_wordpress/</a>
Weave Youth and Community Services	(formerly) South Sydney Youth Services	Provides services to socially excluded young people, women, children and families. A large proportion of clients are Aboriginal or Torres Strait Islander.	Redfern	(02) 9318 0539 <a href="http://www.weave.org.au/b/">http://www.weave.org.au/b/</a>
YouthLink	Salvation Army: FYRST	A specialist youth service, providing: early intervention, intensive case management and vocational training for young people across Greater Western Sydney.	Fairfield West	(02) 9725 7779 <a href="http://salvos.org.au/youthlink/">http://salvos.org.au/youthlink/</a>
Youth Solutions	Youth Solutions	Provides support services to prevent and reduce drug use and related harm among young people.	Macarthur and Wingecarribee regions	(02) 4628 2319 <a href="http://www.youthsolutions.com.au/">http://www.youthsolutions.com.au/</a>

## Other youth services

- **Youth Off the Streets (YOTS)** provides accommodation, educational, vocational, counselling and outreach services in multiple sites. <http://www.youthoffthestreets.com.au/home/w1/i2/>
- **The Children's Hospital Westmead** includes:
  - A clinic that caters to adolescents 12-16 yrs who may be experiencing disabling symptoms, chronic illness, eating disorders, weight management concerns, drug and alcohol and gynaecology assessment.
  - Outreach clinic at High Street Youth Health Service.  
[http://www.chw.edu.au/prof/clinics/adolescent\\_clinics.htm](http://www.chw.edu.au/prof/clinics/adolescent_clinics.htm)
- **Youth health services** – there are multiple across NSW including Youthblock, High Street, TraXside, the Warehouse, CHAIN, Crossroads, Kickstart among others. See a list with contacts at [http://yfoundations.org.au/index.php?option=com\\_content&view=article&id=75&Itemid=120](http://yfoundations.org.au/index.php?option=com_content&view=article&id=75&Itemid=120)
- **headspace** – a national initiative for people aged 12 to 25, providing health advice, support and information from 55 centres across Australia. headspace can assist with general health, mental health and counselling, education and employment, and alcohol and other drug services. [www.headspace.org.au](http://www.headspace.org.au)

## ■ The Justice Health & Forensic Mental Health

**Network** provides health care to those in contact with the NSW criminal justice system. For example:

- The Community Integration Team is a pre and post release program offering continuum of care to recently released adolescents, with an emerging or serious mental illness and/or problematic substance use or dependence.
- The Community Forensic Mental Health Service provides specialist assessment and recommendation reports regarding the management of problematic behaviours which pose a threat to the safety of others. The service operates in a consultation-liaison model and aims to primarily assist Local Health District community mental health teams in the treatment and care of patients with complex mental health and behavioural needs. The CFMHS caters to both civil and forensic patients.  
<http://www.justicehealth.nsw.gov.au/our-services/fmh-youth.html#1>

Further information is available from the Adolescent Health GP Resource Kit<sup>4</sup>  
[http://www.caah.chw.edu.au/resources/gpkit/17\\_Section\\_4.pdf](http://www.caah.chw.edu.au/resources/gpkit/17_Section_4.pdf)

## APPENDIX 2

# Framework working group members, and consultation stakeholders

Working Group members are members of the NSW Ministry of Health Quality in Treatment (QIT) Subcommittee or have been nominated by their Local Health District and Speciality Network QIT representative.

Participant	Organisation
Bronwyn Milne	Children's Hospital Westmead
Catherine Silsbury	Children's Hospital Westmead
Clare Blakemore	Juvenile Justice, Department of Attorney General and Justice
David Hedger	Illawarra Shoalhaven Local Health District, Drug & Alcohol Services
Debbie Kaplan	Mental Health and Drug & Alcohol Office
Deryk Slater	Cannabis Clinic, Central West, Western Local Health District
Fiona Robards	Youth Health and Wellbeing, NSW Kids and Families
Geoff Wilkinson	Juvenile Justice, Department of Attorney General and Justice
Gilbert Whitton	Southern NSW Local Health District, Drug & Alcohol Services
Joe Barry	Mental Health and Drug & Alcohol Office, System Management
John Howard	The National Cannabis Prevention and Information Centre
Julie Carter	Justice and Forensic Mental Health Network
Julie Edwards	Mental Health and Drug & Alcohol Office
Katherine Wiggins	Justice and Forensic Mental Health Network
Kristie Harrison	Aboriginal Health and Medical Research Council
Lisa Kelly	headspace: The National Youth Mental Health Foundation
Mark Montebello	South East Sydney Local Health District
Nghi Phung	Western Sydney Local Health District
Rachel Bienenstock	Northern Sydney Local Health District
Ralph Moore	NSW Health, Drug & Alcohol & Community Programs
Shelley Turner	Juvenile Justice, Department of Attorney General and Justice
Stewart Stubbs	NSW Centre for Advancement of Adolescent Health
Tess Finch	South East Sydney Local Health District

### Other stakeholders consulted

- NSW Kids and Families
- Health Education Training Institute
- Agency for Clinical Innovation
- headspace
- Network of Alcohol and Drug Agencies Youth NGO Services Network
- MH Children and Young People
- NSW Chief Addiction Medicine Specialist, and Assistant Clinical Adviser
- Drug and Alcohol Program Council, and Quality in Treatment Sub-committee

APPENDIX 3

## Risk factors for adolescent problem behaviours

Source: Hawkins and Monahan (data from Brooke-Weiss et al, 2008) – from Institute of Medicine and National Research Council. *The science of adolescent risk-taking: workshop report*. Washington, DC: The National Academies Press, 2011, pp. 92-93.

Risk factors	Substance abuse	Delinquency	Teen pregnancy	School dropout	Violence	Depression and anxiety
<b>Community</b>						
Availability of drugs	✓				✓	
Availability of firearms		✓			✓	
Community laws and norms favourable towards drug use, firearms and crime	✓	✓			✓	
Media portrayals of violence					✓	
Transitions and mobility	✓	✓		✓		✓
Low neighbourhood attachment and community disorganisation	✓	✓			✓	
Extreme economic deprivation	✓	✓	✓	✓	✓	
<b>Family</b>						
Family history of the problem behaviour	✓	✓	✓	✓	✓	✓
Family management problems	✓	✓	✓	✓	✓	
Family conflict	✓	✓	✓	✓	✓	✓
Favourable parental attitudes and involvement	✓	✓			✓	
<b>School</b>						
Academic failure beginning in late elementary school	✓	✓	✓	✓	✓	✓
Lack of commitment to school	✓	✓	✓	✓	✓	
<b>Individual/Peer</b>						
Early and persistent antisocial behaviour	✓	✓	✓	✓	✓	✓
Alienation and rebelliousness	✓	✓		✓		
Friends who engage in the problem behaviour	✓	✓	✓	✓	✓	
Favourable attitude toward the problem behaviour	✓	✓	✓	✓		
Early initiation of the problem behaviour	✓	✓	✓	✓	✓	
Constitutional factors	✓	✓			✓	✓

## Dovetail Resource: Conceptualisation of Young People

The following extract is from the *Youth Alcohol and Drug Good Practice Guide 1: A framework for youth alcohol and other drug practice*.<sup>79</sup> Other useful resources within the Dovetail website are:

- Online training (introduction to AOD);
- Legal and ethical dimensions of practice guide and
- Practice strategies and interventions guide

(Find all of these resources at: <http://www.dovetail.org.au/i-want-to/open-the-good-practice-toolkit.aspx>)

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 Hill 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** (Bronfenbrenner 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 they 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.

### 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**

LOCATION	PROTECTIVE FACTORS	RISK FACTORS
<b>SOCIAL FACTORS</b>		
School	<ul style="list-style-type: none"> <li>• regular school attendance</li> <li>• positive relationships with teachers, coaches and peers</li> <li>• participation and achievement in school activities</li> <li>• access to personal, interactional and academic support</li> </ul>	<ul style="list-style-type: none"> <li>• academic challenges</li> <li>• truancy</li> <li>• peer rejection/bullying</li> <li>• suspension and exclusion</li> <li>• perceived irrelevance of school</li> <li>• lack of support for learning needs</li> <li>• ascertained learning difficulties</li> </ul>
Family	<ul style="list-style-type: none"> <li>• nurturing, supportive attachments to family and extended kinship networks</li> <li>• parental supervision and interest in child’s growth and development</li> <li>• parent access to relevant resources and support</li> </ul>	<ul style="list-style-type: none"> <li>• family conflict and violence</li> <li>• neglect or abuse</li> <li>• parental rejection</li> <li>• lack of consistent nurturing and supervision</li> <li>• family poverty and isolation</li> <li>• parental offending</li> <li>• drug and alcohol dependencies</li> </ul>
Peer	<ul style="list-style-type: none"> <li>• associating with pro-social peers</li> </ul>	<ul style="list-style-type: none"> <li>• associating with offending peers</li> <li>• participating in anti-social behaviour</li> </ul>
<b>ENVIRONMENTAL FACTORS</b>		
Community	<ul style="list-style-type: none"> <li>• stable and affordable housing</li> <li>• access to services</li> <li>• participation in community activities, such as sport and recreation</li> <li>• involvement with supportive adults</li> <li>• income security</li> </ul>	<ul style="list-style-type: none"> <li>• lack of support services</li> <li>• socio-economic disadvantage</li> <li>• discrimination</li> <li>• lack of training or employment</li> <li>• non-participation in sport or social/recreational clubs and activities</li> <li>• lack of income and housing security</li> </ul>
Life events	<ul style="list-style-type: none"> <li>• avoiding, surviving and recovering from the harm caused by loss and trauma</li> </ul>	<ul style="list-style-type: none"> <li>• death and loss</li> <li>• severe trauma</li> <li>• repeated out-of-home-placements</li> <li>• exiting care</li> <li>• early pregnancy</li> <li>• homelessness</li> </ul>

LOCATION	PROTECTIVE FACTORS	RISK FACTORS
<b>INDIVIDUAL FACTORS</b>		
Individual	<ul style="list-style-type: none"> <li>• pro-social attitudes</li> <li>• competent social skills</li> <li>• regard for self and others</li> <li>• substance avoidance</li> <li>• self confidence</li> <li>• positive sense of identity and belonging</li> <li>• healthy diet, weight, activity, fitness and mental wellbeing</li> <li>• sexual health</li> </ul>	<ul style="list-style-type: none"> <li>• offending history</li> <li>• poor social skills</li> <li>• low self-esteem</li> <li>• self injury</li> <li>• substance misuse/dependency</li> <li>• anti-social attitudes and behaviour</li> <li>• low self-control</li> <li>• disregard for others</li> <li>• poor physical, mental or sexual health</li> </ul>

Source: [www.communities.qld.gov.au/resources/communityservices/youth/yari-interim-program-guidelines.pdf](http://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).

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.

## NSW Health Guidelines regarding young people

A number of NSW Health guidelines already contain information regarding dealing with young people. This information is collected below.

### Drug and Alcohol Psychosocial Interventions: Professional Practice Guidelines (2008)<sup>9</sup>

[http://www.health.nsw.gov.au/policies/gl/2008/GL2008\\_009.html](http://www.health.nsw.gov.au/policies/gl/2008/GL2008_009.html)

#### Chapter 7: Intervention for Special Groups

##### 7.10 Young people with emerging problems (page 65-67)

D&A professionals and services need to tailor their treatments differently to young clients with emerging problems. This will not be necessarily in terms of the content of psychosocial interventions offered to young people (e.g. brief interventions, CBT, motivational enhancement, systemic/family therapy, psychodynamic therapy, see Section 4), rather the process of engagement and providing treatment will need to consider the young client differently from an adult client.

Firstly, experimentation, including with drugs and alcohol, forms a relatively normal part of adolescence. Indeed, for some adolescents, this experimentation and experience with trial and error processes may be their way of developing a fully formed, healthy personality. While many young people do not use drugs and alcohol at dangerously high levels, there are known harms associated with all levels of misuse. It is also recognised that some young people will develop chronic patterns of drug use and engage in frequent harmful bingeing. As with adult clients, when drug and alcohol use becomes habitual and/or normal functioning is affected, it is cause for concern.

The assessment and diagnosis of problems among young people is difficult, given adolescence is a time of potentially tumultuous growth and change.

However, the first presentations of psychosis will be emerging for vulnerable clients at this time, and this is often associated with cannabis and amphetamine use. Depression and anxiety disorders also first emerge during adolescence, which can also be exacerbated or 'self-medicated' with problematic drug and alcohol use. Characteristic of these emerging conditions will be obvious changes from previous levels of functioning, and treatment will also need to target these changes and symptoms in addition to problematic drug and alcohol use.

It is important that the D&A professional understands that the adolescent drug and alcohol user is not just a younger version of an adult drug and alcohol user. Adolescence is a time of establishing independence (especially from parents and adult authority figures), where relationships with peers are exceptionally important. D&A professionals working with young people need to recognise this, and use strategies such as humour to assist in the rapport and engagement process. Encouraging the development of 'normal' peer-related activities outside of therapy, such as playing sports, joining various social groups, playing music, drawing/artistic expression, should also be the focus of treatment sessions with adolescence. Or, at least these activities, when they are already occurring for some young people, should be strongly reinforced during therapy.

Young people also typically have higher energy levels than older adults, and as a therapist, the D&A professional must also be prepared to take on a more active, energetic role in treatment, rather than relying on some of the more passive, reflective skills to promote engagement and build rapport. In addition, having a 'youth-friendly' environment in which to see young people is important. Simple strategies such as setting up a waiting room to indicate that young people are welcome can be useful in promoting engagement with a young client population. This might include photos of young people, images of activities relevant to young people displayed, etc.

Marsh and Dale outline several key strategies to consider when working with young people:

- Limit use of scare tactics
- Take longer to establish rapport and trust within therapy
- Ensure confidentiality is maintained
- Provide structure, and set and reinforce clear limits
- Allow the young client some freedom to choose their own goals for behaviour
- Young people learn best when they try out experiences for themselves
- Take a harm reduction approach
- Use concrete, behavioural strategies
- Remember that the young client operates within the context of a family, so they should also be involved where possible.

## Drug and Alcohol Treatment Guidelines for Residential Settings (2007)

[http://www.health.nsw.gov.au/pubs/2007/drug\\_a\\_guidelines.html#80](http://www.health.nsw.gov.au/pubs/2007/drug_a_guidelines.html#80)

### Chapter 11: Groups with particular needs

#### 11.3 Young people (pages 31-44)

The immediate aim when treating young people may be cessation of use, or controlled use, or withdrawal management. There are usually broader objectives, such as reducing criminal activity, increasing involvement in education, employment or training, improving family functioning, improving interpersonal skills and improving physical and mental health. Treatment includes prevention, in that it aims at preventing further harm.

##### 11.3.1 Treatment outcome studies

The literature evaluating treatment of young people is limited and only a few tentative conclusions can be drawn:

- some treatment is usually better than no treatment
- few comparisons of treatment method have consistently demonstrated the superiority of one method over another
- achieving at least brief periods of abstinence is readily achievable, but maintaining abstinence or avoiding relapse is difficult

- post-treatment relapse rates are high (35 per cent to 85 per cent)
- reduced use is a more likely outcome when heroin is the drug of concern than for alcohol, tobacco, cannabis and methamphetamines.

In the few controlled trials of treatments, positive outcomes were found for cognitive-behavioural, skills training and residential treatments. For residential treatment, three months' residence appeared to be the optimal period, and longer stays appeared to produce little additional benefit. However, providing continuing care after the residential period appeared to improve outcomes.

##### 11.3.2 Towards more effective treatment

A suitable goal for residential treatment may be: *to increase the capacity of the young people involved in treatment to manage their lives more effectively.*

The traditional abstinence goal of many programs may need to be reconsidered in situations other than those which already involve organ or other physical damage. Young people are often not ready for abstinence and a harm minimisation approach will be more readily received by them. Whatever the goal, it needs to be clearly articulated, and take into account various local, national, or broader cultural and religious factors.

Possible objectives for consideration include:

#### General:

- Increasing clients' capacity to recognise any negative consequences of substance use for themselves, their families and significant others, and the community
- increasing motivation to address significant issues in their lives.

#### Substance use and related behaviour:

- reducing the number and quantity of substances used and the frequency of use
- reducing binge use patterns
- reducing risky use (e.g. reducing or eliminating sharing of injecting equipment and a change to safer modes of administration, reducing the risk of overdose)
- reducing the number and severity of problems associated with substance use, particularly criminal activities.

### Health and general functioning:

- improving general health
- reducing risky behaviour (e.g. promoting safer sexual behaviour, especially via increased condom use)
- increasing involvement in non-drug related activities
- increasing life satisfaction
- improving psychological health, reducing the frequency of negative mood states (e.g. depression and anxiety) and increasing the capacity to recognise the onset of and manage the course of any negative mood states associated with use
- increasing involvement with non-drug using peers
- improving family functioning, or achieving satisfactory disengagement from the family if necessary.

### Interpersonal and other skills:

- remediating any educational deficits and increasing skills relevant to improving employment possibilities
- increasing access to and participation in education, training or employment
- improving interpersonal, communication, problem solving and coping strategies and skills, including those related to self-care and management (life/living skills).

Life skills are abilities for adaptive and positive behaviour that enable individuals to deal effectively with the demands and challenges of everyday life. It has been claimed that the life skills approach, which is mostly used in schools, has a positive impact which lasts). The WHO publication *Skills for health* identifies these essential life skills:

- communication
- interpersonal skills
- empathy skills
- advocacy skills
- negotiation/refusal skills
- decision making skills
- critical thinking skills
- coping skills
- self-management skills
- skills for increasing personal confidence
- goal setting skills
- self assessment skills
- abilities to assume control, take responsibility, make a difference and bring about change.

The objective of building life skills is part of a comprehensive (holistic) approach to treating people with a drug dependency. It is not being suggested that all young people who use drugs and develop drug-use related difficulties are deficient in intellect, education and interpersonal skills and are psychologically disturbed.

Residential treatment interventions need to build on strengths and identify and address deficits. The general principles of effective treatment developed by NIDA (1999) and quoted in section 3.1 have relevance for the residential treatment of young people.

#### 11.3.3 Assessment

All residential treatment interventions must be preceded by adequate, unbiased assessment (see section 4.1). The assessment can be staged over time, where possible, and ideally conducted in an environment friendly to young people. It should identify strengths and areas requiring attention. Motivational Interviewing appears helpful in engaging young people in assessment and treatment.

#### 11.3.4 Interventions for young people

Interventions need to be *developmental (sub)stage specific*, and take into account the needs and capacities of young people and the young person's stage of development; particularly cognitive capacity, developmental/maturational lags, and the need for recreation and fun. Much adult treatment is very serious business, and young people tend to react to such approaches by acting out and acting up. Unfortunately, this sometimes means that they are discharged from treatment for their "unsatisfactory" behaviour, apparent lack of motivation or because they are "in denial".

Improving the friendliness of programs to young people increases accessibility. Accessibility implies more than location; it has to do with a perception of a non-discriminatory, non-judgmental, non-marginalising, welcoming program.

One model which can inform residential treatment is *relapse prevention*. This model identifies intrapersonal and interpersonal variables and environmental situations and cues which are associated with use and return to use of drugs. Assessment of individuals and groups leads to personalised treatment interventions for the individual or group. For example, young people can

develop the following understanding: “I am more likely to use heroin, when I feel sad, am alone and at home”, or “I am more likely to use methamphetamines when I am bored, with my friends and at a club”.

Program interventions can then target the development of specific skills and alternatives to the benefits gained from using drugs, such as recognising the onset of negative mood states earlier and having strategies to deal with them more appropriately in a positive way. Likewise, family interventions may be necessary if drug use has an association with issues within the family. Teaching living skills, such as self-care, and interpersonal skills (social and communication) may assist those whose drug use is associated with interpersonal conflict, peer influence or peer pressure and social anxiety. Any skills which are taught need to be usable in the general community, and not merely to do with making life in an institutional or other treatment environment easier.

The relapse prevention model appears to offer the most useful framework for residential treatment, and a range of treatment options is helpful, including:

- *Short-term residential* (usually less than three months), especially for withdrawal or assessment and respite when the young person’s life circumstances are chaotic or dangerous and they meet criteria for drug dependence. Interventions during short-term residential treatment include individual, group and family counselling, educational and vocational activities and the development of life/living skills.
- *Longer-term residential* (usually three months) intensive treatment, with interventions similar to those for short-term residential, for those whose drug dependence is more intense, whose social supports may be more limited and where health (including mental health) concerns may be elevated. Longer term residential treatment is often within a therapeutic community, usually adapted to better suit young people. Interventions include group work, individual counselling/therapy, family work, vocational and educational activities, recreation and leisure activities, and living skills.
- *Semi-supported residential*, such as hostels or group homes. These can be used to accommodate young people who are attending a day program, or exiting a residential one.

### 11.3.5 Treatment matching

Matching a young person to the most appropriate treatment may enhance outcome. Residential treatments are expensive, and should only be used when other interventions have not been beneficial, or are assessed as inappropriate. Group treatments tend to be preferred, and are usually more cost-effective. Case management strategies which provide for a coordinated approach aimed at increased access to services, advocacy, and support are essential to ensure a planned, accountable treatment process.

### 11.3.6 A model of residential treatment

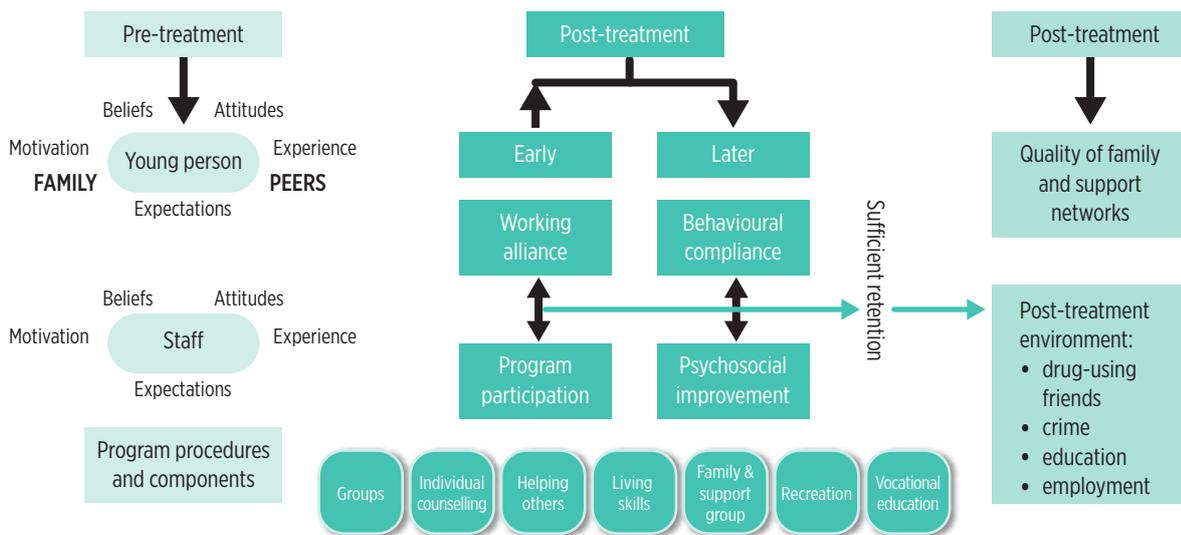
Guiding treatment (residential or other) by a comprehensive and coherent model is crucial. Otherwise, components can be added or removed at whim, making the treatment environment confusing and incoherent, and research extremely difficult.

The Ted Noffs Foundation has developed and adapted the Texas Christian University model of treatment process and outcomes. This model emphasises that treatment does not just occur, but is constructed around the combined influences of the individual, their family and other significant people, events and circumstances, and the similar characteristics of the staff and the treatment environment, processes and components. Some of the relevant characteristics of young people and staff include: motivation, previous experience of treatment, education, family and peer influences, beliefs and attitudes. (See figure below).

Residential treatment has an initial stage where developing a working alliance and program participation are the goals, and a later stage where behavioural compliance and psychosocial improvement in functioning occur. With sufficient retention in treatment, the young person should enter the post-treatment environment (where some of the more significant post-treatment variables, such as the family relationships, peer relationships, education and vocation have received attention during treatment) with better coping skills and strategies.

Program components, then, are understood as having a clearly defined role in the total program experience, and monitoring and evaluation activities can be clearly linked.

**Figure 2. The Tedd Noffs Foundation residential treatment process model (as adapted from Texas Christian University)**



This model recognises that staff do not come with equal characteristics, no matter how well trained and inducted. This highlights the fact that staffing variables must be factored into any analysis of retention and outcomes. The model also shows that treatment actually occurs in many aspects of the daily program (e.g. chores, groups, counselling, helping others, skill development, peer interactions in the program, staff interactions, recreation) and outside the residential facility (among family, peers and community).

