SECTION 3.8

SUBSTANCE USE

3.8 SUBSTANCE USE

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Substance use is a major threat to young people's health. Illicit drug and alcohol use are the risk factors accounting for the greatest harm among 15–24 year-olds. And although the rate of daily smoking by young people has fallen, 11% of young people aged between 12 and 24 still report smoking daily (AIHW 2011). Poly-substance abuse is common among young people and has a range of health implications.

YOUNG PEOPLE, DRUGS AND ALCOHOL

In 2007, 13 per cent of young people aged 16-24 had a substance use disorder. Substance use is common amongst young people who have experienced trauma such as sexual or physical assault, domestic and family violence and child abuse or neglect; but experimenting with smoking, drugs and alcohol is also often a part of adolescence for young people who have not been exposed to traumatic events such as these.

FAST FACTS

- According to the Australian Institute of Health and Welfare (2011):
- 17 per cent of 14-19 year-olds and 27 per cent of 20-24 year-olds are regular or occasional smokers. Indigenous young people are twice as likely to smoke as non-Indigenous young people.
- It is estimated that 37 per cent of 16–19 year-olds and 45 per cent of 20–24 year-olds drink at risky or high risk levels for short-term harm.
- Nearly 40 per cent of young people reported having been a victim of drug- or alcohol-related violence, including threats or intimidation, in the previous 12 months.
- 19 per cent of young people reported using an illicit drug in the preceding 12 months. Rates of use were similar for young men and women.
- There is a high incidence of mental health disorders among young drug users.
- Marijuana is the most commonly used illicit drug among young people – 5 per cent of 12-15 year-olds, 22 per cent of 16-19 year-olds and 27 per cent of 20-24 year-olds reported having used marijuana in the last 12 months.

KEY FEATURES OF YOUTH SUBSTANCE USE

Alcohol and tobacco are the substances most commonly used by young people and account for the highest rates of harm and death. High proportions of young people engage in high risk drinking behaviour such as binge drinking.

Illicit drug use is decreasing, but use of marijuana, amphetamines, ecstasy and hallucinogens still pose health risks. Marijuana is the most frequently used illicit drug: the mean age of starting use is 15.9 years old.

Co-occurrence is common: there is a high prevalence of mental health problems and distress among young drug users, especially depression, anxiety and other mood disorders. In fact, substance use is frequently a contributing factor in the early onset of psychosis. Cannabis use in particular is thought to cause psychosis.

There is also a strong association between substance use and the incidence of other health problems in young people, especially:

- Motor vehicle accidents, pedestrian accidents
- Being both perpetrators and victims of assault
- Unplanned sexual activity
- Blood-borne viral infections, and also sexually transmitted diseases (especially Hepatitis C; HIV)
- Violence and criminal behaviour
- Disruption of schooling and education
- Impact on relationships with families and peers *(AIHW 2011; Bonomo 2001; Rogers 2005)*

FINDING OUT MORE...

You can learn more about individual substances and their effects from:

Australian Drug Information Network. Visit www.adin.com.au

Australian Drug Foundation Clearinghouse for information on drugs. Visit www.druginfo.adf.org.au

Youth Substance Abuse Service (YSAS) – for information about working with high risk, co-morbid young people. Visit www.ysas.org.au

National Drug & Alcohol Research Centre (NDARC). Visit www.ndarc.med.unsw.edu.au

Your room – for drug and alcohol information and resources for young people. Visit www.yourroom.com.au

ALCOHOL AND YOUNG PEOPLE

The adolescent brain is highly vulnerable to the damaging effects of alcohol, and the earlier a person commences drinking, the higher the risk of the person subsequently becoming alcohol dependent. Starting drinking at an early age increases the risk of alcohol dependence in adulthood four-fold.

Young people under 15 years of age are at most risk of harm from drinking alcohol, and so this age group should be particularly discouraged from drinking alcohol (National Health and Medical Research Council 2009).

RISK FACTORS FOR SUBSTANCE ABUSE AMONG YOUNG PEOPLE

In general, young people are more likely to use alcohol and illicit substances if some of the following factors are present:

- Peer use of substances
- Family factors
- Family history of genetic predisposition
- Parental substance use
- Family attitudes favourable to substance use
- Poor parental control and supervision
- Family breakdown including domestic and family violence, child abuse
- School difficulties and truancy
- Early onset of substance use – especially before the age of 15
- Unemployment
- Low self-esteem and poor social support
- Emotional and behavioural problems (e.g. depression, anxiety, conduct disorder)
- Childhood trauma, physical or sexual abuse (Rowe 2000; Spooner and Hetherington 2005)

WHAT DOES SUBSTANCE ABUSE LOOK LIKE?

Substance abuse might show up in some of the following ways:

- Changes in school/work attendance or achievement – frequently absent or late; apathy and lack of effort
- Poor physical appearance and an unusual lack of regard for personal hygiene, red eyes, dilated or constricted pupils
- Marked changes in emotional state – e.g. unusual irritability or aggression, temper flare-ups, sullenness, mood swings (liability)
- Seeming excessively tired or withdrawn
- Withdrawal from usual social, family or recreational activities, reduced social repertoire
- A change in peer group and reluctance to introduce friends to the family
- Furtive behaviour – including lying, stealing or borrowing money

Remember, however, that these are not definitive signs of substance abuse: there may be other explanations for changes in a young person's health and behaviour.

ASSESSING THE EXTENT OF THE PROBLEM

A structured approach to communicating with the young person and learning about their use of drugs and alcohol is beneficial. The HEEADSSS psychosocial assessment (which is outlined in 3.2 Psychosocial Assessment) will help you detect alcohol or drug use (Rowe 2000). It will also help you find out how the substance is affecting the young person, the role it plays in the young person's life and other risk behaviours associated with its use.

FINDING OUT MORE...

Review chapter 3.2 Psychosocial assessment to become more familiar with the HEEADSSS tool. You will also find useful information on building rapport, discussing sensitive issues and asking non-threatening questions.

THE CRAFFT SCREENING TOOL

While HEEADSSS looks very broadly at the range of factors that might be affecting a young person's health and wellbeing, the CRAFFT screening tool examines drug and alcohol use more closely. It comprises six questions which will help you determine whether you should conduct a more detailed assessment.

C: Have you ever ridden in a CAR driven by someone (including yourself) who was high on alcohol or drugs?

R: Do you ever use alcohol or drugs to RELAX, feel better about yourself or fit in?

A: Do you ever use alcohol or drugs while you are ALONE?

F: Do you ever FORGET things you did while using alcohol or drugs?

F: Do your FAMILY or FRIENDS ever tell you that you should cut down on your drinking or drug use?

T: Have you gotten into TROUBLE while you were using alcohol or drugs?

If a young person answers yes to two or more questions, the screen is positive and further assessment is warranted. (Knight et al. 2002 in Milne, Bonomo and Whitton 2013)

TAKING A DRUG HISTORY

If the HEEADSSS or CRAFFT screens are positive for the use of drugs or alcohol, you should take a more in-depth history focusing on the substance use. Many young people do not consider alcohol or tobacco to be drugs, so you need to specifically ask about these.

Explain to the young person why you want more information and remember to request permission to ask sensitive questions.

Example:

"If it's okay with you, I want to ask you some questions about your drug/alcohol use so that I can get a better picture of how it fits into your life. I'd like us to explore what you think the positive effects of your drug use are and what harm it might be causing you. From there you can decide whether you want to do something about your use. How does that sound?"

Adopt an interactive rather than interrogative style. This may help them feel safe enough to open up and share details of their substance use history. The history should cover:

What	What substances are being used? Remember that poly-substance use is common among young people so ask specifically about each substance or group of substances over the last few months: • Licit drugs (alcohol, tobacco, pain medications, cough mixture, over the counter and prescribed medications – especially sedatives and anti-psychotics) • Household products – paints, clues, aerosols, petrol • Illicit drugs – sedatives and stimulants (cannabis, ecstasy, amphetamines, LSD, cocaine, opioids, 'designer' drugs)
How	How often are they using drugs?
Preference	Do they have a "drug of choice" which dominates their usage, or do they use whatever is available?
How Much	What dose is being used? How many drinks on a given occasion? How many times are they smoking cannabis in a day/week?
Method	How are they ingesting the drug? Are they smoking, taking orally, snorting, injecting, sniffing?
Patterns	Does binge use ever occur? Do they experience withdrawals or cravings? Common patterns of drug use include; Experimental, Recreational, Abuse, Dependence, Recovery/relapse
Context	When, where and who with? Do they use drugs/drink alone? With friends? When depressed? When stressed? When angry? Etc. Do they use drugs/drink to be part of the crowd?
Effect	What effect do they achieve when they use drugs or alcohol? What are the effects on them physically, in terms of mood, in terms of their behaviour, socially?
How do they obtain and pay for the substances? Have they attempted to stop using drugs/drinking before? What happened? What do they want to do about their drug or alcohol use?	