### 11.3.7 After treatment

Post-treatment variables warrant particular attention, as pre-treatment ones consistently explain little of the variance in treatment outcome, and post-treatment ones have been consistently associated with outcomes. Better outcomes are achieved by following residential treatment with continuing care, including attention to family functioning, educational and/or vocational functioning, and health. The development of social support networks that will remain beyond treatment, particularly those which emphasise peer to peer assistance, are crucial. All residential treatment should provide options for continuing care, provided by the residential service itself or via other community services.

## NSW Clinical Guidelines For the Care of Persons with Comorbid Mental Illness and Substance Use Disorders in Acute Care Settings (2009)

[http://www0.health.nsw.gov.au/pubs/2009/comorbidity\\_report.html](http://www0.health.nsw.gov.au/pubs/2009/comorbidity_report.html) <sup>35</sup>

### Chapter 14: Specific Populations

#### 14.1 Young people (page 47)

Like those with adult disorders, youth comorbidity is associated with a more severe pathology, significant challenges in terms of service delivery and poorer treatment outcomes.

Australian burden of disease and injury statistics illustrate the breadth of the problem of mental and substance use disorders for young people. Of young people aged 15–24, eight out of ten of the causes of burden for young women were related to mental or substance use disorders and nine out of ten for males.

The disease burden in this group is largely the result of substance use disorders and/or mental health problems as illustrated in the table below. Comorbidity of these disorders is high with over 50% having comorbid disorders.

Males	Females
road traffic accidents	depression
alcohol dependence	bipolar affective
suicide	alcohol dependence
bipolar affective	eating disorders
heroin dependence	social phobia
schizophrenia	heroin
depression	asthma
social phobia	road traffic accidents
borderline personality	schizophrenia
generalised anxiety disorder	generalised anxiety disorder

Young people are likely to come in contact with the health care system at a variety of different access points that include (but are not limited to) the following:

- General practitioners
- Child and adolescent services
- Paediatricians
- Private practitioners (psychologists, psychiatrists, counsellors)
- School counsellors and/or health nurses
- Hospital wards and Emergency departments.

These services must consider the special needs of young people including language, resources and available materials in order to ensure services can adequately address the needs of this population. The NSW Department of Health, several non-government organisations and schools have initiated a number of focussed early identification, treatment and social programs designed to target young people with mental health needs and/or substance use disorders. These resources assist with detection and can link children to specialised services and resources. A list of key contacts and resources is available at Appendix 9.

Young people often attend health care services at the behest of parents and families; not because of their own motivation. Family members play an important role in the care of a young person with a comorbid mental health and substance use disorder particularly when conducting an assessment and in the planning and conduct of care and treatment.<sup>50</sup>

Practitioners have an opportunity to intervene early in a young person's life. Secondary prevention, psychoeducation and engagement are extremely important in the treatment of young people.

## Drug and Alcohol Withdrawal Clinical Practice Guidelines (2009)

[http://www.health.nsw.gov.au/policies/gl/2008/GL2008\\_011.html](http://www.health.nsw.gov.au/policies/gl/2008/GL2008_011.html)<sup>74</sup>

### Chapter 2: General principles of withdrawal management

#### 2.4 Treatment matching for withdrawal management

##### 2.4.1 Special groups (p 15)

Withdrawal services must consider the needs of these specific groups of patients and seek further information from relevant NSW Department of Health documents or services.

Consider the following:

#### Youth

- need to use the least restrictive setting
- risk of exposure to other forms of drug use (information and other patients) in particular settings
- availability of appropriate liaison staff
- vulnerability in residential settings.

### Chapter 5: Opioids

#### 5.4.4 Buprenorphine (page 39)

If a patient is aged 16 or 17 years, a second opinion is required before authority to prescribe buprenorphine can be granted. A second opinion must be obtained from a drug and alcohol specialist in the local drug and alcohol service and be documented. Prescribing buprenorphine to patients less than 16 years of age requires an exemption to the provisions of the *Children and Young Persons (Care and Protection) Act 1998*. The request for an exemption should include a second opinion from a drug and alcohol medical specialist nominated by the Area Health Service and a written application must be made as per the protocol in *New South Wales Opioid Treatment Program: clinical guidelines for methadone and buprenorphine treatment* (NSW Department of Health GL2006\_019 2006, page 22).

## Chapter 6: Cannabis

### 6.5.4 Young People (page 47)

Dependent use of cannabis by people younger than 16 years often exists as one of the many problems experienced by the child. The absence of protective factors, co-existing family discord, poor school attainment, social exclusion, and childhood psychiatric disorder (e.g. conduct disorder, post-traumatic stress disorder and attention deficit hyperactivity disorder) are likely to compound the problems associated with cannabis dependence and withdrawal.

Non-confrontational approaches using motivational interviewing should be used, with family support where available and appropriate. Medication should be avoided. Admission to adult inpatient units should be avoided. Inpatient admission should be to a specialist adolescent unit within or supported by a drug and alcohol service.

### Mental Health Resource for Drug and Alcohol Workers (2007)

[http://www.health.nsw.gov.au/pubs/2007/mh\\_resource.html](http://www.health.nsw.gov.au/pubs/2007/mh_resource.html)<sup>81</sup>

## Chapter 6: Working with clients from particular populations

### Young People (pp. 77-81)

In 2000 a report was released to describe the Child and Adolescent Component of the National Survey of Mental Health and Well-Being. This report provided the following information relating to mental illness of young people in Australia:

- Fourteen percent of children and adolescents in Australia have mental health problems
- There is a higher prevalence of child and adolescent mental health problems among those living in low-income, step/blended and sole-parent families
- Children and adolescents with mental health problems have a poorer quality of life than their peers
- There are a limited number of trained clinicians in child and adolescent mental health
- Only one in four of young people with mental health problems receives professional help
- Adolescents with mental health problems report a high rate of suicidal ideation and other health-risk behaviour, including smoking, drinking and drug use.

In 2001 NSW Health published *Getting in Early - A Framework for Early Intervention and Prevention in Mental Health for Young People in NSW*. This report highlights that the onset of psychosis, anxiety, depression and substance abuse generally occurs in the mid-late adolescent or early-adult years. For example, about 800 young people will experience first episode psychosis each year and it is not uncommon for young people to develop more than one mental illness. As adolescence and early adulthood is a time of significant development of self, relationships, career and social life, mental illness can lead to significant disabling effects for young people, as well as impacting on their families.

Unfortunately, there is often a 1-2 year delay between first symptoms and receiving treatment and the longer the delay in treatment the worse the outcome for young people. There are many reasons why this delay occurs: mental health services may not be culturally or youth friendly; it is at times difficult to distinguish between emerging mental health problems and 'normal' adolescent difficulties and the stigma and discrimination related to mental illness may limit help-seeking behaviour. Instead it is common for young people to present to generic services. This provides opportunities for early recognition, intervention and referral in services that are prepared to work holistically with young people.

Engagement is critical when providing early intervention to young people with emerging mental health problems. Engagement provides a supportive response to lessen the effects of stressors related to symptoms, building competence and strengths and is an ongoing process. It involves developing a therapeutic relationship with young people and their families through rapport building, being interested and respectful, as well as providing information and building trust.

Engaging young people can be difficult because they are usually brought into treatment by a parent or other caregiver. Engagement therefore requires patience and skill. The engagement approach used needs to be adjusted to the age of the young people. Providing information and support is a useful way to improve engagement as young people can often feel confused by their symptoms. Providing information and support to parents on what to expect and what they can do to assist is also important. Working with the family is essential. The younger the child the more critical family or carer involvement becomes. With young people, as with adults, confidentiality and its limits should be explained in detail.

It is important to realise that mental illness in young people can present differently than it does with adults, and therefore, treatment may be different. In all cases early intervention is crucial.

When assessing young people information should be obtained from a variety of sources. Young children may be less able to verbalise feelings. It is important to ask questions at an age appropriate level, use language the child understands and to check that they have understood what you have told them. It is vital to systematically assess all potential areas of difficulty as comorbidity is common and emotional problems are often overlooked in the presence of aggressive and disruptive behaviour.

At assessment, it is important to consider the safety, welfare, and well-being of any children. Health care workers have a duty under the NSW Children and Young Persons (Care and Protection) Act 1998 to notify the Department of Community Services whenever they suspect that a child may be at risk of harm through abuse or neglect. When necessary, this duty overrides the duty to maintain client confidentiality. For further information, refer to:

- Child Wellbeing and Child Protection Policies and Procedures for NSW Health PD 2013\_007 [http://www0.health.nsw.gov.au/policies/pd/2013/pdf/PD2013\\_007.pdf](http://www0.health.nsw.gov.au/policies/pd/2013/pdf/PD2013_007.pdf)

See Appendix 7 for key information contained in the policy.

### *Mood disorders*

Getting early support and treatment can help prevent problems from becoming serious, long term issues. This is especially important for children and young people. Early intervention with depression can lessen the length of depressive episodes and reduce relapse and improve psychosocial outcomes. Unfortunately the degree of depression in young people tends to be underestimated and therefore often goes unrecognised or untreated. Young people who experience depression often appear cranky, grouchy and irritable rather than sad or unhappy. They may not experience weight loss but rather fail to make expected weight gains. In children depression may be displayed through somatic (bodily) symptoms rather than specific mood changes. In fact the commonest diagnosis for children is dysthymic disorder rather than major depression. Although the symptoms are less severe for dysthymic disorder the level of disability such

as poor school performance and problems with peers and family is often high.

Psychosocial interventions should target: enhancing good peer and parental relationships; improving employment and strengthening individual resilience through positive and optimistic thinking styles. In some areas referrals can be made to specialised programs that support children and young people.

### *Anxiety disorders*

Although fears are common during childhood and adolescence an anxiety disorder is likely if fears are intensive or long lasting and cause significant impairment in functioning. Unfortunately, the anxiety disorders are common in young people who tend to display similar symptoms as experienced by adults. Anxiety disorders are however difficult to recognise because young people usually know their fears are not realistic and therefore may not speak about them out of shame.

Interventions for anxiety often include education and counselling to help the person understand their thoughts, emotions and behaviours associated with anxiety.

### *Psychotic disorders*

Different types of psychoses include schizophrenia, bipolar mood disorder and drug induced psychoses. In first onset psychosis early intervention should ideally occur during the 'something is not quite right' prodrome stage where pre-psychosis negative symptoms such as social withdrawal and changes in behaviour occur.

Unfortunately it can be difficult to distinguish between the depressive and psychotic disorders and they can be further complicated by behavioural or developmental issues and/or substance use. Referral to specialist services or consultancy staff is advised

For more information on working with young people:

- Early Psychosis Prevention and Intervention Centre (EPPIC) <http://www.eppic.org.au/>
- Reach Out – factsheets, resources online forums and apps. <http://www.reachout.com.au/>
- Getting in Early – A Framework for Early Intervention and Prevention in Mental Health for Young People in NSW [http://www0.health.nsw.gov.au/pubs/2001/getting\\_in\\_early.html](http://www0.health.nsw.gov.au/pubs/2001/getting_in_early.html)

- Barriers to Service Provision for Young People with Presenting Substance Misuse and Mental Health Problems, by the National Youth Affairs Research Scheme (NYARS): <http://deewr.gov.au/national-youth-affairs-research-scheme-publications>
- The NSW Association for Adolescent Health report Caught in the Gap: Dual Diagnosis and Young People: A Report on the Issues, downloadable from [http://www.nayh.org.au/documents/Dual\\_Diag\\_Final%20Report\\_sml.file.pdf](http://www.nayh.org.au/documents/Dual_Diag_Final%20Report_sml.file.pdf)
- Department of Health and Ageing publications and resources on young people and mental health from <http://www.health.gov.au> and <http://www.mentalhealth.gov.au>

## NSW Drug and Alcohol Clinical Supervision Guidelines (2006)

There is nothing specific in these guidelines about supervising clinicians working with children and young people.<sup>82</sup>

## Clinical guidelines for methadone and buprenorphine treatment of opioid dependence (2006)

[http://www.health.nsw.gov.au/policies/gl/2006/GL2006\\_019.html](http://www.health.nsw.gov.au/policies/gl/2006/GL2006_019.html)<sup>55</sup>

### Chapter 7 Specific Clinical Situations

#### 7.16 Treatment of adolescents (page 77)

There is considerable evidence that the age of first drug use is declining. Many adolescents present to treatment services with serious social and psychological problems associated with frequent dangerous drug use. However, most adolescents use multiple drugs and dependence on heroin alone is extremely uncommon in this age group. Many adolescents use prescription drugs and may seek opioid maintenance treatment as a potential source of continuing drugs despite having relatively little prior exposure to opioids. When a young person clearly has serious and dangerous drug use problems, but may never have been neuroadapted to opioids, the best course of management is a difficult decision and a second opinion is essential before considering opioid treatment.

## Privacy

NSW Health legislation, Statutory Guidelines under the Health Records and Information *Privacy Act 2002*, and policy directives are available from <http://www.health.nsw.gov.au/aboutus/legal/privacy.asp>

From The Privacy Manual (Version 2) - NSW Health:<sup>83</sup>

### 5.5.2 Minors

When treating a minor, the treating health care provider should assess the maturity of the client/patient, in particular their ability to understand the consequences of their decision. The following principles can be used as an age guide:

- Where a client/patient is less than 14-years of age, consent should generally be given by the parent or legal guardian.
- Where the client/patient is between 14 and 16-years of age, efforts should be made to obtain the consent of the parent or legal guardian unless the client/patient indicates a strong objection.
- Where the client/patient is 16-years of age or over, they should generally be capable of deciding on the access issue for themselves.

When deciding if a person has capacity, you must consider whether they would be able to give consent if given appropriate assistance. The rationale for the decision as to whether a person has capacity or not should be recorded in their health record.

If a person does not have the capacity to decide for themselves, an authorised representative can give consent on their behalf.

#### Further information regarding privacy:

There are 12 information protection principles (IPPs). These are the key to the *Privacy and Personal Information Protection Act* (PPIP Act). They are legal obligations that describe what NSW government agencies (including statutory bodies and local councils) must do when they handle personal information. The 12 IPPs cover the collection, storage, use and disclosure of personal information as well as access and correction rights, and are summarised here: [http://www.ipc.nsw.gov.au/privacy/individuals\\_public/privacy\\_indiv\\_public/indiv\\_info\\_protect\\_principles.html](http://www.ipc.nsw.gov.au/privacy/individuals_public/privacy_indiv_public/indiv_info_protect_principles.html)

There are 15 health privacy principles (HPPs). These are the key to the *Health Records and Information Privacy Act (HRIP Act)*. They are legal obligations describing what NSW public sector agencies and private sector organisations and individuals, such as businesses, private hospitals, GPs, gyms and so on must do when they handle health information. The 15 HPPs lay down the basic rules of what an organisation must do when it collects, stores, uses and discloses health information. The HPPs also cover access and correction rights.

[http://www.lawlink.nsw.gov.au/lawlink/privacynsw/ll\\_pnsw.nsf/vwFiles/privacy\\_fact\\_sheet\\_HPP\\_members\\_of\\_public.pdf/\\$file/privacy\\_fact\\_sheet\\_HPP\\_members\\_of\\_public.pdf](http://www.lawlink.nsw.gov.au/lawlink/privacynsw/ll_pnsw.nsf/vwFiles/privacy_fact_sheet_HPP_members_of_public.pdf/$file/privacy_fact_sheet_HPP_members_of_public.pdf)

As they are not specific to young people, they are not reproduced here.

## Consent to Medical Treatment – Patient Information (2005)

[http://www.health.nsw.gov.au/policies/PD/2005/pdf/PD2005\\_406.pdf](http://www.health.nsw.gov.au/policies/PD/2005/pdf/PD2005_406.pdf)<sup>51</sup>

PD2005\_406 is an update of Circular 99/16 – Patient Information and Consent to Medical Treatment in March 1999. It provides additional detail on procedure to follow where conflicts arise between minors and their parent/s guardians in relation to consent for treatment for the minor. Particularly relevant excerpts from this policy document are provided below. Further information is provided in the policy.

### 25. What if the patient is a minor?

#### 25.1 Emergency Treatment

Pursuant to section 174 of the *Children and Young Persons (Care and Protection) Act 1998*, a medical practitioner may carry out medical treatment on a child (a person aged under 16 years) or young person (a person aged 16 or 17) without the consent of the child or young person or a parent of the child or young person, if the medical practitioner is of the opinion that it is necessary, as a matter of urgency, to carry out the treatment on the child or young person in order to save his or her life or to prevent serious damage to his or her health. This means that emergency medical treatment, and emergency first aid treatment (including any procedure, operation or examination) may be provided without the consent of the minor or a parent or guardian.

#### 25.2 Non-Emergency Treatment

It is NSW Health policy that if the patient is under the age of 14 years, the consent of the parent or guardian is necessary understand and appreciate the nature and consequences of the operation procedure or treatment. However, where the child is 14 or 15 years of age, it is prudent for practitioners or hospitals to also obtain the consent of the parent or guardian, unless the patient objects.

Generally, the age at which a young person is sufficiently mature to consent independently to medical treatment depends not only on their age but also on the seriousness of the treatment in question relative to their level of maturity. The health practitioner must decide on a case-by case basis whether the young person has sufficient understanding and intelligence to enable him or her to fully understand what is proposed.

Pursuant to the *Minors (Property and Contracts) Act 1970*, if a minor aged 14 and above consents to their own medical treatment the minor cannot make a claim against the medical practitioner for assault or battery. Also, where medical treatment of a minor aged less than sixteen years is carried out with the consent of a parent or guardian of the minor, the minor cannot make a claim against the medical practitioner for assault or battery.

For patients 16 years or over, their own consent is sufficient.

*Suggested procedure to follow where treatment is not urgent and consent is refused by either the parents of a minor, or a minor aged 14 or above.*

1. Establish that there is no suitable alternative treatment available to which consent would be forthcoming;
2. Obtain a second medical opinion and discuss this with the parent(s) or guardian and/or patient;
3. Attempt to reach agreement by counselling and mediation with the family. These efforts should be documented;

4. If applicable, explain to the parent(s) and patient that although the treatment is not urgent at this stage, if it is not provided in a timely manner, the situation may become urgent. Explain how delay would affect the patient. Explain that in urgent circumstances, treatment can be provided without parental consent, or the consent of the patient, but that the PHO would prefer to provide the treatment now, with consent;
5. If the parents do not consent to treatment on behalf of their child, consider making a report to DOCS that the child is a child at risk. Parents should be told that the PHO intends to notify DOCS before the notification is made. Once DOCS receives a notification, it will appoint a case manager to investigate the situation. This may ultimately lead to a guardian being appointed to consent to the treatment in place of the parents;
6. As a last resort, a court order can be sought authorising the treatment. Legal Branch, NSW Health, or the Department of Community Services can be contacted for advice at any stage in this process.

*26. Who gives consent for a minor if their parents have separated?*

The *Family Law Act* makes it clear that each parent has full responsibility for each of their children who is under 18. Parental responsibility is not affected by changes to relationships (that is, if the parents separate). Each parent has the responsibility for their child's welfare, unless the Court has made an order stipulating that one parent has certain responsibilities to the exclusion of the other parent.

This means that the consent of either parent to their child's medical treatment is usually sufficient. There are two circumstances where the consent of either parent may not be sufficient:

1. Where no formal court orders have been made, and one parent consents and the other refuses. The best way of handling this situation is by counselling the parents and trying to reach agreement on what is in the child's best interests.
2. Where the Court has made an order stipulating that a particular parent has particular responsibilities, i.e. for health care decisions, in which case, consent will have to be obtained in accordance with that order.

The Court can make four types of parental orders. The four types are residence orders, contact orders, child maintenance orders and specific issues orders.

A residence order or specific issues may stipulate that one parent has sole responsibility for the child's day-to-day care welfare and development. If this type of order has been made, that parent will be the only parent that can consent to medical treatment.

If there is an arrangement for a child to live with one parent for part of the time and the other for part of the time, this is a residence order. Both parents would retain full parental authority for the child, however, the consent of either parent would be sufficient to authorise medical treatment.

If a specific issues order is made granting one parent the sole responsibility for health care decisions, that parent will be the only parent that can consent.

Health care workers should assume that either parent can consent (alone) unless a court order stipulating something different is brought to their attention.

*27. Can a parent or guardian of a minor delegate their responsibility for providing consent to another adult?*

Occasionally, a parent delegates their responsibility for consenting to medical treatment on behalf of their minor child, to another adult. This may occur for example, in relation to Aboriginal children, where an extended family member, rather than the child's mother or father, is responsible for giving consent on their behalf.

A parent or legal guardian can authorise another adult to consent to treatment on behalf of their minor child. Ideally, this delegation would be in writing. If a written delegation exists, a copy of it should be placed on the minor's medical record.

If the delegation was given verbally, it should be documented in the minor's medical record. If a minor presents with an adult other than a parent, the attending medical officer should attempt to ascertain the adult's relationship to the child and whether the adult is the child's guardian. Where the adult does not appear to be the child's guardian, but bears some relationship to the child, and confirms that the parent/guardian is aware

that they are accompanying the child, it is reasonable to assume that the parent or guardian has delegated responsibility to that person, unless there is any indication to the contrary (that is, a previous objection by the parent to that person exercising any authority in relation to the child).

28. What is 'special medical treatment' in relation to children?

Practitioners should be aware that the *Children and Young Persons (Care and Protection) Act 1998* classes some procedures as 'special medical treatment'. These procedures cannot be carried out on a child under 16 years unless:

- i. the treatment is required as a matter of urgency to save the child's life or to prevent serious damage to the child's health; or
- ii. if the treatment is described in paragraphs (a), (b) or (c) below, the Guardianship Tribunal consents to the treatment.

The definition of 'special medical treatment' under the *Children and Young Persons (Care and Protection) Act* is different from that which is used under the *Guardianship Act*. The definition of 'Special medical treatment' under the *Children and Young Persons (Care and Protection) Act* includes the following:

- a. procedures or treatments that are intended to remediate a life threatening condition intended or reasonably likely to have the effect of rendering the child permanently infertile.

- d. any medical treatment that involves the administration of a drug of addiction within the meaning of the *Poisons and Therapeutic Goods Act 1966* over a period or periods totalling more than 10 days in any period of 30 days, except for medical treatment in circumstances where the drug is administered in accordance with a written exemption granted, either generally or in a particular case, by the Director-General of the Department of Community Services on the written request of the Director-General of the Department of Health...
- f. any medical treatment that involves the administration of a psychotropic drug to a child in out-of-home care for the purpose of controlling his or her behaviour.

The *Guardianship Act* applies to adults who are unable to consent to their own treatment, however, the Guardianship Tribunal's consent is also required in order to provide some special medical treatment to children under 16, as set out above.

# Relevant Policies

This section outlines key points from a range of relevant policies. This is not an exhaustive overview of government policies, just those that have most relevance to this Framework.

## National Drug Strategy 2010-2015. A framework for action on alcohol, tobacco and other drugs

<http://www.nationaldrugstrategy.gov.au/internet/drugstrategy/Publishing.nsf/content/nds2015>

Since the National Drug Strategy began in 1985, harm minimisation has been its overarching approach.<sup>31</sup> This encompasses the three equally important pillars of demand reduction, supply reduction and harm reduction being applied together in a balanced way.

■ **Demand reduction** means strategies and actions which prevent the uptake and/or delay the onset of use of alcohol, tobacco and other drugs; reduce the misuse of alcohol and the use of tobacco and other drugs in the community; and support people to recover from dependence and reintegrate with the community.

■ **Supply reduction** means strategies and actions which prevent, stop, disrupt or otherwise reduce the production and supply of illegal drugs; and control, manage and/or regulate the availability of legal drugs.

■ **Harm reduction** means strategies and actions that primarily reduce the adverse health, social and economic consequences of the use of drugs.

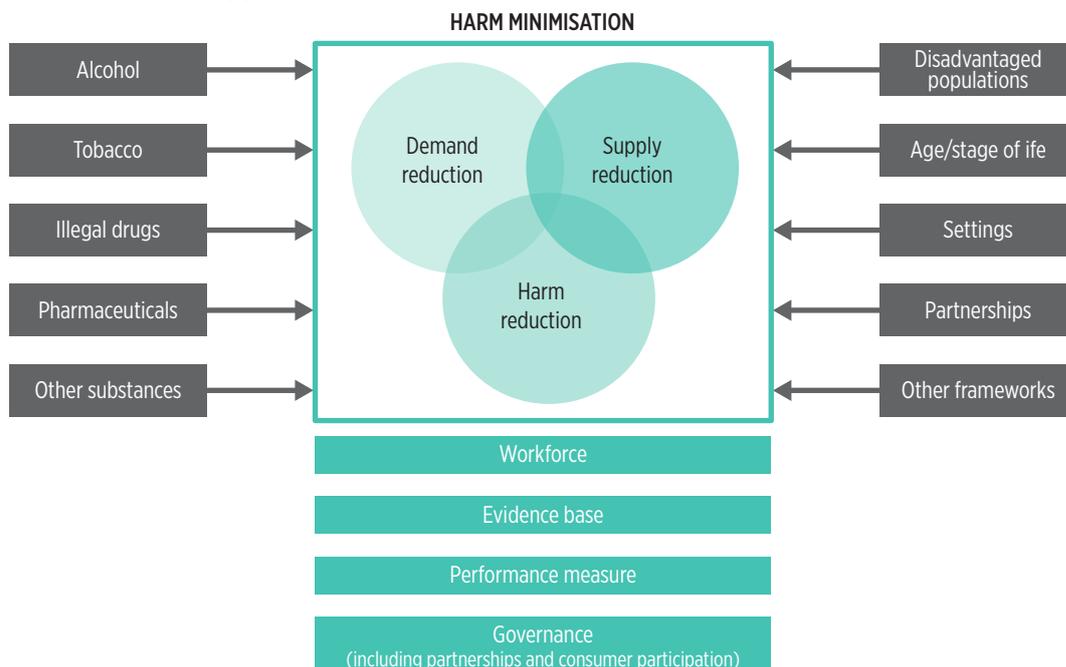
As indicated in Figure 2, the approaches within the three pillars need to be sensitive to age and stage of life.

### Age and stage of life (pp. 5-6)

It is well recognised that people are at greater risk of harm from drugs at points of life transition. These include transitioning from primary to high school, from high school to tertiary education or the workforce, leaving home and retiring.

■ Drinking alcohol in adolescence can be harmful to young people’s physical and psychosocial development. Alcohol-related damage to the brain can be responsible for memory problems, an inability to learn, problems with verbal skills, alcohol dependence and depression.

Figure 3. Harm minimisation approach



- The Australian Secondary School Students Alcohol and Drug Survey has consistently shown that fewer students are smoking overall. However, the secondary school years remain a key risk period for the uptake of smoking, with higher rates in each age group from 12 years onwards through adolescence.
- The adolescent drive to take risks and the need for coping mechanisms during adolescence can be major influences on the uptake of illegal drugs by teenagers.
- Young people are more at risk of motor vehicle accidents, injuries, accidental death and suicide whilst under the influence of alcohol and drugs. They are also highly susceptible to being victims of crime.

## NSW Drug and Alcohol Plan 2006-2010

[http://www0.health.nsw.gov.au/pubs/2007/drug\\_alcohol\\_plan.html](http://www0.health.nsw.gov.au/pubs/2007/drug_alcohol_plan.html)

The NSW Drug and Alcohol Plan aims to:<sup>32</sup>

1. provide a policy framework for drug and alcohol services and health programs in New South Wales
2. Ensure that there are equitable and effective clinical services across New South Wales to assist people with drug and alcohol problems;
3. Set directions based on high standards and the best scientific evidence to treat drug and alcohol related problems; and
4. Increase the capacity and competency of the drug and alcohol workforce.

The Plan commits to equity of service delivery to special population groups, which includes young people with emerging problems:

Within the community there are specific population groups that experience barriers in accessing and receiving drug and alcohol interventions. These groups have specific needs and the service delivery models for these groups are still evolving.

This Plan commits to equity of service delivery so that services are accessible geographically and available to culturally diverse groups, and to people with complex and special needs (p. 19).

## NSW Youth Health Policy 2011-2016: Healthy bodies, healthy minds, vibrant futures

[http://www0.health.nsw.gov.au/policies/pd/2010/PD2010\\_073.html](http://www0.health.nsw.gov.au/policies/pd/2010/PD2010_073.html)

The NSW Youth Health Policy aims to guide the NSW health system to encourage and support young people to achieve optimal health and wellbeing, to ensure young people experience the health system as positive, respectful, supportive and empowering, and to achieve positive outcomes for young people that are organisationally effective.<sup>33</sup>

The three goals of the Policy are:

1. Young people are encouraged & supported to achieve their optimal health & wellbeing
2. Young people experience the health system as positive, respectful, supportive & empowering
3. Responses to the health needs of young people are evidence-based, promote prevention and early intervention and are delivered efficiently and effectively

The Policy was underpinned by the following values:

- Holistic approach to young people's health that focuses on wellbeing
- Young people have capacity to participate in their own health and wellbeing and NSW is committed to supporting young people to do this
- Strength-based approaches
- Social justice
- Creativity and innovative ideas.

## NSW Community Mental Health Strategy 2007-2012

[http://www0.health.nsw.gov.au/pubs/2008/mh\\_strategy.html](http://www0.health.nsw.gov.au/pubs/2008/mh_strategy.html)

The 2007-2012 strategy describes the model for community mental health services to be developed and delivered by 2012. This model provides a framework for improving responses to the needs of people with mental illness, their families and carers across NSW, across the age ranges, and across diverse communities, working in collaboration with service partners.<sup>36</sup>

Under 'Youth mental health services':

Our aim is to enhance the mental health and well being of young people in NSW by:

- Intervening as early as possible to decrease the incidence, prevalence and severity of mental health problems and disorders
- Providing comprehensive, accessible and appropriate services, which address the diversity of need and help young people, their families and others caring for them to optimise their development and build a secure base for their future.

### Overview

NSW is taking a systematic approach to developing and strengthening mental health services for young people. A strategy within NSW: A new direction for Mental Health is the Youth Mental Health Services Model for NSW. This is being developed to meet the needs of young people aged 14 to 24 years by increasing early access to mental health services. All AHSs are receiving new funding to develop and establish youth mental health services from 2007/08. These will be developed and implemented alongside a strengthening of CAMHS.

Young people with emerging mental health problems can 'fall between the gaps' between child and adolescent services and adult services which can significantly delay them receiving appropriate intervention. Young people with mental health problems are unlikely to access mental health services and receive professional help, even when the problems are severe. When young people do access services, their illness has often reached an acute stage and they are more likely to present in crisis situations when they are at greater risk of harm to themselves or others.

Young people want services that are non-stigmatising, flexible, available when other medical services are not available or are difficult to access, holistic, confidential and comprehensive. Services need to have multidisciplinary teams which address multiple and complex problems and ensure provision of outreach, crisis and out-of-hours care, and family support.

## NSW Government Keep Them Safe: A Shared Approach to Child Wellbeing 2009-2014

<http://www.keepthemsafe.nsw.gov.au/home>

*Keep Them Safe* sets out the NSW Government's five year Plan to improve the safety and wellbeing of children and young people.<sup>34</sup> The Plan responds to the Report of the Special Commission of Inquiry into Child Protection Services in NSW.<sup>84</sup>

The goal of *Keep them Safe* is: All children in NSW are healthy, happy and safe, and grow up belonging in families and communities where they have opportunities to reach their full potential.

To achieve this goal, we will pursue the following outcomes for children and young people:

- Children have a safe and healthy start to life
- Children develop well and are ready for school
- Children and young people meet developmental and educational milestones at school
- Children and young people live in families where their physical, emotional and social needs are met
- Children and young people are safe from harm and injury
- Children, young people and their families have access to appropriate and responsive services if needed.

The action plan includes enhanced early intervention and community-based services to support children and families in the community and prevent children from entering the child protection system and a streamlined statutory child protection system focusing on children at greatest risk.

*Keep Them Safe* notes that 'carer drug and alcohol and mental health issues are a significant factor in child protection reports and in decisions taken on the need for statutory intervention.' (p. 13)

## Child Wellbeing and Child Protection Policies and Procedures for NSW Health

[http://www0.health.nsw.gov.au/policies/pd/2013/pdf/PD2013\\_007.pdf](http://www0.health.nsw.gov.au/policies/pd/2013/pdf/PD2013_007.pdf)

The Child Wellbeing and Child Protection Policies and Procedures for NSW Health are intended to help embed in the public health system the reforms to the NSW Child Protection system arising from the Special Commission of Inquiry into Child Protection Services in NSW.

The policies and procedures provide the opportunity to reaffirm and strengthen the role of Health Workers in child wellbeing and child protection. The reforms are set out in *Keep Them Safe: A shared approach to child wellbeing 2009-2014* and provide an important step towards an integrated system that is concerned with child protection and the promotion of child wellbeing.

Child Wellbeing and Child Protection Policies and Procedures for NSW Health operationalise the responsibilities of NSW Health under the *NSW Children and Young Persons (Care and Protection) Act 1998* and the *Child Wellbeing and Child Protection – NSW Interagency Guidelines (2011)*. They build on and incorporate existing good practice. All Health workers have a responsibility to recognise and respond to wellbeing concerns and where appropriate provide or facilitate access to services for children, young people and their families to address their needs. Health workers are also required to identify and report children and young people in need of statutory care and protection.

### **NSW Clinical Guidelines for the Care of Persons with Comorbid Mental Illness and Substance Use Disorders in Acute Care Settings**

[http://www0.health.nsw.gov.au/pubs/2009/comorbidity\\_report.html](http://www0.health.nsw.gov.au/pubs/2009/comorbidity_report.html)

The complex presentations, illness trajectory and poor outcomes for people with comorbid mental health and substance use disorders has led to the need to identify and develop a set of guidelines to provide direction for the care and treatment of this client population. The goal of these guidelines is to improve client care and outcomes. They are intended for those practitioners providing care to people with comorbid mental health and substance use disorders in a variety of clinical settings across various sectors. Information specifically relevant to the different clinical settings has been included within the guidelines.<sup>35</sup>

Section 14.1 relates to specific considerations for working with young people.

### **NSW Aboriginal Mental Health and Well Being Policy 2006-2010**

[http://www0.health.nsw.gov.au/policies/pd/2007/pd2007\\_059.html](http://www0.health.nsw.gov.au/policies/pd/2007/pd2007_059.html)

The NSW Aboriginal Mental Health and Well Being Policy is a framework to guide NSW health services in the provision of culturally sensitive and appropriate mental health and social and emotional well being services to the Aboriginal community of NSW.<sup>37</sup> This Policy aligns with the National Strategic Framework for Aboriginal and Torres Strait Islander Peoples Mental Health and Social and Emotional Well Being 2004-2009.<sup>85</sup>

The Policy cites research that has identified higher rates of risk for emotional and behavioural problems in Aboriginal children than in non-Aboriginal children. It reported that many non-Aboriginal mental health clinicians believe that they lack the necessary knowledge and skills to work effectively with Aboriginal young people. This may lead some workers to miss opportunities for early intervention and proactive outreach to Aboriginal people and communities.

The Policy aims to improve the coordination of care for Aboriginal people in NSW by ensuring:

- partnerships are formed with other relevant organisations resulting in strong working relationships;
- accessible and responsive mental health services that cater for all ages and enable targeted priority areas; and
- a supported and skilled workforce in Aboriginal mental health and well being and increasing the expertise and knowledge base in this area.

## United Nations Conventions on the Rights of the child

<http://www.unicef.org/crc/>

Australia is a signatory to the Convention on the Rights of the Child. As described by the United Nations Children's Fund (UNICEF):<sup>38</sup>

*The Convention is a universally agreed set of non-negotiable standards and obligations. These basic standards – also called human rights – set minimum entitlements and freedoms that should be respected by governments. They are founded on respect for the dignity and worth of each individual, regardless of race, colour, gender, language, religion, opinions, origins, wealth, birth status or ability and therefore apply to every human being everywhere. With these rights comes the obligation on both governments and individuals not to infringe on the parallel rights of others. These standards are both interdependent and indivisible; we cannot ensure some rights without—or at the expense of—other rights.*

*The Convention sets out these rights in 54 articles and two Optional Protocols. It spells out the basic human rights that children everywhere have: the right to survival; to develop to the fullest; to protection from harmful influences, abuse and exploitation; and to participate fully in family, cultural and social life. The four core principles of the Convention are non-discrimination; devotion to the best interests of the child; the right to life, survival and development; and respect for the views of the child. Every right spelled out in the Convention is inherent to the human dignity and harmonious development of every child. The Convention protects children's rights by setting standards in health care; education; and legal, civil and social services.*

Rights include the following

- No child should be treated unfairly on any basis.
- All adults should do what is best for children.
- Governments have a responsibility to take all available measures to make sure children's rights are respected, protected and fulfilled.
- Governments should respect the rights and responsibilities of families to direct and guide their children so that, as they grow, they learn to use their rights properly.
- Governments should ensure that children survive and develop healthily.
- Children have the right to live with their parent(s), unless it is bad for them.

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All health workers have a responsibility to recognise and respond to wellbeing concerns and where appropriate provide or facilitate access to services for children, young people and their families to address their needs. Health workers are also required to identify and report children in need of statutory care and protection.

The Child Wellbeing and Child Protection Policies and Procedures for NSW Health can be accessed at: [http://www0.health.nsw.gov.au/policies/pd/2013/pdf/PD2013\\_007.pdf](http://www0.health.nsw.gov.au/policies/pd/2013/pdf/PD2013_007.pdf) and include the following information for health workers.

### Key Resources

#### **Mandatory Reporter Guide (MRG)**

Guides decision-making about whether or not a report to the Child Protection Helpline is appropriate applying the risk of significant harm (ROSH) reporting threshold.

Mandatory Reporter Guide:  
<http://sdm.community.nsw.gov.au/mrg/>

#### **Child Protection Helpline**

Report a child or young person suspected to be at imminent Risk of Significant Harm.

Telephone: 133 627 (24 hours/7 days)

#### **NSW Health Child Wellbeing Unit (CWU)**

Health workers can telephone for advice, support and assistance in determining the level of risk of harm and in responding to the needs of vulnerable children, young people, pregnant women and

families. Telephone: 1300 480 420 8:30 am–5.30 pm Monday to Friday, excluding public holidays.

Out of hours leave a telephone message on 1300 480 420, or use the After Hours Contact Form:  
<http://www0.health.nsw.gov.au/resources/initiatives/kts/pdf/CWU-Notification-Form.pdf>

and send a fax or email to:  
Northern Child Wellbeing Unit: Fax 02 4924 6208,  
Email: [NCWU@hnehealth.nsw.gov.au](mailto:NCWU@hnehealth.nsw.gov.au)

Southern Child Wellbeing Unit: Fax 02 4228 3507  
Email: [GESCWU@sesiahs.health.nsw.gov.au](mailto:GESCWU@sesiahs.health.nsw.gov.au)

Western Child Wellbeing Unit: Fax 02 6881 4112  
Email: [westernchildwellbeingunit@gwahs.health.nsw.gov.au](mailto:westernchildwellbeingunit@gwahs.health.nsw.gov.au)

#### **Family Referral Services (FRS)**

Refer vulnerable children, young people and families to a Family Referral Service for information, assessment and referral to a range of support services in their local area.

To contact a FRS see Fact Sheet:  
[http://www.dpc.nsw.gov.au/\\_\\_\\_data/assets/pdf\\_file/0009/83646/06\\_Family\\_Referral\\_Services.pdf](http://www.dpc.nsw.gov.au/___data/assets/pdf_file/0009/83646/06_Family_Referral_Services.pdf) or ask the NSW Health CWU.

### Legislation, Systems, Roles and Responsibilities

This section sets out the legal and policy context for the child protection system in NSW. It provides Health workers with guidance on the relevant legislation and their legal responsibilities for child wellbeing and child protection; the key principles for child protection intervention; the NSW Health governance structure for child wellbeing and child protection; and identifies the systems, policies and procedures to be established by local Health services. The key interagency partners with NSW Health in child wellbeing and child protection and the principles for interagency collaboration are also identified in this section. Key links in this section are:

*The Children and Young Persons (Care and Protection Act) 1998:*  
<http://www.legislation.nsw.gov.au/maintop/view/inforce/act+157+1998+cd+O+N>

The Child Wellbeing and Child Protection – NSW Interagency Guidelines (2011):  
[http://www.community.nsw.gov.au/kts/guidelines/info\\_exchange/info\\_index.htm](http://www.community.nsw.gov.au/kts/guidelines/info_exchange/info_index.htm)

*NSW Health Code of Conduct*  
[http://www.health.nsw.gov.au/policies/pd/2012/pdf/PD2012\\_018.pdf](http://www.health.nsw.gov.au/policies/pd/2012/pdf/PD2012_018.pdf)

*Exchanging information*  
[http://www.community.nsw.gov.au/kts/guidelines/info\\_exchange/info\\_index.htm](http://www.community.nsw.gov.au/kts/guidelines/info_exchange/info_index.htm)

This section also sets out the roles and responsibilities for health workers and Health Service managers, the relationship between NSW Health and Community Services and the key mechanisms for interagency collaboration

*Information Sharing*  
This section provides guidance about how information can be shared in relation to the safety, welfare and wellbeing of a child or young person under the *Care Act*.

The care and protection of children and young people is dependent upon shared information. Access to accurate, relevant information will assist organisations working with children and young people to assess risks, make decisions and to identify and deliver appropriate services.

The legal framework for information exchange allows organisations to share information relating to the safety, welfare and wellbeing of children or young people without consent.

It takes precedence over the protection of confidentiality or of an individual's privacy because the safety, welfare and wellbeing of children and young people is considered to be paramount. However, while consent is not necessary, it should be sought where possible. Organisations should at a minimum advise children, young people and their families that information may be shared with other organisations. Key links in this section are:

NSW Health Chapter 16A information exchange forms are available on the NSW Kids and Families website:  
<http://www0.health.nsw.gov.au/nswkids/links.asp>

Providing Information under Chapter 16A  
[http://www.community.nsw.gov.au/kts/guidelines/documents/information\\_response\\_checklist.pdf](http://www.community.nsw.gov.au/kts/guidelines/documents/information_response_checklist.pdf)

Requesting information under Chapter 16A  
[http://www.community.nsw.gov.au/kts/guidelines/documents/Information\\_request\\_checklist.pdf](http://www.community.nsw.gov.au/kts/guidelines/documents/Information_request_checklist.pdf)

Receiving information under Chapter 16A  
[http://www.community.nsw.gov.au/kts/guidelines/documents/informations\\_received\\_checklist.pdf](http://www.community.nsw.gov.au/kts/guidelines/documents/informations_received_checklist.pdf)

Exchanging information under Section 248  
[http://www.community.nsw.gov.au/kts/guidelines/info\\_exchange/section\\_248.htm](http://www.community.nsw.gov.au/kts/guidelines/info_exchange/section_248.htm)

## **Recognising Child Abuse and Neglect**

In the course of their work Health workers may see or hear something about a child, young person or adult client which raises concerns about the possible abuse or neglect of a child or young person.

The indicators in this chapter are a guide and do not provide a comprehensive list of all harms, behaviours or presentations that give rise to concerns or suspicions of child abuse or neglect. One indicator in isolation may or may not necessarily indicate abuse or neglect and each indicator needs to be considered in the context of the child or young person's personal circumstances.

The indicators in this chapter align with the indicators provided in the *Child Wellbeing and Child Protection – NSW Interagency Guidelines (2011)* and are grouped by type: physical, sexual and emotional abuse and neglect. They are described in terms of a child or young person's presentation and the behaviours of those who abuse and neglect children and young people.

## **Responding to Child Wellbeing / Non-Statutory Concerns (non-ROSH)**

Consistent with NSW Health's model of care for child wellbeing and child protection, as well as legal responsibilities, Health workers are required to identify and respond to concerns about child safety, welfare or wellbeing no matter where the Health worker is employed. This includes workers in services where the parent or carer is the Health client.

This section provides guidance for Health workers in responding to cases where a Health worker identifies that a child or young person may be at risk of harm from abuse or neglect but the

concerns do not meet the statutory threshold for making a child protection report.

### **Responding to Children and Young People at Risk of Significant Harm (ROSH)**

This section provides advice and guidance to health workers on:

- Making a child protection report and ongoing health worker involvement
- How to make a report to the Child Protection Helpline
- Child Protection Helpline outcomes and feedback
- Documentation of reports of risk of significant harm
- Ongoing support to children and young people after a report
- Follow up where a ROSH report has been accepted by Community Services
- Request to the Child Protection Helpline to review a screening decision
- Assumption of care responsibility of a child or young person by Community Services on Health premises
- Orders and requests for Health services

### **Responding to Child Sexual Abuse and Serious Abuse or Neglect**

This section provides guidance to health workers on:

- The operations of the Joint Investigation Response Teams (JIRT) and Joint Referral Unit (JRU)
- Forensic and medical examinations
- Sexual Assault Forensic and Medical Examinations
- Adolescent Peer Consensual Sex

### **Responding to Children and Young People with Diverse Needs**

This section provides information for health workers on working with Aboriginal Children and Families including available resources; working with children, young people and Families from culturally diverse backgrounds and working with children and young people with a disability.

### **Health Assessments and Care for Children and Young People in Out-of-Home-Care**

NSW Health provides health assessments for all children and young people entering statutory OOHC who are expected to remain in care for longer than 90 days. Health assessment services are provided through Local Health Districts / Specialty Networks upon referral from Community Services. This section provides information on health assessments and management plans for children and young people in out-of-home-care.

### **Case Management and Case Work**

Section 245E of the *Care Act* requires government and non-government agencies, in order to effectively meet their responsibilities in relation to the safety, welfare or well-being of children and young persons, to take reasonable steps to co-ordinate decision-making and the delivery of services regarding children and young persons. Section 245A includes as a guiding principle that those agencies should work collaboratively in a way that respects each other's functions and expertise.

Further information on case management and case work is set out in the Child Wellbeing and Child Protection Interagency Guidelines [http://www.community.nsw.gov.au/kts/guidelines/info\\_exchange/info\\_index.htm](http://www.community.nsw.gov.au/kts/guidelines/info_exchange/info_index.htm)

### **Documentation**

This section sets out the requirements for documentation of child wellbeing concerns, child protection reports and when a health worker shares information under Chapter 16A and Section 248 of the *Children and Young Persons (Care and Protection) Act 1998*.

Health records must be kept confidential, current, complete and readily available for patient care. All documentation should be in line with NSW Health PD2012\_069 NSW Health Care Records - Documentation and Management. [http://www0.health.nsw.gov.au/policies/pd/2012/pdf/PD2012\\_069.pdf](http://www0.health.nsw.gov.au/policies/pd/2012/pdf/PD2012_069.pdf)

# Youth Health Better Practice Framework checklist

<b>1. ACCESSIBILITY</b>			
<b>HOW ACCESSIBLE IS YOUR SERVICE?</b>	<b>Yes</b>	<b>Part</b>	<b>No</b>
Does your service have a promotion strategy for targeting young people?			
Is there a confidentiality policy? Is this widely publicised to your target group?			
Does your service actively seek to understand young people's concerns and needs, and have the capacity to respond to their needs?			
Does your service use creative, innovative activity-based strategies to improve young people's access to, and engagement with, youth health services?			
Are services provided free, or at a cost affordable to young people?			
Can young people reach the service easily (e.g. by public transport)?			
Is the service open after hours when young people can get there?			
Is it possible for young people to drop in and use the service without having to make an appointment?			
Is there flexibility around consultation times, and the capacity to offer longer sessions to deal with complex issues that may arise?			
Are staff provided with training, supervision and support to maintain the knowledge and skills required for working with young people?			
<b>2. EVIDENCE-BASED APPROACH</b>			
<b>WHICH TYPES OF EVIDENCE DOES YOUR SERVICE USE?</b>	<b>Yes</b>	<b>Part</b>	<b>No</b>
When undertaking a systematic needs assessment, does your service utilise: 1. Existing policies and background documents? 2. 'Normative' research reports (such as epidemiological data, qualitative research studies)? 3. Comparative studies of similar populations or issues — but from a different area? 4. Surveys and direct consultations with key stakeholders and target populations?			
When reviewing programming priorities, does your service systematically monitor changes to the target population or issue (e.g. emerging needs) through regularly reviewing the above?			
When starting a new program, does your service: 1. Use current evidence on the issue, including existing models, standards and practice guidelines? 2. Locate and review reports, articles and publications (e.g. tools and guidelines) from similar programs? 3. Develop expected outcomes based on existing performance indicators (where possible)?			