Other areas to explore:

- **Mental health** – are there any mood, anxiety or depressive symptoms? What about irritability or paranoia?
- **Concurrent problems** – are there problems with sleep? Auditory or visual hallucinations, or other symptoms suggestive of early psychosis?
- If these symptoms are present, refer the young person for a thorough mental health assessment which will take into account past history of mental health symptoms. See 3.9 Mental health for more information.
- **Tolerance** – is the young person developing tolerance to a substance (do they find that they need more of the drug to get the same effect?)? If there is heavy use, do they have trouble controlling their use of the substance? How do they feel when they don't use the substance (withdrawal symptoms)?
- **Problems** – what problems are they experiencing as a result of their drug use (physical, legal, financial, social, school, relationships)?
- **Risk-taking behaviours** – are they involved in any risk-taking behaviours while using drugs or alcohol (drink driving, unplanned or unsafe sex, criminal activity)?
- **Cultural factors** – what is the young person's cultural background and how does that influence their attitudes to substance use? Are there any factors related to their cultural background (migration, refugee status etc.) that may be contributing to their substance use?
- **Morbidity and mortality risks** – what is the toxicity risk associated with the pharmacological action of the drug? What are the risks of the mode of administration the young person is using? Have there been any instances of overdose – deliberate or accidental? What happened and how was it managed?

(Bonomo 2001; Kang 2002)

FAST FACTS – UNDERSTANDING ALCOHOL

The short-term harms of binge drinking include physical symptoms such as nausea, shakiness and vomiting and increased risk of injuries, unsafe sex, and drug use. Alcohol poisoning can cause coma and death.

The long-term harms of regular heavy drinking include physical problems such as stomach, liver, heart and brain damage; increased risk of infections, cancers, depression; and all the legal, financial, and family and relationship harms of addiction.

(AIHW 2011)

A 'TYPICAL WEEK'

Asking the young person to describe a 'typical week' (or day or month) can be a useful way to learn more about a young person's substance use. A 'typical week' assessment:

- Encourages disclosure of the individual's story
- Provides a clinical picture of quantity & frequency of use
- Provides personal context of use
- Increases information & builds rapport

Start with something like:

"The things we've talked about in this session have given me a bit of an idea about what is going on for you. But I really don't know a lot about you and the kind of life you lead. I wonder if I could ask you to tell me a little more about your life and the problems you are coping with right now. It would help me to understand the situation better if you could pick a typical week in your life and take me through it"

Or:

"Tell me about what usually happens from the moment you wake, and move through the day, until the end of your day (or, when you are getting ready for a night out; etc.)"

Allow the young person to continue with as little interruption as possible. If necessary, help the young person move the story along with open-ended questions:

- *"What happened then? And before that? And between doing this and that? What next?"*
- *"What things do you find hard to cope with? How do you feel when that happens?"*
- *"Can you tell me where your substance use (drinking, smoking, etc.) fits in to your usual routine?"*
- *"Are there any times of the day when you use (alcohol, drugs, etc.) more than at other times?"*
- *"How does your week (one of these sessions etc.)? usually end? How do you feel at the end of the week (after one of these sessions etc.)?"*

When the young person has finished, try to summarise their week and remember to ask:

"Is there anything else about this picture you've painted that you would like to tell me?"

WHAT TO DO WITH WHAT YOU KNOW

As with all youth health problems, a trusting relationship forms the basis for effective treatment of substance abuse. A key principle of management is to adopt a holistic approach rather than focusing solely on the drug use. Addressing other areas of concern in the young person's life can often ameliorate the substance use (Kang 2002).