<b>3. YOUTH PARTICIPATION</b>			
<b>HOW DOES YOUR SERVICE INVOLVE AND PROMOTE YOUTH PARTICIPATION?</b>	<b>Yes</b>	<b>Part</b>	<b>No</b>
Does your service have policies and procedures in place that outline how young people's participation and decision-making can be used in program development, implementation, review and evaluation?			
Does your service regularly review and revise its youth participation mechanism in consultation with young people?			
Does your service provide opportunities for increasing young people's confidence, knowledge and skills in using participation mechanisms?			
Does your service have specific ways in which it acknowledges and values young people's input and contributions?			
Does your service ensure that its youth representatives reflect the diversity of young people's views and needs?			
<b>4. COLLABORATION AND PARTNERSHIPS</b>			
<b>HOW DOES YOUR SERVICE WORK COLLABORATIVELY WITH OTHERS?</b>	<b>Yes</b>	<b>Part</b>	<b>No</b>
Does your service propose collaboration and partnerships within its strategic or business plan?			
Does your service identify potential partners for collaboration and have protocols for working out roles, responsibilities and agreements between agencies or services?			
Does your service regularly review and evaluate its collaborative strategies, to ensure effective processes and outcomes?			
Does your service treat young people as equal partners where possible and appropriate?			
<b>5. PROFESSIONAL DEVELOPMENT</b>			
<b>HOW DOES YOUR ORGANISATION SUPPORT PROFESSIONAL DEVELOPMENT?</b>	<b>Yes</b>	<b>Part</b>	<b>No</b>
Is professional development identified as a service objective, and are planned activities costed into service budgets and proposals?			
Are there formalized induction processes for staff taking up new positions – including handover, orientation and probation?			
Does your organisation provide regular opportunities for staff members to review and discuss their professional development needs? Does it assist workers to plan and undertake activities to improve knowledge, skills and performance?			
Does the service collaborate with other agencies/organisations around staff development events, in order to maximise resources, share expertise and ensure a healthy flow of ideas?			
Are there working mechanisms within the service (e.g. team meetings, team forums, internal newsletters etc.) where staff share newly acquired knowledge and information with co-workers?			
Do young people inform staff training around youth issues – and are they directly involved in its delivery?			
Do staff training/development programs have clearly identified outcomes (such as identified competencies) and are they regularly evaluated?			

## 6. SUSTAINABILITY

HOW SUSTAINABLE ARE YOUR ORGANISATION'S PROGRAMS AND ACTIVITIES? YES PART NO	Yes	Part	No
Where possible, does your service develop sustainability strategies within its strategic and business plans, for example: 1. Putting income generation strategies in place 2. Developing partnerships and collaboration, and 3. Building community capacity and planning transition strategies with the ultimate goal of handing over project ownership within an identified time frame?			
Does your service actively integrate its activities into existing mainstream programs where possible?			
Does your service develop programs which can be replicated elsewhere?			
Does your service invest in advocacy and utilisation of Board and other key stakeholder influence, in order to promote programs?			

## 7. EVALUATION

HOW DOES YOUR ORGANISATION EVALUATE ITS SERVICES?	Yes	Part	No
Does your service have clearly articulated aims and objectives against which it can evaluate?			
Does your service incorporate evaluation into its strategic plan, designating resources as required (e.g. time, costs, fees if external evaluator support is required)?			
During the initial stages of project design, does your service include evaluation as an essential activity in all project work plans?			
Does your service take a baseline assessment of the issue or target audience prior to project implementation?			
Does your service evaluate both the qualitative and quantitative aspects of its work, including consumer feedback and identifying unexpected outcomes?			

Source: NSW Health. Youth Health Policy 2011-2016: Healthy bodies, healthy minds, vibrant futures.<sup>33</sup>  
Available from [http://www.health.nsw.gov.au/policies/pd/2010/pdf/PD2010\\_073.pdf](http://www.health.nsw.gov.au/policies/pd/2010/pdf/PD2010_073.pdf)

## WHO Adolescent-Friendly Services

Source: World Health Organization. Adolescent friendly health services: an agenda for change. Geneva: WHO, 2002.

Adolescent friendly health services need to be accessible, equitable, acceptable, appropriate, comprehensive, effective and efficient. These characteristics are based on the WHO Global Consultation in 2001 and discussions at a WHO expert advisory group in Geneva in 2002. They require:

1. Adolescent-friendly policies that
  - fulfil the rights of adolescents as outlined in the UN Convention on the Rights of the Child and other instruments and declarations,
  - take into account the special needs of different sectors of the population, including vulnerable and under-served groups,
  - do not restrict the provision of health services on grounds of gender, disability, ethnic origin, religion or (unless strictly appropriate) age,
  - pay special attention to gender factors,
  - guarantee privacy and confidentiality and promote autonomy so that adolescents can consent to their own treatment and care,
  - ensure that services are either free or affordable by adolescents.
2. Adolescent friendly procedures to facilitate
  - easy and confidential registration of patients, and retrieval and storage of records,
  - short waiting times and (where necessary) swift referral,
  - consultation with or without an appointment.
3. Adolescent-friendly health care providers who
  - are technically competent in adolescent specific areas, and offer health promotion, prevention, treatment and care relevant to each client's maturation and social circumstances,
  - have interpersonal and communication skills,
  - are motivated and supported,
  - are non-judgmental and considerate, easy to relate to and trustworthy,
  - devote adequate time to clients or patients,
  - act in the best interests of their clients,
  - treat all clients with equal care and respect,
  - provide information and support to enable each adolescent to make the right free choices for his or her unique needs.
4. Adolescent-friendly support staff who are
  - understanding and considerate, treating each adolescent client with equal care and respect,
  - competent, motivated and well supported.
5. Adolescent-friendly health facilities that
  - provide a safe environment at a convenient location with an appealing ambience,
  - have convenient working hours,
  - offer privacy and avoid stigma,
  - provide information and education material.
6. Adolescent involvement, so that they are
  - well informed about services and their rights,
  - encouraged to respect the rights of others,
  - involved in service assessment and provision.
7. Community involvement and dialogue to
  - promote the value of health services, and
  - encourage parental and community support.
8. Community based, outreach and peer-to-peer services to increase coverage and accessibility.
9. Appropriate and comprehensive services that
  - address each adolescent's physical, social and psychological health and development needs,
  - provide a comprehensive package of health care and referral to other relevant services,
  - do not carry out unnecessary procedures.
10. Effective health services for adolescents
  - that are guided by evidence-based protocols and guidelines,
  - having equipment, supplies and basic services necessary to deliver the essential care package,
  - having a process of quality improvement to create and maintain a culture of staff support.
11. Efficient services which have
  - a management information system including information on the cost of resources,
  - a system to make use of this information.

# NSW Health Principles for Youth Mental Health Services

The nine key principles listed below underpin the development and provision of Youth Mental Health Services in NSW. The key principles were developed initially by the Northern Sydney Central Coast Area Health Service for the prototype Youth Mental Health Service Model, then further developed by NSW Health in collaboration with the other Area Health Services. They serve as a useful checklist.

## Sustainable Clinical Governance of Youth Mental Health and Quality control

- A youth mental health governance structure to address systemic issues in fragmentation of services for young people and monitor quality, monitoring and evaluation.
- Clear identification of clinical leadership and responsibility for youth mental health.
- Commitment to comply with state mandated monitoring and evaluation tools and strategies
- Commitment to data collection across the traditional boundaries of child and adolescent mental health, adult mental health, drug and alcohol, youth health and general practitioners.
- Development of long and short term outcome indicators for young people 14-24 years with mental health problems and disorders.

## Commitment to a Promotion and Prevention Framework for Mental Health

- An underlying framework of mental health promotion and prevention to provide structures and supports to assist young people to live safe, productive and fulfilling lives.
- A model for youth mental health services that acknowledges promotion and prevention activities as core business.
- Building on and linking with existing Promotion, Prevention and Early Intervention (PPEI) initiatives such as School-Link and COPMI.
- Working with the community to engender an understanding that mental illnesses are treatable, and to encourage early entry to care to improve outcomes and lessen stigma and discrimination related to mental illness.

## Improving Early Access

- Early intervention at the onset of a mental health problem or disorder which is aimed at preventing the progression of a mental illness and minimising the impact to social, educational and vocational functioning.
- Greater access to improved youth specific mental health, drug and alcohol and primary health services delivered within a comprehensive, integrated approach.
- Build the capacity of key partners to detect emerging mental disorders and implement appropriate action.
- Strengthen and formalise referral pathways to mental health services.
- Develop entry criteria that focus on the levels of distress, disability and risk rather than a diagnostic approach.

## Promoting 'Best Practice' Youth Mental Health Clinical Services

- Provides specialised interventions for young people with psychotic or severe mood disorders as well as continuing psychological and medical care to achieve the best education, training and social outcomes.
- Youth mental health clinical services need to be developmentally appropriate youth orientated services with interventions based on the best available evidence.
- Workforce retention strategies that promote ongoing professional development, supervision and mentorship.

## Developing Effective Strategic Partnerships

- Develop strong partnerships between public, private, generalist and specialist health services, in particular adult mental health, child and adolescent, drug and alcohol, general practitioners and human services including youth, vocational, education, housing services and juvenile justice.
- Formalise partnerships with key external partners.

- Support a stepped approach to mental health care for young people relevant to the level of need.
- Provide access to and development of supported primary health care systems for young people 14-24 years.
- Build the capacity of general practitioners to work with young people with mental disorders and to provide for their primary health needs.
- Strengthen pathways to specialist mental health care.
- Build capacity in youth mental health across programs, services and organisations through joint education and training opportunities, joint initiatives and projects and consultation.

### Focus on Recovery and Hope

- A recovery focus is seen as essential for promoting hope, wellbeing, and a valued sense of self-determination for young people with a mental illness.
- A recovery focused youth mental health model is characterised by: maximising well-being, empowerment, the redefinition of self, the emergence of hope and optimism and overcoming symptoms.

### Establishing youth participation in governance, planning and implementation

- Establish a framework and policies for youth participation.
- Develop and implement a mechanism for involving young people as partners in the development a youth mental health model to help validate service provision to reflect the needs of the community in which it is established.
- Review and evaluate youth participation strategies and involvement.
- Provide training and support to young people involved in participation and consultation.

### Improving Participation of Families and Carers in Mental Health Services

- Establish a framework for family/carer participation.
- Provide support and encouragement for families and carers.
- Evaluate participation of families and carers in youth mental health services.

### Developing a Youth Mental Health Workforce

- Assess and re-assess the training needs of staff recruited to youth mental health services.
- Assess and re-assess the training and education needs of partners working closely with youth mental health services, particularly CAMHS, adult mental health, general practitioners, VETE coordinators and relevant mental health NGOs.
- Develop a training and education strategy.
- Provide access to evidence based youth mental health training that allows for knowledge transfer into clinical practice, clinical supervision and mentoring of youth mental health staff.
- Develop and implement clinical reviews and case conferences across CAMHS, youth mental health and adult mental health.

## Guidance on Collaboration and Partnerships

Collaboration requires an investment of resources and commitment. Conditions for effective collaboration that are often cited are those developed by Harris et al:<sup>87</sup>

- The parties have identified a need to work together in order to achieve their goals.
- In the broader operating environment, there are opportunities that promote intersectoral collaboration
- Organisations have the capacity (the required resources, skills, and knowledge) to take collaborative action.
- The parties have developed a relationship on which to base cooperative, planned action. The relationship is clearly defined and is based on trust and respect.
- The planned action is well-conceived and can be implemented and evaluated. The action is clear and there is agreement to undertake it. Roles and responsibilities are clear.
- There are plans to monitor and sustain outcomes.

A resource to assist developing partnerships is provided in the Victorian Council of Social Services Partnership Practice Guides.<sup>88-90</sup>

These resources are available from <http://www.vcss.org.au>.

In these practice guides, VCOSS identified three primary phases that are important to the successful development of a collaboration or partnership:

### Steps One: Preparing to Partner

- Preparation within an organisation – this should include the identification of a appropriate partnership manager(s) and resources available to utilise within the partnership (both financial and non-financial)
- Discussions with potential partners including funding bodies – such discussions should aim to clarify the desire to partner, potential governance structure and membership details of the partnership, in addition to resource contribution and what protocols would be needed to facilitate the partnership.

- Assess the need for a partnership – partnerships should be strategic, enable the production of a new or improved quality product, not damage reputation and have clear outcomes.
- A structured partnership – clearly defined agreements such as a Memorandum of Understanding and Terms of Reference to assist with effective communication and negotiation and the achievement of partnership goals.

### Step Two: Commencing the partnership

- Map the partnership – identify organisations within the partnership, strategic alliances, key relationships between organisations and the value each connection.
- Workflow arrangements – identification and clarification of the roles and responsibilities and partnership working arrangements. This might include the establishment of annual workplans and/or advisory/steering groups.
- Establish a good communication plan and effective lines of communication.
- Monitor progress – structure regular reporting requirements to assess against indicators, timeframes and milestones.
- Conflict management – discuss and document procedures for resolving conflict.

### Step Three: Sustaining the partnership

- Service the partnership – ensure clearly identified and agreed upon roles, responsibilities and expectations within the partnership, a support team and provision of resources.
- Ongoing monitoring – regular assessment of the success of the partnership and any problems encountered so that they can be addressed.
- Regular reporting of progress – to assist in the maintenance of support and role of the partnership and to assure the partnership is delivering outcomes on time.

# Managing Difficult Behaviour: Rogers' Model

Source: Module 4: working with young people. In *Department of Health and Aging. Training frontline workers: young people, alcohol and other drugs.* Pages 67-74. Available from: [www.health.gov.au/internet/main/publishing.nsf/Content/phd-pub-illicit-tfwi-cnt.htm](http://www.health.gov.au/internet/main/publishing.nsf/Content/phd-pub-illicit-tfwi-cnt.htm).

Rogers (1997) proposed a model of managing behaviours that aims to assist workers to help young people to own and manage their behaviours. The goal of the model is not necessarily to stop the challenging behaviours from occurring. Rather, when they do occur, the worker assists the young person to manage the process which, ultimately, contributes to the positive development of that young person.

The purpose for intervention sits at the centre of the model and provides the guiding principles for your intervention:

- behaviour ownership
- self-discipline
- respect for mutual rights
- self-esteem
- relationship building.

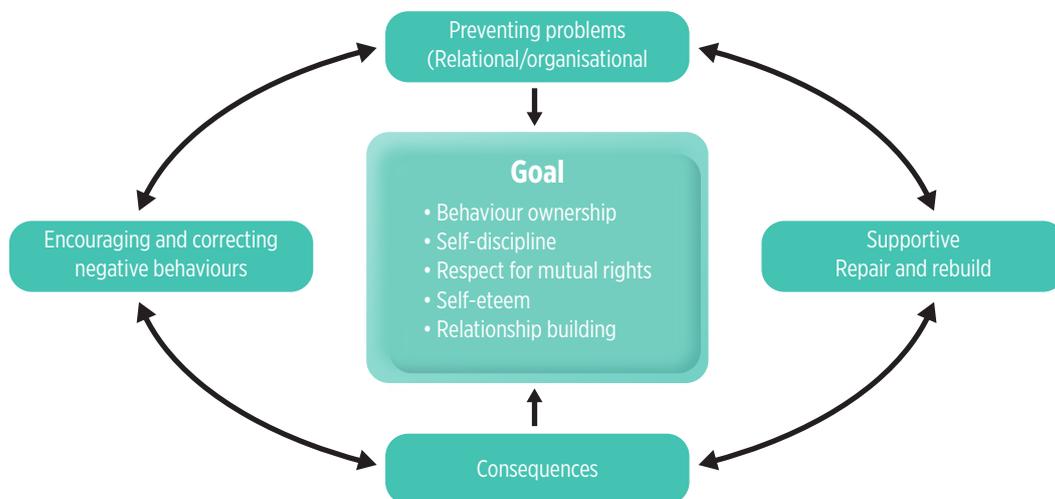
These goals are concerned with the developmental tasks that are so important for a young person to achieve in order to grow into competent adulthood. The developmental perspective recognises that young people never exist in isolation – they are always involved in relationships with others. It is the relationship between the worker and young person that this model addresses.

Rogers identifies four major phases that assist the young person achieve these goals. These phases are dynamic and interactive and cannot always be viewed as sequential stages:

1. Preventing problems
2. Encouraging and correcting negative behaviours
3. Consequences
4. Supportive – repairing and rebuilding relationships.

This model can be used in a one-off interaction or, most usually, as part of an ongoing process. We'll explore these phases in more detail and then apply the model to a case study.

**Figure 4. The Rogers' Model**



## Phase 1: Preventing problems

Rogers suggests that we can minimise the occurrence of problematic behaviours in a number of different ways. He identifies two main areas in our work:

- Organisations – Organisations should be in place to assist young people know what they can realistically expect of your service and what is expected of them. This is particularly important at the beginning of your relationship with a young person.

This includes:

- Ensuring that young people (and staff) are aware of their rights and responsibilities. An important aspect of this is ensuring that everyone is aware of the consequences if someone does not uphold their responsibilities, in particular those relating to confidentiality, duty of care policies and procedures. This understanding needs to occur not only on initial contact but reinforced throughout the agency's contact with a young person.
- Explain the core work provided by the service. This will assist a young person to understand the boundaries that exist.
- Maximise the opportunities for young people's participation into their daily activities. This applies to all aspects of program planning including types of activities, actions and consequences of inappropriate behaviours. This will ensure ownership of the program by the young people.
- Aesthetics of the facility  
Does the facility appear to be well looked after? Is some broken furniture the first thing the young person sees? If a place appears well maintained a young person is more likely to look after it themselves. The way the facility appears is a reflection of how the service perceives the young people it serves.

### ■ Relational structures

The second component of Rogers' model (Preventing Problems) covers such issues as rapport-building and engaging with young people (discussed elsewhere in the training guide and in this document).

Sufficient to say that a safe and trusting relationship between a worker and a young person is likely to:

- reduce the potential for problem behaviours
- assist in the management of the difficult behaviour
- assist in reducing the occurrence and extremity of such behaviour.

Can you identify ways that you and your service could assist in preventing problems from occurring? Some of the following questions will help you to focus on your own workplace:

- When a young person begins contact with your service is there a formal process of introduction to the rights and responsibilities of your workplace?
- Are these reinforced? How?
- How does your workplace ensure there is input from young people into the planning, running and evaluating of any youth related activities?
- During their contact with your service, or at the completion of their time in your facility, is there any process (formal or informal) whereby young people can give feedback about the service?
- How do you ensure congruence between policies or rules and work practice (e.g. posters to remind young people, personal diaries, consistency amongst staff, etc)?
- How do you go about preventing potential problems (e.g. helping the young person find constructive ways to occupy their time)?

## Phase 2: Encouraging positive responses and correcting negative behaviours

Your response to difficult behaviour gives strong messages to the young person. It is important to distinguish between the behaviour and the person. If you adopt the 'aggressive style' or the 'passive style' (discussed in Topic 4 of the training resource), you can send negative messages about how you perceive the young person. You are then unlikely to establish a relationship in which you can encourage positive responses and 'correct' negative behaviour.

Research tells us that behaviour management is most effective if based on reward for positive change rather than punishment for failure. So, supporting and encouraging a young person, and positively acknowledging even the smallest behaviour change, is important. This encouragement will assist in the goals of:

- behaviour ownership
- self-discipline
- building self-esteem.
- responding to positive behaviours. It is easier to notice and respond to negative behaviour rather than positive behaviour.
  - Be aware of the need to encourage the young people (otherwise those seeking attention will only have one avenue – misbehaviour)

- Be specific and sincere in your encouragement
- Generally young persons prefer private rather than public praise
- Ask young people to evaluate their own performance by comparing it to past performance
- Positive notes can also be quite powerful.

### Phase 3: Consequences

The third phase of Rogers' model outlines the avenues open to frontline workers dealing with young people who need to be directed with particular consequences for their behaviour. An important principle proposed by Rogers is the Principle of Least Intrusive Measures. This states that it is best to begin with the least intrusive approach and only use more intrusive approaches when necessary.

When you do have to correct young people's behaviour, using this principle ensures a match between the behaviour and the intervention required. It also ensures, as far as possible, that in addressing the behaviour we don't destroy our relationship with the young person.

- Least intrusive measures, which include:
  - Directional choices such as giving the young person a choice: ownership and empowerment: 'Put the Walkman under your chair or on the desk, thanks.'
  - Casual questions such as an opening: 'How's the chores going?'
  - Reminders such as reminding about the rules: 'Remember our rule about respect.'
  - Encouragement such as 'Put your cigarettes in the ashtray when you're finished, thanks.'
- Range of consequences – Obviously, if a young person continues with behaviours that are inappropriate then we need to ensure that consequences are dealt with accordingly. An important aspect of our role is to assist the young person to recognise the potential consequences of their behaviour. Sometimes the best efforts and the most experienced frontline workers will not be able to shift inappropriate behaviours. The most intrusive consequences include legal sanctions, discharge from a unit, suspension from school and the like. Obviously other consequences also exist.

For consequences to be effective a number of conditions need to be met:

- The consequence and the reason need to be understood by the young person
- Consequences must be appropriate to the behaviour
- Consequences need to be immediate wherever possible.

Defer applying consequences in the case of a critical incident, as this may only inflame the situation. In addition, applying consequences assumes that the young person is able to see what they have done is wrong. When a young person is in a rage, their emotions take over. Expecting that the young person is able to think clearly at this time is therefore unreasonable. Talking to the young person after they have calmed down is a better option.

Any significant consequence should have a written component added to it. Rogers suggests using the '4 W's' as a prelude to problem-solving.

1. What I did
2. What right my behaviour impacted upon
3. Why I did it
4. What I think I should do to fix it.

- Choosing consequences – If the young person refuses to take responsibility for their behaviour they will be faced with choosing the consequences. Young people need to be treated as if they can 'choose' the consequences of their behaviour. To do that they need to know the rules are fair and that there are positive rights behind those rules. They also need encouragement and positive reinforcement when they work by fair rules.

When using choices we put responsibility back on the young person who is challenged to think about their behaviour. Emphasising 'choice' in effect says to young people that they are the active agent, not merely the victim. Choice acts as an empowering tool.

## Phase 4: Supportive – repair and rebuild relationships

Supportive discipline completes Rogers' model. When any consequence has been carried through it is important to re-establish a working relationship between worker and young person as soon as possible, in order to repair emotional breaches.

It is important that workers differentiate between the person and behaviour. The way you model appropriate behaviour can be a very powerful tool for change. If a young person has witnessed and experienced coercive and punitive relationships they are unlikely to have experienced modelling of positive relationship skills. A major part of their difficulty can be the lack of alternative relationship skills that go beyond 'might is right' and their expectations that aggression or violence is the norm in relationships.

We have discussed the importance of boundaries, or limit setting, in earlier topics. We have also considered how our own values can impact on the way we relate with young people, as well as the need for strong communication skills. All of this is critical in our relationship building with the young person.

## Training Resources

There are many resources to assist with training workers to provide services to young people with a substance use problem. This section contains descriptions of a selection of useful resources that can be obtained online.

### EngenderHealth training resource: Youth Friendly Services

Source: <http://www.engenderhealth.org/pubs/gender/youth-friendly-services.php>

Topics cover:

- Service provider values
- Adolescent development
- Youth sexual and reproductive health
- Communication with youth
- Creating youth-friendly services.

Useful handouts include (for example):

- Characteristics of a youth-friendly service
- Adolescent psychological and social development summary table

From the website:

All young people, including those with special needs and from the most vulnerable groups, have the right to quality health care services. Unfortunately, this right is not a reality, particularly in the case of sexual and reproductive health services. Many youth in need of sexual and reproductive health care may either decline or be denied access to health services for a variety of reasons: Providers are often biased and do not feel comfortable serving youth who are sexually active; youth do not feel comfortable accessing existing services because they are not “youth-friendly” and may not meet their needs; and, often, community members do not feel that youth should have access to sexual and reproductive health services.

To address provider and site bias toward serving youth, EngenderHealth created a training curriculum intended to sensitize all staff at a health care facility on the provision of youth-friendly services. The curriculum was created as a result of the

participatory work that we have been doing with youth in Nepal to address the needs of all levels of providers at different service-delivery settings. The curriculum has been field-tested and used in Nepal, Russia, Mongolia, and the United States.

Youth-Friendly Services allows staff to reflect upon and assess their own beliefs about adolescent sexuality while ensuring that those values and attitudes do not compromise the basic sexual and reproductive health rights to which youth are entitled. The curriculum also helps providers understand cross-cultural principles of adolescent development and health needs specific to youth. Once participant knowledge, attitudes, and skills are improved, sites conduct a self-assessment on the youth-friendliness of their services and create an action plan for specific improvements.

### DOHA: Training frontline workers: young people, alcohol and other drugs

Source: [www.health.gov.au/internet/main/publishing.nsf/Content/phd-pub-illicit-tfwi-cnt.htm](http://www.health.gov.au/internet/main/publishing.nsf/Content/phd-pub-illicit-tfwi-cnt.htm)

Learning resources to assist frontline workers address the needs of young people on issues relating to illicit drugs.

Most modules contain two booklets – a facilitator’s guide and a learner’s workbook.

- Module 1: planning for learning at work
- Module 2: perspectives on working with young people
- Module 3: young people, risk and resilience
- Module 4: working with young people
- Module 5: young people, society and AOD
- Module 6: how drugs work
- Module 7: frameworks for alcohol and other drugs work
- Module 8: helping young people identify their needs
- Module 9: working with young people on AOD issues
- Module 10: working with families, peers and communities
- Module 11: young people and drugs – issues for workers
- Module 12: working with intoxicated young people

## For Kids' Sake: A workforce development resource for Family Sensitive Policy and Practice in the Alcohol and other drugs sector

Source: [http://nceta.flinders.edu.au/download\\_file/-/view/563](http://nceta.flinders.edu.au/download_file/-/view/563)

From the resource:<sup>91</sup>

This resource is designed to provide workforce development/capacity building knowledge and strategies for alcohol and other drug interventions that are sensitive to the needs of, and involve, families and children. The focus is on Family Sensitive Policy and Practice where there are parents and caregivers who misuse alcohol or drugs and who have children and adolescents under 18 years in their care.

### A Book plus CD-Rom

The resource comprises three distinct components. One is this hard copy book and the others are the accompanying CD-Rom that contains an e-copy of this resource document together with a range of other electronic resources that are referred to at various places within the document, and a poster containing an assessment and intervention checklist

### The Focus

A significant social harm derived from alcohol and other drug misuse is its impact upon relationships, especially families and children. Family Sensitive Policy and Practice involves raising awareness of the impact of substance abuse upon families, addressing the needs of children and families and seeing them - rather than an individual client - as the unit of intervention. It does not rely on one particular practice model in service delivery, and can be built into existing practices.

### Part 1. Family Sensitive Policy and Practice in context

Provides a definition of Family Sensitive Policy and Practice and a public health approach, along with a rationale for and background knowledge and evidence on Family Sensitive Policy and Practice. It includes information on key barriers and enablers for Family Sensitive Policy and Practice and highlights the link between alcohol and other drugs interventions, health promotion and child wellbeing and protection.

### Part 2. Good Practice in Action

Provides practice examples of Family Sensitive Policy and Practice. The last two sections of the document provide useful resources and tools for the alcohol and other drugs sector

### Part 3. Guidelines for Family Sensitive Policy and Practice

This section aims to help organisations to become more sensitive to the needs of families. It gives suggestions for workforce and organisational development, systems and leadership strategies, government policy and evaluation and monitoring systems to support *Family Sensitive Policy and Practice*. Links to key resources are included. This section also includes a checklist of questions to consider in order to facilitate alcohol and other drugs policy and practices to become more sensitive to the needs of families with children.

### Part 4. Resources for Family Sensitive Policy and Practice

Provides a more extensive list of resources and links to a range of training, development and information resources to enhance Family Sensitive Policy and Practice. This section is supported by the accompanying CD-Rom which includes an electronic version of this resource, along with other electronic resources and links.

## Orientation Programme on Adolescent Health for Health-care Providers

Source: [www.who.int/maternal\\_child\\_adolescent/documents/9241591269/en/index.html](http://www.who.int/maternal_child_adolescent/documents/9241591269/en/index.html)<sup>92, 93</sup>

Information from the website:

### Overview

A range of individuals and institutions have important roles in promoting healthy development in adolescents, and in preventing and responding to health problems challenging this population group. Healthcare providers (HCP) have important contributions to make in both these areas. However, situation analyses and needs assessment exercises carried out in different parts of the world point to shortcomings in their professional capabilities and in their 'human qualities' as a result of which they are unable and oftentimes unwilling to deal with adolescents in an effective and sensitive manner. To bridge this gap, the Department of Child and Adolescent Health and Development (CAH) of the World Health Organization (WHO) is developing the Orientation Programme on Adolescent Health for Healthcare Providers (OP) with other partners. The OP is a joint effort of the Commonwealth Medical Association Trust, UNICEF and WHO.

### Core modules

- A. Introduction
- B. Meaning of adolescence and its implications for public health
- C. Adolescent sexual and reproductive health
- D. Adolescent-friendly health services
- E. Adolescent development\*
- F. Concluding

### Optional modules include:

- K. Substance use in adolescents
- L. Mental health of adolescents \*
- N. HIV/AIDS in adolescents
- X. Young people and injecting drug use

The materials consist of a handout for participants and of a facilitator's guide for the overall course (course director guide) and for all the modules.

It provides detailed guidance on how to run each module. In addition it contains tips for the trainers, lecturing aids such as overhead slides in electronic form with accompanying talking points and study materials. Facilitator's guide, handouts for participants, the lecturing aids and study materials are all available on a CD ROM.

\* In development

## Medico-Legal Issues

This information for GPs is also useful for other health service providers.

Source: Chown P, Kang M, Sancu L, Newnham V, Bennett D. Adolescent Health GP Resource Kit, 2nd Edition / Adolescent Health: Enhancing the skills of General Practitioners in caring for young people from culturally diverse backgrounds. Westmead: NSW Centre for the Advancement of Adolescent Health and Transcultural Mental Health Centre, 2008. Available from [http://www.caah.chw.edu.au/resources/gpkit/Complete\\_GP\\_Resource\\_Kit.pdf](http://www.caah.chw.edu.au/resources/gpkit/Complete_GP_Resource_Kit.pdf)

### Young People and the Law

- ◆ Legal and ethical issues are fundamental to professional conduct and practice in any area of health care
- ◆ Working with young people involves additional considerations in day-to-day practice, because of their legal status and their stage of development
- ◆ The law is not clear-cut in many aspects relating to young people under 18 years – much is left to the judgement of the medical or health professional as to the maturity of the young person and their capacity to consent

This chapter provides a broad overview of the following legal and ethical issues as they might apply to young people, particularly those under 18:

- The **capacity of adolescents** to consent to medical treatment on their own behalf
- **Parental authority** for treatment
- **Confidentiality**
- **Child Protection and Mandatory Reporting**
- **Privacy and Medical Records**

NB: This chapter is *not* a prescriptive statement of the law. If you are faced with a situation in which you are unsure about how the law applies – consult with your **Medical Defence** organisation.

### Terminology Used In This Chapter

- ◆ Terminology varies across different pieces of legislation to describe ‘recipients’ of health care and ‘providers’ of health care
- ◆ Some phrases such as ‘medical treatment’ may not necessarily refer only to ‘treatment’ performed by a medical practitioner
- ◆ The term ‘patient’ will be used to reflect the terminology used in much of the relevant legislation although it is well understood that the term ‘client’ might be used in practice in some health care settings; ‘medical practitioner’ will be used where this is the term used in legislation and ‘[health care] provider’ where applicable due to multiple pieces of legislation that may encompass medical and non-medical health professionals

### Informed Consent

For any age group, the term ‘consent to medical treatment’ means that the patient makes a decision about their treatment based on information and advice given by the medical practitioner:

- ◆ The patient must be given information as to the general nature of the treatment and also on ‘material risks’ to consider – which they may regard as significant in deciding whether or not to undergo treatment
- ◆ If the medical practitioner does not give this information to the patient, they may be held to be negligent

#### Consent must have certain qualities to be valid:

- the patient must have capacity
- the patient must have ability to understand the treatment proposed
- the consent must cover the act performed
- consent must be voluntary

### The Capacity of Young People to Consent

Across Australia, 18 years is the legal age of majority (‘adulthood’). The law assumes that adults are competent to make decisions about their medical treatment, either consent or refusal, even if their decision is deemed not to be in their best interests. Thus, the specific legal issues surrounding consent to medical treatment for young people applies to legal minors, those under 18 years.

#### Clinically relevant questions include:

- ◆ When can a young person under 18 years make their own decisions about medical treatment?
- ◆ Can parents or guardians make decisions about medical treatment for young people under 18?

#### General practitioners may have concerns about these two questions because:

- they are unsure how to assess a young person’s capacity to give their own consent even if, strictly speaking, the law allows them to
- they are unsure how they stand legally if they accept a young person’s capacity to consent
- they are unsure whether they can, or should, involve parents in decisions about consent

## Laws About Consent To Medical Treatment

### The Common Law applies across Australia:

The common law states that young people under 18 *might* be capable of giving informed consent, although the health professional must consider the **nature of the treatment** and the **ability of the young person to understand** the treatment.

### Background to the Common Law

- ◆ The common law position relating to a minor's competency to consent to treatment was established by the English House of Lords decision in a case known as '**Gillick**' and was approved by the High Court of Australia in a case known as "Marion's case". The 'Gillick case' holds that the **authority of a parent decreases as their child becomes increasingly competent**. 'Gillick' prescribes that the parental right to determine their child's treatment terminates once a child under the age of 16 is capable of fully understanding the medical treatment proposed. <sup>1</sup>
- ◆ Note that in recent times the term "Fraser guidelines" has been substituted for 'Gillick test' for competence. Lord Fraser was one of the Law Lords involved in the Gillick case. However the Fraser guidelines are different from the Gillick test as they only relate to the provision of contraception; the Gillick test is broader. <sup>2</sup>

### Victoria, Australian Capital Territory, Western Australia, Queensland, Tasmania and Northern Territory

There are no specific laws about minors and consent to medical treatment. Thus the Common Law applies for those under 18 years.

### Additional Statutory Laws apply in NSW & South Australia <sup>3</sup>

#### New South Wales

- ◆ Specific NSW law means that young people aged 14 and over can consent to their own treatment in so far as medical practitioners are protected from charges of assault and battery against a civil action (as distinct from a criminal action) if the young person has given consent. [Minors (Property and Contracts) Act 1970 s49 (2)]
- ◆ This needs to be applied with caution, as health professionals should still consider how capable

a young person 14 and over is to giving full informed consent

- ◆ This NSW law also allows for parents to give consent to medical treatment for an adolescent child under 16 years, even if the young person is themselves competent to consent
- ◆ The Guardianship Act in NSW also implies that a young person aged 16 can consent to their own treatment [Guardianship Act 1987 (NSW)]
- ◆ Finally the Common Law allows for the mature minor assessment to be applied to young people even younger than 14 if relevant.

It is important to point out that there is no absolutely clear cut, single, law about consent to medical treatment for a minor in NSW. For an in-depth discussion about the relevant legislation in NSW see the NSW Law Reform Commissions Issues Paper 24 (2004) at <http://www.lawlink.nsw.gov.au/lrc.nsf/pages/ip24toc>

#### South Australia

- ◆ A young person 16 years and over can consent to medical treatment "as validly and effectively as an adult"
- ◆ For those under 16, a young person can validly consent to treatment if and when two medical practitioners believe and state in writing that certain treatment is in the best interests of the child and the child is 'capable of understanding the nature, consequences and risks' involved (Consent to Medical Treatment and Palliative Care Act 1995; See:

<http://www.legislation.sa.gov.au/lz/c/a/consent%20to%20medical%20treatment%20and%20palliative%20care%20act%201995/current/1995.26.un.pdf>

- ◆ The Common Law allows for the mature minor assessment to be applied to young people even younger than 14 if relevant.

### The right to refuse treatment

- ◆ The legal right to refuse treatment for minors is unclear. The Gillick principle that allows for a competent minor to consent to treatment does not allow for a corresponding right to refuse treatment
- ◆ Hence, a young person who is competent according to the principles established by Gillick, will generally lack the capacity to refuse life-saving treatment if his/her parents are prepared to consent to it

## A minor's capacity to consent

- ◆ This applies to young people:
  - under the age of 18 in Victoria, Queensland, Tasmania, ACT, NT and Western Australia
  - under the age of 16 in South Australia
  - under the age of 14 - 16 in NSW (this is not absolutely clear, see above)
- ◆ For a medical practitioner to obtain consent to treatment from a minor, they must make a **competency assessment** (see below):
- ◆ This means that a medical practitioner *does not have to seek parental consent* to treat a minor who is deemed competent.
- ◆ Generally, consent from a parent or guardian is asked for if the young person is *14 years or under* – *unless the young person objects*.

The capacity of a young person to consent is also considered to be related to the *gravity* of the treatment being proposed. Thus, procedures such as sterilisation and gender reassignment require court approval because of the need to consider a young persons' ability to fully appreciate the consequences of a certain treatment and impact on their life into the long term. Parental consent in these cases is not sufficient.

## Making A Competency Assessment

Medical practitioners must form their own opinion about a patient's '*intelligence and understanding*'.

- ◆ A minor may be legally competent to consent to medical treatment if he or she '*achieves a sufficient understanding and intelligence to enable him or her to understand fully what is proposed*' (the Gillick test). This particularly involves considerations about their:
  - age
  - level of independence
  - level of schooling
  - maturity
  - ability to express own wishes

**Note:** The medical practitioner's assessment about these factors could be influenced by cultural differences between the doctor and the young person. A cognitively mature adolescent may come across as socially or emotionally immature (or vice versa) because of different cultural expectations about their

roles in the family/society (e.g. they may seem less independent), or differences in the way their thoughts or wishes are communicated. If in doubt, seek advice from a colleague or an appropriate agency.

- ◆ You should be satisfied that the young person has a full understanding of the following:
  - what the treatment is for and why the treatment is necessary
  - any treatment options
  - what the treatment involves
  - likely effects and possible side effects/risks
  - the gravity/seriousness of the treatment
  - consequences of not treating
  - consequences of discovery of treatment by parents/guardians
- ◆ If you are unsure whether a minor is competent:
  - seek the opinion of a colleague or
  - obtain the consent of the minor's parents/guardians
- ◆ Make a **file note** about your assessment:
  - Make a note on the young person's medical record about the competency assessment – particularly if you found the young person to be competent and subsequently administered treatment on the basis of his/her consent

## Dealing with special circumstances

### English language

- ◆ Be aware that informed consent can only be obtained if the young person understands what is being presented in a language with which they are fluent
- ◆ Health care interpreters should be used where appropriate - particularly if you are working with a family from a non-English speaking background (see Section 4 for contact details)
- ◆ Over the telephone interpreting is available through the *Translating and Interpreting Service (TIS)* – Telephone 131 450. This is a national service provided through the Department of Immigration and Multicultural and Indigenous Affairs and is free to GPs
- ◆ TIS is available 24 hours a day, 7 days a week, and is accessible from anywhere in Australia for the cost of a local call.
- ◆ Children should not be used as interpreters for their parents

See Section Four – for contact details of relevant services

## Young people with intellectual disabilities

- ◆ A young person with an intellectual disability is not automatically deemed incompetent to consent to treatment
- ◆ The competence of such an individual should be assessed in each case and each situation

## Young people who are parents

- ◆ A legal minor who is a parent has the legal capacity to consent to treatment for his or her child, in the same way as adult parents
- ◆ However the minor may not necessarily have legal capacity to consent to his or her own treatment

## practice points

- ◆ Obtaining informed consent applies for all patients, not just young people
- ◆ Young people under 18 years require a special assessment of competency to consent. In NSW and SA, additional laws allow for those 14 years (NSW) and 16 years (SA) and over to consent to their own treatment. See below for important detail about these additional laws.
- ◆ Capacity to consent for minors will depend on age, maturity, intelligence, education, level of independence and also on the gravity of the treatment proposed

## Confidentiality

*Confidentiality can be defined in the health care setting as “an agreement between [young person] and provider that information discussed during or after the encounter will not be shared with other parties without the explicit permission of the [young person]”.*

## Exemptions

The exemptions to the duty to maintain confidentiality are both legal and ethical. These are listed below:

### Where the patient consents to disclosure

- ◆ A patient can give expressed verbal or written permission or implied permission for their health provider to disclose information to a third party – e.g. a parent, or another professional involved in their care – such consent should not be coerced

- ◆ It is probably best to make explicit implied consent in case health providers make an incorrect assumption where disclosure to parents or other health professionals is involved, i.e. discuss and clarify with the young person

### Where the provider is compelled by law to disclose

Note that in these instances, information disclosed is kept in confidence and not divulged to outside parties:

- ◆ **Court proceedings** – these may involve a provider giving evidence in court or producing health records under subpoena
- ◆ **Notifications** – Medical practitioners have specific requirements to notify the following (*note these may vary between States and Territories and this is not necessarily complete*):
  - evidence of a notifiable disease (including HIV infection, AIDS, all forms of hepatitis, tuberculosis, and several others)
  - reporting of blood alcohol level test results for patients admitted to hospital after a motor accident
  - births and deaths
- ◆ **Mandatory reporting**

See Mandatory Reporting below

### Best interests of the patient

- ◆ This exemption relates to a situation where a provider believes there is a real risk of serious harm to the patient – e.g. a young person at risk of suicide

### Public interest

- ◆ In practice, this could translate into a situation where a provider is made aware by a patient that they have committed, or intend to commit, a serious criminal offence

### Where disclosure is necessary to treat a client

- ◆ If there are multiple providers involved in a person's health care, it can be considered reasonable that communication between providers would serve in the best interests of the patient – the concept of 'team confidentiality' can be explained to patients when working within a multidisciplinary team. However, it is advisable to seek a patient's permission to disclose any non-urgent communications outside these parameters

## practice points

- ◆ Confidentiality is legally part of the general duty of care to patients
- ◆ Health care providers must keep information divulged by the patient confidential, unless an exemption applies
- ◆ Special care may need to be taken in explaining to parents of young people from a CALD background about their adolescent child's right to confidentiality

### A Common Medical Issue – Prescribing Contraception

- ◆ **Hormonal contraception** (e.g. the oral contraceptive pill, injectable and implantable hormones) can be prescribed for a minor, regardless of the reason/s why, without parental consent, provided that the young woman is deemed competent by her doctor to give informed consent
- ◆ This is also true for emergency hormonal contraception ('morning after pill')

**Note:** That legislation in NSW changed between 2000 and 2005 to remove injectable progesterone from the 'Special Medical Treatment' category that required Guardianship Tribunal approval for women under 16 years – thus NSW is now in line with other states and territories as regards this contraceptive.

- ◆ **Sterilisation** – e.g. tubal ligation, vasectomy – these procedures cannot be performed on a minor without the authority of the Guardianship Tribunal, Family Court of Australia or Supreme Court

### Case Example: Josie

A 15 year old young woman requests a prescription for the oral contraceptive pill and doesn't want her parents to know. A thorough history reveals that she is involved in her first sexual relationship, it is consensual and with a young man of the same age and at the same school.

#### Legal issues to consider:

- ◆ **Consent:** Is the young woman competent to give her own consent to treatment?
- ◆ If yes – there is no legal imperative to seek parental permission
- ◆ If *no*, or *unsure* – the GP may first seek advice from colleagues and/or may not prescribe the treatment, but this *does not mean* the GP has the legal obligation nor the right to breach confidentiality about the consultation – unless the young woman is deemed to be at risk of, or is being, abused.
- ◆ **Confidentiality:** The GP must maintain her confidentiality unless the young woman gives permission for others (e.g. parents) to know

#### Health care issues to consider:

- ◆ Building and maintaining a relationship of trust with Josie – this entails assurances of confidentiality, with the exceptions also explained
- ◆ Performing a comprehensive assessment and giving appropriate information and advice
- ◆ Working within the family context – although there may not be a legal imperative to involve the young woman's parents (and it may be illegal to do so due to breaches in confidentiality), it is still reasonable, if not favourable, to have a discussion with the young woman about her family relationships, e.g.:

*“Josie, you've told me that you don't want your parents to know about your sexual relationship and going on the pill, and I can assure you that I will be able to maintain confidentiality as I explained earlier. However, I am still interested in talking to you about your parents and family particularly in relation to how you get on with them, what kind of support you feel you need from them, and so on. What would happen, for example, if your Mum discovered the pill in your school bag? Or if she found out somehow that you and (boyfriend) were having sex? Do you think you'd be able to talk*

to her about it? Young people have the right to privacy, and sex is obviously a private matter, but when you still live at home with your parents, and they still want and need to care for you, then it can be useful to think about how to deal with issues like this if they arise.”

### **Cultural Considerations:**

An issue like this can be strongly influenced by the young woman’s family and cultural background:

- ◆ If Josie is a middle-class Anglo-Australian with ‘liberal’ parents, the issues of secrecy, discovery and teenage sex might not be as concerning to Josie as if she is from a migrant family from a Middle Eastern background with strong religious beliefs, particularly about female sexuality
- ◆ The legal issues facing the GP, however, will be the same
- ◆ The health care issues need to take into consideration possible reactions and consequences if Josie’s sexual activity is discovered by her parents- you need to discuss this with her carefully
- ◆ Her cultural background may also present a source of emotional distress for her, as she may feel torn between the values of her family and community, and her own feelings towards her friends, boyfriend and herself as a young Australian

## **Termination Of Pregnancy**

- ◆ In Australia abortion is legally available with minor variations from state to state, although the ACT is the only jurisdiction in Australia where it has been decriminalised <sup>4</sup>
- ◆ In some states and territories parental consent for women under 18 is required: <sup>5</sup>
  - **NSW** – parental consent *probably* required if under 14
  - **Northern Territory** – parental consent required if under 16
  - **Western Australia** – parents must be told if under 16 and must be given the opportunity to be involved in counselling and medical consultations, otherwise the young woman must apply to Children’s Court to maintain confidentiality

- ◆ The same laws governing *consent and confidentiality* will apply in the case of a young woman seeking termination, as with any other form of health care
- ◆ The legal onus falls on the abortionist, invariably a medical practitioner, to ensure that *informed consent* is obtained from a woman on whom a termination is to be carried out, regardless of her age
- ◆ In order to make an informed choice about the decision to terminate pregnancy, the woman should be given thorough pre-termination counselling and explanation of all possible adverse effects
- ◆ A doctor (or other health provider) can refuse to discuss, refer or assist a termination based on their own religious or personal beliefs, without risk of anti-discrimination action. *However the provider would be obliged under duty of care, to take appropriate action to explain and offer alternatives to their client*

## **Child Protection And Mandatory Reporting**

### **Child protection laws**

Below is a list of the *principle* child protection laws in each state and territory:

#### **Australian Capital Territory:**

Children and Young People Act 1999

#### **New South Wales:**

Children and Young Persons (Care and Protection) Act 1998

#### **Northern Territory:**

Community Welfare Act 1983; Care and Protection of Children Draft Act (currently before Cabinet)

#### **Queensland:**

Child Protection Act 1999

#### **South Australia:**

Children’s Protection Act 1993

#### **Tasmania:**

Children, Young Persons and their Families Act 1997

#### **Victoria:**

Child, Youth and Families Act 2005

#### **Western Australia:**

Children and Community Services Act 2004

- ◆ You can get more information about these and other relevant Acts of law from the following website:  
<http://www.aifs.gov.au/nch/resources/legislation/legislation.html>

- ◆ For information about which government department in your state or territory is responsible for the care and protection of children and young people, see the following website:  
<http://www.aifs.gov.au/nch/resources/state.html>

### Definition of a child or young person

- ◆ A *child* is a person under 16 years of age in NSW, and under 18 years in other states and territories
- ◆ In NSW, a *young person* is 16 or 17 years old

### What is 'in need of protection'?

For specific information about how the legislation in your State or Territory defines 'a child in need of care and protection' see the following article:  
<http://www.aifs.gov.au/nch/pubs/sheets/rs12/rs12.pdf>

- ◆ In some states and territories, certain incidents or circumstances may be registered as 'concerns' rather than 'at risk of harm'
- ◆ Once there is known or suspected **harm or 'risk of harm'**, the statutory response to protect the child or young person is effected (i.e. they become a child/young person 'in need of care and protection').