Family members or service providers may think that a young person needs 'detox'. But this may not be what is required. Young people's patterns of use are different to adults. They are also less likely to be physically dependent and need detoxification. The social, familial, cultural and physical environment in which the substance abuse occurs is also not changed by detoxification processes.

If substance use is identified as problematic (rather than 'normal risk-taking' or experimental), base your recommended interventions on the young person's pattern of substance use, as well as their readiness and motivation to change.

The Stages of Change model is useful in determining the young person's awareness about the consequences of their substance use and their readiness to change. It enables therapeutic work with the person based on 'where they are at', rather than expecting them to be ready or able to change their substance using behaviour. The model also helps in identifying interventions appropriate to the young person's stage

FINDING OUT MORE...

The Stages of Change model is covered in chapter 3.3 Understanding risk-taking behaviour.

MOTIVATIONAL INTERVIEWING

Motivational Interviewing (MI) provides a practical set of strategies for increasing the person's motivation to change and in assisting the young person to make behavioural changes

Motivational Interviewing aims to:

- Increase the person's motivation and commitment to change
- Provide a range of skills and strategies for decreasing substance use and modifying risk behaviours. (Miller and Rollnick 2002)

Motivational Interviewing is person-centred – it focuses on the concerns and perspectives presented by the young person, and is based on the belief that the resources and motivation for change already exist within the person. At times, the practitioner must also be directive helping the young person to identify the resources and motivation they have. MI is based on research which indicates that people who talk about making change are more likely to do so than those who don't. The core aim of MI is to elicit this 'change talk' from clients, so that they hear themselves talk about their reasons, ability and intention to make change.

There is a core set of skills that practitioners using MI draw on. The micro-skills of MI are remembered by the acronym OARS:

O	Open-ended questions – "How do you think your drug use affects your health?"
A	Affirm – "It's good that you decided to talk to someone about your drug use"
R	Reflectively listen – "It sounds like you're starting to….."
S	Summarise – "Let me see if I understand what you're saying…"

Motivational Interviewing aims to move a young person towards change and commitment talk. The types of change and commitment talk to listen for, elicit and reflect back to the client are remembered by the acronym DARN-C:

D	Desire – "Why do you want to make this change?"
A	Ability – "If you were to make the change, how might you go about it?"
R	Reason – "What are the three main reasons you would want to make this change?"
N	Need – "On a scale of 0-10, how important is it for you right now to make this change? Why are you a 6 and not a zero?" (Frame in the positive to elicit change talk from the person)
C	Commitment – "What do you think you will do?"

(Sanci and Cahill 2006)

When working with a young person using MI, remember to reinforce the young person's belief and confidence in their ability to make changes or to cope with a specific task or challenge. Assist them to learn skills that will help them to achieve change. For example, help them identify alternative ways of coping with problems that drive their substance use; help them identify the risk situations and triggers to substance use and learn new skills for dealing with these (such as assertive communication/refusal skills); and help them identify strategies for coping with barriers to changing.

STEPS IN MOTIVATIONAL INTERVIEWING

1. Assess the young person's readiness to change.
2. Create a favourable climate for change – establish rapport and an atmosphere of collaboration with the young person; adopt a non-judgemental approach
3. Use communication skills – such as reflective listening and open-ended questions to identify the person's concerns – avoid persuasion or coercion
4. Identify the young person's motivation to change:

"How important would you say it is for you to cut down on your alcohol use?"

"On a scale of 0-10 where 0 is not at all important and ten is extremely important?"

5. And – their belief in their ability to change:

"How confident would you say you are, that if you decided to cut down, you could do it?"

Use same scale 0-10 (0 = not at all confident; 10 = extremely confident)

6. Ask about the perceived benefits of substance use for them

"What are the good things for you about drinking alcohol/smoking marijuana, etc.?"

7. Ask about concerns or disadvantages of their substance use (to their health, their family/relation ships, financial, etc.)

"Tell me about any concerns you have about how alcohol/marijuana, etc. is affecting your health or any other parts of your life…"

"How is it affecting your relationships/family?"

"How is it affecting your school/work?"