### 'Risk of harm'

The following is a broad summary of some of the issues that constitute *risk of harm* but it is important to note that there will be differences depending on the laws in your state or territory. If you feel a child or young person is at risk of harm, it generally means that you have *current concerns* about the safety, welfare or wellbeing of a child or young person because of the presence of any one or more of the following circumstances:

- ◆ Their **basic physical or psychological needs are not being met** or are at risk of not being met (*neglect*). A key indicator of *neglect* is where the care of the child is continually or persistently being ignored. These basic needs include:
  - food
  - shelter
  - hygiene
  - safety from harm
  - insufficient or inappropriate interaction or stimulation from parents/caregivers
  - emotional neglect
- ◆ They are not receiving **necessary health or medical care**
  - where parents/caregivers cannot or will not arrange required medical care

- ◆ They have been, or are at risk of being, **physically or sexually abused, or ill treated**. This includes:

- *physical abuse* – an assault or non-accidental injury by parent/caregiver such as severe beating or shaking; excessive discipline; bruising; lacerations, burns; fractures; etc
- *physical assault* – a hostile act by an adult towards a child or young person, even if the adult has not meant to harm – including pushing; shoving; hitting; throwing objects; rough handling, grabbing around the throat, any threatening behaviour. It is now illegal for a parent to hit a child above the shoulders or with an implement
- *sexual abuse* – any sexual act imposed on a child or young person; that exploits their dependency or immaturity

- ◆ They are living in a household where they have been incidents of **domestic violence** and as a consequence, are at risk of serious physical or psychological harm:

- domestic violence is violent, abusive and intimidating behaviour by one person against another in a personal intimate relationship – including physical, psychological, sexual, social and economic abuse

- ◆ They have suffered, or are at risk of suffering, *serious psychological harm* from the behaviour of a parent/caregiver:

- *serious psychological harm* is behaviour by a parent/caregiver which results in emotional deprivation or trauma – e.g. continual scapegoating or rejection
- *psychological abuse* involves serious impairment of a child/young person's social, emotional, cognitive or intellectual development; this might be because of their exposure to a parent's ongoing mental health problems

- ◆ They are **homeless** and at risk of harm; this may occur if they do not have access to food or shelter or if they are living in a situation where they are unsafe. This includes living without family assistance in any of the following circumstances:

- no accommodation; 'roofless'
- temporary or transient accommodation
- emergency, refuge or crisis accommodation
- accommodation where they do not have access to basic utilities (power; running water)

## Recognising risk of harm

A number of things should be considered in determining whether a child/young person is at risk of harm, including:

- ◆ past professional experiences
- ◆ the age, development, functioning, and vulnerability of the child/young person
- ◆ behaviours of a child that suggest they may have been harmed by another person – e.g. mimicking violence; sexualised behaviour, unexplained physical complaints
- ◆ behaviour of another person which might have a negative impact on healthy development, safety or wellbeing (e.g. drug abuse; domestic violence)
- ◆ physical signs of abuse or ill-treatment – e.g. bruises; lacerations; burns; fractures or other injuries
- ◆ concern about other family members – such as recent abuse or neglect of a sibling, or parents experiencing mental health problems

## Cultural issues

Some traditional cultural practices may place a young person at risk of harm. For example, the practice of female genital mutilation (FGM), which is practised in a number of countries, is a criminal offence which the GP is mandated to report.

- ◆ It is important to be aware of different cultural practices and to determine whether there is any risk of harm to the young person *before* reporting such practices
- ◆ Handle such situations sensitively – explain to patients that legal and ethical issues may override cultural considerations and that all Australians are bound by Australian law, regardless of cultural traditions

**Note:** Some children/young people from some ethnic communities have been wrongly assessed as suffering from abuse as a result of culturally determined health practices (e.g.: ‘coining’ or ‘cupping’ in Vietnamese; Lao communities) – which are in fact acceptable and safe practices within the Australian context

## resources

If in doubt about a particular cultural practice – consult with a culturally appropriate or bilingual health professional, or contact:

- ◆ **Diversity Health Institute**  
– 02 9840 3800 – [www.dhi.gov.au](http://www.dhi.gov.au)
- ◆ **Multicultural Mental Health Australia**  
– 02 9840 3391 – [www.mmha.org.au](http://www.mmha.org.au)

See Section Four – for contact details of multicultural health services.

## Mandatory Reporting

An important component of legislation aimed to protect children and young people includes the mandatory reporting of known or suspected child abuse.

- ◆ All States and Territories in Australia have legislation that makes it compulsory for certain professionals to report known or suspected child abuse to a designated authority
- ◆ Medical practitioners are mandatory reporters in all states and territories where mandatory reporting is legislated. In November 2007, Western Australia introduced a Bill to amend the Children and Community Services Act (sect 124B) to make medical practitioners and other professionals mandatory reporters. In the Northern Territory everybody is a mandatory reporter
- ◆ In NSW, mandatory reporting applies to young people up to the age of 16. In the other states and territories, it applies up to the age of 18 years
- ◆ Although each state and territory has slightly different procedures for mandatory reporting, they are broadly similar across Australia.

## resources

The following list provides contact telephone numbers for each State and Territory to report incidences of child abuse:

- ◆ Australian Capital Territory – 133 427
- ◆ New South Wales – 132 111 (24 hours)
- ◆ Northern Territory – 1800 700 250 (24 hours)
- ◆ Queensland – Departmental Head Office: (07) 3224 8045
  - Crisis Care: (07) 3235 9999
  - Rural areas: 1800 177 135
- ◆ South Australia – 131 478 (24 hours)
- ◆ Tasmania – Child and Family Services: 1800 001 219 (24 hours)
- ◆ Victoria – Child Protection Crisis Service: 131 278 (24 hours)
- ◆ Western Australia – Departmental Head Office: (08) 9222 2555
  - After hours: (08) 9222 3111;
  - 1800 199 008

## Making a report

GPs must report a child they suspect to be at risk of harm as soon as they form an opinion that there are current concerns for the child's safety, welfare or wellbeing. The legislation protects GPs (and other mandatory reporters) from:

- ◆ disclosing your identity and the identity of your practice without your consent
- ◆ being sued for making a report
- ◆ breaching professional ethics or standards by making a report
- ◆ being sued for defamation if you make a report

### Note:

- ◆ If you have any concerns or are uncertain about whether you should make a report, call the relevant authority in your state or territory and discuss it with them
- ◆ Over the past decade or so, legislation and accompanying policies and procedures across Australia have been increasingly taking a supportive and collaborative approach to child protection (rather than a punitive approach towards parents)
- ◆ Thus, you are encouraged to work with the relevant child protection authority to support young people

## practice points

- ◆ All states and territories have legislation that protects the welfare of children
- ◆ Medical practitioners are mandatory reporters in all states and territories (see below for Western Australia)
- ◆ The definitions of 'child' and 'child in need of protection' vary slightly between states and territories.

### Case Study: Leah

Leah is a 16 year old girl who lives at home with both parents, a paternal grandmother and 4 siblings. She is third out of 5 children. She is in Year 10 at the local high school. Both her parents are unemployed. She is brought to you by a youth worker from a local youth centre and tells you that she is 6 months pregnant. The only other person who knows is her school principal. She says that the father of the baby is a 17 year old boy, a family friend, who also doesn't know. Leah is quite tall (170cm) and of large build so that her pregnant

abdomen is quite well hidden. She tells you that she wants to give the baby up for adoption without anyone in her family or school knowing, and that she intends to 'run away' for a couple of weeks around the time of confinement. She is willing to be referred to the local hospital for booking in and antenatal care, and is willing to receive assistance to help her find accommodation and support necessary to deliver the baby and organise the adoption.

Leah strikes you as being somewhat emotionally detached from the whole situation and you are unsure as to whether she is an immature 16 yr old, whether she is in a strong state of denial, or whether she might have a mild cognitive impairment.

*What are the legal and ethical issues that you would consider in this case?*

### Points to consider:

#### Leah's welfare

- ◆ It is concerning that Leah is so adamant about not telling anyone in her family. The reasons for this need to be more carefully explored and you should work towards ways of supporting Leah to tell her parents
- ◆ It is important to rally a comprehensive support network – the obstetric and relevant psychosocial support team and adoption agency, the youth worker, the school principal and hopefully family support
- ◆ It is critical to ensure that Leah is as fully informed about her adoption decision as possible – the antenatal team should be active in this as well
- ◆ With all the above in train, you must also decide whether Leah is a young person at risk – of homelessness, or physical and emotional harm (e.g. if she gives birth without proper medical or psychosocial care and support). She is 16 and, depending on which state or territory you are practising in, you may be mandated to report this situation. Even if you are not mandated (e.g. in NSW) you may report any of the above concerns for young people aged 17 or 18

#### The baby's welfare

In NSW, ACT, Victoria, Queensland, South Australia and Western Australia you can report concerns about an unborn child (not mandatory). These jurisdictions have legislation that specifically deals with such reports.

### Cultural considerations

What if Leah is from a Pacific Islander background living with an extended family in a small community of other Islanders? She tells you that this is a highly significant factor in her wishing to maintain secrecy around her pregnancy and confinement. She says that she has made her own decision, knows that this is the best thing to do, and that she and her family could face harsh recriminations within her extended family and community otherwise. Legal and ethical issues, particularly as they relate to human rights conventions (eg Rights of the Child), should override other cultural considerations.

It is sometimes easy to 'hide behind culture', or to use 'culture' as an 'excuse' not to act. Leah's anxieties about the impact of her 'secret' upon her family and community may be well founded, and these can be explored, possibly with the assistance of transcultural experts. However, Leah's and her baby's safety remain paramount, and there may be many other reasons besides her cultural background, as to why Leah is anxious about secrecy.

## Privacy And Medical Records

- ◆ Federal Privacy legislation passed in 2001 applies to the privacy of, and access to, personal and health information and medical records in the private sector, i.e. general practice
- ◆ This legislation does not apply to state and territory public health services
- ◆ This legislation is based on 10 National Privacy Principles, and is succinctly described in the following publication for health professionals:  
<http://www.privacy.gov.au/publications/hics1.pdf>
- ◆ Essentially, consumers of health services in the private sector:
  - have a right to access their medical records for information acquired after 21 December 2001
  - have a right to ask for information in medical records to be corrected if acquired after 21 December 2001
  - have a right to remain anonymous when accessing a health service if lawful and practicable
  - have a right to ask for health information not to be shared with other health providers
- ◆ Health professionals in the private sector:
  - can share health information for a treatment-related purpose, as long as it would reasonably be expected to happen
  - have the right to charge patients a reasonable fee for access to their medical records
  - can deny a patient access to medical records if giving access would pose a serious threat to the life and health of anyone or where legally required
- ◆ Young people under 18 years can exercise their own privacy choices (e.g. not allow parents to see their records) once they become able to understand and make their own decisions (i.e. become competent to consent) <sup>6</sup>

## resources

- ◆ For further information about relevant laws applying to young people – see the following website – [www.austlii.edu.au](http://www.austlii.edu.au)

## References:

- 1 Bowles, K. (2003). Age of consent to medical treatment, FindLaw Australia.  
<<http://www.findlaw.com.au/articles/default.asp?task=read&id=10022&site=CN>> viewed 29 April 2008.
- 2 Wheeler, R.(2006). Gillick or Fraser? A plea for consistency over competence in children. *BMJ* 332:807.
- 3 Bird, S. (2005). Can children and adolescents consent to their own medical treatment? *Australian Family Physician* 34(1/2):73-74.
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- 5 National Children's and Youth Law Centre.  
<[www.lawstuff.org.au](http://www.lawstuff.org.au)> viewed 28 March 2008.
- 6 Office of the Federal Privacy Commissioner (2002). My health, my privacy, my choice: a consumer's guide to privacy and health information.  
<<http://www.privacy.gov.au/publications/chib.pdf>> viewed 5 April 2008.

## Additional References

Sanci, L. (2001) Adolescent Health Care Principles. Centre for Adolescent Health. The Royal Australian College of General Practitioners. Melbourne.

# Conducting a youth-friendly consultation

This information for GPs is also useful for other health service providers.

Source: Chown P, Kang M, Sanci L, Newnham V, Bennett D. Adolescent Health GP Resource Kit, 2nd Edition / Adolescent Health: Enhancing the skills of General Practitioners in caring for young people from culturally diverse backgrounds. Westmead: NSW Centre for the Advancement of Adolescent Health and Transcultural Mental Health Centre, 2008. Available from [http://www.caah.chw.edu.au/resources/gpkit/Complete\\_GP\\_Resource\\_Kit.pdf](http://www.caah.chw.edu.au/resources/gpkit/Complete_GP_Resource_Kit.pdf)

Consulting with young people requires an understanding of the unique emotional, psychological and cognitive changes of adolescence. GPs also need an appreciation of the enormous variation among adolescents – in age, developmental stage and cultural background. The approach you adopt with a younger adolescent may be very different from how you would deal with an older adolescent.

Good communication skills are an essential tool for effective consultation with both the young person and their family. GPs must balance the need for working with the adolescent within the context of their family and their culture with the need to respect the young person's developing identity and independence.

### Steps in Youth Friendly Consultation

- ◆ Spend time engaging the young person
- ◆ Negotiate to see the young person alone
- ◆ Discuss confidentiality
- ◆ Use communication appropriate to the developmental stage of the young person
- ◆ Be sensitive to and respect cultural norms when seeing young people from CALD or other cultural backgrounds
- ◆ Adopt a non-judgemental and collaborative approach
- ◆ Take a comprehensive approach – conduct a psychosocial risk assessment to identify broader concerns in the young person's life
- ◆ Consult with the young person on the development of a management plan
- ◆ Decide with the young person which issues to discuss with parents/guardians
- ◆ Address parents' concerns and involve them where possible

### Engaging the Young Person

- ◆ Engagement is the process of establishing rapport with the young person and a crucial first step in the development of a trusting relationship
- ◆ Engagement involves relating to each young person as a unique individual and connecting with them in a meaningful way

- ◆ Many young people will be anxious or reluctant seeing a GP for the first time – you need to demonstrate warmth and openness and be creative in your approach to engaging the young person
- ◆ Engagement is an ongoing process – it may take a number of sessions to successfully engage some adolescents
- ◆ The initial consultation sets the tone for future interactions. Goals for the first consultation may be to:
  - successfully engage the young person
  - clarify confidentiality
  - make a follow-up appointment
- ◆ As the young person returns to your practice over time, your communication style and the focus of the consultation will change as they grow and encounter new developmental challenges
- ◆ Begin the process of engaging the young person with the first encounter in the waiting room:
  - greet the young person first and ask them to introduce their parent or other accompanying adult
  - invite them both to see you together in order to outline their concerns and reasons for the visit
- ◆ Consultation with a young person may take a little longer – plan your time accordingly and be realistic with what you can achieve in the available time
- ◆ By spending time successfully engaging the adolescent, you will have a much better chance of getting them back for a return visit where you can go into issues in greater depth

### Effective engagement with adolescents requires:

- ◆ understanding of adolescent developmental issues
- ◆ effective communication skills
- ◆ knowledge of medicolegal issues
- ◆ strategies for working with adolescents and their families
- ◆ endeavouring to understand the young person's cultural background and how they see themselves within it

## Negotiate to See the Young Person Alone

Many adolescents will be accompanied by a parent. In order to establish rapport, it is helpful to see the young person alone at some stage of the consultation

- ◆ Seeing the young person alone is:
  - a way of acknowledging the young person's growing independence and need for privacy
  - an opportunity to develop a relationship with them as an individual
  - a chance for the young person to raise issues that they may be reluctant to discuss in front of a parent
- ◆ Consultation with the young person alone also provides an opportunity to:
  - assess their developmental stage
  - screen for health risk behaviours
  - provide preventive health information/education
- ◆ State at the outset that you would like to see the young person alone at some stage of the consultation:
  - this is one occasion when you can use your authority to state to both adolescent and parent/carer that it is your routine practice to see the young person by themselves

*Example: "Mrs Smith, I'd like to see you both together at first to get an idea of what the concerns are for each of you. Then I usually like to see the young person alone for some time. This will help me to get to know Johnny a bit better so I can work out how best to help him. I have found that it helps teenagers learn how to communicate with adults better about their concerns. After I've had a chat with Johnny, I'll ask you to come back in at the end to talk about where to go from here."*

- ◆ Seeing the parent and adolescent together is also important as it allows you to:
  - assess their relationship and observe how they interact with each other
  - facilitate communication between the parent and adolescent
- ◆ Begin the consultation by asking both the young person and parents their reasons for attending
- ◆ Listen to the parents' concerns and acknowledge that you have heard and understood their perspective

- ◆ See the parent after the interview to wrap up, and discuss management and follow-up issues – ensure that the young person has been involved in this and you have clarified with them what they are comfortable with you discussing with their parents

### Seeing the Young Person Alone – Considerations

*The decision to see the young person alone should be based on the needs of each individual patient, and the degree to which parental involvement is indicated as part of the management plan. GPs need to balance the need to engage the young person in a confidential relationship with the need to involve the parents/guardians who are usually the main caregivers and source of physical and emotional support.*

*The decision to see the young person alone will depend on:*

- ◆ *the age and developmental stage of the young person*
- ◆ *the nature of the relationship between the young person and parent(s)*
- ◆ *whether it is culturally appropriate*
- ◆ *the nature of the presenting problem – it may be necessary to involve parents where the consultation concerns major life decisions (even if it is against the young person's wishes) – e.g. whether to keep or terminate a pregnancy; prescription of medications*

*Where the presenting complaint is minor (e.g. a sore throat) seeing the young person alone may not be warranted – however, this can also be an opportunity to develop a relationship with the young person that will make it easier for them to independently consult a GP in the future:*

- ◆ *communicate sensitively and directly both to parents and young person about the need for more/less parental involvement*
- ◆ *frame the decision to see the adolescent alone in a positive way – e.g. that it is a sign of healthy development for the young person to begin to establish their own individual relationship with a health professional*
- ◆ *respect the wishes of the parent/adolescent should they not want the young person to be seen alone*

## Seeing the Young or Immature Adolescent

GPs may feel more comfortable seeing adolescents alone at the age of 14 or 16, because the legal status of young people changes at these ages in some states and territories.

See Chapter 6 – Medicolegal Issues

- ◆ With younger or particularly immature adolescents, it may not yet be appropriate to see them by themselves and more involvement with parents/carers may be needed
- ◆ However by 14 many adolescents are almost fully pubertal and some may have commenced experimenting with health risk behaviours
- ◆ While most adolescents over the age of 14 have the cognitive ability to process health information in a manner similar to adults, they lack the experience of adults in negotiating relationships with health providers and health systems
- ◆ The onus is on the GP to help the young person acquire the knowledge and skills to engage in a doctor / patient relationship and to make informed decisions
- ◆ Begin to foster an independent relationship with adolescent patients as early as possible in their development
- ◆ Raise the issue of 'time alone' and confidentiality early with both the parents/carers and the adolescent, mentioning it as part of routine practice, but acknowledging that the involvement of parents is appropriate at present
- ◆ You can then plan future sessions together to work towards seeing the young person alone at some point:

**Example:** "Perhaps at our next appointment, I'll spend 5 minutes with Stephen by himself."

## Cultural Considerations

*In some cultures, a young person may continue to be seen as a 'child' well into adulthood. Hence, it may not be appropriate to see the young person alone – especially if they are a younger adolescent. In this case, it is important to include the parents in the consultation process. If you detect a need to see the young person alone, you can raise the issue of seeing the young person by themselves and work towards this over time:*

- *develop trust and rapport with the family*
- *sensitively negotiate with them about seeing their adolescent alone*
- *respect the parent's and adolescent's wishes not to be seen alone*
- *explain the role of the GP and how seeing the young person alone will benefit the provision of health care to him/her*

## Defining Confidentiality

*Research has consistently found that adolescents rate confidentiality as the most important element of a health consultation.*

Once you are alone with the young person, begin the consultation by explaining the terms of confidentiality – this will help to facilitate rapport and lessen their discomfort in talking about private concerns:

- ◆ Inform the young person that information they discuss with you will be kept confidential – you may need to explain the meaning of the term 'confidentiality'
- ◆ Explain that it may be necessary to share some information with other professionals in order to provide the best possible treatment – stress that you would ask their permission before doing this
- ◆ Explain that the other staff where you work (e.g. receptionists, other GPs) will also keep their health information (e.g. the medical record, pathology results) confidential within the practice

## Confidentiality – Exceptions

Explain to the patient that there are three main circumstances where it may be necessary to break confidentiality for the young person's safety:

- ◆ *If the young person discloses suicidal intent or is threatening significant self-harming behaviour*
  - ◆ *If someone else is threatening or harming them (e.g. physical, sexual or emotional abuse)*
  - ◆ *If the young person is at risk of physically harming someone else (e.g. assault, abuse)*
- ◆ There may be other reasons for breaching confidentiality (e.g. notification of infectious diseases) but these can be explained if and when appropriate. For the engagement process, only the above exceptions need to be explained

- ◆ It is important to be sensitive in how you explain these limits to confidentiality – especially if it is the first occasion you are seeing the young person
- ◆ It is helpful to have a format for informing adolescents about confidentiality that enables you to discuss it in a way that feels natural and reflects your own style

**Example:** “Rebecca, I’d like to explain to all my patients about confidentiality. Do you know what I mean by confidentiality? This means that what we talk about will be kept private. I won’t tell anyone what you tell me – including your parents – unless you give me permission to do so. There are however a few situations where I might need to talk to other people if I believed that you were in danger in any way. For example: if I was concerned that you might harm yourself or someone else; or if I felt that you were being harmed or at risk of being harmed by somebody else. If any of these situations did happen, it would be my duty to make sure that you are safe. I would talk to you about it first before contacting anyone. Does that sound okay to you?”

- ◆ You may need to reassure the young person about confidentiality at subsequent consultations – especially if you are dealing with sensitive issues such as drug use, sexuality, mental health problems

### Accidental breaches of confidentiality

- ◆ Confidentiality can be accidentally breached if a GP or practice staff contact the young person at home
- ◆ Ask the young person about the best way to contact them with test results, accounts, reminders, etc.; or ask the patient to phone your office

### Confidentiality – Dealing with Parents

*As adolescents become more independent, it is normal for them to not want their parents to know everything they are thinking and doing:*

- ◆ *You can reframe this in a positive way, explaining to parents that it is a sign of healthy adolescent development*
- ◆ *Nevertheless, parents remain the main caregivers for the majority of adolescents, and so should not be alienated from their adolescent’s health care – unless it would be dangerous or inappropriate*
- ◆ *GPs must balance the need to engage an adolescent in a confidential relationship, and the need to engage their parents who provide support*

See Chapter 3 – Negotiating a Management Plan – for further information on dealing with parents

### Conducting The Initial Interview

The GP’s first goal is to establish a trusting relationship in order to help the young person feel at ease to discuss their health concerns and to disclose relevant personal information.

- ◆ After discussing confidentiality, ask how he/she feels about coming to see you:

*“Young people often feel a bit nervous the first time they see a doctor. I’m wondering if you have any concerns or worries about coming to see me today?”*

- ◆ If the young person has come to see you by themselves, compliment them for their initiative
- ◆ Clarify the reasons for their attendance – start with an open-ended question such as:

*“How can I help you today?”*

or:

*“Your mother mentioned a number of things that she’s worried about, but I’m wondering what things you would like to talk about today.”*

- ◆ Summarise their parent’s version of the problem and enquire how they feel about that:

*“Your mother said that you seem to have lost interest in school and your friends, and she’s worried that you might be depressed. I’d really like to hear what you think about that and how you see what’s going on.”*

- ◆ Young people may not perceive that they have a problem at all – or they may define the problem very differently from their parents – explore the presenting complaint with a focus on the young person's view of how they see the problem
- ◆ Take a holistic perspective – try to get a picture of the young person within the context of his/her family, school and social life – explore how the presenting problem relates to other things that may be happening in their life

See Chapter 2 – Conducting a Psychosocial Assessment

- ◆ Identify and agree upon which issues, if any, should be discussed with parents/guardians and decide how to do this

### Strategies for Establishing Rapport

- ◆ Building rapport is the first step in establishing a good relationship with an adolescent patient

### Case Example

Michael, a 16 year old boy, is brought in by his youth worker. He is having conflict with his parents and has been staying in a youth refuge for the past two weeks. He appears reluctant and agitated and stares at the floor while the youth worker explains why he has brought Michael in. Rather than launching straight into trying to identify his problems and concerns, you acknowledge his willingness to come to the appointment and the discomfort he is feeling. You ask him if he wants his youth worker to stay in the room or to leave (he leaves).

- ◆ Respond to the adolescent's initial reactions with empathy and by making a reflective statement. For example:

*"Michael, I understand that you might be feeling uncomfortable about coming to see me today."*

or:

*"I know that it's difficult to talk about personal issues to someone you don't know. Are there any questions you'd like to ask about what's going to happen today?"*

- ◆ Reassure him about confidentiality and discuss any concerns he has about this

- ◆ Follow this up with a statement that gives the young person a sense of choice and control about the direction of the consultation. For example:

*"Michael, I can see that this is difficult for you. Let's see if we can use this time together to identify any concerns you might have about your health right now and to explore how I might help you with any problems happening in your life. Perhaps there are some questions you'd like to ask me about how a GP works and what they can do for young people."*

- ◆ Adopt a 'person-centred' approach rather than a problem-centred approach – this means focussing on the young person in the context of their life and relationships – as opposed to a narrow focus on the 'problem'

- ◆ Take an interest in the adolescent as a person – find out about his home and school life, and his interests. Spend time trying to establish a relationship with Michael by asking about his interests and what it's like for him living in the youth refuge:

*"Tell me a little bit about yourself..."*

*"What are your interests? What do you like to do in your free time?"*

- ◆ You can follow this up with specific questions about home, school, friends, activities, etc.

See Chapter 2 – Conducting a Psychosocial Assessment – for a structured approach to gathering this information

- ◆ Identify and compliment the adolescent on areas in their life that are going well
- ◆ Adopt a relaxed, unhurried, open and flexible approach – remember your goal is not necessarily to diagnose their "problem" – this can lead prematurely to a treatment plan that the young person may not see as relevant to them and their situation

*"Michael, I'm happy to go slowly and use the time today to get to know you a bit until you feel more comfortable talking with me – unless there is something really important or urgent thing that you'd like to talk about today. Otherwise, I'd like to make another appointment to see you again soon. How is that for you?"*

- ◆ By showing your interest in them as a person, a trusting relationship will develop which will encourage the young person to disclose areas of concern and allow you to address these issues as they arise in the course of the discussion

## Communicating with Young People

- ◆ Be yourself throughout the interview, while maintaining a professional manner – adolescents expect a doctor to be an authority, but not authoritarian
- ◆ Adopt a straightforward and honest approach:
  - use plain language
  - avoid medical terminology and adolescent jargon
- ◆ Be sensitive to the young person's cultural background, values and norms – for example:
  - some CALD young people may initially be reluctant to discuss certain issues, such as their relationship with their parents and family life, as they may think that they do not have the right to complain

See Chapter 7 – Culturally Competent Practice – for approaches to working with young people from other cultural backgrounds

- ◆ Respond to non-verbal as well as verbal cues
- ◆ Use an interactive and participatory style of communication:
  - give feedback and let them know what you are thinking
  - foster the young person's participation by asking for their ideas about their health problems and what to do about them
  - involve them in the decision-making and management process
  - encourage them to ask questions
- ◆ Explain the process of what you are doing and why – especially any examination procedures. This demonstrates positive regard and helps to address any fear or discomfort they may be feeling

**Example:** "Michael, I understand that talking about these issues is difficult for you. Would it be all right if I ask you some questions about what is happening at home with your parents? This will help me to get a better understanding of the pressures you are dealing with. Perhaps then together we can look at some ways that might help you to cope better with this situation. How does that sound to you?"

- ◆ Take a one-down approach, let the adolescent educate you:

*"I'm not sure if I've got this right.....was it a bit like....?"*

- ◆ Be non-judgemental in your approach – adolescents will find it difficult to be open and honest if they believe they will be lectured or admonished
- ◆ However, this does not mean condoning risky behaviour
  - share your concerns about any risk behaviours they are engaged in
  - provide information about the health risks of these behaviours – rather than passing judgement about the behaviour

See Chapter 5 – Risk Taking and Health Promotion

- ◆ Provide reassurance – this helps to validate the adolescent's feelings and establish your role as an advocate for them:

**Example:** "I understand that you sometimes get frustrated with your mum. Perhaps I can talk with you and mum together to look at ways that the two of you might work out your disagreements better."

## Assess the Young Person's Developmental Stage

- ◆ Be sensitive to the physical, cognitive, emotional and psychosocial changes the young person may be going through
- ◆ Assess the developmental stage of the young person – are they at the 'early, middle, or late' stage of adolescence?

Refer to Table 1 – Adolescent Developmental Stages

- ◆ This provides an insight into the developmental tasks and issues the young person is dealing with and determines the language and communication style that you use
- ◆ Try to match your questions, explanations and instructions to the developmental level of the adolescent

See Practice Points - Table 1

**Table 1 - Adolescent Developmental Stages**

	Early (10 – 14 years)	Middle (15 – 17 years)	Late (>17 years)
<b>Central Question</b>	“Am I normal?”	“Who am I?” “Where do I belong?”	“Where am I going?”
<b>Major Developmental Issues</b>	<ul style="list-style-type: none"> <li>coming to terms with puberty</li> <li>struggle for autonomy commences</li> <li>same sex peer relationships all important</li> <li>mood swings</li> </ul>	<ul style="list-style-type: none"> <li>new intellectual powers</li> <li>new sexual drives</li> <li>experimentation and risk taking</li> <li>relationships have selfcentred quality</li> <li>need for peer group acceptance</li> <li>emergence of sexual identity</li> </ul>	<ul style="list-style-type: none"> <li>independence from parents</li> <li>realistic body image</li> <li>acceptance of sexual identity</li> <li>clear educational and vocational goals, own value system</li> <li>developing mutually caring and responsible relationships</li> </ul>
<b>Cognitive development</b>	<ul style="list-style-type: none"> <li>still fairly concrete thinkers</li> <li>less able to understand subtlety</li> <li>daydreaming common</li> <li>difficulty identifying how their immediate behaviour impacts on the future</li> </ul>	<ul style="list-style-type: none"> <li>able to think more rationally</li> <li>concerned about individual freedom and rights</li> <li>able to accept more responsibility for consequences of own behaviour</li> <li>begins to take on greater responsibility within family as part of cultural identity</li> </ul>	<ul style="list-style-type: none"> <li>longer attention span</li> <li>ability to think more abstractly</li> <li>more able to synthesise information and apply it to themselves</li> <li>able to think into the future and anticipate consequences of their actions</li> </ul>
<b>Practice Points</b>	<ul style="list-style-type: none"> <li>Reassure about normality</li> <li>Ask more direct than open-ended questions</li> <li>Make explanations short and simple</li> <li>Base interventions needed on immediate or short-term outcomes</li> <li>Help identify possible adverse outcomes if they continue the undesirable behaviour</li> </ul>	<ul style="list-style-type: none"> <li>Address confidentiality concerns</li> <li>Always assess for health risk behavior</li> <li>Focus interventions on short to medium term outcomes</li> <li>Relate behaviours to immediate physical and social concerns – e.g. effects on appearance, relationships</li> </ul>	<ul style="list-style-type: none"> <li>Ask more open-ended questions</li> <li>Focus interventions on short &amp; long term goals</li> <li>Address prevention more broadly</li> </ul>

- ◆ For example – younger adolescents are more concrete in their thinking and may need more specific questions rather than general ones:

**Example:** “What are your best or worst subjects at school?” rather than “How is school going?”

- ◆ The psychosocial changes of adolescence may be different for CALD adolescents

See ‘Cultural Diversity and Adolescence’ – Section One

### Specific Interviewing & Communication Skills

- ◆ Adolescents may not disclose the condition for which they are most in need of assistance until trust and rapport have been established
- ◆ This requires time and the use of specific communication skills to explore beneath the surface
- ◆ This may be particularly so for some CALD young people – for whom it may not be culturally appropriate to disclose personal information or discuss family-related issues with another person

**Some communication skills that are useful in working with young people are:**

#### Active listening

- ◆ Actively encourage the young person to talk – listen for both the facts and feelings they are communicating to ensure that you have correctly understood them

- ◆ Your non-verbal communication shows the young person that you are supportive and listening to them – e.g. a relaxed and attentive body posture; appropriate eye contact
- ◆ Pay attention also to the young person's non-verbal communication – their body posture, tone of voice, facial expression

**Example:** An adolescent patient tells you that they are fine. Yet you notice they are sitting slumped in the chair, their eyes downcast, and speaking very quietly. You might respond by saying:

*"Mark, you said that you're feeling fine, but I notice that you seem a bit down today. I'm wondering if you're feeling a bit sad or depressed and what's happened for you this week..."*

### Reflecting Feelings and Paraphrasing

- ◆ **Paraphrasing** – is a restatement of the content of what the patient has said – in your own words. It helps to clarify what the young person has said and to check the accuracy of your perceptions
- ◆ **Reflecting statements** – mirror the adolescents' feelings they are expressing either verbally or non-verbally – it shows empathy towards the young person and helps them identify their emotions
- ◆ Both these skills demonstrate acceptance and understanding of the young person and their situation

**Example:** "Mark, you've said that you don't seem to be able to get on with the other kids at school and that no-one seems to understand you (**Content**). It sounds like you're feeling really sad and angry about this (**Feelings**)."

### Asking Questions

Explain and normalise the process of asking questions as 'usual practice':

*"I like to ask all my patients about their family background (lifestyle, school, etc.) in order to get a better understanding about how these things may be affecting their health..."*

- ◆ While it is important to ask direct questions about serious health issues, young people feel more in control if their consent is requested:

*"I'm concerned that you seem to be very down today – would it be okay if we talk about what's going on?"*

*"In order for me to work out the best way to help you, I need to know a few things. Would you mind if I asked you about your sexual relationship with your boyfriend?"*

Ask questions in a relaxed way that invite the young person to open up, rather than using an interrogative style:

- ◆ **Open-ended questions** – encourage the young person to talk about themselves, rather than simply giving a 'yes' or 'no' answer. Open-ended questions enable the patient to express their thoughts and feelings about their situation
- ◆ Open-ended questions are also very useful in exploring alternatives and assisting the patient with decision-making
- ◆ Try to avoid 'why' questions – these can put the young person on the defensive. Rather, help them to describe thoughts, feelings and events by asking 'what', 'how', 'where' and 'when' questions

#### Examples:

*"How do you get along with your parents?"*

*"What's happened in the last week that's made you feel like you want to leave school?"*

*"What did you think when your parents told you that you had to see a doctor?"*

*"When you are feeling really sad or down, what do you usually do to cope with this?"*

- ◆ **Probing questions** – are less open-ended and more direct. They are useful with younger adolescents who are more concrete in their thinking, and with adolescents who are non-talkative

**Example:** Rather than asking "How is school?" – You can ask:

- "What do you like/dislike about school?"
- "What are your best/worst subjects at school?"
- "How do you get along with your teachers at school?"

- ◆ **Insight Questions** – these are questions that ask the adolescent to reflect upon themselves and describe abstract feelings or concepts
  - they are useful in getting a broader perspective of the adolescent in the context of their life experience
  - they also help in establishing rapport with the young person, and give an insight into how the young person views themselves

#### Examples:

*"What things do you do well?"*

*"How do you feel about yourself most of the time?"*

*"What do you like most about yourself?"*

*"If I were to ask your friends, how do you think they would describe you?"*

*"If you had three wishes, what would they be?"*

*"If you could describe in one word how you feel about your life right now, what would it be?"*

*"What do you want to do when you finish high school?"*

*"What are your main interests?"*

See also 'Asking Sensitive Questions' – Chapter 2 – Conducting a Psychosocial Assessment

- ◆ **Scaling Questions** – asking the young person to give a rating on a scale is a useful way of eliciting feelings or moods, or for describing the severity of a symptom of a problem. They are also useful in making comparisons and help the patient to monitor their progress towards achieving treatment goals

#### Examples:

*"On a scale of 1 to 10, with 1 being the worst you feel and 10 being really great and positive, how would you rate your mood today?"*

*"On a scale of 1 to 10, how angry (depressed, anxious, sad) have you felt on average over the last week?"*

*"On a scale of 1 to 10, where 1 means little or no control and 10 means total control, how would rate your control over your anger since I last saw you?"*

## Engaging the Difficult Adolescent

GPs often encounter adolescents who are resistant or angry because they have been coerced into attending. The young person may also be silent and withdrawn. The goal for the GP is to still build rapport and encourage the patient to open up:

- ◆ Remember that off putting behaviour – such as monosyllabic answers or hostile body language – may be a normal response in the context of their developmental stage, and the circumstances under which they have come to your clinic
- ◆ Such behaviour may also be a reflection of their anxiety and inexperience with the health system
- ◆ With the young person who is resistant, silent or angry – attempt to engage them by validating their feelings and experience, rather than get involved in a struggle for co-operation

*"My guess is that you're not too happy about being here today and that you're unsure about what is going to happen..."*

## Strategies for Engaging the Difficult Adolescent

Rather than trying to coerce the young person to react differently, respond to their situation with empathy. Different adolescents will respond to different approaches. Here are some strategies for engaging uncommunicative or resistant patients:

- ◆ **Use reflective listening** – make a reflective statement to acknowledge and validate their feelings. For example:

*"I imagine it must feel quite strange to have to come along and talk to someone you don't know about your problems..."*

*"I guess you must be wondering how seeing me is going to help you..."*

*"You seem pretty upset about being here, but I sense you're also feeling pretty down about some things in your life right now..."*

- ◆ **'De-personalise'** – Start with a less personal focus by using a narrative approach:

*"Tell me what it's like being a teenager in the world today"*

or:

*"What do young people think about coming to see a doctor?"*

- ◆ **Multiple choice questions** – offer choices within a question or sentence and invite them to agree or disagree:

*“When that happened I imagine that you might have felt sad / angry / confused / hurt / scared. Can you remember how you felt?”*

- ◆ **Sentence completion** – use unfinished sentences based on what you know about the young person and their situation to help them express themselves. Ask the young person to complete the sentence:

*“Your father was shouting at you and you were thinking...”*

*“And so you felt...”*

*“And after that you decided to...”*

*“When your mother insisted that you come here today, your first response was to...”*

*“Then when you realised you had to come, you thought...”*

- ◆ **Comparisons** – use comparisons in a question form to elicit a response:

*“Do you feel better or worse about yourself than you did before this happened?”*

- ◆ **‘Imagine’ questions** – this can be particularly useful when the young person repeatedly responds with “I don’t know”:

*“Just for a moment, imagine what you would have been thinking when the teacher kicked you out of the classroom...”*

- ◆ **Normalising questions or ‘third-person’ approach** – by reducing the personal focus of your questions, you can normalise their behaviours and begin to indirectly explore the young person’s concerns:

*“Many young people your age experience problems with their parents. How do you usually get along with your parents?”*

*“Some young people your age are starting to try out alcohol or drugs. I’m wondering if any of your friends have tried these. What about yourself?”*

## resources

- ◆ McCutcheon, L.K., Chanen, A.M., Fraser, R.J., Drew, L., Brewer, W. (2007). Tips and techniques for engaging and managing the reluctant, resistant or hostile young person. *Medical Journal of Australia*, 187 (7 Suppl.), S64-S67.
- ◆ NSW Centre for the Advancement of Adolescent Health (NSW CAAH) website has a range of resources for health professionals working with young people and useful links – [www.caah.chw.edu.au](http://www.caah.chw.edu.au)
- ◆ The Centre for Adolescent Health, University of Melbourne – provides training, research, resources and distance education programs in Adolescent Health – [www.rch.org.au/cah](http://www.rch.org.au/cah)

## practice points

- ◆ The key to effective consultation with adolescent patients is the establishment of a supportive and trusting relationship – spend time engaging the young person and building rapport
- ◆ Identify the young person’s developmental stage in order to tailor communication, questions and instructions to the appropriate developmental level
- ◆ Always explain the terms of confidentiality, and its limits, to the young person at the initial consultation
- ◆ Where possible, see the young person on his or her own, even if briefly
- ◆ Be sensitive to the young person’s cultural background, values and norms
- ◆ Use an interactive style of communication – involve them in decision-making, encourage them to ask questions and foster their participation in the consultation process

## References:

This chapter has drawn on the following sources:

- 1 Bennett, D. L. and Kang, M. (2001). Communicating with adolescents in general practice, in *The Missing Link – Adolescent mental health in general practice*. Alpha Biomedical Communications. Darlinghurst. NSW.
- 2 Greydanus, D., Patel, D. and Pratt, H. (2006). *Essential Adolescent Medicine*. McGraw-Hill. New York.
- 3 Sanci, L. (2001). *Adolescent Health Care Principles*. Centre for Adolescent Health. The Royal Australian College of General Practitioners. Melbourne.

## YSAS – Strengthening Therapeutic Practice Frameworks in Youth AOD Services

The Youth Support and Advocacy Service (YSAS) *Resource for strengthening therapeutic practice frameworks in youth AOD services* provides useful material for non-youth specific services to use for making their service for effective for young people.<sup>23</sup> This includes:

- Background information on young people and development; some excerpts are provided below on:
  - Risk chains and protective processes
  - Engagement and retention
  - Developmentally appropriate.
- Characteristics of effective services and programs
- Guide to effective psychosocial therapeutic interventions
- A behaviour change framework based upon the Transtheoretical Model of Change
- A framework for resilience-based intervention
- A discussion of several extra structures, processes and design features of service systems that need to be considered when thinking about how a therapeutic practice framework will be implemented for young people. These extra structures, processes and features are:
  - **Service modalities.** These are the structural platforms used to deliver services and programs. The main ones used in Victoria are: outreach; clinic based, day programs; acute residential services; long-term residential rehabilitation; and specialist programs.
  - **Therapeutic vehicles.** These are the interpersonal, environmental and technological platforms for the delivery of therapeutic interventions. Victorian youth drug and alcohol services tend to rely on two main vehicles: therapeutic relationships (between worker or a team of workers and the young person) and therapeutic environments (e.g. residential).
  - **Therapeutic intentionality.** This means the practitioner having clear and explicit objectives in what they are trying to achieve in their therapeutic work with a client at any particular point in time. Five intentions that repeatedly arise in the literature are briefly

discussed and placed within the wider therapeutic practice framework.

- **Use of a modular practice elements approach.** This is an innovative approach to describing and packaging the content and techniques of psychotherapeutic interventions. Many of the therapeutic models discussed in Section 4 share common ‘practice elements’ – discrete techniques or strategies that are used as part of a larger intervention plan. Services may not be able to implement all of a therapeutic model, but practice elements from it may be suited to their clients’ treatment plans. There is a discussion of the benefits of ‘modular’ design when choosing therapeutic content of a treatment.
- **Processes to support clinical decision-making.** The role of six main processes – assessment, case formulation, care planning, recording case notes, regular supervision and case review – in supporting the implementation of a therapeutic practice framework is described. There is also analysis of how they may need to be improved within youth drug and alcohol services.

### Risk chains and protective processes

From Bruun A, Mitchell P. *A resource for strengthening therapeutic practice frameworks in youth alcohol and other drug services*. Melbourne: YSAS Pty Ltd, 2012. Pages 20-21.

To understand the specific processes that might lead to resilience, researchers have moved beyond the identification of factors and variables. They have turned their attention to the mechanisms or processes by which risk and protective factors interact to shape the life trajectory of each child or young person. Rutter identified the existence of long-term negative chain effects that intensify and entrench the ill-effects of early stress and adversity.

Subsequent research has identified fundamental protective processes and systems for human adaptation that, when operating normally, foster and protect young people’s development. Young people’s exposure to risk factors, and consequent

degree of vulnerability, is heightened when the influence of these key systems has been degraded and the resources and opportunities that go with them diminished (Johnson & Howard, 2007).

The likelihood of serious social problems continuing from adolescence into adulthood seems linked to the extent to which resources are available to the individual and the sheer range of problems they have to contend with. Also, the choices and actions of individuals are crucial in selecting and shaping their experiences. In line with this observation, Masten found that "...resilient youth appear to place themselves in healthier contexts, generating opportunities for success or raising the odds of connecting with pro-social mentors" (p. 234).

Johnson and Howard identify that "...positive and negative chain effects can often have their starting points in random, even accidental events" (p. 4). Opportunities and choices made at crucial junctures play an important role in the life course of resilient individuals. Thomson, Bell, Holland, Henderson, McGrellis et al. demonstrate that "...critical or fateful moments" can become turning points for a young person (p350). An effective, competent response that promotes desirable outcomes and is recognised by others is likely to be repeated. If this happens often enough, certain ways of behaving become part of the individual's behavioural repertoire. This phenomenon is known as a "developmental cascade" or as a "progressive snowball effect".

Masten explains that well-timed interventions geared to respond at critical moments have the potential to disrupt negative cascading effects or initiate healthy developmental processes and positive adaptation. Given favourable conditions, even small changes in an individual's profile and functioning can create a ripple effect, possibly generating momentum for further change and development across a range of life domains. For example, educational success and/or sporting prowess often translate into forming close friendships with pro-social peers. In other words, competence begets competence.

Homel, Freiberg, Lamb, Leech, Batchelor, Carr et al. advocate a developmental pathways approach because it captures the relative influence of risk and protective factors and is understood in the context of each young person's biography, past and present. This approach requires investigation into the "...interconnected systems in which human development unfolds, such as families, schools, and

neighborhoods" to determine how each young person's opportunities for pro-social development are either nurtured or obstructed.

The Social Development Model (SDM) provides a useful theoretical framework for explaining a young person's commitment to prosocial development. The Australian Research Alliance for Children and Youth draws from the extensive body of research into the application of SDM to outline the dynamics by which young people adopt pro-social attitudes and behaviours:

- A child or young person perceives opportunities for pro-social interactions
- Through engaging in pro-social activity and experiencing pro-social interactions, a child or young person comes to understand that he or she is positively rewarded for his or her participation
- The child or young person develops the emotional, cognitive, and behavioural skills that allow him or her to continue earning, perceiving and experiencing positive reinforcement.

In this way, new, more productive ways of dealing with life can be substituted for behaviours that served as coping mechanisms but led to further social dislocation and poor development outcomes.

## Engagement and retention

From Bruun A, Mitchell P. *A resource for strengthening therapeutic practice frameworks in youth alcohol and other drug services*. Melbourne: YSAS Pty Ltd, 2012. Pages 57-59.

A young person's duration of treatment and involvement in the therapeutic process are central to achieving program or intervention delivery. Evidence shows that young people who remain in treatment do better than those who drop out, regardless of the level of impairment.

Similarly, for prevention and early intervention programs to be effective they must reach young people most at risk, and they must reach a sufficient proportion of the target population for the exposure to have self-sustaining effects. Young people are less proactive than adults in seeking treatment for health concerns, particularly psychosocial concerns. Studies of service use for substance and mental health problems generally find that adolescents have lower access or use than adults.

For young people with multiple and complex needs, issues around access to services are complex. While there is some evidence that adolescents with comorbid substance use and mental disorders are more likely to receive substance use treatment compared with adolescents who have substance use disorders alone, other dimensions of need appear to complicate this picture.

Previous or current involvement with statutory authorities is common for youth with substance use problems, combined with other psychosocial difficulties. However, contact with this particular component of health and social care systems does not necessarily translate into appropriate or adequate access to other parts such as drug and alcohol and mental health services.

Youth in child protection and youth justice systems tend to have higher rates of substance use and mental health problems than the general population, as well as higher rates of service use for these problems.

However, studies have found unacceptably high proportions of young people with substance use and mental health problems in these systems who are not receiving appropriate services. Adolescents' substance use problems are often undetected by service providers in youth justice, primary care, mental health, education and social service systems.

Furthermore, two studies have found a dramatic decline in use of mental health services as young people leave the child protection system. These findings highlight the importance of formal transition protocols between service systems such as child to youth and youth to adult.

More generally, there is a body of opinion that many youth with complex needs miss out on the types of services they need relative to youth with less complex needs.

In particular, several studies have found that homeless youth have very high rates of substance use and mental disorders, but very low rates of access to services relative to need. Even when adolescents with complex needs do access services, they are often very difficult to engage and are highly likely to drop out of treatment.

Social research has identified barriers to service access for youth with complex needs. Chassin

(2008) observes that adolescents rarely perceive a need for treatment of substance use problems. Adolescents also lack knowledge of what assistance is available or how to find what they need.

Statham (2004) has observed that one reason children and young people in special circumstances miss out on services is that they do not have advocates (such as parents or stable carers) to request assessment and treatment. Meade and Slesnick (2002) point out that these adolescents have limited resources and diminished power in an adult-centred system.

Mistrust of professionals can create reluctance to ask for help, while a lack of confidence or interpersonal skills can make it difficult for youth with complex problems to negotiate access or advocate for themselves, especially for health services. Meade and Slesnick (2002) argue that many treatment providers are not equipped to address the range of problems these youth face.

In recognition of these issues, researchers compiling consensus-based characteristics of effective drug and alcohol treatment programs have included use of focused engagement and retention strategies on their lists. Several strategies have been identified as necessary and effective in enhancing access and engagement of youth with complex needs.

- Young people in general want attractive, youth-friendly spaces in accessible central locations.
- Young people are sensitive to the potential for stigmatisation, so it is important that services are inclusive and do not make young people feel different from their peers.
- For young people experiencing instability in their lives, a space that is physically and emotionally safe and provides respite from violence at home or the dangers of street life is a critical starting point. Various writers have observed that feeling safe and secure is an important prerequisite for resolving substance use problems.
- Enabling access to services for highly marginalised youth may often require providing for basic needs such as clothing, food, washing facilities, accommodation and practical help. Until these basic needs are met, the effectiveness of drug and alcohol counselling or skill building will be minimal.
- Another way to make access easier is to provide assertive outreach or mobile services in a wide variety of settings where vulnerable youth may be found, as well as providing a variety of different services in a single location.