8. Increase motivation to change:

Provide objective information on the potential health effects and social impact of the substances they are using

Identify associated risks – e.g. unsafe sexual activity; drink driving

For each individual – identify potential triggers for motivating them to change

9. Assist the person to make the decision to change – engage the person in a 'decision balance' process to tip the balance toward changing. (Skinner 2001)

FINDING OUT MORE...

Learn more about MI from:

- The Motivational Interviewing website – www.motivationalinterviewing.org
- Miller W and Rollnick, S. (2002). *Motivational Interviewing: Preparing people for change.* (2nd edn). Guildford Press: London.
- Sanci L and Cahill H. (2006). *Topic 5. Communicating with young people, part two. Youth Health in Primary Care Module* of the Postgraduate Certificate in Primary Care Nursing, Department of General Practice, University of Melbourne.
- Rollnick S, Mason P and Butler C. (2006). *Health Behaviour Change: a guide for practitioners.* Churchill Livingstone: London.

You may also like to review chapter 3.3 on risk-taking assessment.

TABLE 9 – THE DECISION BALANCE PROCESS

Decision balance	Reasons not to change	Reasons to change
Stay the same	**Benefits** **"What do you like about your drinking (smoking, drug use)?"** • Drinking/smoking with my friends • Feeling relaxed/relieving stress • Forgetting about my problems • Helps me sleep • Fun	**Concerns** **"What concerns you about it?"** • Hangovers • Can't study • Get into fights • Poor school performance • Appearance – pimples; weight gain; effects on teeth etc. • The expense
Change	**Concerns** **"What concerns would you have about changing?"** • Lose my friends • No fun • Stress • Not coping with my problems	**Benefits** **"What benefits might you get from changing?"** • No more hangovers • Weight loss • Improved appearance • Can study better • Save money

BRIEF INTERVENTIONS

Even if the young person chooses not to change their drug use, you can still assist them by providing information and education on the effects of substance use, safer using strategies, and support services available.

Harm minimisation is an approach to addressing drug and alcohol issues by reducing the harmful effects that abuse of these substances has on individuals, families and the community. It has been a key element of state and federal government policy since 1985. The goals of harm minimisation are to promote safe usage of a substance where abstinence is neither possible nor chosen.

The policy of harm minimisation is based on an understanding that:

- Drug use occurs within our society
- Drug use occurs across a continuum, ranging from occasional use to dependent use
- Different harms are associated with different types and patterns of use
- A range of approaches can be used to respond to these harms.

A harm minimisation approach recognises that abstinence may not always be an achievable goal, and that it is important to focus on the immediate harm that may result from the use of a particular substance and implement strategies to reduce the risk of harm.

For health practitioners, a harm minimisation approach includes educating a young person about the likely effects of the substance they are using and the potential harm associated with such use. It also includes helping the young person to make healthy choices to reduce those harms. Health practitioners practice harm minimisation when they educate young people about:

- Safe injecting procedures for IV users
- Strategies for reducing alcohol consumption
- Safe sex practices such as condom use
- The increased risks associated with driving, swimming, climbing and other activities while drinking or using drugs
- The risks of mixing drugs
- Safer partying
- How to look after a friend who may be experiencing an overdoes (including the importance of calling 000)
- Where to get help if needed

You can also ask the young person to monitor their drug use. Monitoring can involved keeping a diary or logbook, recording the amounts consumed, patterns of use and high risk situations. It should be done over a period of weeks in order to see patterns emerging

Work with the young person to develop goals based on a shared understanding of the problem. Keep the goals realistic and achievable like cutting down on alcohol/drug use, having drug-free days, or not combining drugs.