- In the absence of multipurpose services, care coordination or case management is critical to the ongoing engagement of young people with complex needs.
- Strong referral networks, awareness raising, and collaborative links among gateway service systems (such as youth justice, mental health, child welfare, school counselling and homeless support) also help to identify and refer young people to drug and alcohol services.

Things to avoid when promoting access and engagement include:

- Overly clinical settings and cumbersome intake and assessment processes;
- Harsh exclusion policies for disruptive behaviour;
- Focusing too much on the past and assigning blame.

Various provider characteristics that help engage youth with complex needs include reliability, a respectful attitude, enthusiasm, an accepting attitude, taking the time to listen and respond, and the ability to give support. These characteristics are the foundations upon which the practitioner/client relationship is built, as is the provision of a safe and caring space where young people can find respite from the chaos that often pervades their lives.

Many transient and homeless adolescents, even those with troubled families, maintain regular contact with family members and turn to them for advice and assistance. For youth who are still maintaining contact with their families, family involvement has been found to enhance youth engagement in drug and alcohol treatment. Parental involvement also appears to help recruit homeless adolescents into primary health care prevention programs.

Several effective interventions have been developed to help family members learn skills that support them in encouraging substance-misusing members into treatment. Interventions that teach parents skills that enhance their own psychosocial and interpersonal functioning can improve the family environment and encourage young people to maintain engagement with family and with services.

Advocates of family involvement acknowledge that it may be difficult or unhelpful if family members are themselves involved in substance use or criminal activities. For disconnected youth whose families experience these problems, families may be unavailable or unwilling to participate. However,

there is now considerable evidence that specially designed, culturally sensitive strategies can be effective in achieving high rates of family engagement.

Finally, an increasing number of researchers and other writers are expressing the view that services will become more accessible, engaging and effective if they recognise the energy, creativity, experience and other strengths of these young people and build youth participation into service development processes.

## Developmentally appropriate

From Bruun A, Mitchell P. *A resource for strengthening therapeutic practice frameworks in youth alcohol and other drug services*. Melbourne: YSAS Pty Ltd, 2012. Pages 49-52.

### 1. Sensitivity to the developmental challenges and changes faced by all adolescents

If a program works with a population of children and adolescents spanning a wide range of ages – say 12 to 25 – and works with individuals over a period of several years, developmentally appropriate practice will need to be sensitive to particular developmental stages, transitions, tasks and challenges faced by adolescents and the ways these change over time.

Young people with alcohol and drug problems continue to be engaged in identity formation, value clarification, cognitive skill development, learning consequential thinking and responsible decision-making, identifying and understanding vocational strengths and inclinations, and forming relationships outside of the family.

Developmentally appropriate services are sensitive to the fact that most adolescents place substantial emphasis on these tasks and can experience considerable anxiety around their achievement. The capacity of service providers to understand and be sensitive to these general themes, as well as the specific concerns of individuals, will influence their ability to successfully engage and retain young people. This is likely to be equally true for prevention and early intervention programs.

### 2. Continuous assessment of client capacity

A key implication for practice in maintaining sensitivity to developmental changes is the need for continuous assessment of client capacity.

Adolescents are constantly evolving and can make marked developmental gains in relatively short periods. Youth drug and alcohol workers need to be aware of emerging developmental capacity and continually revise their assessment of clients' ability to cope with stressors and calculate and respond to risks. Workers also should not assume that older adolescents necessarily have accurate information, knowledge and the skills required for coping and age-appropriate participation in community life. Many young people project an image as an agent who is in control, competent and mature, even when they and others realise that this is not the case.

### **3. Developmentally appropriate expectations**

Services that maintain sensitivity to developmental changes express developmentally appropriate expectations. In general, adolescents require a consistent, reliable service that is uncomplicated and simple to understand. Adolescents require certainty and are very sensitive to injustice and being let down by adults, particularly when they have been exposed to inconsistent parenting.

Early-stage adolescents are more amenable to direction and in the main require more structured programming. Middle-stage adolescents are expected to benefit from structure but become sensitive about direction from adults. Drug and alcohol workers need to ensure the young person feels they are in the 'driver's seat'. In late adolescence, young people need to be allowed progressively more say in managing their own circumstances.

Expectations around the ability to consider and plan for the future also need to shift. Older adolescents can be expected to be more interested in the future and more able to make and enact long-term plans. (This is still subject to the availability of meaningful opportunities.) Early-stage adolescents and those moving into the middle stage are often cited as having an intense 'here and now focus', which increases the propensity for these clients to miss appointments and be difficult to locate. This developmental attribute calls for a service response such as more assertive outreach and more assertive support and follow-up around referrals. In contrast, it is fair to expect older adolescents to take greater personal responsibility for their participation. Young people entering and moving through middle adolescence are expected to be more discerning about the identities they are prepared to consider and the values they adopt.

"Value clarification and thinking beyond the present helps reduce risk behaviours". This process becomes increasingly important as clients develop more capacity for reflection.

Age and the accumulation of experience also interact with general developmental processes to influence the expectations that young people might have for themselves. Older adolescents whose difficulties have become entrenched – particularly those who have become disconnected from school and work – may acquire a sense of learned helplessness that dampens their expectations of themselves and the world around them. Younger adolescents frequently have more hope and optimism about the future.

### **4. Duty of care and confidentiality**

Young people in the early and middle adolescent stages are legally considered to be minors. This requires adults in professional roles to be mindful of threats to their safety, health and ongoing development. A service must have suitable, developmentally attuned risk assessment processes and relevant policies about how the tertiary service system will be engaged. Drug and alcohol workers are well positioned for 'unobtrusive monitoring' of clients, whereby exposure to risk and capacity for adaptive coping can be identified and action taken. This has been shown to have a strong protective effect.

Adolescent clients are expected to be sensitive about their privacy. Clients need to be made aware that the service respects their right to confidentiality. Information held should only be released with client consent. The only exception would be when the health and safety of clients or others would be compromised if information is withheld.

As young people move through middle into the late adolescent stage, both socially and legally there is greater expectation for them to care for themselves. While the drug and alcohol services retain a duty of care, there are differences in how it is structured for younger compared with older clients.

## **5. Developmentally appropriate modes of interaction**

Young people, particularly early and middle stage adolescents, are most likely to learn through direct experience rather than through vicarious experience or counselling. This is consistent with the view that behaviourally oriented interventions focused on development of skills are more effective than purely cognitive and talking-based therapies. Whenever appropriate, young people should be encouraged to 'do' for themselves. The degree to which drug and alcohol workers undertake tasks on behalf of young people should be determined through continuous assessment of their capacity to manage.

Workers should strive to work alongside clients, positioning themselves to provide direct, real-time feedback that recognises pro-social participation and interaction with others. This approach also enables workers to identify, highlight and facilitate naturally occurring rewards for pro-social interactions. Through guided experience, clients can develop the emotional, cognitive, and behavioural skills that reinforce healthy development and promote pro-social behaviour.

## **6. Awareness of differing developmental trajectories**

Young people with substance use problems have frequently had experiences that can alter their developmental trajectory in significant ways. Experiences such as insufficiently attentive, unpredictable, overly harsh or neglectful parenting, family conflict, lack of responsible adult role modelling, frequent physical relocations, lack of a stable and structured learning environment at home, and exposure to substance abuse in the family cause substantial disruptions in the bio-psycho-social processes that drive development.

Young people require structure and guided experience.

Those that have no control over the pace of change and transition are highly susceptible to developmental problems. Without the necessary experiences, young people's development can lose synchronisation with the patterns that characterise the general population.

Developmentally appropriate practice for this client group aims to provide alternative experiences that help them catch up or reshape areas that have been disrupted. This involves providing, or helping young people to find, opportunities to develop the personal and social assets needed to move through the transitions to adulthood.

A major component of this work is providing regulated experience. Many young people have not had or do not have anyone to provide the sense of structure and support that the limit-setting and caring role offers. When this is lacking from parents or caregivers, then workers, particularly those with a statutory responsibility or in residential care roles, are required to do so. Limits are most often set around behaviours that are believed to compromise safety, health and future prospects. Limit setting – linked with fair consequences – provides structure, a sense of containment and a clear set of rules that young people can test out and define themselves against.

## **7. Managing tensions in developmentally appropriate practice for vulnerable youth**

There are several tensions that practitioners will confront over time if they use the principles and practices outlined above. These tensions are further complicated if viewed in the wider context of the other characteristics of effective programs and services described in sections 3.2 to 3.11.

1. Balancing self-determination (a key value in client-centred practice) with protection or duty of care. The individual's level of maturity needs to be considered when making choices, such as encouraging independent decision-making versus setting limits. This balance is particularly pertinent to harm reduction in substance use.
2. Balancing the value of promoting optimism and raising expectations for the future with building realistic expectations about capacities. Developmentally appropriate practice involves gearing expectations of the client to his or her stage of development.

3. Finding a balance between fostering healthy dependence and promoting independence. While we must always look towards helping the client move towards independence or autonomy, a stage of dependency on others is a necessary part of healthy development. This experience has often been badly disturbed for highly vulnerable youth. Experiencing safe, dependable relationships may be a critical therapeutic intervention for some vulnerable young people.
4. Balancing between the need to let young people make mistakes and the need to protect them from experiences of failure that can reinforce negative self-beliefs. Being allowed to fail is essential to the development of true autonomy and the ability to take responsibility. On the other hand, for young people who have repeated experiences of failure and lack of support, new and damaging failures are unhelpful.

The ways in which 'deviant' behaviours such as problematic substance use are viewed in mainstream society can mean that the existing strengths of young people are overlooked. Recognising and building on existing external and internal assets is vital for the development of all young people. It is important to recognise the drive towards healthy development that lies underneath some of the behaviours that are generally labelled as deviant and disordered. One way to understand these behaviours involves considering the developmental functionality of drug use for young people, such as providing pleasure, alleviating boredom, self-regulation and management, individuating identity, conforming to norms, and facilitating social bonding.

Developmentally appropriate and sensitive services and programs also need to be aware of the risks and opportunities inherent in key transitions created by service systems. For example, developmentally appropriate programs for persistent substance use problems will incorporate careful transition planning for young people moving from youth-specific services to the adult system. Another high-risk transition at the early intervention stage concerns adolescents leaving the child protection system. Research has shown that many young people lose access to services such as mental health care when they leave child protection. For vulnerable young people who are beginning to develop problems with substance use, a sudden loss of support at this transition point will not help their situation.

## **8. Application to prevention and early intervention**

Many of the considerations described apply equally to the design of prevention and early intervention programs. It is also imperative that these programs are delivered neither too early nor too late in the individual's development. Primary prevention programs targeting problem behaviours that are delivered in schools may be delivered too early to reach youth who are disconnected from school. Corrective interventions linked to the criminal justice system may be delivered too late to achieve best effect.

The idea of developmental transitions and key transition points has been well elaborated. Transition points are ideal opportunities for intervention because individuals tend to be more open to advice and learning. For young people exposed to multiple risk factors, the transitions from school and the child protection system may be particularly important windows of opportunity. Early interventions seeking to change behaviours such as substance misuse need to be sensitive to individuals' personal readiness or 'stage of change'.

## Resources for young people and parents/carers

Resources for young people and their parents/carers are available from multiple sites. Links to such resources are provided by a number of organisations, for example:

- **Australian Drug Foundation (ADF)**

<http://www.druginfo.adf.org.au/information-for-free-resources-for-young-people>

- **Dovetail** is a Queensland based service providing providing clinical advice and professional support to workers, services and communities who engage with youne people affected by substance use  
<http://dovetail.org.au/latest-news.aspx>

Below is a selection of resources.

- **The National Cannabis Prevention and Information Centre**

(NCPIC) <http://ncpic.org.au/youngpeople/>

For example:

- Clear Your Vision online tool – designed for young people to work under the guidance of a counsellor or healthcare/drug and alcohol worker to gain information about cannabis, its use and potential harms, and to be guided in a way to plan and implement a cessation or reduction of their cannabis use. The website includes the Severity of Dependence (SDS) quiz and also allows for a ‘check up’ about three weeks after completing the online resource. <https://clearyourvision.org.au/>
- A range of fact sheets relating to cannabis: <http://ncpic.org.au/ncpic/publications/factsheets/>

- Resources relating to **sniffing and brain educational resources** (flipcharts and posters). [www.health.gov.au/internet/main/publishing.nsf/Content/phd-petrol-sniffing-cnt](http://www.health.gov.au/internet/main/publishing.nsf/Content/phd-petrol-sniffing-cnt)

- **ADF factsheet on binge drinking**

<http://www.druginfo.adf.org.au/fact-sheets/the-facts-about-binge-drinking>

- **National Drug Strategy resources**, including drug fact sheets

<http://www.drugs.health.gov.au/internet/drugs/publishing.nsf/content/campaign5>

For example:

- Information for parents  
[www.drugs.health.gov.au/internet/drugs/publishing.nsf/content/campaign/\\$file/Information%20for%20parents.pdf](http://www.drugs.health.gov.au/internet/drugs/publishing.nsf/content/campaign/$file/Information%20for%20parents.pdf)
- Top ten tips for parents  
[www.drugs.health.gov.au/internet/drugs/publishing.nsf/content/campaign/\\$file/Top%2010%20tips%20for%20parents.pdf](http://www.drugs.health.gov.au/internet/drugs/publishing.nsf/content/campaign/$file/Top%2010%20tips%20for%20parents.pdf)

- **Parenting Guidelines for Adolescent Alcohol**

**Use**, based upon a collaboration between Orygen Youth Health Research Centre (University of Melbourne), Turning Point Alcohol and Drug Centre (Monash University and Eastern Health), and the Australian Drug Foundation, with funding from VicHealth.

[http://www.parentingstrategies.net/guidelines\\_introduction/](http://www.parentingstrategies.net/guidelines_introduction/)

- **Your Room drug and alcohol information.** This website, offers information about substances, how they can affect people, side effects, withdrawal, support and treatment options and how to get help. The website is very interactive and includes resources to order or download <http://yourroom.com.au/>

## Resources for Workers

There are many resources to assist workers to provide services for young people. Here is a brief selection.

■ **Manual for Brief Alcohol Intervention Group for Young People:** The four-session group intervention presented here was developed taking into consideration the developmental pathway of adolescence and other investigations into drinking behaviours in this client population. The program involves the implementation of psycho-education about alcohol, controlled drinking strategies, and refusal skills within a harm minimisation and motivational interviewing framework.  
<http://ndarc.med.unsw.edu.au/resource/manual-brief-alcohol-intervention-group-young-people>

■ **Clear Your Vision** booklet and online tool  
 The Clear Your Vision booklet resource is designed to be used with young people with cannabis use problems in consultation with healthcare/drug and alcohol workers. The accompanying Facilitator's Manual aims to assist workers in a variety of settings including alcohol and other drug rehabilitation, education, counselling and youth groups to assist clients to quit or reduce their cannabis use.

– **Facilitator's Manual**

<http://ncpic.org.au/static/pdfs/high-res-web-version-facillitators-manual-final.pdf>

– **Clear Your Vision booklet** must be ordered and will be provided free of charge  
<http://ncpic.org.au/workforce/alcohol-and-other-drug-workers/cannabis-information/order-resource/>

The online tool is designed for young people to work under the guidance of a counsellor or healthcare/drug and alcohol worker to gain information about cannabis, its use and potential harms, and to be guided in a way to plan and implement a cessation or reduction of their cannabis use. The website includes the Severity of Dependence (SDS) quiz and also allows for a 'check up' about three weeks after completing the online resource.

<https://clearyourvision.org.au/>

– The US based Screening, Brief Intervention and Referral to Treatment (SBIRT) is described as a comprehensive, integrated, public health approach to the delivery of early intervention and treatment services for persons with substance use disorders, as well as those who are at risk of developing these disorders.  
<http://www.samhsa.gov/prevention/sbirt/>

## Legal Information for Youth Workers

*From Shopfront Youth Legal Centre website.*

The Shopfront cannot provide legal representation or advice for youth workers and services. However, we can give workers information and training about a wide range of legal issues.

We can arrange training sessions to suit individual agencies. Unfortunately we cannot usually travel beyond the Sydney, Central Coast, Blue Mountains, Hawkesbury and Illawarra areas.

Links to the Shopfront series of legal information sheets are below:

- Driving and the law: traffic fact sheets (updated May 2010)
- Young people and the legal system: an overview (updated January 2004)
- Police powers and your rights (updated May 2012)
- Police move-on directions (December 2011)
- Acting as a support person at the police station (November 2013)
- Criminal procedure: an overview (October 2013)
- The Young Offenders Act (January 2011)
- Bail (March 2010)
- Consorting (July 2013)
- Drug offences (September 2012)
- Drug premises (February 2006)
- Common offences: sex work (March 2002)
- Common offences: graffiti (April 2013)
- Common offences: weapons and implements (September 2010)
- Cybercrime (February 2013)
- Apprehended Violence Orders (February 2010)
- Non-Association and Place Restriction Orders (July 2002)
- Mental health and the law (November 2009)
- Mental health and intellectual disability – criminal proceedings in Local and Children’s Courts (April 2009)
- Court reports, references and support letters (July 2011)
- Convictions and criminal records (September 2004)

- Getting a security license (March 2009)
- Fines and their enforcement (November 2009)
- Fines step-by step (November 2009)
- Victim’s support and compensation (June 2013)
- Children and young people at risk – reporting and exchange of information (August 2012)
- Children and healthcare (November 2013)
- Confidentiality and privacy for youth workers (September 2012)
- Age of consent – issues for youth workers (updated September 2012)

Contact details:

Shopfront Youth Legal Centre  
356 Victoria Street  
DARLINGHURST NSW 2000  
Tel: (02) 9322 4808

Email: [shopfront@theshopfront.org](mailto:shopfront@theshopfront.org)

## The HEEDSSS psychosocial interview for adolescents<sup>67</sup>

	Potential first-line questions	Questions if time permits or if situation warrants exploration
<b>Home</b>	<p>Who lives with you? Where do you live?</p> <p>What are relationships like at home?</p> <p>Can you talk to anyone at home about stress? (Who?)</p> <p>Is there anyone new at home? Has someone left recently?</p> <p>Do you have a smart phone or computer at home? In your room? What do you use it for? (May ask this in the activities section.)</p>	<p>Have you moved recently?</p> <p>Have you ever had to live away from home? (Why?)</p> <p>Have you ever run away? (Why?)</p> <p>Is there any physical violence at home?</p>
<b>Education and employment</b>	<p>Tell me about school.</p> <p>Is your school a safe place? (Why?) Have you been bullied at school?</p> <p>Do you feel connected to your school? Do you feel as if you belong?</p> <p>Are there adults at school you feel you could talk to about something important? (Who?)</p> <p>Do you have any failing grades? Any recent changes?</p> <p>What are your future education/employment plans/ goals?</p> <p>Are you working? Where? How much?</p>	<p>How many days have you missed from school this month/ quarter/semester?</p> <p>Have you changed schools in the past few years?</p> <p>Tell me about your friends at school.</p> <p>Have you ever had to repeat a class/grade?</p> <p>Have you ever been suspended? Expelled?</p> <p>Have you ever considered dropping out?</p> <p>How well do you get along with the people at school? Work?</p> <p>Have your responsibilities at work increased?</p> <p>What are your favourite subjects at school? Your least favourite subjects?</p>
<b>Eating</b>	<p>Does your weight or body shape cause you any stress? If so, tell me about it.</p> <p>Have there been any recent changes in your weight?</p> <p>Have you dieted in the last year? How? How often?</p>	<p>What do you like and not like about your body?</p> <p>Have you done anything else to try to manage your weight?</p> <p>Tell me about your exercise routine.</p> <p>What do you think would be a healthy diet? How does that compare to your current eating patterns?</p> <p>What would it be like if you gained (lost) 10 lb?</p> <p>Does it ever seem as though your eating is out of control?</p> <p>Have you ever taken diet pills?</p>
<b>Activities</b>	<p>What do you do for fun? How do you spend time with friends? Family? (With whom, where, when?)</p> <p>Some teenagers tell me that they spend much of their free time online. What types of things do you use the Internet for?</p> <p>How many hours do you spend on any given day in front of a screen, such as a computer, TV, or phone? Do you wish you spent less time on these things?</p>	<p>Do you participate in any sports?</p> <p>Do you regularly attend religious or spiritual activities?</p> <p>Have you messaged photos or texts that you have later regretted?</p> <p>Can you think of a friend who was harmed by spending time online?</p> <p>How often do you view pornography (or nude images or videos) online?</p> <p>What types of books do you read for fun?</p> <p>How do you feel after playing video games?</p> <p>What music do you like to listen to?</p>

	Potential first-line questions	Questions if time permits or if situation warrants exploration
<b>Drugs</b>	<p>Do any of your friends or family members use tobacco? Alcohol? Other drugs?</p> <p>Do you use tobacco or electronic cigarettes? Alcohol? Other drugs, energy drinks, steroids, or medications not prescribed to you?</p>	<p>Is there any history of alcohol or drug problems in your family?</p> <p>Does anyone at home use tobacco?</p> <p>Do you ever drink or use drugs when you're alone?</p> <p>(Assess frequency, intensity, patterns of use or abuse, and how patient obtains or pays for drugs, alcohol, or tobacco.)</p>
<b>Sexuality</b>	<p>Have you ever been in a romantic relationship? Tell me about the people that you've dated.</p> <p>Have any of your relationships ever been sexual relationships (such as involving kissing or touching)?</p> <p>Are you attracted to anyone now? OR: Tell me about your sexual life.</p> <p>Are you interested in boys? Girls? Both? Not yet sure?</p>	<p>Are your sexual activities enjoyable?</p> <p>Have any of your relationships been violent?</p> <p>What does the term "safer sex" mean to you?</p> <p>Have you ever sent unclothed pictures of yourself on e-mail or the Internet?</p> <p>Have you ever been forced or pressured into doing something sexual that you didn't want to do?</p> <p>Have you ever been touched sexually in a way that you didn't want?</p> <p>Have you ever been raped, on a date or any other time?</p> <p>How many sexual partners have you had altogether?</p> <p>(Girls) Have you ever been pregnant or worried that you may be pregnant?</p> <p>(Boys) Have you ever gotten someone pregnant or worried that might have happened?</p> <p>What are you using for birth control? Are you satisfied with your method?</p> <p>Do you use condoms every time you have intercourse? What gets in the way?</p> <p>Have you ever had a sexually transmitted infection or worried that you had an infection?</p>
<b>Suicide/ depression</b>	<p>Do you feel 'stressed' or anxious more than usual (or more than you prefer to feel)?</p> <p>Do you feel sad or down more than usual?</p> <p>Are you 'bored' much of the time?</p> <p>Are you having trouble getting to sleep?</p> <p>Have you thought a lot about hurting yourself or someone else?</p> <p>Tell me about a time when someone picked on you or made you feel uncomfortable online.</p> <p>(Consider the PHQ-2 screening tool [Table 6, page 26] to supplement.)</p>	<p>Tell me about a time when you felt sad while using social media sites like Facebook.</p> <p>Does it seem that you've lost interest in things that you used to really enjoy?</p> <p>Do you find yourself spending less time with friends?</p> <p>Would you rather just be by yourself most of the time?</p> <p>Have you ever tried to kill yourself?</p> <p>Have you ever had to hurt yourself (by cutting yourself, for example) to calm down or feel better?</p> <p>Have you started using alcohol or drugs to help you relax, calm down, or feel better?</p>
<b>Safety</b>	<p>Have you ever been seriously injured? (How?) How about anyone else you know?</p> <p>Do you always wear a seatbelt in the car?</p> <p>Have you ever met in person (or plan to meet) with anyone whom you first encountered online?</p> <p>When was the last time you sent a text message while driving?</p> <p>Tell me about a time when you have ridden with a driver who was drunk or high. When? How often?</p> <p>Is there a lot of violence at your home or school? In your neighborhood? Among your friends?</p>	<p>Do you use safety equipment for sports and/or other physical activities (for example, helmets for biking or skateboarding)?</p> <p>Have you ever been in a car or motorcycle accident? (What happened?)</p> <p>Have you ever been picked on or bullied? Is that still a problem?</p> <p>Have you gotten into physical fights in school or your neighborhood? Are you still getting into fights?</p> <p>Have you ever felt that you had to carry a knife, gun, or other weapon to protect yourself? Do you still feel that way?</p> <p>Have you ever been incarcerated?</p>

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