COMPREHENSIVE INTERVENTIONS

Young people who have developed substance dependence or an entrenched pattern of abuse require comprehensive management. It may include:

- Referral to specialist drug and alcohol treatment services
- Supervised detoxification
- In-patient treatment
- Substitution – e.g. nicotine chewing gum/ patches; methadone replacement therapy (for over 18 year-olds)
- Collaborative case management – depending on your role, you may be able to play a central role in a treating team of professionals (including drug and alcohol services; mental health services; counsellors)

Wherever possible, involve and work with the family of the young person. The support of parents or carers and family can be instrumental in helping a young person recover from drug or alcohol dependence. Family members and carers can often help you get a fuller understanding of the young person's patterns of substance use. Be prepared to support a young person's parents, carers and family members by offering:

- Education about substance use
- Guidance about parenting strategies and effective responses to the young person's substance use
- Counselling for their own anxiety and stress
- Referral to specialist services for family counselling or other support if needed

QUITTING SMOKING

Stopping smoking is the single most important thing an individual can do to improve their health. It can often be overlooked, particularly for young people if their lives are chaotic and the consequences of smoking can seem a long way removed from their immediate concerns.

Quit smoking programs can be effective with young people. All health professionals should be able to offer information and support to quit smoking for the young people they see.

For advice and information about how you can support a young person to quit smoking, contact:

- National Quitline – 131 848
- National Tobacco Campaign – http://www.quitnow.gov.au
- Cancer Council – www.cancercouncil.com.au
- Smarter Than Smoking – www.smarterthansmoking.org.au
- Oxygen – www.oxygen.org.au
- Quit Coach – www.quitcoach.org.au
- Quit now – www.quitnow.gov.au

CASE STUDY: WORKING WITH ROB

Rob is 18 years old and has come to see you because he is becoming concerned about his drinking. His latest girlfriend, whom he says he loved very much, broke up with him after two months saying that she could not tolerate his drinking. Rob says that he has been drinking heavily on weekends for the past few months and from time to time gets into fights.

You take a drug history. Rob smokes up to 20 cigarettes a day and drinks up to 15 standard drinks on Friday and Saturday nights. He uses marijuana occasionally but no other substances, although has tried speed and ecstasy in the past. He enjoys drinking but is also becoming concerned about the pattern that is now established. He finds he is feeling increasingly aggressive and has trouble controlling his anger.

Rob is unemployed. He currently lives with friends, though this is not working well. He has a longstanding history of family conflict. His father is alcoholic and Rob has little contact with him. Rob finished year 9 at school and would like to complete his education so that he can look for an apprenticeship.

YOUR APPROACH

You talk with Rob about the effects of his alcohol use and he agrees to see you once a fortnight or so. He misses his appointments every now and then, but you focus your interventions on:

- Monitoring his drinking and physical and mental health.
- Motivational interviewing – to explore the costs and benefits of his substance use and to explore alternatives to drinking – such as exercise; recreational activities. You also explore his level of motivation to change and assess his readiness using the Stages of Change model.
- Harm minimisation – you talk to Rob about ways to reduce harm, such as switching to beverages with a lower alcohol content; alternating alcoholic and non-alcoholic beverages; not drinking on an empty stomach; not driving when he has been drinking.
- Collaborative case management – you refer Rob to a GP for a Mental Health Care Plan as his increasing levels of aggression and anger are concerning him. Rob is referred to a private psychologist for counselling. Rob is not interested in abstaining from alcohol, but says he'd be willing to talk to someone about his drinking. You refer him to a drug and alcohol counsellor at the community health centre. Because Rob wants to finish school and get a job, you also refer him to a youth support officer at Centrelink. You also locate a local housing support provider who can help Rob find a more positive living arrangement.

CHAPTER SUMMARY – WHAT TO REMEMBER

Working with young people who have a drug or alcohol problem can be difficult. Young people may be secretive about their use of substances and may be fearful of both the consequences of the use and the consequences of revealing their drug and alcohol history.

It is important to work in a collaborative, non-judgemental way with young people. Tools such as HEEADSSS and CRAFFT can help you identify areas of concern and highlight emerging issues in a young person's health and wellbeing.

It is important to identify possible mental health problems, particularly those that may be associated with drug and alcohol use, and (if indicated) refer the young person for a complete mental health assessment.

Harm minimisation is an important element of any management approach you adopt.

REFLECTION QUESTIONS

How well does your service identify substance use issues in the young people you work with?

Do you routinely ask about substance use?

What approaches are appropriate for your service to take with substance use issues?

What current treatments are available within your service or service network for young people?

How well do staff work with substance use issues? Is any training needed?

Are staff able to provide education in harm minimisation?

What resources are available to you?

Do you know your service network and how to access treatments?

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